Brief of *Amici Curiae* American Civil Liberties Union, Center for Reproductive Rights, and Lawyering Project
U.S. Food & Drug Administration v. Alliance for Hippocratic Medicine

APPENDIX OF SOURCES

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF UTAH, CENTRAL DIVISION

* * *

PLANNED PARENTHOOD ASSOCIATION OF UTAH, on behal of itself and its patients, physicians, and staff, Plaintiff, vs. JOSEPH MINER, in his official capacity as Executive Director of the Utah Department of Health, et al., Defendants.	Case No. 2:19-cv-00238 Deposition of: INGRID SKOP, M.D.

* * *

September 2, 2020
8:03 a.m.

Via Web Conference

Kristin Marchant
- Registered Professional Reporter -

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Q. Of any kind. That they don't perceive it as being relevant to their annual checkup?
A. Well, they may not perceive it as being relevant, and it may just be something that they don't want to talk about.
Q. Okay. So if I could go back to my question. Maybe let's think of it in terms of a year. How often would you say that you have a conversation with a patient who describes her decision making with a prior -- with respect to a prior abortion?
A. Maybe once a month.
Q. Okay, maybe 12 times a year. And of those, how many would you say express regret for having the procedure?
A. It is complicated because some of them will affirm that they feel it was the best decision for them. But, inevitably, they also will affirm that they wish that they had not done it, if that makes sense. They wish they had not been in a situation where that was the decision they had to make.
Q. They regret the situation but not the outcome?
A. They're glad they're not pregnant anymore, but they regret that they had to choose an abortion.
Q. When you're using regret in that way, do you

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mean that they're sad that they had to have an abortion?
A. Sometimes. A lot of them cry when they talk about it.
Q. Have you ever had patients who tell you that they regret having children?
A. No, I don't think anyone has ever told me that. Kids are hard at times, but nobody has ever wished they didn't have their child. I've never seen that.
Q. There would probably be a lot of stigma attached to that, correct?
MR. SORENSON: Objection, foundation.
Q. Let me ask it this way. Have you ever encountered patients who have indicated that they are sad because they're parents?
A. Told me they are sad because they were a parent?
Q. Uh-huh, that they have children?
A. No. No, I haven't.
Q. Have you ever had patients who have told you that they regretted the decision to have a baby and place it for adoption?
A. Placing for adoption is very complicated. It is very, very hard for a woman to do that. But I don't think I've ever had anybody who said that they

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regretted making that decision.
Q. Or that they were sad that they had to make the decision to place a baby for adoption?
A. Well, certainly, I think a lot of them are sad, to be perfectly honest. I don't have that conversation very often. Very, very few women will give birth to an unwanted pregnancy and place it for adoption because abortion is so easy to obtain.
Q. Okay. Let's see. Let me make sure -- so later -- if you can turn back to page 4 of your report, that same paragraph that we were just looking at -- towards the end of the paragraph you discuss Florida statistics on reasons that a patient might have an abortion, correct?
A. Yes.
Q. And to support those data you cite a website called Abort73.com; is that right?
A. Yes.
Q. What is that?
A. It is an organization that puts out some information about abortion. I couldn't find the -- the Florida source, but I've seen that statistics from a couple of different website, so I considered it to be accurate.
Q. So you couldn't find any original data that

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would support this finding with respect to Florida; is that correct?
A. I did not find the Florida source, no.
Q. And did you look for it?
A. Yes, but I'm not a really good researcher, so it is possible that it was easy to find and I just didn't find it, but. . .
Q. Okay. Did you consult the Florida state government's website?
A. I don't recall where I looked for it, to tell you the truth.
Q. Do you consider Abort73 a reliable source in your field?
A. I'm not that familiar with who does the research for that website. But based on numbers I've seen on a number of sources, I think that these statistics are probably fairly accurate. And even Guttmacher tells us that 97 percent of abortions are done for social, financial -- not hard cases, not life and health of the mother, not fetal anomalies.
Q. I'm just trying to understand your process of drafting the report, Dr. Skop. So you're not familiar, you said, with who compiles the numbers on the website Abort73; is that right?
A. That's correct.

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Q. Can you think of any colleague who would agree that this is a reliable source of information?
A. I can't say. I haven't discussed this report with anybody.
Q. Would you agree that in medical and social science research, it is better to site primary sources?
A. Yes, I've tried to do that, but in this case I was not able to find it.
Q. And to your knowledge, is the Abort73 website, is that associated with a -- it is called Loxafamosity Ministries? Does that sound familiar?
A. I don't know. I don't know who puts out that website.
Q. So you don't know where this information originally came from; is that correct, with respect to the Florida statistics?
A. Well, ultimately it came from the State of Florida, but I did not find the specific --
Q. How do you know that, Doctor?
A. Because I believe that they were telling me the truth when they said they got it from Florida.
Q. And you believe that they're telling the truth, this website; is that accurate? You believe the website is telling you the truth?
A. Yes.

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Q. But you don't know who created the website?
A. No.
Q. Or who supplies the numbers?
A. It is in line with other statistics that I've seen about how infrequent it is that women really have abortions for life -- serious illness, fetal anomalies, rape, incest. Those statistics are widely available and they are all the same number range.
Q. So based on what you just said, would you agree, then, that HB136, as you understand it, is likely to affect the majority of abortions at and after 18 weeks of pregnancy that occur currently in the state of Utah?
A. You know, the Utah statistics are difficult to interpret. After I have drafted this report, I found some more data about Utah that seems to indicate that two-thirds of their abortions are for therapeutic reasons. The problem --
Q. Where did you find that data?
A. I don't remember where I found it. Do you think it is true? Have you read that?
The problem with therapeutic -- therapeutic to the layman sounds like those would be indicated, right? But therapeutic does not have a specific definition. The Roe versus --

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Q. If we don't know where the source is coming from, I'd rather not go down that route. Certainly if there are materials that you relied on in drafting the report that you recall you did rely on, you know, we can talk about a process for submitting additional information, but if we could table that for now, that would be good.
Okay. So moving on, again, to page 4. Later in that page you refer to a study that, you said, shows that abortions later in pregnancy are more frequently covered by health insurance than earlier abortions; is that correct?
A. Yes, I did write that.
Q. Okay. And can you describe why you think that information is relevant to this case?
A. Well, later abortions are much more expensive. And so if a woman doesn't have an early abortion -- well, let me back up.
There are, I believe, 13 states that will cover abortions through Medicaid. And so it is likely that if a woman is poor and doesn't get an abortion early, if she's not in one of those states and not under Medicaid coverage, it is very likely that she does not get the money together -- which, your average first trimester abortion is about $500, laters run from

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anywhere, depending on the gestational age -- 1,500 to 10,000, I've heard. So if she's not -- if she doesn't have a funding source, then, very likely, she's going to carry that pregnancy to term. So probably many of the later ones are covered by Medicaid in those states that will cover them.
Q. So in other words -- as understood this statistic that you were citing about health insurance, it seemed to me -- well, let me ask it this way. Were you suggesting that it would actually be easier to get an abortion in the second trimester than the first?
A. No. No.
Q. Okay. So do you believe that one potential driver of higher rate of insurance in the second trimester is that the people without insurance are, essentially, priced out of being able to afford the care?
A. That could be the case, yes.
Q. That could be one explanation.
Have you considered whether Utah permits coverage of abortions in private or public insurance plans?
A. I don't know what Utah does there.
Q. Okay. So you haven't done any research in that respect?

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A. The three-ring binder.
Q. The three-ring binder. And did you open up the three-ring binder and look at the -- what did you do when you saw the three-ring binder?
A. I opened it up and saw that it was the documents that I had previously provided.
Q. And then were there four or five envelopes at the end of the binder?
A. Yes.
Q. And how were those marked?
A. They have letters on them.
Q. And what did you do with -- well, were those envelopes sealed as well?
A. Yes.
Q. And you opened each one of those last night?
A. Yes.
Q. Did it occur to you after seeing the binder that had been sealed that perhaps you were not supposed to open the envelopes?
A. No, it didn't occur to me. I figured I was being sent it for use today.
Q. And so you didn't reach out to counsel for any advice?
A. No.

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Q. Okay. And once you received the packages last night, did you -- have you -- did you speak to Mr. Sorenson between the time that you received the package and this morning when the deposition began?
A. I don't think that we spoke.
Q. Did you email or communicate in writing?
A. No.
Q. So you didn't have any communication with him between the time the package arrived and when you got on the deposition this morning?
A. No.
Q. Okay. How much time would you say you spent looking at the documents last night that were provided to you?
A. I just flipped through them. Probably less than 15 minutes because I had read them all before.
Q. And did you spend any other time looking at documents last night related to --
A. Regarding this case --
Q. -- in preparation for this deposition?
A. Yeah, over the past couple of days, I've read -- reread some of the papers.
Q. I'm asking about the time between when you received the packet last night, you said around 6 p.m., and this morning when the deposition began, how much time

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would you say you spent preparing the deposition between then and when the deposition began this morning?
A. Really, at that point, only 15 minutes. I made dinner. I was on a conference call, watched TV, and went to bed. I didn't spend any additional time after that preparing.
Q. Okay. All right. With that, let's talk a little bit about publications. If I understood your CV correctly, it looks like you didn't publish any articles or do any presentations between the late 1990s and 2018. So approximately 20 years. Is that correct?
A. That's correct.
Q. And the first one you published something about abortion was in 2018; is that correct?
A. I believe so.
Q. How many articles have you published in a peer review journal?
A. I believe there have been four or five.
Q. Okay. And of those -- am I correct you said there were two or three that related to abortion?
A. They've all related to -- well, the recent ones all related to abortion. It looks like there have been five peer reviewed; three of them have specific information about abortion safety.
Q. Uh-huh. And you said that -- earlier that

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you had been -- had been deposed in two lawsuits; one as a defendant and one as an expert a couple of years ago in a medical malpractice case; is that correct?
A. That is correct.
Q. Was the name of that case Bates v. Smith; do you recall?
A. Smith?
Q. Actually, that one would have been around 2005. Is that the medical malpractice case that you were referring to, Bates v. Smith?
A. What was the first name?
Q. Bates, B-A-T-E-S?
A. I don't recall that, no.
Q. Okay. What was the -- and you said you don't recall the name of the case that you were involved in a couple of years ago, right?
A. The recent one was -- Carolina Praderio was the doctor. I've forgotten the plaintiff's name.
Q. So Carolina Praderio would have been a defendant in the case?
A. Right. Yes.
Q. To your knowledge, have you ever been subject to a challenge to disqualify you from serving as an expert witness in court?
A. Not that I know of.

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in my CV that I was a member.
Q. No. But in your expert report, it was not a source that you cited, correct?
A. Well, remember I said that when I -- I did look at some intermediate documents that were -- but then I went to the neurologic literature to cite where those statements actually came from.
Q. But it is not -- in terms of what you revealed in your CV that you had considered in preparation of your expert report, you didn't cite AAPLOG, did you?
A. I guess not.
Q. No. And I asked you earlier whether you had made every effort to include in your expert report the facts and data that you relied upon, correct?
A. That's correct.
Q. Would you say you overlooked this one?
A. I did overlook this one, yeah, because I thought it would be more important to go directly to the studies.
Q. Do you think a court might consider -- as you said, AAPLOG has a bias. Would you be concerned that a reader might believe your expert report is less reliable if you relied on AAPLOG?
A. Not necessarily, if they go to the

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neurologic literature.
Q. Okay. And then the document that I just dropped into the chat, have you -- let's see. We've introduced that one. That was Exhibit 12.
A. That was the practice bulletin.
Q. Okay. And that, you said, was not your work, correct?
A. That's correct.
Q. Okay. What about -- do you have any prior existing contracts with AAPLOG for any services of any kind?
A. No, I have not received any money or contribution.
Q. Do you have money from any other pro-life organizations?
A. On occasion I will be paid for work that I've done for Charlotte Lozier, but it is usually on a project basis.
Q. Okay. And what kind of projects do you do for them.
A. I wrote a paper on "No Test Medical Abortion."
Q. And just to confirm, that is not in your CV, correct?
A. Yes, it is not in my CV.

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Q. What other projects have you done for the Charlotte Lozier Institute?
A. I did some -- I did a statement on maternal mortality that was presented at a congressional briefing.
Q. Okay. Is that on your CV?
A. No.
Q. Okay. Did you think that that might be relevant to this case the in the scope of your expert testimony?
A. Well, I thought that the CV just wanted publications that were peer reviewed. I didn't intentionally leave those off. But, you know, like I said, I didn't think it was important enough to put on here.
Q. Okay. Do you -- you mentioned that you have been paid by the Charlotte Lozier Institute, and is that affiliated with AAPLOG?
A. No.
Q. Is it affiliated with any other pro-life organizations?
A. I believe it is affiliated with Susan B. Anthony List.
Q. All right. Any other projects that you've done for the Charlotte Lozier Institute that you can

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recall?
A. No.
Q. Okay. So you've now told me all the projects you've done for them. There were two?
A. Those are the only two things I've been paid for. Oh, I -- you know, two of these articles, the two that were written by Studnicki, those are some Charlotte Lozier researchers as well. So I collaborated on those two papers.
Q. Okay. Were you paid for those?
A. No.
Q. And can we go to Tab O?
Before we go on, you mentioned you looked at these documents for about 15 minutes last night, the documents I sent as exhibits. Did you look at this AAPLOG fact sheet last night?
A. I glanced and saw it was in there. I didn't reread it.
Q. Okay. So Tab O I will mark as Exhibit 13. This is entitled "Medical Abortion: What Physicians Need to Know" authored by you.
A. That is correct.
(Exhibit No. 13 was marked.)
Q. Does it appear complete?
A. Yes, it does.

