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

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

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. Intervenors' 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, Intervenors have 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* Intervenors' Interrog. Resp. Nos. 5, 6 **(Ex. 5)**. The various abortion complications highlighted by Intervenors 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 Intervenors defend 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 Intervenors 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 Intervenors' 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.

Intervenors' 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,[1] suggests that IUP Documentation Requirement was intended "to prevent harm

[1] *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

Kristi Graunke
NC Bar # 51216
Jaclyn Maffetore
NC Bar # 50849
American Civil Liberties Union
of North Carolina Legal Foundation
P.O. Box 28004
Raleigh, NC 27611
Tel.: (919) 354-5066
kgraunke@acluofnc.org
jmaffetore@acluofnc.org

COUNSEL FOR ALL PLAINTIFFS

Brigitte Amiri*
Lindsey Kaley*
Ryan Mendias*
American Civil Liberties Union
Foundation
125 Broad Street, 18th Floor
New York, NY 10004
Tel: (212) 549-2633
bamiri@aclu.org
lkaley@aclu.org
rmendias@aclu.org

COUNSEL FOR BEVERLY GRAY, M.D.

/s/ Hannah Swanson

Hannah Swanson*
Helene T. Krasnoff*
Planned Parenthood Fed. of America
1110 Vermont Avenue NW, Suite 300
Washington, DC 20005
Tel.: (202) 803-4030
hannah.swanson@ppfa.org
helene.krasnoff@ppfa.org

Anjali Salvador*
Planned Parenthood Fed. of America
123 William Street, 9th Floor
New York, NY 10038
Tel.: (212) 541-7800
anjali.salvador@ppfa.org

COUNSEL FOR PLANNED
PARENTHOOD SOUTH ATLANTIC

**Special appearance filed*

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

Hannah Swanson*
Planned Parenthood Fed. of America
1110 Vermont Avenue NW, Suite 300
Washington, DC 20005
Tel.: (202) 803-4030
hannah.swanson@ppfa.org

**Special appearance filed*

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

Hannah Swanson*
Planned Parenthood Fed. of America
1110 Vermont Avenue NW, Suite 300
Washington, DC 20005
Tel.: (202) 803-4030
hannah.swanson@ppfa.org

**Special appearance filed*

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.,

Plaintiffs,

vs.

JOSHUA STEIN, et al.,

Defendants

and

PHILIP E. BERGER and TIMOTHY K. MOORE,

Intervenor-Defendants

VIDEO CONFERENCE DEPOSITION
OF
CHRISTY MARIE BORAAS ALSLEBEN, MD

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.

Gretchen Wells
Court Reporter

REMOTE APPEARANCES

FOR PLANNED PARENTHOOD SOUTH ATLANTIC:

Hannah Swanson, Esquire
Kara L. Grandin, Esquire
Anjali Salvador, Esquire
Dylan Cowit, Esquire
PLANNED PARENTHOOD FEDERATION OF AMERICA
1110 Vermont Avenue NW, Suite 300
Washington, DC 20005
hannah.swanson@ppfa.org
kara.grandin@ppfa.org
anjali.salvador@ppfa.org
dylan.cowit@ppfa.org

FOR ALL PLAINTIFFS:

Jaclyn A. Maffetore, Esquire
ACLU OF NORTH CAROLINA
P.O. Box 28004
Raleigh, NC 27611
jmaffetore@acluofnc.org

FOR THE PLAINTIFF DR. BEVERLY GRAY:

Brigitte Amiri, Esquire
Ryan Mendias, Esquire
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad Street, 18th Floor
New York, NY 10004-2400
bamiri@aclu.org
rmendias@aclu.org

REMOTE APPEARANCES

FOR THE LEGISLATIVE LEADER DEFENDANTS
SENATOR BERGER AND SPEAKER MOORE:

W. Ellis Boyle, Esquire
WARD & SMITH, PA
751 Corporate Center Drive, Suite 300
Raleigh, NC 27607
ewboyle@wardandsmith.com
Julia Payne, Esquire
ALLIANCE DEFENDING FREEDOM
15100 N. 90th Street
Scottsdale, AZ 85260
jpayne@adflegal.org

Denise M. Harle, Esquire
ALLIANCE DEFENDING FREEDOM
1000 Hurricane Shoals Rd NE, Suite D-1100
Lawrenceville, GA 30043
dharle@adflegal.org

Erin M. Hawley, Esquire
ALLIANCE DEFENDING FREEDOM
440 First Street NW, Suite 600
Washington, DC 20001
ehawley@adflegal.org

FOR THE DISTRICT ATTORNEY JIM O'NEILL

Kevin G. Williams
BELL DAVIS & PITT, P.A.
100 N. Cherry Street, Suite 600
Winston-Salem, NC 27101

FOR ATTORNEY GENERAL JOSH STEIN:

South A. Moore
NORTH CAROLINA DEPARTMENT OF JUSTICE
14 West Edenton Street
Raleigh, NC 27603
smoore@ncdoj.gov

REMOTE APPEARANCES

FOR ALL DISTRICT ATTORNEY DEFENDANTS
EXCEPT JIM O'NEILL:

Elizabeth C. O'Brien, Esquire
NORTH CAROLINA DEPARTMENT OF JUSTICE
14 West Edenton Street
Raleigh, NC 27603
eobrien@ncdoj.gov

FOR THE NORTH CAROLINA MEDICAL BOARD,
NORTH CAROLINA BOARD OF NURSING:
Michael E. Bulleri
NORTH CAROLINA DEPARTMENT OF JUSTICE
14 West Edenton Street
Raleigh, NC 27603
mbulleri@ncdoj.gov

FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Colleen M. Crowley, Esquire
NORTH CAROLINA DEPARTMENT OF JUSTICE
14 West Edenton Street
Raleigh, NC 27603
ccrowley@ncdoj.gov

OTHER APPEARANCES

Shealyn Massey
Planned Parenthood Federation of America
Vanisha Kudumuri
Planned Parenthood Federation of America
Joshua Yost
General Counsel, Office of the
Senate President Pro Tempore

I N D E X

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.

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).

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

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

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

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

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

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

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

MR. BOYLE: You're on mute.

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

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

is in the room with me.

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

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

MS. MAFFETORE: Apologies, one more for Plaintiffs.

MR. MOORE: I'm sorry.

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

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

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

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

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

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

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

MR. BOYLE: Very good.

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

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

EXAMINATION

BY MR. BOYLE:

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

A. I have not.

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

A. Sure.

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

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

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

A. Sure.

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

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

A. That sounds great.

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

A. Yes.

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

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

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

A. Yes.

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

A. Absolutely.

Q. In that case, you would have provided

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

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

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

A. For the mother and the fetus, yes.

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

A. Uh-huh (yes).

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

A. Sounds fine to me.

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

MS. GRANDIN: Objection to form.

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

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

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

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

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

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

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

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

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

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

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

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

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

end in a intrauterine fetal demise before birth.

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

A. Not in that particular case, no.

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

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

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

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

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

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

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

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

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

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

A. So the ---

MS. GRANDIN: Objection to form.

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

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

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

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

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

Q. So every time that you performed an induced

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

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

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

A. I don't.

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

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

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

A. Somewhere between those two numbers, yes.

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

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

15. Sometimes, up to 20.

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

A. Sure.

Q. And is that 50 weeks a year?

A. I do take vacation occasionally, so yeah.

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

A. Forty -- 48 weeks a year.

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

A. Yeah.

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

A. Yeah. Okay. Thanks.

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

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

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

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

A. I have been an attending physician since

2014.

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

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

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

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

A. No.

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

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

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

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

Q. Have you ever performed a chemical or

medicine abortion on a patient who was pregnant with twins?

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

Q. And they were pregnant with twins?

A. Correct.

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

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

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

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

patient?

A. No. The medicines are the same.

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

MS. GRANDIN: Objection to form.

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

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

MS. GRANDIN: Objection to form.

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

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

A. Typically, we would know that from ultrasound.

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

MS. GRANDIN: Objection to form.

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

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

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

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

MS. GRANDIN: Objection to form.

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

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

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

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

A. Transvaginal ultrasonography is not required

for diagnosing a multiple gestation.

Q. You can do it without an ultrasound?

A. You don't need a transvaginal one.

Q. Okay. You can -- oh, that's fair. Ultrasound is the way that you tell if your pregnant patient has twins or triplets or quadruplets, right?

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

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

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

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

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

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

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

MS. GRANDIN: Objection to form.

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

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

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

MS. GRANDIN: Objection to form.

THE WITNESS: In the first trimester, no.

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

A. Not that I recall at this moment.

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

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

Q. Well ---

A. If it exists.

Q. Sorry.

A. Sorry.

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

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

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

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

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

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

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

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

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

A. No.

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

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

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

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

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

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

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

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

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

Q. Which portions did you read?

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

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

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

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

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

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

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

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

MS. GRANDIN: Same objection.

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

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

A. In late July.

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

A. That is correct.

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

MS. GRANDIN: Objection to form.

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

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

A. I aim to.

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

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

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

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

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

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

A. I'm the director of research at Planned

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

Q. Do you know Dr. Farris personally?

A. I don't.

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

A. I have never met her directly.

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

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

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

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

Q. Okay. What is a uterine perforation?

A. A uterine perforation is a known risk of

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

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

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

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

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

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

MS. GRANDIN: Objection to form.

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

desired mode of abortion that they are considering.

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

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

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

A. Prior to their procedural abortion.

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

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

Q. What is a cervical laceration?

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

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

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

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

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

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

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

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

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

A. With instruments.

Q. What type of instruments?

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

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

sort of like tongs like you would see in a kitchen? Is that what forceps ---

A. They do not look like ---

Q. A medical version?

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

Q. What do they look like then?

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

Q. Are they sharp?

A. No.

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

A. They do.

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

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

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

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

days.

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

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

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

A. It varies depending on the patient.

Q. What's the typical size?

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

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

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

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

A. Not typically at 14 weeks. Typically at 14

weeks, we would use the biparietal diameter.

Q. What's that?

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

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

A. Yeah.

Q. --- exactly is that?

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

Q. Where is that?

A. In the cranium.

Q. So it's the skull?

A. Colloquially, yes, skull.

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

A. I'm sorry, what?

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

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

Q. What are the parietal bones in the skull?

A. They're bones of the skull.

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

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

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

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

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

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

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

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

MS. GRANDIN: Objection to form.

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

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

MS. GRANDIN: Objection to form.

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

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

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

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

A. Yeah. It dictates a lot of what instruments

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

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

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

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

A. The fetus ---

MS. GRANDIN: Objection to form.

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

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

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

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

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

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

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

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

Q. Okay. So at ---

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

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

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

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

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

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

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

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

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

A. Potentially, yes.

Q. --- procedural abortion? Okay.

A. Uh-huh (yes).

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

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

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

MS. GRANDIN: Objection to form.

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

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

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

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

Q. How big is the diameter?

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

Q. So what is the size and measurement?

A. There are many different sizes of cannulas.

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

A. That is correct.

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

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

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

A. Typically, the gestational age of the pregnancy.

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

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

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

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

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

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

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

A. The operating -- the operating healthcare provider.

Q. So the doctor, or a technician?

A. In our setting, a doctor.

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

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

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

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

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

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

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

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

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

Q. At what point do you ---

A. Oh, sorry, may ---

Q. Go ahead.

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

Q. Yeah.

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

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

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

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

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

Q. Is that tissue used for any scientific

research or anything like that?

MS. GRANDIN: Objection to form.

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

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

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

Q. And what ---

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

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

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

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

North Central States, we contract with a mortuary provider.

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

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

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

MR. BOYLE: Ten minutes is fine.

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

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

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

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

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

Q. Okay. And so you said you use an

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

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

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

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

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

A. To increase safety, no.

Q. Do you need to know for any reason?

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

Q. Okay.

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

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

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

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

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

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

Q. Why?

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

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

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

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

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

A. Correct.

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

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

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

A. In both settings, that would be true.

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

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

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

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

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

A. "The details" meaning what?

Q. How do you do it?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. GRANDIN: Objection to form.

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

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

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

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

think that answered my question though.

A. Okay.

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

A. Oh, no.

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

A. Yeah.

MS. GRANDIN: Objection to form.

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

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

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

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

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

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

A. Yes.

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

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

Q. Okay. So when you say ---

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

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

A. Yes.

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

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

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

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

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

MS. GRANDIN: Objection to form.

THE WITNESS: We call them fenestrations.

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

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

Q. Two loops that come together and ---

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

good ---

Q. Okay.

A. --- description. Yeah.

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

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

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

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

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

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

Q. And when you say "on the individual patient

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

A. Sorry?

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

MS. GRANDIN: Objection to form.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

to go somewhere where it doesn't actually fit.

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

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

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

A. No. No.

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

MS. GRANDIN: Objection to form.

THE WITNESS: Yeah. Generally, in the

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

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

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

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

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

A. Uh-huh (yes).

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

MS. GRANDIN: Objection to form.

THE WITNESS: In that instance where

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

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

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

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

A. Yeah. We compress ---

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

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

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

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

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

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

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

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

Q. With the guiding of the different parts of

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

A. After it's passed through the cervix?

Q. Yes.

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

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

MS. GRANDIN: Objection to form.

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

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

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

A. Oh, no.

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

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

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

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

Q. What do you consider to be curettage?

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

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

MS. GRANDIN: Objection to form.

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

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

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

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

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

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

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

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

MS. GRANDIN: Objection to form.

THE WITNESS: As far as the procedural steps?

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

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

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

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

MS. GRANDIN: Objection to form.

THE WITNESS: The patients that I see

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

Q. (Mr. Boyle) Such as?

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

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

A. Oh, that's okay.

Q. Take your time.

A. I got this one.

Q. Okay.

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

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

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

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

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

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

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

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

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

A. No.

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

A. Thankfully, no.

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

A. Yeah.

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

A. Good.

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

A. No, I am not providing general anesthesia.

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

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

A. Yes.

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

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

A. No.

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

A. Currently, yes.

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

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

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

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

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

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

A. Absolutely.

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

A. Yes.

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

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

Q. Which two?

A. Typically, we use fentanyl and midazolam.

Q. Is midazolam a benzodiazepine?

A. Yes.

Q. Are there any other ways that you are aware

of to provide moderate sedation in your practice?

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

Q. And those are IV administered to your patients?

A. Yes.

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

A. Yes.

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

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

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

A. Yes.

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

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

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

A. Uh-huh (yes).

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

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

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

A. That is correct.

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

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

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

Q. Okay. So ---

A. --- without that.

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

A. That is correct.

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

A. Sure.

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

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

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

A. Not currently.
Q. Has it ever?
A. No.
Q. Let's talk about deep sedation. What does that involve?
A. Deep sedation typically involves an IV medication called propofol.
Q. Is that it?
A. Yeah. Yes.
Q. Okay. So you're -- you've got a patient who chooses deep sedation, you're going to put that patient on IV propofol. Is that correct?
A. I don't administer intravenous propofol.
Q. Okay. So when a patient of yours selects deep sedation for an induced abortion surgical procedure, either D&E or an aspiration, you can't do that at the Planned Parenthood clinic, you have to do that at the hospital. Is that correct?
A. Current -- yes, currently all patients that desire deep sedation would be -- I would take care of them in the hospital setting.
Q. This IV propofol, when it's administered, do you have to have an anesthesiologist or a CRNA present to monitor the patient once the propofol is administered throughout the procedure?

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

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

A. Yeah.

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

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

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

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

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

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

A. I have not.

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

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

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

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

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

A. Yes.

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

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

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

MS. GRANDIN: Objection to form.

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

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

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

colleague ---

Q. Well, I ---

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

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

MS. GRANDIN: Objection to form.

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

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

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

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

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

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

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

MS. GRANDIN: Objection to form.

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

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

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

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

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

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

A. I do not.

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

A. I do not.

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

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

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

anything about that ---

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

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

A. No, that's okay.

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

MS. GRANDIN: Objection to form. Apologies.

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

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

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

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

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

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

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

Q. Well, I appreciate ---

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

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

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

MS. GRANDIN: Objection to form.

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

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

MS. GRANDIN: Objection to form.

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

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

MS. GRANDIN: Objection to form.

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

with the standards and guidelines of the federation.

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

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

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

A. I have ---

MS. GRANDIN: Objection to form.

THE WITNESS: I have never been there or visited.

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

MS. GRANDIN: Objection.

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

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

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

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

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

MS. GRANDIN: Objection to form.

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

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

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

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

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

patient having an induced abortion and an ectopic pregnancy.

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

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

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

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

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

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

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

Q. Okay.

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

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

MR. BOYLE: Okay.

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

THE WITNESS: Yeah, that's fine.

MR. BOYLE: Very good.

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

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

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

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

A. I have never had to transfer a patient with

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

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

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

Q. So somewhere around ten would be the number?

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

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

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

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

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

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

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

A. Yes. A very rare one.

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

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

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

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

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

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

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

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

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

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

A. So for a person that comes and requests a

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

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

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

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

Q. On an ultrasound, right?

A. If a person has an ultrasound.

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

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

Q. But sometimes those people actually have an

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

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

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

A. Okay. Let me try again.

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

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

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

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

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

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

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

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

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

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

A. Not that we know.

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

A. Excuse me, can ---

MS. GRANDIN: Objection to form.

THE WITNESS: Can you say that again?

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

MS. GRANDIN: Objection.

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

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

A. Okay.

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

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

Q. Yes. I apologize.

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

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

MS. GRANDIN: Objection.

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

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

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

Q. Okay.

A. --- and associated clinics.

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

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

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

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

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

A. Oh, no.

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

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

Q. Okay.

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

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

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

A. Yeah. Yeah.

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

A. I did.

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

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

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

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

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

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

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

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

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

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

MS. GRANDIN: Objection to form.

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

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

A. I think ---

MS. GRANDIN: Objection.

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

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

MS. GRANDIN: Objection to form.

THE WITNESS: No.

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

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

MS. GRANDIN: Objection.

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

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

MS. GRANDIN: Objection to form.

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

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

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

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

MS. GRANDIN: Objection to form.

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

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

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

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

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

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

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

MS. GRANDIN: Objection to form.

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

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

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

MS. GRANDIN: Object ---

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

MS. GRANDIN: Objection to form.

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

MS. GRANDIN: Apologies. Objection, form.

MR. BOYLE: Okay.

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

people have that opinion? Right?

MS. GRANDIN: Objection.

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

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

MS. GRANDIN: Apologies.

MR. BOYLE: No. No problem.

THE WITNESS: Sorry.

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

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

MS. GRANDIN: Objection to form.

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

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

MS. GRANDIN: Objection.

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

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

MS. GRANDIN: Objection to form.

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

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

MS. GRANDIN: Objection to form.

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

irrational. That's not based in fact.

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

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

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

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

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

MS. GRANDIN: Objection. Apologies.

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

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

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

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

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

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

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

A. The combination ---

MS. GRANDIN: Objection to form. Go ahead.

THE WITNESS: The combination of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. GRANDIN: Objection to form.

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

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

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

Q. Do you agree that a differential diagnosis

should include all of the possible risks or dangerous situations for a patient that you are treating?

A. I mean, a differential diagnosis is simply a list of possible diagnoses for a certain constellation of signs or symptoms that a patient is reporting.

Q. And typically when you develop that list of possible risks or situations a patient might be facing, your job as a doctor is to treat the worst first, right? You have to focus on the things that could be life threatening, don't you?

MS. GRANDIN: Objection to form.

THE WITNESS: My job is to -- to know the list and communicate the list of possible diagnoses to the patient. Only the patient can decide what risks and -- to accept for a given diagnosis. It's not my job to say what risks a person should accept or shouldn't.

Q. (Mr. Boyle) You said you're a member of ACOG, right?

A. I am a member of ACOG, yes.

Q. Do you follow and agree with the practice bulletins that ACOG publishes?

A. I mean, generally, I think that's true. Some of -- you know, there are committees that review those regularly.

Q. Do you agree that ACOG practice bulletins provide clinical management guidelines for OB/GYNs?

A. Generally speaking, yes. I think the hard part about practice bulletins, again, is it's a collated document of evidence about a specific topic, and patients, individual patients, you know, in my experience, don't always fit guidelines or, you know -- you know, fit specific algorithms.

So that's when the clinical judgment based on experience and training of each individual treating physician comes into play.

Q. You said in your report, your declaration, that you were asked whether there is any medical justification for the two challenged provisions in relation to the Court deciding the Preliminary Injunction Motion. Who asked you to do that?

A. Who asked me to serve as an expert witness in this case?

Q. Who asked you whether there was any medical justification for the two challenged provisions?

A. I would have to understand which challenged positions you're referring to, I guess, first.

Q. Right. I -- I think we talked earlier about the IUP documentation is one and then the 12 -- after 12-week hospitalization for induced abortion was the

other, right?

A. So I reviewed with counsel the -- my opinions based on experience and training for both the requirement for induced abortion care for rape and incest and life-limiting fetal anomaly to be provided in a hospital after the 12th week.

And I also discussed the specific portion about requiring the -- or documenting the existence of an intrauterine pregnancy before a medication abortion.

Q. Do you know what the legal standard is for those issues before the Court at the preliminary injunction?

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

THE WITNESS: Yeah, I'm not an attorney, so I'm not sure I understand what you mean by "legal standard." I'm not -- I can't remember what you said.

Q. (Mr. Boyle) When you have a woman you're treating as your patient who has a positive pregnancy test, what do you consider to be on her differential diagnosis as potential medical risks and issues for her?

A. If I have a pregnant person sitting in front

of me, there are an exhaustive number of risks that I would think about for -- that might occur in a pregnancy.

Q. Such as?

A. Such as nausea and vomiting of pregnancy, such as high blood pressure diseases of pregnancy like gestational hypertension or preeclampsia. Like the need for a cesarean section, like the risk of pre-term birth, like the risk of a premature rupture of membranes, like bleeding in early pregnancy, the -- like -- I mean, the -- the list goes on.

Q. Do you consider the possibility of an ectopic pregnancy to be one of those risks that's immediately on every differential diagnosis ---

A. Of ---

Q. --- for your patients who have tested positive for pregnancy?

A. Yeah. If somebody calls and reports a positive pregnancy test at home, again, we would do a thorough screen of the patient's history and try to determine their risk for an ectopic pregnancy.

Q. Do you agree that unless they are discovered and treated early almost 40 percent of ectopic pregnancies rupture suddenly causing pain and bleeding in the abdominal cavity?

MS. GRANDIN: Objection to form.

THE WITNESS: I'd have to see the specific text where that exact number is quoted. I can, you know, say as a practicing gynecologist, you know, when we identify an ectopic pregnancy, we usually talk about -- we counsel patients about the risks and benefits of expectant management versus medical management versus surgical management.

Q. (Mr. Boyle) Do you agree that ruptured ectopic pregnancies can be fatal?

A. Can be what?

Q. Fatal.

A. Fatal. Yes. Although, thankfully, in the U.S., you know, in 2023, I don't know of a time where that's happened in my hospital.

Q. Has it ever happened, that you're aware of, from one of the Planned Parenthood patients that you see in Minnesota?

A. Nope. Not that I'm aware of.

Q. And we mentioned this earlier, and I got this number from the ACOG bulletin 193, which is the clinical management guidelines for OB/GYNs for tubal ectopic pregnancy from March of 2018. Are you familiar with this document, this bulletin?

A. I have seen ---

MS. GRANDIN: Objection. Go ahead.

THE WITNESS: I have seen this practice bulletin, yes.

Q. (Mr. Boyle) Okay. And that's -- this practice bulletin says, "According to the CDC, ectopic pregnancy accounts for approximately 2 percent of all reported pregnancies." Does that sound accurate to you?

MS. GRANDIN: Objection.

THE WITNESS: I mean, again, it would be best to view the document and -- in order for me to authoritatively answer that question.

Q. (Mr. Boyle) Do you have a copy of it in front of you?

A. Not currently.

Q. We had discussed having available these documents. Do you have the ability to pull that up and look at it?

A. Yes. I should have that ability.

Q. Yeah, just take your time and let me know when you get it.

A. Okay.

MS. GRANDIN: Are you introducing this as an exhibit, Mr. Boyle?

MR. BOYLE: Maybe.

MS. GRANDIN: Okay.

MR. BOYLE: I don't know yet.

THE WITNESS: Okay.

Q. (Mr. Boyle) Let me know when you get it pulled up.

A. I will. My computer is exceedingly slow.

Q. Yeah, that's why I always print these things.

MR. BOYLE: I'll tell you what. We're at about two hours and 50 minutes, and I'm not going to be done in ten or 15 minutes.

THE WITNESS: Okay.

MR. BOYLE: Do you want to take a little bit of a longer break now and -- maybe take 30 minutes and come back and finish up? And hopefully, you can get that pulled up in the interim.

THE WITNESS: Sure. That sounds fine to me.

MR. BOYLE: Does that work for you, Ms. Grandin?

MS. GRANDIN: Yes. Can we go off the record to talk about timing?

THE COURT REPORTER: Off the record at 1:23 p.m.

(Luncheon recess: 1:23 p.m. to 1:52 p.m.)

THE COURT REPORTER: Back on the record at 1:52 p.m.

Q. (Mr. Boyle) Okay. So, Doctor, do you have that ACOG Practice Bulletin 193 from March 2018 available?

A. I do. I have it pulled up here in PDF on my computer.

Q. Okay. Do you agree with the -- that ACOG bulletin 193 that, quote, "Despite improvements in diagnosis and management, ruptured ectopic pregnancy continues to be a significant cause of pregnancy-related mortality and morbidity.

"In 2011 to 2013, ruptured ectopic pregnancy accounted for 2.7 percent of all pregnancy-related deaths and was the leading cause of hemorrhage-related mortality," end quote?

A. Gosh, that's a long sentence. If you could point me kind of specifically in the document where you're discussing, then I can ---

Q. Yeah. In the first page, "Background Epidemiology," about halfway through that paragraph.

A. Okay.

Q. "Despite improvements..." Do you agree that that's what the ACOG says on this topic?

A. Yep. That -- what you read there is written

here in that -- in this practice bulletin, yes.

Q. Is that -- and you agree with the ACOG bulletin, right?

MS. GRANDIN: Objection to form.

THE WITNESS: You know, I haven't seen any specific mortality data related to ectopic pregnancy in those specific years, but I know ACOG takes, you know, the production of their practice bulletins very seriously.

Q. (Mr. Boyle) And you rely on these practice bulletins in your practice to provide you with clinical management guidelines, right?

A. As a -- as a starting point, sure. Yeah. Yes.

Q. If you look under -- sorry. If you look under the "Risk Factors" section, do you agree with ACOG that, quote, "Half of all women who receive a diagnosis of ectopic pregnancy do not have any known risk factors," end quote?

A. Yes.

Q. And so a lot of women who actually end up having an ectopic pregnancy don't have flags for known risks for an ectopic pregnancy. Is that correct?

A. Based in their history, not necessarily what's happening in their body currently, yes.

Q. At what stage in pregnancy do you normally screen a woman for an ectopic pregnancy?

A. Well, certainly if I'm taking care of a patient doing their prenatal care visit at 30 weeks, I usually don't discuss ectopic pregnancy at that time. I don't know if you're asking for a specific gestational age week.

I try to assess -- you know, once a pregnant person has had a positive test, a positive pregnancy test, we -- one of the first things we do is talk about how they're feeling in their body and ask about last menstrual period to try to assess an estimated gestational age of the pregnancy.

Q. And so as I understand it, whenever you become aware that your patients has -- patient has tested positive for pregnancy, you consider an ectopic pregnancy as a risk on that patient's differential diagnosis, right?

A. Generally speaking, sure. Yes.

Q. And you screen that patient as soon as you become aware that they're pregnant for ectopic pregnancy immediately, right?

A. I mean, we have -- in all the locations where I work, we have -- we have, you know, kind of general protocols about how to assess somebody's risk

for an ectopic pregnancy. One of which is, you know, just talking about past history, as we've described. The other is to talk about any current signs or symptoms that might be concerning for an ectopic pregnancy.

Q. And the gold standard to test and look for an ectopic pregnancy is to conduct a transvaginal ultrasound and see if there is an embryo or fetus inside the uterus. Isn't that right?

MS. GRANDIN: Objection to form.

THE WITNESS: There are, you know, kind of five main categories of early pregnancy. Much of which can rely on ultrasonography.

Q. (Mr. Boyle) Yeah. My question was, the gold standard to test and look for an ectopic pregnancy is to conduct a transvaginal ultrasound and see if there is an embryo or fetus seen in the uterus. Isn't that right?

A. The only ---

MS. GRANDIN: Objection to form.

THE WITNESS: The only way to definitively diagnose an ectopic pregnancy is to see an embryo outside of the uterus with ultrasound. It doesn't necessarily have to be a transvaginal one.

Q. (Mr. Boyle) Okay. So you can do a

ultrasound outside the woman's body ---

A. Again, it really -- it really just depends on the patient characteristics. But yes, we, at times, certainly can use transabdominal ultrasonography also.

Q. You said the only time you can definitively diagnose it is when you do the ultrasound and see the ectopic pregnancy. Did I hear you correctly?

A. So what -- if we're using ultrasound in early pregnancy, there are kind of five main diagnoses we could come up with, right? The first is a definite intrauterine pregnancy. The second is a probable intrauterine pregnancy. The third is a pregnancy of unknown location. The fourth is a probable ectopic pregnancy. And the fourth is -- or the fifth, excuse me, the fifth is a definite ectopic pregnancy.

Q. But under those categories, number one, if you do the ultrasound and you see the pregnancy inside the uterus, you've ruled out ectopic pregnancy there, right?

A. In the -- in the vast majority of cases, yes.

Q. You agree that you should always perform an ultrasound on a patient you provide care to when they test positive for pregnancy so that you can confirm if

the pregnancy is intrauterine by seeing it on an ultrasound, don't you?

MS. GRANDIN: Objection to form.

THE WITNESS: Not all patients in early pregnancy need an ultrasound.

Q. (Mr. Boyle) Why not?

A. Lots -- various reasons.

Q. Is there any contraindication to giving a patient an ultrasound?

A. The first and foremost would be the patient doesn't want one.

Q. But you can't see inside the patient's abdomen to see if the pregnancy is intrauterine or ectopic unless you do an ultrasound, can you?

A. The way I could see inside the abdomen would be to provide a laparoscopy or to provide an exploratory laparotomy or any imaging modality that we have available, such as ultrasound, such as CT, such as MRI.

Q. Right. But you're not going to do a exploratory surgery or an MRI. You just do an ultrasound to see where the pregnancy is, right?

MS. GRANDIN: Objection to form.

THE WITNESS: I would recommend an ultrasound if it was indicated.

Q. (Mr. Boyle) And a pregnant patient who you don't know if it's ectopic or not, you have ectopic pregnancy on that pregnant patient's differential diagnosis until you can confirm that it's in the uterus or not, correct?

A. There are many ways to assess a person's risk for an ectopic pregnancy. One of which is using ultrasound. There are many others.

Q. Do you agree with ACOG bulletin 193 which says, "The minimum diagnostic evaluation of a suspected ectopic pregnancy is transvaginal ultrasound evaluation and confirmation of pregnancy"?

A. Can you point me to exactly where in the document you're referring to?

Q. Yeah. It's on the second page under "Clinical Considerations and Recommendations. How is an ectopic pregnancy diagnosed?" I believe it's the first sentence there.

A. So for a patient with a suspected ectopic pregnancy, ultrasound can be very valuable. Most oftentimes, we would use a transvaginal ultrasonography. However, like I said previously, in select patients, transabdominal ultrasound -- ultrasonography would also suffice.

Q. Okay. So you agree with ACOG on that

particular sentence?

MS. GRANDIN: Objection to form.

THE WITNESS: I agree with the statement that diagnostic evaluation of a suspected ectopic pregnancy would -- you know, that ultrasound would be valuable in that case.

Q. (Mr. Boyle) But ectopic pregnancy is on the differential diagnosis for every pregnant woman until you actually rule it in or rule it out, isn't it?

A. That -- it's on the differential, but I don't suspect it in every case, partly because ectopic pregnancy is very rare compared to intrauterine pregnancy. And I also take many more factors about each individual patient into consideration when I'm deciding whether or not I suspect an ectopic pregnancy or not.

Q. All you'd have to do is do an ultrasound and you'd be able to tell one way or the other if it's intrauterine pregnancy or ectopic pregnancy. It doesn't seem that difficult. Why can't you do that for all your patients? Are you -- I don't understand.

A. Because ultrasound ---

MS. GRANDIN: Objection to form. Go ahead.

THE WITNESS: Because ultrasound isn't

indicated for every pregnant person that I see. Many people have pregnancies that don't -- that don't ever have an ultrasound.

Q. (Mr. Boyle) Do you agree with ACOG bulletin 193 where it says that, quote, "Serum hCG values alone should not be used to diagnose an ectopic pregnancy and should be correlated with the patient's history, symptoms and ultrasound findings," end quote?

A. Yeah, where in the document are -- is that section?

Q. If you look at the "Serum Human CHG -- hCG Measurement" section, second sentence.

A. Under the heading "Trends of Serial Serum Human Chorionic Gonadotropin," under that section?

Q. Yeah, under "Serum hCG Measurement."

A. Oh, okay, I see where you're saying now. And where?

Q. Second sentence.

A. Second sentence.

Q. Do you see that?

A. I see that the practice bulletin has that quote in it, yes.

Q. So you would agree that, at least according to the ACOG practice bulletin, it recommends that patients get ultrasound to determine the location of

the pregnancy?

A. In my practice, we use serum hCG levels in conjunction with patient history, symptoms and, at times, ultrasound.

Q. Right. And I understand that's what you say in your practice. But the ACOG here says that you use serum hCG with an ultrasound, right?

MS. GRANDIN: Objection to form.

THE WITNESS: It also states in the practice bulletin, the sentence immediately preceding that, that "Measurement of the serum hCG level aids in the diagnosis of women at risk of ectopic pregnancy."

Q. (Mr. Boyle) Right. It says it aids in it ---

A. It says ---

Q. --- however ---

A. The sentence to follow describes assessment of a patient at risk for ectopic pregnancy.

Q. And you just disagree that every patient is at risk for ectopic pregnancy because you think that the way you screen them means you don't have to consider certain patients at risk. Is that fair?

MS. GRANDIN: Objection to form.

THE WITNESS: Again, the only way to diagnose a definitive ectopic pregnancy is to see that

pregnancy outside the uterus. For patients that come in early pregnancy and request any care, including abortion care, we do a thorough history assessment and recommend the best care for that patient and consistent with medical evidence.

Q. (Mr. Boyle) And you've run studies on whether a patient who is pregnant needs an ultrasound to confirm an ectopic pregnancy early in their pregnancy or if you can just use screening to determine whether they are at risk for an ectopic pregnancy. Is that correct?

A. I have published articles assessing history-based screening in early pregnancy for abortion care, yes.

Q. And that is not the consensus position. It is what you are advocating for through your research should become the consensus position, but it is not established as the consensus position, is it?

A. By "consensus," are you referring to the practice bulletin?

Q. Yes.

A. The practice bulletin states, right, for people at risk of ectopic pregnancy, that serum hCG should correlate with patient history, symptoms and ultrasound findings. So we do our due diligence to

provide best healthcare to people to ensure that we are assessing people for either high risk for ectopic pregnancy or low risk for ectopic pregnancy.

You will also recall that this publication, the practice bulletin about tubal ectopic pregnancy, was published in March of 2018. So it is not uncommon when research is produced showing safety, for example, in this case, providing abortion for people with pregnancy of unknown location, that it takes a few years for those document -- consensus documents, as you referred to them, to be updated and published.

Q. (Mr. Boyle) And there isn't a consensus document from the ACOG that says your version of screening without ultrasound is accepted in the practice yet. Is that correct?

MS. GRANDIN: Objection to form.

THE WITNESS: The study that I published was just published in 2013, so I doubt -- I doubt they've had time to update the practice bulletin.

Q. (Mr. Boyle) And I think you just said it was published in 2013, but it was published in ---

A. I'm sorry, I meant 2023. I am so sorry.

Q. Yeah, yeah. That's okay. I was just ---

A. Thank you. Thank you ---

Q. No, I understood what you meant.

A. Yeah.

Q. Right. So -- and I appreciate that it's fairly new research. But even if it eventually gets adopted, the current standard of care for patients who appear with a pregnancy and you don't know if it's an ectopic pregnancy -- first of all, I think we've established -- let me clarify. You agree that every pregnant woman is at risk on some level for an ectopic pregnancy, right?

MS. GRANDIN: Objection to form.

THE WITNESS: No.

Q. (Mr. Boyle) You don't think that every woman who is pregnant, early in their pregnancy before you're able to establish through other means that it's intrauterine, you don't think you have to treat every single patient as potentially having an ectopic pregnancy when they test pregnant -- positive for pregnancy?

A. If someone hasn't -- doesn't have a intrauterine pregnancy or a probable intrauterine pregnancy, then, yes, we counsel those patients about the potential, albeit low, risk, right? We've discussed the risks of ectopic pregnancy generally in this deposition already. That low risk that a -- the

pregnancy may be growing outside the uterus.

Q. And it's fairly simple to conduct an ultrasound and find out if it's intrauterine, which would relieve that risk. Or if you see it ectopically, it would confirm the risk and you'd treat it that way. Or if you don't see it at all, then you still don't know, correct?

A. I would ---

MS. GRANDIN: Objection to form.

THE WITNESS: I would never perform an ultrasound for a patient that declined that care.

Q. (Mr. Boyle) So you agree, though, that the current status of the ACOG, based on bulletin 193, is that patients should be considered at risk for ectopic pregnancy and should be screened using ultrasound and possibly also serum hCG and history and other screenings, but at least ultrasound to determine whether they have an ectopic pregnancy?

MS. GRANDIN: Objection to form.

THE WITNESS: Again, according to ACOG in this bulletin that was published in 2018, I -- I'm not aware that the -- I don't know what the schedule of review of this practice bulletin is, but I agree that this practice bulletin from 2018 says that hCG values may be helpful when used in conjunction with

patient history, symptoms and potentially ultrasound findings for people at risk of ectopic pregnancy.

Q. (Mr. Boyle) Well, it doesn't say -- so you added, "and potentially." It doesn't say, "and potentially." It actually says, "and ultrasound findings," right?

A. It does.

Q. Okay. So it's including ultrasound in that process of screening a patient to determine whether you can rule in or rule out the ectopic pregnancy risk, correct?

A. As of 2018, that's what -- you know, the sentence says, "patient's history, symptoms, and ultrasound findings."

Q. And again, I'm not trying to exclude or diminish even your research. I've read it. I understand it exists. However, there is some scientific support for conducting an ultrasound with a patient based on this ACOG 193 bulletin. Wouldn't you agree?

A. There is for people at risk of ectopic pregnancy, again, in this -- this paragraph that we're discussing as part of -- as part of this practice bulletin, for people at risk of ectopic pregnancy, then hCG findings "should be correlated with patient's

history, symptoms, and ultrasound findings." That's what the practice bulletin says.

Q. Which you would agree provides some support for having an ultrasound to rule out or rule in that particular risk on every woman's differential diagnosis when she tests positive for pregnancy?

A. The practice ---

MS. GRANDIN: Objection to form.

THE WITNESS: The practice bulletin, again, is a starting point. And for the -- you know, when it's published, the best guidance that we have at that time for how to guide care for people within the obstetrics and gynecology practice.

Now, again, for each individual patient, I'm going to take that guidance and apply it to their specific characteristics and patient experience and then tailor that guidance based on the individual in front of me.

Q. (Mr. Boyle) I understand that and appreciate it and agree that's almost certainly appropriate ---

A. That, I would argue, is the standard of care that we've been -- been discussing.

Q. Okay. Very good.

I asked you earlier -- you've read the

Planned Parenthood South Atlantic documents that they provide to their patients related to informed consent for chemical abortion and for surgical abortion, haven't you?

A. I have not -- I have not read those documents, no.

Q. Okay. So if those documents inform a patient that is there to obtain a chemical abortion that they may have severe cramping and severe bleeding for several weeks, would you agree that those are similar symptoms that a patient who has a ruptured ectopic pregnancy might face?

A. If you're asking me to comment on specific documents, I'd have to review those.

Q. Well, I'm asking you a question. If a patient is told, "After you have the chemical abortion, the two-drug regime, you may experience heavy bleeding for even several weeks and blood clots the size of a lemon, and" -- you would agree that that patient could experience those symptoms but actually have a ruptured ectopic pregnancy and not be able to distinguish between having a ruptured ectopic pregnancy versus what the symptoms described as heavy bleeding were?

A. In my practice, we would counsel a person

about the main signs and symptoms of both ectopic pregnancy and induced abortion with medications so that they could really be in -- you know, the best in tune to their body and know when to access our 24-hour assistance line for assistance and help and -- and guidance if they were not sure if they needed it or if they thought they needed it.

Q. But you agree that the symptoms of a ruptured ectopic pregnancy can include things like bad pain in your abdomen, cramping and heavy bleeding, right?

A. The symptom -- what a person might experience with a ruptured ectopic pregnancy is typically different than the experience in the -- in the vast majority of cases for patients who access medication abortion.

Q. You say, "typically different," but they can be at least similar, right?

A. So the -- the symptoms that someone might have with an ectopic pregnancy are typically different.

Q. I -- I understand, typically they are different. But sometimes they're similar and could very well overlap. Is that correct?

A. The -- the symptoms a person might

experience with a ruptured ectopic pregnancy is going to be severe pain, typically unilaterally. They may experience pain with deep inspiration. They may experience lightheaded and dizziness.

They -- you know, it's not a typical experience of a person with ectopic pregnancy to have significant heavy bleeding noticeable on a pad, for example.

Q. I missed that last part. Can you -- can you say that -- I got confused.

A. Yeah.

Q. I thought you were talking about the chemical abortion. Were you talking about the ectopic?

A. A person with ectopic pregnancy may have some bleeding, but it's typically not very heavy when -- you know, when they're assessing the amount of bleeding they're having, like if they had a pad in their underwear.

Q. And -- well, you haven't looked at the Planned Parenthood for South Atlantic's documents that they produced in this case related to their informed consent. Is that correct?

A. I have not reviewed any Planned Parenthood South Atlantic documents, no.

Q. Okay. You don't know what the Planned Parenthood South Atlantic's protocol is for screening patients for ectopic pregnancy before performing a chemical abortion on them, do you?

A. Again, because -- in order to be an affiliate of the federation, I know that extensive protocols must be in place to continue to be an affiliate. So I know they have one. I just don't know the specific details of that.

Q. And I accept that you believe they exist, and I -- I think they do too. I haven't seen them. But more to the point, you have not seen them, correct?

MS. GRANDIN: Objection to form.

THE WITNESS: I have not seen any documents that Planned Parenthood South Atlantic uses.

Q. (Mr. Boyle) So you are unable to form any opinions about what Planned Parenthood South Atlantic's protocols are based on your review of those because you haven't reviewed them. Is that fair?

A. I haven't reviewed the documents. But again, because I'm an employee of Planned Parenthood North Central States, I understand the requirements that are necessary to continue to participate in the federation and continue to be a Planned Parenthood

site. So I know they exist. I just haven't seen the details of the specific documents.

Q. When is the typical gestational age of a pregnancy that you find yourself providing care to patients in your role in Minnesota?

A. Can you -- can you repeat the question, please?

Q. So you see patients who are testing positive for pregnancy. What's the typical earliest time that you will see that patient? Is it two weeks gestational age? Is it eight weeks gestational age, somewhere in between?

A. When they first make an appointment with me?

Q. When you see them, yes.

A. Oh, it can vary very widely.

Q. Do you typically -- do you agree that typically a woman wouldn't know that she is pregnant until four or five weeks gestational age just based on last menstrual cycle, et cetera?

A. The reason that the medical community uses and dates a pregnancy from the last menstrual period dates back from when we didn't have sophisticated ultrasound -- ultrasonography capacity. And, therefore, a person's first missed period would be a first sign for a person that they may be pregnant.

Q. Okay. So when you typically see patients that are early on, do you ever see patients that have a gestational age pregnancy of two or three weeks, or is it typically after five weeks gestational age?

A. I think, you know, people who -- once they realize they're pregnant and know they need to proceed with abortion care, they often call as soon as they can.

Q. I appreciate that and I don't dispute it. But what's your practical experience as, like, what's the gestational age when that happens?

A. Again, it's varied. Anywhere from -- I mean, a -- a person can make an appointment related to a pregnancy at any -- at any gestation that -- that they would prefer.

Some people, once they have that positive test, know they need to become -- that they need abortion care. So I've seen people in the -- in the third week of pregnancy, for example.

Q. Okay. And that's what I was asking. And so would you say third week of pregnancy is the earliest you've ever encountered a patient under those circumstances?

A. Probably.

Q. And ---

A. I don't write those -- I don't write them down, so I don't -- I don't -- probably.

Q. Have you ever provided an induced abortion to a patient who had a gestational age of less than five or six weeks?

A. Yes.

Q. When do you expect to be able to see a fetus or an embryo of one of your pregnant patients on an ultrasound?

A. General consensus about that is we -- if a person accepts a transvaginal ultrasonography, then we would expect to see a gestational sac starting as early as five weeks.

Q. Would you agree that it would be safer to confirm the intrauterine location of a pregnancy than to not know if it's an ectopic pregnancy using ultrasound when you're treating your patient?

A. I'm not sure I missed -- I think I missed the last part of that. Can you ask that again?

Q. When you're treating a pregnant patient, wouldn't you agree that it's safer for that patient to use ultrasound to rule in or rule out ectopic pregnancy before you provide that patient with a chemical abortion?

A. For a patient who we have assessed as low

risk for an ectopic pregnancy, no.

Q. Have you ever had a patient that you assessed as low risk for an ectopic pregnancy, you performed an induced abortion on that patient, and then later that patient turned out to have an ectopic pregnancy?

A. Okay. Say that one more time.

Q. Have you ever had a situation where you screened a patient, your screening process determined that the patient was low risk for ectopic pregnancy so you did not perform an ultrasound on that patient, you gave that patient a chemical abortion, and then later you found out that that patient had an ectopic pregnancy?

A. I'd have to -- I'd have to go back and look specifically at the -- the only time where that would have occurred -- I'm not sure. I'd have to go back and look.

Q. You can't say definitively that that's never happened?

A. Correct.

Q. And so you agree that there's a risk that, even if you determine a patient is low risk, they might have an ectopic pregnancy, right?

A. So I think, you know, the important thing

when we're counseling a person who's sitting in front of us requesting pregnancy care, including induced abortion care, is to review all of the risks, yeah.

So we go through those with the person, and then the patient accepts or does not accept those risks and decides for themselves how to proceed during that encounter.

Q. Would you be able to look back through your records and determine whether you had a patient that you screened, found that patient to be low risk for ectopic pregnancy, you did not provide them with a -- you did not take an ultrasound of that patient, you did provide them with a chemical abortion, and then afterwards they showed up as having an ectopic pregnancy?

MS. GRANDIN: Objection to form.

THE WITNESS: I could certainly look for that information. I think it ultimately is irrational to require that for every patient for these very, very rare instances even if that occurred in my practice.

Q. (Mr. Boyle) You used the word "irrational." Are you using that word because of the lawsuit? Is that why?

A. I'm using that word -- I don't know. It's

just the word I chose.

Q. Okay. You're not trying to couch it in terms of the law or the lawsuit when you say irrational?

A. I'm not an attorney, so I don't -- I don't know.

Q. Okay. Were you able to confirm that that patient who you saw at gestational age three weeks was pregnant?

A. (No audible answer)

Q. You mentioned earlier the earliest that you had treated a patient -- a pregnant patient was three weeks gestational age, right?

A. Yes.

Q. How were you able to confirm that patient was three weeks gestational age pregnancy?

A. The patient reported a sure last menstrual period, a history of regular, predictable menstrual cycles that lasted -- that were consistent with, you know, the -- her history of menstrual cycles, so we were able to date the pregnancy that way.

And this particular patient that I'm thinking about also had a urine pregnancy test in our health center.

Q. Did you perform an ultrasound on that

patient?

A. I mean, again, I -- it's my -- it's our standard practice to go through a protocol of history-based screening to determine whether or not we need to recommend an ultrasound for a person.

Q. You agree that induced abortion of any type is more complicated after the unborn child reaches the second trimester, don't you?

A. I'm -- I guess I'm not clear what you're asking.

Q. Complications for induced abortions increase, the risks increase the older the gestational age, so when you get to the second trimester it is more risky to perform an induced abortion in the second trimester than the first trimester. Is that correct?

A. Comparing a procedural abortion in the second trimester to a procedural abortion in the first trimester, yes, the risks are -- the risk, generally, for a procedural abortion increases as the gestation of the pregnancy increases. That would also be true for a person who decided to continue their pregnancy.

Q. Do you agree with the Academy of Medicine's article you cited from extensively when it says that, "The risk of serious complication increases with weeks

gestation. As the number of weeks increase, the invasiveness of the required procedures and the need for deeper levels of sedation also increase"?

A. Again, I'd have to review the specific portion of that document that you're, you know, alluding to to determine whether or not I agree with that. I think, generally speaking, you know, the academy didn't -- yeah, I'll just stop there.

Q. Do you agree with this statement: "The risk of serious complication increases with weeks gestation. As the number of weeks increase, the invasiveness of the required surgical procedure for an abortion and the need for deeper levels of sedation also increase"?

A. That was kind of a lot of things there. So generally, you know, as a person who doesn't -- you know, who recognizes the invasive nature of just having a pelvic exam, I don't -- I don't know exactly what the invasive portion means in that, that you're referring to. But generally, the -- again, for a procedural abortion, as the pregnancy advances, the risk -- the risk can increase.

Q. After 11 weeks gestational age, you don't perform a chemical abortion, right?

A. Not after 77 days.

Q. So every induced abortion ---

A. Or, I -- I'm sorry, let me -- can I ---

Q. Okay.

A. Sorry to interrupt.

Q. Sure.

A. Not -- in the first trimester, no, not after the -- after 77 days. If a person wanted induction termination abortion in my practice, then we would provide that.

Q. And the induction chemical abortion that you described earlier where you use more of the chemical drugs -- a higher dose, I should say, that's beyond the FDA-approved usage of those drugs also, isn't it?

A. When we're taking care of a patient for an induction termination in the second trimester, we use the medications off-label.

Q. And I think you said that you start using D&E abortion after 17 weeks. Is that correct?

A. Generally starting in the 17th week.

Q. Okay. So leading up to week 16, you would -- if you were doing a surgical abortion, it would be an aspiration abortion. Is that correct?

A. The vast majority of times, yes.

Q. And you would agree that the simple act of placing forceps and surgical tools repeatedly beyond

the cervix into the uterus increases the risk of both a cervical laceration and uterine perforation, wouldn't you?

MS. GRANDIN: Objection to form.

THE WITNESS: I don't -- I don't think I'm aware of any specific data showing a specific number of times that a person may need to pass a forceps to complete the dilation and evacuation as a known increased risk.

Q. (Mr. Boyle) So you don't think anybody's studied that?

A. I'm not aware of a study. That doesn't mean that it doesn't exist.

Q. You agree that sometimes patients who undergo surgical abortions need to have a blood transfusion as a complication of that procedure, don't you?

A. Yes. I'm aware that pregnant people need transfusions, including those, occasionally, that access induced abortion.

Q. Have you ever had one of your patients who you were performing a surgical abortion, either an aspiration or a D&E abortion, at the Planned Parenthood clinic that needed a blood transfusion during or soon after the procedure?

A. No.
Q. Okay.
A. Not to my knowledge.
Q. You agree that some, at least some, second-trimester induced abortions must occur in a hospital setting, don't you?
A. There are certain characteristics either associated with the pregnancy or associated with the patient that may make hospital-based care a recommendation.
Q. And about -- from my reading of your CV, about half of the second-trimester abortions that you perform, you perform in the hospital setting. Is that correct?
A. That information wouldn't be listed on my CV.
Q. Is it correct?
A. It's not correct.
Q. How many of the second-trimester abortions that you -- procedural, surgical abortions that you perform, what's the percentage breakdown of the ones that you do in the hospital setting versus in the Planned Parenthood clinic setting?
A. Again, speaking generally, I don't -- generally, sorry. I'm going to keep -- stop mumbling

for the transcript. Sorry.

So I provide dilation and evacuation abortion at both the hospital and Planned Parenthood North Central States. The exact numbers of -- numbers of patients I take care of at Planned Parenthood versus number of patients I take care of at the university, I don't have at the ready or in my brain.

The amount of time I spend, you know, providing procedural abortion at both of those locations, right, the university would be about a half day per week and Planned Parenthood would be about one full day per week.

Q. Okay. So would you say one-third of the -- well, let me ask before I go to that. When you say a half day at the hospital and a full day at the clinic, is that full day at the clinic focused solely on second-trimester surgical abortions?

A. No.

Q. What else do you do in that time when you're at the clinic?

A. When I'm providing care at the health center here in St. Paul, I -- we assess people for their need for whatever they make a -- an appointment for, honestly. So I provide medication abortion. I provide procedural abortion in the first and second

trimester. I assess people for management of miscarriage. I assess people for other pregnancy symptoms they may have in the first trimester.

Q. Okay. And as it relates to the hospital setting, that half day, is it not true that primarily what you're doing there are second-trimester surgical abortions?

A. I mean, the bulk of my procedural abortion care at the university is in the second trimester, yes.

Q. Okay. And ---

A. But it's not all -- it's not all that I do in the operating room.

Q. Okay. So taking just the second-trimester surgical abortions that you perform in the hospital and in the clinic, are they not roughly equal amounts at each place?

A. Again, I can only really tell you what the -- the amount of time that I spend at both of those places. I'd have to look at specific numbers to say anything about specific numbers.

Q. You're not able to just give a rough percentage based on you doing all of them yourself and knowing what that would be?

MS. GRANDIN: Objection to form.

THE WITNESS: I do many procedures, and there's no way I can keep them all in my head ---

MR. BOYLE: Okay.

THE WITNESS: --- regardless of whether it's for abortion or another obstetric and gynecologic problem.

Q. (Mr. Boyle) In any event, you do many second-trimester surgical abortions in a hospital setting every week. Is that fair?

A. It depends on what you define as many.

Q. More than five?

A. No.

Q. How many would you say you do on a weekly basis in the hospital setting?

A. Somewhere probably between one and four.

Q. Okay. Sorry, I'm closing out things, I've jumped around a little bit.

A. That's okay.

Q. Does the hospital where you work in Minnesota and you see patient -- pregnant patients to give them surgical abortions, does that hospital provide staff training for dealing with those types of patients and for patients who have survived sexual assaults?

MS. GRANDIN: Objection to form.

THE WITNESS: We -- I -- you know, I can't know what detailed training is required for all levels of staff that work in the hospital, so I'm not sure I can comment authoritatively on that question.

Q. (Mr. Boyle) Do you feel like the staff you work with at the hospital when you bring your patients to the hospital and perform abortions on them, do you feel like the hospital staff is adequately trained to react and deal with those patients?

A. I'm very privileged to work in a hospital that is very supportive of people's access of -- to comprehensive reproductive healthcare. My -- I have the feeling that many nurses, especially in the preoperative area, actually choose to work there and continue to work there because we're able to provide abortion care in the hospital.

Q. So you think that about your hospital in Minnesota, but you ---

A. I do.

Q. --- made or you gave opinions about the hospital staff in North Carolina. Do you recall that?

A. I do not.

Q. You don't recall saying that you think that the hospital staff in North Carolina aren't trained to properly deal with patients who are having abortion --

surgical abortion procedures?

MS. GRANDIN: Objection to form.

THE WITNESS: If you're referring to statements I made in my declaration, I'm happy to review that document in that specific area that you're, you know, discussing.

Q. (Mr. Boyle) Well, you don't remember saying that in your declaration that you provided in this case?

A. What I know to be true is that staff at Planned Parenthood are required to do extensive training at least annually, in my Planned Parenthood, at least annually to review how -- you know, sensitive exams and how to be present with a person that has experienced sexual assault. What I don't know is whether or not that's required for all staff at the hospital.

Q. And you're talking about at your hospital in Minnesota, right?

A. I am. Uh-huh (yes).

Q. And you don't know ---

A. And I certainly -- if I don't work at a place, I certainly wouldn't know the exact specifics that are required for all staff at any hospital in North Carolina. I'm sure the -- that differs greatly.

Q. Well, you cut me off, because that's where I was going.

A. Sorry.

Q. It's okay. I'm kidding.

Yeah, I just -- I just wanted to point out that you don't even know what the training is at your Minnesota hospital, so you don't have any opinions about what the training is for staff at any North Carolina hospital. Is that fair to say?

A. Oh, no, I have -- well, again, I can tell you from my experience in sitting with patients that, generally, people are much more prepared to sit with a person who's experienced sexual assault in my setting at Planned Parenthood than they are in the hospital.

Now, I'm not saying that the nurses who staff preoperative area are going to try to be disrespectful to a person that experienced or discloses that they've been a survivor of sexual assault, because, generally, I think the people who work there are pretty good people. But I'm not aware of any specific training that's required for them to be able to continue their job.

Q. Okay.

A. That also doesn't mean -- well, yeah. Never mind.

MR. BOYLE: Give me just a moment here.

Q. (Mr. Boyle) Let me ask you about the Goldberg study. Do you remember citing that?

A. I do.

Q. That's from 2022. He did a -- they -- he's the lead author, but they did a retrospective cohort study of medical records from Massachusetts Planned Parenthood entities related to giving chemical abortion drugs to a patient with a pregnancy of unknown location. Is that right?

A. Yes. My recollection of the Goldberg study was that they looked backwards, so retrospectively, at care that had already happened that they had provided for patients who presented for induced abortion care, were diagnosed with a pregnancy of unknown location and then requested medication abortion.

Q. And do you recall that 26 of -- well, so there were -- some part of the population decided to delay care and another smaller portion decided to go ahead and take the chemical abortion before there was a specific location of the pregnancy using ultrasound. Is that your recollection?

A. My recollection of that study is that there were two groups of people that they, again, sorted retrospectively that presented for care -- for

abortion care, were diagnosed with a pregnancy of unknown location, and then based on specific patient factors or counseling or the patient's own assessment of the best -- best way to proceed for them, either chose expectant management with close follow-up or proceeding on that day with induced abortion with medication and close follow-up.

Q. Okay. So do you recall that of the group that delayed care, that decided not to have a surgical or chemical abortion when they were initially told that they had a pregnancy of unknown location, do you recall that 26 percent of those patients who delayed care never needed to take the chemical abortion drugs at all because they either had an ectopic pregnancy or an early loss of pregnancy without any medication?

A. I'd have to ---

MS. GRANDIN: Objection to form.

THE WITNESS: Sorry, Kara.

I'd have to see the specific article to comment on specific percentages.

Q. (Mr. Boyle) Okay. If in fact that's what it said and it was 26 percent that did not need -- that delayed care, that did not need the chemical abortion drugs for those two reasons, because they either lost the pregnancy or they had an ectopic

pregnancy, if you extrapolate that to the patient population at large, that would mean that basically one out of four patients who have a pregnancy of unknown location would end up not needing to have the chemical abortion drugs. Do you agree with that?

A. I do not.

MS. GRANDIN: Objection to form.

Q. (Mr. Boyle) Why not?

A. I do not. Because that patient population, again, considering patient factors, patient history, patient's prior access, patient's own assessment of what is happening in their body, a good number of those people chose to remain in the delay-for-diagnosis group.

So again, blanket statements like that aren't honoring the fact that we do a very detailed assessment of patients' history and counsel them about their options. And in this study, you know, there were people who chose to -- you know, to proceed with expectant management.

Part of the reason that a patient might choose that management strategy is that they already think they're having a miscarriage. So I think that's probably more representative of -- of a portion of that group which they described "delay-for-diagnosis"

in their study.

Q. Did you include a delay-for-diagnosis cohort in your study from 2022?

A. Are you referring to my study from 2023?

Q. I'm sorry. Yeah, it was published in 2023, yes.

A. So our -- again, in our setting, our standard protocol for how to proceed when patients are diagnosed with a pregnancy of unknown location is to consider all the options for the patient. So that includes a detailed history, an assessment of a person's risk for ectopic pregnancy, and then also their own, you know, kind of collation of all that information about how they want to proceed.

So there are certainly patients in our setting and, you know -- I presume you've read or at least skimmed the article -- you know, we showed that that -- patients -- that our protocol for how we do that provides that care safely.

Q. Did you study a cohort that delayed after there was a pregnancy of unknown location -- or I'm sorry, after the -- well, yeah. After there was no ultrasound and you didn't know the location of the pregnancy, did you study a delayed cohort to see what happened to them?

A. In our 2023 study, all the patients had been diagnosed with a pregnancy of unknown location.

Q. Right. And ---

A. And some of those patients -- again, retrospectively, right? Some of those patients, you know, collating all the information that we go through with and the counseling we provide on the day of the encounter, chose to proceed with expectant management with close follow-up.

Q. Chose to have a chemical abortion, is that what you mean by that when ---

A. The other option ---

MS. GRANDIN: Objection to form. Go ahead.

THE WITNESS: The other option for a person diagnosed with a pregnancy of unknown location that's deemed low risk for ectopic pregnancy in our setting would include proceeding with medication abortion or a procedural abortion.

Q. (Mr. Boyle) And what was the first one you were describing? I missed that, I'm sorry.

A. Yeah. So if a patient comes into our health center requesting an abortion or made an abortion appointment and we diagnose a pregnancy of unknown location, then from there we do, you know, a detailed

assessment in correlation or in combination to assess a person's risk for ectopic pregnancy.

There are certain, you know, factors and patient-level characteristics that may make a person high risk for ectopic pregnancy. And then we have extensive protocols about how to ensure that patient gets referred out for sometimes, you know, same-day care or close follow-up with their -- with -- to, you know, kind of on -- continue to assess that risk.

Q. Okay. So did you study pregnancy of unknown location with three groups, one group that got chemical abortion, one group that got surgical abortion and then one group that delayed care and waited until they could confirm the location of the pregnancy?

A. Yes. Our study in 2023 included three groups. Patients chose -- after being diagnosed with pregnancy of unknown location and then assessed to be low risk for ectopic pregnancy, those patients chose either expectant management with close follow-up, medication abortion with close follow-up or procedural abortion for -- with close follow-up.

Q. And did some of those who chose expectant management with close follow-up turn out to have a loss of pregnancy or an ectopic pregnancy?

A. I'd have to look at the specific numbers in the article. But again, one of the reasons -- after counseling a person that's diagnosed with a pregnancy of unknown location, some of that is because the patient has had bleeding and suspects that they have had a miscarriage already. And we just can't know that with a single time point at a single encounter.

Q. So did some of those people who delayed their care end up having an ectopic pregnancy or having an early loss of pregnancy without any induced abortion?

A. I'd have to look at the specifics, but I think, again, because ectopic pregnancy, you know, is a part of early pregnancy, I -- I'm pretty sure there were ectopic pregnancies eventually diagnosed in all of the groups.

MS. GRANDIN: Pardon my interruption. I was just wondering if we could get a time check from you, Gretchen. Per my calculation, we're pretty close to four hours.

MR. BOYLE: I agree we are and I've got about two or three questions left. So if that's all right, I'll just proceed, but I'm not going much longer.

MS. GRANDIN: Okay. That sounds good.

MR. BOYLE: Okay.

MS. GRANDIN: Thank you.

MR. BOYLE: Thanks.

Q. (Mr. Boyle) Do you recall that the Goldberg study concluded that waiting to provide chemical abortion drugs until a patient has a confirmed intrauterine pregnancy is reasonably safe and effective?

A. That's not -- I mean, that's not the primary -- that's not my recollection of the primary conclusion that they drew from their study.

Q. Do you recall that it was at least a conclusion that he -- that they drew from their study?

A. I'd have to look specifically. You know, the conclusion that I recollected from that study was that providing abortion care for patients diagnosed with pregnancy of unknown location is safe and effective.

Q. Do you agree, though, that waiting to provide chemical abortion drugs until a patient has a confirmed intrauterine pregnancy is reasonably safe and effective?

A. I think, again, that doesn't honor patient experience very well. I think when we have a -- a perfectly safe and effective way to provide abortion

care in the setting of a pregnancy of unknown location, I think it's -- I think it's rather cruel to make a person wait.

MR. BOYLE: I don't think I have any further questions. Some of these other folks may have some. Doctor, I very much appreciate your time today. Thank you.

THE WITNESS: Indeed. I appreciate yours as well.

MS. GRANDIN: Do you mind if we take about ten minutes, and I might come up -- come back with a couple re-direct questions?

THE COURT REPORTER: Off the record at 2:58 p.m.

(Brief recess: 2:58 p.m. to 3:11 p.m.)

THE COURT REPORTER: Back on the record at 3:11 p.m.

