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

PLANNED PARENTHOOD SOUTH ATLANTIC, *et al.*,	)	
Plaintiffs,	)	
v.	)	
JOSHUA STEIN, *et al.*,	)	Case No. 1:23-cv-00480-CCE-LPA
Defendants,	)	
and	)	
PHILIP E. BERGER, *et al.*,	)	
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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Plaintiffs,	)	
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JOSHUA STEIN, *et al.*,	)	Case No. 1:23-cv-00480-CCE-LPA
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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 abortions[5] 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*. Intervenors have 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 20–21[6]—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 Intervenors have 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 Intervenors' 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). Intervenors' interpretation of the IUP Documentation Requirement, however, would *prohibit* a medication abortion during the earliest weeks of pregnancy. And Intervenors concede that it will force some patients to obtain medication abortions later in pregnancy, *see* DE 75 (Intervenors' Supp. Br.) at 10, when the medical risks have increased, DE 65 at 3.

Intervenors 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 Intervenors' "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 Intervenors' 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, *et al.*,	)	
Plaintiffs,	)	
v.	)	
JOSHUA STEIN, *et al.*,	)	Case No. 1:23-cv-00480-CCE-LPA
Defendants,	)	
and	)	
PHILIP E. BERGER, *et al.*,	)	
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 Requirement[1] 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 Requirement[2] 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).

Carolinians of color, and rural North Carolinians, 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 Carolinians face a critical shortage of reproductive health care providers, including obstetrician-gynecologists, especially in rural areas.[5]

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[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) gestation[6] as measured from the first day of the

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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 Dilation 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

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[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 concerningly, 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]

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[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 Kortsmit 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

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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,

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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

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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

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[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 Kortsmit 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

Katherine A. Farris, MD, FAAFP
3010 Maplewood Avenue Winston-Salem, NC 27603

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

EXHIBIT 3

Medication Abortion Volume by Gestational Age							
		Asheville	Chapel Hill	Charlotte	Fayetteville	Wilmington	Winston-Salem
	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
01/2020-12/20	11 weeks	2	7	2	14	4	7
	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
01/21-12/21	11 weeks	3	14	2	23	3	15
	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
01/22-12/22	11 weeks	14	25	12	22	1	7
	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
01/23-12/23	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
01/20-12/20	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
	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
01/21-12/21	21 weeks	0	28	0	0	0	0
	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
01/22-12/22	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****

*Chart represents total number of complications, not total number of patients with complications. Some patients may have had more than one complication.
** Of these, 34 required transfer to a hospital.

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, *et al.*,	)	
Plaintiffs,	)	
v.	)	
JOSHUA STEIN, *et al.*,	)	Case No. 1:23-cv-00480-CCE-LPA
Defendants,	)	
and	)	
PHILIP E. BERGER, *et al.*,	)	
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 Kortsmit 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

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[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

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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

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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), s*upra* 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), s*upra* 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

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[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]

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[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").

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
St. Paul, MN 55114
1200 Lagoon Avenue
Minneapolis, MN 55408
Telephone [redacted]
FAX [redacted]
Email [redacted]

IDENTIFYING INFORMATION

Education

Degree	**Institution**	**Date Degree Granted**
B.A.	St. Olaf College, Northfield, MN *Biology and English, magna cum laude*	2001
	University of Pittsburgh, Pittsburgh, PA *Semester at Sea Study Abroad Program*	Fall 2000
M.P.H.	University of Minnesota School of Public Health, Minneapolis, MN *Epidemiology*	2004
M.D.	University of Minnesota Medical School, Minneapolis, MN *With Honors*	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

Certifications

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

Licenses

Medical Physician and Surgeon, Minnesota (#58304) 2014-present

Medical Physician and Surgeon, Pennsylvania (#MD445822) 2012-2014

Academic Appointments

University of Minnesota Minnesota Population Center
Faculty Member 2019-present

University of Minnesota Medical School, Twin Cities (2016-2022)
Center for Global Health and Social Responsibility
Associate Global Health Faculty 2016-present

University of Minnesota Medical School, Twin Cities (2015-2022)
Department of Obstetrics, Gynecology and Women's Health
Assistant Professor 2015-present

Department of Obstetrics, Gynecology and Reproductive Sciences
University of Pittsburgh School of Medicine, Pittsburgh, PA
Clinical Instructor 2012-2014

University of Pittsburgh School of Medicine, Pittsburgh, PA
Center for Family Planning Research
Investigator 2012-2014

Academic Administrative Appointments

University of Minnesota Medical School, Twin Cities
Ryan Residency Training Program in Abortion and Family Planning
Director 2015-present

University of Minnesota Medical School, Twin Cities
Fellowship in Family Planning (ACGME approval pending)
Director 2015-present

Planned Parenthood Minnesota, South Dakota, North Dakota, St. Paul, MN
Director of Obstetrics and Gynecology Resident Education 2014-present

The Ohio State University, Columbus, OH
Department of Obstetrics and Gynecology
Chief Administrative Resident 2011-2012

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 Shlafer, 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-QSCTGCClinical 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 gonorrhea 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: Contrasperm: 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

h-Index	*h(fl)*-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 Manifold

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 reults 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, Hodorogea S, Grant M, Sanhueza P, Van Pratt E, Gillespie G, **Boraas C**, Weaver MA, Platais I, Bousieguez 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.

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 Womens' 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 Womens' 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 medciaion 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, Klc 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, Coplon 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

<u>Post Graduate Medical Education</u>

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, 1st 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.,	)	
PLAINTIFFS,	)	Case No. 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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KYLA EASTLING, ESQ.
ERIN KRAMER, ESQ.
VANISHA KIDUMURI
JACLYN MAFFETORE, ESQ.
SUSANNA BIRDSONG, ESQ.
CECILIA DOS SANTOS, ESQ.

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

I N D E X of the E X H I B I T S

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?

A. Yes.

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

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

A. Yes. Thank you.

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

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

A. Yes.

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

A. Yes.

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

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

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

A. Yes.

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

A. Yes.

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

A. I do not.

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

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

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

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

A. No.

And may I make sure that my phone is off?

Q. Sure.

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

about it.

It is off.

Q. Are you ready?

A. Yes, I am. Thank you.

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

A. Yes, I have.

Q. How many times?

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

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

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

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

A. As a fact witness.

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

A. It did not.

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

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

Q. Sure.

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

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

Q. Have you testified in any court before?

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

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

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

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

A. Yes.

Q. Could you describe that case to me.

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

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

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

A. Yes, I have.

Q. Could you describe that testimony, please.

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

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

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

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

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

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

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

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

Q. What do you remember about that case?

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

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

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

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

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

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

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

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

A. That is correct.

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

A. Are you asking about my personal testimony?

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

describe the bills that you testified on in Colorado.

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

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

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

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

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

Q. Okay. Thank you for that.

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

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

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

Q. What was the general gist of your testimony?

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

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

MR. BOYLE: Object to form.

THE WITNESS: I did not.

BY MS. SALVADOR:

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

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

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

MR. BOYLE: Object to form.

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

BY MS. SALVADOR:

Q. Is that practice of prescribing progesterone

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

MR. BOYLE: Objection.

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

BY MS. SALVADOR:

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

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

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

MR. BOYLE: Objection.

THE WITNESS: Can you repeat the question, please.

BY MS. SALVADOR:

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

MR. BOYLE: Objection.

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

BY MS. SALVADOR:

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

MR. BOYLE: Object to the form.

THE WITNESS: Could you please repeat the question.

BY MS. SALVADOR:

Q. Sure.

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

A. Yes, that is correct.

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

MR. BOYLE: Object to form.

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

BY MS. SALVADOR:

Q. Thanks for that.

You also said that you testified on a bill in

Colorado regarding insurance coverage of abortion; is that right?

A. Yes.

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

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

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

MR. BOYLE: Object to form.

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

BY MS. SALVADOR:

Q. Sure.

Do you recall whether you supported that bill?

MR. BOYLE: Object to form.

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

BY MS. SALVADOR:

Q. Did you oppose that bill?

MR. BOYLE: Object to form.

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

BY MS. SALVADOR:

Q. Was your testimony opposing that bill?

MR. BOYLE: Object to form.

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

BY MS. SALVADOR:

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

A. It was approximately November of 2023.

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

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

Q. Who have you communicated with regarding this case?

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

With that instruction, you can answer.

THE WITNESS: Thank you.

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

Lorence, and this morning I spoke with Ellis Boyle.

BY MS. SALVADOR:

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

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

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

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

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

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

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

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

A. My agreement was $250 an hour.

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

A. Yes.

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

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

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

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

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

A. No, I did not.

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

A. Specifically for today's deposition?

Q. Yes.

A. I didn't do anything else specific for

today's deposition. No, the time preparing.

Q. Thank you.

(Exhibit 1 Marked for Identification.)

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

BY MS. SALVADOR:

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

A. We are working on it.

Yes.

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

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

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

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

A. I am checking.

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

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

A. I am scrolling.

It appears accurate.

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

A. I did not hear your question.

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

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

With that instruction, you can answer.

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

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

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

BY MS. SALVADOR:

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

your report in their entirety?

A. Yes, I have.

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

A. No, I did not.

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

A. No, I have not.

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

A. I have not.

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

A. Yes, I did.

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

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

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

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

Q. Did you read the reports that Dr. Borast

submitted in this case in their entirety?

A. Repeat the question, please.

Q. Sure.

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

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

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

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

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

A. I did not have access to that report.

Q. Got it. Thank you.

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

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

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

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

A. I have edited it since submitting this report.

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

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

Q. What was the edit that you made?

A. I have added that I am now on the board of the American Association of Prolife OB/GYNS. That occurred approximately mid-December.

Q. Got it. Thank you.

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

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

MS. SALVADOR: Got it. Thanks.

BY MS. SALVADOR:

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

is that correct?

A. That is correct.

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

A. That is correct.

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

A. That is correct.

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

A. Yes, that is correct.

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

A. That's correct.

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

A. Define "abortion."

Q. How would you define an abortion?

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

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

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

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

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

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

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

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

MR. BOYLE: Object to form.

THE WITNESS: Could you please repeat the question.

BY MS. SALVADOR:

Q. Sure.

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

A. Yes.

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

A. That is correct.

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

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

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

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

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

experience is that's how it was.

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

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

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

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

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

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

Q. Were you trained to provide nonelective

abortions in the first trimester?

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

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

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

Q. Sure.

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

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

MR. BOYLE: Object to form.

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

BY MS. SALVADOR:

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

A. I don't recall any other degrees.

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

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

Q. Sure.

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

Q. Do you have any nonmedical fellowships?

A. I do.

Q. What are those?

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

I am a Colson fellow.

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

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

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

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

Q. Could you describe that fellowship in world view.

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

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

A. It is one of the focuses.

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

A. Well, we learned across all of the religions.

The organization is a Christian organization

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

Q. When did you complete this Colson fellowship?

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

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

A. Yes.

Q. Could you describe those abortion-related contents, please.

A. I can't on the top of my head explain them.

Q. Could you describe generally the abortion-related topics that were covered?

A. I am not sure how to answer that.

We looked at -- we looked at the different world views and the different thoughts on abortion.

Q. Do you recall anything about the different thoughts on abortion that you looked at in that fellowship?

A. I didn't review all of that in preparing for this.

Q. I understand. But do you recall anything about the contents of abortion that you looked at in that fellowship?

MR. BOYLE: Object to form.

THE WITNESS: Well, it's hard for me to separate out my own personal reading from what I learned and from my experience and what I've thought about. So I can't tell you what I can attribute to learning in that because, again, I didn't review the actual course materials before I came in here.

BY MS. SALVADOR:

Q. Were there specific lessons in that fellowship that focused on abortion?

A. There were.

Q. What, if anything, do you recall about those lessons on abortion?

A. Okay. Thank you. I remember the logical thinking through what abortion is and what happens in abortion, which I could relate to since I had done them, and looking at the science of life and the philosophy of life.

Q. After you completed your residency, did you work as an ob-gyn?

A. Yes, I did.

Q. Was one of the places you worked as an ob-gyn at the Millcreek Women's Center?

A. Yes.

Q. How long did you work at Millcreek Women's

Center?

A. I worked there from 1991 until approximately 2008.

Q. What were your duties at Millcreek Women's Center?

A. I was a general ob-gyn physician, which involves seeing patients, helping patients in the office, providing surgeries, and then providing obstetrics.

I was also one of the managing partners, so I helped with development of the business, hiring, firing, protocols, business management, those types of things.

Q. You mentioned performing surgeries. What types of surgeries did you perform in your time at Millcreek Women's Center?

A. In general, I provided the surgeries that you do for gynecology. So examples would be things like cone biopsies, oscopies and biopsies, laparoscopies, laparoscopic tubal ligations, D&Cs, D&Es, hysterectomies, hysteroscopy, those types of procedures, in addition to cesarean sections. Those are examples.

Q. Did all of those surgeries you just mentioned take place in hospital settings?

A. They took place in the hospital operating room. They took place in the ambulatory surgical center, which St. Mark's eventually had two. They also -- I did sometimes do hysteroscopies and I also did colposcopy biopsy and LEEP procedures in my office.

Those are the ones that I recall doing in the office.

Q. Just to clarify, you said that you performed hysteroscopies and colposcopy biopsies in your office; is that correct?

A. A few. I primarily did them -- colposcopies and biopsies I did in my office. I did a small number of hysteroscopies at the end of my practice in the office. The majority of them I performed in the ambulatory surgery center.

Q. Did you perform any other types of surgical procedures in your office?

A. If we're talking about "surgery" being suturing and things like that, no. I would have -- those are under surgical codes, so those I may have done in my office. Certain biopsies I may have done in my office. Those would also be under surgical codes.

As far as what I recall, the major procedural surgeries I did were the colposcopy biopsy, LEEP, and then a small number of hysteroscopies are the only ones

I can recall doing in my office.

Q. You mentioned St. Mark's Hospital. Were you also on the medical staff at St. Mark's Hospital?

A. Yes, I was.

Q. Were St. Mark's Outpatient Surgical Center and the St. Mark's Hospital Surgery Center your primary outpatient surgical center?

A. I'm sorry. Repeat the question.

Q. Sure.

Your report refers to work at St. Mark's Outpatient Surgical Center and St. Mark's Hospital Surgery Center. Were those your primary outpatient surgical centers?

A. There was an additional surgery center that -- I don't remember the year it opened, but it was maybe two blocks from the hospital. It was a short distance.

The hospital was on 39th. The surgery center was on 45th, and so it was literally down the road a few blocks. It might have been more than two blocks. It was a few blocks down the road.

So those were -- during that time, those were primarily where I went. I would have very rarely gone to the University of Utah. Perhaps if I had a patient I had to transfer.

And I'm trying to consider was there anywhere else I went. I don't recall doing surgeries at Cottonwood Hospital, which I don't even know if it's open anymore. I remember going there for some obstetrical patients. Some of my partners had privileges there.

I don't recall going there for surgeries unless -- I don't recall going there for surgeries, but initially I did sometimes go there for obstetrics is what I'm recalling. It was very rare.

I don't recall going to other hospitals, again, except I might have gone to the University of Utah for an occasional patient that needed to be at a higher acuity center.

Q. Got it. Thank you for that.

So in your report you state that early in your time at Millcreek Women's Center you provided second-trimester abortions for established patients who requested induced abortion for fetuses with genetic syndromes and severe fetal anomalies; is that right?

A. Let me ask you -- repeat it one more time. I want to make sure I hear exactly what you're saying.

Q. Sure.

Let's go to paragraph 3 of your report.

A. Okay.

Q. Let me know when you're there.

A. I am at paragraph 3.

Q. In paragraph 3, there's a sentence that states: "Early in my private practice I performed second-trimester abortions for my established patients who requested induced abortions for fetuses with genetic syndromes and severe fetal anomalies"; is that correct?

A. That is correct if they specifically asked me to do it. There was a major center in Salt Lake who did them, but if they specifically asked me to be the one to do them, that is correct.

Q. About how many second-trimester abortions did you provide in your time at Millcreek Women's Center?

A. I don't recall.

Q. Would you say it was more than one a year?

A. I don't recall.

Q. Would you say you remember -- would you say it was rare for you to perform an abortion?

A. It depends on your definition of "rare." I would say it was infrequent, at least.

Q. What do you mean by "infrequent"?

A. Well, I did not do them frequently.

Q. About how often would you say you did them?

A. I don't recall. It was a typical ob-gyn

practice, so -- it would not have been a large number.

Q. How many years did you work at Millcreek Women's Center?

A. From 1991 to approximately 2008.

Q. Did you perform more than one abortion during that time period?

A. Yes, I did.

Q. Would you say you performed 10 abortions during that time period?

A. I don't recall.

Q. Do you recall -- over the course of -- sorry.

Over the course of your career, have you ever provided an abortion outside of second-trimester abortions for the indication of fetuses with genetic syndromes and severe fetal anomalies?

A. Yes.

Q. What were the other circumstances in which you performed abortions?

A. I performed one first-trimester abortion electively.

Q. At what point in your career did you perform that first-trimester abortion electively?

A. Somewhere in the early years of my private practice.

Q. So was that during your time at Millcreek

Women's Center?

A. Yes.

Q. Was that the only first-trimester abortion that you performed electively?

A. It is the only one I recall.

Q. Do you recall the method that you used for performing that abortion?

A. Yes. I used a D&C, a dilation and curettage with suction.

Q. Do you recall where you performed that abortion?

A. Yes, I do. I was at the St. Mark's Ambulatory Surgical Center.

Q. Were you able to perform that abortion safely?

A. Yes, I did.

Q. So going back to the second-trimester abortions that you provided during your time at Millcreek, were all of those abortions dilation and evacuation procedures?

A. My recollection is that they were all dilation and evacuation.

Q. Could you briefly describe the procedure you're referring to when you say "dilation and evacuation."

A. I can describe typically. I don't remember the specifics of these cases.

But typically my practice would have been to have the patient come in the day before. Of course, after informed consent and discussion of her options, I would have had her come in the day prior to her procedure. I would have placed laminaria in her cervix. I would have had her come in for her surgery the following day.

And generally, these would have been done -- I don't recall exactly how they -- what the anesthesiologist did for each one, but typically they would have been either under sedation or general, and I don't recall which one was done for each of them.

Then I would have -- she would have had her laminaria removed. Certain precautions would have been done. I would have been gowned and gloved. Usually the assistant would have the patient at that point in stirrups and have done the prep.

I would have grasped her cervix with something like an Allis clamp. Again, I don't -- I can't tell you the specifics of one, but that would have been typical for me.

I would have assessed for dilation. I would have performed an exam to assess. Usually I would have

done that prior to her being prepped once she was either sedated or asleep. Then I would have dilated it further if necessary with the hope not to have to dilate it further. If necessary, I would have.

I would have ruptured her membranes with an instrument, placed a suction, and then used a combination of grasping forceps, typically Sopher Ovum and the ring forcep, and then using suction to remove all the parts.

The baby's parts would have been handed to my assistant to gather on the table for me to exam. Once I was -- I generally had an ultrasound there. It would have been my typical practice to have an ultrasound so I could watch the direction of my instruments and primarily for grasping the fetal head.

And once I was comfortable that all the major parts of the baby had been accounted for, then I would have used primarily suction to remove the placenta, and then use a curette to gently palpate throughout the cavity to make sure that there was what's called a uterine cry, that burning feel of the mutual cap when all the placenta has been removed.

The ultrasound tech would have assessed the endometrial cavity for me to be sure there did not appear to be any retained products. Instruments would

have been removed and counted. I would examine the remains of the baby. And that would be a completed procedure.

Q. Thank you. That's really helpful.

You said that you typically used ultrasound guidance when providing D&Es. Did you always use ultrasound guidance when providing D&Es?

A. I don't -- I can't tell you that I did a hundred percent of the time. It would have been my typical practice.

Q. Is it your opinion that D&Es can ever be safely performed without ultrasound guidance?

A. My expert opinion is that an ultrasound helps to avoid some of the major complications of a D&E.

Q. I understand. That's not the question I asked, though.

Is it your opinion that D&Es can ever safely be performed without ultrasound guidance?

A. Again, my opinion is that an ultrasound decreases the major complications.

Q. So you would say that an ultrasound -- that a D&E can never be safely performed without ultrasound guidance?

A. I did not say that. My job as a physician is to minimize the risk of the procedure that I'm

performing, because all procedures and medications carry risk. So my job is to do things in a way that minimizes risk.

Q. Would you say that when you were at Millcreek you performed one D&E a month?

I'm sorry. I couldn't hear you.

A. I don't recall how often I performed them. It was -- again, it was not a common part of my practice.

Q. What is the earliest gestational age at which you performed a D&E?

A. I don't recall the earliest.

Q. At what gestational ages would you typically perform a D&E?

A. Typically it would be somewhere around 13 to 14 weeks.

Q. Up to what gestational age did you perform a D&E?

A. I don't recall the exact gestational age, but somewhere between 16 and 18 weeks would be typically when I do them up until.

Q. Did you ever perform a D&E at 18 weeks?

A. I don't recall the oldest gestational age that I did them.

Q. At what gestational age do providers

typically start performing D&Es?

A. In the literature, typically at 13 to 14 weeks.

Q. In your experience, at what gestational age do most providers start performing D&Es?

A. I can't answer for most providers. I can tell you from the literature and typical training is 13 to 14 weeks.

Q. Would that be 13 to 14 weeks post-fertilization or -- would that be from 13 to 14 weeks post-fertilization?

A. This would be menstrual dating, is typically what we would do in obstetrics.

Q. Are you referring to the first day of the patient's last menstrual period?

A. Yes, I am.

Q. I might use the phrase "LMP" to describe that. Is that okay?

A. Yes.

Q. Was your -- so you mentioned that typically providers start performing D&Es at 13 to 14 weeks. Was that your opinion prior to your participation in this case?

A. Actually, I didn't say that.

Q. Sure. Can you clarify what you said, then.

A. I said that I don't know when most -- I can't answer for most providers, but typically the literature and in training it's 13 to 14 weeks.

Q. Was that your understanding from the literature before you started participating in this case?

A. Was what? Can you please explain.

Q. Sure.

Did you have an understanding based on literature that providers start performing D&Es at 13 to 14 weeks? Did you have that understanding prior to your participation in this case?

A. I can't say what providers do, but my understanding prior to this case from my training and from my experience is that typically D&E procedures are -- for induced indication would be performed, again, based on literature and training, somewhere around 13 to 14 weeks.

Q. Did all of the D&Es you performed take place in hospital settings?

A. The D&Es I performed would have been at the University of Utah in the main OR hospital. The ones in St. Mark's, the ambulatory surgical center was actually in the hospital, so it was part of the hospital unit.

So my recollection -- I don't have clear recollections of where I was, but it was an unusual situation in that actually the surgical center was in the hospital complex.

Does that make sense? It was just downstairs, and the operating room was upstairs, the main OR.

Q. Would it be fair to say --

MR. BOYLE: We've been going for about an hour, so -- I don't want to cut you off if you're in mid sort of thought, but if we could take a break soon, that would be great. Thank you.

MS. SALVADOR: Sure. Let me just ask one follow-up clarifying question.

MR. BOYLE: That's fine.

BY MS. SALVADOR:

Q. Would it be fair to say that St. Mark's was an ambulatory surgery center that was physically located in proximity to the hospital; is that right?

A. It was actually part of the hospital's suite. It was connected to the hospital. It was downstairs. It was the surgical center, a hallway into the emergency department, a hall away to -- and the main operating room was on the second floor. The ICU was on the second floor. Labor and delivery was a little

further on the first floor.

So it was part of the suite. I would not have done -- the 45th Street one was not part of the hospital system. I didn't do any there.

My typical practice -- again, I can't remember the exact surgeries. I don't recall. My typical practice would be to be in the main operating room. That would be my typical practice for a D&E.

MS. SALVADOR: Understood.

I think now is a good time for a break.

(Off the record 12:10 p.m. to 12:23 p.m.)

BY MS. SALVADOR:

Q. We were talking, Dr. Wheeler, about your experience performing D&Es.

Did you ever perform D&Es for management of intrauterine fetal demise?

A. Yes.

Q. At what gestational ages?

A. I don't recall the gestational ages.

Q. Typically -- do you recall any of the D&Es for management of intrauterine fetal demise?

A. As far as specifics, I don't remember specific, like, who the patient was. I can remember doing them.

Q. Do you remember about how frequently you

would perform D&Es for management of intrauterine fetal demise?

A. I don't recall how often.

Q. Would you say that it was more than one a year?

A. I don't recall if it was more than that or not at the time.

Q. And would you say that it was -- would you say that you performed one every week?

A. I don't know. It was a typical ob-gyn practice, so that's -- those don't come up regularly. They come up -- thank God they come up infrequently.

Q. What do you mean by "infrequently"?

A. They're just -- they're not common. Thank goodness, they're not common.

Q. Would you say that you've performed more than a handful of D&Es for management of intrauterine fetal demise?

A. I can't conjecture. I have memories of doing them. I don't know how many I did.

Q. So you said you did more than one; is that right?

A. Yes.

Q. And you said it was less frequent than one a week; is that right?

A. Yes.

Q. Could you ballpark for me about how many per year you would do?

A. I don't recall. I would have done them for my own patients. If I was on call, I would have done them on call. If somebody came in or one of my partners, I would have done them at the University of Utah. So -- but I don't have -- I can't recall how many I did.

Q. Would you say you did one at each of those locations every year?

A. I can't tell you that. I don't recall how many I did.

Q. Have you ever done a D&E for intrauterine fetal demise prior to 20 weeks LMP?

A. Have I ever done a D&E for fetal demise prior to 20 weeks? Yes, I have.

Q. Could you describe -- about how many -- well, you said you've done -- have you done more than one D&E for intrauterine fetal demise prior to 20 weeks LMP?

A. Yes.

MR. BOYLE: Object to form.

BY MS. SALVADOR:

Q. About -- about how many D&Es prior to 20 weeks for intrauterine fetal demise have you done?

A. I don't recall.

Q. Have you done more than two?

A. Yes.

Q. At what gestational ages LMP would you perform D&Es for intrauterine fetal demise?

A. Part of that would depend on the size of the baby, because they may have been demised for quite a while.

So at this time the baby would be about the size when I thought that I would need to dismember the baby is when I would need to do a D&E. That would become a different procedure when the baby was big enough to need dismemberment to remove the baby.

Q. Could you repeat that last sentence, please. I'm sorry. I couldn't quite hear you.

A. Yes.

The D&E decision would be based on the baby's size. So if the baby was large enough to need dismemberment -- in other words, to grasp parts and remove them to get the baby delivered out of the cervix -- that's when we would make the decision based on the fetal size.

Q. At what point in gestation would a D&E be required, in your experience?

A. With a living baby growing normally,

approximately 13 to 14 weeks.

Q. And did you ever perform D&Es either for abortion or for intrauterine fetal demise at 13 to 14 weeks?

A. That's a compound question. What is your question?

Q. Did you ever perform D&Es at 13 to 14 weeks' gestation for your patients?

A. Yes, I did.

Q. Were any of those D&Es for intrauterine fetal demise at 13 to 14 weeks?

A. Again, I don't remember the exact gestational age of my patients, but I remember performing D&Es, but I can't remember the exact gestational ages.

Q. So you've said that you remember performing D&Es at approximately 13 to 14 weeks for your patients; is that right?

A. At beyond 13 to 14 weeks. I don't remember the exact gestational ages of the patients.

Q. Okay. But you do remember performing D&Es for some of your patients beyond 13 to 14 weeks; is that right?

A. Whether -- I don't recall if they were my specific patients, meaning from my practice, but -- although they were my patients once I took care of

them, weren't they?

So yes, beyond 13 to 14 weeks, I do remember doing, but I don't remember the exact ages.

Q. Sure.

But do you remember performing D&Es prior to 20 weeks?

A. Yes, I do.

Q. So it's fair to say that you performed at least some D&Es between 13 weeks and before 20 weeks; is that correct?

A. That is correct.

Q. Were those D&Es for both intrauterine fetal demise and for abortion?

A. Well, they would have been for one indication or the other.

Q. Do you recall that you performed D&Es for intrauterine fetal demise between 13 weeks and 20 weeks?

A. Fetal demise, yes.

Q. Do you recall that you performed D&Es for abortion purposes between 13 weeks and 20 weeks?

A. Yes, I do.

Q. Would you say that you performed more of those D&Es for intrauterine fetal demise or for abortion, or was it about equal?

A. I don't recall that.

Q. When you performed D&Es for induced abortion, were those ever in an ambulatory surgical center?

A. Again, I don't recall. I do know I didn't do any of them outside of the hospital complex. As I described, St. Mark's Ambulatory Surgical Center was actually a part of the hospital complex.

Q. Would you say that you performed any D&Es for -- would you say that you performed any D&Es in the St. Mark's Ambulatory Surgical Center?

A. I don't recall performing any there. I don't recall performing any there.

Q. Do you ever perform D&Es in a hospital operating room?

A. Yes.

Q. Did you perform D&Es for induced abortion purposes in a hospital operating room?

A. Yes.

Q. Did you perform D&Es for management of intrauterine fetal demise in a hospital operating room?

A. I don't have specific memories of where I was during the D&Es.

Q. So is it possible that some took place in the St. Mark's Ambulatory Surgical Center?

A. I don't recall doing any of them there.

The only one I recall doing there was the D&C, the first-trimester D&C induced abortion. That's the only one I have a distinct memory of being there.

Q. What proportion of your practice while you were working at Millcreek would you say were surgeries?

A. I guess you'd have to define "proportion of practice."

I had -- every week I had time in the operating room. That's the best I can answer that.

Q. About how much time in the operating room would you have every week?

MR. BOYLE: Object to form.

THE WITNESS: I can't really answer that. We had set operating room days that we shared with a partner, so I was either there doing my own surgeries or assisting my partner with a surgery.

BY MS. SALVADOR:

Q. So you've said you had time in the operating room every week; is that right?

A. Well, either as the primary surgeon or as the primary assistant. We had main operating time, and we had separate ambulatory surgery time.

Q. Were you in the operating room as the primary surgeon every week?

A. I don't know if every single week if I was.

The --

Q. So you said -- sorry.

A. I apologize.

We had block time. So we had the OR available. If we didn't have a patient to operate on, then we could release our block time, or actually, they would take our block time if we didn't have a person scheduled at a certain period of time.

Q. Would you say it was common for them to take your block time?

MR. BOYLE: Objection.

You can answer.

THE WITNESS: I don't remember all of the details of that.

BY MS. SALVADOR:

Q. Would you say that it was common for you to use your block time for surgery?

A. It was common between the two of us. Usually it was two of us sharing an operating block, and it was common for us to be operating.

Q. And you said that it was infrequent that a patient you were caring for needed a D&E; is that right?

A. I'm not sure of the form of your question. Can you please repeat it.

Q. Sure.

Before, we were talking about how often you performed D&Es, and you said that it was infrequent; is that right?

A. It was infrequent, yes.

Q. And you've also said that you had blocked time in the operating room every week; is that right?

A. In most of my practice with -- together with my partner, we would have had block time most of the time every week.

Q. And you've also said that you performed D&Es for abortion purposes and for management of intrauterine fetal demise; is that right?

A. That's correct.

Q. When you're thinking back on your cases, about how many D&Es do you consciously remember performing?

A. I can't give you a number. I can't recollect a number.

Q. What would you say was the most frequent surgery that you performed during your time at Millcreek and St. Mark's?

A. I don't want to conjecture. I'd have to look at my case series. I can't recall the most frequent one.

Q. Sure.

What were some surgeries that you performed frequently during your time at Millcreek and St. Mark's?

A. Frequently would have been things like cesarean sections, hysteroscopy, hysterectomy, primarily vaginal. Those would be among the more common. The D&Cs with the hysteroscopy, those would be -- laparoscopy. Those would be some of the most common surgeries we would have done.

Q. When you say "most common," what do you mean by that?

A. Frequent.

Q. Would you say more than once a month?

A. You know, I don't want to overstate, so I can't accurately answer that without looking at my case series.

Q. Would you say that you performed a C-section more than a few times a year?

A. Yes.

Q. Would you say that you performed a D&C more than a few times a year?

A. Yes.

Q. Would you say that you performed more than 10 C-sections a year?

A. Yes. When I was practicing obstetrics, yes.

Q. Would you say that you performed more than 10 D&Cs a year when you were practicing obstetrics?

A. Again, I don't want to conjecture. It was one of the more frequent -- it was a common gynecological procedure. I don't have the numbers that I can tell you.

Q. Got it. But you did say just now that you performed more than 10 C-sections a year; is that right?

A. When I was practicing obstetrics, yes.

Q. Was it fair to say -- would it be fair to say that you performed more C-sections than D&Cs when you were practicing obstetrics?

A. I don't want to answer in "most likelies," because I don't have those numbers in front of me. So I can't tell you.

In a typical ob-gyn practice, that would be true. I just don't have the numbers in front of me to be specific under oath.

Q. Well, would you say that you performed a C-section every week when you were practicing obstetrics?

A. I can't tell you if I practiced -- if I did one every week.

Q. I'm not saying for certain.

Would it be fair to say that you performed approximately one C-section a week when you were practicing obstetrics?

A. And again, I don't want to overstate or understate. I performed a lot of C-sections. That's all I can say.

Q. Is it fair to say that you performed many more C-sections than you did D&Es when you were practicing obstetrics?

A. Yes, that would be correct.

Q. Going back to those D&Es, were all of them performed with the patient under general anesthesia?

A. I don't have exact recollection of that.

Q. Do you recall any D&Es you've performed when the patient was not under general anesthesia?

A. I don't have specific recollection of that.

Q. So you don't recall any abortion -- I'm sorry. You don't recall any D&E that was performed without -- sorry.

You don't recall any D&E that you performed without the patient being under general anesthesia; is that correct?

A. I don't recall specifics of the anesthesia. I can tell you what typically we would have done, but I

can't tell you what I did for each of the patients.

Q. What typically would you have done for your D&E patients?

A. Typically it would be the anesthesiologist making a recommendation, and typically they would want to control the airway and do general controlling the airway. They may have also done sedation. One of those two would have been discussed based on a lot of factors.

Q. When you refer to controlling the airway, are you referring to intubation?

A. Correct. Most of the time that's what they would be considering, the ease of how easy it would be to intubate if necessary, whether they needed to control the airway prior to starting. Those are discussions we would have had.

Q. So we were just discussing before that you reviewed the literature for your statement that providers start performing D&E around 13 to 14 weeks LMP; is that right?

A. I evaluated the literature and selected relevant references to review.

Q. So you evaluated the literature and concluded that providers start performing D&Es around 13 to 14 weeks LMP; is that right?

A. Based on my experience and the relevant research and the American College of OB-GYN, Dr. Warren Hern, who is an abortionist, yes, I reviewed all of those, and typically the literature states 13 to 14 weeks depending on the baby's size.

Q. Is there any other -- I'm sorry.

A. Go ahead.

Q. Is there any other literature that you recall reviewing for your statement that D&Es start at 13 to 14 weeks LMP depending on the fetus's size?

A. I referenced in there the ones that I have specific references, so you can see those in my report.

Q. When did you stop performing D&Es?

A. I don't remember exactly.

Q. Was it when you were at Millcreek?

A. Yes, I was at Millcreek.

Q. So you have not performed a D&E after leaving Millcreek; is that right?

A. I don't recall when I was at the University of Utah for four years I was involved in any of the resident cases. I can't tell you. I don't recall being involved. It's possible, because I covered residents, but I don't recall any during that time.

Q. Have you performed an induced abortion by any other method since you stopped performing D&Es?

A. No, I have not.

Q. Did you provide -- you referred to one D&C that you provided during your time at Millcreek Women's Center for abortion purposes; is that right?

A. That's correct.

Q. Did you provide any other first-trimester abortions during your time at Millcreek Women's Center?

A. I did not.

Q. In your -- have you ever performed a medication abortion?

A. I have not.

Q. What made you stop performing D&Es?

A. D&Es?

Q. Yes.

A. Well, I made a decision to quit performing abortions.

Q. Do you remember when you made that decision to quit performing abortions?

A. Yes. During a D&C that I did. I don't remember the year.

Q. But it was during your time at Millcreek; is that right?

A. That's correct.

Q. Would you say it was toward the beginning of your time at Millcreek?

A. It was sometime in the earlier years, yes. I can't remember the exact date.

Q. So you referred to the University of Utah. You were also an associate professor at the University of Utah School of Medicine's obstetrics and gynecology department; is that right?

A. In the specific years listed, yes.

Q. What years were those?

A. I don't have the report anymore.

(Whereupon, there was an off-the-record discussion between witness and counsel.)

THE WITNESS: From 2008 to 2012.

BY MS. SALVADOR:

Q. What did your role as an associate professor entail?

A. Primarily I was recruited to develop a midlife women's health clinic which was multidisciplinary. As part of my role there, I also was integrally involved with students and residents, and sometimes fellows and the remainder of the staff.

So I did have some on-call duties. Primarily I had a gynecology clinic that I personally performed plus developing this -- and then implementing this midlife women's health clinic.

I also developed some teaching curricula for

the ob-gyn residents about menopause and midlife health for women.

Q. Did you supervise students in hospital settings?

A. My primary role was on call. I would supervise for gynecology only if I was assigned a call on that day. Primarily -- I did do some teaching, most of it menopause and midlife, women's health related. I did some didactic lectures, most of them again midlife women's health and menopause related.

And then, of course, students and residents were often involved with the surgeries that I performed or I oversaw some of the residents for gynecology surgery.

Q. Did you -- so you referred to being on call. Was that in a hospital setting?

A. Yes. There was an outpatient surgical center. I don't have specific recollections of that, but there was an outpatient surgical center too.

Q. Did you also supervise students in that outpatient surgical center?

A. I don't -- I don't have any specific recollection of that. My recollections are in the main OR.

Q. Did you teach your students at the University

of Utah about abortion?

A. I didn't do anything related to abortion during those four years that I was there.

Q. So you never performed abortions while working at the University of Utah?

A. During my four-year tenure there, I was not involved with any abortions.

Q. While you were an associate professor at the University of Utah, you were also working as a gynecology physician in the Women's Midlife Assessment Clinic; is that right?

A. I was developing the Midlife Women's Health Clinic -- Assessment Clinic, and yes, I was exemplemented. And I was involved there as the director and as one of the gynecology professionals.

Q. Your report uses the specific term "gynecology physician." Is that the same thing as what many people call a gynecologist?

A. Yes.

Q. When -- I'm sorry. I'm trying to find the correct paragraph.

In paragraph 5 of your report -- let me know when you're there.

A. I'm there. Thank you.

Q. You state that: "While at the University of

Utah" -- and now I'm looking at the last sentence -- "I developed menopause and midlife health teaching curricula for the ob-gyn residents and provided gynecological care and surgery"; is that right?

A. Correct.

Q. What types of gynecological surgery did you perform?

A. I don't remember -- excuse me -- the specifics. I can remember doing some hysterectomies.

The other -- as far as separating out that one period of my career, I can't tell you which -- other than I do have specific recollections of hysterectomies. But it would have been whatever my gynecology patients needed that was general gynecology.

Q. Would you -- you referred to, when we were talking about your time at Millcreek, performing colposcopy biopsies; is that right?

A. Repeat that, please.

Q. When we were talking about your time at Millcreek, you referred to performing colposcopy biopsies; is that right?

I'm sorry. I can't hear you.

A. Oh, I'm sorry. Yes, I did perform colposcopy biopsies.

Q. Do you remember if you performed any

colposcopy biopsies while you were at the University of Utah?

I'm sorry?

A. I'm considering. I'm trying to remember details from that time.

I don't remember the specific details. It's a normal part of gynecology practice, but I don't remember specific patients during that time.

Q. When you performed hysterectomies, where would those take place?

MR. BOYLE: Object to form.

THE WITNESS: Would you ask the question again, please.

BY MS. SALVADOR:

Q. Sure.

When you performed hysterectomies, in what setting would those take place?

MR. BOYLE: Object to form.

THE WITNESS: When I performed hysterectomies, I would have been in a main operating room -- in a general operating room in a hospital.

BY MS. SALVADOR:

Q. When you would perform a colposcopy biopsy, when would that typically take place? I'm sorry. Where would that typically case place?

MR. BOYLE: Object to form.

THE WITNESS: Colposcopy biopsies, most of the time I would have performed them in an office setting.

BY MS. SALVADOR:

Q. Could you describe what a colposcopy biopsy is.

A. Colposcopy, you're putting acetic acid on the cervix, which dehydrates tissues, makes potential abnormalities become more visible under a microscope called a colposcope.

And then you're taking appropriate biopsies for suspicious areas of the cervix to send to pathology for pathological diagnosis.

Q. And could you describe the process of taking a biopsy.

A. Please repeat that.

Q. Could you describe the process of taking a biopsy.

A. Which type of biopsy are you referring to?

Q. A colposcopy biopsy.

So you were describing a colposcopy biopsy, and you said as one step you would perform the biopsy. So could you go into more detail about the biopsy piece, please.

A. So biopsy, you have a long instrument with a sharp-edged little, tiny round end that you take a pinch -- a very tiny pinch of tissue. That gets collected to be sent to pathology. You mark on the chart where you took the biopsy from.

Q. Could you describe the risks of a colposcopy biopsy.

A. Well, this is outside of what I was asked to give an opinion on.

Q. I understand. I'm asking about your general medical expertise. So could you answer the question, please.

A. Yes. The general risks are incredibly minimal. Because you're taking a piece of tissue, there would be a small chance of some bleeding, so you do have silver nitrate or suture available for that.

There would be a very minimal risk for infection. I don't recall ever seeing that. And those would be the minimal risks.

Q. Would there also be a risk of cervical laceration with a colposcopy biopsy?

A. That would be incredibly unusual. I'm trying to figure out why that would occur. That would be unusual.

You could -- let's see. Could it ever

happen? I suppose it could happen if you had to hold on to the cervix with something, but that would be incredibly unusual. We would put a stitch in it to tack that up.

Q. Could you repeat that last phrase. You said you would put a stent?

A. Stitch. If you had -- if you had to hold on to the cervix with something and you got a small laceration, you've got a silver nitrate stick that would cauterize it, or you could put a stitch in it if you have to, a suture.

Q. If you had that scenario where you needed to put in a suture, would you be able to do that in the office setting?

MR. BOYLE: Object to form.

THE WITNESS: Yes.

BY MS. SALVADOR:

Q. You also mentioned when we were talking about your time at Millcreek that you would perform hysteroscopies; is that correct?

A. I performed a small number of hysteroscopies, yes.

Q. And would you -- did you also perform hysteroscopies during your time at the University of Utah?

A. I don't have specific recollections. That's a normal part of a gynecology practice, but I can't tell you which places I performed them.

Q. What is a hysteroscopy?

A. A hysteroscopy is a scope that you place through the vagina through the cervix into the uterine cavity, so it's a method of visualizing the uterine cavity.

Q. Would you typically perform a hysteroscopy in an office setting?

A. It depends on the patient's specific situation.

Q. Would you ever perform a hysteroscopy in an office setting?

A. I performed a relatively small number towards the end of my practice. We had a hysteroscopy setup at HCA St. Mark's Gynecology. So I had the availability, and I did do some.

Q. What are the risks of performing a hysteroscopy?

A. Hysteroscopy risk is incredibly minimal. It is a very small risk of infection, of bleeding. I don't recall having a complication of either of those.

Anytime you place an instrument into the uterine cavity through the cervix, there is a small

risk of perforation of the uterus. There is -- those are the very small risks of hysteroscopy.

Q. In your work -- in your work at the University of Utah, you said you never performed abortions; is that correct?

A. That's not correct.

Q. Okay. In your work at the University of Utah from 2008 to 2012, you said that you never performed abortions; is that correct?

A. Induced abortions, no, I did not.

Q. Did you perform any noninduced abortions at the time -- while you were at the University of Utah from 2008 to 2012?

A. Define "abortion."

Q. How would you define "abortion" in this context?

MR. BOYLE: Object to form.

THE WITNESS: I always define "induced abortion" as an intervention that the goal is to not deliver a living fetus or baby.

BY MS. SALVADOR:

Q. So in your time at the University of Utah, I think we've been referring to your practice as primarily gynecological; is that correct?

A. That is correct.

Q. Did you perform any obstetric work during your time at the University of Utah?

A. My practice was limited to gynecology. And I didn't have any liability coverage for obstetrics, so no, I did not.

Q. Okay. After you left the University of Utah School of Medicine, where -- did you also work at St. Mark's HCA MountainStar from 2012 to 2015?

A. Yes, I did.

Q. What did your work there entail?

A. It was a newly developed or developing gynecology clinic, so it was beginning that practice with initially one other physician, and it was providing gynecology services to women and gynecological procedures, general gynecology procedures.

Q. Did you perform any obstetrics work during your time at St. Mark's Gynecology/HCA MountainStar?

A. I did not.

Q. So you've testified that some of your work as an ob-gyn involved hospital practice; is that right?

A. Define "hospital practice."

Q. Performing procedures in a hospital.

A. Yes, that's correct.

Q. Was any of that hospital work you did for

patients who had presented to the emergency room?

A. Yes.

Q. Could you describe the hospital work you did for patients who had presented to the emergency room.

A. Sorry. I didn't quite hear the whole question.

Q. Sure.

Could you describe the hospital work you did for patients who had presented to the emergency room?

A. Emergency room coverage would be essentially anybody who came in with a pregnancy, obstetric, or a gynecological condition through the emergency department that the emergency department physicians needed a specialist to evaluate and either give advice or manage.

Q. And what were some of the conditions that brought those people into the emergency room?

MR. BOYLE: Objection.

THE WITNESS: Some of them that I can recall would be unregistered or people who didn't have an obstetrician in the area who had either labor, bleeding during pregnancy. It might be somebody with an ectopic pregnancy. It could be somebody with complaints of vaginal discharge. Abdominal pain. There was a concern about a gynecology problem, those types of

things.

BY MS. SALVADOR:

Q. Do you remember treating any patients who came into the ER because they were experiencing a complication from an induced abortion?

A. Yes.

Q. Do you remember about how many patients you saw who came into the ER who were experiencing a complication from an induced abortion?

A. I have specific memories of two.

Q. And this was in your time at -- was this in your time at Millcreek Women's Center?

A. Yes.

Q. Do you remember the ultimate outcome for those two cases that you remember?

A. My recollection is that one of them had -- I can't remember if it was a deep vein thrombosis or a pulmonary embolism, so a clotting abnormality.

The second one, my recollection was that it was retained tissue. It was essentially an incomplete abortion.

They were both in the second trimester.

Q. Do you recall whether those patients were safely discharged?

A. I don't have --

MR. BOYLE: Object to form.

THE WITNESS: I don't have that specific recollection.

BY MS. SALVADOR:

Q. During your time at Millcreek, about how often did you work with patients who had presented to the emergency room?

A. I don't -- I don't know how many. I don't have that specific recollection.

Q. Was working with patients who had presented to the emergency room a regular part of your practice?

A. Yes, it was.

Q. Did you have shifts where you were assigned to the emergency room?

A. Not specifically assigned to the emergency room. We had -- it would be called -- I want to be specific.

We had a rotation through the ob-gyn department when our practice was covering the emergency department for unregistered patients. In other words, patients who did not have a physician there.

Q. What was the frequency of those rotations?

A. That would be dependent on how many physicians were in the practice at the time and our specific call schedule, whether our call schedule --

also we had our own practice call schedule, and then there was the hospital for labor and delivery and gynecology ER services.

So when those two hit on the same day, whoever was on call was also covering for the emergency department or unregistered OB patients.

Q. Would you say that you would end up covering the emergency department multiple times a month?

MR. BOYLE: Object to form.

THE WITNESS: I don't have specific recollections of how often that happened. It just ended up you were the person on call and those two schedules intersected.

BY MS. SALVADOR:

Q. But you said it was a regular part of your practice; is that right?

MR. BOYLE: Object to form.

THE WITNESS: It was expected as part of our being credentialed at the hospital that we would participate when we were on call at the same time as it was required for our practice to cover.

BY MS. SALVADOR:

Q. Would you say that you covered the emergency room multiple times a year?

A. Yes.

MR. BOYLE: Object to form.

BY MS. SALVADOR:

Q. Would you say that you covered the emergency room multiple times a month?

MR. BOYLE: Object to form.

THE WITNESS: I can't recall that.

And I'll clarify. When I was no longer doing obstetrics, I was no longer part of the obstetrics rotation.

When I returned to St. Mark's as an employed physician in 2012, my contract specifically excluded me from the general gynecology rotation for the emergency department, and then I covered only my own personal patients already established in my practice who happened to present to the emergency department.

BY MS. SALVADOR:

Q. In the part of your practice when you were doing rotations through the emergency department, would you say that you saw more gynecological complications or more obstetric complications?

A. I don't have a specific recollection of that because they were separate. First trimester up to probably the age of viability, at least first trimester are seen in the emergency department.

Generally at viable ages, obstetrical

patients were transferred to the labor and delivery, not emergency department, so -- but there was overlap. It wasn't -- I mean, it varied.

Q. Got it. Thank you.

Then after your work at St. Mark's from 2012 to 2015, is there any other place where you were employed for the practice of medicine?

A. I have not been employed in the practice of medicine after 2015.

Q. So we've discussed that part of your medical practice included miscarriage management. How would you define "miscarriage management"?

A. Miscarriage management would mean that the baby, the embryo or fetus was not viable, was not alive. And so you would, depending on what gestational age, review with the patient the diagnosis, and then discuss her options and management.

Q. Did your miscarriage management practice ever involve providing patients with medication?

A. Medications?

Q. Yes.

A. I mean, medications could have been pain medications. It could have been -- so I would have probably given pain medications. I would say that I gave pain medications.

Q. Have you ever used mifepristone in your miscarriage management practice?

A. I have not.

Q. Have you ever used misoprostol in your miscarriage management practice?

A. I cannot -- I don't recall that.

Q. So you've testified that you -- that you've provided D&Cs in your career; is that right?

A. That is correct.

Q. Would you commonly give a patient misoprostol as part of performing a D&C?

A. For cervical preparation prior to the procedure, I have distinct recollections of giving misoprostol prior to D&Cs. I don't recall the indication of the D&Cs.

Q. Have you ever provided misoprostol to a patient prior to performing an D&E?

A. I don't recall that.

Q. When -- did your -- I'm sorry.

Did your miscarriage management practice ever involve providing aspiration?

MR. BOYLE: Object to form.

THE WITNESS: Define "aspiration."

BY MS. SALVADOR:

Q. How would you define "aspiration"?

MR. BOYLE: Object to form.

BY MS. SALVADOR:

Q. I'm sorry?

A. I'm considering my answer.

Aspiration is a term of different ways that we can aspirate tissue out of the endometrial cavity. So there's many different types of procedures that we can use for an aspiration. It involves using essentially a vacuum as opposed to typically a sharp instrument.

Q. So when I use the term "aspiration," I'm referring to using a manual or electric vacuum aspirator to empty a uterus. Is that okay with you?

A. Yes.

Q. So have you ever performed aspiration for a miscarriage management?

A. I have used an electrical vacuum aspirator for miscarriage management.

Q. Have you ever used aspiration to provide an elective abortion?

A. Yes. As part of a D&E, I would have used it, and in the one first-trimester D&C, I would have used aspiration.

Q. From a clinical procedure perspective, would you use aspiration any differently when you were

performing a D&E for an abortion as opposed to an intrauterine fetal demise?

A. There is a difference in simply using an instrument versus being prepared clinically for everything that I need to be for what I might encounter during that procedure. So we're talking about the difference between technical use versus the global picture of the procedure.

Q. So I'm talking about technical use. Is there a difference in the technical use of aspiration when performing a D&E for abortion as opposed to for intrauterine fetal demise?

A. The physical placement of the instrument within the uterine cavity would be similar. The ability to dilate the cervix to get that instrument in there may be extremely different.

The amount of bleeding that you encounter the minute you get that instrument in there also tends to be very different between the two procedures.

The difficulty in removing the tissue is also -- tissue -- by tissue I'm meaning the fetus and parts, and the cranium tends to be very different between the two procedures.

Q. So the first -- you referred to the difference in cervical dilation; is that right?

A. Yes.

Q. So tell me about the difference in cervical dilation between intrauterine fetal demise and abortion.

A. In general, by the time you have diagnosed that a baby has passed away in utero, there are already changes similar to the beginning of pregnancy wherein the cervix may be softer. The cervix may be partly dilated.

The internal os is going to tend to be easier to open. If you consider the cervix is meant to keep the uterine contents in and to be a protected -- a protection against infection, it tends to be very tightly closed throughout pregnancy and can be difficult to transcend with instruments.

Again, with miscarriage, some of that process -- like early labor, some of that process may have already have occurred, and there is a tendency from my experience for the dilation to be less difficult when the baby's already passed away.

Q. So for either intrauterine fetal demise or for abortion, you would need the patient's cervix to be dilated; is that right?

A. Those are two separate questions, but I'm going to answer that anytime that you enter a uterine

cavity with an instrument, there needs to be some ability to get it through the internal os, depending on the size of the instrument.

In a D&E, you've got an instrument that's a pretty good size, so universally either it's got to be dilated naturally or you're going to have to dilate it.

Q. Well, what would you use to dilate a cervix if you were performing a D&E for intrauterine fetal demise?

A. Again, this is a subjective -- I mean, this is a question you'd have to see the individual patient. Again, she may have already dilated her cervix.

Q. I'm just referring to your typical practice. So what sorts of tools would you use or medications to dilate a cervix for a D&E in the intrauterine fetal demise situation?

A. As I described earlier, typically the day before you're going to use something. I typically used laminaria in the cervix to dilate the cervix some in advance.

So that's a hypotonic agent that is going to swell and gradually dilate the cervix and soften it and efface it some. In the operating room, that's going to get removed. I'm going to assess the cervix, see if it's dilated.

If we don't have to dilate more, that reduces the risk. If it needs more dilation, then I'm going to use a dilator such as a Pratt blunt, a graduated dilator -- there's some different sizes, gradually increasing the size until it's dilated enough for me to be able to introduce the instruments that I need to.

Q. And I'm sorry. I couldn't quite hear the term for that second type of dilator. Did you call it a crab?

A. I apologize. Pratt, P-R-A-T-T.

Q. P-R-A-T-T.

A. P as in pony.

Q. Got it. Thank you.

Would you also use laminaria when you were performing D&Es for abortion purposes?

A. Yes.

Q. And would you also use the Pratt to dilate the cervix if you were performing a D&E for abortion purposes?

A. So it would depend on the operating room and what the availability is. A Pratt would be the most common one that would be available to me, the one I preferred. But there are other dilators -- metal dilators would be a good term to use.

Q. Got it. And would you also use those metal

dilators when performing a D&E for intrauterine fetal demise?

A. I would assess the cervix once I was in the operating room. I wouldn't use any dilators if the cervix was already adequately dilated. But if it was not, then I would use those dilators.

Q. Got it. So let's go back to -- let's go back to your experience with aspiration.

Did you ever provide aspiration for miscarriage management outside of the hospital setting?

A. I don't recall ever doing that. I may have -- I had a partner who did them. I don't recall actually personally doing them.

Again, I did have a partner who did them in the operating room. Of any of my partners, only one did it. He had the instruments. It is possible that I either assisted him with one or observed one. I don't recall personally ever doing one.

Q. Got it. Thank you.

MS. SALVADOR: I think this might be -- I know we haven't been going for that much longer, but I think this might actually be a good point for a break if we're wanting a lunch break.

(Off the record 1:25 p.m. to 2:02 p.m.)

BY MS. SALVADOR:

Q. So, Dr. Wheeler, I believe we were talking about aspiration.

So you've testified that you've used aspiration in the context of D&C and D&E procedures; is that right?

A. That's correct.

Q. Have you ever used aspiration without additional instrumentation to empty a uterus?

MR. BOYLE: Object to form.

THE WITNESS: I don't recall the specifics.

BY MS. SALVADOR:

Q. Okay. So you -- you testified that you've used an -- an electrical aspiration device; is that right?

A. That's correct.

Q. Okay. And you don't recall whether you've used an electrical aspiration device to empty a uterus without any other instrumentation?

A. I don't recall if I ever did.

Q. And you've stated that you have experience performing D&Cs; is that right?

A. Yes, I have.

Q. And that stands for dilation and curettage; is that right?

A. That's correct.

Q. And you've said that you've performed only one D&C for abort -- for abortion purposes; is that correct?

A. For an elective induced abortion, that's correct.

Q. Were the others all for miscarriage management?

A. My recollection is that the others were for miscarriage.

Q. So we've been using both the terms "miscarriage" and "intrauterine fetal demise," and I just want to be sure that we're using those terms clearly.

So would you say that those two terms are interchangeable?

A. The official definition of intrauterine fetal demise would be the death of an embryo typically after 20 weeks, because the definition for a miscarriage is typically the death or nonviability of the fetus or embryo prior to 20 weeks.

However, you know, the term with the patient is "your baby passed away," would still be the appropriate term of fetal demise. When you're dealing with patients, essentially the baby is nonviable even

if it's before 20 weeks.

Q. So when we were discussing your D&E practice, we sometimes used the term "intrauterine fetal demise," but can I just clarify.

When we were using that term, did you mean -- were you using the term more broadly when we were talking about your D&E practice before?

A. I'll explain. What I was discussing was that the baby had died. So the baby at that gestational age had died in utero. Officially, it would be called a late miscarriage.

Q. Got it. So going back to D&Cs, can you describe for me the process of performing a D&C.

A. A D&C would be performed by -- in the situation I would, depending on what the cervix looked like, assess for whether I needed to put laminaria in in advance.

So during the consultation with the patient, I generally would have them come in the day before their procedure, their surgery, and do an informed consent, evaluation of the patient, completely review the procedure, and then I would assess her cervix, see whether I felt like we needed to use laminaria.

In my later practice when misoprostol was more -- or Cytotec was more commonly used, there were

times when I may have instead offered her misoprostol or Cytotec instead of laminaria in the first trimester.

I'm sorry. Repeat the question.

Q. I was just asking you to walk me through the process of performing a D&C.

A. All right. So then in the operating room, again, she would either be sedated or under general depending on discussion with patient, myself, and anesthesia.

And at that point -- sometimes if she wants sedation, I'd do a paracervical block. She'd be -- of course, by then she'd be in stirrups with whatever anesthetic she decided to have. And there would be an evaluation of her cervix under anesthesia, and the nurses or I would do the prep.

I would be prepped in. I would be surgically scrubbed and dressed. I would then place usually a weighted speculum and grasp the cervix either with a tenaculum or an Allis.

And I would then evaluate for dilation. If I didn't need to dilate any more, I wouldn't. I would assess the uterine size so they knew what size of curette I would need for the procedure.

I would typically for the majority of procedures at that point place the curette and ask for

the suction to be turned on, perform the suction portion of the procedure.

I would commonly at that point, once I felt like I probably removed everything, then I would use the sharp curette and gently palpate throughout the endometrial cavity to make sure everything was out.

Sometimes I had an ultrasound there. For a miscarriage I didn't always, but a lot of times I would have the ultrasound there also to guide my instruments and be sure I've removed everything within the endometrial stripe. Remove the instruments, and that would complete the procedure.

Q. Thanks. That was very helpful. I have some follow-up questions to specific things you said.

So you referenced using laminaria. Was it your typical practice the use laminaria before performing a D&C?

A. I would assess the patient individually. As I previously described with -- did you say D&C or D&E?

Q. D&C.

A. D&C. As I described with D&E, sometimes with miscarriage the cervix is already dilated. So a lot of women -- and sometimes women wanted to be observed. Not everybody would choose the D&C, but if they did and their cervix was already adequately dilated and very

soft, I didn't always use the laminaria.

So it depends. Sometimes -- it just depended on the individual patient that I was caring for.

Q. So you just mentioned that sometimes the cervix would be partly dilated in the miscarriage scenario. Is the cervix always already partly dilated in the miscarriage scenario?

A. No.

Q. Okay. So sometimes you would have to dilate the cervix in the miscarriage scenario?

A. Sometimes. You tended to need preoperative dilation less once the baby had passed away.

As I previously explained, a lot of times there's just -- as in before or simultaneously at the end of pregnancy there's often a lot of changes in the cervix already that's happened and you may not need it.

Q. Got it.

And when you were assessing whether to -- whether you needed to use laminaria for a D&C, was the patient's gestational age a relevant factor in that assessment?

I'm sorry. Was the fetus's gestational age a relevant factor in that assessment?

MR. BOYLE: Object to form.

THE WITNESS: Okay. I'm sorry. Please say

it again.

BY MS. SALVADOR:

Q. Sure.

So you said that depending on the patient's needs, you would sometimes use laminaria to dilate the cervix in preparation for a D&C; is that right?

A. That's correct.

Q. When you were determining whether laminaria were needed, was the fetus's gestational age one of the factors in that determination?

A. It was really very individual to the patient. It came down to do I need to in this specific scenario predilate, prepare the cervix. So it really depended on the individual situation.

Q. In your experience, was the patient more likely to need laminaria if they were further along in gestation?

A. Again, it depends entirely on the situation. I don't -- I did not make that correlation for my clinical practice.

Q. Okay. Got it.

You also -- you also mentioned performing D&Cs in the OR; is that correct?

A. Yes.

Q. Did you perform all of the D&Cs that you did

in an OR?

A. Can you please describe what you mean by "OR."

Q. Were all the D -- you referred to an operating room. So were you always in an operating room when you were providing a D&C?

A. As I explained earlier, I had one partner who sometimes did aspiration and D&Cs for miscarriage. He had his own equipment in the office. So if he asked me to step in with him, especially as a male, he might have wanted a female in there.

I don't recall if I ever did one with him specifically. I don't recall actually ever doing that. So I don't recall ever personally being outside of an operating room segment -- operating room with myself performing D&C.

Q. Understood.

Was your partner who you referenced safely able to provide D&Cs in an office setting?

MR. BOYLE: Objection.

THE WITNESS: I don't know about the safely. I know that he performed them. I don't know his outcomes.

BY MS. SALVADOR:

Q. But you were comfortable partnering

professionally with a physician who performed D&Cs in the office setting; is that correct?

MR. BOYLE: Objection.

THE WITNESS: I'm not aware that that's something that I was aware of until he was actually doing some.

So that was not part of -- he was already in the practice when I joined, so I didn't have a specific -- when I became part of that practice, I was not aware of him doing those.

BY MS. SALVADOR:

Q. Did you terminate that professional association after you learned that your partner was performing D&Cs in an office setting?

MR. BOYLE: Objection.

THE WITNESS: After that he actually -- that practice separated, so I didn't terminate my relationship with him.

BY MS. SALVADOR:

Q. So you testified that as far as you can recall, you performed all of the D&Cs that you did in an operating room; is that correct?

A. Correct.

Q. Were all of your -- I want to be clear. When you refer to "operating room," are you referring

specifically to a hospital operating room?

A. That's why I asked. I just wasn't sure what you were referring to. I -- to me, an operating room could be in an ambulatory surgical center or what I call the main OR, hospital OR.

