

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA**

PLANNED PARENTHOOD SOUTH)	
ATLANTIC, <i>et al.</i> ,)	
)	
Plaintiffs,)	
)	
v.)	
)	
JOSHUA STEIN, <i>et al.</i> ,)	Case No. 1:23-cv-00480-CCE-LPA
)	
Defendants,)	
)	
and)	
)	
PHILIP E. BERGER, <i>et al.</i> ,)	
)	
Intervenor-Defendants.)	

PLAINTIFFS’ MOTION FOR SUMMARY JUDGMENT

Under Federal Rule of Civil Procedure 56(a) and Local Rule 56.1, Plaintiffs Planned Parenthood South Atlantic and Dr. Beverly Gray move for summary judgment on their claims challenging the constitutionality of the Hospitalization Requirement, requiring that abortions after the twelfth week of pregnancy be performed in a hospital,¹ and the IUP Documentation Requirement, requiring that providers document the “existence of an intrauterine pregnancy” before initiating a medication abortion.²

¹ See N.C. Gen. Stat. § 90-21.81A (the “Twelve-Week Ban”); *id.* §§ 90-21.81B(3), 90-21.81B(4) (creating rape, incest, and life-limiting anomaly exceptions to the Twelve-Week Ban); *id.* § 90-21.82A(c) (requiring abortions provided after the twelfth week of pregnancy to be performed in a hospital).

² See N.C. Gen. Stat. § 90-21.83B(a)(7).

As explained more fully in the accompanying brief, summary judgment for Plaintiffs is warranted because the Hospitalization Requirement’s distinction between abortion and miscarriage management is not rationally related to North Carolina’s asserted interest in patient safety, in violation of the Equal Protection Clause of the Fourteenth Amendment. *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 446 (1985); *U.S. Dep’t of Agric. v. Moreno*, 413 U.S. 528, 534 (1973); *Romer v. Evans*, 517 U.S. 620, 632 (1996). Summary judgment for Plaintiffs is further warranted because the IUP Documentation Requirement fails to “include sufficient standards to prevent arbitrary and discriminatory enforcement” or to “give a person of ordinary intelligence adequate notice of what conduct is prohibited,” *Manning v. Caldwell for City of Roanoke*, 930 F.3d 264, 272 (4th Cir. 2019) (en banc), and, moreover, bears no rational relationship to patient safety, *Doe v. Settle*, 24 F.4th 932, 943–44, 953 (4th Cir. 2022), *Romer*, 517 U.S. at 635, all in violation of the Due Process Clause of the Fourteenth Amendment.

Plaintiffs’ motion is supported by their Brief in Support of Plaintiffs’ Motion for Summary Judgment; the Declaration of Katherine Farris, M.D., FAAFP, in Support of Plaintiffs’ Motion for Summary Judgment (Ex. A); the Declaration of Christy M. Boraas Alsleben, M.D., M.P.H., in Support of Plaintiffs’ Motion for Summary Judgment (Ex. B); the transcript of the deposition of Catherine J. Wheeler, M.D. (Ex. C); the transcript of the second deposition of Susan Bane, M.D., Ph.D. (Ex. D); the transcript of the second deposition of Monique Chireau Wubbenhorst, M.D., M.P.H. (Ex. E); the transcript of the September 25, 2023, hearing on Plaintiffs’ motion for a preliminary injunction (Ex. F); and

the existing record in this case, including all previously filed declarations and deposition transcripts.

Plaintiffs respectfully request that this Court grant Plaintiffs' motion for summary judgment; declare the Hospitalization Requirement and IUP Documentation Requirement unconstitutional under the Fourteenth Amendment to the U.S. Constitution; and enter an order permanently enjoining enforcement of these restrictions. Plaintiffs respectfully request the opportunity to present oral argument in support of this motion.

Dated: March 1, 2024

Respectfully submitted,

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**Special appearance filed*

CERTIFICATE OF SERVICE

I hereby certify that, on March 1, 2024, I electronically filed the foregoing with the clerk of the court by using the CM/ECF system, which served notice of this electronic filing to all counsel of record.

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Intervenor-Defendants.)	

**BRIEF IN SUPPORT OF PLAINTIFFS’
MOTION FOR SUMMARY JUDGMENT**

STATEMENT OF THE MATTER

Five months ago, this Court preliminarily enjoined enforcement of two North Carolina abortion restrictions: the Hospitalization Requirement, requiring that abortions after the twelfth week of pregnancy be performed in a hospital,¹ and the IUP Documentation Requirement, requiring that providers document the “existence of an intrauterine pregnancy” before initiating a medication abortion.² The Court’s opinion

¹ See N.C. Gen. Stat. § 90-21.81A (the “Twelve-Week Ban”); *id.* §§ 90-21.81B(3), 90-21.81B(4) (creating rape, incest, and life-limiting anomaly exceptions to the Twelve-Week Ban); *id.* § 90-21.82A(c) (requiring abortions provided after the twelfth week of pregnancy to be performed in a hospital).

² See N.C. Gen. Stat. § 90-21.83B(a)(7).

detailed the facts supporting its conclusions that Plaintiffs were likely to succeed on the merits of their challenges to both laws. Discovery has decisively confirmed the Court’s factual findings.

Abortion procedures are safe—as safe as, and sometimes safer than, equivalent procedures to manage miscarriage. And abortions provided in outpatient clinics are often safer and more affordable than abortions provided in hospitals. As the Court found and the record confirms, there is no health justification for requiring these procedures to be performed in a hospital *only* when provided for the purpose of abortion. DE 80 (PI Order) at 2. And no facts have emerged during discovery contradicting this Court’s conclusion that the IUP Documentation Requirement is unconstitutionally vague. *Id.* If permitted to take effect, these laws will undermine both patient safety and the legislature’s policy choice to make abortion accessible early in pregnancy and in cases of rape, incest, or “life-limiting” anomaly. Plaintiffs therefore seek summary judgment on all claims.

STATEMENT OF FACTS

I. Abortion in North Carolina

Abortion is a basic component of health care and one of the safest medical treatments in the United States. DE 49-1 (Farris PI Decl.) ¶14; DE 49-2 (Boraas PI Decl.) ¶¶21–22, 32; *accord* DE 64 (AG Stein’s Answer) ¶47; DE 55 (DHHS Secretary’s Answer) ¶47. Outpatient clinics in North Carolina provide three methods of abortion: medication abortion, aspiration abortion, and dilation and evacuation (“D&E”). DE 49-1 ¶14.

Medication abortion in the first trimester typically involves two medications: mifepristone and misoprostol. DE 49-1 ¶17; DE 49-2 ¶21; DE 55 ¶48; DE 60 (Licensing Board Defendants' Answer) ¶48. The patient first takes mifepristone and then, usually 24 to 48 hours later, takes misoprostol. DE 49-1 ¶17; DE 55 ¶48; DE 60 ¶48. Together, these medications stop the pregnancy's development and cause uterine contractions that expel the uterus's contents, as in a miscarriage. DE 49-1 ¶17; DE 49-2 ¶21; DE 55 ¶48; DE 60 ¶48. Plaintiffs provide this regimen through eleven weeks of pregnancy. DE 49-1 ¶12; DE 42 (Verified First Am. Compl.) ¶49.

For aspiration abortion, the provider passes a small tube, called a cannula, through the patient's vagina and cervix. DE 49-1 ¶21. The cannula is attached to a syringe or electrical pump that creates suction to empty the uterus. DE 49-1 ¶21; DE 49-2 ¶22. Aspiration abortion involves no incisions, cutting, or suturing. DE 49-1 ¶23; DE 49-2 ¶22. In compliance with the Twelve-Week Ban and its exceptions, PPSAT provides aspiration abortion up to approximately fourteen weeks of pregnancy, as measured from the first day of the patient's last menstrual period ("LMP"). Farris Decl. in Supp. of Pls.' Mot. for Summ. J., attached as **Exhibit A**, ¶22.

For D&E, the provider first dilates the patient's cervix using medications and/or physical dilators, then uses a combination of suction and additional instruments to evacuate the uterus. DE 49-1 ¶26; DE 49-2 ¶35. Like aspiration abortion, D&E does not involve any incisions, cutting, or suturing. DE 49-1 ¶28; DE 49-2 ¶22. Abortion providers generally switch from aspiration to D&E around fifteen weeks LMP, depending on the provider's

practice and the patient’s individual medical characteristics. *See* Ex. A ¶26; DE 74-1 (Boraas Dep.), 58:5–59:4, 151:17–23.

For aspiration and D&E procedures, PPSAT uses local, mild, or moderate sedation, but not deep sedation or general anesthesia. DE 49-1 ¶¶22, 26, 72; DE 74-2 (Farris Dep.) 88:9–25.

While abortion is very safe, abortion remains politically stigmatized in North Carolina. Ex. A ¶76. People seeking abortions, and the medical staff who care for them, face unique and routine prejudice and harassment, which is not the case for any other medical care. *Id.* ¶¶76–77. Abortion providers risk professional retaliation, harassment, and physical violence. *Id.* ¶¶79–82. And though abortion providers in North Carolina are highly trained and provide evidence-based, patient-centered medical care, they face baseless stereotypes that they lack skill and do not care about patient safety. *Id.* ¶78; *e.g.* DE 74-11 (*Chemical Abortion: Protocols for a Risky Business*) at 2–3 (lobbying materials referring to “the negligent and profit-seeking abortion drug industry”).

II. The Hospitalization Requirement Does Not Make Abortion Safer Than It Already Is.

Both medication and procedural abortions can be safely provided in a clinic. DE 49-1 ¶¶14–15, 36, 44; DE 49-2 ¶32; *accord* DE 64 ¶47. PPSAT safely provided abortions in its licensed clinics past the twelfth week of pregnancy for more than fifteen years before the Twelve-Week Ban took effect. DE 49-1 ¶12; *accord* DE 64 ¶¶38, 76.

In fact, because abortion safety is generally a function of the abortion provider’s experience rather than the clinical setting, D&Es can be *safer* in outpatient clinics than in hospitals. DE 80 at 26 & n.15; Ex. A ¶43 & n.35; *see also* DE 74-3 (1st Wubbenhorst Dep.) 131:22–132:1 (Intervenors’ witness acknowledging research supporting this fact). And abortions at outpatient clinics are often more affordable, easier to navigate, and less time-consuming for patients than abortions at hospitals. DE 80 at 26; Ex. A ¶41; DE 49-2 ¶38. Abortions in cases of rape, incest, or “life-limiting” anomaly are usually technically identical to abortions sought for other reasons, and thus can be provided safely in clinics. Ex. A ¶57; Wheeler Dep., attached as **Exhibit C**, 110:20–111:6, 114:17–21, 184:17–20. Indeed, hospital providers in North Carolina refer patients with “life-limiting” anomalies to PPSAT for abortions. Ex. A ¶8.

While the risks associated with abortion increase as gestation progresses, abortion remains very safe throughout pregnancy. DE 80 at 24; Ex. A ¶93; Boraas Decl. in Supp. of Pls.’ Mot. for Summ. J., attached as **Exhibit B** ¶28. Complications from abortion are rare. Ex. A ¶47; *accord* DE 64 ¶47. PPSAT performed 43,339 abortions in North Carolina between January 1, 2020 and December 31, 2023; 596 complications resulted, most of which were minor, such as ongoing pregnancy (201 cases), retained tissue (210 cases), or pain/bleeding less than hemorrhage (105 cases). Ex. A. ¶51; *id.* Ex. 3 (Bates 0146).

The vast majority of abortion complications are treated in outpatient facilities. Ex. A ¶47; *accord* DE 64 ¶47. For example, hemorrhage, uterine infection, cervical laceration,

and uterine perforation can all be treated in a clinic. *See* Ex. A ¶¶46–51; DE 74-1, 170:17–173:7; *accord* DE 74-4 (1st Bane Dep.) 94:18–95:1, 104:20–23.

Research demonstrates that major abortion complications, defined as those requiring hospital admission, surgery, or blood transfusion, occur in just 0.23% of abortions. Ex. A ¶32; *accord* DE 64 ¶¶53, 69; DE 55 ¶¶53, 69. PPSAT has relationships with hospitals near its clinics and emergency management protocols in the rare event that hospital transfer is needed. Ex. A ¶53. Of the 43,339 abortions PPSAT provided from 2020–2023, just 34 (0.078%) resulted in complications requiring hospital transfer. *Id.* All patients were treated and released in stable condition, and only 7 of the 34 were admitted. *Id.*

III. The Hospitalization Requirement Uniquely Burdens Abortion Without Medical Justification.

There is no medical reason to mandate that abortions occur in a hospital, while permitting the same procedures to be performed in clinics for miscarriage management. Ex. B ¶¶18, 20.

“Miscarriage” is when a pregnancy is ending on its own. If the person’s body does not expel the pregnancy, medical treatment, known as “miscarriage management,” is needed to empty the uterus. *See* Ex. A ¶¶18, 25, 29; Ex. B ¶17 n.6. Aspiration and D&E are used for both abortion and miscarriage management. Ex. A ¶¶25, 29; Ex. B ¶¶18, 20; *see* DE 64 ¶73; DE 74-4, 28:12–17, 29:18–20; DE 74-3, 114:19–21; Ex. C, 151:10–22.

It is undisputed that every complication that could result from aspiration or D&E

for induced abortion could *also* result from those same procedures for miscarriage management. Tr. of Prelim. Inj. Proceedings, attached as **Exhibit F**, 120:20–121:5; Ex. A ¶¶25, 29; Ex. C, 147:10-21, 153:1-16, 153:23-25, 154:12–155:14. Complication rates are *higher* for miscarriage than for abortion. Ex. A ¶37 & n.28. And D&E for miscarriage management carries a higher risk of disseminated intravascular coagulopathy (“DIC”), a dangerous clotting disorder, than D&E for induced abortion. *Id.* ¶29 & n.12; *see also* 2nd Bane Dep., attached as **Exhibit D**, 64:16–20.

Although abortion is less risky than miscarriage management, North Carolina requires hospitalization for abortion—but not miscarriage management—after the twelfth week of pregnancy. N.C. Gen. Stat. § 90-21.81(9b)(c) (excluding removal of dead embryo or fetus from definition of “surgical abortion” and, thus, from hospitalization requirement); *see* DE 64 ¶73.

Procedural abortions are similar in technique and risk to certain outpatient diagnostic gynecology procedures. DE 49-1 ¶¶24, 28, 36–44. And abortion is safer than other procedures routinely performed outside of hospital settings, including vasectomies, colonoscopies, and tonsillectomies. DE 49-1 ¶32; DE 64 ¶74.

Complications from term pregnancy and childbirth are far more common than abortion-related complications. Ex. A ¶34; DE 74-1, 92:3–10, 173:8–175:5; *see also* DE 74-4, 94:4–13; 100:5–16; 101:16–23; 103:17–21. The mortality rate for childbirth is approximately 12 to 14 times greater than the rate for abortion. Ex. A ¶35; *accord* DE 64 ¶70; DE 55 ¶70. Yet North Carolina does not require childbirth to occur in a hospital. N.C.

Gen. Stat. § 90-178.4 (as amended by S.B. 20, § 4.3(d), effective Oct. 1, 2023) (providing for “planned birth outside of a hospital setting”).

IV. The IUP Documentation Requirement

North Carolina requires an ultrasound prior to every abortion. 10A N.C. Admin. Code 14E.0305(d), *replaced by* 10A N.C. Admin. Code 14E.0321(d) (effective July 18, 2023). Before the fifth or sixth week of pregnancy, pregnancy tissue may not be visible even by transvaginal ultrasound. DE 80 at 15; Ex. B ¶¶43; DE 49-1 ¶¶49. Patients in this situation are categorized as having pregnancies of unknown location. DE 49-1 ¶¶9.

Using evidence-based practices, PPSAT screens these patients for risk of ectopic pregnancy—a pregnancy that has implanted outside the uterus—by asking questions about their menstrual history, pregnancy history, contraceptive history, and current symptoms. Ex. A ¶¶63 & n.48. If PPSAT determines that the patient is at elevated risk of ectopic pregnancy, the patient is immediately referred to another provider, typically an emergency department, for diagnosis and treatment. *Id.*

Otherwise, PPSAT offers three options: medication abortion; aspiration abortion; or a follow-up appointment when the pregnancy may be visible by ultrasound. *Id.* ¶¶64; DE 74-2, 163:18–164:8. If a low-risk patient chooses medication abortion, PPSAT simultaneously provides the medication abortion and conducts testing to rule out ectopic pregnancy: serial blood draws to test the levels of the pregnancy hormone human chorionic gonadotropin (“hCG”); repeat ultrasounds where feasible; and close follow-up by a clinician. Ex. A ¶¶65–68; DE 74-2, 164:9–24. All patients are educated on signs and

symptoms of both medication abortion and ectopic rupture, and are warned both verbally and in writing of the dangers of untreated ectopic pregnancy. Ex. A ¶¶72; DE 74-15 (PPSAT Patient Education Materials). If this concurrent testing or post-abortion symptoms suggest possible ectopic pregnancy, PPSAT further evaluates the patient and refers them to an emergency department when indicated, even if the patient has already taken the abortion medications. Ex. A ¶¶66–68.

PPSAT’s protocol is evidence-based and has been found to be safe and effective. *See* DE 49-2 ¶¶44–47. It does not delay detection of ectopic pregnancy, and one study concluded that this protocol leads to *earlier* exclusion of ectopic pregnancy than waiting until an intrauterine pregnancy can be seen by ultrasound. *Id.* ¶46 & n.23; DE 69-1 (Boraas PI Reply Decl.) ¶49 & n.61; Ex. A ¶69 & n.50.

Medication abortion does not make ectopic pregnancy more dangerous. DE 80 at 14–15; Ex. A ¶71; DE 69-2 (Farris PI Reply Decl.) ¶11. Rather, medication abortion is contraindicated for patients with confirmed or suspected ectopic pregnancies because it does not treat ectopic pregnancy. DE 80 at 13; Ex. A ¶71; DE 69-1 ¶50; DE 74-2, 155:11–14; DE 74-3, 143:19–21. Mifepristone is not contraindicated where ectopic pregnancy is not suspected. *See* DE 65-2 (FDA Mifeprex Label) at 4; *see also* DE 74-2, 102:22–103:6, 108:2–7, 110:10–19, 162:3–14, 168:17–23; DE 74-1, 127:6–16, 145:20–146:1.

It is undisputed that the IUP Documentation Requirement itself does not require evaluation or treatment for ectopic pregnancy. Ex. A ¶70; *accord* DE (Intervenors’ PI Opp.) 65 at 24; Ex. C, 233:20–234:8; 2nd Wubbenhorst Dep., attached as **Exhibit E**,

61:22–25; Ex. F, 87:21–88:6. And if a patient with a pregnancy of unknown location were referred to a hospital for evaluation instead of receiving a medication abortion, the hospital would generally perform the very same serial blood testing that Plaintiffs perform *simultaneously* with the medication abortion. DE 49-1 ¶59; DE 49-2 ¶48; *see also* DE 74-4, 117:22–118:25. Referring a patient for evaluation instead of providing a medication abortion therefore does not lead to earlier or more accurate diagnosis of ectopic pregnancy. DE 49-1 ¶59; DE 49-2 ¶50. Instead, it just delays the patient’s abortion. DE 49-1 ¶59; DE 49-2 ¶48; *see* DE 55 ¶15.

QUESTIONS PRESENTED

Have Plaintiffs demonstrated that there is no genuine dispute as to any material fact and that they are entitled to summary judgment on their claims that:

1. The Hospitalization Requirement violates the Equal Protection Clause?
2. The IUP Documentation Requirement violates the Due Process Clause?

ARGUMENT

I. Legal Standard

Summary judgment is proper where “there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law.” *Design Res., Inc. v. Leather Indus. of Am.*, 789 F.3d 495, 500 (4th Cir. 2015) (citing Fed. R. Civ. P. 56(a)). While courts must draw all reasonable inferences in the light most favorable to the nonmoving party, the nonmovant bears the burden of demonstrating that a dispute of *material* fact exists.

Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 255 (1986). The nonmovant “must provide more than a scintilla of evidence—and not merely conclusory allegations or speculation—upon which a jury could properly find in its favor.” *Design Res., Inc.*, 789 F.3d at 500 (citation omitted) (quoting *CoreTel Va., LLC v. Verizon Va., LLC*, 752 F.3d 364, 370 (4th Cir. 2014)).

II. The Hospitalization Requirement Irrationally Distinguishes Between Abortion and Miscarriage Management.

The Hospitalization Requirement violates the Equal Protection Clause of the Fourteenth Amendment because—as this Court already found and as the full record confirms—its distinction between abortion and miscarriage management is not rationally related to North Carolina’s asserted interest in patient safety.³ No evidence supports subjecting patients seeking abortion to the increased expense, logistical burden, and even heightened risk of a hospital setting, while exempting patients seeking the *very same procedures* for a different purpose.⁴

Although rational basis is a deferential standard, it is not “toothless.” *See, e.g., Matthews v. Lucas*, 427 U.S. 495, 510 (1976); *St. Joseph Abbey v. Castille*, 712 F.3d 215, 223 (5th Cir. 2013) (“[P]laintiffs may . . . negate a seemingly plausible basis for the law by adducing evidence of irrationality.”). Legislative classifications “must rest upon some ground of difference having a fair and substantial relation to the object of the legislation.”

³ *See* Ex. F, 98:6–16; DE 65 (Intervenors’ PI Opp.) at 2, 8; DE 49 at 11.

⁴ N.C. Gen. Stat. § 90-21.81(9b)(c).

Eisenstadt v. Baird, 405 U.S. 438, 447 (1972). Comparators need not be alike in every way; rather, rational basis review asks whether there are differences between them that relate to the purpose of the challenged law. *Catherine H. Barber Mem'l Shelter, Inc. v. Town of N. Wilkesboro Bd. of Adjustment of Town of N. Wilkesboro*, 576 F. Supp. 3d 318, 338 (W.D.N.C. 2021) (granting summary judgment to plaintiff under rational basis review).

It remains undisputed that aspiration and D&E procedures after the twelfth week of pregnancy are performed with the same clinical techniques and carry the same risks whether performed for abortion or miscarriage management. DE 80 at 23–24, 31–32; Ex. A ¶46; Ex. F, 121:3–5 (undisputed that the same types of complications may arise from abortion and miscarriage management); *see also, e.g.*, Ex. C, 147:15–21 (Intervenors' witness explaining D&E for miscarriage management can cause trauma to the endometrial cavity and cervix); 153:1–3 (same for hemorrhage); 153:23–155:14 (same for infection, cervical laceration, retained products of conception, uterine perforation, abnormal placentation, and embolism). Indeed, as the Court found, when used for abortion these procedures are just as safe as—and can be *safer* than—the same procedures when used for miscarriage management. DE 80 at 24, 26; *supra* Facts, Part III. Intervenors' experts could not identify any research to the contrary. Ex. C, 185:7–13; Ex. D, 55:25–56:8.

Abortion and miscarriage management after the twelfth week of pregnancy are thus similarly situated for purposes of patient safety. DE 80 at 29–30; *Eisenstadt*, 405 U.S. at 450–52. The Hospitalization Requirement treats the same procedures differently “based on the reason the patient needs or wants the procedure, not based on any medical difference

between the procedures or on differing risks.” DE 80 at 30. This classification is “so attenuated” from patient safety “as to render the distinction arbitrary or irrational.” *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 446 (1985).

Moreover, it is not rational to require *all abortion patients* to be hospitalized simply because an exceedingly small number may experience a complication requiring hospitalization. DE 69-2 ¶8; DE 69-1 ¶¶30–34; *O’Day v. George Arakelian Farms, Inc.*, 536 F.2d 856, 860 (9th Cir. 1976) (finding a law irrational where it was “grossly excessive” in relation to government interest). Complications from aspiration and D&E abortions are rare, and can almost always be safely managed in an outpatient clinic. Ex. A ¶¶32–33, 47, 53 (outlining PPSAT transfer protocols and exceptionally low percentage (0.078%) of patients needing transfer from 2020–2023, all of whom were treated and released in stable condition, with only 7 out of 43,339 abortions (0.016%) requiring hospital admission); *see* Ex. B, ¶22. Because hospitalization is not required for miscarriage management, or for riskier procedures like vasectomies or colonoscopies, *supra* Facts, Part III, here “the state seems indifferent to complications from non-hospital procedures other than surgical abortion (especially other gynecological procedures), even when they are more likely to produce complications.” *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 790 (7th Cir. 2013); DE 80 at 29–30.

The Hospitalization Requirement is especially irrational because it applies only to survivors of rape or incest and patients with grave fetal diagnoses. N.C. Gen. Stat. §§ 90-21.81B(3), 90-21.81B(4). The legislature made a policy decision to protect access to

abortion in these circumstances. But the Hospitalization Requirement reduces the number of providers available to these patients, especially if they have lower incomes or live in rural areas. Ex. A ¶¶ 83, 89–93; accord DE 55 ¶16; *Hooper v. Bernalillo Cnty. Assessor*, 472 U.S. 612, 619–23 (1985) (finding no rational basis for legislative classification that ran contrary to government’s purported goals). The Hospitalization Requirement therefore makes accessing abortion even more challenging for people already facing hardships due to the circumstances of their pregnancies.

And it does so without any medical justification. A pregnancy resulting from rape or incest does not increase the patient’s medical risk, and there is no difference in the technical performance of a D&E in these circumstances. Ex. C, 110:20–111:6; 184:17–20. Similarly, “life-limiting” anomalies usually do not make pregnancy riskier or change how a procedural abortion is performed. Ex. A ¶57; Ex. C, 114:17–21, 184:5–7. There is therefore no safety reason to require abortions in these circumstances to be provided in a hospital. Indeed, PPSAT has received referrals from North Carolina hospitals for patients seeking abortion after the twelfth week of pregnancy due to a “life-limiting” anomaly. Ex. A ¶57.

Licensed abortion clinics offer particular benefits over hospitals. PPSAT physicians and staff are trained to provide trauma-informed care and equipped to work with law enforcement if a patient desires. Ex. A ¶¶95–96. At a licensed abortion clinic, patients can trust that their care team—from the front desk staff to the physician performing their procedure—will respect their reproductive decisionmaking. DE 49-1 ¶76; DE 49-2 ¶37.

While there are excellent physicians and staff providing compassionate, patient-centered care in hospital settings, abortion is a uniquely stigmatized procedure, and patients are *more likely* to encounter judgment and providers who refuse to participate in abortions⁵ at a hospital than at a licensed abortion clinic in North Carolina. DE 49-1 ¶76; DE 49-2 ¶37.

Far from advancing North Carolina’s interest in patient health and safety, the Hospitalization Requirement would harm patients. *See Hooper*, 472 U.S. at 619–23. Patients may be more likely to encounter an inexperienced abortion provider at a North Carolina hospital, increasing the risk of the abortion procedure relative to one provided by an experienced provider in a specialized clinic setting. Ex. A ¶¶43, 94. Hospital abortions can be prohibitively expensive, and even patients who can ultimately afford them may be delayed by the need to seek additional funds. DE 80 at 32; Ex. A ¶90. In turn, any delay increases the patient’s medical risk, because while abortion is very safe, it is undisputed that its risks increase with gestational age. DE 80 at 25; Ex. A ¶93; Ex. B ¶28; Ex. F, 72:11–16.

The Hospitalization Requirement is therefore not rationally related to a purported government interest in patient safety. *See Planned Parenthood of Ind. & Ky., Inc. v. Comm’r, Ind. Dep’t of Health*, 64 F. Supp. 3d 1235, 1257 (S.D. Ind. 2014).

Absent a health-related justification, the only remaining purpose for the Hospitalization Requirement is a “bare desire to harm” people who seek or provide

⁵ *See, e.g.*, N.C. Gen. Stat. § 90-21.81C(e), -(f).

abortion, which is not a legitimate state interest. *Cleburne Living Ctr.*, 473 U.S. at 447, 448, 450 (reasoning, after ruling out other purported justifications, that only impermissible animus towards persons with intellectual disabilities could have motivated the challenged regulation); *U.S. Dep't of Agric. v. Moreno*, 413 U.S. 528, 534 (1973); *Romer v. Evans*, 517 U.S. 620, 632 (1996) (requiring a rational relationship to a legitimate legislative end “ensure[s] that classifications are not drawn for the purpose of disadvantaging the group burdened by the law”). Abortion is not “so special a case that all other professional rights and medical norms go out the window.” *Stuart v. Camnitz*, 774 F.3d 238, 255–56 (4th Cir. 2014).

Because the Hospitalization Requirement is not rationally related to a legitimate government interest, it fails rational basis review, and Plaintiffs should be granted summary judgment.

III. The IUP Documentation Requirement Is Unconstitutionally Vague.

To survive Plaintiffs’ vagueness challenge, the IUP Documentation Requirement must “include sufficient standards to prevent arbitrary and discriminatory enforcement” and “give a person of ordinary intelligence adequate notice of what conduct is prohibited.” *Manning v. Caldwell for City of Roanoke*, 930 F.3d 264, 272 (4th Cir. 2019) (en banc); see also *Sessions v. Dimaya*, 138 S. Ct. 1204, 1212 (2018); *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972). As this Court has already held, DE 80 at 18, the IUP Documentation Requirement does neither, and no evidence has emerged that would change this Court’s preliminary determination.

As the Court noted, “providers cannot be sure whether they are facing only civil and quasi-criminal penalties” or “criminal sanctions” for violating the IUP Documentation Requirement. *Id.* Intervenor has taken inconsistent positions, arguing in briefing that the Act *does* impose criminal penalties, while stating at oral argument that the Act imposes *only civil* penalties. *Compare, e.g.,* DE 65 at 18, *with* DE 80 at 21; Ex. F, 95:9–19. Abortion “[p]roviders are entitled to ‘reasonable notice’ of whether they can be criminally prosecuted for violating this provision.” DE 80 at 21 (citing *Johnson v. U.S.*, 576 U.S. 591, 596 (2015)). Failing to provide such notice makes the law impermissibly vague. *See Bittner v. U.S.*, 598 U.S. 85, 102 (2023) (noting the “Due Process Clause’s promise that ‘a fair warning should be given to the world in language that the common world will understand, of what the law intends to do if a certain line is passed’” (citing *McBoyle v. U.S.*, 283 U.S. 25, 27 (1931))).

Moreover, laws with criminal penalties demand a “stricter standard” of review for vagueness than laws that impose purely civil punishments. *See Manning*, 930 F.3d at 272–73; *Vill. of Hoffman Ests. v. Flipside, Hoffman Ests. Inc.*, 455 U.S. 489, 498 (1982). Even “laws that nominally impose only civil consequences warrant a ‘relatively strict test’ for vagueness if the law is ‘quasi-criminal’ and has a stigmatizing effect,” *Manning*, 930 F.3d at 272–73, by, for example, imposing “significant civil and administrative penalties, including fines and license revocation,” *Women’s Med. Ctr. of Nw. Houston v. Bell*, 248 F.3d 411, 422 (5th Cir. 2001). Because the Act unquestionably contains quasi-criminal

penalties—and because criminal penalties are “likely,” DE 80 at 20–21⁶—this Court correctly determined that, “whether applying the strict standard required when criminal prosecution is a possibility or the relatively strict standard when quasi-criminal sanctions are possible, the IUP requirement in the Act is unconstitutionally vague.” *Id.* at 21.

Because discovery has produced nothing that would alter this conclusion, the Court’s initial reasoning still applies. The IUP Documentation Requirement is vague because it fails to make clear what an abortion provider must *actually do*. The Act provides that, prior to providing a medication abortion, “[a] physician . . . shall . . . [d]ocument in the woman’s medical chart the probable gestational age and existence of an intrauterine pregnancy.” N.C. Gen. Stat. § 90-21.83B(a)(7). The Attorney General and Intervenors interpret this provision differently, underscoring its vagueness. The Attorney General has argued “that the provider must only determine that there is a ‘probable existence of an intrauterine pregnancy.’” DE 80 at 19. But as this Court noted, even if the IUP Documentation Requirement were construed as the Attorney General suggests, it would remain unclear how certain the provider’s determination must be. DE 80 at 19, 22. PPSAT screens patients with pregnancies of unknown location for risk of ectopic pregnancy, and only low-risk patients are offered medication abortion. Ex. A ¶¶63–65. But the law does

⁶ The North Carolina Medical Board may discipline physicians who violate the Act. N.C. Gen. Stat. § 90-21.88A. Physicians who perform an abortion in knowing or reckless violation of the Act are subject to civil actions for damages and fees. *Id.* §§ 90-21.88(a), - (c). Additionally, providing an abortion that does not fit within the exceptions to the Twelve-Week Ban is a felony offense. *Id.* §§ 90-21.81A, 90-21.81B; *see also id.* §§ 14-44, -45, -23.7(1).

not indicate whether this safe, evidence-based protocol is legally sufficient to satisfy the IUP Documentation Requirement. And Intervenor has claimed that the provider must be *certain* the pregnancy is intrauterine and must “rule out” ectopic pregnancy to proceed with medication abortion. DE 80 at 19. Thus, although the Attorney General’s “interpretation seems more likely,” *id.*, the IUP Documentation Requirement nevertheless “specifies no standard of conduct,” thereby leaving “uncertainty about . . . what specific conduct is covered by the statute and what is not.” *Manning*, 930 F.3d at 274–75, 278.

The IUP Documentation Requirement thus lacks *any* standards that might guide a physician—or the law’s enforcers—in determining that an intrauterine pregnancy is “probable,” let alone the “explicit standards” that are constitutionally required to avert vague criminal and quasi-criminal laws. *See Grayned*, 408 U.S. at 107–08. Plaintiffs still face a regulatory “trap” and lack “fair warning” of what is proscribed and what is permitted. This all but invites “arbitrary and discriminatory enforcement,” *even if* the Attorney General’s reading of the requirement is correct. *See* DE 80 at 17, 20 (“The Act itself provides no standards for how certain the provider must be before documenting the probable existence of an intrauterine pregnancy.”); Ex. F, 116:9–17 (counsel for the Attorney General explaining that vague laws hamper law enforcement).

Additionally, the IUP Documentation Requirement is vague because, to the extent it bans medication abortion in the earliest weeks of pregnancy, it directly contradicts another provision of the Act, which provides that “it *shall not be unlawful* to procure or cause a miscarriage or an abortion in the State of North Carolina . . . [d]uring the first 12

weeks of a woman’s pregnancy *when a medical abortion is procured.*” N.C. Gen. Stat. § 90-21.81B(2) (emphasis added). As this Court observed, this contradiction “enhance[s]” the “vagueness problem” of the statute, creating a situation in which “[p]roviders cannot know if medical abortion is authorized at any point through the twelfth week, as the statute explicitly says, or if the procedure is implicitly banned in early pregnancy.” DE 80 at 20. To the extent the IUP Documentation Requirement prohibits the earliest medication abortions, its direct conflict with another provision of the same Act leaves “a person of ordinary intelligence” without “adequate notice of what conduct is prohibited.” *Manning*, 930 F.3d at 272; *Raley v. Ohio*, 360 U.S. 423, 438 (1959).

As a matter of law, the IUP Documentation requirement is unconstitutionally vague. Accordingly, Plaintiffs are entitled to summary judgment on this claim.

IV. If the IUP Documentation Requirement Bans Early Medication Abortion, It Is Irrational.

If the Court concludes that the IUP Documentation Requirement is not vague and instead requires PPSAT to document that an intrauterine pregnancy is visible by ultrasound before providing a medication abortion, it is undisputed that the Requirement would ban medication abortion in the first five or six weeks of pregnancy. DE 80 at 15. So interpreted, the IUP Documentation Requirement violates the Due Process Clause because it has no rational relationship to patient safety. *See Doe v. Settle*, 24 F.4th 932, 943–44, 953 (4th Cir. 2022) (“A substantive due process challenge is considered under rational-basis review unless some fundamental right is implicated.”); *Romer*, 517 U.S. at 635 (holding that a law

is irrational if its requirements are “so far removed from [its] particular justifications that . . . it [is] impossible to credit them”). First, it prohibits patients from obtaining abortions at the point in pregnancy when abortion is safest. Second, it does nothing to facilitate prompt screening and treatment for ectopic pregnancy, despite Intervenor’s suggestion that this is its purpose. Instead, it only delays patients’ access to urgently desired medical care by proscribing what this Court deemed an “established,” evidence-based protocol for “safely administering medical abortion before the pregnancy can be seen on an ultrasound but where screening about the patient’s medical history and symptoms permit a physician to determine that an ectopic is unlikely.” DE 80 at 19.

It is undisputed that abortion is safest earlier in pregnancy. *See, e.g.*, Ex. A ¶93; *accord* Ex. F, 72:11–16; DE 74-3, 64:14–65:5; DE 65-1 (Wubbenhorst PI Decl.) ¶38; DE 65-3 (Bane PI Decl.) ¶35. Indeed, the Act’s express authorization of medication abortion through the twelfth week of pregnancy indicates the legislature’s policy preference that abortions occur early in pregnancy. *See* N.C. Gen. Stat. § 90-21.81B(2). Intervenor’s interpretation of the IUP Documentation Requirement, however, would *prohibit* a medication abortion during the earliest weeks of pregnancy. And Intervenor concedes that it will force some patients to obtain medication abortions later in pregnancy, *see* DE 75 (Intervenor’s Supp. Br.) at 10, when the medical risks have increased, DE 65 at 3.

Intervenor instead claim that it is unsafe to provide medication abortion until an ectopic pregnancy has been definitively ruled out. *See, e.g.*, Ex. E, 58:10–14; DE 74-4, 142:24–143:14. The FDA’s mifepristone label is Intervenor’s “primary evidence” on this

point. *See* Ex. F, 91:6–20, 117:13–17. Although the FDA label indicates that mifepristone is “contraindicated” for “confirmed or suspected ectopic pregnancy,” that is because mifepristone “is not effective for terminating ectopic pregnancies.” DE 65-2 at 4. It is undisputed that mifepristone does not increase the likelihood of a negative outcome from an ectopic pregnancy. *See, e.g.*, Ex. F, 88:7–15; DE 74-3, 143:15–18.

Moreover, PPSAT *does not provide* medication abortion to patients with “confirmed or suspected” ectopic pregnancies. Rather, PPSAT’s protocol is designed to ensure that medication abortion is administered only to patients with pregnancies of unknown location who are at low risk of ectopic pregnancy. *See* Ex. A ¶¶62–63. Mifepristone is not contraindicated for pregnancies of unknown location, where ectopic pregnancy is neither “confirmed” nor “suspected.” *See, e.g.*, Ex. C, 220:9–11; DE 74-4, 109:12–14. And there is no material disagreement that a pregnancy of unknown location, without additional ectopic pregnancy risk factors, is not equivalent to a confirmed or suspected ectopic pregnancy. *See* Ex. C, 222:1–16; Ex. E, 54:4–24 (stating that “ectopic pregnancy should be suspected” when a patient has a pregnancy of unknown location *and* additional clinical findings are present). As one of Intervenor’s witnesses conceded, pregnancies should not be assumed to be ectopic until proven otherwise. Ex. C, 220:24–221:1.

Further, as this Court recognized, the FDA label provides that “the medication can safely be administered *even if* an ectopic pregnancy cannot be definitively ruled out, so long as the patient is appropriately monitored.” DE 80 at 20 (emphasis added) (citing DE 65-2 at 7). At PPSAT, patients with a pregnancy of unknown location are educated

specifically about ectopic pregnancy’s risks and symptoms and are closely monitored after receiving a medication abortion. Ex. A ¶¶63–66, 72; DE 74-15. Because PPSAT’s protocol ensures that such patients are “appropriately monitored,” medication abortion “can safely be administered,” even if it is too early to see an intrauterine pregnancy on ultrasound. DE 80 at 16, 19, 20. Intervenors have not identified a single patient who suffered a negative outcome as a result of PPSAT’s protocol. *See, e.g.*, DE 74-3, 153:18–21.

It is undisputed that PPSAT’s protocol for pregnancies of unknown location does not delay detection of ectopic pregnancy, and can even lead to *earlier* exclusion of ectopic pregnancy than waiting to see if an intrauterine pregnancy can be detected later. Ex. A ¶ 69 & n.50; *accord* Ex. D, 35:24–36:16. By contrast, and as Intervenors agree, nothing in the IUP Documentation Requirement requires patients with pregnancy of unknown location to receive *any* further screening for ectopic pregnancy. *See* DE 80 at 16; DE 65 at 24 (“The IUP documentation requirement neither commands nor prevents a physician from ‘referring a patient for ectopic evaluation.’”); Ex. E, 61:22–25; Ex. F, 87:21–88:6. Thus, if Intervenors’ purported justification for the IUP Documentation Requirement is the prompt diagnosis of ectopic pregnancy, it (as interpreted by Intervenors) is plainly irrational because it makes such a prompt diagnosis *less* likely. *Cf. Van Hollen*, 738 F.3d at 790 (finding irrationality where abortion restriction evinced “indifferen[ce]” to unregulated gynecological procedures “even when they are more likely to produce complications”).

Because it is undisputed that the IUP Documentation Requirement delays patients seeking medication abortion and does nothing to identify or treat ectopic pregnancy,

undermining both patient safety and the legislature's own policy aims, Plaintiffs are entitled to summary judgment on their claim that it violates the Due Process Clause.

V. This Court Should Grant Declaratory and Permanent Injunctive Relief.

The Court should declare that the Hospitalization Requirement violates the Equal Protection Clause and that the IUP Documentation Requirement violates the Due Process Clause. Plaintiffs have demonstrated an “actual controversy,” which is synonymous with Article III’s case and controversy requirement. *See* DE 80 at 7–10; *Volvo Constr. Equip. N. Am., Inc. v. CLM Equip. Co., Inc.*, 386 F.3d 581, 592–93 (4th Cir. 2004) (describing criteria for declaratory relief). This Court has independent jurisdiction over Plaintiffs’ claims under 28 U.S.C. §§ 1331 and 1343(a). And declaratory relief “will serve a useful purpose in clarifying and settling the legal relations in issue.” *Volvo Constr. Equip.*, 386 F.3d at 594 (internal quotations omitted).

Permanent injunctive relief against both restrictions is also warranted because enforcement will irreparably harm Plaintiffs and their patients. Ex. A ¶¶8–10, 83–103. Further, the loss of constitutional freedoms unquestionably constitutes irreparable injury, *see Elrod v. Burns*, 427 U.S. 347, 373–74 (1976) (plurality opinion), and monetary damages would be inadequate to compensate for these constitutional harms, *Legend Night Club v. Miller*, 637 F.3d 291, 302–03 (4th Cir. 2011). Defendants and Intervenors will not be harmed by the issuance of an injunction that prevents enforcement of an unconstitutional restriction, *id.*; *Centro Tepeyac v. Montgomery Cnty.*, 722 F.3d 184, 191 (4th Cir. 2013), and upholding constitutional rights serves the public interest, *Newsom ex rel. Newsom v.*

Albemarle Cnty. Sch. Bd., 354 F.3d 249, 261 (4th Cir. 2003).

CONCLUSION

For these reasons, Plaintiffs respectfully request that this Court grant Plaintiffs' motion for summary judgment, declare the Hospitalization Requirement and IUP Documentation Requirement unconstitutional, and enter an order permanently enjoining enforcement of these restrictions.

Dated: March 1, 2024

Respectfully submitted,

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CERTIFICATE OF WORD COUNT

Relying on the word count function of Microsoft Word, I hereby certify that this brief is 6,243 words in length and, therefore, complies with the 6,250 word limitation prescribed by Local Rule 56.1(c) and the Court's text order of October 24, 2023, adopting the parties' Amended Joint Rule 26(f) Report.

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CERTIFICATE OF SERVICE

I hereby certify that, on March 1, 2024, I electronically filed the foregoing with the clerk of the court by using the CM/ECF system, which served notice of this electronic filing to all counsel of record.

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EXHIBIT A

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA**

PLANNED PARENTHOOD SOUTH)	
ATLANTIC, <i>et al.</i> ,)	
)	
Plaintiffs,)	
)	
v.)	
)	
JOSHUA STEIN, <i>et al.</i> ,)	Case No. 1:23-cv-00480-CCE-LPA
)	
Defendants,)	
)	
and)	
)	
PHILIP E. BERGER, <i>et al.</i> ,)	
)	
Intervenor-Defendants.)	

**DECLARATION OF KATHERINE FARRIS, M.D., FAAFP, IN SUPPORT OF
PLAINTIFFS’ MOTION FOR SUMMARY JUDGMENT**

I, Katherine Farris, M.D., FAAFP, declare as follows:

1. I am a physician licensed to practice medicine in North Carolina, South Carolina, West Virginia, and Virginia. I am board-certified by the American Board of Family Physicians in family medicine and have been awarded the degree of Fellow of the American Academy of Family Physicians.

2. I have been employed by Planned Parenthood South Atlantic (“PPSAT”) since 2009 in various capacities as a medical doctor. Since July 2013, I have been PPSAT’s Interim Affiliate Medical Director, then Affiliate Medical Director, then Chief Medical Officer. (From 2013 to 2015, the Planned Parenthood affiliate in North Carolina was named

“Planned Parenthood Health Systems, Inc.”). As Chief Medical Officer, I am responsible for ensuring the high quality of the medical care that we provide to patients. In this position, I provide oversight, supervision, and leadership on all medical services we provide, including abortion. As part of my role, I collaborate with other members of PPSAT senior management to develop policies and procedures to ensure that the medical services we provide follow evidence-based guidelines and comply with all relevant laws.

3. I also provide direct medical services for PPSAT. Specifically, I provide a range of family planning and reproductive health care to patients, including (among other things) both medication and procedural abortion, as well as miscarriage care, referrals for ectopic pregnancy care, contraception, and advanced gynecological care—such as complicated intrauterine device (“IUD”) and Nexplanon removals (Nexplanon is a birth control implant placed under the skin in the upper arm)—at PPSAT’s North Carolina health centers in Winston-Salem, Charlotte, and Asheville (and periodically in Fayetteville, Wilmington, and Chapel Hill), as well as in the other states in which I am licensed.

4. I earned my medical degree from the Northwestern University Medical School in 2000 and completed my residency at Valley Medical Center Family Practice, where I was Chief Resident in my last year. I am often called upon to present at educational institutions as an expert in abortion care and provider advocacy.

5. The facts I state here and the opinions I offer are based on my education, my years of medical practice, my expertise as a doctor and specifically as an abortion provider, my personal knowledge, my review of PPSAT’s business records, information obtained

through the course of my duties at PPSAT, and my familiarity with relevant medical literature and statistical data recognized as reliable in the medical profession—including but not limited to the materials cited here.

6. A copy of my *curriculum vitae* is attached as **Exhibit 1**.

SUMMARY OF OPINIONS

7. I submit this Declaration in support of PPSAT’s and Dr. Beverly Gray’s Motion for Summary Judgment against North Carolina Session Law 2023-14 (“S.B. 20”), as amended by 2023 House Bill 190 (“H.B. 190”), which is codified at Article 1I of Chapter 90 of the North Carolina General Statutes (“the Act”).

8. I understand that the Act’s Hospitalization Requirement¹ for abortions after the twelfth week of pregnancy could bar PPSAT from providing abortion care beyond twelve weeks to survivors of rape or incest or for pregnancies with a “life-limiting anomaly,” despite the Act’s exceptions for those circumstances. Requiring all abortions after the twelfth week of pregnancy to be performed in a hospital is contrary to the standard of care, under which abortions are routinely performed in outpatient clinic settings through twenty weeks. Indeed, PPSAT provides abortion after twelve weeks to patients with fetal diagnoses who have been referred to us *by hospital providers* because abortion appointments at our outpatient clinics may be available sooner, are often less time-consuming, and cost less than they would at the hospital. This Hospitalization Requirement

¹ N.C. Gen. Stat. §§ 90-21.81B(3)–(4), 90-21.82A(c), 131E-153.1.

is also illogical as a matter of patient health and safety because, even if the Act takes effect, licensed clinics like PPSAT's will still be allowed to perform the same procedures after twelve weeks to treat miscarriage. If interpreted to require all abortions after twelve weeks to be performed in hospitals, the Hospitalization Requirement will only serve to harm patients who have experienced sexual assault and those who are facing "life-limiting" fetal diagnoses.

9. I further understand that the Act's Intrauterine Pregnancy ("IUP") Documentation Requirement² could prevent us from providing early medication abortion to patients who have a very early pregnancy that is not yet visible by ultrasound (also known as a "pregnancy of unknown location"). Not only is it safe and evidence-based to provide medication abortion to patients whose pregnancies are too early to see by ultrasound and who are at low risk of ectopic pregnancy, but preserving patients' access to this very early abortion care is all the more important given North Carolina's twelve-week ban. Denying medication abortion to patients whose pregnancies cannot yet be seen on an ultrasound will force those patients either to delay wanted care or to obtain a procedural abortion even if they have important reasons for preferring a medication-only method. Either of these alternatives subverts the patient autonomy that both patient-centered practices and medical evidence support.

10. In particular, the Act is an attack on families with low incomes, North

² N.C. Gen. Stat. § 90-21.83B(a)(7).

Carolínians of color, and rural North Carolínians, who already face inequities in access to medical care and who will bear the brunt of the Act's cruelties. While forced pregnancy carries health risks for everyone, it imposes greater risks for those already suffering from health inequities. Black women,³ who in North Carolina are more than three times as likely as white women to die during pregnancy,⁴ will acutely feel the Act's harms. Furthermore, North Carolínians face a critical shortage of reproductive health care providers, including obstetrician-gynecologists, especially in rural areas.⁵

³ In this declaration, I use "woman" or "women" as a short-hand for people who are or may become pregnant, but people of many gender identities, including transgender men and gender-diverse individuals, may become pregnant and seek abortion and are also harmed by the Act.

⁴ See NC State Ctr. for Health Stats., *Trends in Maternal Mortality Statistics*, NC Dep't Health & Hum. Servs., tbl. 4 (2013), https://schs.dph.ncdhhs.gov/data/maternal/Table4_MMReport2013.pdf (available at <https://schs.dph.ncdhhs.gov/data/maternal/>); *2022 Health of Women and Children Report – Report Data (All States)*, Am.'s Health Rankings, (2022), <https://www.americashealthrankings.org/learn/reports/2022-health-of-women-and-children-report> (reporting a white maternal mortality rate of 17.3 and a Black maternal mortality rate of 52.8 per 100,000 live births); NC Health News, *Childbirth Is Still Killing Black Moms at a Higher Rate. NC Advocates, Policymakers Discuss Solutions*, Carolina Public Press, (Apr. 19, 2023), <https://carolinapublicpress.org/59894/childbirth-is-still-killing-black-moms-at-a-higher-rate-nc-advocates-policymakers-discuss-solutions/>.

⁵ Clarissa Donnelly-DeRoven, *Filling Rural NC's Maternal Health Care Desert*, NC Health News, (May 11, 2022), <https://www.northcarolinahealthnews.org/2022/05/11/filling-rural-ncs-maternal-health-care-desert/> (describing this shortage and mapping 13 rural North Carolina hospitals that closed their maternity units between 2014 and 2019); Isabella Higgins, *Legislative Gaps in Addressing Rural Women's Access to Obstetric Care in the United States: A Case Study of the North Carolina Home Birth Freedom Act*, 26 J. Trachtenburg Sch. Pub. Pol'y & Pub. Admin. at George Washington Univ. 1, 30 (2019), (reporting that about one-third of rural counties in North Carolina did not have an OB/GYN in 2017 (citing Cecil G. Sheps Ctr. for Health Servs. Rsch., *North Carolina Health Professional Supply Data*, Univ. N.C. Chapel Hill (last modified Oct. 31, 2022), <https://nchealthworkforce.unc.edu/supply/>)); see generally NC Maternal Mortality Rev.

I. PPSAT AND ITS SERVICES

11. PPSAT is a non-profit corporation organized under the laws of North Carolina. PPSAT offers a wide range of affordable and reliable reproductive and sexual health care services in our 15 locations across North Carolina, South Carolina, Virginia, and West Virginia. PPSAT operates ten health centers throughout North Carolina, located in Asheville, Chapel Hill, Charlotte, Durham, Fayetteville, Greensboro, Raleigh, Wilmington, and Winston-Salem. PPSAT provides a full range of reproductive and sexual health services, including: cervical cancer screenings; breast and annual gynecological exams; family planning counseling; pregnancy testing and counseling; reproductive health education; testing and treatment for sexually transmitted infections; contraception; procedural and medication abortion services and related care; prenatal consultation; primary care; gender affirming hormone therapy; vasectomies; and health care related to miscarriage. PPSAT provides care to approximately 38,000 patients at its health centers in North Carolina each year.

12. PPSAT provides abortions at six health centers licensed under North Carolina law as abortion clinics located in Asheville, Chapel Hill, Charlotte, Fayetteville, Wilmington, and Winston-Salem. At these health centers, we provide both medication abortion through 77 days (or 11 weeks) gestation⁶ as measured from the first day of the

Comm., *North Carolina Maternal Mortality Review Report*, NC Dep't of Health & Hum. Servs., (2021), https://wicws.dph.ncdhhs.gov/docs/2014-16-MMRCReport_web.pdf.

⁶ Bates 0142 (chart of medication abortions provided by PPSAT from 2020 through 2023, by gestational age), attached as **Exhibit 3**.

patient’s last menstrual period (“LMP”) and, under S.B. 20, procedural abortion through the twelfth week. When one of S.B. 20’s exceptions to the twelve-week ban applies, we may provide procedural abortion up to either 13.6 or 19.6 weeks LMP, depending on location and staffing.⁷ PPSAT has been providing procedural abortions past the twelfth week of pregnancy for more than fifteen years in North Carolina.

13. In the absence of the Hospitalization Requirement and the IUP Documentation Requirement taking effect—both are blocked for now by the Court’s September 30, 2023 preliminary injunction—PPSAT will continue to provide abortion after twelve weeks to survivors of rape or incest and to patients with diagnoses of “life-limiting anomalies” and will continue to provide medication abortion to patients at low risk for ectopic pregnancy whose pregnancies are not yet visible by ultrasound.

II. ABORTION IS COMMON, SAFE, AND CRITICAL HEALTH CARE

A. Abortion Methods Performed in Outpatient Settings

14. All methods of abortion provided at PPSAT—medication abortion, procedural abortion using aspiration, and procedural abortion by dilation and evacuation (“D&E”)—are simple, straightforward medical treatments that have an extremely low complication rate, and, unlike some other office-based procedures such as vasectomies or contraceptive implant removals, involve no incisions. In North Carolina and nationwide,

⁷ Bates 0143–45 (chart of procedural abortions provided by PPSAT from 2020 through 2023, by gestational age), attached as **Exhibit 4**.

these methods are almost always provided in outpatient, office-based settings by clinicians adhering to widely accepted medical standards of care.

15. Although aspiration abortion and D&E are both sometimes referred to as “surgical” abortion, they are not what is commonly understood to be surgery. Both aspiration abortion and D&E are done through the natural opening of the vagina and cervix and therefore involve no incisions. Both can be, and almost always are, performed in outpatient clinics like PPSAT’s.

16. All abortion patients at PPSAT meet with health center staff, including the physician who will provide their abortion, before the abortion itself. All patients are screened for reproductive coercion and provided with information about the risks, benefits, and alternatives to abortion. Before providing an abortion, the physician personally confirms that their patient has knowingly and voluntarily consented to the abortion by the patient’s chosen method. All patients are given detailed instructions regarding what to expect after their abortion and are encouraged to contact PPSAT’s 24-hour help line, which is staffed by licensed nurses, should they have any questions or concerns.

i. First-Trimester Medication Abortion

17. In a medication abortion, a patient takes medications to cause uterine contractions that empty the uterus. Medication abortion requires no anesthesia or sedation. From the time a patient receives a positive pregnancy test through 11 weeks, or 77 days, LMP, PPSAT provides the most common form of medication abortion.

18. In a typical medication abortion, the patient takes a combination of two prescription drugs—mifepristone (also known as RU-486 or by its trade name, Mifeprex) and misoprostol (also known as a prostaglandin analogue or by its trade name, Cytotec)—a day or two apart. Mifepristone works by blocking the hormone progesterone, which is necessary to maintain a pregnancy. Misoprostol causes the cervix to open and the uterus to contract and empty. These same medications are offered as a treatment option to patients who have a miscarriage with retained tissue. Indeed, the process of medication abortion very closely approximates the process of miscarriage.

19. Mifepristone and misoprostol are safe—substantially safer than Tylenol and Viagra, for example.⁸ The FDA approved mifepristone, by its brand name Mifeprex, in 2000. Decades of experience with medication abortion since then have resoundingly confirmed its safety and efficacy. According to the FDA, serious adverse events (including death, hospitalization, serious infection, and bleeding requiring transfusion) among mifepristone patients are “exceedingly rare, generally far below 0.1% for any individual adverse event.”⁹ Indeed, earlier this year, the FDA modified its dispensing requirements for mifepristone to reflect the ever-growing body of evidence demonstrating the safety and

⁸ See Advancing New Standards in Reprod. Health, *Analysis of Medication Abortion Risk and the FDA report, “Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2018,”* Univ. of Cal. S.F. (2019), https://www.ansirh.org/sites/default/files/publications/files/mifepristone_safety_4-23-2019.pdf.

⁹ Ctr. for Drug Evaluation & Rsch., *Application Number 020687Orig1s020: Medical Review(s)*, FDA, 47 (2016), https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020MedR.pdf.

effectiveness of medication abortion.¹⁰ While the FDA-approved labeling for mifepristone reflects its usage through 70 days LMP, there is significant evidence that supports its use through 77 days LMP, as is provided at PPSAT.¹¹

20. For some patients, medication abortion offers important advantages over procedural abortion. Procedural abortion is contraindicated for patients with certain medical conditions, such as intolerance of available sedation or analgesic medications or a history of seizure disorder. And medication abortion may be preferable for patients with some clinical conditions, such as fibroids or other uterine abnormalities such as bicornuate uterus, which can make it difficult to reach the contents of the uterus during a procedural abortion. Some patients prefer medication abortion because it feels more natural to them to have their body expel the pregnancy rather than to have a provider use aspiration or instruments to empty the uterus. And some patients choose medication abortion because of fear or discomfort around a procedure involving aspiration or instruments. For example, survivors of rape and people who have experienced sexual abuse, molestation, or other trauma may choose medication abortion to feel more in control of the experience and to

¹⁰ See *Information About Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, FDA, <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation> (last updated Mar. 23, 2023).

¹¹ See, e.g., Ilana G. Dzuba et al., *A Repeat Dose of Misoprostol 800 mcg Following Mifepristone for Outpatient Medical Abortion at 64–70 and 71–77 Days of Gestation: A Retrospective Chart Review*, 102 *Contraception* 104 (2020); Ilana G. Dzuba et al., *A Non-Inferiority Study of Outpatient Mifepristone-Misoprostol Medical Abortion at 64–70 days and 71–77 Days of Gestation*, 101 *Contraception* 302 (2020).

avoid further trauma from having instruments placed in their vaginas. In the rare event that a medication abortion is unsuccessful, the patient may require follow-up care with procedural abortion, but in the vast majority of cases a patient who prefers medication abortion will be able to use that method, saving them from an unwanted procedure or a hospital referral.

21. Additionally, the logistics of a procedural abortion may be prohibitive for some patients, especially those with lower incomes, those who have difficulty getting time off work and securing childcare, or those who live in rural areas far from facilities where procedural abortion care is provided. Some health care providers charge more for procedural abortions, meaning some patients must wait longer to get an abortion while they gather funds—if they can afford it at all. Survivors of intimate partner violence in particular may struggle to find such support, as telling their partner they are having an abortion could be dangerous. And unlike procedural abortion, medication abortion gives the patient a greater degree of control over when and where they will pass the pregnancy, including who is with them to offer support. For example, patients can time their medications so that they begin the process of passing the pregnancy—involving cramping and bleeding—when their partner is (or is not) home with them or when a family member is available to care for their children. This degree of control and predictability is an important factor for some patients.

ii. Aspiration Abortion

22. Aspiration abortion (also known as suction curettage or dilation & curettage) entails using suction to empty the uterus. It is a straightforward procedure performed in the first and early second trimester. Before the Twelve-Week Ban took effect, PPSAT routinely provided aspiration abortion up to approximately 14 weeks LMP. For this method, a small plastic tube, called a cannula, is passed through the cervical canal. The cannula is attached to a syringe or electrical pump that creates gentle suction to empty the uterus.

23. Prior to starting the suction procedure, the provider dilates the cervix as needed to allow the cannula to enter the uterus. An analgesic such as ibuprofen, an anti-anxiety medication such as Ativan or Valium, a local anesthetic such as Lidocaine, and/or moderate sedation may be used during or prior to the procedure.

24. The entire procedure, including administration of local anesthesia, dilating the cervix, and aspirating the uterine contents usually takes 3 to 5 minutes. It involves no incision, cutting, or suturing.

25. This same aspiration method is used to treat a miscarriage after embryonic or fetal demise has occurred naturally, and for pregnancies of the same gestational age there is no difference in the risk of complications between a procedure to manage early miscarriage and aspiration abortion. PPSAT currently uses this aspiration procedure for miscarriage management up to approximately 14 weeks.

iii. D&E Abortion

26. Dilation and evacuation, or D&E, uses a combination of gentle suction and additional instruments, including specialized forceps, to evacuate the pregnancy contents from the uterus. While we generally refer to procedures starting at 14 weeks LMP as “D&Es,” before the Twelve-Week Ban took effect, instruments were routinely used in addition to suction starting around 15 weeks LMP, depending on the provider’s individual practice and the patient’s individual medical characteristics.

27. Prior to the D&E procedure, the provider dilates the patient’s cervix. This may be done through medications such as misoprostol, which softens the cervix, and/or through the placement of osmotic dilators in the cervix. Osmotic dilators are slender sticks made of a material that gradually swells as it absorbs moisture; as the dilators swell in the cervical opening, they cause the cervix to dilate. The provider may also use mechanical dilators or a combination of these techniques. The provider then empties the uterus using instruments or a combination of suction and instruments. When providing D&Es, PPSAT offers patients the option of local anesthesia or minimal or moderate sedation. PPSAT does not offer deep sedation or general anesthesia at its North Carolina health centers.

28. In the early part of the second trimester, physicians may perform the cervical preparation and evacuation procedure on the same day. Later in the second trimester, the physician may start the dilation process one day before the evacuation. In most cases, PPSAT begins the dilation process for patients from 16 to 20 weeks LMP through the placement of osmotic dilators the day before evacuation. If this first appointment for

dilation also includes tests, examination, education and consent, it may take a few hours, though the actual procedure to place the dilators takes approximately five minutes. After this appointment, the patient then leaves the clinic and returns the next day for the evacuation procedure.

29. Once the patient's cervix is sufficiently dilated, the entire evacuation procedure typically takes 10 to 15 minutes. Like aspiration abortion, D&E does not involve any incision, cutting, or suturing. And like aspiration, the D&E procedure is used both to provide abortion and to manage miscarriage. Notably, the risk of complications from a D&E to manage intrauterine fetal demise (i.e., a miscarriage) later in the second trimester can be higher than the risk of complications from a D&E for abortion at the same gestational age.¹²

B. Abortion Is One of the Safest Procedures in Medicine

30. To the extent the Act requires abortion after twelve weeks to be provided in a hospital, or prohibits medication abortion for low-ectopic-risk patients whose

¹² Jennifer L. Kerns et al., *Society of Family Planning Clinical Recommendation: Management of Hemorrhage at the Time of Abortion*, *Contraception*, 3 (2023) (“Spontaneous fetal demise (as opposed to induced fetal asystole) is a risk factor for both hemorrhage and DIC [disseminated intravascular coagulopathy, a serious clotting disorder], conferring a nearly three times higher odds of hemorrhage and 12 times higher odds of DIC. However, the overall incidence of DIC in the setting of fetal demise is low (2%).”); Jennifer L. Kerns et al., *Disseminated Intravascular Coagulation and Hemorrhage After Dilatation and Evacuation Abortion for Fetal Death*, 134 *Obstetrics & Gynecology* 708 (2019) (“Women undergoing D&E for fetal death are far more likely to experience DIC and hemorrhage than are women without fetal death, yet the absolute risk is low (2%).”).

pregnancies are not yet visible by ultrasound, the Act does not improve patient health and safety.

31. Abortion is one of the safest forms of medical care in contemporary medical practice and is safely and routinely provided in outpatient settings in countries around the world. Leading medical authorities agree that abortion is one of the safest procedures in medical practice,¹³ “stand[ing] in contrast to the extensive regulatory requirements that state laws impose on the provision of abortion services.”¹⁴

32. In fact, major complications, defined as those requiring hospital admission, surgery, or blood transfusion, occur in just 0.23 percent of abortions performed in outpatient, office-based settings.¹⁵

33. Abortion compares favorably, with a markedly lower complication rate, to other procedures routinely performed outside of a hospital setting, including:

- vasectomies, a form of male birth control that involves transecting and cauterizing the vas deferens, the tubes that carry sperm, resulting in

¹³ Nat’l Acads. Scis., Eng’g, & Med., *The Safety and Quality of Abortion Care in the United States* 1, 77 (2018), (available at <http://nap.edu/24950>) (“The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.”).

¹⁴ *Id.*

¹⁵ Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 *Obstetrics & Gynecology* 175, 181 (2015); see also Ushma D. Upadhyay et al., *Abortion-Related Emergency Room Visits in the United States: An Analysis of a National Emergency Department Sample*, 16 *BMC Med.* 1, 1 (2018).

hematoma formation two percent of the time while major complications requiring hospitalization occur in 0.2–0.8 percent of cases;¹⁶

- colonoscopies, an exam used to look for changes in the large intestine (colon) and rectum, such as swollen, irritated tissues, polyps, or cancer, with a complication rate of 1.6 percent;¹⁷
- wisdom teeth extraction, a surgical procedure to remove one or more of the four permanent teeth located at the back corners of the mouth, with a complication rate of 6.9 percent;¹⁸ and
- tonsillectomies, surgical removal of the tonsils, with a complication rate of 7.9 percent.¹⁹

34. Abortion is significantly safer than the alternative of carrying a pregnancy to term and giving birth, and complications related to pregnancy and childbirth are much more common than abortion-related complications.²⁰ The United States has the highest maternal

¹⁶ Christopher E. Adams & Moshe Wald, *Risks and Complications of Vasectomy*, 36 *Urologic Clinics N. Am.* 331, 331 (2009).

¹⁷ Isuru Ranasinghe et al., *Differences in Colonoscopy Quality Among Facilities: Development of a Post-Colonoscopy Risk-Standardized Rate of Unplanned Hospital Visits*, 150 *Gastroenterology* 103, 109 (2016).

¹⁸ Francois Blondeau & Nach G. Daniel, *Extraction of Impacted Mandibular Third Molars: Postoperative Complications and their Risk Factors*, 73 *J. Canadian Dental Ass'n* 325, 325b (2007).

¹⁹ Jack L. Paradise et al., *Tonsillectomy and Adenotonsillectomy for Recurrent Throat Infection in Moderately Affected Children*, 110 *Pediatrics* 7, 12 (2002).

²⁰ See Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *Obstetrics & Gynecology* 215 (2012); Nat'l Acads. Scis., Eng'g, & Med., *supra* note 13, at 11 tbl. S-1.

mortality rate among high-income countries (more than four times the rate of others in that group). Most concerning, it is getting worse.²¹ In 2021 alone, 1,205 pregnant women died of pregnancy-related causes in the United States.²² The Centers for Disease Control and Prevention (“CDC”) measure maternal mortality rates as the number of maternal deaths per 100,000 live births.²³ In 2021, the maternal mortality rate was 32.9 deaths per 100,000 live births.²⁴ And the maternal mortality rate in North Carolina is even higher than the national average.²⁵

35. In contrast, the CDC reported 0.43 deaths per 100,000 legal abortions from 2013 to 2019.²⁶ While the U.S. maternal mortality rate has significantly increased, there is no evidence that has occurred for abortion care, making legal abortion approximately 12 to 14 times safer than live birth.²⁷

²¹ Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2021*, CDC, Nat’l Ctr. for Health Stats.: Health E-Stats, 1 (2023), (available at <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm>).

²² *Id.*

²³ *Id.*

²⁴ *Id.*

²⁵ Teddy Rosenbluth & Tyler Dukes, *Pregnancy Can Be Risky in the US. In North Carolina, the Threat of Death Is Even Higher.*, News & Observer, (last updated July 28, 2023), <https://www.newsobserver.com/news/state/north-carolina/article277397263.html>.

²⁶ Katherine Kortsmitt et al., *Abortion Surveillance — United States, 2020*, 71 *Morbidity & Mortality Wkly. Rep. Surveillance Summaries* 1, 6 (2022).

²⁷ Nat’l Acads. Scis., Eng’g, & Med., *supra* note 13, at 75; Raymond & Grimes, *supra* note 20, at 215.

36. In North Carolina, physicians and certified nurse-midwives can deliver babies in locations other than a hospital, including at birthing centers and even in private homes.

37. Additionally, even under S.B. 20, we can lawfully perform aspiration and D&E procedures in PPSAT's licensed outpatient clinics to empty a patient's uterus following a miscarriage, though we are prohibited from performing those same procedures in PPSAT's clinics for an abortion after the twelfth week of pregnancy. This is so despite the fact that the rates of miscarriage-treatment-related complications are *higher* than documented rates of abortion-related complications.²⁸

38. Aspiration and D&E for miscarriage management are currently performed in licensed outpatient clinics, such as PPSAT's, in ambulatory surgical centers, and in hospitals (both in operating rooms and in procedure rooms).

39. In my experience, the main determinant of where a patient ultimately receives a miscarriage management procedure is cost—specifically, whether the patient has health insurance, and whether that insurance plan would cover the cost of a miscarriage management procedure at a given facility. Some insurance plans cover only care that is

²⁸ Advancing New Standards in Reprod. Health, *Safety of Miscarriage Treatment in Hospitals, ASCs, and Office-Based Settings*, Univ. of Cal. S.F. 1, (2018), https://www.ansirh.org/sites/default/files/publications/files/safety_of_miscarriage_treatment_jps2.pdf (citing Sarah C. M. Roberts et al., *Miscarriage Treatment-Related Morbidities and Adverse Events in Hospitals, Ambulatory Surgery Centers, and Office-Based Settings*, 16 J. Patient Safety e317, e320, e322 (2020) (observing that “[t]he rates of miscarriage treatment-related events are notably higher than published rates of abortion-related events”)).

provided by a contracted in-network provider, such as the patient's regular OB-GYN; those patients usually end up obtaining their miscarriage management procedure at the facility where their OB-GYN practices. By contrast, patients whose insurance covers care at PPSAT often choose to obtain their miscarriage management procedure at PPSAT. And patients without insurance generally prefer to obtain their miscarriage management procedure at PPSAT because it is often far more affordable than obtaining the same procedure at a hospital.

40. In the past, hospitals were not equipped to provide miscarriage management using aspiration outside of an operating room because they did not routinely stock or train staff to use manual vacuum aspirators (MVAs), the syringe device used to create suction for an aspiration procedure. Abortion providers have used MVAs in aspiration abortion for decades, but because MVAs are associated with abortion, hospitals were reluctant to use them for miscarriage treatment. This is another example of how abortion stigma has caused miscarriage management and abortion to be treated differently even though patients' clinical presentation and treatment needs are the same: in both circumstances, the patient needs a procedure to empty their uterus. In recent years, some hospitals have begun offering miscarriage management using MVAs, which—like the same aspiration procedure for the purpose of abortion—can be performed in a procedure room and does not require an operating room.²⁹

²⁹ Lisa H. Harris et al., *Surgical Management of Early Pregnancy Failure: History, Politics, and Safe, Cost-Effective Care*, 196 *Am. J. Obstetrics & Gynecology* 445.e1,

C. Abortions Are Safely Performed in Outpatient, Office-Based Settings

41. There is no medical reason to require that all abortions after twelve weeks take place in hospitals and not abortion clinics. In North Carolina, legal abortions are safely and routinely performed in doctors' offices and outpatient health center settings, as they are throughout the country. Procedural abortions are almost always provided in an outpatient setting; nationwide, only 3% of abortions annually are performed in hospitals.³⁰ In addition, abortions at outpatient clinics are often more affordable, easier to navigate, and generally require considerably less time for patients than abortions in a hospital setting.

42. According to the National Academies of Sciences, Engineering, and Medicine, "most abortions can be provided safely in office-based settings," and a hospital setting is not clinically necessary.³¹ Similarly, major medical associations, including the American College of Obstetricians and Gynecologists ("ACOG") and the American Public Health Association, reject the notion that abortions should be required to be performed in hospitals.³²

(2007) (explaining that abortion stigma likely contributes to clinical-setting differences for procedural abortion and procedural management of miscarriage).

³⁰ Rachel K. Jones et al., *Abortion Incidence and Service Availability in the United States, 2020*, 54 *Persps. on Sexual & Reprod. Health* 128, 134 (2022).

³¹ Nat'l Acads. Scis. Eng'g, & Med., *supra* note 13, at 10.

³² See Comm. on Health Care for Underserved Women, *ACOG Committee Opinion No. 815: Increasing Access to Abortion*, 136 *Obstetrics & Gynecology* e107, e109 (2020); Am. Pub. Health Ass'n, *Policy Statement No. 20083—Need for State Legislation Protecting and Enhancing Women's Ability to Obtain Safe, Legal Abortion Services Without Delay or Government Interference* (Oct. 2008), <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/23/09/30/need-for-state-legislation-protecting-and-enhancing-womens-ability-to-obtain-safe-legal->

43. The technique for a procedural abortion is clinically identical whether performed in a hospital or outpatient setting, and there is no scientific evidence indicating that abortions performed in a hospital are safer than those performed in an appropriate outpatient clinic or office-based setting.³³ To the contrary, as is true for nearly every medical procedure, fewer complications are seen in settings that perform higher volumes of the same procedure,³⁴ making licensed abortion clinics like PPSAT's safer for most patients than most hospitals, many of which do not routinely provide abortion care. In fact, at least one study demonstrated that second-trimester terminations of pregnancy by D&E in appropriate patients in a dedicated outpatient facility can be safer and less expensive than hospital-based D&E or induction of labor.³⁵

44. The North Carolina Department of Health and Human Services inspects all abortion-providing facilities annually.³⁶ Abortion providers are also required to submit

abortion; *see also* Barbara S. Levy et al., *Consensus Guidelines for Facilities Performing Outpatient Procedures: Evidence Over Ideology*, 133 *Obstetrics & Gynecology* 255 (2019) (concluding, based on an analysis of available evidence, that requiring facilities performing abortion to meet standards beyond those currently in effect for all general medical offices and clinics is unjustified).

³³ Sarah C. M. Roberts et al., *Association of Facility Type with Procedural-Related Morbidities and Adverse Events Among Patients Undergoing Induced Abortions*, 319 *JAMA* 2497, 2502 (2018).

³⁴ Steve Sternberg & Geoff Dougherty, *Risks are High at Low-Volume Hospitals*, *U.S. News & World Rep.* (May 18, 2015), <https://www.usnews.com/news/articles/2015/05/18/risks-are-high-at-low-volume-hospitals#:~:text=These%20large%20numbers%20of%20low,similar%20patients%20rather%20than%20by>.

³⁵ David K. Turok et al, *Second Trimester Termination of Pregnancy: A Review by Site and Procedure Type*, 77 *Contraception* 155, 155 (2008).

³⁶ N.C. Gen Stat. § 90-21.81C(g).

reports of each abortion “within 15 days after either the (i) date of the follow-up appointment following a medical abortion, (ii) date of the last patient encounter for treatment directly related to a surgical abortion, or (iii) end of the month in which the last scheduled appointment occurred, whichever is later.”³⁷

45. The features that differentiate hospitals from abortion clinics include different system operations requirements, staffing requirements, and building construction requirements.³⁸ Because these hospital features are irrelevant and unnecessary in the context of abortion care, they provide no medical benefit.

46. Unlike invasive surgical procedures, aspiration abortion and D&E do not involve incisions of any kind. In North Carolina, procedures with risks similar to the risks associated with abortion—including inserting or removing an IUD; endometrial biopsy; colposcopy; hysteroscopy (scoping of the cervix and uterus); Loop Electrosurgical Excision Procedure (removing pre-cancerous cells from the cervix); and miscarriage management (which, from a clinical perspective, involves the exact same procedures and therefore the exact same types of complications as aspiration abortion and D&E, and is distinguished from those treatments only by the absence of embryonic or fetal cardiac activity)—are routinely performed in outpatient clinics and physicians’ offices rather than in hospitals. And the procedures noted above with higher complication rates than abortion

³⁷ *Id.* § 90-21.93.

³⁸ *Compare* 10A N.C. Admin. Code 13B.3201 (hospital requirements) *with* 10A N.C. Admin. Code 14E .0100 *et. seq.* (abortion facility requirements).

(like vasectomies and wisdom-tooth extractions) are routinely, and without controversy, performed outside of the hospital setting throughout North Carolina.

47. Complications from abortions are exceedingly rare, both generally and at PPSAT in particular. And even in the rare event that complications arise during a procedural abortion, management can nearly always be safely and appropriately administered in the clinic where the abortion is being provided.³⁹

48. For example, hemorrhage (the technical term for heavy bleeding), generally understood as losing 500 or more cubic centimeters (“ccs”) of blood, is rare during a procedural abortion. A small amount of bleeding during a procedural abortion is expected and managed; the average procedural abortion patient loses less than 100 ccs of blood. For comparison, blood loss during a vaginal delivery is closer to 400 ccs in the majority of patients, and blood loss during a Cesarean section is often greater. PPSAT is equipped to treat blood loss in our clinics on the rare occasions when it is necessary to do so. Most cases of hemorrhage are managed in the clinic setting; treatment methods include providing medications (such as misoprostol, methergine, tranexamic acid, or pitocin) or mechanical interventions (such as re-suction, uterine massage, or intrauterine tamponade with a foley catheter) depending on the circumstances of the case.⁴⁰ Many of these same treatments would be provided in a hospital in similar circumstances, and they are usually adequate to

³⁹ Roberts et al., *supra* note 33; Nat’l Acads. of Scis., Eng’g, & Med., *supra* note 13.

⁴⁰ Jennifer Kerns & Jody Steinauer, *Management of Postabortion Hemorrhage*, 87 *Contraception* 331, 333 (2013).

treat heavy bleeding. For virtually all of the small number of patients affected, hemorrhage happens during or immediately after a procedural abortion, at which point PPSAT is able to treat the patient on-site or, in rare cases, transfer the patient to a hospital for additional care. From January 2020 through December 2023, 18 patients (0.041 percent) out of the 43,339 abortions that PPSAT provided in North Carolina were transferred to a hospital for treatment of hemorrhage following an abortion.⁴¹

49. Another infrequent complication of abortion is infection, but this would not develop at the time the patient is in the health center (or the hospital) for an abortion. Rather, it would manifest days after a patient has a procedural abortion or after a medication abortion patient has taken misoprostol. Upon diagnosis, oral or intramuscular antibiotics almost always resolve infection without any long-term or permanent injury to the patient. For example, if a patient later presents with symptoms of endometritis, which is inflammation of the uterine lining, we confirm endometritis with a physical exam and/or an ultrasound. We then treat the patient with an antibiotic injection, followed up by oral antibiotics. We do a follow-up appointment 48–72 hours after starting antibiotics to make sure that the patient is improving, then have them finish their course of oral antibiotics and

⁴¹ See Bates 0141 (chart listing the number of abortions provided at PPSAT’s North Carolina health centers between January 1, 2020, and December 31, 2023), attached as **Exhibit 2**; Bates 0147 (chart listing the complications resulting in hospital transfer from abortions provided through the twelfth week of pregnancy at PPSAT’s North Carolina health centers between January 1, 2020, and December 31, 2023), attached as **Exhibit 6**; Bates 0148–49 (chart listing the complications resulting in hospital transfer from abortions provided after the twelfth week of pregnancy at PPSAT’s North Carolina health centers between January 1, 2020, and December 31, 2023), attached as **Exhibit 7**.

return for another follow-up appointment within seven days. If there is retained pregnancy tissue in the uterus—which is also rare and would also not be evident until *after* the patient has left the health center (or hospital)—we offer the patient additional treatment to remove the tissue using medication or a suction procedure. This would be the same treatment as if a patient presented after having an abortion at a hospital. The use of intravenous antibiotics to treat infection arising from procedural abortion is rare, and can often be provided in an outpatient setting.

50. Cervical lacerations from procedural abortion are also incredibly rare. When they do occur, PPSAT is able to treat them with stitches, as most cases of cervical laceration are managed in the clinic setting with suture.⁴² From January 2020 through December 2023, none of PPSAT’s North Carolina abortion patients required hospital transfers as a result of cervical lacerations.⁴³

51. Uterine perforation is similarly rare and would be treated with either transfer to a hospital or, if the patient is completely stable, close observation and follow-up. From January 2020 through December 2023, two of the 43,339 abortions provided at PPSAT in North Carolina—0.0046 percent—resulted in transfer to a hospital for treatment of uterine perforation.⁴⁴ Similarly, perforation of the colon (which is much more dangerous, because it exposes the membrane lining the walls of the abdominal cavity to bowel bacteria) can

⁴² *Id.*

⁴³ *See* Ex. 6; Ex. 7.

⁴⁴ *See* Ex. 2; Ex. 6; Ex. 7.

occur during a colonoscopy, and colonoscopies are not required to be performed in hospitals.

52. Cases of incomplete abortion are generally managed through repeat aspiration or medication, and, at any rate, arise *after* completion of the procedure, such that even if the abortion took place in a hospital, this complication would occur only after the patient leaves the hospital setting. In fact, because the Hospitalization Requirement applies only to abortion and not to identical procedures for miscarriage management or removal of retained pregnancy tissue, patients who have retained tissue as a complication of a procedural abortion *performed in a hospital* could obtain treatment for that complication at an outpatient clinic using aspiration or D&E.

53. As discussed above, major abortion complications occur in fewer than one-quarter of one percent (0.23 percent) of abortions.⁴⁵ In the exceedingly rare event that hospitalization is needed to manage complications, patients are safely stabilized and transferred to a hospital. Overall, just 34 out of the 43,339 abortions that PPSAT performed in North Carolina between January 1, 2020, and December 31, 2023, resulted in hospital transfer (0.078 percent).⁴⁶ All were released in stable condition, and only 7 out of the 34 patients transferred were admitted.⁴⁷ These infrequent emergency transfers are not logistically difficult, since PPSAT has relationships with hospitals close to our clinics and

⁴⁵ Upadhyay et al., (2015), *supra* note 15, at 175.

⁴⁶ *See* Ex. 2; Ex. 5.

⁴⁷ *See* Ex. 6; Ex. 7.

we have clear protocols for emergency management while we are awaiting transport and for a smooth hand-off to the receiving institution.

54. It is unreasonable, and a waste of hospital resources, to require an entire category of procedure to be performed in a hospital when there is no medical benefit for the vast majority of patients. As with any other medical procedure, whether an abortion should be provided in a hospital should be a patient-specific consideration, based on the patient's individual medical circumstances.

55. PPSAT physicians have low abortion complication rates and superb safety records. Because PPSAT specializes in providing patient-centered, holistic sexual and reproductive health care, PPSAT patients benefit from receiving care from highly experienced and specialized providers and staff. This is particularly important for the patient population we are talking about here—survivors of sexual assault or patients with a “life-limiting” fetal anomaly, who may be more comfortable with a specialized provider like Planned Parenthood than having to navigate a hospital, especially one for which they need to travel outside of their community.

56. PPSAT has provided abortions due to rape, incest, or life-limiting anomaly to patients in North Carolina after the twelfth week of pregnancy, both before the Twelve-Week Ban took effect and after the Court entered a preliminary injunction against the Hospitalization Requirement. PPSAT will continue to do so unless the Hospitalization Requirement takes effect.

57. Indeed, PPSAT has received referrals from North Carolina hospital-based physicians for patients seeking abortion after twelve weeks following a fetal anomaly diagnosis. Abortions in these circumstances are almost always clinically identical to abortions where no anomaly is present. For those patients, receiving an abortion at one of PPSAT's licensed abortion clinics is just as safe as getting that care in a hospital, and moreover, for most of them, it is more accessible from a logistical and financial standpoint, particularly where insurance would not cover the patient's abortion in a hospital setting.

58. There is no medical reason to require all abortions for "life-limiting" anomalies to be provided in a hospital, and PPSAT would continue to provide abortions to these patients after the twelfth week of pregnancy under the Act's "life-limiting anomaly" exception but for the Hospitalization Requirement.

D. Medication Abortion Is Safe to Provide to Patients at Low Risk of Ectopic Pregnancy Before an Intrauterine Pregnancy Can Be Documented

59. If the IUP Documentation Requirement requires express confirmation of an intrauterine pregnancy *before* administration of medication abortion, it will be impossible for PPSAT to comply in the early weeks of pregnancy, and accordingly impossible for us to provide medication abortion to patients at that gestational stage.

60. Specifically, some patients present for abortions very early in pregnancy. At these early gestational stages, though the patient has a positive pregnancy test, it may be too soon to see an intrauterine gestational sac via ultrasound because the pregnancy is not yet sufficiently developed. Accordingly, if the IUP Documentation Requirement requires

PPSAT to document that an intrauterine pregnancy is *visible by ultrasound* before providing a medication abortion, it would prohibit PPSAT from providing medication abortion to patients who are very early in their pregnancies.

61. The Act would therefore force patients with pregnancies of unknown location either to delay their abortion until an intrauterine pregnancy can be seen by ultrasound or to undergo a procedural abortion, even if they have been determined to be at low risk for ectopic pregnancy and have decided in consultation with their provider that a medication abortion is the best option for them.

62. Medical evidence supports the safety and efficacy of providing medication abortion to low-ectopic-risk patients before the pregnancy can be seen on an ultrasound, using a protocol that *simultaneously* (1) provides medication abortion to a patient who wants it and (2) conducts further testing to rule out ectopic pregnancy. Moreover, this protocol is more patient-centered than requiring the patient to wait for medication abortion at a later date or to obtain a procedural abortion despite their preference for medication abortion. PPSAT follows this evidence-based protocol at its clinics in North Carolina.

63. Under this protocol, when a patient is seeking abortion and their pregnancy is not visible during the state-mandated pre-abortion ultrasound, PPSAT first screens the patient for risk of ectopic pregnancy (i.e., a pregnancy that has implanted outside of the uterus) by taking the patient's medical history and identifying their symptoms.⁴⁸ As part of

⁴⁸ An ectopic pregnancy occurs when a fertilized egg implants and grows outside of the uterus. Ectopic pregnancies require treatment to terminate the non-viable pregnancy.

this screening, we obtain a detailed menstrual history, pregnancy history (including history of prior ectopic pregnancy), contraceptive history, and symptom evaluation. If we determine that the patient is at high risk of ectopic pregnancy, we refer the patient to another provider, typically an emergency department, for diagnosis and treatment.

64. If the patient is not at high risk of ectopic pregnancy, the provider offers the patient three options for treatment: medication abortion, aspiration abortion, or a follow-up appointment at a later date to see if an intrauterine pregnancy can be seen on an ultrasound at that time. We explain the potential risks and benefits of each option, and the patient, in consultation with the physician, decides which option is best for them.

65. If a low-ectopic-risk patient with a pregnancy of unknown location chooses medication abortion, the provider *simultaneously* provides the medication abortion *and* conducts further testing to rule out ectopic pregnancy—specifically, by drawing a blood sample to test the level of the pregnancy hormone human chorionic gonadotropin (“hCG”). These test results usually come back no more than 24 hours later.

66. If the blood test results indicate that the patient’s hCG levels are sufficiently high (indicating a more developed pregnancy), this may be evidence of ectopic pregnancy. At that point, even if the patient has already taken the medications for medication abortion,

Research has shown that it is safe and effective to screen for ectopic pregnancy by considering known risk factors—including symptoms such as pain and bleeding, history of ectopic pregnancies, past surgery on the fallopian tube, and presence of pelvic inflammatory disease. See Ushma D. Upadhyay et al., *Outcomes and Safety of History-Based Screening for Medication Abortion: A Retrospective Multicenter Cohort Study*, 182 JAMA Internal Med. 482 (2022).

the provider will offer the patient the option of returning for an aspiration procedure as a means of *both* testing for ectopic pregnancy and completing the abortion. If the patient with high hCG levels opts for aspiration, then following that procedure, the provider will examine the aspirated uterine contents to see if gestational tissue is identifiable—confirming that the pregnancy was intrauterine and that the abortion is complete. If the patient with high hCG levels does not opt for aspiration, or if a gestational sac is not identifiable following aspiration, the provider may refer the patient for further ectopic evaluation, usually in an emergency department.

67. If, however, the patient’s hCG levels are low (indicating a pregnancy at a very early gestational age), the patient’s hCG levels are tested again 48–72 hours after taking the misoprostol.

68. Whether or not the patient’s hCG levels have decreased more than 50% after the abortion is evidence of whether the pregnancy has been terminated by the medication abortion, the pregnancy is in the uterus and continuing to grow, or there is still a possibility of ectopic pregnancy. Patients whose hCG levels have not decreased sufficiently are further evaluated for ectopic pregnancy, including, where medically indicated, through referral to a hospital provider.

69. Administration of medication abortion according to this protocol has been shown to be safe and effective in terminating the pregnancy.⁴⁹ And at least one study found

⁴⁹ See, e.g., Alisa B. Goldberg et al., *Mifepristone and Misoprostol for Undesired Pregnancy of Unknown Location*, 139 *Obstetrics & Gynecology* 771 (2022); Karen

that this protocol leads to earlier exclusion of ectopic pregnancy than waiting to see if an intrauterine pregnancy can be detected later.⁵⁰

70. If a low-ectopic-risk patient with a pregnancy of unknown location were referred to a hospital for ectopic evaluation instead of receiving a medication abortion according to this protocol, in most cases the hospital would perform the very same serial hCG testing that, under the protocol, PPSAT performs simultaneously with the medication abortion. Referring a low-ectopic-risk patient with a pregnancy of unknown location for ectopic evaluation instead of providing a medication abortion per this protocol therefore does not lead to earlier or more accurate diagnosis of ectopic pregnancy. Instead, it only delays the patient's abortion.

71. The ability to provide immediate abortion care for patients with pregnancies of unknown location offers important benefits to those patients without compromising their safety. While mifepristone is contraindicated for patients with confirmed or suspected ectopic pregnancy, this is not because there is any safety issue with the provision of medication abortion to a patient with an ectopic pregnancy. Rather, mifepristone is contraindicated because it does not treat ectopic pregnancy—i.e., it is not effective, but it

Borchert et al., *Medication Abortion and Uterine Aspiration for Undesired Pregnancy of Unknown Location: A Retrospective Cohort Study*, 122 *Contraception* 109980 (2023); I. Bizjak et al., *Efficacy and Safety of Very Early Medical Termination of Pregnancy: A Cohort Study*, 124 *BJOG: Int'l J. Obstetrics & Gynaecology* 1993 (2017); Philip Goldstone et al., *Effectiveness of Early Medical Abortion Using Low-Dose Mifepristone and Buccal Misoprostol in Women With No Defined Intrauterine Gestational Sac*, 87 *Contraception* 855 (2013).

⁵⁰ Goldberg et al., *supra* note 49, at 771.

is also not harmful. PPSAT's protocol for treating patients whose pregnancies are too early to see by ultrasound and who are at low risk of ectopic pregnancy ensures both the timely provision of abortion care *and* that the patient receives further testing to identify or rule out ectopic pregnancy.

72. We ensure that patients remain alert to the possibility of ectopic pregnancy by providing tailored education and follow-up to those who receive medication abortion according to this protocol. Only patients with low risk of ectopic pregnancy are eligible for this treatment, and all of these patients are educated on ectopic pregnancy signs and symptoms to watch for so that they can contact the clinic for further guidance or even report to the emergency department if needed. Each patient in this situation leaves the clinic with a plan for when to do their next blood test. We warn patients, both verbally and in writing, that an untreated ectopic pregnancy could result in their death, and we conduct multiple follow-up phone calls. If the provider evaluating the patient has a clinical suspicion of ectopic pregnancy, medication abortion is not offered; rather, the patient is immediately referred for further ectopic evaluation and management.

73. Access to early abortion care is all the more important given the Act's twelve-week ban, which is already in effect in North Carolina. Delaying their abortion may not be possible for some patients, since scheduling constraints due to clinic capacity and personal matters such as work and childcare might force them past the twelve-week mark and prevent them from accessing abortion altogether. Further restrictions on access to abortion in North Carolina and surrounding states will put even more pressure on us to

provide timely care to our patients.

74. Furthermore, banning medication abortion, but not procedural abortion, for low-ectopic-risk patients with pregnancies of unknown location is arbitrary and unnecessary. It puts patients in a position of opting for a procedural abortion even though they feel that a medication abortion is best for them. Aspiration abortion is not the best option for every patient, and it is vital to make the full range of medically appropriate options available to patients.

75. Further, PPSAT sometimes has clinic days on which, for staffing reasons, it is able to offer medication abortion but not procedural abortion. Eliminating the option of medication abortion for some patients would reduce the availability of appointments at PPSAT health centers for them, thus hampering their access to abortion.

III. ABORTION STIGMA IN NORTH CAROLINA

76. While the majority of North Carolinians did not support the law challenged in this case,⁵¹ abortion remains politically stigmatized. People seeking abortions, and the physicians and other health care providers who care for them, face regular prejudice and harassment.

77. People seeking abortions in outpatient clinics in North Carolina often have to pass by anti-abortion protesters before they are able to obtain care. I am aware of no

⁵¹ Steve Doyle, *Poll Says Most North Carolinians Don't Support Abortion Restrictions Recently Passed by General Assembly*, Fox 8 (May 11, 2023) <https://myfox8.com/news/north-carolina/poll-says-most-north-carolinians-dont-support-abortion-restrictions-recently-passed-by-general-assembly/>.

other medical procedures where the patients are subject to protests and harassment while in the process of seeking care. My colleagues and I have seen patients arrive for their abortion appointments visibly rattled by their encounters with these protesters, who deliberately attempt to make abortion patients feel shame and regret about their decision to have an abortion and lie to patients about the safety of abortion to frighten them. When someone has an abortion at a North Carolina hospital, some medical personnel and administrative staff might refuse to participate in the procedure—something that would never happen if the same procedure were being performed to treat a miscarriage. And I understand that other medical providers sometimes express disapproval of abortion when patients seek follow-up care after an abortion, such as for aspiration of retained tissue after a medication abortion.

78. Abortion providers in North Carolina experience abortion stigma in the form of baseless assumptions that physicians who provide abortion are not skilled physicians, that we do not provide quality medical care, and that we do not care about patient safety. This unfounded stereotype has permeated the testimony submitted in this case so far by Dr. Wubbenhorst and Dr. Bane. For example, Dr. Wubbenhorst baselessly asserted in her declaration at the preliminary-injunction stage that “abortionists [the derogatory term she uses instead of “physicians”] refuse to manage their complications.” To the contrary, my abortion-providing colleagues and I are highly trained medical professionals who are proud to provide evidence-based, patient-centered medical care (including appropriate treatment for the rare complications resulting from abortion). We provide abortion because it is part

of comprehensive obstetric and gynecological medical care, and because people deserve to be able to access this care in a compassionate, judgment-free medical setting.

79. Abortion providers in North Carolina can experience professional penalties or retaliation due to our work performing abortions. As in other areas of medicine, physicians who provide abortion often work at multiple sites—for example, at a public hospital as well as at a private medical group or outpatient clinic. Potential employers may refuse to hire a physician who provides abortion at another site, or may include contractual provisions limiting a new employee’s ability to provide abortion even in their capacity at a different employer. Some of these employers are institutionally opposed to abortion; others are merely fearful that anti-abortion protesters will harass their patients and staff if they learn that an abortion provider works for them. This discourages physicians from providing abortion even if they would otherwise want to. And physicians who do provide abortion sometimes feel professional pressure to conceal or omit mention of that part of their practice, even when they are not formally prohibited from providing abortion.

80. In addition to the risk of professional retaliation, abortion providers in North Carolina also face a constant threat of harassment and even physical violence. Abortion providers in other states have been assaulted and murdered, and abortion clinics have been set on fire. According to the National Abortion Federation, since 1977, there have been 11 murders, 42 bombings, 200 arsons, 531 assaults, 492 clinic invasions, 375 burglaries, and thousands of other incidents of criminal activities directed at abortion clinic patients,

providers, and volunteers.⁵² Threats have increased since *Dobbs*, particularly in states where abortion remains legal: for example, incidents of stalking targeting abortion clinic staff and patients increased 229% from 2021 to 2022.⁵³ As a result, abortion providers in North Carolina go to great lengths to maintain the confidentiality of their home addresses. For example, I am aware of some abortion providers who purchased their home through an anonymized legal entity like a trust or an LLC to avoid creating a public record that links their name with a street address. Some abortion providers even choose not to register to vote, because doing so would create a public record of their home address.

81. At PPSAT, we train providers not to arrive at the clinic wearing scrubs, because anti-abortion protesters sit outside the clinic hoping to identify medical staff in order to target them for harassment. One physician who provides abortions at PPSAT also works at a hospital, and anti-abortion activists littered the hospital parking lot with flyers identifying her as an abortion provider. We tell abortion providers to consider taking a different route to and from work every day so that they cannot be tracked. During particularly contentious times, we have had conversations about getting bullet-proof jackets for PPSAT physicians.

82. Abortion providers in North Carolina worry constantly that their loved ones will be targeted because of their relationship with someone who performs abortions. Many

⁵² *2022 Violence & Disruption Statistics*, National Abortion Federation 1, 2 (2022), <https://prochoice.org/wp-content/uploads/2022-VD-Report-FINAL.pdf>.

⁵³ *Id.* at 2, 7.

physicians who provide abortion care choose not to speak publicly, professionally, or socially about this aspect of their work outside of a narrow, trusted circle. This is not out of shame or embarrassment, but rather to minimize the risk of violent threats or harassment against themselves and their families. I know physicians who decided not to take their spouse's last name in marriage in order to protect their spouse and future children from anti-abortion harassment. These physicians have decided to have different last names than their children as a direct result of abortion stigma.

IV. IMPACT ON PPSAT PATIENTS

A. Impact of the Hospitalization Requirement on Survivors of Rape or Incest and Patients with “Life-Limiting” Fetal Anomalies

83. If the Hospitalization Requirement means that PPSAT cannot provide abortion after the twelfth week of pregnancy even under the Act's exceptions for survivors of rape or incest and for people diagnosed with “life-limiting” fetal anomalies, it will limit the number of providers available to these patients, increasing the expense of abortion and delaying or denying their access to desperately needed care. These heightened barriers will force patients who are already facing personal hardship and even trauma due to the circumstances of their pregnancies to remain pregnant against their will even longer—all without any medical benefit.

84. It should go without saying that it is vitally important to preserve access to abortion after the twelfth week of pregnancy for survivors of rape or incest, and for patients who have received a diagnosis of a “life-limiting” fetal anomaly.

85. Thousands of North Carolinians suffer sexual abuse each year.⁵⁴ Because of the non-consensual nature of rape and incest, these survivors are at heightened risk of unwanted pregnancy. And the traumatic circumstances of the pregnancy may increase the urgency of access to abortion. The physical aspects of pregnancy, including the sense of losing control of one's body, can be particularly traumatic for patients who have experienced a forcible loss of control of their bodies or their lives. For these survivors, pregnancy can trigger flashbacks, dissociative episodes, and other symptoms of re-traumatization.⁵⁵ Survivors experiencing mental health challenges may decide they are not healthy enough to parent a child (or an additional child, if they are within the roughly 62% of North Carolina abortion patients who already have children).⁵⁶

86. It is already hard for those who have experienced intimate partner violence to access abortion care in many instances. In particular, it can be difficult if not impossible

⁵⁴ *Sexual Violence in North Carolina, 2018-2019*, NC Dep't of Health & Hum. Servs., (May 2021), <https://injuryfreenc.dph.ncdhhs.gov/preventionResources/docs/BRFSS-SV-Factsheet-Final.pdf> (reporting that over 940,000 North Carolina adults have ever experienced sexual violence); Council for Women & Youth Involvement, *Sexual Assault in North Carolina July 2021–June 2022*, NC Dep't of Admin., (2022), <https://ncadmin.nc.gov/cfwyi/2021-2022-dvsa-statistical-briefpdf-0/download?attachment> (reporting that the North Carolina Department of Administration's Council for Women and Youth Involvement provided sexual-assault support services to 11,933 clients between July 2021 and June 2022).

⁵⁵ L. G. Ward, *Trauma-Informed Perinatal Healthcare for Survivors of Sexual Violence*, 34 J. Perinatal & Neonatal Nursing 199 (2020).

⁵⁶ Katherine Kortsmitt et al., *Abortion Surveillance — United States, 2019*, Morbidity & Mortality Wkly. Rep. Surveillance Summaries 1, 22 tbl. 8 (2021) (reporting that in 2019, 37.4% of North Carolina abortion patients had zero previous live births; 23.9% had one previous live birth; 19.8% had two; 10.5% had three; and 8.5% had four or more).

for people experiencing intimate partner violence to escape their partner's physical, emotional, and financial control long enough to access an abortion without compromising their confidentiality. In cases where they have been physically isolated from the community, they may not be able to leave their homes to seek routine medical care in the hours or days directly following the assault, let alone have access to transportation or the financial means to access abortion providers or follow-up services. At the same time, research has indicated that women who are denied a wanted abortion, when compared to those who are able to obtain abortions, face a greater likelihood of continued physical violence from the man involved in the pregnancy.⁵⁷

87. Even when survivors are able to access abortion, the process of finding a way to do so can delay them substantially, making them more likely to need abortion after twelve weeks of pregnancy. Survivors of repeated abuse may also be unsure of the gestational age of their pregnancies, so they may present to outpatient clinics for the state-mandated informed consent visit but find they are already beyond their twelfth week of pregnancy. If the Hospitalization Requirement applies to patients seeking abortion due to rape or incest, those patients would have to be referred to a hospital provider, despite the clinic being able to safely provide the care, forcing patients who have already experienced trauma to share their stories with additional providers.

⁵⁷ Sarah C.M. Roberts et al., *Risk of Violence From the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Med. 1, 5 (2014).

88. Meanwhile, patients who are diagnosed with a fetal anomaly usually receive this diagnosis after the twelfth week of pregnancy, since the screening and diagnostic procedures for anomalies are generally conducted in the second trimester, and structural anomalies may not be identified by ultrasound until the eighteenth or twentieth week of pregnancy.

89. Requiring abortion after twelve weeks to be provided in hospitals will reduce these patients' access to care. Most obviously, patients required to seek abortions in a hospital will have fewer options for care due to the fact that many hospitals do not provide abortion.⁵⁸

90. In addition, abortions at hospitals are generally much more expensive than they would be at PPSAT. Though hugely variable, abortions in hospitals can cost thousands of dollars. Given that only one in three Americans can comfortably cover a \$400 emergency expense, the financial burden of an abortion at a hospital will be insurmountable for many would-be patients.⁵⁹ At PPSAT, the cost of an abortion varies based on gestational age from \$625 to \$2146—a fraction of the cost charged by some hospitals—and PPSAT

⁵⁸ See Comm. on Health Care for Underserved Women, *supra* note 32, at e108 (recognizing that “many hospitals and health care systems limit the scope of reproductive health care for a range of reasons”); see also David L. Eisenberg & V. C. Leslie, *Threats to Reproductive Health Care: Time for Obstetrician-Gynecologists to Get Involved*, 216 *Am. J. Obstetrics & Gynecology* 256, 256 (2017) (observing that “health care institutions limit the scope of reproductive health care because of hospital policies, financial pressures, and a desire to limit negative press”).

⁵⁹ Bd. Governors Fed. Reserve Sys., *Economic Well-Being of U.S. Households in 2021*, 1, 36 (2022), <https://www.federalreserve.gov/publications/files/2021-report-economic-well-being-us-households-202205.pdf>.

endeavors to work with patients to ensure that they can obtain the care they need, irrespective of their financial circumstances. As I mentioned above, some of the abortions that PPSAT provides are for patients who have been referred to us by hospital providers. Many of those patients prefer to receive an abortion at PPSAT because receiving one in a hospital would be prohibitively expensive.

91. Due to cost alone, if a patient could find a hospital willing to provide their abortion, hospital treatment would not be feasible for many of PPSAT's patients. Arranging for transportation, childcare, and taking time off work to come to PPSAT is challenging enough. A majority of patients seeking abortion are already parents. Many have multiple jobs or jobs with inflexible or unpredictable schedules with no paid sick leave. Some are compromised by physical and/or mental health conditions or struggle with a substance use disorder.

92. Patients who are able to get an appointment at a hospital may also face lengthy wait times, added stress, complicated paperwork and other logistical requirements, loss of confidentiality, and possibly increased medical risk from clinicians who provide abortion care infrequently. Particularly when deep sedation or general anesthesia is used—as is done at some hospitals, but not at PPSAT's clinics—the total appointment time, post-procedure recovery time, staffing and facility requirements, costs, and procedure risks increase, without any medical benefit to the patient.

93. Studies demonstrate that increased barriers to abortion access increase the likelihood a patient will not receive an abortion at all.⁶⁰ In addition, delay of any kind is particularly concerning because, while abortion is safe, its risks increase with gestational age, as does the invasiveness of the procedure and the need for deeper levels of sedation.

94. Moreover, some hospitals may provide abortion using practices that are not patient-centered. Because only 3% of abortions nationwide are provided in hospitals, physicians who primarily practice in a hospital setting are likely less experienced in procedural abortion, particularly D&Es (given that most abortions occur before the point in pregnancy when D&Es are generally provided). Patients seeking abortions at a hospital may therefore be limited, either expressly or functionally, to the induction abortion method, even though induction can be far more expensive, time-consuming, and physically arduous for the patient as compared to D&E.

