

**IN THE SUPERIOR COURT OF FULTON COUNTY
STATE OF GEORGIA**

SISTERSONG WOMEN OF COLOR
REPRODUCTIVE JUSTICE COLLECTIVE, on
behalf of itself and its members; FEMINIST
WOMEN’S HEALTH CENTER, PLANNED
PARENTHOOD SOUTHEAST, INC.,
ATLANTA COMPREHENSIVE WELLNESS
CLINIC, ATLANTA WOMEN’S MEDICAL
CENTER, FEMHEALTH USA d/b/a CARAFEM,
and SUMMIT MEDICAL ASSOCIATES, P.C.,
on behalf of themselves, their physicians and other
staff, and their patients; CARRIE CWIAK, M.D.,
M.P.H., LISA HADDAD, M.D., M.S., M.P.H.,
and EVA LATHROP, M.D., M.P.H., on behalf of
themselves and their patients; and MEDICAL
STUDENTS FOR CHOICE, on behalf of itself, its
members, and their patients,

Plaintiffs,

v.

STATE OF GEORGIA,

Defendant.

Case No. 2022CV367796

**REPLY IN SUPPORT OF PLAINTIFFS’ EMERGENCY MOTION
FOR INTERLOCUTORY INJUNCTION
AND TEMPORARY RESTRAINING ORDER**

INTRODUCTION

The most important factor on this motion is irreparable harm, *W. Sky Fin., LLC v. State ex rel. Olens*, 300 Ga. 340, 354 (2016), and the harms the Six-Week Ban is causing are vast. The State asserts that forcing pregnancy and childbirth on countless Georgians “endangers no one,” State’s Br. 4, but that is contradicted by Plaintiffs’ expert testimony and by *every major medical association* in Georgia and nationally. The State assures this Court that “no woman is at risk of being unable to obtain medical care” for a pregnancy complication, *id.* at 34, yet cannot contest that the Act’s narrow “medical emergency” exception excludes, for instance, an abortion necessary to avert substantial and irreversible harm to a non-“major” bodily function, H.B. 481 § 4(a)(3) (codified at O.C.G.A. § 16-12-141(a)(3)). The State argues that abortion is “[n]ever appropriate treatment” for a mental health emergency, State’s Br. 32, despite (1) a state policy of parity in treatment for physical and mental illness, and (2) Plaintiffs’ undisputed record evidence that some women will kill themselves if forced to continue a pregnancy. As for young girls raped by a family member and still forced to carry that pregnancy to term: regrettable, the State says, but a minority of cases. *See id.* at 33. All of this harm is dispositive on Plaintiffs’ motion.

Plaintiffs are also likely to succeed on the merits. *First*, the Georgia Constitution does not permit the enforcement of a law that was clearly unconstitutional “under court interpretations of that period.” *Adams v. Adams*, 249 Ga. 477, 479 (1982). A law that was void *ab initio* is not revived when the constitutional objections are removed—the General Assembly must reenact it.

Second, the State accuses Plaintiffs of attempting to “force their own views on the public,” State’s Br. 4, but that is exactly backwards: the *State* is attempting to force its view that the existence of a six-week embryo nullifies the rights of the pregnant person carrying it, permitting the government to force the profound medical risks and life-altering consequences of pregnancy and parenthood upon countless Georgians. This is contrary to Georgia Supreme Court precedent

establishing that an interest in human life must be weighed against a pregnant person’s freedom in her own “life, . . . body, . . . [and] health.” *Pavesich v. New Eng. Life Ins.*, 122 Ga. 190, 190 (1905); *see also, e.g., Zant v. Prevatte*, 248 Ga. 832, 833 (1982). That balance of interests begins to shift only when a fetus might be “capable of sustaining life independent[ly].” *Jefferson v. Griffin Spalding Cnty. Hosp. Auth.*, 247 Ga. 86, 88 (1981).

Finally, the State’s attacks on Plaintiffs’ standing to challenge the Records Access Provision are foreclosed by binding precedent. *Feminist Women’s Health Ctr. v. Burgess*, 282 Ga. 433 (2007). Unauthorized disclosure of medical records violates Georgians’ privacy rights, *King v. State*, 272 Ga. 788, 790 (2000)—an interest that is only *stronger* in the context of abortion, where “privacy concerns” are inherent. *Burgess*, 282 Ga. at 436. This Court should enjoin Sections 4, 10, and 11 of H.B. 481 and the Records Access Provision.

ARGUMENT

I. Sovereign Immunity Is Waived.

The State argues that even though the Court can hear this *action*, sovereign immunity has not been waived for this *motion*. But in *Georgia Department of Corrections v. Couch*, the Supreme Court made clear that, unless some form of relief is explicitly excluded, a waiver of sovereign immunity for a particular action applies to all relief available in such action. 295 Ga. 469, 477 (2014); *see also Upper Oconee Basin Water Auth. v. Jackson Cnty.*, 305 Ga. App. 409, 412–13 (2010). Plaintiffs here bring a declaratory-judgment action, and TROs and preliminary injunctions are available in such actions. O.C.G.A. § 9-4-3(b). Likewise, the Civil Practice Act (“CPA”), which “governs the procedure in all courts of record of this state *in all actions* of a civil nature whether cognizable as cases at law or in equity,” permits TROs and preliminary injunctions. O.C.G.A. §§ 9-11-1, 9-11-65 (emphasis added).

In *Couch*, the State argued that an attorney fees award under Rule 68 of the CPA was not within the scope of the Georgia Tort Claims Act's ("GTCA") sovereign-immunity waiver. 295 Ga. at 473. The Court disagreed, holding that all remedies under the CPA are available unless expressly excluded by the sovereign immunity waiver. *Id.* at 477–79. This is because the State waived sovereign immunity for tort “actions[,]” as opposed to tort “claim[s].” *Id.* The use of “*actions*” indicates that such cases proceed under the usual rules of practice and procedure applicable to such tort suits.” *Id.* at 476–77 (emphasis in original).

The State clearly knows how to exclude certain remedies under the CPA from a sovereign immunity waiver, *see, e.g.*, O.C.G.A. § 50-21-30 (excluding punitive damages and prejudgment interest from damages award in GTCA actions), and did just that in the waiver for declaratory-judgment actions on which Plaintiffs rely, Ga. Const. art. I, § 2, ¶ V(b)(4) (“No damages, attorney’s fees, or costs of litigation shall be awarded in an action filed pursuant to this Paragraph, unless specifically authorized by Act of the General Assembly.”). But the waiver does not exclude interlocutory relief, so such relief is permitted. *Couch*, 295 Ga. at 476–79.

The second sentence of Ga. Const. art. I, § 2, ¶ V(b)(1) is not to the contrary. That plain language clearly applies only to permanent injunctions, which (unlike interlocutory relief) are entered after judgment, because it permits a court to enjoin the State’s actions “after awarding declaratory relief . . . to enforce its judgment.” Ga. Const. Art. I, § 2, ¶ V(b)(1) (emphasis added). This simply acknowledges that Georgia law treats actions for declaratory relief and actions for permanent injunctive relief separately. *Compare* O.C.G.A. § 9-4-2, *with id.* § 9-5-1. Thus, the State “further waived” sovereign immunity for permanent injunctions after it waived sovereign immunity for declaratory-relief actions. Ga. Const. Art. I, § 2, ¶ V(b)(1)

In sum, by waiving sovereign immunity for declaratory-judgment actions, the State

waived sovereign immunity for any relief that may be available in such actions, including interlocutory relief.

II. Plaintiffs Are Likely to Succeed on the Merits

A. HB 481 Is Void *Ab Initio*

The State argues that H.B. 481 is not void because *Dobbs v. Jackson Women’s Health Organization*, 142 S. Ct. 2228 (2022), decided three years after H.B. 481’s enactment, shows through hindsight that the Six-Week Ban was always constitutional. State’s Br. 17. But the Georgia Supreme Court has already disposed of that argument. As the State admits, “[t]he time with reference to which the constitutionality of an act of the general assembly is to be determined is the date of its passage,” *Id.* at 18 (quoting *Jones v. McCaskill*, 112 Ga. 453 (1900)). That analysis includes contemporaneous court decisions. *Adams*, 249 Ga. at 477. In *Adams*, the Court upheld Georgia’s “year’s support” statute for widows even though that law originally provided support only to women (but not men) whose spouse had died—because while such a gendered law violates the Equal Protection Clause of the U.S. Constitution now, it “was not violative of the Constitution *under court interpretations of that period.*” *Id.* at 479 (emphasis added). That the Court applied that reasoning to *uphold* the challenged law in *Adams*, *see* State’s Br. 19, is of no moment: the principle that a law’s voidness must be assessed through the constitutional lens that existed at the moment of its enactment applies with equal force here.

The State protests that each void *ab initio* case on which Plaintiffs rely “involve[s] some later legislative change, not a later-reversed judicial ruling.” *Id.* at 18. But of course the circumstances here—where the U.S. Supreme Court erased half a century of case law establishing a constitutional right, *see* Mot. 29–30—are unprecedented, so it is unsurprising that no Georgia case discusses the void *ab initio* doctrine in this precise fact pattern.

Notably, the State does not cite any case where a Georgia court limited the void *ab initio* doctrine as the State proposes. Instead, it cites two cases for general principles concerning the legal effect of overruled case law, neither concerning the void *ab initio* framework. *See* State’s Br. 17 (citing *State v. King*, 164 Ga. App. 834 (1982); *Walker v. Walker*, 247 Ga. 502 (1981)). Nor do the State’s cases support their legal fiction that a federal constitutional right to abortion did not squarely exist in 2019. Rather, those cases acknowledge that, even when a case is overruled, “[t]he past cannot be erased by a new judicial declaration.” *Walker*, 247 Ga. at 503 (refusing to give retroactive effect to decision overruling prior precedent); *see also King*, 164 Ga. App. at 834 (describing exceptions to the “general rule of retrospective application”).¹ “[T]he removal of constitutional objections” cannot revive a statute that was void on arrival. *Grayson-Robinson Stores, Inc.*, 209 Ga. at 618. Instead, the Georgia Supreme Court prescribes a different cure: reenactment. *Id.* at 617; *see also Jamison v. City of Atlanta*, 225 Ga. 51, 51 (1969).

Unhappy with this instruction, the State raises straw-man policy arguments, State’s Br. 19-21, which this Court can readily dismiss: *First*, this Court need not facially invalidate parts of H.B. 481 that *were* constitutional as of 2019. Plaintiffs argue only that the Six-Week Ban is void, which is consistent with the void *ab initio* doctrine. *E.g., In Int. of R. A. S.*, 249 Ga. 236, 237 (1982) (“[W]here a statute is held to be **unconstitutional and void in part**, a subsequent constitutional amendment cannot revive the **void portion**”) (emphasis added).²

¹ The State also cites three out-of-state cases to assert that a law “‘must be regarded for all purposes as having been constitutional . . . from the beginning’” if the basis for a declaration of unconstitutionality is later overruled. State’s Br. 17 (quoting *Pierce v. Pierce*, 46 Ind. 86, 95 (1874)). That is not Georgia’s law. Nor do any of the State’s cases consider the void *ab initio* doctrine. *Christopher v. Mungen*, 61 Fla. 513, 532 (1911); *Falconer v. Simmons*, 51 W. Va. 172, 196 (1902); *Pierce*, 46 Ind. at 95. Indeed, unlike Georgia, the Constitutions of Florida, West Virginia, and Indiana do not declare void any law passed in contravention of the U.S. Constitution. Ga. Const. Art. I, § 2, ¶ V. Moreover, each of these cases concern what happens to the precise statute struck down by a case that is later overruled—a scenario unlike the facts of this case. These inapposite cases cannot override a century of Georgia law.

² The State’s administrability and federalism arguments are also red herrings: it is clear from *Adams* that court interpretations are relevant to the void *ab initio* analysis, and this Court need not opine on “how many court decisions,

Second, whether Mississippi’s abortion ban upheld in *Dobbs* would be void *ab initio* is irrelevant; this case presents a question of *Georgia* law. *See* State’s Br. 19. In any event, the State’s concern with ensuring legislatures can defy binding precedent only underscores the important policy goals underlying this principle: disincentivizing the enactment of plainly unconstitutional legislation that wastes judicial and state resources, foments public discord, scrambles electoral incentives, and undermines the rule of law. *See* Laura Bakst, *Constitutionally Unconstitutional? When State Legislatures Pass Laws Contrary to Supreme Court Precedent*, 53 U.C. Davis L. Rev. (2019). Rather than allowing long-dormant laws to spring to life because of a constitutional change years or decades after their passage, the doctrine enhances democracy by requiring the Legislature to re-enact such laws in a contemporary political environment. Applying the Georgia Constitution and Georgia Supreme Court precedent, Plaintiffs are likely to succeed on their claim that the Six-Week Ban is void *ab initio*.

B. HB 481 Violates the Right to Privacy and Is Causing Irreparable Harm.

1. The Six-Week Ban Is Subject to Strict Scrutiny.

The State contends that Georgians’ fundamental right to be free from unwarranted State interference with their “life, . . . body, . . . [and] health,” *Pavesich*, 122 Ga. at 190, evaporates in the context of forced pregnancy. That cannot be squared with Georgia Supreme Court precedent, which protects even the unauthorized publication of a *picture* of one’s body. *Id.*

There can be no doubt that a law forcing countless Georgians to undergo the severe medical risks and life-altering consequences of carrying a pregnancy to term, including forced labor, delivery, and parenthood, infringes the right to privacy and is subject to strict scrutiny.

and of what court” could hypothetically nullify a statute, State’s Br. 21, when the instant matter deals with 50 years of consistent U.S. Supreme Court precedent. Nor does Plaintiffs’ application of the void *ab initio* doctrine raise any federalism problems when it is the Georgia Constitution itself that voids any law passed in contravention of the U.S. Constitution. State’s Br. 21-22.

Indeed, in upholding a right to sodomy, the Court in *Powell v. State*, 270 Ga. 327, 332-35 (1998), relied on *Campbell v. Sundquist*, a decision of the Tennessee Supreme Court reaffirming its prior holding that an individual has a fundamental privacy right “not to procreate” and could destroy frozen embryos so he would not be “force[d] . . . to become a father against his will,” 926 S.W.2d 250, 260 (Tenn. Ct. App. 1996), *abrogated by Colonial Pipeline Co. v. Morgan*, 263 S.W.3d 827 (Tenn. 2008)). The Georgia Constitution is no less strong.

The State raises two meritless counterarguments. *See* State’s Br. 24–29. *First*, the State asserts that forced pregnancy and childbirth do not trigger heightened scrutiny because an individual’s privacy rights may be cabined to avoid “invas[ing] the rights of [their] neighbor” or those of “other individuals,” *Pavesich*, 122 Ga. at 195; *accord Powell*, 270 Ga. at 330 (quoting *Pavesich*), and the Georgia Legislature made findings in H.B. 481 that embryos “are distinct, living individuals.” *See* State’s Br. 26–27. But it is black-letter law that the Legislature does not get to dictate the meaning or confines of the Georgia Constitution—that is the judiciary’s sole prerogative. *In re Jud. Qualifications Comm’n Formal Advisory Opinion No. 239*, 300 Ga. 291, 298–99 (2016) (“[J]udicial discernment of constitutional, statutory, or common law is an exercise of judicial power, and in Georgia, the judicial power is ‘vested exclusively’ in the” courts (citing *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 177 (1803))). Thus, the legislative findings have no bearing on the threshold constitutional question: Whether a non-viable six-week embryo could possibly count as *Pavesich*’s “other individual” such that the State gets free rein to force Georgians into pregnancy, childbirth, and parenthood against their will.

The answer to that question must be no. At six weeks, an embryo is 1/10th of one inch in size and entirely subsumed by, and attached to, the body of the pregnant person. *Badell Aff.* ¶¶ 23, 27. It is months away from being able to survive outside the pregnant person’s body.

Badell Aff. ¶ 23; Cwiak Aff. ¶ 20. The Supreme Court has never come close to suggesting that, at six weeks, an embryo is an independent “third-party” whose interests can override a pregnant person’s freedoms. *State v. McAfee*, 259 Ga. 579, 580 (1989) (citing *Jefferson*, 247 Ga. at 86). To the contrary, the Court indicated in *Jefferson* that the key milestone in this balancing is viability. 247 Ga. at 86, 87, 88; cf. *Powell*, 270 Ga. at 332, 335.

In *Jefferson*, the Court noted repeatedly that the fetus was “viable and fully capable of sustaining life independent of the mother” before permitting a hospital to compel a woman to undergo a C-Section delivery despite her religious objections, *id.* at 87; accord *id.* at 88. The Court cited three cases to support its ruling: *Roe v. Wade*, which held that a State cannot ban abortion before viability, 410 U.S. 113 (1973); a decision of the New Jersey Supreme Court compelling a Jehovah’s Witness to undergo a blood transfusion after emphasizing that the “pregnancy [was] beyond the 32nd week,” *Raleigh Fitkin-Paul Morgan Mem’l Hosp. v. Anderson*, 42 N.J. 421, 422 (1964); and a case involving a medical dispute among adults. *Strunk v. Strunk*, 445 S.W.2d 145, 145 (Ky. Ct. App. 1969). Nowhere does *Jefferson*—nor any other Georgia Supreme Court decision—suggest that from the earliest weeks of pregnancy, a woman’s fundamental constitutional rights are nullified in service of the embryo she carries.

Second, parroting the U.S. Supreme Court’s reasoning in *Dobbs*, the State asks this Court to defy binding precedent by arguing that a right to abortion did not exist at common law and so the Georgia Constitution presents no bar to government-mandated pregnancy and childbirth now. See State’s Br. 5-8, 27-29. In *Powell*, the Court held that Georgia’s “right of privacy appellate jurisprudence which emanates from *Pavesich*” makes clear “that the ‘right to be let alone’ guaranteed by the Georgia Constitution is *far more extensive* than the right of privacy protected by the U.S. Constitution.” 270 Ga. at 330 & n.3 (emphasis added) (collecting cases); see Mot.

31-35. On that basis, the Georgia Supreme Court found the U.S. Supreme Court’s analysis “not applicable to [its] discussion” when it struck down under the Georgia Constitution the very same sodomy ban the U.S. Supreme Court had recently upheld. *Id.* at 329 n.1.

Moreover, the Court distinguished the source of individual freedoms under Georgia’s Constitution—“the Roman’s conception of justice” and natural law,” *id.* at 329 (quoting *Pavesich*, 122 Ga. at 194), from the narrower liberty protections of the U.S. Constitution, which encompass “only those matters ‘deeply rooted in this Nation’s history and tradition,’” *id.* at 330 (quoting *Bowers v. Hardwick*, 478 U.S. 186 (1986)). As the dissent in *Powell* points out, “[s]odomy was a criminal offense at common law,” 270 Ga. 338 (Carley, J., dissenting) (quoting *Bowers*, 478 U.S. at 192)—yet the majority held Georgia’s sodomy ban unconstitutional nonetheless. The State’s reliance on *Dobbs*’s historical framework is wholly misplaced. *See* State’s Br. 2–4, 6, 17, 27.³

Finally, all of the State’s citations to antiquated Georgia case law imposing penalties for harm to a fetus involve circumstances where the pregnant woman was killed or injured—*i.e.*, similar to *Jefferson*, where the medical interests of the pregnant woman and the fetus were parallel.⁴ By contrast, the question here is whether, from the earliest weeks of pregnancy, the

³ Moreover, the State’s historical discussion is misleading and inapposite even on its own terms. As the *Dobbs* majority did not dispute, but the State here attempts to obscure, *see* State’s Br. 6-8, at common law, abortion was not criminalized before the point of “quickening”—approximately four months of pregnancy—unless the pregnant woman died. *Dobbs*, 142 S. Ct. at 2324 n.3 (Breyer, J., Kagan, J., Sotomayor, J., dissenting) (“The majority offers . . . no example of a founding-era law making pre-quickening abortion a crime (except when a woman died).”). The State does not contest that Georgia’s due process clause was enacted in 1865, *see* State’s Br. 27, and cannot contest that Georgia then waited until 1876, long after other states, to prohibit abortion pre-quickening (and even then, only with lesser penalties). *See Brinkley v. State*, 253 Ga. 541, 542–43 (1984); Mot. 36 n.8. In a case challenging a ban on abortion from the earliest weeks of pregnancy, Badell Aff. ¶ 24, the State’s historical math would not check out for them even if it were relevant to this Court’s analysis—which it is not.

⁴ *See Wilson v. State*, 33 Ga. 207, 218 (1862) (dicta discussing hypothetical death of pregnant woman during abortion); *Summerlin v. State*, 150 Ga. 173 (1920) (pregnant woman killed); *Biegun v. State*, 206 Ga. 618, 630 (1950) (pregnant woman killed); *Hornbuckle v. Plantation Pipe Line Co.*, 212 Ga. 504, 504 (1956) (child born with disabilities due to injury during pregnancy, unrelated to abortion). The only other Georgia case law the State offers is an inapposite case involving a fetus’s right to inherit. State’s Br. 8 (citing *Morrow v. Scott*, 7 Ga. 535, 537 (1849)).

pregnant person's rights, health, and life come *second* to the interests of the six-week embryo inside of her. Even the State's irrelevant historical evidence does not support its position.

2. The State Does Not Meet Its Burden under Strict Scrutiny.

a. The State Does Not Have an Interest in Pre-Viable Embryos and Fetuses Sufficient to Nullify the Pregnant Person's Rights.

The State's central argument is that it "has a compelling interest in preserving human life," and therefore has a sufficiently compelling interest in protecting an embryo beginning at six weeks to subordinate the rights, health, and life of the pregnant person. State's Br. 29–30. To the contrary, the Georgia Supreme Court has repeatedly held that the State does *not* have a boundless compelling interest in human life; that interest can be overcome by other fundamental rights. *See, e.g., Zant*, 248 Ga. at 833 ("The State has not shown such a compelling interest in preserving [a prisoner's] life, as would override his right to refuse medical treatment."); *McAfee*, 259 Ga. at 580 ("The state concedes that its interest in preserving life does not outweigh [the patient's] right to refuse medical treatment."). Just as the State cannot force-feed a prisoner or compel life-saving medical treatment, a pregnant person's constitutional rights to privacy and bodily autonomy take precedence over the non-viable six-week embryo inside of her.

The "compelling interest" prong of strict scrutiny requires the State to demonstrate a compelling interest *sufficient to overcome conflicting rights*, not a compelling interest in the abstract. *Powell*, 270 Ga. at 334 (court must weigh whether exercise of police power "unduly oppress[es] the individual"); *In re J.M.*, 276 Ga. 88, 90 (2003) (state interest in regulating private sexual conduct of sixteen-year-olds "is an insufficient state interest to overcome Georgia's constitutional protections of privacy"); *Zant*, 248 Ga. at 833 ("The State has not shown *such* a compelling interest in preserving Prevatte's life, as would override his right to refuse medical treatment." (emphasis added)). Contrary to the State's contention, Georgia courts have already

identified “[a]n unborn child’s inability to survive outside the womb,” State’s Br. 30, as an important factor in determining the sufficiency of the State’s interest. *See Jefferson; supra* 8-9.

Unable to justify the elevation of a six-week embryo’s rights over a pregnant person’s “life, body, . . . [and] health,” *Pavesich*, 122 Ga. at 190, the State instead pretends that these interests are not in conflict at all. But the State’s claim that H.B. 481 “does not endanger the life or health of pregnant women,” State’s Br. 1, has been unanimously disproven not only by the expert testimony of Drs. Cwiak, Rice, and Badell, but also *by virtually every leading medical organization in Georgia and nationally*. *See, e.g.*, Cwiak Aff. ¶ 11 (citing statement of American Medical Association and more than 75 other leading medical organizations); *id.* (citing Medical Association of Georgia’s statement opposing H.B. 481 because, *inter alia*, it does not “allow women and families to maintain access to quality healthcare in Georgia”). It further endangers the health and safety of Georgians by severely curtailing training opportunities for medical students and residents, exacerbating Georgia’s shortage of obstetricians and gynecologists. Merritt Aff. ¶¶ 15–24; Cwiak Aff. ¶¶ 57–62.

The State does not even attempt to show that the Ban balances the countervailing interest in the health and life of the pregnant person. Instead, it dismisses the extensive evidence showing that denying access to abortion affirmatively harms patients by mandating the far more dangerous course.⁵ The State claims this irreparable harm is “fearmongering,” State’s Br. 4, ignoring the Georgia Department of Public Health’s own findings showing that forced pregnancy

⁵ *See, e.g.*, Cwiak Aff. ¶¶ 14, 16 (abortion is a very safe medical procedure with extremely rare serious complications; pregnancy carries far greater risks to a woman’s health than abortion); *id.* ¶ 16 (maternal mortality rate for pregnancies carried to term much higher than for legally-aborted pregnancies; every pregnancy-related complication more common among those giving birth than among those having abortions); *see also* Badell Aff. ¶¶ 13–22 (risks associated with pregnancy and childbirth include the worsening of comorbidities like diabetes, hypertension, and lupus, and one-in-three likelihood of undergoing major abdominal surgery (C-section)); Meltzer-Brody Aff. ¶ 13 (pregnancy carries one-in-eight chance of developing or exacerbating mental health condition).

and childbirth will prove deadly—especially for Black women in Georgia, for whom the maternal mortality rate is twice that of white women.⁶ Rice Aff. ¶¶ 21-22. The State’s dismissal of the medical risks of continued pregnancy is particularly remarkable given that, during the very same legislative session when it enacted the Six-Week Ban, Georgia’s House of Representatives also enacted House Resolution 589 (2019), finding that “according to numerous organizations that rank mortality rates, Georgia is among the top ten states with the highest maternal death rate” and establishing a special committee to study the problem.

Indeed, the *only* support the State finds for its blithe assertion that the Ban “endangers no one,” State’s Br. 4, is an affidavit from Dr. Ingrid Skop, whose testimony on *precisely that topic* was rejected as not credible by a Florida circuit court just last month. *Planned Parenthood of Sw. & Cent. Fla. v. State*, Case No. 2022 CA 912, Order Granting Pls.’ Mot. for Emerg. Temp. Inj. and/or Temp. Inj. 34 (Fla. Cir. Ct. July 5, 2022) [hereinafter “FL Order”], attached as Exhibit A. As that court concluded, “Dr. Skop has no experience in performing abortions; admitted that her testimony on the risks of certain abortion complications was inaccurate and overstated, or based on data from decades ago; admitted that her views on abortion safety are out of step with mainstream medical organizations; and provided no credible scientific basis for her disagreement with recognized high-level medical organizations in the United States.” *Id.* at 34; *see also id.* at 33 (“[T]he Court found Dr. Skop’s testimony to be unsupported,” including, *inter alia*, when she asserted “her belief that the risks [of abortion] are higher than” rates reported in a comprehensive study by a leading medical authority, but could identify no studies supporting her contrary view);

⁶ The State also argue that Plaintiffs delayed in seeking relief and that such delay counsels against a finding of irreparable harm, State’s Br. 35. This argument is absurd. Plaintiffs challenged the Ban in federal court promptly following its enactment, relying on the established federal right rooted in nearly fifty years of unbroken precedent. Only after the U.S. Supreme Court overturned that precedent, and the Eleventh Circuit ordered the federal permanent injunction dissolved, was further action required. The State ignores, too, that Georgia’s recent constitutional amendment waiving sovereign immunity for constitutional challenges only became effective in January 2021, making it impossible to have brought suit against the State before that time. *See* Ga. Const. art. I, § 2, ¶ V(b)(1).

Planned Parenthood of Sw. & Central Fla. v. State, Case No. 2022 CA 912 (Circuit Court of Florida July 5, 2022) Hearing Tr. 204:21-25, attached as Exhibit B (conceding that her views on the safety of abortion are “inconsistent with the findings of [a] number of medical associations,” including the American College of Obstetricians and Gynecologists, the American Psychological Association, the National Academy of Sciences, Engineering, and Medicine, the American Medical Association, and the Centers for Disease Control and Prevention).

b. H.B. 481 Is Far From the Least Restrictive Means of Advancing the State’s Interest in Potential Life.

Because viability is the first point at which the State’s interest in fetal life may be sufficiently compelling to outweigh the pregnant person’s rights, *preexisting* Georgia law banning abortion at 22 weeks was a less restrictive means of advancing that interest. *See* O.C.G.A. § 16-12-141(c)(1) (amended 2019). And there are myriad policies the State could adopt to advance its asserted interest in potential life without trammeling the rights of pregnant people, including by reducing unintended pregnancies and Georgia’s alarming infant mortality rate. *See* Rice Aff. ¶¶ 13, 24–27; *accord* Skop Aff. ¶42 (“shift[ing] attention . . . to contraception promotion” would further an interest in fetal life as well as “improv[e] outcomes for women”).

But even if the State could demonstrate a sufficiently compelling interest in an embryo at six weeks LMP, which it cannot, H.B. 481 is not the least restrictive means of advancing any such interest. The State contends that H.B. 481 “prohibits only acts which unnecessarily harm otherwise healthy third parties.” State’s Br. 30. But the plain text of H.B. 481 and all of the expert evidence in this case—including from the State’s own expert—flatly contradict this claim.

Far from showing the Six-Week Ban is narrowly tailored, the Act’s narrow exceptions only highlight its sweeping breadth and the Legislature’s deliberate choices to pursue the maximally restrictive course at every turn. *See* Mot. 46–49. The Ban strictly defines “medical

emergency” as “a condition in which an abortion is necessary in order to prevent the death of the pregnant woman or the substantial and irreversible physical impairment of a major bodily function of the pregnant woman.” O.C.G.A. §16-12-141(a)(3). The State does not contest that this exception does not permit abortion care necessary to prevent: (1) substantial but reversible physical impairment of a major bodily function, (2) less than “substantial” but irreversible physical impairment of a major bodily function, or (3) substantial and irreversible physical impairment of a bodily function that is not “major.” The State thus cannot credibly assert that the Ban “does not prohibit care that is medically indicated.” State’s Br. 30.

In addition to drawing the medical emergency exception so strictly that it excludes the majority of pregnant Georgians experiencing severe health risks, *see* Cwiak Aff. ¶¶ 47–48, 50–51, 54–55, Badell Aff. ¶¶ 28–31, 33, the Act expressly prohibits life-saving abortion care for people experiencing a psychiatric emergency, condemning pregnant Georgians experiencing a mental health crisis to death, *see* Meltzer-Brody Aff. ¶¶ 12, 40–41, 43 (explaining that suicide is a leading cause of maternal death and describing patients who were at serious risk of death due to mental health conditions triggered or exacerbated by pregnancy). This exclusion defies the state policy embodied in the unanimous passage this year of H.B. 1013 (“the Mental Health Parity Act”) (finding “a significant need for greater parity of treatment of [mental health and substance use] disorders with other health insurance needs”), codified at O.C.G.A. § 33-1-27; *Williams v. State*, 299 Ga. 632, 634 (2016) (provisions of statute enacted later in time carry greater weight). The State’s only response is to “reject[] the idea that an abortion is ever appropriate treatment for the psychiatric health of the mother.” State’s Br. 32. But that position is wholly unsupported, as the State’s sole expert concedes she is “not . . . an expert in mental health.” *See* Ex. A, at 35; *Planned Parenthood of Utah v. Minor*, Depo. Tr. Ingrid Skop, 71:10-

13, attached as Exhibit C; *see also* Ex. A, at 37 (rejecting Dr. Skop’s opinion that banning abortion would “benefit the mental health of patients” denied abortions).

The reporting requirement for rape and incest victims, rather than ameliorating the Ban’s intrusions, is maximally intrusive on Georgians who have suffered such trauma. It requires that a patient publicize her assault to the police to be eligible for an abortion, which itself violates the privacy rights of pregnant Georgians. *See, e.g., Burgess*, 282 Ga. at 436 (abortion patients are “significantly hinder[ed]” from bringing litigation on their own behalf because of “privacy concerns”); *King*, 272 Ga. at 790 (medical records protected by constitutional right of privacy); *Pavesich*, 50 S.E. at 71 (the fundamental right to privacy is the right “to be let alone”). Rather than engage with any of this precedent, the State simply asserts, without support, that “Georgia can validly determine that if a woman wants to abort her child post-fetal-heartbeat under the . . . exception, she must provide . . . a report.” State’s Br. 33. In other words, the State believes that the rights of a 12-year-old who has been raped by her stepfather and cannot go to the police are outweighed by the interests of the six-week embryo inside of her.

Finally, the State insists that the Ban “does not require that anyone be denied medical care for a miscarriage.” State’s Br. 32. But as the State acknowledges, H.B. 481 permits procedures only to remove “the remains of a” miscarriage. *Id.* at 10. In some cases where “embryonic or fetal cardiac activity persists while the individual is actively miscarrying,” “H.B. 481 ties the doctor’s hands” and “forces a patient to continue undergoing a miscarriage—with experiences including bleeding, cramping, partially passing the embryo/fetus, risk of infection, and physical and emotional pain. . . —unless and until the patient’s condition deteriorates to the point of a ‘medical emergency’ as H.B. 481 narrowly defines it.” *Cwiak Aff.* ¶¶ 53–54. The State’s expert agrees. *See Skop Aff.* ¶ 34 (clinician should and must wait until “the bleeding

w[as] excessive and life-threatening” to intervene “under the [medical emergency] exception included in [the Ban]”). Absent a binding interpretation from this Court or a partial settlement with the State, the State’s argument that the Act’s “medically futile” exception would apply to allow care under those circumstances, State’s Br. 32, is irrelevant to the Court’s analysis.

The Act is virtually the *most*—rather than least—restrictive means of achieving any asserted state interest. Because it fails strict scrutiny, it has no constitutional applications and must be facially invalidated. *See Reed v. Town of Gilbert, Ariz.*, 576 U.S. 155, 163 (2015) (laws subject to strict scrutiny are “presumptively unconstitutional and may be justified only if the government proves that they are narrowly tailored to serve compelling state interests.”) If this Court accepts the State’s position to the contrary, *see* State’s Br. 34, “any moderately clever drafter could insulate an unconstitutional statute from a facial challenge simply by adding a provision to the statute that was clearly constitutional.” *Am. Fed’n of State, Cnty. & Mun. Emps. Council 79 v. Scott*, 717 F.3d 851, 866 n.2 (11th Cir. 2013).

C. The Record Access Provision Violates Georgians’ Fundamental Right to Privacy

1. Plaintiffs Have Standing to Challenge the Records Access Provision

As a matter of law, abortion providers have standing to assert their patients’ constitutional rights. *Burgess*, 282 Ga. at 436. The three requirements for third-party standing in *Burgess* are met here. *First*, the Records Access Provision inflicts injuries-in-fact that each, standing alone, gives Plaintiffs “a sufficiently concrete interest in the outcome of” their challenge, *id.*: (1) it requires the health center and physician Plaintiffs and physician members of Medical Students for Choice (collectively, “the Provider Plaintiffs”) to turn over patients’ personal health records to law enforcement on demand without any due process, under threat of being held in contempt and potentially imprisoned, *see* O.C.G.A. § 24-13-26, and (2) it compels

them to violate their ethical obligation to keep patients' personal health information confidential except with the patient's consent. *See Orr v. Sievert*, 162 Ga. App. 677, 678–79 (1982); Cwiak Aff. ¶¶ 63-66. *Second*, the Provider Plaintiffs have a quintessentially close relationship with their patients, making them “uniquely qualified” to assert their patients' rights to the privacy of personal health information divulged for treatment purposes. *Burgess*, 282 Ga. at 436; Cwiak Aff. ¶¶ 64–65. And the Provider Plaintiffs are “motivated, effective advocate[s]” for their patients' rights because they have “as much a stake in proving” that the Records Access Provision violates Georgians' fundamental right to privacy. *Powers v. Ohio*, 499 U.S. 400, 414 (1991). Finally, the abortion-related “privacy concerns” identified in *Burgess* as “significantly hinder[ing] a woman's assertion of her own right” to abortion are even more salient here, where the very question is whether the State can access her personal health information without her consent in a case where the content of those medical records would specifically be at issue. *Burgess*, 282 Ga. at 436.

SisterSong also has standing to challenge the Records Access Provision on behalf of its members. An association has standing to bring suit on behalf of its members when (1) “its members would otherwise have standing to sue in their own right,” (2) “the interests it seeks to protect are germane to the organization's purpose,” and (3) “neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit. *Aldridge v. Ga. Hosp. & Travel Ass'n*, 251 Ga. 234, 236 (1983). SisterSong members include Georgians who can become pregnant and have a stake in maintaining the privacy of their personal health information, including the decision to end a pregnancy. Ver. Compl. ¶ 18. SisterSong's members would have standing to sue in their own right, and the interests SisterSong seeks to protect are germane to the organization's purpose of protecting the human right to reproductive justice. *Id.*

Finally, neither the claims asserted nor the relief requested here require the participation of individual members in the lawsuit.

2. Plaintiffs Are Likely to Succeed on the Merits of Their Claim that the Records Access Provision Fails Strict Scrutiny

The State's cramped reading of *King v. State* ("*King I*") turns the Georgia Supreme Court's precedent on its head. *See* State's Br. 37–38. While the health records at issue in *King I* were those of a criminal defendant, the Court held, as a general matter, that "the personal medical records of this state's citizens . . . are protected by [the right to privacy] as guaranteed by our constitution" and that "the constitutional right of privacy protects the initial unauthorized disclosure of [personal] medical records to anyone, including the prosecutor." 272 Ga. at 790 (emphasis original). Indeed, Georgia courts have repeatedly recognized the "right to medical privacy" and enforced protections for patients' personal health records in other contexts. *See, e.g., Baker v. Wellstar Health Sys., Inc.*, 288 Ga. 336, 338 (2010); *Ussery v. Child's Healthcare of Atlanta, Inc.*, 289 Ga. App. 255, 269 (2008). Nor has the Georgia Supreme Court excluded any category of health records from privacy protections based on the type of care provided. If anything, abortion patients' health records are especially sensitive, *see Burgess*, 282 Ga. at 436, and doubly entitled to protection: in addition to the *informational* privacy concerns raised by the compelled disclosure of any medical record, the medical care here is itself protected by the Georgia Constitution. *See supra* 6-9. The State's contrary argument does not apply to records regarding abortions provided *in compliance with* the Six-Week Ban. *See* State's Resp. at 38 (asserting only interests "in law enforcement and regulation of the medical profession" to justify the Records Access Provision).

Further, the State's contention that the Records Access Provision is not facially unconstitutional is incorrect. Under *King I*, "[s]ince personal medical records are protected by

the constitutional right of privacy,” the State bears the burden of showing that any statute that requires unconsented disclosure of such records “effectuates a compelling state interest” and “is narrowly tailored to promote only that interest.” 272 Ga. at 790. The relevant inquiry is whether the Records Access Provision satisfies strict scrutiny, not whether there are any potentially constitutional applications. *See supra* 16.

The Records Access Provision fails strict scrutiny as a matter of both law and fact. *See King I*, 272 Ga. at 792-93 (holding that the constitutional right to privacy protects against unconsented disclosure of personal health records absent notice to the patient and opportunity for her to object). Granting district attorneys virtually limitless access to abortion patients’ personal health records without any due process protections is far from the least restrictive means of advancing the State’s interest “in law enforcement and regulation of the medical profession.” State’s Resp. at 38. The State has not demonstrated why it cannot effectuate those interests using “procedural devices”—such as a warrant—already available to its law enforcement officials to the extent such records are “relevant to criminal investigations” under the Six-Week Ban, the State’s asserted goal. *Cf. King I*, 272 Ga. at 791. That abortion patients are not themselves subject to criminal prosecution makes the absence of due process protections for their private medical records *more*, not less, constitutionally suspect. *Contra* State’s Br. 38.

3. The Records Access Provision Threatens Irreparable Harm.

The State’s suggestion that Plaintiffs cannot show irreparable harm from the Records Access Provision also falls flat. Plaintiffs need not wait for irreparable harm to transpire to seek interlocutory injunctive relief. *See King I*, 272 Ga. at 792 (“Postdeprivation remedies are never favored and are constitutionally inadequate unless predeprivation remedies are unavailable or impractical.”). The purpose of interlocutory injunctive relief is to “*prevent* irreparable damage.”

Wood v. Wade, 363 Ga. App. 139, 148-49 (2022); accord *City of Waycross v. Pierce Cnty. Bd. of Comm'rs*, 300 Ga. 109, 111-12 (2016). The State's claim that Plaintiffs can rush to court for emergency relief when a district attorney demands a patient's health records is baseless, especially where Georgia rules require five business days' notice to the State before a request for an interlocutory injunction against enforcement of a statute can be heard. O.C.G.A. § 9-10-2. Given that the Records Access Provision does not provide a defense for noncompliance pending a motion for emergency relief, any delay in turning over health records would expose providers to risk of attachment for contempt and potential imprisonment. See O.C.G.A. § 24-13-26. Accordingly, Plaintiffs have demonstrated "a substantial threat" that their patients and members "will suffer irreparable injury if the injunction is not granted." *City of Waycross*, 300 Ga. at 111.

III. The Remaining Factors for an Interlocutory Injunction are Met.

Finally, the harm to Plaintiffs, their patients, and their members greatly outweighs the alleged harm to the State. As discussed *supra*, an injunction is necessary to prevent grave irreparable harm to thousands of Georgians. In contrast, any supposed harm to the State is minimal. An injunction will simply preserve the status quo in Georgia and will restore the parties to their positions prior to the Six-Week Ban. See *India-Am. Cultural Ass'n, Inc. v. iLink Pros., Inc.*, 296 Ga. 668, 670 (2015) (emphasizing that an injunction serves to maintain the status quo to prevent irreparable injury or harm to parties).

Further, enjoining the Six-Week Ban serves the parties and the public interest by ensuring Georgians are not deprived their constitutionally guaranteed rights. Although it is not "incumbent upon [Plaintiffs] to prove all four factors to obtain [an] interlocutory injunction," Plaintiffs have nevertheless proven each factor. *City of Waycross*, 300 Ga. at 111. This Court should issue the relief sought.

Respectfully submitted, this 8th day of August, 2022.

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**Pro hac vice application pending*

CERTIFICATE OF SERVICE

I hereby certify that I have this day caused a true and correct copy of the foregoing to be filed with the Clerk of Court using the eFile Georgia system, which will serve a true and correct copy of the same upon all counsel of record.

Additionally, I caused a true and correct copy of the foregoing to be served by Statutory Electronic Service upon the below counsel of record:

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This 8th day of August, 2022.

/s/ Julia Blackburn Stone
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EXHIBIT A

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT
IN AND FOR LEON COUNTY, FLORIDA

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

Plaintiffs,

v.

STATE OF FLORIDA, *et al.*,

Defendants.

Case No. 2022 CA 912

Judge Cooper

**ORDER GRANTING PLAINTIFFS' MOTION FOR AN EMERGENCY
TEMPORARY INJUNCTION AND/OR A TEMPORARY INJUNCTION,
ENTERING A TEMPORARY INJUNCTION, AND SETTING BOND**

Plaintiffs Planned Parenthood of Southwest and Central Florida; Planned Parenthood of South, East and North Florida; Gainesville Woman Care, LLC d/b/a Bread and Roses Women's Health Center; A Woman's Choice of Jacksonville, Inc.; Indian Rocks Woman's Center, Inc. d/b/a Bread and Roses; St. Petersburg Woman's Health Center, Inc.; Tampa Woman's Health Center, Inc.; and Shelly Hsiao-Ying Tien, M.D., M.P.H. (collectively, "Plaintiffs"), have moved this Court for a temporary injunction against the enforcement of Ch. 2022-69, §§ 3-4, Laws of Fla. ("HB 5" or "the Act") (to be codified at §§ 390.011, 390.0111, Fla. Stat.).

The Court held an evidentiary hearing on June 27, 2022, and the parties presented oral argument on June 30, 2022. Having considered the legal arguments

and the evidentiary record, and for the reasons that follow, the Court grants Plaintiffs' Motion for an Emergency Temporary Injunction and/or a Temporary Injunction ("the Motion"), enjoins the enforcement of HB 5 as set forth below, and orders Plaintiffs to post a bond of \$5,000.

OVERVIEW

In 1980, Florida amended its Constitution to add an explicit right of privacy that is not contained in the U.S. Constitution. Art. I, § 23, Fla. Const. (the "Privacy Clause") ("Every natural person has the right to be let alone and free from governmental intrusion into his private life except as otherwise provided herein. . . ."). The Florida Supreme Court thereafter determined that this right to privacy is "clearly implicated in a woman's decision of whether or not to continue her pregnancy." *In re T.W.*, 551 So. 2d 1186 (Fla. 1989). The Florida Supreme Court also determined that women have a right, under the Privacy Clause, to decide whether to terminate a pregnancy at least until fetal viability, which is around the completion of the second trimester. *Id.* at 1194. In addition, the Florida Supreme Court has held that "[a]ny law that implicates the right of privacy is presumptively unconstitutional, and the burden falls on the State to prove both the existence of a compelling state interest and that the law serves that compelling state interest through the least restrictive means." *Gainesville Woman Care, LLC v. State*, 210 So. 3d 1243, 1256 (Fla. 2017). Here, the Act bans, with extremely limited exceptions,

pre-viability abortions that were previously allowed under Florida law, thus imposing a burden on the State to justify that law.

The Court’s analysis in this Order is not affected by the U.S. Supreme Court’s recent decision in *Dobbs v. Jackson Women’s Health Organization*, No. 19-1392, slip op. (U.S. June 24, 2022). The right to privacy under the Florida Constitution is “much broader in scope” than any privacy right under the United States Constitution. *In re T.W.*, 551 So. 2d at 1192 (quotation and citation omitted). Concurring in part and dissenting in part in *In re T.W.*, Justice Grimes noted that, “[i]f the United States Supreme Court were to subsequently recede from *Roe v. Wade*, this would not diminish the abortion rights now provided by the privacy amendment of the Florida Constitution.” 551 So. 2d at 1202 (Grimes, J., concurring in part and dissenting in part). And in 2003, the Florida Supreme Court wrote, “any comparison between the federal and Florida rights of privacy is inapposite in light of the fact that there is no express federal right of privacy clause.” *N. Fla. Women’s Health & Counseling Servs., Inc. v. State*, 866 So. 2d 612, 634 (Fla. 2003) (emphasis omitted) (hereinafter, “*North Florida*”). Thus, the Florida Supreme Court has rejected the pre-*Dobbs* federal standard that required a plaintiff to prove that a regulation regarding abortion has placed a substantial obstacle in front of a woman seeking to assert her right to an abortion. *Id.* at 635–36. Accordingly, Plaintiffs in this case do not have a threshold

requirement to show that the law imposes a significant restriction on the right to a pre-viability abortion.

HB 5 implicates the right to privacy and, as Defendants concede, is subject to a standard of review known as “strict scrutiny.” Under *Gainesville*, 210 So. 3d 1243, any law that implicates the fundamental right of privacy is subject to strict scrutiny and presumed to be unconstitutional. In that situation, the burden is on the defendant to prove that the law in question advances a compelling state interest through the least restrictive means. *Id.* at 1256. Here, as set forth more fully below, the asserted interests identified by the State are not legally sufficient to justify HB 5’s ban on abortions after 15 weeks, measured from the first day of a woman’s last menstrual period (“LMP”). And, as set forth more fully below, the Court finds the testimony of Plaintiffs’ witnesses to be more credible and to rebut that offered by the State’s witnesses.

In short, the Court finds that Plaintiffs have demonstrated all of the required elements for a temporary injunction against HB 5.

PROCEDURAL BACKGROUND

1. Plaintiffs are six clinics that provide reproductive health care services across Florida, along with Dr. Shelly Hsiao-Ying Tien, a physician trained and board-certified in obstetrics and gynecology and maternal-fetal medicine who practices in Florida. *See generally* Compl.

2. On June 1, 2022, Plaintiffs filed a Complaint and the Motion, seeking, in part, a temporary injunction against HB 5 and the related definitions of Section 3(6) and 3(7). *See generally* Compl.; Mot. Plaintiffs named, as defendants, the State of Florida; the Florida Department of Health and its Secretary, Joseph Ladapo; the Florida Board of Medicine and its Chair, David Diamond; the Florida Board of Osteopathic Medicine and its Chair, Sandra Schwemmer; the Florida Board of Nursing and its Chair, Maggie Hansen; the Florida Agency for Health Care Administration and its Secretary, Simone Marsteller; and the State Attorneys for all 20 judicial circuits in Florida. Plaintiffs voluntarily dismissed the 20 State Attorneys from this suit without prejudice pursuant to a stipulation that this Court entered on June 17, 2022. The defendants who remain in this case are referred to herein as “the State.”

3. The State filed a response to the Motion on June 20, 2022, and Plaintiffs filed a Reply on June 24, 2022. The parties also filed certain declarations and conducted certain depositions as noted in the Court’s June 27, 2022 case management order.

4. On June 27, 2022, the Court held an evidentiary hearing at which counsel for Plaintiffs and counsel for the State appeared. The Court heard live testimony from three expert witnesses, and the parties consented to the admission of

written and deposition testimony from certain of those witnesses and an additional expert witness.

