

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

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

**SUPPLEMENTAL BRIEF IN SUPPORT OF  
PLAINTIFFS’ AMENDED MOTION FOR PRELIMINARY INJUNCTION**

After discovery, the record remains clear: the Hospitalization and IUP Documentation Requirements are not rationally related to patients’ health, and the IUP Documentation Requirement fails to give adequate notice of what it demands. The Requirements therefore violate the Fourteenth Amendment.

**I. Intervenor’s Witnesses Fail to Undermine the Medical Consensus**

Intervenors’ defense of the challenged provisions rests entirely on the testimony of Drs. Wubbenhorst and Bane, but neither’s testimony should be credited. Neither has ever performed an abortion. Dep. of Dr. Monique Wubbenhorst (“Wubbenhorst Dep.”) 36:5–6 (**Ex. 3**); Dep. of Dr. Susan Bane (“Bane Dep.”) 32:23–24 (**Ex. 4**). Dr. Wubbenhorst has no

clinical or academic background in abortion; she opted out of abortion training in her residency. Wubbenhorst Dep. 36:12–16. And while Dr. Bane relies by analogy on her experience managing miscarriage, she has never performed a D&E to manage miscarriage. Bane Dep. 30:7–9.

Moreover, these witnesses’ anti-abortion bias is evident. Dr. Wubbenhorst opposes abortion in all circumstances, including rape or incest. Wubbenhorst Dep. 31:2–5, 31:23–32:19. Dr. Wubbenhorst opposes abortion even for child victims of rape. *Id.* 32:8–33:1. She believes that doctors who provide abortion are committing murder, and that “all” abortions, even those with no complications, cause harm to women. *Id.* 31:20–22, 33:24–35:9. Dr. Bane referred to herself as a “pro-life advocate,” repeatedly described abortion as the “direct and intentional killing of a human being,” and demonstrated remarkable unfamiliarity with the risks of childbirth, saying that people “rarely” struggle with postpartum anxiety and depression. Bane Dep. 84:18–19, 13:1–2, 40:15–16, 79:22–80:1.

These witnesses’ opinions that abortion is unsafe, and that carrying a pregnancy to term and delivering a baby are safer than abortion, are not supported by credible evidence, and are contrary to every mainstream medical organization’s conclusion. *See, e.g.*, Rebuttal Decl. of Dr. Christy Boraas Alsleben (“Boraas Rebuttal Decl.”) ¶¶ 7–29, DE 69-1.

## **II. Discovery Shows that Plaintiffs Are Likely to Succeed on the Merits**

*A. It is irrational to require hospitalization for abortion after the twelfth week.*

Even under rational basis review, any presumption of rationality can be rebutted with evidence or even “common knowledge.” *Borden’s Farm Prods. Co. v. Baldwin*, 293

U.S. 194, 209–10 (1934); *see also, e.g., St. Joseph Abbey v. Castille*, 712 F.3d 215, 226 (5th Cir. 2013). Here, the overwhelming evidence of abortion’s safety—both before and after the twelfth week of pregnancy—more than rebuts any presumption that the General Assembly acted rationally in requiring hospitalization for abortion, a politically stigmatized type of medical care, but not for less-stigmatized procedures. *See* PI Memo, DE 49 at 9–13; PI Reply, DE 69 at 2–7.

First, complications from abortion are incredibly rare. PPSAT performed 38,795 abortions in North Carolina between January 1, 2020 and June 30, 2023; 522 complications resulted, most of which were minor. Rebuttal Decl. of Dr. Katherine Farris (“Farris Rebuttal Decl.”) ¶ 8, DE 69-2; Bates 0106 (**Ex. 13**). PPSAT screens all abortion patients for conditions that increase the risk of complications and refers high-risk patients to hospitals for their abortions. Dep. of Dr. Katherine A. Farris (“Farris Dep.”) 166:9–22 (**Ex. 2**). Second, when abortion complications do arise, the vast majority can be treated safely in the clinic. Dep. of Dr. Christy Boraas Alsleben (“Boraas Dep.”) 170:17–171:15, 171:21–173:7, 152:14–153:1 (**Ex. 1**); Farris Dep. 65:2–8, 62:20–63:10; *see also* Bane Dep. 94:4–13, 95:17–20; *id.* 104:20–21. Of the 38,795 abortions between January 1, 2020 and June 30, 2023, only 31 patients (or 0.08%) were transferred to a hospital. Farris Rebuttal Decl. ¶ 8, DE 69-2; Bates 0051–0052 (**Ex. 12**); Bates 0106; Bates 0107 (**Ex. 14**). All 31 were treated and released in stable condition, and only 7 (or 0.02%) required admission. Farris Rebuttal Decl. ¶ 8, DE 69-2; Bates 0051–0052; Bates 0107. There is no medical reason to require that abortions be provided in hospitals when the need for hospital treatment is so

extraordinarily rare, and rarer than for other outpatient procedures. *See* PI Memo, DE 49 at 9–11; PI Reply, DE 69 at 5, 7.

Nor does a hospital setting improve patient safety. *See, e.g.*, Boraas Dep. 175:6–9; Farris Dep. 75:4–6. Research shows that second-trimester D&E procedures can be both safer and more affordable in outpatient clinics than in hospitals. Decl. of Dr. Katherine Farris (“First Farris Decl.”) ¶ 38 & n.30, DE 49-1; *accord* Wubbenhorst Dep. 131:22–132:10. And by delaying survivors of rape or incest and patients with life-limiting anomalies, the Hospitalization Requirement forces these patients to obtain abortions later than they otherwise would, when the risk (although still very low) has increased. Farris Dep. 164:25–165:10, 145:17–18; *see* Boraas Dep. 149:11–22; Wubbenhorst Dep. 64:16–18; Bane Dep. 57:5–7. The Hospitalization Requirement therefore undermines patient safety.

Crucially, Intervenor has failed to identify any safety justification for a hospitalization requirement that applies to abortion after the twelfth week of pregnancy, but not to procedures of equal or greater risk, including *clinically identical* procedures to treat miscarriage. *See* Intervenor’s Interrog. Resp. Nos. 5, 6 (**Ex. 5**). The various abortion complications highlighted by Intervenor also arise during miscarriage management and childbirth—indeed, they are *more likely* to occur as a result of childbirth. *E.g.* Boraas Dep. 92:3–10, 173:8–175:5; *accord* Bane Dep. 26:5–9; *see also id.* at 94:4–13, 100:5–16, 101:16–23, 103:17–21.

Finally, to the extent Intervenor defends the Hospitalization Requirement based on

what instruments are used in procedural abortion starting after the twelfth week of pregnancy, the record shows that abortion providers do not routinely start using additional instruments immediately after the twelfth or even fourteenth week of pregnancy. *E.g.* Farris Dep. 17:16–19, 72:10–20, 165:15–19; Boraas Dep. 151:17–23.

*B. The IUP Documentation Requirement is unconstitutionally vague.*

The IUP Documentation Requirement fails to provide notice of what it requires or permits for patients seeking early medication abortion. N.C. Gen. Stat. § 90-21.83B(a)(7); *see* TRO, DE 31 at 6–7; *accord* Def. Att’y General Joshua H. Stein’s PI Response, DE 63 at 14–17.

Intervenors read the IUP Documentation Requirement to demand that an abortion provider *visually identify* an intrauterine pregnancy by transvaginal ultrasound before providing a medication abortion. Int. Br., DE 65 at 20, 22. But this interpretation would effectively ban medication abortion in the earliest weeks of pregnancy. *See* Farris Dep. 20:23–25; Boraas Dep. 145:7–13. Intervenors’ discovery responses confirm that the General Assembly did not intend to ban medication abortion until after the twelfth week of pregnancy—as the General Assembly later clarified directly through H.B. 190. *See* E-mail from Nathan Babcock to Rob Lamme (May 16, 2023, 08:15 AM ET) (**Ex. 6**) (email from Intervenor Senator Philip Berger’s senior policy advisor stating that “SB20 states that medication abortion shall be lawful through 12 weeks”); E-mail from Nathan Babcock to Rob Lamme (June 12, 2023, 03:24 PM ET) (**Ex. 7**) (email from same individual stating that “[t]he intent is to prohibit elective medical abortions after 12 weeks—and that is what

the bill states in the key section listing when abortion is legal and when it is not.”); Session Law 2023-65, DE 26-1 § 14.1(f) (striking language suggesting that medication abortion was lawful only through 70 days’ gestation).

Of course, to the extent the IUP Documentation Requirement requires only that medication abortion patients be screened for ectopic pregnancy, Plaintiffs comply with this requirement, while also giving patients the option of receiving their desired medical care more promptly. *See* Farris Dep. 137:9–15, 86:6–8; 111:4–11, 162:15–163:13 (patients with pregnancies of unknown location are screened for ectopic pregnancy); 107:3–8, 109:14–21, 110:5–9, 163:8–17 (high-ectopic risk patients are not provided medication abortion, but instead referred for prompt evaluation and treatment); 163:18–164:8 (low-ectopic risk patients are given option of medication abortion along with continued screening for ectopic pregnancy); 164:9–24 (low-ectopic-risk patients who choose medication abortion are counseled on ectopic pregnancy risks and symptoms and concurrently receive serial hCG testing and close follow-up to definitively exclude ectopic pregnancy).

Given the threat of possible criminal and/or professional penalties for violating the Act, however, *see* Int. Br., DE 65 at 18, Plaintiffs will be chilled from adopting this reading of the IUP Documentation Requirement absent further clarity from the Court.

*C. If the IUP Documentation Requirement bans early medication abortion, it is irrational.*

To the extent Intervenors’ interpretation of the IUP Documentation Requirement controls, it bans medication abortion in the earliest weeks of pregnancy without any basis

in patient safety and is therefore irrational.

Intervenors suggest that visual confirmation of intrauterine pregnancy by ultrasound is necessary to exclude the possibility of ectopic pregnancy. *See* Intervenors' Interrog. Resp. Nos. 10, 11, 12. Both Drs. Wubbenhorst and Bane testified that they believed PPSAT does not perform ultrasounds before abortions. Bane Dep. 112:5–8; Wubbenhorst Dep. 145:2–7. But North Carolina law *requires* that all patients receive an ultrasound prior to obtaining a medication abortion, *see* 10A N.C. Admin. Code 14E.0305(d), *replaced by* 10A N.C. Admin. Code 14E.0321(d) (effective July 1, 2023), and Plaintiffs are not challenging that requirement here, Farris Dep. 84:18-20, 129:12-18.

Instead, Plaintiffs argue that it is irrational to deny medication abortion to patients whose pregnancies are not yet visible by ultrasound and who are low risk for ectopic pregnancy. Because these patients have been screened *and deemed low risk*, they are considered patients with a pregnancy of unknown location, not patients with a “confirmed” or “suspected” ectopic pregnancy—distinct diagnostic categories. *Compare* Wubbenhorst Dep. 142:6–20, *with* Farris Dep. 102:22–103:6, 108:2–7, 110:10–19, 162:3–14, 168:17–23; Boraas Dep. 127:6–16, 145:20–146:1, 164:22–165:22. These patients need not wait until an intrauterine pregnancy is visible on a *subsequent* ultrasound before initiating medication abortion in accordance with Plaintiffs' evidence-based protocol that concurrently excludes the possibility of ectopic pregnancy. Farris Dep. 98:24–99:11, 137:9–15, 139:22–25; Boraas Dep. 160:2–168:3.

Intervenors suggest that a ban on very early medication abortion is justified because

the FDA label for mifepristone states that it is “contraindicated” for ectopic pregnancy. Int. Br., DE 65 at 3, 21. But Intervenor’s ignore that mifepristone is contraindicated for patients with “*confirmed/suspected* ectopic pregnancy or undiagnosed adnexal mass,” DE 65-2 at 1 (emphasis added), not for patients who have been clinically deemed low-risk for ectopic pregnancy—and low-ectopic-risk patients are the ones Plaintiffs would treat but for the IUP Documentation Requirement.

Even taken at face value, this argument misunderstands what it means for a medication to be contraindicated. As Intervenor’s experts agree, mifepristone does not exacerbate or increase the risk of complications from ectopic pregnancy; it simply does not treat that condition. *See* Boraas Dep. 99:17–100:8; Farris Dep. 123:9–12, 155:8–14; *accord* Wubbenhorst Dep. 143:19–21 (medication abortion cannot cause an ectopic pregnancy to rupture). And Plaintiffs’ evidence-based protocol does not interfere in any way with the detection and treatment of ectopic pregnancy. *See* Farris Dep. 155:8–14, 161:10–15; Boraas Dep. 163:7–19, 167:19–168:3; *accord* Wubbenhorst Dep. 143:22–25; Bane Dep. 108:2–13. Dr. Wubbenhorst testified that she is unaware of any early medication abortion patients who have experienced negative outcomes from an ectopic pregnancy as a result of PPSAT’s protocol. Wubbenhorst Dep. 153:18–22.

Intervenor’s suggestion that patients will confuse the symptoms of an ectopic rupture with those of a medication abortion, Int. Br., DE 65 at 23, is unlikely given the significant differences between the severe, sharp pain associated with ectopic rupture and the midline cramping associated with medication abortion. Boraas Dep. 140:12–16,



140:22–141:19; Farris Dep. 129:8–11, 130:17–25. In fact, Dr. Wubbenhorst says that symptoms of a ruptured ectopic pregnancy are straightforward: “Women will often say they felt a pop, they experienced terrible pain in their right side, and they feel faint.” Wubbenhorst Dep. 182:16–25; *see also* Bane Dep. 119:16–122:19 (explaining that ectopic rupture may involve “spotting” or “a little bit of heavier bleeding,” but not the volume of vaginal bleeding associated with miscarriage). And PPSAT’s patients are counseled to remain alert specifically for symptoms of ectopic pregnancy. *See* Bates 0119–0120 (**Ex. 15**) (PPSAT patient education materials); Farris Dep. 125:2–9, 164:9–24.

One study indicates that ectopic pregnancies are detected *sooner* when patients are allowed to access early medication abortion as compared to when they wait for treatment until their pregnancy can be seen by ultrasound. Boraas Rebuttal Decl. ¶ 49 & n.61, DE 69-1 (citing and discussing Alisa B. Goldberg et al., *Mifepristone and Misoprostol for Undesired Pregnancy of Unknown Location*, 139 *Obstetrics & Gynecology* 771 (2022)); *see also* Boraas Dep. 167:4–168:3. This lack of means-ends fit between the Requirement and the goal of promptly detecting ectopic pregnancies indicates that detecting ectopic pregnancy was not the General Assembly’s true purpose, but rather a justification invented once this litigation was underway. *See* E-mail from John Thorp to Paul Stam (June 30, 2023, 08:23 PM ET) (**Ex. 8**) (John Thorp, a frequent witness in support of abortion restrictions,<sup>1</sup> suggests that IUP Documentation Requirement was intended “to prevent harm

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<sup>1</sup> *See Planned Parenthood of Wis., Inc. v. Van Hollen*, 94 F. Supp. 3d 949, 967 n.16 (W.D. Wis. 2015) (expressing “several concerns with Dr. Thorp’s credibility”).

from ectopic pregnancy” and that the Court “did not understand” this); E-mail from Tami Fitzgerald to Neal Inman & Demi Dowdy (Mar. 23, 2023, 08:02 AM ET) (**Ex. 9**) (email from NC Values Coalition to Speaker Moore’s office attaching “list of things we would like to see in the pro-life bill”); Requirements for the Pro-Life Bill (**Ex. 10**) (number one includes “restrictions on chemical abortion”); *Chemical Abortion: Protocols for a Risky Business*, Chemical Abortion National Coalition (Jan. 2023) (**Ex. 11**) (model legislation including the IUP Documentation Requirement under Section 5(a)(7)).

Of course, banning medication abortion in the earliest weeks of pregnancy is logically incompatible with the Act’s intent—that people obtain abortion as early in pregnancy as possible, and that abortion remain generally lawful through the twelfth week of pregnancy. *See* N.C. Gen. Stat. § 90-21.81A. As both the published research and Plaintiffs’ experts explain, there is no reason for the government to *mandate* that people wait to obtain a medication abortion until their pregnancy is visible by ultrasound, rather than allowing them to opt for a safe and effective medication abortion protocol with concurrent ectopic pregnancy screening. Farris Dep 159:3–20, 161:10–15. As Dr. Boraas testified, “when we have . . . a perfectly safe and effective way to provide abortion care in the setting of a pregnancy of unknown location, . . . I think it’s rather cruel to make a person wait.” Boraas Dep. 167:19–168:3, 98:4–9; *accord* Farris Dep. 148:14–149:11, 152:24–153:11.

## **CONCLUSION**

For the foregoing reasons and those Plaintiffs have presented in previous submissions, this Court should grant Plaintiffs' amended motion for a preliminary injunction.

Dated: September 12, 2023

Respectfully submitted,

*/s/ Kristi Graunke*

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## CERTIFICATE OF WORD COUNT

Relying on the word count function of Microsoft Word, I hereby certify that this brief is 2,498 words in length and, therefore, complies with the 2,500 word limitation prescribed by the Court's scheduling order of July 6, 2023.

*/s/ Hannah Swanson*

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## CERTIFICATE OF SERVICE

I hereby certify that, on September 12, 2023, 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.

*/s/ Hannah Swanson*

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# **EXHIBIT 1**

IN THE UNITED STATES DISTRICT COURT  
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA  
CIVIL ACTION FILE NO. 1:23-CV-480

PLANNED PARENTHOOD SOUTH )  
ATLANTIC, et al., )  
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 ) Defendants )  
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 ) PHILIP E. BERGER and TIMOTHY K. )  
 ) MOORE, )  
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 ) Intervenor- )  
 ) Defendants )

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VIDEO CONFERENCE DEPOSITION  
OF  
CHRISTY MARIE BORAAS ALSLEBEN, MD

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TAKEN VIA VIDEO CONFERENCE AT THE OFFICES OF:  
CHAPLIN AND ASSOCIATES, INC.  
NETWORKING WITH:  
CAPE FEAR COURT REPORTING, INC.

08-29-2023  
10:06 O'CLOCK A.M.

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Gretchen Wells  
Court Reporter



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E X H I B I T S

Name	Offered By	Identified
Exhibit A (Declaration of Deponent)	All parties	7

NOTE: Quoted material has been reproduced as read or quoted by the speaker.

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STIPULATIONS

Pursuant to Notice and/or consent of the parties, the deposition hereon captioned was conducted at the time and location indicated and was conducted before Gretchen Wells, Notary Public in and for the County of Iredell, State of North Carolina at Large.

Notice and/or defect in Notice of time, place, purpose and method of taking the deposition was waived. Formalities with regard to sealing and filing the deposition were waived, and it is stipulated that the original transcript, upon being certified by the undersigned court reporter, shall be made available for use in accordance with the applicable rules as amended.

It is stipulated that objections to questions and motions to strike answers are reserved until the testimony, or any part thereof, is offered for evidence, except that objection to the form of any question shall be noted herein at the time of the taking of the testimony.

Reading and signing of the testimony was requested prior to the filing of same for use as permitted by applicable rule(s).

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PROCEEDINGS

(10:06 o'clock a.m.)

THE COURT REPORTER: We are now on the record. Today's date is Tuesday, August 29th, 2023, and the time is 10:06 a.m. This is the deposition of Dr. Boraas taken in the matter of Planned Parenthood South Atlantic, et al., versus Joshua Stein, et al., Defendants, and Philip E. Berger and Timothy K. Moore in the United States Court for the Middle District of North Carolina, Civil Action File Number 1:23-CV-480.

The witness has signed a Declaration of Deponent which will be attached to the transcript as Exhibit A.

(DEPOSITION EXHIBIT  
LETTER A WAS MARKED  
FOR IDENTIFICATION)

THE COURT REPORTER: I'll ask the attorneys to please introduce yourselves and who you represent, and indicate for the record whether anyone else is present in the room with you.

MR. BOYLE: Good morning. My name is Ellis Boyle. I represent the Legislative Leader Defendants, Senator Berger and Speaker Moore. No one else is in the room with me. And I am joined by my co-counsel, Julia Payne and Denise Harle. I'll let

1       them say whether anyone is in the room with them. And  
2       my clients' lawyer, Joshua Yost, is also joining us.

3                   MS. PAYNE: This is Julia Payne with  
4       the Alliance Defending Freedom. No one is here with  
5       me. I'm in my office by myself.

6                   MS. HARLE: Denise Harle here. No one  
7       is joining me.

8                   MR. YOST: Joshua Yost, general counsel  
9       for Senator Berger, and no one else is in the room  
10      with me.

11                   MS. GRANDIN: Good morning everyone.  
12      My name is Kara Grandin, counsel for Planned  
13      Parenthood South Atlantic. No one else is in the room  
14      with me. I am joined by co-counsel from Planned  
15      Parenthood Federation of America and the ACLU. I'll  
16      let them introduce themselves as well.

17                   MS. SALVADOR: Hi. Anjali Salvador,  
18      also co-counsel for Planned Parenthood South Atlantic.  
19      No one is in the room for -- with me.

20                   MR. BOYLE: You're on mute.

21                   MS. SWANSON: Thanks. This is Hannah  
22      Swanson, also for Planned Parenthood South Atlantic,  
23      and no one is in the room with me.

24                   MS. AMIRI: And this is Brigitte Amiri  
25      from the ACLU, representing Dr. Gray, and no one else

1 is in the room with me.

2 MR. MENDIAS: This is Ryan Mendias,  
3 also for Dr. Gray, also with the ACLU, and no one is  
4 in the room with me.

5 MR. MOORE: Hi. My name is South  
6 Moore. I'm at the North Carolina Department of  
7 Justice, and I'm representing Attorney General Josh  
8 Stein. No one else is in the room with me.

9 MS. MAFFETORE: Apologies, one more for  
10 Plaintiffs.

11 MR. MOORE: I'm sorry.

12 MS. MAFFETORE: My name is Jaclyn  
13 Maffetore. I'm with the ACLU of North Carolina. I  
14 represent all Plaintiffs in this matter, and nobody's  
15 in the room with me.

16 MR. BULLERI: I'm Michael Bulleri. I  
17 represent the North Carolina Medical Board, North  
18 Carolina Board of Nursing, and no one is in the room  
19 with me.

20 MR. WILLIAMS: Good morning everyone.  
21 My name is Kevin Williams, and I represent District  
22 Attorney Jim O'Neill, and no one is in the room with  
23 me.

24 MS. CROWLEY: Colleen Crowley, with the  
25 North Carolina Department of Justice, and I represent



1 DHHS, and no one is in the room with me.

2 MS. O'BRIEN: Good morning. I'm  
3 Elizabeth Curren O'Brien. I -- with North Carolina  
4 Department of Justice, and I represent the DA  
5 Defendants except for District Attorney O'Neill, who  
6 Kevin Williams represents.

7 THE COURT REPORTER: Okay. I believe  
8 that is everyone on my list. And since she has signed  
9 a Declaration of Deponent, we can begin.

10 MR. BOYLE: Very good.

11 THE WITNESS: I'm in the room by myself  
12 too. Just didn't want to get left out.

13 The witness, CHRISTY MARIE BORAAS ALSLEBEN,  
14 MD, under the penalty of perjury, testifies as  
15 follows:

16 EXAMINATION

17 BY MR. BOYLE:

18 Q. Very good. Good morning, Doctor. Have you  
19 ever been deposed before or given testimony under  
20 oath?

21 A. I have not.

22 Q. Okay. So obviously, we're doing this by  
23 Zoom so we're not sitting in a room. It's more formal  
24 than a normal conversation would be. There's a few  
25 ground rules I just want to run over with you.

1 A. Sure.

2 Q. You may have already heard this. If you  
3 have, I apologize for repeating it. First, the court  
4 reporter is going to be typing up and transcribing  
5 everything that we say. So it's important to make her  
6 job easier, two things.

7 One, that we try not to talk over each  
8 other. That can be a little tricky when you're in the  
9 Zoom context because there could be a delay. I think  
10 hopefully we'll get our sea legs as we go along and  
11 we'll try and see when one person's talking until they  
12 finish. And you're doing a great job so far.

13 And I may be guilty of this as well. So I  
14 apologize if we start stepping over each other with  
15 talking, I may politely try and redirect us. If I do  
16 that, please don't be offended. It's not meant to be  
17 offensive. Just trying to keep my court reporter  
18 happy. I always find that's a good thing.

19 A. Sure.

20 Q. Good. And then the second thing is nods and  
21 saying "uh-huh," those are perfectly normal in a  
22 normal conversation. Like I said, this is more  
23 formal. With transcriptions, if you nod your head up  
24 and down and you mean yes, that doesn't really  
25 translate well to the written transcript.

1           So as we go along, if I ask a question and I  
2 can tell what your answer is but you haven't said it  
3 out loud, I may prompt you. Again, if I do that, it's  
4 not intended to be rude at all. It's more for the  
5 formality and the court reporter. Is that okay?

6           A. That sounds great.

7           Q. Good. Doing a good job so far. Finally,  
8 there is an expectation that you will answer the  
9 questions asked even if there is an objection, absent  
10 some type of instruction from your lawyer, the lawyer  
11 representing you, to the contrary, okay?

12          A. Yes.

13          Q. Very good. Your medical specialty is in  
14 obstetrics -- I always say that wrong, obstetrics and  
15 gynecology. Is that correct?

16          A. Yes. I completed an obstetrics and  
17 gynecology residency.

18          Q. And the obstetrics part of the OB/GYN deals  
19 with pregnancy. Is that right?

20          A. Yes.

21          Q. Sometimes, you provide treatment and care to  
22 a pregnant woman as an obstetrician that leads to the  
23 birth of the pregnant woman's child. Is that right?

24          A. Absolutely.

25          Q. In that case, you would have provided

1 obstetrics care to the mother and child through the  
2 birth of the child. Is that right?

3 A. We see -- yeah. I see pregnant people in  
4 clinic all the time and provide antenatal care up  
5 until the point of birth, yes.

6 Q. And just -- I think I understood that, but  
7 just -- I'm a simple man. That means for the mother  
8 and the child up until the point of birth, right?

9 A. For the mother and the fetus, yes.

10 Q. And I -- I understand our terms may be a  
11 little bit different but ---

12 A. Uh-huh (yes).

13 Q. --- can we agree that, within reason, if we  
14 use a little bit different terms but we understand  
15 what each other's saying, we can just keep the  
16 conversation going with our own particular terms? Is  
17 that fair?

18 A. Sounds fine to me.

19 Q. Yeah. And I'm not asking you to adopt my  
20 terminology, and I think it's fine if you don't adopt  
21 mine. I think, typically, unborn child and fetus, I  
22 think we might be able to use interchangeably,  
23 understanding you may say fetus when I say unborn  
24 child. Is that fair?

25 MS. GRANDIN: Objection to form.

1 MR. BOYLE: This is one of those ---

2 THE WITNESS: So I'm going to -- you  
3 know, as a medical expert in -- for this deposition,  
4 I'm going to stick to the medical terminology that's  
5 used in science. So I'm going to stick to that for my  
6 answers.

7 Q. (Mr. Boyle) Yes, and I'm not suggesting you  
8 shouldn't. I'm just saying, so we keep the flow, you  
9 understand what I'm saying and I understand what  
10 you're saying. Unless there's a question, in which  
11 case please stop me and ask me to clarify, okay?

12 A. Yeah. Certainly, if there's -- you know, if  
13 there's certain terminology that you're using that  
14 it's -- that is not clear to me, I'll be sure to ask.  
15 Thank you.

16 Q. Very good. After the child is born,  
17 typically the child's care shifts over to the  
18 pediatrician, and you stop seeing the child as your  
19 patient as an obstetrician. Is that fair?

20 A. That is, yeah, a good characteristic of my  
21 practice. We don't -- I don't see any newborns as a  
22 patient.

23 Q. Okay. An induced abortion involves some  
24 mechanism to terminate a pregnancy before the birth of  
25 what would otherwise appear to be a viable pregnancy

1 that would lead to the birth of a baby in the absence  
2 of the induced abortion. Is that correct?

3 A. So induced abortion is the procedure --  
4 using procedure or medicines to end the pregnancy  
5 without the intention of continuing the pregnancy and  
6 having -- and giving birth.

7 Q. And in the absence of an induced abortion,  
8 the expectation would be that it would be a viable  
9 pregnancy and eventually a child would be born?

10 A. Well, I mean, that's a lot of what, you  
11 know, patients and the lay public think, right? But  
12 there -- miscarriage happens in one-fifth of  
13 pregnancies, so I don't know that that's a completely  
14 accurate statement.

15 Q. Right. Miscarriage being an unplanned  
16 termination of the pregnancy. But absent a  
17 miscarriage, an induced abortion is meant to terminate  
18 a pregnancy that hasn't yet miscarried and,  
19 presumably, if it doesn't miscarry, would proceed all  
20 the way to the birth of the child?

21 A. I would say, you know, generally, that's  
22 true. However, there are certainly problems and  
23 chromosomal abnormalities. There are certainly  
24 pregnancies that continue and, for reasons that  
25 sometimes we know and sometimes we don't, you know,

1 end in a intrauterine fetal demise before birth.

2 Q. Fair enough. But not one that is  
3 intentionally induced by an abortion?

4 A. Not in that particular case, no.

5 Q. You perform surgical abortion for some  
6 pregnant women who are your patients, don't you?

7 A. Yes. I see pregnant people for procedural  
8 abortion.

9 Q. You perform chemical abortion for some  
10 pregnant women who are your patients, don't you?

11 THE WITNESS: I'm not sure what you ---

12 MS. GRANDIN: Objection to form. Go  
13 ahead. You can answer.

14 THE WITNESS: Sorry, Zoom. I'm not  
15 entirely sure what you mean by "chemical."

16 Q. (Mr. Boyle) Well, using chemicals or drugs  
17 to induce an abortion like -- well, I'm going to  
18 butcher these words, misoprotrol (sic) and Mifeprex,  
19 right?

20 A. So if you're -- you -- I think what you're  
21 talking about is using medicines, approved by the FDA  
22 for use in our country, to end a pregnancy in the  
23 first trimester, which would -- or second, depending  
24 on what the patient needs, to induce a -- for the  
25 mifepristone to block progesterone and the misoprostol

1 to cause cramping and bleeding so that the pregnancy  
2 will pass.

3 Q. Okay. And so I may refer to that as  
4 chemical abortion, but you may refer to it as medicine  
5 abortion. Is that sort of talking about the same  
6 thing, using those two drugs to induce an abortion?\

7 A. So the ---

8

9 MS. GRANDIN: Objection to form.

10 THE WITNESS: The medical term for that  
11 is medication abortion.

12 Q. (Mr. Boyle) Okay. And each of the women  
13 that you performed an induced abortion on was  
14 pregnant. Is that right?

15 A. For pregnant people that come to us, they've  
16 had confirmation of the pregnancy and then are  
17 requesting to end the pregnancy. And then we discuss  
18 options about how to do that.

19 Q. And I'm sorry, so is the answer yes, the  
20 people you performed an induced abortion on were  
21 pregnant when you did that procedure?

22 A. People who come requesting abortion have had  
23 confirmation of their pregnancy, yes, so they are  
24 pregnant.

25 Q. So every time that you performed an induced



1 abortion on a woman who was your pregnant -- I'm  
2 sorry, who -- a pregnant woman who was your patient,  
3 what was supposed to happen to the unborn child?

4 A. For people who make an appointment to  
5 discuss abortion care and then have counseling and go  
6 through informed consent and decide to proceed with  
7 either medication or procedural abortion, those people  
8 then have procedural termination of their pregnancy or  
9 termination of the pregnancy with medicines.

10 Q. And as an obstetrician, when you perform  
11 those induced abortions, do you consider the unborn  
12 child or the fetus to be your patient at that point?

13 A. I don't.

14 Q. How many induced abortions have you  
15 performed in your career?

16 A. I don't have an exact number to relay to the  
17 assembled audience here today. Many.

18 Q. Many like a hundred or many like a hundred  
19 thousand? Somewhere in between?

20 A. Somewhere between those two numbers, yes.

21 Q. Okay. Do you have an average per year that  
22 you -- of induced abortions that you perform?

23 A. I don't have an average per year, but maybe  
24 a week. I could provide probably numbers for weekly.  
25 An average week would be somewhere between five and

1 15. Sometimes, up to 20.

2 Q. Okay. So would you say an average week is  
3 ten to 12?

4 A. Sure.

5 Q. And is that 50 weeks a year?

6 A. I do take vacation occasionally, so yeah.

7 Q. So -- yeah, I mean ---

8 A. Forty -- 48 weeks a year.

9 Q. Forty. Okay, 40 weeks a year. Fair enough.  
10 Yeah.

11 A. Yeah.

12 Q. I wasn't trying to make you work all the  
13 time.

14 A. Yeah. Okay. Thanks.

15 Q. So you're talking somewhere like 400 to 450  
16 a year would be a fair estimate?

17 MS. GRANDIN: Objection to form. You  
18 can answer.

19 THE WITNESS: Again, it's hard to give  
20 me -- give an exact number, but that's probably our  
21 best guess for today.

22 Q. (Mr. Boyle) And how many years have you  
23 been in this practice that that would be your typical  
24 practice?

25 A. I have been an attending physician since

1 2014.

2 Q. So nine, coming on ten years. Is that  
3 right?

4 A. Yes. But please don't age me so fast.

5 Q. You're far younger than me, so hopefully you  
6 won't catch up. The -- that sounded like -- that came  
7 out wrong. I apologize. You're going to get older.  
8 It's too bad.

9 The -- and in residency, were you doing the  
10 same rough numbers of induced abortions per year?

11 A. No.

12 Q. Would you have been doing more or less  
13 during residency?

14 A. Less during residency because I was  
15 learning, you know, many other aspects of obstetrics  
16 and gynecology at that time as well.

17 Q. How about during your two-year fellowship  
18 for advanced family planning?

19 A. Yeah. So my fellowship, which you are  
20 entirely correct was two years, was focused on  
21 contraception for complex -- people with complex  
22 medical conditions and clinical research, and also  
23 focused care for induced abortion and abnormal  
24 pregnancy as well as pregnancy of unknown location.

25 Q. Have you ever performed a chemical or

1 medicine abortion on a patient who was pregnant with  
2 twins?

3 A. Yes. Yeah, I have seen a pregnant person  
4 that requested a medication abortion in the first  
5 trimester.

6 Q. And they were pregnant with twins?

7 A. Correct.

8 Q. Does that change the mechanism or the  
9 process that you go through when you're performing a  
10 chemical or medicine abortion with a patient who is  
11 pregnant with twins?

12 A. Our process for when a patient makes an  
13 appointment with us to consider medication abortion is  
14 pretty similar regardless of the characteristics of  
15 the pregnancy.

16 So our process is to, you know, provide  
17 thorough informed consent, to use our extensive  
18 protocols about coercion and to ensure that people are  
19 making their best decisions for themselves, and then  
20 describe in detail expectations about what to expect  
21 with medication abortion and what signs and symptoms  
22 might prompt further follow-up.

23 Q. Does the fact that a patient is pregnant  
24 with twins change the actual amounts of medication or  
25 chemicals given to induce the abortion for that

1 patient?

2 A. No. The medicines are the same.

3 Q. Would that be true of a patient with  
4 triplets or quadruplets or more also?

5 MS. GRANDIN: Objection to form.

6 THE WITNESS: I have never provided a  
7 medication abortion for a patient that had triplets or  
8 a higher-order multiple gestation.

9 Q. (Mr. Boyle) How do you know that?

10 MS. GRANDIN: Objection to form.

11 THE WITNESS: I have never done that to  
12 the -- to my knowledge.

13 Q. (Mr. Boyle) How would you know if a  
14 pregnant patient of yours is pregnant with twins or  
15 triplets or quadruplets?

16 A. Typically, we would know that from  
17 ultrasound.

18 Q. Are there any greater risks involved with a  
19 patient who is pregnant with twins or triplets or  
20 quadruplets getting a chemical or medical abortion?

21 MS. GRANDIN: Objection to form.

22 THE WITNESS: I can really only speak  
23 to patients that I've seen that have had a twin  
24 gestation. And the answer to that part of the  
25 question is no.

1 Q. (Mr. Boyle) Have you seen any studies that  
2 describe that or talk about that?

3 A. I don't recall seeing any studies  
4 specifically discussing higher-order multiples and  
5 medication abortion.

6 Q. So you have your experience but you don't  
7 have any additional scientific literature or studies  
8 to support the question of whether there is a higher  
9 risk for a pregnant patient who has twins or triplets  
10 receiving a medical -- I'm sorry, medicine or chemical  
11 abortion. Is that correct?

12 MS. GRANDIN: Objection to form.

13 THE WITNESS: The risk for a person  
14 with a singleton gestation would be the -- similar to  
15 the risks of a person that has a twin gestation.

16 Q. (Mr. Boyle) But you don't have any studies  
17 to support that conclusion, do you?

18 A. At the ready, no. But I certainly could do  
19 an extensive literature search about that and get back  
20 to you about that.

21 Q. Is there any way to tell if a patient is  
22 pregnant with twins or triplets or quadruplets other  
23 than by taking a transvaginal ultrasound of that  
24 patient?

25 A. Transvaginal ultrasonography is not required

1 for diagnosing a multiple gestation.

2 Q. You can do it without an ultrasound?

3 A. You don't need a transvaginal one.

4 Q. Okay. You can -- oh, that's fair.

5 Ultrasound is the way that you tell if your pregnant  
6 patient has twins or triplets or quadruplets, right?

7 A. That would be -- that would be -- yes, that  
8 -- it would be -- ultrasound is the typical way we  
9 diagnose a multiple gestation, yes.

10 Q. Do you think it's important to know if a  
11 pregnant patient that you're providing an induced  
12 abortion to has twins or triplets or quadruplets  
13 before you provide that induced abortion?

14 A. I think, given the rarity of spontaneous  
15 triplets and certainly higher-order multiple  
16 gestations for pregnant people in our country, that  
17 that would be an irrational thing to require for each  
18 person coming to access medication abortion.

19 Q. I'm sorry, you said "an irrational thing."  
20 What thing are you talking about?

21 A. Like, an irrational thing to require an  
22 ultrasound to ensure that you know whether or not a  
23 person has a singleton gestation, which is the vast  
24 majority of pregnant people, or a twin gestation,  
25 which is a very low amount of people, versus a

1 higher-order multiple gestation like triplets or  
2 quadruplets or quints or something crazy, which is  
3 even -- which is just even more rare. It's irrational  
4 to require transvaginal ultrasonography when safety  
5 isn't known to be improved for that.

6 Q. Well, you said safety isn't known to be  
7 improved but you also, I believe, said that you're not  
8 aware of any studies of the risks in -- associated  
9 with induced abortions for twins or triplets or  
10 quadruplets. Did I misstate that?

11 MS. GRANDIN: Objection to form.

12 THE WITNESS: What I -- what I want to  
13 communicate to this group is that the risks of  
14 medication abortion for somebody with a singleton  
15 gestation or a twin gestation are the same.

16 I don't know of any other studies for --  
17 again, at the top of my head, because -- because the  
18 incidence of triplets, quadruplets, quints is so  
19 exceedingly rare that there wouldn't -- I would not be  
20 surprised if there aren't studies about that because  
21 it is so rare.

22 Q. (Mr. Boyle) Is there any increased risk for  
23 performing a surgical abortion on a patient who is  
24 pregnant with twins or triplets or quadruplets?

25 MS. GRANDIN: Objection to form.



1 THE WITNESS: In the first trimester,  
2 no.

3 Q. (Mr. Boyle) Have you seen any studies that  
4 support your opinion on that?

5 A. Not that I recall at this moment.

6 Q. So you're unaware of any independent  
7 corroborating scientific literature to support that  
8 opinion, but that's your opinion. Is that what you're  
9 saying?

10 A. Again, it's really hard -- with the vast  
11 amount of literature on this topic, it's really hard  
12 to keep all of that in my brain at one time. But I  
13 certainly am well versed at extensive literature  
14 searches and could produce that if you -- if need be.

15 Q. Well ---

16 A. If it exists.

17 Q. Sorry.

18 A. Sorry.

19 Q. No, please finish if you had something else.

20 A. Yeah, so, I mean, it's not uncommon that as  
21 a physician, right, if I have a clinical question,  
22 that I would go to the literature and look things up  
23 and to really examine that.

24 I can tell you that, in my practice, the  
25 risk for a procedural abortion in the first trimester,

1 whether a patient has a singleton IUP or a twin  
2 gestation, those two people would have similar risks.

3 Q. And is that also true for second-trimester  
4 procedural abortions?

5 A. Second-trimester procedural abortions have  
6 similar risks to the first. However, when -- it  
7 really just kind of depends on what the gestation is.  
8 We would certainly, in the second trimester, you know,  
9 be prepared for all the risks associated with the  
10 procedure.

11 Q. Have you looked at any documents or  
12 guidelines from the Plaintiff, Planned Parenthood  
13 South Atlantic, in this case?

14 A. I have reviewed the declarations from  
15 Dr. Farris.

16 Q. Have you looked at any independent documents  
17 beyond what Dr. Farris said in her declarations from  
18 Planned Parenthood South Atlantic?

19 A. No.

20 Q. So you're not basing any of your opinions on  
21 the actual guidelines or protocols from Planned  
22 Parenthood South Atlantic, are you?

23 A. I'm not employed by Planned Parenthood South  
24 Atlantic, so I don't know their specific protocols.  
25 What I do know is that Planned Parenthood Federation

1 of America convenes expert medical -- medically  
2 trained people, advanced practice clinicians,  
3 physicians, certified nurse midwives to review  
4 evidence related to all aspects of care that we  
5 provide at all affiliates, and there are standards  
6 related to those.

7 Q. So this is information that is shared  
8 nationwide among Planned Parenthood subsidiaries. Is  
9 that what you're saying?

10 A. Yeah. There's what -- there's a national  
11 group of medical experts that convenes and reviews  
12 evidence and ensures that we have the most up-to-date,  
13 evidence-based protocols to use in our health centers.

14 Q. But none of your opinions in this case are  
15 based on Planned Parenthood South Atlantic's internal  
16 guides or protocols, because you haven't seen any of  
17 those, correct?

18 A. I have not seen them with my eyeballs, but I  
19 suspect they are very similar to the ones we use here  
20 at Planned Parenthood North Central States.

21 Q. Did you read the laws at issue in this case  
22 in the process of developing your opinions?

23 A. I review -- I've read portions of them.

24 Q. Which portions did you read?

25 A. I mean, I can't -- I don't recall the

1 specifics, but I read the -- I read details related to  
2 both the hospitalization requirement and the portion  
3 that requires existence of -- documentation of the  
4 existence of an intrauterine pregnancy.

5 Q. And how did you know to just read those two  
6 excerpts from the laws?

7 A. In conversations with counsel, we reviewed  
8 those two specific themes and the portions of the law  
9 that pertain to them.

10 Q. So as part of your conversations with the  
11 Plaintiff's lawyers, you were given just specific  
12 excerpts of the laws, not the whole law themselves?

13 MS. GRANDIN: Objection. Calls for  
14 privileged information. You can answer to the extent  
15 you don't disclose any privileged communications.

16 THE WITNESS: We -- I'm sorry, can you  
17 repeat the question?

18 Q. (Mr. Boyle) Yeah. So you were talking  
19 about your conversations with counsel. And I was just  
20 asking specifically the conversations you had with the  
21 Plaintiff's counsel involved just them feeding you the  
22 specific excerpts, not the whole law, so you haven't  
23 read the whole law to base your opinion. Is that  
24 correct?

25 MS. GRANDIN: Same objection.

1 THE WITNESS: I am perfectly capable of  
2 scrolling and reading a PDF myself. And I'm also a  
3 very busy practicing clinician, and so I focused on  
4 the portions of the law that I was planning to provide  
5 expert testimony for.

6 Q. (Mr. Boyle) When were you first contacted  
7 by Plaintiffs to be their expert witness in this case?

8 A. In late July.

9 Q. Did you have -- well, I guess you didn't  
10 have anything to do with the temporary restraining  
11 order portion of the case leading up to July 1st. Is  
12 that correct?

13 A. That is correct.

14 Q. Okay. Do you agree that patient safety is  
15 always the most important consideration when you're  
16 treating a patient?

17 MS. GRANDIN: Objection to form.

18 THE WITNESS: Patient safety is  
19 absolutely near the top, yes.

20 Q. (Mr. Boyle) Do you always choose to treat  
21 your patients in the safest way?

22 A. I aim to.

23 Q. So as I understand it, you work for another  
24 affiliate of the Planned Parenthood Federation of  
25 America. Is that correct?

1           A.    Yeah.  So I'm employed by the University of  
2 Minnesota Medical School.  I'm an associate professor  
3 in obstetrics and gynecology there.  I'm also a board  
4 -- board certified in obstetrics and gynecology.

5           I'm also sub -- board certified in the  
6 subspecialty of complex family planning and I provide  
7 care at Planned Parenthood North Central States, as  
8 you just described.

9           Q.    And so Planned Parenthood North Central  
10 States is like a branch -- subsidiary branch of  
11 Planned Parenthood Federation of America just like  
12 Planned Parenthood South Atlantic is a branch here in  
13 North Carolina.  Is that fair?

14          A.    Planned Parenthood North Central States is  
15 an affiliate, yeah.  We -- that's how they are  
16 described.  Uh-huh (yes).  So there's over -- you  
17 know, sort of guiding principles and, like I said,  
18 medical standards, but each affiliate is responsible  
19 for, you know, the conduct of their -- of the  
20 healthcare provided within their health centers.

21          Q.    And Dr. Farris is the director who runs the  
22 South -- Planned Parenthood South Atlantic.  And  
23 you're the director and you run the Planned Parenthood  
24 Central North States, right?

25          A.    I'm the director of research at Planned

1 Parenthood North Central States and I also serve as  
2 one of the associate medical directors. I am not the  
3 chief medical officer of Planned Parenthood North  
4 Central States.

5 Q. Do you know Dr. Farris personally?

6 A. I don't.

7 Q. Never met her at any Planned Parenthood  
8 convention or seminar or anything like that?

9 A. I have never met her directly.

10 Q. Excluding the lawyers who represent the  
11 Plaintiffs in this case, have you spoken to anyone  
12 else, to include other doctors perhaps, about your  
13 opinions in this case?

14 A. No. I mean, my husband knows I'm here, but  
15 he -- he's not medical and he wouldn't know anything I  
16 was speaking about if I tried to tell him.

17 Q. So you said you looked at Senate Bill 20 in  
18 the process of developing your opinions. Did you see  
19 where it defines possible complications that can arise  
20 from an induced abortion at North Carolina General  
21 Statue Section 90-21.81(2)a?

22 A. I mean, I'd have to see the text again to  
23 say whether or not I reviewed that portion.

24 Q. Okay. What is a uterine perforation?

25 A. A uterine perforation is a known risk of

1 procedural abortion when an instrument goes into the  
2 wall or through the wall of the uterus during the  
3 procedure.

4 Q. When you say "instrument," what do you mean  
5 by instrument?

6 A. A surgical instrument, either a suction  
7 cannula or a forceps, typically.

8 Q. And how does that happen during a procedural  
9 -- I'm sorry, surgical abortion?

10 A. How that happens, you know, really just  
11 depends on the -- on the case. It is a very low risk.  
12 It's a very -- it's a -- it's a known complication and  
13 one that I counsel patients about, but it is not very  
14 common.

15 Q. Do you agree that this is a possible  
16 complication that can arise from an induced abortion,  
17 surgical abortion, that should be disclosed to a  
18 pregnant woman who is a patient considering that type  
19 of abortion so that the patient can make an informed  
20 decision with more complete knowledge of the risks of  
21 the procedure?

22 MS. GRANDIN: Objection to form.

23 THE WITNESS: I believe all people  
24 should -- that are pregnant and considering abortion  
25 should be counseled on the risks and benefits of the



1 desired mode of abortion that they are considering.

2 Q. (Mr. Boyle) And who should inform the  
3 patient of that potential risk?

4 A. I mean, our whole healthcare team takes onus  
5 of that. But ultimately, it's my responsibility as  
6 the treating physician to ensure that the patient has  
7 good informed consent about the procedure that they  
8 have selected.

9 Q. And how -- I'm sorry, when should that  
10 patient be informed of this particular risk?

11 A. Prior to their procedural abortion.

12 Q. Are you aware that in -- under the North  
13 Carolina law, there's a 72-hour informed consent  
14 period where, after the initial counseling, the  
15 patient has to wait 72 hours before the induced  
16 abortion can occur?

17 A. I was not -- I'm -- I was not aware of that  
18 mandatory counseling wait, but that is a common thing  
19 that -- law that some patient -- some states have  
20 enacted accepting and exceptionalizing the healthcare  
21 that we provide during abortion care.

22 Q. What is a cervical laceration?

23 A. A cervical laceration is a tear that -- in  
24 the cervix.

25 Q. And how -- well, do you agree that a

1 cervical laceration is a possible complication that  
2 can arise from an induced abortion?

3 A. Yes. Mostly for -- mostly, we consider that  
4 risk for procedural abortion, and mostly in the second  
5 trimester.

6 Q. And how can that happen during a surgical  
7 abortion?

8 A. Again, the specifics of how those occur are  
9 unique to each case. And the overall risk of cervical  
10 lacerations at the time of procedural abortion is also  
11 very low.

12 Q. Well, how is it even possible that a  
13 cervical laceration could occur during a surgical  
14 abortion?

15 A. How it might occur would be related to  
16 during the evacuation part of the procedure, as the --  
17 there are -- as the -- as we're guiding the fetus out  
18 through the cervix.

19 Q. So explain to me what you mean by that. How  
20 do you guide the fetus out through the cervix?

21 A. With instruments.

22 Q. What type of instruments?

23 A. It's -- it varies for each case. Typically,  
24 a combination, again, of suction and forceps.

25 Q. So forceps are, not to be indelicate, but

1 sort of like tongs like you would see in a kitchen?

2 Is that what forceps ---

3 A. They do not look like ---

4 Q. A medical version?

5 A. They don't look like grilling tongs, no.

6 Q. What do they look like then?

7 A. I don't know. It's hard to -- really to  
8 describe that in words for a person who's -- I would  
9 guess never has seen one. I'd certainly be able to  
10 find an image for you if that would be helpful.

11 Q. Are they sharp?

12 A. No.

13 Q. Are they -- do they have rounded edges?

14 A. They do.

15 Q. How does something that's not sharp cause a  
16 laceration?

17 A. Mostly, that occurs because the cervix  
18 probably suboptimally responded to the preparation of  
19 the cervix that's typically employed, especially in  
20 the second trimester.

21 Q. So when we're talking second trimester, what  
22 weeks are we actually talking about?

23 A. The medical community, medical consensus  
24 about when the second trimester starts is at 14 weeks  
25 and zero days and continues until 27 weeks and six

1 days.

2 Q. And am I correct in understanding that that  
3 14 weeks actually includes an extra two weeks for  
4 implantation?

5 A. Again, the medical community uses and dates  
6 a pregnancy starting with the first day of the last  
7 menstrual period.

8 Q. Okay. And how big is the baby or the fetus  
9 at 14 weeks when the second trimester starts?

10 A. It varies depending on the patient.

11 Q. What's the typical size?

12 A. I don't -- I don't know that there is a  
13 typical size.

14 Q. What's the expected range that you as a  
15 practicing OB/GYN, who has done this for at least nine  
16 years, expect to see?

17 A. Yeah. There are certain -- you know, there  
18 are certain calibrated measurements that we use with  
19 ultrasound that can give an estimated size, but that's  
20 a conglomeration of different measurements that --  
21 that gives an estimated gestational age if someone  
22 doesn't have one already.

23 Q. And would that be head-to-rump measurements?  
24 Is that what it's called?

25 A. Not typically at 14 weeks. Typically at 14

1 weeks, we would use the biparietal diameter.

2 Q. What's that?

3 A. That's a measurement that can be performed  
4 with ultrasound that measures the biparietal diameter,  
5 the distance.

6 Q. Okay. When you say that, "biparietal  
7 diameter," what ---

8 A. Yeah.

9 Q. --- exactly is that?

10 A. It's the distance between the parietal  
11 bones.

12 Q. Where is that?

13 A. In the cranium.

14 Q. So it's the skull?

15 A. Colloquially, yes, skull.

16 Q. Which bones in the cranium or the skull is  
17 it that you're measuring there?

18 A. I'm sorry, what?

19 Q. Which part of the cranium or the skull are  
20 you measuring with the biperimetal (sic) diameter?

21 A. It's biparietal diameter. And again, it's  
22 the distance between both parietal bones. Yeah.

23 Q. What are the parietal bones in the skull?

24 A. They're bones of the skull.

25 Q. Well, I got a head and I can point to it.

1 Can you -- can you point to your head where the  
2 parietal bones are in the skull?

3 A. Well, I -- you know, again, for the sake of  
4 the transcript, I don't think that would be reflected  
5 very well. But I think, you know, the parietal bones  
6 on the side of -- both sides of the skull.

7 Q. Okay. So sort of right above the ears on an  
8 adult would be where the parietal bones are. Is that  
9 correct?

10 A. I don't know that I've ever measured a  
11 biparietal diameter on an adult. But, yes, on the  
12 fetus, that's where we measure them.

13 Q. Okay. So not the top, not the bottom. On  
14 the sides. Not the face, not the back of the head.  
15 Sort of above where the ears will eventually be if  
16 they're not already there, that's what you're  
17 measuring. Is that correct?

18 A. We measure, again, the distance between both  
19 visualized parietal bones on ultrasound. Kind of at  
20 the level of the thalamus, if you want to be more  
21 specific, so that's typically well above of the ears.

22 Q. So explain to me again what that measurement  
23 tells you and why it's important to guide your  
24 decision-making as the doctor who is performing the  
25 D&E abortion.

1 MS. GRANDIN: Objection to form.

2 THE WITNESS: The biparietal diameter  
3 in the early -- you know, in the second trimester, if  
4 one were using one single measurement for dating a  
5 pregnancy, is the best one for dating, providing a  
6 gestational age for the pregnancy if, again, a person  
7 doesn't have -- has not had an ultrasound previously.

8 Q. (Mr. Boyle) And why is that measurement  
9 important to inform you as the doctor about what types  
10 of tools you -- as I understand, you said that's the  
11 driving factor for what type of tools you use.

12 MS. GRANDIN: Objection to form.

13 THE WITNESS: Gestational age is a  
14 consideration sort of preoperatively about what my  
15 initial plan would be for how to accomplish a  
16 procedural abortion safely.

17 Q. (Mr. Boyle) Why? What exactly does it tell  
18 you? How does it inform your decision-making?

19 A. Because it -- because the size of the fetus  
20 is related to how we're able to accomplish the  
21 procedure.

22 Q. In what way does the size of the fetus or  
23 the baby impact your decision-making on how you  
24 accomplish the procedure?

25 A. Yeah. It dictates a lot of what instruments

1 we use, what kind of preparation of the cervix might  
2 be the safest and recommended for increased safety to  
3 decrease the risks of both perforation and cervical  
4 laceration like we've already discussed.

5 Q. So again, I'm still having trouble  
6 understanding how the forceps, which are rounded and  
7 not sharp cause a laceration in the cervix. Can you  
8 explain that to me, please?

9 A. Again, it -- it really just depends on the  
10 case. As the fetus comes through the cervix, there  
11 can be mismatch in size. There can be, as you know --  
12 ossification of certain parts of the fetus can cause  
13 tears in the cervix also.

14 Q. When you say "ossification of certain parts  
15 of the fetus," are you saying that the fetus, the baby  
16 has developed bones that are hard which could be sharp  
17 and cause a cut?

18 A. The fetus ---

19 MS. GRANDIN: Objection to form.

20 THE WITNESS: The fetus certainly  
21 develops bones as it grows, yes.

22 Q. (Mr. Boyle) At what stage does the baby,  
23 the fetus, start to develop ossification or bones that  
24 could be hard enough that they could cause a cervical  
25 laceration?



1           A.    I mean, we're -- to be honest, the --  
2    laceration is something we always worry about, much  
3    more so in the second trimester.  And again, the  
4    overall risk of that complication is extremely low.  
5    When it occurs, you know, we identify and treat it.

6                    And when -- there's not a specific point in  
7    pregnancy where -- that I can, you know, define a week  
8    for you where that risk becomes exceedingly more high.  
9    Because it just -- it's always very low.

10           Q.    Well, at week ten, you're doing an  
11    aspiration abortion, not a D&E abortion, right?

12           A.    So -- I'm sorry, can -- will you repeat the  
13    question?  I don't think I got it, the whole thing.

14           Q.    At week ten -- and when I say "week," are we  
15    talking about gestational age, or is that a different  
16    thing?  Are you saying gestational age when you say  
17    week?

18           A.    Yeah.  So if I -- if I say a pregnancy is  
19    ten weeks, that's -- I consider that the gestational  
20    age.

21           Q.    Okay.  So at ---

22           A.    Calculated from the last menstrual period.  
23    Sorry to speak over.

24           Q.    It's fine.  I understand.  So at week ten,  
25    gestational age, typically the baby or the fetus has

1 not developed any bones in its growth process. Is  
2 that correct?

3 A. Not necessarily. Organogenesis is --  
4 begins, you know, sometime between the eighth and 12th  
5 week of pregnancy.

6 Q. Okay. So at week eight, you would say  
7 there's not likely going to be any bones or  
8 ossification in that baby/fetus. Is that correct?

9 A. I mean, it kind of depends. Certainly --  
10 you know, certainly, it -- I don't -- I don't consider  
11 bones, you know, in the -- when I'm counseling a  
12 person about procedural abortion or continuing a  
13 pregnancy, for that matter, at eight weeks.

14 Q. Because you don't think that the baby or the  
15 fetus has developed bones in eight weeks. Is that  
16 correct?

17 A. No. Not necessarily. It's just when we --  
18 you know, we're good at magnifying things with  
19 ultrasound quite a bit. At the end of an eight-week  
20 procedural abortion, there certainly wouldn't be  
21 identifiable bones for me to see with my -- with my  
22 eyes.

23 Q. But that would be different at the end of a  
24 14-week ---

25 A. Potentially, yes.

1 Q. --- procedural abortion? Okay.

2 A. Uh-huh (yes).

3 Q. So walk me through what happens when you do  
4 an aspiration abortion versus a D&E abortion. What's  
5 the difference between those two? And please explain  
6 the difference by explaining what each one of them is.

7 A. Sure. A procedural abortion that involves  
8 aspiration alone would include dilation of the cervix  
9 and then evacuation of the pregnancy typically with  
10 suction alone.

11 Q. So I'm looking for a little bit more in  
12 depth. What does that actually mean when you say  
13 "suction alone"? What device do you use? How is it  
14 placed? What is it doing when it's placed? What  
15 happens afterwards?

16 MS. GRANDIN: Objection to form.

17 THE WITNESS: Yeah, that's kind of a  
18 lot of questions in a row, so I'm going to try to get  
19 them all. If I don't, please let me know.

20 So after dilation of the cervix, we pass a  
21 cannula, typically plastic. I've only ever used  
22 plastic ones in my professional career. And then the  
23 plastic cannula's attached to either handheld, so  
24 manual vacuum aspiration, or electric vacuum  
25 aspiration, you know, generated with a motor.

1 Q. (Mr. Boyle) So the plastic aspiration tube,  
2 what does that look like?

3 A. It looks like a plastic tube. It's  
4 typically clear.

5 Q. How big is the diameter?

6 A. So we -- cannulas are sized in diameter and  
7 measured in millimeters.

8 Q. So what is the size and measurement?

9 A. There are many different sizes of cannulas.

10 Q. So you have an array of options to choose  
11 from when you decide to do an aspiration abortion. Is  
12 that correct?

13 A. That is correct.

14 Q. How do you determine what size to use in a  
15 particular patient?

16 A. Yes. Typically, we have a prior plan, so a  
17 plan at -- you know, just prior to the start of the  
18 procedure of what cannula we're going to use to  
19 accomplish the abortion safely.

20 Q. And what is it that drives your planning on  
21 that? How do you make that plan?

22 A. Typically, the gestational age of the  
23 pregnancy.

24 Q. What does that impact? How does that impact  
25 your decision-making on what size of the cannula?

1           A.     Because, in my experience, when we use an  
2 eight-millimeter cannula, for example, an eight-week  
3 pregnancy will pass through the cannula successfully.

4           Q.     Okay. So when you say eight millimeters,  
5 that's the top-to-bottom diameter of the inside of the  
6 tube. Is that correct?

7           A.     It's the -- it's diameter of the -- of the  
8 suction cannula, yes.

9           Q.     And is it just a tube with a flush end  
10 opening that is placed and does the suction?

11          A.     Yeah, so the suction cannula is attached  
12 either to a manual vacuum aspirator, which I don't  
13 have here in my office but I certainly could get one  
14 to show you, or electric suction via tubing.

15          Q.     Okay. And if it's the manual version of  
16 suction, who is it that's actually manipulating that  
17 machine to create the suction?

18          A.     The operating -- the operating healthcare  
19 provider.

20          Q.     So the doctor, or a technician?

21          A.     In our setting, a doctor.

22          Q.     Okay. So if you're doing a manual  
23 aspiration abortion, you're the one actually turning  
24 the crank to create the suction on it?

25          A.     It's not a -- it's not a crank. It's --

1 looks similar to maybe a large syringe. So there's a  
2 plunger, right, that once you create the seal at the  
3 top of the device, you pull back the plunger to  
4 create, you know, vacuum in the -- in the -- in the  
5 canister, in the -- you know, again, if you're a  
6 -- you know, thinking of it as akin to a syringe,  
7 right, you would pull back and then -- it's similar to  
8 that.

9 Q. Okay. And then the fetus is pulled through  
10 the cannula tube into that reservoir there that you're  
11 pulling the plunger back from. Is that correct?

12 A. Yeah. The pregnancy -- we evacuate the  
13 pregnancy into the -- into the canister.

14 Q. And does that also include the placenta and  
15 the other parts of the embryonic sac, et cetera, that  
16 is removed with the syringe or the plunger?

17 A. Yeah. So what comes into the canister --  
18 and this would be for an induced abortion or for a  
19 missed abortion or what people would talk about -- you  
20 know, what people would call a miscarriage. We -- we  
21 evacuate all the tissue that's inside the uterus.

22 Typically, in the eighth week of pregnancy,  
23 for example, we don't talk about the tissue being  
24 placenta. It's really the -- the gestational sac and  
25 the villi. And again, in early pregnancy, there's

1 usually not an identifiable fetus. So it really just  
2 depends.

3 Q. At what point do you ---

4 A. Oh, sorry, may ---

5 Q. Go ahead.

6 A. --- can I go back ---

7 Q. Yeah.

8 A. --- for just a second? We also evacuate the  
9 decidual tissue, which is tissue that forms in the  
10 uterus, supporting tissue around the pregnancy.

11 Q. And do you do all of that, if it's manual,  
12 with just one pull, one time pulling back the plunger  
13 from the syringe device?

14 A. Many times, yes. Again, it really -- it  
15 really just depends. Our goal with any aspiration  
16 procedure is to ensure the uterus is empty at the end.

17 Q. So what do you do with the contents of that  
18 plunger when you're doing the manual aspiration  
19 abortion after you're completed with the procedure?

20 A. We examine the tissue to ensure we have the  
21 amount of tissue that we're expecting based on the  
22 gestational age of the pregnancy. And then there are  
23 laws governing the handling of pregnancy tissue in all  
24 states including Minnesota.

25 Q. Is that tissue used for any scientific

1 research or anything like that?

2 MS. GRANDIN: Objection to form.

3 THE WITNESS: In our setting, whether  
4 I'm providing abortion care at the University of  
5 Minnesota or at Planned Parenthood North Central  
6 States, we currently don't have that option for  
7 patients at this time.

8 Q. (Mr. Boyle) How is the material then  
9 treated? What is done with it then?

10 A. Yeah, we follow the laws in Minnesota  
11 regarding the disposal of pregnancy tissue.

12 Q. And what ---

13 A. And all tissue actually, whether or not I  
14 take -- you know, do a biopsy of the vulva or, you  
15 know, culture, exudate from a wound or something like  
16 that.

17 Q. What exactly does the law in Minnesota  
18 require you to do with that?

19 MS. GRANDIN: Objection. Calls for a  
20 legal conclusion.

21 THE WITNESS: The laws in Minnesota  
22 require that in -- well, I have -- most detailed  
23 knowledge about what -- you know, to be honest, at the  
24 University of Minnesota, pathology is the department  
25 that handles that. But here at Planned Parenthood



1 North Central States, we contract with a mortuary  
2 provider.

3 And we also offer the patients the option to  
4 make their own arrangements for handling of the fetal  
5 tissue after the procedure if that's their desire.

6 MR. BOYLE: Okay. I've got us at 58  
7 minutes and I'd just as soon take a break if that's  
8 all right with everyone else. Is everyone okay with  
9 that?

10 MS. GRANDIN: Uh-huh (yes). Does ten  
11 minutes sound good?

12 MR. BOYLE: Ten minutes is fine.

13 THE COURT REPORTER: Off the record at  
14 11:09 a.m.

15 (Brief recess: 11:09 a.m. to 11:20 a.m.)

16 THE COURT REPORTER: Back on the record  
17 at 11:20 a.m.

18 Q. (Mr. Boyle) Okay. Doctor, we were talking  
19 about the differences between aspiration abortion and  
20 D&E abortion. At what point does the fetus or the  
21 baby get to the size where you need to switch from  
22 doing an aspiration abortion to a D&E abortion?

23 A. In my practice, typically, that's around the  
24 17th week.

25 Q. Okay. And so you said you use an

1 eight-millimeter cannula to do the suction with an  
2 aspiration abortion at an eight-week gestational age.  
3 What size cannula are you using at week 16 before you  
4 decide to switch to a D&E in week 17?

5 A. Yeah, typically, at 16 weeks, I would --  
6 again, it kind of depends on the patient-specific  
7 characteristics, but generally I would try to start  
8 with a 16-millimeter cannula.

9 Q. Is it just a roughly number of weeks to  
10 number of millimeters decision?

11 A. That's a -- yeah, that's a general  
12 guideline.

13 Q. And again, going back to doing an aspiration  
14 abortion for twins or -- or triplets, do you need to  
15 know whether there are twins or triplets before you  
16 start that procedure?

17 A. To increase safety, no.

18 Q. Do you need to know for any reason?

19 A. Well, I think it's important -- you know,  
20 it's our standard practice to ask people, if they're  
21 having an ultrasound and the person who is pregnant,  
22 if they want to know whether or not they have a  
23 multiple gestation or not.

24 Q. Okay.

25 A. It's -- I mean, it's their body, so I think

1 that's important, you know, for -- piece of  
2 information to know whether or not the person who's  
3 pregnant wants to know that information.

4 Q. Is it important to the doctor performing the  
5 induced abortion?

6 A. Again, to increase safety, not really. It's  
7 my standard practice to use ultrasound during the  
8 procedure in the -- in the case of a multiple  
9 gestation.

10 Q. So when you've performed aspiration  
11 abortions, and I think you said you've only done it  
12 with twins, on a patient who's pregnant with twins,  
13 you use ultrasound during that procedure. Is that  
14 correct?

15 A. That -- yeah. I mean, generally speaking,  
16 yes, that is my -- the general way I do those  
17 procedures.

18 Q. Why?

19 A. Well, one of the ways, right, we know that  
20 the procedure is complete is how the uterus feels at  
21 the end, right? It feels empty. The other way we  
22 know the procedure is complete is by examining the  
23 products of conception after the procedure.

24 So, for example, if the patient has a  
25 six-week twin-gestation pregnancy, identifying the

1 pregnancy tissue at the end of the procedure and  
2 knowing for sure that a -- that we have both  
3 gestational sac -- gestational sacs present is a  
4 little bit harder, technically, to do.

5 And so in order to both ensure -- to ensure  
6 the uterus is empty at the completion of the  
7 procedure, I use ultrasound guidance.

8 Q. And so for that pregnant woman who is  
9 pregnant with twins that you do an aspiration abortion  
10 for at six weeks, you use an ultrasound during the  
11 actual procedure, during the aspiration abortion. Is  
12 that correct?

13 A. Correct.

14 Q. And how is it that you've come to know that  
15 that particular patient was pregnant with twins before  
16 you started that procedure?

17 A. Prior to procedural abortion, it's our  
18 practice to -- to review ultrasound records that the  
19 patient brings with them, for example, or to provide  
20 an ultrasound in our -- in our health center prior to  
21 procedural abortion.

22 Q. So when you are performing -- and when you  
23 say that, at your center, are you talking about at the  
24 hospital, or are you talking about at the Planned  
25 Parenthood clinic where you work?

1 A. In both settings, that would be true.

2 Q. So at both the hospital and at the Planned  
3 Parenthood clinic, before you do a procedural  
4 abortion, an aspiration abortion or a D&E abortion,  
5 you perform an ultrasound on those patients a hundred  
6 percent of the time. Is that correct?

7 A. I mean, as a experienced healthcare  
8 provider, I try not to say ever a hundred percent,  
9 because that's just not always possible. But, yes, it  
10 is -- it is our general practice to review records of  
11 an ultrasound previously or to provide one on the day  
12 -- or to provide one for a patient prior to a  
13 procedural abortion.

14 Q. And in your memory, have you actually  
15 performed an aspiration abortion on a woman who was  
16 pregnant with twins at six weeks gestational age?

17 A. I mean, the specifics at six weeks, I  
18 couldn't say for sure at six versus seven. But I  
19 certainly have provided a procedural abortion for a  
20 patient who had a twin gestation in the first  
21 trimester. That statement would certainly be  
22 accurate.

23 Q. Okay. We've talked about aspiration  
24 abortion. And if you would now, please explain what  
25 the details are of the D&E abortion, please.

1 A. "The details" meaning what?

2 Q. How do you do it?

3 A. Yeah. How we do it, again, depending on  
4 where somebody is in their -- in their pregnancy, they  
5 -- we may recommend some type of preparation of the  
6 cervix.

7 We know from data and guidelines from the  
8 Society of Family Planning, for example, that cervical  
9 preparation helps reduce the risk of the -- of a D&E  
10 procedure, especially in the -- later in the second  
11 trimester when we're providing that care.

12 Q. Why does -- first of all, what does  
13 preparation of the cervix entail? What does that  
14 mean?

15 A. Yeah. It might entail different things for  
16 -- for each individual, but may include a combination  
17 of the medication misoprostol, which we've talked  
18 about previously, and potentially the use of the  
19 medication mifepristone as well in preparation of the  
20 cervix. And then also placement of osmotic dilators.

21 Q. What is it you're trying to achieve with  
22 this preparation? What exactly is the point of it?

23 A. Yeah, we -- preparation of the cervix, if we  
24 can help the cervix soften some and provide a little  
25 bit of a dilation before the dilation and evacuation

1 starts, the risks of, in particular, cervical  
2 laceration decrease.

3 Q. When you say "dilation," does that mean  
4 increase the diameter of it?

5 A. Yeah. In -- you know, in obstetrics,  
6 commonly refer to a cervix as -- as dilated in  
7 centimeters. So, you know -- if we -- if I do an exam  
8 of the cervix and the cervix is open one centimeter,  
9 then I say the cervix is dilated one, one centimeter.  
10 And that would be true for before a dilation and  
11 evacuation or, you know, if I'm examining a patient's  
12 cervix at the end of a pregnancy in preparation for  
13 birth.

14 Q. What is the typical intent or level of  
15 dilation that you're trying to achieve when you  
16 perform a D&E abortion?

17 A. There's no -- there's no standardized number  
18 that is required before a person, you know, could have  
19 the start of their D&E, necessarily.

20 Q. Why does the size or the diameter of the  
21 cervix dilation matter then if -- what are you trying  
22 to do by dilating it if the particular size doesn't  
23 matter?

24 A. The greater the -- I mean, the -- you know,  
25 as the pregnancy advances, the pregnancy gets larger.

1 And therefore, we have to have, you know, a larger  
2 space with which to be able to complete that  
3 evacuation safely.

4 Q. Meaning the fetus or the baby is getting  
5 bigger as the pregnancy progresses and it's just a  
6 tighter fit to pull the bigger baby out if the cervix  
7 isn't dilated. Is that what you mean?

8 MS. GRANDIN: Objection to form.

9 THE WITNESS: Generally, when -- as  
10 we're, you know, providing a D&E for a patient, we  
11 need, you know, dilation of -- to some extent at -- at  
12 any gestation we're providing a D&E in order to be  
13 able to guide the products of conception through the  
14 cervix safely.

15 Q. (Mr. Boyle) And when you say guide them  
16 through, this isn't simply sticking -- this isn't  
17 simply applying a cannula, the tube, into the uterus  
18 and sucking out the contents because there's  
19 ossification and bone present and those bones won't go  
20 through the tube. Is that correct?

21 A. Well, the largest cannula that I've ever  
22 encountered in my practice is a 16-millimeter cannula.  
23 So that's the largest one we have at our -- at our  
24 ready to be able to use.

25 Q. Okay. I don't -- I don't see -- I don't



1 think that answered my question though.

2 A. Okay.

3 Q. And I'm not trying to be rude. I ---

4 A. Oh, no.

5 Q. I was asking if the reason you can't use  
6 just a cannula and do the aspiration at a certain  
7 point is because the fetus, the baby has gotten so big  
8 and the bones are developed and rigid, more rigid such  
9 that they won't just go through the tube. Is that  
10 correct, that's why you convert it to a D&E?

11 A. Yeah.

12 MS. GRANDIN: Objection to form.

13 THE WITNESS: It's a -- it's a little  
14 bit difficult to answer specifically because, for  
15 example, if there were a 17-millimeter cannula and I  
16 was providing a D&E abortion for a patient at 17 weeks  
17 of pregnancy, it's conceivable that we would be able  
18 to provide an aspiration abortion at that time as  
19 well.

20 Q. (Mr. Boyle) Okay. But since you have a  
21 16-millimeter cannula as the largest option available,  
22 at 17 weeks gestation age -- gestational age, it's  
23 your medical opinion that you would not be able to  
24 suck the contents out through the 16-millimeter  
25 cannula. Is that correct?

1           A.    It -- again, it depends a little bit on the  
2   nuances of each patient, but generally I don't expect  
3   to be able to complete the D&E at 17 weeks with  
4   aspiration alone.

5           Q.    With the D&E procedure, do you -- well,  
6   first of all, what are the options or the array of  
7   options that you have for surgical instruments related  
8   to the D&E procedure?

9           A.    Oh.  I mean, we have many different -- well,  
10   I mean, again, like I said previously, we -- even at  
11   the -- even for a D&E, we use a combination of  
12   instruments, typically forceps and aspiration.

13          Q.    Okay.  So forceps is one type of surgical  
14   tool that you use during D&E.

15          A.    Yes.

16          Q.    Are there any others that you've ever used?

17          A.    Well, let me think about that for a second.  
18   I don't think so, no.

19          Q.    Okay.  So when you say ---

20          A.    I can't -- I can't recall a time.

21          Q.    So when you say "surgical instruments,"  
22   you're really talking about forceps.  Is that correct?

23          A.    Yes.

24          Q.    And how big -- I mean, the forceps sort of  
25   have an X axis like scissors, if you will, and a clamp

1 on one end and a handle on the other end that you hold  
2 the handle in your hand. Is that correct?

3 A. How -- there certainly is a handle and then  
4 there's a -- on the end of the -- on the other -- on  
5 the opposite end of the forceps, there are, you know,  
6 fenestrations at the end that, you know, oppose each  
7 other directly, not necessarily in a, you know,  
8 crossing fashion like in a -- with a scissor.

9 Q. Right. They -- when you say fenestrations,  
10 are they like clamps or grabbers, like my hands here  
11 (demonstrates)?

12 A. Yeah, I mean, we call ---

13 MS. GRANDIN: Objection to form.

14 THE WITNESS: We call them  
15 fenestrations.

16 Q. (Mr. Boyle) Okay. Is there sort of a  
17 layperson word for fenestrations that you could help  
18 us understand?

19 A. There -- all the forceps I have used are  
20 metal. On the end of -- on the non-handle end of the  
21 forceps, there's typically a rounded opening --  
22 rounded opening on either side that then, you know,  
23 can come together and touch each other.

24 Q. Two loops that come together and ---

25 A. Loop. Yeah, loop is a -- probably a

1 good ---

2 Q. Okay.

3 A. --- description. Yeah.

4 Q. And they're metal on the fenestration or  
5 looped end? That's a metal instrument?

6 A. All the forceps that I've ever used are  
7 entirely metal.

8 Q. And how big are those loops? Are they, say,  
9 one inch in diameter? Are they ten millimeters in  
10 diameter? What's -- what would you say the size -- or  
11 are there different sizes?

12 A. It really depends on the forceps. Forceps  
13 aren't sized necessarily like a -- like a suction  
14 cannula would be. So really it just depends on the --  
15 on the forceps.

16 Q. Do you have multiple different forceps  
17 options, or is it all the same set of forceps you use  
18 every single time?

19 A. I have the same, you know, array of forceps  
20 available to me regardless of when I do or where I do  
21 a D&E, so both here at Planned Parenthood as well as  
22 at the university. You know, which one is required  
23 just depends on the, you know, individual patient  
24 characteristics, really.

25 Q. And when you say "on the individual patient

1 characteristics," are some of the forceps sort of  
2 wider at the fenestration or the loop side, the  
3 business end, if you will, the grabbers?

4 A. Sorry?

5 Q. Are they wider and bigger such that if the  
6 cervix isn't dilated to a certain point you wouldn't  
7 want to use the bigger one, you might use a smaller  
8 one?

9 MS. GRANDIN: Objection to form.

10 THE WITNESS: The -- there are  
11 certainly different -- you know, the diameter of the  
12 fenestration of the -- or loop of the forceps can vary  
13 depending on the -- on the forceps, yes.

14 Q. (Mr. Boyle) And you make a medical judgment  
15 based on the field presented, the operative field, as  
16 to what size forceps you choose. Is that correct?

17 A. Yeah. Generally, that's correct. You know,  
18 like with any -- certainly for D&E, that's similar to  
19 -- I mean, I don't use forceps for a diagnostic  
20 laparoscopy, for example. But I certainly would, you  
21 know, call for the instruments that made the most  
22 sense at the time based on my experience and training.

23 Q. So when you're performing a D&E, do you  
24 insert more than one forcep at a time inside the  
25 uterus or is it just one forcep at a time?

1           A.    I have never inserted more than one -- or  
2 placed more than one forceps at a time.

3           Q.    Okay.  When you're doing a D&E and you place  
4 one forceps in -- tool in through the cervix into the  
5 patient's uterus, do you also have the cannula  
6 positioned through the cervix in the uterus at the  
7 same time?

8           A.    No.  I cannot recall a time where that was  
9 true.

10          Q.    So when you're doing a D&E abortion, you  
11 don't have both the cannula and the forceps passing  
12 through the cervix at the same time.  You only have  
13 one at a time.  Is that correct?

14          A.    Yeah.  Generally, I think that's, yeah, been  
15 my experience.

16          Q.    What do you do with the forceps?  What is  
17 the actual technique that you are using those for in  
18 the D&E procedure?

19          A.    Yeah.  So after the -- I pass the forceps  
20 through the cervix, I open them gently and guide the  
21 products of conception out through the cervix.

22          Q.    So you open the forceps gently, meaning you  
23 get the loops or the fenestrations apart.  And then  
24 what do you do with them after you open it to guide  
25 the fetus or the baby out of the uterus?

1           A.    Yeah, so after the forceps are open, then I  
2 would close them, and whatever -- and then remove  
3 whatever tissue is between the fenestrations of the  
4 forceps. That could be, you know, any part of the  
5 pregnancy, including the placenta.

6           Q.    Okay. So you essentially put the forceps in  
7 closed, open them. Do you manipulate it at all at  
8 that point, or do you just open them and then close  
9 it?

10          A.    Typically, manipulation is -- like you're  
11 describing is not -- is not part of my practice.

12          Q.    Okay. So you open the forceps loops, you  
13 close them back and you then pull back the forceps  
14 through the cervix. Is that correct?

15          A.    As I -- as I try to instruct our trainees,  
16 our resident physicians, it's very much more a guiding  
17 of the tissue versus pulling. And that -- you know,  
18 the nuances of that are sometimes lost on them. But  
19 we discuss that at length because we want the -- I  
20 want, as the physician, as the surgeon, for that  
21 tissue to come through the cervix safely.

22          Q.    So the difference between guiding and  
23 pulling is sort of gently retracting it so it's not  
24 causing a cervical laceration. Is that the intent?

25          A.    Yeah. To prevent forcing the tissue to --

1 to go somewhere where it doesn't actually fit.

2 Q. And when you -- how many times does it  
3 typically take for you to position the forceps inside  
4 the uterus, open the loops, close them back, guide  
5 tissue out? How many times of that does it typically  
6 take for you to complete a D&E abortion?

7 A. Oh, that's -- that's a good question.  
8 Sometimes very few if a cervix is dilated, you know,  
9 quite -- you know, significantly. Sometimes, you  
10 know, depending on, again, patient characteristics  
11 and, you know, position of the products of conception,  
12 sometimes more. But I've never -- I don't think I've  
13 ever actually counted how many times.

14 Q. Have you ever had a situation where you  
15 opened the forceps in the uterus, closed them, guided  
16 the tissue out, and the whole fetus came out at one  
17 time?

18 A. No. No.

19 Q. Instead, do you typically close the -- put  
20 -- place the forceps in the uterus, open them, close  
21 them, guide the tissue out, and it's a portion of the  
22 fetus's body, so not the whole entire fetus intact,  
23 but a portion of it?

24 MS. GRANDIN: Objection to form.

25 THE WITNESS: Yeah. Generally, in the



1 -- in the way that we provide dilation and abortion --  
2 dilation and evacuation abortion -- sorry, excuse my  
3 flub there.

4 Dilation and evacuation abortion, yes, the  
5 patient is counseled that it is unlikely that the  
6 products of conception would come out intact.

7 Q. (Mr. Boyle) Do you ever have a situation  
8 where you're performing a D&E abortion where the skull  
9 or the cranium is too big to fit through the cervix so  
10 you have to do something to reduce the size of the  
11 skull?

12 A. I'm sorry, can you rephrase your question  
13 again? I just want to make sure I'm understanding it  
14 correctly.

15 Q. So you've got the cervix opening, let's say  
16 it's three centimeters dilated. And you've got the,  
17 I'm going to say it wrong but, parietal bone  
18 measurements of the cranium.

19 A. Uh-huh (yes).

20 Q. That is, say, five centimeters. So just it  
21 won't fit. What do you do in that situation when the  
22 skull is bigger than whatever dilation level you have  
23 the cervix?

24 MS. GRANDIN: Objection to form.

25 THE WITNESS: In that instance where

1 any part of the, you know, fetus is too large to pass  
2 through the cervix safely, then compressing the tissue  
3 is what we do.

4 Q. (Mr. Boyle) When you say you compress the  
5 tissue, speaking specifically about the skull itself,  
6 what do you mean by that?

7 A. That means the forceps is around the -- you  
8 know, we don't know specifically. On ultrasound, it's  
9 -- you know, for all my -- all my D&E procedures, I  
10 use ultrasound guidance. It's not always possible to  
11 know precisely what portion of the cranium that your  
12 forceps are, you know, directly on, but I -- we  
13 compress the tissue so that it will fit.

14 Q. So you compress the skull to collapse it.  
15 And then once it's collapsed, you extract it, you  
16 guide it back through the cervix. Is that what I  
17 understand?

18 A. Yeah. We compress ---

19 MS. GRANDIN: Objection to form. You  
20 can answer.

21 THE WITNESS: Thank you. We compress  
22 all the tissue so that it fits safely through the  
23 cervix.

24 Q. (Mr. Boyle) And the skull is the most --  
25 typically the biggest part that provides the most

1 difficulty in that D&E procedure. Is that correct?

2 A. Certainly -- you know, certainly, that's the  
3 -- again, if you were going to use ultrasound  
4 measurements, typically, that's the -- in all -- at  
5 all of the gestations where we provide induced  
6 abortion care, that's the -- typically the widest part  
7 of the fetus, yes.

8 Q. Do you ever take the cannula and insert it  
9 into the uterus, pass it through the cervix into the  
10 uterus and try to reduce the size of the skull with  
11 the cannula before you try and remove it with the  
12 forceps?

13 A. So not as part of my Planned Parenthood  
14 practice. There have -- at the university, I can  
15 think of less than a handful of a number of times  
16 where, because of the anomaly affecting the pregnancy,  
17 the cranium was significantly larger than normal.

18 And in order to -- and in one case,  
19 actually, you know, had become entrapped. The patient  
20 wanted an induction of labor at 22 weeks, but the  
21 cranium became trapped in the cervix. So to help her  
22 complete, you know, her desired induction, we -- I,  
23 you know, decompressed the cranium that way with using  
24 aspiration instead.

25 Q. With the guiding of the different parts of

1 the baby or the fetus out of the uterus through the  
2 cervix, once you get a portion out with the forceps,  
3 you guide it through the cervix, what do you do next  
4 with that portion that's being clasped by the forceps?

5 A. After it's passed through the cervix?

6 Q. Yes.

7 A. Typically, I have a tray. You know,  
8 typically I'm seated for dilation and evacuation  
9 procedures and I have a tray that's resting on my lap.  
10 And after the tissue is removed safely through the  
11 cervix, then I place the tissue on the tray.

12 Q. Okay. So you don't use suction from the  
13 cannula once it's past the cervix. You just use the  
14 forceps to remove it from the body -- from the  
15 patient's body and put it in a tray not using suction.  
16 Is that correct?

17 MS. GRANDIN: Objection to form.

18 THE WITNESS: Yeah, I guess I just --  
19 if I'm -- I guess I just want to make sure I  
20 understand the question correctly. So I've used the  
21 forceps to remove a portion of the products of  
22 conception through the cervix, out past the introitus  
23 of the pregnant person and then I place it on the  
24 tray.

25 Q. (Mr. Boyle) Okay. Yeah, I just didn't know

1 if once it -- I was asking if once you guided it  
2 through the cervix then you used the cannula ---

3 A. Oh, no.

4 Q. --- on that remnant and -- but, no, you  
5 extract it all the way sort of manually with the  
6 forceps ---

7 A. Yeah. That's my typical practice, yes, for  
8 sure.

9 Q. Do you use curettage for any of these  
10 surgical abortion procedures that you do?

11 A. Are you -- well, I mean, to be honest, the  
12 procedure in the first trimester is called a dilation  
13 and curettage, right, or D&C. But mostly -- so I  
14 guess it just depends on what you mean by curettage.

15 Q. What do you consider to be curettage?

16 A. I consider curettage to be use of a -- an  
17 actual curette, which is metal and has -- I'm not  
18 going to say sharp edges, but firm, thin edges, to --  
19 again, I don't prefer the word scrape ---

20 Q. Sort of like a -- sort of like a tongue  
21 scrapper but for a different part of your body?

22 MS. GRANDIN: Objection to form.

23 THE WITNESS: I'm not sure what a  
24 tongue scrapper is but -- but, yeah, I mean, people  
25 colloquially kind of refer to curettage as scraping.

1 I think that's an intense word for what we're doing.

2 But I -- to, you know, get back to your  
3 question, if that's what we're defining as curettage,  
4 then I -- the last time I needed to use that in the  
5 setting of a procedural abortion was -- I don't know.  
6 It happens extremely rarely.

7 Q. (Mr. Boyle) Okay. With the D&E abortion,  
8 after you have used the forceps to grasp and guide the  
9 bigger portions of the fetus or baby out of the  
10 uterus, what do you do after you -- you're done with  
11 the forceps portion of the procedure?

12 A. Yeah, so once I'm confident that we have,  
13 you know, nearly all the products of conception  
14 evacuated safely from the uterus, then I would advance  
15 a suction cannula to the fundus of the uterus, or the  
16 top, and aspirate any remaining decidual tissue,  
17 typically, that still remains within the uterus.

18 Q. When you say, "the fundus," or the top,  
19 that's the part farthest away from the cervix, so sort  
20 of up towards the rib cage and the lungs, that  
21 direction of the body?

22 A. Yeah. I guess. It's the portion of the  
23 uterus typically the furthest away both from me as the  
24 operator, as the surgeon and, as you described, from  
25 the cervix, yes.

1 Q. Is there anything else about the D&E  
2 abortion procedure that you do that we didn't cover or  
3 that we've missed?

4 MS. GRANDIN: Objection to form.

5 THE WITNESS: As far as the procedural  
6 steps?

7 Q. (Mr. Boyle) Yes. The start to finish, how  
8 it -- how it actually unfolds and your process.

9 A. Yeah, I mean, for every procedure, we would  
10 start with a surgical timeout and make sure that the  
11 healthcare team, you know, was all on the same page  
12 and prepped and ready for the procedure that we  
13 planned. We discuss, you know, the patient's wishes,  
14 any allergies, planned anesthesia, type of specimen we  
15 will have at the end. You know, we do many things.

16 But if you're talking about the procedure,  
17 you know, the actual operating steps for me as  
18 surgeon, then we've described those pretty much in  
19 detail. The main last one is, you know, assessment of  
20 hemostasis and ensuring that bleeding is appropriate.

21 Q. You mentioned anesthesia. What type of  
22 anesthesia options are available for your patients who  
23 you are performing a D&E abortion on?

24 MS. GRANDIN: Objection to form.

25 THE WITNESS: The patients that I see

1 have a -- a very wide range of anesthesia options.

2 Q. (Mr. Boyle) Such as?

3 A. Such as it is standard practice to ---

4 Q. Go ahead and drink water. I didn't mean to  
5 interrupt you. I'm sorry.

6 A. Oh, that's okay.

7 Q. Take your time.

8 A. I got this one.

9 Q. Okay.

10 A. The standard practice, to use local  
11 anesthesia by the cervix for all patients unless, for  
12 example, a patient has a severe allergy. From there,  
13 patients can opt for mild sedation with medicine or  
14 moderate sedation with medicine, deep sedation with  
15 medicine or a general anesthesia.

16 Q. So local anesthesia, what's the actual  
17 anesthesia used there? Is it lidocaine or something  
18 like that?

19 A. Yeah. Typically, in our current practice,  
20 we use lidocaine plus or minus epinephrine.

21 Q. And that's standard for both aspiration and  
22 D&E unless the patient has a known allergy. Is that  
23 what I heard you say?

24 A. Yeah, generally, I think that's correct.

25 Q. Let's move on to the -- well, start at the



1 end. General anesthesia, that involves intubating a  
2 patient and putting them completely unconscious. Is  
3 that correct?

4 A. General -- again, I'm not an  
5 anesthesiologist, so this is my understanding of that  
6 realm of care. But general anesthesia involves  
7 medications for relaxation and then sometimes muscle  
8 paralysis, and then intubation with a endotracheal  
9 tube that then's connected to an anesthesia machine  
10 that provides oxygenation for the patient during that  
11 general anesthesia.

12 Q. You're not an anesthesiologist and ---

13 A. No.

14 Q. --- and so I'm ---

15 A. Thankfully, no.

16 Q. I'm not asking you for in-depth ---

17 A. Yeah.

18 Q. --- general anesthesia opinions. But ---

19 A. Good.

20 Q. --- is it safe to say that if your patient  
21 is going through one of these two surgical procedures,  
22 and they ask for general anesthesia, you are not  
23 providing the general anesthesia? Is that correct?

24 A. No, I am not providing general anesthesia.

25 Q. Okay. So if the -- if your patient is

1 having general anesthesia, is it correct that there is  
2 an anesthesiologist also involved in that procedure?

3 A. Yes.

4 Q. Do you perform any procedures outside of a  
5 hospital -- let me just -- let me rephrase that.

6 Do you perform any D&E or aspiration  
7 abortion procedures outside of a hospital that use  
8 general anesthesia?

9 A. No.

10 Q. Okay. So when it comes to general  
11 anesthesia, you do all of those patients in the  
12 hospital setting for those procedures. Is that  
13 correct?

14 A. Currently, yes.

15 Q. Mild sedation, what's the process with that?  
16 Are you the doctor who is actually administering the  
17 mild sedation?

18 A. Yes. So I would prescribe an oral  
19 medication, typically a benzodiazepine, for the  
20 patient to take prior to their procedure.

21 Q. Okay. And do you have specialized training,  
22 or do you require specialized anesthesia training to  
23 provide mild sedation to a patient?

24 A. The medications used for mild sedation for a  
25 procedural abortion would be similar to those that are

1 -- and the very same that are sometimes used for other  
2 conditions in medicine, for example, extreme anxiety.  
3 So any physician can prescribe those medicines.

4 Q. Okay. So it's within your practice, then,  
5 to conduct mild sedation using benzodiazepine oral  
6 medication. Is that correct?

7 A. Absolutely.

8 Q. Okay. So you are the responsible doctor  
9 prescribing the mild sedation oral medication for your  
10 patients who opt for that type of sedation for the D&E  
11 and aspiration abortions. Is that correct?

12 A. Yes.

13 Q. Okay. Moderate sedation, what does that  
14 involve?

15 A. Moderate sedation, in our setting -- again,  
16 the official anesthesia definition is based on the  
17 kind of level of responsiveness of the patient. But  
18 in our -- both of our settings, typically moderate  
19 sedation includes the combination of two intravenous  
20 medications.

21 Q. Which two?

22 A. Typically, we use fentanyl and midazolam.

23 Q. Is midazolam a benzodiazepine?

24 A. Yes.

25 Q. Are there any other ways that you are aware

1 of to provide moderate sedation in your practice?

2 A. Those are the two medications that we --  
3 that we use for moderate sedation.

4 Q. And those are IV administered to your  
5 patients?

6 A. Yes.

7 Q. Are you the responsible doctor who is  
8 providing moderate sedation with those -- prescribing  
9 those two IV medications?

10 A. Yes.

11 Q. Can you perform mild and moderate sedation  
12 at the outpatient clinic, at the Planned Parenthood  
13 clinic that you perform surgical abortions at?

14 A. At Planned Parenthood North Central States,  
15 we offer patients who are having a procedural abortion  
16 to a -- you know, again, we talk to them about local  
17 anesthesia is a recommendation for any -- for  
18 everyone, and then give them the option to consider  
19 mild or moderate sedation if that's their preference.

20 Q. Okay. So you are acting within the scope of  
21 your practice in prescribing and monitoring patients  
22 who you're performing a surgical procedure on at the  
23 outpatient clinic when they opt for mild or moderate  
24 sedation. Is that correct?

25 A. Yes.

1 Q. Do you have any type of heart rate or  
2 oxygenation or any other type of monitoring on the  
3 patients who are undergoing moderate sedation?

4 A. We have extensive safety protocols regarding  
5 sedation of any kind in our -- in our setting -- in  
6 both settings, yes.

7 Q. And I'm speaking specifically about in the  
8 setting of your outpatient clinic, the Planned  
9 Parenthood clinic that you both provide clinical care  
10 at and are in the management of that clinic.

11 A. Uh-huh (yes).

12 Q. Do you have heart rate monitoring or  
13 oxygenation monitoring or respiratory monitoring for  
14 your patients who are undergoing moderate sedation  
15 there?

16 A. Yes. We are continually assessing vital  
17 signs throughout the procedure and measure heart rate  
18 and oxygenation during the procedure.

19 Q. So you actually have devices attached to the  
20 patient that have a constant monitoring of their heart  
21 rate and oxygenation. Is that correct?

22 A. That is correct.

23 Q. Okay. Do you have any anesthesiologists or  
24 CRNAs on-site at the Planned Parenthood clinic?

25 A. No, we don't. Because we can administer

1 moderate sedation or mild sedation, for that matter,  
2 safely in our setting ---

3 Q. Okay. So ---

4 A. --- without that.

5 Q. Sorry. So it's not required under Minnesota  
6 licensure and practice to have an actual specialist in  
7 anesthesia, either an anesthesiologist or a CRNA,  
8 present for you to prescribe mild or moderate sedation  
9 to your patient. Is that correct?

10 A. That is correct.

11 Q. Okay. Talk to me about -- well, and just to  
12 jump back to general anesthesia.

13 A. Sure.

14 Q. It is a requirement that you have a  
15 specialist, either an anesthesiologist or a CRNA or  
16 some combination of the two, if you're going to under  
17 -- if your patient is going to undergo general  
18 anesthesia. Is that correct?

19 A. I'm not trained in general anesthesia. So  
20 if my patient is planning that type of anesthesia,  
21 then, yes, I would -- I would request an anesthesia  
22 colleague to be present for that.

23 Q. And that does not occur at the outpatient  
24 Planned Parenthood clinic, the general anesthesia  
25 component. Is that correct?

1 A. Not currently.

2 Q. Has it ever?

3 A. No.

4 Q. Let's talk about deep sedation. What does  
5 that involve?

6 A. Deep sedation typically involves an IV  
7 medication called propofol.

8 Q. Is that it?

9 A. Yeah. Yes.

10 Q. Okay. So you're -- you've got a patient who  
11 chooses deep sedation, you're going to put that  
12 patient on IV propofol. Is that correct?

13 A. I don't administer intravenous propofol.

14 Q. Okay. So when a patient of yours selects  
15 deep sedation for an induced abortion surgical  
16 procedure, either D&E or an aspiration, you can't do  
17 that at the Planned Parenthood clinic, you have to do  
18 that at the hospital. Is that correct?

19 A. Current -- yes, currently all patients that  
20 desire deep sedation would be -- I would take care of  
21 them in the hospital setting.

22 Q. This IV propofol, when it's administered, do  
23 you have to have an anesthesiologist or a CRNA present  
24 to monitor the patient once the propofol is  
25 administered throughout the procedure?

1           A.    Well, again, in my setting, that's typically  
2 the case. I don't know the specific -- because it's  
3 not a medication I administer, I don't know the  
4 specific -- you know, both -- you know, if there's any  
5 law about that, because I don't -- I don't do that.  
6 I'm not -- I don't ---

7           Q.    And that's fair. It's outside your  
8 specialty.

9           A.    Yeah.

10          Q.    In your observation, you typically see some  
11 specialist, anesthesiology specialist monitoring that  
12 patient, but you don't know if that's required or not.  
13 Is that a fair way to say that?

14          A.    So every patient that I've taken care of  
15 that has had propofol administered, yes, there is  
16 someone trained with specific -- I'm sorry, you know,  
17 has either a CRNA, typically, or an anesthesia  
18 resident or an anesthesia attending physician.

19          Q.    And you would not convert a patient of yours  
20 in the Planned Parenthood setting -- if you were doing  
21 a aspiration or a D&E abortion in the Planned  
22 Parenthood clinic on your patient using mild or  
23 moderate sedation, you would not convert that patient  
24 to deep sedation during the procedure, would you?

25          A.    During the procedure, no, we don't have --



1 we don't have the medications on-site for conversion  
2 to deep sedation.

3 Q. Have you reviewed the sedation policy that  
4 Planned Parenthood South Atlantic produced in  
5 discovery in this case?

6 A. I have not.

7 Q. Would you agree that, in your practice, you  
8 would not give your patients at the Planned Parenthood  
9 clinic an option of deep sedation at your clinic  
10 setting to perform an aspiration or D&E abortion?

11 A. Currently, with the capacity that we have in  
12 our health centers that provide procedural abortion,  
13 we do not offer deep sedation.

14 Q. Because you don't have any specialist there  
15 who can actually monitor the patient under deep  
16 sedation and it's outside your scope of practice. Is  
17 that correct?

18 A. Yes. Because I don't -- I don't administer  
19 medications like propofol.

20 Q. And you are aware of what your Planned  
21 Parenthood informed consent and sedation and --  
22 minimal or moderate, paperwork looks like when you  
23 give your patients counseling about what type of  
24 sedation or anesthesia they have available to them?  
25 You're aware of that paperwork, right?

1 A. Yes.

2 Q. And you would not expect in your paperwork  
3 for the Minnesota Planned Parenthood clinic, where you  
4 are, that a patient could receive deep sedation at  
5 that Planned Parenthood clinic under any circumstance,  
6 right?

7 A. Well, for example, there may be an instance  
8 where we're planning to start offering that service  
9 where we would update the consent to reflect the  
10 option for deep sedation, you know, just prior to  
11 being able to offer that service.

12 Q. Are you aware of any anesthesiologists or  
13 CRNAs practicing at Planned Parenthood South Atlantic  
14 facilities in North Carolina?

15 MS. GRANDIN: Objection to form.

16 THE WITNESS: I don't know -- other  
17 than Dr. Farris, I don't know any other physician  
18 that's employed by Planned Parenthood South Atlantic.

19 Q. (Mr. Boyle) So you don't know of any  
20 general -- I'm sorry, you don't know of any  
21 anesthesiologist or CRNA who practices at or with any  
22 of the Planned Parenthood South Atlantic facilities in  
23 North Carolina. Is that correct?

24 A. Again, the -- really, the only physician I  
25 know in North Carolina is Dr. Farris and my residency

1 colleague ---

2 Q. Well, I ---

3 A. --- who is an obstetric and gynecology  
4 physician.

5 Q. But you agree it wouldn't be safe in your  
6 practice in Minnesota to provide deep sedation at a  
7 Planned Parenthood clinic where you work there?

8 MS. GRANDIN: Objection to form.

9 THE WITNESS: We -- we currently can't  
10 offer deep sedation based on the capacity and  
11 personnel that we have on staff.

12 Q. (Mr. Boyle) And you're not aware of any  
13 reason or any practice with the Planned Parenthood  
14 South Atlantic in North Carolina facilities that they  
15 can provide deep sedation, are you?

16 A. I'm not aware whether they can or they  
17 cannot. I don't -- I'm not sure what, you know,  
18 personnel are on the -- on the payroll for that  
19 organization.

20 Q. If they do not have any anesthesiologists or  
21 CRNAs who are present and able to provide care to  
22 patients at the Planned Parenthood clinics in North  
23 Carolina, would you agree that it's not appropriate  
24 for them to offer deep sedation?

25 A. The facilities that I'm aware of, none of

1 which are in -- you know, I don't really know the  
2 details about any facilities in North Carolina, the  
3 specifics. The facilities that I am aware of that  
4 primarily offer abortion care that have the  
5 opportunity to provide deep sedation do have typically  
6 either a CRNA or an anesthesiologist overseeing that  
7 type of sedation.

8 Q. So you don't know anything about Planned  
9 Parenthood South Atlantic North Carolina facilities,  
10 operations or guidelines, or who they have present to  
11 assist with the performance of surgical abortions. Is  
12 that correct?

13 MS. GRANDIN: Objection to form.

14 THE WITNESS: I know that they are very  
15 diligent about following the law in North Carolina.  
16 And I know, because they are a Planned Parenthood  
17 affiliate, that they have very -- very rigorous  
18 medically-evident -- you know, evidence-based  
19 guidelines for providing all the care they provide,  
20 including abortion care and including any type of  
21 sedation.

22 Q. (Mr. Boyle) You said you know that they're  
23 diligent about following the law. How do you know  
24 that? What facts do you have that inform your opinion  
25 about that?

1           A.    I've read Dr. Farris's declarations in this  
2 case.  And as an employee of a Planned Parenthood  
3 affiliate, I know the rigorous attention to the  
4 medical evidence that all affiliates must be up to  
5 date on and providing for their patients.

6           Q.    But you don't have any specific facts about  
7 the North Carolina facilities.  Is that correct?

8           A.    I don't practice in North Carolina, so no.

9           Q.    Do you know how far away from the North  
10 Carolina Planned Parenthood facilities the hospitals  
11 are located?

12          A.    I do not.

13          Q.    So you don't have any idea about how long it  
14 would take to transfer a patient from a Planned  
15 Parenthood facility in North Carolina to any hospital  
16 in North Carolina, do you?

17          A.    I do not.

18          Q.    So you don't have any opinions about whether  
19 it would be easy or not for Planned Parenthood North  
20 Carolina to transfer patients to hospitals in North  
21 Carolina, do you?

22          A.    I'm afraid that I'm not very up to date on  
23 my North Carolina geography, no.

24          Q.    I would've been shocked if your answer was  
25 different, but I just want to clarify.  You don't know

1 anything about that ---

2 A. I lived in North Carolina once upon a time,  
3 but I have not.

4 Q. And I understand and I'm not trying to ---

5 A. No, that's okay.

6 Q. --- overkill it, but just so I'm clear on  
7 your answer. You don't have any opinions about  
8 whether there is a great distance between any Planned  
9 Parenthood facility in North Carolina and any hospital  
10 in North Carolina. Is that correct?

11 MS. GRANDIN: Objection to form.  
12 Apologies.

13 THE WITNESS: I don't have any  
14 information in my brain at this time about the  
15 distance, whether short or long or middle or however  
16 you would define those terms, between a health center  
17 -- Planned Parenthood health center in North Carolina  
18 and any type of hospital.

19 Q. (Mr. Boyle) And you don't have any idea  
20 about what Planned Parenthood in -- facilities in  
21 North Carolina's procedures are to transfer patients  
22 to North Carolina hospitals because you haven't seen  
23 any of that information. Is that correct?

24 A. I have not seen them. However, again,  
25 because I'm an employee of a Planned Parenthood

1 affiliate and I know the rigorous protocols that we  
2 have for -- regarding any patient that needs transfer  
3 out of our facility, I am quite certain that Planned  
4 Parenthood South Atlantic has a similar rigorous  
5 protocol for any type of occurrence where a person  
6 might need to be transferred out of the health center.

7 Q. Well, I appreciate that you think that is  
8 probably the case, and you may even be right. But as  
9 we sit here today, you don't have any factual basis to  
10 make that other than your speculation of how your  
11 experience is with the Planned Parenthood parent  
12 organization. Is that correct?

13 A. All facilities as part of a Planned  
14 Parenthood affiliate go through what's called  
15 accreditation. And safety protocols, including for  
16 patients that need transfer outside of the health  
17 center, are required to continue to be a Planned  
18 Parenthood affiliate.

19 So at that level, I do know that there is a  
20 safety protocol that exists.

21 Q. Well, I appreciate ---

22 A. But I have -- but you're correct, I have not  
23 seen it with my eyeballs.

24 Q. Okay. And I appreciate that I think what  
25 you're saying is is they all should be. But you don't

1 know even if these North Carolina Planned Parenthood  
2 facilities are accredited, do you?

3 MS. GRANDIN: Objection to form.

4 THE WITNESS: In order for the doors to  
5 be open, they must be up to date on accreditation.

6 Q. (Mr. Boyle) And again, not to get too deep,  
7 but I think what you're saying is in order for the  
8 doors to be open, they should be, but you don't know  
9 specifically whether they are or not in North  
10 Carolina, do you?

11 MS. GRANDIN: Objection to form.

12 THE WITNESS: I mean, it's hard for me  
13 -- I mean, I don't -- I don't have really any detailed  
14 knowledge about the safety protocols other than the  
15 ones that I use, so...

16 Q. (Mr. Boyle) And just to close the loop on  
17 that. So you don't have detailed knowledge about  
18 what's going on in the North Carolina facilities. Is  
19 that correct?

20 MS. GRANDIN: Objection to form.

21 THE WITNESS: Again, I know that in  
22 order to continue to be an accredited affiliate within  
23 our -- within in the Planned Parenthood Federation,  
24 that leadership in health centers must demonstrate  
25 that they are up to date and practicing in accordance



1 with the standards and guidelines of the federation.

2 Q. (Mr. Boyle) And you don't know if the North  
3 Carolina facilities have done that, do you?

4 A. I mean, I don't know what -- on a intimate  
5 level what other -- what any other physician is doing  
6 in their -- in their practice.

7 Q. And I appreciate that. But that means you  
8 don't know what's going on at the North Carolina  
9 Planned Parenthood facilities in that regard. Is that  
10 correct?

11 A. I have ---

12 MS. GRANDIN: Objection to form.

13 THE WITNESS: I have never been there  
14 or visited.

15 Q. (Mr. Boyle) And you don't know what's going  
16 on with their accreditation or their safety policies,  
17 do you?

18 MS. GRANDIN: Objection.

19 THE WITNESS: I can't -- it's hard for  
20 me to comment on care that's being provided in a place  
21 where -- you know, the specific details of that care  
22 when I've never been there to observe that care. I  
23 can speak most authoritatively to my own practice.

24 Q. (Mr. Boyle) Is infection a possible  
25 complication that can arise from induced abortion?

1 A. Infection is a known risk associated with  
2 pregnancy and also induced abortion, yes.

3 Q. Is bleeding or vaginal bleeding that  
4 qualifies as a Grade 2 or higher an adverse event --  
5 I'm sorry.

6 Is bleeding or vaginal bleeding that  
7 qualifies as a Grade 2 or higher adverse event,  
8 according to the common terminology criteria for  
9 adverse events, a risk of a surgical abortion?

10 MS. GRANDIN: Objection to form.

11 THE WITNESS: Are you reading from a  
12 document that I could see, or -- I'm not sure what you  
13 mean by Grade 2. That's not standard terminology in  
14 my practice.

15 Q. (Mr. Boyle) Okay. Is bleeding or vaginal  
16 bleeding, heavy vaginal bleeding a risk that can  
17 accompany an induced abortion?

18 A. Heavy vaginal bleeding, which typically,  
19 honestly, arises from the uterus -- so, you know,  
20 heavy bleeding in pregnancy can occur with spontaneous  
21 abortion. It can happen with induced abortion. It  
22 can also happen at the time of giving birth.

23 Q. Is heavy bleeding a risk of both an induced  
24 abortion and a risk of an ectopic pregnancy?

25 A. Bleeding can see -- be seen with both a

1 patient having an induced abortion and an ectopic  
2 pregnancy.