Q. Did you ever perform D&Cs in an ambulatory surgical center OR?

A. Yes, I did.

Q. You also referred to anesthesia. What did you mean when you were referring to anesthesia for your D&C patients?

A. Essentially pain management, whether they wanted sedation. An anesthesiologist was always involved in our -- in both the ambulatory care setting -- surgical center and in the main operating room.

So anesthesia was always involved in one way or another. It was the level of sedation or general that she would want was discussed, patient, myself, and anesthesia together.

Q. So did you consult an anesthesiologist for every D&C you performed?

A. Explain what you mean by "consult."

Q. I believe you just said that there was always an anesthesiologist involved when you performed D&Cs;

is that right?

A. That's right.

Q. So what do you mean by "involved"?

A. "Involved" meaning that I would meet with the patient preoperatively. If I had concerns in advance about the patient's potential anesthetic management, I would contact anesthesia in advance sometimes.

If there wasn't a specific concern, the day of surgery I would meet with the patient. They would have reviewed my H & P. They would meet with the patient. If there was questions about what the patient wanted as far as general versus sedation and local, those would be discussed essentially between the three of us.

If the anesthesiologist didn't need my input and I agreed with their approach, then they would just proceed.

Q. So it's fair to say -- or is it fair to say that every D&C patient you had spoke with an anesthesiologist at some point, whether it was in advance of their procedure or the day of their procedure?

MR. BOYLE: Object to form.

THE WITNESS: Every procedure. So I'm recollecting in residency -- as I recall, in residency

there was a suction machine in the emergency department. And I recall that because I actually had in my -- when I had my miscarriages, that's how that happened.

So there was a possibility in residency that we may have done suction D&Cs in the emergency department as residents, and if that would -- yeah, in that situation, we would not have anesthesia involved.

BY MS. SALVADOR:

Q. And I think you used the phrase "H & P." I think you said that you would review an H & P with a patient. Did I hear that correctly?

A. I would review my H & P -- I would have submitted that prior to taking the patient to the operating room.

The anesthesia would have my H & P, history and physical, to be able to get the patient's history.

Q. Okay. So "H & P" stands for history and physical?

A. Correct.

Q. Got it. Thank you.

So when you and the anesthesiologist would discuss pain management options with patients, what were the options on the table for those D&C patients?

A. So I wasn't always there with anesthesia when

they had the discussion. If there was a specific way I wanted anesthesia to go, I would discuss that with anesthesia in advance.

Otherwise, I would meet with the patient, and then usually -- seems like most of the time the anesthesiologist would come in after. Actually, sometimes they would have been there before me.

And they would present this is how I usually do this procedure. Whether -- they often had assessed the patient. If I had to do an airway, if I had to intubate, what would that look like. Am I going to have access? Do I need to control her airway for other factors?

They would have that discussion, and if I had a specific way I felt it needed to go, then I would talk to anesthesia personally.

Q. So could you describe the pain management options that were available for your D&C patients.

A. I don't know that I'm going to include all of them.

Typically they would have the option of having sedation, IV sedation, and in that situation, I generally would use a paracervical block, which is a local anesthetic to the lower cervix and -- to the cervix and lower uterus, or general anesthesia would be

the typical.

Q. And would you personally administer the paracervical block?

A. Yes.

Q. Was it unusual to -- for you to perform a D&C with a patient under general anesthesia?

A. Can you explain what you mean by "unusual"?

Q. Sure.

So you described a couple of different options. One option was IV sedation with a paracervical block, and one option was general anesthesia. Did I say that correctly?

A. Yes.

Q. In your practice, do you remember one of those methods being used more frequently than the other?

A. I don't recall one more frequent than the other for D&Cs. I just don't have specific memories to which one of those would be most common.

Q. Okay. But you do remember that both of them were used; right?

A. I don't have specific memories of that.

Q. Okay. Then -- so you told me that for your D&C patients, they would have the option of -- or the two options for them were IV sedation and paracervical

block or general anesthesia; is that correct?

A. Yes, that's correct.

Q. But you don't remember either of those actually being used?

A. I can't tell you which one of those specifically were used in the different situations.

Q. I'm just referring to your practice generally. Do you remember that both of those methods were used in your D&C practice generally?

A. It depended on the anesthesiologist, the patient. And so whichever was most appropriate for the patient and her choice, we used.

Q. Do you remember any other pain management methods being used for your patients?

A. In the operating room, I don't.

Q. So do you remember that at least some of your patients went with the general anesthesia option?

A. Again, I don't remember the specific patients, so I can't tell you that.

Q. Do you remember that any of your patients ever had a D&C under general anesthesia?

A. A D&C? Yeah, and I can't tell you -- I mean, I would like to be very clear, but I can't specifically say any of my patients chose one or the other. They were both offered. Anesthesia did what was best for

the patient.

Q. So do you remember ever performing a D&C while a patient was intubated?

A. I can't tell you specifically as to that.

Q. Okay. So you're testifying that your patients had the option of IV sedation with a paracervical block or --

A. Yes.

Q. -- or a general anesthesia?

A. Yes.

Q. But you can't recall in concrete terms either of those methods actually being used; is that -- is that correct?

A. Well, I specifically remember the sedation and paracervical block. Again, as a resident, we did that. So -- yeah, in the emergency department. So I have very specific memories of that.

And of patients in my own personal experience in the operating room, again, it would be I would give input. Primarily it was between the patient and the anesthesiologist. They were very brief procedures. I was comfortable with either one.

Q. When you say "very brief," about how long would a D&C take?

A. The actual procedure part was typically a few

minutes. Typically three to five minutes would be pretty typical.

Q. But you have no specific memory of performing a D&C while one of your patients was under general anesthesia; is that right?

A. I don't have a specific memory of a patient being intubated. I don't. I just don't recall.

Q. Is that because you stopped providing D&Cs a while ago?

A. Yes. That's correct.

Q. And when did you stop performing D&Cs?

A. I cannot tell you about the last D&C that I did. I don't recall. I can tell you when I finished my practice. I don't know when within that was my last D&C.

Q. Do you think it would have been while you were at Millcreek?

A. I performed D&Cs at Millcreek, so that would be reasonable.

Q. Do you recall performing any D&Cs while you were at the University of Utah between 2008 and 2012?

A. I don't specifically remember doing any D&Cs during that time. That doesn't mean I didn't. I just don't have specific memories of doing any during that time.

Q. But is it fair to say that you would not have performed any D&Cs after 2012?

A. I practiced until 2015, so I know that somewhere in my HCA St. Mark's time between 2012 and 2015, I would have performed D&Cs.

Q. Just to go back, I believe you had said that when you were at St. Mark's/HCA MountainStar, your work was primarily gynecology; is that right?

A. That's correct.

Q. And I had thought you said that your contract said that you were not to do any obstetric work; is that right?

A. I'm not talking about obstetrical D&Cs. I'm talking about evaluation of endometrial cavities for other reasons.

Q. Got it. So would you have performed D&Cs for miscarriage management at any point after 2012?

A. I don't have any specific memories. It may have been within my contract depending on how I determined first-trimester pregnancy loss.

I don't have any specific memories of whether that occurred. My liability carrier, as I recall, would not have considered a fetal demise in the first trimester as obstetrics. They would have considered that gynecology, but it was debatable.

So I don't have any recollection of specifically doing any for pregnancy loss.

Q. Got it. So you've testified that your miscarriage management practice also involved performing D&Es; right?

A. Correct.

Q. And you've testified that you've performed more than one D&E in your career; is that correct?

A. Correct.

Q. But you can't recall the number of D&Es that you've performed; is that right?

A. That's correct.

Q. Can you recall whether you did more than one D&E for induced abortion per year while you were at Millcreek?

A. I don't recollect. It depended on if a patient wanted me to do that, and only for my patients, so it did not come up often.

Q. Can you recall whether you did more than one D&E for miscarriage management per year while you were employed at Millcreek?

A. I don't recollect how many I did. That was part of the things that happened within my practice, but I don't remember how often.

Q. And you said that you don't recall whether

the D&Es that you performed took place in the hospital as opposed to the St. Mark's ASC; is that correct?

A. At St. Mark's? Again, I don't have specific memories of that.

I have specific memory of one in the main operating room. My normal practice would be to be in an operating room.

Again, I don't want to misstate anything. So I can't say did I ever do one in the surgery center attached to the hospital. I don't recall doing one there. I only have specific memory of myself in the room for one case.

Q. So the difference between that St. Mark's ASC and the main hospital OR in that D&E context wasn't memorable to you; is that right?

A. It's not that it's not memorable. I just want to make sure I'm being accurate in what I say.

Q. Okay. But you can't recall whether any of the D&Es that you performed were in the St. Mark's ASC; is that right?

A. D&E? Is that the question?

Q. Yes. I'm sorry. You can't -- you cannot recall whether any of the D&Es that you performed were in the ambulatory surgical center; is that right?

A. I don't recall ever doing one in the

ambulatory surgical center.

Q. Clinically speaking, is a D&E performed any differently when the patient is a victim of rape?

A. It depends on the clinical situation of what you're going to do. So clinically is it different? You've got a very traumatized patient. It depends on the indication. It really depends on a lot of factors, so it's very individual.

Q. Physically, referring to the mechanics of the procedure, would you perform a D&E differently if the patient was a victim of rape?

A. A D&E is performed in the clinical situation excluding how she got in that situation, the circumstance of her situation. It has to do with clinical diagnosis. So I would have to know what her clinical diagnosis is, so I can't presume in a hypothetical situation.

Q. Sure.

So if you had to -- let's say you had -- if you had two patients with exactly the same clinical indications --

A. Yes.

Q. -- and one was a victim of rape and one was not, are there any differences in the clinical steps that you would use to perform a D&E?

A. So we're dealing with very different situations as the patient's experience. So if I have the exact same clinical situation, then you're going to deal with the clinical situation.

But in addition, you have a patient who's been severely traumatized, which may change our approach based on what she's most -- how can I help her the best. So it depends on the situation. I can't --

Q. I understand. I'm not referring to the patient's mental state or how you might talk to them differently.

I'm just referring to the clinical steps that you, the provider, would perform. So would those clinical steps be any different?

A. In the exact same situation -- you're asking me a hypothetical, and it makes it really difficult.

But if there's nothing different about her, she's the exact same person except she was raped, or she wasn't raped and the exact same person, I would deal with the clinical situation in a way that helped her, because part of her is emotional state and her psychological state. So I have to factor that into how I manage her.

Q. Of course.

How would a patient's psychological state

affect the clinical steps of performing a D&E?

A. The difference in her can be -- again, there may be some situations I'm not going to be her physician for, so it depends on what situation you're speaking about.

But just say I'm just taking her to the operating room for something as a gynecologist and she's been raped. I'm going to talk to her a lot about what's that experience going to be like for you. Are you better off being anesthetized? Are you better off not being aware?

You know, will that help you to be calm in the situation? Are you going to be -- is it going to be so traumatic that you're going to be moving in the middle of the procedure and all of a sudden we've got a higher complication rate because this is intolerable to you because you're so traumatized?

There are so many different factors in this that I read the situation and, again, be very individual based on the patient. Gynecology is very specific in that horrible things sometimes happen.

Q. So when you're treating patients who are the victims of rape, would you say it's important to consider their psychological state going into the procedure?

A. Oh, absolutely. Absolutely.

Q. And would you say -- in considering that psychological state, how would that -- how would the patient's psychological state impact your actions performing a D&E after the patient was already sedated?

A. So now we're dealing with just the clinical situation?

Q. That's right.

A. It depends on which kind of sedation she offered -- she decided upon and anesthesia decided upon.

What happens with a lot of people who have been abused or raped is if they're not completely sedated, they're often triggered in the middle of a gynecological -- so from that point on, it depends on how -- what form of anesthesia or pain management she's decided on and whether she's being alert enough to be triggered. And if she's triggered, it -- it can change the procedures.

Q. So if a patient of yours who was a victim of rape were undergoing a D&E under general anesthesia, how would the fact of that patient being a rape victim impact how you performed the D&E after the patient was already under?

A. So in that situation, as long as we're not

dealing with the rape and the chain of command and evidence and things like that, we're only dealing with our clinical situation, once she's asleep, other than being especially careful to not traumatize her tissues, which could trigger her afterwards, it would be very similar at that point.

Q. What if a patient was the victim of incest? How would the patient being a victim of incest impact how you perform the D&E?

A. So it would depend a lot on the specific situation, her age, because a lot of that changes anatomy.

Q. So if one of your patients were the victim of incest and they were under a general anesthesia and you were performing a D&E, how would the fact that they were the victim of incest impact your performance of that D&E?

A. So there are a lot of different scenarios that could happen at that point, which it would be hard to say how exactly it would change that.

Q. What types of scenarios do you mean?

A. For example, I've seen somebody who was pregnant at term who had an opening in her vaginal introitus well under a centimeter. There was never penetration. It changed what we had to do for her to

be able to deliver.

So there's -- you know, with incest, sometimes there's penetration and sometimes there isn't. Sometimes they're prepubertal. Sometimes they're postpubertal. So it's very individual.

Q. Sure. So I'm just referring to a D&E context, so I'm not referring to what you just mentioned where a patient was at term.

So if you were performing a D&E on a patient who was the victim of incest, at the point in the process where that patient was already under general anesthesia --

A. Correct.

Q. -- how would the incest impact your next steps in performing that D&E?

A. Again, it's going to depend on her anatomy, her age, whether or not -- again, penetration doesn't always happen with pregnancy. So there are a lot of factors individual to that patient that could change how I would have to proceed to D&E.

Q. Age affects how you would perform a D&E regardless of whether the patient is a victim of incest; is that right?

A. Again, it depends on her anatomy, whether penetration had occurred, whether I have to do things

to access her vagina in order to do the D&E.

Q. But that wasn't -- that wasn't my question.

For all of your D&E patients, you have to consider their age; is that right?

A. For the procedure itself?

MR. BOYLE: Object to form. Go ahead.

BY MS. SALVADOR:

Q. Yes.

A. For the procedure itself, if she's pre- -- if we're doing a D&E, then she would be postpubertal, but she may not have had penetration, so I'm going to have to assess her introitus.

If she's been a victim, she often won't -- can't tolerate that in the office. So sometimes I do my initial evaluation -- if I were to see a patient in that circumstance, I may do that -- actually my first exam may be in the operating room other than the ultrasound.

Q. So if a patient were the victim of incest, that might affect where you did the initial exam; is that correct?

A. It may. It's a potential. That's hypothetical, but yes.

Q. Got it. And for all of your D&E patients, you would have to consider their particular anatomy

before you were to perform a D&E; is that right?

A. You would do an exam. You'd want to have -- if it's at all possible, you'd do the exam.

Q. And you would want to do that exam regardless of whether or not that patient was a victim of incest; is that right?

A. Yes. You always want to do an exam before a surgery.

Q. So you've testified that you've performed D&Es in the circumstance where a fetus has a lethal fetal anomaly; is that right?

A. That's correct.

Q. What sorts of lethal fetal anomalies were at issue when you performed those D&Es?

A. I don't specifically recall which ones we did D&Es for.

Q. Could you describe the procedure of performing a D&E when the fetus has a lethal fetal anomaly.

A. They would be similar to what I've already described.

If you're doing a D&E, the patient has an option of doing induction delivery or induction abortion. I don't recall doing that, but that is an option the patient has so that you can get a better

evaluation by pathology of the fetus.

The other alternative is a D&E, but you don't always get -- you often can't get a good pathology report.

Q. So do you recall whether you've ever performed a previability induction on a pregnant patient?

A. Previability induction. I cannot accurately tell you whether or not I have. I've had patients with previable preterm ruptured membranes. I don't -- these were in residency. After residency, I would have sent those babies to the university.

So I don't have specific recollections of whether we did D&Es, inductions. I do remember them delivering spontaneously.

Q. So would it be fair to say that if you performed an induction, it would have been while you were -- I'm sorry.

Would it be fair to say that if you've performed an induction previability, it would have been while you were in residency?

A. I only recall that during residency. Do I recall that during residency? Again, I remember having patients with premature -- previable premature ruptured membranes. I remember monitoring them all the time.

I don't -- and I remember some of them delivering spontaneously. I don't have specific recollections of induction abortions or of D&Es on those patients, and that would have been the patients that I wouldn't have remembered them. So --

Q. And could I use the term "PPROM" when we're talking about preterm premature ruptured membranes?

A. Sure.

Q. So did you ever treat patients with PPROM after your residency?

A. PPROM being specifically post-viability, yes.

Q. When was that?

A. When was what?

Q. When do you recall treating patients with post-viability PPROM?

A. Well, I don't have specific years, but I know that that occurred during my practice with patients.

Q. Did you ever treat patients with previability PPROM?

A. I did during my residency. I personally had previable PPROM. I didn't treat myself, but after -- after I was in private practice, those patients I would have sent to the university.

Q. I'm sorry. I couldn't hear the end. You would have sent them where?

A. Yes. To the University of Utah.

Q. Okay. So after your residency, you did not personally treat patients with previability PPROM; is that right?

A. Except for my personal experience, no.

Q. When you would send a patient with previability PPROM to the University of Utah, how would they be treated there?

A. Well, I don't have specific recollections of that. I can tell you what happened during my residency. I am not aware of their practice changing, but they would have to tell you that. But the patients that I had appeared to have the same trait -- the same that I was trained to do.

Q. And what were you trained to do when treating a patient with previability PPROM?

A. If they were infected at the time, which I don't recall any of them being infected at the time, that they needed to be delivered. And the training is the appropriate management at that time is to offer D&E and/or induction delivery.

Q. So how sick would that patient have to be before you recommended a D&E or an induction?

A. Well, the discussion with the patient would be depending on how remote she was from viability. The

current literature on the possibility of her infection, her risk for infection, and the literature at that time for the likelihood of her child to survive to the age of viability as well as potential outcomes, and then helping that patient to make that decision.

My recollection of that time is we did not have patients desiring delivery at that point, although some did proceed to delivery, and some continued to pregnancies for very long periods of time, so we monitored.

Distinct recollections of visiting those patients and re-evaluating at periods throughout the day, reviewing their labs, assessing them for infection, and, again, some of them went very long periods of time, including myself.

Q. When you were in residency and treating these patients, would you recommend that the patient wait for sepsis to develop before having a D&E or an induction?

A. Absolutely not.

Q. If you were treating a pregnant patient previability, and due to the pregnancy they had gestational diabetes and were at risk of going blind, would you recommend a D&E or induction in that scenario?

A. You're asking hypothetically? I don't do

obstetrics.

Q. Sure. I'm referring to when you did obstetrics, what would your recommendation be for that patient?

A. And I don't have a clear recommendation for that patient. I don't remember facing that with a patient.

Q. In your medical practice, did you ever prescribe medication off label?

A. Yes.

Q. And under what circumstances would you prescribe medication off label?

A. That's -- again, that's hard to -- I mean, there are so many of the drugs that we use off label, it's almost part of an everyday practice. So I'd have to go back and look, but there's drugs that we use almost every day off label.

Q. So we've discussed your time at Millcreek Women's Center, the University of Utah, and St. Mark's Gynecology.

Did you -- were you employed -- have you been employed as a physician anywhere else in your career?

I'm sorry. I can't hear you.

A. No, I'm thinking through my answer. I'm trying to remember if I've been employed anywhere else.

I've been employed as a resident. I've been employed at St. Mark's. Well, I was employed at the Millcreek Women's Center, back at the university, then I was in an employee position.

I have been -- I was probably compensated -- well, I was compensated a small amount of money when I was Utah Medical Association president. I was probably compensated a small amount when I was at UnitedHealthcare for a brief period of time as a medical director. That was a part-time position. I probably received compensation.

I don't recall any other time being compensated as a physician for services.

Q. Got it.

Why did you leave St. Mark's in 2015?

A. They had trouble recruiting another physician. I joined to start the practice. I very quickly left the practice. They had trouble recruiting a second gynecologist into Utah and decided to close the practice.

Q. So before we get to your current work, I want to talk a little bit about your professional associations.

So are you currently a member of the American College of Obstetricians and Gynecologists?

A. Yes, a lifetime fellow.

Q. And I'm going to use the term "ACOG" to refer to them. Is that okay?

A. Yes.

Q. How long have you been a member of ACOG?

A. Well, from early practice, I was a junior fellow. I don't recall if I was a member the first year. I believe I was. I'd have to look back at my records, but it's been continuous since then.

Q. Are ACOG members required to hold any particular view of abortion as a precondition of membership?

A. No, they're not.

Q. Does ACOG's membership include individuals who are opposed to abortion?

A. I don't have access to their records, but any physician who is -- has completed a residency, is board certified, my understanding is they can be members.

You're not required to be a member, and they don't screen for and, to my knowledge, don't poll us or survey us about our positions on abortion.

Q. Are you personally opposed to abortion?

A. Am I personally opposed to abortion?

I am opposed to the intentional taking of an innocent life. I realize that there are some

circumstances where the mother's life or potentially severe organ -- irreparable organ damage may occur that we may have to deliver.

Which I would consider delivering is different than an abortion. An abortion is the intention of delivering a baby who is not alive, whereas delivering the person without intentional -- directly killing the baby is not, to me, an induced abortion.

That is a separation of the mother and the baby, understanding that the baby previable is probably not going to survive, but I'm not directly taking that child's life.

Q. And as we discussed, you are a member of ACOG; right?

A. I am a member of ACOG.

Q. Do you believe that ACOG is a reliable medical authority?

A. In what sense are you asking me? What do you mean by that?

Q. Well, you cite ACOG bulletins in your report; right?

A. Yes.

Q. And you believe that those are reliable sources of information?

A. The reports that I -- that I cited?

Q. Yes.

A. I find that they're not always reliable, that there appear to be some biases. So a lot of the information's correct.

I often go myself to the literature to make sure that I agree with -- that it makes sense, that the literature is actually evidence based and supports their position.

Q. But at least -- you believe that at least the bulletins that you cite in your report are reliable; is that correct?

A. I believe that there are parts of it that are not reliable. So, again, I have to look if I have questions about whether it's truly evidence based and all the literature's been looked at.

I look at the year of the reference, and I'll often look to see if there's something new that's come out. I might -- if I'm not sure that that's actually factual or a proper conclusion from the facts, I may look at the article itself.

I may see what new has come up, see if there's something more recent, again, to make sure that I'm understanding the evidence appropriately instead of just taking an organization's word for it.

Q. Are there particular topics on which you find ACOG to be unreliable?

A. Again, it would be -- I'm not going to say a blanket statement of unreliable.

I look at it individually. Does this make sense? Does this fit the reality of what I know? Is this accurate? Does it make sense? Does it fit with my clinical experience and my training and what I've read?

And if any of those things are off, I'm going to go look for myself. So it could come up with anything. You know, is there something new since this, because some of them are outdated.

So, I mean, I've learned to always be critically thinking about it as I look at it. Is this really the most recent evidence based? Is this correct? So it could be on almost anything.

Q. And you are also a member of the American Association of Prolife Obstetricians and Gynecologists; is that right?

A. That's correct.

Q. And is it okay if I refer to that as "AAPLOG"?

A. "AAPLOG," yes.

Q. AAPLOG. Sorry about that.

How long have you been a member of AAPLOG?

A. I don't know the exact year, but I'm going to say somewhere between three and four years is probably correct, somewhere in that range.

Q. Was there anything in particular that made you join AAPLOG when you did?

A. I had a friend who encouraged me to join.

Q. You currently serve on its research committee; is that right?

A. I do.

Q. What do your -- what are your duties as a member of the research committee?

A. Our duties are to either write -- research and write new documents or to review previous documents, or to edit. There's a lot of different roles that we can take.

Q. And you said that you're newly on the board of AAPLOG; is that right?

A. Yes. Just middle, late somewhere December after I submitted all this is when that happened.

Q. And what are your duties as a board member?

A. My duties -- again, this is relatively new, so it's not going to be on the top -- I'm not going to have a full recollection yet.

But our job is to be aware of and be an

advocate of what AAPLOG is doing. We as a board meet with our CEO. We help with strategizing and implementing the goals and strategic plan of AAPLOG.

There's different roles that we can play. We're asked to be on at least one of the committees. So I have not yet been in an official capacity at board meetings.

Q. What is AAPLOG's position on abortion?

A. AAPLOG's position on abortion is that -- similar to what I've already told you -- is that it is inappropriate to directly take the life of an innocent human being; that there are rare times when the mother's life or permanent organ damage that is immediate and irremediable may be at risk, and sometimes we have to deliver a baby to save a woman's life or to avoid -- potentially avoid, again, irreparable severe damage to her body organ in that circumstance.

If we have to do it, the ethical way to do that is to not directly kill the baby, but to cause a separation which is typically going to be induced labor, which is respectful of the baby, although we understand the baby is probably not going to survive previable.

Postviable, that's easy. We deliver. If

those circumstances come up, you attempt to save both of our patients' lives.

Q. Have you ever had a malpractice claim filed against you?

A. Yes, I have.

Q. Could you describe the circumstances of that.

A. Okay. So I had one where we had -- I was actually not on call, but my patient needed a cesarean section. So my partner on call asked me to come in and assist with the cesarean section.

And at the time of cesarean section, the baby's head was entrapped. And my partner assisted to -- well, attempted to assist by vaginally elevating the baby's head. The baby's head was trapped.

I attempted. They prescribed nitroglycerin to relax the woman's uterus. I was able to deliver the baby, but the baby needed resuscitation. It turned out the baby had actually had what appeared to be a stroke, a CVA prior to birth, and therefore had abnormal head positioning, which in the end, the suit -- I went through deposition, and I was dropped at that point.

Q. Is that the only malpractice claim you've had filed against you?

A. So I've had things be filed. I had -- but they -- I've never had an ongoing lawsuit. They've

always done the initial evaluation, and then it's dropped.

Q. Could you describe those complaints that were filed.

A. Okay. What I recall is one woman called, wanted to be seen urgently for a vaginal infection. I appropriately diagnosed her with bacterial vaginosis. I gave her the first-line treatment.

The first-line treatment was ineffective. And so she received the second-line treatment from a different physician which was effective, and so she filed a claim, which she then immediately dropped.

Let's see. I had one patient, it was a partner's patient. She was in the operating room. I was in the clinic. The baby had a prolonged bradycardia that never recovered in labor. I ran to the labor and delivery because my partner was unavailable, immediately put on the forceps, delivered the baby.

The baby had ptosis, basically an eyelid drop, which it later came out the baby had a syndrome that ptosis was a part of. And when that got introduced that she'd been evaluated by a specialist and it didn't have anything to do with forceps, they dropped that.

That's what I recall.

Q. Have you ever been disciplined by a licensing board?

A. No.

Q. Have you ever been subject to disciplinary proceedings by an employer?

A. No.

Q. So your CV describes that you have volunteered -- that you volunteered as a client advocate at Path of Life from 2017 to 2018; is that correct?

A. Let's see. That, I believe, is correct.

Q. And could you describe your role at Path of Life.

A. So at Path of Life, I was trained to be a patient advocate, and it was actually a relatively new pregnancy resource center and a relationship center where they educated people about healthy relationships.

When I was there on my days to volunteer, we interestingly only had one person come in on my very last day there with a pregnancy and wanted counseling.

So most of my time there, they were preparing to get an ultrasound. And so most of my time there when I was there as a volunteer, they would have me to help with evaluation of that. I was writing protocols,

evaluating protocols, and essentially setting up that part of their offerings.

Q. And you're also a volunteer with an organization called Life Decisions; is that correct?

A. Yes.

Q. What is Life Decisions?

A. Life Decisions exists to educate people about abortion. We're an educational organization.

Q. What is your role at Life Decisions?

A. Primarily as a speaker educator.

Q. What types of education do you provide?

A. We go to groups that would like to learn about abortion and about prenatal development, and we present evidence-based information about prenatal development, explaining the different stages of development.

We explain what actually happens with the different forms of abortion, and we -- also because we're in Colorado primarily, I'm speaking from Colorado, people want to know what our current legislative climate is, what our laws are. So we might explain that and answer questions.

That's typically what we do.

Q. Is the purpose of the education you provide at Life Decisions to dissuade people from having

elective abortions?

A. At Life Decisions what we would do is we say the truth about prenatal development and about abortion and answer questions.

Q. Is Life Decisions as an organization opposed to abortions?

MR. BOYLE: Objection.

THE WITNESS: Life Decisions exists to educate people about the truth about abortion.

They explain, as somebody who's done abortions, I can -- induced abortions, I can explain what happens, and I can explain with my expertise cranial development and answer questions.

So we're really there just to present evidence-based medicine.

(Exhibit 2 Marked for Identification.)

MS. SALVADOR: I am going to drop into the chat a document. Could you please mark this as exhibit -- I believe we're on Exhibit 2.

BY MS. SALVADOR:

Q. And, Dr. Wheeler, please let me know when you're able to pull up this document.

A. Okay. I have it open.

Q. Have you seen this document before?

A. I don't recall ever seeing this document.

Q. At the top it says "Life Decisions" and a bar -- a menu bar across the top, and then slightly below that, there's a title that says "FAQs."

Did I describe that accurately?

A. Yes.

Q. So this is a PDF of the FAQ page on the Life Decisions website. You said you haven't seen it before; is that correct?

MR. BOYLE: Objection.

Are you asking her if that's what it is, or are you telling her that's what it is?

MS. SALVADOR: I'm describing this document as a PDF of the FAQs decision off the Life Decision's website.

BY MS. SALVADOR:

Q. The question is you said that you have not seen this before, Dr. Wheeler; is that correct?

A. I have not seen this document before.

Q. Do you have any reason to believe that this is not the FAQs page of the Life Decisions website?

MR. BOYLE: Objection.

THE WITNESS: I've never seen it before, so I'd have to look through and see if this is really something that's posted. So I don't have anything to base that on.

BY MS. SALVADOR:

Q. Are you generally familiar with the positions of Life Decisions, the organization?

A. No. I'm asked by the president to speak at events with them because of my expertise. So I -- other than being asked to speak, I don't have any other role within the organization.

Q. So when you've been asked to speak, what events have you been asked to speak at?

A. The ones that I recall, one was at a fundraising event for Proposition 115. As I recall, that was the first time I spoke with that organization.

We have spoken at libraries. We have spoken at benefits for pregnancy resource centers. I mean, I have spoken with one of -- let's see. That was not part of Life Decisions. Yeah, libraries, pregnancy resource center, gala events, and spoken with them at one church that had a specific group, a small group that gets involved in the community that wanted to learn about abortion and prenatal development.

Q. So is it -- I'm sorry.

A. That's okay. Those are the primary places I recall speaking with Life Decisions.

Q. So is it fair to say that you've spoken at several events for Life Decisions over the past three

years?

A. It would be over three years, somewhere around that time, and yes, several events.

Q. So let's go to page 7 of this document. The page numbers are at the bottom right of the document.

In the right column of page 7 towards the top there's a bullet that says: "Abortion is never medically necessary to protect the mother's life or health."

Did I read that correctly?

A. You did read that correctly.

Q. Do you agree with that statement?

A. So you would have to describe "abortion." It comes back to your definition of "abortion."

Q. Are there any circumstances where you would say that abortion is medically necessary to protect the mother's life or health?

A. Again, this is where the definition changes everything, and it depends on what you're meaning by "abortion" whether I can answer that affirmatively or negatively.

Q. How would you have to define "abortion" in order for you to agree with the statement that abortion is medically necessary to protect the mother's life?

A. My understanding -- definition of "induced

abortion" is the intention of delivering a baby who is not alive.

So when a mother has medically indicated to literally save her life due to a significant threat to her life or to significant permanent, immediate irreparable damage to a major body organ system, I would not call that an abortion if you did not directly take the baby's life.

That would be a delivery and medically indicated delivery to save her life, and that's not involved in directly having to take the baby's life, although we are aware that the baby remote from viability is not going to survive.

But we can be respectful and give dignity to that baby and allow comfort care, but not directly kill the baby with the intention of delivering a baby that's not alive.

MR. BOYLE: Can we take a break. It's been, I think, well over an hour.

MS. SALVADOR: Yeah, that's fine.

(Off the record 3:15 p.m. to 3:25 p.m.)

BY MS. SALVADOR:

Q. So we were talking about scenarios where a patient's life or health is in danger.

Dr. Wheeler, are there any circumstances

where a D&E is medically necessary to preserve a patient's life or health?

A. A D&E specifically is an unethical procedure for a living baby. So anything that involves a direct feticide would be -- in my estimation and experience having done them would be unethical.

Q. Going back to the document, Exhibit 2 that we were just referencing, let's go to page 9.

In the right column at the top of the page there's a bullet that reads: "Abortion is not the right option when a child is diagnosed with a serious or a lethal medical condition."

Did I read that correctly?

A. Yes.

Q. Do you agree with that statement?

A. Yes, I do.

Q. What is "anencephaly"?

A. Anencephaly is a condition where the cephalate portion of the mental development is incompletely developed and the cranium is not completely developed.

Q. When you say "cranium," do you mean the brain?

A. The bony -- the skull.

Q. What is the survival rate of an anencephaly?

A. I do not recall the number.

Q. Do you believe that abortion should be an option if a fetus is diagnosed with anencephaly?

A. No, I do not.

Q. The same document, if we could go to page 15.

In the middle column at the top of the page there's a bullet that says: "Abortion does nothing to give a rape victim the healing she needs and deserves."

Did I read that correctly?

A. Yes, you did.

Q. Do you agree with that statement?

A. I do agree with that.

Q. And on the same page, the same column, the fourth bullet down, the bullet reads: "The child conceived in rape can be a reminder that women can rise above after trauma, not a reminder of the trauma."

Did I read that correctly?

A. You read it correctly.

Q. And do you agree with that statement?

A. The statement says that it "can be," as in it possibly could be, and that is possible. I agree.

Q. You're also on the medical advisory board of an organization called Save the Storks; is that correct?

A. Yes, I am.

Q. What do your duties as a member of the medical advisory board of Save the Storks entail?

A. It's a new committee, so I've only recently, sometime, I believe, in the fall is my best recollection, done it. So I can only remember doing two meetings.

It's a medical advisory board. So when the medical director wants input into something as a strategy or a new development, then they will ask the medical opinions of the medical board.

Q. You mentioned that you were physically located in Washington, D.C., right now; is that right?

A. That is correct.

Q. Did you attend events related to the March for Life in D.C. this past Friday?

A. I did.

Q. What events did you attend?

A. I attended the march. I attended the rally prior to the march. I did the march. I joined the stage as one of the prolife leaders.

I went to the Alliance Defending Freedom reception that afternoon, and I went to the rose gala that evening.

Q. Switching gears a little bit, we're going to discuss the safety of abortion.

Is it your understanding that carrying a pregnancy to term carries more medical risk than having an abortion?

A. Is it my understanding? So it depends on when the abortion occurs, so it depends.

This is a hypothetical question, and I don't have the information on the hypothetical that I can answer that enough.

Q. Do you accept that abortion is safer than pregnancy and childbirth for most abortion patients?

A. And, again, it depends on the gestational age and the circumstance.

Q. Under what circumstances would you contend that abortion is riskier than pregnancy and childbirth?

A. Well, it depends on whether you're looking at immediate complications or long-term complications. That's --

MR. BOYLE: If she could please finish her answer, that would be --

BY MS. SALVADOR:

Q. Yeah. I'm sorry about that, Dr. Wheeler.

It's harder because I can't quite see your face close up.

A. Can I do something to make it easier?

Q. No. I'll do better at waiting for you to

complete your response.

So starting with immediate complications, under what circumstances do you say that the immediate complications of abortion are riskier than pregnancy and childbirth?

A. In the -- again, this is going to be very specific to the situation.

One of the concerns I have with the comparison is that we're talking about with pregnancy, a natural event, a reproductive event, whereas with abortion, anytime you have a complication or death, it's what's called iatrogenic.

It's like if I did a hysterectomy and somebody died, if I hadn't have done the hysterectomy, she wouldn't have died.

So we're talking about apples and oranges. They're not really comparable.

Q. Is it true that some people who obtain abortions would have experienced complications from pregnancy if they had remained pregnant?

A. That's a hypothetical that I can't tell what's going to happen in the future to people, so I can't answer that.

Q. Is it your claim that nobody who receives an abortion would have experienced a pregnancy

complication if they'd remained pregnant?

A. Again, it's hypothetical, so I can't tell what's going to happen to an individual.

Q. The likelihood of pregnancy-related death is higher for women with certain preexisting conditions, isn't it?

A. Likelihood -- I'm repeating the question to myself. The likelihood of maternal death is higher in women who have certain conditions. That's true.

Q. What sort -- so -- I'm sorry. Were you finished?

A. Yes. I didn't say "yes," so it's true.

Q. What sorts of conditions increase the risk of death during pregnancy?

A. For example, advanced maternal age. The older -- again, it's not a cut-off point, but the older a woman becomes, that's one of the biggest risk factors is advanced maternal age.

Hypertensive conditions, preexisting heart conditions. If she had, say, a renal transplant, those types of conditions may increase her risk.

Q. Would it be fair to say that at least some women with those conditions you listed obtain abortions?

A. Would it be fair to say some -- yes.

Q. If a patient required a D&C, do you think it would be safer for them to receive one from a provider with extensive experience providing D&Cs than from an inexperienced provider?

A. That has so many facets of -- that's so hypothetical I can't accurately answer.

Q. I want to go to your report in paragraph 18. So this would be Exhibit 1, paragraph 18.

So in paragraph 18, you state in your report, quote: "A survey of all U.S. ob-gyn residency directors found that only 22 percent of residency directors reported that their graduation residents were fully competent to perform D&E up to 17 weeks, 6 days' gestation, on average only performing four D&E surgeries."

Did I read that correctly?

MR. BOYLE: I'm sorry. Did you say this is paragraph 18 of her report?

MS. SALVADOR: Yes.

MR. BOYLE: Okay. Objection.

Oh, I'm sorry. I was starting at the beginning. You were starting at the second sentence. I apologize. I'm not objecting.

MS. SALVADOR: Okay.

MR. BOYLE: I'm sorry. Pardon my

interruption.

BY MS. SALVADOR:

Q. Dr. Wheeler, in what clinical setting do ob-gyn residents generally practice?

A. The residents?

Q. Yes.

A. So I haven't been to all ob-gyn residencies, so I can tell you my experience at the University of Utah. That's the one that I have experience with.

Q. Are you saying that you don't know where ob-gyn residents generally practice?

A. Well, they can practice in a variety of settings. So I don't know all of the ob-gyn residency practices. I can tell you what we did at the University of Utah.

But the training programs may have them -- they're obviously going to spend some of the time at their primary setting, but how many of them go out into the community or that they just do their own clinics, that varies with programs.

Q. Is it your understanding that ob-gyn residents generally practice in hospital settings?

A. During residence -- or residency, the primary place would be at the primary site of the residency program.

Q. Is the primary site of a residency program generally a hospital?

A. In my experience, yes. But, again, I don't know all the residency programs to know what they're like.

But at the University of Utah, we spent the majority of our time at the University of Utah Hospital and in our clinics, which were also at the site.

There was also a second hospital that we went to commonly, so lot of them have satellite sites.

Q. Got it. Thank you.

I'd like to go now to paragraph 12 of your report. In the middle of paragraph 12, there is a sentence that says: "Rarely a woman will require a uterotomy (incision in the uterus through the abdomen) or a hysterectomy for failed D&E or induction labor or for complications."

Did I read that correctly?

A. Yes.

Q. And you cite ACOG Practice Bulletin 135 for that statement; is that right?

A. That's correct.

(Exhibit 3 Marked for Identification.)

MS. SALVADOR: I'm dropping ACOG Practice Bulletin 135 into the chat. Would you please mark that

as Exhibit 3.

BY MS. SALVADOR:

Q. And, Dr. Wheeler, let me know when you have it open, please.

A. It is open.

Q. Dr. Wheeler, do you recognize this document?

A. Yes, I do.

Q. Is it the same ACOG Practice Bulletin 135 that you cite in your report?

A. I'd like to go back to the year. This is 2013, so I want to make sure that it's the same year that I quoted.

Will you please remind me which paragraph.

Q. Sure. It's paragraph 12.

A. Yes, it's the same year.

Q. So going back to the practice bulletin, I'd like to direct your attention to page 1396.

In the right column, there's a subheading that says -- the subheading is titled "Abdominal Surgery."

A. Yes.

Q. The quote right below that says: "In rare instances, second-trimester abortion may be performed by hysterectomy or hysterotomy. These procedures are associated with a much higher risk of complication than

D&E or medical abortion, and should only be performed when the latter two procedures have failed and are contraindicated."

Did I read that correctly?

A. Yes, you did.

Q. Is this the statement that you were referring to when you cited ACOG Practice Bulletin 135 in paragraph 12 of your report?

A. That appears to be what I was referring to.

Q. Going back to your report, in paragraph 13 you state about in the middle of paragraph 13 that you disagree with Dr. Farris's statement that the suction used for a D&C and D&E is gentle; is that correct?

A. I'm trying to get back to the document.

And I am now on the document, and you are on which paragraph?

Q. Paragraph 13.

A. Thirteen. Okay. And which sentence?

Q. Sure.

In paragraph 13 generally towards the middle, you disagree with Dr. Farris's statement that the suction used for a D&C and D&E is gentle; right?

A. Yes.

Q. And the typical suction required for D&C and D&E is 400 to 500 millimeters of mercury; is that

right?

A. Correct.

Q. Would you be able to safely apply that amount of suction to your hand?

A. We often do to test to make sure that the suction's working appropriately.

Q. So you are able to safely test the suction by applying it to your hand; is that right?

A. Yes. The hand is different than a uterus.

Q. Also in paragraph 13, towards the end of the paragraph, you refer to the possibility of trauma to the endometrial cavity and trauma to the cervix; correct?

A. Correct.

Q. Could trauma to the endometrial cavity result from a D&C or a D&E performed for miscarriage management?

A. Yes. Any instrument in the uterine cavity.

Q. Could trauma to the cervix result from a D&C or D&E for the purposes of miscarriage management?

A. Yes. Any instrument through the cervix.

Q. I'd like to go further down in your report to paragraph 31. Let me know when you get there.

A. I am there.

Q. So towards the end of the paragraph in the

second-to-last sentence you say that "The uterus at this early gestation does not respond as well to oxytocics (to induce uterine contraction) as a term uterus does."

Did I read that correctly?

A. Yes.

Q. What gestational age range are you referring to here when you say "early gestation"?

A. Early gestation. So for D&Es, I'm referring to the age ranges of a D&E, which are typically for most providers 13 to 14 weeks up to somewhere between 22, some providers up to 24 weeks.

Q. Are all uterotonics oxytocics?

A. I think we'd have to define what each of those mean.

Q. Sure.

So what is an oxytocic? And I apologize if I'm pronouncing that incorrectly.

A. Yeah. That's okay. So essentially you're talking about things that would make the uterus contract with each of those. Some of them, like Pitocin or oxytocin is what we usually refer to as oxytocic, is -- acts through a receptor which increases throughout the pregnancy.

So there are a few receptors at the age

that -- at the gestational age where the D&Es are performed. They increase, and so that by term as you prepare for labor, the receptors increase.

Q. And what is a uterotonic?

A. So uterotonic, the definition that I would typically use is anything else that would get the uterus to contract. For example, Methergine or prostaglandin, but they act differently.

Q. So even if -- I'm sorry.

So even if the uterus's response to oxytocics varied at different gestational ages, would other uterotonic medications still be effective to induce uterine contractions?

A. "Effectiveness," you know, has different relative terms. I think the primary point is that the uterus does not contract as well to stop bleeding in the second trimester as it does at a later pregnancy.

Q. Are you aware that prophylactic oxytocin has been shown to decrease blood loss and frequency of hemorrhage when used in second-trimester D&Es?

A. I am aware that it is used. I am aware both from personal experience and through the literature that the uterus does not respond as well in the second trimester as at term.

So does it respond some? It depends on how

much of the receptor is present. So yes, we do use it, but it is not as effective as it is when there's more receptors at the end of pregnancy.

Q. And what literature are you referring to that supports that?

A. Well, basically my experience, literature that I've reviewed on oxytocics for postpartum hemorrhage and, again, personal experience. All literature on postpartum hemorrhage would include information on oxytocics and uterotonics.

Q. Is there any specific piece of literature that you can recall that makes that -- that makes that statement?

A. You know, I don't recall on the top of my head because I've read so many, but it's consistent through the literature.

Q. Let's go to paragraph -- I'm sorry.

Before we do that, when was the last time that you used uterotonics to treat bleeding?

MR. BOYLE: Objection.

You can answer.

THE WITNESS: I don't remember the exact time that would have been. I don't have a distinct recollection of when I last used it.

BY MS. SALVADOR:

Q. Have you ever used uterotonics to treat bleeding?

A. Yes, I have.

Q. Have you used uterotonics to treat bleeding in -- when performing a D&E?

A. Yes, I have.

Q. Let's go to paragraph 15 of your report.

A. I'm there.

Q. The first sentence of paragraph 15 says, quote: "While the technical performance of the procedure of first-trimester D&C or second-trimester D&E may be similar for management of miscarriage (spontaneous abortion) and induced abortion, the reality is that with miscarriage, the developing human embryo or fetus has already died, as opposed to abortion, which has the purpose of causing the demise of a living embryo or fetus."

Did I read that correctly?

A. Yes, you did.

Q. Do you agree with that statement?

A. Yes.

Q. Do you think that completion of a complex family planning fellowship is necessary in order to safely perform a D&E?

A. I would have to take issue with the word "safely," so I -- I can't answer that under oath. I don't know. I don't -- it's conjecture.

Q. Do you think that completion of a complex family planning fellowship is necessary in order to perform a D&E without medical complications?

A. No.

Q. Did you complete a fellowship in complex family planning?

A. It was not available during the time, so that wasn't even an option for me.

Q. Going to paragraph 30 of your report -- please let me know when you're there.

A. I'm there.

Q. So in paragraph 30 of your report, you list potential complications of D&E. You specifically mention hemorrhage, cervical laceration, retained products of conception, infection, uterine perforation, abnormal placentation, disseminated intravascular coagulopathy, and embolism; is that correct?

A. Yes.

Q. And for that statement about complications, you cite ACOG Practice Bulletin 135 on second-trimester abortion; is that right?

A. That's correct.

Q. Is hemorrhage a potential complication of D&E when that D&E is performed for miscarriage management?

A. Yes, it is.

Q. What amount of blood loss constitutes hemorrhage in the D&E context?

A. Typically an estimation because it's not exact, but we do have a suction machine there that is measuring, in addition to fluid, blood, so you can get at least a general idea. Approximately 500 ccs.

Q. And is 500 ccs or approximately 500 ccs also the amount of blood loss that would be hemorrhage if the D&E was performed in the abortion context?

A. Yes.

Q. Is there a risk of hemorrhage associated with childbirth as well?

A. Yes.

Q. Do you know whether the risk of hemorrhage is greater with carrying a pregnancy to term as opposed to abortion?

A. I have not seen a direct comparison between the two, so I don't have the grounds to answer that based on literature from what I recall.

Q. Is infection a possible complication of D&E when that D&E is performed for miscarriage management?

A. Yes, it is.

Q. Is there a risk of infection associated with carrying to term also?

A. Yes.

Q. Do you know whether the risk of infection is greater with carrying a pregnancy to term versus abortion?

A. No. I mean, as part of preparation for this, I did not review maternal complications at term, so I don't have the recollection of the percentage of infection. I don't recall that number as I didn't review it for this deposition.

Q. Is cervical laceration a potential complication of D&E when that D&E is performed for miscarriage management?

A. Yes.

Q. Are retained products of conception a potential complication of D&E when that D&E is performed for miscarriage management?

A. Yes.

Q. Is uterine perforation a potential complication of D&E when that D&E is performed for miscarriage management?

A. Yes.

Q. Is abnormal placentation a potential complication of D&E when that D&E is performed for

miscarriage management?

A. A late complication, not immediate, yes.

Q. I'm sorry. Did you say "late complication, not immediate"?

A. Right. So abnormal placentation would refer to a subsequent pregnancy, and it's a possibility with any instrumentation in the uterus.

Q. Is disseminated intravascular coagulopathy a potential complication of D&E when that D&E is performed for miscarriage management?

A. Yes.

Q. Is embolism a potential complication of D&E when that D&E is performed for miscarriage management?

A. Yes.

Q. So going back to your report, paragraph 31, you cite a study by Zane, et al., for the statement that abortion -- I'm sorry -- for the statement that hemorrhage is a primary contributor to abortion mortality; is that right?

A. Paragraph 31?

Q. Yes.

MR. BOYLE: I apologize. Could you ask that question again.

MS. SALVADOR: Sure.

BY MS. SALVADOR:

Q. In paragraph 31 of your report -- and I'm referring to the last sentence of paragraph 31, you cite a study by Zane, et al., for your statement that hemorrhage is a primary contributor to abortion mentality -- mortality. I'm sorry. Is that correct?

MR. BOYLE: Object to form.

THE WITNESS: Yes.

BY MS. SALVADOR:

Q. Didn't that study conclude that deaths associated with legal induced abortions are rare events?

A. I don't recall that statement. I'd be happy if you have the study to throw it up to confirm that that was in there.

(Exhibit 4 Marked for Identification.)

MS. SALVADOR: Sure. I am putting the study into the chat. Please mark it as an exhibit.

BY MS. SALVADOR:

Q. And, Dr. Wheeler, please let me know when you have it open.

A. I have it open.

Q. Are you familiar with this document?

A. I am, yes.

Q. Is this the same study by Zane, et al., that

you cite in paragraph 31 of your report?

A. Yes, it is.

Q. So I'll direct you to the first page of the study.

There's a heading or a subheading that says "Conclusion." The first sentence after that conclusion subheading, quote: "Deaths associated with legal induced abortion continue to be rare events, less than one per 100,000 procedures."

Did I read that correctly?

A. You read it -- well, let me see.

One per 100,000 procedures, yes. Yes.

Q. In your report you also state that the risk of death from induced abortion increases as gestation progresses; is that correct?

A. After eight weeks' gestation, yes.

Q. In paragraph 35 of your report, you cite a study by Bartlett, et al., and you cite it for the proposition -- for the proposition that women whose abortions were performed in the second trimester were significantly more likely to die of abortion-related causes; is that right?

A. Yes.

Q. Do you recall that the study found that for the time period it was discussing, the overall death

rate for women obtaining legally induced abortions was 0.7 per 100,000 legal induced abortions?

A. I am happy to look at that and confirm it.

Q. Sure.

(Exhibit 5 Marked for Identification.)

MS. SALVADOR: I'm dropping the study into the chat. Please mark it as an exhibit.

BY MS. SALVADOR:

Q. And then, Dr. Wheeler, please let me know when you have it open.

A. Okay. It is open.

Q. Dr. Wheeler, are you familiar with this document?

A. Yes, I am.

Q. Is it the study by Bartlett, et al., that you cite in paragraph 35 of your report?

A. Yes, it is.

Q. So I will point you to the first page of the study. In the left column, there's a heading that says "Results"?

A. Yes.

Q. The first sentence after that heading says: "During 1988 to 1997, the overall death rate for women obtaining legally induced abortions was 0.7 per 100,000 of legal induced abortions."

Did I read that correctly?

A. Yes.

Q. Do you recall that one of the methods of second-trimester abortion included in this study was intrauterine instillation?

A. Yes.

Q. What is intrauterine instillation?

A. I'd have to tell you by the literature. I've never actually seen it.

It's essentially putting some kind of compound as an abortive agent into the fluid surrounding the baby.

Q. Is that a commonly used abortion technique today?

A. Today, no. There are rare instances in the literature -- well, in reports, but no, it is not.

Q. Did the study find that more of the deaths resulting from second-trimester abortions were from abortions performed via intrauterine instillation than from D&E?

A. I don't recall that separation, but I'd be happy to look at it.

Q. Sure.

I will point you to page 734 of the study -- sorry. I'm just making sure that I'm looking at the

right page of the study.

I'm sorry. I mean page 733.

A. Okay.

Q. On page 733 in the left column midway through the paragraph, there's a sentence there that says: "For women in the second trimester, the mortality rates for D&E were 2.5 times lower than those for instillation and other procedures."

Did I read that correctly?

A. You did read it correctly.

Q. Going back to your report in paragraph 36, you cite a study by Cohen, et al., for your statement that, quote --

A. I'm not there yet.

Q. Oh, I'm sorry.

A. Paragraph 36?

Q. Yes.

A. Yes.

Q. So paragraph 36 says: "A global review found that induced abortions after 12 to 14 weeks of pregnancy account for a larger proportion of abortion-related serious complications."

Did I read that correctly?

A. Yes.

Q. And did you cite a study by Cohen, et al.,

for that statement?

A. Yes, I did.

Q. This article looks at the safety of abortion worldwide, not just the United States; is that right?

A. That's correct. Well, it looks at abortion care.

Q. And it looks at abortion care both within and outside of the United States; is that right?

A. Yes. It looks at abortion care globally.

(Exhibit 6 Marked for Identification.)

MS. SALVADOR: I'm dropping the study into the chat. Please mark it as an exhibit.

BY MS. SALVADOR:

Q. And then, Dr. Wheeler, please let me know when you have it up.

A. Yes, I have it.

Q. So this study specifically distinguishes the safety of abortion in the U.S. from abortion in countries where the proportion of unsafe abortions is significant, doesn't it?

A. I wouldn't say unsafe abortion. I don't want to disqualifize that. I think you're talking about legal abortion and the practice of abortion globally.

Q. So I'll refer you to page 460, the bottom of the right-hand column.

So the first sentence of the last paragraph says: "Despite comprising a small proportion of total global abortions, later abortion accounts for a large proportion of abortion-related serious complications especially where access to abortion is restricted and the proportion of unsafe abortion is significant."

Did I read that correctly?

A. You did read it correctly.

Q. And this study defines "later abortion" as abortion occurring after the first 12 or 14 weeks of pregnancy; is that right?

A. They didn't necessarily define it that way, although it -- they refer to that in their citation 3 above it, that later abortion occurring after the first 12 to 14 weeks. They then talk about the percentage of it, abortions worldwide.

Q. So with that additional context, would you agree that it would be accurate to describe this article as finding that induced abortions after 12 to 14 weeks of pregnancy account for a larger proportion of serious complications across abortions worldwide?

MR. BOYLE: Objection.

THE WITNESS: Can you please restate that.

BY MS. SALVADOR:

Q. Sure.

Would you agree that it would be accurate to describe this article as finding that induced abortions after 12 to 14 weeks of pregnancy account for a larger proportion of serious complications across abortions worldwide?

MR. BOYLE: Objection.

THE WITNESS: I'm not following your question. You may have to break that on down for me.

BY MS. SALVADOR:

Q. Sure.

So this study discusses abortions globally; is that right?

A. Yes.

Q. So its findings generally apply to abortions globally; is that right?

MR. BOYLE: Objection.

THE WITNESS: They're looking -- they're giving a global perspective on abortion care beyond 13 weeks, yes.

BY MS. SALVADOR:

Q. And -- I'm sorry.

A. That's their proposition.

Q. I'm sorry. I will work harder not to

interrupt you.

So also on page 460 on the -- in the right column toward the bottom of the page, the article describes the United States as a country, quote, "Where generally care is safe"; is that correct?

A. Is the statement -- are you reading it correctly? Is that the question?

Q. Yes. I'm asking if I read correctly that this article refers to the United States as a country "Where generally care is safe"?

A. This article makes that statement, yes.

Q. And right before that, still on the right column of page 460, the article states that: "With safe care, case fatality rates increase slightly with increasing gestational age, but as compared with unsafe care or even term pregnancy, the case fatality rate is lower."

Did I read that correctly?

A. You read what they wrote, yes.

Q. Going back to your report, in paragraph 38 -- please let me know when you're there.

A. Yes, I'm there.

Q. So in paragraph 38 of your report, you discuss a study of uterine perforation during second-trimester D&Es; is that right?

A. Yes, it is.

Q. Didn't that study analyze cases from the 1977 and 1987 time period?

A. I would need to look at the actual dates in that. I'd be happy to do that.

Q. Sure.

(Exhibit 7 Marked for Identification.)

MS. SALVADOR: I am dropping the study into the chat. Please mark it as an exhibit.

BY MS. SALVADOR:

Q. And then, Dr. Wheeler, please let me know when you have it open.

A. Yes, I have it open.

Q. Dr. Wheeler, are you familiar with this document?

A. Yes, I am.

Q. Is it the study that you cite in paragraph 38 of your report?

A. Yes, it is.

Q. So I'll point you to the Materials and Methods subheading on the first page of the study.

A. Yes.

Q. Didn't this study analyze cases from the 1977-to-1987 time period?

A. Yes, it did.

Q. And didn't it find that uterine perforation occurs in about 0.4 percent of D&E procedures?

A. You would have to point that out to me, because they were not studying the incidences. They did not have total numbers to study the incidence.

Q. Sure.

I'm referring to the first page of the study in the left column, the full paragraph in the middle right before the Materials and Methods subheading.

There is a sentence in that paragraph that states: "Uterine perforation occurs in about 0.4 percent of D&E procedures."

Did I read that correctly?

A. I found it. They are referencing. That actually didn't come from this study. They're citing another study.

Q. Understood.

But it was the understanding of this study's authors that uterine perforation occurred in about 0.4 percent of D&E procedures; is that right?

A. They quoted one study that showed that, and in that one study, they -- that was what they quoted.

Q. Let's go back to your report.

Further down in paragraph 56 -- do you have it up?

A. I am close.

Yes, I have it.

Q. So in paragraph 56 of your report, you cite a study by Niinimaki, et al., for the proposition that medication abortions have a four times higher risk of adverse events as compared to procedural abortions; is that right?

A. At the specified gestational age that was in Niinimaki's conclusion from his research at 63 days of gestational age or less.

Q. Didn't the medical abortion group in this study include abortions performed with mifepristone alone?

A. I want to make sure I'm answering properly under oath, so may I look at that study just to confirm that's correct?

Q. Sure.

(Exhibit 8 Marked for Identification.)

MS. SALVADOR: I have put the study in the chat. Please mark it as an exhibit.

BY MS. SALVADOR:

Q. And Dr. Wheeler, please let he know when you have it open.

A. It is open.

Q. Dr. Wheeler, are you familiar with this

document?

A. Yes, I am.

Q. Is it the Niinimaki study that you cite in paragraph 56 of your report?

A. Yes, it is.

Q. I will direct you to page 796.

In the right column in the top paragraph, there's a sentence in the middle of that paragraph that states: "Medical abortion was defined as the use of mifepristone alone or in combination of misoprostol or other prostaglandins."

Did I read that correctly?

A. Yes, you did.

Q. Do you know whether Planned Parenthood South Atlantic provides abortions using mifepristone alone?

A. I do not have that information. I don't know.

They had reported protocols. I don't know if they always follow the protocol.

Q. I'll refer you to page 798 of the study.

A. Yes.

Q. The first sentence of that "Discussion" subheading states: "In the present study, we found that the two methods of pregnancy termination (medical and surgical) are generally safe."

Did I read that correctly?

A. You read that correctly, but I don't agree.

Q. Understood.

Are you aware that the authors of this study characterize all patient reports of heavy bleeding as hemorrhage even if they were in the expected range for medication abortion?

A. I'd be happy to look at the definition.

Q. Are you aware that in response to criticism of this study, the authors of the study conceded that "Many of the," quote/unquote, "complications are not really such, but rather concerns are adverse events that bring women back to the health care system"?

A. I did not see that reported in this citation.

(Exhibit 9 Marked for Identification.)

MS. SALVADOR: I'm going to drop another link into the chat. Please mark it as an exhibit.

BY MS. SALVADOR:

Q. And then, Dr. Wheeler, please let me know when you have it open.

A. I have it open.

Q. Dr. Wheeler, are you familiar with this document?

A. No. I don't know this document.

Q. You'll see at the top it says "Letters to the

Editor," and then at the bottom of each page, there's a footer that refers to Obstetrics and Gynecology, Volume 115, Number 3. Do you see those?

A. I do.

Q. Do you have any reason to believe that this is not a letter to the editor from the Obstetrics and Gynecology Journal?

A. I do not.

Q. So you'll see here that there's a letter to the editor, and then there's a reply that starts in the right column of the first page.

Do you see that reply?

A. On the far right, yes.

Q. So if you keep scrolling down to the second page in the left column, you'll see that the authors of the reply, Niinimaki, Dr. Pouta, and several other names. Do you see that?

A. I don't.

MR. BOYLE: On the next page.

THE WITNESS: Oh, on the next page.

Yes, I see that.

BY MS. SALVADOR:

Q. And do you recognize these names as the authors of the Niinimaki study that we were just discussing?

A. I at least recognize -- I recognize Niinimaki. The others I recognize, but I'd have to -- some of them, but I'd have to go back and verify that they're the same ones on this article.

Q. Got it. And do you recognize that they're discussing that same Journal article?

You can see that from the title of the letter to the editor at the top of the first page. It says: "Immediate complications after medical compared with surgical termination of pregnancy."

Do you see that?

A. I see the title, yes.

Q. So do you agree that this is discussing the same article?

A. From the title and the name of the reply, yes.

Q. So on page 660, in the reply section, the first paragraph of "In Reply," there's a -- it begins with "We thank Fjerstad, et al., for their interest in our article. It is important to keep in mind that the study is registry based, not a randomized study with strict protocols and definitions. Thus, many of the complications are not really such, but rather concerns are adverse events that bring women back to the health care system."

Did I read that correctly?

A. You read what is written, yes.

Q. And then if you go to the very bottom of that column, it reads: "The main contributions that the present article makes to the literature are," and then there's a bullet that says: "Rate of serious real complications is a rare and rather similar between surgical and medical abortion."

Did I read that correctly?

A. You read it correctly, but it doesn't fit with the article.

Q. But you agree that it was the authors of the article who wrote this response; am I right?

A. Yes, it was them.

Q. And they are specifically discussing the article that you cited in this response; is that right?

A. They appear to be.

Q. Does this change your reliance on the Niinimaki study for the proposition that medication abortion has a complication rate four times higher than the rate for procedural abortion?

A. No. As I said, it was the American College of Ob-gyn literature I read through, make sure it's accurate, and then I look at conclusions to see whether the conclusions follow from the research.

And so I was surprised at the end of this article where they said it was relatively safe if you're reporting from linkage studies those, whether you call them complications or adverse events, whatever it is that brings people back in for additional care.

The conclusion I found interesting given the facts, the findings of the article.

Q. Got it. Thank you.

Let's go back to your report in paragraph 23.

A. I'm there.

Q. So in paragraph 23 of your report you state that the traditional norm is to perform second-trimester D&C and D&E in a hospital; is that right?

A. That's correct.

Q. Is that statement referring to second-trimester D&C and D&E for miscarriage management or abortion, or both?

A. Generally, traditionally both were performed in a surgical suite in the hospital. The move out of the hospital has been a later development.

Q. So what's the basis for your view that the traditional norm is to perform D&Cs and D&Es in a hospital?

A. Traditionally -- I think we may be talking

different definitions. "Traditionally" -- I mean, "traditionally" to me is more historically. Traditionally they were performed in the surgical suite in a hospital, and over time some of those procedures have been moving out to other settings.