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Q. And is this one of the articles that was peer reviewed?
A. Yes, this was -- this was peer reviewed.
Q. Okay. And then if we could go to -- actually, let's stay with this. So did you author this article, Dr. Skop?
A. Yes, I did.
Q. You wrote all of it?
A. Yes.
Q. Can we go to Tab P, please? Are you there?
A. Yes.
Q. So we'll mark Tab P as Exhibit 14.
(Exhibit No. 14 was marked.)
Q. And Tab P is the expert report of Byron C. Calhoun and this case, correct?
A. Yes.
Q. And you said you had seen this last night for the first time is that correct?
A. That's correct.
Q. Can you look at paragraph 73 and 74? It says, "However, when one examines the research studies, NAS, the National Academies of Sciences, used for their conclusions, the poor quality of the literature regarding long-term complications becomes apparent.

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"For many questions, there were very few or no studies that met their criteria, and they disqualified many studies (especially those regarding mental health) due to perceived study defects. Thus, in all cases, there were fewer than a handful of studies on which they based their definitive conclusion of 'no long-term impact.' The sparse selection of studies does not support conclusions as definite as those drawn by the NAS."
Did I read that correctly?
A. Yes, ma'am.
Q. And now can we look back at your medical abortion article on page 110, the last full paragraph on the left column? And I'll read that there. At the very end of the paragraph, it says, "However, when one examines the research studies they used for their conclusions, poor quality of the literature regarding long-term complications becomes apparent. For many questions, there were very few or no studies that met their stringent criteria, and they disqualified many studies to perceived study defects. Thus, in all cases, there were less than five studies on which they based their definitive conclusion of 'no long-term impact.'"
Did I read that correctly?
A. Yes, ma'am.

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Q. These passages are identical, aren't they?
A. They sound identical, yes.
Q. It is your testimony that you wrote this?
A. You know, I don't recall if I wrote that statement or if maybe I got it from something I read that Byron wrote. It is hard to know, or possibly we both got it from a statement that someone else wrote. I don't recall exactly.
Q. Would you agree that at least one of you must have taken someone else's work and presented it as your own?
A. I mean, certainly it is the same couple of sentences. I don't think that this means that either one of us did not come to this conclusion independently.
Q. Okay. Why don't we -- let's see. Can you actually take a look at the exhibit --
MS. MURRAY: Leah, can you correct me? Is Exhibit O the Medical Abortion -- or Exhibit 13 is Medical abortion?
MS. FARRELL: That is correct. Tab O or Exhibit 13.
Q. (By Ms. Murray) If you look at Exhibit 13 down there on the bottom, it says the name of the journal, and it says Number 4 Winter 2019; is that

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correct?
A. Yes.
Q. Do you think that means that it is the fourth issue in the year 2019?
A. That's probable.
Q. So this would have come out after the expert reports in this case were submitted, correct?
A. I -- it may have been concordant with the report. This article I wrote based on a talk that I gave at their conference in September of last year.
Q. Okay. Do you expect this journal would have published something it knew to be identical to another source from a different author?
A. You mean that a two sentence identical --
Q. Three sentences. And I will represent to you I haven't actually pulled all of the examples. But assuming it is three sentences, do you think this journal would have published something that it knew to be identical to another source from a different author?
A. I don't know. The content in the article is unique.
Q. These three sentences are unique?
A. Admittedly, they're the same as what Byron has in his report, but the article itself, I have not seen anything that brings all this information together

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in a similar sort of article.
Q. Dr. Skop, do you believe that articles need to be identical in order for one author to have plagiarized from another?
A. No, but I guess I'm questioning what -- what the concern about plagiarism is.
Q. Because you think plagiarism is not a -- well, you say you're questioning that. Why?
A. Well, can you explain to me your concern?
Q. Let me ask the question a different way. Do you have any concerns about plagiarism in your work?
A. I haven't, no.
Q. You haven't had any concerns to date. Do you believe within the medical research community that plagiarism is a -- well, let me ask you this: Within the medical research community, do you believe that plagiarism is an accepted practice among authors?
A. I wouldn't think so.
Q. And would you expect that a peer reviewed article would want only material that is original to the author whose publication is being published?
A. Yes, I would assume that they do want that.
Q. Okay.
A. I'm just not sure what this small portion -- what you think it represents. Do you think it makes the

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article not useful or informative if there is a small -- I mean, probably what happened --
Q. Dr. Skop, because I know we do have a limited amount of time, do you believe that identical republication of material from another author without attribution is consistent with standards of academic integrity in your field?
A. I did not intentionally reproduce anybody else's work.
Q. That's not my question. My question is, do you believe that identical republication of material from another author without attribution is consistent with standards of academic integrity in your field?
A. I don't consider this plagiarism.
Q. Dr. Skop, you paused there, didn't you?
A. Well, I'm just thinking it all through, but. . .
Q. So let the record reflect there was a long pause. I'll ask my question again. Do you believe that identical republication of material from another author without attribution is consistent with standards of academic integrity in your field?
A. I need to -- I need to research that. I'm not sure what -- what the standards say about that.
Q. Okay. And do you -- where would you turn to

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figure out what the standards are? What do you consider standards of academic integrity in your field?
A. I'll have to do some research.
Q. Okay. All right. Can we go back to Tab E? So this would be Exhibit 8, your article, "Abortion Safety: At Home and Abroad."
A. Which tab did you say that was again?
Q. It is Tab E, as in elephant.
A. Okay.
Q. Are you there?
A. Uh-huh.
Q. I believe it was your testimony earlier, Dr. Skop, that you wrote this entire article, correct?
A. That's correct.
Q. And you're the only author listed, correct?
A. That is correct.
Q. Okay. Can we take a look at page 50, the first full paragraph? There's a sentence in there. It says, "Instrumental trauma of the uterus may result in faulty adherence of the placenta in subsequent pregnancies, resulting in chronic abruption or placenta previa/acreta/increta (invasion of the placenta into the cervix, uterine wall, or other adjacent organs)." Is that correct?

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A. That's correct.
Q. Can we now take a look at Exhibit P -- Exhibit 14, Tab P. This is the Calhoun report. Can you take a look at paragraph 52.
Are you there?
A. Not quite. Fifty-two you said?
Q. Uh-huh.
A. Okay.
Q. Are you there now?
A. Yes, ma'am.
Q. And it says, "Instrumental trauma to the uterus in a surgical abortion may lead to faulty adherence of the placenta in subsequent pregnancies. That, in turn, may result in chronic abruption or placenta previa/accreta/increta (invasion of the placenta into the cervix, uterine wall, or other adjacent organs)."
Those are nearly identical, aren't they?
A. Yes.
Q. Now can you turn back to your article? So this would be Exhibit 8, Tab E, on page 50, the second full paragraph.
A. We're going back to the safety article?
Q. Yes. Tab E, page 50.
A. Okay.

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Q. And the second full paragraph says, "One meta-analysis found that there was a 25 percent increased risk of premature birth in a subsequent pregnancy after one abortion, 32 percent after more than one, and 51 percent after more than two abortions. Likewise, another meta-analysis found a 35 percent increased risk of delivery of a very low birthweight infant after one abortion and 72 percent after two or more abortions."
Did I read that correctly?
A. Yes.
Q. And now can we go to the Calhoun report? So this would be Exhibit P -- sorry, Tab P, Exhibit 14, paragraph 50.
A. Okay.
Q. It says, midway down the paragraph, "One meta-analysis found that there was a 25 percent increased risk of premature birth in a subsequent pregnancy after one abortion, 32 percent after more than one, and 51 percent after more than two abortions." Citing Swingle et al., 2019. "Likewise, another meta-analysis found a 35 percent increased risk of delivery of a very low birthweight infant after one abortion, and 72 percent after two or more abortions." Citing Liao et al., 2011. Did I read that correctly?
A. Yes, ma'am.

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Q. And with the exception of the citations, those are identical, correct?
A. Yes.
Q. Okay. And then let's go back to your report. This would be Exhibit 8, Tab E, page 56.
A. Okay.
Q. And you say, in the second full paragraph -- the second sentence starts, "Joyous events (such as the birth of a child) have been associated with improvement in health and well-being, and likewise the stress and guilt that can accompany a pregnancy loss may adversely impact a woman's health. In addition, motherhood may have protective emotional effect, whereas an abortion may have a deleterious emotional effect, leading to greater risk-taking activities. It is evident that a suicide on the anniversary of a coerced abortion or stillbirth should be linked to that pregnancy outcome, but none of these definitions will make that connection."
Did I read that correctly?
A. Yes, ma'am.
Q. And then if we could go back to Exhibit 14, Tab P, paragraph 56 of Dr. Calhoun's report. Are you there?
A. Yes, ma'am.
Q. So the third sentence in this one says,

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"Joyful events (such as the birth of a child) are associated with improvement in health and well-being. Stress and guilt accompanying voluntary or spontaneous pregnancy loss may adversely impact a woman's health and well-being. In addition, motherhood may have a protective emotional effect, whereas an abortion may have a deleterious emotional effect, leading to greater risk-taking activities. The phenomenon of abortion patients committing suicide on anniversaries connected to the abortion is well-documented as well. It is evident that a suicide on the anniversary of an abortion should be linked to that pregnancy outcome, but none of the maternal mortality categories allow that late connection."
Those are nearly identical, correct? Those two passages?
A. Yes, they are.
Q. Dr. Skop, who wrote these two passages -- who wrote these passages that we've been discussing in your article and in Dr. Calhoun's report?
A. I believe that the part about the placenta accreta came from my article on maternal mortality. It is -- I think some of these others probably came from different papers on the AAPLOG website.
Q. Okay. In terms of who wrote these passages,

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your best guess would be neither of you; is that correct?
A. I don't recall to tell you the truth. I've written a lot. I may have written some of these; I may have taken them from something somebody else wrote. You know, I don't -- I can't tell you for sure where they all came from.
Q. Would you agree that one of you must have copied them from the other or someone else?
A. Well, clearly they -- because they're written -- or they're worded identically, they came from the same source, whether, you know, I took it from him, he took it from me, or we both took it from another source. I don't know. The -- you know, the wording, obviously, is identical. But I think that we all have had our independent reports looking at these issues.
Q. And just to ask you -- with respect to the "Abortion Safety: At Home and Broad," so that's Tab E, Exhibit 8.
A. Uh-huh.
Q. To confirm, I may have asked you this, and if so, I apologize. This also is in a peer-reviewed publication; is that correct?
A. Yes.
Q. And do you expect that this publication would have published something that they knew to include

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language that originated with another author without attribution?
A. You know, again, I guess it's been a long time since I've dealt with the definition. I thought that if the ideas were unique that I didn't realize that it was a problem to lift a couple of sentences here and there. I don't know what the rules are for these journals, how they feel about that.
Q. If I were to tell you that the definition of plagiarism is the practice of taking someone else's work or ideas and passing them off as one's own, would you agree that either you, Dr. Calhoun, or both of you engaged in plagiarism?
A. These are a couple of sentences at a time. I thought that plagiarism meant that you'd taken, like, a work, like, you know, a unique idea and said, I had this idea. I didn't realize that, you know, using wording from a paper that you agreed with qualified as plagiarism.
Q. So is it possible that all of your publications include sentences or paragraphs that originated from someone else that are not attributed to them?
A. It is possible that is the case. When I write, I make notes to myself. Sometimes I do take down

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a sentence or two word for word if I think it is written well. And then when I've put papers together, I've probably forgot that I was not the original author of that. It was certainly not intentional.
Q. So do you believe that taking sentences directly from someone else's work or from someone else's publication constitutes taking someone else's work?
A. I never really thought about it in the context of a sentence or two.
Q. Now that you are thinking about it, do you think it constitutes the taking of someone else's work if you copy entire sentences from other authors?
A. I mean, certainly it is the taking of a sentence, but I don't know how serious that is.
Q. And would you agree that a written sentence that you create is your work?
A. Well, if it is a written sentence that I've written it is my work, yes.
Q. Okay.
MS. MURRAY: Do you feel like you need a break?
THE WITNESS: I'm okay. I can keep going.
Q. (By Ms. Murray) So you're affiliated -- I believe you talked earlier about an organization called Any Woman Can, correct?