3 Q. Do you agree that pulmonary embolism is a  
4 possible complication that can arise from induced  
5 abortion?

6 A. Pulmonary embolism, again, is a extremely  
7 rare complication that can happen as a -- as a result  
8 of being pregnant. It is extremely rare after a  
9 person has an induced abortion. It is much more  
10 common and likely after giving birth.

11 Q. Is it a risk of an induced abortion that you  
12 describe to your patients when you are counseling them  
13 about their decision of whether to have an induced  
14 abortion?

15 A. We talk to patients having any sort of  
16 procedure in pregnancy, whether that's a procedural  
17 abortion or a cesarean section, about the risk of  
18 blood clot.

19 Q. And do you include deep vein thrombosis in  
20 that category of risks that you discuss with your  
21 patients in those circumstances?

22 A. Yes. I mean, we usually -- the language  
23 that we use with patients is typically blood clot,  
24 because that's a little bit more -- it's easier to  
25 wrap your head around. Most people don't know the

1 term deep vein thrombosis. Really, the -- you know,  
2 correct term is venous thromboembolism or VTE, which  
3 would encompass a deep vein thrombosis and a pulmonary  
4 embolism.

5 Q. Okay.

6 MR. BOYLE: Folks, we've been going for  
7 another hour. I'm at two hours. I suggest we take a  
8 break unless folks are wanting to keep pushing ahead.  
9 What do you all think?

10 MS. GRANDIN: Yeah, let's take a break.

11 MR. BOYLE: Okay.

12 MS. GRANDIN: Work for you, Dr. Boraas?

13 THE WITNESS: Yeah, that's fine.

14 MR. BOYLE: Very good.

15 THE COURT REPORTER: Off record at  
16 12:26 p.m.

17 (Brief recess: 12:26 p.m. to 12:39 p.m.)

18 THE COURT REPORTER: Back on the record  
19 at 12:39 p.m.

20 Q. (Mr. Boyle) Very good. Doctor, have you  
21 ever had to transfer a patient of yours who you were  
22 treating for an induced abortion, either surgical or  
23 chemical, from your Planned Parenthood clinic to a  
24 hospital because of a complication?

25 A. I have never had to transfer a patient with

1 a medication abortion. I have had a -- a patient that  
2 I had to transfer after a procedural abortion.

3 Q. How many patients have you had to transfer  
4 after a surgical abortion?

5 A. I actually don't have an exact number, but I  
6 can recall -- I can recall, you know -- I'm -- I --  
7 it's certainly not even one per year. Yeah.

8 Q. So somewhere around ten would be the number?

9 A. No. I mean, the ones that I can recall, I  
10 can only recall transferring two people.

11 Q. Would you agree that pelvic inflammatory  
12 disease is a possible complication from -- that can  
13 arise from an induced abortion?

14 A. As a trained gynecologist, a pelvic  
15 inflammatory disease is something that arises from  
16 upper genital tract disease typically associated with  
17 an infectious process.

18 Q. Right. And infection, I think we've already  
19 gone over, is a complication that can arise from an  
20 induced abortion. So sort of derivative from that,  
21 would you agree that pelvic inflammatory disease is  
22 also a complication that can arise from an induced  
23 abortion?

24 A. So infection after an induced abortion --  
25 you know, infection is a risk associated with

1 pregnancy and certainly with induced abortion as well.  
2 It's typically -- it's typically referred to as  
3 endometritis after a procedural abortion when we're  
4 talking about a infection that's affecting the uterus.

5 Q. Okay. Would you agree that endometritis, an  
6 infection of the uterus, is a possible complication  
7 that can arise from an induced abortion?

8 A. Yes. A very rare one.

9 Q. Okay. Would you agree that a missed ectopic  
10 pregnancy is a complication that can arise when you're  
11 providing an induced abortion for a patient?

12 A. I mean, if -- ectopic pregnancy is a -- is a  
13 reality of pregnancy in general. It's not more likely  
14 to be associated with induced abortion versus a  
15 population of people who aren't seeking an induced  
16 abortion.

17 Q. Okay. The general consensus, I believe, is  
18 that 2 percent of pregnant -- positive pregnancies are  
19 ectopic pregnancies. Is that correct?

20 A. I think, depending on the population, the  
21 exact point estimate differs, but somewhere between a  
22 -- probably a half point -- a half a percent up to  
23 three, depending on the population.

24 Q. And would you agree that a missed ectopic  
25 pregnancy, without regard to what the general sort of

1 prevalence of it is in any given population, that a  
2 missed ectopic pregnancy is a potential complication  
3 that can arise with providing an induced abortion to a  
4 patient?

5 A. I guess I'm not sure "missed" is the  
6 appropriate terminology here. People who come for  
7 induced abortion care are assessed for their risk of  
8 ectopic pregnancy regardless of what setting I'm  
9 working in in order to, you know, try to ensure the  
10 person is safe.

11 Q. If you have a patient who receives -- who  
12 you provide a chemical abortion to, and it's actually  
13 -- the patient actually has an ectopic pregnancy, do  
14 those two drugs that you provide the patient for the  
15 chemical abortion have any effect on the ectopic  
16 pregnancy?

17 A. The medicines that we use for medication  
18 abortion do not -- are not treatment for an ectopic  
19 pregnancy.

20 Q. So if the patient has an ectopic pregnancy  
21 and you are unaware of that and you provide a chemical  
22 abortion, that chemical abortion, those drugs, those  
23 two drugs that you provide that patient will not stop  
24 or end the ectopic pregnancy, will they?

25 A. So for a person that comes and requests a

1 medication abortion, we do extensive counseling about  
2 the expectations around what they might experience if  
3 they take the medicines, but also assess their risk  
4 for ectopic pregnancy.

5 So we certainly wouldn't provide medications  
6 for abortion like mifepristone and misoprostol if we  
7 thought a person had an ectopic pregnancy.

8 Q. Right. But sometimes you miss an ectopic  
9 pregnancy even if you do screening, right?

10 A. Sometimes, we're not able to diagnose it  
11 because we can't see it.

12 Q. On an ultrasound, right?

13 A. If a person has an ultrasound.

14 Q. So sometimes a patient who comes to you and  
15 asks for -- tests positive for pregnancy and asks for  
16 a chemical abortion has an ectopic pregnancy that you  
17 don't diagnose, and you give that patient the chemical  
18 abortion drugs, right?

19 A. So if someone screens low risk or -- and  
20 doesn't have an ultrasound or if a person has an  
21 ultrasound and we don't see an ectopic pregnancy, then  
22 those people can safely access medication abortion  
23 with mifepristone and misoprostol with close follow-up  
24 to ensure that the abortion was successful.

25 Q. But sometimes those people actually have an



1 ectopic pregnancy even if you think they were low risk  
2 or you took an ultrasound and did not locate the  
3 pregnancy. Is that correct?

4 A. Again, for a low-risk population, it's  
5 certainly something we discuss with people. But  
6 again, because the risk of ectopic pregnancy is so  
7 low, it's irrational to not provide the care that the  
8 person needs based on that very, very low risk unless  
9 that's a risk that's not acceptable to the patient.

10 Q. And I understand the question you're  
11 answering, but it's not really the question I'm  
12 asking.

13 A. Okay. Let me try again.

14 Q. Yeah. The -- and I appreciate your answer.  
15 It's fine. The question I am asking is, sometimes  
16 when those patients come to you, even if they are low  
17 risk after you screen them and even if you take an  
18 ultrasound and you cannot locate the pregnancy  
19 anywhere on the ultrasound: intrauterine, adnexa,  
20 wherever, sometimes those patients will have an  
21 ectopic pregnancy. Sometimes, it's too early to be  
22 seen on ultrasound and you just might not see it yet,  
23 but sometimes they will have an ectopic pregnancy,  
24 right?

25 A. Some -- a very small percentage of those may

1 go on to eventually be diagnosed with an ectopic  
2 pregnancy, yes.

3 Q. Okay. And in that situation, if you had a  
4 patient who you felt it was safe to give the chemical  
5 abortion drugs to even though they slipped through the  
6 screening process somehow and actually have an ectopic  
7 pregnancy, that particular patient who has ectopic  
8 pregnancy and chemical abortion drugs, those chemical  
9 abortion drugs don't do anything to stop the ectopic  
10 pregnancy, do they?

11 A. Not that is generally known within the  
12 medical community.

13 Q. Okay. Beyond unstudied and unsubstantiated  
14 possibilities, you use methotrexate to actually  
15 medically treat an ectopic pregnancy. Is that  
16 correct?

17 A. If a patient comes to me and has a known  
18 ectopic pregnancy, then I would -- based on, you know,  
19 various patient-level characteristics, I would discuss  
20 with that person their options for treatment, which  
21 would include expectant management with very close  
22 follow-up.

23 That meaning, you know, watch -- what  
24 colloquially people call "watch and wait" with good  
25 symptom assessment and, you know, kind of close

1 follow-up, or medication management with methotrexate  
2 typically, or a surgical procedure to treat the  
3 ectopic pregnancy.

4 Q. But in any event, the two chemical abortion  
5 drugs don't stop an ectopic pregnancy if they're given  
6 to a patient who actually has an ectopic pregnancy.  
7 Is that correct?

8 A. Not that we know.

9 Q. Okay. You agree that misoprostol has an FDA  
10 approval through ten weeks or 70 days. Is that  
11 correct?

12 A. Excuse me, can ---

13 MS. GRANDIN: Objection to form.

14 THE WITNESS: Can you say that again?

15 Q. (Mr. Boyle) Do you agree that the FDA has  
16 approved misoprostol through ten weeks or 70 days?

17 MS. GRANDIN: Objection.

18 THE WITNESS: Are you saying  
19 misoprostol, like m-i-s-o-p-r-o ---

20 Q. (Mr. Boyle) Mispronouncing that ---

21 A. Okay.

22 Q. --- because I have a terrible  
23 pronunciation ---

24 A. Oh, that's okay. I just wanted to make sure  
25 that I know what you're saying.

1 Q. Yes. I apologize.

2 A. Nope. Yep, that's okay. And your -- so now  
3 that I know what medicine you're discussing, can you  
4 say the rest of it again? I'm sorry.

5 Q. Yes. You agree that misoprostol has an FDA  
6 approval through ten weeks or 70 days, don't you?

7 MS. GRANDIN: Objection.

8 THE WITNESS: My understanding of the  
9 FDA label is that medication abortion with a  
10 combination of mifepristone and misoprostol, the FDA  
11 label discusses using those medicines through 70 days  
12 of pregnancy.

13 Q. (Mr. Boyle) Let me ask a question about  
14 your CV. And I'm sure I'm just not quite following.  
15 It says that you got your fellowship in family  
16 planning from the Magee-Womens Hospital. But when I  
17 look that up, it looks like that's not a fellowship  
18 program. Is it just under the umbrella of the  
19 University of Pittsburgh?

20 A. Yeah. Let me clarify. So -- well, I guess  
21 I can't think of a good -- but, so, yes, the  
22 fellowship educational, you know, umbrella is the  
23 University of Pittsburgh and the specific site is  
24 Magee-Womens Hospital ---

25 Q. Okay.

1 A. --- and associated clinics.

2 Q. And you also got a degree in clinical  
3 research. Is that a Ph.D. or...

4 A. I have a master's degree in epidemiology.  
5 And then during my fellowship, I completed a  
6 certificate in clinical research because I already,  
7 you know, had a preceding master's degree.

8 Q. What is the Consortium of Abortion Providers  
9 that you list in your CV?

10 A. The Consortium of Abortion Providers is a  
11 group of healthcare professionals that provide  
12 abortion care committed to, you know, examining the  
13 evidence and producing evidence to help ensure we take  
14 the best care of people.

15 Q. And I apologize, I may have said it all  
16 wrong.

17 A. Oh, no.

18 Q. Is it Mifeprex that has the 70-day FDA  
19 approval? I might've gotten those two confused. One  
20 of them has a 70-day approval. Is that correct?  
21 Or...

22 A. The combination of mifepristone and  
23 misoprostol for induced abortion care to 70 days ---

24 Q. Okay.

25 A. --- is my understanding of the FDA label.

1 Mifeprex is actually a brand name, so we try to stick  
2 to saying the generic name mifepristone.

3 Q. Okay. It's easier for -- I can actually say  
4 Mifeprex so ---

5 A. Yeah. Yeah.

6 Q. You list in your CV that you received a  
7 fellowship in reproductive health advocacy from a  
8 group called Physicians for Reproductive Health in  
9 2014. Is that correct?

10 A. I did.

11 Q. And that's not a fellowship based on  
12 medicine or clinical research or clinical practice of  
13 medicine. Instead, it's a group of  
14 abortion-performing doctors who train how to speak to  
15 government officials and lobby them, and to speak to  
16 media and advocate for abortion. Is that correct?

17 A. The Physicians for Reproductive Health  
18 Leadership Training Academy was an opportunity that I  
19 was able to take advantage of because I was a fellow,  
20 but other physicians are able to apply for and be  
21 accepted into that program as well.

22 The fellowship included, yeah,  
23 evidence-based ways to communicate patient stories to  
24 multiple people, to coworkers, to family, to elected  
25 officials, to anybody really.

1 Q. Have you ever lobbied on behalf of abortion  
2 advocacy to any government officials?

3 A. I -- I'd have to look up the years to be  
4 specific, but I certainly have participated in ACOG,  
5 the American College of Obstetrics and Gynecology's,  
6 annual event called the Congressional Leadership  
7 Conference, which typically takes place in the spring.  
8 Although -- like spring, usually March, early April,  
9 approximately.

10 Which, again, lobbies for -- where we have  
11 the opportunity to talk with, ideally, our elected  
12 officials as constituents, but may -- this last time I  
13 participated was only staffers, about bills that are  
14 important for reproductive health generally.

15 So both for obstetric care as well as  
16 induced abortion and other aspects of ensuring people  
17 get the best healthcare when they're a young person  
18 seeking reproductive health.

19 Q. Do you agree that abortion -- induced  
20 abortion should not be banned after a certain point in  
21 a pregnancy?

22 A. I think bans severely -- I think any  
23 abortion ban severely limits our collective  
24 responsibility to people to ensure that they're able  
25 to access the healthcare that they need.

1 Q. So do you think, then, that abortion should  
2 be allowed up to a normal full-term pregnancy or 40  
3 weeks gestational age?

4 MS. GRANDIN: Objection to form.

5 THE WITNESS: I have never met a  
6 patient who had a term pregnancy that desired an  
7 induced abortion.

8 Q. (Mr. Boyle) But do you support that type of  
9 induced abortion all the way up to the full term of  
10 pregnancy before the mother gives birth?

11 A. I think ---

12 MS. GRANDIN: Objection.

13 THE WITNESS: I think defining a  
14 gestational age week is hard, because there are many,  
15 many patient factors that go into that  
16 decision-making. And again, as an obstetrician,  
17 people who get to term pregnancy don't -- they don't  
18 want an abortion. They want -- they want to continue  
19 their pregnancy and give birth.

20 Q. (Mr. Boyle) Have you ever performed an  
21 induced abortion on a patient who was beyond 30 weeks  
22 gestational age in pregnancy?

23 MS. GRANDIN: Objection to form.

24 THE WITNESS: No.

25 Q. (Mr. Boyle) Do you think that there's any



1 limit that should be put on induced abortions at  
2 gestational age for any reason?

3 MS. GRANDIN: Objection.

4 THE WITNESS: I think limits -- I think  
5 blanket limits are harmful to patient autonomy.

6 Q. (Mr. Boyle) How many induced abortions have  
7 you performed of any type for an unborn child or fetus  
8 with a gestational age of 24 weeks or more?

9 MS. GRANDIN: Objection to form.

10 THE WITNESS: Again, I don't have a  
11 specific number. But because of the unique settings  
12 where I work, we are -- all of those patients that I  
13 would've taken care of in that gestational age range  
14 would've been diagnosed with a pregnancy with a  
15 life-limiting or a fatal lethal anomaly.

16 Q. (Mr. Boyle) So does Minnesota have laws  
17 that provide a limit to performing an induced abortion  
18 for a gestational age of the child or the fetus?

19 A. Minnesota does not have laws defining a  
20 specific gestational age week.

21 Q. You would agree that an unborn child or  
22 fetus, absent some anomaly like you mentioned, is  
23 typically viable or can live outside the womb after 24  
24 weeks gestational age, wouldn't you?

25 MS. GRANDIN: Objection to form.

1 THE WITNESS: The general medical  
2 consensus about the periviable period, yes, includes  
3 the -- you know, the general consensus in my community  
4 is the 24 weeks and zero days would be a gestational  
5 age that if the patient, you know, had a complication  
6 of pregnancy that, with much support for many days,  
7 sometimes even more than a year, that fetus could be  
8 supported and -- outside the uterus.

9 Q. (Mr. Boyle) Could live outside the uterus,  
10 is that what you mean?

11 A. Yeah. Again, with support, typically  
12 extensive support.

13 Q. In your opinion, does the former North  
14 Carolina law that allowed abortion pretty openly up  
15 through 20 weeks, was that too restrictive in your  
16 opinion?

17 MS. GRANDIN: Objection to form. Calls  
18 for a legal conclusion.

19 THE WITNESS: Again, I think it's hard  
20 to define -- after sitting with many patients in this  
21 decision-making space, I think it's hard to define a  
22 specific week that honors the lived experience of  
23 patients.

24 Q. (Mr. Boyle) So you think a 20-week -- ban  
25 after 20 weeks is too restrictive?

1 MS. GRANDIN: Objection to form.

2 THE WITNESS: To be honest, I'm not in  
3 favor of any ban. But I think there are plenty of  
4 circumstances -- albeit if you look up, you know, the  
5 overall percentage of how many abortions occur after  
6 20 weeks, the percentage is very low.

7 But again, for those patients, a ban after  
8 20 weeks doesn't honor their lived experience and the  
9 need for that healthcare.

10 Q. (Mr. Boyle) You understand that at least  
11 some people have the opinion that an abortion should  
12 be restricted after the unborn child or fetus has a  
13 heartbeat or to the first trimester, and some of those  
14 people believe that the unborn child or fetus is a  
15 separate human being who has their own life and,  
16 absent an induced abortion, would be able to progress  
17 and live their own life? Do you understand that ---

18 MS. GRANDIN: Object ---

19 Q. (Mr. Boyle) --- some people ---

20 MS. GRANDIN: Objection to form.

21 Q. (Mr. Boyle) Do you understand that ---

22 MS. GRANDIN: Apologies. Objection,  
23 form.

24 MR. BOYLE: Okay.

25 Q. (Mr. Boyle) Do you understand that some

1 people have that opinion? Right?

2 MS. GRANDIN: Objection.

3 THE WITNESS: Can you restate again in  
4 the -- what opinion people have so I can answer?

5 Q. (Mr. Boyle) Sure. And I understand we're  
6 going to get an objection. So I'll try and say it all  
7 and then objection, and then you answer if we can,  
8 okay?

9 MS. GRANDIN: Apologies.

10 MR. BOYLE: No. No problem.

11 THE WITNESS: Sorry.

12 MR. BOYLE: I kept rambling. It's not  
13 your fault. I'll try it better this time.

14 Q. (Mr. Boyle) Do you understand that at least  
15 some people have the opinion that abortion should be  
16 restricted because the unborn child has a heartbeat in  
17 the first trimester at some point and that the unborn  
18 child is its own separate person that can have a life  
19 if allowed to progress and be born?

20 MS. GRANDIN: Objection to form.

21 THE WITNESS: I certainly, as a person  
22 who's awake many of the days in our country,  
23 understand that there are many legislatures trying to  
24 ban induced abortion care once fetal cardiac activity  
25 is detected on ultrasonography.

1 Q. (Mr. Boyle) So you're aware that some folks  
2 have that opinion. And I'm not suggesting you agree  
3 with it, but some people do have that opinion, right?

4 MS. GRANDIN: Objection.

5 THE WITNESS: I mean, I can't -- I  
6 can't know other people's opinions unless they tell  
7 them to me.

8 Q. (Mr. Boyle) Would you think that someone  
9 who has that opinion is just always unreasonable or  
10 irrational?

11 MS. GRANDIN: Objection to form.

12 THE WITNESS: I think -- I think that  
13 people are entitled to have beliefs about a lot of  
14 topics. Whether or not that relates to rationality, I  
15 think just depends on the topic.

16 Q. (Mr. Boyle) Well, and I appreciate that.  
17 On that particular topic, do you think it's just  
18 impossible for someone to have a reasonable opinion  
19 that says that?

20 MS. GRANDIN: Objection to form.

21 THE WITNESS: Yeah, I'm not -- I'm not  
22 entirely sure. I think the -- well, of exactly what  
23 you're asking. You know, like, if people -- if a  
24 person I met had the opinion that elephants were  
25 endemic to the United States, I would say that's

1 irrational. That's not based in fact.

2 Q. (Mr. Boyle) Do you perform induction  
3 abortions?

4 A. I see patients that are in the second  
5 trimester that prefer induction, decide to proceed  
6 with induction abortion versus dilation and  
7 evacuation, yes.

8 Q. And you have performed those induction  
9 abortions, right?

10 A. I take care of patients who need an  
11 induction termination of pregnancy, yes.

12 Q. Can you tell me what does an induction  
13 abortion entail? What are the -- sort of like we went  
14 through aspiration and then D&E ---

15 MS. GRANDIN: Objection. Apologies.

16 THE WITNESS: Yeah, I will -- I will do  
17 my best. So typically, for the patients that I see  
18 needing an induction of -- induction for -- to end the  
19 pregnancy, typically are, you know, seen through our  
20 clinic. They are counseled about their options. They  
21 -- and the rest of induction versus dilation and  
22 evacuation versus continuing the pregnancy.

23 When they've made their own best healthcare  
24 decisions and decided to proceed with induction, then  
25 they would be -- receive, ideally, would -- because

1 it's the evidence-based protocol, a combination of  
2 medications very similar to those people ending their  
3 pregnancy in the first trimester, which would include  
4 mifepristone and misoprostol.

5 Q. (Mr. Boyle) Is there anything beyond giving  
6 those patients who choose to have an induction  
7 abortion those two drugs that you do to perform the  
8 induction abortion?

9 A. The most effective regimen to ensure the  
10 successful completion of their termination of  
11 pregnancy via induction would be to administer  
12 mifepristone and misoprostol.

13 Typically -- well, at times, people are also  
14 interested and we counsel patients about the options  
15 for pain control during that process because it's a  
16 much longer process than dilation and evacuation would  
17 be.

18 Q. So as I understand it, an induction abortion  
19 performed later in the second trimester is really just  
20 like a chemical abortion that you'd perform in the  
21 first trimester, it just takes longer?

22 A. The combination ---

23 MS. GRANDIN: Objection to form. Go  
24 ahead.

25 THE WITNESS: The combination of

1 medicines is the exact same. The dosing of  
2 misoprostol is typically different.

3 Q. (Mr. Boyle) Is there any surgical or  
4 procedural component of an induction abortion in  
5 addition to the chemical or medicine?

6 A. So induction of labor in the second  
7 trimester, you know, one of the risks that we discuss  
8 with people is the need for a, you know, procedure  
9 during the process. Typically, that would be for  
10 concern for a significant amount of bleeding.

11 So that's one of the things that we discuss  
12 with patients when they're -- when they're deciding  
13 between mode -- the mode of ending the pregnancy in  
14 the second trimester.

15 Q. And what type of procedure is it that you  
16 would possibly need to perform during that induction  
17 abortion?

18 A. It kind of depends on the patient-level  
19 characteristics again. You know, the most common  
20 reason that people need a procedure would be for a  
21 retained placenta.

22 Q. And what type of procedure would you perform  
23 on a patient that had a retained placenta under those  
24 circumstances?

25 A. Well, you know, to, like, be the most



1 succinct, we go in and get the placenta. So -- and  
2 that depends on the provider, honestly, whether or not  
3 they would feel comfortable using an instrument like a  
4 forceps for that. Certainly, I do with ultrasound  
5 guidance. Other people, depending on their training,  
6 may use aspiration or suction alone.

7 Q. So you said the most common is retrieval of  
8 retained placenta. What other circumstances have you  
9 confronted in addition to that most common one?

10 A. Well, for -- I've never -- I've never needed  
11 to provide a procedure for a patient who was having an  
12 induction abortion in the second trimester other than  
13 to help the placenta -- you know, to evacuate the  
14 placenta.

15 Q. So the chemical abortion drugs are given in  
16 different doses to essentially stop the growth and  
17 development of the baby or the fetus at that point.  
18 And then the second drug promotes the uterus to expel  
19 the fetus or the baby, and basically the mother  
20 delivers the -- the now terminated baby or fetus. Is  
21 that correct?

22 A. That was a lot of steps for that question,  
23 so I'll just kind of describe what happens. So  
24 mifepristone -- the science behind mifepristone in use  
25 for induction termination of pregnancy in the second

1 trimester is really to provide cervical softening and  
2 also to provide the decidual necrosis so the  
3 supporting tissue around the pregnancy starts to be  
4 less supportive.

5 And then when we add misoprostol, when we  
6 administer misoprostol, the action of misoprostol is  
7 to provide uterine contraction so that the pregnancy  
8 will pass. Typically, patients need more than one  
9 dose of misoprostol to accomplish that fully.

10 Q. And so that would be a more fully formed  
11 baby/fetus that looked like a baby because it's later  
12 in the second trimester. Is that correct?

13 MS. GRANDIN: Objection to form.

14 THE WITNESS: It really depends on what  
15 gestational age we're talking about when the patient  
16 starts the induction of labor to -- for abortion. In  
17 my experience, people who select induction of labor  
18 versus a dilation and -- a dilation and evacuation are  
19 hoping that they will be able to see -- are hoping  
20 that the pregnancy will pass intact.

21 Q. (Mr. Boyle) Do you use a differential  
22 diagnosis in your clinical practice?

23 A. I would, yeah, venture to guess pretty much  
24 every day.

25 Q. Do you agree that a differential diagnosis

1 should include all of the possible risks or dangerous  
2 situations for a patient that you are treating?

3 A. I mean, a differential diagnosis is simply a  
4 list of possible diagnoses for a certain constellation  
5 of signs or symptoms that a patient is reporting.

6 Q. And typically when you develop that list of  
7 possible risks or situations a patient might be  
8 facing, your job as a doctor is to treat the worst  
9 first, right? You have to focus on the things that  
10 could be life threatening, don't you?

11 MS. GRANDIN: Objection to form.

12 THE WITNESS: My job is to -- to know  
13 the list and communicate the list of possible  
14 diagnoses to the patient. Only the patient can decide  
15 what risks and -- to accept for a given diagnosis.  
16 It's not my job to say what risks a person should  
17 accept or shouldn't.

18 Q. (Mr. Boyle) You said you're a member of  
19 ACOG, right?

20 A. I am a member of ACOG, yes.

21 Q. Do you follow and agree with the practice  
22 bulletins that ACOG publishes?

23 A. I mean, generally, I think that's true.  
24 Some of -- you know, there are committees that review  
25 those regularly.

1 Q. Do you agree that ACOG practice bulletins  
2 provide clinical management guidelines for OB/GYNs?

3 A. Generally speaking, yes. I think the hard  
4 part about practice bulletins, again, is it's a  
5 collated document of evidence about a specific topic,  
6 and patients, individual patients, you know, in my  
7 experience, don't always fit guidelines or, you know  
8 -- you know, fit specific algorithms.

9 So that's when the clinical judgment based  
10 on experience and training of each individual treating  
11 physician comes into play.

12 Q. You said in your report, your declaration,  
13 that you were asked whether there is any medical  
14 justification for the two challenged provisions in  
15 relation to the Court deciding the Preliminary  
16 Injunction Motion. Who asked you to do that?

17 A. Who asked me to serve as an expert witness  
18 in this case?

19 Q. Who asked you whether there was any medical  
20 justification for the two challenged provisions?

21 A. I would have to understand which challenged  
22 positions you're referring to, I guess, first.

23 Q. Right. I -- I think we talked earlier about  
24 the IUP documentation is one and then the 12 -- after  
25 12-week hospitalization for induced abortion was the

1 other, right?

2 A. So I reviewed with counsel the -- my  
3 opinions based on experience and training for both the  
4 requirement for induced abortion care for rape and  
5 incest and life-limiting fetal anomaly to be provided  
6 in a hospital after the 12th week.

7 And I also discussed the specific portion  
8 about requiring the -- or documenting the existence of  
9 an intrauterine pregnancy before a medication  
10 abortion.

11 Q. Do you know what the legal standard is for  
12 those issues before the Court at the preliminary  
13 injunction?

14 MS. GRANDIN: Objection to form. Calls  
15 for a legal conclusion.

16 THE WITNESS: Yeah, I'm not an  
17 attorney, so I'm not sure I understand what you mean  
18 by "legal standard." I'm not -- I can't remember what  
19 you said.

20 Q. (Mr. Boyle) When you have a woman you're  
21 treating as your patient who has a positive pregnancy  
22 test, what do you consider to be on her differential  
23 diagnosis as potential medical risks and issues for  
24 her?

25 A. If I have a pregnant person sitting in front

1 of me, there are an exhaustive number of risks that I  
2 would think about for -- that might occur in a  
3 pregnancy.

4 Q. Such as?

5 A. Such as nausea and vomiting of pregnancy,  
6 such as high blood pressure diseases of pregnancy like  
7 gestational hypertension or preeclampsia. Like the  
8 need for a cesarean section, like the risk of pre-term  
9 birth, like the risk of a premature rupture of  
10 membranes, like bleeding in early pregnancy, the --  
11 like -- I mean, the -- the list goes on.

12 Q. Do you consider the possibility of an  
13 ectopic pregnancy to be one of those risks that's  
14 immediately on every differential diagnosis ---

15 A. Of ---

16 Q. --- for your patients who have tested  
17 positive for pregnancy?

18 A. Yeah. If somebody calls and reports a  
19 positive pregnancy test at home, again, we would do a  
20 thorough screen of the patient's history and try to  
21 determine their risk for an ectopic pregnancy.

22 Q. Do you agree that unless they are discovered  
23 and treated early almost 40 percent of ectopic  
24 pregnancies rupture suddenly causing pain and bleeding  
25 in the abdominal cavity?

1 MS. GRANDIN: Objection to form.

2 THE WITNESS: I'd have to see the  
3 specific text where that exact number is quoted. I  
4 can, you know, say as a practicing gynecologist, you  
5 know, when we identify an ectopic pregnancy, we  
6 usually talk about -- we counsel patients about the  
7 risks and benefits of expectant management versus  
8 medical management versus surgical management.

9 Q. (Mr. Boyle) Do you agree that ruptured  
10 ectopic pregnancies can be fatal?

11 A. Can be what?

12 Q. Fatal.

13 A. Fatal. Yes. Although, thankfully, in the  
14 U.S., you know, in 2023, I don't know of a time where  
15 that's happened in my hospital.

16 Q. Has it ever happened, that you're aware of,  
17 from one of the Planned Parenthood patients that you  
18 see in Minnesota?

19 A. Nope. Not that I'm aware of.

20 Q. And we mentioned this earlier, and I got  
21 this number from the ACOG bulletin 193, which is the  
22 clinical management guidelines for OB/GYNs for tubal  
23 ectopic pregnancy from March of 2018. Are you  
24 familiar with this document, this bulletin?

25 A. I have seen ---

1 MS. GRANDIN: Objection. Go ahead.

2 THE WITNESS: I have seen this practice  
3 bulletin, yes.

4 Q. (Mr. Boyle) Okay. And that's -- this  
5 practice bulletin says, "According to the CDC, ectopic  
6 pregnancy accounts for approximately 2 percent of all  
7 reported pregnancies." Does that sound accurate to  
8 you?

9 MS. GRANDIN: Objection.

10 THE WITNESS: I mean, again, it would  
11 be best to view the document and -- in order for me to  
12 authoritatively answer that question.

13 Q. (Mr. Boyle) Do you have a copy of it in  
14 front of you?

15 A. Not currently.

16 Q. We had discussed having available these  
17 documents. Do you have the ability to pull that up  
18 and look at it?

19 A. Yes. I should have that ability.

20 Q. Yeah, just take your time and let me know  
21 when you get it.

22 A. Okay.

23 MS. GRANDIN: Are you introducing this  
24 as an exhibit, Mr. Boyle?

25 MR. BOYLE: Maybe.



1 MS. GRANDIN: Okay.

2 MR. BOYLE: I don't know yet.

3 THE WITNESS: Okay.

4 Q. (Mr. Boyle) Let me know when you get it  
5 pulled up.

6 A. I will. My computer is exceedingly slow.

7 Q. Yeah, that's why I always print these  
8 things.

9 MR. BOYLE: I'll tell you what. We're  
10 at about two hours and 50 minutes, and I'm not going  
11 to be done in ten or 15 minutes.

12 THE WITNESS: Okay.

13 MR. BOYLE: Do you want to take a  
14 little bit of a longer break now and -- maybe take 30  
15 minutes and come back and finish up? And hopefully,  
16 you can get that pulled up in the interim.

17 THE WITNESS: Sure. That sounds fine  
18 to me.

19 MR. BOYLE: Does that work for you,  
20 Ms. Grandin?

21 MS. GRANDIN: Yes. Can we go off the  
22 record to talk about timing?

23 THE COURT REPORTER: Off the record at  
24 1:23 p.m.

25 (Luncheon recess: 1:23 p.m. to 1:52 p.m.)

1 THE COURT REPORTER: Back on the record  
2 at 1:52 p.m.

3 Q. (Mr. Boyle) Okay. So, Doctor, do you have  
4 that ACOG Practice Bulletin 193 from March 2018  
5 available?

6 A. I do. I have it pulled up here in PDF on my  
7 computer.

8 Q. Okay. Do you agree with the -- that ACOG  
9 bulletin 193 that, quote, "Despite improvements in  
10 diagnosis and management, ruptured ectopic pregnancy  
11 continues to be a significant cause of  
12 pregnancy-related mortality and morbidity.

13 "In 2011 to 2013, ruptured ectopic pregnancy  
14 accounted for 2.7 percent of all pregnancy-related  
15 deaths and was the leading cause of hemorrhage-related  
16 mortality," end quote?

17 A. Gosh, that's a long sentence. If you could  
18 point me kind of specifically in the document where  
19 you're discussing, then I can ---

20 Q. Yeah. In the first page, "Background  
21 Epidemiology," about halfway through that paragraph.

22 A. Okay.

23 Q. "Despite improvements..." Do you agree that  
24 that's what the ACOG says on this topic?

25 A. Yep. That -- what you read there is written

1 here in that -- in this practice bulletin, yes.

2 Q. Is that -- and you agree with the ACOG  
3 bulletin, right?

4 MS. GRANDIN: Objection to form.

5 THE WITNESS: You know, I haven't seen  
6 any specific mortality data related to ectopic  
7 pregnancy in those specific years, but I know ACOG  
8 takes, you know, the production of their practice  
9 bulletins very seriously.

10 Q. (Mr. Boyle) And you rely on these practice  
11 bulletins in your practice to provide you with  
12 clinical management guidelines, right?

13 A. As a -- as a starting point, sure. Yeah.  
14 Yes.

15 Q. If you look under -- sorry. If you look  
16 under the "Risk Factors" section, do you agree with  
17 ACOG that, quote, "Half of all women who receive a  
18 diagnosis of ectopic pregnancy do not have any known  
19 risk factors," end quote?

20 A. Yes.

21 Q. And so a lot of women who actually end up  
22 having an ectopic pregnancy don't have flags for known  
23 risks for an ectopic pregnancy. Is that correct?

24 A. Based in their history, not necessarily  
25 what's happening in their body currently, yes.

1 Q. At what stage in pregnancy do you normally  
2 screen a woman for an ectopic pregnancy?

3 A. Well, certainly if I'm taking care of a  
4 patient doing their prenatal care visit at 30 weeks, I  
5 usually don't discuss ectopic pregnancy at that time.  
6 I don't know if you're asking for a specific  
7 gestational age week.

8 I try to assess -- you know, once a pregnant  
9 person has had a positive test, a positive pregnancy  
10 test, we -- one of the first things we do is talk  
11 about how they're feeling in their body and ask about  
12 last menstrual period to try to assess an estimated  
13 gestational age of the pregnancy.

14 Q. And so as I understand it, whenever you  
15 become aware that your patients has -- patient has  
16 tested positive for pregnancy, you consider an ectopic  
17 pregnancy as a risk on that patient's differential  
18 diagnosis, right?

19 A. Generally speaking, sure. Yes.

20 Q. And you screen that patient as soon as you  
21 become aware that they're pregnant for ectopic  
22 pregnancy immediately, right?

23 A. I mean, we have -- in all the locations  
24 where I work, we have -- we have, you know, kind of  
25 general protocols about how to assess somebody's risk

1 for an ectopic pregnancy. One of which is, you know,  
2 just talking about past history, as we've described.  
3 The other is to talk about any current signs or  
4 symptoms that might be concerning for an ectopic  
5 pregnancy.

6 Q. And the gold standard to test and look for  
7 an ectopic pregnancy is to conduct a transvaginal  
8 ultrasound and see if there is an embryo or fetus  
9 inside the uterus. Isn't that right?

10 MS. GRANDIN: Objection to form.

11 THE WITNESS: There are, you know, kind  
12 of five main categories of early pregnancy. Much of  
13 which can rely on ultrasonography.

14 Q. (Mr. Boyle) Yeah. My question was, the  
15 gold standard to test and look for an ectopic  
16 pregnancy is to conduct a transvaginal ultrasound and  
17 see if there is an embryo or fetus seen in the uterus.  
18 Isn't that right?

19 A. The only ---

20 MS. GRANDIN: Objection to form.

21 THE WITNESS: The only way to  
22 definitively diagnose an ectopic pregnancy is to see  
23 an embryo outside of the uterus with ultrasound. It  
24 doesn't necessarily have to be a transvaginal one.

25 Q. (Mr. Boyle) Okay. So you can do a

1 ultrasound outside the woman's body ---

2 A. Again, it really -- it really just depends  
3 on the patient characteristics. But yes, we, at  
4 times, certainly can use transabdominal  
5 ultrasonography also.

6 Q. You said the only time you can definitively  
7 diagnose it is when you do the ultrasound and see the  
8 ectopic pregnancy. Did I hear you correctly?

9 A. So what -- if we're using ultrasound in  
10 early pregnancy, there are kind of five main diagnoses  
11 we could come up with, right? The first is a definite  
12 intrauterine pregnancy. The second is a probable  
13 intrauterine pregnancy. The third is a pregnancy of  
14 unknown location. The fourth is a probable ectopic  
15 pregnancy. And the fourth is -- or the fifth, excuse  
16 me, the fifth is a definite ectopic pregnancy.

17 Q. But under those categories, number one, if  
18 you do the ultrasound and you see the pregnancy inside  
19 the uterus, you've ruled out ectopic pregnancy there,  
20 right?

21 A. In the -- in the vast majority of cases,  
22 yes.

23 Q. You agree that you should always perform an  
24 ultrasound on a patient you provide care to when they  
25 test positive for pregnancy so that you can confirm if

1 the pregnancy is intrauterine by seeing it on an  
2 ultrasound, don't you?

3 MS. GRANDIN: Objection to form.

4 THE WITNESS: Not all patients in early  
5 pregnancy need an ultrasound.

6 Q. (Mr. Boyle) Why not?

7 A. Lots -- various reasons.

8 Q. Is there any contraindication to giving a  
9 patient an ultrasound?

10 A. The first and foremost would be the patient  
11 doesn't want one.

12 Q. But you can't see inside the patient's  
13 abdomen to see if the pregnancy is intrauterine or  
14 ectopic unless you do an ultrasound, can you?

15 A. The way I could see inside the abdomen would  
16 be to provide a laparoscopy or to provide an  
17 exploratory laparotomy or any imaging modality that we  
18 have available, such as ultrasound, such as CT, such  
19 as MRI.

20 Q. Right. But you're not going to do a  
21 exploratory surgery or an MRI. You just do an  
22 ultrasound to see where the pregnancy is, right?

23 MS. GRANDIN: Objection to form.

24 THE WITNESS: I would recommend an  
25 ultrasound if it was indicated.

1 Q. (Mr. Boyle) And a pregnant patient who you  
2 don't know if it's ectopic or not, you have ectopic  
3 pregnancy on that pregnant patient's differential  
4 diagnosis until you can confirm that it's in the  
5 uterus or not, correct?

6 A. There are many ways to assess a person's  
7 risk for an ectopic pregnancy. One of which is using  
8 ultrasound. There are many others.

9 Q. Do you agree with ACOG bulletin 193 which  
10 says, "The minimum diagnostic evaluation of a  
11 suspected ectopic pregnancy is transvaginal ultrasound  
12 evaluation and confirmation of pregnancy"?

13 A. Can you point me to exactly where in the  
14 document you're referring to?

15 Q. Yeah. It's on the second page under  
16 "Clinical Considerations and Recommendations. How is  
17 an ectopic pregnancy diagnosed?" I believe it's the  
18 first sentence there.

19 A. So for a patient with a suspected ectopic  
20 pregnancy, ultrasound can be very valuable. Most  
21 oftentimes, we would use a transvaginal  
22 ultrasonography. However, like I said previously, in  
23 select patients, transabdominal ultrasound --  
24 ultrasonography would also suffice.

25 Q. Okay. So you agree with ACOG on that



1 particular sentence?

2 MS. GRANDIN: Objection to form.

3 THE WITNESS: I agree with the  
4 statement that diagnostic evaluation of a suspected  
5 ectopic pregnancy would -- you know, that ultrasound  
6 would be valuable in that case.

7 Q. (Mr. Boyle) But ectopic pregnancy is on the  
8 differential diagnosis for every pregnant woman until  
9 you actually rule it in or rule it out, isn't it?

10 A. That -- it's on the differential, but I  
11 don't suspect it in every case, partly because ectopic  
12 pregnancy is very rare compared to intrauterine  
13 pregnancy. And I also take many more factors about  
14 each individual patient into consideration when I'm  
15 deciding whether or not I suspect an ectopic pregnancy  
16 or not.

17 Q. All you'd have to do is do an ultrasound and  
18 you'd be able to tell one way or the other if it's  
19 intrauterine pregnancy or ectopic pregnancy. It  
20 doesn't seem that difficult. Why can't you do that  
21 for all your patients? Are you -- I don't understand.

22 A. Because ultrasound ---

23 MS. GRANDIN: Objection to form. Go  
24 ahead.

25 THE WITNESS: Because ultrasound isn't

1 indicated for every pregnant person that I see. Many  
2 people have pregnancies that don't -- that don't ever  
3 have an ultrasound.

4 Q. (Mr. Boyle) Do you agree with ACOG bulletin  
5 193 where it says that, quote, "Serum hCG values alone  
6 should not be used to diagnose an ectopic pregnancy  
7 and should be correlated with the patient's history,  
8 symptoms and ultrasound findings," end quote?

9 A. Yeah, where in the document are -- is that  
10 section?

11 Q. If you look at the "Serum Human CHG -- hCG  
12 Measurement" section, second sentence.

13 A. Under the heading "Trends of Serial Serum  
14 Human Chorionic Gonadotropin," under that section?

15 Q. Yeah, under "Serum hCG Measurement."

16 A. Oh, okay, I see where you're saying now.  
17 And where?

18 Q. Second sentence.

19 A. Second sentence.

20 Q. Do you see that?

21 A. I see that the practice bulletin has that  
22 quote in it, yes.

23 Q. So you would agree that, at least according  
24 to the ACOG practice bulletin, it recommends that  
25 patients get ultrasound to determine the location of

1 the pregnancy?

2 A. In my practice, we use serum hCG levels in  
3 conjunction with patient history, symptoms and, at  
4 times, ultrasound.

5 Q. Right. And I understand that's what you say  
6 in your practice. But the ACOG here says that you use  
7 serum hCG with an ultrasound, right?

8 MS. GRANDIN: Objection to form.

9 THE WITNESS: It also states in the  
10 practice bulletin, the sentence immediately preceding  
11 that, that "Measurement of the serum hCG level aids in  
12 the diagnosis of women at risk of ectopic pregnancy."

13 Q. (Mr. Boyle) Right. It says it aids in  
14 it ---

15 A. It says ---

16 Q. --- however ---

17 A. The sentence to follow describes assessment  
18 of a patient at risk for ectopic pregnancy.

19 Q. And you just disagree that every patient is  
20 at risk for ectopic pregnancy because you think that  
21 the way you screen them means you don't have to  
22 consider certain patients at risk. Is that fair?

23 MS. GRANDIN: Objection to form.

24 THE WITNESS: Again, the only way to  
25 diagnose a definitive ectopic pregnancy is to see that

1 pregnancy outside the uterus. For patients that come  
2 in early pregnancy and request any care, including  
3 abortion care, we do a thorough history assessment and  
4 recommend the best care for that patient and  
5 consistent with medical evidence.

6 Q. (Mr. Boyle) And you've run studies on  
7 whether a patient who is pregnant needs an ultrasound  
8 to confirm an ectopic pregnancy early in their  
9 pregnancy or if you can just use screening to  
10 determine whether they are at risk for an ectopic  
11 pregnancy. Is that correct?

12 A. I have published articles assessing  
13 history-based screening in early pregnancy for  
14 abortion care, yes.

15 Q. And that is not the consensus position. It  
16 is what you are advocating for through your research  
17 should become the consensus position, but it is not  
18 established as the consensus position, is it?

19 A. By "consensus," are you referring to the  
20 practice bulletin?

21 Q. Yes.

22 A. The practice bulletin states, right, for  
23 people at risk of ectopic pregnancy, that serum hCG  
24 should correlate with patient history, symptoms and  
25 ultrasound findings. So we do our due diligence to

1 provide best healthcare to people to ensure that we  
2 are assessing people for either high risk for ectopic  
3 pregnancy or low risk for ectopic pregnancy.

4 You will also recall that this publication,  
5 the practice bulletin about tubal ectopic pregnancy,  
6 was published in March of 2018. So it is not uncommon  
7 when research is produced showing safety, for example,  
8 in this case, providing abortion for people with  
9 pregnancy of unknown location, that it takes a few  
10 years for those document -- consensus documents, as  
11 you referred to them, to be updated and published.

12 Q. (Mr. Boyle) And there isn't a consensus  
13 document from the ACOG that says your version of  
14 screening without ultrasound is accepted in the  
15 practice yet. Is that correct?

16 MS. GRANDIN: Objection to form.

17 THE WITNESS: The study that I  
18 published was just published in 2013, so I doubt -- I  
19 doubt they've had time to update the practice  
20 bulletin.

21 Q. (Mr. Boyle) And I think you just said it  
22 was published in 2013, but it was published in ---

23 A. I'm sorry, I meant 2023. I am so sorry.

24 Q. Yeah, yeah. That's okay. I was just ---

25 A. Thank you. Thank you ---

1 Q. No, I understood what you meant.

2 A. Yeah.

3 Q. Right. So -- and I appreciate that it's  
4 fairly new research. But even if it eventually gets  
5 adopted, the current standard of care for patients who  
6 appear with a pregnancy and you don't know if it's an  
7 ectopic pregnancy -- first of all, I think we've  
8 established -- let me clarify. You agree that every  
9 pregnant woman is at risk on some level for an ectopic  
10 pregnancy, right?

11 MS. GRANDIN: Objection to form.

12 THE WITNESS: No.

13 Q. (Mr. Boyle) You don't think that every  
14 woman who is pregnant, early in their pregnancy before  
15 you're able to establish through other means that it's  
16 intrauterine, you don't think you have to treat every  
17 single patient as potentially having an ectopic  
18 pregnancy when they test pregnant -- positive for  
19 pregnancy?

20 A. If someone hasn't -- doesn't have a  
21 intrauterine pregnancy or a probable intrauterine  
22 pregnancy, then, yes, we counsel those patients about  
23 the potential, albeit low, risk, right? We've  
24 discussed the risks of ectopic pregnancy generally in  
25 this deposition already. That low risk that a -- the

1 pregnancy may be growing outside the uterus.

2 Q. And it's fairly simple to conduct an  
3 ultrasound and find out if it's intrauterine, which  
4 would relieve that risk. Or if you see it  
5 ectopically, it would confirm the risk and you'd treat  
6 it that way. Or if you don't see it at all, then you  
7 still don't know, correct?

8 A. I would ---

9 MS. GRANDIN: Objection to form.

10 THE WITNESS: I would never perform an  
11 ultrasound for a patient that declined that care.

12 Q. (Mr. Boyle) So you agree, though, that the  
13 current status of the ACOG, based on bulletin 193, is  
14 that patients should be considered at risk for ectopic  
15 pregnancy and should be screened using ultrasound and  
16 possibly also serum hCG and history and other  
17 screenings, but at least ultrasound to determine  
18 whether they have an ectopic pregnancy?

19 MS. GRANDIN: Objection to form.

20 THE WITNESS: Again, according to ACOG  
21 in this bulletin that was published in 2018, I -- I'm  
22 not aware that the -- I don't know what the schedule  
23 of review of this practice bulletin is, but I agree  
24 that this practice bulletin from 2018 says that hCG  
25 values may be helpful when used in conjunction with

1 patient history, symptoms and potentially ultrasound  
2 findings for people at risk of ectopic pregnancy.

3 Q. (Mr. Boyle) Well, it doesn't say -- so you  
4 added, "and potentially." It doesn't say, "and  
5 potentially." It actually says, "and ultrasound  
6 findings," right?

7 A. It does.

8 Q. Okay. So it's including ultrasound in that  
9 process of screening a patient to determine whether  
10 you can rule in or rule out the ectopic pregnancy  
11 risk, correct?

12 A. As of 2018, that's what -- you know, the  
13 sentence says, "patient's history, symptoms, and  
14 ultrasound findings."

15 Q. And again, I'm not trying to exclude or  
16 diminish even your research. I've read it. I  
17 understand it exists. However, there is some  
18 scientific support for conducting an ultrasound with a  
19 patient based on this ACOG 193 bulletin. Wouldn't you  
20 agree?

21 A. There is for people at risk of ectopic  
22 pregnancy, again, in this -- this paragraph that we're  
23 discussing as part of -- as part of this practice  
24 bulletin, for people at risk of ectopic pregnancy,  
25 then hCG findings "should be correlated with patient's



1 history, symptoms, and ultrasound findings." That's  
2 what the practice bulletin says.

3 Q. Which you would agree provides some support  
4 for having an ultrasound to rule out or rule in that  
5 particular risk on every woman's differential  
6 diagnosis when she tests positive for pregnancy?

7 A. The practice ---

8 MS. GRANDIN: Objection to form.

9 THE WITNESS: The practice bulletin,  
10 again, is a starting point. And for the -- you know,  
11 when it's published, the best guidance that we have at  
12 that time for how to guide care for people within the  
13 obstetrics and gynecology practice.

14 Now, again, for each individual patient, I'm  
15 going to take that guidance and apply it to their  
16 specific characteristics and patient experience and  
17 then tailor that guidance based on the individual in  
18 front of me.

19 Q. (Mr. Boyle) I understand that and  
20 appreciate it and agree that's almost certainly  
21 appropriate ---

22 A. That, I would argue, is the standard of care  
23 that we've been -- been discussing.

24 Q. Okay. Very good.

25 I asked you earlier -- you've read the

1 Planned Parenthood South Atlantic documents that they  
2 provide to their patients related to informed consent  
3 for chemical abortion and for surgical abortion,  
4 haven't you?

5 A. I have not -- I have not read those  
6 documents, no.

7 Q. Okay. So if those documents inform a  
8 patient that is there to obtain a chemical abortion  
9 that they may have severe cramping and severe bleeding  
10 for several weeks, would you agree that those are  
11 similar symptoms that a patient who has a ruptured  
12 ectopic pregnancy might face?

13 A. If you're asking me to comment on specific  
14 documents, I'd have to review those.

15 Q. Well, I'm asking you a question. If a  
16 patient is told, "After you have the chemical  
17 abortion, the two-drug regime, you may experience  
18 heavy bleeding for even several weeks and blood clots  
19 the size of a lemon, and" -- you would agree that that  
20 patient could experience those symptoms but actually  
21 have a ruptured ectopic pregnancy and not be able to  
22 distinguish between having a ruptured ectopic  
23 pregnancy versus what the symptoms described as heavy  
24 bleeding were?

25 A. In my practice, we would counsel a person

1 about the main signs and symptoms of both ectopic  
2 pregnancy and induced abortion with medications so  
3 that they could really be in -- you know, the best in  
4 tune to their body and know when to access our 24-hour  
5 assistance line for assistance and help and -- and  
6 guidance if they were not sure if they needed it or if  
7 they thought they needed it.

8 Q. But you agree that the symptoms of a  
9 ruptured ectopic pregnancy can include things like bad  
10 pain in your abdomen, cramping and heavy bleeding,  
11 right?

12 A. The symptom -- what a person might  
13 experience with a ruptured ectopic pregnancy is  
14 typically different than the experience in the -- in  
15 the vast majority of cases for patients who access  
16 medication abortion.

17 Q. You say, "typically different," but they can  
18 be at least similar, right?

19 A. So the -- the symptoms that someone might  
20 have with an ectopic pregnancy are typically  
21 different.

22 Q. I -- I understand, typically they are  
23 different. But sometimes they're similar and could  
24 very well overlap. Is that correct?

25 A. The -- the symptoms a person might

1 experience with a ruptured ectopic pregnancy is going  
2 to be severe pain, typically unilaterally. They may  
3 experience pain with deep inspiration. They may  
4 experience lightheaded and dizziness.

5 They -- you know, it's not a typical  
6 experience of a person with ectopic pregnancy to have  
7 significant heavy bleeding noticeable on a pad, for  
8 example.

9 Q. I missed that last part. Can you -- can you  
10 say that -- I got confused.

11 A. Yeah.

12 Q. I thought you were talking about the  
13 chemical abortion. Were you talking about the  
14 ectopic?

15 A. A person with ectopic pregnancy may have  
16 some bleeding, but it's typically not very heavy when  
17 -- you know, when they're assessing the amount of  
18 bleeding they're having, like if they had a pad in  
19 their underwear.

20 Q. And -- well, you haven't looked at the  
21 Planned Parenthood for South Atlantic's documents that  
22 they produced in this case related to their informed  
23 consent. Is that correct?

24 A. I have not reviewed any Planned Parenthood  
25 South Atlantic documents, no.

1 Q. Okay. You don't know what the Planned  
2 Parenthood South Atlantic's protocol is for screening  
3 patients for ectopic pregnancy before performing a  
4 chemical abortion on them, do you?

5 A. Again, because -- in order to be an  
6 affiliate of the federation, I know that extensive  
7 protocols must be in place to continue to be an  
8 affiliate. So I know they have one. I just don't  
9 know the specific details of that.

10 Q. And I accept that you believe they exist,  
11 and I -- I think they do too. I haven't seen them.  
12 But more to the point, you have not seen them,  
13 correct?

14 MS. GRANDIN: Objection to form.

15 THE WITNESS: I have not seen any  
16 documents that Planned Parenthood South Atlantic uses.

17 Q. (Mr. Boyle) So you are unable to form any  
18 opinions about what Planned Parenthood South  
19 Atlantic's protocols are based on your review of those  
20 because you haven't reviewed them. Is that fair?

21 A. I haven't reviewed the documents. But  
22 again, because I'm an employee of Planned Parenthood  
23 North Central States, I understand the requirements  
24 that are necessary to continue to participate in the  
25 federation and continue to be a Planned Parenthood

1 site. So I know they exist. I just haven't seen the  
2 details of the specific documents.

3 Q. When is the typical gestational age of a  
4 pregnancy that you find yourself providing care to  
5 patients in your role in Minnesota?

6 A. Can you -- can you repeat the question,  
7 please?

8 Q. So you see patients who are testing positive  
9 for pregnancy. What's the typical earliest time that  
10 you will see that patient? Is it two weeks  
11 gestational age? Is it eight weeks gestational age,  
12 somewhere in between?

13 A. When they first make an appointment with me?

14 Q. When you see them, yes.

15 A. Oh, it can vary very widely.

16 Q. Do you typically -- do you agree that  
17 typically a woman wouldn't know that she is pregnant  
18 until four or five weeks gestational age just based on  
19 last menstrual cycle, et cetera?

20 A. The reason that the medical community uses  
21 and dates a pregnancy from the last menstrual period  
22 dates back from when we didn't have sophisticated  
23 ultrasound -- ultrasonography capacity. And,  
24 therefore, a person's first missed period would be a  
25 first sign for a person that they may be pregnant.

1 Q. Okay. So when you typically see patients  
2 that are early on, do you ever see patients that have  
3 a gestational age pregnancy of two or three weeks, or  
4 is it typically after five weeks gestational age?

5 A. I think, you know, people who -- once they  
6 realize they're pregnant and know they need to proceed  
7 with abortion care, they often call as soon as they  
8 can.

9 Q. I appreciate that and I don't dispute it.  
10 But what's your practical experience as, like, what's  
11 the gestational age when that happens?

12 A. Again, it's varied. Anywhere from -- I  
13 mean, a -- a person can make an appointment related to  
14 a pregnancy at any -- at any gestation that -- that  
15 they would prefer.

16 Some people, once they have that positive  
17 test, know they need to become -- that they need  
18 abortion care. So I've seen people in the -- in the  
19 third week of pregnancy, for example.

20 Q. Okay. And that's what I was asking. And so  
21 would you say third week of pregnancy is the earliest  
22 you've ever encountered a patient under those  
23 circumstances?

24 A. Probably.

25 Q. And ---

1 A. I don't write those -- I don't write them  
2 down, so I don't -- I don't -- probably.

3 Q. Have you ever provided an induced abortion  
4 to a patient who had a gestational age of less than  
5 five or six weeks?

6 A. Yes.

7 Q. When do you expect to be able to see a fetus  
8 or an embryo of one of your pregnant patients on an  
9 ultrasound?

10 A. General consensus about that is we -- if a  
11 person accepts a transvaginal ultrasonography, then we  
12 would expect to see a gestational sac starting as  
13 early as five weeks.

14 Q. Would you agree that it would be safer to  
15 confirm the intrauterine location of a pregnancy than  
16 to not know if it's an ectopic pregnancy using  
17 ultrasound when you're treating your patient?

18 A. I'm not sure I missed -- I think I missed  
19 the last part of that. Can you ask that again?

20 Q. When you're treating a pregnant patient,  
21 wouldn't you agree that it's safer for that patient to  
22 use ultrasound to rule in or rule out ectopic  
23 pregnancy before you provide that patient with a  
24 chemical abortion?

25 A. For a patient who we have assessed as low



1 risk for an ectopic pregnancy, no.

2 Q. Have you ever had a patient that you  
3 assessed as low risk for an ectopic pregnancy, you  
4 performed an induced abortion on that patient, and  
5 then later that patient turned out to have an ectopic  
6 pregnancy?

7 A. Okay. Say that one more time.

8 Q. Have you ever had a situation where you  
9 screened a patient, your screening process determined  
10 that the patient was low risk for ectopic pregnancy so  
11 you did not perform an ultrasound on that patient, you  
12 gave that patient a chemical abortion, and then later  
13 you found out that that patient had an ectopic  
14 pregnancy?

15 A. I'd have to -- I'd have to go back and look  
16 specifically at the -- the only time where that would  
17 have occurred -- I'm not sure. I'd have to go back  
18 and look.

19 Q. You can't say definitively that that's never  
20 happened?

21 A. Correct.

22 Q. And so you agree that there's a risk that,  
23 even if you determine a patient is low risk, they  
24 might have an ectopic pregnancy, right?

25 A. So I think, you know, the important thing

1 when we're counseling a person who's sitting in front  
2 of us requesting pregnancy care, including induced  
3 abortion care, is to review all of the risks, yeah.

4 So we go through those with the person, and  
5 then the patient accepts or does not accept those  
6 risks and decides for themselves how to proceed during  
7 that encounter.

8 Q. Would you be able to look back through your  
9 records and determine whether you had a patient that  
10 you screened, found that patient to be low risk for  
11 ectopic pregnancy, you did not provide them with a --  
12 you did not take an ultrasound of that patient, you  
13 did provide them with a chemical abortion, and then  
14 afterwards they showed up as having an ectopic  
15 pregnancy?

16 MS. GRANDIN: Objection to form.

17 THE WITNESS: I could certainly look  
18 for that information. I think it ultimately is  
19 irrational to require that for every patient for these  
20 very, very rare instances even if that occurred in my  
21 practice.

22 Q. (Mr. Boyle) You used the word "irrational."  
23 Are you using that word because of the lawsuit? Is  
24 that why?

25 A. I'm using that word -- I don't know. It's

1 just the word I chose.

2 Q. Okay. You're not trying to couch it in  
3 terms of the law or the lawsuit when you say  
4 irrational?

5 A. I'm not an attorney, so I don't -- I don't  
6 know.

7 Q. Okay. Were you able to confirm that that  
8 patient who you saw at gestational age three weeks was  
9 pregnant?

10 A. (No audible answer)

11 Q. You mentioned earlier the earliest that you  
12 had treated a patient -- a pregnant patient was three  
13 weeks gestational age, right?

14 A. Yes.

15 Q. How were you able to confirm that patient  
16 was three weeks gestational age pregnancy?

17 A. The patient reported a sure last menstrual  
18 period, a history of regular, predictable menstrual  
19 cycles that lasted -- that were consistent with, you  
20 know, the -- her history of menstrual cycles, so we  
21 were able to date the pregnancy that way.

22 And this particular patient that I'm  
23 thinking about also had a urine pregnancy test in our  
24 health center.

25 Q. Did you perform an ultrasound on that

1 patient?

2 A. I mean, again, I -- it's my -- it's our  
3 standard practice to go through a protocol of  
4 history-based screening to determine whether or not we  
5 need to recommend an ultrasound for a person.

6 Q. You agree that induced abortion of any type  
7 is more complicated after the unborn child reaches the  
8 second trimester, don't you?

9 A. I'm -- I guess I'm not clear what you're  
10 asking.

11 Q. Complications for induced abortions  
12 increase, the risks increase the older the gestational  
13 age, so when you get to the second trimester it is  
14 more risky to perform an induced abortion in the  
15 second trimester than the first trimester. Is that  
16 correct?

17 A. Comparing a procedural abortion in the  
18 second trimester to a procedural abortion in the first  
19 trimester, yes, the risks are -- the risk, generally,  
20 for a procedural abortion increases as the gestation  
21 of the pregnancy increases. That would also be true  
22 for a person who decided to continue their pregnancy.

23 Q. Do you agree with the Academy of Medicine's  
24 article you cited from extensively when it says that,  
25 "The risk of serious complication increases with weeks

1 gestation. As the number of weeks increase, the  
2 invasiveness of the required procedures and the need  
3 for deeper levels of sedation also increase"?

4 A. Again, I'd have to review the specific  
5 portion of that document that you're, you know,  
6 alluding to to determine whether or not I agree with  
7 that. I think, generally speaking, you know, the  
8 academy didn't -- yeah, I'll just stop there.

9 Q. Do you agree with this statement: "The risk  
10 of serious complication increases with weeks  
11 gestation. As the number of weeks increase, the  
12 invasiveness of the required surgical procedure for an  
13 abortion and the need for deeper levels of sedation  
14 also increase"?

15 A. That was kind of a lot of things there. So  
16 generally, you know, as a person who doesn't -- you  
17 know, who recognizes the invasive nature of just  
18 having a pelvic exam, I don't -- I don't know exactly  
19 what the invasive portion means in that, that you're  
20 referring to. But generally, the -- again, for a  
21 procedural abortion, as the pregnancy advances, the  
22 risk -- the risk can increase.

23 Q. After 11 weeks gestational age, you don't  
24 perform a chemical abortion, right?

25 A. Not after 77 days.

1 Q. So every induced abortion ---

2 A. Or, I -- I'm sorry, let me -- can I ---

3 Q. Okay.

4 A. Sorry to interrupt.

5 Q. Sure.

6 A. Not -- in the first trimester, no, not after  
7 the -- after 77 days. If a person wanted induction  
8 termination abortion in my practice, then we would  
9 provide that.

10 Q. And the induction chemical abortion that you  
11 described earlier where you use more of the chemical  
12 drugs -- a higher dose, I should say, that's beyond  
13 the FDA-approved usage of those drugs also, isn't it?

14 A. When we're taking care of a patient for an  
15 induction termination in the second trimester, we use  
16 the medications off-label.

17 Q. And I think you said that you start using  
18 D&E abortion after 17 weeks. Is that correct?

19 A. Generally starting in the 17th week.

20 Q. Okay. So leading up to week 16, you would  
21 -- if you were doing a surgical abortion, it would be  
22 an aspiration abortion. Is that correct?

23 A. The vast majority of times, yes.

24 Q. And you would agree that the simple act of  
25 placing forceps and surgical tools repeatedly beyond

1 the cervix into the uterus increases the risk of both  
2 a cervical laceration and uterine perforation,  
3 wouldn't you?

4 MS. GRANDIN: Objection to form.

5 THE WITNESS: I don't -- I don't think  
6 I'm aware of any specific data showing a specific  
7 number of times that a person may need to pass a  
8 forceps to complete the dilation and evacuation as a  
9 known increased risk.

10 Q. (Mr. Boyle) So you don't think anybody's  
11 studied that?

12 A. I'm not aware of a study. That doesn't mean  
13 that it doesn't exist.

14 Q. You agree that sometimes patients who  
15 undergo surgical abortions need to have a blood  
16 transfusion as a complication of that procedure, don't  
17 you?

18 A. Yes. I'm aware that pregnant people need  
19 transfusions, including those, occasionally, that  
20 access induced abortion.

21 Q. Have you ever had one of your patients who  
22 you were performing a surgical abortion, either an  
23 aspiration or a D&E abortion, at the Planned  
24 Parenthood clinic that needed a blood transfusion  
25 during or soon after the procedure?

1 A. No.

2 Q. Okay.

3 A. Not to my knowledge.

4 Q. You agree that some, at least some,  
5 second-trimester induced abortions must occur in a  
6 hospital setting, don't you?

7 A. There are certain characteristics either  
8 associated with the pregnancy or associated with the  
9 patient that may make hospital-based care a  
10 recommendation.

11 Q. And about -- from my reading of your CV,  
12 about half of the second-trimester abortions that you  
13 perform, you perform in the hospital setting. Is that  
14 correct?

15 A. That information wouldn't be listed on my  
16 CV.

17 Q. Is it correct?

18 A. It's not correct.

19 Q. How many of the second-trimester abortions  
20 that you -- procedural, surgical abortions that you  
21 perform, what's the percentage breakdown of the ones  
22 that you do in the hospital setting versus in the  
23 Planned Parenthood clinic setting?

24 A. Again, speaking generally, I don't --  
25 generally, sorry. I'm going to keep -- stop mumbling



1 for the transcript. Sorry.

2 So I provide dilation and evacuation  
3 abortion at both the hospital and Planned Parenthood  
4 North Central States. The exact numbers of -- numbers  
5 of patients I take care of at Planned Parenthood  
6 versus number of patients I take care of at the  
7 university, I don't have at the ready or in my brain.

8 The amount of time I spend, you know,  
9 providing procedural abortion at both of those  
10 locations, right, the university would be about a half  
11 day per week and Planned Parenthood would be about one  
12 full day per week.

13 Q. Okay. So would you say one-third of the --  
14 well, let me ask before I go to that. When you say a  
15 half day at the hospital and a full day at the clinic,  
16 is that full day at the clinic focused solely on  
17 second-trimester surgical abortions?

18 A. No.

19 Q. What else do you do in that time when you're  
20 at the clinic?

21 A. When I'm providing care at the health center  
22 here in St. Paul, I -- we assess people for their need  
23 for whatever they make a -- an appointment for,  
24 honestly. So I provide medication abortion. I  
25 provide procedural abortion in the first and second

1 trimester. I assess people for management of  
2 miscarriage. I assess people for other pregnancy  
3 symptoms they may have in the first trimester.

4 Q. Okay. And as it relates to the hospital  
5 setting, that half day, is it not true that primarily  
6 what you're doing there are second-trimester surgical  
7 abortions?

8 A. I mean, the bulk of my procedural abortion  
9 care at the university is in the second trimester,  
10 yes.

11 Q. Okay. And ---

12 A. But it's not all -- it's not all that I do  
13 in the operating room.

14 Q. Okay. So taking just the second-trimester  
15 surgical abortions that you perform in the hospital  
16 and in the clinic, are they not roughly equal amounts  
17 at each place?

18 A. Again, I can only really tell you what the  
19 -- the amount of time that I spend at both of those  
20 places. I'd have to look at specific numbers to say  
21 anything about specific numbers.

22 Q. You're not able to just give a rough  
23 percentage based on you doing all of them yourself and  
24 knowing what that would be?

25 MS. GRANDIN: Objection to form.

1 THE WITNESS: I do many procedures, and  
2 there's no way I can keep them all in my head ---

3 MR. BOYLE: Okay.

4 THE WITNESS: --- regardless of whether  
5 it's for abortion or another obstetric and gynecologic  
6 problem.

7 Q. (Mr. Boyle) In any event, you do many  
8 second-trimester surgical abortions in a hospital  
9 setting every week. Is that fair?

10 A. It depends on what you define as many.

11 Q. More than five?

12 A. No.

13 Q. How many would you say you do on a weekly  
14 basis in the hospital setting?

15 A. Somewhere probably between one and four.

16 Q. Okay. Sorry, I'm closing out things, I've  
17 jumped around a little bit.

18 A. That's okay.

19 Q. Does the hospital where you work in  
20 Minnesota and you see patient -- pregnant patients to  
21 give them surgical abortions, does that hospital  
22 provide staff training for dealing with those types of  
23 patients and for patients who have survived sexual  
24 assaults?

25 MS. GRANDIN: Objection to form.

1 THE WITNESS: We -- I -- you know, I  
2 can't know what detailed training is required for all  
3 levels of staff that work in the hospital, so I'm not  
4 sure I can comment authoritatively on that question.

5 Q. (Mr. Boyle) Do you feel like the staff you  
6 work with at the hospital when you bring your patients  
7 to the hospital and perform abortions on them, do you  
8 feel like the hospital staff is adequately trained to  
9 react and deal with those patients?

10 A. I'm very privileged to work in a hospital  
11 that is very supportive of people's access of -- to  
12 comprehensive reproductive healthcare. My -- I have  
13 the feeling that many nurses, especially in the  
14 preoperative area, actually choose to work there and  
15 continue to work there because we're able to provide  
16 abortion care in the hospital.

17 Q. So you think that about your hospital in  
18 Minnesota, but you ---

19 A. I do.

20 Q. --- made or you gave opinions about the  
21 hospital staff in North Carolina. Do you recall that?

22 A. I do not.

23 Q. You don't recall saying that you think that  
24 the hospital staff in North Carolina aren't trained to  
25 properly deal with patients who are having abortion --

1 surgical abortion procedures?

2 MS. GRANDIN: Objection to form.

3 THE WITNESS: If you're referring to  
4 statements I made in my declaration, I'm happy to  
5 review that document in that specific area that  
6 you're, you know, discussing.

7 Q. (Mr. Boyle) Well, you don't remember saying  
8 that in your declaration that you provided in this  
9 case?

10 A. What I know to be true is that staff at  
11 Planned Parenthood are required to do extensive  
12 training at least annually, in my Planned Parenthood,  
13 at least annually to review how -- you know, sensitive  
14 exams and how to be present with a person that has  
15 experienced sexual assault. What I don't know is  
16 whether or not that's required for all staff at the  
17 hospital.

18 Q. And you're talking about at your hospital in  
19 Minnesota, right?

20 A. I am. Uh-huh (yes).

21 Q. And you don't know ---

22 A. And I certainly -- if I don't work at a  
23 place, I certainly wouldn't know the exact specifics  
24 that are required for all staff at any hospital in  
25 North Carolina. I'm sure the -- that differs greatly.

1 Q. Well, you cut me off, because that's where I  
2 was going.

3 A. Sorry.

4 Q. It's okay. I'm kidding.

5 Yeah, I just -- I just wanted to point out  
6 that you don't even know what the training is at your  
7 Minnesota hospital, so you don't have any opinions  
8 about what the training is for staff at any North  
9 Carolina hospital. Is that fair to say?

10 A. Oh, no, I have -- well, again, I can tell  
11 you from my experience in sitting with patients that,  
12 generally, people are much more prepared to sit with a  
13 person who's experienced sexual assault in my setting  
14 at Planned Parenthood than they are in the hospital.

15 Now, I'm not saying that the nurses who  
16 staff preoperative area are going to try to be  
17 disrespectful to a person that experienced or  
18 discloses that they've been a survivor of sexual  
19 assault, because, generally, I think the people who  
20 work there are pretty good people. But I'm not aware  
21 of any specific training that's required for them to  
22 be able to continue their job.

23 Q. Okay.

24 A. That also doesn't mean -- well, yeah. Never  
25 mind.

1 MR. BOYLE: Give me just a moment here.

2 Q. (Mr. Boyle) Let me ask you about the  
3 Goldberg study. Do you remember citing that?

4 A. I do.

5 Q. That's from 2022. He did a -- they -- he's  
6 the lead author, but they did a retrospective cohort  
7 study of medical records from Massachusetts Planned  
8 Parenthood entities related to giving chemical  
9 abortion drugs to a patient with a pregnancy of  
10 unknown location. Is that right?

11 A. Yes. My recollection of the Goldberg study  
12 was that they looked backwards, so retrospectively, at  
13 care that had already happened that they had provided  
14 for patients who presented for induced abortion care,  
15 were diagnosed with a pregnancy of unknown location  
16 and then requested medication abortion.

17 Q. And do you recall that 26 of -- well, so  
18 there were -- some part of the population decided to  
19 delay care and another smaller portion decided to go  
20 ahead and take the chemical abortion before there was  
21 a specific location of the pregnancy using ultrasound.  
22 Is that your recollection?

23 A. My recollection of that study is that there  
24 were two groups of people that they, again, sorted  
25 retrospectively that presented for care -- for

1 abortion care, were diagnosed with a pregnancy of  
2 unknown location, and then based on specific patient  
3 factors or counseling or the patient's own assessment  
4 of the best -- best way to proceed for them, either  
5 chose expectant management with close follow-up or  
6 proceeding on that day with induced abortion with  
7 medication and close follow-up.

8 Q. Okay. So do you recall that of the group  
9 that delayed care, that decided not to have a surgical  
10 or chemical abortion when they were initially told  
11 that they had a pregnancy of unknown location, do you  
12 recall that 26 percent of those patients who delayed  
13 care never needed to take the chemical abortion drugs  
14 at all because they either had an ectopic pregnancy or  
15 an early loss of pregnancy without any medication?

16 A. I'd have to ---

17 MS. GRANDIN: Objection to form.

18 THE WITNESS: Sorry, Kara.

19 I'd have to see the specific article to  
20 comment on specific percentages.

21 Q. (Mr. Boyle) Okay. If in fact that's what  
22 it said and it was 26 percent that did not need --  
23 that delayed care, that did not need the chemical  
24 abortion drugs for those two reasons, because they  
25 either lost the pregnancy or they had an ectopic



1 pregnancy, if you extrapolate that to the patient  
2 population at large, that would mean that basically  
3 one out of four patients who have a pregnancy of  
4 unknown location would end up not needing to have the  
5 chemical abortion drugs. Do you agree with that?

6 A. I do not.

7 MS. GRANDIN: Objection to form.

8 Q. (Mr. Boyle) Why not?

9 A. I do not. Because that patient population,  
10 again, considering patient factors, patient history,  
11 patient's prior access, patient's own assessment of  
12 what is happening in their body, a good number of  
13 those people chose to remain in the  
14 delay-for-diagnosis group.

15 So again, blanket statements like that  
16 aren't honoring the fact that we do a very detailed  
17 assessment of patients' history and counsel them about  
18 their options. And in this study, you know, there  
19 were people who chose to -- you know, to proceed with  
20 expectant management.

21 Part of the reason that a patient might  
22 choose that management strategy is that they already  
23 think they're having a miscarriage. So I think that's  
24 probably more representative of -- of a portion of  
25 that group which they described "delay-for-diagnosis"

1 in their study.

2 Q. Did you include a delay-for-diagnosis cohort  
3 in your study from 2022?

4 A. Are you referring to my study from 2023?

5 Q. I'm sorry. Yeah, it was published in 2023,  
6 yes.

7 A. So our -- again, in our setting, our  
8 standard protocol for how to proceed when patients are  
9 diagnosed with a pregnancy of unknown location is to  
10 consider all the options for the patient. So that  
11 includes a detailed history, an assessment of a  
12 person's risk for ectopic pregnancy, and then also  
13 their own, you know, kind of collation of all that  
14 information about how they want to proceed.

15 So there are certainly patients in our  
16 setting and, you know -- I presume you've read or at  
17 least skimmed the article -- you know, we showed that  
18 that -- patients -- that our protocol for how we do  
19 that provides that care safely.

20 Q. Did you study a cohort that delayed after  
21 there was a pregnancy of unknown location -- or I'm  
22 sorry, after the -- well, yeah. After there was no  
23 ultrasound and you didn't know the location of the  
24 pregnancy, did you study a delayed cohort to see what  
25 happened to them?

1 A. In our 2023 study, all the patients had been  
2 diagnosed with a pregnancy of unknown location.

3 Q. Right. And ---

4 A. And some of those patients -- again,  
5 retrospectively, right? Some of those patients, you  
6 know, collating all the information that we go through  
7 with and the counseling we provide on the day of the  
8 encounter, chose to proceed with expectant management  
9 with close follow-up.

10 Q. Chose to have a chemical abortion, is that  
11 what you mean by that when ---

12 A. The other option ---

13 MS. GRANDIN: Objection to form. Go  
14 ahead.

15 THE WITNESS: The other option for a  
16 person diagnosed with a pregnancy of unknown location  
17 that's deemed low risk for ectopic pregnancy in our  
18 setting would include proceeding with medication  
19 abortion or a procedural abortion.

20 Q. (Mr. Boyle) And what was the first one you  
21 were describing? I missed that, I'm sorry.

22 A. Yeah. So if a patient comes into our health  
23 center requesting an abortion or made an abortion  
24 appointment and we diagnose a pregnancy of unknown  
25 location, then from there we do, you know, a detailed

1 assessment in correlation or in combination to assess  
2 a person's risk for ectopic pregnancy.

3 There are certain, you know, factors and  
4 patient-level characteristics that may make a person  
5 high risk for ectopic pregnancy. And then we have  
6 extensive protocols about how to ensure that patient  
7 gets referred out for sometimes, you know, same-day  
8 care or close follow-up with their -- with -- to, you  
9 know, kind of on -- continue to assess that risk.

10 Q. Okay. So did you study pregnancy of unknown  
11 location with three groups, one group that got  
12 chemical abortion, one group that got surgical  
13 abortion and then one group that delayed care and  
14 waited until they could confirm the location of the  
15 pregnancy?

16 A. Yes. Our study in 2023 included three  
17 groups. Patients chose -- after being diagnosed with  
18 pregnancy of unknown location and then assessed to be  
19 low risk for ectopic pregnancy, those patients chose  
20 either expectant management with close follow-up,  
21 medication abortion with close follow-up or procedural  
22 abortion for -- with close follow-up.

23 Q. And did some of those who chose expectant  
24 management with close follow-up turn out to have a  
25 loss of pregnancy or an ectopic pregnancy?

1           A.    I'd have to look at the specific numbers in  
2 the article.  But again, one of the reasons -- after  
3 counseling a person that's diagnosed with a pregnancy  
4 of unknown location, some of that is because the  
5 patient has had bleeding and suspects that they have  
6 had a miscarriage already.  And we just can't know  
7 that with a single time point at a single encounter.

8           Q.    So did some of those people who delayed  
9 their care end up having an ectopic pregnancy or  
10 having an early loss of pregnancy without any induced  
11 abortion?

12           A.    I'd have to look at the specifics, but I  
13 think, again, because ectopic pregnancy, you know, is  
14 a part of early pregnancy, I -- I'm pretty sure there  
15 were ectopic pregnancies eventually diagnosed in all  
16 of the groups.

17                   MS. GRANDIN:  Pardon my interruption.  
18 I was just wondering if we could get a time check from  
19 you, Gretchen.  Per my calculation, we're pretty close  
20 to four hours.

21                   MR. BOYLE:  I agree we are and I've got  
22 about two or three questions left.  So if that's all  
23 right, I'll just proceed, but I'm not going much  
24 longer.

25                   MS. GRANDIN:  Okay.  That sounds good.

1 MR. BOYLE: Okay.

2 MS. GRANDIN: Thank you.

3 MR. BOYLE: Thanks.

4 Q. (Mr. Boyle) Do you recall that the Goldberg  
5 study concluded that waiting to provide chemical  
6 abortion drugs until a patient has a confirmed  
7 intrauterine pregnancy is reasonably safe and  
8 effective?

9 A. That's not -- I mean, that's not the primary  
10 -- that's not my recollection of the primary  
11 conclusion that they drew from their study.

12 Q. Do you recall that it was at least a  
13 conclusion that he -- that they drew from their study?

14 A. I'd have to look specifically. You know,  
15 the conclusion that I recollected from that study was  
16 that providing abortion care for patients diagnosed  
17 with pregnancy of unknown location is safe and  
18 effective.

19 Q. Do you agree, though, that waiting to  
20 provide chemical abortion drugs until a patient has a  
21 confirmed intrauterine pregnancy is reasonably safe  
22 and effective?

23 A. I think, again, that doesn't honor patient  
24 experience very well. I think when we have a -- a  
25 perfectly safe and effective way to provide abortion

1 care in the setting of a pregnancy of unknown  
2 location, I think it's -- I think it's rather cruel to  
3 make a person wait.

4 MR. BOYLE: I don't think I have any  
5 further questions. Some of these other folks may have  
6 some. Doctor, I very much appreciate your time today.  
7 Thank you.

8 THE WITNESS: Indeed. I appreciate  
9 yours as well.

10 MS. GRANDIN: Do you mind if we take  
11 about ten minutes, and I might come up -- come back  
12 with a couple re-direct questions?

13 THE COURT REPORTER: Off the record at  
14 2:58 p.m.

15 (Brief recess: 2:58 p.m. to 3:11 p.m.)

16 THE COURT REPORTER: Back on the record  
17 at 3:11 p.m.

18 EXAMINATION

19 BY MS. GRANDIN:

20 Q. Dr. Boraas, in your experience when a  
21 patient is seeking an abortion involving some level of  
22 sedation, who makes the decision about what level of  
23 sedation to give a patient?

24 A. You know, ultimately, it's the patient's  
25 decision.

1 Q. Does the anesthesiologist ever make that  
2 decision?

3 A. I would say the anesthesiologist strongly  
4 recommends a specific type of anesthesia, if there's  
5 an ---

6 Q. In your ---

7 A. --- if there's an anesthesiologist involved.

8 Q. In your experience, what factors often go  
9 into making the decision of what level of sedation a  
10 patient prefers?

11 A. Well, the first and foremost is what the  
12 patient desires. The second is, you know,  
13 occasionally we will see a patient that just requires  
14 a high -- a high level of sedation in order to  
15 complete the procedure safely.

16 Q. In your experience providing abortions, how  
17 often do patients choose deep sedation as their  
18 sedation option?

19 A. Well, again, the only place where people  
20 would have that -- would be able to access deep  
21 sedation would be in the hospital. And for various  
22 reasons, namely, the first and foremost being  
23 insurance coverage, that's a prohibitive option for  
24 many people in my setting.

25 Q. Do you have a general estimation, or is that



1 just -- is that not something you'd be able to provide  
2 an estimate of?

3 A. Deep sedation compared to general  
4 anesthesia?

5 Q. Deep sedation compared to other options I --  
6 available.

7 A. Yeah, I think it really just depends on the  
8 patient. Many patients are nervous about any type of  
9 sedation and how it might affect their body.

10 Q. When a uterine perforation or a cervical  
11 laceration occurs during a procedural abortion, how do  
12 you generally treat that?

13 A. So treatment for both of those things is  
14 potentially different, so I'm going to talk about one  
15 at a time.

16 Q. Yes. Thank you.

17 A. No problem. If a perforation is suspected  
18 during a procedure, the next sort of -- not question,  
19 but the next thing that we assess is with what  
20 instrument because that -- that determines whether or  
21 not the patient -- whether or not we can ensure the  
22 integrity of the bowel.

23 If we can't ensure the integrity of the  
24 bowel, then the person has to have assessment of that  
25 surgically at the hospital.

1           If the perforation happens with a blunt  
2 instrument, especially in the first trimester, we're  
3 usually able to watch those patients closely in our  
4 outpatient health center, like at Planned Parenthood  
5 North Central States, and closely monitor vitals and  
6 pain level and just sort of overall patient  
7 assessment.

8           Sometimes potentially using ultrasound to --  
9 and sometimes we're also able to, you know, monitor  
10 the patient safety in our health center.

11           Q.    And I -- I think you answered this question  
12 in your general answer, but just to clarify. Does --  
13 in general, when a uterine perforation occurs, does it  
14 always require treatment in a hospital?

15           A.    No.

16           Q.    And when a cervical laceration -- sorry, go  
17 ahead.

18           A.    Yeah, sorry. I just remembered that you  
19 asked about cervical laceration, too, and I haven't  
20 answered that. So ---

21           Q.    That's okay. Let me -- let me ask the  
22 question again specifically to cervical laceration.  
23 So when a cervical laceration occurs during a  
24 procedural abortion, how do you treat that?

25           A.    It depends whether or not the -- the

1 laceration is low or in the distal portion of the  
2 cervix or whether it's higher and not as easily  
3 visible.

4           So for a distal or cervical laceration that  
5 occurs at the end of the cervix, those, if they're  
6 very small, can just be observed and make sure that  
7 they're not bleeding heavily. And if they're not,  
8 those can -- then those heal on their own.

9           If it's more -- if it's a slightly larger  
10 laceration or the laceration is bleeding a fair  
11 amount, then oftentimes we will reapproximate that  
12 laceration with suture, bring it together with suture  
13 and ensure that there isn't any ongoing bleeding.

14           Q.    And ---

15           A.    If ---

16           Q.    Sorry, go ahead.

17           A.    If the -- if the laceration is potentially  
18 higher, that may be treated with tamponade, like with  
19 a intrauterine balloon. And a fair number of times,  
20 that is sufficient for treatment of that. Higher  
21 lacerations sometimes need other procedures depending  
22 on where the -- where it is.

23           Q.    So can a cervical laceration be treated  
24 safely in the clinic, an outpatient clinic where an  
25 abortion is performed?

1 A. Certain types of them, yes, absolutely.

2 Q. Does it -- is it always a requirement for  
3 surgical lacerations that the patient be treated in a  
4 hospital setting?

5 A. It is not always a requirement that cervical  
6 lacerations are better addressed in a hospital  
7 setting, no.

8 Q. Are forceps used in miscarriage management  
9 in your experience?

10 A. If I'm providing a dilation and evacuation  
11 to help complete a miscarriage for a patient, yes.  
12 Again, typically starting around the 17th week of  
13 pregnancy, that would be the same for a person  
14 experiencing a miscarriage also.

15 Q. Are forceps used in labor and delivery in  
16 your experience?

17 A. Yes.

18 Q. Is cervical ---

19 A. When a patient ---

20 Q. Sorry, go ahead.

21 A. Yeah. Yes, when a patient requires an  
22 operative vaginal delivery. Sometimes even at the  
23 time of C-section if the extraction is difficult.

24 Q. Is cervical laceration a possible  
25 complication of miscarriage management?

1 A. Yes.

2 Q. Is it a possible complication of labor and  
3 delivery?

4 A. Yes.

5 Q. Is uterine perforation a possible  
6 complication of miscarriage management?

7 A. Yes.

8 Q. Is it a possible complication of labor and  
9 delivery?

10 A. Yes.

11 Q. Is infection a possible complication of  
12 miscarriage management?

13 A. Yes.

14 Q. Is it a possible complication of labor and  
15 delivery?

16 A. Yes.

17 Q. Is hemorrhage a possible ---  
18 (Off-record comments)

19 Q. (Ms. Grandin) Is hemorrhage a possible  
20 complication of miscarriage management?

21 A. Yes.

22 Q. Is it a possible complication of labor and  
23 delivery?

24 A. Yes.

25 Q. Does that include a hemorrhage requiring a

1 blood transfusion?

2 A. Hemorrhage requiring a blood transfusion is  
3 much more likely at the time of giving birth either  
4 vaginally or by a cesarean section than it would be  
5 for a person accessing induced abortion.

6 Q. In your opinion, do dilation and evacuation  
7 abortions need to be performed in a hospital in order  
8 to be performed safely?

9 A. No.

10 Q. So I think you testified earlier that you  
11 hadn't seen PPSAT's specific abortion protocols.  
12 However, you reviewed Dr. Farris's declaration  
13 submitted in support of the Amended Preliminary  
14 Injunction Motion in this case. Is that correct? Her  
15 two declarations?

16 A. I reviewed the declarations that Dr. Farris  
17 submitted, yes.

18 Q. What from Dr. Farris -- from your review of  
19 Dr. Farris's declaration, what is your understanding  
20 of PPSAT's protocol for a medication abortion in the  
21 circumstance where a patient has a pregnancy of  
22 unknown location?

23 A. From my review of Dr. Farris's declarations,  
24 the protocol at PPSAT would include assessment of  
25 patient's risk for ectopic pregnancy if they have been

1 diagnosed with a pregnancy of unknown location, and  
2 then a thorough review of the risks and benefits of  
3 expectant management in the setting of a PUL,  
4 pregnancy of unknown location, or proceeding with  
5 medication abortion or a procedural abortion.

6 And then my ---

7 Q. Do you -- sorry. Go ahead.

8 A. My -- again, from her declaration, my  
9 understanding of PPSAT's protocol regarding patients  
10 with a PUL also includes review of, you know,  
11 potential warning signs and symptoms associated with  
12 an ectopic pregnancy, as well as recommendation for  
13 very close follow-up.

14 Q. From your review of the -- Dr. Farris's  
15 declaration, do you understand that PPSAT in North  
16 Carolina uses hCG serial testing to evaluate patients  
17 who seek medication abortion but have a pregnancy of  
18 unknown location?

19 A. I do recall that from Dr. Farris's  
20 declaration.

21 Q. Do you recall whether PPSAT in North  
22 Carolina administers ultrasounds to patients who have  
23 a pregnancy of unknown location and seek medication  
24 abortion?

25 A. The only -- the only way to establish a

1 definitive diagnosis of pregnancy of unknown location  
2 is with ultrasonography. So, yes, if they're treating  
3 people with a pregnancy of unknown location, then they  
4 -- that person has had an ultrasound.

5 Q. Is it your understanding from Dr. Farris's  
6 declaration that PPSAT uses a similar protocol as the  
7 protocol whose safety and efficacy you discussed in  
8 your published research on the topic in your article  
9 from 2023 that we discussed previously in this  
10 deposition?

11 A. Our article does, in a box in the article,  
12 describe the protocol that we use here at Planned  
13 Parenthood North Central States. And it's -- from her  
14 declaration, the protocol that Dr. Farris described in  
15 the declarations seems very -- very similar.

16 MS. GRANDIN: Thank you, Dr. Boraas. I  
17 don't have any further questions.

18 MR. BOYLE: I have brief re-direct  
19 based on your questions if I might.

20 MS. GRANDIN: Okay.

21 THE WITNESS: Absolutely.

22 FURTHER EXAMINATION

23 BY MR. BOYLE:

24 Q. You were talking about bleeding from a  
25 cervical laceration. How do you see that? What



1 methodology do you use or mechanism do you use to  
2 visualize that? Do you just see it with your eyes, or  
3 are you using radiograph or some other testing?

4 A. Bleeding is visible with my eyes ---

5 Q. Okay. So you don't have like a fiber optic  
6 or something like that?

7 A. No. No fiber optics.

8 Q. Then how are you able to see it if it's --  
9 not distal, but if it's the other one, farther away?

10 A. We would suspect a high cervical laceration  
11 if there was ongoing bleeding that wasn't coming from  
12 the top portion or fundus of the uterus.

13 Q. Well, you said some cervical lacerations  
14 should be treated in a hospital setting, right?

15 A. I didn't say that. I said many cervical  
16 lacerations can be safely treated in an outpatient  
17 setting.

18 Q. Which means the rest must be treated in a  
19 hospital setting, right?

20 A. There are certain -- you know, there are  
21 certain high cervical lacerations that don't respond  
22 enough to the measures that we use to treat them in  
23 the outpatient center. And then for those people,  
24 they may require transfer to a hospital.

25 Q. And you said that some uterine perforations

1 require hospital exploratory -- exploratory surgery of  
2 the abdomen in a hospital setting, right?

3 A. Some -- depending on what instrument and  
4 where the perforation in the uterus occurs and the  
5 potential risk for injury to the bowel in particular,  
6 some of those patients, yeah, need to be transferred  
7 for -- if the D&E happens in the outpatient setting,  
8 need to be transferred for that surgery in a hospital.

9 Q. You don't do any exploratory abdominal  
10 surgery to determine the scope of damage to different  
11 organs from a uterine perforation in your Planned  
12 Parenthood clinic in Minnesota, do you?

13 A. We don't provide any intraabdominal surgery  
14 at Planned Parenthood North Central States, no.

15 Q. And I know you haven't ---

16 A. However, if I'm taking care of that patient  
17 and that perforation occurs in the hospital, I would  
18 be present as the physician responsible and likely  
19 probably even start the case while we requested, you  
20 know, intraoperative consultation from the general  
21 surgeon.

22 Q. Right. But you wouldn't do that at the  
23 clinic. You would transfer that patient from the  
24 clinic to the hospital before you started that  
25 surgery, right?

1           A.     That type of surgery requires general  
2 anesthesia, and we don't have that capacity at North  
3 -- Planned Parenthood North Central States.

4           Q.     How do you get the serum hCG test from a  
5 patient? What do you do to collect that?

6           A.     We draw their blood.

7           Q.     How do you draw their blood?

8           A.     With a needle.

9           Q.     So do you take hCG testing of every patient  
10 before you give them a chemical abortion drug?

11          A.     Not all patients accessing medication  
12 abortion need serum beta hCG testing.

13          Q.     So is it your testimony that you have  
14 patients that you give chemical abortion drugs to that  
15 have neither had an ultrasound to confirm the location  
16 of the pregnancy nor had a serum hCG blood draw to  
17 test their pregnancy amounts, if you will?

18                   MS. GRANDIN: Objection to form.

19                   THE WITNESS: Testing serum hCG  
20 pregnancy amounts isn't really a thing in medical  
21 practice. The absolute value is rarely of helpful  
22 significance. It's really the trend over time that  
23 helps us take good, safe care of patients.

24                   Now, there are certainly patients who  
25 screened, you know, after a thorough assessment to be

1 low risk for ectopic pregnancy and would need neither  
2 an ultrasound nor serum hCG testing.

3 Q. (Mr. Boyle) Okay. So in your practice in  
4 Minnesota at your Planned Parenthood clinic, you give  
5 patients -- on certain occasions, you give them  
6 chemical abortion drugs without performing an  
7 ultrasound on them or drawing blood to conduct the  
8 first in a series of serum hCG blood tests. Is that  
9 correct?

10 A. The provision of medication abortion without  
11 -- after a history-based screening without ultrasound  
12 or tests like serum hCG is well established in the  
13 medical literature to be safe and effective.

14 Q. And you do that at your clinic in the  
15 Planned Parenthood clinic in Minnesota. Is that  
16 correct?

17 A. For patients who screen out of the need for  
18 ultrasound, yes.

19 Q. And even if they don't have an ultrasound,  
20 you also sometimes don't have either an ultrasound or  
21 the blood draw, correct?

22 A. Those two things are not indicated for every  
23 medication abortion patient.

24 Q. Which is sort of the inverse of what I'm  
25 asking. So sometimes, you give those patients who

1 don't have an ultrasound and don't have the serum  
2 blood draw, you give them chemical abortion drugs. Is  
3 that correct?

4 A. If they are deemed to be a low-risk patient  
5 and have -- and that's what they choose as far as  
6 prevent -- proceeding with abortion care and are able  
7 to, you know, say that they'll, you know, complete the  
8 recommended follow-up.

9 Q. I feel like you left a yes off at the end  
10 there. Was there a yes that -- if all those things,  
11 then, yes, you do that?

12 A. If all those -- if all of those things are  
13 true about a individual in front of me, then yes.

14 Q. Okay. Lawyers are fun, aren't we?

15 A. You -- yeah, you all are fun.

16 Q. So -- and just so I understood your  
17 testimony before with Ms. Grandin, you said that it's  
18 your understanding that Planned Parenthood South  
19 Atlantic performs an ultrasound on every single  
20 pregnant patient before they provide that pregnant  
21 patient with a chemical abortion, just sometimes when  
22 they do the ultrasound it's indeterminate so you have  
23 a pregnancy of unknown location. Is that your  
24 understanding?

25 A. My understanding is that the law in North

1 Carolina -- again, not an expert on laws, specifically  
2 not in states where I don't practice. But my  
3 understanding of the law in North Carolina is that an  
4 ultrasound is required for each patient to access  
5 abortion care.

6 Now, certainly, as people are nervous about  
7 limits and bans on when they're able to access  
8 abortion care, there are certainly patients -- we've  
9 seen this for sure after the Dobbs decision, people  
10 making appointments earlier and earlier in pregnancy  
11 because they're worried they won't be able to access  
12 that care.

13 Q. Yeah. I'm trying ---

14 A. Then naturally, as far as, you know, how  
15 pregnancies progress, many of those people will be  
16 diagnosed with a pregnancy of unknown location because  
17 we don't reasonably expect to see an -- see a  
18 pregnancy on ultrasound, regardless of where it's  
19 growing.

20 Q. Fair enough. My question to you is, I  
21 thought I understood you to say that when you read  
22 Dr. Farris's declarations in this case that it's your  
23 understanding that she said every single patient who  
24 gets a chemical abortion in the Planned Parenthood  
25 South Atlantic clinic has an ultrasound taken of them

1 before they are given that medication. Is that  
2 correct?

3 A. My understanding of the protocol I'm  
4 specifically referring to in her declaration is about  
5 people who have been diagnosed with a pregnancy of  
6 unknown location.

7 That diagnosis can only happen -- a patient  
8 is -- has a pregnancy. We can diagnose a pregnancy  
9 with a urine pregnancy test, but we can't -- we can't  
10 diagnosis -- diagnose a pregnancy of unknown location  
11 unless we've -- unless we've -- unless the patient has  
12 had ultrasound.

13 Q. Or you can simply not take an ultrasound,  
14 and every patient without an ultrasound has a  
15 pregnancy of unknown location, right?

16 A. No.

17 Q. No?

18 A. No. A patient who hasn't had an ultrasound  
19 but has had confirmation of a pregnancy, for example,  
20 most commonly with a urine pregnancy test, that  
21 patient just has a pregnancy.

22 Q. I think you said this, and I promise this is  
23 my last one here. I just want to confirm.

24 A. Okay.

25 Q. Don't believe me because I'm a lawyer, but

1 I'm pretty sure this is my last question.

2 You're saying that every patient at Planned  
3 Parenthood South Atlantic who gets chemical abortion  
4 drugs has had an ultrasound. Is that your  
5 understanding?

6 A. My understanding is that the law requires  
7 ultrasound prior to abortion care in North Carolina.

8 Q. So that law, I believe, that you're talking  
9 about is currently enjoined, which, fancy legal word,  
10 means it's basically on the shelf until this hearing  
11 coming up at the end of September.

12 So are you saying that you think every  
13 single patient -- see, I told you I was going to ask  
14 another question -- every single patient at Planned  
15 Parenthood South Atlantic in North Carolina has an  
16 ultrasound because of that law or because of what you  
17 saw in Dr. Farris's declaration, which is it?

18 A. Dr. ---

19 MS. GRANDIN: Objection to form and  
20 calls for a legal conclusion.

21 THE WITNESS: Dr. Farris's declaration  
22 describes the protocol they use to help treat patients  
23 that are diagnosed with a -- a pregnancy of unknown  
24 location. And again, in order to diagnose a pregnancy  
25 of unknown location, a person would have to have an



1 ultrasound.

2 MR. BOYLE: Okay. I don't think I have  
3 any further questions.

4 THE COURT REPORTER: Anybody else?

5  
6 All right. This concludes the deposition.  
7 The time is 3:34 p.m.

8  
9 WHEREUPON, at 3:34 o'clock p.m., the  
10 deposition was adjourned.

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CERTIFICATION

I, Gretchen Wells, Notary Public in and for the County of Iredell, State of North Carolina at Large, do hereby certify:

That said witness appeared before me, via video conference, at the time and place herein aforementioned and the foregoing consecutively numbered pages are a complete and accurate record of all the testimony given by said witness;

That the witness has executed a Declaration, which is attached as an exhibit hereto, and who made an attestation through this declaration that their testimony is truthful under the penalty of perjury;

That the undersigned is not of kin, nor in anywise associated with any of the parties to said cause of action, nor their counsel, and not interested in the event(s) thereof.

Reading and signing of the testimony was requested.

IN WITNESS WHEREOF, I have hereunto set my hand this 4th day of September, 2023.

*Gretchen Wells*

Notary No. 202110400230

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WITNESS CERTIFICATION

I, CHRISTY MARIE BORAAS ALSLEBEN, MD, do hereby certify,

That I have read and examined the contents of the foregoing pages of record of testimony as given by me at the times and place herein aforementioned;

And that to the best of my knowledge and belief, the foregoing pages are a complete and accurate record of all the testimony given by me at said time, except as noted on the attached here (Addendum A).

I have \_\_\_\_ / have not \_\_\_\_ made changes/corrections to be attached.

\_\_\_\_\_  
(WITNESS SIGNATURE)

I, \_\_\_\_\_, Notary Public

for the County of \_\_\_\_\_, State of

\_\_\_\_\_, do hereby certify:

That the herein-above named personally appeared before me this the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_;

And that I personally witnessed the execution of this document for the intents and purposes herein above described.

\_\_\_\_\_  
NOTARY PUBLIC  
(SEAL)

My Commission Expires:

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ADDENDUM A

Upon the reading and examination of my testimony as herein transcribed, I note the following changes and/or corrections with accompanying reason(s) for said change/correction:

Page	Line	Is Amended to Read

# EXHIBIT 2

IN THE UNITED STATES DISTRICT COURT  
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA  
CIVIL ACTION FILE NO. 1:23-CV-480

Planned Parenthood South	)
Atlantic, et al.,	)
	)
Plaintiffs,	)
	)
vs.	)
	)
JOSHUA STEIN, et al.,	)
	)
Defendants,	)
	)
and	)
	)
PHILIP E. BERGER and TIMOTHY K.	)
MOORE,	)
	)
Intervenor-	)
Defendants.	)
	)

-----

---

VIDEOTAPED DEPOSITION  
OF  
KATHERINE A. FARRIS, MD

---

TAKEN AT THE LAW OFFICES OF:  
WARD AND SMITH, P.A.  
82 PATTON AVENUE, SUITE 300  
ASHEVILLE, NC 28801

09-01-2023  
10:11 O'CLOCK A.M.

Laura Baker  
Court Reporter  
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Wilmington NC 28404

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Joshua Yost

General Counsel, Office of the  
Senate President Pro Tempore

Sam Hayes

General Counsel, North Carolina  
House Speaker Tim Moore

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E X H I B I T S

Name	Offered By	Identified
(None marked)		

NOTE: Quoted material has been reproduced as read or quoted by the speaker.

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STIPULATIONS

Pursuant to Notice and/or consent of the parties, the deposition hereon captioned was conducted at the time and location indicated and was conducted before Laura Baker, Notary Public in and for the County of Iredell, State of North Carolina at Large.

Notice and/or defect in Notice of time, place, purpose and method of taking the deposition was waived. Formalities with regard to sealing and filing the deposition were waived, and it is stipulated that the original transcript, upon being certified by the undersigned court reporter, shall be made available for use in accordance with the applicable rules as amended.

It is stipulated that objections to questions and motions to strike answers are reserved until the testimony, or any part thereof, is offered for evidence, except that objection to the form of any question shall be noted herein at the time of the taking of the testimony.

Reading and signing of the testimony was requested prior to the filing of same for use as permitted by applicable rule(s).

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PROCEEDINGS

(10:11 o'clock a.m.)

THE VIDEOGRAPHER: On record. Today is September 1st, 2023, and the time is 10:11 a.m. I'm the videographer, Rachel Corcione, and the court reporter is Laura Baker.

This is the video deposition of Katherine Farris, MD, in the matter of Planned Parenthood South Atlantic, et al., versus Joshua Stein, et al., and Philip E. Berger and Timothy K. Moore.

Will counsel now introduce themselves for the video record, after which the court reporter will swear in the witness.

MS. SWANSON: Good morning. My name is Hannah Swanson of Planned Parenthood Federation of America. I represent Planned Parenthood South Atlantic, and I'm joined on the phone by my colleagues at Planned Parenthood Federation of America, Anjali Salvador, Kara Grandin, Dylan Cowit, Vanisha Kudumuri, Shealyn Massey. Vanisha and Shealyn are paralegals. And I'm also joined on the phone by Susanna Birdsong of Planned Parenthood South Atlantic.

MR. BOYLE: Good morning. My name is Ellis Boyle from the Wake County Bar. I represent the Legislative Leader Defendants, Speaker Moore and

1 Senator Berger. I believe I'm joined on this Zoom  
2 remotely by my co-counsel, Julia Payne, with the ADF.

3 MS. PAYNE: Yes, I am here.

4 MR. BOYLE: And I might just tick down  
5 the list so we don't overlap. Can we get Attorney  
6 General Stein's counsel next?

7 MS. NARASIMHAN: Morning. My name is  
8 Sripriya Narasimhan. I'm with the North Carolina  
9 Department of Justice, representing Attorney General  
10 Josh Stein.

11 MR. BOYLE: Next, the DAs other than Jim  
12 O'Neill?

13 MS. O'BRIEN: Good morning. Elizabeth  
14 O'Brien from the North Carolina Department of Justice,  
15 and I represent the district attorneys, except for  
16 District Attorney Jim O'Neill.

17 MR. BOYLE: Next, DA Jim O'Neill?

18 MR. WILLIAMS: My name is Kevin Williams  
19 with the Forsyth County Bar, and I represent District  
20 Attorney Jim O'Neill.

21 MR. BOYLE: Next. Secretary Kinsley?

22 MR. WOOD: Hi, good morning. This is  
23 Michael Wood with NCDOJ, and I'm counsel to Secretary  
24 Kody Kinsley of DHHS.

25 MR. BOYLE: Next. The Medical Boards?

1 MR. BULLERI: Good morning. This is  
2 Michael Bulleri with the North Carolina Department of  
3 Justice. I represent the North Carolina Medical Board  
4 and the North Carolina Board of Nursing.

5 MR. BOYLE: I think that's all of the  
6 groups of parties. If there are any other folks that  
7 are on, please identify yourself now. Thanks.

8 MS. AMIRI: Hi, everyone. Brigitte  
9 Amiri from the ACLU, and I represent the Plaintiff, Dr.  
10 Gray.

11 MS. MAFFETORE: Good morning, everyone.  
12 Jaclyn Maffetore of the ACLU North Carolina on behalf  
13 of all Plaintiffs.

14 MR. YOST: Good morning, everyone.  
15 Joshua Yost, General Counsel for Senator Phil Berger.

16 MR. HAYES: And Sam Hayes, General  
17 Counsel for North Carolina House Speaker Tim Moore.

18 MR. BOYLE: Going once? All right.  
19 Ready to begin?

20 THE COURT REPORTER: I need to swear in  
21 our witness.

22 MR. BOYLE: Yes.

23 The witness, KATHERINE A. FARRIS, MD, being  
24 first duly affirmed to state the truth, the whole  
25 truth, and nothing but the truth, testifies as follows:

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EXAMINATION

BY MR. BOYLE:

MR. BOYLE: Good morning. We are on the record for the deposition of Dr. Farris. It's about 10:15 a.m. on September 1st, 2023. And we are located in the Ward and Smith Asheville office, with some counsel appearing remotely.

My name is Ellis Boyle, and I represent the Legislative Defendants in this case.

Q. (Mr. Boyle) Doctor, have you ever been deposed before?

A. No, I have not.

Q. Welcome. I'm sure you've heard this from your counsel, but I just want to go over a few ground rules. A deposition is a more formal conversation than we would have on -- you know, outside of a deposition or court setting, and so there's a few rules.

We like to keep our court reporter happy, because she is transcribing, writing down, all the words that we speak out loud during this deposition. So two big rules for that; number one, if I ask you a question, I ask that you please answer verbally out loud instead of nodding your head or saying, "uh-huh," which would be normal, and I would understand in a non-deposition context, but since we're having the court

1 reporter transcribe it, can you agree to do that,  
2 please?

3 A. I can.

4 Q. Great. And if we get down the path and you  
5 get a little off that, I may politely nudge you back.  
6 I'm not trying to be rude. Please don't be offended if  
7 I do that. Okay?

8 A. I understand.

9 Q. The second one is talking over each other.  
10 Again, to have a clean record for the court reporter,  
11 it's much better if I allow you to finish whatever  
12 you're saying and vice versa before the other one  
13 starts to talk again.

14 So I ask that you please try and be more  
15 cognizant of that than under normal conversation  
16 circumstances where you think you know where I'm going  
17 with my question, and you just start answering. Try to  
18 let me finish, even if I ramble, please.