5. Specifically, Dr. Tien testified as an expert on behalf of Plaintiffs, both in Plaintiffs' case-in-chief and again in rebuttal to the State's evidence, and also provided fact testimony about the care she provides at one Plaintiff health center. Her sworn declaration dated May 27, 2022 and her curriculum vitae ("CV"), both of which were attached to the Motion, were admitted into evidence by consent of the parties. By consent of the parties, an additional expert witness for Plaintiffs, Dr. Antonia Biggs, Associate Professor at the University of California, San Francisco in the Department of Obstetrics, Gynecology, and Reproductive Sciences, submitted rebuttal testimony via her sworn declaration (and attached CV) dated June 23, 2022, and the transcript of her June 24, 2022 deposition taken by the State in this case. The Court references and cites to the declarations provided by Dr. Tien and Dr. Biggs throughout this Order. The CVs for each of these witnesses are attached in the Appendix to this Order.

6. The State presented live testimony from two experts, Dr. Ingrid Skop, an obstetrician and gynecologist and Senior Fellow and Director of Medical Affairs at the Charlotte Lozier Institute, and Dr. Maureen Condic, Associate Professor of Neurobiology and Anatomy at the University of Utah. By consent of the parties, a sworn declaration from Dr. Skop dated June 21, 2022 (and attached CV), a sworn

declaration from Dr. Condic dated June 22, 2022 (and attached CV), and the transcript from Plaintiffs' June 23, 2022 deposition of Dr. Skop in this case also were admitted into evidence. The Court cites to portions of that deposition transcript below. Also by consent of the parties, the three exhibits attached to the State's June 20 brief, and one exhibit attached to Dr. Skop's declaration, were also admitted into evidence.

7. On June 30, 2022, the Court heard argument from counsel on the Motion and issued a ruling from the bench, along with directions on factual findings and conclusions of law. The Court indicated at the end of the hearing that it intended to grant the injunction and set a bond of \$5,000. At the Court's direction, Plaintiffs submitted a proposed order containing proposed findings of fact and conclusions of law. The State had until the morning of July 4, 2022, to respond to the proposed order. Based on these submissions and the Court's evaluation of the applicable law and the evidence, the Court enters the below findings of fact and conclusions of law.

FINDINGS OF FACT

I. HB 5's Provisions

8. On March 3, 2022, the Florida legislature passed House Bill 5, which prohibits the provision of abortions in Florida after fifteen weeks LMP. Fla. HB 5, § 4 (to be codified at § 390.0111(1), Fla. Stat.). Section 4 of HB 5 amends section 390.0111 to include the prohibition on abortions after fifteen weeks LMP. Fla. HB

5, § 4 (to be codified at § 390.0111(1), Fla. Stat.). Section 3 of HB 5 amends section 390.011 to provide definitions for Section 4’s operative terms. Fla. HB 5, § 3 (to be codified at § 390.0111(6)–(7)), Fla. Stat.). Governor Ron DeSantis signed HB 5 on April 14, 2022, and it took effect on July 1, 2022. Fla. HB 5, § 8.

9. HB 5 contains two narrow exceptions. First, an abortion after 15 weeks LMP may be performed if “the termination of the pregnancy is necessary to save the pregnant woman’s life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition,” and either two physicians certify this conclusion “in [their] reasonable medical judgment” in writing, or a single physician certifies that the risks are “imminent” and “another physician is not available for consultation.” Fla. HB 5, § 4 (to be codified at § 390.0111(1)(a)–(b), Fla. Stat.).

10. Second, HB 5 permits an abortion after 15 weeks LMP when “[t]he fetus has not achieved viability under § 390.01112 and two physicians certify in writing that, in [their] reasonable medical judgement, the fetus has a fatal fetal abnormality.” Fla. HB 5, § 4 (to be codified at § 390.0111(1)(c), Fla. Stat.). HB 5 defines “fatal fetal abnormality” to mean “a terminal condition that, in reasonable medical judgment, regardless of the provision of life-saving medical treatment, is

incompatible with life outside the womb and will result in death upon birth or imminently thereafter.” Fla. HB 5, § 3 (to be codified at § 390.0111(6), Fla. Stat.).¹

11. A violation of HB 5 by an abortion provider is a third-degree felony. Specifically, “any person” who “willfully performs” or “actively participates” in an abortion in violation of the law is subject to criminal penalties, including imprisonment of up to five years and monetary penalties up to \$5,000 for a first offense. §§ 390.0111(10)(a), 775.082(8)(e), 775.083(1)(c), Fla. Stat.

12. Physicians and other health care professionals are subject to disciplinary action for violating HB 5, including but not limited to revocation of their licenses to practice medicine and administrative fines. §§ 390.0111(13), 390.018, 456.072(2), 458.331(2), 459.015(2), 464.018(2), Fla. Stat.

13. In addition, abortion clinics may be prevented from renewing their clinic licenses for violating HB 5. Fla. Admin. Code R. 59A-9.020.

14. Plaintiffs all currently provide abortions after 15 weeks LMP.

II. Abortions in Florida After 15 Weeks LMP

15. Abortion is the second most common reproductive intervention that physicians provide for women of reproductive age in the United States; only a Cesarean section is a more common procedure. Tien Decl. ¶ 17. Nearly one in four

¹ Florida law separately bans abortions after fetal viability. § 390.01112, Fla. Stat. That law is not at issue in this case.

U.S. women will have an abortion. *Id.* (citing Guttmacher Inst., Induced Abortion in the United States (Sept. 2019), <https://www.guttmacher.org/fact-sheet/induced-abortion-united-states>).

16. Florida law not at issue in this litigation already prohibits abortion after fetal viability. § 390.01112, Fla. Stat.; *see also* ¶ 19. No pregnancy is viable at 15 weeks LMP, which is early in the second trimester and approximately two months before viability. Tien Decl. ¶ 19. A patient’s due date is 40 weeks and 0 days LMP, and a pregnancy is considered full term at or after 37 weeks LMP. *Id.* The majority of abortions in Florida and throughout the country occur in the first trimester. *See* Tien Decl. ¶ 18; Hr’g Tr. (Rough) 41:17-18, 74:8-16 [Tien].²

17. The parties agree that most abortions in Florida occur prior to 15 weeks LMP. However, approximately 6.1% of the abortions reported in Florida in 2021 (or nearly 5,000 abortions) occurred in the second trimester. Tien Decl. ¶ 18; State’s Resp., Ex. A (Fla. Agency for Health Care Admin., Reported Induced Terminations of Pregnancy (ITOP) by Reason, by Trimester, 2021 – Year to Date (May 9, 2022), https://ahca.myflorida.com/mchq/central_services/training_support/docs/TrimesterByReason_2021.pdf. As Plaintiffs’ expert Dr. Tien testified, patients seek abortion

² “Hr’g Tr. (Rough)” refers to the court reporter’s rough draft of the transcript for the June 27, 2022, evidentiary hearing in this case. A final transcript was not yet available at the time this Order was entered.

in the second trimester, including after 15 weeks LMP, for many reasons, as discussed below.

A. Dr. Tien's Qualifications.

18. Dr. Tien is a board-certified obstetrics and gynecology (“OB/GYN”) physician and maternal-fetal medicine (“MFM”) specialist. Tien Decl. ¶ 1; Hr’g Tr. (Rough) 31:6–7. Maternal-fetal medicine is a subspecialty of OB/GYN focused on the care of women with high-risk pregnancies; MFM specialists undergo years of advanced training in addition to the training they received as OB/GYN physicians. Tien Decl. ¶ 9; *see* Hr’g Tr. (Rough) 32:17-24 [Tien]. After graduating from medical school, Dr. Tien was trained in a four-year residency in obstetrics and gynecology at Advocate Illinois Masonic Medical Center in Chicago, Illinois, and a three-year MFM fellowship at the University of Minnesota in Minneapolis. Tien Decl. ¶ 5; *see* Hr’g Tr. (Rough) 32:11–33:3 [Tien]. Dr. Tien has provided clinical care to pregnant patients for almost 15 years, including caring for patients with high-risk pregnancies and providing abortion and contraceptive care. Tien Decl. ¶¶ 5, 8–9; *see* Hr’g Tr. (Rough) 33:4–35:13 [Tien].

19. Dr. Tien testified that after her fellowship in MFM at the University of Minnesota, she worked for five and a half years as an MFM specialist at NorthShore University Health System in Evanston, Illinois, which is affiliated with University of Chicago. Hr’g Tr. (Rough) 36:13-21 [Tien]. There, she provided prenatal care to

high-risk pregnancies, delivered babies, and performed abortions. *Id.* at 36:19–37:1 [Tien]. She was an educator and trained medical students, residents, and fellows. *Id.* at 37:2-5 [Tien]. She testified that she has cared for thousands of patients, including patients who chose to terminate their pregnancies and patients who chose to continue their pregnancies. *Id.* at 37:6-13 [Tien].

20. Dr. Tien currently provides abortion care and other services at the Jacksonville clinic of Planned Parenthood of South, East and North Florida, including abortion care after 15 weeks LMP. *Id.* at 34:23–35:7 [Tien]. She also currently works as an MFM specialist at Genesis Maternal-Fetal Medicine in Tucson, Arizona, where she treats patients with high-risk pregnancies and has admitting privileges at four Tucson-area hospitals. *Id.* at 33:21–34:22 [Tien]. Dr. Tien previously provided abortion care at Planned Parenthood Southeast in Alabama and Trust Women in Oklahoma, until recent abortion restrictions took effect in those states. *Id.* at 35:8–13 [Tien]. Dr. Tien testified that she currently spends roughly 70% of her time providing abortion care and that she spends approximately 20–30% of her time providing abortion care after 15 weeks LMP. *Id.* at 35:17–36:2 [Tien].

21. The Court credits Dr. Tien’s above-identified qualifications and finds her testimony in the areas of obstetrics and gynecology and MFM, including abortion care, to be persuasive.

B. Reasons Women Seek Abortions.

22. Patients terminate both wanted and unwanted pregnancies for many reasons. Tien Decl. ¶ 28. Those who decide to have an abortion consider many factors, including the health and well-being of their children and other family members; their financial ability to provide for a child or for a child in addition to their existing children; whether they are currently in a safe home environment; and their own health, including any pre-existing medical conditions that can make a pregnancy high risk or new medical conditions that arise directly from the pregnancy. *Id.*

23. The majority of women who obtain an abortion (approximately 60%) have had at least one child. *Id.* ¶ 29. Some patients with children are familiar with the enormous demands that parenting places on their time and resources, and decide to have an abortion based on what is best for them and their existing families. *Id.* Others are not ready to have children. *Id.* Some patients seek abortions because they decide they need to prioritize their education or economic or familial stability. *Id.* Some have elder care responsibilities. *Id.* Some are struggling with food or housing insecurity; homelessness; and/or alcohol, opioid, or other substance addictions, and decide not to become a parent while struggling with those challenges. *Id.* Some decide they do not have the emotional resources necessary to continue the pregnancy and become a parent. *Id.*

24. Other patients seek abortions because they have pre-existing medical conditions that make pregnancy risky for their own physical or mental health. *Id.* ¶ 29. For other patients, regardless of whether their pregnancies were planned or unintended, pregnancy itself creates new significant medical risks to their own health. *Id.* As a result of historical inequities to health care access and economic inequality, approximately 61% of patients seeking abortion care identify as Black, Indigenous, or women of color, and these same populations face disproportionately high rates of maternal mortality and comorbidities that increase the health risks associated with pregnancy. *Id.*

25. Patients also seek abortions after having experienced some form of violence. Some have experienced rape or incest, whether in the form of sexual abuse, sexual assault, gang rape, torture, or human trafficking-sexual slavery; notably, the Act contains no exception for these women and children. Tien Decl. ¶ 30. Access to abortions in this context is just one element of helping survivors of sexual violence regain some semblance of their physical and emotional health. *Id.* Other patients live with intimate partner violence and do not want to continue a pregnancy or raise a child in an abusive environment, or further tie themselves to an abusive partner. *Id.* Patients who are unable to access safe abortion are more likely to stay with a perpetrator of violence. *Id.*

C. Reasons Abortions May Be Sought After 15 Weeks LMP

1. Delay in Identifying the Pregnancy

26. Dr. Tien explained that, because of the way pregnancy is dated, a missed period occurs at the earliest at 4.5 to 5 weeks LMP. Hr’g Tr. (Rough) 50:23–51:7 [Tien]; Tien Decl. ¶ 33. Some patients, especially those with irregular menstrual cycles or who do not experience pregnancy symptoms, may not suspect they are pregnant for weeks or months, or may experience bleeding early in pregnancy that they mistake for a period. Hr’g Tr. (Rough) 51:8-22 [Tien]; Tien Decl. ¶ 33. Patients may be further delayed in confirming the pregnancy, researching and considering their options, contacting an abortion provider, and scheduling an appointment. Hr’g Tr. (Rough) 52:15–57:16 [Tien]; Tien Decl. ¶ 33.

2. Poverty and Financial Challenges

27. As Dr. Tien testified, many patients who seek abortions after 15 weeks LMP do so because they face difficulty in raising the necessary funds both for the procedure itself (as abortion is frequently not covered by insurance) as well as related expenses, including transportation and childcare. Hr’g Tr. (Rough) 53:7-22 [Tien]; Tien Decl. ¶¶ 34–35. Others have difficulty arranging time off from work or school, finding childcare, and arranging transportation. Hr’g Tr. (Rough) 53:7-22 [Tien]; Tien Decl. ¶ 34. The COVID-19 pandemic has increased these challenges. Hr’g Tr. (Rough) 54:6-19 [Tien]; Tien Decl. ¶ 34. These barriers are especially difficult for

the approximately 75% of abortion patients nationwide who live under or near the poverty line. Hr’g Tr. (Rough) 53:23–54:3 [Tien]; Tien Decl. ¶ 34.

28. Dr. Tien testified that Florida’s mandatory delay law, which recently went into effect, adds to these challenges. Hr’g Tr. (Rough) 55:6-11 [Tien]; Tien Decl. ¶ 36. This law requires patients to make two trips to the health center instead of one; the first is to sign state-mandated forms at least 24 hours before the abortion, and the second is to have the abortion procedure. Hr’g Tr. (Rough) 54:6–55:1 [Tien]; Tien Decl. ¶ 36.

29. Dr. Tien testified that, in practice, this law can cause far more than a day’s delay because many patients (and especially patients who have low incomes) are not able to make the trip to their abortion provider twice in close succession. Hr’g Tr. (Rough) 55:15-25 [Tien]; Tien Decl. ¶ 36. Many abortion patients are delayed in accessing care because of the need to find two appointments that accommodate their work schedules, because they cannot afford to take two days off from work in close proximity, or because doing so would jeopardize their jobs—especially if the patient does not want to share the reason for the time-off request. Hr’g Tr. (Rough) 55:6-25 [Tien]; Tien Decl. ¶ 37. Patients may need to delay an appointment by a week or several weeks for these reasons. Hr’g Tr. (Rough) 55:6-11 [Tien]; Tien Decl. ¶ 37. Other patients cannot arrange childcare for multiple days

or cannot do so without compromising the confidentiality of their pregnancy and abortion decision. Hr’g Tr. (Rough) 55:6-25 [Tien]; Tien Decl. ¶ 37.

30. For these reasons, it is not surprising that patients seeking second-trimester abortions are more likely to have low incomes, more likely to report difficulty financing the abortion, and more likely to rely on financial assistance to pay for the procedure. Tien Decl. ¶ 39; *see* Hr’g Tr. (Rough) 53:7–25 [Tien]. Women who are most likely to be delayed in abortion until after 15 weeks LMP are those already facing the challenges of poverty or near-poverty, food insecurity, and economic instability. Tien Decl. ¶ 39.

3. Intimate Partner Violence

31. Dr. Tien also testified that patients experiencing intimate partner violence are often delayed in seeking abortions. Hr’g Tr. (Rough) 56:21-25 [Tien]; Tien Decl. ¶ 40. It is common for women experiencing intimate partner violence to seek abortions. Tien Decl. ¶ 40. This is due to a number of factors, including that abusers frequently sabotage a partner’s ability to use contraception, leading to more unintended pregnancies; that pregnancy is often a time of escalating violence; and that a person experiencing intimate partner violence may not wish to be further tethered to an abusive partner or to bring a child, or an additional child, into an abusive household. *Id.*; *see* Hr’g Tr. (Rough) 56:5–20 [Tien].

32. Dr. Tien testified that, in many abusive relationships, the abuser exerts control over every aspect of their partner's life. Hr'g Tr. (Rough) 56:5-20 [Tien]; Tien Decl. ¶¶ 40–41. Such abusive partners may try to control the patient's reproductive decisions. Hr'g Tr. (Rough) 56:5-10 [Tien]; Tien Decl. ¶¶ 40–41. The abuser's control can complicate a patient's ability to raise funds for the procedure and to schedule multiple appointments. Hr'g Tr. (Rough) 56:5-20 [Tien]; Tien Decl. ¶ 41. Often such patients must wait for a day that their abusive partner will be out of town or otherwise occupied. Hr'g Tr. (Rough) 56:11-17 [Tien]; Tien Decl. ¶ 41. With Florida's two-trip requirement, patients must be able to find two such days when they can attempt to elude an abusive partner. Hr'g Tr. (Rough) 56:11-17 [Tien]; Tien Decl. ¶ 41. The combined effect of these factors can significantly delay abortion access, causing patients in abusive relationships to be disproportionately likely to obtain an abortion after 15 weeks. Hr'g Tr. (Rough) 56:1–25 [Tien]; Tien Decl. ¶ 42.

4. Young Patients

33. Adolescent patients are also disproportionately likely to need abortions after 15 weeks, as they may be more likely to have irregular periods or less knowledgeable about reproductive biology and less likely to be able to access abortion services promptly once they have made a decision. Hr'g Tr. (Rough) 57:22-58:5 [Tien].

5. Substance Abuse

34. Patients struggling with substance abuse disorders face multiple challenges that can cause a delay in obtaining an abortion until after 15 weeks LMP. Hr’g Tr. 57:6–16 [Tien]. Such patients may be addressing their own medical conditions, or they may be trying to admit themselves to a rehab program to improve their lives, which can impede timely access to care. *Id.* Patients who are struggling with substance abuse are also more likely to be living in poverty or even be homeless, making it more difficult to make a clinical appointment and obtain care. *Id.*

6. Changed Life Circumstances

35. Other patients, including women who initially intended to carry their pregnancies to term, may decide to terminate a pregnancy because their life circumstances change: they lose a job, they break up with a partner, or a family member becomes ill.

7. Health Conditions Caused or Exacerbated by Pregnancy

36. Dr. Tien testified that other patients experience health conditions that are caused or exacerbated by pregnancy and often develop after 15 weeks LMP. Tien Decl. ¶ 43; Hr’g Tr. (Rough) 58:15–61:3, 67:8-10 [Tien]. Pregnancy is a stress test for human physiology, impacting multiple organ systems, such as the heart, cardiovascular system, and kidneys. Tien Decl. ¶ 43. And the hormones produced

during pregnancy make a woman more insulin resistant, making it more difficult to maintain blood glucose levels at a stable level. *Id.* Patients with autoimmune disorders such as lupus can experience exacerbation of their disease, as manifested by worsening hypertension and kidney disease. *Id.* Patients with preexisting decreased cardiac function can rapidly decompensate and lose additional heart function. *Id.* Pregnancy can also exacerbate mental health conditions. For instance, women with pre-existing mood disorders, like depression or anxiety, may experience a worsening of symptoms during pregnancy. *Id.* These risks disproportionately impact people with low incomes, who experience more comorbidities such as obesity, hypertension, and diabetes. *Id.* ¶ 45. A legacy of distrust of the healthcare system can deter people from seeking preventative health services and further compound medical comorbidities associated with poverty. *Id.*

8. Diagnoses of Serious Fetal Conditions

37. Many patients who have planned and celebrated their pregnancy with the intention of welcoming a child into their family may learn as the pregnancy progresses of a serious fetal condition, which can be genetic or structural (such as complex brain or heart defects). Tien Decl. ¶ 46; *see* Hr’g Tr. (Rough) 61:12-15 [Tien]. Definitive diagnosis of genetic fetal conditions requires amniocentesis, which can only be performed at 15 weeks LMP or beyond, or chorionic villi sampling (“CVS”), which can be performed between 10 and 13 weeks LMP;

however, many patients in rural or resource-limited areas do not have access to a subspecialist to provide CVS. Tien Decl. ¶ 46. For some genetic conditions, it can take several weeks for the results of either an amniocentesis or CVS to return, further delaying the patient's decision-making regarding these fetal conditions. *Id.* Structural fetal conditions may not be identified until an anatomical ultrasound survey, which occurs between 18 and 22 weeks LMP. *Id.*; Hr'g Tr. (Rough) 60:22–61:24 [Tien].

38. At least some of these serious fetal conditions do not fit squarely within the Act's very limited exceptions. Hr'g Tr. (Rough) 68:4-25 [Tien]. As Dr. Tien explained, many conditions may not be fatal but can have profound and lasting implications for the patient, the family, and the neonate if the pregnancy is carried to term. Hr'g Tr. (Rough) 68:10-13 [Tien].

39. Florida's reporting indicates that in 2021, at least 757 Florida abortions took place because of a serious fetal anomaly and that 484 of those took place in the second trimester. Tien Decl. ¶ 47; *see* State's Resp., Ex. A (Fla. Agency for Health Care Admin., Reported Induced Terminations of Pregnancy (ITOP) by Reason, by Trimester, 2021 – Year to Date (May 9, 2022), https://ahca.myflorida.com/mchq/central_services/training_support/docs/TrimesterByReason_2021.pdf. However, Florida's state-required, web-based abortion reporting system, which records patients' reasons for termination, has limitations, as

it allows for the selection of only one reason for having an abortion. *Id.* Patients frequently have multiple reasons for seeking an abortion, and their own health or a fetal condition may be only one of many considerations. *Id.* Therefore, the reported numbers are likely an under-representation of the instances in which these factors drive or help drive a patient’s decision to have an abortion. *Id.*

40. Patients faced with a diagnosis of a fetal condition also need time to make the right decisions for themselves and their families, based on information from their prenatal care providers and from multiple sources with knowledge about the fetal anomaly at issue, discussion with family and other support systems, and consultation with their clergy, social workers, or other resources. Tien Decl. ¶ 48; *see* Hr’g Tr. 63:10–21.

9. Pregnancy Complications

41. Patients also may seek abortions later in pregnancy because their health is threatened by their ongoing pregnancy. Tien Decl. ¶ 55. In many cases, even patients with significant pregnancy-related health issues may not satisfy the Act’s exception to prevent a “serious risk of substantial and irreversible physical impairment of a major bodily function . . . other than a psychological condition.” *Id.*; *see* HB 5, § 4 (to be codified at § 390.0111(1), Fla. Stat.). Many disease processes present as a spectrum, and the Act would seem to require a physician to delay intervention until it is clear the patient is at serious risk of substantial and permanent

harm or death. Tien Decl. ¶ 55; Hr’g Tr. (Rough) 68:21–70:9 [Tien]. Dr Tien testified that this result is antithetical to quality patient care. *Id.*

42. As an example, some patients experience chronic bleeding throughout their pregnancies that can escalate at any point, requiring active intervention and treatment. Tien Decl. ¶ 56; *see* Hr’g Tr. (Rough) 68:25–69:11 [Tien]. For patients who do not respond to initial treatments, it is the standard of care, depending on the gestational age, to perform an abortion to protect the patient’s life and health. Tien Decl. ¶ 56; *see* Hr’g Tr. (Rough) 69:4-11 [Tien]. Like many maternal health issues, bleeding can progress in unpredictable ways; having to assess at what stage a deteriorating patient’s condition qualifies for the life or health exception—at risk of a prosecutor or jury disagreeing with that assessment—places physicians in an impossible situation. Tien Decl. ¶ 56; *see* Hr’g Tr. (Rough) 69:17-24 [Tien].

D. Likelihood Women Will Seek Earlier Abortions Under HB 5

43. Nearly 5,000 patients obtained abortion care in Florida in the second trimester in Florida in 2021. Tien Decl. ¶ 18; *see* State’s Resp., Ex. A (Fla. Agency for Health Care Admin., Reported Induced Terminations of Pregnancy (ITOP) by Reason, by Trimester, 2021 – Year to Date (May 9, 2022), https://ahca.myflorida.com/mchq/central_services/training_support/docs/TrimesterByReason_2021.pdf). The Court credits the testimony of Dr. Tien and finds, based on the evidence, that under HB 5, many of these patients would be unable to obtain

abortions in Florida prior to 15 weeks LMP and therefore (unless they fell into one of HB 5's narrow exceptions) would be unable to obtain abortions through the medical system in Florida at all. Poverty, substance addiction, intimate partner violence, post-15-week diagnoses, and the other factors identified above that can delay patients in obtaining an abortion will not disappear simply because the law has changed. Hr'g Tr. (Rough) 58:6-14 [Tien]. In other words, the Court finds that HB 5 will not simply encourage all women seeking abortions to obtain them prior to 15 weeks.

44. The Court also credits the testimony of Dr. Tien regarding the limited options available to patients who would be barred from obtaining an abortion under HB 5. She explained that some patients may attempt to travel long distances to obtain care in another state in which such care is still available, Hr'g Tr. (Rough) 64:22, 67:18-24 [Tien], which will result in further delays in accessing an abortion. But doing so would impose substantial economic and logistical burdens, and simply would not be possible for many patients, 75% of whom are poor or have low incomes. *Id.* at 53:23–54:5 [Tien]. Some patients may decide to end their pregnancies on their own, outside the medical system. *Id.* at 66:23–67:3 [Tien]. Others will be prevented from obtaining abortion care entirely and thus will be forced to continue their pregnancies and have children against their will. *Id.* at 66:23–67:3 [Tien].

III. Abortion and Maternal Health

45. The State contends that HB 5 furthers a compelling state interest in protecting maternal health. State’s Resp. at 18–20. The parties presented extensive evidence on the safety of abortion services at and after 15 weeks LMP. The Court makes the following findings concerning the safety of abortion. In doing so, it finds the testimony of Plaintiffs’ experts, Dr. Tien and Dr. Biggs, more persuasive than the testimony of the State’s expert, Dr. Skop.

46. As detailed more fully below, Dr. Skop’s testimony failed to show that abortion is unsafe after 15 weeks LMP or that HB 5 would improve maternal health. The State presented no other evidence on abortion safety.

A. Safety of Abortion Procedures

47. Dr. Tien testified persuasively that, based on her experience and training, abortion is a very safe procedure and that serious complications are very rare, including when abortion is performed after 15 weeks LMP, regardless of the method of abortion that is used. Tien Decl. ¶ 27; *see also* Hr’g Tr. (Rough) 43:3–45:13 [Tien]. She further testified that the safety of abortion has been extensively studied and is well established, and that there is no dispute in mainstream medicine about the safety of abortion. *Id.* at 43:19-25, 45:14–47:19, 48:17–49:22 [Tien]. To the extent that abortion, like all medical procedures, has risks, there is no evidence

in the record that the risks of abortion have increased since the Privacy Clause was added to the Florida Constitution in 1980.

48. Dr. Tien testified that there are two methods of abortion commonly used in the United States: medication abortion and procedural abortion. Tien Decl. ¶ 20; Hr’g Tr. (Rough) 41:23–42:2 [Tien]. Medication abortion using a two-pill regimen is performed only in early pregnancy, prior to 11 weeks LMP, and involves the use of a two-drug medication regimen to induce a process similar to early miscarriage. Tien Decl. ¶ 21; Hr’g Tr. (Rough) 41:23–41:25 [Tien]. At the gestational age relevant here—after 15 weeks LMP—medication abortion is not performed, and procedural abortion is the only generally-available option. Tien Decl. ¶ 20; Hr’g Tr. (Rough) 41:23–42:6 [Tien]. Procedural abortion is sometimes referred to as a “surgical abortion” even though it involves no incisions, requires no operating room, and can be performed with no anesthesia or sedation. Tien Decl. ¶ 20; Hr’g Tr. (Rough) 42:7-12 [Tien]. It is performed by dilating (opening) the cervix and then using either aspiration (suction) alone, or after approximately 14 to 16 weeks in pregnancy, a combination of suction and instruments, to evacuate the contents of the uterus. Tien Decl. ¶ 20; Hr’g Tr. (Rough) 229:22–230:2 [Tien]. When instruments are used, the procedure is known as a dilation and evacuation (“D&E”) procedure. Tien Decl. ¶ 22.

49. Dr. Tien testified that serious complications from legal abortion are extremely rare, occurring in less than 0.5% of cases. *Id.* at 44:1-7, 45:16-46:8 [Tien]; Tien Decl. ¶¶ 26-27 (citing Ushma D. Upadhyay et al., Incidence of Emergency Department Visits and Complications After Abortion, 125 *Obstetrics & Gynecology* 175, 178-79 tbl. 3 (2015)).

50. The Court accepts Dr. Tien's testimony that the risk of serious complications from abortion increases as a pregnancy progresses. Hr'g Tr. (Rough) 89:7-11 [Tien]; Tien Decl. ¶ 27. However, the Court also credits Dr. Tien's testimony that, even after 15 weeks LMP, the risk of serious complications from abortions remains less than 0.5%. Hr'g Tr. (Rough) 44:1-7 [Tien]. By contrast, every pregnancy-related complication is more common among women whose pregnancy results in a live birth than among women who have abortions. Tien Decl. ¶ 26.

51. Patients who seek abortions are pregnant, which itself carries risks. *Id.* ¶ 25. For pregnant patients, having an abortion is safer than carrying a pregnancy to term. *Id.*

52. The mortality rate from abortion procedures is 0.6 to 0.7 per 100,000 procedures. Hr'g Tr. (Rough) 44:8-17 [Tien]; Tien Decl. ¶ 25. Mortality rates are approximately 12 to 14 times higher for women undergoing childbirth than for women having abortions. Hr'g Tr. (Rough) 45:2-13 [Tien]; Tien Decl. ¶ 25. Dr. Tien further testified that maternal mortality rates are not only much higher than those for

abortion, but that the maternal mortality rates for childbirth also show significant racial disparities—the most recent mortality rates, from 2020, show approximately 19 deaths per 100,000 live births for white women, and 55 deaths per 100,000 live births for Black women. Hr’g Tr. (Rough) 44:23–45:1 [Tien]; Tien Decl. ¶ 25. These maternal mortality rates have continued to increase in the last 10 to 20 years, while the mortality rate associated with abortion has not. Hr’g Tr. (Rough) 44:21-23 [Tien]; Tien Decl. ¶ 25. The Court credits this testimony.

53. Dr. Tien further testified that the mortality risk from abortion is extremely low compared to other outpatient procedures, such as a colonoscopy, plastic surgery, or certain dental procedures. Hr’g Tr. (Rough) 47:20–48:7 [Tien]; Tien Decl. ¶ 23.

54. The Court finds that Dr. Tien’s testimony as to the safety of abortion, including when performed after 15 weeks, based on her training and extensive clinical experience in the OB/GYN and MFM fields, is persuasive. In addition, and separately, the literature that Dr. Tien relied upon in formulating her opinions is credible, robust, supports her opinions, and is widely accepted in the scientific community. Hr’g Tr. (Rough) 43:19-25, 45:14–47:19 [Tien] (discussing studies and data supporting opinion as to the safety of abortion and explaining indicia of reliability). The Court therefore accords significant weight to Dr. Tien’s testimony.

55. Dr. Tien's opinion on abortion safety differs from Dr. Skop's opinion. Dr. Skop has been an OB/GYN for 30 years, but she has never performed an abortion. *Id.* at 199:10-17 [Skop]. Until April 1, 2022, Dr. Skop was in private practice with a group for almost 26 years, but none of the physicians in that group performed abortions. Skop Dep. Tr. 14:7-11, 19:8-13, 22:3-4. She has never recommended an abortion to any of her patients. Hr'g Tr. (Rough) 199:18-20 [Skop]. She has never performed intrauterine fetal surgery. *Id.* at 200:7-16 [Skop].

56. Dr. Skop is a full-time, salaried senior fellow at the Charlotte Lozier Institute ("CLI"), a pro-life research institution. *Id.* at 179:20-21, 201:5-20 [Skop].

57. Dr. Skop testified that, based on her experience, she has "not found any medical reasons that women must have" an abortion, and that she thinks abortion "is used for social indications." *Id.* at 204:12-15 [Skop]. She disputes scientific findings that abortion is safer than childbirth based on her belief that the data is "compromised." *Id.* at 191:15-18 [Skop].

58. Dr. Skop conceded that her views on abortion safety are "inconsistent with the findings of [a] number of medical associations." *Id.* at 204:21-25. These institutions include mainstream medical associations in the U.S., such as the American College of Obstetricians and Gynecologists ("ACOG"), the American Psychological Association ("APA"), the National Academies of Sciences, Engineering, and Medicine ("NASEM"), the American Medical Association

(“AMA”), as well as U.S. governmental agencies, such as the Centers for Disease Control and Prevention (“CDC”). *Id.* at 205:4-9, 207:16-25, 208:2-25, 209:2-8, 210:10-22, 212:6-20. Dr. Skop maintains that all these institutions have a “pro choice” bias. *Id.* at 205:1-3. However, Dr. Skop acknowledged that she reads and relies on ACOG for other information, and she conceded that the organization provides useful information on topics other than abortion. *Id.* at 206:6-9.

59. Dr. Skop testified that D&E abortion—*i.e.*, a procedural abortion method used in the second trimester—is unsafe, referencing a 20-year-old study as support for her position. *Id.* at 219:17-25, 220:1-7; Skop Decl. ¶ 24. However, the study Dr. Skop referenced showed only that mortality rates increased as a pregnancy progressed; those rates remained lower than maternal mortality rates are today, and Dr. Skop agreed that the study showed that mortality rates associated with abortion declined over time. Skop Dep. Tr. 154:1-16 (referencing Linda A. Bartlett, et al., *Risk Factors for Legal Induced Abortion–Related Mortality in the United States*, Tables 1 and 2). In her testimony at the hearing, Dr. Skop could not point to any current data to support the conclusion that D&E abortions are not safe. Hr’g Tr. (Rough) 220:16–221:21 [Skop].

60. Dr. Skop also testified that the mortality risk from D&E rises with gestational age. Skop Decl. at 5-6. However, she conceded that this opinion rested on one study from 1981, which “reflects 1970s data,” and that she largely did not

know “the specific details” of how the D&E procedure has evolved since 1981. Skop Dep. Tr. 110:17–111:16, 113:15-20. She further acknowledged that she did not know “how accurate the mortality data” used in the 1981 study was. *Id.* at 118:8–13.

61. Dr. Skop testified that the abortion mortality rate of 0.7 percent per 100,000 procedures reported in a NASEM study was inaccurate because she believes all existing data on abortion mortality in the U.S. are inaccurate, due to pressure on abortion providers to undercount mortality. Skop Dep. Tr. 86:10–23, 172:25—175:9. However, she also testified that she thought “the data on colonoscopy, dental procedures, plastic surgery, [and] tonsillectomy” in the same study were “likely to be more accurate. . . than the data related to abortion.” *Id.* at 173:20–24.

62. Dr. Skop maintained that the complication rate in the United States for D&E abortions is much higher than studies consistently report, but she could point to no data to support that belief. Skop Dep. Tr. 92:1-2. She testified that she believes the United States has poor data on complications from abortions because the United States does not mandate the reporting of complications. *Id.* at 76:12–78:5. Dr. Tien, however, testified that reporting on pregnancy-related complications is more robust than reporting in other areas of medicine, and that the literature showing low rates of complications from abortions rests on scientifically sound CDC data. *Id.* at

231:15-24, 233:12–235:23 [Tien]. The Court credits this testimony of Dr. Tien over Dr. Skop’s conflicting testimony.

63. Dr. Skop testified that there is “good data”—which she did not specify—that D&E procedures cause placental abruption in future pregnancies, which leads to premature delivery and could lead to hemorrhage. *Id.* at 197:11-14 [Skop]. She also testified that later-term abortions can damage the cervix “as the uterus enlarges and the pressure inside increases that can cause a woman to go into preterm labor.” *Id.* at 198:1-3 [Skop]. She also testified that the ACOG “reports the second trimester abortion risks of hemorrhage . . . are 3.3 percent” and risks of “0.5 percent [for] uterine perforation.” Skop Decl. at 4.

64. The Court does not credit Dr. Skop’s opinions on these points. Dr. Skop admitted that her statement in her declaration regarding ACOG’s data on the abortion risks of hemorrhage and uterine perforation was inaccurate, and that ACOG instead reported the risks of hemorrhage at 0.1 to 0.6 percent, and uterine perforation at 0.2 to 0.5 percent. Skop Dep. Tr. 68:21–69:5, 70:6-22, 71:20-23. Dr. Skop also stated that the risk of abortion complications “is far higher than ACOG reports,” but pointed to no evidence for this claim. *Id.* at 71:1–3.

65. Further, the Court found Dr. Skop’s testimony to be unsupported, such as when she asserted that she had “no doubt” that abortion can create complications in future pregnancies yet also said that “at this time we don’t have the ability to

detect those complications to prove that that is happening.” Hr’g Tr. (Rough) 198:8-13 [Skop]. Dr. Skop also testified that she believed a NASEM study undercounted the risks of D&E-related hemorrhage requiring transfusion because, “based on [her] clinical experience and what [she] ha[s] seen, [she] think[s] the rates are higher.” Skop Dep. Tr. 90:16–92:1. But she admitted that “there may not be a study that documents” her belief that the risks are higher than the NASEM study’s reported risks. Skop Dep. Tr. 90:16–92:1.

66. By contrast, Dr. Tien testified persuasively that the risks from abortion that Dr. Skop identified either do not exist or are less serious than Dr. Skop suggests. Hr’g Tr. (Rough) 231:1-11 [Tien]. For example, while Dr. Skop testified that an abortion procedure that involves sharp uterine curettage could theoretically cause placental abruption in a future pregnancy, *id.* at 197:2-14 [Skop], she does not provide abortion care, and Dr. Tien, who does provide abortion care, testified that sharp curettage is not used in contemporary abortion practice, *id.* at 233:8-11 [Tien]. As to Dr. Skop’s assertion that abortion procedures can damage the cervix, Dr. Tien testified that these concerns are not supported. Before performing a procedural abortion, it is standard procedure to ensure that the cervix is adequately dilated using gentle cervical ripening and dilation techniques. *Id.* at 232:7-16 [Tien]. And Dr. Tien testified that, although there is a weak association between abortion and a subsequent premature birth, other risk factors for premature birth, such as multiple gestation,

poverty, and prior pregnancies carried to term, present much higher risks for premature birth. *Id.* at 232:17–233:2 [Tien].

67. Dr. Skop also repeatedly contended that abortion providers are not regulated or are not regulated adequately. *Id.* at 211:24-25, 212:1-5 [Skop]. But Dr. Tien testified that abortion facilities in Florida must be licensed and inspected by a Florida state agency to maintain licensure. *Id.* at 226:18–23 [Tien]. Florida law also requires reporting of abortion complications; if the agency has a concern that an abortion facility is unsafe, it can revoke the facility’s license. *Id.* at 227:3-10 [Tien]. An abortion provider’s medical license also can be revoked if abortion patients treated by that provider experience an excessive number of complications; this is true for physicians in other areas of medicine as well. *Id.* at 228:1-11 [Tien].

68. Overall, Dr. Skop has no experience in performing abortions; admitted that her testimony on the risks of certain abortion complications was inaccurate and overstated, or based on data from decades ago; admitted that her views on abortion safety are out of step with mainstream medical organizations; and provided no credible scientific basis for her disagreement with recognized high-level medical organizations in the United States. The Court thus does not find Dr. Skop as credible on the risks of abortion complications and quality of abortion care as Dr. Tien, who has significant experience in performing abortions and the other qualifications set forth above.

B. Abortion and Mental Health

69. Dr. Skop also testified that abortion has a negative effect on the mental health of the woman who obtains the abortion. Hr’g Tr. (Rough) 193:11-14. However, Dr. Skop acknowledged that she has “no formal training in mental health counseling outside of [her] time in medical school,” *id.* at 199:21-24, and she testified that she would not refer to herself as an expert in mental health, *id.* at 200:3-4.

70. By contrast, Plaintiffs’ rebuttal expert, Dr. Antonia Biggs, is a social psychologist and researcher working in the Department of Obstetrics, Gynecology, and Reproductive Sciences within the Advancing New Standards in Reproductive Health program at the University of California, San Francisco. Declaration of Antonia Biggs (“Biggs Decl.”) ¶ 1. She has conducted research on the association between abortion and mental health; has worked extensively in this field, both nationally and internationally, for over 20 years; and has 84 peer-reviewed publications and three book chapters. *Id.* Given her expertise on abortion and mental health, and Dr. Skop’s comparative lack of expertise, the Court credits Dr. Biggs’ declaration and adopts and incorporates it into this Order. *See* Appendix.

71. In her declaration, Dr. Biggs discusses evidence establishing that abortion does not result in negative mental health outcomes. Biggs Decl. ¶ 9. Dr. Biggs provided a thorough and persuasive analysis of the scientific literature on this

point. She cited, *inter alia*, the Turnaway Study, with which she was involved as a researcher. *Id.* ¶ 20. The Turnaway Study is “the largest study of women denied a wanted abortion, most of whom were beyond the first trimester of pregnancy, and the only one that follows women denied an abortion in the United States over time to track their mental, physical, and financial health and well-being.” *Id.* ¶ 21. It has resulted in the publication of over fifty peer-reviewed articles and a book. *Id.* ¶ 20. NASEM has noted that the Turnaway Study was “designed to address many of the limitations of other studies” and “contributes unique insight into the consequences of receiving a desired abortion versus being denied the procedure and carrying the pregnancy to term.” *Id.*

72. The Turnaway Study concluded that abortion is not associated with negative mental health outcomes, including abortions beyond the first trimester. *Id.* ¶ 22. Specifically, it concluded that abortion does not cause or increase a patient’s risk of experiencing anxiety, depression, dysphoria, or posttraumatic stress symptoms or disorders, nor does it result in substance use disorders. *Id.* ¶ 24.

73. Rather, the Turnaway Study demonstrated that the denial of a desired abortion can negatively impact a patient’s mental health and well-being. *Id.* ¶ 36. It showed that the denial of a desired abortion negatively impacts the mental health, socioeconomic status, and aspirations for the future of the patient in the short and long-term. *Id.* Patients denied an abortion are more likely to be pushed below the

poverty line, raise children alone, receive public assistance, and be unable to afford basic living needs, such as food, housing, and transportation. *Id.* They are less likely to make and achieve aspirational life plans, such as pursuing education, and to be able to exit an abusive relationship. *Id.* ¶ 37. Dr. Biggs concluded, based on her research, that HB 5 will not benefit the mental health of women who are denied abortions after 15 weeks LMP. *Id.* ¶ 38. Dr. Skop critiqued the Turnaway Study’s participation rate, *id.* at 216:44-8, but the Court credits Dr. Biggs’ explanation that the Turnaway Study’s participation rate is within the expected range for a five-year study and similar to other prospective studies of this type, Biggs Decl. ¶ 23.

74. The Court finds the conclusions of this study to be instructive in its analysis of whether HB 5 benefits the mental health of patients seeking abortion after 15 weeks LMP. Based on the depth of Dr. Biggs’ expertise and the quality of the evidence cited, the Court finds her declaration to be precise and persuasive and considers it the best evidence in this case regarding mental health and abortion. As such, the Court gives Dr. Biggs’ opinion substantial weight.

C. The Act’s Effect on Maternal Health

75. Dr. Skop’s opinion that abortion is unsafe after 15 weeks LMP is contrary to the view of major professional organizations and is not supported by sound scientific evidence. Her opinion that HB 5 would benefit the mental health of patients seeking abortion after 15 weeks LMP is also unconvincing. Plaintiffs

presented substantial, persuasive evidence to the contrary. Thus, the Court finds that the State's claimed interest in protecting maternal health is not furthered by HB 5's ban on abortion after 15 weeks LMP.

76. Moreover, the Court finds that HB 5 will not actually cause all the women it targets to obtain their abortions earlier. Instead, the evidence shows that HB 5 will delay some patients in obtaining abortions because they are forced to travel out of state to access care, Hr'g Tr. (Rough) 67:18-68:2; will result in others attempting abortions outside the medical system, *id.* at 67:1-3; and will result in still others being forced to continue their pregnancies to term and give birth against their will, *id.* at 67:8-17, even though that is the medically riskier course. The Court credits Dr. Tien's testimony that, for these additional reasons, HB 5 is likely to undermine rather than advance maternal health. *Id.* at 67:4-70:9.

IV. Abortion and Fetal Pain

77. The State contends that HB 5's ban on abortions after 15 weeks LMP furthers a state interest in preventing fetal pain. State's Resp. at 20-22. The Court makes the following findings on fetal pain. In doing so, it credits the testimony of Plaintiffs' expert Dr. Tien based on her extensive experience as a medical doctor in the areas of maternal-fetal medicine, obstetrics, and gynecology, and gives the testimony of the State's expert, Dr. Maureen Condic, who is not a medical doctor

and whose opinion runs contrary to credible and scientifically supported evidence, little to no weight.

78. Dr. Condic's opinions regarding a fetus's ability to feel pain before 24 weeks LMP are not properly supported, and thus her testimony fails to establish that fetal pain perception is possible during the periods of gestation (after 15 weeks LMP) at issue here.³ The State presents no evidence, other than Dr. Condic's declaration and live testimony, to try to establish that fetal pain perception exists during the gestational period in which HB 5 would ban abortions. Accordingly, the State fails to establish that HB 5 advances any interest the State may have in preventing fetal pain.

79. Dr. Tien, who (unlike Dr. Condic) has clinical experience with patients, testified that if a fetus could feel pain, it would be relevant to her role as an MFM specialist providing care to patients with high-risk pregnancies and that it would inform every discussion with these patients. Hr'g Tr. (Rough) 238:5-15 [Tien].

80. Dr. Tien credibly explained that perception of pain requires several components: the development of receptors to receive information from the external environment; neurologically developed pathways to deliver information between the

³ Dr. Condic also testified about "when life begins." Hr'g Tr. 115:17-22. The Court finds evidence about when life begins irrelevant to the question of HB 5's constitutionality under controlling law.

spinal cord and portions of the brain; and a high level of cortical processing to interpret that information. *Id.* at 238:12–239:9 [Tien].

81. Dr. Tien testified that while the receptors that absorb environmental stimuli may be developed earlier in pregnancy, the “basic foundation building blocks” necessary for fetal pain perception are not in place until 24 to 26 weeks LMP. *Id.* at 90:5–91:11, 238:12–239:9 [Tien].

82. Dr. Tien also testified that as an MFM specialist, part of her role is to diagnose fetal structural defects, counsel patients on the findings, and coordinate the care team involved in intrauterine fetal surgery. *Id.* at 239:13–240:1 [Tien]. The care team for intrauterine fetal surgery also includes the required pediatric subspecialist(s) and an anesthesiologist. *Id.* at 241:4–242:7, 243:15–21 [Tien]. The purpose of anesthesia and analgesia used during intrauterine surgery is not to treat fetal pain, however, so the anesthesiologist does not act directly on the fetus (such as by delivering medication to the fetus by IV). *Id.* at 243:22–244:22 [Tien]. Instead, anesthesia and analgesia are used to maximize uterine relaxation, as a paralytic, to blunt fetal physiological responses (such as a drop in heart rate), and/or to monitor the maternal-fetal unit. *Id.* at II, 242:4–243:21 [Tien].

83. Moreover, Dr. Tien testified that when intrauterine procedures are performed on the fetus that do not involve an incision into the uterus (that is, those that do not constitute surgery as the term is commonly understood), these procedures

do not require anesthesia or analgesia, even though the procedure involves interventions to the fetus, and it is the standard of care not to provide such anesthesia unless it is specifically indicated for some reason other than pain (for example, to relax the uterus for the procedure). *Id.* at 242:20-243:9 [Tien]. The Court finds that such practices by physicians charged with providing care to women with high-risk pregnancies belie Dr. Condic's contention about fetal pain perception during the period of gestation affected by HB 5.

84. Dr. Condic is an "animal biologist" who "does not work on humans." Hr'g Tr. (Rough) 145:4-5 [Condic]. Dr. Condic has never provided clinical care to either adults or babies. *Id.* at 145:22-24 [Condic]. Like Dr. Skop, Dr. Condic is affiliated with CLI. *Id.* at 163:4-11 [Condic].

85. Dr. Condic testified that pain "has many different dimensions," the simplest of which, known as "nociceptive pain," is the ability to detect and respond to a potentially damaging or noxious stimulus. *Id.* at 120:20-121:8 [Condic]. She testified that circuitry responsible for nociceptive pain is in place between 10 to 12 weeks LMP. *Id.* at 121:3-8 [Condic]. Dr. Condic testified that the fetus develops the circuitry capable of supporting a conscious awareness of pain between 14 to 20 weeks LMP. *Id.* at 121:9-25 [Condic]. She provided a range of dates because, in her view, one cannot "set an absolute point for every individual where certain neurodevelopmental events will occur." *Id.* at 128:17-20 [Condic].