EXAMINATION

BY MS. GRANDIN:

Q. Dr. Boraas, in your experience when a patient is seeking an abortion involving some level of sedation, who makes the decision about what level of sedation to give a patient?

A. You know, ultimately, it's the patient's decision.

Q. Does the anesthesiologist ever make that decision?

A. I would say the anesthesiologist strongly recommends a specific type of anesthesia, if there's an ---

Q. In your ---

A. --- if there's an anesthesiologist involved.

Q. In your experience, what factors often go into making the decision of what level of sedation a patient prefers?

A. Well, the first and foremost is what the patient desires. The second is, you know, occasionally we will see a patient that just requires a high -- a high level of sedation in order to complete the procedure safely.

Q. In your experience providing abortions, how often do patients choose deep sedation as their sedation option?

A. Well, again, the only place where people would have that -- would be able to access deep sedation would be in the hospital. And for various reasons, namely, the first and foremost being insurance coverage, that's a prohibitive option for many people in my setting.

Q. Do you have a general estimation, or is that

just -- is that not something you'd be able to provide an estimate of?

A. Deep sedation compared to general anesthesia?

Q. Deep sedation compared to other options I -- available.

A. Yeah, I think it really just depends on the patient. Many patients are nervous about any type of sedation and how it might affect their body.

Q. When a uterine perforation or a cervical laceration occurs during a procedural abortion, how do you generally treat that?

A. So treatment for both of those things is potentially different, so I'm going to talk about one at a time.

Q. Yes. Thank you.

A. No problem. If a perforation is suspected during a procedure, the next sort of -- not question, but the next thing that we assess is with what instrument because that -- that determines whether or not the patient -- whether or not we can ensure the integrity of the bowel.

If we can't ensure the integrity of the bowel, then the person has to have assessment of that surgically at the hospital.

If the perforation happens with a blunt instrument, especially in the first trimester, we're usually able to watch those patients closely in our outpatient health center, like at Planned Parenthood North Central States, and closely monitor vitals and pain level and just sort of overall patient assessment.

Sometimes potentially using ultrasound to -- and sometimes we're also able to, you know, monitor the patient safety in our health center.

Q. And I -- I think you answered this question in your general answer, but just to clarify. Does -- in general, when a uterine perforation occurs, does it always require treatment in a hospital?

A. No.

Q. And when a cervical laceration -- sorry, go ahead.

A. Yeah, sorry. I just remembered that you asked about cervical laceration, too, and I haven't answered that. So ---

Q. That's okay. Let me -- let me ask the question again specifically to cervical laceration. So when a cervical laceration occurs during a procedural abortion, how do you treat that?

A. It depends whether or not the -- the

laceration is low or in the distal portion of the cervix or whether it's higher and not as easily visible.

So for a distal or cervical laceration that occurs at the end of the cervix, those, if they're very small, can just be observed and make sure that they're not bleeding heavily. And if they're not, those can -- then those heal on their own.

If it's more -- if it's a slightly larger laceration or the laceration is bleeding a fair amount, then oftentimes we will reapproximate that laceration with suture, bring it together with suture and ensure that there isn't any ongoing bleeding.

Q. And ---

A. If ---

Q. Sorry, go ahead.

A. If the -- if the laceration is potentially higher, that may be treated with tamponade, like with a intrauterine balloon. And a fair number of times, that is sufficient for treatment of that. Higher lacerations sometimes need other procedures depending on where the -- where it is.

Q. So can a cervical laceration be treated safely in the clinic, an outpatient clinic where an abortion is performed?

A. Certain types of them, yes, absolutely.

Q. Does it -- is it always a requirement for surgical lacerations that the patient be treated in a hospital setting?

A. It is not always a requirement that cervical lacerations are better addressed in a hospital setting, no.

Q. Are forceps used in miscarriage management in your experience?

A. If I'm providing a dilation and evacuation to help complete a miscarriage for a patient, yes. Again, typically starting around the 17th week of pregnancy, that would be the same for a person experiencing a miscarriage also.

Q. Are forceps used in labor and delivery in your experience?

A. Yes.

Q. Is cervical ---

A. When a patient ---

Q. Sorry, go ahead.

A. Yeah. Yes, when a patient requires an operative vaginal delivery. Sometimes even at the time of C-section if the extraction is difficult.

Q. Is cervical laceration a possible complication of miscarriage management?

A. Yes.
Q. Is it a possible complication of labor and delivery?
A. Yes.
Q. Is uterine perforation a possible complication of miscarriage management?
A. Yes.
Q. Is it a possible complication of labor and delivery?
A. Yes.
Q. Is infection a possible complication of miscarriage management?
A. Yes.
Q. Is it a possible complication of labor and delivery?
A. Yes.
Q. Is hemorrhage a possible ---
(Off-record comments)
Q. (Ms. Grandin) Is hemorrhage a possible complication of miscarriage management?
A. Yes.
Q. Is it a possible complication of labor and delivery?
A. Yes.
Q. Does that include a hemorrhage requiring a

blood transfusion?

A. 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.

Q. In your opinion, do dilation and evacuation abortions need to be performed in a hospital in order to be performed safely?

A. No.

Q. So I think you testified earlier that you hadn't seen PPSAT's specific abortion protocols. However, you reviewed Dr. Farris's declaration submitted in support of the Amended Preliminary Injunction Motion in this case. Is that correct? Her two declarations?

A. I reviewed the declarations that Dr. Farris submitted, yes.

Q. What from Dr. Farris -- from your review of Dr. Farris's declaration, what is your understanding of PPSAT's protocol for a medication abortion in the circumstance where a patient has a pregnancy of unknown location?

A. From my review of Dr. Farris's declarations, the protocol at PPSAT would include assessment of patient's risk for ectopic pregnancy if they have been

diagnosed with a pregnancy of unknown location, and then a thorough review of the risks and benefits of expectant management in the setting of a PUL, pregnancy of unknown location, or proceeding with medication abortion or a procedural abortion.

And then my ---

Q. Do you -- sorry. Go ahead.

A. My -- again, from her declaration, my understanding of PPSAT's protocol regarding patients with a PUL also includes review of, you know, potential warning signs and symptoms associated with an ectopic pregnancy, as well as recommendation for very close follow-up.

Q. From your review of the -- Dr. Farris's declaration, do you understand that PPSAT in North Carolina uses hCG serial testing to evaluate patients who seek medication abortion but have a pregnancy of unknown location?

A. I do recall that from Dr. Farris's declaration.

Q. Do you recall whether PPSAT in North Carolina administers ultrasounds to patients who have a pregnancy of unknown location and seek medication abortion?

A. The only -- the only way to establish a

definitive diagnosis of pregnancy of unknown location is with ultrasonography. So, yes, if they're treating people with a pregnancy of unknown location, then they -- that person has had an ultrasound.

Q. Is it your understanding from Dr. Farris's declaration that PPSAT uses a similar protocol as the protocol whose safety and efficacy you discussed in your published research on the topic in your article from 2023 that we discussed previously in this deposition?

A. Our article does, in a box in the article, describe the protocol that we use here at Planned Parenthood North Central States. And it's -- from her declaration, the protocol that Dr. Farris described in the declarations seems very -- very similar.

MS. GRANDIN: Thank you, Dr. Boraas. I don't have any further questions.

MR. BOYLE: I have brief re-direct based on your questions if I might.

MS. GRANDIN: Okay.

THE WITNESS: Absolutely.

FURTHER EXAMINATION

BY MR. BOYLE:

Q. You were talking about bleeding from a cervical laceration. How do you see that? What

methodology do you use or mechanism do you use to visualize that? Do you just see it with your eyes, or are you using radiograph or some other testing?

A. Bleeding is visible with my eyes ---

Q. Okay. So you don't have like a fiber optic or something like that?

A. No. No fiber optics.

Q. Then how are you able to see it if it's -- not distal, but if it's the other one, farther away?

A. We would suspect a high cervical laceration if there was ongoing bleeding that wasn't coming from the top portion or fundus of the uterus.

Q. Well, you said some cervical lacerations should be treated in a hospital setting, right?

A. I didn't say that. I said many cervical lacerations can be safely treated in an outpatient setting.

Q. Which means the rest must be treated in a hospital setting, right?

A. There are certain -- you know, there are certain high cervical lacerations that don't respond enough to the measures that we use to treat them in the outpatient center. And then for those people, they may require transfer to a hospital.

Q. And you said that some uterine perforations

require hospital exploratory -- exploratory surgery of the abdomen in a hospital setting, right?

A. Some -- depending on what instrument and where the perforation in the uterus occurs and the potential risk for injury to the bowel in particular, some of those patients, yeah, need to be transferred for -- if the D&E happens in the outpatient setting, need to be transferred for that surgery in a hospital.

Q. You don't do any exploratory abdominal surgery to determine the scope of damage to different organs from a uterine perforation in your Planned Parenthood clinic in Minnesota, do you?

A. We don't provide any intraabdominal surgery at Planned Parenthood North Central States, no.

Q. And I know you haven't ---

A. However, if I'm taking care of that patient and that perforation occurs in the hospital, I would be present as the physician responsible and likely probably even start the case while we requested, you know, intraoperative consultation from the general surgeon.

Q. Right. But you wouldn't do that at the clinic. You would transfer that patient from the clinic to the hospital before you started that surgery, right?

A. That type of surgery requires general anesthesia, and we don't have that capacity at North -- Planned Parenthood North Central States.

Q. How do you get the serum hCG test from a patient? What do you do to collect that?

A. We draw their blood.

Q. How do you draw their blood?

A. With a needle.

Q. So do you take hCG testing of every patient before you give them a chemical abortion drug?

A. Not all patients accessing medication abortion need serum beta hCG testing.

Q. So is it your testimony that you have patients that you give chemical abortion drugs to that have neither had an ultrasound to confirm the location of the pregnancy nor had a serum hCG blood draw to test their pregnancy amounts, if you will?

MS. GRANDIN: Objection to form.

THE WITNESS: Testing serum hCG pregnancy amounts isn't really a thing in medical practice. The absolute value is rarely of helpful significance. It's really the trend over time that helps us take good, safe care of patients.

Now, there are certainly patients who screened, you know, after a thorough assessment to be

low risk for ectopic pregnancy and would need neither an ultrasound nor serum hCG testing.

Q. (Mr. Boyle) Okay. So in your practice in Minnesota at your Planned Parenthood clinic, you give patients -- on certain occasions, you give them chemical abortion drugs without performing an ultrasound on them or drawing blood to conduct the first in a series of serum hCG blood tests. Is that correct?

A. The provision of medication abortion without -- after a history-based screening without ultrasound or tests like serum hCG is well established in the medical literature to be safe and effective.

Q. And you do that at your clinic in the Planned Parenthood clinic in Minnesota. Is that correct?

A. For patients who screen out of the need for ultrasound, yes.

Q. And even if they don't have an ultrasound, you also sometimes don't have either an ultrasound or the blood draw, correct?

A. Those two things are not indicated for every medication abortion patient.

Q. Which is sort of the inverse of what I'm asking. So sometimes, you give those patients who

don't have an ultrasound and don't have the serum blood draw, you give them chemical abortion drugs. Is that correct?

A. If they are deemed to be a low-risk patient and have -- and that's what they choose as far as prevent -- proceeding with abortion care and are able to, you know, say that they'll, you know, complete the recommended follow-up.

Q. I feel like you left a yes off at the end there. Was there a yes that -- if all those things, then, yes, you do that?

A. If all those -- if all of those things are true about a individual in front of me, then yes.

Q. Okay. Lawyers are fun, aren't we?

A. You -- yeah, you all are fun.

Q. So -- and just so I understood your testimony before with Ms. Grandin, you said that it's your understanding that Planned Parenthood South Atlantic performs an ultrasound on every single pregnant patient before they provide that pregnant patient with a chemical abortion, just sometimes when they do the ultrasound it's indeterminate so you have a pregnancy of unknown location. Is that your understanding?

A. My understanding is that the law in North

Carolina -- again, not an expert on laws, specifically not in states where I don't practice. But my understanding of the law in North Carolina is that an ultrasound is required for each patient to access abortion care.

Now, certainly, as people are nervous about limits and bans on when they're able to access abortion care, there are certainly patients -- we've seen this for sure after the Dobbs decision, people making appointments earlier and earlier in pregnancy because they're worried they won't be able to access that care.

Q. Yeah. I'm trying ---

A. Then naturally, as far as, you know, how pregnancies progress, many of those people will be diagnosed with a pregnancy of unknown location because we don't reasonably expect to see an -- see a pregnancy on ultrasound, regardless of where it's growing.

Q. Fair enough. My question to you is, I thought I understood you to say that when you read Dr. Farris's declarations in this case that it's your understanding that she said every single patient who gets a chemical abortion in the Planned Parenthood South Atlantic clinic has an ultrasound taken of them

before they are given that medication. Is that correct?

A. My understanding of the protocol I'm specifically referring to in her declaration is about people who have been diagnosed with a pregnancy of unknown location.

That diagnosis can only happen -- a patient is -- has a pregnancy. We can diagnose a pregnancy with a urine pregnancy test, but we can't -- we can't diagnosis -- diagnose a pregnancy of unknown location unless we've -- unless we've -- unless the patient has had ultrasound.

Q. Or you can simply not take an ultrasound, and every patient without an ultrasound has a pregnancy of unknown location, right?

A. No.

Q. No?

A. No. A patient who hasn't had an ultrasound but has had confirmation of a pregnancy, for example, most commonly with a urine pregnancy test, that patient just has a pregnancy.

Q. I think you said this, and I promise this is my last one here. I just want to confirm.

A. Okay.

Q. Don't believe me because I'm a lawyer, but

I'm pretty sure this is my last question.

You're saying that every patient at Planned Parenthood South Atlantic who gets chemical abortion drugs has had an ultrasound. Is that your understanding?

A. My understanding is that the law requires ultrasound prior to abortion care in North Carolina.

Q. So that law, I believe, that you're talking about is currently enjoined, which, fancy legal word, means it's basically on the shelf until this hearing coming up at the end of September.

So are you saying that you think every single patient -- see, I told you I was going to ask another question -- every single patient at Planned Parenthood South Atlantic in North Carolina has an ultrasound because of that law or because of what you saw in Dr. Farris's declaration, which is it?

A. Dr. ---

MS. GRANDIN: Objection to form and calls for a legal conclusion.

THE WITNESS: Dr. Farris's declaration describes the protocol they use to help treat patients that are diagnosed with a -- a pregnancy of unknown location. And again, in order to diagnose a pregnancy of unknown location, a person would have to have an

ultrasound.

MR. BOYLE: Okay. I don't think I have any further questions.

THE COURT REPORTER: Anybody else?

All right. This concludes the deposition. The time is 3:34 p.m.

WHEREUPON, at 3:34 o'clock p.m., the deposition was adjourned.

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

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

My Commission Expires: (SEAL)

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
for Cape Fear Court Reporting, Inc.
PO Box 10112
Wilmington NC 28404

APPEARANCES

FOR PLANNED PARENTHOOD SOUTH ATLANTIC:

Hannah Swanson, Esquire
Kara L. Grandin, Esquire (via videoconference)
Anjali Salvador, Esquire (via videoconference)
Dylan Cowit, Esquire (via videoconference)
Helene T. Krasnoff, Esquire (via videoconference)
PLANNED PARENTHOOD FEDERATION OF AMERICA
1110 Vermont Avenue NW, Suite 300
Washington, DC 20005
hannah.swanson@ppfa.org
kara.grandin@ppfa.org
anjali.salvador@ppfa.org
dylan.cowit@ppfa.org
helene.krasnoff@ppfa.org

FOR ALL PLAINTIFFS:

Jaclyn A. Maffetore, Esquire (via videoconference)
ACLU OF NORTH CAROLINA
P.O. Box 28004
Raleigh, NC 27611
jmaffetore@acluofnc.org

FOR THE PLAINTIFF DR. BEVERLY GRAY:

Brigitte Amiri, Esquire (via videoconference)
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad Street, 18th Floor
New York, NY 10004-2400
bamiri@aclu.org

APPEARANCES

FOR THE LEGISLATIVE LEADER DEFENDANTS
SENATOR BERGER AND SPEAKER MOORE:

W. Ellis Boyle, Esquire
WARD & SMITH, PA
751 Corporate Center Drive, Suite 300
Raleigh, NC 27607
weboyle@wardandsmith.com

Julia Payne, Esquire (via videoconference)
ALLIANCE DEFENDING FREEDOM
15100 N. 90th Street
Scottsdale, AZ 85260
jpayne@adflegal.org

FOR ATTORNEY GENERAL JOSH STEIN:

Sripriya Narasimhan, Esquire (via videoconference)
NORTH CAROLINA DEPARTMENT OF JUSTICE
114 West Edenton Street
Raleigh, NC 27603
snarasimhan@ncdoj.gov

FOR ALL DISTRICT ATTORNEY DEFENDANTS
EXCEPT JIM O'NEILL:

Elizabeth C. O'Brien, Esquire (via videoconference)
NORTH CAROLINA DEPARTMENT OF JUSTICE
114 West Edenton Street
Raleigh, NC 27603
eobrien@ncdoj.gov

FOR THE DISTRICT ATTORNEY JIM O'NEILL

Kevin G. Williams, Esquire (via videoconference)
BELL DAVIS & PITT, P.A.
100 N. Cherry Street, Suite 600
Winston-Salem, NC 27101
kwilliams@belldavispitt.com

APPEARANCES

FOR THE NORTH CAROLINA MEDICAL BOARD,
NORTH CAROLINA BOARD OF NURSING:
Michael E. Bulleri (via videoconference)
NORTH CAROLINA DEPARTMENT OF JUSTICE
114 West Edenton Street
Raleigh, NC 27603
mbulleri@ncdoj.gov

FOR SECRETARY KODY H. KINSLEY, DEPARTMENT OF HEALTH AND HUMAN SERVICES
Michael T. Wood, Esquire (via videoconference)
NORTH CAROLINA DEPARTMENT OF JUSTICE
114 West Edenton Street
Raleigh, NC 27603
mwood@ncdoj.gov

OTHER APPEARANCES
Rachael Corcione, Videographer

OTHER REMOTE APPEARANCES
Shealyn Massey
Planned Parenthood Federation of America
Vanisha Kudumuri
Planned Parenthood Federation of America
Susanna Birdsong
General Counsel/Vice President of Compliance
at Planned Parenthood South Atlantic
Joshua Yost
General Counsel, Office of the
Senate President Pro Tempore
Sam Hayes
General Counsel, North Carolina
House Speaker Tim Moore

I N D E X

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.

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).

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

Senator Berger. I believe I'm joined on this Zoom remotely by my co-counsel, Julia Payne, with the ADF.

MS. PAYNE: Yes, I am here.

MR. BOYLE: And I might just tick down the list so we don't overlap. Can we get Attorney General Stein's counsel next?

MS. NARASIMHAN: Morning. My name is Sripriya Narasimhan. I'm with the North Carolina Department of Justice, representing Attorney General Josh Stein.

MR. BOYLE: Next, the DAs other than Jim O'Neill?

MS. O'BRIEN: Good morning. Elizabeth O'Brien from the North Carolina Department of Justice, and I represent the district attorneys, except for District Attorney Jim O'Neill.

MR. BOYLE: Next, DA Jim O'Neill?

MR. WILLIAMS: My name is Kevin Williams with the Forsyth County Bar, and I represent District Attorney Jim O'Neill.

MR. BOYLE: Next. Secretary Kinsley?

MR. WOOD: Hi, good morning. This is Michael Wood with NCDOJ, and I'm counsel to Secretary Kody Kinsley of DHHS.

MR. BOYLE: Next. The Medical Boards?

MR. BULLERI: Good morning. This is Michael Bulleri with the North Carolina Department of Justice. I represent the North Carolina Medical Board and the North Carolina Board of Nursing.

MR. BOYLE: I think that's all of the groups of parties. If there are any other folks that are on, please identify yourself now. Thanks.

MS. AMIRI: Hi, everyone. Brigitte Amiri from the ACLU, and I represent the Plaintiff, Dr. Gray.

MS. MAFFETORE: Good morning, everyone. Jaclyn Maffetore of the ACLU North Carolina on behalf of all Plaintiffs.

MR. YOST: Good morning, everyone. Joshua Yost, General Counsel for Senator Phil Berger.

MR. HAYES: And Sam Hayes, General Counsel for North Carolina House Speaker Tim Moore.

MR. BOYLE: Going once? All right. Ready to begin?

THE COURT REPORTER: I need to swear in our witness.

MR. BOYLE: Yes.

The witness, KATHERINE A. FARRIS, MD, being first duly affirmed to state the truth, the whole truth, and nothing but the truth, testifies as follows:

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

reporter transcribe it, can you agree to do that, please?

A. I can.

Q. Great. And if we get down the path and you get a little off that, I may politely nudge you back. I'm not trying to be rude. Please don't be offended if I do that. Okay?

A. I understand.

Q. The second one is talking over each other. Again, to have a clean record for the court reporter, it's much better if I allow you to finish whatever you're saying and vice versa before the other one starts to talk again.

So I ask that you please try and be more cognizant of that than under normal conversation circumstances where you think you know where I'm going with my question, and you just start answering. Try to let me finish, even if I ramble, please.

A. I understand.

Q. Thank you. And then, finally, your lawyer may object during the course of this deposition. And unless there's an instruction not to answer for some privilege or similar-type reason, the expectation is that you'll respond to the question, even if there's an objection. Okay?

A. Yes.

Q. Very good. You work for Planned Parenthood South Atlantic, right?

A. That's correct.

Q. You're the medical director there?

A. My title is chief medical officer.

Q. Okay. Is there someone else who's the medical director?

A. I have an associate affiliate medical director who works under me.

Q. Okay. Are you the CEO or president or the highest officer in the operational process of the Planned Parenthood South Atlantic?

MS. SWANSON: Objection to form.

THE WITNESS: I am not the CEO. I'm the chief medical officer, and I am the highest ranking licensed person in the organization.

Q. (Mr. Boyle) Okay. Is there someone who has a title that works there day to day who is your boss, or are you sort of the person who runs the day-to-day operations?

A. I have a boss, yes. The CEO.

Q. Planned Parenthood -- and I'm going to call it "PPSA" -- or do you want to call it "P-P-S-A-T" or "PP-SAT"?

A. If we used an acronym, it would be PPSAT.

Q. Okay. I'll try to remember that. I wrote PPSA here, so please forgive me if I say it the wrong way. PPSAT charges money to perform induced abortions. Isn't that true?

A. Yes.

MS. SWANSON: Objection to form.

THE WITNESS: We do charge for the medical services we provide.

Q. (Mr. Boyle) And one of those medical services that PPSAT provides is induced abortions, right?

A. We do provide abortions.

Q. And you do charge for those induced abortions that you provide, right?

A. I do not charge, so I'm not directly involved with charging money.

Q. Would you say you're, what, second in command at PPSAT, or where do you fall on the org chart?

MS. SWANSON: Objection to form.

THE WITNESS: I am not second in command. I do report directly to the CEO, as do a number of other individuals.

Q. (Mr. Boyle) Okay. And you're aware, then, that PPSAT charges money to perform induced abortions

for patients who come to PPSAT seeking an induced abortion, right?

A. Yes. We do charge for our healthcare services.

Q. And I appreciate that. I just want to make sure I'm clear, because I asked about induced abortions. You do charge for induced abortions, including other healthcare?

MS. SWANSON: Objection to form.

THE WITNESS: We charge for all of the healthcare we provide, including induced abortions.

Q. (Mr. Boyle) Okay. Thank you. How much does PPSAT charge for each chemical abortion that it performs in North Carolina?

A. I believe that the cost for self-pay for a medication abortion is $625.

Q. Are there other prices that are charged other than for a self-paid patient who's obtaining a chemical abortion from PPSAT?

MS. SWANSON: Objection to form.

Q. (Mr. Boyle) In North Carolina, I should say.

A. In North Carolina, we also have insurance that we bill for abortion, and I believe that the cost for insurance is based on contracts, but I don't know the exact amount.

Q. Do you know if -- and as I understand, PPSAT operates in four different states, right?

A. That is correct.

Q. And you're the medical officer for PPSAT in all four states. Is that correct?

A. That is correct.

Q. When we're talking about PPSAT today, I'm primarily focused on what PPSAT does at the, what is it, six clinics here in North Carolina. So if there's any confusion, please let me know. But generally, when I'm talking about PPSAT, can we agree that we're talking about those six clinics in North Carolina?

MS. SWANSON: Objection to form.

THE WITNESS: Just to clarify, we have more than six clinics in North Carolina. We only perform abortions at six of the clinics in North Carolina.

Q. (Mr. Boyle) Fair enough. How many clinics do you have in North Carolina?

A. Nine clinics in North Carolina.

Q. Okay. Which six clinics in North Carolina do you perform induced abortions at?

A. Planned Parenthood South Atlantic performs abortions at our Asheville, Charlotte, Winston-Salem, Fayetteville, Chapel Hill and Wilmington clinics in

North Carolina.

Q. So you do not perform them in Raleigh or Greensboro. Is that correct?

A. We do not perform abortions in Raleigh, Durham or Greensboro.

Q. Okay. So I'm primarily going to be asking about the six PPSAT clinics in North Carolina where you perform induced abortions. So if that gets confusing, please clarify and ask me to clarify. But that's my intent. Okay?

A. I understand.

Q. Very good. Do you know if PPSAT charges -- insurance companies that pay for medical or chemical abortions, do they charge more or less than they charge for the individual who's paying directly?

A. I believe that we have contracts with insurance companies in North Carolina that we charge for medication abortion, and I think that cost is higher if a patient is using insurance to pay for their abortion healthcare.

Q. Okay. Do you know how much PPSAT charges for each surgical abortion that it performs in North Carolina?

A. Procedural abortions are charged based on the gestational duration of the pregnancy. So I believe a

first trimester, so up through the 13th week of pregnancy, is $625. And then there are increases in cost based on gestational duration.

Q. What do those increases in cost based on gestational duration look like? What is the amounts?

A. I do not know those numbers off the top of my head.

Q. Do you know why there's an increase in cost-charge as the durational age goes up?

A. I was not part of making those decisions, so I don't know exactly why those costs change.

Q. Is the surgical procedure for an aspiration abortion at 14 weeks the same as a surgical procedure for an aspiration abortion at 16 weeks?

MS. SWANSON: Objection to form.

THE WITNESS: Every procedure is slightly different based on patient factors, but the difference between a 14-week abortion and a 16-week abortion is fairly minimal.

Q. (Mr. Boyle) Do you know if you charge -- if PPSAT charges more for an aspiration abortion at 14 weeks than they do for an aspiration abortion at 16 weeks in North Carolina?

A. No. I believe they do not charge more for 14 weeks than for 16 weeks.

Q. When does that difference, that increased cost, kick in then? Is it at week 17? Is it at week 18?

A. Can you please clarify your question?

Q. You just said that you don't believe that PPSAT North Carolina charges anything different for a 14-week aspiration abortion versus a 16-week aspiration abortion. Is that correct?

THE WITNESS: No.

MS. SWANSON: Objection to form.

THE WITNESS: That's not what I said. I said I do not believe that Planned Parenthood South Atlantic charges more for a 14-week abortion than for a 16-week abortion, which is what I understood you to be asking.

Q. (Mr. Boyle) Okay. That's not what I was asking. That's what I meant. So thank you for the clarification. I apologize for being confusing.

So when would that price difference kick in if it's not, say, 14 to 16 weeks? Is it at 17 weeks? Is it at 18 weeks?

A. I understand there to be a price difference when a patient hits 14 weeks that is higher than an abortion at 13 weeks. And I understand there to be incremental increases in abortion at some gestational

ages, but I don't know the date range.

Q. Okay. But you don't think it's 14 to 16 weeks? You think those would be charged the same?

MS. SWANSON: Objection to form.

THE WITNESS: I don't know without looking at our fee service -- our fee -- I don't remember the name of the document, but there's a document that lists our fees.

Q. (Mr. Boyle) How much money does PPSAT make in one year for chemical abortions it performs in North Carolina?

MS. SWANSON: Objection to form.

THE WITNESS: I do not know.

Q. (Mr. Boyle) How much money does PPSAT make in a year for surgical abortions it performs in North Carolina?

MS. SWANSON: Objection to form.

THE WITNESS: I do not know.

Q. (Mr. Boyle) How much money does PPSAT make in a year for surgical abortions it performs in North Carolina for pregnant women in their 14th or later weeks gestational age?

MS. SWANSON: Objection to form.

THE WITNESS: I do not know.

Q. (Mr. Boyle) But you do know that when a

patient hits 14 weeks gestational age, PPSAT charges more for all of those surgical abortions 14 weeks and later than earlier time? So 13 weeks or less, correct?

A. I do know that the cost of an abortion at 14 weeks and later is higher than the cost prior to 14 weeks.

Q. How many chemical abortions does PPSAT perform in a year in North Carolina on patients who have a pregnancy that is not identified in the mother's uterus by using ultrasound?

MS. SWANSON: Objection to form.

THE WITNESS: I do not know the exact number of abortions that Planned Parenthood provides -- pardon me, medication abortions that Planned Parenthood provides to patients with pregnancy of unknown location.

Q. (Mr. Boyle) Okay. You would agree that leading up until today, Planned Parenthood South Atlantic does perform chemical abortions on patients who have a pregnancy that is not identified in the uterus or located in the uterus by ultrasound. Is that correct?

A. Planned Parenthood does perform medication abortions on select patients who do not have a visible pregnancy within their uterus.

Q. And they charge money -- let me rephrase that.

Planned Parenthood South Atlantic charges money for those chemical abortions that it provides to patients who have an ultrasound, but you are not able to locate the pregnancy in their uterus, correct?

A. Planned Parenthood does charge for abortions on a patient with a pregnancy of unknown location. Yes.

Q. How much money do you think Planned Parenthood South Atlantic will lose in a year if it cannot perform surgical abortions in North Carolina for pregnant women in their 13th -- I'm sorry, 14th or later weeks gestational age?

MS. SWANSON: Objection to form.

THE WITNESS: I do not know.

Q. (Mr. Boyle) But you do know that currently, PPSAT is performing surgical abortions on women in their 14th week gestational age or later, and they are charging money for those abortions, right?

MS. SWANSON: Objection to form.

THE WITNESS: I am not aware of -- I'm not sure if we have performed an abortion beyond the 12th week since the new law went into effect.

Q. (Mr. Boyle) Okay. Leading up to July 1st,

2023, you would agree that PPSAT North Carolina was performing surgical abortions on patients in their 13th week and later gestational age and charging money to perform those abortions, right?

A. Prior to July 1st, Planned Parenthood South Atlantic was performing procedural abortions beyond the 12th week of pregnancy and charging for those abortions, yes.

Q. And this law, this change in the law, has caused PPSAT to lose the income that it made from charging those patients for those abortions, right?

MS. SWANSON: Objection to form.

THE WITNESS: I am not aware of what our income balance is since the change in the law.

Q. (Mr. Boyle) Well, you're aware that if you were performing those abortions before and charging money and getting paid for them, and now you're not, you've lost that money, right?

MS. SWANSON: Objection to form.

THE WITNESS: I am not aware of what money or what our income has been since the change in the law.

Q. (Mr. Boyle) Yes, I'm not asking about your general income or your general balance sheet. I'm saying, the simple fact is, if you were doing those

abortions and charging money for them before, and now you no longer are, you've lost that money that you made before, correct?

MS. SWANSON: Objection to form.

THE WITNESS: I think that would require me to speculate, because we've changed the services we provide since the law went into effect, and I can't speculate as to the exact impact that has had on our income.

Q. (Mr. Boyle) I'm not asking you to compare income. I'm just asking if you simply lose revenue from that potential source if you're no longer doing it.

MS. SWANSON: Objection to form.

THE WITNESS: I can state that we are not charging for abortions that we are not performing, and we are not performing abortions, routinely, beyond the 12th week of pregnancy since the law went into effect.

Q. (Mr. Boyle) You just said, "routinely." Are you performing them at all?

A. Legally, we can perform them. And I'm not personally aware of an abortion that has done -- that has been done past the 12th week that meets one of the exceptions.

Q. So as I understand your testimony, you're saying that it's possible that an abortion after the 12th week that meets one of the exceptions under the new law has been performed at a PPSAT clinic since July 1st leading up to today, September 1st, but you're just not aware of that.

A. Correct.

Q. Okay. I just want to clarify. If you were making money doing that type of abortion before July 1st when the law in effect, and now you're no longer doing it, you would agree that you've lost at least that money that you were able to make and charge for those abortions that you're not able to make and charge now, correct?

MS. SWANSON: Objection to form.

THE WITNESS: I would not characterize that I -- that PPSAT has lost money. I would characterize that PPSAT is not charging for procedures that we are not performing.

Q. (Mr. Boyle) PPSAT is a nonprofit. Is that correct?

A. Yes, that's correct.

Q. Does it provide any charity care to patients?

MS. SWANSON: Objection to form.

THE WITNESS: I am not deeply involved

in exactly how patients pay for abortions, so have some limited knowledge of how that works.

Q. (Mr. Boyle) Does it provide charity abortion care to patients?

MS. SWANSON: Objection to form.

THE WITNESS: I know that there are abortion funds that support patients who cannot afford to pay. So if they don't have insurance that covers the abortion or choose not to use insurance and they are paying the self-pay fee, some patients, it is my understanding, cannot afford to pay it, and I am aware that there are donation funds that support patients.

I'm not exactly sure when or how that money comes directly from Planned Parenthood versus other non-Planned Parenthood abortion funds.

Q. (Mr. Boyle) Fair enough. And when you say Planned Parenthood in that context of your last answer, are you talking about PPSAT, or are you talking about the parent organization, Planned Parenthood, sort of nationwide?

A. Thank you for clarifying. I was referring specifically to Planned Parenthood South Atlantic. I'm also not fully aware of Planned Parenthood Federation of America funds that may be supporting care.

Q. Okay. So it might happen, you're just not

aware of how and when.

A. Correct.

Q. Okay. And I don't need specifics, but you're paid to be the medical director on an annual basis for your work at PPSAT, right?

A. Yes, I am.

Q. Do you have any other jobs -- again, not looking for specifics. Do you have any other jobs where you work for money, you earn income outside of PPSAT, in the past five years, or do you dedicate your full workload and income earning to your job at PPSAT?

A. The only job I have is at PPSAT.

Q. Is that true for the past, say, five years?

A. Yes, that is true.

Q. Are you being paid for your testimony here today?

A. I'm not being paid differently for my testimony. I'm just working as the chief medical officer of Planned Parenthood South Atlantic.

Q. Take a water break.

Right. That -- and that's my question specifically, is, you know, sometimes expert witnesses are paid independently from their day job. Are you being paid as an expert witness beyond your normal salary that you derive working as the medical director

at PPSAT for your time testifying here today?

A. No, I'm not.

Q. So your role here today is as the chief medical director for one of the Plaintiffs in -- the parties in this case. Is that right?

A. My title is chief medical officer, and I am here speaking based on my knowledge as the chief medical officer of Planned Parenthood South Atlantic, who I understand to be a Plaintiff in this case.

Q. Sorry, when I do that weird thing, I'm thinking. I apologize.

Is part of your payment for your job at PPSAT derived from how PPSAT performs overall in any given year?

MS. SWANSON: Objection to form.

THE WITNESS: I do not have any change in compensation related to performance metrics.

Q. (Mr. Boyle) So you don't have incentive payments or bonuses or anything like that related to your job? Again, not asking for specific amounts, but any type of incentive payment.

A. I have received bonuses in the past, but never as an incentive related to -- when I think about bonuses in healthcare, often bonuses are applied for volume. I've never received a bonus from Planned

Parenthood South Atlantic based on the volume of care that I provided.

Q. Without going into details about numbers, why would you have gotten, or why did you get bonuses in the past from PPSAT?

A. I've received a bonus in the past when I took on additional job responsibilities. For example, serving as the interim -- I don't recall the exact title, but it's in my CV. The interim VP of patient services, I think. So it was a substantive change in my job description that they paid me a bonus for.

Q. Very small print on your CV.

MS. SWANSON: And, Ellis, if you're going to be referring to that, could we also have a copy to look at, please?

MR. BOYLE: Yeah, I was just looking to see if I remembered the name she was talking about. I don't know that I have a copy of her CV.

But I accept your explanation.

Q. (Mr. Boyle) So if PPSAT performs a certain metric of induced abortions in a year, are you paid more in that year for achieving that goal or metric?

MS. SWANSON: Objection to form.

THE WITNESS: No.

Q. (Mr. Boyle) But if the North Carolina law

that goes into effect that you're here testifying about in this case, if it goes into effect, your company, PPSAT, could lose money, because it will lose the ability to perform as many induced abortions. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: It's outside the scope of my job to speculate on the exact finances of the organization.

Q. (Mr. Boyle) Sure, but you're a very smart doctor, and common sense would dictate, I believe, that if PPSAT was performing induced abortions that it can no longer perform, and it loses the ability to derive that income from those induced abortions, PPSAT could and probably would lose money from this new law. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: PPSAT could lose money, or we could provide different services which would make up for any change in income.

Q. (Mr. Boyle) Fair enough. Do you engage in fundraising for any Planned Parenthood or abortion group?

MS. SWANSON: Objection to form.

THE WITNESS: I'm not sure what you mean

by, "engage in fundraising."

Q. (Mr. Boyle) Do you raise money for Planned Parenthood?

A. I do not personally raise money for Planned Parenthood, but I have been present at events, fundraising events.

Q. Okay. Your medical specialty is in family medicine. Is that right?

A. Yes, it is.

Q. You're not an OB/GYN, are you?

A. I am a family physician, not an obstetrician/gynecologist.

Q. You said it better than me. I'm going to do terrible with it, but I'm going to call it an OB/GYN, if that's all right. I can say that without confusing myself. You have no residency or fellowship training in OB/GYN, do you?

A. That is not correct.

Q. Okay. What residency or fellowship training do you have in OB/GYN?

A. Family medicine encompasses obstetrics and gynecology in their routine residency training.

Q. Okay. So beyond the -- and as I understand it, family medicine is sort of a combination of pediatrics and internal medicine, so typically, it

would be outpatient care for children and adults in a family medicine practice. Is that a fair assessment of that?

MS. SWANSON: Objection to form.

THE WITNESS: That is not how I would characterize family medicine, no.

Q. (Mr. Boyle) How would you characterize it?

A. Family physicians are trained to care for pregnant people, trained to perform deliveries, to care for pediatrics, to care for adult medicine, to take care of geriatric medicine, which is later adult, to do end-of-life care and to care for patients both in the hospital and in the outpatient setting.

Q. Okay. As part of your family medicine residency -- well, and let me just clarify. You didn't get any fellowship training in OB/GYN, correct?

A. That is correct. I did not do an additional fellowship.

Q. Did you do a fellowship in family medicine?

A. No, I did not.

Q. Are you board certified?

A. I am board certified in family medicine.

Q. Are you board certified as an OB/GYN?

A. No, I am not.

Q. Are you board certified in advanced family

planning?

A. I'm not aware of a board certification in advanced family planning.

Q. You haven't had a fellowship in advanced family training -- I'm sorry, advanced family planning, have you?

A. I'm not aware of a fellowship in advanced family planning.

Q. Which, I guess, means you are not fellowship trained in that.

A. I do ---

Q. Yeah.

A. --- not have a fellowship training in that.

Q. In your residency for family practice, describe for me what your rotations were, related to OB/GYN practice.

A. In my residency, we performed rotations that were more highly focused on obstetrics and gynecology, where we performed obstetrics and gynecologic surgeries, deliveries, both vaginal deliveries and C-sections. And we also, throughout the entire course of our residency, had our own obstetrical patients that we would follow regardless of what rotation we were on.

Q. And where did you do that residency, again?

A. Just outside of Seattle, Washington, in

Renton.

Q. Now did, in your residency, you have any training or experience performing induced abortions?

A. Yes, I did receive training in abortion during my residency.

Q. Describe that training for me, please.

A. Can you clarify what you mean by describing the training?

Q. What did you learn about abortion during your residency in that hospital near Seattle?

MS. SWANSON: Objection to form.

THE WITNESS: My training in abortion was primarily outpatient. I don't recall whether I did any abortions in the hospital, but I was trained to perform induced abortion in an outpatient clinic.

Q. (Mr. Boyle) When you did your training, that was after the chemical abortion protocols had been approved, and they were available as an induced abortion option, weren't they?

A. I don't recall exactly when that was approved.

Q. Did you do any residency training about chemical abortion drugs -- and I'm going to say them wrong, but I'm going to try, mifeprexin (sic), misoprostol, when you were in your residency?

A. I don't recall the exact details of training or the exact timing of when that was approved, but I do recall receiving some training on mifepristone and misoprostol as they are used for abortion.

Q. Did you receive that training you're thinking of during your residency?

A. I received it, I believe, during the time of my residency, yes.

Q. How long was your residency?

A. My residency was three years, if you include internship.

Q. What years were that -- was that again?

A. I started residency in 2000 and completed it in 2003.

Q. And from your residency, you went to work at Planned Parenthood in Massachusetts. Is that correct?

A. That was one of the jobs I took after residency, yes.

Q. What was the other job?

A. It was a comprehensive family practice job.

Q. Where was that?

A. It was in Fitchburg, Massachusetts. Actually, the office was in -- I believe that my office was located in Westminster, Massachusetts, and the hospital that I admitted at was in Gardner,

Massachusetts.

Q. And that was Heywood -- practice in Heywood Hospital?

A. Heywood Hospital was the name of the hospital, yes.

Q. What did you learn in your residency about induced abortions using aspiration or D&E procedures?

A. I learned a great deal about abortion. I'm not sure if you want me to outline everything I learned about abortion in that time.

Q. Probably not everything, but just give me some basics, and if I feel the need to explore further, I will. But just basically, what did you learn about those two procedures?

A. That they are incredibly safe and an important aspect of comprehensive sexual and reproductive healthcare.

Q. Did you learn how to perform any other gynecological surgery procedures?

MS. SWANSON: Objection to form.

Q. (Mr. Boyle) During your residency? Sorry.

MS. SWANSON: Same objection.

THE WITNESS: I learned to perform other gynecologic procedures during my residency, yes.

Q. (Mr. Boyle) Surgical -- gynecological

surgical procedures?

MS. SWANSON: Objection to form.

THE WITNESS: I did learn to perform some gynecologic surgery, primarily first assisting on C-sections.

Q. (Mr. Boyle) Okay. Have you done any C-sections as the lead doctor performing the surgery?

A. I have not been the primary surgeon on a C-section, no.

Q. Have you assisted with any C-section surgeries since you left residency?

A. Yes.

Q. When was the last time you assisted in a C-section surgery after residency?

A. I don't know the exact date or time, but it was when I was practicing in Massachusetts.

Q. So when you were practicing in Massachusetts, which I believe was from 2004 to 2007 -- is that roughly correct? Maybe 2003 to 2007?

A. I believe it was 2003 to 2007, yes.

Q. So during that period of your career, how many C-section surgeries did you assist with?

A. I don't recall the number.

Q. Was it, like, two or 2,000? I mean, can you give me a range maybe?

A. It was a routine part of the care I provided. If I had any patient who needed a C-section, I would first assist on that C-section routinely.

Q. I still don't have a sense, though. I mean, was that something that happened once a week, once a year?

A. I don't know the exact range, but it was on average, I believe, once a month.

Q. Okay. So maybe 40 to 60 times you assisted in a C-section surgery during that three-to-four-year stint?

MS. SWANSON: Objection to form.

THE WITNESS: I can't recall the exact numbers.

Q. (Mr. Boyle) More than 25 times?

A. I believe it would have been more than 25, yes.

Q. And you haven't done any since 2007. Is that correct?

A. I have not assisted in a C-section since 2007.

Q. What other gynecological surgical procedures did you train on and learn how to do in your residency?

A. I did not learn to be the primary surgeon on any other gynecologic surgeries.

Q. Okay. Did you learn how to be the primary provider who would perform an aspiration abortion during your residency?

A. Yes, I did.

Q. Did you learn how to be the primary provider who would lead on a D&E abortion during your residency?

A. No, I did not.

Q. Do you perform D&E abortions?

A. Yes, I do.

Q. When did you learn how to do that?

A. I learned to do that as a provider at Planned Parenthood South Atlantic.

Q. Okay. And you arrived at PPSAT in 2007 when you left Massachusetts. Is that correct?

A. I didn't start at Planned Parenthood South Atlantic until 2009.

Q. What did you do in between?

A. I had a second baby.

Q. Okay. So when you went back to work after that, you went to work at PPSAT in 2009, and you've worked there ever since. Is that correct?

A. That is correct.

Q. Okay. So you never had any formal training in a pedantic or academic setting about how to perform a D&E abortion. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: I don't know what you mean by, "pedantic academic setting."

Q. (Mr. Boyle) In school or residency.

A. I was not trained to perform D&E during a formal residency program.

Q. Who taught you how to do it at PPSAT?

MS. SWANSON: Objection, to the extent this calls for the name of a physician. This is something that ---

Q. (Mr. Boyle) Just give me something general. I don't need to know the name. That's fine.

A. More experienced providers at PPSAT who had extensive experience in D&E.

Q. As a family practice physician, you have experience providing prenatal care, don't you?

A. Yes, I do.

Q. And I think we've established, you've delivered babies in your practice, right?

A. Yes, I have.

Q. Do you still deliver babies currently in your practice?

A. I do not still perform deliveries, no.

Q. When was the last time that you delivered a baby, to rough recollection?

A. It would have been in probably 2007, before I left my practice there.

Q. Okay. So -- and I don't want to mischaracterize, but it sounds to me like -- since you left Massachusetts and stopped having whatever your privileges were at Heywood Hospital, have you not engaged in helping a mother deliver a baby since that time?

A. I have not performed deliveries since I left Massachusetts in 2007.

Q. Does any of your practice at PPSAT, since you've been there, involve prenatal care and providing care to mothers who intend to give birth to their children?

A. We do not provide comprehensive prenatal care. We do provide some general guidance for people who are attempting to become pregnant. And for people who have found they are pregnant and are wishing to continue their pregnancy, we provide primarily referrals to obstetricians for them to receive that prenatal care.

Q. And I'm -- and that makes sense to me. I'm just trying to see if I understand it completely.

So at PPSAT, if a patient comes in who tests positive as pregnant, and they want to continue the

pregnancy, you evaluate them sort of as an initial evaluation/confirmation and then you would refer them out to see an obstetrician for care through the pregnancy. And you all don't actually give that obstetrician care there and assist with the childbirth.

Do I understand that correctly?

MS. SWANSON: Objection to form.

THE WITNESS: I would clarify that when we have a patient who comes in and has a positive pregnancy test and chooses to continue their pregnancy, we provide them with resources to go see either a family physician who provides prenatal care or an obstetrician who provides prenatal care.

Q. (Mr. Boyle) Okay.

A. Or a certified nurse midwife who provides prenatal care.

Q. Does PPSAT provide -- and you may have said this; I apologize. I'm just trying to close it out.

Does PPSAT provide prenatal care for any patients up until the time of birth if they choose to continue a pregnancy?

A. No. PPSAT does not provide comprehensive prenatal care.

Q. When you worked at -- and is that true for the whole time you've worked at PPSAT, from 2009 up

until today?

A. Yes, it is.

Q. When you worked at Planned Parenthood in Massachusetts, did you -- were you involved with delivering any babies there?

A. I did not deliver any babies in my role at Planned Parenthood League of Massachusetts.

Q. Yeah. And I think you've said you did deliver babies in your role working at the hospital in the family practice, right?

A. That is correct.

Q. Okay. How many -- when you were working in Planned Parenthood Massachusetts, did you ever deliver a baby outside of a hospital up there?

A. In my role at Planned Parenthood League of Massachusetts?

Q. I'm sorry, I said that wrong.

During the time that you were working at both Planned Parenthood Massachusetts and at the Heywood Hospital, that 2003 to 2007 time frame, did you ever deliver a baby outside of a hospital when you were delivering babies up there?

A. No, I did not provide home births when I was -- or deliver any babies outside of a hospital when I was working in Massachusetts.

Q. Do you have admitting privileges to any hospital here in North Carolina?

A. Yes, I do.

Q. Which ones?

A. Novant Forsyth.

Q. Okay. Are you -- do you have privileges to perform surgical abortions at Novant Hospital in Forsyth?

A. No, I do not.

Q. Have you ever attempted to get hospital privileges to perform a surgical abortion in a hospital in North Carolina?

A. No, I have not.

Q. Are you eligible to obtain privileges to perform a surgical abortion in a hospital in North Carolina if you are not OB/GYN board certified?

A. I do not know how hospitals make their decision on eligibility for different privileges.

Q. You've just never tried to obtain that particular privilege at any hospital in North Carolina. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: I have not attempted to obtain privileges to perform inpatient procedural abortions.

Q. (Mr. Boyle) Right. What do you have privileges for? I think you said, "admitting privileges." What does that mean? What are your admitting privileges at Novant Forsyth?

A. My admitting privileges at Novant Forsyth allow me to order certain types of tests, review medical records, go in and see patients who are in the hospital.

Q. Okay. Do you have privileges at any ambulatory -- outpatient ambulatory surgery center in North Carolina?

A. I don't actually know if ambulatory surgical centers have a privileging process. I do not work at any ambulatory surgical center in North Carolina.

Q. The only place that you perform surgical abortions in North Carolina since you started in 2009 is in a Planned Parenthood PPSAT clinic, right?

MS. SWANSON: Objection to form.

THE WITNESS: The only place that I have performed procedural abortions in North Carolina is at one of the Planned Parenthood South Atlantic clinics.

Q. (Mr. Boyle) Okay. Which one?

A. I have performed procedural abortions in all of the Planned Parenthood South Atlantic North Carolina locations that provide procedural abortion.

Q. Have you ever provided a surgical abortion in a hospital setting?

MS. SWANSON: Objection to form.

THE WITNESS: Yes, I believe that I have performed a procedural abortion in a hospital setting.

Q. (Mr. Boyle) Please describe what you recall about that.

A. I participated in abortion care during medical school, possibly during residency, but I don't actually recall.

Q. And anything that you would have been doing during medical school would have been more in an observational role, right? Not a hands-on performing a surgical procedure, but observing a doctor or a resident doing that, correct?

A. No, that is not correct.

Q. Were you actually holding the instruments and doing some of the procedures yourself in medical school?

A. Part of medical school includes hands-on training to perform procedures, yes.

Q. Did you hands-on perform any surgical abortions in a hospital setting when you were a medical student? If you don't remember, I don't blame you. I'm just ---

A. I ---

Q. --- clarifying.

A. --- believe I did, yes.

Q. Okay. So you perform D&E abortions now, but as I understand it, you've never received any specialized training or school or resident training on how to perform that procedure. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: I performed D&Es, and I did receive formal training in performing D&Es. It was not in my capacity as a resident.

Q. (Mr. Boyle) When you say you received formal training, is there anything on your CV that would identify what formal training you received?

A. No, there is nothing on my CV.

Q. Is there any other specialized training that you may have received, since your residency completed, about how to perform surgical abortions?

A. I do not understand your question. Can you please rephrase that?

Q. Is there anything else on your CV that would suggest or show us that you had additional training or certification about how to perform a surgical abortion since your residency?

A. None of that training is reflected on my

resume.

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

A. I do not know.

Q. Do you have any way to estimate?

A. Not without doing a great deal of math, no.

Q. How many would you say -- how many induced abortions, chemical and surgical, have you performed for patients within the past month?

A. I believe, in the past month, I've probably performed approximately 50 induced abortions.

Q. Okay. Is that typical -- is that a typical month for you in your practice?

A. Yes, I would say that it is.

Q. So if you typically do 50 a month, would you say that you typically do 600 a year, roughly?

MS. SWANSON: Objection to form.

THE WITNESS: The number of days that I have worked clinic has varied greatly throughout my career. So I would say that I have performed, on average, 50 a month for the past year, and that would probably be accurate.

Q. (Mr. Boyle) Okay. Were you doing more in the past or less than that 50 per month?

A. It ---

MS. SWANSON: Objection to form.

THE WITNESS: It has varied. There have been years where I worked more clinics per month on average, and there have been years where I worked fewer clinics per month on average.

Q. (Mr. Boyle) Would you say that, again, giving it a range, 500 to 700 a year, is a fair estimate based on the variability you've experienced over your career?

MS. SWANSON: Objection to form.

THE WITNESS: I am not good at doing math in my head, and so without actually calculating that, I'm not comfortable saying that.

Q. (Mr. Boyle) Okay. You've been performing induced abortions from 2000 to 2007, so seven years; and then 2009 to 2023, so another 13 and a half years. So for approximately 20 years, is that safe to say, that you've been performing induced abortions in your career?

A. I have been performing induced abortions for approximately 20 years, yes.

Q. Okay. Do you ever use a curette?

MS. SWANSON: Objection to form.

THE WITNESS: For what purpose?

Q. (Mr. Boyle) Do you know what a curette is?

A. Yes, I do.
Q. What is it?
A. A curette is a scraping tool that can be used for many different purposes.
Q. Okay. Have you ever used a curette?
A. Yes, I have used a curette.
Q. For what?
A. Primarily, for skin lesion removal.
Q. Have you ever used a curette -- well, are you performing skin lesion removal in your current practice, or would that have been back when you were working at the hospital in Massachusetts?
A. I do not currently perform.
Q. Do or have you used a curette in the past, say, 14 years, since you've been working at PPSAT, for any reason?
A. No, I have not used a curette since I have been working at PPSAT.
Q. Have you ever used a curette for any OB/GYN purpose?
A. I do not routinely use curettes for any OB/GYN purpose.
Q. Okay. So that's not something in your typical or scope of practice?
MS. SWANSON: Objection to form.

THE WITNESS: I would disagree that it's outside of my scope of practice and state that it's not a tool that I prefer to use.

Q. (Mr. Boyle) Fair enough. Not in your typical practice. Even if you could use it, you choose not to for whatever purpose you're treating a patient?

A. Yes. It's not a tool that I choose to use.

Q. Okay. When were you first contacted by Plaintiffs to be their expert witness, who offered opinions in this case?

A. I don't consider myself here as an expert witness. I -- based on the statements you made earlier about paid expert witnesses, I don't consider myself an expert witness as a paid person contacted.

Q. Okay. Would you consider yourself more of an employee of PPSAT who's here talking about PPSAT?

A. I consider myself an expert on the practices of PPSAT, and I consider myself an expert in the field of abortion care in my role at PPSAT.

Q. Okay. When were you first contacted by the Plaintiffs to give testimony of any kind in this case?

A. I don't remember.

Q. The lawsuit was filed, I believe, June 20th, roughly. Do you recall whether you were involved with the lawsuit before it was filed?

A. I would have participated in conversations prior to the filing of the lawsuit. Yes.

Q. You say you "would have." Did you, in fact?

A. I believe I did, yes.

Q. Okay. So -- and specific dates. You remember participating in conversations with lawyers on behalf of Planned Parenthood South Atlantic before the lawsuit was filed?

MS. SWANSON: Objection. I'm just going to direct you not to reveal the content of any communications with your lawyers.

Q. (Mr. Boyle) Absolutely not asking about the actual words. Just, did you actually speak to them?

A. I ---

Q. Before the lawsuit was filed. Sorry.

A. I did have conversations during the month of June ---

Q. Okay.

A. --- which would have been before the lawsuit was filed.

Q. And you filed a declaration with the original temporary restraining order that was filed sometime in later June. Do you recall that?

A. I recall filing a declaration. I don't recall the exact date of that declaration.

Q. You've seen what Dr. Boraas said -- and I apologize because I'm not very good with saying people's names -- Dr. Boraas said in her deposition on Tuesday, haven't you?

A. No, I have not.

Q. Have you seen what Dr. Wubbenhorst said in her deposition Wednesday?

A. No, I have not.

Q. So you're not aware of what the other three expert witnesses in this case have said in their depositions, are you?

A. No, I am not.

Q. You would agree that patient safety is always the most important consideration when you are treating a patient, wouldn't you?

MS. SWANSON: Objection to form.

THE WITNESS: I would agree that patient safety is one of the critical factors that should be considered for any procedure.

Q. (Mr. Boyle) Do you always choose to treat your patient in the safest way available?

MS. SWANSON: Objection to form.

THE WITNESS: I always consider patient safety when I am doing any procedure.

Q. (Mr. Boyle) And if you have two options

before you, one is safer than the other, do you always select the safer option when you're treating that patient?

MS. SWANSON: Objection to form.

THE WITNESS: I don't believe that there always is a clear differentiation between one option being safer absolutely than another.

Q. (Mr. Boyle) You said that's not always the case, but sometimes it's the case, isn't it?

A. There are times that there is a safer option that is clearly safer for the patient, and when that is the case, I do provide that option to the patient.

Q. What did you do to prepare yourself for this deposition today? Again, don't tell me about conversations you may have had with your lawyers.

A. I had conversations with my lawyers, and I reviewed a number of documents.

Q. Which documents?

A. I'm not sure if I can accurately list every single one. I reviewed both of my declarations. I reviewed -- and I apologize, I don't know legal terms, so I don't know the names of all of the documents.

But I believe that there were two intervener declarations, I think they were called. I reviewed both of those. I reviewed our -- again, I don't know

the term, our filing that we made. I reviewed SB20, the law in question, and I reviewed the amendments to the law ---

Q. HB190.

A. I believe ---

Q. Yeah.

A. --- it was HB190. And I reviewed some of the articles cited, both in my declaration and in the other physicians' declarations. And I reviewed documents that were presented to you.

Q. The ---

A. I'm not sure what they're called.

Q. --- PPSAT documents that were presented in discovery?

A. Yes, I believe so.

Q. Okay. A little bit of follow-up on that. Did you read Dr. Boraas's declaration and rebuttal?

A. Yes, I did.

Q. Okay. And it sounded like you said you read Dr. Wubbenhorst's declaration and Dr. Bane's declaration also.

A. Yes, I did.

Q. Okay. You mentioned some articles. Which articles did you review?

A. I don't remember them by name.

Q. You don't remember anything about them?
MS. SWANSON: Objection to form.
THE WITNESS: I didn't ---
Q. (Mr. Boyle) Can you describe ---
A. --- say that I don't remember anything ---
Q. Fair enough. That ---
A. --- about them, but I don't remember their names.
Q. Without necessarily remembering the formal name, do you recall what they were about?
A. They were about the safety of abortion and data on abortion.
Q. Can you give me a little more specifics so we can maybe ferret out which ones they were?
A. I don't think I can outline every single cited document I read, but I certainly reviewed the National Association of Science ---
Q. "The Academy" ---
A. National ---
Q. It's from 2018?
A. Thank you. The -- I'd have to look at the document to make sure I had the name correct.
Q. Yeah.
A. I reviewed an article, or a study, from Finland that was referenced by one of the other

physicians.

Q. That's the Niinimaki study; do you recall?

A. I do not recall without looking at the document.

Q. Okay.

A. I apologize. I've reviewed a number, probably four or five different -- and I don't recall the exact names ---

Q. Okay.

A. --- or their exact content.

Q. No, that's fine. Do you recall reading the Goldberg study from 2022 that was a retrospective review of, I believe, 2007 to 2012 or so, Planned Parenthood Massachusetts cases that had patients who were presenting with recent positive pregnancy tests, and they had ultrasound findings of pregnancy of unknown location. Do you recall reading that one?

A. I recall reviewing two articles on pregnancy of unknown location. I don't recall the level of detail that you just described, but if I were to look at the article, I could confirm whether I read it.

Q. Okay. Anything else?

A. Anything else?

Q. That you reviewed in preparation for this deposition other than what you've just told me?

A. I don't recall anything other than what I've just told you.

Q. Have you ever performed a surgical abortion on a patient who was pregnant with twins?

A. I have performed procedural abortions on patients who were pregnant with twins.

Q. How many times have you done that over the course of your career?

A. I do not know.

Q. Was it more than once? More than 100 times?

A. I would say it's definitely more than dozens.

Q. So 24? More than 25 times?

A. More than 25, I believe.

Q. Okay. That's fine.

And I asked you earlier about how many induced abortions you performed over the past month. I forgot to ask the sort of breakdown, chemical abortion versus surgical abortion. Can you give me a split? It doesn't have to be precise, but, you know, is it 50/50? Are you doing 75 percent chemical? What do you think that number looks like?

MS. SWANSON: Objection to form.

THE WITNESS: I have access that -- to that information if I were to look at our procedure logs, but I estimate that 60 percent of the abortions

that I performed in the last month were medication abortions and 40 percent were procedural abortions.

Q. (Mr. Boyle) Okay. If you look back over the course of your career, would you say that there's a higher percentage of those induced abortions that you've performed over the course of your career, a higher percentage of them skews to be medical abortion as opposed to surgical abortion?

MS. SWANSON: Objection to form.

THE WITNESS: No. Over the course of my career, I would not say that the majority of the abortions I performed were medical over procedural.

Q. (Mr. Boyle) Okay. Can you give me an idea what you think the percentages would look like comparatively over the course of your career?

MS. SWANSON: Objection to form.

THE WITNESS: I can tell you that until I came to Planned Parenthood South Atlantic, I rarely performed medication abortions.

Q. (Mr. Boyle) Okay.

A. And since I came to Planned Parenthood South Atlantic, I would say that medication abortions accounted for anywhere from 40 to 60 percent of the abortions that I performed.

Q. Okay.

MS. SWANSON: Ellis, I'm just going to do a time check. I think we've been on the record for about an hour. So when you come to a good stopping point ---

MR. BOYLE: Let's take a break.

MS. SWANSON: --- if we could take a break?

MR. BOYLE: Off the record.

THE VIDEOGRAPHER: Off the record at 11:18.

(Brief recess: 11:18 a.m. to 11:29 a.m.)

THE VIDEOGRAPHER: On record, 11:29.

Q. (Mr. Boyle) Doctor, how do you know -- well, is it important to know if your patient is pregnant with twins before you perform a surgical abortion?

MS. SWANSON: Objection to form.

THE WITNESS: If I know that a patient is pregnant with twins when I am performing a procedural abortion, I take extra steps to ensure that I have removed the tissue from the entire pregnancy.

Q. (Mr. Boyle) So you would agree it's important to know that beforehand, going into the procedure?

MS. SWANSON: Objection to form.

THE WITNESS: I would actually disagree.

I don't think it's necessarily important to know that beforehand.

Q. (Mr. Boyle) Is it important to know if a patient is pregnant with twins before you give that patient a medical -- yes, a chemical abortion?

MS. SWANSON: Objection to form.

THE WITNESS: I do not find that being pregnant with twins changes the way we perform a medication abortion in the way that it can sometimes change a procedural abortion.

Q. (Mr. Boyle) What about with triplets? Would that change -- if a patient was pregnant with triplets, would that change the way you perform a chemical abortion?

A. No, it would not.

Q. Have you seen any studies about any increased risks or potential problems for patients who are pregnant with triplets or twins or quadruplets when you give them a chemical abortion?

A. I have not seen any studies on that.

Q. Excluding the lawyers who represent Plaintiffs in this case, have you spoken to anyone else about your involvement in this case?

A. I have spoken to other people from the context that they are aware that I was scheduling a

deposition, but only from the context of them being aware of how my time was being used.

Q. Just to clarify. So you haven't spoken about the substance of your opinions with anyone other than your lawyers. Is that correct?

A. That is correct.

Q. Okay. What is a uterine preforation?

MS. SWANSON: Objection to form.

THE WITNESS: I believe you are asking about a uterine perforation.

Q. (Mr. Boyle) What is it?

A. A uterine perforation is where usually an instrument, but sometimes a device, goes through the wall of the uterus, called the myometrium.

Q. What's on the other side of that wall?

MS. SWANSON: Objection to form.

THE WITNESS: The tissue within the retroperitoneum and abdomen.

Q. (Mr. Boyle) Are there any specific structures or tissues that typically surround the uterus and would be impacted if a surgical instrument or device punctured the uterine wall?

MS. SWANSON: Objection to form.

THE WITNESS: There are many different forms of tissue and organs. In particular, the bladder

is just anterior to the uterus in most patients, although there can be a space, and often is a space, between the uterus and the bladder; and the intestines can be in the space generally surrounding the uterus.

Q. (Mr. Boyle) Any other organs that would be immediately adjacent to the uterus, if there was a uterine perforation?

A. Those are the organs that are closest to the uterus.

Q. You would agree that uterine perforation is a known complication of a surgical abortion, wouldn't you?

A. Uterine perforation is an extremely rare but known complication of procedural abortion.

Q. Have you ever had a patient who you performed a surgical abortion on who suffered from a uterine perforation?

A. I have had a patient that I performed a procedural abortion on who had a uterine perforation.

Q. Did you have to transfer the patients, who you performed a surgical abortion on who suffered a uterine perforation from the Planned Parenthood clinic, to the hospital?