19 A. I understand.

20 Q. Thank you. And then, finally, your lawyer  
21 may object during the course of this deposition. And  
22 unless there's an instruction not to answer for some  
23 privilege or similar-type reason, the expectation is  
24 that you'll respond to the question, even if there's an  
25 objection. Okay?



1 A. Yes.

2 Q. Very good. You work for Planned Parenthood  
3 South Atlantic, right?

4 A. That's correct.

5 Q. You're the medical director there?

6 A. My title is chief medical officer.

7 Q. Okay. Is there someone else who's the  
8 medical director?

9 A. I have an associate affiliate medical  
10 director who works under me.

11 Q. Okay. Are you the CEO or president or the  
12 highest officer in the operational process of the  
13 Planned Parenthood South Atlantic?

14 MS. SWANSON: Objection to form.

15 THE WITNESS: I am not the CEO. I'm the  
16 chief medical officer, and I am the highest ranking  
17 licensed person in the organization.

18 Q. (Mr. Boyle) Okay. Is there someone who has  
19 a title that works there day to day who is your boss,  
20 or are you sort of the person who runs the day-to-day  
21 operations?

22 A. I have a boss, yes. The CEO.

23 Q. Planned Parenthood -- and I'm going to call  
24 it "PPSA" -- or do you want to call it "P-P-S-A-T" or  
25 "PP-SAT"?

1 A. If we used an acronym, it would be PPSAT.

2 Q. Okay. I'll try to remember that. I wrote  
3 PPSA here, so please forgive me if I say it the wrong  
4 way. PPSAT charges money to perform induced abortions.  
5 Isn't that true?

6 A. Yes.

7 MS. SWANSON: Objection to form.

8 THE WITNESS: We do charge for the  
9 medical services we provide.

10 Q. (Mr. Boyle) And one of those medical  
11 services that PPSAT provides is induced abortions,  
12 right?

13 A. We do provide abortions.

14 Q. And you do charge for those induced abortions  
15 that you provide, right?

16 A. I do not charge, so I'm not directly involved  
17 with charging money.

18 Q. Would you say you're, what, second in command  
19 at PPSAT, or where do you fall on the org chart?

20 MS. SWANSON: Objection to form.

21 THE WITNESS: I am not second in  
22 command. I do report directly to the CEO, as do a  
23 number of other individuals.

24 Q. (Mr. Boyle) Okay. And you're aware, then,  
25 that PPSAT charges money to perform induced abortions

1 for patients who come to PPSAT seeking an induced  
2 abortion, right?

3 A. Yes. We do charge for our healthcare  
4 services.

5 Q. And I appreciate that. I just want to make  
6 sure I'm clear, because I asked about induced  
7 abortions. You do charge for induced abortions,  
8 including other healthcare?

9 MS. SWANSON: Objection to form.

10 THE WITNESS: We charge for all of the  
11 healthcare we provide, including induced abortions.

12 Q. (Mr. Boyle) Okay. Thank you. How much does  
13 PPSAT charge for each chemical abortion that it  
14 performs in North Carolina?

15 A. I believe that the cost for self-pay for a  
16 medication abortion is \$625.

17 Q. Are there other prices that are charged other  
18 than for a self-paid patient who's obtaining a chemical  
19 abortion from PPSAT?

20 MS. SWANSON: Objection to form.

21 Q. (Mr. Boyle) In North Carolina, I should say.

22 A. In North Carolina, we also have insurance  
23 that we bill for abortion, and I believe that the cost  
24 for insurance is based on contracts, but I don't know  
25 the exact amount.

1 Q. Do you know if -- and as I understand, PPSAT  
2 operates in four different states, right?

3 A. That is correct.

4 Q. And you're the medical officer for PPSAT in  
5 all four states. Is that correct?

6 A. That is correct.

7 Q. When we're talking about PPSAT today, I'm  
8 primarily focused on what PPSAT does at the, what is  
9 it, six clinics here in North Carolina. So if there's  
10 any confusion, please let me know. But generally, when  
11 I'm talking about PPSAT, can we agree that we're  
12 talking about those six clinics in North Carolina?

13 MS. SWANSON: Objection to form.

14 THE WITNESS: Just to clarify, we have  
15 more than six clinics in North Carolina. We only  
16 perform abortions at six of the clinics in North  
17 Carolina.

18 Q. (Mr. Boyle) Fair enough. How many clinics  
19 do you have in North Carolina?

20 A. Nine clinics in North Carolina.

21 Q. Okay. Which six clinics in North Carolina do  
22 you perform induced abortions at?

23 A. Planned Parenthood South Atlantic performs  
24 abortions at our Asheville, Charlotte, Winston-Salem,  
25 Fayetteville, Chapel Hill and Wilmington clinics in

1 North Carolina.

2 Q. So you do not perform them in Raleigh or  
3 Greensboro. Is that correct?

4 A. We do not perform abortions in Raleigh,  
5 Durham or Greensboro.

6 Q. Okay. So I'm primarily going to be asking  
7 about the six PPSAT clinics in North Carolina where you  
8 perform induced abortions. So if that gets confusing,  
9 please clarify and ask me to clarify. But that's my  
10 intent. Okay?

11 A. I understand.

12 Q. Very good. Do you know if PPSAT charges --  
13 insurance companies that pay for medical or chemical  
14 abortions, do they charge more or less than they charge  
15 for the individual who's paying directly?

16 A. I believe that we have contracts with  
17 insurance companies in North Carolina that we charge  
18 for medication abortion, and I think that cost is  
19 higher if a patient is using insurance to pay for their  
20 abortion healthcare.

21 Q. Okay. Do you know how much PPSAT charges for  
22 each surgical abortion that it performs in North  
23 Carolina?

24 A. Procedural abortions are charged based on the  
25 gestational duration of the pregnancy. So I believe a

1 first trimester, so up through the 13th week of  
2 pregnancy, is \$625. And then there are increases in  
3 cost based on gestational duration.

4 Q. What do those increases in cost based on  
5 gestational duration look like? What is the amounts?

6 A. I do not know those numbers off the top of my  
7 head.

8 Q. Do you know why there's an increase in cost-  
9 charge as the durational age goes up?

10 A. I was not part of making those decisions, so  
11 I don't know exactly why those costs change.

12 Q. Is the surgical procedure for an aspiration  
13 abortion at 14 weeks the same as a surgical procedure  
14 for an aspiration abortion at 16 weeks?

15 MS. SWANSON: Objection to form.

16 THE WITNESS: Every procedure is  
17 slightly different based on patient factors, but the  
18 difference between a 14-week abortion and a 16-week  
19 abortion is fairly minimal.

20 Q. (Mr. Boyle) Do you know if you charge -- if  
21 PPSAT charges more for an aspiration abortion at 14  
22 weeks than they do for an aspiration abortion at 16  
23 weeks in North Carolina?

24 A. No. I believe they do not charge more for 14  
25 weeks than for 16 weeks.

1 Q. When does that difference, that increased  
2 cost, kick in then? Is it at week 17? Is it at week  
3 18?

4 A. Can you please clarify your question?

5 Q. You just said that you don't believe that  
6 PPSAT North Carolina charges anything different for a  
7 14-week aspiration abortion versus a 16-week aspiration  
8 abortion. Is that correct?

9 THE WITNESS: No.

10 MS. SWANSON: Objection to form.

11 THE WITNESS: That's not what I said. I  
12 said I do not believe that Planned Parenthood South  
13 Atlantic charges more for a 14-week abortion than for a  
14 16-week abortion, which is what I understood you to be  
15 asking.

16 Q. (Mr. Boyle) Okay. That's not what I was  
17 asking. That's what I meant. So thank you for the  
18 clarification. I apologize for being confusing.

19 So when would that price difference kick in  
20 if it's not, say, 14 to 16 weeks? Is it at 17 weeks?  
21 Is it at 18 weeks?

22 A. I understand there to be a price difference  
23 when a patient hits 14 weeks that is higher than an  
24 abortion at 13 weeks. And I understand there to be  
25 incremental increases in abortion at some gestational

1 ages, but I don't know the date range.

2 Q. Okay. But you don't think it's 14 to 16  
3 weeks? You think those would be charged the same?

4 MS. SWANSON: Objection to form.

5 THE WITNESS: I don't know without  
6 looking at our fee service -- our fee -- I don't  
7 remember the name of the document, but there's a  
8 document that lists our fees.

9 Q. (Mr. Boyle) How much money does PPSAT make  
10 in one year for chemical abortions it performs in North  
11 Carolina?

12 MS. SWANSON: Objection to form.

13 THE WITNESS: I do not know.

14 Q. (Mr. Boyle) How much money does PPSAT make  
15 in a year for surgical abortions it performs in North  
16 Carolina?

17 MS. SWANSON: Objection to form.

18 THE WITNESS: I do not know.

19 Q. (Mr. Boyle) How much money does PPSAT make  
20 in a year for surgical abortions it performs in North  
21 Carolina for pregnant women in their 14th or later  
22 weeks gestational age?

23 MS. SWANSON: Objection to form.

24 THE WITNESS: I do not know.

25 Q. (Mr. Boyle) But you do know that when a



1 patient hits 14 weeks gestational age, PPSAT charges  
2 more for all of those surgical abortions 14 weeks and  
3 later than earlier time? So 13 weeks or less, correct?

4 A. I do know that the cost of an abortion at 14  
5 weeks and later is higher than the cost prior to 14  
6 weeks.

7 Q. How many chemical abortions does PPSAT  
8 perform in a year in North Carolina on patients who  
9 have a pregnancy that is not identified in the mother's  
10 uterus by using ultrasound?

11 MS. SWANSON: Objection to form.

12 THE WITNESS: I do not know the exact  
13 number of abortions that Planned Parenthood provides --  
14 pardon me, medication abortions that Planned Parenthood  
15 provides to patients with pregnancy of unknown  
16 location.

17 Q. (Mr. Boyle) Okay. You would agree that  
18 leading up until today, Planned Parenthood South  
19 Atlantic does perform chemical abortions on patients  
20 who have a pregnancy that is not identified in the  
21 uterus or located in the uterus by ultrasound. Is that  
22 correct?

23 A. Planned Parenthood does perform medication  
24 abortions on select patients who do not have a visible  
25 pregnancy within their uterus.

1 Q. And they charge money -- let me rephrase  
2 that.

3 Planned Parenthood South Atlantic charges  
4 money for those chemical abortions that it provides to  
5 patients who have an ultrasound, but you are not able  
6 to locate the pregnancy in their uterus, correct?

7 A. Planned Parenthood does charge for abortions  
8 on a patient with a pregnancy of unknown location.  
9 Yes.

10 Q. How much money do you think Planned  
11 Parenthood South Atlantic will lose in a year if it  
12 cannot perform surgical abortions in North Carolina for  
13 pregnant women in their 13th -- I'm sorry, 14th or  
14 later weeks gestational age?

15 MS. SWANSON: Objection to form.

16 THE WITNESS: I do not know.

17 Q. (Mr. Boyle) But you do know that currently,  
18 PPSAT is performing surgical abortions on women in  
19 their 14th week gestational age or later, and they are  
20 charging money for those abortions, right?

21 MS. SWANSON: Objection to form.

22 THE WITNESS: I am not aware of -- I'm  
23 not sure if we have performed an abortion beyond the  
24 12th week since the new law went into effect.

25 Q. (Mr. Boyle) Okay. Leading up to July 1st,

1 2023, you would agree that PPSAT North Carolina was  
2 performing surgical abortions on patients in their 13th  
3 week and later gestational age and charging money to  
4 perform those abortions, right?

5 A. Prior to July 1st, Planned Parenthood South  
6 Atlantic was performing procedural abortions beyond the  
7 12th week of pregnancy and charging for those  
8 abortions, yes.

9 Q. And this law, this change in the law, has  
10 caused PPSAT to lose the income that it made from  
11 charging those patients for those abortions, right?

12 MS. SWANSON: Objection to form.

13 THE WITNESS: I am not aware of what our  
14 income balance is since the change in the law.

15 Q. (Mr. Boyle) Well, you're aware that if you  
16 were performing those abortions before and charging  
17 money and getting paid for them, and now you're not,  
18 you've lost that money, right?

19 MS. SWANSON: Objection to form.

20 THE WITNESS: I am not aware of what  
21 money or what our income has been since the change in  
22 the law.

23 Q. (Mr. Boyle) Yes, I'm not asking about your  
24 general income or your general balance sheet. I'm  
25 saying, the simple fact is, if you were doing those

1 abortions and charging money for them before, and now  
2 you no longer are, you've lost that money that you made  
3 before, correct?

4 MS. SWANSON: Objection to form.

5 THE WITNESS: I think that would require  
6 me to speculate, because we've changed the services we  
7 provide since the law went into effect, and I can't  
8 speculate as to the exact impact that has had on our  
9 income.

10 Q. (Mr. Boyle) I'm not asking you to compare  
11 income. I'm just asking if you simply lose revenue  
12 from that potential source if you're no longer doing  
13 it.

14 MS. SWANSON: Objection to form.

15 THE WITNESS: I can state that we are  
16 not charging for abortions that we are not performing,  
17 and we are not performing abortions, routinely, beyond  
18 the 12th week of pregnancy since the law went into  
19 effect.

20 Q. (Mr. Boyle) You just said, "routinely." Are  
21 you performing them at all?

22 A. Legally, we can perform them. And I'm not  
23 personally aware of an abortion that has done -- that  
24 has been done past the 12th week that meets one of the  
25 exceptions.

1 Q. So as I understand your testimony, you're  
2 saying that it's possible that an abortion after the  
3 12th week that meets one of the exceptions under the  
4 new law has been performed at a PPSAT clinic since July  
5 1st leading up to today, September 1st, but you're just  
6 not aware of that.

7 A. Correct.

8 Q. Okay. I just want to clarify. If you were  
9 making money doing that type of abortion before July  
10 1st when the law in effect, and now you're no longer  
11 doing it, you would agree that you've lost at least  
12 that money that you were able to make and charge for  
13 those abortions that you're not able to make and charge  
14 now, correct?

15 MS. SWANSON: Objection to form.

16 THE WITNESS: I would not characterize  
17 that I -- that PPSAT has lost money. I would  
18 characterize that PPSAT is not charging for procedures  
19 that we are not performing.

20 Q. (Mr. Boyle) PPSAT is a nonprofit. Is that  
21 correct?

22 A. Yes, that's correct.

23 Q. Does it provide any charity care to patients?

24 MS. SWANSON: Objection to form.

25 THE WITNESS: I am not deeply involved

1 in exactly how patients pay for abortions, so have some  
2 limited knowledge of how that works.

3 Q. (Mr. Boyle) Does it provide charity abortion  
4 care to patients?

5 MS. SWANSON: Objection to form.

6 THE WITNESS: I know that there are  
7 abortion funds that support patients who cannot afford  
8 to pay. So if they don't have insurance that covers  
9 the abortion or choose not to use insurance and they  
10 are paying the self-pay fee, some patients, it is my  
11 understanding, cannot afford to pay it, and I am aware  
12 that there are donation funds that support patients.

13 I'm not exactly sure when or how that money  
14 comes directly from Planned Parenthood versus other  
15 non-Planned Parenthood abortion funds.

16 Q. (Mr. Boyle) Fair enough. And when you say  
17 Planned Parenthood in that context of your last answer,  
18 are you talking about PPSAT, or are you talking about  
19 the parent organization, Planned Parenthood, sort of  
20 nationwide?

21 A. Thank you for clarifying. I was referring  
22 specifically to Planned Parenthood South Atlantic. I'm  
23 also not fully aware of Planned Parenthood Federation  
24 of America funds that may be supporting care.

25 Q. Okay. So it might happen, you're just not

1 aware of how and when.

2 A. Correct.

3 Q. Okay. And I don't need specifics, but you're  
4 paid to be the medical director on an annual basis for  
5 your work at PPSAT, right?

6 A. Yes, I am.

7 Q. Do you have any other jobs -- again, not  
8 looking for specifics. Do you have any other jobs  
9 where you work for money, you earn income outside of  
10 PPSAT, in the past five years, or do you dedicate your  
11 full workload and income earning to your job at PPSAT?

12 A. The only job I have is at PPSAT.

13 Q. Is that true for the past, say, five years?

14 A. Yes, that is true.

15 Q. Are you being paid for your testimony here  
16 today?

17 A. I'm not being paid differently for my  
18 testimony. I'm just working as the chief medical  
19 officer of Planned Parenthood South Atlantic.

20 Q. Take a water break.

21 Right. That -- and that's my question  
22 specifically, is, you know, sometimes expert witnesses  
23 are paid independently from their day job. Are you  
24 being paid as an expert witness beyond your normal  
25 salary that you derive working as the medical director

1 at PPSAT for your time testifying here today?

2 A. No, I'm not.

3 Q. So your role here today is as the chief  
4 medical director for one of the Plaintiffs in -- the  
5 parties in this case. Is that right?

6 A. My title is chief medical officer, and I am  
7 here speaking based on my knowledge as the chief  
8 medical officer of Planned Parenthood South Atlantic,  
9 who I understand to be a Plaintiff in this case.

10 Q. Sorry, when I do that weird thing, I'm  
11 thinking. I apologize.

12 Is part of your payment for your job at PPSAT  
13 derived from how PPSAT performs overall in any given  
14 year?

15 MS. SWANSON: Objection to form.

16 THE WITNESS: I do not have any change  
17 in compensation related to performance metrics.

18 Q. (Mr. Boyle) So you don't have incentive  
19 payments or bonuses or anything like that related to  
20 your job? Again, not asking for specific amounts, but  
21 any type of incentive payment.

22 A. I have received bonuses in the past, but  
23 never as an incentive related to -- when I think about  
24 bonuses in healthcare, often bonuses are applied for  
25 volume. I've never received a bonus from Planned



1 Parenthood South Atlantic based on the volume of care  
2 that I provided.

3 Q. Without going into details about numbers, why  
4 would you have gotten, or why did you get bonuses in  
5 the past from PPSAT?

6 A. I've received a bonus in the past when I took  
7 on additional job responsibilities. For example,  
8 serving as the interim -- I don't recall the exact  
9 title, but it's in my CV. The interim VP of patient  
10 services, I think. So it was a substantive change in  
11 my job description that they paid me a bonus for.

12 Q. Very small print on your CV.

13 MS. SWANSON: And, Ellis, if you're  
14 going to be referring to that, could we also have a  
15 copy to look at, please?

16 MR. BOYLE: Yeah, I was just looking to  
17 see if I remembered the name she was talking about. I  
18 don't know that I have a copy of her CV.

19 But I accept your explanation.

20 Q. (Mr. Boyle) So if PPSAT performs a certain  
21 metric of induced abortions in a year, are you paid  
22 more in that year for achieving that goal or metric?

23 MS. SWANSON: Objection to form.

24 THE WITNESS: No.

25 Q. (Mr. Boyle) But if the North Carolina law

1 that goes into effect that you're here testifying about  
2 in this case, if it goes into effect, your company,  
3 PPSAT, could lose money, because it will lose the  
4 ability to perform as many induced abortions. Is that  
5 correct?

6 MS. SWANSON: Objection to form.

7 THE WITNESS: It's outside the scope of  
8 my job to speculate on the exact finances of the  
9 organization.

10 Q. (Mr. Boyle) Sure, but you're a very smart  
11 doctor, and common sense would dictate, I believe, that  
12 if PPSAT was performing induced abortions that it can  
13 no longer perform, and it loses the ability to derive  
14 that income from those induced abortions, PPSAT could  
15 and probably would lose money from this new law. Is  
16 that correct?

17 MS. SWANSON: Objection to form.

18 THE WITNESS: PPSAT could lose money, or  
19 we could provide different services which would make up  
20 for any change in income.

21 Q. (Mr. Boyle) Fair enough. Do you engage in  
22 fundraising for any Planned Parenthood or abortion  
23 group?

24 MS. SWANSON: Objection to form.

25 THE WITNESS: I'm not sure what you mean

1 by, "engage in fundraising."

2 Q. (Mr. Boyle) Do you raise money for Planned  
3 Parenthood?

4 A. I do not personally raise money for Planned  
5 Parenthood, but I have been present at events,  
6 fundraising events.

7 Q. Okay. Your medical specialty is in family  
8 medicine. Is that right?

9 A. Yes, it is.

10 Q. You're not an OB/GYN, are you?

11 A. I am a family physician, not an  
12 obstetrician/gynecologist.

13 Q. You said it better than me. I'm going to do  
14 terrible with it, but I'm going to call it an OB/GYN,  
15 if that's all right. I can say that without confusing  
16 myself. You have no residency or fellowship training  
17 in OB/GYN, do you?

18 A. That is not correct.

19 Q. Okay. What residency or fellowship training  
20 do you have in OB/GYN?

21 A. Family medicine encompasses obstetrics and  
22 gynecology in their routine residency training.

23 Q. Okay. So beyond the -- and as I understand  
24 it, family medicine is sort of a combination of  
25 pediatrics and internal medicine, so typically, it

1 would be outpatient care for children and adults in a  
2 family medicine practice. Is that a fair assessment of  
3 that?

4 MS. SWANSON: Objection to form.

5 THE WITNESS: That is not how I would  
6 characterize family medicine, no.

7 Q. (Mr. Boyle) How would you characterize it?

8 A. Family physicians are trained to care for  
9 pregnant people, trained to perform deliveries, to care  
10 for pediatrics, to care for adult medicine, to take  
11 care of geriatric medicine, which is later adult, to do  
12 end-of-life care and to care for patients both in the  
13 hospital and in the outpatient setting.

14 Q. Okay. As part of your family medicine  
15 residency -- well, and let me just clarify. You didn't  
16 get any fellowship training in OB/GYN, correct?

17 A. That is correct. I did not do an additional  
18 fellowship.

19 Q. Did you do a fellowship in family medicine?

20 A. No, I did not.

21 Q. Are you board certified?

22 A. I am board certified in family medicine.

23 Q. Are you board certified as an OB/GYN?

24 A. No, I am not.

25 Q. Are you board certified in advanced family

1 planning?

2 A. I'm not aware of a board certification in  
3 advanced family planning.

4 Q. You haven't had a fellowship in advanced  
5 family training -- I'm sorry, advanced family planning,  
6 have you?

7 A. I'm not aware of a fellowship in advanced  
8 family planning.

9 Q. Which, I guess, means you are not fellowship  
10 trained in that.

11 A. I do ---

12 Q. Yeah.

13 A. --- not have a fellowship training in that.

14 Q. In your residency for family practice,  
15 describe for me what your rotations were, related to  
16 OB/GYN practice.

17 A. In my residency, we performed rotations that  
18 were more highly focused on obstetrics and gynecology,  
19 where we performed obstetrics and gynecologic  
20 surgeries, deliveries, both vaginal deliveries and C-  
21 sections. And we also, throughout the entire course of  
22 our residency, had our own obstetrical patients that we  
23 would follow regardless of what rotation we were on.

24 Q. And where did you do that residency, again?

25 A. Just outside of Seattle, Washington, in

1 Renton.

2 Q. Now did, in your residency, you have any  
3 training or experience performing induced abortions?

4 A. Yes, I did receive training in abortion  
5 during my residency.

6 Q. Describe that training for me, please.

7 A. Can you clarify what you mean by describing  
8 the training?

9 Q. What did you learn about abortion during your  
10 residency in that hospital near Seattle?

11 MS. SWANSON: Objection to form.

12 THE WITNESS: My training in abortion  
13 was primarily outpatient. I don't recall whether I did  
14 any abortions in the hospital, but I was trained to  
15 perform induced abortion in an outpatient clinic.

16 Q. (Mr. Boyle) When you did your training, that  
17 was after the chemical abortion protocols had been  
18 approved, and they were available as an induced  
19 abortion option, weren't they?

20 A. I don't recall exactly when that was  
21 approved.

22 Q. Did you do any residency training about  
23 chemical abortion drugs -- and I'm going to say them  
24 wrong, but I'm going to try, mifeprexin (sic),  
25 misoprostol, when you were in your residency?

1           A.    I don't recall the exact details of training  
2           or the exact timing of when that was approved, but I do  
3           recall receiving some training on mifepristone and  
4           misoprostol as they are used for abortion.

5           Q.    Did you receive that training you're thinking  
6           of during your residency?

7           A.    I received it, I believe, during the time of  
8           my residency, yes.

9           Q.    How long was your residency?

10          A.    My residency was three years, if you include  
11          internship.

12          Q.    What years were that -- was that again?

13          A.    I started residency in 2000 and completed it  
14          in 2003.

15          Q.    And from your residency, you went to work at  
16          Planned Parenthood in Massachusetts. Is that correct?

17          A.    That was one of the jobs I took after  
18          residency, yes.

19          Q.    What was the other job?

20          A.    It was a comprehensive family practice job.

21          Q.    Where was that?

22          A.    It was in Fitchburg, Massachusetts.

23          Actually, the office was in -- I believe that my office  
24          was located in Westminister, Massachusetts, and the  
25          hospital that I admitted at was in Gardner,

1 Massachusetts.

2 Q. And that was Heywood -- practice in Heywood  
3 Hospital?

4 A. Heywood Hospital was the name of the  
5 hospital, yes.

6 Q. What did you learn in your residency about  
7 induced abortions using aspiration or D&E procedures?

8 A. I learned a great deal about abortion. I'm  
9 not sure if you want me to outline everything I learned  
10 about abortion in that time.

11 Q. Probably not everything, but just give me  
12 some basics, and if I feel the need to explore further,  
13 I will. But just basically, what did you learn about  
14 those two procedures?

15 A. That they are incredibly safe and an  
16 important aspect of comprehensive sexual and  
17 reproductive healthcare.

18 Q. Did you learn how to perform any other  
19 gynecological surgery procedures?

20 MS. SWANSON: Objection to form.

21 Q. (Mr. Boyle) During your residency? Sorry.

22 MS. SWANSON: Same objection.

23 THE WITNESS: I learned to perform other  
24 gynecologic procedures during my residency, yes.

25 Q. (Mr. Boyle) Surgical -- gynecological



1 surgical procedures?

2 MS. SWANSON: Objection to form.

3 THE WITNESS: I did learn to perform  
4 some gynecologic surgery, primarily first assisting on  
5 C-sections.

6 Q. (Mr. Boyle) Okay. Have you done any C-  
7 sections as the lead doctor performing the surgery?

8 A. I have not been the primary surgeon on a C-  
9 section, no.

10 Q. Have you assisted with any C-section  
11 surgeries since you left residency?

12 A. Yes.

13 Q. When was the last time you assisted in a C-  
14 section surgery after residency?

15 A. I don't know the exact date or time, but it  
16 was when I was practicing in Massachusetts.

17 Q. So when you were practicing in Massachusetts,  
18 which I believe was from 2004 to 2007 -- is that  
19 roughly correct? Maybe 2003 to 2007?

20 A. I believe it was 2003 to 2007, yes.

21 Q. So during that period of your career, how  
22 many C-section surgeries did you assist with?

23 A. I don't recall the number.

24 Q. Was it, like, two or 2,000? I mean, can you  
25 give me a range maybe?

1           A.    It was a routine part of the care I provided.  
2    If I had any patient who needed a C-section, I would  
3    first assist on that C-section routinely.

4           Q.    I still don't have a sense, though.  I mean,  
5    was that something that happened once a week, once a  
6    year?

7           A.    I don't know the exact range, but it was on  
8    average, I believe, once a month.

9           Q.    Okay.  So maybe 40 to 60 times you assisted  
10   in a C-section surgery during that three-to-four-year  
11   stint?

12                   MS. SWANSON:  Objection to form.

13                   THE WITNESS:  I can't recall the exact  
14   numbers.

15           Q.    (Mr. Boyle)  More than 25 times?

16           A.    I believe it would have been more than 25,  
17    yes.

18           Q.    And you haven't done any since 2007.  Is that  
19   correct?

20           A.    I have not assisted in a C-section since  
21   2007.

22           Q.    What other gynecological surgical procedures  
23   did you train on and learn how to do in your residency?

24           A.    I did not learn to be the primary surgeon on  
25   any other gynecologic surgeries.

1 Q. Okay. Did you learn how to be the primary  
2 provider who would perform an aspiration abortion  
3 during your residency?

4 A. Yes, I did.

5 Q. Did you learn how to be the primary provider  
6 who would lead on a D&E abortion during your residency?

7 A. No, I did not.

8 Q. Do you perform D&E abortions?

9 A. Yes, I do.

10 Q. When did you learn how to do that?

11 A. I learned to do that as a provider at Planned  
12 Parenthood South Atlantic.

13 Q. Okay. And you arrived at PPSAT in 2007 when  
14 you left Massachusetts. Is that correct?

15 A. I didn't start at Planned Parenthood South  
16 Atlantic until 2009.

17 Q. What did you do in between?

18 A. I had a second baby.

19 Q. Okay. So when you went back to work after  
20 that, you went to work at PPSAT in 2009, and you've  
21 worked there ever since. Is that correct?

22 A. That is correct.

23 Q. Okay. So you never had any formal training  
24 in a pedantic or academic setting about how to perform  
25 a D&E abortion. Is that correct?

1 MS. SWANSON: Objection to form.

2 THE WITNESS: I don't know what you mean  
3 by, "pedantic academic setting."

4 Q. (Mr. Boyle) In school or residency.

5 A. I was not trained to perform D&E during a  
6 formal residency program.

7 Q. Who taught you how to do it at PPSAT?

8 MS. SWANSON: Objection, to the extent  
9 this calls for the name of a physician. This is  
10 something that ---

11 Q. (Mr. Boyle) Just give me something general.  
12 I don't need to know the name. That's fine.

13 A. More experienced providers at PPSAT who had  
14 extensive experience in D&E.

15 Q. As a family practice physician, you have  
16 experience providing prenatal care, don't you?

17 A. Yes, I do.

18 Q. And I think we've established, you've  
19 delivered babies in your practice, right?

20 A. Yes, I have.

21 Q. Do you still deliver babies currently in your  
22 practice?

23 A. I do not still perform deliveries, no.

24 Q. When was the last time that you delivered a  
25 baby, to rough recollection?

1           A.    It would have been in probably 2007, before I  
2 left my practice there.

3           Q.    Okay.  So -- and I don't want to  
4 mischaracterize, but it sounds to me like -- since you  
5 left Massachusetts and stopped having whatever your  
6 privileges were at Heywood Hospital, have you not  
7 engaged in helping a mother deliver a baby since that  
8 time?

9           A.    I have not performed deliveries since I left  
10 Massachusetts in 2007.

11          Q.    Does any of your practice at PPSAT, since  
12 you've been there, involve prenatal care and providing  
13 care to mothers who intend to give birth to their  
14 children?

15          A.    We do not provide comprehensive prenatal  
16 care.  We do provide some general guidance for people  
17 who are attempting to become pregnant.  And for people  
18 who have found they are pregnant and are wishing to  
19 continue their pregnancy, we provide primarily  
20 referrals to obstetricians for them to receive that  
21 prenatal care.

22          Q.    And I'm -- and that makes sense to me.  I'm  
23 just trying to see if I understand it completely.

24                So at PPSAT, if a patient comes in who tests  
25 positive as pregnant, and they want to continue the

1 pregnancy, you evaluate them sort of as an initial  
2 evaluation/confirmation and then you would refer them  
3 out to see an obstetrician for care through the  
4 pregnancy. And you all don't actually give that  
5 obstetrician care there and assist with the childbirth.

6 Do I understand that correctly?

7 MS. SWANSON: Objection to form.

8 THE WITNESS: I would clarify that when  
9 we have a patient who comes in and has a positive  
10 pregnancy test and chooses to continue their pregnancy,  
11 we provide them with resources to go see either a  
12 family physician who provides prenatal care or an  
13 obstetrician who provides prenatal care.

14 Q. (Mr. Boyle) Okay.

15 A. Or a certified nurse midwife who provides  
16 prenatal care.

17 Q. Does PPSAT provide -- and you may have said  
18 this; I apologize. I'm just trying to close it out.

19 Does PPSAT provide prenatal care for any  
20 patients up until the time of birth if they choose to  
21 continue a pregnancy?

22 A. No. PPSAT does not provide comprehensive  
23 prenatal care.

24 Q. When you worked at -- and is that true for  
25 the whole time you've worked at PPSAT, from 2009 up

1 until today?

2 A. Yes, it is.

3 Q. When you worked at Planned Parenthood in  
4 Massachusetts, did you -- were you involved with  
5 delivering any babies there?

6 A. I did not deliver any babies in my role at  
7 Planned Parenthood League of Massachusetts.

8 Q. Yeah. And I think you've said you did  
9 deliver babies in your role working at the hospital in  
10 the family practice, right?

11 A. That is correct.

12 Q. Okay. How many -- when you were working in  
13 Planned Parenthood Massachusetts, did you ever deliver  
14 a baby outside of a hospital up there?

15 A. In my role at Planned Parenthood League of  
16 Massachusetts?

17 Q. I'm sorry, I said that wrong.

18 During the time that you were working at both  
19 Planned Parenthood Massachusetts and at the Heywood  
20 Hospital, that 2003 to 2007 time frame, did you ever  
21 deliver a baby outside of a hospital when you were  
22 delivering babies up there?

23 A. No, I did not provide home births when I was  
24 -- or deliver any babies outside of a hospital when I  
25 was working in Massachusetts.

1 Q. Do you have admitting privileges to any  
2 hospital here in North Carolina?

3 A. Yes, I do.

4 Q. Which ones?

5 A. Novant Forsyth.

6 Q. Okay. Are you -- do you have privileges to  
7 perform surgical abortions at Novant Hospital in  
8 Forsyth?

9 A. No, I do not.

10 Q. Have you ever attempted to get hospital  
11 privileges to perform a surgical abortion in a hospital  
12 in North Carolina?

13 A. No, I have not.

14 Q. Are you eligible to obtain privileges to  
15 perform a surgical abortion in a hospital in North  
16 Carolina if you are not OB/GYN board certified?

17 A. I do not know how hospitals make their  
18 decision on eligibility for different privileges.

19 Q. You've just never tried to obtain that  
20 particular privilege at any hospital in North Carolina.  
21 Is that correct?

22 MS. SWANSON: Objection to form.

23 THE WITNESS: I have not attempted to  
24 obtain privileges to perform inpatient procedural  
25 abortions.



1 Q. (Mr. Boyle) Right. What do you have  
2 privileges for? I think you said, "admitting  
3 privileges." What does that mean? What are your  
4 admitting privileges at Novant Forsyth?

5 A. My admitting privileges at Novant Forsyth  
6 allow me to order certain types of tests, review  
7 medical records, go in and see patients who are in the  
8 hospital.

9 Q. Okay. Do you have privileges at any  
10 ambulatory -- outpatient ambulatory surgery center in  
11 North Carolina?

12 A. I don't actually know if ambulatory surgical  
13 centers have a privileging process. I do not work at  
14 any ambulatory surgical center in North Carolina.

15 Q. The only place that you perform surgical  
16 abortions in North Carolina since you started in 2009  
17 is in a Planned Parenthood PPSAT clinic, right?

18 MS. SWANSON: Objection to form.

19 THE WITNESS: The only place that I have  
20 performed procedural abortions in North Carolina is at  
21 one of the Planned Parenthood South Atlantic clinics.

22 Q. (Mr. Boyle) Okay. Which one?

23 A. I have performed procedural abortions in all  
24 of the Planned Parenthood South Atlantic North Carolina  
25 locations that provide procedural abortion.

1 Q. Have you ever provided a surgical abortion in  
2 a hospital setting?

3 MS. SWANSON: Objection to form.

4 THE WITNESS: Yes, I believe that I have  
5 performed a procedural abortion in a hospital setting.

6 Q. (Mr. Boyle) Please describe what you recall  
7 about that.

8 A. I participated in abortion care during  
9 medical school, possibly during residency, but I don't  
10 actually recall.

11 Q. And anything that you would have been doing  
12 during medical school would have been more in an  
13 observational role, right? Not a hands-on performing a  
14 surgical procedure, but observing a doctor or a  
15 resident doing that, correct?

16 A. No, that is not correct.

17 Q. Were you actually holding the instruments and  
18 doing some of the procedures yourself in medical  
19 school?

20 A. Part of medical school includes hands-on  
21 training to perform procedures, yes.

22 Q. Did you hands-on perform any surgical  
23 abortions in a hospital setting when you were a medical  
24 student? If you don't remember, I don't blame you.  
25 I'm just ---

1 A. I ---

2 Q. --- clarifying.

3 A. --- believe I did, yes.

4 Q. Okay. So you perform D&E abortions now, but  
5 as I understand it, you've never received any  
6 specialized training or school or resident training on  
7 how to perform that procedure. Is that correct?

8 MS. SWANSON: Objection to form.

9 THE WITNESS: I performed D&Es, and I  
10 did receive formal training in performing D&Es. It was  
11 not in my capacity as a resident.

12 Q. (Mr. Boyle) When you say you received formal  
13 training, is there anything on your CV that would  
14 identify what formal training you received?

15 A. No, there is nothing on my CV.

16 Q. Is there any other specialized training that  
17 you may have received, since your residency completed,  
18 about how to perform surgical abortions?

19 A. I do not understand your question. Can you  
20 please rephrase that?

21 Q. Is there anything else on your CV that would  
22 suggest or show us that you had additional training or  
23 certification about how to perform a surgical abortion  
24 since your residency?

25 A. None of that training is reflected on my

1 resume.

2 Q. How many induced abortions have you performed  
3 in your career?

4 A. I do not know.

5 Q. Do you have any way to estimate?

6 A. Not without doing a great deal of math, no.

7 Q. How many would you say -- how many induced  
8 abortions, chemical and surgical, have you performed  
9 for patients within the past month?

10 A. I believe, in the past month, I've probably  
11 performed approximately 50 induced abortions.

12 Q. Okay. Is that typical -- is that a typical  
13 month for you in your practice?

14 A. Yes, I would say that it is.

15 Q. So if you typically do 50 a month, would you  
16 say that you typically do 600 a year, roughly?

17 MS. SWANSON: Objection to form.

18 THE WITNESS: The number of days that I  
19 have worked clinic has varied greatly throughout my  
20 career. So I would say that I have performed, on  
21 average, 50 a month for the past year, and that would  
22 probably be accurate.

23 Q. (Mr. Boyle) Okay. Were you doing more in  
24 the past or less than that 50 per month?

25 A. It ---

1 MS. SWANSON: Objection to form.

2 THE WITNESS: It has varied. There have  
3 been years where I worked more clinics per month on  
4 average, and there have been years where I worked fewer  
5 clinics per month on average.

6 Q. (Mr. Boyle) Would you say that, again,  
7 giving it a range, 500 to 700 a year, is a fair  
8 estimate based on the variability you've experienced  
9 over your career?

10 MS. SWANSON: Objection to form.

11 THE WITNESS: I am not good at doing  
12 math in my head, and so without actually calculating  
13 that, I'm not comfortable saying that.

14 Q. (Mr. Boyle) Okay. You've been performing  
15 induced abortions from 2000 to 2007, so seven years;  
16 and then 2009 to 2023, so another 13 and a half years.  
17 So for approximately 20 years, is that safe to say,  
18 that you've been performing induced abortions in your  
19 career?

20 A. I have been performing induced abortions for  
21 approximately 20 years, yes.

22 Q. Okay. Do you ever use a curette?

23 MS. SWANSON: Objection to form.

24 THE WITNESS: For what purpose?

25 Q. (Mr. Boyle) Do you know what a curette is?

1 A. Yes, I do.

2 Q. What is it?

3 A. A curette is a scraping tool that can be used  
4 for many different purposes.

5 Q. Okay. Have you ever used a curette?

6 A. Yes, I have used a curette.

7 Q. For what?

8 A. Primarily, for skin lesion removal.

9 Q. Have you ever used a curette -- well, are you  
10 performing skin lesion removal in your current  
11 practice, or would that have been back when you were  
12 working at the hospital in Massachusetts?

13 A. I do not currently perform.

14 Q. Do or have you used a curette in the past,  
15 say, 14 years, since you've been working at PPSAT, for  
16 any reason?

17 A. No, I have not used a curette since I have  
18 been working at PPSAT.

19 Q. Have you ever used a curette for any OB/GYN  
20 purpose?

21 A. I do not routinely use curettes for any  
22 OB/GYN purpose.

23 Q. Okay. So that's not something in your  
24 typical or scope of practice?

25 MS. SWANSON: Objection to form.

1 THE WITNESS: I would disagree that it's  
2 outside of my scope of practice and state that it's not  
3 a tool that I prefer to use.

4 Q. (Mr. Boyle) Fair enough. Not in your  
5 typical practice. Even if you could use it, you choose  
6 not to for whatever purpose you're treating a patient?

7 A. Yes. It's not a tool that I choose to use.

8 Q. Okay. When were you first contacted by  
9 Plaintiffs to be their expert witness, who offered  
10 opinions in this case?

11 A. I don't consider myself here as an expert  
12 witness. I -- based on the statements you made earlier  
13 about paid expert witnesses, I don't consider myself an  
14 expert witness as a paid person contacted.

15 Q. Okay. Would you consider yourself more of an  
16 employee of PPSAT who's here talking about PPSAT?

17 A. I consider myself an expert on the practices  
18 of PPSAT, and I consider myself an expert in the field  
19 of abortion care in my role at PPSAT.

20 Q. Okay. When were you first contacted by the  
21 Plaintiffs to give testimony of any kind in this case?

22 A. I don't remember.

23 Q. The lawsuit was filed, I believe, June 20th,  
24 roughly. Do you recall whether you were involved with  
25 the lawsuit before it was filed?

1 A. I would have participated in conversations  
2 prior to the filing of the lawsuit. Yes.

3 Q. You say you "would have." Did you, in fact?

4 A. I believe I did, yes.

5 Q. Okay. So -- and specific dates. You  
6 remember participating in conversations with lawyers on  
7 behalf of Planned Parenthood South Atlantic before the  
8 lawsuit was filed?

9 MS. SWANSON: Objection. I'm just going  
10 to direct you not to reveal the content of any  
11 communications with your lawyers.

12 Q. (Mr. Boyle) Absolutely not asking about the  
13 actual words. Just, did you actually speak to them?

14 A. I ---

15 Q. Before the lawsuit was filed. Sorry.

16 A. I did have conversations during the month of  
17 June ---

18 Q. Okay.

19 A. --- which would have been before the lawsuit  
20 was filed.

21 Q. And you filed a declaration with the original  
22 temporary restraining order that was filed sometime in  
23 later June. Do you recall that?

24 A. I recall filing a declaration. I don't  
25 recall the exact date of that declaration.



1 Q. You've seen what Dr. Boraas said -- and I  
2 apologize because I'm not very good with saying  
3 people's names -- Dr. Boraas said in her deposition on  
4 Tuesday, haven't you?

5 A. No, I have not.

6 Q. Have you seen what Dr. Wubbenhorst said in  
7 her deposition Wednesday?

8 A. No, I have not.

9 Q. So you're not aware of what the other three  
10 expert witnesses in this case have said in their  
11 depositions, are you?

12 A. No, I am not.

13 Q. You would agree that patient safety is always  
14 the most important consideration when you are treating  
15 a patient, wouldn't you?

16 MS. SWANSON: Objection to form.

17 THE WITNESS: I would agree that patient  
18 safety is one of the critical factors that should be  
19 considered for any procedure.

20 Q. (Mr. Boyle) Do you always choose to treat  
21 your patient in the safest way available?

22 MS. SWANSON: Objection to form.

23 THE WITNESS: I always consider patient  
24 safety when I am doing any procedure.

25 Q. (Mr. Boyle) And if you have two options

1 before you, one is safer than the other, do you always  
2 select the safer option when you're treating that  
3 patient?

4 MS. SWANSON: Objection to form.

5 THE WITNESS: I don't believe that there  
6 always is a clear differentiation between one option  
7 being safer absolutely than another.

8 Q. (Mr. Boyle) You said that's not always the  
9 case, but sometimes it's the case, isn't it?

10 A. There are times that there is a safer option  
11 that is clearly safer for the patient, and when that is  
12 the case, I do provide that option to the patient.

13 Q. What did you do to prepare yourself for this  
14 deposition today? Again, don't tell me about  
15 conversations you may have had with your lawyers.

16 A. I had conversations with my lawyers, and I  
17 reviewed a number of documents.

18 Q. Which documents?

19 A. I'm not sure if I can accurately list every  
20 single one. I reviewed both of my declarations. I  
21 reviewed -- and I apologize, I don't know legal terms,  
22 so I don't know the names of all of the documents.

23 But I believe that there were two intervener  
24 declarations, I think they were called. I reviewed  
25 both of those. I reviewed our -- again, I don't know

1 the term, our filing that we made. I reviewed SB20,  
2 the law in question, and I reviewed the amendments to  
3 the law ---

4 Q. HB190.

5 A. I believe ---

6 Q. Yeah.

7 A. --- it was HB190. And I reviewed some of the  
8 articles cited, both in my declaration and in the other  
9 physicians' declarations. And I reviewed documents  
10 that were presented to you.

11 Q. The ---

12 A. I'm not sure what they're called.

13 Q. --- PPSAT documents that were presented in  
14 discovery?

15 A. Yes, I believe so.

16 Q. Okay. A little bit of follow-up on that.  
17 Did you read Dr. Boraas's declaration and rebuttal?

18 A. Yes, I did.

19 Q. Okay. And it sounded like you said you read  
20 Dr. Wubbenhorst's declaration and Dr. Bane's  
21 declaration also.

22 A. Yes, I did.

23 Q. Okay. You mentioned some articles. Which  
24 articles did you review?

25 A. I don't remember them by name.

1 Q. You don't remember anything about them?

2 MS. SWANSON: Objection to form.

3 THE WITNESS: I didn't ---

4 Q. (Mr. Boyle) Can you describe ---

5 A. --- say that I don't remember anything ---

6 Q. Fair enough. That ---

7 A. --- about them, but I don't remember their  
8 names.

9 Q. Without necessarily remembering the formal  
10 name, do you recall what they were about?

11 A. They were about the safety of abortion and  
12 data on abortion.

13 Q. Can you give me a little more specifics so we  
14 can maybe ferret out which ones they were?

15 A. I don't think I can outline every single  
16 cited document I read, but I certainly reviewed the  
17 National Association of Science ---

18 Q. "The Academy" ---

19 A. National ---

20 Q. It's from 2018?

21 A. Thank you. The -- I'd have to look at the  
22 document to make sure I had the name correct.

23 Q. Yeah.

24 A. I reviewed an article, or a study, from  
25 Finland that was referenced by one of the other

1 physicians.

2 Q. That's the Niinimaki study; do you recall?

3 A. I do not recall without looking at the  
4 document.

5 Q. Okay.

6 A. I apologize. I've reviewed a number,  
7 probably four or five different -- and I don't recall  
8 the exact names ---

9 Q. Okay.

10 A. --- or their exact content.

11 Q. No, that's fine. Do you recall reading the  
12 Goldberg study from 2022 that was a retrospective  
13 review of, I believe, 2007 to 2012 or so, Planned  
14 Parenthood Massachusetts cases that had patients who  
15 were presenting with recent positive pregnancy tests,  
16 and they had ultrasound findings of pregnancy of  
17 unknown location. Do you recall reading that one?

18 A. I recall reviewing two articles on pregnancy  
19 of unknown location. I don't recall the level of  
20 detail that you just described, but if I were to look  
21 at the article, I could confirm whether I read it.

22 Q. Okay. Anything else?

23 A. Anything else?

24 Q. That you reviewed in preparation for this  
25 deposition other than what you've just told me?

1 A. I don't recall anything other than what I've  
2 just told you.

3 Q. Have you ever performed a surgical abortion  
4 on a patient who was pregnant with twins?

5 A. I have performed procedural abortions on  
6 patients who were pregnant with twins.

7 Q. How many times have you done that over the  
8 course of your career?

9 A. I do not know.

10 Q. Was it more than once? More than 100 times?

11 A. I would say it's definitely more than dozens.

12 Q. So 24? More than 25 times?

13 A. More than 25, I believe.

14 Q. Okay. That's fine.

15 And I asked you earlier about how many  
16 induced abortions you performed over the past month. I  
17 forgot to ask the sort of breakdown, chemical abortion  
18 versus surgical abortion. Can you give me a split? It  
19 doesn't have to be precise, but, you know, is it 50/50?  
20 Are you doing 75 percent chemical? What do you think  
21 that number looks like?

22 MS. SWANSON: Objection to form.

23 THE WITNESS: I have access that -- to  
24 that information if I were to look at our procedure  
25 logs, but I estimate that 60 percent of the abortions

1 that I performed in the last month were medication  
2 abortions and 40 percent were procedural abortions.

3 Q. (Mr. Boyle) Okay. If you look back over the  
4 course of your career, would you say that there's a  
5 higher percentage of those induced abortions that  
6 you've performed over the course of your career, a  
7 higher percentage of them skews to be medical abortion  
8 as opposed to surgical abortion?

9 MS. SWANSON: Objection to form.

10 THE WITNESS: No. Over the course of my  
11 career, I would not say that the majority of the  
12 abortions I performed were medical over procedural.

13 Q. (Mr. Boyle) Okay. Can you give me an idea  
14 what you think the percentages would look like  
15 comparatively over the course of your career?

16 MS. SWANSON: Objection to form.

17 THE WITNESS: I can tell you that until  
18 I came to Planned Parenthood South Atlantic, I rarely  
19 performed medication abortions.

20 Q. (Mr. Boyle) Okay.

21 A. And since I came to Planned Parenthood South  
22 Atlantic, I would say that medication abortions  
23 accounted for anywhere from 40 to 60 percent of the  
24 abortions that I performed.

25 Q. Okay.

1 MS. SWANSON: Ellis, I'm just going to  
2 do a time check. I think we've been on the record for  
3 about an hour. So when you come to a good stopping  
4 point ---

5 MR. BOYLE: Let's take a break.

6 MS. SWANSON: --- if we could take a  
7 break?

8 MR. BOYLE: Off the record.

9 THE VIDEOGRAPHER: Off the record at  
10 11:18.

11 (Brief recess: 11:18 a.m. to 11:29 a.m.)

12 THE VIDEOGRAPHER: On record, 11:29.

13 Q. (Mr. Boyle) Doctor, how do you know -- well,  
14 is it important to know if your patient is pregnant  
15 with twins before you perform a surgical abortion?

16 MS. SWANSON: Objection to form.

17 THE WITNESS: If I know that a patient  
18 is pregnant with twins when I am performing a  
19 procedural abortion, I take extra steps to ensure that  
20 I have removed the tissue from the entire pregnancy.

21 Q. (Mr. Boyle) So you would agree it's  
22 important to know that beforehand, going into the  
23 procedure?

24 MS. SWANSON: Objection to form.

25 THE WITNESS: I would actually disagree.



1 I don't think it's necessarily important to know that  
2 beforehand.

3 Q. (Mr. Boyle) Is it important to know if a  
4 patient is pregnant with twins before you give that  
5 patient a medical -- yes, a chemical abortion?

6 MS. SWANSON: Objection to form.

7 THE WITNESS: I do not find that being  
8 pregnant with twins changes the way we perform a  
9 medication abortion in the way that it can sometimes  
10 change a procedural abortion.

11 Q. (Mr. Boyle) What about with triplets? Would  
12 that change -- if a patient was pregnant with triplets,  
13 would that change the way you perform a chemical  
14 abortion?

15 A. No, it would not.

16 Q. Have you seen any studies about any increased  
17 risks or potential problems for patients who are  
18 pregnant with triplets or twins or quadruplets when you  
19 give them a chemical abortion?

20 A. I have not seen any studies on that.

21 Q. Excluding the lawyers who represent  
22 Plaintiffs in this case, have you spoken to anyone else  
23 about your involvement in this case?

24 A. I have spoken to other people from the  
25 context that they are aware that I was scheduling a

1 deposition, but only from the context of them being  
2 aware of how my time was being used.

3 Q. Just to clarify. So you haven't spoken about  
4 the substance of your opinions with anyone other than  
5 your lawyers. Is that correct?

6 A. That is correct.

7 Q. Okay. What is a uterine perforation?

8 MS. SWANSON: Objection to form.

9 THE WITNESS: I believe you are asking  
10 about a uterine perforation.

11 Q. (Mr. Boyle) What is it?

12 A. A uterine perforation is where usually an  
13 instrument, but sometimes a device, goes through the  
14 wall of the uterus, called the myometrium.

15 Q. What's on the other side of that wall?

16 MS. SWANSON: Objection to form.

17 THE WITNESS: The tissue within the  
18 retroperitoneum and abdomen.

19 Q. (Mr. Boyle) Are there any specific  
20 structures or tissues that typically surround the  
21 uterus and would be impacted if a surgical instrument  
22 or device punctured the uterine wall?

23 MS. SWANSON: Objection to form.

24 THE WITNESS: There are many different  
25 forms of tissue and organs. In particular, the bladder

1 is just anterior to the uterus in most patients,  
2 although there can be a space, and often is a space,  
3 between the uterus and the bladder; and the intestines  
4 can be in the space generally surrounding the uterus.

5 Q. (Mr. Boyle) Any other organs that would be  
6 immediately adjacent to the uterus, if there was a  
7 uterine perforation?

8 A. Those are the organs that are closest to the  
9 uterus.

10 Q. You would agree that uterine perforation is a  
11 known complication of a surgical abortion, wouldn't  
12 you?

13 A. Uterine perforation is an extremely rare but  
14 known complication of procedural abortion.

15 Q. Have you ever had a patient who you performed  
16 a surgical abortion on who suffered from a uterine  
17 perforation?

18 A. I have had a patient that I performed a  
19 procedural abortion on who had a uterine perforation.

20 Q. Did you have to transfer the patients, who  
21 you performed a surgical abortion on who suffered a  
22 uterine perforation from the Planned Parenthood clinic,  
23 to the hospital?

24 A. No, I did not.

25 Q. You -- are you aware that sometimes, if a

1 patient has a uterine perforation during a surgical  
2 abortion, it's required that they be transferred to a  
3 hospital for higher level of care?

4 MS. SWANSON: Objection to form.

5 THE WITNESS: I am aware that there are  
6 some cases of uterine perforation where the patient  
7 does need to be transferred to a hospital for  
8 additional care.

9 Q. (Mr. Boyle) Has that ever happened at PPSAT?

10 A. Yes, it has.

11 Q. Did you know before the surgical abortion was  
12 performed that those patients who suffered a uterine  
13 perforation would require transfer to the hospital  
14 based on that known complication?

15 MS. SWANSON: Objection to form.

16 THE WITNESS: I just want to clarify.  
17 Are you asking if I knew in advance that a patient  
18 would experience a uterine perforation and require  
19 transfer?

20 Q. (Mr. Boyle) That is what I'm asking.

21 A. No, it is not possible to know that in  
22 advance.

23 Q. Because you can't always know what  
24 complications will arise during a surgical procedure,  
25 can you?

1           A.    It is true that with any procedure, you  
2 cannot always predict accurately what complications may  
3 arise.

4           Q.    What is a cervical laceration?

5           A.    A cervical laceration is a tear of the  
6 cervix.

7           Q.    You agree that a cervical laceration is a  
8 known complication of surgical abortion, don't you?

9           A.    I would agree that a cervical laceration is  
10 an extremely rare but known complication of procedural  
11 abortion.

12          Q.    Have you ever had a patient, who you  
13 performed a surgical abortion on, who suffered from a  
14 cervical laceration?

15          A.    I would say that I have had a patient who  
16 suffered from some bleeding associated with the  
17 instruments we use on the cervix, but I've never had a  
18 cervical laceration that required interventions such as  
19 suturing.

20          Q.    Do some patients who suffer the known  
21 complication of surgical laceration during a surgical  
22 abortion require transfer to a hospital for a higher  
23 level of care?

24                   MS. SWANSON:  Objection to form.

25                   THE WITNESS:  I'm not aware of patients

1 needing to be transferred for cervical laceration.

2 Q. (Mr. Boyle) Are you aware of any patient  
3 from PPSAT who suffered a cervical laceration during a  
4 surgical abortion having to be transferred to a  
5 hospital to care for that known complication?

6 A. I do not recall any patient with a cervical  
7 laceration having to be transferred for that  
8 complication.

9 Q. Have you ever had a situation where you  
10 performed a surgical abortion on a patient and the  
11 patient suffered hemorrhaging such that you needed to  
12 transfer that patient to a hospital for higher level of  
13 care?

14 A. I have had a patient who hemorrhaged during a  
15 procedural abortion who I transferred to the hospital  
16 for care, yes.

17 Q. Is hemorrhage a known complication of  
18 surgical abortion?

19 A. Hemorrhage is an extremely rare and known  
20 complication of procedural abortion.

21 Q. Are you aware of other patients from PPSAT  
22 who have suffered hemorrhage during a surgical abortion  
23 that were transferred to a hospital for a higher level  
24 of care?

25 A. I am aware of patients who have suffered

1 hemorrhage during a procedural abortion who have been  
2 transferred to a hospital.

3 Q. Did you know, before the surgical abortion  
4 was performed, that those patients who suffered  
5 hemorrhage that required transfer to the hospital would  
6 have that complication during that surgical abortion?

7 A. No. You cannot know in advance what  
8 complication a patient may experience from any given  
9 procedure.

10 Q. Do you disclose all possible complications  
11 that can arise from an induced abortion to a woman who  
12 has tested pregnant, who has tested positive for  
13 pregnancy, who is your patient considering obtaining an  
14 induced abortion?

15 A. We disclose the most common and most  
16 concerning potential complications to patients as part  
17 of their informed consent.

18 Q. And tell me, what -- how many days is the  
19 waiting period now, under the new law, SB20 and HB190,  
20 for informed consent for a patient seeking an induced  
21 abortion before the induced abortion can actually  
22 occur?

23 MS. SWANSON: Objection to form.

24 THE WITNESS: My understanding of the  
25 current law is that it requires a 72-hour waiting

1 period from the time the State consent form is reviewed  
2 by the patient and signed and when the abortion takes  
3 place.

4 MR. BOYLE: I'm going to hand you a  
5 document that has Bates numbers that was produced in  
6 discovery.

7 MS. SWANSON: Thank you.

8 Q. (Mr. Boyle) It's Bates Numbers 31 through  
9 50. If you don't mind, down at the bottom right-hand  
10 corner, do you see Bates and then numbers there?

11 A. I do see those numbers, yes.

12 Q. And the first page says Bates 31. Do you see  
13 that?

14 A. I do see that, yes.

15 Q. And then if you turn to the last page,  
16 please, you see Bates 50?

17 A. Yes, I do see that.

18 Q. Okay. So do you recognize this document?

19 A. Yes, I do.

20 Q. What is it?

21 A. This is our education and consent packet for  
22 procedural abortion.

23 Q. Can a patient die from complication of  
24 bleeding if there is a cervical laceration or a uterine  
25 perforation or hemorrhage?



1 MS. SWANSON: Objection to form.

2 THE WITNESS: I do not think a patient  
3 could die from a cervical laceration. Could a patient  
4 die from hemorrhage? They theoretically could die.

5 Q. (Mr. Boyle) Okay. How about uterine  
6 perforation, could a patient die from a uterine  
7 perforation if it's not treated?

8 A. If a complication was untreated, it's  
9 possible that a patient could experience severe  
10 complications that could lead to death.

11 Q. What surgical tools do you use in an  
12 aspiration abortion?

13 A. I use a number of tools, including a ring  
14 forceps, sterile gauze, dilators. I use a suction  
15 cannula that is attached to tubing and electronic  
16 vacuum aspirator or that is attached to a manual or  
17 handheld vacuum aspirator.

18 I use a tenaculum, which is an instrument  
19 used to hold the cervix, and I use a speculum. I  
20 sometimes use an ultrasound -- just thinking through my  
21 tray to see if there's anything I've left off. Those  
22 are the instruments I would routinely use for a suction  
23 abortion.

24 Q. Okay. What surgical tools do you use for a  
25 D&E abortion?

1           A.    I would use the same tools for a D&E abortion  
2 and often use an additional type of forceps in addition  
3 to the ring forceps.  There are different shapes and  
4 types of forceps, so I would often use a Bierer's  
5 forceps.

6           Q.    Sorry, a what type?

7           A.    Bierer's.  I'm not sure how to pronounce it.  
8 I apologize.

9           Q.    How do you spell it?

10          A.    I'm not sure how to spell it.  B-i-e-r-s  
11 (sic).

12          Q.    Okay.

13          A.    Maybe B-r-i-e-r-s (sic).  I apologize.  I  
14 don't recall the exact spelling.

15          Q.    And what do -- what do the Bierer's forceps  
16 look like, if you can describe them?

17          A.    So they are oval shaped.  The best way to  
18 describe them is they look like a pair of scissors  
19 where they open and shut, but they don't cut at the end  
20 like a pair of scissors would.  Instead, they have two  
21 flat plates at the end that are oval shaped and that  
22 close down around tissue.

23          Q.    Like, they clamp on something and grab it?

24          A.    A ---

25                       MS. SWANSON:  Objection to form.

1 THE WITNESS: A forceps will often close  
2 to be able to clamp, for example, on a gauze or on  
3 tissue.

4 Q. (Mr. Boyle) And what type of forceps do you  
5 use in the aspiration abortion, or the suction,  
6 abortion?

7 A. I routinely use a ring forceps in a suction  
8 abortion.

9 Q. And what's the difference between the ring  
10 forceps and the Bierer's forceps?

11 A. Well, I use the ring forceps for any abortion  
12 that I perform routinely. And the Bierer's, I use in a  
13 D&E. And the difference is the size.

14 Q. What's the difference in the size between  
15 them?

16 A. I don't know the exact measurements, but the  
17 Bierer's are slightly larger than the ring forceps.

18 Q. So the ring forceps also have the one end you  
19 have where you put your fingers to open and close the  
20 forceps, then you have a fulcrum, I guess, in the  
21 middle and then on the far end it's got two rings? Or  
22 are they ovals?

23 Are they -- are they loops that are sort of  
24 solid throughout, or do they have, like, just the outer  
25 rim is a loop? What's that like?

1           A.    So a ring forceps has two open loops at the  
2 end that close down, and the other end has the handles  
3 where you would hold it.

4           Q.    Okay.

5           A.    And the Bierer's also has two open loops at  
6 the end, just the loops are oval in shape and slightly  
7 larger.

8           Q.    Okay.

9           A.    And the ring forceps, I would consider more  
10 circular.

11          Q.    Okay.  And the sort of clasping and the  
12 loops, if you will, they're not solid all the way  
13 through, they're just on the outer edge of the circle  
14 or the outer edge of the oval?

15          A.    Correct.  They are both hollow in the middle  
16 of the shape.

17          Q.    What do you use the forceps, the ring forceps  
18 for, in the suction abortion?

19          A.    Primarily, I use them for grasping gauze and  
20 wiping down the tissue within the vagina.  That is the  
21 most common use.  I also use them sometimes to grasp  
22 tissue that's coming out of the vagina.  And very  
23 rarely, I introduce them inside of the cervix itself to  
24 grasp tissue.

25          Q.    Typically, as I understand it, the major

1 difference between the suction abortion and the D&E is  
2 the use of the tongs beyond the cervix to grab tissue  
3 inside the uterus and pull it out. Is that -- am I  
4 understanding that correct?

5 That's the D&E versus the aspiration, you  
6 simply put the cannula in there, and it uses suction to  
7 suction out -- suck it out?

8 MS. SWANSON: Objection to form.

9 Q. (Mr. Boyle) Is that correct?

10 A. So when I am performing a suction abortion, I  
11 use suction throughout all -- as we are calling suction  
12 abortions or D&Cs, we use suction, and the suction  
13 removes most of the tissue of the pregnancy or all of  
14 the tissue of the pregnancy, most of the time.

15 When I am performing a D&E, I still use  
16 suction. That is a continuum where we use suction  
17 throughout a D&E as well. And with a D&E, I am more  
18 likely to use instruments. And later in pregnancy, I  
19 would say that I always use instruments to remove the  
20 pregnancy tissue later in -- with later D&Es.

21 Q. (Mr. Boyle) The pregnancy tissue that you  
22 remove in the later D&Es, what time frame, gestational  
23 age time frame, are you talking about?

24 MS. SWANSON: Objection to form.

25 Q. (Mr. Boyle) What weeks?

1           A.    I consider a D&E any abortion 14 weeks or  
2 later.

3           Q.    Do -- does PPSAT do D&E abortion at all six  
4 of the clinics in North Carolina where they perform  
5 induced abortions?

6           A.    Since I consider a D&E abortion any abortion  
7 over 14 weeks, I believe we have performed abortions at  
8 approximately 14 weeks at all of our six North Carolina  
9 clinics.

10          Q.    Because it looked like, from the chart that  
11 we received in discovery, that it's only Chapel Hill  
12 where the surgical abortions are occurring after, say,  
13 week 16, 17, 18. Is that correct, or are you doing  
14 those surgical abortions at all six clinics in North  
15 Carolina?

16                   MS. SWANSON:  Objection to form.

17                   THE WITNESS:  We do not routinely  
18 perform -- let me rephrase.

19                   We, prior to this ban, were routinely  
20 performing abortions over 16 weeks at only two of our  
21 locations, both Chapel Hill and Asheville.

22          Q.    (Mr. Boyle)  Okay.  On Page Bates 34 -- just  
23 let me know when you get there, please.  Do you see  
24 that?

25          A.    I see Page 34, yes.

1 Q. Top of the page says, "Information for  
2 Informed Consent In-Clinic Abortion," right?

3 A. Yes, that is what it says.

4 Q. Down, under "The risks of the in-clinic  
5 abortion are," I'm looking at "heavy bleeding." Do you  
6 see that?

7 A. I do see "heavy bleeding," yes.

8 Q. And it says, at the end of that, "Very  
9 rarely, you may have to go to the hospital for  
10 treatment." Do you see that?

11 A. Yes, I see that.

12 Q. The next one down, "Infection of the Uterus."  
13 It says, "Very rarely you may have to go to the  
14 hospital for treatment." Do you see that?

15 A. I do see that.

16 Q. You agree that post-twelve-week abortions can  
17 be performed in a hospital section -- setting, don't  
18 you? Let me say that again.

19 Post-twelve-week surgical abortions can be  
20 performed in a hospital setting. Is that correct?

21 A. I believe that they can be performed in some  
22 hospitals, but I am not sure that they are performed in  
23 most or all hospitals.

24 Q. And I understand you think they can be  
25 performed at the PPSAT clinics post twelve weeks for

1 the surgical abortion, right? That is a bad question.

2 You think that post-twelve-week surgical  
3 abortions can be performed in the PPSAT clinics, right?

4 A. I know that procedural abortions beyond  
5 twelve weeks can safely be performed in the PPSAT  
6 clinics.

7 Q. Do you also know that they can safely be  
8 performed in a hospital setting?

9 A. No, I don't know that they can safely be  
10 performed in any hospital setting.

11 Q. Okay. Are you worried that hospitals don't  
12 have the same resources and equipment and tools  
13 available to them that you have at your PPSAT clinic?

14 MS. SWANSON: Objection to form.

15 THE WITNESS: I don't work at a  
16 hospital, so can't speak exactly, but I do know that  
17 they have equipments and tools. I know they have some  
18 resources, but those resources might be different than  
19 PPSAT resources.

20 Q. (Mr. Boyle) But if you have a complication  
21 at PPSAT that PPSAT can't handle, you transfer that  
22 patient to a hospital, right?

23 MS. SWANSON: Objection to form.

24 THE WITNESS: In very rare instances, we  
25 have a complication where a patient does need to be



1 transferred to a hospital.

2 Q. (Mr. Boyle) So if you turn, please -- well,  
3 let me just ask you, on Page 34 there, and Page 35 and  
4 Page 36, that's all -- as I understand it, and you tell  
5 me if I'm wrong, that's all one three-page document  
6 about information for informed consent for in-clinic  
7 abortions. Is that correct?

8 A. You're asking about Bates 34, 35 and 36?

9 Q. Correct.

10 A. Correct. That is one PPSAT document.

11 Q. And it is one PPSAT document that PPSAT gives  
12 to patients who are seeking an in-clinic surgical  
13 abortion at a PPSAT facility. Is that correct?

14 A. This is a document that is given to and  
15 signed by patients who receive a procedural abortion at  
16 Planned Parenthood South Atlantic.

17 Q. Does the patient get a copy of this one  
18 three-page document?

19 A. It is our protocol to give the patient a copy  
20 of this document.

21 Q. When you look at Page 36, this looks like the  
22 signature page for the patient. Is that correct?

23 A. It is a signature page, yes.

24 Q. For the patient to sign when they're going to  
25 get a surgical abortion at a PPSAT facility. Is that

1 correct?

2 A. This is a signature page. We don't actually  
3 use paper forms for signature. We use an electronic  
4 health record, so we use an electronic version of this  
5 form, unless our electronic health system is down, and  
6 then we use the paper form. But the patient does sign  
7 an electronic version of this form, yes.

8 Q. Is the electronic version of this form  
9 exactly the same format as this paper copy here, this  
10 34, 35 and 36?

11 MS. SWANSON: Objection to form.

12 THE WITNESS: I would -- I can't speak  
13 to the exact format, but it contains the same  
14 information. We use this form to create the electronic  
15 form.

16 Q. (Mr. Boyle) So you don't actually hand a  
17 patient this piece of paper, this three-page document.  
18 Is that what you're saying?

19 A. No, that is not what I'm saying. I do hand  
20 the patient this three-page document. We at Planned  
21 Parenthood hand the patient this document.

22 Q. Okay. So someone at -- at PPSAT hands the  
23 patient a three-page document that looks like Bates  
24 Number 34, 35 and 36, and that patient then has that  
25 hard copy paper document to take with them? Is that

1 correct?

2 A. It is correct that the patient receives a  
3 paper copy of this document before they leave the  
4 clinic -- or actually, when they are arriving and going  
5 through consent.

6 Q. Okay. Do the -- does the patient receive a  
7 signed copy of this document?

8 A. The patient does not routinely receive a copy  
9 of this form that they have signed, but they may  
10 receive a copy, if they would like, that can be printed  
11 from the EHR for them if they request it.

12 Q. So when the patient signs an electronic copy  
13 of this document, is the patient looking at a computer  
14 screen and having the opportunity to read all three  
15 pages before they sign, or do they have a paper copy?  
16 What's the method for that?

17 A. They have both. They have a paper copy in  
18 front of them, and they can see the electronic form as  
19 it is being filled out and they are signing it.

20 Q. And who goes over this document with the  
21 patient?

22 A. A trained staff member.

23 Q. What level of training does that staff member  
24 have?

25 MS. SWANSON: Objection to form.

1 THE WITNESS: They are -- they can have  
2 a variety of backgrounds of training, but they are  
3 specifically trained in the process of Planned  
4 Parenthood South Atlantic's informed consent.

5 Q. (Mr. Boyle) Is that person who undertakes  
6 informed consent with the patient, is that a nurse? Is  
7 that a PA? Is that an MD doctor? What level of  
8 training do they have?

9 A. It varies based on which aspect of informed  
10 consent you're referring to.

11 Q. Okay. How about this aspect with this three-  
12 page document? What level of PPSAT employee -- in  
13 terms of training for that employee, what level of  
14 employee is engaging with the patient to ensure  
15 informed consent is obtained?

16 A. It can be multiple levels. I've had nurses  
17 or physicians who participate in that. Routinely, it  
18 is not a licensed person who is going over the form.  
19 It is someone who is trained specifically in the  
20 process of consent who had -- goes over the form with  
21 the patient.

22 Q. Does the law speak to who has to interact  
23 with a patient, what level of training that person has,  
24 in order to ensure informed consent is indeed proper  
25 and legal?

1 MS. SWANSON: Objection to form.

2 THE WITNESS: My understanding of the  
3 law is that -- and I don't know the exact language, but  
4 that I believe it can be a nurse, physician assistant,  
5 advanced practice clinician or advanced practice nurse,  
6 such as nurse midwife, or an NP, or a physician who can  
7 perform -- or pardon me, who must perform the advanced  
8 consent mandated by the State using the State's 72-hour  
9 advanced consent forms for both procedural and  
10 medication abortion.

11 Q. (Mr. Boyle) Does this document we're talking  
12 about here, this three pages Bates Numbered 34, 35, 36,  
13 does that qualify as satisfying the State's required  
14 informed consent you just described?

15 MS. SWANSON: Objection to form.

16 THE WITNESS: No, this is done in  
17 addition to the State's mandated consent.

18 Q. (Mr. Boyle) Is -- and it may be in here, and  
19 I may just ask you to direct me. Does that mandated  
20 consent from the State exist in here in these  
21 documents?

22 MS. SWANSON: Objection to form.

23 Q. (Mr. Boyle) And you can take your time  
24 looking through the package if you'd like.

25 (Witness examines document)

1           A.     This packet does not contain the State's  
2 consent form.

3           Q.     So this packet that was given to us as  
4 PPSAT's informed consent documentation that they give  
5 to patients is missing the actual State-law-required  
6 informed consent. Is that correct?

7                     MS. SWANSON: Objection to form.

8                     THE WITNESS: This packet does not  
9 contain the State consent. The State consent is  
10 performed by necessity and law 72 hours prior to the  
11 abortion. This consent is signed at the time of the  
12 abortion.

13                    So we review and go over the state forms at  
14 the 72-hour consent and provide the patient with a copy  
15 of the form both at that time, and we provide them with  
16 another copy of that form at the time of their  
17 abortion. But because they are separate forms used at  
18 different times in the process, they're not part of the  
19 exact same packet.

20           Q.     (Mr. Boyle) So you're saying there exists a  
21 separate informed consent document from the State  
22 that's not included here, but you know it exists and  
23 you've seen it and participated in those State-law-  
24 required informed consent conversations yourself with  
25 some patients. Is that correct?

1 MS. SWANSON: Objection to form.

2 THE WITNESS: The State requires that we  
3 use State-created forms, so we access those State-  
4 created forms from the State and use them for the  
5 advanced consent.

6 Q. (Mr. Boyle) And you agree that form is not  
7 in this packet starting at Page 31, running to Page 50.  
8 Is that correct?

9 A. That form is not a part of this packet,  
10 correct.

11 Q. And as I understood you to just say, this  
12 packet that we're looking at, specifically Bates 34,  
13 35, 36, that three-page document, is something that is  
14 discussed with the patient and signed at the time of  
15 the abortion, the surgical abortion. So the day of the  
16 surgical abortion. Is that correct?

17 MS. SWANSON: Objection to form.

18 THE WITNESS: A copy of this paper  
19 packet is routinely provided to the patient at the time  
20 of their 72-hour consent for their review. We do  
21 not ---

22 Q. (Mr. Boyle) Okay.

23 A. Let me correct.

24 We review it and sign the actual forms that  
25 require signature in this packet at -- on the day of

1 the abortion, not at the 72-hour consent.

2 Q. Okay. And I think I understand it now. Let  
3 me just -- very slow. I apologize. I'm working  
4 through it.

5 Day one, patient comes in, decides, "I want  
6 to have a surgical abortion."

7 PPSAT says, "We will do that, but there is a  
8 72-hour required waiting period for informed consent  
9 under State law. Here is that form," that we don't  
10 have a copy of. "Here's that form," which you go over  
11 with the patient, they sign, starting the clock.

12 And you also give them a copy of this three-  
13 page document, Bates Number 34, 35, and 36, but you  
14 don't have the patient sign it on day one. You have  
15 the patient sign this three-page document when they  
16 come back 72 or more hours later for the actual  
17 surgical abortion. Do I understand that correctly?

18 THE WITNESS: Yes.

19 MS. SWANSON: Objection to form.

20 THE WITNESS: That is correct that we  
21 have them sign this form at the time of the procedural  
22 abortion.

23 Q. (Mr. Boyle) When do they pay for the  
24 surgical abortion?

25 A. I don't participate in the payment process,



1 but I believe -- it's my understanding the patient pays  
2 for the abortion on the day of the abortion.

3 Q. So not the first day that triggers the 72-  
4 hour clock. It's when they come back for the day of  
5 the actual surgical abortion after at least 72 hours  
6 have passed. Is that correct?

7 MS. SWANSON: Objection to form.

8 THE WITNESS: It is my understanding  
9 that the patient only pays for the services they  
10 receive. So on day one, they might pay for the  
11 ultrasound or labs if they received them. But they do  
12 not pay for the abortion on the day of the consent  
13 process, because they cannot receive the abortion on  
14 that day.

15 Q. (Mr. Boyle) You charge your patients an  
16 independent fee for performing an ultrasound. Is that  
17 right?

18 MS. SWANSON: Objection to form.

19 THE WITNESS: I did not create the forms  
20 or create the fee schedule. But my understanding is  
21 that a patient who's self paying for an abortion would  
22 be charged \$625 for the entire abortion procedure,  
23 including the pretesting that we do.

24 And if that pretesting occurs 72 hours in  
25 advance, including the ultrasound, they pay that

1 portion and then they would pay the remainder to reach  
2 the total on the day of their abortion.

3 Q. (Mr. Boyle) Do you know how much it costs to  
4 have the ultrasound?

5 A. I do not recall that number.

6 Q. I think you also said that there's an  
7 independent separate charge for performing blood work  
8 also.

9 A. If the patient has blood work as part of  
10 their 72-hour consent, then that charge is paid on day  
11 one and reduced from the total that is owed on the  
12 second day.

13 Q. But if they don't come back, then they've  
14 paid whatever for that blood work and that ultrasound.  
15 They don't have to pay the balance of the 625, but they  
16 also don't get a refund for what they paid for the  
17 ultrasound and the blood work. Is that correct?

18 A. The patient only pays for the services they  
19 receive on day one, and those are not reimbursed if  
20 they choose not to return for their abortion.

21 Q. Do you give an ultrasound to every patient  
22 who tests positive for pregnancy at PPSAT?

23 MS. SWANSON: Objection to form.

24 THE WITNESS: No, we don't perform an  
25 ultrasound on every patient who tests positive for

1 pregnancy at PPSAT.

2 Q. (Mr. Boyle) Do you give an ultrasound to  
3 every patient who tests positive for pregnancy at PPSAT  
4 who elects to have a chemical abortion?

5 MS. SWANSON: Objection to form.

6 THE WITNESS: We do require that every  
7 patient who has a medication abortion at PPSAT has had  
8 an ultrasound prior to that abortion.

9 Q. (Mr. Boyle) When you say, "an ultrasound  
10 prior to that abortion," can you be a little more  
11 specific? Is there a time frame?

12 A. The ultrasound would have had to have taken  
13 place during this pregnancy. Yes.

14 Q. That's what I'm asking about.

15 A. Yes.

16 Q. I figured, but lawyers like to clarify.

17 Okay. So as I understand what you just said,  
18 if there is a patient at PPSAT who tests positive for  
19 pregnancy and elects to have a chemical abortion, 100  
20 percent of the time, PPSAT either takes their own  
21 ultrasound if there isn't one already on file, or PPSAT  
22 reviews a recent ultrasound from this particular  
23 pregnancy for that patient. Is that correct?

24 MS. SWANSON: Objection to form.

25 THE WITNESS: It is correct that we

1 require that there is an ultrasound performed prior to  
2 any medication abortion. The vast majority of the  
3 time, we are performing that ultrasound, but there are  
4 cases where we would accept an ultrasound from an  
5 outside source.

6 Q. (Mr. Boyle) Related to that particular  
7 patient's current pregnancy?

8 A. From this current patient that we are  
9 performing an abortion on during this pregnancy.  
10 Correct.

11 Q. So it's fair to say -- and I will tell you,  
12 it did not appear that way to me reading the protocols.  
13 But I want to clarify that PPSAT does not perform any  
14 chemical abortion on a patient who has tested positive  
15 for pregnancy without reviewing at least one  
16 ultrasound, whether they took it or whether it was  
17 taken outside the facility and provided to PPSAT. Is  
18 that correct?

19 A. That is correct, in the state of North  
20 Carolina.

21 Q. Clarification understood. State of North  
22 Carolina. Has that been PPSAT's practice in North  
23 Carolina about always having at least one ultrasound  
24 before giving a medication abortion to a patient before  
25 -- you know, prior to July 1st, 2023?

1 A. That has been the practice throughout my  
2 entire time ---

3 Q. Okay.

4 A. --- at Planned Parent South Atlantic.

5 Q. So since 2009 when you arrived, it's been the  
6 same up to today.

7 A. It has been the practice to perform an  
8 ultrasound prior to medication abortion.

9 Q. Do you -- does PPSAT provide deep sedation at  
10 any of its North Carolina clinics?

11 A. No, we do not.

12 Q. If you look at Page Bates Number 39, please.  
13 And as you're getting there, I'll ask, do you require,  
14 or is it your understanding that there has to be an  
15 anesthesiologist or CRNA or some specialist who has  
16 anesthesia specialization in medicine in order to have  
17 a patient receive deep sedation for a procedure?

18 MS. SWANSON: Objection to form.

19 THE WITNESS: It is my understanding of  
20 the PPFA protocols that a CRNA or an anesthesiologist  
21 is required for deep sedation.

22 Q. (Mr. Boyle) Do -- does PPSAT have any  
23 anesthesiologists who perform anesthesia services at  
24 any of its six clinics in North Carolina?

25 A. No, we do not.

1 Q. Same question for CRNAs.

2 A. No, we do not.

3 Q. So PPSAT does not have any anesthesia  
4 specialists who perform anesthesia services at any of  
5 the clinics in North Carolina. Is that correct?

6 MS. SWANSON: Objection to form.

7 THE WITNESS: It is correct that PPSAT  
8 does not hire anesthesiologists or CRNAs, because we do  
9 not perform deep sedation.

10 Q. (Mr. Boyle) Okay. So when you look at Bates  
11 Number 39, in the middle there, do you see there's a  
12 box that says, "I would like to receive, Select one:  
13 moderate, deep sedation and have read and understood --  
14 and understand the risks and benefits outlined above"?

15 Do you see that?

16 A. I see that.

17 Q. So you're saying that, despite what this  
18 says, that the patient has an option of choosing deep  
19 sedation, that that's just wrong on this form, and  
20 PPSAT North Carolina does not provide deep sedation?

21 A. The patient is only permitted to select  
22 moderate sedation or minimal sedation or no sedation at  
23 PPSAT.

24 Q. But the form here says, "deep sedation,"  
25 doesn't it?

1           A.     The form says, "deep sedation." It is not an  
2 option that the patient can select.

3           Q.     So the form is inaccurate.

4                     MS. SWANSON: Objection to form.

5                     THE WITNESS: The form is -- I can't  
6 speak to the accuracy of the form. I can tell you that  
7 patients are not offered the option of deep sedation at  
8 PPSAT.

9           Q.     (Mr. Boyle) Well, you're reading the same  
10 form I am that says it gives the patient the option of  
11 choosing deep sedation, right?

12                    MS. SWANSON: Objection to form.

13                    THE WITNESS: The patient is not allowed  
14 to choose deep sedation.

15           Q.     (Mr. Boyle) Then what happens when the  
16 patient just reads this form, sees deep sedation as an  
17 option, and selects it?

18                    MS. SWANSON: Objection to form.

19                    THE WITNESS: The patient is informed  
20 that deep sedation is not an option at a Planned  
21 Parenthood clinic.

22           Q.     (Mr. Boyle) Okay. And I'm not saying I  
23 don't believe you. I just -- this gave me pause,  
24 because I didn't know if you all were doing deep  
25 sedation. It sounds like the answer is categorically,

1 "No."

2 A. We are not providing deep sedation.

3 Q. Who witnesses these forms, this Bates 39 and  
4 Bates 36?

5 A. The forms are witnessed by the staff member  
6 who reviews the forms and has the patient sign them, so  
7 the person who sees the patient sign the form witnesses  
8 their signature.

9 Q. And that's different than what we were  
10 talking about with the State law 72-hour requirement  
11 witness. That has to be someone who is one of those  
12 categories: the nurse, nurse practitioner, midwife,  
13 doctor or PA. Correct?

14 MS. SWANSON: Objection to form.

15 THE WITNESS: It is correct that the 72-  
16 hour advance form provided by the State must be done by  
17 one of those select licenses. That person reviews the  
18 form and witnesses the patient's signature.

19 Q. (Mr. Boyle) Now, I haven't seen that form.  
20 Does it include a description of risks of the  
21 procedure?

22 A. I ---

23 MS. SWANSON: Objection to form.

24 THE WITNESS: --- have not looked at  
25 that form in detail in recent days, but it does involve



1 some information about risks of abortion. To speak in  
2 any detail, I would need to look at the form.

3 Q. (Mr. Boyle) When a patient is there, day of,  
4 looking at these documents that we have in this package  
5 in front of us and is signing Bates Number 36 or  
6 signing Bates Number 39, and it's witnessed by someone  
7 who is a staff member at PPSAT, that staff member is  
8 not -- typically not a licensed practitioner who will  
9 be able to answer that patient's questions about risks  
10 of a procedure or risks of anesthesia. Is that  
11 correct?

12 MS. SWANSON: Objection to form.

13 THE WITNESS: No, that is not correct.

14 Q. (Mr. Boyle) What's incorrect about it?

15 A. All of our staff are trained to answer  
16 routine questions that patient asks -- patients ask  
17 about the risks, and all of our staff are trained to  
18 have a licensed provider come in and answer questions  
19 that they do not know how to answer or any additional  
20 questions that the patient may have.

21 Q. What steps do you take to ensure that a  
22 patient who is getting mild or moderate sedation for a  
23 surgical abortion at a PPSAT clinic doesn't drive away  
24 from that clinic after the procedure?

25 A. We review, with any patient who is receiving

1 minimal or moderate sedation, that they are not allowed  
2 to drive, with the exception of nitrous used for  
3 minimal sedation, which does not preclude the patient  
4 from driving. We review with them, ideally at the time  
5 of scheduling, that they cannot receive sedation and  
6 drive after the procedure.

7 Q. Do you take any steps when that patient shows  
8 up on the day of the procedure for that surgical  
9 abortion to ensure that they didn't just drive  
10 themselves, and they have someone to drive them after  
11 they've received that mild or moderate sedation?

12 A. May I look at the form?

13 Q. Absolutely. Just orient us to a Bates ---

14 A. Yeah ---

15 Q. --- Number, if you don't mind.

16 A. --- I'm looking at Bates Page 39. And in the  
17 second box at the top of the document, we review with  
18 the patient that in order to receive and consent to  
19 receiving minimal or moderate sedation, they have to  
20 agree that they will not drive, operate heavy machinery  
21 or make important decisions for at least 12 hours after  
22 sedation or analgesic.

23 Q. You said that this box says you make sure  
24 that in order to receive mild or moderate sedation,  
25 they will not drive and they will not operate heavy

1 machinery, and they will not make important life  
2 decisions for the next 12 hours, right?

3 MS. SWANSON: Objection to form.

4 Q. (Mr. Boyle) That's what you said.

5 A. What I did was read this statement that the  
6 patient is required to review prior to consenting to  
7 sedation.

8 Q. Right. But it doesn't say that they agree to  
9 it. It just says, "do not drive," "do not operate  
10 heavy machinery," "do not make important decisions."

11 My question is, what do you do to ensure that  
12 they didn't drive there themselves and that they have  
13 someone else or some other mechanism of transportation  
14 to get them from the clinic to wherever they're going,  
15 their home or somewhere else? Do you take any steps to  
16 verify that?

17 MS. SWANSON: Objection to form.

18 THE WITNESS: We do confirm with the  
19 patient that they have a plan for leaving the clinic  
20 that does not involve them driving.

21 Q. (Mr. Boyle) That's not something you record  
22 in these documents, though, is it?

23 A. The driver is not recorded in this document.  
24 Our electronic health record, if the patient has a  
25 driver that we'll be contacting when it's time to pick

1 the patient up, does record the name and phone number  
2 of their driver.

3 Q. Do you agree that an unborn child is  
4 typically viable outside of the mother's womb after 24  
5 weeks of gestational age?

6 MS. SWANSON: Objection to form.

7 THE WITNESS: That is not my specialty,  
8 and I do not have significant training or knowledge  
9 about pregnancy viability dates.

10 Q. (Mr. Boyle) So you've performed abortions  
11 for the past 13 and a half years at least, and you're  
12 not able to say when you think a child is typically  
13 viable, at what gestational age?

14 MS. SWANSON: Objection to form.

15 THE WITNESS: I'm saying that is not my  
16 area of expertise. And I have not performed or  
17 participated in abortion in the last 20 years -- no, in  
18 the last 15 years, that occurred past 20 weeks. So my  
19 area of expertise is more in abortions under 20 weeks.

20 Q. (Mr. Boyle) And that's fair enough. And I'm  
21 not saying you should know. I'm just trying to  
22 clarify. You don't know at what gestational age,  
23 you're not able to say -- as a family practice doctor,  
24 who performs abortions, you are not able to say when  
25 you think an unborn child is viable and whether that's

1 after 24 weeks or some other time. Is that correct?

2 MS. SWANSON: Objection to form.

3 THE WITNESS: I understand fetal  
4 viability to be approximately 24 weeks but have a great  
5 deal to do with the circumstances of the fetus, and  
6 that there are experts who know much more about that  
7 than I do.

8 Q. (Mr. Boyle) Do you agree that abortion  
9 should not be banned at any point during a pregnancy?

10 MS. SWANSON: Objection to form.

11 THE WITNESS: I do not believe that  
12 abortion should be banned. I think that the decision  
13 to have an abortion should be made by a healthcare  
14 provider and a patient based on their individual  
15 circumstances.

16 Q. (Mr. Boyle) And that's probably a better way  
17 to say it. So if I understand that, you think that  
18 abortion should be allowed up to the full term of prior  
19 to giving birth, but -- up until basically an unborn  
20 child is ready to be born. Is that correct?

21 MS. SWANSON: Objection to form.

22 THE WITNESS: No, I don't believe that  
23 abortion occurs at term. If a fetus needs to leave the  
24 uterus at term, it is a delivery, not an abortion.

25 Q. (Mr. Boyle) Okay. Do you think that

1 abortion should occur -- induced abortion should occur  
2 at, say, 35 weeks of gestational age?

3 MS. SWANSON: Objection to form.

4 THE WITNESS: I think that if a patient  
5 had tragic circumstances that necessitated no longer  
6 carrying a fetus at 35 weeks, that the decision about  
7 how to handle that should be based entirely on the  
8 patient's circumstances and be a decision between the  
9 patient and their healthcare provider as to whether  
10 delivery or termination is the most appropriate next  
11 step.

12 Q. (Mr. Boyle) Based on that, do you think that  
13 the former North Carolina law that restricted abortion  
14 generally after 20 weeks was too restrictive?

15 MS. SWANSON: Objection to form.

16 THE WITNESS: I think there are medical  
17 circumstances beyond 20 weeks that patients should  
18 absolutely have access to abortion care.

19 Q. (Mr. Boyle) Do you agree that if there is a  
20 safety reason to take some medical action, it can be  
21 considered a rational decision to take that action?

22 MS. SWANSON: Objection to form.

23 THE WITNESS: I believe that safety is  
24 one of the very important factors that should be  
25 considered any time we are making a decision about an

1 action.

2 Q. (Mr. Boyle) Do you use a differential  
3 diagnosis in your clinical practice?

4 A. Yes, I do consider a differential diagnosis  
5 in my clinical practice.

6 Q. Do you agree that a differential diagnosis  
7 should include all of the possible risk or dangerous  
8 situations for a patient that you are providing medical  
9 care to?

10 MS. SWANSON: Objection to form.

11 THE WITNESS: I believe that a  
12 differential diagnosis should include the most likely  
13 or most common. I think stating all possible outcomes  
14 is something that can never truly be known.

15 Q. (Mr. Boyle) Do you agree that if you're  
16 treating a patient and there's something on that  
17 patient's differential diagnosis that could be life  
18 threatening, that you should treat that and rule it in  
19 or rule it out before you stop considering it as  
20 something of importance on your differential diagnosis?

21 MS. SWANSON: Objection to form.

22 THE WITNESS: I don't understand what  
23 you're asking.

24 Q. (Mr. Boyle) If you're treating a patient and  
25 you develop a differential diagnosis, and it includes

1 on that differential diagnosis something that could be  
2 life threatening, you're not sure if it's there or not,  
3 don't you agree that you need to rule it in or rule it  
4 out before you cross it off your list on your  
5 differential diagnosis?

6 A. I believe you need to rule it in or out  
7 before you remove it from your differential diagnosis,  
8 but not that you need to rule it in or rule it out  
9 before you provide some treatment to the patient. They  
10 can be done concurrently. And I'd like to clarify,  
11 that can be done concurrently in some cases.

12 Q. You agree, though, that the concept of the  
13 differential diagnosis is you treat the worst first,  
14 right?

15 MS. SWANSON: Objection to form.

16 THE WITNESS: I think that's too vague a  
17 statement for me to be able to answer.

18 Q. (Mr. Boyle) So if you've got a patient who  
19 comes in and they're having pain in their chest, it  
20 could be heartburn. But it could be a heart attack,  
21 right?

22 A. Those are two things in a differential  
23 diagnosis for chest pain.

24 Q. And a heart attack could kill that patient,  
25 right?



1 MS. SWANSON: Objection to form.

2 THE WITNESS: Heart attacks can be life  
3 threatening, yes.

4 Q. (Mr. Boyle) Heartburn is probably not going  
5 to kill that patient, is it?

6 A. Heartburn is usually not life threatening.

7 Q. If you have a patient who comes in, and they  
8 have an unknown diagnosis with symptoms of things that  
9 are not life threatening but also could be life  
10 threatening, you've got to look at that life-  
11 threatening diagnosis and treat that and rule it out,  
12 don't you?

13 A. Actually, it depends a great deal on the  
14 patient. In my experience of managing patients with  
15 chest pain, the decision to rule out heart attack would  
16 be based on the patient's risk factors, age and the  
17 likelihood that the pain they were feeling was a heart  
18 attack.

19 Q. What is the American College of Obstetricians  
20 and Gynecologists?

21 A. I understand it to be an organization  
22 supporting OB/GYN and ancillary providers of  
23 obstetrical and gynecologic care.

24 Q. And we'll call it ACOG. Is that your  
25 understanding of the ---

1 A. That's ---

2 Q. --- acronym?

3 A. --- my understanding of the acronym.

4 Q. Okay. Are you a member of ACOG?

5 A. Yes, I am.

6 Q. Do you agree that the ACOG practice bulletins  
7 provide clinical management guidelines for -- excuse  
8 me, OB/GYNs and people who are providing similar  
9 services to OB/GYNs?

10 A. I have not reviewed every ACOG bulletin. I  
11 understand that they are intended to provide guidance.

12 Q. Do you review ACOG bulletins on occasion?

13 MS. SWANSON: Objection to form.

14 THE WITNESS: I do review some ACOG  
15 bulletins.

16 Q. (Mr. Boyle) When you have a woman who you  
17 are seeing as a patient who has a positive pregnancy  
18 test result, what is on her differential diagnosis as  
19 potential medical issues and risks, in your mind?

20 MS. SWANSON: Objection to form.

21 THE WITNESS: The depth of what I would  
22 consider as risks would depend on the context in which  
23 I was seeing a patient with a positive pregnancy test.

24 Q. (Mr. Boyle) Okay. You have a patient who  
25 has a positive pregnancy test that comes into PPSAT and

1 is discussing with you the possibility of having a  
2 chemical abortion. What would you have on that  
3 patient's differential diagnosis?

4 A. I do not routinely make a differential  
5 diagnosis based on a positive pregnancy test. When I'm  
6 seeing a patient for a medication abortion, I have  
7 ultrasound information. And so I'm basing my decisions  
8 not on the pregnancy test, but on the ultrasound  
9 results, in most cases.

10 Q. Okay. If you get an ultrasound result from a  
11 patient who's tested pregnancy -- sorry, tested  
12 pregnant -- tested positive for pregnancy. Start over.

13 If you have a patient who has tested positive  
14 for pregnancy and you get an ultrasound result for that  
15 patient, what is on your differential diagnosis for  
16 that patient?

17 MS. SWANSON: Objection to form.

18 THE WITNESS: My differential diagnosis  
19 would be based on the results of the ultrasound.

20 Q. (Mr. Boyle) And what are the options there?

21 MS. SWANSON: Objection to form.

22 THE WITNESS: The most common options in  
23 a pregnant patient when I am looking at their  
24 ultrasound would be one of five categories. Would you  
25 like me to outline those categories?

1 Q. (Mr. Boyle) Please.

2 A. Definite intrauterine pregnancy, probable  
3 intrauterine pregnancy, definite ectopic pregnancy,  
4 probable ectopic pregnancy and pregnancy of unknown  
5 location. There are some other things that could be  
6 considered, but those are the main five categories.

7 Q. Okay. What is your differential diagnosis  
8 for the patient who has definite intrauterine  
9 pregnancy?

10 A. If I have diagnosed a definite intrauterine  
11 pregnancy? I have diagnosed a definite intrauterine  
12 pregnancy, so the differential -- I'm not sure what you  
13 mean by, "What differential diagnosis do you have?"

14 Q. Fair enough. If you have, category one, a  
15 patient who has an ultrasound with a definite  
16 intrauterine pregnancy, do you include ectopic  
17 pregnancy on that patient's differential diagnosis?

18 MS. SWANSON: Objection to form.

19 THE WITNESS: When we are doing an  
20 ultrasound, we routinely evaluate the adnexal with  
21 every ultrasound we do. We do not always -- we  
22 routinely do a full sweep of the uterus and adnexal on  
23 all ultrasounds.

24 If someone has a definite intrauterine  
25 pregnancy, then the likelihood that there is another

1 diagnosis is small, although other diagnoses that I  
2 have seen have been molar pregnancy or partial molar  
3 pregnancy, early pregnancy failure or miscarriage, twin  
4 pregnancy. There can be other things in addition to an  
5 intrauterine pregnancy.

6 Q. (Mr. Boyle) What is twin pregnancy? What is  
7 that?

8 A. Twin pregnancy is generally understood as a  
9 pregnancy that contains either two gestational sacs  
10 and/or two fetal poles.

11 Q. (Mr. Boyle) So twins?

12 A. Correct.

13 Q. Okay.

14 MS. SWANSON: I'd just like to note that  
15 we've been on the record for about another hour, so if  
16 we could wrap up for lunch when you come to a good  
17 stopping point, that'd be great.

18 MR. BOYLE: That's fine with me.

19 THE VIDEOGRAPHER: Off record, 12:31.

20 (Lunch Break: 12:31 p.m. to 1:07 p.m.)

21 THE VIDEOGRAPHER: On record, 1:07.

22 MS. SWANSON: Before we get started, I'd  
23 like to note for the record that my colleague, Helene  
24 Krasnoff, from Planned Parenthood Federation of America  
25 for Planned Parenthood South Atlantic, has joined us.

1 Q. (Mr. Boyle) All right. We ready, Doctor?

2 A. I am.

3 Q. Very good. Thank you. Do -- does PPSAT ever  
4 offer informed consent, like we were talking about, the  
5 second -- the returned trip informed consent, like  
6 Bates Number 36 and Bates Number 39 we were looking at,  
7 in a group setting to patients, or is it always a one-  
8 on-one, employee talking to an individual patient?

9 MS. SWANSON: Objection to form.

10 THE WITNESS: Our protocol is to offer  
11 informed consent one on one.

12 Q. (Mr. Boyle) Okay. So it doesn't happen  
13 with, like, five or ten patients sitting in a room with  
14 one employee giving them all the paperwork and having  
15 them all sign it at the same time?

16 A. No, it does not.

17 Q. Okay. I think we stopped on differential  
18 diagnosis for Category Number 1, when you have an  
19 ultrasound with a patient who has a definite  
20 intrauterine pregnancy.

21 Is there a difference between what you said  
22 the differential diagnosis is for that patient, with an  
23 ultrasound showing an intrauterine pregnancy, versus  
24 Category 2, an ultrasound showing possible intrauterine  
25 pregnancy?

1 MS. SWANSON: Objection to form.

2 THE WITNESS: So the second category I  
3 referred to, we call a probably intrauterine pregnancy.  
4 And I don't know how to answer the question, "Is there  
5 a different differential diagnosis?" I'm not really  
6 clear what you're asking.

7 Q. (Mr. Boyle) Is your differential diagnosis  
8 the same or different compared -- Category 1 to  
9 Category 2?

10 MS. SWANSON: Objection to form.

11 THE WITNESS: I would say it was  
12 different. One of the common ways we would see a  
13 probably intrauterine pregnancy would be in someone who  
14 had a large, empty uterine sac. And depending on the  
15 size of that sac, would make us either suspicious for,  
16 or clinically certain, that the patient was  
17 experiencing a miscarriage.

18 Q. (Mr. Boyle) Okay. How about for Category 3,  
19 which I believe you said was an ultrasound that  
20 definitely showed an ectopic pregnancy? What's your  
21 differential diagnosis for that patient?

22 MS. SWANSON: Objection to form.

23 THE WITNESS: I would consider that  
24 patient to have an ectopic pregnancy or a pregnancy  
25 outside the uterus.

1 Q. (Mr. Boyle) And what would you do as a  
2 result of that?

3 A. If I see a patient with an ectopic pregnancy,  
4 I refer them for treatment of that pregnancy.

5 Q. Refer them where?

6 A. Either to their primary gynecologist, if  
7 that's their preference, and they're able to see them  
8 quickly, or to a hospital for care.

9 Q. Because an ectopic pregnancy is a life-  
10 threatening risk for a patient, isn't it?

11 MS. SWANSON: Objection to form.

12 THE WITNESS: An ectopic pregnancy can  
13 be life threatening if not treated, yes.

14 Q. (Mr. Boyle) Because it's a pregnancy growing  
15 outside of the uterus, where it's supposed to be, and  
16 it can cause -- if it's in the fallopian tubes, it  
17 cause those to rupture and bleed, right?

18 A. That is one form of ectopic pregnancy. There  
19 are many locations that an ectopic pregnancy can exist,  
20 including technically within the uterus.

21 Q. Okay. And if you have -- well, the fourth  
22 category would be an ultrasound that showed a suspected  
23 ectopic pregnancy. How would your differential  
24 diagnosis for that fourth category differ, if any way,  
25 from the third category, where you actually identified



1 ectopic pregnancy?

2 A. So a probable ectopic pregnancy would mean  
3 that I am seeing something outside of the uterus that I  
4 am suspicious is ectopic, but I don't see  
5 characteristics that absolutely confirm that that is a  
6 pregnancy that I'm seeing versus some other structure  
7 such as an ovarian cyst that's complex.

8 Q. And what would your differential diagnosis  
9 -- what would you do with that patient, that Category  
10 4?

11 (Knock at door)

12 Q. You can continue. You can continue. I'm  
13 listening.

14 MR. BOYLE: Thanks.

15 THE WITNESS: Differential diagnosis and  
16 treatment are two very different things. Would you  
17 like me to answer what the differential diagnosis was  
18 or what I would do for it?

19 Q. (Mr. Boyle) Start with the differential,  
20 yes.

21 A. So the differential diagnosis of a probable  
22 ectopic pregnancy is would be that there is an ectopic  
23 pregnancy that I can't definitely diagnosis or that  
24 there is some other structure outside of the uterus  
25 that I -- that could be a complex ovarian cyst, it

1 could be some other structure outside of the uterus  
2 such as bowel that has a strange appearance.

3 Q. If it was a cyst instead of an ectopic  
4 pregnancy, would you consider that patient to be at  
5 risk of danger from that cyst?

6 MS. SWANSON: Objection to form.

7 THE WITNESS: Some cysts can create  
8 danger, but rarely the more immediate, potentially  
9 life-threatening danger of an ectopic.

10 Q. (Mr. Boyle) Okay. So what would you do with  
11 that patient if you -- you couldn't tell if it was an  
12 ectopic pregnancy, but you saw something and you  
13 suspected it might be a cyst? What would you do?

14 A. If I saw something outside of the uterus that  
15 I would categorize as a possible ectopic pregnancy,  
16 even if I thought there was a reasonable possibility  
17 that it was a cyst, if it falls under the category of  
18 probable ectopic pregnancy, I would treat it as an  
19 ectopic pregnancy, where I would refer the patient ---

20 Q. Okay.

21 A. --- for immediate evaluation.

22 Q. And that makes sense, because an ectopic  
23 pregnancy is a potentially life-threatening condition.  
24 So if you have a strong suspicion for it, you have to  
25 rule it out, so you go ahead and refer that patient to

1 their gynecologist or an emergency room so that she can  
2 get worked up further, and they can rule it out or rule  
3 it in. Is that fair?

4 MS. SWANSON: Objection to form.

5 THE WITNESS: If a patient has a  
6 definite or probable ectopic pregnancy, that means that  
7 I am concerned about a potentially life-threatening  
8 condition, and I would refer them for further immediate  
9 evaluation.

10 Q. (Mr. Boyle) A patient with the fifth  
11 category, pregnancy of unknown location, could that be  
12 an ectopic pregnancy?

13 A. It could be.

14 Q. Are you suspicious that it might be an  
15 ectopic pregnancy?

16 MS. SWANSON: Objection to form.

17 THE WITNESS: No. If I'm suspicious  
18 that it might be an ectopic pregnancy, then I would  
19 consider it a probable or definite ectopic pregnancy.

20 Q. (Mr. Boyle) So if you have a pregnancy of  
21 unknown location on an ultrasound, you're not seeing an  
22 actual pregnancy or possible pregnancy either in the  
23 uterus or outside the uterus, correct?

24 A. Correct.

25 Q. Doesn't that raise your suspicion that that

1 patient could have an ectopic pregnancy, because you  
2 haven't ruled it out?

3 MS. SWANSON: Objection to form.

4 THE WITNESS: When I have a patient who  
5 has a probable -- or, pardon me, who has a pregnancy of  
6 unknown location, I consider three -- the most common  
7 three possibilities in my differential diagnosis: that  
8 they have an early intrauterine pregnancy that is not  
9 yet visible; that they have an early intrauterine  
10 pregnancy that is undergoing miscarriage; or that they  
11 have an ectopic pregnancy that is not yet visible.

12 Q. (Mr. Boyle) So when you have a Category 5,  
13 pregnancy of unknown location, on an ultrasound, part  
14 of your differential diagnosis is Number 3, that they  
15 may have an ectopic pregnancy that you just can't see  
16 yet?

17 A. That is correct. That is part of the  
18 differential diagnosis.

19 Q. Unless they are discovered and treated early,  
20 you would agree that almost 40 percent of ectopic  
21 pregnancies rupture suddenly, causing pain and bleeding  
22 in the abdominal cavity, wouldn't you?

23 A. I do not have that data.

24 Q. You don't know that data?

25 A. I do not know that statistic off the top of

1 my head.

2 Q. You would agree, at least, that ruptured  
3 ectopic pregnancies can be fatal, wouldn't you?

4 A. I would agree.

5 Q. At least 2 percent of pregnancies are ectopic  
6 pregnancies. Isn't that right?

7 A. The categorization I have heard is that up to  
8 2 percent of pregnancies are ectopic pregnancies.

9 Q. We were talking about ACOG before. Are you  
10 familiar with ACOG Practice Bulletin 193?

11 A. I would have to look at it to know.

12 Q. You don't know it just off the top of your  
13 head?

14 A. Not from a number.

15 Q. Okay.

16 MR. BOYLE: I'm going to hand you a  
17 document.

18 MS. SWANSON: Thank you.

19 MR. BOYLE: You're welcome.

20 Q. (Mr. Boyle) Take your time, review that  
21 please, and let me know when you're ready to identify  
22 it.

23 A. I have not read it in detail, but I am -- I  
24 do have it in front of me.

25 Q. Okay. Are you able to identify what this is,

1 please?

2 A. It is the ACOG Practice Bulletin, Number 193.

3 Q. And from what -- what time frame?

4 A. From March 2018.

5 Q. What's the topic of this Practice Bulletin?

6 A. Clinical Management Guidelines for  
7 Obstetrician/Gynecologist Tubal Ectopic Pregnancy.

8 Q. Do you see on the first page, under  
9 Background/Epidemiology, where it says, quote,  
10 "According to the CDC, ectopic pregnancy accounts for  
11 approximately two percent of all reported pregnancies,"  
12 end quote?

13 A. Yes, I see that quote.

14 Q. You see a few lines down where it says,  
15 quote, "Despite improvements in diagnosis and  
16 management, ruptured ectopic pregnancy continues to be  
17 a significant cause of pregnancy-related mortality and  
18 morbidity. In 2011 to 2013, ruptured ectopic pregnancy  
19 accounted for 2.7 of all pregnancy-related deaths and  
20 was the leading cause of hemorrhage-related mortality,"  
21 end quote?

22 You see that?

23 A. Yes, I see that.

24 Q. Do you agree with that?

25 A. I do trust this data.

1 Q. Okay. If you look over that Risk Factor  
2 section on the first page, I'm going to read you a  
3 sentence and ask you about that. First sentence says,  
4 quote, "One-half of all women who receive a diagnosis  
5 of an ectopic pregnancy do not have any known risk  
6 factors," end quote. Do you see that?

7 A. I do see that.

8 Q. So you would agree that it's possible that a  
9 woman who comes into a PPSAT clinic has an ectopic  
10 pregnancy but doesn't have any known risk factors for  
11 that ectopic pregnancy?

12 A. Yes, that is possible.

13 Q. And the gold standard to test and look for an  
14 ectopic pregnancy is to conduct a transvaginal  
15 ultrasound and see if there is an embryo or fetus seen  
16 in the uterus. Isn't that right?