95. Specifically for survivors of rape or incest, abortion care in a licensed abortion clinic offers particular benefits related to the specialized setting. At PPSAT, for example, all staff are trained to recognize and counteract abortion stigma, and clinicians are trained to provide trauma-informed care for patients who have experienced intimate partner violence—such as special considerations when performing a physical exam for those patients, and what words to use in their clinical interactions. One such trauma-

⁶⁰ See e.g., Benjamin P. Brown et al., *Association of Highly Restrictive State Abortion Policies With Abortion Rates, 2000-2014*, 3 JAMA Network Open 1, 1 (2020) (“A highly restrictive legislative climate, when compared with a less restrictive one, was associated with . . . a 17% decrease [in] the median abortion rate....”).

informed practice is offering the patient the opportunity to remain conscious during the procedure; while some survivors may prefer general anesthesia (which some hospitals administer as a matter of course for abortion patients), others wish to avoid the experience of being told after waking up from sedation what has happened to their body, with no firsthand memory of the procedure itself.

96. PPSAT always provides patients an opportunity to speak privately with clinic staff to ensure that they are able to discuss their circumstances candidly and confidentially. In particular, we screen patients for intimate partner violence without anyone else in the room, including the patient's parent or partner. If a patient indicates that they fear violence if they do not obtain an abortion, staff will offer to engage law enforcement. If the patient feels that involving law enforcement would increase rather than lessen the danger they are in, we will provide the patient with a safe area in the health center from which they may reach out to resources we suggest in order to develop a safety plan. If a patient indicates that they are being threatened and would not otherwise want an abortion, we will not perform one.

97. And when receiving care at a licensed abortion clinic, survivors and patients diagnosed with fetal anomalies can trust that their care team—from the administrative staff at the front desk to the physician performing their procedure—will not judge their reproductive decision making, whether they decide to continue or end the pregnancy. While there are of course excellent physicians and staff providing compassionate, patient-centered care in hospital settings, too, patients are *more likely* to encounter stigma and

judgment from physicians and staff at a hospital than at a licensed abortion clinic in North Carolina. Requiring people to go to a hospital for their abortion deprives them of the option to receive care in the specialized, supportive environment that a licensed abortion clinic offers.

98. Indeed, many abortion providers specifically choose to work in outpatient clinics because we know we will be providing care in settings where all of the patient-facing staff are supportive and non-judgmental of that care and where the care will be much more affordable to patients.

99. For all of these reasons, limiting access to abortion for survivors of rape or incest and for patients with “life-limiting” fetal anomalies would cause great harm even to those patients who are able to access abortion in a North Carolina hospital. For many others, the Hospitalization Requirement would put that care out of reach within North Carolina, such that the only remaining options will be to travel out of state to get an abortion or to attempt to manage their abortion outside of the medical system. Still others will be forced to remain pregnant and ultimately give birth against their will.

B. Impact of the IUP Documentation Requirement on Access to Early Abortion

100. If PPSAT is unable to offer medication abortion to patients with pregnancies of unknown location, this too will be devastating for patients. This is especially so because the Act already imposes a requirement that patients make two trips to a health center to access care (in addition to the follow-up appointment that must now be scheduled for

medication abortion patients). If we cannot provide medication abortion to low-ectopic-risk patients while simultaneously doing further testing to exclude ectopic pregnancy, as supported by the best medical evidence and principles of patient-centered care, these patients may need to make another, wholly medically unnecessary trip, which will further delay their access to care. Early access to care is always preferable, but even more so because the Act bans almost all abortions after twelve weeks.

101. In my own practice, I see a patient with a pregnancy of unknown location at least once a week. Based on my experience providing abortion in states that have enacted early gestational age bans—for example, South Carolina, where a six-week ban was in effect for roughly 50 days in the summer of 2022 and has been in effect again as of August 2023—I expect that the number of patients who come to PPSAT in North Carolina for a medication abortion before their pregnancy is visible by ultrasound will increase now that the twelve-week ban is in effect. If the IUP Documentation Requirement prevents us from providing evidence-based abortion care to these patients, it will only delay their access to abortion without any effect on the speed or accuracy of ectopic pregnancy diagnosis.

102. It is important to note, however, that while patients who are able to recognize their pregnancies early on and *also* have resources and flexibility (in work schedules, caregiving obligations, and access to transportation) may be able to come to PPSAT earlier in pregnancy than they might have before the twelve-week ban took effect, patients who do not recognize their pregnancies immediately and those lacking resources and flexibility

will not be able to come in any sooner, and in fact will be delayed in accessing abortion by the Act's many other medically unnecessary restrictions.

103. In these ways (and many others), the Act is not only harmful to our patients, but also impairs PPSAT's and its physicians' ability to practice our profession and to satisfy our personal and professional missions and obligations to provide high-quality, evidence-based comprehensive sexual and reproductive health care to people in North Carolina.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: 2/29/2024

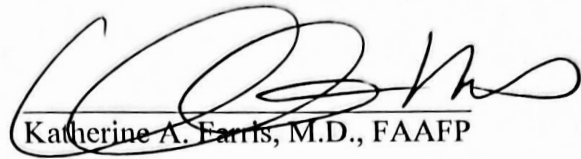

Katherine A. Farris, M.D., FAAFP

EXHIBIT 1

Employment

Planned Parenthood South Atlantic

Winston-Salem/Raleigh, NC

Chief Medical Officer: April 2020 – present

Duties of Affiliate Medical Director with increased focus on strategic planning, oversight of new service lines including Primary Care and telehealth, and increased advocacy work in support of PPSAT mission.

Affiliate Medical Director: December 2014 – April 2020

Clinical, policy, and administrative oversight of all licensed staff and clinical services for 14 health centers located throughout NC, SC, VA, and WV, including developing and implementing medical protocols, ensuring regulatory compliance, and overseeing quality of care provided.

Laboratory Director: December 2014 – present

Oversight of non-waived laboratories WS, NC; AVL, NC; WILM, NC; CLT, NC; waived laboratory VIE, WV

Infection Control Professional: 2014-present

Serves as consultant and expert on any infection prevention concerns as per medical training.

Interim Abortion Facility Administrator: December 2019 – March 2020

Acting Vice President of Patient Services: March – June 2016; May – August 2017

Oversight of administrative and operational departmental functions including regulatory compliance and financial solvency for 14 health centers located throughout NC, SC, VA, and WV including direct and indirect supervision of management and non-licensed staff within the health centers.

Interim Affiliate Medical Director: July 2013 – December 2014

Reproductive Health Care: September 2009-present

Provision of comprehensive family planning services to women of all ages as well as STI counseling, testing and treatment to men and women.

PPFA Succession Planning Task Force, Member: April 2017 – March 2021

Task force was charged with addressing some of the systemic challenges of abortion provider training and recruitment at Planned Parenthood affiliates.

Medical Directors Council (MeDC), Mentor: 2015 – present

Serve as mentor to new Medical Directors/Chief Medical Officers at other PPFA Affiliates.

BetterHealth IT Board of Directors,

Member: September 2020 – present

Chair, Compliance Task Force: January 2023 – present

Board member for the organization responsible for providing revenue cycle services and supporting and rolling out Epic electronic medical records system across PPFA affiliates.

(Prior to merger and name change January 2015, organization was named Planned Parenthood Health Systems, Inc.)

Heywood Medical Group/Henry Heywood Hospital

Westminster/Gardner, MA

Family Practice/Obstetrics: August 2003 – May 2007

Meetinghouse Family Practice; 16 Wyman Rd.; Westminster, MA 01473

Provision of full-spectrum family medicine including comprehensive family planning and reproductive health care.

Planned Parenthood League of Massachusetts

Boston/Worcester, MA

Reproductive Health Care: August 2003 – May 2007

Provision of comprehensive family planning services to women of all ages.

Education

Valley Medical Center Family Practice Residency

Renton, WA

Chief Resident: 2002-2003

Residency: 2001-2003

Internship: 2000-2001
Northwestern University Medical School Chicago, IL
Degree: MD, 1995-2000
Northwestern University College of Arts and Sciences Evanston, IL
Degree: BA, 1991-1995
Major: Molecular and Cellular Biology Minor: Religion Studies

Certifications/Special Training

Physician for Reproductive Health, Leadership Training Academy Fellow 2018-2019
Basic Life Support/AED, Provider: renewed 11/2023
Title X Family Planning Program Training, Provider: 2015
CLIA Laboratory Director Training, Training for non-waived laboratory director: 2013
Single-rod Hormonal Implant Insertion Training, Provider: 2011, Certificate #30001820273

Professional Organizations / Positions

American Academy of Family Physicians (AAFP): 1995-present
North Carolina Academy of Family Physicians: 2007-present
National Abortion Federation (NAF): 2003-2005, 2018-present
Physicians for Reproductive Health: 2018-present
American College of Obstetricians and Gynecologists: 2020-present
Massachusetts Academy of Family Physicians: 2003-2007
Washington Academy of Family Physicians (WAFP): 2000-2003
American Medical Women's Association (AMWA): 1995-2000
 Northwestern University Chapter President: 1997-1998
 Vice-President: 1996-1997

Licenses

NC Physician License, active: 143375-2009
WV Physician License, active: 26126
VA Physician License, active: 0101265486
SC Physician License, active: MMD.84073 MD
American Board of Family Physicians, Board Diplomate, Fellow

Honors/Awards

Fellow of the American Academy of Family Physicians – Awarded December 2023
The Degree of Fellow recognizes AAFP members who have distinguished themselves among their colleagues, as well as in their communities, by their service to family medicine, by their advancement of health care to the American people, and by their professional development through medical education and research. Fellows of the AAFP are recognized as champions of family medicine. They are the physicians who make family medicine the premier specialty in service to their community and profession. From a personal perspective, being a Fellow signifies not only 'tenure' but additional work in your community, within organized medicine, within teaching, and a greater commitment to continuing professional development and/or research.

Sylvia Clark Award for Creativity in Clinical Services – Recipient 2023
Honors a clinical services provider team from a Planned Parenthood affiliate who, through their creativity in clinical services, have demonstrated special commitment and ingenuity in applying the PPFA mission to ensure access to reproductive and sexual health care for all.

Press Ganey Patient Experience Top Performing Provider 2020
Ranked in the top 10% of providers across the country for providing the highest level of patient experience.

2002 Roy Virak Memorial Family Practice Resident Scholarship Recipient
Awarded by the Washington Academy of Family Practice on the basis of academic achievement, excellence in patient care, and strong service to the community.

EXHIBIT 2

Abortion Volume by Method							
		Asheville	Chapel Hill	Charlotte	Fayetteville	Wilmington	Winston-Salem
01/20-12/20	Medication	486	1121	780	1302	433	1017
	Procedural	337	1202	440	705	262	421
	Total	823	2323	1220	2007	695	1438
01/21-12/21	Medication	565	1486	1019	1419	521	1020
	Procedural	346	1283	449	603	283	538
	Total	911	2769	1468	2022	804	1558
01/22-12/22	Medication	1063	1782	1378	1836	672	1057
	Procedural	634	1775	682	822	387	661
	Total	1697	3557	2060	2658	1059	1718
01/23-12/23	Medication	1617	1343	1290	1565	880	1005
	Procedural	1000	1645	896	1077	463	731
	Total	1657	2988	2186	2642	1343	1736

EXHIBIT 3

Medication Abortion Volume by Gestational Age							
		Asheville	Chapel Hill	Charlotte	Fayetteville	Wilmington	Winston-Salem
01/2020-12/20	Under 5 weeks	1	0	0	3	1	6
	5 weeks	43	98	57	109	20	126
	6 weeks	117	298	213	362	72	308
	7 weeks	140	270	219	332	110	232
	8 weeks	98	235	171	252	122	179
	9 weeks	54	143	75	161	68	107
	10 weeks	31	70	43	69	36	52
	11 weeks	2	7	2	14	4	7
01/21-12/21	Under 5 weeks	3	0	1	1	0	3
	5 weeks	39	163	48	71	15	69
	6 weeks	120	428	270	334	75	256
	7 weeks	133	345	279	334	129	233
	8 weeks	130	263	215	311	133	208
	9 weeks	87	167	132	199	102	156
	10 weeks	50	106	72	146	64	80
	11 weeks	3	14	2	23	3	15
01/22-12/22	Under 5 weeks	2	0	2	10	2	0
	5 weeks	61	181	66	180	37	70
	6 weeks	208	465	290	441	162	244
	7 weeks	237	384	355	407	156	240
	8 weeks	242	329	293	398	136	242
	9 weeks	187	243	230	221	101	166
	10 weeks	112	155	130	157	77	88
	11 weeks	14	25	12	22	1	7
01/23-12/23	Under 5 weeks	3	0	0	4	2	0
	5 weeks	113	69	34	75	18	46
	6 weeks	261	272	171	294	124	173
	7 weeks	364	359	269	395	186	231
	8 weeks	373	266	330	330	241	220
	9 weeks	292	233	300	284	161	194
	10 weeks	186	130	168	159	140	125
	11 weeks	25	14	18	24	8	16

EXHIBIT 4

Procedural Abortion Volume by Gestational Age								
		Asheville	Chapel Hill	Charlotte	Fayetteville	Wilmington	Winston-Salem	
01/20-12/20	Under 5 weeks	1	0	0	3	1	0	
	5 weeks	14	33	9	22	3	17	
	6 weeks	51	112	68	91	29	64	
	7 weeks	55	155	73	97	37	51	
	8 weeks	53	114	69	84	45	54	
	9 weeks	32	93	45	72	30	48	
	10 weeks	34	80	35	80	36	38	
	11 weeks	38	98	51	93	35	52	
	12 weeks	29	70	42	67	25	43	
	13 weeks	30	62	30	54	21	40	
	14 weeks	1	82	18	42	0	14	
	15 weeks	0	46	0	0	0	0	
	16 weeks	0	51	0	0	0	0	
	17 weeks	0	64	0	0	0	0	
	18 weeks	0	51	0	0	0	0	
	19 weeks	0	36	0	0	0	0	
	20 weeks	0	38	0	0	0	0	
	21 weeks	0	17	0	0	0	0	
		Under 5 weeks	0	0	0	2	0	0
		5 weeks	15	40	7	14	2	19
		6 weeks	50	136	64	78	18	66
7 weeks		46	115	77	57	29	71	
8 weeks		61	85	53	92	49	79	
9 weeks		44	70	49	70	32	61	
10 weeks		27	55	36	45	37	45	
11 weeks		43	107	59	91	52	71	
12 weeks		36	97	57	75	33	68	
13 weeks		24	65	34	41	31	41	
14 weeks		0	92	13	38	0	16	
15 weeks		0	75	0	0	0	1	

Procedural Abortion Volume by Gestational Age							
		Asheville	Chapel Hill	Charlotte	Fayetteville	Wilmington	Winston-Salem
01/21-12/21	16 weeks	0	72	0	0	0	0
	17 weeks	0	96	0	0	0	0
	18 weeks	0	57	0	0	0	0
	19 weeks	0	56	0	0	0	0
	20 weeks	0	37	0	0	0	0
	21 weeks	0	28	0	0	0	0
01/22-12/22	Under 5 weeks	1	2	0	3	0	0
	5 weeks	10	59	7	38	4	28
	6 weeks	42	179	57	104	35	85
	7 weeks	58	144	88	112	61	89
	8 weeks	93	122	86	100	51	102
	9 weeks	82	128	86	88	49	78
	10 weeks	52	88	68	47	35	43
	11 weeks	111	143	89	128	65	102
	12 weeks	87	97	108	105	51	68
	13 weeks	66	110	68	58	35	43
	14 weeks	25	135	25	39	1	23
	15 weeks	4	108	0	0	0	0
	16 weeks	2	117	0	0	0	0
	17 weeks	1	116	0	0	0	0
	18 weeks	0	94	0	0	0	0
	19 weeks	0	86	0	0	0	0
	20 weeks	0	26	0	0	0	0
21 weeks	0	21	0	0	0	0	
	Under 5 weeks	0	0	0	1	0	0
	5 weeks	7	30	13	18	3	16
	6 weeks	43	126	36	95	21	62
	7 weeks	110	176	78	150	56	100
	8 weeks	126	150	139	134	38	106

Procedural Abortion Volume by Gestational Age								
	Asheville	Chapel Hill	Charlotte	Fayetteville	Wilmington	Winston-Salem		
	9 weeks	119	133	150	126	74	88	
	10 weeks	127	115	102	126	51	77	
	11 weeks	182	157	145	176	87	119	
	12 weeks	142	145	149	167	79	114	
	13 weeks	78	65	52	45	22	37	
	14 weeks	34	114	15	39	3	12	
	15 weeks	17	74	0	0	0	0	
	16 weeks	6	79	0	0	0	0	
	17 weeks	7	92	0	0	0	0	
	18 weeks	2	99	0	0	0	0	
01/23-12/23	19 weeks	0	69	0	0	0	0	

EXHIBIT 5

Complications from 01/2020 - 12/2023*	
Type of Complication	Count
Allergic Reaction	2
Hemorrhage	27
Hematometra	2
Incomplete AB/Retained POCs/Debris	210
Laceration	1
Medication Error	2
Minor Infection	10
Ongoing/Unintended Pregnancy	201
Other Injury (incl. nausea, dizziness, etc)	16
Pain/Bleeding	105
Perforation	4
Seizures/Vaso-vagal Reaction	6
Serious Infection	7
Spontaneous Abortion	2
Thromboembolic Events	1
TOTAL	596**
<p>*Chart represents total number of complications, not total number of patients with complications. Some patients may have had more than one complication.</p> <p>** Of these, 34 required transfer to a hospital.</p>	

EXHIBIT 6

Pre 12-week Complications Resulting in Hospital Transfer for 1/1/2020-12/31/2023

Complication	Weeks LMP	Type of AB	Health Center	Year	Hospital Status
Incomplete AB	6	Medication	Asheville Health Center	2020	Treated & released in stable condition
Incomplete AB	9	Medication	Winston-Salem Health Center	2020	Admitted for treatment & released in stable condition
Seizure	10	Procedural	Chapel Hill Health Center	2020	Treated & released in stable condition
Bleeding/Hemorrhage	11	Procedural	Winston-Salem Health Center	2020	Treated & released in stable condition
Incomplete AB	9	Medication	Winston-Salem Health Center	2021	Treated & released in stable condition
Seizure	8	Medication	Wilmington Health Center	2021	Treated & released in stable condition
Perforation	7	Procedural	Chapel Hill Health Center	2021	Treated & released in stable condition
Bleeding/Hemorrhage	9	Procedural	Fayetteville Health Center	2021	Treated & released in stable condition
Perforation	8	Procedural	Chapel Hill Health Center	2021	Admitted for treatment & released in stable condition
Bleeding/Hemorrhage	6	Procedural	Chapel Hill Health Center	2021	Admitted for treatment & released in stable condition
Bleeding/Hemorrhage	11	Procedural	Winston-Salem Health Center	2021	Treated & released in stable condition
Bleeding/Hemorrhage	8	Procedural	Chapel Hill Health Center	2022	Treated & released in stable condition
Incomplete AB	10	Medication	Chapel Hill Health Center	2022	Admitted for treatment & released in stable condition
Incomplete AB	10	Medication	Wilmington Health Center	2023	Treated & released in stable condition
Allergic Reaction	10	Procedural	Chapel Hill Health Center	2023	Treated & released in stable condition
Bleeding/Hemorrhage	10	Procedural	Chapel Hill Health Center	2023	Treated & released in stable condition
Bleeding/Hemorrhage	6	Procedural	Chapel Hill Health Center	2023	Treated & released in stable condition

EXHIBIT 7

Post 12-week Complications Resulting in Hospital Transfer for 1/1/2020-12/31/2023

Complication	Weeks LMP	Health Center	Year	Hospital Status
Bleeding/Hemorrhage	14	Chapel Hill Health Center	2020	Treated & released in stable condition
Incomplete AB	13	Winston-Salem Health Center	2020	Treated & released in stable condition
Bleeding/Hemorrhage	21	Chapel Hill Health Center	2020	Admitted for treatment & released in stable condition
Incomplete AB	14	Chapel Hill Health Center	2020	Treated & released in stable condition
Incomplete AB	13	Winston-Salem Health Center	2020	Treated & released in stable condition
Bleeding/Hemorrhage	15	Chapel Hill Health Center	2021	Treated & released in stable condition
Incomplete AB	12	Asheville Health Center	2021	Treated & released in stable condition
Bleeding/Hemorrhage	15	Chapel Hill Health Center	2022	Admitted for treatment & released in stable condition
Bleeding/Hemorrhage	17	Chapel Hill Health Center	2022	Treated & released in stable condition
Bleeding/Hemorrhage	19	Chapel Hill Health Center	2022	Treated & released in stable condition
Incomplete AB	19	Chapel Hill Health Center	2022	Treated & released in stable condition
Bleeding/Hemorrhage	14	Asheville Health Center	2022	Treated & released in stable condition

Post 12-week Complications Resulting in Hospital Transfer for 1/1/2020-12/31/2023

Complication	Weeks LMP	Health Center	Year	Hospital Status
Bleeding/Hemorrhage	17	Chapel Hill Health Center	2023	Treated & released in stable condition
Bleeding/Hemorrhage	17	Chapel Hill Health Center	2023	Treated & released in stable condition
Bleeding/Hemorrhage	19	Chapel Hill Health Center	2023	Treated & released in stable condition
Bleeding/Hemorrhage	17	Chapel Hill Health Center	2023	Admitted for treatment & released in stable condition
Syncope	19	Chapel Hill Health Center	2023	Treated & released in stable condition

EXHIBIT B

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA**

PLANNED PARENTHOOD SOUTH)	
ATLANTIC, <i>et al.</i> ,)	
)	
Plaintiffs,)	
)	
v.)	
)	
JOSHUA STEIN, <i>et al.</i> ,)	Case No. 1:23-cv-00480-CCE-LPA
)	
Defendants,)	
)	
and)	
)	
PHILIP E. BERGER, <i>et al.</i> ,)	
)	
Intervenor-Defendants.)	

**DECLARATION OF CHRISTY M. BORAAS ALSLEBEN, M.D., M.P.H., IN
SUPPORT OF PLAINTIFFS’ MOTION FOR SUMMARY JUDGMENT**

I, Christy M. Boraas Alsleben, M.D., M.P.H., declare as follows:

1. I am a board-certified obstetrician-gynecologist (“OB/GYN”) licensed to practice medicine in Minnesota. I provide abortions and other reproductive health care at the University of Minnesota Medical Center, a hospital in Minneapolis, Minnesota. I have worked as an OB/GYN at the University of Minnesota Medical Center since 2015. I provide second trimester abortions at the hospital one day per week.

2. I also provide first and second trimester abortions at outpatient health centers. I have worked at M Health Fairview Women’s Clinic since 2015 and Whole Woman’s Health Minnesota since 2014, both in Minneapolis, Minnesota, and at Planned Parenthood North Central States in St. Paul, Minnesota since 2014. I provide abortions at

the outpatient centers 1.5 days per week. I am also the Associate Medical Director and Director of Research at Planned Parenthood North Central States, which includes Minnesota, South Dakota, North Dakota, Iowa, and Nebraska.

3. Further, I am a faculty member at the University of Minnesota Medical School, and I provide education for trainees in the Department of Obstetrics, Gynecology and Women's Health. I also hold multiple consulting positions, including for the American College of Obstetricians and Gynecologists ("ACOG")—the leading U.S. professional association of OB/GYNs—and the Minnesota Department of Health. I am a member of several professional organizations, and have received honors and awards for my research, teaching, and public service. I have co-authored nearly twenty peer-reviewed research publications, including on the topics of medication abortion for pregnancies of unknown location and history-based screening to determine eligibility for medication abortion and to help rule out ectopic pregnancy.¹

4. I earned a B.A. in Biology and English from St. Olaf College in 2001, a Masters in Public Health from the University of Minnesota School of Public Health in 2004, a doctorate from the University of Minnesota Medical School in 2008, and completed my residency in Obstetrics and Gynecology at The Ohio State University

¹ See, e.g., Karen Borchert, Christy M. Boraas et al., *Medication Abortion and Uterine Aspiration for Undesired Pregnancy of Unknown Location: A Retrospective Cohort Study*, 122 *Contraception* 109980 (2023); Ushma D. Upadhyay, Christy M. Boraas et al., *Outcomes and Safety of History-Based Screening for Medication Abortion: A Retrospective Multicenter Cohort Study*, 182 *J. Am. Med. Ass'n Internal Med.* 482 (2022); Holly A. Anger, Christy Boraas et al., *Clinical and Service Delivery Implications of Omitting Ultrasound Before Medication Provided Abortion via Direct-To-Patient Telemedicine and Mail in the US*, 104 *Contraception* 659 (2021).

Medical Center in Columbus, Ohio in 2012. I also completed a fellowship in complex family planning at Magee-Womens Hospital at the University of Pittsburgh in 2014. In addition to my master's degree, I have a certificate in clinical research from the Institute for Clinical Research Education at the University of Pittsburgh, finished in 2014, and I completed a fellowship in reproductive health advocacy from the Leadership Training Academy, Physicians for Reproductive Health, also in 2014. I became board-eligible in obstetrics and gynecology in 2012 and board-certified in 2017.

5. The opinions I state here are based on my education, clinical training, experience as a practicing physician, regular review of medical research in my field, and regular attendance and presentation at professional conferences, including conferences for abortion providers. The literature considered in forming my opinions includes, but is not limited to, the sources cited in this report.

6. A copy of my *curriculum vitae* is attached as **Exhibit 1**.

Summary of Opinions

7. I submit this Declaration in support of Plaintiffs' Motion for Summary Judgment against two components of North Carolina Session Law 2023-14 ("S.B. 20") (codified as amended by Session Law 2023-65 ("H.B. 190") at N.C. Gen. Stat. art. 1, ch. 90 (the "Act")), which bans abortion after twelve weeks of pregnancy with narrow exceptions.

8. Specifically, I understand that the Act allows abortions in the case of rape or incest through 20 weeks of pregnancy, and abortions in the case of a "life-limiting anomaly" through 24 weeks of pregnancy. However, I also understand that the Act

requires that an abortion provided after the twelfth week of pregnancy in cases of rape, incest, or “life-limiting anomaly” be provided in a hospital, not an outpatient clinic (the “Hospitalization Requirement”). I understand that if these requirements are permitted to take effect, PPSAT and other outpatient abortion providers in North Carolina will be barred from providing abortion care after the twelfth week of pregnancy to survivors of rape or incest and to patients who have received a diagnosis of a “life-limiting” anomaly.

9. I also understand that the Act requires that a physician providing an “abortion-inducing drug,” among other things, “[d]ocument in the woman’s medical chart the . . . existence of an intrauterine pregnancy” (the “IUP Documentation Requirement”). This provision seems like it could be understood to prohibit abortion providers in North Carolina from administering mifepristone and misoprostol to patients who have a very early pregnancy that is not yet visible by ultrasonography (known as a “pregnancy of unknown location”).

10. I have been asked whether there is any medical justification for these provisions of the Act and whether they would affect access to and the quality of reproductive health care. In my opinion, neither the Hospitalization Requirement nor the IUP Documentation Requirement serves patient health, nor are they medically justified to ensure patient safety. In the United States, abortion is already one of the safest procedures a person may need.² In fact, the challenged requirements will most likely harm patient

² See Nat’l Acads. of Scis., Eng’g, & Med., *The Safety and Quality of Abortion Care in the United States*, at 58, 60, 63, 77 (2018), https://nap.nationalacademies.org/cart/download.cgi?record_id=24950 [hereinafter “Nat’l Acads.”].

health by making abortion more difficult to access and, in some cases, putting it entirely out of reach.

11. If allowed to take effect, the Hospitalization Requirement and the IUP Documentation Requirement will have a detrimental impact on North Carolinians because pregnant people seeking abortions face many challenges getting the care they need, and these provisions will only make those challenges worse. People who are ultimately prevented from obtaining an abortion will be compelled to carry pregnancies to term against their wishes or seek ways to end their pregnancies without medical supervision. I am concerned about the effect these provisions of the Act will have on North Carolinians' emotional, physical, and financial wellbeing and the wellbeing of their families.

12. There is no medical reason to require that all abortions after twelve weeks of pregnancy—including abortions specifically in the cases of rape, incest, or life-limiting fetal anomaly—take place in hospitals, because these abortions can be safely performed in outpatient clinic settings. In fact, there are many reasons that non-hospital settings may be preferable.

13. There is no medical reason to require the confirmation of an intrauterine pregnancy before administering medication abortion. With the proper protocol, counseling, surveillance, and follow up, medication abortion may be safely and effectively administered to patients with pregnancies of unknown location who prefer that method of treatment.

Abortions Reasons, Methods, Safety, and Harms of Delay

14. A patient's reasons for terminating a pregnancy depend on their own personal, medical, financial, and/or family circumstances. These reasons are closely tied to each patient's values, culture and religion, health and reproductive history, family situation and support system, education or career goals, and resources and financial stability.

15. In my experience, the majority of patients seeking abortion are already parenting and, after careful consideration of the realities of their situations, decide that expanding their families at that time is not in their or their families' best interests and may be harmful to their families' well-being. Indeed, a majority of patients having abortions in the United States have already had at least one birth.³ The strain of trying to adequately provide for their existing children is all the more apparent if one considers that approximately 75% of abortion patients nationwide are poor or low-income.⁴

16. Some people seeking abortion care feel that they are not ready to become a parent, and others are pursuing school or work opportunities. Some patients have health conditions that are complicated by pregnancy or have been diagnosed with health

³ See Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Inst., at 6–7 (May 2016), <https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014>; see also *Induced Abortion in the United States*, Guttmacher Inst., at 1 (Sept. 2019), https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf; Katherine Kortsmitt et al., *Abortion Surveillance—United States, 2019*, 70 *Morbidity & Mortality Wkly. Rep. Surveillance Summaries* 1, 6 (2021), <https://www.cdc.gov/mmwr/volumes/70/ss/pdfs/ss7009a1-H.pdf> (“Among the 45 areas that reported the number of previous live births for 2019, 40.2%, 24.5%, 20.0%, 9.2%, and 6.0% of women had zero, one, two, three, or four or more previous live births.”).

⁴ Jerman et al., *supra* note 3, at 1.

conditions that cannot be safely treated during pregnancy. These medical conditions can include hypertension, diabetes, lupus and other auto-immune diseases, kidney disease, cancer, and heart disease. I have cared for numerous patients who had abortions in order to protect their health or who have received a diagnosis of fetal anomaly (diagnoses that almost always occur after the twelfth week of pregnancy). Some patients have determined for themselves that they lack the necessary financial resources, family support, physical or mental health, or material stability to become a parent or to care for additional children. Others are in abusive relationships or are pregnant as a result of rape and are concerned that carrying to term will tether them to their abuser.⁵ Each patient's decision is valid in its own right and for many of them, outpatient abortion is an appropriate choice.

17. There are two main methods of abortion: medication abortion and procedural abortion. First-trimester medication abortions most commonly involve the administration of two types of medications (mifepristone and misoprostol) to cause passage of the pregnancy tissue in a manner similar to a miscarriage.⁶ First-trimester

⁵ See, e.g., Sarah C. M. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Med. 1, 5 (2014) (finding that “[a]mong women seeking abortion, having an abortion was associated with a reduction over time in physical violence from the [man involved in the pregnancy], while carrying the pregnancy to term was not”).

⁶ “Miscarriage” is the lay term for a non-viable intrauterine pregnancy in the first trimester. In the first trimester, the terms miscarriage and “spontaneous abortion” are used interchangeably and in the second trimester, a miscarriage may also be called “intrauterine fetal demise.” If the pregnant person's body does not expel the pregnancy, medical treatment may be needed to complete the miscarriage and empty the uterus, which is often referred to as miscarriage management.

medication abortion is extremely safe.⁷ It requires no anesthesia or sedation; the patient simply takes the medications. Moreover, miscarriage is often treated using the same medications.

18. Procedural abortions, which are provided in both the first and second trimesters, are performed by dilating (opening) the cervix and then using gentle suction and/or instruments to empty the contents of the uterus. The two most common methods of procedural abortion are aspiration abortion and dilation and evacuation (“D&E”). Despite sometimes being referred to as “surgical abortions,” these procedures are not surgical in the usual sense: they do not involve any incision into the patient’s skin and in most cases can be performed with local anesthesia or moderate sedation, per patient preference, in an outpatient setting.

19. Another method of abortion is abortion by induction of labor, which is most often performed in hospitals in the second trimester as an alternative to D&E.

20. The procedures used for abortion, including when a patient is choosing abortion because the fetus has been diagnosed with a fetal anomaly, and for miscarriage management are generally the same. While miscarriage management more typically happens in hospitals or ambulatory surgical centers, usually there is no medical or scientific reason for that—it is simply that abortion care has been stigmatized and siloed, whereas miscarriage management has not. Broadly speaking, doctors are willing to provide miscarriage management, but may lack institutional support or fear threats of violence when it comes to providing abortion care. Additionally, because it is much more

⁷ Nat’l Acads., *supra* note 2, at 79.

common for health insurance to cover miscarriage management as opposed to abortion, many patients do not have the same cost barriers to accessing hospital-based care in the miscarriage management context that they have in the abortion context.

21. Abortion is extremely common: nearly one in four women in the United States will have an abortion by age 45.⁸ The American Medical Association (“AMA”), the largest general medical association in the country, and ACOG, the largest association of OB/GYN specialists, have issued ethical guidance that recognizes abortion’s important place within health care.⁹ In fact, ACOG has affirmed that access to safe, legal abortion is not only important but necessary: “Women *require* access to safe, legal abortion.”¹⁰ These organizations recognize the difficult medical decisions sometimes required in reproductive health care, balancing various forms of benefits and harms and the importance of individual autonomy.

22. Abortion is also extremely safe. Both medication and procedural abortion carry a low risk of complications and a very low risk that hospitalization is necessary to treat a complication.¹¹ Numerous high-quality studies exist on the incidence of

⁸ See Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 *Am. J. Pub. Health* 1904, 1907 (2017).

⁹ See, e.g., Br. of Amici Curiae Am. Coll. of Obstetricians & Gynecologists & the Am. Med. Ass’n in Supp. Of Pls.-Appellees & in Supp. of Affirmance at 2, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 748 F.3d 583 (5th Cir. 2014) (No. 13-51008) (“Access to safe and legal abortion is an important aspect of women’s health care.”).

¹⁰ ACOG, *Comm. Op. No. 613, Increasing Access To Abortion*, 124 *Obstetrics & Gynecology* 1060, 1061 (2014) (emphasis added).

¹¹ Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 *Obstetrics & Gynecology* 175, 180 tbl. 4 (2015); see also Ushma D. Upadhyay et al., *Abortion-Related Emergency Department Visits in the*

complications from abortion, and those studies converge on a single conclusion: risks of complications are very low.¹² Major complications including those requiring hospitalization, surgery, or blood transfusion, occur in only 0.23% of outpatient abortions.¹³ Indeed, abortion is considered one of the safest medical procedures in the United States, whether by medication, aspiration, D&E, or induction.¹⁴

23. As the National Academies of Science, Engineering, and Medicine have explained, “[t]he risks of medication abortion are similar in magnitude to the risks of taking commonly prescribed and over-the-counter medications such as antibiotics and NSAIDs [nonsteroidal anti-inflammatory drugs],” such as ibuprofen.¹⁵ A 2018 report by the National Healthcare Cost and Utilization Project found the rate of hospital stays involving adverse drug reactions caused by antibiotics and similar medications, including aspirin, Tylenol, and Viagra, was 151.5 per 10,000 hospital stays, or 1.515 percent.¹⁶ In

United States: An Analysis of a National Emergency Department Sample, 16 BMC Med. 1, 2, 8 (2018).

¹² Nat’l Acads., *supra* note 2, at 10–11, 55–56, 60–65; *id.* at 77–78 (“[s]erious complications are rare; in the vast majority of studies, they occur in fewer than 1 percent of abortions”).

¹³ Upadhyay (2015), *supra* note 11, at 181; *see also* Upadhyay (2018), *supra* note 11, at 1.

¹⁴ Nat’l Acads., *supra* note 2, at 77; *see also* *Frequently Asked Questions: Abortion Care*, ACOG, (Last updated Aug. 2022) <https://www.acog.org/womens-health/faqs/induced-abortion> (“Abortion does not increase the risk of breast cancer, depression, or infertility.”); *see also* *Preterm Birth*, Ctrs. for Disease Control & Prevention, (Last reviewed Nov. 8, 2022) <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm> (listing risk factors for preterm birth, which do not include induced abortion); Megan K. Donovan, *D&E Abortion Bans: The Implications of Banning the Most Common Second-Trimester Procedure*, 20 Guttmacher Pol’y Rev. 35, 35, (2017) (A D&E is a safe and common abortion procedure that “accounts for the majority of second-trimester abortions in the United States.”).

¹⁵ Nat’l Acads., *supra* note 2, at 79.

¹⁶ Audrey J. Weiss et al., *Adverse Drug Events in U.S. Hospitals, 2010 Versus 2014*, Agency for Healthcare Rsch. & Quality, at 4 (2018); *see also* *Advancing New Standards*

contrast, according to the FDA, serious adverse events following medication abortion—including death, hospitalization, serious infection, and bleeding requiring transfusion—among mifepristone patients are “exceedingly rare, generally far below 0.1% for any individual adverse event.”¹⁷

24. Additionally, abortion is approximately 12–14 times safer than continuing a pregnancy through to childbirth.¹⁸ The United States has the highest maternal mortality rate among high-income countries, and in 2021 alone, 1,205 people died of pregnancy-related causes in the U.S.¹⁹ In 2021, the maternal mortality rate increased 40 percent from the previous year,²⁰ making the rate in the U.S. ten times higher than the estimated rate in other high-income countries.²¹ And while the maternal mortality rate in the U.S. has significantly increased, the same has not been true for abortion mortality.²²

25. A 2015 study by Upadhyay and colleagues tracked any complications the study population experienced and confirmed that the complication rate for abortions is

in *Reprod. Health, Analysis of Medication Abortion Risk and the FDA report, “Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2018,”* Univ. of Cal. S.F., (2019).

¹⁷ Ctr. for Drug Evaluation & Rsch., *Application Number 020687Orig1s020: Medical Review(s)*, FDA, 47 (2016).

¹⁸ Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *Obstetrics & Gynecology* 215, 216–17, 217 fig. 1 (2012); Nat’l Acads., *supra* note 2, at 37, 75 tbls. 2–4, 77–78.

¹⁹ Selena Simmons-Duffin & Carmel Wroth, *Maternal Deaths in the U.S. Spiked in 2021*, *CDC Reports*, NPR (Mar. 16, 2023), <https://www.npr.org/sections/health-shots/2023/03/16/1163786037/maternal-deaths-in-the-u-s-spiked-in-2021-cdc-reports#:~:text=The%20U.S.%20rate%20for%202021,deaths%20per%20100%2C000%20in%202020>.

²⁰ Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2021*, Nat’l Ctr. for Health Stats.: Health E-Stats, 1 (2023).

²¹ Selena Simmons-Duffin & Carmel Wroth, *supra* note 19.

²² Raymond & Grimes, *supra* note 18, at 215, 216–17, 217 fig. 1 (2012); Nat’l Acads., *supra* note 2, at 37, 75 tbls. 2–4, 77–78.

much lower than that for childbirth.²³ The study’s authors examined billing data from a one-year period for women insured under California’s Medicaid service, which covers abortion care.²⁴ The authors identified patients who obtained an abortion covered by California Medicaid through their policy number, including those who were treated for complications within six weeks of the abortion, either at the facility providing abortion care or an emergency department. They concluded that the rate of complication resulting from abortion was 2.11 percent, which includes both major complications (defined as necessitating hospitalization, surgery, or blood transfusion) and minor complications (all non-major adverse events) for all abortion methods in the first trimester, second trimester or later.²⁵ The majority of complications were minor.²⁶ For major complications the rate was 0.23 percent.²⁷ By comparison, the rate of severe complications from childbirth is 144 in 10,000, or 1.4 percent.²⁸ The study concluded that the abortion “complication rate is much lower than that found during childbirth and comparable to that found in the literature, even when [emergency department] visits are included and there is no loss to follow-up.”²⁹

26. Maternal mortality is not the only risk presented by pregnancy and birth.

Every year, an estimated 50–60,000 women in the U.S. experience severe maternal

²³ Upadhyay (2015), *supra* note 11.

²⁴ *Id.* at 177.

²⁵ *Id.* at 179.

²⁶ *Id.* at 181.

²⁷ *Id.* at 179-81.

²⁸ *Reproductive Health: Severe Maternal Morbidity*, CDC, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/rates-severe-morbidity-indicator.htm> (last visited Aug. 16, 2023).

²⁹ Upadhyay (2015), *supra* note 11, at 181.

morbidity,³⁰ or “unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman’s health,”³¹ and this rate has been on the rise over the last few decades.³² Every pregnancy-related complication (such as hemorrhage, infection, and injury to other organs) is more common among people having live births than among those having abortions.³³

27. Patients who carry their pregnancies to term may also face a multitude of pregnancy-related complications in the antenatal period, including gestational hypertension, gestational diabetes, infection, preeclampsia, and depression and anxiety.³⁴ Pregnancy-related complications are unsurprisingly more common among patients who ultimately give birth than those who have an abortion, since pregnancies ending in abortion are substantially shorter than those ending in childbirth and thus entail less time for pregnancy-related problems to occur or progress.³⁵

28. Meanwhile, although the risks associated with abortion increase with gestational age, because they are very low to begin with, abortion remains a very safe

³⁰ William M. Callaghan et al., *Severe Maternal Morbidity Among Delivery and Postpartum Hospitalizations in the United States*, 120 *Obstetrics & Gynecology* 1029, 1034 (2012).

³¹ *Severe Maternal Morbidity in the United States*, CDC, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html> (last visited Nov. 8, 2023).

³² *Rates in Severe Morbidity Indicators per 10,000 Delivery Hospitalizations, 1993–2014*, CDC, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/rates-severe-morbidity-indicator.htm> (last visited Aug. 16, 2023).

³³ Raymond & Grimes, *supra* note 18, at 216, 217 fig.1.

³⁴ *What Are Some Common Complications of Pregnancy?*, Nat’l Insts. of Health, <https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/complications> (last accessed Aug. 16, 2023).

³⁵ Raymond & Grimes, *supra* note 18, at 216-17.

procedure even later in the second trimester.³⁶ The salient point from the mentioned studies is that once someone has decided to have an abortion, imposed delays are detrimental because there are increased risks with delaying the procedure and continuing the pregnancy. Abortion is a time-sensitive, essential health service. ACOG and other leading medical organizations stressed in a joint statement that “[a]bortion is an essential component of comprehensive health care” and “a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible.”³⁷

29. Patients generally seek abortion as early in their pregnancy as they can. Nevertheless, in practice, there are many economic and logistical challenges that can cause delays. Some patients cannot afford to take multiple days off work in close proximity, as doing so will risk jeopardizing their jobs. Some patients cannot afford to arrange childcare for multiple days in close proximity without revealing to family or caregivers the reason for their need, thus compromising the confidentiality of their decision to obtain an abortion. Patients who seek abortion care after surviving rape, incest, or other violent abuse may be delayed in seeking care while they deal with associated trauma.³⁸

³⁶ Suzanne Zane et al., *Abortion-Related Mortality in the United States, 1998–2010*, 126 *Obstetrics & Gynecology* 258, 262–63 (2015); Nat’l Acads., *supra* note 2, at 10–11, 65.

³⁷ *Joint Statement on Abortion Access During the COVID-19 Outbreak*, ACOG (Mar. 18, 2020), <https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak>.

³⁸ *See, e.g.*, Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 *Am. J. Pub. Health* 1687, 1689, 1691 fig. 1 (2014); Diana Greene Foster et al., *Timing of Pregnancy Discovery Among Women Seeking Abortion*, 104 *Contraception* 642 (2021); Jenna Jerman et al., *Barriers to*

30. Moreover, delaying abortion forces a pregnant person to remain pregnant longer, experiencing the symptoms, risks, and potential complications of pregnancy. Even an uncomplicated pregnancy stresses a pregnant person's body, affects every organ system, and increasingly compresses abdominal organs as pregnancy progresses. Delay is also problematic for people for whom pregnancy worsens underlying health conditions, such as hypertension, heart failure, lung disease, or sickle cell disease.

31. For some patients, being forced to remain pregnant against their will causes psychological harm. Some patients may need to conceal the pregnancy from an abusive or controlling partner or others who would disapprove of or shame them. Additionally, delay can be very upsetting to patients ending wanted pregnancies due to fetal anomalies.

The Hospitalization Requirement Impedes Access to Abortion Without Adding to Patient Health and Safety

32. I understand that the Hospitalization Requirement mandates that an abortion provided after the twelfth week of pregnancy in cases of rape, incest, or "life-limiting anomaly" be provided in a hospital, not an outpatient abortion clinic. There is no medical reason to require that all abortions after the twelfth week of pregnancy take place in hospitals and not abortion clinics.³⁹ Throughout the country, legal abortions are safely and routinely performed in doctors' offices and outpatient health center

Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States, 49 *Persps. on Sexual & Reprod. Health* 95 (2017).

³⁹ See Nat'l Acads., *supra* note 2, at 10, 77 ("most abortions can be provided safely in office-based settings").

settings, including in the second trimester—in fact, only 3% of abortions are performed in hospitals in the U.S annually.⁴⁰

33. As a highly experienced OB/GYN who has worked providing abortions at both outpatient facilities and in a hospital for 16 years, I have performed and observed abortion care in both settings. At the University of Minnesota Medical Center hospital, I perform second-trimester abortions—including aspiration, D&E, and induction—through 23.6 weeks of pregnancy.

34. When I am providing a second trimester procedural abortion in the hospital, the hospital staff first perform an intake over the phone and then schedule the patient for the next available convenient appointment, which is often two or sometimes three weeks out due to capacity constraints. There are two main physicians who provide second trimester abortions at my hospital, including myself. I provide second trimester abortions at the hospital one day per week. I have time in the operating room in the hospital one half day per week to see patients that need hospital-based abortion care, up to four patients in a typical week.

35. On the day of their procedure, the patient must check in two hours before their scheduled procedure time. Their time in the operating room is about an hour (including resident education, as I work at a teaching hospital), and their recovery time, depending on the type of sedation used, can be between 1–4 hours, making the total time in the hospital between 4–7 hours. D&E patients in a hospital must sit in the waiting

⁴⁰ Rachel K. Jones et al., *Abortion Incidence and Service Availability in the United States, 2020*, 54 *Persps.. on Sexual & Reprod. Health* 128, 134 tbl. 3 (2022).

room or pre-operative area potentially for hours, and alongside patients awaiting other hospital procedures or surgeries, despite the fact the abortion procedure itself typically takes no more than 15–30 minutes in most cases. At the outpatient clinics where I provide second trimester abortions, the total appointment time is much less, usually approximately 2–4 hours.

36. General anesthesia or deep sedation are not necessary for most second trimester abortion patients, and moderate or minimal sedation in addition to local anesthesia are sufficient in the majority of cases. At the outpatient clinics where I work, we recommend local anesthesia for all procedures and also offer minimal and moderate sedation options. Similar to PPSAT, we do not offer deep sedation or general anesthesia. While I always endeavor to consult with patients and honor their preferred level of sedation for a procedural abortion—particularly patients who have survived sexual violence and do not feel comfortable being fully asleep during the procedure—at the hospital, it is most often the anesthesiologist that recommends the level of sedation, and some anesthesiologists prefer general anesthesia. When general anesthesia is used, the recovery time and costs of the procedure usually increase.

37. Further, while staff at the outpatient clinics where I work receive training on how to provide judgment-free abortion care and how to interact compassionately with those who have survived sexual assaults, the same is not true for every staff member that a patient might interact with in a hospital setting. Therefore, patients who worry about the stigma and confidentiality surrounding their abortion may prefer to go to an outpatient facility where abortion care is more frequently provided.

38. Patients may have other valid and compelling reasons to seek abortion care at an outpatient clinic versus a hospital, including cost, facility proximity, total appointment time, confidentiality, staff familiarity with the procedure, sedation options, and more.

39. Regardless of whether the patient receiving an aspiration abortion or D&E is a survivor of rape or incest, or if they have received a diagnosis of a life-limiting fetal anomaly, there is no reason to categorically require either procedure to be performed in a hospital. In my experience, the only patients that are better taken care of in a hospital than an outpatient setting are those who have certain life-threatening maternal health conditions; those for whom the physician may need immediate access to blood products due to an individual patient's pre-existing medical condition in case transfusions may be needed; those who require a deeper level of sedation than would be available at an outpatient clinic; or those for whom the expertise of physicians with other subspecialty experience is critical in providing optimal care. In my experience, many times such patients will often seek a hospital abortion in the first instance because of their condition and the associated risks. But more importantly, these conditions are rare and there is no reason to require *all* patients after 12 weeks to have abortions in hospitals so that these few patients may do so. It is the role of the physician to determine if hospital-based care is required in these rare cases.

40. Furthermore, while outpatient providers in North Carolina can provide procedural abortions through the twelfth week of pregnancy under the Act, they are not allowed to perform the same procedure through the thirteenth week of pregnancy. There

is no difference in the technique or type of risks of an aspiration abortion between these two gestational durations.

41. Based on all the above, it is my opinion that there is no medical reason to require that all abortions after the twelfth week of pregnancy for rape or incest survivors or those who have received a diagnosis of life-limiting fetal anomaly take place in hospitals because these abortions can be safely performed in outpatient settings. There are many reasons that patients justifiably prefer abortions in outpatient centers like PPSAT's, including shorter appointments, lower costs, and treatment from staff and medical professionals with more experience providing abortions.

Medication Abortion is Safe and Effective in Terminating Pregnancies of Unknown Location

42. The IUP Documentation Requirement mandates that a physician providing an “abortion-inducing drug,” among other things, “[d]ocument in the woman’s medical chart the . . . existence of an intrauterine pregnancy.” I understand that the North Carolina legislators who intervened in this case interpret this provision to prohibit abortion providers in North Carolina from administering mifepristone and misoprostol to patients whose pregnancies are not visible by ultrasonography. For low-risk patients, there is no medical reason to require ultrasound confirmation of an intrauterine pregnancy before administration of medication abortion. Therefore, there is no medical reason to deny this care to patients with pregnancy of unknown location, or to mandate that they delay their medication abortion until an intrauterine pregnancy can be documented with ultrasonography, which would expose them to increased and unnecessary medical risks.

43. General categories of pregnancy location include the following:

- a patient has a “definite intrauterine pregnancy” if the gestational sac and yolk sac and/or an embryo with or without cardiac activity are visible in the uterus;
- a patient has a “probable intrauterine pregnancy” if there is a likely gestational sac (intrauterine echogenic sac-like structure), but no yolk sac, visible in the uterus;
- a patient has a “pregnancy of unknown location” if there is no intrauterine or extrauterine pregnancy visible on transvaginal ultrasonography, but the patient has a positive pregnancy test;
- a patient has a “probable ectopic pregnancy” if there is an inhomogeneous adnexal mass or extrauterine sac-like structure;
- a patient has an “ectopic pregnancy” if an extrauterine gestational sac with yolk sac and/or embryo with or without cardiac activity is visualized.⁴¹

When we speak about “pregnancies of unknown location,” we are talking about the category where neither an intrauterine nor an extrauterine pregnancy is visible on transvaginal ultrasonography and the patient has a positive pregnancy test. Generally, an intrauterine pregnancy is not visible via ultrasound images until 5–6 weeks of pregnancy, as measured from the first day of the patient’s last menstrual period.

44. The ability to provide abortion care to patients with a pregnancy of unknown location as quickly as possible offers important benefits to those patients, including those who prefer medication abortion. In my experience, and as is also documented in research studies, most people who choose a medication abortion have a strong preference for this method.⁴² Medication abortion, in contrast to aspiration

⁴¹ See generally Kurt Barnhart et al., *Pregnancy of Unknown Location: A Consensus Statement of Nomenclature, Definitions, and Outcome*, 95 *Fertility & Sterility* 3 (2011).

⁴² Daniel Grossman et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 *Obstetrics & Gynecology* 296, 300 (2011).

abortion, allows the patient to complete the abortion at home or in another safe and private location. It is also less invasive than procedural abortion, and therefore may be preferable for many patients, including those who are sexual assault survivors.

45. Administration of medication abortion for patients with pregnancies of unknown location, combined with simultaneous screening for ectopic pregnancies, has been shown to be both safe and effective. I recently co-authored a study of pregnancy outcomes for patients presenting for abortion at Planned Parenthood in St. Paul, Minnesota, between July 1, 2016, and December 31, 2019, who were diagnosed with a pregnancy of unknown location (the “St. Paul Study”). The St. Paul Study examined the outcomes from a protocol for providing medication abortion for patients with a pregnancy of unknown location who were at low risk for ectopic pregnancy and who had chosen that method of abortion. Our study found that this protocol—immediate medication abortion treatment with simultaneous serial testing of the pregnancy hormone human chorionic gonadotropin (“hCG”) to further exclude ectopic pregnancy—was safe and effective.⁴³ No evidence suggests medication abortion worsens an ectopic pregnancy, but medication abortion does not treat it, which is why simultaneous screening for ectopic pregnancy is an important piece of the protocol.

46. Based on our research, we concluded that the option of proceeding with a medication abortion before the pregnancy location had been diagnosed with

⁴³ Borchert et al., *supra* note 1 at 6; *see also* Alisa B. Goldberg et al., *Mifepristone and Misoprostol for Undesired Pregnancy of Unknown Location*, 139 *Obstetrics & Gynecology* 771, 780 (2022).

ultrasonography has the potential to help improve access to care and patient satisfaction and does not delay the diagnosis of ectopic pregnancy.

47. In addition to the St. Paul Study, another peer-reviewed study, which also demonstrated the safety and efficacy of medication abortion for patients with a pregnancy of unknown location, showed that this protocol leads to earlier exclusion of ectopic pregnancy than waiting to see whether an intrauterine pregnancy can be diagnosed.⁴⁴

48. I understand that PPSAT and Dr. Gray use the same evidence-based protocol for administering medication abortion to patients with pregnancies of unknown location as the one used in the St. Paul Study. At a high level, this protocol involves screening for ectopic pregnancy and referring high-ectopic-risk patients for appropriate treatment; counseling low-ectopic-risk patients on their options (medication abortion, aspiration abortion, or returning at a later date to see if an intrauterine pregnancy can be seen on an ultrasound at that time); performing serial blood testing to test whether the hCG level rises or falls over time; and conducting appropriate surveillance and follow-up to ensure the pregnancy was terminated and any complications are identified and treated (the “Protocol”). This Protocol is substantially identical to the protocol that I use both in outpatient clinics and the hospital.

49. If an outpatient clinic were to refer a patient with a pregnancy of unknown location to a hospital for ectopic evaluation instead of administering a medication abortion according to this Protocol, based on my experience the hospital would likely perform the same serial hCG testing that the outpatient clinic could have performed while

⁴⁴ Goldberg et al., *supra* note 43 at 778.

simultaneously administering the medication abortion (assuming the hospital does not itself offer the patient the option of medication abortion plus serial hCG testing according to the Protocol). Therefore, such a referral would not increase patient safety and would only serve to delay abortion care.

50. It is important to note that the Protocol (both in my research and as employed by PPSAT and Dr. Gray) would only be used to treat patients who have already been determined to be at a low risk for ectopic pregnancy. Ectopic pregnancies continue to be a significant cause of pregnancy-related morbidity and mortality because, if left untreated, they can rupture and cause serious internal bleeding. For this reason, clinicians at both hospitals and outpatient health centers routinely provide detailed counseling and conduct a symptom assessment to identify patients at risk for ectopic pregnancies, including by considering known risk factors, symptoms, and prior and current health history—all of which can be assessed by a conversation with the patient.⁴⁵ For example, when I conduct this type of ectopic screening, I ask patients about their last menstrual cycle (date, timing, regularity, amount of bleeding and cramping); whether they have had a prior ectopic pregnancy or treatment and/or hospitalization for pelvic inflammatory disease or prior tubal sterilization; whether they were using hormonal birth control, an intrauterine device or oral emergency contraception when they became pregnant; whether

⁴⁵ See, e.g., Abigail R. Aiken et al., *Effectiveness, Safety and Acceptability of No-Test Medical Abortion (Termination of Pregnancy) Provided via Telemedicine: A National Cohort Study*, 128 *BJOG: Int'l J. Obstetrics & Gynaecology* 1464, 1466 (2021) (explaining that patients “were offered a consultation via phone or video call, during which an assessment of eligibility for treatment via telemedicine was made,” which included assessing whether “they had a low risk of ectopic pregnancy”); see also Upadhyay et al. (2022), *supra* note 1.

they have had a pregnancy recently and the outcome of that pregnancy; and whether they are experiencing any symptoms such as abdominal or pelvic pain and bleeding that was not typical for a menstrual cycle. I do not rely on one single piece of information to make my assessment.

51. In fact, research demonstrates that screening for medication abortion eligibility without categorically requiring ultrasonography is safe for many patients. I co-authored a research study which showed that screening for medication abortion eligibility based on a patient's medical history can be as safe as screening protocols that utilize an ultrasound or pelvic exam.⁴⁶ Another recent study examining patients screened for ectopic pregnancy via phone or video call, who went on to have medication abortions without prior ultrasound, found no statistically significant difference in the rate of ectopic pregnancy between the group of patients that had ultrasound and the group that did not, further demonstrating the safety and efficacy of using ectopic screening methods other than ultrasound for patients planning medication abortion.⁴⁷

52. Based on all the above, it is my opinion that there is no medical reason to require the confirmation of an intrauterine pregnancy before administering medication abortion. With the proper protocol, counseling, surveillance, and follow-up, medication abortion may be safely and effectively administered to low-ectopic-risk patients with pregnancies of unknown location who prefer that method of treatment. Sending a patient

⁴⁶ Upadhyay et al. (2022), *supra* note 1 at 488; Anger et al., *supra* note 1 at 663–64.

⁴⁷ Aiken et al., *supra* note 45, at 1469 (finding that “[t]he overall incidence of ectopic pregnancy was equivalent in both cohorts — 39 (0.2%) in the traditional cohort and 49 (0.2%) in the telemedicine-hybrid cohort”).

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away solely because they have a pregnancy of unknown location does not serve the patient and only serves to unnecessarily delay care and impede abortion access.

* * *

53. In sum, the Hospitalization Requirement and IUP Documentation Requirement do not improve patient safety. They single out abortion—an extremely safe and common procedure—for burdensome treatment and, rather than helping patients, impede their access to care.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: March 1, 2024

Signed: 

Christy M. Boraas Alsleben, M.D., M.P.H.

EXHIBIT 1

CURRICULUM VITAE FOR PROMOTION AND TENURE

CHRISTY M. BORAAS, M.D., M.P.H
United States

PROFESSIONAL ADDRESS

Address M Health Fairview Women's Clinic
606 24th Avenue South, Suite 300
Minneapolis, MN 55454

Telephone [REDACTED]
FAX [REDACTED]
Email [REDACTED]

Address Planned Parenthood North Central States
671 Vandalia Street 1200 Lagoon Avenue
St. Paul, MN 55114 Minneapolis, MN 55408

Telephone [REDACTED]
FAX [REDACTED]
Email [REDACTED]

IDENTIFYING INFORMATION**Education**

Degree	Institution	Date Degree Granted
B.A.	St. Olaf College, Northfield, MN <i>Biology and English, magna cum laude</i>	2001
	University of Pittsburgh, Pittsburgh, PA <i>Semester at Sea Study Abroad Program</i>	Fall 2000
M.P.H.	University of Minnesota School of Public Health, Minneapolis, MN <i>Epidemiology</i>	2004
M.D.	University of Minnesota Medical School, Minneapolis, MN <i>With Honors</i>	2008
Residency in Obstetrics and Gynecology	The Ohio State University Medical Center, Columbus, OH	07/2008-06/2012
Fellowship in Family Planning	Magee-Womens Hospital, University of Pittsburgh, Pittsburgh, PA	07/2012-07/2014
Certificate in Clinical Research	Institute for Clinical Research Education, University of Pittsburgh, Pittsburgh, PA	07/2012-07/2014

Fellowship in Reproductive Health Advocacy	Leadership Training Academy, Physicians for Reproductive Health, New York, NY	07/2013-06/2014
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Certifications

Fellow, American Board of Obstetrics and Gynecology (#9028922)	2017-present
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Licenses

Medical Physician and Surgeon, Minnesota (#58304)	2014-present
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Medical Physician and Surgeon, Pennsylvania (#MD445822)	2012-2014
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Academic Appointments

University of Minnesota Minnesota Population Center Faculty Member	2019-present
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University of Minnesota Medical School, Twin Cities (2016-2022) Center for Global Health and Social Responsibility Associate Global Health Faculty	2016-present
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University of Minnesota Medical School, Twin Cities (2015-2022) Department of Obstetrics, Gynecology and Women's Health Assistant Professor	2015-present
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Department of Obstetrics, Gynecology and Reproductive Sciences University of Pittsburgh School of Medicine, Pittsburgh, PA Clinical Instructor	2012-2014
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University of Pittsburgh School of Medicine, Pittsburgh, PA Center for Family Planning Research Investigator	2012-2014
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Academic Administrative Appointments

University of Minnesota Medical School, Twin Cities Ryan Residency Training Program in Abortion and Family Planning Director	2015-present
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University of Minnesota Medical School, Twin Cities Fellowship in Family Planning (ACGME approval pending) Director	2015-present
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Planned Parenthood Minnesota, South Dakota, North Dakota, St. Paul, MN Director of Obstetrics and Gynecology Resident Education	2014-present
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The Ohio State University, Columbus, OH Department of Obstetrics and Gynecology Chief Administrative Resident	2011-2012
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Clinical/Hospital Appointments

M Health Fairview Women's Clinic, Minneapolis, MN Staff Physician	2015-present
University of Minnesota Medical Center, Minneapolis, MN Staff Physician	2014-present
Planned Parenthood Minnesota, South Dakota, North Dakota, St. Paul, MN Associate Medical Director	2014-present
Director of Research	2014-present
Whole Woman's Health Twin Cities, Minneapolis, MN Staff Physician	2014-present
Planned Parenthood of Western Pennsylvania, Pittsburgh, PA Staff Physician	2012-2014

Consulting Positions

ViiV Healthcare	2022-present
American College of Obstetricians and Gynecologists, Optimizing Care for Pregnancy Loss (OCPL) Program Trainer	2021-present
American College of Obstetricians and Gynecologists, Implementing Progress in Abortion Care and Training (IMPACT) Trainer	2021-present
University of Global Health Equity, Rwanda	2020-present
American College of Obstetricians and Gynecologists, Immediate Postpartum Long-Acting Reversible Contraception Trainer	2018-present
Minnesota Department of Health	2017-present
Basic Health International	2014-present
American Refugee Committee International	2013-present

Current Membership and Offices in Professional Organizations

Member, Consortium of Abortion Providers Abortion Equity Cohort	2021-2023
Member, Education Committee, Fellowship in Complex Family Planning	2020-present
Minnesota Public Health Association (MPHA) Member	2018-present
Member, MPHA Global Health Committee	2018-present
Society of Family Planning (SFP) (2015-2022) Member, Finance Committee	2021-present

Member, Research Implementation Special Interest Group	2021-present
Junior Fellow	2012-present
Member, Program Committee	2019-2020
Member, Annual Meeting Session Working Group	2019
Member, Audit Committee	2015-2018
Minnesota Medical Association (MMA) (2014-2022)	
Chair, Abortion Policy Work Group	2021-2023
Member, Policy Council	2017-2023
Member	2014-present
Member, Medical Practice and Quality Committee	2014-2018
Minnesota section of ACOG (MN ACOG) (2014-2022)	
Member, Annual Meeting Planning Committee	2021-present
Member, Advisory Council	2019-present
Member	2014-present
Member, Legislative Committee	2014-present
Member, Association of Professionals of Gynecology and Obstetrics (APGO)	2014-present
Member, Physicians for Reproductive Health	2010-present
American Congress of Obstetricians and Gynecologists (ACOG) (2008-2022)	
Fellow	2017-present
Junior Fellow	2008-2017
Member, Academy of Breastfeeding Medicine	2013-2016
Member, Association of Reproductive Health Professionals	2009-2016
Visiting Professorships or Visiting Scholar Positions	
American Refugee Committee International	
Ban Don Yan Refugee Camp, Sangkhlaburi, Thailand	
Family Planning Specialist	2013
Kilimanjaro Christian Medical Center, Moshi, Tanzania	
Clinical Instructor in Obstetrics and Gynecology	2011
Pro-Link Organization, Accra, Ghana	
Reproductive Health Epidemiologist	2003

HONORS AND AWARDS FOR RESEARCH, TEACHING, PUBLIC ENGAGEMENT AND SERVICE

University of Minnesota

Gold Humanism Honor Society	2007-2008
Medical School Basic Science Overall Top Honors (Top 20%)	2006
Student Research Grant, Minnesota Medical Foundation	2005

Walter H. Judd Fellowship in Global Health 2003, 2007

External Sources

UMP Clinical Excellence Award	2022, 2023, 2024
Top Doctor, Minnesota Monthly Magazine	2018, 2021, 2022, 2023
Rising Star, Mpls St. Paul Magazine	2021
David E. Rogers Fellowship	2005
Phi Beta Kappa	2001
St. Olaf College Biological Honor Society	2001
Semester at Sea Dean's List	2000

RESEARCH AND SCHOLARSHIP

Grants and Contracts

External Sources

Current

1. Role: Co-Investigator
 Principal Investigator: David Turok, MD
 External Agency: University of Utah
 Grant Title: LNG 52 mg IUD for Emergency Contraception and Same-Day Start
 Project Dates: 06/01/2022-5/30/2024
 Total costs: \$24,505
 Direct costs/year: \$19,505
 Funded salary support: 1%
2. Role: Co-Investigator
 Principal Investigator: Alison Ojanen-Goldsmith
 External Agency: Male Contraceptive Initiative
 Grant Title: Acceptability, preferences, and values related to contraception for people who produce sperm
 Project Dates: 12/01/20-11/30/22
 Total costs: \$150,000
 Direct costs/year: \$71,442.50
 Funded salary support: 1%

Pending

1. Role: Site Principal Investigator
 External Agency: Gynuity Health Projects
 Grant Title: Extending outpatient medical abortion in the late first trimester of pregnancy
 Submitted: September 2020
 Project Dates: 10/01/22-TBD
 Total costs: TBD
 Direct costs/year: TBD
 Funded salary support: 1%

Completed

1. Role: Co-Investigator
 PI: Sharon Allen, MD, PhD
 Grant Number: 5R01DA047287
 External Agency: National Institutes of Health
 Grant Title: Bupropion for the Prevention of Postpartum Smoking Relapse
 Project Dates: 09/01/18-08/30/23
 Total costs: \$2,372,039
 Direct costs/year: \$440,350
 % Effort/salary support: 5%

2. Role: Site Principal Investigator
 External Agency: Gynuity Health Projects
 Grant Title: Medication Abortion with Autonomous Self-Assessment
 Submitted: November 2021
 Project Dates: 03/01/2022-02/28/2023
 Total costs: \$34,345.84
 Direct costs/year: \$25,759.38
 Funded salary support: 1%

3. Role: Site Principal Investigator
 External Agency: Mayo Clinic
 Grant Title: Validation study of self-collected rectal and pharyngeal swabs for Chlamydia and Gonorrhea testing
 Project Dates: 10/01/21 - 10/01/22
 Direct costs/year: \$34,793.94
 Funded salary support: 1%

4. Role: Site Principal Investigator
 External Agency: University of Pennsylvania
 Grant Title: Development of an implementation strategy to integrate HIV pre-exposure prophylaxis into family planning care
 Project Dates: 11/01/21 - 11/01/22
 Total costs: not applicable
 Direct costs/year: not applicable
 Funded salary support: 1%

5. Role: Site Principal Investigator
 Principal Investigator: Elizabeth Raymond, MD
 External Agency: Gynuity Health Projects
 Grant Title: Feasibility of Medical Abortion by Direct-to-Consumer Telemedicine.
 Project Dates: 09/01/19-11/01/21
 Total costs: \$85,000
 Direct costs/year: \$63,750
 Funded salary support: 1%

6. Role: Co-Investigator

PI: Rebecca Schlafer, PhD
 Grant Number: 5R03HD093961
 External Agency: National Institutes of Health
 Grant Title: Efficacy and Cost-Effectiveness of Doula Care for Incarcerated Pregnant Women
 Project Dates: 07/01/17 - 06/30/20
 Total cost: \$154,000
 Direct costs/year: \$50,000
 Funded salary support: 10%

7. Role: Co-investigator

Principal Investigator: Vivian Bardwell, PhD
 Grant Number: 5R01HD084459
 External Agency: National Institutes of Health
 Grant Title: Control of Trophoblast Differentiation in Placental Development
 Project Dates: 03/01/16-01/01/18
 Total costs: \$1,424,260
 Direct costs/year: \$215,463
 Funded salary support: 0%
8. Role: Site Principal Investigator

Principal Investigator: Ilana Dzuba, MHSc
 External Agency: Gynuity Health Projects
 Grant Title: Non-surgical alternatives to treatment of failed medical abortion: A randomized controlled double-blind trial.
 Project Dates: 03/01/17-01/31/18
 Total costs: \$24,000
 Direct costs/year: \$18,000
 Funded salary support: 1%
9. Role: Principal Investigator

External Agency: William and Flora Hewlett Foundation
 Grant Title: Quantifying contraceptive failure with unprotected intercourse 6-14 days prior to contraceptive initiation.
 Project Dates: 11/01/16-08/30/18
 Total costs: \$63,000
 Direct costs/year: \$50,400
 Funded salary support: 10%
10. Role: Site Principal Investigator

External Agency: Gynuity Health Projects
 Grant Title: Simplified Medical Abortion Screening: A Pilot Demonstration Project
 Project Dates: 08/01/16-01/31/17
 Total: \$24,000
 Direct costs/year: \$19,200
 Funded salary support: 1%
11. Role: Principal Investigator

External Agency: Society of Family Planning Research Fund

Grant Title: Quick start levonorgestrel intrauterine contraceptive initiation in the setting of unprotected intercourse: a pilot study.

Project Dates: 02/01/14-12/31/15

Total costs: \$30,000

Direct costs/year: \$24,000

Funded salary support: 5%

12. Role: Principal Investigator

External Agency: Society of Family Planning Research Fund

Grant Title: Dilapan-S with Adjunctive Misoprostol for Same-day Second Trimester Dilation and Evacuation: A Randomized, Double-Blind, Placebo-Controlled Trial

Project Dates: 06/01/13-07/31/14

Total costs: \$70,000

Direct costs/year: \$56,000

Funded salary support: 10%

Business and Industry (Clinical) Trials

Current

1. Role: Site Principal Investigator

External Agency: Quidel Ortho Corporation

Title: Savanna HVT Validation Study

Submitted: May 2023

Project Dates: 11/01/2023-10/31/2024

Total cost: \$198,373.50

Direct costs/year: \$61,200

Funded salary support: 1%

2. Role: Site Principal Investigator

External Agency: BD

Title: IDS-QSCTGC Clinical Study Clinical Validation of the BD Elience™ POC CT/GC Assay

Submitted: March 2023

Project Dates: 11/01/23-05/01/24

Total cost: \$282,717.50

Direct costs/year: \$241,540.00

Funded salary support: 1%

3. Role: Site Principal Investigator

External Agency: Visby Medical

Title: Clinical Evaluation of Visby Medical Personal PCR Women's Sexual Health Test for the Detection of Chlamydia trachomatis (CT), Neisseria gonorrhoeae (NG), and Trichomonas vaginalis (TV) Using Self-Collected Vaginal Swabs.

Submitted: Jan 2023

Project Dates: 03/01/23-03/01/24

Direct costs/year: \$124,500

Funded salary support: 1%

4. Role: Site Principal Investigator

External Agency: Mylan Technologies Inc., A Viatris Company

Title: A Phase 3, Multicenter, Open-Label, Single Arm Study of MR-100A-01 in Women of Childbearing Potential to Evaluate Contraceptive Efficacy and Safety

Submitted: May 2023

Project Dates: 08/15/2023-01/01/25

Total cost: \$228,750

Direct costs/year: \$214,440

Funded salary support: 1%

5. Role: Site Principal Investigator

External Agency: Sebela, Inc.

Title: A Phase 3, Prospective, Multi-Center, Single-Arm, Open-Label Study to Evaluate VeraCept®, a Long-Acting Reversible Intrauterine Contraceptive for Contraceptive Efficacy, Safety, and Tolerability.

Submitted: March 2017

Project Dates: 10/01/18-06/01/24

Total cost: \$1,165,751

Direct costs/year: \$124,901.89

Funded salary support: 1%

6. Role: Site Principal Investigator

External Agency: Merck, Inc.

Title: A Phase 3, Open-Label, Multi-Center, Single Arm Study to Assess Contraceptive Efficacy and Safety of the Etonogestrel (MK-8415) Implant during Extended Use Beyond 36 months from Insertion in Premenopausal Females up to 35 years of age.

Submitted: June 2020

Project Dates: 12/01/20-11/30/22

Total costs: \$761,364

Direct costs/year: \$266,477.40

Funded salary support: 1%

Pending

1. Role: Site Principal Investigator

External Agency: PRA Health Sciences, Inc.

Title: A Phase 3, Prospective, Multi-Center, Single-Arm, Open-Label Study to Evaluate LevoCept™, a Long-Acting Reversible Intrauterine System (IUS) for Contraceptive Efficacy, Safety, and Tolerability.

Submitted: May 2020

Project Dates: 01/01/22-12/31/29

Total Costs: TBD

Direct costs/year: TBD

Funded salary support: TBD

Completed

1. Role: Site Principal Investigator

External Agency: Roche Molecular Systems, Inc.

Title: Prospective Women's Health Sample Collection_RMS_BAM

Submitted: Feb 2023

Project Dates: 01/01/23-10/31/23

Direct costs/year: \$96,817
 Funded salary support: 1%

2. Role: Site Principal Investigator
 External Agency: Roche Molecular Systems, Inc.
 Title: cobas® CT/NG/MG Nucleic acid test for use on the cobas® Liat® System: Clinical Performance Evaluation
 Submitted: Nov 2022
 Project Dates: 01/01/23-09/30/23
 Direct costs/year: \$229,687
 Funded salary support: 1%

3. Role: Site Principal Investigator
 External Agency: Cepheid
 Title: 248C3: Clinical Evaluation of the Xpert Xpress CT/NG Test in Female Extragenital Specimens
 Submitted: July 2022
 Project Dates: 10/01/22-04/30/2023
 Total costs: \$149,349.50
 Direct costs/year: \$104,544.65
 Funded salary support: 1%

4. Role: Site Principal Investigator
 External Agency: Beckman Coulter, Inc.
 Title: Access HBV Serological Markers Subject Enrollment US Protocol, Access HCV AB Assay Subject Enrollment US Protocol, Access HIV AG/AB Combo Assay US Enrollment Protocol
 Submitted: October 2021
 Project Dates: 11/01/21-11/01/22
 Total Costs: \$828,281.25
 Direct costs/year: \$621,210.94
 Funded salary support: 1%

5. Role: Site Principal Investigator
 External Agency: EvoFem Biosciences
 Title: Phase 3 double-blind placebo-controlled efficacy trial of EVO100 vaginal gel for the prevention of urogenital Chlamydia trachomatis and Neisseria gonorrhoea infection
 Submitted: July 2020
 Project Dates: 10/21/20-10/21/22
 Total costs: \$279,977.50
 Direct costs/year: \$193,692.50
 Funded salary support: 1%

6. Role: Site Principal Investigator
 External Agency: Abbott Molecular, Inc.
 Title: Alinity m HR HPV Specimen Collection Study from Women Referred to Colposcopy
 Submitted: May 2021
 Project Dates: 05/01/21-05/01/22
 Total costs: \$240,000
 Direct costs/year: \$168,000

Funded salary support: 1%

7. Role: Site Principal Investigator
 External Agency: Cepheid
 Title: Clinical Evaluation of the Xpert Xpress CT/NG Test in Female Urogenital Specimens
 Submitted: April 2020
 Project Dates: 04/28/20-4/28/21
 Direct costs/year: \$50,000
 Funded salary support: 1%

8. Role: Site Principal Investigator
 External Agency: Cepheid
 Title: Pre-Clinical Evaluation of the Xpert Xpress CT/NG Test
 Submitted: April 2019
 Project Dates: 07/08/19-10/30/19
 Direct costs/year: \$28,475
 Funded salary support: 1%

9. Role: Site Principal Investigator
 External Agency: Visby Medical (Click Dx)
 Title: Clinical Evaluation of the Click Sexual Health Test for the Detection of Neisseria gonorrhoeae, Trichomonas vaginalis, and Chlamydia trachomatis in Women.
 Submitted: July 2019
 Project Dates: 09/19/19-12/30/19
 Direct costs/year: \$28,650
 Funded salary support: 1%

10. Role: Site Principal Investigator
 External Agency: Abbott (Alere) San Diego
 Title: Alere hCG Test Method Comparison Study.
 Submitted: February 2019
 Project Dates: 03/15/19-07/30/19
 Direct costs/year: \$55,050
 Funded salary support: 5%

11. Role: Site Principal Investigator
 External Agency: HRA Pharma
 Title: Multi-Center Study to Test the Comprehension of the Ovrette® OTC Drug Facts Label
 Project Dates: 10/01/16-01/31/17
 Direct costs/year: \$8,450
 Funded salary support: 1%

12. Role: Site Principal Investigator
 External Agency: Hologic, Inc.
 Title: Prospective Collection and Testing of Lesion Specimens for the Development of a Herpes Simplex Virus Assay.
 Project Dates: 10/01/14-07/31/16
 Direct costs/year: \$30,300

Funded salary support: 1%

University of Minnesota Sources

Current

1. Role: Co-Principal Investigator
Principal Investigator: Karen Borchert, MD
Internal Agency: University of Minnesota Medical School, Department of Family Medicine
Title: Pregnancy of Unknown Location in Abortion Care: Management and Outcomes.
Project Dates: 01/01/17-12/31/22
Direct costs/year: non-applicable

Completed

1. Role: Principal Investigator
Internal Agency: University of Minnesota Medical School, Department of Obstetrics, Gynecology and Women's Health Progressive Grant, Phase II
Title: Identifying predictors of post-abortion contraceptive uptake using a comprehensive, multisite database
Project Dates: 07/01/20-06/30/22
Direct Costs/Year: \$20,000
Funded salary support: 0%
2. Role: Principal Investigator
Internal Agency: University of Minnesota Medical School, Department of Obstetrics, Gynecology and Women's Health Research Support Grant
Title: Quantifying contraceptive failure with unprotected intercourse 6-14 days prior to contraceptive initiation
Project Dates: 01/01/17-6/30/21
Total Cost: \$3,500
Funded salary support: 0%
3. Role: Principal Investigator
Internal Agency: University of Minnesota Medical School, Department of Obstetrics, Gynecology and Women's Health Research Support Grant
Title: Conrasperm: the Future of Male Birth Control
Project Dates: 08/01/19-07/31/20
Total Cost: \$4,500
Funded salary support: 0%
4. Role: Principal Investigator
Internal Agency: University of Minnesota Medical School, Department of Obstetrics, Gynecology and Women's Health Progressive Grant, Phase I
Title: Identifying predictors of post-abortion contraceptive uptake using a comprehensive, multisite database
Project Dates: 08/01/19-07/31/20
Total cost: \$10,000
Funded salary support: 0%

Publications

Impact Analytics

<i>h</i> -Index	<i>h(f)</i> -Index	Total Publications	First/Last Author Publications	Total Citations	First/Last Author Citations
8	2	18	6	231	18

Publication #1-2 not yet in Manifest

Peer-Reviewed Publications

1. Wise MK, Okuyemi O, Flint M, Biscaye EM, Tessier KM, Traxler SA, **Boraas CM**. Intrauterine Device Placement Success for Adolescents and Young Adults at Community-based Reproductive Health Clinics. J Pediatr Adolesc Gynecol. 2023 Dec 8:S1083-3188(23)00451-5. doi: 10.1016/j.jpac.2023.11.013. Online ahead of print.
Impact Factor: 2.298; Times Cited: 0; Role: Developed study concept and design, defined intellectual content, conducted literature search, data acquisition, manuscript preparation, editing and review.
2. Raymond EG, Frye LJ, Tocce K, Gingras S, Almquist A, Firstenberg A, Ortega C, Blumenthal PD, Winikoff B, **Boraas C**. Evaluation of a “smart” screening tool for asynchronous assessment of medication abortion eligibility: A pilot study. Contraception. 2023 Nov 20:110340. doi: 10.1016/j.contraception.2023.110340. Online ahead of print.
Impact Factor: 2.335; Times Cited: 0; Role: Developed study concept and design, defined intellectual content, conducted literature search, data acquisition, manuscript preparation, editing and review.
3. Hassan A, Ojanen-Goldsmith A, Hing A, Mahoney M, Traxler SA, **Boraas CM**. More than tears: associations between exposure to chemical agents used by law enforcement and adverse reproductive health outcomes. Front. Epidemiol. Sec. Occupational and Environmental Epidemiology. 2023 Aug 23:3 - 2023. <https://doi.org/10.3389/fepid.2023.1177874>
<https://www.frontiersin.org/articles/10.3389/fepid.2023.1177874/full>
Impact Factor: n/a; Times Cited: 0; Role: Developed study concept and design, defined intellectual content, conducted literature search, data acquisition, manuscript preparation, editing and review.
4. Martins SL, **Boraas CM**. Willingness to use novel reversible methods of male birth control: a community-based survey of cisgender men in the United States. Contracept Reprod Med. 2023 Aug 10;8(1):41. doi: 10.1186/s40834-023-00242-y.
Impact Factor: 2.9; Times Cited: 0; Role: Developed study concept and design, defined intellectual content, conducted literature search, data acquisition, manuscript preparation, editing and review.
5. Borchert K, Thibodeau C, Varin P, Wipf H, Traxler S, **Boraas CM**. Medication Abortion and Uterine Aspiration for Undesired Pregnancy of Unknown Location: A Retrospective Cohort Study. Contraception. 2023 Jun;122:109980. doi:10.1016/j.contraception.2023.109980.
Impact Factor: 2.335; Times Cited: 0; Role: Developed study concept and design, defined intellectual content, conducted literature search, data acquisition, manuscript preparation, editing and review.

6. Koenig LR, Raymond EG, Gold M, **Boraas CM**, Kaneshiro B, Winikoff B, Coplon L, Upadhyay UD. Mailing abortion Pills does not delay care: a cohort study comparing mailed to in-person dispensing of abortion medications in the United States. Contraception. 2023 Jun;122:109962. doi: 10.1016/j.contraception.2023.109962.
Impact Factor: 2.335; Times Cited: 0; Role: Protocol editing, site administration of multicenter trial, data acquisition, manuscript preparation, editing and review.
7. Groene EA*, **Boraas CM**, Smith MK, Lofgren SM, Rothenberger MK, Enns EA. Evaluation of Strategies to Improve Uptake of Expedited Partner Therapy for *Chlamydia trachomatis* Treatment in Minnesota: A Decision Analytic Model. MDM Policy Pract. 2023 Jan 22;8(1):23814683221150446. doi: 10.1177/23814683221150446. eCollection 2023 Jan-Jun.
Impact Factor: 1.54; Times Cited: 0; Role: Developed study concept and design, defined intellectual content, conducted data acquisition, manuscript preparation, editing and review.
8. Groene EA*, **Boraas CM**, Smith MK, Lofgren SM, Rothenberger MK, Enns EA. A statewide mixed-methods study of provider knowledge and behavior administering Expedited Partner Therapy for chlamydia and gonorrhea. Sex Transm Dis. 2022 Jul 3. doi: 10.1097/OLQ.0000000000001668.
Impact factor: 3.686; Times Cited: 0; Role: Protocol creation, manuscript preparation, editing and review.
9. Ralph JA, Westberg SM, **Boraas CM**, Terrell CA, Fischer JR. PrEP-aring the General Gynecologist to Offer HIV Pre-exposure Prophylaxis. Clin Obstet Gynecol. 2022 Jun 16. doi: 10.1097/GRF.0000000000000713. Online ahead of print.
Impact factor: 1.619; Times Cited: 0; Role: manuscript preparation, editing and review.
10. Henke L*, Martins S*, **Boraas CM**. Associations Between Income Status and Perceived Barriers to Using Long-Acting Reversible Contraception: An Exploratory Study. Front Reprod Health, 12 April 2022. <https://doi.org/10.3389/frph.2022.856866>
Impact factor: NA; Times Cited: 0; Role: Protocol creation, data acquisition, manuscript preparation, editing and review.
11. Upadhyay UD, Raymond EG, Koenig LR, Coplon L, Gold M, Kaneshiro B, **Boraas CM**, Winikoff B. Outcomes and Safety of History-Based Screening for Medication Abortion: A Retrospective Multicenter Cohort Study. JAMA Intern Med. 2022 Mar 21. Online ahead of print.
impact factor: 44.41; Times Cited: 26; Role: Protocol editing, site administration of multicenter trial, data acquisition, manuscript preparation, editing and review.
12. Anger HA, Raymond EG, Grant M, Haskell S, **Boraas C**, Tocee K, Banks J, Coplon L, Shochet T, Platais I, Winikoff B. Clinical and service delivery implications of omitting ultrasound before medication provided abortion via direct-to-patient telemedicine and mail. Contraception. 2021 Dec;104(6):659-665. doi: 10.1016/j.contraception.2021.07.108. Epub 2021 Jul 28.
Journal Impact Factor: 2.335; Times Cited: 8; Role: Protocol editing, site administration of multicenter trial, data acquisition, manuscript preparation, editing and review.
13. Chong E, Shochet T, Raymond E, Platais I, Anger HA, Raidoo S, Soon R, Grant MS, Haskell S, Tocce K, Baldwin MK, **Boraas CM**, Bednarek PH, Banks J, Coplon L, Thompson F, Priegue E,

- Winikoff B. Expansion of a direct-to-patient telemedicine abortion service in the United States and experience during the COVID-19 pandemic. *Contraception*. 2021 Jul;104(1):43-48. doi: 10.1016/j.contraception.2021.03.019. Epub 2021 Mar 27.
Journal Impact Factor: 2.335; Times Cited: 50; Role: Protocol review and editing, site administration of multicenter trial, data acquisition, manuscript preparation, editing and review.
14. **Boraas CM**, Sanders JN, Schwarz EB, Thompson I, Turok DK. Risk of Pregnancy With Levonorgestrel-Releasing Intrauterine System Placement 6-14 Days After Unprotected Sexual Intercourse. *Obstet Gynecol*. 2021 Apr 1;137(4):623-625.
Journal Impact Factor: 4.982; Times Cited: 0; Role: Protocol review and editing, grant writing and submission, site administration of multicenter trial, data acquisition, manuscript preparation, editing and review.
15. Raymond EG, Anger HA, Chong E, Haskell S, Grant M, **Boraas C**, Tocce K, Banks J, Kaneshiro B, Baldwin MK, Coplon L, Bednarek P, Shochet T, Platais I. "False positive" urine pregnancy test results after successful medication abortion. *Contraception*. 2021 Jun;103(6):400-403. doi: 10.1016/j.contraception.2021.02.004. Epub 2021 Feb 14.
Journal Impact Factor: 2.335; Times Cited: 0; Role: Protocol review and editing, site administration of multicenter trial, data acquisition, manuscript preparation, editing and review.
16. Schlafer R, Saunders JB, **Boraas CM**, Kozhimannil KB, Mazumder N, Freese R. Maternal and neonatal among incarcerated women who gave birth in custody. *Birth*. 2021 Mar;48(1):122-131. doi: 10.1111/birt.12524. Epub 2020 Dec 27.
Impact factor 3.689; Times cited 6; Role: Developed study concept and design, defined intellectual content, manuscript preparation, editing and review.
17. Thompson I, Sanders JN, Schwarz EB, **Boraas C**, Turok DK. Copper intrauterine device placement 6-14 days after unprotected sex. *Contraception*. 2019 Sep;100(3):219-221. doi: 10.1016/j.contraception.2019.05.015. Epub 2019 Jun 7.
Impact factor 2.335; Times cited 10; Role: Protocol review and editing, grant writing and submission, site administration of multicenter trial, data acquisition, manuscript preparation, editing and review.
18. Raymond EG, Tan YL, Comendant R, Sagaidac I, Hodorocea S, Grant M, Sanhueza P, Van Pratt E, Gillespie G, **Boraas C**, Weaver MA, Platais I, Bousiequez M, Winikoff B. Simplified medical abortion screening: a demonstration project. *Contraception*. 2018 Apr;97(4):292-296. doi: 10.1016/j.contraception.2017.11.005. Epub 2017 Nov 21. PMID: 29170088
Impact factor 2.335; Times cited 27; Role: Protocol review and editing, site administration of multicenter trial, data acquisition, manuscript preparation, editing and review.
19. **Boraas CM**, Chappell CA, Krajewski CM. Use of an Endotracheal Tube for Surgical Abortion Complicated by a Leiomyomatous Uterus: A Case Report. *J Med Case Rep*. 2017 August 25;11(1):236. doi: 10.1186/s13256-017-1408-y. PMID: 28838323.
Impact factor 1.07; Times cited 1; Role: Developed case report design, defined intellectual content, conducted literature search, data acquisition, manuscript preparation, editing and review.

review.

20. Paul J*, **Boraas CM**, Duvet M*, Chang JC. YouTube and the single-rod contraceptive implant: a content analysis. J Fam Plann Reprod Health Care. 2017 Jul;43(3):195-200. doi: 10.1136/jfprhc-2016-101593. Epub 2017 Jan 20. PMID: 28108504. *Impact factor 2.151, Times cited 15; Role: Developed study concept and design, defined intellectual content, manuscript preparation, editing and review.*
21. **Boraas CM**, Achilles SL, Cremer ML, Chappell CA, Lim SE, Chen BA. Synthetic osmotic dilators with adjunctive misoprostol for same-day dilation and evacuation: a randomized controlled trial. Contraception. 2016 Nov;94(5):467-472. PMID: 27241895. *Impact factor 2.335; Times cited 11; Role: Developed study concept and design, defined intellectual content, conducted literature search, data acquisition, manuscript preparation, editing and review.*
22. Rapkin RB, Achilles SL, Schwarz EB, Meyn L, Cremer M, **Boraas CM**, Chen BA. Self-Administered Lidocaine Gel for Intrauterine Device Insertion in Nulliparous Women: A Randomized Controlled Trial. Obstet Gynecol. 2016 Sep;128(3):621-8. doi: 10.1097/ACOG.0000000000001596. PMID: 27500351. *Impact factor 4.982; Times cited 30; Role: Defined intellectual content, data acquisition, manuscript preparation, editing and review.*
23. Akinsete OO, Sides T, Hirigoyen D, Cartwright C, **Boraas C**, Davey C, Pessoa-Brandao L, McLaughlin M, Kane E, Hall J, Henry K. Demographic, clinical, and virologic characteristics of African-born persons with HIV/AIDS in a Minnesota hospital. AIDS Patient Care STDS. 2007 May;21(5):356-65. PMID: 17518528. *Impact factor 5.944; Times cited 37; Role: Data acquisition, manuscript preparation, editing and review.*

Non-Peer-Reviewed Publications

1. Martins SL*, **Boraas CM**. Contraceptive counseling: an essential travel medicine service. J Travel Med. 2020 Jul 14;27(4):taaa023. doi: 10.1093/jtm/taaa023 *Role: Commentary preparation, editing and review.*
2. Miller KK*, Gewirtz O'Brien JR*, Sajady M, Argo T*, Chaisson N, **Boraas C**. Long Acting Reversible Contraception (LARCs): Beyond Birth Control. Minnesota Pediatrician monthly newsletter, February 2020. Available at: <http://www.mnaap.org/long-acting-reversible-contraceptives-larcs-beyond-birth-control/> *Role: Manuscript preparation, editing and review.*
3. **Boraas CM**, Schwarz EB. Contraceptive Choice for Women with Obesity. Gynecology Forum. 2012 May;17(4):20-3. *Role: Developed review design, conducted literature search, manuscript preparation, editing and review.*

Chapters in Books

1. Ralph JA and **Boraas CM**. Surgical Abortion Complications. In Press. *Major Complications of Female Pelvic Surgery: A Multidisciplinary Approach*. Hoffman M, Bochner B, and Hull T, eds., Springer Nature Publishing, Berlin, Germany.
Role: Author
2. **Boraas CM**. A 32-Year-Old HIV-positive woman requesting IUD. 2019. *Office Gynecology: A Case-Based Approach, First Edition*; Chelmow D, Karjane N, Ricciotti H, Young A, eds., Cambridge University Press, New York, NY.
Role: Author
3. **Boraas CM** and Keder LM. Intrauterine Contraception Insertion and Removal. In Press. *Atlas of Pelvic Surgery and Anatomy, First Edition*; Huh W and Kim K, eds., McGraw Hill Professional, New York, NY.
Role: Author
4. **Boraas CM** and Keder LM. Contraceptive Implant Insertion and Removal. In Press. *Atlas of Pelvic Surgery and Anatomy, First Edition*; Huh, W. and Kim, K., eds, McGraw Hill Professional, New York, NY.
Role: Author
5. **Boraas CM** and Keder LM. Female Sterilization. In Press. *Atlas of Pelvic Surgery and Anatomy, First Edition*; Huh, W. and Kim, K., eds, McGraw Hill Professional, New York, NY.
Role: Author

Presentations

Invited Oral Presentations at International Professional Meetings, Conferences, etc.

1. **Boraas CM**, Nardos R, Ghebre R, Pace S, Chojnacki M. Obstetrics and Gynecology Medicine Panel. University of Minnesota Global Health Course. May 6, 2021. Virtual.
2. **Boraas CM**. Current Contraception Overview. American Refugee Committee Staff Development Conference. March 18-26, 2013. Sangkhlaburi, Thailand.
3. **Boraas CM**. Long-Acting Reversible Contraception – Implants. American Refugee Committee Staff Development Conference. March 18-26, 2013. Sangkhlaburi, Thailand.
4. **Boraas CM**. Long-Acting Reversible Contraception - Intrauterine Devices. American Refugee Committee Staff Development Conference. March 18-26, 2013. Sangkhlaburi, Thailand.

Invited Oral Presentations at National Professional Meetings, Conferences, etc.

1. **Boraas CM**. Asynchronous Medication Abortion: The MA-ASAP Research Study. Planned Parenthood Federation of America Maximizing Abortion Access Meeting. April 4, 2023. Minneapolis, MN.
2. **Boraas CM**. Asynchronous Medication Abortion: The MA-ASAP Research Study. Planned Parenthood Federation of America Medical Directors Council Annual Meeting. November 11, 2022. Tuscon, AZ.
3. **Boraas CM**, Ojanen-Goldsmith A, Torgrimson-Rojerio B, Hassan A*. Time for Action: The

impact of tear gas used by law enforcement on reproductive health. Society of Family Planning Annual Meeting. October 12, 2021. Virtual.

4. **Boraas CM.** Merck Nexplanon Extension Trial, Site Tips and Tricks. MK-8415-060 Lessons Learned – Recruitment and Retention Meeting. May 5, 2021. Virtual.
5. **Boraas CM** and Rapkin RB. Surgical Miscarriage Management in the Office: You Can Do It. ACOG Annual Clinical Meeting. April 30-May 2, 2021. Virtual.
6. **Boraas CM,** Kaneshiro B, Raymond E, Grant M. No Test Medical Abortion. Society of Family Planning Webinar. January 6, 2021. Virtual.
7. Borchert K, Wipf H*, Roeske E*, Clure C*, Traxler S, **Boraas CM.** Pregnancy of Unknown Location in Abortion Care: Management and Outcomes. National Abortion Federation Conference. April 2018. Seattle, WA.
8. **Boraas CM.** Interviewing Basics. Fellowship in Family Planning Career Development Workshop. July 23-24, 2017. Chicago, IL.
9. **Boraas CM.** Searching for a Position. Fellowship in Family Planning Career Development Workshop. July 23-24, 2017. Chicago, IL.
10. **Boraas CM** and Rapkin RB. Surgical Miscarriage Management in the Office: You Can Do It. ACOG Annual Clinical Meeting. May 7, 2017. San Diego, CA.

Invited Oral Presentations at Local and Regional Professional Meetings, Conferences, etc.

1. **Boraas, CM.** Induced Abortion for Genetic Counselors. University of Minnesota Genetic Counselor Graduate Student Education Presentation. November 13, 2023. Minneapolis, MN.
2. **Boraas, CM.** Satin, D. Janoski, E. Clinician responsibilities and vulnerabilities in the face of ethical and legal controversy. University of Minnesota Law 6854 Law, Biomedicine & Bioethics course. November 7, 2023. Minneapolis, MN.
3. **Boraas CM,** Hutto SL. Reproductive Health Skills Workshop. Simulation. University of Minnesota Medical School Obstetrics and Gynecology and Family Medicine Interest Groups Skills Night. March 20, 2023. Minneapolis, MN.
4. **Boraas CM,** Ruud M, Hassan A. Navigating and Innovating Women’s Health Services, Policies and Access Issues. 17th Annual University of Minnesota Women’s Health Research Conference. February 23, 2023. Virtual.
5. **Boraas CM** and Ralph JA. Post-Roe Implications for Reproductive Health Care and Beyond. University of Minnesota Department of Medicine Grand Rounds. December 8, 2022. Virtual.

6. **Boraas CM**, Hasday J, Walker S. Abortion Access After Dobbs. University of Minnesota Center on Women, Gender and Public Policy Hybrid Event. November 8, 2022. Minneapolis, MN.
7. **Boraas, CM**. Satin, D. Janoski, E. Clinician responsibilities and vulnerabilities in the face of ethical and legal controversy. University of Minnesota Law 6854 Law, Biomedicine & Bioethics course. November 8, 2022. Minneapolis, MN.
8. **Boraas, CM**. Trauma-informed Gyn and Pregnancy Care: How we use Language in the Exam Room. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Curriculum Conference. February 14, 2022. Minneapolis, MN.
9. **Boraas, CM**. Contraception for the Medically Complex Patient. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Curriculum Conference, February 14, 2022. Minneapolis, MN.
10. **Boraas, CM**. Induced Abortion for Genetic Counselors. University of Minnesota Genetic Counselor Graduate Student Education Presentation. December 13, 2021. Minneapolis, MN.
11. **Boraas, CM**. Ectopic pregnancy and induced abortion. University of Minnesota Women's Health Nurse Practitioner and Nurse Midwifery Education Presentation. September 17, 2021. Minneapolis, MN
12. **Boraas CM**. Dilation and Curettage Papaya Workshop. Simulation. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Bootcamp. June 21, 2021. St. Paul, MN.
13. **Boraas, CM**. Induced Abortion for Genetic Counselors. University of Minnesota Genetic Counselor Graduate Student Education Presentation. December 14, 2020. Minneapolis, MN.
14. **Boraas, CM**. Breastfeeding Basics for the Ob/Gyn Resident. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Curriculum Conference. December 28, 2020. Minneapolis, MN.
15. **Boraas CM**. Introduction to Family Planning. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Bootcamp. June 22, 2020. St. Paul, MN.
16. **Boraas CM**. Dilation and Curettage Papaya Workshop. Simulation. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Bootcamp. June 22, 2020. St. Paul, MN.
17. **Boraas CM**. Ectopic Pregnancy. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Curriculum Conference. June 22, 2020. Minneapolis, MN.

18. **Boraas CM.** Pregnancy of Unknown Location and Early Pregnancy Loss. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Curriculum Conference. May 4, 2020. Minneapolis, MN.
19. Wise M*, **Boraas CM.** Veracept Phase II Trial. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Journal Club. May 4, 2020. Minneapolis, MN.
20. **Boraas CM.** Breech Vaginal Delivery. Simulation. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Curriculum Conference. February 24, 2020. Minneapolis, MN.
21. **Boraas, CM.** Global Maternal Mortality. University of Minnesota Global Pediatrics Education Presentation. February 6, 2020. Minneapolis, MN.
22. **Boraas CM.** Important Conversations – Challenging Patients, Language, Race and Racism. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Curriculum Conference. February 27, 2020. Minneapolis, MN.
23. **Boraas CM,** Pacala K. Dilation and Curettage Papaya Workshop. Simulation. University of Minnesota Medical School Obstetrics and Gynecology Interest Group Skills Night. February 27, 2020. Minneapolis, MN.
24. **Boraas CM,** Finn K, McKegney C, Ball C. Highlighting work as an abortion provider. Lunch Lecture. Medical Students for Choice. University of Minnesota Medical School. January 13, 2020. Minneapolis, MN.
25. Gerwitz-O'Brien J*, Donlon T*, **Boraas, CM.** Advocacy in Action. Becoming a Doctor Course. University of Minnesota Medical School. January 8, 2020. Minneapolis, MN.
26. **Boraas, CM.** Contraception for Endocrine Fellows. University of Minnesota Endocrinology Fellows Education Presentation. November 21, 2019. Minneapolis, MN.
27. **Boraas, CM.** Induced Abortion for Genetic Counselors. University of Minnesota Genetic Counselor Graduate Student Education Presentation. November 18, 2019. Minneapolis, MN.
28. **Boraas, CM.** Ectopic pregnancy and induced abortion. University of Minnesota Women's Health Nurse Practitioner and Nurse Midwifery Education Presentation. September 13, 2019. Minneapolis, MN.
29. **Boraas CM.** Adolescent Gynecology. University of Minnesota Department of Pediatrics Resident Block Education Conference. August 9, 2019. Minneapolis, MN.
30. **Boraas CM.** Breech Vaginal Delivery. Simulation. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Curriculum Conference. February 18, 2019. Minneapolis, MN.

31. **Boraas CM.** LARC Tips and Tricks. University of Minnesota Department of Obstetrics. Gynecology and Women's Health Resident Curriculum Conference. February 11, 2019. Minneapolis, MN.
32. Kummer L, **Boraas CM**, Chomilo N. Making an Impact through Advocacy. Becoming a Doctor Course. University of Minnesota Medical School. January 9, 2019. Minneapolis, MN.
33. **Boraas CM** and Flanagan S. Uterine Artery Embolization in Obstetric Hemorrhage. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Grand Rounds. December 18, 2018. Minneapolis, MN.
34. **Boraas CM.** Termination of Pregnancy in the Second Trimester. Fetal Diagnosis and Treatment Center. University of Minnesota Medical School. December 6, 2018. Minneapolis, MN.
35. **Boraas CM.** Contraception Overview. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Bootcamp. June 19, 2018. Minneapolis, MN.
36. **Boraas CM.** Introduction to Abortion. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Bootcamp. June 19, 2018. Minneapolis, MN.
37. **Boraas CM.** Cesarean Scar Pregnancy. Fairview Infusion Center Continuing Medical Education. May 25, 2018. Minneapolis, MN.
38. **Boraas CM.** Abortion Cervical Preparation. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Curriculum Conference. February 26, 2018. Minneapolis, MN.
39. **Boraas CM.** Dilation and Evacuation versus Induction of Labor for Termination of Pregnancy. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Curriculum Conference. February 26, 2018. Minneapolis, MN.
40. **Boraas, CM.** Ectopic pregnancy and induced abortion. University of Minnesota Womens' Health Nurse Practitioner and Nurse Midwifery Education Presentation. December 1, 2017. Minneapolis, MN.
41. **Boraas, CM.** Global Maternal Mortality: Focus on Delivery. University of Minnesota Department of Pediatrics Residency Block Education Presentation. Hennepin County Medical Center. November 17, 2017. Minneapolis, MN.
42. **Boraas CM.** Challenging Patient Encounters. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Curriculum Conference. October 30, 2017. Minneapolis, MN.
43. **Boraas, CM**, Terrell, CA, Hutto, SL. Abortion Care at UMMC. University of Minnesota Medical Center ER Department Grand Rounds. September 28, 2017. Minneapolis, MN.

44. **Boraas, CM.** Contraception for Patients with Medical Conditions. Continuing Education Presentation. Planned Parenthood MN-ND-SD. August 8 and 12, 2017. St. Paul, MN.
45. **Boraas, CM,** Terrell, CA, Hutto, SL. Abortion Care at UMMC. UMMC Peri-operative Education Meeting. April 11, 2017. Minneapolis, MN.
46. **Boraas CM.** Mifepristone: Politics and Science in Practice, University of Minnesota Department of Obstetrics, Gynecology and Women's Health Grand Rounds. February 21, 2017. Minneapolis, MN.
47. **Boraas CM.** Breech Vaginal Delivery. Simulation. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Curriculum Conference. February 6, 2017. Minneapolis, MN.
48. **Boraas CM** and Ball CE. Family Planning Questions and Answers, Planned Parenthood MN-ND-SD Clinician Days. January 6, 2017. St. Paul, MN.
49. **Boraas CM.** Abortion Policy. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Curriculum Conference. September 12, 2016. Minneapolis, MN.
50. **Boraas CM.** Abortion Cervical Preparation. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Curriculum Conference. September 12, 2016. Minneapolis, MN.
51. **Boraas CM.** Dilation and Evacuation versus Induction of Labor for Termination of Pregnancy. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Curriculum Conference. September 12, 2016. Minneapolis, MN.
52. **Boraas CM.** Challenging Patient Encounters. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Curriculum Conference. August 29, 2016. Minneapolis, MN.
53. **Boraas CM.** Introduction to Abortion. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Bootcamp. June 20, 2016. Minneapolis, MN.
54. **Boraas CM.** Family Planning Update. University of Minnesota Department of Obstetrics, Gynecology and Women's Health and MN ACOG Autumn Seminar. November 20, 2015. Minneapolis, MN.
55. **Boraas CM.** Introduction to Abortion. University of Minnesota Department of Obstetrics, Gynecology and Women's Health Resident Bootcamp. June 23, 2015. Minneapolis, MN.
56. **Boraas CM** and Ball CE. Family Planning Questions and Answers. Planned Parenthood MN-ND-SD Clinician Days. October 1, 2014. St. Paul, MN.
57. **Boraas CM** and Eggleston K. Family Planning Questions and Answers. Planned Parenthood MN-ND-SD Clinician Days. September 30, 2014. St. Paul, MN.