86. According to Dr. Condic’s testimony—which the Court does not accept as more credible than Dr. Tien’s—a fetus could feel and appreciate pain at 14 weeks LMP, which is before the 15-week LMP point after which HB 5 prohibits abortions. *See Id.* at 121:9-25 [Condic]. Therefore, while the Court does not find Dr. Condic’s testimony that a fetus can experience conscious awareness of pain before 15 weeks LMP to be credible or supported by the evidence, even if it were, her testimony that such pain could exist *before* 15 weeks LMP does not support the State’s contention that avoiding pain is a valid reason to reduce the abortion cut-off from viability to after 15 weeks LMP.

87. Dr. Condic acknowledged that there is a difference between “nociception” and the conscious perception of pain. *Id.* at 146:13-16 [Condic]. She testified that it is “generally [accepted]” that neural connections between the thalamus and the cortex do not develop until 24 to 26 weeks LMP. *Id.* at 147:7-10 [Condic]. Dr. Condic agreed that if the cortex were necessary to have a conscious awareness of pain, pain would not be possible until about 24 weeks LMP. *Id.* at 151:22-152:3, 151:12-17 [Condic].

88. Dr. Condic conceded that, at a September 2020 deposition in another case involving abortion restrictions, she testified that, even at 18 weeks LMP (three weeks after HB’5 cutoff), it is difficult to make a clear, unambiguous case that a fetus has the circuitry in place capable of having a conscious awareness of pain. *Id.*

at 148:16-150:1; 152:10-25 [Condic]. Dr. Condic further admitted that her opinions of fetal consciousness and self-awareness stem from “extrapolating . . . quite a bit.” *Id.* at 127:23-25 [Condic].

89. Dr. Condic conceded that three leading authorities in obstetrics and gynecology and maternal-fetal medicine—ACOG, the Royal College of Obstetricians and Gynecologists, and the Society of Maternal-Fetal Medicine—all disagree with her view about the earliest point in gestation at which a fetus might be consciously aware of pain. *Id.* at 166:15-21.

90. For these reasons, the Court accepts Dr. Tien’s testimony as credible and persuasive based on her experience as an MFM specialist, including her first-hand knowledge of fetal surgery and intrauterine fetal procedures. In contrast, the Court gives no weight to Dr. Condic’s opinions because Dr. Condic has no clinical experience with humans and conceded that her estimation of when fetal pain perception occurs differs from the “generally [accepted]” view among mainstream medical organizations. *Id.* at 147:7-10 [Condic].

91. The Court finds that the scientific evidence supports the conclusion that, due to the lack of the necessary pathways, the earliest point at which a fetus could have the necessary components—or building blocks—to feel pain is 24-26 weeks LMP.⁴ The Court finds that an asserted interest in preventing fetal pain is not

⁴ Existing Florida law bans abortion after fetal viability. §§ 390.011(1), 390.01112, Fla. Stat.

supported by the most persuasive evidence in this case and thus does not support HB 5's ban on abortion after 15 weeks LMP.

V. Effects on Plaintiffs If HB 5 Is in Effect

92. The Court credits Dr. Tien's testimony that HB 5 directly impedes and interferes with the patient-physician relationship. Hr'g Tr. (Rough) 70:15-16 [Tien]. She testified that physicians have a duty to provide evidence-based and compassionate care, including counseling patients on all their options. *Id.* at 70:16-24 [Tien]. The Court finds that HB 5 would force abortion providers in this state to stop providing abortions past 15 weeks, even when that is contrary to their good-faith medical judgment and their patients' needs and wishes, unless one of the Act's limited exceptions applies.

93. With respect to those exceptions, the Court credits Dr. Tien's testimony that waiting until a patient's life is at risk, or until the patient deteriorates to the point that an abortion is needed to prevent substantial, irreversible physical impairment of a major bodily function, is antithetical to the provision of good medical care. *Id.* at 68:21-70:9 [Tien]. Dr. Tien testified that healthcare providers who are not aware of the nuances of the law may not intervene even when one of the narrow exceptions to HB 5 applies, for fear of fines, loss of their license, or imprisonment, and the Court finds that her testimony on this point was credible. *Id.* at 69:17-24 [Tien].

94. Plaintiffs and the State have stipulated as follows: “All Plaintiff facilities perform abortions after 15 weeks. If any Plaintiff facility performed such an abortion with HB 5 in effect, the facility and/or its employees would be subject to enforcement as provided in Florida law.” Case Mgmt. Order, June 27, 2022, at ¶ 5. The Court finds that Dr. Tien also would be subject to the enforcement provisions of HB 5, including imprisonment, if HB 5 were in effect and she provided an abortion in Florida after 15 weeks LMP that did not fall within HB 5’s narrow exceptions.

CONCLUSIONS OF LAW

I. Standing

95. The Court concludes that, under the applicable caselaw, Plaintiffs have third-party standing to bring this suit on behalf of their actual and potential patients.

96. This conclusion is consistent with the Florida Supreme Court’s prior decisions reaching the merits of similar claims brought by abortion clinics and physicians, seeking relief on behalf of their patients. *See generally Gainesville Woman Care, LLC v. State*, 210 So. 3d 1243 (Fla. 2017) (“*Gainesville*”) (suit filed by abortion provider and an abortion advocacy group); *State v. Presidential Women’s Ctr.*, 937 So. 2d 114 (Fla. 2006) (suit filed by two abortion clinics and a doctor who performs abortions); *see also State v. N. Fla. Women’s Health & Counseling Servs., Inc.*, 852 So. 2d 254, 259-60 (Fla. 1st DCA 2001) (“reject[ing]

the state's contention that" physician lacked standing to raise the rights of pregnant minor patients), *rev'd on the merits*, 866 So. 2d 612 (Fla. 2003); *accord Feminist Women's Health Ctr. v. Burgess*, 651 S.E.2d 36, 38-39 (Ga. 2007) ("Virtually every state court considering the issue has similarly held that abortion providers have standing to raise the constitutional rights of their patients," and collecting cases).

97. In all events, Plaintiffs satisfy the three-part inquiry for third-party standing.

98. Florida applies the federal standard for third-party standing, which requires a showing that (1) the plaintiff has suffered an injury in fact giving him or her a sufficiently concrete interest in the dispute; (2) the plaintiff has a close relation to the third party; and (3) there exists some hindrance to the third party's ability to protect his or her own interests. *Alterra Healthcare Corp. v. Estate of Shelley*, 827 So. 2d 936, 941-42 (Fla. 2002).

99. As to the first prong, the Court concludes that Plaintiffs have shown they will suffer an injury in fact arising from HB 5, giving them a sufficiently concrete interest in this dispute. HB 5 will force Plaintiffs either to stop providing abortions after 15 weeks LMP, or to face criminal prosecution, license revocation, and other penalties. *See State v. Benitez*, 395 So. 2d 514, 517 (Fla. 1981) ("A party subject to criminal prosecution clearly has a sufficient personal stake in the penalty which the offense carries."); *N. Fla. Women's Health & Counseling Servs., Inc.*, 852

So. 2d at 259 (physicians had third-party standing to challenge an abortion law because they were subject to license revocation and sanctions for violating the law); *cf. Craig v. Boren*, 429 U.S. 190, 196-97 (1976) (where law impairs third party's constitutional rights by directly imposing "legal duties and disabilities" on someone else, the party subject to those duties and penalties is "the obvious claimant").

100. The Court is not persuaded by the State's argument that Plaintiffs lack standing because they have indicated they will comply with HB 5 if it is in effect and thus will not be subjected to its penalties. State's Resp. at 6 & n.7. Coerced compliance is still an injury in fact. *See Lake Carriers' Ass'n v. MacMullan*, 406 U.S. 498, 508 (1972); *see also MedImmune, Inc. v. Genentech, Inc.*, 549 U.S. 118, 119, 129 (2007) (standing exists even where plaintiffs intend to comply with a law where "the threat-eliminating behavior was effectively coerced" by the threat of prosecution). *San Diego Cnty. Gun Rights Comm. v. Reno*, 98 F.3d 1121 (9th Cir. 1996), cited by the State, does not apply here. Unlike Plaintiffs, who currently offer services that HB 5 will prohibit, the plaintiffs in *San Diego Cnty. Gun Rights Comm.* "merely assert[ed] that they wish[ed] and intend[ed] to engage in activities prohibited by" the law at issue. 98 F.3d at 1127. And as Dr. Tien testified, HB 5 would directly interfere with her relationships with her patients because the law would force her to stop providing abortions past 15 weeks (unless one of the Act's limited exceptions applies), even when doing so would be contrary to her good-faith

medical judgment and her patients’ needs and wishes. Hr’g Tr. 68:22-69:17, 70:15-71:1 [Tien]; Tien Decl. ¶¶ 57, 61. In addition, and also as Dr. Tien testified, HB 5 would create a real risk that healthcare providers, in fear of the potential loss of their licenses and potential criminal penalties, will struggle to evaluate whether one of HB 5’s limited exceptions applies and whether they can intervene to provide abortion care covered by one of those exceptions after 15 weeks. Hr’g Tr. 69:17-70:9 [Tien]; Tien Decl. ¶¶ 56, 60-61.

101. The State conceded the second prong of the standing inquiry—that Plaintiffs have a sufficiently close relation to their patients for the purposes of third-party standing, State’s Resp. at 5 n.6—and the Court agrees. *See* Hr’g Tr. (Rough) 70:15-71:1 (Dr. Tien testifying about the importance and closeness of the relationship between a patient considering an abortion and her healthcare provider). “The closeness of the relationship [between abortion provider and pregnant person seeking abortion care] is patent A woman cannot safely secure an abortion without the aid of a physician” *Singleton v. Wulff*, 428 U.S. 106, 117 (1976).

102. Finally, as to the third prong of the third-party standing inquiry, the Court concludes that Plaintiffs’ patients would face a hindrance to suing to protect their own interests. The Court follows the many courts that have held that the time-limited nature of pregnancy, when compared to how long litigation can take, is an obstacle to the ability of pregnant women to sue to protect their own interests. *See*

Powers v. Ohio, 499 U.S. 400, 410–11 (1991); *Singleton*, 428 U.S. at 116–17; *Feminist Women's Health Ctr.*, 651 S.E.2d at 39; *N.M. Right to Choose/NARAL v. Johnson*, 975 P.2d 841, 847 (N.M. 1998); *Pro-Choice Miss. v. Fordice*, 716 So. 2d 645, 663–64, 665 (Miss. 1998); *N. Fla. Women's Health & Counseling Servs., Inc.*, 852 So. 2d at 259. None of the cases the State cites in which pregnant women did litigate challenges to abortion laws, *see* State's Resp. at 6–7, involved challenges to time-limited abortion bans, *see In re T.W.*, 551 So. 2d 1186 (parental consent for minor abortion); *Renee B. v. Fla. Agency for Health Care Admin.*, 790 So. 2d 1036 (Fla. 2001) (class action on exclusion of medically necessary abortions from Medicaid coverage); *Burton v. State*, 49 So. 3d 263, 264 (Fla. 1st DCA 2010) (non-abortion case involving involuntary confinement of a pregnant person). Thus, none of these cases suggest that pregnant patients would *not* face challenges in bringing individual lawsuits against HB 5.

103. Moreover, the Court is not persuaded by the suggestion that individual abortion patients (most of whom, according to the credible testimony of Dr. Tien, face difficult circumstances, including poverty, Hr'g Tr. (Rough) 52:12-58:14, would be able to litigate the complex matters at issue and in this case individually and on a compressed timeframe (*i.e.*, after 15 weeks LMP but before fetal viability). Those unable to secure relief in time will be forced to remain pregnant and give birth against their will.

104. Because Plaintiffs have standing, the Court will turn to the merits of their request for temporary relief.

II. Temporary Injunction Factors

A. Standard

105. To obtain a temporary injunction, Plaintiffs must demonstrate: “(1) a substantial likelihood of success on the merits, (2) the unavailability of an adequate remedy at law, (3) irreparable harm absent the entry of an injunction, and (4) that the injunction would serve the public interest.” *Fla. Dep’t of Health v. Florigrown, LLC*, 317 So. 3d 1101, 1110 (Fla. 2021); *see also Liberty Couns. v. Fla. Bar Bd. of Governors*, 12 So. 3d 183, 186 n.7 (Fla. 2009); *St. John’s Inv. Mgmt. Co. v. Albaneze*, 22 So. 3d 728, 731 (Fla. 1st DCA 2009).

B. Substantial Likelihood of Success on the Merits

106. Plaintiffs have a substantial likelihood of success on the merits of their claim that HB 5 violates the right to privacy contained in the Florida Constitution.

107. The Privacy Clause of the Florida Constitution expressly grants Floridians a right to privacy. Art. I, § 23, Fla. Const. (“Every natural person has the right to be let alone and free from governmental intrusion into the person’s private life except as otherwise provided herein.”). This right of privacy protects the “fundamental right of self-determination,” which is defined as “an individual’s control over [and] the autonomy of the intimacies of personal identity” and “a

physical and psychological zone within which an individual has the right to be free from intrusion or coercion . . . by government” *In re Guardianship of Browning*, 568 So. 2d 4, 9–10 (Fla. 1990) (internal quotation marks omitted).

108. The Florida Supreme Court has held that the right conferred by the Privacy Clause is broader than any right to privacy the U.S. Constitution affords, and thus that the Florida right to privacy cannot be compared to the federal right. *Gainesville*, 210 So. 3d at 1253; *In re T.W.*, 551 So. 2d 1186, 1191–92 (Fla. 1989); *Winfield v. Div. of Pari-Mutuel Wagering*, 477 So. 2d 544, 548 (Fla. 1985).

109. This Court must follow the Florida Supreme Court’s precedents on the right to privacy as those precedents currently exist, not as they might exist in the future. *See, e.g., Ellis v. State*, 703 So. 2d 1186, 1187 (Fla. 3d DCA 1997) (“[W]hen confronted with binding precedent, trial judges are obliged to follow that precedent even if they might wish to decide the case differently.”); *see also Scott v. Trotti*, 283 So. 3d 340, 343–45 (Fla. 1st DCA 2018) (finding reversible error in the circuit court’s entry of injunction based on disregard of “binding precedent . . . [it] was obligated to follow”).

110. The Florida Supreme Court has held that the Privacy Clause guarantees women the right to abortion prior to viability. Striking down a law that restricted minors’ access to abortion in *In re T.W.*, the Supreme Court explained that the Privacy Clause “is clearly implicated in a woman’s decision of whether or not to

continue her pregnancy.” 551 So. 2d at 1192. The Privacy Clause “embodies the principle that few decisions are more personal and intimate, more properly private, or more basic to individual dignity and autonomy, than a woman’s decision . . . whether to end her pregnancy. A woman’s right to make that choice freely is fundamental.” *Id.* (internal citations and quotation marks omitted).

111. In several decisions since *In re T.W.*, the Supreme Court has reaffirmed that the Florida Constitution preserves for women the fundamental right to decide whether to end their pregnancies. *Gainesville*, 210 So. 3d at 1254 (the Privacy Clause “encompasses a woman’s right to choose to end her pregnancy”); *North Florida*, 866 So. 2d at 621 (“[A] woman has a reasonable expectation of privacy in deciding whether to continue her pregnancy” that is protected by the Privacy Clause); *Renee B.*, 790 So. 2d at 1040 (“The right of privacy in the Florida Constitution protects a woman’s right to choose an abortion.”); *Jones v. State*, 640 So. 2d 1084, 1086 (Fla. 1994) (the Privacy Clause’s “right to be let alone protects adults from government intrusion into matters related to marriage, contraception, and abortion”); *cf. In re Guardianship of Browning*, 568 So. 2d at 13 (the fundamental right of privacy “safeguard[s] an individual’s right to chart his or her own medical course”).

112. Accordingly, the Florida Supreme Court has instructed that “laws that place the State between a woman . . . and her choice to end her pregnancy clearly

implicate the right of privacy,” *Gainesville*, 210 So. 3d at 1254, and are “presumptively unconstitutional,” *id.* at 1246.

113. HB 5 implicates the right to privacy by banning abortions after 15 weeks LMP. Thus, under *Gainesville*, HB 5 is presumptively unconstitutional.

114. Because HB 5 is presumptively unconstitutional, the burden shifts to the State to show that it survives strict scrutiny review, a point the State conceded during the evidentiary hearing. Hr’g Tr. (Rough) 22:8-21. To survive strict scrutiny, the State must demonstrate “that the challenged regulation serves a compelling state interest and accomplishes its goal through the use of the least intrusive means.” *In re T.W.*, 551 So. 2d at 1192 (quoting *Winfield v. Div. of Pari-Mutuel Wagering*, 477 So. 2d 544, 547 (Fla. 1985)); *see also North Florida*, 866 So. 2d at 620-22 (rejecting lower standard of scrutiny applicable under federal law).

115. The State does not dispute that 15 weeks LMP is prior to viability. Fifteen weeks LMP is approximately two months before the point in pregnancy at which fetal viability might occur. Hr’g Tr. (Rough) 50:5-11 [Tien].

116. The Court rejects the State’s argument that HB 5 is not a ban but a regulation that encourages women to seek abortions earlier. State’s Resp. at 19–20. HB 5 prohibits anyone who is seeking an abortion after 15 weeks LMP from obtaining one in Florida, unless they fall within the law’s two limited exceptions. That is a ban on abortions after 15 weeks LMP. *See Isaacson v. Horne*, 716 F.3d

1213, 1226–27 (9th Cir. 2013) (“The availability of abortions earlier in pregnancy does not, however, alter the nature of the burden that [the ban] imposes on a woman once her pregnancy is at or after [the gestational cut-off] but prior to viability,” in which case “the pregnant woman ‘lacks all choice in the matter’ of whether to carry her pregnancy to term.” (citation omitted)). And, as detailed in its factual findings above, the Court credits Dr. Tien’s testimony about the many reasons that patients may be unable to obtain abortions before 15 weeks LMP. Hr’g Tr. (Rough) 52:12-58:14 [Tien].

117. The State asserts that HB 5’s ban on pre-viability abortion advances Florida’s compelling interests in protecting maternal health and preventing fetal pain. State’s Resp. at 18-22. The Court concludes that the State has not sustained its burden to prove that these interests justify HB 5’s complete ban on abortion before viability, nor has it proven that HB 5 is the least restrictive means to achieve either interest.

118. “[T]he Florida Constitution requires a ‘compelling’ state interest in all cases where the right to privacy is implicated.” *In re T.W.*, 551 So. 2d at 1195 (citing *Winfield*, 477 So. 2d at 547). The Florida Supreme Court has recognized two compelling state interests that *could* justify state regulation of abortion—the interest in promoting maternal health and the interest in protecting potential life. *Id.* at 1193–94. However, the Court has also recognized that neither of these interests can support

an outright *prohibition* on abortion before fetal viability. *Id.* HB 5 prohibits abortions between 15 weeks LMP and fetal viability.

119. The Florida Supreme Court has held that, although the State’s interest in protecting maternal health becomes compelling at the beginning of the second trimester, *see In re T.W.*, 551 So. 2d at 1193, this interest can justify only a *regulation* of “the manner in which abortions are performed,” provided the regulation is “the least intrusive [way] designed to safeguard the health of the mother.” *Id.* This interest, however, cannot support a *ban* on abortion before viability, *id.*, but that is what HB 5 is.

120. Furthermore, the evidence demonstrates that HB 5’s ban on abortions after 15 weeks LMP does not, as a factual matter, advance an interest in protecting maternal health because abortion after 15 weeks is safe, and is significantly safer than carrying a pregnancy to term.

121. As noted in its factual findings, the Court credits Dr. Tien’s testimony that abortion is safe at all stages of pregnancy and is safer than carrying a pregnancy to term. Hr’g Tr. (Rough) 43:5–44:7 [Tien]; *cf. In re T.W.*, 551 So. 2d at 1193 (noting that, even as of 1989, based on “technological developments . . . the point [until] which abortions are safer than childbirth” had already been “extended” later into pregnancy than at the time *Roe* was decided).

122. As noted in its factual findings, the Court also credits Dr. Biggs' testimony that being denied a wanted abortion can have harmful effects on the woman's mental health. Biggs Decl. ¶ 36.

123. The State argues that HB 5 will advance an interest in maternal health by encouraging women to have abortions before 15 weeks LMP. State's Resp. at 19–20. Dr. Tien acknowledged that the risks of abortion increase with gestational age but testified that the overall risk of complications from abortion remains very low and that carrying a pregnancy to term is the medically riskier path. Hr'g Tr. (Rough) 44:8-45:6, 68:1-3 [Tien].

124. Furthermore, the State has not shown that HB 5 actually will encourage women to have earlier abortions. As discussed above in the Court's findings of fact, and as Dr. Tien testified, many patients seeking abortions after 15 weeks do so for reasons that would prevent them from simply obtaining abortions earlier. Even the State acknowledges that not all women seeking abortions after 15 weeks LMP would be able to obtain them earlier. *See* State's Resp. at 16–17 (asserting that patients “will *in most cases* have the option to schedule their abortion earlier” (emphasis added)). Thus, the Court concludes that HB 5 will lead to some women who would have obtained abortions after 15 weeks being required to carry their pregnancies to term instead. HB 5 would undermine maternal health for these women by subjecting them to the increased health risks presented by carrying their pregnancies to term.

125. Similarly, the evidence reflects that patients who are unable to obtain an abortion after 15 weeks in Florida may be forced to travel significant distances—including travel in excess of 1,000 miles, round-trip—to access those services out-of-state. Hr’g Tr. (Rough) 64:22-65:10 [Tien]. Arranging and paying for such travel takes time (for those patients who are able to do so at all). The evidence shows that while abortion is an extremely safe procedure at and after 15 weeks, unnecessary delays in access to abortion can increase the risk of the procedure. Accordingly, subjecting patients seeking abortions after 15 weeks to delayed care in other states disserves the State’s asserted interest in maternal health and encouraging earlier abortions; patients delayed by their efforts to access care in distant states would be subject to greater risk than if they were able to obtain such services earlier in Florida. The Court concludes that HB 5 does not further the State’s interest in maternal health, but instead undermines that interest.

126. Moreover, the State did not present evidence showing that a complete ban on pre-viability abortion is the least restrictive means of protecting maternal health. There are ways to encourage earlier abortions that are far less restrictive than a complete ban—the State, for instance, could provide information on abortion or other resources to women in Florida to make it easier to get abortions earlier. Thus, HB 5 is not the least restrictive means for achieving the State’s asserted interest in maternal health.

127. The State's asserted interest in preventing fetal pain also does not justify HB 5's ban on abortion before viability. At the outset, the Court concludes that the State's asserted interest, which, in its own words, is "protecting children in utero," State's Resp. at 18, is not materially distinct from the governmental interest in protecting potential life. Although the State contests this, it does not explain how these interests are distinct. *Id.* at 21. The Florida Supreme Court has held that the State's interest in protecting potential life does not become compelling until *after* viability. *In re T.W.*, 551 So. 2d at 1193. Until that point, and not before, the interests of the pregnant person and the fetus are "inextricably intertwined." *Id.* Accordingly, as a matter of law, protecting potential life cannot justify banning abortion prior to viability. *Id.* at 1193 & n.6 ("Restrictions to protect the state's interest in the potentiality of life . . . also may be imposed, but only after viability"); *Burton v. State*, 49 So. 3d 263, 266 (Fla. 1st DCA 2010) (holding that "[o]nly after the threshold determination of viability has been made may the court weigh the state's compelling interest" in protecting the fetus against patient's constitutional rights). The Court is not persuaded by the State's claim that *In re T.W.*'s holding on the interest in protecting potential life was *dictum*. See State's Resp. at 21-22. The Florida Supreme Court reaffirmed this holding from *In re T.W.* in *Krischer v. McIver*. 697 So. 2d 97, 102 (Fla. 1997) ("[S]tate's interest in prohibiting abortion is compelling after fetus reaches viability" (citing *In re T.W.*, 551 So. 2d at 1194)); see

also N. Fla. Women's Health, 866 So. 2d at 636 (describing the lead opinion as “the majority opinion of the Court and . . . binding precedent”)

128. Although the Court does not believe the existing law permits consideration of the State's asserted interest in preventing fetal pain before fetal viability, the Court also, and as a separate basis for its conclusion, is not persuaded by the State's evidence that HB 5 furthers this asserted interest at all or in the least restrictive manner. As Dr. Tien testified (and as the Court finds above), a fetus cannot feel pain at 15 weeks LMP because the neural connections necessary for a conscious experience of pain do not develop until at least 24-26 weeks LMP. Hr'g Tr. (Rough) 91:3-11 [Tien]. The Court is not persuaded by Dr. Condic's testimony to the contrary. As set forth in the Court's factual findings, Dr. Condic admits that mainstream medical organizations including ACOG, the Royal College of Obstetricians and Gynecologists, and the Society for Maternal-Fetal Medicine, disagree with her opinion that cortical connections are not necessary for the conscious experience of pain. *Id.* at 166:15-21 [Condic]. Other courts have rejected Dr. Condic's views as outside the mainstream and therefore concluded they deserve little weight. See *Whole Woman's Health All. v. Rokita*, 553 F. Supp. 3d 500, 581 (S.D. Ind. 2021) (describing Dr. Condic's opinions on fetal pain as a “‘fringe view’ within the medical community”); *EMW Women's Surgical Ctr. v. Meier*, 373 F.

Supp. 3d 807, 822–23 (W.D. Ky. 2019) (rejecting contention that fetal pain is possible before 24 weeks as contrary to the consensus of the medical community).

129. The Court further notes that Dr. Condic testified that a fetus can feel pain *before* 15 weeks LMP. *Id.* at 120:20-121:8. Accordingly, even if the Court did find Dr. Condic’s testimony persuasive on this point (which it does not), that testimony would lead to the conclusion that HB 5’s 15-week ban is underinclusive. The State’s apparent disagreement with its own expert on this point further supports the Court’s decision not to credit Dr. Condic’s opinions on fetal pain.

130. Further, the State did not present any evidence that a ban on pre-viability abortion is the least restrictive means of preventing fetal pain. The Court, moreover, is persuaded that a complete ban is *not* the least restrictive means. Other States have sought to address the same asserted interest in protecting against fetal pain by passing restrictions on the method of abortion, rather than categorically banning it. *See, e.g., Bernard v. Individual Members of Ind. Med. Licensing Bd.*, 392 F.Supp.3d 935, 942–45 (S.D. Ind. 2019); *EMW Women’s Surgical Center*, 373 F. Supp. 3d at 812–13, 822–23. The Court does not offer an opinion on whether these restrictions would be constitutional under Florida law. But the Court concludes that HB 5’s ban on abortions outright beginning at 15 weeks LMP is not the least restrictive means. The law thus likely violates the Florida Constitution.

131. The Court further concludes that HB 5 is likely unconstitutional on its face. The Court rejects the State’s argument that HB 5 is not facially unconstitutional because it would still allow women to get abortions before 15 weeks LMP. A statute is facially unconstitutional if “no set of circumstances exists in which the statute can be constitutionally applied.” *Abdool v. Bondi*, 141 So. 3d 529, 538 (Fla. 2014); accord *Cashatt v. State*, 873 So. 2d 430, 434 (Fla. 1st DCA 2004). HB 5 does not prohibit abortions prior to 15 weeks LMP, and thus does not apply to women seeking or obtaining abortions prior to 15 weeks LMP, as the State agrees. However, as to the women to whom HB 5 *does* apply—those women seeking or obtaining abortions beginning at 15 weeks yet before viability,⁵ and as to whom HB 5’s exceptions do not apply—there is no set of circumstances in which HB 5 can constitutionally be applied. In other words, without HB 5, women in Florida can obtain abortions for any reason up until fetal viability. With HB 5, women in Florida are unable to obtain an abortion between 15 weeks LMP and fetal viability unless one of HB 5’s narrow exceptions applies.

132. Moreover, the State’s argument that Plaintiffs cannot show HB 5 is facially unconstitutional is inconsistent with the Florida Supreme Court’s decisions

⁵ Florida law already prohibits abortions at and after fetal viability, which is defined as “the stage of fetal development when the life of a fetus is sustainable outside the womb through standard medical measures.” §§ 390.011(13), 390.01112, Fla. Stat.; *see also* §§ 390.011 (6), (12)(c), 390.0111(1), Fla. Stat. (prohibiting abortion in third trimester). Plaintiffs are not challenging Florida’s ban on abortion after viability nor the third-trimester ban. Mot. at 6.)

in *In re T.W.* and *North Florida*. In both those cases, the Supreme Court held the abortion statutes at issue there were facially unconstitutional even though those statutes would not have prevented all abortions in Florida. *In re T.W.*, 551 So. 2d at 551 So. 2d at 1193–95; *North Florida*, 866 So. 2d at 640. The State’s reliance on *State v. Gainesville Woman Care, LLC*, 278 So. 3d 216 (Fla. 1st DCA 2019), is also misplaced because unlike HB 5, the law at issue there applied to all abortions performed at all stages of gestation. 278 So. 3d at 217-18 (law required 24 hours to pass between time patient informed of nature and risks of abortion and abortion performed). The First DCA did not hold that a plaintiff must show that a law like HB 5, which applies only to women seeking abortions after 15 weeks, violates the constitutional rights of women who are not pregnant or who do not seek abortions after 15 weeks LMP.

133. Thus, HB 5’s ban on abortion prior to viability likely violates the right to privacy under the Florida Constitution because it implicates that right and likely cannot survive strict scrutiny. The Court will now consider the remaining temporary injunction factors.

C. Adequate Remedy at Law and Irreparable Harm

134. Plaintiffs have shown that HB 5 would cause irreparable harm for which no adequate remedy is available at law. As explained, HB 5 likely will violate the right to privacy in the Florida Constitution, and the threatened or actual loss of

constitutional rights, even temporarily, is *per se* irreparable harm. *Gainesville*, 210 So. 3d at 1263-64 (“presum[ing] irreparable harm when certain fundamental rights are violated,” including right to privacy, and collecting cases); *Fla. Dep’t of Health v. Florigrown, LLC*, 320 So. 3d 195, 200 (Fla. 1st DCA 2019) (“[T]he law recognizes that a continuing constitutional violation, in and of itself, constitutes irreparable harm.”), *quashed on other grounds*, 317 So. 3d 1101 (Fla. 2021); *Bd. of Cty. Comm’rs, Santa Rosa Cty. v. Home Builders Ass’n of W. Fla., Inc.*, 325 So. 3d 981, 985 (Fla. 1st DCA 2021) (same).

135. The Court rejects the State’s argument that Plaintiffs cannot establish irreparable harm based on HB 5’s harm to their patients’ constitutional right to privacy. As explained, Plaintiffs have third-party standing to represent their patients’ right to privacy in this case and have shown that HB 5 would cause their patients to suffer irreparable harm. Plaintiffs thus do not have to show irreparable harm to themselves. *See, e.g., Gainesville*, 210 So. 3d at 1264 (temporary injunction warranted based on irreparable harm to “women seeking to terminate their pregnancies in Florida” in challenge brought by abortion provider and non-profit organization).

136. Plaintiffs also have shown that HB 5 will cause them to suffer irreparable harm without an adequate remedy at law because Plaintiffs currently provide abortions after 15 weeks LMP, and HB 5 will force them to stop doing so in

likely violation of the Florida Constitution. *See Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 795-96 (7th Cir. 2013) (abortion providers irreparably harmed by abortion restrictions that, absent preliminary injunction, would cause “disruption of the services” the clinics provide). In concluding that Plaintiffs will be irreparably harmed, the Court credits Dr. Tien’s testimony that forcing abortion providers to stop providing abortions between 15 weeks LMP and fetal viability, as HB 5 does, will “directly impede[] and interfere[] on the physician-patient relationship.” Hr’g Tr. (Rough) 70:11-16 [Tien]; *see also id.* 70:17–71:1 [Tien]. Plaintiffs cannot remedy this harm to their ability to provide healthcare to their patients through monetary damages or any other procedure available under Florida law.

137. The Court also rejects the State’s argument that Plaintiffs cannot show irreparable harm because they purportedly waited too long to file this action. *See State’s Resp.* at 13–15. Plaintiffs filed this action a month before HB 5 is set to take effect and have litigated their Motion before the law’s effective date.

138. Thus, Plaintiffs have shown HB 5 will cause irreparable harm for which no adequate remedy is available at law.

D. Public Interest

139. The Court concludes that a temporary injunction of HB 5 will serve the public interest, because HB 5 likely violates the Privacy Clause of the Florida

Constitution. Enjoining a law that would “impose” upon Floridians’ privacy rights “in violation of the Florida Constitution []would serve the public interest.” *Gainesville*, 210 So. 3d at 1264; *accord Green*, 323 So. 3d at 254–55 (public interest factor satisfied when Plaintiffs demonstrate likelihood of success in showing the law is unconstitutional). The State argues that an injunction would not be in the public interest because HB 5 “promotes public health and welfare by protecting maternal health and children in utero.” State’s Resp. at 23. For the same reasons the Court concluded these asserted interests are legally insufficient and factually unsupported, the Court also concludes that these claimed interests do not overcome the public interest in preventing a likely violation of Floridians’ constitutional rights.

III. Scope of Relief and Bond

140. The Court is not persuaded by the State’s argument that this Court should limit any injunctive relief to these Plaintiffs, rather than enter a statewide injunction. State’s Resp. at 23–24. As explained, HB 5 likely is facially unconstitutional, and under existing law, there is likely no set of circumstances in which the State can constitutionally apply it. This conclusion applies to any clinic or doctor in Florida, not just those named as plaintiffs in this suit, and the Court does not believe the law requires every affected person to sue to prevent a violation of the Florida Constitution. In addition, a statewide temporary injunction is consistent with the temporary injunctions the Florida Supreme Court and others have entered against

other abortion restrictions. *See Gainesville*, 210 So. 3d at 1264–65 (affirming trial court temporary injunction of abortion restriction “barring the application of the law in its entirety” on “all Florida women”). Accordingly, the injunction the Court orders, below, applies throughout the State of Florida.

141. The Court determines that an appropriate bond for this temporary injunction is \$5,000. Fla. R. Civ. P. 1.610(b); *see AOT, Inc. v. Hampshire Mgmt. Co.*, 653 So. 2d 476, 478 (Fla. 3d DCA 1995) (amount of injunction bond is within the court’s discretion). Although the purpose of an injunction bond is to “secure[] the enjoined party against any damages it may incur if the injunction turns out to have been wrongfully entered,” *AOT, Inc.*, 653 So. 2d at 478, the State did not present evidence of anticipated damages. The Court is not persuaded by the State’s argument that the bond must be \$1 million, to account for the “more than \$874 million” in lost tax revenue the temporary injunction will allegedly cause the State. State’s Resp. at 25. Moreover, under the law, HB 5 is subject to a strict scrutiny analysis and a rebuttable presumption of unconstitutionality, and the Court believes its injunction complies with the law as it currently exists in Florida. *See Montville v. Mobile Med. Indus., Inc.*, 855 So. 2d 212, 216 (Fla. 4th DCA 2003) (in setting bond, court is “permitted to consider [other] factors,” such as “the adverse party’s chances of overturning the temporary injunction”). Accordingly, the Court holds that a \$5,000 bond in this case is reasonable.

INJUNCTION & BOND ORDER

For all these reasons, it is hereby ORDERED and ADJUDGED that:

Plaintiffs' Motion is GRANTED. Defendants State of Florida, Florida Department of Health, Joseph Ladapo, M.D., in his official capacity as Florida Secretary of Health, Florida Board of Medicine, David Diamond, M.D., in his official capacity as Chair of the Florida Board of Medicine, Chair of Florida Board of Osteopathic Medicine, Sandra Schwemmer, D.O., in her official capacity as Chair of the Florida Board of Osteopathic Medicine, Florida Board of Nursing, Maggie Hansen, M.H.Sc., R.N., in her official capacity as Chair of the Florida Board of Nursing, Florida Agency for Health Care Administration, Simone Marsteller, J.D., in her official capacity as Secretary of the Florida Agency for Health Care Administration, and their officers, agents, servants, employees, appointees, or successors, as well as those in active concert or participation with any of them, are hereby temporarily enjoined from enforcement or threatened enforcement, operation, and execution, in any manner, of Section 4 of 2022-69, Laws of Florida (HB 5) and the related definitions in Section 3(6) and 3(7) of HB 5, in all their applications statewide, until further order of the Court. Defendants are also enjoined from filing or pursuing any future suit or prosecution that seeks to enforce HB 5 against conduct that takes place while this injunction is in effect.

Pursuant to Florida Rule of Civil Procedure 1.610(b), Plaintiffs are jointly ordered, within seven (7) days from the date of this Order, to post a bond in the amount of \$5,000 as a condition for the temporary injunction remaining in effect.

So ORDERED in Tallahassee, Leon County, Florida, July 5, 2022.


JOHN COOPER
CIRCUIT COURT JUDGE

*cc Attorneys
of Record*

APPENDIX

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IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT
IN AND FOR LEON COUNTY, FLORIDA

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

Plaintiffs,

v.

STATE OF FLORIDA, *et al.*,

Defendants.

Case No. 2022 CA 912

**DECLARATION OF ANTONIA BIGGS IN SUPPORT OF PLAINTIFF'S MOTION
FOR A PRELIMINARY INJUNCTION**

I, Antonia Biggs, am over 18 years of age, am competent, and make this declaration based on my own personal knowledge, unless otherwise noted:

I. SUMMARY OF OPINIONS AND THE REASONS AND BASES FOR THEM

1. Since 1998, I have worked at the University of California, San Francisco ("UCSF") and I am currently in the Department of Obstetrics, Gynecology and Reproductive Sciences within the Advancing New Standards in Reproductive Health ("ANSIRH") program. ANSIRH conducts rigorous, innovative, and multidisciplinary social science research on issues relating to reproductive health. I have personally conducted research examining the association of having an abortion and mental health outcomes and I have published extensively on that topic.

2. My current position at ANSIRH is Associate Professor. I received my B.A. in Psychology from the University of Wisconsin–Madison and my Ph.D. in Psychology from

Boston University. My education, training, responsibilities, and publications are set forth in greater detail in my *curriculum vitae*, a true and correct copy of which is attached as Exhibit A.

3. My opinions herein are based upon my education, training, experience, research, participation in conferences, and my ongoing review of the relevant medical and psychological literature. The literature that informs my opinions includes, but is by no means limited to, that identified in the text and footnotes of this report.

4. I submit this declaration in support of Plaintiffs' Motion for a Temporary Injunction to enjoin the enactment of Florida House Bill 5 ("HB 5"). I understand that, with very limited exceptions, HB 5 would ban abortion after 15 weeks gestation as dated from the patient's last menstrual period. I understand that a violation of this law could result in criminal penalties, disciplinary sanctions, and adverse licensing actions.

5. Specifically, I submit this declaration to rebut the claims set forth in the declaration of Dr. Ingrid Skop that: (1) abortion is associated with a risk of adverse mental health outcomes, ¶¶ 27, 28, 39, 41-49, particularly for those patients seeking abortion in the second trimester who face an elevated risk of psychological harms, ¶¶ 27, 39, 41; (2) patients who have abortions experience decisional uncertainty and regret regarding the decision to terminate their pregnancy, ¶ 43, 44; and (3) HB 5's mandate will provide mental health benefits to patients, ¶¶ 29, 47, 49.

6. *First*, Dr. Skop disregards the uniform conclusion of major professional associations and organizations and high-quality research demonstrating that there is no connection between abortion and adverse mental health outcomes, including among those who seek abortion beyond the first trimester. This lack of connection holds true even among people who seek abortion due to fetal diagnosis or among young people. Over a period of decades,

overwhelming evidence has demonstrated that abortion, including abortion past 15 weeks gestation, has no negative effect on mental health outcomes. One important contribution to this evidence is the multi-year Turnaway Study, with which I have been closely involved. The Turnaway Study found that women who obtained abortions near a facility's gestational limit were no worse off than those who had been denied them. In fact, the study demonstrated that being denied a desired abortion can *negatively* impact mental health in the short term. Studies concluding that abortion leads to adverse mental health outcomes, such as those Dr. Skop relies on to support her outlier opinions, have serious methodological shortcomings, as outlined below.

7. *Second*, reliable evidence shows that patients who obtain an abortion — regardless of their point in pregnancy, their reasons for doing so, or their age— have predominantly positive emotions about the abortion, have high levels of decisional certainty, feel the abortion was the right decision shortly after their abortion and in the years that follow, and cite “relief” as the most common emotion related to the abortion. Dr. Skop inappropriately conflates indecision with regret and negative mental health outcomes.

8. *Finally*, Dr. Skop's claim that HB 5's ban on abortions after 15 weeks gestation will improve and/or benefit patients' mental health or emotional well-being is unfounded. Rather, to the extent that HB 5 causes some patients to be denied a wanted abortion, the evidence indicates that such denial will have short-term negative impacts on their mental health and well-being, as well as increase their chances of staying tethered to an abusive partner, of experiencing serious pregnancy complications, of experiencing long-term physical health problems and economic hardship and insecurity, and has long-term consequences for the financial well-being and development of their children.

I. Rebuttal Opinion 1: Abortion Is Not Associated with Adverse Mental Health Outcomes.

9. There are decades of empirical research looking at the effects of abortion on mental health, including several rigorous scientific reviews on the topic. The highest quality evidence all reach the same conclusion: abortion does not have a negative impact on women's mental health. The most robust scientific reviews of the literature by trusted scientific and medical authorities—including reports by the American Psychological Association (“APA”); the National Academies of Sciences, Engineering, and Medicine (“NASEM”); and the Royal College of Psychiatrists in the United Kingdom—have all concluded that abortion does not have a negative impact on women's mental health.¹ The most methodologically rigorous individual studies—that is, those that take into account a woman's pre-pregnancy mental health and employ appropriate comparison groups—reach the same conclusion.

10. It is important to understand that all forms of evidence range in quality and should be ranked based on their strength and ability to contribute to knowledge, and weighed accordingly. There exist high quality, well-designed prospective cohort studies with good comparison groups examining the relationship between abortion and mental health outcomes. These studies clearly demonstrate that abortion does not negatively impact women's mental health. In the face of such high-quality evidence, it is scientifically unsound to rely upon lower quality cross-sectional studies, anecdotal statements and conjecture, as Dr. Skop does. If, for

¹ Brenda Major et al., Am. Psych. Ass'n, Report of the APA Task Force on Mental Health and Abortion 5 (2008) [hereinafter “APA Task Force Report 2008”]; Brenda Major et al., *Abortion and Mental Health: Evaluating the Evidence*, 64 Am. Psych. 863 (2009) (update to APA Task Force Report 2008, which included a review of six additional studies that met inclusion criteria but that were published after the completion of the 2008 Report); Nat'l Acads. of Scis., Eng'g & Med., *The Safety and Quality of Abortion Care in the United States* (2018) [hereinafter, “National Academies Report”]; Nat'l Collaborating Ctr. for Mental Health (NCCMH), Academy of Med. Royal Colls. (AMRC), *Induced Abortion and Mental Health: A Systematic Review of the Mental Health Outcomes of Induced Abortion, Including Their Prevalence and Associated Factors* (2011) [hereinafter “NCCMH Report”]; see also Vignetta E. Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78 Contraception 436 (2008).

example, a rigorously designed study yields result A, and a less-rigorously or poorly designed study on the same question yields result B, researchers looking at the literature do not conclude that the correct answer could be A *or* B; rather, the more rigorously designed studies are given greater weight. Similarly, it is important to utilize comparison groups that are as similar as possible to the abortion group in order to separate the factors that are associated with the wantedness of the pregnancy. The ideal comparison, it has been recommended, is between women who have an abortion and those who want an abortion but are unable to get one.²

a. Findings of scientific reviews

11. In February 1989, the APA, the largest and leading scientific and professional organization of psychologists in the United States, convened a panel of experts to review the available scientific literature on the effect of abortion on women's mental health, and found no evidence of a causal link between abortion and mental health outcomes.³

12. Almost two decades later, in 2006, the APA organized another task force to review new scientific literature examining whether abortion is associated with poor mental health outcomes. The Task Force initially identified 223 articles published since 1989 that were responsive to its search criteria, 73 of which it deemed worthy of closer review.⁴ The 73 articles were selected based on four criteria: "(1) The study reported empirical data of a quantitative nature (qualitative studies were omitted). (2) The study was published in a peer-reviewed journal (dissertations, letters to editors, reviews, book chapters, and conference proceedings were omitted). (3) The study included at least one post-abortion measure related to mental health (those that considered only mental health prior to the abortion were omitted). (4)

² Nada L. Stotland, *Induced Abortion and Adolescent Mental Health*, 23 *Current Opinion, Obstetrics and Gynecology* 340, 341 (2011a).

³ APA Task Force Report 2008, at 5.

⁴ *See id.* at 21–22.

The study focused on induced abortion [those that focused solely on ‘spontaneous’ abortions (miscarriages) or that did not differentiate miscarriage from induced abortion were omitted].”⁵ Articles that failed to include a comparison group of women who did not have an abortion were excluded unless they were based on a U.S. sample.⁶ After “careful evaluation,” the Task Force determined that “the majority [of the studies it considered] suffered from methodological problems, sometimes severely so.”⁷

13. The Task Force “conclude[d] that the most methodologically sound research indicates that among women who have a single, legal, first-trimester abortion of an unplanned pregnancy . . . , the relative risks of mental health problems are no greater than the risks among women who deliver an unplanned pregnancy”—a conclusion “generally consistent with that reached by the first APA task force.”⁸ In addition, the Task Force considered six studies of abortions beyond the first trimester, each of which concerned abortion for reasons of fetal anomaly, and found that they still told “a fairly consistent story”: levels of negative psychological experiences subsequent to a second-trimester abortion of a wanted pregnancy for fetal anomalies were comparable to those of women who experienced a second-trimester miscarriage, stillbirth, or death of a newborn.⁹

14. In 2008, Vignetta Charles and colleagues at the Johns Hopkins Bloomberg School of Public Health evaluated the methodological quality of twenty-one studies that met their inclusion criteria.¹⁰ Charles found that the highest quality studies had findings that were

⁵ *Id.* at 21.

⁶ *Id.*

⁷ *Id.* at 88.

⁸ *Id.* at 92.

⁹ Dr. Skop’s critique of the APA Task Force Report’s finding is unfounded. Skop Decl. ¶ 41. Her complaint that the Task Force should have made a broader conclusion ignores that it would have been inappropriate for the Task Force to do so given the state of literature at the time of the review.

¹⁰ Charles et al. (2008), *supra* note 1.

mostly neutral, indicating few, if any, differences between women who had abortions and their respective comparison groups in terms of subsequent adverse mental health outcomes. Studies deemed of poor quality and using flawed methodology generally reported a relationship between having an abortion and experiencing worse mental health outcomes.

15. In 2009, the authors of the APA Task Force's 2008 report published an update that incorporated several new studies.¹¹ Their scientific review again concluded that abortion does not increase women's risk of experiencing mental health harm, a conclusion "consistent with that reached by the first APA task force."¹² Their review also concluded that other factors, such as pre-existing mental health conditions and other co-occurring risk factors, such as poverty or intimate partner violence, are highly correlated with both the experience of an unintended pregnancy and future mental health problems.¹³ Indeed, multiple studies have found that having a previous history of mental health conditions and trauma is significantly associated with experiencing subsequent mental health problems.¹⁴ They again pointed to the pervasive methodological problems in the existing literature, including "(a) use of inappropriate comparison or contrast groups; (b) inadequate control for co-occurring risk factors/potential confounders; (c) sampling bias; (d) inadequate measurement of reproductive history, under-specification of abortion context, and problems associated with underreporting;

¹¹ Major et al. (2009), *supra* note 1.

¹² *Id.* at 885.

¹³ *Id.* at 868–69, 884–85.

¹⁴ Jenneke van Ditzhuijzen et al., *Psychiatric History of Women Who Have Had an Abortion*, 47 *J. Psychiatric Res.* 1737, 1741 (2013); Anne C. Gilchrist et al., *Termination of Pregnancy and Psychiatric Morbidity*, 167 *Brit. J. Psychiatry* 243, 247 (1995); Brenda Major et al., *Psychological Responses of Women After First-Trimester Abortion*, 57 *Archives Gen. Psychiatry* 777, 781 (2000); Julia R. Steinberg et al., *Psychosocial Factors and Pre-Abortion Psychological Health: The Significance of Stigma*, 150 *Soc. Sci. & Med.* 67, 73 (2016); Julia R. Steinberg & Nancy F. Russo, *Abortion and Anxiety: What's the Relationship?*, 67 *Soc. Sci. & Med.* 238, 245 (2008); Julia R. Steinberg et al., *Abortion and Mental Health: Findings from the National Comorbidity Survey-Replication*, 123 *Obstetrics & Gynecology* 263, 267 (2014); see also Jenneke van Ditzhuijzen et al., *Correlates of Common Mental Disorders Among Dutch Women Who Have Had an Abortion: A Longitudinal Cohort Study*, 49 *Persp. on Sexual & Reprod. Health* 123, 129 (2017); Trine Munk-Olsen et al., *Induced First-Trimester Abortion and Risk of Mental Disorder*, 364 *N. Eng. J. Med.* 332, 336 (2011).