Q. Do you think that D&Cs can ever be performed successfully in an outpatient setting?

A. Define what you mean by "outpatient."

Q. Sure.

Do you believe that D&Cs can be performed safely in, for example, an abortion clinic?

A. I would have to see the clinic and their protocols. There's, you know, "can be," like, things can be done in a lot of places, but it doesn't mean it is safest, in the patient's best interest.

So can you do a procedure somewhere and not have a complication? I think that's a theoretical question versus, you know, where is it best and where's the safest place, the best patient care.

Q. Do you think that D&Cs are ever performed without complications in an abortion clinic setting?

A. Yes, I do.

Q. Do you agree that D&Cs are usually performed without complications in an abortion clinic setting?

A. I don't have -- I don't work in an abortion

clinic setting, so I don't know those numbers. I'd have to -- that would be conjecture on my part.

Q. Are you familiar with any literature regarding how safe it is to perform D&Cs in an outpatient setting?

A. I referenced one that one of the other physicians also referenced.

Q. What is your understanding of where most abortions are performed in terms of clinical setting?

A. Most abortions, in the first trimester particularly, most of them are in specialized clinics that primarily focus on abortion.

Q. Where -- what is your understanding of where most abortions are performed after the first trimester?

A. I don't have that information, so that would be a conjecture on my part.

Q. Are you aware of a study by Jones, et al., finding that only 3 percent of abortions are performed in hospitals in the United States annually?

A. So 90 percent of abortions are performed, according to Google, it's approximately 90 percent are performed in the first trimester. So that would mean that most of them, given that most first-trimester abortions -- induced abortions are performed in specialized clinics with a focus on abortion, that

would make sense.

I don't recall there being a study of separation of gestational ages, but I'd be happy to look at it. But given that most abortions -- induced abortions are in the first trimester, it would certainly be less than 10 percent in a hospital.

Q. Are you familiar with any research concluding that abortion has low rates of complications generally, and very low rates of complications requiring hospitalization?

A. Am I aware of any literature? I have seen the claims in the literature and am concerned about that, because I'm aware that in the United States we don't collect that data.

Consistently in the majority of the states in the United States we, frankly, have no idea how many complications or deaths are happening from abortion with any accuracy.

Q. Do you think that a D&E can be performed without complications in an outpatient setting?

A. That's a conjecture. But is it possible would mean what "can" means to me, and it's possible.

Q. So let's go back to your study -- your study. Let's go back to your report -- I'm sorry -- in paragraph 43.

A. Can we take a break after this, please.

Q. We can take a break before we start discussing this, if you'd prefer.

A. Yeah, to get up for a moment, that would be great. Thank you.

MS. SALVADOR: Why don't we go off the record and come back in five minutes.

(Off the record 4:32 p.m. to 4:44 p.m.)

BY MS. SALVADOR:

Q. So we were at paragraph 43 of your report, Dr. Wheeler.

Do you have it up?

A. I am just getting to it. Paragraph 43, isn't that correct?

Q. Yes.

A. Okay. And I am there, yes.

Q. So in paragraph 43, you criticize Dr. Farris's reliance on a study by Roberts, et al., finding that abortion is equally safe in outpatient clinics and in ambulatory surgical centers, and you note that this study didn't look at the safety of abortion in hospitals as compared to these other clinical settings; is that right?

A. Make sure I'm saying it properly.

Roberts did not look at hospital-based care.

They looked at the comparison of ambulatory care centers and clinic settings.

Q. So in support of your statement, you quote a JAMA editorial review of the Roberts study noting that Roberts didn't consider the comparative safety of hospital-based abortion, and that "Hospitals would be presumed to be simultaneously the safest sites, as well as the site caring for patients with more complex health needs or greater severity of illness"; is that correct?

A. Yes. I quoted the JAMA editorial review, and that's their quote.

(Exhibit 10 Marked for Identification.)

MS. SALVADOR: So I'm dropping the JAMA review into the chat. Please mark it as an exhibit.

BY MS. SALVADOR:

Q. And then, Dr. Wheeler, please let me know when you have it up.

A. I have it open.

Q. Dr. Wheeler, are you familiar with this document?

A. Yes, I am.

Q. Is it the JAMA editorial that you cite in paragraph 43 of your report?

A. Yes, it is.

Q. So doesn't this editorial review state -- and I'm going to quote from page 2482 in the left column, first full paragraph.

Doesn't this editorial review state: "Given that many states require much more than the NASEM and ASA recommendations, there is an apparent mismatch between facility standards that are medically appropriate for patient safety versus what is often required by state law. Examples of additional and expensive requirements include sterile operating rooms, sterile corridors, airflow requirements, scrub sinks, and other requirements that are aimed at reducing infections where physicians perform surgical procedures that penetrate the skin, but these requirements confer no clinical benefit in the context of a nonsterile procedure such as abortion."

Did I read that correctly?

A. You read what the editorial board wrote, yes.

Q. After reviewing these passages of the JAMA editorial, would you agree that the Roberts article provides evidence that abortion is safe in office-based clinical settings?

A. The editorial board specifically looked at some physical requirements for maintaining sterility, but did not look at other potential factors. But as my

quote said, that it may still be the safest place, that they were only looking at safeguards against infection, not at the entire picture of safety and minimizing risk when -- in this section.

Q. Would you agree that the Roberts article provides evidence that abortion is as safe in office-based settings as in ambulatory surgical centers?

A. If you would kindly put the article up there. I want to make sure I'm accurate in what I say.

Q. Sure.

(Exhibit 11 Marked for Identification.)

MS. SALVADOR: I am dropping the article into the chat. Please mark it as Exhibit 11.

BY MS. SALVADOR:

Q. And, Dr. Wheeler, please let me know when you have it open.

A. Yes. I have it open.

Q. Are you familiar with this document?

A. I am.

Q. Is this the Roberts study that we've been discussing that you discuss in paragraph 43 of your report?

A. Yes, it is.

Q. I will point you to the bottom of the first

page. There is a subheading that says "Conclusions and Relevance."

A. Yes.

Q. The first sentence of that subheading states: "Among women with private health insurance who had an induced abortion, performance of the abortion in an ambulatory surgical center compared with an office-based setting was not associated with a significant difference in abortion-related morbidities and adverse events."

Did I read that correctly?

A. You read it, and then I would myself go back to the results to make sure that I agree with their conclusion.

Q. Understood. But your critique of this study in your report was based on the fact that it did not explicitly analyze hospital-based care; is that correct?

A. The question I was asked to answer was related to office or outpatient types of D&Es versus in-hospital D&Es.

So this did not address the relative safety of hospital-based operating-room D&Es and those in clinic settings.

Q. Understood. But you didn't have any other

critique of this study in your report, did you?

A. In the report, no. My specific -- it was quoted as -- it was referenced as support for it being just as safe in a clinical setting, but the comparison is with the hospital, and this doesn't address the hospital.

Q. Let's go back to your report in paragraph 45.

A. There we are. Forty-five?

Q. Yes. Do you have it up?

A. I am close.

I have it up.

Q. Great. Thank you.

So in paragraph 45 of your report you say that fetal anomalies, pregnancy complications, and maternal medical indications and intrauterine fetal demise greatly increase the risk to the pregnant woman for any medical procedure, including D&E; is that correct?

A. I'm not sure where you read that.

Q. Sure. I was kind of combining the first two sentences of paragraph 45.

A. Well --

Q. Sorry. Go ahead.

A. No. I'm sorry. I'm just -- I'm understanding now where you got that from.

So what was your question again?

Q. Sure.

So you're discussing in this paragraph 35 -- I'm sorry -- 45 that fetal anomalies, pregnancy complications, and maternal medical indications and intrauterine fetal demise all increase the risk to a pregnant woman for any medical procedure, including D&E; is that right?

MR. BOYLE: Object to form.

THE WITNESS: I -- the purpose in writing that is that the health condition -- the health conditions of the mother increase the risk to a pregnant woman for a procedure.

BY MS. SALVADOR:

Q. And in this paragraph, are you referring to D&E for abortion, for a miscarriage management, or both?

A. I am referring to health conditions that place the mother at risk for any surgical procedure.

So if she had pregnancy complications, medical indications that were serious enough to have to require the ending of her pregnancy, that -- and even with intrauterine fetal demise, you know, some of those are underlying health conditions that would increase her risk for a surgery or a procedure.

Q. So what fetal anomalies would increase the risk to a pregnant woman of a D&E?

A. I am not aware of fetal anomalies, per se. Every other condition there that I've listed could potentially. I'm not aware of fetal anomalies independently increasing the mother's risk beyond a baseline for pregnancy.

Q. Does a pregnancy resulting from rape or incest increase the medical risk to a pregnant woman for any medical procedure?

MR. BOYLE: Objection.

THE WITNESS: That's conjecture. There may be injuries associated with a rape, so I -- that would be dependent -- independently on the patient's condition and specific health.

BY MS. SALVADOR:

Q. Would you say that a pregnancy resulting from rape or incest always increases the medical risk to a pregnant woman for a medical procedure?

A. Always, no.

Q. In your report in paragraph 50 -- sorry. I'll give you a second. Let me know when you're there.

A. Yes, I'm there.

Q. So in paragraph 50 of your report, you state: "I am not aware of any research directly comparing

safety of D&C or D&E for indications of medical complications, such as spontaneous abortion or intrauterine fetal demise, to those performed electively."

Did I read that correctly?

A. Yes.

Q. From -- so in other words, you're not aware of any research directly comparing the safety of D&C or D&E for induced abortion with the safety of D&E or D&C for spontaneous abortion?

A. Yes. I'm not aware of any direct comparison between the patient groups and indications for those procedures.

Q. In your experience as an ob-gyn, did you ever treat patients who were hemorrhaging?

A. Yes.

Q. Under what circumstances did you treat patients who were hemorrhaging?

A. Boy, that's a wide -- a wide variety.

We treated it in the emergency room with intraabdominal hemorrhages from ruptured corpus luteum cysts. We had hemorrhages in obstetrics. We had hemorrhages with miscarriage. We had -- it can occur from anything that has a blood vessel.

Q. So you mentioned miscarriages. So is it

correct that you treated patients who were hemorrhaging in the miscarriage context?

A. I don't specifically recall personally having any patients hemorrhaging from a miscarriage.

Q. Do you recall treating any patients who were hemorrhaging during labor and delivery?

A. Yes.

Q. How are you defining "hemorrhage" in terms of amount of blood for a miscarriage?

A. So the official definition is 500 ccs of acute blood loss. However, in the situation, they don't have to get to 500 ccs for me to decide this is potentially life threatening, this is something I need to manage in a different way.

So acute active bleeding would be enough to alert me to need for intervention.

Q. And in terms of the amount of blood, how would you define "hemorrhage" in the labor and delivery context?

A. The definition would be -- for simple labor, again, it would be the sudden loss of 500 ccs of blood, which is an estimation, so we're always clinically estimating the briskness of the bleeding.

Q. And would you use the same definition in terms of ccs of blood to define "hemorrhage" in the D&C

context?

A. Yes. It can also be defined as the drop in hemoglobin, but obviously, acutely you're not going to have that.

So you're always estimating, and while it's an official definition, you're always watching for the briskness and whether you're at risk, basically the risk of acute blood loss.

Q. Have you ever treated patients who were hemorrhaging in an outpatient facility?

A. I don't recall that specifically.

Q. Do you ever recall a patient hemorrhaging during an office visit?

A. I don't have any recollection of somebody hemorrhaging in my office, no.

Q. If you were treating a patient and they started hemorrhaging, what interventions would you perform?

MR. BOYLE: Objection.

THE WITNESS: It would depend on the scenario.

BY MS. SALVADOR:

Q. If you were providing a D&C and that patient started hemorrhaging, what types of interventions might you perform?

A. It would depend on where I am in the procedure and which organ is involved.

Q. So let's go through a bunch of different possibilities.

So I'm hearing you saying that there's multiple interventions you could perform depending on the circumstances if a patient were hemorrhaging while you were providing a D&C; is that right?

MR. BOYLE: Objection.

THE WITNESS: You want to be specific as to the source.

BY MS. SALVADOR:

Q. So where -- what might be the source of hemorrhage for a patient during a D&C?

A. It could be coming from any of the organs within reach of your instrument. It could be coming from cervix. It could be coming -- if you've perforated, it could be coming from a large blood vessel.

It could be coming from the fact that you've instrumented the uterus and the uterus has not emptied the contents, and so you have a wide open base of the placenta bleeding. It could be from perforation of the uterus of the fundus and the major vessel. It could be coming from the myometrium.

There's a lot of potential places. It could be coming from a vaginal laceration.

BY MS. SALVADOR:

Q. So let's say -- let's start with that last one.

Let's say you were performing a D&C on a patient, and they started hemorrhaging from a vaginal laceration. What sort of interventions would you perform in that circumstance?

A. It would depend on exactly where it is. You want to make sure that you know where your ureters are.

So it depends on where it is, whether I can stop it by direct pressure, how deep the laceration is, how actively it's bleeding. Potential things I could do is pressure, silver nitrate, suture.

Q. And if a patient were hemorrhaging from their cervix during a D&C, what types of interventions might you perform?

A. Again, it'll depend on the location in the cervix, whether I've perforated the -- some of the major vessels come in that -- near the endocervical os. So if I perforated and gone into a uterine artery.

There's a lot of potential sources. If it's superficial, I would manage it the same as I did in the vagina. If it's higher up and I need to identify where

it is, is there a perforation, or where are my ureters? Where is my bladder?

And, again, it's going to depend on the specifics of where I -- where it is actually and whether there is a risk of perforation in the major blood vessel injury.

Q. Were you ever able to provide sutures to a hemorrhaging patient in an office setting?

A. Was I ever able to? Yes.

Q. Were you ever able to resolve a hemorrhaging -- resolve a hemorrhage with direct pressure in an office setting?

A. I don't recall. So we're talking about the difference between bleeding and active hemorrhaging. I don't recall ever in an office having active hemorrhage, first of all.

Q. In your experience as an ob-gyn, did you ever treat patients with cervical tears?

A. I don't remember specifically having cervical lacerations in my office. I don't have any recollection of any of those happening in my office.

Q. Outside of -- I'm referring to your general practice as an ob-gyn, not necessarily in an office setting.

Did you ever treat patients with cervical

tears?

A. Yes, I had patients with cervical lacerations.

Q. Did you treat patients with cervical lacerations in the miscarriage context?

A. I don't specifically remember having any. I don't recall having any specifically with cervical lacerations with miscarriage.

Q. Do you remember treating patients with cervical lacerations in the labor and delivery context?

A. Yes, I do.

Q. Did any of that treatment occur in outpatient facilities?

A. In labor and delivery, we were able -- we had everything that we needed to do those things in the labor and delivery suite, and there was an operating room literally down the hall if I needed it for visualization for whatever.

Q. And outside of labor and delivery, did you ever treat patients with cervical lacerations?

A. What do you mean by "outside labor and delivery"?

Q. In contexts other than labor and delivery, did you ever treat a patient for a cervical laceration who was not undergoing labor?

A. Yes.

Q. Under -- what was going on with that patient?

A. I don't remember the specific patient, but I am sure that in the context in one of the ORs, I'm sure that at some point I had to put a stitch in somebody's cervix. I don't remember ever having a hemorrhage.

Q. Do you remember whether you would -- let me rephrase this.

If you had to treat a patient's cervical laceration by putting a stitch in their cervix, would you have been able to do that outside of the hospital OR?

A. So, again, it's going to depend on where the laceration is, so it's going to depend on the circumstance.

Q. So does that mean that there are some cervical lacerations that you would have been able to treat with a stitch outside of a hospital OR?

A. Yes.

Q. Can you define "endometritis."

A. Endometritis is an infection that has gone into essentially the muscles of the uterus.

Q. Have you treated patients with endometritis?

A. Yes, I have.

Q. How did you treat those patients?

A. Typically with IV antibiotics.

Q. Were there any other treatments you gave to those patients?

A. Depends on the scenario. So I'm sure there were other treatments that I gave, but it would depend on the situation.

Q. And when you were treating your patients with endometritis with IV antibiotics, did that treatment require hospitalization?

A. At least initially. So my recollection is treating them inpatient.

Q. Do you recall ever treating patients with endometritis in your office?

A. Again, it's going to depend on the situation.

Q. I understand. I'm asking if you can recall any situation in which you treated a patient with endometritis in your office.

A. Again, it's going to depend on the situation. You know, endometritis, mostly you're dealing with postdelivery, and so the majority of those patients are going to be in the hospital.

Q. So you're saying that you cannot recall ever treating endometritis outside of the hospital setting; is that correct?

A. Well, you'd have to give me a scenario. Then

I could say whether or not I have. The majority of the time that I've seen endometritis has been postdelivery.

Q. And do you recall any other circumstances in which you've seen endometritis apart from postdelivery?

A. Well, you can have ascending infections with PID, but by the time that you've got fever and uterine tenderness, you're typically going to have them in the hospital at least initially.

Q. And what is PID?

A. Pelvic inflammatory disease.

Q. Are you familiar with hospital-acquired infections?

A. Yes.

Q. Generally speaking, what are those?

A. Well, any hospital-acquired infection just essentially means that you came -- you were in a hospital when you acquired the infection.

Q. Are hospital patients particularly vulnerable to infection?

MR. BOYLE: Object to form.

THE WITNESS: It depends on the situation.

BY MS. SALVADOR:

Q. What are some reasons that hospital patients might be particularly vulnerable to infection?

MR. BOYLE: Object to form.

THE WITNESS: There's, you know, basically their essential health. If they're immune suppressed.

Literally somebody who is delivering, if they're having a surgery, those are situations that would expose -- that could potentially expose you to infections picked up in a hospital. I couldn't address all of them, but those are some examples.

BY MS. SALVADOR:

Q. In your experience as an ob-gyn, did you ever have an experience where you were treating a patient in an outpatient facility and they needed to be transferred to a hospital?

A. I recollect one person transferring from -- yeah, I recollect one person in a surgical center.

Q. What procedure was that patient undergoing when they had to be transferred?

A. I actually can't remember what the procedure was. I just remember transferring her. It was -- it wasn't hemorrhage --

Q. Were you --

A. -- about what it was, but --

Q. Were you able to transfer that patient safely?

A. Yes. And remember, no matter where I was, the outpatient surgical center was at the hospital,

minutes away.

Q. Did you ever -- sorry. Let me rephrase.

You've testified previously that you used sedation in your practice as an ob-gyn; is that right?

A. Anesthesia did. I didn't personally.

OB did it as residents sometimes do some minimal IV sedation. I didn't do it outside of residency.

Q. Did you ever use sedation in your office practice?

A. No.

Q. What types of pain relief would you give patients in your office practice?

A. Well, primarily we were prescribing medication for them to take elsewhere.

So I think we had Toradol available. We didn't keep narcotics, so primarily we were first giving prescriptions, but we did have Toradol, as I recall, an anti-inflammatory injectable.

Q. And so would you use that inflammatory injectable in your office practice?

A. An anti-inflammatory?

Q. I'm sorry. Yes.

Would you use that anti-inflammatory injectable in your office practice?

A. I did -- I don't remember specifically using it, but I remember having it available.

Q. Do you recall any of your partners using it in their office practice?

A. I don't know what they did.

Q. Do you think that -- do you know why your office kept that available?

A. I don't remember the specific indications. I remember around the time we started doing hysteroscopies, around that time is when I remember having it at the office.

Q. In your opinion, is it medically safe to perform a D&C without general anesthesia?

A. So the question is, is it medically safe to perform a D&C without any anesthesia?

Q. No, without general anesthesia.

A. Oh, without general. Can it be medically safe? I mean, it depends on the situation, but it's, yeah, definitely possible.

Q. Would you say that there's a difference between deep sedation and general anesthesia?

A. Yes, there is.

Q. What's the difference between deep sedation and general anesthesia?

A. The primary difference typically is the level

of sedation. Also, general anesthesia sometimes uses muscle paralyzers, essentially, but it's the level of sedation and also whether the patient is respiring independently and whether they can protect their own airway.

Q. In your opinion, could it be medically safe to perform a D&C without deep sedation?

A. Could it be? Yes.

Q. Would the amount of physical pain experienced by a patient having a D&C for miscarriage management differ from the amount of physical pain experienced by a patient having a D&C for an abortion?

A. Sorry, I lost part of the question. Would you please reask.

Q. Sure.

Would the amount of physical pain experienced by a patient having a D&C change depending on whether that D&C was for the purpose of miscarriage or abortion?

MR. BOYLE: Objection.

THE WITNESS: That's a very -- it's dependent so much on the patient and their history and their circumstance.

So -- and I'm not aware of any head-to-head studies on that to be able to answer under oath. I

don't know. I don't have that information.

BY MS. SALVADOR:

Q. Based on your medical experience, if you had a patient -- if you had two patients with identical medical histories and one was having a D&C for miscarriage management and one was having a D&C for an abortion, would the amount of physical pain they experienced be different?

MR. BOYLE: Objection.

How is she supposed to speculate about two different people's pain thresholds and such? But she can answer.

THE WITNESS: The individual pain experience is so variable that I can't answer that.

BY MS. SALVADOR:

Q. What -- is there any difference in the performance of a D&C for an abortion as compared to performing a D&C for a miscarriage? Is there anything different about the procedure that would cause a difference in physical pain?

MR. BOYLE: Objection.

THE WITNESS: So the amount of pain is very individual. It depends on the number of passes, and it depends on how much tissue there is to remove and whether it's already partly macerated.

There are so many factors that individually, it's hard to say. I'm not able to answer that.

BY MS. SALVADOR:

Q. In your opinion, is it medically safe to perform a D&E without general anesthesia?

A. It again depends on the situation. It adds an extra nuance when the patient is awake.

Q. Does general anesthesia alone carry medical risks separate from the procedure a patient is undergoing?

A. Yes, it does.

Q. In your opinion, could it ever be medically safe to perform a D&E without general anesthesia?

A. You're asking a conjecture question. Could it ever be medically safe?

In other words, are you -- rephrase the question, please. I don't want to --

Q. Sure.

A. Yeah.

Q. Are you aware of any -- are you aware of D&Es being provided without general anesthesia?

A. I am not personally aware. I've not been privy to that.

At the University of Utah, our patients are generally asleep, as I've answered. I don't recall if

some of my patients may have had deep sedation versus general. So I'm not privy outside of that to what providers, medical professionals do.

Q. So is it fair to say that based on your practice, you're not familiar with performing D&Cs with -- I'm sorry -- D&Es without general anesthesia?

A. Well, I am aware of D&Es without general anesthesia.

As I said, I don't recall exactly if any of my patients and the anesthesiologist decided to proceed with deep sedation versus general. It's possible that I did. I don't have that specific recollection.

Q. And are you aware of D&Es being performed without general anesthesia without complications?

A. Again, I don't have personal knowledge of those.

Q. Are you familiar with the performance of D&Es without medical complications from your review of the literature?

A. Yes. But I don't have privy to their anesthetic record.

Q. Are you familiar with the provision of D&Es in your experience without deep sedation?

A. Without deep sedation or general anesthesia? Is that the question? Please help me with your

question.

Q. Sure.

So previously we were talking about general anesthesia for D&Es, and now I'm -- because you articulated before that there was a difference between deep sedation and general anesthesia, so I'm now asking about deep sedation.

A. Okay. So am I -- go ahead and ask the question again.

Q. Are you familiar with the provision of D&Es without deep sedation?

A. Well, sometimes -- we did general anesthesia a lot of the time. Not most of the time.

Q. Are you familiar with the provision of D&Es without either deep sedation or general anesthesia?

A. I am not personally familiar with them.

Q. Does your review of the literature indicate that some providers perform D&Es without either deep sedation or general anesthesia?

A. So the articles that I looked at didn't specify except for, I believe, there were two that looked at anesthesia -- at pain management.

And I don't recall whether they were D&Cs and D&Es, but I'd be happy to look at them. Or if they were both, I'd be happy to look at them.

Q. What about the D&E procedure would cause a patient physical pain?

A. Well, physical pain could just be from the weighted speculum, which is heavy. It's a different kind of speculum so that you can visualize and move your instruments.

It could be from grasping the cervix. It could be from dilation of the cervix. It could be from the instruments in the uterus touching the uterine wall, scraping the uterine wall. It could be from perforation if that happened. It could be from uterine cramping.

Those are the probabilities.

Q. In -- sorry. One more general anesthesia question. What -- you've mentioned before that general anesthesia alone carries medical risks apart from the underlining procedure itself; is that right?

A. Correct.

Q. What are some of those risks caused by general anesthesia?

A. Well, to clarify, there are risks and benefits. That's why we consider things, is because we have to weigh the risk and the benefit.

But the risk can be from -- if you're intubating because she's having general, they could be

from the actual intubation, which is extremely rare. Complications from anesthesia these days even in pregnancy are extremely rare, but it could be that.

It could be the patient aspirating at the time of extubation. And some anesthetics -- those are the primarily -- and obviously when you're asleep and having anesthetic, there are extremely rare cardiopulmonary complications. Again, they're incredibly rare.

Q. Is it -- I'm sorry?

A. So rare that their medical liability cost has plummeted because it is so rare now to have a complication.

Q. Is it your opinion that it's in every patient's best medical interest to receive general anesthesia with intubation when obtaining a second-trimester D&E?

A. I would not say every patient. I think again we need to weigh the risks and benefits of how difficult we expect the procedure to be.

We have to consider all the factors of what it's like both for patient and for the surgeon or operator to perform. They have to know their patient. They have to know her risk factors. They have to have a general idea of what I expect to happen and what may

go right and wrong.

The anesthesiologist may look at her airway and say actually, if I had to intubate her suddenly, that's going to be a hard intubation.

So there's a lot of factors that go into that decision that varies by the patient.

Q. Is it in your -- is it your opinion that it's in most patients' best medical interest to receive general anesthesia with intubation when obtaining second-trimester D&E?

A. I don't know that I can -- that's conjecture. Again, it's very individual.

I have to recognize for my -- each patient is different. Each anesthetic concern and benefit is different, so I have to evaluate it individually.

Q. Are you familiar -- I'm sorry.

Are you aware of the study by Turok, et al., finding that second-trimester D&Es are just as safely performed in clinics as in hospitals?

A. I can't agree with the last part of what you said, but I am aware of his study.

Q. Well, let's go back to paragraph 44 of your report.

A. Yes. I am there.

Q. In paragraph 44 of your report, you critique

the study by Turok on the basis that -- on the basis that, quote -- and this is toward the end of paragraph 44: "The complications in the hospital group's patients were most likely related to the medical conditions indicating the termination of the pregnancy rather than the location or technical skill and experience of the physician"; is that correct?

A. That's part of it. This other part was that the patient population groups were completely different. They were noncomparable.

Q. How is it that the patient groups were noncomparable?

A. Yes. So, as I recall, almost all of the patients with elective terminations at the outpatient clinic were elective, whereas within the hospital, there was a medical indication for the termination. So they were completely different populations.

I would have to look at the study to look at gestational ages to remind myself of the gestational ages whether they were comparable.

(Exhibit 12 Marked for Identification.)

MS. SALVADOR: I am dropping the study into the chat. Please mark it as an exhibit.

BY MS. SALVADOR:

Q. And then, Dr. Wheeler, please let me know

when you're able to open it.

A. Yes. I have it open.

Q. Great.

Dr. Wheeler, are you familiar with this document?

A. Yes, I am.

Q. Is it the study by Turok, et al., that we've been discussing from paragraph 44 of your report?

A. Yes, it is.

Q. So I will direct you to page 160 of the study in the left column.

A. Yes.

Q. I will direct you to the very last sentence of the paragraph -- the last paragraph in the left column.

It states: "However, the increase in complication rates for D&E and induction in the hospital groups persisted when controlling for maternal medical complications, preexisting infections, parity and gestational age in a multivariate regression model."

Did I read that correctly?

A. I wasn't finding the same sentence as you. Could you please direct me to it again.

Q. Sure. I'm on page 160.

A. Yes.

Q. There is a subheading that says "Discussion" in the left column.

A. Yes.

Q. And I'm looking at the very last sentence in that last column in the very bottom of the page.

A. Oh, the very bottom. Okay. I was at the first paragraph.

Q. So the very last sentence states: "However, the increase in complication rates for D&E and induction in the hospital groups persisted when controlling for maternal medical complications, preexisting infections, parity and gestational age in a multivariate regression model."

Did I read that correctly?

A. You read it correctly, but when you go to the table where it actually goes through the complications of the patients, it tells me a different story.

Q. Could you direct me to the table you're referring to.

A. There was a table.

Here we go. "Details of cases with major complications," Table 3. So I am on page 159.

So I see the first patient, hospital D&E, community hospital, severe preeclampsia/HELLP syndrome,

so a complicated patient.

Patient 2, lupus, renal failure on dialysis. Patient 3 transferred from outside hospital with subchorionic hemorrhage. In other words, a separation of the placenta requiring transfusion.

The next patient, Trisomy 13 complicated by uterine perforation. Next patient I see intrauterine fetal demise. Next patient, I see essentially fetal demise chronic abruption.

Next patient, I see nephritis, a renal problem with transfusion. Renal problems often go together with abnormal clotting.

The next patient I see again fetal demise. Next patient I see a complication laminaria, but I don't see her indication for the delivery. The next patient, again hospital induction. I see a fetal demise -- patient with fetal demise.

The next one I see had a baby with anomalies, so there were two anomalies babies. The next one I see previable ruptured membranes. The next one, intrauterine demise.

The next one, previable ruptured membranes. The next one, previable ruptured membranes. The next one, HELLP syndrome. The next one, previable ruptured membranes.

So we're talking about very complicated patients except for the two patients with anomalies. The last one, patient with anomaly.

The clinic D&E patients, I see one anomaly. And then his quoted elective rate I'm recalling is 98 percent. I would want to verify that, but less than 2 percent or so is my recollection that had any -- at least theoretical medical complications.

So we're talking about very different patients.

Q. So you just read out to me the summary of patients from Table 3; is that right?

A. I summarized what I saw on Table 3.

Q. And Table 3 is referring to the details of cases with major complications; is that right?

A. That's correct.

Q. So Table 3 is not listing all of the patients in the hospital population who had maternal medical complications; is that right?

A. According to Table 3, it's details of cases with major complications, which is he's comparing complications and major complication between the two groups and drawing conclusions about -- because the University of Utah does not do elective abortions.

So he's comparing elective abortions in an

outpatient setting, primarily, with hospital patients with medical indications with nearly all of the patients with major complications having an underlying medical condition.

Q. So I'll refer you to the prior page, the last sentence of the prior page which is, I believe, page 158.

So the last sentence of page 158 starts: "The proportion of procedures with major complications was greater --"

A. I don't see that. Where are you? "The need for exploratory surgery" is what I'm seeing.

Q. Yes, it's that paragraph. It's the last sentence before you hit the bottom of the page.

A. Yes. Okay.

Q. So the last sentence before you hit the bottom of the page states: "The proportion of procedures with major complications was greater in both the hospital D&E (11 percent) and hospital induction groups (10 percent) compared to the clinic D&E group (1 percent)."

And then it continues past the chart. "The overall complication rate was greatest for the hospital induction group, Table 2. Details of major complications are shown in Table 3"; is that correct?

A. That is what the -- that is what he wrote.

Q. So doesn't that mean that Table 3 is referring to procedure complications, not the complications that the patients came in with?

A. It's -- well, you have to put the whole picture together.

So these are people who came in and had these procedures done for medical indications and had major complications. So procedure complication rates are affected by the situation.

So -- go ahead.

Q. I just want to clarify. I think you're stating that Table 3 describes the patients who came in with major complications and experienced major complications during their procedures; is that right?

A. Table 3 is patients who had complications of the procedures and some of the details of their medical history.

So when I read what he says -- again, when I see a conclusion drawn, then I have to make sure that it makes sense and fits the evidence that is being presented.

So when he says that 10 percent with hospital induction, 11 percent hospital D&E versus 1 percent clinic D&E had major complications, I have to say to

myself, who are the people -- who are the patients we're talking about, and is it because of location and clinical expertise, or is it because of some other factor?

And so then I go to Table 3, and I say wow, those are complicated patients. I don't think you can explain the difference without looking at the patients saying 98 percent in one group don't have any significant medical problems are purely an elective procedure versus the complexity of these patients. They're noncomparable.

I can't draw that kind of conclusion. I can't say this is because of location or technical acuity. I have to say, well, the patients had a lot to do with this, their medical history.

Q. So is it fair to say that you're assuming that because 98 percent of patients in the clinic D&E group were undergoing elective termination, that they did not have complicated medical histories?

A. I'm not -- I'm not saying that. I'm concluding that, but he did not specifically -- I mean, people who are medically complicated like these people are, I just know at the University of Utah you're going to have some complications if they're getting delivered, because they don't do elective terminations.

There's always a medical indication in Utah.

Q. Are you saying generally that people with complicated medical conditions don't elect to have abortions before they're medically required?

MR. BOYLE: Objection.

THE WITNESS: I'm sorry. Please repeat that.

BY MS. SALVADOR:

Q. Are you saying that people with complicated health-care conditions don't choose to have elective abortions?

MR. BOYLE: Objection.

THE WITNESS: That is not what I'm saying.

I am looking at Table 1, maternal medical problems. So, you know, I'm saying when I'm looking at this particular study when I'm looking at the people who had the complications, they're the people I would expect to have complications, and that the acuity of the patients having terminations of their pregnancy at the University of Utah setting is going to be almost completely women with medical problems compared to an outpatient clinic.

It's just the patient population that's in each of those clinics.

BY MS. SALVADOR:

Q. Have you ever performed a multivariate

logistic regression model?

A. I have not.

Q. Do you know how they work?

A. I do not.

Q. So I will refer you to page 159 in the right column.

The first full paragraph of the right column starts with the sentence: "A multivariate logistics regression model was developed to control for the potential confounding effects of maternal medical complications, preexisting infections, infection that developed during the course of termination, parity, and gestation."

Did I read that correctly?

A. Yes, you did.

Q. Are you familiar with -- actually, I retract that question.

MS. SALVADOR: I think we are at a good time for a break. Can we go off the record.

(Off the record 5:46 p.m. to 5:55 p.m.)

BY MS. SALVADOR:

Q. So, Dr. Wheeler, what is an ectopic pregnancy?

A. An ectopic pregnancy is defined as a pregnancy that has not implanted within the uterine

cavity or endometrium.

Q. How are ectopic pregnancies detected?

A. Well, primarily they're detected by -- you mean how is the diagnosis made? What is your question?

Q. Yes. How is a diagnosis of ectopic pregnancy made?

A. It's most often made by a patient presenting with symptoms, obtaining an intrauterine -- I'm sorry -- an ultrasound, often abdominal first. Transvaginal if you can't see the pregnancy location, assuming, of course, she has a positive pregnancy test.

And if you see the pregnancy is in the endometrial cavity, then it would be very rare to have an heterotopic pregnancy. So typically that's diagnostic by ultrasound.

If you don't see the location, then you have to determine where the location is for a woman who presents with symptoms. And that's typically by following hormone levels, quantitative beta hGC levels in the serum.

Q. How early can an ultrasound detect a pregnancy?

A. Definitively, somewhere between -- typically between five and six weeks you'll see the gestational sac in a normal pregnancy. Typically by six weeks

you'll see the embryo with cardiac motion, typically, if there's accurate dating.

Q. Have you ever treated a patient with an ectopic pregnancy?

A. Yes.

Q. About how many patients have you treated with an ectopic pregnancy?

A. I don't recall a number.

Q. Would you say that treating patients with an ectopic pregnancy was a regular part of your practice when you were an ob-gyn?

A. It was definitely part of my practice. Between my practice and the emergency department, yes.

Q. Would you say that you saw multiple patients with ectopic pregnancies every year when you were practicing as an ob-gyn?

A. I don't know if I can say every year, but I saw multiple patients.

Q. When was the last time you treated a patient with an ectopic pregnancy?

A. I don't recall if I had any in the last few years at St. Mark's. I can't recall, and I can't recall if I did with residents. I know I definitely did them through my practice at St. -- at Millcreek.

Q. Have you ever screened a patient for ectopic

pregnancy?

A. What do you mean, "screen"?

Q. Have you ever evaluated a patient to determine whether they have an ectopic pregnancy?

A. Did I ever evaluate as far as work up? Yes.

Q. What would be involved in that workup?

A. What I've already described. So, you know, essentially either somebody who happens to have high risk factors for ectopic pregnancy and represents with a pregnancy or somebody coming in with pain or with bleeding.

And it's the workup I've described to you if they have a positive pregnancy test, and the next step would be to perform an ultrasound in addition to lab work. But getting an ultrasound, identifying if we can see -- you know, if it's definitive if we see the gestational sac and/or embryo in the endometrial cavity. And if not, then you would begin doing quantitative serum beta hGCs.

Q. About -- or let me rephrase.

Was conducting workups for ectopic pregnancy a regular part of your practice as an ob-gyn?

A. I'm not sure what you mean by "regular." It's part of an ob-gyn practice.

Q. Would you say that you screened -- or

conducted an ectopic workup for a patient of yours multiple times over the course of your time practicing as an ob-gyn?

A. Yes.

Q. Would you agree that a workup protocol for ectopic pregnancies or for potential ectopic -- sorry. I'll start again.

Would you agree that an ectopic workup protocol that uses ultrasound, medical history, current symptoms, and serial hCG testing is appropriate?

A. Appropriate for? Please rephrase that.

Q. Would you agree that an ectopic workup protocol that uses ultrasound, medical history, current symptoms, and serial hCG testing is an appropriate workup to determine whether someone has an ectopic pregnancy?

A. So to qualify, the diagnosis is primarily made with ultrasound, hCGs if we cannot determine the location on ultrasound.

The history primarily guides us to the patients who have not presented with pain and bleeding who are pregnant who may need a ruling out of ectopic because they have high risk factors. I see that as a separate category.

Q. What is a pregnancy of unknown location?

A. What is a pregnancy of unknown location? The definition appears to have evolved in the literature.

The current definition in the majority of articles but not all of them is that there's no evidence of gestational sac in the uterine cavity, that essentially it's an empty uterus with a positive pregnancy test.

Q. Would you consider a pregnancy of unknown location equivalent to a confirmed ectopic pregnancy?

A. No.

Q. If a patient has a pregnancy of unknown location but is not experiencing any symptoms of ectopic pregnancy and doesn't have any indicated risk factors for ectopic in their history, would you consider that a suspected ectopic pregnancy?

A. So this is a difficult question to answer because clinically that normally is not the case, unless I have somebody who has high risk factors and I'm getting an early ultrasound when they don't have symptoms. The majority of the time we're dealing with patients with symptoms. So it's a hard question to answer.

Q. Do you believe that all pregnancies should be assumed to be ectopic until proven otherwise?

A. As in every pregnancy should be? No.

Q. Do you recall ever treating a patient with a pregnancy of unknown location who didn't have symptoms of ectopic pregnancy or risk factors for it?

A. I don't -- I remember having patients who are at a high risk that I identified in early pregnancy as being high risk for ectopic pregnancy that I sent for ultrasounds. I do not recall the outcomes.

Q. In your career as an ob-gyn, how early in a patient's pregnancy would you typically perform an ultrasound?

A. In a routine pregnancy?

Q. Yes.

A. So if there is nothing else going on in the pregnancy to indicate an early -- a medical indication for an early one, our typical first one would be somewhere between 16 and 20 weeks as a screening ultrasound.

Q. Did it ever happen in your practice where a patient had a positive pregnancy test, but an ultrasound did not detect the pregnancy?

A. Did not detect the location of the pregnancy? Yes.

Q. What would your next step have been in treating such a patient?

A. It depends on her symptoms and whether she's clinically stable.

Q. What if that patient didn't have any symptoms, they just came in with a positive pregnancy test and an ultrasound did not detect the pregnancy?

MR. BOYLE: Object to form.

THE WITNESS: So that would be -- that would be an unusual circumstance for somebody to walk in with an ultrasound and no symptoms.

In usual clinical practice, that would be something I don't recall seeing, again, unless they're very high risk. If they're a high risk and she's had an ectopic before, she's going to get an early ultrasound.

So that would be the only circumstance I can think of. In that patient, no location, is high risk, my next step if she's stable is to get a quantitative beta hCG, and depending on her symptoms, possibly other labs.

BY MS. SALVADOR:

Q. If that patient was not having symptoms, would you refer them to the emergency room?

MR. BOYLE: Object to form.

THE WITNESS: I'll be coy. The emergency room is just going to call me, so -- we manage our own

patients with ectopic pregnancies.

So I wouldn't be sending her to the emergency room unless she was unstable or it was after hours and that's the only place I could obtain the workup that she needed.

BY MS. SALVADOR:

Q. What happens if an ectopic pregnancy ruptures?

A. Well, that varies with the patient, so there's a lot of potential different scenarios, but it's a high risk situation. It's a life-threatening situation.

Q. What makes it a life-threatening situation?

A. Hemorrhage. Intraabdominal hemorrhage.

Q. What are the symptoms of ectopic rupture?

A. A ruptured ectopic. You know, I've been impressed with patients with ectopics. It's been one of the hardest parts of my career because the symptoms are all over the place.

But once they rupture, the majority of women are going to have a very severe localizing pain as opposed to general pain. If there is a huge amount of blood in the abdomen already, they may syncope. They may die quickly. They may have irritation of the diaphragm, so right upper quadrant pain and right

shoulder pain. They may have dizziness.

Q. Would people experiencing ectopic rupture potentially feel a popping sensation?

MR. BOYLE: Objection.

THE WITNESS: You know, I'm not aware of any patient ever telling me that. That's not something I typically associate, a popping sensation. That's -- I've never heard a patient say that.

BY MS. SALVADOR:

Q. You referred to bleeding. About how much external bleeding is there with a typical ectopic rupture?

A. Ectopic rupture doesn't necessarily cause vaginal bleeding. So the definition -- the pain -- it could be pain. It could be bleeding. But typically we're not -- we're talking about, with rupture, intraabdominal bleeding. That's the point.

Q. In your experience as an ob-gyn, did you treat patients who had miscarriages prior to 11 weeks LMP?

A. Yes.

Q. What are the typical symptoms of a miscarriage prior to 11 weeks LMP?

A. Again, it's variable, and it depends on the definition, where she is in that process of

miscarriage.

Q. What are some of the symptoms that came up frequently in your practice for patients having miscarriages prior to 11 weeks LMP?

A. It was variable. So it could be just some spotting. It could be minimal spotting. It could be minimal cramping. It could be heavier bleeding. It could be just some vaginal discharge that was different. It could be some low back pain.

Q. You testified earlier that you've never provided a medication abortion; is that correct?

A. That is correct.

Q. In fact, all of the abortion training you received in your residency predated the FDA approval of mifepristone for abortion; is that correct?

A. Yes, that's correct.

Q. What training and education have you received on medication abortion over the course of your career?

A. So primarily with my board certifications and just typical keeping up with literature. So I read the literature.

Q. Did you receive any training on medication abortion from AAPLOG?

A. Training to perform medication abortion?

Q. No. Just training on the subject of

medication abortion.

A. I was not trained by AAPLOG in any manner regarding that. I did not receive any specific training on medication abortion. I've read the literature, a good sample of the literature.

Q. What literature on medication abortion have you reviewed?

A. Well, I can't cite the specific ones, but when mifepristone and misoprostol were initially coming out, I read studies. I can't cite the exact ones. That's been a while.

But I remember reading it with interest, wondering about it, reading about it. Of course, it's been on the board certification which I've continued to do through the years. I have read quite a bit just in my curiosity about it, and I have -- so I've read quite a bit about it as my curiosity about it.

Q. Have you read any literature on medication abortion apart from the sources that are cited in your report?

A. I'm sure I have. As I said, I try to keep up on things. I don't read everything, but I try to sample things that are things that I don't yet know or to add to what I know.

Q. Can you recall any specific literature on

medication abortion that you've reviewed that you did not cite in your report?

A. On the top of my head, I can't recall to tell you exact ones. I think I have cited my most -- I've cited in there the ones that I felt were relevant to my discussion for today.

Q. Other than your participation as a witness in this lawsuit, in what circumstances have you considered the safety of providing medication abortion to patients with pregnancies of unknown location?

MR. BOYLE: Object to form.

THE WITNESS: Yeah, I'm not sure -- I want to make sure I'm following your question. Can you please repeat that.

BY MS. SALVADOR:

Q. Sure.

Did the safety of providing medication abortion to patients with pregnancies of unknown location come up in your medical training?

A. No, it did not.

Q. Did the safety of providing medication abortion to patients with pregnancies of unknown location ever come up in your clinical practice?

A. The question of safety did not, no.

Q. Had you read any medical or scientific

publications on the safety of providing medication abortion to patients with pregnancies of unknown location before beginning work on this case?

A. No, I had not.

Q. Let's go to paragraph 54 of your report, please.

A. Paragraph 54; is that correct?

Q. Yes. That's right.

A. Okay. I have it.

Q. In paragraph 54, you have written here: "Due to the similarity of symptoms of chemical abortion and of ectopic pregnancy, it is not possible for the patient to be able to discern what are normal symptoms of medical abortion and what symptoms require urgent attention for possible ectopic pregnancy."

Did I read that correctly?

A. Yes, you did.

Q. Would talking to a medical professional help a patient determine whether their symptoms are normal for medication abortion or whether they require urgent attention for possible ectopic?

MR. BOYLE: Object to form.

THE WITNESS: To know based on the symptoms alone, as a medical professional, the symptoms are so similar you can't -- based on history, you can't

distinguish the two based on the normal use of medical abortion and the symptoms prior to ectopic rupture.

BY MS. SALVADOR:

Q. Would it be fair to say that it is not possible for a patient to distinguish between symptoms of medication abortion and symptoms of possible ectopic pregnancy on their own without medical guidance?

MR. BOYLE: Object to form.

THE WITNESS: The symptoms are essentially the same, so asking the patient to decide whether their symptoms are one or the other places the patient at risk.

BY MS. SALVADOR:

Q. So is it fair to say that a patient should seek medical guidance in order to distinguish between symptoms of medication abortion and symptoms of possible ectopic pregnancy?

MR. BOYLE: Objection.

THE WITNESS: The patient's not going to be able to differentiate. They're -- the symptoms are the same. So telling a patient to come in if you have these symptoms, those are the symptoms that patients -- I know people who have taken medical abortion. I've heard the stories, personal stories. The symptoms are very similar.

BY MS. SALVADOR:

Q. So would it be fair to say that somebody who has received a medication abortion should seek medical guidance if they are concerned about their symptoms?

A. Well, certainly any patient who's concerned about their symptoms should seek guidance.

Q. In paragraph 65 of your report -- please let me know when you're there.

A. Yes, I'm there.

Q. In paragraph 65 of your report, you quote ACOG Practice Bulletin 193's statement that "Serum hCG alone should not be used to diagnose an ectopic pregnancy"; is that correct?

A. Yes.

Q. Is it your understanding that Planned Parenthood South Atlantic uses hCG alone to diagnose ectopic pregnancy?

A. It is my understanding that with intrauterine -- without seeing an intrauterine pregnancy, so a pregnancy of undetermined location, that at that point serum hCGs are followed and only repeated if there's a question about the 2,000 -- the use of 2,000 discriminatory zone, or if they have particular symptoms.

Otherwise, they're following serum hGC if

they're following and not distinguishing.

Q. So my question was is it your understanding that Planned Parenthood South Atlantic uses serum hCG alone to diagnose ectopic pregnancy?

A. I think the question is whether they're diagnosing ectopic pregnancy.

So I'm not -- you know, I don't work there, so I'm not sure exactly what they're doing. I've only seen their protocol.

Q. Is it your understanding that Planned Parenthood South Atlantic provides medication abortion to patients with pregnancies of unknown location without those patients having an ultrasound?

A. What I've seen is the report of Dr. Farris and the report that they use that protocol. So I don't know if they're doing a protocol ultrasound on everybody.

Q. Let's go to paragraph 78 of your report.

A. Yes.

Q. In paragraph 78 of your report, you state that Planned Parenthood South Atlantic's protocol "May" -- and I'm quoting from the second half of the paragraph, which is on the following page -- quote: "May place women at increased risk of complications from undiagnosed ectopic pregnancy, including a delay

in diagnosis"; is that correct?

A. Yes.

Q. What part of the IUP documentation requirement ensures that patients will be screened for ectopic pregnancy?

A. Please repeat that.

Q. Sure.

What part of the IUP documentation requirement ensures that patients will be screened for ectopic pregnancy?

A. What part of whose IUP document?

Q. I'm referring to the IUP documentation requirement that's being challenged in this case.

A. Okay. So I'm sorry. I'm just -- I don't know why I'm having trouble following this. Go ahead and just ask me again, please.

Q. Sure.

Does the IUP documentation requirement being challenged in this case --

A. Oh, okay.

Q. -- ensure that patients will be screened for ectopic pregnancy?

A. My understanding of this is to be sure that an intrauterine pregnancy is documented prior to giving abortion medication.

Q. So is it your understanding that the IUP documentation requirement prevents patients with pregnancies of unknown location from obtaining a medication abortion?

A. My understanding is if they don't have a documented intrauterine -- if you cannot document that they have an intrauterine pregnancy, then the medication should not be given until that is documented.

Q. Does the IUP documentation requirement require that patients be screened for ectopic pregnancy?

A. Well, it requires them to have a documented intrauterine pregnancy, so that would go hand in hand with verifying where the -- where the pregnancy is.

So the effect of that is, yes, you're ruling out an ectopic pregnancy, making sure it's intrauterine before you give medication that's meant for intrauterine pregnancies that are undesired.

Q. Does the IUP documentation requirement ensure that patients will receive a full ectopic workup?

A. What it does, it has a specific intent. The way that I'm interpreting it is to make sure they have an intrauterine pregnancy. That appears to be the focus.

As a medical professional, it is my medical responsibility as the caretaker of this patient if there's a question that she might have an ectopic to manage her appropriately. I don't need a law for that.

Q. And the law doesn't require that, does it?

MR. BOYLE: Objection.

THE WITNESS: This law -- no, this law doesn't, but that's part of -- I mean, that's medical malpractice if you don't know where the pregnancy is and she has symptoms and there's a question of her health, that's medical malpractice to not determine where it is.

If I have a patient I'm concerned about an ectopic pregnancy, I don't need a law for that.

BY MS. SALVADOR:

Q. Staying in paragraph 78, the very last sentence of paragraph 78, you state that: "Abortion is most commonly not required in such situations due to the high rate of spontaneous abortion in women with ectopic pregnancies"; is that right?

A. That's what it says. That is an editing error, and that should say "with pregnancies with undetermined location."

That was a conclusion. I was just bringing down my conclusions, and I see I should have put "with

pregnancies of undetermined location."

Q. Are you -- I'm sorry. Could you clarify what the sentence should have been.

A. It should say: "Moreover, abortion is most commonly not required in such situations due to the high risk of spontaneous abortion in women with pregnancies of undetermined location."

Q. Understood.

Is that because you believe that spontaneous abortion is preferable to induced abortion?

A. It doesn't have any moral judgment for me. It's just the way it is in the studies showed that -- and I cited the studies that the women in this situation had a very high rate of not taking the medication if they have a delay in treatment, and the delay treatment are a very large number of them spontaneously miscarry with no medical intervention.

In other words, it would be overtreatment to prescribe them the medication in that circumstance. Most of them didn't need it.

Q. Do you believe that a person's desire for medical treatment is a valid reason for clinical urgency?

A. Those are big questions. I'm not sure how to answer that. Can you restate it.

Q. Sure.

Do you believe that a person's desire to have a medical procedure is a valid reason for clinical urgency?

A. Well, I -- I mean, that's conjecture. It depends on what the situation is.

You know, medical urgency -- "urgency" typically means that there's something urgent happening, so it would depend on the situation.

Q. Do you believe that a person's desire not to be pregnant against their will could be a valid reason for clinical urgency?

A. Are we talking about rape and incest?

Q. Let's start with rape and incest.

Do you -- do you believe that a person's desire if they're the victim of rape or incest not to be pregnant against their will is a valid reason for clinical urgency?

A. In what manner are you talking clinical urgency? Like --

Q. So I'll refer you to paragraph 64 of your declaration -- of your report.

A. Okay.

Q. So in the middle of paragraph 64 of your report, you state: "There is no clinical urgency nor

clinical benefit to treating a woman with PUL with chemical abortion"; is that correct?

A. Yes.

Q. So do you believe that a person's desire not to be pregnant against their will could ever be a valid reason for clinical urgency?

A. Well, again, we're -- I'm talking specifically about dealing with PUL, and so I'm talking about a very specific situation is what I'm talking about in 64.

Q. So you did not answer my question, which was do you believe that a person's desire not to be pregnant against their will could ever be in any situation a valid reason for clinical urgency?

A. Again, it would depend on the rest of the clinical situation, but the only people who are pregnant against their will are people who have been forced into becoming pregnant.

So we're talking about abuse, we're talking about rape, and we're talking about incest. Is there a clinical urgency where I have to do something today about that? No.

MS. SALVADOR: Thank you, Dr. Wheeler. I think we're wrapping up.

Can we just take another quick break, and

then we'll see if there are any questions left.

(Off the record 6:32 p.m. to 6:42 p.m.)

BY MS. SALVADOR:

Q. Dr. Wheeler, are you testifying today as an expert in second-trimester D&E for miscarriage management?

A. D&E, yes.

Q. Are you testifying as an expert in second-trimester D&E for induced abortions?

A. Yes.

Q. Are you testifying as an expert in first-trimester D&C for miscarriage management?

A. Yes.

Q. Are you testifying as an expert in first-trimester D&C for induced abortion?

A. Yes.

Q. Are you testifying as an expert in medication abortion?

A. Are you saying as having performed them, or as having the knowledge and expertise?

Q. Are you testifying as having expertise in medication abortion?

A. Yes.

Q. Are you familiar with what's required for doctors to get hospital admitting privileges in

North Carolina?

MR. BOYLE: Object to form.

THE WITNESS: Not in North Carolina.

BY MS. SALVADOR:

Q. Do you know how many hospitals provide abortions in North Carolina?

A. I am not privy to that.

Q. Do you know how much hospitals charge patients who obtain abortions in North Carolina?

A. I do not have that information.

Q. Would it be fair to say that all surgeries carry some level of risk?

A. Yes.

Q. Does that include some risk of complications requiring treatment in a hospital?

A. It depends on the procedure.

Q. Would you say that there are any surgeries that don't carry a risk of complications requiring treatment in a hospital?

A. Is it possible that anything that you do to a patient could require a hospitalization? It's possible.

Q. But we don't require all surgeries to be performed in hospital operating rooms; right?

MR. BOYLE: Objection. Who's "we"?

BY MS. SALVADOR:

Q. Sure.

When you were a practicing ob-gyn, were you required to perform all surgeries in a hospital operating room?

A. All surgeries in a hospital? No.

Q. Do you think it would be good medical practice to require all the surgeries you performed to take place in a hospital?

MR. BOYLE: Objection. Object to form.

THE WITNESS: Every single surgical-type procedure in a hospital as a requirement? It depends on the surgery.

I mean, every single surgery or procedure that you perform on someone, you have to weigh whether there's a risk that it would be safest for the patient. So you're always determining where it's safest -- to perform this surgery or procedure depending on what it is.

BY MS. SALVADOR:

Q. I'm sorry. You kind of -- I couldn't hear you as well toward the end of that answer. Could you repeat it.

A. I'm sorry. My voice is going. Can you please repeat your question so I make sure I'm

answering it.

Q. Sure.

Do you think it would be good medical practice to require every surgery that you performed as an ob-gyn to take place in a hospital?

MR. BOYLE: Objection. And object to form.

THE WITNESS: So, again, my choice of location always would be based on the procedure, the patient, the circumstance. So it would depend on the clinical situation and the patient.

BY MS. SALVADOR:

Q. In paragraph 33 of your report -- please let me know when you get there.

Yes?

A. Yes, I'm there.

Q. The second sentence of paragraph 33 is: "Patient safety is more important than not the relatively small inconveniences of performing abortion in a hospital."

Did I read that correctly?

A. You read it correctly. The "not," I believe, was from editing and moving the paragraphs around and revising it, that when it was revised I -- that's in editing.

Q. So were you trying to say that "Patient

safety is more important than the relatively small inconveniences of performing abortion in a hospital"?

A. That is correct.

Q. What do you mean -- or what did you mean when you referenced "patient safety" here?

A. Well, let me go to what was just before that.

So in this section we're talking about dilation and evacuation and the location of that procedure.

And in my assessing it, as in all of my medicine, that I'm always going to put the patient's safety and best interests before a concern for access. I'm always going to want to do what's in my patient's best interest and in the safest way that I can provide that.

So there may be some things that are inconvenient sometimes for my patient, but as they say, safety first.

Q. When you're referring to patient safety here, do you mean ensuring that any possible complication can be treated on-site?

A. There are multiple aspects to patient safety. Some of them are trying to avoid complications. Some of them are trying to provide it in an environment that's going to be safest. Some of it is going to be

able to manage complications or emergencies should they arise, what additional resources are available. The situation where a complication arises, what's the likelihood of that.

Those -- there are many factors such as that that go into addressing am I doing this in her best interest and in the safest way that I'm able.

Q. Do you -- you previously testified that gynecology is very patient specific; right?

A. I'm sorry. Can you ask that again.

Q. Sure.

You previously testified that providing gynecological care is very patient specific; right?

A. I'm not quite sure what you're asking.

Q. So you testified that whenever you were providing care or treatment to somebody as a gynecologist, that treatment would vary depending on the patient's individual circumstances and needs; is that right?

A. That's correct.

Q. And was the same true of your obstetrics practice?

A. Yes.

Q. You testified more specifically that each D&C you performed was very individualized based on the

specific circumstances of each patient; is that right?

A. That's correct.

Q. And you testified that you provided D&Cs for miscarriage management; is that right?

A. Yes.

Q. And that you performed just one D&C for abortion purposes; is that right?

A. For elective induced abortion, yes.

Q. Did you perform D&Cs for any other purposes?

A. Gynecology.

Q. And what do you mean when you say you performed a D&C for gynecology?

A. So there would be many different indications, but say I'm ruling out a uterine cancer or I am -- the patient has prolonged heavy bleeding and is not pregnant and I need to sample her endometrium, things like that.

Q. Would you say that each D&E you performed was very individualized based on the specific circumstances of each patient?

A. Yes.

Q. Given the patient-specific variables, do you believe it's possible to make categorical statements about the safety of D&Es?

A. My categorical statement is that I'm going to

take patient safety as a priority over inconvenience. My job in medicine is to minimize -- is to do the best I can for my patient and minimize risk.

Q. You testified previously that the literature says that providers, again, performing D&E at around 13 to 14 weeks' gestation; is that right?

A. Please repeat that.

Q. Sure.

You testified that according to the literature, providers begin performing D&Es around 13 to 14 weeks' gestation; is that right?

A. That's correct.

Q. Did you review any literature on that other than what is cited in your report?

A. I've read so much about that over time. Specifically for this, I chose the references that would address the questions. But, yes, I've done a fair amount of reading on that.

Q. Did anyone recommend that you review specific articles or materials on this point?

MR. BOYLE: Objection.

And I'll instruct you not to answer about anything that was a discussion between lawyers and you.

And if you can't answer, just tell her you can't answer, please.

THE WITNESS: I'm not able to answer that.
BY MS. SALVADOR:
Q. Did anyone other than your attorneys recommend that you review specific articles or materials on when providers begin performing D&E?
A. No.
Q. Did anyone -- did you review those materials -- did you review any particular materials to refresh your memory before this deposition?
MR. BOYLE: Objection.
THE WITNESS: I reviewed what I cited.
BY MS. SALVADOR:
Q. Which particular materials did you review on the point that providers begin performing D&E around 13 to 14 weeks' gestation?
A. So I reviewed my citations, and so whatever is cited here, I reviewed.
Q. So to summarize, is it accurate to say that over the course of your career, you provided one D&C elective abortion; is that correct?
A. One D&C elective induced abortion, yes.
Q. Is it fair to say that you provided that elective abortion before approximately the year 2000?
A. I don't recall the year. It was somewhere in my earlier part of my practice.

Q. You had said before that it was in the earlier part of your time at Millcreek; is that correct?

A. That's right.

Q. Is it accurate to say that you provided D&E abortion to a small number of patients while you were at Millcreek?

A. I don't remember the number, but I did provide them at Millcreek, yes.

Q. I believe that you had -- you testified before that you provided abortions infrequently; is that correct?

A. I don't remember the exact word that I used but --

Q. I'm sorry. What was the last thing you said?

A. I don't remember the exact word I used, but I did not perform them frequently.

Q. So is it accurate to say that you did not provide D&E abortions frequently during your time at Millcreek?

A. Yes, that's accurate.

Q. And is it accurate that you did not provide D&E abortions after you left Millcreek?

A. Induced abortions, I don't recall doing any after leaving Millcreek.

Q. Is it accurate to say that you have never provided medication abortion?

A. That is accurate.

Q. Is it accurate to say that you have never provided aspiration abortion, meaning using suction only?

A. Again, I don't recall the one -- the one that I did in the first trimester, I don't recall if that was completely aspiration. It was aspiration was used. I just don't have specific memories whether I had to use a curette.

Q. And are you referring to the one elective D&C that you performed that we've discussed?

A. Yes.

Q. Do you have any experience providing abortion other than what we've discussed?

A. No.

Q. And when you provided D&E abortions, do you recall whether those were performed in a hospital operating room or in an ambulatory surgical center?

A. I've answered that. And my recollection, again, I have specific memory of one in an operating room. I don't recall on the other ones exactly, again, if I did them. But, again, I don't recall the exact circumstances. I have a definite, distinct memory of

one in an operating room in the main OR.

MS. SALVADOR: Thank you, Dr. Wheeler. I have no further questions.

MR. BOYLE: Is it my turn?

EXAMINATION

BY MR. BOYLE:

Q. Dr. Wheeler, good evening.

My name is Ellis Boyle. I represent the intervenor defendants. I have some questions for you. Thank you for your time here today, first.

Is it true that the placenta with a patient mother who is having a miscarriage is already working on unhooking itself, the blood vessels and such from the mother's womb, and removing the dead baby from the woman's body at the point that you would be doing a D&C or a D&E on a patient with a miscarriage?

A. It's true that most of the time, but when you diagnose it, it's -- usually there's been some time since the baby passed, and usually some of those processes are naturally happening.

Q. So it would be true, then, with the situation where mother had a miscarriage and the baby was stillborn yet still inside her womb that the blood vessels from that mother's uterus to the placenta would be clotting and already naturally preparing themselves

to detach when that deceased stillborn baby is removed from the mother's body if it happened naturally; is that correct?

A. Yes. Usually by the time of diagnosis there are some changes in the placenta.

Q. And that would be different than the placenta for an induced abortion context where the baby is alive up until the point of the induced abortion, and all of the blood vessels that are connected and actively engaged from the mother's body in the uterus to the placenta are sending blood and nutrients and oxygen into the baby, the developing baby's body and taking out waste products to help that baby grow and develop; is that correct?