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A. Yes, ma'am.
Q. And you're affiliated with them?
A. Yes.
Q. And what's your role, again, there?
A. I'm the chairman of the board.
Q. Okay. And was it Any Woman Can that you mentioned as evidence of your expertise with respect to mental health issues or was that The Source?
A. It was Any Women Can in my clinical experience.
Q. Any Woman Can. Is it "any women" or "any woman"?
A. "Woman," singular.
Q. Okay. Any Woman Can. So would you agree that you're closely involved with the activities of Any Woman Can?
A. Yes.
Q. Okay. So is Any Woman Can located near a clinic that provides abortions --
A. No, it is not.
Q. -- To your knowledge?
Does it employ medical professionals?
A. Yes, we have two nurses.
Q. Any doctors?
A. We have a medical director, but they're

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not -- he's not employed.
Q. So you have volunteers?
A. Right.
Q. Is he on site?
A. You know, we have two other physician volunteers, so we frequently have physicians on site.
Q. How often would you say that happens?
A. Probably several times a week.
Q. Okay. And does Any Woman Can confirm pregnancy?
A. Yes.
Q. Does it -- how does it confirm pregnancy; what kind of tests?
A. Urine pregnancy test and ultrasound.
Q. So urine pregnancy test. Is that, like, the kind of test you would get from a drugstore?
A. I don't know if it is. It is probably a higher sensitivity, but similar.
Q. So you don't know whether they use any -- a pregnancy test that's any different from what you would buy in a drugstore?
A. I don't know which one they use specifically, no.
Q. Okay. So it could be the same kind of pregnancy test that you could get in a drugstore; is that

IN THE SUPERIOR COURT OF FULTON COUNTY

STATE OF GEORGIA

SISTERSTRONG WOMEN OF COLOR REPRODUCTIVE JUSTICE COLLECTIVE, et al.,	:	Civil Action 2022CV367796
Plaintiffs,	:	
v.	:	
STATE OF GEORGIA,	:	
Defendant.	:	

Partial Remote Zoom Bench Trial

Tuesday, October 25, 2022

9:16 a.m. to 5:39 p.m. ET

Job No.: 468936

Pages: 1 - 415

Reported by: Melody Stephenson, BBA, FCRR, CRR, CRC, RPR, RSA, MO CCR 406, IA CSR 974

woman's anatomy and just of pregnancy that I -- I do have a great deal of respect for the D&E procedure because I think it is very dangerous, and I think that is well documented.

Q And you've just mentioned you have the ability to read literature, correct? But you're not an epidemiologist, correct?

A That wouldn't be applicable here, I don't think.

(Cross-talk.)

They wouldn't really -- they wouldn't under- -- they wouldn't understand the procedure, having not done it, I don't think.

Q But your expertise is based on your experience but you're not an -- and you just told me you read the literature. So you've studied?

A That's correct.

Q Okay. But you're not an epidemiologist, someone who would study public health?

A That's correct. That's true.

Q Okay. And you've said previously that you're not anywhere close to an epidemiologist, correct?

A That's correct.

Q And you haven't held any academic,

university, or faculty positions; is that correct?

A No. But I went to an amazing medical school, Washington University, that is very, very academic, and I learned at that time how to critically read the literature, and I've been doing it for 30 years now.

Q And isn't it true, Dr. Skop, in your Utah deposition, you even previously have admitted, with regard to your own research, you're just not a good researcher?

A I don't know if I said that or not, but --

Q Okay. Well, let's take a look. It's Skop 2 at 32.

THE COURT: You're in good company, if you said that. I'm -- I'm not a good researcher either. It's not a crime but --

(Cross-talk.)

THE WITNESS: I'll bet I said it in relationship to my footnotes. And I definitely could use a -- an assist -- a legal assistant.

MS. MYKKELTVEDT: And it's the deposition page 121, at 25, through 122, at 7. It's the deposition page 121, 25. And but we'll start with this page in the bottom right corner, Ms. Anderson. There we go. We can -- that --

IN THE SUPERIOR COURT OF FULTON COUNTY
STATE OF GEORGIA

Sistersong Women of Color Reproductive Justice Collective, et al., *Plaintiffs,* v. State of Georgia, *Defendant.*	Case No. 2022CV367796

AFFIDAVIT OF DR. INGRID SKOP

I, Ingrid Skop, state under oath that I am of at least 18 years of age, and that I am competent to testify as follows.

Background and Qualifications

1. I have been a board-certified obstetrician and gynecologist since 1998. I received a Bachelor of Science in physiology from Oklahoma State University, and a Doctorate of Medicine from Washington University School of Medicine. I completed a residency in obstetrics and gynecology at the University of Texas Health Science Center at San Antonio. I have been practicing obstetrics and gynecology in San Antonio since 1996. I have delivered over five thousand babies in my career, and I have extensive experience caring for women with complicated pregnancies. A copy of my C.V. is attached to this report as Exhibit A-1.

2. I have been asked to provide expert witness testimony in the above-referenced case with respect to when a human life begins and whether Georgia's restrictions on abortion pose risks to women. In preparation for this report, I have reviewed Georgia HB 481 and I understand that it bans elective abortions after fetal cardiac activity (i.e., a heartbeat) can be detected (subject to exceptions). In formulating the opinions expressed in this report I have relied upon my years of experience in research and clinical practice.

3. As part of my preparation of this report, I have reviewed the following materials, in addition to the references cited in my report:

a. Plaintiffs' Verified Complaint

17% of those initially surveyed, a total of only 516 women, representing 0.32% of the total estimated abortions performed in the 29 participating facilities over the three year recruitment period).[42] It is intuitive that a woman who anticipates she may suffer emotionally from her abortion would decline to participate in such a study, which may recall negative emotions. Even the study authors acknowledged that these women were self-selected to be those most confident in their decision. Other compounding factors, such as mental health history or history of other abortions, were not controlled for.[43]

24. In an international study that did control for these factors (and had a much higher retention rate of 88%), the risks of mental health disorders were found to be 30% higher in women who procured abortions than those who did not.[44] Additionally, a recent analyses of the U.S. National Longitudinal Study of Adolescent to Adult Health revealed that abortion is linked to a 45% higher risk of subsequent mental health problems, also after controlling for prior mental health history and a host of other confounding factors.[45]

There are Many Deficiencies in U.S. Abortion and Maternal Mortality Statistics.

25. Plaintiffs contend that abortion is much safer than childbirth, but that assertion is based on unreliable data produced by often biased sources.

26. There are many data limitations affecting the accuracy of abortion statistics. Due to privacy concerns and out-of-pocket payment for most abortions, there is no accurate central governmental database that tracks the numbers and complications of this voluntarily reported procedure.[46] For example, in the most recent year

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[42] Coleman PK. The Turnaway Study: A Case of Self-Correction in Science Upended by Political Motivation and Unvetted Findings. Frontiers in Psychology. 2022;13:1-11.

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

[44] Fergusson DM, Horwood LJ. Bodon JM. Abortion and mental health disorders, evidence from a 30-year study. BJPsychiatry. 2008;193(6)444.

[45] Sullins DP. Abortion, substance abuse and mental health in early adulthood: Thirteen-year longitudinal evidence from the United States. SAGE Open Med. 2016;4:1-11.

[46] Jones RK, Kost K. Underreporting of induced and spontaneous abortion in the United States: An analysis of the 2002 National Survey of Family Growth. Studies in Family Planning 2007:38:187–197.

reported (2017), state health departments reported 619,591 abortions,[47] whereas the Guttmacher Institute reported 862,320.[48] Some states (27) require abortion providers to report their complications, but there is rarely an enforced penalty for noncompliance. Even fewer states (12) require other physicians, coroners or emergency rooms to report abortion-related complications or deaths for investigation.[49] In short, abortion providers are often allowed to police themselves.

27. It is well established that the Centers for Disease Control has incomplete statistics regarding abortion-related maternal mortality and all-cause maternal mortality, because most of their data is obtained from maternal death certificates, and maternal death certificates are often incomplete, especially regarding early pregnancy events.[50] Studies estimate 39–93% underreporting of all U.S. maternal deaths on death certificates, and the secrecy associated with abortion reporting makes it likely that the problem is even worse with abortion-related deaths.[51] Comprehensive records-linkage studies from Finland demonstrate that death certificate documentation alone detects only 26% of deaths after live birth or stillbirth, 12% of deaths following miscarriage or ectopic pregnancy, and just 1% of deaths following induced abortion.[52] Conversely, the false positive rate of U.S.

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[47] Jatlaoui, T. C., M. E. Boutot, M. G. Mandel, M. K. Whiteman, A. Ti, E. Peterson, and K. Pazol. Abortion Surveillance—United States, 2015. MMWR Surveillance Summaries 2018;67:1–45. www.cdc.gov/mmwr/volumes/67/ss/ss6713a1.htm;http://dx.doi.org/10.15585/mmwr.ss6713a1.

[48] Induced abortion U.S. Available at https://www.guttmacher.org/fact-sheet/induced-abortion-united-states, accessed July 22, 2022.

[49] State legislation tracker. Available at https://www.guttmacher.org/state-policy/explore/overview-abortion-laws, accessed July 30,2022.

[50] Physicians Handbook on Medical Certification of Death. Available at https://www.cdc.gov/nchs/data/misc/hb_cod.pdf, assessed July 20, 2022; http://www.cdc.gov/nchs (under vital statistics, mortality); Hoyert DL. National Center for Health Statistics (US-NCHS-CDC) (2007). Maternal Mortality and Related Concepts. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Hyattsville.

[51] Horon IL, Cheng D, Chang J, et al. Underreporting of Maternal Deaths on Death Certificates and the Magnitude of the Problem of Maternal Mortality. AJ of Public Health. 2005;95:478-82; Dye TD, Gordon H. Retrospective maternal mortality case ascertainment in West Virginia, 1985 to 1989. Am J Obstet Gynecol. 1992;167(1)72-6; Deneux-Tharaux C, Berg C, Bouvier-Colle MH, et al. Underreporting of pregnancy related mortality in the U.S. and Europe. Obstet Gynecol. 2005;106(4):684-692

[52] Gissler M, Berg C, Bouvier-Colle H-H, et al, Methods for identifying pregnancy-associated deaths: population-based data from Finland 1987-2000. Paediatr Perinat

death certificate pregnancy checkbox utilization ranges from 13–50%.[53] It is likely the CDC abortion mortality data is similarly inaccurate and incomplete.

28. Ideally, U.S. maternal mortality data would be reported as a "maternal mortality rate," calculated by comparing the number of maternal deaths to 100,000 pregnancies (at risk individuals). But this calculation is impossible to perform due to lack of all pregnancy outcome data. The reporting of the numbers of spontaneous pregnancy losses, including miscarriages, ectopic pregnancies, molar pregnancies and stillbirths (estimated 15–17% of pregnancies) and induced abortions (estimated 18–20% of pregnancies) are not mandated and thus unavailable.[54] Only live births can be accurately measured due to mandated birth certificates, so it is often assumed that the number of live births is a good representation of the number of pregnancies. The "maternal mortality ratio" is calculated as the number of maternal deaths to 100,000 live births. Using a maternal mortality ratio instead of a maternal mortality rate introduces inaccuracies. Only 2/3 of maternal deaths occur in association with a live birth, erroneously inflating maternal mortality ratios because many deaths are represented in the numerator that are not present in the denominator.[55]

29. Additionally, it should be noted that the definition of maternal mortality encompasses all deaths that occur up to a year from the end of the pregnancy. While catastrophic complications directly related to the pregnancy separation event are more likely to be detected, mental health complications remote from the event are likely not to be detected or attributed to the method in which the pregnancy was resolved. One unexpected finding in the investigation of recent increases in U.S. maternal mortality is the increase in "deaths of despair"—substance abuse and

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Epidemiol 2004;18(6):448-455;Gissler M, Berg C, et al, Pregnancy Associated Mortality After Birth, Spontaneous Abortion or Induced Abortion in Finland. 1987-2000. AJOG 2004;190:422-427.

[53] Brantley, M. D., W. Callaghan, A. Cornell, et al. 2018. Building U.S. Capacity to Review and Prevent Maternal Deaths: Report from Nine Maternal Mortality Review Committees. MMRIA. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services. www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf; Baeva D, Saxton D, Ruggiero K, et al. Identifying Maternal Deaths in Texas Using an Enhanced Method. Obstetrics & Gynecology 2018;131:762–69.

[54] Studnicki, et al. Improving the Metrics and Data Reporting for Maternal Mortality: A Challenge to Public Health Surveillance and Effective Prevention. Online Journal of Public Health Informatics. 2019;11(2):e17.

[55] Jatlaoui TC, Boutot ME, Mandel MG, et al. Abortion Surveillance-United States 2015. Surveillance Summaries. 2018;67(13);1–45, accessed August 1, 2022

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA
CASE NO. 2022 CA 912

PLANNED PARENTHOOD OF SOUTHWEST AND CENTRAL FLORIDA, on behalf of itself, its staff, and its patients, et al.,

Plaintiffs,

-vs-

STATE OF FLORIDA, et al.,

Defendants.
_____/

AUDIO-VISUAL DEPOSITION OF DR. INGRID SKOP

Pages 1 Through 235

Thursday, June 23, 2022
8:56 a.m. - 2:55 p.m.

Dr. Ingrid Skop
Cook County, Illinois

Stenographically Reported By:
Aurora C. Sloan, FPR

Q. So coming back to it, ultimately your position is that there really just isn't any accurate data in the U.S. concerning abortion and mortality rates?

A. That is my -- that is my belief. It's voluntarily reported. There's clearly pressure that would prevent an abortion provider from voluntarily reporting his complications. And so I think that it doesn't get done. And unless somebody on the outside discovers the complication, I don't think it's reported.

Q. Let's turn to your declaration, again that's Exhibit 4, and please turn to page 11. We're looking for paragraph 31.

A. Okay.

Q. And you see the first sentence, it says:

"It is well established that the Center for Disease Control has incomplete statistics regarding abortion-related-maternal mortality, because most of its data is obtained from maternal death certificates."

Did I read that correctly?

A. Yes, ma'am.

Q. So let's turn back to the Zane report in Exhibit 8. Please turn to page 260 when you get there.

A. Okay.

Q. Looking at the last sentence of that first paragraph, it says:

"Additional methods used to identify other potential abortion-related deaths include media reports, such as computerized searches of LexisNexis, and reports by public health agencies, state-based maternal mortality review committees, professional organizations, healthcare providers, and individuals."

Have I read that sentence correctly from the Zane report?

A. That is correct.

Q. Were you aware of these additional methods of the CDC?

A. There was a report where an undercover investigator pulled only malpractice suits related to abortion and was able to document 30 percent more abortion-related deaths than the CDC had documented over a given time period. So those are only the ones that resulted in malpractice cases.