(e) attrition; (f) poor measurement of mental health outcomes and failure to consider clinical significance; (g) statistical errors; and (h) interpretational errors.”¹⁵

16. Similarly, in 2011, Dr. Nada Stotland, former president of the American Psychiatric Association and the author or co-author of several important papers on the topic,¹⁶ published a paper reviewing the literature on the effects of abortion on the mental health of adolescent women.¹⁷ In her paper, Stotland found that the most rigorous studies conclude abortion does not result in adverse mental health outcomes for adolescents.

17. A 2011 review of the evidence by psychologist and associate professor Dr. Julia Steinberg specifically examined the effects of having an abortion later in pregnancy on women’s mental health outcomes.¹⁸ The quality of each study reviewed was analyzed based on the appropriateness of its mental health assessment and comparison groups, and whether they accounted for other factors that might be associated with later abortion and mental health outcomes. Steinberg determined that some of studies on this topic, including studies cited by Dr. Skop, used inappropriate comparison groups, and all studies restricted their analyses to women seeking abortion due to a fetal diagnosis,¹⁹ and did not take into account pre-pregnancy

¹⁵ Major et al. (2009), *supra* note 1, at 884.

¹⁶ Gail Robinson et al., *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 *Brit. J. Psych.* 78 (2012); Gail Robinson et al., *Is There an “Abortion Trauma Syndrome”?* *Critiquing the Evidence*, 17 *Harv. Rev. Psych.* 268 (2009); Nada L. Stotland, *The Myth of the Abortion Trauma Syndrome*, 268 *JAMA* 2078 (1992); Nada L. Stotland, *Assessing the Mental Health Impact of Induced Abortion*, 1 *Medscape Women’s Health* 1 (1996); Nada L. Stotland, *Psychosocial Aspects of Induced Abortion*, 40 *Clinical Obstetrics & Gynecology* 673 (1997); Nada L. Stotland, *Abortion: Social Context, Psychodynamic Implications*, 155 *Am. J. Psych.* 964 (1998a); Nada L. Stotland, *Comments on Abortion*, 155 *Am. J. Psych.* 1305 (1998b); Nada L. Stotland, *Psychiatric Issues Related to Infertility, Reproductive Technologies, and Abortion*, 29 *Primary Care: Clinics in Off. Prac.* 13 (2002); Nada L. Stotland, *Abortion and Psychiatric Practice*, 9 *J. Psych. Prac.* 139 (2003); Nada L. Stotland, *Psychiatric Aspects of Induced Abortion*, 199 *J. Nervous & Mental Disease* 568 (2011b).

¹⁷ Nada L. Stotland, *Induced Abortion and Adolescent Mental Health*, 23 *Current Opinion, Obstetrics and Gynecology* 340, 341 (2011a).

¹⁸ Julia R. Steinberg, *Later Abortions and Mental Health: Psychological Experiences of Women Having Later Abortions—A Critical Review of Research*, 21 *Womens Health Issues* S44 (2011a).

¹⁹ Lawrence B. Finer et al. *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 *Contraception* 334, 335 (2006).

mental health conditions—the most significant predictor of experiencing future mental health problems.²⁰ It concluded that women seeking later abortion due to fetal anomaly have similar mental health outcomes as women who give birth to children with severe mental or physical conditions or who experience other types of later perinatal loss (*i.e.*, stillbirth or later miscarriage), suggesting that “policies based on the notion that later abortions (for reasons of fetal anomaly) harm women’s mental health are misinformed.”²¹

18. That same year, the National Collaborating Centre for Mental Health (“NCCMH”) at the Academy of Medical Royal Colleges systematically reviewed the relevant literature, including studies of people obtaining second-trimester abortions. The Academy of Medical Royal Colleges is “the membership body for the UK and Ireland’s 24 medical royal colleges and faculties,” which “bring[s] together the views of [the Royal Colleges and Faculties’] individual specialties to collectively influence and shape healthcare across the four nations of the UK.”²² NCCMH was “established [in 2001] by the Royal College of Psychiatrists, in partnership with the British Psychological Society, to develop evidence-based mental health reviews and clinical guidelines.”²³ NCCMH concluded that “[t]he rates of mental health problems for women with an unwanted pregnancy were the same whether they had an abortion or gave birth,” and that “[t]he most reliable predictor of post-abortion mental health problems was having a history of mental health problems before the abortion.”²⁴

19. In 2018, the National Academies of Sciences, Engineering, and Medicine, a highly respected group of three national scientific organizations, was established to provide

²⁰ Steinberg (2011a), *supra* note 14, at S46.

²¹ *Id.* at S47.

²² About Us, Academy of Medical Royal Colleges, <https://www.aomrc.org.uk/about-us/> (last accessed June 23, 2022).

²³ National Academies Report at 150 (citing NCCMH Report).

²⁴ NCCMH Report at 8.

advice on scientific and medical issues to the public, published a report entitled “The Safety and Quality of Abortion Care in the United States.” The report reviewed the research on abortion, including studies of people seeking abortion in the second trimester. It found no connection between abortion and negative mental health outcomes, including risk of depression, anxiety, or post-traumatic stress disorder (PTSD).²⁵ The report also pointed to the many methodological shortcomings in the existing research warning that the “utility of most of the published research on mental health outcomes is limited by selective recall bias, inadequate controls for confounding factors, and inappropriate comparators.”²⁶ (“Confounding” factors are outside forces that affect both the independent and dependent variable—here, confounding factors may include the presence of pre-existing mental health disorders, poverty, or intimate partner violence, all of which affect both the likelihood of an abortion and the likelihood of negative mental health outcomes.) In particular, the report noted that several studies, including the

²⁵ Though Dr. Skop critiques NASEM at length in her declaration, her criticisms are meritless and irrelevant. Skop Decl. ¶¶ 20-22. First, Dr. Skop criticizes the report for “their stringent criteria,” that resulted in the exclusion of lower quality studies, ignoring the fact that stringent standards for evaluating literature for inclusion in its report is a hallmark of a rigorous scientific review and not a weakness. *Id.* at ¶ 21. Second, Dr. Skop asserts that NASEM’s study is biased by connections to pro-choice organizations, although NASEM is not composed by abortion advocates. Rather, it is composed of three national organizations (The National Academy of Sciences, the National Academy of Engineering, and the National academy of Medicine) that together “provide independent, objective analysis and advice to the nation.” Contradicting her point, she herself cites articles from pro-life advocacy groups such as the National Right to Life News and the American Association of Pro-Life Obstetricians and Gynecologists. Third, Dr. Skop claims that NASEM’s reliability has been called into question by the Center for Science in the Public Interest (CSPI) due to deficiencies in the committee selection process and conflicts of interest. However, she ignores the fact that CSPI is an organization focused on food safety, not reproductive health, and that their complaints have all been focused on food-related interests. *See* About Us, CSPI, <https://www.cspinet.org/> (last accessed July 22, 2022). The 2006 CSPI report Dr. Skop cites makes clear in its preface that “NAS reports invariably earn high marks from the scientific community, and this study, which did not evaluate the quality of any particular NAS report, makes no effort to question that consensus view.” *Ensuring Independence and Objectivity at the National Academies* (2006), <https://www.cspinet.org/sites/default/files/media/documents/resource/nasreport.pdf> (last accessed July 22, 2022). The 2017 CSPI report Dr. Skop cites in alleging a conflict of interest within NASEM specifically examined conflicts of interest only among the committee members who wrote the 2016 NASEM report on genetically engineered crops. Sheldon Krinsky and Tim Schwab, Conflicts of interest among committee members in the National Academies’ genetically engineered crop study (2017), *PLoS ONE*, 12(2): e0172317. doi:10.1371/journal.pone.0172317. Neither article purports to examine or undermine either “The Safety and Quality of Abortion Care in the United States” report or the work of the NASEM reproductive health committee. Thus, the evidence she cites does not support her opinion and irrelevant to the NASEM report on abortion.

²⁶ National Academies Report at 149.

studies cited by Dr. Skop in her report to support the claim that abortion increases the risk of mental health problems,²⁷ “failed to control adequately for preexisting mental disorders.”²⁸

20. One important recent addition to the research in this area is the Turnaway Study, with which I have been intimately involved. As I explain below, this large-scale, national study—which has resulted in the publication of over fifty peer-reviewed articles and a book—was specifically designed to examine the relationship between abortion and subsequent mental health, and is one of the largest U.S. studies to examine the mental health outcomes of people seeking abortion beyond the first trimester of pregnancy. NASEM described the Turnaway Study as one “designed to address many of the limitations of other studies” and that “contributes unique insight into the consequences of receiving a desired abortion versus being denied the procedure and carrying the pregnancy to term.”²⁹

21. The Turnaway Study, which was launched in 2007, is a prospective longitudinal study examining the effects of unintended pregnancy on women’s lives. From 2008 to 2010, we recruited 956 women from thirty abortion facilities in twenty-two U.S. states. We recruited women who received abortions because they presented for care under the facility’s gestational limit and some who were “turned away” and carried to term because they were past the gestational limit. With a team of researchers, we followed both of these groups of women, through semiannual phone interviews over five years. The Turnaway Study’s robust study design improves on many of the methodological shortcomings of the existing literature on this topic in that it: includes a unique comparison group (people seeking abortion but turned away because they are beyond the gestational age limit); is prospective (follows nearly 1,000 women

²⁷ Skop Decl. at ¶48.

²⁸ National Academies Report at 150.

²⁹ *Id.* at 150–51.

for five years); and controls for known confounding factors, including people's history of mental health conditions. It is the largest study of women denied a wanted abortion, most of whom were beyond the first trimester of pregnancy, and the only one that follows women denied an abortion in the United States over time to track their mental, physical, and financial health and wellbeing. It has published fifty papers in peer-reviewed journals specifically examining the long-term effects on women and their children related to abortion receipt or abortion denial due to gestational age limits.

22. There have been numerous findings from this study, including that, when we compared the mental health outcomes of women who had an abortion to women denied an abortion, women denied an abortion experienced more elevated levels of anxiety and stress symptoms in the short term than those who were able to get their wanted abortions. We found no differences between those who obtained and those who were denied an abortion with regard to depression, suicidal ideation, and post-traumatic stress.³⁰ We also found that having an abortion after the first trimester was not associated with more adverse mental health outcomes than obtaining a first-trimester abortion.

23. Dr. Skop's critiques of the Turnaway Study are without merit.³¹ Although Dr. Skop criticizes the Turnaway Study's participation and attrition rates, these rates are within the expected range for a five-year study, and similar to other prospective studies of this type.

³⁰ M. Antonia Biggs et al., *Mental Health Diagnoses 3 Years After Receiving or Being Denied an Abortion in the United States*, 105 *Am. J. Pub. Health* 2557, 2561 (2015); M. Antonia Biggs et al., *Does Abortion Increase Women's Risk for Post-Traumatic Stress? Findings from a Prospective Longitudinal Cohort Study*, 6 *BMJ Open*, e009698, e009707–08 (2016); M. Antonia Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74 *JAMA Psych.* 169, 174–76 (2017); M. Antonia Biggs et al., *Five-Year Suicidal Ideation Trajectories Among Women Receiving or Being Denied an Abortion*, 175 *Am. J. Psych.* 845, 851 (2018); D.G. Foster et al., *A Comparison of Depression and Anxiety Symptom Trajectories Between Women Who Had an Abortion and Women Denied One*, 45 *Psych. Med.* 2073, 2080 (2015).

³¹ Skop Decl. ¶ 48.

Indeed, our rate of attrition of about five percent from wave to wave represents excellent participant retention compared to other research in the field and is, in fact, a study strength. Furthermore, the lack of differential loss to follow-up³² based on mental health history as well as our ability to control for history of mental health conditions, child abuse and neglect, and substance use mitigates concerns of bias. Concern about bias due to low study participation is further lessened by the consistent findings in our sensitivity analyses restricted to sites with more than 50% participation. To take into account missing observations that naturally occur from longitudinal designs, we used mixed effects regression models, which protect against bias owing to loss to follow up that is predictable from previously measured factors.

b. Findings of high-quality individual studies

24. Like the scientific reviews of the literature, the highest quality individual studies—*e.g.*, those that account for pre-pregnancy risk factors, including mental health history, and use appropriate comparison groups—have found that abortion does not lead to negative mental health outcomes. This remains true whether the mental health outcome is depression or anxiety disorders, suicidal ideation or attempts, or substance use. When women do develop disorders after obtaining an abortion, this is instead strongly related to their mental health history *prior* to the abortion and prior history of trauma, meaning that the post-abortion mental health symptoms are not due to the abortion, but due to other pre-pregnancy risk factors as summarized below.

- ***Mood and anxiety disorders.*** The most reliable and rigorous studies examining this issue, including the Turnaway Study, have concluded that having an abortion does not cause or increase a woman's risk of experiencing anxiety, depression, dysphoria, or

³² Differential loss to follow-up means that people at risk of mental health problems were no more likely to be lost to follow-up than people without mental health problems.

post-traumatic stress symptoms or disorders (PTSD).³³ However, there is evidence that barriers to abortion access can have a *negative* impact on mental health with respect to short-term anxiety and stress.³⁴

- **Suicidal ideation and behaviors.** Recent high-quality evidence shows that having an abortion does not increase women's risk of suicidal thoughts.³⁵ Nevertheless, Dr. Skop's assertion³⁶ that those who have had an abortion have an increased risk of death from suicide disregards the fact that the only studies showing that abortion increases the risk of suicide or suicidal ideation have neglected to account for pre-existing mental health conditions, thereby rendering their results meaningless.³⁷
- **Alcohol use.** Prospective studies indicate that induced abortion is not associated with an increase in subsequent alcohol use or alcohol use disorders.³⁸ Moreover, analyses of Turnaway Study data find that having an abortion does not lead to increases in heavy episodic drinking or potentially problematic alcohol use over five years after having an abortion, and that women with more problematic alcohol use are in fact unable to reduce their drinking when they are unable to obtain an abortion.³⁹
- **Drug use.** The strongest evidence suggests that having an abortion does not increase women's risk of using illicit drugs.⁴⁰ Although Dr. Skop suggests that mental health issues stemming from abortion "may contribute to drug overdoses," she provides no

³³ Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74 JAMA Psych. 169, 174–76 (2017); Steinberg & Russo (2008), *supra* note 19, at 245; Julia R. Steinberg & Lawrence B. Finer, *Examining the Association of Abortion History and Current Mental Health: A Reanalysis of the National Comorbidity Survey Using a Common-Risk-Factors Model*, 72 Soc. Sci. & Med. 72, 73 (2011); Steinberg et al. (2014), *supra* note 19, at 267; see also van Ditzhuijzen et al. (2017), *supra* note 19, at 129. Kimberly Kelly, *The Spread of 'Post Abortion Syndrome' as Social Diagnosis*, 102 Soc. Sci. Med. 18 (2014); Gail Robinson et al., *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Brit. J. Psych. 78 (2012).

³⁴ Biggs et al. (2017), *supra* note 30, at 174; Biggs et al. (2015), *supra* note 30, at 2561.

³⁵ Biggs MA, Gould H, Barar RE, Foster DG. Five-Year Suicidal Ideation Trajectories Among Women Receiving or Being Denied an Abortion. *Am J Psychiatry*. 2018 Sep 1;175(9):845-852. doi: 10.1176/appi.ajp.2018.18010091. Epub 2018 May 24. PMID: 29792049.

³⁶ Skop Decl. at ¶¶ 27, 41, 48.

³⁷ See, e.g., Eerika Jalanko et al., *Increased Risk of Premature Death Following Teenage Abortion and Childbirth—A Longitudinal Cohort Study*, 27 Eur. J. Pub. Health 845 (2017) which uses an inappropriate comparator group; Mika Gissler et al., *Suicides After Pregnancy in Finland, 1987–94: Register Linkage Study*, 313 BMJ 1431 (1996); Mika Gissler et al., *Decreased Suicide Rate After Induced Abortion, After the Current Care Guidelines in Finland 1987–2012*, 43 Scandinavian J. Pub. Health 99 (2015); see also Biggs MA, Roberts SCM. Fatal flaws in recent analysis on the risk of premature death following teenage abortion and childbirth. *Eur J Public Health*. 2017 Oct 1;27(5):794. doi: 10.1093/eurpub/ckx101. PMID: 28957488.

³⁸ See, e.g., Roberts SCM, Foster DG, Gould H, Biggs MA. Changes in Alcohol, Tobacco, and Other Drug Use Over Five Years After Receiving Versus Being Denied a Pregnancy Termination. *J Stud Alcohol Drugs*. 2018 Mar;79(2):293-301. PMID: 29553359.

³⁹ Sarah C.M. Roberts et al., *Receiving Versus Being Denied a Pregnancy Termination and Subsequent Alcohol Use: A Longitudinal Study*, 50 Alcohol & Alcoholism 477, 481 (2015); Sarah C.M. Roberts & Diana Greene Foster, *Receiving Versus Being Denied an Abortion and Subsequent Tobacco Use*, 19 Maternal & Child Health J. 438 (2015); Sarah C.M. Roberts et al., *Receiving Versus Being Denied an Abortion and Subsequent Drug Use*, 134 Drug & Alcohol Dependence 63 (2014a); Sarah C.M. Roberts et al., *Changes in Alcohol, Tobacco, and Drug Use over Five Years After Receiving Versus Being Denied a Pregnancy Termination*, 79 J. Stud. Alcohol & Drugs 293 (2018).

⁴⁰ Roberts SCM, Foster DG, Gould H, Biggs MA. Changes in Alcohol, Tobacco, and Other Drug Use Over Five Years After Receiving Versus Being Denied a Pregnancy Termination. *J Stud Alcohol Drugs*. 2018 Mar;79(2):293-301. PMID: 29553359.

evidence to support this baseless claim.⁴¹ She herself states that “current systems of data collection are not capable of linking these events to induced abortion” even though rigorous data from the Turnaway Study refute her claim.⁴²

II. Rebuttal Opinion 2: Reliable Evidence Shows That Patients Who Obtain an Abortion, Regardless of Their Point in Pregnancy, Their Age, or Their Reasons For Doing So, Have Predominantly Positive Emotions About the Abortion and Have High Levels of Decisional Certainty

25. High quality research shows both that (1) women are more likely to experience positive than negative emotions in response to abortion, including “relief,” and (2) the vast majority of women seeking abortion have high levels of decision certainty and high levels of decision rightness after obtaining an abortion, including those who describe a primarily negative emotional response.⁴³ The most rigorous studies, including findings from the Turnaway Study,⁴⁴ demonstrate that positive emotions, including relief, are the most common emotions expressed in the short and long term and that the intensity of both positive and negative emotions decline over time.⁴⁵ The study also found that emotions did not differ

⁴¹ Skop Decl. ¶ 27.

⁴² Skop Decl. ¶ 27. Studies attributing higher rates of drug use to the experience of having an abortion are rife with methodological problems such as use of inappropriate comparison groups (women who have never been pregnant or had an intended pregnancy) and failure to account for pre-pregnancy drug use and other risk factors. *See, e.g.,* Priscilla K. Coleman et al., *Substance Use Among Pregnant Women in the Context of Previous Reproductive Loss and Desire for Current Pregnancy*, 10 *Brit. J. Health Psych.* 255 (2005); Priscilla K. Coleman et al., *A History of Induced Abortion in Relation to Substance Use During Subsequent Pregnancies Carried to Term*, 187 *Am. Obstetrics & Gynecology* 1673 (2002a); Kaeleen Dingle et al., *Pregnancy Loss and Psychiatric Disorders in Young Women: An Australian Birth Cohort Study*, 193 *Brit. J. Psychiatry* 455 (2008); David M. Fergusson et al., *Abortion and Mental Health Disorders: Evidence from a 30-Year Longitudinal Study*, 193 *Brit. J. Psychiatry* 444 (2008); Willy Pedersen, *Childbirth, Abortion and Subsequent Substance Use in Young Women: A Population-Based Longitudinal Study*, 102 *Addiction* 1971 (2007); *see also* Major et al. (2009), *supra* note 1, at 874–75. Roberts SCM, Foster DG, Gould H, Biggs MA. Changes in Alcohol, Tobacco, and Other Drug Use Over Five Years After Receiving Versus Being Denied a Pregnancy Termination. *J Stud Alcohol Drugs*. 2018 Mar;79(2):293-301. PMID: 29553359.

⁴³ Corinne H. Rocca et al. *Emotions and Decision Rightness over Five Years Following an Abortion: An Examination of Decision Difficulty and Abortion Stigma*, 248 *Soc. Sci. Med.* 112704 (2020).

⁴⁴ Corinne H. Rocca et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, 10 *PLoS One* e0218832, e028841 (2015).

⁴⁵ Brenda Major et al., *Psychological Responses of Women After First-Trimester Abortion*, 57 *Archives Gen. Psychiatry* 777, 778-79 (2000); Rocca et al. (2013), *supra* note 83, at 126; *see also* Anne Broen et al., *Psychological Impact on Women of Miscarriage Versus Induced Abortion: A 2-year Follow Up Study*, 66 *Psychosomatic Med.* 265, 269 (2004); A. Kero et al., *Wellbeing and Mental Growth— Long-Term Effects of Legal Abortion*, 58 *Soc. Sci. & Med.* 2559, 2564 (2004); Rocca et al. (2020), *supra* note 81.

between women having abortions beyond the first trimester and women having first-trimester abortions.⁴⁶ Regarding decisional rightness, the Turnaway study found that 95%-99% of women felt that the abortion was the right decision for them in the weeks, months, and up to five years after the abortion, regardless of their stage in pregnancy.⁴⁷

26. In examining whether patients experience regret following an abortion, it is important to differentiate between situational regret and decisional regret, since women may regret their situation or the circumstances that led to their decision to have an abortion without regretting the decision to have an abortion. Situational regret is a common, expected, and normal reaction for an abortion patient. Having an unintended or unwanted pregnancy may be a stressful life event for some women. Some women may regret having an unintended pregnancy in the first place or regret situational factors such as lack of financial stability, other obligations or dependents that prevent her from being able to support another child at this time, or a lack of supportive partner. By contrast, decisional regret means precisely that – that a woman regrets her decision to have an abortion. Evidence consistently finds that women do not regret their decision to have an abortion. Nevertheless, Dr. Skop speculates that “[w]ith all this indecision, it is likely that another change of mind could occur for the woman after going through with the abortion, and that the choice could be regretted,” but provides no support for her conjecture.⁴⁸

27. Unlike decision rightness which assesses whether the abortion was the right decision after the abortion, as described above, decisional certainty is measured at the time of

⁴⁶ *Id.*

⁴⁷ Rocca et al. (2015), *supra* note 44, at e0218841; Corinne H. Rocca et al., *Women's Emotions One Week After Receiving or Being Denied an Abortion in the United States*, 45 *Persp. on Sexual & Reprod. Health* 122, 128 (2013), at 128; Major et al. (2000), *supra* note 43, at 781; Rocca et al. (2020), *supra* note 43.

⁴⁸ Skop Decl. ¶44.

seeking the abortion. A study of women seeking abortion in Utah measured women's decisional certainty using two separate scales, an abortion-specific scale and a scale widely used by researchers to measure attitudes and decision-making around other health care decisions.⁴⁹ Importantly, the study found that levels of decisional certainty around abortion were the same or even higher than those observed in studies of patients making decisions about various other treatments, such as mastectomy after a breast cancer diagnosis, prenatal testing after infertility, antidepressant use during pregnancy, reconstructive knee surgery, or prostate cancer treatment options.⁵⁰ Furthermore, in this study, decisional certainty did not differ based on pregnancy duration.

III. Rebuttal Opinion 3: The Studies Dr. Skop Cites Showing an Association Between Abortion and Adverse Mental Health Outcomes Are Unreliable Due to Methodological Flaws

28. Studies asserting an association between abortion and adverse mental health outcomes are misinterpreted and/or suffer from methodological limitations and have been consistently refuted by rigorous reviews on the topic. Nevertheless, Dr. Skop relies on such studies to support her assertion that abortion leads to negative mental health outcomes.

29. Dr. Skop relies on a metaanalysis and other studies by Dr. Priscilla Coleman.⁵¹ However, Dr. Coleman's analysis and conclusions have been widely criticized and uniformly rejected by the mainstream scientific community. After the publication of Dr. Coleman's 2011 meta-analysis, eight commentaries were published by reputable scientists refuting her findings

⁴⁹ Lauren J. Ralph et al., *Measuring Decisional Certainty Among Women Seeking Abortion*, 95 *Contraception* 269, 276 (2017)

⁵⁰ *Id.* at 276.

⁵¹ Skop Decl. ¶¶ 27, 41, 42, 44, 48

and pointing to serious methodological concerns that rendered her conclusions meaningless.⁵²

53

30. Another serious methodological flaw with many of the studies Dr. Skop cites is use an inappropriate comparator group. As previously noted, in order to assess whether abortion impacts mental health outcomes, it is important to utilize comparison groups, and to ensure that they are as similar as possible to the group of women obtaining an abortion. It is scientifically unsound to rely on lower-quality studies that compare women who have abortions to women who have never been pregnant⁵⁴ or to women with intended pregnancies that are carried to term⁵⁵, as Dr. Skop does, when we have more rigorous studies with appropriate comparison groups, such as the Turnaway Study, available.

⁵² Kathryn M. Abel et al., *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Brit. J. Psychiatry 74 (2012); Ben Goldacre & William Lee, *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Brit. J. Psychiatry 77 (2012); Louise M. Howard et al., *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Brit. J. Psychiatry 74 (2012); Toine Lagro-Janssen et al., *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Brit. J. Psychiatry 78 (2012); Julia H. Littell & James C. Coyne, *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Brit. J. Psychiatry 75 (2012); Chelsea B. Polis et al., *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Brit. J. Psychiatry 76 (2012); Renzo Puccetti et al., *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Brit. J. Psychiatry 78 (2012); Gail Erlick Robinson et al., *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Brit. J. Psychiatry 78 (2012).

⁵³ Researchers have also pointed out several failures in Dr. Coleman's methodological approach, which violate principles and best practices for meta-analysis. See Chelsea B. Polis et al., *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Brit. J. Psychiatry 76 (2012); Julia H. Littell & James C. Coyne, *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Brit. J. Psychiatry 75 (2012). In particular, numerous critiques have shown that it is inappropriate for Dr. Coleman's use of a Population Attributable Risk (PAR) statistic to estimate that "nearly 10% of the incidence of mental health problems [is] shown to be directly attributable to abortion." Priscilla K. Coleman, *Abortion and Mental Health: Quantitative Synthesis and Analysis of Research Published from 1995-2009*, 199 British J. Psychiatry 180, 183 (2011). This is because estimating PAR assumes a causal relationship between the risk factor (abortion) and the disease (mental ill health) and that the considered risk factor is independent of other risk factors. Because Dr. Coleman failed to fulfill either assumption, it represents one of the most important shortcomings of her analysis. Louise M. Howard et al., *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Brit. J. Psychiatry 74, 74 (2012).

⁵⁴ David M. Fergusson et al., *Abortion and Mental Health Disorders: Evidence from a 30-Year Longitudinal Study*, 193 Brit. J. Psychiatry 444, 447 (2008)

⁵⁵ Coleman et al. (2002a), *supra* note 42, at 1675; Priscilla K. Coleman et al., *State-Funded Abortions Versus Deliveries: A Comparison of Outpatient Mental Health Claims Over 4 Years*, 72 Am. J. Orthopsychiatry 141, 144 (2002b); Jesse R. Cogle et al., *Depression Associated with Abortion and Childbirth: A Long-Term Analysis of the NLSY Cohort*, 9 Med. Sci. Monitor CR157 138 (2003); Mika Gissler et al., *Injury Deaths, Suicides and Homicides Associated with Pregnancy, Finland 1987-2000*, 15 Eur. J. Pub. Health 459, 460 (2005).

31. Multiple studies cited by Dr. Skop also fail to take pregnancy intention or wantedness into account when comparing women who have abortions to women with intended pregnancies that are carried to term.⁵⁶ Thus, studies that don't account for pregnancy intentions are biased in favor of finding that women who have abortions will have more mental health problems than women who deliver as a result of this failure.⁵⁷ Other studies upon which Dr. Skop relies inappropriately control for pre-existing mental health conditions.⁵⁸ For example, although Dr. Skop cites the work of Fergusson and colleagues, their study was conducted in New Zealand, a country where, at the time of the study and according to the study authors, a patient could only legally obtain abortion if the patient was at risk of serious physical or mental health problems, the pregnancy was the result of incest, or the patient was severely mentally handicapped.⁵⁹ The study also uses an inappropriate comparator group and relies on the participants to disclose their own abortions, as their measure of abortion.⁶⁰ The authors of the study also acknowledged that there was underreporting of self-reported abortions.⁶¹

32. Women who have abortions usually have a higher incidence of pre-pregnancy mental health conditions than women without a history of abortion. The reasons women seek abortion—financial, partner-related, the desire to leave an abusive relationship or to avoid exposing children to an abusive relationship—can affect women's mental health outcomes post-abortion. Thus, when studies compare women who have abortions to those with intended

⁵⁶ Coleman et al. (2002a), *supra* note 42, at 1674; Coleman et al. (2002b), *supra* note 55, at 144; Cogle et al. (2003), *supra* note 55, at 159; Gissler et al. (2005), *supra* note 55, at 459;.

⁵⁷ Major et al. (2009), *supra* note 1, at 868–69, 884–85.

⁵⁸ Fergusson et al. (2008), *supra* note 42..

⁵⁹ Fergusson et al. (2008), *supra* note 42. The study explains that at the time, abortion in New Zealand was only allowed if the following conditions were met: Two certifying consultants must then agree: 1) that the pregnancy would seriously harm the life, physical or mental health of the woman or baby; or 2) that the pregnancy is the result of incest; or 3) that the woman is severely mentally handicapped.

⁶⁰ *Id.*

⁶¹ *Id.*

pregnancies that are carried to term or to people who have never given birth, they may erroneously attribute any differences in mental health outcomes to the abortion, when in fact these differences more likely stem from a woman's circumstances around the time she decides to have an abortion or carry to term, or even before she became pregnant.

33. Many of the studies cited by Dr. Skop also lack a prospective design and instead are cross-sectional or rely on retrospective measures, which are prone to biases.⁶² National surveys that rely on patient reporting of abortion, such as those referenced by Dr. Skop,⁶³ are known to miss some people who have had abortions since stigmatized health events, such as abortion, are underreported.⁶⁴ Studies that use subsamples from nationally representative datasets that were collected for other purposes effectively destroy the rigorous sampling procedures of the original dataset and render any results not generalizable.⁶⁵

34. Studies that use differential inclusion criteria in their study groups, such as those Dr. Skop relies upon, can lead to erroneous conclusions.⁶⁶ For example, studies that compare women who deliver their first pregnancy to women who have an abortion, yet exclude women with subsequent abortions from only the delivery group but not the abortion group,⁶⁷ eliminate women who may seek subsequent abortions due to mental health or other reasons from the

⁶² See, e.g., Coleman et al. (2002a), *supra* note 42, at 1674; Coleman et al. (2005), *supra* note 42, at 260; Priscilla K. Coleman, *Resolution of Unwanted Pregnancy During Adolescence Through Abortion Versus Childbirth: Individual and Family Predictors and Psychological Consequences*, 35 *J. Youth & Adolescence* 903, 906 (2006); Cogle et al. (2003), *supra* note 55, at 159.

⁶³ Coleman (2006), *supra* note 55, at 906.

⁶⁴ Radha Jagannathan, *Relying on Surveys to Understand Abortion Behavior: Some Cautionary Evidence*, 91 *Am. J. Pub. Health* 1825 (2001).

⁶⁵ Coleman et al. (2002a), *supra* note 42, at 1674; Coleman (2006), *supra* note 62; Cogle et al. (2003), *supra* note 55.

⁶⁶ Skop Decl. ¶ 48.

⁶⁷ See e.g., Coleman et al. (2002a), *supra* note 42; Coleman et al. (2002b), *supra* note 55; Cogle et al. (2003), *supra* note 55; Jesse R. Cogle et al., *Generalized Anxiety Following Unintended Pregnancies Resolved Through Childbirth: A Cohort Study of the 1995 National Survey of Family Growth*, 19 *J. Anxiety Disorders* 137 (2005).

delivery group, thus creating a bias toward finding that the delivery group has better mental health outcomes.⁶⁸

35. Studies from countries where the legal status of abortion is quite different from the United States, such as Russia⁶⁹ and New Zealand,⁷⁰ cannot be presumed generalizable, although Dr. Skop nonetheless relies on such studies. This is especially important when studies include people from countries with significantly different cultural or legal contexts, or for example from countries where a person can only obtain an abortion for mental health reasons, thereby biasing conclusions.

IV. Rebuttal Opinion 5: Contrary to Dr. Skop's Opinion, HB 5 Will Not Benefit Women's Mental Health or Emotional Well-Being and Evidence Indicates It Could Have the Opposite Effect.

36. It is my understanding that under HB 5, many women who seek abortion after 15 weeks gestation will be unable to obtain an abortion altogether. In the Turnaway Study, we found that women who sought an abortion but were unable to obtain one suffered consequences to their mental health, socioeconomic status, physical health, and lowered their aspirations for the future. For example, women in the Turnaway Study who were denied an abortion were more likely to be pushed below the poverty line than women who were able to receive an abortion.⁷¹ After being denied an abortion, they were also less likely to be employed full-time, more likely to be raising children alone, more likely to receive public assistance, and more likely to not have enough money to meet basic living needs, such as food, housing, and transportation, than women who received an abortion. For some outcomes (*i.e.*, subjective

⁶⁸ Julia R. Steinberg & Nancy Felipe Russo, *Evaluating Research on Abortion and Mental Health*, 80 *Contraception* 500, 502 (2009).

⁶⁹ *Id.* ¶ 41.

⁷⁰ *Id.* ¶ 48.

⁷¹ Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions*, 108 *Am. J. Pub. Health* 407, 410 (2018).

poverty, receiving food assistance), the negative socioeconomic effects of being forced to carry their pregnancies to term due to gestational limits lasted for the entire five-year period we talked to these women.⁷²

37. Findings from the Turnaway Study also demonstrated that women denied an abortion and who later miscarried or had an abortion elsewhere reported lower levels of life satisfaction at the time of being denied an abortion, when compared to women who obtained an abortion near a facility's gestational limit.⁷³ The Turnaway Study also showed that when women were denied an abortion, they lowered their future goals. They were less likely to have aspirational life plans, like getting a better job or finishing school, and six times less likely than women who received an abortion to achieve an aspirational plan in the year after being turned away.⁷⁴ Women who obtained abortions were also more likely to be able to exit abusive relationships and experienced a sharp decrease in violence from the man involved, whereas women who carried a pregnancy to term experienced no such decrease—they continued to be exposed to abuse.⁷⁵ These findings indicate that it is in fact denial of an abortion (something I understand to be an effect of HB 5's mandate) that will have a negative impact on women's well-being.

38. In sum, the best reliable evidence firmly demonstrates that abortion is not associated with an increased risk of negative mental health outcomes. It also shows that denying people access to a wanted abortion will not benefit their mental health or well-being.

⁷² *Id.*

⁷³ M. Antonia Biggs et al., *Does Abortion Reduce Self-Esteem and Life Satisfaction?*, 23 *Quality Life Res.* 2505, 2509 (2014); M. Antonia Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74 *JAMA Psych.* 169, 179 (2017).

⁷⁴ Ushma D. Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 *BMC Women's Health* 102, 108–9 (2015).

⁷⁵ Sarah C.M. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 *BMC Med.* 144, 147 (2014b).

To the contrary, the evidence suggests that policies restricting people's access to abortion has the potential to exacerbate the burdens people experience seeking abortion care, increase their symptoms of stress and anxiety, and will have long-term consequences to the socioemotional, physical and financial well-being of women, their children, and families.

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

Dated: June 23, 2022.



Antonia Biggs, Ph.D.

Prepared: June 22, 2022

University of California, San Francisco
CURRICULUM VITAE

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EDUCATION

DATES	INSTITUTION	DEGREE	FIELD OF STUDY
1987 - 1991	University of Wisconsin-Madison	BA	Psychology
1989 - 1990	Universite Aix-en-Provence, France		Psychology
1994 - 1998	Boston University	PhD	Psychology

PRINCIPAL POSITIONS HELD

1998 - 2013	University of California, San Francisco	Analyst V	Bixby Center for Global Reproductive Health PRL Institute for Health Policy Studies
2013 - 2015	University of California, San Francisco	Associate Researcher	Advancing New Standards in Reproductive Health (ANSIRH)
2015 - 2020	University of California, San Francisco	Full Researcher	Advancing New Standards in Reproductive Health (ANSIRH)
2020 - present	University of California, San Francisco	Associate Professor	Advancing New Standards in Reproductive Health (ANSIRH)

OTHER POSITIONS HELD CONCURRENTLY

2008 - 2010	University of Chile, Santiago, Chile	Consultant	Center for Adolescent Reproductive Medicine and Development
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Prepared: June 22, 2022

HONORS AND AWARDS

1994	Fellowship for graduate studies	Boston University
2014	2nd place poster award (co-author)	North American Forum on Family Planning
2015	Top 4 oral abstracts (lead author), presentation	North American Forum on Family Planning
2015	Outstanding article of the year award nomination (lead author)	International Society for Quality of Life Research
2017	1st place poster award (lead author)	North American Forum on Family Planning
2018	2nd place poster award (lead author)	North American Forum on Family Planning
2019	2nd place poster award (senior author)	North American Forum on Family Planning
2019	Sexual and Reproductive Health Section Poster award (senior author)	American Public Health Association
2020	2nd place poster award (lead author)	North American Forum on Family Planning
2021	The Distinguished Dozen: 2021 JAH Articles Making Distinguished Contributions to Adolescent and Young Adult Health (Senior author)	Journal of Adolescent Health

KEYWORDS/AREAS OF INTEREST

Abortion; abortion stigma; contraception; family planning; medication abortion; mental health.

PROFESSIONAL ACTIVITIESMemberships

2000 - present American Public Health Association

2013 - present Society of Family Planning, Fellow

Service to Professional Organizations

2016 - 2018 Ibis Reproductive Health, OTC OC working group Member

2019 - 2021 Society of Family Planning (SFP) grant review committee, Emerging Scholars in Family Planning Grant reviewer

2020 - 2020 Latin American Consortium Against Unsafe Abortion (CLACAI): Evaluation committee: Initiatives to increase access to sexual and reproductive health services in the context of COVID-19 Grant reviewer

Prepared: June 22, 2022

2021-2022 Society of Family Planning (SFP) Emerging Mentor
Scholars in Family Planning

SERVICE TO PROFESSIONAL PUBLICATIONS

2022 - 2022 Ad hoc referee: BMC Women's Health, Contraception, Journal Adolescent Health Perspectives on Sexual and Reproductive Health

2021 - 2021 Ad hoc referee: BMC Psychiatry; BMJ; BMJ Global Health; Clinical and Experimental Obstetrics and Gynecology; Contraception; The Lancet Regional Health Americas; Journal Adolescent Health; Perspectives on Sexual and Reproductive Health; Sexual and Reproductive Health Matters; Sexuality Research and Social Policy; Social Science and Medicine; Social Science Research; Women's Health Issues.

2019 - 2019 Ad hoc referee: American Journal of Public Health; BMC Pregnancy and Childbirth; Contraception; Journal of Adolescent Health; Journal of Affective Disorders; Perspectives on Sexual and Reproductive Health; The BMJ; Social Currents; Women's Health Issues; Women and Health

2020 - 2020 Ad hoc referee: BMC Medical Education; BMJ Open; BMJ Sexual & Reproductive Health; Contraception; Current Psychology; The European Journal of Contraception and Reproductive Health Care; Journal of Happiness Studies; Journal Health Care Poor and Underserved; Politics, Groups and Identities; Sexual and Reproductive Healthcare; Sexuality, Research and Social Policy; Women's Health Issues.

2018 - 2018 Ad hoc referee: Culture, Health and Sexuality; Journal of Reproductive and Infant Psychology; Journal of Psychiatric Research; Human Reproduction; Maternal and Child Health Journal; Perspectives on Sexual and Reproductive Health; Social Science and Medicine

2017 - 2017 Ad hoc referee: American Journal of Public Health; Demography; Human Reproduction; JAMA; JAMA-Psychiatry; Obstetrics and Gynecology; Social Science and Medicine

2016 - 2016 Ad hoc referee:
American Journal of Transplantation; BJOG; BMC-Women's Health; Contraception; Journal of Adolescent Health; New England Journal of Medicine; Psychological Medicine; Obstetrics and Gynecology

2013 - 2016 Associate Editor: BMC Women's Health

2015 - 2015 Ad hoc referee: American Journal of Preventive Medicine; BMC-Health Services Research; BMC Women's Health; BMJOpen; International Journal of Health Policy and Management; Obstetrics Gynecology; Women's Health Issues

2013 - 2013 Ad hoc referee: American Journal of Public Health; BMC Women's Health; Health Services Research; Hispanic Health Care International; Journal of Immigrant and Minority Health; The Lancet; PlosOne; Social Science and Medicine; Stigma, Research, and Action; Women's Health Issues

2012 - 2012 Ad hoc referee: Contraception; Women's Health Issues

2011 - 2011 Ad hoc referee: Journal of Research on Adolescence; Journal of Women's Health

Prepared: June 22, 2022

INVITED PRESENTATIONS**INTERNATIONAL**

2009	Cost-benefit analysis of California's family planning program, University of Chile, CEMERA, Santiago, Chile	Oral presentation, presenter
2009	Understanding the Reproductive Health of Latino Males, Congreso Chileno de Obstetricia y Ginecología Infantil y de la Adolescencia, Santiago, Chile	Oral presentation, presenter
2017	The effects of abortion on women's mental health outcomes. Provided expert testimony to a congressional commission to support lifting Honduras' complete ban on abortion, Tegucigalpa, Honduras	Provided expert testimony
2017	The effects of abortion on women's mental health outcomes. Provided expert testimony to Chile's constitutional tribunal to support lifting Chile's' complete ban on abortion, Santiago, Chile	Provided expert testimony
2017	Global Turnaway study, CLACAI, Lima, Peru	Oral presentation, presenter
2017	Does abortion increase women's risk of experiencing adverse mental health outcomes? National Abortion Federation, Lima, Peru	Oral presentation, presenter
2018	Medical and midwifery school faculty and student views about abortion and abortion provision, following legal reform in Chile, University of Diego Portales Medical School, Santiago, Chile.	Oral presentation, presenter
2020	Economic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States, International Association for Feminist Economics, Annual Conference, Quito, Ecuador (Conference cancelled due to COVID-19).	Oral presentation, presenter
2021	Abortion and mental health, National Institute of Psychiatry and National Center on Gender Equity and Reproductive Health (Instituto Nacional de Psiquiatría y el Centro Nacional de Equidad de Género y Salud Reproductiva), Mexico City, Mexico (Remote presentation due to COVID-19)	Oral presentation, presenter
2021	Abortion and mental health: Findings from the Turnaway and Burden studies. National Institute of Psychiatry (Instituto Nacional de Psiquiatría), Annual Research Conference, Mexico City, Mexico.	Keynote oral presentation, presenter

NATIONAL

1996	Puerto Rican adolescents' stereotype awareness, ethnic pride, and feelings of self-worth, Society for Research on Child Development, Washington, DC.	Oral presentation, lead author
1996	Defining violence, aggression, and abuse in the context of family violence, New England Psychological Association, Wenham, MA	Oral presentation, lead author
1998	Understanding how Puerto Rican adolescents are worse off than mainstream adolescents? Gaston Institute, University of Massachusetts, Boston, MA	Oral presentation, lead author

Prepared: June 22, 2022

1999	Maternal moods predict infant cognitive development in Barbados, Society for Research on Child Development, Albuquerque, NM	Oral presentation, lead author
2000	Community Challenge Grant: A successful teen pregnancy prevention model for high-risk youth? American Public Health Association, Boston, MA	Poster presentation, lead author
2001	Client satisfaction with California's Family PACT Program, American Public Health Association, Atlanta, GA	Oral presentation, lead author
2001	Reproductive Health Needs of the Latino Population, National Organization on Adolescent Pregnancy, Parenting and Prevention, Inc., Arlington, VA.	Oral presentation, co-author
2001	Acculturation and Latino Adolescent Sexual Behavior: Establishing a Research Agenda for the 21st Century, American Public Health Association, Atlanta, GA.	Oral presentation, co-author
2002	Combined pregnancy prevention approaches are associated with lower teen-birth rates at the zip code level, American Public Health Association, Philadelphia, PA	Oral presentation, lead author
2003	Meeting the reproductive health care needs of adolescents, American Public Health Association, San Francisco, CA	Oral presentation, lead author
2004	The Role of Community Based Organizations in Increasing Access to Family Planning/Reproductive Health (FP/RH) Services in California, American Public Health Association, Washington, DC	Oral presentation, lead author
2004	Adolescents' awareness of family planning policies and services in California's teen pregnancy hot spots, American Public Health Association, Washington DC.	Poster presentation (co-author)
2005	Public savings from averting unintended pregnancy: Cost-benefit analysis of California's family planning program presentation, American Public Health Association, New Orleans, LA	Oral presentation, co-author
2005	Meeting the reproductive health care needs of adolescents: California's Family PACT Program, Teen Pregnancy Prevention Annual Meeting, Burlingame, CA	Oral presentation, lead author
2006	American Evaluation Association Annual Conference, Portland, OR	Oral presentation, lead author
2007	Teens reaching teens, Use of peer outreach workers in family planning clinics, American Public Health Association, Washington, DC	Oral presentation, co-author
2008	Pregnancy intendedness and decision-making among young Latinas: Findings from a qualitative study, American Public Health Association, San Diego, CA	Oral presentation, lead author
2009	Discussing intrauterine contraception at the family planning visit: A (missed) opportunity for client education, American Public Health Association, Philadelphia, CA	Oral presentation, co-author
2009	They'll use it if it's free, Contraceptive choices among uninsured low-income women, with Rostovtseva, American Public Health Association, Philadelphia, CA	Oral presentations, co-author

Prepared: June 22, 2022

2011	A Question of Hope, American Public Health Association, Washington, DC	Film screening
2012	Mental health and physical health consequences of abortion compared to unwanted birth, with Foster, Dobkin, Roberts, and Steinberg, American Public Health Association, San Francisco, CA	Oral presentation, lead author
2012	Misunderstanding the risk of conception from unprotected sex and contraceptive use, with Foster, American Public Health Association, San Francisco, CA	Poster presentation, lead author
2013	Emotional and mental health outcomes from the Turnaway study, National Abortion Federation, New York, NY	Oral presentation, lead author
2013	Pregnancies and Health Expenditures from Dispensing up to a One-Year Supply of Hormonal Contraception, Population Association of America, Annual Meeting, New Orleans, LA	Oral presentation, Co-author
2013	How many visits does it take to provide long-acting reversible contraception (LARC)? Provider perspectives from Colorado and Iowa; American Public Health Association, Boston, MA.	Oral presentation, , lead author
2014	California Family Planning Providers' Challenges to Same Day Long-Acting Reversible Contraception (LARC) Provision, American Public Health Association, New Orleans, LA.	Oral presentation, presenter
2014	A comparison of depression and anxiety symptom trajectories between women who had an abortion and women denied one, American Psychological Association, Annual Meeting, Washington, DC.	Oral presentation, presenter
2014	Potential Role of Family Planning in an Era of Health Care Reform, Patient Perspectives on Primary Care Needs and Insurance Eligibility, American Public Health Association, New Orleans, LA.	Paper presentation, co-author
2014	Where have all the teens gone? Decline in adolescent female participation in California's family planning program following cuts in outreach funding, American Public Health Association, New Orleans, LA.	Paper presentation, co-author
2014	Sexually Transmitted Infection Services and Adoption of Effective Contraceptive Methods, American Public Health Association, New Orleans, LA.	Poster presentation, co-author
2014	Is IUD and contraceptive implant use associated with the decline in abortions in Iowa? with Rocca, Brindis, Hirsch, and Grossman; The North American Forum on Family Planning, Annual Meeting, Miami, FL.	Oral Presentation, presenter
2015	Does abortion increase women's risk for post-traumatic stress disorder? with Rowland and Foster; The North American Forum on Family Planning, Annual Meeting, Chicago, IL.	Oral Presentation, presenter
2016	Does abortion increase women's risk for adverse mental health and well-being outcomes? Findings from a prospective 5-year longitudinal cohort study, American Public Health Association, Denver, CO.	Paper presentation, presenter