A. No, I did not.

Q. You -- are you aware that sometimes, if a

patient has a uterine perforation during a surgical abortion, it's required that they be transferred to a hospital for higher level of care?

MS. SWANSON: Objection to form.

THE WITNESS: I am aware that there are some cases of uterine perforation where the patient does need to be transferred to a hospital for additional care.

Q. (Mr. Boyle) Has that ever happened at PPSAT?

A. Yes, it has.

Q. Did you know before the surgical abortion was performed that those patients who suffered a uterine perforation would require transfer to the hospital based on that known complication?

MS. SWANSON: Objection to form.

THE WITNESS: I just want to clarify. Are you asking if I knew in advance that a patient would experience a uterine perforation and require transfer?

Q. (Mr. Boyle) That is what I'm asking.

A. No, it is not possible to know that in advance.

Q. Because you can't always know what complications will arise during a surgical procedure, can you?

A. It is true that with any procedure, you cannot always predict accurately what complications may arise.

Q. What is a cervical laceration?

A. A cervical laceration is a tear of the cervix.

Q. You agree that a cervical laceration is a known complication of surgical abortion, don't you?

A. I would agree that a cervical laceration is an extremely rare but known complication of procedural abortion.

Q. Have you ever had a patient, who you performed a surgical abortion on, who suffered from a cervical laceration?

A. I would say that I have had a patient who suffered from some bleeding associated with the instruments we use on the cervix, but I've never had a cervical laceration that required interventions such as suturing.

Q. Do some patients who suffer the known complication of surgical laceration during a surgical abortion require transfer to a hospital for a higher level of care?

MS. SWANSON: Objection to form.

THE WITNESS: I'm not aware of patients

needing to be transferred for cervical laceration.

Q. (Mr. Boyle) Are you aware of any patient from PPSAT who suffered a cervical laceration during a surgical abortion having to be transferred to a hospital to care for that known complication?

A. I do not recall any patient with a cervical laceration having to be transferred for that complication.

Q. Have you ever had a situation where you performed a surgical abortion on a patient and the patient suffered hemorrhaging such that you needed to transfer that patient to a hospital for higher level of care?

A. I have had a patient who hemorrhaged during a procedural abortion who I transferred to the hospital for care, yes.

Q. Is hemorrhage a known complication of surgical abortion?

A. Hemorrhage is an extremely rare and known complication of procedural abortion.

Q. Are you aware of other patients from PPSAT who have suffered hemorrhage during a surgical abortion that were transferred to a hospital for a higher level of care?

A. I am aware of patients who have suffered

hemorrhage during a procedural abortion who have been transferred to a hospital.

Q. Did you know, before the surgical abortion was performed, that those patients who suffered hemorrhage that required transfer to the hospital would have that complication during that surgical abortion?

A. No. You cannot know in advance what complication a patient may experience from any given procedure.

Q. Do you disclose all possible complications that can arise from an induced abortion to a woman who has tested pregnant, who has tested positive for pregnancy, who is your patient considering obtaining an induced abortion?

A. We disclose the most common and most concerning potential complications to patients as part of their informed consent.

Q. And tell me, what -- how many days is the waiting period now, under the new law, SB20 and HB190, for informed consent for a patient seeking an induced abortion before the induced abortion can actually occur?

MS. SWANSON: Objection to form.

THE WITNESS: My understanding of the current law is that it requires a 72-hour waiting

period from the time the State consent form is reviewed by the patient and signed and when the abortion takes place.

MR. BOYLE: I'm going to hand you a document that has Bates numbers that was produced in discovery.

MS. SWANSON: Thank you.

Q. (Mr. Boyle) It's Bates Numbers 31 through 50. If you don't mind, down at the bottom right-hand corner, do you see Bates and then numbers there?

A. I do see those numbers, yes.

Q. And the first page says Bates 31. Do you see that?

A. I do see that, yes.

Q. And then if you turn to the last page, please, you see Bates 50?

A. Yes, I do see that.

Q. Okay. So do you recognize this document?

A. Yes, I do.

Q. What is it?

A. This is our education and consent packet for procedural abortion.

Q. Can a patient die from complication of bleeding if there is a cervical laceration or a uterine perforation or hemorrhage?

MS. SWANSON: Objection to form.

THE WITNESS: I do not think a patient could die from a cervical laceration. Could a patient die from hemorrhage? They theoretically could die.

Q. (Mr. Boyle) Okay. How about uterine perforation, could a patient die from a uterine perforation if it's not treated?

A. If a complication was untreated, it's possible that a patient could experience severe complications that could lead to death.

Q. What surgical tools do you use in an aspiration abortion?

A. I use a number of tools, including a ring forceps, sterile gauze, dilators. I use a suction cannula that is attached to tubing and electronic vacuum aspirator or that is attached to a manual or handheld vacuum aspirator.

I use a tenaculum, which is an instrument used to hold the cervix, and I use a speculum. I sometimes use an ultrasound -- just thinking through my tray to see if there's anything I've left off. Those are the instruments I would routinely use for a suction abortion.

Q. Okay. What surgical tools do you use for a D&E abortion?

A. I would use the same tools for a D&E abortion and often use an additional type of forceps in addition to the ring forceps. There are different shapes and types of forceps, so I would often use a Bierer's forceps.

Q. Sorry, a what type?

A. Bierer's. I'm not sure how to pronounce it. I apologize.

Q. How do you spell it?

A. I'm not sure how to spell it. B-i-e-r-s (sic).

Q. Okay.

A. Maybe B-r-i-e-r-s (sic). I apologize. I don't recall the exact spelling.

Q. And what do -- what do the Bierer's forceps look like, if you can describe them?

A. So they are oval shaped. The best way to describe them is they look like a pair of scissors where they open and shut, but they don't cut at the end like a pair of scissors would. Instead, they have two flat plates at the end that are oval shaped and that close down around tissue.

Q. Like, they clamp on something and grab it?

A. A ---

MS. SWANSON: Objection to form.

THE WITNESS: A forceps will often close to be able to clamp, for example, on a gauze or on tissue.

Q. (Mr. Boyle) And what type of forceps do you use in the aspiration abortion, or the suction, abortion?

A. I routinely use a ring forceps in a suction abortion.

Q. And what's the difference between the ring forceps and the Bierer's forceps?

A. Well, I use the ring forceps for any abortion that I perform routinely. And the Bierer's, I use in a D&E. And the difference is the size.

Q. What's the difference in the size between them?

A. I don't know the exact measurements, but the Bierer's are slightly larger than the ring forceps.

Q. So the ring forceps also have the one end you have where you put your fingers to open and close the forceps, then you have a fulcrum, I guess, in the middle and then on the far end it's got two rings? Or are they ovals?

Are they -- are they loops that are sort of solid throughout, or do they have, like, just the outer rim is a loop? What's that like?

A. So a ring forceps has two open loops at the end that close down, and the other end has the handles where you would hold it.

Q. Okay.

A. And the Bierer's also has two open loops at the end, just the loops are oval in shape and slightly larger.

Q. Okay.

A. And the ring forceps, I would consider more circular.

Q. Okay. And the sort of clasping and the loops, if you will, they're not solid all the way through, they're just on the outer edge of the circle or the outer edge of the oval?

A. Correct. They are both hollow in the middle of the shape.

Q. What do you use the forceps, the ring forceps for, in the suction abortion?

A. Primarily, I use them for grasping gauze and wiping down the tissue within the vagina. That is the most common use. I also use them sometimes to grasp tissue that's coming out of the vagina. And very rarely, I introduce them inside of the cervix itself to grasp tissue.

Q. Typically, as I understand it, the major

difference between the suction abortion and the D&E is the use of the tongs beyond the cervix to grab tissue inside the uterus and pull it out. Is that -- am I understanding that correct?

That's the D&E versus the aspiration, you simply put the cannula in there, and it uses suction to suction out -- suck it out?

MS. SWANSON: Objection to form.

Q. (Mr. Boyle) Is that correct?

A. So when I am performing a suction abortion, I use suction throughout all -- as we are calling suction abortions or D&Cs, we use suction, and the suction removes most of the tissue of the pregnancy or all of the tissue of the pregnancy, most of the time.

When I am performing a D&E, I still use suction. That is a continuum where we use suction throughout a D&E as well. And with a D&E, I am more likely to use instruments. And later in pregnancy, I would say that I always use instruments to remove the pregnancy tissue later in -- with later D&Es.

Q. (Mr. Boyle) The pregnancy tissue that you remove in the later D&Es, what time frame, gestational age time frame, are you talking about?

MS. SWANSON: Objection to form.

Q. (Mr. Boyle) What weeks?

A. I consider a D&E any abortion 14 weeks or later.

Q. Do -- does PPSAT do D&E abortion at all six of the clinics in North Carolina where they perform induced abortions?

A. Since I consider a D&E abortion any abortion over 14 weeks, I believe we have performed abortions at approximately 14 weeks at all of our six North Carolina clinics.

Q. Because it looked like, from the chart that we received in discovery, that it's only Chapel Hill where the surgical abortions are occurring after, say, week 16, 17, 18. Is that correct, or are you doing those surgical abortions at all six clinics in North Carolina?

MS. SWANSON: Objection to form.

THE WITNESS: We do not routinely perform -- let me rephrase.

We, prior to this ban, were routinely performing abortions over 16 weeks at only two of our locations, both Chapel Hill and Asheville.

Q. (Mr. Boyle) Okay. On Page Bates 34 -- just let me know when you get there, please. Do you see that?

A. I see Page 34, yes.

Q. Top of the page says, "Information for Informed Consent In-Clinic Abortion," right?

A. Yes, that is what it says.

Q. Down, under "The risks of the in-clinic abortion are," I'm looking at "heavy bleeding." Do you see that?

A. I do see "heavy bleeding," yes.

Q. And it says, at the end of that, "Very rarely, you may have to go to the hospital for treatment." Do you see that?

A. Yes, I see that.

Q. The next one down, "Infection of the Uterus." It says, "Very rarely you may have to go to the hospital for treatment." Do you see that?

A. I do see that.

Q. You agree that post-twelve-week abortions can be performed in a hospital section -- setting, don't you? Let me say that again.

Post-twelve-week surgical abortions can be performed in a hospital setting. Is that correct?

A. I believe that they can be performed in some hospitals, but I am not sure that they are performed in most or all hospitals.

Q. And I understand you think they can be performed at the PPSAT clinics post twelve weeks for

the surgical abortion, right? That is a bad question.

You think that post-twelve-week surgical abortions can be performed in the PPSAT clinics, right?

A. I know that procedural abortions beyond twelve weeks can safely be performed in the PPSAT clinics.

Q. Do you also know that they can safely be performed in a hospital setting?

A. No, I don't know that they can safely be performed in any hospital setting.

Q. Okay. Are you worried that hospitals don't have the same resources and equipment and tools available to them that you have at your PPSAT clinic?

MS. SWANSON: Objection to form.

THE WITNESS: I don't work at a hospital, so can't speak exactly, but I do know that they have equipments and tools. I know they have some resources, but those resources might be different than PPSAT resources.

Q. (Mr. Boyle) But if you have a complication at PPSAT that PPSAT can't handle, you transfer that patient to a hospital, right?

MS. SWANSON: Objection to form.

THE WITNESS: In very rare instances, we have a complication where a patient does need to be

transferred to a hospital.

Q. (Mr. Boyle) So if you turn, please -- well, let me just ask you, on Page 34 there, and Page 35 and Page 36, that's all -- as I understand it, and you tell me if I'm wrong, that's all one three-page document about information for informed consent for in-clinic abortions. Is that correct?

A. You're asking about Bates 34, 35 and 36?

Q. Correct.

A. Correct. That is one PPSAT document.

Q. And it is one PPSAT document that PPSAT gives to patients who are seeking an in-clinic surgical abortion at a PPSAT facility. Is that correct?

A. This is a document that is given to and signed by patients who receive a procedural abortion at Planned Parenthood South Atlantic.

Q. Does the patient get a copy of this one three-page document?

A. It is our protocol to give the patient a copy of this document.

Q. When you look at Page 36, this looks like the signature page for the patient. Is that correct?

A. It is a signature page, yes.

Q. For the patient to sign when they're going to get a surgical abortion at a PPSAT facility. Is that

correct?

A. This is a signature page. We don't actually use paper forms for signature. We use an electronic health record, so we use an electronic version of this form, unless our electronic health system is down, and then we use the paper form. But the patient does sign an electronic version of this form, yes.

Q. Is the electronic version of this form exactly the same format as this paper copy here, this 34, 35 and 36?

MS. SWANSON: Objection to form.

THE WITNESS: I would -- I can't speak to the exact format, but it contains the same information. We use this form to create the electronic form.

Q. (Mr. Boyle) So you don't actually hand a patient this piece of paper, this three-page document. Is that what you're saying?

A. No, that is not what I'm saying. I do hand the patient this three-page document. We at Planned Parenthood hand the patient this document.

Q. Okay. So someone at -- at PPSAT hands the patient a three-page document that looks like Bates Number 34, 35 and 36, and that patient then has that hard copy paper document to take with them? Is that

correct?

A. It is correct that the patient receives a paper copy of this document before they leave the clinic -- or actually, when they are arriving and going through consent.

Q. Okay. Do the -- does the patient receive a signed copy of this document?

A. The patient does not routinely receive a copy of this form that they have signed, but they may receive a copy, if they would like, that can be printed from the EHR for them if they request it.

Q. So when the patient signs an electronic copy of this document, is the patient looking at a computer screen and having the opportunity to read all three pages before they sign, or do they have a paper copy? What's the method for that?

A. They have both. They have a paper copy in front of them, and they can see the electronic form as it is being filled out and they are signing it.

Q. And who goes over this document with the patient?

A. A trained staff member.

Q. What level of training does that staff member have?

MS. SWANSON: Objection to form.

THE WITNESS: They are -- they can have a variety of backgrounds of training, but they are specifically trained in the process of Planned Parenthood South Atlantic's informed consent.

Q. (Mr. Boyle) Is that person who undertakes informed consent with the patient, is that a nurse? Is that a PA? Is that an MD doctor? What level of training do they have?

A. It varies based on which aspect of informed consent you're referring to.

Q. Okay. How about this aspect with this three-page document? What level of PPSAT employee -- in terms of training for that employee, what level of employee is engaging with the patient to ensure informed consent is obtained?

A. It can be multiple levels. I've had nurses or physicians who participate in that. Routinely, it is not a licensed person who is going over the form. It is someone who is trained specifically in the process of consent who had -- goes over the form with the patient.

Q. Does the law speak to who has to interact with a patient, what level of training that person has, in order to ensure informed consent is indeed proper and legal?

MS. SWANSON: Objection to form.

THE WITNESS: My understanding of the law is that -- and I don't know the exact language, but that I believe it can be a nurse, physician assistant, advanced practice clinician or advanced practice nurse, such as nurse midwife, or an NP, or a physician who can perform -- or pardon me, who must perform the advanced consent mandated by the State using the State's 72-hour advanced consent forms for both procedural and medication abortion.

Q. (Mr. Boyle) Does this document we're talking about here, this three pages Bates Numbered 34, 35, 36, does that qualify as satisfying the State's required informed consent you just described?

MS. SWANSON: Objection to form.

THE WITNESS: No, this is done in addition to the State's mandated consent.

Q. (Mr. Boyle) Is -- and it may be in here, and I may just ask you to direct me. Does that mandated consent from the State exist in here in these documents?

MS. SWANSON: Objection to form.

Q. (Mr. Boyle) And you can take your time looking through the package if you'd like.

(Witness examines document)

A. This packet does not contain the State's consent form.

Q. So this packet that was given to us as PPSAT's informed consent documentation that they give to patients is missing the actual State-law-required informed consent. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: This packet does not contain the State consent. The State consent is performed by necessity and law 72 hours prior to the abortion. This consent is signed at the time of the abortion.

So we review and go over the state forms at the 72-hour consent and provide the patient with a copy of the form both at that time, and we provide them with another copy of that form at the time of their abortion. But because they are separate forms used at different times in the process, they're not part of the exact same packet.

Q. (Mr. Boyle) So you're saying there exists a separate informed consent document from the State that's not included here, but you know it exists and you've seen it and participated in those State-law-required informed consent conversations yourself with some patients. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: The State requires that we use State-created forms, so we access those State-created forms from the State and use them for the advanced consent.

Q. (Mr. Boyle) And you agree that form is not in this packet starting at Page 31, running to Page 50. Is that correct?

A. That form is not a part of this packet, correct.

Q. And as I understood you to just say, this packet that we're looking at, specifically Bates 34, 35, 36, that three-page document, is something that is discussed with the patient and signed at the time of the abortion, the surgical abortion. So the day of the surgical abortion. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: A copy of this paper packet is routinely provided to the patient at the time of their 72-hour consent for their review. We do not ---

Q. (Mr. Boyle) Okay.

A. Let me correct.

We review it and sign the actual forms that require signature in this packet at -- on the day of

the abortion, not at the 72-hour consent.

Q. Okay. And I think I understand it now. Let me just -- very slow. I apologize. I'm working through it.

Day one, patient comes in, decides, "I want to have a surgical abortion."

PPSAT says, "We will do that, but there is a 72-hour required waiting period for informed consent under State law. Here is that form," that we don't have a copy of. "Here's that form," which you go over with the patient, they sign, starting the clock.

And you also give them a copy of this three-page document, Bates Number 34, 35, and 36, but you don't have the patient sign it on day one. You have the patient sign this three-page document when they come back 72 or more hours later for the actual surgical abortion. Do I understand that correctly?

THE WITNESS: Yes.

MS. SWANSON: Objection to form.

THE WITNESS: That is correct that we have them sign this form at the time of the procedural abortion.

Q. (Mr. Boyle) When do they pay for the surgical abortion?

A. I don't participate in the payment process,

but I believe -- it's my understanding the patient pays for the abortion on the day of the abortion.

Q. So not the first day that triggers the 72-hour clock. It's when they come back for the day of the actual surgical abortion after at least 72 hours have passed. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: It is my understanding that the patient only pays for the services they receive. So on day one, they might pay for the ultrasound or labs if they received them. But they do not pay for the abortion on the day of the consent process, because they cannot receive the abortion on that day.

Q. (Mr. Boyle) You charge your patients an independent fee for performing an ultrasound. Is that right?

MS. SWANSON: Objection to form.

THE WITNESS: I did not create the forms or create the fee schedule. But my understanding is that a patient who's self paying for an abortion would be charged $625 for the entire abortion procedure, including the pretesting that we do.

And if that pretesting occurs 72 hours in advance, including the ultrasound, they pay that

portion and then they would pay the remainder to reach the total on the day of their abortion.

Q. (Mr. Boyle) Do you know how much it costs to have the ultrasound?

A. I do not recall that number.

Q. I think you also said that there's an independent separate charge for performing blood work also.

A. If the patient has blood work as part of their 72-hour consent, then that charge is paid on day one and reduced from the total that is owed on the second day.

Q. But if they don't come back, then they've paid whatever for that blood work and that ultrasound. They don't have to pay the balance of the 625, but they also don't get a refund for what they paid for the ultrasound and the blood work. Is that correct?

A. The patient only pays for the services they receive on day one, and those are not reimbursed if they choose not to return for their abortion.

Q. Do you give an ultrasound to every patient who tests positive for pregnancy at PPSAT?

MS. SWANSON: Objection to form.

THE WITNESS: No, we don't perform an ultrasound on every patient who tests positive for

pregnancy at PPSAT.

Q. (Mr. Boyle) Do you give an ultrasound to every patient who tests positive for pregnancy at PPSAT who elects to have a chemical abortion?

MS. SWANSON: Objection to form.

THE WITNESS: We do require that every patient who has a medication abortion at PPSAT has had an ultrasound prior to that abortion.

Q. (Mr. Boyle) When you say, "an ultrasound prior to that abortion," can you be a little more specific? Is there a time frame?

A. The ultrasound would have had to have taken place during this pregnancy. Yes.

Q. That's what I'm asking about.

A. Yes.

Q. I figured, but lawyers like to clarify.

Okay. So as I understand what you just said, if there is a patient at PPSAT who tests positive for pregnancy and elects to have a chemical abortion, 100 percent of the time, PPSAT either takes their own ultrasound if there isn't one already on file, or PPSAT reviews a recent ultrasound from this particular pregnancy for that patient. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: It is correct that we

require that there is an ultrasound performed prior to any medication abortion. The vast majority of the time, we are performing that ultrasound, but there are cases where we would accept an ultrasound from an outside source.

Q. (Mr. Boyle) Related to that particular patient's current pregnancy?

A. From this current patient that we are performing an abortion on during this pregnancy. Correct.

Q. So it's fair to say -- and I will tell you, it did not appear that way to me reading the protocols. But I want to clarify that PPSAT does not perform any chemical abortion on a patient who has tested positive for pregnancy without reviewing at least one ultrasound, whether they took it or whether it was taken outside the facility and provided to PPSAT. Is that correct?

A. That is correct, in the state of North Carolina.

Q. Clarification understood. State of North Carolina. Has that been PPSAT's practice in North Carolina about always having at least one ultrasound before giving a medication abortion to a patient before -- you know, prior to July 1st, 2023?

A. That has been the practice throughout my entire time ---

Q. Okay.

A. --- at Planned Parent South Atlantic.

Q. So since 2009 when you arrived, it's been the same up to today.

A. It has been the practice to perform an ultrasound prior to medication abortion.

Q. Do you -- does PPSAT provide deep sedation at any of its North Carolina clinics?

A. No, we do not.

Q. If you look at Page Bates Number 39, please. And as you're getting there, I'll ask, do you require, or is it your understanding that there has to be an anesthesiologist or CRNA or some specialist who has anesthesia specialization in medicine in order to have a patient receive deep sedation for a procedure?

MS. SWANSON: Objection to form.

THE WITNESS: It is my understanding of the PPFA protocols that a CRNA or an anesthesiologist is required for deep sedation.

Q. (Mr. Boyle) Do -- does PPSAT have any anesthesiologists who perform anesthesia services at any of its six clinics in North Carolina?

A. No, we do not.

Q. Same question for CRNAs.
A. No, we do not.
Q. So PPSAT does not have any anesthesia specialists who perform anesthesia services at any of the clinics in North Carolina. Is that correct?
MS. SWANSON: Objection to form.
THE WITNESS: It is correct that PPSAT does not hire anesthesiologists or CRNAs, because we do not perform deep sedation.
Q. (Mr. Boyle) Okay. So when you look at Bates Number 39, in the middle there, do you see there's a box that says, "I would like to receive, Select one: moderate, deep sedation and have read and understood -- and understand the risks and benefits outlined above"?
Do you see that?
A. I see that.
Q. So you're saying that, despite what this says, that the patient has an option of choosing deep sedation, that that's just wrong on this form, and PPSAT North Carolina does not provide deep sedation?
A. The patient is only permitted to select moderate sedation or minimal sedation or no sedation at PPSAT.
Q. But the form here says, "deep sedation," doesn't it?

A. The form says, "deep sedation." It is not an option that the patient can select.

Q. So the form is inaccurate.

MS. SWANSON: Objection to form.

THE WITNESS: The form is -- I can't speak to the accuracy of the form. I can tell you that patients are not offered the option of deep sedation at PPSAT.

Q. (Mr. Boyle) Well, you're reading the same form I am that says it gives the patient the option of choosing deep sedation, right?

MS. SWANSON: Objection to form.

THE WITNESS: The patient is not allowed to choose deep sedation.

Q. (Mr. Boyle) Then what happens when the patient just reads this form, sees deep sedation as an option, and selects it?

MS. SWANSON: Objection to form.

THE WITNESS: The patient is informed that deep sedation is not an option at a Planned Parenthood clinic.

Q. (Mr. Boyle) Okay. And I'm not saying I don't believe you. I just -- this gave me pause, because I didn't know if you all were doing deep sedation. It sounds like the answer is categorically,

"No."

A. We are not providing deep sedation.

Q. Who witnesses these forms, this Bates 39 and Bates 36?

A. The forms are witnessed by the staff member who reviews the forms and has the patient sign them, so the person who sees the patient sign the form witnesses their signature.

Q. And that's different than what we were talking about with the State law 72-hour requirement witness. That has to be someone who is one of those categories: the nurse, nurse practitioner, midwife, doctor or PA. Correct?

MS. SWANSON: Objection to form.

THE WITNESS: It is correct that the 72-hour advance form provided by the State must be done by one of those select licenses. That person reviews the form and witnesses the patient's signature.

Q. (Mr. Boyle) Now, I haven't seen that form. Does it include a description of risks of the procedure?

A. I ---

MS. SWANSON: Objection to form.

THE WITNESS: --- have not looked at that form in detail in recent days, but it does involve

some information about risks of abortion. To speak in any detail, I would need to look at the form.

Q. (Mr. Boyle) When a patient is there, day of, looking at these documents that we have in this package in front of us and is signing Bates Number 36 or signing Bates Number 39, and it's witnessed by someone who is a staff member at PPSAT, that staff member is not -- typically not a licensed practitioner who will be able to answer that patient's questions about risks of a procedure or risks of anesthesia. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: No, that is not correct.

Q. (Mr. Boyle) What's incorrect about it?

A. All of our staff are trained to answer routine questions that patient asks -- patients ask about the risks, and all of our staff are trained to have a licensed provider come in and answer questions that they do not know how to answer or any additional questions that the patient may have.

Q. What steps do you take to ensure that a patient who is getting mild or moderate sedation for a surgical abortion at a PPSAT clinic doesn't drive away from that clinic after the procedure?

A. We review, with any patient who is receiving

minimal or moderate sedation, that they are not allowed to drive, with the exception of nitrous used for minimal sedation, which does not preclude the patient from driving. We review with them, ideally at the time of scheduling, that they cannot receive sedation and drive after the procedure.

Q. Do you take any steps when that patient shows up on the day of the procedure for that surgical abortion to ensure that they didn't just drive themselves, and they have someone to drive them after they've received that mild or moderate sedation?

A. May I look at the form?

Q. Absolutely. Just orient us to a Bates ---

A. Yeah ---

Q. --- Number, if you don't mind.

A. --- I'm looking at Bates Page 39. And in the second box at the top of the document, we review with the patient that in order to receive and consent to receiving minimal or moderate sedation, they have to agree that they will not drive, operate heavy machinery or make important decisions for at least 12 hours after sedation or analgesic.

Q. You said that this box says you make sure that in order to receive mild or moderate sedation, they will not drive and they will not operate heavy

machinery, and they will not make important life decisions for the next 12 hours, right?

MS. SWANSON: Objection to form.

Q. (Mr. Boyle) That's what you said.

A. What I did was read this statement that the patient is required to review prior to consenting to sedation.

Q. Right. But it doesn't say that they agree to it. It just says, "do not drive," "do not operate heavy machinery," "do not make important decisions."

My question is, what do you do to ensure that they didn't drive there themselves and that they have someone else or some other mechanism of transportation to get them from the clinic to wherever they're going, their home or somewhere else? Do you take any steps to verify that?

MS. SWANSON: Objection to form.

THE WITNESS: We do confirm with the patient that they have a plan for leaving the clinic that does not involve them driving.

Q. (Mr. Boyle) That's not something you record in these documents, though, is it?

A. The driver is not recorded in this document. Our electronic health record, if the patient has a driver that we'll be contacting when it's time to pick

the patient up, does record the name and phone number of their driver.

Q. Do you agree that an unborn child is typically viable outside of the mother's womb after 24 weeks of gestational age?

MS. SWANSON: Objection to form.

THE WITNESS: That is not my specialty, and I do not have significant training or knowledge about pregnancy viability dates.

Q. (Mr. Boyle) So you've performed abortions for the past 13 and a half years at least, and you're not able to say when you think a child is typically viable, at what gestational age?

MS. SWANSON: Objection to form.

THE WITNESS: I'm saying that is not my area of expertise. And I have not performed or participated in abortion in the last 20 years -- no, in the last 15 years, that occurred past 20 weeks. So my area of expertise is more in abortions under 20 weeks.

Q. (Mr. Boyle) And that's fair enough. And I'm not saying you should know. I'm just trying to clarify. You don't know at what gestational age, you're not able to say -- as a family practice doctor, who performs abortions, you are not able to say when you think an unborn child is viable and whether that's

after 24 weeks or some other time. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: I understand fetal viability to be approximately 24 weeks but have a great deal to do with the circumstances of the fetus, and that there are experts who know much more about that than I do.

Q. (Mr. Boyle) Do you agree that abortion should not be banned at any point during a pregnancy?

MS. SWANSON: Objection to form.

THE WITNESS: I do not believe that abortion should be banned. I think that the decision to have an abortion should be made by a healthcare provider and a patient based on their individual circumstances.

Q. (Mr. Boyle) And that's probably a better way to say it. So if I understand that, you think that abortion should be allowed up to the full term of prior to giving birth, but -- up until basically an unborn child is ready to be born. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: No, I don't believe that abortion occurs at term. If a fetus needs to leave the uterus at term, it is a delivery, not an abortion.

Q. (Mr. Boyle) Okay. Do you think that

abortion should occur -- induced abortion should occur at, say, 35 weeks of gestational age?

MS. SWANSON: Objection to form.

THE WITNESS: I think that if a patient had tragic circumstances that necessitated no longer carrying a fetus at 35 weeks, that the decision about how to handle that should be based entirely on the patient's circumstances and be a decision between the patient and their healthcare provider as to whether delivery or termination is the most appropriate next step.

Q. (Mr. Boyle) Based on that, do you think that the former North Carolina law that restricted abortion generally after 20 weeks was too restrictive?

MS. SWANSON: Objection to form.

THE WITNESS: I think there are medical circumstances beyond 20 weeks that patients should absolutely have access to abortion care.

Q. (Mr. Boyle) Do you agree that if there is a safety reason to take some medical action, it can be considered a rational decision to take that action?

MS. SWANSON: Objection to form.

THE WITNESS: I believe that safety is one of the very important factors that should be considered any time we are making a decision about an

action.

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

A. Yes, I do consider a differential diagnosis in my clinical practice.

Q. Do you agree that a differential diagnosis should include all of the possible risk or dangerous situations for a patient that you are providing medical care to?

MS. SWANSON: Objection to form.

THE WITNESS: I believe that a differential diagnosis should include the most likely or most common. I think stating all possible outcomes is something that can never truly be known.

Q. (Mr. Boyle) Do you agree that if you're treating a patient and there's something on that patient's differential diagnosis that could be life threatening, that you should treat that and rule it in or rule it out before you stop considering it as something of importance on your differential diagnosis?

MS. SWANSON: Objection to form.

THE WITNESS: I don't understand what you're asking.

Q. (Mr. Boyle) If you're treating a patient and you develop a differential diagnosis, and it includes

on that differential diagnosis something that could be life threatening, you're not sure if it's there or not, don't you agree that you need to rule it in or rule it out before you cross it off your list on your differential diagnosis?

A. I believe you need to rule it in or out before you remove it from your differential diagnosis, but not that you need to rule it in or rule it out before you provide some treatment to the patient. They can be done concurrently. And I'd like to clarify, that can be done concurrently in some cases.

Q. You agree, though, that the concept of the differential diagnosis is you treat the worst first, right?

MS. SWANSON: Objection to form.

THE WITNESS: I think that's too vague a statement for me to be able to answer.

Q. (Mr. Boyle) So if you've got a patient who comes in and they're having pain in their chest, it could be heartburn. But it could be a heart attack, right?

A. Those are two things in a differential diagnosis for chest pain.

Q. And a heart attack could kill that patient, right?

MS. SWANSON: Objection to form.

THE WITNESS: Heart attacks can be life threatening, yes.

Q. (Mr. Boyle) Heartburn is probably not going to kill that patient, is it?

A. Heartburn is usually not life threatening.

Q. If you have a patient who comes in, and they have an unknown diagnosis with symptoms of things that are not life threatening but also could be life threatening, you've got to look at that life-threatening diagnosis and treat that and rule it out, don't you?

A. Actually, it depends a great deal on the patient. In my experience of managing patients with chest pain, the decision to rule out heart attack would be based on the patient's risk factors, age and the likelihood that the pain they were feeling was a heart attack.

Q. What is the American College of Obstetricians and Gynecologists?

A. I understand it to be an organization supporting OB/GYN and ancillary providers of obstetrical and gynecologic care.

Q. And we'll call it ACOG. Is that your understanding of the ---

A. That's ---

Q. --- acronym?

A. --- my understanding of the acronym.

Q. Okay. Are you a member of ACOG?

A. Yes, I am.

Q. Do you agree that the ACOG practice bulletins provide clinical management guidelines for -- excuse me, OB/GYNs and people who are providing similar services to OB/GYNs?

A. I have not reviewed every ACOG bulletin. I understand that they are intended to provide guidance.

Q. Do you review ACOG bulletins on occasion?

MS. SWANSON: Objection to form.

THE WITNESS: I do review some ACOG bulletins.

Q. (Mr. Boyle) When you have a woman who you are seeing as a patient who has a positive pregnancy test result, what is on her differential diagnosis as potential medical issues and risks, in your mind?

MS. SWANSON: Objection to form.

THE WITNESS: The depth of what I would consider as risks would depend on the context in which I was seeing a patient with a positive pregnancy test.

Q. (Mr. Boyle) Okay. You have a patient who has a positive pregnancy test that comes into PPSAT and

is discussing with you the possibility of having a chemical abortion. What would you have on that patient's differential diagnosis?

A. I do not routinely make a differential diagnosis based on a positive pregnancy test. When I'm seeing a patient for a medication abortion, I have ultrasound information. And so I'm basing my decisions not on the pregnancy test, but on the ultrasound results, in most cases.

Q. Okay. If you get an ultrasound result from a patient who's tested pregnancy -- sorry, tested pregnant -- tested positive for pregnancy. Start over.

If you have a patient who has tested positive for pregnancy and you get an ultrasound result for that patient, what is on your differential diagnosis for that patient?

MS. SWANSON: Objection to form.

THE WITNESS: My differential diagnosis would be based on the results of the ultrasound.

Q. (Mr. Boyle) And what are the options there?

MS. SWANSON: Objection to form.

THE WITNESS: The most common options in a pregnant patient when I am looking at their ultrasound would be one of five categories. Would you like me to outline those categories?

Q. (Mr. Boyle) Please.

A. Definite intrauterine pregnancy, probable intrauterine pregnancy, definite ectopic pregnancy, probable ectopic pregnancy and pregnancy of unknown location. There are some other things that could be considered, but those are the main five categories.

Q. Okay. What is your differential diagnosis for the patient who has definite intrauterine pregnancy?

A. If I have diagnosed a definite intrauterine pregnancy? I have diagnosed a definite intrauterine pregnancy, so the differential -- I'm not sure what you mean by, "What differential diagnosis do you have?"

Q. Fair enough. If you have, category one, a patient who has an ultrasound with a definite intrauterine pregnancy, do you include ectopic pregnancy on that patient's differential diagnosis?

MS. SWANSON: Objection to form.

THE WITNESS: When we are doing an ultrasound, we routinely evaluate the adnexal with every ultrasound we do. We do not always -- we routinely do a full sweep of the uterus and adnexal on all ultrasounds.

If someone has a definite intrauterine pregnancy, then the likelihood that there is another

diagnosis is small, although other diagnoses that I have seen have been molar pregnancy or partial molar pregnancy, early pregnancy failure or miscarriage, twin pregnancy. There can be other things in addition to an intrauterine pregnancy.

Q. (Mr. Boyle) What is twin pregnancy? What is that?

A. Twin pregnancy is generally understood as a pregnancy that contains either two gestational sacs and/or two fetal poles.

Q. (Mr. Boyle) So twins?

A. Correct.

Q. Okay.

MS. SWANSON: I'd just like to note that we've been on the record for about another hour, so if we could wrap up for lunch when you come to a good stopping point, that'd be great.

MR. BOYLE: That's fine with me.

THE VIDEOGRAPHER: Off record, 12:31.

(Lunch Break: 12:31 p.m. to 1:07 p.m.)

THE VIDEOGRAPHER: On record, 1:07.

MS. SWANSON: Before we get started, I'd like to note for the record that my colleague, Helene Krasnoff, from Planned Parenthood Federation of America for Planned Parenthood South Atlantic, has joined us.

Q. (Mr. Boyle) All right. We ready, Doctor?

A. I am.

Q. Very good. Thank you. Do -- does PPSAT ever offer informed consent, like we were talking about, the second -- the returned trip informed consent, like Bates Number 36 and Bates Number 39 we were looking at, in a group setting to patients, or is it always a one-on-one, employee talking to an individual patient?

MS. SWANSON: Objection to form.

THE WITNESS: Our protocol is to offer informed consent one on one.

Q. (Mr. Boyle) Okay. So it doesn't happen with, like, five or ten patients sitting in a room with one employee giving them all the paperwork and having them all sign it at the same time?

A. No, it does not.

Q. Okay. I think we stopped on differential diagnosis for Category Number 1, when you have an ultrasound with a patient who has a definite intrauterine pregnancy.

Is there a difference between what you said the differential diagnosis is for that patient, with an ultrasound showing an intrauterine pregnancy, versus Category 2, an ultrasound showing possible intrauterine pregnancy?

MS. SWANSON: Objection to form.

THE WITNESS: So the second category I referred to, we call a probably intrauterine pregnancy. And I don't know how to answer the question, "Is there a different differential diagnosis?" I'm not really clear what you're asking.

Q. (Mr. Boyle) Is your differential diagnosis the same or different compared -- Category 1 to Category 2?

MS. SWANSON: Objection to form.

THE WITNESS: I would say it was different. One of the common ways we would see a probably intrauterine pregnancy would be in someone who had a large, empty uterine sac. And depending on the size of that sac, would make us either suspicious for, or clinically certain, that the patient was experiencing a miscarriage.

Q. (Mr. Boyle) Okay. How about for Category 3, which I believe you said was an ultrasound that definitely showed an ectopic pregnancy? What's your differential diagnosis for that patient?

MS. SWANSON: Objection to form.

THE WITNESS: I would consider that patient to have an ectopic pregnancy or a pregnancy outside the uterus.

Q. (Mr. Boyle) And what would you do as a result of that?

A. If I see a patient with an ectopic pregnancy, I refer them for treatment of that pregnancy.

Q. Refer them where?

A. Either to their primary gynecologist, if that's their preference, and they're able to see them quickly, or to a hospital for care.

Q. Because an ectopic pregnancy is a life-threatening risk for a patient, isn't it?

MS. SWANSON: Objection to form.

THE WITNESS: An ectopic pregnancy can be life threatening if not treated, yes.

Q. (Mr. Boyle) Because it's a pregnancy growing outside of the uterus, where it's supposed to be, and it can cause -- if it's in the fallopian tubes, it cause those to rupture and bleed, right?

A. That is one form of ectopic pregnancy. There are many locations that an ectopic pregnancy can exist, including technically within the uterus.

Q. Okay. And if you have -- well, the fourth category would be an ultrasound that showed a suspected ectopic pregnancy. How would your differential diagnosis for that fourth category differ, if any way, from the third category, where you actually identified

ectopic pregnancy?

A. So a probable ectopic pregnancy would mean that I am seeing something outside of the uterus that I am suspicious is ectopic, but I don't see characteristics that absolutely confirm that that is a pregnancy that I'm seeing versus some other structure such as an ovarian cyst that's complex.

Q. And what would your differential diagnosis -- what would you do with that patient, that Category 4?

(Knock at door)

Q. You can continue. You can continue. I'm listening.

MR. BOYLE: Thanks.

THE WITNESS: Differential diagnosis and treatment are two very different things. Would you like me to answer what the differential diagnosis was or what I would do for it?

Q. (Mr. Boyle) Start with the differential, yes.

A. So the differential diagnosis of a probable ectopic pregnancy is would be that there is an ectopic pregnancy that I can't definitely diagnosis or that there is some other structure outside of the uterus that I -- that could be a complex ovarian cyst, it

could be some other structure outside of the uterus such as bowel that has a strange appearance.

Q. If it was a cyst instead of an ectopic pregnancy, would you consider that patient to be at risk of danger from that cyst?

MS. SWANSON: Objection to form.

THE WITNESS: Some cysts can create danger, but rarely the more immediate, potentially life-threatening danger of an ectopic.

Q. (Mr. Boyle) Okay. So what would you do with that patient if you -- you couldn't tell if it was an ectopic pregnancy, but you saw something and you suspected it might be a cyst? What would you do?

A. If I saw something outside of the uterus that I would categorize as a possible ectopic pregnancy, even if I thought there was a reasonable possibility that it was a cyst, if it falls under the category of probable ectopic pregnancy, I would treat it as an ectopic pregnancy, where I would refer the patient ---

Q. Okay.

A. --- for immediate evaluation.

Q. And that makes sense, because an ectopic pregnancy is a potentially life-threatening condition. So if you have a strong suspicion for it, you have to rule it out, so you go ahead and refer that patient to

their gynecologist or an emergency room so that she can get worked up further, and they can rule it out or rule it in. Is that fair?

MS. SWANSON: Objection to form.

THE WITNESS: If a patient has a definite or probable ectopic pregnancy, that means that I am concerned about a potentially life-threatening condition, and I would refer them for further immediate evaluation.

Q. (Mr. Boyle) A patient with the fifth category, pregnancy of unknown location, could that be an ectopic pregnancy?

A. It could be.

Q. Are you suspicious that it might be an ectopic pregnancy?

MS. SWANSON: Objection to form.

THE WITNESS: No. If I'm suspicious that it might be an ectopic pregnancy, then I would consider it a probable or definite ectopic pregnancy.

Q. (Mr. Boyle) So if you have a pregnancy of unknown location on an ultrasound, you're not seeing an actual pregnancy or possible pregnancy either in the uterus or outside the uterus, correct?

A. Correct.

Q. Doesn't that raise your suspicion that that

patient could have an ectopic pregnancy, because you haven't ruled it out?

MS. SWANSON: Objection to form.

THE WITNESS: When I have a patient who has a probable -- or, pardon me, who has a pregnancy of unknown location, I consider three -- the most common three possibilities in my differential diagnosis: that they have an early intrauterine pregnancy that is not yet visible; that they have an early intrauterine pregnancy that is undergoing miscarriage; or that they have an ectopic pregnancy that is not yet visible.

Q. (Mr. Boyle) So when you have a Category 5, pregnancy of unknown location, on an ultrasound, part of your differential diagnosis is Number 3, that they may have an ectopic pregnancy that you just can't see yet?

A. That is correct. That is part of the differential diagnosis.

Q. Unless they are discovered and treated early, you would agree that almost 40 percent of ectopic pregnancies rupture suddenly, causing pain and bleeding in the abdominal cavity, wouldn't you?

A. I do not have that data.

Q. You don't know that data?

A. I do not know that statistic off the top of

my head.

Q. You would agree, at least, that ruptured ectopic pregnancies can be fatal, wouldn't you?

A. I would agree.

Q. At least 2 percent of pregnancies are ectopic pregnancies. Isn't that right?

A. The categorization I have heard is that up to 2 percent of pregnancies are ectopic pregnancies.

Q. We were talking about ACOG before. Are you familiar with ACOG Practice Bulletin 193?

A. I would have to look at it to know.

Q. You don't know it just off the top of your head?

A. Not from a number.

Q. Okay.

MR. BOYLE: I'm going to hand you a document.

MS. SWANSON: Thank you.

MR. BOYLE: You're welcome.

Q. (Mr. Boyle) Take your time, review that please, and let me know when you're ready to identify it.

A. I have not read it in detail, but I am -- I do have it in front of me.

Q. Okay. Are you able to identify what this is,

please?

A. It is the ACOG Practice Bulletin, Number 193.

Q. And from what -- what time frame?

A. From March 2018.

Q. What's the topic of this Practice Bulletin?

A. Clinical Management Guidelines for Obstetrician/Gynecologist Tubal Ectopic Pregnancy.

Q. Do you see on the first page, under Background/Epidemiology, where it says, quote, "According to the CDC, ectopic pregnancy accounts for approximately two percent of all reported pregnancies," end quote?

A. Yes, I see that quote.

Q. You see a few lines down where it says, quote, "Despite improvements in diagnosis and management, ruptured ectopic pregnancy continues to be a significant cause of pregnancy-related mortality and morbidity. In 2011 to 2013, ruptured ectopic pregnancy accounted for 2.7 of all pregnancy-related deaths and was the leading cause of hemorrhage-related mortality," end quote?

You see that?

A. Yes, I see that.

Q. Do you agree with that?

A. I do trust this data.

Q. Okay. If you look over that Risk Factor section on the first page, I'm going to read you a sentence and ask you about that. First sentence says, quote, "One-half of all women who receive a diagnosis of an ectopic pregnancy do not have any known risk factors," end quote. Do you see that?

A. I do see that.

Q. So you would agree that it's possible that a woman who comes into a PPSAT clinic has an ectopic pregnancy but doesn't have any known risk factors for that ectopic pregnancy?

A. Yes, that is possible.

Q. And the gold standard to test and look for an ectopic pregnancy is to conduct a transvaginal ultrasound and see if there is an embryo or fetus seen in the uterus. Isn't that right?

A. I don't know ---

MS. SWANSON: Object to form.

THE WITNESS: --- what you mean by, "gold standard."

Q. (Mr. Boyle) You don't use the word -- the term "gold standard" in your medical practice?

A. I would not use the term "gold standard" in this context.

Q. Do you use it in any context in your medical

practice?

MS. SWANSON: Objection to form.

THE WITNESS: I don't know that I -- it's not a -- it's not a term that I routinely use, no. I would say that ultrasound is a critical factor in diagnosis of ectopic pregnancy.

Q. (Mr. Boyle) I will accept that. If you turn to the second page of this Bulletin 193, under Clinical Considerations and Recommendations, How is an Ectopic Pregnancy Diagnosed; you see that section?

A. I do see that section.

Q. Okay. You see the sentence that says, quote, "The minimum diagnostic evaluation of a suspected ectopic pregnancy is transvaginal ultrasound evaluation and confirmation of pregnancy," end quote. Do you see that?

A. I do.

Q. So ACOG requires, according to this Bulletin, that in order to rule in or rule out an ectopic pregnancy, you have to have an ultrasound that shows the pregnancy. Is that correct?

A. That ---

MS. SWANSON: Objection to form.

THE WITNESS: That's not actually what it's saying. What it's saying is that the minimum

diagnostic evaluation, so the minimum you must do if you suspect ectopic pregnancy, is a transvaginal ultrasound evaluation.

And when they say, "and confirmation of pregnancy," they mean that if you do a transvaginal ultrasound but you haven't done another test to confirm that the patient is pregnant, such as a urine or blood pregnancy test, then it's not as useful.

For example, if a patient had a negative pregnancy test, then the -- the transvaginal ultrasound wouldn't be helpful. So if you do a transvaginal ultrasound and don't see a pregnancy, you would next do a pregnancy test to see if the patient was even pregnant.

Q. (Mr. Boyle) So you think that sentence there, that's talking clearly about ultrasound, means that a doctor doesn't have to actually confirm the pregnancy with the ultrasound? That's how you interpret that sentence?

MS. SWANSON: Objection to form.

THE WITNESS: No. What I am saying is that this sentence says that you must do an ultrasound, and you must also confirm that the patient is pregnant. Because often, for example, in pregnancy of unknown location, you will do an ultrasound and not see a

pregnancy.

So if you perform an ultrasound, which is often done before a pregnancy test is done, and you see no pregnancy, the very next step is to perform a pregnancy test to confirm that the patient is pregnant. Because if the patient is not pregnant, then the concern for ectopic pregnancy no longer exists.

Q. (Mr. Boyle) I just want to make sure that I understand what you're saying. The next sentence says, quote, "Serial evaluation with transvaginal ultrasonography, or serum HCG level measurements, or both, often is required to confirm the diagnosis," end quote.

Do you see that?

A. Yes, I see that.

Q. And you think that, again, when the prior sentence says, "confirmation of pregnancy," it's not talking about with an ultrasound, it's talking about with a pregnancy test?

MS. SWANSON: Objection to form.

THE WITNESS: I believe that the first sentence is saying that a transvaginal ultrasound in the absence of confirming that the patient is actually pregnancy is not helpful. So you confirm that the patient is pregnant.

And then, I believe, that you must perform not just one ultrasound, unless the ultrasound definitely diagnoses an ectopic pregnancy. If it does not give you a definitive diagnosis, then the next step is to perform serial ultrasounds, usually over the course of several days, and often, serial blood tests, usually over the course of several days.

Q. And I guess I'm -- I'm confused, and maybe I'm just ignorant to this. It's entirely possible. When a woman comes to PPSAT and says, "I think I might be pregnant," isn't the first step, you just give her a pregnancy test as opposed to giving her an ultrasound?

A. It depends on the type of visit. If a patient comes in and says, "I'm not sure if I'm pregnant. I'd like to find out," we perform a pregnancy test.

Most of the patients who are coming to us for abortion come and say, "I did a pregnancy test at home. I'm here for an abortion." In those patients, we start with ultrasound, because they've already performed an equivalent pregnancy test at home.

Q. So -- and that second type of patient, when they show up and say, "I did a pregnancy test at home. I think I'm pregnant. I want an abortion," you perform an ultrasound first.

And then, if you don't see a pregnancy on the ultrasound, that fifth category, pregnancy of unknown location, then you give them the pregnancy test?

A. That's correct.

Q. How much does it cost to give them a pregnancy test?

A. I don't know the cost of pregnancy tests, and I don't know that we actually charge for the pregnancy test in that setting. I'm not sure.

Q. But you charge for the ultrasound?

A. We do charge for the ultrasound.

Q. Why wouldn't you just give them a pregnancy test first, especially if it doesn't cost the patient any money?

MS. SWANSON: Objection to form.

THE WITNESS: We almost never have to do a pregnancy test. If we were performing a pregnancy test on every single patient, I think we probably would have to charge for it.

So a vast majority of patients come to us and say they've had a positive pregnancy test. If a patient came to us and said, "I'm not sure if I'm pregnant," we would start with a pregnancy test before an ultrasound.

Q. (Mr. Boyle) If you look at the next column

over, Serum Human CH -- CG -- HCG, sorry. Serum HCG Measurements, do you see that?

A. I see that.

Q. It says, quote, "Measurement of the Serum HCG levels aids in the diagnosis of women at risk of ectopic pregnancy. However, Serum HCG values alone should not be used to diagnosis an ectopic pregnancy and should be correlated with the patient's history, symptoms, and the ultrasound findings," end quote.

Do you see that?

A. I see that.

Q. So doesn't that say that you have to see an ectopic pregnancy by an ultrasound, either saying it's intrauterine or it's not?

MS. SWANSON: Objection to form.

THE WITNESS: No, that's not at all what it says.

Q. (Mr. Boyle) Okay. If you have a woman who has tested pregnant -- tested positive for pregnancy, and you take an ultrasound of her and you don't see a fetus or an embryo anywhere on that ultrasound, doesn't that actually raise your suspicion for her having an ectopic pregnancy on that differential diagnosis you were discussing earlier?

A. Yes, it does increase my suspicion for

ectopic pregnancy if I do not see a pregnancy either inside or outside of the uterus, including a gestational sac, not just a fetus or embryo.

Q. Okay. When you're treating a -- a woman who's tested positive for pregnancy, but she has a confirmed ectopic pregnancy, you don't provide her with the two chemical abortion drugs, do you?

A. That is correct. We do not treat anyone with a confirmed ectopic pregnancy with medication abortion medications.

Q. Because mifeprex (sic) and misoprostol are drugs that do not assist a woman in treating her for her ectopic pregnancy, are they?

MS. SWANSON: Object to form.

THE WITNESS: Mifepristone and misoprostol, as used in medication abortion, are not effective in treating ectopic pregnancy.

Q. (Mr. Boyle) And the FDA label says that they are contraindicated in patients with confirmed or suspected ectopic pregnancies, doesn't it?

A. I don't know what the FDA label says without looking at it.

Q. You've prescribed these medications several times every week for the past 14 years, correct?

A. That is correct.

Q. And you are unaware that the FDA label says that they are contraindicated for a woman who has an actual diagnosed or suspected ectopic pregnancy?

MS. SWANSON: Object to form.

THE WITNESS: I cannot directly quote the FDA label without looking at it. I am aware that we do not use mifepristone and misoprostol, as designed for medication abortion, in patients with known or suspected ectopic pregnancy.

Q. (Mr. Boyle) A patient who has a suspected ectopic pregnancy needs to be worked up to see if she needs surgical treatment for her ectopic pregnancy or if she qualifies for a different drug treatment, methotrexate, right?

A. There are different treatments for ectopic pregnancy, and those treatments should be offered based on the patient's exact circumstances, yes.

Q. Typically, the drug you give for ectopic pregnancy is methotrexate, not the two chemical abortion drugs, right?

A. I do not treat ectopic pregnancy, but it is -- you do not use mifepristone and misoprostol to treat ectopic pregnancy. Methotrexate is one of the medications that can be used to treat ectopic pregnancy.

Q. If you give a woman who tests positive for pregnancy, who is actually suffering from an ectopic pregnancy, the chemical abortion drugs, and it does not stop her ectopic pregnancy from growing, that ectopic pregnancy can rupture, possibly in her fallopian tubes or some other internal structure, causing damage and bleeding inside her abdomen. Isn't that right?

MS. SWANSON: Object to form.

THE WITNESS: Any woman who has an ectopic pregnancy, that ectopic pregnancy can rupture if it is not treated, regardless of whether the patient receives mifepristone and misoprostol or not.

Q. (Mr. Boyle) That's fair. But the prescription of those two drugs wouldn't have any impact on whether that ectopic pregnancy will continue to grow and possibly rupture, right?

A. I don't believe it's been extensively studied, but we do not treat ectopic pregnancy with mifepristone and misoprostol. There's a possibility that they could stop the growth theoretically, but we do not use it for that purpose.

Q. Okay. I appreciate that there may be further research to be done, but there's none that you're aware of that has been done to suggest that's an appropriate treatment regimen for ectopic pregnancy. Is that

correct?

MS. SWANSON: Object to form.

THE WITNESS: I am unaware that anyone would use mifepristone and misoprostol to treat a known or suspected ectopic pregnancy.

Q. (Mr. Boyle) You agree that many of the symptoms of a ruptured ectopic pregnancy mimic, or are exactly the same as, the expected side effects of a chemical abortion that you or one of your colleagues at PPSAT have counseled your patient could occur if you give that patient a chemical abortion, right?

MS. SWANSON: Object to form.

THE WITNESS: There are some overlapping symptoms between the normal symptoms we expect with medication abortion and the symptoms of an ectopic pregnancy.

Q. (Mr. Boyle) It's possible that a patient who took chemical abortion drugs and then suffered a ruptured ectopic pregnancy, leading to internal bleeding and vaginal bleeding, pain, dizziness, headache, could misconstrue or confuse those symptoms of the ectopic pregnancy with the normal expected side effects of the chemical abortion, as it was described to her by her doctor or other provider at PPSAT. Isn't that true?

MS. SWANSON: Object to form.

THE WITNESS: It would be important to educate any patient on whom we have not diagnosed an intrauterine pregnancy, who takes mifepristone and misoprostol, on the normal symptoms that they would experience with a medication abortion and on the abnormal symptoms that they might experience, including detailed education on the symptoms of ectopic pregnancy.

Q. (Mr. Boyle) But they might confuse a ruptured ectopic pregnancy for the normal side effects from the chemical abortion process, correct?

MS. SWANSON: Object to form.

THE WITNESS: I can't speculate on who might get confused by what. It is important to give clear education and closely follow up with patients.

Q. (Mr. Boyle) If you look at the document, please, at, let's see, Bates 31, on the first page there.

MS. SWANSON: And for the record, we're now switching back to the patient education packet from the ACOG bulletin.

Q. (Mr. Boyle) Right. Bates 31. Do you see that?

A. I see that form, yes.

Q. Okay. You see on the left-hand column, it's talking about abortion pill and it's -- and it's going over what the patient may expect and how it might turn out. Is that fair?

A. I do see that form.

Q. Okay. And there's two columns. There's -- the one on the left is abortion pill, and the other one on the right is in-clinic abortion, right?

A. Correct.

Q. Okay. So when you go down to How Will I Feel, there's a list of symptoms there, right?

A. There is.

Q. It says, "nausea or vomiting, headache, dizziness." You see those?

A. I do.

Q. And then you go down two more rows and it talks about bleeding. It says, "Heavy bleeding with clots is common after taking misoprostol," right?

A. It says, "Heavy bleeding with clots is common after taking misoprostol," yes.

Q. Okay.

MR. BOYLE: I'm going to give you what's been marked as Bates Number 119 and 120.

MS. SWANSON: Thank you.

MR. BOYLE: You're welcome.

Q. (Mr. Boyle) Ask you if you recognize that document?

A. Yes, I do.

Q. And actually it's two documents there, but they're actually separate documents, I believe. Are these given out to your patients at PPSAT?

A. They are given out to some patients at PPSAT, yes.

Q. Not to every patient?

A. No, not to every patient.

Q. Okay. And when we're looking at Bates Number 119, what's the name of this document up at the top, please?

A. Positive Pregnancy Test No Pregnancy Seen on Ultrasound.

Q. Okay. So this is a document, a one-page document, about what we were talking about, that Category 5, pregnancy of unknown location from an ultrasound, right?

A. Correct.

Q. Okay. Look at the second document, Bates Number 120. What's the topic of this particular document?

A. The title of this document is Ectopic Pregnancy.

Q. Okay. And let's stay with 120 there, Bates Number 120, the ectopic pregnancy. Do you see the box that says, "What are the symptoms of ectopic pregnancy"?

A. Yes, I do.

Q. And it says, "Bleeding from the vagina may be heavy or light," right?

A. I see that.

Q. Okay. It says, "Dizziness or fainting," right?

A. I see that.

Q. Okay. Those are similar symptoms that are found on Bates Number 31, talking about what might happen to a patient after they take the chemical abortion drugs, right?

MS. SWANSON: Object to form.

THE WITNESS: There are similarities between the two forms.

Q. (Mr. Boyle) There are similarities between the symptoms that you tell a patient might -- a patient might experience with ectopic pregnancy as the side effects and symptoms you expect the patient to experience after they take the chemical abortion drugs, right?

A. There are similarities, but they are not

identical, yes.

Q. Dizziness is identical, isn't it?

MS. SWANSON: Object to form.

THE WITNESS: There are similarities between the symptoms you asked me, so not ---

Q. (Mr. Boyle) I'm asking, dizziness is in both of them, isn't it?

A. Some of the words in both, some of the symptoms use the identical words. But the entirety of symptoms you might expect are not identical between the two conditions.

Q. You said, "the entirety of the symptoms you might expect," but neither one of these, Bates Number 31 or Bates Number 120 says, "You will experience all of these symptoms if you are taking the medical chemical abortion drugs," or, "You will experience all of these symptoms if you have an ectopic pregnancy," do they?

A. That is correct.

Q. They just say these are some things that may exist under the -- that circumstance or this circumstance, right?

A. That is correct.

Q. You agree that it's possible that a patient who received a chemical abortion drug -- drugs from

PPSAT, and also was suffering from a ruptured ectopic pregnancy, could look at these forms and be experiencing symptoms from both of them and be mistaken that they think it's from the chemical abortion drug, right?

MS. SWANSON: Object to form.

THE WITNESS: Can you repeat that question, please?

Q. (Mr. Boyle) You agree that a patient from PPSAT could receive chemical abortion drugs, and also have a ruptured ectopic pregnancy at the same time or shortly thereafter, and experience overlapping symptoms that are found in both documents and confuse the ectopic pregnancy rupture for a normal side effect from the chemical abortion drug, right?

MS. SWANSON: Object to form.

THE WITNESS: I would actually clarify that the symptoms listed are for the presence of ectopic pregnancy, and not for the presence of a ruptured ectopic pregnancy.

And the presence of a ruptured ectopic pregnancy tend to be much more severe, so it is unlikely to me, clinically, that a patient would experience a ruptured ectopic pregnancy and only experience, in the example you gave, dizziness.

Q. (Mr. Boyle) Right. But it says, on Bates Number 120, "Call us right away if you have dizziness, bleeding from the vagina," down at the bottom. Do you see that?

MS. SWANSON: Object to form.

THE WITNESS: Yes, I see that statement on the document.

Q. (Mr. Boyle) And it's not like the patient is going to know that they have an ectopic pregnancy. You only see that with ultrasound. They can't look inside their own bodies, right?

MS. SWANSON: Object to form.

THE WITNESS: Patients, unless they have access to an ultrasound machine, cannot look inside their own bodies.

Q. (Mr. Boyle) Fair enough. I will grant you that. And you at least perform, or require someone else to perform and give you a copy of an ultrasound, every single time before you give a patient chemical abortion drugs, right?

A. We require that an ultrasound is performed every time before we give a patient medication abortion. And in the setting of pregnancy of unknown location, if I were to receive an ultrasound from an outside individual, I would repeat the ultrasound

myself before giving a patient medication abortion.

Q. So if you have a pregnancy of unknown location from an outside source for this patient who has just arrived and is seeking a chemical abortion, you would take another ultrasound there, at PPSAT, before you gave that patient chemical abortion drugs. Is that correct?

A. It is our protocol to repeat that ultrasound the same day, yes.

Q. You said that's in your protocols?

MS. SWANSON: Object to form.

THE WITNESS: It is our practice. I don't know exactly how it's written in our protocols without reviewing the protocols.

MR. BOYLE: And I'm handing you what has been produced in discovery as Bates Numbers 53 through 105.

Q. (Mr. Boyle) Can you just -- first, before we start, can you look at the first page and see if I'm right on the numbers there?

MS. SWANSON: And before we get started, I'm just going to state for the record that this has been produced, designated confidential under our confidentiality agreement, and not everyone who's viewing this deposition has signed that protective

agreement yet. So if you are going to be asking questions specifically that reflect the content of this document ---

MR. BOYLE: I think the way I ask this question, it won't.

MS. SWANSON: Okay.

MR. BOYLE: If it does, then ---

MS. SWANSON: I'll object.

MR. BOYLE: --- you will object, and we can address that. I suspect the answer is going to be, "No."

MS. SWANSON: Okay.

MR. BOYLE: But if it's anything other than, "No," I understand where you're coming from, and I will respect your objection as stated and we'll deal with it. I don't have a problem with that.

MS. SWANSON: I thank you.

MR. BOYLE: And I'm not making it an exhibit.

MS. SWANSON: Okay. I appreciate that.

MR. BOYLE: Yes.

Q. (Mr. Boyle) So I think we established, without going into detail, Bates Number 53 through 105 is what's been produced as Chapter 1 of the abortion chapter from PPSAT's internal protocols and guidelines.

Is that correct?

A. That is correct.

Q. Okay. I think I heard you say that you have a protocol -- and you might have said just a practice, so that's why I'm asking about the written protocols.

You have a protocol at PPSAT where, if there is a patient who has an ultrasound that gives a result of pregnancy of unknown location, and the patient has tested positive for pregnancy, so under that circumstance, and you get that ultrasound from an outside source, not internal, not done by PPSAT, that you have a protocol that requires PPSAT to do a new ultrasound.

Can you show me in this document where it says that, please?

A. Can you turn to Bates Page 64?

THE WITNESS: Am I allowed to go over what's on this?

MS. SWANSON: Let's...

MR. BOYLE: How about this? Do me a favor, and -- and I know this is bad for keeping a record. Can you just point to it on your piece of paper and let me see? And I may not have a follow-up if you show it to me just by pointing.

(Witness complies)

Q. (Mr. Boyle) Okay. You're saying that you have a policy at PPSAT that says, if a patient arrives with an ultrasound from outside a PPSAT clinic, and that ultrasound shows pregnancy of unknown location, that then, you have a protocol that says you must do a new ultrasound at PPSAT. Is that what you're saying?

A. What I'm saying is that I have a protocol that states that if I have a patient with a positive pregnancy test, in order to follow any of the next steps, I need to see that there is no gestational sac on transvaginal ultrasound.

So a transvaginal ultrasound must be done to show no -- we can't accept an outside ultrasound that has no pregnancy visible. If there's no pregnancy visible, we must do an ultrasound to see if there's a pregnancy visible.

Q. But, I guess, if that's true, why don't you just agree to the law as written, because all the law says is you have to have an ultrasound that shows an intrauterine pregnancy?

MS. SWANSON: Object to form.

THE WITNESS: Am I allowed to talk more about the protocol?

MS. SWANSON: You can talk about the protocols without referring specifically to this

document, if that's possible. If it's not possible, we can go off the record and talk about it a bit more.