17 A. I don't know ---

18 MS. SWANSON: Object to form.

19 THE WITNESS: --- what you mean by,  
20 "gold standard."

21 Q. (Mr. Boyle) You don't use the word -- the  
22 term "gold standard" in your medical practice?

23 A. I would not use the term "gold standard" in  
24 this context.

25 Q. Do you use it in any context in your medical

1 practice?

2 MS. SWANSON: Objection to form.

3 THE WITNESS: I don't know that I --  
4 it's not a -- it's not a term that I routinely use, no.  
5 I would say that ultrasound is a critical factor in  
6 diagnosis of ectopic pregnancy.

7 Q. (Mr. Boyle) I will accept that. If you turn  
8 to the second page of this Bulletin 193, under Clinical  
9 Considerations and Recommendations, How is an Ectopic  
10 Pregnancy Diagnosed; you see that section?

11 A. I do see that section.

12 Q. Okay. You see the sentence that says, quote,  
13 "The minimum diagnostic evaluation of a suspected  
14 ectopic pregnancy is transvaginal ultrasound evaluation  
15 and confirmation of pregnancy," end quote. Do you see  
16 that?

17 A. I do.

18 Q. So ACOG requires, according to this Bulletin,  
19 that in order to rule in or rule out an ectopic  
20 pregnancy, you have to have an ultrasound that shows  
21 the pregnancy. Is that correct?

22 A. That ---

23 MS. SWANSON: Objection to form.

24 THE WITNESS: That's not actually what  
25 it's saying. What it's saying is that the minimum



1 diagnostic evaluation, so the minimum you must do if  
2 you suspect ectopic pregnancy, is a transvaginal  
3 ultrasound evaluation.

4 And when they say, "and confirmation of  
5 pregnancy," they mean that if you do a transvaginal  
6 ultrasound but you haven't done another test to confirm  
7 that the patient is pregnant, such as a urine or blood  
8 pregnancy test, then it's not as useful.

9 For example, if a patient had a negative  
10 pregnancy test, then the -- the transvaginal ultrasound  
11 wouldn't be helpful. So if you do a transvaginal  
12 ultrasound and don't see a pregnancy, you would next do  
13 a pregnancy test to see if the patient was even  
14 pregnant.

15 Q. (Mr. Boyle) So you think that sentence  
16 there, that's talking clearly about ultrasound, means  
17 that a doctor doesn't have to actually confirm the  
18 pregnancy with the ultrasound? That's how you  
19 interpret that sentence?

20 MS. SWANSON: Objection to form.

21 THE WITNESS: No. What I am saying is  
22 that this sentence says that you must do an ultrasound,  
23 and you must also confirm that the patient is pregnant.  
24 Because often, for example, in pregnancy of unknown  
25 location, you will do an ultrasound and not see a

1 pregnancy.

2           So if you perform an ultrasound, which is  
3 often done before a pregnancy test is done, and you see  
4 no pregnancy, the very next step is to perform a  
5 pregnancy test to confirm that the patient is pregnant.  
6 Because if the patient is not pregnant, then the  
7 concern for ectopic pregnancy no longer exists.

8           Q.     (Mr. Boyle) I just want to make sure that I  
9 understand what you're saying. The next sentence says,  
10 quote, "Serial evaluation with transvaginal  
11 ultrasonography, or serum HCG level measurements, or  
12 both, often is required to confirm the diagnosis," end  
13 quote.

14                     Do you see that?

15           A.     Yes, I see that.

16           Q.     And you think that, again, when the prior  
17 sentence says, "confirmation of pregnancy," it's not  
18 talking about with an ultrasound, it's talking about  
19 with a pregnancy test?

20                     MS. SWANSON: Objection to form.

21                     THE WITNESS: I believe that the first  
22 sentence is saying that a transvaginal ultrasound in  
23 the absence of confirming that the patient is actually  
24 pregnancy is not helpful. So you confirm that the  
25 patient is pregnant.

1           And then, I believe, that you must perform  
2 not just one ultrasound, unless the ultrasound  
3 definitely diagnoses an ectopic pregnancy. If it does  
4 not give you a definitive diagnosis, then the next step  
5 is to perform serial ultrasounds, usually over the  
6 course of several days, and often, serial blood tests,  
7 usually over the course of several days.

8           Q.    And I guess I'm -- I'm confused, and maybe  
9 I'm just ignorant to this. It's entirely possible.  
10 When a woman comes to PPSAT and says, "I think I might  
11 be pregnant," isn't the first step, you just give her a  
12 pregnancy test as opposed to giving her an ultrasound?

13           A.    It depends on the type of visit. If a  
14 patient comes in and says, "I'm not sure if I'm  
15 pregnant. I'd like to find out," we perform a  
16 pregnancy test.

17           Most of the patients who are coming to us for  
18 abortion come and say, "I did a pregnancy test at home.  
19 I'm here for an abortion." In those patients, we start  
20 with ultrasound, because they've already performed an  
21 equivalent pregnancy test at home.

22           Q.    So -- and that second type of patient, when  
23 they show up and say, "I did a pregnancy test at home.  
24 I think I'm pregnant. I want an abortion," you perform  
25 an ultrasound first.

1           And then, if you don't see a pregnancy on the  
2 ultrasound, that fifth category, pregnancy of unknown  
3 location, then you give them the pregnancy test?

4           A.    That's correct.

5           Q.    How much does it cost to give them a  
6 pregnancy test?

7           A.    I don't know the cost of pregnancy tests, and  
8 I don't know that we actually charge for the pregnancy  
9 test in that setting. I'm not sure.

10          Q.    But you charge for the ultrasound?

11          A.    We do charge for the ultrasound.

12          Q.    Why wouldn't you just give them a pregnancy  
13 test first, especially if it doesn't cost the patient  
14 any money?

15                   MS. SWANSON:  Objection to form.

16                   THE WITNESS:  We almost never have to do  
17 a pregnancy test.  If we were performing a pregnancy  
18 test on every single patient, I think we probably would  
19 have to charge for it.

20                   So a vast majority of patients come to us and  
21 say they've had a positive pregnancy test.  If a  
22 patient came to us and said, "I'm not sure if I'm  
23 pregnant," we would start with a pregnancy test before  
24 an ultrasound.

25          Q.    (Mr. Boyle)  If you look at the next column

1 over, Serum Human CH -- CG -- HCG, sorry. Serum HCG  
2 Measurements, do you see that?

3 A. I see that.

4 Q. It says, quote, "Measurement of the Serum HCG  
5 levels aids in the diagnosis of women at risk of  
6 ectopic pregnancy. However, Serum HCG values alone  
7 should not be used to diagnosis an ectopic pregnancy  
8 and should be correlated with the patient's history,  
9 symptoms, and the ultrasound findings," end quote.

10 Do you see that?

11 A. I see that.

12 Q. So doesn't that say that you have to see an  
13 ectopic pregnancy by an ultrasound, either saying it's  
14 intrauterine or it's not?

15 MS. SWANSON: Objection to form.

16 THE WITNESS: No, that's not at all what  
17 it says.

18 Q. (Mr. Boyle) Okay. If you have a woman who  
19 has tested pregnant -- tested positive for pregnancy,  
20 and you take an ultrasound of her and you don't see a  
21 fetus or an embryo anywhere on that ultrasound, doesn't  
22 that actually raise your suspicion for her having an  
23 ectopic pregnancy on that differential diagnosis you  
24 were discussing earlier?

25 A. Yes, it does increase my suspicion for

1 ectopic pregnancy if I do not see a pregnancy either  
2 inside or outside of the uterus, including a  
3 gestational sac, not just a fetus or embryo.

4 Q. Okay. When you're treating a -- a woman  
5 who's tested positive for pregnancy, but she has a  
6 confirmed ectopic pregnancy, you don't provide her with  
7 the two chemical abortion drugs, do you?

8 A. That is correct. We do not treat anyone with  
9 a confirmed ectopic pregnancy with medication abortion  
10 medications.

11 Q. Because mifeprex (sic) and misoprostol are  
12 drugs that do not assist a woman in treating her for  
13 her ectopic pregnancy, are they?

14 MS. SWANSON: Object to form.

15 THE WITNESS: Mifepristone and  
16 misoprostol, as used in medication abortion, are not  
17 effective in treating ectopic pregnancy.

18 Q. (Mr. Boyle) And the FDA label says that they  
19 are contraindicated in patients with confirmed or  
20 suspected ectopic pregnancies, doesn't it?

21 A. I don't know what the FDA label says without  
22 looking at it.

23 Q. You've prescribed these medications several  
24 times every week for the past 14 years, correct?

25 A. That is correct.

1 Q. And you are unaware that the FDA label says  
2 that they are contraindicated for a woman who has an  
3 actual diagnosed or suspected ectopic pregnancy?

4 MS. SWANSON: Object to form.

5 THE WITNESS: I cannot directly quote  
6 the FDA label without looking at it. I am aware that  
7 we do not use mifepristone and misoprostol, as designed  
8 for medication abortion, in patients with known or  
9 suspected ectopic pregnancy.

10 Q. (Mr. Boyle) A patient who has a suspected  
11 ectopic pregnancy needs to be worked up to see if she  
12 needs surgical treatment for her ectopic pregnancy or  
13 if she qualifies for a different drug treatment,  
14 methotrexate, right?

15 A. There are different treatments for ectopic  
16 pregnancy, and those treatments should be offered based  
17 on the patient's exact circumstances, yes.

18 Q. Typically, the drug you give for ectopic  
19 pregnancy is methotrexate, not the two chemical  
20 abortion drugs, right?

21 A. I do not treat ectopic pregnancy, but it  
22 is -- you do not use mifepristone and misoprostol to  
23 treat ectopic pregnancy. Methotrexate is one of the  
24 medications that can be used to treat ectopic  
25 pregnancy.

1 Q. If you give a woman who tests positive for  
2 pregnancy, who is actually suffering from an ectopic  
3 pregnancy, the chemical abortion drugs, and it does not  
4 stop her ectopic pregnancy from growing, that ectopic  
5 pregnancy can rupture, possibly in her fallopian tubes  
6 or some other internal structure, causing damage and  
7 bleeding inside her abdomen. Isn't that right?

8 MS. SWANSON: Object to form.

9 THE WITNESS: Any woman who has an  
10 ectopic pregnancy, that ectopic pregnancy can rupture  
11 if it is not treated, regardless of whether the patient  
12 receives mifepristone and misoprostol or not.

13 Q. (Mr. Boyle) That's fair. But the  
14 prescription of those two drugs wouldn't have any  
15 impact on whether that ectopic pregnancy will continue  
16 to grow and possibly rupture, right?

17 A. I don't believe it's been extensively  
18 studied, but we do not treat ectopic pregnancy with  
19 mifepristone and misoprostol. There's a possibility  
20 that they could stop the growth theoretically, but we  
21 do not use it for that purpose.

22 Q. Okay. I appreciate that there may be further  
23 research to be done, but there's none that you're aware  
24 of that has been done to suggest that's an appropriate  
25 treatment regimen for ectopic pregnancy. Is that



1 correct?

2 MS. SWANSON: Object to form.

3 THE WITNESS: I am unaware that anyone  
4 would use mifepristone and misoprostol to treat a known  
5 or suspected ectopic pregnancy.

6 Q. (Mr. Boyle) You agree that many of the  
7 symptoms of a ruptured ectopic pregnancy mimic, or are  
8 exactly the same as, the expected side effects of a  
9 chemical abortion that you or one of your colleagues at  
10 PPSAT have counseled your patient could occur if you  
11 give that patient a chemical abortion, right?

12 MS. SWANSON: Object to form.

13 THE WITNESS: There are some overlapping  
14 symptoms between the normal symptoms we expect with  
15 medication abortion and the symptoms of an ectopic  
16 pregnancy.

17 Q. (Mr. Boyle) It's possible that a patient who  
18 took chemical abortion drugs and then suffered a  
19 ruptured ectopic pregnancy, leading to internal  
20 bleeding and vaginal bleeding, pain, dizziness,  
21 headache, could misconstrue or confuse those symptoms  
22 of the ectopic pregnancy with the normal expected side  
23 effects of the chemical abortion, as it was described  
24 to her by her doctor or other provider at PPSAT. Isn't  
25 that true?

1 MS. SWANSON: Object to form.

2 THE WITNESS: It would be important to  
3 educate any patient on whom we have not diagnosed an  
4 intrauterine pregnancy, who takes mifepristone and  
5 misoprostol, on the normal symptoms that they would  
6 experience with a medication abortion and on the  
7 abnormal symptoms that they might experience, including  
8 detailed education on the symptoms of ectopic  
9 pregnancy.

10 Q. (Mr. Boyle) But they might confuse a  
11 ruptured ectopic pregnancy for the normal side effects  
12 from the chemical abortion process, correct?

13 MS. SWANSON: Object to form.

14 THE WITNESS: I can't speculate on who  
15 might get confused by what. It is important to give  
16 clear education and closely follow up with patients.

17 Q. (Mr. Boyle) If you look at the document,  
18 please, at, let's see, Bates 31, on the first page  
19 there.

20 MS. SWANSON: And for the record, we're  
21 now switching back to the patient education packet from  
22 the ACOG bulletin.

23 Q. (Mr. Boyle) Right. Bates 31. Do you see  
24 that?

25 A. I see that form, yes.

1 Q. Okay. You see on the left-hand column, it's  
2 talking about abortion pill and it's -- and it's going  
3 over what the patient may expect and how it might turn  
4 out. Is that fair?

5 A. I do see that form.

6 Q. Okay. And there's two columns. There's --  
7 the one on the left is abortion pill, and the other one  
8 on the right is in-clinic abortion, right?

9 A. Correct.

10 Q. Okay. So when you go down to How Will I  
11 Feel, there's a list of symptoms there, right?

12 A. There is.

13 Q. It says, "nausea or vomiting, headache,  
14 dizziness." You see those?

15 A. I do.

16 Q. And then you go down two more rows and it  
17 talks about bleeding. It says, "Heavy bleeding with  
18 clots is common after taking misoprostol," right?

19 A. It says, "Heavy bleeding with clots is common  
20 after taking misoprostol," yes.

21 Q. Okay.

22 MR. BOYLE: I'm going to give you what's  
23 been marked as Bates Number 119 and 120.

24 MS. SWANSON: Thank you.

25 MR. BOYLE: You're welcome.

1 Q. (Mr. Boyle) Ask you if you recognize that  
2 document?

3 A. Yes, I do.

4 Q. And actually it's two documents there, but  
5 they're actually separate documents, I believe. Are  
6 these given out to your patients at PPSAT?

7 A. They are given out to some patients at PPSAT,  
8 yes.

9 Q. Not to every patient?

10 A. No, not to every patient.

11 Q. Okay. And when we're looking at Bates Number  
12 119, what's the name of this document up at the top,  
13 please?

14 A. Positive Pregnancy Test No Pregnancy Seen on  
15 Ultrasound.

16 Q. Okay. So this is a document, a one-page  
17 document, about what we were talking about, that  
18 Category 5, pregnancy of unknown location from an  
19 ultrasound, right?

20 A. Correct.

21 Q. Okay. Look at the second document, Bates  
22 Number 120. What's the topic of this particular  
23 document?

24 A. The title of this document is Ectopic  
25 Pregnancy.

1 Q. Okay. And let's stay with 120 there, Bates  
2 Number 120, the ectopic pregnancy. Do you see the box  
3 that says, "What are the symptoms of ectopic  
4 pregnancy"?

5 A. Yes, I do.

6 Q. And it says, "Bleeding from the vagina may be  
7 heavy or light," right?

8 A. I see that.

9 Q. Okay. It says, "Dizziness or fainting,"  
10 right?

11 A. I see that.

12 Q. Okay. Those are similar symptoms that are  
13 found on Bates Number 31, talking about what might  
14 happen to a patient after they take the chemical  
15 abortion drugs, right?

16 MS. SWANSON: Object to form.

17 THE WITNESS: There are similarities  
18 between the two forms.

19 Q. (Mr. Boyle) There are similarities between  
20 the symptoms that you tell a patient might -- a patient  
21 might experience with ectopic pregnancy as the side  
22 effects and symptoms you expect the patient to  
23 experience after they take the chemical abortion drugs,  
24 right?

25 A. There are similarities, but they are not

1 identical, yes.

2 Q. Dizziness is identical, isn't it?

3 MS. SWANSON: Object to form.

4 THE WITNESS: There are similarities  
5 between the symptoms you asked me, so not ---

6 Q. (Mr. Boyle) I'm asking, dizziness is in both  
7 of them, isn't it?

8 A. Some of the words in both, some of the  
9 symptoms use the identical words. But the entirety of  
10 symptoms you might expect are not identical between the  
11 two conditions.

12 Q. You said, "the entirety of the symptoms you  
13 might expect," but neither one of these, Bates Number  
14 31 or Bates Number 120 says, "You will experience all  
15 of these symptoms if you are taking the medical  
16 chemical abortion drugs," or, "You will experience all  
17 of these symptoms if you have an ectopic pregnancy," do  
18 they?

19 A. That is correct.

20 Q. They just say these are some things that may  
21 exist under the -- that circumstance or this  
22 circumstance, right?

23 A. That is correct.

24 Q. You agree that it's possible that a patient  
25 who received a chemical abortion drug -- drugs from

1 PPSAT, and also was suffering from a ruptured ectopic  
2 pregnancy, could look at these forms and be  
3 experiencing symptoms from both of them and be mistaken  
4 that they think it's from the chemical abortion drug,  
5 right?

6 MS. SWANSON: Object to form.

7 THE WITNESS: Can you repeat that  
8 question, please?

9 Q. (Mr. Boyle) You agree that a patient from  
10 PPSAT could receive chemical abortion drugs, and also  
11 have a ruptured ectopic pregnancy at the same time or  
12 shortly thereafter, and experience overlapping symptoms  
13 that are found in both documents and confuse the  
14 ectopic pregnancy rupture for a normal side effect from  
15 the chemical abortion drug, right?

16 MS. SWANSON: Object to form.

17 THE WITNESS: I would actually clarify  
18 that the symptoms listed are for the presence of  
19 ectopic pregnancy, and not for the presence of a  
20 ruptured ectopic pregnancy.

21 And the presence of a ruptured ectopic  
22 pregnancy tend to be much more severe, so it is  
23 unlikely to me, clinically, that a patient would  
24 experience a ruptured ectopic pregnancy and only  
25 experience, in the example you gave, dizziness.

1 Q. (Mr. Boyle) Right. But it says, on Bates  
2 Number 120, "Call us right away if you have dizziness,  
3 bleeding from the vagina," down at the bottom. Do you  
4 see that?

5 MS. SWANSON: Object to form.

6 THE WITNESS: Yes, I see that statement  
7 on the document.

8 Q. (Mr. Boyle) And it's not like the patient is  
9 going to know that they have an ectopic pregnancy. You  
10 only see that with ultrasound. They can't look inside  
11 their own bodies, right?

12 MS. SWANSON: Object to form.

13 THE WITNESS: Patients, unless they have  
14 access to an ultrasound machine, cannot look inside  
15 their own bodies.

16 Q. (Mr. Boyle) Fair enough. I will grant you  
17 that. And you at least perform, or require someone  
18 else to perform and give you a copy of an ultrasound,  
19 every single time before you give a patient chemical  
20 abortion drugs, right?

21 A. We require that an ultrasound is performed  
22 every time before we give a patient medication  
23 abortion. And in the setting of pregnancy of unknown  
24 location, if I were to receive an ultrasound from an  
25 outside individual, I would repeat the ultrasound



1 myself before giving a patient medication abortion.

2 Q. So if you have a pregnancy of unknown  
3 location from an outside source for this patient who  
4 has just arrived and is seeking a chemical abortion,  
5 you would take another ultrasound there, at PPSAT,  
6 before you gave that patient chemical abortion drugs.  
7 Is that correct?

8 A. It is our protocol to repeat that ultrasound  
9 the same day, yes.

10 Q. You said that's in your protocols?

11 MS. SWANSON: Object to form.

12 THE WITNESS: It is our practice. I  
13 don't know exactly how it's written in our protocols  
14 without reviewing the protocols.

15 MR. BOYLE: And I'm handing you what has  
16 been produced in discovery as Bates Numbers 53 through  
17 105.

18 Q. (Mr. Boyle) Can you just -- first, before we  
19 start, can you look at the first page and see if I'm  
20 right on the numbers there?

21 MS. SWANSON: And before we get started,  
22 I'm just going to state for the record that this has  
23 been produced, designated confidential under our  
24 confidentiality agreement, and not everyone who's  
25 viewing this deposition has signed that protective

1 agreement yet. So if you are going to be asking  
2 questions specifically that reflect the content of this  
3 document ---

4 MR. BOYLE: I think the way I ask this  
5 question, it won't.

6 MS. SWANSON: Okay.

7 MR. BOYLE: If it does, then ---

8 MS. SWANSON: I'll object.

9 MR. BOYLE: --- you will object, and we  
10 can address that. I suspect the answer is going to be,  
11 "No."

12 MS. SWANSON: Okay.

13 MR. BOYLE: But if it's anything other  
14 than, "No," I understand where you're coming from, and  
15 I will respect your objection as stated and we'll deal  
16 with it. I don't have a problem with that.

17 MS. SWANSON: I thank you.

18 MR. BOYLE: And I'm not making it an  
19 exhibit.

20 MS. SWANSON: Okay. I appreciate that.

21 MR. BOYLE: Yes.

22 Q. (Mr. Boyle) So I think we established,  
23 without going into detail, Bates Number 53 through 105  
24 is what's been produced as Chapter 1 of the abortion  
25 chapter from PPSAT's internal protocols and guidelines.

1 Is that correct?

2 A. That is correct.

3 Q. Okay. I think I heard you say that you have  
4 a protocol -- and you might have said just a practice,  
5 so that's why I'm asking about the written protocols.

6 You have a protocol at PPSAT where, if there  
7 is a patient who has an ultrasound that gives a result  
8 of pregnancy of unknown location, and the patient has  
9 tested positive for pregnancy, so under that  
10 circumstance, and you get that ultrasound from an  
11 outside source, not internal, not done by PPSAT, that  
12 you have a protocol that requires PPSAT to do a new  
13 ultrasound.

14 Can you show me in this document where it  
15 says that, please?

16 A. Can you turn to Bates Page 64?

17 THE WITNESS: Am I allowed to go over  
18 what's on this?

19 MS. SWANSON: Let's...

20 MR. BOYLE: How about this? Do me a  
21 favor, and -- and I know this is bad for keeping a  
22 record. Can you just point to it on your piece of  
23 paper and let me see? And I may not have a follow-up  
24 if you show it to me just by pointing.

25 (Witness complies)

1 Q. (Mr. Boyle) Okay. You're saying that you  
2 have a policy at PPSAT that says, if a patient arrives  
3 with an ultrasound from outside a PPSAT clinic, and  
4 that ultrasound shows pregnancy of unknown location,  
5 that then, you have a protocol that says you must do a  
6 new ultrasound at PPSAT. Is that what you're saying?

7 A. What I'm saying is that I have a protocol  
8 that states that if I have a patient with a positive  
9 pregnancy test, in order to follow any of the next  
10 steps, I need to see that there is no gestational sac  
11 on transvaginal ultrasound.

12 So a transvaginal ultrasound must be done to  
13 show no -- we can't accept an outside ultrasound that  
14 has no pregnancy visible. If there's no pregnancy  
15 visible, we must do an ultrasound to see if there's a  
16 pregnancy visible.

17 Q. But, I guess, if that's true, why don't you  
18 just agree to the law as written, because all the law  
19 says is you have to have an ultrasound that shows an  
20 intrauterine pregnancy?

21 MS. SWANSON: Object to form.

22 THE WITNESS: Am I allowed to talk more  
23 about the protocol?

24 MS. SWANSON: You can talk about the  
25 protocols without referring specifically to this

1 document, if that's possible. If it's not possible, we  
2 can go off the record and talk about it a bit more.

3 THE WITNESS: If I were to receive an  
4 ultrasound from an outside organization that showed  
5 a intrauterine pregnancy, definite intrauterine  
6 pregnancy at eight weeks, four days, and I can see that  
7 that ultrasound was done four days ago, and, for  
8 example, the patient came in with their ultrasound and  
9 their consent for the procedure, our protocol would not  
10 absolutely require me to repeat that ultrasound,  
11 although the clinician always, always has the clinical  
12 prerogative to repeat the ultrasound if they have any  
13 reason they want to.

14 Our protocol for management of pregnancy of  
15 unknown location requires that we have an ultrasound  
16 that shows a pregnancy of unknown location. So if, for  
17 example, a patient had an ultrasound elsewhere and then  
18 came to see me at my clinic and said, "They did and  
19 ultrasound and they didn't see a pregnancy," I would  
20 not use that ultrasound clinically.

21 I would need to perform an ultrasound to see  
22 if the patient has a pregnancy of unknown location  
23 before proceeding with treatment.

24 Q. (Mr. Boyle) Okay. And if you then do that  
25 ultrasound at PPSAT and it still shows a pregnancy of

1 unknown location, that fifth category, you think that  
2 you should be able to simultaneously provide the  
3 chemical abortion drugs before you get the positive  
4 confirmation that that patient has an intrauterine  
5 pregnancy. Is ---

6 MS. SWANSON: Object ---

7 Q. (Mr. Boyle) --- that correct?

8 MS. SWANSON: Object to form.

9 THE WITNESS: So we follow excellent  
10 evidence-based protocols that show that it is  
11 appropriate to simultaneously determine the location of  
12 the pregnancy, which the ACOG Bulletin expresses is  
13 usually done through serial ultrasounds and/or serial  
14 blood tests, and, at the same time, provide the  
15 medication abortion to patients.

16 Q. (Mr. Boyle) Do you think it would be safer  
17 to give that patient another ultrasound a few days  
18 later or a week later to determine if it was an ectopic  
19 pregnancy or not, before you gave the contraindicated  
20 chemical abortion drugs?

21 MS. SWANSON: Object to form.

22 THE WITNESS: I think that it is not  
23 necessarily safer to delay starting the medication  
24 abortion for patients, and safety is one of several  
25 factors that we consider in the options that the

1 patient has to choose from.

2 Q. (Mr. Boyle) What other option -- what other  
3 factors are you considering other than the safe -- the  
4 patient's safety?

5 A. We are considering patient history and risks,  
6 which is part of safety. We are considering patient  
7 preference very strongly. That many patients, even if  
8 they know that if they have an ectopic pregnancy, the  
9 medications won't work.

10 Given that ectopic pregnancy occurs in less  
11 than 2 percent of patients, if they have no risk  
12 factors and no other concerning signs, there's a very  
13 good chance they just have an early pregnancy. My  
14 patients strongly prefer to begin definitive treatment  
15 at the same time that we are performing the serial  
16 ultrasounds and/or serial blood tests.

17 Q. You said you follow the evidence-based  
18 medicine. How long as PPSAT been providing medical  
19 chemical abortion drugs to patients who have pregnancy  
20 of unknown location on their ultrasound findings before  
21 confirming either ectopic or intrauterine pregnancy?  
22 How long has that been going on?

23 MS. SWANSON: Object to form.

24 THE WITNESS: I do not know exactly when  
25 that protocol was first made available to us.

1 Q. (Mr. Boyle) It's something that would have  
2 come, literally, across your desk as the chief medical  
3 officer, right?

4 A. Our protocols are updated every one to three  
5 years and different aspects of the protocols are  
6 updated at different times, so I cannot recall exactly  
7 when that update started without looking back at our  
8 historical protocols.

9 Q. And you just don't have any memory if you've  
10 been doing it for one year or for three years or more?

11 MS. SWANSON: Object to form.

12 THE WITNESS: That wasn't your original  
13 question.

14 Q. (Mr. Boyle) Well, I'm -- I know. I'm asking  
15 another question.

16 A. We have been doing it for at least a year,  
17 but I don't recall how long over a year we've been  
18 doing it.

19 Q. Okay. Because you say it's based on  
20 evidence-based medicine, what evidence-based medicine  
21 are you basing it on?

22 A. All of the medical standards that we use,  
23 which include the option of medication abortion while  
24 simultaneously determining the location of a pregnancy,  
25 are based on a large amount of research and data. And



1 we can look to the last pages to show the references,  
2 but I don't recall the exact references without  
3 actually looking at them.

4 Q. Can you -- can you tell me -- you can go  
5 ahead and take that. That's the Chapter 1 Abortion.  
6 Again, I'm not asking for anything really specific  
7 about it other than what you think supports your  
8 contention that providing simultaneous chemical  
9 abortion drugs to a patient with a pregnancy of unknown  
10 location is supported by any evidence-based medicine  
11 practice. And this is Bates Number 53 through 105,  
12 that document.

13 A. It is not possible for me, reading the titles  
14 of all of the articles that are referenced in this  
15 book, to know the full content of every article. So  
16 there are some of these articles that are very broad,  
17 which means that it is possible that the information  
18 exists in those.

19 Q. What page are you looking at, if I might ask?

20 A. I am looking at -- starting at Bates 102, and  
21 the references go through Bates 104, and I have not  
22 finished reading through every title yet.

23 Q. If you find any titles here that you think  
24 support your contention that there is evidence-based  
25 medicine that underlies the PPSAT's decision to, at the

1 same time, provide chemical abortion with a pregnancy  
2 of unknown location, please identify that for me.

3 MS. SWANSON: Object to form.

4 THE WITNESS: I would want to read  
5 through the Management of Unintended and Abnormal  
6 Pregnancy Comprehensive Abortion Care.

7 Q. (Mr. Boyle) Which one is that, please?

8 A. It's labeled throughout, and at approximately  
9 halfway down Bates 103.

10 Q. What's the date on that document?

11 A. 2009. So based on that date, it may or may  
12 not have reference to that.

13 Q. But you would agree that this is fairly new  
14 and evolving theory that you can provide  
15 contemporaneous chemical abortion drugs to a patient  
16 with a pregnancy of unknown location on an ultrasound,  
17 right? That research is from, like, the past two or  
18 three years, right?

19 MS. SWANSON: Object to form.

20 THE WITNESS: Without looking at the  
21 actual studies, I cannot state the exact time frame.  
22 But it is relatively new, and the newness of data does  
23 not mean that the data is not valid.

24 Q. (Mr. Boyle) It's come out since ACOG 193 in  
25 March of 2018, that new theory about giving chemical

1 abortion drugs at the same time as a patient has a  
2 pregnancy of unknown location on ultrasound, right?

3 MS. SWANSON: Object to form.

4 THE WITNESS: I don't know that. And I  
5 have not read through the entirety of ACOG Practice  
6 Bulletin 193 to see whether it references simultaneous  
7 provision of abortion while determining the location of  
8 pregnancy.

9 Q. (Mr. Boyle) How about you turn to the third  
10 page of the ACOG Bulletin, please? It's down at the  
11 bottom. It says, "E-93".

12 A. I'm on that page.

13 Q. Okay. If you go down to the bottom of the  
14 left-hand column, "Pregnancy of Unknown Location," you  
15 see that?

16 A. The -- I'm sorry, the bottom of -- yes, I do  
17 see that.

18 Q. Okay. So let me read this to you and then  
19 I'll ask you a question. Just making sure I've read it  
20 properly for the record.

21 Quote, "A pregnant woman without a definitive  
22 finding of an intrauterine or ectopic pregnancy on an  
23 ultrasound examination has a pregnancy of unknown  
24 location. A pregnancy of unknown location should not  
25 be considered a diagnosis. Rather, it should be

1 treated as a transient state. An effort should be made  
2 to establish a definitive diagnosis when possible," end  
3 quote.

4 Do you see that?

5 A. I see that statement.

6 Q. So does that inform your opinions about what  
7 was going on back in 2018, as it relates to how to  
8 diagnosis and treat a patient with -- or ultrasound of  
9 pregnancy of unknown location?

10 MS. SWANSON: Object to form.

11 THE WITNESS: I would state that it is  
12 true now that we should make efforts to establish a  
13 definitive diagnosis when possible. We are just not  
14 required to make those efforts in isolation.

15 Q. (Mr. Boyle) And I did not mean to interrupt  
16 you in your review of -- I apologize, I did interrupt  
17 you. I'm sorry.

18 You were looking at Bates Number 102, Bates  
19 Number 103 and Bates Number 104 to tell us if there was  
20 any recent research identified by PPSAT that would  
21 support its position that it is acceptable medical  
22 practice to provide chemical abortion drugs  
23 simultaneous with a patient who has a diagnosis or a  
24 transient state of pregnancy of unknown location on an  
25 ultrasound.

1 MS. SWANSON: Object to form. I'm not  
2 sure there's a question in there.

3 Q. (Mr. Boyle) The question is: show it to me,  
4 please.

5 MS. SWANSON: Object to form.

6 THE WITNESS: So I do not see some of  
7 the articles that I know are used to create those  
8 protocols. I also don't think that the list of table  
9 references are the sole source of the protocols.

10 Q. (Mr. Boyle) And that's fine. I was just  
11 basing that off of what I understood you to say, that  
12 they were. If you're saying they're not, then there  
13 may be other things out there that go into the  
14 protocols. Is that what you're saying?

15 Maybe other research out there -- I  
16 apologize, maybe other research out there that goes  
17 into making these protocols that's not included at the  
18 end in that table?

19 A. There is much research and expert analysis  
20 that goes into making these. I do not personally  
21 create these protocols, so cannot speak to all of the  
22 details.

23 Q. You would agree that induced abortions,  
24 surgical abortions, become more complicated after the  
25 gestational age is beyond 14 weeks, wouldn't you?

1 MS. SWANSON: Object to form.

2 THE WITNESS: The complexity of a  
3 procedural abortion varies throughout gestational  
4 duration. And over seven or eight weeks, I would say  
5 that there is an incremental increase in complexity of  
6 the procedure with increasing gestational duration.

7 Q. (Mr. Boyle) You cited the "Academies of  
8 Medicine" article, and it says that "The risk of  
9 serious complication increases with weeks gestation; as  
10 the number of weeks increase, the invasiveness of  
11 required procedure and the need for deeper levels of  
12 sedation also increase."

13 Do you agree with that?

14 MS. SWANSON: Object to form.

15 THE WITNESS: I can't agree that that's  
16 the exact quote without looking at the actual document.  
17 I do agree that there is an incremental increase in  
18 risk as gestational duration increases.

19 Q. (Mr. Boyle) I'm sorry, I'm working through  
20 here.

21 You agree that some second trimester induced  
22 abortions must take place in a hospital setting, don't  
23 you?

24 MS. SWANSON: Object to form.

25 THE WITNESS: I would agree that some

1 abortions, regardless of gestational duration, must  
2 take place in a hospital.

3 Q. (Mr. Boyle) You would agree that anything  
4 beyond moderate sedation -- I think we've discussed it.  
5 But anything beyond moderate sedation anesthesia level  
6 for a surgical abortion must happen in a hospital, not  
7 at a PPSAT clinic, right?

8 MS. SWANSON: Object to form.

9 THE WITNESS: No, I would not agree to  
10 that. Deep sedation can be offered in an outpatient  
11 setting if you have the right equipment and staff.  
12 PPSAT does not have the staff to perform deep sedation  
13 in our outpatient clinics, but that doesn't preclude  
14 the safety of performing it in a clinic that has that  
15 staff.

16 Q. (Mr. Boyle) If a patient comes to PPSAT and  
17 has an ultrasound, and it's an ultrasound of unknown --  
18 pregnancy of unknown location, do you charge for an  
19 additional -- does PPSAT charge for an additional  
20 ultrasound if that patient gets an additional  
21 ultrasound?

22 MS. SWANSON: Object to form.

23 THE WITNESS: Do you mean that if the  
24 patient had an ultrasound at an outside location that  
25 showed a pregnancy of an unknown location, and then we

1 performed an ultrasound, would we charge the patient  
2 for the ultrasound we performed?

3 Q. (Mr. Boyle) I didn't mean that, but do you?

4 A. If we perform an ultrasound, yes, we charge  
5 them for ---

6 Q. And if ---

7 A. --- the ultrasound performed.

8 Q. I'm sorry. If you come up with an ultrasound  
9 of pregnancy of unknown location and you take another  
10 one at PPSAT, do you charge for the second one also?

11 A. We do not routinely charge for repeat  
12 ultrasounds that we feel are clinically necessary, no.

13 Q. So if you charge for an ultrasound and the  
14 patient gets a second or even a third, you don't charge  
15 for the second or the third. Is that correct?

16 A. It is my understanding that we do not  
17 routinely charge for repeat ultrasounds that we deem  
18 clinically necessary.

19 Q. Have you ever had a situation where you had a  
20 patient with ultrasound finding of pregnancy of unknown  
21 location, you gave that patient chemical abortion drugs  
22 and then later, you determined that that patient had an  
23 ectopic pregnancy?

24 A. Yes, that has occurred.

25 Q. Did you give that patient a refund for the



1 unnecessary procedure that you performed?

2 MS. SWANSON: Object to form.

3 THE WITNESS: The patient is charged for  
4 the services they receive on the day they receive them,  
5 so the patient paid for the services they received,  
6 which included medications that they took.

7 Q. (Mr. Boyle) And you would agree that in that  
8 circumstance, the medications that the patient paid for  
9 were unnecessary, right?

10 MS. SWANSON: Object to form.

11 THE WITNESS: At the time that the  
12 medications were given, we did not know that they were  
13 unnecessary, so they were given in good faith.

14 Q. (Mr. Boyle) Absolutely. But had you waited,  
15 eventually you were able to determine that that  
16 particular patient had an ectopic pregnancy, right?

17 A. If it had been the patient's preference to  
18 wait, we certainly could have waited and not done the  
19 medication abortion yet.

20 Q. Well, you also could have just waited because  
21 you don't know where the pregnancy is, regardless of  
22 the patient's preference, right?

23 MS. SWANSON: Object to ---

24 Q. (Mr. Boyle) That's at least an option?

25 MS. SWANSON: Object to form.

1 THE WITNESS: We provide the patient  
2 with their options and let them choose. So a patient  
3 who is taking medication abortion in the setting of  
4 pregnancy of unknown location is aware and informed  
5 that they may not have an intrauterine pregnancy, and  
6 that if they have an ectopic pregnancy, this medication  
7 will not be sufficient to treat that condition.

8 And then the patient chooses that option, or  
9 they choose the other option, such as a diagnostic  
10 suction, or to wait while determining the location of  
11 the pregnancy.

12 Q. (Mr. Boyle) You're talking about the  
13 evidence-based studies that support your proposition  
14 that Planned Parenthood should be able to give chemical  
15 abortion drugs simultaneously with a patient with an  
16 ultrasound findings of pregnancy of unknown location.  
17 Did you consider the Goldberg study?

18 A. I believe I did look at the Goldberg study,  
19 but I'd want to see it to be sure.

20 Q. Okay. Copy for you.

21 MS. SWANSON: Thank you.

22 THE WITNESS: Thank you.

23 Q. (Mr. Boyle) And take your time, take a look  
24 at it, and when you're ready, I'll ask you some  
25 questions, please.

1 A. I see the study.

2 Q. Okay. Now that you've reviewed that  
3 document, is that what you were talking about, with the  
4 Goldberg study from 2022, that supports your position  
5 that PPSAT should be able to give chemical abortion  
6 drugs simultaneously with a ultrasound finding of  
7 pregnancy of unknown location?

8 A. This is one of the studies. I believe I  
9 cited two studies on providing medication abortion  
10 concurrent with pregnancy of unknown location.

11 Q. Did you also cite the Boraas study from  
12 Minnesota? Do you recall if -- if that were her study?  
13 I believe Upadhyay, and I'm terrible with names, I  
14 apologize, Upadyay, Upadie (sic), I'm saying that  
15 wrong, I know by the look on your face, but that lady  
16 who is in San Francisco that does a lot of research.  
17 Did you consider that report also?

18 MS. SWANSON: Object to form.

19 THE WITNESS: Without seeing the actual  
20 document ---

21 MR. BOYLE: Conceded.

22 THE WITNESS: --- I'm not comfortable  
23 confirming that this is the study.

24 Q. (Mr. Boyle) Okay.

25 A. There was a second study that I did cite.

1 Q. Okay. Well, if it's that one, then that one  
2 was published in 2023, and this Goldberg study was  
3 published in 2022, right?

4 MS. SWANSON: Object to form.

5 THE WITNESS: I can see that this study  
6 was published in 2022.

7 Q. (Mr. Boyle) Are you aware of any other  
8 studies from prior to 2022 that would support PPSAT's  
9 position on this?

10 A. I do not have knowledge of all of the full  
11 literature on this topic.

12 Q. When you look at this study, it's a  
13 retrospective cohort study of medical records from  
14 Massachusetts Planned Parenthood related to giving  
15 chemical abortion drugs to a patient with a pregnancy  
16 of unknown location. And I was wrong on the dates. It  
17 was from 2014 to 2019. Is that correct?

18 A. That is what I understand this study to be.

19 Q. Okay. And if you turn to Page Number 779,  
20 the second to last page, please. It's -- yeah. And  
21 you look on the left-hand column, there's a paragraph  
22 that starts with, "Additionally". Do you see that?

23 A. On the left-hand column, a ---

24 Q. I'm sorry.

25 A. --- paragraph ---

1 Q. Right. Right.

2 A. --- that starts ---

3 Q. Right.

4 A. --- with, "Additionally"?

5 Q. Right.

6 A. Yes, on the right-hand column, I do.

7 Q. Okay. And I'm going to read that and then  
8 ask you a question. Quote, "Additionally, some  
9 patients who present with undesired pregnancies of  
10 unknown location may never require an abortion.

11 "We found that 18 percent of patients in the  
12 delay for diagnosis group were eventually diagnosed  
13 with early pregnancy loss, and eight percent with  
14 ectopic pregnancy. Thus, collectively, 26 percent did  
15 not require abortion," end quote.

16 Did I read that correctly?

17 A. You did correctly read that.

18 Q. And if you extrapolate that, that would  
19 suggest that possibly a quarter of the patients that  
20 you are treating with pregnancies of unknown location  
21 with chemical abortion drugs, one out of four of them  
22 don't actually need those drugs, do they?

23 MS. SWANSON: Object to form.

24 THE WITNESS: In my clinical experience,  
25 and in my education of patients, I discuss with them

1 that they may be having a miscarriage, as I mentioned,  
2 or they may have an ectopic pregnancy, neither of which  
3 would be treated by the medications we use.

4 And in my clinical experience, my patients  
5 are exceedingly anxious to complete their abortion, and  
6 those who choose the option of medication abortion in  
7 the setting of pregnancy of unknown location, are doing  
8 so aware of that and wanting to take the chance that  
9 this might actually end their pregnancy, rather than  
10 delay their treatment and thus delay their ability to  
11 end their pregnancy, especially in the setting of bans.

12 Q. (Mr. Boyle) And I appreciate all of that and  
13 understand your position. I believe my question is a  
14 little bit more specific than that.

15 Doesn't this research support a conclusion  
16 that up to a quarter, one out of four of those patients  
17 who you are giving chemical abortion drugs to when you  
18 have a pregnancy of unknown location, if you just  
19 waited until you either ruled it in or ruled it out,  
20 they wouldn't have needed those medications, right?

21 MS. SWANSON: Object to form.

22 THE WITNESS: I believe that this data  
23 show that in this study, a quarter of the patients may  
24 not have needed the medication and that every patient  
25 should have the right to make the decision that is

1 right for them once they have the medical information.

2 Q. (Mr. Boyle) Well, I only bring up this  
3 study, because you said you relied on it to support  
4 your position of giving the chemical abortion drugs to  
5 a patient with a pregnancy of unknown location on  
6 ultrasound, right?

7 A. Correct.

8 Q. And part of this also says that maybe up to  
9 25 percent of them don't need that, right?

10 A. Which is why patients are informed of the  
11 differential diagnosis before they make the decision  
12 that is right for them.

13 Q. There's a risk associated with giving a  
14 patient chemical abortion drugs every time they get it,  
15 even if they are indicated and needed, right?

16 MS. SWANSON: Object to form.

17 THE WITNESS: Every treatment and every  
18 decision to not treat carries a risk, because the  
19 decision to not treat is also a decision.

20 Q. (Mr. Boyle) Eight percent of the people he  
21 studied, Goldberg and his group studied, who had  
22 ectopic pregnancies and waited, they didn't get the  
23 chemical abortion drugs. And if they had gotten them,  
24 it actually would have been contraindicated for them  
25 under that circumstance, right?

1 MS. SWANSON: Object to form.

2 THE WITNESS: First of all, I believe  
3 Dr. Goldberg uses she pronouns. Second, the 8 percent  
4 of ---

5 MR. BOYLE: I'm sorry. I apologize. I  
6 had never looked at the first name, and that was very  
7 sexist of me. I apologize.

8 THE WITNESS: So the medication abortion  
9 in 8 percent of patients who had an ectopic pregnancy,  
10 the medication abortion would not treat that ectopic  
11 pregnancy. Medication abortion is contraindicated when  
12 you know you have an ectopic pregnancy, but it does not  
13 cause harm itself to an ectopic pregnancy, nor does it  
14 treat an ectopic pregnancy.

15 Q. (Mr. Boyle) But there are some associated  
16 risks with the mere fact of taking mifoprex (sic) and  
17 misoprostol, right?

18 MS. SWANSON: Object to form.

19 THE WITNESS: Any medication that is  
20 taken does carry potential risks, including  
21 mifepristone and misoprostol.

22 Q. (Mr. Boyle) You would agree that there's at  
23 least some consensus today that a patient with a  
24 pregnancy of unknown location should not be given  
25 chemical abortion drugs until serial ultrasounds are



1 taken to either rule in ectopic pregnancy or rule it  
2 out, wouldn't you?

3 MS. SWANSON: Object to form.

4 THE WITNESS: No.

5 Q. (Mr. Boyle) You agree there's no ACOG  
6 Bulletin that says that it's okay to give a patient  
7 with a pregnancy of unknown location chemical  
8 medication -- or chemical abortion drugs, right?

9 MS. SWANSON: Object to form.

10 THE WITNESS: I am not familiar with the  
11 contents of every ACOG Bulletin.

12 Q. (Mr. Boyle) I'm just going to be willing to  
13 bet that if there was an ACOG that supported that  
14 position, you would have included it in your  
15 Declaration, right?

16 MS. SWANSON: Object to form.

17 THE WITNESS: I did not read all of the  
18 ACOG Bulletins in my preparation for this Declaration.

19 Q. (Mr. Boyle) Fair enough. And if there had  
20 been one that said that was okay, or the common  
21 practice, don't you think you would have included it?

22 MS. SWANSON: Object to form.

23 THE WITNESS: That's speculation. I'm  
24 not familiar with all of the ACOG Bulletins.

25 Q. (Mr. Boyle) Okay. So if you turn to Page

1 780, the last page of the Goldberg study.

2 A. 780?

3 Q. 7-8-0. This one.

4 A. Yes.

5 Q. Okay. If you look at the last sentence, it  
6 says, quote, "Given that both management strategies are  
7 reasonably safe and effective, and that each carries  
8 benefits and risks, our data informed shared decision  
9 making and enabled choices heavily weighted toward  
10 patient priorities and preferences," end quote.

11 Do you see that?

12 A. I see that statement.

13 Q. And that means that Goldberg, she may have  
14 found that it's okay to give chemical abortion  
15 medications to a patient with pregnancy of an unknown  
16 location, but she also found that it's also -- it's  
17 also reasonable and safe to wait, didn't she?

18 A. What I read -- understand that statement to  
19 say is that patients should be informed of their  
20 options and make a choice that works best for their  
21 preferences and their personal medical condition.

22 Q. And the choice is between getting chemical  
23 abortion drugs with a pregnancy of unknown location  
24 ultrasound finding before you confirm intrauterine or  
25 waiting and confirming intrauterine or ruling in

1 ectopic, right? Those are the two choices there, one  
2 or the other?

3 MS. SWANSON: Object to form.

4 THE WITNESS: There is -- there are  
5 other choices. She references in this sentence those  
6 two choices.

7 Q. (Mr. Boyle) Yes. I'm -- that's what I'm  
8 talking about. I'm sorry. This sentence, she  
9 references go ahead and taking the chemical abortion  
10 drug or waiting and ruling in or out ectopic pregnancy,  
11 right?

12 MS. SWANSON: Object ---

13 THE WITNESS: I'd like to reread the  
14 paragraph before I answer that question.

15 Q. (Mr. Boyle) Help yourself. Please do.

16 (Witness examines document)

17 A. Actually, I'm going to go back further.

18 All right. Can you repeat your question?

19 Q. (Mr. Boyle) Yes. On Page 780, the end of  
20 the study, she determines that the option that PPSAT is  
21 promoting the giving of chemical abortion drugs while a  
22 patient has an ultrasound finding of pregnancy of  
23 unknown location, option one, versus option two,  
24 waiting and having repeat tests to actually rule in or  
25 rule out ectopic pregnancy with ultrasound. She found

1 that both of them carry risks and benefits, and they're  
2 reasonable safe, didn't she?

3 A. To be clear, Planned Parenthood South  
4 Atlantic offers both options to patients with pregnancy  
5 of an unknown location. We don't only offer medication  
6 abortion in the setting of pregnancy of unknown  
7 location.

8 We offer the patient both options so that  
9 they can, as she says, use shared decision making and  
10 choose the choice that makes the most sense for them.

11 Q. She says both options are reasonably safe and  
12 effective, right?

13 A. Correct.

14 Q. Which would mean that the option in the law  
15 is reasonably safe and effective, right?

16 MS. SWANSON: Object to form.

17 THE WITNESS: It is an option that is  
18 reasonably safe and effective, but significantly limits  
19 the patient and does not provide them with an equally  
20 safe and effective option.

21 Q. (Mr. Boyle) Okay.

22 MR. BOYLE: I don't think I have any  
23 further questions. And I thank you very much for your  
24 time. Other folks may, so you're not off the hook yet,  
25 but close.

1 THE WITNESS: I'd actually love a break  
2 if I can ---

3 MR. BOYLE: Suits me.

4 MS. SWANSON: Yeah. If we could --  
5 could we take maybe a ---

6 THE WITNESS: Twenty?

7 MS. SWANSON: --- 20-minute break?  
8 Yeah.

9 THE COURT REPORTER: It's 2:20 now.

10 MS. SWANSON: Oh. It's 2:20 now?

11 THE COURT REPORTER: Uh-huh.

12 MS. SWANSON: Okay. Then let's take 15  
13 minutes, come back at 2:35, if that's okay?

14 MR. BOYLE: Don't trip -- the unplug ---

15 THE WITNESS: I know. I was actually,  
16 this time, for the first time ---

17 THE VIDEOGRAPHER: Off record.

18 (Brief recess: 2:20 p.m. to 2:41 p.m.)

19 THE VIDEOGRAPHER: On record, 2:41.

20 MS. SWANSON: All right. I have just a  
21 few follow-up questions for Dr. Farris.

22 EXAMINATION

23 BY MS. SWANSON:

24 Q. So Dr. Farris, we've been talking about the  
25 Goldberg study that you cited in your Declaration. Do

1 you have that in front of you?

2 A. Yes, I do.

3 Q. I'd like you to look at Page 780 of the  
4 Goldberg study.

5 A. I see that.

6 Q. And this is the final paragraph that we were  
7 just discussing before the break. Do you see that  
8 paragraph?

9 A. I do.

10 Q. I'm going to read a section of that  
11 paragraph. "There is no reason to mandate that these  
12 patients with pregnancies of unknown location delay  
13 initiating abortion to first obtain a definitive  
14 diagnosis." Do you agree with that statement?

15 A. I do.

16 Q. I'd now like to look at the ACOG Bulletin  
17 that we were discussing earlier. This is ACOG Bulletin  
18 Number 193.

19 A. I have that.

20 Q. I'm on Page E-92.

21 A. Yes.

22 Q. Under Clinical Considerations and  
23 Recommendations, subpart How is an Ectopic Pregnancy  
24 Diagnosed, I'm going to read the first sentence of that  
25 paragraph. "The minimum diagnostic evaluation of a

1 suspected ectopic pregnancy is a transvaginal  
2 ultrasound evaluation and confirmation of pregnancy."

3 Dr. Farris, is a patient with a pregnancy of  
4 unknown location, who has been determined low risk of  
5 ectopic, a suspected -- a patient with a suspected  
6 ectopic pregnancy?

7 A. No, I would not consider them as having a  
8 suspected ectopic pregnancy.

9 Q. So for patients who have obtained an  
10 ultrasound and been determined to have a pregnancy of  
11 unknown location, are those patients with a suspected  
12 ectopic pregnancy?

13 A. No, I would not consider that they are  
14 suspected to have an ectopic pregnancy.

15 Q. Earlier, you testified that at that point,  
16 after an ultrasound has been done and they have been  
17 determined to have a pregnancy of unknown location,  
18 ectopic pregnancy might be on their differential  
19 diagnosis, right?

20 A. That is correct.

21 Q. What do you do to continue to exclude ectopic  
22 pregnancy in your differential diagnosis from that  
23 point?

24 A. We would do serial ultrasounds and/or serial  
25 blood tests for beta HCG.

1 Q. Do you do any additional screening through  
2 questions about the patient's medical history?

3 A. We very carefully screen the patient, both in  
4 their medical history, their pregnancy history, the  
5 history of their last menstrual period and other risk  
6 factors that might put them at higher risk for ectopic  
7 pregnancy.

8 Q. And based on that screening, that ectopic  
9 pregnancy screening, might somebody from the pregnancy  
10 of unknown location category, move to a patient with a  
11 suspected ectopic pregnancy?

12 A. Yes, those screening questions could make me  
13 suspect ectopic pregnancy.

14 Q. And for those patients, would you provide  
15 medication abortion using the pregnancy of unknown  
16 location protocol?

17 A. No, I would not.

18 Q. So for patients who have been screened for  
19 ectopic pregnancy, patients with pregnancies of unknown  
20 location who have been screened for ectopic pregnancy  
21 and determined to be low risk for ectopic pregnancy,  
22 what happens next in your counseling of those patients?

23 A. We counsel the patients that they essentially  
24 have three options. They can undergo what we call a  
25 diagnostic suction, which is performing a procedural



1 abortion and looking to see if we see pregnancy tissue  
2 removed from the uterus.

3 They can undergo a medication abortion while  
4 we concurrently evaluate for the presence of ectopic  
5 pregnancy through serial ultrasounds and serial blood  
6 tests. Or they can choose to wait to initiate abortion  
7 care and only go through the concurrent screening  
8 process of serial ultrasounds and/or blood tests.

9 Q. What additional counseling do you provide to  
10 those patients who do choose to have a medication  
11 abortion with a pregnancy of unknown location?

12 A. We speak to them at length and very carefully  
13 about not only the normal symptoms they should expect  
14 with mifepristone and misoprostol, but also any  
15 abnormal symptoms that might occur with ectopic  
16 pregnancy.

17 We make sure they understand how critical it  
18 is that they seek out care, either by calling us or  
19 going to a local emergency department should they  
20 experience those symptoms.

21 And we also inform them that we will be  
22 closely following up with them about their lab results,  
23 and that it's very important that they answer the phone  
24 when we call so we can check in on how they're doing.

25 Q. Shifting gears a bit. Even if it's true that

1 abortion becomes riskier as pregnancy advances, why  
2 does a hospitalization requirement starting at 12 weeks  
3 of pregnancy undermine patient safety?

4 A. For two reasons. First of all, we know that  
5 outpatient abortion is safe well beyond 12 weeks. We  
6 have plenty of data for that. But the other thing we  
7 know is that when we require abortions to be -- take  
8 place in a hospital, that usually delays their care.  
9 So by delaying their care, we are actually increasing  
10 their incremental risk of those complications.

11 Q. You testified that you consider abortions  
12 after 14 weeks zero days of pregnancy to be D&Es,  
13 correct?

14 A. That's correct.

15 Q. Do you ever provide an abortion, a procedural  
16 abortion, after 14 weeks without the need for  
17 additional instrumentation on top of the aspiration  
18 using a suction cannula?

19 A. Yes. Very frequently.

20 Q. Shifting back to medication abortion for a  
21 moment. What does it mean for mifepristone to be  
22 contraindicated for ectopic pregnancy?

23 A. That means that if you know a patient has an  
24 ectopic pregnancy, or if you strongly suspect a patient  
25 has an ectopic pregnancy, it is not appropriate to give

1 mifepristone and misoprostol, because they will not  
2 treat that condition.

3 Q. In what capacity do you understand yourself  
4 to be testifying here today?

5 A. I am here testifying as an expert on abortion  
6 care, and specifically also as an expert on the  
7 clinical care provided by Planned Parenthood South  
8 Atlantic.

9 Q. You testified that it's not possible to know  
10 in advance whether a patient will experience a  
11 complication from any given procedure. But is it  
12 possible to know in advance whether some patients have  
13 specific medical characteristics that would make them  
14 candidates for obtaining an abortion at a hospital  
15 rather than in the outpatient setting?

16 A. Yes, it is possible to screen patients for  
17 likelihood of complications. And at PPSAT, we screen  
18 all of our patients for different conditions that make  
19 it more likely. If we identify a patient that we feel  
20 is highly likely to experience a complication, we will  
21 refer them rather than performing the abortion in the  
22 outpatient setting.

23 Q. Why haven't you pursued hospital admitting  
24 privileges to provide abortion in North Carolina?

25 A. Hospital admitting privileges are a business

1 agreement, traditionally between an outside or a  
2 community provider who then does a lot of business with  
3 the hospital or has a lot of patients who need to be in  
4 the hospital.

5 It's my experience that very, very, very few  
6 of the patients that I treat need to be seen in a  
7 hospital, so it doesn't make sense for me to enter into  
8 that business agreement.

9 MS. SWANSON: Thank you, Dr. Farris.  
10 I'm going to pause just for a few moments to confirm I  
11 have no further questions.

12 A couple more.

13 Q. (Ms. Swanson) Approximately what percentage  
14 of patients in North Carolina use insurance to pay for  
15 their abortions?

16 A. I don't know exactly, but I believe it is  
17 less than 5 percent.

18 MS. SWANSON: I have no further  
19 questions for you, Dr. Farris.

20 THE WITNESS: I'm sorry, my phone's  
21 buzzing.

22 MR. BOYLE: Just one brief follow-up  
23 there.

24 FURTHER EXAMINATION

25 BY MR. BOYLE:

1 Q. Dr. Farris, you said that the chemical med  
2 -- chemical abortion drugs are contraindicated if you  
3 strongly suspect there is an ectopic pregnancy or if  
4 you confirm that there is ectopic pregnancy. But are  
5 you aware that the FDA regulation label itself actually  
6 says, "if you confirm or suspect there is an ectopic  
7 pregnancy"?

8 MS. SWANSON: Object ---

9 THE WITNESS: I wouldn't ---

10 MS. SWANSON: Object to form.

11 THE WITNESS: I'd need you to show me  
12 the label to be able to say what the label says.

13 Q. (Mr. Boyle) If it says what I'm suggesting,  
14 then you agree that's different than "strongly  
15 suspect," right?

16 MS. SWANSON: Object to form.

17 THE WITNESS: I think that there are  
18 varying degrees of suspicion. So you can have very low  
19 suspicion, where something is in your differential  
20 diagnosis, or you can have a very high suspicion, and  
21 there is a spectrum. I think clinicians should be  
22 using their judgment to determine where on that  
23 spectrum a patient's risk falls.

24 Q. (Mr. Boyle) And I'm just asking though,  
25 specifically, it's different -- you would agree there's

1 a difference if the FDA labels says, "Suspect ectopic  
2 pregnancy," as opposed to what you just said, which was  
3 "strong suspicion," right? There's a difference?

4 MS. SWANSON: Object to form.

5 THE WITNESS: I agree that there is a  
6 difference between the phrase "suspect" and the phrase  
7 "strongly suspect."

8 MR. BOYLE: Okay. No further questions.  
9 Thank you.

10 THE COURT REPORTER: Follow-up?

11 MS. SWANSON: No more for me.

12 THE COURT REPORTER: Okay.

13 THE VIDEOGRAPHER: Off record, 2:51.

14 That concludes the deposition.

15 (Brief recess: 2:51 p.m. to 2:52 p.m.)

16 THE VIDEOGRAPHER: On record, 2:52.

17 THE COURT REPORTER: Is there any other  
18 counsel appearing via Zoom that would like to question  
19 the witness?

20 MR. WILLIAMS: No, thank you.

21 MR. WOOD: This is Michael Wood. No  
22 questions by me.

23 THE COURT REPORTER: Thank you.

24 MS. NARASIMHAN: No questions for  
25 Sripriya Narasimhan.

1 THE COURT REPORTER: Okay. All right.  
2 Thank you, Counselors. This concludes our deposition.

3 THE VIDEOGRAPHER: This concludes the  
4 deposition. The time is 2:52.

5  
6 WHEREUPON, at 2:52 o'clock p.m., the  
7 deposition was adjourned.

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CERTIFICATION

I, Laura Baker, Notary Public in and for the County of Iredell, State of North Carolina at Large, do hereby certify:

That said witness was sworn by me to state the truth, the whole truth, and nothing but the truth, in said cause and appeared before me at the time and place herein aforementioned and the foregoing consecutively numbered pages are a complete and accurate record of all the testimony given by said witness;

That the undersigned is not of kin, nor in anywise associated with any of the parties to said cause of action, nor their counsel, and not interested in the event(s) thereof.

Reading and signing of the testimony was requested.

IN WITNESS WHEREOF, I have hereunto set my hand this 6th day of September, 2023.

*Laura Baker*

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CHAPLIN & ASSOCIATES

Notary No. 202029500095



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WITNESS CERTIFICATION

I, KATHERINE A. FARRIS, MD, do hereby certify,  
That I have read and examined the contents of the  
foregoing pages of record of testimony as given by me  
at the times and place herein aforementioned;

And that to the best of my knowledge and belief,  
the foregoing pages are a complete and accurate record  
of all the testimony given by me at said time, except  
as noted on the attached here (Addendum A).

I have \_\_\_\_ / have not \_\_\_\_ made changes/corrections  
to be attached.

\_\_\_\_\_  
(WITNESS SIGNATURE)

I, \_\_\_\_\_, Notary Public  
for the County of \_\_\_\_\_, State of  
\_\_\_\_\_, do hereby certify:

That the herein-above named personally appeared  
before me this the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_;

And that I personally witnessed the execution  
of this document for the intents and purposes herein  
above described.

\_\_\_\_\_  
NOTARY PUBLIC

My Commission Expires: (SEAL)

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ADDENDUM A

Upon the reading and examination of my testimony as herein transcribed, I note the following changes and/or corrections with accompanying reason(s) for said change/correction:

Page	Line	Is Amended to Read

# EXHIBIT 3

IN THE UNITED STATES DISTRICT COURT  
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA  
CIVIL ACTION NO. 1:23-cv-00480-CCE-LPA

PLANNED PARENTHOOD SOUTH )  
ATLANTIC, ET AL., )  
 )  
Plaintiffs, )  
 )  
vs. )  
 )  
JOSHUA STEIN, ET AL., )  
 )  
Defendants, )  
 )  
-and- )  
 )  
PHILIP E. BERGER, ET AL., )  
 )  
Intervenor- )  
Defendants. )

VIDEOTAPE DEPOSITION OF

MONIQUE WUBBENHORST, M.D., M.P.H.

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1:16 P.M.

WEDNESDAY, AUGUST 30, 2023

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WARD AND SMITH  
751 CORPORATE CENTER DRIVE, SUITE 300  
RALEIGH, NORTH CAROLINA

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Kara Grandin, Esq.  
Peter Im, Esq.  
Vanisha Kudumuri  
Shealyn Massey  
Sam Delaria, Videographer

Stenographically  
Reported By: Discovery Court Reporters and  
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WUBBENHORST		
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## P R O C E E D I N G S

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2  
3 THE VIDEOGRAPHER: We're now on the  
4 record. The time is 1:16, August 30th, 2023.  
5 This is the video deposition of Dr. Monique  
6 Wubbenhorst. Case name is Planned Parenthood  
7 South Atlantic, et al., v. Joshua Stein, et  
8 al.

9 Counsel, if you would please introduce  
10 yourselves.

11 MR. MENDIAS: This is Ryan Mendias with  
12 ACLU on behalf of Dr. Beverly Gray, one of  
13 the plaintiffs in this case.

14 MS. AMIRI: Brigitte Amiri also with  
15 ACLU representing Dr. Gray.

16 MS. GRAUNKE: Kristi Graunke, ACLU  
17 North Carolina, representing all plaintiffs.

18 MR. BENJAMIN WOOD: Benjamin Wood, law  
19 student intern at the ACLU of North Carolina.

20 MR. BOYLE: Ellis Boyle, Wake County  
21 Bar, representing the legislative leader  
22 defendants, Senator Berger and Speaker Moore.  
23 Kevin, you're up.

24 MR. MOORE: South --

25 MR. WILLIAMS: This is Kevin Williams

1 and -- on the Zoom and I am representing  
2 defendant District Attorney Jim O'Neill.

3 MS. PAYNE: Julia Payne --

4 MS. O'BRIEN: Good after- --

5 MS. PAYNE: -- with Alliance --

6 MS. O'BRIEN: Good afternoon. I'm --  
7 if I could just go after Kevin. Good  
8 afternoon. I am Elizabeth O'Brien. I'm  
9 representing the remaining district attorneys  
10 in the lawsuit.

11 MS. PAYNE: Julia Payne with Alliance  
12 Defending Freedom representing the  
13 legislators.

14 MR. MICHAEL WOOD: This is Michael  
15 Wood. I am counsel to Secretary Kinsley from  
16 DHHS.

17 MR. BULLERI: This is Michael Bulleri.  
18 I am counsel for the North Carolina Medical  
19 Board and the North Carolina Board of  
20 Nursing.

21 MS. SALVADOR: This is Anjali Salva- --

22 MR. MOORE: This is South --

23 MS. SALVADOR: Oh, go ahead.

24 MR. MOORE: Sorry. This is South  
25 Moore, North Carolina Department of Justice,

1 representing Attorney General Stein.

2 MS. SALVADOR: This is Anjali Salvador  
3 with Planned Parenthood Federation of America  
4 representing Planned Parenthood South  
5 Atlantic. Also on the Zoom from Planned  
6 Parenthood Federation of America are Kara  
7 Grandin, Peter Im, and then the 11W-13 is a  
8 conference room with our paralegals, Vanisha  
9 Kudumuri and Shealyn Massey.

10 THE REPORTER: Is that everyone?

11 \* \* \*

12 MONIQUE WUBBENHORST, M.D., M.P.H.,  
13 having been first sworn or affirmed by the court  
14 reporter and Notary Public to tell the truth, the  
15 whole truth, and nothing but the truth, testified  
16 as follows:

17 EXAMINATION

18 BY MR. MENDIAS:

19 Q. Good afternoon, Doctor.

20 A. Good afternoon.

21 Q. My name is Ryan Mendias and, like I said, I'm  
22 an attorney with the ACLU. I represent  
23 Dr. Beverly Gray, one of the plaintiffs in  
24 this case. So just some initial housekeeping  
25 questions.

1           You understand that you're under oath  
2           and that you have a legal obligation to  
3           answer everything truthfully and completely?

4           A.    Yes.

5           Q.    I'll ask that you wait until I finish my  
6           question before you start answering and that  
7           way we can avoid talking over one another.

8           A.    Yes.

9           Q.    And if you don't understand a question,  
10          please let me know. I can rephrase or repeat  
11          it and I'll do so.

12          If you do answer a question without  
13          asking for clarification, I will assume that  
14          you've understood it, okay?

15          A.    Yes.

16          Q.    And so please answer all questions verbally  
17          as you've been doing instead of shaking your  
18          head or saying uh-uh or uh-huh.

19          And so during this deposition your  
20          attorney may object, but his objections are  
21          just for the record. So after he makes them,  
22          you should proceed to answer the question.

23          A.    Yes.

24          Q.    And if at any point you realize that an  
25          answer that you previously gave wasn't

1 complete or wasn't fully correct, you should  
2 feel free to stop me and we can go back and  
3 discuss the answer again.

4 Does that sound all right?

5 A. Thank you. Yes.

6 Q. Okay. And if you don't do so, we can assume  
7 that you stand by the accuracy and  
8 completeness of your questions?

9 A. Yes.

10 Q. Great. And if you need a break, please let  
11 me know. We can definitely do that but -- as  
12 long as there's not a question pending. If  
13 there is a question pending, you'll need to  
14 answer the question and then we can proceed  
15 to the break.

16 A. Yes.

17 Q. Okay. Is there anything today that would  
18 prevent you from giving a full and accurate  
19 testimony, medications, illness, anything  
20 like that?

21 A. No.

22 Q. Okay. Is this the first time you've given a  
23 deposition?

24 A. No.

25 Q. When have you given depositions before?

- 1 A. I gave a deposition in 2017 for a Texas case.
- 2 Q. Is that the only deposition that you've
- 3 given?
- 4 A. Yes.
- 5 Q. Okay.
- 6 A. No. I've given one deposition when I was a
- 7 resident that -- no, I wasn't a resident. It
- 8 was -- I graduated from residency. It was
- 9 around 1995 or 1996.
- 10 Q. What was the subject of that deposition?
- 11 A. It was an infant that had delivered in the
- 12 hospital when -- while I was a resident.
- 13 Q. Was it a malpractice case? What -- what sort
- 14 of case was it?
- 15 A. Yeah, I think it was a malpractice case. I
- 16 wasn't very educated about legal questions at
- 17 that time.
- 18 Q. Were you a defendant in that case?
- 19 A. The hospital that I did my residency at,
- 20 which was Yale New Haven Hospital, was the
- 21 def- -- defendant.
- 22 Q. Have you ever participated -- oh, I'm sorry.
- 23 Did you have more to add to that?
- 24 A. I -- I'm not a lawyer so I'm just making sure
- 25 I say the right thing.

1 Q. Sure. Sure. Have you ever participated in a  
2 lawsuit as a defendant?

3 A. No.

4 Q. Have you ever participated in a lawsuit as a  
5 plaintiff?

6 A. No.

7 Q. Have you participated in a lawsuit in any  
8 other capacity?

9 A. No.

10 Q. Well, I assume you've participated as an  
11 expert witness in --

12 A. Oh, as an expert witness --

13 Q. Yes.

14 A. -- but not where it was me --

15 Q. Not as --

16 A. -- personally.

17 Q. -- a party?

18 A. Right.

19 Q. Okay. And when have you participated as an  
20 expert witness in previous lawsuits?

21 A. You mean -- not speaking to giving a  
22 deposition, just being involved? Okay.

23 Q. Correct.

24 A. So let's see. Kentucky -- for the state of  
25 Kentucky, for the state of Minne- --



1 Minnesota. The cases were in the state of  
2 Kentucky, state of Minnesota, state of  
3 Kansas. And I feel like I'm forgetting one.  
4 Kentucky, Minnesota, Kansas. Oh, and Texas,  
5 as I said, uh-huh.

6 Q. And in your role as an expert, have you  
7 testified in court?

8 A. Yes.

9 Q. In which of those cases did you testify in  
10 court?

11 A. Texas.

12 Q. Any others?

13 A. No.

14 Q. And have you testified before any legislative  
15 body?

16 A. Yes.

17 Q. Could you say more about that testimony that  
18 you gave.

19 A. Yes. The Senate Judiciary Committee in --  
20 2007, 2008, or 2009 was their -- I'm sorry.  
21 I --

22 Q. That's all right.

23 A. -- don't know. And then the House of  
24 Representatives last fall and the Senate in  
25 April.

1 Q. And what was the nature of the testimony that  
2 you gave before those legislative bodies?

3 A. I was testifying on the -- abortion safety  
4 and maternal mortality.

5 Q. And is it fair to say that the expert  
6 opinions that you offered in those cases that  
7 we just discussed were in support of laws  
8 restricting or regulating abortion?

9 A. I don't -- no, I don't think so because I  
10 think that in the Senate case, as I  
11 understood it, it was a -- regarding  
12 legislation that was being proposed that  
13 would remove abortion restrictions, as I  
14 understood it.

15 Q. Right. So I think my question is more  
16 specifically about the cases in which you've  
17 been an expert witness so Kentucky, Texas --

18 A. Oh. Oh. Oh. Yes.

19 Q. -- Minnesota.

20 A. Right.

21 Q. And in those cases, you were offering an  
22 opinion in support of abortion restrictions;  
23 is that correct?

24 A. Yes.

25 Q. And the piece of legislation in the Senate

1           that you mentioned, is that the Women's  
2           Health Protection Act?

3           A.    That's correct.

4           Q.    And were you in favor or opposition of  
5           that --

6           A.    I was --

7           Q.    -- act?

8           A.    -- in opposition. I'm sorry. Didn't mean  
9           to --

10          Q.    Oh, no, no.

11          A.    -- speak too early.

12          Q.    Totally fine. Thank you. So you're aware  
13               that the Speaker of the North Carolina House  
14               of Representatives and the President of the  
15               North Carolina Senate have intervened in this  
16               litigation to defend the constitutionality of  
17               several laws relating to abortion; is that --

18          A.    Yes.

19          Q.    Okay. So if I say the intervenors, can we  
20               agree that I'm referring to those  
21               individuals, the Speaker and the Senate  
22               President?

23                       MR. BOYLE: Object to form.

24          A.    I'm sorry. I don't understand what you mean.

25          Q.    So I might refer to the intervenors, who your

1 attorney here is counsel for --

2 A. Uh-huh.

3 Q. -- as the intervenors. When I say the  
4 intervenors, I mean the President of the  
5 North Carolina Senate --

6 A. Uh-huh.

7 Q. -- and the Speaker of the House of North  
8 Carolina's House of Representatives.

9 A. Yes.

10 MR. BOYLE: Object to form. You can  
11 answer.

12 BY MR. MENDIAS:

13 Q. So when were you first contacted by counsel  
14 for intervenors about participating in this  
15 case?

16 A. I would have to look at my scheduler.

17 Q. Was it months ago, weeks ago?

18 A. Let's see. This is now August. It was no  
19 more than two months ago, but, again, I -- I  
20 can't -- you can't hold me to that because I  
21 would have to look at my scheduler. I -- I  
22 don't want to not respond truthfully.

23 Q. I understand. Thank you. Who have you been  
24 communicating with regarding this -- your  
25 participation in this case?

1 A. Julia Payne, who's counsel for ADF, and  
2 Attorney Ellis.

3 Q. And are you being paid for your participation  
4 in this case?

5 A. Yes.

6 Q. How much are you being paid?

7 A. \$700 an hour.

8 Q. And roughly how many hours have you spent  
9 preparing for this case so far?

10 A. More than 30.

11 Q. And did you bring anything with you to this  
12 deposition?

13 A. Yes.

14 Q. What did you bring?

15 A. I brought my declaration, which is here.  
16 Would you like to see it?

17 Q. No. It's all right.

18 A. Okay. And then I brought ACOG Practice  
19 Bulletin 193, a study by Alisa Goldberg, a  
20 study by Ushma Upadhyay, and a study by Karen  
21 Borchert.

22 Q. Okay. And I have my own copy, but I think  
23 the answer will be yes.

24 MR. MENDIAS: But I will just ask that  
25 this be marked as Exhibit B.

1 (WUBBENHORST EXHIBIT B, Declaration of  
2 Monique Chireau Wubbenhorst, M.D., M.P.H.,  
3 was marked for identification.)

4 BY MR. MENDIAS:

5 Q. But can you confirm that this is an accurate  
6 copy of the declaration that you submitted in  
7 this case.

8 A. It looks as though it is, yes.

9 MR. MENDIAS: Oh, and then I have a  
10 copy for you, Ellis, as well.

11 MR. BOYLE: Thanks.

12 BY MR. MENDIAS:

13 Q. Can you please describe the process of  
14 drafting this declaration.

15 A. The process. In other words, how I arrived  
16 at my opinion? Is that what you mean?

17 Q. I mean more specifically how you went about  
18 writing the -- this particular document.

19 A. So I had at hand the declarations from  
20 Dr. Alsle- -- Dr. Boraas, actually, I'm  
21 sorry, and Dr. Farris. I reviewed those, I  
22 reviewed the studies that they cited, and  
23 then I did a literature search on the topics  
24 that they discussed, used the snowball  
25 technique to add additional studies and used

1 the -- distilled those into my declaration  
2 and my opinion.

3 Q. And what keywords did you use in doing that  
4 search?

5 A. I looked at abortion complications. I looked  
6 at terms abortion plus complications,  
7 abortion-related mortality, ectopic  
8 pregnancy, pregnancy of unknown location.  
9 And there -- I'm sure there were others, but  
10 those -- those were the major -- some of the  
11 main ones.

12 Q. Did anyone provide any particular studies  
13 they wanted you to cite in this expert  
14 declaration?

15 A. No.

16 Q. Did anyone ask that you include a particular  
17 fact or opinion in this declaration?

18 A. No.

19 Q. And I'd like to talk about your CV, which I  
20 will ask to be marked, please.

21 (WUBBENHORST EXHIBIT C, Curriculum  
22 Vitae, was marked for identification.)

23 MR. MENDIAS: Thank you.

24 BY MR. MENDIAS:

25 Q. Is this an -- look like a -- oh, sorry.

1 MR. BOYLE: Thank you.

2 BY MR. MENDIAS:

3 Q. Does this look like an accurate copy of the  
4 CV that was attached to your expert  
5 declaration?

6 A. Yes.

7 Q. Okay. And I note that the date is May 25th,  
8 2023.

9 A. Uh-huh.

10 Q. Is this the most recent version of your CV?

11 A. No, there's a more recent version.

12 Q. What would have changed between that version  
13 that you submitted and -- and the most recent  
14 version?

15 A. I think I discovered an error in my previous  
16 CV. There was a hospital that I worked at in  
17 North Carolina that I hadn't listed on my CV.  
18 It's -- I believe it was Moses Cone Hospital.  
19 I'm actually in the process of updating it  
20 now.

21 Q. And when did you work at Moses Cone Hospital?

22 A. 2004, 2005. I was there once as a locum  
23 tenens.

24 Q. And I note on your CV as well that you're a  
25 fellow of the American College of



1           Obstetricians and Gynecologists, which I'll  
2           refer to as ACOG; is that accurate?

3           A.    Yes.

4           Q.    And what is ACOG?

5           A.    It is a professional organization that  
6           many -- I think most OB/GYNs but not all  
7           belong to in the United States.

8           Q.    And you've presented papers at ACOG  
9           conferences; is that correct?

10          A.    That's correct.

11          Q.    Do you believe that ACOG is a reliable source  
12          of information for OB/GYNs?

13          A.    Not always.

14          Q.    On which topics is it not reliable?

15          A.    I think that in terms of their abortion  
16          advocacy, they do not always reflect the --  
17          the, I would say, preferences and practices  
18          of their constituency.

19          Q.    Are there any other topics besides abortion  
20          that you find ACOG to be unreliable on?

21          A.    I haven't reviewed all of their literature so  
22          I couldn't answer that.

23          Q.    But of the literature that you've reviewed,  
24          you find it all reliable except for abortion;  
25          is that correct?

1 A. I think that there are some areas that I  
2 couldn't bring to mind at this exact moment  
3 where I would say that they have not cited  
4 all of the available literature.

5 Q. Is there -- can you give any inkling as to  
6 what those areas might be?

7 A. I would have to go back because I haven't  
8 looked at those areas recently.

9 Q. I understand. To be a member of ACOG, does  
10 a -- an OB/GYN need to express any particular  
11 view of abortion?

12 A. No.

13 Q. So ACOG then has members who are opposed to  
14 abortion?

15 A. Actually, the vast majority do not perform  
16 abortions.

17 Q. My question was whether they have members who  
18 are opposed to abortion.

19 A. Yes, they do.

20 Q. Great. You also indicate on your CV that  
21 you're a member of the American Association  
22 of Pro-Life Obstetricians and Gynecologists,  
23 which --

24 A. Yes.

25 Q. -- I'll refer to as AAPLOG; is that correct?

1 A. Yes.

2 Q. And you actually served on their board. Is  
3 that right, too?

4 A. Yes.

5 Q. How long was your time as a board member?

6 A. I want to say about three years.

7 Q. And was it continuous or did you have various  
8 stints as a board member?

9 A. No. It was continuous.

10 Q. And what did your duties as a board member of  
11 AAPLOG include?

12 A. They were most -- similar to any board. We  
13 oversaw the activities of the organization,  
14 coordinated with the CEO, reviewed scientific  
15 papers that AAPLOG put out, among others.  
16 AAPLOG is A-A-P-L-O-G. Yeah.

17 Q. Thank you for that. Could a physician become  
18 a member of AAPLOG if they did not oppose  
19 abortion?

20 A. I don't know.

21 Q. What if I -- I'm going to introduce another  
22 exhibit. This, I believe, is Exhibit --  
23 so...

24 MR. MENDIAS: Thank you.

25 (WUBBENHORST EXHIBIT D, AAPLOG Mission

1           & Vision Statement, was marked for  
2           identification.)

3       BY MR. MENDIAS:

4       Q.     Does this look like the mission and vision  
5           statement of AAPLOG?

6       A.     It does.

7       Q.     Okay.

8       A.     But I can't confirm that because I haven't  
9           looked at it in a while.

10      Q.     Okay. Do you remember what the mission and  
11           vision of AAPLOG was when you were on the  
12           board?

13      A.     I think similar to what's here. And, again,  
14           not being able to quote it because it's been  
15           some time, it was to defend the lives of the  
16           pregnant mother and her unborn child.

17      Q.     And that necessarily means prohibiting  
18           abortion in most circumstances, correct?

19      A.     Yes.

20      Q.     Okay. And I actually have another exhibit.

21                       (WUBBENHORST EXHIBIT E, AAPLOG  
22           Practicing Physician of any Specialty Form,  
23           was marked for identification.)

24      BY MR. MENDIAS:

25      Q.     And, Dr. Wubbenhorst, do you recognize this

1 document, if not necessarily its particular  
2 form, what it is with respect to AAPLOG?

3 A. Yeah. I haven't -- I -- it's been a while  
4 since I've seen this so I don't know if this  
5 is the current one or not.

6 Q. But when you say one, what -- one of what?  
7 What do you mean?

8 A. Well, this looks like the form that you would  
9 use to join --

10 Q. Okay.

11 A. -- but it's been -- I've been a member for  
12 some time so I can't speak to this.

13 Q. But you would have filled something similar  
14 out when you became a member, correct?

15 A. Yes.

16 Q. And physicians joining the organization while  
17 you were on the board would have filled out a  
18 similar form --

19 A. Uh-huh.

20 Q. -- correct?

21 A. Yes. Sorry.

22 Q. And could you read the first sentence under  
23 the heading, Practicing Physician of any  
24 Specialty?

25 A. Practicing Physician of any Specialty --

1 Physicians of any Specialty are those  
2 Physicians (either M.D. or D.O.) who agree  
3 with our mission statement and su- -- support  
4 AAPLOG with annual dues and donations.

5 Q. And as we just discussed, AAPLOG's mission  
6 statement includes prohibiting abortion; is  
7 that right?

8 A. I don't think it's prohibiting abortion. I  
9 think it's restricting abortion or advocating  
10 for the life of the mother and the unborn  
11 child.

12 Q. Okay. So restricting.

13 You were also on the board of Americans  
14 United for Life, which I'll refer to as AUL;  
15 is that correct?

16 A. That's correct.

17 Q. You're currently on the board?

18 A. Yes.

19 Q. And what are your duties on that board?

20 A. So it is to oversee the -- the board oversees  
21 the activities of the organizations -- of the  
22 organization and also works with the CEO in  
23 accomplishing its mission.

24 Q. And what is the mission of AUL?

25 A. It is to serve as the architects of the

1 pro-life movement or --

2 Q. And -- I'm sorry. Did you have more to say  
3 that --

4 A. No.

5 Q. Apologies if I cut you off at all. When you  
6 say, architects of the pro-life movement,  
7 what does that specifically mean?

8 A. Well, I think I'm not articulating very  
9 clearly, you know, what the mission is.  
10 That's kind of what I would call the general  
11 way that they -- general -- how they're seen  
12 and how they see themselves. I would have to  
13 review the curr- -- the mission statement to  
14 give you a precise answer. I don't want to  
15 give you an imprecise answer.

16 Q. So speaking generally, what is it that the  
17 organization hopes to accomplish in this  
18 country?

19 A. It supports legislation supporting the life  
20 of the wo- -- woman and her unborn child.

21 Q. And is it true that AUL advocates for what  
22 they call abortion abolition?

23 A. I don't know.

24 Q. Does AUL believe that abortion should be a  
25 matter of state law as opposed to something

1 regulated at the federal level?

2 A. I think that they consider both pathways --  
3 I'm sorry. I saw your cup that said,  
4 Pathways, and that's what came into my mind.  
5 I think they consider both strategies.

6 Q. And whether it's a pathway or a strategy,  
7 what is the ultimate goal of AUL?

8 A. I think it's to promote life.

9 Q. Not to ban abortion nationwide?

10 A. I would say that if you were to ask members  
11 of the board and people working in the  
12 organization that, similar to AAPLOG, it is  
13 to advocate for the life of the unborn child  
14 and for the mother.

15 Q. Okay. I'm -- I'm going to play a video  
16 briefly and I'll ask the court reporter how  
17 best to --

18 MR. MENDIAS: Do you mind if we go off  
19 the record to discuss how we do this? We  
20 can...

21 THE VIDEOGRAPHER: Going off the  
22 record. The time is 1:37.

23 (Discussion off the record.)

24 THE VIDEOGRAPHER: Back on the record.  
25 The time is 1:37.



1 MR. MENDIAS: All right. And I will  
2 mark this as the next exhibit.

3 (WUBBENHORST EXHIBIT F, AUL Video Clip,  
4 was marked for identification.)

5 (Video played and stopped.)

6 BY MR. MENDIAS:

7 Q. Dr. Wubbenhorst, do you believe that that  
8 fairly represents the mission of AUL?

9 MR. BOYLE: Objection. Are you saying  
10 that's an AUL document?

11 MR. MENDIAS: It -- I am, yes.

12 MR. BOYLE: Can you establish that  
13 first, please. Sorry. Not to --

14 BY MR. MENDIAS:

15 Q. Does this -- or do you recognize this video  
16 at all?

17 A. Yeah. I have seen it, yes.

18 Q. And it is from AUL?

19 A. Uh-huh.

20 Q. Correct?

21 A. I'm sorry. Yes.

22 Q. Thanks. So do you believe that this  
23 accurately encapsulates the mission of AUL?

24 A. Yes.

25 Q. Do you agree with this mission?

1 A. Yes.

2 Q. And so I take that to mean that you  
3 personally oppose abortion in all  
4 circumstances?

5 A. Yes.

6 Q. In fact, you believe that abortion is a moral  
7 and social evil, correct?

8 A. Yes.

9 Q. Is it fair to say that you believe abortion  
10 is murder?

11 A. I think it's a nuanced question. I think  
12 that if you are saying -- and, again, I'm not  
13 a lawyer, but are you referring to the mother  
14 who has the abortion or are you referring to  
15 the abortionist who performs the abortion?

16 Q. Let's deal with them one by one. Do you  
17 think a woman who seeks and obtains an  
18 abortion has committed murder?

19 A. No.

20 Q. Do you think a physician who performs an  
21 abortion has committed murder?

22 A. Yes.

23 Q. Do you believe that what you might call  
24 elective abortions should be illegal in all  
25 circumstances?

1 A. Yes.

2 Q. Does that include cases where the pregnancy  
3 is the result of rape or incest?

4 A. Yes.

5 Q. And that would include cases no matter the  
6 age of the rape victim?

7 A. I'm sorry.

8 Q. Would you oppose abortion in a case where  
9 pregnancy is the result of rape or incest  
10 when the rape victim is a child?

11 A. Yes, because I have taken care of minors who  
12 were the victims of incest who chose to carry  
13 their children to term and said that this --  
14 they -- in particular, they've told me two  
15 things. They said that, without this baby, I  
16 would not have evidence that he did it, and,  
17 I also feel that this child is redeeming this  
18 circumstance -- this terrible circumstance  
19 that has happened to me.

20 Q. Do you believe that all child victims of rape  
21 feel the same way about carrying their  
22 rapist's baby to term?

23 A. I can't speak for how all child victims feel.

24 Q. Do you think it's possible that some would  
25 not feel that way?

1 A. I think it's possible.

2 Q. And do you think that delivering a child is  
3 the only way to establish the paternity of a  
4 rapist?

5 A. I'm not understanding your question. Without  
6 DNA, how would you establish paternity?

7 Q. Do you believe that DNA can only be obtained  
8 from a child that has been delivered?

9 A. I think that there are techniques now for  
10 confirming paternity, but at the time that I  
11 was speaking of with these children, that  
12 technology was not available.

13 Q. Do you think that when an abortion is  
14 performed, a -- that there is a way to  
15 determine forensically who the rapist was  
16 based on the products of conception?

17 A. That's not what I'm -- what I was saying. I  
18 was telling you what a patient had actually  
19 told me.

20 Q. Okay. But you would agree that after an  
21 abortion, the products of conception can be  
22 used to identify the rapist?

23 A. Yes.

24 Q. And do you believe that all abortions, even  
25 those that have no medical complications,

1           cause harm to women?

2           A.    Yes.  That's based on my clinical experience  
3           of caring for thousands of woman.  I've never  
4           met a woman who was happy that she had an  
5           abortion.  Relieved?  Yes.  Feeling as though  
6           she couldn't do anything else?  Yes.  But all  
7           women to one degree or another were damaged  
8           by that experience, some very damaged, some  
9           not so much.

10          Q.    When you say women were relieved, what about  
11          their relief made you think that they were  
12          damaged?

13          A.    Because they all expressed sorrow at having  
14          undergone the abortion and many of my  
15          patients report that every year when that  
16          child would have been born, they have a  
17          ceremony to mourn their death.

18          Q.    What percentage of patients would you say  
19          have disclosed to you that they had an  
20          abortion?

21                       MR. BOYLE:  Object to form.

22          BY MR. MENDIAS:

23          Q.    You can answer.

24          A.    I'm not understanding the question.  You mean  
25          if I asked -- you -- you're talking about

1 patients that I ask?

2 Q. How did you come to know that those patients  
3 had had abortions?

4 A. I routinely ask them.

5 Q. And in answering that question, do you then  
6 ask how they felt about their abortion  
7 experience?

8 A. I do.

9 Q. All of them?

10 A. Yes.

11 Q. Are you currently practicing medicine?

12 A. Yes.

13 Q. Where?

14 A. Indiana.

15 Q. Where specifically in Indiana are you  
16 practicing medicine?

17 A. Saint Joseph's Regional Medical Center.

18 Q. And what do you do there?

19 A. I'm a hospitalist there.

20 Q. And what does that mean?

21 A. I cover the labor floor in shifts and any  
22 women that come in through the emergency room  
23 or come into triage or who are laboring, I  
24 provide backup for the other clinicians or we  
25 have our own practice where we care for those

1 patients in labor as well. And I also  
2 practice internationally.

3 Q. You don't perform abortions, do you?

4 A. No.

5 Q. And you've never performed an abortion?

6 A. No.

7 Q. Have you ever observed a physician performing  
8 an abortion?

9 A. Yes.

10 Q. How many?

11 A. One.

12 Q. In residency were you offered the opportunity  
13 to learn how to perform an abortion?

14 A. Yes.

15 Q. And you declined that opportunity?

16 A. Yes.

17 Q. What -- have you ever induced labor in a  
18 pregnant patient before the fetus was viable?

19 A. Yes.

20 Q. In what circumstance would you have to do  
21 that?

22 A. Would I or have I?

23 Q. Have you?

24 A. Where a woman had infection and needed to be  
25 delivered because she had clear signs of

1           chorioamnionitis.

2           Q.    And do you remember how far along in her  
3           pregnancy this patient was?

4           A.    She was between 21 and 23 weeks.

5           Q.    You don't consider induction in that  
6           circumstance to be an abortion?

7           A.    No, because of the principle of double  
8           effect.

9           Q.    Could you say more about what that is.

10          A.    It means that when your intention is to save  
11          the life of the mother, the outcome of fetal  
12          death may be an unavoidable and tragic  
13          consequence, but that is not the intent,  
14          whereas, in abortion, the intent is clearly  
15          the death of the unborn child.

16          Q.    Where -- do you think that some physicians  
17          would call induction in that circumstance an  
18          abortion?

19          A.    I can't say.

20          Q.    How do you --

21          A.    I think they would. I think there are some  
22          people that would say that.

23          Q.    Have you ever performed a dilation and  
24          curettage procedure on a patient?

25          A.    Yes.



1 Q. In what circumstances have you performed a --  
2 a dilation and curettage?

3 A. Can you be more specific? Are you referring  
4 to a living fetus or a dead fetus?

5 Q. I'm talking about any time that you've  
6 performed that particular procedure.

7 A. Yes.

8 Q. So in what circumstances have you performed a  
9 D&C, either for a living or dead fetus?

10 A. Hemorrhage, a woman who was infected with a  
11 demised fetus in the second trimester. And  
12 I -- if you can clarify, you're referring  
13 strictly to D&C in pregnancy, not D&C in a  
14 nonpregnant woman?

15 Q. Correct.

16 A. Okay.

17 Q. Thank you for that clarification. So have  
18 you ever performed a D&C when there is  
19 embryonic or fetal cardiac activity?

20 A. No.

21 Q. Do you believe that physicians who perform  
22 abortions are degraded by the pos- --  
23 procedure?

24 A. I do. And I have a great deal of sympathy  
25 for them. I feel that many people -- it's --

1           it's very interesting. When you look at  
2           statistics, people graduate from residency  
3           and a high percentage stopped -- planning to  
4           do abortions and a high percentage stopped  
5           doing abortions within five years. And I  
6           think others really feel very -- speaking to  
7           physicians who were abortionists who then  
8           decided to leave -- stop becoming  
9           abortionists, they've described to me how  
10          they felt terrible going to work every day,  
11          they felt morally conflicted, so I have a  
12          great deal of sympathy for them.

13        Q.    About how many physicians who previously  
14              provided abortions but no longer do have you  
15              spoken to?

16        A.    Five.

17        Q.    Five. When you provide medical care in the  
18              hospital, you've -- do you encounter patients  
19              who were referred to your care from the  
20              emergency room?

21        A.    Are you -- you're talking about obstetrical  
22              patients?

23        Q.    Correct.

24        A.    Yes.

25        Q.    And throughout your career, how many do you

1 think you have encountered who are  
2 transferred from the ER to your service?

3 A. So you're referring to my current practice in  
4 the first -- let me -- when you asked me the  
5 question the first time, you said right now.  
6 Are -- were you referring to my current  
7 practice?

8 Q. I'm not sure if I said right now and if I  
9 did, I misspoke. I meant throughout the  
10 entirety of your medical career.

11 A. Have I -- just to make sure I understand, so  
12 have I cared for patients who were referred  
13 through the emergency room?

14 Q. Correct.

15 A. Yes.

16 Q. And my question is, about how many over  
17 your --

18 A. Thousands.

19 Q. Thousands. Is it more than 10,000?

20 A. No, less than 10,000. Somewhere between  
21 probably 5- and 10,000.

22 Q. And about how many of those patients were in  
23 North Carolina?

24 A. I would have to think because I practiced in  
25 nine hospitals in North Carolina but a total

1 of close to 30 hospitals elsewhere. So it --  
2 I -- I would have to think about that.

3 Q. If I give you a few seconds or a minute, do  
4 you think you could come up with a ballpark?

5 A. It would be quite a few. It would be quite a  
6 few, yeah.

7 Q. Would you say closer to a hundred or a  
8 thousand?

9 A. It would be more than a hundred, probably  
10 considerably more than a hundred --

11 Q. So --

12 A. -- because I was a solo practitioner at many  
13 of these hospitals when the covering OB/GYN  
14 went out of town.

15 Q. And so would it be closer to 500 or a  
16 thousand?

17 A. It's somewhere in that range, yeah.

18 Q. Okay. And so out of all the patients -- now  
19 I'm talking in any hospital in any state that  
20 you've described as --

21 A. Or country.

22 Q. -- in -- or country. I -- I would like to  
23 limit in -- to the United States so any  
24 state.

25 A. The pathologies are the same, though.

1 Q. Sure. I'm specifically wondering about  
2 patients transferred from emergency rooms to  
3 your obstetrical service.

4 A. Right.

5 Q. Does that -- does that alter the number of  
6 patients --

7 A. No, because I've practiced --

8 Q. -- you --

9 A. -- more here than --

10 MR. BOYLE: Object to form. You can  
11 answer.

12 BY MR. MENDIAS:

13 Q. Sure. So I believe you said it was thousands  
14 of patients throughout your career.

15 A. Yeah. I've been in practice more than 30  
16 years.

17 Q. Okay. And of -- out of those thousands of  
18 patients, how many have you encountered who  
19 were experiencing complications from an  
20 induced abortion?

21 A. None from an induced abortion. From  
22 procedural abortion, yes.

23 Q. Okay. From an abortion of any kind?

24 A. Yes.

25 Q. How many?

1 A. Two.

2 Q. Two.

3 A. No. More than two. Yeah, more than two.

4 Let me just think for a minute.

5 Q. Sure.

6 A. I'd say ten or less.

7 Q. Ten. Dr. Wubbenhorst, do you recall earlier  
8 you said that you were -- you participated in  
9 a deposition in Texas?

10 A. Yes.

11 Q. Is that correct? Okay.

12 MR. MENDIAS: So I'm going to mark the  
13 transcript of that deposition as an exhibit.

14 (WUBBENHORST EXHIBIT G, Deposition  
15 Transcript of Monique Chireau, M.D., October  
16 14, 2017, was marked for identification.)

17 BY MR. MENDIAS:

18 Q. So, Dr. Wubbenhorst, you'll see that the  
19 numbers are on the top right of each page and  
20 that there are four pages per printed page.  
21 So direct you to Page 138. So it would be in  
22 the top right. Are you there?

23 A. Yes.

24 Q. Okay. So beginning with Line Number 9,  
25 there's a question. Have you ever managed a

1 patient who is experiencing a complication  
2 from an induced abortion?

3 A. Yes.

4 Q. Your answer was, Yes?

5 A. Uh-huh.

6 Q. And then the question was, How many times?

7 A. Right.

8 Q. And then you answered, Probably four times.

9 A. Yes.

10 Q. So are you suggesting now that it was  
11 actually ten times or have --

12 A. No. I've seen --

13 Q. -- there been --

14 A. -- more patients --

15 MR. BOYLE: Objection.

16 A. -- with --

17 MR. BOYLE: You can answer.

18 A. Yeah. I'm not suggesting that this was  
19 incorrect. I'm saying that I've seen more  
20 patients since then.

21 Q. Okay. Where have you seen those patients?

22 A. Internationally.

23 Q. Internationally. In the United States, have  
24 you seen any patients --

25 A. No.

1 Q. -- suffering from -- okay. And have you seen  
2 any patients experiencing complications from  
3 an abortion of any type in North Carolina?

4 A. No.

5 Q. So just because I know that your CV might be  
6 a little out of date, I wanted to ask, are  
7 you currently a senior research associate at  
8 the Center for Ethics and Culture at the  
9 University of Notre Dame?

10 A. Yes. Well, my job title has changed. I  
11 think I'm a senior fellow.

12 Q. Okay. What does that position entail?

13 A. I use -- I'm still do- -- I'm doing research  
14 and so I have an office at Notre Dame and I  
15 have access to -- I work with people in the  
16 center on different projects and I use Notre  
17 Dame's considerable resources to carry out my  
18 research.

19 Q. What sort of research do you do?

20 A. Women's health epidemiology, demography,  
21 maternal mortality.

22 Q. Do you -- would you say that abortion is a  
23 focus of your research?

24 A. No. It's one focus.

25 Q. So I -- I asked if you would say abortion is



1 a focus of your research and I just want to  
2 be clear. What is your answer?

3 A. I'm just clarifying that it's one focus.

4 Q. Okay. So you consider it to be a focus of  
5 your research?

6 A. Yes.

7 Q. Have you ever served as a peer reviewer for a  
8 publication?

9 A. Multiple publications, yes. I think that's  
10 in my CV as well. You've seen that.

11 Q. Yeah. What do you understand the purpose of  
12 peer review to be?

13 A. In peer review what we attempt to do is to  
14 evaluate papers for their research methods,  
15 their applicability to the general literature  
16 and so on, and decide whether they should be  
17 published.

18 Q. Have you ever published a peer-reviewed  
19 article or paper on the topic of abortion?

20 A. No.

21 Q. Are you familiar with the complication rate  
22 for abortion in North Carolina?

23 A. Yes.

24 Q. And what is it?

25 A. I would have to look at my deposition, but I

1 believe that the -- the overall complication  
2 rate is listed by CDC. I would have to look  
3 at the -- the exact data to be sure.

4 Q. So are you familiar with the abortion  
5 reporting requirements in North Carolina?

6 A. Yes.

7 Q. What are they?

8 A. They state that abortionists need to report  
9 the com- -- their complications and -- to the  
10 North Carolina Department of Public Health as  
11 I understand it.

12 Q. And are you familiar with the  
13 pregnancy-associated death rate in North  
14 Carolina?

15 A. Yes.

16 Q. And can you say what that is?

17 A. I would have to just confirm it. I don't  
18 want to give you a wrong number.

19 Q. When you say confirm it, do you mean in your  
20 declaration or --

21 A. I believe I brought that up in my  
22 declaration, but, again, the maternal  
23 mortality rate is -- it depends on -- when  
24 you say, pregnancy-associated death rate, I  
25 think those are two different numbers. The

1 pregnancy-associated death rate would include  
2 deaths in the first trimester, for example,  
3 from ectopic pregnancy. It would also  
4 include deaths from abortion and it would  
5 include maternal deaths toward the end of  
6 gestation as well and those are three very  
7 different numbers.

8 By far, the number that we have the best  
9 data for, in my opinion, is maternal  
10 mortality. We have -- our data on -- on  
11 deaths due to ectopic pregnancy and abortion  
12 is very limited.

13 Q. So during your testimony before the court in  
14 Kentucky last year -- do you remember  
15 testifying in --

16 A. Yes.

17 Q. -- Kentucky? -- you described treating  
18 preeclamptic women.

19 A. Yes.

20 Q. And you testified that if a woman was getting  
21 sicker, you would deliver her. Sometimes  
22 depending on the capacity of the place you  
23 were when you were delivering her, you might  
24 have to call helicopters or planes or  
25 ambulances to transport the woman and her

1 infant to a better-equipped hospital.

2 Does that sound correct?

3 A. Yes.

4 Q. And I think your specific testimony was that  
5 you had done so plenty of times. Does that  
6 sound right?

7 A. Yes.

8 Q. About how many times, if you had to estimate,  
9 have you had to transfer -- we can just pick  
10 one of those forms of transportation --  
11 transfer a woman via ambulance to a place  
12 where she could get care that could not be  
13 provided where you had delivered her?

14 MR. BOYLE: Object to form. You can  
15 answer.

16 A. I would say for ambulance transfers, most of  
17 the places where -- most of the facilities  
18 where I worked where I had to transfer  
19 patients, time was of the essence so  
20 relatively few ambulance transfers and more  
21 helicopter or plane transfers.

22 Q. If you had to give a ballpark, could you?

23 A. For both?

24 Q. Yes, please.

25 A. I would say somewhere between 20 -- somewhere

1 around 20 --

2 Q. For ambulance?

3 A. -- patients.

4 Q. Oh, that includes both?

5 A. Yes.

6 Q. And could you be more specific within that 20  
7 how many were in ambulances, how many were in  
8 helicopters?

9 A. Helicopters or planes, probably ten to a  
10 dozen and then maybe ten to -- probably not  
11 as many as -- I would have to think about it  
12 a little bit more.

13 Q. Okay. So --

14 A. Again, mostly, those were in places like  
15 South Dakota or remote parts of Arizona.

16 Q. And you'd say -- so eight to ten is maybe a  
17 fair ballpark for how many --

18 A. For?

19 Q. For ambulance transfers.

20 A. I would have to really think about it, yeah.

21 Q. All right. So in your declaration you cite  
22 five examples of patients transferred from  
23 Planned Parenthood South Atlantic, which I'll  
24 call PPSAT, that -- their Chapel Hill clinic  
25 to UNC Hospital between February 2022 and May

1 of 2023; is that --

2 A. Yes.

3 Q. Yes? Okay. Do you have firsthand knowledge  
4 of these patients?

5 A. The patients who were transferred?

6 Q. Yes.

7 A. No.

8 Q. How did you learn of these hospital -- or  
9 these ambulance transfers?

10 A. I don't remember exactly how I came across  
11 them. I think that when I was looking at the  
12 question of hospital transfers, transfers  
13 from facilities to hospitals, this  
14 information popped up and then I started to  
15 dig a little bit deeper into it and found the  
16 9-1-1 transcripts.

17 Q. I notice in your declaration you cite for one  
18 of these ambulance transfers a website called  
19 operationrescue.org.

20 A. Yes.

21 Q. Did they all come from Operation Rescue?

22 A. No.

23 Q. And Operation Rescue is an antiabortion  
24 organization, correct?

25 A. Yes. I don't know very much about them.

1 Q. Okay. Are you aware that the man who  
2 murdered Dr. George Tiller, an abortion  
3 provider in Kansas, in 2009 asserted that he  
4 was affiliated with Operation Rescue?

5 A. I can't speak to that.

6 Q. Are you aware of any other ambulance  
7 transfers from any of PPSAT's clinics during  
8 the period of February 2022 to May 2023?

9 A. I'm not.

10 Q. Do you know how many abortions PPSAT provided  
11 between February 2022 to May 2023?

12 A. No.

13 Q. If you were to go about calculating the rate  
14 of hospital transfers per abortion patient,  
15 how would you do that?

16 A. Hospital transfers from PPSAT Chapel Hill?

17 Q. Correct.

18 A. I think that what I would look at is how many  
19 abortions were performed and how many  
20 ambulance transfers actually occurred.

21 Q. So in your declaration you also say that it's  
22 an axiom in medicine that physicians should  
23 not perform procedures if they are not able  
24 to manage their complications.

25 Do you agree with that statement?

1 A. That's correct for most procedures.

2 Q. Which procedures does it not apply to?

3 A. I think that a good example is screening  
4 colonoscopy because with screening  
5 colonoscopy, if a patient undergoes a  
6 perforation, that's usually a -- a  
7 complication that would be managed  
8 surgically.

9 Q. So you don't believe that colonoscopies  
10 should always be performed in hospitals?

11 A. No, I don't.

12 Q. Why not?

13 A. Because I think that the available literature  
14 shows that the complication rate for  
15 colonoscopies is much lower than for, say,  
16 induced abortions, especially abortion in the  
17 second trimester, and most abortion --  
18 second-trimester abortion procedures -- I'm  
19 sorry, second abortion tri- --  
20 second-trimester abortion procedures can  
21 become very complicated very quickly.

22 Q. And you don't believe that a rupture of -- or  
23 a perforation of a patient's colon can become  
24 very serious very quickly?

25 A. I think that it can be, but I think that when



1           you look at complication rates and types of  
2           complications, it -- including especially  
3           where uterine perforation has occurred with  
4           damage to vascular structures, perforation  
5           has occurred with damage to bowel and  
6           bladder, which I've personally had to care  
7           for patients with those complications, the  
8           rationale for doing those procedures in -- as  
9           well as potential anesthesia complications,  
10          the rationale for doing those procedures in a  
11          hospital is re- -- is much clearer.

12        Q.    As an obstetrician/gynecologist, if someone  
13            had a perforation of their colon during a  
14            colonoscopy, they would not ever be  
15            transferred to your service for care,  
16            correct?

17        A.    No.

18        Q.    Do you know the complication rate for  
19            perforations in the course of a colonoscopy?

20        A.    I would have to look at my declaration  
21            because I believe that that was a question  
22            that I discussed in my declaration.  Would  
23            you like me to do that?

24        Q.    Sure.

25        A.    Okay.  Oh.  Yeah.  I did not put the

1 complication rates in here.

2 Q. Okay.

3 A. I think that what I had -- the point I was  
4 trying to make in my declaration about  
5 colonoscopy safety was that Dr. Farris cited  
6 a paper to try to compare colonoscopy  
7 complications to abortion complications, but  
8 the particular paper that she cited did not  
9 focus on colonoscopy complications. It was  
10 looking at risk stratification to arrive at  
11 an outcome measure so that outpatient  
12 facilities could be profiled in terms of what  
13 their rates of unplanned hospital visits  
14 were. It did not have as its purpose the  
15 estimation of overall incidence of  
16 complication. So that was why -- that was  
17 why I felt that that particular paper was not  
18 speaking to the question of being able to  
19 compare abortion complications with  
20 colonoscopy.

21 Q. Understood. But you didn't then look for the  
22 complication rate?

23 A. It was in the -- it was in the -- I'm sorry.  
24 What -- what's your question?

25 Q. The -- that after -- in the course of

1 drafting your declaration, you did not look  
2 up the --

3 A. Oh, no, I did.

4 Q. -- complication rate --

5 A. I did. I didn't put --

6 MR. BOYLE: Let -- let him finish the  
7 question.

8 A. Oh, I'm sorry. Sorry. Sorry. Sorry.  
9 Sorry.

10 Q. That's all right. So my question is, in the  
11 course of your declaration, did you look up  
12 the complication rate associated with  
13 perforations during a colonoscopy?