It has been documented on many occasions that there are known deaths that have been reported by media in certain states. And when you look at those media reported deaths and you look at what the CDC has reported for that given state and that given year, the CDC has reported less deaths than the media did.

So they say they do that, but I am skeptical as to how many additional deaths they are picking up and whether they diligently do that.

Q. So let's back up for a minute.

First, what you're saying is that, despite it being reported, that the CDC relies on more than just maternal death certificates, are you saying the CDC is lying about the other sources?

A. I'm not saying that they are lying. Certainly not.

I'm saying that when they say they get additional -- that they pick up additional deaths this way, I'm not sure how diligent they are in exhaustively looking to external sources other than death certificates, because it has been documented by journalists who don't have the bias that the CDC does about abortion, that there are other ways that deaths are picked up that document far more deaths

than the CDC has documented.

Q. So the reason the CDC data is incomplete is because they are pro abortion? Is that what you're saying?

A. I think they are more passive in letting data come to them. I think they honestly record it if it comes on a death certificate. But I'm not sure -- I know that they say they look at these additional methods, but I do not have any personal knowledge of how diligent they are to find every death, or whether it's more of a passive reporting program where they just wait for someone to tell them about a death.

Q. So what's your basis for saying that CDC passively collects data and does not affirmatively do what they say they do, which is do searches of LexisNexis, public health agencies, et cetera? What's your basis for saying that?

A. The extraordinarily low numbers of abortion-related deaths that they report. I think -- from outside sources, I think that there clearly are many more deaths than the CDC reports.

So I think that, since their numbers are so low, I think to me that's an example that they are not reporting all the deaths.

you know, like I say --

Q. Look at the first full paragraph on the left side of page 260, please, starting with, "for all potential."

A. Uh-huh.

Q. "So for all potential abortion-related deaths, medical records and autopsy reports are requested, and an in-depth investigation conducted. Two clinically-trained CDC epidemiologists separately review the data, reach consensus on the cause of death, abortion type, legally induced, illegal induced, spontaneous or unknown, and gestational age."

Have I read that sentence correctly?

A. Yes, ma'am.

Q. So were you aware that CDC seeks medical records and autopsy reports for all abortion-related deaths?

A. They do this for all maternal deaths. But I'll tell you one problem, too, is that that data is not available to researchers, such as me and my colleagues.

So they do this, but they do it in a

very secretive way, and they will not release the data to other researchers to do our own independent evaluation of what we think is going on.

Q. So in that context, you think the CDC might have accurate data. They are just not sharing it with you?

Am I understanding that correctly?

A. No, I don't think they are -- again, I don't think they're picking up all deaths, because I think some deaths of immediate complications just, for whatever reason, maybe it was hidden, maybe it was assumed to be a miscarriage --

Q. Dr. Skop, I am going to stop you there. I want to focus on what I'm talking about.

A. Uh-huh. Right.

Q. So here we're talking about medical records and autopsy reports for abortion-related deaths.

Do you agree that the CDC collects that data?

A. Yes.

Q. Are you aware that an in-depth investigation was conducted for each of those deaths by the CDC?

A. I'm aware that they say they do that,

yes.

Q. When you say -- do you believe that they do not do it when you say that they say they do that?

A. No. I'll give you an example.

There's an organization called Operation Rescue, and you can look on their website, and they actually have obtained through FOIA requests, death certificates, actual death certificates of women who have died. There's a very dangerous abortionist in Albuquerque who does a lot of late procedures, and several women have died under his care. And if you look at those death certificates, what you will find is that it will not list abortion as the initiating event, even though the abortion was what caused the chain of complications that led to the woman's death, but it will acknowledge she died from an amniotic fluid embolism, which is a very unusual thing to happen in an uncomplicated delivery -- or uncomplicated abortion.

So, even in the case of knowing that, many death certificates don't -- they try to obscure the initiating event was abortion.

Q. Doctor, it says that they perform an

in-depth investigation for each of these abortion-related deaths.

So are you saying that those would not be uncovered because they don't say "abortion" on the death certificate?

A. I'm saying, if it comes to their attention as abortion-related, they probably do uncover it, I agree. But I'm just saying, those type of deaths may not come to their attention, because if the death certificate says AFE, but does not say abortion, it may never reach the CDC's attention.

Q. Are you aware there are two clinically-trained epidemiologists separately reviewing this data and reaching consensus on the cause of death?

A. Again, once the data is in their hands, I believe that they probably do that. I don't have a problem with that.

I'm just saying I think that there's probably a lot that they don't reach, especially the stuff related to mental health deaths, suicides, drug overdoses. I mean, there's a world of things that may cause a woman to die that don't necessarily make it to a death certificate and make

it to the CDC's attention.

The Gissler Finnish studies that I mentioned earlier consistently show that a woman is at two to three times the risk to die after an abortion in a given year than after a term pregnancy, and many of those are mental health related deaths, suicides, homicides even.

Q. Doctor, I'm going to stop you, and I apologize. I'm going to ask if you could just focus on the question I ask, only because we're very short on time now.

A. Sure.

Q. I'm going to focus us back to what I was asking about.

A. Okay.

Q. So again, you have now acknowledged that the CDC does obtain these medical records and autopsy reports; you have acknowledged that they probably do do the in-depth investigation; and that two epidemiologists separately reviewed them.

Did I understand that correctly?

MR. FARUQUI: Object to form.

A. Yeah, I agree. They say they do. I think they analyze the deaths that come to their attention.

IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA

(1) OKLAHOMA COALITION FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; and (2) NOVA HEALTH SYSTEMS, D/B/A REPRODUCTIVE SERVICES, on behalf of itself, its staff, and its patients, Plaintiffs, v. (3) TERRY L. CLINE, in his official capacity as Oklahoma Commissioner of Health; and, (4) LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision, Defendants.	Case No. CV-2014-1886 Judge Patricia G. Parrish

ORDER GRANTING IN PART AND DENYING IN PART PLAINTIFFS' MOTION TO STRIKE THE THIRD AFFIDAVIT OF DONNA HARRISON, M.D., AND MOTION TO STRIKE THE FOURTH AFFIDAVIT OF DONNA HARRISON, M.D.

The Court heard oral argument on Plaintiffs' Renewed Motion to Strike the Affidavit of Donna Harrison, M.D., and Motion to Strike the Fourth Affidavit of Donna Harrison, M.D. on August 25, 2017. Plaintiffs appeared by Autumn Katz, Jenny Ma, and Blake Patton. Defendants appeared by Solicitor General Mithun Mansinghani and Assistant Solicitor General Michael Velchik. For the reasons stated on the record at the August 25, 2017 hearing, the Court hereby GRANTS IN PART and DENIES IN PART Plaintiffs' motions, as follows:

1. The following portions of Donna Harrison's Fourth Affidavit, dated June 16, 2017, are hereby stricken:

- Paragraph 15: Strike the last sentence.
- Paragraph 16: Strike the last two sentences.
- Paragraphs 18 through 40: All paragraphs stricken in their entirety.

2. The last sentence of paragraph 36 of Donna Harrison's Third Affidavit, dated September 7, 2016, is hereby stricken.

The remaining portions of Dr. Harrison's Third and Fourth Affidavits stands

IT IS SO ORDERED.

Dated: Sept. 5th, 2017

Patricia G. Parrish
District Court Judge

Respectfully submitted,

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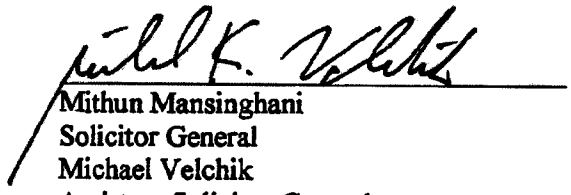
Admitted pro hac vice

ATTORNEYS FOR PLAINTIFFS



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ATTORNEYS FOR DEFENDANTS

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 6 of September 2017, of a copy of the foregoing was served via U.S. mail, postage prepaid, on the following:

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Michael Velchik, Assistant Solicitor General
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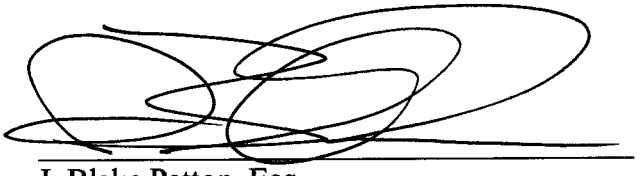

J. Blake Patton, Esq.

DONNA HARRISON M.D.

EXECUTIVE DIRECTOR
AMERICAN ASSOCIATION OF PRO-LIFE OBSTETRICIANS AND GYNECOLOGISTS

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Dr. Donna Harrison is a physician, board-certified in obstetrics and gynecology. She is currently serving as Executive Director of the American Association of Pro-Life Obstetricians and Gynecologists, the largest non-sectarian pro-life physician organization in the world, with over 4000 members across the United States, and associate members on every continent. Under her leadership, AAPLOG has doubled membership, launched the annual Matthew Bulfin Educational Conference, developed an up to date website and social media presence, and launched systematic outreaches to the medical, legal and policy communities to discuss the effects of abortion on women.

Dr. Harrison's research interests include Selective Progesterone Receptor Modulators, Endometrial Contraception, Maternal mortality, and Abortion Mortality and Morbidity. She has authored peer reviewed papers on the approval of RU-486 and on Ulipristal (Ella) as well as on the embryocidal potential of hormonal contraception. Dr. Harrison is a Continuing Medical Education Speaker in the United States and internationally on topics of Medical Abortion with Mifepristone and Misoprostol, Adverse Events associated with Mifepristone and Misoprostol, Emergency Contraception with Ulipristal, Maternal Mortality, and Abortion Morbidity.

She is an Adjunct Professor at Trinity International University in Deerfield, IL, teaching post graduate seminars at the annual Center for Bio Ethics and Human Dignity summer workshops. She is Associate Editor of the peer reviewed medical journal "Issues in Law and Medicine".

Dr. Harrison is married to Dr. Mark Harrison M.D, and is the mother of 5 children and 5 grandchildren.

Donna J. Harrison M.D. dip. A.B.O.G. Professional Credentials

PROFESSIONAL CERTIFICATION AND LICENSURE

- **1993-current. Diplomat of the American Board of Obstetrics and Gynecology (ABOG)**
- **1986-current. State of Michigan Board of Physician Licensing Unrestricted Medical License**
- **1997-1999. American Institute of Ultrasound in Medicine (AIUM)** (voluntary non-renewal)

EDUCATION

Medical Education:

- **1986-1990 Residency in Obstetrics and Gynecology St. Joseph Mercy Hospital, Ypsilanti, MI (affiliate of University of Michigan)**
- **1982-1986 University of Michigan Medical School, Ann Arbor, MI (top 10% of graduating class)**
- **1984 (summer) University of Arizona School of Medicine Tucson, AZ International Health Intensive**

Undergraduate Education:

- **1978-1982 Michigan State University, E. Lansing, MI. Honors Biochemistry B.S. + Chemistry B.A.**
- **1978 University of Iowa Summer Science Intensive Rocky Mountain and Boundary Waters**
- **1977 Michigan State University Summer Science Research Program Soil Science Division**

PROFESSIONAL EXPERIENCE

- **2000 – current. American Association of Pro-Life Obstetricians and Gynecologists**
  - 2013 - current. Executive Director
  - 2011 - 2013. Director of Research and Public Policy
  - 2008 - 2011 President
  - 2006 – 2008 President-Elect
  - 2000 – 2006 Chairman, Subcommittee on Mifepristone (RU-486)

- **Lakeland Regional Health System Affiliate Hospitals**

  - **1993-2000 Obstetrician/Gynecologist Private Practice Southwestern Medical Clinic, P.C**
    1995-1998 Chairman, Department of Obstetrics and Gynecology
    Lakeland Regional Health Systems, Berrien Center, MI
    1996-1999 Chairman, Quality Improvement Committee

- **University of Michigan and Affiliate Hospitals**

  - **1991-1993 Clinical Associate Professor Obstetrics and Gynecology**
    University of Michigan Medical Center 1500 E. Medical Center Dr. Ann Arbor, MI 48109

  - **1991-1993 Obstetrician/Gynecologist Private Practice Leland, Fleming, Dindoffer and Associates** R2106 Reichert Health Bldg. 5333 McAuley Dr. Ypsilanti, MI 48197

INTERNATIONAL AND DOMESTIC MEDICAL SERVICE

Visiting Lecturer Mt. Hope Nursing Schools (Bamenda and Buea Cameroon) 2014, 2017

Consultant physician, Tet Kole Nan Kris Clinic, Montrois, Haiti. 1989-1994 Trained community health workers and ran indigenous medical clinic.

Volunteer Physician, Hope Clinic, Ypsilanti, MI. 1986-1990 Provided medical care at free clinic for low income patients.

Visiting Physician, Tiruvalla Medical Mission, Kerala, India. July-Aug, 1988 provided medical and surgical care. July 1988.

Volunteer Medical Student, Hospital le Bon Samaritan, Limbe, Haiti. June-Aug, l986 provided medical care at one of the largest hospitals in Northern Haiti.