THE WITNESS: If I were to receive an ultrasound from an outside organization that showed a intrauterine pregnancy, definite intrauterine pregnancy at eight weeks, four days, and I can see that that ultrasound was done four days ago, and, for example, the patient came in with their ultrasound and their consent for the procedure, our protocol would not absolutely require me to repeat that ultrasound, although the clinician always, always has the clinical prerogative to repeat the ultrasound if they have any reason they want to.

Our protocol for management of pregnancy of unknown location requires that we have an ultrasound that shows a pregnancy of unknown location. So if, for example, a patient had an ultrasound elsewhere and then came to see me at my clinic and said, "They did and ultrasound and they didn't see a pregnancy," I would not use that ultrasound clinically.

I would need to perform an ultrasound to see if the patient has a pregnancy of unknown location before proceeding with treatment.

Q. (Mr. Boyle) Okay. And if you then do that ultrasound at PPSAT and it still shows a pregnancy of

unknown location, that fifth category, you think that you should be able to simultaneously provide the chemical abortion drugs before you get the positive confirmation that that patient has an intrauterine pregnancy. Is ---

MS. SWANSON: Object ---

Q. (Mr. Boyle) --- that correct?

MS. SWANSON: Object to form.

THE WITNESS: So we follow excellent evidence-based protocols that show that it is appropriate to simultaneously determine the location of the pregnancy, which the ACOG Bulletin expresses is usually done through serial ultrasounds and/or serial blood tests, and, at the same time, provide the medication abortion to patients.

Q. (Mr. Boyle) Do you think it would be safer to give that patient another ultrasound a few days later or a week later to determine if it was an ectopic pregnancy or not, before you gave the contraindicated chemical abortion drugs?

MS. SWANSON: Object to form.

THE WITNESS: I think that it is not necessarily safer to delay starting the medication abortion for patients, and safety is one of several factors that we consider in the options that the

patient has to choose from.

Q. (Mr. Boyle) What other option -- what other factors are you considering other than the safe -- the patient's safety?

A. We are considering patient history and risks, which is part of safety. We are considering patient preference very strongly. That many patients, even if they know that if they have an ectopic pregnancy, the medications won't work.

Given that ectopic pregnancy occurs in less than 2 percent of patients, if they have no risk factors and no other concerning signs, there's a very good chance they just have an early pregnancy. My patients strongly prefer to begin definitive treatment at the same time that we are performing the serial ultrasounds and/or serial blood tests.

Q. You said you follow the evidence-based medicine. How long as PPSAT been providing medical chemical abortion drugs to patients who have pregnancy of unknown location on their ultrasound findings before confirming either ectopic or intrauterine pregnancy? How long has that been going on?

MS. SWANSON: Object to form.

THE WITNESS: I do not know exactly when that protocol was first made available to us.

Q. (Mr. Boyle) It's something that would have come, literally, across your desk as the chief medical officer, right?

A. Our protocols are updated every one to three years and different aspects of the protocols are updated at different times, so I cannot recall exactly when that update started without looking back at our historical protocols.

Q. And you just don't have any memory if you've been doing it for one year or for three years or more?

MS. SWANSON: Object to form.

THE WITNESS: That wasn't your original question.

Q. (Mr. Boyle) Well, I'm -- I know. I'm asking another question.

A. We have been doing it for at least a year, but I don't recall how long over a year we've been doing it.

Q. Okay. Because you say it's based on evidence-based medicine, what evidence-based medicine are you basing it on?

A. All of the medical standards that we use, which include the option of medication abortion while simultaneously determining the location of a pregnancy, are based on a large amount of research and data. And

we can look to the last pages to show the references, but I don't recall the exact references without actually looking at them.

Q. Can you -- can you tell me -- you can go ahead and take that. That's the Chapter 1 Abortion. Again, I'm not asking for anything really specific about it other than what you think supports your contention that providing simultaneous chemical abortion drugs to a patient with a pregnancy of unknown location is supported by any evidence-based medicine practice. And this is Bates Number 53 through 105, that document.

A. It is not possible for me, reading the titles of all of the articles that are referenced in this book, to know the full content of every article. So there are some of these articles that are very broad, which means that it is possible that the information exists in those.

Q. What page are you looking at, if I might ask?

A. I am looking at -- starting at Bates 102, and the references go through Bates 104, and I have not finished reading through every title yet.

Q. If you find any titles here that you think support your contention that there is evidence-based medicine that underlies the PPSAT's decision to, at the

same time, provide chemical abortion with a pregnancy of unknown location, please identify that for me.

MS. SWANSON: Object to form.

THE WITNESS: I would want to read through the Management of Unintended and Abnormal Pregnancy Comprehensive Abortion Care.

Q. (Mr. Boyle) Which one is that, please?

A. It's labeled throughout, and at approximately halfway down Bates 103.

Q. What's the date on that document?

A. 2009. So based on that date, it may or may not have reference to that.

Q. But you would agree that this is fairly new and evolving theory that you can provide contemporaneous chemical abortion drugs to a patient with a pregnancy of unknown location on an ultrasound, right? That research is from, like, the past two or three years, right?

MS. SWANSON: Object to form.

THE WITNESS: Without looking at the actual studies, I cannot state the exact time frame. But it is relatively new, and the newness of data does not mean that the data is not valid.

Q. (Mr. Boyle) It's come out since ACOG 193 in March of 2018, that new theory about giving chemical

abortion drugs at the same time as a patient has a pregnancy of unknown location on ultrasound, right?

MS. SWANSON: Object to form.

THE WITNESS: I don't know that. And I have not read through the entirety of ACOG Practice Bulletin 193 to see whether it references simultaneous provision of abortion while determining the location of pregnancy.

Q. (Mr. Boyle) How about you turn to the third page of the ACOG Bulletin, please? It's down at the bottom. It says, "E-93".

A. I'm on that page.

Q. Okay. If you go down to the bottom of the left-hand column, "Pregnancy of Unknown Location," you see that?

A. The -- I'm sorry, the bottom of -- yes, I do see that.

Q. Okay. So let me read this to you and then I'll ask you a question. Just making sure I've read it properly for the record.

Quote, "A pregnant woman without a definitive finding of an intrauterine or ectopic pregnancy on an ultrasound examination has a pregnancy of unknown location. A pregnancy of unknown location should not be considered a diagnosis. Rather, it should be

treated as a transient state. An effort should be made to establish a definitive diagnosis when possible," end quote.

Do you see that?

A. I see that statement.

Q. So does that inform your opinions about what was going on back in 2018, as it relates to how to diagnosis and treat a patient with -- or ultrasound of pregnancy of unknown location?

MS. SWANSON: Object to form.

THE WITNESS: I would state that it is true now that we should make efforts to establish a definitive diagnosis when possible. We are just not required to make those efforts in isolation.

Q. (Mr. Boyle) And I did not mean to interrupt you in your review of -- I apologize, I did interrupt you. I'm sorry.

You were looking at Bates Number 102, Bates Number 103 and Bates Number 104 to tell us if there was any recent research identified by PPSAT that would support its position that it is acceptable medical practice to provide chemical abortion drugs simultaneous with a patient who has a diagnosis or a transient state of pregnancy of unknown location on an ultrasound.

MS. SWANSON: Object to form. I'm not sure there's a question in there.

Q. (Mr. Boyle) The question is: show it to me, please.

MS. SWANSON: Object to form.

THE WITNESS: So I do not see some of the articles that I know are used to create those protocols. I also don't think that the list of table references are the sole source of the protocols.

Q. (Mr. Boyle) And that's fine. I was just basing that off of what I understood you to say, that they were. If you're saying they're not, then there may be other things out there that go into the protocols. Is that what you're saying?

Maybe other research out there -- I apologize, maybe other research out there that goes into making these protocols that's not included at the end in that table?

A. There is much research and expert analysis that goes into making these. I do not personally create these protocols, so cannot speak to all of the details.

Q. You would agree that induced abortions, surgical abortions, become more complicated after the gestational age is beyond 14 weeks, wouldn't you?

MS. SWANSON: Object to form.

THE WITNESS: The complexity of a procedural abortion varies throughout gestational duration. And over seven or eight weeks, I would say that there is an incremental increase in complexity of the procedure with increasing gestational duration.

Q. (Mr. Boyle) You cited the "Academies of Medicine" article, and it says that "The risk of serious complication increases with weeks gestation; as the number of weeks increase, the invasiveness of required procedure and the need for deeper levels of sedation also increase."

Do you agree with that?

MS. SWANSON: Object to form.

THE WITNESS: I can't agree that that's the exact quote without looking at the actual document. I do agree that there is an incremental increase in risk as gestational duration increases.

Q. (Mr. Boyle) I'm sorry, I'm working through here.

You agree that some second trimester induced abortions must take place in a hospital setting, don't you?

MS. SWANSON: Object to form.

THE WITNESS: I would agree that some

abortions, regardless of gestational duration, must take place in a hospital.

Q. (Mr. Boyle) You would agree that anything beyond moderate sedation -- I think we've discussed it. But anything beyond moderate sedation anesthesia level for a surgical abortion must happen in a hospital, not at a PPSAT clinic, right?

MS. SWANSON: Object to form.

THE WITNESS: No, I would not agree to that. Deep sedation can be offered in an outpatient setting if you have the right equipment and staff. PPSAT does not have the staff to perform deep sedation in our outpatient clinics, but that doesn't preclude the safety of performing it in a clinic that has that staff.

Q. (Mr. Boyle) If a patient comes to PPSAT and has an ultrasound, and it's an ultrasound of unknown -- pregnancy of unknown location, do you charge for an additional -- does PPSAT charge for an additional ultrasound if that patient gets an additional ultrasound?

MS. SWANSON: Object to form.

THE WITNESS: Do you mean that if the patient had an ultrasound at an outside location that showed a pregnancy of an unknown location, and then we

performed an ultrasound, would we charge the patient for the ultrasound we performed?

Q. (Mr. Boyle) I didn't mean that, but do you?

A. If we perform an ultrasound, yes, we charge them for ---

Q. And if ---

A. --- the ultrasound performed.

Q. I'm sorry. If you come up with an ultrasound of pregnancy of unknown location and you take another one at PPSAT, do you charge for the second one also?

A. We do not routinely charge for repeat ultrasounds that we feel are clinically necessary, no.

Q. So if you charge for an ultrasound and the patient gets a second or even a third, you don't charge for the second or the third. Is that correct?

A. It is my understanding that we do not routinely charge for repeat ultrasounds that we deem clinically necessary.

Q. Have you ever had a situation where you had a patient with ultrasound finding of pregnancy of unknown location, you gave that patient chemical abortion drugs and then later, you determined that that patient had an ectopic pregnancy?

A. Yes, that has occurred.

Q. Did you give that patient a refund for the

unnecessary procedure that you performed?

MS. SWANSON: Object to form.

THE WITNESS: The patient is charged for the services they receive on the day they receive them, so the patient paid for the services they received, which included medications that they took.

Q. (Mr. Boyle) And you would agree that in that circumstance, the medications that the patient paid for were unnecessary, right?

MS. SWANSON: Object to form.

THE WITNESS: At the time that the medications were given, we did not know that they were unnecessary, so they were given in good faith.

Q. (Mr. Boyle) Absolutely. But had you waited, eventually you were able to determine that that particular patient had an ectopic pregnancy, right?

A. If it had been the patient's preference to wait, we certainly could have waited and not done the medication abortion yet.

Q. Well, you also could have just waited because you don't know where the pregnancy is, regardless of the patient's preference, right?

MS. SWANSON: Object to ---

Q. (Mr. Boyle) That's at least an option?

MS. SWANSON: Object to form.

THE WITNESS: We provide the patient with their options and let them choose. So a patient who is taking medication abortion in the setting of pregnancy of unknown location is aware and informed that they may not have an intrauterine pregnancy, and that if they have an ectopic pregnancy, this medication will not be sufficient to treat that condition.

And then the patient chooses that option, or they choose the other option, such as a diagnostic suction, or to wait while determining the location of the pregnancy.

Q. (Mr. Boyle) You're talking about the evidence-based studies that support your proposition that Planned Parenthood should be able to give chemical abortion drugs simultaneously with a patient with an ultrasound findings of pregnancy of unknown location. Did you consider the Goldberg study?

A. I believe I did look at the Goldberg study, but I'd want to see it to be sure.

Q. Okay. Copy for you.

MS. SWANSON: Thank you.

THE WITNESS: Thank you.

Q. (Mr. Boyle) And take your time, take a look at it, and when you're ready, I'll ask you some questions, please.

A. I see the study.

Q. Okay. Now that you've reviewed that document, is that what you were talking about, with the Goldberg study from 2022, that supports your position that PPSAT should be able to give chemical abortion drugs simultaneously with a ultrasound finding of pregnancy of unknown location?

A. This is one of the studies. I believe I cited two studies on providing medication abortion concurrent with pregnancy of unknown location.

Q. Did you also cite the Boraas study from Minnesota? Do you recall if -- if that were her study? I believe Upadhyay, and I'm terrible with names, I apologize, Upadyay, Upadie (sic), I'm saying that wrong, I know by the look on your face, but that lady who is in San Francisco that does a lot of research. Did you consider that report also?

MS. SWANSON: Object to form.

THE WITNESS: Without seeing the actual document ---

MR. BOYLE: Conceded.

THE WITNESS: --- I'm not comfortable confirming that this is the study.

Q. (Mr. Boyle) Okay.

A. There was a second study that I did cite.

Q. Okay. Well, if it's that one, then that one was published in 2023, and this Goldberg study was published in 2022, right?

MS. SWANSON: Object to form.

THE WITNESS: I can see that this study was published in 2022.

Q. (Mr. Boyle) Are you aware of any other studies from prior to 2022 that would support PPSAT's position on this?

A. I do not have knowledge of all of the full literature on this topic.

Q. When you look at this study, it's a retrospective cohort study of medical records from Massachusetts Planned Parenthood related to giving chemical abortion drugs to a patient with a pregnancy of unknown location. And I was wrong on the dates. It was from 2014 to 2019. Is that correct?

A. That is what I understand this study to be.

Q. Okay. And if you turn to Page Number 779, the second to last page, please. It's -- yeah. And you look on the left-hand column, there's a paragraph that starts with, "Additionally". Do you see that?

A. On the left-hand column, a ---

Q. I'm sorry.

A. --- paragraph ---

Q. Right. Right.
A. --- that starts ---
Q. Right.
A. --- with, "Additionally"?
Q. Right.
A. Yes, on the right-hand column, I do.
Q. Okay. And I'm going to read that and then ask you a question. Quote, "Additionally, some patients who present with undesired pregnancies of unknown location may never require an abortion.

"We found that 18 percent of patients in the delay for diagnosis group were eventually diagnosed with early pregnancy loss, and eight percent with ectopic pregnancy. Thus, collectively, 26 percent did not require abortion," end quote.

Did I read that correctly?
A. You did correctly read that.
Q. And if you extrapolate that, that would suggest that possibly a quarter of the patients that you are treating with pregnancies of unknown location with chemical abortion drugs, one out of four of them don't actually need those drugs, do they?

MS. SWANSON: Object to form.

THE WITNESS: In my clinical experience, and in my education of patients, I discuss with them

that they may be having a miscarriage, as I mentioned, or they may have an ectopic pregnancy, neither of which would be treated by the medications we use.

And in my clinical experience, my patients are exceedingly anxious to complete their abortion, and those who choose the option of medication abortion in the setting of pregnancy of unknown location, are doing so aware of that and wanting to take the chance that this might actually end their pregnancy, rather than delay their treatment and thus delay their ability to end their pregnancy, especially in the setting of bans.

Q. (Mr. Boyle) And I appreciate all of that and understand your position. I believe my question is a little bit more specific than that.

Doesn't this research support a conclusion that up to a quarter, one out of four of those patients who you are giving chemical abortion drugs to when you have a pregnancy of unknown location, if you just waited until you either ruled it in or ruled it out, they wouldn't have needed those medications, right?

MS. SWANSON: Object to form.

THE WITNESS: I believe that this data show that in this study, a quarter of the patients may not have needed the medication and that every patient should have the right to make the decision that is

right for them once they have the medical information.

Q. (Mr. Boyle) Well, I only bring up this study, because you said you relied on it to support your position of giving the chemical abortion drugs to a patient with a pregnancy of unknown location on ultrasound, right?

A. Correct.

Q. And part of this also says that maybe up to 25 percent of them don't need that, right?

A. Which is why patients are informed of the differential diagnosis before they make the decision that is right for them.

Q. There's a risk associated with giving a patient chemical abortion drugs every time they get it, even if they are indicated and needed, right?

MS. SWANSON: Object to form.

THE WITNESS: Every treatment and every decision to not treat carries a risk, because the decision to not treat is also a decision.

Q. (Mr. Boyle) Eight percent of the people he studied, Goldberg and his group studied, who had ectopic pregnancies and waited, they didn't get the chemical abortion drugs. And if they had gotten them, it actually would have been contraindicated for them under that circumstance, right?

MS. SWANSON: Object to form.

THE WITNESS: First of all, I believe Dr. Goldberg uses she pronouns. Second, the 8 percent of ---

MR. BOYLE: I'm sorry. I apologize. I had never looked at the first name, and that was very sexist of me. I apologize.

THE WITNESS: So the medication abortion in 8 percent of patients who had an ectopic pregnancy, the medication abortion would not treat that ectopic pregnancy. Medication abortion is contraindicated when you know you have an ectopic pregnancy, but it does not cause harm itself to an ectopic pregnancy, nor does it treat an ectopic pregnancy.

Q. (Mr. Boyle) But there are some associated risks with the mere fact of taking mifoprex (sic) and misoprostol, right?

MS. SWANSON: Object to form.

THE WITNESS: Any medication that is taken does carry potential risks, including mifepristone and misoprostol.

Q. (Mr. Boyle) You would agree that there's at least some consensus today that a patient with a pregnancy of unknown location should not be given chemical abortion drugs until serial ultrasounds are

taken to either rule in ectopic pregnancy or rule it out, wouldn't you?

MS. SWANSON: Object to form.

THE WITNESS: No.

Q. (Mr. Boyle) You agree there's no ACOG Bulletin that says that it's okay to give a patient with a pregnancy of unknown location chemical medication -- or chemical abortion drugs, right?

MS. SWANSON: Object to form.

THE WITNESS: I am not familiar with the contents of every ACOG Bulletin.

Q. (Mr. Boyle) I'm just going to be willing to bet that if there was an ACOG that supported that position, you would have included it in your Declaration, right?

MS. SWANSON: Object to form.

THE WITNESS: I did not read all of the ACOG Bulletins in my preparation for this Declaration.

Q. (Mr. Boyle) Fair enough. And if there had been one that said that was okay, or the common practice, don't you think you would have included it?

MS. SWANSON: Object to form.

THE WITNESS: That's speculation. I'm not familiar with all of the ACOG Bulletins.

Q. (Mr. Boyle) Okay. So if you turn to Page

780, the last page of the Goldberg study.

A. 780?

Q. 7-8-0. This one.

A. Yes.

Q. Okay. If you look at the last sentence, it says, quote, "Given that both management strategies are reasonably safe and effective, and that each carries benefits and risks, our data informed shared decision making and enabled choices heavily weighted toward patient priorities and preferences," end quote.

Do you see that?

A. I see that statement.

Q. And that means that Goldberg, she may have found that it's okay to give chemical abortion medications to a patient with pregnancy of an unknown location, but she also found that it's also -- it's also reasonable and safe to wait, didn't she?

A. What I read -- understand that statement to say is that patients should be informed of their options and make a choice that works best for their preferences and their personal medical condition.

Q. And the choice is between getting chemical abortion drugs with a pregnancy of unknown location ultrasound finding before you confirm intrauterine or waiting and confirming intrauterine or ruling in

ectopic, right? Those are the two choices there, one or the other?

MS. SWANSON: Object to form.

THE WITNESS: There is -- there are other choices. She references in this sentence those two choices.

Q. (Mr. Boyle) Yes. I'm -- that's what I'm talking about. I'm sorry. This sentence, she references go ahead and taking the chemical abortion drug or waiting and ruling in or out ectopic pregnancy, right?

MS. SWANSON: Object ---

THE WITNESS: I'd like to reread the paragraph before I answer that question.

Q. (Mr. Boyle) Help yourself. Please do.

(Witness examines document)

A. Actually, I'm going to go back further.

All right. Can you repeat your question?

Q. (Mr. Boyle) Yes. On Page 780, the end of the study, she determines that the option that PPSAT is promoting the giving of chemical abortion drugs while a patient has an ultrasound finding of pregnancy of unknown location, option one, versus option two, waiting and having repeat tests to actually rule in or rule out ectopic pregnancy with ultrasound. She found

that both of them carry risks and benefits, and they're reasonable safe, didn't she?

A. To be clear, Planned Parenthood South Atlantic offers both options to patients with pregnancy of an unknown location. We don't only offer medication abortion in the setting of pregnancy of unknown location.

We offer the patient both options so that they can, as she says, use shared decision making and choose the choice that makes the most sense for them.

Q. She says both options are reasonably safe and effective, right?

A. Correct.

Q. Which would mean that the option in the law is reasonably safe and effective, right?

MS. SWANSON: Object to form.

THE WITNESS: It is an option that is reasonably safe and effective, but significantly limits the patient and does not provide them with an equally safe and effective option.

Q. (Mr. Boyle) Okay.

MR. BOYLE: I don't think I have any further questions. And I thank you very much for your time. Other folks may, so you're not off the hook yet, but close.

THE WITNESS: I'd actually love a break if I can ---

MR. BOYLE: Suits me.

MS. SWANSON: Yeah. If we could -- could we take maybe a ---

THE WITNESS: Twenty?

MS. SWANSON: --- 20-minute break? Yeah.

THE COURT REPORTER: It's 2:20 now.

MS. SWANSON: Oh. It's 2:20 now?

THE COURT REPORTER: Uh-huh.

MS. SWANSON: Okay. Then let's take 15 minutes, come back at 2:35, if that's okay?

MR. BOYLE: Don't trip -- the unplug ---

THE WITNESS: I know. I was actually, this time, for the first time ---

THE VIDEOGRAPHER: Off record.

(Brief recess: 2:20 p.m. to 2:41 p.m.)

THE VIDEOGRAPHER: On record, 2:41.

MS. SWANSON: All right. I have just a few follow-up questions for Dr. Farris.

EXAMINATION

BY MS. SWANSON:

Q. So Dr. Farris, we've been talking about the Goldberg study that you cited in your Declaration. Do

you have that in front of you?

A. Yes, I do.

Q. I'd like you to look at Page 780 of the Goldberg study.

A. I see that.

Q. And this is the final paragraph that we were just discussing before the break. Do you see that paragraph?

A. I do.

Q. I'm going to read a section of that paragraph. "There is no reason to mandate that these patients with pregnancies of unknown location delay initiating abortion to first obtain a definitive diagnosis." Do you agree with that statement?

A. I do.

Q. I'd now like to look at the ACOG Bulletin that we were discussing earlier. This is ACOG Bulletin Number 193.

A. I have that.

Q. I'm on Page E-92.

A. Yes.

Q. Under Clinical Considerations and Recommendations, subpart How is an Ectopic Pregnancy Diagnosed, I'm going to read the first sentence of that paragraph. "The minimum diagnostic evaluation of a

suspected ectopic pregnancy is a transvaginal ultrasound evaluation and confirmation of pregnancy."

Dr. Farris, is a patient with a pregnancy of unknown location, who has been determined low risk of ectopic, a suspected -- a patient with a suspected ectopic pregnancy?

A. No, I would not consider them as having a suspected ectopic pregnancy.

Q. So for patients who have obtained an ultrasound and been determined to have a pregnancy of unknown location, are those patients with a suspected ectopic pregnancy?

A. No, I would not consider that they are suspected to have an ectopic pregnancy.

Q. Earlier, you testified that at that point, after an ultrasound has been done and they have been determined to have a pregnancy of unknown location, ectopic pregnancy might be on their differential diagnosis, right?

A. That is correct.

Q. What do you do to continue to exclude ectopic pregnancy in your differential diagnosis from that point?

A. We would do serial ultrasounds and/or serial blood tests for beta HCG.

Q. Do you do any additional screening through questions about the patient's medical history?

A. We very carefully screen the patient, both in their medical history, their pregnancy history, the history of their last menstrual period and other risk factors that might put them at higher risk for ectopic pregnancy.

Q. And based on that screening, that ectopic pregnancy screening, might somebody from the pregnancy of unknown location category, move to a patient with a suspected ectopic pregnancy?

A. Yes, those screening questions could make me suspect ectopic pregnancy.

Q. And for those patients, would you provide medication abortion using the pregnancy of unknown location protocol?

A. No, I would not.

Q. So for patients who have been screened for ectopic pregnancy, patients with pregnancies of unknown location who have been screened for ectopic pregnancy and determined to be low risk for ectopic pregnancy, what happens next in your counseling of those patients?

A. We counsel the patients that they essentially have three options. They can undergo what we call a diagnostic suction, which is performing a procedural

abortion and looking to see if we see pregnancy tissue removed from the uterus.

They can undergo a medication abortion while we concurrently evaluate for the presence of ectopic pregnancy through serial ultrasounds and serial blood tests. Or they can choose to wait to initiate abortion care and only go through the concurrent screening process of serial ultrasounds and/or blood tests.

Q. What additional counseling do you provide to those patients who do choose to have a medication abortion with a pregnancy of unknown location?

A. We speak to them at length and very carefully about not only the normal symptoms they should expect with mifepristone and misoprostol, but also any abnormal symptoms that might occur with ectopic pregnancy.

We make sure they understand how critical it is that they seek out care, either by calling us or going to a local emergency department should they experience those symptoms.

And we also inform them that we will be closely following up with them about their lab results, and that it's very important that they answer the phone when we call so we can check in on how they're doing.

Q. Shifting gears a bit. Even if it's true that

abortion becomes riskier as pregnancy advances, why does a hospitalization requirement starting at 12 weeks of pregnancy undermine patient safety?

A. For two reasons. First of all, we know that outpatient abortion is safe well beyond 12 weeks. We have plenty of data for that. But the other thing we know is that when we require abortions to be -- take place in a hospital, that usually delays their care. So by delaying their care, we are actually increasing their incremental risk of those complications.

Q. You testified that you consider abortions after 14 weeks zero days of pregnancy to be D&Es, correct?

A. That's correct.

Q. Do you ever provide an abortion, a procedural abortion, after 14 weeks without the need for additional instrumentation on top of the aspiration using a suction cannula?

A. Yes. Very frequently.

Q. Shifting back to medication abortion for a moment. What does it mean for mifepristone to be contraindicated for ectopic pregnancy?

A. That means that if you know a patient has an ectopic pregnancy, or if you strongly suspect a patient has an ectopic pregnancy, it is not appropriate to give

mifepristone and misoprostol, because they will not treat that condition.

Q. In what capacity do you understand yourself to be testifying here today?

A. I am here testifying as an expert on abortion care, and specifically also as an expert on the clinical care provided by Planned Parenthood South Atlantic.

Q. You testified that it's not possible to know in advance whether a patient will experience a complication from any given procedure. But is it possible to know in advance whether some patients have specific medical characteristics that would make them candidates for obtaining an abortion at a hospital rather than in the outpatient setting?

A. Yes, it is possible to screen patients for likelihood of complications. And at PPSAT, we screen all of our patients for different conditions that make it more likely. If we identify a patient that we feel is highly likely to experience a complication, we will refer them rather than performing the abortion in the outpatient setting.

Q. Why haven't you pursued hospital admitting privileges to provide abortion in North Carolina?

A. Hospital admitting privileges are a business

agreement, traditionally between an outside or a community provider who then does a lot of business with the hospital or has a lot of patients who need to be in the hospital.

It's my experience that very, very, very few of the patients that I treat need to be seen in a hospital, so it doesn't make sense for me to enter into that business agreement.

MS. SWANSON: Thank you, Dr. Farris. I'm going to pause just for a few moments to confirm I have no further questions.

A couple more.

Q. (Ms. Swanson) Approximately what percentage of patients in North Carolina use insurance to pay for their abortions?

A. I don't know exactly, but I believe it is less than 5 percent.

MS. SWANSON: I have no further questions for you, Dr. Farris.

THE WITNESS: I'm sorry, my phone's buzzing.

MR. BOYLE: Just one brief follow-up there.

FURTHER EXAMINATION

BY MR. BOYLE:

Q. Dr. Farris, you said that the chemical med -- chemical abortion drugs are contraindicated if you strongly suspect there is an ectopic pregnancy or if you confirm that there is ectopic pregnancy. But are you aware that the FDA regulation label itself actually says, "if you confirm or suspect there is an ectopic pregnancy"?

MS. SWANSON: Object ---

THE WITNESS: I wouldn't ---

MS. SWANSON: Object to form.

THE WITNESS: I'd need you to show me the label to be able to say what the label says.

Q. (Mr. Boyle) If it says what I'm suggesting, then you agree that's different than "strongly suspect," right?

MS. SWANSON: Object to form.

THE WITNESS: I think that there are varying degrees of suspicion. So you can have very low suspicion, where something is in your differential diagnosis, or you can have a very high suspicion, and there is a spectrum. I think clinicians should be using their judgment to determine where on that spectrum a patient's risk falls.

Q. (Mr. Boyle) And I'm just asking though, specifically, it's different -- you would agree there's

a difference if the FDA labels says, "Suspect ectopic pregnancy," as opposed to what you just said, which was "strong suspicion," right? There's a difference?

MS. SWANSON: Object to form.

THE WITNESS: I agree that there is a difference between the phrase "suspect" and the phrase "strongly suspect."

MR. BOYLE: Okay. No further questions. Thank you.

THE COURT REPORTER: Follow-up?

MS. SWANSON: No more for me.

THE COURT REPORTER: Okay.

THE VIDEOGRAPHER: Off record, 2:51. That concludes the deposition.

(Brief recess: 2:51 p.m. to 2:52 p.m.)

THE VIDEOGRAPHER: On record, 2:52.

THE COURT REPORTER: Is there any other counsel appearing via Zoom that would like to question the witness?

MR. WILLIAMS: No, thank you.

MR. WOOD: This is Michael Wood. No questions by me.

THE COURT REPORTER: Thank you.

MS. NARASIMHAN: No questions for Sripriya Narasimhan.

THE COURT REPORTER: Okay. All right. Thank you, Counselors. This concludes our deposition.

THE VIDEOGRAPHER: This concludes the deposition. The time is 2:52.

WHEREUPON, at 2:52 o'clock p.m., the deposition was adjourned.

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

CHAPLIN & ASSOCIATES

Notary No. 202029500095

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)

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.

1:16 P.M.

WEDNESDAY, AUGUST 30, 2023

WARD AND SMITH
751 CORPORATE CENTER DRIVE, SUITE 300
RALEIGH, NORTH CAROLINA

A P P E A R A N C E S

Counsel for the Plaintiff Beverly Gray:

American Civil Liberties Union Foundation
BY: Ryan Mendias
Brigitte Amiri
125 Broad Street, 18th Floor
New York, New York 10004
(212) 549-2633
rmendias@aclu.org
bamiri@aclu.org

Counsel for all Plaintiffs:

American Civil Liberties Union of North Carolina Legal Foundation
BY: Kristi Graunke
P.O. Box 28004
Raleigh, North Carolina 27611
(919) 354-5066
kgraunke@acluofnc.org

Counsel for the Defendant Joshua Stein:

North Carolina Department of Justice
BY: South A. Moore
(Appeared remotely)
114 West Edenton Street
Raleigh, North Carolina 27603
(919) 716-0914
smoore@ncdoj.gov

Counsel for the Defendants Senator Berger and Speaker Moore:

Ward and Smith
BY: W. Ellis Boyle
751 Corporate Center Drive, Suite 300
Raleigh, North Carolina 27607
(919) 277-9187
weboyle@wardandsmith.co

Counsel for the North Carolina Medical Board and North Carolina Board of Nursing:

North Carolina Department of Justice
BY: Michael Bulleri
(Appeared remotely)
114 West Edenton Street
Raleigh, North Carolina 27603
(919) 716-6600
mbulleri@ncdoj.gov

Counsel for the Defendant District Attorney Jim O'Neill:

Bell Davis Pitt
BY: Kevin G. Williams
(Appeared remotely)
100 North Cherry Street, Suite 600
Winston-Salem, North Carolina 27101
(336) 722-3700
kwilliams@belldavispitt.com

Counsel for the District Attorney Defendants (with the exception of Jim O'Neill):

North Carolina Department of Justice
BY: Elizabeth Curran O'Brien
(Appeared remotely)
114 West Edenton Street
Raleigh, North Carolina 27602-0629
(919) 716-0091
eobrien@ncdoj.gov

Counsel for Secretary Kinsley of the Department of Health and Human Services:

North Carolina Department of Justice
BY: Michael T. Wood
114 West Edenton Street
Raleigh, North Carolina 27602-0629
(919) 716-0186
mwood@ncdoj.gov

Counsel for the Legislative Intervenors:
Alliance Defending Freedom
BY: Julia Payne
(Appeared remotely)
Erin Hawley
(Appeared remotely)
15100 North 90th Street
Scottsdale, Arizona 85260
(800) 835-5233
jpayne@adflegal.org
ehawley@adflegal.org

Also Present: Anjali Salvador, Esq.
Kara Grandin, Esq.
Peter Im, Esq.
Vanisha Kudumuri
Shealyn Massey
Sam Delaria, Videographer

Stenographically
Reported By: Discovery Court Reporters and
Legal Videographers
BY: Lisa A. Wheeler, RPR, CRR
4208 Six Forks Road, Suite 1000
Raleigh, North Carolina 27609
(919) 649-9998
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I N D E X

E X H I B I T S

P R O C E E D I N G S

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THE VIDEOGRAPHER: We're now on the record. The time is 1:16, August 30th, 2023. This is the video deposition of Dr. Monique Wubbenhorst. Case name is Planned Parenthood South Atlantic, et al., v. Joshua Stein, et al.

Counsel, if you would please introduce yourselves.

MR. MENDIAS: This is Ryan Mendias with ACLU on behalf of Dr. Beverly Gray, one of the plaintiffs in this case.

MS. AMIRI: Brigitte Amiri also with ACLU representing Dr. Gray.

MS. GRAUNKE: Kristi Graunke, ACLU North Carolina, representing all plaintiffs.

MR. BENJAMIN WOOD: Benjamin Wood, law student intern at the ACLU of North Carolina.

MR. BOYLE: Ellis Boyle, Wake County Bar, representing the legislative leader defendants, Senator Berger and Speaker Moore. Kevin, you're up.

MR. MOORE: South --

MR. WILLIAMS: This is Kevin Williams

and -- on the Zoom and I am representing defendant District Attorney Jim O'Neill.

MS. PAYNE: Julia Payne --

MS. O'BRIEN: Good after- --

MS. PAYNE: -- with Alliance --

MS. O'BRIEN: Good afternoon. I'm -- if I could just go after Kevin. Good afternoon. I am Elizabeth O'Brien. I'm representing the remaining district attorneys in the lawsuit.

MS. PAYNE: Julia Payne with Alliance Defending Freedom representing the legislators.

MR. MICHAEL WOOD: This is Michael Wood. I am counsel to Secretary Kinsley from DHHS.

MR. BULLERI: This is Michael Bulleri. I am counsel for the North Carolina Medical Board and the North Carolina Board of Nursing.

MS. SALVADOR: This is Anjali Salva- --

MR. MOORE: This is South --

MS. SALVADOR: Oh, go ahead.

MR. MOORE: Sorry. This is South Moore, North Carolina Department of Justice,

representing Attorney General Stein.

MS. SALVADOR: This is Anjali Salvador with Planned Parenthood Federation of America representing Planned Parenthood South Atlantic. Also on the Zoom from Planned Parenthood Federation of America are Kara Grandin, Peter Im, and then the 11W-13 is a conference room with our paralegals, Vanisha Kudumuri and Shealyn Massey.

THE REPORTER: Is that everyone?

* * *

MONIQUE WUBBENHORST, M.D., M.P.H.,

having been first sworn or affirmed by the court reporter and Notary Public to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. MENDIAS:

Q. Good afternoon, Doctor.

A. Good afternoon.

Q. My name is Ryan Mendias and, like I said, I'm an attorney with the ACLU. I represent Dr. Beverly Gray, one of the plaintiffs in this case. So just some initial housekeeping questions.

You understand that you're under oath and that you have a legal obligation to answer everything truthfully and completely?

A. Yes.

Q. I'll ask that you wait until I finish my question before you start answering and that way we can avoid talking over one another.

A. Yes.

Q. And if you don't understand a question, please let me know. I can rephrase or repeat it and I'll do so.

If you do answer a question without asking for clarification, I will assume that you've understood it, okay?

A. Yes.

Q. And so please answer all questions verbally as you've been doing instead of shaking your head or saying uh-uh or uh-huh.

And so during this deposition your attorney may object, but his objections are just for the record. So after he makes them, you should proceed to answer the question.

A. Yes.

Q. And if at any point you realize that an answer that you previously gave wasn't

complete or wasn't fully correct, you should feel free to stop me and we can go back and discuss the answer again.

Does that sound all right?

A. Thank you. Yes.

Q. Okay. And if you don't do so, we can assume that you stand by the accuracy and completeness of your questions?

A. Yes.

Q. Great. And if you need a break, please let me know. We can definitely do that but -- as long as there's not a question pending. If there is a question pending, you'll need to answer the question and then we can proceed to the break.

A. Yes.

Q. Okay. Is there anything today that would prevent you from giving a full and accurate testimony, medications, illness, anything like that?

A. No.

Q. Okay. Is this the first time you've given a deposition?

A. No.

Q. When have you given depositions before?

A. I gave a deposition in 2017 for a Texas case.
Q. Is that the only deposition that you've given?
A. Yes.
Q. Okay.
A. No. I've given one deposition when I was a resident that -- no, I wasn't a resident. It was -- I graduated from residency. It was around 1995 or 1996.
Q. What was the subject of that deposition?
A. It was an infant that had delivered in the hospital when -- while I was a resident.
Q. Was it a malpractice case? What -- what sort of case was it?
A. Yeah, I think it was a malpractice case. I wasn't very educated about legal questions at that time.
Q. Were you a defendant in that case?
A. The hospital that I did my residency at, which was Yale New Haven Hospital, was the def- -- defendant.
Q. Have you ever participated -- oh, I'm sorry. Did you have more to add to that?
A. I -- I'm not a lawyer so I'm just making sure I say the right thing.

Q. Sure. Sure. Have you ever participated in a lawsuit as a defendant?
A. No.
Q. Have you ever participated in a lawsuit as a plaintiff?
A. No.
Q. Have you participated in a lawsuit in any other capacity?
A. No.
Q. Well, I assume you've participated as an expert witness in --
A. Oh, as an expert witness --
Q. Yes.
A. -- but not where it was me --
Q. Not as --
A. -- personally.
Q. -- a party?
A. Right.
Q. Okay. And when have you participated as an expert witness in previous lawsuits?
A. You mean -- not speaking to giving a deposition, just being involved? Okay.
Q. Correct.
A. So let's see. Kentucky -- for the state of Kentucky, for the state of Minne- --

Minnesota. The cases were in the state of Kentucky, state of Minnesota, state of Kansas. And I feel like I'm forgetting one. Kentucky, Minnesota, Kansas. Oh, and Texas, as I said, uh-huh.

Q. And in your role as an expert, have you testified in court?

A. Yes.

Q. In which of those cases did you testify in court?

A. Texas.

Q. Any others?

A. No.

Q. And have you testified before any legislative body?

A. Yes.

Q. Could you say more about that testimony that you gave.

A. Yes. The Senate Judiciary Committee in -- 2007, 2008, or 2009 was their -- I'm sorry. I --

Q. That's all right.

A. -- don't know. And then the House of Representatives last fall and the Senate in April.

Q. And what was the nature of the testimony that you gave before those legislative bodies?
A. I was testifying on the -- abortion safety and maternal mortality.
Q. And is it fair to say that the expert opinions that you offered in those cases that we just discussed were in support of laws restricting or regulating abortion?
A. I don't -- no, I don't think so because I think that in the Senate case, as I understood it, it was a -- regarding legislation that was being proposed that would remove abortion restrictions, as I understood it.
Q. Right. So I think my question is more specifically about the cases in which you've been an expert witness so Kentucky, Texas --
A. Oh. Oh. Oh. Yes.
Q. -- Minnesota.
A. Right.
Q. And in those cases, you were offering an opinion in support of abortion restrictions; is that correct?
A. Yes.
Q. And the piece of legislation in the Senate

that you mentioned, is that the Women's Health Protection Act?

A. That's correct.

Q. And were you in favor or opposition of that --

A. I was --

Q. -- act?

A. -- in opposition. I'm sorry. Didn't mean to --

Q. Oh, no, no.

A. -- speak too early.

Q. Totally fine. Thank you. So you're aware that the Speaker of the North Carolina House of Representatives and the President of the North Carolina Senate have intervened in this litigation to defend the constitutionality of several laws relating to abortion; is that --

A. Yes.

Q. Okay. So if I say the intervenors, can we agree that I'm referring to those individuals, the Speaker and the Senate President?

MR. BOYLE: Object to form.

A. I'm sorry. I don't understand what you mean.

Q. So I might refer to the intervenors, who your

attorney here is counsel for --
A. Uh-huh.
Q. -- as the intervenors. When I say the intervenors, I mean the President of the North Carolina Senate --
A. Uh-huh.
Q. -- and the Speaker of the House of North Carolina's House of Representatives.
A. Yes.
MR. BOYLE: Object to form. You can answer.
BY MR. MENDIAS:
Q. So when were you first contacted by counsel for intervenors about participating in this case?
A. I would have to look at my scheduler.
Q. Was it months ago, weeks ago?
A. Let's see. This is now August. It was no more than two months ago, but, again, I -- I can't -- you can't hold me to that because I would have to look at my scheduler. I -- I don't want to not respond truthfully.
Q. I understand. Thank you. Who have you been communicating with regarding this -- your participation in this case?

A. Julia Payne, who's counsel for ADF, and Attorney Ellis.
Q. And are you being paid for your participation in this case?
A. Yes.
Q. How much are you being paid?
A. $700 an hour.
Q. And roughly how many hours have you spent preparing for this case so far?
A. More than 30.
Q. And did you bring anything with you to this deposition?
A. Yes.
Q. What did you bring?
A. I brought my declaration, which is here. Would you like to see it?
Q. No. It's all right.
A. Okay. And then I brought ACOG Practice Bulletin 193, a study by Alisa Goldberg, a study by Ushma Upadhyay, and a study by Karen Borchert.
Q. Okay. And I have my own copy, but I think the answer will be yes.

MR. MENDIAS: But I will just ask that this be marked as Exhibit B.

(WUBBENHORST EXHIBIT B, Declaration of Monique Chireau Wubbenhorst, M.D., M.P.H., was marked for identification.)

BY MR. MENDIAS:

Q. But can you confirm that this is an accurate copy of the declaration that you submitted in this case.

A. It looks as though it is, yes.

MR. MENDIAS: Oh, and then I have a copy for you, Ellis, as well.

MR. BOYLE: Thanks.

BY MR. MENDIAS:

Q. Can you please describe the process of drafting this declaration.

A. The process. In other words, how I arrived at my opinion? Is that what you mean?

Q. I mean more specifically how you went about writing the -- this particular document.

A. So I had at hand the declarations from Dr. Alsle- -- Dr. Boraas, actually, I'm sorry, and Dr. Farris. I reviewed those, I reviewed the studies that they cited, and then I did a literature search on the topics that they discussed, used the snowball technique to add additional studies and used

the -- distilled those into my declaration and my opinion.

Q. And what keywords did you use in doing that search?

A. I looked at abortion complications. I looked at terms abortion plus complications, abortion-related mortality, ectopic pregnancy, pregnancy of unknown location. And there -- I'm sure there were others, but those -- those were the major -- some of the main ones.

Q. Did anyone provide any particular studies they wanted you to cite in this expert declaration?

A. No.

Q. Did anyone ask that you include a particular fact or opinion in this declaration?

A. No.

Q. And I'd like to talk about your CV, which I will ask to be marked, please.

(WUBBENHORST EXHIBIT C, Curriculum Vitae, was marked for identification.)

MR. MENDIAS: Thank you.

BY MR. MENDIAS:

Q. Is this an -- look like a -- oh, sorry.

MR. BOYLE: Thank you.

BY MR. MENDIAS:

Q. Does this look like an accurate copy of the CV that was attached to your expert declaration?

A. Yes.

Q. Okay. And I note that the date is May 25th, 2023.

A. Uh-huh.

Q. Is this the most recent version of your CV?

A. No, there's a more recent version.

Q. What would have changed between that version that you submitted and -- and the most recent version?

A. I think I discovered an error in my previous CV. There was a hospital that I worked at in North Carolina that I hadn't listed on my CV. It's -- I believe it was Moses Cone Hospital. I'm actually in the process of updating it now.

Q. And when did you work at Moses Cone Hospital?

A. 2004, 2005. I was there once as a locum tenens.

Q. And I note on your CV as well that you're a fellow of the American College of

Obstetricians and Gynecologists, which I'll refer to as ACOG; is that accurate?

A. Yes.

Q. And what is ACOG?

A. It is a professional organization that many -- I think most OB/GYNs but not all belong to in the United States.

Q. And you've presented papers at ACOG conferences; is that correct?

A. That's correct.

Q. Do you believe that ACOG is a reliable source of information for OB/GYNs?

A. Not always.

Q. On which topics is it not reliable?

A. I think that in terms of their abortion advocacy, they do not always reflect the -- the, I would say, preferences and practices of their constituency.

Q. Are there any other topics besides abortion that you find ACOG to be unreliable on?

A. I haven't reviewed all of their literature so I couldn't answer that.

Q. But of the literature that you've reviewed, you find it all reliable except for abortion; is that correct?

A. I think that there are some areas that I couldn't bring to mind at this exact moment where I would say that they have not cited all of the available literature.
Q. Is there -- can you give any inkling as to what those areas might be?
A. I would have to go back because I haven't looked at those areas recently.
Q. I understand. To be a member of ACOG, does a -- an OB/GYN need to express any particular view of abortion?
A. No.
Q. So ACOG then has members who are opposed to abortion?
A. Actually, the vast majority do not perform abortions.
Q. My question was whether they have members who are opposed to abortion.
A. Yes, they do.
Q. Great. You also indicate on your CV that you're a member of the American Association of Pro-Life Obstetricians and Gynecologists, which --
A. Yes.
Q. -- I'll refer to as AAPLOG; is that correct?

A. Yes.
Q. And you actually served on their board. Is that right, too?
A. Yes.
Q. How long was your time as a board member?
A. I want to say about three years.
Q. And was it continuous or did you have various stints as a board member?
A. No. It was continuous.
Q. And what did your duties as a board member of AAPLOG include?
A. They were most -- similar to any board. We oversaw the activities of the organization, coordinated with the CEO, reviewed scientific papers that AAPLOG put out, among others. AAPLOG is A-A-P-L-O-G. Yeah.
Q. Thank you for that. Could a physician become a member of AAPLOG if they did not oppose abortion?
A. I don't know.
Q. What if I -- I'm going to introduce another exhibit. This, I believe, is Exhibit -- so...

MR. MENDIAS: Thank you.

(WUBBENHORST EXHIBIT D, AAPLOG Mission

& Vision Statement, was marked for identification.)

BY MR. MENDIAS:

Q. Does this look like the mission and vision statement of AAPLOG?

A. It does.

Q. Okay.

A. But I can't confirm that because I haven't looked at it in a while.

Q. Okay. Do you remember what the mission and vision of AAPLOG was when you were on the board?

A. I think similar to what's here. And, again, not being able to quote it because it's been some time, it was to defend the lives of the pregnant mother and her unborn child.

Q. And that necessarily means prohibiting abortion in most circumstances, correct?

A. Yes.

Q. Okay. And I actually have another exhibit.

(WUBBENHORST EXHIBIT E, AAPLOG Practicing Physician of any Specialty Form, was marked for identification.)

BY MR. MENDIAS:

Q. And, Dr. Wubbenhorst, do you recognize this

document, if not necessarily its particular form, what it is with respect to AAPLOG?

A. Yeah. I haven't -- I -- it's been a while since I've seen this so I don't know if this is the current one or not.

Q. But when you say one, what -- one of what? What do you mean?

A. Well, this looks like the form that you would use to join --

Q. Okay.

A. -- but it's been -- I've been a member for some time so I can't speak to this.

Q. But you would have filled something similar out when you became a member, correct?

A. Yes.

Q. And physicians joining the organization while you were on the board would have filled out a similar form --

A. Uh-huh.

Q. -- correct?

A. Yes. Sorry.

Q. And could you read the first sentence under the heading, Practicing Physician of any Specialty?

A. Practicing Physician of any Specialty --

Physicians of any Specialty are those Physicians (either M.D. or D.O.) who agree with our mission statement and su- -- support AAPLOG with annual dues and donations.

Q. And as we just discussed, AAPLOG's mission statement includes prohibiting abortion; is that right?

A. I don't think it's prohibiting abortion. I think it's restricting abortion or advocating for the life of the mother and the unborn child.

Q. Okay. So restricting.

You were also on the board of Americans United for Life, which I'll refer to as AUL; is that correct?

A. That's correct.

Q. You're currently on the board?

A. Yes.

Q. And what are your duties on that board?

A. So it is to oversee the -- the board oversees the activities of the organizations -- of the organization and also works with the CEO in accomplishing its mission.

Q. And what is the mission of AUL?

A. It is to serve as the architects of the

pro-life movement or --

Q. And -- I'm sorry. Did you have more to say that --

A. No.

Q. Apologies if I cut you off at all. When you say, architects of the pro-life movement, what does that specifically mean?

A. Well, I think I'm not articulating very clearly, you know, what the mission is. That's kind of what I would call the general way that they -- general -- how they're seen and how they see themselves. I would have to review the curr- -- the mission statement to give you a precise answer. I don't want to give you an imprecise answer.

Q. So speaking generally, what is it that the organization hopes to accomplish in this country?

A. It supports legislation supporting the life of the wo- -- woman and her unborn child.

Q. And is it true that AUL advocates for what they call abortion abolition?

A. I don't know.

Q. Does AUL believe that abortion should be a matter of state law as opposed to something

regulated at the federal level?
A. I think that they consider both pathways -- I'm sorry. I saw your cup that said, Pathways, and that's what came into my mind. I think they consider both strategies.
Q. And whether it's a pathway or a strategy, what is the ultimate goal of AUL?
A. I think it's to promote life.
Q. Not to ban abortion nationwide?
A. I would say that if you were to ask members of the board and people working in the organization that, similar to AAPLOG, it is to advocate for the life of the unborn child and for the mother.
Q. Okay. I'm -- I'm going to play a video briefly and I'll ask the court reporter how best to --

MR. MENDIAS: Do you mind if we go off the record to discuss how we do this? We can...

THE VIDEOGRAPHER: Going off the record. The time is 1:37.

(Discussion off the record.)

THE VIDEOGRAPHER: Back on the record. The time is 1:37.

MR. MENDIAS: All right. And I will mark this as the next exhibit.

(WUBBENHORST EXHIBIT F, AUL Video Clip, was marked for identification.)

(Video played and stopped.)

BY MR. MENDIAS:

Q. Dr. Wubbenhorst, do you believe that that fairly represents the mission of AUL?

MR. BOYLE: Objection. Are you saying that's an AUL document?

MR. MENDIAS: It -- I am, yes.

MR. BOYLE: Can you establish that first, please. Sorry. Not to --

BY MR. MENDIAS:

Q. Does this -- or do you recognize this video at all?

A. Yeah. I have seen it, yes.

Q. And it is from AUL?

A. Uh-huh.

Q. Correct?

A. I'm sorry. Yes.

Q. Thanks. So do you believe that this accurately encapsulates the mission of AUL?

A. Yes.

Q. Do you agree with this mission?

A. Yes.
Q. And so I take that to mean that you personally oppose abortion in all circumstances?
A. Yes.
Q. In fact, you believe that abortion is a moral and social evil, correct?
A. Yes.
Q. Is it fair to say that you believe abortion is murder?
A. I think it's a nuanced question. I think that if you are saying -- and, again, I'm not a lawyer, but are you referring to the mother who has the abortion or are you referring to the abortionist who performs the abortion?
Q. Let's deal with them one by one. Do you think a woman who seeks and obtains an abortion has committed murder?
A. No.
Q. Do you think a physician who performs an abortion has committed murder?
A. Yes.
Q. Do you believe that what you might call elective abortions should be illegal in all circumstances?

A. Yes.
Q. Does that include cases where the pregnancy is the result of rape or incest?
A. Yes.
Q. And that would include cases no matter the age of the rape victim?
A. I'm sorry.
Q. Would you oppose abortion in a case where pregnancy is the result of rape or incest when the rape victim is a child?
A. Yes, because I have taken care of minors who were the victims of incest who chose to carry their children to term and said that this -- they -- in particular, they've told me two things. They said that, without this baby, I would not have evidence that he did it, and, I also feel that this child is redeeming this circumstance -- this terrible circumstance that has happened to me.
Q. Do you believe that all child victims of rape feel the same way about carrying their rapist's baby to term?
A. I can't speak for how all child victims feel.
Q. Do you think it's possible that some would not feel that way?

A. I think it's possible.
Q. And do you think that delivering a child is the only way to establish the paternity of a rapist?
A. I'm not understanding your question. Without DNA, how would you establish paternity?
Q. Do you believe that DNA can only be obtained from a child that has been delivered?
A. I think that there are techniques now for confirming paternity, but at the time that I was speaking of with these children, that technology was not available.
Q. Do you think that when an abortion is performed, a -- that there is a way to determine forensically who the rapist was based on the products of conception?
A. That's not what I'm -- what I was saying. I was telling you what a patient had actually told me.
Q. Okay. But you would agree that after an abortion, the products of conception can be used to identify the rapist?
A. Yes.
Q. And do you believe that all abortions, even those that have no medical complications,

cause harm to women?

A. Yes. That's based on my clinical experience of caring for thousands of woman. I've never met a woman who was happy that she had an abortion. Relieved? Yes. Feeling as though she couldn't do anything else? Yes. But all women to one degree or another were damaged by that experience, some very damaged, some not so much.

Q. When you say women were relieved, what about their relief made you think that they were damaged?

A. Because they all expressed sorrow at having undergone the abortion and many of my patients report that every year when that child would have been born, they have a ceremony to mourn their death.

Q. What percentage of patients would you say have disclosed to you that they had an abortion?

MR. BOYLE: Object to form.

BY MR. MENDIAS:

Q. You can answer.

A. I'm not understanding the question. You mean if I asked -- you -- you're talking about

patients that I ask?
Q. How did you come to know that those patients had had abortions?
A. I routinely ask them.
Q. And in answering that question, do you then ask how they felt about their abortion experience?
A. I do.
Q. All of them?
A. Yes.
Q. Are you currently practicing medicine?
A. Yes.
Q. Where?
A. Indiana.
Q. Where specifically in Indiana are you practicing medicine?
A. Saint Joseph's Regional Medical Center.
Q. And what do you do there?
A. I'm a hospitalist there.
Q. And what does that mean?
A. I cover the labor floor in shifts and any women that come in through the emergency room or come into triage or who are laboring, I provide backup for the other clinicians or we have our own practice where we care for those

patients in labor as well. And I also practice internationally.

Q. You don't perform abortions, do you?

A. No.

Q. And you've never performed an abortion?

A. No.

Q. Have you ever observed a physician performing an abortion?

A. Yes.

Q. How many?

A. One.

Q. In residency were you offered the opportunity to learn how to perform an abortion?

A. Yes.

Q. And you declined that opportunity?

A. Yes.

Q. What -- have you ever induced labor in a pregnant patient before the fetus was viable?

A. Yes.

Q. In what circumstance would you have to do that?

A. Would I or have I?

Q. Have you?

A. Where a woman had infection and needed to be delivered because she had clear signs of

chorioamnionitis.
Q. And do you remember how far along in her pregnancy this patient was?
A. She was between 21 and 23 weeks.
Q. You don't consider induction in that circumstance to be an abortion?
A. No, because of the principle of double effect.
Q. Could you say more about what that is.
A. It means that when your intention is to save the life of the mother, the outcome of fetal death may be an unavoidable and tragic consequence, but that is not the intent, whereas, in abortion, the intent is clearly the death of the unborn child.
Q. Where -- do you think that some physicians would call induction in that circumstance an abortion?
A. I can't say.
Q. How do you --
A. I think they would. I think there are some people that would say that.
Q. Have you ever performed a dilation and curettage procedure on a patient?
A. Yes.

Q. In what circumstances have you performed a -- a dilation and curettage?
A. Can you be more specific? Are you referring to a living fetus or a dead fetus?
Q. I'm talking about any time that you've performed that particular procedure.
A. Yes.
Q. So in what circumstances have you performed a D&C, either for a living or dead fetus?
A. Hemorrhage, a woman who was infected with a demised fetus in the second trimester. And I -- if you can clarify, you're referring strictly to D&C in pregnancy, not D&C in a nonpregnant woman?
Q. Correct.
A. Okay.
Q. Thank you for that clarification. So have you ever performed a D&C when there is embryonic or fetal cardiac activity?
A. No.
Q. Do you believe that physicians who perform abortions are degraded by the pos- -- procedure?
A. I do. And I have a great deal of sympathy for them. I feel that many people -- it's --

it's very interesting. When you look at statistics, people graduate from residency and a high percentage stopped -- planning to do abortions and a high percentage stopped doing abortions within five years. And I think others really feel very -- speaking to physicians who were abortionists who then decided to leave -- stop becoming abortionists, they've described to me how they felt terrible going to work every day, they felt morally conflicted, so I have a great deal of sympathy for them.

Q. About how many physicians who previously provided abortions but no longer do have you spoken to?

A. Five.

Q. Five. When you provide medical care in the hospital, you've -- do you encounter patients who were referred to your care from the emergency room?

A. Are you -- you're talking about obstetrical patients?

Q. Correct.

A. Yes.

Q. And throughout your career, how many do you

think you have encountered who are transferred from the ER to your service?

A. So you're referring to my current practice in the first -- let me -- when you asked me the question the first time, you said right now. Are -- were you referring to my current practice?

Q. I'm not sure if I said right now and if I did, I misspoke. I meant throughout the entirety of your medical career.

A. Have I -- just to make sure I understand, so have I cared for patients who were referred through the emergency room?

Q. Correct.

A. Yes.

Q. And my question is, about how many over your --

A. Thousands.

Q. Thousands. Is it more than 10,000?

A. No, less than 10,000. Somewhere between probably 5- and 10,000.

Q. And about how many of those patients were in North Carolina?

A. I would have to think because I practiced in nine hospitals in North Carolina but a total

of close to 30 hospitals elsewhere. So it -- I -- I would have to think about that.

Q. If I give you a few seconds or a minute, do you think you could come up with a ballpark?

A. It would be quite a few. It would be quite a few, yeah.

Q. Would you say closer to a hundred or a thousand?

A. It would be more than a hundred, probably considerably more than a hundred --

Q. So --

A. -- because I was a solo practitioner at many of these hospitals when the covering OB/GYN went out of town.

Q. And so would it be closer to 500 or a thousand?

A. It's somewhere in that range, yeah.

Q. Okay. And so out of all the patients -- now I'm talking in any hospital in any state that you've described as --

A. Or country.

Q. -- in -- or country. I -- I would like to limit in -- to the United States so any state.

A. The pathologies are the same, though.

Q. Sure. I'm specifically wondering about patients transferred from emergency rooms to your obstetrical service.
A. Right.
Q. Does that -- does that alter the number of patients --
A. No, because I've practiced --
Q. -- you --
A. -- more here than --
MR. BOYLE: Object to form. You can answer.
BY MR. MENDIAS:
Q. Sure. So I believe you said it was thousands of patients throughout your career.
A. Yeah. I've been in practice more than 30 years.
Q. Okay. And of -- out of those thousands of patients, how many have you encountered who were experiencing complications from an induced abortion?
A. None from an induced abortion. From procedural abortion, yes.
Q. Okay. From an abortion of any kind?
A. Yes.
Q. How many?

A. Two.
Q. Two.
A. No. More than two. Yeah, more than two. Let me just think for a minute.
Q. Sure.
A. I'd say ten or less.
Q. Ten. Dr. Wubbenhorst, do you recall earlier you said that you were -- you participated in a deposition in Texas?
A. Yes.
Q. Is that correct? Okay.

MR. MENDIAS: So I'm going to mark the transcript of that deposition as an exhibit.

(WUBBENHORST EXHIBIT G, Deposition Transcript of Monique Chireau, M.D., October 14, 2017, was marked for identification.)

BY MR. MENDIAS:
Q. So, Dr. Wubbenhorst, you'll see that the numbers are on the top right of each page and that there are four pages per printed page. So direct you to Page 138. So it would be in the top right. Are you there?
A. Yes.
Q. Okay. So beginning with Line Number 9, there's a question. Have you ever managed a

patient who is experiencing a complication from an induced abortion?
A. Yes.
Q. Your answer was, Yes?
A. Uh-huh.
Q. And then the question was, How many times?
A. Right.
Q. And then you answered, Probably four times.
A. Yes.
Q. So are you suggesting now that it was actually ten times or have --
A. No. I've seen --
Q. -- there been --
A. -- more patients --
MR. BOYLE: Objection.
A. -- with --
MR. BOYLE: You can answer.
A. Yeah. I'm not suggesting that this was incorrect. I'm saying that I've seen more patients since then.
Q. Okay. Where have you seen those patients?
A. Internationally.
Q. Internationally. In the United States, have you seen any patients --
A. No.

Q. -- suffering from -- okay. And have you seen any patients experiencing complications from an abortion of any type in North Carolina?
A. No.
Q. So just because I know that your CV might be a little out of date, I wanted to ask, are you currently a senior research associate at the Center for Ethics and Culture at the University of Notre Dame?
A. Yes. Well, my job title has changed. I think I'm a senior fellow.
Q. Okay. What does that position entail?
A. I use -- I'm still do- -- I'm doing research and so I have an office at Notre Dame and I have access to -- I work with people in the center on different projects and I use Notre Dame's considerable resources to carry out my research.
Q. What sort of research do you do?
A. Women's health epidemiology, demography, maternal mortality.
Q. Do you -- would you say that abortion is a focus of your research?
A. No. It's one focus.
Q. So I -- I asked if you would say abortion is

a focus of your research and I just want to be clear. What is your answer?
A. I'm just clarifying that it's one focus.
Q. Okay. So you consider it to be a focus of your research?
A. Yes.
Q. Have you ever served as a peer reviewer for a publication?
A. Multiple publications, yes. I think that's in my CV as well. You've seen that.
Q. Yeah. What do you understand the purpose of peer review to be?
A. In peer review what we attempt to do is to evaluate papers for their research methods, their applicability to the general literature and so on, and decide whether they should be published.
Q. Have you ever published a peer-reviewed article or paper on the topic of abortion?
A. No.
Q. Are you familiar with the complication rate for abortion in North Carolina?
A. Yes.
Q. And what is it?
A. I would have to look at my deposition, but I

believe that the -- the overall complication rate is listed by CDC. I would have to look at the -- the exact data to be sure.

Q. So are you familiar with the abortion reporting requirements in North Carolina?

A. Yes.

Q. What are they?

A. They state that abortionists need to report the com- -- their complications and -- to the North Carolina Department of Public Health as I understand it.

Q. And are you familiar with the pregnancy-associated death rate in North Carolina?

A. Yes.

Q. And can you say what that is?

A. I would have to just confirm it. I don't want to give you a wrong number.

Q. When you say confirm it, do you mean in your declaration or --

A. I believe I brought that up in my declaration, but, again, the maternal mortality rate is -- it depends on -- when you say, pregnancy-associated death rate, I think those are two different numbers. The

pregnancy-associated death rate would include deaths in the first trimester, for example, from ectopic pregnancy. It would also include deaths from abortion and it would include maternal deaths toward the end of gestation as well and those are three very different numbers.

By far, the number that we have the best data for, in my opinion, is maternal mortality. We have -- our data on -- on deaths due to ectopic pregnancy and abortion is very limited.

Q. So during your testimony before the court in Kentucky last year -- do you remember testifying in --

A. Yes.

Q. -- Kentucky? -- you described treating preeclamptic women.

A. Yes.

Q. And you testified that if a woman was getting sicker, you would deliver her. Sometimes depending on the capacity of the place you were when you were delivering her, you might have to call helicopters or planes or ambulances to transport the woman and her

infant to a better-equipped hospital.

Does that sound correct?

A. Yes.

Q. And I think your specific testimony was that you had done so plenty of times. Does that sound right?

A. Yes.

Q. About how many times, if you had to estimate, have you had to transfer -- we can just pick one of those forms of transportation -- transfer a woman via ambulance to a place where she could get care that could not be provided where you had delivered her?

MR. BOYLE: Object to form. You can answer.