14 A. Yes, I did.

15 Q. But you did not include that in your  
16 declaration?

17 A. No. There was a lot of other ground to  
18 cover.

19 Q. Do you know what the mortality rate of an  
20 outpatient colonoscopy is?

21 A. No.

22 Q. Do you know what kind of sedation is  
23 typically used in an outpatient colonoscopy?

24 A. Mild to moderate.

25 Q. And do you know if tissue is ever biopsied

1           during a colonoscopy?

2           A.    Yes.

3           Q.    And how would the person performing the  
4           colonoscopy go about biopsying that tissue?

5           A.    They use a hot snare.

6           Q.    And what does that mean?

7           A.    It's a either loop or -- or they -- they may  
8           use a punch.  They either use a loop or a  
9           punch device to obtain a biopsy of what they  
10          consider might be malignant tissue or even  
11          nonmalignant if it's an adenoma -- I mean, a  
12          polyp.

13          Q.    And what is the process like of removing that  
14          tissue or potential malignancy from the  
15          colon?

16          A.    As I said, they use a snare or they use a  
17          biopsy forcep.  They snip the biopsy and then  
18          they -- if there's bleeding, they may or may  
19          not cauterize it or they may use something  
20          else to achieve hemostasis.

21          Q.    So other than abortion clinics, do you know  
22          whether North Carolina inspects outpatient  
23          health centers that perform procedures or  
24          surgeries?

25          A.    I don't know for sure because I haven't

1 researched the information, but I do know  
2 that ambulatory surgical centers have an  
3 accreditation and inspection process.

4 Q. Are you aware of how frequently ambulatory  
5 surgical centers receive notices of  
6 deficiencies following those inspections?

7 A. No.

8 Q. Do you know what kind of sedation is provided  
9 in outpatient surgical facilities in North  
10 Carolina?

11 A. Ambulatory surgical centers?

12 Q. Yeah.

13 A. So at ambulatory surgical centers they have  
14 anesthesiologists and anesthesiologists so they  
15 provide the full gamut of anesthesia from  
16 general anesthesia to sedation.

17 Q. So what is general anesthesia?

18 A. So general endotracheal anesthesia is where a  
19 patient is paralyzed and intubated and the  
20 ventilator breathes for them.

21 Q. And I believe you said deeper sedation.

22 A. Deep sedation.

23 Q. Deep sedation. What do you understand that  
24 term to mean as you've used it in your  
25 declaration?

1 A. It typically means that a patient will  
2 receive a combination of barbiturate and --  
3 b-a-r-b-i- -- okay. -- barbiturate and  
4 narcotic and will put them into a state of  
5 profound relaxation. They won't feel pain  
6 and their breathing will slow. In general,  
7 deep sedation is a procedure that should be  
8 performed with an anesthetist or an  
9 anesthesiology -- anesthesiologist present  
10 because those patients can rapidly  
11 decompensate and require intubation.

12 Q. And what do you understand moderate sedation  
13 to be as you used that term in your  
14 declaration?

15 A. The line -- the line between mild and  
16 moderate simply means that the patient is  
17 still able to breathe on their own and they  
18 can often respond to you when you speak to  
19 them, whereas, with deep sedation, they  
20 usually can't. They have -- can maintain --  
21 they can manage their secretions and breathe  
22 on their own.

23 Q. And what medications are used to achieve this  
24 level of sedation?

25 A. There's a wide variety.

1 Q. And I meant to ask earlier. What medications  
2 are used to achieve general anesthesia?

3 A. There is a wide variety. I'm not an  
4 anesথে- -- anesthesiologist.

5 Q. Okay. Do you know what kind of sedation is  
6 provided to abortion patients at PPSAT's  
7 clinics?

8 A. My understanding is that they provide mild,  
9 moderate, and deep sedation according to  
10 their own information.

11 Q. What information specifically are you  
12 referring to?

13 A. Their protocols.

14 Q. When you say, protocols, can you be more  
15 specific? How did you come to read these  
16 protocols?

17 A. My understanding is that -- I believe that  
18 she said in -- somewhere in -- one of --  
19 Dr. Farris said in one of her declarations  
20 that that's what they provide.

21 Q. So you have not seen anything produced by  
22 PPSAT itself on this topic?

23 A. Yes, I have.

24 Q. Distinct from Dr. Farris's declaration?

25 A. Yes.

1 Q. How did you obtain those documents?

2 A. I was given to them -- I saw them through the  
3 discovery process.

4 Q. In this case?

5 A. Yes. But I have seen them also in other  
6 cases as well, in particular the Texas case,  
7 and there was one other case where I'd seen  
8 them as well.

9 Q. And you believe that the protocols in Texas  
10 are comparable to the protocols in North  
11 Carolina?

12 A. In general, my experience with Planned  
13 Parenthood is that they seek to standardize  
14 their procedures as much as possible across  
15 different affiliates. So if I'm recalling  
16 correctly, I had seen these in Texas and I  
17 may have seen them in another case as well.  
18 I just can't remember which one.

19 Q. Okay. Thank you. And do you know what kind  
20 of medications PPSAT uses to achieve the  
21 levels of sedation that they provide to their  
22 abortion --

23 A. No.

24 Q. -- patients? Sorry. As -- I'm not sure that  
25 the court reporter got your answer.



1 A. No.

2 Q. Thank you.

3 A. Yeah.

4 Q. So in Paragraph 180 of your declaration you  
5 say that during the first six weeks of  
6 pregnancy is when maternal morbidity and  
7 mortality are highest.

8 Can you explain what you meant by that.

9 A. I think that what that is -- the -- I'm  
10 referring to -- not referring to the entirety  
11 of pregnancy; I'm referring to the first  
12 trimester.

13 Q. Sorry. Can you just read that sentence that  
14 begins, Deaths during.

15 A. It says, Deaths during the first six weeks of  
16 pregnancy when maternal mortal- -- morbidity  
17 and mortality are highest are kept classified  
18 as maternal deaths and placed together with  
19 deaths due to births and delivery.

20 Q. So you're not asserting that the first six  
21 weeks of pregnancy are the most dangerous  
22 part of the entire period of pregnancy, are  
23 you?

24 A. No. What I'm saying is that the first six  
25 weeks of the first trimester are the most

1 dangerous because that is typically when  
2 ectopic pregnancies occur.

3 Q. And in Paragraph 238 of your declaration,  
4 which I believe is on Page 41 in the upper  
5 right-hand corner --

6 A. Yes.

7 Q. -- you say that, Carrying a pregnancy to term  
8 is safer than an abortion.

9 Do you believe that that's true?

10 A. Yes.

11 Q. Do you -- as you mentioned earlier, you  
12 submitted a declaration in a Minnesota case  
13 in September of last year; is that right?

14 A. Yes.

15 Q. Okay.

16 MR. MENDIAS: And I'd like to mark that  
17 as the next exhibit.

18 (WUBBENHORST EXHIBIT H, Declaration and  
19 Expert Report of Monique Chireau Wubbenhorst,  
20 M.D., M.P.H., Minnesota Case, was marked for  
21 identification.)

22 MR. BOYLE: Thank you.

23 MR. MENDIAS: Thanks.

24 BY MR. MENDIAS:

25 Q. So on Page 10, Paragraph Number 47, can you

1 read that paragraph.

2 A. Yes. It is my opinion that without an  
3 accurate estimate of the number of abortions  
4 performed in the United States or the number  
5 of maternal deaths from abortion, it is  
6 impossible to estimate abortion-related  
7 mortality with any precision.

8 Q. Do you agree that that's true?

9 A. Yes.

10 Q. If it is impossible to estimate the true  
11 abortion-related mortality with any  
12 precision, how are you now able to say that  
13 abortion is more dangerous than childbirth?

14 A. Because if we look at the available data, and  
15 the study I'm thinking of in particular is  
16 the Bartlett study which shows that the risk  
17 of death from abortion increases 38 percent  
18 by every additional gestational -- week of  
19 gestational age, that is not -- and that by  
20 the end of midtrimester, the risk of death is  
21 76 times greater than that -- than risk of  
22 death in the first trimester. There is no  
23 corresponding increase -- there is no  
24 increase in risk in pregnancy that  
25 corresponds to that risk.

1           And another study, I believe it was by  
2           Lidiro, but don't quote me, found similarly  
3           that there is a 30 percent increase in death  
4           from abortion by -- with each additional  
5           gestational week.

6           So what that says is that as you proceed  
7           in gestation, the risks of abortion increase  
8           exponentially, not just linearly but they  
9           increase exponentially, and that is not the  
10          case for mortality in pregnancy.

11        Q.    Do you believe that people regularly obtain  
12            abortions in pregnancy at the point in which  
13            childbirth is most dangerous or in which  
14            pregnancy is most dangerous?

15        A.    Can you --

16                   MR. BOYLE:   Object to form.

17        A.    I'm not sure I understand your question.

18        Q.    That was a very confusingly worded  
19            question --

20        A.    Yeah.

21        Q.    -- on my part.  When do people typically  
22            obtain abortions?

23        A.    Well, this is an important question.  Most  
24            people -- so 93 percent of abortions in the  
25            United States are performed -- 91 to 93

1 percent are performed before the first  
2 trimester. And this is a significant problem  
3 in ascertaining maternal complications and  
4 death because the lar- -- much larger number  
5 of abortions that are performed in the first  
6 trimester when risk for mortality and  
7 morbidity is lower basically drowns out all  
8 of the additional morbidity and mortality  
9 that's occurring in the second and third  
10 trimester. We know that those abortions  
11 occur because Warren Hern advertises on his  
12 website that he does abortions up to 36 weeks  
13 so we know that that happens. We know that  
14 those occur.

15 We also know that simply based on  
16 uterine and maternal physiology, the risk of  
17 abortion at higher gestational ages is higher  
18 and is not amenable to intervention because  
19 the difference between a fetus at six  
20 weeks -- an unborn child at six weeks and an  
21 unborn child at 36 weeks is there's an  
22 astronomical difference. You know, you're  
23 talking about several grams -- 15 grams  
24 versus eight -- you know, somewhere between  
25 six and eight pounds. So I think that that's

1 the basis of that statement.

2 MR. BOYLE: Not immediately  
3 necessarily, but can we take a break at some  
4 point? It's been about an hour.

5 MR. MENDIAS: Sure. I'm -- if you  
6 would like to take a break now --

7 THE WITNESS: Yeah, because you haven't  
8 asked another question --

9 MR. MENDIAS: Sure.

10 THE WITNESS: -- so this might --

11 MR. MENDIAS: Okay.

12 THE WITNESS: -- be a good place.

13 MR. MENDIAS: Great.

14 THE WITNESS: Thank you.

15 THE VIDEOGRAPHER: Going off the  
16 record. The time is 2:16.

17 (Whereupon, there was a recess in the  
18 proceedings from 2:16 p.m. to 2:30 p.m.)

19 THE VIDEOGRAPHER: Back on the record.  
20 The time is 2:30.

21 BY MR. MENDIAS:

22 Q. Doctor, during the break did you speak with  
23 anyone about the deposition so far?

24 MR. BOYLE: Objection. To the extent  
25 she spoke with me, that's work product and I

1           would instruct her not to divulge anything  
2           that we spoke about.

3           BY MR. MENDIAS:

4           Q.    Did you speak to anyone other than an  
5           attorney --

6           A.    No.

7           Q.    -- during the break?   Okay.

8           A.    Well, I said hello to the front desk person.

9           Q.    Did you consult -- did you consult any  
10          studies or materials during the break?

11          A.    No.

12          Q.    So before we broke, you had mentioned  
13          Dr. Hern.   And your testimony was that he  
14          performs abortions through 36 weeks; is that  
15          right?

16          A.    The last I saw on his website, yes.

17          Q.    Does Dr. Hern practice in North Carolina?

18          A.    No.

19          Q.    Is abortion permitted through 36 weeks in  
20          North Carolina?

21          A.    No.

22          Q.    If a woman is pregnant and is considering  
23          whether to have an abortion or to carry to  
24          term, isn't the relevant comparison for the  
25          mortality associated with abortion at eight

1 weeks versus -- I'm sorry. I might have  
2 omitted that from -- so I'll withdraw that  
3 question.

4 If a woman is pregnant at eight weeks  
5 and is considering an abortion, if she is  
6 deciding between carrying to term and  
7 delivering and having an abortion, isn't it  
8 relevant for her to compare the mortality  
9 associated with an abortion performed at  
10 eight weeks with mortality associated with  
11 childbirth?

12 A. No, it's not relevant at all.

13 Q. Why?

14 A. Because the mortality from abortion at eight  
15 weeks -- the more relevant comparison would  
16 be abortion at term or near term and maternal  
17 mortality at the same gestational age.

18 Q. For that patient making the decision, you  
19 believe that is the relevant comparison?

20 A. I guess I'm not understanding your question.  
21 Are you saying that if -- if a woman is  
22 looking -- wanting to understand what is  
23 abortion-related mortality? Can you please  
24 clarify?

25 Q. If a woman is eight weeks pregnant and is



1           deciding between continuing a pregnancy or  
2           having an abortion at eight weeks --

3           A.    Right.

4           Q.    -- isn't it relevant for her to compare the  
5           mortality associated with an abortion at  
6           eight weeks with the mortality associated  
7           with childbirth?

8                         MR. BOYLE:   Object to form.

9           A.    So the mortality at eight weeks when the  
10           fetus weighs 50 -- 15 grams is not applicable  
11           or similar in any way to an abortion close to  
12           term, as I said earlier, where the fetus  
13           weighs five or six pounds, maybe seven  
14           pounds.  And abortion, as we've said, has a  
15           38 percent -- the risks of mortality increase  
16           exponentially, by 38 percent, for each week  
17           of gestational age so I don't think that's an  
18           accurate comparison.

19                         I think the second problem with that  
20           reasoning is that you cannot predict for any  
21           given patient what their -- you know, risk is  
22           a population-based assessment.  It's not an  
23           expression of whether an individual patient  
24           will have an outcome or not.  So you can't  
25           say that, well, this patient had an abortion

1 and it kept her from having gestational  
2 diabetes because you simply can't predict for  
3 any individual patient with any certainty  
4 that they will have a specific outcome.

5 Q. It's true that a person who has an abortion  
6 will not suffer any complication from  
7 pregnancy after that -- after the point in  
8 which they had an abortion, correct?

9 A. Because you've performed the abortion and  
10 they're no longer pregnant, but that's not  
11 the point. The point of this discussion is  
12 often that you can perform an abortion to  
13 prevent maternal morbidity and mortality and  
14 that's just not true. Number one, because we  
15 know that where abortion is legal -- and the  
16 specific examples that I'm aware of are Chile  
17 during the Pinochet regime, Ireland, and  
18 Malta. They had -- especially in Malta where  
19 abortion is banned for any reason, they've  
20 had zero maternal mortality for five years.  
21 Same thing in Ireland. Ireland had one of  
22 the lowest rates of maternal mortality in the  
23 world prior to them legalizing abortion and  
24 the same thing in Chile.

25 So it doesn't follow from that argument

1           that if you do an abortion, it's going to  
2           lower maternal mortality or reduce maternal  
3           morbidity.

4           Q.    It's true that some women have preexisting  
5           conditions that put them at very high risks  
6           of negative outcomes during pregnancy,  
7           correct?

8           A.    Yes, that's correct.  But you cannot say to  
9           someone with diabetes, you're going to  
10          develop diabetes and have a diabetic coma or  
11          if you have high blood pressure, you're going  
12          to develop preeclampsia and die.  You simply  
13          cannot do that.  All of our assessments of  
14          risk are population based; they are not  
15          predictive for an individual.

16          Q.    What is the risk that a woman with pulmonary  
17          hypertension dies during pregnancy?

18          A.    50 percent.

19          Q.    Do you believe a woman deciding whether or  
20          not to have an abortion when she has  
21          pulmonary hypertension might consider the  
22          risk associated with abortion versus the risk  
23          of a pregnancy in which there's a 50 percent  
24          chance of dying?

25                   MR. BOYLE:  Objection and object to

1 form.

2 A. I guess --

3 MR. BOYLE: You can answer.

4 A. Okay. So your question -- let me just  
5 rephrase your question back to you. So  
6 you're saying that that woman should -- are  
7 you saying that she should have the option to  
8 have an abortion because she -- of her -- the  
9 50 percent risk of mortality?

10 Q. That's a good question. Do you think that  
11 she should?

12 A. I don't believe that abortion is -- elective  
13 abortion is -- as -- as you've said before, I  
14 don't agree with elective abortion. I think  
15 that in the patient with pulmonary  
16 hypertension, if she develops worsening  
17 symptoms saying she could be delivered,  
18 that's certainly an option.

19 Q. If a woman with pulmonary hypertension  
20 becomes pregnant and not yet experienced any  
21 negative outcome from her hypertension, you  
22 don't think that she should be permitted to  
23 have an abortion?

24 MR. BOYLE: Objection and object to  
25 form. You can answer.

1 A. Yeah. I -- I -- I could not speak to that  
2 situation. I think that, as I said, if she  
3 became pregnant and she continued to carry  
4 the pregnancy, she became symptomatic to the  
5 extent that she needed to be delivered, then  
6 that's an appropriate management plan.

7 Q. In Paragraph 196 of your declaration --

8 MR. BOYLE: Is this Exhibit B?

9 MR. MENDIAS: Yes.

10 A. Okay. Let me just read --

11 Q. Sure.

12 A. -- back so I can get context here. Okay.  
13 Yes.

14 Q. Can you read the last sentence of that  
15 paragraph.

16 A. In other words, the authors made estimates  
17 for a substantial number of caseloads using  
18 sources such as media stories which weakens  
19 the validity of their study.

20 Q. Why do you believe re- -- relying on media  
21 stories is inappropriate --

22 MR. BOYLE: Object to form.

23 BY MR. MENDIAS:

24 Q. -- in this context?

25 A. Because what we're talking about here is

1 epidemiology and epidemiology -- rather than  
2 being based on what a media story says,  
3 epidemiology ideally looks at patient-level  
4 data.

5 Q. So in your report you provide the names of  
6 women you say died following an abortion.  
7 Did you have firsthand knowledge of any of  
8 these women?

9 A. No.

10 Q. How did you first learn about these deaths?

11 A. I was, again, as I said earlier, looking at  
12 data on abortion-related mortality and came  
13 across the names of these women and I felt  
14 that it was truly tragic that young, healthy  
15 women underwent abortions that related --  
16 resulted in their deaths.

17 Q. Did you find information about these women's  
18 deaths in newspaper articles?

19 A. No. I found their -- can you just remind me  
20 where that is?

21 Q. Sure. That is in Paragraph 188.

22 A. Yes. No. These were not -- I think in one  
23 situation, it was -- the -- the first one, it  
24 was a -- it was an article from the New York  
25 Daily News.

1 Q. And in Subparagraph 7 you also cite the New  
2 York Times, correct?

3 A. Yes.

4 Q. You also cite a website called  
5 abortiondocs.org. Do you know what that is?

6 A. This was a website that had information, and  
7 I believe this one had a autopsy report as  
8 well.

9 Q. Do you know anything else about that website?

10 A. No.

11 Q. Did you review the medical charts of any of  
12 these women?

13 A. No. I reviewed the autopsy reports as they  
14 were presented on the internet.

15 Q. How many of them had autopsy reports?

16 A. I would have to count, but it looks like one,  
17 two, three, four, five, six -- six or seven.  
18 And then --

19 Q. Which --

20 A. -- the others had depos- -- were from a  
21 deposition, another one was from an EMS  
22 report, and two were from -- oh, I just saw  
23 the numbers are out of order. Okay.

24 Q. Did any of the autopsy reports or articles  
25 that you consulted detail the women's medical

1 histories?

2 A. Yes.

3 Q. Which ones?

4 A. All of the autopsy reports. That's routine  
5 with autopsy reports.

6 Q. Do you know how much time elapsed between the  
7 abortion procedure and the complications --

8 A. I would have to look at --

9 Q. -- each women suffered?

10 A. -- each -- I would have to look at each one.  
11 I'm sorry. Sorry. Did not mean to cut you  
12 off.

13 Q. Are you aware of any women who died following  
14 second-trimester abortions in hospitals?

15 A. Yes. I think I mentioned a couple of those.

16 Q. Can you specify which ones occurred in  
17 hospitals?

18 A. I believe Keisha Atkins did and I believe --  
19 in fact, I'm pretty sure -- I would have to  
20 look at the autopsy reports but -- I believe  
21 that most of these women died in hospital,  
22 but I would have to confirm that.

23 Q. Oh, I'm sorry. My question was, do you know  
24 if any of the abortions were performed in  
25 hospitals?



1 A. I think that information was in the autopsy  
2 reports, but I would have to reread them.

3 Q. But you didn't include any of that  
4 information in the declaration, did you?

5 A. No.

6 Q. Do you know how many abortions were performed  
7 at the clinics where these patients received  
8 their abortions?

9 A. No.

10 Q. Throughout your report you cite studies that  
11 suggest that a woman is at a high risk of  
12 suicide following abortion; is that right?

13 A. I think that the more precise way of  
14 expressing it is that there is evidence that  
15 in- -- there are increased risks for suicide  
16 among women who've undergone abortion.

17 Q. So to be clear, you're not arguing that  
18 abortion causes suicidality?

19 A. I would say that more accurately that there  
20 is an association between abortion and  
21 suicidality, yes.

22 Q. And so what is an association?

23 A. Association can be positive or negative, but  
24 it does not necessarily -- to -- it doesn't  
25 address the issue of causality. It's a -- it

1 indicates that there is an association.

2 Q. Is an association synonymous with a  
3 correlation?

4 A. Not exactly, no.

5 Q. How do they differ?

6 A. Correlation means that you compare one set of  
7 outcomes or one set of values with another to  
8 see if the relationship is linear or colinear  
9 or nonlinear so it's a -- it's a slightly  
10 different -- slightly different way of  
11 approaching it.

12 An association is simply that you can  
13 have a positive or a negative association  
14 between an exposure and an outcome.

15 Q. Doctor, what is the American Psychological  
16 Association, if you know?

17 A. The APA? Yeah.

18 Q. Correct.

19 A. It's an association of -- I don't know -- I  
20 know of the organization's existence. I  
21 don't know whether they are the same as ACOG  
22 or as a professional society. I can't speak  
23 to that.

24 Q. Do you believe that they're a reliable  
25 source?

1 A. I can't speak to that either. I do know that  
2 they've engaged in considerable abortion  
3 advocacy starting in 1979.

4 Q. What makes you describe their -- what makes  
5 you describe what they do as advocacy?

6 A. One of their statements that they made in  
7 1979 was that they felt that abortion was --  
8 and I'm paraphrasing. I would have to look  
9 at the exact quote. But they made statements  
10 strongly supporting abortion.

11 Q. Do you believe that a statement either in  
12 favor of or in opposition to abortion is  
13 necessarily advocacy?

14 A. I think it depends on how you define  
15 advocacy.

16 Q. How would --

17 A. I think on some level, what it means is  
18 that -- when an organization engages in  
19 pro-abortion statements, it means that it's  
20 worth looking very carefully at their  
21 statements and the particular conclusions  
22 they draw regarding abortion.

23 Q. Do you believe the same applies to  
24 organizations that oppose abortion?

25 A. Yes. I think that you have to look at the

1           quality of the science that they're proposing  
2           and I think that in some studies, for  
3           example, because this is a contentious topic,  
4           some researchers will -- will look -- will  
5           provide -- will look at both -- will look at  
6           what's called the null hypothesis, which is  
7           in their research to say, you know, we're --  
8           we're not going to assume a benefit or a  
9           risk; we're just going to approach this  
10          agnostically to try to account for that.

11        Q.    Do you consider yourself an advocate?

12        A.    No.  I would say my advocacy more falls in  
13              terms of scientific advocacy.

14        Q.    But you would describe yourself as a  
15              scientific advocate then?

16        A.    No, I would not.  I would say that I am  
17              interested in looking at the science,  
18              critiquing the science, and applying the  
19              science appropriately.

20        Q.    But you engage in advocacy?

21        A.    I don't engage in formal advocacy efforts as  
22              in -- I think I would -- if you can define  
23              what you mean by advocacy, that would help me  
24              to answer the question.

25        Q.    All right.  Well, earlier, in response to one

1 of my questions you referred to, my advocacy,  
2 and so I'm just wondering what you mean by  
3 that.

4 A. I'm -- I'm sorry. I don't remember -- if she  
5 can read the question, that would be helpful.

6 Q. Sure.

7 MR. MENDIAS: Would you mind doing  
8 that, Lisa?

9 (The following question and answer were  
10 read back:

11 Q: Do you consider yourself an  
12 advocate?

13 A: No. I would say my advocacy more  
14 falls in terms of scientific advocacy.)

15 A. Right. So what I would say is that my  
16 advocacy is for women and children. That's  
17 what I'm about. To the extent that that  
18 impinges on the question of abortion, yes,  
19 but I've devoted my career and my life to  
20 serving women, especially vulnerable women,  
21 vulnerable children, women in socioeconomic  
22 deprivation and otherwise. So that's the  
23 source of my advocacy and the reason for it.

24 Q. Have you ever testified before Congress on a  
25 topic unrelated to abortion?

1 A. No.

2 MR. MENDIAS: All right. So I'm going  
3 to mark this as an exhibit.

4 (WUBBENHORST EXHIBIT I, Article, The  
5 facts about abortion and mental health,  
6 American Psychological Association, was  
7 marked for identification.)

8 MR. BOYLE: Thank you.

9 MR. MENDIAS: Thanks.

10 BY MR. MENDIAS:

11 Q. And so this is the APA, and it has said that,  
12 More than 50 years of international  
13 psychological research shows that having an  
14 abortion is not linked to mental health  
15 problems, but restricting access to safe,  
16 legal abortions does cause harm.

17 You consider that statement to be  
18 advocacy, correct?

19 A. I'm sorry. I -- I started reading it.

20 Q. Oh, apologies.

21 A. Distract- -- got distracted.

22 Q. I'm sorry.

23 A. Yeah. Go ahead.

24 Q. You would consider the statement -- I -- I --  
25 I'm sorry. I'll -- I'll read the statement

1           again. More than 50 years of international  
2           psychological research shows that having an  
3           abortion is not linked to mental health  
4           problems, but restricting access to safe,  
5           legal abortions does cause harm.

6                        Do you believe that that conclusion is  
7           advocacy?

8           A. I can't speak to that because I don't know  
9           the intent of the person saying it. I can  
10          say that I disagree with that statement.

11          Q. Are you aware that the APA has cited large  
12          longitudinal and international studies which  
13          have found that obtaining a wanted abortion  
14          does not increase risk for depression,  
15          anxiety, or suicidal thoughts?

16                       MR. BOYLE: Objection.

17          A. I am not -- I haven't -- I haven't seen this  
18          particular -- this particular document so I  
19          can't really comment on it. When I look at  
20          this -- documents like this, I need to look  
21          at the studies they're citing, critique their  
22          statistical methods, and so on and so forth  
23          so I can't really speak to that.

24          Q. That's fair. Are you familiar with the  
25          Turnaway Study?

1 A. Yes.

2 Q. And what is it?

3 A. So the Turnaway Study was a study -- was a  
4 survey of women who had undergone abortion at  
5 differing intervals over -- out to five years  
6 and looked at various outcomes associated  
7 with the women who -- women who remained in  
8 the study until the -- the end of the study.

9 Q. And would you agree that it was extremely  
10 well-designed?

11 A. Yes. I think I've stated that, actually.

12 Q. And --

13 A. But the best design can't overcome the  
14 vagaries of surveys. Survey data is the  
15 weakest form of data as opposed to  
16 observational studies, clinical trials, and  
17 others.

18 Second of all, the Turnaway Study, as  
19 I've said, while it was well-designed, had  
20 very significant dropoff to the extent that  
21 only 19 percent of patients finished.

22 And more to the point, by the end of the  
23 study, if you look very carefully at the  
24 data, 95 percent of women who kept their  
25 children said they were happy with their



1 decision.

2 Q. Are you aware of the comparable percentage of  
3 women who reported life satisfaction after  
4 they had obtained abortions?

5 A. The comparable percent?

6 Q. (Nods head).

7 A. I would have to look at it again. I think I  
8 cited it in my -- but I think -- again, I  
9 would like to come back to the point that the  
10 methodological problems associated with  
11 Turnaway Study are very significant.

12 Another important issue, and forgive me  
13 if this is not the most current data, is that  
14 people have repeatedly requested Turnaway  
15 Study -- the authors to put their data in a  
16 data repository and to date, as far as I  
17 know, they've refused to do that.

18 Q. Do you know whether there were any  
19 significant differences between the women who  
20 continued in the study and those who were  
21 lost to follow-up?

22 A. Yes. I think that if you look at the  
23 study -- and I would have -- it would be  
24 great if I could refer to my -- oh, actually,  
25 I don't know if I went into a detailed

1 critique here. There were differences in  
2 gestational age at the time of abortion  
3 versus no abortion. And, again, the -- the  
4 question really is that if only one in five  
5 patients at the end of a study stayed in the  
6 study, no matter how well-designed it was --  
7 and I think it was -- it was a very  
8 well-designed study, asked a lot of  
9 questions, but that cast doubt on the  
10 validity of the study simply based on the  
11 lack of follow-up.

12 Q. Do you believe that that's true even if there  
13 were no meaningful differences between the  
14 women who were lost to follow-up and the  
15 women who stayed in the study?

16 A. You can't make any conclusions. If one --  
17 only one in five patients stayed till the  
18 end, you simply cannot draw conclusions.

19 Q. Are you familiar with a 2018 report published  
20 by the National Academies of Science,  
21 Engineering, and Medicine concerning the  
22 safety of abortion in the United States?

23 A. Yes.

24 Q. So in your declaration you criticize it for  
25 being funded by abortion advocates; is that

1 correct?

2 A. Yes.

3 Q. Do you believe that a study should be  
4 discounted on the basis that the people who  
5 funded it have a strong political view of  
6 abortion?

7 A. No. I think that that means that you should  
8 scrutinize the methods and the results more  
9 carefully.

10 Q. Are you familiar with the criteria that the  
11 National Academies used in deciding whether  
12 to include a study in its review?

13 A. Yes. And I think that they eliminated a vast  
14 number of studies that were -- would have  
15 spoken to the issue and ended up with a very  
16 small amount -- very small number of studies  
17 that did not accurately reflect the  
18 literature.

19 They also continued to discuss this  
20 statistic of, you know, women are more -- 12  
21 to 14 times more likely to die in childbirth  
22 when preg- -- than from abortion when that  
23 statistic is based on a paper by Raymond and  
24 Grimes which has severe methodological  
25 problems. It combines different data sets.

1 It uses different denominators. It does not  
2 use -- does not account for the majority --  
3 I'm sorry. -- does not account for  
4 differences in -- in those databases.

5 So, again, I -- I would have to say that  
6 on the merits, the National Academy study  
7 suffers from one of the typical problems of  
8 systematic evidence reviews and metaanalyses,  
9 which is that they're very dependent on what  
10 criteria you use for your metaanalysis and  
11 how biased those studies are or are not.

12 Q. You -- I believe the answer was, yes, you are  
13 familiar with the criteria that the National  
14 Academies used so can you say what criteria  
15 those are.

16 A. I would have to look to be precise.

17 Q. But when you say you're familiar, you have a  
18 general sense of what they used to exclude or  
19 include studies?

20 A. Yes. I think that what they -- they used in  
21 their metaanalysis, they used metaanalytic  
22 rules that -- again, I would have to look at  
23 the study to be precise because I don't want  
24 to misquote them. But they -- through their  
25 process, the point is that their rules

1 excluded a very large number of studies that  
2 were responsive to the question.

3 Q. Do you believe that they excluded only  
4 studies that showed a -- a -- an association  
5 with negative outcomes and abortion?

6 A. I'm not following your question.

7 Q. Do you believe they --

8 A. Will you rephrase, please.

9 Q. Sure. They -- do you believe that they  
10 excluded studies that showed no negative  
11 outcomes associated with abortion?

12 A. Studies that showed no negative -- I -- I  
13 would have to go back and look at the studies  
14 they excluded. I can't say off the top of my  
15 head.

16 Q. Can you give an example of one criterion that  
17 they used to exclude studies?

18 A. Again, I don't want to misquote. I have read  
19 the study in great detail and critiqued its  
20 methods, but if you want me to pull up the  
21 study and look at it, if you have a copy of  
22 it, I'm happy to do that.

23 Q. I don't so we can continue.

24 A. Yeah.

25 Q. In your report you cite a 2009 Finnish study

1 by Niinimäki, which is N-i-i-n-i-m-a-k-i,  
2 called, Immediate Complications After Medical  
3 Compared With Surgical Termination of  
4 Pregnancy.

5 A. What -- what paragraph is that?

6 Q. So that would be Paragraph 32. And did you  
7 bring a copy of that study? I forget if that  
8 was one of the ones that you said you had.

9 A. No, I didn't bring one.

10 Q. So just give me a moment.

11 MR. MENDIAS: I'm going to mark this as  
12 well.

13 (WUBBENHORST EXHIBIT J, Article,  
14 Immediate Complications After Medical  
15 Compared With Surgical Termination of  
16 Pregnancy, was marked for identification.)

17 MR. BOYLE: Thank you.

18 MR. MENDIAS: Uh-huh.

19 BY MR. MENDIAS:

20 Q. And in Paragraph 32 you cite this study in  
21 support of your claim that first-trimester  
22 medication abortion carries substantial risks  
23 to the mother; is that right?

24 A. Yes.

25 Q. And are you aware what sorts of medication

1           abortion regimens patients had received in  
2           this study?

3           A.    Yes.  I think that they used vaginal  
4           misoprostol, which is somewhat different from  
5           the regimen that's used in the United States;  
6           however, there have never been any  
7           head-to-head trials to show that that regimen  
8           is less safe or more safe or -- there have  
9           been -- never been any effectiveness or  
10          efficacy trials to compare those two.

11          Q.    So I'm going to direct you to a particular  
12          paragraph.  So on Page 796, the first  
13          paragraph of the column on the right side, do  
14          you see the sentence after Footnote 14 that  
15          begins, The time of follow-up?

16          A.    Yes.

17          Q.    Would you please read that sentence.

18          A.    The time of follow-up after abortion was 42  
19          days.

20          Q.    Then could you read the next sentence as  
21          well.

22          A.    Medical abortion was defined as the use of  
23          mif- -- mifepristone alone or in combination  
24          with misoprostol or other prostaglandins.

25          Q.    So do you know whether PPSAT uses a

1 medication abortion regimen different from  
2 those methods?

3 A. I think PPSAT does use a -- an abort- -- a  
4 regimen that's different. But, again, as I  
5 said earlier, there's never been a  
6 head-to-head comparison to show that the  
7 efficacy, safety, or effectiveness of this  
8 regimen differs from the one used by PPSAT.

9 Q. Okay. And so returning to the first page,  
10 can you read the paragraph after the all caps  
11 word conclusion.

12 A. Both meso- -- methods of abortion are  
13 generally safe, but medical termination is  
14 associated with a higher incidence of adverse  
15 effects. These observations are relevant  
16 when counseling women seeking early abortion.

17 Q. So are you aware that the authors later  
18 explained that the study was based on a  
19 Finnish health registry that coded all  
20 follow-up visits as complications even if  
21 those visits were just for additional  
22 consultation?

23 A. Yes, I'm aware of that, but I don't think  
24 that's relevant to the point that I was  
25 trying to make. The point that I was trying



1 to make was that the risk of hemorrhage was  
2 very significant. It was almost 16 percent.  
3 So the risk of incomplete abortion was 6.7  
4 percent and 1.6 percent with surgical  
5 abortion. And the risk of emergency surgery  
6 was also close to 6.7 -- 6 percent.

7 So the point I was trying to make was  
8 not the study design. It was the fact that  
9 these hard outcomes that they looked at  
10 including hemorrhage, including need for  
11 surgical evacuation, in- -- including risk of  
12 incomplete abortion, were higher than  
13 surgical abortion and higher than what's  
14 reported in the United States.

15 Moreover, I want to emphasize that these  
16 Finnish studies have the advantage of  
17 complete ascertainment, which we do not have  
18 in the United States ever. They track every  
19 woman from birth -- every human being from  
20 birth until death, all of their interactions  
21 with the medical system, so this is a  
22 comprehensive way of looking at all tort --  
23 tor- -- sorts of medical outcomes. I've  
24 spoken with Mika Gissler. The research that  
25 they do is really excellent and that's the

1 point I was trying to make.

2 MR. MENDIAS: So I'm going to mark  
3 this.

4 (WUBBENHORST EXHIBIT K, Letters to the  
5 Editor, Immediate Complications After Medical  
6 Compared With Surgical Termination of  
7 Pregnancy, was marked for identification.)

8 MR. BOYLE: Thank you.

9 BY MR. MENDIAS:

10 Q. Doctor, you mentioned hemorrhage. In the  
11 second paragraph on -- in the leftmost  
12 column, do you see a sentence in the middle  
13 of that paragraph that begins, Based on?

14 MR. BOYLE: Objection. What -- what  
15 are we looking at here?

16 BY MR. MENDIAS:

17 Q. This is -- do you rec- -- do you recognize  
18 this publication that --

19 A. Yes. Uh-huh.

20 Q. Okay. Do you see the paragraph -- the second  
21 paragraph in the leftmost column?

22 A. Yes.

23 Q. And do you see the sentence about halfway  
24 through that begins, Based on?

25 A. Uh-huh.

1 Q. Could you --

2 MR. BOYLE: Objection. Can we -- can  
3 we just clarify what it is on the record,  
4 please.

5 BY MR. MENDIAS:

6 Q. All right. Can you say what this document  
7 is.

8 A. Oh, this is a letter to the editor from --  
9 I'm familiar with this. -- I think her name  
10 is Mary Fjerstad to the editors of The Green  
11 Journal OB/GYN asking -- presenting some  
12 questions for the authors.

13 Q. Okay. And can you read that sentence we were  
14 just talking about.

15 A. Based on correspondence with the Dr. --  
16 H-e-i-k-i-n-h-e-i-m-o, one of the authors of  
17 the Niinimäki -- I'll spell that,  
18 N-i-i-n-i-m-ä-k-i, and there's an umlaut over  
19 the A -- in Finnish health registries, any  
20 return visit, even for additional  
21 consultation, is categorized as a  
22 complication. Thus, a woman who is bleeding  
23 may have been within the normal range but who  
24 sought reassurance could have been coded as  
25 having had a hem- -- hemorrhage.

1 Q. So isn't it true that the rates of hemorrhage  
2 might have been inflated in the original  
3 Niinimäki study?

4 A. I don't think that's true. This author is  
5 making a presumption not based on any data.  
6 She said a woman may -- her bleeding may have  
7 been in the normal range and could have been  
8 coded, but she doesn't present any data or  
9 any critique of the data to support that  
10 statement.

11 Q. And the doctor she refers to, Heikinheimo, he  
12 was a -- an coauthor of the 2009 --

13 A. Right.

14 Q. -- Niinimäki story -- or article?

15 A. But they don't present the correspondence so  
16 I can't comment on that.

17 Q. How do you define hemorrhage?

18 A. It depends on the procedure. So typically,  
19 you can have as much as -- I mean, again, it  
20 depends on the procedure.

21 Q. Is any amount of bleeding in a patient  
22 hemorrhage?

23 A. No.

24 Q. So how much bleeding is a minimum to be  
25 considered hemorrhage?

1 A. It's usually prespecified in patients and in  
2 clinical data so that's why I'm asking you  
3 which procedure you're referring to. For  
4 example, if it's a labor-and-delivery  
5 patient, we would consider bleeding up to  
6 about 400 milliliters to be normal and then  
7 once past that, maybe 3- to 400, and then  
8 once it's beyond that, we count that as  
9 postpartum hemorrhage. So it's procedure  
10 specific and in papers, as I said, they  
11 usually provide a predefined cutoff as to  
12 what they consider to be hemorrhage.

13 Q. How much bleeding is considered hemorrhage in  
14 a medication abortion patient?

15 A. I think that it's -- they can bleed as much  
16 as 80 to 100, but, again -- 100 is --  
17 milliliters. But, again, the amount is  
18 subjective. And unless you weigh pads, which  
19 is what we do -- weigh pads and surgical  
20 sponges and so on and so forth, which is what  
21 we do with hemorrhage at term, it is  
22 difficult to quantify.

23 Q. And in the right column of this letter to the  
24 editor page, this was written by the authors  
25 of the study, Niinimäki 2009, et al.,

1 correct?

2 A. Yes.

3 Q. And can you read the bullet point at the  
4 bottom of that rightmost column on the first  
5 page.

6 A. Rate of serious real complications is rare  
7 and rather similar between surgical and  
8 medical abortion.

9 Q. And was the 2009 Niinimäki study a  
10 retrospective administrative database study?

11 A. Yes.

12 Q. And you say a strength of that study is to  
13 completely ascertain all abortions and all  
14 complications, correct?

15 A. Yes.

16 Q. But in your declaration at Paragraph 36, you  
17 criticize a study by Upadhyay, et al., from  
18 2015.

19 A. Yes.

20 Q. And you specifically say that it has many  
21 limitations similar to other retrospective  
22 administrative database research studies,  
23 correct?

24 A. Yes. That's because studies that are done in  
25 the United States cannot have complete

1           ascertainment. We don't have the types of  
2           databases, we don't have the types of  
3           registration, we don't have the types of  
4           statistical methodology and power that they  
5           do in Scandinavia so they're not com- --  
6           comparable at all.

7           Q. But didn't Upadhyay in the 2015 study look at  
8           Medicaid data which included all Medicaid  
9           beneficiaries who had received an abortion  
10          and any follow-up care that they obtained?

11                   MR. BOYLE: Objection. You can answer.

12          A. They're -- the Medicaid databases are  
13          notorious. I've worked extensively -- you  
14          can look at my CV and see that I have two,  
15          maybe three papers looking -- doing heavy  
16          power lifts using Medicaid data. Medicaid  
17          data is notorious for being limited. There  
18          is miscoding. There are patients that, for  
19          example, will code for having two deliveries  
20          in one year. The ability to -- for them to  
21          follow up on patients is -- is not -- it is  
22          not comparable in any way to what the Finnish  
23          people can do with their databases.

24                   And in addition to that, the Finnish  
25          database is designed to capture both medical

1 and administrative and financial data.  
2 Medicaid is designed just to capture  
3 financial data. That's it. It's -- it is  
4 not -- and it doesn't have information on  
5 gestational age, doesn't have information on  
6 complications at the patient level. These  
7 databases do.

8 Q. So looking back at the reply that Niinimäki  
9 wrote in response to Mary Fjerstad's letter  
10 to the editor, isn't it true that she writes  
11 that complications -- many of the  
12 complications are not really such but,  
13 rather, concerns or adverse events that bring  
14 women back to the healthcare system?

15 A. Yes. That's what she says.

16 Q. Does that imply that there was some  
17 miscoding?

18 MR. BOYLE: Objection.

19 BY MR. MENDIAS:

20 Q. You can answer.

21 A. No, I don't think that there's miscoding  
22 because, as I've said, they organize their  
23 database very differently from ours and  
24 miscoding is very rare if -- and unusual.

25 What I would say is that the specific



1 outcomes that I mentioned, which were  
2 hemorrhage, incomplete abortion, and  
3 emergency surgery, are hard outcomes and they  
4 were demonstrated to be more common and they  
5 were demonstrated to occur at a  
6 specific incidence or prevalence within a  
7 population that we were looking at.

8 Q. And you also criticized the 2015 Upadhyay  
9 study saying that, There is a likelihood that  
10 patients with complications didn't engage  
11 with the medical system; is that right?

12 A. Yes. And what I meant by that was that they  
13 did not engage with the medical system in a  
14 way that was visible through a Medicaid  
15 administrative database. That's the point  
16 that I was trying to make. If a patient had  
17 complications, of course, they would  
18 reasonably engage with the medical system,  
19 but the fact of the matter is that what we  
20 find very frequently is that when patients  
21 suffer abortion complications, they do not  
22 return to the abortion clinic. They are seen  
23 by physicians like myself who go to hospital  
24 emergency rooms and that was the point that I  
25 was trying to make, that they did not engage

1 with the medical system in a way that was  
2 visible through a Medicaid database.

3 Q. In Paragraph -- my -- my apologies. So in  
4 general, you criticize record linkage study  
5 involving the Medicaid program.

6 Is that a fair representation of your  
7 position in the declaration?

8 A. I think it's open to critique, but sometimes  
9 it's the data that we have. But I do think  
10 that it is not adequate to answer certain  
11 questions and that's what I'm -- the point  
12 I'm trying to make.

13 Q. So in Paragraph 57 of your declaration you  
14 cite a study by Reardon, et al., from 2002.

15 A. Uh-huh.

16 Q. That was also a California Medicaid record  
17 linkage study, correct?

18 A. Right. Yes.

19 Q. Would you agree that the 2015 Upadhyay study  
20 was well-designed?

21 A. I would have to go back and look at the study  
22 design because I cannot say off the top of my  
23 head whether it was well-designed or not. I  
24 don't believe I commented on the study  
25 design. I said there were methodologic

1 issues, but I didn't say whether it was  
2 well-designed or not well-designed.

3 Q. So do you have your Minnesota expert report?  
4 And I'm -- apologies. I do not remember what  
5 exhibit it was marked as.

6 MR. BOYLE: H.

7 BY MR. MENDIAS:

8 Q. H. So --

9 A. Oh. Oh. Oh. You already --

10 Q. Yeah.

11 A. -- gave it. Okay.

12 Q. Yeah.

13 A. Wait a minute. Wait a minute.

14 Q. So on Page 16 -- or -- I'm sorry. Yes.  
15 Actually, Page 16, Paragraph 71. And that  
16 would be the fifth line of that paragraph.

17 A. Yes.

18 Q. You did say it was well-designed, correct?

19 A. Yes.

20 Q. Okay.

21 A. Uh-huh. And in Paragraph 143 you also  
22 criticize another Upadhyay study.

23 MR. BOYLE: Object to form. What --  
24 what exhibit are you on now?

25 MR. MENDIAS: It's -- I haven't marked

1           that exhibit yet. I'm talking about her  
2           declaration.

3           A.     But you didn't tell me which --

4                     MR. BOYLE:   So you're back to --

5           A.     -- document --

6                     MR. BOYLE:   -- Exhibit B?

7           A.     -- we're referring to.

8           Q.     No. No. No. I -- this is another Upadhyay  
9           study and I will mark that, but I haven't  
10          marked it yet. So --

11                    MR. BOYLE:   But you're back in  
12          Exhibit B --

13                    MR. MENDIAS:  Oh, in Exhibit B --

14                    MR. BOYLE:   -- 4- --

15                    MR. MENDIAS:  -- yes. Correct.

16                    THE WITNESS:  Okay.

17                    MR. BOYLE:   -- Paragraph 143?

18                    MR. MENDIAS:  Apologies. Yeah.

19                    MR. BOYLE:   Yeah. Thank you.

20           BY MR. MENDIAS:

21           Q.     So Paragraph 143 of your declaration. So in  
22           the --

23           A.     Yes. Uh-huh.

24           Q.     So that was a 2018 Upadhyay study?

25           A.     Uh-huh. And I just want to say, I have

1 nothing against Dr. Upadhyay.

2 Q. Sure. You point out that it only included  
3 data from 15.7 percent of the country.

4 MR. BOYLE: Objection.

5 BY MR. MENDIAS:

6 Q. You can answer.

7 A. I think that what I said was that it's 15.7  
8 percent of hospitals.

9 Q. Sure.

10 A. And then I went on to say, quote -- quote, It  
11 undersampled some regions west and south and  
12 oversampled others.

13 Q. Do you have a reason to believe that abortion  
14 complications are more likely in some regions  
15 of the country than others?

16 A. Yes.

17 Q. What would those reasons be?

18 A. I think that the -- actually, not the  
19 complications themselves. I can't really  
20 comment on whether the complications  
21 themselves would be more likely in different  
22 parts of the country, but the management of  
23 those complications might depend on the  
24 availability of health services.

25 Q. And so with respect to your criticism that it

1           only included 15.7 percent of hospitals in  
2           the country, are you aware of any data set  
3           that includes emergency room data from every  
4           hospital in the United States?

5           A.    I think there are data sets like that that  
6           exist, but I would have to confirm that.

7           Q.    You've never -- you couldn't provide a name  
8           of such a data set?

9           A.    It would be very easy to get that.

10          Q.    Okay.  Who do you think maintains this data  
11          set?

12          A.    I think the Hospital Association of America  
13          has similar data sets.  Again, I can't really  
14          comment on which ones they are or who  
15          maintains them, but I know that they exist.

16          Q.    So the authors of that study say they used  
17          data from the nationwide emergency department  
18          sample.

19                    Are you familiar with what that is?

20          A.    Yes.

21          Q.    What is it?

22          A.    It is a sampling -- but it's not a random  
23          sampling.  It's a sampling of emergency  
24          department encounters with -- from patients  
25          with the medical system through the emergency

1 department.

2 Q. And they also, the authors, that is, say that  
3 that sample is maintained by the Agency for  
4 Healthcare Research and Quality.

5 Are you familiar with that --

6 A. Yes.

7 Q. -- agency? What is that agency?

8 A. HRQ is an agency of the Federal Government  
9 that looks at -- its mandate is health  
10 services research in the United States.

11 Q. Do you believe that it's a reliable source of  
12 data?

13 A. It's reliable to the extent that -- of the  
14 data's quality. No source is reliable in and  
15 of itself; it depends on data quality and  
16 integrity.

17 Q. Do you believe that the data from the  
18 national emergency department sample is of  
19 low quality?

20 A. I haven't reviewed it and I can't really say.

21 Q. You note as well in your declaration that 15  
22 deaths were noted in the Upadhyay 2018 study;  
23 is that right?

24 A. Can you direct me to where -- where you  
25 are --

1 Q. Sure. That's --

2 A. -- referring to?

3 Q. -- Paragraph 146.

4 A. It says -- yes. It says, 15 patients in the  
5 sample had ED visits that ended in the  
6 patient's death.

7 Q. Are you aware what the total sample size was?

8 A. I would have to look at the paper, but I was  
9 not using that statistic as the numerator for  
10 an assessment of deaths from abortion. That  
11 was not the purpose. The point I was trying  
12 to make is that patients present to the  
13 emergency room and died in the emergency  
14 room. That was the point I was making. I  
15 was not making an epidemiologic assessment  
16 that this is the numerator over some  
17 denominator of encounters in the ER. That's  
18 not what I was trying to do.

19 Q. What was the relevance of the point you were  
20 trying to make?

21 A. That patients presented to the emergency room  
22 and died in the emergency room.

23 Q. Isn't it possible that if a woman did not  
24 disclose that she had had an abortion, she  
25 would have been excluded from the study



1 sample?

2 A. It's possible, but that's speculation.

3 Q. But you believe that abortion providers tell  
4 their patients not to inform emergency  
5 departments staff that they've had an  
6 abortion?

7 A. I don't believe it, but I believe that I've  
8 documented in my declaration where that has  
9 occurred.

10 Q. Has it occurred in North Carolina?

11 A. I don't know.

12 Q. Have you ever seen anything from PPSAT to  
13 suggest that it tells its patients such a  
14 thing?

15 A. I would not say that. I have not seen that.

16 Q. In Paragraph 67 of your declaration --

17 A. Okay. Give me just a minute here.

18 Q. Sure.

19 A. Yes.

20 Q. -- you assert that aspiration abortion is  
21 surgery.

22 A. Yes.

23 Q. And in the next paragraph you say, It  
24 requires surgical training distinct from  
25 other types of training.

1 A. Yes.

2 Q. Is that training that you've received?

3 A. No. But as an academic physician, I was  
4 aware of and continue to be aware of the fact  
5 that physicians who are being trained to do  
6 abortions are trained in surgical technique  
7 of doing abor- -- performing abortion.

8 Q. Do you consider a D&C to be a form of  
9 surgery?

10 A. Yes.

11 Q. In Paragraph 69 you say, It requires surgical  
12 operative sterile technique. What do you  
13 mean by that phrase?

14 A. What are we referring to?

15 Q. In Paragraph 69 you say, It requires --

16 A. When you say -- are you referring to surgical  
17 abortion?

18 Q. Well, I -- I'm asking about the paragraph  
19 that you wrote so I'm wondering what the it  
20 is there and --

21 A. Right.

22 Q. -- what you mean --

23 A. So it's surgical --

24 Q. -- by that phrase.

25 A. -- abor- -- oh, sorry. Sorry. I'm sorry.

1 Q. No. Go ahead. I -- I'm asking you to  
2 explain that paragraph in -- both in terms of  
3 what it's referring to and what you mean by  
4 surgical operative sterile technique.

5 A. So when surgery is performed, typically, we  
6 perform surgery using instruments that have  
7 undergone high-level sterilization to prevent  
8 the introduction of spores and resistant  
9 organisms into body cavities. That is part  
10 of operative technique. We also use sterile  
11 gloves, sterile gowns, sterile instruments,  
12 and sterile conditions, sterile surfaces, and  
13 that defines what sterile operative technique  
14 is.

15 Q. And what is curettage?

16 A. It's French because many of our medical terms  
17 are from French or Greek and it means  
18 scraping.

19 Q. Can you explain how that scraping constitutes  
20 a, quote, linear incision through the lining  
21 of the uterus, end quote, as you assert in  
22 Paragraph 71 of your report.

23 A. Because when you perform an abortion or when  
24 you are doing dilation and curettage for  
25 retained products of conception, you apply

1 the curette until you hear something called a  
2 cri, c-r-i, and what that is is the sound of  
3 you scraping through the layer of the uterus  
4 to make linear incisions in the endometrium,  
5 the lining of the uterus, down to the  
6 beginning of the -- down to the interface  
7 between the muscle -- the -- what's -- down  
8 to the base of the endometrium. And that is  
9 characteristically a gritty sensation that  
10 you encounter and that tells you that you've  
11 removed the tissue either through an  
12 incomplete abortion or whatever procedure  
13 you're doing.

14 Q. And do you consider that scraping to be an  
15 incision?

16 A. It is because you're incising through the  
17 lining of the uterus.

18 Q. Are you aware that ACOG does not describe  
19 curettage as involving an incision?

20 A. I'm aware that ACOG makes that distinction.  
21 I don't agree with that.

22 Q. In Paragraph 74 of your declaration you  
23 suggest that, 15 to 20 percent of patients  
24 receiving curettage due to an induced or  
25 spontaneous abortion develop intrauterine

1           adhesions, correct?

2           A.    I didn't say that.  I quoted these authors as  
3           saying that.

4           Q.    And you agree with that statement?

5           A.    Yes.

6           Q.    What is a spontaneous abortion?

7           A.    It's a miscarriage where you have in utero  
8           fetal demise.

9           Q.    So the figure that you cite doesn't  
10          differentiate between those patients who  
11          miscarried and those who obtain an abortion  
12          and then subsequently developed intrauterine  
13          adhesions, correct?

14          A.    In the paper and in subsequent papers they do  
15          make that distinction.  The point I was  
16          trying to make there is that curettage is  
17          surgery and it leads to surgical  
18          complications.  It leads to scar tissue.

19          Q.    And like you said, you've performed D&Cs for  
20          patients experiencing miscarriage, correct?

21          A.    Yes.

22          Q.    Do you know how frequently your patients  
23          develop intrauterine adhesions after you  
24          perform a D&C?

25          A.    No.

1 Q. When an embryo or a fetus has died in utero,  
2 what are physician -- physician's options for  
3 removing it?

4 A. So I'm going to rephrase it a little bit  
5 differently. So if a patient comes to me --  
6 and miscarriage is a very sad situation.  
7 Many times women are devastated by the loss  
8 of a child that they had already planned and  
9 thought about and contemplated their birth.  
10 When patients come to me with a miscarriage,  
11 I typically offer them the opportunity of  
12 expected management versus immediate  
13 management with a D&C. Does that answer your  
14 question?

15 Q. Yeah. I think I have a follow-up question,  
16 though. What happens if there is fetal death  
17 in the second trimester?

18 A. So with fetal death in the second trimester,  
19 we are much more concerned with abort- --  
20 with infection and hemorrhage. And so  
21 typically, those patients in my experience in  
22 every hospital in every program that I've  
23 worked at are managed in the hospital.

24 Q. And --

25 A. They're not managed as outpatients.

1 Q. Have you managed those patients yourself?

2 A. Yes.

3 Q. What have you done to manage them?

4 A. Either -- before misoprostol we would have to  
5 dilate the patient's cervix with laminaria  
6 and then do essentially a D&E, dilation and  
7 evacuation, but not a D&E in the sense that  
8 it was not on a living -- it was on a demised  
9 fetus. With misoprostol, management has  
10 become much more straightforward.

11 Q. What is management like now that  
12 misoprostol --

13 A. We give them --

14 Q. -- exists?

15 A. -- high doses of -- of -- I'm sorry. We give  
16 them misoprostol orally. I -- some  
17 clinicians may give it vaginally and that  
18 usually effects expulsion. E -- that should  
19 be e-f-f-e-c- -- thank you.

20 Q. So in Paragraph 94 of your declaration you  
21 discuss a report produced by an organization  
22 called Advancing New Standards in  
23 Reproductive Health, correct?

24 A. Uh-huh. I'm sorry. Yes.

25 Q. And that report was an analysis of a report

1 produced by the FDA entitled, Mifepristone  
2 U.S. Post-Marketing Adverse Events Summary  
3 through 12/31/2018, right?

4 A. Yes.

5 Q. And you describe as demonstrably false the  
6 report's assertion that it is mandatory to  
7 report any death among someone who used  
8 mifepristone, correct?

9 A. Yes.

10 Q. What is your view to arrive at your  
11 conclusion that that statement was  
12 demonstrably false?

13 A. I reviewed FDA's REMS for mifepristone and I  
14 also reviewed their postmarketing protocols.  
15 Their postmarketing protocols are very  
16 specific in stating for the REMS that  
17 prescribers must report complications to  
18 Danco or -- actually, it's not just Danco  
19 because there's a generic manufacturer. But  
20 let's say for this -- just the manufacturer  
21 of mifepristone, prescribers must report  
22 those to the -- complications to the  
23 manufacturer who then reports them to FDA.  
24 But if prescribers are not notified of  
25 complications and those complications occur



1 and are managed in an emergency room or  
2 elsewhere, they are never reported. And so,  
3 therefore, it is not true. There is no  
4 mandate on practitioners, physicians,  
5 emergency room docs, gynecologists to report  
6 those complications to FDA. That does not  
7 exist.

8 Q. Do you consider yourself an expert on the  
9 Federal Food, Drug, and Cosmetic Act?

10 A. Only an expert insofar as it affects my  
11 practice and needing to understand the ways  
12 that FDA's mandates and rules affect my  
13 practice.

14 Q. Do the REMS for mifepristone affect your  
15 practice?

16 A. No -- no, because I do not perform abortion.  
17 However, it is incumbent to understand, as in  
18 this situation, that, as I said earlier,  
19 there is no mandatory reporting on the part  
20 of everyday pres- -- of -- there's mandatory  
21 reporting on the part of prescribers but not  
22 on the part of other physicians who may  
23 manage those complications. Without having  
24 that information, it is impossible to  
25 accurately ascertain what the true

1 complication rate is from mifepristone  
2 abortions -- mifepristone/misoprostol  
3 abortions.

4 Q. So between Paragraphs 113 and 114 of your  
5 declaration you include a table, correct?

6 A. Yes.

7 Q. And that table includes deaths that the FDA  
8 was aware of after a patient took  
9 mifepristone, correct?

10 A. Yes.

11 Q. Does that suggest that those deaths were  
12 caused by mifepristone?

13 A. They were associated with mifepristone.

14 Q. And what is your basis for saying that they  
15 were associated?

16 A. The statement there under the paragraph --  
17 the second double dagger where it says, The  
18 fatal cases are included regardless of causal  
19 attribution. So if there is no cause, then  
20 you're really talking about association, that  
21 the woman took it -- mifepristone and then  
22 had -- experienced these outcomes.

23 Q. But doesn't the paragraph go on to say that  
24 some of these deaths involved causes that  
25 could not possibly have been associated with

1 mifepristone?

2 A. I disagree with that statement because I  
3 believe and I think that there's evidence,  
4 which I have supplied in my declaration, that  
5 women do engage in risk-taking behavior, do  
6 engage in unhealthy behaviors which can lead  
7 to them dying from drug intoxication,  
8 suicide, and so on and so forth.

9 Q. Do you believe that there's an association  
10 between medication abortion and being the  
11 victim of a homicide?

12 A. I think that if a woman undergoes a  
13 medication abortion and then engages in  
14 risk-taking activities, in particular drug  
15 use, and I documented associations between  
16 abortion and drug use, that she could put  
17 herself in a situation where she could be the  
18 victim of homicide.

19 MR. BOYLE: We've been going for about  
20 another hour so whenever it's convenient, I'd  
21 like to take a break.

22 MR. MENDIAS: Sure. I've got a few  
23 more questions in this -- on this topic but  
24 then after that, maybe ten minutes from now.

25 A. Yes, because I could use the ladies' room.

1 Q. So did this report -- or -- I'm sorry. This  
2 table here includes all the deaths the FDA  
3 was aware of between September 28th, 2000,  
4 and June 30th, 2021; is that correct?

5 A. As far as I know, yes.

6 MR. BOYLE: Object to form.

7 BY MR. MENDIAS:

8 Q. And that was a yes?

9 A. No. It was -- I said, as far as I know. I  
10 can't say yes or no because I wasn't the FDA  
11 and I didn't collect the data.

12 Q. Did the report indicate how many women had  
13 taken mifepristone in that period of time?

14 A. There are two parts to this report and I  
15 didn't include everything, but they -- there  
16 is a -- somewhere in here there is a  
17 denominator. Again, I think that it would be  
18 very difficult to identify which -- whether  
19 women took mifepristone or not because,  
20 again, we are relying on data that were  
21 reported to the manufacturer. And as I said  
22 earlier, those data are necessarily com- --  
23 incomplete because there is no mandated --  
24 mandated reporting for nonprescribers.

25 Q. Do you believe that the denominator is

1           inaccurate that the FDA reported?

2           A.    Can you define what you mean by the  
3           denominator.

4           Q.    The number of women who took mifepristone in  
5           that time period.

6           A.    I don't know.  I haven't reviewed their raw  
7           data so I can't say.

8           Q.    Did you encounter a figure that the FDA  
9           provided as the number of women who had taken  
10          mifepristone in that time period?

11          A.    I want to say it was in the millions and the  
12          number 2.6 million comes to mind, but that is  
13          recollection so I can't really say that  
14          that's completely accurate.

15          Q.    And last month you submitted a declaration in  
16          a case in Kansas, correct?

17          A.    Yes.

18                       MR. MENDIAS:  Could I mark this as the  
19          next exhibit.  Thank you.

20                       (WUBBENHORST EXHIBIT L, Declaration of  
21          Monique Chireau Wubbenhorst, M.D., M.P.H.,  
22          Kansas Case, was marked for identification.)

23                       MR. BOYLE:  Thank you.

24          BY MR. MENDIAS:

25          Q.    And so on Page 39 of that declaration --

1 A. Yes.

2 Q. -- you include a very similar chart, correct?

3 A. Yes.

4 Q. And it reports the same number of deaths and  
5 ectopic pregnancies; is that right?

6 A. Yes.

7 Q. Just give me one second. And above the chart  
8 there is text from the FDA report, right?

9 A. Yes.

10 Q. And do you see the number of women indicated  
11 there who took mifepristone through the time  
12 period covered in the chart?

13 A. Yes. I think I said earlier it was in the  
14 millions.

15 Q. Great. And what -- how many specifically  
16 millions is it?

17 A. They say approximately 5.6 million.

18 Q. Why didn't you include that figure in your  
19 report for this case?

20 A. I was at the point where I needed to keep my  
21 text as short as possible. It was certainly  
22 not because I was trying to run away from  
23 that figure. I'm well aware of that figure.  
24 It's commonly cited in the literature so it  
25 was simply a question of trying to shorten --

1 keep my testimony as brief and to the point  
2 as possible.

3 Q. And how long is your declaration report --  
4 or, I'm sorry, your declaration submitted in  
5 this case? That would be Exhibit B.

6 A. 64 pages.

7 Q. Okay.

8 MR. MENDIAS: I'm willing to take a  
9 break at this point.

10 THE VIDEOGRAPHER: Going off the  
11 record. The time is 3:33.

12 (Whereupon, there was a recess in the  
13 proceedings from 3:33 p.m. to 3:49 p.m.)

14 THE VIDEOGRAPHER: Back on the record.  
15 The time is 3:49.

16 BY MR. MENDIAS:

17 Q. Dr. Wubbenhorst, do you believe that maternal  
18 mortality surveillance relies exclusively on  
19 death certificates?

20 A. No.

21 Q. And do you agree that the gold standard for  
22 ascertaining maternal mortality is to collect  
23 data and then have a state-level group of  
24 obstetricians and epidemiologists review  
25 every case? Correct?

1 A. I don't think that's the gold standard for  
2 ascertaining mortality. I think that that is  
3 more related to ascertaining causes of  
4 mortality.

5 Q. Okay. And you -- we were discussing earlier  
6 the testimony that you gave in Kentucky. You  
7 remember that testimony, correct?

8 A. I do. I'm thinking you have a copy of it.

9 Q. I might have given it already, but let me  
10 see.

11 A. I don't believe you've given it yet.

12 Q. Correct.

13 MR. MENDIAS: So I'll mark this. Thank  
14 you.

15 (WUBBENHORST EXHIBIT M, Excerpt of  
16 Hearing Testimony by Dr. Wubbenhorst, was  
17 marked for identification.)

18 BY MR. MENDIAS:

19 Q. And this is a transcript of the direct and  
20 cross-examination you underwent, I believe,  
21 last summer in Kentucky.

22 Does that look like -- correct to you?

23 A. Yes.

24 Q. Okay. And on Page 197 -- so -- and the  
25 pages, again, are in the upper right-hand



1 corner of each small page in the --

2 MR. BOYLE: So objection. Is there  
3 anything to identify this with?

4 MR. MENDIAS: Yeah. Let me -- well,  
5 the witness has said that it looks familiar  
6 so I can look for the full copy in a moment  
7 but --

8 A. Yeah. I haven't -- I haven't seen this so...

9 Q. So on Page 197 --

10 A. Yes.

11 Q. Okay. Pardon me one second. All right.  
12 Actually, we'll set that aside for the -- a  
13 moment. I apologize for that.

14 Are you aware that the CDC has obtained  
15 data on abortion mortality from all 50  
16 states?

17 A. I -- on abortion mortality. I haven't looked  
18 lately but, yes.

19 Q. Do you know the sources that the CDC relies  
20 on to identify abortion-related deaths?

21 A. They pull from a variety of sources and I  
22 would need to look precisely at their actual  
23 method section of their MMWR.

24 Q. Do you know off the top of your head some of  
25 those sources even if we'll acknowledge that

1           it's not all of them?

2           A.    They rely on reports from the states.  They  
3           rely on death certificate data.  There --  
4           there are a few sour- -- data sources that  
5           they use.

6           Q.    Do they rely on reports by private citizens?

7           A.    I don't know.

8           Q.    Do you know what happens after the CDC  
9           obtains a -- a report of an abortion-related  
10          death?

11          A.    My understanding is that they will try to get  
12          as much information as they can regarding  
13          that death.

14          Q.    And then what happens, if you know?

15          A.    Then they compile their data and report them.

16          Q.    Are you aware of any review of the reports  
17          that the CDC undertakes?

18          A.    Well, that's what I meant, trying to get as  
19          much information as possible.

20          Q.    Okay.  So could you say a little bit more  
21          about what you mean when you say they try to  
22          get as much information as possible.

23          A.    They will try to get information about things  
24          like gestational age and so on and so forth.  
25          Again, I don't have their protocol in front

1 of me so I don't want to try to recite it  
2 from memory.

3 Q. And are you aware of who at the CDC  
4 undertakes the review of these reports?

5 A. I do not know. I would have to look at their  
6 report to see that, which should be very  
7 straightforward and easy to do.

8 Q. Okay. So back to Ex- -- Exhibition -- or  
9 Exhibit B, your declaration in this case.

10 A. Just give me a moment. Yes.

11 Q. So in Paragraph 39 of your declaration you  
12 cite a study by Cates and Grimes, correct?

13 A. Yes.

14 Q. And that study is to support your assertions  
15 about the mortality rate of the D&E abortion  
16 procedure; is that right?

17 A. No.

18 Q. What is it for?

19 A. It's to show trends. I was not citing  
20 because that study's obviously very old, but  
21 I was trying to make the point about methods  
22 of D&E -- methods of abortion in the second  
23 trimester and trends in how abortion data  
24 were collected and so on and so forth. I was  
25 not making a comment about mortality per se

1 in that era compared to this era.

2 Q. What trend do you think the study  
3 exemplifies?

4 A. I think that it shows that the -- again,  
5 using contemporaneous -- their techniques  
6 were similar to what we use now, but it  
7 showed that their rate -- the increase in  
8 mortality in their study was fairly  
9 substantial between 13 to 15 weeks and  
10 greater than 16 weeks. That was the point  
11 that I was trying to make.

12 Q. So you acknowledge that the study is fairly  
13 old and, as you say in your report, it looked  
14 at D&E procedures performed from 1972 to  
15 1978, correct?

16 A. That's correct.

17 Q. And that was before -- at least some of the  
18 abortions in the study were performed before  
19 the Supreme Court's decision in 1973 in Roe  
20 v. Wade, correct?

21 A. That's correct.

22 Q. Do you know the circumstances under which an  
23 abortion prior to Roe could be performed in  
24 most states?

25 A. It depended on the state and it was -- it was

1 not as much of a patchwork as it was that the  
2 legalization of abortion proceeded starting  
3 with -- I believe was California and New  
4 York. I don't know which one was first.

5 But, again, that's not the point I was  
6 trying to make. The point I was trying to  
7 make was the change in mortality rates that  
8 occurred from 5.6 per hundred thousand at 13  
9 to 15 weeks to 14 at greater than 16 weeks.  
10 That's the point I was trying to make.

11 Q. Do you think that the rates -- the trend that  
12 you're discussing might have been affected by  
13 the medical procedures used 40 years ago?

14 A. I think that the D&E procedure they were  
15 using then was similar to what we're using  
16 now. And in the second part where I talked  
17 about installation procedures and  
18 prostaglandin and hysterotomy, the point I  
19 was making there is that those procedures are  
20 actually still used in some states and that  
21 they're associated with significantly  
22 increased rates of mortality.

23 Q. Do you believe that PPSAT uses any procedure  
24 other than D&E for abortions in the second  
25 trimester?

1 A. Not to the best of my knowledge, but, again,  
2 that's not the point I was making. I was  
3 looking at overall abortion-related  
4 mortality.

5 Q. Do you believe that advances in medicine  
6 could have undermined the conclusions of the  
7 study with respect to the trend across  
8 gestational ages?

9 A. I can't speak to that. I can't say what  
10 could or could not have happened.

11 Q. Do you believe that medicine does advance  
12 over time?

13 A. Yes.

14 Q. And are you aware that the study's authors  
15 found that out of 234,000 D&E abortions,  
16 there were only 18 deaths?

17 A. Yes, I'm aware of that. But, again, the  
18 point I'm trying to make was not related to  
19 mortality rate per se; it was related to  
20 mortality rate as it increases with  
21 gestational age.

22 Q. Are you aware that the authors of the study  
23 concluded that D&Es performed in nonhospital  
24 settings had lower death-to-case rates than  
25 those performed in hospitals?

1 A. I'm aware of that, but, again, that's not the  
2 point I was trying to make by citing this  
3 study. And, again, the study is not  
4 contemporaneous.

5 Q. And are you aware that the study's authors  
6 concluded that comparative mortality data  
7 indicate that performing D&E outside of  
8 hospitals carries no greater risk of death?

9 A. Oh, yeah, I'm aware of that, but, again, as  
10 you said, this study is how old now?

11 Q. Doctor, you've expressed doubts with the  
12 completeness of the CDC's surveillance of  
13 abortion-related mortality; is that correct?

14 A. Yes.

15 Q. Are you aware that this study relies on  
16 annual abortion surveillance conducted by the  
17 CDC at the time?

18 A. Am I aware of what?

19 Q. That the study relied on CDC's annual sur- --  
20 abortion surveillance activities when  
21 calculating mortality rate.

22 A. You're talking about the 1991 study?

23 Q. Yes.

24 A. Correct. I'm familiar with Willard Cates'  
25 and David Grimes's work.

1 Q. Is it your view that abortion mortality  
2 surveillance is more accurate in countries  
3 like the United Kingdom with nationalized  
4 health systems?

5 A. No, because I think they have the same  
6 problem of ascertainment that we have here  
7 and they also have significant problems with  
8 issues around miscoding just as we have here.  
9 And what I mean by that is that some abortion  
10 deaths are coded as being due to pregnancy or  
11 natural causes. And an excellent example of  
12 that is the unfortunate young lady who I  
13 mentioned earlier, Keisha Atkins, who died  
14 as -- due to complications from a late -- I  
15 believe it was between 38 -- 28- and 32-week  
16 abortion who was listed as -- the cause of  
17 death was pregnancy. So they suffer from the  
18 same issues that we have in terms of  
19 miscoding, in terms of inaccurate --  
20 insufficient ascertainment.

21 Q. To be clear, Keisha Atkins died in the United  
22 States, not the United Kingdom, right?

23 A. But I'm using that as an example of something  
24 that I think is a phenomenon common to all  
25 abortion statistics and not just abortion,



1 other causes of death as well.

2 Q. So why is the ascertainment better in Finland  
3 than in the United Kingdom?

4 A. Because once you enter the health system when  
5 you're born, you don't exit it till you die.  
6 Every encounter with the medical system is  
7 documented and every encounter with the  
8 medical system, when researchers go to look  
9 at it, they can look at what the coding was  
10 and correlate it to a hospital chart if they  
11 want to. We do not have those capa- --  
12 capabilities.

13 Q. Sure. I asked you about the United Kingdom.  
14 So do you have any basis to believe in the  
15 United Kingdom the surveillance is different  
16 than in Finland?

17 A. It is because the national health service is  
18 a national health service, but it does not  
19 enroll patients from birth to death and  
20 collect comprehensive data on every encounter  
21 with the medical system. They can collect  
22 data administratively and then try to go back  
23 and look at patient-level data, but to have  
24 granular patient-level data requires  
25 something like what they have in Scandinavia.

1 Q. Have you examined patient-level data or any  
2 health service data from the United Kingdom?

3 A. Yes, I have looked at some -- some of their  
4 data.

5 Q. In what context?

6 A. I was interested in some of their maternal  
7 mortality data because what their data was  
8 showing was that there were disparities in  
9 maternal mortality between women of color and  
10 white women even though they have a  
11 nationalized health system. I have not  
12 looked at patient charts because I haven't  
13 gotten permission to do that.

14 Q. Do you believe that the data that you  
15 reviewed was inaccurate?

16 A. It was aggregate data and I can't vouch for  
17 its integrity or its quality.

18 Q. Do you -- are you aware that the authors of  
19 the 1981 Cates and Grimes study found that  
20 the death case rates for D&E in the United  
21 States are consistent with British data?

22 A. I was not aware of that. And, again, the  
23 point of my citing that study was simply to  
24 show the difference -- the issues around  
25 increasing mortality with increasing

1 gestational age. That was the point of my  
2 citing it.

3 Q. And in Paragraph 179 of your declaration you  
4 cite a source by Lanska. Can you say what  
5 that source is.

6 MR. BOYLE: What paragraph is that,  
7 please?

8 MR. MENDIAS: That was 179.

9 MR. BOYLE: Thank you.

10 A. Yes.

11 Q. What is that source?

12 A. It's a journal article.

13 Q. Okay.

14 MR. MENDIAS: I'm going to mark this,  
15 please. Thank you so much.

16 (WUBBENHORST EXHIBIT N, Letters to the  
17 Editor, 2/17/2017, was marked for  
18 identification.)

19 MR. BOYLE: Thank you.

20 BY MR. MENDIAS:

21 Q. And, Doctor, this is not a journal article,  
22 is it?

23 A. It's a letter to the editor. That's correct.  
24 Yeah.

25 Q. So it was not peer reviewed?

1 A. Uh-huh. That's correct.

2 Q. And the letter was written in 1983, correct?

3 A. That's correct.

4 Q. And isn't it true that the only source cited  
5 in this article -- or the only sources cited  
6 in this article are from 1981 or earlier?

7 A. That's correct.

8 Q. And the --

9 A. The point -- I'm sorry.

10 Q. No. Go ahead.

11 A. If I can continue, the point I was making in  
12 including these -- including this particular  
13 letter is that it's stated in a very clear  
14 and understand way that the -- I think it's  
15 the first, second -- third paragraph on Page  
16 362 where it says, The mortality rate for  
17 vaginal deliver- -- excuse me. Excuse me.  
18 The mortality rate for vaginal deliveries may  
19 be artificially low because high-risk mothers  
20 are more likely to have a cesarean delivery.  
21 This effect could be eliminated by adjusting  
22 for preexisting medical conditions between  
23 the vaginal and cesarean delivery subgroups  
24 as the authors did in calculating rates for  
25 women who had an abortion.

1           So the only reason I was including this  
2           was not as a way of comparing maternal  
3           mortality, which was higher at that time.  
4           And certainly, this is, you know, 40 year --  
5           some-odd years ago, but it was easily -- an  
6           easy-to-understand way of talking about how  
7           high-risk moms are more likely to have a  
8           cesarean delivery, which is associated with  
9           increased risk for mortality than low-risk  
10          moms.

11        Q.    In defining a high-risk delivery, the  
12           letter's authors assume that maternal  
13           mortality following a cesarean is  
14           approximately a hundred per 100,000; isn't  
15           that correct?

16        A.    Yes.  But, again, I'm not looking at their --  
17           or not citing their specific data.  What I'm  
18           trying to help to present and perhaps didn't  
19           need -- and appreciate the opportunity to  
20           make it clearer is that cesarean delivery is  
21           associated with a higher mortality rate than  
22           vaginal delivery --

23        Q.    Do you believe --

24        A.    -- and that when you combine maternal  
25           mortality statistics, very often that

1           distinction is not made. That's the only  
2           point I was trying to make.

3           Q. Do you believe that the mortality rate today  
4           following C-section is a hundred per 100,000?

5           A. I just said a moment ago that I am not  
6           relying on the maternal mortality statistics.  
7           I am simply making the point that cesarean  
8           delivery is associated with higher mortality  
9           and morbidity than vaginal delivery.

10          Q. I understand. But I'm asking you if you  
11          believe that the mortality rate today  
12          following a cesarean section --

13          A. No, it's not.

14          Q. What do you think it is?

15          A. I think that the most recent statistics I saw  
16          were that the -- I would have to look, but I  
17          think the mortality rate for a cesarean  
18          delivery is about ten times greater, but,  
19          again, I would have to look to be sure of  
20          that.

21          Q. And the authors of the letter conclude that,  
22          Cesarean sections account for only 10 percent  
23          of deliveries and 90 percent of maternal  
24          mortality associated with childbirth; is that  
25          right?

1 A. That was true then, but it's not true right  
2 now --

3 Q. So you're not --

4 A. -- because we have a much higher -- sir?

5 Q. No. Go ahead.

6 A. No. Please complete your question.

7 Q. I just wanted to confirm. So you don't  
8 believe that 90 percent of maternal deaths  
9 associated with childbirth are attributable  
10 to C-sections today?

11 A. No, I don't think that that's the case. I  
12 think that the other point is that our  
13 cesarean rate is much -- what I was going to  
14 say is that the -- our cesarean rate is much  
15 higher than it was at that point.

16 Q. Understood. Doctor, what is an ectopic  
17 pregnancy?

18 A. It's an -- ectopic pregnancy, excuse me, is a  
19 pregnancy that implants outside of the  
20 uterus. It can implant in a variety of other  
21 sites, but the majority of them implant in  
22 the fallopian tube.

23 Q. And how common is ectopic pregnancy?

24 A. 1 to 2 percent of pregnancies in the United  
25 States.

1 Q. What are the risks of an ectopic pregnancy?

2 A. Rupture with hemorrhage requiring urgent  
3 surgical intervention; death; complications  
4 of hypovolemia, for example, if she bleeds  
5 and then suffers heart attack or other  
6 complications as well.

7 Q. Do you know what the rate of each of those  
8 risks is, how frequently they occur in an  
9 ectopic pregnancy?

10 A. I couldn't tell you what -- the risks  
11 associated with hypovolemia. I do -- I can  
12 affirm that ectopic pregnancy is the leading  
13 cause of first-trimester maternal death.

14 Q. Sure. Do you know the specific rate, how  
15 many women per ectopic pregnancy die in this  
16 country?

17 A. No. I think that the point is -- as I was  
18 saying earlier, that it's fairly common,  
19 happening in 1 to 2 percent, and it is not an  
20 easy diagnosis to make always.

21 Q. Do you know at what point in pregnancy an  
22 embryo can be visualized with a transvaginal  
23 ultrasound?

24 A. Depends on the woman. So most pregnancies  
25 and the radiology literature state that you



1 should be able to visualize an embryo  
2 sometime between four and six weeks, but it  
3 can be longer. Relates to tissue  
4 characteristics, to the skill of the  
5 operator.

6 Q. Would you consider a pregnancy of unknown  
7 location to be equivalent to a confirmed  
8 ectopic pregnancy?

9 A. No.

10 Q. And if a patient has a pregnancy of unknown  
11 location but no symptoms of ectopic  
12 pregnancy, do you consider that a suspected  
13 ectopic pregnancy?

14 A. It's suspected until proven otherwise.  
15 That's axiomatic in OB/GYN.

16 Q. So your opinion is that all pregnancies of  
17 unknown location should be assumed to be  
18 ectopic until ruled out?

19 A. Yes, because if you miss it and a woman dies,  
20 then that's very bad.

21 Q. And so you said in your declaration that  
22 ectopic pregnancy is a contraindication to  
23 medication abortion.

24 A. That's correct.

25 Q. Why is it contraindicated?

1 A. I'm just quoting FDA's -- the prescribing  
2 information there.

3 Q. Do you have your own basis for believing that  
4 it's contraindicated?

5 A. I was just quoting the prescribing  
6 information. I'm sorry. I'm just putting  
7 this in order. Just my little thing here  
8 of --

9 Q. Uh-huh.

10 A. -- keeping papers straight. Yeah.

11 Q. Okay. So you don't have any other knowledge  
12 about why it might be contraindicated?

13 A. No, sir. I'm relying on what the prescribing  
14 information states.

15 Q. Do you believe that mifepristone causes tubal  
16 rupture?

17 MR. BOYLE: Object to form.

18 A. No.

19 Q. Do you believe that misoprostol can cause a  
20 tubal rupture of an ectopic pregnancy?

21 A. Not to my knowledge.

22 Q. Would you agree that an ectopic screening  
23 protocol that uses ultrasound and hCG testing  
24 is appropriate?

25 A. Yes.

1 Q. Do you know PPSAT's protocol for providing  
2 medication abortion when there is a pregnancy  
3 of unknown location?

4 A. My understanding is that it relies on ruling  
5 out ectopic pregnancy through -- or  
6 attempting to rule out ectopic pregnancy  
7 based on symptoms and history and not  
8 ultrasound.

9 Q. Do you believe that PPSAT provides medication  
10 abortion to patients without having first  
11 performed an ultrasound?

12 A. Yes.

13 Q. Do you believe that PPSAT provides medication  
14 abortion to patients without doing hCG  
15 testing?

16 A. Can I just --

17 Q. Sure.

18 A. -- clarify that? So your question was do I  
19 believe that PPSAT provides medication  
20 abortion to patients without an ultrasound.  
21 Yes. In -- in all cases, I don't know.

22 Q. So do you believe that PPSAT provides  
23 medication abortion to patients without doing  
24 hCG testing?

25 A. My understanding and the specific issue that

1 I was responsive to here was the pregnancy of  
2 unknown location. Reading the -- what  
3 Dr. Farris said, it appears that PPSAT does  
4 not perform -- routinely perform transvaginal  
5 ultrasound in a patient with pregnancy of  
6 unknown location to rule out ectopic  
7 pregnancy.

8 Q. If a patient seeking medication abortion  
9 can't obtain one because she has a pregnancy  
10 of unknown location, do you believe that the  
11 law's requirement to document an intrauterine  
12 pregnancy requires that patient to seek  
13 further screening --

14 A. Can you --

15 Q. -- for ectopic pregnancy?

16 A. Can you --

17 MR. BOYLE: Object to form.

18 A. Yeah. Can you break that question down? I'm  
19 sorry. It's --

20 Q. Sure.

21 A. -- long.

22 Q. So you understand that the law that you are  
23 here testifying in support of requires the  
24 documentation of an intrauterine pregnancy  
25 before a medication abortion can be provided,

1 correct?

2 A. Yes.

3 MR. BOYLE: Object to form. You can  
4 answer.

5 BY MR. MENDIAS:

6 Q. And if a patient because of that requirement  
7 cannot obtain a medication abortion, is it  
8 your understanding that anything in the law  
9 requires her to seek further screening for  
10 ectopic pregnancy?

11 MR. BOYLE: Object to form. You can  
12 answer.

13 A. I'm really having trouble following you.  
14 What -- what do you mean by cannot obtain an  
15 abortion?

16 Q. Well, as you understand, the law does not  
17 permit a medication abortion in cases of  
18 pregnancy of unknown location, correct?

19 MR. BOYLE: Object to form. You can  
20 answer.

21 A. That's correct. But if the patient has a  
22 pregnancy of unknown location, it's -- you  
23 must triage that patient to either a  
24 diagnosis of ectopic pregnancy, intrauterine  
25 pregnancy, or a failing pregnancy,

1 miscarriage. It doesn't mean that she can't  
2 have an abortion. I don't understand what  
3 you mean by that.

4 Q. If a patient prefers a medication abortion  
5 but she doesn't have a documented  
6 intrauterine pregnancy, do you believe that  
7 she can get an abortion under the law?

8 A. If she has an ultrasound that diagnoses her  
9 to have a living intrauterine pregnancy.  
10 If -- if she has -- if -- she could either  
11 have an ectopic pregnancy, in which  
12 medication abortion would be entirely  
13 inappropriate; she could have a miscarriage,  
14 in which case medication abortion would be  
15 inappropriate because she would have passed  
16 that demised fetus on her own or potentially  
17 needed follow-up down the road but certainly  
18 wouldn't have necessarily needed to -- to be  
19 treated for and charged for an abortion; or  
20 she has a viable intrauterine pregnancy that  
21 she could have an abortion.

22 So I'm -- I'm just not understanding  
23 your question, maybe. Maybe I just don't --  
24 I don't get what you're saying.

25 Q. You understand that some patients prefer

1 medication abortion over surgical abortion,  
2 correct?

3 A. Yes. And those patients have the option to  
4 get it when an -- a vi- -- an intrauterine  
5 pregnancy is seen.

6 Q. And if they don't have a documented  
7 intrauterine pregnancy --

8 A. Then they must be triaged to a diagnosis of  
9 either intrauterine pregnancy, failing  
10 pregnancy or miscarriage, or ectopic  
11 pregnancy.

12 Q. And what does triaging mean?

13 A. You apply the appropriate diagnostic  
14 procedures to make -- to identify the  
15 location of the pregnancy.

16 Q. And if a patient refuses to comply with those  
17 diagnostic procedures, what happens then?

18 A. Then you have an obligation to not administer  
19 a medication that could -- that she either  
20 doesn't need or would not be effective.

21 Q. Does anything in the law require that woman  
22 to then seek ectopic screening elsewhere?

23 MR. BOYLE: Objection.

24 BY MR. MENDIAS:

25 Q. You can answer.

1 A. I don't understand the -- the legal issue. I  
2 mean, I'm here as a witness on medical  
3 issues; I can't speak to the legal issue.

4 Q. Okay. You've read the laws in question?

5 A. Yes, I have. But, again, I'm -- I'm here to  
6 speak to the -- to the -- to the -- the  
7 medical issues as an expert.

8 Q. Okay. So in Paragraph 268 of your  
9 declaration...

10 A. Just give me one moment, sir.

11 Q. Sure.

12 A. Yes.

13 Q. So you say that if a patient's h- -- well,  
14 you quote Dr. Farris who says that if a  
15 patient's hCG levels are sufficiently high,  
16 this may be evidence of ectopic pregnancy,  
17 correct?

18 A. Yes.

19 Q. And you suggest that implicit in that  
20 statement is that the patient must now  
21 undergo surgical abortion in addition to  
22 medical abortion; is that correct?

23 A. Okay. What I say is, Implicit in this  
24 statement is the fact that because  
25 appropriate diagnostic steps to rule out



1 ectopic pregnancy were not taken at the time  
2 of the patient's initial visit, she must now  
3 undergo surgical abortion in addition to  
4 medical abortion.

5 Q. So --

6 A. So that's what I said and what I mean by that  
7 is the fact that if the patient had had an  
8 ultrasound that could confirm a diagnosis of  
9 intrauterine pregnancy, ectopic pregnancy, or  
10 miscarriage, she would have not received a  
11 medication that she did not need and then she  
12 would not have had to have both a medical  
13 abortion and a surgical abortion.

14 Q. Is it your understanding that PPSAT only  
15 offers the patient the option of a surgical  
16 abortion in this circumstance?

17 A. That's not what I said here. What I said is  
18 that the patient has already undergone a  
19 medical abortion and now, because she did not  
20 have an ultrasound to triage her to the  
21 appropriate diagnostic category, she has to  
22 have a surgical abortion in addition to her  
23 medical abortion.

24 Q. Well, what is your basis for saying that she  
25 has to have just now or in the report she

- 1 must now undergo a surgical abortion?
- 2 A. Because that's what their protocol says. It  
3 says that if the hCG is elevated, they would  
4 now do a surgical abortion. If there were --  
5 was no -- if there were no chorionic villi or  
6 gestational sac on that surgical abortion,  
7 then she would have to go and be seen for an  
8 ectopic preg- -- to diagnose an ectopic  
9 pregnancy, whereas, if they had done the  
10 transvaginal ultrasound initially and said,  
11 okay, this is either -- we -- we don't --  
12 this is either a -- we can't really tell what  
13 this is, this could be a miscarriage, this  
14 could be an ectopic pregnancy, it could be an  
15 intrauterine pregnancy, and had tri- --  
16 triaged her to the appropriate diagnostic  
17 category, she would not have had to undergo  
18 those procedures and pay for both of those.
- 19 Q. So my question is, if a patient returns after  
20 a medication abortion with high hCG levels,  
21 you believe the only option PPSAT says to her  
22 is a surgical abortion?
- 23 A. No.
- 24 Q. What else do they offer her?
- 25 A. First of all, again, I'm not talking about --

1 I am talking about in the pre- -- patient  
2 with a pregnancy of unknown origin where  
3 you -- they did not do a screening ultrasound  
4 to ascertain the location of the pregnancy.  
5 If they then -- they did not do that  
6 ultrasound, she comes back with high hCG  
7 levels, they have no basis -- no diagnostic  
8 basis for -- to have triaged her into one of  
9 those three categories, then their own  
10 protocol says that they perform a surgical  
11 abortion.

12 Q. You believe that the protocol only includes a  
13 surgical abortion at that point?

14 A. No. That's not what I'm saying. I'm saying  
15 that is what their protocol says is part of  
16 their algorithm.

17 Q. Do you believe a physician provides  
18 substandard care if they do not provide every  
19 medical service a patient might need?

20 A. I don't -- I think that that's a -- it's a  
21 question that I really can't answer because  
22 it's -- a patient's perception of need has  
23 nothing to do necessarily -- or may not have  
24 anything to do with actually what's medically  
25 appropriate.

1 Q. When you treat patients, do you occasionally  
2 refer them for services that you do not  
3 provide?

4 A. Yes.

5 Q. Do you think that that's a shortcoming of  
6 your medical practice?

7 A. Well, not so much in my current medical  
8 practice, actually --

9 Q. It's something --

10 A. -- because I'm a hospitalist and my primary  
11 responsibility is patients in labor.

12 Q. Do you believe that a physician who practices  
13 in an outpatient setting and refers a patient  
14 for medical services that physician does not  
15 provide is deficient in some way?

16 A. Not necessarily. Depends on the clinical  
17 situation.

18 Q. Are you aware of any early medication  
19 abortion patients who have experienced  
20 negative outcomes from an ectopic pregnancy  
21 as a result of PPSAT's protocol?

22 A. No.

23 Q. In Paragraph 351 of your report --

24 A. Yes.

25 Q. -- you discuss a study by Barnhart, et al.,

1 correct?

2 A. Yes.

3 Q. And you say -- one moment. And -- okay.  
4 Actually, Paragraph 354 you say in reference  
5 to this study that, Performing a medical  
6 abortion without identifying the location of  
7 pregnancy goes against the recommendations in  
8 this paper.

9 Where in Barnhart, et al., do they  
10 discuss medication abortion?

11 A. They talk -- it's -- it's -- the point that  
12 I'm trying to make there is not Barn- --  
13 whether Barnhart discusses medication  
14 abortion. The point -- the overarching and  
15 much bigger point and the reason why there is  
16 an enormous literature on pregnancy of  
17 unknown location is that you must triage a  
18 patient -- as it says in Paragraph 353,  
19 Pat- -- patients must have an ultimate  
20 diagnosis of an IUP, an ectopic pregnancy, or  
21 spontaneous resolution of a pregnancy.

22 That is the point that I'm trying to  
23 make. It's not whether they mention  
24 medication abortion or not. It is simply one  
25 of the best studies that synthesizes the

1 available consensus on pregnancy of unknown  
2 location.

3 Q. So does the paper discuss medication abortion  
4 at all?

5 A. It doesn't discuss it, but that's not why I  
6 included it. The reason I included it here  
7 is because it clearly states unequivocally  
8 and as consensus that pregnancies of unknown  
9 location must be appropriately diagnosed --  
10 triaged into appropriate diagnostic  
11 categories. That is the important point that  
12 I'm trying to make here.

13 Q. I know you say that you are a hospitalist  
14 now, but did you provide treatment to  
15 patients in an outpatient setting?

16 A. Yes.

17 Q. Did you provide prenatal care to patients in  
18 an outpatient setting?

19 A. Did I?

20 Q. Yes.

21 A. Yes.

22 Q. When you did provide prenatal care to  
23 outpatients, at what point in pregnancy do  
24 you typically begin seeing them for prenatal  
25 care?

1 A. I started seeing them sometimes from very  
2 soon after they had a positive home pregnancy  
3 test.

4 Q. Can you estimate about how many weeks since  
5 the patient's last menstrual period that  
6 would have been?

7 A. So typically, for most women, they present  
8 for care if they've done a home pregnancy  
9 test early because they -- they -- when they  
10 come in to see -- see us, it's typically  
11 sometime between six and ten weeks I would  
12 say.

13 Q. And when you provided prenatal care in an  
14 outpatient setting, when would your patients  
15 typically receive their first ultrasound?

16 A. As soon as they came in or maybe within a  
17 week after they came in if they couldn't stay  
18 for an ultrasound.

19 Q. And what sort of ultrasound was that?

20 A. Usually transvaginal -- abdominal and if, you  
21 know, we couldn't see anything, then  
22 transvaginal.

23 Q. And in Paragraph 358 of your declaration you  
24 discuss -- well, apologies. You -- you first  
25 cite the study in Paragraph 356 but are

1           discussing it there, a study by Borchert, et  
2           al., correct?

3           A.    Yes.

4           Q.    And that is coauthored by Dr. Boraas, an  
5           expert witness for plaintiffs in this case,  
6           correct?

7           A.    Yes.

8           Q.    And you assert that, With a high  
9           loss-to-follow-up rate, no conclusions can be  
10          drawn related to risks for complications,  
11          right?

12          A.    Yes.

13          Q.    Is there anything in the paper that you read  
14          that suggests the patients who were lost to  
15          follow-up were different in any meaningful  
16          way from the ones who remained in the study?

17          A.    You can't say.  They -- they were lost to  
18          follow-up so you can't say.

19          Q.    Do you think that there was any information  
20          taken about those patients initially?

21          A.    I think that some information was taken, but  
22          there's absolutely no way to determine from  
23          the paper how the patients -- how the  
24          distribution of risk factors or  
25          sociodemographic factors or anything else



1           differed between the patients lost to  
2           follow-up versus the ones that stayed.

3           Q.    Dr. Wubbenhorst, you submitted a report to  
4           the Inter-American Court of Human Rights,  
5           correct?

6           A.    Yes.

7           Q.    And that was specifically an expert opinion  
8           in support of the Republic of El Salvador in  
9           a legal challenge to the application of its  
10          abortion ban for a woman known as Beatriz,  
11          correct?

12          A.    Yes.

13          Q.    Is it fair to say that you support  
14          El Salvador's abortion laws?

15          A.    Yes.

16          Q.    Are you aware that abortion in El Salvador is  
17          illegal in every circumstance?

18          A.    Yes.

19          Q.    Are you aware that it is punishable by up to  
20          40 years in prison?

21          A.    Yes.

22          Q.    Are you aware that there are dozens of women  
23          currently imprisoned in El Salvador?

24          A.    I was not aware of that.

25          Q.    Do you believe that pregnant women in North

1 Carolina who seek and obtain abortions should  
2 be criminally prosecuted?

3 A. I think I said earlier in this deposition  
4 that I do not believe that women should be  
5 prosecuted. If I didn't say it then, then  
6 I'm going to say it now. I think that we  
7 need compassion for women. We need to help  
8 them to see that there are alternatives to  
9 abortion and help provide the -- that --  
10 those alternatives, whether it's financial,  
11 whether it's walking with them through  
12 pregnancy. In talking with many, many women  
13 who were looking at having abortions, the  
14 number one thing they have said to me is, I  
15 have no one to go with me through this  
16 pregnancy. So I think that if we can provide  
17 that, that's what we do. I do not agree in  
18 prosecu- -- -cuting women or putting them in  
19 jail just to be very clear.

20 Q. If you don't agree with that, then what  
21 motivated your expert opinion -- or what  
22 motivated you to submit an expert opinion in  
23 support of a country that does such a thing?

24 A. I'm not a lawyer and I don't necessarily  
25 agree with that, but the goal -- the stated

1 goal of the challenge to El Salvador's law  
2 was to create abortion on demand at any  
3 gestational age. The people challenging the  
4 statute were very clear that that was what  
5 they were trying to do. I do not agree with  
6 that. How El Salvador deals with the  
7 question of pregnant women who have abortions  
8 is -- I don't nec- -- I do not agree with  
9 that. I'll be very clear with that. But I  
10 do not agree that their laws should be  
11 overturned -- and not just El Salvador but  
12 the rest of Latin America -- their laws  
13 should be overturned to allow abortion on  
14 demand at any gestational age.

15 Q. Do you believe that Beatriz was seeking  
16 abortion on demand at any age?

17 A. I'm very familiar with the case. She was  
18 not. She was seeking the -- looking for an  
19 abortion because her child had anencephaly.  
20 However, as I've just said, the people who  
21 are seeking to overturn -- -turn the laws  
22 have made it very clear in multiple arenas  
23 that that was their goal.

24 Q. But Beatriz's family was a participant in  
25 this litigation, correct?

1 A. The -- I don't know. I don't know.

2 Q. It's also true that Beatriz suffered from  
3 lupus, correct?

4 A. That's correct.

5 Q. And isn't it true that women with lupus  
6 occasionally suffers negative pregnancy  
7 outcomes as a result of the lupus?

8 A. But I'm going to return to something I said  
9 earlier. You cannot predict whether a given  
10 woman -- all of our strategies around risk  
11 are population-based risk stratification  
12 strategies. They do -- cannot predict  
13 whether a single patient will undergo a  
14 complication. And in her case, she did not.

15 Q. And my question is whether a woman with  
16 lupus -- at a population level, women with  
17 lupus, if they face higher risks of  
18 complications during their pregnancy as a  
19 result of lupus.

20 A. They do. And if those complications occur,  
21 then we intervene appropriately.

22 Q. And do those women also experience a higher  
23 rate of death during pregnancy as a result of  
24 lupus?

25 A. With good medical care, it is very unusual.

1           And as I've said, if a woman develops  
2           complications like nephritis, encephalitis,  
3           any other complication from lupus, we  
4           intervene urgently and do what is best for  
5           the mom.

6           Q.   Do you believe that El Salvador is a place  
7           that provides good medical care to women with  
8           lupus who are pregnant?

9           A.   From reviewing the -- her chart, which I did,  
10          I reviewed her chart in its entirety, yes,  
11          they provided excellent medical care.

12          Q.   She had a C-section at 26 weeks, correct?

13          A.   That's correct.

14          Q.   Do you believe that is the standard of care  
15          for a woman who seeks an abortion at 13 weeks  
16          because of health concerns?

17          A.   It has nothing to do --

18                         MR. BOYLE:  Objection to form.  You can  
19          answer.

20          A.   It has nothing to do with abortion.  It has  
21          to do with the clinician's assessment of what  
22          was the appropriate management for her at  
23          that stage.

24          Q.   If Beatriz decided that she didn't want to  
25          bear the risk, whatever it might be, for any

1 individual woman with lupus --

2 A. Bear the risk of what?

3 Q. A negative complication or death from lupus  
4 during pregnancy, the standard of care is to  
5 deny her an abortion you feel?

6 MR. BOYLE: Objection to form. You can  
7 answer.

8 A. I don't think we're talking about a standard  
9 of care; we are talking about the law. The  
10 law states that abortion is illegal. If she  
11 had a complication and she needed to have  
12 urgent delivery, that is not an abortion.  
13 I've made that clear previously and I think  
14 you understand that. That is not an  
15 abortion. That is simply acting to preserve  
16 the life of the mother, but the intent is not  
17 to kill the -- the infant.

18 Q. But you did refer to good medical care that  
19 met the standard of care that Beatriz  
20 allegedly received, correct?

21 A. Because I reviewed the chart and I felt that  
22 she did receive good medical care.

23 Q. And you say that that care helped her achieve  
24 a goal of good medical care during pregnancy,  
25 correct?

1 MR. BOYLE: Object to form.

2 A. I don't understand your question.

3 MR. MENDIAS: So I can -- I'll mark  
4 this as an exhibit. Thank you.

5 (WUBBENHORST EXHIBIT O, Expert Opinion  
6 Report, Dr. Monique Chireau Wubbenhorst,  
7 Beatriz, was marked for identification.)

8 MR. BOYLE: Thank you.

9 MR. MENDIAS: Uh-huh.

10 A. Great. Thank you for providing this.

11 Q. Uh-huh. So on Page 38 of that report, the  
12 first nonindented paragraph, the one that  
13 begins, Like other women --

14 A. Yes.

15 Q. -- can you read the first two sentences --

16 A. Uh-huh.

17 Q. -- of that paragraph.

18 A. Like other women, Beatriz had the right to  
19 enjoy a good state of health to the extent  
20 possible given her lupus. Good medical care  
21 that met the standard of care helped her  
22 achieve that goal during her pregnancy.

23 Q. So you believe her goal was to have an  
24 emergency C-section at 26 weeks?

25 A. I'm not understanding your question. If

1 she -- she -- that was not her goal, but that  
2 was an outcome of her pregnancy based on the  
3 clinicians that were caring for her. And in  
4 my review of the chart, that was an  
5 appropriate decision.

6 Q. Her goal was to have an abortion at 13 weeks,  
7 wasn't it?

8 A. I can't -- I'm not speaking to that question  
9 of what her goal was or what her goal was  
10 not. The question here is good medical care  
11 met the standard of care that helped her  
12 achieve the goal of having a -- a good state  
13 of health during pregnancy. That is the  
14 question that I am opining -- I opined on in  
15 here.

16 Q. Do you believe that the risks of a C-section  
17 at 26 weeks of pregnancy are greater than the  
18 risks of an abortion at 13 weeks of  
19 pregnancy?

20 A. Again, I don't think that that is a relevant  
21 concept here. She continued her pregnancy.  
22 She needed an emergency cesarean section at  
23 26 weeks for indications that were well  
24 understood, that were -- reflected good  
25 medical care. It was -- would have been



1 impossible to foresee that she was going to  
2 need a cesarean section at 26 weeks and so,  
3 therefore, you can't compare the outcome of  
4 her having an emergency C-section with the  
5 outcome of her having an abortion. She had  
6 good care. She got, from my viewpoint --  
7 again, reviewing the chart in detail, she had  
8 good care and when it was necessary to  
9 deliver the baby, this was the mode of  
10 delivery that was chosen.

11 Q. Okay. But my question was whether the -- you  
12 believe that the risk of complications is  
13 higher from a 13-week abortion than a  
14 C-section at 26 weeks.

15 A. No. I think the risk of complications is  
16 higher for -- I think the com- -- risk of  
17 complications is higher for an -- for a  
18 cesarean section 26 weeks, but I don't think  
19 that's relevant to the question here.

20 Q. But she sought an abortion at 13 weeks,  
21 correct?

22 A. That's correct.

23 Q. And if she had been permitted to obtain an  
24 abortion at 13 weeks, the risk for  
25 complications for a 13-week abortion would

1 have been relevant to her, correct?

2 A. I don't think so because, again, she could  
3 have had an abortion at 13 weeks and had  
4 perforation, had infection, had hemorrhage.  
5 She could have had any one of a number of  
6 outcomes. As I've said, risk is population  
7 stratified. You cannot say what could or  
8 could not have happened. That's speculative.  
9 I can't respond to that.

10 Q. The population of women having C-sections at  
11 26 weeks undergo much higher risks of  
12 complications than the population of women --

13 A. But we're not --

14 Q. -- obtaining abortions --

15 A. -- talking about --

16 MR. BOYLE: Object. Object to form.

17 BY MR. MENDIAS:

18 Q. -- at 13 weeks.

19 A. We're not talking about --

20 MR. BOYLE: Object to form.

21 THE WITNESS: Okay.

22 MR. BOYLE: You can answer.

23 THE WITNESS: Thank you.

24 A. We're not talking about population; we're  
25 talking about her. You can't say that she

1 would have had no risk to an abortion at 13  
2 weeks. You can't say that. And she didn't  
3 have any complications from her cesarean  
4 section at 26 weeks. She died in a car  
5 accident a few years later.

6 Q. Do you believe that her death was  
7 attributable to the fact that she wanted an  
8 abortion?

9 A. No. She died in a car accident.

10 Q. In Paragraph 47 of your report you say that,  
11 Black women have two to three times higher  
12 mortality from abortion compared to white  
13 women.

14 A. Give me -- give me a chance to get there.  
15 Give me a chance to get there. Yes.

16 Q. Do you know if black women also have a higher  
17 mortality from childbirth than white women?

18 A. Yes, they do.

19 Q. Why would the mortality rate be higher for  
20 black women from both abortion and  
21 childbirth?

22 A. Because I think there are underlying  
23 comorbidities that are more common in  
24 African-American women, in particular  
25 diabetes and hypertension. I think the other

1 reason that it's difficult to make that  
2 comparison is that if you look at maternal  
3 mortality statistics, the morbidity and  
4 mortality for African-American women tends to  
5 cluster in older ages and typically, women  
6 undergoing abortion -- late abortion may be  
7 older as well, but that discrepancy is most  
8 likely due to -- although it's -- you know,  
9 there's -- this is a very active area of  
10 research. -- that those differences are  
11 probably due to the distribution of  
12 underlying health factors and possibly to  
13 access to care as well.

14 Q. And in Paragraph 19 of your declaration you  
15 reference, the deliberate targeting and  
16 destruction of 17 million African-American  
17 lives through abortions since Roe; is that  
18 right?

19 A. Yes.

20 Q. Who deliberately targeted African-American  
21 women for abortion?

22 A. I think that if you look at the history of --  
23 of abortion and specifically population  
24 control, it is very clear that black women  
25 and African-Americans in general were seen as

1 the other -- especially in eugenic terms.  
2 That's going all the way back to Galton and  
3 Darwin and those other folks. But as you  
4 continue that thread through the 20th  
5 century, Fredrick Osborn said that abortion  
6 is turning out to -- and contraception  
7 turning out to be great eugenic advances of  
8 our time. Others have said that abortion  
9 is -- I think it was Lawrence Lader said that  
10 abortion is -- is -- is especially useful  
11 given in minorities who are likely to rise up  
12 in armed rebellion. So you have a consistent  
13 thread of a worldview that says that  
14 African-Americans are subhuman and,  
15 therefore, that the -- that abortion can --  
16 has the potential for being a eugenic tool of  
17 injustice.

18 Now, I want to be very clear in saying  
19 that I am not saying that individual abortion  
20 providers have eugenic intent in performing  
21 abortions. I want to be very clear in saying  
22 that. What I am saying is that the outcomes  
23 of policy, especially as -- and practice  
24 especially as they are related to abortion  
25 have led to eugenic outcomes, namely, that

1 most abortions occur in African-Americans  
2 even though we constitute only 13 to 14  
3 percent of the population, that the  
4 African-American population principally  
5 because of abortion is in decline and has  
6 been since the 1990s in terms of the number  
7 of births every year.

8 So that's the point that I'm trying to  
9 make, not attributing intent to anyone  
10 because I can't know someone's intent, but  
11 the outcome remains the same.

12 Q. Is it possible to have deliberate targeting  
13 without intent?

14 A. I think you can -- again, I'm looking at the  
15 outcome.

16 Q. Do --

17 A. I understand -- I understand what you're  
18 saying, but, again, if the result is that you  
19 have this enormous racial disparity in  
20 abortion, I can't ascertain intent, but the  
21 eugenic outcome is -- remains the same.