Prepared: June 22, 2022

2016	Changes in alcohol, tobacco, and drug use over five years after receiving versus being denied an abortion, American Public Health Association, Denver, CO.	Paper presentation, co-author
2016	Effect of abortion receipt and denial on women's existing and subsequent children, American Public Health Association, Denver, CO.	Paper presentation, co-author
2016	Effects of Receiving vs. Being Denied an Abortion on Quality of Women's Intimate Relationships at 5 years, American Public Health Association, Denver, CO.	Paper presentation, co-author
2016	Effect of being denied a wanted abortion on women's socioeconomic wellbeing, with Foster, Gerds, Korenman, Ralph, and Roberts; American Public Health Association, Denver, CO.	Paper presentation, co-author
2016	Role of Proctoring to Increase LARC Access in Community Health Centers, with Mays, Harper, Freedman, Kaller; American Public Health Association, Denver, CO.	Paper presentation, co-author
2016	IUD and implant counseling in Community Health Care Centers, American Public Health Association, Denver, CO.	Roundtable discussion, co-author
2016	'It takes the stars aligning': Challenges to providing the Copper IUD as emergency contraception (EC) and same-day IUD visits in community health care settings, North American Forum on Family Planning, Denver, CO	Poster presentation, presenter
2017	Does abortion increase women's risk for adverse mental health and well-being outcomes? UCSF Family Planning Conference, San Francisco, CA	Oral presentation, lead author
2017	Five-year suicidal ideation trajectories among women receiving versus being denied an abortion, North American Forum on Family Planning, Atlanta, GA (received the 1st place best poster award).	Poster presentation, lead author, first place award
2017	Distance travelled by young women accessing abortion services in the Midwest, North American Forum on Family Planning, Atlanta, GA	Poster presentation, lead author
2018	Interest and support for alternative models of medication abortion provision according to a U.S. national probability sample, North American Forum on Family Planning, New Orleans, LA (received the 2nd place best poster award).	Poster presentation, lead author
2018	Shifting abortion access in Latin America: advocacy, research, and service delivery efforts in the region, North American Forum on Family Planning, New Orleans, LA	Oral presentation, panelist
2018	Women's experiences with telemedicine for preabortion informed consent visits in Utah, North American Forum on Family Planning, New Orleans, LA	Poster presentation, co-author
2019	Young women's experiences with EC method choice and contraceptive counseling at the EC visit, American Society for Emergency Contraception, Washington, D.C.	Oral presentation, lead author

Prepared: June 22, 2022

2019	Women's five-year anticipated abortion stigma trajectories after receiving or being denied an abortion', North American Forum on Family Planning, Los Angeles, CA	Poster presentation, lead author
2019	Attitudes about self-managed abortion legality in the United States: results from a nationally representative survey, North American Forum on Family Planning, Los Angeles, CA	Oral presentation, co-author
2019	Minors' reasons for and experience with obtaining judicial bypass for abortion in Illinois, North American Forum on Family Planning, Los Angeles, CA (received the 2nd place best poster award).	Poster presentation, senior author
2019	Understanding young women's preferences for lower-efficacy contraceptive methods: A mixed-methods study, America Public Health Association, Philadelphia, PA (received the SRH section poster award).	Poster presentation, senior author
2020	Young Women's Preferences for Lower Efficacy Contraceptive Methods: Balancing Reproductive Autonomy and Pregnancy Prevention Goals, Society of Adolescent Health and Medicine (SAHM) Annual Meeting, San Diego, CA (Conference cancelled due to COVID-19).	Oral presentation, senior author
2020	Barriers accessing abortion care and their association with psychological well-being, has been selected for oral presentation at the National Abortion Federation (NAF) Annual Meeting, Washington, DC (Conference cancelled due to COVID-19).	Oral presentation, lead author
2020	Consequences of abortion received and denied: The Turnaway study). American Public Health Association, Annual Meeting, Remote meeting due to COVID-19.	Oral presentation, co-author
2020	Consideration of self-managed abortion among people seeking facility-based care in three haven states. Society of Family Planning (SFP) Annual Meeting, Remote meeting due to COVID-19.	Poster presentation, senior author
2020	Abortion patients' interest in obtaining medication abortion over the counter (OTC). Society of Family Planning (SFP) Annual Meeting, Remote meeting due to COVID-19.	Poster presentation, lead author
2020	Development and validation of a new scale to measure the psychosocial burden of accessing abortion care. Society of Family Planning (SFP) Annual Meeting, Remote meeting due to COVID-19.	Poster presentation, lead author
2021	Feasibility, acceptability, and effectiveness of mail-order pharmacy dispensing of mifepristone for medication abortion. Society of Family Planning (SFP) Annual Meeting, Remote meeting due to COVID-19.	Poster presentation, co-author
2021	"Absolutely horrific." Attitudes towards self-managed abortion legality and criminalization: A qualitative study. Society of Family Planning (SFP) Annual Meeting, Remote meeting due to COVID-19.	Poster presentation, co-author

Prepared: June 22, 2022

2021 Abortion terminology preferences among people accessing abortion care. Society of Family Planning (SFP) Annual Meeting, Remote meeting due to COVID-19. Poster presentation, senior author

UNIVERSITY AND PUBLIC SERVICE

UNIVERSITY SERVICE

DEPARTMENTAL SERVICE

2018 - 2018	Core Funding Task Force, Advancing New Standards in Reproductive Health, University of California, San Francisco	Member
2018 - 2018	Resource Allocation Program (RAP), Request for Applications (RFA) planning team, Bixby Center for Global Reproductive Health, University of California, San Francisco	Member
2019 - 2020	Internal Collaboration Workgroup, Bixby Center for Global Reproductive Health, University of California, San Francisco	Member
2019 - present	Faculty DEI Hiring Workgroup, Advancing New Standards in Reproductive Health, University of California, San Francisco	Member
2019 - present	Culture and Inclusion Workgroup, Advancing New Standards in Reproductive Health, University of California, San Francisco	Member
2019 - present	Steering Committee for Research in Ob/Gyn at ZSFG, University of California, San Francisco	Member
2020 - present	DEI post-doctoral search committee, Advancing New Standards in Reproductive Health, University of California, San Francisco	Member
2020 - present	DEI liaison group, Advancing New Standards in Reproductive Health, University of California, San Francisco	Member
2021 - present	Research Strategy Committee, Department of Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco	Member

PUBLIC SERVICE

2010 - 2018	Escuela Bilingüe Internacional, Emeryville, CA	Class Parent
2014 - 2019	Emeryville-4H Club	Co-Founder; Treasurer
2017 - 2017	Provided expert testimony to a congressional commission to support lifting Honduras' complete ban on abortion, Tegucigalpa, Honduras	Expert witness
2017 - 2017	Provided expert testimony to Chile's Constitutional Court in support of lifting Chile's complete ban on abortion, Santiago, Chile	Expert witness
2014 - 2019	Glide Memorial Church	Volunteer

Prepared: June 22, 2022

2018 - 2019	Provided expert testimony challenging Tennessee's 48-hour waiting period and mandated counseling for abortions law	Expert witness
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PEER REVIEWED PUBLICATIONS

1. Galler JR, Harrison RH, **Biggs MA**, Ramsey F, Forde V. Maternal moods predict breastfeeding in Barbados. *Journal of Developmental and Behavioral Pediatrics*, 1999 Apr, 20(2): 80-7.
2. Driscoll AK, **Biggs MA**, Brindis CD, Yankah E. Adolescent Latino Reproductive Health: A review of the literature. *Hispanic Journal of the Behavioral Sciences*, 2001 Oct, 23(3): 255-326.
3. Brindis CD, Llewelyn L, Marie K, Blum M, Biggs A, Maternowska C. Meeting the reproductive health care needs of adolescents: California's Family Planning Access, Care, and Treatment (Family PACT) Program. *Journal Adolescent Health*. 2003 Jun; 32(6 Suppl):79-90.
4. McConnell J, Packel L, **Biggs MA**, Chow JM, Brindis C. Integrating Chlamydia Trachomatis Control Services for Males in Female Reproductive Health Programs. *Perspectives on Sexual and Reproductive Health*. 2003 Sept/Oct, 35(5):226-228.
5. Foster DG, **Biggs MA**, Amaral G, Brindis C, Navarro S, Bradsberry M, Stewart F. Estimates of Pregnancies Averted Through California's Family Planning Waiver Program in 2002. *Perspectives on Sexual and Reproductive Health*. 2006 Sep;38(3):126-31.
6. Amaral G, Foster DG, **Biggs MA**, Jasik CB, Judd S, Brindis CD. Public Savings from the Prevention of Unintended Pregnancy: A Cost Analysis of Family Planning Services in California. *Health Services Research* 2007 Oct;42(5):1960-80.
7. Foster DG, **Biggs MA**, Ralph LJ, Arons A, Brindis CD. Family planning and life planning reproductive intentions among individuals seeking reproductive health care. *Women's Health Issues*. 2008 Sep-Oct;18(5):351-9.
8. Foster DG, Rostovtseva DP, Brindis C, **Biggs MA**, Hulett D, Darney PD. Cost-Savings from the Provision of Specific Methods of Contraception. *American Journal of Public Health*. 2009;99: 446-451.
9. **Biggs MA**, Ralph L, Minnis AM, Arons A, Marchi LS, Lehrer JA, Braveman PA, Brindis CD. Factors associated with delayed childbearing: from the voices of expectant Latina adults and teens in California. *Hispanic Journal of Behavioral Science*. 2010;32(1) 77-103.
10. Foster DG, Higgins JA, **Biggs MA**, McCain C, Holtby S, Brindis CD. Willingness to have unprotected sex. *Journal of Sex Research*. 2011;0(0), 1-8.
11. Schwartz SL, Brindis CD, Ralph LJ, **Biggs MA**. Latina adolescents' perceptions of their male partners' influences on childbearing: findings from a qualitative study in California. *Cult Health Sex*. 2011 Sep;13(8):873-86.
12. Foster DG, **Biggs MA**, Rostovtseva D, de Bocanegra HT, Darney PD, Brindis CD. Estimating the fertility effect of expansions of publicly funded family planning services in California. *Women's Health Issues*. 2011 Nov-Dec;21(6):418-24.
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3. **Biggs MA, Brindis CD, Ralph L, Santelli J.** The Sexual and Reproductive Health of Young Latino Men Living in the US, In Molina-Aguirre M. (Ed) Social and Structural Factors Affecting the Health of Latino Males in the US. Published by Rutgers University Press, Newark, New Jersey (2010).

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2. "A Review of the Scientific Literature on the Effects of Abortion on Women's Mental Health and Emotional Outcomes", Amicus Brief, (lead author), submitted to Chile's constitutional tribunal to support lifting Chile's complete ban on abortion.
3. **Biggs MA.** "Chile Has Relaxed Its Abortion Ban, But Does That Go Far Enough?" Op-ed featured in Rewire magazine, Aug 29, 2017, <https://rewire.news/article/2017/08/29/chile-relaxed-abortion-ban-go-far-enough/>
4. **Biggs MA, Roberts SCM.** Fatal flaws in recent analysis on the risk of premature death following teenage abortion and childbirth. European Journal of Public Health. 2017;27:794.
5. **Biggs MA & Grossman D.** "With abortion clinic restrictions tightening, women want more access at home", Op-ed featured in Salon, Nov 28, 2018, <https://www.salon.com/2018/11/28/with-abortion-clinic-restrictions-tightening-women-want-more-access-at-home/>

OTHER CREATIVE ACTIVITIES

1. **Biggs MA.** Puerto Rican adolescents' cultural orientation: Contextual determinants and psychosocial outcomes. Doctoral dissertation. 1998.
2. **Brindis CD, Cagampang H, Biggs A, McCarter V.** 2000. Report of the Evaluation Enhancement: The Community Challenge Grant Program. Prepared for the U.S. DHHS, Office of the Assistant Secretary for Planning and Evaluation, Grant 98ASPE296A.
3. **Brindis CD, Driscoll AK, Biggs MA, Valderrama LT.** 2002. Issue Brief on Latino Youth: Reproductive Health. University of California, San Francisco, Center for Reproductive Health Research and Policy, Department of Obstetrics, Gynecology and Reproductive Health Sciences and the Institute for Health Policy Studies, San Francisco, CA.
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6. Driscoll A, **Biggs MA**, Brindis CD. 2003. The Influence of Acculturation on Latino Adolescent Childbearing. *Cultural Dimensions of Teen Pregnancy Prevention and Parenting*, 22(4): 14-15.
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<http://www.minsal.gob.cl/portal/url/item/ace74d077631463de04001011e011b94.pdf>
 20. Foster DG, Malvin J, **Biggs MA**, Bradsberry M, Brindis C and Darney P. Cost Benefits from the Provision of Specific Methods of Contraception in 2009. Submitted to the California Department of Public Health, Office of Family Planning Division. Bixby Center for Global Reproductive Health, University of California, San Francisco: San Francisco, CA. April 2012. http://www.familypact.org/Research/reports/FINAL_CBA-SM_ExecSummary_508.pdf
 21. **Biggs MA**, Brindis C and Darney P. Delivery of Long-Acting Reversible and Permanent Contraception (LAC) Among Female Family PACT Clients. Submitted to the California Department of Public Health, Office of Family Planning Division. Bixby Center for Global Reproductive Health, University of California, San Francisco: San Francisco, CA. June 2012.
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 24. **Biggs MA**. Effects of Abortion on Women's Mental Health, as part of UCSF's Bixby Center Explained video series. <http://innovating-education.org/2017/01/explained-series-topics/>

Shelly Hsiao-Ying Tien, M.D./M.P.H.

Genesis Maternal-Fetal Medicine, Tucson, Arizona
04/2022 – current, part-time physician

Planned Parenthood – South, East and North Florida
03/2021 – current, part-time physician

Trust Women, Oklahoma city, Oklahoma
02/2021 - current, contract physician

Planned Parenthood – Southeast, Alabama
12/2021 - current, contract physician

NorthShore University Health System/University of Chicago
07/2015 – 12/2020

Fellowship, Maternal-Fetal Medicine
University of Minnesota, Minneapolis
07/2012 – 06/2015

Residency, Obstetrics and Gynecology
Advocate Illinois Masonic Medical Center, Chicago, Illinois
07/2008 – 06/2012

Medical Education
Tufts University School of Medicine, Boston, Massachusetts
08/2003 - 05/2008
M.D./M.P.H.

Education
Undergraduate - University of Illinois, Champaign/Urbana
Biology
08/1999 - 06/2003
B.S.

Board certification
Maternal-Fetal Medicine 2018
Obstetrics and Gynecology 2013

Memberships

Society for Maternal-Fetal Medicine

2012 – current

American College of Obstetricians and Gynecologists

2008 – current

Committees

Northshore University Health System Obstetric Practice Committee - Chair, 2016 – 2020

- Educational committee that creates physician guidelines and nursing protocols for obstetric care for Evanston and Highland Park hospitals.

Northshore University Health System Epic Physician builder, 2018 – 2020

- Developed and implemented obstetric clinical workflows for our Epic electronic medical record system.

Illinois Perinatal Quality Collaborative (ILPQC) - Clinical lead for the Immediate Postpartum Long Acting Reversible Contraception initiative, 2018 – 2020

- Implementation of immediate postpartum LARCs for patients at Evanston and Highland Park hospitals.
- Provision of educational support for other birthing hospitals in the state.

Maternal-Fetal Medicine Clinical Competency Committee, 2018 - 2020

- Biannual meeting and evaluation of educational progress for maternal-fetal medicine fellows.

Volunteer Experience

Medical Students for Choice (MSFC), Massachusetts, 09/2003-04/2008

Student coordinator

- Facilitated multiple lectures and workshops on reproductive education and contraception.
- Organized the 2005 regional student conference for MSFC.

Cross Cultural Solutions, Ghana, 06/2003-07/2003

Medical Volunteer

- Volunteered through the organization Cross Cultural Solutions.
- Provided immunizations to children, assisted in the local health center pharmacy, and taught women's health education in the maternity ward.

Provena Mental Health, Illinois, 04/2001-05/2002

Suicide Hotline Volunteer

- Volunteer counselor on the suicide hotline.

- Provided mental health interventions to clients in crisis, and general health resources and information for family members and support persons.

Rape Crisis Services, Illinois, 05/2000-05/2003

Medical Advocate and Hotline Volunteer

- Hotline volunteer providing counseling, support and resources to survivors of sexual violence.
- Medical advocate for patients – provided education and support during the emergency room visits for patients who presented after an assault.

Publications

Tien SH, Crabtree JN, Gray HL, Peterson EJ. Immunologic response to vaccine challenge in pregnant PTPN22 R620W carriers and non-carriers. *PLoS One*. 2017 Jul 19;12(7):e0181338.

Tien S and Yamamura Y. Cervical ectopic pregnancy: persistence despite a serologically negative β -hCG. *J Reprod Med* 2015;60(5-6):257-60.

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Grimes K, Schulz M, Cohen S, Mullin B, Lehar S, Tien S. Pursuing Cost-Effectiveness in Mental Health Service Delivery for Youth with Complex Needs. *J Ment Health Policy Econ* 2011;14:73-86.

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Cockrum RH, Tien SH. Strip of the Month: August 2016. *NeoReviews* August 2016, Volume 17/Issue 8.

Schneider P, Tien SH. Strip of the Month: February 2016. *NeoReviews* February 2016, Volume 17/Issue 2.

Presentations

Tien S, Crabtree J, Gray H, Peterson E. (2015, February). "Immunologic response to vaccine challenge in PTPN22 gene variants in pregnancy." Poster presentation at: the Society for Maternal-Fetal Medicine, San Diego, CA.

Tien S, Aguilera M. (2014, October). "Monochorionic Monoamniotic Twin Gestation: A review of antenatal management at three tertiary care centers." Poster presentation at: Central Association of Obstetricians and Gynecologists, Albuquerque, NM.

Tien S, Gray H, Jacobs K, Giacobbe L, Wagner W, Aguilera M. (2013, October). "A review of ten years' experience with placenta accreta at a single tertiary care center." Poster presentation at: Central Association of Obstetricians and Gynecologists, Napa Valley, CA.

Tien S, Gray H, Jacobs K, Giacobbe L, Swartout J, Aguilera M. (2013, October). "Spinal anesthesia converted to general anesthesia for cesarean hysterectomy is associated with improved neonatal Apgar scores versus general anesthesia alone." Poster presentation at: Central Association of Obstetricians and Gynecologists, Napa Valley, CA.

Tien S, Casserly K, Rauk P. (2013, April). "A right atrial thrombus in the setting of puerperal coagulopathy." Poster presentation at: Society for Obstetric Anesthesia and Perinatology, San Juan, Puerto Rico.

Tien S, Gray H, Jacobs K, Giacobbe L, Swartout J, Aguilera M. (2013, April). "Maternal obesity associated with clinically increased blood loss and postoperative hospital stay in patients undergoing peripartum hysterectomy." Poster presentation at: Society for Obstetric Anesthesia and Perinatology, San Juan, Puerto Rico.

Tien S, August C, Fernandez C, Dini M. (2012, October). "Metastatic colon cancer presenting as an adnexal mass." Poster presentation at: the Advocate Research Forum, Advocate Illinois Masonic Medical Center, Chicago, IL.

Tien S, Villines D, Parilla B. (2012, October). "Gestational Weight Gain in Obese Patients and Adverse Pregnancy Events." Oral presentation at: Central Association of Obstetricians and Gynecologists, Chicago, IL.

Tien S, Popper F. (2009, October). "A Retrospective Review of Misoprostol Efficacy for the Treatment of Early Pregnancy Failure." Poster presentation at: Central Association of Obstetricians and Gynecologists, Maui, HI.

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EXHIBIT B

IN THE CIRCUIT COURT OF THE SECOND CIRCUIT
IN AND FOR LEON COUNTY, FLORIDA

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

Plaintiffs, Case No. 2022 CA 000912
v.

STATE OF FLORIDA, et al.,

Defendants.
-----/

HEARING BEFORE THE HONORABLE JOHN C. COOPER
VOLUME II
(Pages 95 to 267)

DATE TAKEN: Monday, June 27, 2022

TIME: Commenced at 12:57 p.m.
Concluded at 5:30 p.m.

PLACE: Leon County Courthouse
Courtroom 3G
301 South Monroe Street
Tallahassee, Florida 32301

Reported by:
Doreen Mannino, Certified Court Reporter

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I N D E X
V O L U M E I I

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Witnesses for Plaintiffs:

- Shelly Hsiao-Ying Tien
 - Continued Cross-Examination by Mr. Guard.....98
 - Redirect Examination by Ms. Sandman.....105

Witnesses for Defendants:

- Maureen Condic
 - Direct Examination by Mr. Faruqui.....111
 - Cross-Examination by Ms. Sacerdote..... 146
- Ingrid Skop
 - Direct Examination by Mr. Faruqui.....178
 - Cross-Examination by Ms. Pillay.....203
- State Rests.....232

Rebuttal Witness for Plaintiffs:

- Shelly Hsiao-Ying Tien
 - Direct Examination by Ms. Sandman.....232
 - Cross-Examination by Mr. Guard.....257
- Plaintiffs Rest.....264
- Certificate of Oath.....267

P R O C E E D I N G S

(Proceedings continued from Volume I.)

THE BAILIFF: All rise. Court is back in session.

THE COURT: Everybody have a seat. You may continue cross.

MR. GUARD: Thank you, Your Honor.

C O N T I N U E D C R O S S - E X A M I N A T I O N

BY MR. GUARD:

Q. Before we took a break, Dr. Tien, I had asked you of the 67 abortions in 2021 that Planned Parenthood of Southeast and North Florida performed after 15 weeks of LMP how many of them would have been subject to an exemption pertaining to HB5; do you recall being asked that question?

A. Yes.

Q. Your answer was none. Did I get that right, ma'am?

A. That is correct.

Q. And you were deposed just a few days ago, correct?

A. Yes.

Q. And you were under oath in that deposition, right?

THE COURT: Let's keep the tone of voice --

1 MR. GUARD: Sorry, Your Honor.

2 THE COURT: -- equal level.

3 MR. GUARD: Sure.

4 THE COURT: We're not on TV. Well, we are on
5 TV. Let's keep the tone of voice level.

6 MR. GUARD: Sorry, Your Honor.

7 THE COURT: Okay.

8 BY MR. GUARD:

9 Q. And you were asked that question in the
10 deposition, right?

11 A. Yes.

12 Q. You were asked and of those 67 abortions that
13 were performed after 15 weeks of LMP --

14 MS. SANDMAN: I'm sorry. Counselor, can you
15 give me a page number?

16 MR. GUARD: Page 53, line 11.

17 BY MR. GUARD:

18 Q. If you want to get the deposition, ma'am, you
19 can get the deposition.

20 Question: And of those 67 abortions that
21 were performed after 15 weeks of LMP, how many of the
22 67 would have been subject to exemption pertaining to
23 HB5?

24 Answer: I would have to look at each
25 specific clinical chart for those numbers. As I

1 understand it the exemptions in HB5 include maternal
2 life exceptions as well as a narrow exception for
3 permanent disability to the bodily system as well as
4 lethal fetal condition.

5 Question: Sitting here dot dot dot women
6 have abortions for lots of reasons and per our Florida
7 state required web based reporting, we do document
8 those reasons. One of the limitations of the
9 reporting is that staff was inputting numbers and can
10 only select one reason. And so the reasons that are
11 listed included elective abortion, emotional reasons,
12 financial hardship, health concerns, fetal conditions.
13 There are patients that likely have multiple reasons
14 for seeking abortion. And as the staff input this
15 information there is only one option allowed. And so
16 the elective option is chosen most frequently because
17 these patients are here of their own volition at the
18 clinic. Without looking at each particular patient's
19 chart I would not be able to tell you specifically.
20 And actually without reviewing each patient's chart in
21 detail or speaking with each patient I would not be
22 able to tell you specifically how many of those would
23 meet the very narrow exceptions within HB5. Correct?

24 A. Yes.

25 Q. Now, you didn't review since your deposition

1 two or three days ago each chart in detail, right?

2 A. I have not reviewed the charts.

3 Q. And you didn't speak with each one of those
4 67 patients; did you?

5 A. I have not spoken with them.

6 Q. Okay. Would you agree medical science has
7 made huge leaps forward since Roe versus Wade was
8 decided?

9 THE COURT: This is not about Roe versus
10 Wade. This is about Florida's right of privacy.

11 MR. GUARD: Your Honor, I'm just trying to
12 put forward that medical science has made advances
13 in the past 30 or 50 years.

14 THE COURT: You can ask that question, but
15 Roe versus Wade is not relevant in this case.

16 BY MR. GUARD:

17 Q. All right. Dr. Tien, in the last 30 to
18 50 years would you agree that medical science has made
19 huge leaps forward?

20 A. Yes.

21 Q. In the last 50 years what we know -- strike
22 that.

23 In the last 50 years we now know more about
24 reproductive health than we did then, correct?

25 A. Yes.

1 Q. Medical technology has made great leaps
2 forward in the last 50 years as well, right?

3 A. Yes.

4 Q. For example, ultrasounds, right, have made
5 progress in the last 50 years?

6 A. Yes.

7 Q. Ultrasounds 50 years ago would be gray scaled
8 and pixillated; would they not?

9 A. Yes, the image quality was poor compared to
10 what it can be today.

11 Q. And today you can get a 3D image from an
12 ultrasound, right?

13 A. Yes. Though 3D imaging is used for specific
14 anatomic concerns. It's not used to evaluate detailed
15 internal anatomy.

16 Q. Okay. Doctor, you were paid under your
17 initial contract with Planned Parenthood Southeast and
18 North Florida almost \$300,000 a year, correct?

19 A. That is correct. My salary when I was a
20 full-time physician there was 285,000.

21 Q. And this year you have contracts to make
22 almost \$400,000 a year, right?

23 A. As a part-time physician at Planned
24 Parenthood my salary was adjusted to 185,000. My
25 salary as a maternal-fetal medicine physician in

1 Arizona is 200,000.

2 Q. And you're a party in this case, correct?

3 A. Yes.

4 Q. And you've been an expert or served as an
5 expert before in another case, right?

6 A. In a deposition. It did not go to trial.
7 That is right.

8 Q. That was in another abortion restriction
9 case, correct?

10 A. It was in the 24-hour mandated delay, yes.

11 Q. And you've never testified on behalf of a
12 government entity in support of an abortion
13 restriction; have you?

14 A. I have never testified in a court setting.

15 Q. Never offered an opinion in any kind of a
16 abortion restriction case in favor of an abortion
17 restriction; have you?

18 THE COURT: That's a very broad question.

19 Lawyers understand what you mean. When you say
20 has she ever offered an opinion that could be the
21 next door neighbor. I understand what you mean.
22 You're limiting it to as expert witness.

23 BY MR. GUARD:

24 Q. In a court case, Dr. Tien?

25 THE COURT: Okay.

1 BY MR. GUARD:

2 Q. You have never offered an opinion in support
3 of an abortion restriction; have you?

4 A. In a court setting I have never offered an
5 opinion in support of an abortion restriction.

6 Q. And earlier on you testified that you are
7 pro-choice, correct?

8 A. Yes.

9 Q. But you're a little bit more than just
10 pro-choice, right?

11 A. Can you define a little bit more than
12 pro-choice?

13 Q. You've actually advocated to the legislature
14 regarding abortion restrictions, correct?

15 A. I consider that being pro-choice.

16 Q. Okay. But you have you actually advocated
17 against HB5, right?

18 A. I, myself and other physicians did sign a
19 letter in response to learning of HB5 being passed in
20 the State of Florida, yes.

21 MR. GUARD: If I can have a moment, Your
22 Honor.

23 THE COURT: Sure.

24 MR. GUARD: I pass the witness, Your Honor.

25 THE COURT: Thank you, Counselor. Redirect.

1 MS. SANDMAN: Yes, Your Honor. I'll keep it
2 brief.

3 **R E D I R E C T E X A M I N A T I O N**

4 BY MS. SANDMAN:

5 Q. Dr. Tien, opposing counsel asked you some
6 questions from your deposition testimony about fetal
7 pain and then he read a section of that testimony back
8 to you and I'm just going to read that so that we're
9 clear. And it said, And so you discussed fetal pain
10 and offered some information about whether it might or
11 might not be present. And then you said, and so in
12 recognition of this I provide abortions in the second
13 trimester. I do not provide abortions after 24 weeks.

14 Can you explain what you meant in that
15 section of your testimony?

16 A. In that section I was outlining the basic
17 building blocks of pain perception of which the basic
18 building blocks are in place between 24 to 26 weeks in
19 the higher level cortical processing recognition, and
20 awareness is present thereafter.

21 Q. Let me ask a better question, Doctor. When
22 you said in recognition of that I don't provide after
23 24 weeks, is fetal pain a reason that you don't?

24 THE COURT: You mean don't provide after
25 24 weeks.

1 MS. SANDMAN: Thank you, Your Honor. After
2 24 weeks.

3 BY MS. SANDMAN

4 Q. Is fetal pain the reason that you don't
5 provide after 24 weeks?

6 A. No, I do not provide after 24 weeks because I
7 do not have the technical expertise and because it is
8 illegal.

9 Q. And, Dr. Tien, do you recall opposing counsel
10 asked you some questions about deposition testimony
11 that you gave about whether some patients in Texas
12 were able to get abortions earlier than six weeks
13 after Texas's abortion ban went into effect?

14 A. Yes.

15 Q. Do you think the same thing would happen in
16 Florida if a 15-week ban went into effect?

17 A. No.

18 Q. Why not?

19 A. The type of patients who need abortions after
20 15 weeks are inherently a different population of
21 patients than those who have abortions prior to six
22 weeks.

23 Q. And, Dr. Tien, the State also asked some
24 questions about the overall relatively low number of
25 abortions after 15 weeks compared to abortions even

1 earlier in pregnancy. The State asked you some
2 questions about Planned Parenthood Central and
3 Northeast Florida's relatively low number. I think it
4 was 67 after 15 weeks. Is that number representative
5 of the percentage of abortions that are after 15 weeks
6 in the state as a whole?

7 A. No.

8 Q. Why is that?

9 A. Planned Parenthood is only one small picture
10 of the provision of abortion care in the entire state
11 of Florida.

12 Q. Do you know whether certain other abortion
13 providers in the state provide services to a later
14 gestational age than Planned Parenthood Southeast and
15 North Florida do?

16 A. Yes.

17 Q. And you've been focussing on Planned
18 Parenthood Southeast and North Florida. Do you know
19 if that number would be similar for this year than it
20 was for last year?

21 A. I would not know specifically without
22 reviewing their numbers; however, I am aware that
23 there are other clinics in the entire State of Florida
24 that offer services past 15 weeks not just our
25 Jacksonville location.

1 Q. The State asked you a lot of questions about
2 the percentage of patients who get abortions in the
3 first trimester. Does that change anything about
4 those relatively small numbers? Does that change
5 anything about your testimony today?

6 A. It does not.

7 Q. Does anything about the questions they asked
8 you help patients who need abortions after 15 weeks?

9 A. It does not. The data that was presented was
10 excellent. It was compiled by the Centers for Disease
11 Control and data that I'm familiar with. Again, it
12 does not affect the patients who need abortions after
13 15 weeks because they're a separate population. And
14 it also does not affect every woman and girl who
15 becomes pregnant in Florida and develops a
16 complication after 15 weeks.

17 MS. SANDMAN: No further questions.

18 THE COURT: Thank you, Doctor. You may step
19 down. I'm assuming no other party on the
20 Plaintiff's side have question for her. You may
21 step down.

22 Call your next witness.

23 MS. WHITE: Your Honor, before I proceed I
24 have one question for clarification based on some
25 procedural issues that came up earlier today. You

1 mentioned the possibility of continuing the trial
 2 until Thursday and then also mentioned that based
 3 on however you rule you would want the prevailing
 4 party to submit an order within 24 hours for the
 5 other party to respond. We had understood that
 6 Your Honor would be transferring off this case at
 7 the end of this week.

8 THE COURT: Things change so much. Since
 9 this morning I got a new emergency election case
 10 which they're clamoring to have an emergency
 11 hearing on and two weeks ago my assignment
 12 changed. I'm not going anywhere.

13 MS. WHITE: Excellent. Thank you for
 14 clarifying that, Your Honor. We just wanted to
 15 make sure that wouldn't affect your availability.

16 THE COURT: No.

17 MS. WHITE: Thank you.

18 THE COURT: Unrelated to this case. It was
 19 this is 1 of 800 plus cases I have.

20 MS. WHITE: Understood.

21 THE COURT: Defense Counsel.

22 MR. GUARD: Your Honor, over the lunch break
 23 we did file an errata sheet. I've got a courtesy
 24 copy if I may approach. It's very limited.

25 THE COURT: Thank You. All right.

1 Excellent. Appreciate it. The orders that I
2 signed earlier should have been eserved to both
3 your mailboxes by now.

4 All right. Who's next? Witness?

5 MS. WHITE: Plaintiffs have no further
6 witnesses in the case in chief.

7 THE COURT: State, do you want to take a
8 break before you call your next witness for
9 anything?

10 MR. FARQUI: I think we're fine, Your Honor.
11 The state will call Dr. Condic first.

12 Your Honor, the witness has a copy of her
13 declaration and the exhibit. I've already
14 conferred with counsel.

15 THE COURT: Raise your right hand. The clerk
16 will place you under oath.

17 THE CLERK: Do you solemnly swear or affirm
18 the testimony you shall give in this issue will be
19 the truth, the whole truth, and nothing but the
20 truth?

21 DR. CONDIC: I do.

22 THE COURT: Have a seat. Speak up so the
23 court reporter and I can hear you and also
24 moderately slow.

25 THEREUPON,

1 MAUREEN CONDIC,

2 having been first duly sworn by the Clerk, was
3 examined and testified upon her oath as follows:

4 **D I R E C T E X A M I N A T I O N**

5 BY MR. FARUQUI:

6 Q. Good afternoon, Dr. Condic. Can you state
7 and spell your name for the record, please?

8 A. My name is Maureen Condic, C-O-N-D-I-C.

9 Q. And can you please tell the Court what you do
10 for a living?

11 A. I'm faculty at the University of Utah School
12 of Medicine.

13 Q. In what subject matter are you a professor?

14 A. I'm a professor of neurobiology at the
15 university and my training is in neuroscience.

16 Q. And have you ever had positions in other
17 departments at the university?

18 A. I have an adjunct appointment in the
19 Department of Pediatrics.

20 Q. And how many years have you been a university
21 professor?

22 A. Since 1997.

23 Q. Could you just briefly tell me your duties
24 and functions as a university professor in your
25 current position?

1 A. Running a research laboratory, competing for
 2 funding from national agencies, publishing papers,
 3 teaching in the medical school. I teach first year
 4 medical students, human embryology, and teaching
 5 graduate education and occasionally undergraduate
 6 courses.

7 Q. And could you let the Court know your
 8 academic background that lead you to this career?

9 A. So I did my undergraduate degree at the
 10 University of Chicago. I did graduate training at the
 11 University of California at Berkley where I received a
 12 Ph.D. in developmental neuroscience. I did post
 13 doctoral training also at the University of California
 14 Berkley and at the University of Minnesota studying
 15 development of nervous system. And then I was hired
 16 as a faculty member at the University of Utah.

17 Q. And you mentioned that you teach human
 18 embryology. Can you just briefly explain what that
 19 is?

20 A. So human embryology is typically a first year
 21 medical student course to cover all of human
 22 development from the very beginning through formation
 23 of systems and development of systems up until birth.

24 Q. And do you have any particular focus within
 25 embryology in terms of specific systems, development

1 of specific systems?

2 A. My two areas of specialization are early
3 human development, preimplantation development, and
4 development of the nervous system.

5 Q. Have you taught or given any presentations
6 outside of your duties as a professor in this field?

7 A. Oh, yes.

8 Q. And have you published peer-reviewed papers
9 in these fields?

10 A. Yes.

11 Q. Have you refereed any scientific journals?

12 A. Yes.

13 Q. Have you won any awards in your field?

14 A. Yes, I have.

15 Q. Are you affiliated with any government
16 agencies dedicated to research?

17 A. Yes. I was pointed as a member of the
18 National Science Board, and I've served the National
19 Institute Health Research Ethics Panel.

20 Q. Dr. Condic, are you affiliated with any
21 organizations that would be fairly characterized as
22 pro-life?

23 A. I'm a fellow of the Charlotte Lozier
24 Institute.

25 THE COURT: I'm sorry. I didn't hear that.

1 THE WITNESS: I'm a scientific fellow of the
2 Charlotte Lozier Institute.

3 THE COURT: Okay. You are going to ask her
4 what that is; aren't you?

5 BY MR. FARUQUI:

6 Q. Can you please explain what the Charlotte
7 Lozier Institute is?

8 A. Charlotte Lozier Institute is an institute
9 dedicated to providing educational materials. And
10 it's a wing of the Susan B. Anthony group, which is
11 hoping to put forth pro-life candidates for public
12 office.

13 THE COURT: Ask her to please speak up. I
14 heard it's a pro-life political group best I could
15 hear.

16 THE WITNESS: Yes, that's a fair
17 characterizations and political and educational.

18 BY MR. FARUQUI:

19 Q. Okay. Have you ever testified in court as an
20 expert witness?

21 A. Yes, I have.

22 Q. Do you recall how many times?

23 A. I've testified in court twice and I've
24 testified by deposition a fair number of times.

25 Q. And your court testimony what was the subject

1 matter of the testimony at those times?

2 A. In one case it was regarding when does human
3 life begin from a scientific perspective. And in one
4 case it was the scientific basis for understanding the
5 experience of fetal pain.

6 THE COURT: I'm sorry. I just can't hear her
7 or understand what she's saying.

8 THE COURT REPORTER: I need her to speak up,
9 Your Honor.

10 THE COURT: Yes. She's a soft-spoken person,
11 which lots of people are. Court tends to make you
12 speak softer sometimes.

13 THE WITNESS: I will do my best to speak up.
14 Is that better, sir?

15 THE COURT: Yes. Just if I can hear her I
16 guarantee you the court reporter can.

17 MR. FARQUI: Thank you, Your Honor.

18 BY MR. FARQUI:

19 Q. So you've attached your CV to your expert
20 declaration. Does the CV contain a more thorough
21 summary of your qualifications and experience?

22 A. Yes, it does.

23 Q. Dr. Condic, can you tell the Court how you
24 became involved in this case?

25 A. I was contacted by the attorneys representing

1 the State of Florida and asked whether I would provide
2 expert testimony on topics of when human life begins
3 and on the topic of fetal pain.

4 THE COURT: Can I have sidebar with counsel?
5 I don't think we need the court reporter.

6 (An off-the-record discussion was held out of
7 the presence of the court reporter.)

8 THE COURT: We're going to take a ten-minute
9 break.

10 (A recess was taken from 1:34 p.m. to 1:45
11 p.m.)

12 THE COURT: You may proceed.

13 MR. FARQUI: May it please the Court.

14 THE COURT: Yes.

15 BY MR. FARQUI:

16 Q. Dr. Condic, we left off talking about how you
17 got involved in this case. Are you being compensated
18 for your time working on this case?

19 A. Yes, I am.

20 Q. And are those rates specified in your
21 declaration?

22 A. Yes, they are.

23 Q. What were you asked to do for this case?

24 A. I was asked to provide expert testimony on
25 when human life begins and on fetal pain.

1 Q. What did you consider in formulating your
2 opinions?

3 A. I considered my own personal experience, my
4 research experience, my teaching over 25 years in the
5 medical school, and the current scientific literature.

6 Q. Okay. Let's talk about when life begins.
7 What is your opinion on when life begins
8 scientifically?

9 A. I think the conclusion that life begins at
10 the instant of sperm-egg fusion is scientifically
11 incontrovertible.

12 THE COURT: I'm sorry, but how is that
13 relevant to this case?

14 MR. FARQUI: Your Honor, we'll reserve --

15 THE COURT: I'm not here to litigate
16 abortion. I'm here to litigate the right of
17 privacy in Florida. I'm not here to litigate Roe
18 versus Wade. But what is -- what's the relevancy
19 of that issue here because Florida says under HB5
20 that abortions can be decisions can be made to
21 receive an abortion up to 15 weeks without using
22 any of the exceptions post 15 weeks. Does the
23 decision on when life begins does that enter into
24 does the State of Florida say life begins at the
25 moment the sperm meets the egg, or does the State

1 of Florida take an official position on that? And
2 how does that relate to the status quo that's in
3 effect at least as of until July 1. Because when
4 life begins is a topic that's been talked about
5 for as your co-counsel says at least 50 years.

6 MR. FARQUI: So, Your Honor, the question of
7 when life begins is going to be relevant to the
8 State's interest in the regulation.

9 MR. PERCIVAL: Your Honor, I'll just add part
10 of what we're doing in this case, Your Honor, is
11 you know we clearly preserved arguments for
12 appeal. There are arguments we want to make about
13 revisiting Florida precedent and we believe that
14 we have the right to create a record that
15 facilitates any arguments we would make on appeal
16 with respect to a revisiting of precedent.

17 THE COURT: Okay. I get that. All right.
18 Let's do that. How much how long are we going to
19 devote to this topic of when life begins?

20 MR. FARQUI: I was hoping to get that done in
21 about 10 to 15 minutes.

22 THE COURT: Okay. Well, go ahead. You've
23 given a sufficient reason to justify. That's why
24 I said another day in addition to today so that we
25 could have time to explore all these issues. So

1 you may proceed. I totally understand the State
2 wanting to set a record to ask the Supreme Court
3 to change those three opinions. That's the
4 Supreme Court's. That's in the category that's
5 their business not my business. So I understand
6 your comment on that. So you may proceed.

7 MR. FARUQUI: Thank you, Your Honor.

8 BY MR. FARUQUI:

9 Q. Now, you mentioned that there's a consensus
10 among scientists that life begins at sperm-egg fusion.
11 Can you tell us what happens after sperm-egg fusion?
12 I'm sorry. I think I said infusion. What I meant was
13 fusion.

14 A. After sperm-egg fusion those two cells give
15 rise to a single cell. That is known as the one cell
16 embryo or zygote. The zygote enters into a period of
17 a very rapid cell division generating an eight cell
18 embryo known as the morula stage of development by
19 about day two to three. By about day five the embryo
20 has grown to approximately 100 cells and it has formed
21 a structure known as the blastocyst stage. And that's
22 when implementation typically occurs. After that the
23 next seven, seven and a half weeks is the period of
24 embryonic development where all of the tissues,
25 organs, and structures of the embryo of a mature body

1 are formed albeit in very small size. And the
2 remaining period of prenatal life is known as the
3 fetal period where the organs and structures will grow
4 in size. They will mature biochemically, but you will
5 not produce any new organs or structures.

6 Q. And let's go back to zygote. Is the zygote
7 considered a new cell type?

8 A. Yes.

9 Q. And could you briefly explain why?

10 A. Scientist use two very simple criteria to
11 determine when a new cell type forms either in the
12 laboratory or in the process of normal development.
13 Those criteria are changes in the composition of the
14 cell, so what the cell is made out of. Typically that
15 reflects a change in gene utilization and changes in
16 cell behavior. And often those two things go
17 together. So that if you change what a cell is made
18 out of you will also change what the cell is capable
19 of doing.

20 Q. Is the zygote considered a new human being?

21 A. Similarly to how we decide if there's any
22 subtype there are clear criteria and I should note
23 that the zygote clearly meets both of the criteria for
24 being a new cell type. It has a change in its
25 composition because it is made of up everything that

1 used to be in both the egg and the sperm and very
2 rapidly it enters into within one or two minutes of
3 sperm-egg fusion into a novel pattern of behavior that
4 is never seen in either an egg or a sperm cell. So it
5 is clearly a new cell. Your question is whether it's
6 also a new human being and the scientific criteria to
7 distinguish between cells and human beings is also
8 very well agreed upon. A living being is an entity
9 that consists of parts and all of those parts work
10 together to autonomously direct maturation and
11 continued health of the entity as a whole. So we
12 distinguish between collection of cells or a clump of
13 cells and a living human being by examining how do the
14 cells of that entity interact with each other. And
15 based on an enormous body of data from the one-cell
16 stage forward the human embryo behaves in an
17 integrated self-regulating manner to direct its own
18 development. It's unambiguously an organism or a
19 human being.

20 Q. Dr. Condic, does the fact that an embryo is
21 dependant on the mother change your opinion on when a
22 new human life begins?

23 A. All living organisms are dependant on things
24 outside of their bodies. We in this room are
25 dependant on oxygen and food to survive. And it is

1 certainly a fact of evolution that has given us a
2 million creatures like ourselves that for a brief
3 period of our life we are dependant upon resources
4 supplied by a mother, oxygen, food, waste removal to
5 continue in healthy form. But the mother does not
6 provide any instructed information to the embryo. The
7 mother doesn't direct the development of the embryo or
8 determine other than by perhaps limiting nutritional
9 factors how development proceeds.

10 Q. Okay. So we talked about the first part of
11 your opinion. Let's talk about the second part fetal
12 pain. Dr. Condic, at what point during prenatal
13 development is a fetus capable of experiencing pain?

14 A. So pain has many different dimensions. The
15 simplest possible definition of pain is the ability to
16 detect and respond to a potentially damaging or
17 noxious stimulus. And that simplest form of pain
18 often called reflexion response or nociceptive pain
19 the circuitry of the nervous system that's capable of
20 detecting and responding to typically withdrawing from
21 a potentially damaging stimulus that circuitry is in
22 place in human development between 8 and 10 weeks of
23 life or 10 to 12 weeks LMP.

24 Q. And at what point can a fetus be consciously
25 aware of pain?

1 A. It's difficult to determine what the
2 psychological and mental state of a fetus might be
3 because we can't communicate effectively with a fetus.
4 What I can tell you is we know from Neural Development
5 a number of facts about what structures are in place
6 when and we know what those structures do at more
7 mature stages of human life. So based on that
8 evidence the circuitry that exists within the
9 subcortical regions of the brain particularly in the
10 thalamus appear to be sufficient for a fetus to have
11 self-awareness and consciousness and to experience
12 pain in a manner that reflects an understanding of
13 pain at the level of awareness or self-consciousness
14 and that would happen between 12 to 18 weeks of life
15 or 14 to 20 weeks LMP.

16 THE COURT: I'm going to have to ask the
17 witness some questions. So, Doctor, that was 12
18 to 16 weeks; is that right?

19 THE WITNESS: 12 to 18 weeks.

20 THE COURT: So it's your testimony that the
21 State of Florida has decided to allow abortions
22 when the fetus had the ability for self-awareness,
23 consciousness and awareness of pain because
24 15 weeks is within your time frame? It's three
25 weeks past 12 weeks. Is that your position?

1 MR. FARQUI: Your Honor, I have some
2 follow-up questions to her testimony that will
3 help clarify.

4 THE COURT: She said pain 10 to 12 weeks and
5 that's within the 15 weeks provided by the
6 legislature, so how can that be a basis for your
7 position unless you're not going to accept your
8 expert's position.

9 MR. FARQUI: We will have some follow-up
10 questions that will clarify why.

11 THE COURT: So let me ask this, Doctor, since
12 life begins when the sperm meets the egg is it
13 your opinion that using an IUD is an abortion?

14 THE WITNESS: So it's a difficult question.
15 I'm not an obstetrician or a gynecologist. I do
16 know a fair amount about the mechanism of action
17 for IUDs and they are different depending on the
18 type of IUD employed.

19 THE COURT: But don't most IUDs operate by
20 separating a fertilized egg from the uterine wall?
21 Person back there the blond person says no.

22 THE WITNESS: Some of them do and some of
23 them do not.

24 THE COURT: So are some IUDs abortions then?

25 THE WITNESS: Some IUDs could be considered

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embryocidal so a device that's intended to end the life of an embryo that has already come into existence.

THE COURT: Does birth control in the normal sense of taking a birth control pill is that considered an abortion or interfering with life that exists?

THE WITNESS: Again, the mechanisms of different contraceptive pills are different. The great majority of them work by preventing ovulation, so preventing an egg from being present to undergo fertilization.

THE COURT: That would be prelife then.

THE WITNESS: That would be an action against, which is not anything anyone objects to.

THE COURT: Okay. Are there other types of birth control pills that are available in the market that affect the fertilized egg to keep it from implanting or something like that?

THE WITNESS: The emergency abortion pills, the morning-after pills for example would have the intended effect of both preventing ovulation should ovulation had not occurred and also have the effect of preventing implantation should fertilization have occurred.

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THE COURT: Do you have an opinion on whether the morning-after pill would be prohibited after 15 weeks?

THE WITNESS: Your Honor, I believe you're definitely moving outside my area of expertise. As I said, I'm not a reproductive biologist, and I'm not a physician, and I don't have an expert opinion on that.

THE COURT: I think I just answered my question however because the morning-after pill is only taken in less than 15 weeks.

THE WITNESS: Typically less than 15 weeks.

THE COURT: I don't know that the name is scientifically descriptive, but you're not going to take it 16 weeks after, right?

THE WITNESS: I would ask the physician here to comment.

MR. FARQUI: I have not researched the question, Your Honor.

THE COURT: Okay. I understand. I am struggling with your expert's statement that pain begins in 10 to 12 weeks and self-awareness begins as early 12 weeks yet the State of Florida as decided to allow abortion during those periods. Is that a basis for your opinion abortion should

1 be banned later so there could be pain during part
 2 of the time but not after the fact? Are you
 3 saying that part of the rationalization to
 4 overcome the presumption that exists is to show
 5 that this is to prevent fetal pain the 15 week?

6 MR. FARQUI: I think that part of the
 7 rationale is to prevent conscious awareness.

8 THE WITNESS: Okay. So if the 15-week pill
 9 allows fetal pain for three weeks, is that
 10 consistent with your argument that the purpose of
 11 the 15-week ban is to prevent fetal pain?