A. Yes.

Q. And so when you're cutting out a live baby in an induced abortion and the placenta is not clotted off and all the blood vessels are active and sending and receiving blood from the mother's body to the baby's body, would you agree that that is a situation with an induced abortion that could lead to much more bleeding and hemorrhage than you would typically find in a miscarriage situation?

A. In my clinical experience -- first I'd say we're not cutting the baby out. We're usually grasping

and pulling out. So I'd clarify that.

But my clinical experience is the bleeding is typically entirely different. Much heavier bleeding. Literally you put your instrument in sometimes, and it's a bloodletting when there is a live baby.

Q. And, in fact, though -- I realize you're grasping the baby's body and sometimes dismembering it and pulling it out of the uterus, but at a minimum, the placenta itself is connected with live, active, back-and-forth transfer of blood, blood vessels to the mother's uterus, and that's why the "C" is the curettage where they scrape that off of the uterine wall; correct?

A. Typically there's usually not mixing of blood, but there's a big deal of spaces, and you're most of the time suctioning as much out as you can using the curette as little as possible, but between the two of those, removing it, yes.

Q. And there was a whole line of questions about a colposcopy biopsy earlier, and I may be saying that wrong.

But is that in any way, shape, or form as dangerous as performing a surgical abortion, when you simply take a tiny pinch of tissue from outside the uterus when -- with the biopsy, as opposed to dilating

the cervix, going into the uterus, sucking out the baby, dismembering the baby on occasion, and scraping off the placenta from the uterine walls? Would you agree that that's a completely different and far less dangerous procedure?

A. I would agree with that.

Q. When you were looking at the Turok report, the study, does the Turok study support your opinion that it is safer for patients with dangerous conditions to have surgical abortions in a hospital setting because more of the resources for those patients with complicated medical presentations are present and available in the hospital, than performing that same procedure in an outside outpatient clinical setting which if the patient did suffer one of those complications with their complicated presentation in the outside clinic, the practitioner would then have to emergently rush that patient to the hospital to deal with those complications in the hospital?

A. Yes.

Q. And I just want to make sure. Was that the point you were trying to make when you looked at Table 3 in the Turok study?

A. Yes. So the very complicated patients were -- extreme complicated patients were being managed

at the hospital, which increased the likelihood of those outcomes.

Q. Right. And it's sort of a self-selection process where if you've got a patient that's so complicated that it's good to start them in the hospital, and when you have complicated patients you want them to be in a hospital, not in an outpatient setting where they might bleed to death if they have a complication before they are emergently rushed to the hospital; is that correct?

A. Yes.

Q. I want to talk about your study of providing abortion drugs to patients with pregnancy of unknown location.

You did not study the safety of providing abortion drugs to a patient with a pregnancy of unknown location on an ultrasound finding, because it was not considered a safe thing to do without first determining if that patient had an intrauterine pregnancy or an ectopic pregnancy using an ultrasound to rule in or rule out ectopic pregnancy; isn't that right?

A. I'm sorry. Would you mind repeating that.

Q. Yes.

You did not study the safety of providing abortion drugs to a patient with a pregnancy of unknown

location, because it was not considered safe to do so without first taking an ultrasound and ruling in or ruling out an ectopic pregnancy for that patient; isn't that right?

A. I don't understand the beginning where you asked about study, did I study.

I didn't practice that. I wasn't trained in that. We weren't doing that.

Q. That's what I'm asking.

A. That's what you're asking?

Q. Yeah.

A. Yes. Right.

Q. In fact, is it not true that in 2018 in ACOG Practice Bulletin 193 titled "Tubal Ectopic Pregnancy," it says that the way to diagnose an ectopic pregnancy or to rule it out is by positive confirmation in an ultrasound; right?

A. Yes.

Q. And when that ACOG Bulletin 193 says that serum hCG alone is not enough to diagnose ectopic pregnancy, what it means is that you also need to have that ultrasound to rule it in or rule it out; right?

A. Yes.

Q. And that's the standard of care; right?

A. Yes.

Q. The ACOG Bulletin 193 statement does not say that Planned Parenthood can use serum hCG and patient interviews in combination without having an ultrasound that rules in or rules out an ectopic pregnancy before giving chemical abortion drugs, does it?

A. No, it does not.

Q. And Planned Parenthood provides chemical abortion drugs to patients that it takes an ultrasound and has a pregnancy of unknown location before Planned Parenthood gets an affirmative ultrasound reading to rule in or rule out an ectopic pregnancy; isn't that right?

A. Per protocol in Dr. Farris's report, yes.

Q. So Planned Parenthood might give a patient an initial ultrasound, but if that ultrasound shows that it is a pregnancy of unknown location, then Planned Parenthood has a protocol that they use to give the chemical abortion drugs to that patient anyway, even though they've not yet received an ultrasound that rules in or rules out an ectopic pregnancy; isn't that right?

A. Yes.

Q. If a patient wants you to perform a dangerous medical procedure, you wouldn't perform that dangerous medical procedure just because the patient wanted to do

it, would you?

A. If that's the sole indication, no.

Q. If a patient has a desire for you to perform a dangerous medical procedure, that does not create some exception to your duty to follow the Hippocratic Oath, the law, and the standard of care when you're making a decision of how to treat that patient, does it?

A. No, it does not.

Q. Wouldn't you agree that if you have a patient who you give an ultrasound to and it is determined that they have a pregnancy of unknown location such that you had not ruled in or ruled out an ectopic pregnancy, that even if it may be a bit inconvenient for that patient to wait a few days and take another ultrasound to determine whether the ectopic pregnancy is ruled in or ruled out affirmatively by an ultrasound, that it may inconvenience the patient, but it is safer for the patient and the standard of care?

A. In seeking abortion, medication abortion? Is that the question?

Q. Yes.

A. Yes. Yes, it would definitely be safer for the patient to wait a few days for diagnosis.

Q. And when you look at the Planned Parenthood

protocol that they are advocating in this case and you look at the studies that have -- they rely upon that I believe came out in 2022 or so, those are not reflected in the ACOG bulletins as the standard of care, are they?

A. No.

MR. BOYLE: No further questions.

MS. SALVADOR: I have a couple more based on your follow-up, Counsel, but does anyone else on the call want to ask any questions?

EXAMINATION

BY MS. SALVADOR:

Q. All right. Dr. Wheeler, you testified that you're not aware of any medical literature comparing the risks of complications from a D&E for abortion to the risk of complications from a D&E for miscarriage management; is that correct?

A. I was not able to locate any.

Q. So your opinions on the comparative risks of these procedures are based on your memory of your personal experience; is that right?

A. They're based on my experience in the operating room.

Q. You just answered a line of questions from Mr. Boyle about the risk of bleeding from D&E for

abortion as compared to the risk of bleeding from a D&E for intrauterine fetal demise; right?

A. Yes.

Q. But you don't recall the specific clinical setting where you performed the D&E that you described; is that right?

A. Which D&E? The one that I described in my answer?

Q. That's right.

A. No. It's just my very clear memories of what it was like to sit down and do elective terminations as D&Es.

Q. So that D&E for induced abortion that you referred to as a bloodletting may have occurred in an ASC rather than in a hospital operating room; is that right?

A. It would be very unlikely.

Q. But you don't recall where it occurred; is that right?

A. Again, I can't recall which operating suite I was in. I can tell you my standard practice. You didn't ask my standard practice, but --

Q. So it might have occurred in the suite at St. Mark's Ambulatory Surgical Center; is that right?

A. Possible, but very unlikely.

Q. Do you recall whether that D&E patient required transfer for a higher level of care?

A. I don't recall ever transferring a patient, again. You know, I just remember the differences in the procedure. I don't remember ever having to transfer a patient for a second-trimester D&E. But most of the time I would have been -- potentially all the times I was in the main OR.

Again, I want to answer honestly, so --

Q. So you -- I'm so sorry.

A. I don't have specific recollections that I can tell you exactly where I was. My practice would have been to be in a main OR.

Q. So you recall the briskness of this specific patient's bleeding, but not whether you were in a hospital OR when it occurred; is that right?

A. My recollection is of being in an OR, and my statement is in general sitting down for them, you often would put in your instruments and there would be incredibly brisk bleeding.

Q. But you don't recall whether it was in a hospital OR specifically; right?

A. My practice would have been in an OR. Again, I can't say -- I want to be very -- I want to be a hundred percent truthful. So can I say I ever did one?

I don't recall ever doing one in an outpatient surgical center, but I can't remember exactly where I was in all of them.

MS. SALVADOR: Thank you. I have no further questions.

MR. BOYLE: Nothing further from me.

THE COURT REPORTER: E-tran for you, Ms. Salvador?

MS. SALVADOR: Yes, please.

THE COURT REPORTER: And, Mr. Boyle?

MR. BOYLE: I'd like a PDF please.

(Signature not reserved.)

(Deposition concluded at 7:16 p.m.)

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

D

V

W

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.

PREPARED BY: Susan A. Hurrey, RPR

Discovery Court Reporters

and Legal Videographers, LLC

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Cecilia Dos Santos

Kyla Eastling, Esquire

Meghan Fernandez

Ellis Foxwood

Vanisha Kudumuri

Shealyn Massey

Tallin Moyer

Elizabeth O'Brien

Ella Spottswood

I N D E X

E X A M I N A T I O N S

E X H I B I T S

SUSAN BANE, M.D., Ph.D., after having been first duly sworn, was examined and testified as follows:

BY MS. PAI-THOMPSON:

Q. So Dr. Boyle -- Dr. Bane, I'm sorry. I was of course looking at Mr. Boyle's name and you'll see me drinking coffee during our deposition and you'll understand why. I'm on the West Coast, so it's early for me. Still early for me.

So my name is Vanessa Pai-Thompson and I am one of the lawyers representing Planned Parenthood South Atlantic in this case.

A. Nice to meet you.

Q. Nice to meet you as well. So I'm going to begin by just kind of going through some of what I'll think of as our agreed ground principals for the deposition. A lot of this will be duplicative of what you went over on August 31st of last year, but we just have to do it again since we're back here again.

A. Okay.

Q. And so just beginning with your having taken an oath. Do you understand that the oath that you take here in a deposition is the same as taking an oath in court?

A. I do.

Q. And that we have our court reporter here helping us today who will be taking down everything that you say and everything that I or Mr. Boyle say.

A. I do understand that.

Q. Thanks. And if at any point if you realize you made a mistake, that's completely fine. Just let me know and we can clarify or correct anything so that you feel like the statement is accurate.

A. Okay.

Q. Throughout the deposition, just as you have been doing, since we do have a court reporter, if you can just make sure that all of your responses are verbal, in words, so like yes rather than uh-huh or a shake of the head.

A. Okay.

Q. And as we go through, I will ask you questions and you finish any responsive answers to those questions.

A. Okay.

Q. And that as part of that, I would just ask that you also let me complete my questions before beginning to respond to those questions.

A. I'll do that.

Q. At some point if it seems like -- and I don't anticipate that this will be something that will come up often, if at all, but just in case, if an answer doesn't respond to my question, it's possible that I will chime in just to ensure that my question was clear and that we have the same understanding of what I'm asking.

A. Okay.

Q. It may be that Mr. Boyle, at points during the deposition, makes an objection to a question that I have asked. That is for our record, but unless he instructs you not to answer the question, you're still to answer the question that I posed.

A. Correct.

Q. And we will be taking breaks. We will endeavor to take a break about every hour or so, but if you feel like you need a break or I have lost track of the clock, please let me know.

A. I will.

Q. And we won't break mid-question, but if you need a break at some point, we can finish up the question that we're doing and then give us a break in.

A. That makes sense.

Q. There are just two other things that I wanted to flag for you given the forum that we're in, because if it were me and this just happened, I could imagine it feeling disrespectful and I just want to make sure that you don't feel that way at any point during the deposition.

A. Okay.

Q. The first is that I will at some point probably be looking down or looking away from the camera and not at you. I am someone who will always use a certain amount of paper. So like you I have some paper documents in front of me as well.

So that's not a sign that I'm not listening or a sign of disrespect. It's just that I may be looking down from time to time.

A. Yeah. And I have a binder that has the documents from today -- my expert report. And then on this side is a binder with the documents from the first deposition and a few overlap. So if I'm going that way, that's what I'm doing.

Q. Fabulous. Thank you. I appreciate that. And I did just want to note if everyone who is observing can just check to make sure that they are muted so that we don't have any break in. I think there was one that just happened. So if folks can just double check, that would awesome.

The second thing is -- and this is really just to try to avoid us talking over one another potentially during the deposition because that makes it difficult for court reporters under any circumstances, but especially in a Zoom context. So it may be that at some point I put my hand up, if for example your audio goes out or I can't hear what you're saying just so that I'm not talking over you. That's not something I would ever do if we were in person together and I know it might feel weird. So I just want to let you know if I do that, that's why. Just so we're keeping the transcript as clean as we can.

A. Okay.

Q. So I now have some of the sort of background questions that feel a little bit awkward and uncomfortable to ask and I

imagine to answer but that are important for us to go through. So the first is whether you're dealing with any illness that would impact your memory or prevent you from being able to understand my questions today?

A. No, I am not.

Q. Thank you. Are you taking any substances that would impact your memory or prevent you from being able to understand my questions today, such as medication?

A. No, I'm not.

Q. Is there anything else that's currently impacting your ability to understand and answer my questions today?

A. No, it's not.

Q. Fabulous. Thank you. So can you please tell us -- I see that you're in an office. What city are you located in currently?

A. Wilson, North Carolina. And I'm actually in my basement of my house.

Q. Well, it's lovely and doesn't look like a basement. So mission accomplished.

A. You should see the rest of it.

Q. The Zoom background is all that matters.

A. Right.

Q. So just from your camera view, I don't see that there is any off-camera seating or anyone off camera in the room?

A. No, there's not.

Q. Thank you.

A. I will note, I have a son with special needs who gets off the bus at 2:30 and I share this space with him, but my husband's role is to not let him down here. But if somebody comes running past -- well, actually there's nobody behind me, but you might hear a few strange noises. But we'll work on avoiding that.

Q. Fabulous. And you actually foresaw my next question, which was just if anyone else enters the room at any point during the deposition, just let us know. It may be that that's a good time for us to take a break, if needed. So thank you for that.

A. Are there only four of us on the call?

Q. There are more of us on the call, but as observers. So at this point there is -- in terms of screens where you should see images, you should see myself, Mr. Boyle, our court reporter and then yourself, if you have yourself on camera.

A. Yeah. Okay.

Q. So have that view up.

A. I know last time there were a lot of people, but everybody was on the screen.

Q. Yeah. It's just -- I think it makes it less distracting. But yes, there are people who are observing -- you don't need to worry that there will be other screens popping up with random questions coming from everywhere. The

questions will be coming from me.

MR. BOYLE: Are we going to identify all the other folks, the lawyers?

MS. PAI-THOMPSON: We can certainly do that and I appreciate that reminder. Why don't we do that at this point.

MR. BOYLE: I might suggest -- and forgive if I'm saying it wrong -- Ms. Pai-Thompson, that you might represent or introduce all the various folks and then we cycle through the other sort of groups of attendants just because I don't know who all these other folks are.

MS. PAI-THOMPSON: Absolutely. And I think that I may also -- Hannah Swanson has just joined on video and she may provide me with an assist as well. But absolutely. I apologize for not doing that. I think one that we observed earlier we hadn't, but it's not at all intended to hide information about who is here.

So from my office, Planned Parenthood Federation of America, on the call is Cecilia Dos Santos, Ellis Foxwood, Hannah Swanson. I'm continuing to scroll. Shealyn Massey, Valentina De Fex and Vanisha Kudumuri.

And, Hannah, have I missed anyone in my scrolling through?

MS. SWANSON: I don't think so. I'll just note for the record that Anjali Salvador, Vanessa Pai-Thompson and

myself are the attorneys who rendered appearances in this case and everyone else is simply here as observers.

MS. PAI-THOMPSON: And then I would also note that Ryan Mendias who, Mr. Boyle, you have met in other proceedings is also here, the ACLU and is also counsel for the plaintiffs.

And I did notice also that Kyla Eastling with our office has just joined who again, is here just observing.

MS. MAFFETORE: Sorry, one last person. Jaclyn Maffetore from the ACLU of North Carolina. I'm on the call as well observing and I am counsel of record on the case.

MS. PAI-THOMPSON: Thank you, Jaclyn. And my apologies.

MR. THERIOT: I'm Kevin Theriot and I just entered an appearance as counsel of record for the defendants.

MR. BOYLE: And I'm Ellis Boyle and Mr. Theriot and I are counsel on behalf of the defendant intervenors legislative leaders.

MS. NARASIMHAN: This is Priya Narasimhan on behalf of Attorney General Stein, counsel for Attorney General Stein.

MR. WILLIAMS: This is Kevin Williams on behalf of defendant District Attorney Jim O'Neill.

MR. BULLERI: This is Michael Bulleri on behalf of the North Carolina Medical Board.

MS. CROWLEY: Colleen Crowley on behalf of the Department of Health and Human Services.

MS. PAI-THOMPSON: Have we covered everyone? Hearing nothing I will --

MR. BOYLE: Did we get Elizabeth O'Brien? If we did, I'm sorry. I missed --

MS. PAI-THOMPSON: No. No. Absolutely.

MS. NARASIMHAN: Elizabeth O'Brien works at the North Carolina Department of Justice and at least she is on the Zoom so -- this is Priya Narasimhan and I will represent that she represents the other defendant.

MS. PAI-THOMPSON: Fabulous. Thank you so much. I was just going to suggest that someone might have stepped away and we might just break if we needed to.

Any other appearances that you wanted to note, Mr. Boyle?

MR. BOYLE: I think that covered most everybody, if not everyone, hopefully.

MS. PAI-THOMPSON: Perfect. Thank you.

BY MS. PAI-THOMPSON:

Q. So Dr. Bane, then I'm going to kind of turn back to some of our initial questions. So we have gone through who's in the room with you, where you are. Can you describe to me what technology you're using to be part of this call?

A. Sure. I have a PC laptop and I think this is a Zoom

meeting. That's it.

Q. Fabulous. Do you have any other screens or just the one screen from your laptop?

A. Just one.

Q. Is there any other technology in the room with you?

A. So I do have my phone. It's upside down, but I do have, as I mentioned, a son with special needs so I like to keep it close by because he has seizures. In case the school calls me.

Q. Is it on silent?

A. I am getting ready to make sure. It is.

Q. Okay. And then understanding the reasons that it's important for you to have it there with you, if at any point you look at the screen of the phone if something comes in, can you please let us know right away?

A. I will.

Q. Perfect. And then we may have follow-up questions based upon that.

A. Okay. Can I do this? So I'll turn it over, but if I silence it that means I can't hear them text me. Would it be okay if I unmute it so I can have it turned over? It will be less distracting, I think.

Q. Yes. Our preference would be that the screen not be facing up. So yes, that's certainly fine.

A. Okay. I'm all set.

Q. And then this is just kind of following up on what we were talking about. Do you agree not to communicate with anyone while we're on the record, other than communications that are being transcribed by the court reporter?

A. Absolutely. Yes.

MR. BOYLE: Objection.

BY MS. PAI-THOMPSON:

Q. You described the binders that you have with the reports and the exhibits. Do you have any other printed documents with you?

A. I have my deposition -- or my expert report, sorry.

Q. Perfect. Thank you. Any other documents other than those binders and your report?

A. Not right here, no.

Q. Okay. So not visible to you?

A. Correct.

Q. Great. So do you agree not to look at any documents during the deposition other than when we identify a document and are discussing it together on the record with the court reporter?

MR. BOYLE: Objection. I'll instruct you that that's not part of the rules or a requirement. And I'll instruct you that that's not -- you don't have to agree to that.

BY MS. PAI-THOMPSON:

Q. Do you agree that if you look at a document or a source of information while we are on the record that you will identify what you're looking at so that you won't be looking at anything that isn't recorded by our court reporter?

MR. BOYLE: Objection. Same objection. She'll answer questions but...

MS. PAI-THOMPSON: Sorry, I'm just looking at a note to myself.

BY MS. PAI-THOMPSON:

Q. I think that we'll follow up on this more because again, I think that we will have questions about what information you're relying on, and I may just ask you more specific questions as we go along.

So moving now to -- basically since you were last here on August 31, 2023. Do you recall the deposition that you took part in that day?

A. I do.

Q. And you recall there was a court reporter there also taking a transcript at that point?

A. Yes.

Q. Great. You recall that you were under oath and agreed to testify truthfully there as well?

A. I remember that.

Q. And that you had an opportunity to review the deposition transcript and make any corrections or address any

corrections that you may have had?

A. So I -- I didn't do that immediately afterwards, but I noted some when I was reviewing for this and I had four or five typos that -- for example, they put -- and I may have said it this way, AAPLOG versus ACOG and intertwined those once and I think -- it was minor things. I think there was an is when it should have been an isn't one time. I think there were four or five things and I don't think they got sent to you all.

Q. I would ask if at any some point I direct you to a portion of the deposition or transcript where something comes up that you have not corrected in writing already, just let me know.

A. Thank you.

Q. So other than those kind of minor, what it sounds like, typographical issues, is there anything that you want to change about the sworn testify that you gave previously?

A. No.

Q. Other than your expert report in this case, have you submitted any documents in other cases, like declarations or reports since your deposition on August 31st?

MR. BOYLE: Let me just stop and give you an instruction on that. To the extent that you have given any report such as the one you've given here that's been exchanged to an opposing side like yours was in this case, you can respond to that. But if it's just an internal report or a

conversation or correspondence with some other lawyers that have hired you as an expert witness and it hasn't been exchanged to the other side, I will instruct you not to respond and answer in the affirmative or negative for that.

THE WITNESS: Okay. So I --

BY MS. PAI-THOMPSON:

Q. Do you understand the question?

A. Well, I think I understand it. So no, I have not done any other reports. I did submit an addendum yesterday in this case.

Q. Yes. And when you refer to that, you're referring to the one-page addendum that was accompanied by some textbook pages, correct?

A. Yes.

Q. So other than that -- and again, not including any communications with attorneys, but no other documents submitted in other cases?

A. No.

Q. Have you given any testimony in other cases, either orally or in writing?

A. Since August 31st?

MR. BOYLE: Object to form.

BY MS. PAI-THOMPSON:

Q. Have you given any testimony since August 31st in other cases orally?

A. No, I have not.

Q. Have you given any testimony in other cases since August 31st in writing?

A. No.

Q. And again, these will be between August 31, 2023, your deposition that day and today, have you reviewed your report again?

A. My expert report I wrote for today?

Q. Correct.

A. I have, yes.

Q. When did you most recently review it?

A. Again this morning.

Q. Great. Have you reviewed again the sources that you cited in your report?

A. I have.

Q. Did you review every -- each of the citations that are in your report?

A. I have.

Q. And did you review them in full?

A. Yes. But I don't have them memorized.

Q. Memorization isn't expected. Just checking in about review. Have you conducted any other research since your deposition on August 31st related to this case?

A. Well, I got the textbook that I gave you the addendum, so I reviewed the textbook and, you know, my -- I have reviewed

the other individuals' declarations, their expert reports, their depositions, yeah.

Q. So for the textbook, did you review any pages of that textbook other than the ones that you sent us with your addendum?

A. I read a lot of the textbook. But there were some pieces that weren't relevant to this case so...

Q. Okay. Do you recall which portions of it you reviewed?

A. I've got the book. Do you want me to tell you the chapters?

Q. That would be great. Thank you.

A. So there's a forward that I reviewed, a preface I reviewed. Chapter one is Abortion in Historical Perspective. Chapter two is Unintended Pregnancy and Abortion and Public Health Perspective. Chapter three is Informed Consent, Counseling and Patient Preparation. Chapter four is Documenting Pregnancy and Gestational Age. Let me look at chapter five. I reviewed chapter five. Let me get back to the table of contents. Medical Evaluation and Management. I reviewed chapter six, Procedure Selection. Chapter seven, Pain Management. Chapter eight, Medical Abortion and Early Pregnancy. Chapter nine, Surgical Abortion in First Trimester. Chapter ten, Surgical Abortion After First Trimester. Let me look. I skimmed the latter chapters. Chapter 11. Chapter 11,

Abortion by Labor Induction. And I would say I skimmed the rest of the chapters. Let's see. Actually I went through the whole book, to be honest.

Q. Great. Well, thank you for going through that with us.

A. I won't say I read every single page. But I did go through the book.

Q. So is it fair to say that the pages that you sent to us are the ones that you judge most relevant to your opinions in this case?

A. I particularly wanted to -- well, I guess yes. But there were -- there are other ones. But -- I'll say yes.

Q. You say that there are other ones. The ones that you sent us are the ones that you're relying on for the purpose of supporting your opinions in this case, is that correct?

A. Yes.

MS. PAI-THOMPSON: And I am going to just drop into the chat a PDF that is -- that I'll ask to be marked as an exhibit.

BY MS. PAI-THOMPSON:

Q. We're not going to go into questions about this right now, but since it's come up I just want to confirm at this point that we're talking about the same document or excerpts?

A. Okay.

Q. And so once that has come up and you're able to open

it, if you can scroll through and let me know if that is all the pages that you believe that you sent to us or if there are any that seem to be missing.

A. I'm trying to download it because I remember on the 31st, in August when we did this, I couldn't just open them. I had to download them first. So just a second.

Q. Let me know if you would like me to screenshare, if that feels more efficient.

A. I'm going to try.

Q. And again, at this point I'm not going to be asking you about the content other than reviewing that it's all of the pages that you believe you sent to us.

A. Yeah. Okay.

(Pause.)

Q. Why don't we do this just because I know how Internet speeds go. Why don't we just put a pin in this for the moment and then you can go ahead and take that time to have that finish downloading when we take our first break, and then we'll just circle around so that we're not missing any pages.

A. Okay.

Q. So other than the materials that we have identified so far, was there anything else that you have reviewed in preparing for this case between August 31st and today?

A. I reviewed Williams Obstetrics from -- which is a mainstay textbook. I wanted to refresh myself on some basic

maternal fetal circulation. I hadn't reviewed that in a while.

Q. So Williams Obstetrics about maternal fetal circulation. Were there any other portions of that that you described -- or that you reviewed?

A. No. Just those areas.

Q. And then other than your attorney, I'm not asking about communications with counsel, have you spoken with anyone about this case since August 31, 2023?

A. No. My husband, my family. But not specifics of the case.

Q. When you say your family, other than your husband, who did you speak with?

A. I have grown children who know that I'm doing this. I have a mom who knows. I have sisters who know I'm involved in this case. I mean, so when you say spoke about, people know I'm involved in this case. My colleagues at work know. People who -- I'm on the board at AAPLOG. They know. But am I getting resources from them, answers from them? No. But they're aware that I'm involved in this case.

Q. Understood. Do they know what opinions you're providing in this case?

MR. BOYLE: Objection. You can answer.

THE WITNESS: Did you say you can answer?

MR. BOYLE: You can answer.

THE WITNESS: No, they do not.

BY MS. PAI-THOMPSON:

Q. So the fact of your participation, but not the substance it looks like?

A. Correct.

MR. BOYLE: Object to form.

BY MS. PAI-THOMPSON:

Q. Now, you described -- or referenced earlier having read reports or materials submitted by other people in this case. Did that include materials prepared by Dr. Christy Boraas?

A. Yes.

Q. And which documents -- document or documents created by Dr. Christy Boraas did you review?

A. Her original declaration, her rebuttal and her new expert report.

Q. Did you read all of the -- did you read all of the materials cited in those documents?

A. Do you mean references?

Q. Yes.

A. No, I saw what she referenced, but I did not necessarily review every single one of them.

Q. Did any of the information that you read in the -- or the citations that you saw that she had made in rebuttal, did any of those change any of the opinions that you provided either in writing or in your deposition on August 31st?

A. No.

Q. And when you reference the rebuttal, are you referring to the rebuttal report that Dr. Boris submitted in January of 2024?

A. No. I'm talking about when we initially wrote our explanation -- or our declarations last summer, she and Dr. Farris wrote rebuttals. That's the only thing I was aware of rebuttals that they had done.

Q. So you have not received a copy of a report that she prepared in January of 2024?

A. So I have read one thing, but I thought it was -- I don't know the title of it. I have read one thing since August of hers.

Q. Okay. And we can circle back to this if we need to. For Dr. Katherine Farris, can you list for us the documents that you have read that she prepared as well?

A. Her original declaration and her rebuttal to our original declarations and then her expert report this time.

Q. And when you say this time, can you tell us what month you're referring to?

A. It would have been December -- November, December of 2023.

Q. Thank you. Did you read all of the references that were cited in that document?

A. I noted them all, but I can't tell you yes or no that

I read every one of them.

Q. And same question for the declaration that she provided. I know that you hadn't read all of them at your initial deposition on August 31st. Have you read all of her references in that initial declaration since then?

A. I have reviewed them, but I have not read them all.

Q. Has any of the information from either her reports or your review of the records change any of the opinions that you have provided in this case?

A. No.

Q. Have you read written materials provided by Dr. Timothy Johnson?

A. I don't recall that I have.

Q. Okay. So you don't recall having been provided an expert report from Dr. Johnson in January of 2024, is that correct?

A. That's correct.

Q. How many hours would you say that you have spent preparing your expert report at this point?

A. Just my expert report?

Q. Uh-huh.

A. Probably 30.

Q. And how many hours would you say that you have spent preparing for your deposition today and -- so again, between August 31st and today, how many hours would you estimate you

have spent preparing for deposition?

A. So I really didn't start preparing for deposition until I knew the date, which I didn't find out maybe a month or so -- no, I can't remember when I found out. Maybe -- yeah, I think it was early January maybe. So I would say around 20 hours or so.

Q. Okay. And then other than the time that's been captured by the 30 or so hours that you spent preparing your expert report and the 20 or so hours spent preparing for the deposition, have you spent any other time working on this case which haven't captured through those questions?

A. No.

Q. And you're being paid $500 per hour for your work in this case. Is that still correct?

A. Yes.

Q. I'm switching gears just a bit.

A. Okay.

Q. Did you attend the March for Life in Washington D.C. on January 19th of this year?

A. I did.

Q. And did you attend any other events while you were in D.C.?

MR. BOYLE: Object to form.

THE WITNESS: Yes.

BY MS. PAI-THOMPSON:

Q. Did you attend any other events in Washington D.C. while you were there for the March for Life?

MR. BOYLE: Object to form.

MS. PAI-THOMPSON: And you can answer the question.

THE WITNESS: Okay. Yes, I did.

BY MS. PAI-THOMPSON:

Q. What events did you attend?

A. So I attended a reception at Heritage Foundation for AAPLOG and I actually spoke there. Sorry, it was a busy week. I attended a reception at ADF and I had some internal meetings that weren't events. Some dinners, but they weren't events. Those are the main things. And of course the march is all day long.

Q. For the -- you said that you spoke at the AAPLOG reception. What was your talk about?

A. Having courage to basically stand for what you believe and fight for -- as a doctor that practices life-affirming medicine, to stand for both my maternal and fetal patient. The theme of this year's march was with every woman -- for every woman with every child or vice versa. So talked about that. I talked about the past, present and future of medicine in our field. My talk was maybe three to five minutes. So it was extremely brief about what I think about the history of our field, what the present and then future of our field.

Q. When you talk about the history of our field, can you -- or your field, can you tell me what the kind of -- give me the gist of that.

A. Yeah. So I talked a lot about ACOG and AAPLOG's relationship and how we really work together well. We were included in ACOG cog for years. And when I say we, I mean physicians who had a pro-life perspective and -- which is a lot of us. As you know, you know, from all the depositions and the reports that there's a minority of physicians that actually do induced abortions. And that which actually -- we had collaboration. And unfortunately that's gone away. And that we were part of a very large special interest group in ACOG for years. ACOG special interest groups of all types and there was a pro-life one. And in 2013, unfortunately ACOG got rid of all their special interest groups. And so we had -- we formed our own organization. Even though we had the organization, we were within ACOG as the special interest group. But we're no longer welcome there. And that -- so now we're a second voice, second medical organization that takes a life-affirming approach. So that was historically what I shared.

Q. Thank you. Did you discuss your involvement in this case at any of the meetings or dinners that you -- I think you mentioned receptions that you attended?

A. I did not.

Q. Who paid for your travel to Washington D.C.?

A. I did.

Q. So I know that you have your copy of your expert report. I'm going to drop it into the chat as well so that we can -- and ask that it be marked as an exhibit for the purpose of this deposition. And I'm dropping in what you provided to us. So your expert report that includes your C.V. as well.

- - -

(Document marked as Exhibit-25 for identification.)

- - -

BY MS. PAI-THOMPSON:

Q. Are you able to see that?

A. I am going to try a different way this time. See if I can get it.

Q. We can also note, we sent to Mr. Boyle this morning the PDF that we would be using for exhibits today. So if a copy that you have, that you showed printed in front of you is printed from that version that he provided you, you can also look at that.

A. So it's not the one from today. I mean, it's my final report that I, you know, gave. But it's not based on your list. But what I can do is easily pull up your list and compare them, because I think your list is easy to pull up.

Q. And since we're talking about your report that's been produced to us through discovery, and I think we're talking

about the same document, we'll go ahead and just like with the other -- go through some of it you can reference the paper copy that you have and then we're getting pretty close to where we'll take our first break, and you can follow up with the downloads at that point.

A. That will be fine.

Q. It's going to jump around just a little bit, just so that you know, because we're endeavoring not to repeat information that you have already gone over in your initial deposition. So if that creates confusion at any point, please let me know and I'll be sure to clarify.

A. Thank you.

Q. Of course. Directing your training during medical school, you never provided an induced abortion during medical school, correct?

A. Correct.

Q. And you never provided an induced abortion during your residency, correct?

A. I'm going to say correct, but I want to make sure that we put on the record that we're agreeing on what induced abortion is, right? So the definition when I say correct is the CDC's definition, which is an intervention designed to intervene for a suspected or ongoing pregnancy with the intention of not having a live birth. So the purpose of the intervention is to end the life of the fetus or the embryo. So

produce a dead baby. I never have done either of those.

Q. And for our reference, you have defined those terms, and then also some other terms related to abortion in your initial deposition on August 31st. So I will -- we can have a common understanding that we are using those definitions that you gave. If at some point you feel like you need to redefine or clarify one of them, that's fine. But thank you for highlighting that and I'll just note that those definitions that you gave will stand.

A. Thank you.

Q. Absolutely. Now that we have talked, I'm missing -- want to make sure that we got an answer to a question. So you did not provide an induced abortion based on that definition you gave us during residency, correct?

A. Correct.

Q. And you did not provide an induced abortion during your time as a practicing physician, correct?

A. Correct.

Q. And just as a brief clarification on the induced abortion definition, just again to ensure that we're talking about -- we're using shared terms. Just to be clear, you would not include an induction abortion before viability with the intent to separate the fetus from the patient's body in the definition of induced abortion, is that right?

A. That is correct. I did those procedures, but my

intention was to try to save both knowing that some times the unintended consequence is that the fetal patient doesn't survive.

Q. Okay. But just to be clear, that -- actually I'm going to withdraw that question. So you also taught at Barton College from 20 -- you also taught at Barton College, correct?

A. Yes.

Q. That was beginning in 2010?

A. Part time and full time in 2011.

Q. Correct. And you taught there through 2023, is that correct?

A. Correct.

Q. Have you ever taught any courses involving induced abortion?

A. So -- not at Barton College. So I did teach a class that was actually -- okay. So I'm going to correct that last answer. So I taught a gen 301 class. I think it was gen 301 back then. It might have been gen 300. It's called the Capstone course in the humanities in the general education curriculum where students put together critical thinking, oral thinking, writing. So actually I did teach a class. When you asked the question, I'm sorry, I was thinking medical -- not Barton. So yeah, I actually did teach one class.

Q. And just so that we're clear, when you say gen 301, you mean general, that's referring to the general education

requirement?

A. So at Barton College we have a general education curriculum and then we have a major specific curriculum. Students take both. And the Capstone course in the general education curriculum is called gen. And so students all across campus could take that and I had a variety of students in that class.

Q. I think that if -- well, no, we still have time. Sorry, I'm trying to be mindful of the clock because I'm someone who can just roll on through and I don't want to do that to you.

So I'm going to refer to your report, if you can pull your copy of that and to paragraph 68 of your report. And just let me know when you're there.

A. I'm here.

Q. Perfect. Thank you. So I'm going to read a passage of this to you and then I'll ask you whether I have read it correctly. And feel free to let me know if I have missed a word or gotten any incorrect.

A. Before you do, my phone just went off. So let me look at something real quick. Okay. It's not my son.

Q. Great. Thank you. And thank you for letting us know.

A. You're welcome.

Q. So in your report in paragraph 68, you say in quotes, as I have examined the literature related to very early

abortions, I agree with some authors that state diagnosing an ectopic pregnancy as early as possible is a benefit of these protocols.

Did I read that accurately?

A. You did.

Q. And you agree with your statement in your report there in paragraph 68 that, quote, diagnosing an ectopic pregnancy as early as possible is a benefit of those protocols, correct?

A. I agree that diagnosing an ectopic pregnancy is beneficial for any woman. Where I disagree is that it justifies doing an abortion without a documented IUP.

Q. Thank you. So by these protocols that you're -- that reference in paragraph 68, you're referring to the medication abortion protocols for pregnancies of unknown location, is that correct?

A. Yes.

Q. Okay.

MS. PAI-THOMPSON: So I am going to drop another document into the chat and I will ask that this be marked as an exhibit. And this again you should have received in the documents that we provided to Mr. Boyle earlier today. This is a statement from ASA. It's a statement from ASA on the continuum of levels of sedation.

- - -

(Document marked as Exhibit-26 for

identification.)

- - -

BY MS. PAI-THOMPSON:

Q. Do you have the document that I'm referring to?

A. Yes, I do.

Q. And have you read this document before?

A. Well, I need to look at the one I referenced to make sure -- it doesn't seem like this first page is the same as my first page.

Q. Okay.

A. Do you know the number of my reference for the ASA? If not, I can look. Let's see.

(Pause.)

A. I'm going to just pull up my hard copy that I have.

Q. And we're at footnote 45 in your report, if that's helpful.

A. I found that. Thank you.

Q. Yeah. Absolutely.

A. So mine starts with statement on granting privileges for administration of moderate sedation to practitioners who are not anesthesia professionals. That's page one of mine.

Q. All right. I think that we have -- so let's do this. Can you -- the document that I dropped in the chat is short. Can you take a moment to review the first two pages of that document and I will -- the questions I have I think will be --

basic enough that given your expertise we'll be fine moving forward. But let me know if after I have asked the question you feel like you need more time.

A. Okay.

(Pause.)

Q. So looking at the document that I moved into the chat, just clarifying for us non-doctors in the room. By spontaneous ventilation there, that would be referring to breathing, is that correct?

A. Could I have a minute just to look at the document?

Q. Oh, absolutely. I'm sorry. When you said okay, I thought you meant okay, proceed.

A. No. Give me just a second.

Q. Absolutely.

(Pause.)

Q. So let's actually, Dr. Bane, just given our time and to get us to our first break, I'm actually going to do this. I'm going to ask you some questions about sedation and we'll just do this just independent of the document. Just based upon your knowledge and expertise. Is that okay?

A. That's fine. But I was almost done if you want to refer to the document.

Q. Yeah. Sure. Then go for it.

A. Okay.

(Pause.)

A. Okay. You can reference it now.

Q. Okay. Thank you. Do you agree with the description of the levels of sedation that are provided in that document?

MR. BOYLE: Objection. You can answer.

THE WITNESS: Could you repeat the question?

BY MS. PAI-THOMPSON:

Q. Yes. Do you agree with the description of the levels of sedation provided in that document?

MR. BOYLE: Objection. You can answer.

THE WITNESS: Yes.

BY MS. PAI-THOMPSON:

Q. Thank you. Do you know what kind of sedation options are available at Planned Parenthood South Atlantic?

A. Based on the protocols I reviewed, they have documentation that you can opt for everything except general anesthesia. However, I believe it was Dr. Farris's deposition that she stated that they don't actually offer deep sedation, even though that is an option on their form.

Q. So your understanding is that Planned Parenthood South Atlantic offers minimal and moderate sedation, but not deep sedation? Have I summarized that correctly?

A. That is my recollection of reviewing everything.

Q. Great. And for minimal sedation, a patient is conscious throughout the sedation, is that correct?

A. Conscious, yes, but sometimes asleep.

Q. But they can be roused by verbal or physical stimuli?

A. Typically, yes.

Q. And same question for moderate sedation, that a patient is typically conscious during the sedation, and by that I mean the sedation doesn't render them unconscious?

A. Correct. Typically. Everybody responds differently, and that's the biggest concern is what you think is moderate sedation can move to deep, what you think is moderate can lead to someone being unarousable and that's the biggest concern with sedation.

Q. And you reference that can lead to a patient being unarousable. At the point that a patient was unarousable, the provider would know that they were no longer in minimal or moderate sedation, correct?

MR. BOYLE: Objection.

THE WITNESS: I would sure hope so. There's no information from the protocols that there is somebody different than the person doing the induced abortion, the surgical abortion that's separately monitoring the person. So I think there is concern that they may not recognize if they have moved into a level of deeper sedation. And I think that's consistent with the document that I provided that that's a major concern of the American Society of Anesthesiologists.

BY MS. PAI-THOMPSON:

Q. And that's because of your understanding that there --

withdrawn. That was going to be a confusing question, so I'm going to ask it differently. What I hear you expressing there is that if there wasn't another person in the room other than the provider, they might be focused on the procedure and not notice. Is that a fair summary?

MR. BOYLE: Objection.

THE WITNESS: I think that's one element of it if they're responsible for both of those. So when I'm in the operating room I'm focused on doing my surgery and I'm trusting the anesthesia professional to monitor all the various things, responsiveness, airway, cardiovascular system, spontaneous ventilation. So I am -- I don't understand that that is happening based on the protocols that I have seen at Planned Parenthood. Also recognizing that I have no idea all the other protocols that are happening across the state knowing that, you know, only about 30 percent of the surgical abortions are happening -- abortions are happening at the Planned Parenthood. We have many other facilities that are happening. And so I'm very concerned based on what the American Society of Anesthesiologists -- they talk about individuals who are not professionals having the adequate level of training to be able to recognize that somebody is -- you know, got normal cardiovascular function, they're spontaneously breathing. So that's my concern.

BY MS. PAI-THOMPSON:

Q. Is it your opinion that only an anesthesiologist or a nurse anesthetist would be qualified to provide or supervise moderate sedation?

MR. BOYLE: Objection.

THE WITNESS: My opinion is consistent with what the American Society of Anesthesiologists suggests is that it takes special training and education. In their document that I cited, they talk about non-anesthesiologist sedation practitioners and the special training they get. And I don't have evidence that that is occurring across the State of North Carolina in our abortion clinics.

BY MS. PAI-THOMPSON:

Q. So is it your opinion that no one else is qualified to provide or supervise moderate sedation other than anesthesiologists or people who are receiving that special training that you just referred to?

MR. BOYLE: Objection. You can answer.

THE WITNESS: So I'll reference -- I'm sorry, but it doesn't have page numbers. But under section one, non-anesthesiologist sedation practitioners. It says here that non-anesthesiologist sedation practitioners may directly supervise patient monitoring in the administration of sedatives -- sedative and analgesic medications by a supervised sedation professional. Alternatively, a person may perform these functions with the provision that the individual monitoring the

patient should be distinct from the individual monitoring the diagnostic and therapeutic procedures. Single operator sedation should not be permitted and is deemed unsafe.

So I follow their recommendations because they're the experts in anesthesiology and sedation.

BY MS. PAI-THOMPSON:

Q. And just one clarification in the paragraph that you just read. I think -- at least what is in my printout, the third line from the top of that paragraph, I think that you said should be distinct from the individual monitoring the diagnostic or therapeutic procedure. Does the document actually say the individual performing the diagnostic or therapeutic procedure?

A. I'm sorry, which line are you referencing?

Q. On my printout -- let's do it this way. It is the second to last sentence. Just before see practice guidelines for moderate procedural sedation.

A. Alternatively, they may personally perform these functions with the provision that the individual monitoring the patient should be distinct from the individual performing the diagnostic or therapeutic procedure.

Q. Can you tell me, what date is the last amended date on the version that you have?

A. 2021.

Q. October 13, 2021?

A. Mine actually says October 12, 2021.

Q. Okay. Thank you. And we are almost at our break point, so I'll give you that. So is your opinion based upon anything other than what is in this ASA document that we just talked about?

MR. BOYLE: Object to form.

THE WITNESS: Could you repeat that?

MS. PAI-THOMPSON: Yes. Absolutely.

BY MS. PAI-THOMPSON:

Q. I'm referring back to your testimony that a person should be an anesthesiologist or should have the training that's referenced in this ASA document in order to provided moderate sedation?

A. So my opinion is --

MR. BOYLE: Object to form. You can answer.

THE WITNESS: Okay. So my opinion follows what this document says as it relates to the safety of a patient. This document doesn't address pain management in a patient and that's also a concern for me that we -- it's hard to believe we would accept a level of pain that women describe that for abortions that we would not accept for other procedures, all in the name of doing it in an outpatient setting. And so I do -- -- I do want patients to not -- I want to control their pain as much as possible, their physical pain, in the case of anesthesia.

BY MS. PAI-THOMPSON:

Q. Thank you. Referring to the comments that you just made. Do you think this is a result of abortion patients being treated less well than patients seeking other obstetric or gynecological care?

A. I think sometimes we get -- I think there is such a desire for everything to be done in an abortion clinic, in an outpatient setting that sometimes that overrides the thought that we can more safely provide better, deeper sedation for a second trimester abortion. Even a first trimester abortion can be very painful. So I do think sometimes, yeah, abortion is treated differently by the people who are providing the abortions.

Q. So is it your opinion that it would be safer to provide deep sedation to every patient obtaining a second trimester abortion?

A. No, that's not what I'm saying.

Q. Are you -- do you -- is it your opinion that it would be better from a pain management perspective?

MR. BOYLE: Object to form.

THE WITNESS: So I think you're going to -- you'll have a conversation with a woman to talk about her options and her preference. Some patients over my 20-plus years of practicing will walk in and say there is no way I'm getting "X" procedure done unless I am asleep. And there are

other people who want more minimum sedation. So I do think you can't -- it's a hypothetical to try to say for everyone. But I think we have to be careful that we don't sacrifice and hurt women all in the name of trying to stay out of the hospital.

BY MS. PAI-THOMPSON:

Q. Thank you. So for the safety piece, is there anything that you are basing your opinion on other than the ASA guidelines that you have referenced? And by that I mean experience, other papers, things like that.

A. So I have only documented in my expert report this. But from an -- from a 20-plus year experience doing thousands of surgeries, absolutely. My experience definitely tells me that I can concentrate more on the job that I'm responsible for if I know that there's a competent person who's making sure my patient stays alive. And so, you know, that most definitely influences it. And I do care about pain management. So it would be a combination of experts like the American Society of Anesthesiologists, as well as anecdotal experience as an obstetrician/gynecologist.

Q. Sorry, I don't mean to cut off.

A. I just said obstetrician/gynecologist.

Q. Yes. So you reference experts like ASA. Are there other sources or other associations whose opinions you're relying on for your opinion here?

A. This is the main society that I relied on and so I'll

have to say just them in terms of a professional organization. And there are studies out there also that look at, you know, pain control, but I chose not to cite them. I chose to site more of -- kind of like with ACOG, practice bulletins or committee opinions. A conglomeration of the sites -- of the studies that lead to a statement.

Q. Okay. And then just a couple more quick questions before we'll take our first break. So looking at general anesthesia itself. Does general anesthesia alone carry medical risks? And by alone I mean risks that are separate from whatever the risks are of the procedure that the general anesthesia is connected to.

A. All sedation carries risks.

Q. So with respect to general anesthesia, what kind of risks does it carry?

A. Well, for that one, you're actually intubating someone and so, you know, there's a risk of intubation in terms of not being properly intubated or actually tearing, for example, the esophagus when someone is intubated or something like that. So there's that risk. There's risks -- pregnant women have risk for -- greater risk for aspiration than do other women that are not pregnant. You're taking someone and you're putting them in such a deep sedation, there are some people that take a while to come out of that and I have even had patients who have had to stay intubated. So yes, there are risks.

Q. Thank you. When you say that there are risks that a patient might not be properly intubated, what risks does that create?

A. Well, if you think you're in the trachea and you're actually in the esophagus the person is not going to be getting adequate oxygenation and could have cardiovascular collapse, stroke, a heart attack. So you have to properly intubate someone. And then in terms of the -- it's a metal instrument that people use to intubate so you can actually have tears. It can cause bleeding. So those are the main things.

MR. BOYLE: We have been going for about an hour if you're at a spot where you might take a break.

MS. PAI-THOMPSON: Yeah. I just have two quick follow-up questions on Dr. Bane's comments about the risks and then we are at a perfect point for a break. Thank you.

BY MS. PAI-THOMPSON:

Q. So Dr. Bane, you mentioned that with some patients they stay in deep sedation, like they have a tougher time coming out and may have to remain intubated. What are the kind of risks that go along with remaining intubated?

A. The biggest one is that you never get extubated, you know. And so that can lead to death. It can lead to aspiration pneumonias. All the things that go with a long term intubation. You may have to get a trachea -- it often is a sign of some underlying neuromuscular condition -- other

conditions besides neuromuscular. But often if breathing doesn't come back. You know, I have seen it and then a patient gets diagnosed with myasthenia gravis or ALS or something like that. So it's uncommon, but it can happen. The majority of people do just fine, but there are risks with general anesthesia.

Q. Thank you. And then my final question before our break. For pregnant women you said that there is increased risk of aspiration. Can you describe what aspiration means, what that is, kind of how that looks?

A. Sure. So, you know, if you have ever had surgery, you have been told don't eat anything after midnight, maybe you can drink some water, brush your teeth the next day. So you basically don't want food in the stomach because when you have general anesthesia it can relax the sphincters, and there's an esophageal sphincter between the stomach and the esophagus, which is the tube that goes to the stomach after you swallow. And so if food gets refluxed back or contents of the stomach and get into the lungs, that can lead to infection.

Q. Are there any other risks beyond infection of aspiration?

A. I'm sure there are, but not that I can recall right now.

Q. Perfect. And I'm sorry that I promised one question and there were two, but I do think this is a good time to take

our first break. Should we say -- does 10 minutes feel like enough?

THE WITNESS: Sure.

MR. BOYLE: Sure.

MS. PAI-THOMPSON: And then for our court reporter, when we come back I'll ask just for a time check.

MR. BOYLE: I have got one hour and seven minutes.

MS. PAI-THOMPSON: Great. Thank you. We'll see everyone in 10.

- - -

(A break was taken, 2:44 p.m. - 3:00 p.m.)

- - -

BY MS. PAI-THOMPSON:

Q. So Dr. Bane, I'm going to be talking more about your expert report. So just in terms of what you have in front of you. And I'll be looking at paragraph 56, but referring back to our earlier discussion about just ensuring that we have -- that we're using the same definitions so we have common understand. Just kind of a preference question for that. So can you tell us -- or just describe to us how you would define a missed abortion?

A. Yes. So a missed abortion is when a woman is asymptomatic, so she doesn't have any bleeding or cramping, and typically we're doing an ultrasound for dating and we don't see

a heartbeat.

Q. Thank you. So in paragraph 56 of your expert report, you identify some things that can happen when an embryo or fetus has no cardiac activity and the pregnant person's body is physiologically preparing to expel it. Do you see the section that I'm referring to?

A. Yes, I do.

Q. Perfect. And is what you're describing there what can happen with a missed abortion, as you just defined it?

A. Would you clarify the question? I'm sorry.

Q. Sure. So in paragraph 56 where you are talking about -- these will just be examples. We'll go back -- that -- sorry. Let me just actually -- I'm going to look in my note and see that I have not -- I can't just more easily ask the question in a different way. Let's actually -- I'm going to withdraw the question that I had and move to another question and we may circle back, but you can tell me if you feel like we missed something given that.

So I would like to talk about some of the things that you identify can be happening physiologically in a pregnant person's body when they are preparing to expel an embryo or fetus with no cardiac activity. You described in your report that the cervix may already be softening and partially open, is that accurate?

A. Yes. I state the cervix may already be softening and

partially opening. It's not always the case, but it can be. I have operated on women to do a D&C and they -- I go to do my exam and I can already put my finger in. Now those are not women typically with a missed abortion. Those are women that usually have symptoms in terms of their cervix making those changes because they'll often start spotting if their cervix is starting to open.

Q. And so if they -- just again so we're using the same terminology. How would you define a situation or what term would you use for that, where they are having some symptoms such as spotting?

A. So if they don't -- if they're having those symptoms and they are -- and we have diagnosed the embryo or fetus has died then they -- if they're already partially open, the cervix, then they would -- particularly if you can see any of the products of conception, whether it's the embryo, fetus, or the extra, the placenta, other tissue that's not the actually embryo or fetus, you can sometimes see them at the opening. So that would be an incomplete abortion. So she's in the middle of miscarrying.

Q. And I appreciate the juxtaposition there. So you said that not all patients have this softening and partially open. Does that mean that some would have cervixes that are what you describe as closed and thick?

A. Yes. For the cervix, yes.

Q. Thank you. So same paragraph of your report, in paragraph 56, you say that most women will naturally expel the pregnancy within two weeks and thus expected management is an option given to them. Is that an accurate summary of what's there?

A. Yes, it is an accurate summary.

Q. And are there some miscarriages or miscarriage patients who don't naturally expel the embryo or fetus within two weeks?

A. There are. The data suggests that 80 percent of women will miscarry within two weeks --

Q. I'm sorry.

A. -- on their own.

Q. On their own. Thank you. Is there anything other than those two things that we just talked about? Is there anything else about the state of the pregnant person's body that is maybe different?

A. Between what? Sorry.

Q. No. No. Absolutely. So with the situation where there is no longer embryonic or fetal cardiac activity, you say that the body is preparing to expel the pregnancy, other than the cervical changes and the sort of time frame that we just discussed, are there other physiological changes that you see?

A. Oh, most definitely. So the woman will often times say that she no longer has breast tenderness, she's not tired

like she was. And that is related to a drop in hormonal function. So she's no longer feeling the symptoms of pregnancy. And she may start cramping, which is the uterus preparing to expel the embryo or the fetus. You know, I think from the standpoint of when you deliver or you examine -- so let me back up. So, you know, when a woman is in her first trimester and has had a miscarriage, we will offer her expectant management, medication management, or surgical management. And every woman, you know, there are different conversations that you have with the women regarding that. But when I have done surgical or we do -- if she's a little further along, second trimester, induction, the biggest change you see is actually in the embryo or the fetus because they have lost their blood supply. And so just like if you and I lose our blood supply, our cells, our tissues die and we decompose, so do these embryos and fetuses. And so, you know, that's the other big thing that you see in our second patient is that going on.

Q. Okay. Any other physiological changes in the pregnant patient?

A. So we have talked about bleeding. She may be -- maybe we haven't talked about bleeding.

Q. Okay.

A. You know, I mentioned it, yeah. So bleeding and cramping are the biggest things. Loss of her pregnancy

symptoms. And then her cervix may start to open on its own. And then the fact that the baby or -- the embryo, the fetus is basically decomposing, autolyzing, maceration, I think, are terms that we use tells us that the physiology of blood flow is changing internally. We can't see that on the outside, but the evidence, the fact that she has a reduction of blood flow now going to the baby is evidenced by what we see in the baby. And there are studies, for example, that show like placental atrophy in women who have had a pregnancy loss in the second trimester and the placenta actually gets smaller. They do expectant management for a little while and they notice the volume of the placenta by ultrasound is smaller. I can't see those externally, of course.

Q. Thank you. So I'm focused now on some questions that deal with gestational age.

A. Okay.

Q. We'll be jumping around some so we're not repeating. Are you aware of any published medical research discussing the comparative safety of procedural miscarriage management and procedural induced abortion at the same gestational age?

A. Using the term procedural, are you also -- I know there's a lot of conversation about surgery versus procedure. So could you say that question and replace it with surgical also?

Q. Absolutely. So are you aware of any published medical

research discussing the comparative safety of surgical miscarriage management and surgical induced abortion at the same gestational age?

A. Surgical miscarriage compared to surgical induced abortion?

Q. Correct. At the same gestational age.

A. I am not aware of any direct studies that compare those.

Q. Thank you. Are you aware of any books or other publications that compare those?

A. I'm aware of a lot of conversation that happens in labor and delivery, in operating rooms, among colleagues anecdotally about differences that people describe. I'm aware of in textbooks conversations about the technical difficulty of an induced abortion compared to a miscarriage, particularly because on a miscarriage you already have a dead fetus if it's second trimester and you have a live one with the first one, and of course you'll have the bony structures that make for a more technically difficult procedure. And that's supported in the addendum information I gave yesterday about, you know, within 16, I think, to 24 hours the bones, the cortical bones soften. And I'm aware that the bones, removing them, particularly the skull are -- the calvarium, which is the skull, is where a lot of the cervical injury and hemorrhage can come from. That's what I'm aware of.

Q. Thank you. And I think that this is clear, but I just want to make sure that I know that it is. The textbook that you just referred to and you mentioned the addendum, that's those excerpted pages that you sent over to us and the textbook we talked about earlier, correct?

A. Correct.

Q. Any others?

A. Not off the top of my head.

Q. Okay. Thank you. And you describe the written sources and then also anecdotal kind of accounts from other people. You talk about -- you don't have personal experience with this, with induced abortions since you haven't performed them, correct?

A. So I have a lot of personal experience with labor inductions where we have second trimester either -- fetal demises or I had to do previable inductions. And the difference in terms of when there has been a loss, so the fetus is dead, those babies come out and sometimes their skin is sloughed off. They have macerated and their -- you can tell their bones are soft. They're kind of bent and their skulls collapse. So I do have that experience. I don't have the experience of a D&E extraction where I am removing the dead fetus or living fetus.

Q. And as you said, just to clarify, so no experience with D&E to provide an induced abortion as you have defined

that earlier, correct?

A. Correct.

Q. Thank you. So I'm going to turn now actually to the textbook pages.

A. Can I pause you real quickly? So my son is home. I'm going to turn -- my phone is going crazy. I'm going to silence it real quick. But he's home and my husband is here so I don't have to worry about my phone.

Q. Thank you. I appreciate you letting us know and I'm glad that he's home.

A. Thank you.

Q. Again, I'm turning now to the supplement and then the textbook pages. And since we're having the download issues, my plan is I will refer to some of the textbook pages. I'm not going to refer to all of them. If for some reason my reference makes you think there's an issue with what we have, please let me know. But other than that, we'll just --

A. And I have the book right here.

Q. We'll act on our good faith that we have -- everything that you think you gave us you did, and you can always follow up with us and we'll ask that Mr. Boyle does if you realize that there's anything you thought you provided that we didn't receive.

A. Okay.

Q. So based upon the passages that you cited in the

supplemental source, so that supplement that you gave us, would you agree that your training in miscarriage management does not qualify you to provide induced abortion by aspiration or D&E?

A. That's a loaded question. Say that again.

Q. Absolutely. So based upon the passages that you have cited -- and I'm just flipping here myself because I should have flipped earlier -- so based upon the passages that you have cited in the addendum -- and so just for reference those are the passages at pages 111, 131 and 158.

A. Okay.

Q. So then the follow-up -- and just also flagging that it's page 111 that refers specifically to training, but I want to kind of key us into the different passages that we're dealing with.

A. Okay.

Q. So based upon those passages at page 111.

A. Okay.

Q. And I'm going to just read from the addendum you were provided, the passage that's there, which is, quote, although abortion is among the most common medical needs of women, fewer than half of graduating obstetrics, gynecology residents in the United States have ever performed a first trimester induced abortion. And then the second section -- or second sentence you have bolded in the addendum. Training and the management of incomplete spontaneous abortion is not an adequate

substitute. So that's the passage that I'm referring to with this question.

A. Okay.

Q. The question is would you agree that your training in miscarriage management does not qualify you to provide induced abortion by aspiration or D&E?

A. Would you define qualify me?

Q. Well -- sorry, I'm just looking back to the wording. Okay. So I'm focusing on the training and the management of incomplete spontaneous abortion is not an adequate substitute. So would you agree that your training in incomplete spontaneous abortion is not an adequate substitute for specific training in providing induced abortion by aspiration or D&E?

A. That's a long sentence. Can you simplify what you're asking me?

Q. Yes. I will break it out into a few questions. You have training in the management of incomplete and spontaneous abortions, correct?

A. Correct. Among other things that I'm trained to do, yes.

Q. For the purpose of this question. And you have stated the opinion that -- or highlighted this passage for us that talks about an absence of, quote -- well, I'm going to change perform to performing. Performing a first trimester induced abortion as part of an obstetric, gynecological resident's

training, correct?

A. Right. That's what it says, yes.

Q. And in providing this in the addendum, you are providing it to support the position that management of incomplete spontaneous abortion isn't a substitute for that experience performing a first trimester induced abortion in residency, correct?

A. I think that's simplifying it. So I am providing it to highlight the fact that they're not identical procedures. And so my operative note may say that my procedure was a D&C, but in all -- or a D&E for that matter. But in all reality, each procedure is technically very different. And there's a big difference between doing a D&E in the second trimester for a dead fetus or a live fetus. And that it is recognized in our field that they are so different that not only do you need to go to four years of training to be an ob-gyn and all the things we do, that you need additional training if you're going to do them and be a complex family planning fellow and get two more years on top of four years. So I am not a trained complex family planning fellow. I have not done that program. And so I don't have that training. That's my point.

Q. Okay. Thank you. And again, just following up, you also haven't performed a first trimester induced abortion as it's referred to in the passage on page 111, correct?

A. All D&Cs I have done in the first trimester, the

embryos had -- fetuses had a heartbeat. Or didn't have a heart beat. Sorry.

Q. Thank you.

MS. PAI-THOMPSON: And I am going to, just so I don't forget, I am going to drop into the chat and ask to have marked as an exhibit the addendum first and then the textbook pages second. And again, that's for our record, but you and I will see it on paper copies given the Internet.

- - -

(Documents marked as Exhibit-27 and Exhibit-28 for identification.)

- - -

BY MS. PAI-THOMPSON:

Q. Do you agree that you're not qualified to provide an induced abortion?

A. No, I don't agree necessarily with that statement as simply as it is and as flat as it is. Because of the extensive training that I have had as an ob-gyn I have a lot of skills, and if I had to do one, I could -- I could work my way through it probably. But I think the complication rate -- I'm not as experienced as somebody who has done them for 20 years or who has done a complex family training fellowship. Which is why I think we have to be really careful about who's doing our second trimester abortions here in North Carolina. So I don't think it's a black and white question the way you asked it.

Q. I appreciate the followup. And what I'm hearing you say is that a provider's experience, right, like their level of experience in providing a procedure is important to the safety of that procedure? Is that what you're saying?

A. I think there's formal training, and obstetricians and gynecologists, we are trained as surgeons. And so I think that in itself is very different than, for example, Dr. Farris who is a trained family practitioner who is doing second trimester abortions here in North Carolina based on informal training she's received from people in the office, per her deposition. And so I think we're very different in that respect. So I think it's very hard to categorize me as not qualified.