ACADEMIC HONORS

American Business Womens Scholarship recipient 1978

National Merit Scholar 1978-82

Harry S. Truman Public Policy Scholar 1980-1984

Rhodes Scholarship Competition Semi-Finalist for Ohio 1981

SELECTED PUBLICATIONS

Doctors Who Perform Abortions: Their Characteristics and Patterns of Holding and Using Hospital Privileges. Studnicki J, Longbons T, Fisher JW, Harrison DJ, Skop I, MacKinnon SJ. Health Serv Res Manag Epidemiol. 2019 Apr 15;6:2333392819841211. doi: 10.1177/2333392819841211. eCollection 2019 Jan-Dec. PMID: 31020009

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

PLANNED PARENTHOOD OF TENNESSEE AND NORTH MISSISSIPPI, et al,	)	
Plaintiffs,	)	
v.	)	NO. 3:20-cv-00740
	)	JUDGE CAMPBELL
HERBERT H. SLATERY, III, Attorney General of Tennessee, in his official capacity, et al,	)	
Defendants.	)	

DEPOSITION OF DONNA HARRISON, M.D.

November 13, 2020

Taken on Behalf of the Plaintiffs

Videotaped deposition of DONNA HARRISON, M.D. held via Zoom video conference commencing at 9:00 a.m., on the above date, before Marilyn Morgan, Tennessee Licensed Court Reporter, pursuant to the Federal Rules of Civil Procedure governing depositions.

tabs for peer reviewers for medical articles.

Q. Okay. Do you know who else might tab peer reviewers for medical articles?

A. I don't. You'd have to ask Barry Bostrom.

Q. Do you know what the Watson Bowes Institute is?

A. Yes.

Q. What's the Watson Bowes Institute?

A. Watson Bowes Institute is an institute that's devoted to truth in life issues in research.

Q. When you say the life issues, we're talking about abortion and euthanasia?

A. Yes.

Q. Is the Watson Bowes Institute located within AAPLOG?

A. Yes.

Q. What does that mean?

A. Watson Bowes Institute is a DBA of AAPLOG.

Q. And the Watson Bowes Institute is a co-sponsor of Issues in Law and Medicine; is that correct?

A. That's correct.

Q. And the other co-sponsor of Issues in Law and Medicine is the National Legal Center for Medically Dependent and Disabled; is that right?

A. That's correct.

Q. And what is that?

A. I don't know.

Q. Do you have any idea what --

A. I know that Barry Bostrom knows. That is his organization. But I have not talked about what his organization does.

Q. When you say it's his organization, does he have like a leadership role in that organization?

A. You would have to ask Barry about the details of the National Center for Medically Dependent and Disabled.

Q. Were you aware that the National Legal Center for the Medically Dependent and Disabled was founded by James Bopp?

A. Okay.

Q. Do you know who James Bopp is?

A. Yes, I do.

Q. Who is James Bopp?

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

PLANNED PARENTHOOD OF TENNESSEE AND NORTH MISSISSIPPI, et al.
vs
HERBERT H. SLATERY III, Attorney General of Tennessee, in his official capacity, et al.,

Case No. 3:20-cv-00740

- -

BEFORE THE HONORABLE

WILLIAM L. CAMPBELL, JR., U.S. DISTRICT COURT

TRANSCRIPT OF PROCEEDINGS

December 2, 2020

VOLUME II

- -

Patricia A. Jennings, RMR, CRR
Official Court Reporter
837-A U.S. Courthouse
Nashville, TN 37203
patty_jennings@tnmd.uscourts.gov

I N D E X

PLAINTIFFS' PROOF

DEFENDANTS' PROOF

PLAINTIFFS' EXHIBITS

Q. She's the executive director?
A. That's correct.
Q. And as the statement implies, it's a pro-life group?
A. Yes.
Q. And before you submitted your 2018 case series to Issues in Law and Medicine, you submitted it to other journals?
A. That's correct.
Q. And all those journals declined to publish it?
A. That's correct.
Q. Now, before your case series was published, you sought approval from the Institutional Review Board at the University of San Diego; is that correct?
A. Yes.
Q. And you received what's called an IRB exemption from the University of San Diego?
A. That's correct.
Q. And then after your case series was published, it was temporarily withdrawn?
A. Correct.
Q. And that was because the Institutional Review Board of the University of San Diego asked you to withdraw that study?
A. That's correct.
Q. And after the study was withdrawn, you then went to a different IRB for approval; is that correct?
A. That's correct.

Q. And at the time you sought approval from the second IRB, your study had already been completed, published and withdrawn?
A. Correct.
Q. And that's unusual to seek IRB approval for a study that's already been completed?
A. Correct.
Q. During that study, you had been collecting data on patients since 2012?
A. Approximately, yes.
Q. And because you had not yet analyzed the data when you sought IRB approval, you believed that the research constituted a retroactive data analysis?
A. That's correct.
Q. But after you obtained the IRB waiver and the university learned that you were continuing to collect data and include it in your retrospective case series, they asked you to withdraw the paper?
A. Well, it was that the data that we included was outside of the bounds of the dates that we had submitted. So we inadvertently included some cases that were beyond the closed date of the dataset. That was their concern.
Q. So it wouldn't be at that point -- it wouldn't have been a retroactive data analysis? That was the concern?
A. It was still retro -- it was still retroactive. It was

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT TENNESSEE

PLANNED PARENTHOOD OF TENNESSEE AND NORTH MISSISSIPPI, MEMPHIS CENTER FOR REPRODUCTIVE HEALTH, KNOXVILLE CENTER FOR REPRODUCTIVE HEALTH, FEMHEALTH USA, INC., d/b/a CARAFEM, and AUDREY LANCE,	)	
Plaintiffs,	)	Case No. 3:20-CV-00740
v.	)	
HERBERT H. SLATERY III, Attorney General of Tennessee, in his official capacity; LISA PIERCEY, M.D., Commissioner of the Tennessee Department of Health, in her official capacity; RENE SAUNDERS, M.D., Chair of the Board for Licensing Health Care Facilities, in her official capacity; W. REEVES JOHNSON, JR., M.D., President of the Tennessee Board of Medical Examiners, in his official capacity; HONORABLE AMY P. WEIRCH, District Attorney General of Shelby County, Tennessee, in her official capacity; GLENN FUNK, District Attorney General of Davidson County, Tennessee, in his official capacity; CHARME P. ALLEN, District Attorney General of Knox County, Tennessee, in her official capacity; and TOM P. THOMPSON, JR., District Attorney General for Wilson County, Tennessee, in his official capacity,	)	
Defendants.	)	

VIDEOTAPED ZOOM DEPOSITION OF
GEORGE DELGADO, M.D.

November 17, 2020

Deposition of GEORGE DELGADO, M.D., taken at the offices of Zoom Videoconference at 9:00 a.m. (CST) on the above date before Stephanie A. Branim, LCR, CRI, CPE, Tennessee Licensed Court Reporter, pursuant to the Federal Rules of Civil Procedure.

PDF. Tell me when you're there.

A. I'm at page 85.

Q. Great. So do you see where the question was at line 7, "Have you ever served as a peer reviewer for any medical publication?"

And the answer was "No."

A. I see that.

Q. And is that still true?

A. Yes.

Q. And you also testified that you have never served on an institutional review board to review medical research. Is that still true today?

A. Yes.

Q. And you also testified that you haven't wanted to serve in such a capacity. Is that also still correct?

A. Yes.

Q. Look at page 88, please, at line 14. You were asked, "Would you say you have expertise in designing studies for medical research?"

And you answered "No."

Is that still correct today?

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

WHOLE WOMAN'S HEALTH ALLIANCE, et al,	)	
Plaintiff,	)	CAUSE NO.: 1:18-C-0194-SEB/MJD
-v-	)	Indianapolis, Indiana June 24th, 2021
	)	VOLUME II
TODD ROKITA, ATTORNEY GENERAL OF THE STATE OF INDIANA, in his official capacity, et al,	)	
Defendants.	)	

Before the Honorable
SARAH EVANS BARKER, JUDGE

OFFICIAL REPORTER'S TRANSCRIPT OF
BENCH TRIAL

Court Reporter: Laura Howie-Walters, FCRR/RPR/CSR
Official Court Reporter
United States District Court
Room 217
46 East Ohio Street
Indianapolis, Indiana 46204

PROCEEDINGS TAKEN BY MACHINE SHORTHAND
TRANSCRIPT PRODUCED BY ECLIPSE NT COMPUTER-AIDED TRANSCRIPTION

have any further questions.

THE COURT: All right. Cross-examine, Mr. Rodriguez.

CROSS-EXAMINATION

BY MR. RODRIGUEZ:

Q. Good afternoon, Dr. Wozniak. My name is Juanluis Rodriguez. I'm an attorney for the plaintiffs.

A. Good afternoon.

Q. Your expert testimony today is based on your clinical experience, correct?

A. Yes.

Q. And you did not consult any medical literature in forming your opinion for this case?

A. No.

Q. And you do not have any training to provide abortion, correct?

A. First-trimester D&Cs for miscarriage are identical to that of an elective abortion in the first trimester.

Q. And so the answer to my question is you do not have any training to provide abortion; is that correct?

A. There are spontaneous abortions, and there are elective abortions. So when you use the term "abortion," you can be speaking to either.

Q. And you've had no training to provide elective abortion?

A. Correct.

Q. And you've never performed an elective abortion?

Immediate Complications After Medical Compared With Surgical Termination of Pregnancy

To the Editor:

The article by Niinimäki et al reports a 20% compared with 5.6% incidence of adverse events in the medical compared with surgical abortion cohorts, respectively.[1] Other databases and peer-reviewed literature about medical abortion report a dramatically lower incidence of complications, such as hemorrhage and infection, than are reported by Niinimäki and colleagues.[2]

The most frequent adverse event reported was hemorrhage (15.6%). Using a mifepristone and misoprostol regimen for medical abortion, the previously published rate of blood transfusion (indicative of hemorrhage) in large trials ranges from 0.1% to 0.4%.[3] In short, the rate of hemorrhage reported in the Niinimäki article is inconsistent with rates previously reported. Based on correspondence with Dr. Heikinheimo, one of the authors of the Niinimäki article, in Finnish health registries any return visit to the health facility, even for additional consultation, is categorized as a complication. Thus, a woman whose bleeding may have been within the normal range but who sought reassurance could have been coded as having had a "hemorrhage."

Similarly, the rate of "incomplete" abortion both with and without surgical evacuation was reported to be 12.6%; without a definition of incomplete abortion, we cannot know what condition(s) the authors describe. The rate of surgical intervention for reasons other than ongoing pregnancy (a possible definition of incomplete abortion) reported in the literature is 2.8%[4] when using mifepristone with buccal misoprostol and 1.8% when using mifepristone with vaginal misoprostol.[5] The rate of ongoing pregnancy in the Winikoff et al[4] study was 1% and 0.55% in the Ashok et al[5] study.

The data collected for the article began with the initiation of medical abortion in Finland in 2000 and continued for 8 years. We have seen in other countries, with increased provider experience, the rate of intervention decline significantly over time. Although the use of routinely collected data often can be valuable, in this instance, the lack of strict definitions for hemorrhage and incomplete abortion may have led to inflated reports of these complications.

Medical abortion is very safe, but definitions of adverse events need to be defined clearly when outcomes are compared. In published clinical trials, the rate of complications of medical abortion is far less than the 20% rate reported in the Niinimäki article.

Financial Disclosure: *The authors did not report any potential conflicts of interest.*

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Department of Obstetrics and Gynecology, Boston University School of Medicine, Boston, Massachusetts

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In Reply:

We thank Fjerstad et al for their interest in our article. It is important to keep in mind that the study is registry based, not a randomized study with strict protocols and definitions. Thus, many of the "complications" are not really such, but rather concerns or adverse events that bring women back to the health care system. Such consultations result in diagnoses in the registries. These limitations are discussed in the article. Moreover, the term "adverse event" is used for the most part in the article.

The advantage of such a study is that it shows what is happening in the field. Also, the Finnish health registries used in the work are state-of-the-art, especially with regard to coverage of the patients.

The rate of these consultations also reflects the availability of services. Reproductive health care services are readily available in Finland, so the threshold for seeking help may be low in some cases.

Medical abortion was introduced in Finland in August 2000. As Fjerstad et al point out, the number of these consultations declined significantly over time, reflecting the learning curve of the health care system.

Regarding the regimens of medical abortion, practically all women received 200 mg of mifepristone after vaginal administration of misoprostol as recommended in the Finnish guidelines.[1] For infection prevention, the screen-and-treat strategy is used. All women are screened for *Chlamydia trachomatis*, and the threshold for treatment of bacterial vaginosis before abortion is low.

Since its introduction in 2000, the use of medical abortion has increased steadily in Finland. In 2008, some 70% of all pregnancy terminations were performed medically.[2]

We see these data as reassuring. The main contributions that the present article makes to the literature are:

- Rate of serious, "real" complications is rare and rather similar between surgical and medical abortion.

- Rate of infectious complications – even if defined using loose clinical criteria – is similar between the two methods.
- Bleeding associated with the medical method increases the likelihood that women will seek advice. This must be thought of when designing abortion services and calculating eventual costs of the different methods to the service provider.
- A high rate of complete abortion, ie, greater than 93%, can be achieved with the medical method at the national level, outside of the centers of excellence.

We hope our article is of value when designing abortion services, both medical and surgical.

Financial Disclosure: *Dr. Suhonen has lectured at meetings organized by Schering Plough (Helsinki, Finland). Dr. Heikinheimo has been a paid consultant and lecturer for Bayer Schering Pharma AG (Berlin, Germany) and for Schering-Plough (Helsinki, Finland). He also belongs to both the international and Finnish advisory board for Bayer Schering Pharma. The other authors did not disclose any potential conflicts of interest.*

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REFERENCES

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Labor Pain at the Time of Epidural Analgesia and Mode of Delivery in Nulliparous Women Presenting for an Induction of Labor

To the Editor:

It was interesting to read the retrospective analysis by Beilin et al in the October issue of *Obstetrics & Gynecology*,[1] which states that they did not find any association between the degree of labor pain at initiation of epidural analgesia and the resulting mode of delivery of the patient.