12 MR. FARQUI: So I think the analysis is a
 13 little bit more nuance than that and I can have
 14 the doctor explain.

15 THE COURT: Okay. And could you ask your
 16 witness to identify what she means by
 17 self-awareness?

18 THE WITNESS: So I will address the question
 19 of self-awareness and then I will also attempt to
 20 address some of the complexities that counsel was
 21 referring to. So self-awareness is again
 22 difficult to asses in a fetus because we can't
 23 directly communicate with a fetus, but what we can
 24 do is observe fetal behavior using ultrasound.
 25 And to be aware of yourself or to be conscious you

1 have to detect things in the environment. So when
2 you're unconscious or asleep you're not responding
3 to things that are happening about you, you're not
4 distinguishing between different kinds of input.
5 And it's clear from ultrasound recordings of
6 children in the uterus or in the womb fetuses that
7 they are capable of distinguishing between
8 different nursery rhymes that have different
9 syllables. They're capable of learning from past
10 experience. They're capable of distinguishing
11 vibroacoustic noise from music. They respond
12 differently to those different inputs. So they're
13 alert. They're aware. They're conscious.
14 Self-awareness the evidence for self-awareness in
15 the fetus has to do with the same kind of analysis
16 we use in sports. When people are trying to
17 analyze whether an athlete is behaving, their
18 movements are effective, where they're generating
19 force, where they're not, they use an analysis
20 called a kinematic analysis where they analyze the
21 movement and determine its speed, its
22 acceleration, other elements of the movement. Now
23 when you do that kind of analysis on a fetus what
24 you find is that when a fetus is making a movement
25 towards its face it starts off rapidly, it very

1 quickly decelerates, and then touches its face
2 very gently. When it's making a movement towards
3 mom, it couldn't care less. It slams full force
4 into mom with no deceleration. And in twin
5 gestations when a fetus is making a movement
6 towards its co-twin it treats the co-twin as if it
7 was itself. So they are both aware of their own
8 bodies, aware that poking themselves in the eye is
9 not a good thing to do, and also show some degree
10 of social awareness that this other co-resident of
11 the womb is a person like myself or an entity like
12 myself who can experience the same kind of
13 negative feelings I get when I poke myself in the
14 eye. So I'm extrapolating here quite a bit, but
15 the observation of intentional behavior on behalf
16 of the fetus is pretty strong evidence for
17 consciousness and self-awareness.

18 BY MR. FARUQUI:

19 Q. Dr. Condic, I think you just testified a few
20 minutes ago that from 12 to 18 weeks of development
21 the fetus develops the circuitry capable of supporting
22 a conscious awareness of pain, so I have a couple of
23 clarifying questions. When you mentioned 12 to
24 18 weeks is that post fertilization or post last
25 menstrual period?

1 A. In the study of embryology you typically
2 refer to the fetal age which would be post sperm-egg
3 fusion. I try to always also clarify LMP which would
4 be to add two weeks to that. So this is fetal age 12
5 to 18 weeks. LMP 14 to 20 weeks.

6 Q. Can you explain why you've provided a range
7 rather than a specific week?

8 A. For two reasons. There is a fair amount of
9 variation across individuals, so you can't set an
10 absolute point for every individual where a certain
11 neurodevelopmental event will occur. So there is
12 always a range because there's a range in variation in
13 individual humans. Moreover, the nervous system is a
14 relatively slow-developing piece of tissue, so there
15 is a range over which individual cells within the
16 nervous system will establish the appropriate
17 contacts. So in the case of developing the circuitry
18 sufficient to support conscious awareness like most
19 things in the nervous testimony, there's a big the
20 great amount of that circuitry is established early on
21 in range of time. So probably in the first two to
22 three weeks and then there is some stragglers that
23 come in over the next several weeks. So if you were
24 to look and say when does consciousness develop or
25 when does that circuitry mature, you would have to

1 point to that entire range. But the great majority of
2 it would happen early in the range rather than later
3 in the range.

4 Q. You mentioned conscious awareness of pain and
5 earlier you talked about detecting and responding to
6 pain. Can you explain the difference?

7 A. So there are three major divisions of the
8 nervous system and they all play somewhat different
9 roles in pain response. So detection response to
10 pain, nociceptive pain, or reflex response to pain is
11 largely controlled by neurocircuits that exist within
12 the spinal cord. So in the spinal cord there are
13 cells that will receive information from the body,
14 bring it to the spinal cord, and there are other cells
15 that will then cause that region of the body to be
16 withdrawn from the painful stimulus. So that kind of
17 reflex response can occur without consciousness. But
18 it is the earliest type of response to pain that we
19 see. Cells in the spinal cord will then send
20 connections up to subcortical regions of the brain
21 most particularly the thalamus. And it's that place
22 in the nervous system where we first establish a
23 picture of the body as a whole. So what
24 neuroscientists would call a representation of the
25 body. And those circuits are connected between 12 and

1 18 weeks of life or 14 to 20 weeks LMP. And once
2 those connections begin to form we have the capability
3 of self-awareness and consciousness. The latest
4 developing part of the nervous system is the cortex,
5 and the cortex is the part of the nervous system that
6 is largely responsible for what we call executive
7 functions. So language, memory, reasoning, planning,
8 some components, the more analytic components of
9 emotion. And because that part of the brain or the
10 nervous system develops very late, connections between
11 the subcortical regions and the cortex begin to
12 develop around 24 weeks and continue for a very, very
13 long time up to 25 years after birth.

14 Q. Dr. Condic, is there any literature that is
15 widely read that addresses the question of when a
16 fetus is capable of consciously perceiving pain?

17 A. There is an enormous body of literature that
18 addresses that question. The two most commonly
19 referenced articles are the 2005 review by Lee, et al.
20 in the Journal of the American Medical Association,
21 and the 2010 review by the Royal College of
22 Obstetricians and Gynecologists or RCOG published as a
23 monograph.

24 Q. And what do those two papers suggest
25 regarding the question of when a fetus is capable of

1 consciously perceiving pain?

2 A. At the time they were written both papers
3 asserted that connections between subcortical regions
4 and the cortex were necessary for a fetus to
5 experience pain; and therefore, a fetus could not
6 experience pain prior to 24 weeks when those
7 connections begin to be formed.

8 Q. And do you consider those two papers to be
9 persuasive?

10 A. No.

11 Q. And why not?

12 A. First, many of the scientific articles that
13 are cited by those two reviews in support of that
14 conclusion do not in fact support the conclusion or in
15 some cases actually contradict that conclusion.

16 Second, even at the time those reviews were
17 written there were many other reviews that directly
18 disagreed with those conclusions.

19 And third, both of the reviews are
20 significantly out of date and do not reflect a modern
21 understanding of fetal pain experience.

22 Q. Is there any research to support your opinion
23 that the cortex is not necessary for conscious and
24 emotional pain perception?

25 A. Yes. In my report I outline 12 independent

1 lines of research from an enormously broad area of
2 science. These are researchers who have nothing to do
3 with each other, couldn't possibly have been
4 collaborating or trying to create a story, but
5 independently working on very, very different fields
6 have come to have produced evidence in support of the
7 conclusion that the cortex is not required for a
8 conscious experience of pain.

9 Q. Can you just briefly for the Court summarize
10 some of the conclusions in those 12 independent lines
11 of research that you mentioned?

12 A. I'll do what I can from memory, but I might
13 have to refer to my report. So the first five lines
14 of evidence have to do with what do we observe in
15 humans and in animals when they are missing most or
16 all of the cortex. So we know that animals that never
17 develop a cortex, these are the animals like
18 amphibians, reptiles, and birds, those animals have no
19 cortical structures and yet they are clearly
20 conscious. They're not asleep. They're not
21 anesthetized. They're interacting with their
22 environments. And they also clearly experience pain.
23 Similarly animals that naturally have cortex like us,
24 mammals, this would include dogs, cats, and monkeys,
25 and rats, and mice, when you remove their cortex

1 completely those animals remain conscious and remain
2 very responsive to pain.

3 Similarly, humans who as a consequence of a
4 birth defect are missing all or most of their cortical
5 tissue nonetheless are conscious, they are not asleep,
6 and they are pain responsive, they cry out and avoid
7 pain stimulus.

8 Fourth, disorders of consciousness. So there
9 are many cases of disease or injury where people have
10 altered states of consciousness. They're minimally
11 responsive. They're in a comma. They're partially
12 conscious. All of those disorders are typically
13 associated with loss of subcortical circuitry not
14 cortical circuitry.

15 Lastly, our conscious perception of pain
16 remains pretty constant across our lifespan and yet
17 the cortical circuitry is very, very slow developing.
18 So we don't have mature cortical circuitry or all of
19 the circuits in the cortex until we're about 25 years
20 old and yet the pain experiences of children in spite
21 of the fact that they have very, very rudimentary
22 cortical circuitry are quite intense. In fact more
23 intense than adults.

24 So those are 5 lines of evidence out of 12.
25 I can continue if you'd like.

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Q. Yes. And if you need to refer to your report to refresh your recollection, that's appropriate.

A. So the next four lines of evidence have to do with what we know about the normal circuitry of the brain and what it does. So as you can already see, I'm relying on evidence that comes from animal studies, animal evolution, human medical studies, studies of people with disorders of consciousness. So these are very independent areas of research and yet they all support the same conclusion that the cortex is not required for consciousness and for pain.

So I'm going to turn to the next four lines of evidence to what we know about a normal function of the nervous system. So many, many independent lines of work show that emotional feelings including suffering or emotional response to pain, emotional awareness of pain do not require the cortex but are in fact supported by circuits in many different regions of the brain. So it's a very diffuse activity of the nervous system to have emotions. And we share our emotions with animals that have very primitive nervous systems. We know that from about 150 years of research on anesthesia that when an anesthesiologist will knock someone out to cause them to lose consciousness loss of consciousness is associated with

1 loss of subcortical activity not cortical activity.
2 So you fall asleep when your subcortex stops working.
3 Similarly, if you directly test whether the cortex is
4 involved in pain by stimulating different regions of
5 the cortex, so this is data from epilepsy surgery with
6 alert patients, what you find is you almost never get
7 a response to pain from stimulating pain part of the
8 cortex. So only 1.4% of over 5,000 stimulations did
9 they observe any kind of report of a painful
10 experience. And even in those 1.4% that only occurred
11 in 10% of the patients. So it's a very, very rare
12 thing for activity in the cortex to induce an
13 experience of pain.

14 And lastly, we can alter patient's experience
15 of pain by altering the activity in subcortical
16 regions of the brain. The last three lines of
17 evidence have to do with our observations of newborns.
18 So from about 20 weeks it's clear -- so from 20 weeks
19 of gestation -- actually, 20 weeks of fetal life,
20 22 weeks of gestation LMP fetuses have a hormonal and
21 physiologic response to pain that's very similar to
22 what we see in adult patients. Infants born as early
23 as 21 weeks show clear pain-related behaviors, so
24 premature infants will respond to pain stimuli very
25 much in the same way that newborns and young children

1 do. Crying, grimacing, pulling their affected part
2 away. Based on this and also on their knowledge of
3 pain responses most anesthesiologists who are involved
4 in fetal surgery recommend fetal pain relief not
5 simply to keep the babies from moving, but to avoid
6 long term consequences of pain in the fetus that have
7 known neurodevelopmental consequences. So those are
8 the lines of research, all of which suggest that the
9 assumption of the two commonly cited reviews from more
10 than a decade ago that the cortex is required in order
11 to have a conscious awareness of pain are simply not
12 consistent with the evidence.

13 THE COURT: She was distinguishing the two
14 reviews from ten years ago? Could I ask you just
15 to repeat that again?

16 THE WITNESS: One of them is a review written
17 by a committee from the Royal College of
18 Obstetricians and Gynecologists in the United
19 Kingdom, often referred to as the RCOG review, the
20 initials. That was written in 2010. And the
21 other one is a review published in the Journal of
22 the American Medical Association. First author is
23 Lee.

24 THE COURT: 2005.

25 THE WITNESS: 2005.

1 THE COURT: Are both of those journals
2 peer-reviewed?

3 THE WITNESS: The Journal of the American
4 Medical Association is peer-reviewed. This was
5 not a basic research article. It was a review
6 article and the standards for review are somewhat
7 different. The RCOG review was a committee
8 authored piece published by a professional society
9 and it did not undergo peer-review.

10 THE COURT: So the AMA Journal article what
11 did it conclude?

12 THE WITNESS: The Journal of the American
13 Medical Association and my report are in 100%
14 agreement for all of the data that was available
15 at the time. We interpret the data the same and
16 we make the same conclusions with one exception.
17 The Journal of the American Medical Association
18 article, the Lee article asserts without a single
19 reference to any literature or support that most
20 neuroscientists believe that cortex is required
21 for a conscious awareness of pain. So it makes an
22 assertion, but it does not review any literature
23 in support of that assertion.

24 THE COURT: Is this where they said that pain
25 perception probably doesn't function before the

1 third trimester is that the essential?

2 THE WITNESS: This is one of the two review
3 articles that are often used in support of that
4 assertion.

5 THE COURT: RCOG is Royal College; ACOG is
6 American College, right?

7 THE WITNESS: Correct. If I may, Your Honor,
8 RCOG does actually cite three articles in support
9 of that central difference between what I'm
10 asserting, what I am providing evidence for and
11 their assertion that the cortex is required. They
12 provide three papers supporting that assertion.
13 One of them is a study of resting brain activity
14 in infants, and it does not in anyway address the
15 pain experience of infants. The second study is a
16 study of adults and pain perception in adults, and
17 it actually concludes in contrast to RCOG's
18 conclusion that pain is represented by multiple
19 circuits in the nervous system only one of which
20 is the cortex, and it does not in anyway suggest
21 that the cortex is necessary. The third paper is
22 a paper published in 2003, and that paper actually
23 directly contradicts the conclusion that RCOG uses
24 it in support of. It was a study with adults
25 where they took ten volunteers who were very

1 sensitive to pain stimulus, ten volunteers who
2 were relatively incentive. All of them
3 experienced pain. And then they gave them a
4 painful input and recorded where their nervous
5 system was active. And what they found is all of
6 the subjects who experienced pain had activity in
7 the thalamus, and only the subjects who were very
8 sensitive to pain had activity in the cortex. A
9 result that directly proves you do not need
10 cortical activation in order to experience pain.
11 So it does suggests that for people who are very
12 sensitive to pain the cortex is doing something to
13 enhance that pain experience. Perhaps making
14 associations with bad experiences or fear or bad
15 memories that they have regarding pain. But it is
16 certainly not a necessary piece of circuitry in
17 order to experience pain.

18 THE COURT: The group that you are affiliated
19 with is one of many I'm sure not the only is it
20 Charlotte Lozier Institute?

21 THE WITNESS: Yes, sir.

22 THE COURT: Does it have position on these
23 issues?

24 THE WITNESS: On fetal pain?

25 THE COURT: Yes, ma'am.

1 THE WITNESS: Help me out here. I think no.
2 I don't think they have an official position, no.

3 THE COURT: They don't have a fact sheet that
4 states what you just told me.

5 MS. CHRISTMAS: They do.

6 THE WITNESS: They do. Okay. I'm sure I --

7 MS. SANDMAN: Objection, Your Honor.

8 THE COURT: On what? What I asked or what?

9 MS. SANDMAN: Objection to Counsel.

10 MR. GUARD: I've instructed the witness not
11 to answer.

12 THE COURT: Okay. She's fine. Overruled.
13 She didn't say anything that you know this is
14 nonjury so I understand. Go ahead, Counsel. I
15 think we interrupted you, Doctor, a little bit, so
16 I apologize for that. You can complete any
17 thoughts you want.

18 THE WITNESS: That's perfectly fine. I'm
19 asked by Charlotte Lozier very rarely to provide
20 scientific data or analysis of information they
21 present to me. I've never been involved in
22 writing material for their public release.

23 MR. FARUQUI: May it please the Court?

24 THE COURT: Yes.

25 BY MR. FARUQUI:

1 Q. Forgive me, Dr. Condic, if I'm retreading old
2 ground, but I wasn't sure if you concluded your last
3 answer from a couple questions ago. Would you mind
4 taking a look on page 39 at paragraph 85 of your
5 report and explain that line of research as well?

6 THE COURT: Page 39. Okay.

7 THE WITNESS: Paragraph 85?

8 BY MR. FARUQUI:

9 Q. Yes.

10 A. So this was simply the last line of evidence
11 that I was noting that professional anesthesiologists
12 who are providing in utero surgery for fetuses
13 recommend fetal pain relief not only due to the
14 desirability of keeping the fetus from moving during
15 surgery, which is certainly one of the reasons that
16 fetuses are anesthetized, but many of the expert
17 reviews from anesthesiologists in this field
18 specifically cite the need to prevent a fetal
19 experience of pain because it's well-understood that
20 early painful experiences can impact subsequent
21 development of the nervous system.

22 Q. And I just have a couple more questions,
23 Dr. Condic, but you may have sort of partially
24 addressed some of them. Is there empirical evidence
25 of fetal consciousness in the second trimester?

1 A. Yes. I've already mentioned several of the
2 studies that have to do with observing fetal behavior.
3 They're believed to distinguish between similar kinds
4 of sensory input. Their ability to recognize the
5 difference between their faces and mom's uterine wall
6 or their face and their co-twin's face. So they show
7 intentional behavior. They show self-awareness and
8 clear consciously mediated behavior that is not
9 consistent with it being simple reflex or with the
10 fetus not having consciousness.

11 Q. Can you just describe the sorts of tests that
12 research derives from?

13 A. Typically, these are studies looking with 3D
14 ultrasound, so you've got a surface view of the
15 fetus's face. It's well-established throughout early
16 infancy and childhood that increases in activity or
17 changes in activity can detect or illustrate when an
18 individual sees something as different. So a startle,
19 an increase in facial movement, eye movement, other
20 types of activity will show when a fetus thinks it's
21 hearing something different or experiencing something
22 different. And they use those kinds of readouts to
23 see if fetuses recognize the difference between noise
24 and music for example.

25 Q. And is there really a consensus in the

1 scientific community that fetuses cannot consciously
2 experience pain until after the second trimester?

3 A. I think the answer is no. There is not a
4 consensus that they cannot.

5 Q. And can you explain why you believe there's
6 not a consensus?

7 A. I believe there's not a consensus because
8 modern reviews of literature have clearly drawn
9 different conclusions. As recently as 2022 there was
10 a review by two authors, Derbyshire and Brockman.
11 Derbyshire was actually one of the main
12 neuroscientific authors of the RCOG review in 2010.
13 And at that time he strongly supported the conclusion
14 that a fetus could not experience pain prior to
15 24 weeks, but in 2022 he reversed his position. He's
16 still strongly pro-choice, but his conclusions on
17 fetal pain experience is that the evidence and a
18 balanced reading of the evidence supports the
19 conclusion that a fetus experiences pain as early as
20 12 weeks.

21 MR. FARQUI: Your Honor, I do not have any
22 additional questions for this witness.

23 THE COURT: Okay. Cross.

24 MS. SACERDOTE: For the record, Your Honor,
25 my name is Caroline Sacerdote. I'm with the

1 Center for Reproductive Rights, and I'm here for
2 the Plaintiffs.

3 THE COURT: Okay. Thank you.

4 **C R O S S - E X A M I N A T I O N**

5 BY MS. SACERDOTE:

6 Q. Good afternoon, Dr. Condic. You testified in
7 direct that you have testified in other cases,
8 correct?

9 A. Yes.

10 Q. This isn't the first time you've testified in
11 support of a law that regulates abortion or abortion
12 providers, correct?

13 A. This is not the first time I have been asked
14 to testify and have testified, yes.

15 Q. In fact, you've testified in multiple other
16 cases concerning abortion restrictions in the past
17 four years, right?

18 A. Yes.

19 Q. And in each of those cases you provided
20 testimony on the topic of fetal pain?

21 A. Within the last four years, I believe that's
22 correct.

23 Q. You haven't published any peer-reviewed
24 articles on the topic of human fetal pain, correct?

25 A. Correct.

1 Q. And none of the research and review articles
2 that you list on your CV are on the topic of human
3 fetal pain?

4 A. I'm an animal biologist. I do not work on
5 humans.

6 Q. So none of the books or book chapters that
7 you list on your CV have a primary focus on the topics
8 of human fetal pain either?

9 A. Correct.

10 Q. So it's fair to say that the vast majority of
11 your research is not on the topic of human fetal pain?

12 A. That is correct. My academic research that
13 has been published is not on the topic of human fetal
14 pain.

15 Q. And the vast majority of everything that you
16 have written on this topic has been in response to
17 requests for expert reports and testimony in legal
18 proceedings?

19 A. Correct.

20 Q. Dr. Condic, you testified on direct that
21 you're not a physician, correct?

22 A. Correct.

23 Q. You've never provided clinical care to either
24 adults or babies?

25 A. Other than my own children, no.

1 Q. So no clinical care?

2 A. No clinical care.

3 Q. And you have no professional experience
4 working directly with newborns?

5 A. No professional experience, correct.

6 Q. And no professional experience observing
7 newborns?

8 A. Correct.

9 Q. On direct I believe you describe nociception
10 as the most basic ability to detect and respond to
11 painful or a noxious stimulus; is that correct?

12 A. Correct.

13 Q. And you say that there is a distinction
14 between nociception and the conscious awareness of
15 pain?

16 A. Yes.

17 Q. And that's an important distinction?

18 A. From the perspective of science and the
19 behavior of the nervous system, the response to pain
20 exists pretty much in a continuum, so it's an
21 important conceptual distinction and to some extent
22 it's an important physiologic distinction. But would
23 I call it in a global term an important distinction,
24 it depends on what your question is.

25 Q. A reflex response does not necessarily mean

1 | there is a conscious awareness of pain, correct?

2 | A. Correct.

3 | Q. And consciousness is not required for a
4 | hormonal stress response?

5 | A. Hormonal stress response does not require
6 | consciousness.

7 | Q. You testified also on direct that the neuro
8 | connections between the thalamus and the cortex don't
9 | develop until 24 to 26 weeks LMP, correct?

10 | A. That is generally accepted.

11 | Q. And you understand LMP to be short for last
12 | menstrual period?

13 | A. Correct.

14 | Q. The earliest point at which cells within the
15 | cortex could be responsive to noxious stimuli would be
16 | 24 to 26 weeks LMP, correct?

17 | A. I have to qualify my answer just a tiny bit
18 | because there is a structure below the cortex known as
19 | the subplate and the function and development of that
20 | region has not been well-appreciated until recently.
21 | And in fact, the main basis for Derbyshire changing
22 | his opinion on fetal pain was the early development of
23 | the subplate structures which are considered a
24 | transient cortical structure. So that region of the
25 | nervous system develops very early and is certainly in

1 place between 12 and 18 weeks.

2 Q. My question, Dr. Condic, is whether the
3 earliest point at which cells within the cortex could
4 be responsive to noxious stimuli?

5 A. If you consider cells of the subplate to be
6 cortical cells, which is one of the definitions of
7 that region of the nervous system, then, no, you're
8 wrong. The earliest point at which cells within the
9 cortex could be responsive to pain would be 12 weeks.
10 If you consider as some people do the subplate to be a
11 structure that is a precursor to the cortex because
12 it's transient, it does not persist into adult stages,
13 then cells that are currently in your cortex, yes, the
14 earliest time point at which those cells could be
15 responsive would be about 24 weeks.

16 Q. You were deposed in a Utah case regarding
17 abortion restrictions in September of 2020, correct?

18 A. Correct.

19 Q. That was for a case called Planned Parenthood
20 Association of Utah versus Miner?

21 A. I will trust you on that, yes.

22 Q. Your testimony in that deposition was under
23 oath?

24 A. Correct.

25 Q. So you understood that you were required to

1 tell the truth?

2 A. Yes.

3 Q. And you did in fact tell the truth?

4 A. Yes.

5 Q. So I'm going to ask Plaintiff's counsel to
6 hand you what's been marked Condic 3. So I'd like you
7 to start by taking a look at page 1 of this document.

8 A. Yes.

9 Q. This is the transcript of the deposition I
10 just referenced, correct?

11 A. It appears to be, yes.

12 Q. Page 1 has a caption that says Kaitlyn --
13 excuse me. It think I might have pulled up the wrong
14 document. One moment, please.

15 A. The document I have says, Planned Parenthood
16 Association of Utah versus Joseph.

17 Q. Well, that's great. So you have the right
18 document, I don't.

19 THE COURT: I do, too.

20 BY MS. SACERDOTE:

21 Q. Okay. So this document states, Planned
22 Parenthood Association of Utah versus Miner, correct?

23 A. Correct.

24 Q. And it reflects that you were deposed on
25 September 14, 2020?

1 A. Correct.

2 Q. So now I'll ask you to turn to page 119?

3 A. Yes.

4 Q. So I'll direct your attention to line 3 and
5 I'll read starting from there and I'll ask that you
6 follow along with me. Excuse me. I should start at
7 line 22 on page 118 right above there.

8 A. Yes.

9 Q. So starting at 118 line 22.

10 Question: So the 24 to 26 weeks that what
11 does that represent in terms of cortical development?
12 Is that sort of the earliest point at which there is
13 some connection between the thalamus and the cortex?

14 Answer: Correct.

15 Question: Okay.

16 Answer: So what I said originally is that if
17 if you are asking me what is the earliest point in
18 time at which cells within the cortex could be
19 responsive to noxious stimuli, the earliest point
20 in time where that could occur would be 24 to
21 26 weeks.

22 Did you I read that correctly?

23 A. You did.

24 BY MS. SACERDOTE:

25 Q. You can set that document aside. So you

1 would agree that if the cortex is necessary to have a
2 conscious awareness of pain then such an awareness
3 would not be possible until 24 weeks LMP, correct?

4 A. With the caveat that I've already noted
5 depending on how you view this transient subplate
6 structure whether it's cortical or not cortical. So
7 with the definition of cortex as being the cells that
8 currently reside within your cortex today as an adult
9 human, yes, I would agree.

10 Q. So setting aside the subcortical structures
11 you just referenced?

12 A. The subplate structures.

13 Q. Thank you. I'll start again. Setting aside
14 the subplate structures you just referenced you would
15 agree that if the cortex is necessary to have a
16 conscious awareness of pain then such an awareness
17 would not be possible until 24 weeks LMP, correct?

18 A. If the cortex was necessary, yes.

19 Q. It is your opinion that it is difficult to
20 make a clear, unambiguous case that the neurocircuitry
21 for a fetus to have a conscious awareness of pain is
22 in place by 18 weeks LMP; is that right?

23 A. It is my opinion that it is difficult to make
24 a clear, unambiguous judgment on internal experience
25 of any other human at any stage in life. And that

1 would include a fetus at any stage of development not
2 because of the uncertainty of the data, but because of
3 our inability to query the fetus regarding its
4 experience.

5 Q. So it would be accurate to say it is your
6 opinion that it is difficult to make a clear,
7 unambiguous case that the neurocircuitry for a fetus
8 to have a conscious awareness of pain is in place by
9 18 weeks LMP, correct?

10 A. No.

11 Q. So I'll ask you to turn to that Utah
12 deposition again. The case is Planned Parenthood
13 Association of Utah versus Miner, and this time I'll
14 ask you to turn to page 268.

15 A. I'm there.

16 Q. Okay. I'll ask you to look at line 5. I'll
17 read from there and ask you to follow along.

18 Question: So, Dr. Condic, would you say that
19 18 weeks LMP it's hard to make a clear, solid,
20 unambiguous case that we have the neurocircuitry in
21 place for a fetus to have a conscious awareness of
22 pain?

23 Answer: Clear and unambiguous, yes, I would
24 say it's difficult to make that case.

25 Question: At 18 weeks LMP, correct?

1 Answer: Yes.

2 Did I read that correctly?

3 A. You did.

4 BY MS. SACERDOTE:

5 Q. You can set that aside for now. So on direct
6 you addressed ACOG's views on the issue of human fetal
7 pain, correct?

8 A. RCOG's views, yes.

9 Q. Excuse me. So in your declaration you
10 addressed ACOG's views on the issue of human fetal
11 pain, correct?

12 A. I believe in my declaration I noted that ACOG
13 has reiterated the conclusions of RCOG and has
14 published an opinion piece without evidence. But I
15 did not discuss ACOG's position beyond the fact that
16 they reference RCOG.

17 Q. In your declarations you characterize ACOG's
18 conclusions regarding human fetal pain as perplexing,
19 correct?

20 A. I believe so.

21 Q. So you disagree with ACOG's views on human
22 fetal pain?

23 A. In light of substantial evidence that I
24 present in my declaration, I believe their conclusion
25 is perplexing because it relies on no evidence.

1 THE COURT: I know what ACOG is, but I want
2 to make sure we have this on the record. ACOG is
3 American College of Obstetricians and
4 Gynecologists, correct?

5 THE WITNESS: Correct.

6 THE COURT: And most board certified OB-GYNs
7 are members of ACOG? I say most. I can't say all
8 about anything.

9 THE WITNESS: I am not an obstetrician or
10 gynecologist. I'm not familiar with what level of
11 representation they have.

12 THE COURT: That's fine. RCOG again is the
13 British version of ACOG because it's Royal
14 College.

15 THE WITNESS: Yes.

16 THE COURT: Thanks.

17 BY MS. SACERDOTE:

18 Q. It's your view that ACOG likely has a
19 significant conflict of interest on the topic of fetal
20 pain?

21 A. No, I believe it's possible they have a
22 conflict of interest.

23 Q. Dr. Condic, I asked if it's your view that
24 ACOG likely has a significant conflict of interest on
25 the topic of fetal pain, and did I hear you say that

1 your answer to that question is no?

2 A. May I consult my report to see exactly how I
3 worded it?

4 Q. Let's all take a look at your report.

5 THE COURT: I think she said, no, it's
6 possible they have a conflict of interest.

7 THE WITNESS: Yes, that was certainly my
8 intention.

9 THE COURT: I don't know what the report says
10 on that specific point, but that is what she
11 answered here.

12 MS. SACERDOTE: Thank you, Your Honor.

13 BY MS. SACERDOTE:

14 Q. So let's all take a look at the declaration
15 that you submitted in this case. So please turn to
16 page 25, paragraph 62. Looking at paragraph 62 I'll
17 read starting at the first sentence.

18 In considering this paradox, it's important
19 to note that RCOG and ACOG represent the primary
20 providers of abortion services both in the United
21 States and the United Kingdom, and therefore the views
22 of these societies are likely to entail significant
23 conflicts of interest. Did I read that correctly?

24 A. You did.

25 Q. You can set that aside. And so it is also

1 your view that RCOG likely has a conflict of interest
2 as well?

3 A. Based on my understanding of a conflict of
4 interest, the type of conflict of interest statements
5 I'm required to make as a professor in the University
6 of Utah, this would certainly constitute a likely
7 conflict of interest.

8 Q. On direct you discussed three studies cited
9 by RCOG, correct?

10 A. Yes.

11 Q. And you still have your declaration in front
12 of you, right?

13 A. Yes.

14 Q. So now I'd like to turn to page 25, paragraph
15 65.

16 A. Yes.

17 Q. So in this paragraph you talk about three
18 studies, correct?

19 A. Yes.

20 Q. And the second study and I'll read from this
21 paragraph. The declaration states, The second study,
22 conducted in adults, demonstrates that multiple
23 non-cortical regions are involved in pain perception.
24 There is a parenthetical and then the sentence goes
25 on. And provides no evidence that the cortex is

1 critically required for pain perception, correct?

2 A. Yes.

3 Q. There is a footnote 70 there, correct?

4 A. Yes.

5 Q. And the article referenced or cited in
6 footnote 70 is Rosen, S.D. and Camici PG, The
7 Brain-Heart Axis in the Perception of Cardiac Pain.
8 Is that correct?

9 A. Yes.

10 Q. I'm going to ask Plaintiff's counsel to again
11 hand you a document. This time it's what's been
12 marked Condic 14.

13 THE COURT: Let me guess. That's Rosen and
14 Camici's article.

15 MS. SACERDOTE: Yes. Excellent guess.

16 BY MS. SACERDOTE:

17 Q. So I'll ask the witness, looking at the first
18 page of the document that's now before you it's
19 titled, The Brain-Heart Axis in the Perception of
20 Cardiac Pain The Elusive Link Between Ischaemia and
21 Pain, correct?

22 A. Yes.

23 Q. And this is the Rosen article that we just
24 referenced?

25 A. Yes.

1 Q. So if you turn to page 362, under the heading
2 of Unified Perspective, which is in the left column.
3 Excuse me. I'll ask you to look in the left column
4 under the heading Unified Perspective?

5 A. Yes.

6 Q. So I'm looking at the third line from the
7 bottom and I'm going to read from that article. The
8 thalamus may have a key role in the perception of pain
9 from the heart acting as a gate to afferent pain
10 signals with cortical activation being necessary for
11 the sensation of pain. Did I read that correctly?

12 A. You did.

13 Q. You can set that aside. In your direct
14 testimony you also discussed an article published in
15 Jama authored by Lee and other authors, correct?

16 A. Yes.

17 Q. And the Lee review's conclusion was that
18 certain functional regions in the cortex are required
19 to experience pain, correct?

20 A. I will assume that they said that at some
21 place in their article. That is their general
22 conclusion, yes.

23 Q. And it's your view that the authors of the
24 Lee review also likely have a significant conflict of
25 interest?

1 A. Some of the authors, yes.

2 Q. You're familiar with the Society for
3 Maternal-Fetal Medicine?

4 A. Yes.

5 Q. You are aware that the Society for
6 Maternal-Fetal Medicine has a view on the potential
7 for fetal awareness of pain?

8 A. Yes. Recently published, yes.

9 Q. But you disagree with that view?

10 A. I disagree with that view, yes.

11 Q. And you chose not to include the Society for
12 Maternal-Fetal Medicine's view in your declaration?

13 A. I made the judgment that my declaration was
14 already quite long. Yes, so I did omit that
15 particular paper. I believe that it is I address it
16 that the reasons I do not find that argument
17 persuasive are very similar if not identical.

18 Q. And you did not cite to the Society for
19 Maternal-Fetal Medicine document in your declaration,
20 correct?

21 A. I did not.

22 Q. You aren't aware of any medical or scientific
23 professional organizations that have concluded that a
24 fetus has a capacity to consciously experience pain
25 prior to 24 weeks gestation; are you?

1 A. I am not a physician and I'm not familiar
2 with the positions of all medical professional
3 organizations.

4 Q. And you can't identify a single medical or
5 scientific professional organization that has
6 concluded that a fetus has a capacity to consciously
7 experience pain prior to 24 weeks LMP, correct?

8 A. As I stated I'm not a medical professional.
9 I'm not familiar with positions of all medical
10 organizations that I am not familiar with anyhow.

11 Q. On direct you discussed 12 lines of evidence
12 that you say clearly indicate that the cortex is not
13 required for consciousness, correct?

14 A. I identified 12 lines of evidence that
15 provide support for that conclusion, yes.

16 Q. But you don't assert that the authors of each
17 of those studies in these 12 lines of evidence reach
18 the same conclusion that you do, correct?

19 A. May I ask for a clarification? Are you
20 asking me whether I assert the authors make a
21 statement within the papers to the effect that the
22 cortex is not required for fetal pain?

23 Q. I'm asking you whether the authors of the
24 sources that you cite in your declaration or your
25 proposition that a fetus can consciously experience

1 pain prior to 24 weeks agree with your conclusion on
2 that point?

3 A. I have no idea what the author's saying. I
4 know what they've written.

5 THE COURT: What page are we on on her
6 report?

7 MS. SACERDOTE: Your Honor, I am not
8 referring to a specific page. The question I'm
9 asking relates to the 12 lines of evidence cited
10 within her declaration.

11 THE COURT: Okay.

12 MS. SACERDOTE: And throughout the portions
13 of her declaration that discuss these 12 lines of
14 evidence a number of articles are cited.

15 THE COURT: Okay. I understand.

16 BY MS. SACERDOTE:

17 Q. It's your view that the kind of proof needed
18 to prove a fetus experiences pain is not possible with
19 any scientific evidence?

20 A. It's my opinion that it is impossible with
21 scientific evidence to prove that any human
22 experiences pain including a human fetus.

23 Q. You discussed on direct a Derbyshire and
24 Brockman article, correct?

25 A. Yes.

1 Q. And is that an article titled, Reconsidering
2 Fetal Pain?

3 A. Correct.

4 Q. In that article the authors question the
5 necessity of the cortex for the apprehension of pain,
6 correct?

7 A. Yes.

8 Q. And Derbyshire and Brockman do not state in
9 their article that this immediate apprehension has a
10 conscious component, correct?

11 A. The term apprehension is used in neuroscience
12 to refer to a conscious emotional awareness that does
13 not necessarily reflect a cognitive component. So
14 they're making no assertion regarding whether or not a
15 fetus thinks about painful experiences, but they are
16 asserting that the fetus apprehends pain which means
17 it has a conscious emotional awareness of pain.

18 Q. I understand that that's your conclusion,
19 Dr. Condic. What I'm asking is whether Derbyshire and
20 Brockman state that this immediate apprehension that
21 they discussed has a conscious component?

22 A. That is what the meaning of the term
23 apprehension is when it's used in scientific context.

24 Q. Do the authors say that this immediate
25 apprehension has a conscious component?

1 A. The authors do not need to define a cognitive
2 neuroscientific term within the context of the
3 published article. They simply use it with the
4 assumption that the reader will understand what it
5 means.

6 Q. So they don't say that an immediate
7 apprehension of pain has a conscious component?

8 A. They do not define the word apprehension,
9 yes.

10 Q. You testified on direct that you're
11 affiliated with the Charlotte Lozier Institute?

12 A. Yes.

13 Q. The Charlotte Lozier Institute's stated
14 mission is to diminish and ultimately overcome what
15 its mission characterizes as the scorch of abortion;
16 is that correct?

17 A. I will trust that that is their mission.

18 Q. You testified on direct that you characterize
19 yourself as pro-life?

20 A. I don't believe I testified to that.

21 Q. Excuse me. You would characterize yourself
22 as pro-life?

23 A. I would characterize myself as a scientist
24 and the scientific evidence has lead me to conclude
25 that a human being exists from sperm-egg fusion and is

1 capable of pain experience. And those two conclusions
2 have lead to me a position that protecting life is an
3 important interest.

4 Q. It is your view that abortion should not be
5 legal except when a pregnant person's life is at
6 stake?

7 A. No.

8 Q. Okay. You were deposed in a North Carolina
9 case regarding abortion in September of 2017, correct?

10 A. I will trust you on that.

11 Q. Well, let's see. Plaintiff's counsel is
12 going to hand you what's been marked Condic 15, so
13 I'll ask you to look on the first page in the top left
14 corner of the document that you were just handed.

15 A. Yes.

16 Q. The first page states that this is a
17 deposition of Maureen Condic, correct?

18 A. Yes.

19 Q. In a case captioned Amy Bryant versus Jim
20 Little, correct?

21 A. Yes.

22 Q. And it's dated September 13, 2017?

23 A. Yes.

24 Q. And I should specify the document reflects
25 that the deposition was taken on September 13, 2017,

1 correct?

2 A. Yes.

3 Q. So please turn to page 198.

4 A. Which page number are you referring to?

5 MS. SACERDOTE: Sure. This is one of the
6 four panel deposition transcripts. Apologies to
7 the court.

8 THE COURT: That's okay.

9 BY MS. SACERDOTE:

10 Q. So I am looking at within the four squares
11 the page numbers listed in those four squares and
12 we're turning to page 198.

13 A. Yes, I'm here.

14 Q. So I'll start reading at line 4 and then I'll
15 skip some lines where the attorney and reporter are
16 speaking and start again at line 12, and I'll ask that
17 you follow along.

18 So line 4, Question: Well, do you think that
19 abortion should ever be legal when a woman's life
20 isn't at stake?

21 Line 12: The Witness: Excuse me while I try
22 to run through all possible circumstances under which
23 that situation could occur.

24 Question: Please take your time.

25 Answer: With a caveat in the absence of

1 extremely extenuating circumstances that I cannot
2 imagine that might alter my opinion, I would say, no,
3 abortion should not be legal in situations where a
4 woman's life is not threatened immediately.

5 Did I read that correctly?

6 A. Yes, you did.

7 Q. And you can set that aside. You believe that
8 abortion is the killing of a living human being?

9 A. Yes.

10 Q. And you believe that abortion is the killing
11 of a full and complete human being?

12 A. Full and complete albeit in the immature
13 stage of the life span.

14 MS. SACERDOTE: Your Honor, may have a moment
15 to confer with my colleagues?

16 THE COURT: Sure.

17 MS. SACERDOTE: So one clarification for the
18 record. The Condic declaration is Joint Exhibit 5
19 for the record, and with that I'll pass the
20 witness.

21 THE COURT: Could I ask just a couple
22 questions, Doctor? I think I read this right.
23 Your opinion on fetal pain does it differ from the
24 RCOG, ACOG and Society of Maternal-Fetal Health
25 position? That's what my notes say. I want to

1 see if I'm right on that.

2 THE WITNESS: Yes, it does.

3 THE COURT: In looking at this deposition
4 that was just cited here on page 199 it says you
5 were asked if you had an opinion on contraception
6 and you said you did not have an opinion on
7 whether contraception should be legal. Is that
8 still your opinion today?

9 THE WITNESS: I don't have that opinion.

10 THE COURT: You still have no opinion on it?

11 THE WITNESS: No opinion.

12 THE COURT: Okay. And you were asked about
13 IVF, which is in vitro fertilization, short
14 nonmedical term test-tube babies, but that's
15 probably not approved as correct. But do you --
16 you were asked if you opposed the availability of
17 procedures for women to get pregnant, and I'm not
18 sure whether you said you opposed it or not.
19 Could you just tell me what your opinion was then
20 and is it the same now?

21 THE WITNESS: Well, I'm referring to my
22 testimony on page 200.

23 THE COURT: Yes, ma'am.

24 THE WITNESS: And I did state at that time
25 back in 2017 that IVF is largely an unregulated

1 medical practice that is legal in the United
2 States. I think it has some very significant
3 negative health consequences for women. I would
4 qualify that today by saying for some women. And
5 it clearly has negative medical consequences for
6 children who are conceived, and I think that
7 evidence has only grown stronger in the last five
8 years. I think all of those things should be
9 taken into consideration by anyone who's
10 considering regulating the IVF industry.

11 THE COURT: Does in vitro fertilization does
12 that in your opinion include the issues of
13 abortion or termination of pregnancy?

14 THE WITNESS: I think they're quite different
15 topics. I think that obviously they have some
16 relationship to each other, but I believe that
17 there are many different kinds of issues that face
18 both those general areas.

19 THE COURT: I didn't hear part of your answer
20 so I want to make sure. Do you still believe that
21 IVF -- for some reason I have trouble saying those
22 few letters -- IVF presents significant health
23 consequences for women and the children conceived,
24 or have you changed your opinion on that? That's
25 what I didn't pick up.

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THE WITNESS: I believe that today five years later I'm only more convinced that IVF practices as they are conducted in the United States have significant health consequences for some women and have significant health consequences for many if not all of the children conceived.

THE COURT: Okay. Thanks. That's all I had. Does that raise anything that Plaintiff's counsel wishes to go into?

MS. SACERDOTE: No, Your Honor.

THE COURT: Defense counsel is on redirect now. Do you have anything?

MR. FARQUI: No, Your Honor, we don't have any redirect.

THE COURT: Thank you, Doctor. I appreciate you coming all the way from Utah.

Do we have another witness?

MR. GUARD: Yes, Your Honor. I was going to suggest Dr. Skop has to go back home today so we were going to just try to power through if we can.

THE COURT: Let's have a ten-minute break. We'll back at 15 after and your next witness we'll get her in and out today. Thank you, we'll be back in ten minutes.

(A recess was taken from 3:05 p.m. to 3:24

1 p.m.)

2 THE BAILFF: All rise. Court is back in
3 session.

4 THE COURT: Everybody have a seat. You may
5 call your next witness.

6 MR. GUARD: Before we do that, Your Honor,
7 just some housekeeping. At the request of the
8 Clerk we've cleaned up the exhibits, and so I was
9 going to read out exhibit numbers and what they
10 are just so the record is clear.

11 THE COURT: All right. Go for it.

12 MR. GUARD: Exhibit 1 is going to be Exhibit
13 A to the State's response, which is AHCA ITOP
14 reports.

15 Exhibit 2 is Exhibit B to the State's
16 response, which is the Tien export report for the
17 Gainesville Woman Care case.

18 Exhibit 3 is Exhibit C to the State's
19 response, which is the CDC Abortion Surveillance
20 Data from 2019.

21 Exhibit 4 is going to be the Skop declaration
22 including the two attachments which are listed as
23 A and B.

24 Exhibit 5 is the Condic declaration including
25 the attachment, which is her CV, which is

1 Exhibit A to Exhibit 5 now.

2 Exhibit 6 is the Tien declaration including
3 the CV, which is attached as Exhibit A to 6.

4 Exhibit 7 is the Biggs declaration including
5 the attached CV.

6 Exhibit 8 is going to be the Biggs
7 deposition.

8 Exhibit 9 is going to be the Skop deposition
9 transcript, which you already have.

10 And there is an agreement that all those are
11 admissible and admitted.

12 MR. PERCIVAL: Have we explained to Your
13 Honor yet the issues with Biggs's deposition?

14 MS. CHRISTMAS: I thought we'd do that after.

15 MR. PERCIVAL: I just don't want the Judge to
16 think we're blind siding him with another
17 deposition transcript.

18 THE COURT: I like reading deposition
19 transcripts.

20 MR. GUARD: So I guess we will go into it
21 now. We were trying to keep -- well, she can't
22 come back on Thursday, so Dr. Biggs who traveled
23 here from California, we put in her declaration.
24 And then we're putting in the deposition
25 transcript of what is mostly my cross, which is

1 54 pages long, which is a pretty short deposition.
 2 So that's my way of selling it to you. We're
 3 doing that in lieu of trying to make her come back
 4 from California, which she can't.

5 THE COURT: So we're putting in Dr. Biggs's
 6 declaration. Does she have a deposition, too?

7 MR. GUARD: Yes, I took a deposition of her
 8 and basically her cross.

9 THE COURT: Okay. That's fine. If possible
 10 I'd like to get that tonight.

11 MR. GUARD: Your clerk has it. He's doing
 12 his thing and then you can get it.

13 THE COURT: So Dr. Biggs can't be here. Your
 14 second witness will finish today.

15 MR. GUARD: Yes.

16 THE COURT: And so are there any other
 17 witnesses?

18 MR. GUARD: Dr. Tien is going to testify as a
 19 rebuttal witness my understanding is, and I don't
 20 think I'm going to have much cross because I've
 21 already done the cross once.

22 THE COURT: So Dr. Tien. Okay.

23 MR. GUARD: And then we're done.

24 THE COURT: All right. Then we have
 25 argument.

1 MR. GUARD: Yes, Your Honor.

2 THE COURT: Okay. All right. Do you all
3 want to try to do that all today?

4 MS. PILLAY: As much as possible, Your Honor.
5 If it's possible to get it all done today, great.

6 MR. GUARD: If we get everything done other
7 than argument. Most of these lawyers are from
8 places other than Florida. We'll be happy to if
9 Your Honor would allow us to allow them to do it
10 by Zoom or however Your Honor would like to do it,
11 or if you prefer it here in-person, we'll do it
12 in-person.

13 THE COURT: I hate making you come in-person,
14 but I rather not do closing argument or ruling by
15 Zoom. I'd rather do it in-person. Obviously, the
16 media is certainly invited and it's not just a
17 spur of the moment thing. I think it's better if
18 we handle this case the way did before COVID. And
19 we can talk about when that is whether it -- it
20 depends. It could be tomorrow, but I will be
21 under the influence of novocaine for a couple
22 hours afterwards if that creates any concern for
23 anyone. As far as I know the only thing it does
24 is keep me from drinking anything I mean like
25 liquid without spilling it. I could probably

1 shuffle some stuff around tomorrow afternoon if
2 you want to do that. I certainly know I can do it
3 Thursday.

4 MR. GUARD: We obviously don't want to
5 inconvenience anyone. I was trying to be as kind
6 as I can.

7 THE COURT: I understand. It's probably
8 hotter in Tallahassee than it is in some of the
9 places Plaintiff's counsel are from, but it was
10 quite cool this morning when I got up. But I do
11 want to have time to give justice to these
12 depositions and to think through where we are on
13 everything, so let me think about it. We can talk
14 about it some more today. I don't want to delay
15 your other witness.

16 MS. PILLAY: Thank you very much, Your Honor.

17 THE COURT: Do you swear or affirm the
18 testimony you're about to give will be the truth,
19 the whole truth, and nothing but the truth?

20 THE WITNESS: I do.

21 THE COURT: Have a seat.

22 MR. FARQUI: Your Honor, would it make it
23 easier if we give you an extra courtesy copy of
24 Dr. Biggs's transcript so you don't have to rely
25 on the Clerk's copy?

1 THE COURT: Yes. Thank you. That would be
2 good if you have it. If you don't, I will not
3 mark on the Clerk's copy. If I have my own, I can
4 mark.

5 MR. GAURD: May I approach, Your Honor?

6 THE COURT: So I have Dr. Skop's deposition.

7 MR. GAURD: There's Dr. Biggs.

8 THE COURT: And this is Dr. Biggs's
9 deposition, so I will reread her statement and her
10 deposition.

11 MS. PILLAY: For the record, the extra copy
12 was a rough copy that we received Friday and then
13 we received the final one this morning that was
14 delivered to the Clerk in case there is any we
15 haven't had a chance to look for discrepancies.