58. **Boraas CM.** Family Planning in Conflict Settings. University of Pittsburgh Global Health and Underserved Lecture Series. February 10, 2014. Pittsburgh, PA.
59. **Boraas CM.** Why Women ‘Wait’: Abortion in the Second Trimester. University of Illinois at Chicago Department of Obstetrics and Gynecology Grand Rounds. January 31, 2014. Chicago, IL.
60. **Boraas CM.** Abortion and Long-Term Health Outcomes: Examining the Evidence. University of Pittsburgh Department of Obstetrics, Gynecology and Reproductive Sciences Gynecology Conference. January 6, 2014. Pittsburgh, PA.
61. **Boraas CM.** Misoprostol in Gynecologic Practice. Magee-Womens Hospital Gynecology Conference. University of Pittsburgh. November 11, 2013. Pittsburgh, PA.
62. **Boraas CM.** Towards Equity: Reproductive Health along the Thai-Burma Border. University of Pittsburgh Department of Obstetrics, Gynecology and Reproductive Sciences Gynecology Conference. July 8, 2013. Pittsburgh, PA.
63. **Boraas CM.** Fit to be Tied: Sterilization in the USA. University of Pittsburgh Department of Obstetrics, Gynecology and Reproductive Sciences Gynecology Conference. February 22, 2013. Pittsburgh, PA.
64. **Boraas CM.** Health Reform 101: What’s in it for Women? University of Pittsburgh Medical School Medical Students for Choice Lecture Series. November 2, 2012. Pittsburgh, PA.
65. **Boraas CM.** Health Reform 101: What’s in it for Women? University of Pittsburgh Department of Obstetrics, Gynecology and Reproductive Sciences Gynecology Conference. October 22, 2012. Pittsburgh, PA.
66. **Boraas CM.** Maternal Mortality: The Promise of Progress. The Ohio State University Department of Obstetrics and Gynecology Grand Rounds. May 17, 2012. Columbus, OH.
67. **Boraas CM.** Current Contraception Overview. Kilimanjaro Christian Medical College Department of Obstetrics and Gynecology Grand Rounds. March 10, 2011. Moshi, Tanzania.
68. **Boraas CM.** Morbidity and Mortality Report – Case of the Lost IUD. The Ohio State University Department of Obstetrics and Gynecology Grand Rounds. September 2, 2010. Columbus, OH.
69. **Boraas CM.** Malaria in Pregnancy. University of Minnesota Department of Obstetrics, Gynecology and Women’s Health Resident Curriculum Conference. August 27, 2010. Minneapolis, MN.

Peer-Reviewed Oral Presentations at National Professional Meetings, Conferences, etc.

1. Gawron LM, Roe AH, **Boraas CM**, Bernard C, Westhoff CL, Culwell K, Turok DK. Bleeding and pain over time with a novel low-dose copper intrauterine device with a flexible nitinol frame. Society of Family Planning Meeting. October 28-30, 2023.
2. Faherty E*, Smith K, **Boraas C**, Lofgren S, Rothenberger M, and Enns E. Using mixed methods to identify and evaluate strategies to improve uptake of Expedited Partner Therapy for *chlamydia trachomatis* infection in Minnesota. Society for Medical Decision Making Virtual Meeting, October 18-20, 2021.
3. Martins SL* and **Boraas CM**. Willingness to use the 'male' birth control pill: Demographic and reproductive health correlates among a community-based sample of U.S. men. Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research. June 21-22, 2021. Virtual.
4. Upadhyay U, Raymond E, Koenig L, Coplon L, Gold M, Kaneshiro B, **Boraas C**, Winikoff B. Safety and Efficacy of No-test Medication Abortion: A Retrospective Multi-Site Study. National Abortion Federation Meeting. May 11-12, 2021. Virtual.
5. Anger H, Raymond E, Chong E, Haskell S, Grant M, **Boraas C**, Tocce K, Banks J, Coplon L, Shochet T, Platais I. Comparison of clinical outcomes among patients who did and did not have a screening ultrasound or pelvic exam prior to obtaining medication abortion services via direct-to-patient telemedicine. National Abortion Federation Meeting, May 11-12, 2021. Virtual
6. Sayarath M*, Gerwitz O'Brien J*, Shramko M*, Argo T*, Brown E, Mishra P, **Boraas CM** McRee, A. Assessing the Gap in Sexual and Reproductive Health Services among Hospitalized Adolescents. Works in Progress Session. Society of Adolescent Medicine Conference, March 11, 2020. San Diego, CA. Due to COVID-19 related conference cancellation, this invited presentation was not given.
7. Borchert K, Wipf K*, Roeske E*, Clure C*, Traxler S, **Boraas CM**. Pregnancy of Unknown Location in Abortion Care: Management and Outcomes. National Abortion Federation Conference, April 23, 2018. Seattle, WA.
8. **Boraas CM**, Thompson I, Turok DK, Baldauf E, Borrero S, Schwarz EB, Sanders JN. Extending the window for insertion of the intrauterine device. American Society for Reproductive Medicine Scientific Congress, October 19, 2016. Salt Lake City, UT.
9. **Boraas CM**, Isley MM. Chlamydia and gonococcal infections and screening in women receiving intrauterine devices in a resident obstetrics and gynecology clinic. The Ohio State Department of Obstetrics and Gynecology Resident Research Day. October 2011. Columbus, OH.

Poster Abstract Presentations at National Professional Meetings, Conferences, etc.

1. Carroll AL, Strauss AM, Philipps, NM, Kaczmarczik KD, Shakur Z, Ramirez G, Klac TR, Tessier KM, **Boraas CM**. Concurrent administration of depot medroxyprogesterone acetate with mifepristone may decrease medication abortion efficacy: A retrospective cohort study. Society of Family Planning Meeting. October 28-30, 2023.

2. Carroll AL, Strauss AM, Philipps, NM, Kaczmarczik KD, Shakur Z, Ramirez G, Klc TR, Tessier KM, **Boraas CM**. Concurrent placement of an etonogestrel implant with mifepristone does not decrease medication abortion efficacy: A retrospective cohort study. Society of Family Planning Meeting. October 28-30, 2023.
3. Mahoney M, Ojanen-Goldsmith A, Hassan A, **Boraas CM**. I waited years for an option other than vasectomy”: Interest in new contraceptive methods for sperm among people with vasectomies. 2023 IAPHS Annual Meeting. October 2-5, 2023. Baltimore, MD.
4. Raymond EG, Frye LJ, **Boraas CM**, Tocce K, Gingras S, Firstenberg BS, Almquist A, Ortega C, Mahoney M, Hernandez K, Blumenthal P, Winikoff B. “MA-ASAP”: Asynchronous, Web-Based Provision of Medication Abortion. National Abortion Federation Annual Meeting. April 30-May 2, 2023. Denver, CO.
5. **Boraas CM**, Wise M, Miller J, Jafari N, Martins S. New male contraception: Yea or Nay? Correlates of supportive attitudes in a community-based sample of men and women. University of Minnesota Annual Women's Health Research Conference. February 23, 2023. Virtual.
6. Groene E*, **Boraas C**, Smith K, Lofgren S, Rothenberger M, Enns E. Offering Expedited Partner Therapy: a mixed methods study of Minnesota health providers. 2022 STD Prevention Conference. September 19-22, 2022. Virtual.
7. Keonig LR, Raymond EG, Gold M, **Boraas C**, Kaneshiro B, Winikoff B, Coplion L, Upadhyay UD. Time to Care Among Patients Who Receive Medication Abortion with History-Based Screening in the United States. Population Association of America Annual Meeting. April 6-9, 2022. Atlanta, GA.
8. Creinin M, Gawron L, Westhoff C, **Boraas CM**, Blumenthal P, Turok D. Phase 3 data of a novel low-dose copper intrauterine device with a nitinol frame: 1-year outcomes. ACOG Annual Clinical Meeting. April 30-May 2, 2021. Virtual.
9. Martins S*, Miller JJ*, Wise M*, Jafari N*, **Boraas CM**. Willingness to Use Novel Reversible Male-Controlled Contraceptive Methods in a Community-Based Sample of Adult Men. ACOG Annual Clinical Meeting. April 30-May 2, 2021. Virtual.
10. Wise M*, Martins S*, Tessier K, Traxler SA, **Boraas CM**. Success of Intrauterine Device Placement in Adolescents at Planned Parenthood. ACOG Annual Clinical Meeting. April 30-May 2, 2021. Virtual.
11. Miller JJ*, Martins S*, Mahoney MA*, Tessier K, Traxler SA, **Boraas CM**. Correlates of long acting reversible contraception uptake at 30 days following medication abortion. ACOG Annual Clinical Meeting. April 30-May 2, 2021. Virtual.
12. Faherty E*, **Boraas CM**, Smith K, Lofgren S, Rothenberger M, and Enns E. Expedited Partner Therapy for Sexually Transmitted Infections in Minnesota: A Mixed-Methods

Review of Current Practices and Barriers to Implementation. ISPOR 2021, May 17-20, 2021. Virtual.

13. Gerwitz O'Brien J*, Shramko M*, Sayarath M*, Brown E, Argo T*, **Boraas CM**, McRee A. Missed Opportunities to Provide Comprehensive Sexual and Reproductive Healthcare among Hospitalized Adolescents. Society for Adolescent Health and Medicine Annual Meeting. March 10-12, 2021. Due to COVID-19 related conference cancellation, this peer-reviewed poster was presented in electronic format.
14. Henke L*, Martins S*, Bangdiwala A, **Boraas CM**. Barriers to Obtaining Long-Acting Reversible Contraception Among Low-Income Women. ACOG Annual Clinical Meeting, April 24-27, 2020, Seattle, WA. Due to COVID-19 related conference cancellation, this peer-reviewed poster was presented in electronic format.
15. Gerwitz O'Brien J*, Shramko M*, Sayarath M*, Argo T*, Brown E, Mishra P, **Boraas CM** McRee A. Missed Opportunities to Provide Comprehensive Sexual and Reproductive Healthcare among Hospitalized Adolescents. Pediatric Research, Education and Scholarship Symposium. April 24, 2020. Minneapolis, MN.
16. Argo T*, Gerwitz O'Brien J*, Miller KK*, Prince A, Bahr T*, **Boraas CM**, Chaisson N, Borman-Shoap E. No Missed Opportunities: A trainee-driven long acting reversible contraceptive workshop for pediatric primary care clinicians. Society of Adolescent Medicine Conference. March 11, 2020. San Diego, CA.
17. Argo T*, Miller KK*, Bahr T*, Prince A, **Boraas CM**, Chaisson N, Borman-Shoap E, Gerwitz O'Brien J*. No Missed Opportunities: A trainee-driven long acting reversible contraceptive workshop for pediatric primary care clinicians. Minnesota American Academy of Pediatrics Conference. May 3, 2019. Minneapolis, MN.
18. Borchert K, Wipf K*, Roeske E*, Clure C*, Traxler S, **Boraas CM**. Pregnancy of Unknown Location in Abortion Care: Expectant Management and Ectopic Pregnancy Outcomes. National Abortion Federation Conference. May 6, 2019. Chicago, IL.
19. Raymond E, Tan Y, Comendant R, Sagaidac I, Platais I, Grant M, Sanhueza P, Van Pratt E, Bousiequez M, Gillespie G, **Boraas CM**, Weaver M. Simplified Medical Abortion Screening: A Pilot Study. National Abortion Federation Conference. April 23, 2017. Montreal, Canada.
20. Paul J*, Duvet M, **Boraas CM**. YouTube and the contraceptive implant: a content analysis. North American Forum on Family Planning. October 11, 2014. Miami, FL.
21. Lewis L*, **Boraas CM**, Dunn SA, Krans EE. Postpartum contraceptive intention and initiation among opioid dependent women. North American Forum on Family Planning. October 11, 2014. Miami, FL.
22. **Boraas CM**, Achilles SL, Cremer ML, Chappell CA, Chen BA. Dilapan-S with adjunctive misoprostol for same-day dilation and evacuation: a randomized controlled trial. North American Forum on Family Planning. October 11, 2014. Miami, FL.

23. Rapkin RB, Achilles SL, **Boraas C**, Cremer M, Schwarz EB, Chen BA. Self-administered lidocaine gel for intrauterine device insertion in nulliparous women: a randomized controlled trial. ACOG Annual Clinical Meeting. April 28, 2014. Chicago, IL.
24. **Boraas CM**, Isley MM. Chlamydia and gonococcal infections and screening in women receiving intrauterine devices in a resident obstetrics and gynecology clinic. North American Forum on Family Planning. October 23, 2012. Denver, CO.
25. **Boraas CM**. Emergency contraception knowledge, attitudes and practices – A survey of future providers in Minnesota and Guatemala. Global Health Council Conference. 2006. Washington, DC.
26. **Boraas CM**, Asante L, Heloo B. Female condom knowledge, attitudes and practices in Ghana's highest HIV prevalence regions. Global Health Education Consortium.

TEACHING AND CURRICULUM DEVELOPMENT

University of Minnesota

Course List

Undergraduate Courses

Annual speaker, The Future Physician II: The Life and Work of a Physician 2016-2020

Professional Medical Courses

Becoming a Doctor II: Making an Impact Through Advocacy Facilitator 2019-present

Obstetrics and Gynecology Core Clerkship Problem-Based Learning Facilitator 2018-present

Obstetrics and Gynecology Preceptor, Rural Physicians Associate Program 2017-present

Obstetrics and Gynecology Core Clerkship Attending Physician 2017-present

Participation two times per academic year (4 week rotation) as a faculty problem-based learning mentor for the third-year students during the clerkship in Obstetrics and Gynecology. I also present a one-hour lecture on the clinical aspects of abortion and contraception approximately four times per year to the entire clerkship. Additionally, students can spend one day with me at Planned Parenthood MN-ND-SD or Whole Woman's Health learning about reproductive choice and counseling, medical and surgical abortion, and contraceptive counseling.

Advanced Family Planning Elective Attending Physician 2015-present

The purpose of this elective is to learn more about the subspecialty of family planning. During the two-four week elective, students will be present in several clinical settings, including Planned Parenthood MN-ND-SD, Whole Woman's Health, Women's Health Specialists clinic, and the operating room for D&E procedures. The student also makes a presentation on a topic from the current medical literature to the family planning faculty and staff.

Curriculum Development

Post Graduate Medical Education

Global Pediatrics Curriculum 2019-present

Developed lectures for pediatrics providers about maternal morbidity and mortality.

Global Obstetrics Simulation for Pediatrics Residents 2017-present

Developed a yearly simulation curriculum for delivery of a baby in the case of emergency for Pediatrics residents.

- Fellowship in Family Planning, Director 2016-present
I serve as the future director of the family planning fellowship for graduated obstetrics and gynecology residents. This position has involved developing clinical, research and advocacy curriculum, which was approved by the University of Minnesota Board of Regents in Fall 2016. Application is currently under review by the national office of the Fellowship in Family Planning.
- Ryan Residency in Abortion and Family Planning, Director 2015-present
I serve as the director of the family planning rotation for second year residents. This involves teaching and supervising the resident at Planned Parenthood in performing surgical abortions up to 23 6/7 weeks and medical abortions up to 10 0/7 weeks and in the operating room for D&E procedures up to 23 6/7 weeks. I also supervise office hysteroscopic sterilization and OR laparoscopic and hysteroscopic sterilization procedures. For residents who choose not to perform abortions, their education includes learning about early pregnancy counseling and decision making as well as performing ultrasounds for pregnancy dating.

Undergraduate Medical Education

- Consultant, Endocrine and Reproductive Health Course 2021-present
Consultant, Diversity, Equity and Inclusion Thread 2021-present

Nationally Available Published Curricula

- Boraas, CM. Invited Lecturer *Obstetric Emergencies: Focus on Delivery. Clinical Tropical Medicine & Online Global Health Curriculum*. Editors Kristina Krohn, Brett Hendel-Paterson, and William Stauffer. Available at <https://med.umn.edu/dom/education/global-medicine/courses-certificates/online/global-health-curriculum>. The entire curriculum consists of 7 modules with over 180 hours of online material, including reviews and assessments. Pair with the in-person course, the curriculum qualifies participants to sit for the CTropMed and DTMH. With over 1300 unique enrollees from 47 states and over 28 countries, this curriculum helps providers learn how to address health disparities across the globe. Curriculum originally launched 2006, converted to online in 2010, and last updated in 2021.
- Boraas, CM. *Maternal Mortality. GPEDS (Global Pediatric Education Series) for Medical Students*. Clerkship Directors: Winter J, Danich E, Howard C. This Virtual Medical Student Clerkship consists of 4 modules (approximately 25 hours) of online content covering topics in global child health. Available for enrollment September 2020.
- Boraas, CM. *Maternal Mortality. GPEDS 2.0 (Global Pediatric Education Series)*. Editors Winter J, Danich E, Howard C. Available at globalpeds.umn.edu/gpeds. Curriculum consists of 4 modules (approximately 25 hours) of online content on global child health that serves as the primary global health curriculum for pediatric residents at multiple institutions. The content is also available to individual subscribers for CME credit. Curriculum originally launched May 2014, Updated November 1, 2019.

ADVISING AND MENTORING

Undergraduate Student Activities

Research Mentor, B.A. Candidate	01/2021-06/2023
Graduate Student Activities	
PhD Candidate	06/2022-present
MPH Candidate	06/2022-6/2023
MPH Candidate	06/2022-6/2023
TRACT TL1 Program Mentor, PhD Candidate	07/2020-06/2022
Master's Theses Directed	
MS in Medical Device Innovation Candidate	06/2022-12/2022
MPH Candidate	09/2015-12/2015
Professional Student Activities	
Twin Cities Medical Society Public Health Advocacy Fellowship Mentee	Jun 2020-2021
Medical student research advisees	Jul 2015-2018
Medical student advisees	Jul 2015-2018
Clinical Supervision	
3rd year medical students on Education in Pediatrics Along the Curriculum, 2017-present	
3rd and 4th year medical students on OB/GYN clerkship rotations at Women's Health Specialists, 2015 – present	
3rd and 4th year medical students on family planning elective rotations at Women's Health Specialists and community sites, 2015 – present	
Residents Supervised	
Clinical Supervision, 1 st year residents on general gynecology rotations at Women's Health Specialists, 2015 – present	
Clinical Supervision, 4th year residents on general gynecology rotations at Women's Health Specialists, 2015 – present	
Clinical Supervision, 2nd year residents on general obstetrics rotations at UMMC L&D (The Birthplace), 2015 – present	
Clinical Supervision, 3rd year residents on general obstetrics rotations at UMMC L&D (The Birthplace), 2015 – present	
Clinical Supervision, 2nd year residents on family planning rotation at Planned Parenthood Minnesota, North Dakota, South Dakota, 2014 – present	
Post Doctoral Fellows Supervised	
Adolescent Health Fellowship	September 2018 - June 2021
Post-doctoral Fellowship	May 2019 - May 2020
Other Mentoring Activities	
Faculty Advisor	2016-present
University of Minnesota Obstetrics and Gynecology Interest Group	

Faculty Advisor 2016-present
University of Minnesota Medical Students for Choice

CLINICAL SERVICE

Clinical Leadership Accomplishments

Associate Medical Director, Planned Parenthood MN-ND-SD 2014-present

Clinical Service Responsibilities

Obstetrics, Gynecology, Midwifery and Family Planning Division 2015-present

Attending Physician

Consulting Physician

Clinics: 2 half days per week, 2015-present

OR: 1 half day per week, 2015-present

Planned Parenthood MN-ND-SD 2014-present

Clinics: 2 half days per week, 2016-present; 3 half days per week, 2015-2016; 4 half days per week 2014-2015

Whole Woman's Health 2014-present

Clinics: 2 half days per week, 2016-present; 1 half day per week, 2015-2016; 3 half days per week, 2014-2015

PROFESSIONAL SERVICE AND PUBLIC OUTREACH

Service To The Discipline/Profession/Interdisciplinary Area(s)

Editorships/Journal Reviewer Experience

Journal Reviewer, Obstetrics and Gynecology 2017-present

Recognized as Top 10% Peer Reviewer 2020

Journal Reviewer, Contraception 2013-present

Organization of conferences, workshops, panels, symposia

Member, University of Minnesota Department of Obstetrics, Gynecology and Women's Health and MN ACOG Joint Autumn Seminar Planning Committee 2016

Role: Organized educational themes and curricula, recruited speakers.

Member, University of Minnesota Department of Obstetrics, Gynecology and Women's Health and MN ACOG Joint Autumn Seminar Planning Committee 2015

Role: Organized educational themes and curricula, recruited speakers.

National Committee Memberships

Member, Society of Family Planning Finance Committee 2021-present

Member, Society of Family Planning Research Implementation Interest Group 2021-present

Member, M-POWER Advisory Committee 2021-present

Member, No Test Medication Abortion Safety and Outcomes Working Group 2021-2023

Member, Complex Family Planning Fellowship Core Education Working Group 2021-2023

Member, Complex Family Planning Fellowship Education Committee 2020-2021

Member, Society of Family Planning Program Committee 2019-2020

Member, North American Forum on Family Planning Scientific Committee 2018-2020

Member, Society of Family Planning Audit Committee	2016-2018
Member, ACOG Online Learning in Ob-Gyn Advisory Committee	2014-2022
Member, ACOG Global Health Committee	2015-present
Member, Fellowship in Family Planning Guide to Learning Revision Subcommittee, 2016-2018	

State Committee Memberships

Member, Minnesota Medical Association Health Equity Task Force	2020
Member, Minnesota PRAMS Advisory Committee	2017-present
Member, Reproductive Health Access Project, MN cluster	2017-present
Member, MN ACOG Advisory Council	2016-present
Member, MN ACOG Legislative Committee	2015-present

Public Advocacy

Physician Advocate, Minnesota ACOG Day at the Capitol	3/8/2022
Physician Advocate, Minnesota Medical Association Day at the Capitol	3/4/2020
Member, Minnesota Doctors for Health Equity	2018-present
Physician Advocate, Minnesota Medical Association Day at the Capitol	2/13/2019
Physician Advocate, Minnesota Medical Association Day at the Capitol	3/14/2018
Physician Advocate, Minnesota Medical Association Day at the Capitol	2/15/2017
Speaker, Press Conference on MN H.F. 411/S.F. 281, Physician's Integrity Act	1/23/2017
Physician Advocate, Minnesota Medical Association Day at the Capitol	3/23/2016

Service to the University/Medical School/Department

University of Minnesota

University-wide Service

Member, Medical School Faculty Advisory Committee	2022-present
Judge, Global Health Case Competition	2022
Faculty, Walter H. Judd Fellowships Selection Committee	2018
Faculty, Center for Global Health and Social Responsibility	2016-present
Chair, Students' International Health Committee	2002-2008
Representative, Center for Health Interprofessional Programs	2002-2004
Vice President, Student Senate, University of Minnesota School of Public Health, 2003	

Medical School Service and Intercollegiate Service

Participant, Master Mentor Program	2017-2020
Member, Medical School Admissions Committee	2007-2008, 2018-2020
Member, Learning Environment Rounds	2017-2019
Member, Essentials of Modern Medicine Curriculum Initiative	2007-2008
Member, Med2010 Education Initiative	2007-2008
Representative, Student Council	2004-2008
Representative, Education Council	2004-2008

Department/Unit Service

Member, ARTS Committee	2020-present
Member, Residency Program Evaluation Committee	2016-present
Member, Clinical Competency Committee	2016-present

Member, Education Council	2016-present
Member, Residency Interview Committee	2016-present
Moderator, Research Day	2016, 2019
M Health Fairview Service	
Member, UMMC Obstetric Case Review Committee	2022-present
Member, Perinatal Loss Policy Committee	2021-present
Member, Termination of Pregnancy Policy Committee	2020-present
University of Pittsburgh	
Medical School Service and Intercollegiate Service	
Fellow Advisor, Medical Students for Choice	2012-2014
The Ohio State University	
Department/Unit Service	
Resident Supervisor, Columbus Free Clinic	2010-2012
Resident Advisor, Obstetrics and Gynecology Interest Group	2009-2012
St. Olaf College, Northfield, MN	
University-wide service	
Co-Founder, Helping Overcome Poverty through Education (H.O.P.E.)	2000-2001
Community Outreach Activities	
Family Planning Consultant, Teen Annex Clinic	2021-present
Family Planning Consultant, Alight	2019-present
Mentor, Upward Bound, St. Paul, MN	2004-2008
Global Health Volunteer, Mano a Mano Organization, St. Paul, MN	2004-2008

EXHIBIT C

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

)
PLANNED PARENTHOOD SOUTH)
ATLANTIC, ET AL.,)
) Case No.
PLAINTIFFS,) 1:23-cv-00480-CCE-LPA
)
v.)
)
JOSHUA STEIN, ET AL.,)
)
DEFENDANTS,)
)
and)
)
PHILIP E. BERGER, ET AL.,)
)
INTERVENOR-DEFENDANTS.)
)

DEPOSITION OF CATHERINE J. WHEELER, M.D.
(TAKEN by PLAINTIFFS)
ATTENDING VIA ZOOM IN WASHINGTON, D.C.
JANUARY 22, 2024

REPORTED BY: Meredith R. Schramek
Registered Professional Reporter
Notary Public
(via Zoom in Mecklenburg County)

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A P P E A R A N C E S

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VALENTINA DE FEX, ESQ.
KYLA EASTLING, ESQ.
ERIN KRAMER, ESQ.
VANISHA KIDUMURI
JACLYN MAFFETORE, ESQ.
SUSANNA BIRDSONG, ESQ.
CECILIA DOS SANTOS, ESQ.

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Deposition of Catherine J. Wheeler, taken by the plaintiffs via Zoom on the 22nd day of January, 2024, at 11:05 a.m., before Meredith R. Schramek, RPR, Notary Public.

C O N T E N T S

The Witness: CATHERINE J. WHEELER

Examination By Ms. Salvador5

Examination By Mr. Boyle249

Examination By Ms. Salvador257

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P R O C E E D I N G S

CATHERINE J. WHEELER,

was examined and testified as follows:

EXAMINATION BY COUNSEL FOR PLAINTIFFS

BY MS. SALVADOR:

Q. So, Dr. Wheeler, good morning, and thank you so much for being here.

My name is Anjali Salvador, like I said, and I'm one of the attorneys representing Plaintiff Planned Parenthood South Atlantic in this case.

Could you state your full name for the record.

A. Catherine J. Wheeler.

Q. Great. Thank you.

So we're going to start with some housekeeping and ground rules. Do you understand that you are obligated to answer all of my questions truthfully and completely and that you're testifying under penalty of perjury?

A. Yes, I do.

Q. As you can see, we have a court reporter with us today who is taking down what we say for a transcript. So please make an effort to give all of your answers verbally like you have been doing instead of nodding or shaking your head. Is that okay?

1 A. Yes.

2 Q. Great. Because the court reporter will be
3 creating a transcript, we both need to do our best not
4 to talk over each other.

5 So please wait for me to finish each question
6 before answering even if you think you know where I'm
7 going with it, and I'll do my best to wait for you to
8 finish before I ask my next question. Okay?

9 A. Yes. Thank you.

10 Q. And I will do my very best to ask questions
11 clearly. If you don't understand a question, please
12 feel free to say something and stop me, and I'll
13 rephrase it.

14 But if you do answer, I'm going to assume
15 that that means you've understood my question. Is that
16 okay?

17 A. Yes.

18 Q. If at any point either in the moment or later
19 in the deposition you've realized you've made a mistake
20 or you want to clarify something, that's totally fine.
21 Just say so. Okay?

22 A. Yes.

23 Q. If at any point you need a break, please let
24 me or your attorney know, and we'll take one.

25 But if I'm in the middle of a question,

1 you'll have to answer whatever the pending question is
2 before we break. Is that okay?

3 A. Yes.

4 Q. So during this deposition your attorney may
5 object to some of my questions, but unless your
6 attorney directly tells you not to answer the question,
7 you still have to answer after they object. Do you
8 understand?

9 A. Yes.

10 Q. Do you have any notes or files related to
11 this case with you right now?

12 A. I do not.

13 Q. Do you have a cell phone with you right now?

14 A. My cell phone is in my purse turned off.

15 Q. Great. And I'm sorry, because this one's a
16 little invasive, but it's a standard question at the
17 start of depositions.

18 So are you dealing with any illness or taking
19 any substance that would affect your memory or prevent
20 you from being able to understand or answer my
21 questions today?

22 A. No.

23 And may I make sure that my phone is off?

24 Q. Sure.

25 A. I turned it off, but now that I'm thinking

1 about it.

2 It is off.

3 Q. Are you ready?

4 A. Yes, I am. Thank you.

5 Q. Great. Have you ever had your deposition
6 taken before?

7 A. Yes, I have.

8 Q. How many times?

9 A. I don't recall. Either once or twice. I
10 don't know the exact number.

11 Q. Could you tell me about those cases you were
12 deposed in.

13 A. Yes. And, again, I'm trying to remember
14 exactly. One of them was an intention of a medical
15 lawsuit, which was then dropped. The second one, I
16 believe, was in my divorce.

17 Q. Were you -- were you deposed as an expert in
18 the medical lawsuit you referred to or as a fact
19 witness?

20 A. As a fact witness.

21 Q. Did that case relate to abortion in any way?

22 A. It did not.

23 Q. Other than the report you submitted in this
24 case, have you submitted a report in a legal case
25 before?

1 A. I'm sorry. Would you please restate the
2 question.

3 Q. Sure.

4 Other than the expert report you submitted
5 for this case, have you submitted a legal report
6 before?

7 A. A legal report. No, I have not.

8 Q. Have you testified in any court before?

9 A. Have I testified -- does that mean in a --
10 this capacity? I don't recall.

11 Q. No. Have you testified in any court at all
12 before?

13 A. I'm not sure what that exactly means. What
14 does it mean, testifying in court? Does that mean like
15 personal, legal?

16 Q. It could be either. Have you appeared before
17 a judge before, a participant in a case?

18 A. Yes.

19 Q. Could you describe that case to me.

20 A. I believe this is what you're asking.

21 My dog got loose and got in another dog's
22 face, and so I had to present myself to the court and
23 to the judge.

24 Q. Got it. Have you testified before any
25 legislative body?

1 A. Yes, I have.

2 Q. Could you describe that testimony, please.

3 A. I have testified both as the Utah Medical
4 Association president, and it was -- I don't remember
5 which exact cases, but I was the representative of the
6 medical physicians in Utah, and so I would testify at
7 the legislature.

8 And I have testified in Colorado personally
9 in front of the legislature, primarily in the last
10 three years.

11 Q. About how many times did you testify before a
12 legislative body as the Utah Medical Association
13 president?

14 A. I don't recollect. I was in this capacity as
15 president for one year, so whatever legislation came up
16 that I was asked to testify, I did. I don't recall the
17 number.

18 Q. Do you recall whether any of that testimony
19 related to abortion?

20 A. My recollection is that there was one case
21 related to abortion.

22 Q. I'm sorry. You broke up at the end. Can you
23 repeat that, please.

24 A. Yes. My recollection is that there was one
25 case related to abortion.

1 Q. What do you remember about that case?

2 A. What I remember is that it was a fetal pain
3 bill. I don't remember the specifics of it.

4 Q. Do you remember anything about the nature of
5 your testimony for that bill?

6 A. My testimony at that time was that my
7 understanding of the science at that time, which would
8 have been about 2006 perhaps, approximately, my
9 understanding of the science at that time was that the
10 fetus did not feel pain.

11 Q. Did you -- is that the only bill regarding
12 abortion that you can recall testifying on as Utah
13 Medical Association president?

14 A. It is the only one that I can recall.

15 Q. Did you ever testify before a legislative
16 body in Utah in your personal capacity?

17 A. I don't recall ever doing that in a personal
18 capacity.

19 Q. You also said that you've testified in
20 Colorado in your personal capacity; is that right?

21 A. That is correct.

22 Q. Could you describe the legislative testimony
23 you've made in Colorado.

24 A. Are you asking about my personal testimony?

25 Q. Let's start with do you recall -- could you

1 describe the bills that you testified on in Colorado.

2 A. What I recall -- and I have not reviewed
3 these testimonies or the bills prior to this, as a
4 clarification.

5 The first bill I remember testifying about
6 was the Reproductive Health Equity Act, which would
7 have been, I believe, two years ago, which was
8 specifically to place in Colorado law protection --
9 well, to remove protections of the unborn baby and to
10 place in law an abortion bill. That's my recollection
11 of that law.

12 Last year, there were three bills. One of
13 them was to essentially make it illegal to prescribe
14 progesterone after pregnancy -- after the abortion
15 medication and also to limit the ability of pregnancy
16 resource centers to advertise.

17 The second one was about insurance
18 regarding -- and, again, this is from the top of my
19 head -- insurance regarding being required to cover.

20 And the third one, I honestly don't remember
21 the details right now.

22 Q. Okay. Thank you for that.

23 Could you describe the nature of your
24 testimony on the Reproductive Health Equity Act.

25 A. I don't recall exactly what I said through

1 that testimony. I'm sure it's in the legislative
2 report.

3 Q. What was the general gist of your testimony?

4 A. I did not review that for this, and I don't
5 want to misstate myself, so I can't tell you exactly
6 what I said.

7 Q. Did you testify in favor of the Reproductive
8 Health Equity Act?

9 MR. BOYLE: Object to form.

10 THE WITNESS: I did not.

11 BY MS. SALVADOR:

12 Q. I'm sorry, Dr. Wheeler. Could you repeat
13 your answer.

14 A. I did not testify in favor. I testified
15 against.

16 Q. Could you describe what you remember of your
17 testimony on the bill that made it illegal to prescribe
18 progesterone after medication abortion and to limit the
19 ability of crisis pregnancy centers to advertise.

20 MR. BOYLE: Object to form.

21 THE WITNESS: I don't remember the exact
22 details of -- I did not review that for this
23 deposition.

24 BY MS. SALVADOR:

25 Q. Is that practice of prescribing progesterone

1 after a medication abortion also sometimes referred to
2 as "abortion reversal"?

3 MR. BOYLE: Objection.

4 THE WITNESS: It is sometimes referred to as
5 abortion reversal.

6 BY MS. SALVADOR:

7 Q. Do you understand the prescribing of
8 progesterone after a medication abortion to function as
9 abortion reversal?

10 A. That is what progesterone does. It is --
11 yes. It potentially reverses an abortion.

12 Q. And what was your general position on the
13 bill that would have made it illegal to prescribe
14 progesterone after a medication abortion?

15 MR. BOYLE: Objection.

16 THE WITNESS: Can you repeat the question,
17 please.

18 BY MS. SALVADOR:

19 Q. What was your general position on that bill
20 that made it illegal to prescribe progesterone after
21 medication abortion?

22 MR. BOYLE: Objection.

23 THE WITNESS: My general position was that
24 progesterone is a safe medication and potentially can
25 reverse a medication abortion.

1 BY MS. SALVADOR:

2 Q. What, if anything, do you recall about the
3 piece of your testimony regarding the part of the bill
4 that made it -- that limited the ability of crisis
5 pregnancy centers to advertise?

6 MR. BOYLE: Object to the form.

7 THE WITNESS: Could you please repeat the
8 question.

9 BY MS. SALVADOR:

10 Q. Sure.

11 So you mentioned that one of the bills you
12 testified on in Colorado would limit the ability of
13 crisis pregnancy centers to advertise their services;
14 is that right?

15 A. Yes, that is correct.

16 Q. Do you remember what your position on that
17 bill was?

18 MR. BOYLE: Object to form.

19 THE WITNESS: What I recall testifying to was
20 that of first going into a pregnancy resource center,
21 being surprised at what I'd expected versus what I saw,
22 and essentially supporting pregnancy resource centers.

23 BY MS. SALVADOR:

24 Q. Thanks for that.

25 You also said that you testified on a bill in

1 Colorado regarding insurance coverage of abortion; is
2 that right?

3 A. Yes.

4 Q. Do you recall the general substance of your
5 testimony?

6 A. I did not review that before this deposition.
7 And so I don't recall exactly what I spoke on that
8 time.

9 Q. Do you recall whether you supported, opposed,
10 or were neutral on that bill?

11 MR. BOYLE: Object to form.

12 THE WITNESS: Can you please repeat what
13 you're asking.

14 BY MS. SALVADOR:

15 Q. Sure.

16 Do you recall whether you supported that
17 bill?

18 MR. BOYLE: Object to form.

19 THE WITNESS: Do I recall whether I supported
20 the bill? I did not support that bill.

21 BY MS. SALVADOR:

22 Q. Did you oppose that bill?

23 MR. BOYLE: Object to form.

24 THE WITNESS: Did I personally oppose the
25 bill? Is that the question?

1 BY MS. SALVADOR:

2 Q. Was your testimony opposing that bill?

3 MR. BOYLE: Object to form.

4 THE WITNESS: My testimony was in opposition
5 of the bill.

6 BY MS. SALVADOR:

7 Q. When were you first contacted about
8 participating as an expert witness in this case?

9 A. It was approximately November of 2023.

10 Q. Who contacted you about participating as an
11 expert in this case?

12 A. I don't recall the exact person who contacted
13 me.

14 Q. Who have you communicated with regarding this
15 case?

16 MR. BOYLE: And I'll just have an objection
17 and an instruction to -- Doctor, don't go into any of
18 the substance of conversations that you've had with the
19 lawyers involved in this case, but you can say who
20 you've spoken to if you've spoken with someone.

21 With that instruction, you can answer.

22 THE WITNESS: Thank you.

23 The attorney I spoke to is Julia Payne. I've
24 spoken with the attorney, Kevin. I don't recall his
25 last name right now. And I have spoken with Jordan

1 Lorence, and this morning I spoke with Ellis Boyle.

2 BY MS. SALVADOR:

3 Q. Other than the attorneys you mentioned, have
4 you communicated with anyone else regarding this case?

5 A. I have spoken with people that I am doing a
6 deposition. I have not spoken -- and that I am an
7 expert witness, but I have not discussed the case.

8 Q. What topics are you providing your opinion on
9 in this case?

10 A. I am providing my opinion on second-trimester
11 D&E procedures -- their location, the safety, and the
12 difference between a miscarriage and elective abortion
13 in the second trimester.

14 I'm also offering my opinion about ectopic
15 pregnancies and about medication abortion prior to
16 documentation --

17 Q. Are you being paid for your participation in
18 this case?

19 A. I was not paid for my additional -- for my
20 initial report. From the deposition stage forward, I
21 am being paid.

22 Q. How much are you being paid from deposition
23 stage forward?

24 A. My agreement was \$250 an hour.

25 Q. I'm sorry. Did you say \$250 an hour?

1 A. Yes.

2 Q. About how many hours have you spent working
3 on this case so far?

4 A. I did not keep track of my earlier part, so
5 I've only really kept track -- and I did not look at
6 the actual numbers. I would say I've spent most of the
7 last week when I'm able looking at it.

8 Q. Without telling me about the substance of
9 conversations you've had with your attorneys, how did
10 you prepare for today's deposition?

11 A. For today's deposition, I reviewed the -- my
12 expert witness report. I reviewed my citations. I
13 reviewed the reports of Dr. Farris, Dr. Borast, and
14 Dr. Bane. I reviewed the North Carolina law that is in
15 question and the injunction.

16 Q. Other than your attorneys, did you speak with
17 anyone about the substance of the deposition testimony
18 you're giving today?

19 A. No, I did not.

20 Q. Other than speaking with your attorneys and
21 reviewing the documents you listed out, did you do
22 anything else to prepare for today's deposition?

23 A. Specifically for today's deposition?

24 Q. Yes.

25 A. I didn't do anything else specific for

1 today's deposition. No, the time preparing.

2 Q. Thank you.

3 (Exhibit 1 Marked for Identification.)

4 MS. SALVADOR: I'm dropping into the chat
5 window here what I'd like marked as Exhibit 1.

6 BY MS. SALVADOR:

7 Q. Dr. Wheeler, are you able to access the
8 exhibits that I'm going to be dropping into the chat?

9 A. We are working on it.

10 Yes.

11 Q. Okay. I have dropped into the chat a
12 document entitled "Expert Report of Catherine J.
13 Wheeler, MD."

14 Dr. Wheeler, is this an accurate copy of the
15 expert report you submitted in this case?

16 A. I have page 1, is what I see.

17 Q. Okay. We're going to be frequently referring
18 back to this document. Are you able to scroll through
19 as we reference specific paragraphs and look at those?

20 A. I am checking.

21 And yes, it looks like I can. Thank you.

22 Q. So, again, is this an accurate copy of the
23 expert report you submitted in this case?

24 A. I am scrolling.

25 It appears accurate.

1 Q. Could you describe the process of drafting
2 this report, please.

3 A. I did not hear your question.

4 Q. Could you describe the process of drafting
5 this report, please.

6 MR. BOYLE: And I'll instruct you that to the
7 extent that there were conversations or communications
8 with counsel in the process, you should not divulge any
9 of that information because it would be both privileged
10 and work product.

11 With that instruction, you can answer.

12 THE WITNESS: I originally received a copy of
13 the law and what was at question. And then -- so I
14 reviewed that to see if it was within my expertise.

15 I then had copies of Dr. Borast and
16 Dr. Farris's reports and reviewed those to see if it
17 was within my expertise.

18 I then began looking at current literature
19 and evaluated the literature for what was out there in
20 the literature, and then decided that it was within my
21 expertise and understood what the literature was saying
22 and began writing the report.

23 BY MS. SALVADOR:

24 Q. You cite a number of documents in your
25 report. Have you read all of the documents cited in

1 your report in their entirety?

2 A. Yes, I have.

3 Q. Other than your attorneys, did you work with
4 anyone to prepare your report?

5 A. No, I did not.

6 Q. Have you discussed the content of your report
7 with anyone other than your attorneys?

8 A. No, I have not.

9 Q. Did you send a copy of your report to anyone
10 other than your attorneys?

11 A. I have not.

12 Q. So you mentioned reviewing reports from
13 Dr. Farris. Did you read the reports that Dr. Farris
14 submitted in this case in their entirety?

15 A. Yes, I did.

16 Q. Did you read the sources cited in
17 Dr. Farris's reports?

18 A. When there was something cited that I wanted
19 to look at further, then I did. I did not look at
20 every one of her citations.

21 Q. Do you recall any particular sources cited in
22 Dr. Farris's reports that you reviewed?

23 A. I referenced in my report one that comes to
24 mind is Dr. Turok's report. I don't recall others.

25 Q. Did you read the reports that Dr. Borast

1 submitted in this case in their entirety?

2 A. Repeat the question, please.

3 Q. Sure.

4 Did you read the reports that Dr. Borast
5 submitted in this case in their entirety?

6 A. You said "reports." I saw one report, and I
7 read that in its entirety, yes.

8 Q. Okay. Did you read the sources cited in
9 Dr. Borast's report?

10 A. I do not recall if I particularly had
11 questions about any of his and looked them up. I don't
12 recall.

13 Q. Did you read any report that Dr. Johnson
14 submitted in this case?

15 A. I did not have access to that report.

16 Q. Got it. Thank you.

17 I want to turn now to your CV. It's
18 Exhibit A attached to your report. It begins on
19 page 40 if you're looking at the PDF file. Let me know
20 when you get there.

21 A. I have page 1 as -- oh, my CV. I'm sorry.

22 I don't have page numbers that you're citing,
23 but I do have my CV.

24 Q. Okay. Could you look at your CV and let me
25 know whether it's a current version of your CV?

1 A. I have edited it since submitting this
2 report.

3 Q. What edits have you made since submitting
4 this report?

5 A. Under professional -- and this is -- this is
6 the only part that I recall editing -- is under
7 professional volunteer experience.

8 Q. What was the edit that you made?

9 A. I have added that I am now on the board of
10 the American Association of Pro-life OB/GYNs. That
11 occurred approximately mid-December.

12 Q. Got it. Thank you.

13 MS. SALVADOR: Counsel, would you be able to
14 send us an updated copy of Dr. Wheeler's CV after this
15 deposition, please.

16 MR. BOYLE: We're not going to agree to
17 anything formal discovery-wise unless you send formal
18 discovery. But I think if she just explained the one
19 edit she made, I don't know that you actually need an
20 updated CV to have, but if you make a request, we'll
21 honor it.

22 MS. SALVADOR: Got it. Thanks.

23 BY MS. SALVADOR:

24 Q. Dr. Wheeler, you graduated with a Bachelor of
25 Science degree from Colorado State University in 1981;

1 is that correct?

2 A. That is correct.

3 Q. And after that, you began a PhD program in
4 nutrition at Cornell in 1981; is that right?

5 A. That is correct.

6 Q. And then you attended and graduated with an
7 MD from the Tulane University School of Medicine in
8 1987; is that right?

9 A. That is correct.

10 Q. And after that, did you complete your ob-gyn
11 residency at the University of Utah from 1987 to 1991?

12 A. Yes, that is correct.

13 Q. During your residency, you were trained in
14 second-trimester abortions for the indication of
15 fetuses with genetic syndromes and severe fetal
16 anomalies; is that right?

17 A. That's correct.

18 Q. During your residency, were you also trained
19 to provide second-trimester abortions for patients
20 outside of the fetal anomaly context?

21 A. Define "abortion."

22 Q. How would you define an abortion?

23 A. I would define "abortion" as the removal of
24 the baby or delivery of the baby with the intention of
25 not delivering a living baby.

1 Q. When you were trained in second-trimester
2 abortions for fetuses with genetic syndromes and severe
3 fetal anomalies, what did that training entail?

4 A. That training was dilation and evacuation. I
5 do not recall doing inductions. What I recall is doing
6 dilation and evacuation procedures.

7 Q. Were you also trained to provide dilation and
8 evacuation procedures for patients outside of the fetal
9 anomaly context?

10 A. We would also do them for babies with
11 fetal -- intrauterine fetal demise, or essentially a
12 miscarriage. It would be a -- we would call that an
13 intrauterine fetal demise.

14 So that is not an abortion. The baby had
15 already died.

16 Q. How was the training for D&E -- let me
17 rephrase that.

18 Was the training for D&Es for abortion
19 purposes different from the training for D&Es for
20 intrauterine fetal demise purposes?

21 MR. BOYLE: Object to form.

22 THE WITNESS: Could you please repeat the
23 question.

24 BY MS. SALVADOR:

25 Q. Sure.

1 So you said that you performed D&Es for the
2 purposes of abortion for fetuses with severe fetal
3 anomalies; is that right?

4 A. Yes.

5 Q. You also testified that you were trained to
6 provide D&Es in the situation of intrauterine fetal
7 demise; is that right?

8 A. That is correct.

9 Q. Was the training that you received for D&Es
10 different depending on whether the purpose was for
11 abortion or for intrauterine fetal demise?

12 A. The training was a little different in that
13 while technically the experience was similar, we
14 expected more bleeding for people who had living
15 babies.

16 So it was -- technically we used the same
17 instruments, but it was a different procedure in the
18 reality of the performing with those instruments. The
19 baby would be moving. There would be more bleeding.
20 It was -- other than using the exact same instruments,
21 they were not the same procedure.

22 Q. Can you explain medically why there would be
23 more bleeding in a D&E performed in the abortion
24 context.

25 A. Normally when you have -- well, first, my

1 experience is that's how it was.

2 So I would offer to be one of the residents
3 to do the -- to perform the D&Es for patients with
4 fetal demises, essentially to keep my skills up for the
5 more complicated procedure, which was the termination
6 or actual induced abortion of a baby with anomalies.

7 First you have a baby that when it's living
8 it tries to get away from you, frankly. So it's harder
9 to grasp the baby.

10 Secondly, there is no maceration of the
11 placenta yet. In a baby who is still alive, the
12 placenta is usually a healthy placenta.

13 In babies with fetal demise, the majority of
14 the time there is some perfusion problem or clotting
15 within the placenta. Often the placentas are smaller.
16 So it's a different procedure. There's less blood flow
17 when the baby's already passed away. They tend to be
18 simpler procedures from my personal experience.

19 Q. Were you also trained to provide
20 first-trimester abortions during your residency?

21 A. We were -- we at the University of Utah did
22 not perform elective abortions. So we were not trained
23 to do -- to perform elective induced abortions in the
24 first trimester.

25 Q. Were you trained to provide nonelective

1 abortions in the first trimester?

2 A. I don't recall being trained to do that. I
3 don't recall that.

4 Q. Are there any educational credentials that
5 you have that are not on your CV?

6 A. That's a broad question. Can you repeat it.

7 Q. Sure.

8 Are there any educational credentials you
9 have that are not on your CV?

10 And just to clarify, you know, you don't need
11 to list every continuing education course you've taken.
12 I mean, generally speaking, qualifications such as
13 additional degrees.

14 MR. BOYLE: Object to form.

15 THE WITNESS: I've done a lot of education
16 since then. So I'm not sure how to answer that
17 question.

18 BY MS. SALVADOR:

19 Q. Do you have any degrees that are not listed
20 on your CV?

21 A. I don't recall any other degrees.

22 Q. Have you completed any fellowships that are
23 not listed on your CV?

24 A. No, I have not done any other fellowships.
25 Well, that's -- as far as medical?

1 Q. Sure.

2 A. I don't have any other medical fellowships.

3 Q. Do you have any nonmedical fellowships?

4 A. I do.

5 Q. What are those?

6 A. I am -- I'm so sorry for my voice.

7 I am a Colson fellow.

8 Q. What does it mean to be a Colson fellow?

9 A. A Colson fellow, I did -- I'm so sorry. I
10 did a 10-month fellowship in world view.

11 Q. I'm sorry. I didn't hear. What was the last
12 word? You did a 10-month fellowship in what?

13 A. I did a 10-month fellowship in world view.

14 Q. Could you describe that fellowship in world
15 view.

16 A. Yes. It is a fellowship where we learn about
17 essentially all of the world views and how to think
18 deeply about world view.

19 Q. Is there a focus in that fellowship on
20 religious world view?

21 A. It is one of the focuses.

22 Q. Is there a particular religion that it
23 focuses on?

24 A. Well, we learned across all of the religions.
25 The organization is a Christian organization

1 that really looks deeply at how we see the world and in
2 general how do different people see the world.

3 Q. When did you complete this Colson fellowship?

4 A. It would be approximately, I believe -- I
5 can't say exactly. I believe it was three years ago.
6 It might have been two years ago.

7 Q. Did any of the contents of the fellowship
8 training relate to abortion?

9 A. Yes.

10 Q. Could you describe those abortion-related
11 contents, please.

12 A. I can't on the top of my head explain them.

13 Q. Could you describe generally the
14 abortion-related topics that were covered?

15 A. I am not sure how to answer that.

16 We looked at -- we looked at the different
17 world views and the different thoughts on abortion.

18 Q. Do you recall anything about the different
19 thoughts on abortion that you looked at in that
20 fellowship?

21 A. I didn't review all of that in preparing for
22 this.

23 Q. I understand. But do you recall anything
24 about the contents of abortion that you looked at in
25 that fellowship?

1 MR. BOYLE: Object to form.

2 THE WITNESS: Well, it's hard for me to
3 separate out my own personal reading from what I
4 learned and from my experience and what I've thought
5 about. So I can't tell you what I can attribute to
6 learning in that because, again, I didn't review the
7 actual course materials before I came in here.

8 BY MS. SALVADOR:

9 Q. Were there specific lessons in that
10 fellowship that focused on abortion?

11 A. There were.

12 Q. What, if anything, do you recall about those
13 lessons on abortion?

14 A. Okay. Thank you. I remember the logical
15 thinking through what abortion is and what happens in
16 abortion, which I could relate to since I had done
17 them, and looking at the science of life and the
18 philosophy of life.

19 Q. After you completed your residency, did you
20 work as an ob-gyn?

21 A. Yes, I did.

22 Q. Was one of the places you worked as an ob-gyn
23 at the Millcreek Women's Center?

24 A. Yes.

25 Q. How long did you work at Millcreek Women's

1 Center?

2 A. I worked there from 1991 until approximately
3 2008.

4 Q. What were your duties at Millcreek Women's
5 Center?

6 A. I was a general ob-gyn physician, which
7 involves seeing patients, helping patients in the
8 office, providing surgeries, and then providing
9 obstetrics.

10 I was also one of the managing partners, so I
11 helped with development of the business, hiring,
12 firing, protocols, business management, those types of
13 things.

14 Q. You mentioned performing surgeries. What
15 types of surgeries did you perform in your time at
16 Millcreek Women's Center?

17 A. In general, I provided the surgeries that you
18 do for gynecology. So examples would be things like
19 cone biopsies, ooscopies and biopsies, laparoscopies,
20 laparoscopic tubal ligations, D&Cs, D&Es,
21 hysterectomies, hysteroscopy, those types of
22 procedures, in addition to cesarean sections. Those
23 are examples.

24 Q. Did all of those surgeries you just mentioned
25 take place in hospital settings?

1 A. They took place in the hospital operating
2 room. They took place in the ambulatory surgical
3 center, which St. Mark's eventually had two. They
4 also -- I did sometimes do hysteroscopies and I also
5 did colposcopy biopsy and LEEP procedures in my office.

6 Those are the ones that I recall doing in the
7 office.

8 Q. Just to clarify, you said that you performed
9 hysteroscopies and colposcopy biopsies in your office;
10 is that correct?

11 A. A few. I primarily did them -- colposcopies
12 and biopsies I did in my office. I did a small number
13 of hysteroscopies at the end of my practice in the
14 office. The majority of them I performed in the
15 ambulatory surgery center.

16 Q. Did you perform any other types of surgical
17 procedures in your office?

18 A. If we're talking about "surgery" being
19 suturing and things like that, no. I would have --
20 those are under surgical codes, so those I may have
21 done in my office. Certain biopsies I may have done in
22 my office. Those would also be under surgical codes.

23 As far as what I recall, the major procedural
24 surgeries I did were the colposcopy biopsy, LEEP, and
25 then a small number of hysteroscopies are the only ones

1 I can recall doing in my office.

2 Q. You mentioned St. Mark's Hospital. Were you
3 also on the medical staff at St. Mark's Hospital?

4 A. Yes, I was.

5 Q. Were St. Mark's Outpatient Surgical Center
6 and the St. Mark's Hospital Surgery Center your primary
7 outpatient surgical center?

8 A. I'm sorry. Repeat the question.

9 Q. Sure.

10 Your report refers to work at St. Mark's
11 Outpatient Surgical Center and St. Mark's Hospital
12 Surgery Center. Were those your primary outpatient
13 surgical centers?

14 A. There was an additional surgery center
15 that -- I don't remember the year it opened, but it was
16 maybe two blocks from the hospital. It was a short
17 distance.

18 The hospital was on 39th. The surgery center
19 was on 45th, and so it was literally down the road a
20 few blocks. It might have been more than two blocks.
21 It was a few blocks down the road.

22 So those were -- during that time, those were
23 primarily where I went. I would have very rarely gone
24 to the University of Utah. Perhaps if I had a patient
25 I had to transfer.

1 And I'm trying to consider was there anywhere
2 else I went. I don't recall doing surgeries at
3 Cottonwood Hospital, which I don't even know if it's
4 open anymore. I remember going there for some
5 obstetrical patients. Some of my partners had
6 privileges there.

7 I don't recall going there for surgeries
8 unless -- I don't recall going there for surgeries, but
9 initially I did sometimes go there for obstetrics is
10 what I'm recalling. It was very rare.

11 I don't recall going to other hospitals,
12 again, except I might have gone to the University of
13 Utah for an occasional patient that needed to be at a
14 higher acuity center.

15 Q. Got it. Thank you for that.

16 So in your report you state that early in
17 your time at Millcreek Women's Center you provided
18 second-trimester abortions for established patients who
19 requested induced abortion for fetuses with genetic
20 syndromes and severe fetal anomalies; is that right?

21 A. Let me ask you -- repeat it one more time. I
22 want to make sure I hear exactly what you're saying.

23 Q. Sure.

24 Let's go to paragraph 3 of your report.

25 A. Okay.

1 Q. Let me know when you're there.

2 A. I am at paragraph 3.

3 Q. In paragraph 3, there's a sentence that
4 states: "Early in my private practice I performed
5 second-trimester abortions for my established patients
6 who requested induced abortions for fetuses with
7 genetic syndromes and severe fetal anomalies"; is that
8 correct?

9 A. That is correct if they specifically asked me
10 to do it. There was a major center in Salt Lake who
11 did them, but if they specifically asked me to be the
12 one to do them, that is correct.

13 Q. About how many second-trimester abortions did
14 you provide in your time at Millcreek Women's Center?

15 A. I don't recall.

16 Q. Would you say it was more than one a year?

17 A. I don't recall.

18 Q. Would you say you remember -- would you say
19 it was rare for you to perform an abortion?

20 A. It depends on your definition of "rare." I
21 would say it was infrequent, at least.

22 Q. What do you mean by "infrequent"?

23 A. Well, I did not do them frequently.

24 Q. About how often would you say you did them?

25 A. I don't recall. It was a typical ob-gyn

1 practice, so -- it would not have been a large number.

2 Q. How many years did you work at Millcreek
3 Women's Center?

4 A. From 1991 to approximately 2008.

5 Q. Did you perform more than one abortion during
6 that time period?

7 A. Yes, I did.

8 Q. Would you say you performed 10 abortions
9 during that time period?

10 A. I don't recall.

11 Q. Do you recall -- over the course of -- sorry.
12 Over the course of your career, have you ever
13 provided an abortion outside of second-trimester
14 abortions for the indication of fetuses with genetic
15 syndromes and severe fetal anomalies?

16 A. Yes.

17 Q. What were the other circumstances in which
18 you performed abortions?

19 A. I performed one first-trimester abortion
20 electively.

21 Q. At what point in your career did you perform
22 that first-trimester abortion electively?

23 A. Somewhere in the early years of my private
24 practice.

25 Q. So was that during your time at Millcreek

1 Women's Center?

2 A. Yes.

3 Q. Was that the only first-trimester abortion
4 that you performed electively?

5 A. It is the only one I recall.

6 Q. Do you recall the method that you used for
7 performing that abortion?

8 A. Yes. I used a D&C, a dilation and curettage
9 with suction.

10 Q. Do you recall where you performed that
11 abortion?

12 A. Yes, I do. I was at the St. Mark's
13 Ambulatory Surgical Center.

14 Q. Were you able to perform that abortion
15 safely?

16 A. Yes, I did.

17 Q. So going back to the second-trimester
18 abortions that you provided during your time at
19 Millcreek, were all of those abortions dilation and
20 evacuation procedures?

21 A. My recollection is that they were all
22 dilation and evacuation.

23 Q. Could you briefly describe the procedure
24 you're referring to when you say "dilation and
25 evacuation."

1 A. I can describe typically. I don't remember
2 the specifics of these cases.

3 But typically my practice would have been to
4 have the patient come in the day before. Of course,
5 after informed consent and discussion of her options,
6 I would have had her come in the day prior to her
7 procedure. I would have placed laminaria in her
8 cervix. I would have had her come in for her surgery
9 the following day.

10 And generally, these would have been done --
11 I don't recall exactly how they -- what the
12 anesthesiologist did for each one, but typically they
13 would have been either under sedation or general, and I
14 don't recall which one was done for each of them.

15 Then I would have -- she would have had her
16 laminaria removed. Certain precautions would have been
17 done. I would have been gowned and gloved. Usually
18 the assistant would have the patient at that point in
19 stirrups and have done the prep.

20 I would have grasped her cervix with
21 something like an Allis clamp. Again, I don't -- I
22 can't tell you the specifics of one, but that would
23 have been typical for me.

24 I would have assessed for dilation. I would
25 have performed an exam to assess. Usually I would have

1 done that prior to her being prepped once she was
2 either sedated or asleep. Then I would have dilated it
3 further if necessary with the hope not to have to
4 dilate it further. If necessary, I would have.

5 I would have ruptured her membranes with an
6 instrument, placed a suction, and then used a
7 combination of grasping forceps, typically Sopher Ovum
8 and the ring forcep, and then using suction to remove
9 all the parts.

10 The baby's parts would have been handed to my
11 assistant to gather on the table for me to exam. Once
12 I was -- I generally had an ultrasound there. It would
13 have been my typical practice to have an ultrasound so
14 I could watch the direction of my instruments and
15 primarily for grasping the fetal head.

16 And once I was comfortable that all the major
17 parts of the baby had been accounted for, then I would
18 have used primarily suction to remove the placenta, and
19 then use a curette to gently palpate throughout the
20 cavity to make sure that there was what's called a
21 uterine cry, that burning feel of the mutual cap when
22 all the placenta has been removed.

23 The ultrasound tech would have assessed the
24 endometrial cavity for me to be sure there did not
25 appear to be any retained products. Instruments would

1 have been removed and counted. I would examine the
2 remains of the baby. And that would be a completed
3 procedure.

4 Q. Thank you. That's really helpful.

5 You said that you typically used ultrasound
6 guidance when providing D&Es. Did you always use
7 ultrasound guidance when providing D&Es?

8 A. I don't -- I can't tell you that I did a
9 hundred percent of the time. It would have been my
10 typical practice.

11 Q. Is it your opinion that D&Es can ever be
12 safely performed without ultrasound guidance?

13 A. My expert opinion is that an ultrasound helps
14 to avoid some of the major complications of a D&E.

15 Q. I understand. That's not the question I
16 asked, though.

17 Is it your opinion that D&Es can ever safely
18 be performed without ultrasound guidance?

19 A. Again, my opinion is that an ultrasound
20 decreases the major complications.

21 Q. So you would say that an ultrasound -- that a
22 D&E can never be safely performed without ultrasound
23 guidance?

24 A. I did not say that. My job as a physician is
25 to minimize the risk of the procedure that I'm

1 performing, because all procedures and medications
2 carry risk. So my job is to do things in a way that
3 minimizes risk.

4 Q. Would you say that when you were at Millcreek
5 you performed one D&E a month?

6 I'm sorry. I couldn't hear you.

7 A. I don't recall how often I performed them.
8 It was -- again, it was not a common part of my
9 practice.

10 Q. What is the earliest gestational age at which
11 you performed a D&E?

12 A. I don't recall the earliest.

13 Q. At what gestational ages would you typically
14 perform a D&E?

15 A. Typically it would be somewhere around
16 13 to 14 weeks.

17 Q. Up to what gestational age did you perform a
18 D&E?

19 A. I don't recall the exact gestational age, but
20 somewhere between 16 and 18 weeks would be typically
21 when I do them up until.

22 Q. Did you ever perform a D&E at 18 weeks?

23 A. I don't recall the oldest gestational age
24 that I did them.

25 Q. At what gestational age do providers

1 typically start performing D&Es?

2 A. In the literature, typically at 13 to
3 14 weeks.

4 Q. In your experience, at what gestational age
5 do most providers start performing D&Es?

6 A. I can't answer for most providers. I can
7 tell you from the literature and typical training is
8 13 to 14 weeks.

9 Q. Would that be 13 to 14 weeks
10 post-fertilization or -- would that be from 13 to
11 14 weeks post-fertilization?

12 A. This would be menstrual dating, is typically
13 what we would do in obstetrics.

14 Q. Are you referring to the first day of the
15 patient's last menstrual period?

16 A. Yes, I am.

17 Q. I might use the phrase "LMP" to describe
18 that. Is that okay?

19 A. Yes.

20 Q. Was your -- so you mentioned that typically
21 providers start performing D&Es at 13 to 14 weeks. Was
22 that your opinion prior to your participation in this
23 case?

24 A. Actually, I didn't say that.

25 Q. Sure. Can you clarify what you said, then.

1 A. I said that I don't know when most -- I can't
2 answer for most providers, but typically the literature
3 and in training it's 13 to 14 weeks.

4 Q. Was that your understanding from the
5 literature before you started participating in this
6 case?

7 A. Was what? Can you please explain.

8 Q. Sure.

9 Did you have an understanding based on
10 literature that providers start performing D&Es at
11 13 to 14 weeks? Did you have that understanding prior
12 to your participation in this case?

13 A. I can't say what providers do, but my
14 understanding prior to this case from my training and
15 from my experience is that typically D&E procedures
16 are -- for induced indication would be performed,
17 again, based on literature and training, somewhere
18 around 13 to 14 weeks.

19 Q. Did all of the D&Es you performed take place
20 in hospital settings?

21 A. The D&Es I performed would have been at the
22 University of Utah in the main OR hospital. The ones
23 in St. Mark's, the ambulatory surgical center was
24 actually in the hospital, so it was part of the
25 hospital unit.

1 So my recollection -- I don't have clear
2 recollections of where I was, but it was an unusual
3 situation in that actually the surgical center was in
4 the hospital complex.

5 Does that make sense? It was just
6 downstairs, and the operating room was upstairs, the
7 main OR.

8 Q. Would it be fair to say --

9 MR. BOYLE: We've been going for about an
10 hour, so -- I don't want to cut you off if you're in
11 mid sort of thought, but if we could take a break soon,
12 that would be great. Thank you.

13 MS. SALVADOR: Sure. Let me just ask one
14 follow-up clarifying question.

15 MR. BOYLE: That's fine.

16 BY MS. SALVADOR:

17 Q. Would it be fair to say that St. Mark's was
18 an ambulatory surgery center that was physically
19 located in proximity to the hospital; is that right?

20 A. It was actually part of the hospital's suite.
21 It was connected to the hospital. It was downstairs.
22 It was the surgical center, a hallway into the
23 emergency department, a hall away to -- and the main
24 operating room was on the second floor. The ICU was on
25 the second floor. Labor and delivery was a little

1 further on the first floor.

2 So it was part of the suite. I would not
3 have done -- the 45th Street one was not part of the
4 hospital system. I didn't do any there.

5 My typical practice -- again, I can't
6 remember the exact surgeries. I don't recall. My
7 typical practice would be to be in the main operating
8 room. That would be my typical practice for a D&E.

9 MS. SALVADOR: Understood.

10 I think now is a good time for a break.

11 (Off the record 12:10 p.m. to 12:23 p.m.)

12 BY MS. SALVADOR:

13 Q. We were talking, Dr. Wheeler, about your
14 experience performing D&Es.

15 Did you ever perform D&Es for management of
16 intrauterine fetal demise?

17 A. Yes.

18 Q. At what gestational ages?

19 A. I don't recall the gestational ages.

20 Q. Typically -- do you recall any of the D&Es
21 for management of intrauterine fetal demise?

22 A. As far as specifics, I don't remember
23 specific, like, who the patient was. I can remember
24 doing them.

25 Q. Do you remember about how frequently you

1 would perform D&Es for management of intrauterine fetal
2 demise?

3 A. I don't recall how often.

4 Q. Would you say that it was more than one a
5 year?

6 A. I don't recall if it was more than that or
7 not at the time.

8 Q. And would you say that it was -- would you
9 say that you performed one every week?

10 A. I don't know. It was a typical ob-gyn
11 practice, so that's -- those don't come up regularly.
12 They come up -- thank God they come up infrequently.

13 Q. What do you mean by "infrequently"?

14 A. They're just -- they're not common. Thank
15 goodness, they're not common.

16 Q. Would you say that you've performed more than
17 a handful of D&Es for management of intrauterine fetal
18 demise?

19 A. I can't conjecture. I have memories of doing
20 them. I don't know how many I did.

21 Q. So you said you did more than one; is that
22 right?

23 A. Yes.

24 Q. And you said it was less frequent than one a
25 week; is that right?

1 A. Yes.

2 Q. Could you ballpark for me about how many per
3 year you would do?

4 A. I don't recall. I would have done them for
5 my own patients. If I was on call, I would have done
6 them on call. If somebody came in or one of my
7 partners, I would have done them at the University of
8 Utah. So -- but I don't have -- I can't recall how
9 many I did.

10 Q. Would you say you did one at each of those
11 locations every year?

12 A. I can't tell you that. I don't recall how
13 many I did.

14 Q. Have you ever done a D&E for intrauterine
15 fetal demise prior to 20 weeks LMP?

16 A. Have I ever done a D&E for fetal demise prior
17 to 20 weeks? Yes, I have.

18 Q. Could you describe -- about how many -- well,
19 you said you've done -- have you done more than one D&E
20 for intrauterine fetal demise prior to 20 weeks LMP?

21 A. Yes.

22 MR. BOYLE: Object to form.

23 BY MS. SALVADOR:

24 Q. About -- about how many D&Es prior to
25 20 weeks for intrauterine fetal demise have you done?

1 A. I don't recall.

2 Q. Have you done more than two?

3 A. Yes.

4 Q. At what gestational ages LMP would you
5 perform D&Es for intrauterine fetal demise?

6 A. Part of that would depend on the size of the
7 baby, because they may have been demised for quite a
8 while.

9 So at this time the baby would be about the
10 size when I thought that I would need to dismember the
11 baby is when I would need to do a D&E. That would
12 become a different procedure when the baby was big
13 enough to need dismemberment to remove the baby.

14 Q. Could you repeat that last sentence, please.
15 I'm sorry. I couldn't quite hear you.

16 A. Yes.

17 The D&E decision would be based on the baby's
18 size. So if the baby was large enough to need
19 dismemberment -- in other words, to grasp parts and
20 remove them to get the baby delivered out of the
21 cervix -- that's when we would make the decision based
22 on the fetal size.

23 Q. At what point in gestation would a D&E be
24 required, in your experience?

25 A. With a living baby growing normally,

1 approximately 13 to 14 weeks.

2 Q. And did you ever perform D&Es either for
3 abortion or for intrauterine fetal demise at 13 to
4 14 weeks?

5 A. That's a compound question. What is your
6 question?

7 Q. Did you ever perform D&Es at 13 to 14 weeks'
8 gestation for your patients?

9 A. Yes, I did.

10 Q. Were any of those D&Es for intrauterine fetal
11 demise at 13 to 14 weeks?

12 A. Again, I don't remember the exact gestational
13 age of my patients, but I remember performing D&Es, but
14 I can't remember the exact gestational ages.

15 Q. So you've said that you remember performing
16 D&Es at approximately 13 to 14 weeks for your patients;
17 is that right?

18 A. At beyond 13 to 14 weeks. I don't remember
19 the exact gestational ages of the patients.

20 Q. Okay. But you do remember performing D&Es
21 for some of your patients beyond 13 to 14 weeks; is
22 that right?

23 A. Whether -- I don't recall if they were my
24 specific patients, meaning from my practice, but --
25 although they were my patients once I took care of

1 them, weren't they?

2 So yes, beyond 13 to 14 weeks, I do remember
3 doing, but I don't remember the exact ages.

4 Q. Sure.

5 But do you remember performing D&Es prior to
6 20 weeks?

7 A. Yes, I do.

8 Q. So it's fair to say that you performed at
9 least some D&Es between 13 weeks and before 20 weeks;
10 is that correct?

11 A. That is correct.

12 Q. Were those D&Es for both intrauterine fetal
13 demise and for abortion?

14 A. Well, they would have been for one indication
15 or the other.

16 Q. Do you recall that you performed D&Es for
17 intrauterine fetal demise between 13 weeks and
18 20 weeks?

19 A. Fetal demise, yes.

20 Q. Do you recall that you performed D&Es for
21 abortion purposes between 13 weeks and 20 weeks?

22 A. Yes, I do.

23 Q. Would you say that you performed more of
24 those D&Es for intrauterine fetal demise or for
25 abortion, or was it about equal?

1 A. I don't recall that.

2 Q. When you performed D&Es for induced abortion,
3 were those ever in an ambulatory surgical center?

4 A. Again, I don't recall. I do know I didn't do
5 any of them outside of the hospital complex. As I
6 described, St. Mark's Ambulatory Surgical Center was
7 actually a part of the hospital complex.

8 Q. Would you say that you performed any D&Es
9 for -- would you say that you performed any D&Es in the
10 St. Mark's Ambulatory Surgical Center?

11 A. I don't recall performing any there. I don't
12 recall performing any there.

13 Q. Do you ever perform D&Es in a hospital
14 operating room?

15 A. Yes.

16 Q. Did you perform D&Es for induced abortion
17 purposes in a hospital operating room?

18 A. Yes.

19 Q. Did you perform D&Es for management of
20 intrauterine fetal demise in a hospital operating room?

21 A. I don't have specific memories of where I was
22 during the D&Es.

23 Q. So is it possible that some took place in the
24 St. Mark's Ambulatory Surgical Center?

25 A. I don't recall doing any of them there.

1 The only one I recall doing there was the
2 D&C, the first-trimester D&C induced abortion. That's
3 the only one I have a distinct memory of being there.

4 Q. What proportion of your practice while you
5 were working at Millcreek would you say were surgeries?

6 A. I guess you'd have to define "proportion of
7 practice."

8 I had -- every week I had time in the
9 operating room. That's the best I can answer that.

10 Q. About how much time in the operating room
11 would you have every week?

12 MR. BOYLE: Object to form.

13 THE WITNESS: I can't really answer that. We
14 had set operating room days that we shared with a
15 partner, so I was either there doing my own surgeries
16 or assisting my partner with a surgery.

17 BY MS. SALVADOR:

18 Q. So you've said you had time in the operating
19 room every week; is that right?

20 A. Well, either as the primary surgeon or as the
21 primary assistant. We had main operating time, and we
22 had separate ambulatory surgery time.

23 Q. Were you in the operating room as the primary
24 surgeon every week?

25 A. I don't know if every single week if I was.

1 The --

2 Q. So you said -- sorry.

3 A. I apologize.

4 We had block time. So we had the OR
5 available. If we didn't have a patient to operate on,
6 then we could release our block time, or actually, they
7 would take our block time if we didn't have a person
8 scheduled at a certain period of time.

9 Q. Would you say it was common for them to take
10 your block time?

11 MR. BOYLE: Objection.

12 You can answer.

13 THE WITNESS: I don't remember all of the
14 details of that.

15 BY MS. SALVADOR:

16 Q. Would you say that it was common for you to
17 use your block time for surgery?

18 A. It was common between the two of us. Usually
19 it was two of us sharing an operating block, and it was
20 common for us to be operating.

21 Q. And you said that it was infrequent that a
22 patient you were caring for needed a D&E; is that
23 right?

24 A. I'm not sure of the form of your question.
25 Can you please repeat it.

1 Q. Sure.

2 Before, we were talking about how often you
3 performed D&Es, and you said that it was infrequent; is
4 that right?

5 A. It was infrequent, yes.

6 Q. And you've also said that you had blocked
7 time in the operating room every week; is that right?

8 A. In most of my practice with -- together with
9 my partner, we would have had block time most of the
10 time every week.

11 Q. And you've also said that you performed D&Es
12 for abortion purposes and for management of
13 intrauterine fetal demise; is that right?

14 A. That's correct.

15 Q. When you're thinking back on your cases,
16 about how many D&Es do you consciously remember
17 performing?

18 A. I can't give you a number. I can't recollect
19 a number.

20 Q. What would you say was the most frequent
21 surgery that you performed during your time at
22 Millcreek and St. Mark's?

23 A. I don't want to conjecture. I'd have to look
24 at my case series. I can't recall the most frequent
25 one.

1 Q. Sure.

2 What were some surgeries that you performed
3 frequently during your time at Millcreek and
4 St. Mark's?

5 A. Frequently would have been things like
6 cesarean sections, hysteroscopy, hysterectomy,
7 primarily vaginal. Those would be among the more
8 common. The D&Cs with the hysteroscopy, those would
9 be -- laparoscopy. Those would be some of the most
10 common surgeries we would have done.

11 Q. When you say "most common," what do you mean
12 by that?

13 A. Frequent.

14 Q. Would you say more than once a month?

15 A. You know, I don't want to overstate, so I
16 can't accurately answer that without looking at my case
17 series.

18 Q. Would you say that you performed a C-section
19 more than a few times a year?

20 A. Yes.

21 Q. Would you say that you performed a D&C more
22 than a few times a year?

23 A. Yes.

24 Q. Would you say that you performed more than 10
25 C-sections a year?

1 A. Yes. When I was practicing obstetrics, yes.

2 Q. Would you say that you performed more than
3 10 D&Cs a year when you were practicing obstetrics?

4 A. Again, I don't want to conjecture. It was
5 one of the more frequent -- it was a common
6 gynecological procedure. I don't have the numbers that
7 I can tell you.

8 Q. Got it. But you did say just now that you
9 performed more than 10 C-sections a year; is that
10 right?

11 A. When I was practicing obstetrics, yes.

12 Q. Was it fair to say -- would it be fair to say
13 that you performed more C-sections than D&Cs when you
14 were practicing obstetrics?

15 A. I don't want to answer in "most likelies,"
16 because I don't have those numbers in front of me. So
17 I can't tell you.

18 In a typical ob-gyn practice, that would be
19 true. I just don't have the numbers in front of me to
20 be specific under oath.

21 Q. Well, would you say that you performed a
22 C-section every week when you were practicing
23 obstetrics?

24 A. I can't tell you if I practiced -- if I did
25 one every week.

1 Q. I'm not saying for certain.

2 Would it be fair to say that you performed
3 approximately one C-section a week when you were
4 practicing obstetrics?

5 A. And again, I don't want to overstate or
6 understate. I performed a lot of C-sections. That's
7 all I can say.

8 Q. Is it fair to say that you performed many
9 more C-sections than you did D&Es when you were
10 practicing obstetrics?

11 A. Yes, that would be correct.

12 Q. Going back to those D&Es, were all of them
13 performed with the patient under general anesthesia?

14 A. I don't have exact recollection of that.

15 Q. Do you recall any D&Es you've performed when
16 the patient was not under general anesthesia?

17 A. I don't have specific recollection of that.

18 Q. So you don't recall any abortion -- I'm
19 sorry. You don't recall any D&E that was
20 performed without -- sorry.

21 You don't recall any D&E that you performed
22 without the patient being under general anesthesia; is
23 that correct?

24 A. I don't recall specifics of the anesthesia.
25 I can tell you what typically we would have done, but I

1 can't tell you what I did for each of the patients.

2 Q. What typically would you have done for your
3 D&E patients?

4 A. Typically it would be the anesthesiologist
5 making a recommendation, and typically they would want
6 to control the airway and do general controlling the
7 airway. They may have also done sedation. One of
8 those two would have been discussed based on a lot of
9 factors.

10 Q. When you refer to controlling the airway, are
11 you referring to intubation?

12 A. Correct. Most of the time that's what they
13 would be considering, the ease of how easy it would be
14 to intubate if necessary, whether they needed to
15 control the airway prior to starting. Those are
16 discussions we would have had.

17 Q. So we were just discussing before that you
18 reviewed the literature for your statement that
19 providers start performing D&E around 13 to 14 weeks
20 LMP; is that right?

21 A. I evaluated the literature and selected
22 relevant references to review.

23 Q. So you evaluated the literature and concluded
24 that providers start performing D&Es around 13 to 14
25 weeks LMP; is that right?

1 A. Based on my experience and the relevant
2 research and the American College of OB-GYN, Dr. Warren
3 Hern, who is an abortionist, yes, I reviewed all of
4 those, and typically the literature states 13 to
5 14 weeks depending on the baby's size.

6 Q. Is there any other -- I'm sorry.

7 A. Go ahead.

8 Q. Is there any other literature that you recall
9 reviewing for your statement that D&Es start at
10 13 to 14 weeks LMP depending on the fetus's size?

11 A. I referenced in there the ones that I have
12 specific references, so you can see those in my report.

13 Q. When did you stop performing D&Es?

14 A. I don't remember exactly.

15 Q. Was it when you were at Millcreek?

16 A. Yes, I was at Millcreek.

17 Q. So you have not performed a D&E after leaving
18 Millcreek; is that right?

19 A. I don't recall when I was at the University
20 of Utah for four years I was involved in any of the
21 resident cases. I can't tell you. I don't recall
22 being involved. It's possible, because I covered
23 residents, but I don't recall any during that time.

24 Q. Have you performed an induced abortion by any
25 other method since you stopped performing D&Es?

1 A. No, I have not.

2 Q. Did you provide -- you referred to one D&C
3 that you provided during your time at Millcreek Women's
4 Center for abortion purposes; is that right?

5 A. That's correct.

6 Q. Did you provide any other first-trimester
7 abortions during your time at Millcreek Women's Center?

8 A. I did not.

9 Q. In your -- have you ever performed a
10 medication abortion?

11 A. I have not.

12 Q. What made you stop performing D&Es?

13 A. D&Es?

14 Q. Yes.

15 A. Well, I made a decision to quit performing
16 abortions.

17 Q. Do you remember when you made that decision
18 to quit performing abortions?

19 A. Yes. During a D&C that I did. I don't
20 remember the year.

21 Q. But it was during your time at Millcreek; is
22 that right?

23 A. That's correct.

24 Q. Would you say it was toward the beginning of
25 your time at Millcreek?

1 A. It was sometime in the earlier years, yes. I
2 can't remember the exact date.

3 Q. So you referred to the University of Utah.
4 You were also an associate professor at the University
5 of Utah School of Medicine's obstetrics and gynecology
6 department; is that right?

7 A. In the specific years listed, yes.

8 Q. What years were those?

9 A. I don't have the report anymore.

10 (Whereupon, there was an off-the-record discussion
11 between witness and counsel.)

12 THE WITNESS: From 2008 to 2012.

13 BY MS. SALVADOR:

14 Q. What did your role as an associate professor
15 entail?

16 A. Primarily I was recruited to develop a
17 midlife women's health clinic which was
18 multidisciplinary. As part of my role there, I also
19 was integrally involved with students and residents,
20 and sometimes fellows and the remainder of the staff.

21 So I did have some on-call duties. Primarily
22 I had a gynecology clinic that I personally performed
23 plus developing this -- and then implementing this
24 midlife women's health clinic.

25 I also developed some teaching curricula for

1 the ob-gyn residents about menopause and midlife health
2 for women.

3 Q. Did you supervise students in hospital
4 settings?

5 A. My primary role was on call. I would
6 supervise for gynecology only if I was assigned a call
7 on that day. Primarily -- I did do some teaching, most
8 of it menopause and midlife, women's health related. I
9 did some didactic lectures, most of them again midlife
10 women's health and menopause related.

11 And then, of course, students and residents
12 were often involved with the surgeries that I performed
13 or I oversaw some of the residents for gynecology
14 surgery.

15 Q. Did you -- so you referred to being on call.
16 Was that in a hospital setting?

17 A. Yes. There was an outpatient surgical
18 center. I don't have specific recollections of that,
19 but there was an outpatient surgical center too.

20 Q. Did you also supervise students in that
21 outpatient surgical center?

22 A. I don't -- I don't have any specific
23 recollection of that. My recollections are in the
24 main OR.

25 Q. Did you teach your students at the University

1 of Utah about abortion?

2 A. I didn't do anything related to abortion
3 during those four years that I was there.

4 Q. So you never performed abortions while
5 working at the University of Utah?

6 A. During my four-year tenure there, I was not
7 involved with any abortions.

8 Q. While you were an associate professor at the
9 University of Utah, you were also working as a
10 gynecology physician in the Women's Midlife Assessment
11 Clinic; is that right?

12 A. I was developing the Midlife Women's Health
13 Clinic -- Assessment Clinic, and yes, I was
14 exemented. And I was involved there as the
15 director and as one of the gynecology professionals.

16 Q. Your report uses the specific term
17 "gynecology physician." Is that the same thing as what
18 many people call a gynecologist?

19 A. Yes.

20 Q. When -- I'm sorry. I'm trying to find the
21 correct paragraph.

22 In paragraph 5 of your report -- let me know
23 when you're there.

24 A. I'm there. Thank you.

25 Q. You state that: "While at the University of

1 Utah" -- and now I'm looking at the last sentence -- "I
2 developed menopause and midlife health teaching
3 curricula for the ob-gyn residents and provided
4 gynecological care and surgery"; is that right?

5 A. Correct.

6 Q. What types of gynecological surgery did you
7 perform?

8 A. I don't remember -- excuse me -- the
9 specifics. I can remember doing some hysterectomies.

10 The other -- as far as separating out that
11 one period of my career, I can't tell you which --
12 other than I do have specific recollections of
13 hysterectomies. But it would have been whatever my
14 gynecology patients needed that was general gynecology.

15 Q. Would you -- you referred to, when we were
16 talking about your time at Millcreek, performing
17 colposcopy biopsies; is that right?

18 A. Repeat that, please.

19 Q. When we were talking about your time at
20 Millcreek, you referred to performing colposcopy
21 biopsies; is that right?

22 I'm sorry. I can't hear you.

23 A. Oh, I'm sorry. Yes, I did perform colposcopy
24 biopsies.

25 Q. Do you remember if you performed any

1 colposcopy biopsies while you were at the University of
2 Utah?

3 I'm sorry?

4 A. I'm considering. I'm trying to remember
5 details from that time.

6 I don't remember the specific details. It's
7 a normal part of gynecology practice, but I don't
8 remember specific patients during that time.

9 Q. When you performed hysterectomies, where
10 would those take place?

11 MR. BOYLE: Object to form.

12 THE WITNESS: Would you ask the question
13 again, please.

14 BY MS. SALVADOR:

15 Q. Sure.

16 When you performed hysterectomies, in what
17 setting would those take place?

18 MR. BOYLE: Object to form.

19 THE WITNESS: When I performed
20 hysterectomies, I would have been in a main operating
21 room -- in a general operating room in a hospital.

22 BY MS. SALVADOR:

23 Q. When you would perform a colposcopy biopsy,
24 when would that typically take place? I'm sorry.
25 Where would that typically case place?

1 MR. BOYLE: Object to form.

2 THE WITNESS: Colposcopy biopsies, most of
3 the time I would have performed them in an office
4 setting.

5 BY MS. SALVADOR:

6 Q. Could you describe what a colposcopy biopsy
7 is.

8 A. Colposcopy, you're putting acetic acid on the
9 cervix, which dehydrates tissues, makes potential
10 abnormalities become more visible under a microscope
11 called a colposcope.

12 And then you're taking appropriate biopsies
13 for suspicious areas of the cervix to send to pathology
14 for pathological diagnosis.

15 Q. And could you describe the process of taking
16 a biopsy.

17 A. Please repeat that.

18 Q. Could you describe the process of taking a
19 biopsy.

20 A. Which type of biopsy are you referring to?

21 Q. A colposcopy biopsy.

22 So you were describing a colposcopy biopsy,
23 and you said as one step you would perform the biopsy.
24 So could you go into more detail about the biopsy
25 piece, please.

1 A. So biopsy, you have a long instrument with a
2 sharp-edged little, tiny round end that you take a
3 pinch -- a very tiny pinch of tissue. That gets
4 collected to be sent to pathology. You mark on the
5 chart where you took the biopsy from.

6 Q. Could you describe the risks of a colposcopy
7 biopsy.

8 A. Well, this is outside of what I was asked to
9 give an opinion on.

10 Q. I understand. I'm asking about your general
11 medical expertise. So could you answer the question,
12 please.

13 A. Yes. The general risks are incredibly
14 minimal. Because you're taking a piece of tissue,
15 there would be a small chance of some bleeding, so you
16 do have silver nitrate or suture available for that.

17 There would be a very minimal risk for
18 infection. I don't recall ever seeing that. And those
19 would be the minimal risks.

20 Q. Would there also be a risk of cervical
21 laceration with a colposcopy biopsy?

22 A. That would be incredibly unusual. I'm trying
23 to figure out why that would occur. That would be
24 unusual.

25 You could -- let's see. Could it ever

1 happen? I suppose it could happen if you had to hold
2 on to the cervix with something, but that would be
3 incredibly unusual. We would put a stitch in it to
4 tack that up.

5 Q. Could you repeat that last phrase. You said
6 you would put a stent?

7 A. Stitch. If you had -- if you had to hold on
8 to the cervix with something and you got a small
9 laceration, you've got a silver nitrate stick that
10 would cauterize it, or you could put a stitch in it if
11 you have to, a suture.

12 Q. If you had that scenario where you needed to
13 put in a suture, would you be able to do that in the
14 office setting?

15 MR. BOYLE: Object to form.

16 THE WITNESS: Yes.

17 BY MS. SALVADOR:

18 Q. You also mentioned when we were talking about
19 your time at Millcreek that you would perform
20 hysteroscopies; is that correct?

21 A. I performed a small number of hysteroscopies,
22 yes.

23 Q. And would you -- did you also perform
24 hysteroscopies during your time at the University of
25 Utah?

1 A. I don't have specific recollections. That's
2 a normal part of a gynecology practice, but I can't
3 tell you which places I performed them.

4 Q. What is a hysteroscopy?

5 A. A hysteroscopy is a scope that you place
6 through the vagina through the cervix into the uterine
7 cavity, so it's a method of visualizing the uterine
8 cavity.

9 Q. Would you typically perform a hysteroscopy in
10 an office setting?

11 A. It depends on the patient's specific
12 situation.

13 Q. Would you ever perform a hysteroscopy in an
14 office setting?

15 A. I performed a relatively small number towards
16 the end of my practice. We had a hysteroscopy setup at
17 HCA St. Mark's Gynecology. So I had the availability,
18 and I did do some.

19 Q. What are the risks of performing a
20 hysteroscopy?

21 A. Hysteroscopy risk is incredibly minimal. It
22 is a very small risk of infection, of bleeding. I
23 don't recall having a complication of either of those.

24 Anytime you place an instrument into the
25 uterine cavity through the cervix, there is a small

1 risk of perforation of the uterus. There is -- those
2 are the very small risks of hysteroscopy.

3 Q. In your work -- in your work at the
4 University of Utah, you said you never performed
5 abortions; is that correct?

6 A. That's not correct.

7 Q. Okay. In your work at the University of Utah
8 from 2008 to 2012, you said that you never performed
9 abortions; is that correct?

10 A. Induced abortions, no, I did not.

11 Q. Did you perform any noninduced abortions at
12 the time -- while you were at the University of Utah
13 from 2008 to 2012?

14 A. Define "abortion."

15 Q. How would you define "abortion" in this
16 context?

17 MR. BOYLE: Object to form.

18 THE WITNESS: I always define "induced
19 abortion" as an intervention that the goal is to not
20 deliver a living fetus or baby.

21 BY MS. SALVADOR:

22 Q. So in your time at the University of Utah, I
23 think we've been referring to your practice as
24 primarily gynecological; is that correct?

25 A. That is correct.

1 Q. Did you perform any obstetric work during
2 your time at the University of Utah?

3 A. My practice was limited to gynecology. And I
4 didn't have any liability coverage for obstetrics, so
5 no, I did not.

6 Q. Okay. After you left the University of Utah
7 School of Medicine, where -- did you also work at
8 St. Mark's HCA MountainStar from 2012 to 2015?

9 A. Yes, I did.

10 Q. What did your work there entail?

11 A. It was a newly developed or developing
12 gynecology clinic, so it was beginning that practice
13 with initially one other physician, and it was
14 providing gynecology services to women and
15 gynecological procedures, general gynecology
16 procedures.

17 Q. Did you perform any obstetrics work during
18 your time at St. Mark's Gynecology/HCA MountainStar?

19 A. I did not.

20 Q. So you've testified that some of your work as
21 an ob-gyn involved hospital practice; is that right?

22 A. Define "hospital practice."

23 Q. Performing procedures in a hospital.

24 A. Yes, that's correct.

25 Q. Was any of that hospital work you did for

1 patients who had presented to the emergency room?

2 A. Yes.

3 Q. Could you describe the hospital work you did
4 for patients who had presented to the emergency room.

5 A. Sorry. I didn't quite hear the whole
6 question.

7 Q. Sure.

8 Could you describe the hospital work you did
9 for patients who had presented to the emergency room?

10 A. Emergency room coverage would be essentially
11 anybody who came in with a pregnancy, obstetric, or a
12 gynecological condition through the emergency
13 department that the emergency department physicians
14 needed a specialist to evaluate and either give advice
15 or manage.

16 Q. And what were some of the conditions that
17 brought those people into the emergency room?

18 MR. BOYLE: Objection.

19 THE WITNESS: Some of them that I can recall
20 would be unregistered or people who didn't have an
21 obstetrician in the area who had either labor, bleeding
22 during pregnancy. It might be somebody with an ectopic
23 pregnancy. It could be somebody with complaints of
24 vaginal discharge. Abdominal pain. There was a
25 concern about a gynecology problem, those types of

1 things.

2 BY MS. SALVADOR:

3 Q. Do you remember treating any patients who
4 came into the ER because they were experiencing a
5 complication from an induced abortion?

6 A. Yes.

7 Q. Do you remember about how many patients you
8 saw who came into the ER who were experiencing a
9 complication from an induced abortion?

10 A. I have specific memories of two.

11 Q. And this was in your time at -- was this in
12 your time at Millcreek Women's Center?

13 A. Yes.

14 Q. Do you remember the ultimate outcome for
15 those two cases that you remember?

16 A. My recollection is that one of them had -- I
17 can't remember if it was a deep vein thrombosis or a
18 pulmonary embolism, so a clotting abnormality.

19 The second one, my recollection was that it
20 was retained tissue. It was essentially an incomplete
21 abortion.

22 They were both in the second trimester.

23 Q. Do you recall whether those patients were
24 safely discharged?

25 A. I don't have --

1 MR. BOYLE: Object to form.

2 THE WITNESS: I don't have that specific
3 recollection.

4 BY MS. SALVADOR:

5 Q. During your time at Millcreek, about how
6 often did you work with patients who had presented to
7 the emergency room?

8 A. I don't -- I don't know how many. I don't
9 have that specific recollection.

10 Q. Was working with patients who had presented
11 to the emergency room a regular part of your practice?

12 A. Yes, it was.

13 Q. Did you have shifts where you were assigned
14 to the emergency room?

15 A. Not specifically assigned to the emergency
16 room. We had -- it would be called -- I want to be
17 specific.

18 We had a rotation through the ob-gyn
19 department when our practice was covering the emergency
20 department for unregistered patients. In other words,
21 patients who did not have a physician there.

22 Q. What was the frequency of those rotations?

23 A. That would be dependent on how many
24 physicians were in the practice at the time and our
25 specific call schedule, whether our call schedule --

1 also we had our own practice call schedule, and then
2 there was the hospital for labor and delivery and
3 gynecology ER services.

4 So when those two hit on the same day,
5 whoever was on call was also covering for the emergency
6 department or unregistered OB patients.

7 Q. Would you say that you would end up covering
8 the emergency department multiple times a month?

9 MR. BOYLE: Object to form.

10 THE WITNESS: I don't have specific
11 recollections of how often that happened. It just
12 ended up you were the person on call and those two
13 schedules intersected.

14 BY MS. SALVADOR:

15 Q. But you said it was a regular part of your
16 practice; is that right?

17 MR. BOYLE: Object to form.

18 THE WITNESS: It was expected as part of our
19 being credentialed at the hospital that we would
20 participate when we were on call at the same time as it
21 was required for our practice to cover.

22 BY MS. SALVADOR:

23 Q. Would you say that you covered the emergency
24 room multiple times a year?

25 A. Yes.

1 MR. BOYLE: Object to form.

2 BY MS. SALVADOR:

3 Q. Would you say that you covered the emergency
4 room multiple times a month?

5 MR. BOYLE: Object to form.

6 THE WITNESS: I can't recall that.

7 And I'll clarify. When I was no longer doing
8 obstetrics, I was no longer part of the obstetrics
9 rotation.

10 When I returned to St. Mark's as an employed
11 physician in 2012, my contract specifically excluded me
12 from the general gynecology rotation for the emergency
13 department, and then I covered only my own personal
14 patients already established in my practice who
15 happened to present to the emergency department.

16 BY MS. SALVADOR:

17 Q. In the part of your practice when you were
18 doing rotations through the emergency department, would
19 you say that you saw more gynecological complications
20 or more obstetric complications?

21 A. I don't have a specific recollection of that
22 because they were separate. First trimester up to
23 probably the age of viability, at least first trimester
24 are seen in the emergency department.

25 Generally at viable ages, obstetrical

1 patients were transferred to the labor and delivery,
2 not emergency department, so -- but there was overlap.
3 It wasn't -- I mean, it varied.

4 Q. Got it. Thank you.

5 Then after your work at St. Mark's from 2012
6 to 2015, is there any other place where you were
7 employed for the practice of medicine?

8 A. I have not been employed in the practice of
9 medicine after 2015.

10 Q. So we've discussed that part of your medical
11 practice included miscarriage management. How would
12 you define "miscarriage management"?

13 A. Miscarriage management would mean that the
14 baby, the embryo or fetus was not viable, was not
15 alive. And so you would, depending on what gestational
16 age, review with the patient the diagnosis, and then
17 discuss her options and management.

18 Q. Did your miscarriage management practice ever
19 involve providing patients with medication?

20 A. Medications?

21 Q. Yes.

22 A. I mean, medications could have been pain
23 medications. It could have been -- so I would have
24 probably given pain medications. I would say that I
25 gave pain medications.

1 Q. Have you ever used mifepristone in your
2 miscarriage management practice?

3 A. I have not.

4 Q. Have you ever used misoprostol in your
5 miscarriage management practice?

6 A. I cannot -- I don't recall that.

7 Q. So you've testified that you -- that you've
8 provided D&Cs in your career; is that right?

9 A. That is correct.

10 Q. Would you commonly give a patient misoprostol
11 as part of performing a D&C?

12 A. For cervical preparation prior to the
13 procedure, I have distinct recollections of giving
14 misoprostol prior to D&Cs. I don't recall the
15 indication of the D&Cs.

16 Q. Have you ever provided misoprostol to a
17 patient prior to performing an D&E?

18 A. I don't recall that.

19 Q. When -- did your -- I'm sorry.

20 Did your miscarriage management practice ever
21 involve providing aspiration?

22 MR. BOYLE: Object to form.

23 THE WITNESS: Define "aspiration."

24 BY MS. SALVADOR:

25 Q. How would you define "aspiration"?

1 MR. BOYLE: Object to form.

2 BY MS. SALVADOR:

3 Q. I'm sorry?

4 A. I'm considering my answer.

5 Aspiration is a term of different ways that
6 we can aspirate tissue out of the endometrial cavity.
7 So there's many different types of procedures that we
8 can use for an aspiration. It involves using
9 essentially a vacuum as opposed to typically a sharp
10 instrument.

11 Q. So when I use the term "aspiration," I'm
12 referring to using a manual or electric vacuum
13 aspirator to empty a uterus. Is that okay with you?

14 A. Yes.

15 Q. So have you ever performed aspiration for a
16 miscarriage management?

17 A. I have used an electrical vacuum aspirator
18 for miscarriage management.

19 Q. Have you ever used aspiration to provide an
20 elective abortion?

21 A. Yes. As part of a D&E, I would have used it,
22 and in the one first-trimester D&C, I would have used
23 aspiration.

24 Q. From a clinical procedure perspective, would
25 you use aspiration any differently when you were

1 performing a D&E for an abortion as opposed to an
2 intrauterine fetal demise?

3 A. There is a difference in simply using an
4 instrument versus being prepared clinically for
5 everything that I need to be for what I might encounter
6 during that procedure. So we're talking about the
7 difference between technical use versus the global
8 picture of the procedure.

9 Q. So I'm talking about technical use. Is there
10 a difference in the technical use of aspiration when
11 performing a D&E for abortion as opposed to for
12 intrauterine fetal demise?

13 A. The physical placement of the instrument
14 within the uterine cavity would be similar. The
15 ability to dilate the cervix to get that instrument in
16 there may be extremely different.

17 The amount of bleeding that you encounter the
18 minute you get that instrument in there also tends to
19 be very different between the two procedures.

20 The difficulty in removing the tissue is
21 also -- tissue -- by tissue I'm meaning the fetus and
22 parts, and the cranium tends to be very different
23 between the two procedures.

24 Q. So the first -- you referred to the
25 difference in cervical dilation; is that right?

1 A. Yes.

2 Q. So tell me about the difference in cervical
3 dilation between intrauterine fetal demise and
4 abortion.

5 A. In general, by the time you have diagnosed
6 that a baby has passed away in utero, there are already
7 changes similar to the beginning of pregnancy wherein
8 the cervix may be softer. The cervix may be partly
9 dilated.

10 The internal os is going to tend to be easier
11 to open. If you consider the cervix is meant to keep
12 the uterine contents in and to be a protected -- a
13 protection against infection, it tends to be very
14 tightly closed throughout pregnancy and can be
15 difficult to transcend with instruments.

16 Again, with miscarriage, some of that
17 process -- like early labor, some of that process may
18 have already have occurred, and there is a tendency
19 from my experience for the dilation to be less
20 difficult when the baby's already passed away.

21 Q. So for either intrauterine fetal demise or
22 for abortion, you would need the patient's cervix to be
23 dilated; is that right?

24 A. Those are two separate questions, but I'm
25 going to answer that anytime that you enter a uterine

1 cavity with an instrument, there needs to be some
2 ability to get it through the internal os, depending on
3 the size of the instrument.

4 In a D&E, you've got an instrument that's a
5 pretty good size, so universally either it's got to be
6 dilated naturally or you're going to have to dilate it.

7 Q. Well, what would you use to dilate a cervix
8 if you were performing a D&E for intrauterine fetal
9 demise?

10 A. Again, this is a subjective -- I mean, this
11 is a question you'd have to see the individual patient.
12 Again, she may have already dilated her cervix.

13 Q. I'm just referring to your typical practice.
14 So what sorts of tools would you use or medications to
15 dilate a cervix for a D&E in the intrauterine fetal
16 demise situation?

17 A. As I described earlier, typically the day
18 before you're going to use something. I typically used
19 laminaria in the cervix to dilate the cervix some in
20 advance.

21 So that's a hypotonic agent that is going to
22 swell and gradually dilate the cervix and soften it and
23 efface it some. In the operating room, that's going to
24 get removed. I'm going to assess the cervix, see if
25 it's dilated.

1 If we don't have to dilate more, that reduces
2 the risk. If it needs more dilation, then I'm going to
3 use a dilator such as a Pratt blunt, a graduated
4 dilator -- there's some different sizes, gradually
5 increasing the size until it's dilated enough for me to
6 be able to introduce the instruments that I need to.

7 Q. And I'm sorry. I couldn't quite hear the
8 term for that second type of dilator. Did you call it
9 a crab?

10 A. I apologize. Pratt, P-R-A-T-T.

11 Q. P-R-A-T-T.

12 A. P as in pony.

13 Q. Got it. Thank you.

14 Would you also use laminaria when you were
15 performing D&Es for abortion purposes?

16 A. Yes.

17 Q. And would you also use the Pratt to dilate
18 the cervix if you were performing a D&E for abortion
19 purposes?

20 A. So it would depend on the operating room and
21 what the availability is. A Pratt would be the most
22 common one that would be available to me, the one I
23 preferred. But there are other dilators -- metal
24 dilators would be a good term to use.

25 Q. Got it. And would you also use those metal

1 dilators when performing a D&E for intrauterine fetal
2 demise?

3 A. I would assess the cervix once I was in the
4 operating room. I wouldn't use any dilators if the
5 cervix was already adequately dilated. But if it was
6 not, then I would use those dilators.

7 Q. Got it. So let's go back to -- let's go back
8 to your experience with aspiration.

9 Did you ever provide aspiration for
10 miscarriage management outside of the hospital setting?

11 A. I don't recall ever doing that. I may
12 have -- I had a partner who did them. I don't recall
13 actually personally doing them.

14 Again, I did have a partner who did them in
15 the operating room. Of any of my partners, only one
16 did it. He had the instruments. It is possible that I
17 either assisted him with one or observed one. I don't
18 recall personally ever doing one.

19 Q. Got it. Thank you.

20 MS. SALVADOR: I think this might be -- I
21 know we haven't been going for that much longer, but I
22 think this might actually be a good point for a break
23 if we're wanting a lunch break.

24 (Off the record 1:25 p.m. to 2:02 p.m.)

25

1 BY MS. SALVADOR:

2 Q. So, Dr. Wheeler, I believe we were talking
3 about aspiration.

4 So you've testified that you've used
5 aspiration in the context of D&C and D&E procedures; is
6 that right?

7 A. That's correct.

8 Q. Have you ever used aspiration without
9 additional instrumentation to empty a uterus?

10 MR. BOYLE: Object to form.

11 THE WITNESS: I don't recall the specifics.

12 BY MS. SALVADOR:

13 Q. Okay. So you -- you testified that you've
14 used an -- an electrical aspiration device; is that
15 right?

16 A. That's correct.

17 Q. Okay. And you don't recall whether you've
18 used an electrical aspiration device to empty a uterus
19 without any other instrumentation?

20 A. I don't recall if I ever did.

21 Q. And you've stated that you have experience
22 performing D&Cs; is that right?

23 A. Yes, I have.

24 Q. And that stands for dilation and curettage;
25 is that right?

1 A. That's correct.

2 Q. And you've said that you've performed only
3 one D&C for abort -- for abortion purposes; is that
4 correct?

5 A. For an elective induced abortion, that's
6 correct.

7 Q. Were the others all for miscarriage
8 management?

9 A. My recollection is that the others were for
10 miscarriage.

11 Q. So we've been using both the terms
12 "miscarriage" and "intrauterine fetal demise," and I
13 just want to be sure that we're using those terms
14 clearly.

15 So would you say that those two terms are
16 interchangeable?

17 A. The official definition of intrauterine fetal
18 demise would be the death of an embryo typically after
19 20 weeks, because the definition for a miscarriage is
20 typically the death or nonviability of the fetus or
21 embryo prior to 20 weeks.

22 However, you know, the term with the patient
23 is "your baby passed away," would still be the
24 appropriate term of fetal demise. When you're dealing
25 with patients, essentially the baby is nonviable even

1 if it's before 20 weeks.

2 Q. So when we were discussing your D&E practice,
3 we sometimes used the term "intrauterine fetal demise,"
4 but can I just clarify.