A. I would say for ambulance transfers, most of the places where -- most of the facilities where I worked where I had to transfer patients, time was of the essence so relatively few ambulance transfers and more helicopter or plane transfers.

Q. If you had to give a ballpark, could you?

A. For both?

Q. Yes, please.

A. I would say somewhere between 20 -- somewhere

around 20 --
Q. For ambulance?
A. -- patients.
Q. Oh, that includes both?
A. Yes.
Q. And could you be more specific within that 20 how many were in ambulances, how many were in helicopters?
A. Helicopters or planes, probably ten to a dozen and then maybe ten to -- probably not as many as -- I would have to think about it a little bit more.
Q. Okay. So --
A. Again, mostly, those were in places like South Dakota or remote parts of Arizona.
Q. And you'd say -- so eight to ten is maybe a fair ballpark for how many --
A. For?
Q. For ambulance transfers.
A. I would have to really think about it, yeah.
Q. All right. So in your declaration you cite five examples of patients transferred from Planned Parenthood South Atlantic, which I'll call PPSAT, that -- their Chapel Hill clinic to UNC Hospital between February 2022 and May

of 2023; is that --
A. Yes.
Q. Yes? Okay. Do you have firsthand knowledge of these patients?
A. The patients who were transferred?
Q. Yes.
A. No.
Q. How did you learn of these hospital -- or these ambulance transfers?
A. I don't remember exactly how I came across them. I think that when I was looking at the question of hospital transfers, transfers from facilities to hospitals, this information popped up and then I started to dig a little bit deeper into it and found the 9-1-1 transcripts.
Q. I notice in your declaration you cite for one of these ambulance transfers a website called operationrescue.org.
A. Yes.
Q. Did they all come from Operation Rescue?
A. No.
Q. And Operation Rescue is an antiabortion organization, correct?
A. Yes. I don't know very much about them.

Q. Okay. Are you aware that the man who murdered Dr. George Tiller, an abortion provider in Kansas, in 2009 asserted that he was affiliated with Operation Rescue?
A. I can't speak to that.
Q. Are you aware of any other ambulance transfers from any of PPSAT's clinics during the period of February 2022 to May 2023?
A. I'm not.
Q. Do you know how many abortions PPSAT provided between February 2022 to May 2023?
A. No.
Q. If you were to go about calculating the rate of hospital transfers per abortion patient, how would you do that?
A. Hospital transfers from PPSAT Chapel Hill?
Q. Correct.
A. I think that what I would look at is how many abortions were performed and how many ambulance transfers actually occurred.
Q. So in your declaration you also say that it's an axiom in medicine that physicians should not perform procedures if they are not able to manage their complications.

Do you agree with that statement?

A. That's correct for most procedures.
Q. Which procedures does it not apply to?
A. I think that a good example is screening colonoscopy because with screening colonoscopy, if a patient undergoes a perforation, that's usually a -- a complication that would be managed surgically.
Q. So you don't believe that colonoscopies should always be performed in hospitals?
A. No, I don't.
Q. Why not?
A. Because I think that the available literature shows that the complication rate for colonoscopies is much lower than for, say, induced abortions, especially abortion in the second trimester, and most abortion -- second-trimester abortion procedures -- I'm sorry, second abortion tri- -- second-trimester abortion procedures can become very complicated very quickly.
Q. And you don't believe that a rupture of -- or a perforation of a patient's colon can become very serious very quickly?
A. I think that it can be, but I think that when

you look at complication rates and types of complications, it -- including especially where uterine perforation has occurred with damage to vascular structures, perforation has occurred with damage to bowel and bladder, which I've personally had to care for patients with those complications, the rationale for doing those procedures in -- as well as potential anesthesia complications, the rationale for doing those procedures in a hospital is re- -- is much clearer.

Q. As an obstetrician/gynecologist, if someone had a perforation of their colon during a colonoscopy, they would not ever be transferred to your service for care, correct?

A. No.

Q. Do you know the complication rate for perforations in the course of a colonoscopy?

A. I would have to look at my declaration because I believe that that was a question that I discussed in my declaration. Would you like me to do that?

Q. Sure.

A. Okay. Oh. Yeah. I did not put the

complication rates in here.

Q. Okay.

A. I think that what I had -- the point I was trying to make in my declaration about colonoscopy safety was that Dr. Farris cited a paper to try to compare colonoscopy complications to abortion complications, but the particular paper that she cited did not focus on colonoscopy complications. It was looking at risk stratification to arrive at an outcome measure so that outpatient facilities could be profiled in terms of what their rates of unplanned hospital visits were. It did not have as its purpose the estimation of overall incidence of complication. So that was why -- that was why I felt that that particular paper was not speaking to the question of being able to compare abortion complications with colonoscopy.

Q. Understood. But you didn't then look for the complication rate?

A. It was in the -- it was in the -- I'm sorry. What -- what's your question?

Q. The -- that after -- in the course of

drafting your declaration, you did not look up the --

A. Oh, no, I did.

Q. -- complication rate --

A. I did. I didn't put --

MR. BOYLE: Let -- let him finish the question.

A. Oh, I'm sorry. Sorry. Sorry. Sorry. Sorry.

Q. That's all right. So my question is, in the course of your declaration, did you look up the complication rate associated with perforations during a colonoscopy?

A. Yes, I did.

Q. But you did not include that in your declaration?

A. No. There was a lot of other ground to cover.

Q. Do you know what the mortality rate of an outpatient colonoscopy is?

A. No.

Q. Do you know what kind of sedation is typically used in an outpatient colonoscopy?

A. Mild to moderate.

Q. And do you know if tissue is ever biopsied

during a colonoscopy?
A. Yes.
Q. And how would the person performing the colonoscopy go about biopsying that tissue?
A. They use a hot snare.
Q. And what does that mean?
A. It's a either loop or -- or they -- they may use a punch. They either use a loop or a punch device to obtain a biopsy of what they consider might be malignant tissue or even nonmalignant if it's an adenoma -- I mean, a polyp.
Q. And what is the process like of removing that tissue or potential malignancy from the colon?
A. As I said, they use a snare or they use a biopsy forcep. They snip the biopsy and then they -- if there's bleeding, they may or may not cauterize it or they may use something else to achieve hemostasis.
Q. So other than abortion clinics, do you know whether North Carolina inspects outpatient health centers that perform procedures or surgeries?
A. I don't know for sure because I haven't

researched the information, but I do know that ambulatory surgical centers have an accreditation and inspection process.

Q. Are you aware of how frequently ambulatory surgical centers receive notices of deficiencies following those inspections?

A. No.

Q. Do you know what kind of sedation is provided in outpatient surgical facilities in North Carolina?

A. Ambulatory surgical centers?

Q. Yeah.

A. So at ambulatory surgical centers they have anesthesiologists and anesthetists so they provide the full gamut of anesthesia from general anesthesia to sedation.

Q. So what is general anesthesia?

A. So general endotracheal anesthesia is where a patient is paralyzed and intubated and the ventilator breathes for them.

Q. And I believe you said deeper sedation.

A. Deep sedation.

Q. Deep sedation. What do you understand that term to mean as you've used it in your declaration?

A. It typically means that a patient will receive a combination of barbiturate and -- b-a-r-b-i- -- okay. -- barbiturate and narcotic and will put them into a state of profound relaxation. They won't feel pain and their breathing will slow. In general, deep sedation is a procedure that should be performed with an anesthetist or an anesthesiology -- anesthesiologist present because those patients can rapidly decompensate and require intubation.

Q. And what do you understand moderate sedation to be as you used that term in your declaration?

A. The line -- the line between mild and moderate simply means that the patient is still able to breathe on their own and they can often respond to you when you speak to them, whereas, with deep sedation, they usually can't. They have -- can maintain -- they can manage their secretions and breathe on their own.

Q. And what medications are used to achieve this level of sedation?

A. There's a wide variety.

Q. And I meant to ask earlier. What medications are used to achieve general anesthesia?
A. There is a wide variety. I'm not an anesthe- -- anesthesiologist.
Q. Okay. Do you know what kind of sedation is provided to abortion patients at PPSAT's clinics?
A. My understanding is that they provide mild, moderate, and deep sedation according to their own information.
Q. What information specifically are you referring to?
A. Their protocols.
Q. When you say, protocols, can you be more specific? How did you come to read these protocols?
A. My understanding is that -- I believe that she said in -- somewhere in -- one of -- Dr. Farris said in one of her declarations that that's what they provide.
Q. So you have not seen anything produced by PPSAT itself on this topic?
A. Yes, I have.
Q. Distinct from Dr. Farris's declaration?
A. Yes.

Q. How did you obtain those documents?
A. I was given to them -- I saw them through the discovery process.
Q. In this case?
A. Yes. But I have seen them also in other cases as well, in particular the Texas case, and there was one other case where I'd seen them as well.
Q. And you believe that the protocols in Texas are comparable to the protocols in North Carolina?
A. In general, my experience with Planned Parenthood is that they seek to standardize their procedures as much as possible across different affiliates. So if I'm recalling correctly, I had seen these in Texas and I may have seen them in another case as well. I just can't remember which one.
Q. Okay. Thank you. And do you know what kind of medications PPSAT uses to achieve the levels of sedation that they provide to their abortion --
A. No.
Q. -- patients? Sorry. As -- I'm not sure that the court reporter got your answer.

A. No.
Q. Thank you.
A. Yeah.
Q. So in Paragraph 180 of your declaration you say that during the first six weeks of pregnancy is when maternal morbidity and mortality are highest.

Can you explain what you meant by that.

A. I think that what that is -- the -- I'm referring to -- not referring to the entirety of pregnancy; I'm referring to the first trimester.
Q. Sorry. Can you just read that sentence that begins, Deaths during.
A. It says, Deaths during the first six weeks of pregnancy when maternal mortal- -- morbidity and mortality are highest are kept classified as maternal deaths and placed together with deaths due to births and delivery.
Q. So you're not asserting that the first six weeks of pregnancy are the most dangerous part of the entire period of pregnancy, are you?
A. No. What I'm saying is that the first six weeks of the first trimester are the most

dangerous because that is typically when ectopic pregnancies occur.

Q. And in Paragraph 238 of your declaration, which I believe is on Page 41 in the upper right-hand corner --

A. Yes.

Q. -- you say that, Carrying a pregnancy to term is safer than an abortion.

Do you believe that that's true?

A. Yes.

Q. Do you -- as you mentioned earlier, you submitted a declaration in a Minnesota case in September of last year; is that right?

A. Yes.

Q. Okay.

MR. MENDIAS: And I'd like to mark that as the next exhibit.

(WUBBENHORST EXHIBIT H, Declaration and Expert Report of Monique Chireau Wubbenhorst, M.D., M.P.H., Minnesota Case, was marked for identification.)

MR. BOYLE: Thank you.

MR. MENDIAS: Thanks.

BY MR. MENDIAS:

Q. So on Page 10, Paragraph Number 47, can you

read that paragraph.

A. Yes. It is my opinion that without an accurate estimate of the number of abortions performed in the United States or the number of maternal deaths from abortion, it is impossible to estimate abortion-related mortality with any precision.

Q. Do you agree that that's true?

A. Yes.

Q. If it is impossible to estimate the true abortion-related mortality with any precision, how are you now able to say that abortion is more dangerous than childbirth?

A. Because if we look at the available data, and the study I'm thinking of in particular is the Bartlett study which shows that the risk of death from abortion increases 38 percent by every additional gestational -- week of gestational age, that is not -- and that by the end of midtrimester, the risk of death is 76 times greater than that -- than risk of death in the first trimester. There is no corresponding increase -- there is no increase in risk in pregnancy that corresponds to that risk.

And another study, I believe it was by Lidiro, but don't quote me, found similarly that there is a 30 percent increase in death from abortion by -- with each additional gestational week.

So what that says is that as you proceed in gestation, the risks of abortion increase exponentially, not just linearly but they increase exponentially, and that is not the case for mortality in pregnancy.

Q. Do you believe that people regularly obtain abortions in pregnancy at the point in which childbirth is most dangerous or in which pregnancy is most dangerous?

A. Can you --

MR. BOYLE: Object to form.

A. I'm not sure I understand your question.

Q. That was a very confusingly worded question --

A. Yeah.

Q. -- on my part. When do people typically obtain abortions?

A. Well, this is an important question. Most people -- so 93 percent of abortions in the United States are performed -- 91 to 93

percent are performed before the first trimester. And this is a significant problem in ascertaining maternal complications and death because the lar- -- much larger number of abortions that are performed in the first trimester when risk for mortality and morbidity is lower basically drowns out all of the additional morbidity and mortality that's occurring in the second and third trimester. We know that those abortions occur because Warren Hern advertises on his website that he does abortions up to 36 weeks so we know that that happens. We know that those occur.

We also know that simply based on uterine and maternal physiology, the risk of abortion at higher gestational ages is higher and is not amenable to intervention because the difference between a fetus at six weeks -- an unborn child at six weeks and an unborn child at 36 weeks is there's an astronomical difference. You know, you're talking about several grams -- 15 grams versus eight -- you know, somewhere between six and eight pounds. So I think that that's

the basis of that statement.

MR. BOYLE: Not immediately necessarily, but can we take a break at some point? It's been about an hour.

MR. MENDIAS: Sure. I'm -- if you would like to take a break now --

THE WITNESS: Yeah, because you haven't asked another question --

MR. MENDIAS: Sure.

THE WITNESS: -- so this might --

MR. MENDIAS: Okay.

THE WITNESS: -- be a good place.

MR. MENDIAS: Great.

THE WITNESS: Thank you.

THE VIDEOGRAPHER: Going off the record. The time is 2:16.

(Whereupon, there was a recess in the proceedings from 2:16 p.m. to 2:30 p.m.)

THE VIDEOGRAPHER: Back on the record. The time is 2:30.

BY MR. MENDIAS:

Q. Doctor, during the break did you speak with anyone about the deposition so far?

MR. BOYLE: Objection. To the extent she spoke with me, that's work product and I

would instruct her not to divulge anything that we spoke about.

BY MR. MENDIAS:

Q. Did you speak to anyone other than an attorney --

A. No.

Q. -- during the break? Okay.

A. Well, I said hello to the front desk person.

Q. Did you consult -- did you consult any studies or materials during the break?

A. No.

Q. So before we broke, you had mentioned Dr. Hern. And your testimony was that he performs abortions through 36 weeks; is that right?

A. The last I saw on his website, yes.

Q. Does Dr. Hern practice in North Carolina?

A. No.

Q. Is abortion permitted through 36 weeks in North Carolina?

A. No.

Q. If a woman is pregnant and is considering whether to have an abortion or to carry to term, isn't the relevant comparison for the mortality associated with abortion at eight

weeks versus -- I'm sorry. I might have omitted that from -- so I'll withdraw that question.

If a woman is pregnant at eight weeks and is considering an abortion, if she is deciding between carrying to term and delivering and having an abortion, isn't it relevant for her to compare the mortality associated with an abortion performed at eight weeks with mortality associated with childbirth?

A. No, it's not relevant at all.

Q. Why?

A. Because the mortality from abortion at eight weeks -- the more relevant comparison would be abortion at term or near term and maternal mortality at the same gestational age.

Q. For that patient making the decision, you believe that is the relevant comparison?

A. I guess I'm not understanding your question. Are you saying that if -- if a woman is looking -- wanting to understand what is abortion-related mortality? Can you please clarify?

Q. If a woman is eight weeks pregnant and is

deciding between continuing a pregnancy or having an abortion at eight weeks --

A. Right.

Q. -- isn't it relevant for her to compare the mortality associated with an abortion at eight weeks with the mortality associated with childbirth?

MR. BOYLE: Object to form.

A. So the mortality at eight weeks when the fetus weighs 50 -- 15 grams is not applicable or similar in any way to an abortion close to term, as I said earlier, where the fetus weighs five or six pounds, maybe seven pounds. And abortion, as we've said, has a 38 percent -- the risks of mortality increase exponentially, by 38 percent, for each week of gestational age so I don't think that's an accurate comparison.

I think the second problem with that reasoning is that you cannot predict for any given patient what their -- you know, risk is a population-based assessment. It's not an expression of whether an individual patient will have an outcome or not. So you can't say that, well, this patient had an abortion

and it kept her from having gestational diabetes because you simply can't predict for any individual patient with any certainty that they will have a specific outcome.

Q. It's true that a person who has an abortion will not suffer any complication from pregnancy after that -- after the point in which they had an abortion, correct?

A. Because you've performed the abortion and they're no longer pregnant, but that's not the point. The point of this discussion is often that you can perform an abortion to prevent maternal morbidity and mortality and that's just not true. Number one, because we know that where abortion is legal -- and the specific examples that I'm aware of are Chile during the Pinochet regime, Ireland, and Malta. They had -- especially in Malta where abortion is banned for any reason, they've had zero maternal mortality for five years. Same thing in Ireland. Ireland had one of the lowest rates of maternal mortality in the world prior to them legalizing abortion and the same thing in Chile.

So it doesn't follow from that argument

that if you do an abortion, it's going to lower maternal mortality or reduce maternal morbidity.

Q. It's true that some women have preexisting conditions that put them at very high risks of negative outcomes during pregnancy, correct?

A. Yes, that's correct. But you cannot say to someone with diabetes, you're going to develop diabetes and have a diabetic coma or if you have high blood pressure, you're going to develop preeclampsia and die. You simply cannot do that. All of our assessments of risk are population based; they are not predictive for an individual.

Q. What is the risk that a woman with pulmonary hypertension dies during pregnancy?

A. 50 percent.

Q. Do you believe a woman deciding whether or not to have an abortion when she has pulmonary hypertension might consider the risk associated with abortion versus the risk of a pregnancy in which there's a 50 percent chance of dying?

MR. BOYLE: Objection and object to

form.

A. I guess --

MR. BOYLE: You can answer.

A. Okay. So your question -- let me just rephrase your question back to you. So you're saying that that woman should -- are you saying that she should have the option to have an abortion because she -- of her -- the 50 percent risk of mortality?

Q. That's a good question. Do you think that she should?

A. I don't believe that abortion is -- elective abortion is -- as -- as you've said before, I don't agree with elective abortion. I think that in the patient with pulmonary hypertension, if she develops worsening symptoms saying she could be delivered, that's certainly an option.

Q. If a woman with pulmonary hypertension becomes pregnant and not yet experienced any negative outcome from her hypertension, you don't think that she should be permitted to have an abortion?

MR. BOYLE: Objection and object to form. You can answer.

A. Yeah. I -- I -- I could not speak to that situation. I think that, as I said, if she became pregnant and she continued to carry the pregnancy, she became symptomatic to the extent that she needed to be delivered, then that's an appropriate management plan.

Q. In Paragraph 196 of your declaration --

MR. BOYLE: Is this Exhibit B?

MR. MENDIAS: Yes.

A. Okay. Let me just read --

Q. Sure.

A. -- back so I can get context here. Okay. Yes.

Q. Can you read the last sentence of that paragraph.

A. In other words, the authors made estimates for a substantial number of caseloads using sources such as media stories which weakens the validity of their study.

Q. Why do you believe re- -- relying on media stories is inappropriate --

MR. BOYLE: Object to form.

BY MR. MENDIAS:

Q. -- in this context?

A. Because what we're talking about here is

epidemiology and epidemiology -- rather than being based on what a media story says, epidemiology ideally looks at patient-level data.

Q. So in your report you provide the names of women you say died following an abortion. Did you have firsthand knowledge of any of these women?

A. No.

Q. How did you first learn about these deaths?

A. I was, again, as I said earlier, looking at data on abortion-related mortality and came across the names of these women and I felt that it was truly tragic that young, healthy women underwent abortions that related -- resulted in their deaths.

Q. Did you find information about these women's deaths in newspaper articles?

A. No. I found their -- can you just remind me where that is?

Q. Sure. That is in Paragraph 188.

A. Yes. No. These were not -- I think in one situation, it was -- the -- the first one, it was a -- it was an article from the New York Daily News.

Q. And in Subparagraph 7 you also cite the New York Times, correct?
A. Yes.
Q. You also cite a website called abortiondocs.org. Do you know what that is?
A. This was a website that had information, and I believe this one had a autopsy report as well.
Q. Do you know anything else about that website?
A. No.
Q. Did you review the medical charts of any of these women?
A. No. I reviewed the autopsy reports as they were presented on the internet.
Q. How many of them had autopsy reports?
A. I would have to count, but it looks like one, two, three, four, five, six -- six or seven. And then --
Q. Which --
A. -- the others had depos- -- were from a deposition, another one was from an EMS report, and two were from -- oh, I just saw the numbers are out of order. Okay.
Q. Did any of the autopsy reports or articles that you consulted detail the women's medical

histories?
A. Yes.
Q. Which ones?
A. All of the autopsy reports. That's routine with autopsy reports.
Q. Do you know how much time elapsed between the abortion procedure and the complications --
A. I would have to look at --
Q. -- each women suffered?
A. -- each -- I would have to look at each one. I'm sorry. Sorry. Did not mean to cut you off.
Q. Are you aware of any women who died following second-trimester abortions in hospitals?
A. Yes. I think I mentioned a couple of those.
Q. Can you specify which ones occurred in hospitals?
A. I believe Keisha Atkins did and I believe -- in fact, I'm pretty sure -- I would have to look at the autopsy reports but -- I believe that most of these women died in hospital, but I would have to confirm that.
Q. Oh, I'm sorry. My question was, do you know if any of the abortions were performed in hospitals?

A. I think that information was in the autopsy reports, but I would have to reread them.
Q. But you didn't include any of that information in the declaration, did you?
A. No.
Q. Do you know how many abortions were performed at the clinics where these patients received their abortions?
A. No.
Q. Throughout your report you cite studies that suggest that a woman is at a high risk of suicide following abortion; is that right?
A. I think that the more precise way of expressing it is that there is evidence that in- -- there are increased risks for suicide among women who've undergone abortion.
Q. So to be clear, you're not arguing that abortion causes suicidality?
A. I would say that more accurately that there is an association between abortion and suicidality, yes.
Q. And so what is an association?
A. Association can be positive or negative, but it does not necessarily -- to -- it doesn't address the issue of causality. It's a -- it

indicates that there is an association.

Q. Is an association synonymous with a correlation?

A. Not exactly, no.

Q. How do they differ?

A. Correlation means that you compare one set of outcomes or one set of values with another to see if the relationship is linear or colinear or nonlinear so it's a -- it's a slightly different -- slightly different way of approaching it.

An association is simply that you can have a positive or a negative association between an exposure and an outcome.

Q. Doctor, what is the American Psychological Association, if you know?

A. The APA? Yeah.

Q. Correct.

A. It's an association of -- I don't know -- I know of the organization's existence. I don't know whether they are the same as ACOG or as a professional society. I can't speak to that.

Q. Do you believe that they're a reliable source?

A. I can't speak to that either. I do know that they've engaged in considerable abortion advocacy starting in 1979.
Q. What makes you describe their -- what makes you describe what they do as advocacy?
A. One of their statements that they made in 1979 was that they felt that abortion was -- and I'm paraphrasing. I would have to look at the exact quote. But they made statements strongly supporting abortion.
Q. Do you believe that a statement either in favor of or in opposition to abortion is necessarily advocacy?
A. I think it depends on how you define advocacy.
Q. How would --
A. I think on some level, what it means is that -- when an organization engages in pro-abortion statements, it means that it's worth looking very carefully at their statements and the particular conclusions they draw regarding abortion.
Q. Do you believe the same applies to organizations that oppose abortion?
A. Yes. I think that you have to look at the

quality of the science that they're proposing and I think that in some studies, for example, because this is a contentious topic, some researchers will -- will look -- will provide -- will look at both -- will look at what's called the null hypothesis, which is in their research to say, you know, we're -- we're not going to assume a benefit or a risk; we're just going to approach this agnostically to try to account for that.

Q. Do you consider yourself an advocate?

A. No. I would say my advocacy more falls in terms of scientific advocacy.

Q. But you would describe yourself as a scientific advocate then?

A. No, I would not. I would say that I am interested in looking at the science, critiquing the science, and applying the science appropriately.

Q. But you engage in advocacy?

A. I don't engage in formal advocacy efforts as in -- I think I would -- if you can define what you mean by advocacy, that would help me to answer the question.

Q. All right. Well, earlier, in response to one

of my questions you referred to, my advocacy, and so I'm just wondering what you mean by that.

A. I'm -- I'm sorry. I don't remember -- if she can read the question, that would be helpful.

Q. Sure.

MR. MENDIAS: Would you mind doing that, Lisa?

(The following question and answer were read back:

Q: Do you consider yourself an advocate?

A: No. I would say my advocacy more falls in terms of scientific advocacy.)

A. Right. So what I would say is that my advocacy is for women and children. That's what I'm about. To the extent that that impinges on the question of abortion, yes, but I've devoted my career and my life to serving women, especially vulnerable women, vulnerable children, women in socioeconomic deprivation and otherwise. So that's the source of my advocacy and the reason for it.

Q. Have you ever testified before Congress on a topic unrelated to abortion?

A. No.

MR. MENDIAS: All right. So I'm going to mark this as an exhibit.

(WUBBENHORST EXHIBIT I, Article, The facts about abortion and mental health, American Psychological Association, was marked for identification.)

MR. BOYLE: Thank you.

MR. MENDIAS: Thanks.

BY MR. MENDIAS:

Q. And so this is the APA, and it has said that, More than 50 years of international psychological research shows that having an abortion is not linked to mental health problems, but restricting access to safe, legal abortions does cause harm.

You consider that statement to be advocacy, correct?

A. I'm sorry. I -- I started reading it.

Q. Oh, apologies.

A. Distract- -- got distracted.

Q. I'm sorry.

A. Yeah. Go ahead.

Q. You would consider the statement -- I -- I -- I'm sorry. I'll -- I'll read the statement

again. More than 50 years of international psychological research shows that having an abortion is not linked to mental health problems, but restricting access to safe, legal abortions does cause harm.

Do you believe that that conclusion is advocacy?

A. I can't speak to that because I don't know the intent of the person saying it. I can say that I disagree with that statement.

Q. Are you aware that the APA has cited large longitudinal and international studies which have found that obtaining a wanted abortion does not increase risk for depression, anxiety, or suicidal thoughts?

MR. BOYLE: Objection.

A. I am not -- I haven't -- I haven't seen this particular -- this particular document so I can't really comment on it. When I look at this -- documents like this, I need to look at the studies they're citing, critique their statistical methods, and so on and so forth so I can't really speak to that.

Q. That's fair. Are you familiar with the Turnaway Study?

A. Yes.
Q. And what is it?
A. So the Turnaway Study was a study -- was a survey of women who had undergone abortion at differing intervals over -- out to five years and looked at various outcomes associated with the women who -- women who remained in the study until the -- the end of the study.
Q. And would you agree that it was extremely well-designed?
A. Yes. I think I've stated that, actually.
Q. And --
A. But the best design can't overcome the vagaries of surveys. Survey data is the weakest form of data as opposed to observational studies, clinical trials, and others.

Second of all, the Turnaway Study, as I've said, while it was well-designed, had very significant dropoff to the extent that only 19 percent of patients finished.

And more to the point, by the end of the study, if you look very carefully at the data, 95 percent of women who kept their children said they were happy with their

decision.

Q. Are you aware of the comparable percentage of women who reported life satisfaction after they had obtained abortions?

A. The comparable percent?

Q. (Nods head).

A. I would have to look at it again. I think I cited it in my -- but I think -- again, I would like to come back to the point that the methodological problems associated with Turnaway Study are very significant.

Another important issue, and forgive me if this is not the most current data, is that people have repeatedly requested Turnaway Study -- the authors to put their data in a data repository and to date, as far as I know, they've refused to do that.

Q. Do you know whether there were any significant differences between the women who continued in the study and those who were lost to follow-up?

A. Yes. I think that if you look at the study -- and I would have -- it would be great if I could refer to my -- oh, actually, I don't know if I went into a detailed

critique here. There were differences in gestational age at the time of abortion versus no abortion. And, again, the -- the question really is that if only one in five patients at the end of a study stayed in the study, no matter how well-designed it was -- and I think it was -- it was a very well-designed study, asked a lot of questions, but that cast doubt on the validity of the study simply based on the lack of follow-up.

Q. Do you believe that that's true even if there were no meaningful differences between the women who were lost to follow-up and the women who stayed in the study?

A. You can't make any conclusions. If one -- only one in five patients stayed till the end, you simply cannot draw conclusions.

Q. Are you familiar with a 2018 report published by the National Academies of Science, Engineering, and Medicine concerning the safety of abortion in the United States?

A. Yes.

Q. So in your declaration you criticize it for being funded by abortion advocates; is that

correct?

A. Yes.

Q. Do you believe that a study should be discounted on the basis that the people who funded it have a strong political view of abortion?

A. No. I think that that means that you should scrutinize the methods and the results more carefully.

Q. Are you familiar with the criteria that the National Academies used in deciding whether to include a study in its review?

A. Yes. And I think that they eliminated a vast number of studies that were -- would have spoken to the issue and ended up with a very small amount -- very small number of studies that did not accurately reflect the literature.

They also continued to discuss this statistic of, you know, women are more -- 12 to 14 times more likely to die in childbirth when preg- -- than from abortion when that statistic is based on a paper by Raymond and Grimes which has severe methodological problems. It combines different data sets.

It uses different denominators. It does not use -- does not account for the majority -- I'm sorry. -- does not account for differences in -- in those databases.

So, again, I -- I would have to say that on the merits, the National Academy study suffers from one of the typical problems of systematic evidence reviews and metaanalyses, which is that they're very dependent on what criteria you use for your metaanalysis and how biased those studies are or are not.

Q. You -- I believe the answer was, yes, you are familiar with the criteria that the National Academies used so can you say what criteria those are.

A. I would have to look to be precise.

Q. But when you say you're familiar, you have a general sense of what they used to exclude or include studies?

A. Yes. I think that what they -- they used in their metaanalysis, they used metaanalytic rules that -- again, I would have to look at the study to be precise because I don't want to misquote them. But they -- through their process, the point is that their rules

excluded a very large number of studies that were responsive to the question.

Q. Do you believe that they excluded only studies that showed a -- a -- an association with negative outcomes and abortion?

A. I'm not following your question.

Q. Do you believe they --

A. Will you rephrase, please.

Q. Sure. They -- do you believe that they excluded studies that showed no negative outcomes associated with abortion?

A. Studies that showed no negative -- I -- I would have to go back and look at the studies they excluded. I can't say off the top of my head.

Q. Can you give an example of one criterion that they used to exclude studies?

A. Again, I don't want to misquote. I have read the study in great detail and critiqued its methods, but if you want me to pull up the study and look at it, if you have a copy of it, I'm happy to do that.

Q. I don't so we can continue.

A. Yeah.

Q. In your report you cite a 2009 Finnish study

by Niinimäki, which is N-i-i-n-i-m-a-k-i, called, Immediate Complications After Medical Compared With Surgical Termination of Pregnancy.

A. What -- what paragraph is that?

Q. So that would be Paragraph 32. And did you bring a copy of that study? I forget if that was one of the ones that you said you had.

A. No, I didn't bring one.

Q. So just give me a moment.

MR. MENDIAS: I'm going to mark this as well.

(WUBBENHORST EXHIBIT J, Article, Immediate Complications After Medical Compared With Surgical Termination of Pregnancy, was marked for identification.)

MR. BOYLE: Thank you.

MR. MENDIAS: Uh-huh.

BY MR. MENDIAS:

Q. And in Paragraph 32 you cite this study in support of your claim that first-trimester medication abortion carries substantial risks to the mother; is that right?

A. Yes.

Q. And are you aware what sorts of medication

abortion regimens patients had received in this study?

A. Yes. I think that they used vaginal misoprostol, which is somewhat different from the regimen that's used in the United States; however, there have never been any head-to-head trials to show that that regimen is less safe or more safe or -- there have been -- never been any effectiveness or efficacy trials to compare those two.

Q. So I'm going to direct you to a particular paragraph. So on Page 796, the first paragraph of the column on the right side, do you see the sentence after Footnote 14 that begins, The time of follow-up?

A. Yes.

Q. Would you please read that sentence.

A. The time of follow-up after abortion was 42 days.

Q. Then could you read the next sentence as well.

A. Medical abortion was defined as the use of mif- -- mifepristone alone or in combination with misoprostol or other prostaglandins.

Q. So do you know whether PPSAT uses a

medication abortion regimen different from those methods?

A. I think PPSAT does use a -- an abort- -- a regimen that's different. But, again, as I said earlier, there's never been a head-to-head comparison to show that the efficacy, safety, or effectiveness of this regimen differs from the one used by PPSAT.

Q. Okay. And so returning to the first page, can you read the paragraph after the all caps word conclusion.

A. Both meso- -- methods of abortion are generally safe, but medical termination is associated with a higher incidence of adverse effects. These observations are relevant when counseling women seeking early abortion.

Q. So are you aware that the authors later explained that the study was based on a Finnish health registry that coded all follow-up visits as complications even if those visits were just for additional consultation?

A. Yes, I'm aware of that, but I don't think that's relevant to the point that I was trying to make. The point that I was trying

to make was that the risk of hemorrhage was very significant. It was almost 16 percent. So the risk of incomplete abortion was 6.7 percent and 1.6 percent with surgical abortion. And the risk of emergency surgery was also close to 6.7 -- 6 percent.

So the point I was trying to make was not the study design. It was the fact that these hard outcomes that they looked at including hemorrhage, including need for surgical evacuation, in- -- including risk of incomplete abortion, were higher than surgical abortion and higher than what's reported in the United States.

Moreover, I want to emphasize that these Finnish studies have the advantage of complete ascertainment, which we do not have in the United States ever. They track every woman from birth -- every human being from birth until death, all of their interactions with the medical system, so this is a comprehensive way of looking at all tort -- tor- -- sorts of medical outcomes. I've spoken with Mika Gissler. The research that they do is really excellent and that's the

point I was trying to make.

MR. MENDIAS: So I'm going to mark this.

(WUBBENHORST EXHIBIT K, Letters to the Editor, Immediate Complications After Medical Compared With Surgical Termination of Pregnancy, was marked for identification.)

MR. BOYLE: Thank you.

BY MR. MENDIAS:

Q. Doctor, you mentioned hemorrhage. In the second paragraph on -- in the leftmost column, do you see a sentence in the middle of that paragraph that begins, Based on?

MR. BOYLE: Objection. What -- what are we looking at here?

BY MR. MENDIAS:

Q. This is -- do you rec- -- do you recognize this publication that --

A. Yes. Uh-huh.

Q. Okay. Do you see the paragraph -- the second paragraph in the leftmost column?

A. Yes.

Q. And do you see the sentence about halfway through that begins, Based on?

A. Uh-huh.

Q. Could you --

MR. BOYLE: Objection. Can we -- can we just clarify what it is on the record, please.

BY MR. MENDIAS:

Q. All right. Can you say what this document is.

A. Oh, this is a letter to the editor from -- I'm familiar with this. -- I think her name is Mary Fjerstad to the editors of The Green Journal OB/GYN asking -- presenting some questions for the authors.

Q. Okay. And can you read that sentence we were just talking about.

A. Based on correspondence with the Dr. -- H-e-i-k-i-n-h-e-i-m-o, one of the authors of the Niinimäki -- I'll spell that, N-i-i-n-i-m-ä-k-i, and there's an umlaut over the A -- in Finnish health registries, any return visit, even for additional consultation, is categorized as a complication. Thus, a woman who is bleeding may have been within the normal range but who sought reassurance could have been coded as having had a hem- -- hemorrhage.

Q. So isn't it true that the rates of hemorrhage might have been inflated in the original Niinimäki study?
A. I don't think that's true. This author is making a presumption not based on any data. She said a woman may -- her bleeding may have been in the normal range and could have been coded, but she doesn't present any data or any critique of the data to support that statement.
Q. And the doctor she refers to, Heikinheimo, he was a -- an coauthor of the 2009 --
A. Right.
Q. -- Niinimäki story -- or article?
A. But they don't present the correspondence so I can't comment on that.
Q. How do you define hemorrhage?
A. It depends on the procedure. So typically, you can have as much as -- I mean, again, it depends on the procedure.
Q. Is any amount of bleeding in a patient hemorrhage?
A. No.
Q. So how much bleeding is a minimum to be considered hemorrhage?

A. It's usually prespecified in patients and in clinical data so that's why I'm asking you which procedure you're referring to. For example, if it's a labor-and-delivery patient, we would consider bleeding up to about 400 milliliters to be normal and then once past that, maybe 3- to 400, and then once it's beyond that, we count that as postpartum hemorrhage. So it's procedure specific and in papers, as I said, they usually provide a predefined cutoff as to what they consider to be hemorrhage.

Q. How much bleeding is considered hemorrhage in a medication abortion patient?

A. I think that it's -- they can bleed as much as 80 to 100, but, again -- 100 is -- milliliters. But, again, the amount is subjective. And unless you weigh pads, which is what we do -- weigh pads and surgical sponges and so on and so forth, which is what we do with hemorrhage at term, it is difficult to quantify.

Q. And in the right column of this letter to the editor page, this was written by the authors of the study, Niinimäki 2009, et al.,

correct?
A. Yes.
Q. And can you read the bullet point at the bottom of that rightmost column on the first page.
A. Rate of serious real complications is rare and rather similar between surgical and medical abortion.
Q. And was the 2009 Niinimäki study a retrospective administrative database study?
A. Yes.
Q. And you say a strength of that study is to completely ascertain all abortions and all complications, correct?
A. Yes.
Q. But in your declaration at Paragraph 36, you criticize a study by Upadhyay, et al., from 2015.
A. Yes.
Q. And you specifically say that it has many limitations similar to other retrospective administrative database research studies, correct?
A. Yes. That's because studies that are done in the United States cannot have complete

ascertainment. We don't have the types of databases, we don't have the types of registration, we don't have the types of statistical methodology and power that they do in Scandinavia so they're not com- -- comparable at all.

Q. But didn't Upadhyay in the 2015 study look at Medicaid data which included all Medicaid beneficiaries who had received an abortion and any follow-up care that they obtained?

MR. BOYLE: Objection. You can answer.

A. They're -- the Medicaid databases are notorious. I've worked extensively -- you can look at my CV and see that I have two, maybe three papers looking -- doing heavy power lifts using Medicaid data. Medicaid data is notorious for being limited. There is miscoding. There are patients that, for example, will code for having two deliveries in one year. The ability to -- for them to follow up on patients is -- is not -- it is not comparable in any way to what the Finnish people can do with their databases.

And in addition to that, the Finnish database is designed to capture both medical

and administrative and financial data. Medicaid is designed just to capture financial data. That's it. It's -- it is not -- and it doesn't have information on gestational age, doesn't have information on complications at the patient level. These databases do.

Q. So looking back at the reply that Niinimäki wrote in response to Mary Fjerstad's letter to the editor, isn't it true that she writes that complications -- many of the complications are not really such but, rather, concerns or adverse events that bring women back to the healthcare system?

A. Yes. That's what she says.

Q. Does that imply that there was some miscoding?

MR. BOYLE: Objection.

BY MR. MENDIAS:

Q. You can answer.

A. No, I don't think that there's miscoding because, as I've said, they organize their database very differently from ours and miscoding is very rare if -- and unusual.

What I would say is that the specific

outcomes that I mentioned, which were hemorrhage, incomplete abortion, and emergency surgery, are hard outcomes and they were demonstrated to be more common and they were demonscra- -- -strated to occur at a specific incidence or prevalence within a population that we were looking at.

Q. And you also criticized the 2015 Upadhyay study saying that, There is a likelihood that patients with complications didn't engage with the medical system; is that right?

A. Yes. And what I meant by that was that they did not engage with the medical system in a way that was visible through a Medicaid administrative database. That's the point that I was trying to make. If a patient had complications, of course, they would reasonably engage with the medical system, but the fact of the matter is that what we find very frequently is that when patients suffer abortion complications, they do not return to the abortion clinic. They are seen by physicians like myself who go to hospital emergency rooms and that was the point that I was trying to make, that they did not engage

with the medical system in a way that was visible through a Medicaid database.

Q. In Paragraph -- my -- my apologies. So in general, you criticize record linkage study involving the Medicaid program.

Is that a fair representation of your position in the declaration?

A. I think it's open to critique, but sometimes it's the data that we have. But I do think that it is not adequate to answer certain questions and that's what I'm -- the point I'm trying to make.

Q. So in Paragraph 57 of your declaration you cite a study by Reardon, et al., from 2002.

A. Uh-huh.

Q. That was also a California Medicaid record linkage study, correct?

A. Right. Yes.

Q. Would you agree that the 2015 Upadhyay study was well-designed?

A. I would have to go back and look at the study design because I cannot say off the top of my head whether it was well-designed or not. I don't believe I commented on the study design. I said there were methodologic

issues, but I didn't say whether it was well-designed or not well-designed.

Q. So do you have your Minnesota expert report? And I'm -- apologies. I do not remember what exhibit it was marked as.

MR. BOYLE: H.

BY MR. MENDIAS:

Q. H. So --

A. Oh. Oh. Oh. You already --

Q. Yeah.

A. -- gave it. Okay.

Q. Yeah.

A. Wait a minute. Wait a minute.

Q. So on Page 16 -- or -- I'm sorry. Yes. Actually, Page 16, Paragraph 71. And that would be the fifth line of that paragraph.

A. Yes.

Q. You did say it was well-designed, correct?

A. Yes.

Q. Okay.

A. Uh-huh. And in Paragraph 143 you also criticize another Upadhyay study.

MR. BOYLE: Object to form. What -- what exhibit are you on now?

MR. MENDIAS: It's -- I haven't marked

that exhibit yet. I'm talking about her declaration.

A. But you didn't tell me which --

MR. BOYLE: So you're back to --

A. -- document --

MR. BOYLE: -- Exhibit B?

A. -- we're referring to.

Q. No. No. No. I -- this is another Upadhyay study and I will mark that, but I haven't marked it yet. So --

MR. BOYLE: But you're back in Exhibit B --

MR. MENDIAS: Oh, in Exhibit B --

MR. BOYLE: -- 4- --

MR. MENDIAS: -- yes. Correct.

THE WITNESS: Okay.

MR. BOYLE: -- Paragraph 143?

MR. MENDIAS: Apologies. Yeah.

MR. BOYLE: Yeah. Thank you.

BY MR. MENDIAS:

Q. So Paragraph 143 of your declaration. So in the --

A. Yes. Uh-huh.

Q. So that was a 2018 Upadhyay study?

A. Uh-huh. And I just want to say, I have

nothing against Dr. Upadhyay.

Q. Sure. You point out that it only included data from 15.7 percent of the country.

MR. BOYLE: Objection.

BY MR. MENDIAS:

Q. You can answer.

A. I think that what I said was that it's 15.7 percent of hospitals.

Q. Sure.

A. And then I went on to say, quote -- quote, It undersampled some regions west and south and oversampled others.

Q. Do you have a reason to believe that abortion complications are more likely in some regions of the country than others?

A. Yes.

Q. What would those reasons be?

A. I think that the -- actually, not the complications themselves. I can't really comment on whether the complications themselves would be more likely in different parts of the country, but the management of those complications might depend on the availability of health services.

Q. And so with respect to your criticism that it

only included 15.7 percent of hospitals in the country, are you aware of any data set that includes emergency room data from every hospital in the United States?

A. I think there are data sets like that that exist, but I would have to confirm that.

Q. You've never -- you couldn't provide a name of such a data set?

A. It would be very easy to get that.

Q. Okay. Who do you think maintains this data set?

A. I think the Hospital Association of America has similar data sets. Again, I can't really comment on which ones they are or who maintains them, but I know that they exist.

Q. So the authors of that study say they used data from the nationwide emergency department sample.

Are you familiar with what that is?

A. Yes.

Q. What is it?

A. It is a sampling -- but it's not a random sampling. It's a sampling of emergency department encounters with -- from patients with the medical system through the emergency

department.

Q. And they also, the authors, that is, say that that sample is maintained by the Agency for Healthcare Research and Quality.

Are you familiar with that --

A. Yes.

Q. -- agency? What is that agency?

A. HRQ is an agency of the Federal Government that looks at -- its mandate is health services research in the United States.

Q. Do you believe that it's a reliable source of data?

A. It's reliable to the extent that -- of the data's quality. No source is reliable in and of itself; it depends on data quality and integrity.

Q. Do you believe that the data from the national emergency department sample is of low quality?

A. I haven't reviewed it and I can't really say.

Q. You note as well in your declaration that 15 deaths were noted in the Upadhyay 2018 study; is that right?

A. Can you direct me to where -- where you are --

Q. Sure. That's --
A. -- referring to?
Q. -- Paragraph 146.
A. It says -- yes. It says, 15 patients in the sample had ED visits that ended in the patient's death.
Q. Are you aware what the total sample size was?
A. I would have to look at the paper, but I was not using that statistic as the numerator for an assessment of deaths from abortion. That was not the purpose. The point I was trying to make is that patients present to the emergency room and died in the emergency room. That was the point I was making. I was not making an epidemiologic assessment that this is the numerator over some denominator of encounters in the ER. That's not what I was trying to do.
Q. What was the relevance of the point you were trying to make?
A. That patients presented to the emergency room and died in the emergency room.
Q. Isn't it possible that if a woman did not disclose that she had had an abortion, she would have been excluded from the study

sample?
A. It's possible, but that's speculation.
Q. But you believe that abortion providers tell their patients not to inform emergency departments staff that they've had an abortion?
A. I don't believe it, but I believe that I've documented in my declaration where that has occurred.
Q. Has it occurred in North Carolina?
A. I don't know.
Q. Have you ever seen anything from PPSAT to suggest that it tells its patients such a thing?
A. I would not say that. I have not seen that.
Q. In Paragraph 67 of your declaration --
A. Okay. Give me just a minute here.
Q. Sure.
A. Yes.
Q. -- you assert that aspiration abortion is surgery.
A. Yes.
Q. And in the next paragraph you say, It requires surgical training distinct from other types of training.

A. Yes.
Q. Is that training that you've received?
A. No. But as an academic physician, I was aware of and continue to be aware of the fact that physicians who are being trained to do abortions are trained in surgical technique of doing abor- -- performing abortion.
Q. Do you consider a D&C to be a form of surgery?
A. Yes.
Q. In Paragraph 69 you say, It requires surgical operative sterile technique. What do you mean by that phrase?
A. What are we referring to?
Q. In Paragraph 69 you say, It requires --
A. When you say -- are you referring to surgical abortion?
Q. Well, I -- I'm asking about the paragraph that you wrote so I'm wondering what the it is there and --
A. Right.
Q. -- what you mean --
A. So it's surgical --
Q. -- by that phrase.
A. -- abor- -- oh, sorry. Sorry. I'm sorry.

Q. No. Go ahead. I -- I'm asking you to explain that paragraph in -- both in terms of what it's referring to and what you mean by surgical operative sterile technique.

A. So when surgery is performed, typically, we perform surgery using instruments that have undergone high-level sterilization to prevent the introduction of spores and resistant organisms into body cavities. That is part of operative technique. We also use sterile gloves, sterile gowns, sterile instruments, and sterile conditions, sterile surfaces, and that defines what sterile operative technique is.

Q. And what is curettage?

A. It's French because many of our medical terms are from French or Greek and it means scraping.

Q. Can you explain how that scraping constitutes a, quote, linear incision through the lining of the uterus, end quote, as you assert in Paragraph 71 of your report.

A. Because when you perform an abortion or when you are doing dilation and curettage for retained products of conception, you apply

the curette until you hear something called a cri, c-r-i, and what that is is the sound of you scraping through the layer of the uterus to make linear incisions in the endometrium, the lining of the uterus, down to the beginning of the -- down to the interface between the muscle -- the -- what's -- down to the base of the endometrium. And that is characteristically a gritty sensation that you encounter and that tells you that you've removed the tissue either through an incomplete abortion or whatever procedure you're doing.

Q. And do you consider that scraping to be an incision?

A. It is because you're incising through the lining of the uterus.

Q. Are you aware that ACOG does not describe curettage as involving an incision?

A. I'm aware that ACOG makes that distinction. I don't agree with that.

Q. In Paragraph 74 of your declaration you suggest that, 15 to 20 percent of patients receiving curettage due to an induced or spontaneous abortion develop intrauterine

adhesions, correct?
A. I didn't say that. I quoted these authors as saying that.
Q. And you agree with that statement?
A. Yes.
Q. What is a spontaneous abortion?
A. It's a miscarriage where you have in utero fetal demise.
Q. So the figure that you cite doesn't differentiate between those patients who miscarried and those who obtain an abortion and then subsequently developed intrauterine adhesions, correct?
A. In the paper and in subsequent papers they do make that distinction. The point I was trying to make there is that curettage is surgery and it leads to surgical complications. It leads to scar tissue.
Q. And like you said, you've performed D&Cs for patients experiencing miscarriage, correct?
A. Yes.
Q. Do you know how frequently your patients develop intrauterine adhesions after you perform a D&C?
A. No.

Q. When an embryo or a fetus has died in utero, what are physician -- physician's options for removing it?

A. So I'm going to rephrase it a little bit differently. So if a patient comes to me -- and miscarriage is a very sad situation. Many times women are devastated by the loss of a child that they had already planned and thought about and contemplated their birth. When patients come to me with a miscarriage, I typically offer them the opportunity of expected management versus immediate management with a D&C. Does that answer your question?

Q. Yeah. I think I have a follow-up question, though. What happens if there is fetal death in the second trimester?

A. So with fetal death in the second trimester, we are much more concerned with abort- -- with infection and hemorrhage. And so typically, those patients in my experience in every hospital in every program that I've worked at are managed in the hospital.

Q. And --

A. They're not managed as outpatients.

Q. Have you managed those patients yourself?
A. Yes.
Q. What have you done to manage them?
A. Either -- before misoprostol we would have to dilate the patient's cervix with laminaria and then do essentially a D&E, dilation and evacuation, but not a D&E in the sense that it was not on a living -- it was on a demised fetus. With misoprostol, management has become much more straightforward.
Q. What is management like now that misoprostol --
A. We give them --
Q. -- exists?
A. -- high doses of -- of -- I'm sorry. We give them misoprostol orally. I -- some clinicians may give it vaginally and that usually effects expulsion. E -- that should be e-f-f-e-c- -- thank you.
Q. So in Paragraph 94 of your declaration you discuss a report produced by an organization called Advancing New Standards in Reproductive Health, correct?
A. Uh-huh. I'm sorry. Yes.
Q. And that report was an analysis of a report

produced by the FDA entitled, Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2018, right?

A. Yes.

Q. And you describe as demonstrably false the report's assertion that it is mandatory to report any death among someone who used mifepristone, correct?

A. Yes.

Q. What is your view to arrive at your conclusion that that statement was demonstrably false?

A. I reviewed FDA's REMS for mifepristone and I also reviewed their postmarketing protocols. Their postmarketing protocols are very specific in stating for the REMS that prescribers must report complications to Danco or -- actually, it's not just Danco because there's a generic manufacturer. But let's say for this -- just the manufacturer of mifepristone, prescribers must report those to the -- complications to the manufacturer who then reports them to FDA. But if prescribers are not notified of complications and those complications occur

and are managed in an emergency room or elsewhere, they are never reported. And so, therefore, it is not true. There is no mandate on practitioners, physicians, emergency room docs, gynecologists to report those complications to FDA. That does not exist.

Q. Do you consider yourself an expert on the Federal Food, Drug, and Cosmetic Act?

A. Only an expert insofar as it affects my practice and needing to understand the ways that FDA's mandates and rules affect my practice.

Q. Do the REMS for mifepristone affect your practice?

A. No -- no, because I do not perform abortion. However, it is incumbent to understand, as in this situation, that, as I said earlier, there is no mandatory reporting on the part of everyday pres- -- of -- there's mandatory reporting on the part of prescribers but not on the part of other physicians who may manage those complications. Without having that information, it is impossible to accurately ascertain what the true

complication rate is from mifepristone abortions -- mifepristone/misoprostol abortions.

Q. So between Paragraphs 113 and 114 of your declaration you include a table, correct?

A. Yes.

Q. And that table includes deaths that the FDA was aware of after a patient took mifepristone, correct?

A. Yes.

Q. Does that suggest that those deaths were caused by mifepristone?

A. They were associated with mifepristone.

Q. And what is your basis for saying that they were associated?

A. The statement there under the paragraph -- the second double dagger where it says, The fatal cases are included regardless of causal attribution. So if there is no cause, then you're really talking about association, that the woman took it -- mifepristone and then had -- experienced these outcomes.

Q. But doesn't the paragraph go on to say that some of these deaths involved causes that could not possibly have been associated with

mifepristone?

A. I disagree with that statement because I believe and I think that there's evidence, which I have supplied in my declaration, that women do engage in risk-taking behavior, do engage in unhealthy behaviors which can lead to them dying from drug intoxication, suicide, and so on and so forth.

Q. Do you believe that there's an association between medication abortion and being the victim of a homicide?

A. I think that if a woman undergoes a medication abortion and then engages in risk-taking activities, in particular drug use, and I documented associations between abortion and drug use, that she could put herself in a situation where she could be the victim of homicide.

MR. BOYLE: We've been going for about another hour so whenever it's convenient, I'd like to take a break.

MR. MENDIAS: Sure. I've got a few more questions in this -- on this topic but then after that, maybe ten minutes from now.

A. Yes, because I could use the ladies' room.

Q. So did this report -- or -- I'm sorry. This table here includes all the deaths the FDA was aware of between September 28th, 2000, and June 30th, 2021; is that correct?
A. As far as I know, yes.
MR. BOYLE: Object to form.
BY MR. MENDIAS:
Q. And that was a yes?
A. No. It was -- I said, as far as I know. I can't say yes or no because I wasn't the FDA and I didn't collect the data.
Q. Did the report indicate how many women had taken mifepristone in that period of time?
A. There are two parts to this report and I didn't include everything, but they -- there is a -- somewhere in here there is a denominator. Again, I think that it would be very difficult to identify which -- whether women took mifepristone or not because, again, we are relying on data that were reported to the manufacturer. And as I said earlier, those data are necessarily com- -- incomplete because there is no mandated -- mandated reporting for nonprescribers.
Q. Do you believe that the denominator is

inaccurate that the FDA reported?
A. Can you define what you mean by the denominator.
Q. The number of women who took mifepristone in that time period.
A. I don't know. I haven't reviewed their raw data so I can't say.
Q. Did you encounter a figure that the FDA provided as the number of women who had taken mifepristone in that time period?
A. I want to say it was in the millions and the number 2.6 million comes to mind, but that is recollection so I can't really say that that's completely accurate.
Q. And last month you submitted a declaration in a case in Kansas, correct?
A. Yes.
MR. MENDIAS: Could I mark this as the next exhibit. Thank you.
(WUBBENHORST EXHIBIT L, Declaration of Monique Chireau Wubbenhorst, M.D., M.P.H., Kansas Case, was marked for identification.)
MR. BOYLE: Thank you.
BY MR. MENDIAS:
Q. And so on Page 39 of that declaration --

A. Yes.
Q. -- you include a very similar chart, correct?
A. Yes.
Q. And it reports the same number of deaths and ectopic pregnancies; is that right?
A. Yes.
Q. Just give me one second. And above the chart there is text from the FDA report, right?
A. Yes.
Q. And do you see the number of women indicated there who took mifepristone through the time period covered in the chart?
A. Yes. I think I said earlier it was in the millions.
Q. Great. And what -- how many specifically millions is it?
A. They say approximately 5.6 million.
Q. Why didn't you include that figure in your report for this case?
A. I was at the point where I needed to keep my text as short as possible. It was certainly not because I was trying to run away from that figure. I'm well aware of that figure. It's commonly cited in the literature so it was simply a question of trying to shorten --

keep my testimony as brief and to the point as possible.

Q. And how long is your declaration report -- or, I'm sorry, your declaration submitted in this case? That would be Exhibit B.

A. 64 pages.

Q. Okay.

MR. MENDIAS: I'm willing to take a break at this point.

THE VIDEOGRAPHER: Going off the record. The time is 3:33.

(Whereupon, there was a recess in the proceedings from 3:33 p.m. to 3:49 p.m.)

THE VIDEOGRAPHER: Back on the record. The time is 3:49.

BY MR. MENDIAS:

Q. Dr. Wubbenhorst, do you believe that maternal mortality surveillance relies exclusively on death certificates?

A. No.

Q. And do you agree that the gold standard for ascertaining maternal mortality is to collect data and then have a state-level group of obstetricians and epidemiologists review every case? Correct?

A. I don't think that's the gold standard for ascertaining mortality. I think that that is more related to ascertaining causes of mortality.
Q. Okay. And you -- we were discussing earlier the testimony that you gave in Kentucky. You remember that testimony, correct?
A. I do. I'm thinking you have a copy of it.
Q. I might have given it already, but let me see.
A. I don't believe you've given it yet.
Q. Correct.

MR. MENDIAS: So I'll mark this. Thank you.

(WUBBENHORST EXHIBIT M, Excerpt of Hearing Testimony by Dr. Wubbenhorst, was marked for identification.)

BY MR. MENDIAS:
Q. And this is a transcript of the direct and cross-examination you underwent, I believe, last summer in Kentucky.

Does that look like -- correct to you?

A. Yes.
Q. Okay. And on Page 197 -- so -- and the pages, again, are in the upper right-hand

corner of each small page in the --

MR. BOYLE: So objection. Is there anything to identify this with?

MR. MENDIAS: Yeah. Let me -- well, the witness has said that it looks familiar so I can look for the full copy in a moment but --

A. Yeah. I haven't -- I haven't seen this so...

Q. So on Page 197 --

A. Yes.

Q. Okay. Pardon me one second. All right. Actually, we'll set that aside for the -- a moment. I apologize for that.

Are you aware that the CDC has obtained data on abortion mortality from all 50 states?

A. I -- on abortion mortality. I haven't looked lately but, yes.

Q. Do you know the sources that the CDC relies on to identify abortion-related deaths?

A. They pull from a variety of sources and I would need to look precisely at their actual method section of their MMWR.

Q. Do you know off the top of your head some of those sources even if we'll acknowledge that

it's not all of them?
A. They rely on reports from the states. They rely on death certificate data. There -- there are a few sour- -- data sources that they use.
Q. Do they rely on reports by private citizens?
A. I don't know.
Q. Do you know what happens after the CDC obtains a -- a report of an abortion-related death?
A. My understanding is that they will try to get as much information as they can regarding that death.
Q. And then what happens, if you know?
A. Then they compile their data and report them.
Q. Are you aware of any review of the reports that the CDC undertakes?
A. Well, that's what I meant, trying to get as much information as possible.
Q. Okay. So could you say a little bit more about what you mean when you say they try to get as much information as possible.
A. They will try to get information about things like gestational age and so on and so forth. Again, I don't have their protocol in front

of me so I don't want to try to recite it from memory.

Q. And are you aware of who at the CDC undertakes the review of these reports?

A. I do not know. I would have to look at their report to see that, which should be very straightforward and easy to do.

Q. Okay. So back to Ex- -- Exhibition -- or Exhibit B, your declaration in this case.

A. Just give me a moment. Yes.

Q. So in Paragraph 39 of your declaration you cite a study by Cates and Grimes, correct?

A. Yes.

Q. And that study is to support your assertions about the mortality rate of the D&E abortion procedure; is that right?

A. No.

Q. What is it for?

A. It's to show trends. I was not citing because that study's obviously very old, but I was trying to make the point about methods of D&E -- methods of abortion in the second trimester and trends in how abortion data were collected and so on and so forth. I was not making a comment about mortality per se

in that era compared to this era.

Q. What trend do you think the study exemplifies?

A. I think that it shows that the -- again, using contemporaneous -- their techniques were similar to what we use now, but it showed that their rate -- the increase in mortality in their study was fairly substantial between 13 to 15 weeks and greater than 16 weeks. That was the point that I was trying to make.

Q. So you acknowledge that the study is fairly old and, as you say in your report, it looked at D&E procedures performed from 1972 to 1978, correct?

A. That's correct.

Q. And that was before -- at least some of the abortions in the study were performed before the Supreme Court's decision in 1973 in Roe v. Wade, correct?

A. That's correct.

Q. Do you know the circumstances under which an abortion prior to Roe could be performed in most states?

A. It depended on the state and it was -- it was

not as much of a patchwork as it was that the legalization of abortion proceeded starting with -- I believe was California and New York. I don't know which one was first.

But, again, that's not the point I was trying to make. The point I was trying to make was the change in mortality rates that occurred from 5.6 per hundred thousand at 13 to 15 weeks to 14 at greater than 16 weeks. That's the point I was trying to make.

Q. Do you think that the rates -- the trend that you're discussing might have been affected by the medical procedures used 40 years ago?

A. I think that the D&E procedure they were using then was similar to what we're using now. And in the second part where I talked about installation procedures and prostaglandin and hysterotomy, the point I was making there is that those procedures are actually still used in some states and that they're associated with significantly increased rates of mortality.

Q. Do you believe that PPSAT uses any procedure other than D&E for abortions in the second trimester?

A. Not to the best of my knowledge, but, again, that's not the point I was making. I was looking at overall abortion-related mortality.

Q. Do you believe that advances in medicine could have undermined the conclusions of the study with respect to the trend across gestational ages?

A. I can't speak to that. I can't say what could or could not have happened.

Q. Do you believe that medicine does advance over time?

A. Yes.

Q. And are you aware that the study's authors found that out of 234,000 D&E abortions, there were only 18 deaths?

A. Yes, I'm aware of that. But, again, the point I'm trying to make was not related to mortality rate per se; it was related to mortality rate as it increases with gestational age.

Q. Are you aware that the authors of the study concluded that D&Es performed in nonhospital settings had lower death-to-case rates than those performed in hospitals?

A. I'm aware of that, but, again, that's not the point I was trying to make by citing this study. And, again, the study is not contemporaneous.
Q. And are you aware that the study's authors concluded that comparative mortality data indicate that performing D&E outside of hospitals carries no greater risk of death?
A. Oh, yeah, I'm aware of that, but, again, as you said, this study is how old now?
Q. Doctor, you've expressed doubts with the completeness of the CDC's surveillance of abortion-related mortality; is that correct?
A. Yes.
Q. Are you aware that this study relies on annual abortion surveillance conducted by the CDC at the time?
A. Am I aware of what?
Q. That the study relied on CDC's annual sur- -- abortion surveillance activities when calculating mortality rate.
A. You're talking about the 1991 study?
Q. Yes.
A. Correct. I'm familiar with Willard Cates' and David Grimes's work.

Q. Is it your view that abortion mortality surveillance is more accurate in countries like the United Kingdom with nationalized health systems?

A. No, because I think they have the same problem of ascertainment that we have here and they also have significant problems with issues around miscoding just as we have here. And what I mean by that is that some abortion deaths are coded as being due to pregnancy or natural causes. And an excellent example of that is the unfortunate young lady who I mentioned earlier, Keisha Atkins, who died as -- due to complications from a late -- I believe it was between 38 -- 28- and 32-week abortion who was listed as -- the cause of death was pregnancy. So they suffer from the same issues that we have in terms of miscoding, in terms of inaccurate -- insufficient ascertainment.

Q. To be clear, Keisha Atkins died in the United States, not the United Kingdom, right?

A. But I'm using that as an example of something that I think is a phenomenon common to all abortion statistics and not just abortion,

other causes of death as well.

Q. So why is the ascertainment better in Finland than in the United Kingdom?

A. Because once you enter the health system when you're born, you don't exit it till you die. Every encounter with the medical system is documented and every encounter with the medical system, when researchers go to look at it, they can look at what the coding was and correlate it to a hospital chart if they want to. We do not have those capa- -- capabilities.

Q. Sure. I asked you about the United Kingdom. So do you have any basis to believe in the United Kingdom the surveillance is different than in Finland?

A. It is because the national health service is a national health service, but it does not enroll patients from birth to death and collect comprehensive data on every encounter with the medical system. They can collect data administratively and then try to go back and look at patient-level data, but to have granular patient-level data requires something like what they have in Scandinavia.

Q. Have you examined patient-level data or any health service data from the United Kingdom?
A. Yes, I have looked at some -- some of their data.
Q. In what context?
A. I was interested in some of their maternal mortality data because what their data was showing was that there were disparities in maternal mortality between women of color and white women even though they have a nationalized health system. I have not looked at patient charts because I haven't gotten permission to do that.
Q. Do you believe that the data that you reviewed was inaccurate?
A. It was aggregate data and I can't vouch for its integrity or its quality.
Q. Do you -- are you aware that the authors of the 1981 Cates and Grimes study found that the death case rates for D&E in the United States are consistent with British data?
A. I was not aware of that. And, again, the point of my citing that study was simply to show the difference -- the issues around increasing mortality with increasing

gestational age. That was the point of my citing it.