The information for the study was retrieved from their Anesthesia Information Management System, the database used to search all patient charts, suggesting that the pain score was recorded by the anesthesia team and was not independent from the providers of epidural analgesia. As was appropriately pointed out, the pain-scoring method was not standardized across the groups being investigated, inherent in a retrospective study. The demographic variables of the patient groups were well controlled, with no significant differences between each group, specifically in terms of body mass index, a variable we have shown to affect local anesthetic requirements and, hence, pain levels in labor.[2]

There is evidence from multiple approaches that would argue the contrary to Beilin and colleagues' conclusion of a lack of an association between the degree of pain and eventual mode of delivery. Wuitchik et al show that women in severe pain are more likely to have instrumental deliveries,[3] Hess et al show that women who request more epidural analgesia boluses are more likely to have cesarean deliveries,[4] Alexander et al show that increased meperidine requirements (more than 50 mg/h) in patients result in higher cesarean delivery rates,[5] and, finally, we show a significantly higher local anesthetic requirement in patients at time of epidural placement in those who go on to have cesarean delivery for dystocia, even before a diagnosis of dystocia is made.[6]

It may be that the retrospective study presented here focused on a population of patients that included many more patients experiencing dystocia than did other studies, with a high cesarean delivery rate in all three groups, reaching a different conclusion. I would suggest that, despite the study published by Beilin and colleagues, there is much evidence of the association between labor pain and mode of delivery.

Financial Disclosure: *The author did not report any potential conflicts of interest.*

Moeen K. Panni, MD, PhD
Department of Anesthesiology, University of Florida, College of Medicine, Jacksonville, Florida

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In Reply:

I thank Dr. Panni for his comments. The studies that Dr. Panni cites only indirectly studied the issue of the degree of labor pain and mode of delivery.[1–3] In all three studies, the amount of analgesic medication given either at the beginning of or throughout labor was used as a

Deaths Associated With Pregnancy Outcome:
A Record Linkage Study of Low Income Women*

DAVID C. REARDON, PhD, PHILIP G. NEY, MD, FRITZ SCHEUREN, PhD, JESSE COUGLE, MSc, PRISCILLA K. COLEMAN, PhD, and THOMAS W. STRAHAN, JD, Springfield, Ill

ABSTRACT

Background. A national study in Finland showed significantly higher death rates associated with abortion than with childbirth. Our objective was to examine this association using an American population over a longer period.

Methods. California Medicaid records for 173,279 women who had an induced abortion or a delivery in 1989 were linked to death certificates for 1989 to 1997.

Results. Compared with women who delivered, those who aborted had a significantly higher age-adjusted risk of death from all causes (1.62), from suicide (2.54), and from accidents (1.82), as well as a higher relative risk of death from natural causes (1.44), including the acquired immunodeficiency syndrome (AIDS) (2.18), circulatory diseases (2.87), and cerebrovascular disease (5.46). Results are stratified by age and time.

Conclusions. Higher death rates associated with abortion persist over time and across socioeconomic boundaries. This may be explained by self-destructive tendencies, depression, and other unhealthy behavior aggravated by the abortion experience.

THE REDUCTION of maternal mortality rates is a major goal of national health care initiatives. The accuracy of maternal mortality figures has been questioned, however, because of inadequate reporting mechanisms and confusion about when a woman's pregnancy actually contributes to the cause of death. It is difficult, for example, to reliably determine whether pregnancy has contributed to death resulting from tumor, stroke, or suicide.

To overcome the difficulties involved when using an *a priori* definition of "pregnancy-related" deaths, researchers at Stakes, the National Research and Development Centre for Welfare and Health in Finland, undertook two important record linkage studies.[1,2] They identified all death certificates from 1987 to 1994 for all women aged 15 to 49, linked them to Finland's centralized Birth, Abortion, and Hospital Discharge Registers, and examined death rates relative to all pregnancy events among these women during the year before their deaths.

The Stakes studies revealed remarkable variations in death rates relative to pregnancy outcome. Women who had given birth had half the death rate of women who had not been pregnant in the year before death. By contrast, women who had had an induced abortion were 76% more likely to die than women who had not been pregnant, 102% more likely to die than women who miscarried, and 252% more likely to die than women who had carried to term. Compared with women who delivered, the age-adjusted odds ratio of dying during the year after an induced abortion was 1.6 for death from nonviolent causes, 4.2 for death from injuries related to accidents, 6.5 for suicide, and 14.0 for homicide.

If the findings reported by Stakes identify a true association between mortality rates and previous pregnancy outcomes, one would expect them to be replicable elsewhere. In addition,

KEY POINTS

- Low-income women in California have differential rates of death associated with childbirth and abortion that are similar to the pattern observed in Finland.
- Compared with women who give birth, those who had abortions were more likely to subsequently die of suicide, accidents, homicide, mental disease, and cerebrovascular disease.
- Previous psychiatric history does not appear to explain the higher relative death rates.
- The differential in subsequent death rates persists over a period of at least 8 years.
- Previous pregnancy outcomes may interact with the most recent pregnancy outcome to increase or decrease the relative risk of death.

From Elliot Institute, Springfield, Ill.

*Presented at the First World Congress on Women's Health, Berlin, Germany, March, 2001.

Reprint requests to David C. Reardon, PhD, Elliot Institute, PO Box 7348, Springfield, IL 62791-7348.

TABLE 1. Overall Cause-Specific Risk of Death in 8 Subsequent Years for Women Whose First Pregnancy Event Was an Abortion or a Delivery (and No Subsequent Abortions)

Cause of Death	All Cases			Controlling for at Least 1 Year Previous Psychiatric History		
	Number of Deaths (Rate per 100,000)			Number of Deaths (Rate per 100,000)		
	First Pregnancy Delivery (n = 83,690)	First Pregnancy Abortion (n = 50,260)	Age-Adjusted Relative Risk (95% CI)	Delivery of First Pregnancy and No Abortions (n = 41,956)	Abortion of First Pregnancy (n = 17,472)	Age-Adjusted Relative Risk (95% CI)
All deaths	490 (585.5)	366 (728.2)	1.30 (1.13 to 1.49)*	213 (507.7)	141 (807.0)	1.61 (1.30 to 1.99)*
Violent causes	207 (247.3)	179 (356.1)	1.43 (1.17 to 1.74)†	82 (195.4)	63 (360.6)	1.78 (1.28 to 2.47)†
Nonviolent causes	281 (335.8)	183 (364.1)	1.17 (0.97 to 1.12)	130 (309.8)	76 (435.0)	1.44 (1.08 to 1.91)**

*$P < .0002$.
†$P < .001$.
**$P < .013$.

the Stakes findings raise the question of how long the effects of previous pregnancy outcomes on mortality rates may persist. The goals of our study were to investigate whether the Stakes findings would be observed in a homogeneous socioeconomic population and to examine any associations between pregnancy history and subsequent mortality over a longer period.

MATERIALS AND METHODS

The California Department of Health Services (DHS) identified 249,625 women who had received funding for either abortion or delivery in calendar year 1989 under the state-funded medical insurance program known as Medi-Cal. Of this population, 194,694 were citizens whose beneficiary identification codes could be record linked to valid social security numbers, a provision that eliminated illegal immigrants whose medical needs are irregularly covered by Medi-Cal. All "short paid claim" records for these women were obtained for 6 fiscal years beginning in July 1988 and extending through June 1994 with encrypted social security numbers provided for data linkage. In addition, the social security numbers (SSNs) linked to these patient IDs were also linked by DHS to California death certificates between 1989 and 1998, resulting in the identification of 1,713 deaths. A file containing cause of death, date of death, and the appropriate encrypted social security number for linking the two data sets was provided to our research team. An important limitation in our study is that we were not provided with any information regarding race, marital status, and parity. This information was either not readily available in government records or was omitted to protect the privacy and anonymity of individual patients.

Since data were collected from government records representing medical claims reported by thousands of health care providers, data integrity was carefully examined. The record linkage to the death certificate file was carried out by the state of California using the encrypted social security numbers. The linkage of multiple events for the same individual was done by us, using the encrypted SSN provided.

Linkage errors by SSN are not uncommon.[3] Therefore, we checked both our own linkages and those done by DHS to assure that a high quality match had been carried out. The confirmatory variables available on both the Medi-Cal and death certificate files used in this checking included the woman's date of birth, date of pregnancy event, and the cost of medical treatment.

Screening for aberrant, indeterminate, and out-of-scope data resulted in the elimination of 21,415 cases (419 deaths) for the following reasons: (1) unlinkable social security numbers, (2) the age recorded for an individual woman in the medical records and/or the death certificates could not be reasonably verified by reference to multiple records, (3) the abortion was identified as illegal or unknown (ICD-9 codes 636 and 637), (4) reported age below 13 or above 49 at the time of their first pregnancy event, (5) first delivery or induced abortion occurred after 1990, (6) the cost associated with the target pregnancy event was below $100 (suggesting that only counseling for a possible procedure was received), or (7) the first recorded pregnancy event was a miscarriage.

Our primary analysis included all women in the sample who met the stated conditions. Since it has been postulated, however, that previous psychiatric problems may be a common risk factor for both abortion and shorter longevity, we also examined the subset of women who had their first known delivery after July 1, 1989. This allowed us to control for at least 1 year before psychiatric history.

All data handling steps were blind to the pregnancy outcome. Age-adjusted relative risks and 95% confidence intervals were calculated by means of a logistic regression using age as a covariate. In the secondary analysis, the number of psychiatric claims within a year of the target pregnancy event was also used as a covariate. In addition, sensitivity analyses based on alternative matching rules revealed that stricter matching rules, eg, allowing no date of birth discrepancies over 6 years of medical claims, would still have produced similar results. Often, stricter rules would have resulted in even higher odds ratios and greater statistical significance, despite the loss of cases. The software used for all statistical calculations was SPSS 10.0.

RESULTS

Overall Analysis

The first analysis compared death rates between women whose first pregnancy event was an abortion (average age: mean = 24.83, SD = 5.8) and women with no known history of abortion who had a delivery for their first pregnancy event (average age: mean = 25.63, SD = 5.8). As seen in Table 1, deaths from all causes in the 8 years after the first known pregnancy outcome were significantly higher among women with a known history of abortion.

Disaggregated Analysis

In our second analysis, we explored the interaction of multiple and varied pregnancy outcomes on differential cause-specific mortality. To do this, we used all of the reproductive history information available for the 6 years included in our data. This time all women (n = 8,703 including 48 deaths) with a history of both abortion and miscarriage (and possibly childbirth as well) were excluded to avoid confusing the effects of voluntary and involuntary pregnancy loss.

The remaining women were categorized into five groups by experience with each pregnancy outcome (Table 2). Women who had only abortion outcomes were more likely to die overall than women in each of the other four groups. Only in comparison to women who had a miscarriage after a birth was this finding not statistically significant ($P < .05$).

Stratification by cause of death revealed that the abortion only group had the highest death rate of all five groups for both natural and violent causes. The greatest number of significant differences occurred between the abortion only and delivery only groups.

Women in the three groups having both delivery and pregnancy loss (abortion or miscarriage) had lower deaths rates than the abortion only group for nearly every cause of death. Lower deaths rates for these three groups, however, would be expected since women in these groups must necessarily have lived long enough to have two or more pregnancies.

Single Known Pregnancy Events

For our third analysis, we limited our comparison to the two most disparate groups—births only and abortions only. To further control for the confounding factor of multiple pregnancy outcomes, this analysis included women with only one known pregnancy event. The mean age was 26.39 (SD = 5.9) for women who delivered and 25.96 (SD = 6.3) for women who aborted.

During the 8-year period after the first pregnancy event, women who aborted were 62% more likely to die (all causes) than women who carried to term (Table 3). They were also significantly more likely to die of nonviolent causes, suicide, and accidents.

The greatest number of deaths were due to nonviolent causes; therefore, these were disaggregated. Examination of major categories of

TABLE 2. Detailed Cause-Specific Deaths and Death Rates in 8 Subsequent Years for Women With a History of at Least One Abortion Compared With Women Having No Known History of Abortion, by Reproductive History

Cause of Death	*Number of Deaths (Rate per 100,000)*					
	(1) Delivery Only	*(2) Abortion Only*	*(3) Abortion Followed by Delivery*	*(4) Delivery Followed by Abortion*	*(5) Delivery Followed by Miscarriage*	**Significantly Different Pairs*
All deaths	464 (549.6)	272 (853.9)	85 (462.4)	132 (514.2)	26 (612.3)	1 & 2, 2 & 3, 2 & 4
Nonviolent causes	266 (315.1)	137 (430.1)	39 (212.2)	53 (206.4)	15 (353.3)	1 & 2, 2 & 3, 2 & 4
Violent causes	196 (232.2)	132 (414.4)	45 (244.8)	79 (307.7)	11 (259.1)	1 & 2, 2 & 3
Suicides	21 (24.9)	20 (62.8)	3 (16.3)	7 (27.3)	2 (47.1)	1 & 2
Accidents	109 (129.1)	65 (204.1)	24 (130.6)	38 (148.0)	6 (141.3)	1 & 2
Homicides	66 (78.2)	47 (147.5)	18 (97.9)	34 (132.4)	3 (70.7)	1 & 2
AIDS	22 (26.1)	21 (65.9)	4 (21.8)	11 (42.8)	4 (94.2)	1 & 2
Circulatory disease	39 (46.2)	34 (106.7)	7 (38.1)	12 (46.7)	2 (47.1)	1 & 2, 2 & 3, 2 & 4

Number of cases by group: (1) 84,420, (2) 31,854, (3) 18,383, (4) 25,673, (5) 4,246.
Mean age by group, in years: (1) 25.66, (2) 25.58, (3) 23.48, (4) 23.15, (5) 25.12.
Standard deviation of age, by group: (1) 5.8, (2) 6.0, (3) 5.1, (4) 5.0, (5) 6.0.
*Pairwise significance determined at $P < .05$ or less.

death from nonviolent causes revealed that the most significant differences were in relation to deaths from AIDS and from circulatory diseases (ICD-9 codes 390-459). Additional analysis of those who died of circulatory diseases revealed that aborting women had significantly higher rates of death from cerebrovascular disease (ICD-9 codes 430-438) and other heart diseases (ICD-9 codes 415-423, 425-429).