5 When we were using that term, did you mean --
6 were you using the term more broadly when we were
7 talking about your D&E practice before?

8 A. I'll explain. What I was discussing was that
9 the baby had died. So the baby at that gestational age
10 had died in utero. Officially, it would be called a
11 late miscarriage.

12 Q. Got it. So going back to D&Cs, can you
13 describe for me the process of performing a D&C.

14 A. A D&C would be performed by -- in the
15 situation I would, depending on what the cervix looked
16 like, assess for whether I needed to put laminaria in
17 in advance.

18 So during the consultation with the patient,
19 I generally would have them come in the day before
20 their procedure, their surgery, and do an informed
21 consent, evaluation of the patient, completely review
22 the procedure, and then I would assess her cervix, see
23 whether I felt like we needed to use laminaria.

24 In my later practice when misoprostol was
25 more -- or Cytotec was more commonly used, there were

1 times when I may have instead offered her misoprostol
2 or Cytotec instead of laminaria in the first trimester.

3 I'm sorry. Repeat the question.

4 Q. I was just asking you to walk me through the
5 process of performing a D&C.

6 A. All right. So then in the operating room,
7 again, she would either be sedated or under general
8 depending on discussion with patient, myself, and
9 anesthesia.

10 And at that point -- sometimes if she wants
11 sedation, I'd do a paracervical block. She'd be -- of
12 course, by then she'd be in stirrups with whatever
13 anesthetic she decided to have. And there would be an
14 evaluation of her cervix under anesthesia, and the
15 nurses or I would do the prep.

16 I would be prepped in. I would be surgically
17 scrubbed and dressed. I would then place usually a
18 weighted speculum and grasp the cervix either with a
19 tenaculum or an Allis.

20 And I would then evaluate for dilation. If I
21 didn't need to dilate any more, I wouldn't. I would
22 assess the uterine size so they knew what size of
23 curette I would need for the procedure.

24 I would typically for the majority of
25 procedures at that point place the curette and ask for

1 the suction to be turned on, perform the suction
2 portion of the procedure.

3 I would commonly at that point, once I felt
4 like I probably removed everything, then I would use
5 the sharp curette and gently palpate throughout the
6 endometrial cavity to make sure everything was out.

7 Sometimes I had an ultrasound there. For a
8 miscarriage I didn't always, but a lot of times I would
9 have the ultrasound there also to guide my instruments
10 and be sure I've removed everything within the
11 endometrial stripe. Remove the instruments, and that
12 would complete the procedure.

13 Q. Thanks. That was very helpful. I have some
14 follow-up questions to specific things you said.

15 So you referenced using laminaria. Was it
16 your typical practice the use laminaria before
17 performing a D&C?

18 A. I would assess the patient individually. As
19 I previously described with -- did you say D&C or D&E?

20 Q. D&C.

21 A. D&C. As I described with D&E, sometimes with
22 miscarriage the cervix is already dilated. So a lot of
23 women -- and sometimes women wanted to be observed.
24 Not everybody would choose the D&C, but if they did and
25 their cervix was already adequately dilated and very

1 soft, I didn't always use the laminaria.

2 So it depends. Sometimes -- it just depended
3 on the individual patient that I was caring for.

4 Q. So you just mentioned that sometimes the
5 cervix would be partly dilated in the miscarriage
6 scenario. Is the cervix always already partly dilated
7 in the miscarriage scenario?

8 A. No.

9 Q. Okay. So sometimes you would have to dilate
10 the cervix in the miscarriage scenario?

11 A. Sometimes. You tended to need preoperative
12 dilation less once the baby had passed away.

13 As I previously explained, a lot of times
14 there's just -- as in before or simultaneously at the
15 end of pregnancy there's often a lot of changes in the
16 cervix already that's happened and you may not need it.

17 Q. Got it.

18 And when you were assessing whether to --
19 whether you needed to use laminaria for a D&C, was the
20 patient's gestational age a relevant factor in that
21 assessment?

22 I'm sorry. Was the fetus's gestational age a
23 relevant factor in that assessment?

24 MR. BOYLE: Object to form.

25 THE WITNESS: Okay. I'm sorry. Please say

1 it again.

2 BY MS. SALVADOR:

3 Q. Sure.

4 So you said that depending on the patient's
5 needs, you would sometimes use laminaria to dilate the
6 cervix in preparation for a D&C; is that right?

7 A. That's correct.

8 Q. When you were determining whether laminaria
9 were needed, was the fetus's gestational age one of the
10 factors in that determination?

11 A. It was really very individual to the patient.
12 It came down to do I need to in this specific scenario
13 predilate, prepare the cervix. So it really depended
14 on the individual situation.

15 Q. In your experience, was the patient more
16 likely to need laminaria if they were further along in
17 gestation?

18 A. Again, it depends entirely on the situation.
19 I don't -- I did not make that correlation for my
20 clinical practice.

21 Q. Okay. Got it.

22 You also -- you also mentioned performing
23 D&Cs in the OR; is that correct?

24 A. Yes.

25 Q. Did you perform all of the D&Cs that you did

1 in an OR?

2 A. Can you please describe what you mean by
3 "OR."

4 Q. Were all the D -- you referred to an
5 operating room. So were you always in an operating
6 room when you were providing a D&C?

7 A. As I explained earlier, I had one partner who
8 sometimes did aspiration and D&Cs for miscarriage. He
9 had his own equipment in the office. So if he asked me
10 to step in with him, especially as a male, he might
11 have wanted a female in there.

12 I don't recall if I ever did one with him
13 specifically. I don't recall actually ever doing that.
14 So I don't recall ever personally being outside of an
15 operating room segment -- operating room with myself
16 performing D&C.

17 Q. Understood.

18 Was your partner who you referenced safely
19 able to provide D&Cs in an office setting?

20 MR. BOYLE: Objection.

21 THE WITNESS: I don't know about the safely.
22 I know that he performed them. I don't know his
23 outcomes.

24 BY MS. SALVADOR:

25 Q. But you were comfortable partnering

1 professionally with a physician who performed D&Cs in
2 the office setting; is that correct?

3 MR. BOYLE: Objection.

4 THE WITNESS: I'm not aware that that's
5 something that I was aware of until he was actually
6 doing some.

7 So that was not part of -- he was already in
8 the practice when I joined, so I didn't have a
9 specific -- when I became part of that practice, I was
10 not aware of him doing those.

11 BY MS. SALVADOR:

12 Q. Did you terminate that professional
13 association after you learned that your partner was
14 performing D&Cs in an office setting?

15 MR. BOYLE: Objection.

16 THE WITNESS: After that he actually -- that
17 practice separated, so I didn't terminate my
18 relationship with him.

19 BY MS. SALVADOR:

20 Q. So you testified that as far as you can
21 recall, you performed all of the D&Cs that you did in
22 an operating room; is that correct?

23 A. Correct.

24 Q. Were all of your -- I want to be clear. When
25 you refer to "operating room," are you referring

1 specifically to a hospital operating room?

2 A. That's why I asked. I just wasn't sure what
3 you were referring to. I -- to me, an operating room
4 could be in an ambulatory surgical center or what I
5 call the main OR, hospital OR.

6 Q. Did you ever perform D&Cs in an ambulatory
7 surgical center OR?

8 A. Yes, I did.

9 Q. You also referred to anesthesia. What did
10 you mean when you were referring to anesthesia for your
11 D&C patients?

12 A. Essentially pain management, whether they
13 wanted sedation. An anesthesiologist was always
14 involved in our -- in both the ambulatory care
15 setting -- surgical center and in the main operating
16 room.

17 So anesthesia was always involved in one way
18 or another. It was the level of sedation or general
19 that she would want was discussed, patient, myself, and
20 anesthesia together.

21 Q. So did you consult an anesthesiologist for
22 every D&C you performed?

23 A. Explain what you mean by "consult."

24 Q. I believe you just said that there was always
25 an anesthesiologist involved when you performed D&Cs;

1 is that right?

2 A. That's right.

3 Q. So what do you mean by "involved"?

4 A. "Involved" meaning that I would meet with the
5 patient preoperatively. If I had concerns in advance
6 about the patient's potential anesthetic management, I
7 would contact anesthesia in advance sometimes.

8 If there wasn't a specific concern, the day
9 of surgery I would meet with the patient. They would
10 have reviewed my H & P. They would meet with the
11 patient. If there was questions about what the patient
12 wanted as far as general versus sedation and local,
13 those would be discussed essentially between the three
14 of us.

15 If the anesthesiologist didn't need my input
16 and I agreed with their approach, then they would just
17 proceed.

18 Q. So it's fair to say -- or is it fair to say
19 that every D&C patient you had spoke with an
20 anesthesiologist at some point, whether it was in
21 advance of their procedure or the day of their
22 procedure?

23 MR. BOYLE: Object to form.

24 THE WITNESS: Every procedure. So I'm
25 recollecting in residency -- as I recall, in residency

1 there was a suction machine in the emergency
2 department. And I recall that because I actually had
3 in my -- when I had my miscarriages, that's how that
4 happened.

5 So there was a possibility in residency that
6 we may have done suction D&Cs in the emergency
7 department as residents, and if that would -- yeah, in
8 that situation, we would not have anesthesia involved.

9 BY MS. SALVADOR:

10 Q. And I think you used the phrase "H & P." I
11 think you said that you would review an H & P with a
12 patient. Did I hear that correctly?

13 A. I would review my H & P -- I would have
14 submitted that prior to taking the patient to the
15 operating room.

16 The anesthesia would have my H & P, history
17 and physical, to be able to get the patient's history.

18 Q. Okay. So "H & P" stands for history and
19 physical?

20 A. Correct.

21 Q. Got it. Thank you.

22 So when you and the anesthesiologist would
23 discuss pain management options with patients, what
24 were the options on the table for those D&C patients?

25 A. So I wasn't always there with anesthesia when

1 they had the discussion. If there was a specific way I
2 wanted anesthesia to go, I would discuss that with
3 anesthesia in advance.

4 Otherwise, I would meet with the patient, and
5 then usually -- seems like most of the time the
6 anesthesiologist would come in after. Actually,
7 sometimes they would have been there before me.

8 And they would present this is how I usually
9 do this procedure. Whether -- they often had assessed
10 the patient. If I had to do an airway, if I had to
11 intubate, what would that look like. Am I going to
12 have access? Do I need to control her airway for other
13 factors?

14 They would have that discussion, and if I had
15 a specific way I felt it needed to go, then I would
16 talk to anesthesia personally.

17 Q. So could you describe the pain management
18 options that were available for your D&C patients.

19 A. I don't know that I'm going to include all of
20 them.

21 Typically they would have the option of
22 having sedation, IV sedation, and in that situation, I
23 generally would use a paracervical block, which is a
24 local anesthetic to the lower cervix and -- to the
25 cervix and lower uterus, or general anesthesia would be

1 the typical.

2 Q. And would you personally administer the
3 paracervical block?

4 A. Yes.

5 Q. Was it unusual to -- for you to perform a D&C
6 with a patient under general anesthesia?

7 A. Can you explain what you mean by "unusual"?

8 Q. Sure.

9 So you described a couple of different
10 options. One option was IV sedation with a
11 paracervical block, and one option was general
12 anesthesia. Did I say that correctly?

13 A. Yes.

14 Q. In your practice, do you remember one of
15 those methods being used more frequently than the
16 other?

17 A. I don't recall one more frequent than the
18 other for D&Cs. I just don't have specific memories to
19 which one of those would be most common.

20 Q. Okay. But you do remember that both of them
21 were used; right?

22 A. I don't have specific memories of that.

23 Q. Okay. Then -- so you told me that for your
24 D&C patients, they would have the option of -- or the
25 two options for them were IV sedation and paracervical

1 block or general anesthesia; is that correct?

2 A. Yes, that's correct.

3 Q. But you don't remember either of those
4 actually being used?

5 A. I can't tell you which one of those
6 specifically were used in the different situations.

7 Q. I'm just referring to your practice
8 generally. Do you remember that both of those methods
9 were used in your D&C practice generally?

10 A. It depended on the anesthesiologist, the
11 patient. And so whichever was most appropriate for the
12 patient and her choice, we used.

13 Q. Do you remember any other pain management
14 methods being used for your patients?

15 A. In the operating room, I don't.

16 Q. So do you remember that at least some of your
17 patients went with the general anesthesia option?

18 A. Again, I don't remember the specific
19 patients, so I can't tell you that.

20 Q. Do you remember that any of your patients
21 ever had a D&C under general anesthesia?

22 A. A D&C? Yeah, and I can't tell you -- I mean,
23 I would like to be very clear, but I can't specifically
24 say any of my patients chose one or the other. They
25 were both offered. Anesthesia did what was best for

1 the patient.

2 Q. So do you remember ever performing a D&C
3 while a patient was intubated?

4 A. I can't tell you specifically as to that.

5 Q. Okay. So you're testifying that your
6 patients had the option of IV sedation with a
7 paracervical block or --

8 A. Yes.

9 Q. -- or a general anesthesia?

10 A. Yes.

11 Q. But you can't recall in concrete terms either
12 of those methods actually being used; is that -- is
13 that correct?

14 A. Well, I specifically remember the sedation
15 and paracervical block. Again, as a resident, we did
16 that. So -- yeah, in the emergency department. So I
17 have very specific memories of that.

18 And of patients in my own personal experience
19 in the operating room, again, it would be I would give
20 input. Primarily it was between the patient and the
21 anesthesiologist. They were very brief procedures. I
22 was comfortable with either one.

23 Q. When you say "very brief," about how long
24 would a D&C take?

25 A. The actual procedure part was typically a few

1 minutes. Typically three to five minutes would be
2 pretty typical.

3 Q. But you have no specific memory of performing
4 a D&C while one of your patients was under general
5 anesthesia; is that right?

6 A. I don't have a specific memory of a patient
7 being intubated. I don't. I just don't recall.

8 Q. Is that because you stopped providing D&Cs a
9 while ago?

10 A. Yes. That's correct.

11 Q. And when did you stop performing D&Cs?

12 A. I cannot tell you about the last D&C that I
13 did. I don't recall. I can tell you when I finished
14 my practice. I don't know when within that was my last
15 D&C.

16 Q. Do you think it would have been while you
17 were at Millcreek?

18 A. I performed D&Cs at Millcreek, so that would
19 be reasonable.

20 Q. Do you recall performing any D&Cs while you
21 were at the University of Utah between 2008 and 2012?

22 A. I don't specifically remember doing any D&Cs
23 during that time. That doesn't mean I didn't. I just
24 don't have specific memories of doing any during that
25 time.

1 Q. But is it fair to say that you would not have
2 performed any D&Cs after 2012?

3 A. I practiced until 2015, so I know that
4 somewhere in my HCA St. Mark's time between 2012 and
5 2015, I would have performed D&Cs.

6 Q. Just to go back, I believe you had said that
7 when you were at St. Mark's/HCA MountainStar, your work
8 was primarily gynecology; is that right?

9 A. That's correct.

10 Q. And I had thought you said that your contract
11 said that you were not to do any obstetric work; is
12 that right?

13 A. I'm not talking about obstetrical D&Cs. I'm
14 talking about evaluation of endometrial cavities for
15 other reasons.

16 Q. Got it. So would you have performed D&Cs for
17 miscarriage management at any point after 2012?

18 A. I don't have any specific memories. It may
19 have been within my contract depending on how I
20 determined first-trimester pregnancy loss.

21 I don't have any specific memories of whether
22 that occurred. My liability carrier, as I recall,
23 would not have considered a fetal demise in the first
24 trimester as obstetrics. They would have considered
25 that gynecology, but it was debatable.

1 So I don't have any recollection of
2 specifically doing any for pregnancy loss.

3 Q. Got it. So you've testified that your
4 miscarriage management practice also involved
5 performing D&Es; right?

6 A. Correct.

7 Q. And you've testified that you've performed
8 more than one D&E in your career; is that correct?

9 A. Correct.

10 Q. But you can't recall the number of D&Es that
11 you've performed; is that right?

12 A. That's correct.

13 Q. Can you recall whether you did more than one
14 D&E for induced abortion per year while you were at
15 Millcreek?

16 A. I don't recollect. It depended on if a
17 patient wanted me to do that, and only for my patients,
18 so it did not come up often.

19 Q. Can you recall whether you did more than one
20 D&E for miscarriage management per year while you were
21 employed at Millcreek?

22 A. I don't recollect how many I did. That was
23 part of the things that happened within my practice,
24 but I don't remember how often.

25 Q. And you said that you don't recall whether

1 the D&Es that you performed took place in the hospital
2 as opposed to the St. Mark's ASC; is that correct?

3 A. At St. Mark's? Again, I don't have specific
4 memories of that.

5 I have specific memory of one in the main
6 operating room. My normal practice would be to be in
7 an operating room.

8 Again, I don't want to misstate anything. So
9 I can't say did I ever do one in the surgery center
10 attached to the hospital. I don't recall doing one
11 there. I only have specific memory of myself in the
12 room for one case.

13 Q. So the difference between that St. Mark's ASC
14 and the main hospital OR in that D&E context wasn't
15 memorable to you; is that right?

16 A. It's not that it's not memorable. I just
17 want to make sure I'm being accurate in what I say.

18 Q. Okay. But you can't recall whether any of
19 the D&Es that you performed were in the St. Mark's ASC;
20 is that right?

21 A. D&E? Is that the question?

22 Q. Yes. I'm sorry. You can't -- you cannot
23 recall whether any of the D&Es that you performed were
24 in the ambulatory surgical center; is that right?

25 A. I don't recall ever doing one in the

1 ambulatory surgical center.

2 Q. Clinically speaking, is a D&E performed any
3 differently when the patient is a victim of rape?

4 A. It depends on the clinical situation of what
5 you're going to do. So clinically is it different?
6 You've got a very traumatized patient. It depends on
7 the indication. It really depends on a lot of factors,
8 so it's very individual.

9 Q. Physically, referring to the mechanics of the
10 procedure, would you perform a D&E differently if the
11 patient was a victim of rape?

12 A. A D&E is performed in the clinical situation
13 excluding how she got in that situation, the
14 circumstance of her situation. It has to do with
15 clinical diagnosis. So I would have to know what her
16 clinical diagnosis is, so I can't presume in a
17 hypothetical situation.

18 Q. Sure.

19 So if you had to -- let's say you had -- if
20 you had two patients with exactly the same clinical
21 indications --

22 A. Yes.

23 Q. -- and one was a victim of rape and one was
24 not, are there any differences in the clinical steps
25 that you would use to perform a D&E?

1 A. So we're dealing with very different
2 situations as the patient's experience. So if I have
3 the exact same clinical situation, then you're going to
4 deal with the clinical situation.

5 But in addition, you have a patient who's
6 been severely traumatized, which may change our
7 approach based on what she's most -- how can I help her
8 the best. So it depends on the situation. I can't --

9 Q. I understand. I'm not referring to the
10 patient's mental state or how you might talk to them
11 differently.

12 I'm just referring to the clinical steps that
13 you, the provider, would perform. So would those
14 clinical steps be any different?

15 A. In the exact same situation -- you're asking
16 me a hypothetical, and it makes it really difficult.

17 But if there's nothing different about her,
18 she's the exact same person except she was raped, or
19 she wasn't raped and the exact same person, I would
20 deal with the clinical situation in a way that helped
21 her, because part of her is emotional state and her
22 psychological state. So I have to factor that into how
23 I manage her.

24 Q. Of course.

25 How would a patient's psychological state

1 affect the clinical steps of performing a D&E?

2 A. The difference in her can be -- again, there
3 may be some situations I'm not going to be her
4 physician for, so it depends on what situation you're
5 speaking about.

6 But just say I'm just taking her to the
7 operating room for something as a gynecologist and
8 she's been raped. I'm going to talk to her a lot about
9 what's that experience going to be like for you. Are
10 you better off being anesthetized? Are you better off
11 not being aware?

12 You know, will that help you to be calm in
13 the situation? Are you going to be -- is it going to
14 be so traumatic that you're going to be moving in the
15 middle of the procedure and all of a sudden we've got a
16 higher complication rate because this is intolerable to
17 you because you're so traumatized?

18 There are so many different factors in this
19 that I read the situation and, again, be very
20 individual based on the patient. Gynecology is very
21 specific in that horrible things sometimes happen.

22 Q. So when you're treating patients who are the
23 victims of rape, would you say it's important to
24 consider their psychological state going into the
25 procedure?

1 A. Oh, absolutely. Absolutely.

2 Q. And would you say -- in considering that
3 psychological state, how would that -- how would the
4 patient's psychological state impact your actions
5 performing a D&E after the patient was already sedated?

6 A. So now we're dealing with just the clinical
7 situation?

8 Q. That's right.

9 A. It depends on which kind of sedation she
10 offered -- she decided upon and anesthesia decided
11 upon.

12 What happens with a lot of people who have
13 been abused or raped is if they're not completely
14 sedated, they're often triggered in the middle of a
15 gynecological -- so from that point on, it depends on
16 how -- what form of anesthesia or pain management she's
17 decided on and whether she's being alert enough to be
18 triggered. And if she's triggered, it -- it can change
19 the procedures.

20 Q. So if a patient of yours who was a victim of
21 rape were undergoing a D&E under general anesthesia,
22 how would the fact of that patient being a rape victim
23 impact how you performed the D&E after the patient was
24 already under?

25 A. So in that situation, as long as we're not

1 dealing with the rape and the chain of command and
2 evidence and things like that, we're only dealing with
3 our clinical situation, once she's asleep, other than
4 being especially careful to not traumatize her tissues,
5 which could trigger her afterwards, it would be very
6 similar at that point.

7 Q. What if a patient was the victim of incest?
8 How would the patient being a victim of incest impact
9 how you perform the D&E?

10 A. So it would depend a lot on the specific
11 situation, her age, because a lot of that changes
12 anatomy.

13 Q. So if one of your patients were the victim of
14 incest and they were under a general anesthesia and you
15 were performing a D&E, how would the fact that they
16 were the victim of incest impact your performance of
17 that D&E?

18 A. So there are a lot of different scenarios
19 that could happen at that point, which it would be hard
20 to say how exactly it would change that.

21 Q. What types of scenarios do you mean?

22 A. For example, I've seen somebody who was
23 pregnant at term who had an opening in her vaginal
24 introitus well under a centimeter. There was never
25 penetration. It changed what we had to do for her to

1 be able to deliver.

2 So there's -- you know, with incest,
3 sometimes there's penetration and sometimes there
4 isn't. Sometimes they're prepubertal. Sometimes
5 they're postpubertal. So it's very individual.

6 Q. Sure. So I'm just referring to a D&E
7 context, so I'm not referring to what you just
8 mentioned where a patient was at term.

9 So if you were performing a D&E on a patient
10 who was the victim of incest, at the point in the
11 process where that patient was already under general
12 anesthesia --

13 A. Correct.

14 Q. -- how would the incest impact your next
15 steps in performing that D&E?

16 A. Again, it's going to depend on her anatomy,
17 her age, whether or not -- again, penetration doesn't
18 always happen with pregnancy. So there are a lot of
19 factors individual to that patient that could change
20 how I would have to proceed to D&E.

21 Q. Age affects how you would perform a D&E
22 regardless of whether the patient is a victim of
23 incest; is that right?

24 A. Again, it depends on her anatomy, whether
25 penetration had occurred, whether I have to do things

1 to access her vagina in order to do the D&E.

2 Q. But that wasn't -- that wasn't my question.

3 For all of your D&E patients, you have to
4 consider their age; is that right?

5 A. For the procedure itself?

6 MR. BOYLE: Object to form. Go ahead.

7 BY MS. SALVADOR:

8 Q. Yes.

9 A. For the procedure itself, if she's pre- -- if
10 we're doing a D&E, then she would be postpubertal, but
11 she may not have had penetration, so I'm going to have
12 to assess her introitus.

13 If she's been a victim, she often won't --
14 can't tolerate that in the office. So sometimes I do
15 my initial evaluation -- if I were to see a patient in
16 that circumstance, I may do that -- actually my first
17 exam may be in the operating room other than the
18 ultrasound.

19 Q. So if a patient were the victim of incest,
20 that might affect where you did the initial exam; is
21 that correct?

22 A. It may. It's a potential. That's
23 hypothetical, but yes.

24 Q. Got it. And for all of your D&E patients,
25 you would have to consider their particular anatomy

1 before you were to perform a D&E; is that right?

2 A. You would do an exam. You'd want to have --
3 if it's at all possible, you'd do the exam.

4 Q. And you would want to do that exam regardless
5 of whether or not that patient was a victim of incest;
6 is that right?

7 A. Yes. You always want to do an exam before a
8 surgery.

9 Q. So you've testified that you've performed
10 D&Es in the circumstance where a fetus has a lethal
11 fetal anomaly; is that right?

12 A. That's correct.

13 Q. What sorts of lethal fetal anomalies were at
14 issue when you performed those D&Es?

15 A. I don't specifically recall which ones we did
16 D&Es for.

17 Q. Could you describe the procedure of
18 performing a D&E when the fetus has a lethal fetal
19 anomaly.

20 A. They would be similar to what I've already
21 described.

22 If you're doing a D&E, the patient has an
23 option of doing induction delivery or induction
24 abortion. I don't recall doing that, but that is an
25 option the patient has so that you can get a better

1 evaluation by pathology of the fetus.

2 The other alternative is a D&E, but you don't
3 always get -- you often can't get a good pathology
4 report.

5 Q. So do you recall whether you've ever
6 performed a previability induction on a pregnant
7 patient?

8 A. Previability induction. I cannot accurately
9 tell you whether or not I have. I've had patients with
10 previable preterm ruptured membranes. I don't -- these
11 were in residency. After residency, I would have sent
12 those babies to the university.

13 So I don't have specific recollections of
14 whether we did D&Es, inductions. I do remember them
15 delivering spontaneously.

16 Q. So would it be fair to say that if you
17 performed an induction, it would have been while you
18 were -- I'm sorry.

19 Would it be fair to say that if you've
20 performed an induction previability, it would have been
21 while you were in residency?

22 A. I only recall that during residency. Do I
23 recall that during residency? Again, I remember having
24 patients with premature -- previable premature ruptured
25 membranes. I remember monitoring them all the time.

1 I don't -- and I remember some of them
2 delivering spontaneously. I don't have specific
3 recollections of induction abortions or of D&Es on
4 those patients, and that would have been the patients
5 that I wouldn't have remembered them. So --

6 Q. And could I use the term "PPROM" when we're
7 talking about preterm premature ruptured membranes?

8 A. Sure.

9 Q. So did you ever treat patients with PPROM
10 after your residency?

11 A. PPROM being specifically post-viability, yes.

12 Q. When was that?

13 A. When was what?

14 Q. When do you recall treating patients with
15 post-viability PPROM?

16 A. Well, I don't have specific years, but I know
17 that that occurred during my practice with patients.

18 Q. Did you ever treat patients with previability
19 PPROM?

20 A. I did during my residency. I personally had
21 previable PPROM. I didn't treat myself, but after --
22 after I was in private practice, those patients I would
23 have sent to the university.

24 Q. I'm sorry. I couldn't hear the end. You
25 would have sent them where?

1 A. Yes. To the University of Utah.

2 Q. Okay. So after your residency, you did not
3 personally treat patients with previability PPRM; is
4 that right?

5 A. Except for my personal experience, no.

6 Q. When you would send a patient with
7 previability PPRM to the University of Utah, how would
8 they be treated there?

9 A. Well, I don't have specific recollections of
10 that. I can tell you what happened during my
11 residency. I am not aware of their practice changing,
12 but they would have to tell you that. But the patients
13 that I had appeared to have the same trait -- the same
14 that I was trained to do.

15 Q. And what were you trained to do when treating
16 a patient with previability PPRM?

17 A. If they were infected at the time, which I
18 don't recall any of them being infected at the time,
19 that they needed to be delivered. And the training is
20 the appropriate management at that time is to offer D&E
21 and/or induction delivery.

22 Q. So how sick would that patient have to be
23 before you recommended a D&E or an induction?

24 A. Well, the discussion with the patient would
25 be depending on how remote she was from viability. The

1 current literature on the possibility of her infection,
2 her risk for infection, and the literature at that time
3 for the likelihood of her child to survive to the age
4 of viability as well as potential outcomes, and then
5 helping that patient to make that decision.

6 My recollection of that time is we did not
7 have patients desiring delivery at that point, although
8 some did proceed to delivery, and some continued to
9 pregnancies for very long periods of time, so we
10 monitored.

11 Distinct recollections of visiting those
12 patients and re-evaluating at periods throughout the
13 day, reviewing their labs, assessing them for
14 infection, and, again, some of them went very long
15 periods of time, including myself.

16 Q. When you were in residency and treating these
17 patients, would you recommend that the patient wait for
18 sepsis to develop before having a D&E or an induction?

19 A. Absolutely not.

20 Q. If you were treating a pregnant patient
21 previability, and due to the pregnancy they had
22 gestational diabetes and were at risk of going blind,
23 would you recommend a D&E or induction in that
24 scenario?

25 A. You're asking hypothetically? I don't do

1 obstetrics.

2 Q. Sure. I'm referring to when you did
3 obstetrics, what would your recommendation be for that
4 patient?

5 A. And I don't have a clear recommendation for
6 that patient. I don't remember facing that with a
7 patient.

8 Q. In your medical practice, did you ever
9 prescribe medication off label?

10 A. Yes.

11 Q. And under what circumstances would you
12 prescribe medication off label?

13 A. That's -- again, that's hard to -- I mean,
14 there are so many of the drugs that we use off label,
15 it's almost part of an everyday practice. So I'd have
16 to go back and look, but there's drugs that we use
17 almost every day off label.

18 Q. So we've discussed your time at Millcreek
19 Women's Center, the University of Utah, and St. Mark's
20 Gynecology.

21 Did you -- were you employed -- have you been
22 employed as a physician anywhere else in your career?

23 I'm sorry. I can't hear you.

24 A. No, I'm thinking through my answer. I'm
25 trying to remember if I've been employed anywhere else.

1 I've been employed as a resident. I've been
2 employed at St. Mark's. Well, I was employed at the
3 Millcreek Women's Center, back at the university, then
4 I was in an employee position.

5 I have been -- I was probably compensated --
6 well, I was compensated a small amount of money when I
7 was Utah Medical Association president. I was probably
8 compensated a small amount when I was at
9 UnitedHealthcare for a brief period of time as a
10 medical director. That was a part-time position. I
11 probably received compensation.

12 I don't recall any other time being
13 compensated as a physician for services.

14 Q. Got it.

15 Why did you leave St. Mark's in 2015?

16 A. They had trouble recruiting another
17 physician. I joined to start the practice. I very
18 quickly left the practice. They had trouble recruiting
19 a second gynecologist into Utah and decided to close
20 the practice.

21 Q. So before we get to your current work, I want
22 to talk a little bit about your professional
23 associations.

24 So are you currently a member of the American
25 College of Obstetricians and Gynecologists?

1 A. Yes, a lifetime fellow.

2 Q. And I'm going to use the term "ACOG" to refer
3 to them. Is that okay?

4 A. Yes.

5 Q. How long have you been a member of ACOG?

6 A. Well, from early practice, I was a junior
7 fellow. I don't recall if I was a member the first
8 year. I believe I was. I'd have to look back at my
9 records, but it's been continuous since then.

10 Q. Are ACOG members required to hold any
11 particular view of abortion as a precondition of
12 membership?

13 A. No, they're not.

14 Q. Does ACOG's membership include individuals
15 who are opposed to abortion?

16 A. I don't have access to their records, but any
17 physician who is -- has completed a residency, is board
18 certified, my understanding is they can be members.

19 You're not required to be a member, and they
20 don't screen for and, to my knowledge, don't poll us or
21 survey us about our positions on abortion.

22 Q. Are you personally opposed to abortion?

23 A. Am I personally opposed to abortion?

24 I am opposed to the intentional taking of an
25 innocent life. I realize that there are some

1 circumstances where the mother's life or potentially
2 severe organ -- irreparable organ damage may occur that
3 we may have to deliver.

4 Which I would consider delivering is
5 different than an abortion. An abortion is the
6 intention of delivering a baby who is not alive,
7 whereas delivering the person without intentional --
8 directly killing the baby is not, to me, an induced
9 abortion.

10 That is a separation of the mother and the
11 baby, understanding that the baby preivable is probably
12 not going to survive, but I'm not directly taking that
13 child's life.

14 Q. And as we discussed, you are a member of
15 ACOG; right?

16 A. I am a member of ACOG.

17 Q. Do you believe that ACOG is a reliable
18 medical authority?

19 A. In what sense are you asking me? What do you
20 mean by that?

21 Q. Well, you cite ACOG bulletins in your report;
22 right?

23 A. Yes.

24 Q. And you believe that those are reliable
25 sources of information?

1 A. The reports that I -- that I cited?

2 Q. Yes.

3 A. I find that they're not always reliable, that
4 there appear to be some biases. So a lot of the
5 information's correct.

6 I often go myself to the literature to make
7 sure that I agree with -- that it makes sense, that the
8 literature is actually evidence based and supports
9 their position.

10 Q. But at least -- you believe that at least the
11 bulletins that you cite in your report are reliable; is
12 that correct?

13 A. I believe that there are parts of it that are
14 not reliable. So, again, I have to look if I have
15 questions about whether it's truly evidence based and
16 all the literature's been looked at.

17 I look at the year of the reference, and I'll
18 often look to see if there's something new that's come
19 out. I might -- if I'm not sure that that's actually
20 factual or a proper conclusion from the facts, I may
21 look at the article itself.

22 I may see what new has come up, see if
23 there's something more recent, again, to make sure that
24 I'm understanding the evidence appropriately instead of
25 just taking an organization's word for it.

1 Q. Are there particular topics on which you find
2 ACOG to be unreliable?

3 A. Again, it would be -- I'm not going to say a
4 blanket statement of unreliable.

5 I look at it individually. Does this make
6 sense? Does this fit the reality of what I know? Is
7 this accurate? Does it make sense? Does it fit with
8 my clinical experience and my training and what I've
9 read?

10 And if any of those things are off, I'm going
11 to go look for myself. So it could come up with
12 anything. You know, is there something new since this,
13 because some of them are outdated.

14 So, I mean, I've learned to always be
15 critically thinking about it as I look at it. Is this
16 really the most recent evidence based? Is this
17 correct? So it could be on almost anything.

18 Q. And you are also a member of the American
19 Association of Pro-life Obstetricians and Gynecologists;
20 is that right?

21 A. That's correct.

22 Q. And is it okay if I refer to that as
23 "AAPLOG"?

24 A. "AAPLOG," yes.

25 Q. AAPLOG. Sorry about that.

1 How long have you been a member of AAPLOG?

2 A. I don't know the exact year, but I'm going to
3 say somewhere between three and four years is probably
4 correct, somewhere in that range.

5 Q. Was there anything in particular that made
6 you join AAPLOG when you did?

7 A. I had a friend who encouraged me to join.

8 Q. You currently serve on its research
9 committee; is that right?

10 A. I do.

11 Q. What do your -- what are your duties as a
12 member of the research committee?

13 A. Our duties are to either write -- research
14 and write new documents or to review previous
15 documents, or to edit. There's a lot of different
16 roles that we can take.

17 Q. And you said that you're newly on the board
18 of AAPLOG; is that right?

19 A. Yes. Just middle, late somewhere December
20 after I submitted all this is when that happened.

21 Q. And what are your duties as a board member?

22 A. My duties -- again, this is relatively new,
23 so it's not going to be on the top -- I'm not going to
24 have a full recollection yet.

25 But our job is to be aware of and be an

1 advocate of what AAPLOG is doing. We as a board meet
2 with our CEO. We help with strategizing and
3 implementing the goals and strategic plan of AAPLOG.

4 There's different roles that we can play.
5 We're asked to be on at least one of the committees.
6 So I have not yet been in an official capacity at board
7 meetings.

8 Q. What is AAPLOG's position on abortion?

9 A. AAPLOG's position on abortion is that --
10 similar to what I've already told you -- is that it is
11 inappropriate to directly take the life of an innocent
12 human being; that there are rare times when the
13 mother's life or permanent organ damage that is
14 immediate and irremediable may be at risk, and
15 sometimes we have to deliver a baby to save a woman's
16 life or to avoid -- potentially avoid, again,
17 irreparable severe damage to her body organ in that
18 circumstance.

19 If we have to do it, the ethical way to do
20 that is to not directly kill the baby, but to cause a
21 separation which is typically going to be induced
22 labor, which is respectful of the baby, although we
23 understand the baby is probably not going to survive
24 preivable.

25 Postviable, that's easy. We deliver. If

1 those circumstances come up, you attempt to save both
2 of our patients' lives.

3 Q. Have you ever had a malpractice claim filed
4 against you?

5 A. Yes, I have.

6 Q. Could you describe the circumstances of that.

7 A. Okay. So I had one where we had -- I was
8 actually not on call, but my patient needed a cesarean
9 section. So my partner on call asked me to come in and
10 assist with the cesarean section.

11 And at the time of cesarean section, the
12 baby's head was entrapped. And my partner assisted
13 to -- well, attempted to assist by vaginally elevating
14 the baby's head. The baby's head was trapped.

15 I attempted. They prescribed nitroglycerin
16 to relax the woman's uterus. I was able to deliver the
17 baby, but the baby needed resuscitation. It turned out
18 the baby had actually had what appeared to be a stroke,
19 a CVA prior to birth, and therefore had abnormal head
20 positioning, which in the end, the suit -- I went
21 through deposition, and I was dropped at that point.

22 Q. Is that the only malpractice claim you've had
23 filed against you?

24 A. So I've had things be filed. I had -- but
25 they -- I've never had an ongoing lawsuit. They've

1 always done the initial evaluation, and then it's
2 dropped.

3 Q. Could you describe those complaints that were
4 filed.

5 A. Okay. What I recall is one woman called,
6 wanted to be seen urgently for a vaginal infection. I
7 appropriately diagnosed her with bacterial vaginosis.
8 I gave her the first-line treatment.

9 The first-line treatment was ineffective.
10 And so she received the second-line treatment from a
11 different physician which was effective, and so she
12 filed a claim, which she then immediately dropped.

13 Let's see. I had one patient, it was a
14 partner's patient. She was in the operating room.
15 I was in the clinic. The baby had a prolonged
16 bradycardia that never recovered in labor. I ran to
17 the labor and delivery because my partner was
18 unavailable, immediately put on the forceps, delivered
19 the baby.

20 The baby had ptosis, basically an eyelid
21 drop, which it later came out the baby had a syndrome
22 that ptosis was a part of. And when that got
23 introduced that she'd been evaluated by a specialist
24 and it didn't have anything to do with forceps, they
25 dropped that.

1 That's what I recall.

2 Q. Have you ever been disciplined by a licensing
3 board?

4 A. No.

5 Q. Have you ever been subject to disciplinary
6 proceedings by an employer?

7 A. No.

8 Q. So your CV describes that you have
9 volunteered -- that you volunteered as a client
10 advocate at Path of Life from 2017 to 2018; is that
11 correct?

12 A. Let's see. That, I believe, is correct.

13 Q. And could you describe your role at Path of
14 Life.

15 A. So at Path of Life, I was trained to be a
16 patient advocate, and it was actually a relatively new
17 pregnancy resource center and a relationship center
18 where they educated people about healthy relationships.

19 When I was there on my days to volunteer, we
20 interestingly only had one person come in on my very
21 last day there with a pregnancy and wanted counseling.

22 So most of my time there, they were preparing
23 to get an ultrasound. And so most of my time there
24 when I was there as a volunteer, they would have me to
25 help with evaluation of that. I was writing protocols,

1 evaluating protocols, and essentially setting up that
2 part of their offerings.

3 Q. And you're also a volunteer with an
4 organization called Life Decisions; is that correct?

5 A. Yes.

6 Q. What is Life Decisions?

7 A. Life Decisions exists to educate people about
8 abortion. We're an educational organization.

9 Q. What is your role at Life Decisions?

10 A. Primarily as a speaker educator.

11 Q. What types of education do you provide?

12 A. We go to groups that would like to learn
13 about abortion and about prenatal development, and we
14 present evidence-based information about prenatal
15 development, explaining the different stages of
16 development.

17 We explain what actually happens with the
18 different forms of abortion, and we -- also because
19 we're in Colorado primarily, I'm speaking from
20 Colorado, people want to know what our current
21 legislative climate is, what our laws are. So we might
22 explain that and answer questions.

23 That's typically what we do.

24 Q. Is the purpose of the education you provide
25 at Life Decisions to dissuade people from having

1 elective abortions?

2 A. At Life Decisions what we would do is we say
3 the truth about prenatal development and about abortion
4 and answer questions.

5 Q. Is Life Decisions as an organization opposed
6 to abortions?

7 MR. BOYLE: Objection.

8 THE WITNESS: Life Decisions exists to
9 educate people about the truth about abortion.

10 They explain, as somebody who's done
11 abortions, I can -- induced abortions, I can explain
12 what happens, and I can explain with my expertise
13 cranial development and answer questions.

14 So we're really there just to present
15 evidence-based medicine.

16 (Exhibit 2 Marked for Identification.)

17 MS. SALVADOR: I am going to drop into the
18 chat a document. Could you please mark this as
19 exhibit -- I believe we're on Exhibit 2.

20 BY MS. SALVADOR:

21 Q. And, Dr. Wheeler, please let me know when
22 you're able to pull up this document.

23 A. Okay. I have it open.

24 Q. Have you seen this document before?

25 A. I don't recall ever seeing this document.

1 Q. At the top it says "Life Decisions" and a
2 bar -- a menu bar across the top, and then slightly
3 below that, there's a title that says "FAQs."

4 Did I describe that accurately?

5 A. Yes.

6 Q. So this is a PDF of the FAQ page on the Life
7 Decisions website. You said you haven't seen it
8 before; is that correct?

9 MR. BOYLE: Objection.

10 Are you asking her if that's what it is, or
11 are you telling her that's what it is?

12 MS. SALVADOR: I'm describing this document
13 as a PDF of the FAQs decision off the Life Decision's
14 website.

15 BY MS. SALVADOR:

16 Q. The question is you said that you have not
17 seen this before, Dr. Wheeler; is that correct?

18 A. I have not seen this document before.

19 Q. Do you have any reason to believe that this
20 is not the FAQs page of the Life Decisions website?

21 MR. BOYLE: Objection.

22 THE WITNESS: I've never seen it before, so
23 I'd have to look through and see if this is really
24 something that's posted. So I don't have anything to
25 base that on.

1 BY MS. SALVADOR:

2 Q. Are you generally familiar with the positions
3 of Life Decisions, the organization?

4 A. No. I'm asked by the president to speak at
5 events with them because of my expertise. So I --
6 other than being asked to speak, I don't have any other
7 role within the organization.

8 Q. So when you've been asked to speak, what
9 events have you been asked to speak at?

10 A. The ones that I recall, one was at a
11 fundraising event for Proposition 115. As I recall,
12 that was the first time I spoke with that organization.

13 We have spoken at libraries. We have spoken
14 at benefits for pregnancy resource centers. I mean, I
15 have spoken with one of -- let's see. That was not
16 part of Life Decisions. Yeah, libraries, pregnancy
17 resource center, gala events, and spoken with them at
18 one church that had a specific group, a small group
19 that gets involved in the community that wanted to
20 learn about abortion and prenatal development.

21 Q. So is it -- I'm sorry.

22 A. That's okay. Those are the primary places I
23 recall speaking with Life Decisions.

24 Q. So is it fair to say that you've spoken at
25 several events for Life Decisions over the past three

1 years?

2 A. It would be over three years, somewhere
3 around that time, and yes, several events.

4 Q. So let's go to page 7 of this document. The
5 page numbers are at the bottom right of the document.

6 In the right column of page 7 towards the top
7 there's a bullet that says: "Abortion is never
8 medically necessary to protect the mother's life or
9 health."

10 Did I read that correctly?

11 A. You did read that correctly.

12 Q. Do you agree with that statement?

13 A. So you would have to describe "abortion." It
14 comes back to your definition of "abortion."

15 Q. Are there any circumstances where you would
16 say that abortion is medically necessary to protect the
17 mother's life or health?

18 A. Again, this is where the definition changes
19 everything, and it depends on what you're meaning by
20 "abortion" whether I can answer that affirmatively or
21 negatively.

22 Q. How would you have to define "abortion" in
23 order for you to agree with the statement that abortion
24 is medically necessary to protect the mother's life?

25 A. My understanding -- definition of "induced

1 abortion" is the intention of delivering a baby who is
2 not alive.

3 So when a mother has medically indicated to
4 literally save her life due to a significant threat to
5 her life or to significant permanent, immediate
6 irreparable damage to a major body organ system, I
7 would not call that an abortion if you did not directly
8 take the baby's life.

9 That would be a delivery and medically
10 indicated delivery to save her life, and that's not
11 involved in directly having to take the baby's life,
12 although we are aware that the baby remote from
13 viability is not going to survive.

14 But we can be respectful and give dignity to
15 that baby and allow comfort care, but not directly kill
16 the baby with the intention of delivering a baby that's
17 not alive.

18 MR. BOYLE: Can we take a break. It's been,
19 I think, well over an hour.

20 MS. SALVADOR: Yeah, that's fine.

21 (Off the record 3:15 p.m. to 3:25 p.m.)

22 BY MS. SALVADOR:

23 Q. So we were talking about scenarios where a
24 patient's life or health is in danger.

25 Dr. Wheeler, are there any circumstances

1 where a D&E is medically necessary to preserve a
2 patient's life or health?

3 A. A D&E specifically is an unethical procedure
4 for a living baby. So anything that involves a direct
5 feticide would be -- in my estimation and experience
6 having done them would be unethical.

7 Q. Going back to the document, Exhibit 2 that we
8 were just referencing, let's go to page 9.

9 In the right column at the top of the page
10 there's a bullet that reads: "Abortion is not the
11 right option when a child is diagnosed with a serious
12 or a lethal medical condition."

13 Did I read that correctly?

14 A. Yes.

15 Q. Do you agree with that statement?

16 A. Yes, I do.

17 Q. What is "anencephaly"?

18 A. Anencephaly is a condition where the
19 cephalate portion of the mental development is
20 incompletely developed and the cranium is not
21 completely developed.

22 Q. When you say "cranium," do you mean the
23 brain?

24 A. The bony -- the skull.

25 Q. What is the survival rate of an anencephaly?

1 A. I do not recall the number.

2 Q. Do you believe that abortion should be an
3 option if a fetus is diagnosed with anencephaly?

4 A. No, I do not.

5 Q. The same document, if we could go to page 15.

6 In the middle column at the top of the page
7 there's a bullet that says: "Abortion does nothing to
8 give a rape victim the healing she needs and deserves."

9 Did I read that correctly?

10 A. Yes, you did.

11 Q. Do you agree with that statement?

12 A. I do agree with that.

13 Q. And on the same page, the same column, the
14 fourth bullet down, the bullet reads: "The child
15 conceived in rape can be a reminder that women can rise
16 above after trauma, not a reminder of the trauma."

17 Did I read that correctly?

18 A. You read it correctly.

19 Q. And do you agree with that statement?

20 A. The statement says that it "can be," as in it
21 possibly could be, and that is possible. I agree.

22 Q. You're also on the medical advisory board of
23 an organization called Save the Storks; is that
24 correct?

25 A. Yes, I am.

1 Q. What do your duties as a member of the
2 medical advisory board of Save the Storks entail?

3 A. It's a new committee, so I've only recently,
4 sometime, I believe, in the fall is my best
5 recollection, done it. So I can only remember doing
6 two meetings.

7 It's a medical advisory board. So when the
8 medical director wants input into something as a
9 strategy or a new development, then they will ask the
10 medical opinions of the medical board.

11 Q. You mentioned that you were physically
12 located in Washington, D.C., right now; is that right?

13 A. That is correct.

14 Q. Did you attend events related to the March
15 for Life in D.C. this past Friday?

16 A. I did.

17 Q. What events did you attend?

18 A. I attended the march. I attended the rally
19 prior to the march. I did the march. I joined the
20 stage as one of the prolife leaders.

21 I went to the Alliance Defending Freedom
22 reception that afternoon, and I went to the rose gala
23 that evening.

24 Q. Switching gears a little bit, we're going to
25 discuss the safety of abortion.

1 Is it your understanding that carrying a
2 pregnancy to term carries more medical risk than having
3 an abortion?

4 A. Is it my understanding? So it depends on
5 when the abortion occurs, so it depends.

6 This is a hypothetical question, and I don't
7 have the information on the hypothetical that I can
8 answer that enough.

9 Q. Do you accept that abortion is safer than
10 pregnancy and childbirth for most abortion patients?

11 A. And, again, it depends on the gestational age
12 and the circumstance.

13 Q. Under what circumstances would you contend
14 that abortion is riskier than pregnancy and childbirth?

15 A. Well, it depends on whether you're looking at
16 immediate complications or long-term complications.
17 That's --

18 MR. BOYLE: If she could please finish her
19 answer, that would be --

20 BY MS. SALVADOR:

21 Q. Yeah. I'm sorry about that, Dr. Wheeler.

22 It's harder because I can't quite see your
23 face close up.

24 A. Can I do something to make it easier?

25 Q. No. I'll do better at waiting for you to

1 complete your response.

2 So starting with immediate complications,
3 under what circumstances do you say that the immediate
4 complications of abortion are riskier than pregnancy
5 and childbirth?

6 A. In the -- again, this is going to be very
7 specific to the situation.

8 One of the concerns I have with the
9 comparison is that we're talking about with pregnancy,
10 a natural event, a reproductive event, whereas with
11 abortion, anytime you have a complication or death,
12 it's what's called iatrogenic.

13 It's like if I did a hysterectomy and
14 somebody died, if I hadn't have done the hysterectomy,
15 she wouldn't have died.

16 So we're talking about apples and oranges.
17 They're not really comparable.

18 Q. Is it true that some people who obtain
19 abortions would have experienced complications from
20 pregnancy if they had remained pregnant?

21 A. That's a hypothetical that I can't tell
22 what's going to happen in the future to people, so I
23 can't answer that.

24 Q. Is it your claim that nobody who receives an
25 abortion would have experienced a pregnancy

1 complication if they'd remained pregnant?

2 A. Again, it's hypothetical, so I can't tell
3 what's going to happen to an individual.

4 Q. The likelihood of pregnancy-related death is
5 higher for women with certain preexisting conditions,
6 isn't it?

7 A. Likelihood -- I'm repeating the question to
8 myself. The likelihood of maternal death is higher in
9 women who have certain conditions. That's true.

10 Q. What sort -- so -- I'm sorry. Were you
11 finished?

12 A. Yes. I didn't say "yes," so it's true.

13 Q. What sorts of conditions increase the risk of
14 death during pregnancy?

15 A. For example, advanced maternal age. The
16 older -- again, it's not a cut-off point, but the older
17 a woman becomes, that's one of the biggest risk factors
18 is advanced maternal age.

19 Hypertensive conditions, preexisting heart
20 conditions. If she had, say, a renal transplant, those
21 types of conditions may increase her risk.

22 Q. Would it be fair to say that at least some
23 women with those conditions you listed obtain
24 abortions?

25 A. Would it be fair to say some -- yes.

1 Q. If a patient required a D&C, do you think it
2 would be safer for them to receive one from a provider
3 with extensive experience providing D&Cs than from an
4 inexperienced provider?

5 A. That has so many facets of -- that's so
6 hypothetical I can't accurately answer.

7 Q. I want to go to your report in paragraph 18.
8 So this would be Exhibit 1, paragraph 18.

9 So in paragraph 18, you state in your report,
10 quote: "A survey of all U.S. ob-gyn residency
11 directors found that only 22 percent of residency
12 directors reported that their graduation residents were
13 fully competent to perform D&E up to 17 weeks, 6 days'
14 gestation, on average only performing four D&E
15 surgeries."

16 Did I read that correctly?

17 MR. BOYLE: I'm sorry. Did you say this is
18 paragraph 18 of her report?

19 MS. SALVADOR: Yes.

20 MR. BOYLE: Okay. Objection.

21 Oh, I'm sorry. I was starting at the
22 beginning. You were starting at the second sentence.
23 I apologize. I'm not objecting.

24 MS. SALVADOR: Okay.

25 MR. BOYLE: I'm sorry. Pardon my

1 interruption.

2 BY MS. SALVADOR:

3 Q. Dr. Wheeler, in what clinical setting do
4 ob-gyn residents generally practice?

5 A. The residents?

6 Q. Yes.

7 A. So I haven't been to all ob-gyn residencies,
8 so I can tell you my experience at the University of
9 Utah. That's the one that I have experience with.

10 Q. Are you saying that you don't know where
11 ob-gyn residents generally practice?

12 A. Well, they can practice in a variety of
13 settings. So I don't know all of the ob-gyn residency
14 practices. I can tell you what we did at the
15 University of Utah.

16 But the training programs may have them --
17 they're obviously going to spend some of the time at
18 their primary setting, but how many of them go out into
19 the community or that they just do their own clinics,
20 that varies with programs.

21 Q. Is it your understanding that ob-gyn
22 residents generally practice in hospital settings?

23 A. During residence -- or residency, the primary
24 place would be at the primary site of the residency
25 program.

1 Q. Is the primary site of a residency program
2 generally a hospital?

3 A. In my experience, yes. But, again, I don't
4 know all the residency programs to know what they're
5 like.

6 But at the University of Utah, we spent the
7 majority of our time at the University of Utah Hospital
8 and in our clinics, which were also at the site.

9 There was also a second hospital that we went
10 to commonly, so lot of them have satellite sites.

11 Q. Got it. Thank you.

12 I'd like to go now to paragraph 12 of your
13 report. In the middle of paragraph 12, there is a
14 sentence that says: "Rarely a woman will require a
15 uterotomy (incision in the uterus through the abdomen)
16 or a hysterectomy for failed D&E or induction labor or
17 for complications."

18 Did I read that correctly?

19 A. Yes.

20 Q. And you cite ACOG Practice Bulletin 135 for
21 that statement; is that right?

22 A. That's correct.

23 (Exhibit 3 Marked for Identification.)

24 MS. SALVADOR: I'm dropping ACOG Practice
25 Bulletin 135 into the chat. Would you please mark that

1 as Exhibit 3.

2 BY MS. SALVADOR:

3 Q. And, Dr. Wheeler, let me know when you have
4 it open, please.

5 A. It is open.

6 Q. Dr. Wheeler, do you recognize this document?

7 A. Yes, I do.

8 Q. Is it the same ACOG Practice Bulletin 135
9 that you cite in your report?

10 A. I'd like to go back to the year. This is
11 2013, so I want to make sure that it's the same year
12 that I quoted.

13 Will you please remind me which paragraph.

14 Q. Sure. It's paragraph 12.

15 A. Yes, it's the same year.

16 Q. So going back to the practice bulletin, I'd
17 like to direct your attention to page 1396.

18 In the right column, there's a subheading
19 that says -- the subheading is titled "Abdominal
20 Surgery."

21 A. Yes.

22 Q. The quote right below that says: "In rare
23 instances, second-trimester abortion may be performed
24 by hysterectomy or hysterotomy. These procedures are
25 associated with a much higher risk of complication than

1 D&E or medical abortion, and should only be performed
2 when the latter two procedures have failed and are
3 contraindicated."

4 Did I read that correctly?

5 A. Yes, you did.

6 Q. Is this the statement that you were referring
7 to when you cited ACOG Practice Bulletin 135 in
8 paragraph 12 of your report?

9 A. That appears to be what I was referring to.

10 Q. Going back to your report, in paragraph 13
11 you state about in the middle of paragraph 13 that you
12 disagree with Dr. Farris's statement that the suction
13 used for a D&C and D&E is gentle; is that correct?

14 A. I'm trying to get back to the document.

15 And I am now on the document, and you are on
16 which paragraph?

17 Q. Paragraph 13.

18 A. Thirteen. Okay. And which sentence?

19 Q. Sure.

20 In paragraph 13 generally towards the middle,
21 you disagree with Dr. Farris's statement that the
22 suction used for a D&C and D&E is gentle; right?

23 A. Yes.

24 Q. And the typical suction required for D&C and
25 D&E is 400 to 500 millimeters of mercury; is that

1 right?

2 A. Correct.

3 Q. Would you be able to safely apply that amount
4 of suction to your hand?

5 A. We often do to test to make sure that the
6 suction's working appropriately.

7 Q. So you are able to safely test the suction by
8 applying it to your hand; is that right?

9 A. Yes. The hand is different than a uterus.

10 Q. Also in paragraph 13, towards the end of the
11 paragraph, you refer to the possibility of trauma to
12 the endometrial cavity and trauma to the cervix;
13 correct?

14 A. Correct.

15 Q. Could trauma to the endometrial cavity result
16 from a D&C or a D&E performed for miscarriage
17 management?

18 A. Yes. Any instrument in the uterine cavity.

19 Q. Could trauma to the cervix result from a D&C
20 or D&E for the purposes of miscarriage management?

21 A. Yes. Any instrument through the cervix.

22 Q. I'd like to go further down in your report to
23 paragraph 31. Let me know when you get there.

24 A. I am there.

25 Q. So towards the end of the paragraph in the

1 second-to-last sentence you say that "The uterus at
2 this early gestation does not respond as well to
3 oxytocics (to induce uterine contraction) as a term
4 uterus does."

5 Did I read that correctly?

6 A. Yes.

7 Q. What gestational age range are you referring
8 to here when you say "early gestation"?

9 A. Early gestation. So for D&Es, I'm referring
10 to the age ranges of a D&E, which are typically for
11 most providers 13 to 14 weeks up to somewhere between
12 22, some providers up to 24 weeks.

13 Q. Are all uterotonics oxytocics?

14 A. I think we'd have to define what each of
15 those mean.

16 Q. Sure.

17 So what is an oxytocic? And I apologize if
18 I'm pronouncing that incorrectly.

19 A. Yeah. That's okay. So essentially you're
20 talking about things that would make the uterus
21 contract with each of those. Some of them, like
22 Pitocin or oxytocin is what we usually refer to as
23 oxytocic, is -- acts through a receptor which increases
24 throughout the pregnancy.

25 So there are a few receptors at the age

1 that -- at the gestational age where the D&Es are
2 performed. They increase, and so that by term as you
3 prepare for labor, the receptors increase.

4 Q. And what is a uterotonic?

5 A. So uterotonic, the definition that I would
6 typically use is anything else that would get the
7 uterus to contract. For example, Methergine or
8 prostaglandin, but they act differently.

9 Q. So even if -- I'm sorry.

10 So even if the uterus's response to oxytocics
11 varied at different gestational ages, would other
12 uterotonic medications still be effective to induce
13 uterine contractions?

14 A. "Effectiveness," you know, has different
15 relative terms. I think the primary point is that the
16 uterus does not contract as well to stop bleeding in
17 the second trimester as it does at a later pregnancy.

18 Q. Are you aware that prophylactic oxytocin has
19 been shown to decrease blood loss and frequency of
20 hemorrhage when used in second-trimester D&Es?

21 A. I am aware that it is used. I am aware both
22 from personal experience and through the literature
23 that the uterus does not respond as well in the second
24 trimester as at term.

25 So does it respond some? It depends on how

1 much of the receptor is present. So yes, we do use it,
2 but it is not as effective as it is when there's more
3 receptors at the end of pregnancy.

4 Q. And what literature are you referring to that
5 supports that?

6 A. Well, basically my experience, literature
7 that I've reviewed on oxytocics for postpartum
8 hemorrhage and, again, personal experience. All
9 literature on postpartum hemorrhage would include
10 information on oxytocics and uterotonics.

11 Q. Is there any specific piece of literature
12 that you can recall that makes that -- that makes that
13 statement?

14 A. You know, I don't recall on the top of my
15 head because I've read so many, but it's consistent
16 through the literature.

17 Q. Let's go to paragraph -- I'm sorry.

18 Before we do that, when was the last time
19 that you used uterotonics to treat bleeding?

20 MR. BOYLE: Objection.

21 You can answer.

22 THE WITNESS: I don't remember the exact time
23 that would have been. I don't have a distinct
24 recollection of when I last used it.

25

1 BY MS. SALVADOR:

2 Q. Have you ever used uterotonics to treat
3 bleeding?

4 A. Yes, I have.

5 Q. Have you used uterotonics to treat bleeding
6 in -- when performing a D&E?

7 A. Yes, I have.

8 Q. Let's go to paragraph 15 of your report.

9 A. I'm there.

10 Q. The first sentence of paragraph 15 says,
11 quote: "While the technical performance of the
12 procedure of first-trimester D&C or second-trimester
13 D&E may be similar for management of miscarriage
14 (spontaneous abortion) and induced abortion, the
15 reality is that with miscarriage, the developing human
16 embryo or fetus has already died, as opposed to
17 abortion, which has the purpose of causing the demise
18 of a living embryo or fetus."

19 Did I read that correctly?

20 A. Yes, you did.

21 Q. Do you agree with that statement?

22 A. Yes.

23 Q. Do you think that completion of a complex
24 family planning fellowship is necessary in order to
25 safely perform a D&E?

1 A. I would have to take issue with the word
2 "safely," so I -- I can't answer that under oath. I
3 don't know. I don't -- it's conjecture.

4 Q. Do you think that completion of a complex
5 family planning fellowship is necessary in order to
6 perform a D&E without medical complications?

7 A. No.

8 Q. Did you complete a fellowship in complex
9 family planning?

10 A. It was not available during the time, so that
11 wasn't even an option for me.

12 Q. Going to paragraph 30 of your report --
13 please let me know when you're there.

14 A. I'm there.

15 Q. So in paragraph 30 of your report, you list
16 potential complications of D&E. You specifically
17 mention hemorrhage, cervical laceration, retained
18 products of conception, infection, uterine perforation,
19 abnormal placentation, disseminated intravascular
20 coagulopathy, and embolism; is that correct?

21 A. Yes.

22 Q. And for that statement about complications,
23 you cite ACOG Practice Bulletin 135 on second-trimester
24 abortion; is that right?

25 A. That's correct.

1 Q. Is hemorrhage a potential complication of D&E
2 when that D&E is performed for miscarriage management?

3 A. Yes, it is.

4 Q. What amount of blood loss constitutes
5 hemorrhage in the D&E context?

6 A. Typically an estimation because it's not
7 exact, but we do have a suction machine there that is
8 measuring, in addition to fluid, blood, so you can get
9 at least a general idea. Approximately 500 ccs.

10 Q. And is 500 ccs or approximately 500 ccs also
11 the amount of blood loss that would be hemorrhage if
12 the D&E was performed in the abortion context?

13 A. Yes.

14 Q. Is there a risk of hemorrhage associated with
15 childbirth as well?

16 A. Yes.

17 Q. Do you know whether the risk of hemorrhage is
18 greater with carrying a pregnancy to term as opposed to
19 abortion?

20 A. I have not seen a direct comparison between
21 the two, so I don't have the grounds to answer that
22 based on literature from what I recall.

23 Q. Is infection a possible complication of D&E
24 when that D&E is performed for miscarriage management?

25 A. Yes, it is.

1 Q. Is there a risk of infection associated with
2 carrying to term also?

3 A. Yes.

4 Q. Do you know whether the risk of infection is
5 greater with carrying a pregnancy to term versus
6 abortion?

7 A. No. I mean, as part of preparation for this,
8 I did not review maternal complications at term, so I
9 don't have the recollection of the percentage of
10 infection. I don't recall that number as I didn't
11 review it for this deposition.

12 Q. Is cervical laceration a potential
13 complication of D&E when that D&E is performed for
14 miscarriage management?

15 A. Yes.

16 Q. Are retained products of conception a
17 potential complication of D&E when that D&E is
18 performed for miscarriage management?

19 A. Yes.

20 Q. Is uterine perforation a potential
21 complication of D&E when that D&E is performed for
22 miscarriage management?

23 A. Yes.

24 Q. Is abnormal placentation a potential
25 complication of D&E when that D&E is performed for

1 miscarriage management?

2 A. A late complication, not immediate, yes.

3 Q. I'm sorry. Did you say "late complication,
4 not immediate"?

5 A. Right. So abnormal placentation would refer
6 to a subsequent pregnancy, and it's a possibility with
7 any instrumentation in the uterus.

8 Q. Is disseminated intravascular coagulopathy a
9 potential complication of D&E when that D&E is
10 performed for miscarriage management?

11 A. Yes.

12 Q. Is embolism a potential complication of D&E
13 when that D&E is performed for miscarriage management?

14 A. Yes.

15 Q. So going back to your report, paragraph 31,
16 you cite a study by Zane, et al., for the statement
17 that abortion -- I'm sorry -- for the statement that
18 hemorrhage is a primary contributor to abortion
19 mortality; is that right?

20 A. Paragraph 31?

21 Q. Yes.

22 MR. BOYLE: I apologize. Could you ask that
23 question again.

24 MS. SALVADOR: Sure.

25

1 BY MS. SALVADOR:

2 Q. In paragraph 31 of your report -- and I'm
3 referring to the last sentence of paragraph 31, you
4 cite a study by Zane, et al., for your statement that
5 hemorrhage is a primary contributor to abortion
6 mentality -- mortality. I'm sorry. Is that correct?

7 MR. BOYLE: Object to form.

8 THE WITNESS: Yes.

9 BY MS. SALVADOR:

10 Q. Didn't that study conclude that deaths
11 associated with legal induced abortions are rare
12 events?

13 A. I don't recall that statement. I'd be happy
14 if you have the study to throw it up to confirm that
15 that was in there.

16 (Exhibit 4 Marked for Identification.)

17 MS. SALVADOR: Sure. I am putting the study
18 into the chat. Please mark it as an exhibit.

19 BY MS. SALVADOR:

20 Q. And, Dr. Wheeler, please let me know when you
21 have it open.

22 A. I have it open.

23 Q. Are you familiar with this document?

24 A. I am, yes.

25 Q. Is this the same study by Zane, et al., that

1 you cite in paragraph 31 of your report?

2 A. Yes, it is.

3 Q. So I'll direct you to the first page of the
4 study.

5 There's a heading or a subheading that says
6 "Conclusion." The first sentence after that conclusion
7 subheading, quote: "Deaths associated with legal
8 induced abortion continue to be rare events, less than
9 one per 100,000 procedures."

10 Did I read that correctly?

11 A. You read it -- well, let me see.

12 One per 100,000 procedures, yes. Yes.

13 Q. In your report you also state that the risk
14 of death from induced abortion increases as gestation
15 progresses; is that correct?

16 A. After eight weeks' gestation, yes.

17 Q. In paragraph 35 of your report, you cite a
18 study by Bartlett, et al., and you cite it for the
19 proposition -- for the proposition that women whose
20 abortions were performed in the second trimester were
21 significantly more likely to die of abortion-related
22 causes; is that right?

23 A. Yes.

24 Q. Do you recall that the study found that for
25 the time period it was discussing, the overall death

1 rate for women obtaining legally induced abortions was
2 0.7 per 100,000 legal induced abortions?

3 A. I am happy to look at that and confirm it.

4 Q. Sure.

5 (Exhibit 5 Marked for Identification.)

6 MS. SALVADOR: I'm dropping the study into
7 the chat. Please mark it as an exhibit.

8 BY MS. SALVADOR:

9 Q. And then, Dr. Wheeler, please let me know
10 when you have it open.

11 A. Okay. It is open.

12 Q. Dr. Wheeler, are you familiar with this
13 document?

14 A. Yes, I am.

15 Q. Is it the study by Bartlett, et al., that you
16 cite in paragraph 35 of your report?

17 A. Yes, it is.

18 Q. So I will point you to the first page of the
19 study. In the left column, there's a heading that says
20 "Results"?

21 A. Yes.

22 Q. The first sentence after that heading says:
23 "During 1988 to 1997, the overall death rate for women
24 obtaining legally induced abortions was 0.7 per 100,000
25 of legal induced abortions."

1 Did I read that correctly?

2 A. Yes.

3 Q. Do you recall that one of the methods of
4 second-trimester abortion included in this study was
5 intrauterine instillation?

6 A. Yes.

7 Q. What is intrauterine instillation?

8 A. I'd have to tell you by the literature. I've
9 never actually seen it.

10 It's essentially putting some kind of
11 compound as an abortive agent into the fluid
12 surrounding the baby.

13 Q. Is that a commonly used abortion technique
14 today?

15 A. Today, no. There are rare instances in the
16 literature -- well, in reports, but no, it is not.

17 Q. Did the study find that more of the deaths
18 resulting from second-trimester abortions were from
19 abortions performed via intrauterine instillation than
20 from D&E?

21 A. I don't recall that separation, but I'd be
22 happy to look at it.

23 Q. Sure.

24 I will point you to page 734 of the study --
25 sorry. I'm just making sure that I'm looking at the

1 right page of the study.

2 I'm sorry. I mean page 733.

3 A. Okay.

4 Q. On page 733 in the left column midway through
5 the paragraph, there's a sentence there that says:
6 "For women in the second trimester, the mortality rates
7 for D&E were 2.5 times lower than those for
8 instillation and other procedures."

9 Did I read that correctly?

10 A. You did read it correctly.

11 Q. Going back to your report in paragraph 36,
12 you cite a study by Cohen, et al., for your statement
13 that, quote --

14 A. I'm not there yet.

15 Q. Oh, I'm sorry.

16 A. Paragraph 36?

17 Q. Yes.

18 A. Yes.

19 Q. So paragraph 36 says: "A global review found
20 that induced abortions after 12 to 14 weeks of
21 pregnancy account for a larger proportion of
22 abortion-related serious complications."

23 Did I read that correctly?

24 A. Yes.

25 Q. And did you cite a study by Cohen, et al.,

1 for that statement?

2 A. Yes, I did.

3 Q. This article looks at the safety of abortion
4 worldwide, not just the United States; is that right?

5 A. That's correct. Well, it looks at abortion
6 care.

7 Q. And it looks at abortion care both within and
8 outside of the United States; is that right?

9 A. Yes. It looks at abortion care globally.

10 (Exhibit 6 Marked for Identification.)

11 MS. SALVADOR: I'm dropping the study into
12 the chat. Please mark it as an exhibit.

13 BY MS. SALVADOR:

14 Q. And then, Dr. Wheeler, please let me know
15 when you have it up.

16 A. Yes, I have it.

17 Q. So this study specifically distinguishes the
18 safety of abortion in the U.S. from abortion in
19 countries where the proportion of unsafe abortions is
20 significant, doesn't it?

21 A. I wouldn't say unsafe abortion. I don't want
22 to disqualify that. I think you're talking about
23 legal abortion and the practice of abortion globally.

24 Q. So I'll refer you to page 460, the bottom of
25 the right-hand column.

1 So the first sentence of the last paragraph
2 says: "Despite comprising a small proportion of total
3 global abortions, later abortion accounts for a large
4 proportion of abortion-related serious complications
5 especially where access to abortion is restricted and
6 the proportion of unsafe abortion is significant."

7 Did I read that correctly?

8 A. You did read it correctly.

9 Q. And this study defines "later abortion" as
10 abortion occurring after the first 12 or 14 weeks of
11 pregnancy; is that right?

12 A. They didn't necessarily define it that way,
13 although it -- they refer to that in their citation 3
14 above it, that later abortion occurring after the first
15 12 to 14 weeks. They then talk about the percentage of
16 it, abortions worldwide.

17 Q. So with that additional context, would you
18 agree that it would be accurate to describe this
19 article as finding that induced abortions after
20 12 to 14 weeks of pregnancy account for a larger
21 proportion of serious complications across abortions
22 worldwide?

23 MR. BOYLE: Objection.

24 THE WITNESS: Can you please restate that.

25

1 BY MS. SALVADOR:

2 Q. Sure.

3 Would you agree that it would be accurate to
4 describe this article as finding that induced abortions
5 after 12 to 14 weeks of pregnancy account for a larger
6 proportion of serious complications across abortions
7 worldwide?

8 MR. BOYLE: Objection.

9 THE WITNESS: I'm not following your
10 question. You may have to break that on down for me.

11 BY MS. SALVADOR:

12 Q. Sure.

13 So this study discusses abortions globally;
14 is that right?

15 A. Yes.

16 Q. So its findings generally apply to abortions
17 globally; is that right?

18 MR. BOYLE: Objection.

19 THE WITNESS: They're looking -- they're
20 giving a global perspective on abortion care beyond 13
21 weeks, yes.

22 BY MS. SALVADOR:

23 Q. And -- I'm sorry.

24 A. That's their proposition.

25 Q. I'm sorry. I will work harder not to

1 interrupt you.

2 So also on page 460 on the -- in the right
3 column toward the bottom of the page, the article
4 describes the United States as a country, quote, "Where
5 generally care is safe"; is that correct?

6 A. Is the statement -- are you reading it
7 correctly? Is that the question?

8 Q. Yes. I'm asking if I read correctly that
9 this article refers to the United States as a country
10 "Where generally care is safe"?

11 A. This article makes that statement, yes.

12 Q. And right before that, still on the right
13 column of page 460, the article states that: "With
14 safe care, case fatality rates increase slightly with
15 increasing gestational age, but as compared with unsafe
16 care or even term pregnancy, the case fatality rate is
17 lower."

18 Did I read that correctly?

19 A. You read what they wrote, yes.

20 Q. Going back to your report, in paragraph 38 --
21 please let me know when you're there.

22 A. Yes, I'm there.

23 Q. So in paragraph 38 of your report, you
24 discuss a study of uterine perforation during
25 second-trimester D&Es; is that right?

1 A. Yes, it is.

2 Q. Didn't that study analyze cases from the 1977
3 and 1987 time period?

4 A. I would need to look at the actual dates in
5 that. I'd be happy to do that.

6 Q. Sure.

7 (Exhibit 7 Marked for Identification.)

8 MS. SALVADOR: I am dropping the study into
9 the chat. Please mark it as an exhibit.

10 BY MS. SALVADOR:

11 Q. And then, Dr. Wheeler, please let me know
12 when you have it open.

13 A. Yes, I have it open.

14 Q. Dr. Wheeler, are you familiar with this
15 document?

16 A. Yes, I am.

17 Q. Is it the study that you cite in paragraph 38
18 of your report?

19 A. Yes, it is.

20 Q. So I'll point you to the Materials and
21 Methods subheading on the first page of the study.

22 A. Yes.

23 Q. Didn't this study analyze cases from the
24 1977-to-1987 time period?

25 A. Yes, it did.

1 Q. And didn't it find that uterine perforation
2 occurs in about 0.4 percent of D&E procedures?

3 A. You would have to point that out to me,
4 because they were not studying the incidences. They
5 did not have total numbers to study the incidence.

6 Q. Sure.

7 I'm referring to the first page of the study
8 in the left column, the full paragraph in the middle
9 right before the Materials and Methods subheading.

10 There is a sentence in that paragraph that
11 states: "Uterine perforation occurs in about
12 0.4 percent of D&E procedures."

13 Did I read that correctly?

14 A. I found it. They are referencing. That
15 actually didn't come from this study. They're citing
16 another study.

17 Q. Understood.

18 But it was the understanding of this study's
19 authors that uterine perforation occurred in about
20 0.4 percent of D&E procedures; is that right?

21 A. They quoted one study that showed that, and
22 in that one study, they -- that was what they quoted.

23 Q. Let's go back to your report.

24 Further down in paragraph 56 -- do you have
25 it up?

1 A. I am close.

2 Yes, I have it.

3 Q. So in paragraph 56 of your report, you cite a
4 study by Niinimaki, et al., for the proposition that
5 medication abortions have a four times higher risk of
6 adverse events as compared to procedural abortions; is
7 that right?

8 A. At the specified gestational age that was in
9 Niinimaki's conclusion from his research at 63 days of
10 gestational age or less.

11 Q. Didn't the medical abortion group in this
12 study include abortions performed with mifepristone
13 alone?

14 A. I want to make sure I'm answering properly
15 under oath, so may I look at that study just to confirm
16 that's correct?

17 Q. Sure.

18 (Exhibit 8 Marked for Identification.)

19 MS. SALVADOR: I have put the study in the
20 chat. Please mark it as an exhibit.

21 BY MS. SALVADOR:

22 Q. And Dr. Wheeler, please let he know when you
23 have it open.

24 A. It is open.

25 Q. Dr. Wheeler, are you familiar with this

1 document?

2 A. Yes, I am.

3 Q. Is it the Niinimaki study that you cite in
4 paragraph 56 of your report?

5 A. Yes, it is.

6 Q. I will direct you to page 796.

7 In the right column in the top paragraph,
8 there's a sentence in the middle of that paragraph that
9 states: "Medical abortion was defined as the use of
10 mifepristone alone or in combination of misoprostol or
11 other prostaglandins."

12 Did I read that correctly?

13 A. Yes, you did.

14 Q. Do you know whether Planned Parenthood South
15 Atlantic provides abortions using mifepristone alone?

16 A. I do not have that information. I don't
17 know.

18 They had reported protocols. I don't know if
19 they always follow the protocol.

20 Q. I'll refer you to page 798 of the study.

21 A. Yes.

22 Q. The first sentence of that "Discussion"
23 subheading states: "In the present study, we found
24 that the two methods of pregnancy termination (medical
25 and surgical) are generally safe."

1 Did I read that correctly?

2 A. You read that correctly, but I don't agree.

3 Q. Understood.

4 Are you aware that the authors of this study
5 characterize all patient reports of heavy bleeding as
6 hemorrhage even if they were in the expected range for
7 medication abortion?

8 A. I'd be happy to look at the definition.

9 Q. Are you aware that in response to criticism
10 of this study, the authors of the study conceded that
11 "Many of the," quote/unquote, "complications are not
12 really such, but rather concerns are adverse events
13 that bring women back to the health care system"?

14 A. I did not see that reported in this citation.
15 (Exhibit 9 Marked for Identification.)

16 MS. SALVADOR: I'm going to drop another link
17 into the chat. Please mark it as an exhibit.

18 BY MS. SALVADOR:

19 Q. And then, Dr. Wheeler, please let me know
20 when you have it open.

21 A. I have it open.

22 Q. Dr. Wheeler, are you familiar with this
23 document?

24 A. No. I don't know this document.

25 Q. You'll see at the top it says "Letters to the

1 Editor," and then at the bottom of each page, there's a
2 footer that refers to Obstetrics and Gynecology, Volume
3 115, Number 3. Do you see those?

4 A. I do.

5 Q. Do you have any reason to believe that this
6 is not a letter to the editor from the Obstetrics and
7 Gynecology Journal?

8 A. I do not.

9 Q. So you'll see here that there's a letter to
10 the editor, and then there's a reply that starts in the
11 right column of the first page.

12 Do you see that reply?

13 A. On the far right, yes.

14 Q. So if you keep scrolling down to the second
15 page in the left column, you'll see that the authors of
16 the reply, Niinimaki, Dr. Pouta, and several other
17 names. Do you see that?

18 A. I don't.

19 MR. BOYLE: On the next page.

20 THE WITNESS: Oh, on the next page.

21 Yes, I see that.

22 BY MS. SALVADOR:

23 Q. And do you recognize these names as the
24 authors of the Niinimaki study that we were just
25 discussing?

1 A. I at least recognize -- I recognize
2 Niinimaki. The others I recognize, but I'd have to --
3 some of them, but I'd have to go back and verify that
4 they're the same ones on this article.

5 Q. Got it. And do you recognize that they're
6 discussing that same Journal article?

7 You can see that from the title of the letter
8 to the editor at the top of the first page. It says:
9 "Immediate complications after medical compared with
10 surgical termination of pregnancy."

11 Do you see that?

12 A. I see the title, yes.

13 Q. So do you agree that this is discussing the
14 same article?

15 A. From the title and the name of the reply,
16 yes.

17 Q. So on page 660, in the reply section, the
18 first paragraph of "In Reply," there's a -- it begins
19 with "We thank Fjerstad, et al., for their interest in
20 our article. It is important to keep in mind that the
21 study is registry based, not a randomized study with
22 strict protocols and definitions. Thus, many of the
23 complications are not really such, but rather concerns
24 are adverse events that bring women back to the health
25 care system."

1 Did I read that correctly?

2 A. You read what is written, yes.

3 Q. And then if you go to the very bottom of that
4 column, it reads: "The main contributions that the
5 present article makes to the literature are," and then
6 there's a bullet that says: "Rate of serious real
7 complications is a rare and rather similar between
8 surgical and medical abortion."

9 Did I read that correctly?

10 A. You read it correctly, but it doesn't fit
11 with the article.

12 Q. But you agree that it was the authors of the
13 article who wrote this response; am I right?

14 A. Yes, it was them.

15 Q. And they are specifically discussing the
16 article that you cited in this response; is that right?

17 A. They appear to be.

18 Q. Does this change your reliance on the
19 Niinimaki study for the proposition that medication
20 abortion has a complication rate four times higher than
21 the rate for procedural abortion?

22 A. No. As I said, it was the American College
23 of Ob-gyn literature I read through, make sure it's
24 accurate, and then I look at conclusions to see whether
25 the conclusions follow from the research.

1 And so I was surprised at the end of this
2 article where they said it was relatively safe if
3 you're reporting from linkage studies those, whether
4 you call them complications or adverse events, whatever
5 it is that brings people back in for additional care.

6 The conclusion I found interesting given the
7 facts, the findings of the article.

8 Q. Got it. Thank you.

9 Let's go back to your report in paragraph 23.

10 A. I'm there.

11 Q. So in paragraph 23 of your report you state
12 that the traditional norm is to perform
13 second-trimester D&C and D&E in a hospital; is that
14 right?

15 A. That's correct.

16 Q. Is that statement referring to
17 second-trimester D&C and D&E for miscarriage management
18 or abortion, or both?

19 A. Generally, traditionally both were performed
20 in a surgical suite in the hospital. The move out of
21 the hospital has been a later development.

22 Q. So what's the basis for your view that the
23 traditional norm is to perform D&Cs and D&Es in a
24 hospital?

25 A. Traditionally -- I think we may be talking

1 different definitions. "Traditionally" -- I mean,
2 "traditionally" to me is more historically.
3 Traditionally they were performed in the surgical suite
4 in a hospital, and over time some of those procedures
5 have been moving out to other settings.

6 Q. Do you think that D&Cs can ever be performed
7 successfully in an outpatient setting?

8 A. Define what you mean by "outpatient."

9 Q. Sure.

10 Do you believe that D&Cs can be performed
11 safely in, for example, an abortion clinic?

12 A. I would have to see the clinic and their
13 protocols. There's, you know, "can be," like, things
14 can be done in a lot of places, but it doesn't mean it
15 is safest, in the patient's best interest.

16 So can you do a procedure somewhere and not
17 have a complication? I think that's a theoretical
18 question versus, you know, where is it best and where's
19 the safest place, the best patient care.

20 Q. Do you think that D&Cs are ever performed
21 without complications in an abortion clinic setting?

22 A. Yes, I do.

23 Q. Do you agree that D&Cs are usually performed
24 without complications in an abortion clinic setting?

25 A. I don't have -- I don't work in an abortion

1 clinic setting, so I don't know those numbers. I'd
2 have to -- that would be conjecture on my part.

3 Q. Are you familiar with any literature
4 regarding how safe it is to perform D&Cs in an
5 outpatient setting?

6 A. I referenced one that one of the other
7 physicians also referenced.

8 Q. What is your understanding of where most
9 abortions are performed in terms of clinical setting?

10 A. Most abortions, in the first trimester
11 particularly, most of them are in specialized clinics
12 that primarily focus on abortion.

13 Q. Where -- what is your understanding of where
14 most abortions are performed after the first trimester?

15 A. I don't have that information, so that would
16 be a conjecture on my part.

17 Q. Are you aware of a study by Jones, et al.,
18 finding that only 3 percent of abortions are performed
19 in hospitals in the United States annually?

20 A. So 90 percent of abortions are performed,
21 according to Google, it's approximately 90 percent are
22 performed in the first trimester. So that would mean
23 that most of them, given that most first-trimester
24 abortions -- induced abortions are performed in
25 specialized clinics with a focus on abortion, that

1 would make sense.

2 I don't recall there being a study of
3 separation of gestational ages, but I'd be happy to
4 look at it. But given that most abortions -- induced
5 abortions are in the first trimester, it would
6 certainly be less than 10 percent in a hospital.

7 Q. Are you familiar with any research concluding
8 that abortion has low rates of complications generally,
9 and very low rates of complications requiring
10 hospitalization?

11 A. Am I aware of any literature? I have seen
12 the claims in the literature and am concerned about
13 that, because I'm aware that in the United States we
14 don't collect that data.

15 Consistently in the majority of the states in
16 the United States we, frankly, have no idea how many
17 complications or deaths are happening from abortion
18 with any accuracy.

19 Q. Do you think that a D&E can be performed
20 without complications in an outpatient setting?

21 A. That's a conjecture. But is it possible
22 would mean what "can" means to me, and it's possible.

23 Q. So let's go back to your study -- your study.
24 Let's go back to your report -- I'm sorry -- in
25 paragraph 43.

1 A. Can we take a break after this, please.

2 Q. We can take a break before we start
3 discussing this, if you'd prefer.

4 A. Yeah, to get up for a moment, that would be
5 great. Thank you.

6 MS. SALVADOR: Why don't we go off the record
7 and come back in five minutes.

8 (Off the record 4:32 p.m. to 4:44 p.m.)

9 BY MS. SALVADOR:

10 Q. So we were at paragraph 43 of your report,
11 Dr. Wheeler.

12 Do you have it up?

13 A. I am just getting to it. Paragraph 43, isn't
14 that correct?

15 Q. Yes.

16 A. Okay. And I am there, yes.

17 Q. So in paragraph 43, you criticize
18 Dr. Farris's reliance on a study by Roberts, et al.,
19 finding that abortion is equally safe in outpatient
20 clinics and in ambulatory surgical centers, and you
21 note that this study didn't look at the safety of
22 abortion in hospitals as compared to these other
23 clinical settings; is that right?

24 A. Make sure I'm saying it properly.

25 Roberts did not look at hospital-based care.

1 They looked at the comparison of ambulatory care
2 centers and clinic settings.

3 Q. So in support of your statement, you quote a
4 JAMA editorial review of the Roberts study noting that
5 Roberts didn't consider the comparative safety of
6 hospital-based abortion, and that "Hospitals would be
7 presumed to be simultaneously the safest sites, as well
8 as the site caring for patients with more complex
9 health needs or greater severity of illness"; is that
10 correct?

11 A. Yes. I quoted the JAMA editorial review, and
12 that's their quote.

13 (Exhibit 10 Marked for Identification.)

14 MS. SALVADOR: So I'm dropping the JAMA
15 review into the chat. Please mark it as an exhibit.

16 BY MS. SALVADOR:

17 Q. And then, Dr. Wheeler, please let me know
18 when you have it up.

19 A. I have it open.

20 Q. Dr. Wheeler, are you familiar with this
21 document?

22 A. Yes, I am.

23 Q. Is it the JAMA editorial that you cite in
24 paragraph 43 of your report?

25 A. Yes, it is.

1 Q. So doesn't this editorial review state -- and
2 I'm going to quote from page 2482 in the left column,
3 first full paragraph.

4 Doesn't this editorial review state: "Given
5 that many states require much more than the NASEM and
6 ASA recommendations, there is an apparent mismatch
7 between facility standards that are medically
8 appropriate for patient safety versus what is often
9 required by state law. Examples of additional and
10 expensive requirements include sterile operating rooms,
11 sterile corridors, airflow requirements, scrub sinks,
12 and other requirements that are aimed at reducing
13 infections where physicians perform surgical procedures
14 that penetrate the skin, but these requirements confer
15 no clinical benefit in the context of a nonsterile
16 procedure such as abortion."

17 Did I read that correctly?

18 A. You read what the editorial board wrote, yes.

19 Q. After reviewing these passages of the JAMA
20 editorial, would you agree that the Roberts article
21 provides evidence that abortion is safe in office-based
22 clinical settings?

23 A. The editorial board specifically looked at
24 some physical requirements for maintaining sterility,
25 but did not look at other potential factors. But as my

1 quote said, that it may still be the safest place, that
2 they were only looking at safeguards against infection,
3 not at the entire picture of safety and minimizing risk
4 when -- in this section.

5 Q. Would you agree that the Roberts article
6 provides evidence that abortion is as safe in
7 office-based settings as in ambulatory surgical
8 centers?

9 A. If you would kindly put the article up there.
10 I want to make sure I'm accurate in what I say.

11 Q. Sure.

12 (Exhibit 11 Marked for Identification.)

13 MS. SALVADOR: I am dropping the article into
14 the chat. Please mark it as Exhibit 11.

15 BY MS. SALVADOR:

16 Q. And, Dr. Wheeler, please let me know when you
17 have it open.

18 A. Yes. I have it open.

19 Q. Are you familiar with this document?

20 A. I am.

21 Q. Is this the Roberts study that we've been
22 discussing that you discuss in paragraph 43 of your
23 report?

24 A. Yes, it is.

25 Q. I will point you to the bottom of the first

1 page. There is a subheading that says "Conclusions and
2 Relevance."

3 A. Yes.

4 Q. The first sentence of that subheading states:
5 "Among women with private health insurance who had an
6 induced abortion, performance of the abortion in an
7 ambulatory surgical center compared with an
8 office-based setting was not associated with a
9 significant difference in abortion-related morbidities
10 and adverse events."

11 Did I read that correctly?

12 A. You read it, and then I would myself go back
13 to the results to make sure that I agree with their
14 conclusion.

15 Q. Understood. But your critique of this study
16 in your report was based on the fact that it did not
17 explicitly analyze hospital-based care; is that
18 correct?

19 A. The question I was asked to answer was
20 related to office or outpatient types of D&Es versus
21 in-hospital D&Es.

22 So this did not address the relative safety
23 of hospital-based operating-room D&Es and those in
24 clinic settings.

25 Q. Understood. But you didn't have any other

1 critique of this study in your report, did you?

2 A. In the report, no. My specific -- it was
3 quoted as -- it was referenced as support for it being
4 just as safe in a clinical setting, but the comparison
5 is with the hospital, and this doesn't address the
6 hospital.

7 Q. Let's go back to your report in paragraph 45.

8 A. There we are. Forty-five?

9 Q. Yes. Do you have it up?

10 A. I am close.

11 I have it up.

12 Q. Great. Thank you.

13 So in paragraph 45 of your report you say
14 that fetal anomalies, pregnancy complications, and
15 maternal medical indications and intrauterine fetal
16 demise greatly increase the risk to the pregnant woman
17 for any medical procedure, including D&E; is that
18 correct?

19 A. I'm not sure where you read that.

20 Q. Sure. I was kind of combining the first two
21 sentences of paragraph 45.

22 A. Well --

23 Q. Sorry. Go ahead.

24 A. No. I'm sorry. I'm just -- I'm
25 understanding now where you got that from.

1 So what was your question again?

2 Q. Sure.

3 So you're discussing in this paragraph 35 --
4 I'm sorry -- 45 that fetal anomalies, pregnancy
5 complications, and maternal medical indications and
6 intrauterine fetal demise all increase the risk to a
7 pregnant woman for any medical procedure, including
8 D&E; is that right?

9 MR. BOYLE: Object to form.

10 THE WITNESS: I -- the purpose in writing
11 that is that the health condition -- the health
12 conditions of the mother increase the risk to a
13 pregnant woman for a procedure.

14 BY MS. SALVADOR:

15 Q. And in this paragraph, are you referring to
16 D&E for abortion, for a miscarriage management, or
17 both?

18 A. I am referring to health conditions that
19 place the mother at risk for any surgical procedure.

20 So if she had pregnancy complications,
21 medical indications that were serious enough to have to
22 require the ending of her pregnancy, that -- and even
23 with intrauterine fetal demise, you know, some of those
24 are underlying health conditions that would increase
25 her risk for a surgery or a procedure.

1 Q. So what fetal anomalies would increase the
2 risk to a pregnant woman of a D&E?

3 A. I am not aware of fetal anomalies, per se.
4 Every other condition there that I've listed could
5 potentially. I'm not aware of fetal anomalies
6 independently increasing the mother's risk beyond a
7 baseline for pregnancy.

8 Q. Does a pregnancy resulting from rape or
9 incest increase the medical risk to a pregnant woman
10 for any medical procedure?

11 MR. BOYLE: Objection.

12 THE WITNESS: That's conjecture. There may
13 be injuries associated with a rape, so I -- that would
14 be dependent -- independently on the patient's
15 condition and specific health.

16 BY MS. SALVADOR:

17 Q. Would you say that a pregnancy resulting from
18 rape or incest always increases the medical risk to a
19 pregnant woman for a medical procedure?

20 A. Always, no.

21 Q. In your report in paragraph 50 -- sorry.
22 I'll give you a second. Let me know when you're there.

23 A. Yes, I'm there.

24 Q. So in paragraph 50 of your report, you state:
25 "I am not aware of any research directly comparing

1 safety of D&C or D&E for indications of medical
2 complications, such as spontaneous abortion or
3 intrauterine fetal demise, to those performed
4 electively."

5 Did I read that correctly?

6 A. Yes.

7 Q. From -- so in other words, you're not aware
8 of any research directly comparing the safety of D&C or
9 D&E for induced abortion with the safety of D&E or D&C
10 for spontaneous abortion?

11 A. Yes. I'm not aware of any direct comparison
12 between the patient groups and indications for those
13 procedures.

14 Q. In your experience as an ob-gyn, did you ever
15 treat patients who were hemorrhaging?

16 A. Yes.

17 Q. Under what circumstances did you treat
18 patients who were hemorrhaging?

19 A. Boy, that's a wide -- a wide variety.

20 We treated it in the emergency room with
21 intraabdominal hemorrhages from ruptured corpus luteum
22 cysts. We had hemorrhages in obstetrics. We had
23 hemorrhages with miscarriage. We had -- it can occur
24 from anything that has a blood vessel.

25 Q. So you mentioned miscarriages. So is it

1 correct that you treated patients who were hemorrhaging
2 in the miscarriage context?

3 A. I don't specifically recall personally having
4 any patients hemorrhaging from a miscarriage.

5 Q. Do you recall treating any patients who were
6 hemorrhaging during labor and delivery?

7 A. Yes.

8 Q. How are you defining "hemorrhage" in terms of
9 amount of blood for a miscarriage?

10 A. So the official definition is 500 ccs of
11 acute blood loss. However, in the situation, they
12 don't have to get to 500 ccs for me to decide this is
13 potentially life threatening, this is something I need
14 to manage in a different way.

15 So acute active bleeding would be enough to
16 alert me to need for intervention.

17 Q. And in terms of the amount of blood, how
18 would you define "hemorrhage" in the labor and delivery
19 context?

20 A. The definition would be -- for simple labor,
21 again, it would be the sudden loss of 500 ccs of blood,
22 which is an estimation, so we're always clinically
23 estimating the briskness of the bleeding.

24 Q. And would you use the same definition in
25 terms of ccs of blood to define "hemorrhage" in the D&C

1 context?

2 A. Yes. It can also be defined as the drop in
3 hemoglobin, but obviously, acutely you're not going to
4 have that.

5 So you're always estimating, and while it's
6 an official definition, you're always watching for the
7 briskness and whether you're at risk, basically the
8 risk of acute blood loss.

9 Q. Have you ever treated patients who were
10 hemorrhaging in an outpatient facility?

11 A. I don't recall that specifically.

12 Q. Do you ever recall a patient hemorrhaging
13 during an office visit?

14 A. I don't have any recollection of somebody
15 hemorrhaging in my office, no.

16 Q. If you were treating a patient and they
17 started hemorrhaging, what interventions would you
18 perform?

19 MR. BOYLE: Objection.

20 THE WITNESS: It would depend on the
21 scenario.

22 BY MS. SALVADOR:

23 Q. If you were providing a D&C and that patient
24 started hemorrhaging, what types of interventions might
25 you perform?

1 A. It would depend on where I am in the
2 procedure and which organ is involved.

3 Q. So let's go through a bunch of different
4 possibilities.

5 So I'm hearing you saying that there's
6 multiple interventions you could perform depending on
7 the circumstances if a patient were hemorrhaging while
8 you were providing a D&C; is that right?

9 MR. BOYLE: Objection.

10 THE WITNESS: You want to be specific as to
11 the source.

12 BY MS. SALVADOR:

13 Q. So where -- what might be the source of
14 hemorrhage for a patient during a D&C?

15 A. It could be coming from any of the organs
16 within reach of your instrument. It could be coming
17 from cervix. It could be coming -- if you've
18 perforated, it could be coming from a large blood
19 vessel.

20 It could be coming from the fact that you've
21 instrumented the uterus and the uterus has not emptied
22 the contents, and so you have a wide open base of the
23 placenta bleeding. It could be from perforation of the
24 uterus of the fundus and the major vessel. It could be
25 coming from the myometrium.

1 There's a lot of potential places. It could
2 be coming from a vaginal laceration.

3 BY MS. SALVADOR:

4 Q. So let's say -- let's start with that last
5 one.

6 Let's say you were performing a D&C on a
7 patient, and they started hemorrhaging from a vaginal
8 laceration. What sort of interventions would you
9 perform in that circumstance?

10 A. It would depend on exactly where it is. You
11 want to make sure that you know where your ureters are.

12 So it depends on where it is, whether I can
13 stop it by direct pressure, how deep the laceration is,
14 how actively it's bleeding. Potential things I could
15 do is pressure, silver nitrate, suture.

16 Q. And if a patient were hemorrhaging from their
17 cervix during a D&C, what types of interventions might
18 you perform?

19 A. Again, it'll depend on the location in the
20 cervix, whether I've perforated the -- some of the
21 major vessels come in that -- near the endocervical os.
22 So if I perforated and gone into a uterine artery.

23 There's a lot of potential sources. If it's
24 superficial, I would manage it the same as I did in the
25 vagina. If it's higher up and I need to identify where

1 it is, is there a perforation, or where are my ureters?
2 Where is my bladder?

3 And, again, it's going to depend on the
4 specifics of where I -- where it is actually and
5 whether there is a risk of perforation in the major
6 blood vessel injury.

7 Q. Were you ever able to provide sutures to a
8 hemorrhaging patient in an office setting?

9 A. Was I ever able to? Yes.

10 Q. Were you ever able to resolve a
11 hemorrhaging -- resolve a hemorrhage with direct
12 pressure in an office setting?

13 A. I don't recall. So we're talking about the
14 difference between bleeding and active hemorrhaging. I
15 don't recall ever in an office having active
16 hemorrhage, first of all.

17 Q. In your experience as an ob-gyn, did you ever
18 treat patients with cervical tears?

19 A. I don't remember specifically having cervical
20 lacerations in my office. I don't have any
21 recollection of any of those happening in my office.

22 Q. Outside of -- I'm referring to your general
23 practice as an ob-gyn, not necessarily in an office
24 setting.

25 Did you ever treat patients with cervical

1 tears?

2 A. Yes, I had patients with cervical
3 lacerations.

4 Q. Did you treat patients with cervical
5 lacerations in the miscarriage context?

6 A. I don't specifically remember having any. I
7 don't recall having any specifically with cervical
8 lacerations with miscarriage.

9 Q. Do you remember treating patients with
10 cervical lacerations in the labor and delivery context?

11 A. Yes, I do.

12 Q. Did any of that treatment occur in outpatient
13 facilities?

14 A. In labor and delivery, we were able -- we had
15 everything that we needed to do those things in the
16 labor and delivery suite, and there was an operating
17 room literally down the hall if I needed it for
18 visualization for whatever.

19 Q. And outside of labor and delivery, did you
20 ever treat patients with cervical lacerations?

21 A. What do you mean by "outside labor and
22 delivery"?

23 Q. In contexts other than labor and delivery,
24 did you ever treat a patient for a cervical laceration
25 who was not undergoing labor?

1 A. Yes.

2 Q. Under -- what was going on with that patient?

3 A. I don't remember the specific patient, but I
4 am sure that in the context in one of the ORs, I'm sure
5 that at some point I had to put a stitch in somebody's
6 cervix. I don't remember ever having a hemorrhage.

7 Q. Do you remember whether you would -- let me
8 rephrase this.

9 If you had to treat a patient's cervical
10 laceration by putting a stitch in their cervix, would
11 you have been able to do that outside of the hospital
12 OR?

13 A. So, again, it's going to depend on where the
14 laceration is, so it's going to depend on the
15 circumstance.

16 Q. So does that mean that there are some
17 cervical lacerations that you would have been able to
18 treat with a stitch outside of a hospital OR?

19 A. Yes.

20 Q. Can you define "endometritis."

21 A. Endometritis is an infection that has gone
22 into essentially the muscles of the uterus.

23 Q. Have you treated patients with endometritis?

24 A. Yes, I have.

25 Q. How did you treat those patients?

1 A. Typically with IV antibiotics.

2 Q. Were there any other treatments you gave to
3 those patients?

4 A. Depends on the scenario. So I'm sure there
5 were other treatments that I gave, but it would depend
6 on the situation.

7 Q. And when you were treating your patients with
8 endometritis with IV antibiotics, did that treatment
9 require hospitalization?

10 A. At least initially. So my recollection is
11 treating them inpatient.

12 Q. Do you recall ever treating patients with
13 endometritis in your office?

14 A. Again, it's going to depend on the situation.

15 Q. I understand. I'm asking if you can recall
16 any situation in which you treated a patient with
17 endometritis in your office.

18 A. Again, it's going to depend on the situation.
19 You know, endometritis, mostly you're dealing with
20 postdelivery, and so the majority of those patients are
21 going to be in the hospital.

22 Q. So you're saying that you cannot recall ever
23 treating endometritis outside of the hospital setting;
24 is that correct?

25 A. Well, you'd have to give me a scenario. Then

1 I could say whether or not I have. The majority of the
2 time that I've seen endometritis has been postdelivery.

3 Q. And do you recall any other circumstances in
4 which you've seen endometritis apart from postdelivery?

5 A. Well, you can have ascending infections with
6 PID, but by the time that you've got fever and uterine
7 tenderness, you're typically going to have them in the
8 hospital at least initially.

9 Q. And what is PID?

10 A. Pelvic inflammatory disease.

11 Q. Are you familiar with hospital-acquired
12 infections?

13 A. Yes.

14 Q. Generally speaking, what are those?

15 A. Well, any hospital-acquired infection just
16 essentially means that you came -- you were in a
17 hospital when you acquired the infection.

18 Q. Are hospital patients particularly vulnerable
19 to infection?

20 MR. BOYLE: Object to form.

21 THE WITNESS: It depends on the situation.

22 BY MS. SALVADOR:

23 Q. What are some reasons that hospital patients
24 might be particularly vulnerable to infection?

25 MR. BOYLE: Object to form.

1 THE WITNESS: There's, you know, basically
2 their essential health. If they're immune suppressed.

3 Literally somebody who is delivering, if
4 they're having a surgery, those are situations that
5 would expose -- that could potentially expose you to
6 infections picked up in a hospital. I couldn't address
7 all of them, but those are some examples.

8 BY MS. SALVADOR:

9 Q. In your experience as an ob-gyn, did you ever
10 have an experience where you were treating a patient in
11 an outpatient facility and they needed to be
12 transferred to a hospital?

13 A. I recollect one person transferring from --
14 yeah, I recollect one person in a surgical center.

15 Q. What procedure was that patient undergoing
16 when they had to be transferred?

17 A. I actually can't remember what the procedure
18 was. I just remember transferring her. It was -- it
19 wasn't hemorrhage --

20 Q. Were you --

21 A. -- about what it was, but --

22 Q. Were you able to transfer that patient
23 safely?

24 A. Yes. And remember, no matter where I was,
25 the outpatient surgical center was at the hospital,

1 minutes away.

2 Q. Did you ever -- sorry. Let me rephrase.

3 You've testified previously that you used
4 sedation in your practice as an ob-gyn; is that right?

5 A. Anesthesia did. I didn't personally.

6 OB did it as residents sometimes do some
7 minimal IV sedation. I didn't do it outside of
8 residency.

9 Q. Did you ever use sedation in your office
10 practice?

11 A. No.

12 Q. What types of pain relief would you give
13 patients in your office practice?

14 A. Well, primarily we were prescribing
15 medication for them to take elsewhere.

16 So I think we had Toradol available. We
17 didn't keep narcotics, so primarily we were first
18 giving prescriptions, but we did have Toradol, as I
19 recall, an anti-inflammatory injectable.

20 Q. And so would you use that inflammatory
21 injectable in your office practice?

22 A. An anti-inflammatory?

23 Q. I'm sorry. Yes.

24 Would you use that anti-inflammatory
25 injectable in your office practice?

1 A. I did -- I don't remember specifically using
2 it, but I remember having it available.

3 Q. Do you recall any of your partners using it
4 in their office practice?

5 A. I don't know what they did.

6 Q. Do you think that -- do you know why your
7 office kept that available?

8 A. I don't remember the specific indications. I
9 remember around the time we started doing
10 hysteroscopies, around that time is when I remember
11 having it at the office.

12 Q. In your opinion, is it medically safe to
13 perform a D&C without general anesthesia?

14 A. So the question is, is it medically safe to
15 perform a D&C without any anesthesia?

16 Q. No, without general anesthesia.

17 A. Oh, without general. Can it be medically
18 safe? I mean, it depends on the situation, but it's,
19 yeah, definitely possible.

20 Q. Would you say that there's a difference
21 between deep sedation and general anesthesia?

22 A. Yes, there is.

23 Q. What's the difference between deep sedation
24 and general anesthesia?

25 A. The primary difference typically is the level

1 of sedation. Also, general anesthesia sometimes uses
2 muscle paralyzers, essentially, but it's the level of
3 sedation and also whether the patient is respiring
4 independently and whether they can protect their own
5 airway.

6 Q. In your opinion, could it be medically safe
7 to perform a D&C without deep sedation?

8 A. Could it be? Yes.

9 Q. Would the amount of physical pain experienced
10 by a patient having a D&C for miscarriage management
11 differ from the amount of physical pain experienced by
12 a patient having a D&C for an abortion?

13 A. Sorry, I lost part of the question. Would
14 you please reask.

15 Q. Sure.

16 Would the amount of physical pain experienced
17 by a patient having a D&C change depending on whether
18 that D&C was for the purpose of miscarriage or
19 abortion?