Q. And in Paragraph 179 of your declaration you cite a source by Lanska. Can you say what that source is.

MR. BOYLE: What paragraph is that, please?

MR. MENDIAS: That was 179.

MR. BOYLE: Thank you.

A. Yes.

Q. What is that source?

A. It's a journal article.

Q. Okay.

MR. MENDIAS: I'm going to mark this, please. Thank you so much.

(WUBBENHORST EXHIBIT N, Letters to the Editor, 2/17/2017, was marked for identification.)

MR. BOYLE: Thank you.

BY MR. MENDIAS:

Q. And, Doctor, this is not a journal article, is it?

A. It's a letter to the editor. That's correct. Yeah.

Q. So it was not peer reviewed?

A. Uh-huh. That's correct.
Q. And the letter was written in 1983, correct?
A. That's correct.
Q. And isn't it true that the only source cited in this article -- or the only sources cited in this article are from 1981 or earlier?
A. That's correct.
Q. And the --
A. The point -- I'm sorry.
Q. No. Go ahead.
A. If I can continue, the point I was making in including these -- including this particular letter is that it's stated in a very clear and understand way that the -- I think it's the first, second -- third paragraph on Page 362 where it says, The mortality rate for vaginal deliver- -- excuse me. Excuse me. The mortality rate for vaginal deliveries may be artificially low because high-risk mothers are more likely to have a cesarean delivery. This effect could be eliminated by adjusting for preexisting medical conditions between the vaginal and cesarean delivery subgroups as the authors did in calculating rates for women who had an abortion.

So the only reason I was including this was not as a way of comparing maternal mortality, which was higher at that time. And certainly, this is, you know, 40 year -- some-odd years ago, but it was easily -- an easy-to-understand way of talking about how high-risk moms are more likely to have a cesarean delivery, which is associated with increased risk for mortality than low-risk moms.

Q. In defining a high-risk delivery, the letter's authors assume that maternal mortality following a cesarean is approximately a hundred per 100,000; isn't that correct?

A. Yes. But, again, I'm not looking at their -- or not citing their specific data. What I'm trying to help to present and perhaps didn't need -- and appreciate the opportunity to make it clearer is that cesarean delivery is associated with a higher mortality rate than vaginal delivery --

Q. Do you believe --

A. -- and that when you combine maternal mortality statistics, very often that

distinction is not made. That's the only point I was trying to make.

Q. Do you believe that the mortality rate today following C-section is a hundred per 100,000?

A. I just said a moment ago that I am not relying on the maternal mortality statistics. I am simply making the point that cesarean delivery is associated with higher mortality and morbidity than vaginal delivery.

Q. I understand. But I'm asking you if you believe that the mortality rate today following a cesarean section --

A. No, it's not.

Q. What do you think it is?

A. I think that the most recent statistics I saw were that the -- I would have to look, but I think the mortality rate for a cesarean delivery is about ten times greater, but, again, I would have to look to be sure of that.

Q. And the authors of the letter conclude that, Cesarean sections account for only 10 percent of deliveries and 90 percent of maternal mortality associated with childbirth; is that right?

A. That was true then, but it's not true right now --
Q. So you're not --
A. -- because we have a much higher -- sir?
Q. No. Go ahead.
A. No. Please complete your question.
Q. I just wanted to confirm. So you don't believe that 90 percent of maternal deaths associated with childbirth are attributable to C-sections today?
A. No, I don't think that that's the case. I think that the other point is that our cesarean rate is much -- what I was going to say is that the -- our cesarean rate is much higher than it was at that point.
Q. Understood. Doctor, what is an ectopic pregnancy?
A. It's an -- ectopic pregnancy, excuse me, is a pregnancy that implants outside of the uterus. It can implant in a variety of other sites, but the majority of them implant in the fallopian tube.
Q. And how common is ectopic pregnancy?
A. 1 to 2 percent of pregnancies in the United States.

Q. What are the risks of an ectopic pregnancy?
A. Rupture with hemorrhage requiring urgent surgical intervention; death; complications of hypovolemia, for example, if she bleeds and then suffers heart attack or other complications as well.
Q. Do you know what the rate of each of those risks is, how frequently they occur in an ectopic pregnancy?
A. I couldn't tell you what -- the risks associated with hypovolemia. I do -- I can affirm that ectopic pregnancy is the leading cause of first-trimester maternal death.
Q. Sure. Do you know the specific rate, how many women per ectopic pregnancy die in this country?
A. No. I think that the point is -- as I was saying earlier, that it's fairly common, happening in 1 to 2 percent, and it is not an easy diagnosis to make always.
Q. Do you know at what point in pregnancy an embryo can be visualized with a transvaginal ultrasound?
A. Depends on the woman. So most pregnancies and the radiology literature state that you

should be able to visualize an embryo sometime between four and six weeks, but it can be longer. Relates to tissue characteristics, to the skill of the operator.

Q. Would you consider a pregnancy of unknown location to be equivalent to a confirmed ectopic pregnancy?

A. No.

Q. And if a patient has a pregnancy of unknown location but no symptoms of ectopic pregnancy, do you consider that a suspected ectopic pregnancy?

A. It's suspected until proven otherwise. That's axiomatic in OB/GYN.

Q. So your opinion is that all pregnancies of unknown location should be assumed to be ectopic until ruled out?

A. Yes, because if you miss it and a woman dies, then that's very bad.

Q. And so you said in your declaration that ectopic pregnancy is a contraindication to medication abortion.

A. That's correct.

Q. Why is it contraindicated?

A. I'm just quoting FDA's -- the prescribing information there.
Q. Do you have your own basis for believing that it's contraindicated?
A. I was just quoting the prescribing information. I'm sorry. I'm just putting this in order. Just my little thing here of --
Q. Uh-huh.
A. -- keeping papers straight. Yeah.
Q. Okay. So you don't have any other knowledge about why it might be contraindicated?
A. No, sir. I'm relying on what the prescribing information states.
Q. Do you believe that mifepristone causes tubal rupture?
MR. BOYLE: Object to form.
A. No.
Q. Do you believe that misoprostol can cause a tubal rupture of an ectopic pregnancy?
A. Not to my knowledge.
Q. Would you agree that an ectopic screening protocol that uses ultrasound and hCG testing is appropriate?
A. Yes.

Q. Do you know PPSAT's protocol for providing medication abortion when there is a pregnancy of unknown location?
A. My understanding is that it relies on ruling out ectopic pregnancy through -- or attempting to rule out ectopic pregnancy based on symptoms and history and not ultrasound.
Q. Do you believe that PPSAT provides medication abortion to patients without having first performed an ultrasound?
A. Yes.
Q. Do you believe that PPSAT provides medication abortion to patients without doing hCG testing?
A. Can I just --
Q. Sure.
A. -- clarify that? So your question was do I believe that PPSAT provides medication abortion to patients without an ultrasound. Yes. In -- in all cases, I don't know.
Q. So do you believe that PPSAT provides medication abortion to patients without doing hCG testing?
A. My understanding and the specific issue that

I was responsive to here was the pregnancy of unknown location. Reading the -- what Dr. Farris said, it appears that PPSAT does not perform -- routinely perform transvaginal ultrasound in a patient with pregnancy of unknown location to rule out ectopic pregnancy.

Q. If a patient seeking medication abortion can't obtain one because she has a pregnancy of unknown location, do you believe that the law's requirement to document an intrauterine pregnancy requires that patient to seek further screening --

A. Can you --

Q. -- for ectopic pregnancy?

A. Can you --

MR. BOYLE: Object to form.

A. Yeah. Can you break that question down? I'm sorry. It's --

Q. Sure.

A. -- long.

Q. So you understand that the law that you are here testifying in support of requires the documentation of an intrauterine pregnancy before a medication abortion can be provided,

correct?

A. Yes.

MR. BOYLE: Object to form. You can answer.

BY MR. MENDIAS:

Q. And if a patient because of that requirement cannot obtain a medication abortion, is it your understanding that anything in the law requires her to seek further screening for ectopic pregnancy?

MR. BOYLE: Object to form. You can answer.

A. I'm really having trouble following you. What -- what do you mean by cannot obtain an abortion?

Q. Well, as you understand, the law does not permit a medication abortion in cases of pregnancy of unknown location, correct?

MR. BOYLE: Object to form. You can answer.

A. That's correct. But if the patient has a pregnancy of unknown location, it's -- you must triage that patient to either a diagnosis of ectopic pregnancy, intrauterine pregnancy, or a failing pregnancy,

miscarriage. It doesn't mean that she can't have an abortion. I don't understand what you mean by that.

Q. If a patient prefers a medication abortion but she doesn't have a documented intrauterine pregnancy, do you believe that she can get an abortion under the law?

A. If she has an ultrasound that diagnoses her to have a living intrauterine pregnancy. If -- if she has -- if -- she could either have an ectopic pregnancy, in which medication abortion would be entirely inappropriate; she could have a miscarriage, in which case medication abortion would be inappropriate because she would have passed that demised fetus on her own or potentially needed follow-up down the road but certainly wouldn't have necessarily needed to -- to be treated for and charged for an abortion; or she has a viable intrauterine pregnancy that she could have an abortion.

So I'm -- I'm just not understanding your question, maybe. Maybe I just don't -- I don't get what you're saying.

Q. You understand that some patients prefer

medication abortion over surgical abortion, correct?

A. Yes. And those patients have the option to get it when an -- a vi- -- an intrauterine pregnancy is seen.

Q. And if they don't have a documented intrauterine pregnancy --

A. Then they must be triaged to a diagnosis of either intrauterine pregnancy, failing pregnancy or miscarriage, or ectopic pregnancy.

Q. And what does triaging mean?

A. You apply the appropriate diagnostic procedures to make -- to identify the location of the pregnancy.

Q. And if a patient refuses to comply with those diagnostic procedures, what happens then?

A. Then you have an obligation to not administer a medication that could -- that she either doesn't need or would not be effective.

Q. Does anything in the law require that woman to then seek ectopic screening elsewhere?

MR. BOYLE: Objection.

BY MR. MENDIAS:

Q. You can answer.

A. I don't understand the -- the legal issue. I mean, I'm here as a witness on medical issues; I can't speak to the legal issue.
Q. Okay. You've read the laws in question?
A. Yes, I have. But, again, I'm -- I'm here to speak to the -- to the -- to the -- the medical issues as an expert.
Q. Okay. So in Paragraph 268 of your declaration...
A. Just give me one moment, sir.
Q. Sure.
A. Yes.
Q. So you say that if a patient's h- -- well, you quote Dr. Farris who says that if a patient's hCG levels are sufficiently high, this may be evidence of ectopic pregnancy, correct?
A. Yes.
Q. And you suggest that implicit in that statement is that the patient must now undergo surgical abortion in addition to medical abortion; is that correct?
A. Okay. What I say is, Implicit in this statement is the fact that because appropriate diagnostic steps to rule out

ectopic pregnancy were not taken at the time of the patient's initial visit, she must now undergo surgical abortion in addition to medical abortion.

Q. So --

A. So that's what I said and what I mean by that is the fact that if the patient had had an ultrasound that could confirm a diagnosis of intrauterine pregnancy, ectopic pregnancy, or miscarriage, she would have not received a medication that she did not need and then she would not have had to have both a medical abortion and a surgical abortion.

Q. Is it your understanding that PPSAT only offers the patient the option of a surgical abortion in this circumstance?

A. That's not what I said here. What I said is that the patient has already undergone a medical abortion and now, because she did not have an ultrasound to triage her to the appropriate diagnostic category, she has to have a surgical abortion in addition to her medical abortion.

Q. Well, what is your basis for saying that she has to have just now or in the report she

must now undergo a surgical abortion?
A. Because that's what their protocol says. It says that if the hCG is elevated, they would now do a surgical abortion. If there were -- was no -- if there were no chorionic villi or gestational sac on that surgical abortion, then she would have to go and be seen for an ectopic preg- -- to diagnose an ectopic pregnancy, whereas, if they had done the transvaginal ultrasound initially and said, okay, this is either -- we -- we don't -- this is either a -- we can't really tell what this is, this could be a miscarriage, this could be an ectopic pregnancy, it could be an intrauterine pregnancy, and had tri- -- triaged her to the appropriate diagnostic category, she would not have had to undergo those procedures and pay for both of those.
Q. So my question is, if a patient returns after a medication abortion with high hCG levels, you believe the only option PPSAT says to her is a surgical abortion?
A. No.
Q. What else do they offer her?
A. First of all, again, I'm not talking about --

I am talking about in the pre- -- patient with a pregnancy of unknown origin where you -- they did not do a screening ultrasound to ascertain the location of the pregnancy. If they then -- they did not do that ultrasound, she comes back with high hCG levels, they have no basis -- no diagnostic basis for -- to have triaged her into one of those three categories, then their own protocol says that they perform a surgical abortion.

Q. You believe that the protocol only includes a surgical abortion at that point?

A. No. That's not what I'm saying. I'm saying that is what their protocol says is part of their algorithm.

Q. Do you believe a physician provides substandard care if they do not provide every medical service a patient might need?

A. I don't -- I think that that's a -- it's a question that I really can't answer because it's -- a patient's perception of need has nothing to do necessarily -- or may not have anything to do with actually what's medically appropriate.

Q. When you treat patients, do you occasionally refer them for services that you do not provide?
A. Yes.
Q. Do you think that that's a shortcoming of your medical practice?
A. Well, not so much in my current medical practice, actually --
Q. It's something --
A. -- because I'm a hospitalist and my primary responsibility is patients in labor.
Q. Do you believe that a physician who practices in an outpatient setting and refers a patient for medical services that physician does not provide is deficient in some way?
A. Not necessarily. Depends on the clinical situation.
Q. Are you aware of any early medication abortion patients who have experienced negative outcomes from an ectopic pregnancy as a result of PPSAT's protocol?
A. No.
Q. In Paragraph 351 of your report --
A. Yes.
Q. -- you discuss a study by Barnhart, et al.,

correct?

A. Yes.

Q. And you say -- one moment. And -- okay. Actually, Paragraph 354 you say in reference to this study that, Performing a medical abortion without identifying the location of pregnancy goes against the recommendations in this paper.

Where in Barnhart, et al., do they discuss medication abortion?

A. They talk -- it's -- it's -- the point that I'm trying to make there is not Barn- -- whether Barnhart discusses medication abortion. The point -- the overarching and much bigger point and the reason why there is an enormous literature on pregnancy of unknown location is that you must triage a patient -- as it says in Paragraph 353, Pat- -- patients must have an ultimate diagnosis of an IUP, an ectopic pregnancy, or spontaneous resolution of a pregnancy.

That is the point that I'm trying to make. It's not whether they mention medication abortion or not. It is simply one of the best studies that synthesizes the

available consensus on pregnancy of unknown location.

Q. So does the paper discuss medication abortion at all?

A. It doesn't discuss it, but that's not why I included it. The reason I included it here is because it clearly states unequivocally and as consensus that pregnancies of unknown location must be appropriately diagnosed -- triaged into appropriate diagnostic categories. That is the important point that I'm trying to make here.

Q. I know you say that you are a hospitalist now, but did you provide treatment to patients in an outpatient setting?

A. Yes.

Q. Did you provide prenatal care to patients in an outpatient setting?

A. Did I?

Q. Yes.

A. Yes.

Q. When you did provide prenatal care to outpatients, at what point in pregnancy do you typically begin seeing them for prenatal care?

A. I started seeing them sometimes from very soon after they had a positive home pregnancy test.
Q. Can you estimate about how many weeks since the patient's last menstrual period that would have been?
A. So typically, for most women, they present for care if they've done a home pregnancy test early because they -- they -- when they come in to see -- see us, it's typically sometime between six and ten weeks I would say.
Q. And when you provided prenatal care in an outpatient setting, when would your patients typically receive their first ultrasound?
A. As soon as they came in or maybe within a week after they came in if they couldn't stay for an ultrasound.
Q. And what sort of ultrasound was that?
A. Usually transvaginal -- abdominal and if, you know, we couldn't see anything, then transvaginal.
Q. And in Paragraph 358 of your declaration you discuss -- well, apologies. You -- you first cite the study in Paragraph 356 but are

discussing it there, a study by Borchert, et al., correct?
A. Yes.
Q. And that is coauthored by Dr. Boraas, an expert witness for plaintiffs in this case, correct?
A. Yes.
Q. And you assert that, With a high loss-to-follow-up rate, no conclusions can be drawn related to risks for complications, right?
A. Yes.
Q. Is there anything in the paper that you read that suggests the patients who were lost to follow-up were different in any meaningful way from the ones who remained in the study?
A. You can't say. They -- they were lost to follow-up so you can't say.
Q. Do you think that there was any information taken about those patients initially?
A. I think that some information was taken, but there's absolutely no way to determine from the paper how the patients -- how the distribution of risk factors or sociodemographic factors or anything else

differed between the patients lost to follow-up versus the ones that stayed.

Q. Dr. Wubbenhorst, you submitted a report to the Inter-American Court of Human Rights, correct?

A. Yes.

Q. And that was specifically an expert opinion in support of the Republic of El Salvador in a legal challenge to the application of its abortion ban for a woman known as Beatriz, correct?

A. Yes.

Q. Is it fair to say that you support El Salvador's abortion laws?

A. Yes.

Q. Are you aware that abortion in El Salvador is illegal in every circumstance?

A. Yes.

Q. Are you aware that it is punishable by up to 40 years in prison?

A. Yes.

Q. Are you aware that there are dozens of women currently imprisoned in El Salvador?

A. I was not aware of that.

Q. Do you believe that pregnant women in North

Carolina who seek and obtain abortions should be criminally prosecuted?

A. I think I said earlier in this deposition that I do not believe that women should be prosecuted. If I didn't say it then, then I'm going to say it now. I think that we need compassion for women. We need to help them to see that there are alternatives to abortion and help provide the -- that -- those alternatives, whether it's financial, whether it's walking with them through pregnancy. In talking with many, many women who were looking at having abortions, the number one thing they have said to me is, I have no one to go with me through this pregnancy. So I think that if we can provide that, that's what we do. I do not agree in prosecu- -- -cuting women or putting them in jail just to be very clear.

Q. If you don't agree with that, then what motivated your expert opinion -- or what motivated you to submit an expert opinion in support of a country that does such a thing?

A. I'm not a lawyer and I don't necessarily agree with that, but the goal -- the stated

goal of the challenge to El Salvador's law was to create abortion on demand at any gestational age. The people challenging the statute were very clear that that was what they were trying to do. I do not agree with that. How El Salvador deals with the question of pregnant women who have abortions is -- I don't nec- -- I do not agree with that. I'll be very clear with that. But I do not agree that their laws should be overturned -- and not just El Salvador but the rest of Latin America -- their laws should be overturned to allow abortion on demand at any gestational age.

Q. Do you believe that Beatriz was seeking abortion on demand at any age?

A. I'm very familiar with the case. She was not. She was seeking the -- looking for an abortion because her child had anencephaly. However, as I've just said, the people who are seeking to overturn -- -turn the laws have made it very clear in multiple arenas that that was their goal.

Q. But Beatriz's family was a participant in this litigation, correct?

A. The -- I don't know. I don't know.
Q. It's also true that Beatriz suffered from lupus, correct?
A. That's correct.
Q. And isn't it true that women with lupus occasionally suffers negative pregnancy outcomes as a result of the lupus?
A. But I'm going to return to something I said earlier. You cannot predict whether a given woman -- all of our strategies around risk are population-based risk stratification strategies. They do -- cannot predict whether a single patient will undergo a complication. And in her case, she did not.
Q. And my question is whether a woman with lupus -- at a population level, women with lupus, if they face higher risks of complications during their pregnancy as a result of lupus.
A. They do. And if those complications occur, then we intervene appropriately.
Q. And do those women also experience a higher rate of death during pregnancy as a result of lupus?
A. With good medical care, it is very unusual.

And as I've said, if a woman develops complications like nephritis, encephalitis, any other complication from lupus, we intervene urgently and do what is best for the mom.

Q. Do you believe that El Salvador is a place that provides good medical care to women with lupus who are pregnant?

A. From reviewing the -- her chart, which I did, I reviewed her chart in its entirety, yes, they provided excellent medical care.

Q. She had a C-section at 26 weeks, correct?

A. That's correct.

Q. Do you believe that is the standard of care for a woman who seeks an abortion at 13 weeks because of health concerns?

A. It has nothing to do --

MR. BOYLE: Objection to form. You can answer.

A. It has nothing to do with abortion. It has to do with the clinician's assessment of what was the appropriate management for her at that stage.

Q. If Beatriz decided that she didn't want to bear the risk, whatever it might be, for any

individual woman with lupus --

A. Bear the risk of what?

Q. A negative complication or death from lupus during pregnancy, the standard of care is to deny her an abortion you feel?

MR. BOYLE: Objection to form. You can answer.

A. I don't think we're talking about a standard of care; we are talking about the law. The law states that abortion is illegal. If she had a complication and she needed to have urgent delivery, that is not an abortion. I've made that clear previously and I think you understand that. That is not an abortion. That is simply acting to preserve the life of the mother, but the intent is not to kill the -- the infant.

Q. But you did refer to good medical care that met the standard of care that Beatriz allegedly received, correct?

A. Because I reviewed the chart and I felt that she did receive good medical care.

Q. And you say that that care helped her achieve a goal of good medical care during pregnancy, correct?

MR. BOYLE: Object to form.

A. I don't understand your question.

MR. MENDIAS: So I can -- I'll mark this as an exhibit. Thank you.

(WUBBENHORST EXHIBIT O, Expert Opinion Report, Dr. Monique Chireau Wubbenhorst, Beatriz, was marked for identification.)

MR. BOYLE: Thank you.

MR. MENDIAS: Uh-huh.

A. Great. Thank you for providing this.

Q. Uh-huh. So on Page 38 of that report, the first nonindented paragraph, the one that begins, Like other women --

A. Yes.

Q. -- can you read the first two sentences --

A. Uh-huh.

Q. -- of that paragraph.

A. Like other women, Beatriz had the right to enjoy a good state of health to the extent possible given her lupus. Good medical care that met the standard of care helped her achieve that goal during her pregnancy.

Q. So you believe her goal was to have an emergency C-section at 26 weeks?

A. I'm not understanding your question. If

she -- she -- that was not her goal, but that was an outcome of her pregnancy based on the clinicians that were caring for her. And in my review of the chart, that was an appropriate decision.

Q. Her goal was to have an abortion at 13 weeks, wasn't it?

A. I can't -- I'm not speaking to that question of what her goal was or what her goal was not. The question here is good medical care met the standard of care that helped her achieve the goal of having a -- a good state of health during pregnancy. That is the question that I am opining -- I opined on in here.

Q. Do you believe that the risks of a C-section at 26 weeks of pregnancy are greater than the risks of an abortion at 13 weeks of pregnancy?

A. Again, I don't think that that is a relevant concept here. She continued her pregnancy. She needed an emergency cesarean section at 26 weeks for indications that were well understood, that were -- reflected good medical care. It was -- would have been

impossible to foresee that she was going to need a cesarean section at 26 weeks and so, therefore, you can't compare the outcome of her having an emergency C-section with the outcome of her having an abortion. She had good care. She got, from my viewpoint -- again, reviewing the chart in detail, she had good care and when it was necessary to deliver the baby, this was the mode of delivery that was chosen.

Q. Okay. But my question was whether the -- you believe that the risk of complications is higher from a 13-week abortion than a C-section at 26 weeks.

A. No. I think the risk of complications is higher for -- I think the com- -- risk of complications is higher for an -- for a cesarean section 26 weeks, but I don't think that's relevant to the question here.

Q. But she sought an abortion at 13 weeks, correct?

A. That's correct.

Q. And if she had been permitted to obtain an abortion at 13 weeks, the risk for complications for a 13-week abortion would

have been relevant to her, correct?
A. I don't think so because, again, she could have had an abortion at 13 weeks and had perforation, had infection, had hemorrhage. She could have had any one of a number of outcomes. As I've said, risk is population stratified. You cannot say what could or could not have happened. That's speculative. I can't respond to that.
Q. The population of women having C-sections at 26 weeks undergo much higher risks of complications than the population of women --
A. But we're not --
Q. -- obtaining abortions --
A. -- talking about --
MR. BOYLE: Object. Object to form.
BY MR. MENDIAS:
Q. -- at 13 weeks.
A. We're not talking about --
MR. BOYLE: Object to form.
THE WITNESS: Okay.
MR. BOYLE: You can answer.
THE WITNESS: Thank you.
A. We're not talking about population; we're talking about her. You can't say that she

would have had no risk to an abortion at 13 weeks. You can't say that. And she didn't have any complications from her cesarean section at 26 weeks. She died in a car accident a few years later.

Q. Do you believe that her death was attributable to the fact that she wanted an abortion?

A. No. She died in a car accident.

Q. In Paragraph 47 of your report you say that, Black women have two to three times higher mortality from abortion compared to white women.

A. Give me -- give me a chance to get there. Give me a chance to get there. Yes.

Q. Do you know if black women also have a higher mortality from childbirth than white women?

A. Yes, they do.

Q. Why would the mortality rate be higher for black women from both abortion and childbirth?

A. Because I think there are underlying comorbidities that are more common in African-American women, in particular diabetes and hypertension. I think the other

reason that it's difficult to make that comparison is that if you look at maternal mortality statistics, the morbidity and mortality for African-American women tends to cluster in older ages and typically, women undergoing abortion -- late abortion may be older as well, but that discrepancy is most likely due to -- although it's -- you know, there's -- this is a very active area of research. -- that those differences are probably due to the distribution of underlying health factors and possibly to access to care as well.

Q. And in Paragraph 19 of your declaration you reference, the deliberate targeting and destruction of 17 million African-American lives through abortions since Roe; is that right?

A. Yes.

Q. Who deliberately targeted African-American women for abortion?

A. I think that if you look at the history of -- of abortion and specifically population control, it is very clear that black women and African-Americans in general were seen as

the other -- especially in eugenic terms. That's going all the way back to Galton and Darwin and those other folks. But as you continue that thread through the 20th century, Fredrick Osborn said that abortion is turning out to -- and contraception turning out to be great eugenic advances of our time. Others have said that abortion is -- I think it was Lawrence Lader said that abortion is -- is -- is especially useful given in minorities who are likely to rise up in armed rebellion. So you have a consistent thread of a worldview that says that African-Americans are subhuman and, therefore, that the -- that abortion can -- has the potential for being a eugenic tool of injustice.

Now, I want to be very clear in saying that I am not saying that individual abortion providers have eugenic intent in performing abortions. I want to be very clear in saying that. What I am saying is that the outcomes of policy, especially as -- and practice especially as they are related to abortion have led to eugenic outcomes, namely, that

most abortions occur in African-Americans even though we constitute only 13 to 14 percent of the population, that the African-American population principally because of abortion is in decline and has been since the 1990s in terms of the number of births every year.

So that's the point that I'm trying to make, not attributing intent to anyone because I can't know someone's intent, but the outcome remains the same.

Q. Is it possible to have deliberate targeting without intent?

A. I think you can -- again, I'm looking at the outcome.

Q. Do --

A. I understand -- I understand what you're saying, but, again, if the result is that you have this enormous racial disparity in abortion, I can't ascertain intent, but the eugenic outcome is -- remains the same.

Q. And you can't ascertain whether it's deliberate, correct?

A. What's that?

Q. And you couldn't ascertain whether the

discrepancy is deliberate?
A. Then how else would you arrive at the -- at the discrepancy if it's not deliberate on some level and --
Q. So the --
A. -- and especially if policy, especially population control policy, has been directed in -- in -- along those lines --
Q. Since --
A. -- since --
Q. -- 1972 -- '73?
A. No. Since -- since before that. Since the Nixon era and since the 1960s. This -- this antedates 1973. This has been going on for a while.
Q. Okay. So, Doctor, I'm curious specifically who you say is deliberately targeting and destroying 17 million African-American lives.

Can you identify who's doing that deliberate targeting?
A. I think that -- again, I am looking at the outcome and I am looking at the fact that, whether we like it or not, that disparity exists. Whether we like it or not, the ugly fact is that we have had 17 million

African-American lives destroyed, that we are looking at the decline in the number of births to African-American woman -- women, that for every three births to African-American women that occur, there are two abortions.

So whether an individual practitioner makes a deliberate -- is deliberately targeting African-Americans, I don't know. That may be true; that may not be true. But as a policy statement, the net out- -- the net outcome is the same.

Q. Do you believe that African-Americans who obtain abortions are complicit in eugenics?

MR. BOYLE: Objection.

BY MR. MENDIAS:

Q. You can answer.

A. I'm not -- I don't know what that statement means. How can you be complicit in eugenics because eugenics is a worldview? Eugenics says that one group of people is human and one group of people is not human and because this group of people is not human, you can subject them to anything, any kind of mistreatment, any kind of suppression.

That's -- that's the essence of eugenics as defined by Galton in his speech in 1901. He was very clear, according to Darwinian theories, that some people were the fit and others were not the fit. And the slogan of the -- one of the slogans of the American Eugenics Board was less from the fit -- less from the unfit, more from the fit. That's one of the goals of eugenics.

Q. Changing topics a little bit, Doctor, what is, in medicine, an off-label use?

A. It's when a medication has been approved for one specific indication but physicians use it for another indication.

Q. Have you ever prescribed medications for uses that differ than what's on their FDA-approved label?

A. Yes. This is something, actually, that -- for a number of different medications, using nifedipine to control blood pressure in pregnancy. There's -- there's a list of -- of those -- of those medications.

Q. Is off-label use common in obstetrics and gynecology?

A. I can't speak to how it's common -- whether

it's common or uncommon. I know that it's something that I do and that many of the clicians -- clinicians that I know do as well.

Q. In going back to something we talked about much earlier today, you mentioned that you had seen -- that you had treated patients who were suffering from postabortion complications outside the United States; is that right?

A. Yes.

Q. Where did you treat those patients?

A. Kenya.

Q. Is abortion legal in Kenya?

A. No. Well, it's -- the current status is that it's -- I believe it's legal with restrictions. I would have to check on the exact -- the laws changed recently.

Q. Was abortion legal in Kenya when you treated these patients?

A. Yes --

Q. How --

A. -- for specific indications. And the patients that I treated were actually not -- had not been aborted by, like, back alley

abortions or, you know, self-abortions. The abortions were carried out by NGOs, nongovernment organizations, who had set up abortion clinics in those areas and then when their patients -- when those patients had complications, they would -- they would come in and be seen.

Q. Did you ever report NGOs performing illegal abortions in Kenya to anyone?

MR. BOYLE: Object to form. You can answer.

THE WITNESS: What's that?

MR. BOYLE: Object to form. You can answer.

A. Yeah, I don't know what the indication was for the abortions.

Q. So another topic. We discussed earlier forensic use of the products of conception after an abortion to identify a rapist.

A. Yes.

Q. Do you remember that? Do you know what protocol PPSAT follows for maintaining a chain of custody when it provides an abortion to someone who's been a victim of rape?

A. No.

Q. You believe that a major flaw in studies demonstrating the safety of abortion is that they don't include review of patient medical charts, correct?

A. I wouldn't say it's a --

MR. BOYLE: Object to form.

THE WITNESS: Okay.

MR. BOYLE: You can answer.

THE WITNESS: Okay. Thank you.

A. No, sir. I wouldn't say that it's a major flaw because sometimes I think you have to work with the data that you have and sometimes the data that you have is not perfect.

MR. MENDIAS: Can I ask how long we've been --

THE REPORTER: I have three hours.

MR. MENDIAS: Three hours. Do you want to take a brief break?

THE WITNESS: Thank you, sir. That would be great. Another bathroom break would be great. Oops. Wait.

THE VIDEOGRAPHER: Going off the record. The time is 4:46.

(Whereupon, there was a recess in the

proceedings from 4:46 p.m. to 5:04 p.m.)

THE VIDEOGRAPHER: Back on the record. The time is 5:04.

MR. MENDIAS: So, Counsel, I'd just like to request given that Dr. Wubbenhorst stated that she has an updated CV if, Ellis, you could provide that by the end of the week.

THE WITNESS: No problem at all. Yeah.

MR. MENDIAS: Wonderful.

THE WITNESS: Uh-huh.

BY MR. MENDIAS:

Q. Okay. So, Doctor, you testified that abortion patients with complications do not frequently return to the clinic that provided the abortion; is that correct?

A. That's correct.

Q. What's your basis for that statement?

A. I believe it's in my declaration that ACOG noted that 50 percent or fewer of patients returned to clinic following their abortion.

Q. Do you know what year that ACOG statement is from?

A. I'd have to look in here.

Q. Do you know if that's examined data from

North Carolina?

A. I don't know if that was including Nor- -- data from North Carolina.

Q. And going back to our conversation about intrauterine adhesions after a D&C, you remember that, correct?

A. Yes.

Q. So I think I asked how frequently your patients had developed intrauterine adhesions, but I just wanted to clarify.

Have any of your parent -- patients that you've provided a D&C to developed such adhesions?

A. So I have cared for women who have developed intrauterine adhesions following prior D&C. I have not seen my -- any of my own patients who I performed D&C on return with intrauterine adhesions.

Q. Is it possible that they sought care for intrauterine adhesions from other providers?

A. I think that's possibly it. I think it's also that I've practiced in a lot of geographic locales over, you know, the last 30 years so it's entirely possible that if they developed them, they could have seen

another provider.

Q. And what does it mean if a patient has developed an intrauterine adhesion in terms of consequences for her health?

A. So with Asherman's syndrome, intrauterine -- intrauterine adhesions, they're associated with infertility and dysfunctional uterine bleeding.

Q. Do you characterize that as a serious condition?

A. With -- in the case of dysfunctional uterine bleeding and -- I -- and I -- there's another entity with which they're associated and that's abnormal placental adherence and that's actually quite serious.

Q. How frequently do patients develop abnormal placentation as a result of Asherman's syndrome?

A. I think that I describe that in my statement and I can take a look and see, but the real question was not so much the frequency because, again, it's hard to get at the frequency. It's that when patients develop intrauterine adhesions, they are at higher risk for going on to have abnormal

placentation and -- leading to adhering placenta, which is a real obstetrical problem.

Q. When you provided prenatal care to patients, did you tell them about ectopic pregnancy?

A. I am not following your argument.

Q. Well, it was a question. When you --

A. I mean, your question. I'm not following your question. Sorry.

Q. When you provided prenatal care to your patients -- you remember testifying that you did that, correct?

A. Yes. Yes.

Q. Did you counsel them on symptoms of ectopic pregnancy?

A. If they came in and they did not have a -- a pregnancy that could be seen in the uterus on ultrasound, definitely.

Q. And what did you say to them as part of that counseling?

A. So if we did not see a pregnancy on -- then we would warn them that they might have a -- a -- an ectopic pregnancy, describe what an ectopic pregnancy was, what the risks were. And then they would return within 48 hours so

that we could rescan them and recheck their hCG.

Q. Did any patients not return?

A. I've never had a patient not return.

Q. What symptoms would you counsel them to look for concerning a ruptured eptoc- -- ectopic pregnancy?

A. Well, I think that it's important to make a distinction here between symptoms of ectopic pregnancy which are transient and fleeting -- and, in fact, I wrote a paper -- cowrote a paper in the Journal of American Medical Association some years back that looked at the unreliability -- how reliable were different symptoms.

So the diagnosis of a ruptured ectopic pregnancy is fairly straightforward. Women will often say they felt a pop, they experienced terrible pain in their right side, and they may feel faint. But one of the problems that arises with that is that they don't always associate that with -- they think, oh, I have, you know, a ruptured cyst or something like that. And so the real danger is that they are not symptomatic

enough that they seek medical care and they bleed and bleed. And healthy young women have an amazing ability to adapt to loss of blood, but once they run out of those adaptive capabilities, they just die. So this is why diagnosing ectopic pregnancy is so treacherous. Yes, if they rupture, it's a little bit more straightforward, but even sometimes when they're rupturing, it's not until they become faint or pass out or have some other complication. And before that, it's -- it's -- it's very protean. It can be very difficult. They can -- they can have bleeding that looks like a miscarriage and they'll think that they've miscarried, for example.

Q. At what point in pregnancy does ectopic pregnancy typically present on an ultrasound?

A. So are you talking about at what point in pregnancy is it typically diagnosed, sir? Is that what you're saying?

Q. Sure.

A. Right. So usually, about the same time plus -- you know, plus a few weeks as you see an intrauterine preg- -- that you might

expect that you would see an intra- -- inter- -- intrauterine pregnancy you could potentially see an ectopic pregnancy. Again, the problem is that even with skilled hands, it depends on -- very much on the hCG level and there's some -- it depends on the hCG level and there are sort of formulae or algorithms that you use.

Q. So throughout your medical career as an attending, did you train medical residents?

A. Yes.

Q. Has a medical resident ever lodged a complaint about you?

A. No.

Q. Throughout your medical career have you ever faced any disciplinary action --

A. No.

Q. -- from a hospital?

A. No.

Q. Have you ever received any disciplinary or remedial action from a hospital?

A. No.

Q. Have you ever received any disciplinary action from a state medical board?

A. No.

Q. You were with the faculty of Duke University School of Medicine from 2003 to 2018?
A. Yes.
Q. It's correct that this is where you practiced medicine for the significant majority of your medical career, correct?
A. Yes.
Q. Under what circumstances did you leave Duke?
A. I was recruited starting in fall of 2017 to the U.S. Agency for International Development.
Q. How would you characterize your relationship with Duke when you left?
A. I would say that it wasn't great. I think that the -- it was hard to totally assess this, but I had a sense that they were not -- you know, they were -- people were not in favor of the pro-life work I was doing.
Q. What led you to that conclusion?
A. I think that people would say things to me.
Q. Such as?
A. You know, what -- what's the -- you know, why are you doing this, you know, that type of thing.
Q. So you weren't asked to resign from your

position at Duke?

A. No. No, I was not asked to resign.

MR. MENDIAS: Okay. I think that's all the questions that I have.

MR. BOYLE: Give me just a moment, if you would --

MR. MENDIAS: Sure.

MR. BOYLE: -- please. If -- if anyone on the Zoom has any questions, I'll -- I'll defer to y'all.

This is Ellis Boyle on behalf of the legislative leader defendants. I don't have any questions and I don't hear any from the Zoom so unless -- I -- I guess that concludes the deposition.

THE REPORTER: Sam?

MR. MENDIAS: Thank you very much, Doctor.

THE WITNESS: Okay. Thank you.

THE VIDEOGRAPHER: Anybody on the Zoom?

MR. BOYLE: No. I think -- I think we're -- we're clear. You can go off the record. Thank you.

THE VIDEOGRAPHER: This concludes the deposition. We're going off the record. The

time is 5:15.

[SIGNATURE RESERVED]

[DEPOSITION CONCLUDED AT 5:15 P.M.]

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

I, MONIQUE WUBBENHORST, M.D., M.P.H., declare under the penalties of perjury under the State of North Carolina that I have read the foregoing 187 pages, which contain a correct transcription of answers made by me to the question therein recorded, with the exception(s) and/or addition(s) reflected on the correction sheet attached hereto, if any.

Signed this, the _____ day of _____, 2023.

_____

MONIQUE WUBBENHORST, M.D., M.P.H.

State of:_____

County of:_____

Subscribed and sworn to before me this _____ day of _____, 2023.

_____

Notary Public

My commission expires:_____

E R R A T A S H E E T

Case Name: Planned Parenthood South Atlantic, Et Al. vs. Joshua Stein, Et Al.

Witness Name: Monique Wubbenhorst, M.D., M.P.H.

Deposition Date: Wednesday, August 30, 2023

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_____ _____

Signature Date

STATE OF NORTH CAROLINA)
) C E R T I F I C A T E
COUNTY OF WAKE)

I, LISA A. WHEELER, RPR, CRR, Stenographic Court Reporter and Notary Public, the officer before whom the foregoing proceeding was conducted, do hereby certify that the witness whose testimony appears in the foregoing proceeding was duly sworn by me; that the testimony of said witness was taken by me to the best of my ability and thereafter transcribed by me; and that the foregoing pages, inclusive, constitute a true and accurate transcription of the testimony of the witness.

I do further certify that I am neither counsel for, related to, nor employed by any of the parties to this action and, further, that I am not a relative or employee of any attorney or counsel employed by the parties thereof, nor financially or otherwise interested in the outcome of said action.

This the 4th day of September, 2023.

_____

Lisa A. Wheeler, RPR, CRR
Notary Public #19981350007

D

Q

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
4208 Six Forks Road
Suite 1000
Raleigh, North Carolina 27609
919-424-8242
www.discoverydepo.com

A P P E A R A N C E S:

Plaintiffs:

PLANNED PARENTHOOD FEDERATION OF AMERICA
BY: Anjali Salvador, Esquire
Dylan Cowit, Esquire
Shealyn Massey, Esquire
123 William Street, 9th Floor
New York, New York 10038
212-541-7800
anjali.salvador@ppfa.org,
dylan.cowit@ppfa.org, Shealyn.massey@ppfa.org
Counsel for Planned Parenthood South Atlantic
PLANNED PARENTHOOD FEDERATION OF AMERICA
By: Hannah Swanson, Esquire
Peter Im, Esquire
1110 Vermont Avenue, NW
Suite 300
Washington, DC 20005
202-973-4800
Hannah.swanson@ppfa.org, peter.im@ppfa.org
Counsel for Planned Parenthood South Atlantic

Counsel for the Plaintiff Beverly Gray:
American Civil Liberties Union Foundation
By: Ryan Mendias, Esquire
Brigitte Amiri, Esquire
125 Broad Street, 18th Floor
New York, New York 10004
212-549-2633
Rmendias@aclu.org
Bamiri@aclu.org

Counsel for all Plaintiffs:

American Civil Liberties Union of North
By: Carolina Legal Foundation
Kristi Graunke, Esquire
P.O. Box 28004
Raleigh, North Carolina 27611
919-354-5066
kgraunke@acluofnc.org
Counsel for the Defendant Joshua Stein

North Carolina Department of Justice
By: Sripiya Narasimhan, Esquire
114 West Edenton Street
Raleigh, North Carolina 27603
919-716-6421
snarasimhan@ncgov.gov
Counsel for Attorney General Joshua Stein
Ward and Smith
By: W. Ellis Boyle, Esquire
751 Corporate Center Drive, Suite 300
Raleigh, North Carolina 27607
919-277-9187
weboyle@ardandsmith.com
Counsel for the North Carolina Medical Board
and North Carolina Board of Nursing

North Carolina Department of Justice
By: Michael Bulleri, Esquire
114 West Edenton Street
Raleigh, North Carolina 27603
919-716-6600
Mbulleri@ncdoj.gov
Counsel for the Defendant District Attorney
Jim O'Neill

Bell Davis Pitt
By: Kevin G. Williams, Esquire
100 North Cherry Street, Suite 600
Winston-Salem, North Carolina 27101
336-722-3700
kwilliams@belldavispitt.com
Counsel for the District Attorney Defendants
(with the exception of Jim O'Neill)
North Carolina Department of Justice
By: Colleen Crowley, Esquire
Elizabeth Curran O'Brien, Esquire
114 West Edenton Street
Raleigh, North Carolina 27602-0629
919-716-0091
ccrowley@ncjog.gov
eobrien@ncdoj.gov
Counsel for Secretary Kinsley of the
Department of Health and Human Services

Alliance Defending Freedom

By: Julia Payne, Esquire

15100 North 90th Street

Scottsdale, Arizona 85260

800-835-5233

jpayne@adflegal.org

ALSO PRESENT:

Vanisha Kudumuri

Kara Grandin, Esquire

Kristi Graunke, Esquire

Elisa Sturkie

Vanisha Kudumuri

Carrie Rapaport - Videographer

I N D E X

E X A M I N A T I O N S

E X H I B I T S

SUSAN BANE, M.D., PhD, after having been first duly sworn, was examined and testified as follows:

VIDEOTAPE TECHNICIAN: Good afternoon, ladies and gentlemen. We are going on the remote video record on Thursday, August 31, 2023 at 2:05 p.m. I am Carrie Rapaport in association with Discovery Court Reporters in Raleigh, North Carolina. This is a matter pending before the United States District Court for the Middle District of North Carolina in the case captioned Planned Parenthood South Atlantic, et al. versus Joshua Stein, et al. and Philip E. Berger, et al. Case number 1:23-cv-00480-CCE-LPA.

This is the start of media one, volume one of the deposition of Susan Bane, M.D., Ph.D. The deposition is being taken on behalf of the plaintiffs. Starting with the questioning attorney, I will ask counsel to identify yourselves, state who you represent and whether co-counsel or your client are in attendance.

MS. SALVADOR: This is Anjali Salvador with Planned Parenthood Federation of America on behalf of Planned Parenthood South Atlantic. I do have co-counsel with me here today.

MR. BOYLE: Good afternoon. My name is Ellis Boyle, Wake County Bar. I am representing the legislative defendants Berger and Moore and I am joined by Julie Payne with the ADF who is co-counsel.

MS. GRAUNKE: Hi, everyone. I'm Kristi Graunke from the ACLU of North Carolina Legal Foundation, appearing for all plaintiffs. I'm joined today by Elisa Sturkie who is a UNC law student who is externing with us, and also by my co-counsel Brigitte Amiri and Ryan Mendias from ACLU's national office.

MS. SWANSON: Hi. This is Hannah --

MR. WILLIAMS: My name is --

MS. SWANSON: Oh, I'm sorry.

MR. WILLIAMS: Go ahead, Hannah.

MS. SWANSON: Thank you. This is Hannah Swanson also from Planned Parenthood Federation of America for Planned Parenthood South Atlantic.

MR. WILLIAMS: My name is Kevin Williams from the Forsyth County Bar and I represent District Attorney Jim O'Neill.

MS. NARASIMHAN: Good afternoon. My name is Sripiya Narasimhan with the North Carolina Department of Justice representing Attorney General Joshua Stein.

MS. O'BRIEN: Good afternoon. I'm Elizabeth O'Brien also from the North Carolina Department of Justice. I represent the DA defendants other than DA O'Neill and my clients are not present, nor is co-counsel.

MR. BULLERI: I'm Michael Bulleri, also with the North Carolina Department of Justice. I represent the North Carolina Medical Board, North Carolina Board of Nursing.

MS. CROWLEY: Colleen Crowley also with the North Carolina Department of Justice. I represent North Carolina Department of Health and Human Services.

VIDEOTAPE TECHNICIAN: Thank you. As the witness has already been sworn in, you may proceed, Counsel.

BY MS. SALVADOR:

Q. Dr. Bane, good afternoon and thank you for being here today. My name is Anjali Salvador and I'm one of the attorneys representing Planned Parenthood South Atlantic in this case. While we're talking here I might refer to it as PPSAT.

Could you please state your full name for the record?

A. Yes, I'm Susan Bane.

Q. All right. Thank you. We're going to start with some housekeeping and ground rules. Do you understand that you're under oath today the same way that you would be in a court room and that you're obligated to answer my questions truthfully and completely?

A. Yes.

Q. So as you heard, we have a court reporter with us today who will be taking down what we say for a transcript. So please make an effort to continue giving all of your answers verbally like you are instead of nodding or shaking your head. Okay?

A. Yes.

Q. Also, because of the transcript, we're going to need

to do our best not to talk over each other. So please wait for me to finish each question before answering and I'll wait for you to finish before asking my next question. Okay?

A. Yes.

Q. Great. I'll do my very best to ask clear questions. If you don't understand a question, please feel free to let me know and I'll rephrase it or repeat it, whatever you need. But if you do answer I'm going to assume you have understood my question. Okay?

A. That sounds good.

Q. Great. If at any point either in the moment or later in the deposition you realize that you have made a mistake with a prior answer or you want to clarify something, that's totally fine, just let me know. Okay?

A. Okay.

Q. If at any point you need a break, please let me or your attorney know and we'll take one, with the exception that if I'm in the middle of a question you'll have to answer it before we take that break.

Do you understand?

A. I do.

Q. During the deposition your attorney may object to some of my questions. But unless your attorney directly tells you not to answer the question, you still have to answer it.

Do you understand?

A. Yes.

Q. And have you turned off your cell phone like the videographer asked?

A. I have.

Q. Great.

A. Excuse me. Did you say turn off it or -- I muted it.

Q. It would be great if you could either -- definitely silence it, but turning it off would be preferable just so we know you're not looking at it during the deposition.

A. Okay. So I just have it turned over on its backside, plus it's muted.

Q. That's fine. So this is a little invasive and I apologize, but it's a standard question at the start of depositions. Are you dealing with any illness or taking any substance that would affect your memory or prevent you from being able to understand and answer my questions today?

A. No.

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

A. I have.

Q. How many times?

A. As in expert witness?

Q. Both as an expert witness or as a fact witness, if that's happened.

A. So I was an expert in a medical malpractice case and

then I have a son with special needs and I was an expert in a case related to him.

Q. Did either of those --

A. Sorry, I wasn't an expert. I was his mom.

Q. Understood. Did either of those cases relate to abortion in any way?

A. They did not.

Q. Other than the report you submitted in this case, have you submitted a -- I'm sorry, the declaration -- have you submitted a declaration in a legal case before?

A. I have not.

Q. Have you testified in any court before?

A. Yes, in the case that I was the expert witness, the malpractice case.

Q. Got it. What -- so you said you were an expert in that case, correct?

A. Correct.

Q. So you were not a party in that case?

A. No, I was not.

Q. Have you testified before any legislative body?

A. Yes.

Q. Can you describe that testimony, please?

A. Sure. I have testified three times at the North Carolina State Legislation. One was on the Bill SB20. One was on a conscience right, conscience protection bill, and the

other was on the bill related to gender affirmation care in minors.

Q. Got it.

MS. SALVADOR: Counsel, at the break could we get copies of that testimony, please?

MR. BOYLE: Are you asking me?

MS. SALVADOR: Yes. I think we had asked you to produce Dr. Bane's testimony as one of our requests for production.

MR. BOYLE: I don't think she has it.

MS. SALVADOR: Okay.

BY MS. SALVADOR:

Q. Dr. Bane, was that verbal testimony?

A. Yes.

Q. Okay. Could you describe the nature of your testimony on SB20, please?

A. Yes. I was one of -- I believe they had 10 individuals have -- I think we had one-and-a-half -- one or two minutes and it was -- so it was the public who could testify. I think they had 10 of us who supported the bill and 10 who did not. And so I spoke as a citizen of North Carolina and a medical doctor, an ob-gyn, why I supported the bill.

Q. Why did you support the bill, according to your testimony?

A. I supported the bill because as a medical doctor I

don't believe the direct and intentional killing of another human being is part of medical practice and that for 50 years we have basically had unfettered access to abortion in the United States and it has not impacted maternal mortality, that women in North Carolina need solutions, not greater access. And that we need to look at root causes. And that this bill has provisions to support women who are in that position of an unplanned pregnancy and have socioeconomic, typically, factors are the main ones that both the literature and I see in my practice as the reasons and there are provisions in the bill to support them.

Q. Thank you for that description. You mentioned that you also testified on a bill relating to I believe you said freedom of conscience, is that correct?

A. I did.

Q. Could you please describe your testimony for that bill?

MR. BOYLE: Objection. I want to put on the record that there's been a lot of comment from the plaintiff's side about focusing this case on -- at this stage of discovery on the preliminary injunction hearing and I don't know if she may be talking about something that's germane to that.

MS. SALVADOR: That's a speaking objection and speaking objections aren't allowed under the rules. So your objection is noted.

BY MS. SALVADOR:

Q. Dr. Bane, if you could please answer.

A. Sure. So I don't have in my head what I said as fresh, but I spoke basically about the fact that conscience rights, so what is ethically and morally allowed -- that we have a right both as healthcare practitioners of all sorts to be able to recognize our conscience and not have to do things that go against our conscience. I would say that's the gist of what I talked about.

Q. And you said the third bill was related to gender, is that correct?

A. Yes.

Q. Was there anything in your testimony related to abortion for that bill?

A. No.

Q. Got it. Thank you. Do you have any notes or files related to this case with you right now either in front of you in hard copy or open digitally?

A. I don't have anything open digitally that I can see. If you ask me to go to something I have digital copies of things. I have my clean copy of my declaration here and then I have -- sometimes when I listen I like to take notes, so I have this pad which I put all your names when you introduced yourselves, but it's empty otherwise.

Q. Understood. Thank you.

A. And then over -- way over -- I'm in a hotel room, a desk, I have all the copies of -- in my declaration of the references I used. Actually I probably have the majority of them. Some were digital and too long.

Q. Got it. Thank you. So when were you first contacted about participating as an expert witness in this case?

A. I think it was about a month ago.

Q. And who specifically have you communicated with regarding this case?

A. Julia Payne with ADF reached out to me and then -- and I have talked to Ellis about it. The other person is Dr. John Thorpe who's at Chapel Hill. He is a colleague and friend of mine and was -- I think and potentially be involved and then they decided I would do it.

Q. What did you speak to Dr. Thorpe about?

A. He is experienced regarding -- he's done a lot of depositions. So I actually asked him because I had never done one with the law, what to expect with the deposition.

Q. Did he contribute any sources for you to use in your declaration?

A. He did not.

Q. Did he give you advice on what would go into your declaration?

A. No. We talked about the logistics of the deposition itself.

Q. And you mentioned that you thought he was originally going to be involved in this case. How do you know that?

A. When Julia reached out to individuals to potentially be in the case, he was one of the people on the email.

Q. Do you know why you rather than he are an expert in this case?

MR. BOYLE: I'm going to object and I'm going to instruct you not to answer that. That would be work product. That's protected.

BY MS. SALVADOR:

Q. Other than the folks you have already named, have you communicated with anyone else regarding this case?

A. No.

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

A. Can I go back to the last question? I have family -- my family knows I'm in the case. I'm a very literal thinker so when you said have you talked with anyone, of course some of my family and colleagues know about it, but not the specifics of my declaration.

Q. So they know that you're in a deposition right now, but do they know what you're talking about?

A. They know it's about SB20.

Q. Okay. But did you discuss the specific contents of your declaration with them?

A. No.

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

A. I'm providing my opinion on the hospitalization requirement and the documentation of an intrauterine pregnancy prior to chemical or medication abortion.

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

A. Yes.

Q. How much are you being paid for your participation in this case?

A. $500 per hour.

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

A. A lot. I can't quantify -- I don't have -- I mean, I have it written down elsewhere, but I haven't tallied it. But a month ago I was asked and I know towards the end of July I started working on a declaration and the declaration itself took several hours so...

Q. Would you say that since you were contacted you have spent several hours a week on this case?

A. Yes.

Q. Would you say you have spent more than 10 hours a week on this case?

A. Yes.

Q. Got it. Thank you. How did you prepare for today's deposition?

MR. BOYLE: I'll just instruct you not to discuss anything specifically that you said with your lawyer, but you can answer generally.

THE WITNESS: Sure. It was -- sorry. And I'm sorry -- is it -- how do I pronounce your name?

BY MS. SALVADOR:

Q. Sure. It's Anjali.

A. Anjali. And you asked me specifically for today?

Q. No. How did you prepare generally for today's deposition, without revealing the contents of any conversation you had with your attorneys?

A. Sure. So really reviewing my declaration was the biggest thing and then reviewing the responses from the other individuals who are witnesses. They have declarations too.

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

A. I did not.

Q. You mentioned reviewing your own declaration and the other declarations in this case. Did you review any other documents to prepare for this deposition?

A. So I -- the resources that I used and then some of the other literature in this area I reviewed.

Q. When you say some of the other literature in this area, what do you mean by that?

A. Literature related to complications related to pregnancy. I think all the ACOG guidelines I used are part of my references, so they are above and -- I mean, I already said I included those. I did get information about Planned Parenthood South Atlantic and their policies, as well as some of the other information they provided. For example, numbers that they -- of abortions they do in their centers and things like that.

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

A. I prayed.

Q. So you have -- you have already mentioned that you prepared an expert declaration in this case, right?

A. I have.

Q. Okay.

MS. SALVADOR: So I am going to drop it into the chat so that every one can access it. It's already been premarked as an exhibit. I believe it is Exhibit-P.

- - -

(Document marked as Exhibit-P for identification.)

- - -

BY MS. SALVADOR:

Q. So Dr. Bane, is this an accurate copy of the -- well, first I should say, are you able to open the document that I dropped into the chat?

A. Let me try because I have my own copy, so I wasn't looking to do that. It's wanting me to save it first, so just a sec.

Q. Sure.

(Pause.)

A. Yes, I have it now.

Q. And is this an accurate copy of the expert declaration you submitted in this case?

A. Give me a minute.

Q. Sure.

(Pause.)

A. Yes, it's what I submitted.

Q. Thank you. And if it's easier, for your purposes, to refer to your paper copy rather than the digital copy, that's fine. We just needed to make sure that everyone on this deposition is looking at the same document.

A. Okay.

Q. Please describe the process of drafting this declaration.

A. So really understanding what specifically I was being asked to address was the first thing, which was the two things

I already mentioned regarding the IUP documentation requirement and hospital requirement and reviewing the literature related to that, including the maternal mortality report for North Carolina that I thought was an important document related to this.

Q. And did you write all of this declaration yourself?

A. One hundred percent.

Q. Have you read all of the documents cited in your declaration in their entirety?

A. Yes.

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

A. No.

Q. Have you discussed the contents of your declaration with anyone other than your attorneys?

A. No.

Q. Did you read the declarations that Dr. Farris submitted in this case in their entirety?

A. Yes.

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

A. I looked at them, but I can't say that I read all of them.

Q. Got it. Thank you. And did you read the declarations that Dr. Borass submitted in this case in their entirety?

A. Yes. And I'll add that I had those when I was writing my declaration, so I should have included them as part of my answer regarding how I prepared this.

Q. Got it. Thank you. And did you read the sources cited in Dr. Borass's declarations?

A. I looked at them and -- so I can't say I read them from front to back.

Q. So I'd like to turn now to your C.V., which is Exhibit-A, attached to your declaration which we have already pulled up and you have in front of you.

So is this C.V. current?

A. It's very current. It's not current as of today. I have done two talks this week at a conference that aren't on there, things like that.

Q. Got it. Thank you. And you graduated from -- with a Bachelor of Science degree from Atlantic Christian College in 1987, correct?

A. Correct.

Q. And now it's called Barton College, is that right?

A. Correct.

Q. So we'll get to the specifics of your career in a bit, but am I correct that you also ended up working at Barton College for a number of years?

A. Yes.

Q. After you attended Barton College, you graduated from

the University of Illinois with a Master of Science in kinesiology in 1989, is that right?

A. Yes.

Q. And then you received a Ph.D. in kinesiology from the University of Illinois in 1995, is that right?

A. Correct.

Q. And you also got an M.D. from the same place in 1997, is that right?

A. Correct.

Q. Did those two programs overlap?

A. So they are -- it was a 10-year program from the standpoint of I went there in 1987 and I finished in 1997. So from '87 to '89 I did my master's degree and then I was in a M.D. Ph.D. medical scholars program. So I had a total of six years of graduate work with my master's and my Ph.D. and four years of medical school.

Q. Got it. Thank you. And you completed your residency in obstetrics and gynecology at the East Carolina University School of Medicine, right?

A. Right.

Q. And you completed that in 2001?

A. Yes.

Q. Are there any other educational credentials you have that are not on your C.V.?

A. Not that are graduate level degrees and a master

level. I have certifications, but I think they're all on my C.V.

Q. Okay. Thanks. So after you completed your residency, did you work as an ob-gyn?

A. I did. I was in private practice at Greenville Obstetrics and Gynecology in Greenville, North Carolina for nine years.

Q. And what were your duties at Greenville?

A. So in my practice -- it was a private practice, obstetrics and gynecology. We were part of a bigger group called Physicians East, which was a multispecialty group. So I did obstetrical care and gynecological care both in the office and in the hospital taking call. I had medical students and residents from the Brody School of Medicine at East Carolina that were with me. I also had students from UNC Chapel Hill who rotated with me.

Q. And in your declaration you state that you helped women deliver over 1,000 babies and supervised midwives who helped women deliver several thousand babies, is that right?

A. Correct.

Q. Did all of those deliveries take place in hospitals?

A. Yes.

Q. What is your familiarity, if any, with midwives in North Carolina delivering babies outside of hospitals?

A. I'm not familiar.

Q. And you mentioned your gynecological practice included gynecological surgery, is that right?

A. Yes.

Q. What type of gynecological surgery did you perform?

A. I performed D&Cs for miscarriage. I performed vaginal and abdominal hysterectomies. I performed urogynecological surgery. That was more limited. And I'm talking about basically in the hospital. If a woman had an ectopic pregnancy I would do laparoscopy for removing cysts, things like that.

Q. And just to clarify, you used a word -- did you say urogynecological?

A. Sorry, uro. U-r-o. So it's bladder issues.

Q. Got it. Thank you. And did you ever perform any of those procedures outside of the hospital?

A. Those procedures, no.

Q. Which of the procedures you mentioned, if any, did you perform outside of the hospital?

A. None of those procedures outside of the hospital.

Q. So you never --

A. So -- excuse me. We did have as part of our hospital a surgical center. So it would be like a same-day surgery center. So I don't know if you're calling that -- that was freestanding outpatient surgical center. So I didn't think of that as a hospital. But I did not provide any of those surgeries I mentioned in my outpatient clinic.

Q. Got it. Thank you. So you mentioned miscarriage D&Cs as one of the procedures you performed, is that right?

A. Correct.

Q. What are the risks of miscarriage D&Cs?

A. So the risks are -- the biggest one acutely is hemorrhage and infection. You can also have a uterine perforation and that can lead to damage of adjacent organs around the uterus, which are primarily bowel and bladder. And you can also have death.

Q. Thank you for that. And we'll go into all of those a little bit more later, but just kind of continuing with the description of your work at Greenville. In your work at Greenville did you ever prescribe contraception?

A. Yes.

Q. What types of contraception?

A. Hormonal and non-hormonal. So hormonal included birth control pills or patch, Depo-Provera, which is an injection shot, IUDs, tubal ligations, which are actually surgeries. I would say those are the main things.

Q. And in your work at Greenville did you ever perform abortions?

A. I did not perform induced abortions, which I'm using that as the CDC's definition of an induced abortion.

Q. What is that definition?

A. So it's an intervention that is designed to -- whether

it's a suspected or a documented pregnancy, to not result in a live birth.

Q. And so you referred to induced abortions as though they were one type of abortion, is that right?

A. Correct.

Q. What are the other types of abortion?

A. So abortion is a term -- it's an umbrella term in medicine and induced abortion is one type. We have what's called a spontaneous abortion, commonly known as a miscarriage. A threatened abortion would be when somebody comes into our office, maybe they're cramping or bleeding and we do an ultrasound and everything looks fine but they're possibly going to miscarry. There's incomplete abortions, which would be a woman who's in the middle of miscarrying. A complete abortion is typically she's already miscarried. So those are examples of terminology.

Q. So you described your practice as involving treatment of spontaneous abortions, by your definition, is that correct?

A. Yes.

Q. And colloquially is that referred to as miscarriage management?

A. Yes.

Q. So did miscarriage management ever involve providing patients with medication?

A. We could give that as an option, but it was primarily

expectant management, meaning if she was bleeding and didn't want to have a D&C, we had confirmed that she did not have a viable pregnancy. But often times we would do surgery or we would do expectant management.

Q. And that expectant management would sometimes involve providing the patient with medication, is that right?

A. No. I'm sorry. Them on their own doing it. So you can do medication management also.

Q. Okay.

A. We can do that. We just didn't have many people that wanted that option.

Q. Got it. But did you ever provide medication management?

A. Yes.

Q. Did that medication include Mifepistone and Misoprostol?

A. Just Misoprostol.

Q. Got it. Thank you. Did you ever provide Misoprostol to a patient outside of a hospital setting?

A. So if -- I can't recall a specific patient, but in terms of being able to -- if she had a miscarriage and hadn't passed it and wanted to have medical management, that was an option she was given.

Q. And that was an option that she would be given in an outpatient facility, is that right?

A. Yes.

Q. Did you consider providing Misoprostol to a patient in an outpatient facility to be safe?

A. Sorry, I heard a ding from somebody. Could you say it again? Did I consider it to be safe like doing that?

Q. Yes. That's right.

A. Yeah. So if it was clinically indicated, I'm going to do things that I think are safe and that the patient and I align with in terms of her, you know, shared decisionmaking in the process.

Q. And that would sometimes include providing Misoprostol to a patient in an outpatient clinic as part of miscarriage management, is that right?

A. Yes.

Q. To your knowledge did you ever provide Misoprostol to a patient where there was fetal cardiac activity still present?

A. No.

Q. Did your miscarriage management involve providing aspiration procedures?

A. If you're calling an aspiration procedure a D&C, yes, and that would have been at the hospital.

Q. Could you define a D&C, please?

A. So dilatation and curettage. But it -- in the past that was equated with sharp curettage where you would scrape the lining. And we know that that's associated with something

called Asherman's syndrome, which is adhesions. And so now I think the term is still used but it's usually with suction aspiration. But we still use the term D&C often.