As shown in Table 4, stratification by 2-year increments revealed significant differences in the death rates during the first 2 years for overall deaths, deaths due to nonviolent causes, and deaths due to violent causes. Other significant differences were found in all but the fifth and sixth years.

Stratification by age is shown in Table 5. Differences were significant for four of the six age groups. As would be expected, the risk of death from nonviolent causes increased with age, while the risk of death from violent causes generally declined.

Previous Psychiatric Claims

Our fourth analysis was that of women who had their first pregnancy event between July 1 and December 31, 1989. By limiting the analysis to these 6 months, we were able to examine any inpatient and outpatient psychiatric claims women had 1 year before the target pregnancy events. The resulting sample consisted of 17,472 women (mean age = 24.91, SD = 6.0) whose first pregnancy event was abortion and 41,956 women (mean age = 25.48, SD = 5.8) who had delivery as their first pregnancy event and no history of abortion. Among these women, number of previous psychiatric claims was significantly correlated with overall deaths (r [59,428] = .020, $P < .0001$), deaths by violent causes (r [59,428] = .009, $P < .023$), and deaths by nonviolent causes (r [59,428] = .018, $P < .0001$).

Logistic regression analyses were done using number of psychiatric claims within 1 year before the target pregnancy event and age as covariates. The results of these analyses are given in Tables 3, 4, and 5. In several circumstances, most notably deaths related to mental illness, the relative risk of death for aborting women compared with that of delivering women increased after removing the effects of previous psychiatric history.

DISCUSSION

The death rate from all causes was significantly higher for women with a history of

TABLE 3. Risk of Death by Specific Causes in 8 Subsequent Years for Women With Only One Known Pregnancy (Those With an Abortion vs Those With a Delivery)

Cause of Death	All Cases			Controlling for 1-Year Previous Psychiatric History		
	Number of Deaths (Rate per 100,000)			Number of Deaths (Rate per 100,000)		
	One Delivery Only	One Abortion Only	Age-Adjusted Relative Risk (95% CI)	Delivery of First Pregnancy and No Abortions	Abortion of First Pregnancy	Age and Psychiatric History-Adjusted Relative Risk (95% CI)
All causes	335 (614.7)	173 (974.6)	1.62 (1.34 to 1.94)*	213 (507.7)	141 (807.0)	1.61 (1.30 to 1.99)†
Violent causes	127 (233.0)	76 (428.2)	1.81 (1.36 to 2.41)*	82 (195.4)	63 (360.6)	1.78 (1.28 to 2.47)†
Suicide	13 (23.9)	11 (62.0)	2.54 (1.14 to 5.67)*	8 (19.1)	11 (63.0)	3.12 (1.25 to 7.78)*
Homicide	50 (91.7)	27 (152.1)	1.59 (1.00 to 2.55)	28 (66.7)	24 (137.4)	1.93 (1.11 to 3.33)*
Accident or undetermined	64 (117.4)	38 (214.1)	1.82 (1.22 to 2.73)†	46 (109.6)	28 (160.3)	1.44 (0.90 to 2.30)
Nonviolent causes	206 (378.0)	95 (535.2)	1.44 (1.13 to 1.84)†	130 (309.8)	76 (435.0)	1.44 (1.08 to 1.91)*
AIDS	20 (36.7)	14 (78.9)	2.18 (1.10 to 4.31)*	10 (23.8)	12 (68.7)	2.96 (1.28 to 6.87)*
Mental disease	11 (21.6)	7 (43.9)	2.05 (0.79 to 5.28)	6 (14.3)	8 (45.8)	3.21 (1.11 to 9.27)*
Circulatory disease	28 (51.4)	26 (146.5)	2.87 (1.68 to 4.89)†	18 (42.9)	15 (85.9)	2.00 (1.00 to 3.99)*
Cerebrovascular disease	4 (7.3)	7 (39.4)	5.46 (1.60 to 18.65)‡	3 (7.2)	5 (28.6)	4.42 (1.06 to 18.48)*
Other heart diseases	12 (22.0)	10 (56.3)	2.59 (1.12 to 5.99)*	8 (19.1)	7 (40.1)	2.10 (0.76 to 5.82)

*$P < .0001$.
†$P < .005$.
**$P < .05$.
‡$P < .01$.

abortion than for delivering women with no known history of abortion (Table 1). Comparisons across the five possible combinations of pregnancy experiences analyzed here (Table 2) suggest that childbirth without any pregnancy losses (abortion or miscarriage) may have a protective effect, while abortion without any childbirth experiences may have a deleterious effect. These effects, over the course of a combination of pregnancy outcomes, may also interact.

The most pronounced differences in relative risk of death by various causes were found between women with a history of only one known pregnancy comparing women who aborted and women who carried to term (Tables 3, 4, and 5). The key finding is that the elevated death rates associated with women who had abortions were observed throughout the 8 years examined. This indicates that the association between abortion and higher subsequent mortality rates previously observed in Finland is a persistent one.

Higher deaths rates after abortion may be explained by a number of factors. Women who have children may be more likely to avoid risk-taking and to take better care of their health. Alternatively, a history of abortion may be a marker for other stress factors that decrease longevity; or the higher death rate among aborting women may stem from increased psychologic stresses related to unresolved guilt, grief, or depression. This hypothesis is supported by another analysis of this same population in which it was found that even after controlling for previous psychiatric treatment, women who had abortions, across all age groups, had significantly higher rates of subsequent psychiatric admissions.[4] The highest relative risks (>2.5) were related to adjustment reactions, bipolar disorder, and depressive psychoses.

The findings of this study are consistent with a substantial body of literature demonstrating an association between abortion and suicide.[5-11] A record-based measurement of suicide attempts before and after abortion has shown that the increase in suicide rates among aborting women is not related to previous suicidal behavior but is most likely related to adverse reactions to the procedure.[12] Pregnancy and childbirth, on the other hand, reduce the risk of suicide.[13-15]

The greater risk of fatal accidents and homicides may result from unrecognized suicides or increased risk-taking behavior.

TABLE 4. Risk of Specific Causes of Death in 8 Subsequent Years (in 2-Year Increments) for Women With Only One Known Pregnancy (Those With an Abortion vs Those With a Delivery

Cause of Death	Time Interval (years)	All Cases			Controlling for 1-Year Previous Psychiatric History		
		Number of Deaths (Rate per 100,000)			Number of Deaths (Rate per 100,000)		
		One Delivery Only	One Abortion Only	Age-Adjusted Relative Risk (95% CI)	Delivery of First Pregnancy and No Abortions	Abortion of First Pregnancy	Age and Psychiatry History-Adjusted Relative Risk (95% CI)
Overall deaths	1-2	97 (178.0)	61 (343.7)	1.95 (1.42 to 2.69) *	47 (112.0)	40 (228.9)	2.03 (1.33 to 3.10)†
	3-4	84 (154.1)	42 (236.6)	1.56 (1.07 to 2.25) *	40 (95.3)	33 (188.9)	1.98 (1.25 to 3.15)†
	5-6	76 (139.5)	29 (163.4)	1.19 (0.78 to 1.83)	63 (150.2)	35 (200.3)	1.35 (0.89 to 2.05)
	7-8	78 (143.1)	41 (231.0)	1.64 (1.12 to 2.39)‡	63 (150.2)	33 (188.9)	1.29 (0.84 to 1.96)
Violent causes	1-2	52 (95.4)	37 (208.5)	2.12 (1.39 to 3.23)†	19 (45.3)	23 (131.6)	2.62 (1.42 to 4.82)†
	3-4	32 (58.7)	23 (129.6)	2.18 (1.28 to 3.73)†	14 (33.4)	18 (103.0)	3.00 (1.49 to 6.04)†
	5-6	28 (51.4)	7 (39.4)	0.77 (0.34 to 1.76)	27 (64.4)	13 (74.4)	1.15 (0.59 to 2.24)
	7-8	15 (27.5)	9 (50.7)	1.85 (0.81 to 4.23)	22 (52.4)	9 (51.5)	0.98 (0.45 to 2.13)
Nonviolent causes	1-2	45 (82.6)	24 (135.2)	1.66 (1.01 to 2.72)*	28 (66.7)	17 (97.3)	1.49 (0.81 to 2.73)
	3-4	51 (93.6)	18 (101.4)	1.10 (0.64 to 1.88)	26 (62.0)	15 (85.9)	1.40 (0.74 to 2.66)
	5-6	47 (86.2)	22 (123.9)	1.46 (0.88 to 2.42)	35 (83.4)	22 (125.9)	1.54 (0.90 to 2.63)
	7-8	63 (115.6)	31 (174.6)	1.53 (0.99 to 2.35)	41 (97.7)	22 (125.9)	1.33 (0.79 to 2.23)

*$P < .0001$.
†$P < .005$.
**$P < .05$.
‡$P < .01$.

Deaths from accidents may also be related to higher rates of alcohol consumption[16-20] or drug abuse[21-26] among aborting women. The higher risk of death from homicide may reflect increased levels of anger, self-destructive behavior, or domestic violence after abortion.[27,28]

The heightened risk of death from nonviolent causes may reflect a decline in general health after abortion, as reported elsewhere.[29-31] Other unhealthy behaviors linked to abortion are increased alcohol consumption, drug abuse, and smoking.[32-40]

In regard to the unexpected finding of increased deaths related to cardiovascular disease, a substantial body of research has shown that psychologic problems, especially depression, increase cardiovascular morbidity and mortality.[41-44] Compared with delivering women, women who abort have significantly higher rates of depression an average of 10 years after their first pregnancy event, even after controlling for previous psychologic state.[45,46] It is possible that persistent emotional reactions to abortion may aggravate or cause cardiovascular illnesses. Additional investigation of this association is warranted.

Unfortunately, as in the case of the Finland study of pregnancy-associated deaths, this data set did not include any information on race, marital status, or parity, all of which may be significant variables. This limitation is partially offset by the fact that these data represent a homogeneous socioeconomic population. The fact that it includes only low income women, who would generally face similar stressful life events, would tend to help control for socioeconomic factors. By comparison, the Finland studies, which included a heterogeneous national population without controls for socioeconomic factors, also revealed a trend toward substantially higher death rates after abortion. The fact that these large prospective record-based studies, using different types of populations (heterogeneous population of Finns and a racially diverse population of low income Americans), found such similar results indicates that the trend in higher death rates among aborting women is likely to hold across racial, economic, and national boundaries.

In addition, comparison of these results with national data suggests that these findings are likely to hold true across race, martial status, and parity. The 1997 suicide rate per 100,000 American women aged 15 to 24 for all races was 3.5—3.7 for whites and 2.4 for blacks. For ages 25 to 44, the suicide rate was 6.0 for all races—6.6

TABLE 5. Risk of Specific Causes of Death in 8 Subsequent Years for Women With Only One Known Pregnancy (Those With an Abortion vs Those With a Delivery) Based on Age at Time of First Pregnancy Event