16 THE COURT: If there are, we can talk about
17 them. I don't mind taking the Clerk's home.
18 Usually, with a rough copy you can get about 99%
19 of what it says, but I don't mind reading both.
20 So we've placed this witness under oath.

21 THEREUPON,

22 INGRID SKOP,
23 having been first duly sworn by the Court, was
24 examined and testified upon her oath as follows:

25 **D I R E C T E X A M I N A T I O N**

1 BY MR. FARUQUI:

2 Q. Dr. Skop, can you please state your name and
3 spell it for the record?

4 A. My name is Ingrid Skop, I-N-G-R-I-D, S-K-O-P.

5 Q. And I'm just going to these microphones are a
6 little bit weird I'm going to ask you to not lean too
7 far in.

8 Can you please tell the Court what your
9 occupation is?

10 A. I'm a board-certified
11 obstetrician-gynecologist in Texas, and I've been
12 practicing for 30 years.

13 Q. And where are you currently employed?

14 A. I am currently working full time for the
15 Charlotte Lozier Institute as their senior fellow and
16 Director of Medical Affairs. In addition, I'm working
17 part time as an obstetrics hospitalist at a hospital
18 in San Antonio.

19 Q. How long have you had this position with the
20 Charlotte Lozier Institute?

21 A. I began this position on April 1st of this
22 year. Prior to that I was in the same group practice
23 in San Antonio for 25 years.

24 Q. And just to make this short is the Charlotte
25 Lozier Institute is this the same organization that

1 was referenced in Dr. Condic's testimony?

2 A. It is. If I can clarify, Susan B. Anthony
3 Pro-Life America is a lobbying firm. Charlotte Lozier
4 Institute is their research arm. We are a nonprofit.
5 We are not a lobbying group. Similar to the
6 relationship between Planned Parenthood and Guttmacher
7 Institute prior to the two of them separating.

8 Q. Do you agree that the Charlotte Lozier
9 Institute would be fairly characterized as a pro-life
10 organization?

11 A. Yes. It was mentioned earlier that our
12 mission is to support life in the womb.

13 Q. Do you hold any hospital appointments?

14 A. Yes, sir, I do. I'm on staff at the Baptist
15 Hospital System in San Antonio.

16 Q. And how long have you been on staff there?

17 A. 26 years.

18 Q. Have you ever had any leadership positions on
19 staff?

20 A. Yes, sir. I was the chairman of the
21 department of OB-GYN for a couple of years.

22 Q. Can you quickly walk us through your academic
23 and training background before you -- well, walk us
24 through your academic and training background, please.

25 A. Sure. I received a Bachelor's of Science in

1 Physiology from Oklahoma State University. I received
2 Medical Doctorate from Washington University in St.
3 Louis. I did my obstetric gynecology residency
4 training with the University of Texas Health Science
5 Center at San Antonio.

6 Q. Did you hold any leadership positions during
7 your residency?

8 A. I was the chief resident my final year.

9 Q. Where are you licensed?

10 A. I'm licensed in Texas.

11 Q. And licensed as a medical doctor, correct?

12 A. Yes, sir.

13 Q. And how long have you been a licensed medical
14 doctor?

15 A. I have had my medical doctorate for 30 years.

16 Q. Do you have any professional certifications
17 in that field?

18 A. My membership in professional organizations
19 I'm a fellow of the American College of Obstetricians
20 and Gynecologists. In addition, I am a member of the
21 American Association of Pro-Life Obstetricians and
22 Gynecologists.

23 Q. Are you board certified in obstetrics and
24 gynecology?

25 A. Yes, sir.

1 Q. And is that field -- can you explain what the
2 field of obstetrics and gynecology is?

3 A. Sure. Obstetrics refers to the prenatal care
4 and the delivery of babies. Gynecology refers to more
5 general women's reproductive issues relating to
6 menstruation, other non-pregnancy events.

7 Q. Have you published any peer-reviewed papers
8 in the field of obstetrics or gynecology?

9 A. Yes, sir, I have.

10 Q. Have you given any oral presentations in the
11 field?

12 A. Yes, sir, I have.

13 Q. Have you ever testified in court as an expert
14 witness?

15 A. Not on this topic. I have testified as a
16 defense witness in a medical malpractice case.

17 Q. Was that within the field of obstetrics and
18 gynecology?

19 A. Yes. Specifically, it was a gynecologic
20 case.

21 Q. And you've provided a CV; does that CV
22 contain within there some of your qualifications and
23 experience?

24 A. I believe it does.

25 Q. I do have one question about your CV. What

1 is the San Antonio Maternal Morbidity and Mortality
2 Task Force?

3 A. That was a task force that was put together
4 by the city department of health, and we spent about
5 three years reviewing and forming protocols to assist
6 with the problem of maternal mortality in our county.

7 Q. What did that review entail?

8 A. Unfortunately, it was not as thorough as I
9 would have liked it to have been. We had difficulty
10 getting the State Maternal Morbidity and Mortality
11 Committee to share information with us due to privacy
12 concerns.

13 Q. When did you become involved in this case?

14 A. I believe that one of the State's attorneys
15 reached out to me. He had received information about
16 me from Alliance Defending Freedom.

17 Q. And what is the Alliance Defending Freedom?

18 A. It is a legal nonprofit that works on issues
19 of life and conscious protection.

20 Q. And is that also characterized as a pro-life
21 organization?

22 A. Probably.

23 Q. Are you being compensated for your time in
24 this case?

25 A. I'm a full-time salary position at Charlotte

1 Lozier Institute. Our mission is education. This
2 falls within the context of our mission, and I'm not
3 receiving any additional compensation other than my
4 salary and expenses for travel.

5 Q. What were you asked by the State to do for
6 this case?

7 A. I was asked to give my expert testimony
8 regarding the issues of safety in later abortion.

9 Q. And what did you consider in formulating your
10 opinions?

11 A. I considered my 30 years of clinical
12 experience as an obstetrician-gynecologist as well as
13 an extensive review of the literature.

14 Q. Have you ever performed an abortion yourself?

15 A. No, sir, I have not.

16 Q. Why is that?

17 A. As an obstetrician I feel that I have an
18 ethical responsibility to both of my patients, the
19 woman and her unborn child.

20 Q. Have you ever received training on how to
21 perform an abortion?

22 A. Yes, sir, I have as a standard part of an
23 obstetrics and gynecology residency, we participate in
24 pre and post-abortion care. For those who wish they
25 can perform the procedure, but all of us see

1 procedures, receive lectures on how to do the
2 procedures. And in fact, every abortion procedure
3 there is a similar procedure that can be done for
4 reasons that are not related to ending the life of a
5 fetus and so I have vast clinical experience in
6 performing those types of surgical procedures.

7 Q. Have you ever worked at a Planned Parenthood
8 facility?

9 A. Yes, sir, I have. I worked as a resident
10 providing contraceptive services and general
11 gynecologic care, but not abortions.

12 Q. In your career, have you ever provided care
13 to women who previously had abortions?

14 A. Many times.

15 Q. Have you ever provided care to women who had
16 complications from abortions?

17 A. Yes, sir. I've seen many women who have
18 suffered complications of abortion. I've seen many
19 physical complications including significant injuries
20 that require surgery. I've cared for two patients who
21 died of sepsis after surgical abortion; one in the
22 first trimester, one in the second trimester. And
23 I've cared for many women in my clinical setting who
24 have been injured emotionally by abortion.

25 Q. Let's talk about your opinions in this case.

1 Briefly, what is your opinion regarding the Florida
2 statutes challenged in this case?

3 A. I believe that setting an abortion limit at
4 15 weeks will significantly improve the safety for
5 women undergoing abortion. I believe that there is
6 significant data to indicate that abortions become
7 substantially more difficult and dangerous after the
8 15th week of gestation.

9 Q. You believe that the -- what is your opinion
10 on whether the challenged statute would impede the
11 access to abortion for women?

12 A. As discussed earlier, I think a limitation
13 may cause some women to seek earlier abortions which
14 would be safer for them. The interpretation of the
15 literature that discusses the reasons that women
16 obtain later abortions, which is primarily from
17 abortion providers such as Guttmacher Institute, tell
18 me unequivocally that many women who seek these very
19 late abortions do so under coercion. They do so under
20 indecision. And I have seen and cared for many women
21 who initially had unintended and sometimes unwanted
22 pregnancies. If they encounter barriers and continue
23 through the pregnancy to term, 100% of the time I have
24 seen them love and cherish and value their child at
25 the time they deliver.

1 Q. What is the earliest a pregnancy can be
2 detected with over-the-counter tests?

3 A. Over-the-counter urine tests are so sensitive
4 that many times HCG can be detected even before the
5 period is missed. So two weeks after fertilization.
6 Four weeks by last menstrual period.

7 Q. And that would be almost three months before
8 abortions would be restricted under the new Florida
9 law, correct?

10 A. That is correct.

11 Q. Are there any options available for women who
12 seek an abortion during the first trimester?

13 A. Yes. The traditional procedural is called a
14 suction, a dilation and suction. But increasingly I
15 believe more than 50% of abortions in our country are
16 performed by medical abortion up until 10 weeks
17 gestation.

18 Q. What abortion procedures are commonly
19 performed after 10 weeks?

20 A. So the dilation and suction continues to
21 occur, but of course we all know the fetus gets
22 bigger, there's more placental tissue, there's more
23 amniotic fluid. At about -- ACOG tells us that around
24 13 to 14 weeks the procedure changes to what's called
25 a dilation and extraction. Essentially, it's a

1 continuum of the same procedure, but around that
2 gestational age the fetal bones have calcified so he
3 cannot be removed through suction alone. He must be
4 removed in a dismemberment procedure. This procedure
5 becomes significantly more dangerous for a woman
6 because it is necessary for the abortion provider to
7 introduce instruments blindly multiple times into the
8 uterus to extract the portions of the fetus. It is
9 possible to incompletely extract the tissue. It is
10 possible to leave fetal parts behind, and those parts
11 that are calcified can puncture the uterus. They
12 could lead to infection or even infertility if left
13 for too long. And so the procedure becomes more
14 difficult as we have to convert to the D&E procedure.
15 And particularly beyond about 15 weeks the literature
16 tells us that it probably triples in the number of
17 complications and the risk to maternal mortality.

18 Q. Have you ever performed a dilation and
19 extraction procedure?

20 A. I have. The same procedure is used when a
21 woman has a late miscarriage at these gestational
22 ages. So in that situation when the baby is deceased,
23 I have performed that procedure.

24 Q. Are there any differences between performing
25 a D&E for a miscarriage versus an abortion?

1 A. Technically the procedure is the same, but
2 there are some significant differences. When a
3 pregnancy passes away, the body starts to recognize
4 it. The cervix becomes softer. It's a little easier
5 to dilate the cervix to introduce instruments. In
6 addition, the fetus is softer, so it's easier to
7 remove him. Contrast that to a D&E on a living fetus
8 this is a fetus who is going to actively move away
9 from the instruments. And of course, he's going to be
10 a firmer. And it's going to be more difficult for the
11 abortion provider to grasp and remove his parts than
12 with a deceased baby.

13 Q. You may have mentioned this, but can you let
14 me know the sort of the range of time during which a
15 D&E procedure can be performed?

16 A. Like I say it's a little bit of a continuum,
17 but between 13 and 15 weeks. That's when it starts to
18 be performed. Essentially, the difference is that the
19 fetus is firm and cannot be suctioned out solely, so
20 he has to be removed in apiece meal fashion. I
21 believe that different abortion providers have
22 different comfort levels with how far into a pregnancy
23 that they will do. I believe Dr. Tien said her
24 comfort level was at about 24 weeks. Obviously, the
25 bigger the baby gets the more solid, the more fully

1 formed the joints and the bones are, the more
2 difficult it is going to be to disarticulate him to
3 remove him from the uterus. There is a point at which
4 many abortion providers will switch to an induction
5 abortion due to that difficulty and to the risk to the
6 woman.

7 Q. Can you explain what potential complications
8 can occur from a D&E procedure?

9 A. Sure. The first problem is that the cervix,
10 which is designed to hold the baby in until full term,
11 when there is 10 to 15 pounds of baby and fluid and
12 placenta in the uterus this muscle is very strong.
13 And so in order to enter the muscle to dilate the
14 cervix several things must be done. There are osmotic
15 that is water absorbing dilators. There are
16 pharmacologic dilators. We can use mechanical
17 dilators. Each of those if the cervix is resistant
18 has the possibility that damage could occur to the
19 cervix. Even instruments can be misdirected into the
20 cervical blood flow or through the back of the uterus.
21 Once inside of the uterus instruments are placed. And
22 again, particularly as you get into the further the
23 more higher gestational ages, the uterine muscle is
24 quite thin at that point so it is easy for an
25 abortionist to accidentally puncture through the uterus.

1 And sometimes this can happen in such a way that it
2 causes a very large tear in the uterus. At that point
3 you have the problem not only of fetal parts being
4 extruded into the abdominal cavity, but you also have
5 the potential for abdominal contents to be
6 inadvertently grasped and to be brought into the
7 uterus. Things such as bowel, bladder's in the area,
8 blood vessels. So it's a blind procedure and it does
9 have the risk particularly in inexperienced hands or
10 potentially a poor quality abortion provider
11 horrendous complications have happened and I have seen
12 this.

13 Q. Exhibit B to your declaration is an emergency
14 suspension order from the Florida Agency for Health
15 Care Administration. Did you review that before
16 preparing your declarations?

17 A. I did review it. It's not part of the
18 declaration I have because this is my personal copy,
19 but I recall it well enough. I think I can discuss
20 it.

21 Q. Okay. And did you consider those incidents
22 described in that order in formulating your opinions?

23 A. I did. As I discussed in my deposition, our
24 country does not mandate on a federal level reporting
25 of complications. Some states do, but in general even

1 if they do mandate it there's frequently little
2 oversight and little supervision of those reportings,
3 so I think a lot of times complications are not
4 accurately reported. And I feel that the
5 complications that we see listed in the literature are
6 a vast underestimation.

7 Pensacola is an example of things that can
8 happen when providers are poor quality. There were
9 two complications that were described in the report.
10 One woman was 19 and six weeks along, so further than
11 we would allow an abortion if this legislation were to
12 go into effect. Although she had her abortion at 10
13 in the morning, she did not leave the abortion
14 facility until midnight. During that time it was
15 documented that she was bleeding heavily. In fact,
16 they gave her seven doses of Misoprostol, which is a
17 medication you use to stop bleeding. Clearly, if they
18 had to give her seven doses there was something else
19 going on other than a mild bleed. She spent part of
20 the time unsupervised in the car with her husband.
21 There was very little documentation of vital signs,
22 estimated blood loss. And eventually, the abortionist
23 told the husband to take her across the state border
24 to Alabama for care despite the fact that by Florida
25 law that facility had an agreement with a local

1 hospital for admission. I think that was probably
2 because he was trying to avoid detection of his
3 complication. And that women ended up having an
4 exploratory laparotomy, a massive transfusion
5 protocol. She was responsive only to pain on
6 evaluation in the emergency room, and she had to have
7 part of her bowel removed and a colostomy.

8 The second patient a very similar situation.
9 She was 20 weeks and two days. She had an abortion.
10 She was at the clinic being largely unsupervised
11 despite bleeding until midnight. When she left the
12 clinic and went to the nearby hospital, she had 10
13 units of blood transfusion there. Her blood pressure
14 was not detectable at the time that she was admitted
15 to the emergency room, and she required a total
16 abdominal histonectomy and removal of her ovaries from
17 her complications. The provider said that he didn't
18 know that there was a protocol. That's hard for me to
19 believe that any doctor in this country would not know
20 if they had that much of a horrendous complication
21 that they needed to facilitate transfer of that
22 patient immediately to an emergency facility and that
23 they needed to get on the phone and call that facility
24 and let them know what was coming.

25 So that's the kind of stuff that can happen

1 and does happen in this country. It's been documented
2 many times.

3 Q. And both of those examples the provider that
4 treated the complication was someone other than the
5 abortion provider, correct?

6 A. That is the case and that is frequently the
7 case.

8 Q. And that was going to be my next question.
9 Is there any data on how many women seek treatment of
10 their complications from abortion from their abortion
11 provider versus someone else?

12 A. There is. There is -- for one thing, there
13 is actually a study of abortion providers in Florida
14 that documented that only half of them have hospital
15 admitting privileges, so in my cases these doctors
16 could not care for a serious complication even if they
17 wanted to. Regarding medical abortion I was involved
18 in a study that purchased Medicaid data from 17 states
19 that paid for abortions. And we were able to document
20 that about 5% of women did present to an emergency
21 room within 30 days for complications related to
22 abortion. And of those women, 60% were cared for by
23 and received surgery by someone other than the
24 abortion provider. Similarly, FDA data documents
25 similar numbers of the women who are actually cared

1 for for the complications of abortions.

2 Q. Could encouraging women to perform abortions
3 before 15 weeks post LMP decrease maternal mortality
4 rates?

5 A. I believe that it could. The CDC -- well,
6 similar to abortion complication data I believe that
7 the data related to abortion mortality is
8 underestimated in our country. There are various
9 reasons for that. Again, largely because they're
10 often taken care of by someone other than the abortion
11 provider.

12 I was not aware until just a couple of years
13 ago after 30 years of practice that if I as the
14 provider did not take the initiative to get on the
15 state department of health website and report a
16 complication I was not aware that there was no system
17 in place to detect that complication. And I think
18 that is the case for many providers. They may care
19 for these complications, but they may have no idea
20 that if they are not the one that reports it that
21 nobody will know about it and that the CDC ultimately
22 will not know about it if it results in a death. It's
23 been documented in various venues that many, many
24 maternal death certificates do not record the
25 pregnancy that preceded the death even if the

1 pregnancy was the cause of the death. The CDC
2 primarily analyzes death certificate data, and so it's
3 highly possible that they are missing a lot of deaths
4 that occur.

5 Q. Are you familiar with the literature that
6 suggests that abortions are safer than childbirth?

7 A. I'm familiar with that study. I think the
8 study compares compromised data. And in fact, it does
9 not even have the same denominators, so to me it's not
10 a valid comparison. And again, the CDC data is
11 undercounted. Better studies are obtained in the
12 Scandinavian countries. They have single parent
13 health care. They know every pregnancy event. They
14 know every medical event. And what we see over there
15 unlike the CDC's data is that a woman is six times as
16 likely to die of a suicide in the year following an
17 abortion. She is two to three times as likely to die
18 of any cause following an abortion than if she had
19 carried the child and given birth.

20 Q. Are you familiar with the American
21 Psychological Association's statement on mental health
22 consequences of abortion?

23 A. I am familiar with that statement and I think
24 that this an example of how often statements that
25 sound reassuring are made. But if you look at them in

1 some detail, you can recognize that they're not giving
 2 you all the information. The APA statement said that
 3 there is no evidence that a single elective abortion
 4 in an adult woman carries with it mental health
 5 consequences. But what they left out is the caveats
 6 that there are many subgroups of women that we know
 7 and the literature is quite clear on this that are at
 8 high-risk for mental health complications. That is
 9 those that have had multiple abortions and that's 40
 10 to 50% of our country. Teenagers that's 20% of the
 11 women obtaining abortions. Elective although it's
 12 often assumed that everybody who chooses an abortion
 13 did not want that pregnancy, data tells us otherwise.
 14 Many times these are initially desired pregnancies
 15 that women have and yet they find themselves in a
 16 situation either financially or socially where they
 17 don't feel they have the support to carry the baby.
 18 So that is a woman who wants her baby and yet doesn't
 19 feel like she can do it. And many times there is not
 20 the support of a man.

21 Second trimester later abortions are
 22 well-known to be associated with more mental health
 23 consequences, too. So the APA put out a statement
 24 that sounds reassuring on the surface, but when we dig
 25 deeper we discover that it actually does not include

1 the vast majority of women who have abortions.

2 Q. So in your opinion, there are mental health
3 consequences of obtaining an abortion, right?

4 A. There certainly can be and I've seen many of
5 them in my 30-year career. What happens with the
6 mental health literature particularly is it's
7 extraordinarily difficult to design a good study. The
8 gold standard for studies in medicine and in research
9 in general is what's called a randomized placebo
10 controlled study where you take people and you give
11 one an intervention, give the other no intervention,
12 you try to control for as many factors as possible to
13 make them as alike as possible and then you see what
14 the outcomes are. Well, clearly we couldn't do that
15 with abortion. That would be unethical. And so what
16 we see is that there's quite a few studies that
17 indicate mental health problems. There's also
18 studies, and I think some of these will be discussed
19 in this room, that seem to indicate no mental health
20 problems, but many times when you look at the study
21 design you see some significant problems.

22 One of the big problems with a study that's
23 called the Turnaway that's been widely reported is
24 that there is almost certainly selection bias. 30
25 abortion clinics over a three-year period of time

1 encompassing probably at least 100,000 abortions,
2 7,500 women were screened as possible participants.
3 About 3,000 were approached. Of the women who were
4 approached even though they were offered money to
5 participate in the surveys of those only a little over
6 1,000 were willing to participate. Of those women who
7 did participate, the vast majority of them dropped out
8 throughout the planned five years. And in fact, at
9 the end of the five years only 516 women were
10 participating out of a potential pool of 100,000
11 women. So I think we can all see intuitively that the
12 researchers may have either intentionally or
13 inadvertently chosen women who would be more secure in
14 their abortion decision. And the women might have
15 anticipated that they would have mental health
16 consequences would be the women who would choose not
17 to participate in that study. I think just -- I'm
18 sorry. As a thought experiment we can see that a
19 woman who is a professional woman perhaps in her 30s
20 who never desired children perhaps a secular woman
21 might have an unintended pregnancy and have an
22 abortion and not have issues. I mean certainly most
23 women who have abortions don't have issues that we can
24 see externally, but then we can also see perhaps a
25 16-year-old who is a religious young girl who perhaps

1 has very poor self-image or poor home life who becomes
2 pregnant and initially is excited she's going to get
3 the chance to be a mother. It's what she's always
4 wanted to do. If that young woman is coerced by her
5 boyfriend or by her parents into an abortion, I think
6 we can all see intuitively that is someone who may
7 have some mental health problems. So a study that
8 looks very broadly at the population particularly if
9 it's not a well-designed study, may not indicate
10 mental health problems. But we see them. I work
11 closely with some crisis pregnancy centers. And one
12 of the things that we see is that many women after
13 their abortions come to us for counseling. And they
14 will tell me my abortion caused me to have anxiety,
15 depression, substance abuse, self-harm. And I'm
16 inclined to believe women when they tell me that their
17 abortion caused those things to them.

18 Q. Do you know whether the risk of mental health
19 complications from an abortion can increase based on
20 what point in the pregnancy the abortion is elected?

21 A. Yes, I believe so. Like I said, there is
22 significant data that the later abortions are more
23 difficult emotionally for women. And this makes
24 sense. I've seen on a number of occasions women who
25 maybe the situation was complex but they did desire

1 their baby, but they kept that knowledge hidden from
2 their parents or from the boyfriend under the
3 impression that when the information came out that
4 they were pregnant that there would be pressure on
5 them to have an abortion. And so a young girl who is
6 in that situation who now is clearly pregnant, in that
7 situation if she is coerced into an abortion after
8 she's felt the baby move, after she's began to bond
9 with the baby I mean to me that seems very clear that
10 that could result in mental health complications. So
11 from a mental health perspective, I think limiting
12 abortion at 15 weeks allows plenty of time for women
13 who desire abortion to get one in general, but it does
14 not allow nine months of coercion for a woman who is
15 vulnerable to that pressure to be pushed into ending a
16 pregnancy that she desires.

17 Q. Turning away from mental health for a second,
18 can abortions or excuse me. Can the D&E procedure
19 cause complications in subsequent pregnancies?

20 A. I believe there's good data for that. Any
21 type of surgery it is well-known can cause damage to
22 the lining of the uterus. We do a lot of c-sections
23 in this country. This is something that definitely
24 leads to it. But also you know particularly a
25 surgical procedure that might require scrapping of the

1 uterus what's called a uterine curettage can cause
2 damage to the uterus. In a subsequent pregnancy the
3 placenta may attach tenuously because of that damage
4 and it could separate prematurely. That's called a
5 placental abruption. That will lead to premature
6 delivery. It can lead to terrible outcomes for the
7 baby, but in addition it can lead to women having
8 hemorrhage and there have been maternal deaths from
9 that. The flip side is that sometimes the placenta
10 attaches too strongly. It invades into the uterus or
11 into the cervix or into the bladder. And at the time
12 of delivery it's very, very difficult to separate the
13 placenta and women have died. That's called placenta
14 accreta spectrum disorder and women have died from
15 that. Both of those things are associated with prior
16 uterine surgery which does include surgical abortion.

17 Additionally, there is compelling data that
18 particularly a later abortion that is dilating that
19 strong cervix that we talked about can damage the
20 cervix. And so then subsequently as the uterus
21 enlarges and the pressure inside increases that can
22 cause a woman to go into preterm labor or sometimes
23 have preterm rupture of membranes. And those are
24 situations that of course can lead to terrible
25 outcomes for the babies, but also for the mother. As

1 we're trying to stop the labor and give her magnesium
2 sulfate sometimes that leads to toxicity. So yes,
3 there are definitely things that happen in subsequent
4 pregnancies that can be related to an abortion. But
5 again at this time we don't have the ability to detect
6 those complications to prove that that's happening,
7 but I have no doubt that it does happen.

8 Q. I just have a few more questions, Dr. Skop.
9 About how much time did you have to prepare your
10 expert declaration?

11 A. It was probably two to three weeks ago that
12 you guys reached out to me, so I've been working on it
13 in the midst of my other responsibilities since then.

14 Q. And given the short time frame is it possible
15 that there may be some typographical errors or
16 citation errors because of that time period?

17 A. I think that is certainly possible.

18 Q. And would corrections of any of these
19 drafting errors change the substance of your opinion?

20 A. No, it would not.

21 MR. FARQUI: May I just have a moment?

22 THE COURT: Sure.

23 MR. FARQUI: I have no additional questions,
24 Your Honor.

25 THE COURT: Let's go to cross.

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MS. PILLAY: May it please the Court. Shoba Pillay from Jenner & Block for the Plaintiffs.

THE COURT: Thank you.

C R O S S - E X A M I N A T I O N

BY MS. PILLAY:

Q. Good afternoon, Dr. Skop.

A. Hello.

Q. You mentioned that you've been an OB and an MD for approximately 30 years; is that right?

A. Yes, ma'am.

Q. But you've never performed an abortion; is that right?

A. That is correct.

Q. You never actually recommended an abortion to any of your patients; is that right?

A. I have not.

Q. And you have no formal training in mental health counseling outside of your time in medical school; is that fair?

A. That is true. My husband's a psychiatrist so I get a little peripherally from him, but no formal training.

Q. But you don't consider yourself an expert in mental health; is that fair?

A. I would say I'm not an expert in mental

1 health, but I do think I have expertise based on my
2 30 years of experience of understanding mental health
3 concerns for women related to pregnancy issues.

4 Q. You don't consider yourself an expert in
5 epidemiology; is that right?

6 A. No. I've read quite about it, but I am
7 certainly nowhere close to an expert.

8 Q. You don't perform intrauterine fetal surgery;
9 is that right?

10 A. No. That's correct.

11 Q. You don't consider yourself an expert in
12 neonatology; is that right?

13 A. No. That's a pediatrician who does
14 specialized training after residency.

15 Q. And it's fair to say you've never obtained
16 informed consent from a patient to perform a D&E
17 abortion; is that right?

18 A. I don't believe that that is correct. Like I
19 mentioned earlier, as a resident even if we didn't
20 perform the abortions we were involved in the pre and
21 the post-abortion care. And we did perform abortions
22 at the hospital, so I believe I probably was involved
23 in care surrounding that which would have included
24 informed consent.

25 Q. So that was over 25 years ago?

1 A. That's true.

2 Q. And you mentioned on direct that you are
3 currently employed with the Charlotte Lozier
4 Institute; is that right?

5 A. Yes, ma'am.

6 Q. Since April?

7 A. Yes.

8 Q. As part of your employment it's expected that
9 you provide expert testimony in furtherance of the
10 Charlotte Lozier Institute's research and the Susan B.
11 Anthony Pro-Life America's policies; is that right?

12 A. We're an education arm and I am willing to
13 follow the evidence where it goes, so it is not
14 anticipated that I will gear my testimony toward
15 promoting the pro-life desires of Susan B. Anthony
16 List, but in the course of my research and clinical
17 experience I feel very comfortable saying that I do
18 not believe that there are compelling medical reasons
19 that women need abortions.

20 Q. You've received training from the CLI in
21 furtherance of that expert testimony; is that right?

22 A. I have received some training about
23 testimony, yes.

24 Q. And that's most recently in May of 2022?

25 A. That's correct.

1 Q. Providing advice on how to formulate your
2 message?

3 A. That's true.

4 Q. You've actually previously testified as an
5 expert either orally or written testimony in multiple
6 other court matters; isn't that right?

7 A. That is correct.

8 Q. So in about four other cases; does that
9 sounds fair?

10 A. I believe I've done written testimony
11 probably six or seven.

12 Q. And some of that written testimony is also in
13 state legislatures?

14 A. That's correct.

15 Q. As well as oral testimony?

16 A. Yes, ma'am.

17 Q. And you're sometimes paid for that work;
18 isn't that right?

19 A. I have been in the past, yes.

20 Q. But you're currently not paid for this
21 engagement because you're actually salaried by the
22 Charlotte Lozier Institute because it's expected of
23 you as part of that role among other things to do
24 research, provide education, and to testify in matters
25 like this; is that right?

1 A. It is part of my job to do all of that you
2 just mentioned, but the opinions are my own and I feel
3 comfortable with them based on the literature that
4 I've read and all my clinical experience.

5 Q. You mentioned I think on direct that you're a
6 member of the American Association of Pro-Life
7 Obstetricians and Gynecologists; is that right?

8 A. Yes, ma'am.

9 Q. That's AAPLOG for short?

10 A. Yes, ma'am.

11 Q. And you have been a member about seven years;
12 is that fair?

13 A. That's about right, yes.

14 Q. In fact, you've worked with them to update
15 their practice bulletins and committee opinions?

16 A. Yes.

17 Q. In furthering a number of opinions that are
18 now published on their website?

19 A. Yes.

20 Q. Typically providing pro-life perspective of
21 OB-GYN practices; is that fair?

22 A. That is correct.

23 Q. In fact, you served on the board of AAPLOG
24 for a couple of years; is that right?

25 A. Yes, I did.

1 Q. You understand and I think you've
2 acknowledged before that AAPLOG has a bias against
3 abortion; is that fair?

4 A. Yes.

5 Q. And you even admitted that you yourself have
6 a bias against abortion in light of your views?

7 A. Well, morally as a Christian I believe that
8 every human life is made in the image of God and is
9 valuable. As an obstetrician I believe that the
10 unborn human is my patient and I should advocate for
11 that patient. But based on my years of experience and
12 research, I have not found any medical reasons that
13 women must have this procedure. I think it is used
14 for social indications, but I think it is
15 extraordinarily rare to be used for an actual medical
16 indication. If a woman's life is at risk because of
17 her complicated pregnancy, she can be separated from
18 her baby in a way that is not an abortion. The
19 purpose of an abortion is to end the fetal life.

20 Q. Dr. Skop, your opinion that testimony you
21 just provided it's actually inconsistent with the
22 findings of number of medical associations; isn't that
23 right?

24 A. That is correct. Many of the medical
25 associations that I assume you're going to mention

1 right now have well-documented to have a pro-choice
2 bias.

3 Q. So you consider their positions to be bias;
4 is that fair?

5 A. Yes.

6 Q. So let's start with American College of
7 Obstetricians and Gynecologists. The Court has
8 referenced this before as ACOG; is that right?

9 A. That is correct.

10 Q. And it's the largest professional association
11 of physicians providing women's health care in the
12 country; is that right?

13 A. They are the largest association of OB-GYNs.
14 I am a member. And just for the record, they actually
15 don't ask their memberships what we feel about their
16 abortion advocacy. They have been advocates for
17 abortion since the 1960s. And in fact, studies show
18 that only 7 to 14% of OB-GYNs will perform an abortion
19 if requested by their patient. So even though they
20 represent us, they do not represent in my opinion the
21 views of most OB-GYNs --

22 Q. Well --

23 A. -- regarding abortion.

24 Q. -- represent your view?

25 A. Well, that is my view. But when you look at

1 the statistic that's only 7 to 14% do abortions,
2 they've never told us they've never asked us what we
3 think about that.

4 Q. Well, you can't speak for every physician in
5 the country; is that right?

6 A. Well, you're right. I can't.

7 Q. But you also rely on the materials and that
8 education that's provided by ACOG, don't you, in your
9 regular practice?

10 A. I do. Interestingly, when it's not related
11 to abortion I think they give pretty good advice. And
12 even related to abortion I think there can be utility
13 in reading what they say. For example, I did
14 reference their second trimester abortion bulletin in
15 my expert witness testimony. But I have to read that
16 in light of what I also know from other sources.

17 Q. They also publish a journal, isn't that
18 right, what's known as the Green Journal or Obstetrics
19 & Gynecology?

20 A. Yes, ma'am.

21 Q. And you also believe that the Green Journal
22 is useful in your everyday practice; is that fair?

23 A. That is correct.

24 Q. It's peer-reviewed?

25 A. Yes.

1 Q. But just like ACOG, it's your view that the
2 Green Journal has a pro-abortion ideology and is
3 therefore bias; is that fair?

4 A. That is what I have noticed.

5 Q. Likewise, the American Medical Association
6 that's the largest professional association of
7 physicians in the country; is that correct?

8 A. Probably. The case law though it's my
9 understanding that that they now represent only about
10 20% of physicians.

11 Q. Are you a member?

12 A. No, I am not.

13 Q. And on non-abortion medical topics, would you
14 consider the AMA general trustworthy?

15 A. To tell the truth I don't think I reference
16 their material very much.

17 Q. Just ACOG like you believe the AMA is an
18 abortion advocacy organization?

19 A. They have become that.

20 Q. So suffer from the same bias that you
21 perceive in ACOG and in the Green Journal?

22 A. Based on their recent statements, I think
23 that is obvious.

24 Q. What about the American Psychological
25 Association; you were testifying about that on direct?

1 Do you consider APA to be an abortion advocacy
2 organization and therefore bias?

3 A. Just like ACOG, the APA has had abortion
4 advocacy as a central component of their mission since
5 the 1960s. They said at that time that they
6 considered abortion to be a civil right of a pregnant
7 woman, so I think again many of these organizations
8 advocate for abortion for social reasons. But I think
9 that's inappropriate, because they should be medical
10 organizations sticking to medicine.

11 Q. But you've testified that you also have a
12 personal objection to abortion; is that fair?

13 A. Yes.

14 Q. So APA is the largest professional
15 association of psychologists and it's weighed in on
16 the topic of mental health and abortion, and you had
17 deemed their conclusions untrustworthy because they
18 have a bias; is that accurate?

19 A. Well, as we discussed a few minutes ago on
20 that APA statement, they made a statement to try to
21 reassure people. But when you dig into the statement,
22 you see that actually it does not refer to most women
23 having abortion. So I think that's just kind of a
24 demonstration of how some of these organizations are
25 falsely trying to reassure the American public and

1 understanding that most people don't have the
2 knowledge to dig into their statements and understand
3 what's really being said.

4 Q. So these large medical organizations are
5 engaging in false messaging; is that what you're
6 saying?

7 A. I wouldn't say that. I would just say that
8 they have demonstrated themselves to have a pro-choice
9 position, and I think that many times they create
10 publications to promote that.

11 Q. So the National Academies of Sciences,
12 Engineering, and Medicine, that's an institution
13 that's supposed advise the country on matters of
14 health and medicine among other things; is that fair?

15 A. That is their stated purpose, yes.

16 Q. And in 2018, and I think Counsel referenced
17 this on direct that they issued a consensus study on
18 the quality and safety of abortion here in the United
19 States; are you familiar with that study?

20 A. Yes, I am.

21 THE COURT: Which association?

22 MS. PILLAY: The National Academies of
23 Sciences, Engineering, and Medicine.

24 THE COURT: Okay.

25 MS. PILLAY: And I will refer to it going

1 forward as the National Academy if that's helpful.

2 THE COURT: Okay. All right.

3 BY MS. PILLAY:

4 Q. And we were just talking about a consensus
5 study that they issued in 2018 entitled The Quality
6 and Safety of Abortion Care in the United States, and
7 it's your opinion that that study is likewise
8 influenced by pro-abortion bias; is that right?

9 A. When you look at the funding sources, you
10 will see that all of the funders are organizations
11 that have been known for abortion advocacy.

12 Q. So just like CLI is funded by SBA which is a
13 pro-life organization, that's a similar concept?

14 A. Yes.

15 Q. So in fact, you believe the National
16 Academies cherry picked data to reach a conclusion
17 that would promote abortion; isn't that fair?

18 A. For some of the topics that they looked at,
19 they looked at between 3 and 5 studies. When in fact
20 for these particular topics that I'm thinking of,
21 preterm birth, breast cancer, and mental health
22 issues, there were between 75 and 160 peer-reviewed
23 studies available many of which showed positive
24 correlation. So I think that what they did is that
25 they set their standards and their restrictions in

1 such a way that they were able to find just a few
2 studies that showed what they would like them to say.

3 Q. And we're talking about this 208 page study,
4 right, this is the one you're saying that does not
5 have sufficient information or data to rely on?

6 A. The booklet from NAS, yes. But there's
7 long-term complications that I just mentioned. On the
8 short-term complications, if you look at who they
9 quote most of the time they are studies out of
10 abortion advocacy organizations, University of
11 California at San Francisco, Advancing New Standards
12 in Reproductive Health, Bixby Center.

13 And going back to the problem with
14 complications reporting in our country, many times
15 they have studies that show that supposedly show low
16 levels of complications. And I would say that they
17 are not picking up all the complications, and that's
18 why they are showing such low numbers. In the study
19 that I was involved in where we bought the data from
20 17 states that paid for Medicaid abortions, we
21 actually did a very similar study to what Upadhyay did
22 and we found significantly higher abortion related
23 complications.

24 Q. So all of these medical associations, the
25 National Academies they're all these large

1 organizations they do not have correct data and are
2 biased according to you, Dr. Skop, am I getting that
3 right?

4 A. Well, let me just say this because they have
5 gone on the record as feeling that abortion is a
6 social good, so I think they have that motivation.
7 And in the United States we have very, very poor
8 quality data regarding complications because we do not
9 mandate reporting, and so we are vastly
10 underestimating complications. When we can do records
11 linkage studies we discover consistently far more
12 complications than we do than when we just randomly
13 look at emergency room data.

14 Q. You also find many of the US government
15 agencies to struggle from the same bias; is that fair?

16 A. I think you'd have to give me some more
17 specifics.

18 Q. Like the CDC?

19 A. The CDC again possibly collects information
20 regarding maternal mortality, and I think that they
21 could more actively look for data regarding that.

22 Q. So you had mentioned, let's talk about the
23 data from the CDC. You acknowledge that you have
24 scepticism of the CDC's data because they're passive;
25 is that right?

1 A. Well, I have skepticism of the CDC's death
2 certificate data because it's been proven in a number
3 of articles unrelated to abortion even and unrelated
4 to the whole political issue of abortion that death
5 certificate data across the board is poor.

6 Q. And you've actually not noted a lot of the
7 DCD data is actually utilized in that National
8 Academies report that we were talking about, The
9 Safety of Abortion; isn't that right?

10 A. I believe they do reference some CDC data.

11 Q. And you take the position I believe that a
12 lot of these authors of studies that come out of that
13 National Academies report are also hiding data or
14 limiting data based on their knowledge for their bias
15 for pro-abortion like Dr. Grimes you've mentioned that
16 before; is that right?

17 A. What I said in terms of Dr. Grimes he was the
18 head of the CDC Abortion Surveillance Division, and he
19 if I can see as an outside observer how limited the
20 data is I would have assumed that he also would see
21 that and yet he published a study comparing data with
22 two different denominators alleging that abortion was
23 14 times safer than child birth. And it wasn't even
24 comparing apples and oranges. It was different
25 denominators. And I don't have time to go into it

1 all, but there were so many methodological problems
2 with that data collection that I just wonder what was
3 his, you know, one has to ask what was the point of
4 publishing when you knew the data was so poor.

5 Q. Let 's talk about that data. On direct you
6 testified that the rate of mortality is significantly
7 higher in second trimester abortions, right, did I get
8 that right?

9 A. It is higher.

10 Q. Bu isn't it true you even cited the Zane
11 study, which actually reports at a 14 to 17-week
12 gestation it's 2.5 deaths out of 100,000 legal
13 abortion procedures; isn't that right?

14 A. That is based on the data that the CDC has
15 collected passively from death certificates. I think
16 that if our country cared to know the real answers, we
17 would mandate reporting of complications, we would
18 mandate reporting of all pregnancy events, so that we
19 can have clear and consistent data with which to work.

20 Q. But, dr. Skop, the CDC doesn't just passively
21 collect data, I mean you've seen the reports that the
22 CDC says we also search LexisNexis for information, we
23 got information from private abortion clinics and
24 public abortion clinics, we got it from the states, we
25 have epidemiologists analyze it, all of that is

1 reported in the studies, so it's not passive?

2 A. Well, they do say they have a couple of
3 additional ways of getting information. It's not
4 clear because it's not reported how many additional
5 deaths they pick up that way. As we discussed in the
6 deposition, one way they could find more complications
7 in deaths would be to do a public search of medical
8 malpractice claims. And a researcher did that and he
9 as able to document in a given year that based only on
10 medical malpractice claims he found 30% more deaths
11 than the CDC had documented. So I think that if they
12 really had a strong desire to get every death, I think
13 there are additional things that they could be doing.

14 Q. Okay. So CDC's data is not sufficient, the
15 National Academies's reporting is not sufficient if I
16 understand your testimony today, Doctor. Let's talk
17 about another study that you referenced on direct
18 examination. The Turnaway Study are you familiar with
19 what I'm talking about?

20 A. Yes, ma'am.

21 Q. You mentioned that The Turnaway Study has
22 deep flaws; is that correct?

23 A. Well, I think it is subject to significant
24 selection bias.

25 Q. Would you agree though that in the medical

1 community including the American Psychiatric
2 Association that you mentioned earlier it is widely
3 accepted within that medical community?

4 A. Certainly I think that many medical
5 organizations with a pro-choice ideologic backing have
6 been happy to see the conclusions that have been
7 generated by the Turnaway.

8 Q. And you mentioned you were troubled by the
9 attrition rate. So this Turnaway Study employed a
10 Longitudinal Perspective Cohort Study and they
11 interviewed all of these 1,000 women that were
12 included from 30 abortion facilities in 21 states
13 every six months over five years and there was a 5%
14 attrition rate every year over that time in the
15 various waves, and it's your testimony that that's
16 really high and therefore invalid, it invalidates the
17 data, that attrition rate is so high it invalidates
18 the data. That's what I believe you testified on
19 direct; is that right.

20 A. Yes, I mean the attrition I'd like to expand
21 a little bit. They asked 3,000 women. Only about
22 1,100 were willing to participate. And then at the
23 end of the time period only 516 were left. So they
24 actually ended up with about 17% of what they had
25 initially planned. And I think that intuitively we

1 can recognize that because we do know that sometimes
2 women do feel immediate relief in the week after their
3 abortion and I think that they one of the studies
4 indicated that there was more anxiety in the women who
5 had not receive the abortion, but what they actually
6 do tell us is that over the five-year time period
7 women are pretty equivalent on the real health
8 outcomes at the end of the five years. It should be
9 noted that there has never ever been a study that
10 showed improvement in mental health after an abortion.
11 So the best the studies can show us is that it didn't
12 hurt the woman potentially. But you know when it was
13 the companion case to Roe v. Wade, Doe v. Bolton was
14 all about allowing abortion for mental health reasons
15 for the health of the woman so.

16 Q. Dr. Skop.

17 A. Go ahead.

18 Q. You mentioned that people you've talked to.
19 You didn't participate in the Turnaway Study; isn't
20 that right?

21 A. No.

22 Q. And you actually haven't engaged in your own
23 mental health study per se? In other words, you
24 haven't engaged in any kind of study to analyze the
25 mental health impact of abortion; is that fair?

1 A. I have not been a researcher in a study like
2 that. I'm working on getting some stuff together, but
3 I do have 30 years of clinical experience talking to
4 women who tell me that they have suffered from their
5 abortion and I trust them.

6 Q. So speaking of your patients, you've
7 mentioned that on direct that an over-the-counter
8 pregnancy test can detect even before a woman misses
9 her period. Did I get that correct?

10 A. That is true. They are that sensitive.

11 Q. So how would the woman know to go get that
12 pregnancy test?

13 A. Well, I mean many women that are seeking
14 pregnancy are excited to find out as early as they can
15 so.

16 Q. So we're just talking about the women that
17 are actually trying to get pregnant?

18 A. Right.

19 Q. The rest of the women you're not suggesting
20 they should go every week now to make sure early --

21 A. That's not the point. The point is by the
22 time she misses a period it's readily it's easily
23 provable that she's pregnant.

24 Q. I'd like to turn now to some of the
25 literature we were talking about earlier. You had

1 mentioned we were talking about ACOG. Is it fair to
2 say that ACOG has weighed in on second trimester
3 abortions in a practice bulletin?

4 A. Yes, they have.

5 Q. And they have determined that D&E abortions
6 are safe and effective; is that right?

7 A. ACOG has never submitted any sort of
8 testimony in favor of any restriction on abortion.
9 And surely with all the restrictions that are out
10 there, there are some that can improve safety for
11 women. So I think the fact that they're promoting
12 second trimester abortion is just consistent with
13 their ideology.

14 Q. You testified that there are a lot of risk of
15 complications as a result of abortion; is that right?

16 A. Yes, ma'am.

17 Q. So while hemorrhage is a potential
18 complication, ACOG concludes that serious hemorrhage
19 occurs in less than 1% of D&E abortions; is that
20 right?

21 A. They did report that in their 2013 practice
22 bulletin. There was actually a recent study out of
23 University of California at San Francisco where they
24 were looking at using a medication called Methergine
25 after an abortion to decrease blood loss. And

1 interestingly they didn't find an improvement with the
2 medication, but what they did document was that 50% of
3 the women obtaining D&Es at the San Francisco Hospital
4 with experienced clinicians met their criteria for
5 excessive hemorrhage 50%, 1 out of 2.

6 Q. What's the name of that report?

7 A. I believe the author was Kerns, K-E-R-N-S.

8 Q. Is that report cited in your declaration?

9 A. It is not. I just found it recently.

10 Q. You also mentioned and we were talking about
11 the National Academies. The National Academies is
12 also concluded in that Safety of Abortion paper that
13 the evidence clearly shows again that D&E abortions
14 are safe and effective and you reject that again in
15 light of your concerns of the National Academies's
16 bias; is that right?

17 A. Not so much the bias, although there may be a
18 component of that. But just the flaws in our data
19 collection, so that we are undoubtedly underreporting.
20 But even the CDC's data tells us that when we go from
21 the 13 to 15 week D&E to the 16 to 20 week D&E that
22 there is about triple the complications. And, in
23 fact, Bartlett and Berg in their CDC study tell us
24 that there is a 38% increase in the risk of maternal
25 mortality for every week past eight weeks that a

1 termination is performed. In the early second
2 trimester, there is a 15-fold increase in maternal
3 mortality. In the mid-second trimester which is the
4 gestational age that we're discussing related to this
5 legislation, there is a 30-fold increase in maternal
6 mortality. And after viability after approximately
7 21 weeks, there is a 76-fold increase in maternal
8 mortality and death from a D&E procedure. Again, I'm
9 not saying every provider does dangerous D&Es. But
10 I'm just saying since we do not supervise abortion
11 providers very well in this country, the providers
12 like whoever was in Pensacola at that clinic are
13 hurting women. And there is a smattering of news
14 releases or news reports around the country, New
15 Mexico, Maryland. There are late-term abortion
16 providers who do not provide good care and they are
17 hurting women.

18 Q. And the Bartlett and Berg study that you cite
19 that's from 2004, right?

20 A. It is an old study, yes.

21 Q. Right. So a lot of the data that you're
22 referencing and support your conclusion that D&E
23 abortions are unsafe, are actually quite outdated at
24 this point. The reports that we've talked about today
25 are actually relatively recent; isn't that fair?

1 A. That is true that it's an older study. I
2 think what's helpful about that study is to show that
3 as the gestational age increases the risk increases
4 sometimes in an expediential way. I think that's the
5 key take-home point. I'm not saying that I
6 necessarily feel that the CDC numbers reported at that
7 time or even now accurately reflect the deaths, but
8 the increase that we see I think is probably an
9 accurate reflection of how much more dangerous they
10 get as the pregnancy increases.