20 MR. BOYLE: Objection.

21 THE WITNESS: That's a very -- it's dependent
22 so much on the patient and their history and their
23 circumstance.

24 So -- and I'm not aware of any head-to-head
25 studies on that to be able to answer under oath. I

1 don't know. I don't have that information.

2 BY MS. SALVADOR:

3 Q. Based on your medical experience, if you had
4 a patient -- if you had two patients with identical
5 medical histories and one was having a D&C for
6 miscarriage management and one was having a D&C for an
7 abortion, would the amount of physical pain they
8 experienced be different?

9 MR. BOYLE: Objection.

10 How is she supposed to speculate about two
11 different people's pain thresholds and such? But she
12 can answer.

13 THE WITNESS: The individual pain experience
14 is so variable that I can't answer that.

15 BY MS. SALVADOR:

16 Q. What -- is there any difference in the
17 performance of a D&C for an abortion as compared to
18 performing a D&C for a miscarriage? Is there anything
19 different about the procedure that would cause a
20 difference in physical pain?

21 MR. BOYLE: Objection.

22 THE WITNESS: So the amount of pain is very
23 individual. It depends on the number of passes, and it
24 depends on how much tissue there is to remove and
25 whether it's already partly macerated.

1 There are so many factors that individually,
2 it's hard to say. I'm not able to answer that.

3 BY MS. SALVADOR:

4 Q. In your opinion, is it medically safe to
5 perform a D&E without general anesthesia?

6 A. It again depends on the situation. It adds
7 an extra nuance when the patient is awake.

8 Q. Does general anesthesia alone carry medical
9 risks separate from the procedure a patient is
10 undergoing?

11 A. Yes, it does.

12 Q. In your opinion, could it ever be medically
13 safe to perform a D&E without general anesthesia?

14 A. You're asking a conjecture question. Could
15 it ever be medically safe?

16 In other words, are you -- rephrase the
17 question, please. I don't want to --

18 Q. Sure.

19 A. Yeah.

20 Q. Are you aware of any -- are you aware of D&Es
21 being provided without general anesthesia?

22 A. I am not personally aware. I've not been
23 privy to that.

24 At the University of Utah, our patients are
25 generally asleep, as I've answered. I don't recall if

1 some of my patients may have had deep sedation versus
2 general. So I'm not privy outside of that to what
3 providers, medical professionals do.

4 Q. So is it fair to say that based on your
5 practice, you're not familiar with performing D&Cs
6 with -- I'm sorry -- D&Es without general anesthesia?

7 A. Well, I am aware of D&Es without general
8 anesthesia.

9 As I said, I don't recall exactly if any of
10 my patients and the anesthesiologist decided to proceed
11 with deep sedation versus general. It's possible that
12 I did. I don't have that specific recollection.

13 Q. And are you aware of D&Es being performed
14 without general anesthesia without complications?

15 A. Again, I don't have personal knowledge of
16 those.

17 Q. Are you familiar with the performance of D&Es
18 without medical complications from your review of the
19 literature?

20 A. Yes. But I don't have privy to their
21 anesthetic record.

22 Q. Are you familiar with the provision of D&Es
23 in your experience without deep sedation?

24 A. Without deep sedation or general anesthesia?
25 Is that the question? Please help me with your

1 question.

2 Q. Sure.

3 So previously we were talking about general
4 anesthesia for D&Es, and now I'm -- because you
5 articulated before that there was a difference between
6 deep sedation and general anesthesia, so I'm now asking
7 about deep sedation.

8 A. Okay. So am I -- go ahead and ask the
9 question again.

10 Q. Are you familiar with the provision of D&Es
11 without deep sedation?

12 A. Well, sometimes -- we did general anesthesia
13 a lot of the time. Not most of the time.

14 Q. Are you familiar with the provision of D&Es
15 without either deep sedation or general anesthesia?

16 A. I am not personally familiar with them.

17 Q. Does your review of the literature indicate
18 that some providers perform D&Es without either deep
19 sedation or general anesthesia?

20 A. So the articles that I looked at didn't
21 specify except for, I believe, there were two that
22 looked at anesthesia -- at pain management.

23 And I don't recall whether they were D&Cs and
24 D&Es, but I'd be happy to look at them. Or if they
25 were both, I'd be happy to look at them.

1 Q. What about the D&E procedure would cause a
2 patient physical pain?

3 A. Well, physical pain could just be from the
4 weighted speculum, which is heavy. It's a different
5 kind of speculum so that you can visualize and move
6 your instruments.

7 It could be from grasping the cervix. It
8 could be from dilation of the cervix. It could be from
9 the instruments in the uterus touching the uterine
10 wall, scraping the uterine wall. It could be from
11 perforation if that happened. It could be from uterine
12 cramping.

13 Those are the probabilities.

14 Q. In -- sorry. One more general anesthesia
15 question. What -- you've mentioned before that general
16 anesthesia alone carries medical risks apart from the
17 underlining procedure itself; is that right?

18 A. Correct.

19 Q. What are some of those risks caused by
20 general anesthesia?

21 A. Well, to clarify, there are risks and
22 benefits. That's why we consider things, is because we
23 have to weigh the risk and the benefit.

24 But the risk can be from -- if you're
25 intubating because she's having general, they could be

1 from the actual intubation, which is extremely rare.
2 Complications from anesthesia these days even in
3 pregnancy are extremely rare, but it could be that.

4 It could be the patient aspirating at the
5 time of extubation. And some anesthetics -- those are
6 the primarily -- and obviously when you're asleep and
7 having anesthetic, there are extremely rare
8 cardiopulmonary complications. Again, they're
9 incredibly rare.

10 Q. Is it -- I'm sorry?

11 A. So rare that their medical liability cost has
12 plummeted because it is so rare now to have a
13 complication.

14 Q. Is it your opinion that it's in every
15 patient's best medical interest to receive general
16 anesthesia with intubation when obtaining a
17 second-trimester D&E?

18 A. I would not say every patient. I think again
19 we need to weigh the risks and benefits of how
20 difficult we expect the procedure to be.

21 We have to consider all the factors of what
22 it's like both for patient and for the surgeon or
23 operator to perform. They have to know their patient.
24 They have to know her risk factors. They have to have
25 a general idea of what I expect to happen and what may

1 go right and wrong.

2 The anesthesiologist may look at her airway
3 and say actually, if I had to intubate her suddenly,
4 that's going to be a hard intubation.

5 So there's a lot of factors that go into that
6 decision that varies by the patient.

7 Q. Is it in your -- is it your opinion that it's
8 in most patients' best medical interest to receive
9 general anesthesia with intubation when obtaining
10 second-trimester D&E?

11 A. I don't know that I can -- that's conjecture.
12 Again, it's very individual.

13 I have to recognize for my -- each patient is
14 different. Each anesthetic concern and benefit is
15 different, so I have to evaluate it individually.

16 Q. Are you familiar -- I'm sorry.

17 Are you aware of the study by Turok, et al.,
18 finding that second-trimester D&Es are just as safely
19 performed in clinics as in hospitals?

20 A. I can't agree with the last part of what you
21 said, but I am aware of his study.

22 Q. Well, let's go back to paragraph 44 of your
23 report.

24 A. Yes. I am there.

25 Q. In paragraph 44 of your report, you critique

1 the study by Turok on the basis that -- on the basis
2 that, quote -- and this is toward the end of
3 paragraph 44: "The complications in the hospital
4 group's patients were most likely related to the
5 medical conditions indicating the termination of the
6 pregnancy rather than the location or technical skill
7 and experience of the physician"; is that correct?

8 A. That's part of it. This other part was that
9 the patient population groups were completely
10 different. They were noncomparable.

11 Q. How is it that the patient groups were
12 noncomparable?

13 A. Yes. So, as I recall, almost all of the
14 patients with elective terminations at the outpatient
15 clinic were elective, whereas within the hospital,
16 there was a medical indication for the termination.
17 So they were completely different populations.

18 I would have to look at the study to look at
19 gestational ages to remind myself of the gestational
20 ages whether they were comparable.

21 (Exhibit 12 Marked for Identification.)

22 MS. SALVADOR: I am dropping the study into
23 the chat. Please mark it as an exhibit.

24 BY MS. SALVADOR:

25 Q. And then, Dr. Wheeler, please let me know

1 when you're able to open it.

2 A. Yes. I have it open.

3 Q. Great.

4 Dr. Wheeler, are you familiar with this
5 document?

6 A. Yes, I am.

7 Q. Is it the study by Turok, et al., that we've
8 been discussing from paragraph 44 of your report?

9 A. Yes, it is.

10 Q. So I will direct you to page 160 of the study
11 in the left column.

12 A. Yes.

13 Q. I will direct you to the very last sentence
14 of the paragraph -- the last paragraph in the left
15 column.

16 It states: "However, the increase in
17 complication rates for D&E and induction in the
18 hospital groups persisted when controlling for maternal
19 medical complications, preexisting infections, parity
20 and gestational age in a multivariate regression
21 model."

22 Did I read that correctly?

23 A. I wasn't finding the same sentence as you.
24 Could you please direct me to it again.

25 Q. Sure. I'm on page 160.

1 A. Yes.

2 Q. There is a subheading that says "Discussion"
3 in the left column.

4 A. Yes.

5 Q. And I'm looking at the very last sentence in
6 that last column in the very bottom of the page.

7 A. Oh, the very bottom. Okay. I was at the
8 first paragraph.

9 Q. So the very last sentence states: "However,
10 the increase in complication rates for D&E and
11 induction in the hospital groups persisted when
12 controlling for maternal medical complications,
13 preexisting infections, parity and gestational age in a
14 multivariate regression model."

15 Did I read that correctly?

16 A. You read it correctly, but when you go to the
17 table where it actually goes through the complications
18 of the patients, it tells me a different story.

19 Q. Could you direct me to the table you're
20 referring to.

21 A. There was a table.

22 Here we go. "Details of cases with major
23 complications," Table 3. So I am on page 159.

24 So I see the first patient, hospital D&E,
25 community hospital, severe preeclampsia/HELLP syndrome,

1 so a complicated patient.

2 Patient 2, lupus, renal failure on dialysis.
3 Patient 3 transferred from outside hospital with
4 subchorionic hemorrhage. In other words, a separation
5 of the placenta requiring transfusion.

6 The next patient, Trisomy 13 complicated by
7 uterine perforation. Next patient I see intrauterine
8 fetal demise. Next patient, I see essentially fetal
9 demise chronic abruption.

10 Next patient, I see nephritis, a renal
11 problem with transfusion. Renal problems often go
12 together with abnormal clotting.

13 The next patient I see again fetal demise.
14 Next patient I see a complication laminaria, but I
15 don't see her indication for the delivery. The next
16 patient, again hospital induction. I see a fetal
17 demise -- patient with fetal demise.

18 The next one I see had a baby with anomalies,
19 so there were two anomalies babies. The next one I see
20 previable ruptured membranes. The next one,
21 intrauterine demise.

22 The next one, previable ruptured membranes.
23 The next one, previable ruptured membranes. The next
24 one, HELLP syndrome. The next one, previable ruptured
25 membranes.

1 So we're talking about very complicated
2 patients except for the two patients with anomalies.
3 The last one, patient with anomaly.

4 The clinic D&E patients, I see one anomaly.
5 And then his quoted elective rate I'm recalling is
6 98 percent. I would want to verify that, but less than
7 2 percent or so is my recollection that had any -- at
8 least theoretical medical complications.

9 So we're talking about very different
10 patients.

11 Q. So you just read out to me the summary of
12 patients from Table 3; is that right?

13 A. I summarized what I saw on Table 3.

14 Q. And Table 3 is referring to the details of
15 cases with major complications; is that right?

16 A. That's correct.

17 Q. So Table 3 is not listing all of the patients
18 in the hospital population who had maternal medical
19 complications; is that right?

20 A. According to Table 3, it's details of cases
21 with major complications, which is he's comparing
22 complications and major complication between the two
23 groups and drawing conclusions about -- because the
24 University of Utah does not do elective abortions.

25 So he's comparing elective abortions in an

1 outpatient setting, primarily, with hospital patients
2 with medical indications with nearly all of the
3 patients with major complications having an underlying
4 medical condition.

5 Q. So I'll refer you to the prior page, the last
6 sentence of the prior page which is, I believe,
7 page 158.

8 So the last sentence of page 158 starts:
9 "The proportion of procedures with major complications
10 was greater --"

11 A. I don't see that. Where are you? "The need
12 for exploratory surgery" is what I'm seeing.

13 Q. Yes, it's that paragraph. It's the last
14 sentence before you hit the bottom of the page.

15 A. Yes. Okay.

16 Q. So the last sentence before you hit the
17 bottom of the page states: "The proportion of
18 procedures with major complications was greater in both
19 the hospital D&E (11 percent) and hospital induction
20 groups (10 percent) compared to the clinic D&E group
21 (1 percent)."

22 And then it continues past the chart. "The
23 overall complication rate was greatest for the hospital
24 induction group, Table 2. Details of major
25 complications are shown in Table 3"; is that correct?

1 A. That is what the -- that is what he wrote.

2 Q. So doesn't that mean that Table 3 is
3 referring to procedure complications, not the
4 complications that the patients came in with?

5 A. It's -- well, you have to put the whole
6 picture together.

7 So these are people who came in and had these
8 procedures done for medical indications and had major
9 complications. So procedure complication rates are
10 affected by the situation.

11 So -- go ahead.

12 Q. I just want to clarify. I think you're
13 stating that Table 3 describes the patients who came in
14 with major complications and experienced major
15 complications during their procedures; is that right?

16 A. Table 3 is patients who had complications of
17 the procedures and some of the details of their medical
18 history.

19 So when I read what he says -- again, when I
20 see a conclusion drawn, then I have to make sure that
21 it makes sense and fits the evidence that is being
22 presented.

23 So when he says that 10 percent with hospital
24 induction, 11 percent hospital D&E versus 1 percent
25 clinic D&E had major complications, I have to say to

1 myself, who are the people -- who are the patients
2 we're talking about, and is it because of location and
3 clinical expertise, or is it because of some other
4 factor?

5 And so then I go to Table 3, and I say wow,
6 those are complicated patients. I don't think you can
7 explain the difference without looking at the patients
8 saying 98 percent in one group don't have any
9 significant medical problems are purely an elective
10 procedure versus the complexity of these patients.
11 They're noncomparable.

12 I can't draw that kind of conclusion. I
13 can't say this is because of location or technical
14 acuity. I have to say, well, the patients had a lot to
15 do with this, their medical history.

16 Q. So is it fair to say that you're assuming
17 that because 98 percent of patients in the clinic D&E
18 group were undergoing elective termination, that they
19 did not have complicated medical histories?

20 A. I'm not -- I'm not saying that. I'm
21 concluding that, but he did not specifically -- I mean,
22 people who are medically complicated like these people
23 are, I just know at the University of Utah you're going
24 to have some complications if they're getting
25 delivered, because they don't do elective terminations.

1 There's always a medical indication in Utah.

2 Q. Are you saying generally that people with
3 complicated medical conditions don't elect to have
4 abortions before they're medically required?

5 MR. BOYLE: Objection.

6 THE WITNESS: I'm sorry. Please repeat that.

7 BY MS. SALVADOR:

8 Q. Are you saying that people with complicated
9 health-care conditions don't choose to have elective
10 abortions?

11 MR. BOYLE: Objection.

12 THE WITNESS: That is not what I'm saying.

13 I am looking at Table 1, maternal medical
14 problems. So, you know, I'm saying when I'm looking at
15 this particular study when I'm looking at the people
16 who had the complications, they're the people I would
17 expect to have complications, and that the acuity of
18 the patients having terminations of their pregnancy at
19 the University of Utah setting is going to be almost
20 completely women with medical problems compared to an
21 outpatient clinic.

22 It's just the patient population that's in
23 each of those clinics.

24 BY MS. SALVADOR:

25 Q. Have you ever performed a multivariate

1 logistic regression model?

2 A. I have not.

3 Q. Do you know how they work?

4 A. I do not.

5 Q. So I will refer you to page 159 in the right
6 column.

7 The first full paragraph of the right column
8 starts with the sentence: "A multivariate logistics
9 regression model was developed to control for the
10 potential confounding effects of maternal medical
11 complications, preexisting infections, infection that
12 developed during the course of termination, parity, and
13 gestation."

14 Did I read that correctly?

15 A. Yes, you did.

16 Q. Are you familiar with -- actually, I retract
17 that question.

18 MS. SALVADOR: I think we are at a good time
19 for a break. Can we go off the record.

20 (Off the record 5:46 p.m. to 5:55 p.m.)

21 BY MS. SALVADOR:

22 Q. So, Dr. Wheeler, what is an ectopic
23 pregnancy?

24 A. An ectopic pregnancy is defined as a
25 pregnancy that has not implanted within the uterine

1 cavity or endometrium.

2 Q. How are ectopic pregnancies detected?

3 A. Well, primarily they're detected by -- you
4 mean how is the diagnosis made? What is your question?

5 Q. Yes. How is a diagnosis of ectopic pregnancy
6 made?

7 A. It's most often made by a patient presenting
8 with symptoms, obtaining an intrauterine -- I'm
9 sorry -- an ultrasound, often abdominal first.
10 Transvaginal if you can't see the pregnancy location,
11 assuming, of course, she has a positive pregnancy test.

12 And if you see the pregnancy is in the
13 endometrial cavity, then it would be very rare to have
14 an heterotopic pregnancy. So typically that's
15 diagnostic by ultrasound.

16 If you don't see the location, then you have
17 to determine where the location is for a woman who
18 presents with symptoms. And that's typically by
19 following hormone levels, quantitative beta hGC levels
20 in the serum.

21 Q. How early can an ultrasound detect a
22 pregnancy?

23 A. Definitively, somewhere between -- typically
24 between five and six weeks you'll see the gestational
25 sac in a normal pregnancy. Typically by six weeks

1 you'll see the embryo with cardiac motion, typically,
2 if there's accurate dating.

3 Q. Have you ever treated a patient with an
4 ectopic pregnancy?

5 A. Yes.

6 Q. About how many patients have you treated with
7 an ectopic pregnancy?

8 A. I don't recall a number.

9 Q. Would you say that treating patients with an
10 ectopic pregnancy was a regular part of your practice
11 when you were an ob-gyn?

12 A. It was definitely part of my practice.
13 Between my practice and the emergency department, yes.

14 Q. Would you say that you saw multiple patients
15 with ectopic pregnancies every year when you were
16 practicing as an ob-gyn?

17 A. I don't know if I can say every year, but I
18 saw multiple patients.

19 Q. When was the last time you treated a patient
20 with an ectopic pregnancy?

21 A. I don't recall if I had any in the last few
22 years at St. Mark's. I can't recall, and I can't
23 recall if I did with residents. I know I definitely
24 did them through my practice at St. -- at Millcreek.

25 Q. Have you ever screened a patient for ectopic

1 pregnancy?

2 A. What do you mean, "screen"?

3 Q. Have you ever evaluated a patient to
4 determine whether they have an ectopic pregnancy?

5 A. Did I ever evaluate as far as work up? Yes.

6 Q. What would be involved in that workup?

7 A. What I've already described. So, you know,
8 essentially either somebody who happens to have high
9 risk factors for ectopic pregnancy and represents with
10 a pregnancy or somebody coming in with pain or with
11 bleeding.

12 And it's the workup I've described to you if
13 they have a positive pregnancy test, and the next step
14 would be to perform an ultrasound in addition to lab
15 work. But getting an ultrasound, identifying if we can
16 see -- you know, if it's definitive if we see the
17 gestational sac and/or embryo in the endometrial
18 cavity. And if not, then you would begin doing
19 quantitative serum beta hGCs.

20 Q. About -- or let me rephrase.

21 Was conducting workups for ectopic pregnancy
22 a regular part of your practice as an ob-gyn?

23 A. I'm not sure what you mean by "regular."
24 It's part of an ob-gyn practice.

25 Q. Would you say that you screened -- or

1 conducted an ectopic workup for a patient of yours
2 multiple times over the course of your time practicing
3 as an ob-gyn?

4 A. Yes.

5 Q. Would you agree that a workup protocol for
6 ectopic pregnancies or for potential ectopic -- sorry.
7 I'll start again.

8 Would you agree that an ectopic workup
9 protocol that uses ultrasound, medical history, current
10 symptoms, and serial hCG testing is appropriate?

11 A. Appropriate for? Please rephrase that.

12 Q. Would you agree that an ectopic workup
13 protocol that uses ultrasound, medical history, current
14 symptoms, and serial hCG testing is an appropriate
15 workup to determine whether someone has an ectopic
16 pregnancy?

17 A. So to qualify, the diagnosis is primarily
18 made with ultrasound, hCGs if we cannot determine the
19 location on ultrasound.

20 The history primarily guides us to the
21 patients who have not presented with pain and bleeding
22 who are pregnant who may need a ruling out of ectopic
23 because they have high risk factors. I see that as a
24 separate category.

25 Q. What is a pregnancy of unknown location?

1 A. What is a pregnancy of unknown location?
2 The definition appears to have evolved in the
3 literature.

4 The current definition in the majority of
5 articles but not all of them is that there's no
6 evidence of gestational sac in the uterine cavity, that
7 essentially it's an empty uterus with a positive
8 pregnancy test.

9 Q. Would you consider a pregnancy of unknown
10 location equivalent to a confirmed ectopic pregnancy?

11 A. No.

12 Q. If a patient has a pregnancy of unknown
13 location but is not experiencing any symptoms of
14 ectopic pregnancy and doesn't have any indicated risk
15 factors for ectopic in their history, would you
16 consider that a suspected ectopic pregnancy?

17 A. So this is a difficult question to answer
18 because clinically that normally is not the case,
19 unless I have somebody who has high risk factors and
20 I'm getting an early ultrasound when they don't have
21 symptoms. The majority of the time we're dealing with
22 patients with symptoms. So it's a hard question to
23 answer.

24 Q. Do you believe that all pregnancies should be
25 assumed to be ectopic until proven otherwise?

1 A. As in every pregnancy should be? No.

2 Q. Do you recall ever treating a patient with a
3 pregnancy of unknown location who didn't have symptoms
4 of ectopic pregnancy or risk factors for it?

5 A. I don't -- I remember having patients who are
6 at a high risk that I identified in early pregnancy as
7 being high risk for ectopic pregnancy that I sent for
8 ultrasounds. I do not recall the outcomes.

9 Q. In your career as an ob-gyn, how early in a
10 patient's pregnancy would you typically perform an
11 ultrasound?

12 A. In a routine pregnancy?

13 Q. Yes.

14 A. So if there is nothing else going on in the
15 pregnancy to indicate an early -- a medical indication
16 for an early one, our typical first one would be
17 somewhere between 16 and 20 weeks as a screening
18 ultrasound.

19 Q. Did it ever happen in your practice where a
20 patient had a positive pregnancy test, but an
21 ultrasound did not detect the pregnancy?

22 A. Did not detect the location of the pregnancy?
23 Yes.

24 Q. What would your next step have been in
25 treating such a patient?

1 A. It depends on her symptoms and whether she's
2 clinically stable.

3 Q. What if that patient didn't have any
4 symptoms, they just came in with a positive pregnancy
5 test and an ultrasound did not detect the pregnancy?

6 MR. BOYLE: Object to form.

7 THE WITNESS: So that would be -- that would
8 be an unusual circumstance for somebody to walk in with
9 an ultrasound and no symptoms.

10 In usual clinical practice, that would be
11 something I don't recall seeing, again, unless they're
12 very high risk. If they're a high risk and she's had
13 an ectopic before, she's going to get an early
14 ultrasound.

15 So that would be the only circumstance I can
16 think of. In that patient, no location, is high risk,
17 my next step if she's stable is to get a quantitative
18 beta hCG, and depending on her symptoms, possibly other
19 labs.

20 BY MS. SALVADOR:

21 Q. If that patient was not having symptoms,
22 would you refer them to the emergency room?

23 MR. BOYLE: Object to form.

24 THE WITNESS: I'll be coy. The emergency
25 room is just going to call me, so -- we manage our own

1 patients with ectopic pregnancies.

2 So I wouldn't be sending her to the emergency
3 room unless she was unstable or it was after hours and
4 that's the only place I could obtain the workup that
5 she needed.

6 BY MS. SALVADOR:

7 Q. What happens if an ectopic pregnancy
8 ruptures?

9 A. Well, that varies with the patient, so
10 there's a lot of potential different scenarios, but
11 it's a high risk situation. It's a life-threatening
12 situation.

13 Q. What makes it a life-threatening situation?

14 A. Hemorrhage. Intraabdominal hemorrhage.

15 Q. What are the symptoms of ectopic rupture?

16 A. A ruptured ectopic. You know, I've been
17 impressed with patients with ectopics. It's been one
18 of the hardest parts of my career because the symptoms
19 are all over the place.

20 But once they rupture, the majority of women
21 are going to have a very severe localizing pain as
22 opposed to general pain. If there is a huge amount of
23 blood in the abdomen already, they may syncope. They
24 may die quickly. They may have irritation of the
25 diaphragm, so right upper quadrant pain and right

1 shoulder pain. They may have dizziness.

2 Q. Would people experiencing ectopic rupture
3 potentially feel a popping sensation?

4 MR. BOYLE: Objection.

5 THE WITNESS: You know, I'm not aware of any
6 patient ever telling me that. That's not something I
7 typically associate, a popping sensation. That's --
8 I've never heard a patient say that.

9 BY MS. SALVADOR:

10 Q. You referred to bleeding. About how much
11 external bleeding is there with a typical ectopic
12 rupture?

13 A. Ectopic rupture doesn't necessarily cause
14 vaginal bleeding. So the definition -- the pain -- it
15 could be pain. It could be bleeding. But typically
16 we're not -- we're talking about, with rupture,
17 intraabdominal bleeding. That's the point.

18 Q. In your experience as an ob-gyn, did you
19 treat patients who had miscarriages prior to 11 weeks
20 LMP?

21 A. Yes.

22 Q. What are the typical symptoms of a
23 miscarriage prior to 11 weeks LMP?

24 A. Again, it's variable, and it depends on the
25 definition, where she is in that process of

1 miscarriage.

2 Q. What are some of the symptoms that came up
3 frequently in your practice for patients having
4 miscarriages prior to 11 weeks LMP?

5 A. It was variable. So it could be just some
6 spotting. It could be minimal spotting. It could be
7 minimal cramping. It could be heavier bleeding. It
8 could be just some vaginal discharge that was
9 different. It could be some low back pain.

10 Q. You testified earlier that you've never
11 provided a medication abortion; is that correct?

12 A. That is correct.

13 Q. In fact, all of the abortion training you
14 received in your residency predated the FDA approval of
15 mifepristone for abortion; is that correct?

16 A. Yes, that's correct.

17 Q. What training and education have you received
18 on medication abortion over the course of your career?

19 A. So primarily with my board certifications and
20 just typical keeping up with literature. So I read the
21 literature.

22 Q. Did you receive any training on medication
23 abortion from AAPLOG?

24 A. Training to perform medication abortion?

25 Q. No. Just training on the subject of

1 medication abortion.

2 A. I was not trained by AAPLOG in any manner
3 regarding that. I did not receive any specific
4 training on medication abortion. I've read the
5 literature, a good sample of the literature.

6 Q. What literature on medication abortion have
7 you reviewed?

8 A. Well, I can't cite the specific ones, but
9 when mifepristone and misoprostol were initially coming
10 out, I read studies. I can't cite the exact ones.
11 That's been a while.

12 But I remember reading it with interest,
13 wondering about it, reading about it. Of course, it's
14 been on the board certification which I've continued to
15 do through the years. I have read quite a bit just in
16 my curiosity about it, and I have -- so I've read quite
17 a bit about it as my curiosity about it.

18 Q. Have you read any literature on medication
19 abortion apart from the sources that are cited in your
20 report?

21 A. I'm sure I have. As I said, I try to keep up
22 on things. I don't read everything, but I try to
23 sample things that are things that I don't yet know or
24 to add to what I know.

25 Q. Can you recall any specific literature on

1 medication abortion that you've reviewed that you did
2 not cite in your report?

3 A. On the top of my head, I can't recall to tell
4 you exact ones. I think I have cited my most -- I've
5 cited in there the ones that I felt were relevant to my
6 discussion for today.

7 Q. Other than your participation as a witness in
8 this lawsuit, in what circumstances have you considered
9 the safety of providing medication abortion to patients
10 with pregnancies of unknown location?

11 MR. BOYLE: Object to form.

12 THE WITNESS: Yeah, I'm not sure -- I want to
13 make sure I'm following your question. Can you please
14 repeat that.

15 BY MS. SALVADOR:

16 Q. Sure.

17 Did the safety of providing medication
18 abortion to patients with pregnancies of unknown
19 location come up in your medical training?

20 A. No, it did not.

21 Q. Did the safety of providing medication
22 abortion to patients with pregnancies of unknown
23 location ever come up in your clinical practice?

24 A. The question of safety did not, no.

25 Q. Had you read any medical or scientific

1 publications on the safety of providing medication
2 abortion to patients with pregnancies of unknown
3 location before beginning work on this case?

4 A. No, I had not.

5 Q. Let's go to paragraph 54 of your report,
6 please.

7 A. Paragraph 54; is that correct?

8 Q. Yes. That's right.

9 A. Okay. I have it.

10 Q. In paragraph 54, you have written here: "Due
11 to the similarity of symptoms of chemical abortion and
12 of ectopic pregnancy, it is not possible for the
13 patient to be able to discern what are normal symptoms
14 of medical abortion and what symptoms require urgent
15 attention for possible ectopic pregnancy."

16 Did I read that correctly?

17 A. Yes, you did.

18 Q. Would talking to a medical professional help
19 a patient determine whether their symptoms are normal
20 for medication abortion or whether they require urgent
21 attention for possible ectopic?

22 MR. BOYLE: Object to form.

23 THE WITNESS: To know based on the symptoms
24 alone, as a medical professional, the symptoms are so
25 similar you can't -- based on history, you can't

1 distinguish the two based on the normal use of medical
2 abortion and the symptoms prior to ectopic rupture.

3 BY MS. SALVADOR:

4 Q. Would it be fair to say that it is not
5 possible for a patient to distinguish between symptoms
6 of medication abortion and symptoms of possible ectopic
7 pregnancy on their own without medical guidance?

8 MR. BOYLE: Object to form.

9 THE WITNESS: The symptoms are essentially
10 the same, so asking the patient to decide whether their
11 symptoms are one or the other places the patient at
12 risk.

13 BY MS. SALVADOR:

14 Q. So is it fair to say that a patient should
15 seek medical guidance in order to distinguish between
16 symptoms of medication abortion and symptoms of
17 possible ectopic pregnancy?

18 MR. BOYLE: Objection.

19 THE WITNESS: The patient's not going to be
20 able to differentiate. They're -- the symptoms are the
21 same. So telling a patient to come in if you have
22 these symptoms, those are the symptoms that patients --
23 I know people who have taken medical abortion. I've
24 heard the stories, personal stories. The symptoms are
25 very similar.

1 BY MS. SALVADOR:

2 Q. So would it be fair to say that somebody who
3 has received a medication abortion should seek medical
4 guidance if they are concerned about their symptoms?

5 A. Well, certainly any patient who's concerned
6 about their symptoms should seek guidance.

7 Q. In paragraph 65 of your report -- please let
8 me know when you're there.

9 A. Yes, I'm there.

10 Q. In paragraph 65 of your report, you quote
11 ACOG Practice Bulletin 193's statement that "Serum hCG
12 alone should not be used to diagnose an ectopic
13 pregnancy"; is that correct?

14 A. Yes.

15 Q. Is it your understanding that Planned
16 Parenthood South Atlantic uses hCG alone to diagnose
17 ectopic pregnancy?

18 A. It is my understanding that with
19 intrauterine -- without seeing an intrauterine
20 pregnancy, so a pregnancy of undetermined location,
21 that at that point serum hCGs are followed and only
22 repeated if there's a question about the 2,000 -- the
23 use of 2,000 discriminatory zone, or if they have
24 particular symptoms.

25 Otherwise, they're following serum hCG if

1 they're following and not distinguishing.

2 Q. So my question was is it your understanding
3 that Planned Parenthood South Atlantic uses serum hCG
4 alone to diagnose ectopic pregnancy?

5 A. I think the question is whether they're
6 diagnosing ectopic pregnancy.

7 So I'm not -- you know, I don't work there,
8 so I'm not sure exactly what they're doing. I've only
9 seen their protocol.

10 Q. Is it your understanding that Planned
11 Parenthood South Atlantic provides medication abortion
12 to patients with pregnancies of unknown location
13 without those patients having an ultrasound?

14 A. What I've seen is the report of Dr. Farris
15 and the report that they use that protocol. So I don't
16 know if they're doing a protocol ultrasound on
17 everybody.

18 Q. Let's go to paragraph 78 of your report.

19 A. Yes.

20 Q. In paragraph 78 of your report, you state
21 that Planned Parenthood South Atlantic's protocol
22 "May" -- and I'm quoting from the second half of the
23 paragraph, which is on the following page -- quote:
24 "May place women at increased risk of complications
25 from undiagnosed ectopic pregnancy, including a delay

1 in diagnosis"; is that correct?

2 A. Yes.

3 Q. What part of the IUP documentation
4 requirement ensures that patients will be screened for
5 ectopic pregnancy?

6 A. Please repeat that.

7 Q. Sure.

8 What part of the IUP documentation
9 requirement ensures that patients will be screened for
10 ectopic pregnancy?

11 A. What part of whose IUP document?

12 Q. I'm referring to the IUP documentation
13 requirement that's being challenged in this case.

14 A. Okay. So I'm sorry. I'm just -- I don't
15 know why I'm having trouble following this. Go ahead
16 and just ask me again, please.

17 Q. Sure.

18 Does the IUP documentation requirement being
19 challenged in this case --

20 A. Oh, okay.

21 Q. -- ensure that patients will be screened for
22 ectopic pregnancy?

23 A. My understanding of this is to be sure that
24 an intrauterine pregnancy is documented prior to giving
25 abortion medication.

1 Q. So is it your understanding that the IUP
2 documentation requirement prevents patients with
3 pregnancies of unknown location from obtaining a
4 medication abortion?

5 A. My understanding is if they don't have a
6 documented intrauterine -- if you cannot document that
7 they have an intrauterine pregnancy, then the
8 medication should not be given until that is
9 documented.

10 Q. Does the IUP documentation requirement
11 require that patients be screened for ectopic
12 pregnancy?

13 A. Well, it requires them to have a documented
14 intrauterine pregnancy, so that would go hand in hand
15 with verifying where the -- where the pregnancy is.

16 So the effect of that is, yes, you're ruling
17 out an ectopic pregnancy, making sure it's intrauterine
18 before you give medication that's meant for
19 intrauterine pregnancies that are undesired.

20 Q. Does the IUP documentation requirement ensure
21 that patients will receive a full ectopic workup?

22 A. What it does, it has a specific intent. The
23 way that I'm interpreting it is to make sure they have
24 an intrauterine pregnancy. That appears to be the
25 focus.

1 As a medical professional, it is my medical
2 responsibility as the caretaker of this patient if
3 there's a question that she might have an ectopic to
4 manage her appropriately. I don't need a law for that.

5 Q. And the law doesn't require that, does it?

6 MR. BOYLE: Objection.

7 THE WITNESS: This law -- no, this law
8 doesn't, but that's part of -- I mean, that's medical
9 malpractice if you don't know where the pregnancy is
10 and she has symptoms and there's a question of her
11 health, that's medical malpractice to not determine
12 where it is.

13 If I have a patient I'm concerned about an
14 ectopic pregnancy, I don't need a law for that.

15 BY MS. SALVADOR:

16 Q. Staying in paragraph 78, the very last
17 sentence of paragraph 78, you state that: "Abortion is
18 most commonly not required in such situations due to
19 the high rate of spontaneous abortion in women with
20 ectopic pregnancies"; is that right?

21 A. That's what it says. That is an editing
22 error, and that should say "with pregnancies with
23 undetermined location."

24 That was a conclusion. I was just bringing
25 down my conclusions, and I see I should have put "with

1 pregnancies of undetermined location."

2 Q. Are you -- I'm sorry. Could you clarify what
3 the sentence should have been.

4 A. It should say: "Moreover, abortion is most
5 commonly not required in such situations due to the
6 high risk of spontaneous abortion in women with
7 pregnancies of undetermined location."

8 Q. Understood.

9 Is that because you believe that spontaneous
10 abortion is preferable to induced abortion?

11 A. It doesn't have any moral judgment for me.
12 It's just the way it is in the studies showed that --
13 and I cited the studies that the women in this
14 situation had a very high rate of not taking the
15 medication if they have a delay in treatment, and the
16 delay treatment are a very large number of them
17 spontaneously miscarry with no medical intervention.

18 In other words, it would be overtreatment to
19 prescribe them the medication in that circumstance.
20 Most of them didn't need it.

21 Q. Do you believe that a person's desire for
22 medical treatment is a valid reason for clinical
23 urgency?

24 A. Those are big questions. I'm not sure how to
25 answer that. Can you restate it.

1 Q. Sure.

2 Do you believe that a person's desire to have
3 a medical procedure is a valid reason for clinical
4 urgency?

5 A. Well, I -- I mean, that's conjecture. It
6 depends on what the situation is.

7 You know, medical urgency -- "urgency"
8 typically means that there's something urgent
9 happening, so it would depend on the situation.

10 Q. Do you believe that a person's desire not to
11 be pregnant against their will could be a valid reason
12 for clinical urgency?

13 A. Are we talking about rape and incest?

14 Q. Let's start with rape and incest.

15 Do you -- do you believe that a person's
16 desire if they're the victim of rape or incest not to
17 be pregnant against their will is a valid reason for
18 clinical urgency?

19 A. In what manner are you talking clinical
20 urgency? Like --

21 Q. So I'll refer you to paragraph 64 of your
22 declaration -- of your report.

23 A. Okay.

24 Q. So in the middle of paragraph 64 of your
25 report, you state: "There is no clinical urgency nor

1 clinical benefit to treating a woman with PUL with
2 chemical abortion"; is that correct?

3 A. Yes.

4 Q. So do you believe that a person's desire not
5 to be pregnant against their will could ever be a valid
6 reason for clinical urgency?

7 A. Well, again, we're -- I'm talking
8 specifically about dealing with PUL, and so I'm talking
9 about a very specific situation is what I'm talking
10 about in 64.

11 Q. So you did not answer my question, which was
12 do you believe that a person's desire not to be
13 pregnant against their will could ever be in any
14 situation a valid reason for clinical urgency?

15 A. Again, it would depend on the rest of the
16 clinical situation, but the only people who are
17 pregnant against their will are people who have been
18 forced into becoming pregnant.

19 So we're talking about abuse, we're talking
20 about rape, and we're talking about incest. Is there a
21 clinical urgency where I have to do something today
22 about that? No.

23 MS. SALVADOR: Thank you, Dr. Wheeler. I
24 think we're wrapping up.

25 Can we just take another quick break, and

1 then we'll see if there are any questions left.

2 (Off the record 6:32 p.m. to 6:42 p.m.)

3 BY MS. SALVADOR:

4 Q. Dr. Wheeler, are you testifying today as an
5 expert in second-trimester D&E for miscarriage
6 management?

7 A. D&E, yes.

8 Q. Are you testifying as an expert in
9 second-trimester D&E for induced abortions?

10 A. Yes.

11 Q. Are you testifying as an expert in
12 first-trimester D&C for miscarriage management?

13 A. Yes.

14 Q. Are you testifying as an expert in
15 first-trimester D&C for induced abortion?

16 A. Yes.

17 Q. Are you testifying as an expert in medication
18 abortion?

19 A. Are you saying as having performed them, or
20 as having the knowledge and expertise?

21 Q. Are you testifying as having expertise in
22 medication abortion?

23 A. Yes.

24 Q. Are you familiar with what's required for
25 doctors to get hospital admitting privileges in

1 North Carolina?

2 MR. BOYLE: Object to form.

3 THE WITNESS: Not in North Carolina.

4 BY MS. SALVADOR:

5 Q. Do you know how many hospitals provide
6 abortions in North Carolina?

7 A. I am not privy to that.

8 Q. Do you know how much hospitals charge
9 patients who obtain abortions in North Carolina?

10 A. I do not have that information.

11 Q. Would it be fair to say that all surgeries
12 carry some level of risk?

13 A. Yes.

14 Q. Does that include some risk of complications
15 requiring treatment in a hospital?

16 A. It depends on the procedure.

17 Q. Would you say that there are any surgeries
18 that don't carry a risk of complications requiring
19 treatment in a hospital?

20 A. Is it possible that anything that you do to a
21 patient could require a hospitalization? It's
22 possible.

23 Q. But we don't require all surgeries to be
24 performed in hospital operating rooms; right?

25 MR. BOYLE: Objection. Who's "we"?

1 BY MS. SALVADOR:

2 Q. Sure.

3 When you were a practicing ob-gyn, were you
4 required to perform all surgeries in a hospital
5 operating room?

6 A. All surgeries in a hospital? No.

7 Q. Do you think it would be good medical
8 practice to require all the surgeries you performed to
9 take place in a hospital?

10 MR. BOYLE: Objection. Object to form.

11 THE WITNESS: Every single surgical-type
12 procedure in a hospital as a requirement? It depends
13 on the surgery.

14 I mean, every single surgery or procedure
15 that you perform on someone, you have to weigh whether
16 there's a risk that it would be safest for the patient.
17 So you're always determining where it's safest -- to
18 perform this surgery or procedure depending on what it
19 is.

20 BY MS. SALVADOR:

21 Q. I'm sorry. You kind of -- I couldn't hear
22 you as well toward the end of that answer. Could you
23 repeat it.

24 A. I'm sorry. My voice is going. Can you
25 please repeat your question so I make sure I'm

1 answering it.

2 Q. Sure.

3 Do you think it would be good medical
4 practice to require every surgery that you performed as
5 an ob-gyn to take place in a hospital?

6 MR. BOYLE: Objection. And object to form.

7 THE WITNESS: So, again, my choice of
8 location always would be based on the procedure, the
9 patient, the circumstance. So it would depend on the
10 clinical situation and the patient.

11 BY MS. SALVADOR:

12 Q. In paragraph 33 of your report -- please let
13 me know when you get there.

14 Yes?

15 A. Yes, I'm there.

16 Q. The second sentence of paragraph 33 is:
17 "Patient safety is more important than not the
18 relatively small inconveniences of performing abortion
19 in a hospital."

20 Did I read that correctly?

21 A. You read it correctly. The "not," I believe,
22 was from editing and moving the paragraphs around and
23 revising it, that when it was revised I -- that's in
24 editing.

25 Q. So were you trying to say that "Patient

1 safety is more important than the relatively small
2 inconveniences of performing abortion in a hospital"?

3 A. That is correct.

4 Q. What do you mean -- or what did you mean when
5 you referenced "patient safety" here?

6 A. Well, let me go to what was just before that.

7 So in this section we're talking about
8 dilation and evacuation and the location of that
9 procedure.

10 And in my assessing it, as in all of my
11 medicine, that I'm always going to put the patient's
12 safety and best interests before a concern for access.
13 I'm always going to want to do what's in my patient's
14 best interest and in the safest way that I can provide
15 that.

16 So there may be some things that are
17 inconvenient sometimes for my patient, but as they say,
18 safety first.

19 Q. When you're referring to patient safety here,
20 do you mean ensuring that any possible complication can
21 be treated on-site?

22 A. There are multiple aspects to patient safety.
23 Some of them are trying to avoid complications. Some
24 of them are trying to provide it in an environment
25 that's going to be safest. Some of it is going to be

1 able to manage complications or emergencies should they
2 arise, what additional resources are available. The
3 situation where a complication arises, what's the
4 likelihood of that.

5 Those -- there are many factors such as that
6 that go into addressing am I doing this in her best
7 interest and in the safest way that I'm able.

8 Q. Do you -- you previously testified that
9 gynecology is very patient specific; right?

10 A. I'm sorry. Can you ask that again.

11 Q. Sure.

12 You previously testified that providing
13 gynecological care is very patient specific; right?

14 A. I'm not quite sure what you're asking.

15 Q. So you testified that whenever you were
16 providing care or treatment to somebody as a
17 gynecologist, that treatment would vary depending on
18 the patient's individual circumstances and needs; is
19 that right?

20 A. That's correct.

21 Q. And was the same true of your obstetrics
22 practice?

23 A. Yes.

24 Q. You testified more specifically that each
25 D&C you performed was very individualized based on the

1 specific circumstances of each patient; is that right?

2 A. That's correct.

3 Q. And you testified that you provided D&Cs for
4 miscarriage management; is that right?

5 A. Yes.

6 Q. And that you performed just one D&C for
7 abortion purposes; is that right?

8 A. For elective induced abortion, yes.

9 Q. Did you perform D&Cs for any other purposes?

10 A. Gynecology.

11 Q. And what do you mean when you say you
12 performed a D&C for gynecology?

13 A. So there would be many different indications,
14 but say I'm ruling out a uterine cancer or I am -- the
15 patient has prolonged heavy bleeding and is not
16 pregnant and I need to sample her endometrium, things
17 like that.

18 Q. Would you say that each D&E you performed was
19 very individualized based on the specific circumstances
20 of each patient?

21 A. Yes.

22 Q. Given the patient-specific variables, do you
23 believe it's possible to make categorical statements
24 about the safety of D&Es?

25 A. My categorical statement is that I'm going to

1 take patient safety as a priority over inconvenience.
2 My job in medicine is to minimize -- is to do the best
3 I can for my patient and minimize risk.

4 Q. You testified previously that the literature
5 says that providers, again, performing D&E at around
6 13 to 14 weeks' gestation; is that right?

7 A. Please repeat that.

8 Q. Sure.

9 You testified that according to the
10 literature, providers begin performing D&Es around
11 13 to 14 weeks' gestation; is that right?

12 A. That's correct.

13 Q. Did you review any literature on that other
14 than what is cited in your report?

15 A. I've read so much about that over time.
16 Specifically for this, I chose the references that
17 would address the questions. But, yes, I've done a
18 fair amount of reading on that.

19 Q. Did anyone recommend that you review specific
20 articles or materials on this point?

21 MR. BOYLE: Objection.

22 And I'll instruct you not to answer about
23 anything that was a discussion between lawyers and you.

24 And if you can't answer, just tell her you
25 can't answer, please.

1 THE WITNESS: I'm not able to answer that.

2 BY MS. SALVADOR:

3 Q. Did anyone other than your attorneys
4 recommend that you review specific articles or
5 materials on when providers begin performing D&E?

6 A. No.

7 Q. Did anyone -- did you review those
8 materials -- did you review any particular materials to
9 refresh your memory before this deposition?

10 MR. BOYLE: Objection.

11 THE WITNESS: I reviewed what I cited.

12 BY MS. SALVADOR:

13 Q. Which particular materials did you review on
14 the point that providers begin performing D&E around
15 13 to 14 weeks' gestation?

16 A. So I reviewed my citations, and so whatever
17 is cited here, I reviewed.

18 Q. So to summarize, is it accurate to say that
19 over the course of your career, you provided one D&C
20 elective abortion; is that correct?

21 A. One D&C elective induced abortion, yes.

22 Q. Is it fair to say that you provided that
23 elective abortion before approximately the year 2000?

24 A. I don't recall the year. It was somewhere in
25 my earlier part of my practice.

1 Q. You had said before that it was in the
2 earlier part of your time at Millcreek; is that
3 correct?

4 A. That's right.

5 Q. Is it accurate to say that you provided D&E
6 abortion to a small number of patients while you were
7 at Millcreek?

8 A. I don't remember the number, but I did
9 provide them at Millcreek, yes.

10 Q. I believe that you had -- you testified
11 before that you provided abortions infrequently; is
12 that correct?

13 A. I don't remember the exact word that I used
14 but --

15 Q. I'm sorry. What was the last thing you said?

16 A. I don't remember the exact word I used, but I
17 did not perform them frequently.

18 Q. So is it accurate to say that you did not
19 provide D&E abortions frequently during your time at
20 Millcreek?

21 A. Yes, that's accurate.

22 Q. And is it accurate that you did not provide
23 D&E abortions after you left Millcreek?

24 A. Induced abortions, I don't recall doing any
25 after leaving Millcreek.

1 Q. Is it accurate to say that you have never
2 provided medication abortion?

3 A. That is accurate.

4 Q. Is it accurate to say that you have never
5 provided aspiration abortion, meaning using suction
6 only?

7 A. Again, I don't recall the one -- the one that
8 I did in the first trimester, I don't recall if that
9 was completely aspiration. It was aspiration was used.
10 I just don't have specific memories whether I had to
11 use a curette.

12 Q. And are you referring to the one elective D&C
13 that you performed that we've discussed?

14 A. Yes.

15 Q. Do you have any experience providing abortion
16 other than what we've discussed?

17 A. No.

18 Q. And when you provided D&E abortions, do you
19 recall whether those were performed in a hospital
20 operating room or in an ambulatory surgical center?

21 A. I've answered that. And my recollection,
22 again, I have specific memory of one in an operating
23 room. I don't recall on the other ones exactly, again,
24 if I did them. But, again, I don't recall the exact
25 circumstances. I have a definite, distinct memory of

1 one in an operating room in the main OR.

2 MS. SALVADOR: Thank you, Dr. Wheeler. I
3 have no further questions.

4 MR. BOYLE: Is it my turn?

5 EXAMINATION

6 BY MR. BOYLE:

7 Q. Dr. Wheeler, good evening.

8 My name is Ellis Boyle. I represent the
9 intervenor defendants. I have some questions for you.
10 Thank you for your time here today, first.

11 Is it true that the placenta with a patient
12 mother who is having a miscarriage is already working
13 on unhooking itself, the blood vessels and such from
14 the mother's womb, and removing the dead baby from the
15 woman's body at the point that you would be doing a D&C
16 or a D&E on a patient with a miscarriage?

17 A. It's true that most of the time, but when you
18 diagnose it, it's -- usually there's been some time
19 since the baby passed, and usually some of those
20 processes are naturally happening.

21 Q. So it would be true, then, with the situation
22 where mother had a miscarriage and the baby was
23 stillborn yet still inside her womb that the blood
24 vessels from that mother's uterus to the placenta would
25 be clotting and already naturally preparing themselves

1 to detach when that deceased stillborn baby is removed
2 from the mother's body if it happened naturally; is
3 that correct?

4 A. Yes. Usually by the time of diagnosis there
5 are some changes in the placenta.

6 Q. And that would be different than the placenta
7 for an induced abortion context where the baby is alive
8 up until the point of the induced abortion, and all of
9 the blood vessels that are connected and actively
10 engaged from the mother's body in the uterus to the
11 placenta are sending blood and nutrients and oxygen
12 into the baby, the developing baby's body and taking
13 out waste products to help that baby grow and develop;
14 is that correct?

15 A. Yes.

16 Q. And so when you're cutting out a live baby in
17 an induced abortion and the placenta is not clotted off
18 and all the blood vessels are active and sending and
19 receiving blood from the mother's body to the baby's
20 body, would you agree that that is a situation with an
21 induced abortion that could lead to much more bleeding
22 and hemorrhage than you would typically find in a
23 miscarriage situation?

24 A. In my clinical experience -- first I'd say
25 we're not cutting the baby out. We're usually grasping

1 and pulling out. So I'd clarify that.

2 But my clinical experience is the bleeding is
3 typically entirely different. Much heavier bleeding.
4 Literally you put your instrument in sometimes, and
5 it's a bloodletting when there is a live baby.

6 Q. And, in fact, though -- I realize you're
7 grasping the baby's body and sometimes dismembering it
8 and pulling it out of the uterus, but at a minimum, the
9 placenta itself is connected with live, active,
10 back-and-forth transfer of blood, blood vessels to the
11 mother's uterus, and that's why the "C" is the
12 curettage where they scrape that off of the uterine
13 wall; correct?

14 A. Typically there's usually not mixing of
15 blood, but there's a big deal of spaces, and you're
16 most of the time suctioning as much out as you can
17 using the curette as little as possible, but between
18 the two of those, removing it, yes.

19 Q. And there was a whole line of questions about
20 a colposcopy biopsy earlier, and I may be saying that
21 wrong.

22 But is that in any way, shape, or form as
23 dangerous as performing a surgical abortion, when you
24 simply take a tiny pinch of tissue from outside the
25 uterus when -- with the biopsy, as opposed to dilating

1 the cervix, going into the uterus, sucking out the
2 baby, dismembering the baby on occasion, and scraping
3 off the placenta from the uterine walls? Would you
4 agree that that's a completely different and far less
5 dangerous procedure?

6 A. I would agree with that.

7 Q. When you were looking at the Turok report,
8 the study, does the Turok study support your opinion
9 that it is safer for patients with dangerous conditions
10 to have surgical abortions in a hospital setting
11 because more of the resources for those patients with
12 complicated medical presentations are present and
13 available in the hospital, than performing that same
14 procedure in an outside outpatient clinical setting
15 which if the patient did suffer one of those
16 complications with their complicated presentation in
17 the outside clinic, the practitioner would then have to
18 emergently rush that patient to the hospital to deal
19 with those complications in the hospital?

20 A. Yes.

21 Q. And I just want to make sure. Was that the
22 point you were trying to make when you looked at
23 Table 3 in the Turok study?

24 A. Yes. So the very complicated patients
25 were -- extreme complicated patients were being managed

1 at the hospital, which increased the likelihood of
2 those outcomes.

3 Q. Right. And it's sort of a self-selection
4 process where if you've got a patient that's so
5 complicated that it's good to start them in the
6 hospital, and when you have complicated patients you
7 want them to be in a hospital, not in an outpatient
8 setting where they might bleed to death if they have a
9 complication before they are emergently rushed to the
10 hospital; is that correct?

11 A. Yes.

12 Q. I want to talk about your study of providing
13 abortion drugs to patients with pregnancy of unknown
14 location.

15 You did not study the safety of providing
16 abortion drugs to a patient with a pregnancy of unknown
17 location on an ultrasound finding, because it was not
18 considered a safe thing to do without first determining
19 if that patient had an intrauterine pregnancy or an
20 ectopic pregnancy using an ultrasound to rule in or
21 rule out ectopic pregnancy; isn't that right?

22 A. I'm sorry. Would you mind repeating that.

23 Q. Yes.

24 You did not study the safety of providing
25 abortion drugs to a patient with a pregnancy of unknown

1 location, because it was not considered safe to do so
2 without first taking an ultrasound and ruling in or
3 ruling out an ectopic pregnancy for that patient; isn't
4 that right?

5 A. I don't understand the beginning where you
6 asked about study, did I study.

7 I didn't practice that. I wasn't trained in
8 that. We weren't doing that.

9 Q. That's what I'm asking.

10 A. That's what you're asking?

11 Q. Yeah.

12 A. Yes. Right.

13 Q. In fact, is it not true that in 2018 in ACOG
14 Practice Bulletin 193 titled "Tubal Ectopic Pregnancy,"
15 it says that the way to diagnose an ectopic pregnancy
16 or to rule it out is by positive confirmation in an
17 ultrasound; right?

18 A. Yes.

19 Q. And when that ACOG Bulletin 193 says that
20 serum hCG alone is not enough to diagnose ectopic
21 pregnancy, what it means is that you also need to have
22 that ultrasound to rule it in or rule it out; right?

23 A. Yes.

24 Q. And that's the standard of care; right?

25 A. Yes.

1 Q. The ACOG Bulletin 193 statement does not say
2 that Planned Parenthood can use serum hCG and patient
3 interviews in combination without having an ultrasound
4 that rules in or rules out an ectopic pregnancy before
5 giving chemical abortion drugs, does it?

6 A. No, it does not.

7 Q. And Planned Parenthood provides chemical
8 abortion drugs to patients that it takes an ultrasound
9 and has a pregnancy of unknown location before Planned
10 Parenthood gets an affirmative ultrasound reading to
11 rule in or rule out an ectopic pregnancy; isn't that
12 right?

13 A. Per protocol in Dr. Farris's report, yes.

14 Q. So Planned Parenthood might give a patient an
15 initial ultrasound, but if that ultrasound shows that
16 it is a pregnancy of unknown location, then Planned
17 Parenthood has a protocol that they use to give the
18 chemical abortion drugs to that patient anyway, even
19 though they've not yet received an ultrasound that
20 rules in or rules out an ectopic pregnancy; isn't that
21 right?

22 A. Yes.

23 Q. If a patient wants you to perform a dangerous
24 medical procedure, you wouldn't perform that dangerous
25 medical procedure just because the patient wanted to do

1 it, would you?

2 A. If that's the sole indication, no.

3 Q. If a patient has a desire for you to perform
4 a dangerous medical procedure, that does not create
5 some exception to your duty to follow the Hippocratic
6 Oath, the law, and the standard of care when you're
7 making a decision of how to treat that patient, does
8 it?

9 A. No, it does not.

10 Q. Wouldn't you agree that if you have a patient
11 who you give an ultrasound to and it is determined that
12 they have a pregnancy of unknown location such that you
13 had not ruled in or ruled out an ectopic pregnancy,
14 that even if it may be a bit inconvenient for that
15 patient to wait a few days and take another ultrasound
16 to determine whether the ectopic pregnancy is ruled in
17 or ruled out affirmatively by an ultrasound, that it
18 may inconvenience the patient, but it is safer for the
19 patient and the standard of care?

20 A. In seeking abortion, medication abortion? Is
21 that the question?

22 Q. Yes.

23 A. Yes. Yes, it would definitely be safer for
24 the patient to wait a few days for diagnosis.

25 Q. And when you look at the Planned Parenthood

1 protocol that they are advocating in this case and you
2 look at the studies that have -- they rely upon that I
3 believe came out in 2022 or so, those are not reflected
4 in the ACOG bulletins as the standard of care, are
5 they?

6 A. No.

7 MR. BOYLE: No further questions.

8 MS. SALVADOR: I have a couple more based on
9 your follow-up, Counsel, but does anyone else on the
10 call want to ask any questions?

11 EXAMINATION

12 BY MS. SALVADOR:

13 Q. All right. Dr. Wheeler, you testified that
14 you're not aware of any medical literature comparing
15 the risks of complications from a D&E for abortion to
16 the risk of complications from a D&E for miscarriage
17 management; is that correct?

18 A. I was not able to locate any.

19 Q. So your opinions on the comparative risks of
20 these procedures are based on your memory of your
21 personal experience; is that right?

22 A. They're based on my experience in the
23 operating room.

24 Q. You just answered a line of questions from
25 Mr. Boyle about the risk of bleeding from D&E for

1 abortion as compared to the risk of bleeding from a D&E
2 for intrauterine fetal demise; right?

3 A. Yes.

4 Q. But you don't recall the specific clinical
5 setting where you performed the D&E that you described;
6 is that right?

7 A. Which D&E? The one that I described in my
8 answer?

9 Q. That's right.

10 A. No. It's just my very clear memories of what
11 it was like to sit down and do elective terminations as
12 D&Es.

13 Q. So that D&E for induced abortion that you
14 referred to as a bloodletting may have occurred in an
15 ASC rather than in a hospital operating room; is that
16 right?

17 A. It would be very unlikely.

18 Q. But you don't recall where it occurred; is
19 that right?

20 A. Again, I can't recall which operating suite I
21 was in. I can tell you my standard practice. You
22 didn't ask my standard practice, but --

23 Q. So it might have occurred in the suite at
24 St. Mark's Ambulatory Surgical Center; is that right?

25 A. Possible, but very unlikely.

1 Q. Do you recall whether that D&E patient
2 required transfer for a higher level of care?

3 A. I don't recall ever transferring a patient,
4 again. You know, I just remember the differences in
5 the procedure. I don't remember ever having to
6 transfer a patient for a second-trimester D&E. But
7 most of the time I would have been -- potentially all
8 the times I was in the main OR.

9 Again, I want to answer honestly, so --

10 Q. So you -- I'm so sorry.

11 A. I don't have specific recollections that I
12 can tell you exactly where I was. My practice would
13 have been to be in a main OR.

14 Q. So you recall the briskness of this specific
15 patient's bleeding, but not whether you were in a
16 hospital OR when it occurred; is that right?

17 A. My recollection is of being in an OR, and my
18 statement is in general sitting down for them, you
19 often would put in your instruments and there would be
20 incredibly brisk bleeding.

21 Q. But you don't recall whether it was in a
22 hospital OR specifically; right?

23 A. My practice would have been in an OR. Again,
24 I can't say -- I want to be very -- I want to be a
25 hundred percent truthful. So can I say I ever did one?

1 I don't recall ever doing one in an outpatient surgical
2 center, but I can't remember exactly where I was in all
3 of them.

4 MS. SALVADOR: Thank you. I have no further
5 questions.

6 MR. BOYLE: Nothing further from me.

7 THE COURT REPORTER: E-tran for you,
8 Ms. Salvador?

9 MS. SALVADOR: Yes, please.

10 THE COURT REPORTER: And, Mr. Boyle?

11 MR. BOYLE: I'd like a PDF please.

12 (Signature not reserved.)

13 (Deposition concluded at 7:16 p.m.)

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CERTIFICATE OF REPORTER

STATE OF NORTH CAROLINA)
COUNTY OF MECKLENBURG)

I, MEREDITH R. SCHRAMEK, the officer before whom the foregoing deposition was taken, do hereby certify that the testimony of said witness was taken by me to the best of my ability and thereafter reduced to typewriting under my direction; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and, further, that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

This, the 2nd day of February, 2024.

MEREDITH R. SCHRAMEK
Notary Public in and for
County of Mecklenburg
State of North Carolina
Notary Number 200814200186

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EXHIBIT D

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

PLANNED PARENTHOOD SOUTH)
ATLANTIC, et al.,)
Plaintiffs)
)
vs.)
)
JOSHUA STEIN, et al.,)
Defendants)
)
and)
)
PHILIP E. BERGER, et al.,)
Intervenor-Defendants)

REMOTE DEPOSITION
OF
SUSAN BANE, M.D., Ph.D.
January 31, 2024, 1:33 P.M.

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I N D E X
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1 SUSAN BANE, M.D., Ph.D., after having been
2 first duly sworn, was examined and testified as follows:

3 BY MS. PAI-THOMPSON:

4 Q. So Dr. Boyle -- Dr. Bane, I'm sorry. I was of course
5 looking at Mr. Boyle's name and you'll see me drinking coffee
6 during our deposition and you'll understand why. I'm on the
7 West Coast, so it's early for me. Still early for me.

8 So my name is Vanessa Pai-Thompson and I am one of the
9 lawyers representing Planned Parenthood South Atlantic in this
10 case.

11 A. Nice to meet you.

12 Q. Nice to meet you as well. So I'm going to begin by
13 just kind of going through some of what I'll think of as our
14 agreed ground principals for the deposition. A lot of this
15 will be duplicative of what you went over on August 31st of
16 last year, but we just have to do it again since we're back
17 here again.

18 A. Okay.

19 Q. And so just beginning with your having taken an oath.
20 Do you understand that the oath that you take here in a
21 deposition is the same as taking an oath in court?

22 A. I do.

23 Q. And that we have our court reporter here helping us
24 today who will be taking down everything that you say and
25 everything that I or Mr. Boyle say.

1 A. I do understand that.

2 Q. Thanks. And if at any point if you realize you made a
3 mistake, that's completely fine. Just let me know and we can
4 clarify or correct anything so that you feel like the statement
5 is accurate.

6 A. Okay.

7 Q. Throughout the deposition, just as you have been
8 doing, since we do have a court reporter, if you can just make
9 sure that all of your responses are verbal, in words, so like
10 yes rather than uh-huh or a shake of the head.

11 A. Okay.

12 Q. And as we go through, I will ask you questions and you
13 finish any responsive answers to those questions.

14 A. Okay.

15 Q. And that as part of that, I would just ask that you
16 also let me complete my questions before beginning to respond
17 to those questions.

18 A. I'll do that.

19 Q. At some point if it seems like -- and I don't
20 anticipate that this will be something that will come up often,
21 if at all, but just in case, if an answer doesn't respond to my
22 question, it's possible that I will chime in just to ensure
23 that my question was clear and that we have the same
24 understanding of what I'm asking.

25 A. Okay.

1 Q. It may be that Mr. Boyle, at points during the
2 deposition, makes an objection to a question that I have asked.
3 That is for our record, but unless he instructs you not to
4 answer the question, you're still to answer the question that I
5 posed.

6 A. Correct.

7 Q. And we will be taking breaks. We will endeavor to
8 take a break about every hour or so, but if you feel like you
9 need a break or I have lost track of the clock, please let me
10 know.

11 A. I will.

12 Q. And we won't break mid-question, but if you need a
13 break at some point, we can finish up the question that we're
14 doing and then give us a break in.

15 A. That makes sense.

16 Q. There are just two other things that I wanted to flag
17 for you given the forum that we're in, because if it were me
18 and this just happened, I could imagine it feeling
19 disrespectful and I just want to make sure that you don't feel
20 that way at any point during the deposition.

21 A. Okay.

22 Q. The first is that I will at some point probably be
23 looking down or looking away from the camera and not at you. I
24 am someone who will always use a certain amount of paper. So
25 like you I have some paper documents in front of me as well.

1 So that's not a sign that I'm not listening or a sign of
2 disrespect. It's just that I may be looking down from time to
3 time.

4 A. Yeah. And I have a binder that has the documents from
5 today -- my expert report. And then on this side is a binder
6 with the documents from the first deposition and a few overlap.
7 So if I'm going that way, that's what I'm doing.

8 Q. Fabulous. Thank you. I appreciate that. And I did
9 just want to note if everyone who is observing can just check
10 to make sure that they are muted so that we don't have any
11 break in. I think there was one that just happened. So if
12 folks can just double check, that would awesome.

13 The second thing is -- and this is really just to try
14 to avoid us talking over one another potentially during the
15 deposition because that makes it difficult for court reporters
16 under any circumstances, but especially in a Zoom context. So
17 it may be that at some point I put my hand up, if for example
18 your audio goes out or I can't hear what you're saying just so
19 that I'm not talking over you. That's not something I would
20 ever do if we were in person together and I know it might feel
21 weird. So I just want to let you know if I do that, that's
22 why. Just so we're keeping the transcript as clean as we can.

23 A. Okay.

24 Q. So I now have some of the sort of background questions
25 that feel a little bit awkward and uncomfortable to ask and I

1 imagine to answer but that are important for us to go through.
2 So the first is whether you're dealing with any illness that
3 would impact your memory or prevent you from being able to
4 understand my questions today?

5 A. No, I am not.

6 Q. Thank you. Are you taking any substances that would
7 impact your memory or prevent you from being able to understand
8 my questions today, such as medication?

9 A. No, I'm not.

10 Q. Is there anything else that's currently impacting your
11 ability to understand and answer my questions today?

12 A. No, it's not.

13 Q. Fabulous. Thank you. So can you please tell us -- I
14 see that you're in an office. What city are you located in
15 currently?

16 A. Wilson, North Carolina. And I'm actually in my
17 basement of my house.

18 Q. Well, it's lovely and doesn't look like a basement.
19 So mission accomplished.

20 A. You should see the rest of it.

21 Q. The Zoom background is all that matters.

22 A. Right.

23 Q. So just from your camera view, I don't see that there
24 is any off-camera seating or anyone off camera in the room?

25 A. No, there's not.

1 Q. Thank you.

2 A. I will note, I have a son with special needs who gets
3 off the bus at 2:30 and I share this space with him, but my
4 husband's role is to not let him down here. But if somebody
5 comes running past -- well, actually there's nobody behind me,
6 but you might hear a few strange noises. But we'll work on
7 avoiding that.

8 Q. Fabulous. And you actually foresaw my next question,
9 which was just if anyone else enters the room at any point
10 during the deposition, just let us know. It may be that that's
11 a good time for us to take a break, if needed. So thank you
12 for that.

13 A. Are there only four of us on the call?

14 Q. There are more of us on the call, but as observers.
15 So at this point there is -- in terms of screens where you
16 should see images, you should see myself, Mr. Boyle, our court
17 reporter and then yourself, if you have yourself on camera.

18 A. Yeah. Okay.

19 Q. So have that view up.

20 A. I know last time there were a lot of people, but
21 everybody was on the screen.

22 Q. Yeah. It's just -- I think it makes it less
23 distracting. But yes, there are people who are observing --
24 you don't need to worry that there will be other screens
25 popping up with random questions coming from everywhere. The

1 questions will be coming from me.

2 MR. BOYLE: Are we going to identify all the
3 other folks, the lawyers?

4 MS. PAI-THOMPSON: We can certainly do that and
5 I appreciate that reminder. Why don't we do that at this
6 point.

7 MR. BOYLE: I might suggest -- and forgive if
8 I'm saying it wrong -- Ms. Pai-Thompson, that you might
9 represent or introduce all the various folks and then we cycle
10 through the other sort of groups of attendants just because I
11 don't know who all these other folks are.

12 MS. PAI-THOMPSON: Absolutely. And I think
13 that I may also -- Hannah Swanson has just joined on video and
14 she may provide me with an assist as well. But absolutely. I
15 apologize for not doing that. I think one that we observed
16 earlier we hadn't, but it's not at all intended to hide
17 information about who is here.

18 So from my office, Planned Parenthood
19 Federation of America, on the call is Cecilia Dos Santos, Ellis
20 Foxwood, Hannah Swanson. I'm continuing to scroll. Shealyn
21 Massey, Valentina De Fex and Vanisha Kudumuri.

22 And, Hannah, have I missed anyone in my
23 scrolling through?

24 MS. SWANSON: I don't think so. I'll just note
25 for the record that Anjali Salvador, Vanessa Pai-Thompson and

1 myself are the attorneys who rendered appearances in this case
2 and everyone else is simply here as observers.

3 MS. PAI-THOMPSON: And then I would also note
4 that Ryan Mendias who, Mr. Boyle, you have met in other
5 proceedings is also here, the ACLU and is also counsel for the
6 plaintiffs.

7 And I did notice also that Kyla Eastling with
8 our office has just joined who again, is here just observing.

9 MS. MAFFETORE: Sorry, one last person. Jaclyn
10 Maffetore from the ACLU of North Carolina. I'm on the call as
11 well observing and I am counsel of record on the case.

12 MS. PAI-THOMPSON: Thank you, Jaclyn. And my
13 apologies.

14 MR. THERIOT: I'm Kevin Theriot and I just
15 entered an appearance as counsel of record for the defendants.

16 MR. BOYLE: And I'm Ellis Boyle and Mr. Theriot
17 and I are counsel on behalf of the defendant intervenors
18 legislative leaders.

19 MS. NARASIMHAN: This is Priya Narasimhan on
20 behalf of Attorney General Stein, counsel for Attorney General
21 Stein.

22 MR. WILLIAMS: This is Kevin Williams on behalf
23 of defendant District Attorney Jim O'Neill.

24 MR. BULLERI: This is Michael Bulleri on behalf
25 of the North Carolina Medical Board.

1 MS. CROWLEY: Colleen Crowley on behalf of the
2 Department of Health and Human Services.

3 MS. PAI-THOMPSON: Have we covered everyone?
4 Hearing nothing I will --

5 MR. BOYLE: Did we get Elizabeth O'Brien? If
6 we did, I'm sorry. I missed --

7 MS. PAI-THOMPSON: No. No. Absolutely.

8 MS. NARASIMHAN: Elizabeth O'Brien works at the
9 North Carolina Department of Justice and at least she is on the
10 Zoom so -- this is Priya Narasimhan and I will represent that
11 she represents the other defendant.

12 MS. PAI-THOMPSON: Fabulous. Thank you so
13 much. I was just going to suggest that someone might have
14 stepped away and we might just break if we needed to.

15 Any other appearances that you wanted to note,
16 Mr. Boyle?

17 MR. BOYLE: I think that covered most
18 everybody, if not everyone, hopefully.

19 MS. PAI-THOMPSON: Perfect. Thank you.

20 BY MS. PAI-THOMPSON:

21 Q. So Dr. Bane, then I'm going to kind of turn back to
22 some of our initial questions. So we have gone through who's
23 in the room with you, where you are. Can you describe to me
24 what technology you're using to be part of this call?

25 A. Sure. I have a PC laptop and I think this is a Zoom

1 meeting. That's it.

2 Q. Fabulous. Do you have any other screens or just the
3 one screen from your laptop?

4 A. Just one.

5 Q. Is there any other technology in the room with you?

6 A. So I do have my phone. It's upside down, but I do
7 have, as I mentioned, a son with special needs so I like to
8 keep it close by because he has seizures. In case the school
9 calls me.

10 Q. Is it on silent?

11 A. I am getting ready to make sure. It is.

12 Q. Okay. And then understanding the reasons that it's
13 important for you to have it there with you, if at any point
14 you look at the screen of the phone if something comes in, can
15 you please let us know right away?

16 A. I will.

17 Q. Perfect. And then we may have follow-up questions
18 based upon that.

19 A. Okay. Can I do this? So I'll turn it over, but if I
20 silence it that means I can't hear them text me. Would it be
21 okay if I unmute it so I can have it turned over? It will be
22 less distracting, I think.

23 Q. Yes. Our preference would be that the screen not be
24 facing up. So yes, that's certainly fine.

25 A. Okay. I'm all set.

1 Q. And then this is just kind of following up on what we
2 were talking about. Do you agree not to communicate with
3 anyone while we're on the record, other than communications
4 that are being transcribed by the court reporter?

5 A. Absolutely. Yes.

6 MR. BOYLE: Objection.

7 BY MS. PAI-THOMPSON:

8 Q. You described the binders that you have with the
9 reports and the exhibits. Do you have any other printed
10 documents with you?

11 A. I have my deposition -- or my expert report, sorry.

12 Q. Perfect. Thank you. Any other documents other than
13 those binders and your report?

14 A. Not right here, no.

15 Q. Okay. So not visible to you?

16 A. Correct.

17 Q. Great. So do you agree not to look at any documents
18 during the deposition other than when we identify a document
19 and are discussing it together on the record with the court
20 reporter?

21 MR. BOYLE: Objection. I'll instruct you that
22 that's not part of the rules or a requirement. And I'll
23 instruct you that that's not -- you don't have to agree to
24 that.

25 BY MS. PAI-THOMPSON:

1 Q. Do you agree that if you look at a document or a
2 source of information while we are on the record that you will
3 identify what you're looking at so that you won't be looking at
4 anything that isn't recorded by our court reporter?

5 MR. BOYLE: Objection. Same objection. She'll
6 answer questions but...

7 MS. PAI-THOMPSON: Sorry, I'm just looking at a
8 note to myself.

9 BY MS. PAI-THOMPSON:

10 Q. I think that we'll follow up on this more because
11 again, I think that we will have questions about what
12 information you're relying on, and I may just ask you more
13 specific questions as we go along.

14 So moving now to -- basically since you were last here
15 on August 31, 2023. Do you recall the deposition that you took
16 part in that day?

17 A. I do.

18 Q. And you recall there was a court reporter there also
19 taking a transcript at that point?

20 A. Yes.

21 Q. Great. You recall that you were under oath and agreed
22 to testify truthfully there as well?

23 A. I remember that.

24 Q. And that you had an opportunity to review the
25 deposition transcript and make any corrections or address any

1 corrections that you may have had?

2 A. So I -- I didn't do that immediately afterwards, but I
3 noted some when I was reviewing for this and I had four or five
4 typos that -- for example, they put -- and I may have said it
5 this way, AAPLOG versus ACOG and intertwined those once and I
6 think -- it was minor things. I think there was an is when it
7 should have been an isn't one time. I think there were four or
8 five things and I don't think they got sent to you all.

9 Q. I would ask if at any some point I direct you to a
10 portion of the deposition or transcript where something comes
11 up that you have not corrected in writing already, just let me
12 know.

13 A. Thank you.

14 Q. So other than those kind of minor, what it sounds
15 like, typographical issues, is there anything that you want to
16 change about the sworn testify that you gave previously?

17 A. No.

18 Q. Other than your expert report in this case, have you
19 submitted any documents in other cases, like declarations or
20 reports since your deposition on August 31st?

21 MR. BOYLE: Let me just stop and give you an
22 instruction on that. To the extent that you have given any
23 report such as the one you've given here that's been exchanged
24 to an opposing side like yours was in this case, you can
25 respond to that. But if it's just an internal report or a

1 conversation or correspondence with some other lawyers that
2 have hired you as an expert witness and it hasn't been
3 exchanged to the other side, I will instruct you not to respond
4 and answer in the affirmative or negative for that.

5 THE WITNESS: Okay. So I --

6 BY MS. PAI-THOMPSON:

7 Q. Do you understand the question?

8 A. Well, I think I understand it. So no, I have not done
9 any other reports. I did submit an addendum yesterday in this
10 case.

11 Q. Yes. And when you refer to that, you're referring to
12 the one-page addendum that was accompanied by some textbook
13 pages, correct?

14 A. Yes.

15 Q. So other than that -- and again, not including any
16 communications with attorneys, but no other documents submitted
17 in other cases?

18 A. No.

19 Q. Have you given any testimony in other cases, either
20 orally or in writing?

21 A. Since August 31st?

22 MR. BOYLE: Object to form.

23 BY MS. PAI-THOMPSON:

24 Q. Have you given any testimony since August 31st in
25 other cases orally?

1 A. No, I have not.

2 Q. Have you given any testimony in other cases since
3 August 31st in writing?

4 A. No.

5 Q. And again, these will be between August 31, 2023, your
6 deposition that day and today, have you reviewed your report
7 again?

8 A. My expert report I wrote for today?

9 Q. Correct.

10 A. I have, yes.

11 Q. When did you most recently review it?

12 A. Again this morning.

13 Q. Great. Have you reviewed again the sources that you
14 cited in your report?

15 A. I have.

16 Q. Did you review every -- each of the citations that are
17 in your report?

18 A. I have.

19 Q. And did you review them in full?

20 A. Yes. But I don't have them memorized.

21 Q. Memorization isn't expected. Just checking in about
22 review. Have you conducted any other research since your
23 deposition on August 31st related to this case?

24 A. Well, I got the textbook that I gave you the addendum,
25 so I reviewed the textbook and, you know, my -- I have reviewed

1 the other individuals' declarations, their expert reports,
2 their depositions, yeah.

3 Q. So for the textbook, did you review any pages of that
4 textbook other than the ones that you sent us with your
5 addendum?

6 A. I read a lot of the textbook. But there were some
7 pieces that weren't relevant to this case so...

8 Q. Okay. Do you recall which portions of it you
9 reviewed?

10 A. I've got the book. Do you want me to tell you the
11 chapters?

12 Q. That would be great. Thank you.

13 A. So there's a forward that I reviewed, a preface I
14 reviewed. Chapter one is Abortion in Historical Perspective.
15 Chapter two is Unintended Pregnancy and Abortion and Public
16 Health Perspective. Chapter three is Informed Consent,
17 Counseling and Patient Preparation. Chapter four is
18 Documenting Pregnancy and Gestational Age. Let me look at
19 chapter five. I reviewed chapter five. Let me get back to the
20 table of contents. Medical Evaluation and Management. I
21 reviewed chapter six, Procedure Selection. Chapter seven, Pain
22 Management. Chapter eight, Medical Abortion and Early
23 Pregnancy. Chapter nine, Surgical Abortion in First Trimester.
24 Chapter ten, Surgical Abortion After First Trimester. Let me
25 look. I skimmed the latter chapters. Chapter 11. Chapter 11,

1 Abortion by Labor Induction. And I would say I skimmed the
2 rest of the chapters. Let's see. Actually I went through the
3 whole book, to be honest.

4 Q. Great. Well, thank you for going through that with
5 us.

6 A. I won't say I read every single page. But I did go
7 through the book.

8 Q. So is it fair to say that the pages that you sent to
9 us are the ones that you judge most relevant to your opinions
10 in this case?

11 A. I particularly wanted to -- well, I guess yes. But
12 there were -- there are other ones. But -- I'll say yes.

13 Q. You say that there are other ones. The ones that you
14 sent us are the ones that you're relying on for the purpose of
15 supporting your opinions in this case, is that correct?

16 A. Yes.

17 MS. PAI-THOMPSON: And I am going to just drop
18 into the chat a PDF that is -- that I'll ask to be marked as an
19 exhibit.

20 BY MS. PAI-THOMPSON:

21 Q. We're not going to go into questions about this right
22 now, but since it's come up I just want to confirm at this
23 point that we're talking about the same document or excerpts?

24 A. Okay.

25 Q. And so once that has come up and you're able to open

1 it, if you can scroll through and let me know if that is all
2 the pages that you believe that you sent to us or if there are
3 any that seem to be missing.

4 A. I'm trying to download it because I remember on the
5 31st, in August when we did this, I couldn't just open them. I
6 had to download them first. So just a second.

7 Q. Let me know if you would like me to screenshare, if
8 that feels more efficient.

9 A. I'm going to try.

10 Q. And again, at this point I'm not going to be asking
11 you about the content other than reviewing that it's all of the
12 pages that you believe you sent to us.

13 A. Yeah. Okay.

14 (Pause.)

15 Q. Why don't we do this just because I know how Internet
16 speeds go. Why don't we just put a pin in this for the moment
17 and then you can go ahead and take that time to have that
18 finish downloading when we take our first break, and then we'll
19 just circle around so that we're not missing any pages.

20 A. Okay.

21 Q. So other than the materials that we have identified so
22 far, was there anything else that you have reviewed in
23 preparing for this case between August 31st and today?

24 A. I reviewed Williams Obstetrics from -- which is a
25 mainstay textbook. I wanted to refresh myself on some basic

1 maternal fetal circulation. I hadn't reviewed that in a while.

2 Q. So Williams Obstetrics about maternal fetal
3 circulation. Were there any other portions of that that you
4 described -- or that you reviewed?

5 A. No. Just those areas.

6 Q. And then other than your attorney, I'm not asking
7 about communications with counsel, have you spoken with anyone
8 about this case since August 31, 2023?

9 A. No. My husband, my family. But not specifics of the
10 case.

11 Q. When you say your family, other than your husband, who
12 did you speak with?

13 A. I have grown children who know that I'm doing this. I
14 have a mom who knows. I have sisters who know I'm involved in
15 this case. I mean, so when you say spoke about, people know
16 I'm involved in this case. My colleagues at work know. People
17 who -- I'm on the board at AAPLOG. They know. But am I
18 getting resources from them, answers from them? No. But
19 they're aware that I'm involved in this case.

20 Q. Understood. Do they know what opinions you're
21 providing in this case?

22 MR. BOYLE: Objection. You can answer.

23 THE WITNESS: Did you say you can answer?

24 MR. BOYLE: You can answer.

25 THE WITNESS: No, they do not.

1 BY MS. PAI-THOMPSON:

2 Q. So the fact of your participation, but not the
3 substance it looks like?

4 A. Correct.

5 MR. BOYLE: Object to form.

6 BY MS. PAI-THOMPSON:

7 Q. Now, you described -- or referenced earlier having
8 read reports or materials submitted by other people in this
9 case. Did that include materials prepared by Dr. Christy
10 Boraas?

11 A. Yes.

12 Q. And which documents -- document or documents created
13 by Dr. Christy Boraas did you review?

14 A. Her original declaration, her rebuttal and her new
15 expert report.

16 Q. Did you read all of the -- did you read all of the
17 materials cited in those documents?

18 A. Do you mean references?

19 Q. Yes.

20 A. No, I saw what she referenced, but I did not
21 necessarily review every single one of them.

22 Q. Did any of the information that you read in the -- or
23 the citations that you saw that she had made in rebuttal, did
24 any of those change any of the opinions that you provided
25 either in writing or in your deposition on August 31st?

1 A. No.

2 Q. And when you reference the rebuttal, are you referring
3 to the rebuttal report that Dr. Boris submitted in January of
4 2024?

5 A. No. I'm talking about when we initially wrote our
6 explanation -- or our declarations last summer, she and Dr.
7 Farris wrote rebuttals. That's the only thing I was aware of
8 rebuttals that they had done.

9 Q. So you have not received a copy of a report that she
10 prepared in January of 2024?

11 A. So I have read one thing, but I thought it was -- I
12 don't know the title of it. I have read one thing since August
13 of hers.

14 Q. Okay. And we can circle back to this if we need to.
15 For Dr. Katherine Farris, can you list for us the documents
16 that you have read that she prepared as well?

17 A. Her original declaration and her rebuttal to our
18 original declarations and then her expert report this time.

19 Q. And when you say this time, can you tell us what month
20 you're referring to?

21 A. It would have been December -- November, December of
22 2023.

23 Q. Thank you. Did you read all of the references that
24 were cited in that document?

25 A. I noted them all, but I can't tell you yes or no that

1 I read every one of them.

2 Q. And same question for the declaration that she
3 provided. I know that you hadn't read all of them at your
4 initial deposition on August 31st. Have you read all of her
5 references in that initial declaration since then?

6 A. I have reviewed them, but I have not read them all.

7 Q. Has any of the information from either her reports or
8 your review of the records change any of the opinions that you
9 have provided in this case?

10 A. No.

11 Q. Have you read written materials provided by Dr.
12 Timothy Johnson?

13 A. I don't recall that I have.

14 Q. Okay. So you don't recall having been provided an
15 expert report from Dr. Johnson in January of 2024, is that
16 correct?

17 A. That's correct.

18 Q. How many hours would you say that you have spent
19 preparing your expert report at this point?

20 A. Just my expert report?

21 Q. Uh-huh.

22 A. Probably 30.

23 Q. And how many hours would you say that you have spent
24 preparing for your deposition today and -- so again, between
25 August 31st and today, how many hours would you estimate you

1 have spent preparing for deposition?

2 A. So I really didn't start preparing for deposition
3 until I knew the date, which I didn't find out maybe a month or
4 so -- no, I can't remember when I found out. Maybe -- yeah, I
5 think it was early January maybe. So I would say around 20
6 hours or so.

7 Q. Okay. And then other than the time that's been
8 captured by the 30 or so hours that you spent preparing your
9 expert report and the 20 or so hours spent preparing for the
10 deposition, have you spent any other time working on this case
11 which haven't captured through those questions?

12 A. No.

13 Q. And you're being paid \$500 per hour for your work in
14 this case. Is that still correct?

15 A. Yes.

16 Q. I'm switching gears just a bit.

17 A. Okay.

18 Q. Did you attend the March for Life in Washington D.C.
19 on January 19th of this year?

20 A. I did.

21 Q. And did you attend any other events while you were in
22 D.C.?

23 MR. BOYLE: Object to form.

24 THE WITNESS: Yes.

25 BY MS. PAI-THOMPSON:

1 Q. Did you attend any other events in Washington D.C.
2 while you were there for the March for Life?

3 MR. BOYLE: Object to form.

4 MS. PAI-THOMPSON: And you can answer the
5 question.

6 THE WITNESS: Okay. Yes, I did.

7 BY MS. PAI-THOMPSON:

8 Q. What events did you attend?

9 A. So I attended a reception at Heritage Foundation for
10 AAPLOG and I actually spoke there. Sorry, it was a busy week.
11 I attended a reception at ADF and I had some internal meetings
12 that weren't events. Some dinners, but they weren't events.
13 Those are the main things. And of course the march is all day
14 long.

15 Q. For the -- you said that you spoke at the AAPLOG
16 reception. What was your talk about?

17 A. Having courage to basically stand for what you believe
18 and fight for -- as a doctor that practices life-affirming
19 medicine, to stand for both my maternal and fetal patient. The
20 theme of this year's march was with every woman -- for every
21 woman with every child or vice versa. So talked about that. I
22 talked about the past, present and future of medicine in our
23 field. My talk was maybe three to five minutes. So it was
24 extremely brief about what I think about the history of our
25 field, what the present and then future of our field.

1 Q. When you talk about the history of our field, can you
2 -- or your field, can you tell me what the kind of -- give me
3 the gist of that.

4 A. Yeah. So I talked a lot about ACOG and AAPLOG's
5 relationship and how we really work together well. We were
6 included in ACOG cog for years. And when I say we, I mean
7 physicians who had a pro-life perspective and -- which is a lot
8 of us. As you know, you know, from all the depositions and the
9 reports that there's a minority of physicians that actually do
10 induced abortions. And that which actually -- we had
11 collaboration. And unfortunately that's gone away. And that
12 we were part of a very large special interest group in ACOG for
13 years. ACOG special interest groups of all types and there was
14 a pro-life one. And in 2013, unfortunately ACOG got rid of all
15 their special interest groups. And so we had -- we formed our
16 own organization. Even though we had the organization, we were
17 within ACOG as the special interest group. But we're no longer
18 welcome there. And that -- so now we're a second voice, second
19 medical organization that takes a life-affirming approach. So
20 that was historically what I shared.

21 Q. Thank you. Did you discuss your involvement in this
22 case at any of the meetings or dinners that you -- I think you
23 mentioned receptions that you attended?

24 A. I did not.

25 Q. Who paid for your travel to Washington D.C.?

1 A. I did.

2 Q. So I know that you have your copy of your expert
3 report. I'm going to drop it into the chat as well so that we
4 can -- and ask that it be marked as an exhibit for the purpose
5 of this deposition. And I'm dropping in what you provided to
6 us. So your expert report that includes your C.V. as well.

7 - - -

8 (Document marked as Exhibit-25 for
9 identification.)

10 - - -

11 BY MS. PAI-THOMPSON:

12 Q. Are you able to see that?

13 A. I am going to try a different way this time. See if I
14 can get it.

15 Q. We can also note, we sent to Mr. Boyle this morning
16 the PDF that we would be using for exhibits today. So if a
17 copy that you have, that you showed printed in front of you is
18 printed from that version that he provided you, you can also
19 look at that.

20 A. So it's not the one from today. I mean, it's my final
21 report that I, you know, gave. But it's not based on your
22 list. But what I can do is easily pull up your list and
23 compare them, because I think your list is easy to pull up.

24 Q. And since we're talking about your report that's been
25 produced to us through discovery, and I think we're talking

1 about the same document, we'll go ahead and just like with the
2 other -- go through some of it you can reference the paper copy
3 that you have and then we're getting pretty close to where
4 we'll take our first break, and you can follow up with the
5 downloads at that point.

6 A. That will be fine.

7 Q. It's going to jump around just a little bit, just so
8 that you know, because we're endeavoring not to repeat
9 information that you have already gone over in your initial
10 deposition. So if that creates confusion at any point, please
11 let me know and I'll be sure to clarify.

12 A. Thank you.

13 Q. Of course. Directing your training during medical
14 school, you never provided an induced abortion during medical
15 school, correct?

16 A. Correct.

17 Q. And you never provided an induced abortion during your
18 residency, correct?

19 A. I'm going to say correct, but I want to make sure that
20 we put on the record that we're agreeing on what induced
21 abortion is, right? So the definition when I say correct is
22 the CDC's definition, which is an intervention designed to
23 intervene for a suspected or ongoing pregnancy with the
24 intention of not having a live birth. So the purpose of the
25 intervention is to end the life of the fetus or the embryo. So

1 produce a dead baby. I never have done either of those.

2 Q. And for our reference, you have defined those terms,
3 and then also some other terms related to abortion in your
4 initial deposition on August 31st. So I will -- we can have a
5 common understanding that we are using those definitions that
6 you gave. If at some point you feel like you need to redefine
7 or clarify one of them, that's fine. But thank you for
8 highlighting that and I'll just note that those definitions
9 that you gave will stand.

10 A. Thank you.

11 Q. Absolutely. Now that we have talked, I'm missing --
12 want to make sure that we got an answer to a question. So you
13 did not provide an induced abortion based on that definition
14 you gave us during residency, correct?

15 A. Correct.

16 Q. And you did not provide an induced abortion during
17 your time as a practicing physician, correct?

18 A. Correct.

19 Q. And just as a brief clarification on the induced
20 abortion definition, just again to ensure that we're talking
21 about -- we're using shared terms. Just to be clear, you would
22 not include an induction abortion before viability with the
23 intent to separate the fetus from the patient's body in the
24 definition of induced abortion, is that right?

25 A. That is correct. I did those procedures, but my

1 intention was to try to save both knowing that some times the
2 unintended consequence is that the fetal patient doesn't
3 survive.

4 Q. Okay. But just to be clear, that -- actually I'm
5 going to withdraw that question. So you also taught at Barton
6 College from 20 -- you also taught at Barton College, correct?

7 A. Yes.

8 Q. That was beginning in 2010?

9 A. Part time and full time in 2011.

10 Q. Correct. And you taught there through 2023, is that
11 correct?

12 A. Correct.

13 Q. Have you ever taught any courses involving induced
14 abortion?

15 A. So -- not at Barton College. So I did teach a class
16 that was actually -- okay. So I'm going to correct that last
17 answer. So I taught a gen 301 class. I think it was gen 301
18 back then. It might have been gen 300. It's called the
19 Capstone course in the humanities in the general education
20 curriculum where students put together critical thinking, oral
21 thinking, writing. So actually I did teach a class. When you
22 asked the question, I'm sorry, I was thinking medical -- not
23 Barton. So yeah, I actually did teach one class.

24 Q. And just so that we're clear, when you say gen 301,
25 you mean general, that's referring to the general education

1 requirement?

2 A. So at Barton College we have a general education
3 curriculum and then we have a major specific curriculum.
4 Students take both. And the Capstone course in the general
5 education curriculum is called gen. And so students all across
6 campus could take that and I had a variety of students in that
7 class.

8 Q. I think that if -- well, no, we still have time.
9 Sorry, I'm trying to be mindful of the clock because I'm
10 someone who can just roll on through and I don't want to do
11 that to you.

12 So I'm going to refer to your report, if you can pull
13 your copy of that and to paragraph 68 of your report. And just
14 let me know when you're there.

15 A. I'm here.

16 Q. Perfect. Thank you. So I'm going to read a passage
17 of this to you and then I'll ask you whether I have read it
18 correctly. And feel free to let me know if I have missed a
19 word or gotten any incorrect.

20 A. Before you do, my phone just went off. So let me look
21 at something real quick. Okay. It's not my son.

22 Q. Great. Thank you. And thank you for letting us know.

23 A. You're welcome.

24 Q. So in your report in paragraph 68, you say in quotes,
25 as I have examined the literature related to very early

1 abortions, I agree with some authors that state diagnosing an
2 ectopic pregnancy as early as possible is a benefit of these
3 protocols.

4 Did I read that accurately?

5 A. You did.

6 Q. And you agree with your statement in your report there
7 in paragraph 68 that, quote, diagnosing an ectopic pregnancy as
8 early as possible is a benefit of those protocols, correct?

9 A. I agree that diagnosing an ectopic pregnancy is
10 beneficial for any woman. Where I disagree is that it
11 justifies doing an abortion without a documented IUP.

12 Q. Thank you. So by these protocols that you're -- that
13 reference in paragraph 68, you're referring to the medication
14 abortion protocols for pregnancies of unknown location, is that
15 correct?

16 A. Yes.

17 Q. Okay.

18 MS. PAI-THOMPSON: So I am going to drop
19 another document into the chat and I will ask that this be
20 marked as an exhibit. And this again you should have received
21 in the documents that we provided to Mr. Boyle earlier today.
22 This is a statement from ASA. It's a statement from ASA on the
23 continuum of levels of sedation.

24 - - -

25 (Document marked as Exhibit-26 for

1 identification.)

2 - - -

3 BY MS. PAI-THOMPSON:

4 Q. Do you have the document that I'm referring to?

5 A. Yes, I do.

6 Q. And have you read this document before?

7 A. Well, I need to look at the one I referenced to make
8 sure -- it doesn't seem like this first page is the same as my
9 first page.

10 Q. Okay.

11 A. Do you know the number of my reference for the ASA?
12 If not, I can look. Let's see.

13 (Pause.)

14 A. I'm going to just pull up my hard copy that I have.

15 Q. And we're at footnote 45 in your report, if that's
16 helpful.

17 A. I found that. Thank you.

18 Q. Yeah. Absolutely.

19 A. So mine starts with statement on granting privileges
20 for administration of moderate sedation to practitioners who
21 are not anesthesia professionals. That's page one of mine.

22 Q. All right. I think that we have -- so let's do this.
23 Can you -- the document that I dropped in the chat is short.
24 Can you take a moment to review the first two pages of that
25 document and I will -- the questions I have I think will be --

1 basic enough that given your expertise we'll be fine moving
2 forward. But let me know if after I have asked the question
3 you feel like you need more time.

4 A. Okay.

5 (Pause.)

6 Q. So looking at the document that I moved into the chat,
7 just clarifying for us non-doctors in the room. By spontaneous
8 ventilation there, that would be referring to breathing, is
9 that correct?

10 A. Could I have a minute just to look at the document?

11 Q. Oh, absolutely. I'm sorry. When you said okay, I
12 thought you meant okay, proceed.

13 A. No. Give me just a second.

14 Q. Absolutely.

15 (Pause.)

16 Q. So let's actually, Dr. Bane, just given our time and
17 to get us to our first break, I'm actually going to do this.
18 I'm going to ask you some questions about sedation and we'll
19 just do this just independent of the document. Just based upon
20 your knowledge and expertise. Is that okay?

21 A. That's fine. But I was almost done if you want to
22 refer to the document.

23 Q. Yeah. Sure. Then go for it.

24 A. Okay.

25 (Pause.)

1 A. Okay. You can reference it now.

2 Q. Okay. Thank you. Do you agree with the description
3 of the levels of sedation that are provided in that document?

4 MR. BOYLE: Objection. You can answer.

5 THE WITNESS: Could you repeat the question?

6 BY MS. PAI-THOMPSON:

7 Q. Yes. Do you agree with the description of the levels
8 of sedation provided in that document?

9 MR. BOYLE: Objection. You can answer.

10 THE WITNESS: Yes.

11 BY MS. PAI-THOMPSON:

12 Q. Thank you. Do you know what kind of sedation options
13 are available at Planned Parenthood South Atlantic?

14 A. Based on the protocols I reviewed, they have
15 documentation that you can opt for everything except general
16 anesthesia. However, I believe it was Dr. Farris's deposition
17 that she stated that they don't actually offer deep sedation,
18 even though that is an option on their form.

19 Q. So your understanding is that Planned Parenthood South
20 Atlantic offers minimal and moderate sedation, but not deep
21 sedation? Have I summarized that correctly?

22 A. That is my recollection of reviewing everything.

23 Q. Great. And for minimal sedation, a patient is
24 conscious throughout the sedation, is that correct?

25 A. Conscious, yes, but sometimes asleep.

1 Q. But they can be roused by verbal or physical stimuli?

2 A. Typically, yes.

3 Q. And same question for moderate sedation, that a
4 patient is typically conscious during the sedation, and by that
5 I mean the sedation doesn't render them unconscious?

6 A. Correct. Typically. Everybody responds differently,
7 and that's the biggest concern is what you think is moderate
8 sedation can move to deep, what you think is moderate can lead
9 to someone being unarousable and that's the biggest concern
10 with sedation.

11 Q. And you reference that can lead to a patient being
12 unarousable. At the point that a patient was unarousable, the
13 provider would know that they were no longer in minimal or
14 moderate sedation, correct?

15 MR. BOYLE: Objection.

16 THE WITNESS: I would sure hope so. There's no
17 information from the protocols that there is somebody different
18 than the person doing the induced abortion, the surgical
19 abortion that's separately monitoring the person. So I think
20 there is concern that they may not recognize if they have moved
21 into a level of deeper sedation. And I think that's consistent
22 with the document that I provided that that's a major concern
23 of the American Society of Anesthesiologists.

24 BY MS. PAI-THOMPSON:

25 Q. And that's because of your understanding that there --

1 withdrawn. That was going to be a confusing question, so I'm
2 going to ask it differently. What I hear you expressing there
3 is that if there wasn't another person in the room other than
4 the provider, they might be focused on the procedure and not
5 notice. Is that a fair summary?

6 MR. BOYLE: Objection.

7 THE WITNESS: I think that's one element of it
8 if they're responsible for both of those. So when I'm in the
9 operating room I'm focused on doing my surgery and I'm trusting
10 the anesthesia professional to monitor all the various things,
11 responsiveness, airway, cardiovascular system, spontaneous
12 ventilation. So I am -- I don't understand that that is
13 happening based on the protocols that I have seen at Planned
14 Parenthood. Also recognizing that I have no idea all the other
15 protocols that are happening across the state knowing that, you
16 know, only about 30 percent of the surgical abortions are
17 happening -- abortions are happening at the Planned Parenthood.
18 We have many other facilities that are happening. And so I'm
19 very concerned based on what the American Society of
20 Anesthesiologists -- they talk about individuals who are not
21 professionals having the adequate level of training to be able
22 to recognize that somebody is -- you know, got normal
23 cardiovascular function, they're spontaneously breathing. So
24 that's my concern.

25 BY MS. PAI-THOMPSON:

1 Q. Is it your opinion that only an anesthesiologist or a
2 nurse anesthetist would be qualified to provide or supervise
3 moderate sedation?

4 MR. BOYLE: Objection.

5 THE WITNESS: My opinion is consistent with
6 what the American Society of Anesthesiologists suggests is that
7 it takes special training and education. In their document
8 that I cited, they talk about non-anesthesiologist sedation
9 practitioners and the special training they get. And I don't
10 have evidence that that is occurring across the State of North
11 Carolina in our abortion clinics.

12 BY MS. PAI-THOMPSON:

13 Q. So is it your opinion that no one else is qualified to
14 provide or supervise moderate sedation other than
15 anesthesiologists or people who are receiving that special
16 training that you just referred to?

17 MR. BOYLE: Objection. You can answer.

18 THE WITNESS: So I'll reference -- I'm sorry,
19 but it doesn't have page numbers. But under section one,
20 non-anesthesiologist sedation practitioners. It says here that
21 non-anesthesiologist sedation practitioners may directly
22 supervise patient monitoring in the administration of sedatives
23 -- sedative and analgesic medications by a supervised sedation
24 professional. Alternatively, a person may perform these
25 functions with the provision that the individual monitoring the

1 patient should be distinct from the individual monitoring the
2 diagnostic and therapeutic procedures. Single operator
3 sedation should not be permitted and is deemed unsafe.

4 So I follow their recommendations because
5 they're the experts in anesthesiology and sedation.

6 BY MS. PAI-THOMPSON:

7 Q. And just one clarification in the paragraph that you
8 just read. I think -- at least what is in my printout, the
9 third line from the top of that paragraph, I think that you
10 said should be distinct from the individual monitoring the
11 diagnostic or therapeutic procedure. Does the document
12 actually say the individual performing the diagnostic or
13 therapeutic procedure?

14 A. I'm sorry, which line are you referencing?

15 Q. On my printout -- let's do it this way. It is the
16 second to last sentence. Just before see practice guidelines
17 for moderate procedural sedation.

18 A. Alternatively, they may personally perform these
19 functions with the provision that the individual monitoring the
20 patient should be distinct from the individual performing the
21 diagnostic or therapeutic procedure.

22 Q. Can you tell me, what date is the last amended date on
23 the version that you have?

24 A. 2021.

25 Q. October 13, 2021?

1 A. Mine actually says October 12, 2021.

2 Q. Okay. Thank you. And we are almost at our break
3 point, so I'll give you that. So is your opinion based upon
4 anything other than what is in this ASA document that we just
5 talked about?

6 MR. BOYLE: Object to form.

7 THE WITNESS: Could you repeat that?

8 MS. PAI-THOMPSON: Yes. Absolutely.

9 BY MS. PAI-THOMPSON:

10 Q. I'm referring back to your testimony that a person
11 should be an anesthesiologist or should have the training
12 that's referenced in this ASA document in order to provided
13 moderate sedation?

14 A. So my opinion is --

15 MR. BOYLE: Object to form. You can answer.

16 THE WITNESS: Okay. So my opinion follows what
17 this document says as it relates to the safety of a patient.
18 This document doesn't address pain management in a patient and
19 that's also a concern for me that we -- it's hard to believe we
20 would accept a level of pain that women describe that for
21 abortions that we would not accept for other procedures, all in
22 the name of doing it in an outpatient setting. And so I do --
23 -- I do want patients to not -- I want to control their pain as
24 much as possible, their physical pain, in the case of
25 anesthesia.

1 BY MS. PAI-THOMPSON:

2 Q. Thank you. Referring to the comments that you just
3 made. Do you think this is a result of abortion patients being
4 treated less well than patients seeking other obstetric or
5 gynecological care?

6 A. I think sometimes we get -- I think there is such a
7 desire for everything to be done in an abortion clinic, in an
8 outpatient setting that sometimes that overrides the thought
9 that we can more safely provide better, deeper sedation for a
10 second trimester abortion. Even a first trimester abortion can
11 be very painful. So I do think sometimes, yeah, abortion is
12 treated differently by the people who are providing the
13 abortions.

14 Q. So is it your opinion that it would be safer to
15 provide deep sedation to every patient obtaining a second
16 trimester abortion?

17 A. No, that's not what I'm saying.

18 Q. Are you -- do you -- is it your opinion that it would
19 be better from a pain management perspective?

20 MR. BOYLE: Object to form.

21 THE WITNESS: So I think you're going to --
22 you'll have a conversation with a woman to talk about her
23 options and her preference. Some patients over my 20-plus
24 years of practicing will walk in and say there is no way I'm
25 getting "X" procedure done unless I am asleep. And there are

1 other people who want more minimum sedation. So I do think you
2 can't -- it's a hypothetical to try to say for everyone. But I
3 think we have to be careful that we don't sacrifice and hurt
4 women all in the name of trying to stay out of the hospital.

5 BY MS. PAI-THOMPSON:

6 Q. Thank you. So for the safety piece, is there anything
7 that you are basing your opinion on other than the ASA
8 guidelines that you have referenced? And by that I mean
9 experience, other papers, things like that.

10 A. So I have only documented in my expert report this.
11 But from an -- from a 20-plus year experience doing thousands
12 of surgeries, absolutely. My experience definitely tells me
13 that I can concentrate more on the job that I'm responsible for
14 if I know that there's a competent person who's making sure my
15 patient stays alive. And so, you know, that most definitely
16 influences it. And I do care about pain management. So it
17 would be a combination of experts like the American Society of
18 Anesthesiologists, as well as anecdotal experience as an
19 obstetrician/gynecologist.