22 Q. And you can't ascertain whether it's  
23 deliberate, correct?

24 A. What's that?

25 Q. And you couldn't ascertain whether the

1 discrepancy is deliberate?

2 A. Then how else would you arrive at the -- at  
3 the discrepancy if it's not deliberate on  
4 some level and --

5 Q. So the --

6 A. -- and especially if policy, especially  
7 population control policy, has been directed  
8 in -- in -- along those lines --

9 Q. Since --

10 A. -- since --

11 Q. -- 1972 -- '73?

12 A. No. Since -- since before that. Since the  
13 Nixon era and since the 1960s. This -- this  
14 antedates 1973. This has been going on for a  
15 while.

16 Q. Okay. So, Doctor, I'm curious specifically  
17 who you say is deliberately targeting and  
18 destroying 17 million African-American lives.

19 Can you identify who's doing that  
20 deliberate targeting?

21 A. I think that -- again, I am looking at the  
22 outcome and I am looking at the fact that,  
23 whether we like it or not, that disparity  
24 exists. Whether we like it or not, the ugly  
25 fact is that we have had 17 million

1 African-American lives destroyed, that we are  
2 looking at the decline in the number of  
3 births to African-American woman -- women,  
4 that for every three births to  
5 African-American women that occur, there are  
6 two abortions.

7 So whether an individual practitioner  
8 makes a deliberate -- is deliberately  
9 targeting African-Americans, I don't know.  
10 That may be true; that may not be true. But  
11 as a policy statement, the net out- -- the  
12 net outcome is the same.

13 Q. Do you believe that African-Americans who  
14 obtain abortions are complicit in eugenics?

15 MR. BOYLE: Objection.

16 BY MR. MENDIAS:

17 Q. You can answer.

18 A. I'm not -- I don't know what that statement  
19 means. How can you be complicit in eugenics  
20 because eugenics is a worldview? Eugenics  
21 says that one group of people is human and  
22 one group of people is not human and because  
23 this group of people is not human, you can  
24 subject them to anything, any kind of  
25 mistreatment, any kind of suppression.



1 That's -- that's the essence of eugenics as  
2 defined by Galton in his speech in 1901. He  
3 was very clear, according to Darwinian  
4 theories, that some people were the fit and  
5 others were not the fit. And the slogan of  
6 the -- one of the slogans of the American  
7 Eugenics Board was less from the fit -- less  
8 from the unfit, more from the fit. That's  
9 one of the goals of eugenics.

10 Q. Changing topics a little bit, Doctor, what  
11 is, in medicine, an off-label use?

12 A. It's when a medication has been approved for  
13 one specific indication but physicians use it  
14 for another indication.

15 Q. Have you ever prescribed medications for uses  
16 that differ than what's on their FDA-approved  
17 label?

18 A. Yes. This is something, actually, that --  
19 for a number of different medications, using  
20 nifedipine to control blood pressure in  
21 pregnancy. There's -- there's a list of --  
22 of those -- of those medications.

23 Q. Is off-label use common in obstetrics and  
24 gynecology?

25 A. I can't speak to how it's common -- whether

1           it's common or uncommon. I know that it's  
2           something that I do and that many of the  
3           clicians -- clinicians that I know do as  
4           well.

5           Q. In going back to something we talked about  
6           much earlier today, you mentioned that you  
7           had seen -- that you had treated patients who  
8           were suffering from postabortion  
9           complications outside the United States; is  
10          that right?

11          A. Yes.

12          Q. Where did you treat those patients?

13          A. Kenya.

14          Q. Is abortion legal in Kenya?

15          A. No. Well, it's -- the current status is that  
16          it's -- I believe it's legal with  
17          restrictions. I would have to check on the  
18          exact -- the laws changed recently.

19          Q. Was abortion legal in Kenya when you treated  
20          these patients?

21          A. Yes --

22          Q. How --

23          A. -- for specific indications. And the  
24          patients that I treated were actually not --  
25          had not been aborted by, like, back alley

1 abortions or, you know, self-abortions. The  
2 abortions were carried out by NGOs,  
3 nongovernment organizations, who had set up  
4 abortion clinics in those areas and then when  
5 their patients -- when those patients had  
6 complications, they would -- they would come  
7 in and be seen.

8 Q. Did you ever report NGOs performing illegal  
9 abortions in Kenya to anyone?

10 MR. BOYLE: Object to form. You can  
11 answer.

12 THE WITNESS: What's that?

13 MR. BOYLE: Object to form. You can  
14 answer.

15 A. Yeah, I don't know what the indication was  
16 for the abortions.

17 Q. So another topic. We discussed earlier  
18 forensic use of the products of conception  
19 after an abortion to identify a rapist.

20 A. Yes.

21 Q. Do you remember that? Do you know what  
22 protocol PPSAT follows for maintaining a  
23 chain of custody when it provides an abortion  
24 to someone who's been a victim of rape?

25 A. No.

1 Q. You believe that a major flaw in studies  
2 demonstrating the safety of abortion is that  
3 they don't include review of patient medical  
4 charts, correct?

5 A. I wouldn't say it's a --

6 MR. BOYLE: Object to form.

7 THE WITNESS: Okay.

8 MR. BOYLE: You can answer.

9 THE WITNESS: Okay. Thank you.

10 A. No, sir. I wouldn't say that it's a major  
11 flaw because sometimes I think you have to  
12 work with the data that you have and  
13 sometimes the data that you have is not  
14 perfect.

15 MR. MENDIAS: Can I ask how long we've  
16 been --

17 THE REPORTER: I have three hours.

18 MR. MENDIAS: Three hours. Do you want  
19 to take a brief break?

20 THE WITNESS: Thank you, sir. That  
21 would be great. Another bathroom break would  
22 be great. Oops. Wait.

23 THE VIDEOGRAPHER: Going off the  
24 record. The time is 4:46.

25 (Whereupon, there was a recess in the

1 proceedings from 4:46 p.m. to 5:04 p.m.)

2 THE VIDEOGRAPHER: Back on the record.  
3 The time is 5:04.

4 MR. MENDIAS: So, Counsel, I'd just  
5 like to request given that Dr. Wubbenhorst  
6 stated that she has an updated CV if, Ellis,  
7 you could provide that by the end of the  
8 week.

9 THE WITNESS: No problem at all. Yeah.

10 MR. MENDIAS: Wonderful.

11 THE WITNESS: Uh-huh.

12 BY MR. MENDIAS:

13 Q. Okay. So, Doctor, you testified that  
14 abortion patients with complications do not  
15 frequently return to the clinic that provided  
16 the abortion; is that correct?

17 A. That's correct.

18 Q. What's your basis for that statement?

19 A. I believe it's in my declaration that ACOG  
20 noted that 50 percent or fewer of patients  
21 returned to clinic following their abortion.

22 Q. Do you know what year that ACOG statement is  
23 from?

24 A. I'd have to look in here.

25 Q. Do you know if that's examined data from

1 North Carolina?

2 A. I don't know if that was including Nor- --  
3 data from North Carolina.

4 Q. And going back to our conversation about  
5 intrauterine adhesions after a D&C, you  
6 remember that, correct?

7 A. Yes.

8 Q. So I think I asked how frequently your  
9 patients had developed intrauterine  
10 adhesions, but I just wanted to clarify.

11 Have any of your parent -- patients that  
12 you've provided a D&C to developed such  
13 adhesions?

14 A. So I have cared for women who have developed  
15 intrauterine adhesions following prior D&C.  
16 I have not seen my -- any of my own patients  
17 who I performed D&C on return with  
18 intrauterine adhesions.

19 Q. Is it possible that they sought care for  
20 intrauterine adhesions from other providers?

21 A. I think that's possibly it. I think it's  
22 also that I've practiced in a lot of  
23 geographic locales over, you know, the last  
24 30 years so it's entirely possible that if  
25 they developed them, they could have seen

1 another provider.

2 Q. And what does it mean if a patient has  
3 developed an intrauterine adhesion in terms  
4 of consequences for her health?

5 A. So with Asherman's syndrome, intrauterine --  
6 intrauterine adhesions, they're associated  
7 with infertility and dysfunctional uterine  
8 bleeding.

9 Q. Do you characterize that as a serious  
10 condition?

11 A. With -- in the case of dysfunctional uterine  
12 bleeding and -- I -- and I -- there's another  
13 entity with which they're associated and  
14 that's abnormal placental adherence and  
15 that's actually quite serious.

16 Q. How frequently do patients develop abnormal  
17 placentation as a result of Asherman's  
18 syndrome?

19 A. I think that I describe that in my statement  
20 and I can take a look and see, but the real  
21 question was not so much the frequency  
22 because, again, it's hard to get at the  
23 frequency. It's that when patients develop  
24 intrauterine adhesions, they are at higher  
25 risk for going on to have abnormal

1           placentation and -- leading to adhering  
2           placenta, which is a real obstetrical  
3           problem.

4           Q.    When you provided prenatal care to patients,  
5           did you tell them about ectopic pregnancy?

6           A.    I am not following your argument.

7           Q.    Well, it was a question.  When you --

8           A.    I mean, your question.  I'm not following  
9           your question.  Sorry.

10          Q.    When you provided prenatal care to your  
11          patients -- you remember testifying that you  
12          did that, correct?

13          A.    Yes.  Yes.

14          Q.    Did you counsel them on symptoms of ectopic  
15          pregnancy?

16          A.    If they came in and they did not have a -- a  
17          pregnancy that could be seen in the uterus on  
18          ultrasound, definitely.

19          Q.    And what did you say to them as part of that  
20          counseling?

21          A.    So if we did not see a pregnancy on -- then  
22          we would warn them that they might have a --  
23          a -- an ectopic pregnancy, describe what an  
24          ectopic pregnancy was, what the risks were.  
25          And then they would return within 48 hours so



1           that we could rescan them and recheck their  
2           hCG.

3           Q.    Did any patients not return?

4           A.    I've never had a patient not return.

5           Q.    What symptoms would you counsel them to look  
6           for concerning a ruptured eptoc- -- ectopic  
7           pregnancy?

8           A.    Well, I think that it's important to make a  
9           distinction here between symptoms of ectopic  
10          pregnancy which are transient and fleeting --  
11          and, in fact, I wrote a paper -- cowrote a  
12          paper in the Journal of American Medical  
13          Association some years back that looked at  
14          the unreliability -- how reliable were  
15          different symptoms.

16                        So the diagnosis of a ruptured ectopic  
17          pregnancy is fairly straightforward.  Women  
18          will often say they felt a pop, they  
19          experienced terrible pain in their right  
20          side, and they may feel faint.  But one of  
21          the problems that arises with that is that  
22          they don't always associate that with -- they  
23          think, oh, I have, you know, a ruptured cyst  
24          or something like that.  And so the real  
25          danger is that they are not symptomatic

1           enough that they seek medical care and they  
2           bleed and bleed. And healthy young women  
3           have an amazing ability to adapt to loss of  
4           blood, but once they run out of those  
5           adaptive capabilities, they just die. So  
6           this is why diagnosing ectopic pregnancy is  
7           so treacherous. Yes, if they rupture, it's a  
8           little bit more straightforward, but even  
9           sometimes when they're rupturing, it's not  
10          until they become faint or pass out or have  
11          some other complication. And before that,  
12          it's -- it's -- it's very protean. It can be  
13          very difficult. They can -- they can have  
14          bleeding that looks like a miscarriage and  
15          they'll think that they've miscarried, for  
16          example.

17        Q.    At what point in pregnancy does ectopic  
18              pregnancy typically present on an ultrasound?

19        A.    So are you talking about at what point in  
20              pregnancy is it typically diagnosed, sir? Is  
21              that what you're saying?

22        Q.    Sure.

23        A.    Right. So usually, about the same time  
24              plus -- you know, plus a few weeks as you see  
25              an intrauterine preg- -- that you might

1           expect that you would see an intra- --  
2           inter- -- intrauterine pregnancy you could  
3           potentially see an ectopic pregnancy. Again,  
4           the problem is that even with skilled hands,  
5           it depends on -- very much on the hCG level  
6           and there's some -- it depends on the hCG  
7           level and there are sort of formulae or  
8           algorithms that you use.

9           Q.    So throughout your medical career as an  
10           attending, did you train medical residents?

11           A.    Yes.

12           Q.    Has a medical resident ever lodged a  
13           complaint about you?

14           A.    No.

15           Q.    Throughout your medical career have you ever  
16           faced any disciplinary action --

17           A.    No.

18           Q.    -- from a hospital?

19           A.    No.

20           Q.    Have you ever received any disciplinary or  
21           remedial action from a hospital?

22           A.    No.

23           Q.    Have you ever received any disciplinary  
24           action from a state medical board?

25           A.    No.

1 Q. You were with the faculty of Duke University  
2 School of Medicine from 2003 to 2018?

3 A. Yes.

4 Q. It's correct that this is where you practiced  
5 medicine for the significant majority of your  
6 medical career, correct?

7 A. Yes.

8 Q. Under what circumstances did you leave Duke?

9 A. I was recruited starting in fall of 2017 to  
10 the U.S. Agency for International  
11 Development.

12 Q. How would you characterize your relationship  
13 with Duke when you left?

14 A. I would say that it wasn't great. I think  
15 that the -- it was hard to totally assess  
16 this, but I had a sense that they were not --  
17 you know, they were -- people were not in  
18 favor of the pro-life work I was doing.

19 Q. What led you to that conclusion?

20 A. I think that people would say things to me.

21 Q. Such as?

22 A. You know, what -- what's the -- you know, why  
23 are you doing this, you know, that type of  
24 thing.

25 Q. So you weren't asked to resign from your

1 position at Duke?

2 A. No. No, I was not asked to resign.

3 MR. MENDIAS: Okay. I think that's all  
4 the questions that I have.

5 MR. BOYLE: Give me just a moment, if  
6 you would --

7 MR. MENDIAS: Sure.

8 MR. BOYLE: -- please. If -- if anyone  
9 on the Zoom has any questions, I'll -- I'll  
10 defer to y'all.

11 This is Ellis Boyle on behalf of the  
12 legislative leader defendants. I don't have  
13 any questions and I don't hear any from the  
14 Zoom so unless -- I -- I guess that concludes  
15 the deposition.

16 THE REPORTER: Sam?

17 MR. MENDIAS: Thank you very much,  
18 Doctor.

19 THE WITNESS: Okay. Thank you.

20 THE VIDEOGRAPHER: Anybody on the Zoom?

21 MR. BOYLE: No. I think -- I think  
22 we're -- we're clear. You can go off the  
23 record. Thank you.

24 THE VIDEOGRAPHER: This concludes the  
25 deposition. We're going off the record. The

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time is 5:15.

[SIGNATURE RESERVED]

[DEPOSITION CONCLUDED AT 5:15 P.M.]

1 A C K N O W L E D G E M E N T O F D E P O N E N T

2

3 I, MONIQUE WUBBENHORST, M.D., M.P.H.,  
4 declare under the penalties of perjury under the  
5 State of North Carolina that I have read the  
6 foregoing 187 pages, which contain a correct  
7 transcription of answers made by me to the question  
8 therein recorded, with the exception(s) and/or  
9 addition(s) reflected on the correction sheet  
10 attached hereto, if any.

11 Signed this, the \_\_\_\_\_ day of  
12 \_\_\_\_\_, 2023.

13

14

15

\_\_\_\_\_  
MONIQUE WUBBENHORST, M.D., M.P.H.

17

18 State of: \_\_\_\_\_

19 County of: \_\_\_\_\_

20 Subscribed and sworn to before me this  
21 \_\_\_\_\_ day of \_\_\_\_\_, 2023.

22

23

\_\_\_\_\_  
Notary Public

24

25 My commission expires: \_\_\_\_\_







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# EXHIBIT 4

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., PhD.  
August 31, 2023 - 2:05 P.M.

PREPARED BY: Susan A. Hurrey, RPR  
Discovery Court Reporters  
and Legal Videographers, LLC  
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Carrie Rapaport - Videographer

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1                   SUSAN BANE, M.D., PhD, after having been  
2 first duly sworn, was examined and testified as follows:

3                   VIDEOTAPE TECHNICIAN: Good afternoon, ladies  
4 and gentlemen. We are going on the remote video record on  
5 Thursday, August 31, 2023 at 2:05 p.m. I am Carrie Rapaport in  
6 association with Discovery Court Reporters in Raleigh, North  
7 Carolina. This is a matter pending before the United States  
8 District Court for the Middle District of North Carolina in the  
9 case captioned Planned Parenthood South Atlantic, et al.  
10 versus Joshua Stein, et al. and Philip E. Berger, et al. Case  
11 number 1:23-cv-00480-CCE-LPA.

12                   This is the start of media one, volume one of  
13 the deposition of Susan Bane, M.D., Ph.D. The deposition is  
14 being taken on behalf of the plaintiffs. Starting with the  
15 questioning attorney, I will ask counsel to identify  
16 yourselves, state who you represent and whether co-counsel or  
17 your client are in attendance.

18                   MS. SALVADOR: This is Anjali Salvador with  
19 Planned Parenthood Federation of America on behalf of Planned  
20 Parenthood South Atlantic. I do have co-counsel with me here  
21 today.

22                   MR. BOYLE: Good afternoon. My name is Ellis  
23 Boyle, Wake County Bar. I am representing the legislative  
24 defendants Berger and Moore and I am joined by Julie Payne with  
25 the ADF who is co-counsel.

1 MS. GRAUNKE: Hi, everyone. I'm Kristi Graunke  
2 from the ACLU of North Carolina Legal Foundation, appearing for  
3 all plaintiffs. I'm joined today by Elisa Sturkie who is a UNC  
4 law student who is externing with us, and also by my co-counsel  
5 Brigitte Amiri and Ryan Mendias from ACLU's national office.

6 MS. SWANSON: Hi. This is Hannah --

7 MR. WILLIAMS: My name is --

8 MS. SWANSON: Oh, I'm sorry.

9 MR. WILLIAMS: Go ahead, Hannah.

10 MS. SWANSON: Thank you. This is Hannah  
11 Swanson also from Planned Parenthood Federation of America for  
12 Planned Parenthood South Atlantic.

13 MR. WILLIAMS: My name is Kevin Williams from  
14 the Forsyth County Bar and I represent District Attorney Jim  
15 O'Neill.

16 MS. NARASIMHAN: Good afternoon. My name is  
17 Sripiya Narasimhan with the North Carolina Department of  
18 Justice representing Attorney General Joshua Stein.

19 MS. O'BRIEN: Good afternoon. I'm Elizabeth  
20 O'Brien also from the North Carolina Department of Justice. I  
21 represent the DA defendants other than DA O'Neill and my  
22 clients are not present, nor is co-counsel.

23 MR. BULLERI: I'm Michael Bulleri, also with  
24 the North Carolina Department of Justice. I represent the  
25 North Carolina Medical Board, North Carolina Board of Nursing.

1 MS. CROWLEY: Colleen Crowley also with the  
2 North Carolina Department of Justice. I represent North  
3 Carolina Department of Health and Human Services.

4 VIDEOTAPE TECHNICIAN: Thank you. As the  
5 witness has already been sworn in, you may proceed, Counsel.

6 BY MS. SALVADOR:

7 Q. Dr. Bane, good afternoon and thank you for being here  
8 today. My name is Anjali Salvador and I'm one of the attorneys  
9 representing Planned Parenthood South Atlantic in this case.  
10 While we're talking here I might refer to it as PPSAT.

11 Could you please state your full name for the record?

12 A. Yes, I'm Susan Bane.

13 Q. All right. Thank you. We're going to start with some  
14 housekeeping and ground rules. Do you understand that you're  
15 under oath today the same way that you would be in a court room  
16 and that you're obligated to answer my questions truthfully and  
17 completely?

18 A. Yes.

19 Q. So as you heard, we have a court reporter with us  
20 today who will be taking down what we say for a transcript. So  
21 please make an effort to continue giving all of your answers  
22 verbally like you are instead of nodding or shaking your head.  
23 Okay?

24 A. Yes.

25 Q. Also, because of the transcript, we're going to need

1 to do our best not to talk over each other. So please wait for  
2 me to finish each question before answering and I'll wait for  
3 you to finish before asking my next question. Okay?

4 A. Yes.

5 Q. Great. I'll do my very best to ask clear questions.  
6 If you don't understand a question, please feel free to let me  
7 know and I'll rephrase it or repeat it, whatever you need. But  
8 if you do answer I'm going to assume you have understood my  
9 question. Okay?

10 A. That sounds good.

11 Q. Great. If at any point either in the moment or later  
12 in the deposition you realize that you have made a mistake with  
13 a prior answer or you want to clarify something, that's totally  
14 fine, just let me know. Okay?

15 A. Okay.

16 Q. If at any point you need a break, please let me or  
17 your attorney know and we'll take one, with the exception that  
18 if I'm in the middle of a question you'll have to answer it  
19 before we take that break.

20 Do you understand?

21 A. I do.

22 Q. During the deposition your attorney may object to some  
23 of my questions. But unless your attorney directly tells you  
24 not to answer the question, you still have to answer it.

25 Do you understand?

1 A. Yes.

2 Q. And have you turned off your cell phone like the  
3 videographer asked?

4 A. I have.

5 Q. Great.

6 A. Excuse me. Did you say turn off it or -- I muted it.

7 Q. It would be great if you could either -- definitely  
8 silence it, but turning it off would be preferable just so we  
9 know you're not looking at it during the deposition.

10 A. Okay. So I just have it turned over on its backside,  
11 plus it's muted.

12 Q. That's fine. So this is a little invasive and I  
13 apologize, but it's a standard question at the start of  
14 depositions. Are you dealing with any illness or taking any  
15 substance that would affect your memory or prevent you from  
16 being able to understand and answer my questions today?

17 A. No.

18 Q. Thanks. Have you ever had your deposition taken  
19 before?

20 A. I have.

21 Q. How many times?

22 A. As in expert witness?

23 Q. Both as an expert witness or as a fact witness, if  
24 that's happened.

25 A. So I was an expert in a medical malpractice case and



1 then I have a son with special needs and I was an expert in a  
2 case related to him.

3 Q. Did either of those --

4 A. Sorry, I wasn't an expert. I was his mom.

5 Q. Understood. Did either of those cases relate to  
6 abortion in any way?

7 A. They did not.

8 Q. Other than the report you submitted in this case, have  
9 you submitted a -- I'm sorry, the declaration -- have you  
10 submitted a declaration in a legal case before?

11 A. I have not.

12 Q. Have you testified in any court before?

13 A. Yes, in the case that I was the expert witness, the  
14 malpractice case.

15 Q. Got it. What -- so you said you were an expert in  
16 that case, correct?

17 A. Correct.

18 Q. So you were not a party in that case?

19 A. No, I was not.

20 Q. Have you testified before any legislative body?

21 A. Yes.

22 Q. Can you describe that testimony, please?

23 A. Sure. I have testified three times at the North  
24 Carolina State Legislation. One was on the Bill SB20. One was  
25 on a conscience right, conscience protection bill, and the

1 other was on the bill related to gender affirmation care in  
2 minors.

3 Q. Got it.

4 MS. SALVADOR: Counsel, at the break could we  
5 get copies of that testimony, please?

6 MR. BOYLE: Are you asking me?

7 MS. SALVADOR: Yes. I think we had asked you  
8 to produce Dr. Bane's testimony as one of our requests for  
9 production.

10 MR. BOYLE: I don't think she has it.

11 MS. SALVADOR: Okay.

12 BY MS. SALVADOR:

13 Q. Dr. Bane, was that verbal testimony?

14 A. Yes.

15 Q. Okay. Could you describe the nature of your  
16 testimony on SB20, please?

17 A. Yes. I was one of -- I believe they had 10  
18 individuals have -- I think we had one-and-a-half -- one or two  
19 minutes and it was -- so it was the public who could testify.  
20 I think they had 10 of us who supported the bill and 10 who did  
21 not. And so I spoke as a citizen of North Carolina and a  
22 medical doctor, an ob-gyn, why I supported the bill.

23 Q. Why did you support the bill, according to your  
24 testimony?

25 A. I supported the bill because as a medical doctor I

1 don't believe the direct and intentional killing of another  
2 human being is part of medical practice and that for 50 years  
3 we have basically had unfettered access to abortion in the  
4 United States and it has not impacted maternal mortality, that  
5 women in North Carolina need solutions, not greater access.  
6 And that we need to look at root causes. And that this bill  
7 has provisions to support women who are in that position of an  
8 unplanned pregnancy and have socioeconomic, typically, factors  
9 are the main ones that both the literature and I see in my  
10 practice as the reasons and there are provisions in the bill to  
11 support them.

12 Q. Thank you for that description. You mentioned that  
13 you also testified on a bill relating to I believe you said  
14 freedom of conscience, is that correct?

15 A. I did.

16 Q. Could you please describe your testimony for that  
17 bill?

18 MR. BOYLE: Objection. I want to put on the  
19 record that there's been a lot of comment from the plaintiff's  
20 side about focusing this case on -- at this stage of discovery  
21 on the preliminary injunction hearing and I don't know if she  
22 may be talking about something that's germane to that.

23 MS. SALVADOR: That's a speaking objection and  
24 speaking objections aren't allowed under the rules. So your  
25 objection is noted.

1 BY MS. SALVADOR:

2 Q. Dr. Bane, if you could please answer.

3 A. Sure. So I don't have in my head what I said as  
4 fresh, but I spoke basically about the fact that conscience  
5 rights, so what is ethically and morally allowed -- that we  
6 have a right both as healthcare practitioners of all sorts to  
7 be able to recognize our conscience and not have to do things  
8 that go against our conscience. I would say that's the gist of  
9 what I talked about.

10 Q. And you said the third bill was related to gender, is  
11 that correct?

12 A. Yes.

13 Q. Was there anything in your testimony related to  
14 abortion for that bill?

15 A. No.

16 Q. Got it. Thank you. Do you have any notes or files  
17 related to this case with you right now either in front of you  
18 in hard copy or open digitally?

19 A. I don't have anything open digitally that I can see.  
20 If you ask me to go to something I have digital copies of  
21 things. I have my clean copy of my declaration here and then I  
22 have -- sometimes when I listen I like to take notes, so I have  
23 this pad which I put all your names when you introduced  
24 yourselves, but it's empty otherwise.

25 Q. Understood. Thank you.

1           A. And then over -- way over -- I'm in a hotel room, a  
2 desk, I have all the copies of -- in my declaration of the  
3 references I used. Actually I probably have the majority of  
4 them. Some were digital and too long.

5           Q. Got it. Thank you. So when were you first contacted  
6 about participating as an expert witness in this case?

7           A. I think it was about a month ago.

8           Q. And who specifically have you communicated with  
9 regarding this case?

10          A. Julia Payne with ADF reached out to me and then -- and  
11 I have talked to Ellis about it. The other person is Dr. John  
12 Thorpe who's at Chapel Hill. He is a colleague and friend of  
13 mine and was -- I think and potentially be involved and then  
14 they decided I would do it.

15          Q. What did you speak to Dr. Thorpe about?

16          A. He is experienced regarding -- he's done a lot of  
17 depositions. So I actually asked him because I had never done  
18 one with the law, what to expect with the deposition.

19          Q. Did he contribute any sources for you to use in your  
20 declaration?

21          A. He did not.

22          Q. Did he give you advice on what would go into your  
23 declaration?

24          A. No. We talked about the logistics of the deposition  
25 itself.

1 Q. And you mentioned that you thought he was originally  
2 going to be involved in this case. How do you know that?

3 A. When Julia reached out to individuals to potentially  
4 be in the case, he was one of the people on the email.

5 Q. Do you know why you rather than he are an expert in  
6 this case?

7 MR. BOYLE: I'm going to object and I'm going  
8 to instruct you not to answer that. That would be work  
9 product. That's protected.

10 BY MS. SALVADOR:

11 Q. Other than the folks you have already named, have you  
12 communicated with anyone else regarding this case?

13 A. No.

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

16 A. Can I go back to the last question? I have family --  
17 my family knows I'm in the case. I'm a very literal thinker so  
18 when you said have you talked with anyone, of course some of my  
19 family and colleagues know about it, but not the specifics of  
20 my declaration.

21 Q. So they know that you're in a deposition right now,  
22 but do they know what you're talking about?

23 A. They know it's about SB20.

24 Q. Okay. But did you discuss the specific contents of  
25 your declaration with them?

1 A. No.

2 Q. So what topics are you providing your opinion on in  
3 this case?

4 A. I'm providing my opinion on the hospitalization  
5 requirement and the documentation of an intrauterine pregnancy  
6 prior to chemical or medication abortion.

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

9 A. Yes.

10 Q. How much are you being paid for your participation in  
11 this case?

12 A. \$500 per hour.

13 Q. And about how many hours have you spent working on  
14 this case so far?

15 A. A lot. I can't quantify -- I don't have -- I mean, I  
16 have it written down elsewhere, but I haven't tallied it. But  
17 a month ago I was asked and I know towards the end of July I  
18 started working on a declaration and the declaration itself  
19 took several hours so...

20 Q. Would you say that since you were contacted you have  
21 spent several hours a week on this case?

22 A. Yes.

23 Q. Would you say you have spent more than 10 hours a week  
24 on this case?

25 A. Yes.

1 Q. Got it. Thank you. How did you prepare for today's  
2 deposition?

3 MR. BOYLE: I'll just instruct you not to  
4 discuss anything specifically that you said with your lawyer,  
5 but you can answer generally.

6 THE WITNESS: Sure. It was -- sorry. And I'm  
7 sorry -- is it -- how do I pronounce your name?

8 BY MS. SALVADOR:

9 Q. Sure. It's Anjali.

10 A. Anjali. And you asked me specifically for today?

11 Q. No. How did you prepare generally for today's  
12 deposition, without revealing the contents of any conversation  
13 you had with your attorneys?

14 A. Sure. So really reviewing my declaration was the  
15 biggest thing and then reviewing the responses from the other  
16 individuals who are witnesses. They have declarations too.

17 Q. Other than your attorneys, did you speak with anyone  
18 about the substance of the deposition testimony you'll give  
19 today?

20 A. I did not.

21 Q. You mentioned reviewing your own declaration and the  
22 other declarations in this case. Did you review any other  
23 documents to prepare for this deposition?

24 A. So I -- the resources that I used and then some of the  
25 other literature in this area I reviewed.



1 Q. When you say some of the other literature in this  
2 area, what do you mean by that?

3 A. Literature related to complications related to  
4 pregnancy. I think all the ACOG guidelines I used are part of  
5 my references, so they are above and -- I mean, I already said  
6 I included those. I did get information about Planned  
7 Parenthood South Atlantic and their policies, as well as some  
8 of the other information they provided. For example, numbers  
9 that they -- of abortions they do in their centers and things  
10 like that.

11 Q. Thanks. Other than speaking with your attorneys and  
12 reviewing the documents you mentioned, did you do anything else  
13 to prepare for today's deposition?

14 A. I prayed.

15 Q. So you have -- you have already mentioned that you  
16 prepared an expert declaration in this case, right?

17 A. I have.

18 Q. Okay.

19 MS. SALVADOR: So I am going to drop it into  
20 the chat so that every one can access it. It's already been  
21 premarked as an exhibit. I believe it is Exhibit-P.

22 - - -

23 (Document marked as Exhibit-P for  
24 identification.)

25 - - -

1 BY MS. SALVADOR:

2 Q. So Dr. Bane, is this an accurate copy of the -- well,  
3 first I should say, are you able to open the document that I  
4 dropped into the chat?

5 A. Let me try because I have my own copy, so I wasn't  
6 looking to do that. It's wanting me to save it first, so just  
7 a sec.

8 Q. Sure.

9 (Pause.)

10 A. Yes, I have it now.

11 Q. And is this an accurate copy of the expert declaration  
12 you submitted in this case?

13 A. Give me a minute.

14 Q. Sure.

15 (Pause.)

16 A. Yes, it's what I submitted.

17 Q. Thank you. And if it's easier, for your purposes, to  
18 refer to your paper copy rather than the digital copy, that's  
19 fine. We just needed to make sure that everyone on this  
20 deposition is looking at the same document.

21 A. Okay.

22 Q. Please describe the process of drafting this  
23 declaration.

24 A. So really understanding what specifically I was being  
25 asked to address was the first thing, which was the two things

1 I already mentioned regarding the IUP documentation requirement  
2 and hospital requirement and reviewing the literature related  
3 to that, including the maternal mortality report for North  
4 Carolina that I thought was an important document related to  
5 this.

6 Q. And did you write all of this declaration yourself?

7 A. One hundred percent.

8 Q. Have you read all of the documents cited in your  
9 declaration in their entirety?

10 A. Yes.

11 Q. Other than your attorneys, did you work with anyone to  
12 prepare your declaration?

13 A. No.

14 Q. Have you discussed the contents of your declaration  
15 with anyone other than your attorneys?

16 A. No.

17 Q. Did you read the declarations that Dr. Farris  
18 submitted in this case in their entirety?

19 A. Yes.

20 Q. Did you read the sources cited in Dr. Farris's  
21 declarations?

22 A. I looked at them, but I can't say that I read all of  
23 them.

24 Q. Got it. Thank you. And did you read the declarations  
25 that Dr. Borass submitted in this case in their entirety?

1           A. Yes. And I'll add that I had those when I was writing  
2 my declaration, so I should have included them as part of my  
3 answer regarding how I prepared this.

4           Q. Got it. Thank you. And did you read the sources  
5 cited in Dr. Borass's declarations?

6           A. I looked at them and -- so I can't say I read them  
7 from front to back.

8           Q. So I'd like to turn now to your C.V., which is  
9 Exhibit-A, attached to your declaration which we have already  
10 pulled up and you have in front of you.

11                   So is this C.V. current?

12           A. It's very current. It's not current as of today. I  
13 have done two talks this week at a conference that aren't on  
14 there, things like that.

15           Q. Got it. Thank you. And you graduated from -- with a  
16 Bachelor of Science degree from Atlantic Christian College in  
17 1987, correct?

18           A. Correct.

19           Q. And now it's called Barton College, is that right?

20           A. Correct.

21           Q. So we'll get to the specifics of your career in a bit,  
22 but am I correct that you also ended up working at Barton  
23 College for a number of years?

24           A. Yes.

25           Q. After you attended Barton College, you graduated from

1 the University of Illinois with a Master of Science in  
2 kinesiology in 1989, is that right?

3 A. Yes.

4 Q. And then you received a Ph.D. in kinesiology from the  
5 University of Illinois in 1995, is that right?

6 A. Correct.

7 Q. And you also got an M.D. from the same place in 1997,  
8 is that right?

9 A. Correct.

10 Q. Did those two programs overlap?

11 A. So they are -- it was a 10-year program from the  
12 standpoint of I went there in 1987 and I finished in 1997. So  
13 from '87 to '89 I did my master's degree and then I was in a  
14 M.D. Ph.D. medical scholars program. So I had a total of six  
15 years of graduate work with my master's and my Ph.D. and four  
16 years of medical school.

17 Q. Got it. Thank you. And you completed your residency  
18 in obstetrics and gynecology at the East Carolina University  
19 School of Medicine, right?

20 A. Right.

21 Q. And you completed that in 2001?

22 A. Yes.

23 Q. Are there any other educational credentials you have  
24 that are not on your C.V.?

25 A. Not that are graduate level degrees and a master

1 level. I have certifications, but I think they're all on my  
2 C.V.

3 Q. Okay. Thanks. So after you completed your residency,  
4 did you work as an ob-gyn?

5 A. I did. I was in private practice at Greenville  
6 Obstetrics and Gynecology in Greenville, North Carolina for  
7 nine years.

8 Q. And what were your duties at Greenville?

9 A. So in my practice -- it was a private practice,  
10 obstetrics and gynecology. We were part of a bigger group  
11 called Physicians East, which was a multispecialty group. So I  
12 did obstetrical care and gynecological care both in the office  
13 and in the hospital taking call. I had medical students and  
14 residents from the Brody School of Medicine at East Carolina  
15 that were with me. I also had students from UNC Chapel Hill  
16 who rotated with me.

17 Q. And in your declaration you state that you helped  
18 women deliver over 1,000 babies and supervised midwives who  
19 helped women deliver several thousand babies, is that right?

20 A. Correct.

21 Q. Did all of those deliveries take place in hospitals?

22 A. Yes.

23 Q. What is your familiarity, if any, with midwives in  
24 North Carolina delivering babies outside of hospitals?

25 A. I'm not familiar.

1 Q. And you mentioned your gynecological practice included  
2 gynecological surgery, is that right?

3 A. Yes.

4 Q. What type of gynecological surgery did you perform?

5 A. I performed D&Cs for miscarriage. I performed vaginal  
6 and abdominal hysterectomies. I performed urogynecological  
7 surgery. That was more limited. And I'm talking about  
8 basically in the hospital. If a woman had an ectopic pregnancy  
9 I would do laparoscopy for removing cysts, things like that.

10 Q. And just to clarify, you used a word -- did you say  
11 urogynecological?

12 A. Sorry, uro. U-r-o. So it's bladder issues.

13 Q. Got it. Thank you. And did you ever perform any of  
14 those procedures outside of the hospital?

15 A. Those procedures, no.

16 Q. Which of the procedures you mentioned, if any, did you  
17 perform outside of the hospital?

18 A. None of those procedures outside of the hospital.

19 Q. So you never --

20 A. So -- excuse me. We did have as part of our hospital  
21 a surgical center. So it would be like a same-day surgery  
22 center. So I don't know if you're calling that -- that was  
23 freestanding outpatient surgical center. So I didn't think of  
24 that as a hospital. But I did not provide any of those  
25 surgeries I mentioned in my outpatient clinic.

1 Q. Got it. Thank you. So you mentioned miscarriage D&Cs  
2 as one of the procedures you performed, is that right?

3 A. Correct.

4 Q. What are the risks of miscarriage D&Cs?

5 A. So the risks are -- the biggest one acutely is  
6 hemorrhage and infection. You can also have a uterine  
7 perforation and that can lead to damage of adjacent organs  
8 around the uterus, which are primarily bowel and bladder. And  
9 you can also have death.

10 Q. Thank you for that. And we'll go into all of those a  
11 little bit more later, but just kind of continuing with the  
12 description of your work at Greenville. In your work at  
13 Greenville did you ever prescribe contraception?

14 A. Yes.

15 Q. What types of contraception?

16 A. Hormonal and non-hormonal. So hormonal included birth  
17 control pills or patch, Depo-Provera, which is an injection  
18 shot, IUDs, tubal ligations, which are actually surgeries. I  
19 would say those are the main things.

20 Q. And in your work at Greenville did you ever perform  
21 abortions?

22 A. I did not perform induced abortions, which I'm using  
23 that as the CDC's definition of an induced abortion.

24 Q. What is that definition?

25 A. So it's an intervention that is designed to -- whether



1 it's a suspected or a documented pregnancy, to not result in a  
2 live birth.

3 Q. And so you referred to induced abortions as though  
4 they were one type of abortion, is that right?

5 A. Correct.

6 Q. What are the other types of abortion?

7 A. So abortion is a term -- it's an umbrella term in  
8 medicine and induced abortion is one type. We have what's  
9 called a spontaneous abortion, commonly known as a miscarriage.  
10 A threatened abortion would be when somebody comes into our  
11 office, maybe they're cramping or bleeding and we do an  
12 ultrasound and everything looks fine but they're possibly going  
13 to miscarry. There's incomplete abortions, which would be a  
14 woman who's in the middle of miscarrying. A complete abortion  
15 is typically she's already miscarried. So those are examples  
16 of terminology.

17 Q. So you described your practice as involving treatment  
18 of spontaneous abortions, by your definition, is that correct?

19 A. Yes.

20 Q. And colloquially is that referred to as miscarriage  
21 management?

22 A. Yes.

23 Q. So did miscarriage management ever involve providing  
24 patients with medication?

25 A. We could give that as an option, but it was primarily

1 expectant management, meaning if she was bleeding and didn't  
2 want to have a D&C, we had confirmed that she did not have a  
3 viable pregnancy. But often times we would do surgery or we  
4 would do expectant management.

5 Q. And that expectant management would sometimes involve  
6 providing the patient with medication, is that right?

7 A. No. I'm sorry. Them on their own doing it. So you  
8 can do medication management also.

9 Q. Okay.

10 A. We can do that. We just didn't have many people that  
11 wanted that option.

12 Q. Got it. But did you ever provide medication  
13 management?

14 A. Yes.

15 Q. Did that medication include Mifepistone and  
16 Misoprostol?

17 A. Just Misoprostol.

18 Q. Got it. Thank you. Did you ever provide Misoprostol  
19 to a patient outside of a hospital setting?

20 A. So if -- I can't recall a specific patient, but in  
21 terms of being able to -- if she had a miscarriage and hadn't  
22 passed it and wanted to have medical management, that was an  
23 option she was given.

24 Q. And that was an option that she would be given in an  
25 outpatient facility, is that right?

1 A. Yes.

2 Q. Did you consider providing Misoprostol to a patient in  
3 an outpatient facility to be safe?

4 A. Sorry, I heard a ding from somebody. Could you say it  
5 again? Did I consider it to be safe like doing that?

6 Q. Yes. That's right.

7 A. Yeah. So if it was clinically indicated, I'm going to  
8 do things that I think are safe and that the patient and I  
9 align with in terms of her, you know, shared decisionmaking in  
10 the process.

11 Q. And that would sometimes include providing Misoprostol  
12 to a patient in an outpatient clinic as part of miscarriage  
13 management, is that right?

14 A. Yes.

15 Q. To your knowledge did you ever provide Misoprostol to  
16 a patient where there was fetal cardiac activity still present?

17 A. No.

18 Q. Did your miscarriage management involve providing  
19 aspiration procedures?

20 A. If you're calling an aspiration procedure a D&C, yes,  
21 and that would have been at the hospital.

22 Q. Could you define a D&C, please?

23 A. So dilatation and curettage. But it -- in the past  
24 that was equated with sharp curettage where you would scrape  
25 the lining. And we know that that's associated with something

1 called Asherman's syndrome, which is adhesions. And so now I  
2 think the term is still used but it's usually with suction  
3 aspiration. But we still use the term D&C often.

4 Q. Have you ever performed a D&C, to your knowledge,  
5 where there was fetal cardiac activity present?

6 A. No.

7 Q. Did your miscarriage management involve any dilatation  
8 and evacuation procedures or D&Es?

9 A. No.

10 Q. Just one second, I'm going back and forth in my  
11 document just to make sure I didn't miss any questions. So you  
12 mentioned -- we were talking about your work at Greenville and  
13 your resume lists your work at Greenville and East Carolina  
14 University separately, but you kind of described them as  
15 together. So could you clarify that relationship, please?

16 A. Sure. So I was not an employee of East Carolina  
17 University. We were clinical faculty members if we taught  
18 residents and had medical students on there. So I was employed  
19 a hundred percent by Greenville Ob-Gyn and part of Physicians  
20 East and I volunteered because I love to educate and had  
21 students with me. I also taught some lectures -- not  
22 regularly, but I did teach a two-week fourth year elective  
23 called Residency 101 and that was volunteer service work also.

24 Q. Go it. So in our discussion of your practice so far,  
25 is there anything different about your East Carolina practice

1 versus your Greenville practice?

2 A. I don't consider that I ever had an East Carolina  
3 practice. If it comes across as that in my C.V. I should  
4 change it. But no, I was never employed as -- I guess when I  
5 was a resident they paid me, but once I graduated from  
6 residency I was at Greenville Ob-Gyn.

7 Q. Got it. And in your teaching, did you ever teach your  
8 students about abortion?

9 A. No. I mean, I did do lectures on that, I guess I  
10 would say.

11 Q. Understood. So we have generally been talking about  
12 your ob-gyn practice from 2001 to 2010, is that correct?

13 A. Yes.

14 Q. Okay. And is there any part of that ob-gyn work --  
15 or, I'm sorry. Have we discussed basically everything you did  
16 in your ob-gyn work?

17 A. No.

18 Q. So what else did you do as part of that ob-gyn work?

19 A. So I took call. I delivered babies. I did vaginally  
20 and vacuum-assisted. I did c-sections and the full gamut of  
21 what an obstetrician who is covering a hospital would do.  
22 Consults all across the hospital. In my practice a big part of  
23 my gyn practice was yearly physicals with women. And I did  
24 prenatal care.

25 Q. And in your medical practice, have you ever prescribed

1 medication off label?

2 A. Yes.

3 Q. In what circumstances?

4 A. When women are menopausal and having hot flashes, for  
5 example, SSRIs, which are antidepressants, have been shown to  
6 help with hot flashes, for example. So I may prescribe one of  
7 those.

8 Q. Did you consider that safe?

9 A. Yeah. Yes, I did.

10 Q. Why did you consider that to be safe?

11 A. I think that there were several studies that showed  
12 that it was effective. The potential side effects of  
13 prescribing it were minimal. It was well studied in women --  
14 it is a drug that has been well studied and so it's been  
15 commonly used. Like, for example, Prozac, let's say, was one  
16 of them that we would use. So I felt comfortable that there  
17 was not a harm that I was causing. And I also knew that if she  
18 didn't like it, we could stop it.

19 Q. Got it. Thank you. And we have already discussed  
20 Misoprostol. Have you ever prescribed Mifepistone or Mifeprex  
21 to a patient?

22 A. I have not.

23 Q. Have you ever provided an abortion?

24 A. I have never performed an induced abortion, no.

25 Q. You state in your declaration that while you were in

1 private practice you cared for preborn children with  
2 life-limiting conditions, is that correct?

3 A. Yes.

4 Q. Could you describe what you mean by that?

5 A. So they are -- typically -- I mean, so a fetus is  
6 after eight weeks. So usually the diagnoses aren't made when  
7 they're embryos. And so they have a diagnoses that we know  
8 that if the normal age limit for men and women is in the 70s  
9 and 80s, that they have a condition that has been diagnosed  
10 that the likelihood of them surviving to 70 or 80 is not  
11 expected. So that would be a life-limiting condition.

12 Q. And how did you treat -- how did you treat your  
13 patients in that situation?

14 A. A lot of love. It was hard because they -- you know,  
15 it's a tragedy when you expect to have a healthy child and  
16 you're told that. So we would refer them to maternal-fetal  
17 medicine because maternal-fetal medicine works with high-risk  
18 pregnancies. And then depending on the situation they may come  
19 back to our practice and we provide their prenatal care or  
20 there may be a transfer of care.

21 Q. And a transfer of care for what?

22 A. Well, usually for the maternal-fetal medicine  
23 specialist to take over the care of them, whether it's -- there  
24 was going to be a delivery or if the patient had decided that  
25 they wanted to have an induced abortion, they would provide

1 that.

2 Q. And would you ever refer those patients directly for  
3 an induced abortion?

4 A. No.

5 Q. Have you ever performed a previability induction on a  
6 pregnant patient?

7 A. Can you define previability?

8 Q. Sure. How would you define viability?

9 A. Well, traditionally it is able to survive outside the  
10 mother. And that's changed over time of course because our  
11 understanding of how to care for premature babies is better.  
12 So I assume you're asking babies that -- maybe I shouldn't  
13 assume -- but that are too young to survive if they were born  
14 at the time of the induction.

15 Q. That's right. Have you ever performed an induction on  
16 a pregnant patient at the stage where their fetus was not  
17 developed enough to survive outside the womb?

18 A. Yes, I have.

19 Q. About how many times?

20 A. Lots and lots. Residency in four years because we  
21 were a Level 1 hospital where we had a lot of transfers that  
22 came in -- excuse me. I'm sorry. I have a reminder coming up  
23 that was loud. We had a lot of patients transferred to us that  
24 had, for example, preterm premature rupture of membranes. And  
25 -- or other things that caused us to have to do a premature



1 separation of the maternal and fetal patient. So that was four  
2 years and then I had nine years in private practice. So, you  
3 know, greater than a hundred.

4 Q. Got it. Thank you. And did you consider those  
5 inductions to be abortions?

6 A. No, not induced abortions.

7 Q. So you referred to preterm premature rupture of  
8 membranes or pprom. What other conditions would lead you to  
9 perform an induction in these circumstances?

10 A. That would probably be the most common. Really it  
11 would be situations in which typically the mom is so sick that  
12 if we do not do an induction and separate our maternal and  
13 fetal patient, both patients would die. So, you know, it would  
14 be any indication that the mom was so sick. And occasionally  
15 it's a fetal indication, but it's usually the mother.

16 Q. Did you ever recommend to one of your patients that  
17 they have an induction before the fetus could survive outside  
18 the woman?

19 A. Yeah, I had a lot of hard conversations about that.

20 Q. Would you have recommended an induction to, for  
21 example, a patient with gestational diabetes at risk of going  
22 blind?

23 A. I would need more clinical context than a hypothetical  
24 like that.

25 Q. Would you wait until the patient was dying before you

1 recommended such an induction?

2 MR. BOYLE: Objection. You can answer.

3 THE WITNESS: Did you say you can answer?

4 MR. BOYLE: Yes, you can answer.

5 THE WITNESS: Okay. Would you repeat the  
6 question, please.

7 BY MS. SALVADOR:

8 Q. Sure. Would you wait until the patient -- would you  
9 recommend waiting until the patient -- sorry. Let me start  
10 over. Would you wait until the patient was dying to recommend  
11 such an induction?

12 MR. BOYLE: Objection. You can answer.

13 THE WITNESS: So I just want to kind of pull  
14 back for a second and clarify. So an induced abortion has the  
15 intention of not having a live birth. So when I would  
16 recommend an induction in these cases, my intention was  
17 hopefully to have a live mom for sure and a live baby. And so  
18 there were times, for example, if she's what's called  
19 periviable, she's near where maybe the baby did have a fighting  
20 chance and her risks are small at that point that we could do  
21 expectant management. So, for example, with pprom, one of the  
22 -- ACOG'S, you know, practice bulletin on pprom says expectant  
23 management. And so I'm trained to be able to watch for signs  
24 of infection in the mom and daily, you know, go see her and  
25 multiple times a day do vital signs and at the very beginning

1 of the process say to her, you know -- let's say she's 22 weeks  
2 is we have a couple different options here and one of them is  
3 to go ahead and deliver you. And -- well, there are 22 weekers  
4 that have survived. So let me say 20 weeks. And say to her  
5 that we can wait. We can do expectant management and if we do  
6 that we're going to have to monitor you very closely and if  
7 there's a sign that you have what's called chorioamnionitis I'm  
8 going to recommend induction.

9 Q. And you said -- please repeat that term,  
10 chorioamnionitis?

11 A. Chorioamnionitis. So it's an infection of the  
12 amniotic fluid.

13 Q. Would you recommend -- would you ever recommend to a  
14 patient waiting until sepsis develops to have an induction?

15 A. Heck, no.

16 Q. Between when you finished residency in 2010, did you  
17 work as an ob-gyn anywhere other than Greenville and then its  
18 associated work at East Carolina University?

19 A. No.

20 Q. After you stopped working at Greenville, where did you  
21 work next?

22 A. So I worked at Barton College, which was Atlantic  
23 Christian when I was there, and I have been there since 2010 --  
24 well, I was an adjunct, but full time starting in 2011, until  
25 this summer and I'm no longer there.

1 Q. Could you generally describe your role at Barton,  
2 please?

3 A. Sure. I was initially hired as an associate professor  
4 of Allied Health and Sports Studies, although I think our  
5 department had a different name back then. But I was an  
6 associate professor. So my Ph.D. is in kinesiology, which is  
7 exercise science. And so I taught classes ranging from anatomy  
8 and physiology to exercise physiology, exercise psychology.  
9 After I believe my first year I was asked to run the honors  
10 program. So I taught in the honors program and had an  
11 administrative role there and continued to teach, but as time  
12 went on I taught less and had more administrative  
13 responsibilities, including dean of graduate and professional  
14 studies. And then the last few years I have been the director  
15 of a partnership with Area L AHEC, at Barton College.

16 Q. I'm sorry, what is that term, Area L AHEC?

17 A. AHEC. So AHEC is a system within -- actually, it's a  
18 national organization, but each state -- I believe most of the  
19 states have AHECs. And they work on workforce development,  
20 retention and diversity. And so we ran a program on campus  
21 with college students trying to increase health careers  
22 awareness, but also diversity within the healthcare system.

23 Q. And did your work at Barton also involve practicing as  
24 a women's health physician at Lee Student Health Center?

25 A. Yes, it did. I was in there a few half days a week

1 when I first started. I think it was the first couple years.  
2 But then as my administrative duties increased I wasn't able to  
3 do direct patient care in there and I served more on a  
4 consultative role.

5 Q. Did you prescribe contraception to your patients at  
6 Lee Student Health Center?

7 A. Yes.

8 Q. Did you ever talk to any of them -- I'm sorry. Were  
9 any students you treated at Lee Student Health Center pregnant?

10 A. Yes.

11 Q. Would your treatment of students ever involve talking  
12 to them about abortion?

13 A. Yes.

14 Q. Describe those conversations about abortion, please.

15 A. Yeah. So I basically want women to be empowered with  
16 information before they make a decision of such massive  
17 consequence. And so it would really be helping them understand  
18 their legal choices in the State of North Carolina. Some of  
19 our students are from out of state. And so helping them  
20 understand they had the option to give birth, to give birth and  
21 parent, to give birth and place the child for adoption, or to  
22 give permission to a healthcare practitioner to do an abortion.  
23 We have a lot of student athletes at our campus. Probably  
24 close to 70 percent of our students are athletes, so there was  
25 always conversation typically about how it would impact their

1 play and scholarships and things like that. So I really just  
2 wanted them to be really well informed before they made a  
3 decision.

4 Q. Did any of the students who you spoke with about their  
5 decision ever express to you a desire to have an abortion?

6 A. Yes.

7 Q. And would you support them in that decision?

8 A. You would have to define support them.

9 Q. Sure. Would you ever affirm their decision to have an  
10 abortion?

11 MR. BOYLE: Objection. Object to form. You  
12 can answer.

13 THE WITNESS: So what I would talk to them  
14 about are -- well, risks -- I would not refer them for an  
15 abortion because for me the direct and intentional killing of  
16 another human being is not part of healthcare and so I didn't  
17 want to contribute to harming one of my patients because I have  
18 -- when she's in front of me, I have two patients in front of  
19 me. So I wouldn't refer them. What I would do is help them  
20 understand the risks, benefits and alternatives.

21 BY MS. SALVADOR:

22 Q. And -- I'm sorry, I didn't mean to interrupt you.

23 A. It's okay.

24 Q. So you said risks, benefits and alternatives. What  
25 would the benefits be?

1 A. Of which choice?

2 Q. Of an abortion.

3 A. Oh, risk, benefit. Basically that nobody would have  
4 to know they're pregnant typically and that they would likely  
5 be able to compete in their sport.

6 Q. Why did you leave Barton?

7 A. I left Barton -- probably should have left two years  
8 ago because I really felt like God was calling me to work more  
9 with women with unplanned pregnancy. I have been a volunteer  
10 for years at Pregnancy Centers and often times when you're a  
11 volunteer medical director you are reading all the ultrasounds.  
12 But we had -- we needed -- we didn't have a nurse and we had  
13 trouble finding one a few years back and I said well, I can do  
14 ultrasound. I will go in there and do it. And I just love  
15 working with these women. Every woman now has an unplanned  
16 pregnancy and I just have a heart for women. And I want them  
17 to be able to -- I want to be able to address the barriers for  
18 why women feel like the best choice in front of them is ending  
19 the life of their own child. I think that it's sad that we  
20 have the best of our legal and medical minds in our country and  
21 that's the best we can offer for women for equality is to end  
22 the life of their children and I just think that's wrong. So I  
23 wanted to work full time caring for women in these situations  
24 and there wasn't time to do my job at Barton and that.

25 Q. Understood. Thank you. So before we get to your

1 Pregnancy Center work I want to talk a little bit about your  
2 professional associations.

3 A. Okay.

4 Q. Are you currently a member of the American College of  
5 Obstetricians and Gynecologists?

6 A. I am currently not.

7 Q. Okay. And we'll call that ACOG, is that okay?

8 A. Yes.

9 Q. Were you ever a member of ACOG?

10 A. Yeah, for a long time.

11 Q. And do you remember what years?

12 A. I believe when I first started private practice, 2001.

13 I might have been a member during residency, but I'm not a

14 hundred percent sure of that. Because if so, I think they

15 would have paid for a membership. And so I started in 2001 and

16 I stopped my membership a year or two ago.

17 Q. Got it. I think your C.V. says 1997 and 2021. Does  
18 that sound right?

19 A. It does.

20 Q. So why are you no longer a member of ACOG?

21 A. So I have got -- I think ACOG does great work, but I  
22 really philosophically disagree in the abortion area with  
23 induced abortion. And I feel like it was an organization that  
24 did not represent so many of us who really feel like the direct  
25 and intentional killing of our fetal patient, there's no



1 purpose in medicine for that. And I -- ACOG has I think it's  
2 eight percent of our dues that go towards advocacy work. I  
3 will say they do some great advocacy work, but I couldn't --  
4 they wouldn't allow us to not contribute that part. And so I  
5 just in good faith, I didn't want to know that some of my dues  
6 were going to advocate for induced abortion.

7 Q. Did anyone suggest to you that you end your ACOG  
8 membership?

9 A. No.

10 Q. ACOG members aren't required to hold any particular  
11 view of abortion as a precondition of membership, are they?

12 A. No.

13 Q. And ACOG'S membership includes individuals who are  
14 opposed to abortion, is that right?

15 MR. BOYLE: Objection.

16 THE WITNESS: I know lots of colleagues that  
17 are members of ACOG that are pro-life and pro-choice, so I --  
18 there are members of both in ACOG.

19 BY MS. SALVADOR:

20 Q. And you cite ACOG bulletins on early pregnancy loss  
21 and tubal ectopic pregnancy in your declaration, is that right?

22 A. Do.

23 Q. And you also cite an ACOG committee opinion on methods  
24 of estimating pregnancy due date, is that right?

25 A. Yes.

1 Q. So you believe that ACOG is a reliable source of  
2 information?

3 A. So, as I said when you asked me the question about why  
4 I left, ACOG does a lot of great work. I just disagree that  
5 they -- their position on abortion access, their abortion  
6 policy. And so there's a part of ACOG that I don't agree with  
7 and for a while I considered leaving and it was just in the  
8 last few years I felt like -- particularly when they wouldn't  
9 allow me to not contribute to their advocacy work.

10 MR. BOYLE: I just ask -- we have been going  
11 for about an hour. When you get a chance, can we take a break,  
12 please?

13 MS. SALVADOR: Sure. We have just got one or  
14 two more questions on ACOG and then we can break after that, if  
15 that works.

16 BY MS. SALVADOR:

17 Q. So would you find ACOG bulletins on abortion to be  
18 reliable?

19 A. Well, I disagree with them and so it is -- a lot of it  
20 is ACOG'S opinion, without even caring that so many of us, the  
21 majority of -- based on studies that have been cited, you know,  
22 don't do induced abortions. So they advocate for laws that I  
23 don't agree with. And so --

24 Q. But is it your position that the medical information  
25 in ACOG'S bulletins on abortion is unreliable?

1           A. I don't think I can answer that without looking at  
2 them. Like what medical information you're asking me to answer  
3 about.

4           Q. Okay. Understood.

5                       MS. SALVADOR: We can take a break now. Would  
6 10 minutes work?

7                       THE WITNESS: Sure.

8                       MS. SALVADOR: Okay. Why don't we go off the  
9 record.

10                      VIDEOTAPE TECHNICIAN: Thank you. We are now  
11 going off the video record. The time is 3:07 p.m.

12                      (A break was taken.)

13                      VIDEOTAPE TECHNICIAN: We are now back on the  
14 video record. The time is 3:17 p.m.

15 BY MS. SALVADOR:

16           Q. Thank you, Dr. Bane. So before we go back to your  
17 professional associations, I wanted to ask you whether John  
18 Thorpe reviewed a draft of your declaration?

19           A. No, he did not.

20           Q. Okay. Thank you. So going back to your professional  
21 associations, you're a member of the American Association of  
22 Pro-Life Obstetricians and Gynecologists, is that correct?

23           A. Yes.

24           Q. And I'll refer to that as AAPLOG, if that's all right?

25           A. Yes.

1 Q. How long have you been a member of AAPLOG?

2 A. I think two years maybe.

3 Q. You currently serve on their board, is that right?

4 A. I do.

5 Q. Do you have a title other than board member?

6 A. I just got a title. I am the team leader for  
7 education advocacy. The CEO, Donna Harrison, stepped down as  
8 the CEO and Dr. Christina Francis became the CEO. So I took  
9 her place.

10 Q. So you took her place as CEO?

11 A. No. No. No. Sorry. As the team leader on the board  
12 for education and advocacy.

13 Q. Understood. So what does your role as team leader for  
14 education and advocacy entail?

15 A. Well, it's brand new so my understanding -- I haven't  
16 really had a board meeting in which I have lead it yet, but  
17 it's really going to be related to both patient and  
18 practitioner educational material that looks at the medical  
19 evidence and advocacy work in terms of really equipping  
20 practitioners who have a pro-life perspective to be able to  
21 communicate their -- why they have that perspective.

22 Q. Would it be fair to say that communicating their  
23 perspective is advocacy?

24 A. Yes.

25 Q. Do you consider yourself a pro-life advocate?

1           A. I stand up for pro-life values. I stand up for both  
2 my maternal and my fetal patients. So that would be my  
3 definition of being an advocate for them. I also stand up for  
4 medical students and residents and healthcare practitioners of  
5 all types who acknowledge and want to have health and wholeness  
6 for both their maternal and fetal patients.

7           Q. So you said you were new to this -- I'm sorry, I  
8 forget exactly what it's called, but the education and  
9 advocacy --

10          A. Team leader.

11          Q. -- team leader role. But you have been on the board  
12 of AAPLOG for sometime, is that correct?

13          A. For a year.

14          Q. What do your duties entail as a board member?

15          A. So -- what do my duties entail? So in terms of  
16 oversight -- things that I have had to do. So I have attended  
17 one face-to-face meeting and two virtual meetings. So  
18 basically going over the strategic plan, which was already made  
19 when I was there, but reviewing that. Updating the strategic  
20 plan. So more a visionary picture for the organization.  
21 Fiscal responsibility. We are a nonprofit and we do not have a  
22 lobbying arm to what we do in terms of -- I think it's called a  
23 C4 maybe. I don't know that for sure. So making sure that we  
24 are educating, but not lobbying. So, so far I would say big  
25 decisions that are strategic are what our role is in our

1 governance.

2 Q. What's your understanding of AAPLOG's position on  
3 abortion?

4 A. You said AAPLOG, right?

5 Q. Yes.

6 A. That induced abortion as defined earlier, that it --  
7 it is not healthcare and it is not -- the direct intentional  
8 killing of one of our patients we should never do.

9 Q. Have you attended any expert witness trainings  
10 conducted by AAPLOG?

11 A. Yes, I did attend one.

12 Q. Could you generally describe what that training  
13 entailed?

14 A. Yes. A communications -- it was one day -- I think it  
15 was one day. It might have been -- no, it was one day. A  
16 communications expert spent the morning just kind of talking to  
17 us regarding interviews with reporters and kind of what that  
18 world is like. And then the other half of the day was more  
19 about being an expert witness as I'm being now.

20 Q. And what training or do you remember what the training  
21 covered on being an expert witness like you're doing right now?

22 A. So they had some lawyers that came and just kind of  
23 talked about depositions and we did a -- each of us did an  
24 individual short mock deposition. We ran out of time, to be  
25 honest, so I didn't really do much with that part.

1 Q. Well, now you're getting the real thing.

2 A. Amen.

3 Q. And you were a committee member of the Preborn to End  
4 of Life Advisory Committee for the Diocese of Raleigh from 2013  
5 to 2020, is that correct?

6 A. I was a member and we had one meeting during that  
7 time.

8 Q. Got it. So it sounds like not much. But what did  
9 your duties as a committee member entail?

10 A. Basically if the diocese needed direction on life  
11 issues, then they would come to us.

12 Q. Did you do any work relating to abortion as part of  
13 that committee?

14 A. Well, the one meeting we had, which was my first and  
15 only time going to Raleigh for it, I honestly can't remember  
16 the content. I do know the woman who is in charge of their  
17 Right to Life program was there, but I don't recall that it was  
18 specific to abortion.

19 Q. Got it. Thank you. Have you ever had a complaint  
20 made against you by a patient?

21 A. Yes.

22 Q. Could you describe that, please?

23 A. I had a patient that she was in our practice. She had  
24 twins. I had not met her until I was on call and she came in  
25 and -- when I took over call she was in labor and her twins

1 were vertex. Vertex. So you can do a vaginal delivery. And  
2 the first baby was delivered and he did fine, but as soon as he  
3 was delivered the second baby had a big deceleration, which I  
4 was worried about. But then that baby recovered. And I had --  
5 so I had taken off the fetal heart rate monitors because I was  
6 using ultrasound to make sure the second baby didn't change  
7 positions. And so I manually palpated her abdomen. I was  
8 looking at the heart rate monitor and everything and that baby  
9 was born and he was very flaccid and had to be resuscitated  
10 and he died four days later. And looking back at it I did not  
11 recognize that that baby was having a hard time. I thought it  
12 was what are called early decelerations. But looking closely  
13 at it they were called late decelerations. And so I should  
14 have done an emergency c-section.

15 Q. And what was the resolution of that complaint?

16 A. Am I allowed to share -- I thought that was -- I mean,  
17 I'm happy to say we settled, but I don't know if I'm allowed to  
18 share more than that. The hospital settled and then my  
19 practice settled.

20 Q. Got it. And have you ever had a complaint made  
21 against you by a student?

22 A. By a student? Well, they do evaluations at the end of  
23 the year and not all of them are, you know -- you know, some  
24 students don't like me, but not from the context of what you're  
25 talking about medically. So I'll have to say no, other than



1 what I have already said.

2 Q. Understood. Thank you.

3 A. Yeah.

4 Q. Have you ever had a complaint made against you, an  
5 official complaint made against you by a colleague?

6 A. So I would say -- so an official complaint like with  
7 human resources?

8 Q. Sure.

9 A. No.

10 Q. Have you ever had a -- what sort of, if any,  
11 unofficial complaints have you had made against you by  
12 colleagues?

13 A. I had a time this year at the college where I -- when  
14 the Dobbs decision happened last June I wanted to do a talk on  
15 campus so that the students could understand the new decision,  
16 how it impacted them, because we have -- as I said before, 60  
17 to 70 percent of our students are athletes. I wanted to make  
18 sure they understood the NCAA policy as it relates to unplanned  
19 pregnancy. And eight of my colleagues at Barton campus wrote  
20 the administration and did not want me to present.

21 Q. Why did they not want you to present?

22 A. Sorry. I can answer. In their letter that they wrote  
23 they said it's because they felt like we -- they needed -- I  
24 would bring my pro-life perspective and not -- it needed to be  
25 balanced with someone who is pro-choice.

1 Q. Did you end up giving that talk?

2 A. I did give the talk. Instead of in October, I gave it  
3 in April.

4 Q. Did you end up -- did you end up giving your pro-life  
5 perspective to that talk?

6 A. No. As a matter of fact, my daughter was in  
7 attendance and she said if I didn't know you I wouldn't have  
8 known whether you were pro-life or pro-choice.

9 Q. Have you ever had a malpractice claim filed against  
10 you?

11 A. The one that I told you about earlier I have. When I  
12 was a chief resident, there was a claim that was filed and I  
13 was included on it. But right before the jury was being  
14 selected the case was dropped. And I believe that's the only  
15 one.

16 Q. And what was that dropped case regarding?

17 A. A baby that had cerebral palsy. You know, I don't  
18 know if it was cerebral palsy. But had some chronic medical  
19 illnesses and they-- I think they felt like we didn't do the  
20 c-section maybe fast enough, but it turned out that they  
21 dropped the case.

22 Q. Have you ever been disciplined by a licensing board?

23 A. No.

24 Q. Have you ever been subject to disciplinary proceedings  
25 by an employer?

1 A. No.

2 Q. Got it. Thank you. So we're going to switch gears a  
3 little bit.

4 A. Okay.

5 Q. Do you believe that national data underestimates  
6 complications from abortions?

7 A. Yes.

8 Q. Are you aware that the CDC has obtained data on  
9 abortion mortality from all 50 states?

10 A. I'm aware that there is voluntary reporting from the  
11 states.

12 Q. Other than voluntary reporting from the states, do you  
13 know what sources the CDC relies on to identify  
14 abortion-related deaths?

15 A. I don't know a complete list. I could go to the CDC  
16 and look it up, but not off the top of my head.

17 Q. Are you aware that they rely on state vital records?

18 A. I am aware that they rely on state vital records and  
19 that those vital records are also voluntary.

20 Q. Are you aware that the CDC relies on individual case  
21 reports by public health agencies?

22 A. Yes, I'm aware that public health agencies do report  
23 information.

24 Q. Are you aware that the CDC relies on data from state  
25 maternal mortality review committees?

1 A. I'm aware that some states have those committees. I  
2 don't believe all states have those committees.

3 Q. Are you aware though that for where those committees  
4 exist, that the CDC relies on their data?

5 A. Yes.

6 Q. Are you aware that the CDC relies on reports by  
7 private citizens?

8 A. I'm not aware of the complete list, no.

9 Q. Are you aware that the CDC relies on media reports to  
10 identify abortion-related deaths?

11 A. Did you say media?

12 Q. Yes.

13 A. No, I'm not aware of that.

14 Q. Are you aware that for each death that is possibly  
15 related to abortion the CDC requests clinical records and  
16 autopsy reports?

17 A. I'm not aware of all the sources in which the CDC  
18 uses. What I will say is I'm aware that none of it is  
19 mandatory. And -- sorry.

20 Q. Sorry. Go ahead.

21 A. And that there is -- there are a lot of holes in terms  
22 of the fact that we don't have to have -- we don't have  
23 mandatory abortion reporting data.

24 Q. So you were not aware that the CDC requests clinical  
25 records and autopsy reports for deaths possibly related to

1 abortion, correct?

2 MR. BOYLE: Objection. You can answer.

3 THE WITNESS: Once again, I may have read it,  
4 but I don't have that list in my head of everything. So I  
5 can't truthfully say to you all the places I'm aware that they  
6 get their data.

7 BY MS. SALVADOR:

8 Q. And are you aware that where the CDC reviews autopsy  
9 reports two epidemiologists review these reports to determine  
10 the cause of death and whether it was abortion related?

11 A. I'll repeat that I'm not aware of all the sources off  
12 the top of my head that the CDC uses.

13 Q. Is it your understanding that carrying a pregnancy to  
14 term carries more medical risk for the patient -- for the  
15 pregnant patient than having an abortion?

16 A. Could you say that one more time? You switched on me  
17 and --

18 Q. Sure. Is it your understanding that carrying a  
19 pregnancy to term carries more medical risk for the pregnant  
20 patient than having an abortion?

21 A. I disagree with that.

22 Q. So you disagree that carrying a pregnancy to term has  
23 more risk for the pregnant patient than having an abortion?

24 A. Yes. Because we have inaccurate data and so you --  
25 that leads to inaccurate conclusions. The only -- when we

1 compare those two, it's very difficult when you have a data  
2 collection system that basically live birth is the only thing  
3 we know for sure because everybody has a birth certificate.  
4 And when you look at maternal mortality it is, you know, number  
5 of deaths per hundred thousand live births. And pregnancies  
6 don't just end in live births. You know, as a matter of fact  
7 in our country about 65 percent of pregnancies end in live  
8 birth. About 35 percent don't. And if you look at black  
9 women, almost half of their pregnancies don't. So you have a  
10 statistic in which the denominator -- we have 35 to 50 percent  
11 that we're not even accounting for the fact that those  
12 pregnancies can end in abortion, induced abortion, or natural  
13 losses or ectopics or hydatiform moles. So yeah, there are  
14 great limitations in how we collect our data.

15 Q. Do you accept that abortion is safer than child birth  
16 for most abortion patients?

17 A. I cannot make that conclusion given the data we have.

18 Q. Are there circumstances in which you would say that  
19 abortion is riskier than a pregnancy and child birth?

20 A. Could you repeat that for me, Anjali?

21 Q. Sure.

22 MS. SALVADOR: Could I actually ask the court  
23 reporter to read that back so the words are exactly the  
24 same. - - -

25 (The requested portion was read back by the

1 reporter.)

2 - - -

3 THE WITNESS: So that's a hypothetical  
4 question. So it's difficult to know because circumstances  
5 often change. We know that abortion -- you know, the greatest  
6 predictors of complications and death from abortion -- induced  
7 abortion is gestational age. So it's very difficult to make a  
8 comparison of a pregnancy to an abortion.

9 BY MS. SALVADOR:

10 Q. Is it true that some people who get abortions would  
11 have experienced pregnancy complications if they had stayed  
12 pregnant?

13 A. Yes.

14 Q. The likelihood of pregnancy-related death is higher  
15 for women with certain preexisting conditions, isn't that  
16 right?

17 A. The likelihood of pregnancy-related deaths is higher  
18 for some women with preexisting conditions?

19 Q. Yes. Is that right?

20 A. That is correct.

21 Q. What sorts of conditions would increase the risk of  
22 death during pregnancy?

23 A. So certain types of cardiac issues. Women who have  
24 kidney failure are, you know, some of the worst mortality  
25 risks. You know, uncontrolled diabetes. When a woman has it

1 uncontrolled during pregnancy, uncontrolled hypertension. So  
2 various chronic diseases do make the pregnancy more difficult,  
3 which is why we have a subspecialty of maternal-fetal medicine  
4 and designed to care for those women and if we do our job well,  
5 we really can hopefully reduces those risks for her.

6 Q. And at least some of women with those preexisting  
7 conditions you have just named obtain abortions, is that right?

8 A. Yes.

9 Q. So in your declaration -- and I'll point you to --  
10 it's the bottom of page 12.

11 A. Okay.

12 Q. Sorry, I'm going there myself. You write it is  
13 possible that the higher rate of induced abortion and later  
14 abortions in black women account for a portion of the racial  
15 disparity noted in pregnancy mortality, is that right?

16 A. You said page -- is it page or paragraph? I'm doing  
17 the hard copy here.

18 Q. Okay. Sorry. It's paragraph 25. It's the end of  
19 paragraph 25. And if anyone is looking at the page numbers,  
20 it's the bottom of page 12 of the PDF.

21 A. Just give me a second.

22 Q. Sure.

23 (Pause.)

24 A. Okay. I'm there.

25 Q. Okay. So the declaration says it is possible that the



1 higher rate of induced abortion and later abortions in black  
2 women account for a portion of the racial disparity noted in  
3 pregnancy mortality and this level actually be protected for  
4 black women.

5 Did I read that sentence correctly?

6 A. Yes.

7 Q. But you don't cite any sources for that statement, is  
8 that right?

9 A. No. It's based on the full paragraph in terms of the  
10 sentences before in that we know that black women have more  
11 abortions, induced abortions than white women. We also know  
12 their mortality rate is higher.

13 Q. When you say the mortality rate, you mean that we know  
14 that their maternal mortality is higher, is that right?

15 A. Yes. Well, the data suggests that, yeah, it is higher  
16 and that they have more second trimester abortions, later  
17 abortions, which we know have greater risk for complication and  
18 death. So the answer for woman -- black women to addressing  
19 maternal mortality is not more abortion. That's what I'm  
20 saying in this. It's really that we have to get to the root  
21 causes of why black women die and they're multifactorial,  
22 including chronic diseases, which we have talked about, but  
23 also health disparities that happen in their treatment of care.  
24 They're not often heard the same. And it also is access to  
25 early prenatal care, transportation issues, education about

1 warning signs. So my point in this paragraph is that the  
2 answer to help women who are black or white and have chronic  
3 disease is not to destroy their children. It's get to the root  
4 cause of why they're dying.

5 Q. But you're not aware of a source that draws a causal  
6 link between abortion-related mortality and the relatively high  
7 black maternal mortality rate, are you?

8 A. Not off the top of my head, no.

9 Q. So in your declaration -- and this is also in  
10 paragraph 25.

11 A. Okay.

12 Q. You state that the risk of death from induced abortion  
13 increases as gestation progresses, is that right?

14 A. Yes.

15 Q. And you cite a study by Bartlett, et al. for the idea  
16 that women whose abortions were performed in the second  
17 trimester were significantly more likely to die of  
18 abortion-related causes, is that right?

19 A. Yes, I do cite that study.

20 Q. Do you recall that that study found that for the time  
21 period it was discussing the overall death rate for women  
22 obtaining legally-induced abortion was 0.7 per 100,000 legal  
23 induced abortions?

24 A. I would need to look at the study. I don't recall  
25 those exact numbers.

1 Q. Sure. One second.

2 A. Can I -- I have a copy of it. Is it --

3 Q. Sure. You can use your copy.

4 MS. SALVADOR: And then I am dropping the  
5 digital copy into the chat right now. So could we please have  
6 that marked as an exhibit.

7 - - -

8 (Document marked as Exhibit-Q for  
9 identification.)

10 - - -

11 BY MS. SALVADOR:

12 Q. Dr. Bane, I'm going to ask you to pull up the digital  
13 copy too and just confirm that it's the same as what you're  
14 looking at.

15 A. Okay. Sorry, it's making me save it again.

16 Q. That's fine.

17 (Pause.)

18 A. Okay. It's the same.

19 Q. Okay. Great. And so this document is the Bartlett  
20 study that we were discussing, is that correct?

21 A. That's correct.

22 Q. So I'm going to point you to the first page, left hand  
23 column where it says results.

24 A. Okay.

25 Q. The first sentence there is during 1988 to 1997 the

1 overall death rate for women obtaining legally induced  
2 abortions was 0.7 per 100,000 legally-induced abortions.

3 Did I read that correctly?

4 A. You did.

5 Q. So do you recall that CDC data states that in 2021 the  
6 maternal mortality rate was 32.9 deaths per 100,000 live  
7 births?

8 A. No, I don't recall the exact number.

9 Q. One second, please.

10 MS. SALVADOR: So I'm dropping a document into  
11 the chat entitled 2021 Maternal Mortality Rates as the file  
12 name. Could we please have that marked as an exhibit and, Dr.  
13 Bane, could you please open it?

14 THE WITNESS: Sure.

15 - - -

16 (Document marked as Exhibit-R for  
17 identification.)

18 - - -

19 BY MS. SALVADOR:

20 Q. Just tell me when you have it open.

21 A. Just a sec. Let me try again.

22 Q. Sure.

23 A. Okay.

24 Q. If that doesn't work for you I can try to screen share  
25 it.

1 A. No. I actually got it and I actually think I have  
2 that same document.

3 Q. Okay. I just have a couple of questions about it, so  
4 if you have to find it, it might be easier to use the digital  
5 copy.

6 A. Okay. That will be fine.

7 Q. So is this document we're looking at the CDC data for  
8 maternal mortality rates in the United States for 2021?

9 A. Yes.

10 Q. So if you go to the second full paragraph on the first  
11 page.

12 A. Okay.

13 Q. Do you see that it says that the maternal mortality  
14 rate for 2021 was 32.9 deaths per 100,000 live births?

15 A. I do see that.

16 Q. And then do you see that at the very beginning of the  
17 next paragraph it says in 2021 the maternal mortality rate for  
18 non-Hispanic, black, in parentheses, subsequently black women  
19 was 69.9 deaths per 100,000 live births?

20 A. Yes.

21 Q. And in your declaration you also discuss a North  
22 Carolina Maternal Mortality Review report from 2021, is that  
23 correct?

24 A. Yes.

25 Q. Do you recall that the report states that in 2016 the

1 maternal mortality rate was 20.7 deaths per 100,000 live  
2 births?

3 A. I don't recall that number, but I have easy access to  
4 that document if you would like me to get it out.

5 Q. Sure.

6 MS. SALVADOR: I'm going to drop that into the  
7 chat as well. So if we could please have it marked as an  
8 exhibit.

9 - - -  
10 (Document marked as Exhibit-S for  
11 identification.)

12 - - -  
13 THE WITNESS: I have it.

14 BY MS. SALVADOR:

15 Q. And then, Dr. Bane, could you just please verify that  
16 the digital copy is the same as what you're looking at?

17 A. Okay. Let me look. Yes, it's the same.

18 Q. Okay. Thank you. Could you go to page 12 of that  
19 report, please.

20 A. Sure.

21 Q. So do you see on page 12 there is a paragraph that  
22 starts with pregnancy-related death ratios from 2007 to 2016.  
23 And the end of it says that the pregnancy-related death ratio  
24 is 20.7 deaths in 2016, is that right?

25 A. Yes.

1 Q. Are you familiar with the CDC's abortion surveillance  
2 data from 2020?

3 A. I looked at it, but I don't have it on the tip of my  
4 tongue. I would need to see it also.

5 Q. Got it. Thank you.

6 MS. SALVADOR: So I am dropping that into the  
7 chat as well. It's the file name entitled CDC Abortion  
8 Surveillance. If we could please have that marked as an  
9 exhibit and then, Dr. Bane, just let me know when you have it  
10 opened.

11 - - -

12 (Document marked as Exhibit-T for  
13 identification.)

14 - - -

15 THE WITNESS: Okay. I have it open.

16 BY MS. SALVADOR:

17 Q. Okay. And do you recognize this document as CDC  
18 Abortion Surveillance Data from 2020?

19 A. I have not seen this exact document. I have seen a  
20 summary. So I -- I --

21 Q. Okay. If you could go to the title page. Do you see  
22 there that it has the CDC logo at the bottom and then at the  
23 top it says Centers for Disease Control and Prevention, MMWR,  
24 Morbidity and Mortality Weekly Report, is that right?

25 A. Yes.

1 Q. Do you have any reason to believe that this document  
2 is -- or sorry. Do you have any reason to believe that this  
3 document is not the CDC abortion surveillance data from 2020?

4 A. No, I have no reason to believe that.

5 Q. So if you could please go to page 27 of the document.

6 A. All right.

7 Q. Let me know when you're there.

8 A. Okay.

9 Q. Do you see that it is -- it's a table labeled table  
10 15, number of deaths in case fatality rate for abortion-related  
11 deaths reported to CDC by type of abortion, United States, 1973  
12 to 2019?

13 A. Yes, I see that table.

14 Q. And then do you see that the far right column of that  
15 table is CFR, or case fatality rate, per 100,000 legal  
16 abortions?

17 A. Yes.

18 Q. And then do you see at the bottom right of the table  
19 that the fatality rate of abortions, according to the table,  
20 was 0.43 per 100,000 live births from 2013 to 2019?

21 A. I see that.

22 Q. Okay. Thank you. In your study and it's on -- it's  
23 in paragraph -- I'm sorry, not in your study. In your  
24 declaration in paragraph 33, you state that a study of 32  
25 states in Mexico found that states with less permissive



1 abortion legislation exhibited lower maternal mortality rates  
2 overall, is that right?

3 A. Correct.

4 Q. But that study didn't know that restrictive abortion  
5 laws cause lower mortality rates, did it?

6 A. It was a correlation association.

7 Q. Right. So it didn't show causation, did it?

8 A. No. You can't do causation with induced abortion  
9 studies. You're not going to ever randomize people to an  
10 induced abortion. So yes, you have to do correlational  
11 studies.

12 Q. And didn't that study explicitly state that the  
13 initial estimated effects for all mortality outcomes were  
14 explained by differences in other independent factors known to  
15 influence maternal health rather than by abortion legislation  
16 itself?

17 A. I need to look -- pull it up. But I do not recall  
18 that -- I think it -- it recognized that it is multifactorial  
19 why women die. So, you know, any time you're doing a  
20 correlational study you're going to have to try to control for  
21 confounding factors. So we of course have to recognize that  
22 it's multifactorial.

23 Q. Understood.

24 MS. SALVADOR: So I am dropping the study  
25 itself into the chat. If we could please have it marked as an

1 exhibit and then, Dr. Bane, please let me know if you have it  
2 open.

3 - - -

4 (Document marked as Exhibit-U for  
5 identification.)

6 - - -

7 THE WITNESS: Yeah. Give me just a second.  
8 I'm trying to figure out in my -- did you say paragraph 33,  
9 right?

10 BY MS. SALVADOR:

11 Q. Of your declaration?

12 A. Uh-huh.

13 Q. Yes. Paragraph 33. But it goes on to the next page.  
14 Okay.

15 A. Okay. I'm just going to get that article.

16 Q. Yeah, I know it's hard to juggle these documents.

17 A. I was going to say, is there going to be a question at  
18 the end of all of this?

19 Q. There absolutely will.

20 A. I figured as much. I'm looking through my stack for  
21 that one. I'm a hard copy gal.

22 Q. Sure.

23 A. Okay. And you want me to confirm it's the same one,  
24 right?

25 Q. Yes, please.

1 A. Okay.

2 (Pause.)

3 A. Sorry, I'm having a hard time getting it to come up.  
4 So let's see. Okay. Let me just look. Okay.

5 Q. So is this the same study regarding abortion  
6 legislation in Mexico that we have been talking about?

7 A. It is.

8 Q. So could you please go to page 10 of the document and  
9 I'm using the numbers that are printed on the bottom right and  
10 left.

11 A. Yes. I'm there.

12 Q. Okay. So in the discussion there is a section that  
13 starts with discussion and then in the column on the right  
14 there's a long paragraph and it's kind of in the middle  
15 paragraph. So I'm going to read the sentence, nevertheless,  
16 after an exhaustive analysis adjusting for multiple cofounders,  
17 the initial estimated effects for all mortality outcomes were  
18 explained by differences in other independent factors known to  
19 influence maternal health rather than by abortion legislation  
20 itself.

21 Did I read that correctly?

22 MR. BOYLE: Object to form. I think you said  
23 cofounders and it's confounders.

24 MS. SALVADOR: I'm sorry, confounders.

25 THE WITNESS: Yes.

1 BY MS. SALVADOR:

2 Q. And going a little bit further down in that paragraph,  
3 there's a sentence that says consequently, making a direct or  
4 independent causal link between a less permissive abortion law  
5 and the lower incidence of maternal death, or conversely by  
6 considering a more permissive abortion law would be a premature  
7 or even erroneous conclusion. Is that right?

8 A. Yes.

9 Q. Okay. Thank you. And we're done with this particular  
10 study.

11 A. Okay.

12 Q. So going back to your declaration, paragraph 35. You  
13 cite a -- you state that medication abortions have a four times  
14 higher rate -- I'm sorry, four times higher risk of  
15 complications as compared to procedural abortions, is that  
16 right?

17 A. You're in paragraph 35 now?

18 Q. Yes.

19 A. Yes.

20 Q. And for that statement you're citing a study by --  
21 there's a bunch of authors, but it's by Niinimaki, et al., is  
22 that right?

23 A. Yes. And then Mantula for the next statement, yes.

24 Q. Okay. So starting with Niinimaki, didn't the  
25 medication abortion group in that study include abortions

1 performed with Misoprostol alone?

2 A. Yes.

3 Q. Do you know whether PPSAT provides medication  
4 abortions using Misoprostol alone?

5 A. I would need to look again at the policies and  
6 procedures in order to answer that a hundred percent.

7 Q. And didn't the study describe both medication and  
8 procedural abortion as generally safe?

9 A. I don't know what you mean by generally safe.

10 Q. Sure. One second.

11 MS. SALVADOR: So I am dropping a document into  
12 the chat that starts -- the file name is Niinimaki, et al. Can  
13 we please mark it as an exhibit and then, Dr. Bane, let me know  
14 when you have it up, please.

15 - - -

16 (Document marked as Exhibit-V for  
17 identification.)

18 - - -

19 THE WITNESS: Okay. I have it up. I'm just  
20 going to get it out of my stack over here. Okay. I've got it.

21 BY MS. SALVADOR:

22 Q. And is the digital document the same as your hard copy  
23 document?

24 A. It is.

25 Q. And is that the same Niinimaki study that we were

1 discussing?

2 A. Yes.

3 Q. So could you please go to page 798?

4 A. Okay.

5 Q. Do you see that in the discussion -- right under the  
6 discussion heading the first sentence is in the present study  
7 we found that the two methods of pregnancy termination, medical  
8 and surgical, are generally safe, is that correct?

9 A. Just a second. I'm trying to -- I'm missing a page.  
10 So is that 798 you said?

11 Q. That's right. And if it's easier, I can also share my  
12 screen.

13 A. No, I have got it up on my screen. For some reason I  
14 don't have page 798 printed. So would you repeat that?

15 Q. Sure. Under the discussion heading, the first  
16 sentence right there is in the present study, we found that the  
17 two methods of pregnancy termination, medical and surgical, are  
18 generally safe.

19 Did I read that sentence correctly?

20 A. Yes.

21 Q. And are you aware that this study characterized all  
22 patient reports of heavy bleeding as hemorrhage even if they  
23 were within the expected range for medication abortion?

24 A. I'm aware that that's a limitation of the study.

25 Q. And are you aware that in response to criticism that

1 other literature about medical abortion reported a dramatically  
2 lower rate of complications that the authors of this study  
3 conceded that many of the complications are not really such,  
4 but rather concerns or adverse events that bring women back to  
5 the healthcare system?

6 MR. BOYLE: Object to form. You can answer.

7 THE WITNESS: So I'm aware just based on  
8 reading this study myself. I don't know about other  
9 conversations that I've had. But in reading it, I'm aware that  
10 there was probably some over reporting, which is a limitation.  
11 When you document in studies you always document limitations.  
12 And so I'm aware of that.

13 BY MS. SALVADOR:

14 Q. Are you aware that the study authors conceded that the  
15 rate of serious real complications is rare and rather similar  
16 between surgical and medical abortions?

17 A. I have no awareness that they have conceded that and  
18 this study has not been retracted.

19 Q. Understood.

20 MS. SALVADOR: I am dropping another document  
21 into the chat. The file name is Fjerstad-Niinimaki, letter to  
22 editor. Could we please mark it as an exhibit and then Dr.  
23 Bane, let me know when you have it open, please.

24 - - -

25 (Document marked as Exhibit-W for

1 identification.)

2 - - -

3 THE WITNESS: I have it open.

4 BY MS. SALVADOR:

5 Q. And you testified that you had reviewed Dr. Borass's  
6 declarations in this case, is that right?

7 A. Yes.

8 Q. And you also said that you reviewed some, but not all,  
9 of the literature she cited in her declarations, is that right?

10 A. Correct.

11 Q. Do you remember reviewing this particular document as  
12 one of the sources she cited in her declaration?

13 A. Not immediately, but I need to read it. Do you want  
14 me to do that?

15 Q. Sure. If you could just review. It says -- the  
16 relevant part is going to be that end reply column on the  
17 right.

18 A. Okay.

19 Q. And then it will go down to the next page.

20 (Pause.)

21 A. Okay. Thank you.

22 Q. So was the reply written by Niinimaki and the other  
23 coauthors of the study we're discussing?

24 A. Yes.

25 Q. And do you see at the bottom of page 660 on the right



1 that they write the main contributions that the present article  
2 makes to the literature are rate of serious and then in  
3 quotations, real. Complications is rare and rather similar  
4 between surgical and medical abortions?

5 A. I do see that.

6 Q. In your declaration you claim that there is a  
7 relationship between abortions and mental health complications,  
8 is that right?

9 A. Yes.

10 Q. And if you could go to paragraph 39 of your  
11 declaration.

12 A. Sure. Okay.

13 Q. So you describe a study by Mota or Mota and some  
14 others as discovering that abortion was associated with an  
15 increased likelihood of several mental disorders, substance  
16 abuse disorders, and suicidal ideation, is that right?

17 A. Yes.

18 Q. Is it true that in this study mental disorders were  
19 assessed by lay interviewers rather than by clinicians?

20 A. Let me get the study.

21 Q. Sure. And since you're looking at it, I'm going to  
22 put it in the chat and we'll mark it as an exhibit. Just one  
23 second.

24 - - -

25 (Document marked as Exhibit-X for

1 identification.)

2 - - -

3 THE WITNESS: Let me go to the chat and get it.

4 BY MS. SALVADOR:

5 Q. I'm sorry. I know it's tedious.

6 A. It's okay. I could use a potty break soon, just so  
7 y'all know.

8 Q. Okay. I just have a couple of questions about this  
9 study and then maybe we can take another break.

10 A. Okay. Let me just confirm it's the same study. Okay.

11 Q. So the study that you're looking at the hard copy of  
12 in the digital exhibit we just made, that's the same study,  
13 right, that we have been talking about?

14 A. Yes.

15 Q. And do you see on the first page there's a box there  
16 and it's got headings for clinical implications and  
17 limitations?

18 A. On the first page?

19 Q. Yeah.

20 A. I see that box, yes.

21 Q. And do you see that the first bullet point under  
22 limitations says mental disorders were assessed by lay  
23 interviewers?

24 A. I do see that.

25 Q. And then could you please go to page 245 of the study?

1 A. Okay.

2 Q. There's a heading that says conclusions. And then in  
3 the middle of that paragraph it says exposure to violence is a  
4 confounding factor in several of the associations between  
5 mental disorders and abortions.

6 Did I read that correctly?

7 A. I'm sorry, where -- you're on page 244 under the  
8 discussion?

9 Q. I'm sorry, 245 under the conclusion.

10 A. Oh, okay. Let me look on here. Okay.

11 Q. Should I repeat that question?

12 A. That would be nice. Thank you.

13 Q. Sure. So in that conclusion paragraph, in the middle  
14 of the paragraph it says exposure to violence is a confounding  
15 factor in several of the associations between mental disorders  
16 and abortions.

17 Did I read that correctly?

18 A. I'm sorry, Anjali, I don't see where that is.

19 Q. Okay. I'm going to just for this one --

20 A. I see it now. I see it now.

21 Q. Okay.

22 A. Yes.

23 Q. So yes, I read that correctly?

24 A. You did.

25 Q. And then do you see that the next sentence says our

1 study does not support a unidirectional relation between  
2 abortion and mental disorders?

3 A. Yes.

4 Q. And so this study didn't conclude that abortion caused  
5 the mental disorders it discusses, did it?

6 A. So, once again, when you do research, there are  
7 limitations and -- so when -- you're looking for associations  
8 and -- when it's correlational research of this type. And so  
9 you can't make the statement of cause and effect in this  
10 literature. What you can do though is note that there are lots  
11 of associations. It's similar to lung cancer. We can't say --  
12 you can't say okay, you have to smoke for the next 20 years and  
13 you don't and we're going to see who gets cancer and the  
14 complications. But when you get an aggregate of data that  
15 consistently show those associations, that then allows you to  
16 draw inferences from that. So yes, you're talking about the  
17 Mota study, but there are hundreds of studies looking at the  
18 association. And yes, there are confounding variables, but we  
19 know how to control those in research and look for the impact  
20 -- you know, one of the strongest one is who I reference next,  
21 Dr. Fergusson who is openly pro-choice and he's greatly  
22 disturbed by the fact that his research shows me that women who  
23 have had an abortion when he looks at them longitudinally have  
24 similar to what this Mota study showed and, you know, his -- he  
25 had trouble publishing it, unfortunately, because sometimes the

1 conclusions aren't what journals want. But it would be  
2 scientifically irresponsible if I didn't. And so, you know,  
3 there are just so many articles in this literature to show that  
4 some women really do struggle with anxiety, depression,  
5 substance use disorder and suicidal ideations. So something  
6 that one in four women experience, I would think as a  
7 scientific community we would want know as much as possible for  
8 the safety and health and well-being of those women. So I  
9 think categorizing correlational research as not good research  
10 is a misnomer. We would never be able to say lung cancer is  
11 caused, you know, by cigarette smoking.

12 Q. For sure. And we'll get -- I know you wanted a break,  
13 so we'll get to the Fergusson study after the break. But just  
14 on this study, would you say that it's fair that one of the  
15 flaws of the particular Mota research used in this study is  
16 that it cannot concretely establish causation?

17 A. So it is a limitation in all correlational research  
18 that by itself causation -- it's not a randomized trial in  
19 which you have an abortion and you don't. So you cannot by  
20 itself say causation and that's not what I implied in my  
21 declaration.

22 Q. Got it. Thank you. And based on your experience as a  
23 physician, would you say that anxiety, depression, substance  
24 use and suicidal ideation are things that folks might struggle  
25 with after giving birth also?

1 A. Rarely.

2 Q. All right.

3 A. Yes. But I don't -- most women have tremendous amount  
4 of joy after giving birth. And so to equate that women who  
5 have a pregnancy loss of any kind, whether it's an abortion or  
6 a miscarriage, an ectopic, those women struggle in a different  
7 capacity than women who give birth.

8 Q. Okay. Thank you very much. We can take a break and  
9 go off the record.

10 VIDEOTAPE TECHNICIAN: Thank you.

11 MS. SALVADOR: 10 minutes.

12 VIDEOTAPE TECHNICIAN: We are now going off the  
13 video record. The time is 4:18 p.m.

14 (A break was taken.)

15 VIDEOTAPE TECHNICIAN: We are now back on the  
16 video record. The time is 4:29 p.m.

17 BY MS. SALVADOR:

18 Q. Okay. So Dr. Bane, we left off discussing paragraph  
19 39 of your declaration and the studies you cite there.

20 A. Okay.

21 Q. So in your declaration you describe a study by  
22 Fergusson, et al. as finding that women who had abortions had  
23 30 percent increased rates of mental disorders, is that right?

24 A. Yeah. Let me get that one.

25 Q. Sure.

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(Pause.)

A. I got the right one.

Q. Could you define confounding in the research context, please.

A. Sure. So basically we know that many relationships are multifactorial. So in research you -- if you're trying to look at an association between two variables, you want to control for confounding variables, other things that might be associated. So in studies what you could do is you can control for those and see if a relationship still exists after controlling for those.

Q. Got it. Thank you. So didn't the study state, the Fergusson study state that the small association between abortion and mental health found in the study could be explained by uncontrolled residual confounding?

A. I would need to look at the sentence you're talking about.

Q. Okay. One second.

MS. SALVADOR: I am dropping the study into the chat. Can we please mark it as an exhibit. And then, Dr. Bane, if you can please confirm that we're all looking at the same thing.

THE WITNESS: Okay.

- - -

(Document marked as Exhibit-Y for

1 identification.)

2 - - -

3 THE WITNESS: Okay. They're the same.

4 BY MS. SALVADOR:

5 Q. Great. So if you go to page 450 of the study.

6 A. Sorry, my sheet was out of order. My page numbers got  
7 cut off when I printed it. Yes, the page with implications on  
8 it?

9 Q. Yes, that's right. So right before that implications  
10 heading, there's a sentence that starts in particular in that  
11 paragraph right before. And it says in particular, it could be  
12 suggested that the small association between abortion and  
13 mental health found in this study could be explained by  
14 uncontrolled residual confounding.

15 Did I read that correctly?

16 A. You read it correctly.

17 Q. Going back to your declaration. And we're still in  
18 paragraph 39. You also describe a study by Coleman as finding  
19 that adolescents who aborted an unwanted pregnancy were more  
20 likely than adolescents who delivered to seek psychological  
21 counseling and that they reported more frequent problems  
22 sleeping and more frequent marijuana use, is that correct?

23 A. Yes.

24 Q. Are you aware that Coleman's work on abortion and  
25 mental health has been heavily criticized by scientific



1 experts, including the Royal College of Psychiatrists?

2 A. I am quite aware that Dr. Coleman has had one study  
3 that was retracted. She also had another study that was  
4 attempted to be retracted and in her study that was attempted  
5 to be retracted, that study was then in -- I believe it was in  
6 the British Journal of Psychiatry, which is one of the highest  
7 impact factor publications, that they actually -- there was a  
8 group of people that wanted it retracted, they did an  
9 investigation and this is a very reputable journal and they  
10 kept it in there. I'm aware in the Frontiers of Psychology, I  
11 believe that's the one that retracted it, she did not even have  
12 the opportunity to give a rebuttal, which is extremely -- it's  
13 malpractice in research for that. And she has had a long  
14 career of a variety of studies that are in the literature and  
15 are well published and well respected. So I am quite aware  
16 that there is that one study.

17 Q. And would you say that retraction of the study is a  
18 fairly significant thing to have happen?

19 A. I am aware of retraction being a significant one.  
20 It's kind of like what I experienced at Barton College this  
21 year. They didn't like -- a group of people didn't like the  
22 fact that I was going to be sharing information that wasn't  
23 from -- it didn't have a conclusion that they particularly  
24 liked and they tried to retract and not allow me to talk.  
25 Fortunately my administration eventually allowed me, supported

1 me to talk. So I wish that she had had the opportunity to give  
2 -- to do what the other journal did and found there was nothing  
3 wrong in what she did. There has to be scientific integrity  
4 and sadly, she's being classified as somebody who doesn't have  
5 that when she has a tremendous amount to offer in her work.

6 Q. Generally speaking wouldn't you say that a scientific  
7 journal would not retract a study just because some people  
8 dislike it?

9 A. When I was training in my Ph.D. I would have said  
10 that, but I don't think that is necessarily true anymore. I  
11 think that a lot of the professional societies who print their  
12 own journals, they decide which studies to have in those  
13 journals. And, you know, we all have bias, all of us. And I  
14 gave a talk on diversity, equity and inclusion at this  
15 conference I'm at and I spoke about implicit bias and I said  
16 the most important thing is for us to be aware that we have it.  
17 And so in research every one of us on this call have biases and  
18 I'm aware that I have biases. As you said earlier, I'm a  
19 pro-life advocate. Okay. That should make me be an even  
20 better researcher because I know my biases and if I care more  
21 about the truth than I care about being right, then I can look  
22 at my research, my data, just like Dr. Coleman does, Dr.  
23 Fergusson who this study I cited, it took him four journals to  
24 get it accepted because they didn't like his conclusion. And  
25 he -- he basically is -- said I'm pro-choice. I didn't like my

1 results either, but I want women to be safe, so we need to  
2 publish my results. He said I get my stuff -- he's so  
3 internationally known he gets his research published the first  
4 try. It took him four tries to get a journal. So I get scared  
5 about where publication and the ability to publish when it goes  
6 against what certain professional organizations want to see.

7 Q. Just to be clear, just now you were talking about Dr.  
8 Fergusson and not Dr. Coleman, is that right?

9 A. I was talking about both of them. But Dr. Fergusson,  
10 I was talking about his article that I cited in my declaration  
11 took him four tries to get published and he -- it was very  
12 discouraging because of the fact that he is so well respect  
13 had. You know, there are certain people that when they submit  
14 and you're the author in a journal there, they are happy you  
15 chose their journal and he's one of those type people, yet his  
16 finding weren't consistent with what some wanted to get out  
17 there, which is very sad and scares me.

18 Q. Going back to the study -- the Coleman study that we  
19 were talking about, are you -- the one that you cited in your  
20 declaration, to be clear. Didn't the study also explicitly  
21 state that design limitations precluded definitive assumptions  
22 about causation for some of the same reasons that we talked  
23 about today?

24 A. Yes, it's -- once again, this whole body of literature  
25 is -- you can't randomize people to have an abortion or not.

1 And so you have to either retrospectively look back at charts  
2 or you can prospectively follow them. Which both Dr.  
3 Fergusson and Dr. Coleman's studies were longitudinal studies.  
4 They were prospective, which gives them great strength. But  
5 once again, because mental health issues are not going to  
6 necessarily -- they're going to be multifactorial, you can set  
7 up your study design to control for those and still see  
8 associations.

9 Q. And going back to your declaration. Again, we're  
10 still in paragraph 39. You also discuss a -- or, I'm sorry,  
11 we're now in paragraph 40. You also discuss a Finnish study  
12 showing a higher suicide rate after abortion when compared to  
13 giving birth, is that right?

14 A. I do.

15 Q. Are you aware of how the maternal mortality rate in  
16 Finland compares to the maternal mortality rate in the United  
17 States?

18 A. I would have to -- not off the top of my head, no. I  
19 would have to look at the study.

20 Q. Is it your opinion that abortion causes increased  
21 suicidality?

22 A. It is my opinion there's an association between  
23 abortion and suicidal ideation, as well as suicide. Once  
24 again, being an increased risk. So we know mental disorders,  
25 anxiety, particularly depression, and they can be comorbid,

1 meaning about half the people who have depression also have an  
2 element of anxiety, is a significant risk factor for suicide.  
3 And so it follows that if a woman struggles after an abortion  
4 with anxiety or depression, that could lead to suicidal  
5 ideation and suicide. So once again, the type of study is  
6 correlational and there's an association. But there are  
7 criteria so that if you continue over and over again to get the  
8 same correlational studies showing this, then that strengthens,  
9 as I said with the lung cancer example, that there is a very  
10 strong association.

11 Q. And to your knowledge is increased suicidal ideation  
12 ever associated with child birth for the period post-child  
13 birth?

14 A. Yes. So postpartum depression occurs and with the  
15 same rationale I just explained, a woman has postpartum  
16 depression would have an increased risk of suicidal ideation as  
17 well as suicide.

18 Q. And doesn't the Finnish study that you cite in your  
19 declaration also say social circumstances might be a common  
20 risk factor in terms of deaths from suicide and homicide?

21 A. I'll need to pull up the study.

22 Q. Sure.

23 MS. SALVADOR: So I'm dropping the study into  
24 the chat like we have been doing. If we could please mark it  
25 as an exhibit and then, Dr. Bane, please confirm that we're

1 looking at the same document.

2 - - -

3 (Document marked as Exhibit-Z for  
4 identification.)

5 - - -

6 THE WITNESS: Okay.

7 MR. BOYLE: I believe this one is already --

8 THE WITNESS: Yeah, it's not in my stack.

9 MR. BOYLE: You're talking about the Niinimaki  
10 study?

11 MS. SALVADOR: No, this is Karalis.

12 MR. BOYLE: Oh.

13 THE WITNESS: Just a second. Let me look. So  
14 paragraph 40. So number 28. Okay. My reference 28.

15 (Pause.)

16 THE WITNESS: I'm going to have to rely on  
17 yours. I misplaced it. We pulled out a lot of documents. Let  
18 me go to the chat.

19 BY MS. SALVADOR:

20 Q. We're almost to the end of the part that's heavy on  
21 studies so...

22 A. Okay. My desk looks like a mess over there. Okay.  
23 Oh, yeah. Okay. So where did you want me to look?

24 Q. So first, could you please confirm that this is the  
25 same Karalis study that you cite in your declaration?

1 A. It is.

2 Q. So could you please go to page 1119.

3 A. Okay.

4 Q. And under the sentence right before conclusion it says  
5 higher mortality rates after termination of pregnancy among  
6 teenagers, and especially deaths from suicide and homicide,  
7 indicate that women are very vulnerable at this stage and that  
8 social circumstances might be a common risk factor.

9 Did I read that correctly?

10 A. You read that correctly and it's consistent with all  
11 the other examples we have gone through of correlational  
12 studies. A design always in studies is, you know, when you  
13 present your research you're going to want to put the  
14 limitations and the confounding so that you're -- the reader  
15 knows you're not looking just narrowly. And, you know, they're  
16 highlighting the fact that suicides among teenagers, and  
17 especially deaths from suicide and homicide, while they  
18 increase, it's not going to be the only factor. So it's  
19 consistent with all the studies that are out there showing an  
20 association.

21 Q. Would you agree that it's important that studying and  
22 examining mental health and abortion control for the person's  
23 reason for getting an abortion?

24 A. Sure.

25 Q. Would you agree that someone who had an abortion of a

1 wanted pregnancy might have a different emotional reaction than  
2 someone who had an abortion of a pregnancy they didn't want?

3 A. We know that there are actually several factors. I  
4 didn't cite it in my declaration, but I believe -- I think it's  
5 up to 14 factors that are more commonly associated with mental  
6 health disorders and this doesn't just come from -- gosh, it's  
7 a text that looks at abortion and psychological impact. I  
8 can't recall it right now, but I could get the reference for  
9 you. But it is very commonly known that there are certain risk  
10 factors that are more associated with a risk for mental health  
11 issues afterwards and adjustment, negative emotions like anger  
12 and guilt. So yes, not every woman is exactly alike when it  
13 comes to her risk.

14 Q. Would you agree that a good comparison for studies  
15 examining mental health and abortion would be between people  
16 who wanted an abortion and got one versus people who wanted an  
17 abortion but couldn't get one?

18 A. So you're talking about the Turnaway Study, it sounds  
19 like. I think a better one is an -- comparing women who had an  
20 unwanted pregnancy or an unplanned let's -- let me correct  
21 that. An unplanned pregnancy, which is what I see all the  
22 time, and comparing women who had an abortion and women who  
23 chose to give birth and following them longitudinally. That is  
24 a much better comparison.

25 Q. So it sounds like you're familiar with the Turnaway



1 Study?

2 A. Yes. I don't have it in front of me, but yes, I am.

3 Q. And are you familiar with how the Turnaway Study was  
4 designed?

5 A. I'm familiar to the extent that they -- they provided  
6 their sampling plan. If you look in their very long document  
7 about it they don't actually give you very specifics and so  
8 that's a major limitation. And it's actually not a great  
9 research from the standpoint of one of the strengths of  
10 research is that it's reproducible. So I should be able to  
11 take their methods and replicate their methods and see what I  
12 find. That's when studies are stronger. And unfortunately  
13 they don't clarify that very well.

14 Q. And are you aware that Dr. Wubbenhorst, your fellow  
15 expert in this case, has referred to the Turnaway Study as  
16 extremely well designed?

17 A. No, I'm not aware of that.

18 Q. So you would not agree with that?

19 A. No, I would not.

20 Q. Got it. And are you aware that the American  
21 Psychological Association has said that research shows that  
22 having an abortion is not linked to mental health problems?