Q. Thank you. Are you aware -- well, actually, let me back up. I'm sorry. Do you know what -- and this is a mouthful for me as not a doctor, what disseminated intravascular coagulation or DIC is?

A. I do.

Q. Can you define that for us?

A. Yeah. It's a situation that's often secondary to hemorrhage in which -- so a lot of people just think our blood is -- I'm not sure what people think. But it's mainly water. But it's made up of red blood cells too, but it also has clotting factors in it. And so when somebody hemorrhages they will often deplete their clotting factors. So they then don't clot and throughout their entire body they can have

disseminated, which means throughout the entire body, intravascular coagulation problems.

Q. And can you -- when you say problems, can you say more about what problems looks like in that context?

A. They can bleed to death. I mean, they literally will die if you can't help them clot their blood. And so you replace -- when someone is having a hemorrhage, whether it's postpartum or after an abortion, car accident, whatever, you have to not just give them red blood cells in volume, you also have to replace clotting factors.

Q. Thank you. Are you aware of research demonstrating that the risk of -- actually, let me back up. Is it okay if I refer to disseminated intravascular coagulation as DIC so I don't have to keep saying the words?

A. Yeah.

Q. Thank you. Are you aware of research demonstrating that the risk of DIC as a complication of D&E increases as the time since fetal demise increases?

A. Yes, I am aware of that, particularly in IUFDs after 20 weeks.

Q. Just when you say IUFDs after --

A. Intrauterine fetal demises. So, yeah.

Q. Would you agree that the risk for D&E for miscarriage management can be higher than the risk of D&E for induced abortion at the same gestational age?

A. I'm sorry, repeat that.

Q. Yeah. Would you agree that the risk of D&E for miscarriage management can be higher than the risk of D&E for induced abortion at the same gestational age?

A. I have to answer that anecdotally. We don't have head-to-head data. And, you know, women all present very differently. So a woman who has had a loss, so her baby is dead, the longer she goes without it being known, she does have that risk for DIC, as you said. It's extremely uncommon though. I have seen it a couple times, but it's very uncommon. Whereas when you have an induced abortion it's very, very different physiology that's going on when you have in a woman's body and the blood flow. So, you know, the -- the aorta is the biggest artery in our body and it has these two vessels that come out in our groin. They're called our internal iliac arteries. And then our uterine arteries come off of those. They're branches. And they come off right at the cervix and they travel kind of up the sides and they are huge as a term, for sure, especially in C-section. But the bigger the uterus -- the uterus starts off awful small. It's like a lemon or orange. It depends. And then it gets basketball size at term. And so as it grows, the demand for blood flow is greater. And so that demand when you have a live baby is still in place. That demand goes away when the baby dies, which is why we see the maceration and things like that. As a matter of fact, the

blood flow is so brisk in a living baby, it's like 500 cc a minute. That's like a half Coke bottle, a big liter bottle in a minute. And that changes when we have a baby that has already died. And so, you know, when you look at risk of bleeding and hemorrhage just anecdotally, it's a very different system. I think the other thing I would add is that -- and I mentioned this before is a lot of the risk for hemorrhage comes from -- and I think Dr. Boraas said this in her deposition. You know, when she teaches residents, you know, having to be very careful about removing the fetal parts that have bones because they're what tear that cervix. And that uterine artery is juicy. It's big. It's right there. So, you know, when you're doing a second trimester induced abortion compared to -- with a dead baby the blood flow is going to be different.

Q. Thank you. So going to be turning now to the textbook pages.

A. Okay.

Q. On page 131. Just let me know once you're there.

A. I'm there.

Q. Okay. So do you see the underlined passage in the second to last paragraph on the last column?

A. What I underlined?

Q. Yes.

A. Yes.

Q. Yes. I assumed, but it came to us with the underline

so --

A. It wasn't a used book.

Q. Okay. And this is one of the passages that you cited in your addendum, correct?

A. Yes.

Q. And the header for the subsection that it falls under is feticidal techniques, correct?

A. Right. Where they intentionally are ending the life of the fetus.

Q. Sorry, I'm dealing with a last bit of crud from a cold so I apologize for coughing in your ear.

A. I'm about a week from getting over mine. So no apologies needed.

Q. Thank you. So I'm going to read the first full paragraph of that subsection and I'll ask you whether I have read it correctly.

A. Okay.

Q. So it says the degree of softening of fetal cortical bones affect the amount of dilation needed for D&E. Softening is facilitated by fetal demise. Noticeable cortical softening begins to occur as soon as 16 to 24 hours after demise. The most common pharmacological agents used to induce demise in developed countries are potassium chloride, KCl, and digoxin and then parentheses Chapter 12.

Have I read that correctly?

A. Yes. Although mine says Chapter 11.

Q. Mine does as well and I appreciate you catching my typo in my head.

A. No worries.

Q. So this paragraph of the textbook is referring to cortical bone softening as a result of fetal demise induced by the abortion provider, correct?

A. Yes. They actually, before doing the abortion, the induced abortion, they actually either gave digoxin or potassium chloride that immediately stops the heart and then the baby dies.

Q. And so to clarify, so we're not talking about a situation with spontaneous fetus demise, right?

A. Correct.

Q. And not talking about cortical softening in that context, correct?

A. Not in this particular paragraph.

Q. Exactly. Are you aware of any research comparing the rate of cortical softening in the D&E setting to manage spontaneous abortion, as opposed to the rate of cortical softening in the setting of D&E for induced abortion?

A. I cannot say that I have read a study or I have looked for a study. I have read in various sources, including later in this book about, you know, just the statement of cortical softening after a fetus demise. And I have definitely

witnessed it many, many times when a woman has a spontaneous loss.

Q. And when you say you have witnessed it many times, do you mean in your experience in practice?

A. Yeah. So when doing inductions and the babies are born and their heads are very crushed.

Q. And for the various sources that you -- when you said various sources including the textbook, what other sources are you referring to?

A. So throughout the years there is textbooks that we have had in our training and -- gosh, various papers that -- where people almost -- almost like they say later, I think it's 158 they talk about softening of cortical bone makes it easier to do it. I'm trying to think if ACOG's second trimester bulletin talks about that. But there's a wide variety of places where, you know, it's almost in passing. This happens, you know.

Q. Thank you. So I'm going to turn now to page 157 of the textbook excerpt.

A. Okay.

Q. And again, I'm going to read a passage aloud and then I'll ask you to let me know if I have read it correctly.

A. All right.

Q. And I'm going to be looking at the last paragraph in the right-hand column. So it says surgical evacuation of a

nonviable pregnancy by suction curettage is performed in a fashion similar to first trimester pregnancy termination, parentheses, chapter nine. It is readily accomplished in an outpatient facility, except in cases of severe maternal disease or serious pregnancy-related complications.

Did I read that correctly?

A. You did.

Q. Thank you. And do you agree with that statement?

A. So not for me personally. I choose to do -- have chosen over the years to do my first trimester miscarriages, and that's what this is specifically talking about is first trimester, in an ambulatory surgical center or a hospital because of the risk of hemorrhage, the risk of uterine perforation, anesthesia risk, pain control risk. All those things. So I recognize that some other people may choose to do them in an outpatient setting, but I do not.

Q. So your practice is -- sounds likes your choice for where you do this is different than what they describe there?

A. Well, I think my choice and I think the majority of ob-gyns actually practice in a setting -- do their miscarriages first trimester in -- not in their clinics. And I know Dr. Boraas talks about that, and I even think in her C.V. she's given a talk called something along the lines of don't be afraid to do miscarriages outside the first trimester outside of your clinic setting. So...

Q. So I'm going to continue on with the same paragraph in 157.

A. Okay.

Q. And we are still at the last paragraph in the right-hand column. So it says with some nonviable pregnancies, the cervical softening associated with normal pregnancy is absent or minimal, making mechanical dilatation more difficult. Pretreatment with osmotic dilators or Misoprostol may help in those circumstances, parentheses, chapter nine.

Did I read that correctly?

A. Yes.

Q. And do you agree with that statement?

A. I do agree with that statement. As we talked about last hour, not all women will have -- will start having their cervix changing, and so sometimes you do have to use a mechanical prep, Laminaria, or the Misoprostol to help soften the cervix.

Q. Thank you. And then I'm going to be continuing on in that same paragraph and then into page 158.

A. Okay.

Q. So it says, quote, in contrast, when the spontaneous abortion process has already begun, the cervix is often dilated to some extent rendering mechanical dilatation easier. Although placental tissue may be more tenacious and difficult to evacuate with some nonviable pregnancies, no studies show an

increase in incomplete procedures for nonviable gestations compared to abortion of apparently normal pregnancies.

Did I read that correctly?

A. Yes, you did.

Q. And do you agree with that statement?

A. You know, I agree that -- kind of let's take it in two parts. In contrast, when the spontaneous abortion process has already begun, the cervix is already dilated to some extent rendering mechanical dilatation easier. Yeah. I mean, it's always a pleasant surprise when you go in the operating room and you think you're going to have to use your Pratt dilator to serially dilate and wa-lah, she's already open. It does make it easier because we know that the mechanical dilatation is where the potential for uterine perforation can occur. So yes.

The second one, although placental tissue may be more tenacious and difficult to evacuate with some nonviable pregnancies, no studies show an increase in incomplete procedures for nonviable gestations compared to abortion of apparently normal pregnancies. I would have to say I have not seen any studies myself. I will say this text is an older text and so there may be studies now. But I am not aware of them at this moment that I have looked in particular for.

Q. Thank you. So the quote, and then you have described to us, referred to cervical dilation that can make that mechanical dilatation easier. Is there any other way that the

textbook pages you provided to us identify that might make the procedure technically easier with spontaneous abortion?

A. Specific to these pages? I would have to review them to answer that. Would you like me to do that?

Q. I think we can come back to it. So is there -- there's nothing that comes to mind at this point?

A. Not specific to the pages I gave you.

Q. Thank you. Based on the passages in the textbook that you cited, so those three that I reviewed at the outset, including that bolded passage, would you agree that there are some circumstances in which procedural management of miscarriage is more difficult than a procedural induced abortion?

A. So that is a massively hypothetical question. And so I think every situation is unique and you can prepare and expect for various technical difficulties patient by patient. So I can't say -- answer that question the way you have answered sic it. I can say overall when you look at induced abortion compared to miscarriage, there are technical differences that make it more risky, particularly in the second trimester to do induced abortions.

Q. So let me then -- just because that was a longer paragraph, I'm going to pull it back and ask a shorter question. So would you agree that there are some circumstances in which procedural management of miscarriage is more difficult

than procedural induced abortion in some circumstances or any circumstances?

A. So procedural meaning a surgical?

Q. Yes. I'm sorry. Yes, I will work on making that change. So would you agree that there are some circumstances in which surgical management of miscarriage is more difficult than surgical induced abortion?

A. I can't say I would agree to that because each case is unique. But I guess I'm replicating myself, but I'll go back to say that there are more inherent risks to -- when you're doing an induced abortion with a live baby who -- I think it's in Dr. David Grime's words, at that stage of the pregnancy is tenaciously trying to stay in place. And then a situation where the fetus has already died and physiological changes are already happening, particularly a change in blood flow leading to the changes we see in the fetus. So, you know, I think I can only answer that globally. But yes, can you have a difficult D&C for miscarriage? Yes. And can you have a straightforward -- D&E, I should say, for an induced abortion? Yes. But we're talking -- we're not talking about one unique case. We're talking about the overall risk. And, you know, I clearly stand by my expert report that there are much greater risks due to the physiology that's going on with an induced abortion.

Q. Thank you. And looking back to the inherent risks

that you just mentioned. Are you referring to the risks that are the result of less cervical dilatation in induced abortion patients?

A. I'm really referring to the fact that there are greater risks for hemorrhage when you -- in the second trimester induced abortion. I'm talking about the fact that you have bones that have not -- you're having to dismember the fetus and disarticulate joints. And that's very different when you don't have a body that's already dead and macerated.

Q. Are you -- but you're not aware of research -- I'm sorry, let me back up. So you have been describing the experience that you have seen -- talking about the textbook. You're not aware of research stating that D&E for induced abortion is riskier than D&E for spontaneous abortion at the same gestational age, is that correct?

A. I'm not saying that I have seen a head-to-head study in terms of that, but there's a whole lot of anecdotal experience, even, you know, individuals who have done complex family planning rotations, you know, talking about dialogue with, you know, people, you know, so...

Q. Thank you. I am not trying to beat a dead horse here with some of these follow-up questions. I just want to make sure that we are talking about the same thing and have a common understanding of the full range of information you're talking about. And so the anecdotal experience that you're referring

to is not your own direct experience since you have never provided a D&E for induced abortion, is that correct?

A. So it's really reading case reports from other people, it's an interest in learning about it because I care about the safety of both my patients. Unfortunately the Society For Family Planning is very exclusive, so I can't become a member and learn some more of these, hence I ordered this text. It's just like anything else in our field. There's so many different areas to learn about. I'm a lifelong learner. I'm continuing to learn and want to continue to learn, and I think the vast experience I have in the operating room, particularly with miscarriages, as well as on labor and delivery with demises or previable inductions, I think allow me to have a lot of knowledge in this area.

Q. And so the case reports that you reference, you haven't cited those case reports or other sources in your expert report, correct?

A. No, I have not.

Q. Can you think of any of those sources just sitting here today?

A. I think the one that jumps off at me is a case report series of two women who had placenta previas and showing that with expected management -- of course making sure they didn't get DIC -- showing -- I think I mentioned this earlier, how much the placenta shrinks because it losses its blood supply,

and them noting when they did the D&E procedures that they had much less bleeding than they would have even expected because of the placental atrophy. That one jumps off.

Q. And where was that one from?

A. I could get that to you. I don't know off the top of my head.

Q. Okay. We'll ask Mr. Boyle to follow up with you about that.

A. Sure.

Q. And you mentioned placenta previa. So those are complicated cases, is that correct?

A. Well, yes. If you have a placenta over the cervical os it is complicated. But it is -- their point that they were making in it was that they could reduce the complication of hemorrhage from a placenta previa by reducing the blood flow and the size of the placenta. So not immediately doing the D&E. And so what it does is you can use it to show that the physiological changes that make it more risky to do a procedure like induced abortion the second trimester, the physiological changes that support that is what I'm using that for.

Q. Thank you. And can you think of any case studies, just following up, as you sit here today, involving non-complicated pregnancies to suggest that the risk of hemorrhage is greater with induced abortion than with spontaneous abortion?

A. I can't think of case studies. I have talked to MFMs about it so in the past. I have talked to general ob-gyns about it. But from a literature standpoint, I can't think of something off the top of my head right now.

Q. Thank you. And then just one other from a literature standpoint question. Sorry. Are you aware of research comparing the risk of hemorrhage as a complication for D&E for miscarriage management to the risks of hemorrhage as a complication of D&E for induced abortion?

A. Could you repeat it? Am I aware of which?

Q. Sure. Are you aware of research comparing the risk of hemorrhage as a complication of D&E for miscarriage management to the risk of hemorrhage as a complication of D&E for induced abortion?

A. The main literature in that area is not comparing those two. It's really just showing that as gestational age increases, so does risk for hemorrhage. And so that's the emphasis of those studies.

Q. All right. And when you say the main researcher of those studies, are there specific studies that you're referring to?

A. There are.

Q. Are there any -- same question. Any that you can think of as you sit here today?

A. I think I document some in my expert report.

Q. Are there studies that you can think of beyond that? I'm just wanting to make sure that we have the universe of information for that.

A. I will not claim that my expert report is inclusive of every study. It's only, I think, 30 pages long. So there are other studies I have read and I just summarized.

Q. Thank you. So I'm going to return us back to the textbook and back to page 158.

A. All right.

Q. And we are now at the top of the left-hand column in the first full paragraph in that column beginning with the phrase uterine evacuation.

Do you see what I'm referring to?

A. Yeah.

Q. Is this the passage that you cited to in your addendum -- or a passage that you cited to in your addendum?

A. It is.

Q. And specifically you cite the sentence that reads uterine evacuation may be technically easier after fetal demise. Softening of cortical bone makes surgical extraction easier. With medical aborted patients, induction abortion intervals are often shorter, parentheses, Chapter 11. Is that correct?

A. Yes.

Q. And did I read that correctly?

A. You did.

Q. So I'm going to continue reading in that same paragraph. Quote, regardless of the evacuation method chosen, patients with second and third trimester fetal death may require evaluation for coagulopathy, in addition to routine preoperative laboratory tests. Dead fetuses retained in utero for four weeks or more may cause consumptive coagulopathy, a condition that can lead to severe perioperative hemorrhage. Clotting factor therapy prior to uterine evacuation avoids this complication.

Did I read that correctly, other than almost certainly mispronouncing coagulopathy because I can never say the word?

A. It's not an easy one. I think you did pretty good. Coagulopathy. Yes, you read it correctly.

Q. Thank you. And do you agree with that passage?

A. Yes, I agree that you do not want a woman to have a coagulopathy and it rarely happens. Four weeks is an awful long time. And so, you know, most women know way beyond four weeks, but you do occasionally have a woman who has DIC and you have to take care of her. But to try to generalize that to mean that a missed abortion leads to a coagulopathy more easily and that's what happens in real life ob-gyn is just not true. But I do think it is warning you that you need to pay attention to the fact that you should do lab work and make sure that a woman doesn't have severe anemia, she doesn't have low

platelets, particularly if let's say she comes in and she's supposed to be 20 weeks and her baby is only measuring 16 weeks, then that maybe died a month ago and you're going to, you know, know a little bit more than that. So fortunately, this is very rare, but when it does happen, it does increase her risk for hemorrhage.

Q. Thank you. And I think that you answered my next question, but just so that -- just so that I'm clear. So is consumptive coagulopathy the same condition as DIC?

A. Yes.

Q. Thank you. So just some general stuff about the textbook and it may be that you refer to the inside cover for some of this, just as a heads up. But it was published in 1999, is that correct?

A. Yes, it was. And I was intentional about getting this one, an old one for the purposes of today.

Q. Why is that?

A. A couple reasons. One is the editors are very well published and they also -- I think this was written at a time that I think I'm a lot -- I was a lot less skeptical. I think they would be more honest in a way a lot of publications are written today. Not that abortion has not historically been political. But when you look at the writings, even the textbooks when I was a resident in '97 to 2001, which this would have been published during that time, it seemed to be

much more objective. There is so much publication bias that's happening right now, difficulty getting things published if -- if the society owns the journal and they don't have the same belief structure as you. I have lost trust sadly. You know, I have a Ph.D. and I don't think some of the integrity we used to have, we still have in medicine. I have sadly seen ACOG make some changes in things that I don't think are science based. And so I intentionally did an older textbook hoping to see a little more objectivity. And so, yeah, that's why I chose it. And a second reason, Dr. Boraas has a book -- a chapter coming out in a surgical gynecology book and she's talking about surgical complications in her chapter and it's not going to be published until March. So couldn't access that one.

Q. Thank you. And I appreciate you explaining the thinking behind choosing a textbook from that time period. So medical education -- medical education in 2024 isn't exactly the same as in 1999, correct?

MR. BOYLE: Objection.

THE WITNESS: A whole lot of it is the same. A whole lot of it is the same. Now, what's different? Is first day of my rotation, third year of medical school, I was told I was entering the most unique specialty in all of medicine because I got to take care of two patients simultaneously, a maternal and a fetal patient. Same thing was repeated to me two years later when I was starting residency and I was an

intern in ob-gyn. That's changed. Sadly the absence of acknowledgment of our fetal patient and trying to normalize that has changed. But so much of this textbook is very true still today. So I would disagree with your statement.

BY MS. PAI-THOMPSON:

Q. Thank you. I'm switching topics again and then I'll just flag -- you may be wondering in terms of our break. I think we'll take our next break after we get through this set of questions.

A. That will be fine.

Q. So I'm going to be talking about the subject of live birth. Are you aware of any live births that occurred following a D&E procedure as opposed to an induced abortion?

A. Yes.

Q. Let me re-ask the question because I just want to make sure I have the wording clear. Are you aware of any live births that occurred following a D&E procedure as opposed to an induction abortion?

A. I think it's much more common with an induction abortion, which is actually why people will sometimes -- clinicians will use feticide before because it's the concern of a live birth. And then they would actually have -- they would have failed their intention of the procedure and they would have to hopefully care for that newborn. But yes, I am aware of people who have survived the other type, a dismemberment

procedure, D&E.

Q. And so when you're saying that -- what -- for the cases that you're aware of, how are you aware of those?

A. Just have heard their story. Like I think one is a public speaker and I think doesn't have an arm.

Q. Do you know at what gestational age that their live birth occurred?

A. I don't.

MS. PAI-THOMPSON: I think this is a good time for our next break. Does 10 minutes work again?

THE WITNESS: Sure.

MS. PAI-THOMPSON: Mr. Boyle?

MR. BOYLE: Yeah.

MS. PAI-THOMPSON: And then I'll just also, for our court reporter, ask for a time check when we come back.

- - -

(A break was taken - 4:01 p.m. - 4:13 p.m.)

- - -

MS. PAI-THOMPSON: Dr. Bane, I'm going to direct you now to the Desai study that you cited. I'm going to drop that into the chat and ask that it be marked as an exhibit for the deposition, but then we'll go off of our paper copies.

- - -

(Document marked as Exhibit-29 for identification.)

- - -

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 --

never mind. Okay. Fabulous. It has taken over my entire screen and that I don't want.

BY MS. PAI-THOMPSON:

Q. All right. So looking at -- we're going to begin with the first page here. The study that Desai and colleagues did, the study's aim as it's described in the objective was not to assess why providers did or didn't provide abortion, correct?

A. No, that was actually not done in this study. It was actually done --

Q. I'll have a follow-up question to that. So the question of why in this study, they only put that question to a smaller subset of the participants, correct?

A. I'd have to review it to know that they did a subset. I just recall the Grossman study being able to have statistics as to why. I don't recall that in this one.

Q. Okay. Well, let's go to then table one, which is at the very last page of this study. And it will be a landscape view rotation.

So looking at the top of the table which describes -- gives us the results from the study about why people didn't provide abortions. It describes the table as the percent distribution of reasons cited for not providing abortion referrals among obstetrician-gynecologists who do not perform abortions, by type of survey response correct?

A. Yeah. Can the person make it a little bigger? These

are trifocals. I need a little more. Yeah. Great. Thank you. That's plenty.

Q. Okay. So I read that correctly, right?

A. You did.

Q. So this is describing results from people who indicated that they did not perform abortions and were then asked the follow-up questions about why, correct?

A. For this subset of it looks like 271 people.

Q. Correct.

A. There were over 800 initially. So I'm not sure why it's just this subset.

Q. We'll get into that. So looking at this 271 of all respondents in that subset, you see that there are initial respondents and there were 81 initial respondents. I'm sorry, 58 initial respondents, correct?

A. Yes.

Q. And then 213 follow-up respondents, correct?

A. Yeah. But I would have to see the study to know what the difference in the two are.

Q. So of these smaller subsets that's discussed in table one for the -- I'm going to be in the all respondents column. The 16 -- it was 16 percent of that smaller subset that identified personal, moral, or ethical objections, correct?

A. I have a moral or ethical objection to abortion. 16 percent, right.

Q. And then of that smaller subset, 17 percent identified office policy, correct?

A. Office -- my office has a policy specifically against discussing abortions, 17 percent.

Q. Correct. And then 14 percent identify N/A, not applicable. I have not encountered a patient seeking abortion at this office, correct?

A. Correct.

Q. And then nine percent identified, quote, my office staff is against abortion, correct?

A. Correct.

Q. Eight percent, I do not know any abortion providers in my area, correct?

A. Correct.

Q. And two percent, my community is against abortion, correct?

A. Correct.

Q. And things like office staff and community being against abortion, those can be caused by abortion stigma, correct?

A. So, I mean --

Q. My question is they can be caused. I'm not asking you to say what would occur in every case. But they can occur because of abortion stigma, correct?

A. The reason why they're not done in an office?

Q. Or why staff would be against.

A. Well, I mean, I think the stigma is potentially more on the patient side that I think has to go away in terms of I think we stigmatize when we're with unplanned, unexpected pregnancies.

Q. My question though is about the choice that an office might make.

A. Okay.

Q. Policy to not provide abortion could be the result of community stigma in the community that that office is in, correct?

MR. BOYLE: Objection. You're asking this doctor what now?

MS. PAI-THOMPSON: I will repeat my question.

BY MS. PAI-THOMPSON:

Q. My question is -- and we're looking at, again, the 17 percent of that smaller subset that identified an office policy as the reason that they don't provide abortion. So we have that 17 percent. Okay.

A. Okay.

Q. For an office that is situated in a community that is against abortion, that can contribute -- against abortion where there is abortion stigma, that can contribute to choices around office policy, such as not providing abortions, correct?

MR. BOYLE: Objection. She's not an expert --

MS. PAI-THOMPSON: I'm going to object to speaking objections. If the objection is to my form, we'll note that. But my question stands and I would ask the witness to answer.

MR. BOYLE: Object to form.

THE WITNESS: Okay. So I can't say I agree with you in terms of knowing how this person interpreted their decision to do an induced abortion based on the community they live in. I can't -- I don't know what was going through that person's head. I can't claim that it was stigma that they may experience. Perhaps it is an influence of the community making them think, boy, the direct and intentional killing of another human, maybe that isn't a good thing to do. But they haven't got to the place where they morally or ethically object. So I really don't think I can say I know the reason is stigma.

BY MS. PAI-THOMPSON:

Q. So I'd like to talk -- referring to -- you mentioned the person who's providing the abortion and directing you again to the column in table one about follow-up respondents.

A. Okay.

Q. At the bottom it describes -- at the very, very bottom of the page that begins follow up.

A. Yes.

Q. And it says, quote, follow up respondents are those who provided information during telephone follow-up, correct?

A. Yes.

Q. So that's giving us that the 213 out of 271 respondents were those who provided information during telephone followup, correct?

A. Yes.

Q. I'm going to refer you, and then my kind colleague who is helping me out, to page three. And we'll go to the bottom of the second paragraph on page three. All right. And in that section this study describes, quote, information obtained during followup was provided by office staff rather than physician as surveyors were seldom, if ever, connected to the physician by phone, correct?

A. Yes. That's correct.

Q. So this 213 out of 271 number of follow-up respondents, those are not actually opinions directly expressed by the physicians to the researchers, correct?

MR. BOYLE: Objection.

MS. PAI-THOMPSON: You can answer the question.

THE WITNESS: Could you repeat it, please, Vanessa?

MS. PAI-THOMPSON: Sure. I can back up.

BY MS. PAI-THOMPSON:

Q. So page three, the study discloses that information obtained during phone followup, which is the phone followup that they refer to at the bottom table one, that followup

respondents were those who provided information during telephone followup, again, the bottom of page three, the page that we have up, that information obtained during phone followup was provided by office staff rather than physicians and surveyors.

MR. BOYLE: Objection.

BY MS. PAI-THOMPSON:

Q. Seldom, if ever, connected to the physician via phone, correct?

MR. BOYLE: Objection. You can answer.

THE WITNESS: I agree with what you're reading. I don't know if there's another question in there.

BY MS. PAI-THOMPSON:

Q. So the question was do you agree with my reading and as you -- let me actually withdraw that question.

So it's common as part of a study that the researchers will describe their process, correct?

A. The method is that process, yes.

Q. And you don't have any reason to believe that in this study the processes that they described in the article are accurate, correct?

MR. BOYLE: Objection.

BY MS. PAI-THOMPSON:

Q. Do you have any reason to doubt that they described what they did in the method section?

A. I don't have any reason to doubt if that's what they're describing. I have a lot of concern about their methodology though.

Q. My question though was whether they described their methodology in the method section.

A. So it would have been nice to know what office staff is, but you don't want me to go there yet?

Q. I'm just going to refer us back then to -- and you have answered this question already, that I have read correctly the section where they discussed information during follow-up, correct? At page three at the bottom of the second paragraph.

MR. BOYLE: Objection.

THE WITNESS: So Vanessa, the only thing I would agree with right now is I have some concerns about, you know, the figure and this methodology, but I agree that you have read that last sentence correctly.

BY MS. PAI-THOMPSON:

Q. The study also focused only on private practice, correct?

A. Correct.

Q. And it specifically excluded ob-gyns who practice in clinics, correct?

A. Practice in clinics? What do you mean by that? Are you talking about academic?

Q. What's that? A clinic like Planned Parenthood, they

specifically excluded from this study participants -- or providers who practice in clinics?

MR. BOYLE: Objection.

THE WITNESS: I would need to review to be able to answer that. I know it's private practice.

BY MS. PAI-THOMPSON:

Q. So we're at the top of the same page, the second sentence -- I'm sorry, the first sentence. Physicians who are clinic based, retired or deceased or did not provide accurate contact information were excluded from the sample. Prior to mailing the survey, 29 physicians were identified as clinic based and were removed from the sample, correct?

A. What you're reading is correct, but I don't know how they define clinic based in this study.

Q. Well, we can move on and then we can go back to that. I'm going to move on now to Grossman.

A. Okay.

Q. Yes. And I'm going to -- do you have the paper copy of that handy?

A. I don't. You'll need to share that.

Q. Okay.

MS. PAI-THOMPSON: And I'm also going to drop that in the chat and ask that it be moved as an exhibit.

- - -

(Document marked as Exhibit-30 for

identification.)

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BY MS. PAI-THOMPSON:

Q. Do you have it in front of you or are we screen sharing?

A. I don't have anything in front of me yet, but it took a minute for it to come up last time. Here it comes. I have it.

Q. Okay. So again with Grossman, they did not identify as their reason, their purpose in performing this study discerning why people chose not to provide abortions, correct?

A. I think that was an element of it, that they did that.

Q. They did do it, but it was not identified as a reason --

MR. BOYLE: Can you let her finish her answer, please? She was not finished.

THE WITNESS: So I think that if you look at just their objective to estimate proportion of obstetricians, gynecologists who provide induced abortions in the prior year and document -- disaggregated by surgical and medication methods and document barriers to provision of medication abortion, I think that is an element of the why.

BY MS. PAI-THOMPSON:

Q. And so it actually was -- you brought up the objective piece. It was in the documenting barriers to provision of

medication abortion. That was actually where they asked the question why, correct?

A. I would need to review their methods one more time.

Q. I will focus you on something as you do that. That here the smaller subset of participants they asked the why question to were participants who did not provide medication abortion, correct?

A. I would need to review the methods to know that for sure.

Q. So at table four in this study. And this is the table that gives us that 34.2 percentage figure that you cite to in your expert report, correct? Or it reflects that figure.

A. Could you make it a little bigger for me? Yes.

Q. Again, for the why question, it gives the heading for table four that includes this data is, quote, perspectives of obstetricians, gynecologists who do not provide medication abortion among those who have patients seeking abortion, correct?

A. Correct. That's the title.

Q. So this -- according to the title, this table reflects the subset of people who do not provide medication abortion and were asked the why question, correct?

A. Yes.

Q. And in that section the most common reasons listed are discussed. And you also discuss that in paragraph 22 of your

report, correct?

A. Yes.

Q. And in paragraph 22 of your report you refer to that 34 percentage as the most common reasons for not providing abortions included personal, religious or moral beliefs against abortion, correct?

A. Yes.

Q. The study here when describing the same information actually says that it is the reasons for not providing medication abortion here, correct?

A. Yes, I stand corrected that I left out the word medication.

Q. And in addition to that 34 percent that you noted referenced moral reasons in that table we see that probably 19 percent reference practice setting restrictions?

A. Yes.

Q. And 16 percent reference office staff attitudes?

A. Yes.

Q. Do you believe that abortion providers experience more or less verbal harassment than physicians who do not provide abortion?

MR. BOYLE: Objection.

THE WITNESS: I have no way of answering objectively that question. I will tell you that there's stigma in various aspects of medicine. I'm stigmatized often being a

medical director for Pregnancy Centers. ACOG has called me unethical in their issue brief about Pregnancy Centers. So I think stigma is wrong regardless of who is getting it. But whether it is somebody who is trying to practice from a life-affirming approach like myself or -- I don't think individuals who provide abortion should be stigmatized. But I cannot tell you they are more stigmatized than other people are.

BY MS. PAI-THOMPSON:

Q. You're not aware of any other specialty other than providers who provide abortions in which physicians have been murdered for the medical care they provide, are you?

MR. BOYLE: Objection.

THE WITNESS: I don't know the answer to that question.

MS. PAI-THOMPSON: I'm going to move now to the Niinimaki study and the letter to the editor. And I'm going to drop both of those into the chat and ask that they be marked as exhibits.

- - -

(Document marked as Exhibit-31 for identification.)

- - -

BY MS. PAI-THOMPSON:

Q. Do you have those in paper copy or do we need to --

A. No, I actually have -- I have Niinimaki. I don't have the second part.

Q. Okay. So we will get ready to screenshare the letter to the editor as needed and we'll begin with the paper itself then. So in the United States, medication abortion procedures are generally a combination -- I'm going to withdraw that question and ask it more clearly.

In the United States one commonly used regimen for medication abortion is a combination of Mifepristone and Misoprostol, correct?

A. Yes.

Q. And then another common regimen is the use of Misoprostol alone, correct?

A. Much less common.

Q. In your discussion on August 31st in your deposition, you and Ms. Salvador discussed some facets of the Niinimaki. I'm not going to retread that ground, so we'll just get into a few additional questions. The study identified medication abortion protocols that are available -- that are used in Finland that are not those two that we just identified, correct?

A. Let me review it again. I believe that they only go up to 63 days.

Q. So I'm asking just about the drugs that were used. And specifically in one instance they say that there was a

Mifepristone-only regimen that's used in Finland?

A. Yes, I do know that.

Q. During the August 31st deposition, you and Ms. Salvador reviewed the letter to the editor and we'll go ahead -- we can screenshare that as well for our reference here. And in that deposition, do you recall discussing concessions that are in the letter to the editor about limitations of the study?

A. Yes, I remember just the aspect related to hemorrhage. The study also looked at incomplete abortions and having to go back to surgery. But the letter saying that some of the people who went to the -- to follow-up care, would it truly be classified as hemorrhage as -- that was the gist of our conversation.

Q. Okay. Thank you. And do the concessions from the authors of the Niinimaki study change your opinion about the study's reliability as a source for your statement in paragraph 48 of your report that, quote, chemical abortions have a four times higher risk of complications compared to surgical abortions?

A. I think the absolute numbers may change, but I think the ratio comparing surgical abortion and medication or chemical abortion, you're still going to -- and it's not just this study. I think it's the Mintua study I also reference. We consistently see that there are higher complications with medication abortion compared to surgical. But I think the

absolute numbers would have to be reevaluated.

Q. And so is your answer that it doesn't change your opinion about the study's reliability as described in paragraph 48 or that it does?

A. It impacts it, but that piece is one part of this entire study. But I still -- with the collective body of research still, the fact that surgery -- I'm sorry, medication, chemical abortion leads to more complications I still stand by.

Q. In your opinion, in general -- is it your opinion, in general, that abortion is not safe?

A. Are we talking about induced abortion?

Q. Yes. I will rephrase. It's your opinion that, in general, induced abortion is not safe, correct?

A. It is my opinion that we need to do a much better job collecting data to make that conclusion. I think it's an assumption at this point for many different reasons that I outline in my expert report.

Q. And so when you say that it's an assumption, do you mean that it's your assumption that it's not safe?

A. It's an assumption that Dr. Boraas and Dr. Farris make throughout the entirety of all of their documentation.

Q. My question is not about the conclusion that abortion is safe. My question is about your opinion. So I'll re-ask the question. And that's why I say I might need to jump in to clarify if it seems like we're talking about different things.

My question is it's your opinion that, in general, induced abortion is not safe, correct?

A. So once again, an extremely loaded question. So it is never safe for my fetal patient, and I was taught and continue to believe, the purpose of health is for -- of medicine is for health and wholeness and that I have a maternal and a fetal patient to take care of. It is never safe for my fetal patient. I have grave concerns for keeping my patients safe who choose to have an induced abortion, and I want to do everything in my power to minimize their risk. And so that's what I can agree to you to say.

Q. Thank you.

MS. PAI-THOMPSON: I think that we will take a break here. Shall we do 10 minutes?

THE WITNESS: Okay.

MS. PAI-THOMPSON: Thank you. If I could get actually a time check from our court reporter, that would be hugely appreciated as well. Thank you.

- - -

(A break was taken, 4:43 p.m. - 4:53 p.m.)

- - -

MS. PAI-THOMPSON: And I just want to confirm also -- I'm sure that we -- I dropped -- I am going to -- because I thought I had and I hadn't, drop just for the purposes of our record, the letter to the editor into the chat

and ask that it be marked as an exhibit.

- - -

(Document marked as Exhibit-32 for identification.)

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BY MS. PAI-THOMPSON:

Q. Dr. Bane, you're not familiar with the training that any Planned Parenthood South Atlantic receives regarding administering anesthesia, are you?

A. I can only talk about what -- the deposition that Dr. Farris did.

Q. Okay. So no knowledge beyond that deposition?

A. In the protocols -- I've reviewed the policies and procedures in the protocols and there's no mention of any anesthesia professionals.

Q. And so my question was the extent of your knowledge about the training that any Planned Parenthood South Atlantic employee would receive is from exclusively from the deposition of Dr. Farris, is that correct?

A. From the deposition and any policies and procedures that I was given to review.

Q. Thank you. And you don't know the sedation practices that non-Planned Parenthood South Atlantic providers in North Carolina use, correct?

A. As part of this case, there was no discovery related

to that. I can't even really talk to you about patients who have gone to some of those places.

Q. You don't have comprehensive information --

MR. BOYLE: She's not done with her answer.

THE WITNESS: Yeah. So talking about how difficult their experience was. But I do not have any documentation. I have patient anecdotal experiences.

MS. PAI-THOMPSON: Thank you. And I am just now dropping that letter into the chat. Sorry. My window had closed out.

BY MS. PAI-THOMPSON:

Q. Is it your testimony that only people who have completed a complex family planning fellowship can safely provide D&Es for induced abortion?

A. It is my testimony that the purpose of the complex family planning fellowship, above and beyond four years of training, is that there is an additional need for second trimester or third trimester abortions and then contraception is the second element. And that it is now not just resident -- or fellowship programs. It's actually a board certification. So based on that, it is my opinion that the American College -- the American Board of Ob-Gyn, excuse me, and residency programs believe that it is necessary.

Q. So my question isn't about what you believe they believe. My question is, is it your testimony that it's your

opinion that only people who have completed a complex family planning fellowship can safely provide D&Es for induced abortion?

A. At what gestation are you talking about?

Q. After the twelfth week.

A. Okay. So second trimester. I -- so repeat the question now that we have clarified the gestational age.

Q. Is it your testimony that it's your opinion that only people who have completed a complex family planning fellowship can safely provide D&Es for induced abortions after the twelfth week of pregnancy?

A. So I can't say yes or no to that question. There are --

Q. If you can't say yes or no, that's fine. I can --

A. Can I finish what I was going to say? So there are people who have 20-plus years experience and have done a tremendous amount of them, and this is a fairly new complex family planning program. I think it's only become a board certification the last few years. So I think there are people who have practiced a long time. As a matter of fact, all the editors of this book do abortions, from my understanding, or did. They're not all practicing right now. And they didn't complete the program. And so I think that you can't just make a blanket statement like that that I could easily say yes or no to. I think that it is technically a very difficult procedure,

as many people have alluded to from reading the literature. And it is a fact that our governing bodies think that we need additional training beyond four years is consistent with that.

Q. Thank you. So I'm going to refer back to the textbook. And you described that you intentionally chose a textbook from 1999. You intentionally chose a textbook from 1999, and knowing that it might not reflect the current state of medical practice, is that correct?

A. No, that's not correct at all. If you recall, I said that the names are very respected and well-known in ob-gyn. So that drew me to it. And then what drew me to it also is the fact that I felt that perhaps they would write it from a more objective standpoint than what I see so much of what's being written today. I knew there would be a critique of how old it is and I think there are some things in there that they might say we don't know this, and now I kind of can go oh, yeah, we do. But there are many things in there that are the same as what we do now.

Q. So is it your opinion that everything -- just the textbook pages that you sent us, not the entire textbook, but the textbook pages you sent to us reflects current medical practice?

A. Well, once again, I think you're trying to oversimplify the situation. For example, I think the data have changed where they say that I think it was 50 percent have not

received training in first trimester abortions. Now that number is lower. And so I think there are some shifts in even then. They -- medication abortion, chemical abortion was -- you know, it wasn't -- Mifepristone wasn't approved until 2000 and so this is written in 1999. There's a very fascinating statement in the first or second chapter that states that if medication abortion can happen before implantation, then maybe we'll call it contraception one day. And I find that fascinating because ACOG has now changed the beginning of pregnancy to implantation. So some of the story lines that I see historically playing out, the stage was set in this book.

Q. What's the basis for your belief that women receive inadequate pain management during second trimester abortion?

A. Well, I didn't -- if I came across as saying that every woman receives inadequate pain management, then I will pull back on that statement. I don't believe every woman does. I believe that pain management takes a second seat to trying to get abortions often done in a setting where you cannot do deep sedation or general anesthesia. That's the point that I made. And I also anecdotally have had patients who have talked about that they did not feel like they were adequately managed with their pain with their surgical abortions. From reading, I think it was Dr. Wheeler and Dr. Rubinhorse's expert reports, they cite studies of inadequate pain management. I did not site those studies. So it's multiple reasons. But do I

believe a woman can get adequate pain management? Yes, I do.

Q. Thank you. And you referred to the studies that Dr. Wheeler and Dr. Rubinhorse relied on. Did you review those studies or just see the citations?

A. I just saw the citations.

Q. Thank you. Was it your practice when you were providing care, was it your practice to provide either deep sedation or general anesthesia to every patient who you provided a D&E?

A. I didn't provide the anesthesia. The anesthesiologist or nurse anesthetist -- the anesthesia professional provided that. And I would say the majority chose general anesthesia.

Q. And so referring to practice statements and committee opinions that we have kind of talked about through this deposition. You agree that practice statements and committee opinions are the result of a review of the relevant literature, correct?

A. That's what they should be based on.

Q. And them being based upon that allows them to represent something close to a professional consensus, correct?

A. Could you define what you mean by a professional consensus?

Q. A general consensus among the providers for whom the body issuing the practice statement or committee opinion.

A. So I wouldn't necessarily agree with that statement.

I would agree that it is a -- it should be that. It should be a consensus of membership. It's not always consensus of membership. At the bottom of committee opinions they'll have the individuals who actually were on that committee and made that decision. And so I think a ACOG, while it does a lot of great work in areas -- some areas, I think in the -- their abortion statement they don't represent a consensus of their membership.

Q. And you referenced ACOG'S statements, you don't believe they represent a consensus?

A. Not all of them. Just --

Q. Yes. That's going to be my follow-up question to clarify. That's, as you were talking about earlier there, statements that refer to policy about abortion, correct?

A. Correct. And so, you know, I'm watching like a hawk if they -- if they make statement changes that are -- seem to be politically driven instead of science driven. And I think their abortion policy -- the way they changed it from after viability they did not support abortion for a healthy fetus. And as soon as the Dobbs leak came out they changed it to full with no barriers and no limitations. And that was like the Dobbs leak. That wasn't even the Dobbs decision. So those types of things are not professional and do not show integrity. And those are the things that I'm very concerned about.

Q. Thank you. And you sort of jumped and corrected -- I

was talking about -- you said not all ACOG statements and have described how you disagree with their policy statements. You generally think that the technical medical information that they include is accurate?

A. We'd have to go statement by statement. But the ones I chose to include in my expert report, I fully support the position they gave.

Q. And that was 191 and 193, right?

A. I think 191 was my first declaration. 193 for this one where they did an interim update.

Q. Thank you. Do you have any reason to believe that a patient is more likely to see a CFP trained physician at a hospital than at an outpatient abortion clinic?

A. You say CFP trained, are you talking about fellowship trained?

Q. Sorry. Yes. Yes.

A. So could you ask me that question again?

Q. Absolutely. Do you have any reason to believe that a patient is more likely to see a complex family planning fellowship trained physician at a hospital than at an outpatient abortion clinic?

A. I don't know the percentage of those individuals that go into academic positions. I know Dr. Boraas does a lot of her procedures in the hospital. But I don't know the statistics for what their -- where their graduates go.

Q. Thank you.

MS. PAI-THOMPSON: And I have no further questions at this time.

BY MR. BOYLE:

Q. Doctor, good afternoon. My name is Ellis Boyle and I represent the defendant intervenor legislative leaders and I would just like to ask a few questions. Could you please tell us if you have any concerns with the Desai conclusions from that study?

A. So we never got to kind of what my concerns were, but I think from a methodological standpoint they have very different ways that they are getting to their data, and the fact that one is a survey that's likely anonymous versus a telephone call. We know that individuals are more honest and feel free to give their opinions when they're doing an anonymous survey or a survey that no one -- they don't have to attach their name to it, versus I pick up the phone and I say hey, why don't you do medication abortions was the table -- was it medication abortions for that particular study? And so I -- I have a problem with that. And then, you know, I do think that there are multiple reasons why ob-gyn physicians do not choose to do abortions, but I think we have to be careful that just -- while a third of them stated specifically I have moral or ethical objections, the fact that they have chosen a practice which they knew didn't do them, then that's also an

indirect reason that -- they knew they weren't going to be able to do them, so that also goes towards those numbers. And so I think we just have to weed out and cipher out that study better, which we didn't really go into.

Q. And not to be too broad, but there were some other studies that you were asked about in the textbook. Was there anything that you wanted to followup and say -- that you would like to have the opportunity to say now about what you were asked about for the previous three hours?

MS. PAI-THOMPSON: Objection to form.

THE WITNESS: Not that comes -- I can think of right now.

MR. BOYLE: Okay. I don't have any further questions. Thank you.

MS. PAI-THOMPSON: I have no further questions either. Thank you.

MR. BOYLE: Anyone else?

MR. BULLERI: I do not have any questions. Thank you.

- - -

(Witness excused.)

- - -

(Deposition concluded 5:11 p.m.)

- - -

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

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:_____

E R R A T A S H E E T

PAGE LINE CORRECTION

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I, _____, after having read the foregoing transcript of my deposition, wish to make the above corrections.

SIGNATURE_____

DATE_____

T

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:

2 4

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 Date: _2/26/2024_

ND:4875-5970-8073, v. 1

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.

PREPARED BY: Susan A. Hurrey, RPR
Discovery Court Reporters
and Legal Videographers, LLC
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ALSO PRESENT:

Sarah Corning
Megan Fernandez
Tamika Henderson
Vanisha Kudumuri
Ronelle Tshiela

I N D E X

E X A M I N A T I O N S

E X H I B I T S

MONIQUE CHIREAU WUBBENHORST, M.D., M.P.H.,
after having been first duly sworn, was examined and testified as follows:
BY MR. MENDIAS:
Q. Good afternoon, Doctor. You and I met at your last deposition in this case in August. My name is Ryan Mendias. I'm an attorney with the ACLU. I represent Dr. Beverly Gray, one of the plaintiffs in this case. So I just want to ask a few ground rule questions before we begin. You understand that you're currently under oath and you have a legal obligation to answer all questions truthfully, is that right?
A. Yes.
Q. And I'll ask that you wait until I finish a question before you begin answering. And I'll just ask because we're on Zoom, this part is especially important so that we can agree -- so I'm going to ask that you agree that we both -- or I'll make an effort as well, to ensure that the other person is finished speaking before answering a question or asking one. Does that sound all right?
A. Yes.
Q. Okay. If you don't understand a question, you should feel free to ask me to clarify and I'll do so. And if you do answer a question without asking for a clarification, I will assume that you understood it.
Does that make sense?

A. Yes.

Q. And so you should answer all questions verbally instead of shaking or nodding your head or saying uh-huh or uh-uh. Do you understand?

A. Yes.

Q. And during this deposition your attorney may object, and his objections are just for the record. So unless he tells you not to answer a question, you still go ahead and provide an answer after he has made his objection.

MR. BOYLE: Objection. You can answer.

THE WITNESS: I'm sorry, what did you say?

MR. BOYLE: You can answer.

THE WITNESS: Okay.

BY MR. MENDIAS:

Q. Do you understand?

MR. BOYLE: Objection. You can answer.

THE WITNESS: Yes.

BY MR. MENDIAS:

Q. If you need a break, just let me know. We can take a break as long as there's not a pending question.

A. Yes.

Q. Great. Is there anything that would prevent you from giving a full and accurate testimony here today? Any medications or illnesses or anything like that?

A. No.

Q. Where are you testifying from today?

A. I'm testifying from Raleigh, North Carolina.

Q. And where specifically in Raleigh, North Carolina?

A. I'm testifying from the offices of Smith and Ward.

Q. And what form of technology are you using to participate in this deposition?

A. I don't know the answer to that, sir. Can you be more clear?

Q. Are you using an iPad, a laptop?

A. I'm using the -- it's a screen which is projecting the image of the stenographer, yourself and myself and Attorney Boyle.

Q. Okay. Is Attorney Boyle the only other person in the room with you right now?

A. Yes.

Q. Did you bring any materials into the room?

A. Yes.

Q. What did you bring?

A. A copy of my expert -- my expert report.

Q. Do you have any electronic documents that you brought in any form?

A. No.

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

A. No. Well, it's in my pocketbook which is behind me, because I had to get my driver's license for the stenographer.

Q. Understood. Do you agree to refrain from communicating with anyone while we're on the record during this deposition, other than the communications that will be transcribed by the stenographer?

MR. BOYLE: Objection. You can answer.

THE WITNESS: Yes.

BY MR. MENDIAS:

Q. So back in August of 2023 --

A. Can you just excuse me for a moment. My cell phone is in the room and it's beeping, so I'm going to turn it off. Is that okay?

Q. Sure.

A. I'm ready.

Q. In August of 2023 you were deposed as part of this case. Do you remember that?

A. Yes.

Q. Do you remember that after the deposition a transcript of the deposition was produced, right?

A. Yes.

Q. You read and signed that transcript?

A. I read it. I don't remember whether I signed it.

Q. Did you suggest any corrections to the transcript after you had read it?

A. I don't remember whether I did.

Q. Since August of 2023 have you been deposed in any

other lawsuit?

A. No, I have not.

Q. Have you prepared any new declarations or expert reports since August of 2023?

MR. BOYLE: Object to form. And I'll instruct you to the extent that you have prepared any written information in this case or any other case that has not been produced in discovery in that case, I will instruct you not to respond to that. But if there's anything other than what I just described, you can respond.

THE WITNESS: Anything that was not produced in discovery?

MR. BOYLE: My instruction is that if you created any written documents in this case or in another case that have not been produced to opposing counsel, such as internally for whichever lawyer has hired you, you should not describe that. But if you created something that's been produced to the other side, like this report, you can describe that. That's my instruction.

THE WITNESS: So since August of 2023 I have produced expert reports for Indiana, State of Indiana and Kansas.

BY MR. MENDIAS:

Q. Have you have participated in any depositions since 2023 in any of those cases?

A. No.

Q. Have you testified at trial since August of 2023 in any capacity?

A. No.

Q. Since August of 2023 have you appeared before any legislative body?

A. No.

Q. So I am going to drop into the chat for, I guess, the stenographer's benefit, but the first exhibit which I'll continue the numbering from earlier this week, which is Exhibit-13, is your expert report submitted in this case. But you have brought that with you, is that correct, Doctor?

A. Yes.

MR. BOYLE: Could you clarify? You're talking about the one from December 12, 2023, is that correct?

MR. MENDIAS: Correct.

- - -

(Document marked as Exhibit-13 for identification.)

- - -

BY MR. MENDIAS:

Q. Doctor, the report you have with you is from December 2023, is that right?

A. Yes.

Q. Okay. And I will share my screen just to show you

briefly the document that I have up, and if it looks to be the same document can you please indicate that?

MR. BOYLE: Could you just show us the last page, please?

BY MR. MENDIAS:

Q. Does this appear to be a digital copy of what you have before you?

A. It's a digital copy, but I can't verify its authenticity without reviewing the entire document.

Q. Do you have any reason to believe, based on the few pages that you have seen, including your signature, that this is not your document?

A. I'm just saying that I can't verify its authenticity without reviewing it.

Q. But there's nothing that you have seen that would suggest that it isn't an authentic copy? I know that you can't verify it, but is there anything that makes you think that there is not an authentic copy?

A. Other than the fact that I can't review it again, I can't say whether it's authentic or not.

Q. Understood. Doctor, could you please describe the process of drafting your report?

A. Yes. I drafted my report by reviewing medical literature and by reviewing the expert reports of the plaintiff's experts.

Q. Did anybody suggest that you cite a particular study or statistic in your report?

MR. BOYLE: Objection. And I'm going to instruct you not to answer to the extent that your answer would reveal anything about conversations between lawyers who hired you to be an expert witness in this case and yourself. Do not divulge any specific contents of any conversations that were -- that occurred.

THE WITNESS: No.

BY MR. MENDIAS:

Q. No one provided you any fact or data to be included in your report?

A. No.

Q. Did anyone provide you with any written materials to review in preparing your report?

MR. BOYLE: Objection. To the extent that this would encompass something other than just a factual matter in relation to a conversation between lawyers and you or the lawyers who hired you for this case and yourself, I instruct you not to answer. If you can answer otherwise, feel free.

THE WITNESS: I was given copies of the expert reports from the plaintiff's experts.

BY MR. MENDIAS:

Q. But nothing else?

MR. BOYLE: Objection. Same instruction. You

can answer.

THE WITNESS: No.

BY MR. MENDIAS:

Q. Did anyone besides you draft any portion of this report?

MR. BOYLE: Objection. I'm going to instruct you not to answer that because any drafts are privileged material under the federal rules. So do not answer that.

BY MR. MENDIAS:

Q. Were you responsible for composing the entire document?

MR. BOYLE: Objection. Same instruction.

BY MR. MENDIAS:

Q. Did you draft the citations to the sources in your expert report?

MR. BOYLE: Objection. Same instruction.

BY MR. MENDIAS:

Q. Did you read all of the sources cited in your expert report, Doctor?

A. Yes.

Q. How did you prepare for this deposition?

MR. BOYLE: I'll instruct you not to reveal any conversation that you had with any attorney that hired you to be an expert in this case, otherwise you may respond.

THE WITNESS: Can you repeat the question?

BY MR. MENDIAS:

Q. Please describe the process of preparing for this deposition.

MR. BOYLE: Same objection. Same instruction. You can answer.

THE WITNESS: I reviewed my deposition and the papers that I cited in the deposition, as well as the expert reports that the experts -- plaintiff's experts submitted.

BY MR. MENDIAS:

Q. Are you being compensated for the time that you spent preparing for this deposition?

A. Yes.

Q. The rate at which you're compensated is $700 per hour, correct?

A. Yes.

Q. About how many hours have you spent so far preparing for this deposition?

A. More than five.

Q. Without divulging any communications between you and your attorneys, who did you speak to in order to prepare for this deposition?

A. I spoke with Attorney Boyle.

Q. Did you speak with anyone other than Attorney Boyle in preparing for this deposition?

A. No.

Q. Have you attended any training sessions on how to serve as an expert witness hosted by professional organizations?

A. Yes.

Q. Which organization?

A. American Association of Pro-Life Ob-Gyns.

Q. What sort of information was conveyed at that training session?

A. What was conveyed at the training session was the information and training on how to write an expert report and how to -- how to participate in a deposition and participate in a trial.

Q. How many such trainings have you attended?

A. Two.

Q. When did you attend them?

A. The first training I attended was in either 2021 or 2022. The second training I attended was this past weekend.

Q. Did those trainings provide you with any written materials?

A. No.

Q. About how many hours were each of those trainings?

A. I would estimate that the training was approximately seven hours with breaks, but I don't have an exact time in front of me.

Q. Understood. If you recall, who were the individuals

who lead these trainings?

A. They were members of APPLOG and attorneys. I don't remember all of their names.

Q. Can you state the names of the individuals you do remember?

A. I think one attorney's name was Mark Rienzi and another's name was Theresa Collette. But I don't remember the names of the other attorneys.

Q. Understood. All right. So, Doctor, can you please turn to paragraph 87 of your report, which I believe is on the bottom of page 31. And please let me know once you're there.

A. I'm at paragraph 87.

Q. And in paragraph 87 of your report, you say that Dr. Farus, quote, cites Kerns et al. regarding increased risk for D&E performed for miscarriage versus abortion, end quote, is that correct?

A. Yes.

Q. The next paragraph of your report, paragraph 88 on the top of page 32, you say in this study, major complications occurred in two percent of patients, with no difference between patients undergoing D&E for abortion versus D&E for miscarriage, is that correct?

A. Yes.

Q. And the citation for this study is in footnote 82 of your report on the bottom of page 32, which is Jennifer L.

Kerns, et al., Society of Family Planning Clinical Recommendation: Management of Hemorrhage at the Time of Abortion, Contraception, 2023, is that correct?

A. Yes.

Q. And then you provide a quotation from that study in the middle of paragraph 88 which says for most cases, we did not have documentation of the time since fetal death, limiting any analysis of complication incidence by duration of fetal retention after fetal death, is that right?

A. Yes.

MR. MENDIAS: So I'm going to introduce this as Exhibit-14. I will drop that into the chat.

- - -

(Document marked as Exhibit-14 for identification.)

- - -

BY MR. MENDIAS:

Q. I will share this on my screen. Doctor, this is the citation you provided for the statement about the comparison between D&E for abortion and D&E for miscarriage, correct?

A. I would have to read through it to confirm that.

Q. Can you look at the title of the article that you gave in footnote 82?

A. Yes.

Q. Can you read it, please?

A. Society of Family Planning Clinical Recommendation: Management of hemorrhage at the time of abortion.

Q. And can you read the title of the article that is on the screen right now?

A. Society of Family Planning Clinical Recommendation: Management of hemorrhage at the time of abortion.

Q. Can you please direct me to what part of the article that quotation is from?

A. I don't have the paper in front of me so I can't really direct you to where the quotation is.

Q. Can you provide citation for the quotation, including a page number?

MR. BOYLE: Could I ask that you please make that larger on the screen? It's a little too small for us to read at this point.

BY MR. MENDIAS:

Q. Is there a specific page I should turn to, Doctor, in order for you to identify where the quotation is?

A. I think if you scroll down I can take a look.

Q. Sure.

A. Can you keep scrolling?

Q. (Complies.)

A. Can you keep scrolling?

Q. Yes.

A. Can you keep scrolling?

Q. (Complies.)

A. Okay. Can you go to the next page, please?

Q. Sure.

MR. BOYLE: Could you enlarge it, please? That's too small to read. Thank you.

THE WITNESS: Can you go up one page, please?

MR. MENDIAS: (Complies.)

THE WITNESS: Can you scroll down, please?

MR. MENDIAS: The next page or further down on this page?

THE WITNESS: Further down on this page.

MR. MENDIAS: (Complies.)

THE WITNESS: Can you keep scrolling down, please?

MR. MENDIAS: Sure. This is the next page.

MR. BOYLE: Could I ask, is it possible to search for terms in this document, like the term fetal death, perhaps?

MR. MENDIAS: Sure. So there's one appearance of fetal death in a footnote, one additional appearance of the term fetal death in another footnote. Third and then a footnote. A fourth in a footnote and that seems to be it.

BY MR. MENDIAS:

Q. Doctor, is it possible that you mis-cited this article?

A. It's possible. I would have to look at my citations list with references.

Q. Doctor, you agree that the article you cited in footnote 82 for this quotation is in fact the article here, correct?

A. Yes.

Q. And that the quotation does not appear in this article, correct?

A. Yes.

Q. So this citation is incorrect?

A. Yes.

Q. All right. So let's discuss this article that you inadvertently cited. Can you please read the highlighted portion of this article?

A. I can't really discuss this article because I have not -- I don't remember reading it. So if you would like me to -- allow me an hour and a half or so to take this article and read it, I could do that. But I can't just review an article and make a comment about it without going -- doing a comprehensive review of it.

Q. So if I understand you correctly, you were amending your earlier testimony that you have read this citation?

A. I don't remember whether I have read this one or not. I would have to go back and check my list.

Q. Okay. Can you please read the highlighted portion?

A. Abortion in the United States is a very safe procedure, with minor complications occurring in an estimated eight per 1,000 abortions, major complications occurring in 0.7 per 1,000 abortions, and mortality occurring in 0.7 per 100,000 legal abortions per year.

Q. Thank you.

A. I do want to add that I don't agree with that statement and I would have to review the reference from which it is drawn in order to comment on it.

Q. Understood. Can you please read this highlighted sentence?

A. Again, I'm not comfortable reading this because I have not read this paper and I can't put this statement in context. I don't want to have anything that I read to be taken out of context.

Q. I understand. I'm asking you to read what was in this article that you inadvertently cited. I'm not asking you to comment on it.

A. The fact that I inadvertently cited it means that I'm not comfortable commenting on this article or reading from it as though it is somehow authoritative. I'm not comfortable doing that.

MR. BOYLE: If he's asking you to read that, you have should read it. Okay?

THE WITNESS: Okay. Similarly, most

second-trimester procedural abortions can be safely completed in the outpatient setting, a practice that is reflected in a survey of second-trimester abortion providers where a minority reported providing services in a hospital-based site.

BY MR. MENDIAS:

Q. Thank you. Can you please read this highlighted portion?

A. While most patients in the moderate risk category can receive care in an outpatient setting, we encourage clinicians to use their clinical judgment in deciding whom to refer. Delays in care result in procedures occurring later in pregnancy, which places patients at higher risk for complications. This increased risk may outweigh the need to refer.

Q. Doctor, you understand that under the hospitalization requirement from the law challenged in this case, a clinician would not be able to exercise their clinical judgement about where a patient in their second trimester should receive an abortion, correct?

A. Yes.

Q. And under the Act, a second trimester abortion patient would have to be referred to a hospital for the abortion, even if that would cause significant delay, is that correct?

MR. BOYLE: Objection to form.

THE WITNESS: I don't understand your question.

It's two questions there. Can you please simplify your question?

BY MR. MENDIAS:

Q. If obtaining an abortion in the second trimester would delay a patient's obtaining of that abortion, the law requires it nonetheless, correct?

MR. BOYLE: Object to form.

THE WITNESS: I don't understand the question. How does obtaining an abortion -- what does that have to do with delay? The hospitalization requirement doesn't cause delays in and of itself. It simply specifies that when a patient chooses to undergo abortion, that it has to happen in a hospital.

BY MR. MENDIAS:

Q. Is it your understanding that a patient can obtain an abortion at a hospital with as little delay as they could in obtaining abortion at an outpatient clinic?

MR. BOYLE: Object to form.

THE WITNESS: I haven't seen any data to suggest otherwise, number one. And number two, one of the plaintiffs, Beverly Gray for example, performs abortions in a hospital.

BY MR. MENDIAS:

Q. If obtaining -- so assume that obtaining an abortion as a hospital would cause delay.

A. I can't assume that because I don't know that as a fact.

Q. I'm asking you to suppose this for the point of a hypothetical. So if a hospital -- if obtaining an abortion in a hospital takes longer than obtaining it in an outpatient setting, you would agree that the law does not -- or the law -- I'll rephrase the question.