20 Q. Sorry, I don't mean to cut off.

21 A. I just said obstetrician/gynecologist.

22 Q. Yes. So you reference experts like ASA. Are there
23 other sources or other associations whose opinions you're
24 relying on for your opinion here?

25 A. This is the main society that I relied on and so I'll

1 have to say just them in terms of a professional organization.
2 And there are studies out there also that look at, you know,
3 pain control, but I chose not to cite them. I chose to site
4 more of -- kind of like with ACOG, practice bulletins or
5 committee opinions. A conglomeration of the sites -- of the
6 studies that lead to a statement.

7 Q. Okay. And then just a couple more quick questions
8 before we'll take our first break. So looking at general
9 anesthesia itself. Does general anesthesia alone carry medical
10 risks? And by alone I mean risks that are separate from
11 whatever the risks are of the procedure that the general
12 anesthesia is connected to.

13 A. All sedation carries risks.

14 Q. So with respect to general anesthesia, what kind of
15 risks does it carry?

16 A. Well, for that one, you're actually intubating someone
17 and so, you know, there's a risk of intubation in terms of not
18 being properly intubated or actually tearing, for example, the
19 esophagus when someone is intubated or something like that. So
20 there's that risk. There's risks -- pregnant women have risk
21 for -- greater risk for aspiration than do other women that are
22 not pregnant. You're taking someone and you're putting them in
23 such a deep sedation, there are some people that take a while
24 to come out of that and I have even had patients who have had
25 to stay intubated. So yes, there are risks.

1 Q. Thank you. When you say that there are risks that a
2 patient might not be properly intubated, what risks does that
3 create?

4 A. Well, if you think you're in the trachea and you're
5 actually in the esophagus the person is not going to be getting
6 adequate oxygenation and could have cardiovascular collapse,
7 stroke, a heart attack. So you have to properly intubate
8 someone. And then in terms of the -- it's a metal instrument
9 that people use to intubate so you can actually have tears. It
10 can cause bleeding. So those are the main things.

11 MR. BOYLE: We have been going for about an
12 hour if you're at a spot where you might take a break.

13 MS. PAI-THOMPSON: Yeah. I just have two quick
14 follow-up questions on Dr. Bane's comments about the risks and
15 then we are at a perfect point for a break. Thank you.

16 BY MS. PAI-THOMPSON:

17 Q. So Dr. Bane, you mentioned that with some patients
18 they stay in deep sedation, like they have a tougher time
19 coming out and may have to remain intubated. What are the kind
20 of risks that go along with remaining intubated?

21 A. The biggest one is that you never get extubated, you
22 know. And so that can lead to death. It can lead to
23 aspiration pneumonias. All the things that go with a long term
24 intubation. You may have to get a trachea -- it often is a
25 sign of some underlying neuromuscular condition -- other

1 conditions besides neuromuscular. But often if breathing
2 doesn't come back. You know, I have seen it and then a patient
3 gets diagnosed with myasthenia gravis or ALS or something like
4 that. So it's uncommon, but it can happen. The majority of
5 people do just fine, but there are risks with general
6 anesthesia.

7 Q. Thank you. And then my final question before our
8 break. For pregnant women you said that there is increased
9 risk of aspiration. Can you describe what aspiration means,
10 what that is, kind of how that looks?

11 A. Sure. So, you know, if you have ever had surgery, you
12 have been told don't eat anything after midnight, maybe you can
13 drink some water, brush your teeth the next day. So you
14 basically don't want food in the stomach because when you have
15 general anesthesia it can relax the sphincters, and there's an
16 esophageal sphincter between the stomach and the esophagus,
17 which is the tube that goes to the stomach after you swallow.
18 And so if food gets refluxed back or contents of the stomach
19 and get into the lungs, that can lead to infection.

20 Q. Are there any other risks beyond infection of
21 aspiration?

22 A. I'm sure there are, but not that I can recall right
23 now.

24 Q. Perfect. And I'm sorry that I promised one question
25 and there were two, but I do think this is a good time to take

1 our first break. Should we say -- does 10 minutes feel like
2 enough?

3 THE WITNESS: Sure.

4 MR. BOYLE: Sure.

5 MS. PAI-THOMPSON: And then for our court
6 reporter, when we come back I'll ask just for a time check.

7 MR. BOYLE: I have got one hour and seven
8 minutes.

9 MS. PAI-THOMPSON: Great. Thank you. We'll
10 see everyone in 10.

11 - - -

12 (A break was taken, 2:44 p.m. - 3:00 p.m.)

13 - - -

14 BY MS. PAI-THOMPSON:

15 Q. So Dr. Bane, I'm going to be talking more about your
16 expert report. So just in terms of what you have in front of
17 you. And I'll be looking at paragraph 56, but referring back
18 to our earlier discussion about just ensuring that we have --
19 that we're using the same definitions so we have common
20 understand. Just kind of a preference question for that. So
21 can you tell us -- or just describe to us how you would define
22 a missed abortion?

23 A. Yes. So a missed abortion is when a woman is
24 asymptomatic, so she doesn't have any bleeding or cramping, and
25 typically we're doing an ultrasound for dating and we don't see

1 a heartbeat.

2 Q. Thank you. So in paragraph 56 of your expert report,
3 you identify some things that can happen when an embryo or
4 fetus has no cardiac activity and the pregnant person's body is
5 physiologically preparing to expel it. Do you see the section
6 that I'm referring to?

7 A. Yes, I do.

8 Q. Perfect. And is what you're describing there what can
9 happen with a missed abortion, as you just defined it?

10 A. Would you clarify the question? I'm sorry.

11 Q. Sure. So in paragraph 56 where you are talking about
12 -- these will just be examples. We'll go back -- that --
13 sorry. Let me just actually -- I'm going to look in my note
14 and see that I have not -- I can't just more easily ask the
15 question in a different way. Let's actually -- I'm going to
16 withdraw the question that I had and move to another question
17 and we may circle back, but you can tell me if you feel like we
18 missed something given that.

19 So I would like to talk about some of the things that
20 you identify can be happening physiologically in a pregnant
21 person's body when they are preparing to expel an embryo or
22 fetus with no cardiac activity. You described in your report
23 that the cervix may already be softening and partially open, is
24 that accurate?

25 A. Yes. I state the cervix may already be softening and

1 partially opening. It's not always the case, but it can be. I
2 have operated on women to do a D&C and they -- I go to do my
3 exam and I can already put my finger in. Now those are not
4 women typically with a missed abortion. Those are women that
5 usually have symptoms in terms of their cervix making those
6 changes because they'll often start spotting if their cervix is
7 starting to open.

8 Q. And so if they -- just again so we're using the same
9 terminology. How would you define a situation or what term
10 would you use for that, where they are having some symptoms
11 such as spotting?

12 A. So if they don't -- if they're having those symptoms
13 and they are -- and we have diagnosed the embryo or fetus has
14 died then they -- if they're already partially open, the
15 cervix, then they would -- particularly if you can see any of
16 the products of conception, whether it's the embryo, fetus, or
17 the extra, the placenta, other tissue that's not the actually
18 embryo or fetus, you can sometimes see them at the opening. So
19 that would be an incomplete abortion. So she's in the middle
20 of miscarrying.

21 Q. And I appreciate the juxtaposition there. So you said
22 that not all patients have this softening and partially open.
23 Does that mean that some would have cervixes that are what you
24 describe as closed and thick?

25 A. Yes. For the cervix, yes.

1 Q. Thank you. So same paragraph of your report, in
2 paragraph 56, you say that most women will naturally expel the
3 pregnancy within two weeks and thus expected management is an
4 option given to them. Is that an accurate summary of what's
5 there?

6 A. Yes, it is an accurate summary.

7 Q. And are there some miscarriages or miscarriage
8 patients who don't naturally expel the embryo or fetus within
9 two weeks?

10 A. There are. The data suggests that 80 percent of women
11 will miscarry within two weeks --

12 Q. I'm sorry.

13 A. -- on their own.

14 Q. On their own. Thank you. Is there anything other
15 than those two things that we just talked about? Is there
16 anything else about the state of the pregnant person's body
17 that is maybe different?

18 A. Between what? Sorry.

19 Q. No. No. Absolutely. So with the situation where
20 there is no longer embryonic or fetal cardiac activity, you say
21 that the body is preparing to expel the pregnancy, other than
22 the cervical changes and the sort of time frame that we just
23 discussed, are there other physiological changes that you see?

24 A. Oh, most definitely. So the woman will often times
25 say that she no longer has breast tenderness, she's not tired

1 like she was. And that is related to a drop in hormonal
2 function. So she's no longer feeling the symptoms of
3 pregnancy. And she may start cramping, which is the uterus
4 preparing to expel the embryo or the fetus. You know, I think
5 from the standpoint of when you deliver or you examine -- so
6 let me back up. So, you know, when a woman is in her first
7 trimester and has had a miscarriage, we will offer her
8 expectant management, medication management, or surgical
9 management. And every woman, you know, there are different
10 conversations that you have with the women regarding that. But
11 when I have done surgical or we do -- if she's a little further
12 along, second trimester, induction, the biggest change you see
13 is actually in the embryo or the fetus because they have lost
14 their blood supply. And so just like if you and I lose our
15 blood supply, our cells, our tissues die and we decompose, so
16 do these embryos and fetuses. And so, you know, that's the
17 other big thing that you see in our second patient is that
18 going on.

19 Q. Okay. Any other physiological changes in the pregnant
20 patient?

21 A. So we have talked about bleeding. She may be -- maybe
22 we haven't talked about bleeding.

23 Q. Okay.

24 A. You know, I mentioned it, yeah. So bleeding and
25 cramping are the biggest things. Loss of her pregnancy

1 symptoms. And then her cervix may start to open on its own.
2 And then the fact that the baby or -- the embryo, the fetus is
3 basically decomposing, autolyzing, maceration, I think, are
4 terms that we use tells us that the physiology of blood flow is
5 changing internally. We can't see that on the outside, but the
6 evidence, the fact that she has a reduction of blood flow now
7 going to the baby is evidenced by what we see in the baby. And
8 there are studies, for example, that show like placental
9 atrophy in women who have had a pregnancy loss in the second
10 trimester and the placenta actually gets smaller. They do
11 expectant management for a little while and they notice the
12 volume of the placenta by ultrasound is smaller. I can't see
13 those externally, of course.

14 Q. Thank you. So I'm focused now on some questions that
15 deal with gestational age.

16 A. Okay.

17 Q. We'll be jumping around some so we're not repeating.
18 Are you aware of any published medical research discussing the
19 comparative safety of procedural miscarriage management and
20 procedural induced abortion at the same gestational age?

21 A. Using the term procedural, are you also -- I know
22 there's a lot of conversation about surgery versus procedure.
23 So could you say that question and replace it with surgical
24 also?

25 Q. Absolutely. So are you aware of any published medical

1 research discussing the comparative safety of surgical
2 miscarriage management and surgical induced abortion at the
3 same gestational age?

4 A. Surgical miscarriage compared to surgical induced
5 abortion?

6 Q. Correct. At the same gestational age.

7 A. I am not aware of any direct studies that compare
8 those.

9 Q. Thank you. Are you aware of any books or other
10 publications that compare those?

11 A. I'm aware of a lot of conversation that happens in
12 labor and delivery, in operating rooms, among colleagues
13 anecdotally about differences that people describe. I'm aware
14 of in textbooks conversations about the technical difficulty of
15 an induced abortion compared to a miscarriage, particularly
16 because on a miscarriage you already have a dead fetus if it's
17 second trimester and you have a live one with the first one,
18 and of course you'll have the bony structures that make for a
19 more technically difficult procedure. And that's supported in
20 the addendum information I gave yesterday about, you know,
21 within 16, I think, to 24 hours the bones, the cortical bones
22 soften. And I'm aware that the bones, removing them,
23 particularly the skull are -- the calvarium, which is the
24 skull, is where a lot of the cervical injury and hemorrhage can
25 come from. That's what I'm aware of.

1 Q. Thank you. And I think that this is clear, but I just
2 want to make sure that I know that it is. The textbook that
3 you just referred to and you mentioned the addendum, that's
4 those excerpted pages that you sent over to us and the textbook
5 we talked about earlier, correct?

6 A. Correct.

7 Q. Any others?

8 A. Not off the top of my head.

9 Q. Okay. Thank you. And you describe the written
10 sources and then also anecdotal kind of accounts from other
11 people. You talk about -- you don't have personal experience
12 with this, with induced abortions since you haven't performed
13 them, correct?

14 A. So I have a lot of personal experience with labor
15 inductions where we have second trimester either -- fetal
16 demises or I had to do previable inductions. And the
17 difference in terms of when there has been a loss, so the fetus
18 is dead, those babies come out and sometimes their skin is
19 sloughed off. They have macerated and their -- you can tell
20 their bones are soft. They're kind of bent and their skulls
21 collapse. So I do have that experience. I don't have the
22 experience of a D&E extraction where I am removing the dead
23 fetus or living fetus.

24 Q. And as you said, just to clarify, so no experience
25 with D&E to provide an induced abortion as you have defined

1 that earlier, correct?

2 A. Correct.

3 Q. Thank you. So I'm going to turn now actually to the
4 textbook pages.

5 A. Can I pause you real quickly? So my son is home. I'm
6 going to turn -- my phone is going crazy. I'm going to silence
7 it real quick. But he's home and my husband is here so I don't
8 have to worry about my phone.

9 Q. Thank you. I appreciate you letting us know and I'm
10 glad that he's home.

11 A. Thank you.

12 Q. Again, I'm turning now to the supplement and then the
13 textbook pages. And since we're having the download issues, my
14 plan is I will refer to some of the textbook pages. I'm not
15 going to refer to all of them. If for some reason my reference
16 makes you think there's an issue with what we have, please let
17 me know. But other than that, we'll just --

18 A. And I have the book right here.

19 Q. We'll act on our good faith that we have -- everything
20 that you think you gave us you did, and you can always follow
21 up with us and we'll ask that Mr. Boyle does if you realize
22 that there's anything you thought you provided that we didn't
23 receive.

24 A. Okay.

25 Q. So based upon the passages that you cited in the

1 supplemental source, so that supplement that you gave us, would
2 you agree that your training in miscarriage management does not
3 qualify you to provide induced abortion by aspiration or D&E?

4 A. That's a loaded question. Say that again.

5 Q. Absolutely. So based upon the passages that you have
6 cited -- and I'm just flipping here myself because I should
7 have flipped earlier -- so based upon the passages that you
8 have cited in the addendum -- and so just for reference those
9 are the passages at pages 111, 131 and 158.

10 A. Okay.

11 Q. So then the follow-up -- and just also flagging that
12 it's page 111 that refers specifically to training, but I want
13 to kind of key us into the different passages that we're
14 dealing with.

15 A. Okay.

16 Q. So based upon those passages at page 111.

17 A. Okay.

18 Q. And I'm going to just read from the addendum you were
19 provided, the passage that's there, which is, quote, although
20 abortion is among the most common medical needs of women, fewer
21 than half of graduating obstetrics, gynecology residents in the
22 United States have ever performed a first trimester induced
23 abortion. And then the second section -- or second sentence
24 you have bolded in the addendum. Training and the management
25 of incomplete spontaneous abortion is not an adequate

1 substitute. So that's the passage that I'm referring to with
2 this question.

3 A. Okay.

4 Q. The question is would you agree that your training in
5 miscarriage management does not qualify you to provide induced
6 abortion by aspiration or D&E?

7 A. Would you define qualify me?

8 Q. Well -- sorry, I'm just looking back to the wording.
9 Okay. So I'm focusing on the training and the management of
10 incomplete spontaneous abortion is not an adequate substitute.
11 So would you agree that your training in incomplete spontaneous
12 abortion is not an adequate substitute for specific training in
13 providing induced abortion by aspiration or D&E?

14 A. That's a long sentence. Can you simplify what you're
15 asking me?

16 Q. Yes. I will break it out into a few questions. You
17 have training in the management of incomplete and spontaneous
18 abortions, correct?

19 A. Correct. Among other things that I'm trained to do,
20 yes.

21 Q. For the purpose of this question. And you have stated
22 the opinion that -- or highlighted this passage for us that
23 talks about an absence of, quote -- well, I'm going to change
24 perform to performing. Performing a first trimester induced
25 abortion as part of an obstetric, gynecological resident's

1 training, correct?

2 A. Right. That's what it says, yes.

3 Q. And in providing this in the addendum, you are
4 providing it to support the position that management of
5 incomplete spontaneous abortion isn't a substitute for that
6 experience performing a first trimester induced abortion in
7 residency, correct?

8 A. I think that's simplifying it. So I am providing it
9 to highlight the fact that they're not identical procedures.
10 And so my operative note may say that my procedure was a D&C,
11 but in all -- or a D&E for that matter. But in all reality,
12 each procedure is technically very different. And there's a
13 big difference between doing a D&E in the second trimester for
14 a dead fetus or a live fetus. And that it is recognized in our
15 field that they are so different that not only do you need to
16 go to four years of training to be an ob-gyn and all the things
17 we do, that you need additional training if you're going to do
18 them and be a complex family planning fellow and get two more
19 years on top of four years. So I am not a trained complex
20 family planning fellow. I have not done that program. And so
21 I don't have that training. That's my point.

22 Q. Okay. Thank you. And again, just following up, you
23 also haven't performed a first trimester induced abortion as
24 it's referred to in the passage on page 111, correct?

25 A. All D&Cs I have done in the first trimester, the

1 embryos had -- fetuses had a heartbeat. Or didn't have a heart
2 beat. Sorry.

3 Q. Thank you.

4 MS. PAI-THOMPSON: And I am going to, just so I
5 don't forget, I am going to drop into the chat and ask to have
6 marked as an exhibit the addendum first and then the textbook
7 pages second. And again, that's for our record, but you and I
8 will see it on paper copies given the Internet.

9 - - -

10 (Documents marked as Exhibit-27 and Exhibit-28
11 for identification.)

12 - - -

13 BY MS. PAI-THOMPSON:

14 Q. Do you agree that you're not qualified to provide an
15 induced abortion?

16 A. No, I don't agree necessarily with that statement as
17 simply as it is and as flat as it is. Because of the extensive
18 training that I have had as an ob-gyn I have a lot of skills,
19 and if I had to do one, I could -- I could work my way through
20 it probably. But I think the complication rate -- I'm not as
21 experienced as somebody who has done them for 20 years or who
22 has done a complex family training fellowship. Which is why I
23 think we have to be really careful about who's doing our second
24 trimester abortions here in North Carolina. So I don't think
25 it's a black and white question the way you asked it.

1 Q. I appreciate the followup. And what I'm hearing you
2 say is that a provider's experience, right, like their level of
3 experience in providing a procedure is important to the safety
4 of that procedure? Is that what you're saying?

5 A. I think there's formal training, and obstetricians and
6 gynecologists, we are trained as surgeons. And so I think that
7 in itself is very different than, for example, Dr. Farris who
8 is a trained family practitioner who is doing second trimester
9 abortions here in North Carolina based on informal training
10 she's received from people in the office, per her deposition.
11 And so I think we're very different in that respect. So I
12 think it's very hard to categorize me as not qualified.

13 Q. Thank you. Are you aware -- well, actually, let me
14 back up. I'm sorry. Do you know what -- and this is a
15 mouthful for me as not a doctor, what disseminated
16 intravascular coagulation or DIC is?

17 A. I do.

18 Q. Can you define that for us?

19 A. Yeah. It's a situation that's often secondary to
20 hemorrhage in which -- so a lot of people just think our blood
21 is -- I'm not sure what people think. But it's mainly water.
22 But it's made up of red blood cells too, but it also has
23 clotting factors in it. And so when somebody hemorrhages they
24 will often deplete their clotting factors. So they then don't
25 clot and throughout their entire body they can have

1 disseminated, which means throughout the entire body,
2 intravascular coagulation problems.

3 Q. And can you -- when you say problems, can you say more
4 about what problems looks like in that context?

5 A. They can bleed to death. I mean, they literally will
6 die if you can't help them clot their blood. And so you
7 replace -- when someone is having a hemorrhage, whether it's
8 postpartum or after an abortion, car accident, whatever, you
9 have to not just give them red blood cells in volume, you also
10 have to replace clotting factors.

11 Q. Thank you. Are you aware of research demonstrating
12 that the risk of -- actually, let me back up. Is it okay if I
13 refer to disseminated intravascular coagulation as DIC so I
14 don't have to keep saying the words?

15 A. Yeah.

16 Q. Thank you. Are you aware of research demonstrating
17 that the risk of DIC as a complication of D&E increases as the
18 time since fetal demise increases?

19 A. Yes, I am aware of that, particularly in IUFDS after
20 20 weeks.

21 Q. Just when you say IUFDS after --

22 A. Intrauterine fetal demises. So, yeah.

23 Q. Would you agree that the risk for D&E for miscarriage
24 management can be higher than the risk of D&E for induced
25 abortion at the same gestational age?

1 A. I'm sorry, repeat that.

2 Q. Yeah. Would you agree that the risk of D&E for
3 miscarriage management can be higher than the risk of D&E for
4 induced abortion at the same gestational age?

5 A. I have to answer that anecdotally. We don't have
6 head-to-head data. And, you know, women all present very
7 differently. So a woman who has had a loss, so her baby is
8 dead, the longer she goes without it being known, she does have
9 that risk for DIC, as you said. It's extremely uncommon
10 though. I have seen it a couple times, but it's very uncommon.
11 Whereas when you have an induced abortion it's very, very
12 different physiology that's going on when you have in a woman's
13 body and the blood flow. So, you know, the -- the aorta is the
14 biggest artery in our body and it has these two vessels that
15 come out in our groin. They're called our internal iliac
16 arteries. And then our uterine arteries come off of those.
17 They're branches. And they come off right at the cervix and
18 they travel kind of up the sides and they are huge as a term,
19 for sure, especially in C-section. But the bigger the uterus
20 -- the uterus starts off awful small. It's like a lemon or
21 orange. It depends. And then it gets basketball size at term.
22 And so as it grows, the demand for blood flow is greater. And
23 so that demand when you have a live baby is still in place.
24 That demand goes away when the baby dies, which is why we see
25 the maceration and things like that. As a matter of fact, the

1 blood flow is so brisk in a living baby, it's like 500 cc a
2 minute. That's like a half Coke bottle, a big liter bottle in
3 a minute. And that changes when we have a baby that has
4 already died. And so, you know, when you look at risk of
5 bleeding and hemorrhage just anecdotally, it's a very different
6 system. I think the other thing I would add is that -- and I
7 mentioned this before is a lot of the risk for hemorrhage comes
8 from -- and I think Dr. Boraas said this in her deposition.
9 You know, when she teaches residents, you know, having to be
10 very careful about removing the fetal parts that have bones
11 because they're what tear that cervix. And that uterine artery
12 is juicy. It's big. It's right there. So, you know, when
13 you're doing a second trimester induced abortion compared to --
14 with a dead baby the blood flow is going to be different.

15 Q. Thank you. So going to be turning now to the textbook
16 pages.

17 A. Okay.

18 Q. On page 131. Just let me know once you're there.

19 A. I'm there.

20 Q. Okay. So do you see the underlined passage in the
21 second to last paragraph on the last column?

22 A. What I underlined?

23 Q. Yes.

24 A. Yes.

25 Q. Yes. I assumed, but it came to us with the underline

1 so --

2 A. It wasn't a used book.

3 Q. Okay. And this is one of the passages that you cited
4 in your addendum, correct?

5 A. Yes.

6 Q. And the header for the subsection that it falls under
7 is feticidal techniques, correct?

8 A. Right. Where they intentionally are ending the life
9 of the fetus.

10 Q. Sorry, I'm dealing with a last bit of crud from a cold
11 so I apologize for coughing in your ear.

12 A. I'm about a week from getting over mine. So no
13 apologies needed.

14 Q. Thank you. So I'm going to read the first full
15 paragraph of that subsection and I'll ask you whether I have
16 read it correctly.

17 A. Okay.

18 Q. So it says the degree of softening of fetal cortical
19 bones affect the amount of dilation needed for D&E. Softening
20 is facilitated by fetal demise. Noticeable cortical softening
21 begins to occur as soon as 16 to 24 hours after demise. The
22 most common pharmacological agents used to induce demise in
23 developed countries are potassium chloride, KCl, and digoxin
24 and then parentheses Chapter 12.

25 Have I read that correctly?

1 A. Yes. Although mine says Chapter 11.

2 Q. Mine does as well and I appreciate you catching my
3 typo in my head.

4 A. No worries.

5 Q. So this paragraph of the textbook is referring to
6 cortical bone softening as a result of fetal demise induced by
7 the abortion provider, correct?

8 A. Yes. They actually, before doing the abortion, the
9 induced abortion, they actually either gave digoxin or
10 potassium chloride that immediately stops the heart and then
11 the baby dies.

12 Q. And so to clarify, so we're not talking about a
13 situation with spontaneous fetus demise, right?

14 A. Correct.

15 Q. And not talking about cortical softening in that
16 context, correct?

17 A. Not in this particular paragraph.

18 Q. Exactly. Are you aware of any research comparing the
19 rate of cortical softening in the D&E setting to manage
20 spontaneous abortion, as opposed to the rate of cortical
21 softening in the setting of D&E for induced abortion?

22 A. I cannot say that I have read a study or I have looked
23 for a study. I have read in various sources, including later
24 in this book about, you know, just the statement of cortical
25 softening after a fetus demise. And I have definitely

1 witnessed it many, many times when a woman has a spontaneous
2 loss.

3 Q. And when you say you have witnessed it many times, do
4 you mean in your experience in practice?

5 A. Yeah. So when doing inductions and the babies are
6 born and their heads are very crushed.

7 Q. And for the various sources that you -- when you said
8 various sources including the textbook, what other sources are
9 you referring to?

10 A. So throughout the years there is textbooks that we
11 have had in our training and -- gosh, various papers that --
12 where people almost -- almost like they say later, I think it's
13 158 they talk about softening of cortical bone makes it easier
14 to do it. I'm trying to think if ACOG's second trimester
15 bulletin talks about that. But there's a wide variety of
16 places where, you know, it's almost in passing. This happens,
17 you know.

18 Q. Thank you. So I'm going to turn now to page 157 of
19 the textbook excerpt.

20 A. Okay.

21 Q. And again, I'm going to read a passage aloud and then
22 I'll ask you to let me know if I have read it correctly.

23 A. All right.

24 Q. And I'm going to be looking at the last paragraph in
25 the right-hand column. So it says surgical evacuation of a

1 nonviable pregnancy by suction curettage is performed in a
2 fashion similar to first trimester pregnancy termination,
3 parentheses, chapter nine. It is readily accomplished in an
4 outpatient facility, except in cases of severe maternal disease
5 or serious pregnancy-related complications.

6 Did I read that correctly?

7 A. You did.

8 Q. Thank you. And do you agree with that statement?

9 A. So not for me personally. I choose to do -- have
10 chosen over the years to do my first trimester miscarriages,
11 and that's what this is specifically talking about is first
12 trimester, in an ambulatory surgical center or a hospital
13 because of the risk of hemorrhage, the risk of uterine
14 perforation, anesthesia risk, pain control risk. All those
15 things. So I recognize that some other people may choose to do
16 them in an outpatient setting, but I do not.

17 Q. So your practice is -- sounds likes your choice for
18 where you do this is different than what they describe there?

19 A. Well, I think my choice and I think the majority of
20 ob-gyns actually practice in a setting -- do their miscarriages
21 first trimester in -- not in their clinics. And I know Dr.
22 Boraas talks about that, and I even think in her C.V. she's
23 given a talk called something along the lines of don't be
24 afraid to do miscarriages outside the first trimester outside
25 of your clinic setting. So...

1 Q. So I'm going to continue on with the same paragraph in
2 157.

3 A. Okay.

4 Q. And we are still at the last paragraph in the
5 right-hand column. So it says with some nonviable pregnancies,
6 the cervical softening associated with normal pregnancy is
7 absent or minimal, making mechanical dilatation more difficult.
8 Pretreatment with osmotic dilators or Misoprostol may help in
9 those circumstances, parentheses, chapter nine.

10 Did I read that correctly?

11 A. Yes.

12 Q. And do you agree with that statement?

13 A. I do agree with that statement. As we talked about
14 last hour, not all women will have -- will start having their
15 cervix changing, and so sometimes you do have to use a
16 mechanical prep, Laminaria, or the Misoprostol to help soften
17 the cervix.

18 Q. Thank you. And then I'm going to be continuing on in
19 that same paragraph and then into page 158.

20 A. Okay.

21 Q. So it says, quote, in contrast, when the spontaneous
22 abortion process has already begun, the cervix is often dilated
23 to some extent rendering mechanical dilatation easier.

24 Although placental tissue may be more tenacious and difficult
25 to evacuate with some nonviable pregnancies, no studies show an

1 increase in incomplete procedures for nonviable gestations
2 compared to abortion of apparently normal pregnancies.

3 Did I read that correctly?

4 A. Yes, you did.

5 Q. And do you agree with that statement?

6 A. You know, I agree that -- kind of let's take it in two
7 parts. In contrast, when the spontaneous abortion process has
8 already begun, the cervix is already dilated to some extent
9 rendering mechanical dilatation easier. Yeah. I mean, it's
10 always a pleasant surprise when you go in the operating room
11 and you think you're going to have to use your Pratt dilator to
12 serially dilate and wa-lah, she's already open. It does make
13 it easier because we know that the mechanical dilatation is
14 where the potential for uterine perforation can occur. So yes.

15 The second one, although placental tissue may be more
16 tenacious and difficult to evacuate with some nonviable
17 pregnancies, no studies show an increase in incomplete
18 procedures for nonviable gestations compared to abortion of
19 apparently normal pregnancies. I would have to say I have not
20 seen any studies myself. I will say this text is an older text
21 and so there may be studies now. But I am not aware of them at
22 this moment that I have looked in particular for.

23 Q. Thank you. So the quote, and then you have described
24 to us, referred to cervical dilation that can make that
25 mechanical dilatation easier. Is there any other way that the

1 textbook pages you provided to us identify that might make the
2 procedure technically easier with spontaneous abortion?

3 A. Specific to these pages? I would have to review them
4 to answer that. Would you like me to do that?

5 Q. I think we can come back to it. So is there --
6 there's nothing that comes to mind at this point?

7 A. Not specific to the pages I gave you.

8 Q. Thank you. Based on the passages in the textbook that
9 you cited, so those three that I reviewed at the outset,
10 including that bolded passage, would you agree that there are
11 some circumstances in which procedural management of
12 miscarriage is more difficult than a procedural induced
13 abortion?

14 A. So that is a massively hypothetical question. And so
15 I think every situation is unique and you can prepare and
16 expect for various technical difficulties patient by patient.
17 So I can't say -- answer that question the way you have
18 answered sic it. I can say overall when you look at induced
19 abortion compared to miscarriage, there are technical
20 differences that make it more risky, particularly in the second
21 trimester to do induced abortions.

22 Q. So let me then -- just because that was a longer
23 paragraph, I'm going to pull it back and ask a shorter
24 question. So would you agree that there are some circumstances
25 in which procedural management of miscarriage is more difficult

1 than procedural induced abortion in some circumstances or any
2 circumstances?

3 A. So procedural meaning a surgical?

4 Q. Yes. I'm sorry. Yes, I will work on making that
5 change. So would you agree that there are some circumstances
6 in which surgical management of miscarriage is more difficult
7 than surgical induced abortion?

8 A. I can't say I would agree to that because each case is
9 unique. But I guess I'm replicating myself, but I'll go back
10 to say that there are more inherent risks to -- when you're
11 doing an induced abortion with a live baby who -- I think it's
12 in Dr. David Grime's words, at that stage of the pregnancy is
13 tenaciously trying to stay in place. And then a situation
14 where the fetus has already died and physiological changes are
15 already happening, particularly a change in blood flow leading
16 to the changes we see in the fetus. So, you know, I think I
17 can only answer that globally. But yes, can you have a
18 difficult D&C for miscarriage? Yes. And can you have a
19 straightforward -- D&E, I should say, for an induced abortion?
20 Yes. But we're talking -- we're not talking about one unique
21 case. We're talking about the overall risk. And, you know, I
22 clearly stand by my expert report that there are much greater
23 risks due to the physiology that's going on with an induced
24 abortion.

25 Q. Thank you. And looking back to the inherent risks

1 that you just mentioned. Are you referring to the risks that
2 are the result of less cervical dilatation in induced abortion
3 patients?

4 A. I'm really referring to the fact that there are
5 greater risks for hemorrhage when you -- in the second
6 trimester induced abortion. I'm talking about the fact that
7 you have bones that have not -- you're having to dismember the
8 fetus and disarticulate joints. And that's very different when
9 you don't have a body that's already dead and macerated.

10 Q. Are you -- but you're not aware of research -- I'm
11 sorry, let me back up. So you have been describing the
12 experience that you have seen -- talking about the textbook.
13 You're not aware of research stating that D&E for induced
14 abortion is riskier than D&E for spontaneous abortion at the
15 same gestational age, is that correct?

16 A. I'm not saying that I have seen a head-to-head study
17 in terms of that, but there's a whole lot of anecdotal
18 experience, even, you know, individuals who have done complex
19 family planning rotations, you know, talking about dialogue
20 with, you know, people, you know, so...

21 Q. Thank you. I am not trying to beat a dead horse here
22 with some of these follow-up questions. I just want to make
23 sure that we are talking about the same thing and have a common
24 understanding of the full range of information you're talking
25 about. And so the anecdotal experience that you're referring

1 to is not your own direct experience since you have never
2 provided a D&E for induced abortion, is that correct?

3 A. So it's really reading case reports from other people,
4 it's an interest in learning about it because I care about the
5 safety of both my patients. Unfortunately the Society For
6 Family Planning is very exclusive, so I can't become a member
7 and learn some more of these, hence I ordered this text. It's
8 just like anything else in our field. There's so many
9 different areas to learn about. I'm a lifelong learner. I'm
10 continuing to learn and want to continue to learn, and I think
11 the vast experience I have in the operating room, particularly
12 with miscarriages, as well as on labor and delivery with
13 demises or previable inductions, I think allow me to have a lot
14 of knowledge in this area.

15 Q. And so the case reports that you reference, you
16 haven't cited those case reports or other sources in your
17 expert report, correct?

18 A. No, I have not.

19 Q. Can you think of any of those sources just sitting
20 here today?

21 A. I think the one that jumps off at me is a case report
22 series of two women who had placenta previas and showing that
23 with expected management -- of course making sure they didn't
24 get DIC -- showing -- I think I mentioned this earlier, how
25 much the placenta shrinks because it losses its blood supply,

1 and them noting when they did the D&E procedures that they had
2 much less bleeding than they would have even expected because
3 of the placental atrophy. That one jumps off.

4 Q. And where was that one from?

5 A. I could get that to you. I don't know off the top of
6 my head.

7 Q. Okay. We'll ask Mr. Boyle to follow up with you about
8 that.

9 A. Sure.

10 Q. And you mentioned placenta previa. So those are
11 complicated cases, is that correct?

12 A. Well, yes. If you have a placenta over the cervical
13 os it is complicated. But it is -- their point that they were
14 making in it was that they could reduce the complication of
15 hemorrhage from a placenta previa by reducing the blood flow
16 and the size of the placenta. So not immediately doing the
17 D&E. And so what it does is you can use it to show that the
18 physiological changes that make it more risky to do a procedure
19 like induced abortion the second trimester, the physiological
20 changes that support that is what I'm using that for.

21 Q. Thank you. And can you think of any case studies,
22 just following up, as you sit here today, involving
23 non-complicated pregnancies to suggest that the risk of
24 hemorrhage is greater with induced abortion than with
25 spontaneous abortion?

1 A. I can't think of case studies. I have talked to MFMs
2 about it so in the past. I have talked to general ob-gyns
3 about it. But from a literature standpoint, I can't think of
4 something off the top of my head right now.

5 Q. Thank you. And then just one other from a literature
6 standpoint question. Sorry. Are you aware of research
7 comparing the risk of hemorrhage as a complication for D&E for
8 miscarriage management to the risks of hemorrhage as a
9 complication of D&E for induced abortion?

10 A. Could you repeat it? Am I aware of which?

11 Q. Sure. Are you aware of research comparing the risk of
12 hemorrhage as a complication of D&E for miscarriage management
13 to the risk of hemorrhage as a complication of D&E for induced
14 abortion?

15 A. The main literature in that area is not comparing
16 those two. It's really just showing that as gestational age
17 increases, so does risk for hemorrhage. And so that's the
18 emphasis of those studies.

19 Q. All right. And when you say the main researcher of
20 those studies, are there specific studies that you're referring
21 to?

22 A. There are.

23 Q. Are there any -- same question. Any that you can
24 think of as you sit here today?

25 A. I think I document some in my expert report.

1 Q. Are there studies that you can think of beyond that?
2 I'm just wanting to make sure that we have the universe of
3 information for that.

4 A. I will not claim that my expert report is inclusive of
5 every study. It's only, I think, 30 pages long. So there are
6 other studies I have read and I just summarized.

7 Q. Thank you. So I'm going to return us back to the
8 textbook and back to page 158.

9 A. All right.

10 Q. And we are now at the top of the left-hand column in
11 the first full paragraph in that column beginning with the
12 phrase uterine evacuation.

13 Do you see what I'm referring to?

14 A. Yeah.

15 Q. Is this the passage that you cited to in your addendum
16 -- or a passage that you cited to in your addendum?

17 A. It is.

18 Q. And specifically you cite the sentence that reads
19 uterine evacuation may be technically easier after fetal
20 demise. Softening of cortical bone makes surgical extraction
21 easier. With medical aborted patients, induction abortion
22 intervals are often shorter, parentheses, Chapter 11. Is that
23 correct?

24 A. Yes.

25 Q. And did I read that correctly?

1 A. You did.

2 Q. So I'm going to continue reading in that same
3 paragraph. Quote, regardless of the evacuation method chosen,
4 patients with second and third trimester fetal death may
5 require evaluation for coagulopathy, in addition to routine
6 preoperative laboratory tests. Dead fetuses retained in utero
7 for four weeks or more may cause consumptive coagulopathy, a
8 condition that can lead to severe perioperative hemorrhage.
9 Clotting factor therapy prior to uterine evacuation avoids this
10 complication.

11 Did I read that correctly, other than almost certainly
12 mispronouncing coagulopathy because I can never say the word?

13 A. It's not an easy one. I think you did pretty good.
14 Coagulopathy. Yes, you read it correctly.

15 Q. Thank you. And do you agree with that passage?

16 A. Yes, I agree that you do not want a woman to have a
17 coagulopathy and it rarely happens. Four weeks is an awful
18 long time. And so, you know, most women know way beyond four
19 weeks, but you do occasionally have a woman who has DIC and you
20 have to take care of her. But to try to generalize that to
21 mean that a missed abortion leads to a coagulopathy more easily
22 and that's what happens in real life ob-gyn is just not true.
23 But I do think it is warning you that you need to pay attention
24 to the fact that you should do lab work and make sure that a
25 woman doesn't have severe anemia, she doesn't have low

1 platelets, particularly if let's say she comes in and she's
2 supposed to be 20 weeks and her baby is only measuring 16
3 weeks, then that maybe died a month ago and you're going to,
4 you know, know a little bit more than that. So fortunately,
5 this is very rare, but when it does happen, it does increase
6 her risk for hemorrhage.

7 Q. Thank you. And I think that you answered my next
8 question, but just so that -- just so that I'm clear. So is
9 consumptive coagulopathy the same condition as DIC?

10 A. Yes.

11 Q. Thank you. So just some general stuff about the
12 textbook and it may be that you refer to the inside cover for
13 some of this, just as a heads up. But it was published in
14 1999, is that correct?

15 A. Yes, it was. And I was intentional about getting this
16 one, an old one for the purposes of today.

17 Q. Why is that?

18 A. A couple reasons. One is the editors are very well
19 published and they also -- I think this was written at a time
20 that I think I'm a lot -- I was a lot less skeptical. I think
21 they would be more honest in a way a lot of publications are
22 written today. Not that abortion has not historically been
23 political. But when you look at the writings, even the
24 textbooks when I was a resident in '97 to 2001, which this
25 would have been published during that time, it seemed to be

1 much more objective. There is so much publication bias that's
2 happening right now, difficulty getting things published if --
3 if the society owns the journal and they don't have the same
4 belief structure as you. I have lost trust sadly. You know, I
5 have a Ph.D. and I don't think some of the integrity we used to
6 have, we still have in medicine. I have sadly seen ACOG make
7 some changes in things that I don't think are science based.
8 And so I intentionally did an older textbook hoping to see a
9 little more objectivity. And so, yeah, that's why I chose it.
10 And a second reason, Dr. Boraas has a book -- a chapter coming
11 out in a surgical gynecology book and she's talking about
12 surgical complications in her chapter and it's not going to be
13 published until March. So couldn't access that one.

14 Q. Thank you. And I appreciate you explaining the
15 thinking behind choosing a textbook from that time period. So
16 medical education -- medical education in 2024 isn't exactly
17 the same as in 1999, correct?

18 MR. BOYLE: Objection.

19 THE WITNESS: A whole lot of it is the same. A
20 whole lot of it is the same. Now, what's different? Is first
21 day of my rotation, third year of medical school, I was told I
22 was entering the most unique specialty in all of medicine
23 because I got to take care of two patients simultaneously, a
24 maternal and a fetal patient. Same thing was repeated to me
25 two years later when I was starting residency and I was an

1 intern in ob-gyn. That's changed. Sadly the absence of
2 acknowledgment of our fetal patient and trying to normalize
3 that has changed. But so much of this textbook is very true
4 still today. So I would disagree with your statement.

5 BY MS. PAI-THOMPSON:

6 Q. Thank you. I'm switching topics again and then I'll
7 just flag -- you may be wondering in terms of our break. I
8 think we'll take our next break after we get through this set
9 of questions.

10 A. That will be fine.

11 Q. So I'm going to be talking about the subject of live
12 birth. Are you aware of any live births that occurred
13 following a D&E procedure as opposed to an induced abortion?

14 A. Yes.

15 Q. Let me re-ask the question because I just want to make
16 sure I have the wording clear. Are you aware of any live
17 births that occurred following a D&E procedure as opposed to an
18 induction abortion?

19 A. I think it's much more common with an induction
20 abortion, which is actually why people will sometimes --
21 clinicians will use feticide before because it's the concern of
22 a live birth. And then they would actually have -- they would
23 have failed their intention of the procedure and they would
24 have to hopefully care for that newborn. But yes, I am aware
25 of people who have survived the other type, a dismemberment

1 procedure, D&E.

2 Q. And so when you're saying that -- what -- for the
3 cases that you're aware of, how are you aware of those?

4 A. Just have heard their story. Like I think one is a
5 public speaker and I think doesn't have an arm.

6 Q. Do you know at what gestational age that their live
7 birth occurred?

8 A. I don't.

9 MS. PAI-THOMPSON: I think this is a good time
10 for our next break. Does 10 minutes work again?

11 THE WITNESS: Sure.

12 MS. PAI-THOMPSON: Mr. Boyle?

13 MR. BOYLE: Yeah.

14 MS. PAI-THOMPSON: And then I'll just also, for
15 our court reporter, ask for a time check when we come back.

16 - - -

17 (A break was taken - 4:01 p.m. - 4:13 p.m.)

18 - - -

19 MS. PAI-THOMPSON: Dr. Bane, I'm going to
20 direct you now to the Desai study that you cited. I'm going to
21 drop that into the chat and ask that it be marked as an exhibit
22 for the deposition, but then we'll go off of our paper copies.

23 - - -

24 (Document marked as Exhibit-29 for
25 identification.)

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THE WITNESS: Sorry, I'm just trying to locate it.

MS. PAI-THOMPSON: Absolutely. Let me know when you have it.

THE WITNESS: I have a hard copy of it. I'll pull it up. It's fine.

MS. PAI-THOMPSON: Okay. Let me know when you have it up.

THE WITNESS: Let me just see something real quick here. Maybe it's in this one. Do you mind just screensharing it?

MS. PAI-THOMPSON: Absolutely. For some reason Acrobat is not giving me that field to screenshare. So I think what we're going to do is I will move on while I also figure out why Acrobat is behaving that way. Oh, perfect. Actually I have a colleague who is going to screenshare who is not having the same issue as I am.

THE WITNESS: Okay.

MS. PAI-THOMPSON: So I think Hannah is going to screenshare and let me know when you can see the document up.

THE WITNESS: Not yet. And I'm still looking too. Still just the four of us on the screen.

MS. PAI-THOMPSON: Okay. Let's do this --

1 never mind. Okay. Fabulous. It has taken over my entire
2 screen and that I don't want.

3 BY MS. PAI-THOMPSON:

4 Q. All right. So looking at -- we're going to begin with
5 the first page here. The study that Desai and colleagues did,
6 the study's aim as it's described in the objective was not to
7 assess why providers did or didn't provide abortion, correct?

8 A. No, that was actually not done in this study. It was
9 actually done --

10 Q. I'll have a follow-up question to that. So the
11 question of why in this study, they only put that question to a
12 smaller subset of the participants, correct?

13 A. I'd have to review it to know that they did a subset.
14 I just recall the Grossman study being able to have statistics
15 as to why. I don't recall that in this one.

16 Q. Okay. Well, let's go to then table one, which is at
17 the very last page of this study. And it will be a landscape
18 view rotation.

19 So looking at the top of the table which describes --
20 gives us the results from the study about why people didn't
21 provide abortions. It describes the table as the percent
22 distribution of reasons cited for not providing abortion
23 referrals among obstetrician-gynecologists who do not perform
24 abortions, by type of survey response correct?

25 A. Yeah. Can the person make it a little bigger? These

1 are trifocals. I need a little more. Yeah. Great. Thank
2 you. That's plenty.

3 Q. Okay. So I read that correctly, right?

4 A. You did.

5 Q. So this is describing results from people who
6 indicated that they did not perform abortions and were then
7 asked the follow-up questions about why, correct?

8 A. For this subset of it looks like 271 people.

9 Q. Correct.

10 A. There were over 800 initially. So I'm not sure why
11 it's just this subset.

12 Q. We'll get into that. So looking at this 271 of all
13 respondents in that subset, you see that there are initial
14 respondents and there were 81 initial respondents. I'm sorry,
15 58 initial respondents, correct?

16 A. Yes.

17 Q. And then 213 follow-up respondents, correct?

18 A. Yeah. But I would have to see the study to know what
19 the difference in the two are.

20 Q. So of these smaller subsets that's discussed in table
21 one for the -- I'm going to be in the all respondents column.
22 The 16 -- it was 16 percent of that smaller subset that
23 identified personal, moral, or ethical objections, correct?

24 A. I have a moral or ethical objection to abortion. 16
25 percent, right.

1 Q. And then of that smaller subset, 17 percent identified
2 office policy, correct?

3 A. Office -- my office has a policy specifically against
4 discussing abortions, 17 percent.

5 Q. Correct. And then 14 percent identify N/A, not
6 applicable. I have not encountered a patient seeking abortion
7 at this office, correct?

8 A. Correct.

9 Q. And then nine percent identified, quote, my office
10 staff is against abortion, correct?

11 A. Correct.

12 Q. Eight percent, I do not know any abortion providers in
13 my area, correct?

14 A. Correct.

15 Q. And two percent, my community is against abortion,
16 correct?

17 A. Correct.

18 Q. And things like office staff and community being
19 against abortion, those can be caused by abortion stigma,
20 correct?

21 A. So, I mean --

22 Q. My question is they can be caused. I'm not asking you
23 to say what would occur in every case. But they can occur
24 because of abortion stigma, correct?

25 A. The reason why they're not done in an office?

1 Q. Or why staff would be against.

2 A. Well, I mean, I think the stigma is potentially more
3 on the patient side that I think has to go away in terms of I
4 think we stigmatize when we're with unplanned, unexpected
5 pregnancies.

6 Q. My question though is about the choice that an office
7 might make.

8 A. Okay.

9 Q. Policy to not provide abortion could be the result of
10 community stigma in the community that that office is in,
11 correct?

12 MR. BOYLE: Objection. You're asking this
13 doctor what now?

14 MS. PAI-THOMPSON: I will repeat my question.
15 BY MS. PAI-THOMPSON:

16 Q. My question is -- and we're looking at, again, the 17
17 percent of that smaller subset that identified an office policy
18 as the reason that they don't provide abortion. So we have
19 that 17 percent. Okay.

20 A. Okay.

21 Q. For an office that is situated in a community that is
22 against abortion, that can contribute -- against abortion where
23 there is abortion stigma, that can contribute to choices around
24 office policy, such as not providing abortions, correct?

25 MR. BOYLE: Objection. She's not an expert --

1 MS. PAI-THOMPSON: I'm going to object to
2 speaking objections. If the objection is to my form, we'll
3 note that. But my question stands and I would ask the witness
4 to answer.

5 MR. BOYLE: Object to form.

6 THE WITNESS: Okay. So I can't say I agree
7 with you in terms of knowing how this person interpreted their
8 decision to do an induced abortion based on the community they
9 live in. I can't -- I don't know what was going through that
10 person's head. I can't claim that it was stigma that they may
11 experience. Perhaps it is an influence of the community making
12 them think, boy, the direct and intentional killing of another
13 human, maybe that isn't a good thing to do. But they haven't
14 got to the place where they morally or ethically object. So I
15 really don't think I can say I know the reason is stigma.

16 BY MS. PAI-THOMPSON:

17 Q. So I'd like to talk -- referring to -- you mentioned
18 the person who's providing the abortion and directing you again
19 to the column in table one about follow-up respondents.

20 A. Okay.

21 Q. At the bottom it describes -- at the very, very bottom
22 of the page that begins follow up.

23 A. Yes.

24 Q. And it says, quote, follow up respondents are those
25 who provided information during telephone follow-up, correct?

1 A. Yes.

2 Q. So that's giving us that the 213 out of 271
3 respondents were those who provided information during
4 telephone followup, correct?

5 A. Yes.

6 Q. I'm going to refer you, and then my kind colleague who
7 is helping me out, to page three. And we'll go to the bottom
8 of the second paragraph on page three. All right. And in that
9 section this study describes, quote, information obtained
10 during followup was provided by office staff rather than
11 physician as surveyors were seldom, if ever, connected to the
12 physician by phone, correct?

13 A. Yes. That's correct.

14 Q. So this 213 out of 271 number of follow-up
15 respondents, those are not actually opinions directly expressed
16 by the physicians to the researchers, correct?

17 MR. BOYLE: Objection.

18 MS. PAI-THOMPSON: You can answer the question.

19 THE WITNESS: Could you repeat it, please,
20 Vanessa?

21 MS. PAI-THOMPSON: Sure. I can back up.

22 BY MS. PAI-THOMPSON:

23 Q. So page three, the study discloses that information
24 obtained during phone followup, which is the phone followup
25 that they refer to at the bottom table one, that followup

1 respondents were those who provided information during
2 telephone followup, again, the bottom of page three, the page
3 that we have up, that information obtained during phone
4 followup was provided by office staff rather than physicians
5 and surveyors.

6 MR. BOYLE: Objection.

7 BY MS. PAI-THOMPSON:

8 Q. Seldom, if ever, connected to the physician via phone,
9 correct?

10 MR. BOYLE: Objection. You can answer.

11 THE WITNESS: I agree with what you're reading.
12 I don't know if there's another question in there.

13 BY MS. PAI-THOMPSON:

14 Q. So the question was do you agree with my reading and
15 as you -- let me actually withdraw that question.

16 So it's common as part of a study that the researchers
17 will describe their process, correct?

18 A. The method is that process, yes.

19 Q. And you don't have any reason to believe that in this
20 study the processes that they described in the article are
21 accurate, correct?

22 MR. BOYLE: Objection.

23 BY MS. PAI-THOMPSON:

24 Q. Do you have any reason to doubt that they described
25 what they did in the method section?

1 A. I don't have any reason to doubt if that's what
2 they're describing. I have a lot of concern about their
3 methodology though.

4 Q. My question though was whether they described their
5 methodology in the method section.

6 A. So it would have been nice to know what office staff
7 is, but you don't want me to go there yet?

8 Q. I'm just going to refer us back then to -- and you
9 have answered this question already, that I have read correctly
10 the section where they discussed information during follow-up,
11 correct? At page three at the bottom of the second paragraph.

12 MR. BOYLE: Objection.

13 THE WITNESS: So Vanessa, the only thing I
14 would agree with right now is I have some concerns about, you
15 know, the figure and this methodology, but I agree that you
16 have read that last sentence correctly.

17 BY MS. PAI-THOMPSON:

18 Q. The study also focused only on private practice,
19 correct?

20 A. Correct.

21 Q. And it specifically excluded ob-gyns who practice in
22 clinics, correct?

23 A. Practice in clinics? What do you mean by that? Are
24 you talking about academic?

25 Q. What's that? A clinic like Planned Parenthood, they

1 specifically excluded from this study participants -- or
2 providers who practice in clinics?

3 MR. BOYLE: Objection.

4 THE WITNESS: I would need to review to be able
5 to answer that. I know it's private practice.

6 BY MS. PAI-THOMPSON:

7 Q. So we're at the top of the same page, the second
8 sentence -- I'm sorry, the first sentence. Physicians who are
9 clinic based, retired or deceased or did not provide accurate
10 contact information were excluded from the sample. Prior to
11 mailing the survey, 29 physicians were identified as clinic
12 based and were removed from the sample, correct?

13 A. What you're reading is correct, but I don't know how
14 they define clinic based in this study.

15 Q. Well, we can move on and then we can go back to that.
16 I'm going to move on now to Grossman.

17 A. Okay.

18 Q. Yes. And I'm going to -- do you have the paper copy
19 of that handy?

20 A. I don't. You'll need to share that.

21 Q. Okay.

22 MS. PAI-THOMPSON: And I'm also going to drop
23 that in the chat and ask that it be moved as an exhibit.

24 - - -

25 (Document marked as Exhibit-30 for

1 identification.)

2 - - -

3 BY MS. PAI-THOMPSON:

4 Q. Do you have it in front of you or are we screen
5 sharing?

6 A. I don't have anything in front of me yet, but it took
7 a minute for it to come up last time. Here it comes. I have
8 it.

9 Q. Okay. So again with Grossman, they did not identify
10 as their reason, their purpose in performing this study
11 discerning why people chose not to provide abortions, correct?

12 A. I think that was an element of it, that they did that.

13 Q. They did do it, but it was not identified as a
14 reason --

15 MR. BOYLE: Can you let her finish her answer,
16 please? She was not finished.

17 THE WITNESS: So I think that if you look at
18 just their objective to estimate proportion of obstetricians,
19 gynecologists who provide induced abortions in the prior year
20 and document -- disaggregated by surgical and medication
21 methods and document barriers to provision of medication
22 abortion, I think that is an element of the why.

23 BY MS. PAI-THOMPSON:

24 Q. And so it actually was -- you brought up the objective
25 piece. It was in the documenting barriers to provision of

1 medication abortion. That was actually where they asked the
2 question why, correct?

3 A. I would need to review their methods one more time.

4 Q. I will focus you on something as you do that. That
5 here the smaller subset of participants they asked the why
6 question to were participants who did not provide medication
7 abortion, correct?

8 A. I would need to review the methods to know that for
9 sure.

10 Q. So at table four in this study. And this is the table
11 that gives us that 34.2 percentage figure that you cite to in
12 your expert report, correct? Or it reflects that figure.

13 A. Could you make it a little bigger for me? Yes.

14 Q. Again, for the why question, it gives the heading for
15 table four that includes this data is, quote, perspectives of
16 obstetricians, gynecologists who do not provide medication
17 abortion among those who have patients seeking abortion,
18 correct?

19 A. Correct. That's the title.

20 Q. So this -- according to the title, this table reflects
21 the subset of people who do not provide medication abortion and
22 were asked the why question, correct?

23 A. Yes.

24 Q. And in that section the most common reasons listed are
25 discussed. And you also discuss that in paragraph 22 of your

1 report, correct?

2 A. Yes.

3 Q. And in paragraph 22 of your report you refer to that
4 34 percentage as the most common reasons for not providing
5 abortions included personal, religious or moral beliefs against
6 abortion, correct?

7 A. Yes.

8 Q. The study here when describing the same information
9 actually says that it is the reasons for not providing
10 medication abortion here, correct?

11 A. Yes, I stand corrected that I left out the word
12 medication.

13 Q. And in addition to that 34 percent that you noted
14 referenced moral reasons in that table we see that probably 19
15 percent reference practice setting restrictions?

16 A. Yes.

17 Q. And 16 percent reference office staff attitudes?

18 A. Yes.

19 Q. Do you believe that abortion providers experience more
20 or less verbal harassment than physicians who do not provide
21 abortion?

22 MR. BOYLE: Objection.

23 THE WITNESS: I have no way of answering
24 objectively that question. I will tell you that there's stigma
25 in various aspects of medicine. I'm stigmatized often being a

1 medical director for Pregnancy Centers. ACOG has called me
2 unethical in their issue brief about Pregnancy Centers. So I
3 think stigma is wrong regardless of who is getting it. But
4 whether it is somebody who is trying to practice from a
5 life-affirming approach like myself or -- I don't think
6 individuals who provide abortion should be stigmatized. But I
7 cannot tell you they are more stigmatized than other people
8 are.

9 BY MS. PAI-THOMPSON:

10 Q. You're not aware of any other specialty other than
11 providers who provide abortions in which physicians have been
12 murdered for the medical care they provide, are you?

13 MR. BOYLE: Objection.

14 THE WITNESS: I don't know the answer to that
15 question.

16 MS. PAI-THOMPSON: I'm going to move now to the
17 Niinimaki study and the letter to the editor. And I'm going to
18 drop both of those into the chat and ask that they be marked as
19 exhibits.

20 - - -
21 (Document marked as Exhibit-31 for
22 identification.)

23 - - -

24 BY MS. PAI-THOMPSON:

25 Q. Do you have those in paper copy or do we need to --

1 A. No, I actually have -- I have Niinimaki. I don't have
2 the second part.

3 Q. Okay. So we will get ready to screenshare the letter
4 to the editor as needed and we'll begin with the paper itself
5 then. So in the United States, medication abortion procedures
6 are generally a combination -- I'm going to withdraw that
7 question and ask it more clearly.

8 In the United States one commonly used regimen for
9 medication abortion is a combination of Mifepristone and
10 Misoprostol, correct?

11 A. Yes.

12 Q. And then another common regimen is the use of
13 Misoprostol alone, correct?

14 A. Much less common.

15 Q. In your discussion on August 31st in your deposition,
16 you and Ms. Salvador discussed some facets of the Niinimaki.
17 I'm not going to retread that ground, so we'll just get into a
18 few additional questions. The study identified medication
19 abortion protocols that are available -- that are used in
20 Finland that are not those two that we just identified,
21 correct?

22 A. Let me review it again. I believe that they only go
23 up to 63 days.

24 Q. So I'm asking just about the drugs that were used.
25 And specifically in one instance they say that there was a

1 Mifepristone-only regimen that's used in Finland?

2 A. Yes, I do know that.

3 Q. During the August 31st deposition, you and Ms.
4 Salvador reviewed the letter to the editor and we'll go ahead
5 -- we can screenshare that as well for our reference here. And
6 in that deposition, do you recall discussing concessions that
7 are in the letter to the editor about limitations of the study?

8 A. Yes, I remember just the aspect related to hemorrhage.
9 The study also looked at incomplete abortions and having to go
10 back to surgery. But the letter saying that some of the people
11 who went to the -- to follow-up care, would it truly be
12 classified as hemorrhage as -- that was the gist of our
13 conversation.

14 Q. Okay. Thank you. And do the concessions from the
15 authors of the Niinimaki study change your opinion about the
16 study's reliability as a source for your statement in paragraph
17 48 of your report that, quote, chemical abortions have a four
18 times higher risk of complications compared to surgical
19 abortions?

20 A. I think the absolute numbers may change, but I think
21 the ratio comparing surgical abortion and medication or
22 chemical abortion, you're still going to -- and it's not just
23 this study. I think it's the Mintua study I also reference.
24 We consistently see that there are higher complications with
25 medication abortion compared to surgical. But I think the

1 absolute numbers would have to be reevaluated.

2 Q. And so is your answer that it doesn't change your
3 opinion about the study's reliability as described in paragraph
4 48 or that it does?

5 A. It impacts it, but that piece is one part of this
6 entire study. But I still -- with the collective body of
7 research still, the fact that surgery -- I'm sorry, medication,
8 chemical abortion leads to more complications I still stand by.

9 Q. In your opinion, in general -- is it your opinion, in
10 general, that abortion is not safe?

11 A. Are we talking about induced abortion?

12 Q. Yes. I will rephrase. It's your opinion that, in
13 general, induced abortion is not safe, correct?

14 A. It is my opinion that we need to do a much better job
15 collecting data to make that conclusion. I think it's an
16 assumption at this point for many different reasons that I
17 outline in my expert report.

18 Q. And so when you say that it's an assumption, do you
19 mean that it's your assumption that it's not safe?

20 A. It's an assumption that Dr. Boraas and Dr. Farris make
21 throughout the entirety of all of their documentation.

22 Q. My question is not about the conclusion that abortion
23 is safe. My question is about your opinion. So I'll re-ask
24 the question. And that's why I say I might need to jump in to
25 clarify if it seems like we're talking about different things.

1 My question is it's your opinion that, in general,
2 induced abortion is not safe, correct?

3 A. So once again, an extremely loaded question. So it is
4 never safe for my fetal patient, and I was taught and continue
5 to believe, the purpose of health is for -- of medicine is for
6 health and wholeness and that I have a maternal and a fetal
7 patient to take care of. It is never safe for my fetal
8 patient. I have grave concerns for keeping my patients safe
9 who choose to have an induced abortion, and I want to do
10 everything in my power to minimize their risk. And so that's
11 what I can agree to you to say.

12 Q. Thank you.

13 MS. PAI-THOMPSON: I think that we will take a
14 break here. Shall we do 10 minutes?

15 THE WITNESS: Okay.

16 MS. PAI-THOMPSON: Thank you. If I could get
17 actually a time check from our court reporter, that would be
18 hugely appreciated as well. Thank you.

19 - - -

20 (A break was taken, 4:43 p.m. - 4:53 p.m.)

21 - - -

22 MS. PAI-THOMPSON: And I just want to confirm
23 also -- I'm sure that we -- I dropped -- I am going to --
24 because I thought I had and I hadn't, drop just for the
25 purposes of our record, the letter to the editor into the chat

1 and ask that it be marked as an exhibit.

2 - - -

3 (Document marked as Exhibit-32 for
4 identification.)

5 - - -

6 BY MS. PAI-THOMPSON:

7 Q. Dr. Bane, you're not familiar with the training that
8 any Planned Parenthood South Atlantic receives regarding
9 administering anesthesia, are you?

10 A. I can only talk about what -- the deposition that Dr.
11 Farris did.

12 Q. Okay. So no knowledge beyond that deposition?

13 A. In the protocols -- I've reviewed the policies and
14 procedures in the protocols and there's no mention of any
15 anesthesia professionals.

16 Q. And so my question was the extent of your knowledge
17 about the training that any Planned Parenthood South Atlantic
18 employee would receive is from exclusively from the deposition
19 of Dr. Farris, is that correct?

20 A. From the deposition and any policies and procedures
21 that I was given to review.

22 Q. Thank you. And you don't know the sedation practices
23 that non-Planned Parenthood South Atlantic providers in North
24 Carolina use, correct?

25 A. As part of this case, there was no discovery related

1 to that. I can't even really talk to you about patients who
2 have gone to some of those places.

3 Q. You don't have comprehensive information --

4 MR. BOYLE: She's not done with her answer.

5 THE WITNESS: Yeah. So talking about how
6 difficult their experience was. But I do not have any
7 documentation. I have patient anecdotal experiences.

8 MS. PAI-THOMPSON: Thank you. And I am just
9 now dropping that letter into the chat. Sorry. My window had
10 closed out.

11 BY MS. PAI-THOMPSON:

12 Q. Is it your testimony that only people who have
13 completed a complex family planning fellowship can safely
14 provide D&Es for induced abortion?

15 A. It is my testimony that the purpose of the complex
16 family planning fellowship, above and beyond four years of
17 training, is that there is an additional need for second
18 trimester or third trimester abortions and then contraception
19 is the second element. And that it is now not just resident --
20 or fellowship programs. It's actually a board certification.
21 So based on that, it is my opinion that the American College --
22 the American Board of Ob-Gyn, excuse me, and residency programs
23 believe that it is necessary.

24 Q. So my question isn't about what you believe they
25 believe. My question is, is it your testimony that it's your

1 opinion that only people who have completed a complex family
2 planning fellowship can safely provide D&Es for induced
3 abortion?

4 A. At what gestation are you talking about?

5 Q. After the twelfth week.

6 A. Okay. So second trimester. I -- so repeat the
7 question now that we have clarified the gestational age.

8 Q. Is it your testimony that it's your opinion that only
9 people who have completed a complex family planning fellowship
10 can safely provide D&Es for induced abortions after the twelfth
11 week of pregnancy?

12 A. So I can't say yes or no to that question. There are
13 --

14 Q. If you can't say yes or no, that's fine. I can --

15 A. Can I finish what I was going to say? So there are
16 people who have 20-plus years experience and have done a
17 tremendous amount of them, and this is a fairly new complex
18 family planning program. I think it's only become a board
19 certification the last few years. So I think there are people
20 who have practiced a long time. As a matter of fact, all the
21 editors of this book do abortions, from my understanding, or
22 did. They're not all practicing right now. And they didn't
23 complete the program. And so I think that you can't just make
24 a blanket statement like that that I could easily say yes or no
25 to. I think that it is technically a very difficult procedure,

1 as many people have alluded to from reading the literature.
2 And it is a fact that our governing bodies think that we need
3 additional training beyond four years is consistent with that.

4 Q. Thank you. So I'm going to refer back to the
5 textbook. And you described that you intentionally chose a
6 textbook from 1999. You intentionally chose a textbook from
7 1999, and knowing that it might not reflect the current state
8 of medical practice, is that correct?

9 A. No, that's not correct at all. If you recall, I said
10 that the names are very respected and well-known in ob-gyn. So
11 that drew me to it. And then what drew me to it also is the
12 fact that I felt that perhaps they would write it from a more
13 objective standpoint than what I see so much of what's being
14 written today. I knew there would be a critique of how old it
15 is and I think there are some things in there that they might
16 say we don't know this, and now I kind of can go oh, yeah, we
17 do. But there are many things in there that are the same as
18 what we do now.

19 Q. So is it your opinion that everything -- just the
20 textbook pages that you sent us, not the entire textbook, but
21 the textbook pages you sent to us reflects current medical
22 practice?

23 A. Well, once again, I think you're trying to
24 oversimplify the situation. For example, I think the data have
25 changed where they say that I think it was 50 percent have not

1 received training in first trimester abortions. Now that
2 number is lower. And so I think there are some shifts in even
3 then. They -- medication abortion, chemical abortion was --
4 you know, it wasn't -- Mifepristone wasn't approved until 2000
5 and so this is written in 1999. There's a very fascinating
6 statement in the first or second chapter that states that if
7 medication abortion can happen before implantation, then maybe
8 we'll call it contraception one day. And I find that
9 fascinating because ACOG has now changed the beginning of
10 pregnancy to implantation. So some of the story lines that I
11 see historically playing out, the stage was set in this book.

12 Q. What's the basis for your belief that women receive
13 inadequate pain management during second trimester abortion?

14 A. Well, I didn't -- if I came across as saying that
15 every woman receives inadequate pain management, then I will
16 pull back on that statement. I don't believe every woman does.
17 I believe that pain management takes a second seat to trying to
18 get abortions often done in a setting where you cannot do deep
19 sedation or general anesthesia. That's the point that I made.
20 And I also anecdotally have had patients who have talked about
21 that they did not feel like they were adequately managed with
22 their pain with their surgical abortions. From reading, I
23 think it was Dr. Wheeler and Dr. Rubinhorse's expert reports,
24 they cite studies of inadequate pain management. I did not
25 site those studies. So it's multiple reasons. But do I

1 believe a woman can get adequate pain management? Yes, I do.

2 Q. Thank you. And you referred to the studies that Dr.
3 Wheeler and Dr. Rubinhorse relied on. Did you review those
4 studies or just see the citations?

5 A. I just saw the citations.

6 Q. Thank you. Was it your practice when you were
7 providing care, was it your practice to provide either deep
8 sedation or general anesthesia to every patient who you
9 provided a D&E?

10 A. I didn't provide the anesthesia. The anesthesiologist
11 or nurse anesthetist -- the anesthesia professional provided
12 that. And I would say the majority chose general anesthesia.

13 Q. And so referring to practice statements and committee
14 opinions that we have kind of talked about through this
15 deposition. You agree that practice statements and committee
16 opinions are the result of a review of the relevant literature,
17 correct?

18 A. That's what they should be based on.

19 Q. And them being based upon that allows them to
20 represent something close to a professional consensus, correct?

21 A. Could you define what you mean by a professional
22 consensus?

23 Q. A general consensus among the providers for whom the
24 body issuing the practice statement or committee opinion.

25 A. So I wouldn't necessarily agree with that statement.

1 I would agree that it is a -- it should be that. It should be
2 a consensus of membership. It's not always consensus of
3 membership. At the bottom of committee opinions they'll have
4 the individuals who actually were on that committee and made
5 that decision. And so I think a ACOG, while it does a lot of
6 great work in areas -- some areas, I think in the -- their
7 abortion statement they don't represent a consensus of their
8 membership.

9 Q. And you referenced ACOG'S statements, you don't
10 believe they represent a consensus?

11 A. Not all of them. Just --

12 Q. Yes. That's going to be my follow-up question to
13 clarify. That's, as you were talking about earlier there,
14 statements that refer to policy about abortion, correct?

15 A. Correct. And so, you know, I'm watching like a hawk
16 if they -- if they make statement changes that are -- seem to
17 be politically driven instead of science driven. And I think
18 their abortion policy -- the way they changed it from after
19 viability they did not support abortion for a healthy fetus.
20 And as soon as the Dobbs leak came out they changed it to full
21 with no barriers and no limitations. And that was like the
22 Dobbs leak. That wasn't even the Dobbs decision. So those
23 types of things are not professional and do not show integrity.
24 And those are the things that I'm very concerned about.

25 Q. Thank you. And you sort of jumped and corrected -- I

1 was talking about -- you said not all ACOG statements and have
2 described how you disagree with their policy statements. You
3 generally think that the technical medical information that
4 they include is accurate?

5 A. We'd have to go statement by statement. But the ones
6 I chose to include in my expert report, I fully support the
7 position they gave.

8 Q. And that was 191 and 193, right?

9 A. I think 191 was my first declaration. 193 for this
10 one where they did an interim update.

11 Q. Thank you. Do you have any reason to believe that a
12 patient is more likely to see a CFP trained physician at a
13 hospital than at an outpatient abortion clinic?

14 A. You say CFP trained, are you talking about fellowship
15 trained?

16 Q. Sorry. Yes. Yes.

17 A. So could you ask me that question again?

18 Q. Absolutely. Do you have any reason to believe that a
19 patient is more likely to see a complex family planning
20 fellowship trained physician at a hospital than at an
21 outpatient abortion clinic?

22 A. I don't know the percentage of those individuals that
23 go into academic positions. I know Dr. Boraas does a lot of
24 her procedures in the hospital. But I don't know the
25 statistics for what their -- where their graduates go.

1 Q. Thank you.

2 MS. PAI-THOMPSON: And I have no further
3 questions at this time.

4 BY MR. BOYLE:

5 Q. Doctor, good afternoon. My name is Ellis Boyle and I
6 represent the defendant intervenor legislative leaders and I
7 would just like to ask a few questions. Could you please tell
8 us if you have any concerns with the Desai conclusions from
9 that study?

10 A. So we never got to kind of what my concerns were, but
11 I think from a methodological standpoint they have very
12 different ways that they are getting to their data, and the
13 fact that one is a survey that's likely anonymous versus a
14 telephone call. We know that individuals are more honest and
15 feel free to give their opinions when they're doing an
16 anonymous survey or a survey that no one -- they don't have to
17 attach their name to it, versus I pick up the phone and I say
18 hey, why don't you do medication abortions was the table -- was
19 it medication abortions for that particular study? And so I --
20 I have a problem with that. And then, you know, I do think
21 that there are multiple reasons why ob-gyn physicians do not
22 choose to do abortions, but I think we have to be careful that
23 just -- while a third of them stated specifically I have moral
24 or ethical objections, the fact that they have chosen a
25 practice which they knew didn't do them, then that's also an

1 indirect reason that -- they knew they weren't going to be able
 2 to do them, so that also goes towards those numbers. And so I
 3 think we just have to weed out and cipher out that study
 4 better, which we didn't really go into.

5 Q. And not to be too broad, but there were some other
 6 studies that you were asked about in the textbook. Was there
 7 anything that you wanted to followup and say -- that you would
 8 like to have the opportunity to say now about what you were
 9 asked about for the previous three hours?

10 MS. PAI-THOMPSON: Objection to form.

11 THE WITNESS: Not that comes -- I can think of
 12 right now.

13 MR. BOYLE: Okay. I don't have any further
 14 questions. Thank you.

15 MS. PAI-THOMPSON: I have no further questions
 16 either. Thank you.

17 MR. BOYLE: Anyone else?

18 MR. BULLERI: I do not have any questions.
 19 Thank you.

20 - - -

21 (Witness excused.)

22 - - -

23 (Deposition concluded 5:11 p.m.)

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CERTIFICATE OF REPORTER

STATE OF NORTH CAROLINA)
COUNTY OF ALAMANCE)

I, Susan A. Hurrey, RPR, the officer before whom the foregoing remote deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me to the best of my ability and thereafter reduced to typewriting under my direction; that the witness reserves the right to read and sign the transcript of the deposition prior to filing; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and further, that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

This the 13th day of February, 2024.

SUSAN A. HURREY, RPR
Notary Public 201826800211

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I, SUSAN BANE, M.D., Ph.D., do hereby state
under oath that I have read the above and
foregoing deposition in its entirety and that
the same is a full, true and correct transcript
of my testimony, subject to the attached list of
corrections, if any.

SUSAN BANE, M.D., Ph.D.

STATE OF _____

COUNTY OF _____

Sworn to and subscribed before me this _____ day
of _____, 20____.

Notary Public

My commission expires: _____

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DISCOVERY

COURT REPORTERS AND LEGAL VIDEOGRAPHERS

ERRATA SHEET FOR THE DEPOSITION OF:

Deponent: Susan Bane, M.D., Ph.D.

Case Name: Planned Parenthood South Atlantic, et al. v. Joshua Stein, et al.

Date of Deposition: 01/31/2024

CORRECTIONS:

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Page	Line	Now Reads:	Should Read:	Reason Therefor:
30	6	included in ACOG cog	Included in ACOG	Extra word
48	24	trachea	tracheostomy	Wrong word
69	6	is	are	Grammar
73	18	answered	asked	Wrong word
75	16	I am not saying	I am saying	Incorrect
107	23	Rubinhorse's	Dr. Wubbenhorst	Spelling
108	3	Rubinhorse's	Dr. Wubbenshorst	Spelling

Signature of Deponent
ND:4875-5970-8073, v. 1

Date: 2/26/2024

EXHIBIT E

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

PLANNED PARENTHOOD SOUTH)
ATLANTIC, et al.,)
Plaintiffs)
)
vs.)
)
JOSHUA STEIN, et al.,)
Defendants)
)
and)
)
PHILIP E. BERGER, et al.,)
Intervenor-Defendants)

REMOTE DEPOSITION

OF

MONIQUE CHIREAU WUBBENHORST, M.D., M.P.H.

January 24, 2024, 1:00 P.M.

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and Legal Videographers, LLC
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22 ALSO PRESENT:

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Sarah Corning
Megan Fernandez
Tamika Henderson
Vanisha Kudumuri
Ronelle Tshiela

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1 MONIQUE CHIREAU WUBBENHORST, M.D., M.P.H.,
2 after having been first duly sworn, was examined and testified
3 as follows:

4 BY MR. MENDIAS:

5 Q. Good afternoon, Doctor. You and I met at your last
6 deposition in this case in August. My name is Ryan Mendias.
7 I'm an attorney with the ACLU. I represent Dr. Beverly Gray,
8 one of the plaintiffs in this case. So I just want to ask a
9 few ground rule questions before we begin. You understand that
10 you're currently under oath and you have a legal obligation to
11 answer all questions truthfully, is that right?

12 A. Yes.

13 Q. And I'll ask that you wait until I finish a question
14 before you begin answering. And I'll just ask because we're on
15 Zoom, this part is especially important so that we can agree --
16 so I'm going to ask that you agree that we both -- or I'll make
17 an effort as well, to ensure that the other person is finished
18 speaking before answering a question or asking one. Does that
19 sound all right?

20 A. Yes.

21 Q. Okay. If you don't understand a question, you should
22 feel free to ask me to clarify and I'll do so. And if you do
23 answer a question without asking for a clarification, I will
24 assume that you understood it.

25 Does that make sense?

1 A. Yes.

2 Q. And so you should answer all questions verbally
3 instead of shaking or nodding your head or saying uh-huh or
4 uh-uh. Do you understand?

5 A. Yes.

6 Q. And during this deposition your attorney may object,
7 and his objections are just for the record. So unless he tells
8 you not to answer a question, you still go ahead and provide an
9 answer after he has made his objection.

10 MR. BOYLE: Objection. You can answer.

11 THE WITNESS: I'm sorry, what did you say?

12 MR. BOYLE: You can answer.

13 THE WITNESS: Okay.

14 BY MR. MENDIAS:

15 Q. Do you understand?

16 MR. BOYLE: Objection. You can answer.

17 THE WITNESS: Yes.

18 BY MR. MENDIAS:

19 Q. If you need a break, just let me know. We can take a
20 break as long as there's not a pending question.

21 A. Yes.

22 Q. Great. Is there anything that would prevent you from
23 giving a full and accurate testimony here today? Any
24 medications or illnesses or anything like that?

25 A. No.

1 Q. Where are you testifying from today?

2 A. I'm testifying from Raleigh, North Carolina.

3 Q. And where specifically in Raleigh, North Carolina?

4 A. I'm testifying from the offices of Smith and Ward.

5 Q. And what form of technology are you using to
6 participate in this deposition?

7 A. I don't know the answer to that, sir. Can you be more
8 clear?

9 Q. Are you using an iPad, a laptop?

10 A. I'm using the -- it's a screen which is projecting the
11 image of the stenographer, yourself and myself and Attorney
12 Boyle.

13 Q. Okay. Is Attorney Boyle the only other person in the
14 room with you right now?

15 A. Yes.

16 Q. Did you bring any materials into the room?

17 A. Yes.

18 Q. What did you bring?

19 A. A copy of my expert -- my expert report.

20 Q. Do you have any electronic documents that you brought
21 in any form?

22 A. No.

23 Q. Do you have a cell phone with you right now?

24 A. No. Well, it's in my pocketbook which is behind me,
25 because I had to get my driver's license for the stenographer.

1 Q. Understood. Do you agree to refrain from
2 communicating with anyone while we're on the record during this
3 deposition, other than the communications that will be
4 transcribed by the stenographer?

5 MR. BOYLE: Objection. You can answer.

6 THE WITNESS: Yes.

7 BY MR. MENDIAS:

8 Q. So back in August of 2023 --

9 A. Can you just excuse me for a moment. My cell phone is
10 in the room and it's beeping, so I'm going to turn it off. Is
11 that okay?

12 Q. Sure.

13 A. I'm ready.

14 Q. In August of 2023 you were deposed as part of this
15 case. Do you remember that?

16 A. Yes.

17 Q. Do you remember that after the deposition a transcript
18 of the deposition was produced, right?

19 A. Yes.

20 Q. You read and signed that transcript?

21 A. I read it. I don't remember whether I signed it.

22 Q. Did you suggest any corrections to the transcript
23 after you had read it?

24 A. I don't remember whether I did.

25 Q. Since August of 2023 have you been deposed in any

1 other lawsuit?

2 A. No, I have not.

3 Q. Have you prepared any new declarations or expert
4 reports since August of 2023?

5 MR. BOYLE: Object to form. And I'll instruct
6 you to the extent that you have prepared any written
7 information in this case or any other case that has not been
8 produced in discovery in that case, I will instruct you not to
9 respond to that. But if there's anything other than what I
10 just described, you can respond.

11 THE WITNESS: Anything that was not produced in
12 discovery?

13 MR. BOYLE: My instruction is that if you
14 created any written documents in this case or in another case
15 that have not been produced to opposing counsel, such as
16 internally for whichever lawyer has hired you, you should not
17 describe that. But if you created something that's been
18 produced to the other side, like this report, you can describe
19 that. That's my instruction.

20 THE WITNESS: So since August of 2023 I have
21 produced expert reports for Indiana, State of Indiana and
22 Kansas.

23 BY MR. MENDIAS:

24 Q. Have you have participated in any depositions since
25 2023 in any of those cases?

1 A. No.

2 Q. Have you testified at trial since August of 2023 in
3 any capacity?

4 A. No.

5 Q. Since August of 2023 have you appeared before any
6 legislative body?

7 A. No.

8 Q. So I am going to drop into the chat for, I guess, the
9 stenographer's benefit, but the first exhibit which I'll
10 continue the numbering from earlier this week, which is
11 Exhibit-13, is your expert report submitted in this case. But
12 you have brought that with you, is that correct, Doctor?

13 A. Yes.

14 MR. BOYLE: Could you clarify? You're talking
15 about the one from December 12, 2023, is that correct?

16 MR. MENDIAS: Correct.

17 - - -

18 (Document marked as Exhibit-13 for
19 identification.)

20 - - -

21 BY MR. MENDIAS:

22 Q. Doctor, the report you have with you is from December
23 2023, is that right?

24 A. Yes.

25 Q. Okay. And I will share my screen just to show you

1 briefly the document that I have up, and if it looks to be the
2 same document can you please indicate that?

3 MR. BOYLE: Could you just show us the last
4 page, please?

5 BY MR. MENDIAS:

6 Q. Does this appear to be a digital copy of what you have
7 before you?

8 A. It's a digital copy, but I can't verify its
9 authenticity without reviewing the entire document.

10 Q. Do you have any reason to believe, based on the few
11 pages that you have seen, including your signature, that this
12 is not your document?

13 A. I'm just saying that I can't verify its authenticity
14 without reviewing it.

15 Q. But there's nothing that you have seen that would
16 suggest that it isn't an authentic copy? I know that you can't
17 verify it, but is there anything that makes you think that
18 there is not an authentic copy?

19 A. Other than the fact that I can't review it again, I
20 can't say whether it's authentic or not.

21 Q. Understood. Doctor, could you please describe the
22 process of drafting your report?

23 A. Yes. I drafted my report by reviewing medical
24 literature and by reviewing the expert reports of the
25 plaintiff's experts.

1 Q. Did anybody suggest that you cite a particular study
2 or statistic in your report?

3 MR. BOYLE: Objection. And I'm going to
4 instruct you not to answer to the extent that your answer would
5 reveal anything about conversations between lawyers who hired
6 you to be an expert witness in this case and yourself. Do not
7 divulge any specific contents of any conversations that were --
8 that occurred.

9 THE WITNESS: No.

10 BY MR. MENDIAS:

11 Q. No one provided you any fact or data to be included in
12 your report?

13 A. No.

14 Q. Did anyone provide you with any written materials to
15 review in preparing your report?

16 MR. BOYLE: Objection. To the extent that this
17 would encompass something other than just a factual matter in
18 relation to a conversation between lawyers and you or the
19 lawyers who hired you for this case and yourself, I instruct
20 you not to answer. If you can answer otherwise, feel free.

21 THE WITNESS: I was given copies of the expert
22 reports from the plaintiff's experts.

23 BY MR. MENDIAS:

24 Q. But nothing else?

25 MR. BOYLE: Objection. Same instruction. You

1 can answer.

2 THE WITNESS: No.

3 BY MR. MENDIAS:

4 Q. Did anyone besides you draft any portion of this
5 report?

6 MR. BOYLE: Objection. I'm going to instruct
7 you not to answer that because any drafts are privileged
8 material under the federal rules. So do not answer that.

9 BY MR. MENDIAS:

10 Q. Were you responsible for composing the entire
11 document?

12 MR. BOYLE: Objection. Same instruction.

13 BY MR. MENDIAS:

14 Q. Did you draft the citations to the sources in your
15 expert report?

16 MR. BOYLE: Objection. Same instruction.

17 BY MR. MENDIAS:

18 Q. Did you read all of the sources cited in your expert
19 report, Doctor?

20 A. Yes.

21 Q. How did you prepare for this deposition?

22 MR. BOYLE: I'll instruct you not to reveal any
23 conversation that you had with any attorney that hired you to
24 be an expert in this case, otherwise you may respond.

25 THE WITNESS: Can you repeat the question?

1 BY MR. MENDIAS:

2 Q. Please describe the process of preparing for this
3 deposition.

4 MR. BOYLE: Same objection. Same instruction.
5 You can answer.

6 THE WITNESS: I reviewed my deposition and the
7 papers that I cited in the deposition, as well as the expert
8 reports that the experts -- plaintiff's experts submitted.

9 BY MR. MENDIAS:

10 Q. Are you being compensated for the time that you spent
11 preparing for this deposition?

12 A. Yes.

13 Q. The rate at which you're compensated is \$700 per hour,
14 correct?

15 A. Yes.

16 Q. About how many hours have you spent so far preparing
17 for this deposition?

18 A. More than five.

19 Q. Without divulging any communications between you and
20 your attorneys, who did you speak to in order to prepare for
21 this deposition?

22 A. I spoke with Attorney Boyle.

23 Q. Did you speak with anyone other than Attorney Boyle in
24 preparing for this deposition?

25 A. No.

1 Q. Have you attended any training sessions on how to
2 serve as an expert witness hosted by professional
3 organizations?

4 A. Yes.

5 Q. Which organization?

6 A. American Association of Pro-Life Ob-Gyns.

7 Q. What sort of information was conveyed at that training
8 session?

9 A. What was conveyed at the training session was the
10 information and training on how to write an expert report and
11 how to -- how to participate in a deposition and participate in
12 a trial.

13 Q. How many such trainings have you attended?

14 A. Two.

15 Q. When did you attend them?

16 A. The first training I attended was in either 2021 or
17 2022. The second training I attended was this past weekend.

18 Q. Did those trainings provide you with any written
19 materials?

20 A. No.

21 Q. About how many hours were each of those trainings?

22 A. I would estimate that the training was approximately
23 seven hours with breaks, but I don't have an exact time in
24 front of me.

25 Q. Understood. If you recall, who were the individuals

1 who lead these trainings?

2 A. They were members of APLOG and attorneys. I don't
3 remember all of their names.

4 Q. Can you state the names of the individuals you do
5 remember?

6 A. I think one attorney's name was Mark Rienzi and
7 another's name was Theresa Collette. But I don't remember the
8 names of the other attorneys.

9 Q. Understood. All right. So, Doctor, can you please
10 turn to paragraph 87 of your report, which I believe is on the
11 bottom of page 31. And please let me know once you're there.

12 A. I'm at paragraph 87.

13 Q. And in paragraph 87 of your report, you say that Dr.
14 Farus, quote, cites Kerns et al. regarding increased risk for
15 D&E performed for miscarriage versus abortion, end quote, is
16 that correct?

17 A. Yes.

18 Q. The next paragraph of your report, paragraph 88 on the
19 top of page 32, you say in this study, major complications
20 occurred in two percent of patients, with no difference between
21 patients undergoing D&E for abortion versus D&E for
22 miscarriage, is that correct?

23 A. Yes.

24 Q. And the citation for this study is in footnote 82 of
25 your report on the bottom of page 32, which is Jennifer L.

1 Kerns, et al., Society of Family Planning Clinical
2 Recommendation: Management of Hemorrhage at the Time of
3 Abortion, Contraception, 2023, is that correct?

4 A. Yes.

5 Q. And then you provide a quotation from that study in
6 the middle of paragraph 88 which says for most cases, we did
7 not have documentation of the time since fetal death, limiting
8 any analysis of complication incidence by duration of fetal
9 retention after fetal death, is that right?

10 A. Yes.

11 MR. MENDIAS: So I'm going to introduce this as
12 Exhibit-14. I will drop that into the chat.

13 - - -

14 (Document marked as Exhibit-14 for
15 identification.)

16 - - -

17 BY MR. MENDIAS:

18 Q. I will share this on my screen. Doctor, this is the
19 citation you provided for the statement about the comparison
20 between D&E for abortion and D&E for miscarriage, correct?

21 A. I would have to read through it to confirm that.

22 Q. Can you look at the title of the article that you gave
23 in footnote 82?

24 A. Yes.

25 Q. Can you read it, please?

1 A. Society of Family Planning Clinical Recommendation:
2 Management of hemorrhage at the time of abortion.

3 Q. And can you read the title of the article that is on
4 the screen right now?

5 A. Society of Family Planning Clinical Recommendation:
6 Management of hemorrhage at the time of abortion.

7 Q. Can you please direct me to what part of the article
8 that quotation is from?

9 A. I don't have the paper in front of me so I can't
10 really direct you to where the quotation is.

11 Q. Can you provide citation for the quotation, including
12 a page number?

13 MR. BOYLE: Could I ask that you please make
14 that larger on the screen? It's a little too small for us to
15 read at this point.

16 BY MR. MENDIAS:

17 Q. Is there a specific page I should turn to, Doctor, in
18 order for you to identify where the quotation is?

19 A. I think if you scroll down I can take a look.

20 Q. Sure.

21 A. Can you keep scrolling?

22 Q. (Complies.)

23 A. Can you keep scrolling?

24 Q. Yes.

25 A. Can you keep scrolling?

1 Q. (Complies.)

2 A. Okay. Can you go to the next page, please?

3 Q. Sure.

4 MR. BOYLE: Could you enlarge it, please?

5 That's too small to read. Thank you.

6 THE WITNESS: Can you go up one page, please?

7 MR. MENDIAS: (Complies.)

8 THE WITNESS: Can you scroll down, please?

9 MR. MENDIAS: The next page or further down on
10 this page?

11 THE WITNESS: Further down on this page.

12 MR. MENDIAS: (Complies.)

13 THE WITNESS: Can you keep scrolling down,
14 please?

15 MR. MENDIAS: Sure. This is the next page.

16 MR. BOYLE: Could I ask, is it possible to
17 search for terms in this document, like the term fetal death,
18 perhaps?

19 MR. MENDIAS: Sure. So there's one appearance
20 of fetal death in a footnote, one additional appearance of the
21 term fetal death in another footnote. Third and then a
22 footnote. A fourth in a footnote and that seems to be it.

23 BY MR. MENDIAS:

24 Q. Doctor, is it possible that you mis-cited this
25 article?

1 A. It's possible. I would have to look at my citations
2 list with references.

3 Q. Doctor, you agree that the article you cited in
4 footnote 82 for this quotation is in fact the article here,
5 correct?

6 A. Yes.

7 Q. And that the quotation does not appear in this
8 article, correct?

9 A. Yes.

10 Q. So this citation is incorrect?

11 A. Yes.

12 Q. All right. So let's discuss this article that you
13 inadvertently cited. Can you please read the highlighted
14 portion of this article?

15 A. I can't really discuss this article because I have not
16 -- I don't remember reading it. So if you would like me to --
17 allow me an hour and a half or so to take this article and read
18 it, I could do that. But I can't just review an article and
19 make a comment about it without going -- doing a comprehensive
20 review of it.

21 Q. So if I understand you correctly, you were amending
22 your earlier testimony that you have read this citation?

23 A. I don't remember whether I have read this one or not.
24 I would have to go back and check my list.

25 Q. Okay. Can you please read the highlighted portion?

1 A. Abortion in the United States is a very safe
2 procedure, with minor complications occurring in an estimated
3 eight per 1,000 abortions, major complications occurring in 0.7
4 per 1,000 abortions, and mortality occurring in 0.7 per 100,000
5 legal abortions per year.

6 Q. Thank you.

7 A. I do want to add that I don't agree with that
8 statement and I would have to review the reference from which
9 it is drawn in order to comment on it.

10 Q. Understood. Can you please read this highlighted
11 sentence?

12 A. Again, I'm not comfortable reading this because I have
13 not read this paper and I can't put this statement in context.
14 I don't want to have anything that I read to be taken out of
15 context.

16 Q. I understand. I'm asking you to read what was in this
17 article that you inadvertently cited. I'm not asking you to
18 comment on it.

19 A. The fact that I inadvertently cited it means that I'm
20 not comfortable commenting on this article or reading from it
21 as though it is somehow authoritative. I'm not comfortable
22 doing that.

23 MR. BOYLE: If he's asking you to read that,
24 you have should read it. Okay?

25 THE WITNESS: Okay. Similarly, most

1 second-trimester procedural abortions can be safely completed
2 in the outpatient setting, a practice that is reflected in a
3 survey of second-trimester abortion providers where a minority
4 reported providing services in a hospital-based site.

5 BY MR. MENDIAS:

6 Q. Thank you. Can you please read this highlighted
7 portion?

8 A. While most patients in the moderate risk category can
9 receive care in an outpatient setting, we encourage clinicians
10 to use their clinical judgment in deciding whom to refer.
11 Delays in care result in procedures occurring later in
12 pregnancy, which places patients at higher risk for
13 complications. This increased risk may outweigh the need to
14 refer.

15 Q. Doctor, you understand that under the hospitalization
16 requirement from the law challenged in this case, a clinician
17 would not be able to exercise their clinical judgement about
18 where a patient in their second trimester should receive an
19 abortion, correct?

20 A. Yes.

21 Q. And under the Act, a second trimester abortion patient
22 would have to be referred to a hospital for the abortion, even
23 if that would cause significant delay, is that correct?

24 MR. BOYLE: Objection to form.

25 THE WITNESS: I don't understand your question.

1 It's two questions there. Can you please simplify your
2 question?

3 BY MR. MENDIAS:

4 Q. If obtaining an abortion in the second trimester would
5 delay a patient's obtaining of that abortion, the law requires
6 it nonetheless, correct?

7 MR. BOYLE: Object to form.

8 THE WITNESS: I don't understand the question.
9 How does obtaining an abortion -- what does that have to do
10 with delay? The hospitalization requirement doesn't cause
11 delays in and of itself. It simply specifies that when a
12 patient chooses to undergo abortion, that it has to happen in a
13 hospital.

14 BY MR. MENDIAS:

15 Q. Is it your understanding that a patient can obtain an
16 abortion at a hospital with as little delay as they could in
17 obtaining abortion at an outpatient clinic?

18 MR. BOYLE: Object to form.

19 THE WITNESS: I haven't seen any data to
20 suggest otherwise, number one. And number two, one of the
21 plaintiffs, Beverly Gray for example, performs abortions in a
22 hospital.

23 BY MR. MENDIAS:

24 Q. If obtaining -- so assume that obtaining an abortion
25 as a hospital would cause delay.

1 A. I can't assume that because I don't know that as a
2 fact.

3 Q. I'm asking you to suppose this for the point of a
4 hypothetical. So if a hospital -- if obtaining an abortion in
5 a hospital takes longer than obtaining it in an outpatient
6 setting, you would agree that the law does not -- or the law --
7 I'll rephrase the question.

8 If obtaining an abortion in a hospital takes longer
9 than obtaining an abortion in an outpatient setting, there is
10 no exception to the law based on the fact that it would be
11 faster to obtain an abortion in an outpatient clinic, correct?

12 MR. BOYLE: Object to form.

13 THE WITNESS: Counselor, I am here based on my
14 expertise as a clinician and researcher. You are asking me
15 about a hypothetical situation and I can't comment on that.

16 BY MR. MENDIAS:

17 Q. You would agree that the risk of an abortion grows
18 with increasing gestational age?

19 A. Yes.

20 Q. I'm going to drop another document into the chat that
21 I'll ask be marked as Exhibit-15.

22 - - -

23 (Document marked as Exhibit-15 for
24 identification.)

25 - - -

1 BY MR. MENDIAS:

2 Q. Doctor, is it possible that this is the article you
3 intended to cite?

4 A. Can you --

5 MR. BOYLE: Object to form.

6 THE WITNESS: Can you do -- search this for the
7 term fetal death?

8 MR. MENDIAS: Sure.

9 THE WITNESS: I'm sorry, can you blow it up a
10 little bit more?

11 BY MR. MENDIAS:

12 Q. Sure thing. I'm just trying to find more words from
13 that quotation so that I can see if it's in here.

14 (Pause.)

15 Q. Doctor, this is the quotation you provided in your
16 expert report in paragraph 88, correct?

17 A. Yes.

18 Q. All right. So this is the study that you intended to
19 cite?

20 A. Yes.

21 Q. I'd like to talk about a couple of things related to
22 this study. Are you familiar, in the context of medical
23 research, with a term unadjusted analysis, Doctor?

24 A. Yes.

25 Q. What does that mean?

1 A. Usually unadjusted analysis is referring to an
2 analysis that is carried out where logistic regression was not
3 performed to adjust for confounders.

4 Q. And are you familiar with the term adjusted analysis?

5 A. Yes.

6 Q. And what is that term?

7 A. It means that the analysis was adjusted for known
8 confounders. And I might add also characteristics of the study
9 population or the intervention.

10 Q. Understood. So, Doctor, in paragraph 88 of your
11 report, you claim that the study -- that in the study rates of
12 major hemorrhage, retained products of conception, and cervical
13 laceration did not differ between the two groups, is that
14 correct?

15 A. Yes.

16 Q. Doctor, can you please read the highlighted portion of
17 this article?

18 A. Finally, in our adjusted analysis of any abortion
19 complication, we found significant associations with the
20 following covariants.

21 Q. Okay. Can you continue to read?

22 A. Sure.

23 (Reporter interrupted for clarification.)

24 Q. Doctor, I'll just ask, can you please reread the
25 highlighted portion and include the words in the highlighted

1 portion after the colon?

2 A. After the colon?

3 Q. Yes. I believe you omitted the last two words of the
4 highlighted sentence. So can you please just read it again?

5 A. Finally, in our adjusted analysis of any abortion
6 complication, we found significant associations with the
7 following covariates: Fetal death, odds ratio 3.0, 95 percent
8 confidence interval 1.6 to 5.9, P equals 0.001, prior vaginal
9 delivery, odds ratio 1.5, 95 percent confidence interval 1.2 to
10 1.9, P less than .001, prior cesarean delivery, odds ratio 1.8,
11 95 percent confidence interval 1.4 to 2.3, P less than .001,
12 and each additional week of gestation, odds ratio 1.4, 95
13 percent confidence interval 1.3 to 1.4, P less than 0.001.

14 Q. Thank you. Do you understand this to mean that when
15 adjusting for confounding factors, the authors of this study
16 found that fetal death was associated significantly with any
17 complication of a D&E?

18 MR. BOYLE: Object to form.

19 THE WITNESS: No, I don't understand that to be
20 the case.

21 BY MR. MENDIAS:

22 Q. What do you understand the significant association
23 between fetal death and any abortion complication to be?

24 MR. BOYLE: Object to form.

25 THE WITNESS: The study states in the column --

1 the first column on the page that we only conducted an
2 unadjusted analysis for the association between fetal death and
3 DIC, and that the number of cases of DIC was too low to permit
4 adjustment. So they didn't -- they didn't include all
5 complications. They did not include DIC.

6 BY MR. MENDIAS:

7 Q. So when they say any abortion complication, you
8 understand that to mean any complication except DIC?

9 MR. BOYLE: Objection.

10 THE WITNESS: Can you show me where they say
11 any abortion complication?

12 BY MR. MENDIAS:

13 Q. Do you see the highlighted phrase there?

14 A. Yes. But they did not include DIC.

15 Q. So you would understand that they did find a
16 significant association between fetal death and any abortion
17 complication other than DIC?

18 A. Yes. I do want to point out, as I say in my
19 deposition, that the authors acknowledge that the results may
20 be confounded by the lack of data on the length of time the
21 fetus was dead. The longer the fetus has been deceased, the
22 more likely it is that a woman will develop coagulation
23 abnormalities. And they go on to say in their conclusion -- in
24 the discussion rather, that for most cases we did not have
25 documentation of the time since fetal death, limiting any

1 analysis of complication incidence by duration of fetal
2 retention after fetal death. In other words, their analysis
3 with limited by the fact that they could not say in the study
4 how long the fetus had been retained after fetal death and this
5 has an impact on complications.

6 Q. Thank you, Doctor. Can you please read the
7 highlighted portion of this study?

8 A. After adjusting for all covariates, hemorrhage was
9 significantly associated with fetal death. If I can finish.
10 But again, they state, and I'll repeat this, that for most
11 cases we did not have documentation of the time since fetal
12 death, limiting any analysis of complication incidence. And
13 that refers to all complications.

14 Q. Paragraph 88 of your report on that point you say,
15 without knowing the length of time a fetus has been dead, there
16 is uncertainty about the conclusion that rates of DIC were
17 higher in women undergoing D&E for miscarriage versus abortion,
18 is that right?

19 A. Yes.

20 Q. When you refer to uncertainty about the conclusion,
21 are you suggesting that there is uncertainty as to whether the
22 study found among the women in the study that rates of DIC were
23 higher in miscarriage patients than abortion patients?

24 A. I'm going back to what the authors themselves said,
25 which is their ability to analyze complication incidence was

1 limited because they could not assess how long a fetus had been
2 dead. I'm just quoting what they said.

3 Q. The authors do say that setting aside the length of
4 time of fetal demise, miscarriage patients have higher rates of
5 DIC though, don't they?

6 A. Can you show me that in the paper, please?

7 Q. Can you read the highlighted portion?

8 A. They say that fetal death was significantly associated
9 with increased odds of DIC. But again, because they did not
10 know how long the fetus had been dead, it's impossible to say
11 -- their ability to analyze that particular complication is
12 limited. They also noted further down in that same column that
13 the number of cases of DIC was too low to permit adjustment.

14 Q. Doctor, you would agree that the population of women
15 obtaining a D&E for miscarriage all have demised fetuses,
16 correct?

17 A. Can you repeat the question, please?

18 Q. Would you agree that among women obtaining a D&E for
19 miscarriage, all of them have demised fetuses?

20 A. Yes.

21 Q. And you would agree that among those women obtaining
22 D&E for miscarriage, the amount of time that the fetus had been
23 dead is not the same among every woman, correct?

24 A. Yes.

25 Q. And some of those women will have had demised fetuses

1 longer than others, correct?

2 A. Yes.

3 Q. You would agree that the population of women obtaining
4 D&E for induced abortion do not have demised fetuses, correct?

5 A. Yes.

6 Q. Doctor, can you please look at paragraph 89 of your
7 report?

8 A. Yes, I have it.

9 Q. You refer to a study by Trinder, et al., right?

10 A. Yes.

11 Q. That study involved patients who received medical
12 management for first trimester miscarriage, right?

13 A. Yes.

14 Q. And it doesn't describe anything about the safety of
15 miscarriage in the second trimester, is that right?

16 A. Yes.

17 Q. And then in paragraph 90, you refer to a prospective
18 cohort study and the citation you provide is to Jensen, et al.,
19 is that right?

20 A. Yes.

21 Q. And this study involved patients who received
22 abortions in the first trimester, is that right?

23 A. Yes.

24 Q. And it doesn't comment on the outcomes for second
25 trimester abortion patients, right?

1 A. Yes.

2 Q. So you're aware that the law at issue in this case
3 permits abortions in the first trimester be performed in an
4 outpatient setting? Are you?

5 MR. BOYLE: Object to form.

6 THE WITNESS: Can you repeat the question
7 because it sounded like you slurred for a moment? Can you
8 repeat the question?

9 MR. BOYLE: Yes. Absolutely.

10 BY MR. MENDIAS:

11 Q. You're aware that the law at issue in this case
12 permits abortions in the first trimester to be performed in
13 outpatient clinics?

14 MR. BOYLE: Objection. You can answer.

15 THE WITNESS: Yes.

16 BY MR. MENDIAS:

17 Q. And you're aware of the law at issue in this case
18 requires abortions be performed in a hospital only after 12
19 weeks of pregnancy, right?

20 A. Yes.

21 Q. All right. Doctor, can you please look at paragraph
22 91 and 92 of your report?

23 A. Yes.

24 Q. And in those paragraphs, you're comparing the
25 mortality rate of miscarriage to the mortality rates of induced

1 abortion, is that right?

2 A. Yes.

3 Q. In paragraph 93 you say rates of death from
4 miscarriage are lower than from induced abortion, is that
5 correct?

6 A. Yes.

7 Q. So going back to paragraph 91. You say that Berman,
8 et al., 1985, found that the miscarriage rate -- apologies.
9 Berman, et al., 1985 found that the miscarriage mortality
10 ratio, deaths per one million miscarriages, increased up to 16
11 to 19 weeks and then declined. Did I read that correctly?

12 A. Yes.

13 Q. So in this context, the mortality ratio indicates how
14 many women died from miscarriage out of every one million
15 miscarriages, is that right?

16 A. Yes.

17 Q. And the chart at the top of page 34 of your report,
18 table one. You say the Berman, et al. reported that between 12
19 and 15 weeks, the mortality rate was five deaths per million
20 miscarriages, is that right?

21 A. Yes.

22 Q. And between 16 and 19 weeks, the mortality rate was
23 also five deaths per million miscarriages?

24 A. Yes.

25 Q. Between 20 and 24 weeks, the mortality rate was 2.2

1 deaths per million miscarriages?

2 A. Yes.

3 MR. MENDIAS: I'd like to mark as Exhibit-16
4 the study that I'm now putting into the chat.

5 - - -

6 (Document marked as Exhibit-16 for
7 identification.)