23 A. I am aware of their statement. I disagree with it,  
24 but I am aware of it.

25 Q. So you also state in your declaration that hemorrhage

1 is a risk of abortion, right? And this is in paragraph 35.

2 A. Did you say hemorrhage?

3 Q. Yes.

4 A. Okay. Sorry. You switched gears.

5 Q. I did. I'm sorry.

6 A. We're going to paragraph 35?

7 Q. Yes, we are.

8 A. Okay. I am aware that hemorrhage is a risk of  
9 abortion.

10 Q. I'm sorry, I didn't mean to cut you off.

11 A. Oh, no. No. You're fine.

12 Q. So in your opinion what amount of blood loss  
13 constitutes hemorrhage in the abortion context?

14 A. So we'll typically when a woman is bleeding say to her  
15 if you're filling two pads an hour full of blood for more than  
16 two hours is typically what I will tell them, I want you to  
17 call me. I'm concerned about that level of bleeding.

18 Q. And is there a risk of hemorrhage associated with  
19 childbirth as well?

20 A. Yes.

21 Q. Do you know whether the risk of hemorrhage is greater  
22 with carrying a pregnancy to term or abortion?

23 A. I don't know head-to-head studies that look at that  
24 particular thing. I know the average birth is -- a vaginal  
25 delivery is about 500 cc of blood. A c-section is more. And

1 so if a woman does not have hemorrhage you would expect much  
2 less than that. But if she has hemorrhage, it could be a wide  
3 range of amounts.

4 Q. So you don't know whether the risk of hemorrhage is  
5 greater with childbirth versus abortion?

6 A. I don't know of studies that have like -- I can't  
7 reference a study, so that's just a big generalization.

8 Q. Got it. And you state in your declaration also that  
9 infection is a risk of abortion, correct?

10 A. Yes.

11 Q. Is there a risk of infection associated with carrying  
12 to term in childbirth also?

13 A. Yes.

14 Q. Could you describe how that infection might arise in  
15 the childbirth context?

16 A. Yeah. So postpartum --- well, if we're talking about  
17 -- and if you could clarify, Anjali, that would help me.  
18 You're saying after a woman has had a baby or during her  
19 pregnancy?

20 Q. Both. Let's do both. So why don't you go one by one.

21 A. Okay. So I guess what I'll probably do just to not  
22 make this too long is what I'm talking about in my declaration  
23 is an infection after a pregnancy -- after an induced abortion.  
24 So probably just an infection after delivery. Because, I mean,  
25 a woman can get every type of infection during pregnancy that

1 she can get when she's not pregnant, plus she can get, for  
2 example, the chorioamnionitis that I mentioned also because she  
3 has a gestational sac that she wouldn't have when she's not  
4 pregnant. But after pregnancy women can get something called  
5 postpartum endometritis where they get an infection of the  
6 lining of the uterus and that infection -- when you think about  
7 the fact that the cervix opens to 10 centimeters to deliver a  
8 baby vaginally or by c-section that while it's a sterile  
9 environment, you still have the risk of infection. You're  
10 using instruments and things like that. So she can present  
11 with a fever. It's usually after she has gone home and she  
12 presents with a fever and sometimes abnormal discharge that's  
13 consistent with infection. And we treat it with antibiotics.

14 Q. Do you know whether the risk of endometritis is  
15 greater after childbirth like you have been describing or after  
16 an abortion?

17 A. No, I do not. And -- yeah. No.

18 Q. So it sounds like you have treated patients with  
19 endometritis, is that right?

20 A. I have.

21 Q. And you said you treated them with antibiotics, is  
22 that right?

23 A. Yes.

24 Q. Did that treatment always require hospitalization of  
25 the patient?

1 A. Not always.

2 Q. How often does that treatment require hospitalization?

3 A. I can't give you a percentage. I don't know the  
4 answer to that.

5 Q. Would you say more often than not you had to  
6 hospitalize those patients?

7 A. Yes.

8 Q. Do you think that endometritis can only be treated  
9 safely in a hospital?

10 A. I think you have to look at the clinical context and  
11 how sick the woman is and make a decision also how reliable she  
12 is and how -- whether or not she wants to go to the hospital.  
13 She's got a newborn now. You know, so I think that you can  
14 give her the option if you feel like she can be safely treated  
15 as an outpatient and check in with her. So I think you can  
16 give options.

17 Q. Okay. So in certain circumstances you can safely  
18 treat endometritis outside of the hospital setting, is that  
19 right?

20 A. Yeah. But it usually requires I.V. antibiotics  
21 typically. So the majority are in the hospital. I'm trying to  
22 think even now -- I think -- to be honest, I have to change my  
23 statement. I'm pretty sure we did everybody in the hospital.  
24 It's been over 10 years. There may be a protocol now for  
25 outpatient. I also think I was thinking about someone with

1 mastitis, which is infection in the breast. And we have  
2 treated a lot of those women as an outpatient.

3 Q. Got it. Thank you. So you also state in your  
4 declaration -- and now we're at paragraph 37.

5 A. All right.

6 Q. You also state in your declaration that a single  
7 induced abortion increases the risk of preterm birth, is that  
8 right?

9 A. Yes.

10 Q. And you cite a study by Hanes, et al., is that right?

11 A. Yes.

12 Q. But didn't that study also say that association  
13 between abortion and preterm birth may be due to chance or bias  
14 or confounding variables?

15 A. Once again, good researchers actually talk about  
16 limitations and recognize that preterm birth has many factors  
17 associated with it. So what they're trying to do is -- in this  
18 case it was a review of the literature and take all the  
19 different studies and -- that met the criteria for their  
20 metaanalysis and look at it recognizing that an association  
21 does exist, yet there are other factors that come into play.

22 Q. Right. So they recognize that the association could  
23 be due to chance, bias, or confounding variables, is that  
24 right?

25 A. They do recognize that. But they do also say that

1 there is consistent evidence that there's an association and it  
2 is a risk factor for preterm birth.

3 Q. Got it. Thank you. And your declaration also states  
4 in that same paragraph 37 that more than one abortion has been  
5 shown to increase the risk for preterm birth by 93 percent, is  
6 that right?

7 A. Yes.

8 Q. And that's the study by Shah, et al., is that right,  
9 or Shah and Zao?

10 A. Yes.

11 Q. But didn't that study also explicitly note that it  
12 doesn't establish that multiple abortions cause that increased  
13 risk, correct?

14 A. Let me get that study. Just a second.

15 Q. Sure.

16 MS. SALVADOR: And I'm going to put that in the  
17 chat as well and please mark that as an exhibit. And, Dr.  
18 Bane, please confirm that we're looking at the same thing.

19 THE WITNESS: Okay.

20 - - -

21 (Document marked as Exhibit-AA for  
22 identification.)

23 - - -

24 THE WITNESS: Yes, I have got the study now.

25 BY MS. SALVADOR:

1 Q. Okay. And it's the same study by Shah and Zao that  
2 we've been discussing?

3 A. It is.

4 Q. Okay. Could we go to page 1438, please.

5 A. I'm there.

6 Q. Okay. So if you go to the right column there is a  
7 heading that says implications for practice. And above that  
8 heading there is a long paragraph. And I'm going to read  
9 starting from the middle of it. So it says we must caution  
10 readers that we have restricted ourselves to explore the  
11 association of I-TOP -- I-TOP being previously defined as  
12 induced termination of pregnancy -- and pregnancy outcomes.  
13 Several biomedical, social, environmental, lifestyle-related,  
14 genetic and other factors contribute to a preterm and/or LBW --  
15 that's low birth weight -- births and this needs to be kept in  
16 mind in interpreting our results. We caution interpretation  
17 being causal as confounding effects of socioeconomic factors,  
18 which are important, were considered in very few studies only.  
19 Discussion regarding downsides of I-TOP are incomplete without  
20 discussing downside of unwanted pregnancies as they are also at  
21 risk of adverse outcomes.

22 Did I read that correctly?

23 A. You did.

24 Q. So we have gone over a lot of studies. Have any of  
25 these studies that we have gone over lead you to want to modify



1 the opinions you state in your declarations -- in your  
2 declaration, I'm sorry?

3 A. No, they simply reinforce what I have repeatedly said  
4 this afternoon, that really good research recognizes the  
5 limitations of the research. But we also know that -- like for  
6 example, what you just read, if I was -- if I was a reviewer  
7 for this paper, I would be looking for that paragraph right  
8 there. And the fact that it is there and the fact that they  
9 acknowledge that it is there shows me that bias I was talking  
10 about earlier. They're trying to control for that. They're  
11 not in any way trying to say that this is a causal  
12 relationship. But once again, this is review of a lot of  
13 studies. And what I like about this is we know that the  
14 preterm birth rate is so high in this country. We also know  
15 that it's higher in black women. And we also know that black  
16 women have more abortions. And so wouldn't we care enough  
17 about black women and their children to want to really  
18 understand this relationship. So if indeed induced abortion is  
19 a contributing factor, not the only factor, but a contributing  
20 factor to why they're delivering premature children that have  
21 chronic diseases, because that's a risk factor of prematurity,  
22 not all of them have them, wouldn't we want women to know when  
23 they're making that decision about whether or not to give birth  
24 or to have an abortion. And so I -- I applaud these authors  
25 for doing that and so many of what you have cited just

1 reinforces that these are really important studies that I  
2 included and that the authors are doing good research.

3 Q. I got it. Thanks for your explanation. So we're  
4 going to switch gears a little bit. We talked a little bit  
5 about hemorrhage earlier. Did you ever treat patients who were  
6 hemorrhaging in your medical practice?

7 A. Yes.

8 Q. Under what circumstances?

9 A. Probably the most common would be postpartum  
10 hemorrhage. So a woman delivers a baby and then her bleeding  
11 doesn't slow down. It could also be that she had a placental  
12 abruption, which means the placenta comes off the edge of the  
13 uterine wall and she could bleed. She could have a placenta  
14 previa where the placenta is implanted over the internal os,  
15 which is the internal opening of the cervix, and she could  
16 bleed. Intraoperatively I dealt with hemorrhages in women. I  
17 particularly remember some traumas of pregnant women who were  
18 in car accidents, one in a train accident. Yeah.

19 Q. And in the labor and delivery context, I think you  
20 might have mentioned the number before, but in terms of the  
21 amount of blood, what do you mean by hemorrhage?

22 A. So, you know, in terms of labor and delivery, you  
23 know, it's not normal when you're not giving birth to bleed.  
24 And so, you know, the placenta accreta, the placental  
25 abruptions, these women are coming in and they're soaking pads

1 or, you know, they can't control the bleeding.

2 In terms of postpartum hemorrhage after a delivery, it  
3 would be -- I mentioned 500 ccs, but -- for a vaginal delivery.  
4 When you're in the middle of a postpartum hemorrhage, holy cow,  
5 the bleeding is so brisk because the -- a pregnant uterus, the  
6 blood vessels are -- particularly at term are very large.  
7 They're engorged. They have a lot of blood flow. So you have  
8 to act fast and you have -- in your head you have to go through  
9 your differential diagnosis. You know, do you have uterine  
10 atony, meaning the uterus is not contracting down to top --  
11 when the uterus contracts down, it squeezes the blood vessels  
12 and helps. You have to think of that. You have to think is  
13 there a laceration in there. Is there some retained placenta  
14 in there. So you're differentially diagnosing while you're  
15 calling for treatment options.

16 Q. And have you ever treated patients who are  
17 hemorrhaging in the miscarriage management context?

18 A. So yes, I have. And the -- typically there we did  
19 most of our D&Cs in the operating room where we could use  
20 suction aspiration and often times control that well. But, you  
21 know, if they were still bleeding heavily, we would have to  
22 give them -- well, you can do uterine massage, you can give  
23 medicines that help contract the uterus, things like that.

24 Q. So you said you handled most of your D&Cs in the  
25 operating room. So where would the other -- where else would

1 you handle D&Cs?

2 A. Oh, so what I meant is some that do expectant  
3 management. I never did D&Cs in the outpatient setting.

4 Q. And would the definition of hemorrhage for a D&C be a  
5 different amount than the labor and delivery amount we just  
6 talked about?

7 A. Yes, it would be less typically.

8 Q. About how much?

9 A. I would probably say 200 cc.

10 Q. Do you think that hemorrhage can only ever be treated  
11 safely in hospitals?

12 A. I think that --

13 MR. BOYLE: Objection to form. You can answer.

14 THE WITNESS: Okay. I think hospitals are much  
15 more equipped to handle hemorrhage, particularly with a  
16 pregnant uterus. And the risk of uterine atony that we can  
17 have with it and lacerations, I think hospitals have the  
18 resources they -- if I need to do an immediate transfusion they  
19 have blood banks, they have -- if she bleeds so much that she  
20 needs support from an ICU team, if she were to, God forbid,  
21 code, they have code teams there. I have anesthesiologists  
22 that can intubate her and nurse anesthetists. So I think that  
23 every pregnant woman's life matters and because of that I want  
24 her, should I have hemorrhaging, to be near the resources that  
25 can best save her life.

1 BY MS. SALVADOR:

2 Q. Do you think a hemorrhage of 200 cc can be treated  
3 safely in an outpatient setting?

4 MR. BOYLE: Object to form.

5 THE WITNESS: I think that if you -- so when I  
6 said 200 cc, what I'm talking about is maybe she initially  
7 comes in and complains and has 200 cc, but it's not like then  
8 it's turned off. She's continuing to bleed. And so, you know,  
9 I have reviewed the protocols that Planned Parenthood -- PPS --  
10 I'm sorry, the acronym you said at the beginning -- southern  
11 states has. And it's obvious that they do have protocols, but  
12 it's obvious that they recognize that they can have an awful  
13 lot of hemorrhaging because their protocols are very, you know,  
14 multilayered that go way beyond what you would do if there was  
15 200 cc of loss only.

16 BY MS. SALVADOR:

17 Q. In your medical practice have you ever treated  
18 patients with cervical tears or lacerations?

19 A. I have.

20 Q. Under what circumstances?

21 A. Usually childbirth is where you can have it. I'm  
22 trying to think if any other times that I recall cervical  
23 lacerations. When you're dilating the cervix using the  
24 dilators, which are metal instruments that you sequentially  
25 dilate the cervix when you're doing a D&C, you can have a

1 laceration from that.

2 Q. Got it. And so -- and then you said before also that  
3 all of your D&Cs you would perform in a hospital setting, is  
4 that right?

5 A. Correct.

6 Q. Is it your opinion that cervical tears can only be  
7 treated safely in a hospital?

8 A. It's my opinion that cervical tears bleed really  
9 rapidly and that I would not try to be -- in a hospital setting  
10 your ability to visualize, you have to picture your -- the  
11 cervix is, you know, four, five centimeters inside the vaginal  
12 canal. And so if you're in an office setting, to try to  
13 visualize it and control the blood is a lot more difficult than  
14 it is in a hospital. So as much as anything, yes, you have the  
15 resources if you can't get the bleeding to stop in a hospital,  
16 but you also have the ability in terms of -- with the amount of  
17 blood loss I have seen with cervical tears to just have, you  
18 know, the surgical packs that are available to help you have  
19 the instrumentation that you need.

20 Q. I'm sorry, that isn't quite what I asked. So I asked  
21 whether you think that cervical tears can only ever be treated  
22 safely in hospitals?

23 A. No. I think that if you have a cervical tear -- and  
24 I'm just trying to recall if I ever had a cervical tear when I  
25 was in my office that I had to try to repair that -- I think it

1 would be harder. But I think that if you had to repair it, you  
2 would do the best you could. But it would be more difficult  
3 without having the instrumentation.

4 Q. And you mentioned doing a D&C with four to five  
5 centimeters of dilatation. Do you always have to dilate to  
6 that amount when you're doing a D&C?

7 A. No. I'm sorry, that's not what I said. Maybe it  
8 sounded like what I said. I apologize. Let me fix that. The  
9 cervix is four to five centimeters like in the vaginal canal.  
10 So you have to put a speculum in and it's not like the cervix  
11 is right at the opening. It's deep in the canal. So no, no,  
12 you do not have to dilate four to five centimeters. I was just  
13 saying from a landmark perspective the cervix -- if you have a  
14 cervical laceration you have to get deep into the vagina. And  
15 so visualization -- you're not just going to start throwing  
16 stitches without seeing where you think your source of the  
17 bleeding is and that's difficult because the cervix is so far  
18 away.

19 Q. Understood. Thank you for clarifying.

20 A. You're welcome.

21 Q. Did you ever use sedation in your medical practice?

22 A. Not that I was overseeing. The nurse anesthetist or  
23 the anesthesiologist was overseeing the sedation because that's  
24 out of the scope of my practice.

25 Q. And what types of sedation were you overseeing? I'm

1 sorry, you said you were not overseeing, is that right?

2 A. So it depends -- I guess I should clarify. If  
3 somebody was -- let's say she was coming in for something  
4 called a LEEP procedure or a colposcopy procedure, which is  
5 what we use to manage abnormal Pap smears, and she just said  
6 I'm really anxious. Like I would go to the radiology  
7 department and do something called a hysterosalpingogram to  
8 look for whether tubes were opened or closed for women who had  
9 infertility. If she said to me I'm really anxious then I would  
10 give her potentially something called a benzodiazapine, which  
11 is an over-the-counter medicine for anxiety. That could be  
12 categorized as like very mild sedation. But I would give those  
13 to women who potentially had an anxiety disorder. What I think  
14 I want to just make sure I clarify is that I don't think it's  
15 the role of an obstetrician and gynecologist to manage deeper  
16 levels of sedation that anesthesiologists, nurse anesthetists  
17 are specifically trained to do.

18 Q. And so for those patients who you would prescribe  
19 benzos, was that ever in an outpatient facility?

20 A. Yes, it would potentially be in the office, that they  
21 would get -- you know, 30 minutes before their procedure that  
22 they would get that medicine.

23 Q. And were you able to administer that medicine safely  
24 in an outpatient facility?

25 A. So they -- I didn't administer it. I would write a



1 prescription and they would take it before they came. So if  
2 that's your definition of administer it, then yes, I was for  
3 those situations.

4 Q. And did you ever supervise the use of I.V. sedation?

5 A. I did not.

6 Q. And did you ever supervise the use of kind of local  
7 anesthesia?

8 A. So I use local anesthesia. So, for example, if you're  
9 doing a procedure in the office sometimes we would put it in  
10 the cervix. If we're removing like a -- doing a vulvar biopsy.  
11 So I would do local anesthesia, yes. But not any sort of  
12 systemic anesthesia. That's what I'm referencing to. I think  
13 that's out of the scope of the practice of anyone but an  
14 anesthesiologist and nurse anesthetist.

15 Q. Understood. And that local -- that local anesthesia  
16 that you're referring to, you were able to administer that in  
17 an outpatient facility?

18 A. I was.

19 Q. So we're going to switch gears a little bit. What is  
20 an ectopic pregnancy?

21 A. An ectopic pregnancy is a pregnancy that is outside of  
22 the uterine cavity. It can be -- well, most commonly it's in  
23 the fallopian tube, but it can occur in other places such as  
24 the ovary, can even be intraabdominal, cervical.

25 Q. And how are ectopic pregnancies detected?

1 A. Ectopic pregnancies are detected by ultrasound.

2 Q. Would you agree that an ectopic screening protocol  
3 that uses ultrasound, the patient's medical history, and hCG  
4 testing is an appropriate protocol?

5 A. So you said three things. You said ultrasound,  
6 history and hCG?

7 Q. That's right.

8 A. So I follow the protocol from ACOG and I think it's a  
9 committee opinion or a Practical Bulletin 191. It got updated  
10 to 193. I think I used 191 in my declaration. There's an  
11 updated 193 and I follow their protocol which includes, yes,  
12 doing those things to document whether an individual has an  
13 ectopic pregnancy.

14 Q. And how early can ultrasounds detect pregnancy?

15 A. We can usually see a gestational sac about five weeks.  
16 It doesn't confirm that it's not an intrauterine pregnancy just  
17 to see a sac. So we have to be cautious with that because you  
18 can something called a pseudosac with an ectopic pregnancy.  
19 You can also have what's called a heterotopic pregnancy, which  
20 is fortunately very rare, but it's an intrauterine pregnancy  
21 and an ectopic pregnancy at the same time.

22 Q. What is a pregnancy of unknown location?

23 A. So a pregnancy of unknown location is a transient  
24 situation. It not a diagnosis. It is where you don't know  
25 exactly if the person -- if the woman has as intrauterine

1 pregnancy or an ectopic. So you have to have a high clinical  
2 suspicion when you have -- any time you have a pregnant patient  
3 you have to have a high clinical suspicion that she has an  
4 ectopic until you prove otherwise. But particularly if you  
5 were expecting to see an intrauterine pregnancy based on a sure  
6 last menstrual period for example, which we know unfortunately  
7 only happens about 50 percent of the time. A lot of women  
8 don't know their last menstrual period. But yeah, it's  
9 particularly important that we follow those women who have  
10 pregnancy of unknown location because we really -- for her  
11 safety we haven't confirmed where her pregnancy is located.

12 Q. So you wouldn't consider a pregnancy of unknown  
13 location equivalent to a confirmed ectopic then, would you?

14 A. No, I would not. I would basically have a high  
15 clinical suspicion until proven otherwise that she had an  
16 ectopic. If she has an intrauterine pregnancy I'm not going to  
17 send her home and she potentially die on me. But if she has an  
18 ectopic pregnancy and I send her home she could rupture that  
19 and unfortunately it's one of the leading causes of maternal  
20 mortality in the first trimester.

21 Q. So is it your medical opinion that all pregnancies  
22 should be assumed to be ectopic until proven otherwise?

23 A. It is my medical opinion than I want to document every  
24 pregnancy to confirm an IUP and that gives me a great sense of  
25 reassurance. So yes, I think all pregnancies we have to

1 document that we have an IUP.

2 Q. If a pregnancy has -- sorry. If a patient has a  
3 pregnancy of unknown location --

4 A. Okay.

5 Q. -- but doesn't have symptoms of ectopic pregnancy and  
6 doesn't have risk factors for ectopic pregnancy in their  
7 medical history --

8 A. Okay.

9 Q. -- would you consider that a suspected ectopic  
10 pregnancy?

11 A. So we know that 50 percent of our patients who have no  
12 risk factors have ectopic pregnancies. So the standard of care  
13 is not screening them. And so yes, I would still be very  
14 concerned and want to make sure she has an intrauterine  
15 pregnancy.

16 Q. So you would consider that a suspected ectopic  
17 pregnancy then, just to make sure I understand your answer?

18 A. Could you give me the clinical situation again?

19 Q. Sure. So if a patient has a pregnancy of unknown  
20 location, has no symptoms of ectopic pregnancy, no risk factors  
21 for ectopic pregnancy indicated in their medical history, would  
22 you consider that a suspected ectopic?

23 A. I would consider -- I would have a certain level of  
24 clinical suspicion, but often times when I document I will say  
25 I have a low level of clinical suspicion or I have a higher

1 level of clinical suspicion, but there is suspicion there  
2 because I have not proven that she has an intrauterine  
3 pregnancy.

4 Q. Got it. Thank you. I'm sorry, I was just trying to  
5 find your declaration again because I accidently closed a tab.  
6 So let's go to paragraph 61 of your declaration.

7 A. Okay. I'm there.

8 Q. So in paragraph 61 of your declaration you state that  
9 people who receive abortion medication without an ultrasound  
10 may result and delay detection and treatment of an ectopic  
11 pregnancy, is that right?

12 A. I state the pregnant woman with an ectopic -- oh, yes.  
13 Yes.

14 Q. Sorry, I should have clarified where I was starting to  
15 quote. So the quote is women who desire an induced abortion  
16 and receive abortion medications Mifepistone and Misoprostol  
17 without an ultrasound may result in delayed detection and  
18 treatment of an ectopic pregnancy.

19 Did I read that correctly?

20 A. Yes.

21 Q. Is it your understanding that PPSAT uses a patient's  
22 recollection of their last menstrual period alone to date a  
23 pregnancy?

24 A. I would have to look at their documentation.

25 Q. Okay. So you're not sure?

1 A. No. I know that they -- based on what I reviewed,  
2 that they use last menstrual period. And I am aware that they  
3 do give Mifepistone and Misoprostol without -- on the same day  
4 sometimes without a documented IUP, if that's your question.

5 Q. So is it your understanding then that PPSAT provides  
6 medication abortion to patients with pregnancies of unknown  
7 location without those patients having an ultrasound?

8 A. I am aware of that and it bothers me. It's -- I don't  
9 think it's standard of care and it's inconsistent with ACOG'S  
10 recommendations in Practice Bulletin 193.

11 Q. Is it your understanding that PPSAT uses hCG levels  
12 alone to diagnose ectopic pregnancy?

13 A. They have an algorithm, but I would have to review the  
14 algorithm when you say hCG along.

15 Q. So I'll just point you to paragraph 62 of your  
16 declaration.

17 A. Okay.

18 Q. So it says they falsely claim that hCG levels alone  
19 can be used to diagnose an ectopic, is that right?

20 A. So I'm talking about what the witnesses say with  
21 protocols using Mifepistone and Misoprostol that are  
22 inconsistent with practice guideline 193. So when I say using  
23 it alone, they're not using an ultrasound with it.

24 Q. Okay. Got it. So in your declaration discussion of  
25 the IUP -- the intrauterine pregnancy requirement, you rely

1 heavily on ACOG'S practice bulletin on tubal ectopic pregnancy,  
2 is that right?

3 A. Yes, I do.

4 Q. And I believe the document you cite in your  
5 declaration is Practice Bulletin 191, isn't that right?

6 A. Yes. They did an update and I did not include that  
7 update, but I have reviewed 193, which is actually -- I think  
8 they updated it two months after and I did 191.

9 Q. From what you remember, how does the update differ  
10 from the protocol you cite -- I'm sorry, from the bulletin you  
11 cite in your declaration?

12 A. I have it. Let me look. I have both of them.

13 Q. I'm just going to ask you generally what you remember,  
14 because we don't have that as a cited document in your  
15 declaration. So if you remember and if you don't, that's fine.

16 A. I think there is -- I don't remember exactly. It was  
17 just on one page they clarified something, but I honestly --  
18 without looking at it I can't tell you exactly what that  
19 paragraph said.

20 Q. But generally speaking do you stand by, you know, the  
21 discussion of intrauterine pregnancy and ectopic pregnancy  
22 that's in your declaration?

23 A. Yes, I do.

24 MR. BOYLE: We have been going for about an  
25 hour. If you're getting close to the end, we don't need to

1 break. But if you're going to go for more than, say, 15  
2 minutes I would request a break, please.

3 MS. SALVADOR: Yeah, we can break now. We're  
4 going to talk about the bulletin, but we can do that after we  
5 come back.

6 VIDEOTAPE TECHNICIAN: We are now going off the  
7 video record. The time is 5:29 p.m.

8 (A break was taken.)

9 VIDEOTAPE TECHNICIAN: We are now back on the  
10 video record. The time is 5:40 p.m.

11 BY MS. SALVADOR:

12 Q. Okay. Dr. Bane, we were discussing ACOG's practice  
13 bulletin on tubal ectopic pregnancy. According to the bulletin  
14 the minimum diagnostic evaluation of a suspected ectopic  
15 pregnancy is a transvaginal ultrasound evaluation to confirm  
16 the pregnancy, is that right?

17 A. Can I just get the document?

18 Q. Sure.

19 MS. SALVADOR: For the folks on Zoom, I am  
20 dropping the document into the chat. Attempting to drop the  
21 document into the chat. I'm dropping the document into the  
22 chat and then can we please have it marked as an exhibit and  
23 then Dr. Bane can just confirm that we're looking at the same  
24 thing.

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(Document marked as Exhibit-BB for identification.)

- - -

THE WITNESS: Yes, we are.

BY MS. SALVADOR:

Q. Okay. On this document is the ACOG bulletin that we have been discussing, correct?

MR. BOYLE: Object to form.

THE WITNESS: Yes.

BY MS. SALVADOR:

Q. It's the ACOG Practice Bulletin 191 on tubal ectopic pregnancy, is that right?

A. Yes.

Q. Okay. So if you go to page E66. Let me know when you're there.

A. I'm there.

Q. So there's a heading that says Clinical Considerations and Recommendations. And then there's a subheading that says how is an ectopic pregnancy diagnosed. And then the first sentence right after that is the minimum diagnostic evaluation of a suspected ectopic pregnancy is a transvaginal ultrasound evaluation and confirmation of pregnancy, is that correct?

A. Yes.

Q. Do you agree that that statement is discussing the evaluation of a suspected ectopic pregnancy?

1           A. So consistent with what I said before, yes, it has the  
2 word suspected and because on page E65 of the same bulletin  
3 under risk factors it says one half of all women who receive a  
4 diagnosis of an ectopic do not have known risk factors. As a  
5 clinician who really wants my patients to be safe, every single  
6 one of them is a suspected IUP until I have confirmed  
7 otherwise. I will honestly tell you that every woman that  
8 walks in my door now and in the past I needed to know where her  
9 pregnancy was because of the risk of death of an ectopic.

10           Q. But the bulletin itself doesn't directly say that a  
11 transvaginal ultrasound evaluation is required when an ectopic  
12 pregnancy is not suspected, correct?

13           A. So it's speaking about how do we take care of our  
14 patients with -- associated with tubal ectopics. And so, you  
15 know, it starts off with the background, risk factors,  
16 epidemiology, and then it gives us our clinical  
17 recommendations. And included in that very clearly is that an  
18 ultrasound is central to that, as well as following hCG levels.  
19 But an ultrasound is central to it.

20           Q. But the clinical -- actually, strike that. So in your  
21 career, in your medical practice, did you perform ultrasounds?

22           A. Yes, I did.

23           Q. How early in pregnancy would you perform ultrasounds?

24           A. So, you know, a lot of it depended on the clinical  
25 scenario. But if she was coming in for just confirmation of

1 gestational age, we can usually do a crown rump length about  
2 five weeks and five days. So five to six weeks would be the  
3 earliest. But, you know, so -- so that's in that clinical  
4 scenario. I may do -- I may do it at a different time, you  
5 know, in a different scenario. But the earliest I can usually  
6 confirm a documented IUP with an embryo is going to be five to  
7 six weeks. We know that if you see a gestational sac that also  
8 has a yolk sac in it, that's also -- and you can see that  
9 before -- like earlier in the five weeks, that's also very  
10 reassuring that you don't have an ectopic pregnancy. You may  
11 not have a viable pregnancy if you only see the yolk sac,  
12 meaning you haven't confirmed fetal heart rate or seen the  
13 embryo, yeah.

14 Q. Did it ever occur in your medical practice where a  
15 patient had a positive pregnancy test but an ultrasound did not  
16 detect a pregnancy?

17 A. Sure. Meaning we did an ultrasound and we didn't see  
18 anything?

19 Q. That's right.

20 A. Yes. So that would be that pregnancy of unknown  
21 location.

22 Q. So what would your next step be in treating such a  
23 patient?

24 A. It would basically be if -- if she were coming in and  
25 she had a positive pregnancy test and she was completely

1 asymptomatic and she, you know, was just there for prenatal  
2 care, we would typically wait until she was six to seven weeks  
3 and do an ultrasound at that point. If she was coming in with  
4 a complaint then we would -- depending on the complaint. But  
5 if it was a complaint that for example, abdominal pain or some  
6 bleeding, you know, depending on how far along she was, we  
7 would do an ultrasound potentially then and then do hCG levels,  
8 so draw blood.

9 Q. And would you refer that patient to the emergency  
10 room?

11 A. No. I would usually manage her. I would refer her to  
12 the emergency room if I thought that she had -- if she was  
13 unstable or she potentially needed to be observed in the  
14 hospital. If she needed to have surgery. But that's not the  
15 clinical scenario I gave you. So that's why I would say no.  
16 But, yeah, if she was unstable and/or she was -- you know, I  
17 was worried that she had a ruptured ectopic at that moment,  
18 most definitely I would.

19 Q. So you shifted over to talking about a patient who was  
20 unstable, but before that you were talking about a patient who  
21 was stable. So for those stable patients, would you recommend  
22 that they return to your clinic for followup?

23 A. Most definitely we would follow their hCG levels and  
24 get what are called serial hCG levels. We would also do a  
25 repeat ultrasound.

1 Q. Did it ever happen that those patients didn't show up  
2 for followup at the schedule you recommended?

3 A. I can't -- I can't picture -- think of a patient off  
4 the top of my head. I was also in a large practice where  
5 sometimes they didn't follow up with the same person, but if I  
6 had somebody that I was following up, I would make sure that,  
7 you know, I was coordinating her care with one of my partners.  
8 There's not a patient that I -- that jumps out because you  
9 don't sleep. I mean, you're taught early in your ob rotations  
10 that a woman that you're concerned with a high level of  
11 suspicion for an ectopic you don't go to sleep on because she  
12 might go to sleep and die. So those are the women that I'm  
13 following very closely. But I can't tell you about a patient  
14 who didn't come back, off the top of my head.

15 Q. So what happens if an ectopic pregnancy ruptures?

16 A. So if an ectopic pregnancy ruptures a woman will --  
17 and I'll say from let's say a tubal pregnancy -- she will  
18 typically have pain. We have two tubes, a left and a right.  
19 So sometimes that pain is one-sided. It can become in her  
20 entire abdomen though because she will start to bleed and she  
21 can actually fill her abdomen with blood and blood is very  
22 irritating to the peritoneal lining. And she can have just  
23 generalized abdominal pain. She can also -- if she's like  
24 filling her abdomen with blood she can actually get blood under  
25 the diaphragm that irritates the diaphragm and can even have

1 referred shoulder pain. Those are the women that have a high  
2 risk of dying because our abdomen has the ability to hold an  
3 awful lot of blood. Some of the women will have some bleeding  
4 but it's usually not heavy, heavy bleeding like a miscarriage  
5 type of bleeding. But they can complain of spotting too.

6 Q. Got it. So you said a lot just there. So I'm going  
7 to ask about some details of what you just said.

8 A. Okay.

9 Q. So you mentioned that the pain typically starts as a  
10 sharp pain on one side of the abdomen, is that right?

11 A. So, I mean, I have seen it present in lots of  
12 different ways. But when a woman comes into me, she's got pain  
13 on one side or the other, you know, my differential diagnosis  
14 -- and I know she's pregnant, you know, it can be appendicitis,  
15 it can be a ruptured ovarian cyst. If I haven't confirmed an  
16 intrauterine pregnancy it can be an ectopic pregnancy. And it  
17 usually, I would say, is one-sided, but I have seen it present  
18 with just lower abdominal pain. I'm absolutely amazed -- and  
19 maybe this is judgemental on my part because I feel like I know  
20 my body really well -- how poorly some women and men, my  
21 husband being one, to try to describe like is this muscle pain,  
22 is this a different type of pain. And so, you know, I am going  
23 to assume it's an ectopic if I have a pregnancy of unknown  
24 location until otherwise proven.

25 Q. I got it. Thank you. And would those -- would

1 patients suffering -- I'm sorry, let me rephrase that. So  
2 would that pain typically be a sharp pain or more of like a  
3 cramping type of pain?

4 A. So I have heard women describe it as both. But I do  
5 think one-sided sharp pain is a presentation I would get for  
6 sure. But I have also heard women talk about cramping pain.  
7 When I hear them say sharp pain, you know, it perks my ears up  
8 to an ectopic. But my concern is that it presents not just in  
9 one way, from my clinical experience. And so I can't  
10 differentiate out blood in the abdomen, it fills the abdomen  
11 can feel different for different people.

12 Q. Got it. And would somebody suffering ectopic rupture  
13 ever feel a popping sensation or anything like that?

14 A. You know, I have actually not had a woman use that  
15 terminology with me. I have heard people with appendicitis  
16 after it ruptures actually for a little bit have a sense of  
17 relief, but I -- I honestly have never had anyone describe it  
18 as popping.

19 Q. And you mentioned that there is bleeding and I -- I  
20 don't want to put words in your mouth. I think you  
21 characterized it as mostly internal bleeding at first, is that  
22 right?

23 A. No, not necessarily at first. A woman can come into  
24 me and have spotting, bleeding and not have a ruptured ectopic  
25 at that point. She may have a small amount of bleeding and we

1 can actually look on ultrasound. That's one of the things you  
2 can look for. It talks about this in Practice Bulletin 191,  
3 ultrasound finding of fluid in the cul-de-sac. So the  
4 cul-de-sac is kind of in the lower part of the pelvis behind  
5 the uterus and -- so when I see blood in the cul-de-sac, which  
6 is in the abdomen, so not coming out the vagina but inside the  
7 woman's peritoneal cavity, that I have to pay attention to when  
8 I see it. Sometimes you can have a ruptured ovarian cyst that  
9 can cause that and sometimes a little bit can be normal to see.  
10 But if I have a woman who is -- I'm concerned about with  
11 asymptomatic and I see that on the ultrasound, I don't see an  
12 intrauterine pregnancy, even if I don't see a mass in the  
13 adnexa, the adnexa would be the left and right side of the  
14 lower pelvis, but I see fluid in the cul-de-sac, that would  
15 concern me for some blood there. But in terms of vaginal  
16 bleeding, women can have spotting, but they can have a little  
17 bit of heavier bleeding. But it is true that I'd characterize  
18 the bleeding of a miscarriage, the soaking pads I don't see as  
19 much in ectopic as I see in miscarriages.

20 Q. Got it. Thank you. Would it surprise you to learn  
21 that PPSAT does not provide medication abortion if a patient  
22 has not had an ultrasound?

23 A. Say that one more time.

24 Q. Sure. Would it surprise you to learn that PPSAT  
25 doesn't provide medication abortion if a patient hasn't had an



1 ultrasound?

2 A. You're doing a double negative there and we're on the  
3 fourth hour.

4 Q. Sure.

5 A. Ask me that one more time at the end. Doesn't and  
6 doesn't it you said.

7 Q. Sure. I'll ask it the other way. Would it surprise  
8 you to learn that all of PPSAT's medication abortion patients  
9 have had ultrasounds before receiving the medication abortion?

10 A. Would it surprise me? I would have expected them to  
11 all have had them to confirm an IUD -- IUP because it's  
12 contraindicated to use Mifepistone and Misoprostol without  
13 excluding an IUP. That's straight from the prescribing  
14 information from the FDA, that you have -- you have to exclude  
15 it. So I was very surprised when I received their protocols  
16 and they actually do that. And I read in Dr. Farris I think is  
17 where I read it first. I was very surprised that they do that.

18 Q. So we're going to change gears a little bit here and  
19 we're going to go to your current work.

20 A. Oh, okay.

21 Q. So you're a member of the National Medical Advisory  
22 Board of Care Net, is that right?

23 A. I am. And I'm at the Care Net conference right now.

24 Q. So what is Care Net?

25 A. Care Net is a Christian organization that helps

1 support men and women who face an unplanned pregnancy with  
2 resources to help them know that they can choose life. So  
3 life-affirming choices.

4 Q. So what is Care Net's position on abortion?

5 A. Induced abortion is never indicated.

6 Q. What are your duties as a member of Care Net's  
7 national medical and advisory board entail?

8 A. The national medical director of the board is Dr.  
9 Sandy Christiansen and she will ask our opinions regarding  
10 maybe language that is clear -- this is an organization that  
11 helps the thousands of Pregnancy Centers across the country  
12 provide exceptional care to our clients and patients. Many of  
13 those organizations -- all the organizations started as really  
14 client advocacy -- helping with those socioeconomic barriers  
15 for women. But in I think it was the '90s they began also  
16 having medical clinics. And so those of us on the medical  
17 board help to guide centers who have medical clinics.

18 Q. So you mentioned that you're at the Care Net national  
19 conference right now, right?

20 A. I am, in Mobile, Alabama.

21 Q. I think you mentioned that you lead a couple of  
22 breakout sessions, is that right?

23 A. Yes. Yesterday I did one on diversity, equity and  
24 inclusion in Pregnancy Centers and today I did it on stress,  
25 burnout, compassion, satisfaction, compassion fatigue.

1 Q. And according to your C.V. you gave a keynote  
2 presentation at the Care Net national conference last year, is  
3 that right?

4 A. Well, I got COVID and didn't get to come. So -- but  
5 they prerecorded it and -- what did I -- what was it on? I  
6 can't remember the exact title. But yes, they did show my  
7 prerecorded talk.

8 Q. So your C.V. says the title was the Science of  
9 Decisionmaking, Implications for Pregnancy Centers, is that  
10 right?

11 A. Yeah. That rings a bell now. Thank you.

12 Q. Do you remember whether that presentation discussed  
13 abortion?

14 A. Okay. Let me think through. So a big part of it was  
15 really looking at -- yeah. I mean, it did. But I would have  
16 to go back to that to look at the details of it. But yes,  
17 there was -- it was -- the big picture of healthcare in general  
18 and our role as -- like really healthcare practitioners, our  
19 role of -- we're really journeying with these women. We are  
20 partnering with them. They bring their own life experiences.  
21 They bring their expertise and their own bodies and we bring  
22 medical expertise to the table. And it's not our job to make  
23 their decision. It's not our job to -- they're not broken.  
24 It's not our job to try to fix them. It's not our job to judge  
25 them should they choose abortion. It's really our job to

1 empower them with information and to really partner with them.  
2 And so I brought up a lot of concepts. I trained I think it  
3 was '21/'22 at Duke Divinity School. I completed a  
4 certification in theology medicine and culture looking at the  
5 intersection of religion and medicine and a lot of what I  
6 shared were some of the concepts I learned there.

7 Q. Got it. Thank you. And you're currently the medical  
8 director of three different organizations, is that right?

9 A. Three different Pregnancy Centers.

10 Q. Okay. Could you name those three Pregnancy Centers,  
11 please.

12 A. Sure. So Choices Women's Center is in Wilson, North  
13 Carolina. And Albemarle Pregnancy Resource Center and Clinic  
14 in Elizabeth City, North Carolina. And then Waterlife  
15 Pregnancy Center which is in the Outer Banks in North Carolina.

16 Q. Got it. Thanks. And all three of those Pregnancy  
17 Centers are affiliated with Care Net, is that right?

18 A. They are.

19 Q. So that means that they all have to sign a Care Net  
20 affiliation agreement, is that right?

21 A. They do.

22 MS. SALVADOR: So I am dropping a document into  
23 the chat and then if we could please mark it as an exhibit.

24 - - -

25 (Document marked as Exhibit-CC for

1 identification.)

2 - - -

3 BY MS. SALVADOR:

4 Q. Dr. Bane, let me know when you have this pulled up.

5 A. Okay.

6 Q. Are you familiar with this document?

7 A. I am familiar. I'm not sure if it's the exact one  
8 that all three of the centers sign. I'd have to look at it. I  
9 don't know how old this one is.

10 Q. Sure. But this document is a Care Net affiliation  
11 agreement, is that right?

12 A. That's its title, yes.

13 Q. And all three of the Pregnancy Centers you work at  
14 would have signed some version of this agreement, is that  
15 right?

16 A. Yes.

17 Q. And are they required to remain in compliance with the  
18 agreement they signed in order to remain affiliated with Care  
19 Net?

20 A. That would be my assumption. I have never known --  
21 been involved in a practice that, like, Care Net kicked out.

22 Q. Got it. So number one on the document states the  
23 Pregnancy Center concurs with each and every affirmation set  
24 forth in the statement of faith attached hereto and  
25 incorporated herein by reference. The Pregnancy Center will

1 not engage the services of any board member, director, or  
2 volunteer who does not concur with each and every such  
3 affirmation.

4 Did I read that correctly?

5 A. You did.

6 Q. And so did all three of the Pregnancy Centers where  
7 you work concur with the statement of faith?

8 A. I know the one in Wilson did. I honestly don't know  
9 about the other two in terms of -- I would assume they did  
10 since they're affiliated with Care Net. But I cannot -- I have  
11 not laid my eyes on this document.

12 Q. I understand. But all three -- you said all three are  
13 Care Net affiliates, right?

14 A. Yes.

15 Q. And you have no reason to believe that they did not  
16 sign something like this?

17 A. Correct.

18 MS. SALVADOR: So I am dropping another  
19 document into the chat. The file name is Care Net Statement of  
20 Faith. Please mark it as an exhibit and then, Dr. Bane, let me  
21 know when you have it open.

22 - - -

23 (Document marked as Exhibit-DD for  
24 identification.)

25 - - -

1 THE WITNESS: Thank you.

2 BY MS. SALVADOR:

3 Q. Okay. Do you recognize this document?

4 A. Let me read it.

5 Q. Sure.

6 (Pause.)

7 A. I do recognize it.

8 Q. So what is this document?

9 A. Care Net Statement of Faith.

10 Q. So all three of the Pregnancy Centers where you work  
11 have certified that they concur with the Statement of Faith, is  
12 that right?

13 A. I can only speak specifically for Wilson because I  
14 have not had a conversation about Care Net -- the executive  
15 director's decision to be a Care Net-affiliated center. I have  
16 spoken directly with my center before I signed this. I am  
17 Catholic and number one, we believe the bible to be the  
18 inspired and only infallible authoritative word of God in the  
19 Catholic Church. The Catholic Church also believes in oral  
20 tradition of their early church fathers. And so I think this  
21 is a very strong document from an Evangelical Christian  
22 perspective. And so I shared that I thought it could be less  
23 than inclusive for Catholic Christians.

24 Q. Okay. Got it. So is that why you disagreed with --  
25 I'm sorry. Did you say that you disagreed with the Wilson

1 Center's decision to become a Care Net affiliate?

2 A. No. No. No. No. I just said that I have some  
3 concerns with how this is written as a Catholic Christian. I  
4 think Care Net is a wonderful organization. It has -- does  
5 many wonderful things. I think it comes from a more narrow  
6 perspective. I even -- you know, before I agreed to be on the  
7 board I thought long and hard about it. I prayed about it. I  
8 talked to Dr. Christiansen who she actually had me speak to a  
9 priest who -- a Catholic priest regarding it. And so at first  
10 glance I did have some reservations, but then I felt  
11 comfortable afterwards.

12 Q. Got it. Thank you.

13 A. You're welcome.

14 Q. And so let's go back to the Care Net affiliation  
15 agreement.

16 A. Okay.

17 Q. Do you still have that document up?

18 A. I'm pretty sure it's this one right here. Statement  
19 of Faith. Yes.

20 Q. Okay. And so number two says the Pregnancy Center  
21 agrees to fully comply with each and every standard set forth  
22 in the Standards of Affiliation for Pregnancy Centers, attached  
23 hereto and incorporated herein by reference.

24 Did I read that correctly?

25 A. You did.



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Q. Okay.

MS. SALVADOR: So I am dropping a document into the chat. Please mark it as an exhibit and then, Dr. Bane, let me know when you have it open.

- - -

(Document marked as Exhibit-EE for identification.)

- - -

THE WITNESS: I have it open.

BY MS. SALVADOR:

Q. Do you recognize this document?

A. Give me just a second.

Q. Sure.

(Pause.)

A. Okay.

Q. So do you recognize this document?

A. I do.

Q. Are these the Standards of Affiliation that are referenced in the affiliation agreement that we were discussing?

A. Yes, they are.

Q. So do the three Pregnancy Centers where you work comply with these Standards of Affiliation?

A. There was nothing I read that was a red flag to me. The one related to contraception, we don't provide

1     contraception at all from the standpoint of like I used to do  
2     in private practice.  When we have a woman come in and she has  
3     -- let's say she wants a pregnancy test and she's not pregnant,  
4     then we have a handout for her that includes her options, as  
5     well as resources in our community for contraception.  But I  
6     don't particularly prescribe contraception at the Pregnancy  
7     Center.

8           Q.  So are -- looking at number six on the document.

9           A.  Okay.

10          Q.  It says the Pregnancy Center does not recommend,  
11     provide or refer single people for contraceptives.  Married  
12     women and men seeking contraceptive information should be urged  
13     to seek counsel along with their spouses from their pastor  
14     and/or physician.  Is that what you're referring to?

15          A.  I was referring to the first sentence is what I was  
16     talking about.  I have had discussions related to Care Net's  
17     single versus married and -- but I also recognize that as --  
18     because we don't even do contraception there, I was comfortable  
19     signing this knowing that -- and I'll tell you, when I first  
20     started working there as a contracted doctor -- I used to  
21     volunteer, now I'm a contracted doctor -- I had to work really  
22     hard to advocate for my patients to even get a handout I  
23     developed related to contraception and being able to, you know,  
24     have the health department information on there and things like  
25     that.  And they had to check with Care Net and make sure it was

1 in compliance. So, you know, as I said before, I love this  
2 organization, but I do push back on some things.

3 Q. Do you know why the Care Net standards of affiliation  
4 make a distinction between single and married had people?

5 A. Yeah. Because of the desire for abstinence in single  
6 people.

7 Q. In your opinion and experience of your medical  
8 practice, can an unmarried woman ever have a healthy sexual  
9 relationship?

10 MR. BOYLE: Objection.

11 THE WITNESS: Boy, that was a loaded question.  
12 I do think there are consequences of being sexually active for  
13 all of us, whether we're married or not. But particularly with  
14 single I do think there's literature that shows that sexual --  
15 sexual risk avoidance, not just reduction is very effective.  
16 And so -- what I do is once again what I said earlier about  
17 that partnership between the woman and I'm not living in her  
18 lived experience, but I don't want to ever do anything that is  
19 potentially going to harm one of my patients. And so if it's a  
20 single woman who is sexually active, I'm not just going to  
21 blindly give her contraception. I'm talking to her about, you  
22 know, her risk factors for sexually transmitted infections,  
23 what is her sexual behavior, is this somebody she's been with  
24 for a long time and they have a monogamous relationship where  
25 there's a lot of trust built in. And I also know that men and

1 women fall hard and they hurt hard when they break up. And so,  
2 you know, I -- kind of like earlier with the multifactorial  
3 nature of studies, I know that there are many different factors  
4 related to the choice to become sexually active.

5 BY MS. SALVADOR:

6 Q. Got it. Thank you for clarifying that. Going to  
7 number one on the Standards of Affiliation document. It states  
8 that the primary mission of the pregnancy center is to share  
9 the compassion, hope, and help of Jesus Christ, both in word and  
10 deed, with those facing pregnancy decisions. The pregnancy  
11 center is equally committed to sharing the gospel of salvation  
12 through Jesus Christ with those that serve.

13 Did I read that correctly?

14 A. Yes, you did.

15 Q. Is that statement true for the three pregnancy centers  
16 where you work?

17 MR. BOYLE: Objection.

18 THE WITNESS: Yeah. So I believe that love is  
19 a verb and we are clearly Christian pregnancy centers. And so  
20 I believe that when you love others you're willing their good  
21 and it's -- it is doing good for people. I believe that you  
22 can meet this statement without ever mentioning the word Jesus.  
23 And you -- you can love people the way Christ loved. I think  
24 that when you look at -- in the literature with medicine when  
25 -- about 60 percent of people at least in the psychiatry

1 literature are in a crisis and this -- in their case it's a  
2 mental health crisis, but you can make some inferences, they  
3 want a healthcare practitioner who wants to talk about  
4 spirituality. So I will talk about that. I will sometimes  
5 pray with people if they want me to, but I -- I know they're  
6 there for a medical appointment when they're seeing me. And  
7 remember, we have two sides of the house. We have this -- the  
8 medical side of the house and so I integrate spirituality in  
9 that. But my goal -- they're in the middle of a challenge and  
10 I want to respect that they -- whatever their faith is, whether  
11 they're Christian or not, if spirituality is going to help them  
12 through that challenge, I want to encourage them in that way.  
13 The client advocacy side where they provide -- connect them  
14 with community partners and services they may need like  
15 subsidized daycare and the parenting classes, those are where I  
16 think this statement really lies and the recognition that these  
17 women are often scared and alone, sometimes being coerced, and  
18 maybe they were -- they grew up in a church and they are  
19 disconnected. And so like how could a church walk alongside  
20 them and help them. So I think, you know, yes, this is an  
21 extremely strong Evangelical statement, but it's not like we  
22 have something that says everybody must leave with a gospel  
23 pamphlet.

24 Q. Right. So the statement -- the Standards of  
25 Affiliation, I'm sorry, referred to sharing the gospel of

1 salvation through Jesus Christ. So what does that mean on the  
2 medical side as you described it as two sides?

3 A. Yeah. I mean, on the medical side it's really being  
4 the hands, the feet, the eyes of Jesus. Which is loving people  
5 in a way that -- like when they leave I want them to know  
6 whatever their choice is, my door is always open. And we will  
7 never judge them. And so it's in our actions. It's how we  
8 care for them, how we respect them, how we love them as we're,  
9 you know, providing information for them. And, you know, if as  
10 part of the conversation, which it doesn't happen every time,  
11 you know, some of them will say like without me even prompting  
12 them -- I mean, I have had women say everything from I'm going  
13 to hell for murdering my child, I have had them say I know God  
14 is going to be so mad at me, things like that, and I try to  
15 really meet them where they are and help them realize no,  
16 you're not murdering your child and you're trying to make the  
17 best decision at this moment that you think for yourself and I  
18 hope it can be a life-affirming decision for you. But don't  
19 own that.

20 Q. Are the pregnancy centers where you work subject to  
21 any form of regulation by a health agency?

22 A. So we -- we have -- in the State of North Carolina we  
23 have -- we actually don't have to follow HIPAA guidelines like  
24 the way my other practice did. I think that should change, to  
25 be honest. We're a medical clinic and we should follow HIPAA

1 guidelines and I am very strict about that. Everybody is HIPAA  
2 trained. We have medical policies and procedures that I'm in  
3 the middle of -- because I'm just starting to work with the  
4 other centers and I'm updating ours. I think our standards  
5 should be exceptional.

6 Q. So the pregnancy centers where you work are not  
7 inspected by any sort of state agency?

8 A. Not that I am aware of. I think they should be. But  
9 I don't think in North Carolina that we have that.

10 Q. What medical training are Pregnancy Center staff  
11 required to have -- the ones who have medical duties that is?

12 A. Yeah. I mean, they have to have some sort of medical  
13 license. So I have everything from nurses to medical  
14 assistants to ultrasonographers, RDMSs in the three different  
15 centers. So they have to stay licensed according to what their  
16 particular license is, their scope of practice. We do HIPAA  
17 training regularly. We do OSHA training. We do CPR training.  
18 That's all that can come to my mind right now.

19 Q. Thanks. That's really helpful. So going to number  
20 four on the Standards of Affiliation document.

21 A. Yeah.

22 Q. It says the pregnancy center does not perform or refer  
23 for abortion and provides a written disclaimer to this effect  
24 to clients requesting services.

25 Did I read that correctly?

1 A. You did.

2 Q. Is that statement true for the Pregnancy Centers where  
3 you work?

4 A. We don't have a written disclaimer. I have never had  
5 a patient request something like that, so I'm not sure, to be  
6 honest, what that's all about. But we do not perform or refer  
7 for induced abortions.

8 Q. Are the Pregnancy Centers where you work open with  
9 clients about their position on abortion?

10 A. So we are not -- when you say open, could you define?  
11 What do you mean by that? We're open to our clients about our  
12 position. Do we tell them? Make statements?

13 Q. Yeah. Do you tell them about your position on  
14 abortion?

15 A. Yes. So they know that we do not perform abortions.  
16 It's on our Website and the people who answer the phone who are  
17 trained to let them know that. They also know that when I  
18 counsel them and give them an informed consent I say to them my  
19 hope is you can choose a life-affirming choice for your child  
20 and yourself, but I recognize that's your decision and not  
21 mine.

22 Q. Thank you. And how do you split your time between the  
23 three pregnancy centers where you work?

24 A. Yeah. So I am in Wilson, North Carolina, about an  
25 hour east of Raleigh. And I am there actually Tuesdays,



1 Wednesdays, and Thursdays for about half a day each on average.  
2 And then in the Outer Banks in Nags Head I physically go there  
3 once a month, but I talk to them most days when they have a  
4 patient who's getting an ultrasound. And I'm available if they  
5 -- the ultrasonographer needs to talk to me. I just last week  
6 had -- we had a patient who was coming in and she had a 12-week  
7 intrauterine pregnancy, but the baby looked like it had some  
8 very significant skeletal abnormalities. And so as the patient  
9 was in one room the ultrasonographer reached out to me and  
10 electronically we looked at the pictures together and then I  
11 gave the staff recommendation on followup so that she could get  
12 an ultrasound and see an ob-gyn at the practice. So I'm  
13 available. None of the centers are open on weekends. They're  
14 Monday through Friday if they need consults. And then I also  
15 -- I try to read all scans within 24 hours.

16 Q. Got it. So for that patient you just mentioned, I  
17 just want to make sure I understand what you said. So you  
18 ended up referring that patient to an ob-gyn, is that correct?

19 A. I did.

20 Q. Okay. So you refer them out of the pregnancy center,  
21 is that right?

22 A. Yes. We don't do prenatal care or deliveries in terms  
23 of the -- the biggest thing that we try to do is if a woman  
24 decides to carry her pregnancy often times because of shortages  
25 in healthcare practitioners, especially in rural eastern North

1 Carolina, we may have some gaps so sometimes we really try to  
2 facilitate if she needs to see a maternal-fetal medicine  
3 specialist. So we do referrals. We just don't do referrals  
4 for induced abortion. As I said earlier in my testimony I have  
5 a maternal and a fetal patient and I want health and wholeness  
6 for both of them. So referral for ending the life of one of  
7 them is not a part of medicine.

8 Q. So understanding that you don't refer patients to  
9 pregnancy centers for induced abortions, do you ever talk to  
10 them about induced abortions?

11 A. Yes, I do.

12 Q. What types of things do you say in those  
13 conversations?

14 A. So I usually -- I ask their permission and if they  
15 want to talk, what information they would like and I say would  
16 you like to know about the different types of abortion. And so  
17 I may explain the difference in a medication/chemical abortion  
18 and a surgical abortion. And then I will talk to them about  
19 risks related from a medical perspective, things that we have  
20 talked about today.

21 Q. Have you ever received a complaint from a patient at  
22 the pregnancy centers where you work?

23 A. No.

24 Q. Has any of the centers where you work ever received a  
25 complaint related to how they handle abortion counseling?

1           A. Not that I -- since I have been the medical director  
2 of the three. There could have been something before that I'm  
3 unaware of.

4           Q. Got it. I think we're basically done here. So why  
5 don't we just take a brief break and then we'll come back.  
6 I'll ask a few more questions if I have them, which I might  
7 not, and then your counsel will have the opportunity to ask  
8 questions. So why don't we just take a -- how about a  
9 five-minute break. Does that work?

10                   THE WITNESS: Yes. Thank you.

11                   MS. SALVADOR: Sorry. Let's go off the record.

12                   VIDEOTAPE TECHNICIAN: We are now going off the  
13 video record. The time is 6:29 p.m.

14                           (A break was taken.)

15                   VIDEOTAPE TECHNICIAN: We are now back on the  
16 video record. The time is 6:36 p.m.

17 BY MS. SALVADOR:

18           Q. Dr. Bane, are you the only ob-gyn who is employed by  
19 those three pregnancy centers where you work?

20           A. I am.

21           Q. Okay. And that's -- so that's all I have on the  
22 Pregnancy Centers. And then just going back, you mentioned  
23 that you completed a witness training through ACOG, is that  
24 right?

25           A. Yes, that one-day course.

1 Q. Did you review any materials from that training to  
2 prepare for this deposition?

3 A. No.

4 Q. Okay.

5 MS. SALVADOR: I don't have any further  
6 questions.

7 MR. BOYLE: Okay. Thank you. If it's all  
8 right, I'll go ahead.

9 BY MR. BOYLE:

10 Q. This is Ellis Boyle. I represent the legislative  
11 leaders, Speaker Moore and Senator Berger. Doctor, thank you  
12 for your time today. I have a few questions. You said in your  
13 testimony in that last hour that Mifeprex and Misoprostol are  
14 contraindicated until you exclude an intrauterine pregnancy.  
15 And I think you may have mixed up your wording a little bit and  
16 I want to give you an opportunity to clarify that if you want  
17 to. Did you mean that Mifeprex and Misoprostol are  
18 contraindicated until you would exclude an ectopic pregnancy  
19 instead of the IUP?

20 A. Okay. So it's Misoprostol, so I think that's what  
21 you're talking about, Mifeprex and Misoprostol. So yeah, the  
22 FDA, their prescribing information, if I said it wrong, what I  
23 meant to say is that they state that you have to exclude an  
24 ectopic pregnancy before giving the medication.

25 Q. Okay. Do you agree that it is safer to suspect every

1 patient who tests positive for pregnancy has an ectopic  
2 pregnancy until you can rule that out?

3 A. Yes.

4 Q. If you have a patient who tests positive for pregnancy  
5 and has an ultrasound that does not show either an ectopic  
6 pregnancy or an intrauterine pregnancy, so it's a pregnancy of  
7 an unknown location on that ultrasound finding, what would you  
8 say the safest way is to treat that patient?

9 A. I have had many patients over the years that are in  
10 that situation and I -- we do a combination of serial hCG  
11 levels, so lab work, and then a repeat ultrasound.

12 Q. Why would you do the repeat ultrasound?

13 A. To document an IUP hopefully, but also to rule out  
14 ectopic pregnancy.

15 Q. If you take an ultrasound of a patient who tested  
16 positive for pregnancy and it neither shows the IUP nor an  
17 ectopic pregnancy, so again, it's an ultrasound that shows a  
18 pregnancy of unknown location, does that lower or increase your  
19 suspicion that that patient has an ectopic pregnancy?

20 A. So it increases my suspicion because I would want, as  
21 I have said earlier, to have diagnostic certainty in something  
22 that is potentially fatal, which ectopic pregnancies can be.

23 Q. Doctor, if I can direct you to a couple of the  
24 exhibits that you were asked questions about. First, I believe  
25 it's Exhibit-Q. And, Madam Court Reporter, if you could tell

1 me if I'm correct, this would be the CDC's maternal mortality  
2 rates in the United States for 2021. I believe that's  
3 Exhibit-Q.

4 A. I'm going to have to find that. Just a second.

5 Q. Well, that's what I'm talking about, Exhibit-Q,  
6 correct?

7 COURT REPORTER: I don't know.

8 MR. BOYLE: Okay. Well, that's what I'm  
9 talking about and I think it's Q. We'll correct it after the  
10 fact, if necessary.

11 THE WITNESS: Is it the 2021 mortality rates?

12 MR. BOYLE: Yes. That's correct.

13 THE WITNESS: Okay.

14 BY MR. BOYLE:

15 Q. So as I understand it, when you were asked questions  
16 about these maternal mortality rates from the CDC in 2021, am I  
17 correct in saying that these are maternal mortality rates not  
18 specifically related to abortion but just for all maternal  
19 mortality in the United States?

20 A. Correct.

21 Q. Okay. And then if I can direct you to what I believe  
22 again is Exhibit-R, which would be the North Carolina 2016  
23 maternal mortality review report. If you let me know when you  
24 get there, please.

25 A. Okay.

1 Q. Do you have that one up?

2 A. No. I'm sorry.

3 Q. Okay. Let me know.

4 A. Okay. Yes, I have it up.

5 Q. And I believe you were asked questions on page 11 of  
6 that document. Do you see page 11?

7 A. I'm getting there. Yes.

8 Q. Again, I believe you were asked questions about this  
9 page and these numbers at that chart on the bottom. And I just  
10 want to clarify again, are these numbers in that chart that  
11 represent maternal mortality in the State of North Carolina for  
12 these various years, are they specific to abortion or are they  
13 just general maternal mortality?

14 A. Let me look at the chart here. Overall. Pregnancy  
15 mortality ratio. So they are for all deaths, not just deaths  
16 related to abortion.

17 Q. Right. So all maternal death, not the specific  
18 question that you were asked later about the CDC numbers, which  
19 were the abortion-related maternal mortality, right?

20 A. Correct.

21 Q. Let me direct you to what I believe is Exhibit-S,  
22 which is the CDC mortality -- morbidity and mortality weekly  
23 report from November 2022. This is the abortion surveillance  
24 for the United States in 2020. Please let me know when you  
25 have got that up and go to page 27.

1 A. Actually it was still on page 27.

2 Q. There you go. So you were asked questions about this  
3 exhibit and it was represented that this table on page 27 for  
4 the 2013 to 2019 abortion-related maternal mortality was .43 or  
5 43 deaths per 100,000 I believe, is that correct?

6 A. Yes.

7 Q. And this question wasn't asked, but I want you to  
8 please look at the asterisk and look at the little small print  
9 there at the bottom of this chart and tell me if I'm reading  
10 this particular part of that correctly, quote, because a  
11 substantial number of legal induced abortions occurred outside  
12 reporting areas that provided data to CDC, national CFRs, i.e.  
13 number of legal induced abortion-related deaths per 100,000  
14 reported legal induced abortions in the United States, were  
15 calculated with denominator data from the Guttmacher  
16 Institute's national survey of abortion-providing facilities,  
17 end quote. Did I read that sentence properly?

18 A. Yes.

19 Q. And what does that sentence tell or inform your  
20 opinions in this case, please?

21 A. They're consistent with my opinions in my declaration  
22 that we don't have accurate information on the number of  
23 legal-induced abortions. So our -- it's difficult for us to  
24 really know the true and accurate number of complications and  
25 deaths.



1 Q. Okay. And does the fact that they don't have accurate  
2 data of actual abortion deaths from places that just didn't  
3 give it to the CDC and then they use the Guttmacher Institute's  
4 number as the denominator, does that impact what you think  
5 those numbers might reflect in this chart?

6 A. Well, I mean, I think I said earlier that your  
7 conclusions that you draw are only as accurate as the  
8 information you're drawing them from. And so I think a  
9 consistent message that I have had is that we don't do a good  
10 job because we have this voluntary reporting. And, you know,  
11 the fact that the CDC is having to rely on someone else's data  
12 is concerning. It's not surprising because if you look at the  
13 number of abortions reported between Guttmacher and the CDC,  
14 they differ vastly. So we have got to do a better job if we're  
15 going to truly understand and keep women safe.

16 Q. And you say the Guttmacher number is different. Isn't  
17 it much larger than the CDC number?

18 A. Yes, it is much larger.

19 Q. So if you have underreporting of the actual deaths on  
20 the voluntary information provided on that side and then you  
21 have an overinflation on the denominator from the Guttmacher,  
22 what does that tell you about your opinion about that actual  
23 number in this chart?

24 A. You're going to have to repeat that. Sorry.

25 Q. Yes. So you have underreporting of that number of

1 actual deaths on the top of the division, right, the numerator?  
2 Because the CDC is not getting all those deaths, is that  
3 correct?

4 A. Correct.

5 Q. And then on the bottom part, the denominator, you have  
6 got a higher number because Guttmacher has a bigger number than  
7 the CDC's reported number?

8 A. Right.

9 Q. So if you're dividing fewer on top than more on the  
10 bottom doesn't it under inflate the likely actual number --  
11 misrepresent to the low end of the spectrum how many maternal  
12 deaths are actually attributable to an abortion in that year?

13 A. Yes. Your number -- your fraction would be different.  
14 It would be lower.

15 Q. I would like to direct you to what I believe is  
16 Exhibit-10, the Koch report from I believe the study of  
17 abortion legislation, maternal healthcare, fertility, et  
18 cetera, et cetera, in the 32 Mexican states. Can you let me  
19 know when you're at that document, please?

20 A. I'm there.

21 Q. Okay. If you turn to page 10. I believe you were  
22 asked a question about one particular sentence on page 10. Do  
23 you recall that?

24 A. Let me get to 10. I don't remember what sentence I  
25 was asked a question about.

1 Q. Okay. I believe you were asked a question about the,  
2 quote, consequently making a direct or independent causal link  
3 between a less permissive abortion law and a lower incidence of  
4 maternal deaths, or conversely by considering a more permissive  
5 abortion law would be a premature or even erroneous conclusion,  
6 end quote. Do you remember that question?

7 A. I do.

8 Q. Let me read you the next sentence and ask you your  
9 opinion of that and whether it impacts your declaration.  
10 Quote, rather, from an epidemiological perspective the Mexican  
11 natural experiment provides evidence to support three  
12 complimentary assumptions at the population level. First,  
13 abortion legislation per se did not appear to have an  
14 independent effect on overall maternal mortality rates.  
15 Second, a less permissive abortion law in terms of not  
16 considering exemptions from criminal prosecution of abortion in  
17 cases of genetic or congenital fetal anomalies was not  
18 associated with increased maternal and abortion-related deaths.  
19 And third, differences in maternal mortality incidents in the  
20 context of different abortion legislation, more or less  
21 permissive, appear to be mainly explained by the distribution  
22 of other major independent factors most likely facilitating an  
23 epidemiological transition for its low maternal mortality rates  
24 independently from abortion legislation itself, end quote.

25 Did I read that correctly?

1 A. You did.

2 Q. Does adding that other sentence there for context help  
3 explain why you included this report? I'm sorry, yes, this  
4 report in your declaration.

5 A. Yeah. I mean, it's consistent with the message that I  
6 have shared earlier about the difference between correlation  
7 and causal and the fact that we know that there are multiple  
8 factors that cause women to die and that this is -- they're  
9 acknowledging the fact that they're -- it is not one factor  
10 alone, but actually proposing that we have to look at many of  
11 the different factors. But just because you're looking at  
12 things like education and warning signs and transportation and  
13 clean sanitation and things like that, it doesn't exclude that  
14 your other observation on the trends -- you don't discount  
15 those. You just recognize the multifactorial nature of this  
16 issue.

17 Q. And finally, I'd like to ask you about the Fergusson  
18 study, which I believe was Exhibit-X. Again, I could be off.  
19 That's what my internal numbering was. So if we can fix that  
20 later. But you let me know, please, when you've got the  
21 Fergusson study up.

22 A. Okay.

23 Q. And go to page 450 once you get there, please.

24 A. All right. I can't easily find it, so I'm just going  
25 to pull up my hard copy.

1 Q. That's fine.

2 A. What page again?

3 Q. 450 with the implications section.

4 A. Okay. I'm there.

5 Q. Okay. Again, you weren't asked about this, so I want  
6 to give you the opportunity to explain more fulsomely why you  
7 included this study in your declaration. There's a sentence  
8 under implication that's, quote, specifically, the results do  
9 not support strong pro-life positions that claim that abortion  
10 has large and devastating effects on the mental health of  
11 women. Neither do the results support strong pro-choice  
12 positions that imply that abortion is without any mental health  
13 effects, end quote.

14 Do you see that?

15 A. Yes.

16 Q. And I think you were talking about that, but does that  
17 particular sentence there, and anything else that you would  
18 like to point to in this study to explain why you included  
19 this, please?

20 A. So I know a little bit of the back story of this study  
21 from Dr. Fergusson's -- some interviews he did because he  
22 struggled so much with getting it published and he was really  
23 disheartened that the scientific community would not publish  
24 something because they didn't like the results. And he was  
25 afraid that pro-life -- the pro-life side would use it to say

1 it's causal and the pro-choice side would use it to say that  
2 abortion doesn't cause mental health effects. So the next  
3 sentence is actually, I think, one of the most powerful. In  
4 general, the results lead to a middle-of-the-road position that  
5 for some women, abortion is likely to be a stressful and  
6 traumatic life event which places those exposed to it at  
7 modestly increased risk of a range of common mental health  
8 problems.

9 So what he's saying is that he saw an association and  
10 the scientific community has to take that association and  
11 explore it more. You know, when Tobacco was first blamed for  
12 -- and cigarettes for lung cancer, there was a whole pushback  
13 from people who wanted tobacco out there. And it took a long  
14 time for people to take that relationship seriously and he  
15 doesn't want that to happen. And he says -- I think in his  
16 study I think he says one in 10 women in New Zealand have  
17 abortions. It's one in four in our country. And why wouldn't  
18 we want to dig our feet in deeper and find out are we really  
19 helping or harming women. And that's why I think this is a  
20 critical paper.

21 Q. Okay.

22 MR. BOYLE: Doctor, I don't think I have any  
23 other questions. Thank you very much for your time. There may  
24 be some redirect or another lawyer may have a question. But  
25 thank you.

1 THE WITNESS: You're welcome.

2 VIDEOTAPE TECHNICIAN: Anyone else? All right.  
3 Before we do go off the video record I did need to see if  
4 anyone needed transcript copies, rough drafts, or video copies.

5 MR. BOYLE: Can I say for my side, can I just  
6 put in the chat what we want? Would that work for you?

7 VIDEOTAPE TECHNICIAN: It won't be on the  
8 record.

9 MR. BOYLE: Oh, you need it on the record?  
10 Yeah, we want a -- please, if we can for the legislative  
11 defendants, can we have an expedited by next Tuesday, if  
12 possible, and a video whenever. I imagine that's easier to do,  
13 but it does need to be synced.

14 VIDEOTAPE TECHNICIAN: But you don't need an  
15 expedite for the video?

16 MR. BOYLE: I mean, I would hope that it would  
17 come around -- if I'm paying for an expedited transcript, I'm  
18 hoping the video is coming too.

19 VIDEOTAPE TECHNICIAN: Okay. We'll make sure  
20 -- we'll take care of it for you.

21 MR. BOYLE: Okay. Thank you.

22 VIDEOTAPE TECHNICIAN: Certainly.

23 MS. SALVADOR: We would also like an expedited  
24 transcript, please. And if you have the rough ready sooner we  
25 will take that too.

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VIDEOTAPE TECHNICIAN: All right. Anything else?

MS. NARASIMHAN: We would appreciate a rough, but don't need an expedited transcript. Thank you.

MR. BOYLE: Do you have contact information for where to send that, Ms. Rapaport?

VIDEOTAPE TECHNICIAN: For you, Mr. Boyle? If you could give me that in chat, that would be great.

MR. BOYLE: Sure. I'll do it right now.

VIDEOTAPE TECHNICIAN: Thank you so very much. All right. That said, today's deposition is now concluded. We are going off the video record at 6:57 p.m.

- - -

(Witness excused.)

- - -

(Deposition concluded 6:57 p.m.)

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CERTIFICATE OF REPORTER

STATE OF NORTH CAROLINA        )  
COUNTY OF ALAMANCE            )

I, Susan A. Hurrey, RPR, the officer before whom the foregoing remote deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn; 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 September, 2023.

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SUSAN A. HURREY, RPR  
Notary Public #201826800211

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I, SUSAN BANE, M.D., PhD, 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., PhD.

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

My commission expires: \_\_\_\_\_



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# **EXHIBIT 5**

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

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

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**LEGISLATIVE LEADER DEFENDANTS' RESPONSES AND OBJECTIONS  
TO PLAINTIFFS' FIRST SET OF INTERROGATORIES AND  
REQUESTS FOR PRODUCTION**

Pursuant to Federal Rules of Civil Procedure 26, 33, and 34 and pursuant to the Court’s July 6, 2023 Scheduling Order (DE 37), Defendants, Philip E. Berger, in his official capacity as President *Pro Tempore* of the North Carolina Senate, and Timothy K. Moore, in his official capacity as Speaker of the North Carolina House of Representatives, (“Legislative Leader Defendants”), by and through their undersigned counsel, hereby respond to Plaintiffs’ first set of interrogatories and requests for production of documents. Legislative Leader Defendants respond to each interrogatory and request in compliance with the applicable Federal Rules of Civil Procedure, without regard to any purported instructions or definitions included by Plaintiffs that allegedly modify or add to the requirements under the Rules.

**GENERAL OBJECTIONS**

1. Legislative Leader Defendants make the following General Objections to Plaintiffs’ first set of discovery requests as if separately set forth in each response. An assertion of a specific

objection in any response does not waive these General Objections that are intended to apply throughout.

2. Legislative Leader Defendants do not admit, adopt, or acquiesce in any factual or legal contention, assumption, or implication contained in any of these discovery requests by responding to these discovery requests,

3. Legislative Leader Defendants respond to these discovery requests without waiving, and instead intending to preserve and preserving, all objections to competency, relevance, materiality, privilege, or admissibility, or to object on any other grounds that may arise later, related to any documents or information provided or produced in response to these requests in any subsequent proceeding, including any trial.

4. Legislative Leader Defendants object to these discovery requests read alone or in conjunction with the “Definitions” or “Instructions,” to the extent that they seek any document, information, or material protected by Attorney-Client Privilege or Legislative Privilege, or any other applicable privilege or protection doctrine or immunity. Inadvertent disclosure of any such privileged or protected information shall not be considered a waiver of any applicable privilege or protection.

#### **RESPONSES AND OBJECTIONS TO PLAINTIFFS’ FIRST SET OF INTERROGATORIES**

1. Identify every person Intervenor-Defendants will rely on as an expert witness, including by declaration, at the preliminary injunction stage.

**RESPONSE:** At the preliminary injunction stage, Legislative Leader Defendants designated Dr. Bane and Dr. Wubbenhorst, who have both filed declarations as expert witnesses. Legislative Leader Defendants reserve the right to designate additional expert witnesses later in the course of discovery in accordance with the Rules and any applicable Court Orders.

2. For each expert identified in Interrogatory No. 1, state the subject matter on which the expert is expected to testify, the substance of the facts and opinions to which the expert

is expected to testify, a summary of the grounds for each opinion, and a description of any and all prior litigation relating to abortion in which the expert has participated.

**RESPONSE:** Dr. Bane and Dr. Wubbenhorst have both filed declarations that provide the subject matter on which each is expected to testify, the substance of the facts and opinions to which each is expected to testify, and a summary of the grounds for each opinion. Legislative Leader Defendants object to this Interrogatory to the extent that it seeks information beyond what is required in Rule 26. However, pursuant to FRCP 26(A)(2)(B)(v), these designated expert witnesses hereby provide a list of other cases in which, during the prior 4 years, the witness testified as an expert at trial or by deposition.

Dr. Bane: none

Dr. Wubbenhorst:

1. USA v. Texas, Case No. 1:21-cv-000796-RP US District Court for the Western District of Texas October 1, 2021
  2. Planned Parenthood Great Northwest, et al., v. Members of the Medical Licensing Board of Indiana, et al., Case No.: 53C06-2208-PL-001756 State Monroe County Circuit Court Sept. 16, 2022
  3. EMW Women's Surgical Center v. Daniel Cameron, et al. Case No. 22-CI-3225
  4. Hodes & Nauser v. Kobach, Case No. 23 CV 3140 – July 7, 2023
  5. Beatriz y Otros v. El Salvador, Case No. CDH-01-2022 in 2023
  6. Dr. Jane Doe, et al., v. State of Minn., et al., and Mothers Offering Maternal Support, Case No.: 62-CV-19-3868 Sept. 12, 2022
3. Identify the General Assembly's legislative intent, purpose, and/or reasons for the Hospitalization Requirement.

**RESPONSE:** Objection, to this Interrogatory for vagueness and relevance. The best evidence of the General Assembly's "legislative intent" is the law it enacted. *See United States v. Perkins*, 67 F.4th 583, 609 (4th Cir. 2023) ("Congress expresses its intentions through statutory text passed by both Houses and signed by the President (or passed over a Presidential veto). As this Court has

repeatedly stated, the text of a law controls over purported legislative intentions unmoored from any statutory text. The Court may not replace the actual text with speculation as to Congress' intent.") (internal citations omitted); *see also*, *Connecticut Nat. Bank v. Germain*, 503 U.S. 249, 253–54, 112 S. Ct. 1146, 1149, 117 L. Ed. 2d 391 (1992) ("We have stated time and again that courts must presume that a legislature says in a statute what it means and means in a statute what it says there.") In any event, the General Assembly's intent or purpose or reasons are not relevant because rational basis review simply requires that a rational basis exists for the enacted law. Without waiving those objections, Dr. Bane and Dr. Wubbenhorst have both filed declarations relied upon by Legislative Leader Defendants in their brief that provide details as to how the Hospitalization Requirement is rationally related to advancing the health and safety of a patient who has an abortion after the twelfth week of pregnancy.

4. Identify all facts that support any claim by Intervenor-Defendants that the Hospitalization Requirement is rationally related to advancing the health and/or safety of a patient who has an abortion after the twelfth week of pregnancy.

**RESPONSE:** Dr. Bane and Dr. Wubbenhorst have both filed declarations relied upon by Legislative Leader Defendants in their brief that provide details as to how the Hospitalization Requirement is rationally related to advancing the health and safety of a patient who has an abortion after the twelfth week of pregnancy.

5. Identify all facts that support any claim that hospitalization is medically necessary for abortion after the twelfth week of pregnancy but not medically necessary for labor and delivery.

**RESPONSE:** Objection, to this Interrogatory for vagueness and relevance. It is unclear what is meant by "medically necessary," and regardless it is not relevant because that is not an issue before the Court in this case. Without waiving those objections, Dr. Bane and Dr. Wubbenhorst have both filed declarations relied upon by Legislative Leader Defendants in their brief that provide detail as

to how the Hospitalization Requirement is rationally related to advancing the health and safety of a patient who has an abortion after the twelfth week of pregnancy and a law need not address every potential harm to be rational.

6. Identify all facts that support any claim that hospitalization is medically necessary for abortion after the twelfth week of pregnancy but not medically necessary for miscarriage management at the same gestational age.

**RESPONSE:** Objection, to this Interrogatory for vagueness and relevance. It is unclear what is meant by “medically necessary,” and regardless that is not an issue before the Court in this case. Without waiving those objections, Dr. Bane and Dr. Wubbenhorst have both filed declarations relied upon by Legislative Leader Defendants in their brief that provide detail as to how the Hospitalization Requirement is rationally related to advancing the health and safety of a patient who has an abortion after the twelfth week of pregnancy and a law need not address every potential harm to be rational.

7. Identify all persons and/or organizations outside of the General Assembly with which members of the General Assembly had any communications regarding the Hospitalization Requirement.

**RESPONSE:** Objection, to the extent Plaintiffs seek information about conversations, correspondence, or any other communications between and among legislators or their staff related to the passage of a law, Legislative Leader Defendants object to this Interrogatory because it seeks information protected from disclosure by the well-established and long-standing Legislative Privilege. *See e.g., North Carolina State Conference v. McCrory*, 2015 WL 12683665, at \*7 (M.D.N.C. Feb. 4, 2015). Also, Legislative Leader Defendants and their staff have had communications, written and verbal, with in-house counsel and outside counsel regarding the topic of the Hospitalization Requirement, both before the passage of the laws and since. To the extent that Plaintiffs seek information about conversations or correspondence or any other

communications between and among Legislative Leader Defendants and their staff with in-house counsel and outside counsel regarding the topic of the Hospitalization Requirement, then Legislative Leader Defendants object to this Interrogatory because it seeks information protected from disclosure by Attorney-Client Privilege. To the extent that this Interrogatory seeks documents withheld based on the assertion of Legislative Privilege or Attorney Client Privilege, Legislative Leader Defendants object to creating a privilege log. Courts have often recognized that preparing a privilege log is not necessary where the communications are plainly protected from disclosure. *See e.g., id.*

Legislative Leader Defendants also object because they do not have knowledge of all the other various Senators' and Representatives' actions and communications, written or verbal, as it relates to any topic, much less this topic. Legislative Leader Defendants do not purport to speak with particularity for every individual Senator or Representative. Nor can Legislative Leader Defendants purport to waive Legislative Privilege as it applies to other Senators and Representatives.

Legislative Leader Defendants also object because information about conversations or communications between legislators and people who are not legislators or staff covered by the Legislative Privilege or Attorney-Client Privilege are not relevant to the questions at issue before the Court. It does not matter what any Senator or Representative, or even someone working on staff at the General Assembly, may have said or known, individually, at any given time. All that matters is whether the law is vague as enacted, or whether a reasonable basis for it exists. Individual intent or purpose is irrelevant because rational basis review simply requires a rational basis exists for the enacted law.



Without waiving these objections, Legislative Leader Defendants or members of their staff met with a broad array of individuals and organizations with differing viewpoints about the issue of abortion generally before the passage SB20 and HB190. Legislative Leader Defendants identify the following persons or organizations outside of the General Assembly who had any communications with the Speaker, the President *Pro Tem*, or their staff regarding the abortion bills which may have included discussion specifically about the Hospitalization Requirement: Doug Herron and Dr. Beverly Gray, on behalf of Duke University; Dr. Martin McCaffrey; Tami Fitzgerald and Mary Suma, on behalf of the NC Values Coalition; Chip Baggett and Dave Horne, on behalf of the NC Medical Society; Dr. Bill Pincus, on behalf of NC Right to Life; Rob Lamme, on behalf of the NC OBGYN Society; John Rustin, Jere Royall, and Sharon Sullivan, on behalf of NC Family Policy Council; Dr. Grant Campbell; Rev. Mark Creech, on behalf of the Christian Action League; Dr. Stacy Boulton; Jim Quick, on behalf of the NC Faith and Freedom Coalition; Paul Stam; and Sarah Marshall, Wendy Bonano, and Melinda Delahoyde, on behalf of Gateway Women's Care.

8. Identify all documents Intervenor-Defendants or other members of the General Assembly relied upon when drafting the Hospitalization Requirement.

**RESPONSE:** Objection, to the extent Plaintiffs seek information about conversations, correspondence, or any other communications between and among legislators or their staff related to the passage of a law, Legislative Leader Defendants object to this Interrogatory because it seeks information protected from disclosure by the well-established and long-standing Legislative Privilege. *See e.g., North Carolina State Conference v. McCrory*, 2015 WL 12683665, at \*7 (M.D.N.C. Feb. 4, 2015). Also, Legislative Leader Defendants and their staff have had communications, written and verbal, with in-house counsel and outside counsel regarding the topic of the Hospitalization Requirement, both before the passage of the laws and since. To the extent

that Plaintiffs seek information about conversations or correspondence or any other communications between and among Legislative Leader Defendants and their staff with in-house counsel and outside counsel regarding the topic of the Hospitalization Requirement, then Legislative Leader Defendants object to this Interrogatory because it seeks information protected from disclosure by Attorney-Client Privilege. To the extent that this Interrogatory seeks documents withheld based on the assertion of Legislative Privilege or Attorney Client Privilege, Legislative Leader Defendants object to creating a privilege log. Courts have often recognized that preparing a privilege log is not necessary where the communications are plainly protected from disclosure. *See e.g., id.*

Legislative Leader Defendants also object because they do not have knowledge of documents that other Senators and Representatives reviewed or relied upon when drafting the Hospitalization Requirement. Legislative Leader Defendants do not purport to speak with particularity for every individual Senator or Representative. Nor can Legislative Leader Defendants purport to waive Legislative Privilege as it applies to other Senators and Representatives.

Legislative Leader Defendants also object because information about documents any particular Senator or Representative may have reviewed or even relied upon when drafting the Hospitalization Requirement is not relevant to the questions at issue before the Court. It does not matter what any Senator or Representative, or even someone working on staff at the General Assembly, may have said or known, individually, at any given time. All that matters is whether the law is vague as enacted, or if a reasonable basis for it exists. Individual intent or purpose or a particular document being reviewed at any time is irrelevant because rational basis review simply requires a rational basis exists for the enacted law.

Without waiving these objections, Legislative Leader Defendants are gathering and will soon produce documents the Speaker, the President *Pro Tem*, or their staff received from persons or organizations outside of the General Assembly who had any communications with them regarding the abortion bills which may have included information specifically about the Hospitalization Requirement pursuant to Rule 33(d).

9. Identify the General Assembly's legislative intent, purpose, and/or reasons for the IUP Documentation Requirement.

**RESPONSE:** Objection, to this Interrogatory for vagueness and relevance. The best evidence of the General Assembly's "legislative intent" is the law it enacted. *See United States v. Perkins*, 67 F.4th 583, 609 (4th Cir. 2023) ("Congress expresses its intentions through statutory text passed by both Houses and signed by the President (or passed over a Presidential veto). As this Court has repeatedly stated, the text of a law controls over purported legislative intentions unmoored from any statutory text. The Court may not replace the actual text with speculation as to Congress' intent.") (internal citations omitted); *see also, Connecticut Nat. Bank v. Germain*, 503 U.S. 249, 253–54, 112 S. Ct. 1146, 1149, 117 L. Ed. 2d 391 (1992) ("We have stated time and again that courts must presume that a legislature says in a statute what it means and means in a statute what it says there.") In any event, the General Assembly's intent or purpose or reasons are not relevant because rational basis review simply requires that a rational basis exists for the enacted law. Without waiving those objections, Dr. Bane and Dr. Wubbenhorst have both filed declarations relied upon by Legislative Leader Defendants in their brief that provide details as to how the IUP Documentation Requirement is rationally related to advancing the health and safety of a patient who has a chemical abortion.

10. Identify all facts that support any claim by Intervenor-Defendants that the IUP Documentation Requirement is rationally related to advancing the health and/or safety of a

patient who has a medication abortion, when that patient has already been screened for an ectopic pregnancy.

**RESPONSE:** Dr. Bane and Dr. Wubbenhorst have both filed declarations relied upon by Legislative Leader Defendants in their brief that provide detail as to how the IUP Documentation Requirement is rationally related to advancing the health and safety of a patient who has a chemical abortion and explain that using an ultrasound is the way to accurately diagnose an ectopic pregnancy.

11. Identify all facts that support any claim that the IUP Documentation Requirement leads to more frequent detection of an ectopic pregnancy.

**RESPONSE:** Dr. Bane and Dr. Wubbenhorst have both filed declarations relied upon by Legislative Leader Defendants in their brief that provide detail as to how the IUP Documentation Requirement is rationally related to advancing the health and safety of a patient who has a chemical abortion and explain that using an ultrasound is the way to accurately diagnose an ectopic pregnancy.

12. Identify all facts that support any claim that the IUP Documentation Requirement leads to earlier detection of an ectopic pregnancy.

**RESPONSE:** Objection, this Interrogatory is vague and Legislative Leader Defendants do not understand how to respond to it other than by objecting because they do not understand it. Without waiving those objections, Dr. Bane and Dr. Wubbenhorst have both filed declarations relied upon by Legislative Leader Defendants in their brief that provide detail as to how the IUP Documentation Requirement is rationally related to advancing the health and safety of a patient who has a chemical abortion and explain that using an ultrasound is the way to accurately diagnose an ectopic pregnancy.

13. Identify all persons and/or organizations outside of the General Assembly with which members of the General Assembly had any communications regarding the IUP Documentation Requirement.

**RESPONSE:** Objection, to the extent Plaintiffs seek information about conversations, correspondence, or any other communications between and among legislators or their staff related to the passage of a law, the Legislative Leader Defendants object to this Interrogatory because it seeks information protected from disclosure by the well-established and long-standing Legislative Privilege. *See e.g., North Carolina State Conference v. McCrory*, 2015 WL 12683665, at \*7 (M.D.N.C. Feb. 4, 2015). Also, Legislative Leader Defendants and their staff have had communications, written and verbal, with in-house counsel and outside counsel regarding the topic of the IUP Documentation Requirement, both before the passage of the laws and since. To the extent that Plaintiffs seek information about conversations or correspondence or any other communications between and among Legislative Leader Defendants and their staff with in-house counsel and outside counsel regarding the topic of the IUP Documentation Requirement, then Legislative Leader Defendants object to this Interrogatory because it seeks information protected from disclosure by Attorney-Client Privilege. To the extent that this Interrogatory seeks documents withheld based on the assertion of Legislative Privilege or Attorney Client Privilege, Legislative Leader Defendants object to creating a privilege log. Courts have often recognized that preparing a privilege log is not necessary where the communications are plainly protected from disclosure. *See e.g., id.*

Legislative Leader Defendants also object because they do not have knowledge of all the other various Senators' and Representatives' actions and communications, written or verbal, as it relates to any topic, much less this topic. Legislative Leader Defendants do not purport to speak with particularity for every individual Senator or Representative. Nor can Legislative Leader Defendants purport to waive Legislative Privilege as it applies to other Senators and Representatives.

Legislative Leader Defendants also object because information about conversations or communications between legislators and people who are not legislators or staff covered by the Legislative Privilege or Attorney-Client Privilege are not relevant to the questions at issue. It does not matter what any Senator or Representative, or even someone working on staff at the General Assembly, may have said or known, individually, at any given time. All that matters is whether the law is vague as enacted, or whether a reasonable basis for it exists. Individual intent or purpose is irrelevant because rational basis review simply requires a rational basis exists for the enacted law.

Without waiving these objections, Legislative Leader Defendants or members of their staff met with a broad array of individuals and organizations with differing viewpoints about the issue of abortion generally before the passage SB20 and HB190. Legislative Leader Defendants identify the following persons or organizations outside of the General Assembly who had any communications with the Speaker, the President *Pro Tem*, or their staff regarding the abortion bills which may have included discussion specifically about the IUP Documentation Requirement: Doug Herron and Dr. Beverly Gray, on behalf of Duke University; Dr. Martin McCaffrey; Tami Fitzgerald and Mary Suma, on behalf of the NC Values Coalition; Chip Baggett and Dave Horne, on behalf of the NC Medical Society; Dr. Bill Pincus, on behalf of NC Right to Life; Rob Lamme, on behalf of the NC OBGYN Society; John Rustin, Jere Royall, and Sharon Sullivan, on behalf of NC Family Policy Council; Dr. Grant Campbell; Rev. Mark Creech, on behalf of the Christian Action League; Dr. Stacy Boulton; Jim Quick, on behalf of the NC Faith and Freedom Coalition; Paul Stam; and Sarah Marshall, Wendy Bonano, and Melinda Delahoyde, on behalf of Gateway Women's Care.

14. Identify all documents Intervenor-Defendants or other members of the General Assembly relied upon when drafting the IUP Documentation Requirement.

**RESPONSE:** Objection, to the extent Plaintiffs seek information about conversations, correspondence, or any other communications between and among legislators or their staff related to the passage of a law, the Legislative Leader Defendants object to this Request because it seeks information protected from disclosure by the well-established and long-standing Legislative Privilege. *See e.g., North Carolina State Conference v. McCrory*, 2015 WL 12683665, at \*7 (M.D.N.C. Feb. 4, 2015). Also, Legislative Leader Defendants and their staff have had communications, written and verbal, with in-house counsel and outside counsel regarding the topic of the IUP Documentation Requirement, both before the passage of the laws and since. To the extent that Plaintiffs seek information about conversations or correspondence or any other communications between and among Legislative Leader Defendants and their staff with in-house counsel and outside counsel regarding the topic of the IUP Documentation Requirement, then Legislative Leader Defendants object to this Interrogatory because it seeks information protected from disclosure by Attorney-Client Privilege. To the extent that this Interrogatory seeks documents withheld based on the assertion of Legislative Privilege or Attorney Client Privilege, Legislative Leader Defendants object to creating a privilege log. Courts have often recognized that preparing a privilege log is not necessary where the communications are plainly protected from disclosure. *See e.g., id.*

Legislative Leader Defendants also object because they do not have knowledge of documents that other Senators and Representatives reviewed or relied upon when drafting the IUP Documentation Requirement. Legislative Leader Defendants do not purport to speak with particularity for every individual Senator or Representative. Nor can Legislative Leader Defendants purport to waive Legislative Privilege as it applies to other Senators and Representatives.

Legislative Leader Defendants also object because information about documents any particular Senator or Representative may have reviewed or even relied upon when drafting the IUP Documentation Requirement is not relevant to the questions at issue. It does not matter what any Senator or Representative, or even someone working on staff at the General Assembly, may have said or known, individually, at any given time. All that matters is whether the law is vague as enacted, or if a reasonable basis for it exists. Individual intent or purpose or a particular document being reviewed at any time is irrelevant because rational basis review simply requires a rational basis exists for the enacted law.

Without waiving these objections, Legislative Leader Defendants are gathering and will soon produce documents the Speaker, the President *Pro Tem*, or their staff received from persons or organizations outside of the General Assembly who had any communications with them regarding the abortion bills which may have included information specifically about the IUP Documentation Requirement pursuant to Rule 33(d).

#### **PLAINTIFFS' FIRST SET OF REQUESTS FOR PRODUCTION**

1. Produce all documents that Intervenor-Defendants' expert witnesses named in the response to Interrogatory No. 1 have referred to, cited, or relied upon in forming their expert opinions.

**RESPONSE:** See documents produced.

2. For each of Intervenor-Defendants' expert witnesses named in the response to Interrogatory No. 1, provide copies of their curricula vitae, and declarations or expert reports submitted in any and all prior litigation involving abortion in which the expert has participated.

**RESPONSE:** Legislative Leader Defendants object to this Interrogatory to the extent that it seeks information beyond what is required in Rule 26. However, without waiving that objection, pursuant to FRCP 26(A)(2)(B)(v), see documents produced.



3. For each of Intervenor-Defendants' expert witnesses named in the response to Interrogatory No. 1, provide transcripts of any and all deposition or trial testimony the experts have provided in any and all prior litigation involving abortion in which the expert has participated.

**RESPONSE:** Legislative Leader Defendants object to this Interrogatory to the extent that it seeks information beyond what is required in Rule 26. However, without waiving that objection, pursuant to FRCP 26(A)(2)(B)(v), see documents produced.

4. Produce all non-publicly-available documents concerning the legislative history, legislative purpose, and/or intent of the Hospitalization and the IUP Documentation Requirements.

**RESPONSE:** Objection, to this Interrogatory for vagueness and relevance. The best evidence of the General Assembly's "legislative intent" is the law it enacted. *See United States v. Perkins*, 67 F.4th 583, 609 (4th Cir. 2023) ("Congress expresses its intentions through statutory text passed by both Houses and signed by the President (or passed over a Presidential veto). As this Court has repeatedly stated, the text of a law controls over purported legislative intentions unmoored from any statutory text. The Court may not replace the actual text with speculation as to Congress' intent.") (internal citations omitted); *see also, Connecticut Nat. Bank v. Germain*, 503 U.S. 249, 253–54, 112 S. Ct. 1146, 1149, 117 L. Ed. 2d 391 (1992) ("We have stated time and again that courts must presume that a legislature says in a statute what it means and means in a statute what it says there.") In any event, the General Assembly's intent or purpose or reasons are not relevant because rational basis review simply requires that a rational basis exists for the enacted law.

To the extent Plaintiffs seek information about conversations, correspondence, or any other communications between and among legislators or their staff related to the passage of a law, the Legislative Leader Defendants object to this Request because it seeks information protected from disclosure by the well-established and long-standing Legislative Privilege. *See e.g., North Carolina State Conference v. McCrory*, 2015 WL 12683665, at \*7 (M.D.N.C. Feb. 4, 2015). Also,

Legislative Leader Defendants and their staff have had communications, written and verbal, with in-house counsel and outside counsel regarding the topic of the IUP Documentation or Hospitalization Requirement, both before the passage of the law and since. To the extent that Plaintiffs seek information about conversations or correspondence or any other communications between and among Legislative Leader Defendants and their staff with in-house counsel and outside counsel regarding the topic of the IUP Documentation or Hospitalization Requirement, then Legislative Leader Defendants object to this Interrogatory because it seeks information protected from disclosure by Attorney-Client Privilege. To the extent that this Interrogatory seeks documents withheld based on the assertion of Legislative Privilege or Attorney Client Privilege, Legislative Leader Defendants object to creating a privilege log. Courts have often recognized that preparing a privilege log is not necessary where the communications are plainly protected from disclosure. *See e.g., id.*

Legislative Leader Defendants also object because they do not have knowledge of documents that other Senators and Representatives reviewed or relied upon when drafting the IUP Documentation or Hospitalization Requirement. Legislative Leader Defendants do not purport to speak with particularity for every individual Senator or Representative. Nor can Legislative Leader Defendants purport to waive Legislative Privilege as it applies to other Senators and Representatives.

Legislative Leader Defendants also object because information about documents any particular Senator or Representative may have reviewed or even relied upon when drafting the IUP Documentation or Hospitalization Requirement are not relevant to the questions at issue before the Court. It does not matter what any Senator or Representative, or even someone working on staff at the General Assembly, may have said or known, individually, at any given time. All that matters

is whether the law is vague as enacted, or if a reasonable basis for it exists. Individual intent or purpose or a particular document being reviewed at any time is irrelevant because rational basis review simply requires a rational basis exists for the enacted law.

Without waiving those objections, see Dr. Bane and Dr. Wubbenhorst declarations which are being produced and, to the extent any video or audio recordings of any floor debate exist that may have included discussion of the Hospitalization and the IUP Requirements, any party can request to review those recordings at the General Assembly, and arrangements will be made to accommodate such requests.

5. Produce copies of all documents that Intervenor-Defendants believe support the contention that the Hospitalization Requirement furthers the interests of the State of North Carolina.

**RESPONSE:** See the objections and response to Request #4 which is incorporated in full in response to this Request.

6. Produce copies of all documents that Intervenor-Defendants believe support the contention that the IUP Documentation Requirement furthers the interests of the State of North Carolina.

**RESPONSE:** See the objections and response to Request #4 which is incorporated in full in response to this Request.

7. Produce all documents reflecting any communications between any members of the General Assembly and any individuals and/or organizations identified in Interrogatory No. 7.

**RESPONSE:** See the objections and response to Interrogatory #7 which are incorporated in full in this response to this Request. Without waiving these objections, Legislative Leader Defendants are gathering and will soon produce documents the Speaker, the President *Pro Tem*, or their staff received from persons or organizations outside of the General Assembly who had communications

with them regarding the abortion bills which may have included information specifically about the Hospitalization Requirement pursuant to Rule 33(d).

8. Produce all documents reflecting any communications between any members of the General Assembly and any individuals and/or organizations identified in Interrogatory No. 13.

**RESPONSE:** See the objections and response to Interrogatory #13 which are incorporated in full response in this Request. Without waiving these objections Legislative Leader Defendants are gathering and will soon produce documents the Speaker, the President *Pro Tem*, or their staff received from persons or organizations outside of the General Assembly who had communications with them regarding the abortion bills which may have included information specifically about the IUP Documentation Requirement pursuant to Rule 33(d).

9. Produce all documents the General Assembly relied on when drafting the Hospitalization and IUP Documentation Requirements.

**RESPONSE:** See the objections and response to Request #4 which is incorporated in full in response to this Request.

This the 17th day of August, 2023.

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*\*\*\* Notice of Special Appearance Filed*

\*This email address must be used in order to effectuate service under the Federal Rules of Civil Procedure.

\*\* Email address to be used for all communications other than service.

CERTIFICATE OF SERVICE

I hereby certify that I have this day served a copy of the foregoing LEGISLATIVE LEADER DEFENDANTS' RESPONSES AND OBJECTIONS TO PLAINTIFFS' FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION by electronic mail to the email addresses identified below which are the last email addresses known to me:

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    William West, District Attorney for District 14  
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    Benjamin R. David, District Attorney for District 6

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    Health and Human Services

Michael E. Bulleri

North Carolina Department of Justice

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114 West Edenton Street

Raleigh, NC 27603

Attorney for Michaux R. Kilpatrick, MD, PHD, President of the NC Medical Board and Racquel Ingram, PHD, RN, Chair of the North Carolina Board of Nursing

This the 17th day of August, 2023.

*s/ W. Ellis Boyle*

W. Ellis Boyle

Attorney for Defendants Philip E. Berger and  
Timothy K. Moore



# EXHIBIT 6

## Nathan Babcock (President Pro Tems Office)

---

**From:** Rob Lamme <roblamme@rlamme.com>  
**Sent:** Wednesday, May 17, 2023 08:06 AM  
**To:** Nathan Babcock (President Pro Tems Office)  
**Subject:** Re: Medication abortion confusion

Thanks for the reply. Some thoughts -

I see the blanket statement that medication abortion is legal up until 12 weeks, but my docs and their attorneys don't see how to square that up with the 70 day requirement. As we have discussed, the bill essentially says that medication abortion is allowed up until 12 weeks, but then goes on to say that a doctor can't administer it after 10. If a doctor can't certify that the pregnancy is under 70 days, then they can't provide the medication abortion. If a doctor can't do it, then no one can. That seems unclear at best – and hospital lawyers and their docs are unlikely to do anything that is within shouting distance of being in violation of any section of law (even if there is contradictory language).

If you're thinking that doctors can continue to admin medication abortion whenever it is within their medical judgement and commonly accepted practices to do so, and they are otherwise meeting the other requirements (pre-12 week or one of the exceptions) then I think the 70 day language needs to be changed/deleted.

Re: enforcement mechanisms:

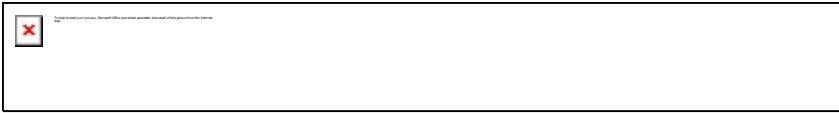
- A civil lawsuit can be brought by “any father of an unborn child that was subject of an abortion may maintain an action for damages against the person who performed the abortion in knowing or reckless violation of this Article.” (90-21.88 Civil Remedies) and
- 90-21.88A “Violation of this Article” provides that they “shall be subject to discipline by the NC Medical Board...”
- You could argue that a civil lawsuit wouldn't be successful here or that the NC Med Board wouldn't take action but we don't know that and a doctor shouldn't have to face the possibility of being taken before the board/sued. Nor will they do anything that would even remotely risk that kind of legal exposure/sanction.
- I don't read the bill to say that all of the requirements under 90-21.83B are mere suggestions, but if you do, then we need a clear statement to that effect.

As for when medication abortion is used after 11 weeks, the concern is that given the way that “abortion inducing drug” is defined (basically any medicine used to terminate a pregnancy), the restrictions would apply not only to mifepristone and misoprostol, but also to pitocin and other drugs used in abortions that may occur under the exceptions.

So, say there is a life limiting anomaly at 20 weeks – no chance that the fetus will survive long after birth and the mother, instead of carrying for another 20 weeks only to face the loss of her child, decides to terminate. In that scenario, the doc would offer an “induction abortion” or a c-section. The way that many doctors (and their lawyers) are reading this is that they wouldn't be able to *prescribe any medications* that would induce an abortion after 10 weeks, so the doctors wouldn't be able to offer the mother an induction abortion but would only be left with the option having a c-section.

Does any of that help? I would love for you to talk this through with an OB who can help with the medical options/issues. Let me know if you would like me to arrange that.

--



116 North East Street, Raleigh, NC 27601  
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[www.roblammepolicy.com](http://www.roblammepolicy.com)

On Tue, May 16, 2023 at 8:15 AM Nathan Babcock (President Pro Tems Office) <[Nathan.Babcock@ncleg.gov](mailto:Nathan.Babcock@ncleg.gov)> wrote:

Why does the FDA only approve mifepristone to 10 weeks? Are you doctors willing to say that they want clarify about prescribing and administering mifepristone off-label? SB20 states that medication abortion shall be lawful through 12 weeks:

- (2) During the first 12 weeks of a woman's pregnancy, when the procedure is performed by a qualified physician licensed to practice medicine in this State in a hospital, ambulatory surgical center, or clinic certified by the Department of Health and Human Services to be a suitable facility for the performance of abortions, in accordance with G.S. 90-21.82A or during the first 12 weeks of a woman's pregnancy when a medical abortion is procured.
- (3) After the twelfth week and through the twentieth week of a woman's pregnancy, when the procedure is performed by a qualified physician in a suitable facility in accordance with G.S. 90-21.82A when the woman's pregnancy is a result of rape or incest.
- (4) During the first 24 weeks of a woman's pregnancy, if a qualified physician determines there exists a life-limiting anomaly in accordance with this Article.

There is also not a specific ban on medication abortion after 12 weeks in cases of rape, incest, fetal anomaly, or medical emergency (although I'd still like to understand why medication abortion is the safest option under some conditions despite the FDA approval only being through 10 weeks and WTO approval only being through 12 weeks).

The language in the bill instructing the physician to verify the gestational age at 70 days does not have an enforcement or punishment mechanism either.

Despite all this, I'm looking at it.

**Nathan Babcock**

Senior Policy Advisor

Office of Senator Phil Berger

(o) 919.715.8348

(c) 980.406.7707

[Nathan.Babcock@ncleg.gov](mailto:Nathan.Babcock@ncleg.gov)

---

**From:** RLamme <[roblamme@rlamme.com](mailto:roblamme@rlamme.com)>

**Sent:** Tuesday, May 16, 2023 8:04 AM

**To:** Nathan Babcock (President Pro Tems Office) <[Nathan.Babcock@ncleg.gov](mailto:Nathan.Babcock@ncleg.gov)>

**Subject:** Medication abortion confusion

Good morning. Here's a more detailed outline of the issues some of my folks/their lawyers are having with the questions we discussed last week.

Senate Bill 20 prevents doctors from providing medication abortion after 10 weeks of pregnancy due to the new requirement that the doctor shall confirm the pregnancy is less than 70 days (or 10 weeks) before providing the abortion. Currently, doctors in the state routinely provide medication abortions up to 11 weeks of pregnancy, in line with commonly accepted best practices for the medications. Additionally, Senate Bill 20 prevents doctors from using the medications commonly used for an abortion after 10 weeks, including in cases of medical emergency, rape, incest, or where the fetus has a “life-limiting anomaly” — even when this medication is used as part of the safest care plan for the patient, which may be true at later stages of pregnancy.

- In section 90-21.88A of the bill, the text states that before a physician provides a medication abortion, they must examine the woman in person and they shall meet all of the conditions listed thereafter. Each of the conditions listed — including verification that the pregnancy exists, determination of blood type, and verification that the pregnancy is under 70 days — is a condition that must be met in order to provide the medication abortion. There is no doctor discretion written into the bill. As a result, under the Article, if the doctor cannot verify that the pregnancy is under 70 days because, for example, the ultrasound estimates that it is 73

days, they cannot provide the medication abortion. If the doctor cannot comply with all provisions of the bill (as stated in 90-21.83B(8), and again in 90-21.88A), they will be violating a provision of the Article and shall be subject to discipline by the North Carolina Medical Board.