Q. Have you ever performed a D&C, to your knowledge, where there was fetal cardiac activity present?

A. No.

Q. Did your miscarriage management involve any dilatation and evacuation procedures or D&Es?

A. No.

Q. Just one second, I'm going back and forth in my document just to make sure I didn't miss any questions. So you mentioned -- we were talking about your work at Greenville and your resume lists your work at Greenville and East Carolina University separately, but you kind of described them as together. So could you clarify that relationship, please?

A. Sure. So I was not an employee of East Carolina University. We were clinical facility members if we taught residents and had medical students on there. So I was employed a hundred percent by Greenville Ob-Gyn and part of Physicians East and I volunteered because I love to educate and had students with me. I also taught some lectures -- not regularly, but I did teach a two-week fourth year elective called Residency 101 and that was volunteer service work also.

Q. Go it. So in our discussion of your practice so far, is there anything different about your East Carolina practice

versus your Greenville practice?

A. I don't consider that I ever had an East Carolina practice. If it comes across as that in my C.V. I should change it. But no, I was never employed as -- I guess when I was a resident they paid me, but once I graduated from residency I was at Greenville Ob-Gyn.

Q. Got it. And in your teaching, did you ever teach your students about abortion?

A. No. I mean, I did do lectures on that, I guess I would say.

Q. Understood. So we have generally been talking about your ob-gyn practice from 2001 to 2010, is that correct?

A. Yes.

Q. Okay. And is there any part of that ob-gyn work -- or, I'm sorry. Have we discussed basically everything you did in your ob-gyn work?

A. No.

Q. So what else did you do as part of that ob-gyn work?

A. So I took call. I delivered babies. I did vaginally and vacuum-assisted. I did c-sections and the full gamut of what an obstetrician who is covering a hospital would do. Consults all across the hospital. In my practice a big part of my gyn practice was yearly physicals with women. And I did prenatal care.

Q. And in your medical practice, have you ever prescribed

medication off label?

A. Yes.

Q. In what circumstances?

A. When women are menopausal and having hot flashes, for example, SSRIs, which are antidepressants, have been shown to help with hot flashes, for example. So I may prescribe one of those.

Q. Did you consider that safe?

A. Yeah. Yes, I did.

Q. Why did you consider that to be safe?

A. I think that there were several studies that showed that it was effective. The potential side effects of prescribing it were minimal. It was well studied in women -- it is a drug that has been well studied and so it's been commonly used. Like, for example, Prozac, let's say, was one of them that we would use. So I felt comfortable that there was not a harm that I was causing. And I also knew that if she didn't like it, we could stop it.

Q. Got it. Thank you. And we have already discussed Misoprostol. Have you ever prescribed Mifepistone or Mifeprex to a patient?

A. I have not.

Q. Have you ever provided an abortion?

A. I have never performed an induced abortion, no.

Q. You state in your declaration that while you were in

private practice you cared for preborn children with life-limiting conditions, is that correct?

A. Yes.

Q. Could you describe what you mean by that?

A. So they are -- typically -- I mean, so a fetus is after eight weeks. So usually the diagnoses aren't made when they're embryos. And so they have a diagnoses that we know that if the normal age limit for men and women is in the 70s and 80s, that they have a condition that has been diagnosed that the likelihood of them surviving to 70 or 80 is not expected. So that would be a life-limiting condition.

Q. And how did you treat -- how did you treat your patients in that situation?

A. A lot of love. It was hard because they -- you know, it's a tragedy when you expect to have a healthy child and you're told that. So we would refer them to maternal-fetal medicine because maternal-fetal medicine works with high-risk pregnancies. And then depending on the situation they may come back to our practice and we provide their prenatal care or there may be a transfer of care.

Q. And a transfer of care for what?

A. Well, usually for the maternal-fetal medicine specialist to take over the care of them, whether it's -- there was going to be a delivery or if the patient had decided that they wanted to have an induced abortion, they would provide

that.

Q. And would you ever refer those patients directly for an induced abortion?

A. No.

Q. Have you ever performed a previability induction on a pregnant patient?

A. Can you define previability?

Q. Sure. How would you define viability?

A. Well, traditionally it is able to survive outside the mother. And that's changed over time of course because our understanding of how to care for premature babies is better. So I assume you're asking babies that -- maybe I shouldn't assume -- but that are too young to survive if they were born at the time of the induction.

Q. That's right. Have you ever performed an induction on a pregnant patient at the stage where their fetus was not developed enough to survive outside the womb?

A. Yes, I have.

Q. About how many times?

A. Lots and lots. Residency in four years because we were a Level 1 hospital where we had a lot of transfers that came in -- excuse me. I'm sorry. I have a reminder coming up that was loud. We had a lot of patients transferred to us that had, for example, preterm premature rupture of membranes. And -- or other things that caused us to have to do a premature

separation of the maternal and fetal patient. So that was four years and then I had nine years in private practice. So, you know, greater than a hundred.

Q. Got it. Thank you. And did you consider those inductions to be abortions?

A. No, not induced abortions.

Q. So you referred to preterm premature rupture of membranes or pprom. What other conditions would lead you to perform an induction in these circumstances?

A. That would probably be the most common. Really it would be situations in which typically the mom is so sick that if we do not do an induction and separate our maternal and fetal patient, both patients would die. So, you know, it would be any indication that the mom was so sick. And occasionally it's a fetal indication, but it's usually the mother.

Q. Did you ever recommend to one of your patients that they have an induction before the fetus could survive outside the woman?

A. Yeah, I had a lot of hard conversations about that.

Q. Would you have recommended an induction to, for example, a patient with gestational diabetes at risk of going blind?

A. I would need more clinical context than a hypothetical like that.

Q. Would you wait until the patient was dying before you

recommended such an induction?

MR. BOYLE: Objection. You can answer.

THE WITNESS: Did you say you can answer?

MR. BOYLE: Yes, you can answer.

THE WITNESS: Okay. Would you repeat the question, please.

BY MS. SALVADOR:

Q. Sure. Would you wait until the patient -- would you recommend waiting until the patient -- sorry. Let me start over. Would you wait until the patient was dying to recommend such an induction?

MR. BOYLE: Objection. You can answer.

THE WITNESS: So I just want to kind of pull back for a second and clarify. So an induced abortion has the intention of not having a live birth. So when I would recommend an induction in these cases, my intention was hopefully to have a live mom for sure and a live baby. And so there were times, for example, if she's what's called periviable, she's near where maybe the baby did have a fighting chance and her risks are small at that point that we could do expectant management. So, for example, with pprom, one of the -- ACOG'S, you know, practice bulletin on pprom says expectant management. And so I'm trained to be able to watch for signs of infection in the mom and daily, you know, go see her and multiple times a day do vital signs and at the very beginning

of the process say to her, you know -- let's say she's 22 weeks is we have a couple different options here and one of them is to go ahead and deliver you. And -- well, there are 22 weekers that have survived. So let me say 20 weeks. And say to her that we can wait. We can do expectant management and if we do that we're going to have to monitor you very closely and if there's a sign that you have what's called chorioamnionitis I'm going to recommend induction.

Q. And you said -- please repeat that term, chorioamnionitis?

A. Chorioamnionitis. So it's an infection of the amniotic fluid.

Q. Would you recommend -- would you ever recommend to a patient waiting until sepsis develops to have an induction?

A. Heck, no.

Q. Between when you finished residency in 2010, did you work as an ob-gyn anywhere other than Greenville and then its associated work at East Carolina University?

A. No.

Q. After you stopped working at Greenville, where did you work next?

A. So I worked at Barton College, which was Atlantic Christian when I was there, and I have been there since 2010 -- well, I was an adjunct, but full time starting in 2011, until this summer and I'm no longer there.

Q. Could you generally describe your role at Barton, please?

A. Sure. I was initially hired as an associate professor of Allied Health and Sports Studies, although I think our department had a different name back then. But I was an associate professor. So my Ph.D. is in kinesiology, which is exercise science. And so I taught classes ranging from anatomy and physiology to exercise physiology, exercise psychology. After I believe my first year I was asked to run the honors program. So I taught in the honors program and had an administrative role there and continued to teach, but as time went on I taught less and had more administrative responsibilities, including dean of graduate and professional studies. And then the last few years I have been the director of a partnership with Area L AHEC, at Barton College.

Q. I'm sorry, what is that term, Area L AHEC?

A. AHEC. So AHEC is a system within -- actually, it's a national organization, but each state -- I believe most of the states have AHECs. And they work on workforce development, retention and diversity. And so we ran a program on campus with college students trying to increase health careers awareness, but also diversity within the healthcare system.

Q. And did your work at Barton also involve practicing as a women's health physician at Lee Student Health Center?

A. Yes, it did. I was in there a few half days a week

when I first started. I think it was the first couple years. But then as my administrative duties increased I wasn't able to do direct patient care in there and I served more on a consultative role.

Q. Did you prescribe contraception to your patients at Lee Student Health Center?

A. Yes.

Q. Did you ever talk to any of them -- I'm sorry. Were any students you treated at Lee Student Health Center pregnant?

A. Yes.

Q. Would your treatment of students ever involve talking to them about abortion?

A. Yes.

Q. Describe those conversations about abortion, please.

A. Yeah. So I basically want women to be empowered with information before they make a decision of such massive consequence. And so it would really be helping them understand their legal choices in the State of North Carolina. Some of our students are from out of state. And so helping them understand they had the option to give birth, to give birth and parent, to give birth and place the child for adoption, or to give permission to a healthcare practitioner to do an abortion. We have a lot of student athletes at our campus. Probably close to 70 percent of our students are athletes, so there was always conversation typically about how it would impact their

play and scholarships and things like that. So I really just wanted them to be really well informed before they made a decision.

Q. Did any of the students who you spoke with about their decision ever express to you a desire to have an abortion?

A. Yes.

Q. And would you support them in that decision?

A. You would have to define support them.

Q. Sure. Would you ever affirm their decision to have an abortion?

MR. BOYLE: Objection. Object to form. You can answer.

THE WITNESS: So what I would talk to them about are -- well, risks -- I would not refer them for an abortion because for me the direct and intentional killing of another human being is not part of healthcare and so I didn't want to contribute to harming one of my patients because I have -- when she's in front of me, I have two patients in front of me. So I wouldn't refer them. What I would do is help them understand the risks, benefits and alternatives.

BY MS. SALVADOR:

Q. And -- I'm sorry, I didn't mean to interrupt you.

A. It's okay.

Q. So you said risks, benefits and alternatives. What would the benefits be?

A. Of which choice?

Q. Of an abortion.

A. Oh, risk, benefit. Basically that nobody would have to know they're pregnant typically and that they would likely be able to compete in their sport.

Q. Why did you leave Barton?

A. I left Barton -- probably should have left two years ago because I really felt like God was calling me to work more with women with unplanned pregnancy. I have been a volunteer for years at Pregnancy Centers and often times when you're a volunteer medical director you are reading all the ultrasounds. But we had -- we needed -- we didn't have a nurse and we had trouble finding one a few years back and I said well, I can do ultrasound. I will go in there and do it. And I just love working with these women. Every woman now has an unplanned pregnancy and I just have a heart for women. And I want them to be able to -- I want to be able to address the barriers for why women feel like the best choice in front of them is ending the life of their own child. I think that it's sad that we have the best of our legal and medical minds in our country and that's the best we can offer for women for equality is to end the life of their children and I just think that's wrong. So I wanted to work full time caring for women in these situations and there wasn't time to do my job at Barton and that.

Q. Understood. Thank you. So before we get to your

Pregnancy Center work I want to talk a little bit about your professional associations.

A. Okay.

Q. Are you currently a member of the American College of Obstetricians and Gynecologists?

A. I am currently not.

Q. Okay. And we'll call that ACOG, is that okay?

A. Yes.

Q. Were you ever a member of ACOG?

A. Yeah, for a long time.

Q. And do you remember what years?

A. I believe when I first started private practice, 2001. I might have been a member during residency, but I'm not a hundred percent sure of that. Because if so, I think they would have paid for a membership. And so I started in 2001 and I stopped my membership a year or two ago.

Q. Got it. I think your C.V. says 1997 and 2021. Does that sound right?

A. It does.

Q. So why are you no longer a member of ACOG?

A. So I have got -- I think ACOG does great work, but I really philosophically disagree in the abortion area with induced abortion. And I feel like it was an organization that did not represent so many of us who really feel like the direct and intentional killing of our fetal patient, there's no

purpose in medicine for that. And I -- ACOG has I think it's eight percent of our dues that go towards advocacy work. I will say they do some great advocacy work, but I couldn't -- they wouldn't allow us to not contribute that part. And so I just in good faith, I didn't want to know that some of my dues were going to advocate for induced abortion.

Q. Did anyone suggest to you that you end your ACOG membership?

A. No.

Q. ACOG members aren't required to hold any particular view of abortion as a precondition of membership, are they?

A. No.

Q. And ACOG'S membership includes individuals who are opposed to abortion, is that right?

MR. BOYLE: Objection.

THE WITNESS: I know lots of colleagues that are members of ACOG that are pro-life and pro-choice, so I -- there are members of both in ACOG.

BY MS. SALVADOR:

Q. And you cite ACOG bulletins on early pregnancy loss and tubal ectopic pregnancy in your declaration, is that right?

A. Do.

Q. And you also cite an ACOG committee opinion on methods of estimating pregnancy due date, is that right?

A. Yes.

Q. So you believe that ACOG is a reliable source of information?

A. So, as I said when you asked me the question about why I left, ACOG does a lot of great work. I just disagree that they -- their position on abortion access, their abortion policy. And so there's a part of ACOG that I don't agree with and for a while I considered leaving and it was just in the last few years I felt like -- particularly when they wouldn't allow me to not contribute to their advocacy work.

MR. BOYLE: I just ask -- we have been going for about an hour. When you get a chance, can we take a break, please?

MS. SALVADOR: Sure. We have just got one or two more questions on ACOG and then we can break after that, if that works.

BY MS. SALVADOR:

Q. So would you find ACOG bulletins on abortion to be reliable?

A. Well, I disagree with them and so it is -- a lot of it is ACOG'S opinion, without even caring that so many of us, the majority of -- based on studies that have been cited, you know, don't do induced abortions. So they advocate for laws that I don't agree with. And so --

Q. But is it your position that the medical information in ACOG'S bulletins on abortion is unreliable?

A. I don't think I can answer that without looking at them. Like what medical information you're asking me to answer about.

Q. Okay. Understood.

MS. SALVADOR: We can take a break now. Would 10 minutes work?

THE WITNESS: Sure.

MS. SALVADOR: Okay. Why don't we go off the record.

VIDEOTAPE TECHNICIAN: Thank you. We are now going off the video record. The time is 3:07 p.m.

(A break was taken.)

VIDEOTAPE TECHNICIAN: We are now back on the video record. The time is 3:17 p.m.

BY MS. SALVADOR:

Q. Thank you, Dr. Bane. So before we go back to your professional associations, I wanted to ask you whether John Thorpe reviewed a draft of your declaration?

A. No, he did not.

Q. Okay. Thank you. So going back to your professional associations, you're a member of the American Association of Pro-Life Obstetricians and Gynecologists, is that correct?

A. Yes.

Q. And I'll refer to that as AAPLOG, if that's all right?

A. Yes.

Q. How long have you been a member of AAPLOG?

A. I think two years maybe.

Q. You currently serve on their board, is that right?

A. I do.

Q. Do you have a title other than board member?

A. I just got a title. I am the team leader for education advocacy. The CEO, Donna Harrison, stepped down as the CEO and Dr. Christina Francis became the CEO. So I took her place.

Q. So you took her place as CEO?

A. No. No. No. Sorry. As the team leader on the board for education and advocacy.

Q. Understood. So what does your role as team leader for education and advocacy entail?

A. Well, it's brand new so my understanding -- I haven't really had a board meeting in which I have lead it yet, but it's really going to be related to both patient and practitioner educational material that looks at the medical evidence and advocacy work in terms of really equipping practitioners who have a pro-life perspective to be able to communicate their -- why they have that perspective.

Q. Would it be fair to say that communicating their perspective is advocacy?

A. Yes.

Q. Do you consider yourself a pro-life advocate?

A. I stand up for pro-life values. I stand up for both my maternal and my fetal patients. So that would be my definition of being an advocate for them. I also stand up for medical students and residents and healthcare practitioners of all types who acknowledge and want to have health and wholeness for both their maternal and fetal patients.

Q. So you said you were new to this -- I'm sorry, I forget exactly what it's called, but the education and advocacy --

A. Team leader.

Q. -- team leader role. But you have been on the board of AAPLOG for sometime, is that correct?

A. For a year.

Q. What do your duties entail as a board member?

A. So -- what do my duties entail? So in terms of oversight -- things that I have had to do. So I have attended one face-to-face meeting and two virtual meetings. So basically going over the strategic plan, which was already made when I was there, but reviewing that. Updating the strategic plan. So more a visionary picture for the organization. Fiscal responsibility. We are a nonprofit and we do not have a lobbying arm to what we do in terms of -- I think it's called a C4 maybe. I don't know that for sure. So making sure that we are educating, but not lobbying. So, so far I would say big decisions that are strategic are what our role is in our

governance.

Q. What's your understanding of AAPLOG's position on abortion?

A. You said AAPLOG, right?

Q. Yes.

A. That induced abortion as defined earlier, that it -- it is not healthcare and it is not -- the direct intentional killing of one of our patients we should never do.

Q. Have you attended any expert witness trainings conducted by AAPLOG?

A. Yes, I did attend one.

Q. Could you generally describe what that training entailed?

A. Yes. A communications -- it was one day -- I think it was one day. It might have been -- no, it was one day. A communications expert spent the morning just kind of talking to us regarding interviews with reporters and kind of what that world is like. And then the other half of the day was more about being an expert witness as I'm being now.

Q. And what training or do you remember what the training covered on being an expert witness like you're doing right now?

A. So they had some lawyers that came and just kind of talked about depositions and we did a -- each of us did an individual short mock deposition. We ran out of time, to be honest, so I didn't really do much with that part.

Q. Well, now you're getting the real thing.

A. Amen.

Q. And you were a committee member of the Preborn to End of Life Advisory Committee for the Diocese of Raleigh from 2013 to 2020, is that correct?

A. I was a member and we had one meeting during that time.

Q. Got it. So it sounds like not much. But what did your duties as a committee member entail?

A. Basically if the diocese needed direction on life issues, then they would come to us.

Q. Did you do any work relating to abortion as part of that committee?

A. Well, the one meeting we had, which was my first and only time going to Raleigh for it, I honestly can't remember the content. I do know the woman who is in charge of their Right to Life program was there, but I don't recall that it was specific to abortion.

Q. Got it. Thank you. Have you ever had a complaint made against you by a patient?

A. Yes.

Q. Could you describe that, please?

A. I had a patient that she was in our practice. She had twins. I had not met her until I was on call and she came in and -- when I took over call she was in labor and her twins

were vertex. Vertex. So you can do a vaginal delivery. And the first baby was delivered and he did fine, but as soon as he was delivered the second baby had a big deceleration, which I was worried about. But then that baby recovered. And I had -- so I had taken off the fetal heart rate monitors because I was using ultrasound to make sure the second baby didn't change positions. And so I manually palpated her abdomen. I was looking at the heart rate monitor and everything and that baby was born and he was very flaccid and had to be resuscitated and he died four days later. And looking back at it I did not recognize that that baby was having a hard time. I thought it was what are called early decelerations. But looking closely at it they were called late decelerations. And so I should have done an emergency c-section.

Q. And what was the resolution of that complaint?

A. Am I allowed to share -- I thought that was -- I mean, I'm happy to say we settled, but I don't know if I'm allowed to share more than that. The hospital settled and then my practice settled.

Q. Got it. And have you ever had a complaint made against you by a student?

A. By a student? Well, they do evaluations at the end of the year and not all of them are, you know -- you know, some students don't like me, but not from the context of what you're talking about medically. So I'll have to say no, other than

what I have already said.

Q. Understood. Thank you.

A. Yeah.

Q. Have you ever had a complaint made against you, an official complaint made against you by a colleague?

A. So I would say -- so an official complaint like with human resources?

Q. Sure.

A. No.

Q. Have you ever had a -- what sort of, if any, unofficial complaints have you had made against you by colleagues?

A. I had a time this year at the college where I -- when the Dobbs decision happened last June I wanted to do a talk on campus so that the students could understand the new decision, how it impacted them, because we have -- as I said before, 60 to 70 percent of our students are athletes. I wanted to make sure they understood the NCAA policy as it relates to unplanned pregnancy. And eight of my colleagues at Barton campus wrote the administration and did not want me to present.

Q. Why did they not want you to present?

A. Sorry. I can answer. In their letter that they wrote they said it's because they felt like we -- they needed -- I would bring my pro-life perspective and not -- it needed to be balanced with someone who is pro-choice.

Q. Did you end up giving that talk?

A. I did give the talk. Instead of in October, I gave it in April.

Q. Did you end up -- did you end up giving your pro-life perspective to that talk?

A. No. As a matter of fact, my daughter was in attendance and she said if I didn't know you I wouldn't have known whether you were pro-life or pro-choice.

Q. Have you ever had a malpractice claim filed against you?

A. The one that I told you about earlier I have. When I was a chief resident, there was a claim that was filed and I was included on it. But right before the jury was being selected the case was dropped. And I believe that's the only one.

Q. And what was that dropped case regarding?

A. A baby that had cerebral palsy. You know, I don't know if it was cerebral palsy. But had some chronic medical illnesses and they -- I think they felt like we didn't do the c-section maybe fast enough, but it turned out that they dropped the case.

Q. Have you ever been disciplined by a licensing board?

A. No.

Q. Have you ever been subject to disciplinary proceedings by an employer?

A. No.

Q. Got it. Thank you. So we're going to switch gears a little bit.

A. Okay.

Q. Do you believe that national data underestimates complications from abortions?

A. Yes.

Q. Are you aware that the CDC has obtained data on abortion mortality from all 50 states?

A. I'm aware that there is voluntary reporting from the states.

Q. Other than voluntary reporting from the states, do you know what sources the CDC relies on to identify abortion-related deaths?

A. I don't know a complete list. I could go to the CDC and look it up, but not off the top of my head.

Q. Are you aware that they rely on state vital records?

A. I am aware that they rely on state vital records and that those vital records are also voluntary.

Q. Are you aware that the CDC relies on individual case reports by public health agencies?

A. Yes, I'm aware that public health agencies do report information.

Q. Are you aware that the CDC relies on data from state maternal mortality review committees?

A. I'm aware that some states have those committees. I don't believe all states have those committees.

Q. Are you aware though that for where those committees exist, that the CDC relies on their data?

A. Yes.

Q. Are you aware that the CDC relies on reports by private citizens?

A. I'm not aware of the complete list, no.

Q. Are you aware that the CDC relies on media reports to identify abortion-related deaths?

A. Did you say media?

Q. Yes.

A. No, I'm not aware of that.

Q. Are you aware that for each death that is possibly related to abortion the CDC requests clinical records and autopsy reports?

A. I'm not aware of all the sources in which the CDC uses. What I will say is I'm aware that none of it is mandatory. And -- sorry.

Q. Sorry. Go ahead.

A. And that there is -- there are a lot of holes in terms of the fact that we don't have to have -- we don't have mandatory abortion reporting data.

Q. So you were not aware that the CDC requests clinical records and autopsy reports for deaths possibly related to

abortion, correct?

MR. BOYLE: Objection. You can answer.

THE WITNESS: Once again, I may have read it, but I don't have that list in my head of everything. So I can't truthfully say to you all the places I'm aware that they get their data.

BY MS. SALVADOR:

Q. And are you aware that where the CDC reviews autopsy reports two epidemiologists review these reports to determine the cause of death and whether it was abortion related?

A. I'll repeat that I'm not aware of all the sources off the top of my head that the CDC uses.

Q. Is it your understanding that carrying a pregnancy to term carries more medical risk for the patient -- for the pregnant patient than having an abortion?

A. Could you say that one more time? You switched on me and --

Q. Sure. Is it your understanding that carrying a pregnancy to term carries more medical risk for the pregnant patient than having an abortion?

A. I disagree with that.

Q. So you disagree that carrying a pregnancy to term has more risk for the pregnant patient than having an abortion?

A. Yes. Because we have inaccurate data and so you -- that leads to inaccurate conclusions. The only -- when we

compare those two, it's very difficult when you have a data collection system that basically live birth is the only thing we know for sure because everybody has a birth certificate. And when you look at maternal mortality it is, you know, number of deaths per hundred thousand live births. And pregnancies don't just end in live births. You know, as a matter of fact in our country about 65 percent of pregnancies end in live birth. About 35 percent don't. And if you look at black women, almost half of their pregnancies don't. So you have a statistic in which the denominator -- we have 35 to 50 percent that we're not even accounting for the fact that those pregnancies can end in abortion, induced abortion, or natural losses or ectopics or hydatiform moles. So yeah, there are great limitations in how we collect our data.

Q. Do you accept that abortion is safer than child birth for most abortion patients?

A. I cannot make that conclusion given the data we have.

Q. Are there circumstances in which you would say that abortion is riskier than a pregnancy and child birth?

A. Could you repeat that for me, Anjali?

Q. Sure.

MS. SALVADOR: Could I actually ask the court reporter to read that back so the words are exactly the same.

- - -

(The requested portion was read back by the

reporter.)

- - -

THE WITNESS: So that's a hypothetical question. So it's difficult to know because circumstances often change. We know that abortion -- you know, the greatest predictors of complications and death from abortion -- induced abortion is gestational age. So it's very difficult to make a comparison of a pregnancy to an abortion.

BY MS. SALVADOR:

Q. Is it true that some people who get abortions would have experienced pregnancy complications if they had stayed pregnant?

A. Yes.

Q. The likelihood of pregnancy-related death is higher for women with certain preexisting conditions, isn't that right?

A. The likelihood of pregnancy-related deaths is higher for some women with preexisting conditions?

Q. Yes. Is that right?

A. That is correct.

Q. What sorts of conditions would increase the risk of death during pregnancy?

A. So certain types of cardiac issues. Women who have kidney failure are, you know, some of the worst mortality risks. You know, uncontrolled diabetes. When a woman has it

uncontrolled during pregnancy, uncontrolled hypertension. So various chronic diseases do make the pregnancy more difficult, which is why we have a subspecialty of maternal-fetal medicine and designed to care for those women and if we do our job well, we really can hopefully reduces those risks for her.

Q. And at least some of women with those preexisting conditions you have just named obtain abortions, is that right?

A. Yes.

Q. So in your declaration -- and I'll point you to -- it's the bottom of page 12.

A. Okay.

Q. Sorry, I'm going there myself. You write it is possible that the higher rate of induced abortion and later abortions in black women account for a portion of the racial disparity noted in pregnancy mortality, is that right?

A. You said page -- is it page or paragraph? I'm doing the hard copy here.

Q. Okay. Sorry. It's paragraph 25. It's the end of paragraph 25. And if anyone is looking at the page numbers, it's the bottom of page 12 of the PDF.

A. Just give me a second.

Q. Sure.

(Pause.)

A. Okay. I'm there.

Q. Okay. So the declaration says it is possible that the

higher rate of induced abortion and later abortions in black women account for a portion of the racial disparity noted in pregnancy mortality and this level actually be protected for black women.

Did I read that sentence correctly?

A. Yes.

Q. But you don't cite any sources for that statement, is that right?

A. No. It's based on the full paragraph in terms of the sentences before in that we know that black women have more abortions, induced abortions than white women. We also know their mortality rate is higher.

Q. When you say the mortality rate, you mean that we know that their maternal mortality is higher, is that right?

A. Yes. Well, the data suggests that, yeah, it is higher and that they have more second trimester abortions, later abortions, which we know have greater risk for complication and death. So the answer for woman -- black women to addressing maternal mortality is not more abortion. That's what I'm saying in this. It's really that we have to get to the root causes of why black women die and they're multifactorial, including chronic diseases, which we have talked about, but also health disparities that happen in their treatment of care. They're not often heard the same. And it also is access to early prenatal care, transportation issues, education about

warning signs. So my point in this paragraph is that the answer to help women who are black or white and have chronic disease is not to destroy their children. It's get to the root cause of why they're dying.

Q. But you're not aware of a source that draws a causal link between abortion-related mortality and the relatively high black maternal mortality rate, are you?

A. Not off the top of my head, no.

Q. So in your declaration -- and this is also in paragraph 25.

A. Okay.

Q. You state that the risk of death from induced abortion increases as gestation progresses, is that right?

A. Yes.

Q. And you cite a study by Bartlett, et al. for the idea that women whose abortions were performed in the second trimester were significantly more likely to die of abortion-related causes, is that right?

A. Yes, I do cite that study.

Q. Do you recall that that study found that for the time period it was discussing the overall death rate for women obtaining legally-induced abortion was 0.7 per 100,000 legal induced abortions?

A. I would need to look at the study. I don't recall those exact numbers.

Q. Sure. One second.

A. Can I -- I have a copy of it. Is it --

Q. Sure. You can use your copy.

MS. SALVADOR: And then I am dropping the digital copy into the chat right now. So could we please have that marked as an exhibit.

- - -

(Document marked as Exhibit-Q for identification.)

- - -

BY MS. SALVADOR:

Q. Dr. Bane, I'm going to ask you to pull up the digital copy too and just confirm that it's the same as what you're looking at.

A. Okay. Sorry, it's making me save it again.

Q. That's fine.

(Pause.)

A. Okay. It's the same.

Q. Okay. Great. And so this document is the Bartlett study that we were discussing, is that correct?

A. That's correct.

Q. So I'm going to point you to the first page, left hand column where it says results.

A. Okay.

Q. The first sentence there is during 1988 to 1997 the

overall death rate for women obtaining legally induced abortions was 0.7 per 100,000 legally-induced abortions.

Did I read that correctly?

A. You did.

Q. So do you recall that CDC data states that in 2021 the maternal mortality rate was 32.9 deaths per 100,000 live births?

A. No, I don't recall the exact number.

Q. One second, please.

MS. SALVADOR: So I'm dropping a document into the chat entitled 2021 Maternal Mortality Rates as the file name. Could we please have that marked as an exhibit and, Dr. Bane, could you please open it?

THE WITNESS: Sure.

- - -

(Document marked as Exhibit-R for identification.)

- - -

BY MS. SALVADOR:

Q. Just tell me when you have it open.

A. Just a sec. Let me try again.

Q. Sure.

A. Okay.

Q. If that doesn't work for you I can try to screen share it.

A. No. I actually got it and I actually think I have that same document.

Q. Okay. I just have a couple of questions about it, so if you have to find it, it might be easier to use the digital copy.

A. Okay. That will be fine.

Q. So is this document we're looking at the CDC data for maternal mortality rates in the United States for 2021?

A. Yes.

Q. So if you go to the second full paragraph on the first page.

A. Okay.

Q. Do you see that it says that the maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births?

A. I do see that.

Q. And then do you see that at the very beginning of the next paragraph it says in 2021 the maternal mortality rate for non-Hispanic, black, in parentheses, subsequently black women was 69.9 deaths per 100,000 live births?

A. Yes.

Q. And in your declaration you also discuss a North Carolina Maternal Mortality Review report from 2021, is that correct?

A. Yes.

Q. Do you recall that the report states that in 2016 the

maternal mortality rate was 20.7 deaths per 100,000 live births?

A. I don't recall that number, but I have easy access to that document if you would like me to get it out.

Q. Sure.

MS. SALVADOR: I'm going to drop that into the chat as well. So if we could please have it marked as an exhibit.

- - -

(Document marked as Exhibit-S for identification.)

- - -

THE WITNESS: I have it.

BY MS. SALVADOR:

Q. And then, Dr. Bane, could you just please verify that the digital copy is the same as what you're looking at?

A. Okay. Let me look. Yes, it's the same.

Q. Okay. Thank you. Could you go to page 12 of that report, please.

A. Sure.

Q. So do you see on page 12 there is a paragraph that starts with pregnancy-related death ratios from 2007 to 2016. And the end of it says that the pregnancy-related death ratio is 20.7 deaths in 2016, is that right?

A. Yes.

Q. Are you familiar with the CDC's abortion surveillance data from 2020?

A. I looked at it, but I don't have it on the tip of my tongue. I would need to see it also.

Q. Got it. Thank you.

MS. SALVADOR: So I am dropping that into the chat as well. It's the file name entitled CDC Abortion Surveillance. If we could please have that marked as an exhibit and then, Dr. Bane, just let me know when you have it opened.

- - -

(Document marked as Exhibit-T for identification.)

- - -

THE WITNESS: Okay. I have it open.

BY MS. SALVADOR:

Q. Okay. And do you recognize this document as CDC Abortion Surveillance Data from 2020?

A. I have not seen this exact document. I have seen a summary. So I -- I --

Q. Okay. If you could go to the title page. Do you see there that it has the CDC logo at the bottom and then at the top it says Centers for Disease Control and Prevention, MMWR, Morbidity and Mortality Weekly Report, is that right?

A. Yes.

Q. Do you have any reason to believe that this document is -- or sorry. Do you have any reason to believe that this document is not the CDC abortion surveillance data from 2020?

A. No, I have no reason to believe that.

Q. So if you could please go to page 27 of the document.

A. All right.

Q. Let me know when you're there.

A. Okay.

Q. Do you see that it is -- it's a table labeled table 15, number of deaths in case fatality rate for abortion-related deaths reported to CDC by type of abortion, United States, 1973 to 2019?

A. Yes, I see that table.

Q. And then do you see that the far right column of that table is CFR, or case fatality rate, per 100,000 legal abortions?

A. Yes.

Q. And then do you see at the bottom right of the table that the fatality rate of abortions, according to the table, was 0.43 per 100,000 live births from 2013 to 2019?

A. I see that.

Q. Okay. Thank you. In your study and it's on -- it's in paragraph -- I'm sorry, not in your study. In your declaration in paragraph 33, you state that a study of 32 states in Mexico found that states with less permissive

abortion legislation exhibited lower maternal mortality rates overall, is that right?

A. Correct.

Q. But that study didn't know that restrictive abortion laws cause lower mortality rates, did it?

A. It was a correlation association.

Q. Right. So it didn't show causation, did it?

A. No. You can't do causation with induced abortion studies. You're not going to ever randomize people to an induced abortion. So yes, you have to do correlational studies.

Q. And didn't that study explicitly state that the initial estimated effects for all mortality outcomes were explained by differences in other independent factors known to influence maternal health rather than by abortion legislation itself?

A. I need to look -- pull it up. But I do not recall that -- I think it -- it recognized that it is multifactorial why women die. So, you know, any time you're doing a correlational study you're going to have to try to control for confounding factors. So we of course have to recognize that it's multifactorial.

Q. Understood.

MS. SALVADOR: So I am dropping the study itself into the chat. If we could please have it marked as an

exhibit and then, Dr. Bane, please let me know if you have it open.

- - -

(Document marked as Exhibit-U for identification.)

- - -

THE WITNESS: Yeah. Give me just a second. I'm trying to figure out in my -- did you say paragraph 33, right?

BY MS. SALVADOR:

Q. Of your declaration?

A. Uh-huh.

Q. Yes. Paragraph 33. But it goes on to the next page. Okay.

A. Okay. I'm just going to get that article.

Q. Yeah, I know it's hard to juggle these documents.

A. I was going to say, is there going to be a question at the end of all of this?

Q. There absolutely will.

A. I figured as much. I'm looking through my stack for that one. I'm a hard copy gal.

Q. Sure.

A. Okay. And you want me to confirm it's the same one, right?

Q. Yes, please.

A. Okay.

(Pause.)

A. Sorry, I'm having a hard time getting it to come up. So let's see. Okay. Let me just look. Okay.

Q. So is this the same study regarding abortion legislation in Mexico that we have been talking about?

A. It is.

Q. So could you please go to page 10 of the document and I'm using the numbers that are printed on the bottom right and left.

A. Yes. I'm there.

Q. Okay. So in the discussion there is a section that starts with discussion and then in the column on the right there's a long paragraph and it's kind of in the middle paragraph. So I'm going to read the sentence, nevertheless, after an exhaustive analysis adjusting for multiple cofounders, the initial estimated effects for all mortality outcomes were explained by differences in other independent factors known to influence maternal health rather than by abortion legislation itself.

Did I read that correctly?

MR. BOYLE: Object to form. I think you said cofounders and it's confounders.

MS. SALVADOR: I'm sorry, confounders.

THE WITNESS: Yes.

BY MS. SALVADOR:

Q. And going a little bit further down in that paragraph, there's a sentence that says consequently, making a direct or independent causal link between a less permissive abortion law and the lower incidence of maternal death, or conversely by considering a more permissive abortion law would be a premature or even erroneous conclusion. Is that right?

A. Yes.

Q. Okay. Thank you. And we're done with this particular study.

A. Okay.

Q. So going back to your declaration, paragraph 35. You cite a -- you state that medication abortions have a four times higher rate -- I'm sorry, four times higher risk of complications as compared to procedural abortions, is that right?

A. You're in paragraph 35 now?

Q. Yes.

A. Yes.

Q. And for that statement you're citing a study by -- there's a bunch of authors, but it's by Niinimaki, et al., is that right?

A. Yes. And then Mantula for the next statement, yes.

Q. Okay. So starting with Niinimaki, didn't the medication abortion group in that study include abortions

performed with Misoprostol alone?

A. Yes.

Q. Do you know whether PPSAT provides medication abortions using Misoprostol alone?

A. I would need to look again at the policies and procedures in order to answer that a hundred percent.

Q. And didn't the study describe both medication and procedural abortion as generally safe?

A. I don't know what you mean by generally safe.

Q. Sure. One second.

MS. SALVADOR: So I am dropping a document into the chat that starts -- the file name is Niinimaki, et al. Can we please mark it as an exhibit and then, Dr. Bane, let me know when you have it up, please.

- - -

(Document marked as Exhibit-V for identification.)

- - -

THE WITNESS: Okay. I have it up. I'm just going to get it out of my stack over here. Okay. I've got it.

BY MS. SALVADOR:

Q. And is the digital document the same as your hard copy document?

A. It is.

Q. And is that the same Niinimaki study that we were

discussing?

A. Yes.

Q. So could you please go to page 798?

A. Okay.

Q. Do you see that in the discussion -- right under the discussion heading the first sentence is in the present study we found that the two methods of pregnancy termination, medical and surgical, are generally safe, is that correct?

A. Just a second. I'm trying to -- I'm missing a page. So is that 798 you said?

Q. That's right. And if it's easier, I can also share my screen.

A. No, I have got it up on my screen. For some reason I don't have page 798 printed. So would you repeat that?

Q. Sure. Under the discussion heading, the first sentence right there is in the present study, we found that the two methods of pregnancy termination, medical and surgical, are generally safe.

Did I read that sentence correctly?

A. Yes.

Q. And are you aware that this study characterized all patient reports of heavy bleeding as hemorrhage even if they were within the expected range for medication abortion?

A. I'm aware that that's a limitation of the study.

Q. And are you aware that in response to criticism that

other literature about medical abortion reported a dramatically lower rate of complications that the authors of this study conceded that many of the complications are not really such, but rather concerns or adverse events that bring women back to the healthcare system?

MR. BOYLE: Object to form. You can answer.

THE WITNESS: So I'm aware just based on reading this study myself. I don't know about other conversations that I've had. But in reading it, I'm aware that there was probably some over reporting, which is a limitation. When you document in studies you always document limitations. And so I'm aware of that.

BY MS. SALVADOR:

Q. Are you aware that the study authors conceded that the rate of serious real complications is rare and rather similar between surgical and medical abortions?

A. I have no awareness that they have conceded that and this study has not been retracted.

Q. Understood.

MS. SALVADOR: I am dropping another document into the chat. The file name is Fjerstad-Niinimaki, letter to editor. Could we please mark it as an exhibit and then Dr. Bane, let me know when you have it open, please.

- - -

(Document marked as Exhibit-W for

identification.)

- - -

THE WITNESS: I have it open.

BY MS. SALVADOR:

Q. And you testified that you had reviewed Dr. Borass's declarations in this case, is that right?

A. Yes.

Q. And you also said that you reviewed some, but not all, of the literature she cited in her declarations, is that right?

A. Correct.

Q. Do you remember reviewing this particular document as one of the sources she cited in her declaration?

A. Not immediately, but I need to read it. Do you want me to do that?

Q. Sure. If you could just review. It says -- the relevant part is going to be that end reply column on the right.

A. Okay.

Q. And then it will go down to the next page.

(Pause.)

A. Okay. Thank you.

Q. So was the reply written by Niinimaki and the other coauthors of the study we're discussing?

A. Yes.

Q. And do you see at the bottom of page 660 on the right

that they write the main contributions that the present article makes to the literature are rate of serious and then in quotations, real. Complications is rare and rather similar between surgical and medical abortions?

A. I do see that.

Q. In your declaration you claim that there is a relationship between abortions and mental health complications, is that right?

A. Yes.

Q. And if you could go to paragraph 39 of your declaration.

A. Sure. Okay.

Q. So you describe a study by Mota or Mota and some others as discovering that abortion was associated with an increased likelihood of several mental disorders, substance abuse disorders, and suicidal ideation, is that right?

A. Yes.

Q. Is it true that in this study mental disorders were assessed by lay interviewers rather than by clinicians?

A. Let me get the study.

Q. Sure. And since you're looking at it, I'm going to put it in the chat and we'll mark it as an exhibit. Just one second.

- - -

(Document marked as Exhibit-X for

identification.)

- - -

THE WITNESS: Let me go to the chat and get it.

BY MS. SALVADOR:

Q. I'm sorry. I know it's tedious.

A. It's okay. I could use a potty break soon, just so y'all know.

Q. Okay. I just have a couple of questions about this study and then maybe we can take another break.

A. Okay. Let me just confirm it's the same study. Okay.

Q. So the study that you're looking at the hard copy of in the digital exhibit we just made, that's the same study, right, that we have been talking about?

A. Yes.

Q. And do you see on the first page there's a box there and it's got headings for clinical implications and limitations?

A. On the first page?

Q. Yeah.

A. I see that box, yes.

Q. And do you see that the first bullet point under limitations says mental disorders were assessed by lay interviewers?

A. I do see that.

Q. And then could you please go to page 245 of the study?

A. Okay.

Q. There's a heading that says conclusions. And then in the middle of that paragraph it says exposure to violence is a confounding factor in several of the associations between mental disorders and abortions.

Did I read that correctly?

A. I'm sorry, where -- you're on page 244 under the discussion?

Q. I'm sorry, 245 under the conclusion.

A. Oh, okay. Let me look on here. Okay.

Q. Should I repeat that question?

A. That would be nice. Thank you.

Q. Sure. So in that conclusion paragraph, in the middle of the paragraph it says exposure to violence is a confounding factor in several of the associations between mental disorders and abortions.

Did I read that correctly?

A. I'm sorry, Anjali, I don't see where that is.

Q. Okay. I'm going to just for this one --

A. I see it now. I see it now.

Q. Okay.

A. Yes.

Q. So yes, I read that correctly?

A. You did.

Q. And then do you see that the next sentence says our

study does not support a unidirectional relation between abortion and mental disorders?

A. Yes.

Q. And so this study didn't conclude that abortion caused the mental disorders it discusses, did it?

A. So, once again, when you do research, there are limitations and -- so when -- you're looking for associations and -- when it's correlational research of this type. And so you can't make the statement of cause and effect in this literature. What you can do though is note that there are lots of associations. It's similar to lung cancer. We can't say -- you can't say okay, you have to smoke for the next 20 years and you don't and we're going to see who gets cancer and the complications. But when you get an aggregate of data that consistently show those associations, that then allows you to draw inferences from that. So yes, you're talking about the Mota study, but there are hundreds of studies looking at the association. And yes, there are confounding variables, but we know how to control those in research and look for the impact -- you know, one of the strongest one is who I reference next, Dr. Fergusson who is openly pro-choice and he's greatly disturbed by the fact that his research shows me that women who have had an abortion when he looks at them longitudinally have similar to what this Mota study showed and, you know, his -- he had trouble publishing it, unfortunately, because sometimes the

conclusions aren't what journals want. But it would be scientifically irresponsible if I didn't. And so, you know, there are just so many articles in this literature to show that some women really do struggle with anxiety, depression, substance use disorder and suicidal ideations. So something that one in four women experience, I would think as a scientific community we would want know as much as possible for the safety and health and well-being of those women. So I think categorizing correlational research as not good research is a misnomer. We would never be able to say lung cancer is caused, you know, by cigarette smoking.

Q. For sure. And we'll get -- I know you wanted a break, so we'll get to the Fergusson study after the break. But just on this study, would you say that it's fair that one of the flaws of the particular Mota research used in this study is that it cannot concretely establish causation?

A. So it is a limitation in all correlational research that by itself causation -- it's not a randomized trial in which you have an abortion and you don't. So you cannot by itself say causation and that's not what I implied in my declaration.

Q. Got it. Thank you. And based on your experience as a physician, would you say that anxiety, depression, substance use and suicidal ideation are things that folks might struggle with after giving birth also?

A. Rarely.

Q. All right.

A. Yes. But I don't -- most women have tremendous amount of joy after giving birth. And so to equate that women who have a pregnancy loss of any kind, whether it's an abortion or a miscarriage, an ectopic, those women struggle in a different capacity than women who give birth.

Q. Okay. Thank you very much. We can take a break and go off the record.

VIDEOTAPE TECHNICIAN: Thank you.

MS. SALVADOR: 10 minutes.

VIDEOTAPE TECHNICIAN: We are now going off the video record. The time is 4:18 p.m.

(A break was taken.)

VIDEOTAPE TECHNICIAN: We are now back on the video record. The time is 4:29 p.m.

BY MS. SALVADOR:

Q. Okay. So Dr. Bane, we left off discussing paragraph 39 of your declaration and the studies you cite there.

A. Okay.

Q. So in your declaration you describe a study by Fergusson, et al. as finding that women who had abortions had 30 percent increased rates of mental disorders, is that right?

A. Yeah. Let me get that one.

Q. Sure.

(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

identification.)

- - -

THE WITNESS: Okay. They're the same.

BY MS. SALVADOR:

Q. Great. So if you go to page 450 of the study.

A. Sorry, my sheet was out of order. My page numbers got cut off when I printed it. Yes, the page with implications on it?

Q. Yes, that's right. So right before that implications heading, there's a sentence that starts in particular in that paragraph right before. And it says in particular, it could be suggested that the small association between abortion and mental health found in this study could be explained by uncontrolled residual confounding.

Did I read that correctly?

A. You read it correctly.

Q. Going back to your declaration. And we're still in paragraph 39. You also describe a study by Coleman as finding that adolescents who aborted an unwanted pregnancy were more likely than adolescents who delivered to seek psychological counseling and that they reported more frequent problems sleeping and more frequent marijuana use, is that correct?

A. Yes.

Q. Are you aware that Coleman's work on abortion and mental health has been heavily criticized by scientific

experts, including the Royal College of Psychiatrists?

A. I am quite aware that Dr. Coleman has had one study that was retracted. She also had another study that was attempted to be retracted and in her study that was attempted to be retracted, that study was then in -- I believe it was in the British Journal of Psychiatry, which is one of the highest impact factor publications, that they actually -- there was a group of people that wanted it retracted, they did an investigation and this is a very reputable journal and they kept it in there. I'm aware in the Frontiers of Psychology, I believe that's the one that retracted it, she did not even have the opportunity to give a rebuttal, which is extremely -- it's malpractice in research for that. And she has had a long career of a variety of studies that are in the literature and are well published and well respected. So I am quite aware that there is that one study.

Q. And would you say that retraction of the study is a fairly significant thing to have happen?

A. I am aware of retraction being a significant one. It's kind of like what I experienced at Barton College this year. They didn't like -- a group of people didn't like the fact that I was going to be sharing information that wasn't from -- it didn't have a conclusion that they particularly liked and they tried to retract and not allow me to talk. Fortunately my administration eventually allowed me, supported

me to talk. So I wish that she had had the opportunity to give -- to do what the other journal did and found there was nothing wrong in what she did. There has to be scientific integrity and sadly, she's being classified as somebody who doesn't have that when she has a tremendous amount to offer in her work.

Q. Generally speaking wouldn't you say that a scientific journal would not retract a study just because some people dislike it?

A. When I was training in my Ph.D. I would have said that, but I don't think that is necessarily true anymore. I think that a lot of the professional societies who print their own journals, they decide which studies to have in those journals. And, you know, we all have bias, all of us. And I gave a talk on diversity, equity and inclusion at this conference I'm at and I spoke about implicit bias and I said the most important thing is for us to be aware that we have it. And so in research every one of us on this call have biases and I'm aware that I have biases. As you said earlier, I'm a pro-life advocate. Okay. That should make me be an even better researcher because I know my biases and if I care more about the truth than I care about being right, then I can look at my research, my data, just like Dr. Coleman does, Dr. Fergusson who this study I cited, it took him four journals to get it accepted because they didn't like his conclusion. And he -- he basically is -- said I'm pro-choice. I didn't like my

results either, but I want women to be safe, so we need to publish my results. He said I get my stuff -- he's so internationally known he gets his research published the first try. It took him four tries to get a journal. So I get scared about where publication and the ability to publish when it goes against what certain professional organizations want to see.

Q. Just to be clear, just now you were talking about Dr. Fergusson and not Dr. Coleman, is that right?

A. I was talking about both of them. But Dr. Fergusson, I was talking about his article that I cited in my declaration took him four tries to get published and he -- it was very discouraging because of the fact that he is so well respect had. You know, there are certain people that when they submit and you're the author in a journal there, they are happy you chose their journal and he's one of those type people, yet his finding weren't consistent with what some wanted to get out there, which is very sad and scares me.

Q. Going back to the study -- the Coleman study that we were talking about, are you -- the one that you cited in your declaration, to be clear. Didn't the study also explicitly state that design limitations precluded definitive assumptions about causation for some of the same reasons that we talked about today?

A. Yes, it's -- once again, this whole body of literature is -- you can't randomize people to have an abortion or not.

And so you have to either retrospectively look back at charts or you can prospectively follow them. Which both Dr. Fergusson and Dr. Coleman's studies were longitudinal studies. They were prospective, which gives them great strength. But once again, because mental health issues are not going to necessarily -- they're going to be multifactorial, you can set up your study design to control for those and still see associations.

Q. And going back to your declaration. Again, we're still in paragraph 39. You also discuss a -- or, I'm sorry, we're now in paragraph 40. You also discuss a Finnish study showing a higher suicide rate after abortion when compared to giving birth, is that right?

A. I do.

Q. Are you aware of how the maternal mortality rate in Finland compares to the maternal mortality rate in the United States?

A. I would have to -- not off the top of my head, no. I would have to look at the study.

Q. Is it your opinion that abortion causes increased suicidality?

A. It is my opinion there's an association between abortion and suicidal ideation, as well as suicide. Once again, being an increased risk. So we know mental disorders, anxiety, particularly depression, and they can be comorbid,

meaning about half the people who have depression also have an element of anxiety, is a significant risk factor for suicide. And so it follows that if a woman struggles after an abortion with anxiety or depression, that could lead to suicidal ideation and suicide. So once again, the type of study is correlational and there's an association. But there are criteria so that if you continue over and over again to get the same correlational studies showing this, then that strengthens, as I said with the lung cancer example, that there is a very strong association.

Q. And to your knowledge is increased suicidal ideation ever associated with child birth for the period post-child birth?

A. Yes. So postpartum depression occurs and with the same rationale I just explained, a woman has postpartum depression would have an increased risk of suicidal ideation as well as suicide.

Q. And doesn't the Finnish study that you cite in your declaration also say social circumstances might be a common risk factor in terms of deaths from suicide and homicide?

A. I'll need to pull up the study.

Q. Sure.

MS. SALVADOR: So I'm dropping the study into the chat like we have been doing. If we could please mark it as an exhibit and then, Dr. Bane, please confirm that we're

looking at the same document.

- - -

(Document marked as Exhibit-Z for identification.)

- - -

THE WITNESS: Okay.

MR. BOYLE: I believe this one is already --

THE WITNESS: Yeah, it's not in my stack.

MR. BOYLE: You're talking about the Niinimaki study?

MS. SALVADOR: No, this is Karalis.

MR. BOYLE: Oh.

THE WITNESS: Just a second. Let me look. So paragraph 40. So number 28. Okay. My reference 28.

(Pause.)

THE WITNESS: I'm going to have to rely on yours. I misplaced it. We pulled out a lot of documents. Let me go to the chat.

BY MS. SALVADOR:

Q. We're almost to the end of the part that's heavy on studies so...

A. Okay. My desk looks like a mess over there. Okay. Oh, yeah. Okay. So where did you want me to look?

Q. So first, could you please confirm that this is the same Karalis study that you cite in your declaration?

A. It is.

Q. So could you please go to page 1119.

A. Okay.

Q. And under the sentence right before conclusion it says higher mortality rates after termination of pregnancy among teenagers, and especially deaths from suicide and homicide, indicate that women are very vulnerable at this stage and that social circumstances might be a common risk factor.

Did I read that correctly?

A. You read that correctly and it's consistent with all the other examples we have gone through of correlational studies. A design always in studies is, you know, when you present your research you're going to want to put the limitations and the confounding so that you're -- the reader knows you're not looking just narrowly. And, you know, they're highlighting the fact that suicides among teenagers, and especially deaths from suicide and homicide, while they increase, it's not going to be the only factor. So it's consistent with all the studies that are out there showing an association.

Q. Would you agree that it's important that studying and examining mental health and abortion control for the person's reason for getting an abortion?

A. Sure.

Q. Would you agree that someone who had an abortion of a

wanted pregnancy might have a different emotional reaction than someone who had an abortion of a pregnancy they didn't want?

A. We know that there are actually several factors. I didn't cite it in my declaration, but I believe -- I think it's up to 14 factors that are more commonly associated with mental health disorders and this doesn't just come from -- gosh, it's a text that looks at abortion and psychological impact. I can't recall it right now, but I could get the reference for you. But it is very commonly known that there are certain risk factors that are more associated with a risk for mental health issues afterwards and adjustment, negative emotions like anger and guilt. So yes, not every woman is exactly alike when it comes to her risk.

Q. Would you agree that a good comparison for studies examining mental health and abortion would be between people who wanted an abortion and got one versus people who wanted an abortion but couldn't get one?

A. So you're talking about the Turnaway Study, it sounds like. I think a better one is an -- comparing women who had an unwanted pregnancy or an unplanned let's -- let me correct that. An unplanned pregnancy, which is what I see all the time, and comparing women who had an abortion and women who chose to give birth and following them longitudinally. That is a much better comparison.

Q. So it sounds like you're familiar with the Turnaway

Study?

A. Yes. I don't have it in front of me, but yes, I am.

Q. And are you familiar with how the Turnaway Study was designed?

A. I'm familiar to the extent that they -- they provided their sampling plan. If you look in their very long document about it they don't actually give you very specifics and so that's a major limitation. And it's actually not a great research from the standpoint of one of the strengths of research is that it's reproducible. So I should be able to take their methods and replicate their methods and see what I find. That's when studies are stronger. And unfortunately they don't clarify that very well.

Q. And are you aware that Dr. Wubbenhorst, your fellow expert in this case, has referred to the Turnaway Study as extremely well designed?

A. No, I'm not aware of that.

Q. So you would not agree with that?

A. No, I would not.

Q. Got it. And are you aware that the American Psychological Association has said that research shows that having an abortion is not linked to mental health problems?

A. I am aware of their statement. I disagree with it, but I am aware of it.

Q. So you also state in your declaration that hemorrhage

is a risk of abortion, right? And this is in paragraph 35.

A. Did you say hemorrhage?

Q. Yes.

A. Okay. Sorry. You switched gears.

Q. I did. I'm sorry.

A. We're going to paragraph 35?

Q. Yes, we are.

A. Okay. I am aware that hemorrhage is a risk of abortion.

Q. I'm sorry, I didn't mean to cut you off.

A. Oh, no. No. You're fine.

Q. So in your opinion what amount of blood loss constitutes hemorrhage in the abortion context?

A. So we'll typically when a woman is bleeding say to her if you're filling two pads an hour full of blood for more than two hours is typically what I will tell them, I want you to call me. I'm concerned about that level of bleeding.

Q. And is there a risk of hemorrhage associated with childbirth as well?

A. Yes.

Q. Do you know whether the risk of hemorrhage is greater with carrying a pregnancy to term or abortion?

A. I don't know head-to-head studies that look at that particular thing. I know the average birth is -- a vaginal delivery is about 500 cc of blood. A c-section is more. And

so if a woman does not have hemorrhage you would expect much less than that. But if she has hemorrhage, it could be a wide range of amounts.

Q. So you don't know whether the risk of hemorrhage is greater with childbirth versus abortion?

A. I don't know of studies that have like -- I can't reference a study, so that's just a big generalization.

Q. Got it. And you state in your declaration also that infection is a risk of abortion, correct?

A. Yes.

Q. Is there a risk of infection associated with carrying to term in childbirth also?

A. Yes.

Q. Could you describe how that infection might arise in the childbirth context?

A. Yeah. So postpartum --- well, if we're talking about -- and if you could clarify, Anjali, that would help me. You're saying after a woman has had a baby or during her pregnancy?

Q. Both. Let's do both. So why don't you go one by one.

A. Okay. So I guess what I'll probably do just to not make this too long is what I'm talking about in my declaration is an infection after a pregnancy -- after an induced abortion. So probably just an infection after delivery. Because, I mean, a woman can get every type of infection during pregnancy that

she can get when she's not pregnant, plus she can get, for example, the chorioamnionitis that I mentioned also because she has a gestational sac that she wouldn't have when she's not pregnant. But after pregnancy women can get something called postpartum endometritis where they get an infection of the lining of the uterus and that infection -- when you think about the fact that the cervix opens to 10 centimeters to deliver a baby vaginally or by c-section that while it's a sterile environment, you still have the risk of infection. You're using instruments and things like that. So she can present with a fever. It's usually after she has gone home and she presents with a fever and sometimes abnormal discharge that's consistent with infection. And we treat it with antibiotics.

Q. Do you know whether the risk of endometritis is greater after childbirth like you have been describing or after an abortion?

A. No, I do not. And -- yeah. No.

Q. So it sounds like you have treated patients with endometritis, is that right?

A. I have.

Q. And you said you treated them with antibiotics, is that right?

A. Yes.

Q. Did that treatment always require hospitalization of the patient?

A. Not always.

Q. How often does that treatment require hospitalization?

A. I can't give you a percentage. I don't know the answer to that.

Q. Would you say more often than not you had to hospitalize those patients?

A. Yes.

Q. Do you think that endometritis can only be treated safely in a hospital?

A. I think you have to look at the clinical context and how sick the woman is and make a decision also how reliable she is and how -- whether or not she wants to go to the hospital. She's got a newborn now. You know, so I think that you can give her the option if you feel like she can be safely treated as an outpatient and check in with her. So I think you can give options.

Q. Okay. So in certain circumstances you can safely treat endometritis outside of the hospital setting, is that right?

A. Yeah. But it usually requires I.V. antibiotics typically. So the majority are in the hospital. I'm trying to think even now -- I think -- to be honest, I have to change my statement. I'm pretty sure we did everybody in the hospital. It's been over 10 years. There may be a protocol now for outpatient. I also think I was thinking about someone with

mastitis, which is infection in the breast. And we have treated a lot of those women as an outpatient.

Q. Got it. Thank you. So you also state in your declaration -- and now we're at paragraph 37.

A. All right.

Q. You also state in your declaration that a single induced abortion increases the risk of preterm birth, is that right?

A. Yes.

Q. And you cite a study by Hanes, et al., is that right?

A. Yes.

Q. But didn't that study also say that association between abortion and preterm birth may be due to chance or bias or confounding variables?

A. Once again, good researchers actually talk about limitations and recognize that preterm birth has many factors associated with it. So what they're trying to do is -- in this case it was a review of the literature and take all the different studies and -- that met the criteria for their metaanalysis and look at it recognizing that an association does exist, yet there are other factors that come into play.

Q. Right. So they recognize that the association could be due to chance, bias, or confounding variables, is that right?

A. They do recognize that. But they do also say that

there is consistent evidence that there's an association and it is a risk factor for preterm birth.

Q. Got it. Thank you. And your declaration also states in that same paragraph 37 that more than one abortion has been shown to increase the risk for preterm birth by 93 percent, is that right?

A. Yes.

Q. And that's the study by Shah, et al., is that right, or Shah and Zao?

A. Yes.

Q. But didn't that study also explicitly note that it doesn't establish that multiple abortions cause that increased risk, correct?

A. Let me get that study. Just a second.

Q. Sure.

MS. SALVADOR: And I'm going to put that in the chat as well and please mark that as an exhibit. And, Dr. Bane, please confirm that we're looking at the same thing.

THE WITNESS: Okay.

- - -

(Document marked as Exhibit-AA for identification.)

- - -

THE WITNESS: Yes, I have got the study now.

BY MS. SALVADOR:

Q. Okay. And it's the same study by Shah and Zao that we've been discussing?

A. It is.

Q. Okay. Could we go to page 1438, please.

A. I'm there.

Q. Okay. So if you go to the right column there is a heading that says implications for practice. And above that heading there is a long paragraph. And I'm going to read starting from the middle of it. So it says we must caution readers that we have restricted ourselves to explore the association of I-TOP -- I-TOP being previously defined as induced termination of pregnancy -- and pregnancy outcomes. Several biomedical, social, environmental, lifestyle-related, genetic and other factors contribute to a preterm and/or LBW -- that's low birth weight -- births and this needs to be kept in mind in interpreting our results. We caution interpretation being causal as confounding effects of socioeconomic factors, which are important, were considered in very few studies only. Discussion regarding downsides of I-TOP are incomplete without discussing downside of unwanted pregnancies as they are also at risk of adverse outcomes.

Did I read that correctly?

A. You did.

Q. So we have gone over a lot of studies. Have any of these studies that we have gone over lead you to want to modify

the opinions you state in your declarations -- in your declaration, I'm sorry?

A. No, they simply reinforce what I have repeatedly said this afternoon, that really good research recognizes the limitations of the research. But we also know that -- like for example, what you just read, if I was -- if I was a reviewer for this paper, I would be looking for that paragraph right there. And the fact that it is there and the fact that they acknowledge that it is there shows me that bias I was talking about earlier. They're trying to control for that. They're not in any way trying to say that this is a causal relationship. But once again, this is review of a lot of studies. And what I like about this is we know that the preterm birth rate is so high in this country. We also know that it's higher in black women. And we also know that black women have more abortions. And so wouldn't we care enough about black women and their children to want to really understand this relationship. So if indeed induced abortion is a contributing factor, not the only factor, but a contributing factor to why they're delivering premature children that have chronic diseases, because that's a risk factor of prematurity, not all of them have them, wouldn't we want women to know when they're making that decision about whether or not to give birth or to have an abortion. And so I -- I applaud these authors for doing that and so many of what you have cited just

reinforces that these are really important studies that I included and that the authors are doing good research.

Q. I got it. Thanks for your explanation. So we're going to switch gears a little bit. We talked a little bit about hemorrhage earlier. Did you ever treat patients who were hemorrhaging in your medical practice?

A. Yes.

Q. Under what circumstances?

A. Probably the most common would be postpartum hemorrhage. So a woman delivers a baby and then her bleeding doesn't slow down. It could also be that she had a placental abruption, which means the placenta comes off the edge of the uterine wall and she could bleed. She could have a placenta previa where the placenta is implanted over the internal os, which is the internal opening of the cervix, and she could bleed. Intraoperatively I dealt with hemorrhages in women. I particularly remember some traumas of pregnant women who were in car accidents, one in a train accident. Yeah.

Q. And in the labor and delivery context, I think you might have mentioned the number before, but in terms of the amount of blood, what do you mean by hemorrhage?

A. So, you know, in terms of labor and delivery, you know, it's not normal when you're not giving birth to bleed. And so, you know, the placenta accreta, the placental abruptions, these women are coming in and they're soaking pads

or, you know, they can't control the bleeding.

In terms of postpartum hemorrhage after a delivery, it would be -- I mentioned 500 ccs, but -- for a vaginal delivery. When you're in the middle of a postpartum hemorrhage, holy cow, the bleeding is so brisk because the -- a pregnant uterus, the blood vessels are -- particularly at term are very large. They're engorged. They have a lot of blood flow. So you have to act fast and you have -- in your head you have to go through your differential diagnosis. You know, do you have uterine atony, meaning the uterus is not contracting down to top -- when the uterus contracts down, it squeezes the blood vessels and helps. You have to think of that. You have to think is there a laceration in there. Is there some retained placenta in there. So you're differentially diagnosing while you're calling for treatment options.