8 - - -

9 BY MR. MENDIAS:

10 Q. Doctor, does this appear to be the Berman, et al.
11 1985 study that you cite and that you use for the source of
12 data in your chart?

13 A. Yes.

14 Q. I'm going to scroll to the page on which the data that
15 I believe you drew from is. Is this the chart that provided
16 the data that you used in your expert report?

17 A. I would have to go back and look to be sure.

18 Q. What makes you unsure that this is the source of that
19 data?

20 A. Because I have not looked at this paper in a bit, and
21 I'm not sure whether this was the chart that I was looking at.

22 Q. All right. So you were reporting what Berman said the
23 deaths per one million spontaneous abortions were, correct?

24 A. Yes.

25 Q. And so you see here there's a dagger, and if we read

1 the dagger it says deaths per million spontaneous abortions.
2 That is the same rate that you were reporting in your chart,
3 correct?

4 MR. BOYLE: Objection.

5 THE WITNESS: I would have to go back and look
6 at this paper. I'm sorry, I can't do this on the fly because I
7 may have -- yeah.

8 BY MR. MENDIAS:

9 Q. All right. Sorry. I didn't mean to cut you off.
10 Please continue.

11 A. No, I would have to go back and look at this paper.

12 Q. I understand. But my question is whether you are
13 reporting deaths per one million miscarriages.

14 A. I would have to go back and look at this paper. I
15 can't say just looking at it on the screen.

16 Q. Well, I'm asking you a different question. So you see
17 here you cite in your report Berman, et al. 1985, correct?

18 A. Yes.

19 Q. And the specific figure you give is mortality ratio
20 deaths per one million miscarriages, correct?

21 A. Yes.

22 Q. And this figure here, these ratios in Berman, et al.
23 1985 are deaths per million spontaneous abortions, correct?

24 A. As I said, I'd have to go back and look at the paper
25 and understand how I derive those newspapers.

1 Q. My question is simpler. It's, does this say deaths
2 per million spontaneous abortions?

3 A. That's what the paper says. But I'm not saying that
4 that is where I derive the numbers that I represented there.

5 Q. Okay. So let's just look at Berman et al. 1985's
6 chart. Do you see between 12 and 15 weeks? You see that here?

7 A. Yes.

8 Q. Berman, et al. reported 50 deaths per million
9 spontaneous abortions, correct?

10 A. Again, I would need to go back -- because your
11 question relates to where I derive the data in the chart, and I
12 would have to go back and review where I made that calculation.

13 Q. My question right now is just about what this study
14 says. And does this study report that between 12 and 15 weeks
15 the mortality ratio is 50 deaths per million spontaneous
16 abortions?

17 MR. BOYLE: Objection.

18 THE WITNESS: I need to look at this paper
19 again because it is combining -- looking at both percent
20 numbers by weeks of gestation and not IUD-associated deaths.
21 So I would need to go back and look at this to understand
22 exactly what they were saying.

23 BY MR. MENDIAS:

24 Q. So you don't believe that this ratio of 50 point zero
25 deaths per million spontaneous abortions is clear from this

1 table?

2 MR. BOYLE: Objection.

3 THE WITNESS: It's not anything to do with what
4 I believe. It has to do with me looking at the paper again to
5 understand how I derived those specific numbers, and I need to
6 have the paper in front of me to look at that.

7 BY MR. MENDIAS:

8 Q. I understand that that's how you feel about the
9 deriving of this data for your report, but I'm asking
10 specifically about the table that you see on the screen before
11 you. Does this table report between 16 and 19 weeks that the
12 mortality ratio is 50 point zero per one million spontaneous
13 abortions?

14 MR. BOYLE: Objection.

15 THE WITNESS: I'm looking at this and it's
16 saying deaths per million spontaneous abortions. So, yes.

17 BY MR. MENDIAS:

18 Q. Okay. And for 12 to 15 weeks it's 50 point zero
19 spontaneous -- or 50 point zero deaths per million spontaneous
20 abortions, correct?

21 A. That is correct.

22 MR. BOYLE: Objection.

23 BY MR. MENDIAS:

24 Q. And between 16 and 19 weeks it's 50 deaths per million
25 spontaneous abortions, correct?

1 MR. BOYLE: Objection. You can answer.

2 THE WITNESS: Yes.

3 BY MR. MENDIAS:

4 Q. And between 20 and 24 weeks it reports 22.2 deaths per
5 million spontaneous abortions, correct?

6 MR. BOYLE: Objection. You can answer.

7 THE WITNESS: Yes.

8 BY MR. MENDIAS:

9 Q. So, Doctor, in this column of your chart, mortality
10 ratio deaths per one million miscarriages that you attribute to
11 Berman, et al. 1985, you only reported five deaths per million
12 miscarriages for 12 to 15 weeks, isn't that right?

13 A. Yes.

14 Q. And that's one-tenth of what Berman, et al. reported,
15 isn't it?

16 MR. BOYLE: Objection. You can answer.

17 THE WITNESS: Okay. As I said earlier, I have
18 to go back to the paper and understand how I derive those
19 numbers.

20 BY MR. MENDIAS:

21 Q. Is it possible that you made a mistake?

22 A. Yes, it's possible.

23 Q. Do you think it's likely that you made a mistake?

24 A. It's possible that I made a mistake.

25 Q. My question is, is it likely that you made a mistake

1 reporting the mortality ratio for induced abortions as reported
2 in Berman, et al., 1985?

3 A. I can't say without reviewing the paper again.

4 Q. But you would agree that these numbers in your report
5 are one-tenth of the numbers reported in Berman for the same
6 gestational weeks, correct?

7 MR. BOYLE: Objection. Objection. You can
8 answer.

9 THE WITNESS: As I said before, I would need to
10 go back and read the paper and understand how I derived. It's
11 possible that I made a mistake. But I will not agree that it's
12 likely.

13 BY MR. MENDIAS:

14 Q. Do you have any other ideas about how you arrived at
15 these figures that you reported as the mortality ratio of
16 deaths per one million miscarriages from Berman, et al.?

17 A. I don't. But I'm happy to review it and get back to
18 you.

19 Q. I would like to look now at this study that you cite
20 by Saraiya, et al. I believe this would be Exhibit-17 and I'll
21 drop that in the chat right now.

22 - - -

23 (Document marked as Exhibit-17 for
24 identification.)

25 - - -

1 BY MR. MENDIAS:

2 Q. Doctor, do you believe that this is the study that you
3 cited as Saraiya, et al.?

4 A. Yes.

5 Q. And in your chart, page 34 of your expert report, you
6 say that between 16 and 19 weeks of gestation the mortality
7 ratio deaths per 100,000 miscarriages was 4.1, correct?

8 A. Yes.

9 Q. And does this appear to be in Saraiya, et al. where
10 you derived that data from?

11 A. Yes. But again, I would have to have the paper to
12 really see if that's the case.

13 Q. Okay. So in paragraph 92 of your report, you cite
14 Bartlett, et al. for a proposition that the risk of a woman
15 dying from abortion increased 38 percent for each week of
16 gestational age, is that right?

17 A. Yes.

18 MR. MENDIAS: I'm going to go ask that
19 Bartlett, et al. be marked as Exhibit-18 and I'm putting it in
20 the chat right now.

21 - - -

22 (Document marked as Exhibit-18 for
23 identification.)

24 - - -

25 BY MR. MENDIAS:

1 Q. Doctor, does this appear to be the study that you have
2 cited?

3 A. Yes.

4 Q. Okay. Table two, can you see that, Doctor?

5 A. Yes.

6 Q. And this is the legal induced abortion-related deaths,
7 mortality rates, and relative risks, by Selected
8 Characteristics between 1988 and 1997, correct?

9 A. Yes.

10 Q. And so Bartlett reports the mortality rate from
11 abortion between 16 and 20 weeks as 3.4 deaths per 100,000
12 legal induced abortions, is that right?

13 A. Yes.

14 Q. And that's lower than the mortality rate Saraiya
15 reported for spontaneous abortions per 100,000 -- I'm sorry.
16 This figure, 3.4 deaths per 100,000 legal abortions, is lower
17 than the rate that Saraiya reported for deaths per 100,000
18 spontaneous abortions between 16 and 19 weeks, correct?

19 MR. BOYLE: Object to form. You can answer.

20 THE WITNESS: I think that you're simplifying a
21 very complicated concept and I'm going to go back to something
22 that I said in my deposition, which is that the rates of deaths
23 -- in paragraph 93, I said the rates of deaths from miscarriage
24 are lower than they are from induced abortion, and likely to be
25 markedly lower. And then I go on to say why that is the case.

1 I did not intend to have a direct comparison of the numbers.
2 The point that I was making here was that the risk of death
3 increases exponentially by 38 percent for every week of
4 gestation. And based on the data that's presented by Saraiya
5 that is not the case. So that's the point I was trying to
6 make.

7 BY MR. MENDIAS:

8 Q. But you agree, Doctor, that 3.4 is a smaller number
9 than 4.1, correct?

10 A. I don't think that that's relevant to what I'm trying
11 -- the point that I was trying to make. And as I said, I want
12 to reiterate the fact that the rates of death per miscarriage
13 that are outlined in the Saraiya study are likely to be much
14 lower. First because most miscarriages are not documented and
15 so the denominators of total estimated miscarriages are likely
16 to be lower than the true number. And then the second is that
17 the number of miscarriages are complete. The demised fetus
18 passes in its entirety and so women don't undergo any medical
19 interventions. Women undergoing abortion are always subject to
20 both procedural risk and anesthetic risk. So that is why I was
21 not making a direct comparison here, because these studies are
22 comparable. The analysis of mortality rate for miscarriages is
23 probably an underestimate for the reasons that I just cited.
24 And the risks that are associated with abortion are higher
25 because of the procedural and anesthetic risks. But I was not

1 making comparison between the two studies because they are not
2 comparable.

3 Q. Doctor, I didn't ask you what you thought was
4 relevant. I'm asking you a very straightforward question. 3.4
5 is smaller than 4.1, correct?

6 A. And I'm going to respond to you the same way. That
7 you cannot compare this number 3.4 to the 4.1 in the
8 miscarriage study. They're not --

9 Q. Again, the question is 3.4 is smaller than 4.1? Can
10 you answer that question, Doctor?

11 A. Yes.

12 Q. Thank you. So on the points you just raised about
13 miscarriages, you understand that the issue in this case is
14 whether abortion in the second trimester should be required to
15 be performed in a hospital setting, correct?

16 A. Yes.

17 Q. And miscarriage in the second trimester would not be
18 an early pregnancy loss, would it?

19 A. Can you rephrase the question? What do you mean by an
20 early pregnancy loss? Can you define what you mean by an early
21 pregnancy loss, please?

22 Q. Sure. You see how in paragraph 94 you say many
23 miscarriages are never documented as they occur very early in
24 pregnancy, correct?

25 A. Yes.

1 Q. Do you think that a miscarriage in the second
2 trimester is one that occurred very early in pregnancy?

3 A. No. By definition a miscarriage in the second
4 trimester is not the same. The point that I'm making in
5 paragraph 94 is that because many miscarriages occur early in
6 pregnancy, the denominator of cases for the Saraiya study is
7 probably larger and therefore the estimated mortality that
8 they're describing is probably lower. That's the point I was
9 trying to make. I was not trying to say anything other than
10 that.

11 Q. Do you believe that miscarriages that occur in the
12 second trimester frequently go unreported?

13 A. No, I don't believe that they go -- I mean, unreported
14 to who and how?

15 Q. Well, you say in paragraph 94, many miscarriages are
16 never documented. Do you believe that second trimester
17 miscarriages are frequently not documented?

18 A. They may not be.

19 Q. What is the basis for that belief?

20 A. That if a patient underwent a second trimester loss
21 and the physician did not report that loss to the relevant
22 public health authorities, it would not be counted.

23 Q. Have you, as a physician treating a patient with
24 second trimester pregnancy loss, not reported that loss?

25 MR. BOYLE: Object to form.

1 THE WITNESS: I typically have not -- I have
2 not reported those losses because those losses occur -- or the
3 treatment of those losses occurs in the hospital. I don't know
4 the mechanism for how hospitals report those to public health
5 authorities. So I can't speak to that question.

6 BY MR. MENDIAS:

7 Q. Paragraph 95, you provide a second reason and you say
8 a number of miscarriages are complete, that is the demised
9 fetus passes in his or her entirety, is that right?

10 A. Yes.

11 Q. Do you contend that complete miscarriage is common in
12 the second trimester of pregnancy?

13 A. That's not what I said in the statement.

14 Q. I'm asking --

15 A. What I said in the statement is that a number of
16 miscarriages are complete. I did not talk about whether they
17 were complete in the first or the second trimester. Some are
18 complete. Some are incomplete.

19 Q. Is it common for there to be complete miscarriage in
20 the second trimester of pregnancy?

21 A. I can't say whether it's common or uncommon. I have
22 seen patients have both. And I'm not aware of any specific
23 data on whether -- on the percentage of them that are complete.

24 MR. BOYLE: We've been going for about an hour.
25 If you would like to take a break at some point when it's

1 convenient, please.

2 MR. MENDIAS: Sure. I have one more question
3 and then we can take maybe a five-minute break.

4 BY MR. MENDIAS:

5 Q. Doctor, scrolling up a bit to paragraph 81 of your
6 report.

7 A. Yes.

8 Q. You say that Dr. Farris does not provide supporting
9 statistics for her claim that D&E for second trimester
10 miscarriages are routinely performed in inpatient and
11 outpatient settings, is that right?

12 A. Yes.

13 Q. Do you have any supporting statistics where D&Es for
14 second trimester miscarriages are performed?

15 A. I think that I have cited -- some of the papers that I
16 have cited list the number of D&Es -- list that D&Es are done
17 in both the hospital setting -- or done in a hospital setting.

18 Q. Do they say the relative frequency with which they're
19 done in a hospital setting as opposed to an outpatient setting?

20 A. I'm sorry, can you rephrase the question? I think I
21 don't quite understand what you're asking me.

22 Q. So your testimony just now was that they say -- these
23 sources say that D&E for miscarriages occur in both outpatient
24 and inpatient settings. I'm wondering if they say what
25 percentage happen in outpatient settings versus inpatient

1 settings?

2 A. No, I haven't seen that data.

3 Q. All right.

4 MR. MENDIAS: Okay. I think we can take a
5 six-minute break. We can reconvene at 2:20.

6 MR. BOYLE: Thanks.

7 - - -

8 (A break was taken, 2:13 p.m. - 2:23 p.m.)

9 - - -

10 BY MR. MENDIAS:

11 Q. Doctor, in paragraph 134 of your expert report.

12 Please turn to that.

13 A. Yes.

14 Q. So there you say that the term abortionist is used in
15 the biomedical literature, including as a title by which
16 abortionists refer to themselves.

17 Did I read that correctly?

18 A. Yes.

19 Q. So as a part of your claim you have several articles
20 cited in footnote 142, correct?

21 A. Yes.

22 Q. The first is by Michaels, M.O., Michaels, F.I. and
23 Otto, S. Inception of Life on the Pendulum of Death: Common
24 Paradigms and Uncommon Narratives on the Polemics between
25 Birthers and Abortionists, is that right?

1 A. Yes.

2 Q. None of the authors of that paper are abortion
3 providers, are they?

4 A. No.

5 Q. In fact, they oppose abortion, don't they?

6 MR. BOYLE: Objection.

7 THE WITNESS: I can't really say whether the
8 authors oppose abortion or not as a matter of fact.

9 BY MR. MENDIAS:

10 Q. So --

11 A. And in fact of -- I'm sorry, if I can go on. I think
12 that the other studies that I cited quotes abortionists
13 themselves as calling themselves happy abortionists.

14 Q. So we'll discuss that study in a second, but I'm just
15 going to ask that this Michaels study be marked as Exhibit-19.

16 - - -

17 (Document marked as Exhibit-19 for
18 identification.)

19 - - -

20 BY MR. MENDIAS:

21 Q. Doctor, this is the study that we were talking about
22 that you cited in that footnote, correct?

23 A. Yes.

24 Q. Please read the highlighted sentence.

25 A. It is only justifiable to reason that the state,

1 Government, as the defender of the citizenry must establish
2 mechanisms and strategies to defend unborn babies and ensure
3 that only health-related, inevitable complications are grounds
4 for an abortion procedure.

5 Q. You also in support of your claim in paragraph 134
6 cite an article by Matthew Lee Anderson, Antiabortionist Action
7 Theory and the Asymmetry between Spontaneous and Induced
8 Abortions, is that right?

9 A. Yes.

10 Q. And that article was also not written by an abortion
11 provider, was it?

12 A. No.

13 Q. Are you aware that that article does not describe any
14 physician as an abortionist?

15 A. Yes.

16 Q. In fact, the article never uses the term abortionist
17 but instead refers to only antiabortionists, is that correct?

18 A. Yes. The point I am trying to make here is that the
19 question was whether the term abortionist appears in the
20 medical literature, and therefore, according to the fact that
21 it appears in the titles, it does appear in medical literature.
22 That's the point I'm trying to make. I'm not making a point
23 about the content or the political leanings of the authors or
24 what they believe about abortion. I am simply making a point
25 that this term does appear legitimately in the medical

1 literature.

2 Q. Do you believe that the article by Michaels, et al. is
3 medical literature?

4 A. This is -- sociology is part of the sciences related
5 to medicine. We routinely look at sociological literature and
6 the -- for example, the Turnaway study is a sociological study
7 and we routinely look at sociological literature as a part --
8 as an adjunct to our efforts in medicine. So it's perfectly
9 legitimate to look at the sociology literature as part of the
10 biomed literature.

11 MR. MENDIAS: I'm going to put the Lee Anderson
12 study in the chat and I'll mark that as Exhibit-20.

13 - - -

14 (Document marked as Exhibit-20 for
15 identification.)

16 - - -

17 BY MR. MENDIAS:

18 Q. Doctor, this is the Michael Lee Anderson -- sorry.
19 This is the Matthew Lee Anderson that you cited, correct?

20 A. Yes.

21 Q. And can you read this highlighted portion?

22 A. Antiabortionists' relative unconcern about spontaneous
23 abortions is prima facie evidence that their focus on induced
24 abortions is either inconsistent or hypocritical.

25 Q. You would agree, as you testified earlier, that this

1 article does not refer to any physician as an abortionist,
2 correct?

3 A. I will agree to that, but I will also point out, as I
4 said earlier, that I was looking at the titles of articles
5 simply to point out that this term appears in the medical
6 literature. I am not referring to the content or the authors.

7 Q. But if the term abortionist doesn't appear in this
8 article, does that not support your point?

9 MR. BOYLE: Object to form.

10 THE WITNESS: I don't understand your question,
11 sir.

12 BY MR. MENDIAS:

13 Q. The phrase abortionist to describe a physician does
14 not appear in this article, as you testified. So my question
15 is how does this support your claim that it is common in the
16 biomedical literature to refer to physicians who provide
17 abortions as abortionists?

18 A. I never said that it was common, sir.

19 Q. All right. Have you mentioned the last study in that
20 footnote by Baird?

21 A. Yes.

22 Q. Considering the Place of Doctors in the Practice of
23 Abortion in Australia since the Early 1990s, correct?

24 A. Yes.

25 Q. And it was published in a journal called Australia

1 Feminist Studies, right?

2 A. Yes.

3 Q. This article did not discuss the terms used to
4 describe abortion providers in North Carolina, did it?

5 A. No.

6 Q. In fact, the article didn't discuss the terms used to
7 describe abortion providers in the United States at all, did
8 it?

9 A. I'm not sure what your question is, sir. These people
10 -- the abortionists referring to themselves as happy
11 abortionists. They share -- they have in common with abortion
12 practitioners abortionists in the United States and in North
13 Carolina the fact that they provide abortions, so therefore
14 they're in the same discipline.

15 Q. My question is whether this article described any
16 physician in the United States as an abortionist.

17 A. No.

18 Q. And in fact, it does not say anything about whether
19 the term abortionist is used by physicians in the United States
20 to refer to themselves, did it?

21 A. I'm afraid that I don't -- again, what's the question
22 that you're asking me? Can you repeat it, please?

23 Q. Yes. Did this article describe any physician in the
24 United States as referring to themselves as an abortionist?

25 A. No. But that wasn't the point of my including the

1 article. The question that was -- I was responding to was that
2 the term abortionist refers to the clinical activity of
3 abortion providers, which is correct. I practice as a laborist
4 because I take care of women in labor. Abortionists perform
5 abortions, therefore they are abortionists. And I only mention
6 that it is used in the biomedical literature, including as a
7 title by which abortionists refer to themselves. That's all I
8 said.

9 Q. Are you aware of any abortion provider in this country
10 who refers to themselves abortionist?

11 A. I don't see how it would be possible for me to be
12 aware of what all abortionists in the United States refer to
13 themselves as. I don't see how I could have that knowledge.

14 Q. I didn't ask if you knew whether all abortion
15 providers call themselves abortionists. I'm asking if you're
16 aware of any abortion provider who calls themselves an
17 abortionist?

18 A. I don't know.

19 Q. You don't know whether you know or you don't know of
20 any physicians who call themselves abortionists?

21 A. I don't know if I can remember any.

22 Q. Do you think you have heard abortion providers call
23 themselves an abortionist?

24 A. Yes, I may have in the past.

25 Q. When?

1 A. I just said I don't remember, sir.

2 Q. Do you have any details about this recollection?

3 A. I don't.

4 Q. So turning to paragraph 203 of your report. Please
5 let me know when you have gone there.

6 A. Sure.

7 (Pause.)

8 A. Yes. I'm at paragraph 203.

9 Q. In this paragraph you say the diagnosis of ectopic
10 pregnancy should be suspected in a pregnant patient with no
11 evidence of an intrauterine pregnancy on transvaginal
12 ultrasound (TVUS) and any of the following, is that right?

13 A. Yes.

14 Q. And then you provide a list of factors, including
15 visualization on certain ultrasound findings such as an adnexal
16 mass or intraperitoneal bleeding, right?

17 A. Yes.

18 Q. Or A serum hCG that rises abnormally more than 35
19 percent over two days, right?

20 A. It's actually less than 35 percent over two days.

21 Q. Apologies. Less than 35 percent over two days. Or
22 abdominal pain and/or vaginal bleeding, especially in patients
23 with risk factors for ectopics, is that right?

24 A. Yes.

25 Q. According to this diagnostic criteria, a pregnant

1 patient whose pregnancy can't be seen on ultrasound but does
2 not have any of those additional factors would not be
3 considered to have a suspected ectopic, would she?

4 A. I don't think that's true. I think that the diagnosis
5 of ectopic pregnancy should be suspected in virtually any
6 pregnant woman who presents with bleeding and pain.

7 Q. My question is whether a pregnant patient with no
8 evidence of an intrauterine pregnancy on transvaginal
9 ultrasound but without any of the following should be
10 considered to have a suspected ectopic?

11 A. So if I -- I'm sorry. So you're saying if a pregnant
12 woman has no intrauterine pregnancy on ultrasound then what?

13 Q. And none of the following factors that you list in
14 paragraph 203, does that mean she does not have a suspected
15 ectopic?

16 A. No. This is -- no.

17 Q. Why not?

18 A. Why not what, sir?

19 Q. Well, just to be clear. In paragraph 203 you say that
20 a pregnant patient with no evidence of an intrauterine
21 pregnancy who has any of the following should be suspected for
22 ectopic pregnancy, correct?

23 A. Yes.

24 Q. So my question is if she does not have any of the
25 following, would you still consider that a suspected ectopic

1 pregnancy?

2 A. Yes. I'm laying out an algorithm here. I'm laying
3 out an algorithm here. This algorithm is to provide guidelines
4 and this is from up to date. The purpose of the algorithm is
5 to provide guidelines for a clinician. But in actual clinical
6 practice if I have a woman that has a positive hCG that is
7 rising and I can't see a -- can't see an embryo or a fetus, I
8 would have a high suspicion nonetheless that she has an ectopic
9 pregnancy, and in fact I would consider that to be an ectopic
10 pregnancy until proven otherwise.

11 Q. Doctor, you just said if she had a rise in hCG,
12 correct?

13 A. I think what I am trying to say here is that if I am
14 unable to see -- if a patient has a positive pregnancy test and
15 I am unable to see an intrauterine pregnancy, my clinical
16 suspicion would be high for an ectopic pregnancy, and I will
17 consider it to be an ectopic pregnancy until proven otherwise.

18 Q. And you would consider it to be an ectopic pregnancy
19 even absent any of the factors you enumerate in paragraph 203A,
20 203B and 203C, is that right?

21 A. What I am trying to say here is that I would have a
22 suspicion that I would then use subsequent diagnostic -- take
23 subsequent diagnostic steps to confirm a diagnosis of an
24 ectopic pregnancy. I'm not saying that you need all of these
25 things to suspect an ectopic pregnancy. I am saying this is

1 outlining what you would do to resolve the patient into either
2 an ectopic pregnancy, a failing intrauterine pregnancy, that is
3 to say a miscarriage, or an intrauterine pregnancy that cannot
4 be seen at that point in time. And I think that that is a
5 critical step of -- diagnostic steps that need to be undertaken
6 for every patient in order to rule out ectopic pregnancy, which
7 is the leading cause of first trimester maternal death.

8 Q. You mean any of the three -- any of the factors listed
9 in those three lettered bullets, in addition to a pregnancy of
10 unknown location to determine that a patient has a suspected
11 ectopic?

12 A. This is not a determination. These are diagnostic
13 steps. These don't say this is what you do, this is what you
14 say. These are diagnostic steps. For example, the first
15 complex -- the first letter, which is A, which is visualization
16 of a complex structure, could be a corpus luteal cyst, it could
17 be a cyst of pregnancy. So these are diagnostic steps that
18 need to be undertaken to help confirm the diagnosis. They are
19 not in and of themselves directives.

20 Q. My question is whether you would suspect that a
21 pregnant patient without an intrauterine pregnancy on
22 ultrasound is suspected for ectopic pregnancy if none of the
23 following are present?

24 A. Yes, I would still be suspicious there could be an
25 ectopic pregnancy. In my clinical experience, yes.

1 Q. So your practice is more conservative than the
2 algorithm that you laid out here?

3 MR. BOYLE: Objection.

4 THE WITNESS: You're asking me a hypothetical
5 question, counselor, and I can't answer that.

6 BY MR. MENDIAS:

7 Q. Why not?

8 A. Because I think that medicine is not strictly steps
9 and rules and algorithms. Part of the art of medicine is
10 undertaking to do the best thing for the patient. And the best
11 thing for the patient is to exercise the utmost discretion, and
12 perform the necessary diagnostic steps for the sake of safety
13 in every woman who could have an ectopic pregnancy until you
14 rule it out.

15 Q. So in paragraph 209 of your report -- can you let me
16 know when you have gotten there?

17 A. Sure. I'm there.

18 Q. You discuss a relationship between contraceptive use
19 and ectopic pregnancy, is that right?

20 A. Yes.

21 Q. And in paragraph 210 on the next page you say that the
22 population of women who are likely to seek abortion, women who
23 are using contraception, who become pregnant, the population of
24 women seeking abortion is likely to be at higher risk for
25 ectopic pregnancy, is that right?

1 A. That's correct.

2 Q. Is it your belief that all forms of contraception
3 increase a patient's risk for ectopic pregnancy?

4 A. No. I think I have outlined very clearly in paragraph
5 209 that some methods are associated with increased risk. And
6 it talks about the specific risk of -- here as being
7 intrauterine device users, the risk is one in two, to one in
8 16. And then the Li study from 2015 found that current use of
9 most contraceptives was significantly correlated with the
10 incidence of ectopic pregnancy following contraceptive failure.

11 So the contraceptive methods that are described here
12 are intrauterine devices, oral contraceptives, emergency
13 contraceptives, and that these are most -- these are some of
14 the most common methods that are used by women. It doesn't
15 address barrier methods.

16 Q. If a patient with a pregnancy of unknown location who
17 has an IUD inserted sought a medication abortion at Planned
18 Parenthood South Atlantic's clinic, do you believe that they
19 would provide her with medication abortion regimen?

20 A. I think you're asking me a hypothetical question that
21 I just can't answer. I don't know the circumstances. I don't
22 know how far along she is. I don't know what the physical exam
23 showed. I don't know what the ultrasound showed and what her
24 hCG showed. So it's very hypothetical and I can't answer it.

25 Q. Well, I understand that you're not familiar with

1 PPSAT'S protocol for medication abortion.

2 A. It's not a question of the protocol. It's a question
3 of the clinical care of the patient.

4 Q. Well, I'm asking you if you are familiar with PPSAT'S
5 protocol for the administration of medication abortions.

6 A. I have looked at the PPSAT'S protocol in the past and
7 would be happy to review it again if you would like for me to.

8 Q. But as you sit here in this deposition, you don't
9 recall specific information about their protocol for
10 administration of medication abortion?

11 A. No. I would have to look at their protocol, which I
12 think is a reasonable thing before I answered your question.

13 Q. So you're not aware then if a patient with an IUD can
14 receive a medication abortion from PPSAT?

15 A. No. What I am trying to address is the fact that your
16 question is hypothetical and the real question at hand is what
17 is the clinical situation. I can't speak to protocols that do
18 not dictate how you manage a patient. Protocols provide
19 guidelines, but there has to flexibility because every patient
20 situation is different. So I can't comment on whether the
21 protocols are adequate or inadequate or how they apply to a
22 specific patient because I don't know enough about the patient
23 you're describing. This is a hypothetical situation.

24 Q. I'm not asking about what you would do for that
25 hypothetical patient. I'm asking whether you understand

1 PPSAT's medication abortion protocol to provide -- whether it
2 would provide medication abortion to patients with IUDs.

3 MR. BOYLE: Objection. Asked and answered.

4 THE WITNESS: Sir?

5 MR. BOYLE: You can answer.

6 THE WITNESS: I don't know.

7 BY MR. MENDIAS:

8 Q. So please go to paragraph 225 of your report.

9 A. Yes, I'm there.

10 Q. Can you read the first line of that paragraph?

11 A. The Act requires abortion providers to exercise their
12 due diligence in pursuing a diagnosis -- I'm slowing down. I'm
13 sorry, I know I read fast -- in patients with PUL. The same
14 due diligence that would be exercised by any Ob/Gyn caring for
15 a woman with a PUL, as outlined in the consensus statements and
16 papers listed above.

17 Q. Can you say what part of the Act imposes such a
18 requirement on abortion providers?

19 A. I don't have the Act in front of me, but my
20 understanding is that the Act says that the intrauterine
21 pregnancy must be documented.

22 Q. If an intrauterine pregnancy can't be documented, is
23 there a requirement in the Act to conduct further screening for
24 ectopic pregnancy?

25 A. No. My understanding is that an intrauterine

1 pregnancy must be documented before an abortion can be
2 performed. And I think that it's a very common sense -- it's a
3 very common sense measure.

4 Q. And you believe that Ob-Gyns as a general matter would
5 diligently try to rule out ectopic pregnancy for their
6 patients, is that correct?

7 A. Yes.

8 MR. MENDIAS: Ellis, do you have the exhibit
9 that I emailed to you?

10 MR. BOYLE: I do.

11 BY MR. MENDIAS:

12 Q. Doctor, can you please turn to paragraph 255 of your
13 report.

14 A. Yes.

15 Q. You have paragraph 255?

16 A. Yes.

17 Q. All right. So you discuss an article in the New
18 England Journal of Medicine describing a women who presented to
19 a hospital emergency room after a medication abortion and have
20 her ruptured tubal ectopic pregnancy misdiagnosed, is that
21 right?

22 A. Yes.

23 Q. The citation you provide for that article is in
24 footnote 260. Harris Allen and Grossman D., Complications of
25 Unsafe and Self-Managed Abortion, New England Journal of

1 Medicine 2020, is that right?

2 A. Yes.

3 MR. MENDIAS: I'm going to drop into the chat
4 the document that Mr. Boyle has given to you and I will mark
5 that as Exhibit-20.

6 MR. BOYLE: I think you already have a 20.

7 MR. MENDIAS: Sorry, I guess this is actually
8 21. Apologies. This is Exhibit-21.

9

- - -

10 (Document marked as Exhibit-21 for
11 identification.)

12

- - -

13 BY MR. MENDIAS:

14 Q. Doctor, can you please identify where in that article
15 the discussion of the patient referred to in your expert
16 report?

17 A. This isn't the right citation.

18 Q. So this is another citation error in your report?

19 MR. BOYLE: Objection.

20 MR. MENDIAS: You can answer, Doctor.

21 THE WITNESS: Yes, I think that the -- it's
22 another New England Journal study.

23 BY MR. MENDIAS:

24 Q. I'm sorry, I didn't mean to cut you off.

25 A. I think it's another study by -- not another study.

1 It's another citation by Dr. Grossman.

2 Q. Have you read the article that you have here that you
3 cited?

4 A. No, I have not read this one.

5 Q. Can you identify in your expert report where you cited
6 the article you intended to site here?

7 A. Can I identify where in which paragraph?

8 Q. Sure. My question is whether the article you actually
9 wanted to cite is cited somewhere in your expert report.

10 A. Let me take a look and if not, I can certainly give
11 you that reference.

12 (Pause.)

13 A. Yeah, I can certainly give you that reference.

14 MR. MENDIAS: I actually think this may be the
15 article that you intend to cite, which I'm going to drop into
16 the chat and mark as, I believe, Exhibit-22.

17 - - -

18 (Document marked as Exhibit-22 for
19 identification.)

20 - - -

21 BY MR. MENDIAS:

22 Q. Doctor, is this the source you intended to site?

23 A. Go down a little further. Yes, I believe this is --
24 can you go down a little further?

25 Q. Sure. So let's look at the quote in your expert

1 report.

2 A. Yes.

3 Q. So this is who was at 5 weeks 4 days gestation on the
4 basis of the last menstrual period presented to the emergency
5 department with severe abdominal pain.

6 A. Yes.

7 Q. And that is the text that I have just highlighted in
8 this source, correct?

9 A. Yes. So that's the correct article.

10 Q. You refer to it as an article, but this is in fact a
11 letter to the editor, isn't that right?

12 A. That's correct.

13 Q. And you didn't actually cite this letter anywhere else
14 in your expert report, did you?

15 A. No.

16 Q. And do you recognize that the woman describes in this
17 letter obtained medication abortion pills on the Internet,
18 correct?

19 A. I'm sorry, say that again.

20 Q. You understand that the woman describes in this letter
21 obtained medication abortion pills on the Internet, correct?

22 A. Yes.

23 Q. And do you recognize that because she self-managed her
24 abortion she did not receive any counseling about the symptoms
25 of medication abortion as compared to a ruptured ectopic,

1 correct?

2 A. That's correct.

3 Q. You're aware that PPSAT's protocol specifically
4 counsels patients on the symptoms associated with both
5 medication abortion and ectopic pregnancy, correct?

6 A. Yes.

7 Q. And you recognize that because this woman did not
8 receive the medication abortion from a clinician she never
9 spoke to an abortion provider about her symptoms, correct?

10 MR. BOYLE: Objection.

11 THE WITNESS: I don't -- the point that I would
12 like to make here is not the difference between her having
13 undergone self-managed abortion versus undergoing abortion at
14 an abortion facility. The significance is that she had a
15 history of having undergone abortion, whether it was
16 self-induced or through an abortion provider and the emergency
17 department clinician, based on that history, did not pursue a
18 diagnosis of ectopic pregnancy. And so in a sense this is
19 similar to the situation of not identifying an intrauterine
20 pregnancy before doing an abortion because the woman was not
21 triaged appropriately to either failing intrauterine pregnancy,
22 intrauterine pregnancy, living intrauterine pregnancy or
23 ectopic pregnancy, and that is the point I'm trying to make.

24 BY MR. MENDIAS:

25 Q. My question was whether you're aware that this woman

1 because she received medication abortion online and not from a
2 clinician, did not speak to an abortion provider about her
3 symptoms.

4 MR. BOYLE: Objection.

5 THE WITNESS: Yes.

6 BY MR. MENDIAS:

7 Q. I'm sorry, what was your answer?

8 A. I'm sorry, repeat the question again.

9 Q. You recognize that because this woman received -- did
10 not receive medication abortion from a clinician she never
11 spoke to an abortion provider about her symptoms?

12 MR. BOYLE: Objection.

13 THE WITNESS: Yes.

14 BY MR. MENDIAS:

15 Q. You're aware that PPSAT counsels all their abortion
16 patients to reach out to them about any concerns regarding
17 post-abortion symptoms, are you?

18 MR. BOYLE: Objection.

19 THE WITNESS: I'm aware of that, yes.

20 BY MR. MENDIAS:

21 Q. And you're aware that patients with pregnancies of
22 unknown location who receive medication abortion at PPSAT
23 specifically receive close follow-up with a physician about
24 their symptoms?

25 MR. BOYLE: Objection.

1 THE WITNESS: I think the point that needs to
2 be made here is that she could walk out the door without having
3 an ectopic pregnancy and rupture and die. And she had an
4 opportunity -- she had an opportunity -- because she engaged
5 with the medical system, she had an opportunity to seek proper
6 diagnosis and didn't. She underwent an abortion procedure --
7 I'm talking about at Planned Parenthood, for example. A
8 patient would undergo an abortion procedure, which would then
9 confound the diagnosis of an ectopic pregnancy because the --
10 an emergency room physician, as these emergency room physicians
11 did, did not pursue a diagnosis of ectopic pregnancy and she
12 was at high risk for fatal outcome, and that's the heart of the
13 matter. Patient can receive counseling, they can be told, you
14 know, you need to follow up with us. But if they go home and
15 rupture and die, that's a problem.

16 BY MR. MENDIAS:

17 Q. My question was whether you're aware that PPSAT
18 specifically closely follows up all of their patients who
19 receive medication abortion who have pregnancy complications?
20 Are you aware of that now?

21 MR. BOYLE: Objection. You can answer.

22 THE WITNESS: Yeah. The follow-up does not
23 include diagnosing an ectopic pregnancy. Follow-up is not the
24 same as diagnosis.

25 BY MR. MENDIAS:

1 Q. Doctor, in August of 2023 you submitted an expert
2 report in this case, is that right?

3 A. Yes.

4 Q. And in that report you used the phrase medication
5 abortion numerous times, is that right?

6 A. Yes.

7 Q. I'll represent to you that the phrase medication
8 abortion appears in your first declaration 48 times. Do you
9 have any basis to dispute that?

10 A. I haven't counted it, so I can't agree with your
11 statement.

12 Q. Do you have any reason to think it's not that high?

13 MR. BOYLE: Objection.

14 THE WITNESS: I would be speculating if I said
15 that. I would need to count and see if that's the number of
16 times.

17 BY MR. MENDIAS:

18 Q. In the report you submitted in January, you changed
19 most of the references to medication abortion to say chemical
20 abortion instead, is that right?

21 MR. BOYLE: Objection.

22 THE WITNESS: I don't remember whether I made
23 that change or not. I'm sorry.

24 BY MR. MENDIAS:

25 Q. Okay. Is it possible that someone else made that

1 change?

2 MR. BOYLE: Objection. I'm instructing you not
3 to answer about the drafting process for your report.

4 BY MR. MENDIAS:

5 Q. All right.

6 MR. MENDIAS: Doctor, I'm going to put your
7 first declaration into the chat and I believe this is
8 Exhibit-23.

9 - - -

10 (Document marked as Exhibit-23 for
11 identification.)

12 - - -

13 BY MR. MENDIAS:

14 Q. Doctor, does this appear to be the report you
15 submitted in August?

16 A. It has the same face sheet, but as I said earlier with
17 another document, I don't know if the content is the same
18 because I have not reviewed the document.

19 Q. This appears to be your signature under penalty of
20 perjury on the first expert report you submitted in this case,
21 correct?

22 A. That's correct.

23 Q. And you see that here the document has been stamped by
24 a federal district court indicating it was filed with that
25 court, correct?

1 A. That's correct. But I don't have the document in hand
2 so I can't attest to its authenticity.

3 Q. Doctor, do you have paragraph 116 of that first
4 declaration you submitted?

5 A. Yes.

6 Q. Can you read the last sentence of that paragraph?

7 A. Yes. Hold on one second. We do know that serious
8 complications are rare with medication abortion.

9 Q. And that quote you attribute to an organization called
10 ANSIRH, A-N-S-I-R-H, is that right?

11 A. Yes.

12 Q. Can you please go to paragraph 26 of the declaration
13 you submitted in January?

14 MR. BOYLE: Objection. I believe she submitted
15 it in December, just for the record.

16 MR. MENDIAS: My apologies.

17 THE WITNESS: Which document are we talking
18 about now, sir?

19 BY MR. MENDIAS:

20 Q. Now we're talking about the more recent expert
21 declaration from December?

22 A. Thank you for the clarification. Yes.

23 Q. Can you read the last sentence of that paragraph?

24 A. We do know that --

25 MR. BOYLE: What paragraph?

1 THE WITNESS: Paragraph 26, you said?

2 MR. MENDIAS: Correct.

3 MR. BOYLE: Thank you.

4 THE WITNESS: We do know that serious
5 complications are rare with chemical abortion.

6 BY MR. MENDIAS:

7 Q. So this was the same source that you cited in your
8 first declaration, correct?

9 A. Yes.

10 Q. And the change in that sentence was from medication
11 abortion to chemical abortion, correct?

12 A. Yes.

13 Q. And although this is a quotation, you did not indicate
14 in any way that it had been altered from what it originally
15 stated, correct?

16 A. Yes.

17 Q. Why did you not indicate any change that you had made
18 to this sentence?

19 A. When I -- when I did this expert report, I looked at
20 the usage of chemical abortion versus medication abortion and
21 there was discussion -- there had been discussions as to these
22 terms of art, as to which might be more appropriate.

23 MR. BOYLE: Don't talk about discussions you
24 had with lawyers internally, if that's what you're talking
25 about.

1 THE WITNESS: No. No. No. This is in the
2 scientific community.

3 MR. BOYLE: Okay. My instruction is the same,
4 but if it's not about lawyer conversations you can proceed.

5 THE WITNESS: Okay. So there has been some
6 discussion as to whether a chemical abortion and medication
7 abortion is the better term. They're both terms of art and
8 they're both interchangeable.

9 BY MR. MENDIAS:

10 Q. Medication abortion is a term used by the FDA,
11 correct?

12 A. Yes. If I can just finish. And so I substituted
13 throughout the document because I felt that the term chemical
14 abortion was a better term, and I should have left this as
15 medication abortion as the quote.

16 Q. ACOG, the American College of Obstetricians and
17 Gynecologists uses the term medication abortion, correct?

18 A. Yes. But as I said, this is a term of art and the two
19 terms are essentially interchangeable.

20 Q. What organizations use the term chemical abortion?

21 MR. BOYLE: Objection.

22 THE WITNESS: I'm not aware of whether any
23 specific organizations use this specific term because it's a
24 term of art. It's not a term that is required to be used in a
25 certain way. But as a term of art, it is used in conversations

1 and discussions about abortion using mifepristone and
2 misoprostol.

3 Q. When you say term of art, what do you mean?

4 A. A term of art is a term that is used within a specific
5 discipline, whether it's law or medicine, to describe a
6 particular thing. And that description reflects its usage
7 within that field, which may not necessarily be its common
8 usage.

9 Q. But which segments of the discipline use the term
10 chemical abortion?

11 MR. BOYLE: Objection.

12 THE WITNESS: I have heard the term used by
13 various colleagues in the field and I can't tell you
14 specifically -- I don't remember specifically who was in those
15 discussions or what the content of the discussions was. But I
16 have known that this is a term that is used, and it is
17 referring to mifepristone and misoprostol abortion.

18 BY MR. MENDIAS:

19 Q. But you can't say by who that term is used?

20 MR. BOYLE: Objection.

21 THE WITNESS: It's a term of art.

22 BY MR. MENDIAS:

23 Q. Right. My question is who uses that term of art?

24 MR. BOYLE: Objection.

25 THE WITNESS: Ob-Gyns.

1 BY MR. MENDIAS:

2 Q. Do you think chemical abortion is the more common term
3 among Ob-Gyns?

4 MR. BOYLE: Objection.

5 THE WITNESS: I can't say whether it's more
6 common or not. I'm simply saying that it is a term that is
7 used.

8 BY MR. MENDIAS:

9 Q. Doctor, going to your first declaration from August of
10 last year. Can you please go to paragraph 396.

11 A. Yes.

12 Q. And there you're talking about the study by Ushma
13 Upadhyay from 2022, correct?

14 A. Yes.

15 Q. And then in the next paragraph you quote from that
16 study. Can you read that quote in the first sentence of
17 paragraph 397?

18 A. This was a retrospective cohort study assessing the
19 effectiveness and safety of using history-based screening alone
20 for medication abortion. The study was designed --

21 Q. I'm sorry, I just need you to read the first sentence.
22 Thank you. Can you go to your December expert report to
23 paragraph 59?

24 A. Yes.

25 Q. And in that paragraph you're discussing the same Ushma

1 Upadhyay 2022 study, correct?

2 A. Yes.

3 Q. And can you read the second sentence of that
4 paragraph?

5 A. Yes. This was a retrospective cohort study assessing
6 the effectiveness and safety of using history-based screening
7 alone for chemical abortion.

8 Q. So again, in this quotation you changed the term
9 medication abortion to chemical abortion, correct?

10 A. Yes.

11 Q. And again, you did not indicate that you had made any
12 such change, correct?

13 A. Yes.

14 Q. Do you remember now making these changes?

15 A. Do I remember making these changes?

16 Q. Yes.

17 A. Yes.

18 Q. Did you make those changes?

19 A. Yes.

20 Q. Did anyone else make those changes?

21 MR. BOYLE: Objection. I'm going to give you
22 the same instruction. Don't divulge any information about
23 drafting and discussions with your lawyers.

24 THE WITNESS: No. I'm sorry, repeat the
25 question again, sir.

1 MR. MENDIAS: That's all right.

2 BY MR. MENDIAS:

3 Q. Do you believe that the change from medication
4 abortion to chemical abortion is an ideological one?

5 A. No. I believe that the terms are synonymous.

6 Q. Doctor, look at your last deposition. And in your
7 current C.V. you state that you are a member of the board of
8 the American Association of Pro-Life Obstetricians and
9 Gynecologists, AAPLOG, is that right?

10 A. Yes.

11 Q. And AAPLOG produces a glossary of preferred terms that
12 it instructs its members to use, is that right?

13 MR. BOYLE: Objection.

14 THE WITNESS: I'm not aware of that glossary,
15 sir.

16 BY MR. MENDIAS:

17 Q. Are you aware of AAPLOG's preference for certain terms
18 over others?

19 MR. BOYLE: Objection.

20 THE WITNESS: I'm aware that they may have a
21 preference, but that doesn't necessarily -- what I choose to
22 put in my documents.

23 BY MR. MENDIAS:

24 Q. Do you believe that AAPLOG has a preference for the
25 term chemical abortion over medical abortion?

1 MR. BOYLE: Objection.

2 THE WITNESS: I'm not aware of that. I don't
3 know.

4 BY MR. MENDIAS:

5 Q. As a former board member, you never had discussions
6 about which terms to use regarding mifepristone and
7 misoprostol?

8 MR. BOYLE: Objection. Object to form. You
9 can answer.

10 THE WITNESS: I haven't been a board member for
11 many years, sir.

12 MR. MENDIAS: I am going to put a document in
13 the chat which I'll have marked as Exhibit-24.

14 - - -

15 (Document marked as Exhibit-24 for
16 identification.)

17 - - -

18 BY MR. MENDIAS:

19 Q. Doctor, have you ever seen this document?

20 A. I don't think so.

21 Q. Do you have any reason to believe that this document
22 does not come from AAPLOG?

23 MR. BOYLE: Objection.

24 THE WITNESS: I'm saying that I don't think I
25 have seen this document.

1 BY MR. MENDIAS:

2 Q. I know. My question was whether you have any reason
3 to believe that this is not from AAPLOG?

4 MR. BOYLE: Objection.

5 THE WITNESS: I'm sorry, I didn't -- do I --
6 can you rephrase your question? Do I have any reason to
7 believe that this is not from AAPLOG?

8 MR. MENDIAS: Correct. That was my question.

9 MR. BOYLE: Objection. You can answer.

10 THE WITNESS: I haven't seen this document so I
11 cannot attest to its authenticity or whether it comes from
12 AAPLOG or not.

13 BY MR. MENDIAS:

14 Q. Can you read the highlighted portion of this page,
15 please.

16 A. Medication abortion. Medication implies that an
17 illness is being treated and that there is therapeutic benefit.

18 Q. Does that inform your decision to refer to the
19 medication abortion regimen as chemical abortion?

20 A. No. As I said, I have never seen this document.

21 Q. I'm not asking about this document specifically. But
22 do you agree that medication implies that an illness is being
23 treated and that there is a therapeutic benefit?

24 A. That is not my conviction, no.

25 Q. So why specifically do you feel chemical abortion is a

1 more appropriate term than medication abortion for the regimen
2 of mifepristone and misoprostol to terminate a pregnancy?

3 A. I arrived at the decision to use the term chemical
4 abortion because I felt that it was more appropriate in terms
5 of describing the fact that these drugs are used with -- for --
6 in the context of abortion as for intentional feticide. As I
7 said earlier, I had discussions with colleagues about the use
8 of the terms medication abortion versus chemical abortion and
9 felt that this was an appropriate term to use. There was no
10 ideological intent.

11 Q. Doctor, can you read this highlighted portion of the
12 document?

13 A. Intentional embryo/feticide or induced abortion by
14 chemical or pharmacologic agent or via mifepristone.

15 Q. Why do you believe that medication abortion is
16 inappropriate?

17 A. I didn't say that it was inappropriate. I said that
18 the terms are interchangeable.

19 Q. Why did you feel that the term chemical abortion is
20 more appropriate than medication abortion?

21 A. Because as I was discussing this with my colleagues in
22 different venues, the term was felt to be appropriate to
23 describe the process of using specific chemicals to either
24 effect abortion or -- to effect abortion.

25 Q. Which colleagues did you have those discussions with?

1 A. I don't remember who they were at this moment.

2 Q. Do you remember where you had such discussions?

3 A. I don't remember. It was in the course of talking
4 with other Ob-Gyns, but I don't remember the exact
5 circumstances.

6 Q. Without divulging ruling any communication between you
7 and any lawyers, did anyone ever suggest to you that you
8 should, as a general matter, refer to mifepristone and
9 misoprostol as chemical abortion?

10 A. No. This was my decision.

11 Q. Doctor, can you please go to paragraph 173 of your
12 December expert report.

13 A. Yes.

14 Q. And there you state as an alternative to abortion
15 patients who have received fatal fetal diagnoses can benefit
16 from neonatal hospice, is that right?

17 A. Perinatal hospice, yes.

18 Q. You say in paragraph 174 of that report that hospitals
19 are often associated with a perinatal hospice program, is that
20 right?

21 A. Yes.

22 Q. Are you aware of any hospitals in North Carolina that
23 are associated with perinatal hospice programs?

24 A. My understanding is that UNC Hospital is. I'm not
25 sure about Duke. And the other hospital that I work at --

1 other hospitals that I have worked at, for example in other --
2 in Indiana is affiliated. I can't speak for all hospitals and
3 that's why I said many. There are many.

4 Q. I appreciate that. I am wondering in North Carolina.
5 So you, I believe, said UNC. Is that the only hospital you
6 know in North Carolina that has a perinatal hospice program?

7 A. I don't know and that's why I said often.

8 Q. Sure. I just want to be very clear. You only know
9 for sure that one hospital in North Carolina has such a
10 program?

11 A. Or is affiliated with.

12 Q. The answer is yes, there's only one hospital that you
13 know that has or is affiliated with such a program in North
14 Carolina?

15 A. I think -- I would have to verify this, but I think
16 that Baptist Hospital in Winston-Salem is also affiliated. But
17 I would have to confirm that and I'm happy to do that and get
18 you that information, if you like.

19 Q. So to confirm, you know of one hospital that certainly
20 has such an affiliation and you think possibly a second does as
21 well?

22 A. Yes. But there may be others.

23 Q. For the one hospital that is affiliated with such a
24 program, do you know what the earliest gestational age a
25 patient could make use of that program services?

1 A. No. Because I don't -- I'm not familiar with the
2 specific program. My understanding is that in general
3 perinatal hospice programs are available from the time of the
4 diagnosis of a lethal fetal anomaly.

5 Q. So it's a general understanding, not anything
6 particular to the one hospital in North Carolina that you're
7 aware of that is affiliated with such a program?

8 A. Yes. But as I said, I would be happy to get more
9 information for you.

10 Q. You're aware that under the law challenged in this
11 case abortion performed because of a fetal anomaly is permitted
12 only before 24 weeks of pregnancy, right?

13 A. Yes.

14 Q. And you're aware that PPSAT does not perform abortions
15 after 20 weeks of pregnancy, right?

16 A. Yes.

17 MR. BOYLE: At some point can we take a break?
18 I think we have been going another hour.

19 MR. MENDIAS: Sure. We can take a five-minute
20 break right now.

21 - - -

22 (A break was taken, 3:18 p.m. - 3:25 p.m.)

23 - - -

24 BY MR. MENDIAS:

25 Q. Doctor, I just want to go back to some of the things

1 that you said very early on in this deposition. I believe you
2 said that you provided expert reports in Indiana and Kansas,
3 correct, since August of 2023?

4 A. I feel like I'm forgetting one. Oh, and Colorado.

5 Q. What were the topics of those expert reports?

6 A. Colorado, it was regarding abortion pill rescue -- I
7 would have to go back and look. I just don't want to misquote.
8 I would have to go back and look at my expert reports.

9 Q. What do you mean by abortion pill rescue?

10 A. So people refer to abortion pill, reversal abortion,
11 but abortion pill rescue is a better term actually.

12 Q. Why is that a better term? And can you describe what
13 abortion pill reversal is?

14 A. So abortion pill rescue is a situation where a woman
15 is given mifepristone and then changes her mind, wants to try
16 to salvage her pregnancy and then receives progesterone. It's
17 better to call it abortion pill rescue though because there's
18 precedent for this type of procedure in medicine and the term
19 rescue is used.

20 Q. Are you aware of any studies that demonstrate the
21 effectiveness of this particular treatment?

22 MR. BOYLE: I'm just going to object. Are you
23 asking her about her expert testimony in a completely separate
24 case that has nothing to do with the facts in this case? If
25 that's true, I would like to suggest that it's relevant and I

1 might let you have one or two questions, but then I'm going to
2 instruct her not to answer.

3 MR. MENDIAS: I'm asking questions about the
4 expert that the state of -- the intervenors has put forward as
5 an expert on abortion medicine, about her expert opinions on
6 abortion.

7 THE WITNESS: I don't have those --

8 MR. BOYLE: Let's get the question -- please
9 pose a question.

10 MR. MENDIAS: I can return to that.

11 BY MR. MENDIAS:

12 Q. You mentioned earlier that you had been a part of an
13 AAPLOG training session on expert witness -- or serving as an
14 expert witness, is that correct?

15 A. Yes.

16 Q. Did you take notes during that training?

17 A. Yes.

18 Q. Did you review those notes before this deposition?

19 A. No. I destroyed them at the end of the training.

20 Q. During the break that you just took or the break that
21 you took earlier today, did you consult any of the articles we
22 discussed earlier that were incorrectly cited in your report?

23 MR. BOYLE: Objection to form. You can answer.

24 THE WITNESS: No.

25 BY MR. MENDIAS:

1 Q. Doctor, do you understand that the law at issue in
2 this case does not prevent any patient who wants it from
3 seeking the services of a perinatal hospice program, correct?

4 MR. BOYLE: Object to form.

5 THE WITNESS: I don't understand the question,
6 sir. I'm sorry.

7 BY MR. MENDIAS:

8 Q. If someone wants to engage the services of a perinatal
9 hospice program, they may do so notwithstanding the law at
10 issue in this case?

11 MR. BOYLE: Object to form.

12 THE WITNESS: Yes.

13 BY MR. MENDIAS:

14 Q. And if a patient has a pregnancy of unknown location,
15 the law does not prohibit her from simply waiting until an
16 intrauterine pregnancy can be documented to receive a
17 medication abortion, correct?

18 A. No, the law does not prohibit her from doing that. Am
19 I understanding the question correctly?

20 Q. Do you understand that abortions that are a result of
21 -- I'm sorry, pregnancies that are a result of rape or incest
22 are permitted after 12 weeks of pregnancy under the Act,
23 correct?

24 A. Yes.

25 Q. And I believe your expert report refers to the

1 possibility that such victims of sexual violence will receive
2 better care in hospitals than at abortion clinics, is that
3 right?

4 A. Can you tell me which paragraph you're referring to
5 and which expert report you're referring to, sir?

6 Q. Sure. In paragraph 168 of your December expert
7 report.

8 A. Yes. I think I say in paragraph 168, to the best of
9 my knowledge, such resources are not available at abortion
10 clinics.

11 Q. How did you come to know what you know about the
12 available resources at abortion clinics?

13 A. The -- one of the expert reports from the plaintiffs
14 stated that the -- they have -- they evaluated the patient and
15 asked them questions about whether they are being abused or in
16 trafficking, I believe. But I don't remember exactly where
17 that was.

18 Q. But you're not aware of any specific services for
19 victims of sexual violence that Planned Parenthood offers to
20 its patients?

21 A. The plaintiffs did not describe any of those services.

22 Q. And nothing in the law would prevent a person from
23 seeking out such services even if they were being seen for an
24 abortion at a Planned Parenthood clinic, correct?

25 MR. BOYLE: Object to form. You can answer.

1 THE WITNESS: Having worked with many victims
2 of abuse and victims of trafficking, one of the axioms in
3 caring for survivors is that the interaction with the medical
4 system represents a significant opportunity for those survivors
5 to obtain the care that they need and -- in terms of
6 potentially leaving their situation. And in my expert report,
7 I don't have the exact location, I talk about a study that
8 documented that patients had as many as 17 abortions. Each of
9 those abortions represented a missed opportunity for them to be
10 appropriately evaluated and offered an opportunity to leave the
11 trafficking situation. So that data in and of itself speaks to
12 the fact that these survivors often do not receive an
13 opportunity to have their -- those needs assessed and to leave
14 their situation.

15 BY MR. MENDIAS:

16 Q. Do you know anything specifically about PPSAT's
17 clinics in North Carolina and whether they offer such
18 interventions to their patients?

19 A. I don't. But I also will point out that they haven't
20 provided any data to show that those services are provided.

21 Q. When did you attend the most recent AAPLOG training
22 for expert witnesses?

23 A. It was last Saturday.

24 Q. And you said it was in Washington D.C.?

25 A. I didn't say that, but obviously you knew that.

1 Q. Were you in Washington D.C. for the March for Life?

2 A. No.

3 Q. Why were you in Washington D.C.?

4 A. To visit my mother-in-law who we take care of.

5 Q. Did you attend any events related to the March for
6 Life?

7 A. No.

8 Q. During this deposition, did you take any notes?

9 A. No.

10 Q. During this deposition, did anyone pass you any notes?

11 MR. BOYLE: Objection. Don't answer that.

12 BY MR. MENDIAS:

13 Q. During this deposition, did anyone other than a lawyer
14 provide any communication to you at all?

15 A. I spoke to the lady at the front desk of the office,
16 but that's it.

17 Q. During this deposition, did you engage in any
18 communications other than those that were transcribed by the
19 court reporter?

20 MR. BOYLE: Objection. Don't answer that as it
21 relates to any communications you had with lawyers.

22 BY MR. MENDIAS:

23 Q. Doctor, other than communication with lawyers, did you
24 engage in any communications that were not transcribed by the
25 court reporter?

1 A. No. I don't understand. Okay.

2 Q. Did you not understand the question?

3 A. No. No. I just wanted -- yeah, I think I understand
4 the question. I'm fine.

5 Q. Okay. I can ask again if you're unsure.

6 A. Sir?

7 Q. I can ask the question again if you're unsure.

8 A. No. I think I understand.

9 Q. Okay.

10 MR. MENDIAS: I don't have any further
11 questions.

12 BY MR. BOYLE:

13 Q. Doctor, good afternoon. My name is Ellis Boyle. I
14 represent the intervenor defendants. I have just a few
15 questions.

16 A. Yes, sir.

17 Q. In the Bartlett study that you were shown earlier,
18 table two said the mortality rate for 16 to 20 weeks was 3.4
19 deaths per 100,000 patients, right?

20 A. Yes.

21 Q. And in the Saraiya study, I believe it talked about
22 the 16th and 19 weeks mortality rate was 4.1 deaths per 100,000
23 patients, is that correct?

24 A. Yes, sir.

25 Q. So those two studies weren't comparing the same thing,

1 were they?

2 A. No, they were not. In fact, the Bartlett study
3 included that additional cohort of patients from 19 to 20
4 weeks. And as noted in their study, the risk for abortion
5 increases exponentially by 38 percent for every week of
6 gestation. So that figure of 3.4 is not analogous to the 4.9
7 -- 4.1 number in -- okay. Let me rephrase that. The 3.4
8 mortality ratio in the Bartlett study is not analogous to the
9 4.1 mortality ratio in the Saraiya study because it's a
10 different sampling. It's from 16 to 20 weeks, and not 16 to 19
11 weeks. So the numbers are not comparable.

12 Q. I forget the lady's name, but do you recall talking
13 about the study with the lady who's from Oakland, California?
14 Do you remember her name?

15 A. What was the study?

16 Q. Ushma -- I forget the last name. It's the walk-up
17 study.

18 A. The Turnaway?

19 Q. What's that?

20 A. The Turnaway study?

21 Q. Yes, sorry, the Turnaway study. Do you recall that
22 lady's name who is the lead author there?

23 A. I don't remember her name.

24 Q. You're aware that she is a sociologist, right?

25 A. Yes, that's correct.

1 Q. She's not a medical doctor, is she?

2 A. That's correct, she's not a medical doctor?

3 MR. BOYLE: No further questions. That's all.

4 MR. MENDIAS: One follow-up question.

5 BY MR. MENDIAS:

6 Q. Doctor, you agree that the risk from an abortion would
7 be higher in the 20th week of pregnancy than in the 19th week
8 of pregnancy, correct?

9 A. Based on Bartlett's study, yes.

10 Q. Okay.

11 MR. MENDIAS: No further questions. Thank you,
12 Doctor.

13 BY MR. BOYLE:

14 Q. Doctor, one follow-up based on that. Just a moment.
15 If you can find table one and let me know when you find that.

16 A. Mortality rates for miscarriage?

17 Q. Yes. Can I see that, please?

18 A. Yes.

19 Q. So this is from your second report in December 2023.
20 It's been marked as an exhibit. This is on page 34, paragraph
21 91, table one. In the Berman study from 1985, it finds that
22 once you get to weeks 20 to 24, the mortality deaths per
23 hundred or a million thousand patients decreases, correct?

24 A. That's correct.

25 Q. So adding the 20th week to the study for -- with the

1 Bartlett study could actually have it decrease the mortality
2 rate, and it would be explained by the fact that in week 20 the
3 mortality rate starts to decrease based on the Bartlett study,
4 is that correct?

5 A. That's correct.

6 MR. BOYLE: No further questions.

7 MR. MENDIAS: Nothing from me.

8 - - -

9 (Witness excused.)

10 - - -

11 (Deposition concluded 3:44 p.m.)

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CERTIFICATE OF REPORTER

STATE OF NORTH CAROLINA)

COUNTY OF ALAMANCE)

I, Susan A. Hurrey, RPR, the officer before whom the foregoing remote deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me to the best of my ability and thereafter reduced to typewriting under my direction; that the witness reserves the right to read and sign the transcript of the deposition prior to filing; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and further, that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

This the 5th day of February, 2024.

SUSAN A. HURREY, RPR

Notary Public 201826800211

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I, MONIQUE CHIREAU WUBBENHORST, M.D., M.P.H.,
do hereby state under oath that I have read the
above and foregoing deposition in its entirety
and that the same is a full, true and correct
transcript of my testimony, subject to the
attached list of corrections, if any.

MONIQUE CHIREAU WUBBENHORST, M.D., M.P.H.

STATE OF _____
COUNTY OF _____

Sworn to and subscribed before me this _____ day
of _____, 20____.

Notary Public

My commission expires: _____

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E R R A T A S H E E T

PAGE LINE CORRECTION

I, _____, after having read the foregoing transcript of my deposition, wish to make the above corrections.

SIGNATURE _____
DATE _____

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DISCOVERY

COURT REPORTERS AND LEGAL VIDEOGRAPHERS

Signature of Deponent 

Date: 2.19.2024

EXHIBIT F

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

PLANNED PARENTHOOD SOUTH
ATLANTIC, et al,

Civil Action
No. 1:23CV480

Plaintiffs,

vs.

Greensboro, North Carolina
September 25, 2023

JOSHUA STEIN, et al.,

Defendants,

PHILIP BERGER & TIMOTHY MOORE,

Intervenors,

_____ /

TRANSCRIPT OF PRELIMINARY INJUNCTION PROCEEDINGS
BEFORE THE HONORABLE CATHERINE C. EAGLES,
CHIEF UNITED STATES DISTRICT JUDGE

APPEARANCES:

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KRISTI GRAUNKE, ESQ.
BRIGITTE AMIRI, ESQ.
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Proceedings reported by stenotype reporter.
Transcript produced by computer-aided transcription.

1 **APPEARANCES CONTINUED**

2 For Defendant Jim O'Neill:

3 KEVIN GUY WILLIAMS, ESQ.

4 For Defendant Secretary Kinsley and DHHS:

5 MICHAEL WOOD, ESQ.

6

7 For Defendants Medical Board and North Carolina Board of
8 Nursing:

9 MICHAEL BULLERI, ESQ.

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11 For the District Attorney Defendants:

12 LIZ O'BRIEN, ESQ.

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P R O C E E D I N G S

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(All parties were present.)

THE COURT Good morning. We're here on Gray and Planned Parenthood against Stein, et al.

So first, I'll have everybody tell me who is here and who is going to speak, and then I'm going to tell you what my questions are.

I'm going to give you a five minute break for you to get organized after you hear what my questions are, and then we'll come back and I'll hear from you.

Okay. For the plaintiff.

MS. SWANSON My name is Hannah Swanson of Planned Parenthood Federation of America. I represent the plaintiff Planned Parenthood South Atlantic, and by agreement, I will be presenting argument on behalf of both.

THE COURT All right. Thank you.

MS. RAUN E Good morning, Your Honor, Kristi Graunke from the ACLU of North Carolina Legal Foundation for all plaintiffs.

MS. AMIRI I'm Brigitte Amiri from the ACLU on behalf of Dr. Gray.

MS. MA ETORE Good morning, Your Honor, Jaclyn Maffetore from the ACLU Legal Foundation, also on behalf of all of the plaintiffs.

THE COURT All right, Ms.Swanson will be speaking.

1 Proceed.

2 **MR. OYLE** Good morning, Your Honor, Ellis Boyle
3 from the Wake County Bar on behalf of the legislative leader
4 defendant intervenors, and I'm joined by Erik Baptist from the
5 Virginia and Washington, D.C. Bar, who made a special
6 appearance, and he will be speaking on behalf of the
7 legislature leaders.

8 **THE COURT** Tell me your name again.

9 **MR. APTIST** Erik Baptist.

10 **THE COURT** Okay. And who is here for Mr. Stein?

11 **MS. OYCE** Good morning, Your Honor. My name is
12 Sarah Boyce, and I'm with the North Carolina Department of
13 Justice on behalf of Attorney General Joshua Stein.

14 **MS. NARASIMHAN** Good morning, Your Honor, Sripriya
15 Baraimhan --

16 **THE COURT** You are going to have to speak into the
17 microphone, because I can't hear you.

18 **MS. NARASIMHAN** My name is Sripriya Narasimhan from
19 the North Carolina Department of Justice. I'm also here on
20 behalf of Attorney General Stein.

21 **THE COURT** Is anybody going to be arguing on behalf
22 of the district attorneys?

23 **MS. O RIAN** Good morning, Your Honor, Liz O'Brian
24 for the North Carolina Department of Justice. I'm here on
25 behalf of the district attorneys. I do not intend to offer

1 argument.

2 **MR. WILLIAMS** Kevin Williams on behalf of District
3 Attorney Jim O'Neill, and also do not anticipate needing to be
4 heard this morning.

5 **THE COURT** All right. So here are my -- did I get
6 everybody? Sorry.

7 **MR. ULLERI** Michael Bulleri, also with the North
8 Carolina Department of Justice. I represent the North Carolina
9 Medical Board and the North Carolina Board of Nursing.

10 **THE COURT** The boards. I forgot about them.

11 **MR. ULLERI** I also do not anticipate needing to be
12 heard this morning.

13 **MR. WOOD** Michael Wood, with the Department of
14 Justice, counsel to Secretary Kinsley of DHHS. We have not
15 taken a position, and I do not intend to present argument
16 today.

17 **THE COURT** Thank you. Okay. Here are my questions:
18 First, I want everybody to talk to me about standing.
19 This was raised in the intervenors' supplemental brief, and I
20 did not see it addressed otherwise. I would like particularly
21 to hear from the plaintiffs, but from the intervenors, and the
22 attorney general as well.

23 If you tell me something as a fact, I would like you
24 to direct my attention to where it is in the record. As I
25 understand the law, I have to make findings of fact in

1 connection with motions for preliminary injunction and findings
2 of fact that have to be based on evidence. So statements in
3 briefs are not evidence, unless -- I mean, they are not
4 evidence. You have to cite to the evidence in the brief, and I
5 think my standing order is pretty clear, you know, I don't have
6 to go search it out myself, though in this context in court,
7 often seems to take facts from amicus briefs, but I don't do
8 that, and I don't take it from briefs from parties, unless you
9 direct my attention to the evidence. So, you know, you all
10 aren't witnesses, so whatever you all say, not evidence.

11 There is a lot of reasons for that, and it is pretty
12 important. It is not fair. First of all, the other side
13 doesn't get to cross-examine you about that like you got to
14 cross-examine these deponents.

15 In this situation I know you all have seen the
16 briefs, and I don't have any amicus briefs but, you know, you
17 really -- if somebody says something in a supplemental brief
18 and there is no evidence to support it, the other side doesn't
19 have the opportunity to offer evidence in opposition to that,
20 so there is a lot of reasons.

21 It is not fair to either side to do it, and I'm
22 pretty strict about that. It would be very helpful to me if
23 you could direct my attention.

24 So for the plaintiffs, you do seem to make a number
25 of what I would call policy arguments, essentially asking the

1 Court to weigh competing medical evidence, but I read *Dobbs* to
2 not allow that. You know, it doesn't -- *Dobbs* doesn't do away
3 with the rational basis test, but it has changed the law, and
4 some of your arguments don't seem to completely recognize that,
5 but specifically, your argument about the health risks of other
6 procedures that don't have to be done in the hospital, and
7 maybe to a lesser extent this one might be a little more open
8 for discussion.

9 The intervenors can address this if they want. Your
10 argument about the statutory provisions as allowing for home
11 births, so if you all can talk to me about that a little bit
12 more and why your arguments are consistent with *Dobbs*.

13 Then for the intervenors, you know, I would -- it
14 seems like you all believe that the legislature could make it
15 illegal for a woman to give birth at home. You don't, but
16 based on your health and safety argument about requiring
17 surgical abortions after 12-weeks to be done in the hospital,
18 it seems like you could just make it a crime to give birth at
19 home because the risks -- the health and safety risks are more
20 serious to the child and the mother.

21 So if you could talk to me about that, and how
22 that -- what limits are on the legislature's health and safety
23 authority, I appreciate that, if you think there are any
24 limits.

25 I would like both of you to, I think confirm -- if

1 not confirm, tell me what the briefs and evidence have
2 called -- I'm just going to use the shorthand, miscarriage
3 management. That's essentially the situation -- I think it is
4 in 90-21.81(1)(c) and (d). That's the provision that excludes
5 from the definition of abortion -- I can't remember now if it's
6 in there twice, once for medication and once for surgical, or
7 if it's just in there once, but it excludes from the definition
8 of an abortion the removal of a dead or unborn child who died
9 as a result of natural causes in utero, accidental trauma or
10 criminal assault or to remove an ectopic pregnancy. That seems
11 to me to be what people are talking about when they talk about
12 miscarriage management.

13 If that is not right, if somebody would tell me that
14 and direct me to the evidence on that point.

15 I think it is undisputed that the risk of aspiration
16 and D&E procedures, that those are both done for miscarriage
17 management. They are done for abortions, and I think the
18 evidence is that the risks are the same, regardless of the
19 purpose. If that is not true, please tell me the evidence on
20 that point.

21 In that context, I think I might like to hear from
22 the intervenors in particular, about the holdings in *Eisenstadt*
23 *against Baird*, *City of Cleburne*, and how you rationally
24 distinguish between groups the equal protection argument there.

25 On that point, I would like everybody to talk about

1 *Lee Optical*, which the plaintiffs don't give much attention to,
2 and which if I read it the way the intervenors read it, it
3 pretty much does away with the equal protection clause.

4 So, what does *Lee Optical* mean, because it's got to
5 mean something other than -- I don't know what it means. I'm
6 asking you all to help me on that. I'm curious about its
7 limits, you know, just thinking out loud about hypotheticals,
8 if California passed a law requiring every one in a hospital or
9 doctor's office to wear a mask, then there would be no equal
10 protection or due process problem with such a law under the
11 intervenors' argument because it has a rational basis, clearly.

12 The evidence is pretty strong that masks reduce
13 transmission of disease. It has a rational basis, and the fact
14 that it doesn't cover every possible group health setting or
15 every possible group setting means it would fall under *Lee*
16 *Optical*.

17 We can talk about other reasons that it might be
18 unconstitutional, but put those aside, because we're just here
19 about equal protection and due process, right?

20 There would be no problem if the intervenors are
21 correct about what *Lee Optical* means. So I kind of like to
22 think about the limits of *Lee Optical*, if there are any.

23 I would like the plaintiffs to take another stab at
24 telling me why the defendants' interpretation of the
25 intrauterine location provision is vague. For both of you, the

1 word -- the statute says, "before providing an abortion
2 inducing drug, a physician shall document the probable
3 gestational age and existence of an intrauterine pregnancy." So
4 it seems like the word "probable" modifies -- or clearly
5 modifies gestational age, and it seems like it modifies
6 existence of an intrauterine pregnancy.

7 So I would like you to think about whether that is so
8 or not, and if it is so, what does that mean. Does it matter?
9 Would the plaintiff say it is still vague? And, would the
10 defendant say it would still -- as I read the intervenors'
11 argument, you're basically saying that a medication abortion
12 before six weeks is illegal. If you're right about what that
13 statute means, that's your position, as I understand it. If
14 that's not right, I want you to tell me why that is not so.

15 I did have some concerns about the way the
16 intervenors characterized the health risks of -- I'm going to
17 probably pronounce it wrong, Mifepristone, early in pregnancy.
18 The evidence I saw in the record is, that the drug does not
19 terminate an ectopic pregnancy and thus is ineffective to treat
20 it, but I did not see any evidence that that drug itself
21 increases -- that administering it to someone who has an
22 ectopic pregnancy increases harm or risk to the woman or
23 increases the risk of complications from an ectopic pregnancy.
24 If that's not right, I would like the intervenors to point me
25 to the evidence.

1 I saw no evidence that the way that Dr. Gray and
2 other physicians treat patients who want a medication abortion
3 very early in pregnancy, before the location can be determined
4 by ultrasound, why that approach is not medically reasonable or
5 that it doesn't fully protect the health of the mother.

6 I'm really not sure how that plays into the decision,
7 if it does at all, but it does seem like the intervenors
8 overstated what the FDA says about the use of the drug in the
9 brief. So I would just like you to clarify that for me, and
10 point me to the evidence that supports some of your factual
11 claims about that, and how it plays into the health and safety
12 justification.

13 I was also a little confused about the evidence on
14 blood testing to confirm intrauterine pregnancy. What does the
15 evidence say about how early that can be done? I got a little
16 confused about that from the briefing.

17 Those are my questions. I'm not trying to prevent
18 you from addressing anything else, but I thought it might be
19 helpful to you to just know that I only have three whole pages
20 of questions, but I am hoping that you all will address those
21 things while we talk.

22 I thought I would give you maybe ten minutes to
23 figure out how -- I apologize for not getting them to you in
24 advance but, you know, I worked on it over the weekend, like
25 you all did. You know, I don't want to take you out of rhythm

1 on your argument, but I would like to address those points, if
2 you can.

3 Let's be in recess until 10 o'clock.

4 (Court was in recess from 9:48 to 10:09 a.m.)

5 **THE COURT** Okay. What I thought we would do is hear
6 from the plaintiffs, and I thought I would hear from the
7 Attorney General, and then the intervenors, and then I would
8 just let you all go round and round until you start repeating
9 yourselves or we all give out of energy. So that's how I
10 thought we would go forward, and have the plaintiffs address
11 everything and the same for the other folks.

12 Ms. Swanson, go ahead.

13 **MS. SWANSON** Good morning, Your Honor, may it please
14 the Court. I'm looking forward to addressing the Court's
15 questions, but I wanted to start with a piece of context that I
16 think is crucially important to this case, and that is, since
17 July 1st, abortions have been broadly illegal in North Carolina
18 after the first 12-weeks of pregnancy.

19 **THE COURT** Speak up.

20 **MS. SWANSON** Even under the 12-week ban, North
21 Carolina is one of the few remaining states, south of
22 Washington, D.C., where abortion is available at all, and it is
23 impossible to understand the stakes of this case without
24 bearing that broader picture in mind.

25 **THE COURT** The legislature can prohibit it, right?

1 **MS. SWANSON** Even under rational basis, plaintiffs
2 can rebut presumption of rationality.

3 **THE COURT** But, they could just say abortion is
4 completely totally illegal, because we think abortion is
5 morally wrong and reprehensible and a crime and they could make
6 it a crime, right, under **Do s**?

7 **MS. SWANSON** **Do s** upheld the rationality of a 15
8 week ban, and I think we would have argument about the
9 rationality of a total ban. Here, plaintiffs aren't
10 challenging a 12-week gestational line, rather we are
11 challenging these two pieces of the 12-week ban, Bill 20, the
12 hospitalization requirement, which we argue is vague, and also
13 fundamentally irrational in violation of the Fourteenth
14 Amendment.

15 Our arguments are that both of these provisions have
16 no rational relationship to the health and safety
17 justifications that the intervenors have raised in their
18 defense, and before getting to the specific evidentiary
19 questions about why those provisions fail to further be
20 asserted interest, I would like to address Your Honor's
21 standing question, which the intervenors did raise for the
22 first time in their supplemental brief.

23 I think there is a legal component to this challenge,
24 and a factual one, and I'll address the legal component first.
25 It is Black Letter Law under (indecipherable) under most

1 recently the --

2 **THE COURT** The what?

3 **MS. SWANSON** The *June Medical Services versus Gee*
4 Supreme Court case, that a regulated party like an abortion
5 provider, has third-party standing to bring constitutional
6 claims on behalf of people whose constitutional rights would be
7 violated if the law were enforced against the plaintiffs. That
8 has been applied in the abortion context in decades of federal
9 cases before *Dobbs*, and the Supreme Court in *Dobbs* did not
10 overrule that standing holding, which again a majority of the
11 Supreme Court affirmed as recently as the *June Medical Services*
12 case.

13 I think it is clear as a legal matter that the
14 plaintiffs do have standing to bring constitutional claims on
15 behalf of patients.

16 As a factual matter, the intervenor suggests that the
17 plaintiffs have not shown evidence that they will provide
18 abortion under these circumstances, and respectfully that was
19 not true.

20 Dr. Farris's declaration, which is at docket entry
21 49-1, in paragraph 13, asserts that Planned Parenthood --

22 **THE COURT** Slow down, please.

23 **MS. SWANSON** I'm sorry. That Planned Parenthood
24 South Atlantic does provide abortions under the exceptions and
25 would continue to do so, but for the hospitalization

1 requirement.

2 **THE COURT** Which paragraph?

3 **MS. SWANSON** This is paragraph 13 -- or 14, and
4 specifically as to abortions in the case of life-limiting
5 anomaly.

6 Docket entry 49-1, paragraph 46 describes how
7 hospitals in North Carolina refer patients to Planned
8 Parenthood South Atlantic's clinics for patients who have been
9 diagnosed with a fetal anomaly. This has happened in the past.
10 The plaintiffs have alleged that they would continue to provide
11 these abortions, and Dr. Farris's sworn declaration testimony
12 is sufficient evidence of that, but for the challenge
13 provisions, they would continue to do so. That's all that is
14 required for constitutional standing, and the law is clear that
15 plaintiffs have also met the standard for third-party standing,
16 which is prudential rather than jurisdictional.

17 If the Court has no further questions on standing, I
18 will proceed to the question about whether this is just a
19 policy dispute. Again, Your Honor, even under *Dobbs* rational
20 basis is the standard, and as the Court recognized, if rational
21 basis required the Court to defer not only to the State's
22 allegations, but it has legitimate purpose for its laws, but
23 also to the State's assertion that the chosen means do in fact
24 have a rational relationship to the State's ends, rational
25 basis would have no meaning whatsoever and the equal protection

1 clause would fail to guard against truly arbitrary and
2 irrational provisions like these.

3 So beginning with --

4 **THE COURT** Well, wait a minute. If there is a
5 rational basis, I do have to defer. I thought you just said I
6 didn't.

7 **MS. SWANSON** The Court does not need to defer to the
8 legislature's assertion that the means chosen is a rational way
9 of furthering its purported interest.

10 **THE COURT** Okay. I understand that.

11 **MS. SWANSON** I think the Borden's Dairy Products
12 case is a great example of this. So that was a straightforward
13 rational basis review, looking at whether a price-fixing
14 provision that applied to New York City dairy distributors had
15 a rational relationship to the asserted interests in promoting
16 the dairy industry within New York.

17 **THE COURT** I take it that's an older case.

18 **MS. SWANSON** It is an older case, Your Honor.

19 **THE COURT** All of the cases where the Supreme Court
20 has said no rational basis, this might not be right, which is
21 why I am asking you, but they appear to all be pretty old. You
22 know, that doesn't appear to have been a successful argument
23 with the Supreme Court in 30 or 40 years.

24 Is that wrong? What does that mean?

25 **MS. SWANSON** Your Honor, I would characterize those

1 cases as venerable, and that they have not been overruled by
2 the Supreme Court. I think *Cleburne* and *Moreno* are bedrock
3 Fourteenth Amendments cases that have not been overruled by the
4 Supreme Court.

5 The Fifth Circuit most recently in the *St. Joseph*
6 *Abbey* case, this was in 2013, applied rational basis review to
7 a Louisiana law that required people selling caskets to be
8 licensed as funeral directors. On its face, this is a
9 regulation of an economic industry, the sort of thing that the
10 State defendant, by pointing to *Williams* and *Lee Optical*, which
11 I will address in a moment, but the Court, in determining
12 whether or not there was in fact a rational basis for that law,
13 looked at the operation in the real world of that provision.
14 It looked at the other ways in which the state had regulated
15 the purchase of caskets in the funeral industry more broadly,
16 and it looked at the record in front of it.

17 So again, I think this requirement that the Court can
18 consider evidence and while the legislature is not responsible
19 for putting on evidence to justify its justifications for the
20 law, that presumption of rational justifications can be
21 rebutted if the plaintiffs put forth evidence that was
22 reaffirmed in the *Carolene* products case, I think the *Hooper*
23 case from 1985. This is a Supreme Court case looking at New
24 Mexico's prior residence requirement for veterans tax
25 exemption. That case is very helpful, because it is a line

1 that the legislature drew, May 8th, 1976, and it said if you
2 lived in New Mexico before this date and you currently are a
3 veteran residing in New Mexico, you are entitled to this tax
4 exemption. Every one who is a resident of New Mexico after
5 that date, you don't qualify for the exemption.

6 Even over the defense objection that there is limited
7 financial resources in the state, legislature has to draw a
8 line somewhere. We should defer to them. The Supreme Court
9 still approved the lower court's decision that looked at
10 whether that line, the May 8th, 1976 line, had any rational
11 relationship to the state's interest in encouraging the Vietnam
12 Veterans to move to the state, or in rewarding veterans for
13 their service. Not only did the court conclude that there was
14 no rational relationship between this classification of
15 veterans with prior residence before May 8, 1976, the court
16 found that this line actually ran contrary to the State's
17 purported interest, because it would discourage some Vietnam
18 Veterans from moving to the state.

19 I think the hospitalization requirement and the IUP
20 documentation requirement not only serve no safety
21 justification, they also undermine the State's interest in
22 patient safety by delaying people seeking abortions that the
23 legislature has expressly authorized them to receive, again,
24 this is abortions in the case of rape, incest or life limiting
25 anomaly, or people seeking an abortion in the very early weeks

1 of pregnancy. By delaying these patients, it not only
2 increases the cost of the procedure, it also increases the
3 marginal medical risk of the procedure, because while the
4 parties disagree about the extent to which abortion becomes
5 risky or gestational advances, the parties do agree that there
6 is some incremental increase in risk, and by delaying patients
7 to a later point in pregnancy, both provisions run contrary to
8 the State's asserted interest in safety.

9 This is one of those cases where the legislature's
10 asserted justifications are not backed up by evidence, and the
11 plaintiffs have shown through the declaration testimony we
12 submitted, through the depositions and through our supplemental
13 briefing which surveys that evidence, that the State's
14 justifications are simply not furthered by these two
15 provisions.

16 **THE COURT** Because the State, the intervenors have
17 not offered any other reason beyond health and safety, right?
18 This is not a case where they have said we want to discourage
19 abortions and these provisions discourage abortions, like some
20 of the informational provisions that have been at issue in the
21 past. That's my understanding. Is that your understandings?

22 **MS. SWANSON** That's my understanding, Your Honor.

23 **THE COURT** I'm sure they'll correct me if I'm wrong.
24 Go ahead.

25 **MS. SWANSON** Again, we believe that this is a case

1 like Hooper, Merrifield --

2 **THE COURT** Slow down.

3 **MS. SWANSON** Saint Joseph Abby and Greg Miles. So
4 turning to the Court's question about whether miscarriage
5 management is identical to procedural abortion for purposes of
6 the hospitalization requirement, yes, the record shows, and I
7 will direct the Court to Dr. Farris's declaration. This is
8 docket entry 49-1, paragraphs 24, 28, 40.

9 Dr. Boraas's declaration, this is docket entry 49-2,
10 at paragraph 21, footnote seven and paragraph 24 that
11 miscarriage management is identical to aspiration and D&E for
12 purposes of abortion.

13 In fact, the only difference between procedural
14 abortion and miscarriage management, the same gestational age
15 is, whether there is fetal cardiac activity. If there is fetal
16 cardiac activity, it is an abortion and North Carolina requires
17 it to happen in a hospital. If there is no fetal cardia
18 activity, it is miscarriage management, and North Carolina
19 permits that procedure to happen in a licensed outpatient
20 clinic. There is no rational basis grounded in patient safety
21 between these procedures.

22 I think the provisions that Your Honor directed our
23 attention to in the definition section of SB 20, this is
24 90-21.81, the definitions provision Subsection (1)(c), and then
25 again little c., which expressly excludes miscarriage

1 management from the definition of surgical abortion, and that's
2 because absent this exclusion, the procedures would be
3 identical, but the fact that the legislature expressly accepted
4 the same procedure for a different purpose, demonstrates the
5 irrationality of its hospitalization requirement for procedural
6 abortion, and that makes this like the Merrifield case, which
7 is out of the Ninth Circuit, and that was a case challenging
8 the requirement that certain pest control companies pass a
9 licensing exam and preserve licenses in order to manage
10 structural pest control, and that provision had a general
11 exception for pest control companies that don't work with
12 pesticides, but then it had a subsection, which carved out
13 nonpesticide using pest control companies that work with mice,
14 rats, and pigeons, and that I want to say is very, very similar
15 to this exception for miscarriage, because the Court looked at
16 the subsection for the nonpesticide using pest control
17 companies.

18 **THE COURT** The exception to the exception?

19 **MS. SWANSON** Exactly. And concluded, you've
20 actually brought back under regulatory control a group that is
21 less in need of the benefits of this licensing exception. So
22 it said everybody who is excepted from licensing is more likely
23 to come into contact with pesticides, and the safety benefit of
24 this licensing requirement is that it insures people doing this
25 sort of pest control understand what to look out for when they

1 encounter pesticides, and you've carved out everybody who is
2 more likely to encounter pesticides in their work, while
3 maintaining this licensing requirement for these other people,
4 so this classification is just not rationally related to your
5 interest in insuring that pest control companies understand how
6 to work with pesticides.

7 So I think the Court has honed in on the specific
8 irrationality of classifying between procedural abortion and
9 miscarriage management in requiring one, but not the other to
10 occur in a hospital.

11 Of course I think the overarching point is that both
12 of these are incredibly safe. They have safety data that is
13 far better than other procedures that are permitted to occur in
14 the outpatient setting and specifically, childbirth and labor
15 are 12 to 14 times riskier than abortion. And as Your Honor
16 identified, North Carolina permits labor and delivery to occur
17 outside the hospital setting, including in private homes, and
18 Section 4.3D of SB-20 expressly provides for planned birth
19 outside a hospital setting. That's a quote.

20 So I think it is undisputed that the risk is the
21 same. There is no rational justification for distinguishing
22 between the two, and I think this only reinforces the safety
23 evidence that the National Academy of Sciences, Engineering and
24 Medicine summarized in their flagship report, which concluded
25 that based on decades of methodologically sound research into

1 the safety of abortion hospitalization requirements do not make
2 abortion any safer than it already is. They just delay people
3 in seeking abortion, and again, here it is going to be people
4 seeking abortion, rape, incest, life limiting anomaly and the
5 legislature has already said those people should be able to
6 have abortions, so there is no rational justification for that
7 law.

8 **THE COURT** Those things don't increase the risks of
9 abortion, right? If you are pregnant because of rape, the
10 risks are the same as if you're pregnant not by rape?

11 **MS. SWANSON** That's correct, Your Honor. And
12 Dr. Farris explained that the -- correct, the procedure for
13 abortion is the same if you are doing the abortion due to a
14 life limiting anomaly, and as I mentioned earlier, hospitals in
15 North Carolina actually refer patients to Planned Parenthood
16 South Atlantic clinics for abortions under those circumstances.

17 Additionally, there is published research cited in
18 Dr. Farris's declaration, docket entry 49-1, in paragraph 38,
19 footnote 30. Research published by Dr. Turock and colleagues,
20 that expressly compared the safety of second trimester D&Es in
21 an outpatient setting, and found that it could be both safer
22 and more affordable than second trimester D&E.

23 **THE COURT** As I recall the intervenors' evidence, I
24 think it might have been in a deposition, I'm not remembering
25 right this second, at least one of their doctors said they

1 weren't -- they questioned that evidence. I don't recall that
2 they offered any evidence to the contrary beyond that doctor
3 saying in her experience, anecdotally, that was not right.

4 Am I remembering correctly?

5 **MS. SWANSON** So in fact, you may be remembering
6 Dr. Wubbenhorst's deposition, and at a separate point in the
7 deposition, Dr. Wubbenhorst in fact agreed that she cites the
8 same Dr. Turock study for a different proposition elsewhere in
9 her declaration, and when questioned about this, she agreed,
10 yes, I see that that study does recognize that abortion can be
11 just as safe in the outpatient clinic setting as in the
12 hospital setting.

13 **THE COURT** But she disagreed with that?

14 **MS. SWANSON** She did disagree with that, Your Honor,
15 but she did not point to anything to substantiate that
16 disagreement, and she also -- I think the overarching point is
17 that both of the intervenors' witnesses do not do more than
18 criticize the methodology of plaintiffs' experts studies.
19 Neither of them has direct experience providing abortion. Both
20 are philosophically opposed to abortion, and Dr. Wubbenhorst
21 specifically testified she believes abortion harms patients,
22 even when there are no complications.

23 So I think Dr. Wubbenhorst's testimony on abortion
24 safety, there are questions about the reliability of that
25 testimony and it stands --

1 **THE COURT** See, that raises, though, the very
2 interesting question, you know, what if -- just take it out of
3 abortion. There is issues out there like -- I think I remember
4 dentists and gold fillings, you know, where the legislature or
5 the regulatory body in various places has said the research on
6 you have to have gold fillings, which are very expensive, is
7 what I would just say is fringe research, and so even though
8 there is a dentist, several dentists, lots of dentists who say,
9 yeah, you got to have gold, the legislature or regulatory body
10 in various states has said, no, and if you tell patients that,
11 that's malpractice.

12 You know, when does something become -- how many
13 doctors do you have to have on your side in order for it to be
14 rational; one, 20, published research? When does it become
15 rational? I mean, you apparently think one or two doctors'
16 opinions is not enough.

17 **MS. SWANSON** Your Honor, I would point the Court to
18 not only the declaration testimony and deposition testimony of
19 our experts, but the decades of medical research that they rely
20 on in forming their opinions about the safety of abortion, and
21 that's in addition to their professional experience providing
22 abortion to patients for years, including specifically in North
23 Carolina.

24 Every mainstream medical organization for
25 obstetricians and gynecologists agrees that hospitalization

1 requirements do not make abortion any safer than it already is,
2 and that in general, abortion is one of the safest procedures
3 available.

4 **THE COURT** Of course 50 years ago, every mainstream
5 medical organization thought the informed consent laws were
6 crazy and did not benefit patients, and doctors kicked and
7 screamed at that requirement, and yet now, we're -- I mean,
8 that passed muster 50 years ago, even though every mainstream
9 medical organization opposed it and said it was bad for
10 patients.

11 So, I mean, I'm having a little trouble figuring this
12 out here.

13 **MS. SWANSON** Sure. The Court isn't controlled by
14 what the mainstream medical --

15 **THE COURT** Say again.

16 **MS. SWANSON** The Court is not controlled by what
17 mainstream medical organizations say, but I think that is
18 another piece of record evidence that allows the plaintiffs to
19 overcome the presumption that a law is rational.

20 So I think -- the intervenors point to a case about
21 whether Minnesota can ban plastic milk cartons, and in that
22 case, the court considered -- this was a 1981 case, and the
23 court considered, you know, recognized that the legislature
24 looked at extensive reports. This was extensively debated.
25 The legislature had lots of research in front of it and made a

1 distinction based on the research in front of it between one
2 policy and another, and that's not the case here.

3 SB-20 was rushed through legislature in a zeal to ban
4 abortion at 12-weeks, and even in litigation --

5 **THE COURT** It is hard to say it was rushed through.
6 *Dobbs* was decided last year, and it -- you know, I don't know
7 when the legislature went into session. January. Several
8 months.

9 **MS. SWANSON** So I think even after that 1981 case
10 about the milk cartons, *Hooper*, this case about the New Mexico
11 tax exemption for the veterans comes in 1985, and said -- the
12 Supreme Court as well, and that court again looked at the
13 operation of the classification that was challenged and
14 concluded based on how this particular classification operates,
15 it has no rational relationship to the state's asserted ends.

16 So of course rational basis is a more differential
17 standard, and heightened standard of review, but the point of
18 *Dobbs* is not that every abortion regulation is per se
19 constitutional. The point of *Dobbs* is, that rational basis
20 applies, and that abortion should be treated just like other
21 healthcare, and that's what we are asking for in this case.

22 We're seeking a preliminary injunction not because
23 abortion is special, but because it is just like other safe
24 routine outpatient healthcare, and there is no legitimate
25 reason to treat it otherwise.

1 So I think in light of all of the record evidence,
2 this is a case where we have rebutted the presumption that the
3 State was acting rationally in requiring hospitalization for
4 abortion.

5 Of course many courts leading up to *Dobbs* also struck
6 down hospitalization requirements, and as part of their
7 analysis they found there was no safety justification for those
8 hospitalization requirements, and even after *Dobbs*, a District
9 Court in Utah, is a state district court, struck down a
10 hospitalization requirement for all abortions under Utah's
11 counterpart to the rational basis standard.

12 So this was under Utah's Uniform operation of law
13 clause and the court considering evidence at the preliminary
14 injunction stage, concluded that there was no rational
15 relationship between the hospitalization requirement for
16 abortion and the state's purported health and safety in
17 abortion.

18 **THE COURT** So if the legislature had a few doctors
19 who said that the vasectomy should be done in hospitals, and
20 similar evidence that that was not necessary, you would say
21 that doesn't meet the rational basis standard? You are saying
22 this is the same, it ought to be treated like any other
23 decision by the legislature that something has to be done in
24 the hospital?

25 **MS. SWANSON** Your Honor, yes, we're saying the

1 legislature is required to treat like alike. That is what the
2 Fourteenth Amendment requires, and the rational basis standard
3 requires that even when it is an economic regulation, and of
4 course the *Cleburne* case, which is -- I'm sorry, the *Carolene*
5 *Products* case which is the cornerstone of modern equal
6 protection review, says that evidence can be considered and
7 that the record does matter even under rational basis review.

8 So I did want to leave time to talk -- I'm sorry,
9 about *Lee Optical*, *lee Optical*, was another case where under
10 the equal protection challenge, to the distinction between
11 opticians and people who were selling ready-to-wear glasses,
12 opticians had to receive a prescription before they could sell
13 lenses that had been refitted to a frame, and this requirement
14 did not apply to vendors who were selling ready-to-wear lenses.
15 The Court said there was probably a rational justification for
16 that and that the record was silent as to whether there was
17 any -- as to whether there was no reason for this requirement,
18 and in light of a silent record, the court deferred to the
19 presumption of rationality for that classification.

20 This case is not like that part of *Lee Optical*
21 because here we do have a record, and the record is far from
22 silent. It is very clear that there is no health and safety
23 justification for the IUP documentation requirement if it is
24 interpreted as the intervenors urge or for the hospitalization
25 requirement.

1 So again, I think even under this most differential
2 standard of review, the facts matter, and here the facts are
3 very clear that these provisions are irrational.

4 I would like to address the vagueness argument about
5 the IUP documentation requirement. As the Court alluded to in
6 the TRO order, there is a conflict between the provision of the
7 IUP documentation requirement and a separate provision of
8 SB-20, which expressly provides that it shall not be unlawful
9 to procure or cause a miscarriage or abortion during the first
10 12-weeks of a woman's pregnancy, when a medical abortion is
11 procured and that's North Carolina Statute 90-21.81B, part two.

12 I think on its face, it is unclear what it means to
13 document the existence of an intrauterine pregnancy.

14 **THE COURT** I don't understand that. I mean, you
15 write down it is an intrauterine pregnancy, you've documented
16 that. I don't know how that is vague. "Document" means you
17 write it down.

18 **MS. SWANSON** I think because what it means to
19 confirm the existence of an intrauterine pregnancy.

20 **THE COURT** That is a different question, but what
21 does it mean to document? That doesn't seem vague. I want to
22 be sure that I understand what you are saying.

23 **MS. SWANSON** Our argument is that it is unclear
24 whether a person providing an abortion, whether a doctor
25 providing an abortion must visually identify an intrauterine

1 pregnancy on ultrasound and document that before they can
2 provide a medication abortion.

3 I think the best reading of the IUP documentation is
4 the one that harmonizes it with the other provisions of SB-20,
5 which expressly provides medical abortion shall not be unlawful
6 in the first 12-weeks of pregnancy is that this is a -- this
7 documentation requirement asks physicians to document whether
8 they identified an intrauterine pregnancy by ultrasound, but
9 even if they didn't, they can still proceed to provide the
10 medication abortion. In that way, the IUP documentation
11 requirement does not function as a ban in the earliest weeks of
12 pregnancy.

13 **THE COURT** If you read it that that way, the word
14 existence is meaningless.

15 **MS. SWANSON** I think -- so Dr. Farris and
16 Dr. Boraas's testimony in their declarations -- I'm looking at
17 Dr. Farris's declaration, document entry 49-1, paragraphs 53
18 through 58, and Dr. Farris's rebuttal declaration, which is
19 document entry 69-1, paragraph 12, and also Dr. Boraas's
20 declaration which is 49-2, paragraph 46, they explain -- and
21 also in their deposition testimony, that when a person comes in
22 and has an ultrasound, there is not a binary between
23 intrauterine pregnancy, and no intrauterine pregnancy. There
24 is a range of possible categories.

25 There is five categories they both agreed on between

1 confirmed intrauterine pregnancy, probable and intrauterine,
2 pregnancy of unknown location, suspected ectopic pregnancy and
3 confirmed ectopic pregnancy. What we are talking about here is
4 the middle, pregnancy of unknown location. So at that point,
5 the patient -- no pregnancy is visible by ultrasound, but these
6 patients have also been screened through questions about their
7 medical history, their current symptoms and review of the
8 ultrasound results, and they have been low risk for ectopic
9 pregnancy.

10 So the intervenor suggests that there is, again, just
11 two options. There is either an ectopic pregnancy, or there is
12 an intrauterine pregnancy, such that the opposite of not seeing
13 an intrauterine pregnancy means you necessarily have an ectopic
14 pregnancy.

15 **THE COURT** I don't know. I didn't understand them
16 to say that. I understood them to say that before you
17 can -- this is what I understand their argument to be, I'll
18 just make it for them, that they don't want the medicine given
19 unless you are either sure or probably sure that it is an
20 intrauterine pregnancy, because it is ineffective as to an
21 ectopic pregnancy.

22 They seem to say -- I'm not sure they cited me any
23 evidence for this, but they'll tell me that a patient who is
24 given abortion drugs and who had the ectopic pregnancy might
25 overlook symptoms associated with the ectopic pregnancy to the

1 detriment of their health.

2 I'm really not seeing that their argument is as black
3 and white as you are saying, and what I also hear you saying
4 is, if I interpret the statute to mean probable existence, that
5 that does not solve your concern.

6 **MS. SWANSON** That's correct, Your Honor, because
7 what we're talking about are patients in pregnancy of unknown
8 location category, which is that middle of the five categories.
9 I do think that --

10 **THE COURT** I mean, the evidence appears to be
11 undisputed that at least as to ultrasound you can't see it
12 until -- you know, at the earliest, the fifth week and often by
13 the sixth week, counting from the last day of the woman's
14 cycle. Right?

15 **MS. SWANSON** Correct.

16 **THE COURT** And this raises my blood testing
17 question.

18 **MS. SWANSON** Yes, I did want to address that. I
19 will write down blood testing, but I also want to address their
20 contraindications.

21 They rely heavily on the Mifeprex label.

22 **THE COURT** The what?

23 **MS. SWANSON** The Mifeprex label, the trade name for
24 Mifepristone, and that label explains that Mifepristone is
25 contraindicated for confirmed or suspected ectopic pregnancy.

1 **THE COURT** I understood your argument about that.
2 They are going to have to explain that to me, because their
3 factual assertions appear inconsistent with what the record
4 shows. If they explain it to me satisfactorily, you can
5 address it on rebuttal.

6 **MS. SWANSON** And as Your Honor indicated in
7 teeing-up these questions for us, medication abortion is
8 contraindicated not because it makes ectopic pregnancy more
9 dangerous or exacerbates an ectopic pregnancy, but because it
10 does not treat ectopic pregnancy, and indeed the Mifeprex label
11 itself recognizes that, and that is docket entry -- I believe
12 65-2, and it is on page six of the Mifeprex label that's in the
13 record.

14 It says, "Mifeprex" is contraindicated in patients
15 with a confirmed or suspected ectopic pregnancy because
16 Mifeprex is not effective for terminating an ectopic
17 pregnancy."

18 **THE COURT** So of those five categories, it is the
19 two on the other end?

20 **MS. SWANSON** Correct.

21 **THE COURT** Of known or probable intrauterine, and
22 then -- okay.

23 **MS. SWANSON** Yes. Correct. And so for these
24 patients who are in that middle category, pregnancy of unknown
25 location, currently, those patients -- again, it is not just

1 people in the pregnancy of unknown location, it is also people
2 who have been screened and deemed low risk for ectopic
3 pregnancy, because people with pregnancies of unknown location
4 who are high risk, are going to be further evaluated and
5 treated for ectopic pregnancy.

6 So it is an even narrower category, and currently
7 those people have the option of both receiving further testing
8 for ectopic pregnancy using the blood testing, which I'll
9 address, while also receiving their medication abortion
10 simultaneously. This allows people to obtain the abortion that
11 they have determined that they want at the earliest possible
12 date.

13 As Dr. Farris testified, her North Carolina patients
14 are anxious to receive their abortions as early as they can,
15 particularly when a 12-week ban is in effect.

16 The blood testing question is -- so this refers to
17 testing for the levels of pregnancy hormone. I'm going to
18 mispronounce it, but human chorionic gonadotropin, and
19 Dr. Farris will correct me if I mispronounced that, but this is
20 the same pregnancy hormone that an over-the-counter pregnancy
21 test tests for, but a blood test is much more sensitive. So
22 this blood test for hormone HCG can detect pregnancy even
23 earlier than an over-the-counter stick pregnancy test.

24 The significance of HCG to screening for ectopic
25 pregnancy is that the level of the pregnancy hormone is a good

1 indicator of how developed the pregnancy is. So if the levels
2 of pregnancy hormone are past a certain threshold, the provider
3 would expect that pregnancy to be developed enough that you
4 could see it on the ultrasound. So if the patient --

5 **THE COURT** Where is this in the record?

6 **MS. SWANSON** So this is in Dr. Farris's declaration.
7 Again, it starts at docket 49-1. It starts at paragraph 53.
8 This is her discussion of the protocol.

9 **THE COURT** Are you saying if it was ectopic, it
10 would not have developed enough to show that level of hormone?

11 **MS. SWANSON** No. It would be showing a higher level
12 of the hormones, because it would -- the concern is that if a
13 provider is looking at the ultrasound and they see nothing in
14 the uterus, it is possible that the patient is experiencing a
15 miscarriage. It is possible that they have a pregnancy outside
16 the uterus, ectopic, or it is possible that the pregnancy is
17 just so early that you can't yet see it.