- The language in the bill in section 90-21.88A uses the word “shall,” which medical and legal experts assert leaves no room for discretion or the use of medical judgment in providing an off-label medication abortion beyond the 70 days. Senate Bill 20 presents the gestational confirmation as a condition that must be satisfied in order to provide the medication abortion in compliance with the Article, and if the condition is not met, the physician shall be subject to discipline. The bill text plainly amounts to a mandate.
- Medical evidence demonstrates that medical providers may safely and effectively provide medication abortion for up to 77 days (11 weeks) in a pregnancy. Many Providers recommend a medication abortion to patients up to 11 weeks of pregnancy.
- Additionally, Senate Bill 20 also impacts hospital-based care for any abortion allowed to occur after 12 weeks of pregnancy. The bill may prevent doctors in a hospital from using medications, including mifepristone and misoprostol, to assist with procedures later in pregnancy, including in cases where the patient or fetus has a serious medical condition. Senate Bill 20 would remove those medication options which are routinely used, potentially forcing doctors into a course of care or unnecessary surgery that is against the patient’s wishes or doctor’s recommendation.
- Some patients — for example those having an abortion for a wanted pregnancy with life-limiting anomalies — prefer a labor induction abortion with medications instead of surgery because they want to see and hold their baby. Senate Bill 20 removes this option.

Rob Lamme and Associates

Government Relations, Communications and Policy Consulting

(919) 630-3375

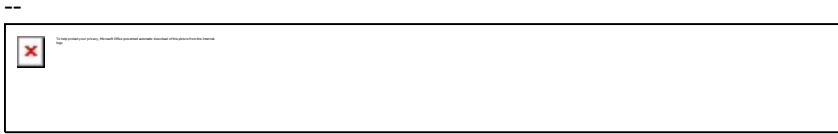
# EXHIBIT 7

## Nathan Babcock (President Pro Tems Office)

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**From:** Rob Lamme <roblamme@rlamme.com>  
**Sent:** Monday, June 12, 2023 04:06 PM  
**To:** Nathan Babcock (President Pro Tems Office)  
**Subject:** Re: medication abortion summary

Thanks - that is helpful. I think we disagree about the penalties docs might face if they provide a medication abortion but cannot comply with the requirement regarding gestational age. The larger point of course is that the confusion in the bill will prevent a provider or a facility from providing a medication abortion after ten weeks, as they will not want to risk violating the 70 day requirement, or for those pregnancies that come under the bill's exception language.



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On Mon, Jun 12, 2023 at 3:24 PM Nathan Babcock (President Pro Tems Office) <[Nathan.Babcock@ncleg.gov](mailto:Nathan.Babcock@ncleg.gov)> wrote:  
Hey Rob. I'm not a lawyer, but I don't agree with how this is couched. Here are my thoughts:

1. There is seemingly contradictory language in SB20: elective medical abortions are prohibited after 12 weeks, however in the section of the bill listing the physician's responsibilities for medical abortions, one requirement is verifying the gestational age is no more than 10 weeks.
2. The intent is to prohibit elective medical abortions after 12 weeks — and that is what the bill states in the key section listing when abortion is legal and when it is not.
3. While there is no enforcement mechanism nor penalties for a physician administering a medical abortion in weeks 11 or 12, the confusion of having language requiring the physician to verify the gestational age as 10 weeks or less will, in practice, cause physicians to err on the side of caution and not offer medical abortions after 10 weeks.

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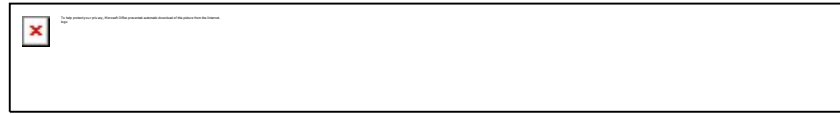
**From:** Rob Lamme <[roblamme@rlamme.com](mailto:roblamme@rlamme.com)>  
**Sent:** Monday, June 12, 2023 2:58:37 PM  
**To:** Nathan Babcock (President Pro Tems Office) <[Nathan.Babcock@ncleg.gov](mailto:Nathan.Babcock@ncleg.gov)>  
**Subject:** medication abortion summary

Hey Nathan. I drafted this to summarize the issue. Does it read correctly to you?

Thanks -

Rob

--



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# EXHIBIT 8

## Kimberly W. Overton

---

**From:** Paul Stam <paulstam@stamlawfirm.com>  
**Sent:** Friday, June 30, 2023 9:09 PM  
**To:** Neal Inman (Speaker Moore's Office); Brian Fork (President Pro Tem's Office); Joshua Yost (President Pro Tem's Office)  
**Cc:** Reese, Pamela D.; John Thorp  
**Subject:** RE: last issue before eagles can you get this to ellis boyle asap re 4-5 week pregnancies intrauterine?

Inclusion of pam reese was a mistake computer glitch she is a finance person in wake special proceedings sorry pam my computer is acting up

Paul Stam  
Stam Law Firm, PLLC  
P.O. Box 1600  
Apex, NC 27502  
Direct: 919-642-8971  
Email: [paulstam@stamlawfirm.com](mailto:paulstam@stamlawfirm.com)

---

**From:** Paul Stam  
**Sent:** Friday, June 30, 2023 9:07 PM  
**To:** 'Neal.Inman@ncleg.net' <[Neal.Inman@ncleg.net](mailto:Neal.Inman@ncleg.net)>; 'Brian Fork (President Pro Tem's Office)' <[Brian.Fork@ncleg.net](mailto:Brian.Fork@ncleg.net)>; Yost <[joshua.yost@ncleg.gov](mailto:joshua.yost@ncleg.gov)>  
**Cc:** 'Reese, Pamela D.' <[pamela.d.reese@nccourts.org](mailto:pamela.d.reese@nccourts.org)>; 'John Thorp' <[drjmthorp@gmail.com](mailto:drjmthorp@gmail.com)>  
**Subject:** last issue before eagles can you get this to ellis boyle asap re 4-5 week pregnancies intrauterine?

Dr john thorp can help He is the expert in NC g reat testimony in 20 week case -- used to be head of women's primary care at unc ch med school 300 publications

Paul Stam  
Stam Law Firm, PLLC  
P.O. Box 1600  
Apex, NC 27502  
Direct: 919-642-8971  
Email: [paulstam@stamlawfirm.com](mailto:paulstam@stamlawfirm.com)

---

**From:** John Thorp  
**Sent:** Friday, June 30, 2023 8:23 PM  
**To:** Paul Stam <[paulstam@stamlawfirm.com](mailto:paulstam@stamlawfirm.com)>  
**Subject:** Re: NC Pro-Life Law Survives Restraining Order, Goes into Effect Tomorrow!

They are saying that with very early pregnancy(between 4 and 5 weeks from LMP) that gestational sac my not be visible on ultrasound and thus intrauterine pregnancy cannot be documented. I think the requirement for documentation was put in the law with the intent to prevent harm from an ectopic pregnancy(outside the uterus) and my guess is Judge did not understand that someone can have an ectopic between 4 and 5 weeks and giving them abortion medicine could mislead them and their clinician about the existence of an ectopic pregnancy and harm the woman. I think this needs to get properly described and the law will stand.

On another note-I have an OBG friend in Wilson, North Carolina, who IS on the American pro-life obstetrician board and concerned about the table and the informed consent document. I told her about our struggles with the original informed consent and she wondered if we could get together on a teleconference so that she could learn how to suggest changes. Would you be amenable to such if I set it up?

Sent from my iPhone

On Jun 30, 2023, at 7:31 PM, Paul Stam <[paulstam@stamlawfirm.com](mailto:paulstam@stamlawfirm.com)> wrote:

John third paragraph down. Is that something you can shed light on skip

Paul Stam  
Stam Law Firm, PLLC  
P.O. Box 1600  
Apex, NC 27502  
Direct: 919-642-8971  
Email: [paulstam@stamlawfirm.com](mailto:paulstam@stamlawfirm.com)

---

**From:** NC Family  
**Sent:** Friday, June 30, 2023 3:55 PM  
**To:** Paul Stam <[paulstam@stamlawfirm.com](mailto:paulstam@stamlawfirm.com)>  
**Subject:** NC Pro-Life Law Survives Restraining Order, Goes into Effect Tomorrow!



**FAMILY POLICY FACTS**  
NC Family Updates

## NC Pro-Life Law Survives Restraining Order, Goes into Effect Tomorrow

June 30, 2023

By NC Family Staff

The majority of a landmark pro-life law passed by the North Carolina General Assembly last month will go into effect on July 1, surviving a legal attempt by Planned Parenthood and other abortion activists to block it. As [NC Family has covered in previous reports](#), Planned Parenthood and abortion activists challenged several provisions of [SB 20—Care for Women, Children, and Families Act](#) claiming they were unconstitutional. Judge Catherine Eagles, the federal district court judge in the case, heard arguments on Wednesday.

A significant part of the debate was whether modifications to SB 20 passed by the General Assembly this week would effectively address the issues raised by Planned Parenthood and the other plaintiffs in the case. Those [amendments](#), signed into law by Governor Cooper on Thursday as part of [House Bill 190](#),



appear to have addressed all but one of the issues before the court, according to [Judge Eagles' ruling](#) block a portion of the law that requires an abortionist to document in the patient's record the existence of a pregnancy.

Speaker of the NC House Tim Moore and President Pro Tempore of the NC Senate Phil Berger have in fact defend SB 20, since NC Attorney General Josh Stein refused to defend the law.

This judicial order is temporary, lasting for only 14 days, after which Judge Eagles will hear more arguments from attorneys.

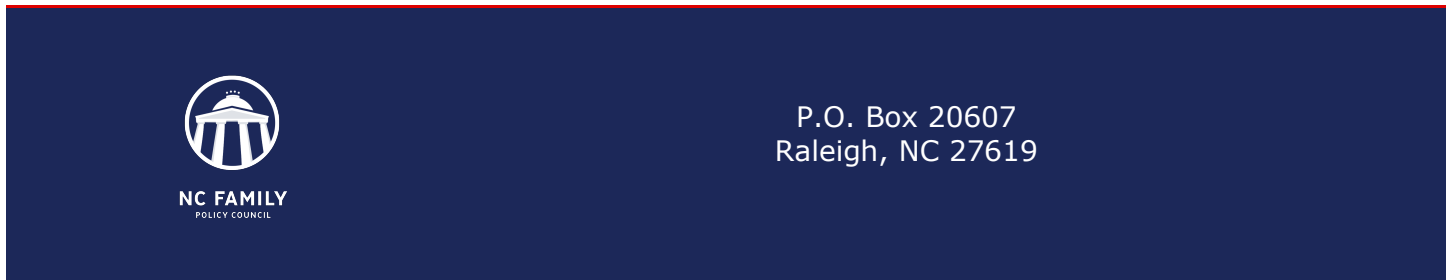
NC Family will continue to monitor updates surrounding this case.



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UNSUBSCRIBE



# EXHIBIT 9

Date: Thu, 23 Mar 2023 2:08:26 PM (UTC)  
Sent: Thu, 23 Mar 2023 2:08:02 PM (UTC)  
Subject: The List  
From: Tami Fitzgerald <tfitzgerald@ncvalues.org >  
To: Neal Inman (Speaker Moore's Office) <Neal.Inman@ncleg.gov >; Demi Dowdy (Dir. of Communications, Speaker Moore's Office) <Demi.Dowdy@ncleg.gov >;  
CC: Mary Summa <mary@ncvalues.org >; Sebastian King <sebastiankingnc@gmail.com >;  
Attachments: Requirements for Pro-Life Bill.docx; Care for Women & Babies Act-final draft 1132023.pdf; Care for Women & Babies-Index-final draft[50].pdf

Neal and Demi,

I wanted to share with you the list of things we would like to see in the pro-life bill, as well as other bills we would like to see pass. The list is attached. I've also attached the Care for Women and Babies Act which we wrote and gave to you in February, for easy reference to the sections in the list. I've copied Mary and Sebastian on this email in case you need to talk to us.

Thank you so much!

Tami

**Tami L. Fitzgerald**

Executive Director | (919) 349-3655 | tfitzgerald@ncvalues.org



# EXHIBIT 10

## Requirements for the Pro-Life bill (besides the gestational age restriction)

**Selections are ranked in order of importance.**

\*All references are to the bill submitted to House and Senate leadership by the Pro-life coalition made up of NC Values Coalition, NC Family Policy Council, NC Right to Life, NC Faith & Freedom Coalition, Christian Action League, and Human Coalition

1. Protecting Women Who Choose Abortions—restrictions on chemical abortion, informed consent reforms for surgical and chemical abortion; adding criminal penalties for violations of the abortion and informed consent statutes; expanding civil remedies for both. (Page 7, Part II, Sec. 5 through top of Page 23)
2. Prohibit direct mail/advertising for do-it-yourself abortions using abortion pills. (Page 23, Part II, Sec. 6 through
3. Require reporting to law enforcement for rape/incest exception for minors and law enforcement/DHHS for adults. (Page 30, Part II, Sec. 10, (c) through end of page 30)
4. No fetal anomaly exception. If the bill cannot pass without an exception for fetal anomaly, it shall be narrowly drawn as follows:

### ***Exception on Fetal Anomaly***

*...except in the case of an unborn child who has anomalies defined as fatal by current medical evidence and that are uniformly diagnosable, but only under the following conditions:*

- a. *The qualified physician who proposes to perform the abortion explains in writing and orally to the woman the basis upon which this diagnosis is made;*
  - b. *The diagnosis has been confirmed in writing and orally to the woman by a second qualified physician who has personally examined the woman and her medical records, and the second qualified physician is not affiliated with the qualified physician by a common employer or practice;*
  - c. *If the abortion is to be performed after 12 weeks of gestation, the unborn child shall be anesthetized sufficiently to experience no pain during the abortion; and*
  - d. *For statistical purposes, the medical records shall be promptly delivered to the Center for Health Statistics. These records are not a public record.*
5. Hospital admitting privileges and abortion clinic regulations requiring compliance with report back to the GA on an annual basis.
  6. Provide funding for Pregnancy Care Centers (funding for LifeLink Carolina dba Carolina Pregnancy Care Fellowship equal to Human Coalition funding),



Specific Adoption Agencies (Christian Adoption Services, Amazing Grace, Lifeline Children's Services), Maternity Home Fund (Page 1, Part II, Sec. 2)

7. Expressed intention to take up a Heartbeat bill and pass it in 2 years, provided we have a Republican Governor **or** veto-proof majorities in the General Assembly.
8. Advance and have a vote on:
  - a) Parents Bill of Rights—SB 49
  - b) Save Women's Sports
  - c) Youth Health Protection Act prohibiting medical transitioning for minors
  - d) Medical Ethics Defense Act
  - e) Drag Queen Bill
  - f) Universal ESA—HB 420
9. Raising Awareness, Reducing the Cost and Increasing Efficiency of Adoption. (Page 24, Part II, Sec. 8 through bottom of Page 26)
10. Protecting Babies Who are Diagnosed with NAS or FAS with reporting requirements, designation as child abuse to trigger emergency custody order and termination of parental rights. (Page 33, Part II, Sec. 11 through top of page 34)
11. Protecting Mothers Who Relinquish Their Babies—extending the period for Safe Surrender laws from 7 days to 30 days. (Page 7, Part II, Sec. 4)
12. Conscience Clause for Private Adoption and Foster Care Agencies. (Page 27, Sec. II, Section 9 through top of Page 28)

# **EXHIBIT 11**

# RISKY BUSINESS

THE CHEMICAL ABORTION INDUSTRY HURTS WOMEN



## Chemical Abortion: Protocols for a Risky Business

Chemical abortion is a serious procedure. Even though abortion-inducing drugs are four times more dangerous than surgical abortion, we continue to see a reckless, all-out push for their expansion without proper safeguards. This is risky business.

On June 24, 2022, the Supreme Court of the United States overturned *Roe v. Wade*, returning authority over abortion to the legislative branches of government and reestablishing rational basis review, the legal standard most permissive to the government, for abortion laws. The Court suggested several legitimate interests that states could defend throughout pregnancy: respecting fetal life, protecting maternal health and safety, and preserving the integrity of the medical profession. *Dobbs v. Jackson Women’s Health Org.*, 597 U.S. \_\_\_ at 77-8 (2022).

State lawmakers can—and must—strengthen protections for women and girls, ensuring that abortion is not carved out from laws that apply to everyone else, and that necessary safeguards specific to the chemical abortion procedure are in place. In every state that allows for *any* abortions, even under narrow exceptions, lawmakers should ensure that their citizens receive counseling and follow up care, and that bad actors cannot obtain drugs from improper sources.

The abortion industry brazenly promotes abortion inducing drugs as “DIY abortions.” They want to convince women that these abortions are safe, easy, and nearly painless. They want to expand telemedicine to quickly distribute more abortion pills so providers can dispense these drugs en masse then sit back to enjoy the profits – leaving women to fend for themselves. They even abandon women with complications to emergency rooms, refusing to deal with or even monitor the consequences of this dangerous drug. Nefarious drug companies overseas capitalize on these vulnerable women who are ingesting these drugs with no meaningful medical oversight. Women have died because of the dangerous side effects involved, which include severe infection, heavy bleeding, and temporary or permanent loss of fertility. *Chemical abortion shifts all risk to the woman. And she is usually alone.*

Recognizing the potential harmful impact of these drugs, the U.S. Food & Drug Administration (FDA) currently requires manufacturers, doctors, and now pharmacies to follow “Risk Evaluation Mitigation Strategies (REMS)” to approve use of these pills. These medically indicated protocols simply put some basic limits and reporting in place for chemical abortion. Unsurprisingly, the abortion industry is politically pressuring the FDA to deny women these specialized safeguards.

On December 16<sup>th</sup>, 2021, the FDA made permanent a total removal of the in-person dispensing requirement. For the first time, it permitted the only approved abortion drug regimen (mifepristone and misoprostol) to be mailed to a woman’s home for a DIY abortion or dispensed through certified pharmacies rather than directly from certified providers. The abortion industry used this loosening of the rules as pretext for “advance prescribing,” or selling pills to a woman who is not pregnant so she can keep them for later use or give them to someone else. In October 2022, the FDA pushed back against this dangerous practice, calling it an “unauthorized use”, and raising concerns about the lack of screening or oversight which places women at even higher risk of complications.

States can no longer rely on the FDA to regulate chemical abortions. Thus, lawmakers must incorporate safeguards into state law to protect women from this dangerous overreach. The Supreme Court made it clear in *Dobbs* that states may regulate, or even prohibit, abortion throughout pregnancy, *regardless of the method*, for many legitimate reasons including respecting human life, ensuring women and girls receive appropriate medical care, and preventing the degradation of the medical profession.

In response to *Dobbs*, the Biden administration has gone on the attack against states that seek to utilize their authority to limit abortion. In an August 2022 report, the U.S. Department of Health and Human Services (HHS) laid out an action plan utilizing the full force and multiple agencies of the federal government to push abortion, especially abortion-inducing drugs, January 2023

onto the states, threatening the loss of federal funds and other leverage. This plan includes guidance to roughly 60,000 U.S. retail pharmacies, asserting the authority of the FDA, indefensible threats to emergency rooms, threatening to invoke civil rights laws against health care providers who oppose abortion based on moral, ethical, or religious grounds, and much more. However, most of the items in the HHS report are ‘paper tigers’ that states should push back against, as Texas and Idaho have already done in federal courts.

Additionally, in July 2022, the Biden Administration’s Department of Education published a proposed rule that would redefine “discrimination on the basis of sex” in Title IX to include “termination of pregnancy.” This would mean that any school receiving federal funding could be forced to make chemical abortion drugs available to its students or else forfeit those federal funds. The Department of Education would thereby circumvent any life-protecting laws the states in which these schools operate may have. If this report and proposed rule are any indication of the passion that the Biden administration has for pushing abortion, states should take note and immediately pass the health and safety protections contained in this model bill.

In 2021, we saw a dangerous influx of abortion-inducing drugs at an alarming rate. The growing use of telemedicine during the coronavirus pandemic, the multiple legal and regulatory threats against the FDA’s REMS, and the political climate all suggest that states should adopt key health and safety measures for the distribution and dispensing of abortion-inducing drugs under their jurisdictions and monitor usage of hospital emergency rooms for post-procedure complications.

Even states that have enforceable gestational protections throughout pregnancy—meaning there will be virtually no legal abortions happening in your state—need to collect public health data from emergency rooms and have strong enforcement provisions to seek justice against lawbreakers. In states with exceptions for rape and incest, women still deserve information, options, and safeguards when they seek abortion under the exception. Abortion is never the best, or only, option.

A coalition of national groups has collaborated to offer model state legislation to codify longstanding health and safety protections, with a special focus on preventing the use of mail-order abortion. This model also offers a regulatory framework to certify and track the dispensing of abortion-inducing drugs in the state, including tracking medical complications like sepsis and emergency surgery. Transparency in this area is crucial in enhancing the safety of women who undergo chemical abortion.

Patient safety achieved through pharmaceutical protocols are of immediate concern to our coalition. Our goal is to create a united front of states that move quickly to codify longstanding FDA REMS and make relevant key additions to fortify their laws and protect their citizens from the dangers of chemical abortion. Very few states employ oversight mechanisms to certify physicians or track the sale and delivery of abortion-inducing drugs. This must be rectified. This legislation will provide strong and much-needed oversight over the negligent and profit-seeking abortion drug industry in your state.

**Compiled by the Chemical Abortion National Coalition – we are here to connect you with the resources you need:**



## THE ABORTION-INDUCING DRUG RISK PROTOCOL

HOUSE/SENATE BILL No. \_\_\_\_\_  
By Representatives/Senators \_\_\_\_\_

### Section 1. Title. The [State Name] Abortion-Inducing Drug Risk Protocol

[Drafter's Note: We encourage states to incorporate existing findings, definitions, and provisions that mirror this bill when they are relevant and comprehensive to address today's threats. The post-Dobbs landscape provides an opportunity to evaluate and modernize laws.]

### Section 2. Legislative Findings and Purposes.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) In September 2000, the Food and Drug Administration (FDA) approved the distribution and use of mifepristone (brand name Mifeprex), originally referred to as "RU-486", an abortion-inducing drug, under the authority of 21 C.F.R. § 314.520, also referred to as "Subpart H," which is the only FDA approval process that allows for post-marketing restrictions. Specifically, the Code of Federal Regulations (CFR) provides for accelerated approval of certain drugs that are shown to be effective but "can be safely used only if distribution or use is restricted."
  - (2) The FDA does not treat Subpart H drugs in the same manner as drugs which undergo the typical approval process, giving them heightened scrutiny after approval.
  - (3) In September 2000, the FDA prescribed a specific gestation (49 days LMP), dosage, and administration protocol for Mifeprex/mifepristone.
  - (4) The approved FDA protocol for Mifeprex/mifepristone was modified in March 2016 and December 2021 yet maintains that certain distribution restrictions are still necessary because of the drug's potential for serious complications.
  - (5) As approved by the FDA, the 2016 administration protocol consists of Mifeprex/mifepristone (one 200 mg tablet in a single oral dose), followed by misoprostol (four 200 mcg tablets) taken 24 to 48 hours later buccally (in the cheek pouch), through seventy (70) days LMP. The patient is to return for a follow-up visit to confirm that a complete abortion has occurred (7 to 14 days after administration of the abortion-inducing drug).
  - (6) The 2016 FDA protocol also required that the distribution and use of Mifeprex/mifepristone be under the supervision of a qualified healthcare provider who can assess the duration of pregnancy, diagnose ectopic pregnancies, and provide surgical intervention (or has made plans to provide surgical intervention through another qualified physician).
  - (7) On December 16, 2021, the FDA announced that it would no longer require an in-person medical examination and allow the drugs to be mailed to the patient, meaning that for the first time, pharmacies may fill prescriptions for abortion-inducing drugs if they are certified to do so by the manufacturers per FDA guidelines.
  - (8) In October 2022, the FDA pushed back against "advanced prescribing," or selling pills to a man or woman who is not pregnant, calling it an "unauthorized use" and raising concerns about the lack of screening or oversight which places women at even higher risk of complications.
  - (9) The use of Mifeprex/mifepristone presents significant medical risks including, but not limited to, uterine hemorrhage, viral infections, abdominal pain, cramping, vomiting, headache, fatigue, and pelvic inflammatory disease.
  - (10) A study of 423,000 abortions funded by state tax dollars through Medicaid programs found that chemical abortions were 53% more likely than surgical abortions to result in an abortion-related emergency room visit within 30 days of the abortion, and that the rate of chemical abortion-related ER visits increased over 500% from 2002-2015. The study also found that by 2015, more than 60% of chemical abortion-related ER visits were miscoded as miscarriages.

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- (11) A follow-up study found that among women admitted to the hospital following an emergency room visit, women whose chemical abortions were miscoded were twice as likely to be admitted for surgery to complete the abortion and significantly more likely to require multiple hospitalizations.
- (12) If the woman is Rh negative and does not receive an injection of RH immunoglobulin at the time of the abortion, she may experience Rh incompatibility in future pregnancies, which can lead to complications and miscarriage. Therefore, it is critical for a qualified physician to determine blood type and administer Rh immunoglobulin if a woman is Rh negative.
- (13) The risk of complications increases with advancing gestational age and with the failure to either complete the two-step dosage process for the Mifeprex/mifepristone regimen or to receive abortion pill reversal care from a qualified healthcare professional.
- (14) Studies document that increased rates of complications (including incomplete abortion) occur even within the FDA-approved gestational limit.
- (15) As of March 2020, the FDA reported 4,480 adverse events after women used Mifeprex/mifepristone for abortions (Mifeprex/mifepristone --- outcome: abortion/abortion induced). Among these events were 1,183 hospitalizations, 339 blood transfusions, and 256 infections (including 48 “severe infections”).
- (16) The Adverse Event Reports (AER) systems relied upon by the FDA have limitations and typically detect only a small proportion of events that actually occur.
- (17) As of March 2020, 27 women have reportedly died after administration of Mifeprex/mifepristone, with six deaths attributed to severe bacterial infections. Eight of those women administered the Mifeprex/mifepristone regimen in an “off-label” or “evidence-based” manner then-advocated by abortion providers (only found four “off label use” deaths – not linked to the bacterial infection deaths). The FDA has not been able to determine whether this off-label use led to the deaths.
- (18) Medical evidence demonstrates that women who use abortion-inducing drugs risk four times more complications than those who undergo surgical abortions. At least 3-8% of chemical abortions fail to evacuate the pregnancy tissue and require surgical completion. One percent will fail to kill the fetus. If surgical completion is required after a failed chemical abortion, the risk of premature delivery in a subsequent pregnancy is more than three times higher. Failure rates increase as gestational age increases. The gestational age range of 63-70 days has been inadequately studied. The 2016 FDA gestational age extension was based on only one study worldwide of little more than three hundred women.
- (19) After enacting a new abortion complication reporting law in 2019, Arkansas found that of the forty-five complications reported in 2020, forty of them, or 88%, resulted from chemical abortions. In 2021, although chemical abortions decreased by 31% (to 38% of in-state abortions that year), they still represented 74% of total reported abortion complications.
- (20) One study reviewing abortion-related deaths found that the most common cause of death related to chemical abortion before 13 weeks’ gestation is infection. Beyond 13 weeks’ gestation, the most common causes of death are hemorrhage and infection.
- (21) Women traveling out of state for chemical abortions may experience complications that will be treated in their home state. In Missouri in 2019, due to women obtaining abortions in other states, far more chemical abortion-related complications were reported than the total number of chemical abortions occurring in Missouri.
- (22) A woman’s ability to provide informed consent depends on the extent to which the woman receives information sufficient to make an informed choice.
- (23) The decision to abort “is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences.” *Planned Parenthood v. Danforth*, 428 U.S. 52, 67 (1976).

- (24) Some women come to regret their decision to abort shortly after ingesting Mifeprex/mifepristone, the first drug in the chemical abortion regimen.
- (25) In recent years, physicians have developed a method to potentially reverse the effects of Mifeprex/mifepristone. This abortion pill reversal (or “rescue”) process, which has been discussed in a peer-reviewed study and is based on decades of the safe use of progesterone to stabilize and continue pregnancies.
- (26) Understanding the science behind the mechanism of action of Mifeprex/mifepristone has allowed physicians to design a specific “rescue” for a woman who has used Mifeprex/mifepristone to induce an abortion but has not yet ingested the second drug in the chemical abortion regimen. Since physicians know exactly how Mifeprex/mifepristone works (*i.e.*, by blocking progesterone, a hormone naturally created by the pregnant woman’s body), physicians know that treating a woman with progesterone can “kick off” the Mifeprex/mifepristone (*i.e.*, displace Mifeprex/mifepristone from the progesterone receptors). This allows the woman's body to respond naturally to the progesterone and to effectively fight the effects of the Mifeprex/mifepristone-induced blockage.
- (27) It has long been known that mifepristone acts reversibly at the molecular level of receptor binding. Progesterone and mifepristone compete for the binding site of the receptor, making the antiprogestosterone activity of mifepristone reversible.
- (28) In short, Mifeprex/mifepristone floods the progesterone receptors (thus, blocking progesterone). To block or “reverse” the effects of the Mifeprex/mifepristone, a pregnant woman is prescribed additional progesterone to outcompete and outnumber the mifepristone and restore adequate progesterone in her body to sustain the pregnancy.
- (29) Progesterone itself has been used safely in pregnancies for decades. It is used in *in vitro* fertilization, infertility treatments, and high-risk pregnancies (such as those experiencing pre-term labor). Using progesterone to reverse the effects of Mifeprex/mifepristone is a targeted response that is safe for the woman.
- (30) Statistics show that, as of January 2022, more than 3,000 lives have been saved following this reversal process and that babies born following this reversal process have a rate of birth defects no higher than the general population.
- (31) Studies show that following this reversal process or otherwise treating a woman with progesterone during pregnancy does not lead to increased mortality rates.
- (32) To facilitate reliable scientific studies and research on the safety and efficacy of abortion-inducing drugs, it is essential that the medical and public health communities have access to accurate information both on the efficacy and use of abortion-inducing drugs, as well as on resulting complications.
- (33) Abortion “record keeping and reporting provisions that are reasonably directed to the preservation of maternal health and that properly respect a patient’s confidentiality and privacy are permissible.” *Planned Parenthood v. Danforth*, 428 U.S. 80 at 52, 79-81 (1976).
- (34) The Supreme Court of the United States has explicitly permitted abortion and complication reporting provisions for three decades, most recently in *Dobbs v. Jackson Women’s Health Org.*, 597 U.S. \_\_\_ (2022). Specifically, “[t]he collection of information with respect to actual patients is a vital element of medical research. . . .” *Planned Parenthood v. Casey*, 505 U.S. 833 at 900-901 (1992).
- (35) To promote its interest in maternal health and life:
- (a) The State maintains an interest in:
1. Collecting certain demographic information on all drug-induced abortions performed in the State;

2. Collecting information on all abortion complications from all drug-induced abortions diagnosed or treated in the State; and
3. Compiling statistical reports based on abortion complication information collected pursuant to this Act for future scientific studies and public health research.

(b) Based on the findings in subsection (a), it is the purpose of this Act to:

1. Protect the health and welfare of every woman considering a drug-induced abortion;
2. Ensure that a physician examines a woman prior to dispensing an abortion-inducing drug in order to confirm the gestational age of the unborn child prior to administering the abortion inducing drug, the intrauterine location of the unborn child, and that the unborn child is alive, since administration of Mifeprex/mifepristone following spontaneous miscarriage exposes the woman to unnecessary risks associated with both Mifeprex/mifepristone and misoprostol if not medically indicated;
3. Ensure that a physician does not prescribe or dispense an abortion-inducing drug beyond 70 days' gestation;
4. Reduce "the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed." *Planned Parenthood v. Casey*, 505 U.S. 833, 882 (1992);
5. Ensure that women considering a drug-induced abortion receives comprehensive information on abortion-inducing drugs, including the potential to reverse the effects of the drugs should she change her mind, and that women submitting to an abortion do so only after giving voluntary and fully informed consent to the procedure; and
6. Promote the health and safety of women, by adding to the sum of medical and public health knowledge through the compilation of relevant data on drug-induced abortions performed in the State, as well as on all medical complications and maternal deaths resulting from these abortions.

### Section 3. Definitions.

As used in this Act:

(a) "**Abortion**" means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate a clinically diagnosable pregnancy, with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child, or the act of prescribing an abortion-inducing drug with reasonable certainty that the drug will prevent growth or implantation, or otherwise cause the death of an unborn child, if ingested prior to confirmation of a clinically diagnosed pregnancy (i.e. "missed period pills").

Such use, prescription, or means is not an abortion if done with the intent to:

1. Save the life or preserve the health of the unborn child;
2. Remove a dead unborn child caused by spontaneous abortion;
3. Remove an ectopic pregnancy; or
4. Treat a maternal disease or illness for which the prescribed drug is medically indicated.

(b) "**Abortion-inducing drug**" means a medicine, drug, or any other substance prescribed or dispensed with the intent of terminating the clinically diagnosable pregnancy of a woman, with knowledge that the termination will with reasonable likelihood cause the death of the unborn child. This includes the off-label use of drugs known to have abortion-inducing properties, which are prescribed specifically with the intent of causing an abortion, such as mifepristone (Mifeprex), misoprostol (Cytotec), and methotrexate. This definition includes the off-label use of drugs known to have abortion-inducing properties, which are prescribed without a diagnosed pregnancy (sometimes called "pre-prescribing" or "advanced prescribing") for the purpose of causing an abortion at some future date rather than contemporaneously with a clinically

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diagnosed pregnancy. This definition does not apply to drugs that may be known to cause an abortion, but which are prescribed for other medical indications (e.g., chemotherapeutic agents, diagnostic drugs, etc.).

The use of such drugs to induce abortion is also known as “medical,” “medication,” “RU-486,” “chemical,” “Mifeprex regimen,” “missed period pill,” “Plan C,” or “drug-induced” abortion.

(c) **“Adverse Event”** according to the U.S. Food and Drug Administration, means any untoward medical occurrence associated with the use of a drug in humans, whether or not considered drug related. It does not include an adverse event or suspected adverse reaction that, had it occurred in a more severe form, might have caused death (21 CFR 312.32).

(d) **“Associated Physician”** means a person licensed to practice medicine in the state, including medical doctors and doctors of osteopathy, who has entered into a “Associated Physician Agreement.”

(e) **“Complication”** or **“Abortion Complication”** means only the following physical or psychological conditions which, in the reasonable medical judgment of a licensed healthcare professional, arise as a primary or secondary result of an induced abortion: uterine perforation, cervical laceration, infection, bleeding, vaginal bleeding that qualifies as a Grade 2 or higher adverse event according to the Common Terminology Criteria for Adverse Events (CTCAE), pulmonary embolism, deep vein thrombosis, failure to actually terminate the pregnancy, incomplete abortion (retained tissue), pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, shock, amniotic fluid embolism, coma, free fluid in the abdomen, allergic reactions to anesthesia and abortion-inducing-drugs, psychological complications as diagnosed that are listed in the current Diagnostic and Statistical Manual (DSM) and any related complication arising under the following ICD 10 codes: O04.2, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.84, O04.86, O04.87, O04.88, O07.0, O07.1, O07.2, O07.34, O07.38.

(f) **“Department”** means the Department of [Appropriate State Agency] of the State of [Name of State].

(g) **“Hospital”** means an institution providing medical and surgical treatment and nursing care for sick or injured people, and/or institutions defined under [*Insert applicable state codes defining hospital(s)*].

(h) **“Facility”** means any public or private hospital, clinic, center, medical school, medical training institution, healthcare business, physician’s office, infirmary, dispensary, ambulatory surgical center, or other institution or location or business wherein medical care or pharmaceuticals are provided to any person.

(i) **“LMP”** or **“gestational age”** means the time that has elapsed since the first day of the woman’s last menstrual period.

(j) **“Physician”** means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.

(k) **“Pregnant”** or **“pregnancy”** means that female reproductive condition of having an unborn child in the uterus.

(l) **“Provide”** means, when used regarding abortion-inducing drugs, any act of giving, selling, dispensing, administering, transferring possession to or otherwise providing or prescribing an abortion-inducing drug.

(m) **“Qualified physician”** means a physician licensed in this State who has the ability to:

1. identify and document a viable intrauterine pregnancy,
2. assess the gestational age of pregnancy and to inform the patient of gestational age-specific risks,
3. diagnose ectopic pregnancy,
4. determine blood type and administer RhoGAM if a woman is Rh negative,
5. assess for signs of domestic abuse, reproductive control, human trafficking, and other signals of coerced abortion,
6. provide surgical intervention or has entered into a contract with another qualified physician to provide surgical intervention, and
7. supervise and bear legal responsibility for any agent, employee, or contractor who is participating in any part of procedure, including but not limited to, pre-procedure evaluation and care.

(n) “**Unborn child**” means an individual organism of the species homo sapiens, beginning at fertilization, until the point of being born-alive as defined in section 8(b) of Title 1, U.S. Code.

#### **Section 4. In-person Requirement.**

Abortion-inducing drugs shall only be provided in-person by a qualified physician following procedures laid out in this Bill. It shall be unlawful for any manufacturer, supplier, pharmacy, physician, qualified physician, or any other person to provide any abortion-inducing drug via courier, delivery, or mail service.

#### **Section 5. Distribution of Abortion-Inducing Drugs.**

(a) Because the failure and complication rates from a chemical abortion increase with advancing gestational age; because the physical symptoms of chemical abortion can be identical to the symptoms of ectopic pregnancy; and, because abortion-inducing drugs do not treat ectopic pregnancies but rather are contraindicated in ectopic pregnancies, the qualified physician providing an abortion-inducing drug must examine the woman in person, and prior to providing an abortion-inducing drug, must:

1. independently verify that a pregnancy exists,
2. determine the woman’s blood type, and if she is Rh negative, be able to and offer to administer RhoGAM at the time of the abortion,
3. provide any other medically indicated diagnostic tests such as iron or hemoglobin/hematocrit (H/H test) to determine if the woman has heightened risks of complications,
4. screen the woman for coercion, abuse, and anxiety, and refer her to the appropriate healthcare professional for treatment consistent with the screening results,
5. inform the patient that she may see the remains or her unborn child in the process of completing the abortion,
6. follow all informed consent practices required by this code and as required by [State], and
7. document, in the woman’s medical chart, the gestational age and intrauterine location of the pregnancy, and whether she received treatment for Rh negativity or any other diagnostic tests, as diagnosed by the most accurate standard of medical care.

(b) A qualified physician providing an abortion-inducing drug must be credentialed and competent to manage complications, including emergency transfer, or must have a signed contract with an associated physician who is credentialed to handle complications and be able to produce that signed contract on demand by the pregnant woman or by the Department. Every pregnant woman to whom a qualified physician provides any abortion-inducing drug shall be given the name and phone number of the associated physician.

(c) The qualified physician providing any abortion-inducing drug, or an agent of the qualified physician, shall schedule a follow-up visit for the woman at approximately seven (7) to fourteen (14) days after administration of the abortion-inducing drug to confirm that the pregnancy is completely terminated and to assess the degree of bleeding. The qualified physician shall make all reasonable efforts to ensure that the woman returns for the scheduled appointment. A brief description of the efforts made to comply with this subsection, including the date, time, and identification by name of the person making such efforts, shall be included in the woman’s medical record.

#### **Section 6. Prohibition on State Funding of Abortion-Inducing Drugs at Public Schools, Colleges, and Universities.**

Abortion-inducing drugs shall not be provided on state grounds, or in any school building, including but not limited to, elementary, secondary, and institutions of higher education in [State], nor may funds appropriated to or collected by a public educational institution be spent to perform, refer for, or reimburse travel expenses for any abortion.

#### **Section 7. Informed Consent Requirements for Abortion-Inducing Drugs.**

(a) No abortion-inducing drug shall be provided without the informed consent of the pregnant woman as described in this section to whom the abortion-inducing drug is provided.

(b) Informed consent to a chemical abortion must be obtained at least [*twenty-four (24) or insert existing state law requirement*] hours before abortion-inducing drug are provided to the pregnant woman, except if in reasonable medical judgment, compliance with this subsection would pose a greater risk of the death or substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions of the pregnant woman.

(c) A “consent form” created by the Department shall be used by a qualified physician to obtain the consent required prior to providing an abortion-inducing drug.

(d) A consent form is not valid, and consent is not sufficient unless:

1. The patient initials each entry, list, description, or declaration required to be on the consent form (as detailed in subsections (e)(1) through (e)(10) of this Section);
2. The patient signs the “acknowledgement of risks and consent statement” described in subsection (e)(6) of this Section; and
3. The qualified physician signs the “qualified physician declaration” described in subsection (g)(7) of this Section.

(e) The consent form shall include, but is not limited to, the following:

1. The probable gestational age of the unborn child as determined by both patient history and by ultrasound results used to confirm gestational age;
2. A detailed description of the steps to complete the chemical abortion;
3. A detailed list of the risks related to the specific abortion-inducing drug or drugs to be used including, but not limited to hemorrhage (heavy bleeding); failure to remove all tissue of the unborn child which may require an additional procedure; sepsis; sterility; and possible continuation of pregnancy;
4. Information about Rh incompatibility, including that if she has an Rh-negative blood type, she should receive an injection of Rh immunoglobulin (brand name RhoGAM) at the time of the abortion to prevent Rh incompatibility in future pregnancies, which can lead to complications and miscarriage in future pregnancies;
5. That the risks of complications from a chemical abortion, including incomplete abortion, increase with advancing gestational age, and that infection and hemorrhage are the most common causes of deaths related to chemical abortions
6. That it may be possible to reverse the effects of the chemical abortion should she change her mind, but that time is of the essence;
7. That she may see the remains or her unborn child in the process of completing the abortion;
8. That initial studies suggest that children born after reversing the effects of Mifeprex/mifepristone have no greater risk of birth defects than the general population;
9. That initial studies suggest that there is no increased risk of maternal mortality after reversing the effects of Mifeprex/mifepristone;
10. That information on and assistance with reversing the effects of abortion-inducing drugs are available in the state-prepared materials; and

(f) An “acknowledgment of risks and consent statement” which must be signed by the patient. The statement must include, but is not limited to the following declarations, which must be individually initialed by the patient:

1. That the patient understands that the abortion-inducing drug regimen or procedure is intended to end her pregnancy and will result in the death of her unborn child;

2. That the patient is not being forced to have an abortion, that she has the choice not to have the abortion, and that she may withdraw her consent to the abortion-inducing drug regimen even after she has begun the abortion-inducing drug regimen;
  3. That the patient understands that the chemical abortion regimen or procedure to be used has specific risks and may result in specific complications;
  4. That the patient has been given the opportunity to ask questions about her pregnancy, the development of her unborn child, alternatives to abortion, the abortion-inducing drug or drugs to be used, and the risks and complications inherent to the abortion-inducing drug or drugs to be used;
  5. That she was specifically told that “Information on the potential ability of qualified medical professionals to reverse the effects of an abortion obtained through the use of abortion-inducing drugs is available at [www.abortionpillreversal.com](http://www.abortionpillreversal.com), or you can contact (877) 558-0333 for assistance in locating a medical professional that can aid in the reversal of an abortion.”
  6. That she has been provided access to state-prepared, printed materials on informed consent for abortion [*and*] the state-prepared and maintained website on informed consent for abortion [*and the state-prepared informational DVD on informed consent for abortion, if applicable*], [and any other resources made available by the state, including adoption or parenting support, ability to obtain child support, etc.].
  7. If applicable, that she has been given the name and phone number of the associated physician who has agreed to provide medical care and treatment in the event of complications associated with the abortion-inducing drug regimen or procedure;
  8. That the qualified physician will schedule an in-person follow-up visit for the patient at approximately seven (7) to fourteen (14) days after providing the abortion-inducing drug or drugs to confirm that the pregnancy is completely terminated and to assess the degree of bleeding and other complications;
  9. That the patient has received or been given sufficient information to give her informed consent to the abortion-inducing drug regimen or procedure, and
  10. That the patient has a private right of action to sue the qualified physician under the laws of [State] if she feels that she has been coerced or misled prior to obtaining an abortion, and how to access state resources regarding her legal right to obtain relief.
  11. That she will be given a copy of the forms and materials with all signatures as required by this Act, including in Sections 7(c), 7(f), 7(g), and 8(a) to take home, as well as all other forms of informed consent required by [State].
- (g) A “qualified physician declaration,” which must be signed by the qualified physician, stating that the qualified physician has explained the abortion-inducing drug or drugs to be used, has provided all of the information required in subsections (e)(1) through (e)(10) of this Section, and has answered all of the woman’s questions.

#### **Section 8. Information Required in State-Prepared Materials.**

- (a) The Department shall cause to be published in the state-prepared, printed materials on informed consent for abortion [*and*] the state-prepared and maintained website on informed consent for abortion, [*and the state-prepared informational DVD, if applicable*] required under [*Insert reference(s) to state statutes, administrative rules, or other authority related to informed consent for abortion*] the following statement:

“Information on the potential ability of qualified medical professionals to reverse the effects of an abortion obtained through the use of abortion-inducing drugs is available at [www.abortionpillreversal.com](http://www.abortionpillreversal.com), or you can contact (877) 558-0333 for assistance in locating a medical professional that can aid in the reversal of an abortion.”

(b) On an annual basis, the Department shall review and update, if necessary, the statement required in subsection (a) of this Section.

(c) As part of the informed consent counseling required in Sec. 7 of this Bill, the qualified physician will inform the pregnant woman about abortion pill reversal and provide her with the state-prepared materials and website link as proscribed by Sec. 8(a) of this Bill.

### **Section 9. State Public Information Campaigns.**

(a) The Department of Education shall display a public awareness sign developed under (c) in every restroom in public secondary schools and institutions of higher education.

(b) Emergency rooms and emergency care facilities shall display a public awareness sign developed under (c) in waiting areas and patient facilities.

(c) The required public awareness sign must be at least 8.5 inches by 11 inches in size, must be printed in at least a 16-point type, and must state substantially the following in English and Spanish:

“Information on the potential ability of qualified medical professionals to reverse the effects of an abortion obtained through the use of abortion-inducing drugs is available at [www.abortionpillreversal.com](http://www.abortionpillreversal.com) and (*state's website*), or you can contact (877) 558-0333 for assistance in locating a medical professional that can aide in the reversal of an abortion.”

(d) The Department shall direct all hospital emergency rooms and emergency care facilities to post a sign in each patient room that is at least 8.5 inches by 11 inches in size, printed in at least 16-point type, and state substantially the following in English and Spanish:

“If you have had an abortion, including if you have taken abortion pills obtained online, please tell the doctor so your medical treatment can be as effective as possible.”

### **Section 10. Reporting on Abortion-Inducing Drugs and Chemical Abortions.**

(a) For the purpose of promoting maternal health and adding to the sum of medical and public health knowledge through the compilation of relevant data, a report of each [*medical or drug-induced*] abortion performed shall be made to the Department on forms prescribed by it. The reports shall be completed by the hospital or other [*licensed*] facility in which the abortion-inducing drug was provided or prescribed; signed by the qualified physician who gave, sold, dispensed, administered, or otherwise provided or prescribed the abortion-inducing drug; and transmitted to the Department within fifteen (15) days after each reporting month. The Department shall update forms as needed to reflect changes to diagnostic and reimbursement coding classifications.

(b) Each report shall include, at minimum, the following information:

1. Identification of the qualified physician who provided the abortion-inducing drug;
2. Whether the chemical abortion was completed at the hospital or [*licensed*] facility in which the abortion-inducing drug was provided or at an alternative location;
3. The referring physician, agency, or service, if any;
4. The pregnant woman's county, state, and country of residence;
5. The pregnant woman's age and race;
6. The number of previous pregnancies, number of live births, and number of previous abortions of the pregnant woman;

7. The probable gestational age of the unborn child as determined by both patient history and by ultrasound results used to confirm the gestational age, and the date of the ultrasound and gestational age determined on that date;
8. The abortion-inducing drug or drugs used, the date each was provided to the pregnant woman, and the reason for the abortion, if known;
9. Preexisting medical condition(s) of the pregnant woman which would complicate her pregnancy, if any;
10. Whether the woman returned for a follow-up examination to determine completion of the abortion procedure and to assess bleeding and the date and results of any such follow-up examination, and what reasonable efforts were made by the qualified physician to encourage that she return for a follow-up examination if she did not.
11. Whether the woman suffered any abortion complications, and what specific abortion complication(s) as defined in Section 3(e) that led to the diagnosis or treatment of abortion complications.
12. The amount billed to cover the treatment for specific complications, including whether the treatment was billed to Medicaid, private insurance, private pay, or other method. This should include ICD-10 diagnosis code(s) reported, any other treatment or procedure codes reported, charges for any physician, hospital, emergency room, prescription or other drugs, laboratory tests, and any other costs for treatment rendered.

(c) Reports required under this subsection shall not contain:

1. The name of the pregnant woman;
2. Common identifiers such as her social security number or [*motor vehicle operator's license number*]; or
3. Other information or identifiers that would make it possible to identify, in any manner or under any circumstances, a woman who has obtained or seeks to obtain a chemical abortion.

(d) If a qualified physician provides an abortion-inducing drug to a pregnant woman for the purpose of inducing an abortion as authorized in Sections 4 and 5 of this Act, and if the qualified physician knows that the woman who uses the abortion-inducing drug for the purpose of inducing an abortion experiences, during or after the use of the abortion-inducing drug, an abortion complication or an adverse event, the qualified physician shall provide a written report of the adverse event within three (3) days of the event to the FDA via the MedWatch Reporting System [*and*] to the Department [*and to the State Medical Board*].

(e) Any physician, qualified physician, associated physician, or other healthcare provider who diagnoses or treats a woman, either contemporaneously to or at any time after the procedure, for an adverse event or abortion complication subsequent to a chemical abortion shall make a report of the adverse event or complication to the Department on forms prescribed by it. The reports shall be completed by the hospital or other facility in which the adverse event or abortion complications diagnosis or treatment was provided; signed by the physician, qualified physician, or other healthcare provider who diagnosed or treated the abortion complication or adverse event; and transmitted to the Department within (15) days after each reporting month.

Each report shall include, at minimum, the following information:

1. The date the woman presented for treatment;
2. The age and race of the woman;
3. The woman's state and county of residence;
4. The number of previous pregnancies, number of live births, and number of previous abortions of the woman;
5. The date the abortion was performed, and type of abortion;
6. Identification of the physician who performed the abortion, the facility where the abortion was performed or the drug was prescribed, and the referring physician, agency, or service, if any;
7. The specific complication(s) that led to the treatment, including the following physical or psychological conditions which, in the reasonable medical judgment of a licensed healthcare professional, arise as a primary or secondary result of an induced abortion: uterine perforation, cervical laceration, infection, bleeding, vaginal bleeding that

qualifies as a Grade 2 or higher adverse event according to the Common Terminology Criteria for Adverse Events (CTCAE), pulmonary embolism, deep vein thrombosis, failure to actually terminate the pregnancy, incomplete abortion (retained tissue), pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, shock, amniotic fluid embolism, coma, free fluid in the abdomen, allergic reactions to anesthesia and abortion-inducing-drugs, psychological complications as diagnosed that are listed in the current Diagnostic and Statistical Manual (DSM) and any related complication arising under the following ICD 10 codes: O04.2, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.84, O04.86, O04.87, O04.88, O07.0, O07.1, O07.2, O07.34, O07.38.

8. Whether the patient obtained abortion-inducing drugs via mail order or Internet website, and, if so, information identifying the name of the source, URL address, or telemedicine provider.
9. Whether the abortion was completed at the hospital or [*licensed*] facility in which the abortion-inducing drug was provided or at an alternative location;

(f) The Department shall prepare a comprehensive annual statistical report for the [*Legislature*] based upon the data gathered from reports under this Section. The aggregated data shall also be made available to the public by the Department in a downloadable format.

(g) The Department shall summarize aggregate data from the reports required under this Act and submit the data to the U.S. Centers for Disease Control and Prevention (CDC) for the purpose of inclusion in the annual Vital Statistics Report.

(h) Reports filed pursuant to this Section shall be deemed public records and shall be available to the public in accordance with the confidentiality and public records reporting laws of [State]. Original copies of all reports filed under this subsection shall be available to the [State medical board], [State Board of Pharmacy], state law enforcement offices, and child protective services for use in the performance of their official duties.

(i) Absent a valid court order or judicial subpoena, neither the Department, any other state department, agency, or office nor any employees thereof shall compare data concerning abortions or abortion complications maintained in an electronic or other information system file with data in any other electronic or other information system, the comparison of which could result in identifying, in any manner or under any circumstances, a woman obtaining or seeking to obtain a drug-induced abortion.

(j) The Department and any other state department, agency, office, or any employee or contractor thereof shall not maintain statistical information that may reveal the identity of a woman obtaining or seeking to obtain a drug-induced abortion.

(k) Original copies of all reports filed under this Section shall be available to the Department [*and the State Medical Board*] for use in the performance of its official duties.

(l) The Department shall communicate the reporting requirements in this Section to all medical professional organizations, licensed physicians, hospitals, emergency rooms, abortion facilities [*or other appropriate term such as "reproductive health center"*], Department [*of Health*] clinics, ambulatory surgical facilities, and other healthcare facilities operating in the State.

1. Any physician, including emergency medical personnel, who diagnoses or treats a woman for abortion complications or adverse event arising from an abortion, shall file a written report as required by Section 10 of this Act with the Department.
2. A physician filing a written report with the Department after diagnosing or treating a woman for abortion complications or otherwise in an emergency capacity shall make reasonable efforts to include all the required information that may be obtained without violating the privacy of the woman.
3. The reports required in section (a) shall be completed by the hospital or other [*licensed*] facility in which the abortion-inducing drug was given, sold, dispensed, administered, or otherwise provided or prescribed; signed by the qualified physician who gave, sold, dispensed, administered, or otherwise provided or prescribed the abortion-inducing drug; and transmitted to the Department within fifteen (15) days after each reporting month. However, if

an abortion is for a female who is [*age of a minor under state law that constitutes a crime if pregnant and must be reported as child abuse*], the healthcare provider shall transmit the form in the manner prescribed by section (a) to the Department and separately to the [*appropriate state child abuse department*] within three (3) days after the abortion is performed.

### **Section 11. Production of Reporting Forms.**

The Department shall create and distribute the forms required by this Act within sixty (60) days after the effective date of this Act. No provision of this Act requiring the reporting of information on forms published by the Department shall be applicable until ten (10) days after the requisite forms are first created and distributed or until the effective date of this Act, whichever is later.

### **Section 12. Criminal Penalties.**

- (a) A [*person*] who intentionally, knowingly, or recklessly violates any provision of this Act is guilty of a [*Insert appropriate penalty/offense classification*]. In this Section, “intentionally” is defined by Section [*Insert section number or other appropriate reference*] of the [*state penal/criminal code*].
- (b) A [*person*] who intentionally, knowingly, or recklessly violates any provision of this Act by fraudulent use of an abortion-inducing drug, with or without the knowledge of the pregnant woman, is guilty of a [*Insert appropriate penalty/offense classification*].
- (c) A [*person*] who intentionally or knowingly offers or provides abortion doula services, with the intent that the services will be used, or are reasonably likely to be used, for an unlawful abortion is guilty of a [*Insert appropriate penalty/offense classification*].
- (d) A [*person*] who intentionally or knowingly provides a referral to an unlawful abortion provider, with the intent that the referral will result, or is reasonably likely to result, in an unlawful abortion, regardless of whether the referrer receives compensation, is guilty of a [*Insert appropriate penalty/offense classification*].
- (e) A [*person*] who intentionally or knowingly obtains or possesses abortion-inducing drugs with the intent to deliver it to another person is guilty of a [*Insert appropriate penalty/offense classification*].
- (f) A non-parent or guardian [*adult*] who intentionally, knowingly, or recklessly transports a minor with the intent to conceal an unlawful abortion from the parent(s) and/or guardian(s) of that minor, or to procure an unlawful abortion, or to obtain abortion-inducing drugs for that minor, is guilty of a [*Insert appropriate penalty/offense classification*].
- (g) No criminal penalty may be assessed against the pregnant woman upon whom the drug-induced abortion is attempted, induced, or performed.

[Drafter’s Note: When determining appropriate penalty/offense classification, the state should consider mandatory minimums, extradition for violators living outside of the state, elevated sentencing, automatic triggering of state licensing penalties, etc. Please reach out and our team can help you identify the appropriate classifications for your state.]

### **Section 13. Civil Remedies.**

- (a) In addition to whatever remedies are available under the common or statutory law of this State, failure to comply with the requirements of this Act shall:
  - 1. Provide a basis for a civil malpractice action for actual and punitive damages, and injunctive, declaratory, or any other appropriate relief;
  - 2. Provide a basis for recovery for the woman’s [insert language used in existing state law for surviving relatives] for the wrongful death of the woman under the [state’s *Wrongful Death Act*].



(b) Notwithstanding any other provision of law, a woman upon whom the drug-induced abortion has been attempted, induced, or performed, or her parent or guardian if she is a minor girl at the time of the attempted or completed abortion, may bring an action under this Act at any time from the point of the alleged violation until [XX years] after the alleged violation, or from the point that harm is discovered until [XX years] after the initial discovery of harm.

[Drafter's Note: insert timeframe and language consistent with existing state laws re: criminal and civil statutes of limitations.]

(c) Notwithstanding any other provision of law, an action under this subchapter may be commenced, and relief may be granted, in a judicial proceeding without regard to whether the person commencing the action has sought or exhausted available administrative remedies;

(d) When requested, the court shall allow a woman to proceed using solely her initials or a pseudonym and may close any proceedings in the case and enter other protective orders to preserve the privacy of the woman upon whom the drug-induced abortion was attempted, induced, or performed.

(e) If judgment is rendered in favor of the plaintiff, the court shall also render judgment for reasonable attorney's fees in favor of the plaintiff against the defendant.

(f) If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court may render judgment for reasonable attorney's fees in favor of the defendant against the plaintiff.

(g) No civil liability may be assessed against the pregnant woman upon whom the drug-induced abortion is attempted, induced, or performed.

#### **Section 14. Professional Sanctions.**

(a) In addition to whatever remedies are available under the common or statutory law of this State, failure to comply with the requirements of this Act shall provide a basis for a professional disciplinary action under [state's *Medical Malpractice Act*, *state's applicable medical, nursing, or pharmacy licensure board*, *an existing admitting privileges or emergency transfer agreement*, or *any other governing body overseeing the individual's professional status in this state*].

(b) No professional sanction may be assessed against the pregnant woman upon whom the drug-induced abortion is attempted, induced, or performed.

#### **Section 15. Construction.**

(a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.

(b) It is not the intention of this Act to make lawful an abortion that is otherwise unlawful.

(c) Nothing in this Act repeals, replaces, or otherwise invalidates existing federal or [State] laws, regulations, or policies.

[Drafter's Note: If the bill explicitly *does* repeal existing law (as for states with an FDA reference), this needs to be edited to state the repealed provision.]

#### **Section 16. Right of Intervention.**

(a) The [*Legislature*], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this Act is challenged, or

(b) The [state] Attorney General may bring an action to enforce compliance with this Act or intervene as a matter of right in any case in which the constitutionality of this Act is challenged.

**Section 17. Severability.**

Any provision of this Act held to be invalid or unenforceable by its terms or as applied to any person or circumstance shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

**Section 18. Effective Date.**

This Act takes effect on [Insert date].

**Compiled by the Chemical Abortion National Coalition – we are here to connect you with the resources you need:**



**Resources and References:**

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January 2023

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# EXHIBIT 12

**Post 12-week Complications Resulting in Hospital Transfer for 1/1/2020-6/30/2023**

<b>Complication</b>	<b>Weeks LMP</b>	<b>Health Center</b>	<b>Year</b>	<b>Hospital Status</b>
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 1/1/2020-6/30/2023**

<b>Complication</b>	<b>Weeks LMP</b>	<b>Health Center</b>	<b>Year</b>	<b>Hospital Status</b>
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 13**

<b>Complications from 01/2020 - 06/2023*</b>	
<b>Type of Complication</b>	<b>Count</b>
Allergic Reaction	1
Hemorrhage	24
Incomplete AB/Retained POCs/Debris	183
Laceration	1
Medication Error	2
Minor Infection	9
Ongoing/Unintended Pregnancy	180
Other Injury (incl. nausea, dizziness, etc)	16
Pain/Bleeding	91
Perforation	3
Seizures/Vaso-vagal Reaction	5
Serious Infection	5
Spontaneous Abortion	2
<b>TOTAL</b>	<b>522**</b>
<p>*Chart represents total number of complications, not total number of patients with complications. Some patients may have had more than one complication.  ** Of these, 31 required transfer to a hospital.</p>	



# **EXHIBIT 14**

**Pre 12-week Complications Resulting in Hospital Transfer for 1/1/2020-6/30/2023**

<b>Complication</b>	<b>Weeks LMP</b>	<b>Type of AB</b>	<b>Health Center</b>	<b>Year</b>	<b>Hospital Status</b>
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

# EXHIBIT 15


 Asheville  
 Columbia  
 Roanoke

 Chapel Hill  
 Durham  
 Vienna

 Charleston  
 Fayetteville  
 Wilmington

 Charlotte  
 Greensboro  
 Winston-Salem

 Charlottesville  
 Raleigh

You have had a positive urine pregnancy test and we have done an ultrasound to find out how many weeks pregnant you are. The pregnancy was not seen inside your uterus.

#### Why couldn't the doctor or nurse see the pregnancy?

- You could have a very early pregnancy that is too early to see with our ultrasound. This is the most common reason (75-80% of the time).
- You could be pregnant but may be having a miscarriage. This happens in about 10-20% of pregnancies.
- You could have an ectopic pregnancy, where the pregnancy is outside of the uterus (usually in the tube). This happens in 1-2% of pregnancies. The tube can burst when it is stretched too much by the growing pregnancy. This can cause bleeding, which very rarely can lead to death.
- The pregnancy test could be wrong, and you are not pregnant. This is rare and happens less than 1% of the time.

#### What happens next?

##### Will I need more tests?

More tests may be needed to find out why the pregnancy cannot be seen. These tests are important because an ectopic pregnancy can be life threatening, so we want to find out if that could be happening. More tests may include

- two blood tests 48-72 hours apart.
- returning to the clinic for a repeat ultrasound.
- a different type of ultrasound done outside of Planned Parenthood to get more information about your pregnancy.
- seeing a doctor outside of Planned Parenthood for more tests and/or treatment.

##### Is abortion an option at this time?

Yes. Even though no pregnancy was seen on ultrasound, it is still an option to use the abortion pill or have in an in-clinic abortion. The follow-up tests you may need will depend on what type of abortion you have.

#### Call us right away if you have

- pain in your lower belly, especially if sudden and severe or on one side.
- shoulder pain.
- weakness, dizziness or fainting.
- bleeding from the vagina.
- low back pain.



Planned Parenthood South Atlantic

 Asheville  
 Columbia  
 Roanoke

 Chapel Hill  
 Durham  
 Vienna

 Charleston  
 Fayetteville  
 Wilmington

 Charlotte  
 Greensboro  
 Winston-Salem

 Charlottesville  
 Raleigh

### What is an ectopic pregnancy?

An ectopic pregnancy is a pregnancy outside of the uterus (usually in the tube). The tube can burst when it is stretched too much by the growing pregnancy. This can cause bleeding, which very rarely can lead to death.

A pregnancy will not survive if it's ectopic.

### What causes an ectopic pregnancy?

We do not always know the cause, but it is more common in people who

- have scarring of the tubes from infection or surgery.
- have had an ectopic pregnancy in the past.
- become pregnant while using an intrauterine contraceptive device (IUD).

It may also be more likely if you

- are 35 years or older.
- smoke cigarettes.
- have a history of infertility or use fertility treatments.

### What are the symptoms of ectopic pregnancy?

Early on, an ectopic pregnancy can have the symptoms of normal pregnancy, like a missed period, nausea, and breast tenderness. There can also be other early symptoms such as

- bleeding from the vagina (may be heavy or light).
- lower belly pain, especially on one side.
- low back pain.

More serious symptoms may include

- sudden, severe belly pain that does not go away.
- shoulder pain.
- dizziness or fainting.

### How do I know if I have an ectopic pregnancy?

Getting checked by a doctor or nurse is the only way to know for sure if you have an ectopic pregnancy. They may do a pelvic exam, blood tests, and/or an ultrasound to find out.

### How is ectopic pregnancy treated?

Sometimes medication can be given to try to end the pregnancy. Other times, surgery will be needed.

### Call us right away if you have

- pain in your lower belly, especially if sudden and severe or on one side
- shoulder pain
- weakness, dizziness or fainting
- bleeding from the vagina
- low back pain

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

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

**[PROPOSED] ORDER GRANTING PLAINTIFFS’ AMENDED MOTION FOR  
PRELIMINARY INJUNCTION**

Plaintiffs Planned Parenthood South Atlantic (“PPSAT”) and Dr. Beverly Gray, M.D. (together, “Plaintiffs”) have moved pursuant to Federal Rule of Civil Procedure 65 and Local Rule 65.1 for a preliminary injunction enjoining enforcement of two components of North Carolina Session Law 2023-14 (“S.B. 20,” *see* DE 1-1) (codified as amended by Session Law 2023-65 (“H.B. 190,” *see* DE 26-1) at N.C. Gen. Stat. art. 1I, ch. 90 (entitled “Abortion Laws,” here referred to as the “Act”). Specifically, Plaintiffs seek preliminary injunctive relief against (i) N.C. Gen. Stat. §§ 90-21.81B(3), -(4), 90-21.82A(c), 131E-153.1 (the “Hospitalization Requirement”); and (ii) *id.* § 90-21.83B(a)(7) (the “IUP Documentation Requirement”).

The Court entered a temporary restraining order enjoining enforcement of the IUP Documentation Requirement, DE 31 (TRO) at 6–9, and, by consent of the parties, extended that restraining order up to the date of this ruling. DE 35 (Consent Order Extending TRO); DE 37 (Scheduling Order). The effective date of the Hospitalization Requirement is October 1, 2023. *See* DE 30 (Joint Stipulation) at 2; DE 31 (TRO) at 9. A hearing on Plaintiffs’ Amended Motion for a Preliminary Injunction (DE 48) was held on September 25, 2023.

After review of the briefing and supporting evidence submitted by all parties, as well as oral argument, this Court will grant Plaintiffs’ Amended Motion for a Preliminary Injunction as to both of the challenged requirements.<sup>1</sup>

## **BACKGROUND**

Until July 1, 2023, abortion was broadly lawful in North Carolina before 20 weeks of pregnancy and was routinely provided at licensed outpatient abortion clinics such as PPSAT’s up to the legal gestational limit. Now, under the Act, it is “unlawful after the twelfth week of a woman’s pregnancy to procure or cause a miscarriage or abortion in the

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<sup>1</sup> “When a party moves for a preliminary injunction, . . . it invites the district court to act as the finder of fact on a limited record.” *Speech First, Inc. v. Sands*, 69 F.4th 184, 190 (4th Cir. 2023). The Court notes that, “[b]ecause preliminary injunction proceedings are informal ones designed to prevent irreparable harm before a later trial governed by the full rigor of usual evidentiary standards, district courts may look to, and indeed in appropriate circumstances rely on, hearsay or other inadmissible evidence when deciding whether a preliminary injunction is warranted.” *G.G. ex rel. Grimm v. Gloucester Cnty. Sch. Bd.*, 822 F.3d 709, 725–26 (4th Cir. 2016), *vacated and remanded on other grounds*, *Gloucester Cnty. Sch. Bd. v. G. G. ex rel. Grimm*, 137 S. Ct. 1239 (2017). The declarations and deposition testimony in this case include facts and expert opinions. At this stage in the case, the Court need not rule on which facts and opinions are admissible.

State of North Carolina.” N.C. Gen. Stat. § 90-21.81A (the “Twelve-Week Ban”). While the Act creates exceptions to the Twelve-Week Ban in cases of rape, incest, or life-limiting anomalies, the Hospitalization Requirement—if it takes effect on October 1, 2023—will mandate that abortions provided after the twelfth week of pregnancy occur in a hospital. *Id.* §§ 90-21.81B(3), 90-21.81B(4), 90-21.82A(c). As to early medication abortion, the IUP Documentation Requirement states that physicians must “[d]ocument in the woman’s medical chart the . . . existence of an intrauterine pregnancy.” *Id.* § 90-21.83B(a)(7).

Providing an abortion that does not fit within the Act’s 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). Additionally, a physician who violates the Act is subject to discipline by the North Carolina Medical Board, and any other licensed health care provider who violates the Act is subject to discipline by their respective licensing agency or board. *Id.* § 90-21.88A.

## **I. The Hospitalization Requirement**

Three methods of abortion are provided in outpatient clinics in North Carolina: medication abortion, aspiration abortion, and dilation and evacuation (“D&E”). First Decl. of Katherine Farris, M.D., in Supp. of Pls.’ Am. Mot. for a Prelim. Inj. (“First Farris Decl.”) DE 49-1 ¶ 14. Medication abortion typically involves two prescription drugs: mifepristone, which blocks progesterone, a hormone necessary to maintain a pregnancy, and misoprostol, which causes the cervix to open and the uterus to contract and empty its contents. *Id.* ¶ 17. Aspiration abortion (also known as dilation & curettage (“D&C”)) entails using suction to empty the uterus. *Id.* ¶ 21. D&E uses a combination of suction and additional instruments



to empty the uterus. *Id.* ¶ 25. All of these abortion methods require no incisions and typically take no more than fifteen minutes to perform. *Id.* ¶ 14. In the outpatient setting generally and at PPSAT specifically, local, mild, or moderate sedation might be used for these procedures, but deep sedation and general anesthesia are not. First Farris Decl., DE 49-1 ¶¶ 22, 26, 72; Dep. of Katherine A. Farris (“Farris Dep.”), Pls.’ Supp. Br. Ex. 2, 88:9–25. The types of sedation offered by PPSAT are safely provided in the outpatient setting. Dep. of Dr. Susan Bane (“Bane Dep.”), Pls.’ Supp. Br. Ex. 4, 106:18–107:3, 107:15–18.

The evidence conclusively demonstrates that abortion is safe, including in outpatient clinics—safer than other medical procedures that are routinely performed outside of hospital settings in North Carolina, including vasectomies, colonoscopies, wisdom tooth extractions, and tonsillectomies. First Farris Decl., DE 49-1 ¶ 32. A study relied upon by both of Intervenor-Defendants’ experts describes abortion as “generally safe.” Decl. of Monique Chireau Wubbenhorst, M.D., M.P.H. (“Wubbenhorst Decl.”), DE 65-1 ¶¶ 32–35; Decl. of Susan Bane, M.D., Ph.D (“Bane Decl.”), DE 65-3 ¶ 35; Bane Dep. 72:15–20. Another 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. First Farris Decl., DE 49-1 ¶ 38 & n.30; *see also* Dep. of Dr. Monique Wubbenhorst (“Wubbenhorst Dep.”), Pls.’ Supp. Br. Ex. 3, 131:22–132:1 (study cited by Dr. Wubbenhorst concluded that D&Es performed in non-hospital settings had lower death rates than those performed in hospitals). PPSAT has safely provided abortions in its licensed outpatient clinics past the twelfth week of pregnancy for

more than fifteen years in North Carolina. First Farris Decl., DE 49-1 ¶ 12; Farris Dep. 75:4–6.

Abortion is approximately twelve to fourteen times safer than live birth. First Farris Decl., DE 49-1 ¶ 34. Hospitalization is not required for childbirth under North Carolina law, as the Act itself recognizes. 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”). North Carolina law also does not require hospitalization for miscarriage management after the twelfth week of pregnancy, and many of the procedures used for miscarriage management are clinically identical to the procedures used for abortion. *See* First Farris Decl., DE 49-1 ¶ 41; Bane Dep. 28:12–17 (medication used for miscarriage management), Bane Dep. 29:18–20 (D&Cs used for miscarriage management); Wubbenhorst Dep. 114:19–21 (same).

Complications from abortion are extremely rare, and the vast majority are easily treatable in outpatient facilities. PPSAT performed 38,795 abortions in North Carolina between January 1, 2020 and June 30, 2023; only 522 complications resulted, most of which were minor. Rebuttal Decl. of Katherine Farris, M.D. in Supp. of Pls.’ Am. Mot. for a Prelim. Inj. (“Farris Rebuttal Decl.”) DE 69-2 ¶ 8; Bates 0106, Pls.’ Supp. Br. Ex. 13. Major abortion complications, defined as those requiring hospital admission, surgery, or blood transfusion, occur in just 0.23% of abortions. First Farris Decl., DE 49-1 ¶ 31. PPSAT’s transfer rate is lower than that rate; it transferred 0.08% of its 38,795 North Carolina abortion patients to hospitals in three and a half years. Farris Rebuttal Decl., DE

69-2 ¶ 8; Bates 0051–0052, Pls.’ Supp. Br. Ex. 12; Bates 0106; Bates 0107, Pls.’ Supp. Br. Ex. 14. All were released in stable condition, and only 7 out of the 31 patients transferred were admitted. Farris Rebuttal Decl., DE 69-2 ¶ 8; Bates 0051–0052; Bates 0106; Bates 0107. PPSAT has relationships with hospitals near its clinics and emergency management protocols for the rare event that hospital transfer is needed. Farris Rebuttal Decl., DE 69-2 ¶ 8.

Specifically, hemorrhage, infection of the uterine lining, cervical lacerations, and uterine perforation are rare and can all be treated in outpatient facilities. *See* Farris Rebuttal Decl., DE 69-2 ¶¶ 5–7; Farris Dep. 65:2–8; Dep. of Christy Marie Boraas Alsleben, MD (“Boraas Dep.”), Pls.’ Supp. Br. Ex. 1, 170:17–171:15, 171:21–173:7; *accord* Bane Dep. 94:18–95:1 (discussing outpatient treatment of endometritis), 104:20–23 (discussing outpatient treatment of cervical lacerations). The same complications can also arise during miscarriage management and childbirth, and indeed are more likely to occur during childbirth than during abortion. *E.g.* First Farris Decl., DE 49-1 ¶ 33; Boraas Dep. 92:3–10 (pulmonary embolism “is extremely rare after a person has an induced abortion. It is much more common and likely after giving birth”); 173:8–175:5 (“Hemorrhage requiring a blood transfusion is much more likely at the time of giving birth either vaginally or by a cesarean section than it would be for a person accessing induced abortion.”); *accord* Bane Dep. 26:5–9 (explaining that risks of miscarriage management include hemorrhage; infection; uterine perforation; and even death); *see also id.* at 94:4–13; 100:5–16; 101:16–23; 103:17–21 (testifying that “usually childbirth” is where cervical lacerations occur).

## II. The IUP Documentation Requirement

There are five categories that physicians use when evaluating an early pregnancy via ultrasound: definite intrauterine pregnancy, probable intrauterine pregnancy, probable ectopic pregnancy (i.e., a pregnancy that has implanted outside of the uterus), definite ectopic pregnancy, and pregnancy of unknown location. Farris Dep. 102:22–103:6; Boraas Dep. 127:6–16. In the earliest weeks of pregnancy—up to approximately the fifth or sixth week of pregnancy, as dated from the first day of the patient’s last menstrual period—pregnancy tissue may not yet be seen even by transvaginal ultrasound. Patients in this situation, who have positive pregnancy tests but no pregnancy tissue visible on an ultrasound, are categorized as having pregnancies of unknown location. First Farris Decl., DE 49-1 ¶ 9. 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 these patients who are very early in their pregnancies.<sup>2</sup>

Intervenors defend their interpretation of the IUP Documentation Requirement by stating that mifepristone is “contraindicated” for ectopic pregnancies. While mifepristone is contraindicated for suspected or confirmed ectopic pregnancy, the contraindication

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<sup>2</sup> While it is unclear on the face of the statute whether the IUP Documentation Requirement actually requires visual confirmation of an IUP by ultrasound, *see infra* Analysis Section I.B.i, intervenors take the position that visual confirmation by ultrasound is required to comply with the requirement. *See* Def.-Intervenors’ Resp. in Opp. to Pls.’ Am. Mot. for Prelim. Inj. (“Int. Resp.”) DE 65 at 20.

exists not because mifepristone harms patients with ectopic pregnancies but because mifepristone does not treat ectopic pregnancy. Rebuttal Decl. of Christy M. Boraas Alsleben, M.D., M.P.H. in Supp. of Pls.’ Am. Mot. for a Prelim. Inj. (“Boraas Rebuttal Decl.”) DE 69-1 ¶ 50; Farris Dep. 155:11–14; Wubbenhorst Dep. 143:19–21. Mifepristone is not contraindicated for patients where ectopic pregnancy is not suspected. *See* FDA Mifeprex Label, DE 65-2 at 4; *see also* Farris Dep. 102:22–103:6, 108:2–7, 110:10–19, 162:3–14, 168:17–23; Boraas Dep. 127:6–16, 145:20–146:1.

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 1, 2023). If a pregnancy is not visible on the ultrasound, PPSAT screens the patient for risk of ectopic pregnancy by asking questions about their menstrual history, pregnancy history (including history of prior ectopic pregnancy), contraceptive history, and any symptoms they are experiencing. First Farris Decl., DE 49-1 ¶ 52; Farris Rebuttal Decl., DE 69-2 ¶ 12; Farris Dep. 137:9–15, 86:6–8; 111:4–11, 162:15–163:13. If PPSAT determines that the patient is at high risk of ectopic pregnancy, the patient is not eligible for an abortion at that time and is immediately referred to another provider, typically an emergency department, for diagnosis and treatment. First Farris Decl., DE 49-1 ¶ 52; Farris Dep. 107:3–8, 109:14–21, 110:5–9, 163:8–17.

If the patient is *not* at high risk of ectopic pregnancy, the provider offers the patient three options: medication abortion, aspiration abortion, or a follow-up appointment to see if an intrauterine pregnancy can be seen on an ultrasound at a later date. First Farris Decl.,

DE 49-1 ¶ 53; Farris Dep. 163:18–164:8. If a low-risk patient chooses medication abortion, PPSAT simultaneously provides the medication abortion and conducts further testing to rule out ectopic pregnancy, the first step of which is drawing a blood sample to test the level of the pregnancy hormone human chorionic gonadotropin (“hCG”). First Farris Decl., DE 49-1 ¶ 54; Farris Dep. 164:9–24.

If a patient’s initial blood test results indicate that their hCG levels are sufficiently high, PPSAT considers this evidence of potential ectopic pregnancy and provides further evaluation and treatment accordingly, including potential referral to an emergency department, even though the patient has already taken the abortion medications. First Farris Decl., DE 49-1 ¶ 55. If the hCG levels are not high, the patient’s hCG levels are tested again 48-72 hours after taking the misoprostol. *Id.* ¶ 56. If the pregnancy hormone levels have dropped following the medication abortion, this is evidence that the abortion is complete. *Id.* ¶ 57. But if the patient’s hormone levels remain high or have increased even after the patient has taken the abortion medications, this is evidence that no abortion has occurred and PPSAT conducts further evaluation for ectopic pregnancy, including referral as medically indicated. *Id.* ¶ 57.

All patients treated using this protocol are educated on signs and symptoms of both medication abortion and ectopic rupture—which both parties’ experts agree are typically distinguishable<sup>3</sup>—and they are warned both verbally and in writing that untreated ectopic

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<sup>3</sup> Generally speaking, patients experiencing ectopic rupture feel sharp pain that is often located on one side of the lower abdomen, as opposed to the more general cramping that miscarriage and medication abortion patients experience; additionally, patients typically

pregnancy could result in death. Farris Rebuttal Decl., DE 69-2 ¶ 12; Bates 0119–0120, Pls.’ Supp. Br. Ex. 15.

PPSAT’s protocol is evidence-based and has been shown to be safe and effective. *See* Decl. of Christy M. Boraas Alsleben, M.D., M.P.H. in Supp. of Pls.’ Am. Mot. for a Prelim. Inj. (“First Boraas Decl.”) DE 49-2 ¶¶ 44–47. One study found that this protocol leads to earlier exclusion of ectopic pregnancy than waiting to see whether an intrauterine pregnancy can be diagnosed. *Id.* ¶ 46 & n.23; Boraas Rebuttal Decl., DE 69-1 ¶ 49 & n.61. Intervenor-Defendants’ experts agree that ectopic screening protocols that use ultrasounds, medical histories, and serial hCG testing are appropriate. Bane Dep. 117:22–118:25, 143:4–11; Wubbenhorst Dep. 143:22–25. Dr. Bane testified that if a patient presented with a positive pregnancy test but had no symptoms, she would wait until six to seven weeks of pregnancy to do an ultrasound and would not refer a stable patient to the ER, even if they had minor complaints such as “abdominal pain or some bleeding.” Bane Dep. 117:22–118:25.

## ANALYSIS

A preliminary injunction is warranted upon a showing that: “(1) the party is likely to succeed on the merits of the claim; (2) the party is likely to suffer irreparable harm in the absence of an injunction; (3) the balance of hardships weighs in the party’s favor; and

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have less vaginal bleeding during ectopic rupture than they do during miscarriage or medication abortion. Boraas Rebuttal Decl., DE 69-1 ¶ 53; Wubbenhorst Dep. 182:16–25; Bane Dep. 120:3–5, 120:17.

(4) the injunction serves the public interest.” *HIAS, Inc. v. Trump*, 985 F.3d 309, 318 (4th Cir. 2021). Plaintiffs have met their burden on each of these four factors.

## **I. Likelihood of Success on the Merits**

### **A. The Hospitalization Requirement**

Plaintiffs argue that the Hospitalization Requirement violates the Fourteenth Amendment’s Due Process and Equal Protection Clauses. They argue that for abortions permitted after the twelfth week of pregnancy under the Act—namely abortions in cases of rape, incest, or life-limiting anomaly—there is no rational basis for restricting access to abortion by requiring that these abortions be performed in a hospital. The Court agrees.

Under *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228 (2022), there is no longer a fundamental right to abortion under the substantive due process component of the Fourteenth Amendment. Therefore, this Court applies rational basis review to Plaintiffs’ due process challenge, as it would to a restriction on any other medical procedure. *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.”).

With respect to equal protection, Plaintiffs argue that the Act singles out for unequal treatment physicians who provide, and patients who seek, abortion in outpatient settings after the twelfth week of pregnancy because of rape, incest, or life-limiting anomaly, compared to those who provide or seek medical procedures of equal or greater risk, including miscarriage management at the same gestational age. Because Plaintiffs do not allege that the Act discriminates against a protected class, the Court applies rational basis



review to this claim as well. *See Wilkins v. Gaddy*, 734 F.3d 344, 347 (4th Cir. 2013) (“[U]nless a statute affects a fundamental right or some protected class, courts generally accord the legislation a ‘strong presumption of validity’ by applying a rational basis standard of review.” (quoting *Heller v. Doe*, 509 U.S. 312, 319 (1993))).

The rational basis standard is “quite deferential,” and a statute passes constitutional muster if it is, “at a minimum, rationally related to legitimate governmental goals.” *Wilkins*, 734 F.3d at 347, 348; *see also Dobbs*, 142 S. Ct. at 2284 (holding abortion restrictions “must be sustained if there is a rational basis on which the legislature could have thought it would serve legitimate state interests.”). In engaging in the rational basis inquiry, the Court need not determine whether the interest proffered by the government is the “actual reason” for the legislation. *McDaniels v. U.S.*, 300 F.3d 407, 412 n.2 (4th Cir. 2002); *see also U.S. R.R. Ret. Bd. v. Fritz*, 449 U.S. 166, 179 (1980).

However, the rational basis standard is “not a toothless one.” *Mathews v. Lucas*, 427 U.S. 495, 510 (1976). A “bare [legislative] desire to harm a politically unpopular group cannot constitute a legitimate governmental interest.” *U.S. Dep’t of Agric. v. Moreno*, 413 U.S. 528, 534 (1973). And courts engaged in rational basis review may and should “consider plaintiffs’ extrinsic evidence” and conduct fact-finding to determine the realities underlying the challenged regulation and the proffered justification. *Trump v. Haw.*, 138 S. Ct. 2392, 2420 (2018); *see also U.S. v. Carolene Prods. Co.*, 304 U.S. 144, 153 (1938) (“Where the existence of a rational basis for legislation whose constitutionality is attacked depends upon facts beyond the sphere of judicial notice, such facts may properly be made

the subject of judicial inquiry.”); *see also Planned Parenthood of Ind. & Ky., Inc. v. Comm’r, Ind. Dep’t of Health*, 64 F. Supp. 3d 1235, 1257 (S.D. Ind. 2014) (“[Supreme Court precedent] does not . . . authorize the unequal treatment of those providing the exact same procedure, without a rational basis, and equal protection demands otherwise.”).

The Court therefore turns to the question of whether, based on the facts presented by the parties, the Hospitalization Requirement is rationally related to the governmental interest in patient safety. Intervenor-Defendants argue that hospitals are better equipped to address complications that may arise from procedural abortions, which include hemorrhage, infection, cervical laceration, uterine perforation, sepsis, and death, and that the Hospitalization Requirement therefore furthers patient safety. While furthering patient safety is certainly a legitimate governmental interest, the operative inquiry here is not whether there are differences between outpatient clinics and hospitals, but whether the differences matter for purposes of providing abortion safely after the twelfth week of pregnancy. Reply in Supp. of Pls.’ Am. Mot. for Prelim. Inj. (“Pl. Reply”), DE 69 at 4; *see 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, 341 (W.D.N.C. 2021). The Court concludes that they do not.

Plaintiffs have presented evidence that procedural abortion is as safe as or safer than a broad range of other medical procedures routinely performed in outpatient settings, including other gynecological procedures like endometrial biopsy and hysteroscopy. First Farris Decl., DE 49-1 ¶¶ 32, 40. And abortion procedures after twelve weeks—both

aspiration and D&E—are nearly identical to procedures for managing miscarriage at the same gestational age, which can be provided in outpatient settings. *Id.* ¶¶ 24, 28, 40. In fact, Intervenor-Defendants’ expert Dr. Bane conceded that the complications from miscarriage procedures are extremely similar to those for abortion procedures. Bane Dep. 26:5–9.

Plaintiffs have also introduced evidence that complications from procedural abortion are rare and can nearly always be managed at outpatient clinics, with no need for hospitalization. First Farris Decl., DE 49-1 ¶ 41. Serious complications requiring hospitalization occur in 0.23% of all abortions performed in outpatient settings, and the PPSAT-specific rate is even lower; when such complications occur, PPSAT has established procedures to ensure patients are safely transferred to a hospital. *Id.* ¶¶ 31, 43; Farris Rebuttal Decl., DE 69-2 ¶ 8. The risk of death is lower still; the mortality rate for legal abortions—the vast majority of which are not provided in hospitals—is 0.43 per 100,000 procedures, making abortion at least twelve times safer than childbirth. First Farris Decl., DE 49-1 ¶ 34.

The Court finds persuasive Plaintiffs’ evidence that procedural abortion after twelve weeks is as safe as or safer than medical procedures routinely performed in outpatient environments, that it is nearly identical in risk and technique to miscarriage care, that complications requiring hospitalization are extremely rare, and that PPSAT safely transfers patients to hospitals in such cases. While Intervenor-Defendants have offered competing evidence, *see, e.g.*, Bane Decl., DE 65-3 ¶¶ 31-41, the sources they rely on do not show

causal links between abortion and increased mortality, and some actually affirm the finding that abortion is safe. *See* Bane Dep. 67:4–9 (causation cannot be established with abortion studies), 72:15–20 (conceding that study cited by Intervenor-Defendants’ experts found that abortion is “generally safe”), 61:25–62:4 (conceding that cited study found extremely low death rates for legally induced abortions). The Court is also concerned by the bias expressed by Intervenor-Defendants’ experts.<sup>4</sup> *See Underwood v. Elkay Min, Inc.*, 105 F.3d 946, 951 (4th Cir. 1997), *superseded on other grounds by Mountaineer Coal Dev. Co., Inc. v. Dingess*, 538 F. App’x 367 (4th Cir. 2013) (in considering expert opinions, courts should examine “the qualifications of the experts, the opinions’ reasoning, their reliance on objectively determinable symptoms and established science, their detail of analysis, and their freedom from irrelevant distractions and prejudices”). The Court therefore credits Plaintiffs’ experts’ testimony, which is supported by the National Academies of Sciences, Engineering, and Medicine, as well as major medical associations including the American College of Obstetricians and Gynecologists (“ACOG”) and the American Public Health

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<sup>4</sup> Dr. Wubbenhorst opposes abortion in all circumstances, including in cases of rape or incest (the circumstances under which the Hospitalization Requirement applies); she believes that doctors who provide abortion are committing murder; and she believes that “all” abortions, even those with no medical complications, cause harm to women. Wubbenhorst Dep. 31:2–5, 31:23–32:4, 31:20–22, 33:24–35:9. Dr. Bane referred to herself as a “pro-life advocate,” repeatedly described abortion as the “direct and intentional killing of a human being,” and dramatically minimized the health risks of childbirth by saying that people “rarely” struggle with anxiety and depression after giving birth. Bane Dep. 84:18–19, 13:1–2, 40:15–16, 79:22–80:1.

Association, which have all made clear that hospitalization requirements for abortion lack any scientific or medical basis. First Farris Decl., DE 49-1 ¶ 37.<sup>5</sup>

Plaintiffs have also introduced evidence that D&E procedures in a dedicated outpatient abortion facility can in fact be *safer* than the same procedures provided in a hospital and that fewer complications from abortion are seen in outpatient clinics that routinely provide abortions than in hospitals, many of which do not routinely provide abortion. *Id.* ¶¶ 38, 74. Intervenor-Defendants state that Dr. Farris cites a news article and not a scientific research paper for these points, but Dr. Farris does in fact cite a research paper for the conclusion that “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.” *Id.* ¶ 38 & n.30 (citing David K. Turok et al., *Second Trimester Termination of Pregnancy: A Review by Site and Procedure Type*, 77 *Contraception* 155, 155 (2008)). More to the point, Intervenor-Defendants do not offer any evidence to the contrary. In fact, Dr. Wubbenhorst admitted that a study she cited concluded that D&Es performed in nonhospital settings had *lower* death-to-case rates than those performed in hospitals. Wubbenhorst Dep. 131:22–132:1. The Court credits Dr. Farris’s testimony on this point.

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<sup>5</sup> Intervenor-Defendants correctly argue that the State is not required to defer to the policy choices of professional organizations. But the Court finds that the opinions of medical associations are relevant to the question of whether hospitalization requirements actually further patient safety. The Court further notes that Intervenor-Defendants’ experts relied on ACOG publications in their declarations. *See, e.g.*, Wubbenhorst Decl., DE 65-1 ¶ 105, Bane Decl., DE 65-3 ¶¶ 56–68.

Further, the Hospitalization Requirement applies *only* to survivors of rape or incest and patients with life-limiting fetal diagnoses. It therefore makes accessing abortion harder for people whose pregnancies are causing them immense hardship. As Plaintiffs' experts testified, survivors of sexual violence are often dealing with trauma, and specialized outpatient clinics can be better equipped to serve such patients. First Farris Decl., DE 49-1 ¶¶ 65–67, 75; First Boraas Decl., DE 49-2 ¶ 36. They also may be better equipped to serve patients with fetal anomalies, which are often diagnosed after twelve weeks of pregnancy; indeed, hospital providers in North Carolina sometimes refer patients with fetal anomalies to PPSAT. First Farris Decl., DE 49-1 ¶¶ 8, 46, 68.

Finally, Plaintiffs have introduced evidence that requiring hospitalization creates additional burdens for patients and usually delays patient care. First Farris Decl., DE 49-1 ¶¶ 70–72; Farris Dep. 162:4–14. Both sides' experts agree that the risks associated with abortion increase as gestation progresses. Boraas Rebuttal Decl., DE 69-1 ¶ 19; Wubbenhorst Decl., DE 65-1 ¶ 38; Bane Decl., DE 65-3 ¶ 35. Faced with the difficult circumstances of rape, incest, or fetal anomaly, a patient's pain and suffering may be prolonged and increased by a delay accessing an abortion they have already chosen. Increased delay is detrimental to patients' health and safety. Farris Dep. 164:25–165:10 (requiring hospitalization undermines safety because it usually delays patient care and the risk of abortion increases with gestational age, though abortion is very safe overall).

In summary, based on the evidence in this case, the Court finds that procedural abortions after the twelfth week of pregnancy are as safe as or safer than other procedures

provided in outpatient settings, including miscarriage management, which involve nearly identical risks; that leading medical associations have concluded that there is *no* safety rationale for hospitalization requirements, including in the second trimester; and that procedural abortions at outpatient clinics may in fact be safer and more patient-friendly than those at hospitals. Thus, the Court concludes that Plaintiffs have shown they are likely to succeed on their claim that the Hospitalization Requirement is not rationally related to the State's legitimate interest in patient safety. The mere fact that, like any other medical procedure, a small number of complications requiring hospitalization will occur is not sufficient to establish this rational relationship, absent a showing that performing the procedure itself in a hospital actually promotes safety. *See, e.g., 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).

Finally, although Intervenor-Defendants do not offer any other interest to support the Hospitalization Requirement, they attempt to rely on *Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000). In that case, the Fourth Circuit held that it is rational to "distinguish[] between abortion services and other medical services when regulating physicians or women's healthcare." *Id.* at 173. But the *Greenville* court relied on "the State's interest in protecting prenatal life" for its holding, *id.*, and Intervenor-Defendants do not argue that the Hospitalization Requirement promotes this interest. Nor could they, since the General Assembly has already determined that abortions after the twelfth week of pregnancy in cases of rape or incest or upon diagnosis of a life-limiting anomaly are

permissible. *See* N.C. Gen. Stat. §§ 90-21.81B(3)–(4). The Hospitalization Requirement merely governs the clinical setting for legal abortions.

Although “[a]bortion may well be a special case” in some regards, “it cannot be 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). *Greenville* does not abrogate the requirement that an abortion regulation must be rationally related to a legitimate governmental interest to pass constitutional muster. The Hospitalization Requirement should be preliminarily enjoined because it fails this test.

## **B. The IUP Documentation Requirement**

### *i. Vagueness*

Plaintiffs argue that the Act is unconstitutionally vague because it fails to provide notice as to when medication abortion is lawful for pregnancies of unknown location. “To survive a vagueness challenge, a statute must give a person of ordinary intelligence adequate notice of what conduct is prohibited and must include sufficient standards to prevent arbitrary and discriminatory enforcement.” *Manning v. Caldwell for City of Roanoke*, 930 F.3d 264, 272 (4th Cir. 2019) (en banc). For statutes that, like the IUP Documentation Requirement, may carry the threat of criminal penalties, a stricter standard applies. *See id.* (“Less clarity is required in purely civil statutes . . .”).<sup>6</sup> And even if

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<sup>6</sup> Intervenor-Defendants’ argument that the scienter requirements of the criminal prohibitions ameliorate the vagueness concerns is not persuasive. They fail to explain how the scienter requirements for the fetal homicide and unlawful abortion statutes resolves the conflict in the IUP Documentation Requirement. *See* Pl. Reply, DE 69 at 8.



criminal penalties do not apply, failing to comply with the intrauterine documentation requirement subjects the physician to professional discipline, thus warranting, at a minimum, a relatively strict standard. *Id.* at 273 (noting a “relatively strict test” applies to quasi-criminal laws that have stigmatizing effects).

As interpreted by Intervenor-Defendants, the Act is self-contradictory. On one hand, it provides that medication abortion is lawful up to twelve weeks of pregnancy. On the other, it requires physicians to “[d]ocument in the woman’s medical chart the . . . existence of an intrauterine pregnancy,” N.C. Gen. Stat. § 90-21.83B(a)(7). Intervenor-Defendants take the position that visual confirmation by ultrasound is required to comply with this requirement, DE 65 at 20, but the evidence in this case supports the conclusion that intrauterine pregnancy cannot be visually confirmed in the early weeks of pregnancy, when an intrauterine embryo cannot always be detected by ultrasound. *See* First Farris Decl., DE 49-1 ¶ 49; First Boraas Decl., DE 49-2 ¶ 41; Bane Dep. 108:14–15. Intervenor-Defendants’ interpretation would therefore mean that medication abortion is banned in the earliest weeks of pregnancy, despite the Act’s clear intent that abortion remain lawful in North Carolina until after the twelfth week of pregnancy.

On its face, the Act fails to give Plaintiffs notice as to whether they can provide medication abortion before an intrauterine pregnancy can be seen on an ultrasound. Thus, it “fails to provide any standard of conduct by which persons can determine whether they are violating the statute” and “invite[s] arbitrary enforcement.” *Manning*, 930 F.3d at 274, 276. It is, therefore, impermissibly vague. However, to avoid this constitutional infirmity

and internal contradiction within the Act itself, this Court will construe the IUP Documentation Requirement to require that a physician document *whether* an intrauterine pregnancy is visible by ultrasound—but even if an intrauterine pregnancy is not yet visible, they may still perform a medication abortion through twelve weeks of pregnancy. So construed, the IUP Documentation Requirement does not contradict the provision of the Act that permits medication abortion through the twelfth week of pregnancy.

*ii. Substantive Due Process*

To the extent that the IUP Documentation Requirement prohibits providing medication abortion to patients with pregnancies of unknown location, Plaintiffs also argue that it violates substantive due process because it does not satisfy the rational basis standard. Intervenor-Defendants argue that the IUP Documentation Requirement is rationally related to the State’s interest in the protection of maternal health by “ensuring that physicians do not prescribe chemical abortion drugs to a woman suffering from an ectopic pregnancy.” DE 65 at 21. The Court agrees that this is a legitimate governmental interest and turns to the question of whether the IUP Documentation Requirement is rationally related to that interest.

Plaintiffs have presented evidence that for patients with pregnancies of unknown location who are deemed to be at low risk of ectopic pregnancy, providing medication abortion while *simultaneously* using additional testing to rule out ectopic pregnancy is safe, based both on published research and PPSAT’s experience. *See supra* Background, Part II. Drs. Bane and Wubbenhorst conceded that ectopic screening protocols that use

ultrasounds, medical histories, and serial hCG testing are appropriate. Bane Dep. 117:22–118:25, 143:4–11; Wubbenhorst Dep. 143:22–25. Dr. Bane agreed that patients with pregnancies of unknown location in stable condition do not immediately need to be referred to the emergency room, even those with minor complaints such as “abdominal pain or some bleeding,” Bane Dep. 117:22–118:25—and of course, the IUP Documentation Requirement itself does not require such referral. Further, both Drs. Wubbenhorst and Bane testified that they believed that PPSAT does not require an ultrasound in every case, demonstrating a lack of understanding of both North Carolina law and PPSAT’s protocols. *Id.* at 112:5–8; Wubbenhorst Dep. at 145:2–7. The Court therefore credits Plaintiffs’ experts’ testimony that PPSAT’s protocols are safe and evidence-based.

Plaintiffs have introduced evidence that waiting to provide medication abortion until an intrauterine pregnancy is visible by ultrasound does not lead to earlier or more accurate diagnosis of ectopic pregnancy than providing a medication abortion and concurrently testing for ectopic pregnancy, but rather leads only to delay. First Farris Decl., DE 49-1 ¶ 59; First Boraas Decl., DE 49-2 ¶ 50. One study relied on by Plaintiffs’ experts found that providing a medication abortion simultaneously with screening for an ectopic pregnancy led to *faster* detection of ectopic pregnancies than waiting until an intrauterine pregnancy is visible. First Boraas Decl., DE 49-2 ¶ 46; Boraas Rebuttal Decl., DE 69-1 ¶ 49. Plaintiffs have also introduced evidence that many patients prefer medication abortion to procedural abortion for a variety of reasons, and PPSAT’s protocol allows them to receive their desired method of care in a timely manner—which patients are generally anxious to do, particularly

when state law will prevent them from obtaining an abortion after the twelfth week of pregnancy. First Farris Decl., DE 49-1 ¶ 19; First Boraas Decl., DE 49-2 ¶ 43; Boraas Dep. 167:19–168:3; Farris Dep. 148:14–149:11, 152:24–153:11. Additionally, denying Plaintiffs the ability to provide medication abortion to patients with pregnancies of unknown location would not necessarily lead to any patient seeking screening for a potential ectopic pregnancy, at PPSAT or elsewhere.

Intervenor-Defendants argue that Plaintiffs’ protocols are unsafe because mifepristone is contraindicated for ectopic pregnancy. DE 65 at 21–22. But the FDA label cited by Intervenor-Defendants actually states that mifepristone is contraindicated for patients with “*confirmed/suspected* ectopic pregnancy,” FDA Mifeprex Label, DE 65-2 at 1 (emphasis added), not for patients who have been clinically deemed low-risk for ectopic pregnancy—and low-ectopic-risk patients are the ones Plaintiffs would treat but for the IUP Documentation Requirement. *See* Farris Dep. 107:3–8, 109:14–21, 110:5–9, 163:8–17. And Dr. Wubbenhorst conceded that mifepristone is contraindicated for patients with ectopic pregnancy not because it harms them (it does not), but rather because it does not *treat* ectopic pregnancy. Wubbenhorst Dep. 143:19–21; *see also* Farris Dep. 155:11–14; Boraas Rebuttal Decl., DE 69-1 ¶ 50. Thus, merely preventing a patient with a pregnancy of unknown location from taking mifepristone is not, by itself, rationally related to advancing the safety of patients with ectopic pregnancies.<sup>7</sup>

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<sup>7</sup> Intervenor-Defendants also argue that medication abortion is generally unsafe as compared to procedural abortion and insinuate that PPSAT’s provision of medication abortion through eleven weeks’ gestation is unsafe. DE 65 at 3; Bane Decl., DE 65-3 ¶ 35;

Intervenor-Defendants also argue that a patient may mistake ectopic rupture for the bleeding and cramping associated with a medication abortion. But both sides' experts agree that the symptoms of ectopic rupture and those associated with medication abortion are typically distinguishable. Wubbenhorst Dep. 182:16–20; Bane Dep. 120:3–5, 120:17; Boraas Rebuttal Decl., DE 69-1 ¶ 53. And Plaintiffs introduced testimony and documentary evidence that PPSAT educates patients about these symptoms and encourages them to contact PPSAT immediately if they experience any. Farris Rebuttal Decl., DE 69-2 ¶ 12; Farris Dep. 125:2–9, 164:9–24; *see* Bates 0119–0120 (PPSAT patient education materials regarding pregnancy of unknown location and ectopic pregnancy).

The Court credits the testimony of Dr. Farris, who has experience providing abortions to patients with pregnancies of unknown location in North Carolina, and of Dr. Boraas, who has this experience outside of North Carolina and has also specifically researched the safety of medication abortion for patients with pregnancies of unknown location. The evidence offered in this case establishes that providing medication abortion to patients with a pregnancy of unknown location is safe, evidence-based, and may actually

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Wubbenhorst Decl., DE 65-1 ¶¶ 33–34. However, Plaintiffs persuasively refute the study that Intervenor-Defendants' experts cite concerning the relative safety of medication abortion. Boraas Rebuttal Decl., DE 69-1 ¶ 14. Nor is there any issue with Plaintiffs' provision of medication abortion through eleven weeks. The off-label usage of mifepristone has been shown to be safe at more advanced gestations than what appears on the FDA-approved label, and off-label drug prescription is common in the medical field and practiced by many physicians including Drs. Bane and Wubbenhorst. *Id.* ¶ 52; Bane Dep. 31:25–32:15; Wubbenhorst Dep. 174:15–18. Indeed, the General Assembly explicitly amended the Act to permit medication abortions at later gestational ages than what is indicated on the FDA label.

lead to earlier detection of ectopic pregnancies. Based on the evidence presented, the Court concludes that the IUP Documentation Requirement is not rationally related to the State’s interest in patient health and safety, and Plaintiffs are therefore likely to succeed on their challenge to the IUP Documentation Requirement.

## **II. Irreparable Harm**

If the Hospitalization and IUP Documentation Requirements take effect, Plaintiffs and their patients will suffer irreparable harm. Plaintiffs and their patients would be denied their constitutional rights to due process and equal protection, Verified First Am. Compl. for Declaratory & Inj. Relief (“First Am. Compl.”) DE 42 ¶¶ 82–86, which alone is sufficient to establish irreparable harm. *See Leaders of a Beautiful Struggle v. Balt. Police Dep’t*, 2 F.4th 330, 346 (4th Cir. 2021) (en banc). The provisions would also delay or prevent patients’ access to abortion, forcing some to remain pregnant against their will and to give birth without adequate prenatal, obstetric, or postpartum medical support, and interfere with Plaintiffs’ ability to practice evidence-based, patient-centered medicine. *See* First Farris Decl., DE 49-1 ¶ 81; First Am. Compl., DE 42 ¶¶ 15–16. Delaying access to care could cause additional harm to patients because the risks associated with abortion, although small, increase with gestational age. Boraas Rebuttal Decl., DE 69-1 ¶ 19; Wubbenhorst Decl., DE 65-1 ¶ 38; Bane Decl., DE 65-3 ¶ 35. The harms created by the challenged provisions would be borne especially by families with low incomes, North Carolinians of color, and rural North Carolinians, who already face inequities in access to health care. First Farris Decl., DE 49-1 ¶ 10. These are harms “that cannot be compensated

by money damages at a later trial.” *Int’l Refugee Assistance Project v. Trump*, 265 F. Supp. 3d 570, 629 (D. Md. 2017), *vacated sub nom. Trump v. Int’l Refugee Assistance Project*, 138 S. Ct 2710 (2018).

In particular, the Hospitalization Requirement would delay and deny access to urgently needed health care for some of the most vulnerable populations—survivors of sexual violence and patients with life-limiting fetal diagnoses. By preventing patients from seeking abortions in outpatient settings after the twelfth week, the Hospitalization Requirement would increase the cost of abortions, limit the number of available providers, and delay access to care. First Farris Decl., DE 49-1 ¶¶ 67, 69–71. Those harms and attendant suffering would fall particularly acutely on those who have survived sexual violence or are in abusive relationships, who may find it difficult or even impossible to escape their abuser’s control long enough to access an abortion. *Id.* ¶ 66. Moreover, physicians who primarily practice in hospital settings may be less experienced in procedural abortions, forcing patients who have abortions at hospitals to undergo induction abortions—which can be far more expensive, time-consuming, and physically arduous than the D&Es routinely provided in outpatient settings, *id.* ¶ 74—or to undergo a deeper level of sedation, even if they would have preferred to have more minimal sedation that could have been safely provided in an outpatient setting. *See id.* ¶¶ 35–36.

The IUP Documentation Requirement will also harm patients by delaying their access to abortions, unnecessarily exposing them to increased medical risk, and compelling them to consider a procedural abortion even if medication abortion may offer important

advantages over procedural abortion for them. *Id.* ¶ 19; First Am. Compl., DE 42 ¶¶ 50–52. For example, survivors of rape or other sexual abuse may choose medication abortion to feel more in control and to avoid further trauma from having instruments placed in their vaginas. First Farris Decl., DE 49-1 ¶ 19; First Am. Compl., DE 42 ¶ 50.

### **III. The Balance of the Equities and the Public Interest**

Finally, the balance of equities and public interest weigh heavily in favor of injunctive relief. Defendants are “in no way harmed by issuance of a preliminary injunction which prevents [them] from enforcing” the provisions of the Act that are “likely to be found unconstitutional.” *Newsom ex rel. Newsom v. Albemarle Cnty. Sch. Bd.*, 354 F.3d 249, 261 (4th Cir. 2003); *see also Legend Night Club v. Miller*, 637 F.3d 291, 303 (4th Cir. 2011) (recognizing that “upholding constitutional rights is in the public interest”). Nor have Intervenor-Defendants provided any evidence that any patient in North Carolina—or anywhere—with a pregnancy of unknown location has been harmed by the performance of a medication abortion. Their expert Dr. Wubbenhorst admitted that she is unaware of any early medication abortion patients who have experienced negative outcomes from an ectopic pregnancy as a result of PPSAT’s protocol. Wubbenhorst Dep. 153:18–22. Plaintiffs safely provided abortions after the twelfth week of pregnancy and to patients with pregnancies of unknown location prior to the passage of the Act. First Farris Decl., DE 49-1 ¶ 12; Farris Dep. 75:4–6.

In contrast, Plaintiffs and their patients would suffer grave harm in the absence of an injunction. *See supra* Analysis, Part II. In addition to preserving constitutional rights,



an injunction would advance North Carolinians’ health and safety by allowing abortion access without the challenged restrictions impeding Plaintiffs’ ability to continue to provide evidence-based, patient-centered care. *See Fruth, Inc. v. Pullin*, No. 3:15-16266, 2015 WL 9451066, at \*8 (S.D. W. Va. Dec. 23, 2015) (observing that “an injunction here will safeguard the public health and thereby serve the public interest”).

### CONCLUSION

For the foregoing reasons, Plaintiffs’ Amended Motion for Preliminary Injunction is hereby **GRANTED**. In the Court’s discretion, the bond requirement under Rule 65(c) is waived.

This the \_\_\_\_ day of \_\_\_\_\_, 2023.

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United States District Judge

Dated: September 12, 2023

Respectfully submitted,

*/s/ Kristi Graunke*

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## CERTIFICATE OF SERVICE

I hereby certify that, on September 12, 2023, 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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