If obtaining an abortion in a hospital takes longer than obtaining an abortion in an outpatient setting, there is no exception to the law based on the fact that it would be faster to obtain an abortion in an outpatient clinic, correct?

MR. BOYLE: Object to form.

THE WITNESS: Counselor, I am here based on my expertise as a clinician and researcher. You are asking me about a hypothetical situation and I can't comment on that.

BY MR. MENDIAS:

Q. You would agree that the risk of an abortion grows with increasing gestational age?

A. Yes.

Q. I'm going to drop another document into the chat that I'll ask be marked as Exhibit-15.

- - -

(Document marked as Exhibit-15 for identification.)

- - -

BY MR. MENDIAS:

Q. Doctor, is it possible that this is the article you intended to cite?

A. Can you --

MR. BOYLE: Object to form.

THE WITNESS: Can you do -- search this for the term fetal death?

MR. MENDIAS: Sure.

THE WITNESS: I'm sorry, can you blow it up a little bit more?

BY MR. MENDIAS:

Q. Sure thing. I'm just trying to find more words from that quotation so that I can see if it's in here.

(Pause.)

Q. Doctor, this is the quotation you provided in your expert report in paragraph 88, correct?

A. Yes.

Q. All right. So this is the study that you intended to cite?

A. Yes.

Q. I'd like to talk about a couple of things related to this study. Are you familiar, in the context of medical research, with a term unadjusted analysis, Doctor?

A. Yes.

Q. What does that mean?

A. Usually unadjusted analysis is referring to an analysis that is carried out where logistic regression was not performed to adjust for confounders.

Q. And are you familiar with the term adjusted analysis?

A. Yes.

Q. And what is that term?

A. It means that the analysis was adjusted for known confounders. And I might add also characteristics of the study population or the intervention.

Q. Understood. So, Doctor, in paragraph 88 of your report, you claim that the study -- that in the study rates of major hemorrhage, retained products of conception, and cervical laceration did not differ between the two groups, is that correct?

A. Yes.

Q. Doctor, can you please read the highlighted portion of this article?

A. Finally, in our adjusted analysis of any abortion complication, we found significant associations with the following covariants.

Q. Okay. Can you continue to read?

A. Sure.

(Reporter interrupted for clarification.)

Q. Doctor, I'll just ask, can you please reread the highlighted portion and include the words in the highlighted

portion after the colon?

A. After the colon?

Q. Yes. I believe you omitted the last two words of the highlighted sentence. So can you please just read it again?

A. Finally, in our adjusted analysis of any abortion complication, we found significant associations with the following covariates: Fetal death, odds ratio 3.0, 95 percent confidence interval 1.6 to 5.9, P equals 0.001, prior vaginal delivery, odds ratio 1.5, 95 percent confidence interval 1.2 to 1.9, P less than .001, prior cesarean delivery, odds ratio 1.8, 95 percent confidence interval 1.4 to 2.3, P less than .001, and each additional week of gestation, odds ratio 1.4, 95 percent confidence interval 1.3 to 1.4, P less than 0.001.

Q. Thank you. Do you understand this to mean that when adjusting for confounding factors, the authors of this study found that fetal death was associated significantly with any complication of a D&E?

MR. BOYLE: Object to form.

THE WITNESS: No, I don't understand that to be the case.

BY MR. MENDIAS:

Q. What do you understand the significant association between fetal death and any abortion complication to be?

MR. BOYLE: Object to form.

THE WITNESS: The study states in the column --

the first column on the page that we only conducted an unadjusted analysis for the association between fetal death and DIC, and that the number of cases of DIC was too low to permit adjustment. So they didn't -- they didn't include all complications. They did not include DIC.

BY MR. MENDIAS:

Q. So when they say any abortion complication, you understand that to mean any complication except DIC?

MR. BOYLE: Objection.

THE WITNESS: Can you show me where they say any abortion complication?

BY MR. MENDIAS:

Q. Do you see the highlighted phrase there?

A. Yes. But they did not include DIC.

Q. So you would understand that they did find a significant association between fetal death and any abortion complication other than DIC?

A. Yes. I do want to point out, as I say in my deposition, that the authors acknowledge that the results may be confounded by the lack of data on the length of time the fetus was dead. The longer the fetus has been deceased, the more likely it is that a woman will develop coagulation abnormalities. And they go on to say in their conclusion -- in the discussion rather, that for most cases we did not have documentation of the time since fetal death, limiting any

analysis of complication incidence by duration of fetal retention after fetal death. In other words, their analysis with limited by the fact that they could not say in the study how long the fetus had been retained after fetal death and this has an impact on complications.

Q. Thank you, Doctor. Can you please read the highlighted portion of this study?

A. After adjusting for all covariates, hemorrhage was significantly associated with fetal death. If I can finish. But again, they state, and I'll repeat this, that for most cases we did not have documentation of the time since fetal death, limiting any analysis of complication incidence. And that refers to all complications.

Q. Paragraph 88 of your report on that point you say, without knowing the length of time a fetus has been dead, there is uncertainty about the conclusion that rates of DIC were higher in women undergoing D&E for miscarriage versus abortion, is that right?

A. Yes.

Q. When you refer to uncertainty about the conclusion, are you suggesting that there is uncertainty as to whether the study found among the women in the study that rates of DIC were higher in miscarriage patients than abortion patients?

A. I'm going back to what the authors themselves said, which is their ability to analyze complication incidence was

limited because they could not assess how long a fetus had been dead. I'm just quoting what they said.

Q. The authors do say that setting aside the length of time of fetal demise, miscarriage patients have higher rates of DIC though, don't they?

A. Can you show me that in the paper, please?

Q. Can you read the highlighted portion?

A. They say that fetal death was significantly associated with increased odds of DIC. But again, because they did not know how long the fetus had been dead, it's impossible to say -- their ability to analyze that particular complication is limited. They also noted further down in that same column that the number of cases of DIC was too low to permit adjustment.

Q. Doctor, you would agree that the population of women obtaining a D&E for miscarriage all have demised fetuses, correct?

A. Can you repeat the question, please?

Q. Would you agree that among women obtaining a D&E for miscarriage, all of them have demised fetuses?

A. Yes.

Q. And you would agree that among those women obtaining D&E for miscarriage, the amount of time that the fetus had been dead is not the same among every woman, correct?

A. Yes.

Q. And some of those women will have had demised fetuses

longer than others, correct?

A. Yes.

Q. You would agree that the population of women obtaining D&E for induced abortion do not have demised fetuses, correct?

A. Yes.

Q. Doctor, can you please look at paragraph 89 of your report?

A. Yes, I have it.

Q. You refer to a study by Trinder, et al., right?

A. Yes.

Q. That study involved patients who received medical management for first trimester miscarriage, right?

A. Yes.

Q. And it doesn't describe anything about the safety of miscarriage in the second trimester, is that right?

A. Yes.

Q. And then in paragraph 90, you refer to a prospective cohort study and the citation you provide is to Jensen, et al., is that right?

A. Yes.

Q. And this study involved patients who received abortions in the first trimester, is that right?

A. Yes.

Q. And it doesn't comment on the outcomes for second trimester abortion patients, right?

A. Yes.

Q. So you're aware that the law at issue in this case permits abortions in the first trimester be performed in an outpatient setting? Are you?

MR. BOYLE: Object to form.

THE WITNESS: Can you repeat the question because it sounded like you slurred for a moment? Can you repeat the question?

MR. BOYLE: Yes. Absolutely.

BY MR. MENDIAS:

Q. You're aware that the law at issue in this case permits abortions in the first trimester to be performed in outpatient clinics?

MR. BOYLE: Objection. You can answer.

THE WITNESS: Yes.

BY MR. MENDIAS:

Q. And you're aware of the law at issue in this case requires abortions be performed in a hospital only after 12 weeks of pregnancy, right?

A. Yes.

Q. All right. Doctor, can you please look at paragraph 91 and 92 of your report?

A. Yes.

Q. And in those paragraphs, you're comparing the mortality rate of miscarriage to the mortality rates of induced

abortion, is that right?

A. Yes.

Q. In paragraph 93 you say rates of death from miscarriage are lower than from induced abortion, is that correct?

A. Yes.

Q. So going back to paragraph 91. You say that Berman, et al., 1985, found that the miscarriage rate -- apologies. Berman, et al., 1985 found that the miscarriage mortality ratio, deaths per one million miscarriages, increased up to 16 to 19 weeks and then declined. Did I read that correctly?

A. Yes.

Q. So in this context, the mortality ratio indicates how many women died from miscarriage out of every one million miscarriages, is that right?

A. Yes.

Q. And the chart at the top of page 34 of your report, table one. You say the Berman, et al. reported that between 12 and 15 weeks, the mortality rate was five deaths per million miscarriages, is that right?

A. Yes.

Q. And between 16 and 19 weeks, the mortality rate was also five deaths per million miscarriages?

A. Yes.

Q. Between 20 and 24 weeks, the mortality rate was 2.2

deaths per million miscarriages?

A. Yes.

MR. MENDIAS: I'd like to mark as Exhibit-16 the study that I'm now putting into the chat.

- - -

(Document marked as Exhibit-16 for identification.)

- - -

BY MR. MENDIAS:

Q. Doctor, does this appear to be the Berman, et al. 1985 study that you cite and that you use for the source of data in your chart?

A. Yes.

Q. I'm going to scroll to the page on which the data that I believe you drew from is. Is this the chart that provided the data that you used in your expert report?

A. I would have to go back and look to be sure.

Q. What makes you unsure that this is the source of that data?

A. Because I have not looked at this paper in a bit, and I'm not sure whether this was the chart that I was looking at.

Q. All right. So you were reporting what Berman said the deaths per one million spontaneous abortions were, correct?

A. Yes.

Q. And so you see here there's a dagger, and if we read

the dagger it says deaths per million spontaneous abortions. That is the same rate that you were reporting in your chart, correct?

MR. BOYLE: Objection.

THE WITNESS: I would have to go back and look at this paper. I'm sorry, I can't do this on the fly because I may have -- yeah.

BY MR. MENDIAS:

Q. All right. Sorry. I didn't mean to cut you off. Please continue.

A. No, I would have to go back and look at this paper.

Q. I understand. But my question is whether you are reporting deaths per one million miscarriages.

A. I would have to go back and look at this paper. I can't say just looking at it on the screen.

Q. Well, I'm asking you a different question. So you see here you cite in your report Berman, et al. 1985, correct?

A. Yes.

Q. And the specific figure you give is mortality ratio deaths per one million miscarriages, correct?

A. Yes.

Q. And this figure here, these ratios in Berman, et al. 1985 are deaths per million spontaneous abortions, correct?

A. As I said, I'd have to go back and look at the paper and understand how I derive those newspapers.

Q. My question is simpler. It's, does this say deaths per million spontaneous abortions?

A. That's what the paper says. But I'm not saying that that is where I derive the numbers that I represented there.

Q. Okay. So let's just look at Berman et al. 1985's chart. Do you see between 12 and 15 weeks? You see that here?

A. Yes.

Q. Berman, et al. reported 50 deaths per million spontaneous abortions, correct?

A. Again, I would need to go back -- because your question relates to where I derive the data in the chart, and I would have to go back and review where I made that calculation.

Q. My question right now is just about what this study says. And does this study report that between 12 and 15 weeks the mortality ratio is 50 deaths per million spontaneous abortions?

MR. BOYLE: Objection.

THE WITNESS: I need to look at this paper again because it is combining -- looking at both percent numbers by weeks of gestation and not IUD-associated deaths. So I would need to go back and look at this to understand exactly what they were saying.

BY MR. MENDIAS:

Q. So you don't believe that this ratio of 50 point zero deaths per million spontaneous abortions is clear from this

table?

MR. BOYLE: Objection.

THE WITNESS: It's not anything to do with what I believe. It has to do with me looking at the paper again to understand how I derived those specific numbers, and I need to have the paper in front of me to look at that.

BY MR. MENDIAS:

Q. I understand that that's how you feel about the deriving of this data for your report, but I'm asking specifically about the table that you see on the screen before you. Does this table report between 16 and 19 weeks that the mortality ratio is 50 point zero per one million spontaneous abortions?

MR. BOYLE: Objection.

THE WITNESS: I'm looking at this and it's saying deaths per million spontaneous abortions. So, yes.

BY MR. MENDIAS:

Q. Okay. And for 12 to 15 weeks it's 50 point zero spontaneous -- or 50 point zero deaths per million spontaneous abortions, correct?

A. That is correct.

MR. BOYLE: Objection.

BY MR. MENDIAS:

Q. And between 16 and 19 weeks it's 50 deaths per million spontaneous abortions, correct?

MR. BOYLE: Objection. You can answer.

THE WITNESS: Yes.

BY MR. MENDIAS:

Q. And between 20 and 24 weeks it reports 22.2 deaths per million spontaneous abortions, correct?

MR. BOYLE: Objection. You can answer.

THE WITNESS: Yes.

BY MR. MENDIAS:

Q. So, Doctor, in this column of your chart, mortality ratio deaths per one million miscarriages that you attribute to Berman, et al. 1985, you only reported five deaths per million miscarriages for 12 to 15 weeks, isn't that right?

A. Yes.

Q. And that's one-tenth of what Berman, et al. reported, isn't it?

MR. BOYLE: Objection. You can answer.

THE WITNESS: Okay. As I said earlier, I have to go back to the paper and understand how I derive those numbers.

BY MR. MENDIAS:

Q. Is it possible that you made a mistake?

A. Yes, it's possible.

Q. Do you think it's likely that you made a mistake?

A. It's possible that I made a mistake.

Q. My question is, is it likely that you made a mistake

reporting the mortality ratio for induced abortions as reported in Berman, et al., 1985?

A. I can't say without reviewing the paper again.

Q. But you would agree that these numbers in your report are one-tenth of the numbers reported in Berman for the same gestational weeks, correct?

MR. BOYLE: Objection. Objection. You can answer.

THE WITNESS: As I said before, I would need to go back and read the paper and understand how I derived. It's possible that I made a mistake. But I will not agree that it's likely.

BY MR. MENDIAS:

Q. Do you have any other ideas about how you arrived at these figures that you reported as the mortality ratio of deaths per one million miscarriages from Berman, et al.?

A. I don't. But I'm happy to review it and get back to you.

Q. I would like to look now at this study that you cite by Saraiya, et al. I believe this would be Exhibit-17 and I'll drop that in the chat right now.

- - -

(Document marked as Exhibit-17 for identification.)

- - -

BY MR. MENDIAS:

Q. Doctor, do you believe that this is the study that you cited as Saraiya, et al.?

A. Yes.

Q. And in your chart, page 34 of your expert report, you say that between 16 and 19 weeks of gestation the mortality ratio deaths per 100,000 miscarriages was 4.1, correct?

A. Yes.

Q. And does this appear to be in Saraiya, et al. where you derived that data from?

A. Yes. But again, I would have to have the paper to really see if that's the case.

Q. Okay. So in paragraph 92 of your report, you cite Bartlett, et al. for a proposition that the risk of a woman dying from abortion increased 38 percent for each week of gestational age, is that right?

A. Yes.

MR. MENDIAS: I'm going to go ask that Bartlett, et al. be marked as Exhibit-18 and I'm putting it in the chat right now.

- - -

(Document marked as Exhibit-18 for identification.)

- - -

BY MR. MENDIAS:

Q. Doctor, does this appear to be the study that you have cited?

A. Yes.

Q. Okay. Table two, can you see that, Doctor?

A. Yes.

Q. And this is the legal induced abortion-related deaths, mortality rates, and relative risks, by Selected Characteristics between 1988 and 1997, correct?

A. Yes.

Q. And so Bartlett reports the mortality rate from abortion between 16 and 20 weeks as 3.4 deaths per 100,000 legal induced abortions, is that right?

A. Yes.

Q. And that's lower than the mortality rate Saraiya reported for spontaneous abortions per 100,000 -- I'm sorry. This figure, 3.4 deaths per 100,000 legal abortions, is lower than the rate that Saraiya reported for deaths per 100,000 spontaneous abortions between 16 and 19 weeks, correct?

MR. BOYLE: Object to form. You can answer.

THE WITNESS: I think that you're simplifying a very complicated concept and I'm going to go back to something that I said in my deposition, which is that the rates of deaths -- in paragraph 93, I said the rates of deaths from miscarriage are lower than they are from induced abortion, and likely to be markedly lower. And then I go on to say why that is the case.

I did not intend to have a direct comparison of the numbers. The point that I was making here was that the risk of death increases exponentially by 38 percent for every week of gestation. And based on the data that's presented by Saraiya that is not the case. So that's the point I was trying to make.

BY MR. MENDIAS:

Q. But you agree, Doctor, that 3.4 is a smaller number than 4.1, correct?

A. I don't think that that's relevant to what I'm trying -- the point that I was trying to make. And as I said, I want to reiterate the fact that the rates of death per miscarriage that are outlined in the Saraiya study are likely to be much lower. First because most miscarriages are not documented and so the denominators of total estimated miscarriages are likely to be lower than the true number. And then the second is that the number of miscarriages are complete. The demised fetus passes in its entirety and so women don't undergo any medical interventions. Women undergoing abortion are always subject to both procedural risk and anesthetic risk. So that is why I was not making a direct comparison here, because these studies are comparable. The analysis of mortality rate for miscarriages is probably an underestimate for the reasons that I just cited. And the risks that are associated with abortion are higher because of the procedural and anesthetic risks. But I was not

making comparison between the two studies because they are not comparable.

Q. Doctor, I didn't ask you what you thought was relevant. I'm asking you a very straightforward question. 3.4 is smaller than 4.1, correct?

A. And I'm going to respond to you the same way. That you cannot compare this number 3.4 to the 4.1 in the miscarriage study. They're not --

Q. Again, the question is 3.4 is smaller than 4.1? Can you answer that question, Doctor?

A. Yes.

Q. Thank you. So on the points you just raised about miscarriages, you understand that the issue in this case is whether abortion in the second trimester should be required to be performed in a hospital setting, correct?

A. Yes.

Q. And miscarriage in the second trimester would not be an early pregnancy loss, would it?

A. Can you rephrase the question? What do you mean by an early pregnancy loss? Can you define what you mean by an early pregnancy loss, please?

Q. Sure. You see how in paragraph 94 you say many miscarriages are never documented as they occur very early in pregnancy, correct?

A. Yes.

Q. Do you think that a miscarriage in the second trimester is one that occurred very early in pregnancy?

A. No. By definition a miscarriage in the second trimester is not the same. The point that I'm making in paragraph 94 is that because many miscarriages occur early in pregnancy, the denominator of cases for the Saraiya study is probably larger and therefore the estimated mortality that they're describing is probably lower. That's the point I was trying to make. I was not trying to say anything other than that.

Q. Do you believe that miscarriages that occur in the second trimester frequently go unreported?

A. No, I don't believe that they go -- I mean, unreported to who and how?

Q. Well, you say in paragraph 94, many miscarriages are never documented. Do you believe that second trimester miscarriages are frequently not documented?

A. They may not be.

Q. What is the basis for that belief?

A. That if a patient underwent a second trimester loss and the physician did not report that loss to the relevant public health authorities, it would not be counted.

Q. Have you, as a physician treating a patient with second trimester pregnancy loss, not reported that loss?

MR. BOYLE: Object to form.

THE WITNESS: I typically have not -- I have not reported those losses because those losses occur -- or the treatment of those losses occurs in the hospital. I don't know the mechanism for how hospitals report those to public health authorities. So I can't speak to that question.

BY MR. MENDIAS:

Q. Paragraph 95, you provide a second reason and you say a number of miscarriages are complete, that is the demised fetus passes in his or her entirety, is that right?

A. Yes.

Q. Do you contend that complete miscarriage is common in the second trimester of pregnancy?

A. That's not what I said in the statement.

Q. I'm asking --

A. What I said in the statement is that a number of miscarriages are complete. I did not talk about whether they were complete in the first or the second trimester. Some are complete. Some are incomplete.

Q. Is it common for there to be complete miscarriage in the second trimester of pregnancy?

A. I can't say whether it's common or uncommon. I have seen patients have both. And I'm not aware of any specific data on whether -- on the percentage of them that are complete.

MR. BOYLE: We've been going for about an hour. If you would like to take a break at some point when it's

convenient, please.

MR. MENDIAS: Sure. I have one more question and then we can take maybe a five-minute break.

BY MR. MENDIAS:

Q. Doctor, scrolling up a bit to paragraph 81 of your report.

A. Yes.

Q. You say that Dr. Farris does not provide supporting statistics for her claim that D&E for second trimester miscarriages are routinely performed in inpatient and outpatient settings, is that right?

A. Yes.

Q. Do you have any supporting statistics where D&Es for second trimester miscarriages are performed?

A. I think that I have cited -- some of the papers that I have cited list the number of D&Es -- list that D&Es are done in both the hospital setting -- or done in a hospital setting.

Q. Do they say the relative frequency with which they're done in a hospital setting as opposed to an outpatient setting?

A. I'm sorry, can you rephrase the question? I think I don't quite understand what you're asking me.

Q. So your testimony just now was that they say -- these sources say that D&E for miscarriages occur in both outpatient and inpatient settings. I'm wondering if they say what percentage happen in outpatient settings versus inpatient

settings?

A. No, I haven't seen that data.

Q. All right.

MR. MENDIAS: Okay. I think we can take a six-minute break. We can reconvene at 2:20.

MR. BOYLE: Thanks.

- - -

(A break was taken, 2:13 p.m. - 2:23 p.m.)

- - -

BY MR. MENDIAS:

Q. Doctor, in paragraph 134 of your expert report. Please turn to that.

A. Yes.

Q. So there you say that the term abortionist is used in the biomedical literature, including as a title by which abortionists refer to themselves.

Did I read that correctly?

A. Yes.

Q. So as a part of your claim you have several articles cited in footnote 142, correct?

A. Yes.

Q. The first is by Michaels, M.O., Michaels, F.I. and Otto, S. Inception of Life on the Pendulum of Death: Common Paradigms and Uncommon Narratives on the Polemics between Birthers and Abortionists, is that right?

A. Yes.

Q. None of the authors of that paper are abortion providers, are they?

A. No.

Q. In fact, they oppose abortion, don't they?

MR. BOYLE: Objection.

THE WITNESS: I can't really say whether the authors oppose abortion or not as a matter of fact.

BY MR. MENDIAS:

Q. So --

A. And in fact of -- I'm sorry, if I can go on. I think that the other studies that I cited quotes abortionists themselves as calling themselves happy abortionists.

Q. So we'll discuss that study in a second, but I'm just going to ask that this Michaels study be marked as Exhibit-19.

- - -

(Document marked as Exhibit-19 for identification.)

- - -

BY MR. MENDIAS:

Q. Doctor, this is the study that we were talking about that you cited in that footnote, correct?

A. Yes.

Q. Please read the highlighted sentence.

A. It is only justifiable to reason that the state,

Government, as the defender of the citizenry must establish mechanisms and strategies to defend unborn babies and ensure that only health-related, inevitable complications are grounds for an abortion procedure.

Q. You also in support of your claim in paragraph 134 cite an article by Matthew Lee Anderson, Antiabortionist Action Theory and the Asymmetry between Spontaneous and Induced Abortions, is that right?

A. Yes.

Q. And that article was also not written by an abortion provider, was it?

A. No.

Q. Are you aware that that article does not describe any physician as an abortionist?

A. Yes.

Q. In fact, the article never uses the term abortionist but instead refers to only antiabortionists, is that correct?

A. Yes. The point I am trying to make here is that the question was whether the term abortionist appears in the medical literature, and therefore, according to the fact that it appears in the titles, it does appear in medical literature. That's the point I'm trying to make. I'm not making a point about the content or the political leanings of the authors or what they believe about abortion. I am simply making a point that this term does appear legitimately in the medical

literature.

Q. Do you believe that the article by Michaels, et al. is medical literature?

A. This is -- sociology is part of the sciences related to medicine. We routinely look at sociological literature and the -- for example, the Turnaway study is a sociological study and we routinely look at sociological literature as a part -- as an adjunct to our efforts in medicine. So it's perfectly legitimate to look at the sociology literature as part of the biomed literature.

MR. MENDIAS: I'm going to put the Lee Anderson study in the chat and I'll mark that as Exhibit-20.

- - -

(Document marked as Exhibit-20 for identification.)

- - -

BY MR. MENDIAS:

Q. Doctor, this is the Michael Lee Anderson -- sorry. This is the Matthew Lee Anderson that you cited, correct?

A. Yes.

Q. And can you read this highlighted portion?

A. Antiabortionists' relative unconcern about spontaneous abortions is prima facie evidence that their focus on induced abortions is either inconsistent or hypocritical.

Q. You would agree, as you testified earlier, that this

article does not refer to any physician as an abortionist, correct?

A. I will agree to that, but I will also point out, as I said earlier, that I was looking at the titles of articles simply to point out that this term appears in the medical literature. I am not referring to the content or the authors.

Q. But if the term abortionist doesn't appear in this article, does that not support your point?

MR. BOYLE: Object to form.

THE WITNESS: I don't understand your question, sir.

BY MR. MENDIAS:

Q. The phrase abortionist to describe a physician does not appear in this article, as you testified. So my question is how does this support your claim that it is common in the biomedical literature to refer to physicians who provide abortions as abortionists?

A. I never said that it was common, sir.

Q. All right. Have you mentioned the last study in that footnote by Baird?

A. Yes.

Q. Considering the Place of Doctors in the Practice of Abortion in Australia since the Early 1990s, correct?

A. Yes.

Q. And it was published in a journal called Australia

Feminist Studies, right?

A. Yes.

Q. This article did not discuss the terms used to describe abortion providers in North Carolina, did it?

A. No.

Q. In fact, the article didn't discuss the terms used to describe abortion providers in the United States at all, did it?

A. I'm not sure what your question is, sir. These people -- the abortionists referring to themselves as happy abortionists. They share -- they have in common with abortion practitioners abortionists in the United States and in North Carolina the fact that they provide abortions, so therefore they're in the same discipline.

Q. My question is whether this article described any physician in the United States as an abortionist.

A. No.

Q. And in fact, it does not say anything about whether the term abortionist is used by physicians in the United States to refer to themselves, did it?

A. I'm afraid that I don't -- again, what's the question that you're asking me? Can you repeat it, please?

Q. Yes. Did this article describe any physician in the United States as referring to themselves as an abortionist?

A. No. But that wasn't the point of my including the

article. The question that was -- I was responding to was that the term abortionist refers to the clinical activity of abortion providers, which is correct. I practice as a laborist because I take care of women in labor. Abortionists perform abortions, therefore they are abortionists. And I only mention that it is used in the biomedical literature, including as a title by which abortionists refer to themselves. That's all I said.

Q. Are you aware of any abortion provider in this country who refers to themselves abortionist?

A. I don't see how it would be possible for me to be aware of what all abortionists in the United States refer to themselves as. I don't see how I could have that knowledge.

Q. I didn't ask if you knew whether all abortion providers call themselves abortionists. I'm asking if you're aware of any abortion provider who calls themselves an abortionist?

A. I don't know.

Q. You don't know whether you know or you don't know of any physicians who call themselves abortionists?

A. I don't know if I can remember any.

Q. Do you think you have heard abortion providers call themselves an abortionist?

A. Yes, I may have in the past.

Q. When?

A. I just said I don't remember, sir.

Q. Do you have any details about this recollection?

A. I don't.

Q. So turning to paragraph 203 of your report. Please let me know when you have gone there.

A. Sure.

(Pause.)

A. Yes. I'm at paragraph 203.

Q. In this paragraph you say the diagnosis of ectopic pregnancy should be suspected in a pregnant patient with no evidence of an intrauterine pregnancy on transvaginal ultrasound (TVUS) and any of the following, is that right?

A. Yes.

Q. And then you provide a list of factors, including visualization on certain ultrasound findings such as an adnexal mass or intraperitoneal bleeding, right?

A. Yes.

Q. Or A serum hCG that rises abnormally more than 35 percent over two days, right?

A. It's actually less than 35 percent over two days.

Q. Apologies. Less than 35 percent over two days. Or abdominal pain and/or vaginal bleeding, especially in patients with risk factors for ectopics, is that right?

A. Yes.

Q. According to this diagnostic criteria, a pregnant

patient whose pregnancy can't be seen on ultrasound but does not have any of those additional factors would not be considered to have a suspected ectopic, would she?

A. I don't think that's true. I think that the diagnosis of ectopic pregnancy should be suspected in virtually any pregnant woman who presents with bleeding and pain.

Q. My question is whether a pregnant patient with no evidence of an intrauterine pregnancy on transvaginal ultrasound but without any of the following should be considered to have a suspected ectopic?

A. So if I -- I'm sorry. So you're saying if a pregnant woman has no intrauterine pregnancy on ultrasound then what?

Q. And none of the following factors that you list in paragraph 203, does that mean she does not have a suspected ectopic?

A. No. This is -- no.

Q. Why not?

A. Why not what, sir?

Q. Well, just to be clear. In paragraph 203 you say that a pregnant patient with no evidence of an intrauterine pregnancy who has any of the following should be suspected for ectopic pregnancy, correct?

A. Yes.

Q. So my question is if she does not have any of the following, would you still consider that a suspected ectopic

pregnancy?

A. Yes. I'm laying out an algorithm here. I'm laying out an algorithm here. This algorithm is to provide guidelines and this is from up to date. The purpose of the algorithm is to provide guidelines for a clinician. But in actual clinical practice if I have a woman that has a positive hCG that is rising and I can't see a -- can't see an embryo or a fetus, I would have a high suspicion nonetheless that she has an ectopic pregnancy, and in fact I would consider that to be an ectopic pregnancy until proven otherwise.

Q. Doctor, you just said if she had a rise in hCG, correct?

A. I think what I am trying to say here is that if I am unable to see -- if a patient has a positive pregnancy test and I am unable to see an intrauterine pregnancy, my clinical suspicion would be high for an ectopic pregnancy, and I will consider it to be an ectopic pregnancy until proven otherwise.

Q. And you would consider it to be an ectopic pregnancy even absent any of the factors you enumerate in paragraph 203A, 203B and 203C, is that right?

A. What I am trying to say here is that I would have a suspicion that I would then use subsequent diagnostic -- take subsequent diagnostic steps to confirm a diagnosis of an ectopic pregnancy. I'm not saying that you need all of these things to suspect an ectopic pregnancy. I am saying this is

outlining what you would do to resolve the patient into either an ectopic pregnancy, a failing intrauterine pregnancy, that is to say a miscarriage, or an intrauterine pregnancy that cannot be seen at that point in time. And I think that that is a critical step of -- diagnostic steps that need to be undertaken for every patient in order to rule out ectopic pregnancy, which is the leading cause of first trimester maternal death.

Q. You mean any of the three -- any of the factors listed in those three lettered bullets, in addition to a pregnancy of unknown location to determine that a patient has a suspected ectopic?

A. This is not a determination. These are diagnostic steps. These don't say this is what you do, this is what you say. These are diagnostic steps. For example, the first complex -- the first letter, which is A, which is visualization of a complex structure, could be a corpus luteal cyst, it could be a cyst of pregnancy. So these are diagnostic steps that need to be undertaken to help confirm the diagnosis. They are not in and of themselves directives.

Q. My question is whether you would suspect that a pregnant patient without an intrauterine pregnancy on ultrasound is suspected for ectopic pregnancy if none of the following are present?

A. Yes, I would still be suspicious there could be an ectopic pregnancy. In my clinical experience, yes.

Q. So your practice is more conservative than the algorithm that you laid out here?

MR. BOYLE: Objection.

THE WITNESS: You're asking me a hypothetical question, counselor, and I can't answer that.

BY MR. MENDIAS:

Q. Why not?

A. Because I think that medicine is not strictly steps and rules and algorithms. Part of the art of medicine is undertaking to do the best thing for the patient. And the best thing for the patient is to exercise the utmost discretion, and perform the necessary diagnostic steps for the sake of safety in every woman who could have an ectopic pregnancy until you rule it out.

Q. So in paragraph 209 of your report -- can you let me know when you have gotten there?

A. Sure. I'm there.

Q. You discuss a relationship between contraceptive use and ectopic pregnancy, is that right?

A. Yes.

Q. And in paragraph 210 on the next page you say that the population of women who are likely to seek abortion, women who are using contraception, who become pregnant, the population of women seeking abortion is likely to be at higher risk for ectopic pregnancy, is that right?

A. That's correct.

Q. Is it your belief that all forms of contraception increase a patient's risk for ectopic pregnancy?

A. No. I think I have outlined very clearly in paragraph 209 that some methods are associated with increased risk. And it talks about the specific risk of -- here as being intrauterine device users, the risk is one in two, to one in 16. And then the Li study from 2015 found that current use of most contraceptives was significantly correlated with the incidence of ectopic pregnancy following contraceptive failure.

So the contraceptive methods that are described here are intrauterine devices, oral contraceptives, emergency contraceptives, and that these are most -- these are some of the most common methods that are used by women. It doesn't address barrier methods.

Q. If a patient with a pregnancy of unknown location who has an IUD inserted sought a medication abortion at Planned Parenthood South Atlantic's clinic, do you believe that they would provide her with medication abortion regimen?

A. I think you're asking me a hypothetical question that I just can't answer. I don't know the circumstances. I don't know how far along she is. I don't know what the physical exam showed. I don't know what the ultrasound showed and what her hCG showed. So it's very hypothetical and I can't answer it.

Q. Well, I understand that you're not familiar with

PPSAT'S protocol for medication abortion.

A. It's not a question of the protocol. It's a question of the clinical care of the patient.

Q. Well, I'm asking you if you are familiar with PPSAT's protocol for the administration of medication abortions.

A. I have looked at the PPSAT's protocol in the past and would be happy to review it again if you would like for me to.

Q. But as you sit here in this deposition, you don't recall specific information about their protocol for administration of medication abortion?

A. No. I would have to look at their protocol, which I think is a reasonable thing before I answered your question.

Q. So you're not aware then if a patient with an IUD can receive a medication abortion from PPSAT?

A. No. What I am trying to address is the fact that your question is hypothetical and the real question at hand is what is the clinical situation. I can't speak to protocols that do not dictate how you manage a patient. Protocols provide guidelines, but there has to flexibility because every patient situation is different. So I can't comment on whether the protocols are adequate or inadequate or how they apply to a specific patient because I don't know enough about the patient you're describing. This is a hypothetical situation.

Q. I'm not asking about what you would do for that hypothetical patient. I'm asking whether you understand

PPSAT's medication abortion protocol to provide -- whether it would provide medication abortion to patients with IUDs.

MR. BOYLE: Objection. Asked and answered.

THE WITNESS: Sir?

MR. BOYLE: You can answer.

THE WITNESS: I don't know.

BY MR. MENDIAS:

Q. So please go to paragraph 225 of your report.

A. Yes, I'm there.

Q. Can you read the first line of that paragraph?

A. The Act requires abortion providers to exercise their due diligence in pursuing a diagnosis -- I'm slowing down. I'm sorry, I know I read fast -- in patients with PUL. The same due diligence that would be exercised by any Ob/Gyn caring for a woman with a PUL, as outlined in the consensus statements and papers listed above.

Q. Can you say what part of the Act imposes such a requirement on abortion providers?

A. I don't have the Act in front of me, but my understanding is that the Act says that the intrauterine pregnancy must be documented.

Q. If an intrauterine pregnancy can't be documented, is there a requirement in the Act to conduct further screening for ectopic pregnancy?

A. No. My understanding is that an intrauterine

pregnancy must be documented before an abortion can be performed. And I think that it's a very common sense -- it's a very common sense measure.

Q. And you believe that Ob-Gyns as a general matter would diligently try to rule out ectopic pregnancy for their patients, is that correct?

A. Yes.

MR. MENDIAS: Ellis, do you have the exhibit that I emailed to you?

MR. BOYLE: I do.

BY MR. MENDIAS:

Q. Doctor, can you please turn to paragraph 255 of your report.

A. Yes.

Q. You have paragraph 255?

A. Yes.

Q. All right. So you discuss an article in the New England Journal of Medicine describing a women who presented to a hospital emergency room after a medication abortion and have her ruptured tubal ectopic pregnancy misdiagnosed, is that right?

A. Yes.

Q. The citation you provide for that article is in footnote 260. Harris Allen and Grossman D., Complications of Unsafe and Self-Managed Abortion, New England Journal of

Medicine 2020, is that right?

A. Yes.

MR. MENDIAS: I'm going to drop into the chat the document that Mr. Boyle has given to you and I will mark that as Exhibit-20.

MR. BOYLE: I think you already have a 20.

MR. MENDIAS: Sorry, I guess this is actually 21. Apologies. This is Exhibit-21.

- - -

(Document marked as Exhibit-21 for identification.)

- - -

BY MR. MENDIAS:

Q. Doctor, can you please identify where in that article the discussion of the patient referred to in your expert report?

A. This isn't the right citation.

Q. So this is another citation error in your report?

MR. BOYLE: Objection.

MR. MENDIAS: You can answer, Doctor.

THE WITNESS: Yes, I think that the -- it's another New England Journal study.

BY MR. MENDIAS:

Q. I'm sorry, I didn't mean to cut you off.

A. I think it's another study by -- not another study.

It's another citation by Dr. Grossman.

Q. Have you read the article that you have here that you cited?

A. No, I have not read this one.

Q. Can you identify in your expert report where you cited the article you intended to site here?

A. Can I identify where in which paragraph?

Q. Sure. My question is whether the article you actually wanted to cite is cited somewhere in your expert report.

A. Let me take a look and if not, I can certainly give you that reference.

(Pause.)

A. Yeah, I can certainly give you that reference.

MR. MENDIAS: I actually think this may be the article that you intend to cite, which I'm going to drop into the chat and mark as, I believe, Exhibit-22.

- - -

(Document marked as Exhibit-22 for identification.)

- - -

BY MR. MENDIAS:

Q. Doctor, is this the source you intended to site?

A. Go down a little further. Yes, I believe this is -- can you go down a little further?

Q. Sure. So let's look at the quote in your expert

report.

A. Yes.

Q. So this is who was at 5 weeks 4 days gestation on the basis of the last menstrual period presented to the emergency department with severe abdominal pain.

A. Yes.

Q. And that is the text that I have just highlighted in this source, correct?

A. Yes. So that's the correct article.

Q. You refer to it as an article, but this is in fact a letter to the editor, isn't that right?

A. That's correct.

Q. And you didn't actually cite this letter anywhere else in your expert report, did you?

A. No.

Q. And do you recognize that the woman describes in this letter obtained medication abortion pills on the Internet, correct?

A. I'm sorry, say that again.

Q. You understand that the woman describes in this letter obtained medication abortion pills on the Internet, correct?

A. Yes.

Q. And do you recognize that because she self-managed her abortion she did not receive any counseling about the symptoms of medication abortion as compared to a ruptured ectopic,

correct?

A. That's correct.

Q. You're aware that PPSAT's protocol specifically counsels patients on the symptoms associated with both medication abortion and ectopic pregnancy, correct?

A. Yes.

Q. And you recognize that because this woman did not receive the medication abortion from a clinician she never spoke to an abortion provider about her symptoms, correct?

MR. BOYLE: Objection.

THE WITNESS: I don't -- the point that I would like to make here is not the difference between her having undergone self-managed abortion versus undergoing abortion at an abortion facility. The significance is that she had a history of having undergone abortion, whether it was self-induced or through an abortion provider and the emergency department clinician, based on that history, did not pursue a diagnosis of ectopic pregnancy. And so in a sense this is similar to the situation of not identifying an intrauterine pregnancy before doing an abortion because the woman was not triaged appropriately to either failing intrauterine pregnancy, intrauterine pregnancy, living intrauterine pregnancy or ectopic pregnancy, and that is the point I'm trying to make.

BY MR. MENDIAS:

Q. My question was whether you're aware that this woman

because she received medication abortion online and not from a clinician, did not speak to an abortion provider about her symptoms.

MR. BOYLE: Objection.

THE WITNESS: Yes.

BY MR. MENDIAS:

Q. I'm sorry, what was your answer?

A. I'm sorry, repeat the question again.

Q. You recognize that because this woman received -- did not receive medication abortion from a clinician she never spoke to an abortion provider about her symptoms?

MR. BOYLE: Objection.

THE WITNESS: Yes.

BY MR. MENDIAS:

Q. You're aware that PPSAT counsels all their abortion patients to reach out to them about any concerns regarding post-abortion symptoms, are you?

MR. BOYLE: Objection.

THE WITNESS: I'm aware of that, yes.

BY MR. MENDIAS:

Q. And you're aware that patients with pregnancies of unknown location who receive medication abortion at PPSAT specifically receive close follow-up with a physician about their symptoms?

MR. BOYLE: Objection.

THE WITNESS: I think the point that needs to be made here is that she could walk out the door without having an ectopic pregnancy and rupture and die. And she had an opportunity -- she had an opportunity -- because she engaged with the medical system, she had an opportunity to seek proper diagnosis and didn't. She underwent an abortion procedure -- I'm talking about at Planned Parenthood, for example. A patient would undergo an abortion procedure, which would then confound the diagnosis of an ectopic pregnancy because the -- an emergency room physician, as these emergency room physicians did, did not pursue a diagnosis of ectopic pregnancy and she was at high risk for fatal outcome, and that's the heart of the matter. Patient can receive counseling, they can be told, you know, you need to follow up with us. But if they go home and rupture and die, that's a problem.

BY MR. MENDIAS:

Q. My question was whether you're aware that PPSAT specifically closely follows up all of their patients who receive medication abortion who have pregnancy complications? Are you aware of that now?

MR. BOYLE: Objection. You can answer.

THE WITNESS: Yeah. The follow-up does not include diagnosing an ectopic pregnancy. Follow-up is not the same as diagnosis.

BY MR. MENDIAS:

Q. Doctor, in August of 2023 you submitted an expert report in this case, is that right?

A. Yes.

Q. And in that report you used the phrase medication abortion numerous times, is that right?

A. Yes.

Q. I'll represent to you that the phase medication abortion appears in your first declaration 48 times. Do you have any basis to dispute that?

A. I haven't counted it, so I can't agree with your statement.

Q. Do you have any reason to think it's not that high?

MR. BOYLE: Objection.

THE WITNESS: I would be speculating if I said that. I would need to count and see if that's the number of times.

BY MR. MENDIAS:

Q. In the report you submitted in January, you changed most of the references to medication abortion to say chemical abortion instead, is that right?

MR. BOYLE: Objection.

THE WITNESS: I don't remember whether I made that change or not. I'm sorry.

BY MR. MENDIAS:

Q. Okay. Is it possible that someone else made that

change?

MR. BOYLE: Objection. I'm instructing you not to answer about the drafting process for your report.

BY MR. MENDIAS:

Q. All right.

MR. MENDIAS: Doctor, I'm going to put your first declaration into the chat and I believe this is Exhibit-23.

- - -

(Document marked as Exhibit-23 for identification.)

- - -

BY MR. MENDIAS:

Q. Doctor, does this appear to be the report you submitted in August?

A. It has the same face sheet, but as I said earlier with another document, I don't know if the content is the same because I have not reviewed the document.

Q. This appears to be your signature under penalty of perjury on the first expert report you submitted in this case, correct?

A. That's correct.

Q. And you see that here the document has been stamped by a federal district court indicating it was filed with that court, correct?

A. That's correct. But I don't have the document in hand so I can't attest to its authenticity.

Q. Doctor, do you have paragraph 116 of that first declaration you submitted?

A. Yes.

Q. Can you read the last sentence of that paragraph?

A. Yes. Hold on one second. We do know that serious complications are rare with medication abortion.

Q. And that quote you attribute to an organization called ANSIRH, A-N-S-I-R-H, is that right?

A. Yes.

Q. Can you please go to paragraph 26 of the declaration you submitted in January?

MR. BOYLE: Objection. I believe she submitted it in December, just for the record.

MR. MENDIAS: My apologies.

THE WITNESS: Which document are we talking about now, sir?

BY MR. MENDIAS:

Q. Now we're talking about the more recent expert declaration from December?

A. Thank you for the clarification. Yes.

Q. Can you read the last sentence of that paragraph?

A. We do know that --

MR. BOYLE: What paragraph?

THE WITNESS: Paragraph 26, you said?

MR. MENDIAS: Correct.

MR. BOYLE: Thank you.

THE WITNESS: We do know that serious complications are rare with chemical abortion.

BY MR. MENDIAS:

Q. So this was the same source that you cited in your first declaration, correct?

A. Yes.

Q. And the change in that sentence was from medication abortion to chemical abortion, correct?

A. Yes.

Q. And although this is a quotation, you did not indicate in any way that it had been altered from what it originally stated, correct?

A. Yes.

Q. Why did you not indicate any change that you had made to this sentence?

A. When I -- when I did this expert report, I looked at the usage of chemical abortion versus medication abortion and there was discussion -- there had been discussions as to these terms of art, as to which might be more appropriate.

MR. BOYLE: Don't talk about discussions you had with lawyers internally, if that's what you're talking about.

THE WITNESS: No. No. No. This is in the scientific community.

MR. BOYLE: Okay. My instruction is the same, but if it's not about lawyer conversations you can proceed.

THE WITNESS: Okay. So there has been some discussion as to whether a chemical abortion and medication abortion is the better term. They're both terms of art and they're both interchangeable.

BY MR. MENDIAS:

Q. Medication abortion is a term used by the FDA, correct?

A. Yes. If I can just finish. And so I substituted throughout the document because I felt that the term chemical abortion was a better term, and I should have left this as medication abortion as the quote.

Q. ACOG, the American College of Obstetricians and Gynecologists uses the term medication abortion, correct?

A. Yes. But as I said, this is a term of art and the two terms are essentially interchangeable.

Q. What organizations use the term chemical abortion?

MR. BOYLE: Objection.

THE WITNESS: I'm not aware of whether any specific organizations use this specific term because it's a term of art. It's not a term that is required to be used in a certain way. But as a term of art, it is used in conversations

and discussions about abortion using mifepristone and misoprostol.

Q. When you say term of art, what do you mean?

A. A term of art is a term that is used within a specific discipline, whether it's law or medicine, to describe a particular thing. And that description reflects its usage within that field, which may not necessarily be its common usage.

Q. But which segments of the discipline use the term chemical abortion?

MR. BOYLE: Objection.

THE WITNESS: I have heard the term used by various colleagues in the field and I can't tell you specifically -- I don't remember specifically who was in those discussions or what the content of the discussions was. But I have known that this is a term that is used, and it is referring to mifepristone and misoprostol abortion.

BY MR. MENDIAS:

Q. But you can't say by who that term is used?

MR. BOYLE: Objection.

THE WITNESS: It's a term of art.

BY MR. MENDIAS:

Q. Right. My question is who uses that term of art?

MR. BOYLE: Objection.

THE WITNESS: Ob-Gyns.

BY MR. MENDIAS:

Q. Do you think chemical abortion is the more common term among Ob-Gyns?

MR. BOYLE: Objection.

THE WITNESS: I can't say whether it's more common or not. I'm simply saying that it is a term that is used.

BY MR. MENDIAS:

Q. Doctor, going to your first declaration from August of last year. Can you please go to paragraph 396.

A. Yes.

Q. And there you're talking about the study by Ushma Upadhyay from 2022, correct?

A. Yes.

Q. And then in the next paragraph you quote from that study. Can you read that quote in the first sentence of paragraph 397?

A. This was a retrospective cohort study assessing the effectiveness and safety of using history-based screening alone for medication abortion. The study was designed --

Q. I'm sorry, I just need you to read the first sentence. Thank you. Can you go to your December expert report to paragraph 59?

A. Yes.

Q. And in that paragraph you're discussing the same Ushma

Upadhyay 2022 study, correct?

A. Yes.

Q. And can you read the second sentence of that paragraph?

A. Yes. This was a retrospective cohort study assessing the effectiveness and safety of using history-based screening alone for chemical abortion.

Q. So again, in this quotation you changed the term medication abortion to chemical abortion, correct?

A. Yes.

Q. And again, you did not indicate that you had made any such change, correct?

A. Yes.

Q. Do you remember now making these changes?

A. Do I remember making these changes?

Q. Yes.

A. Yes.

Q. Did you make those changes?

A. Yes.

Q. Did anyone else make those changes?

MR. BOYLE: Objection. I'm going to give you the same instruction. Don't divulge any information about drafting and discussions with your lawyers.

THE WITNESS: No. I'm sorry, repeat the question again, sir.

MR. MENDIAS: That's all right.

BY MR. MENDIAS:

Q. Do you believe that the change from medication abortion to chemical abortion is an idealogical one?

A. No. I believe that the terms are synonymous.

Q. Doctor, look at your last deposition. And in your current C.V. you state that you are a member of the board of the American Association of Pro-Life Obstetricians and Gynecologists, AAPLOG, is that right?

A. Yes.

Q. And AAPLOG produces a glossary of preferred terms that it instructs its members to use, is that right?

MR. BOYLE: Objection.

THE WITNESS: I'm not aware of that glossary, sir.

BY MR. MENDIAS:

Q. Are you aware of AAPLOG's preference for certain terms over others?

MR. BOYLE: Objection.

THE WITNESS: I'm aware that they may have a preference, but that doesn't necessarily -- what I choose to put in my documents.

BY MR. MENDIAS:

Q. Do you believe that AAPLOG has a preference for the term chemical abortion over medical abortion?

MR. BOYLE: Objection.

THE WITNESS: I'm not aware of that. I don't know.

BY MR. MENDIAS:

Q. As a former board member, you never had discussions about which terms to use regarding mifepristone and misoprostol?

MR. BOYLE: Objection. Object to form. You can answer.

THE WITNESS: I haven't been a board member for many years, sir.

MR. MENDIAS: I am going to put a document in the chat which I'll have marked as Exhibit-24.

- - -

(Document marked as Exhibit-24 for identification.)

- - -

BY MR. MENDIAS:

Q. Doctor, have you ever seen this document?

A. I don't think so.

Q. Do you have any reason to believe that this document does not come from AAPLOG?

MR. BOYLE: Objection.

THE WITNESS: I'm saying that I don't think I have seen this document.

BY MR. MENDIAS:

Q. I know. My question was whether you have any reason to believe that this is not from AAPLOG?

MR. BOYLE: Objection.

THE WITNESS: I'm sorry, I didn't -- do I -- can you rephrase your question? Do I have any reason to believe that this is not from AAPLOG?

MR. MENDIAS: Correct. That was my question.

MR. BOYLE: Objection. You can answer.

THE WITNESS: I haven't seen this document so I cannot attest to its authenticity or whether it comes from AAPLOG or not.

BY MR. MENDIAS:

Q. Can you read the highlighted portion of this page, please.

A. Medication abortion. Medication implies that an illness is being treated and that there is therapeutic benefit.

Q. Does that inform your decision to refer to the medication abortion regimen as chemical abortion?

A. No. As I said, I have never seen this document.

Q. I'm not asking about this document specifically. But do you agree that medication implies that an illness is being treated and that there is a therapeutic benefit?

A. That is not my conviction, no.

Q. So why specifically do you feel chemical abortion is a

more appropriate term than medication abortion for the regimen of mifepristone and misoprostol to terminate a pregnancy?

A. I arrived at the decision to use the term chemical abortion because I felt that it was more appropriate in terms of describing the fact that these drugs are used with -- for -- in the context of abortion as for intentional feticide. As I said earlier, I had discussions with colleagues about the use of the terms medication abortion versus chemical abortion and felt that this was an appropriate term to use. There was no ideological intent.

Q. Doctor, can you read this highlighted portion of the document?

A. Intentional embryo/feticide or induced abortion by chemical or pharmacologic agent or via mifepristone.

Q. Why do you believe that medication abortion is inappropriate?

A. I didn't say that it was inappropriate. I said that the terms are interchangeable.

Q. Why did you feel that the term chemical abortion is more appropriate than medication abortion?

A. Because as I was discussing this with my colleagues in different venues, the term was felt to be appropriate to describe the process of using specific chemicals to either effect abortion or -- to effect abortion.

Q. Which colleagues did you have those discussions with?

A. I don't remember who they were at this moment.

Q. Do you remember where you had such discussions?

A. I don't remember. It was in the course of talking with other Ob-Gyns, but I don't remember the exact circumstances.

Q. Without divulging ruling any communication between you and any lawyers, did anyone ever suggest to you that you should, as a general matter, refer to mifepristone and misoprostol as chemical abortion?

A. No. This was my decision.

Q. Doctor, can you please go to paragraph 173 of your December expert report.

A. Yes.

Q. And there you state as an alternative to abortion patients who have received fatal fetal diagnoses can benefit from neonatal hospice, is that right?

A. Perinatal hospice, yes.

Q. You say in paragraph 174 of that report that hospitals are often associated with a perinatal hospice program, is that right?

A. Yes.

Q. Are you aware of any hospitals in North Carolina that are associated with perinatal hospice programs?

A. My understanding is that UNC Hospital is. I'm not sure about Duke. And the other hospital that I work at --

other hospitals that I have worked at, for example in other -- in Indiana is affiliated. I can't speak for all hospitals and that's why I said many. There are many.

Q. I appreciate that. I am wondering in North Carolina. So you, I believe, said UNC. Is that the only hospital you know in North Carolina that has a perinatal hospice program?

A. I don't know and that's why I said often.

Q. Sure. I just want to be very clear. You only know for sure that one hospital in North Carolina has such a program?

A. Or is affiliated with.

Q. The answer is yes, there's only one hospital that you know that has or is affiliated with such a program in North Carolina?

A. I think -- I would have to verify this, but I think that Baptist Hospital in Winston-Salem is also affiliated. But I would have to confirm that and I'm happy to do that and get you that information, if you like.

Q. So to confirm, you know of one hospital that certainly has such an affiliation and you think possibly a second does as well?

A. Yes. But there may be others.

Q. For the one hospital that is affiliated with such a program, do you know what the earliest gestational age a patient could make use of that program services?

A. No. Because I don't -- I'm not familiar with the specific program. My understanding is that in general perinatal hospice programs are available from the time of the diagnosis of a lethal fetal anomaly.

Q. So it's a general understanding, not anything particular to the one hospital in North Carolina that you're aware of that is affiliated with such a program?

A. Yes. But as I said, I would be happy to get more information for you.

Q. You're aware that under the law challenged in this case abortion performed because of a fetal anomaly is permitted only before 24 weeks of pregnancy, right?

A. Yes.

Q. And you're aware that PPSAT does not perform abortions after 20 weeks of pregnancy, right?

A. Yes.

MR. BOYLE: At some point can we take a break? I think we have been going another hour.

MR. MENDIAS: Sure. We can take a five-minute break right now.

- - -

(A break was taken, 3:18 p.m. - 3:25 p.m.)

- - -

BY MR. MENDIAS:

Q. Doctor, I just want to go back to some of the things

that you said very early on in this deposition. I believe you said that you provided expert reports in Indiana and Kansas, correct, since August of 2023?

A. I feel like I'm forgetting one. Oh, and Colorado.

Q. What were the topics of those expert reports?

A. Colorado, it was regarding abortion pill rescue -- I would have to go back and look. I just don't want to misquote. I would have to go back and look at my expert reports.

Q. What do you mean by abortion pill rescue?

A. So people refer to abortion pill, reversal abortion, but abortion pill rescue is a better term actually.

Q. Why is that a better term? And can you describe what abortion pill reversal is?

A. So abortion pill rescue is a situation where a woman is given mifepristone and then changes her mind, wants to try to salvage her pregnancy and then receives progesterone. It's better to call it abortion pill rescue though because there's precedent for this type of procedure in medicine and the term rescue is used.

Q. Are you aware of any studies that demonstrate the effectiveness of this particular treatment?

MR. BOYLE: I'm just going to object. Are you asking her about her expert testimony in a completely separate case that has nothing to do with the facts in this case? If that's true, I would like to suggest that it's relevant and I

might let you have one or two questions, but then I'm going to instruct her not to answer.

MR. MENDIAS: I'm asking questions about the expert that the state of -- the intervenors has put forward as an expert on abortion medicine, about her expert opinions on abortion.

THE WITNESS: I don't have those --

MR. BOYLE: Let's get the question -- please pose a question.

MR. MENDIAS: I can return to that.

BY MR. MENDIAS:

Q. You mentioned earlier that you had been a part of an AAPLOG training session on expert witness -- or serving as an expert witness, is that correct?

A. Yes.

Q. Did you take notes during that training?

A. Yes.

Q. Did you review those notes before this deposition?

A. No. I destroyed them at the end of the training.

Q. During the break that you just took or the break that you took earlier today, did you consult any of the articles we discussed earlier that were incorrectly cited in your report?

MR. BOYLE: Objection to form. You can answer.

THE WITNESS: No.

BY MR. MENDIAS:

Q. Doctor, do you understand that the law at issue in this case does not prevent any patient who wants it from seeking the services of a perinatal hospice program, correct?

MR. BOYLE: Object to form.

THE WITNESS: I don't understand the question, sir. I'm sorry.

BY MR. MENDIAS:

Q. If someone wants to engage the services of a perinatal hospice program, they may do so notwithstanding the law at issue in this case?

MR. BOYLE: Object to form.

THE WITNESS: Yes.

BY MR. MENDIAS:

Q. And if a patient has a pregnancy of unknown location, the law does not prohibit her from simply waiting until an intrauterine pregnancy can be documented to receive a medication abortion, correct?

A. No, the law does not prohibit her from doing that. Am I understanding the question correctly?

Q. Do you understand that abortions that are a result of -- I'm sorry, pregnancies that are a result of rape or incest are permitted after 12 weeks of pregnancy under the Act, correct?

A. Yes.

Q. And I believe your expert report refers to the

possibility that such victims of sexual violence will receive better care in hospitals than at abortion clinics, is that right?

A. Can you tell me which paragraph you're referring to and which expert report you're referring to, sir?

Q. Sure. In paragraph 168 of your December expert report.

A. Yes. I think I say in paragraph 168, to the best of my knowledge, such resources are not available at abortion clinics.

Q. How did you come to know what you know about the available resources at abortion clinics?

A. The -- one of the expert reports from the plaintiffs stated that the -- they have -- they evaluated the patient and asked them questions about whether they are being abused or in trafficking, I believe. But I don't remember exactly where that was.

Q. But you're not aware of any specific services for victims of sexual violence that Planned Parenthood offers to its patients?

A. The plaintiffs did not describe any of those services.

Q. And nothing in the law would prevent a person from seeking out such services even if they were being seen for an abortion at a Planned Parenthood clinic, correct?

MR. BOYLE: Object to form. You can answer.

THE WITNESS: Having worked with many victims of abuse and victims of trafficking, one of the axioms in caring for survivors is that the interaction with the medical system represents a significant opportunity for those survivors to obtain the care that they need and -- in terms of potentially leaving their situation. And in my expert report, I don't have the exact location, I talk about a study that documented that patients had as many as 17 abortions. Each of those abortions represented a missed opportunity for them to be appropriately evaluated and offered an opportunity to leave the trafficking situation. So that data in and of itself speaks to the fact that these survivors often do not receive an opportunity to have their -- those needs assessed and to leave their situation.

BY MR. MENDIAS:

Q. Do you know anything specifically about PPSAT's clinics in North Carolina and whether they offer such interventions to their patients?

A. I don't. But I also will point out that they haven't provided any data to show that those services are provided.

Q. When did you attend the most recent AAPLOG training for expert witnesses?

A. It was last Saturday.

Q. And you said it was in Washington D.C.?

A. I didn't say that, but obviously you knew that.

Q. Were you in Washington D.C. for the March for Life?

A. No.

Q. Why were you in Washington D.C.?

A. To visit my mother-in-law who we take care of.

Q. Did you attend any events related to the March for Life?

A. No.

Q. During this deposition, did you take any notes?

A. No.

Q. During this deposition, did anyone pass you any notes?

MR. BOYLE: Objection. Don't answer that.

BY MR. MENDIAS:

Q. During this deposition, did anyone other than a lawyer provide any communication to you at all?

A. I spoke to the lady at the front desk of the office, but that's it.

Q. During this deposition, did you engage in any communications other than those that were transcribed by the court reporter?

MR. BOYLE: Objection. Don't answer that as it relates to any communications you had with lawyers.

BY MR. MENDIAS:

Q. Doctor, other than communication with lawyers, did you engage in any communications that were not transcribed by the court reporter?

A. No. I don't understand. Okay.

Q. Did you not understand the question?

A. No. No. I just wanted -- yeah, I think I understand the question. I'm fine.

Q. Okay. I can ask again if you're unsure.

A. Sir?

Q. I can ask the question again if you're unsure.

A. No. I think I understand.

Q. Okay.

MR. MENDIAS: I don't have any further questions.

BY MR. BOYLE:

Q. Doctor, good afternoon. My name is Ellis Boyle. I represent the intervenor defendants. I have just a few questions.

A. Yes, sir.

Q. In the Bartlett study that you were shown earlier, table two said the mortality rate for 16 to 20 weeks was 3.4 deaths per 100,000 patients, right?

A. Yes.

Q. And in the Saraiya study, I believe it talked about the 16th and 19 weeks mortality rate was 4.1 deaths per 100,000 patients, is that correct?

A. Yes, sir.

Q. So those two studies weren't comparing the same thing,

were they?

A. No, they were not. In fact, the Bartlett study included that additional cohort of patients from 19 to 20 weeks. And as noted in their study, the risk for abortion increases exponentially by 38 percent for every week of gestation. So that figure of 3.4 is not analogous to the 4.9 -- 4.1 number in -- okay. Let me rephrase that. The 3.4 mortality ratio in the Bartlett study is not analogous to the 4.1 mortality ratio in the Saraiya study because it's a different sampling. It's from 16 to 20 weeks, and not 16 to 19 weeks. So the numbers are not comparable.

Q. I forget the lady's name, but do you recall talking about the study with the lady who's from Oakland, California? Do you remember her name?

A. What was the study?

Q. Ushma -- I forget the last name. It's the walk-up study.

A. The Turnaway?

Q. What's that?

A. The Turnaway study?

Q. Yes, sorry, the Turnaway study. Do you recall that lady's name who is the lead author there?

A. I don't remember her name.

Q. You're aware that she is a sociologist, right?

A. Yes, that's correct.

Q. She's not a medical doctor, is she?

A. That's correct, she's not a medical doctor?

MR. BOYLE: No further questions. That's all.

MR. MENDIAS: One follow-up question.

BY MR. MENDIAS:

Q. Doctor, you agree that the risk from an abortion would be higher in the 20th week of pregnancy than in the 19th week of pregnancy, correct?

A. Based on Bartlett's study, yes.

Q. Okay.

MR. MENDIAS: No further questions. Thank you, Doctor.

BY MR. BOYLE:

Q. Doctor, one follow-up based on that. Just a moment. If you can find table one and let me know when you find that.

A. Mortality rates for miscarriage?

Q. Yes. Can I see that, please?

A. Yes.

Q. So this is from your second report in December 2023. It's been marked as an exhibit. This is on page 34, paragraph 91, table one. In the Berman study from 1985, it finds that once you get to weeks 20 to 24, the mortality deaths per hundred or a million thousand patients decreases, correct?