Q. And have you ever treated patients who are hemorrhaging in the miscarriage management context?

A. So yes, I have. And the -- typically there we did most of our D&Cs in the operating room where we could use suction aspiration and often times control that well. But, you know, if they were still bleeding heavily, we would have to give them -- well, you can do uterine massage, you can give medicines that help contract the uterus, things like that.

Q. So you said you handled most of your D&Cs in the operating room. So where would the other -- where else would

you handle D&Cs?

A. Oh, so what I meant is some that do expectant management. I never did D&Cs in the outpatient setting.

Q. And would the definition of hemorrhage for a D&C be a different amount than the labor and delivery amount we just talked about?

A. Yes, it would be less typically.

Q. About how much?

A. I would probably say 200 cc.

Q. Do you think that hemorrhage can only ever be treated safely in hospitals?

A. I think that --

MR. BOYLE: Objection to form. You can answer.

THE WITNESS: Okay. I think hospitals are much more equipped to handle hemorrhage, particularly with a pregnant uterus. And the risk of uterine atony that we can have with it and lacerations, I think hospitals have the resources they -- if I need to do an immediate transfusion they have blood banks, they have -- if she bleeds so much that she needs support from an ICU team, if she were to, God forbid, code, they have code teams there. I have anesthesiologists that can intubate her and nurse anesthetists. So I think that every pregnant woman's life matters and because of that I want her, should I have hemorrhaging, to be near the resources that can best save her life.

BY MS. SALVADOR:

Q. Do you think a hemorrhage of 200 cc can be treated safely in an outpatient setting?

MR. BOYLE: Object to form.

THE WITNESS: I think that if you -- so when I said 200 cc, what I'm talking about is maybe she initially comes in and complains and has 200 cc, but it's not like then it's turned off. She's continuing to bleed. And so, you know, I have reviewed the protocols that Planned Parenthood -- PPS -- I'm sorry, the acronym you said at the beginning -- southern states has. And it's obvious that they do have protocols, but it's obvious that they recognize that they can have an awful lot of hemorrhaging because their protocols are very, you know, multilayered that go way beyond what you would do if there was 200 cc of loss only.

BY MS. SALVADOR:

Q. In your medical practice have you ever treated patients with cervical tears or lacerations?

A. I have.

Q. Under what circumstances?

A. Usually childbirth is where you can have it. I'm trying to think if any other times that I recall cervical lacerations. When you're dilating the cervix using the dilators, which are metal instruments that you sequentially dilate the cervix when you're doing a D&C, you can have a

laceration from that.

Q. Got it. And so -- and then you said before also that all of your D&Cs you would perform in a hospital setting, is that right?

A. Correct.

Q. Is it your opinion that cervical tears can only be treated safely in a hospital?

A. It's my opinion that cervical tears bleed really rapidly and that I would not try to be -- in a hospital setting your ability to visualize, you have to picture your -- the cervix is, you know, four, five centimeters inside the vaginal canal. And so if you're in an office setting, to try to visualize it and control the blood is a lot more difficult than it is in a hospital. So as much as anything, yes, you have the resources if you can't get the bleeding to stop in a hospital, but you also have the ability in terms of -- with the amount of blood loss I have seen with cervical tears to just have, you know, the surgical packs that are available to help you have the instrumentation that you need.

Q. I'm sorry, that isn't quite what I asked. So I asked whether you think that cervical tears can only ever be treated safely in hospitals?

A. No. I think that if you have a cervical tear -- and I'm just trying to recall if I ever had a cervical tear when I was in my office that I had to try to repair that -- I think it

would be harder. But I think that if you had to repair it, you would do the best you could. But it would be more difficult without having the instrumentation.

Q. And you mentioned doing a D&C with four to five centimeters of dilatation. Do you always have to dilate to that amount when you're doing a D&C?

A. No. I'm sorry, that's not what I said. Maybe it sounded like what I said. I apologize. Let me fix that. The cervix is four to five centimeters like in the vaginal canal. So you have to put a speculum in and it's not like the cervix is right at the opening. It's deep in the canal. So no, no, you do not have to dilate four to five centimeters. I was just saying from a landmark perspective the cervix -- if you have a cervical laceration you have to get deep into the vagina. And so visualization -- you're not just going to start throwing stitches without seeing where you think your source of the bleeding is and that's difficult because the cervix is so far away.

Q. Understood. Thank you for clarifying.

A. You're welcome.

Q. Did you ever use sedation in your medical practice?

A. Not that I was overseeing. The nurse anesthetist or the anesthesiologist was overseeing the sedation because that's out of the scope of my practice.

Q. And what types of sedation were you overseeing? I'm

sorry, you said you were not overseeing, is that right?

A. So it depends -- I guess I should clarify. If somebody was -- let's say she was coming in for something called a LEEP procedure or a colposcopy procedure, which is what we use to manage abnormal Pap smears, and she just said I'm really anxious. Like I would go to the radiology department and do something called a hysterosalpingogram to look for whether tubes were opened or closed for women who had infertility. If she said to me I'm really anxious then I would give her potentially something called a benzodiazapine, which is an over-the-counter medicine for anxiety. That could be categorized as like very mild sedation. But I would give those to women who potentially had an anxiety disorder. What I think I want to just make sure I clarify is that I don't think it's the role of an obstetrician and gynecologist to manage deeper levels of sedation that anesthesiologists, nurse anesthetists are specifically trained to do.

Q. And so for those patients who you would prescribe benzos, was that ever in an outpatient facility?

A. Yes, it would potentially be in the office, that they would get -- you know, 30 minutes before their procedure that they would get that medicine.

Q. And were you able to administer that medicine safely in an outpatient facility?

A. So they -- I didn't administer it. I would write a

prescription and they would take it before they came. So if that's your definition of administer it, then yes, I was for those situations.

Q. And did you ever supervise the use of I.V. sedation?

A. I did not.

Q. And did you ever supervise the use of kind of local anesthesia?

A. So I use local anesthesia. So, for example, if you're doing a procedure in the office sometimes we would put it in the cervix. If we're removing like a -- doing a vulvar biopsy. So I would do local anesthesia, yes. But not any sort of systemic anesthesia. That's what I'm referencing to. I think that's out of the scope of the practice of anyone but an anesthesiologist and nurse anesthetist.

Q. Understood. And that local -- that local anesthesia that you're referring to, you were able to administer that in an outpatient facility?

A. I was.

Q. So we're going to switch gears a little bit. What is an ectopic pregnancy?

A. An ectopic pregnancy is a pregnancy that is outside of the uterine cavity. It can be -- well, most commonly it's in the fallopian tube, but it can occur in other places such as the ovary, can even be intraabdominal, cervical.

Q. And how are ectopic pregnancies detected?

A. Ectopic pregnancies are detected by ultrasound.

Q. Would you agree that an ectopic screening protocol that uses ultrasound, the patient's medical history, and hCG testing is an appropriate protocol?

A. So you said three things. You said ultrasound, history and hCG?

Q. That's right.

A. So I follow the protocol from ACOG and I think it's a committee opinion or a Practical Bulletin 191. It got updated to 193. I think I used 191 in my declaration. There's an updated 193 and I follow their protocol which includes, yes, doing those things to document whether an individual has an ectopic pregnancy.

Q. And how early can ultrasounds detect pregnancy?

A. We can usually see a gestational sac about five weeks. It doesn't confirm that it's not an intrauterine pregnancy just to see a sac. So we have to be cautious with that because you can something called a pseudosac with an ectopic pregnancy. You can also have what's called a heterotopic pregnancy, which is fortunately very rare, but it's an intrauterine pregnancy and an ectopic pregnancy at the same time.

Q. What is a pregnancy of unknown location?

A. So a pregnancy of unknown location is a transient situation. It not a diagnosis. It is where you don't know exactly if the person -- if the woman has as intrauterine

pregnancy or an ectopic. So you have to have a high clinical suspicion when you have -- any time you have a pregnant patient you have to have a high clinical suspicion that she has an ectopic until you prove otherwise. But particularly if you were expecting to see an intrauterine pregnancy based on a sure last menstrual period for example, which we know unfortunately only happens about 50 percent of the time. A lot of women don't know their last menstrual period. But yeah, it's particularly important that we follow those women who have pregnancy of unknown location because we really -- for her safety we haven't confirmed where her pregnancy is located.

Q. So you wouldn't consider a pregnancy of unknown location equivalent to a confirmed ectopic then, would you?

A. No, I would not. I would basically have a high clinical suspicion until proven otherwise that she had an ectopic. If she has an intrauterine pregnancy I'm not going to send her home and she potentially die on me. But if she has an ectopic pregnancy and I send her home she could rupture that and unfortunately it's one of the leading causes of maternal mortality in the first trimester.

Q. So is it your medical opinion that all pregnancies should be assumed to be ectopic until proven otherwise?

A. It is my medical opinion than I want to document every pregnancy to confirm an IUP and that gives me a great sense of reassurance. So yes, I think all pregnancies we have to

document that we have an IUP.

Q. If a pregnancy has -- sorry. If a patient has a pregnancy of unknown location --

A. Okay.

Q. -- but doesn't have symptoms of ectopic pregnancy and doesn't have risk factors for ectopic pregnancy in their medical history --

A. Okay.

Q. -- would you consider that a suspected ectopic pregnancy?

A. So we know that 50 percent of our patients who have no risk factors have ectopic pregnancies. So the standard of care is not screening them. And so yes, I would still be very concerned and want to make sure she has an intrauterine pregnancy.

Q. So you would consider that a suspected ectopic pregnancy then, just to make sure I understand your answer?

A. Could you give me the clinical situation again?

Q. Sure. So if a patient has a pregnancy of unknown location, has no symptoms of ectopic pregnancy, no risk factors for ectopic pregnancy indicated in their medical history, would you consider that a suspected ectopic?

A. I would consider -- I would have a certain level of clinical suspicion, but often times when I document I will say I have a low level of clinical suspicion or I have a higher

level of clinical suspicion, but there is suspicion there because I have not proven that she has an intrauterine pregnancy.

Q. Got it. Thank you. I'm sorry, I was just trying to find your declaration again because I accidently closed a tab. So let's go to paragraph 61 of your declaration.

A. Okay. I'm there.

Q. So in paragraph 61 of your declaration you state that people who receive abortion medication without an ultrasound may result and delay detection and treatment of an ectopic pregnancy, is that right?

A. I state the pregnant woman with an ectopic -- oh, yes. Yes.

Q. Sorry, I should have clarified where I was starting to quote. So the quote is women who desire an induced abortion and receive abortion medications Mifepistone and Misoprostol without an ultrasound may result in delayed detection and treatment of an ectopic pregnancy.

Did I read that correctly?

A. Yes.

Q. Is it your understanding that PPSAT uses a patient's recollection of their last menstrual period alone to date a pregnancy?

A. I would have to look at their documentation.

Q. Okay. So you're not sure?

A. No. I know that they -- based on what I reviewed, that they use last menstrual period. And I am aware that they do give Mifepistone and Misoprostol without -- on the same day sometimes without a documented IUP, if that's your question.

Q. So is it your understanding then that PPSAT provides medication abortion to patients with pregnancies of unknown location without those patients having an ultrasound?

A. I am aware of that and it bothers me. It's -- I don't think it's standard of care and it's inconsistent with ACOG'S recommendations in Practice Bulletin 193.

Q. Is it your understanding that PPSAT uses hCG levels alone to diagnose ectopic pregnancy?

A. They have an algorithm, but I would have to review the algorithm when you say hCG along.

Q. So I'll just point you to paragraph 62 of your declaration.

A. Okay.

Q. So it says they falsely claim that hCG levels alone can be used to diagnose an ectopic, is that right?

A. So I'm talking about what the witnesses say with protocols using Mifepistone and Misoprostol that are inconsistent with practice guideline 193. So when I say using it alone, they're not using an ultrasound with it.

Q. Okay. Got it. So in your declaration discussion of the IUP -- the intrauterine pregnancy requirement, you rely

heavily on ACOG'S practice bulletin on tubal ectopic pregnancy, is that right?

A. Yes, I do.

Q. And I believe the document you cite in your declaration is Practice Bulletin 191, isn't that right?

A. Yes. They did an update and I did not include that update, but I have reviewed 193, which is actually -- I think they updated it two months after and I did 191.

Q. From what you remember, how does the update differ from the protocol you cite -- I'm sorry, from the bulletin you cite in your declaration?

A. I have it. Let me look. I have both of them.

Q. I'm just going to ask you generally what you remember, because we don't have that as a cited document in your declaration. So if you remember and if you don't, that's fine.

A. I think there is -- I don't remember exactly. It was just on one page they clarified something, but I honestly -- without looking at it I can't tell you exactly what that paragraph said.

Q. But generally speaking do you stand by, you know, the discussion of intrauterine pregnancy and ectopic pregnancy that's in your declaration?

A. Yes, I do.

MR. BOYLE: We have been going for about an hour. If you're getting close to the end, we don't need to

break. But if you're going to go for more than, say, 15 minutes I would request a break, please.

MS. SALVADOR: Yeah, we can break now. We're going to talk about the bulletin, but we can do that after we come back.

VIDEOTAPE TECHNICIAN: We are now going off the video record. The time is 5:29 p.m.

(A break was taken.)

VIDEOTAPE TECHNICIAN: We are now back on the video record. The time is 5:40 p.m.

BY MS. SALVADOR:

Q. Okay. Dr. Bane, we were discussing ACOG's practice bulletin on tubal ectopic pregnancy. According to the bulletin the minimum diagnostic evaluation of a suspected ectopic pregnancy is a transvaginal ultrasound evaluation to confirm the pregnancy, is that right?

A. Can I just get the document?

Q. Sure.

MS. SALVADOR: For the folks on Zoom, I am dropping the document into the chat. Attempting to drop the document into the chat. I'm dropping the document into the chat and then can we please have it marked as an exhibit and then Dr. Bane can just confirm that we're looking at the same thing.

- - -

(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?

A. So consistent with what I said before, yes, it has the word suspected and because on page E65 of the same bulletin under risk factors it says one half of all women who receive a diagnosis of an ectopic do not have known risk factors. As a clinician who really wants my patients to be safe, every single one of them is a suspected IUP until I have confirmed otherwise. I will honestly tell you that every woman that walks in my door now and in the past I needed to know where her pregnancy was because of the risk of death of an ectopic.

Q. But the bulletin itself doesn't directly say that a transvaginal ultrasound evaluation is required when an ectopic pregnancy is not suspected, correct?

A. So it's speaking about how do we take care of our patients with -- associated with tubal ectopics. And so, you know, it starts off with the background, risk factors, epidemiology, and then it gives us our clinical recommendations. And included in that very clearly is that an ultrasound is central to that, as well as following hCG levels. But an ultrasound is central to it.

Q. But the clinical -- actually, strike that. So in your career, in your medical practice, did you perform ultrasounds?

A. Yes, I did.

Q. How early in pregnancy would you perform ultrasounds?

A. So, you know, a lot of it depended on the clinical scenario. But if she was coming in for just confirmation of

gestational age, we can usually do a crown rump length about five weeks and five days. So five to six weeks would be the earliest. But, you know, so -- so that's in that clinical scenario. I may do -- I may do it at a different time, you know, in a different scenario. But the earliest I can usually confirm a documented IUP with an embryo is going to be five to six weeks. We know that if you see a gestational sac that also has a yolk sac in it, that's also -- and you can see that before -- like earlier in the five weeks, that's also very reassuring that you don't have an ectopic pregnancy. You may not have a viable pregnancy if you only see the yolk sac, meaning you haven't confirmed fetal heart rate or seen the embryo, yeah.

Q. Did it ever occur in your medical practice where a patient had a positive pregnancy test but an ultrasound did not detect a pregnancy?

A. Sure. Meaning we did an ultrasound and we didn't see anything?

Q. That's right.

A. Yes. So that would be that pregnancy of unknown location.

Q. So what would your next step be in treating such a patient?

A. It would basically be if -- if she were coming in and she had a positive pregnancy test and she was completely

asymptomatic and she, you know, was just there for prenatal care, we would typically wait until she was six to seven weeks and do an ultrasound at that point. If she was coming in with a complaint then we would -- depending on the complaint. But if it was a complaint that for example, abdominal pain or some bleeding, you know, depending on how far along she was, we would do an ultrasound potentially then and then do hCG levels, so draw blood.

Q. And would you refer that patient to the emergency room?

A. No. I would usually manage her. I would refer her to the emergency room if I thought that she had -- if she was unstable or she potentially needed to be observed in the hospital. If she needed to have surgery. But that's not the clinical scenario I gave you. So that's why I would say no. But, yeah, if she was unstable and/or she was -- you know, I was worried that she had a ruptured ectopic at that moment, most definitely I would.

Q. So you shifted over to talking about a patient who was unstable, but before that you were talking about a patient who was stable. So for those stable patients, would you recommend that they return to your clinic for followup?

A. Most definitely we would follow their hCG levels and get what are called serial hCG levels. We would also do a repeat ultrasound.

Q. Did it ever happen that those patients didn't show up for followup at the schedule you recommended?

A. I can't -- I can't picture -- think of a patient off the top of my head. I was also in a large practice where sometimes they didn't follow up with the same person, but if I had somebody that I was following up, I would make sure that, you know, I was coordinating her care with one of my partners. There's not a patient that I -- that jumps out because you don't sleep. I mean, you're taught early in your ob rotations that a woman that you're concerned with a high level of suspicion for an ectopic you don't go to sleep on because she might go to sleep and die. So those are the women that I'm following very closely. But I can't tell you about a patient who didn't come back, off the top of my head.

Q. So what happens if an ectopic pregnancy ruptures?

A. So if an ectopic pregnancy ruptures a woman will -- and I'll say from let's say a tubal pregnancy -- she will typically have pain. We have two tubes, a left and a right. So sometimes that pain is one-sided. It can become in her entire abdomen though because she will start to bleed and she can actually fill her abdomen with blood and blood is very irritating to the peritoneal lining. And she can have just generalized abdominal pain. She can also -- if she's like filling her abdomen with blood she can actually get blood under the diaphragm that irritates the diaphragm and can even have

referred shoulder pain. Those are the women that have a high risk of dying because our abdomen has the ability to hold an awful lot of blood. Some of the women will have some bleeding but it's usually not heavy, heavy bleeding like a miscarriage type of bleeding. But they can complain of spotting too.

Q. Got it. So you said a lot just there. So I'm going to ask about some details of what you just said.

A. Okay.

Q. So you mentioned that the pain typically starts as a sharp pain on one side of the abdomen, is that right?

A. So, I mean, I have seen it present in lots of different ways. But when a woman comes into me, she's got pain on one side or the other, you know, my differential diagnosis -- and I know she's pregnant, you know, it can be appendicitis, it can be a ruptured ovarian cyst. If I haven't confirmed an intrauterine pregnancy it can be an ectopic pregnancy. And it usually, I would say, is one-sided, but I have seen it present with just lower abdominal pain. I'm absolutely amazed -- and maybe this is judgemental on my part because I feel like I know my body really well -- how poorly some women and men, my husband being one, to try to describe like is this muscle pain, is this a different type of pain. And so, you know, I am going to assume it's an ectopic if I have a pregnancy of unknown location until otherwise proven.

Q. I got it. Thank you. And would those -- would

patients suffering -- I'm sorry, let me rephrase that. So would that pain typically be a sharp pain or more of like a cramping type of pain?

A. So I have heard women describe it as both. But I do think one-sided sharp pain is a presentation I would get for sure. But I have also heard women talk about cramping pain. When I hear them say sharp pain, you know, it perks my ears up to an ectopic. But my concern is that it presents not just in one way, from my clinical experience. And so I can't differentiate out blood in the abdomen, it fills the abdomen can feel different for different people.

Q. Got it. And would somebody suffering ectopic rupture ever feel a popping sensation or anything like that?

A. You know, I have actually not had a woman use that terminology with me. I have heard people with appendicitis after it ruptures actually for a little bit have a sense of relief, but I -- I honestly have never had anyone describe it as popping.

Q. And you mentioned that there is bleeding and I -- I don't want to put words in your mouth. I think you characterized it as mostly internal bleeding at first, is that right?

A. No, not necessarily at first. A woman can come into me and have spotting, bleeding and not have a ruptured ectopic at that point. She may have a small amount of bleeding and we

can actually look on ultrasound. That's one of the things you can look for. It talks about this in Practice Bulletin 191, ultrasound finding of fluid in the cul-de-sac. So the cul-de-sac is kind of in the lower part of the pelvis behind the uterus and -- so when I see blood in the cul-de-sac, which is in the abdomen, so not coming out the vagina but inside the woman's peritoneal cavity, that I have to pay attention to when I see it. Sometimes you can have a ruptured ovarian cyst that can cause that and sometimes a little bit can be normal to see. But if I have a woman who is -- I'm concerned about with asymptomatic and I see that on the ultrasound, I don't see an intrauterine pregnancy, even if I don't see a mass in the adnexa, the adnexa would be the left and right side of the lower pelvis, but I see fluid in the cul-de-sac, that would concern me for some blood there. But in terms of vaginal bleeding, women can have spotting, but they can have a little bit of heavier bleeding. But it is true that I'd characterize the bleeding of a miscarriage, the soaking pads I don't see as much in ectopic as I see in miscarriages.

Q. Got it. Thank you. Would it surprise you to learn that PPSAT does not provide medication abortion if a patient has not had an ultrasound?

A. Say that one more time.

Q. Sure. Would it surprise you to learn that PPSAT doesn't provide medication abortion if a patient hasn't had an

ultrasound?

A. You're doing a double negative there and we're on the fourth hour.

Q. Sure.

A. Ask me that one more time at the end. Doesn't and doesn't it you said.

Q. Sure. I'll ask it the other way. Would it surprise you to learn that all of PPSAT's medication abortion patients have had ultrasounds before receiving the medication abortion?

A. Would it surprise me? I would have expected them to all have had them to confirm an IUD -- IUP because it's contraindicated to use Mifepistone and Misoprostol without excluding an IUP. That's straight from the prescribing information from the FDA, that you have -- you have to exclude it. So I was very surprised when I received their protocols and they actually do that. And I read in Dr. Farris I think is where I read it first. I was very surprised that they do that.

Q. So we're going to change gears a little bit here and we're going to go to your current work.

A. Oh, okay.

Q. So you're a member of the National Medical Advisory Board of Care Net, is that right?

A. I am. And I'm at the Care Net conference right now.

Q. So what is Care Net?

A. Care Net is a Christian organization that helps

support men and women who face an unplanned pregnancy with resources to help them know that they can choose life. So life-affirming choices.

Q. So what is Care Net's position on abortion?

A. Induced abortion is never indicated.

Q. What are your duties as a member of Care Net's national medical and advisory board entail?

A. The national medical director of the board is Dr. Sandy Christiansen and she will ask our opinions regarding maybe language that is clear -- this is an organization that helps the thousands of Pregnancy Centers across the country provide exceptional care to our clients and patients. Many of those organizations -- all the organizations started as really client advocacy -- helping with those socioeconomic barriers for women. But in I think it was the '90s they began also having medical clinics. And so those of us on the medical board help to guide centers who have medical clinics.

Q. So you mentioned that you're at the Care Net national conference right now, right?

A. I am, in Mobile, Alabama.

Q. I think you mentioned that you lead a couple of breakout sessions, is that right?

A. Yes. Yesterday I did one on diversity, equity and inclusion in Pregnancy Centers and today I did it on stress, burnout, compassion, satisfaction, compassion fatigue.

Q. And according to your C.V. you gave a keynote presentation at the Care Net national conference last year, is that right?

A. Well, I got COVID and didn't get to come. So -- but they prerecorded it and -- what did I -- what was it on? I can't remember the exact title. But yes, they did show my prerecorded talk.

Q. So your C.V. says the title was the Science of Decisionmaking, Implications for Pregnancy Centers, is that right?

A. Yeah. That rings a bell now. Thank you.

Q. Do you remember whether that presentation discussed abortion?

A. Okay. Let me think through. So a big part of it was really looking at -- yeah. I mean, it did. But I would have to go back to that to look at the details of it. But yes, there was -- it was -- the big picture of healthcare in general and our role as -- like really healthcare practitioners, our role of -- we're really journeying with these women. We are partnering with them. They bring their own life experiences. They bring their expertise and their own bodies and we bring medical expertise to the table. And it's not our job to make their decision. It's not our job to -- they're not broken. It's not our job to try to fix them. It's not our job to judge them should they choose abortion. It's really our job to

empower them with information and to really partner with them. And so I brought up a lot of concepts. I trained I think it was '21/'22 at Duke Divinity School. I completed a certification in theology medicine and culture looking at the intersection of religion and medicine and a lot of what I shared were some of the concepts I learned there.

Q. Got it. Thank you. And you're currently the medical director of three different organizations, is that right?

A. Three different Pregnancy Centers.

Q. Okay. Could you name those three Pregnancy Centers, please.

A. Sure. So Choices Women's Center is in Wilson, North Carolina. And Albemarle Pregnancy Resource Center and Clinic in Elizabeth City, North Carolina. And then Waterlife Pregnancy Center which is in the Outer Banks in North Carolina.

Q. Got it. Thanks. And all three of those Pregnancy Centers are affiliated with Care Net, is that right?

A. They are.

Q. So that means that they all have to sign a Care Net affiliation agreement, is that right?

A. They do.

MS. SALVADOR: So I am dropping a document into the chat and then if we could please mark it as an exhibit.

- - -

(Document marked as Exhibit-CC for

identification.)

- - -

BY MS. SALVADOR:

Q. Dr. Bane, let me know when you have this pulled up.

A. Okay.

Q. Are you familiar with this document?

A. I am familiar. I'm not sure if it's the exact one that all three of the centers sign. I'd have to look at it. I don't know how old this one is.

Q. Sure. But this document is a Care Net affiliation agreement, is that right?

A. That's its title, yes.

Q. And all three of the Pregnancy Centers you work at would have signed some version of this agreement, is that right?

A. Yes.

Q. And are they required to remain in compliance with the agreement they signed in order to remain affiliated with Care Net?

A. That would be my assumption. I have never known -- been involved in a practice that, like, Care Net kicked out.

Q. Got it. So number one on the document states the Pregnancy Center concurs with each and every affirmation set forth in the statement of faith attached hereto and incorporated herein by reference. The Pregnancy Center will

not engage the services of any board member, director, or volunteer who does not concur with each and every such affirmation.

Did I read that correctly?

A. You did.

Q. And so did all three of the Pregnancy Centers where you work concur with the statement of faith?

A. I know the one in Wilson did. I honestly don't know about the other two in terms of -- I would assume they did since they're affiliated with Care Net. But I cannot -- I have not laid my eyes on this document.

Q. I understand. But all three -- you said all three are Care Net affiliates, right?

A. Yes.

Q. And you have no reason to believe that they did not sign something like this?

A. Correct.

MS. SALVADOR: So I am dropping another document into the chat. The file name is Care Net Statement of Faith. Please mark it as an exhibit and then, Dr. Bane, let me know when you have it open.

- - -

(Document marked as Exhibit-DD for identification.)

- - -

THE WITNESS: Thank you.

BY MS. SALVADOR:

Q. Okay. Do you recognize this document?

A. Let me read it.

Q. Sure.

(Pause.)

A. I do recognize it.

Q. So what is this document?

A. Care Net Statement of Faith.

Q. So all three of the Pregnancy Centers where you work have certified that they concur with the Statement of Faith, is that right?

A. I can only speak specifically for Wilson because I have not had a conversation about Care Net -- the executive director's decision to be a Care Net-affiliated center. I have spoken directly with my center before I signed this. I am Catholic and number one, we believe the bible to be the inspired and only infallible authoritative word of God in the Catholic Church. The Catholic Church also believes in oral tradition of their early church fathers. And so I think this is a very strong document from an Evangelical Christian perspective. And so I shared that I thought it could be less than inclusive for Catholic Christians.

Q. Okay. Got it. So is that why you disagreed with -- I'm sorry. Did you say that you disagreed with the Wilson

Center's decision to become a Care Net affiliate?

A. No. No. No. No. I just said that I have some concerns with how this is written as a Catholic Christian. I think Care Net is a wonderful organization. It has -- does many wonderful things. I think it comes from a more narrow perspective. I even -- you know, before I agreed to be on the board I thought long and hard about it. I prayed about it. I talked to Dr. Christiansen who she actually had me speak to a priest who -- a Catholic priest regarding it. And so at first glance I did have some reservations, but then I felt comfortable afterwards.

Q. Got it. Thank you.

A. You're welcome.

Q. And so let's go back to the Care Net affiliation agreement.

A. Okay.

Q. Do you still have that document up?

A. I'm pretty sure it's this one right here. Statement of Faith. Yes.

Q. Okay. And so number two says the Pregnancy Center agrees to fully comply with each and every standard set forth in the Standards of Affiliation for Pregnancy Centers, attached hereto and incorporated herein by reference.

Did I read that correctly?

A. You did.

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

contraception at all from the standpoint of like I used to do in private practice. When we have a woman come in and she has -- let's say she wants a pregnancy test and she's not pregnant, then we have a handout for her that includes her options, as well as resources in our community for contraception. But I don't particularly prescribe contraception at the Pregnancy Center.

Q. So are -- looking at number six on the document.

A. Okay.

Q. It says the Pregnancy Center does not recommend, provide or refer single people for contraceptives. Married women and men seeking contraceptive information should be urged to seek counsel along with their spouses from their pastor and/or physician. Is that what you're referring to?

A. I was referring to the first sentence is what I was talking about. I have had discussions related to Care Net's single versus married and -- but I also recognize that as -- because we don't even do contraception there, I was comfortable signing this knowing that -- and I'll tell you, when I first started working there as a contracted doctor -- I used to volunteer, now I'm a contracted doctor -- I had to work really hard to advocate for my patients to even get a handout I developed related to contraception and being able to, you know, have the health department information on there and things like that. And they had to check with Care Net and make sure it was

in compliance. So, you know, as I said before, I love this organization, but I do push back on some things.

Q. Do you know why the Care Net standards of affiliation make a distinction between single and married had people?

A. Yeah. Because of the desire for abstinence in single people.

Q. In your opinion and experience of your medical practice, can an unmarried woman ever have a healthy sexual relationship?

MR. BOYLE: Objection.

THE WITNESS: Boy, that was a loaded question. I do think there are consequences of being sexually active for all of us, whether we're married or not. But particularly with single I do think there's literature that shows that sexual -- sexual risk avoidance, not just reduction is very effective. And so -- what I do is once again what I said earlier about that partnership between the woman and I'm not living in her lived experience, but I don't want to ever do anything that is potentially going to harm one of my patients. And so if it's a single woman who is sexually active, I'm not just going to blindly give her contraception. I'm talking to her about, you know, her risk factors for sexually transmitted infections, what is her sexual behavior, is this somebody she's been with for a long time and they have a monogamous relationship where there's a lot of trust built in. And I also know that men and

women fall hard and they hurt hard when they break up. And so, you know, I -- kind of like earlier with the multifactorial nature of studies, I know that there are many different factors related to the choice to become sexually active.

BY MS. SALVADOR:

Q. Got it. Thank you for clarifying that. Going to number one on the Standards of Affiliation document. It states that the primary mission of the pregnancy center is to share the compassion, hope, and help of Jesus Chris, both in word and deed, with those facing pregnancy decisions. The pregnancy center is equally committed to sharing the gospel of salvation through Jesus Christ with those that serve.

Did I read that correctly?

A. Yes, you did.

Q. Is that statement true for the three pregnancy centers where you work?

MR. BOYLE: Objection.

THE WITNESS: Yeah. So I believe that love is a verb and we are clearly Christian pregnancy centers. And so I believe that when you love others you're willing their good and it's -- it is doing good for people. I believe that you can meet this statement without ever mentioning the word Jesus. And you -- you can love people the way Christ loved. I think that when you look at -- in the literature with medicine when -- about 60 percent of people at least in the psychiatry

literature are in a crisis and this -- in their case it's a mental health crisis, but you can make some inferences, they want a healthcare practitioner who wants to talk about spirituality. So I will talk about that. I will sometimes pray with people if they want me to, but I -- I know they're there for a medical appointment when they're seeing me. And remember, we have two sides of the house. We have this -- the medical side of the house and so I integrate spirituality in that. But my goal -- they're in the middle of a challenge and I want to respect that they -- whatever their faith is, whether they're Christian or not, if spirituality is going to help them through that challenge, I want to encourage them in that way. The client advocacy side where they provide -- connect them with community partners and services they may need like subsidized daycare and the parenting classes, those are where I think this statement really lies and the recognition that these women are often scared and alone, sometimes being coerced, and maybe they were -- they grew up in a church and they are disconnected. And so like how could a church walk alongside them and help them. So I think, you know, yes, this is an extremely strong Evangelical statement, but it's not like we have something that says everybody must leave with a gospel pamphlet.

Q. Right. So the statement -- the Standards of Affiliation, I'm sorry, referred to sharing the gospel of

salvation through Jesus Christ. So what does that mean on the medical side as you described it as two sides?

A. Yeah. I mean, on the medical side it's really being the hands, the feet, the eyes of Jesus. Which is loving people in a way that -- like when they leave I want them to know whatever their choice is, my door is always open. And we will never judge them. And so it's in our actions. It's how we care for them, how we respect them, how we love them as we're, you know, providing information for them. And, you know, if as part of the conversation, which it doesn't happen every time, you know, some of them will say like without me even prompting them -- I mean, I have had women say everything from I'm going to hell for murdering my child, I have had them say I know God is going to be so mad at me, things like that, and I try to really meet them where they are and help them realize no, you're not murdering your child and you're trying to make the best decision at this moment that you think for yourself and I hope it can be a life-affirming decision for you. But don't own that.

Q. Are the pregnancy centers where you work subject to any form of regulation by a health agency?

A. So we -- we have -- in the State of North Carolina we have -- we actually don't have to follow HIPAA guidelines like the way my other practice did. I think that should change, to be honest. We're a medical clinic and we should follow HIPAA

guidelines and I am very strict about that. Everybody is HIPAA trained. We have medical policies and procedures that I'm in the middle of -- because I'm just starting to work with the other centers and I'm updating ours. I think our standards should be exceptional.

Q. So the pregnancy centers where you work are not inspected by any sort of state agency?

A. Not that I am aware of. I think they should be. But I don't think in North Carolina that we have that.

Q. What medical training are Pregnancy Center staff required to have -- the ones who have medical duties that is?

A. Yeah. I mean, they have to have some sort of medical license. So I have everything from nurses to medical assistants to ultrasonographers, RDMSs in the three different centers. So they have to stay licensed according to what their particular license is, their scope of practice. We do HIPAA training regularly. We do OSHA training. We do CPR training. That's all that can come to my mind right now.

Q. Thanks. That's really helpful. So going to number four on the Standards of Affiliation document.

A. Yeah.

Q. It says the pregnancy center does not perform or refer for abortion and provides a written disclaimer to this effect to clients requesting services.

Did I read that correctly?

A. You did.

Q. Is that statement true for the Pregnancy Centers where you work?

A. We don't have a written disclaimer. I have never had a patient request something like that, so I'm not sure, to be honest, what that's all about. But we do not perform or refer for induced abortions.

Q. Are the Pregnancy Centers where you work open with clients about their position on abortion?

A. So we are not -- when you say open, could you define? What do you mean by that? We're open to our clients about our position. Do we tell them? Make statements?

Q. Yeah. Do you tell them about your position on abortion?

A. Yes. So they know that we do not perform abortions. It's on our Website and the people who answer the phone who are trained to let them know that. They also know that when I counsel them and give them an informed consent I say to them my hope is you can choose a life-affirming choice for your child and yourself, but I recognize that's your decision and not mine.

Q. Thank you. And how do you split your time between the three pregnancy centers where you work?

A. Yeah. So I am in Wilson, North Carolina, about an hour east of Raleigh. And I am there actually Tuesdays,

Wednesdays, and Thursdays for about half a day each on average. And then in the Outer Banks in Nags Head I physically go there once a month, but I talk to them most days when they have a patient who's getting an ultrasound. And I'm available if they -- the ultrasonographer needs to talk to me. I just last week had -- we had a patient who was coming in and she had a 12-week intrauterine pregnancy, but the baby looked like it had some very significant skeletal abnormalities. And so as the patient was in one room the ultrasonographer reached out to me and electronically we looked at the pictures together and then I gave the staff recommendation on followup so that she could get an ultrasound and see an ob-gyn at the practice. So I'm available. None of the centers are open on weekends. They're Monday through Friday if they need consults. And then I also -- I try to read all scans within 24 hours.

Q. Got it. So for that patient you just mentioned, I just want to make sure I understand what you said. So you ended up referring that patient to an ob-gyn, is that correct?

A. I did.

Q. Okay. So you refer them out of the pregnancy center, is that right?

A. Yes. We don't do prenatal care or deliveries in terms of the -- the biggest thing that we try to do is if a woman decides to carry her pregnancy often times because of shortages in healthcare practitioners, especially in rural eastern North

Carolina, we may have some gaps so sometimes we really try to facilitate if she needs to see a maternal-fetal medicine specialist. So we do referrals. We just don't do referrals for induced abortion. As I said earlier in my testimony I have a maternal and a fetal patient and I want health and wholeness for both of them. So referral for ending the life of one of them is not a part of medicine.

Q. So understanding that you don't refer patients to pregnancy centers for induced abortions, do you ever talk to them about induced abortions?

A. Yes, I do.

Q. What types of things do you say in those conversations?

A. So I usually -- I ask their permission and if they want to talk, what information they would like and I say would you like to know about the different types of abortion. And so I may explain the difference in a medication/chemical abortion and a surgical abortion. And then I will talk to them about risks related from a medical perspective, things that we have talked about today.

Q. Have you ever received a complaint from a patient at the pregnancy centers where you work?

A. No.

Q. Has any of the centers where you work ever received a complaint related to how they handle abortion counseling?

A. Not that I -- since I have been the medical director of the three. There could have been something before that I'm unaware of.

Q. Got it. I think we're basically done here. So why don't we just take a brief break and then we'll come back. I'll ask a few more questions if I have them, which I might not, and then your counsel will have the opportunity to ask questions. So why don't we just take a -- how about a five-minute break. Does that work?

THE WITNESS: Yes. Thank you.

MS. SALVADOR: Sorry. Let's go off the record.

VIDEOTAPE TECHNICIAN: We are now going off the video record. The time is 6:29 p.m.

(A break was taken.)

VIDEOTAPE TECHNICIAN: We are now back on the video record. The time is 6:36 p.m.

BY MS. SALVADOR:

Q. Dr. Bane, are you the only ob-gyn who is employed by those three pregnancy centers where you work?

A. I am.

Q. Okay. And that's -- so that's all I have on the Pregnancy Centers. And then just going back, you mentioned that you completed a witness training through ACOG, is that right?

A. Yes, that one-day course.

Q. Did you review any materials from that training to prepare for this deposition?

A. No.

Q. Okay.

MS. SALVADOR: I don't have any further questions.

MR. BOYLE: Okay. Thank you. If it's all right, I'll go ahead.

BY MR. BOYLE:

Q. This is Ellis Boyle. I represent the legislative leaders, Speaker Moore and Senator Berger. Doctor, thank you for your time today. I have a few questions. You said in your testimony in that last hour that Mifeprex and Misoprostol are contraindicated until you exclude an intrauterine pregnancy. And I think you may have mixed up your wording a little bit and I want to give you an opportunity to clarify that if you want to. Did you mean that Mifeprex and Misoprostol are contraindicated until you would exclude an ectopic pregnancy instead of the IUP?

A. Okay. So it's Misoprostol, so I think that's what you're talking about, Mifeprex and Misoprostol. So yeah, the FDA, their prescribing information, if I said it wrong, what I meant to say is that they state that you have to exclude an ectopic pregnancy before giving the medication.

Q. Okay. Do you agree that it is safer to suspect every

patient who tests positive for pregnancy has an ectopic pregnancy until you can rule that out?

A. Yes.

Q. If you have a patient who tests positive for pregnancy and has an ultrasound that does not show either an ectopic pregnancy or an intrauterine pregnancy, so it's a pregnancy of an unknown location on that ultrasound finding, what would you say the safest way is to treat that patient?

A. I have had many patients over the years that are in that situation and I -- we do a combination of serial hCG levels, so lab work, and then a repeat ultrasound.

Q. Why would you do the repeat ultrasound?

A. To document an IUP hopefully, but also to rule out ectopic pregnancy.

Q. If you take an ultrasound of a patient who tested positive for pregnancy and it neither shows the IUP nor an ectopic pregnancy, so again, it's an ultrasound that shows a pregnancy of unknown location, does that lower or increase your suspicion that that patient has an ectopic pregnancy?

A. So it increases my suspicion because I would want, as I have said earlier, to have diagnostic certainty in something that is potentially fatal, which ectopic pregnancies can be.

Q. Doctor, if I can direct you to a couple of the exhibits that you were asked questions about. First, I believe it's Exhibit-Q. And, Madam Court Reporter, if you could tell

me if I'm correct, this would be the CDC's maternal mortality rates in the United States for 2021. I believe that's Exhibit-Q.

A. I'm going to have to find that. Just a second.

Q. Well, that's what I'm talking about, Exhibit-Q, correct?

COURT REPORTER: I don't know.

MR. BOYLE: Okay. Well, that's what I'm talking about and I think it's Q. We'll correct it after the fact, if necessary.

THE WITNESS: Is it the 2021 mortality rates?

MR. BOYLE: Yes. That's correct.

THE WITNESS: Okay.

BY MR. BOYLE:

Q. So as I understand it, when you were asked questions about these maternal mortality rates from the CDC in 2021, am I correct in saying that these are maternal mortality rates not specifically related to abortion but just for all maternal mortality in the United States?

A. Correct.

Q. Okay. And then if I can direct you to what I believe again is Exhibit-R, which would be the North Carolina 2016 maternal mortality review report. If you let me know when you get there, please.

A. Okay.

Q. Do you have that one up?

A. No. I'm sorry.

Q. Okay. Let me know.

A. Okay. Yes, I have it up.

Q. And I believe you were asked questions on page 11 of that document. Do you see page 11?

A. I'm getting there. Yes.

Q. Again, I believe you were asked questions about this page and these numbers at that chart on the bottom. And I just want to clarify again, are these numbers in that chart that represent maternal mortality in the State of North Carolina for these various years, are they specific to abortion or are they just general maternal mortality?

A. Let me look at the chart here. Overall. Pregnancy mortality ratio. So they are for all deaths, not just deaths related to abortion.

Q. Right. So all maternal death, not the specific question that you were asked later about the CDC numbers, which were the abortion-related maternal mortality, right?

A. Correct.

Q. Let me direct you to what I believe is Exhibit-S, which is the CDC mortality -- morbidity and mortality weekly report from November 2022. This is the abortion surveillance for the United States in 2020. Please let me know when you have got that up and go to page 27.

A. Actually it was still on page 27.

Q. There you go. So you were asked questions about this exhibit and it was represented that this table on page 27 for the 2013 to 2019 abortion-related maternal mortality was .43 or 43 deaths per 100,000 I believe, is that correct?

A. Yes.

Q. And this question wasn't asked, but I want you to please look at the asterisk and look at the little small print there at the bottom of this chart and tell me if I'm reading this particular part of that correctly, quote, because a substantial number of legal induced abortions occurred outside reporting areas that provided data to CDC, national CFRs, i.e. number of legal induced abortion-related deaths per 100,000 reported legal induced abortions in the United States, were calculated with denominator data from the Guttmacher Institute's national survey of abortion-providing facilities, end quote. Did I read that sentence properly?

A. Yes.

Q. And what does that sentence tell or inform your opinions in this case, please?

A. They're consistent with my opinions in my declaration that we don't have accurate information on the number of legal-induced abortions. So our -- it's difficult for us to really know the true and accurate number of complications and deaths.

Q. Okay. And does the fact that they don't have accurate data of actual abortion deaths from places that just didn't give it to the CDC and then they use the Guttmacher Institute's number as the denominator, does that impact what you think those numbers might reflect in this chart?

A. Well, I mean, I think I said earlier that your conclusions that you draw are only as accurate as the information you're drawing them from. And so I think a consistent message that I have had is that we don't do a good job because we have this voluntary reporting. And, you know, the fact that the CDC is having to rely on someone else's data is concerning. It's not surprising because if you look at the number of abortions reported between Guttmacher and the CDC, they differ vastly. So we have got to do a better job if we're going to truly understand and keep women safe.

Q. And you say the Guttmacher number is different. Isn't it much larger than the CDC number?

A. Yes, it is much larger.

Q. So if you have underreporting of the actual deaths on the voluntary information provided on that side and then you have an overinflation on the denominator from the Guttmacher, what does that tell you about your opinion about that actual number in this chart?

A. You're going to have to repeat that. Sorry.

Q. Yes. So you have underreporting of that number of

actual deaths on the top of the division, right, the numerator? Because the CDC is not getting all those deaths, is that correct?

A. Correct.

Q. And then on the bottom part, the denominator, you have got a higher number because Guttmacher has a bigger number than the CDC's reported number?

A. Right.

Q. So if you're dividing fewer on top than more on the bottom doesn't it under inflate the likely actual number -- misrepresent to the low end of the spectrum how many maternal deaths are actually attributable to an abortion in that year?

A. Yes. Your number -- your fraction would be different. It would be lower.

Q. I would like to direct you to what I believe is Exhibit-10, the Koch report from I believe the study of abortion legislation, maternal healthcare, fertility, et cetera, et cetera, in the 32 Mexican states. Can you let me know when you're at that document, please?

A. I'm there.

Q. Okay. If you turn to page 10. I believe you were asked a question about one particular sentence on page 10. Do you recall that?

A. Let me get to 10. I don't remember what sentence I was asked a question about.

Q. Okay. I believe you were asked a question about the, quote, consequently making a direct or independent causal link between a less permissive abortion law and a lower incidence of maternal deaths, or conversely by considering a more permissive abortion law would be a premature or even erroneous conclusion, end quote. Do you remember that question?

A. I do.

Q. Let me read you the next sentence and ask you your opinion of that and whether it impacts your declaration. Quote, rather, from an epidemiological perspective the Mexican natural experiment provides evidence to support three complimentary assumptions at the population level. First, abortion legislation per se did not appear to have an independent effect on overall maternal mortality rates. Second, a less permissive abortion law in terms of not considering exemptions from criminal prosecution of abortion in cases of genetic or congenital fetal anomalies was not associated with increased maternal and abortion-related deaths. And third, differences in maternal mortality incidents in the context of different abortion legislation, more or less permissive, appear to be mainly explained by the distribution of other major independent factors most likely facilitating an epidemiological transition for its low maternal mortality rates independently from abortion legislation itself, end quote.

Did I read that correctly?

A. You did.

Q. Does adding that other sentence there for context help explain why you included this report? I'm sorry, yes, this report in your declaration.

A. Yeah. I mean, it's consistent with the message that I have shared earlier about the difference between correlation and causal and the fact that we know that there are multiple factors that cause women to die and that this is -- they're acknowledging the fact that they're -- it is not one factor alone, but actually proposing that we have to look at many of the different factors. But just because you're looking at things like education and warning signs and transportation and clean sanitation and things like that, it doesn't exclude that your other observation on the trends -- you don't discount those. You just recognize the multifactorial nature of this issue.

Q. And finally, I'd like to ask you about the Fergusson study, which I believe was Exhibit-X. Again, I could be off. That's what my internal numbering was. So if we can fix that later. But you let me know, please, when you've got the Fergusson study up.

A. Okay.

Q. And go to page 450 once you get there, please.

A. All right. I can't easily find it, so I'm just going to pull up my hard copy.

Q. That's fine.

A. What page again?

Q. 450 with the implications section.

A. Okay. I'm there.

Q. Okay. Again, you weren't asked about this, so I want to give you the opportunity to explain more fulsomely why you included this study in your declaration. There's a sentence under implication that's, quote, specifically, the results do not support strong pro-life positions that claim that abortion has large and devastating effects on the mental health of women. Neither do the results support strong pro-choice positions that imply that abortion is without any mental health effects, end quote.

Do you see that?

A. Yes.

Q. And I think you were talking about that, but does that particular sentence there, and anything else that you would like to point to in this study to explain why you included this, please?

A. So I know a little bit of the back story of this study from Dr. Fergusson's -- some interviews he did because he struggled so much with getting it published and he was really disheartened that the scientific community would not publish something because they didn't like the results. And he was afraid that pro-life -- the pro-life side would use it to say

it's causal and the pro-choice side would use it to say that abortion doesn't cause mental health effects. So the next sentence is actually, I think, one of the most powerful. In general, the results lead to a middle-of-the-road position that for some women, abortion is likely to be a stressful and traumatic life event which places those exposed to it at modestly increased risk of a range of common mental health problems.

So what he's saying is that he saw an association and the scientific community has to take that association and explore it more. You know, when Tobacco was first blamed for -- and cigarettes for lung cancer, there was a whole pushback from people who wanted tobacco out there. And it took a long time for people to take that relationship seriously and he doesn't want that to happen. And he says -- I think in his study I think he says one in 10 women in New Zealand have abortions. It's one in four in our country. And why wouldn't we want to dig our feet in deeper and find out are we really helping or harming women. And that's why I think this is a critical paper.

Q. Okay.

MR. BOYLE: Doctor, I don't think I have any other questions. Thank you very much for your time. There may be some redirect or another lawyer may have a question. But thank you.

THE WITNESS: You're welcome.

VIDEOTAPE TECHNICIAN: Anyone else? All right. Before we do go off the video record I did need to see if anyone needed transcript copies, rough drafts, or video copies.

MR. BOYLE: Can I say for my side, can I just put in the chat what we want? Would that work for you?

VIDEOTAPE TECHNICIAN: It won't be on the record.

MR. BOYLE: Oh, you need it on the record? Yeah, we want a -- please, if we can for the legislative defendants, can we have an expedited by next Tuesday, if possible, and a video whenever. I imagine that's easier to do, but it does need to be synced.

VIDEOTAPE TECHNICIAN: But you don't need an expedite for the video?

MR. BOYLE: I mean, I would hope that it would come around -- if I'm paying for an expedited transcript, I'm hoping the video is coming too.

VIDEOTAPE TECHNICIAN: Okay. We'll make sure -- we'll take care of it for you.

MR. BOYLE: Okay. Thank you.

VIDEOTAPE TECHNICIAN: Certainly.

MS. SALVADOR: We would also like an expedited transcript, please. And if you have the rough ready sooner we will take that too.

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.

_____

SUSAN A. HURREY, RPR

Notary Public #201826800211

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:_____

E R R A T A S H E E T

PAGE LINE CORRECTION

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I, _____, after having read the foregoing transcript of my deposition, wish to make the above corrections.

SIGNATURE_____

DATE_____

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EXHIBIT 5

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

PLANNED PARENTHOOD SOUTH ATLANTIC, *et al*.,	)	
Plaintiffs,	)	Case No. 1:23-cv-00480-CCE-LPA
v.	)	
JOSHUA STEIN, *et al*.,	)	
Defendants.	)	

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.

Erin Hawley***
DC Bar No. 500782
ehawley@adflegal.org
Erica Steinmiller-Perdomo***
DC Bar No. 90009737
esteinmiller@ADFlegal.org
ALLIANCE DEFENDING FREEDOM
440 First Street NW, Suite 600
Washington, DC 20001
Tel.: (202) 393-8690
Fax: (202) 347-3622

s/ W. Ellis Boyle
W. Ellis Boyle
N.C. State Bar I.D. No. 33826
email: docket@wardandsmith.com *
email: weboyle@wardandsmith.com **
WARD AND SMITH, P.A.
Post Office Box 33009
Raleigh, NC 27636-3009
Tel.: (919) 277-9100
Fax: (919) 277-9177

Julia Payne***
IN Bar No. 34728-53
jpayne@adflegal.org
ALLIANCE DEFENDING FREEDOM
15100 N. 90th Street
Scottsdale, AZ 85260
Tel.: (480) 388-8028
Fax: (480) 444-0028
Attorneys for Defendants Berger and Moore

Denise M. Harle***
GA Bar No. 176758
dharle@adflegal.org
ALLIANCE DEFENDING FREEDOM
1000 Hurricane Shoals Rd. NE
Ste D-1100
Lawrenceville, GA 30043
Tel.: (770) 339-0774
Fax: (480) 444-0028

*** *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:

Hannah Swanson
Anjali Salvador, Esq.
Helene T. Krasnoff, Esq.
email: Anjali.salvador@ppfa.org
email: Helene.krasnoff@ppfa.org
Planned Parenthood Federation of America
1110 Vermont Avenue NW, Suite 300
Washington, DC 20005
Attorneys for Planned Parenthood South Atlantic

Kristi L. Graunke, Esq.
Jaclyn A. Maffetore, Esq.
ACLU of North Carolina
email: kgraunke@acluofnc.org
email: jmaffetore@acluofnc.org
P. O. Box 28004
Raleigh, NC 27611
Attorneys for ACLU of North Carolina

Brigitte Amiri, Esq.
Lindsey Kaley, Esq.
Ryan Mendias, Esq.
American Civil Liberties Union Foundation
email: bamiri@aclu.org
email: lkaley@aclu.org
email: rmendias@aclu.org
125 Broad Street, 18th Floor
New York, NY 10004-2400
Attorneys for American Civil Liberties Union Foundation

Amar Majmundar, Esq.
Stephanie A. Brennan, Esq.
Sarah G. Boyce, Esq.
South A. Moore, Esq.
Sripriya Narasimhan, Esq.
North Carolina Department of Justice
email: amajmundar@ncdoj.gov
email: sbrennan@ncdoj.gov
email: sboyce@ncdoj.gov

email: smoore@ncdoj.gov
email: snarasimhan@ncdoj.gov
North Carolina Department of Justice
P. O. Box 629
Raleigh, NC 27603
Attorneys for Joshua Stein, Attorney General of North Carolina

Elizabeth C. O'Brien, Esq.
North Carolina Department of Justice
email: eobrien@ncdoj.gov
P. O. Box 629
Raleigh, NC 27603
Attorney for Todd M. Williams, District Attorney for District 40

Kevin Guy Williams, Esq.
email: kwilliams@belldavispitt.com
Bell Davis & Pitt, P.A.
P. O. Box 21029
Winston-Salem, NC 27120-1029
Attorney for Jim O'Neill , District Attorney for District 31

Elizabeth C. O'Brien, Esq.
North Carolina Department of Justice
email: eobrien@ncdoj.gov
P. O. Box 629
Raleigh, NC 27603
Attorney for:
Spencer Merriweather, District Attorney for District 26
Avery Crump, District Attorney for District 24
Jeff Nieman, District Attorney for District 18
Satana Deberry, District Attorney for District 16
William West, District Attorney for District 14
Lorrin Freeman, District Attorney for District 10
Benjamin R. David, District Attorney for District 6

Colleen Mary Crowley, Esq.
Michael T. Wood, Esq.
email: ccrowley@ncdoj.gov
email: mwood@ncdoj.gov
555 Fayetteville Street, Suite 720
Raleigh, NC 27516
Attorney for Kody H. Kinsley, Secretary of the North Carolina Department of Health and Human Services

Michael E. Bulleri

North Carolina Department of Justice
email: mbulleri@ncdoj.gov
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.

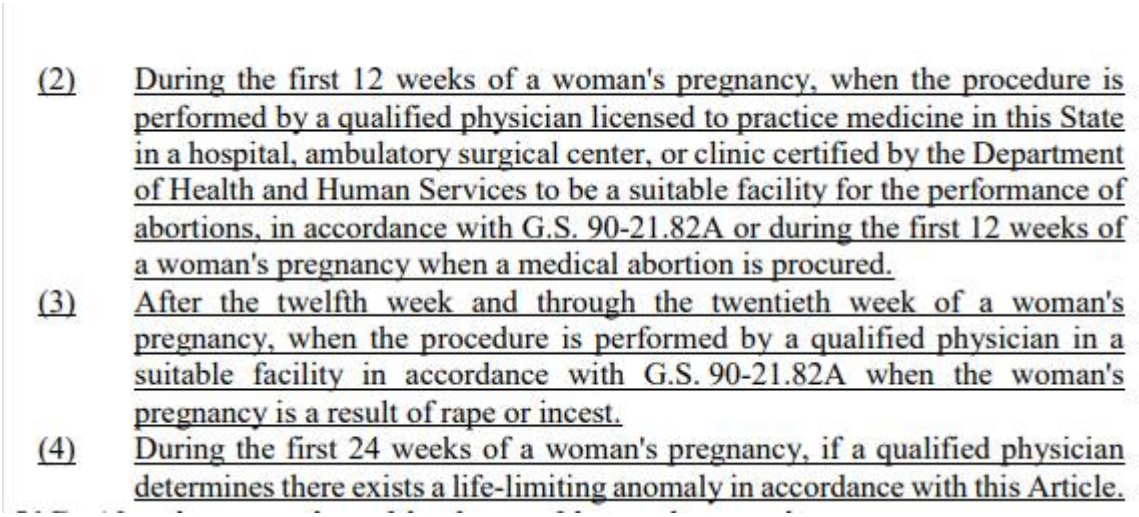
So, say there is a life limiting anomaly at 20 weeks – no chance that the fetus will survive long after birth and the mother, instead of carrying for another 20 weeks only to face the loss of her child, decides to terminate. In that scenario, the doc would offer an "induction abortion" or a c-section. 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
919.630.3375 919.883.9955 (fax)
www.roblammepolicy.com

On Tue, May 16, 2023 at 8:15 AM Nathan Babcock (President Pro Tems Office) <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

From: RLamme <roblamme@rlamme.com>
Sent: Tuesday, May 16, 2023 8:04 AM
To: Nathan Babcock (President Pro Tems Office) <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)

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.

--

116 North East Street, Raleigh, NC 27601
919.630.3375 919.883.9955 (fax)
www.roblammepolicy.com

On Mon, Jun 12, 2023 at 3:24 PM Nathan Babcock (President Pro Tems Office) <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>
Sent: Monday, June 12, 2023 2:58:37 PM
To: Nathan Babcock (President Pro Tems Office) <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

--

116 North East Street, Raleigh, NC 27601
919.630.3375 919.883.9955 (fax)
www.roblammepolicy.com

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

From: Paul Stam
Sent: Friday, June 30, 2023 9:07 PM
To: 'Neal.Inman@ncleg.net' <Neal.Inman@ncleg.net>; 'Brian Fork (President Pro Tem's Office)' <Brian.Fork@ncleg.net>; Yost <joshua.yost@ncleg.gov>
Cc: 'Reese, Pamela D.' <pamela.d.reese@nccourts.org>; 'John Thorp' <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

From: John Thorp
Sent: Friday, June 30, 2023 8:23 PM
To: Paul Stam <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> 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

From: NC Family
Sent: Friday, June 30, 2023 3:55 PM
To: Paul Stam <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 To

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 pregnancy.

Speaker of the NC House Tim Moore and President Pro Tempore of the NC Senate Phil Berger have in 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 arg attorneys.

NC Family will continue to monitor updates surrounding this case.

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<image002.png>

NC FAMILY
POLICY COUNCIL

P.O. Box 20607
Raleigh, NC 27619

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

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 16th, 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,

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:

SUSAN B. ANTHONY PRO-LIFE AMERICA

Americans United for Life

Christian Medical & Dental Associations® Changing Hearts in Healthcare

Family Policy ALLIANCE

Heartbeat INTERNATIONAL

STUDENTS FOR LIFE ACTION ELECTIONS. LAWS. LEADERS.

ABORTION PILL REVERSAL™

LOZIER INSTITUTE

January 2023

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.

(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 antiprogesterone 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

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, 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, or you can contact (877) 558-0333 for assistance in locating a medical professional that can aide 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 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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EXHIBIT 12

Post 12-week Complications Resulting in Hospital Transfer for 1/1/2020-6/30/2023				
Complication	**Weeks LMP**	**Health Center**	**Year**	**Hospital Status**
Bleeding/Hemmorhage	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/Hemmorhage	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/Hemmorhage	15	Chapel Hill Health Center	2021	Treated & released in stable condition
Incomplete AB	12	Asheville Health Center	2021	Treated & released in stable condition
Bleeding/Hemmorhage	15	Chapel Hill Health Center	2022	Admitted for treatment & released in stable condition
Bleeding/Hemmorhage	17	Chapel Hill Health Center	2022	Treated & released in stable condition
Bleeding/Hemmorhage	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/Hemmorhage	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				
Complication	**Weeks LMP**	**Health Center**	**Year**	**Hospital Status**
Bleeding/Hemmorhage	17	Chapel Hill Health Center	2023	Treated & released in stable condition
Bleeding/Hemmorhage	17	Chapel Hill Health Center	2023	Treated & released in stable condition
Bleeding/Hemmorhage	19	Chapel Hill Health Center	2023	Treated & released in stable condition
Bleeding/Hemmorhage	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

Complications from 01/2020 - 06/2023*	
Type of Complication	**Count**
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
TOTAL	**522****

*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.

EXHIBIT 14

Pre 12-week Complications Resulting in Hospital Transfer for 1/1/2020-6/30/2023					
Complication	**Weeks LMP**	**Type of AB**	**Health Center**	**Year**	**Hospital Status**
Incomplete AB	6	Medication	Asheville Health Center	2020	Treated & released in stable condition
Incomplete AB	9	Medication	Winston-Salem Health Center	2020	Admitted for treatment & released in stable condition
Seizure	10	Procedural	Chapel Hill Health Center	2020	Treated & released in stable condition
Bleeding/Hemmorhage	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/Hemmorhage	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/Hemmorhage	6	Procedural	Chapel Hill Health Center	2021	Admitted for treatment & released in stable condition
Bleeding/Hemmorhage	11	Procedural	Winston-Salem Health Center	2021	Treated & released in stable condition
Bleeding/Hemmorhage	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

Planned Parenthood
Care. No matter what.
Planned Parenthood South Atlantic

☐ *Asheville* ☐ *Chapel Hill* ☐ *Charleston* ☐ *Charlotte* ☐ *Charlottesville*
☐ *Columbia* ☐ *Durham* ☐ *Fayetteville* ☐ *Greensboro* ☐ *Raleigh*
☐ *Roanoke* ☐ *Vienna* ☐ *Wilmington* ☐ *Winston-Salem*

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® Care. No matter what.
Planned Parenthood South Atlantic

☐ *Asheville* ☐ *Chapel Hill* ☐ *Charleston* ☐ *Charlotte* ☐ *Charlottesville*
☐ *Columbia* ☐ *Durham* ☐ *Fayetteville* ☐ *Greensboro* ☐ *Raleigh*
☐ *Roanoke* ☐ *Vienna* ☐ *Wilmington* ☐ *Winston-Salem*

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

[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.[1]

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

[1] "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.[2]

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

[2] 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[3]—and they are warned both verbally and in writing that untreated ectopic

[3] 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.[4] *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

[4] 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.[5]

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.

[5] 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 . . . .").[6] And even if

[6] 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.[7]

[7] 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.

_____
United States District Judge

Dated: September 12, 2023

Respectfully submitted,

/s/ Kristi Graunke
Kristi Graunke
NC Bar # 51216
Jaclyn Maffetore
NC Bar # 50849
American Civil Liberties Union
of North Carolina Legal Foundation
P.O. Box 28004
Raleigh, NC 27611
Tel.: (919) 354-5066
kgraunke@acluofnc.org
jmaffetore@acluofnc.org

COUNSEL FOR ALL PLAINTIFFS

Brigitte Amiri*
Lindsey Kaley*
Ryan Mendias*
American Civil Liberties Union
Foundation
125 Broad Street, 18th Floor
New York, NY 10004
Tel: (212) 549-2633
bamiri@aclu.org
lkaley@aclu.org
rmendias@aclu.org

COUNSEL FOR BEVERLY GRAY, M.D.

/s/ Hannah Swanson
Hannah Swanson*
Helene T. Krasnoff*
Planned Parenthood Fed. of America
1110 Vermont Avenue NW, Suite 300
Washington, DC 20005
Tel.: (202) 803-4030
hannah.swanson@ppfa.org
helene.krasnoff@ppfa.org

Anjali Salvador*
Planned Parenthood Fed. of America
123 William Street, 9th Floor
New York, NY 10038
Tel.: (212) 541-7800
anjali.salvador@ppfa.org

COUNSEL FOR PLANNED
PARENTHOOD SOUTH ATLANTIC

**Special appearance filed*

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
Hannah Swanson*
Planned Parenthood Fed. of America
1110 Vermont Avenue NW, Suite 300
Washington, DC 20005
Tel.: (202) 803-4030
hannah.swanson@ppfa.org

**Special appearance filed*