Cause of Death	Age at First Known Pregnancy	All Cases			Controlling for 1-Year Previous Psychiatric History		
		Number of Deaths (Rate per 100,000)			Number of Deaths (Rate per 100,000)		
		One Delivery Only	One Abortion Only	Age-Adjusted Relative Risk (95% CI)	Delivery of First Pregnancy and No Abortions	Abortion of First Pregnancy	Age and Psychiatry History-Adjusted Relative Risk (95% CI)
Overall deaths	13-19	37 (636.9)	22 (866.5)	1.38 (0.81 to 2.35)	32 (494.3)	24 (703.0)	1.45 (0.85 to 2.48)
	20-24	60 (346.1)	40 (692.9)	1.99 (1.33 to 2.98)*	53 (379.0)	35 (605.4)	1.60 (1.04 to 2.45)†
	25-29	94 (590.2)	40 (844.8)	1.44 (1.00 to 2.09)	48 (419.3)	31 (688.9)	1.63 (1.03 to 2.56)†
	30-34	80 (816.2)	38 (1389.4)	1.71 (1.16 to 2.52)*	44 (663.1)	28 (1155.6)	1.73 (1.07 to 2.79)†
	35-39	46 (1050.5)	29 (2032.2)	1.93 (1.21 to 3.09)*	26 (944.1)	19 (1814.7)	1.77 (0.97 to 3.26)
	40-49	18 (1444.6)	4 (739.4)	0.49 (0.17 to 1.45)	10 (1515.2)	4 (1302.9)	0.75 (0.23 to 2.47)
Violent causes	13-19	26 (447.6)	15 (590.8)	1.35 (0.71 to 2.55)	22 (339.8)	15 (439.4)	1.31 (0.68 to 2.55)
	20-24	31 (178.8)	29 (502.3)	2.79 (1.68 to 4.64)**	29 (207.4)	26 (449.7)	2.17 (1.28 to 3.69)**
	25-29	39 (244.9)	12 (253.4)	1.04 (0.54 to 1.98)	17 (148.5)	11 (244.4)	1.67 (0.78 to 3.57)
	30-34	23 (234.6)	14 (511.9)	2.19 (1.13 to 4.26)†	9 (135.6)	7 (288.9)	2.15 (0.80 to 5.80)
	35-39	7 (159.9)	6 (420.5)	2.61 (0.88 to 7.79)	4 (145.2)	3 (286.5)	1.39 (0.27 to 7.07)
	40-49	1 (80.3)	0 (00.0)	–	1 (151.5)	1 (325.7)	1.82 (0.11 to 31.04)
Nonviolent causes	13-19	11 (189.4)	7 (275.7)	1.46 (0.56 to 3.80)	10 (154.5)	8 (234.3)	1.56 (0.61 to 3.99)
	20-24	29 (167.3)	11 (190.5)	1.13 (0.57 to 2.27)	24 (171.6)	9 (155.7)	0.90 (0.42 to 1.95)
	25-29	54 (339.0)	27 (570.2)	1.70 (1.07 to 2.70)†	30 (262.1)	20 (444.4)	1.66 (0.94 to 2.93)
	30-34	56 (571.3)	24 (877.5)	1.54 (0.95 to 2.48)	35 (527.5)	21 (866.7)	1.62 (0.94 to 2.80)
	35-39	39 (890.6)	22 (1541.7)	1.72 (1.02 to 2.92)†	22 (798.8)	15 (1,432.7)	1.74 (0.89 to 3.38)
	40-49	17 (1364.4)	4 (739.4)	0.52 (0.17 to 1.55)	9 (1,363.6)	3 (977.2)	0.66 (0.18 to 2.48)

*$P < .01$.
†$P < .05$.
**$P < .0001$.
‡$P < .005$.

for whites and less than 3.7 for blacks.[47] In our sample (Table 3), the average annual suicide rate for women with a history of delivery was only 3.0, while it was 7.8 for women with a history of abortion. Our findings bracket the national averages, regardless of race, suggesting a strong protective effect related to childbirth and a strong detrimental effect related to abortion.

Our finding that pregnancy events may affect mortality over several years, and may counterbalance each other when childbirth and pregnancy loss are both experienced, underscores another limitation of both this study and the Stakes studies: incomplete obstetric histories. It appears most likely that more complete data could have revealed an even greater disparity between "abortion only" and "delivery only." This is likely since unknown childbirth events would have a protective effect on women otherwise identified as being in the "abortion only" group (Table 2). Conversely, however, unknown abortion events would tend to inflate the association between death and the delivery only group.

It may be that the diluting effect of unknown previous pregnancies is seen in the age stratification results shown in Table 5. The level of significance generally appears to drop with increasing age. Indeed, in the oldest age group, 40 to 49, not only is all statistical significance lost, but also the relative rate of death suddenly appears to shift in favor of those who had an abortion. However, it is certainly true that the oldest age groups of women will proportionally have far more pregnancy events that are unknown to us than the younger women for whom the 6-year data set captures a major portion of their reproductive years. Our classification of women as "abortion only" or "delivery only" would therefore be increasingly inaccurate with increasing age. The use of data sets that include complete reproductive histories would eliminate this problem.

Finally, at the request of the California DPH, this population was limited to only those women who had

a Medi-Cal funded abortion or hospital delivery in 1989. This made it impossible for us to compare these women to a group of Medi-Cal eligible women without any pregnancy history or to a group of women who had miscarriages in 1989. In future research, comparisons with both nulliparous women and women who miscarry would be valuable.

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App.055

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF UTAH, CENTRAL DIVISION

* * *

PLANNED PARENTHOOD ASSOCIATION OF UTAH, on behalf of itself and its patients, physicians, and staff, Plaintiff, vs. JOSEPH MINER, in his official capacity as Executive Director of the Utah Department of Health, et al., Defendants.	Case No. 2:19-cv-00238 Deposition of: PRISCILLA K. COLEMAN, PHD

* * *

September 16, 2020
9:00 a.m. MDT

Via Web Conference

Kristin Marchant
- Registered Professional Reporter -

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abortion, then that can be a -- you know, that -- that impact can follow you over time and interact with other life events. And I'm not certain on the civil case --

Q. But a little bit outside the scope. These are not abortion-related mortality figures; is that right?

A. They're not directly related to the procedure, if that's what you're asking. They're -- they're associated deaths.

Q. So did this study define --

A. Statistically associated.

Q. Did this study find a causal relationship between abortion and the adverse outcomes measured?

A. No. As I've said maybe ten times today, none of these studies can determine causality. We cannot randomly assign people to have an abortion, a birth, an adoption. It's not a variable that can be manipulated. So it is not -- the nature of this work precludes causal conclusion. Every single one of them. There's not a study that is an exception.

Q. So, to be clear, these are abortion-associated deaths eight years out, not abortion-related deaths?

A. Right. There -- there were correlations between the experience of an abortion and death rates.

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Q. So that's a yes?

A. Yes.

Q. Okay. Can you look at the abstract for me, the conclusion section on the first page?

A. Yes.

Q. And it says, "Higher death rates associated with abortion persist over time and across socioeconomic boundaries. This may be explained by self-destructive tendencies, depression, and other unhealthy behavior aggravated by the abortion experience."

Did I read that correctly?

A. Yes.

Q. Could you point me to the place in the article where you and your coauthors put forward the findings that support that conclusion?

A. Well, the -- first of all, the conclusion is stated tentatively. This may be explained. Kind of like what Gissler said and some of the other --

Q. I'm just asking for you to point me to the place in the article where there are findings that support that conclusion.

A. The higher death rates that persist over time.

Q. And the self-destructive tendencies, the depression, and other unhealthy behavior aggravated by the abortion experience?

A. Well, that's where it's stated tentatively. This may be. There's a review -- there was a review of literature, so there's -- that -- that wasn't a statement that was based on the actual findings. It's connected to other literature.

Q. So can you just show me where it's connected?

A. I'll look in the discussion. Hang on.

In the discussion on page 838, the third paragraph -- I believe it's the second complete paragraph. It says, "Higher death rates after abortion may be explained by a number of factors. Women who have children may be more likely to avoid risk-taking and to take better care of their health. Alternatively, a history of abortion may be a marker for other stress factors that decrease longevity, or the higher death rate among aborting women may stem from increased psychological stresses related to unresolved guilt, grief, or depression. This hypothesis is supported by another analysis of this same population in which it was found that even after controlling for previous psychiatric treatment, women who had abortions across all age groups had significantly higher rates of subsequent psychiatric admissions. The highest relative risk, over

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2.5, were related to adjustment reactions, bipolar disorder, and depressive psychoses."

Q. These are all hypotheses, right? That's what it says in that paragraph?

A. Yeah. It says -- yeah. And this is what you do when you write a paper. You --

Q. Right, but they're not the conclusions of the study. They're hypotheses?

A. They're -- it's an attempt to explain why the possible -- the multiple hypotheses or multiple reasons why you might see an increased death rate.

Q. And even though they are hypotheses, they were listed in the conclusions of the abstract?

A. In a tentative -- in a tentative way, yes. May as -- this may be explained by self-destructive -- yes.

Q. Yes?

A. This is what authors do. They consider possible explanations for the findings, and that gives us ideas for future studies. I mean, it's not --

Q. Are you suggesting that authors list hypotheses in conclusions frequently?

A. I'm suggesting, yes, they interpret their findings in a tentative way that provides ideas for future research. There are many possible reasons why the

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data in this study and the data in the Gissler study demonstrated significant increased risk. And the 2006 Gissler article that I didn't cite to but dealt with suicide, there was a six-fold increase. And -- and so that's -- that's a dramatic effect. There's got to be an explanation for it, but we --

Q. Just so that I can understand the data in this article. If somebody got hit by a car five years after her abortion and died, she would be counted by this article as a nonviolent death; is that right?

A. Yes.

Q. Okay. What about someone who was randomly robbed in a parking lot five years after her abortion and shot and killed? She would be included here among people who died of a violent death; is that right?

A. Correct. And a possible mediating factor is there's evidence that when women suffer from an abortion, that there's less attention to self-care. There's more risk-taking behavior that can make them more vulnerable to becoming victims of crime or having other things occur.

Q. But that was a yes, right?

A. Yes.

Q. Okay. So are you suggesting that the woman randomly shot in the parking lot didn't have enough

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self-care? I'm just confused about what you mean by self-care here.

A. I'm just saying that there's -- there's research evidence to indicate that when women undergo an abortion and suffer psychologically from it, there may be self-destructive tendencies or less attention to safety. There's -- I published a study that demonstrated association with more casual sexual activity based on --

Q. How is that related to randomly getting robbed in a parking lot? I don't understand.

A. Because if you're not -- if you're taking more risks with your personal safety --

Q. By being in a parking lot?

A. Well, who knows? In what parking lot -- which parking lot?

Q. I don't know. She's outside the Kroger and she gets robbed randomly. That's somehow related to risk-taking behavior?

A. It could be, if it's late at night and there's --

Q. Say it's 5 p.m. Does that study count her as a violent death if she's robbed and murdered in the parking lot of Kroger at 5 p.m.?

A. It would -- I mean, she would be included if she --

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Q. And you think that's somehow related to risk-taking behavior or promiscuity?

A. It could be, or it could be random --

Q. Being in a Kroger at 5 p.m. is related to risk-taking behavior and promiscuity?

A. In this COVID environment, being anywhere near Kroger can be -- I'm being facetious.

But there will end up being people in both groups that are randomly killed at Kroger, but -- but, statistically, you would see the -- what this suggests is that more of the women in the abortion group compared to the first group were in situations because of lacking self-care. So you'll see -- you would see those random acts in both, but if there's a significant effect, that means that something systematic is going on between the groups.

Q. So are women who have abortions more likely to live in poverty?

A. I haven't --

Q. When they have abortions?

A. When they have abortions?

Q. Before they have abortions, aren't women who have abortions -- aren't women who have abortions more likely to have lived in poverty before their abortion?

A. I believe there is data to suggest that,

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that they're more likely to be -- have economic challenges.

Q. Okay.

A. They're also likely to be more -- likely to be victims of domestic violence. There's -- but it cuts across all strata in terms of socioeconomic background. It's not just poor women getting abortions.

Q. Right. But wouldn't they potentially live in higher crime neighborhoods?

A. They might.

Q. So isn't it sort of poverty that's tied to this?

A. There are very poor rural environments, so, I don't know -- that are not crime ridden.

Q. Okay. I think we can move on.

I know we talked earlier about how you wanted to look back at certain studies to check on things you'd said. Is there anything you'd like to clarify from your prior testimony?

A. I actually spent my lunch eating and my breaks, but it -- so, no, I don't think so.

Q. Okay. There's nothing that you want to correct for the record?

A. Not that I can think -- well, related to those hypothetical -- all those hypotheticals that were

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE, TENNESSEE

ADAMS & BOYLE, P.C.,	)	
	)	
Plaintiffs,	)	
vs.	)	No. 3:15-cv-0705
	)	Judge Friedman
HERBERT H. SLATERY III, et al.,	)	Mag. Judge Frensley
	)	
Defendants.	)	
	)	

TRANSCRIPT OF PROCEEDINGS

September 25, 2019

Volume 3-A

BEFORE THE HONORABLE JUDGE BERNARD A. FRIEDMAN

DISTRICT JUDGE

Kathleen Elmore, RPR, LCR, CCR
Contract Court Reporter
U.S. Courthouse
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WITNESS:

PRISCILLA K. COLEMAN, Ph.D.:

Q. You relied on those articles as support for your opinion that abortion increases the risk of negative mental-health outcomes; correct?
A. Correct.
Q. And according to your CV, you have co-authored at least 27 articles with Dr. Reardon; isn't that correct?
A. I do not think that's correct. I would have to count them. That seems awful high, but possibly. Seriously, I do not think I worked on 27 papers. It may have been presentations. Are you specifically referring to peer-reviewed journal articles?
Q. All together, presentations, articles. I'm referring to journal articles, but I will ask you this question.

All together, considering presentations, journal articles, you have done more than 20 such things with Dr. Reardon in your experience?
A. I'd like to count them before I say yes to that.
Q. Would it be more than ten?
A. Probably. I haven't worked with him in ten years, so --
Q. Dr. Reardon is, in your view, quote, political; isn't that right?

A. Yes, I see him as political.
Q. Thank you. And he's also not good at statistics; correct?
A. That is my opinion.
Q. And he's also not good at writing; isn't that correct?
A. I don't think I said, "writing." He's a pretty good writer.
Q. I will refer you to page 98 of your deposition, lines 20 through 23.
"Q. So even though Dr. Reardon is, in your view, too political and not good at statistics and writing, you were still able to --
"A. They weren't his strengths."
Do you still agree with that testimony today?
A. I agree with that. I have much stronger opinions on his statistics.
Q. Thank you. You've answered the question.
MR. HART: Your Honor, could we -- for completeness, could we read the rest of her answer in the deposition?
THE COURT: Sure.
BY MR. MOFF:
Q. "A. They weren't his strengths. I mean, I don't want it going on the record, but, I mean, I guess