A. That's correct.

Q. So adding the 20th week to the study for -- with the

Bartlett study could actually have it decrease the mortality rate, and it would be explained by the fact that in week 20 the mortality rate starts to decrease based on the Bartlett study, is that correct?

A. That's correct.

MR. BOYLE: No further questions.

MR. MENDIAS: Nothing from me.

- - -

(Witness excused.)

- - -

(Deposition concluded 3:44 p.m.)

- - -

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

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:_____

E R R A T A S H E E T

PAGE LINE CORRECTION

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I, _____, after having read the foregoing transcript of my deposition, wish to make the above corrections.

SIGNATURE_____

DATE_____

S

DISCOVERY

COURT REPORTERS AND LEGAL VIDEOGRAPHERS

ERRATA SHEET FOR THE DEPOSITION OF:

Deponent: Monique Chireau Wubbenhorst, M.D., M.P.H.

Case Name: Planned Parenthood South Atlantic, et al. v. Joshua Stein, et al.

Date of Deposition: 01/24/2024

CORRECTIONS:

Page	Line	Now Reads:	Should Read:	Reason Therefor:
28	1	…the first column on the page that we only conducted an unadjusted analysis for the association between fetal death and DIC, and that the number of cases of DIC was too low to permit adjustment.	…the first column on the page that "we only conducted an unadjusted analysis for the association between fetal death and DIC, and that the number of cases of DIC was too low to permit adjustment".	The text in blue is a quote.
29	4	In other words, their analysis with limited by the fact that they could not say…	In other words, their analysis was limited by the fact that they could not say…	Should read "was" instead of "with".
42	17	And then the second is that the number of miscarriages are complete.	And then the second is that a number of miscarriages are complete.	Should read "a" instead of "the"
42	22	So that is why I was not making a direct comparison here, because these studies are comparable.	So that is why I was not making a direct comparison here, because these studies are not comparable.	Should have "not" inserted before "studies".
56	4	This algorithm is to provide guidelines and is from up to date.	This algorithm is to provide guidelines and is from *Up to Date*.	*Up to Date* is a clinical guideline publication.

Signature of Deponent _____ Date: 2.19.2024

EXHIBIT F

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

PLANNED PARENTHOOD SOUTH ATLANTIC, et al,

Plaintiffs,

vs.

JOSHUA STEIN, et al.,

Defendants,

PHILIP BERGER & TIMOTHY MOORE,

Intervenors,

_____/

Civil Action
No. 1:23CV480

Greensboro, North Carolina
September 25, 2023

TRANSCRIPT OF PRELIMINARY INJUNCTION PROCEEDINGS
BEFORE THE HONORABLE CATHERINE C. EAGLES,
CHIEF UNITED STATES DISTRICT JUDGE

APPEARANCES:

For the Plaintiffs: HANNAH SWANSON, ESQ.
KRISTI GRAUNKE, ESQ.
BRIGITTE AMIRI, ESQ.
JACLYN A. MAFFETORE, ESQ.

For the Defendant Attorney General Joshua Stein:

SARAH BOYCE, ESQ.
SPRIPRIYA NARASHIMHAN, ESQ.

Court Reporter: J. Calhoun, RPR
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Proceedings reported by stenotype reporter.
Transcript produced by computer-aided transcription.

APPEARANCES CONTINUED

For Defendant Jim O'Neill:

KEVIN GUY WILLIAMS, ESQ.

For Defendant Secretary Kinsley and DHHS:

MICHAEL WOOD, ESQ.

For Defendants Medical Board and North Carolina Board of Nursing:

MICHAEL BULLERI, ESQ.

For the District Attorney Defendants:

LIZ O'BRIEN, ESQ.

P R O C E E D I N S

(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.

Proceed.

MR. OYLE Good morning, Your Honor, Ellis Boyle from the Wake County Bar on behalf of the legislative leader defendant intervenors, and I'm joined by Erik Baptist from the Virginia and Washington, D.C. Bar, who made a special appearance, and he will be speaking on behalf of the legislature leaders.

THE COURT Tell me your name again.

MR. APTIST Erik Baptist.

THE COURT Okay. And who is here for Mr. Stein?

MS. OYCE Good morning, Your Honor. My name is Sarah Boyce, and I'm with the North Carolina Department of Justice on behalf of Attorney General Joshua Stein.

MS. NARASIMHAN Good morning, Your Honor, Sripriya Baraimhan --

THE COURT You are going to have to speak into the microphone, because I can't hear you.

MS. NARASIMHAN My name is Sripriya Narasimhan from the North Carolina Department of Justice. I'm also here on behalf of Attorney General Stein.

THE COURT Is anybody going to be arguing on behalf of the district attorneys?

MS. O RIAN Good morning, Your Honor, Liz O'Brian for the North Carolina Department of Justice. I'm here on behalf of the district attorneys. I do not intend to offer

argument.

MR. WILLIAMS Kevin Williams on behalf of District Attorney Jim O'Neill, and also do not anticipate needing to be heard this morning.

THE COURT All right. So here are my -- did I get everybody? Sorry.

MR. ULLERI Michael Bulleri, also with the North Carolina Department of Justice. I represent the North Carolina Medical Board and the North Carolina Board of Nursing.

THE COURT The boards. I forgot about them.

MR. ULLERI I also do not anticipate needing to be heard this morning.

MR. WOOD Michael Wood, with the Department of Justice, counsel to Secretary Kinsley of DHHS. We have not taken a position, and I do not intend to present argument today.

THE COURT Thank you. Okay. Here are my questions:

First, I want everybody to talk to me about standing. This was raised in the intervenors' supplemental brief, and I did not see it addressed otherwise. I would like particularly to hear from the plaintiffs, but from the intervenors, and the attorney general as well.

If you tell me something as a fact, I would like you to direct my attention to where it is in the record. As I understand the law, I have to make findings of fact in

connection with motions for preliminary injunction and findings of fact that have to be based on evidence. So statements in briefs are not evidence, unless -- I mean, they are not evidence. You have to cite to the evidence in the brief, and I think my standing order is pretty clear, you know, I don't have to go search it out myself, though in this context in court, often seems to take facts from amicus briefs, but I don't do that, and I don't take it from briefs from parties, unless you direct my attention to the evidence. So, you know, you all aren't witnesses, so whatever you all say, not evidence.

There is a lot of reasons for that, and it is pretty important. It is not fair. First of all, the other side doesn't get to cross-examine you about that like you got to cross-examine these deponents.

In this situation I know you all have seen the briefs, and I don't have any amicus briefs but, you know, you really -- if somebody says something in a supplemental brief and there is no evidence to support it, the other side doesn't have the opportunity to offer evidence in opposition to that, so there is a lot of reasons.

It is not fair to either side to do it, and I'm pretty strict about that. It would be very helpful to me if you could direct my attention.

So for the plaintiffs, you do seem to make a number of what I would call policy arguments, essentially asking the

Court to weigh competing medical evidence, but I read *Dobbs* to not allow that. You know, it doesn't -- *Dobbs* doesn't do away with the rational basis test, but it has changed the law, and some of your arguments don't seem to completely recognize that, but specifically, your argument about the health risks of other procedures that don't have to be done in the hospital, and maybe to a lesser extent this one might be a little more open for discussion.

The intervenors can address this if they want. Your argument about the statutory provisions as allowing for home births, so if you all can talk to me about that a little bit more and why your arguments are consistent with Dobbs.

Then for the intervenors, you know, I would -- it seems like you all believe that the legislature could make it illegal for a woman to give birth at home. You don't, but based on your health and safety argument about requiring surgical abortions after 12-weeks to be done in the hospital, it seems like you could just make it a crime to give birth at home because the risks -- the health and safety risks are more serious to the child and the mother.

So if you could talk to me about that, and how that -- what limits are on the legislature's health and safety authority, I appreciate that, if you think there are any limits.

I would like both of you to, I think confirm -- if

not confirm, tell me what the briefs and evidence have called -- I'm just going to use the shorthand, miscarriage management. That's essentially the situation -- I think it is in 90-21.81(1)(c) and (d). That's the provision that excludes from the definition of abortion -- I can't remember now if it's in there twice, once for medication and once for surgical, or if it's just in there once, but it excludes from the definition of an abortion the removal of a dead or unborn child who died as a result of natural causes in utero, accidental trauma or criminal assault or to remove an ectopic pregnancy. That seems to me to be what people are talking about when they talk about miscarriage management.

If that is not right, if somebody would tell me that and direct me to the evidence on that point.

I think it is undisputed that the risk of aspiration and D&E procedures, that those are both done for miscarriage management. They are done for abortions, and I think the evidence is that the risks are the same, regardless of the purpose. If that is not true, please tell me the evidence on that point.

In that context, I think I might like to hear from the intervenors in particular, about the holdings in *Eisenstadt against Baird*, City of Cleburne, and how you rationally distinguish between groups the equal protection argument there.

On that point, I would like everybody to talk about

Lee Optical, which the plaintiffs don't give much attention to, and which if I read it the way the intervenors read it, it pretty much does away with the equal protection clause.

So, what does *Lee Optical* mean, because it's got to mean something other than -- I don't know what it means. I'm asking you all to help me on that. I'm curious about its limits, you know, just thinking out loud about hypotheticals, if California passed a law requiring every one in a hospital or doctor's office to wear a mask, then there would be no equal protection or due process problem with such a law under the intervenors' argument because it has a rational basis, clearly.

The evidence is pretty strong that masks reduce transmission of disease. It has a rational basis, and the fact that it doesn't cover every possible group health setting or every possible group setting means it would fall under *Lee Optical*.

We can talk about other reasons that it might be unconstitutional, but put those aside, because we're just here about equal protection and due process, right?

There would be no problem if the intervenors are correct about what *Lee Optical* means. So I kind of like to think about the limits of *Lee Optical*, if there are any.

I would like the plaintiffs to take another stab at telling me why the defendants' interpretation of the intrauterine location provision is vague. For both of you, the

word -- the statute says, "before providing an abortion inducing drug, a physician shall document the probable gestational age and existence of an intrauterine pregnancy." So it seems like the word "probable" modifies -- or clearly modifies gestational age, and it seems like it modifies existence of an intrauterine pregnancy.

So I would like you to think about whether that is so or not, and if it is so, what does that mean. Does it matter? Would the plaintiff say it is still vague? And, would the defendant say it would still -- as I read the intervenors' argument, you're basically saying that a medication abortion before six weeks is illegal. If you're right about what that statute means, that's your position, as I understand it. If that's not right, I want you to tell me why that is not so.

I did have some concerns about the way the intervenors characterized the health risks of -- I'm going to probably pronounce it wrong, Mifepristone, early in pregnancy. The evidence I saw in the record is, that the drug does not terminate an ectopic pregnancy and thus is ineffective to treat it, but I did not see any evidence that that drug itself increases -- that administering it to someone who has an ectopic pregnancy increases harm or risk to the woman or increases the risk of complications from an ectopic pregnancy. If that's not right, I would like the intervenors to point me to the evidence.

I saw no evidence that the way that Dr. Gray and other physicians treat patients who want a medication abortion very early in pregnancy, before the location can be determined by ultrasound, why that approach is not medically reasonable or that it doesn't fully protect the health of the mother.

I'm really not sure how that plays into the decision, if it does at all, but it does seem like the intervenors overstated what the FDA says about the use of the drug in the brief. So I would just like you to clarify that for me, and point me to the evidence that supports some of your factual claims about that, and how it plays into the health and safety justification.

I was also a little confused about the evidence on blood testing to confirm intrauterine pregnancy. What does the evidence say about how early that can be done? I got a little confused about that from the briefing.

Those are my questions. I'm not trying to prevent you from addressing anything else, but I thought it might be helpful to you to just know that I only have three whole pages of questions, but I am hoping that you all will address those things while we talk.

I thought I would give you maybe ten minutes to figure out how -- I apologize for not getting them to you in advance but, you know, I worked on it over the weekend, like you all did. You know, I don't want to take you out of rhythm

on your argument, but I would like to address those points, if you can.

Let's be in recess until 10 o'clock.

(Court was in recess from 9:48 to 10:09 a.m.)

THE COURT Okay. What I thought we would do is hear from the plaintiffs, and I thought I would hear from the Attorney General, and then the intervenors, and then I would just let you all go round and round until you start repeating yourselves or we all give out of energy. So that's how I thought we would go forward, and have the plaintiffs address everything and the same for the other folks.

Ms. Swanson, go ahead.

MS. SWANSON Good morning, Your Honor, may it please the Court. I'm looking forward to addressing the Court's questions, but I wanted to start with a piece of context that I think is crucially important to this case, and that is, since July 1st, abortions have been broadly illegal in North Carolina after the first 12-weeks of pregnancy.

THE COURT Speak up.

MS. SWANSON Even under the 12-week ban, North Carolina is one of the few remaining states, south of Washington, D.C., where abortion is available at all, and it is impossible to understand the stakes of this case without bearing that broader picture in mind.

THE COURT The legislature can prohibit it, right?

MS. SWANSON Even under rational basis, plaintiffs can rebut presumption of rationality.

THE COURT But, they could just say abortion is completely totally illegal, because we think abortion is morally wrong and reprehensible and a crime and they could make it a crime, right, under **Do s**?

MS. SWANSON **Do s** upheld the rationality of a 15 week ban, and I think we would have argument about the rationality of a total ban. Here, plaintiffs aren't challenging a 12-week gestational line, rather we are challenging these two pieces of the 12-week ban, Bill 20, the hospitalization requirement, which we argue is vague, and also fundamentally irrational in violation of the Fourteenth Amendment.

Our arguments are that both of these provisions have no rational relationship to the health and safety justifications that the intervenors have raised in their defense, and before getting to the specific evidentiary questions about why those provisions fail to further be asserted interest, I would like to address Your Honor's standing question, which the intervenors did raise for the first time in their supplemental brief.

I think there is a legal component to this challenge, and a factual one, and I'll address the legal component first. It is Black Letter Law under (indecipherable) under most

recently the --

THE COURT The what?

MS. SWANSON The *June Medical Services versus Gee* Supreme Court case, that a regulated party like an abortion provider, has third-party standing to bring constitutional claims on behalf of people whose constitutional rights would be violated if the law were enforced against the plaintiffs. That has been applied in the abortion context in decades of federal cases before *Dobbs*, and the Supreme Court in *Dobbs* did not overrule that standing holding, which again a majority of the Supreme Court affirmed as recently as the *June Medical Services* case.

I think it is clear as a legal matter that the plaintiffs do have standing to bring constitutional claims on behalf of patients.

As a factual matter, the intervenor suggests that the plaintiffs have not shown evidence that they will provide abortion under these circumstances, and respectfully that was not true.

Dr. Farris's declaration, which is at docket entry 49-1, in paragraph 13, asserts that Planned Parenthood --

THE COURT Slow down, please.

MS. SWANSON I'm sorry. That Planned Parenthood South Atlantic does provide abortions under the exceptions and would continue to do so, but for the hospitalization

requirement.

THE COURT Which paragraph?

MS. SWANSON This is paragraph 13 -- or 14, and specifically as to abortions in the case of life-limiting anomaly.

Docket entry 49-1, paragraph 46 describes how hospitals in North Carolina refer patients to Planned Parenthood South Atlantic's clinics for patients who have been diagnosed with a fetal anomaly. This has happened in the past. The plaintiffs have alleged that they would continue to provide these abortions, and Dr. Farris's sworn declaration testimony is sufficient evidence of that, but for the challenge provisions, they would continue to do so. That's all that is required for constitutional standing, and the law is clear that plaintiffs have also met the standard for third-party standing, which is prudential rather than jurisdictional.

If the Court has no further questions on standing, I will proceed to the question about whether this is just a policy dispute. Again, Your Honor, even under *Dobbs* rational basis is the standard, and as the Court recognized, if rational basis required the Court to defer not only to the State's allegations, but it has legitimate purpose for its laws, but also to the State's assertion that the chosen means do in fact have a rational relationship to the State's ends, rational basis would have no meaning whatsoever and the equal protection

clause would fail to guard against truly arbitrary and irrational provisions like these.

So beginning with --

THE COURT Well, wait a minute. If there is a rational basis, I do have to defer. I thought you just said I didn't.

MS. SWANSON The Court does not need to defer to the legislature's assertion that the means chosen is a rational way of furthering its purported interest.

THE COURT Okay. I understand that.

MS. SWANSON I think the Borden's Dairy Products case is a great example of this. So that was a straightforward rational basis review, looking at whether a price-fixing provision that applied to New York City dairy distributors had a rational relationship to the asserted interests in promoting the dairy industry within New York.

THE COURT I take it that's an older case.

MS. SWANSON It is an older case, Your Honor.

THE COURT All of the cases where the Supreme Court has said no rational basis, this might not be right, which is why I am asking you, but they appear to all be pretty old. You know, that doesn't appear to have been a successful argument with the Supreme Court in 30 or 40 years.

Is that wrong? What does that mean?

MS. SWANSON Your Honor, I would characterize those

cases as venerable, and that they have not been overruled by the Supreme Court. I think *Cleburne* and *Moreno* are bedrock Fourteenth Amendments cases that have not been overruled by the Supreme Court.

The Fifth Circuit most recently in the *St. Joseph Abbey* case, this was in 2013, applied rational basis review to a Louisiana law that required people selling caskets to be licensed as funeral directors. On its face, this is a regulation of an economic industry, the sort of thing that the State defendant, by pointing to *Williams* and *Lee Optical*, which I will address in a moment, but the Court, in determining whether or not there was in fact a rational basis for that law, looked at the operation in the real world of that provision. It looked at the other ways in which the state had regulated the purchase of caskets in the funeral industry more broadly, and it looked at the record in front of it.

So again, I think this requirement that the Court can consider evidence and while the legislature is not responsible for putting on evidence to justify its justifications for the law, that presumption of rational justifications can be rebutted if the plaintiffs put forth evidence that was reaffirmed in the *Carolene* products case, I think the *Hooper* case from 1985. This is a Supreme Court case looking at New Mexico's prior residence requirement for veterans tax exemption. That case is very helpful, because it is a line

that the legislature drew, May 8th, 1976, and it said if you lived in New Mexico before this date and you currently are a veteran residing in New Mexico, you are entitled to this tax exemption. Every one who is a resident of New Mexico after that date, you don't qualify for the exemption.

Even over the defense objection that there is limited financial resources in the state, legislature has to draw a line somewhere. We should defer to them. The Supreme Court still approved the lower court's decision that looked at whether that line, the May 8th, 1976 line, had any rational relationship to the state's interest in encouraging the Vietnam Veterans to move to the state, or in rewarding veterans for their service. Not only did the court conclude that there was no rational relationship between this classification of veterans with prior residence before May 8, 1976, the court found that this line actually ran contrary to the State's purported interest, because it would discourage some Vietnam Veterans from moving to the state.

I think the hospitalization requirement and the IUP documentation requirement not only serve no safety justification, they also undermine the State's interest in patient safety by delaying people seeking abortions that the legislature has expressly authorized them to receive, again, this is abortions in the case of rape, incest or life limiting anomaly, or people seeking an abortion in the very early weeks

of pregnancy. By delaying these patients, it not only increases the cost of the procedure, it also increases the marginal medical risk of the procedure, because while the parties disagree about the extent to which abortion becomes risky or gestational advances, the parties do agree that there is some incremental increase in risk, and by delaying patients to a later point in pregnancy, both provisions run contrary to the State's asserted interest in safety.

This is one of those cases where the legislature's asserted justifications are not backed up by evidence, and the plaintiffs have shown through the declaration testimony we submitted, through the depositions and through our supplemental briefing which surveys that evidence, that the State's justifications are simply not furthered by these two provisions.

THE COURT Because the State, the intervenors have not offered any other reason beyond health and safety, right? This is not a case where they have said we want to discourage abortions and these provisions discourage abortions, like some of the informational provisions that have been at issue in the past. That's my understanding. Is that your understandings?

MS. SWANSON That's my understanding, Your Honor.

THE COURT I'm sure they'll correct me if I'm wrong. Go ahead.

MS. SWANSON Again, we believe that this is a case

like Hooper, Merrifield --

THE COURT Slow down.

MS. SWANSON Saint Joseph Abby and Greg Miles. So turning to the Court's question about whether miscarriage management is identical to procedural abortion for purposes of the hospitalization requirement, yes, the record shows, and I will direct the Court to Dr. Farris's declaration. This is docket entry 49-1, paragraphs 24, 28, 40.

Dr. Boraas's declaration, this is docket entry 49-2, at paragraph 21, footnote seven and paragraph 24 that miscarriage management is identical to aspiration and D&E for purposes of abortion.

In fact, the only difference between procedural abortion and miscarriage management, the same gestational age is, whether there is fetal cardiac activity. If there is fetal cardiac activity, it is an abortion and North Carolina requires it to happen in a hospital. If there is no fetal cardia activity, it is miscarriage management, and North Carolina permits that procedure to happen in a licensed outpatient clinic. There is no rational basis grounded in patient safety between these procedures.

I think the provisions that Your Honor directed our attention to in the definition section of SB 20, this is 90-21.81, the definitions provision Subsection (1)(c), and then again little c., which expressly excludes miscarriage

management from the definition of surgical abortion, and that's because absent this exclusion, the procedures would be identical, but the fact that the legislature expressly accepted the same procedure for a different purpose, demonstrates the irrationality of its hospitalization requirement for procedural abortion, and that makes this like the Merrifield case, which is out of the Ninth Circuit, and that was a case challenging the requirement that certain pest control companies pass a licensing exam and preserve licenses in order to manage structural pest control, and that provision had a general exception for pest control companies that don't work with pesticides, but then it had a subsection, which carved out nonpesticide using pest control companies that work with mice, rats, and pigeons, and that I want to say is very, very similar to this exception for miscarriage, because the Court looked at the subsection for the nonpesticide using pest control companies.

THE COURT The exception to the exception?

MS. SWANSON Exactly. And concluded, you've actually brought back under regulatory control a group that is less in need of the benefits of this licensing exception. So it said everybody who is excepted from licensing is more likely to come into contact with pesticides, and the safety benefit of this licensing requirement is that it insures people doing this sort of pest control understand what to look out for when they

encounter pesticides, and you've carved out everybody who is more likely to encounter pesticides in their work, while maintaining this licensing requirement for these other people, so this classification is just not rationally related to your interest in insuring that pest control companies understand how to work with pesticides.

So I think the Court has honed in on the specific irrationality of classifying between procedural abortion and miscarriage management in requiring one, but not the other to occur in a hospital.

Of course I think the overarching point is that both of these are incredibly safe. They have safety data that is far better than other procedures that are permitted to occur in the outpatient setting and specifically, childbirth and labor are 12 to 14 times riskier than abortion. And as Your Honor identified, North Carolina permits labor and delivery to occur outside the hospital setting, including in private homes, and Section 4.3D of SB-20 expressly provides for planned birth outside a hospital setting. That's a quote.

So I think it is undisputed that the risk is the same. There is no rational justification for distinguishing between the two, and I think this only reinforces the safety evidence that the National Academy of Sciences, Engineering and Medicine summarized in their flagship report, which concluded that based on decades of methodologically sound research into

the safety of abortion hospitalization requirements do not make abortion any safer than it already is. They just delay people in seeking abortion, and again, here it is going to be people seeking abortion, rape, incest, life limiting anomaly and the legislature has already said those people should be able to have abortions, so there is no rational justification for that law.

THE COURT Those things don't increase the risks of abortion, right? If you are pregnant because of rape, the risks are the same as if you're pregnant not by rape?

MS. SWANSON That's correct, Your Honor. And Dr. Farris explained that the -- correct, the procedure for abortion is the same if you are doing the abortion due to a life limiting anomaly, and as I mentioned earlier, hospitals in North Carolina actually refer patients to Planned Parenthood South Atlantic clinics for abortions under those circumstances.

Additionally, there is published research cited in Dr. Farris's declaration, docket entry 49-1, in paragraph 38, footnote 30. Research published by Dr. Turock and colleagues, that expressly compared the safety of second trimester D&Es in an outpatient setting, and found that it could be both safer and more affordable than second trimester D&E.

THE COURT As I recall the intervenors' evidence, I think it might have been in a deposition, I'm not remembering right this second, at least one of their doctors said they

weren't -- they questioned that evidence. I don't recall that they offered any evidence to the contrary beyond that doctor saying in her experience, anecdotally, that was not right.

Am I remembering correctly?

MS. SWANSON So in fact, you may be remembering Dr. Wubbenhorst's deposition, and at a separate point in the deposition, Dr. Wubbenhorst in fact agreed that she cites the same Dr. Turock study for a different proposition elsewhere in her declaration, and when questioned about this, she agreed, yes, I see that that study does recognize that abortion can be just as safe in the outpatient clinic setting as in the hospital setting.

THE COURT But she disagreed with that?

MS. SWANSON She did disagree with that, Your Honor, but she did not point to anything to substantiate that disagreement, and she also -- I think the overarching point is that both of the intervenors' witnesses do not do more than criticize the methodology of plaintiffs' experts studies. Neither of them has direct experience providing abortion. Both are philosophically opposed to abortion, and Dr. Wubbenhorst specifically testified she believes abortion harms patients, even when there are no complications.

So I think Dr. Wubbenhorst's testimony on abortion safety, there are questions about the reliability of that testimony and it stands --

THE COURT See, that raises, though, the very interesting question, you know, what if -- just take it out of abortion. There is issues out there like -- I think I remember dentists and gold fillings, you know, where the legislature or the regulatory body in various places has said the research on you have to have gold fillings, which are very expensive, is what I would just say is fringe research, and so even though there is a dentist, several dentists, lots of dentists who say, yeah, you got to have gold, the legislature or regulatory body in various states has said, no, and if you tell patients that, that's malpractice.

You know, when does something become -- how many doctors do you have to have on your side in order for it to be rational; one, 20, published research? When does it become rational? I mean, you apparently think one or two doctors' opinions is not enough.

MS. SWANSON Your Honor, I would point the Court to not only the declaration testimony and deposition testimony of our experts, but the decades of medical research that they rely on in forming their opinions about the safety of abortion, and that's in addition to their professional experience providing abortion to patients for years, including specifically in North Carolina.

Every mainstream medical organization for obstetricians and gynecologists agrees that hospitalization

requirements do not make abortion any safer than it already is, and that in general, abortion is one of the safest procedures available.

THE COURT Of course 50 years ago, every mainstream medical organization thought the informed consent laws were crazy and did not benefit patients, and doctors kicked and screamed at that requirement, and yet now, we're -- I mean, that passed muster 50 years ago, even though every mainstream medical organization opposed it and said it was bad for patients.

So, I mean, I'm having a little trouble figuring this out here.

MS. SWANSON Sure. The Court isn't controlled by what the mainstream medical --

THE COURT Say again.

MS. SWANSON The Court is not controlled by what mainstream medical organizations say, but I think that is another piece of record evidence that allows the plaintiffs to overcome the presumption that a law is rational.

So I think -- the intervenors point to a case about whether Minnesota can ban plastic milk cartons, and in that case, the court considered -- this was a 1981 case, and the court considered, you know, recognized that the legislature looked at extensive reports. This was extensively debated. The legislature had lots of research in front of it and made a

distinction based on the research in front of it between one policy and another, and that's not the case here.

SB-20 was rushed through legislature in a zeal to ban abortion at 12-weeks, and even in litigation --

THE COURT It is hard to say it was rushed through. *Dobbs* was decided last year, and it -- you know, I don't know when the legislature went into session. January. Several months.

MS. SWANSON So I think even after that 1981 case about the milk cartons, *Hooper*, this case about the New Mexico tax exemption for the veterans comes in 1985, and said -- the Supreme Court as well, and that court again looked at the operation of the classification that was challenged and concluded based on how this particular classification operates, it has no rational relationship to the state's asserted ends.

So of course rational basis is a more differential standard, and heightened standard of review, but the point of *Dobbs* is not that every abortion regulation is per se constitutional. The point of *Dobbs* is, that rational basis applies, and that abortion should be treated just like other healthcare, and that's what we are asking for in this case.

We're seeking a preliminary injunction not because abortion is special, but because it is just like other safe routine outpatient healthcare, and there is no legitimate reason to treat it otherwise.

So I think in light of all of the record evidence, this is a case where we have rebutted the presumption that the State was acting rationally in requiring hospitalization for abortion.

Of course many courts leading up to *Dobbs* also struck down hospitalization requirements, and as part of their analysis they found there was no safety justification for those hospitalization requirements, and even after *Dobbs*, a District Court in Utah, is a state district court, struck down a hospitalization requirement for all abortions under Utah's counterpart to the rational basis standard.

So this was under Utah's Uniform operation of law clause and the court considering evidence at the preliminary injunction stage, concluded that there was no rational relationship between the hospitalization requirement for abortion and the state's purported health and safety in abortion.

THE COURT So if the legislature had a few doctors who said that the vasectomy should be done in hospitals, and similar evidence that that was not necessary, you would say that doesn't meet the rational basis standard? You are saying this is the same, it ought to be treated like any other decision by the legislature that something has to be done in the hospital?

MS. SWANSON Your Honor, yes, we're saying the

legislature is required to treat like alike. That is what the Fourteenth Amendment requires, and the rational basis standard requires that even when it is an economic regulation, and of course the *Cleburne* case, which is -- I'm sorry, the *Carolene Products* case which is the cornerstone of modern equal protection review, says that evidence can be considered and that the record does matter even under rational basis review.

So I did want to leave time to talk -- I'm sorry, about *Lee Optical, lee Optical*, was another case where under the equal protection challenge, to the distinction between opticians and people who were selling ready-to-wear glasses, opticians had to receive a prescription before they could sell lenses that had been refitted to a frame, and this requirement did not apply to vendors who were selling ready-to-wear lenses. The Court said there was probably a rational justification for that and that the record was silent as to whether there was any -- as to whether there was no reason for this requirement, and in light of a silent record, the court deferred to the presumption of rationality for that classification.

This case is not like that part of *Lee Optical* because here we do have a record, and the record is far from silent. It is very clear that there is no health and safety justification for the IUP documentation requirement if it is interpreted as the intervenors urge or for the hospitalization requirement.

So again, I think even under this most differential standard of review, the facts matter, and here the facts are very clear that these provisions are irrational.

I would like to address the vagueness argument about the IUP documentation requirement. As the Court alluded to in the TRO order, there is a conflict between the provision of the IUP documentation requirement and a separate provision of SB-20, which expressly provides that it shall not be unlawful to procure or cause a miscarriage or abortion during the first 12-weeks of a woman's pregnancy, when a medical abortion is procured and that's North Carolina Statute 90-21.81B, part two.

I think on its face, it is unclear what it means to document the existence of an intrauterine pregnancy.

THE COURT I don't understand that. I mean, you write down it is an intrauterine pregnancy, you've documented that. I don't know how that is vague. "Document" means you write it down.

MS. SWANSON I think because what it means to confirm the existence of an intrauterine pregnancy.

THE COURT That is a different question, but what does it mean to document? That doesn't seem vague. I want to be sure that I understand what you are saying.

MS. SWANSON Our argument is that it is unclear whether a person providing an abortion, whether a doctor providing an abortion must visually identify an intrauterine

pregnancy on ultrasound and document that before they can provide a medication abortion.

I think the best reading of the IUP documentation is the one that harmonizes it with the other provisions of SB-20, which expressly provides medical abortion shall not be unlawful in the first 12-weeks of pregnancy is that this is a -- this documentation requirement asks physicians to document whether they identified an intrauterine pregnancy by ultrasound, but even if they didn't, they can still proceed to provide the medication abortion. In that way, the IUP documentation requirement does not function as a ban in the earliest weeks of pregnancy.

THE COURT If you read it that that way, the word existence is meaningless.

MS. SWANSON I think -- so Dr. Farris and Dr. Boraas's testimony in their declarations -- I'm looking at Dr. Farris's declaration, document entry 49-1, paragraphs 53 through 58, and Dr. Farris's rebuttal declaration, which is document entry 69-1, paragraph 12, and also Dr. Boraas's declaration which is 49-2, paragraph 46, they explain -- and also in their deposition testimony, that when a person comes in and has an ultrasound, there is not a binary between intrauterine pregnancy, and no intrauterine pregnancy. There is a range of possible categories.

There is five categories they both agreed on between

confirmed intrauterine pregnancy, probable and intrauterine, pregnancy of unknown location, suspected ectopic pregnancy and confirmed ectopic pregnancy. What we are talking about here is the middle, pregnancy of unknown location. So at that point, the patient -- no pregnancy is visible by ultrasound, but these patients have also been screened through questions about their medical history, their current symptoms and review of the ultrasound results, and they have been low risk for ectopic pregnancy.

So the intervenor suggests that there is, again, just two options. There is either an ectopic pregnancy, or there is an intrauterine pregnancy, such that the opposite of not seeing an intrauterine pregnancy means you necessarily have an ectopic pregnancy.

THE COURT I don't know. I didn't understand them to say that. I understood them to say that before you can -- this is what I understand their argument to be, I'll just make it for them, that they don't want the medicine given unless you are either sure or probably sure that it is an intrauterine pregnancy, because it is ineffective as to an ectopic pregnancy.

They seem to say -- I'm not sure they cited me any evidence for this, but they'll tell me that a patient who is given abortion drugs and who had the ectopic pregnancy might overlook symptoms associated with the ectopic pregnancy to the

detriment of their health.

I'm really not seeing that their argument is as black and white as you are saying, and what I also hear you saying is, if I interpret the statute to mean probable existence, that that does not solve your concern.

MS. SWANSON That's correct, Your Honor, because what we're talking about are patients in pregnancy of unknown location category, which is that middle of the five categories. I do think that --

THE COURT I mean, the evidence appears to be undisputed that at least as to ultrasound you can't see it until -- you know, at the earliest, the fifth week and often by the sixth week, counting from the last day of the woman's cycle. Right?

MS. SWANSON Correct.

THE COURT And this raises my blood testing question.

MS. SWANSON Yes, I did want to address that. I will write down blood testing, but I also want to address their contraindications.

They rely heavily on the Mifeprex label.

THE COURT The what?

MS. SWANSON The Mifeprex label, the trade name for Mifepristone, and that label explains that Mifepristone is contraindicated for confirmed or suspected ectopic pregnancy.

THE COURT I understood your argument about that. They are going to have to explain that to me, because their factual assertions appear inconsistent with what the record shows. If they explain it to me satisfactorily, you can address it on rebuttal.

MS. SWANSON And as Your Honor indicated in teeing-up these questions for us, medication abortion is contraindicated not because it makes ectopic pregnancy more dangerous or exacerbates an ectopic pregnancy, but because it does not treat ectopic pregnancy, and indeed the Mifeprex label itself recognizes that, and that is docket entry -- I believe 65-2, and it is on page six of the Mifeprex label that's in the record.

It says, "Mifeprex" is contraindicated in patients with a confirmed or suspected ectopic pregnancy because Mifeprex is not effective for terminating an ectopic pregnancy."

THE COURT So of those five categories, it is the two on the other end?

MS. SWANSON Correct.

THE COURT Of known or probable intrauterine, and then -- okay.

MS. SWANSON Yes. Correct. And so for these patients who are in that middle category, pregnancy of unknown location, currently, those patients -- again, it is not just

people in the pregnancy of unknown location, it is also people who have been screened and deemed low risk for ectopic pregnancy, because people with pregnancies of unknown location who are high risk, are going to be further evaluated and treated for ectopic pregnancy.

So it is an even narrower category, and currently those people have the option of both receiving further testing for ectopic pregnancy using the blood testing, which I'll address, while also receiving their medication abortion simultaneously. This allows people to obtain the abortion that they have determined that they want at the earliest possible date.

As Dr. Farris testified, her North Carolina patients are anxious to receive their abortions as early as they can, particularly when a 12-week ban is in effect.

The blood testing question is -- so this refers to testing for the levels of pregnancy hormone. I'm going to mispronounce it, but human chorionic gonadotropin, and Dr. Farris will correct me if I mispronounced that, but this is the same pregnancy hormone that an over-the-counter pregnancy test tests for, but a blood test is much more sensitive. So this blood test for hormone HCG can detect pregnancy even earlier than an over-the-counter stick pregnancy test.

The significance of HCG to screening for ectopic pregnancy is that the level of the pregnancy hormone is a good

indicator of how developed the pregnancy is. So if the levels of pregnancy hormone are past a certain threshold, the provider would expect that pregnancy to be developed enough that you could see it on the ultrasound. So if the patient --

THE COURT Where is this in the record?

MS. SWANSON So this is in Dr. Farris's declaration. Again, it starts at docket 49-1. It starts at paragraph 53. This is her discussion of the protocol.

THE COURT Are you saying if it was ectopic, it would not have developed enough to show that level of hormone?

MS. SWANSON No. It would be showing a higher level of the hormones, because it would -- the concern is that if a provider is looking at the ultrasound and they see nothing in the uterus, it is possible that the patient is experiencing a miscarriage. It is possible that they have a pregnancy outside the uterus, ectopic, or it is possible that the pregnancy is just so early that you can't yet see it.

Whether there are -- if there are high levels of pregnancy hormone, that suggests that the pregnancy is probably developed enough that you should be able to see it on the ultrasound, so if you are not seeing it in the uterus, it might be an ectopic pregnancy, so people who receive blood testing and that comes back with high levels of HCG hormone, those patients are then -- are suspected as possibly having an ectopic pregnancy, and they are referred for further screening

and treatment, including to a hospital, if necessary.

Contrast patients whose pregnancy hormone levels are low, that's a good clue that the pregnancy is just very early and very small and we wouldn't expect to be able to see it by ultrasound, because as the Court recognized before, approximately five to six weeks, it is just not -- it is just too small to see it by ultrasound.

THE COURT So if the law went into effect and it meant that unknown, people with unknown location could not get a medication abortion, they would come in, you wouldn't see the pregnancy, you would say, I can't give you the medicine for another week or two. Come back if you still want one, and we'll do another ultrasound. That person -- there would be no reason to send that person for evaluation of an ectopic pregnancy?

MS. SWANSON Correct.

THE COURT So nothing -- for most of these people, they wouldn't go see anybody about an ectopic pregnancy. They would come back in a couple of weeks and then if you didn't see it --

MS. SWANSON That's exactly right, Your Honor, and research has shown that people who receive concurrent HCG testing for -- to test for ectopic pregnancy, while simultaneously receiving the medication abortion, that practice actually detects ectopic pregnancy sooner than when a person is

sent home to wait until their pregnancy has developed and is sufficiently --

THE COURT Where is that in the record?

MS. SWANSON That is in Dr. Farris's deposition. This is docket entry 49-1, at paragraph 58. And Dr. Boraas's declaration, which is docket 49-2, at paragraph 46.

And they are citing Dr. Elisa Goldberg and colleagues who looked at the safety and effectiveness of providing this concurrent testing and medication abortion, and compared it to the safety of sending someone home to wait, and they found that the medication abortion option was safe and effective and, in fact, it excluded ectopic pregnancies sooner than people who were sent home to wait, and that makes sense, because as the Court identified, if someone is sent home to wait, they are not continuing to be in the medical system and receiving followup HCG testing, which is part of the continuing ectopic pregnancy testing that people receive while having medication abortions.

Of course the IUP documentation requirement itself does nothing to insure that patients with pregnancies of unknown location receive prompt ectopic pregnancy testing or screening or treatment once an ectopic pregnancy is confirmed, and in this way, the IUP documentation requirement is similar to the -- again, this is another casket case, the *Craigmiles* case from the Sixth Circuit, where the court looked at the state's justification for requiring casket dealers to be

licensed, and said there is no relationship between this licensure requirement and your interest in consumer protection or your interest in public health because your licensing requirement doesn't tell people what kind of casket they need to have. It doesn't actually insure that people buying caskets are receiving the caskets that are particularly safe. It is not addressed to the problem that the legislature claims it is addressing through this provision, and so the Sixth Circuit affirmed the decision striking down that license requirement even under rational basis review.

So if the Court doesn't have further questions about the HCG testing, I will turn to -- let's see, I think that was the last -- I had seven questions written down from the Court. I want to be sure that I touched on all of them.

If the Court has no further questions about those things, I do think I would like to return briefly to the vagueness argument. Not only is there a -- it is unclear what the law requires and that makes this law vague under the *Raley versus Ohio* case that the Attorney General cites in their brief. It says, "Laws that are contradictory fail to provide notice and can be enjoined as unconstitutionally vague."

Additionally, while the legislature says the scienter requirement for other abortion prohibitions in the code cure the vagueness --

THE COURT That actually reminds me, that I did have

a question about the scienter requirement, though I think it is more for the intervenors, because I wasn't sure exactly what it was, you know, what act has to be willful, what act has to be intentional. What act has to be -- whatever the various standards are.

The Supreme Court in the last six or seven years, has really honed in on these scienter requirements. You all aren't criminal lawyers, but in that context, they have set aside -- they have not set aside -- well, they have set aside a number of criminal convictions because the Court did not accurately describe the scienter requirement to the jury and, you know, the *Rehaif* case -- I'll just say the names out loud, even though you don't know what I'm talking about -- is one honest services stuff coming out of the *Enron* cases.

You know, there are a bunch of cases in this area where the Supreme Court has really honed in on exactly what these scienter requirements mean. So when we say, oh, well there is a scienter requirement, well, for what? You know, for the documentation? The problem with the statute is not really with the document, as least as far as I'm looking at it. It is, what has to be documented.

What is it that the legislature is requiring the practitioner to determine. It is really a determination requirement or a confinding requirement. Yeah, you have to document it, but that -- I don't really -- that's not the

problem. It is what do you have to find. What does the doctor have to find before they can administer the medicine, and so what is it, if you intentionally don't write it down? If you intentionally lie about it, you write down that it is intrauterine when you don't know for sure when it is unknown? Is that what is intentional?

I don't know what the -- so I'm going to ask the intervenors. Thank you for reminding me. I'll have the intervenors address that when it comes to your turn.

Go ahead.

MS. SWANSON Perhaps I can provide a preview. I understand that they are arguing that the scienter requirement from other criminal prohibitions against abortion at North Carolina Statute 14-44 and 14-45, as well as possibly the requirement at 14-23.2, these are all other criminal prohibitions against abortion.

THE COURT They cited all of those, but it didn't help me line it up.

MS. SWANSON Right. I think, actually, when you look at the text of those provisions, it just makes things more confusing. So the 14-44 has a willfully scienter requirement. It makes it illegal to willfully prescribe with the intent to cause abortion, but then there are different scienter requirements in the other provisions that they cited.

So 14-45, with intent to cause abortion, but it might

also have a strict liability standard potentially, because there is -- it says, if any person shall administer or prescribe or advise and procure such woman to take any medicine, drug or anything whatsoever, and then, importantly, with intent thereby to procure the miscarriage of such woman, or disjunctive, shall use any instrument or application for any of the above purposes.

THE COURT We're only talking about abortion here, so what is the standard for the failure to determine it is intrauterine? That's the question. What is the scienter requirement for that? Because, obviously, they are doing it for abortion or we wouldn't be talking about it at all.

MS. SWANSON Right.

THE COURT Right. So it can't -- I'm still having a little trouble with how it matches up to this particular requirement.

MS. SWANSON I am as well, Your Honor, and I think the disjunctive also makes this like the Carolina Youth Action Project, which was the 2023 case from the Fourth Circuit and there the court held -- I'm at page 786 -- so this is volume 60, Federal Fourth at page 786, where the court says that although a scienter requirement may mitigate a law's vagueness --

THE COURT Slow down.

MS. SWANSON I'm sorry. It recognizes that although

a scienter requirement may mitigate a law's vagueness, this statute seeks in a disjunctive, and that both fails to provide notice to the regulated people of what conduct is allowed, what mental state is criminally prohibited, and it also fails to provide sufficient standards to law enforcement.

Part of the problem that the court identified in the Carolina Youth Action Project, was this unbridled enforcement discretion that the vague statute delegated to enforcement officials.

In this case, the Attorney General agrees that the statute is vague because it fails to provide sufficient standards for law enforcement to follow.

So I think the -- first, none of the scienter requirements that we've just been discussing actually appear in the text of the IUP documentation requirement itself, so it is very unclear how any of these other statutes would import the scienter requirement.

THE COURT What would it -- does it mean -- I know that it is intrauterine. I'm sitting here looking at the ultrasound, it is all intrauterine, I just forget to write it down, or I don't write it down; intentionally, willfully, negligently, carelessly, I don't know.

Is that what the scienter is about, failing to write it down, or is it failing to determine it or lying about it? I'm going to ask the intervenors to deal with that.

Can you move on? I do want to finish up this morning, or at least early afternoon.

MS. SWANSON Yes, Your Honor. I appreciate your patience and I know there is a lot of record and fact here.

The overarching point is that the intervenors read *Dobbs* as a free pass to regulate abortion however they want, but even under *Dobbs*, the State still must act rationally when they regulate abortion, and we're not saying that abortion deserves special treatment, just that it needs to be treated like all other safe routine outpatient healthcare, and that's what *Dobbs* requires is, that abortion be regulated just like colonoscopies, just like vasectomies, and there is no legitimate justification for doing otherwise here.

So we would ask the Court to enter a preliminary injunction against both the hospitalization and the IUP documentation requirement without bond and respectfully request this relief before October 1st, when the hospitalization requirement takes effect.

THE COURT Thank you.

For the Attorney General.

MS. OYCE Good morning, Your Honor.

THE COURT Please speak into that microphone so I can hear you well.

MS. OYCE I'll try not belabor too much of what the plaintiff said. I will reiterate their point about standing.

The U.S. Supreme Court has had numerous cases, including *Dobbs*, where it permitted providers of reproductive services to proceed with arguments on behalf of their patients, as well as arguments on behalf of themselves.

I won't duplicate the citations that counsel for Planned Parenthood gave on behalf of or from the declarations of Dr. Farris and Dr. Boraas, but those included numerous paragraphs that set forth that they are providing these procedures, trying to document intrauterine pregnancies and the like, and thus they should have standing to bring suit both on their own behalf, and on behalf of the patients for whom they wish to provide services.

Moving to Your Honor's questions about *Dobbs*. We agree wholeheartedly with the plaintiffs that *Dobbs* does say you don't get to second-guess legislature's weighing of different policy considerations, but it does not obviate the need for the legislature to establish that the law bears a rational relationship to the stated government interest.

The legislature has insisted that this law is intended to protect the health of the mother, that "the health of the mother," are not magic words that the legislature can simply say and not establish that there is a risk to the mother, that the law they have passed would mitigate. Here, they have utterly failed to do that with the evidence that they have put forward.

To take this to a less politically charged analogy if, for instance, the legislature passed a law that said that anyone who is ever diagnosed with the flu needs to be immediately hospitalized, you would expect them to put forward some kind of evidence of the complications that arise from the flu justifying that particular law and proving that immediately hospitalizing someone mitigated the risk and did not impose a burden that made the law so irrational that it couldn't be justified.

If we draw back to this particular context, that's the kind of evidence that we don't see here. They have not proven either that providing these abortions outside the context of a hospital is dangerous to mothers, nor that the line they have drawn here, that they chosen to draw would mitigate that risk, rather as the evidence from Planned Parenthood has shown in some instances requiring women to go to the hospital can exacerbate those safety risks and impose additional burdens.

THE COURT The way the plaintiffs framed this was, I think I heard Ms. Swanson say, that the legislature does not have to come forward with evidence because you do presume that there is a rational basis. But if the challenger does rebut that presumption, then you would expect the legislature to come forward with the evidence supporting their policy decision, if policy decision it was.

MS. OYCE I think that's correct, Your Honor.

Just to walk-through the evidence that we do have here a little bit on both sides, Planned Parenthood certainly satisfied the responsibility to rebut any presumption that the legislature might enjoy here. They have put forward declarations from doctors who perform these procedures day in and day out, both at hospitals and at clinics, and that's relevant particularly in distinction to the experts on the other side. So these are women who see patients like the ones we're talking about all the time every day and are intimately aware of the risks that these procedures pose, or more accurately, I suppose, the lack of risk that these procedures impose.

It is important to note, of course, that the evidence of the safety of these particular procedures is accumulating every single day because ten of thousands, if not hundreds of thousands of these procedures are being provided every single year, and that continues to this day.

These procedures are being provided in states across the country in outpatient clinics without evidence piling up of the risk of these procedures posed to women.

Of course Planned Parenthood has also established that the risk posed by these procedures is exactly the same --

THE COURT Slow down. What did you say again?

MS. OYCE Planned Parenthood has established that

the risk that these procedures pose is the same as in the miscarriage management setting as it is in the abortion setting, as Your Honor has pointed out, and that distinction, underscores the irrationality here of the line that the legislature has chosen to draw.

On the other side, when it comes to the legislature and their effort to rebut the evidence that Planned Parenthood has put forward, Your Honor asked a question about how many doctors they need to put forward to establish that they have rebutted that presumption, and the problem here, I don't think is the number of doctors, it is the qualifications of the doctors that they have shown on their side.

They have identified two doctors, neither of whom have ever performed these kinds of procedures in the context of an abortion, and the one who sometimes performs these procedures in the context of a miscarriage, performs them in a hospital, and thus is not qualified to speak on whether performing these procedures in a clinic poses risks to the mother.

Dr. Wubbenhorst in particular conceded in her deposition that out of the thousands and thousands of patients she has seen, she has never encountered one who suffered a major complication after undergoing one of these kinds of procedures, and that's consistent with the evidence that Planned Parenthood has put forward.

THE COURT Can you point me to that?

MS. OYCE Sure. In Dr. Wubbenhorst's deposition, it was on page 42 of the transcript, and it goes on for several paragraphs at length, clarifying that while she has seen a few such individuals internationally, she has never seen any in the United States, and certainly not in North Carolina.

THE COURT Go ahead.

MS. OYCE I was just getting to the percentages in terms of the complications, Your Honor.

Planned Parenthood has put forward both studies, whether the California Medicaid study or the National Academy of Engineering Science and Medicine study that both underscore that the risk of major complications here, even from second trimester abortion, is well under one percent, specifically in the range of .4 percent. So we're talking about an extremely small number of women who suffer any kind of major complications, and as Planned Parenthood's own personal evidence showed, the women who have suffered those kinds of complications have nevertheless been released from the hospital in stable condition after being successful transferred from a clinic like Planned Parenthood.

The question is not whether a legislature needs a certain number of doctors to rebut evidence. I think the question here is whether the doctors they have chosen have the qualifications or experience to rebut the evidence that Planned

Parenthood has put forward, or can point to any studies to undermine the evidence that Planned Parenthood has put forward, and they simply haven't. They have questioned whether there is underreporting in terms of the data of abortion complications, but to believe what they have to say would require you to believe that there are women undergoing abortion procedures and suffering major complications and hemorrhages across the county, and simply failing to be noticed or failing to be reported, and that just defies belief.

The reasons there are not studies to back up the idea that these abortion procedures are dangerous is, simply because they are not dangerous, and for that reason the legislature has failed to rebut the evidence that Planned Parenthood has put forward showing that this law bears no rational relationship to the stated government objective of protecting the life of the mother.

I'll touch briefly now, if I may, on the vagueness point that Your Honor has raised for the intrauterine documentation requirement. I think the law on this front poses a problem for several reasons.

The first of those is the one that Your Honor identified in your TRO order, and that is, that it does not make clear exactly what a doctor is to do in the event that it is impossible to confirm the existence of an intrauterine pregnancy via an ultrasound. The law does not make clear

whether it is sufficient to document that it is probably an intrauterine pregnancy, as Your Honor has pointed out through the language in the law, or whether simply being able to confirm that means that the doctor must stop right there and wait one or two weeks until the intrauterine pregnancy can be confirmed.

One other problem that the briefing in this case pointed out is, that the law is unclear as to the consequences of proceeding, and this is a separate point than the mens rea point, but the last time we were before Your Honor, you had a colloquy with counsel for the legislature leaders where you asked, what was the penalty, or what made it unlawful. Was it unlawful if you chose to proceed with an abortion even though as a doctor you could not confirm the existence of an intrauterine pregnancy?

I understood counsel for the legislature leaders to say there are no criminal penalties for doing this. You would suffer a civil penalty, but not a criminal penalty in the event that you proceeded with the abortion, and that is at page 49 and 50 of the transcript from the last hearing.

Now legislature leaders clearly say in their briefs before this Court at the PI stage, that there are criminal penalties for proceeding with an abortion in this context, but that just underscores, again, the problem with this law and the vagueness in terms of what exactly is unlawful conduct and what

happens in the event that you proceed. Are you simply subject to a civil penalty as Mr. Boyle seemed to suggest at the last hearing; or are you subject to criminal penalties as they say now. And if you are subject to criminal penalty, as Your Honor pointed out, what state of mind is necessary.

The law does not make that clear. It is unconstitutionally vague, and for that reason, it should either be construed to eliminate the vagueness problem or enjoined entirely.

I'll stop there, unless Your Honor has specific questions for the Attorney General.

THE COURT Thank you. For the intervenors.

MR. APTIST Good morning, Your Honor, Erik Baptist on behalf of the intervenors. I appreciate your questions and I'm going to try to make sure I address them all.

THE COURT Pull the mic a little closer to you. It's a beautiful courtroom, but you cannot hear, at least I cannot hear, and I know the court reporter cannot hear you.

MR. APTIST I represent the intervenors in this case, and appreciate your candid questions, and I want to make sure that I answer them completely, so forgive me if I miss one.

I want to start off with kind of a high level picture of this case where we stand today. We're here discussing plaintiffs' motion for preliminary injunction. The burden is

on plaintiff to show that they have a substantial likelihood of success on the merits. They have failed to meet that burden in particular on the success of the merits, and I want to talk about that briefly.

I originally was going to start with the IUP documentation requirement, but I think there is a general question about the rational basis, and I think I want to focus on that equal protection clause context and the Supreme Court cases that plaintiffs have cited in their brief, and kind of unpack it, because I think there are three different levels that we can talk about and try to make sense of what the Supreme Court has done and maybe sometimes we can't make complete sense of what the Court has done.

Generally, as you've seen from *Dobbs* and from our *Minnesota versus Glover Leaf Creamery* cases. There is a lot of deference given to the state legislature to enact laws, and under *Lee Optical*, there could be differences in treatment under the law. Where the court has taken an exception, if you will, and said, well, that general deference is true, but we need to have some separate -- sometimes there is more of a heightened scrutiny -- not heightened scrutiny, more of what I call sceptical or needing more scrutiny.

There are two separate cases cited by plaintiff in this case. I think one deals with the fundamental rights, and the other deals with animus.

The *Moreno* case, the *USA versus Moreno*, the limited legislature record that the Supreme Court looked at to determine that there was this animus involved, it had explicitly in the record that this law denied food stamps to certain households that had people who were not of the same family was to deny this government benefit to -- I'm going to use quotes from the Supreme Court here, "hippies, or hippy communes," and that raised the question with the court like, okay, that leads to more search and scrutiny. Did the rationale that the legislature purported in front of the court matched the statutory scheme, and that's what the court looked at.

Again, another case would be the *City of Cleburne*. That's again the one that we discussed here, and also in the plaintiffs' briefs. That case again was a city council that enacted a special ordinance that specifically discriminated against the mentally disabled and prevented them from having a group home, and what again was in the record was, that the city council made its decision based on irrational unsubstantiated fear of the mentally disabled. That simply could not pass muster, but the Court still went searching in their scrutiny of the ordinance to see if it actually met the justification reported by the city council. And they said, well, if you are worried about congestion or other problems associated with group homes, you would have addressed it more broadly than you

did here, and given the animus that you already demonstrated in the record, that's when the court set it aside.

The two other cases would be the case from Alaska, the *Moreno* case, and the *Hooper* case from New Mexico, and *Zobel* case from Alaska. Those were dealing with the fundamental right to travel, where they were discriminating against out of state citizens inferring benefits to long time residents and again, the court just looked at that, well, what are your justifications to discriminate, there may be purposes to do so retroactive since the State of Alaska to give benefits and money to your citizens, doesn't actually necessarily invite folks to come move to your state and maintain a residence.

The same with New Mexico, the way they designed the scheme was not actually going to incentivize folks to -- Vietnam Veterans in particular, to reside in New Mexico and maintain residence. As the court noted, someone could be born in New Mexico and not spend a day in New Mexico until after the war and come in within that time period, so that didn't justify the -- one of the justifications as well during the time you sacrificed by your time and services in the country in Vietnam, you were a resident of New Mexico, that was not a requirement, so the Court had more scrutiny in those cases.

So what the plaintiffs are doing is saying, well, yes, there is a line of cases that the intervenors have cited, whether it was *Dobbs* or *Lee Optical* or *Minnesota versus Glover*

Leaf Creamery, but when there is animus or a fundamental right, you have these other lines of cases.

I want to unpack it further. Even if you could go down to this level and search, because right now they have not actually submitted any evidence of animus in this case. I don't think we're dealing with a fundamental right anymore so, frankly, it would be inappropriate for the Court to do this searching analysis, but we're happy to invite that conversation.

THE COURT Okay. So you are saying that if there is no animus and no fundamental right, then you don't even have to have a rational basis. I presume a rational basis and there is no looking at it at all? That's what I hear you saying. If that's not so, then what does the rational basis test mean?

MR. APTIST I apologize, Your Honor, I didn't mean to interrupt you. No, that's not what we meant to say.

So rational basis still invites the Court to look at the justifications and make sure there is a rational basis, but if there is evidence before the Court from both sides showing that there was a legitimate government interest and this was irrationally connective, the legislation is rationally connected to that legitimate government interest, that should be sufficient enough, and so the plaintiffs say, well, you know, if you were concerned about maternal health or complications with regards to surgery overall, you would

require hospitalizations, not just for post-12-week surgical abortions, you would have done it for other types of surgeries and they submitted evidence.

I will point you to page 14 of Dr. Farris's declaration in support of their motion for preliminary injunction. That is located at ECF 49-1, page -- actually, page 15 of 39, but page 14 of her declaration. It highlights four different surgical procedures; vasectomy, colonoscopy, wisdom teeth extraction and tonsillectomy, and it talks about the complication rates or hospitalization rates for each of these, but they are missing the point, because complications are deferred in terms of severity --

THE COURT Complications, what?

MR. APTIST Complications have differences in terms of severity and timing of when they manifest and when you unpack the limited studies that they provide, it actually shows that this is not the real concern here. I'm happy -- I don't know if --

THE COURT I'm less concerned about that argument, I mean, than I am about some of their other arguments on the rational basis. I hear what you are saying about that. The legislature does not have to solve every single problem, you know, in its entirety when it acts. I mean, that is true.

You can tackle a problem, I think, generally speaking in categories, and I'm less concerned about evidence about

tonsillectomy and colonoscopies, than I am about some of their other arguments, but I hear what you are saying about that.

MR. APTIST I would submit to you, because that is important only because what is really important in this context and what the legislature is concerned about is many times, yes, Planned Parenthood performed these surgeries --

THE COURT Slow down.

MR. APTIST Many times Planned Parenthood could perform these surgeries in their outpatient facilities, as the record shows, and they have submitted data that show --

THE COURT Who has submitted data?

MR. APTIST I'm sorry, Planned Parenthood has. We submitted it as an exhibit to our supplemental brief where they had had hospital transfers from their facilities to emergency rooms and hospitals across North Carolina over the years.

So there is data, there is a hospital transfer rate, and if you look at the data based on what we have most recently for 2021, they actually have a hospital transfer rate of .52 percent.

THE COURT Where is that in the record?

MR. APTIST It is going to be a little bit of my math here, but it is based on our Exhibits 6 and 7 of our supplemental brief, ECF 75-6 and 75-7, which provides the total number of complications with surgical abortion after 12-weeks for 2020 through 2023.

I'm focusing on 2023 to date or at least what they submitted to us up to June, and then for the full year of 2022, that if you look at the total amount of surgeries that they have performed and how many hospital transfers they've had based on those post-12-weeks abortions, the hospital transfer rate is actually higher. They say in their brief --

THE COURT I'm having a little trouble following you. Can you just speak a little slower?

MR. APTIST Apologies, Your Honor.

THE COURT That's okay.

MR. APTIST So the concern here is the transfer is the inability of Planned Parenthood facilities to treat women who are suffering from severe complications immediately where they require a transfer in an ambulance to the hospital, to an emergency room to be treated and seen by a professional there.

What we're trying to do here is -- what I'm trying to do is breakdown what the hospital transfer rate is, why it is important compared to other surgical procedures, but there is a transfer rate in 2023 of .52 percent.

THE COURT Why is it okay to do the exact same procedures for a miscarriage in a clinic, when as I understand it, the exact same complications can arise? I hear what you are saying, you've got -- I think it is undisputed that there could be complications from these procedures, and occasionally somebody needs to go to the hospital as a result of these

procedures.

I hear what you are saying. I think that's undisputed, but I think it also is undisputed that it is the same if you do it for a miscarriage where the fetus is already dead, as for an abortion. If there is evidence that is inconsistent with that, if you would point that out to me, I would appreciate it.

MR. APTIST I'll just start with, the burden is on the plaintiffs to submit this evidence. I'm not aware of any party submitting evidence talking about the actual complication rate with regard specifically to miscarriage. I may be wrong on that, Your Honor.

THE COURT I agree with you, it is not detailed, but footnote seven, they pointed out it does say the complications are the same.

MR. APTIST The types of complications are the same. The rate in which they occur, I'm not sure is before this Court, but one thing I would note based on the limited information or evidence in this record is with regard to miscarriages, especially in the second trimester. My only understanding is that they are done in the hospital setting, so it doesn't require the legislature to actually mandate something that is already occurring.

What plaintiffs' witness --

THE COURT I'm sorry, say that again. I didn't -- I

thought right now they were doing abortion after 12-weeks in the clinic, and the whole thing that we're talking about is the requirement that after 12-weeks they have to be done at a hospital.

MR. APTIST I was talking about miscarriage management, not abortion. So, yes, right now I think plaintiffs have submitted evidence that says upwards of 97-percent of surgical abortions are -- or all abortions are performed outside of the hospital setting. The legislature saw that in particular with regards to post 12-week surgical abortions and said, for various reasons I will get into, wanted to have them performed in the hospital.

The only evidence we have right now before this Court about miscarriage management in the second trimester is that they are performed uniformly or typically in the hospital setting. My point is, the legislature --

THE COURT Where is that evidence?

MR. APTIST Dr. Wubbenhorst's deposition, it is submitted in full by plaintiffs at ECF 74-3, page 115, lines 15 through 25, wherein her experience in hospitals and elsewhere she has only treated these types of miscarriages in the hospital setting.

THE COURT That just has to do with her experience. Is she saying that's the only place they are done?

MR. APTIST That is essentially what she said in

her testimony in the deposition. I admit that it is not very clear in the back and forth with counsel, but that was the takeaway that I received.

But to that point, though, plaintiffs have not said -- this again is the burden on them, where they have to show that miscarriages for the second trimester are treated differently and they are actually performed 97-percent or even a significant percentage outside of the hospital setting.

The only evidence that we have now is Dr. Wubbenhorst's deposition, where she said in her experience -- yes, I know this is her experience and she can't speak for all doctors in the State of North Carolina, but she said based on her experience and her understanding, this occurs in the hospital setting, which makes sense.