18 Whether there are -- if there are high levels of
19 pregnancy hormone, that suggests that the pregnancy is probably
20 developed enough that you should be able to see it on the
21 ultrasound, so if you are not seeing it in the uterus, it might
22 be an ectopic pregnancy, so people who receive blood testing
23 and that comes back with high levels of HCG hormone, those
24 patients are then -- are suspected as possibly having an
25 ectopic pregnancy, and they are referred for further screening

1 and treatment, including to a hospital, if necessary.

2 Contrast patients whose pregnancy hormone levels are
3 low, that's a good clue that the pregnancy is just very early
4 and very small and we wouldn't expect to be able to see it by
5 ultrasound, because as the Court recognized before,
6 approximately five to six weeks, it is just not -- it is just
7 too small to see it by ultrasound.

8 **THE COURT** So if the law went into effect and it
9 meant that unknown, people with unknown location could not get
10 a medication abortion, they would come in, you wouldn't see the
11 pregnancy, you would say, I can't give you the medicine for
12 another week or two. Come back if you still want one, and
13 we'll do another ultrasound. That person -- there would be no
14 reason to send that person for evaluation of an ectopic
15 pregnancy?

16 **MS. SWANSON** Correct.

17 **THE COURT** So nothing -- for most of these people,
18 they wouldn't go see anybody about an ectopic pregnancy. They
19 would come back in a couple of weeks and then if you didn't see
20 it --

21 **MS. SWANSON** That's exactly right, Your Honor, and
22 research has shown that people who receive concurrent HCG
23 testing for -- to test for ectopic pregnancy, while
24 simultaneously receiving the medication abortion, that practice
25 actually detects ectopic pregnancy sooner than when a person is

1 sent home to wait until their pregnancy has developed and is
2 sufficiently --

3 **THE COURT** Where is that in the record?

4 **MS. SWANSON** That is in Dr. Farris's deposition.
5 This is docket entry 49-1, at paragraph 58. And Dr. Boraas's
6 declaration, which is docket 49-2, at paragraph 46.

7 And they are citing Dr. Elisa Goldberg and colleagues
8 who looked at the safety and effectiveness of providing this
9 concurrent testing and medication abortion, and compared it to
10 the safety of sending someone home to wait, and they found that
11 the medication abortion option was safe and effective and, in
12 fact, it excluded ectopic pregnancies sooner than people who
13 were sent home to wait, and that makes sense, because as the
14 Court identified, if someone is sent home to wait, they are not
15 continuing to be in the medical system and receiving followup
16 HCG testing, which is part of the continuing ectopic pregnancy
17 testing that people receive while having medication abortions.

18 Of course the IUP documentation requirement itself
19 does nothing to insure that patients with pregnancies of
20 unknown location receive prompt ectopic pregnancy testing or
21 screening or treatment once an ectopic pregnancy is confirmed,
22 and in this way, the IUP documentation requirement is similar
23 to the -- again, this is another casket case, the *Craigmiles*
24 case from the Sixth Circuit, where the court looked at the
25 state's justification for requiring casket dealers to be

1 licensed, and said there is no relationship between this
2 licensure requirement and your interest in consumer protection
3 or your interest in public health because your licensing
4 requirement doesn't tell people what kind of casket they need
5 to have. It doesn't actually insure that people buying caskets
6 are receiving the caskets that are particularly safe. It is
7 not addressed to the problem that the legislature claims it is
8 addressing through this provision, and so the Sixth Circuit
9 affirmed the decision striking down that license requirement
10 even under rational basis review.

11 So if the Court doesn't have further questions about
12 the HCG testing, I will turn to -- let's see, I think that was
13 the last -- I had seven questions written down from the Court.
14 I want to be sure that I touched on all of them.

15 If the Court has no further questions about those
16 things, I do think I would like to return briefly to the
17 vagueness argument. Not only is there a -- it is unclear what
18 the law requires and that makes this law vague under the *Raley*
19 *versus Ohio* case that the Attorney General cites in their
20 brief. It says, "Laws that are contradictory fail to provide
21 notice and can be enjoined as unconstitutionally vague."

22 Additionally, while the legislature says the scienter
23 requirement for other abortion prohibitions in the code cure
24 the vagueness --

25 **THE COURT** That actually reminds me, that I did have

1 a question about the scienter requirement, though I think it is
2 more for the intervenors, because I wasn't sure exactly what it
3 was, you know, what act has to be willful, what act has to be
4 intentional. What act has to be -- whatever the various
5 standards are.

6 The Supreme Court in the last six or seven years, has
7 really honed in on these scienter requirements. You all aren't
8 criminal lawyers, but in that context, they have set
9 aside -- they have not set aside -- well, they have set aside a
10 number of criminal convictions because the Court did not
11 accurately describe the scienter requirement to the jury and,
12 you know, the *Rehaif* case -- I'll just say the names out loud,
13 even though you don't know what I'm talking about -- is one
14 honest services stuff coming out of the *Enron* cases.

15 You know, there are a bunch of cases in this area
16 where the Supreme Court has really honed in on exactly what
17 these scienter requirements mean. So when we say, oh, well
18 there is a scienter requirement, well, for what? You know, for
19 the documentation? The problem with the statute is not really
20 with the document, as least as far as I'm looking at it. It
21 is, what has to be documented.

22 What is it that the legislature is requiring the
23 practitioner to determine. It is really a determination
24 requirement or a confinding requirement. Yeah, you have to
25 document it, but that -- I don't really -- that's not the

1 problem. It is what do you have to find. What does the doctor
2 have to find before they can administer the medicine, and so
3 what is it, if you intentionally don't write it down? If you
4 intentionally lie about it, you write down that it is
5 intrauterine when you don't know for sure when it is unknown?
6 Is that what is intentional?

7 I don't know what the -- so I'm going to ask the
8 intervenors. Thank you for reminding me. I'll have the
9 intervenors address that when it comes to your turn.

10 Go ahead.

11 **MS. SWANSON** Perhaps I can provide a preview. I
12 understand that they are arguing that the scienter requirement
13 from other criminal prohibitions against abortion at North
14 Carolina Statute 14-44 and 14-45, as well as possibly the
15 requirement at 14-23.2, these are all other criminal
16 prohibitions against abortion.

17 **THE COURT** They cited all of those, but it didn't
18 help me line it up.

19 **MS. SWANSON** Right. I think, actually, when you
20 look at the text of those provisions, it just makes things more
21 confusing. So the 14-44 has a willfully scienter requirement.
22 It makes it illegal to willfully prescribe with the intent to
23 cause abortion, but then there are different scienter
24 requirements in the other provisions that they cited.

25 So 14-45, with intent to cause abortion, but it might

1 also have a strict liability standard potentially, because
2 there is -- it says, if any person shall administer or
3 prescribe or advise and procure such woman to take any
4 medicine, drug or anything whatsoever, and then, importantly,
5 with intent thereby to procure the miscarriage of such woman,
6 or disjunctive, shall use any instrument or application for any
7 of the above purposes.

8 **THE COURT** We're only talking about abortion here,
9 so what is the standard for the failure to determine it is
10 intrauterine? That's the question. What is the scienter
11 requirement for that? Because, obviously, they are doing it
12 for abortion or we wouldn't be talking about it at all.

13 **MS. SWANSON** Right.

14 **THE COURT** Right. So it can't -- I'm still having a
15 little trouble with how it matches up to this particular
16 requirement.

17 **MS. SWANSON** I am as well, Your Honor, and I think
18 the disjunctive also makes this like the Carolina Youth Action
19 Project, which was the 2023 case from the Fourth Circuit and
20 there the court held -- I'm at page 786 -- so this is volume
21 60, Federal Fourth at page 786, where the court says that
22 although a scienter requirement may mitigate a law's
23 vagueness --

24 **THE COURT** Slow down.

25 **MS. SWANSON** I'm sorry. It recognizes that although

1 a scienter requirement may mitigate a law's vagueness, this
2 statute seeks in a disjunctive, and that both fails to provide
3 notice to the regulated people of what conduct is allowed, what
4 mental state is criminally prohibited, and it also fails to
5 provide sufficient standards to law enforcement.

6 Part of the problem that the court identified in the
7 Carolina Youth Action Project, was this unbridled enforcement
8 discretion that the vague statute delegated to enforcement
9 officials.

10 In this case, the Attorney General agrees that the
11 statute is vague because it fails to provide sufficient
12 standards for law enforcement to follow.

13 So I think the -- first, none of the scienter
14 requirements that we've just been discussing actually appear in
15 the text of the IUP documentation requirement itself, so it is
16 very unclear how any of these other statutes would import the
17 scienter requirement.

18 **THE COURT** What would it -- does it mean -- I know
19 that it is intrauterine. I'm sitting here looking at the
20 ultrasound, it is all intrauterine, I just forget to write it
21 down, or I don't write it down; intentionally, willfully,
22 negligently, carelessly, I don't know.

23 Is that what the scienter is about, failing to write
24 it down, or is it failing to determine it or lying about it?
25 I'm going to ask the intervenors to deal with that.

1 Can you move on? I do want to finish up this
2 morning, or at least early afternoon.

3 **MS. SWANSON** Yes, Your Honor. I appreciate your
4 patience and I know there is a lot of record and fact here.

5 The overarching point is that the intervenors read
6 *Dobbs* as a free pass to regulate abortion however they want,
7 but even under *Dobbs*, the State still must act rationally when
8 they regulate abortion, and we're not saying that abortion
9 deserves special treatment, just that it needs to be treated
10 like all other safe routine outpatient healthcare, and that's
11 what *Dobbs* requires is, that abortion be regulated just like
12 colonoscopies, just like vasectomies, and there is no
13 legitimate justification for doing otherwise here.

14 So we would ask the Court to enter a preliminary
15 injunction against both the hospitalization and the IUP
16 documentation requirement without bond and respectfully request
17 this relief before October 1st, when the hospitalization
18 requirement takes effect.

19 **THE COURT** Thank you.

20 For the Attorney General.

21 **MS. OYCE** Good morning, Your Honor.

22 **THE COURT** Please speak into that microphone so I
23 can hear you well.

24 **MS. OYCE** I'll try not belabor too much of what the
25 plaintiff said. I will reiterate their point about standing.

1 The U.S. Supreme Court has had numerous cases, including *Dobbs*,
2 where it permitted providers of reproductive services to
3 proceed with arguments on behalf of their patients, as well as
4 arguments on behalf of themselves.

5 I won't duplicate the citations that counsel for
6 Planned Parenthood gave on behalf of or from the declarations
7 of Dr. Farris and Dr. Boraas, but those included numerous
8 paragraphs that set forth that they are providing these
9 procedures, trying to document intrauterine pregnancies and the
10 like, and thus they should have standing to bring suit both on
11 their own behalf, and on behalf of the patients for whom they
12 wish to provide services.

13 Moving to Your Honor's questions about *Dobbs*. We
14 agree wholeheartedly with the plaintiffs that *Dobbs* does say
15 you don't get to second-guess legislature's weighing of
16 different policy considerations, but it does not obviate the
17 need for the legislature to establish that the law bears a
18 rational relationship to the stated government interest.

19 The legislature has insisted that this law is
20 intended to protect the health of the mother, that "the health
21 of the mother," are not magic words that the legislature can
22 simply say and not establish that there is a risk to the
23 mother, that the law they have passed would mitigate. Here,
24 they have utterly failed to do that with the evidence that they
25 have put forward.

1 To take this to a less politically charged analogy
2 if, for instance, the legislature passed a law that said that
3 anyone who is ever diagnosed with the flu needs to be
4 immediately hospitalized, you would expect them to put forward
5 some kind of evidence of the complications that arise from the
6 flu justifying that particular law and proving that immediately
7 hospitalizing someone mitigated the risk and did not impose a
8 burden that made the law so irrational that it couldn't be
9 justified.

10 If we draw back to this particular context, that's
11 the kind of evidence that we don't see here. They have not
12 proven either that providing these abortions outside the
13 context of a hospital is dangerous to mothers, nor that the
14 line they have drawn here, that they chosen to draw would
15 mitigate that risk, rather as the evidence from Planned
16 Parenthood has shown in some instances requiring women to go to
17 the hospital can exacerbate those safety risks and impose
18 additional burdens.

19 **THE COURT** The way the plaintiffs framed this was, I
20 think I heard Ms. Swanson say, that the legislature does not
21 have to come forward with evidence because you do presume that
22 there is a rational basis. But if the challenger does rebut
23 that presumption, then you would expect the legislature to come
24 forward with the evidence supporting their policy decision, if
25 policy decision it was.

1 **MS. OYCE** I think that's correct, Your Honor.

2 Just to walk-through the evidence that we do have
3 here a little bit on both sides, Planned Parenthood certainly
4 satisfied the responsibility to rebut any presumption that the
5 legislature might enjoy here. They have put forward
6 declarations from doctors who perform these procedures day in
7 and day out, both at hospitals and at clinics, and that's
8 relevant particularly in distinction to the experts on the
9 other side. So these are women who see patients like the ones
10 we're talking about all the time every day and are intimately
11 aware of the risks that these procedures pose, or more
12 accurately, I suppose, the lack of risk that these procedures
13 impose.

14 It is important to note, of course, that the evidence
15 of the safety of these particular procedures is accumulating
16 every single day because ten of thousands, if not hundreds of
17 thousands of these procedures are being provided every single
18 year, and that continues to this day.

19 These procedures are being provided in states across
20 the country in outpatient clinics without evidence piling up of
21 the risk of these procedures posed to women.

22 Of course Planned Parenthood has also established
23 that the risk posed by these procedures is exactly the same --

24 **THE COURT** Slow down. What did you say again?

25 **MS. OYCE** Planned Parenthood has established that

1 the risk that these procedures pose is the same as in the
2 miscarriage management setting as it is in the abortion
3 setting, as Your Honor has pointed out, and that distinction,
4 underscores the irrationality here of the line that the
5 legislature has chosen to draw.

6 On the other side, when it comes to the legislature
7 and their effort to rebut the evidence that Planned Parenthood
8 has put forward, Your Honor asked a question about how many
9 doctors they need to put forward to establish that they have
10 rebutted that presumption, and the problem here, I don't think
11 is the number of doctors, it is the qualifications of the
12 doctors that they have shown on their side.

13 They have identified two doctors, neither of whom
14 have ever performed these kinds of procedures in the context of
15 an abortion, and the one who sometimes performs these
16 procedures in the context of a miscarriage, performs them in a
17 hospital, and thus is not qualified to speak on whether
18 performing these procedures in a clinic poses risks to the
19 mother.

20 Dr. Wubbenhorst in particular conceded in her
21 deposition that out of the thousands and thousands of patients
22 she has seen, she has never encountered one who suffered a
23 major complication after undergoing one of these kinds of
24 procedures, and that's consistent with the evidence that
25 Planned Parenthood has put forward.

1 **THE COURT** Can you point me to that?

2 **MS. OYCE** Sure. In Dr. Wubbenhorst's deposition,
3 it was on page 42 of the transcript, and it goes on for several
4 paragraphs at length, clarifying that while she has seen a few
5 such individuals internationally, she has never seen any in the
6 United States, and certainly not in North Carolina.

7 **THE COURT** Go ahead.

8 **MS. OYCE** I was just getting to the percentages in
9 terms of the complications, Your Honor.

10 Planned Parenthood has put forward both studies,
11 whether the California Medicaid study or the National Academy
12 of Engineering Science and Medicine study that both underscore
13 that the risk of major complications here, even from second
14 trimester abortion, is well under one percent, specifically in
15 the range of .4 percent. So we're talking about an extremely
16 small number of women who suffer any kind of major
17 complications, and as Planned Parenthood's own personal
18 evidence showed, the women who have suffered those kinds of
19 complications have nevertheless been released from the hospital
20 in stable condition after being successful transferred from a
21 clinic like Planned Parenthood.

22 The question is not whether a legislature needs a
23 certain number of doctors to rebut evidence. I think the
24 question here is whether the doctors they have chosen have the
25 qualifications or experience to rebut the evidence that Planned

1 Parenthood has put forward, or can point to any studies to
2 undermine the evidence that Planned Parenthood has put forward,
3 and they simply haven't. They have questioned whether there is
4 underreporting in terms of the data of abortion complications,
5 but to believe what they have to say would require you to
6 believe that there are women undergoing abortion procedures and
7 suffering major complications and hemorrhages across the
8 county, and simply failing to be noticed or failing to be
9 reported, and that just defies belief.

10 The reasons there are not studies to back up the idea
11 that these abortion procedures are dangerous is, simply because
12 they are not dangerous, and for that reason the legislature has
13 failed to rebut the evidence that Planned Parenthood has put
14 forward showing that this law bears no rational relationship to
15 the stated government objective of protecting the life of the
16 mother.

17 I'll touch briefly now, if I may, on the vagueness
18 point that Your Honor has raised for the intrauterine
19 documentation requirement. I think the law on this front poses
20 a problem for several reasons.

21 The first of those is the one that Your Honor
22 identified in your TRO order, and that is, that it does not
23 make clear exactly what a doctor is to do in the event that it
24 is impossible to confirm the existence of an intrauterine
25 pregnancy via an ultrasound. The law does not make clear

1 whether it is sufficient to document that it is probably an
2 intrauterine pregnancy, as Your Honor has pointed out through
3 the language in the law, or whether simply being able to
4 confirm that means that the doctor must stop right there and
5 wait one or two weeks until the intrauterine pregnancy can be
6 confirmed.

7 One other problem that the briefing in this case
8 pointed out is, that the law is unclear as to the consequences
9 of proceeding, and this is a separate point than the mens rea
10 point, but the last time we were before Your Honor, you had a
11 colloquy with counsel for the legislature leaders where you
12 asked, what was the penalty, or what made it unlawful. Was it
13 unlawful if you chose to proceed with an abortion even though
14 as a doctor you could not confirm the existence of an
15 intrauterine pregnancy?

16 I understood counsel for the legislature leaders to
17 say there are no criminal penalties for doing this. You would
18 suffer a civil penalty, but not a criminal penalty in the event
19 that you proceeded with the abortion, and that is at page 49
20 and 50 of the transcript from the last hearing.

21 Now legislature leaders clearly say in their briefs
22 before this Court at the PI stage, that there are criminal
23 penalties for proceeding with an abortion in this context, but
24 that just underscores, again, the problem with this law and the
25 vagueness in terms of what exactly is unlawful conduct and what

1 happens in the event that you proceed. Are you simply subject
2 to a civil penalty as Mr. Boyle seemed to suggest at the last
3 hearing; or are you subject to criminal penalties as they say
4 now. And if you are subject to criminal penalty, as Your Honor
5 pointed out, what state of mind is necessary.

6 The law does not make that clear. It is
7 unconstitutionally vague, and for that reason, it should either
8 be construed to eliminate the vagueness problem or enjoined
9 entirely.

10 I'll stop there, unless Your Honor has specific
11 questions for the Attorney General.

12 **THE COURT** Thank you. For the intervenors.

13 **MR. APTIST** Good morning, Your Honor, Erik Baptist
14 on behalf of the intervenors. I appreciate your questions and
15 I'm going to try to make sure I address them all.

16 **THE COURT** Pull the mic a little closer to you.
17 It's a beautiful courtroom, but you cannot hear, at least I
18 cannot hear, and I know the court reporter cannot hear you.

19 **MR. APTIST** I represent the intervenors in this
20 case, and appreciate your candid questions, and I want to make
21 sure that I answer them completely, so forgive me if I miss
22 one.

23 I want to start off with kind of a high level picture
24 of this case where we stand today. We're here discussing
25 plaintiffs' motion for preliminary injunction. The burden is

1 on plaintiff to show that they have a substantial likelihood of
2 success on the merits. They have failed to meet that burden in
3 particular on the success of the merits, and I want to talk
4 about that briefly.

5 I originally was going to start with the IUP
6 documentation requirement, but I think there is a general
7 question about the rational basis, and I think I want to focus
8 on that equal protection clause context and the Supreme Court
9 cases that plaintiffs have cited in their brief, and kind of
10 unpack it, because I think there are three different levels
11 that we can talk about and try to make sense of what the
12 Supreme Court has done and maybe sometimes we can't make
13 complete sense of what the Court has done.

14 Generally, as you've seen from *Dobbs* and from our
15 *Minnesota versus Glover Leaf Creamery* cases. There is a lot of
16 deference given to the state legislature to enact laws, and
17 under *Lee Optical*, there could be differences in treatment
18 under the law. Where the court has taken an exception, if you
19 will, and said, well, that general deference is true, but we
20 need to have some separate -- sometimes there is more of a
21 heightened scrutiny -- not heightened scrutiny, more of what I
22 call sceptical or needing more scrutiny.

23 There are two separate cases cited by plaintiff in
24 this case. I think one deals with the fundamental rights, and
25 the other deals with animus.

1 The *Moreno* case, the *USA versus Moreno*, the limited
2 legislature record that the Supreme Court looked at to
3 determine that there was this animus involved, it had
4 explicitly in the record that this law denied food stamps to
5 certain households that had people who were not of the same
6 family was to deny this government benefit to -- I'm going to
7 use quotes from the Supreme Court here, "hippies, or hippy
8 communes," and that raised the question with the court like,
9 okay, that leads to more search and scrutiny. Did the
10 rationale that the legislature purported in front of the court
11 matched the statutory scheme, and that's what the court looked
12 at.

13 Again, another case would be the *City of Cleburne*.
14 That's again the one that we discussed here, and also in the
15 plaintiffs' briefs. That case again was a city council that
16 enacted a special ordinance that specifically discriminated
17 against the mentally disabled and prevented them from having a
18 group home, and what again was in the record was, that the city
19 council made its decision based on irrational unsubstantiated
20 fear of the mentally disabled. That simply could not pass
21 muster, but the Court still went searching in their scrutiny of
22 the ordinance to see if it actually met the justification
23 reported by the city council. And they said, well, if you are
24 worried about congestion or other problems associated with
25 group homes, you would have addressed it more broadly than you

1 did here, and given the animus that you already demonstrated in
2 the record, that's when the court set it aside.

3 The two other cases would be the case from Alaska,
4 the *Moreno* case, and the *Hooper* case from New Mexico, and *Zobel*
5 case from Alaska. Those were dealing with the fundamental
6 right to travel, where they were discriminating against out of
7 state citizens inferring benefits to long time residents and
8 again, the court just looked at that, well, what are your
9 justifications to discriminate, there may be purposes to do so
10 retroactive since the State of Alaska to give benefits and
11 money to your citizens, doesn't actually necessarily invite
12 folks to come move to your state and maintain a residence.

13 The same with New Mexico, the way they designed the
14 scheme was not actually going to incentivize folks to --
15 Vietnam Veterans in particular, to reside in New Mexico and
16 maintain residence. As the court noted, someone could be born
17 in New Mexico and not spend a day in New Mexico until after the
18 war and come in within that time period, so that didn't justify
19 the -- one of the justifications as well during the time you
20 sacrificed by your time and services in the country in Vietnam,
21 you were a resident of New Mexico, that was not a requirement,
22 so the Court had more scrutiny in those cases.

23 So what the plaintiffs are doing is saying, well,
24 yes, there is a line of cases that the intervenors have cited,
25 whether it was *Dobbs* or *Lee Optical* or *Minnesota versus Glover*

1 *Leaf Creamery*, but when there is animus or a fundamental right,
2 you have these other lines of cases.

3 I want to unpack it further. Even if you could go
4 down to this level and search, because right now they have not
5 actually submitted any evidence of animus in this case. I
6 don't think we're dealing with a fundamental right anymore so,
7 frankly, it would be inappropriate for the Court to do this
8 searching analysis, but we're happy to invite that
9 conversation.

10 **THE COURT** Okay. So you are saying that if there is
11 no animus and no fundamental right, then you don't even have to
12 have a rational basis. I presume a rational basis and there is
13 no looking at it at all? That's what I hear you saying. If
14 that's not so, then what does the rational basis test mean?

15 **MR. APTIST** I apologize, Your Honor, I didn't mean
16 to interrupt you. No, that's not what we meant to say.

17 So rational basis still invites the Court to look at
18 the justifications and make sure there is a rational basis, but
19 if there is evidence before the Court from both sides showing
20 that there was a legitimate government interest and this was
21 irrationally connective, the legislation is rationally
22 connected to that legitimate government interest, that should
23 be sufficient enough, and so the plaintiffs say, well, you
24 know, if you were concerned about maternal health or
25 complications with regards to surgery overall, you would

1 require hospitalizations, not just for post-12-week surgical
2 abortions, you would have done it for other types of surgeries
3 and they submitted evidence.

4 I will point you to page 14 of Dr. Farris's
5 declaration in support of their motion for preliminary
6 injunction. That is located at ECF 49-1, page -- actually,
7 page 15 of 39, but page 14 of her declaration. It highlights
8 four different surgical procedures; vasectomy, colonoscopy,
9 wisdom teeth extraction and tonsillectomy, and it talks about
10 the complication rates or hospitalization rates for each of
11 these, but they are missing the point, because complications
12 are deferred in terms of severity --

13 **THE COURT** Complications, what?

14 **MR. APTIST** Complications have differences in terms
15 of severity and timing of when they manifest and when you
16 unpack the limited studies that they provide, it actually shows
17 that this is not the real concern here. I'm happy -- I don't
18 know if --

19 **THE COURT** I'm less concerned about that argument, I
20 mean, than I am about some of their other arguments on the
21 rational basis. I hear what you are saying about that. The
22 legislature does not have to solve every single problem, you
23 know, in its entirety when it acts. I mean, that is true.

24 You can tackle a problem, I think, generally speaking
25 in categories, and I'm less concerned about evidence about

1 tonsillectomy and colonoscopies, than I am about some of their
2 other arguments, but I hear what you are saying about that.

3 **MR. APTIST** I would submit to you, because that is
4 important only because what is really important in this context
5 and what the legislature is concerned about is many times, yes,
6 Planned Parenthood performed these surgeries --

7 **THE COURT** Slow down.

8 **MR. APTIST** Many times Planned Parenthood could
9 perform these surgeries in their outpatient facilities, as the
10 record shows, and they have submitted data that show --

11 **THE COURT** Who has submitted data?

12 **MR. APTIST** I'm sorry, Planned Parenthood has. We
13 submitted it as an exhibit to our supplemental brief where they
14 had had hospital transfers from their facilities to emergency
15 rooms and hospitals across North Carolina over the years.

16 So there is data, there is a hospital transfer rate,
17 and if you look at the data based on what we have most recently
18 for 2021, they actually have a hospital transfer rate of
19 .52 percent.

20 **THE COURT** Where is that in the record?

21 **MR. APTIST** It is going to be a little bit of my
22 math here, but it is based on our Exhibits 6 and 7 of our
23 supplemental brief, ECF 75-6 and 75-7, which provides the total
24 number of complications with surgical abortion after 12-weeks
25 for 2020 through 2023.

1 I'm focusing on 2023 to date or at least what they
2 submitted to us up to June, and then for the full year of 2022,
3 that if you look at the total amount of surgeries that they
4 have performed and how many hospital transfers they've had
5 based on those post-12-weeks abortions, the hospital transfer
6 rate is actually higher. They say in their brief --

7 **THE COURT** I'm having a little trouble following
8 you. Can you just speak a little slower?

9 **MR. APTIST** Apologies, Your Honor.

10 **THE COURT** That's okay.

11 **MR. APTIST** So the concern here is the transfer is
12 the inability of Planned Parenthood facilities to treat women
13 who are suffering from severe complications immediately where
14 they require a transfer in an ambulance to the hospital, to an
15 emergency room to be treated and seen by a professional there.

16 What we're trying to do here is -- what I'm trying to
17 do is breakdown what the hospital transfer rate is, why it is
18 important compared to other surgical procedures, but there is a
19 transfer rate in 2023 of .52 percent.

20 **THE COURT** Why is it okay to do the exact same
21 procedures for a miscarriage in a clinic, when as I understand
22 it, the exact same complications can arise? I hear what you
23 are saying, you've got -- I think it is undisputed that there
24 could be complications from these procedures, and occasionally
25 somebody needs to go to the hospital as a result of these

1 procedures.

2 I hear what you are saying. I think that's
3 undisputed, but I think it also is undisputed that it is the
4 same if you do it for a miscarriage where the fetus is already
5 dead, as for an abortion. If there is evidence that is
6 inconsistent with that, if you would point that out to me, I
7 would appreciate it.

8 **MR. APTIST** I'll just start with, the burden is on
9 the plaintiffs to submit this evidence. I'm not aware of any
10 party submitting evidence talking about the actual complication
11 rate with regard specifically to miscarriage. I may be wrong
12 on that, Your Honor.

13 **THE COURT** I agree with you, it is not detailed, but
14 footnote seven, they pointed out it does say the complications
15 are the same.

16 **MR. APTIST** The types of complications are the
17 same. The rate in which they occur, I'm not sure is before
18 this Court, but one thing I would note based on the limited
19 information or evidence in this record is with regard to
20 miscarriages, especially in the second trimester. My only
21 understanding is that they are done in the hospital setting, so
22 it doesn't require the legislature to actually mandate
23 something that is already occurring.

24 What plaintiffs' witness --

25 **THE COURT** I'm sorry, say that again. I didn't -- I

1 thought right now they were doing abortion after 12-weeks in
2 the clinic, and the whole thing that we're talking about is the
3 requirement that after 12-weeks they have to be done at a
4 hospital.

5 **MR. APTIST** I was talking about miscarriage
6 management, not abortion. So, yes, right now I think
7 plaintiffs have submitted evidence that says upwards of
8 97-percent of surgical abortions are -- or all abortions are
9 performed outside of the hospital setting. The legislature saw
10 that in particular with regards to post 12-week surgical
11 abortions and said, for various reasons I will get into, wanted
12 to have them performed in the hospital.

13 The only evidence we have right now before this Court
14 about miscarriage management in the second trimester is that
15 they are performed uniformly or typically in the hospital
16 setting. My point is, the legislature --

17 **THE COURT** Where is that evidence?

18 **MR. APTIST** Dr. Wubbenhorst's deposition, it is
19 submitted in full by plaintiffs at ECF 74-3, page 115, lines 15
20 through 25, wherein her experience in hospitals and elsewhere
21 she has only treated these types of miscarriages in the
22 hospital setting.

23 **THE COURT** That just has to do with her experience.
24 Is she saying that's the only place they are done?

25 **MR. APTIST** That is essentially what she said in

1 her testimony in the deposition. I admit that it is not very
2 clear in the back and forth with counsel, but that was the
3 takeaway that I received.

4 But to that point, though, plaintiffs have not
5 said -- this again is the burden on them, where they have to
6 show that miscarriages for the second trimester are treated
7 differently and they are actually performed 97-percent or even
8 a significant percentage outside of the hospital setting.

9 The only evidence that we have now is
10 Dr. Wubbenhorst's deposition, where she said in her
11 experience -- yes, I know this is her experience and she can't
12 speak for all doctors in the State of North Carolina, but she
13 said based on her experience and her understanding, this occurs
14 in the hospital setting, which makes sense.

15 So if the State legislature wanted to address a
16 problem, the problem is the out of the hospital -- the
17 outpatient facility by Planned Parenthood and other abortion
18 providers do the same surgery, whereas miscarriage management
19 in the second trimester is already done in the hospital.

20 To me, to say that they need to now require it is a
21 solution in search of a problem. That problem does not exist
22 in the miscarriage management situation. It does exist in the
23 surgical abortion post-12-week context, and that was the
24 specific area where the legislature looked to bring it into the
25 hospital context, given the known amount of transfers that

1 occur from the abortion facility for post-12-week surgical
2 abortions going to the hospital.

3 **THE COURT** Are these exhibits you pointed me to,
4 75-6 and 75-7, the hospitalization rate and complications rate,
5 they distinguish based on gestational age?

6 **MR. APTIST** I'm sorry, I missed that citation.

7 **THE COURT** I was backing up to something you pointed
8 me to earlier. The two exhibits that you submitted with your
9 supplemental brief about the hospitalization rate and the
10 complication right, which I think were Exhibit 6 and 7 on the
11 docket 75-6 and 75-7. Are you saying those two exhibits
12 distinguish between complication and hospitalization rate by
13 gestational age?

14 **MR. APTIST** Correct, Your Honor. I apologize for
15 my confusion there.

16 **THE COURT** I'm just making sure I understood you.

17 **MR. APTIST** So 75-6 is procedural abortion volume
18 by gestational age. This was produced by plaintiff here in
19 this case, and it is done by both facility and by gestational
20 week, and it just gives you the volume numbers.

21 **THE COURT** It is done by facility, so you can look
22 at that and tell whether they're post-12-weeks?

23 **MR. APTIST** There is an X access with would be the
24 facility. The Y access goes down and tells you the week
25 gestational age in its group by year, and then within each

1 grouping it goes 5-weeks, 5-weeks, and it goes all the way up
2 to 21-weeks.

3 **THE COURT** And they have zeros in the post-12-weeks?

4 **MR. APTIST** It does.

5 **THE COURT** All zeros?

6 **MR. APTIST** I'm sorry -- well, no. So I was -- let
7 me clarify, that was the raw numbers. It does have zeros for
8 certain facilities, but some facilities do perform them after
9 14 weeks.

10 **THE COURT** Twelve weeks is what we are talking
11 about. Twelve weeks is what the legislature has imposed as the
12 hospitalization requirement, 12, right, not 14?

13 **MR. APTIST** Correct. Correct. Twelve is the
14 minimum and then everything after that. So when complications
15 arise anywhere between 12 and 20, that's what we are trying to
16 capture here with that, and so I want to make sure I get my
17 citations right, Your Honor, so your indulgence one second.

18 **THE COURT** Take your time.

19 **MR. APTIST** So, Your Honor, I apologize for that.
20 If I can just correct the record so you can understand what --
21 I was right to represent that 75-6 is the procedural abortion
22 by volume by gestational age.

23 **THE COURT** Slow down. Say it again.

24 **MR. APTIST** It is entitled procedural abortion
25 volume by gestational age.

1 **THE COURT** Okay.

2 **MR. APTIST** And it will give you the breakdown at
3 12-weeks and up to 19-weeks of the raw numbers that Planned
4 Parenthood has performed surgical abortions in this state, and
5 then cross-reference that with ECF 74-12 that's entitled,
6 post-12-week complications resulting in hospital transfer for
7 the years 2020 through June of 2023, and that's where you can
8 see from the raw numbers versus how many women have had to be
9 transferred during those years and that is how I calculated for
10 2023 up through June at 5.2 percent hospital transfer rate for
11 2023, and then .41 percent hospital transfer rate for 2022.

12 **THE COURT** Okay. Would this -- whenever you get to
13 a stopping point, let's take a short recess. Tell me when you
14 hit a good point.

15 **MR. APTIST** I'm happy to stop now.

16 **THE COURT** Let's take a ten minute recess.

17 (Court was in recess from 11:28 a.m. 11:40.)

18 **THE COURT** Go ahead, Mr. Baptist.

19 **MR. APTIST** I want to pick up where we left off in
20 comparing surgical abortions after the 12-weeks to -- I think
21 you wanted to focus on miscarriage management and also home
22 births.

23 I want to ask you, do you have anymore questions with
24 regards to the comparison that we have in the record today with
25 regard to miscarriage management post-12-weeks, or can I move

1 on to the other?

2 **THE COURT** I'm sorry, I thought you were about to
3 address that. Maybe I misunderstood what you just said.

4 **MR. APTIST** I was comparing second trimester
5 miscarriages in terms of what we have in the record today with
6 Dr. Wubbenhorst's uncontested testimony that --

7 **THE COURT** Well, I haven't had time to go back and
8 look at it, but I hear what you are saying, and I've written it
9 all down.

10 **MR. APTIST** Okay. And then how the plaintiffs have
11 not brought in any other testimony with regards to second
12 trimester miscarriage management and where they are treated and
13 the complication rate associated with that or hospital transfer
14 rate.

15 **THE COURT** I understand that. I do have a question.
16 You seem to be arguing that there are tiers of rational basis
17 review. Has the Supreme Court ever said that? I mean, isn't
18 rational basis?

19 **MR. APTIST** The Supreme Court has never said that,
20 correct, Your Honor. There are law review articles out there
21 that say there is rational basis and there is rational basis
22 plus, and no one can really make sense of the laws, so this is
23 my way -- I've not written a law review article on it.

24 **THE COURT** Thank you.

25 **MR. APTIST** If I were to do one now, I would say

1 that there is a separate tier analysis, or at least there are
2 exceptions to the general rule. Maybe it is all part of the
3 same analysis, Your Honor.

4 **THE COURT** Okay. Go ahead.

5 **MR. APTIST** The other part about home births versus
6 post-12-week surgical abortions, I'm not aware -- and, Your
7 Honor, I think you mentioned, and I want to make sure that I
8 got your question right there. You said the health and safety
9 risks to mom and child are significantly higher in that
10 setting -- in the home setting. I'm not sure if that's in the
11 record, or I'm not aware if there is anything like that.

12 **THE COURT** I think what I meant to say is, the
13 health risks from childbirth are higher. Your evidence is that
14 the health risks increase with gestational age. That, by
15 definition, means that the risk of childbirth, which happens at
16 the end of pregnancy after nine-plus months, are higher. I
17 mean, women die from childbirth, and not just one or two women
18 die, so I didn't mean to -- that is what I meant to say, that
19 the risks of complications from childbirth are way higher than
20 the risks of complications from a surgical abortion at
21 12-weeks, 13, 14-weeks. That's what I meant to say. And, is
22 that not so?

23 **MR. APTIST** I would submit --

24 **THE COURT** I thought the evidence supported that.

25 **MR. APTIST** I would submit Dr. Wubbenhorst's

1 testimony on that issue, where she has testified if you control
2 for gestational age, there is a correlation for both live birth
3 or miscarriages for a nonaborative outcome, let's say. If you
4 control for that, you will see that there is actually a
5 difference in terms of maternal health outcomes.

6 **THE COURT** Where is that?

7 **MR. APTIST** I will tell you that in a second.

8 **THE COURT** But if gestational age doesn't matter,
9 then why do you require surgical abortions after 12-weeks and
10 not before 12-weeks? Well, address both of those things. I
11 didn't mean to ask you another question before you answered the
12 first one.

13 **MR. APTIST** I'm sorry, Your Honor, gestational age
14 is crucially important. That's what I was trying to say.

15 **THE COURT** I thought you said that the doctor said
16 if you controlled for it, which means if you take it out of the
17 equation, doesn't it? Isn't that what it means?

18 **MR. APTIST** Maybe I'm using the word "control"
19 wrong, but when you take into account gestational age, how
20 about that.

21 **THE COURT** Okay.

22 **MR. APTIST** I apologize for my terminology. When
23 you take into account for gestational age, then it actually
24 shows that at first there is a, I think, comparable risk to
25 mother, both in the abortive context, and then to the mother

1 who is going to have a live birth, and then at some point it
2 exceeds -- the surgical abortion risks exceed that of live
3 childbirth.

4 **THE COURT** Where is that?

5 **MR. APTIST** That's in her deposition, and I'm going
6 to try to pull that up real quickly.

7 **THE COURT** So you are saying that she said that the
8 risks of complications are higher for an abortion at 13-weeks
9 than they are for full-term childbirth?

10 **MR. APTIST** No. Just in case -- I'm sorry.

11 **THE COURT** That's what I thought you said.

12 **MR. APTIST** She said we are comparing apples and
13 oranges when comparing an abortion at 6-weeks, let's say,
14 versus a live childbirth, and that is where she starts the
15 conversation.

16 **THE COURT** Let me give you a minute to find it
17 before -- I apologize for continuing to ask you questions while
18 you are looking for the evidence.

19 **MR. APTIST** Your Honor, apologies for that delay.
20 It is going to be document 65-1, Dr. Wubbenhorst's declaration
21 in support of intervenors' response in opposition to the motion
22 for preliminary injunction.

23 **THE COURT** What page?

24 **MR. APTIST** Point you to page 31 of 81.

25 **THE COURT** Go ahead.

1 **MR. APTIST** It starts with paragraph 179 and 180,
2 and she says, "Comparisons without regard to gestational age
3 are flawed, in particular, because death during the first
4 6-weeks of pregnancy when the maternal morbidity and mortality
5 are highest are classified as maternal deaths and placed
6 together with deaths due to birth and delivery." She says,
7 "this is inappropriate since" --

8 **THE COURT** Slow down. What?

9 **MR. APTIST** She says, "this is inappropriate since
10 the intended outcomes are unknown. Women who reach the common
11 point of awareness of pregnancy make a decision to abort, which
12 6-six-to- 8-weeks gestation, have already survived beyond the
13 period of pregnancy's greatest risk."

14 **THE COURT** Risks to the unborn -- whether you want
15 to call it fetus, child, whatever you want to call it, that's
16 not talking about maternal risk, right? I'm not following what
17 you are saying.

18 I thought we were talking about pregnancy after
19 12-weeks, not for 6-weeks, and abortion, surgical abortions
20 after 12-weeks, not the first six weeks. I'm not following
21 what you are saying and how it relates to the question.

22 **MR. APTIST** I guess generally, I think -- the
23 general point, is it is more dangerous to have a surgical
24 abortion or is it more dangerous to have a live birth. She
25 questions the studies or how they come to that conclusion,

1 because they are comparing different outcomes at different
2 gestational ages, and if you say for control gestational ages,
3 like, let's say an abortion at 12-weeks and a miscarriage at
4 12-weeks that will have a different outcome than what has been
5 represented by the plaintiffs.

6 **THE COURT** That's what you are saying she says at
7 docket 65-1, page 31?

8 **MR. APTIST** Correct, Your Honor. Page 31 of 81 and
9 it goes on to the next page and then she cites a series of
10 studies there to support her opinion or conclusion on this, but
11 I want to bring you back to her -- back to the declaration
12 earlier on, on page seven where she talks about the mortality
13 rate.

14 **THE COURT** This is her declaration, not her
15 deposition?

16 **MR. APTIST** Correct, Your Honor, 65-1 is her
17 declaration.

18 **THE COURT** Hold on just a second. Let me get it up,
19 because I'm -- I might have an easier time following what you
20 are telling me. All right.

21 **MR. APTIST** It is page eight of 81.

22 **THE COURT** Page eight?

23 **MR. APTIST** Correct, Your Honor.

24 **THE COURT** I thought you said 31.

25 **MR. APTIST** Page eight.

1 **THE COURT** Back off from that mic a little.

2 **MR. APTIST** The top says seven, but it is really
3 page eight of 81 of the PDF.

4 **THE COURT** Which paragraph?

5 **MR. APTIST** It starts with paragraph 39 where she
6 proceeds to go systematically down through the studies, citing
7 Kates and Grimes from 1981. That cite talks about the increase
8 of maternal mortality with regards to D&Es from 13 to 15-weeks,
9 and than greater than 16 weeks, and then she talks about the
10 Zane study in paragraph 42 --

11 **THE COURT** I think it is undisputed that the risks
12 increase with gestational age, right? I didn't hear any
13 disagreement -- there is a disagreement about how much they
14 increase, how serious the risks are, et cetera, but they agree
15 on that point, right?

16 **MR. APTIST** Correct, Your Honor.

17 **THE COURT** So what does this say beyond that?

18 **MR. APTIST** I guess, Your Honor, I'm going to try
19 to maybe get above where I am at right now, because I think I'm
20 in the weeds too much.

21 Can I just assert back to the home births, at least
22 we don't have any record evidence that show home births are
23 worse for paternal health versus hospitals, and I think -- I
24 can't testify today, but I think I would submit that we will
25 provide more evidence on that fact that it may actually be

1 better for maternal health to be at the home versus in the
2 hospital. It may not be the same for the fetal outcome and the
3 baby's health outcome, but we don't have that in the record
4 today, so I don't mean to posit that today, but at the same
5 time, the plaintiffs have not submitted such evidence, either.
6 That's my point.

7 So again, why did the legislature focus on post
8 12-week surgical abortion, because it was a known problem where
9 there were women being transferred to the hospital at a
10 significant rate, and I will have to note that I think Planned
11 Parenthood would concede they are not the only abortion
12 provider in the state. I think they represent, based on their
13 numbers, maybe 29 percent of all abortions in the most recent
14 comprehensive year 2021.

15 I can tell you how I get that math, if you would
16 like, but that is -- again, we have to look at the totality,
17 not just their hospital transfers, but everybody else's
18 hospital transfers as well.

19 Again, at the PI stage, the burden is on the
20 plaintiffs to prove their case. They made the allegation that
21 miscarriage management and live births are not required to be
22 in the hospital setting. I think the only record evidence
23 shows that we have is for second trimester miscarriage
24 management surgeries. Those are already performed in the
25 hospital, so the legislature did not need to require such an

1 action because it is already occurring for home births. By
2 definition, they are occurring at home and not in the hospital,
3 and we simple don't have any data except for the general
4 proposition that they cited about the maternal mortality rate
5 for surgical abortions versus live births, but we don't have
6 anything with regards to post-12-week second trimester home
7 births, let's say -- I'm sorry, I should just say full term
8 live births.

9 So I guess at this point we don't have the evidence
10 and the plaintiffs have not met their burden to show it was
11 irrational for the State to focus only on post-12-week surgical
12 abortions.

13 **THE COURT** Can I ask you a more general question?
14 The plaintiffs say that regulation of abortion should be in
15 terms of a rational basis test, should be treated the same as
16 any other health and safety statute or regulation.

17 Do you agree with that?

18 **MR. APTIST** Yes, Your Honor.

19 **THE COURT** Okay. Go ahead.

20 **MR. APTIST** I'm going to address your first
21 question on standing. I know this was mainly for the
22 plaintiffs, but it seems, just listening to the plaintiffs, I
23 don't think they set forth their affirmative case for their
24 primary standing. I think they are hinging their standing on
25 their third-party patients, or at least they are representing

1 that's how they are establishing standing.

2 I think the core point is to remember they have not
3 asserted any economic harm in this case. I think they
4 specifically disavowed economic or financial harm where that is
5 usually in the abortion context. That's kind of the obvious
6 harm that could be assumed, but we can't assume that here, so
7 they really rely on third-party harm in this context.

8 **THE COURT** Economic harm is -- you are saying
9 that's usually asserted by healthcare providers?

10 **MR. APTIST** If they are the direct object of a
11 regulation of a law, then they are being burdened by some
12 regulation or requirement.

13 **THE COURT** In the abortion context, I have never
14 heard an economic argument. It has always been on behalf of
15 patients.

16 **MR. APTIST** It is usually both, and that's
17 usually -- I think if you go back and look at June Medical,
18 there is a discussion in that case about the harms to the
19 doctors having to go get admitting privileges. I believe that
20 was the issue in that case. But, again, that's -- the focus
21 was really primarily, and in this case, too, the patients and
22 the women who come to them, but here they have specifically
23 disavowed any economic harm, at least to us, and so I think
24 they're relying on this third-party standing argument, and for
25 medication abortion, I think that's different than surgical

1 abortion, and they have to establish a close relationship with
2 their patients.

3 Again, I'm not aware of any actual assertions that
4 they have developed such as a close relationship. That's one
5 of the requirements for third-party standing. I understand
6 there is a lot of precedent in this context where abortion
7 providers can represent their patients, but they still need to
8 establish their standing and how they get those close
9 relationships.

10 I will point to you a case that neither party has
11 cited to date, but it may be helpful for your consideration
12 within this circuit from a different court. It is the *American*
13 *Colleges of Obstetricians and Gynecologists versus United*
14 *States Food and Drug Administration*. It is from the District
15 Court in Maryland. It is found at 472 F. Supp. 38, 183,
16 because the defendants in that case actually raised the same
17 argument that we've raised here, where they said there is no
18 establishment of a close relationship, and the Court went on
19 and said, well, we're not sure if you need to do that, given
20 the prior case law, but here we think there is enough, and the
21 court did its searching of the record and the declarations to
22 find that third-party standing, in particular that close
23 relationship --

24 **THE COURT** Wait. I'm trying to understand your
25 point. Before you get into what you said at the very, very

1 beginning, you're saying you have to establish standing for
2 each challenge. Okay, I understand that. So you have to show
3 third-party standing for the intrauterine pregnancy. I don't
4 know if it is documentation requirement or determination
5 requirement. We'll talk about that, I'm sure in a minute. And
6 separately for the hospitalization requirement, and are you
7 challenging both of those or only the intrauterine pregnancy
8 requirement, which is the medication abortion provision?

9 **MR. APTIST** We're challenging standing as to each
10 of those claims.

11 **THE COURT** What is your point about that, about how
12 it has to be looked at differently and third-party, which is
13 the one you were saying?

14 **MR. APTIST** American College of Obstetricians and
15 Gynecologists, it's called the ACOG case, that deals with a
16 challenge to the FDA's regulation that Mifepristone, or
17 chemical abortion drugs, and they challenged the FDA
18 requirements or prevention of doing telemed during the COVID
19 pandemic.

20 The defendants in that case, the FDA, alleged that
21 you haven't established a close relationship in the medication
22 context. All of the other cases to date, have focused on the
23 surgical abortion context.

24 **THE COURT** Don't you have to have a prescription
25 from a healthcare provider to get a medication abortion?

1 **MR. APTIST** Correct, Your Honor.

2 **THE COURT** A doctor can't prescribe it if they don't
3 meet the statutory requirements, which according to you, are
4 that you actually determine that there is an intrauterine
5 pregnancy, and that's contrary to current medical practice, but
6 the plaintiffs have offered pretty compelling evidence, so that
7 means that women are not going to be able to get an abortion
8 between five and six weeks of gestational age, medication
9 abortion, and they can get it now. They are going to have to
10 wait, the legislature says, until seven weeks, when it can be
11 determined that there is an intrauterine pregnancy. So why is
12 that not standing, because you are basically prohibiting
13 medication abortions until six or seven weeks.

14 Right or wrong?

15 **MR. APTIST** To answer that question, in effect, it
16 would prohibit, I think, medication abortions, at least until
17 five and six weeks. You typically can find a location of a
18 pregnancy at that point, but in fact, that would happen.

19 What we're challenging is there is a different
20 relationship. Planned Parenthood, their witnesses have said
21 the doctors don't meet with the patients before giving the
22 drugs, it is somebody else, a staff member who meets with them
23 and goes over the informed consent documents, and it is a
24 different type of relationship in terms of surgeries, and it
25 obviously is invasive, it is more comprehensive and there is

1 necessarily a doctor involved.

2 There is no established ongoing relationship with
3 medication abortion, and so I point to this case because this
4 case did find a close relationship. The ACOG case against the
5 FDA from the District of Maryland, but how that court --

6 **THE COURT** Where is it in the evidence that the
7 doctor doesn't meet with the patient?

8 **MR. APTIST** That is supplied in our supplemental
9 brief, which I'll give you the exact -- it is attached as an
10 exhibit. It is Exhibit 2 to our supplemental brief, the Farris
11 deposition, page 78, lines 12 through 22.

12 **THE COURT** Okay. Go ahead.

13 **MR. APTIST** And so in this other case, this ACOG
14 case, the Court found that plaintiffs had provided specific
15 evidence of close patient/physician relationships, including
16 between one of the doctors and her patients, but it was based
17 on the declaration where the doctor said she sees many patients
18 -- she has patients whom she sees regularly, and then she had
19 one patient in particular who was a recurrent patient, a
20 longtime patient who could not obtain a medication abortion
21 because of the FDA's restrictions on telemedicine at the time,
22 and that's why the court established that you have an ongoing
23 relationship with a patient, you have -- that was established
24 here, where they come and see the doctor on a regular basis.

25 **THE COURT** So an emergency room doctor could never,

1 never challenge a state regulation on behalf of patients
2 because there is no ongoing relationship? I don't know, the
3 State -- whatever they do, it requires something for emergency
4 room procedures, and you're saying that the emergency room
5 doctor could never establish standing because they have no
6 ongoing relationship with the patient?

7 **MR. APTIST** No. I distinguish between surgical and
8 just kind of I would argue more the pharmacist/patient
9 relationship. So the emergency room doctor, I'm going to
10 presume, is doing some type of emergency surgery, let's say.

11 **THE COURT** Well, maybe not. Let's say prescribing
12 something. Emergency room docs can't give -- I don't know,
13 imagine the legislature said emergency room doctors can't give
14 antibiotics. I don't know why they would say that, but what if
15 they say that, or you can't give a particular medicine,
16 emergency room doctor, only specialists can give this
17 particular medicine, and you are saying the emergency room
18 doctor could not challenge that because they don't have an
19 ongoing relationship?

20 **MR. APTIST** I think it is the intimacy of the
21 relationship and the nature of the medication.

22 **THE COURT** It is hard to get more intimate than an
23 abortion request, is it not?

24 **MR. APTIST** Understood, Your Honor. But that
25 request is usually funneled through a staffer as opposed to the

1 doctor, and the doctor is writing a prescription here, but not
2 having that relationship -- let's say in the emergency room
3 context that you said, the antibiotics. Literally the doctor
4 comes in and hands antibiotics based on a test result that
5 shows there is an infection. I would submit that may not be
6 sufficient to establish -- that alone would not necessarily be
7 enough to establish --

8 **THE COURT** What is your authority for that beyond
9 this District of Maryland case?

10 **MR. APTIST** There is no authority. This is
11 unprecedented territory in terms of medication abortion, and I
12 would note for other reasons the Supreme Court kind of
13 overruled the district court, but not based on standing
14 reasons, but I flagged this as one of our reasons why we think
15 they don't -- we say have not established that.

16 So again, on the plaintiffs at this stage to, one,
17 prove standing, but also to show that it is highly substantial
18 that they have standing here, and they submitted no evidence
19 establishing such a close relationship, that is a requirement
20 to have third-party standing. Based on what we have seen to
21 date, they do not have such a relationship.

22 They may develop the record later on that shows that
23 they do have that close relationship, but what we have seen
24 through discovery and deposition shows that there is not this
25 ongoing or immediate serious long, even a ten minute, 15 minute

1 conversation with the doctor. It seems to be it is going to be
2 with a staffer who may not be trained as a medical
3 professional, and then the doctor gives the drugs, that's just
4 a moment. That's not an intimate relationship where the
5 patient is truly sharing her thoughts and other concerns or
6 getting that informed consent to share or talk about the risks
7 and benefits of what she is seeking that you normally see in
8 the doctor/patient relationship.

9 **THE COURT** Okay. I'm just thinking about nurse
10 practitioners and PAs, then you would say -- I mean, those
11 people prescribe medicine all of the time and you would say --
12 so a doctor would have no standing to challenge any regulations
13 about medicines being prescribed by PAs or nurse practitioners?
14 I just -- you know, we're here talking about abortion, which is
15 highly politicized, but this is about regulation of medical
16 care and so, you know, you can't just talk about it in terms of
17 abortion, because how does it apply to the rest of the medical
18 world? I'm asking, because it seems important.

19 **MR. APTIST** I think the line I would draw is with
20 formal medical education, so a medical professional these days
21 is a broader term. It is not just doctors any more, as you
22 recognize, and I think nurse practitioners, PAs, nurses. If
23 you were having that conversation and getting an informed
24 consent with them, the doctor gives you the drugs. That's a
25 different situation.

1 Here, there is no evidence that any of those people
2 are meeting with the woman before she gets the drugs, and so I
3 take your point, Your Honor. This is precedential outside of
4 the abortion context and not trying to overreach here.

5 **THE COURT** I'm not accusing you of that. I'm just
6 trying to make sure I'm thinking through it, because it
7 is -- the legislature is accused of practicing medicine, you
8 know, people -- that's one of the arguments here implicit in
9 the plaintiffs' briefing, and -- how does that play into it?

10 It is a big question, because the legislature is not
11 made up of trained medical professionals, yet they are
12 authorized to regulate the practice of medicine, that's clear.
13 So I'm just trying to figure out the test.

14 **MR. APTIST** They do receive input during the
15 legislature process and meet with people who are medical
16 professionals who can provide their opinions and obviously
17 disagree in opinions.

18 I'll quickly move to third-party standing for the
19 second claim, the hospitalization requirement. I understand
20 that Dr. Farris says she historically has seen women, or maybe
21 Dr. Gray has said that she had seen women who have been
22 referred to hospitals -- from hospitals for babies with life
23 limiting fetal anomalies or for the other situations
24 post-12-weeks. That has not been the case since this law went
25 into effect, based on, again, the plaintiffs's own evidence.

1 They have not seen a single patient under the limited
2 exceptions since the new law went into effect in June, at least
3 partially went into effect in June, so we again just question
4 whether they actually have those women who seek those services
5 since the new law went in effect, but we raise the question,
6 have they met their burden at this point. They may end up
7 showing that, but they haven't established it to date.

8 **THE COURT** Okay.

9 **MR. APTIST** I'm going to move back to the IUP
10 documentation. I know Your Honor has some questions about
11 those, and I want to address those now. I don't think I need
12 to go over our interpretation in terms of just there is this
13 general provision that says --

14 **THE COURT** I mean, your interpretation is, we're not
15 really even talking about a documentation requirement because,
16 I mean, we're talking about a determination requirement. They
17 have to determine gestational age and write it down and they
18 have to determine -- or probable gestational age, and they have
19 to determine either intrauterine location or probable
20 intrauterine location and write it down. So unless -- I'm not
21 concerned about the writing it down part.

22 I think what my concern is about is the determination
23 part of it. What do they have to determine and what are the
24 penalties if they don't do that?

25 **MR. APTIST** What they have to determine is -- well,

1 Your Honor asked whether it is probable or an actual
2 intrauterine pregnancy, and you raised a good question, and we
3 read it to mean an intrauterine pregnancy, but your reading of
4 the statute we would not oppose, either. I think it is -- it
5 could lend itself to that, but either way, it would exclude a
6 pregnancy of unknown location, because I don't think a doctor
7 can document or determine probable or actual intrauterine
8 pregnancies based on anything but an ultrasound or -- because I
9 think the serial blood testing that Planned Parenthood performs
10 doesn't get you to the probable or actual intrauterine
11 pregnancy determination, and so that's the requirement as we
12 see it under the law that you need to determine.

13 I think that's right, you need to determine whether
14 an ectopic pregnancy exists or can you exclude it, and if you
15 can't, you can't actually document it.

16 **THE COURT** So the woman has to wait a week, two
17 weeks, and in the meantime, if it's ectopic, which is the only
18 reason you've offered as justifying this requirement, which I
19 mean I understand, you don't want -- if somebody has an ectopic
20 pregnancy, that's a serious matter, but there is nothing --
21 they just wait for two weeks and no requirement for any sort of
22 treatment for ectopic pregnancy or further referral and then
23 they come back.

24 **MR. APTIST** I think that's not quite right in the
25 sense of if there is a pregnancy of unknown location, whether

1 under Planned Parenthood's protocol or doctors who submitted
2 their declarations in support of this case, if you have a
3 pregnancy of unknown location, you are going, I would argue, to
4 be suspecting or thinking this may be ectopic.

5 **THE COURT** You are saying if a woman goes to the
6 doctor and she says, I'm pregnant, she doesn't want an
7 abortion, at six weeks, you're saying -- at five weeks, six
8 weeks, eight, they would do an ultrasound and treat her as an
9 expected ectopic pregnancy, if there weren't an abortion
10 involved?

11 **MR. APTIST** Your Honor, I want to make sure I
12 understand your term "treat," and I think treat for an ectopic
13 pregnancy or just treat it as it may be an ectopic pregnancy.

14 **THE COURT** I'm asking you. I mean, you're -- the
15 legislature is the one regulating this. I'm trying to
16 understand exactly what it is that you are saying.

17 **MR. APTIST** Correct, Your Honor. Doctors would --
18 if a woman comes in at five or six weeks and says, I'm
19 pregnant, can you show me where the baby is, or I want to see
20 if it is healthy and the doctor is like, I can't find it, under
21 the normal course of business, the doctor would closely monitor
22 and continue to communicate with that woman and have her come
23 back in the following week.

24 **THE COURT** All the evidence is that's what Planned
25 Parenthood does.

1 **MR. APTIST** Correct, Your Honor. They have her
2 come in multiple times, I think up to four times to do the
3 serial blood testing and maybe eventually refer her to the
4 emergency room for a suspected or known ectopic pregnancy.

5 The problem is what the State was trying to address
6 is the overlapping symptoms with an ectopic -- ruptured ectopic
7 pregnancy and the normal expected complications, or I should
8 not say complications, the effects of a medication abortion,
9 because I think their witnesses have testified, too, that there
10 are overlapping symptoms, and there is evidence in the record
11 that women have actually died, at least two women have died
12 because their ectopic pregnancy was not identified and they
13 were still given the Mifepristone or medication abortion drugs,
14 and almost a hundred of them have actually ended up with severe
15 adverse events reported to the FDA.

16 **THE COURT** From the ectopic pregnancy?

17 **MR. APTIST** Because they were given the drugs and
18 had to go to the hospital because of that. If it was
19 identified as an ectopic pregnancy, they would have been
20 treated.

21 **THE COURT** But it wouldn't have been. If they
22 couldn't tell, if it was unknown, they would do -- the law
23 requires them to do nothing, the healthcare provider. It
24 says -- it just says they can't give them the abortion
25 medicine. It does not require them to do anything else. It

1 doesn't say they have to do anything to determine if it is
2 ectopic or anything else. It just says if you still want an
3 abortion in a couple of weeks, come back. Right?

4 **MR. APTIST** Correct. There is nothing that
5 obligates the abortion provider to do something or anything
6 else.

7 **THE COURT** If she has an ectopic pregnancy, it still
8 might rupture. It still -- I mean, the complication is from
9 the ectopic pregnancy, right?

10 **MR. APTIST** Yes.

11 **THE COURT** Not from the abortion medicine and not
12 from the treatment that she gets associated with the provision
13 of that medicine. Am I right about that?

14 **MR. APTIST** Correct. We concede that Mifepristone
15 doesn't do anything to aggravate an ectopic pregnancy, but the
16 concern is, and I'll go back to the FDA label, because I know
17 you wanted to talk about this, too, and how we represented what
18 the FDA has done.

19 I think there are two parts to that label. One would
20 be the contraindications on that where it says, a confirmed or
21 suspected ectopic pregnancy or undiagnosed -- it is pronounced
22 an axial mass. Those are reasons why not to give the drugs to
23 the women at that time.

24 **THE COURT** But they don't give them in that
25 situation.

1 **MR. APTIST** Correct, Your Honor, but there is also
2 the warnings and precautions section right below the
3 contraindications and that says, "ectopic pregnancy: exclude
4 before treatment," and that is a concern of the FDA's, that
5 they think it is important enough you have to exclude before
6 giving these drugs, not that it just has to be monitored. It
7 is just, don't give them the drugs and we can see why you look
8 at part four, I'll turn to the page and tell you which one that
9 is.

10 Yes, it says, "confirmed or suspected ectopic
11 pregnancy will not be effective to terminate an ectopic
12 pregnancy." We don't disagree with that, but there is --

13 **THE COURT** And where does it say, "exclude ectopic
14 pregnancy before giving the medicine."?

15 **MR. APTIST** That's not the contraindications. It
16 is back on the warnings and precautions on page one.

17 **THE COURT** Okay.

18 **MR. APTIST** Of the document, and that's where it
19 says, "Ectopic pregnancy: Exclude before treatment."

20 **THE COURT** That's on page one of -- which document
21 is that?

22 **MR. APTIST** This is the FDA label. It is Exhibit 2
23 to our opposition brief. I'll give you the ECF number in a
24 second.

25 **THE COURT** 65-2.

1 **MR. APTIST** Correct, Your Honor.

2 **THE COURT** At page one, right?

3 **MR. APTIST** Yes, Your Honor.

4 **THE COURT** Okay. Thank you.

5 **MR. APTIST** Going to that, it cites on that
6 warning, it says 5.4.

7 **THE COURT** I'm sorry, it says what?

8 **MR. APTIST** 5.4, so that means to go to 5.4 of the
9 label, so --

10 **THE COURT** Were you looking at the first page? You
11 are saying the first page refers you to Section 5.4?

12 **MR. APTIST** Correct, Your Honor. Right after it,
13 it says, exclude before treatment, it has in a parenthetical
14 5.4, that means you refer to 5.4 or Section 5.4 of this label,
15 and that's where it talks about Mifepristone being
16 contraindicated for confirmed or suspected ectopic pregnancies,
17 but then the next sentence admonishes the healthcare providers
18 to remain alert to the possibility that a patient who is
19 undergoing a medical abortion could have an undiagnosed ectopic
20 pregnancy because some of the expected symptoms experienced
21 with a medical abortion; abdominal pain, uterine bleeding may
22 be similar to those of a ruptured ectopic pregnancy. So that's
23 what the FDA's concern was.

24 This is directly linked to the exclude before
25 treatment provision, because there are serious risks and known

1 deaths associated with it, and that's why --

2 **THE COURT** With ectopic pregnancies?

3 **MR. APTIST** With the missed ectopic pregnancies
4 using ruptures with the normal symptoms of Mifepristone.

5 I will point you --

6 **THE COURT** And your evidence on that is the label,
7 or have you presented other evidence of that?

8 **MR. APTIST** Yes, Your Honor, we have. The label is
9 the primary evidence. The FDA made this determination.

10 Secondly, Dr. Wubbenhorst's declaration at ECF 65-1,
11 page 18 of 81, that provides the FDA -- this is -- again, she
12 cut-and-paste from the FDA their adverse events and known
13 deaths associated with medical abortion, and she identified at
14 least two women who have died from a ruptured ectopic pregnancy
15 after taking these drugs, and at least 97 women had severe
16 adverse reactions and needed to be treated for an ectopic
17 pregnancy after taking these drugs.

18 I would submit to you that this is the reason why the
19 FDA included such a requirement is, because this is a known
20 issue and concern of the FDA.

21 **THE COURT** But they still have that. They still
22 have the ruptured ectopic pregnancy, if the law goes into
23 effect. Right?

24 **MR. APTIST** Correct, Your Honor. They would still
25 have an ectopic pregnancy.

1 **THE COURT** And so they still die? I mean, if those
2 two women -- I'm trying to understand what you are saying about
3 this, because under the law, you got to get the medication
4 abortion and they say come back in a week or two, and if it is
5 ectopic and if it ruptures -- I mean, or are you saying
6 something different from that? I'm just trying to -- I'm
7 trying to be sure I completely understand what you are saying.

8 **MR. APTIST** No. So say you have a pregnancy, you
9 come in and you want to have an abortion and say -- they say,
10 well, we don't know where it is. Let's say it is ectopic, but
11 it was a pregnancy of unknown location, then the woman should
12 be continued to be screened for this, not given the drugs,
13 because she may manifest symptoms of a rupture that she will
14 confuse for symptoms of Mifepristone.

15 **THE COURT** So you are saying if she is given the
16 drugs, that's where the problem arises, because she could
17 confuse the symptoms?

18 **MR. APTIST** Correct, Your Honor. And the concern
19 is, that if she's experiencing these symptoms, she may not
20 realize that it is a ruptured ectopic pregnancy. Instead, she
21 may think it may actually be just the normal symptoms of
22 abdominal pain associated with Mifepristone that she was
23 counseled on during the informed consent part of it.

24 I do want to recognize --

25 **THE COURT** I've caught up with you, I think.

1 **MR. APTIST** I just want to make sure, because I
2 don't want plaintiffs to think that I'm misrepresenting
3 anything, because they do get counseled to be aware of ectopic
4 pregnancies, so I'm not trying to say they don't give that
5 counseling, but I want to make sure that would be the case with
6 that, and so I will point you to *Lee Optical* where it talks
7 about general --

8 **THE COURT** Is there a requirement that if they don't
9 give the medication, that they counsel about ectopic pregnancy?
10 There is no requirement that they do that, right?

11 **MR. APTIST** Correct, Your Honor. Not in the North
12 Carolina law.

13 **THE COURT** Yes, in the North Carolina law.
14 Go ahead.

15 **MR. APTIST** One in 50 pregnancies are ectopic,
16 that's about two percent.

17 **THE COURT** Where is that in the record?

18 **MR. APTIST** That is in two different locations,
19 Dr. Banes's declaration at 65-3, paragraph 58, that is page 27
20 of 45, which she cited an ACOG --

21 **THE COURT** That's all right. You directed my
22 attention. I'll go look. They may not dispute that.

23 Go ahead.

24 **MR. APTIST** I guess Dr. Farris, at page 113 of her
25 deposition, which is attached to plaintiffs' supplemental brief

1 at 74-2, page 113, lines 14 through 25, where she agrees with
2 the same data that shows that ruptured ectopic pregnancies
3 account for about 2.7 of all pregnancy related deaths.

4 **THE COURT** That's not the one out of 50 number?

5 **MR. APTIST** Correct. That would be at page 112,
6 lines seven and eight, where she says up to two percent of
7 pregnancies are ectopic pregnancies.

8 **THE COURT** Okay. Go ahead.

9 **MR. APTIST** So understand that the majority of
10 women do not have this life-threatening condition. I think
11 everybody agrees that it is a life-threatening condition, but
12 under *Lee Optical*, it is well within the purview of the General
13 Assembly to balance the advantages and disadvantages of this
14 requirement as *Lee Optical* held, as recognizing that some
15 requirements may or may not be necessary in every case, but it
16 if it is necessary in some of the cases, that is well within
17 the jurisdiction of the State General Assembly to weigh the
18 pros and cons and cause and benefits of such a requirement, and
19 that's what the State did.

20 **THE COURT** You are saying -- and I understand your
21 argument about how abortions are legal up to 12-weeks, your
22 argument subject to the other provisions of the statute, so I
23 completely understood that, but basically what you are saying
24 is, medication abortions are illegal up to the point where you
25 can see the location of the pregnancy and that it is in the

1 uterus, which is going to be at least five or six weeks.

2 **MR. APTIST** Your Honor, that's the practical effect
3 of the law, yes.

4 **THE COURT** Go ahead.

5 **MR. APTIST** If you don't have any other questions
6 with regard to the IUP documentation requirement --

7 **THE COURT** I do want to know about the scienter
8 requirement.

9 **MR. APTIST** Sure, Your Honor. I'll address that
10 with the penalty for failing to comply with the IUP
11 documentation requirement. It is not criminal. The penalty is
12 focused on disciplinary actions of the medical board within the
13 state, and I can find that statute, Section 90-21.88A.

14 **THE COURT** 88A?

15 **MR. APTIST** Correct, Your Honor. That is the
16 provision that says a physician who violates any provisions of
17 this article shall be subject to discipline by the North
18 Carolina Medical Board under GS 90-14n(a)(2), and so that would
19 be the consequence for failing to violate this provision.

20 **THE COURT** Violating it means they failed to write
21 it down or they failed to determine it or they give the
22 medicine even though they can't tell? What do you mean by
23 "violating"?

24 **MR. APTIST** It is not intended to be a paperwork
25 violation. It is intended to be, you failed to do the actual

1 determination and, again, this goes back to the board where it
2 talks about the board can subject you to discipline, but
3 realize, like, you did the work, but you failed to document the
4 location because you have the ultrasound paperwork or just the
5 documentation there but you didn't check the box, then you're
6 not going to, you know, be held liable, but at the same time,
7 if you knowingly failed to comply with the law to determine
8 gestational age, that would be where the evaluation would
9 occur.

10 **THE COURT** That would subject you to discipline?

11 **MR. APTIST** Correct, Your Honor.

12 **THE COURT** So if the doctor couldn't tell, wrote
13 down that they couldn't tell and gave the medicine any way,
14 there is no criminal penalty for that?

15 **MR. APTIST** That is my understanding.

16 **THE COURT** Can you explain that to me exactly? Walk
17 me through the statute on that. You cited 21.88A, and it is --

18 **MR. APTIST** A violation of this article.

19 **THE COURT** And the article --

20 **MR. APTIST** The Article is 1-I. That's the kind of
21 the abortion-related all encompassing article that deals with
22 all of the provisions at issue in this case.

23 **THE COURT** Okay. All right.

24 Go ahead.

25 **MR. APTIST** Thank you, Your Honor. I just want to

1 make sure I've covered what you were wanting to talk about.

2 Your Honor, I think unless you have any further
3 questions --

4 **MR. OYLE** If I can have one second, Your Honor.
5 (Counsel confer.)

6 **MR. APTIST** Your Honor, I guess two points I want
7 to raise in the evidentiary record here as well. One is,
8 Dr. Farris's deposition, which you can find at 74-2, page 158,
9 where she is being questioned by my co-counsel about the
10 opinions to give a woman an ultrasound to determine gestational
11 age, and I don't know if you would like me to kind of talk
12 about the colloquy that was here, but the short --

13 **THE COURT** Tell me why you want me to read that
14 page.

15 **MR. APTIST** Okay. She concludes that the option of
16 waiting for an ultrasound to determine the location of an
17 intrauterine pregnancy is reasonably safe and effective. That
18 is found actually on the next page, so page 159 of the
19 deposition transcript, lines 17 through 20, or the ECF filing
20 page 160 of 174. I just want to make sure you have that line.

21 **THE COURT** That's all on page 158?

22 **MR. APTIST** The question begins on page 158 and
23 continues to 159.

24 **THE COURT** I got you. Thank you.

25 I did want to ask you, I'm not sure about this

1 language in the Greenville Woman's Clinic case that I think you
2 all cited. There, that case talked about distinguishing
3 between abortion services and other medical services because of
4 the particular gravitas of the decision, but I can't remember
5 what they were regulating in that one, but you're not relying
6 on that here. You cited it, but I think you told me earlier,
7 that it is just maternal safety and health that you are relying
8 on here as the governmental interest.

9 **MR. APTIST** Correct, Your Honor, we're relying on
10 maternal health here, not only fetal life in this situation.

11 **THE COURT** All right. And not on a difference
12 between abortion and anything else because you already told me
13 earlier it is the same test for abortion here as in this case,
14 for abortion and any other medical service.

15 **MR. APTIST** Under the rational basis test, it is
16 going to be treated the same, yes, Your Honor.

17 Do you have any other questions, Your Honor?

18 **THE COURT** I do think you've addressed everything.
19 I think you probably have. Okay. Thank you.

20 Rebuttal for the plaintiff.

21 **MS. SWANSON** Thank you, Your Honor. I will make
22 this brief, I hope.

23 First, I want to be clear that animus is not a
24 required element of a successful rational basis challenge. It
25 is just not a sufficient government justification for a law

1 that is challenged under rational basis standard.

2 The *Moreno* case is clear, that animus is an
3 insufficient justification, but it is not a mandatory showing.
4 The intervenors said that the *Hooper* case is a heightened
5 scrutiny case, and that's not true.

6 At 472 U.S. on page 618, the Court says, "If the
7 statutory scheme cannot pass even the minimum rationality test,
8 our inquiry ends," and that's the inquiry they proceed to do in
9 *Hooper*.

10 So they are not applying any sort of rational basis
11 plus based on an allegation of animus, and of course in *Hooper*,
12 in the *St. Joseph Abbey* case, the Court found that the
13 challenge restrictions failed rational basis, even though there
14 was no showing of animus against, on the one hand, Vietnam
15 Veterans, or in *St. Joseph Abbey* case against the monks who
16 were selling caskets.

17 We don't have to show animus in order to prevail in a
18 rational basis case, even though there is evidence of animus
19 here. We win because --

20 **THE COURT** What is your evidence of animus and who
21 is the animus against?

22 **MS. SWANSON** The animus is against abortion
23 providers as compared to providers of other medical care. On
24 this point, I want to be clear, for the purposes of the
25 standing inquiry, both our vagueness challenge to the IUP

1 documentation requirement and our equal protection challenge to
2 the hospitalization requirement, both claims are brought in a
3 first party standing basis.

4 We also assert the hospitalization requirement and an
5 equal protection violation and a substantive due process
6 violation on behalf of plaintiffs' patients, but both claims
7 are asserted on behalf of the plaintiffs themselves, so we
8 don't even have to get into the third-party standing inquiry,
9 even though as we discussed --

10 **THE COURT** What is your harm?

11 **MS. SWANSON** The harm is that the plaintiffs are
12 regulated and stand to risk criminal penalties and professional
13 licensing penalties if they provide this healthcare. That is,
14 you know, the *Craig v Boren* case that was a third-party
15 standing case, but I think this is certainly sufficient under
16 *Lujan*, under the third-party -- I'm sorry, under the Article
17 III traditional standing test, but the risk that the challenge
18 provisions will be enforced against the plaintiffs gives them
19 injury, causation and redress-ability. These provisions are
20 enjoined. They don't face the risk of criminal or professional
21 penalties.

22 **THE COURT** Okay.

23 **MS. SWANSON** The intervenors said there is no
24 evidence in the record that miscarriage management is performed
25 on an outpatient basis. That's not true. Dr. Farris's

1 declaration, this is ECF 49-1, in paragraphs 8, 24, 28, 40, and
2 41, she explains that Planned Parenthood South Atlantic
3 provides miscarriage management using the aspiration procedure
4 up to 14-weeks of pregnancy and using the D&E procedure in the
5 second trimester, and in paragraph 41, she also says that
6 because of the way the hospitalization requirement applies to
7 procedural abortion but not to the same procedures for
8 miscarriage management, the plaintiffs could even treat
9 complications from an abortion provided in a hospital or for
10 miscarriage management provided in a hospital in their Planned
11 Parenthood outpatient clinics. That's paragraph 41.

12 There is evidence in the record that miscarriage
13 management is currently being performed on an outpatient basis
14 in North Carolina.

15 As to the hospital transfer rate, there was some
16 discussion of what the exact percentage of Planned Parenthood
17 South Atlantic's hospital transfer rate is, and that rate -- we
18 ran the math, and it is 0.08 percent of the abortions that
19 Planned Parenthood provided between January 1st, 2020 and
20 June 30, 2023, resulted in hospital transfer.

21 **THE COURT** You get that from?

22 **MS. SWANSON** That is from Dr. Farris's rebuttal
23 declaration which is docket entry 69-2, and paragraph eight
24 where she says that Planned Parenthood provided 38,795
25 abortions in North Carolina in those dates.

1 She explains that only 522 complications resulted,
2 most of which were minor. This is also in the record as it is
3 Exhibit 12 to Plaintiffs's Supplemental Brief, so it would be
4 docket entry 74-12, as well as docket entry 74-13 and 14.

5 Docket entry 13 is the one that has the
6 complication -- the total number of complications which was 522
7 out of 38,795 total abortions, and then docket entries 74-12
8 and 14, respectively, show the number of hospital transfers.

9 Of those nearly 39,000 abortions provided in North
10 Carolina, Planned Parenthood of South Atlantic transferred 31
11 patients to the hospital. All of those patients were treated
12 and released in stable condition and only seven of those
13 patients were actually admitted to the hospital. That's seven
14 patients out of nearly 39,000 over the course of two and a half
15 years.

16 I think the overarching point is, that it is simply
17 not rational to require that all abortions be provided in a
18 hospital, given the --

19 **THE COURT** Is that 39,000, 38,795 all or after
20 12-weeks?

21 **MS. SWANSON** That is all, Your Honor. It is not
22 broken out by 12-weeks.

23 **THE COURT** By gestational age?

24 **MS. SWANSON** Correct. But the number of hospital
25 transfers after 12-weeks was 17, and I think four of those

1 resulted in hospital admission.

2 The O'Day case, this is the Ninth Circuit rational
3 basis case about the double bond requirement for administrative
4 appeals, and in that case, the court said where a law is so
5 vastly over-inclusive as to be attenuated from the assertive
6 legislative purpose it fails rational basis, even if there is
7 no animus at issue in the case, and relies on *Moreno* and the
8 language from there is this point about the statute being
9 attenuated in *Moreno* and also in the *Cleburne* case at page 446,
10 the state may not rely on means so attenuated --

11 **THE COURT** May not what?

12 **MS. SWANSON** Rely on means so attenuated from the
13 purported justification for the law, and that is what is
14 happening here. I think like with all medical care there is a
15 risk of complication, but the risk of complication requiring
16 hospital treatment is so dramatically low and so much lower
17 than, for example, labor and delivery, and there is simply no
18 rational connection between the hospitalization requirement and
19 the state purported safety justification.

20 As to whether criminal penalties apply to the IUP
21 requirement, the intervenors are saying that professional
22 penalties are the only penalty for the IUP penalty requirement,
23 but as the Court recognized in the TRO order, professional
24 penalties have a stigmatizing effect, are sufficient to require
25 a heightened level of vagueness scrutiny, and that's from the

1 *Manning* case.

2 **THE COURT** That's from what?

3 **MS. SWANSON** *Manning*.

4 As to whether there is a risk of confusion between
5 the symptoms of ruptured ectopic pregnancy and symptoms of
6 medication abortion, docket entry 74-15 is the patient
7 education forms that Planned Parenthood South Atlantic provides
8 to patients with pregnancies of unknown location, and it
9 counsels them both on the symptoms, the expected symptoms of
10 medication abortion and on the possible symptoms of a ruptured
11 ectopic pregnancy, so the patients are provided with this
12 counseling. They are given access to a 24-hour helpline. They
13 are encouraged to reach out to the abortion provider if they
14 have any concerning symptoms and then, of course, patients who
15 are being concurrently tested, use this blood testing procedure
16 for ectopic pregnancy, are required to submit a second blood
17 test after they've had their medication abortion, and so they
18 are continually in contact with their abortion provider. They
19 are continuing to receive testing for ectopic pregnancy, while
20 simultaneously receiving the medication abortion that they
21 want, and this is again an evidence-based practice.

22 Dr. Goldberg's research found that ectopic pregnancy
23 is excluded sooner under this concurrent treatment and testing
24 protocol rather than when a patient is simply sent home to wait
25 until a pregnancy can be seen on ultrasound, and that's what

1 the intervenors are advocating for.

2 On the question of comparative risk of childbirth and
3 abortion, it makes sense to --

4 **THE COURT** Can I back you up to animus? You are
5 contending that the statute shows animus against the provider
6 of abortion?

7 **MS. SWANSON** Yes.

8 **THE COURT** What is your evidence on that point? Why
9 do you say that?

10 **MS. SWANSON** I think because the statute in
11 regulating abortion providers differently than it regulates
12 comparable medical care, and then in expressly carving out
13 miscarriage in those provisions that the Court identified
14 earlier.

15 Those procedures are identical, but for the purpose
16 for which they are performed. No secret that the legislature
17 is opposed to abortion, and I think in discovery, the
18 intervenors produced evidence of communication between key
19 legislators who are now intervenors in this case and
20 anti-abortion advocates who were making statements that were
21 false accusations or false descriptions of the way that
22 abortion providers care for their patients.

23 I think the record is very clear that abortion
24 providers provide excellent evidence-based medical care for all
25 of their patients, and the suggestion that abortion providers

1 are profit motivated, that they have a conveyor belt of
2 patients coming through is simply -- it is rebutted by the
3 evidence, by evidence-based and compassionate patient centered
4 care that the plaintiffs provide.

5 In particular --

6 **THE COURT** Well, I mean, that's different from
7 animus. That's just being wrong. I mean --

8 **MS. SWANSON** Correct.

9 **THE COURT** You are saying they are just wrong, but
10 that's different from animus.

11 **MS. SWANSON** I think either one is sufficient for us
12 to win here. I think -- we believe that there is evidence of
13 animus, that even if we can't persuade the Court that there is
14 evidence of animus in this case, it is enough that we have
15 produced evidence rebutting their purported safety
16 justifications.

17 **THE COURT** They haven't come in here and offered
18 anything to show anything about bad care from your client or
19 other providers. I haven't heard anything that that is a basis
20 for this.

21 **MS. SWANSON** That's correct.

22 **THE COURT** So tell me -- point me to your evidence
23 of animus.

24 **MS. SWANSON** So I think the declaration that they
25 admitted from Dr. Wubbenhorst is ripe with suggestions that

1 abortion providers provide substandard care. None of that is
2 supported by citations to anything. It is simply
3 Dr. Wubbenhorst's personal opinion about abortion providers,
4 and I think the -- the other rational basis cases, after doing
5 the analysis of whether the purported justifications for the
6 law are actually supported by evidence, upon concluding that
7 there is no rational relationship to those legitimate
8 government interests, courts say I can't really understand what
9 the basis for this could have been, other than animus. But it
10 is still not necessary for the Court to even reach that animus
11 question in order for the plaintiffs to prevail in a rational
12 basis case.

13 So I think the *Hooper* case, I think the *O'Day* case,
14 *Craigmiles* cases are all, you know, good cases where the Court
15 ruled for plaintiff in a rational basis challenge without
16 requiring a showing of animus.

17 Of course abortion is an incredibly politically
18 charged topic. It is a politically stigmatized type of
19 healthcare, and I think Dr. Farris testifies in her rebuttal
20 declaration that in North Carolina providing abortion -- she
21 does receive stigma as a result of being an abortion provider
22 in North Carolina.

23 **THE COURT** Where does she say that?

24 **MS. SWANSON** In her rebuttal declaration, which is
25 docket entry 69-2.

1 I will ask my able co-counsel to find this while I
2 proceed to the gestational age point.

3 So the intervenor suggests that the proper comparator
4 is abortion at a particular gestational age and childbirth at
5 the same gestational age, or perhaps abortion at term compared
6 to childbirth at term. They suggest that you should be looking
7 at the same thing at the same gestational age, and that makes
8 no sense, because right now, abortion starting after the
9 twelfth week of pregnancy must happen in a hospital, while
10 childbirth must happen or can happen outside of the hospital,
11 so those are the proper comparators to look at the safety.

12 The record shows that -- this is in Dr. Boraas's
13 rebuttal declaration, ECF 69-1, paragraph 16. The major
14 complication rate for abortion is just 0.23 percent, while
15 severe complications from childbirth occur in 1.4 percent of
16 childbirths.

17 Then in paragraph 17 she makes clear that every
18 pregnancy complication is more common among people having live
19 births than those having abortion. So labor and childbirth is
20 riskier than abortion.

21 We discussed a standing point as for whether
22 plaintiffs have seen patients under the exceptions to the
23 12-week ban since July 1st. There is actually -- there is not
24 evidence in the record, but the plaintiffs have not seen
25 patients. What intervenors point to is Dr. Farris's deposition

1 testimony saying she is not personally aware of whether they
2 have but, again, we have evidence in Dr. Farris's opening
3 declaration that they have treated patients in these
4 circumstances in the past and would continue to do it again,
5 and under *Lujan*, that's sufficient to establish standing.

6 If the Court is interested, we could also submit a
7 supplemental declaration with the exact numbers.

8 **THE COURT** I don't have time for that. You all --

9 **MS. SWANSON** Understood.

10 **THE COURT** -- have had your chance, at least for
11 preliminary injunction.

12 **MS. SWANSON** Yes.

13 Lastly, the intervenors make this point that
14 Dr. Farris recognizes that it is a reasonable medical option
15 for a patient to wait, and then come back, just as it is a safe
16 and reasonable option for the patient to receive the medication
17 abortion, while simultaneously undergoing further testing for
18 ectopic pregnancy.

19 I want to be very clear, that what is a reasonable
20 menu of medical options for a patient to choose between, in
21 consultation with her doctor, is very different from what it is
22 rational for the legislature to mandate or prohibit. It is not
23 rational for the legislature to require that all patients go to
24 a hospital for an abortion, or that patients wait until a later
25 point in pregnancy, rather than receiving medication abortion.

1 Again, the evidence shows that ectopic pregnancy is
2 excluded sooner when patients are able to both receive their
3 medication abortion and undergo further testing for ectopic
4 pregnancy in contrast to being required to wait.

5 It is not just irrational to take one option fully
6 off the table for patients, but as Dr. Boraas testified in her
7 deposition, given the existence of the safe and effective
8 medical options, it is rather cruel to make patients wait.

9 I will continue to -- no, never mind. So we will
10 withdraw the point about Dr. Farris's rebuttal declaration
11 stigma. I will continue to look for that.

12 In the meantime, we would reiterate that there is no
13 rational justification for either of these laws. They will
14 harm patients. There is no harm to the status quo from
15 allowing the plaintiffs to continue to provide the safe
16 evidence-based medical care that they have been providing in
17 North Carolina for years, and we would ask the Court to enter a
18 preliminary injunction against both provisions before
19 October 1st.

20 **THE COURT** Anything else for the Attorney General?

21 **MS. OYCE** Yes, Your Honor, just a few things.

22 First, we don't take issue with the test that
23 Mr. Baptist has set forth. We agree that the proper test here
24 is not one of rational basis plus, but rather simply rational
25 basis.

1 I think Mr. Baptist articulated the test, that is
2 that the law must be rationally connected to a legitimate State
3 interest, and we agree with that test.

4 We similarly agree that it is a low bar, but we
5 disagree with whether the legislature has managed to satisfy
6 the threshold here.

7 The key here is the rational connection that
8 Mr. Baptist highlighted. Again, simply saying that the law has
9 been passed to protect the health and safety of the mother is
10 not sufficient. Those are not magic words. You need to
11 justify that basis once it has been put into question by a
12 plaintiff like Planned Parenthood has done here, and to do
13 that, we believe it make senses for the legislature to rebut
14 the idea both that there is not adequate risk to justify this
15 law, and to rebut the idea that requiring hospitalization does
16 not in fact mitigate the risk, and rather in fact sometimes can
17 exacerbate that risk for the patients who undergo these
18 procedures.

19 I haven't heard the legislature take issue with the
20 statistics as Planned Parenthood has put them forward. I think
21 I heard Mr. Baptist say that the risk is about .52 percent in
22 one year, and .41 percent in another year. That's entirely
23 consistent with the statistics that Planned Parenthood has put
24 forward.

25 **THE COURT** I thought he said 5.2 percent.

1 **MS. OYCE** He said 5.2 to start, and then the second
2 time --

3 (Cross-talk.)

4 **THE COURT** Thank you for clarifying. I heard a
5 different number.

6 **MS. OYCE** The first time I think he said .52, and I
7 think he meant the second time .52. But again, .52, which is
8 quite inline with the studies that Planned Parenthood has
9 submitted as part of discovery in this case, which similarly
10 underscores that it is well under one percent and more in the
11 vain of about a half a percent.

12 They similarly have not put forth evidence that it is
13 more dangerous for these women to be treated in a clinic as
14 opposed to a hospital or that it is impossible for clinics to
15 get women who do have major complications arise to a hospital
16 in time for them to be treated there.

17 Your Honor raised *Lee Optical*. They have spoken a
18 little bit about *Lee Optical*, and while both they and Your
19 Honor is correct, that the legislature doesn't have to solve
20 every single problem at once. They can focus on risks posed by
21 certain medical procedures one at a time, and mitigate those
22 risks.

23 It is also true that the legislature should not be
24 drawing arbitrary lines about the same medical procedure based
25 on the group who you is seeking them, and that's the problem

1 here.

2 You asked the question about whether the legislature
3 could perhaps require all childbirths to take place at a
4 hospital as opposed to allowing them to ever occur at home, and
5 I think the answer to that is, perhaps, maybe, if they put
6 forward evidence that it was risky to give birth at home and
7 that giving birth in a hospital would mitigate that risk.

8 What they couldn't do, though, is require any
9 unmarried woman who wants to give birth to a child in a
10 hospital, and to allow married women to give birth at home, if
11 there is no evidence that the risk to those different groups of
12 women is any different, and that's what is happening here with
13 respect to women who want to get these procedures because they
14 had a miscarriage, and women who want to get these procedures
15 because they wish to have an abortion.

16 The plaintiffs have not, and the legislature has not
17 put forth any evidence that there is a different risk posed, or
18 has not rebutted the evidence that Planned Parenthood has put
19 forward that the risk posed to those two groups of women is the
20 same, and that the medical procedure is equally received or not
21 received, we believe safe for both of those groups.

22 **THE COURT** I mean, post-12-weeks, you are only
23 talking about women who need an abortion or want an abortion
24 because of rape or incest, fetal anomaly or a life-threatening
25 issue. Right?

1 **MS. OYCE** Exactly, Your Honor.

2 **THE COURT** There is no evidence that risks are
3 higher for those groups?

4 **MS. OYCE** Exactly, Your Honor.

5 Moving quickly to the vagueness argument that we've
6 touched on throughout the day, I am pleased to hear now again
7 from the legislature that they have reverted to their position
8 at the TRO hearing that there are only civil penalties for this
9 law. That is not what they said in their brief at page 18,
10 where they said, "and while the IUP documentation requirement
11 gives rise to both civil and criminal penalties, each of the
12 possible criminal penalties include a scienter requirement."

13 I think this again underscores another vagueness
14 problem that arises from this law, and that is, that it is not
15 clear whether the provision they cited now about the Medical
16 Board's authority is an additional penalty, an additional
17 penalty that can be imposed on doctors that proceed with these
18 abortions without satisfying these requirements, or is the only
19 penalty that can arise, and their position here has vacillated
20 back and forth, and only speaks to the predicament that doctors
21 will find themselves in as they try to navigate this
22 requirement, and whether if they do choose to move forward,
23 they will only be subject to medical board discipline, or
24 criminal penalties as well, and that's not to disagree with the
25 plaintiffs about whether civil penalties are still enough to

1 give rise to a searching inquiry with respect to vagueness.

2 We totally agree that even if it is just civil
3 penalties, nevertheless, that is a significant enough penalty
4 that the law needs to be extremely clear, but I do think that
5 the fact even counsel for the legislature cannot agree as to
6 how this law should be interpreted and what happens if you
7 proceed with a pregnancy if you cannot figure out for certain
8 whether the pregnancy is intrauterine or not, speaks to the
9 constitutional problem that is at the heart of this law.

10 I do want to pick up on, I think, a potential
11 concession that Mr. Baptist made when he said that he would
12 agree with Your Honor that it could be interpreted to mean the
13 probable existence of an intrauterine pregnancy, because that
14 does strike me as a possible way forward here.

15 Everything I've seen in record from Planned
16 Parenthood about the way that they approach ruling out an
17 ectopic pregnancy, suggests that they only proceed to
18 administer medication abortion if they believe that it is
19 probably an intrauterine pregnancy, and I believe Dr. Farris's
20 declaration says, in the event that they think the patient is
21 at risk of an ectopic pregnancy, they will simply refer the
22 patient to a hospital.

23 So it is my understanding based on the record, that
24 Planned Parenthood does not proceed with medication abortions
25 unless they would feel comfortable certifying that there is a

1 probable existence of an intrauterine pregnancy. They simply,
2 I don't believe, are able to document with any certainty an
3 intrauterine pregnancy, and so insofar as the legislature is
4 willing to concede that that is a possible construction of this
5 law, it does strike me as perhaps a construction that this
6 Court could enter that we would all agree with and that might
7 be consistent with Planned Parenthood's approach to ruling out
8 ectopic pregnancies.

9 The only other point that I would make on vagueness
10 is just, of course, vagueness challenges are not just a problem
11 for doctors, they are also a problem for law enforcement, and
12 this is of course something that is important to the Attorney
13 General. If prosecutors don't know whether they can bring
14 charges or who has violated the law, it puts them in a
15 difficult position, just as it puts doctors and patients in a
16 difficult position with respect to what conduct is prescribed
17 by the law and what is not.

18 Finally, I'll just conclude in a similar place to
19 counsel for Planned Parenthood, and that is to underscore the
20 fact that the preliminary injunction standard places great
21 emphasis on the question of irreparable harm. We talked a lot
22 about the likelihood of success on the merits. We haven't
23 talked nearly as much about the irreparable harm that would be
24 caused if the legislature's approach to this law or
25 understanding of this law is permitted to take effect on

1 October 1st, that it would cause grave harm to women who cannot
2 access the productive care that they need, and it will put both
3 doctors and law enforcement officials in the possible position
4 of trying to figure out what is permissible and what is
5 prohibited under the law of North Carolina.

6 We would ask for those reasons that Your Honor enjoin
7 the provisions that we talked about today, or adopt
8 construction of those provisions that are consistent with our
9 interpretation of the law or our evidence.

10 **THE COURT** Rebuttal for intervenors.

11 **MR. APTIST** Just a few.

12 **THE COURT** Or sur rebuttal.

13 **MR. APTIST** Just a few points, Your Honor. We
14 submit that it was entirely rational for the State General
15 Assembly to codify the FDA requirement to exclude an ectopic
16 pregnancy before giving abortion drugs to a woman who seeks
17 abortion.

18 We also think it was entirely rational for the state
19 to require post-12-week surgical abortions to be performed in a
20 hospital setting, even based on Planned Parenthood's own
21 documentation and, again, I'll point you to 74-12, which is
22 their list of post-12-week complications resulting in hospital
23 transfer. That just demonstrates to show that there are
24 serious complications that they cannot treat themselves within
25 their facilities requiring an emergency situation transferring

1 these women before they suffered enough trauma in their life,
2 they are having another traumatic event to be rushed to the
3 hospital.

4 Their last entry, I will note, on Bates No. 052 or
5 74-12, page three of three, I may pronounce this wrong, it is
6 called syncope, that means a woman is unconscious, so think
7 about a rape victim who is pregnant and going through an
8 abortion at the Planned Parenthood facility.

9 **THE COURT** They don't have to.

10 **MR. APTIST** Pardon.

11 **THE COURT** You said they to have.

12 **MR. APTIST** She decided to have an abortion at the
13 Planned Parenthood facility and she's being transferred and
14 losing consciousness for an unknown amount of time and waking
15 up in an unknown situation or emergency room. That's doubly
16 traumatic and the State is trying to prevent that situation
17 from happening again.

18 I will also note that based on their own data, there
19 is a significant increase. We kind of quibbled about numbers,
20 and I have .52 percent. I apologize for speaking to the
21 post-12-weeks surgical abortions for 2023. I haven't run the
22 numbers and I can't tell you what it is, just assuming they
23 have .08 percent for the entirety of all of their abortions
24 performed in an average year, I think that shows there is a
25 significant increase in hospital transfers after 12-weeks, and

1 so it was well within the realm of rationale for the State to
2 focus at 12 and require those to be performed in a hospital as
3 opposed pre-12-week surgical abortions, they still can be
4 performed.

5 **THE COURT** And that is in -- you are telling me that
6 evidence is where? I think you may have pointed it out to me
7 earlier. I just want to be sure.

8 **MR. APTIST** I will point you to our supplemental
9 brief. It is going to be 75-6, procedural abortion by volume
10 and by gestational age, and if you run the numbers based on how
11 many they performed, and they've represented how many have been
12 transferred in their briefs, I think it was 31 over the last
13 three and a half years.

14 **THE COURT** I think they said only 17 of those were
15 post-12-weeks.

16 **MR. APTIST** That's correct, Your Honor. By my
17 math, like I say, it is lawyer's math. I think that is 14
18 pre-12-weeks. Given the higher volume that they performed,
19 that just shows that they have a lower hospital transfer rate
20 for the pre-12-weeks surgical abortions versus the
21 post-12-weeks surgical abortions, which shows that the
22 legislature had a rational basis to focus on those and required
23 them to be performed in the hospital to prevent the trauma that
24 occurs when they have to be transferred to a hospital and
25 treated for complications that cannot be treated in the Planned

1 Parenthood facility.

2 **THE COURT** I still am not completely sure I've heard
3 you provide a rational basis for requiring abortions after 12
4 -- when I say abortions, I'm talking about these two procedures
5 that we've been talking about, the aspirations and the D&Es,
6 why those have to be done in a hospital, if the purpose is
7 abortion, but they don't have to be done in a hospital when the
8 purpose is miscarriage management.

9 Can you explain that to me?

10 **MR. APTIST** I can explain it to you. I am going to
11 have to give the caveat that I can't point to the record, but
12 there are different medical conditions associated with a dead
13 baby versus one that is still alive and intact and has cardiac
14 activity, or a heartbeat.

15 **THE COURT** I didn't see you point me to that.

16 **MR. APTIST** No, I said with the caveat that there
17 is nothing in the record that I can point to you that they --
18 they deal with two different conditions. The procedures may be
19 the same, but the woman's condition --

20 **THE COURT** Because the evidence I saw -- I mean, I
21 went back and read all the Reddit, they pointed me to it, the
22 risks are the same. It is hemorrhage -- I have forgotten now
23 what the other ones are. The doctor -- one of them, at least,
24 went through, and maybe even your doctor, your expert also, the
25 risks are the same, and I just didn't see anything that says

1 they are different, and you're telling me you don't think there
2 is anything in the record saying they are different.

3 **MR. APTIST** I would say, I think their evidence
4 shows -- or even our doctors may agree the types of
5 complications are the same.

6 I'm not sure that the rates of complications have
7 been demonstrated to be the same as well, because they deal
8 with different situations, but I understand that they pointed
9 to Dr. Farris's declaration where she said she performed some
10 post-12-week miscarriage management surgeries in Planned
11 Parenthood facilities. I posit again that I'm not sure. They
12 have not submitted the frequency of that occurrence outside of
13 the hospital setting. All we have is Dr. Wubbenhorst's
14 testimony that I pointed to earlier that she says in her
15 experience they are always performed in the hospital setting.

16 So I just compare what did the State look at in terms
17 of the problem, if 90 percent of -- 97 percent of all abortions
18 are performed outside of the hospital setting, compared to, I'm
19 going to say 97 percent of all miscarriage management surgeries
20 in second trimester are performed in the hospital setting, the
21 State would have a rational basis to focus on post-12-week
22 surgical portion versus post-12-week miscarriage management
23 surgeries which are predominantly performed in the hospital
24 setting with the exception of Dr. Farris and Planned Parenthood
25 within North Carolina, they maybe perform some, not sure how

1 many in their experience.

2 **THE COURT** I didn't mean to cut you off, if you had
3 other things that you wanted to talk about.

4 **MR. APTIST** I'll just note in terms of discussion
5 of animus, the plaintiffs cite to meetings or emails associated
6 with pro-life advocacy groups. I will note that the State
7 legislature met with many groups with different opinions and
8 that is supported by even plaintiffs' supplemental brief where
9 they submitted exhibits and email communications with
10 nonpro-life groups discussing the legislation, so I just submit
11 that there is no animus here. They met with anybody who was
12 wanting to discuss the proposed legislation with them.

13 **THE COURT** Thank you. Anything else?

14 **MS. SWANSON** I just wanted to apologize for
15 misstating the stigma point. We have located the paragraph. I
16 was misremembering. This was in Dr. Farris's rebuttal
17 declaration ECF 69-2, paragraph 15, where she discusses the
18 stigma that patients seeking abortion face, including walking
19 past protestors on their way to their appointments at the
20 Planned Parenthood Health Center.

21 I also wanted to just state clearly for the record,
22 but I don't believe that counsel for intervenors intended to
23 state this as a fact that 97 percent of (cross-talk) --

24 **THE COURT** I didn't take it that he was stating that
25 as a fact.

1 **MS. SWANSON** Wanted to be clear, that's not in the
2 record.

3 Lastly, just wanted to reiterate that this risk of
4 possible ectopic -- risk of confusion between symptoms of
5 ectopic rupture and the symptoms of medication abortion, not
6 only are patients counseled on what to expect from both, but
7 there is deposition testimony from both Dr. Boraas and
8 Dr. Farris as well as from intervenors' witnesses,
9 Dr. Wubbenhorst and Dr. Bane, that explain the ways that these
10 symptoms present in a clinically distinct way.

11 So ectopic rupture will be a sharp pain on one side
12 of a patient's body with minimal vaginal bleeding, whereas the
13 symptoms of medication abortion are midline cramping and
14 vaginal bleeding, because that's how the pregnancy is passed
15 from the patient's body.

16 So given the distinction between the clinical
17 presentation of ruptured ectopic pregnancy and the symptoms of
18 medication abortion, comprehensive counseling that patients
19 receive, their encouragement to reach out if they have
20 concerning symptoms to their abortion provider and the fact
21 that they are receiving ongoing testing for ectopic pregnancy
22 simultaneous with a medication abortion, there is no risk of
23 confusion here, and so in light of all of that, we would just
24 thank the Court for your time and ask respectfully for a
25 preliminary injunction against both provisions.

1 Thank you.

2 **THE COURT** Thank you. Anything else?

3 **MS. OYCE** The only other minor point that I would
4 make, Your Honor, is just about this point from Dr. Wubbenhorst
5 that keeps coming up repeatedly. I just want to clarify what
6 Dr. Wubbenhorst seems to be saying in her deposition. She says
7 on page 115, that in her experience based on the programs at
8 hospitals where she has worked at, these kinds of procedures
9 happen in hospitals.

10 One of the glaring problems with Dr. Wubbenhorst as a
11 witness here in this case is, that she has never worked in a
12 clinic or participated in any programs at a clinic. So her
13 point is a very narrow one, which is very simply based on her
14 experience in hospitals. They performed these procedures in
15 hospitals. She doesn't speak at all as to whether they do not
16 happen in clinics, because of course she hasn't worked in a
17 clinic, and she ties her experience to the places that she has
18 worked.

19 I don't think that that rebuts the evidence on the
20 other side from Planned Parenthood that these procedures do
21 occur with great frequency at the clinics here in North
22 Carolina and here and around the country.

23 **THE COURT** Anything else?

24 **MR. APTIST** One quick point in response to the
25 Attorney General. I don't think there is evidence from

1 plaintiffs that show that great frequency of miscarriage
2 managed surgeries occur within the state.

3 **THE COURT** I'm sorry, what?

4 **MR. APTIST** I'm sorry. Miscarriage management
5 surgeries in the second trimester occur outside of a hospital
6 setting. There is just no evidence outside of Dr. Farris's
7 limited declaration. That's it, Your Honor.

8 **THE COURT** I'm going to do my best to get you an
9 order on Friday. That said, I have until Saturday so, you
10 know, I'm going to try to do it by Friday, but I'm not making
11 any promises. I can't think of anything else.

12 Thank you. Court is adjourned.

13 (Court was adjourned at 1:10 p.m.)

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C E R T I F I C A T E

I, J. ALLEN, RPR, United States District Court Reporter
for the Middle District of North Carolina, DO HEREBY CERTIFY:

That the foregoing is a true and correct transcript of
the proceedings had in the above-entitled matter.

January 22, 2024

J. Allen, RPR
United States Court Reporter
324 W. Market Street
Greensboro, NC 27401