So if the State legislature wanted to address a problem, the problem is the out of the hospital -- the outpatient facility by Planned Parenthood and other abortion providers do the same surgery, whereas miscarriage management in the second trimester is already done in the hospital.

To me, to say that they need to now require it is a solution in search of a problem. That problem does not exist in the miscarriage management situation. It does exist in the surgical abortion post-12-week context, and that was the specific area where the legislature looked to bring it into the hospital context, given the known amount of transfers that

occur from the abortion facility for post-12-week surgical abortions going to the hospital.

THE COURT Are these exhibits you pointed me to, 75-6 and 75-7, the hospitalization rate and complications rate, they distinguish based on gestational age?

MR. APTIST I'm sorry, I missed that citation.

THE COURT I was backing up to something you pointed me to earlier. The two exhibits that you submitted with your supplemental brief about the hospitalization rate and the complication right, which I think were Exhibit 6 and 7 on the docket 75-6 and 75-7. Are you saying those two exhibits distinguish between complication and hospitalization rate by gestational age?

MR. APTIST Correct, Your Honor. I apologize for my confusion there.

THE COURT I'm just making sure I understood you.

MR. APTIST So 75-6 is procedural abortion volume by gestational age. This was produced by plaintiff here in this case, and it is done by both facility and by gestational week, and it just gives you the volume numbers.

THE COURT It is done by facility, so you can look at that and tell whether they're post-12-weeks?

MR. APTIST There is an X access with would be the facility. The Y access goes down and tells you the week gestational age in its group by year, and then within each

grouping it goes 5-weeks, 5-weeks, and it goes all the way up to 21-weeks.

THE COURT And they have zeros in the post-12-weeks?

MR. APTIST It does.

THE COURT All zeros?

MR. APTIST I'm sorry -- well, no. So I was -- let me clarify, that was the raw numbers. It does have zeros for certain facilities, but some facilities do perform them after 14 weeks.

THE COURT Twelve weeks is what we are talking about. Twelve weeks is what the legislature has imposed as the hospitalization requirement, 12, right, not 14?

MR. APTIST Correct. Correct. Twelve is the minimum and then everything after that. So when complications arise anywhere between 12 and 20, that's what we are trying to capture here with that, and so I want to make sure I get my citations right, Your Honor, so your indulgence one second.

THE COURT Take your time.

MR. APTIST So, Your Honor, I apologize for that. If I can just correct the record so you can understand what -- I was right to represent that 75-6 is the procedural abortion by volume by gestational age.

THE COURT Slow down. Say it again.

MR. APTIST It is entitled procedural abortion volume by gestational age.

THE COURT Okay.

MR. APTIST And it will give you the breakdown at 12-weeks and up to 19-weeks of the raw numbers that Planned Parenthood has performed surgical abortions in this state, and then cross-reference that with ECF 74-12 that's entitled, post-12-week complications resulting in hospital transfer for the years 2020 through June of 2023, and that's where you can see from the raw numbers versus how many women have had to be transferred during those years and that is how I calculated for 2023 up through June at 5.2 percent hospital transfer rate for 2023, and then .41 percent hospital transfer rate for 2022.

THE COURT Okay. Would this -- whenever you get to a stopping point, let's take a short recess. Tell me when you hit a good point.

MR. APTIST I'm happy to stop now.

THE COURT Let's take a ten minute recess.

(Court was in recess from 11:28 a.m. 11:40.)

THE COURT Go ahead, Mr. Baptist.

MR. APTIST I want to pick up where we left off in comparing surgical abortions after the 12-weeks to -- I think you wanted to focus on miscarriage management and also home births.

I want to ask you, do you have anymore questions with regards to the comparison that we have in the record today with regard to miscarriage management post-12-weeks, or can I move

on to the other?

THE COURT I'm sorry, I thought you were about to address that. Maybe I misunderstood what you just said.

MR. APTIST I was comparing second trimester miscarriages in terms of what we have in the record today with Dr. Wubbenhorst's uncontested testimony that --

THE COURT Well, I haven't had time to go back and look at it, but I hear what you are saying, and I've written it all down.

MR. APTIST Okay. And then how the plaintiffs have not brought in any other testimony with regards to second trimester miscarriage management and where they are treated and the complication rate associated with that or hospital transfer rate.

THE COURT I understand that. I do have a question. You seem to be arguing that there are tiers of rational basis review. Has the Supreme Court ever said that? I mean, isn't rational basis?

MR. APTIST The Supreme Court has never said that, correct, Your Honor. There are law review articles out there that say there is rational basis and there is rational basis plus, and no one can really make sense of the laws, so this is my way -- I've not written a law review article on it.

THE COURT Thank you.

MR. APTIST If I were to do one now, I would say

that there is a separate tier analysis, or at least there are exceptions to the general rule. Maybe it is all part of the same analysis, Your Honor.

THE COURT Okay. Go ahead.

MR. APTIST The other part about home births versus post-12-week surgical abortions, I'm not aware -- and, Your Honor, I think you mentioned, and I want to make sure that I got your question right there. You said the health and safety risks to mom and child are significantly higher in that setting -- in the home setting. I'm not sure if that's in the record, or I'm not aware if there is anything like that.

THE COURT I think what I meant to say is, the health risks from childbirth are higher. Your evidence is that the health risks increase with gestational age. That, by definition, means that the risk of childbirth, which happens at the end of pregnancy after nine-plus months, are higher. I mean, women die from childbirth, and not just one or two women die, so I didn't mean to -- that is what I meant to say, that the risks of complications from childbirth are way higher than the risks of complications from a surgical abortion at 12-weeks, 13, 14-weeks. That's what I meant to say. And, is that not so?

MR. APTIST I would submit --

THE COURT I thought the evidence supported that.

MR. APTIST I would submit Dr. Wubbenhorst's

testimony on that issue, where she has testified if you control for gestational age, there is a correlation for both live birth or miscarriages for a nonaborative outcome, let's say. If you control for that, you will see that there is actually a difference in terms of maternal health outcomes.

THE COURT Where is that?

MR. APTIST I will tell you that in a second.

THE COURT But if gestational age doesn't matter, then why do you require surgical abortions after 12-weeks and not before 12-weeks? Well, address both of those things. I didn't mean to ask you another question before you answered the first one.

MR. APTIST I'm sorry, Your Honor, gestational age is crucially important. That's what I was trying to say.

THE COURT I thought you said that the doctor said if you controlled for it, which means if you take it out of the equation, doesn't it? Isn't that what it means?

MR. APTIST Maybe I'm using the word "control" wrong, but when you take into account gestational age, how about that.

THE COURT Okay.

MR. APTIST I apologize for my terminology. When you take into account for gestational age, then it actually shows that at first there is a, I think, comparable risk to mother, both in the abortive context, and then to the mother

who is going to have a live birth, and then at some point it exceeds -- the surgical abortion risks exceed that of live childbirth.

THE COURT Where is that?

MR. APTIST That's in her deposition, and I'm going to try to pull that up real quickly.

THE COURT So you are saying that she said that the risks of complications are higher for an abortion at 13-weeks than they are for full-term childbirth?

MR. APTIST No. Just in case -- I'm sorry.

THE COURT That's what I thought you said.

MR. APTIST She said we are comparing apples and oranges when comparing an abortion at 6-weeks, let's say, versus a live childbirth, and that is where she starts the conversation.

THE COURT Let me give you a minute to find it before -- I apologize for continuing to ask you questions while you are looking for the evidence.

MR. APTIST Your Honor, apologies for that delay. It is going to be document 65-1, Dr. Wubbenhorst's declaration in support of intervenors' response in opposition to the motion for preliminary injunction.

THE COURT What page?

MR. APTIST Point you to page 31 of 81.

THE COURT Go ahead.

MR. APTIST It starts with paragraph 179 and 180, and she says, "Comparisons without regard to gestational age are flawed, in particular, because death during the first 6-weeks of pregnancy when the maternal morbidity and mortality are highest are classified as maternal deaths and placed together with deaths due to birth and delivery." She says, "this is inappropriate since" --

THE COURT Slow down. What?

MR. APTIST She says, "this is inappropriate since the intended outcomes are unknown. Women who reach the common point of awareness of pregnancy make a decision to abort, which 6-six-to- 8-weeks gestation, have already survived beyond the period of pregnancy's greatest risk."

THE COURT Risks to the unborn -- whether you want to call it fetus, child, whatever you want to call it, that's not talking about maternal risk, right? I'm not following what you are saying.

I thought we were talking about pregnancy after 12-weeks, not for 6-weeks, and abortion, surgical abortions after 12-weeks, not the first six weeks. I'm not following what you are saying and how it relates to the question.

MR. APTIST I guess generally, I think -- the general point, is it is more dangerous to have a surgical abortion or is it more dangerous to have a live birth. She questions the studies or how they come to that conclusion,

because they are comparing different outcomes at different gestational ages, and if you say for control gestational ages, like, let's say an abortion at 12-weeks and a miscarriage at 12-weeks that will have a different outcome than what has been represented by the plaintiffs.

THE COURT That's what you are saying she says at docket 65-1, page 31?

MR. APTIST Correct, Your Honor. Page 31 of 81 and it goes on to the next page and then she cites a series of studies there to support her opinion or conclusion on this, but I want to bring you back to her -- back to the declaration earlier on, on page seven where she talks about the mortality rate.

THE COURT This is her declaration, not her deposition?

MR. APTIST Correct, Your Honor, 65-1 is her declaration.

THE COURT Hold on just a second. Let me get it up, because I'm -- I might have an easier time following what you are telling me. All right.

MR. APTIST It is page eight of 81.

THE COURT Page eight?

MR. APTIST Correct, Your Honor.

THE COURT I thought you said 31.

MR. APTIST Page eight.

THE COURT Back off from that mic a little.

MR. APTIST The top says seven, but it is really page eight of 81 of the PDF.

THE COURT Which paragraph?

MR. APTIST It starts with paragraph 39 where she proceeds to go systematically down through the studies, citing Kates and Grimes from 1981. That cite talks about the increase of maternal mortality with regards to D&Es from 13 to 15-weeks, and than greater than 16 weeks, and then she talks about the Zane study in paragraph 42 --

THE COURT I think it is undisputed that the risks increase with gestational age, right? I didn't hear any disagreement -- there is a disagreement about how much they increase, how serious the risks are, et cetera, but they agree on that point, right?

MR. APTIST Correct, Your Honor.

THE COURT So what does this say beyond that?

MR. APTIST I guess, Your Honor, I'm going to try to maybe get above where I am at right now, because I think I'm in the weeds too much.

Can I just assert back to the home births, at least we don't have any record evidence that show home births are worse for paternal health versus hospitals, and I think -- I can't testify today, but I think I would submit that we will provide more evidence on that fact that it may actually be

better for maternal health to be at the home versus in the hospital. It may not be the same for the fetal outcome and the baby's health outcome, but we don't have that in the record today, so I don't mean to posit that today, but at the same time, the plaintiffs have not submitted such evidence, either. That's my point.

So again, why did the legislature focus on post 12-week surgical abortion, because it was a known problem where there were women being transferred to the hospital at a significant rate, and I will have to note that I think Planned Parenthood would concede they are not the only abortion provider in the state. I think they represent, based on their numbers, maybe 29 percent of all abortions in the most recent comprehensive year 2021.

I can tell you how I get that math, if you would like, but that is -- again, we have to look at the totality, not just their hospital transfers, but everybody else's hospital transfers as well.

Again, at the PI stage, the burden is on the plaintiffs to prove their case. They made the allegation that miscarriage management and live births are not required to be in the hospital setting. I think the only record evidence shows that we have is for second trimester miscarriage management surgeries. Those are already performed in the hospital, so the legislature did not need to require such an

action because it is already occurring for home births. By definition, they are occurring at home and not in the hospital, and we simple don't have any data except for the general proposition that they cited about the maternal mortality rate for surgical abortions versus live births, but we don't have anything with regards to post-12-week second trimester home births, let's say -- I'm sorry, I should just say full term live births.

So I guess at this point we don't have the evidence and the plaintiffs have not met their burden to show it was irrational for the State to focus only on post-12-week surgical abortions.

THE COURT Can I ask you a more general question? The plaintiffs say that regulation of abortion should be in terms of a rational basis test, should be treated the same as any other health and safety statute or regulation.

Do you agree with that?

MR. APTIST Yes, Your Honor.

THE COURT Okay. Go ahead.

MR. APTIST I'm going to address your first question on standing. I know this was mainly for the plaintiffs, but it seems, just listening to the plaintiffs, I don't think they set forth their affirmative case for their primary standing. I think they are hinging their standing on their third-party patients, or at least they are representing

that's how they are establishing standing.

I think the core point is to remember they have not asserted any economic harm in this case. I think they specifically disavowed economic or financial harm where that is usually in the abortion context. That's kind of the obvious harm that could be assumed, but we can't assume that here, so they really rely on third-party harm in this context.

THE COURT Economic harm is -- you are saying that's usually asserted by healthcare providers?

MR. APTIST If they are the direct object of a regulation of a law, then they are being burdened by some regulation or requirement.

THE COURT In the abortion context, I have never heard an economic argument. It has always been on behalf of patients.

MR. APTIST It is usually both, and that's usually -- I think if you go back and look at June Medical, there is a discussion in that case about the harms to the doctors having to go get admitting privileges. I believe that was the issue in that case. But, again, that's -- the focus was really primarily, and in this case, too, the patients and the women who come to them, but here they have specifically disavowed any economic harm, at least to us, and so I think they're relying on this third-party standing argument, and for medication abortion, I think that's different than surgical

abortion, and they have to establish a close relationship with their patients.

Again, I'm not aware of any actual assertions that they have developed such as a close relationship. That's one of the requirements for third-party standing. I understand there is a lot of precedent in this context where abortion providers can represent their patients, but they still need to establish their standing and how they get those close relationships.

I will point to you a case that neither party has cited to date, but it may be helpful for your consideration within this circuit from a different court. It is the *American Colleges of Obstetricians and Gynecologists versus United States Food and Drug Administration*. It is from the District Court in Maryland. It is found at 472 F. Supp. 38, 183, because the defendants in that case actually raised the same argument that we've raised here, where they said there is no establishment of a close relationship, and the Court went on and said, well, we're not sure if you need to do that, given the prior case law, but here we think there is enough, and the court did its searching of the record and the declarations to find that third-party standing, in particular that close relationship --

THE COURT Wait. I'm trying to understand your point. Before you get into what you said at the very, very

beginning, you're saying you have to establish standing for each challenge. Okay, I understand that. So you have to show third-party standing for the intrauterine pregnancy. I don't know if it is documentation requirement or determination requirement. We'll talk about that, I'm sure in a minute. And separately for the hospitalization requirement, and are you challenging both of those or only the intrauterine pregnancy requirement, which is the medication abortion provision?

MR. APTIST We're challenging standing as to each of those claims.

THE COURT What is your point about that, about how it has to be looked at differently and third-party, which is the one you were saying?

MR. APTIST American College of Obstetricians and Gynecologists, it's called the ACOG case, that deals with a challenge to the FDA's regulation that Mifepristone, or chemical abortion drugs, and they challenged the FDA requirements or prevention of doing telemed during the COVID pandemic.

The defendants in that case, the FDA, alleged that you haven't established a close relationship in the medication context. All of the other cases to date, have focused on the surgical abortion context.

THE COURT Don't you have to have a prescription from a healthcare provider to get a medication abortion?

MR. APTIST Correct, Your Honor.

THE COURT A doctor can't prescribe it if they don't meet the statutory requirements, which according to you, are that you actually determine that there is an intrauterine pregnancy, and that's contrary to current medical practice, but the plaintiffs have offered pretty compelling evidence, so that means that women are not going to be able to get an abortion between five and six weeks of gestational age, medication abortion, and they can get it now. They are going to have to wait, the legislature says, until seven weeks, when it can be determined that there is an intrauterine pregnancy. So why is that not standing, because you are basically prohibiting medication abortions until six or seven weeks.

Right or wrong?

MR. APTIST To answer that question, in effect, it would prohibit, I think, medication abortions, at least until five and six weeks. You typically can find a location of a pregnancy at that point, but in fact, that would happen.

What we're challenging is there is a different relationship. Planned Parenthood, their witnesses have said the doctors don't meet with the patients before giving the drugs, it is somebody else, a staff member who meets with them and goes over the informed consent documents, and it is a different type of relationship in terms of surgeries, and it obviously is invasive, it is more comprehensive and there is

necessarily a doctor involved.

There is no established ongoing relationship with medication abortion, and so I point to this case because this case did find a close relationship. The ACOG case against the FDA from the District of Maryland, but how that court --

THE COURT Where is it in the evidence that the doctor doesn't meet with the patient?

MR. APTIST That is supplied in our supplemental brief, which I'll give you the exact -- it is attached as an exhibit. It is Exhibit 2 to our supplemental brief, the Farris deposition, page 78, lines 12 through 22.

THE COURT Okay. Go ahead.

MR. APTIST And so in this other case, this ACOG case, the Court found that plaintiffs had provided specific evidence of close patient/physician relationships, including between one of the doctors and her patients, but it was based on the declaration where the doctor said she sees many patients -- she has patients whom she sees regularly, and then she had one patient in particular who was a recurrent patient, a longtime patient who could not obtain a medication abortion because of the FDA's restrictions on telemedicine at the time, and that's why the court established that you have an ongoing relationship with a patient, you have -- that was established here, where they come and see the doctor on a regular basis.

THE COURT So an emergency room doctor could never,

never challenge a state regulation on behalf of patients because there is no ongoing relationship? I don't know, the State -- whatever they do, it requires something for emergency room procedures, and you're saying that the emergency room doctor could never establish standing because they have no ongoing relationship with the patient?

MR. APTIST No. I distinguish between surgical and just kind of I would argue more the pharmacist/patient relationship. So the emergency room doctor, I'm going to presume, is doing some type of emergency surgery, let's say.

THE COURT Well, maybe not. Let's say prescribing something. Emergency room docs can't give -- I don't know, imagine the legislature said emergency room doctors can't give antibiotics. I don't know why they would say that, but what if they say that, or you can't give a particular medicine, emergency room doctor, only specialists can give this particular medicine, and you are saying the emergency room doctor could not challenge that because they don't have an ongoing relationship?

MR. APTIST I think it is the intimacy of the relationship and the nature of the medication.

THE COURT It is hard to get more intimate than an abortion request, is it not?

MR. APTIST Understood, Your Honor. But that request is usually funneled through a staffer as opposed to the

doctor, and the doctor is writing a prescription here, but not having that relationship -- let's say in the emergency room context that you said, the antibiotics. Literally the doctor comes in and hands antibiotics based on a test result that shows there is an infection. I would submit that may not be sufficient to establish -- that alone would not necessarily be enough to establish --

THE COURT What is your authority for that beyond this District of Maryland case?

MR. APTIST There is no authority. This is unprecedented territory in terms of medication abortion, and I would note for other reasons the Supreme Court kind of overruled the district court, but not based on standing reasons, but I flagged this as one of our reasons why we think they don't -- we say have not established that.

So again, on the plaintiffs at this stage to, one, prove standing, but also to show that it is highly substantial that they have standing here, and they submitted no evidence establishing such a close relationship, that is a requirement to have third-party standing. Based on what we have seen to date, they do not have such a relationship.

They may develop the record later on that shows that they do have that close relationship, but what we have seen through discovery and deposition shows that there is not this ongoing or immediate serious long, even a ten minute, 15 minute

conversation with the doctor. It seems to be it is going to be with a staffer who may not be trained as a medical professional, and then the doctor gives the drugs, that's just a moment. That's not an intimate relationship where the patient is truly sharing her thoughts and other concerns or getting that informed consent to share or talk about the risks and benefits of what she is seeking that you normally see in the doctor/patient relationship.

THE COURT Okay. I'm just thinking about nurse practitioners and PAs, then you would say -- I mean, those people prescribe medicine all of the time and you would say -- so a doctor would have no standing to challenge any regulations about medicines being prescribed by PAs or nurse practitioners? I just -- you know, we're here talking about abortion, which is highly politicized, but this is about regulation of medical care and so, you know, you can't just talk about it in terms of abortion, because how does it apply to the rest of the medical world? I'm asking, because it seems important.

MR. APTIST I think the line I would draw is with formal medical education, so a medical professional these days is a broader term. It is not just doctors any more, as you recognize, and I think nurse practitioners, PAs, nurses. If you were having that conversation and getting an informed consent with them, the doctor gives you the drugs. That's a different situation.

Here, there is no evidence that any of those people are meeting with the woman before she gets the drugs, and so I take your point, Your Honor. This is precedential outside of the abortion context and not trying to overreach here.

THE COURT I'm not accusing you of that. I'm just trying to make sure I'm thinking through it, because it is -- the legislature is accused of practicing medicine, you know, people -- that's one of the arguments here implicit in the plaintiffs' briefing, and -- how does that play into it?

It is a big question, because the legislature is not made up of trained medical professionals, yet they are authorized to regulate the practice of medicine, that's clear. So I'm just trying to figure out the test.

MR. APTIST They do receive input during the legislature process and meet with people who are medical professionals who can provide their opinions and obviously disagree in opinions.

I'll quickly move to third-party standing for the second claim, the hospitalization requirement. I understand that Dr. Farris says she historically has seen women, or maybe Dr. Gray has said that she had seen women who have been referred to hospitals -- from hospitals for babies with life limiting fetal anomalies or for the other situations post-12-weeks. That has not been the case since this law went into effect, based on, again, the plaintiffs's own evidence.

They have not seen a single patient under the limited exceptions since the new law went into effect in June, at least partially went into effect in June, so we again just question whether they actually have those women who seek those services since the new law went in effect, but we raise the question, have they met their burden at this point. They may end up showing that, but they haven't established it to date.

THE COURT Okay.

MR. APTIST I'm going to move back to the IUP documentation. I know Your Honor has some questions about those, and I want to address those now. I don't think I need to go over our interpretation in terms of just there is this general provision that says --

THE COURT I mean, your interpretation is, we're not really even talking about a documentation requirement because, I mean, we're talking about a determination requirement. They have to determine gestational age and write it down and they have to determine -- or probable gestational age, and they have to determine either intrauterine location or probable intrauterine location and write it down. So unless -- I'm not concerned about the writing it down part.

I think what my concern is about is the determination part of it. What do they have to determine and what are the penalties if they don't do that?

MR. APTIST What they have to determine is -- well,

Your Honor asked whether it is probable or an actual intrauterine pregnancy, and you raised a good question, and we read it to mean an intrauterine pregnancy, but your reading of the statute we would not oppose, either. I think it is -- it could lend itself to that, but either way, it would exclude a pregnancy of unknown location, because I don't think a doctor can document or determine probable or actual intrauterine pregnancies based on anything but an ultrasound or -- because I think the serial blood testing that Planned Parenthood performs doesn't get you to the probable or actual intrauterine pregnancy determination, and so that's the requirement as we see it under the law that you need to determine.

I think that's right, you need to determine whether an ectopic pregnancy exists or can you exclude it, and if you can't, you can't actually document it.

THE COURT So the woman has to wait a week, two weeks, and in the meantime, if it's ectopic, which is the only reason you've offered as justifying this requirement, which I mean I understand, you don't want -- if somebody has an ectopic pregnancy, that's a serious matter, but there is nothing -- they just wait for two weeks and no requirement for any sort of treatment for ectopic pregnancy or further referral and then they come back.

MR. APTIST I think that's not quite right in the sense of if there is a pregnancy of unknown location, whether

under Planned Parenthood's protocol or doctors who submitted their declarations in support of this case, if you have a pregnancy of unknown location, you are going, I would argue, to be suspecting or thinking this may be ectopic.

THE COURT You are saying if a woman goes to the doctor and she says, I'm pregnant, she doesn't want an abortion, at six weeks, you're saying -- at five weeks, six weeks, eight, they would do an ultrasound and treat her as an expected ectopic pregnancy, if there weren't an abortion involved?

MR. APTIST Your Honor, I want to make sure I understand your term "treat," and I think treat for an ectopic pregnancy or just treat it as it may be an ectopic pregnancy.

THE COURT I'm asking you. I mean, you're -- the legislature is the one regulating this. I'm trying to understand exactly what it is that you are saying.

MR. APTIST Correct, Your Honor. Doctors would -- if a woman comes in at five or six weeks and says, I'm pregnant, can you show me where the baby is, or I want to see if it is healthy and the doctor is like, I can't find it, under the normal course of business, the doctor would closely monitor and continue to communicate with that woman and have her come back in the following week.

THE COURT All the evidence is that's what Planned Parenthood does.

MR. APTIST Correct, Your Honor. They have her come in multiple times, I think up to four times to do the serial blood testing and maybe eventually refer her to the emergency room for a suspected or known ectopic pregnancy.

The problem is what the State was trying to address is the overlapping symptoms with an ectopic -- ruptured ectopic pregnancy and the normal expected complications, or I should not say complications, the effects of a medication abortion, because I think their witnesses have testified, too, that there are overlapping symptoms, and there is evidence in the record that women have actually died, at least two women have died because their ectopic pregnancy was not identified and they were still given the Mifepristone or medication abortion drugs, and almost a hundred of them have actually ended up with severe adverse events reported to the FDA.

THE COURT From the ectopic pregnancy?

MR. APTIST Because they were given the drugs and had to go to the hospital because of that. If it was identified as an ectopic pregnancy, they would have been treated.

THE COURT But it wouldn't have been. If they couldn't tell, if it was unknown, they would do -- the law requires them to do nothing, the healthcare provider. It says -- it just says they can't give them the abortion medicine. It does not require them to do anything else. It

doesn't say they have to do anything to determine if it is ectopic or anything else. It just says if you still want an abortion in a couple of weeks, come back. Right?

MR. APTIST Correct. There is nothing that obligates the abortion provider to do something or anything else.

THE COURT If she has an ectopic pregnancy, it still might rupture. It still -- I mean, the complication is from the ectopic pregnancy, right?

MR. APTIST Yes.

THE COURT Not from the abortion medicine and not from the treatment that she gets associated with the provision of that medicine. Am I right about that?

MR. APTIST Correct. We concede that Mifepristone doesn't do anything to aggravate an ectopic pregnancy, but the concern is, and I'll go back to the FDA label, because I know you wanted to talk about this, too, and how we represented what the FDA has done.

I think there are two parts to that label. One would be the contraindications on that where it says, a confirmed or suspected ectopic pregnancy or undiagnosed -- it is pronounced an axial mass. Those are reasons why not to give the drugs to the women at that time.

THE COURT But they don't give them in that situation.

MR. APTIST Correct, Your Honor, but there is also the warnings and precautions section right below the contraindications and that says, "ectopic pregnancy: exclude before treatment," and that is a concern of the FDA's, that they think it is important enough you have to exclude before giving these drugs, not that it just has to be monitored. It is just, don't give them the drugs and we can see why you look at part four, I'll turn to the page and tell you which one that is.

Yes, it says, "confirmed or suspected ectopic pregnancy will not be effective to terminate an ectopic pregnancy." We don't disagree with that, but there is --

THE COURT And where does it say, "exclude ectopic pregnancy before giving the medicine."?

MR. APTIST That's not the contraindications. It is back on the warnings and precautions on page one.

THE COURT Okay.

MR. APTIST Of the document, and that's where it says, "Ectopic pregnancy: Exclude before treatment."

THE COURT That's on page one of -- which document is that?

MR. APTIST This is the FDA label. It is Exhibit 2 to our opposition brief. I'll give you the ECF number in a second.

THE COURT 65-2.

MR. APTIST Correct, Your Honor.

THE COURT At page one, right?

MR. APTIST Yes, Your Honor.

THE COURT Okay. Thank you.

MR. APTIST Going to that, it cites on that warning, it says 5.4.

THE COURT I'm sorry, it says what?

MR. APTIST 5.4, so that means to go to 5.4 of the label, so --

THE COURT Were you looking at the first page? You are saying the first page refers you to Section 5.4?

MR. APTIST Correct, Your Honor. Right after it, it says, exclude before treatment, it has in a parenthetical 5.4, that means you refer to 5.4 or Section 5.4 of this label, and that's where it talks about Mifepristone being contraindicated for confirmed or suspected ectopic pregnancies, but then the next sentence admonishes the healthcare providers to remain alert to the possibility that a patient who is undergoing a medical abortion could have an undiagnosed ectopic pregnancy because some of the expected symptoms experienced with a medical abortion; abdominal pain, uterine bleeding may be similar to those of a ruptured ectopic pregnancy. So that's what the FDA's concern was.

This is directly linked to the exclude before treatment provision, because there are serious risks and known

deaths associated with it, and that's why --

THE COURT With ectopic pregnancies?

MR. APTIST With the missed ectopic pregnancies using ruptures with the normal symptoms of Mifepristone.

I will point you --

THE COURT And your evidence on that is the label, or have you presented other evidence of that?

MR. APTIST Yes, Your Honor, we have. The label is the primary evidence. The FDA made this determination.

Secondly, Dr. Wubbenhorst's declaration at ECF 65-1, page 18 of 81, that provides the FDA -- this is -- again, she cut-and-paste from the FDA their adverse events and known deaths associated with medical abortion, and she identified at least two women who have died from a ruptured ectopic pregnancy after taking these drugs, and at least 97 women had severe adverse reactions and needed to be treated for an ectopic pregnancy after taking these drugs.

I would submit to you that this is the reason why the FDA included such a requirement is, because this is a known issue and concern of the FDA.

THE COURT But they still have that. They still have the ruptured ectopic pregnancy, if the law goes into effect. Right?

MR. APTIST Correct, Your Honor. They would still have an ectopic pregnancy.

THE COURT And so they still die? I mean, if those two women -- I'm trying to understand what you are saying about this, because under the law, you got to get the medication abortion and they say come back in a week or two, and if it is ectopic and if it ruptures -- I mean, or are you saying something different from that? I'm just trying to -- I'm trying to be sure I completely understand what you are saying.

MR. APTIST No. So say you have a pregnancy, you come in and you want to have an abortion and say -- they say, well, we don't know where it is. Let's say it is ectopic, but it was a pregnancy of unknown location, then the woman should be continued to be screened for this, not given the drugs, because she may manifest symptoms of a rupture that she will confuse for symptoms of Mifepristone.

THE COURT So you are saying if she is given the drugs, that's where the problem arises, because she could confuse the symptoms?

MR. APTIST Correct, Your Honor. And the concern is, that if she's experiencing these symptoms, she may not realize that it is a ruptured ectopic pregnancy. Instead, she may think it may actually be just the normal symptoms of abdominal pain associated with Mifepristone that she was counseled on during the informed consent part of it.

I do want to recognize --

THE COURT I've caught up with you, I think.

MR. APTIST I just want to make sure, because I don't want plaintiffs to think that I'm misrepresenting anything, because they do get counseled to be aware of ectopic pregnancies, so I'm not trying to say they don't give that counseling, but I want to make sure that would be the case with that, and so I will point you to *Lee Optical* where it talks about general --

THE COURT Is there a requirement that if they don't give the medication, that they counsel about ectopic pregnancy? There is no requirement that they do that, right?

MR. APTIST Correct, Your Honor. Not in the North Carolina law.

THE COURT Yes, in the North Carolina law.

Go ahead.

MR. APTIST One in 50 pregnancies are ectopic, that's about two percent.

THE COURT Where is that in the record?

MR. APTIST That is in two different locations, Dr. Banes's declaration at 65-3, paragraph 58, that is page 27 of 45, which she cited an ACOG --

THE COURT That's all right. You directed my attention. I'll go look. They may not dispute that.

Go ahead.

MR. APTIST I guess Dr. Farris, at page 113 of her deposition, which is attached to plaintiffs' supplemental brief

at 74-2, page 113, lines 14 through 25, where she agrees with the same data that shows that ruptured ectopic pregnancies account for about 2.7 of all pregnancy related deaths.

THE COURT That's not the one out of 50 number?

MR. APTIST Correct. That would be at page 112, lines seven and eight, where she says up to two percent of pregnancies are ectopic pregnancies.

THE COURT Okay. Go ahead.

MR. APTIST So understand that the majority of women do not have this life-threatening condition. I think everybody agrees that it is a life-threatening condition, but under *Lee Optical*, it is well within the purview of the General Assembly to balance the advantages and disadvantages of this requirement as *Lee Optical* held, as recognizing that some requirements may or may not be necessary in every case, but it if it is necessary in some of the cases, that is well within the jurisdiction of the State General Assembly to weigh the pros and cons and cause and benefits of such a requirement, and that's what the State did.

THE COURT You are saying -- and I understand your argument about how abortions are legal up to 12-weeks, your argument subject to the other provisions of the statute, so I completely understood that, but basically what you are saying is, medication abortions are illegal up to the point where you can see the location of the pregnancy and that it is in the

uterus, which is going to be at least five or six weeks.

MR. APTIST Your Honor, that's the practical effect of the law, yes.

THE COURT Go ahead.

MR. APTIST If you don't have any other questions with regard to the IUP documentation requirement --

THE COURT I do want to know about the scienter requirement.

MR. APTIST Sure, Your Honor. I'll address that with the penalty for failing to comply with the IUP documentation requirement. It is not criminal. The penalty is focused on disciplinary actions of the medical board within the state, and I can find that statute, Section 90-21.88A.

THE COURT 88A?

MR. APTIST Correct, Your Honor. That is the provision that says a physician who violates any provisions of this article shall be subject to discipline by the North Carolina Medical Board under GS 90-14n(a)(2), and so that would be the consequence for failing to violate this provision.

THE COURT Violating it means they failed to write it down or they failed to determine it or they give the medicine even though they can't tell? What do you mean by "violating"?

MR. APTIST It is not intended to be a paperwork violation. It is intended to be, you failed to do the actual

determination and, again, this goes back to the board where it talks about the board can subject you to discipline, but realize, like, you did the work, but you failed to document the location because you have the ultrasound paperwork or just the documentation there but you didn't check the box, then you're not going to, you know, be held liable, but at the same time, if you knowingly failed to comply with the law to determine gestational age, that would be where the evaluation would occur.

THE COURT That would subject you to discipline?

MR. APTIST Correct, Your Honor.

THE COURT So if the doctor couldn't tell, wrote down that they couldn't tell and gave the medicine any way, there is no criminal penalty for that?

MR. APTIST That is my understanding.

THE COURT Can you explain that to me exactly? Walk me through the statute on that. You cited 21.88A, and it is --

MR. APTIST A violation of this article.

THE COURT And the article --

MR. APTIST The Article is 1-I. That's the kind of the abortion-related all encompassing article that deals with all of the provisions at issue in this case.

THE COURT Okay. All right.

Go ahead.

MR. APTIST Thank you, Your Honor. I just want to

make sure I've covered what you were wanting to talk about.

Your Honor, I think unless you have any further questions --

MR. OYLE If I can have one second, Your Honor.

(Counsel confer.)

MR. APTIST Your Honor, I guess two points I want to raise in the evidentiary record here as well. One is, Dr. Farris's deposition, which you can find at 74-2, page 158, where she is being questioned by my co-counsel about the opinions to give a woman an ultrasound to determine gestational age, and I don't know if you would like me to kind of talk about the colloquy that was here, but the short --

THE COURT Tell me why you want me to read that page.

MR. APTIST Okay. She concludes that the option of waiting for an ultrasound to determine the location of an intrauterine pregnancy is reasonably safe and effective. That is found actually on the next page, so page 159 of the deposition transcript, lines 17 through 20, or the ECF filing page 160 of 174. I just want to make sure you have that line.

THE COURT That's all on page 158?

MR. APTIST The question begins on page 158 and continues to 159.

THE COURT I got you. Thank you.

I did want to ask you, I'm not sure about this

language in the Greenville Woman's Clinic case that I think you all cited. There, that case talked about distinguishing between abortion services and other medical services because of the particular gravitas of the decision, but I can't remember what they were regulating in that one, but you're not relying on that here. You cited it, but I think you told me earlier, that it is just maternal safety and health that you are relying on here as the governmental interest.

MR. APTIST Correct, Your Honor, we're relying on maternal health here, not only fetal life in this situation.

THE COURT All right. And not on a difference between abortion and anything else because you already told me earlier it is the same test for abortion here as in this case, for abortion and any other medical service.

MR. APTIST Under the rational basis test, it is going to be treated the same, yes, Your Honor.

Do you have any other questions, Your Honor?

THE COURT I do think you've addressed everything. I think you probably have. Okay. Thank you.

Rebuttal for the plaintiff.

MS. SWANSON Thank you, Your Honor. I will make this brief, I hope.

First, I want to be clear that animus is not a required element of a successful rational basis challenge. It is just not a sufficient government justification for a law

that is challenged under rational basis standard.

The *Moreno* case is clear, that animus is an insufficient justification, but it is not a mandatory showing. The intervenors said that the *Hooper* case is a heightened scrutiny case, and that's not true.

At 472 U.S. on page 618, the Court says, "If the statutory scheme cannot pass even the minimum rationality test, our inquiry ends," and that's the inquiry they proceed to do in *Hooper*.

So they are not applying any sort of rational basis plus based on an allegation of animus, and of course in *Hooper*, in the *St. Joseph Abbey* case, the Court found that the challenge restrictions failed rational basis, even though there was no showing of animus against, on the one hand, Vietnam Veterans, or in *St. Joseph Abbey* case against the monks who were selling caskets.

We don't have to show animus in order to prevail in a rational basis case, even though there is evidence of animus here. We win because --

THE COURT What is your evidence of animus and who is the animus against?

MS. SWANSON The animus is against abortion providers as compared to providers of other medical care. On this point, I want to be clear, for the purposes of the standing inquiry, both our vagueness challenge to the IUP

documentation requirement and our equal protection challenge to the hospitalization requirement, both claims are brought in a first party standing basis.

We also assert the hospitalization requirement and an equal protection violation and a substantive due process violation on behalf of plaintiffs' patients, but both claims are asserted on behalf of the plaintiffs themselves, so we don't even have to get into the third-party standing inquiry, even though as we discussed --

THE COURT What is your harm?

MS. SWANSON The harm is that the plaintiffs are regulated and stand to risk criminal penalties and professional licensing penalties if they provide this healthcare. That is, you know, the *Craig v Boren* case that was a third-party standing case, but I think this is certainly sufficient under *Lujan*, under the third-party -- I'm sorry, under the Article III traditional standing test, but the risk that the challenge provisions will be enforced against the plaintiffs gives them injury, causation and redress-ability. These provisions are enjoined. They don't face the risk of criminal or professional penalties.

THE COURT Okay.

MS. SWANSON The intervenors said there is no evidence in the record that miscarriage management is performed on an outpatient basis. That's not true. Dr. Farris's

declaration, this is ECF 49-1, in paragraphs 8, 24, 28, 40, and 41, she explains that Planned Parenthood South Atlantic provides miscarriage management using the aspiration procedure up to 14-weeks of pregnancy and using the D&E procedure in the second trimester, and in paragraph 41, she also says that because of the way the hospitalization requirement applies to procedural abortion but not to the same procedures for miscarriage management, the plaintiffs could even treat complications from an abortion provided in a hospital or for miscarriage management provided in a hospital in their Planned Parenthood outpatient clinics. That's paragraph 41.

There is evidence in the record that miscarriage management is currently being performed on an outpatient basis in North Carolina.

As to the hospital transfer rate, there was some discussion of what the exact percentage of Planned Parenthood South Atlantic's hospital transfer rate is, and that rate -- we ran the math, and it is 0.08 percent of the abortions that Planned Parenthood provided between January 1st, 2020 and June 30, 2023, resulted in hospital transfer.

THE COURT You get that from?

MS. SWANSON That is from Dr. Farris's rebuttal declaration which is docket entry 69-2, and paragraph eight where she says that Planned Parenthood provided 38,795 abortions in North Carolina in those dates.

She explains that only 522 complications resulted, most of which were minor. This is also in the record as it is Exhibit 12 to Plaintiffs's Supplemental Brief, so it would be docket entry 74-12, as well as docket entry 74-13 and 14.

Docket entry 13 is the one that has the complication -- the total number of complications which was 522 out of 38,795 total abortions, and then docket entries 74-12 and 14, respectively, show the number of hospital transfers.

Of those nearly 39,000 abortions provided in North Carolina, Planned Parenthood of South Atlantic transferred 31 patients to the hospital. All of those patients were treated and released in stable condition and only seven of those patients were actually admitted to the hospital. That's seven patients out of nearly 39,000 over the course of two and a half years.

I think the overarching point is, that it is simply not rational to require that all abortions be provided in a hospital, given the --

THE COURT Is that 39,000, 38,795 all or after 12-weeks?

MS. SWANSON That is all, Your Honor. It is not broken out by 12-weeks.

THE COURT By gestational age?

MS. SWANSON Correct. But the number of hospital transfers after 12-weeks was 17, and I think four of those

resulted in hospital admission.

The O'Day case, this is the Ninth Circuit rational basis case about the double bond requirement for administrative appeals, and in that case, the court said where a law is so vastly over-inclusive as to be attenuated from the assertive legislative purpose it fails rational basis, even if there is no animus at issue in the case, and relies on *Moreno* and the language from there is this point about the statute being attenuated in *Moreno* and also in the *Cleburne* case at page 446, the state may not rely on means so attenuated --

THE COURT May not what?

MS. SWANSON Rely on means so attenuated from the purported justification for the law, and that is what is happening here. I think like with all medical care there is a risk of complication, but the risk of complication requiring hospital treatment is so dramatically low and so much lower than, for example, labor and delivery, and there is simply no rational connection between the hospitalization requirement and the state purported safety justification.

As to whether criminal penalties apply to the IUP requirement, the intervenors are saying that professional penalties are the only penalty for the IUP penalty requirement, but as the Court recognized in the TRO order, professional penalties have a stigmatizing effect, are sufficient to require a heightened level of vagueness scrutiny, and that's from the

Manning case.

THE COURT That's from what?

MS. SWANSON *Manning*.

As to whether there is a risk of confusion between the symptoms of ruptured ectopic pregnancy and symptoms of medication abortion, docket entry 74-15 is the patient education forms that Planned Parenthood South Atlantic provides to patients with pregnancies of unknown location, and it counsels them both on the symptoms, the expected symptoms of medication abortion and on the possible symptoms of a ruptured ectopic pregnancy, so the patients are provided with this counseling. They are given access to a 24-hour helpline. They are encouraged to reach out to the abortion provider if they have any concerning symptoms and then, of course, patients who are being concurrently tested, use this blood testing procedure for ectopic pregnancy, are required to submit a second blood test after they've had their medication abortion, and so they are continually in contact with their abortion provider. They are continuing to receive testing for ectopic pregnancy, while simultaneously receiving the medication abortion that they want, and this is again an evidence-based practice.

Dr. Goldberg's research found that ectopic pregnancy is excluded sooner under this concurrent treatment and testing protocol rather than when a patient is simply sent home to wait until a pregnancy can be seen on ultrasound, and that's what

the intervenors are advocating for.

On the question of comparative risk of childbirth and abortion, it makes sense to --

THE COURT Can I back you up to animus? You are contending that the statute shows animus against the provider of abortion?

MS. SWANSON Yes.

THE COURT What is your evidence on that point? Why do you say that?

MS. SWANSON I think because the statute in regulating abortion providers differently than it regulates comparable medical care, and then in expressly carving out miscarriage in those provisions that the Court identified earlier.

Those procedures are identical, but for the purpose for which they are performed. No secret that the legislature is opposed to abortion, and I think in discovery, the intervenors produced evidence of communication between key legislators who are now intervenors in this case and anti-abortion advocates who were making statements that were false accusations or false descriptions of the way that abortion providers care for their patients.

I think the record is very clear that abortion providers provide excellent evidence-based medical care for all of their patients, and the suggestion that abortion providers

are profit motivated, that they have a conveyer belt of patients coming through is simply -- it is rebutted by the evidence, by evidence-based and compassionate patient centered care that the plaintiffs provide.

In particular --

THE COURT Well, I mean, that's different from animus. That's just being wrong. I mean --

MS. SWANSON Correct.

THE COURT You are saying they are just wrong, but that's different from animus.

MS. SWANSON I think either one is sufficient for us to win here. I think -- we believe that there is evidence of animus, that even if we can't persuade the Court that there is evidence of animus in this case, it is enough that we have produced evidence rebutting their purported safety justifications.

THE COURT They haven't come in here and offered anything to show anything about bad care from your client or other providers. I haven't heard anything that that is a basis for this.

MS. SWANSON That's correct.

THE COURT So tell me -- point me to your evidence of animus.

MS. SWANSON So I think the declaration that they admitted from Dr. Wubbenhorst is ripe with suggestions that

abortion providers provide substandard care. None of that is supported by citations to anything. It is simply Dr. Wubbenhorst's personal opinion about abortion providers, and I think the -- the other rational basis cases, after doing the analysis of whether the purported justifications for the law are actually supported by evidence, upon concluding that there is no rational relationship to those legitimate government interests, courts say I can't really understand what the basis for this could have been, other than animus. But it is still not necessary for the Court to even reach that animus question in order for the plaintiffs to prevail in a rational basis case.

So I think the *Hooper* case, I think the *O'Day* case, *Craigmiles* cases are all, you know, good cases where the Court ruled for plaintiff in a rational basis challenge without requiring a showing of animus.

Of course abortion is an incredibly politically charged topic. It is a politically stigmatized type of healthcare, and I think Dr. Farris testifies in her rebuttal declaration that in North Carolina providing abortion -- she does receive stigma as a result of being an abortion provider in North Carolina.

THE COURT Where does she say that?

MS. SWANSON In her rebuttal declaration, which is docket entry 69-2.

I will ask my able co-counsel to find this while I proceed to the gestational age point.

So the intervenor suggests that the proper comparator is abortion at a particular gestational age and childbirth at the same gestational age, or perhaps abortion at term compared to childbirth at term. They suggest that you should be looking at the same thing at the same gestational age, and that makes no sense, because right now, abortion starting after the twelfth week of pregnancy must happen in a hospital, while childbirth must happen or can happen outside of the hospital, so those are the proper comparators to look at the safety.

The record shows that -- this is in Dr. Boraas's rebuttal declaration, ECF 69-1, paragraph 16. The major complication rate for abortion is just 0.23 percent, while severe complications from childbirth occur in 1.4 percent of childbirths.

Then in paragraph 17 she makes clear that every pregnancy complication is more common among people having live births than those having abortion. So labor and childbirth is riskier than abortion.

We discussed a standing point as for whether plaintiffs have seen patients under the exceptions to the 12-week ban since July 1st. There is actually -- there is not evidence in the record, but the plaintiffs have not seen patients. What intervenors point to is Dr. Farris's deposition

testimony saying she is not personally aware of whether they have but, again, we have evidence in Dr. Farris's opening declaration that they have treated patients in these circumstances in the past and would continue to do it again, and under *Lujan*, that's sufficient to establish standing.

If the Court is interested, we could also submit a supplemental declaration with the exact numbers.

THE COURT I don't have time for that. You all --

MS. SWANSON Understood.

THE COURT -- have had your chance, at least for preliminary injunction.

MS. SWANSON Yes.

Lastly, the intervenors make this point that Dr. Farris recognizes that it is a reasonable medical option for a patient to wait, and then come back, just as it is a safe and reasonable option for the patient to receive the medication abortion, while simultaneously undergoing further testing for ectopic pregnancy.

I want to be very clear, that what is a reasonable menu of medical options for a patient to choose between, in consultation with her doctor, is very different from what it is rational for the legislature to mandate or prohibit. It is not rational for the legislature to require that all patients go to a hospital for an abortion, or that patients wait until a later point in pregnancy, rather than receiving medication abortion.

Again, the evidence shows that ectopic pregnancy is excluded sooner when patients are able to both receive their medication abortion and undergo further testing for ectopic pregnancy in contrast to being required to wait.

It is not just irrational to take one option fully off the table for patients, but as Dr. Boraas testified in her deposition, given the existence of the safe and effective medical options, it is rather cruel to make patients wait.

I will continue to -- no, never mind. So we will withdraw the point about Dr. Farris's rebuttal declaration stigma. I will continue to look for that.

In the meantime, we would reiterate that there is no rational justification for either of these laws. They will harm patients. There is no harm to the status quo from allowing the plaintiffs to continue to provide the safe evidence-based medical care that they have been providing in North Carolina for years, and we would ask the Court to enter a preliminary injunction against both provisions before October 1st.

THE COURT Anything else for the Attorney General?

MS. OYCE Yes, Your Honor, just a few things.

First, we don't take issue with the test that Mr. Baptist has set forth. We agree that the proper test here is not one of rational basis plus, but rather simply rational basis.

I think Mr. Baptist articulated the test, that is that the law must be rationally connected to a legitimate State interest, and we agree with that test.

We similarly agree that it is a low bar, but we disagree with whether the legislature has managed to satisfy the threshold here.

The key here is the rational connection that Mr. Baptist highlighted. Again, simply saying that the law has been passed to protect the health and safety of the mother is not sufficient. Those are not magic words. You need to justify that basis once it has been put into question by a plaintiff like Planned Parenthood has done here, and to do that, we believe it make senses for the legislature to rebut the idea both that there is not adequate risk to justify this law, and to rebut the idea that requiring hospitalization does not in fact mitigate the risk, and rather in fact sometimes can exacerbate that risk for the patients who undergo these procedures.

I haven't heard the legislature take issue with the statistics as Planned Parenthood has put them forward. I think I heard Mr. Baptist say that the risk is about .52 percent in one year, and .41 percent in another year. That's entirely consistent with the statistics that Planned Parenthood has put forward.

THE COURT I thought he said 5.2 percent.

MS. OYCE He said 5.2 to start, and then the second time --

(Cross-talk.)

THE COURT Thank you for clarifying. I heard a different number.

MS. OYCE The first time I think he said .52, and I think he meant the second time .52. But again, .52, which is quite inline with the studies that Planned Parenthood has submitted as part of discovery in this case, which similarly underscores that it is well under one percent and more in the vain of about a half a percent.

They similarly have not put forth evidence that it is more dangerous for these women to be treated in a clinic as opposed to a hospital or that it is impossible for clinics to get women who do have major complications arise to a hospital in time for them to be treated there.

Your Honor raised *Lee Optical*. They have spoken a little bit about *Lee Optical*, and while both they and Your Honor is correct, that the legislature doesn't have to solve every single problem at once. They can focus on risks posed by certain medical procedures one at a time, and mitigate those risks.

It is also true that the legislature should not be drawing arbitrary lines about the same medical procedure based on the group who you is seeking them, and that's the problem

here.

You asked the question about whether the legislature could perhaps require all childbirths to take place at a hospital as opposed to allowing them to ever occur at home, and I think the answer to that is, perhaps, maybe, if they put forward evidence that it was risky to give birth at home and that giving birth in a hospital would mitigate that risk.

What they couldn't do, though, is require any unmarried woman who wants to give birth to a child in a hospital, and to allow married women to give birth at home, if there is no evidence that the risk to those different groups of women is any different, and that's what is happening here with respect to women who want to get these procedures because they had a miscarriage, and women who want to get these procedures because they wish to have an abortion.

The plaintiffs have not, and the legislature has not put forth any evidence that there is a different risk posed, or has not rebutted the evidence that Planned Parenthood has put forward that the risk posed to those two groups of women is the same, and that the medical procedure is equally received or not received, we believe safe for both of those groups.

THE COURT I mean, post-12-weeks, you are only talking about women who need an abortion or want an abortion because of rape or incest, fetal anomaly or a life-threatening issue. Right?

MS. OYCE Exactly, Your Honor.

THE COURT There is no evidence that risks are higher for those groups?

MS. OYCE Exactly, Your Honor.

Moving quickly to the vagueness argument that we've touched on throughout the day, I am pleased to hear now again from the legislature that they have reverted to their position at the TRO hearing that there are only civil penalties for this law. That is not what they said in their brief at page 18, where they said, "and while the IUP documentation requirement gives rise to both civil and criminal penalties, each of the possible criminal penalties include a scienter requirement."

I think this again underscores another vagueness problem that arises from this law, and that is, that it is not clear whether the provision they cited now about the Medical Board's authority is an additional penalty, an additional penalty that can be imposed on doctors that proceed with these abortions without satisfying these requirements, or is the only penalty that can arise, and their position here has vacillated back and forth, and only speaks to the predicament that doctors will find themselves in as they try to navigate this requirement, and whether if they do choose to move forward, they will only be subject to medical board discipline, or criminal penalties as well, and that's not to disagree with the plaintiffs about whether civil penalties are still enough to

give rise to a searching inquiry with respect to vagueness.

We totally agree that even if it is just civil penalties, nevertheless, that is a significant enough penalty that the law needs to be extremely clear, but I do think that the fact even counsel for the legislature cannot agree as to how this law should be interpreted and what happens if you proceed with a pregnancy if you cannot figure out for certain whether the pregnancy is intrauterine or not, speaks to the constitutional problem that is at the heart of this law.

I do want to pick up on, I think, a potential concession that Mr. Baptist made when he said that he would agree with Your Honor that it could be interpreted to mean the probable existence of an intrauterine pregnancy, because that does strike me as a possible way forward here.

Everything I've seen in record from Planned Parenthood about the way that they approach ruling out an ectopic pregnancy, suggests that they only proceed to administer medication abortion if they believe that it is probably an intrauterine pregnancy, and I believe Dr. Farris's declaration says, in the event that they think the patient is at risk of an ectopic pregnancy, they will simply refer the patient to a hospital.

So it is my understanding based on the record, that Planned Parenthood does not proceed with medication abortions unless they would feel comfortable certifying that there is a

probable existence of an intrauterine pregnancy. They simply, I don't believe, are able to document with any certainty an intrauterine pregnancy, and so insofar as the legislature is willing to concede that that is a possible construction of this law, it does strike me as perhaps a construction that this Court could enter that we would all agree with and that might be consistent with Planned Parenthood's approach to ruling out ectopic pregnancies.

The only other point that I would make on vagueness is just, of course, vagueness challenges are not just a problem for doctors, they are also a problem for law enforcement, and this is of course something that is important to the Attorney General. If prosecutors don't know whether they can bring charges or who has violated the law, it puts them in a difficult position, just as it puts doctors and patients in a difficult position with respect to what conduct is prescribed by the law and what is not.

Finally, I'll just conclude in a similar place to counsel for Planned Parenthood, and that is to underscore the fact that the preliminary injunction standard places great emphasis on the question of irreparable harm. We talked a lot about the likelihood of success on the merits. We haven't talked nearly as much about the irreparable harm that would be caused if the legislature's approach to this law or understanding of this law is permitted to take effect on

October 1st, that it would cause grave harm to women who cannot access the productive care that they need, and it will put both doctors and law enforcement officials in the possible position of trying to figure out what is permissible and what is prohibited under the law of North Carolina.

We would ask for those reasons that Your Honor enjoin the provisions that we talked about today, or adopt construction of those provisions that are consistent with our interpretation of the law or our evidence.

THE COURT Rebuttal for intervenors.

MR. APTIST Just a few.

THE COURT Or sur rebuttal.

MR. APTIST Just a few points, Your Honor. We submit that it was entirely rational for the State General Assembly to codify the FDA requirement to exclude an ectopic pregnancy before giving abortion drugs to a woman who seeks abortion.

We also think it was entirely rational for the state to require post-12-week surgical abortions to be performed in a hospital setting, even based on Planned Parenthood's own documentation and, again, I'll point you to 74-12, which is their list of post-12-week complications resulting in hospital transfer. That just demonstrates to show that there are serious complications that they cannot treat themselves within their facilities requiring an emergency situation transferring

these women before they suffered enough trauma in their life, they are having another traumatic event to be rushed to the hospital.

Their last entry, I will note, on Bates No. 052 or 74-12, page three of three, I may pronounce this wrong, it is called syncope, that means a woman is unconscious, so think about a rape victim who is pregnant and going through an abortion at the Planned Parenthood facility.

THE COURT They don't have to.

MR. APTIST Pardon.

THE COURT You said they to have.

MR. APTIST She decided to have an abortion at the Planned Parenthood facility and she's being transferred and losing consciousness for an unknown amount of time and waking up in an unknown situation or emergency room. That's doubly traumatic and the State is trying to prevent that situation from happening again.

I will also note that based on their own data, there is a significant increase. We kind of quibbled about numbers, and I have .52 percent. I apologize for speaking to the post-12-weeks surgical abortions for 2023. I haven't run the numbers and I can't tell you what it is, just assuming they have .08 percent for the entirety of all of their abortions performed in an average year, I think that shows there is a significant increase in hospital transfers after 12-weeks, and

so it was well within the realm of rationale for the State to focus at 12 and require those to be performed in a hospital as opposed pre-12-week surgical abortions, they still can be performed.

THE COURT And that is in -- you are telling me that evidence is where? I think you may have pointed it out to me earlier. I just want to be sure.

MR. APTIST I will point you to our supplemental brief. It is going to be 75-6, procedural abortion by volume and by gestational age, and if you run the numbers based on how many they performed, and they've represented how many have been transferred in their briefs, I think it was 31 over the last three and a half years.

THE COURT I think they said only 17 of those were post-12-weeks.

MR. APTIST That's correct, Your Honor. By my math, like I say, it is lawyer's math. I think that is 14 pre-12-weeks. Given the higher volume that they performed, that just shows that they have a lower hospital transfer rate for the pre-12-weeks surgical abortions versus the post-12-weeks surgical abortions, which shows that the legislature had a rational basis to focus on those and required them to be performed in the hospital to prevent the trauma that occurs when they have to be transferred to a hospital and treated for complications that cannot be treated in the Planned

Parenthood facility.

THE COURT I still am not completely sure I've heard you provide a rational basis for requiring abortions after 12 -- when I say abortions, I'm talking about these two procedures that we've been talking about, the aspirations and the D&Es, why those have to be done in a hospital, if the purpose is abortion, but they don't have to be done in a hospital when the purpose is miscarriage management.

Can you explain that to me?

MR. APTIST I can explain it to you. I am going to have to give the caveat that I can't point to the record, but there are different medical conditions associated with a dead baby versus one that is still alive and intact and has cardiac activity, or a heartbeat.

THE COURT I didn't see you point me to that.

MR. APTIST No, I said with the caveat that there is nothing in the record that I can point to you that they -- they deal with two different conditions. The procedures may be the same, but the woman's condition --

THE COURT Because the evidence I saw -- I mean, I went back and read all the Reddit, they pointed me to it, the risks are the same. It is hemorrhage -- I have forgotten now what the other ones are. The doctor -- one of them, at least, went through, and maybe even your doctor, your expert also, the risks are the same, and I just didn't see anything that says

they are different, and you're telling me you don't think there is anything in the record saying they are different.

MR. APTIST I would say, I think their evidence shows -- or even our doctors may agree the types of complications are the same.

I'm not sure that the rates of complications have been demonstrated to be the same as well, because they deal with different situations, but I understand that they pointed to Dr. Farris's declaration where she said she performed some post-12-week miscarriage management surgeries in Planned Parenthood facilities. I posit again that I'm not sure. They have not submitted the frequency of that occurrence outside of the hospital setting. All we have is Dr. Wubbenhorst's testimony that I pointed to earlier that she says in her experience they are always performed in the hospital setting.

So I just compare what did the State look at in terms of the problem, if 90 percent of -- 97 percent of all abortions are performed outside of the hospital setting, compared to, I'm going to say 97 percent of all miscarriage management surgeries in second trimester are performed in the hospital setting, the State would have a rational basis to focus on post-12-week surgical portion versus post-12-week miscarriage management surgeries which are predominantly performed in the hospital setting with the exception of Dr. Farris and Planned Parenthood within North Carolina, they maybe perform some, not sure how

many in their experience.

THE COURT I didn't mean to cut you off, if you had other things that you wanted to talk about.

MR. APTIST I'll just note in terms of discussion of animus, the plaintiffs cite to meetings or emails associated with pro-life advocacy groups. I will note that the State legislature met with many groups with different opinions and that is supported by even plaintiffs' supplemental brief where they submitted exhibits and email communications with nonpro-life groups discussing the legislation, so I just submit that there is no animus here. They met with anybody who was wanting to discuss the proposed legislation with them.

THE COURT Thank you. Anything else?

MS. SWANSON I just wanted to apologize for misstating the stigma point. We have located the paragraph. I was misremembering. This was in Dr. Farris's rebuttal declaration ECF 69-2, paragraph 15, where she discusses the stigma that patients seeking abortion face, including walking past protestors on their way to their appointments at the Planned Parenthood Health Center.

I also wanted to just state clearly for the record, but I don't believe that counsel for intervenors intended to state this as a fact that 97 percent of (cross-talk) --

THE COURT I didn't take it that he was stating that as a fact.

MS. SWANSON Wanted to be clear, that's not in the record.

Lastly, just wanted to reiterate that this risk of possible ectopic -- risk of confusion between symptoms of ectopic rupture and the symptoms of medication abortion, not only are patients counseled on what to expect from both, but there is deposition testimony from both Dr. Boraas and Dr. Farris as well as from intervenors' witnesses, Dr. Wubbenhorst and Dr. Bane, that explain the ways that these symptoms present in a clinically distinct way.

So ectopic rupture will be a sharp pain on one side of a patient's body with minimal vaginal bleeding, whereas the symptoms of medication abortion are midline cramping and vaginal bleeding, because that's how the pregnancy is passed from the patient's body.

So given the distinction between the clinical presentation of ruptured ectopic pregnancy and the symptoms of medication abortion, comprehensive counseling that patients receive, their encouragement to reach out if they have concerning symptoms to their abortion provider and the fact that they are receiving ongoing testing for ectopic pregnancy simultaneous with a medication abortion, there is no risk of confusion here, and so in light of all of that, we would just thank the Court for your time and ask respectfully for a preliminary injunction against both provisions.

Thank you.

THE COURT Thank you. Anything else?

MS. OYCE The only other minor point that I would make, Your Honor, is just about this point from Dr. Wubbenhorst that keeps coming up repeatedly. I just want to clarify what Dr. Wubbenhorst seems to be saying in her deposition. She says on page 115, that in her experience based on the programs at hospitals where she has worked at, these kinds of procedures happen in hospitals.

One of the glaring problems with Dr. Wubbenhorst as a witness here in this case is, that she has never worked in a clinic or participated in any programs at a clinic. So her point is a very narrow one, which is very simply based on her experience in hospitals. They performed these procedures in hospitals. She doesn't speak at all as to whether they do not happen in clinics, because of course she hasn't worked in a clinic, and she ties her experience to the places that she has worked.

I don't think that that rebuts the evidence on the other side from Planned Parenthood that these procedures do occur with great frequency at the clinics here in North Carolina and here and around the country.

THE COURT Anything else?

MR. APTIST One quick point in response to the Attorney General. I don't think there is evidence from

plaintiffs that show that great frequency of miscarriage managed surgeries occur within the state.

THE COURT I'm sorry, what?

MR. APTIST I'm sorry. Miscarriage management surgeries in the second trimester occur outside of a hospital setting. There is just no evidence outside of Dr. Farris's limited declaration. That's it, Your Honor.

THE COURT I'm going to do my best to get you an order on Friday. That said, I have until Saturday so, you know, I'm going to try to do it by Friday, but I'm not making any promises. I can't think of anything else.

Thank you. Court is adjourned.

(Court was adjourned at 1:10 p.m.)

C E R T I 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