11 Q. So the accurate reflection from 20 years ago?

12 A. Well, I mean just the you know again 20 years
13 ago a 20-week fetus was the same size that a 20-week
14 fetus is now. 20 years ago the uterus had the same
15 degree of thin muscle that it has now. So even
16 though there'd been some small changes in the
17 procedure notably cervical ripening agents that make
18 it a little easier to get into the uterus, the
19 procedure itself has not changed significantly so that
20 we would expect a 20-week D&E to be so much more safe
21 than it was 20 years ago because it's essentially the
22 same procedure.

23 Q. But you can't cite to any current data that
24 supports the conclusion that you're making which is
25 that D&E abortions are not safe; is that right?

1 A. Well --

2 Q. Yes or no question at this point, Dr. Skop?

3 A. If we collected accurate data, we would
4 probably see that.

5 MS. PILLAY: Nothing further, Your Honor.

6 THE COURT: Doctor, a couple things. Is
7 there data that you're familiar with, if this is
8 not part of your testimony let me know, but is
9 there data that you are aware of that compares
10 mortality and morbidity of full term where the
11 woman carries full term versus abortion in the
12 first 15 weeks? Are they compared in mortality
13 and morbidity?

14 THE WITNESS: Well, the CDC again they're
15 data reflects what comes to their attention, which
16 I think is probably not complete. We can look at
17 the record linkage studies that I mentioned in
18 Finland and Denmark and other countries and
19 actually see the likelihood that a woman dies
20 within a year of her pregnancy outcome, and we see
21 the exact opposite of what the CDC tells us that
22 she's much more likely to die after an abortion
23 procedure. And that's several things. That's
24 both the physical risk, but it's also mental
25 health risk which we have no way of detecting

1 either.

2 THE COURT: What does the CDC does it give
3 mortality of women after full-time delivery versus
4 abortion; what do they say about it?

5 THE WITNESS: You mean what are the numbers?

6 THE COURT: Yes, ma'am.

7 THE WITNESS: Right now they are reporting
8 higher numbers after a term pregnancy, but there's
9 been a lot in the literature independent of
10 abortion. The CDC in 2016 some researchers at
11 University of Maryland told us that you know what
12 we have not the United States didn't even release
13 a maternal mortality statistic for about 15 years
14 because they knew the data was so bad. And I
15 don't think we've corrected all those data
16 problems yet. It's on everybody's radar screen,
17 but even in regards to a term pregnancy we're
18 missing a lot. 50% is the number that several
19 studies have shown, but we miss 50% of the deaths
20 even in a term pregnancy.

21 THE COURT: In a delivery on a term
22 pregnancy, there are doctors that commit
23 malpractice in those also just like they do in
24 abortions, right?

25 THE WITNESS: Well, certainly it can happen,

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yes, but I think that hospitals have committees in place monitoring physician quality.

THE COURT: Well, doctors have severely injured babies through improper use of forceps in delivery, correct?

THE WITNESS: That can happen, yes.

THE COURT: Babies have been severely injured or died because of an umbilical cord compression that's not picked up correctly on fetal heart monitor or fetal heart monitor sheets?

THE WITNESS: Yes, I mean certainly medical malpractice can occur, but I think when it occurs related to a term pregnancy it's almost certain going to become a medical practice case. But I would say that because of the stigma and the embarrassment of abortion, many times when that medical practice occurs the woman or her family do not sue.

THE COURT: Breech delivery, mishandling breech delivery is another common potential negligence area.

THE WITNESS: It can happen.

THE COURT: Okay. I think that's all I have, so thank you.

THE WITNESS: Thank you.

1 THE COURT: Does anyone else have anyone more
2 questions?

3 MR. FARQUI: No redirect, Your Honor.

4 MS. PILLAY: No, Your Honor.

5 THE COURT: Thank you very much and good luck
6 on your I assume it's a flight back.

7 So are we done except for a rebuttal witness
8 and then I have to read two depositions and then
9 we have -- frankly, I think I'd like to read the
10 declarations again before we do closing arguments.
11 You all could put them in context. So how long is
12 the rebuttal witness going to take?

13 MS. SANDMAN: I anticipate about 20 minutes,
14 Your Honor.

15 THE COURT: Including cross?

16 MR. GUARD: I'll try to be brief, Your Honor.

17 THE COURT: So here's what I think. Whether
18 we do the rebuttal witness today or not and I can
19 go after 5 if we can do the rebuttal witness in 20
20 to 30 minutes, but I need time to read these
21 things, these things, the exhibits, the
22 depositions and to consider what I've heard. I
23 want to take a look at the Florida Supreme Court
24 cases again and then I want to consider your
25 closing arguments. And I just don't think I can

1 do it justice by doing that tomorrow. I think I
2 need to do that Thursday and I think I need to do
3 this live and in court. Now, that doesn't mean --
4 I mean obviously the press has a right to be here
5 and is invited to be here. And I understand that
6 creates a certain amount of inconvenience, but I
7 want to do the best I can do before this case if
8 it does go someplace else I want to do my job the
9 best I can do. Probably half the people will
10 agree with me and half will disagree with me in
11 this courtroom regardless of what I finally
12 determine. But since I've not read these
13 depositions and I want to read these declarations
14 again, I just don't think I can do it justice
15 until Thursday. I think we can have closing
16 argument Thursday. I can then consider what
17 you've said and then give you a verbal ruling.
18 Can I give verbal ruling that you can put down
19 exactly in writing, no, but I can cover the areas
20 that you have covered in the case and rule that
21 way. So Dr. Tien if she needs for her convenience
22 to have her testimony heard today I'd be glad to
23 hear that, but at that point I think I'd like to
24 reconvene on Thursday. You want to call Dr. Tien?

25 MS. SANDMAN: I would appreciate that if

1 that's possible, Your Honor.

2 THE COURT: Sure.

3 MR. GUARD: Your Honor, the State rests.

4 THE COURT: All right. Thank you.

5 (State rests.)

6 THE COURT: Dr. Tien, can we just have her
7 still be under oath from this morning. Dr. Tien,
8 you're still under oath. If you'll have a seat.
9 We're not so rushed that anybody has to talk fast.

10 MS. SANDMAN: I'll try to suppress the New
11 Yorker in me.

12 THE COURT: All right. Thank you. You may
13 proceed.

14 **D I R E C T E X A M I N A T I O N**

15 BY MS. SANDMAN:

16 Q. Dr. Tien, are abortion facilities in Florida
17 required to be licensed?

18 A. Yes.

19 Q. Are they inspected by a Florida State agency
20 to maintain that licensure?

21 A. Yes.

22 Q. Do you know how often those inspections
23 happen?

24 A. I don't. I know that they happen. I know
25 that care coordination occurs with our chief operating

1 officer.

2 Q. And do you know whether Florida State law
3 imposes a requirement to report abortion complications
4 to the State?

5 A. Yes.

6 Q. And if Florida had a concern that an abortion
7 facility was providing unsafe services, could they
8 revoke its license?

9 A. Yes.

10 Q. Dr. Tien, when you became credentialed as an
11 abortion provider at Planned Parenthood Southeast and
12 North Florida, what did you have to do to become
13 credentialed?

14 A. Aside from interviews with the chief medical
15 officer, interviews with the chief operating officer,
16 I had to submit proof of my training, my expertise,
17 procedures I have performed in other settings. I also
18 had to undergo additional educational training
19 specific to the clinic in regards to HIPAA, OSHA, and
20 that's actually an annual training.

21 Q. And do you know whether Planned Parenthood
22 tracks your complication rates as part of its quality
23 control process?

24 A. Yes, it does.

25 Q. If you know, do you know from your

1 professional experience is that process of tracking
2 complication rates and credentialing process before
3 providing services, is that typical of the way that
4 abortion providers are typically credentialed?

5 A. Yes, absolutely.

6 Q. If an abortion provider had an excessive
7 number of credentials, do you know whether the State
8 of Florida could revoke their medical license?

9 A. Yes.

10 Q. And is that true for physicians other than
11 abortion providers as well?

12 A. Yes, absolutely.

13 Q. Is there anything that's different about how
14 issues of quality and care are handled in the context
15 of abortion than other areas of medicine?

16 A. No.

17 Q. You've heard some testimony today about the
18 American Family Planning Clinic; are you familiar with
19 the reports of what happened there?

20 A. I heard initially what happened through media
21 reports. Prior to the media reports I was not aware
22 of that clinic's existence.

23 Q. And since that time have you become broad
24 strokes familiar with the claims?

25 A. Yes.

1 Q. And if those allegations are true, are they
2 typical of the way that abortion care is provided?

3 A. No.

4 Q. Do you have any idea how often serious
5 complications occur such as what happened to the
6 patients at issue in those charges?

7 A. Extremely rarely, less than .5% both
8 documented in the literature and in my clinical
9 experience.

10 Q. To be clear, the less than .5% statistic that
11 you're giving that's a general statistic for
12 complications, right?

13 A. Correct.

14 Q. Not for the specific series of events that
15 are claimed to have happened at that clinic?

16 A. That's correct.

17 Q. Doctor, the State thinks that a subpar or
18 dangerous provider sort of that one occurrence
19 supports their idea of a ban on abortion after
20 15 weeks. In your view, is that a basis to ban
21 abortions?

22 A. No. I'm not familiar with this clinic. I
23 don't know who works there. Clearly some very
24 dangerous things occurred and clearly the State
25 detected it as that clinic was shut down.

1 Q. Doctor, I'd like to ask you some general
2 questions about abortion procedures, the way that
3 they're performed in this country in modern medicine.
4 What are the basic types of procedures that can be
5 used after 15 weeks for in clinic abortion?

6 A. After 15 weeks an in clinic suction procedure
7 is most commonly done. Every abortion procedure after
8 15 weeks requires some amount of preparing or dilating
9 the cervix, suction to empty the uterus, and later in
10 pregnancy it may require additional instruments to
11 enter the uterus.

12 Q. Would you normally use forceps at 15 weeks?

13 A. I do not.

14 Q. You heard Dr. Skop's testimony about what she
15 considers to be the dangers of a D&E procedure. Did
16 anything in that testimony change your opinion on
17 abortion safety?

18 A. No, it did not.

19 Q. And why not?

20 A. The dangers described are absolutely real
21 complications that can occur when caring for a
22 pregnant woman. And in discussing informed consent
23 and the procedure that is absolutely part of the
24 discussion. The expectation as a physician is that if
25 you are offering these procedures you have a

1 tremendous and stellar level of expertise prior to
2 doing so as is the case for any area of medicine. So
3 it does not change my opinion because that is part of
4 the informed consent process. It is something that
5 should only be offered by appropriately trained
6 physicians. And overall abortion complications are
7 very, very low.

8 Q. Is a D&E procedure a dangerous procedure?

9 A. No.

10 Q. Does it have a high complication rate just to
11 be clear?

12 A. No, it does not.

13 Q. Now, you also heard Dr. Skop's testimony that
14 abortion complication rates are I believe she said
15 vastly underreported. Do you agree with that
16 testimony?

17 A. No, I do not.

18 Q. Why not?

19 A. In every state that I have provided abortion
20 care and also in the context of providing pregnancy
21 care, there has been a requirement for reporting of
22 complications. And specifically in the hospital
23 setting, every pregnancy-related event is reported,
24 recorded, and evaluated.

25 Q. How does that reporting obligation compare to

1 reporting complications in other areas of medicine?

2 A. I actually believe specific to pregnancy it's
3 tremendously robust. We track and report pregnancy
4 outcomes much more carefully and in much more detail
5 than for example other nonmedical areas.

6 Q. I'm sorry. Could you clarify other
7 nonmedical areas?

8 A. For example, general surgery, removal of the
9 appendix. Our tracking of pregnancy related events is
10 very detailed. And yes, it varies from state to state
11 because we are a large country, we are heterogenous
12 country, but we do an excellent job of tracking
13 outcomes of pregnancy-related events.

14 Q. Dr. Tien, how do you open the cervix to
15 perform abortion?

16 A. There are several options. Medication,
17 mostly Misoprostol can be used to soften and open the
18 cervix. The cervix could also be opened with
19 dilators. And then there can be dilators that are
20 either synthetic or natural that are placed in the
21 cervix the day prior to a procedure.

22 Q. Dr. Skop testified that the cervix is
23 resistant to being dilated and roughly speaking that
24 complications are common as a result. Do you agree
25 with that testimony?

1 A. No, I do not.

2 Q. And why not?

3 A. It is understood that in the provision of a
4 safe abortion procedure the cervix needs to be gently
5 dilated, so it is done so. And so that it is done via
6 medication or mechanical dilators, or for a patient
7 who's farther in pregnancy and requires more cervical
8 dilation with dilators that are placed overnight to
9 slowly absorb the moisture of the cervix and open the
10 cervix.

11 Q. Does this process weaken the cervix and make
12 premature birth more likely in the future?

13 A. There is some literature suggesting that
14 there may be a weak association; however, overall it
15 is not something that on the very long list of risk
16 factors for preterm birth is as markedly strong as
17 prior preterm birth, multiple gestation, poverty,
18 being young, being black.

19 Q. Can prior pregnancies that are carried to
20 term also result in an increased risk of premature
21 birth?

22 A. Absolutely.

23 Q. Dr. Tien, what is -- I'm let me try that
24 again. Can having an abortion increase the risk for
25 placental abruption in future pregnancies?

1 A. No.

2 Q. You heard Dr. Skop's testimony that placental
3 abruptio occurs as a result of sharp curettage. How
4 common is sharp curettage in contemporary provision of
5 abortion care?

6 A. It is never performed.

7 Q. You also heard Dr. Skop's testimony that the
8 CDC does an inadequate job of evaluating whether a
9 death is related to abortion; do you agree?

10 A. I do not.

11 Q. And why not?

12 A. The CDC has scientists and epidemiologists
13 who are trained specifically to evaluate complications
14 and look for root cause of death.

15 Q. And in doing that does the CDC, and I'm doing
16 my best to quote from Dr. Skop's testimony, just
17 report the data that comes to it? Is that how the CDC
18 data collection process functions?

19 A. No. The CDC is quite proactive, so the data
20 sources are multiple. They can be submitted by the
21 state. They can be submitted by multiple maternal
22 morbidity review committees, which are state and local
23 committees convening looking at maternal mortality and
24 safety. And they can also be proactive evaluating
25 additional patient surveillance and patient surveys.

1 Q. As a result of those multiple processes in
2 your expert opinion, how would you evaluate the
3 quality of the CDC data in this area?

4 A. I feel that it is excellent.

5 Q. You also heard Dr. Skop's testimony that the
6 CDC data comparing abortion-related deaths to deaths
7 from pregnancy and childbirth makes an inaccurate
8 comparison because the numerators and denominators are
9 inconsistent; do you agree with that criticisms?

10 A. I do not agree.

11 Q. And why not?

12 A. The data looking at abortion mortality looks
13 at abortion mortality per legal induced abortion
14 procedures. The data looking at maternal mortality
15 looks at maternal mortality for women who have
16 continued pregnancies against 100,000 live births. So
17 those denominators are comparable and appropriate for
18 the numerators.

19 Q. Dr. Tien, can you explain what is ACOG
20 briefly?

21 A. ACOG is the American College of Obstetricians
22 and Gynecologists. It is the largest educational and
23 women's health professional association in this
24 country specific for OB-GYNs. When I last looked,
25 there is over 58,000 members of

1 obstetrician-gynecologist. They are responsible for
2 reviewing the literature and publishing guidelines on
3 education and clinical guidance both for clinicians
4 and also for patients.

5 Q. Would you consider ACOG to be biased in
6 connection with abortion?

7 A. No.

8 Q. It doesn't have a conflict of interest?

9 A. It does not.

10 Q. Is there any serious debate on that topic in
11 mainstream medicine?

12 A. No.

13 Q. What is the Royal College of Obstetrics and
14 Gynecology?

15 A. It is a comparable association in the United
16 Kingdom.

17 Q. I won't ask you to describe it in more
18 detail, but would you consider it to be a biased
19 organization?

20 A. No.

21 Q. And the Society for Maternal-Fetal Medicine?

22 A. The Society for Maternal-Fetal Medicine is
23 the leading organization for professionals who provide
24 care for high-risk pregnancies such as myself.

25 Q. And within your field what degree of weight

1 are conclusions from the Society for Maternal-Fetal
2 Medicine afforded?

3 A. Tremendous weight.

4 Q. And what is the Green Journal?

5 A. The Green Journal is the title is Obstetrics
6 and Gynecology. It is the well-known published
7 peer-reviewed journal of ACOG.

8 Q. And what are the National Academies of
9 Medicine and Engineering? I think I got that wrong.

10 A. National Academies of Sciences, Engineering,
11 and Medicine. Similarly they used to be known as the
12 Institute of Medicine, but similarly they are a
13 committee of researchers, scientists, physicians, and
14 experts in policy and law that review the evidence and
15 make guidelines.

16 Q. What kind of weight are their conclusions
17 afforded?

18 A. Tremendous.

19 Q. And in mainstream medicine are any of those
20 organizations we've been discussing understood to be
21 biased organizations?

22 A. No.

23 MR. PERCIVAL: Your Honor, objection. Scope.

24 The doctor did not submit a declaration on any of
25 these testimony that she's given and she did not

1 disclose it in her deposition that I took.

2 THE COURT: Sustained.

3 BY MS. SANDMAN:

4 Q. Dr. Tien, does the morning-after pill cause
5 abortions?

6 A. It does not. The primary function of the
7 morning after pill is similar to taking a large dose
8 of birth control pills. It prevents ovulation. It
9 can in some circumstances prevent a fertilized egg
10 from implanting, but the most common mechanism is that
11 it prevents ovulation or release of the egg from the
12 ovary.

13 Q. Do IUDs cause abortions?

14 A. No.

15 Q. Do birth control pills cause abortions?

16 A. No.

17 Q. Is there any dispute on this in mainstream
18 medicine for any of those items?

19 A. No.

20 Q. I'm going to turn now to the testimony that
21 you've heard from Dr. Condic in connection with fetal
22 pain. First, Dr. Tien, is knowledge of fetal
23 development important to your work as an MFM?

24 A. Yes.

25 Q. Can you explain how?

1 A. A lot of what I do for maternal-fetal
2 medicine is care for pregnant women. And that also
3 includes performing their ultrasounds at different
4 stages of pregnancy as well as performing what we in
5 medicine call fetal testing, so ultrasounds to ensure
6 that the baby is healthy and developing well or fetal
7 testing which is monitoring of the fetal heart readout
8 on the monitor. So in all of these settings, I need
9 to be able to discuss with patients what I am seeing
10 on ultrasound during their prenatal care and also on
11 fetal testing.

12 Q. If a fetus could feel pain, would that be
13 relevant to any clinical decisions that you're
14 involved in in your role as an MFM?

15 A. If a fetus could feel pain, because I as an
16 MFM care for high-risk pregnant women, it would be a
17 part of every discussion. However because it cannot,
18 it is not a part of my discussion with my patients.

19 Q. And, Dr. Tien, just to be clear, what is your
20 opinion on whether a fetus at 15 weeks can feel pain
21 in utero?

22 A. A fetus at 15 weeks cannot feel pain in
23 utero.

24 Q. And how do you know that?

25 A. I know that it has been alluded to that the

1 perception of pain requires several factors. It
2 requires the establishment of building blocks for
3 pathways to interpret the pain from the external
4 environment, carry the signals through the spinal cord
5 into multiple portions of the brain including the
6 thalamus and the cortex, so there needs to be an
7 establishment of the building blocks or the basic
8 circuitry. In addition, there needs to be a higher
9 level of cortical processing recognition and awareness
10 of pain.

11 Q. And when are those pathways formed?

12 A. The early absorption of environmental stimuli
13 is present very early in pregnancy from 8 to 15 weeks.
14 The beginnings of the pathways up through the spinal
15 cord to the brain are present between 20 to 22 weeks.
16 And when I say weeks, I speak by gestational age by
17 LMP as I'm clinician and not an embryologist. So the
18 basic fundamental building blocks are in place by 24
19 to 26 weeks, but the higher level cortical processing
20 recognition and awareness is not in place until later
21 in pregnancy in the third trimester.

22 Q. Dr. Tien, what is intrauterine surgery? Can
23 you explain for the Court?

24 A. Intrauterine surgery is a procedure performed
25 on a fetus on a pregnant woman.

1 Q. What are the types of situations where the
2 need for intrauterine surgery would arise?

3 A. Sometimes during a routine ultrasound there
4 can be a lesion or birth defect that is detected. A
5 good example is neural tube defect where the spine is
6 open. And in certain select scenarios the patient can
7 be offered in utero fetal surgery to help optimize the
8 outcomes for that pregnancy and that baby.

9 Q. Is intrauterine surgery an area that you
10 studied as part of your MFM training?

11 A. Yes.

12 Q. Are MFMs involved in the care team providing
13 surgeries in utero?

14 A. MFMs are integral to the care team.

15 Q. Tell the Court about how that care team
16 functions and what the MFM --

17 MR. GUARD: Again, Your Honor, we've wandered
18 way outside the scope of any testimony that's been
19 disclosed in the declaration or that was testified
20 to in her deposition that I took three days ago.

21 MS. SANDMAND: Your Honor, she disclosed --

22 THE COURT: I think she's -- go ahead.

23 MS. SANDMAND: I apologize, Your Honor.

24 THE COURT: I think this is a proper area of
25 rebuttal testimony. She's an MFM. I'm saying all

1 these acronyms. She's an MFM. And yes, Counsel.

2 MR. GUARD: But, Your Honor, we had a
3 procedure where they were supposed to disclose the
4 expert testimony and this was not disclosed. I
5 inquired in a deposition about the kinds of
6 testimony she was going to offer as rebuttal and
7 she did not disclose this testimony. So I'm
8 impeded in my cross-examination because it was not
9 disclosed.

10 MS. SANDMAN: Your Honor, we disclosed that
11 she would be a rebuttal witness including on the
12 topic of fetal pain. And very shortly I'll be
13 transferring this area of my testimony to the part
14 of the basis for the conclusion that she's
15 offering on fetal pain, which is that it cannot be
16 perceived prior to 24 weeks.

17 THE COURT: Overruled. I think this is
18 related to the issue of fetal pain because there
19 was testimony that in fetal surgery there is
20 anesthesia given to the fetus, so I think it's
21 related to the fetal pain. Go ahead.

22 BY MS. SANDMAN:

23 Q. So I believe that I'll ask the question
24 again. Could you tell the Court about the care team
25 that's involved in fetal surgery and what the role of

1 an MFM is in that team?

2 A. So the MFM is usually the one making the
3 diagnosis of the fetal structural defect usually on
4 ultrasound. So in making that diagnosis in that
5 setting the MFM is the one that counsels the patient
6 on the finding, counsels them on the options, and
7 counsels them on the care moving forward. The MFM is
8 responsible for care coordination including
9 neonatology, making sure that the delivery occurs at a
10 hospital that has a tertiary level of care to be able
11 to care for a neonate with such anatomic concern as
12 well as whatever necessary pediatric subspecialists
13 are required as well as an anesthesia team that is
14 familiar with obstetric anesthesia in particular.

15 Q. Dr. Tien, just to make sure that we're all
16 straight in terms what is anesthesia?

17 A. Anesthesia is a general term that covers a
18 broad area of medications that can be used to sedate a
19 patient, treat pain, cause amnesia, or also relieve
20 anxiety. It's a broad term for medication.

21 Q. What is analgesia?

22 A. Analgesia is a board term for medication used
23 to treat pain.

24 Q. Do you know if anesthesia or analgesia are
25 ever used for fetal pain in the setting of fetal

1 surgery?

2 A. They are used in the setting of in utero
3 surgery not for fetal pain.

4 Q. What are they used for?

5 A. So there are four very important things that
6 need to be considered to make these very delicate
7 surgeries successful. I'm going to use the example of
8 spina bifida or open neural tube defect. So a woman
9 is in the operating room, an OB usually MFM makes the
10 initial incision to open the skin and then open the
11 uterus. The baby is then delivered to the level of
12 the anatomic defect of concern. The surgeon repairs
13 that defect. The fetus is returned into the uterus
14 and the uterus is then closed. The hope then of
15 course is that the woman remains pregnant for many,
16 many more weeks. So you can imagine there are lots of
17 things that need to be balanced carefully for the best
18 outcome. So analgesia and anesthesia has four
19 essentially roles in this setting.

20 No. 1, maximum uterine relaxation. The
21 uterus must stay relaxed during this procedure. If
22 there's contractions, it can preempt a preterm birth
23 and that's obviously not the goal. It can also
24 preempt what's called a placental abruption where the
25 placenta tears off the uterus again promoting a

1 preterm birth which is not what we want.

2 The second role is a paralytic. So we want
3 the fetus to not be moving, to be still. And the
4 reason is that primarily we want it to be an optimal
5 surgical space for the operating surgeon so that he or
6 she can do his or her best job repairing the lesion of
7 concern.

8 The third role is to blunt fetal
9 physiological response. So not to treat fetal pain,
10 but to blunt physiological response. Anytime we are
11 exposed to something in the environment we have a
12 response. Heart rate changes, our blood pressure
13 changes. It does not necessarily mean that we are
14 perceiving pain, but that we have a response. And
15 what we don't want to happen for one of the
16 physiological responses is what's called fetal
17 bradycardia where the heart rate drops. If that
18 happens that can also prompt a premature delivery and
19 that is not what we want.

20 And the fourth important part is what we say
21 in medicine is monitoring of maternal and fetal
22 hemodynamics, and so that's just a fancy way of saying
23 the maternal and fetal unit are one and we need to
24 make sure that both are staying safe. And so the role
25 of the MFM, who is actually scrubbed into operative

1 field along with the pediatric surgeon, is to monitor
2 the tone of the uterus, the heart rate of the fetus,
3 and then also communicate with the anesthesia team to
4 make sure that from the operative field those goals
5 are being met and the anesthesia team is also making
6 sure that the woman is safe.

7 Q. So if fetal pain was what the care team was
8 trying to address, would the team do something
9 different in administering medications during the
10 surgery?

11 A. Yes.

12 Q. Say more about that.

13 A. If the focus was treating fetal pain then we
14 would be treating the fetus like we do an adult who
15 needs pain medicine, so giving pain medicine by pills,
16 starting an IV and giving pain medicine through the
17 IV, injecting pain medicine into the muscle. Pain
18 control can include a spinal, which is numbing
19 medicine in the back or an epidural that's used during
20 labor. So we would be acting on the fetus directly to
21 administer pain control.

22 Q. Just to be clear is it the standard of care
23 in medicine to do any of those things in intrauterine
24 surgery?

25 A. It is not.

1 Q. On a slightly different topic, if the care
2 team is doing a procedure on the fetus that does not
3 require an incision in the uterus, so a different type
4 of procedure, no incision, in that type of procedure
5 is anesthesia or analgesia required?

6 A. No.

7 Q. Is there a medical consensus that anesthesia
8 and analgesia are not required for that type of
9 procedure?

10 A. Yes.

11 Q. Despite the fact that certain interventions
12 are being done in the fetus?

13 A. That is correct.

14 Q. At what gestational ages have you been
15 involved in intrauterine surgeries?

16 A. It depends on the lesion of concern, but most
17 commonly this is later in the second trimester.

18 Q. So later than the time that we're talking
19 about with the 15-week abortion ban for example?

20 A. Yes.

21 Q. Just a few more questions in this area. You
22 heard Dr. Condic testify that a cortex in her view is
23 not necessary for a fetus to feel pain; is that
24 accurate?

25 A. Yes.

1 Q. Let me ask it a different way. Do you agree
2 with the statement that it's not necessary for the
3 fetus to have a cortex in order to feel pain?

4 A. I do not agree.

5 Q. Why is that?

6 A. I think there is good scientific literature
7 that is based on histopathological studies, so studies
8 of tissues, studies evaluated in the laboratory
9 setting establishing our fundamental understanding of
10 pain pathways.

11 Q. Is there a controversy in mainstream medicine
12 as to whether a fetus at 24 weeks in utero can feel
13 pain?

14 A. No.

15 Q. Are there medical associations that have
16 given analysis on this question?

17 A. Yes.

18 Q. Are you familiar with the Society for
19 Maternal-Fetal Medicine report on the use of analgesia
20 and anesthesia for maternal-fetal procedures?

21 A. Yes.

22 Q. Did that come out in 2021?

23 A. Yes.

24 Q. And what did it conclude in regard to fetal
25 pain?

1 A. It had three general conclusions based on
2 their review of the literature. The first is that
3 paralytics can be used in fetal procedures if needed
4 to decrease fetal movement to help with the success of
5 a procedure.

6 The second conclusion was that analgesia and
7 anesthesia may be used in in utero fetal procedures
8 for the reasons that I just stated.

9 And the third was that due to lack of good
10 data they recommended against the use of analgesia for
11 the purpose of any concerns for fetal pain in the
12 setting of pregnancy termination.

13 Q. And did it include a conclusion that the
14 connections to the cortex prior to 24 weeks are not
15 present -- excuse me -- prior to the late second or
16 early third trimester?

17 A. Yes.

18 Q. And do you agree with that conclusion?

19 A. Yes.

20 Q. Are you familiar with Royal College's fetal
21 awareness review of research and recommendation for
22 practice from 2010?

23 A. Yes.

24 Q. What weight would you give its conclusions?

25 A. I would give it tremendous weight.

1 Q. And do you know what it concluded with regard
2 to fetal pain?

3 A. A very, very similar conclusion that the
4 basic fundamental building blocks for pain are not
5 present until after 24 weeks and the higher level
6 cortical processing recognition and interpretation is
7 not present until much later in the third trimester.

8 Q. Are you familiar with the ACOG gestational
9 development and capacity for pain statement?

10 A. Yes.

11 Q. What did it conclude?

12 A. Similarly that the fundamental building
13 blocks are present at 24 weeks and beyond, but that
14 additional higher lever processing was not present
15 until later in the third trimester.

16 Q. Dr. Tien, are you aware of any leading
17 medical association at all that supports Dr. Condic's
18 view?

19 A. No.

20 Q. My last question, Dr. Tien, is there anything
21 else that you would want the Court to understand about
22 fetal pain?

23 MR. GUARD: Objection. Calls for a
24 narrative.

25 THE COURT: Sustained.

1 BY MS. SANDMAN:

2 Q. Dr. Tien, is there anything from your
3 perspective as a maternal-fetal medicine doctor, do
4 you have any additional views on fetal pain?

5 MR. GUARD: Objection. Calls for a
6 narrative.

7 THE COURT: I think I know where she is on
8 this topic. Sustained.

9 MS. SANDMAN: I'll pass the witness.

10 THE COURT: Okay. Cross.

11 MR. GUARD: Yes, Your Honor.

12 **C R O S S - E X A M I N A T I O N**

13 BY MR. GUARD:

14 Q. I apologize, Dr. Tien, since you did not
15 disclose that you were going to testify on some of
16 this information I don't actually have hardcopies of
17 documents. Doctor, you talked about a few minutes ago
18 the Society for Maternal-Fetal Medicine's report on
19 the use of analgesia and anesthesia for maternal-fetal
20 procedures?

21 A. Yes.

22 Q. And that was based largely on a paper whose
23 primary author was a Dr. Chatterjee; are you familiar
24 with Dr. Chatterjee's paper?

25 A. That consult series was based on several

1 studies.

2 Q. But one of the studies that it was primarily
3 based on is one by Dr. Chatterjee, correct?

4 A. Yes.

5 Q. And Dr. Chatterjee on page 1167 of that
6 consult said pain is a subjective phenomena that is
7 difficult to assess, right?

8 A. Yes.

9 Q. It also said because it remains uncertain
10 exactly when a fetus has the capacity to feel pain, it
11 is best to administer adequate fetal anesthesia in all
12 invasive maternal-fetal procedures to inhibit the
13 humoral -- I said that wrong -- stress response,
14 decrease fetal movement, and blunt any perception of
15 pain as has been the standard practice since the start
16 of maternal-fetal surgery in the early 1980s, correct?

17 A. Yes.

18 Q. So it's been the standard of care and the
19 standard practice for maternal-fetal surgery since the
20 '80s to administer adequate anesthesia to fetuses,
21 correct?

22 A. As I previously discussed, the purposes of
23 analgesia and anesthesia in in utero fetal surgery is
24 several fold. Blunting fetal physiologic response is
25 one of them.

1 Q. So it's the standard practice to use
2 anesthesia since the 1980s with fetuses having
3 surgery, right?

4 A. In the setting of in utero surgery where
5 there is an incision required on the uterus it is the
6 standard to offer analgesia and anesthesia for the
7 reasons I previously alluded to and to blunt fetal
8 physiologic response. For procedures that do not
9 involve an incision on the uterus, it is not the
10 standard.

11 Q. Maybe this goes to the category of things
12 that are understated but would you agree with me,
13 Doctor, that abortion is a politically charged issue
14 in this country?

15 THE COURT: I --

16 MR. GUARD: I'll withdraw.

17 THE COURT: Okay. Thank you.

18 BY MR. GUARD:

19 Q. You are not a neurologist, right?

20 A. I'm not a neurologist.

21 Q. You are not an embryologist, right?

22 A. I'm not an embryologist.

23 Q. You're a doctor who spends 70% of her time
24 providing abortion services, right?

25 A. As part of my expertise in obstetrics,

1 gynecology and maternal-fetal medicine a large part of
2 that is a provision of abortion services.

3 MR. GUARD: Your Honor, would you instruct
4 the witness to answer the question.

5 THE COURT: I think she just answered it. I
6 mean you haven't asked her anything she hasn't
7 answered already a couple times today.

8 BY MR. GUARD:

9 Q. You've not done any research on fetal pain
10 yourself, correct?

11 A. Correct.

12 Q. And you've never been part of a fetal pain
13 study, right?

14 A. That is correct.

15 Q. And you're not a university professor,
16 correct?

17 A. That is correct.

18 Q. And you've never been a university professor,
19 right?

20 A. That is correct.

21 Q. On your direct testimony you made a whole
22 bunch of statements and testified about being a
23 Florida medical doctor; do you recall that?

24 A. Yes, I am a physician who works in Florida.

25 Q. Your experience as a doctor in Florida is

1 extremely limited, right?

2 A. Can you clarify limited?

3 Q. Well, you've been a licensed doctor in
4 Florida for 19 months, right?

5 A. So I've had an active medical license in
6 Florida for 19 months, but I've been caring for
7 pregnant women for many more years than that.

8 Q. You've actually been a practicing doctor in
9 Florida for 15 months, right?

10 THE COURT: How long have your witnesses been
11 licensed in Florida and practiced in Florida,
12 Counsel?

13 MR. GUARD: I did not have them testify about
14 being a Florida doctor.

15 THE COURT: I know. We're getting into the
16 weeds here. She's a licensed doctor in Florida.
17 You've got one who's a professor. You've got one
18 who is a practicing physician for 30 years. Each
19 has their differences. I've listened to all of
20 it.

21 MR. GUARD: All right. Your Honor, I'll move
22 on.

23 THE COURT: Okay.

24 BY MR. GUARD:

25 Q. You've only performed abortions in Florida

1 for one provider, right?

2 A. Yes.

3 Q. And almost all of those abortions have been
4 performed at a single location in Jacksonville,
5 Florida, correct?

6 A. Yes.

7 Q. Before you became an expert or while you were
8 an expert in this case or before, you didn't speak to
9 any other providers in any other part of Florida as
10 part of your getting ready to be an expert, right?

11 A. Correct.

12 Q. And you're not familiar with any clinics
13 other than how Planned Parenthood Southeast and North
14 Florida performs abortions, right?

15 A. Not in Florida.

16 Q. All right. Now, you made some statements
17 about ACOG. Have you ever been to ACOG's website?

18 A. Yes.

19 Q. On its website doesn't it have advocacy
20 papers and even letters for doctors to sign advocating
21 against abortion restrictions?

22 A. There is an area for advocacy, yes.

23 Q. So ACOG does have as part of its mission to
24 advocate for abortion against abortion restrictions,
25 right?

1 A. As part of its mission for patient advocacy
2 ACOG advocates for patient health based on the
3 science. Abortion is one of those issues. It's not
4 the only one.

5 Q. I'm just going to move on. I don't think
6 that really answers the question but.

7 THE COURT: I thought it did.

8 MR. GUARD: Okay. Well, I respectfully
9 disagree with that. If I could just have a
10 minute.

11 THE COURT: Sure.

12 MR. GUARD: Nothing further, Your Honor.

13 THE COURT: Any redirect?

14 MS. SANDMAN: No, Your Honor.

15 THE COURT: Thank you, Doctor. You can step
16 down.

17 I have Dr. Skop's transcript. Dr. Biggs.
18 The only thing I didn't have was a corrected copy
19 of Dr. Biggs's deposition, so I'm going to borrow
20 that from the Clerk. I have all the declarations
21 already in the file. I'm going to take home
22 Exhibit 8 and give the Clerk back the rest of the
23 exhibits.

24 MR. GUARD: Your Honor, most of those
25 depositions were also notices of filing on the

1 docket, so if you have trouble.

2 THE COURT: I can look them up. All right.
3 I'll do that. Do you all want to start at 8:30 on
4 Thursday morning instead of 9:00? I've got a
5 couple of hearings around 10 or so.

6 MR. GUARD: Yes, Your Honor.

7 THE COURT: So Thursday at 8:30. Same place.
8 Same courtroom.

9 MS. SANDMAN: Your Honor, for the record,
10 I'll rest our rebuttal case.

11 (Plaintiffs rest.)

12 THE COURT: Okay. Thank you. Thursday at
13 8:30, Courtroom 3G. Okay. Anything else before
14 we go?

15 MR. GUARD: No, Your Honor.

16 THE COURT: I'm aware that July 1st is on
17 Friday, but all I can do is what I can do. So I'm
18 going to be honest with you when I hear closing
19 argument and if I make a ruling on Thursday, I
20 don't think it's going to be reduced in writing by
21 Friday because I'm going to give whoever is not
22 the prevailing party 24 hours to review. I would
23 just say the thing we can do to make it fastest is
24 both sides, you may already have done this, both
25 sides be working on orders which can easily be

1 modified depending upon the ruling as quickly as
2 possible. In some cases where I've had a little
3 bit more time, I've asked lawyers to send me
4 competing orders beforehand, but we just didn't
5 have the time to do that here.

6 Anything else from Plaintiff?

7 MS. PILLAY: Yes, Your Honor. Thank You. We
8 understand that your judicial assistant is out
9 this week.

10 THE COURT: Yes, she is.

11 MS. PILLAY: We apologize for the difficulty
12 for you, but if there is a way that the parties
13 can contact chambers if necessary with any
14 scheduling issues or any follow-up questions.

15 THE COURT: Okay. See this is difficult
16 because I don't know what my email address is.
17 I'll tell you the way that you can contact me is
18 she's going to love that I do this, but Paula
19 Watkins at Court Administration. She doesn't know
20 I've just given her name out. And Court
21 Administration, the Clerk can tell you how to get
22 through them. And if I had a little bit more
23 time, I'd go down and get my email address. But I
24 never email myself. And usually I think I know
25 what it is, but I'm not exactly sure I do know

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what it is. I will have it by Thursday for sure.
We can go off the record. Let's go off the
record.

(Hearing concluded at 5:30 p.m.)

CERTIFICATE OF REPORTER

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STATE OF FLORIDA)
COUNTY OF LEON)

I, Doreen M. Mannino, Court Reporter, do hereby certify that I was authorized to and did report in stenotypy and electronically the foregoing proceedings and evidence and the captioned case, and that the foregoing pages constitute a true and correct transcription of my recording thereof.

IN WITNESS WHEREOF, I have hereunto affixed my hand the 4th day of July 2022 at Tallahassee, Leon County, Florida.

Doreen M. Mannino
Doreen M. Mannino

EXHIBIT C

PLANNED PARENTHOOD ASSOCIATION OF UTAH

VS

MINER

INGRID SKOP, M.D.

September 02, 2020



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September 02, 2020

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:

INGRID SKOP, M.D.



* * *

September 2, 2020
8:03 a.m.

Via Web Conference

Kristin Marchant
- Registered Professional Reporter -

6	<p>1 malpractice case and the other is as an expert witness in 2 a medical malpractice case. 3 Q. What -- so the case that you were a 4 defendant, do you recall the name of that case? 5 A. To tell you the truth, I don't. 6 Q. What did it involve; what kind of procedure 7 or care? 8 A. It was after a delivery where the baby had 9 some problems. 10 Q. What kind of problems? 11 A. He had seizures. 12 Q. Okay. And then was that in Texas, I 13 assume? 14 A. It was in Texas -- it was about 24 years 15 ago. 16 Q. Okay. So it's been a while. 17 A. Yes. 18 Q. What about the other case you mentioned 19 where you had been a expert witness? 20 A. It was also in Texas, probably about two 21 years ago, and it was a surgical complication. 22 Q. Okay. 23 A. I was the expert witness for the defense. 24 Q. Okay. Was that in your report? I don't 25 recall seeing that one. So two years ago for the</p>	8	<p>1 A. A little. 2 Q. A little bit. Some of it has been a while. 3 But just so that we're all on the same page today, I want 4 to go over some ground rules for today's deposition. 5 First, you understand that you're testifying 6 under oath today and that your answers are subject to the 7 penalties of perjury? 8 A. Yes. 9 Q. And do you understand that this is the 10 same -- the oath that you took this morning is the same 11 oath that you would take in court if you were testifying 12 at trial? 13 A. Yes. 14 Q. Do you understand that today I'll ask 15 questions, you'll provide answers, and the court reporter 16 will take down the questions and answers verbatim and put 17 them in a written transcript? 18 A. Yes. 19 Q. Okay. So we're interested in finding out 20 everything you know and think about the opinions that you 21 intend to offer as an expert witness in this case. So we 22 want your answers to be as complete and accurate as 23 possible. Is that fair? 24 A. Yes. 25 Q. Okay. So it is my job to ask understandable</p>
7	<p>1 defense. And what kind of complication was that, again? 2 I'm sorry. 3 A. It was a woman who had a hysterectomy and 4 she had a bladder injury afterwards that required surgery 5 to repair it. 6 Q. Okay. And you were testifying that the care 7 provided was within the standard of care, is that -- 8 A. That is correct. 9 Q. Okay. And then you said maybe -- 10 MS. MURRAY: Sorry, does -- I'm getting some 11 feedback. 12 Q. (By Ms. Murray) You said there may have 13 been a third case in which you were deposed; is that 14 correct? 15 A. There was another medical malpractice case, 16 again, probably 15 to 20 years ago. Now that I think 17 about it, I don't think there was a deposition in that 18 case. 19 Q. Okay. So it sounds like, then, that this is 20 the first kind of case where you've been deposed that 21 involves abortion; is that correct? 22 A. That is correct. 23 Q. All right. So it sounds like based on what 24 you've described, you have some experience with having 25 your deposition taken, correct?</p>	9	<p>1 questions. If at some point during the day I ask a 2 question and you don't understand it, which is probably 3 likely to happen despite my best efforts, if you could 4 just flag that for me, I would be happy to rephrase. But 5 if you don't flag a question for me as something you 6 don't understand, I'll assume that you do understand it. 7 Okay? 8 A. Okay. 9 Q. And then the other ground rule, I'm guilty 10 of this quite a bit as well, it is very important for the 11 court reporter that she be able to get full answers from 12 both -- and record things accurately. So if you could 13 try to wait until I finish my question to provide your 14 answer, and I'll try to wait until you finish answering 15 before I start talking again, just so we can keep things 16 straight on the record. 17 A. Okay. 18 Q. Okay. So let's talk about breaks. I'll 19 plan -- and Mr. Sorenson may have told you this. I'll 20 plan to stop at least once every hour to every hour and a 21 half so we can take a break. You can get up and stretch; 22 you can get food, whatever you need. But if you feel 23 like you need a break in between those points in the 24 deposition today, you know, please flag them for me or 25 Mr. Sorenson, and I would be happy to take a break. So</p>

10	<p>1 one thing I would ask, however, is that if there is a</p> <p>2 question pending at the time you would like to take a</p> <p>3 break that you provide an answer to that question before</p> <p>4 we break. Okay?</p> <p>5 A. Okay.</p> <p>6 Q. So sometimes it happens during a deposition</p> <p>7 that you'll remember later in the day that there are</p> <p>8 things that you forgot to say or documents that you</p> <p>9 remembered that might help refresh your recollection to</p> <p>10 respond to one of my questions. If that happens, will</p> <p>11 you let me know?</p> <p>12 A. Yes.</p> <p>13 Q. Okay. It may be that we have some of the</p> <p>14 documents, and I can send them along. Certainly, if</p> <p>15 there is anything you want to get corrected on the record</p> <p>16 today as we go along, just flag that.</p> <p>17 So because we're doing this deposition</p> <p>18 remotely, the judge has put in place special rules for</p> <p>19 conducting a remote deposition. Did Mr. Sorenson share</p> <p>20 with you the judge's order about remote depositions?</p> <p>21 A. Yes, he did.</p> <p>22 Q. Okay. So you understand that today during</p> <p>23 the deposition, you're barred from using notes or any</p> <p>24 other materials that I have not provided to you?</p> <p>25 A. Yes.</p>	12	<p>1 circumstances. It may have been because I have some</p> <p>2 friends who also do expert witness -- on cases like this.</p> <p>3 Q. So would it be accurate to say that you</p> <p>4 first learned about the case and the opportunity to be an</p> <p>5 expert from someone other than Mr. Sorenson?</p> <p>6 A. That is possible. I don't recall who</p> <p>7 reached out to me first, if it was Mr. Sorenson or</p> <p>8 someone else.</p> <p>9 Q. Are there any documents that might refresh</p> <p>10 your recollection in that respect: emails, letters?</p> <p>11 A. Possibly.</p> <p>12 Q. Do you have any sense of who else might have</p> <p>13 contacted you to provide an opportunity to act as an</p> <p>14 expert in this case?</p> <p>15 A. I don't remember who contacted me, no.</p> <p>16 Q. Okay. What have you done to prepare for</p> <p>17 this deposition?</p> <p>18 A. I have reread the -- many of the articles</p> <p>19 that I cited in my expert witness report.</p> <p>20 Q. Anything else?</p> <p>21 A. I think I've looked on the internet a little</p> <p>22 bit to find out about abortion in Utah.</p> <p>23 Q. And what would you -- what did you read on</p> <p>24 the internet?</p> <p>25 A. I looked at the information through</p>
11	<p>1 Q. Okay. And do you understand that under the</p> <p>2 court's order you're also barred from having any</p> <p>3 communication with anyone other than Mr. Sorenson via</p> <p>4 chat, text, or any other way of communication?</p> <p>5 A. Yes.</p> <p>6 Q. Do you agree to comply with those rules,</p> <p>7 Dr. Skop?</p> <p>8 A. Yes.</p> <p>9 Q. So because it is critical that we get your</p> <p>10 full and accurate answers today, I have to ask, is there</p> <p>11 any reason why you would be unable to provide full and</p> <p>12 accurate answers in response to my questions today?</p> <p>13 A. No.</p> <p>14 Q. Okay. All right. So in the Notice of</p> <p>15 Deposition, we had asked for some documents from you, and</p> <p>16 I appreciate you sending along some of your articles and</p> <p>17 materials. Is there anything else in response to that</p> <p>18 request that you brought with you to share today?</p> <p>19 A. No.</p> <p>20 Q. All right. So let's talk a little bit about</p> <p>21 how you came to serve as an expert in this case. Can you</p> <p>22 tell me when you first learned that you might be an</p> <p>23 expert in this case?</p> <p>24 A. I believe it was probably last fall that --</p> <p>25 I don't recall exactly who I heard from or the</p>	13	<p>1 Guttmacher.</p> <p>2 Q. Anything else that you looked at online to</p> <p>3 prepare for the deposition?</p> <p>4 A. I don't think so.</p> <p>5 Q. Okay. And you said you reviewed articles</p> <p>6 that you cited in your expert report, correct?</p> <p>7 A. Yes.</p> <p>8 Q. Had you read all of those articles</p> <p>9 previously?</p> <p>10 A. Yes.</p> <p>11 Q. Okay. Did you review anything else in</p> <p>12 preparation for today's deposition?</p> <p>13 A. Possibly some other articles that I have not</p> <p>14 cited.</p> <p>15 Q. And what might those articles be?</p> <p>16 A. Other articles related to the topic abortion</p> <p>17 complications, some articles about the reasons that women</p> <p>18 choose abortions late in pregnancy.</p> <p>19 Q. Do you have the authors of those articles or</p> <p>20 any information that might help identify them?</p> <p>21 A. The reasons -- there are a couple of -- or</p> <p>22 researchers associated with Guttmacher that do a lot of</p> <p>23 publishing on that: Finer, Foster, Jones. So I've looked</p> <p>24 at several articles from that group of researchers.</p> <p>25 Q. Uh-huh. And would say -- you mentioned</p>

14	<p>1 Foster. Would that have been Diana Greene Foster?</p> <p>2 A. Yes.</p> <p>3 Q. Would that have been an article with respect</p> <p>4 to findings from the Turnaway studies; do you recall?</p> <p>5 A. I have looked at some of the Turnaway</p> <p>6 studies, yes.</p> <p>7 Q. But you're not sure if it is what you looked</p> <p>8 at with respect to reasons for abortion?</p> <p>9 A. It is likely, but I don't recall</p> <p>10 specifically.</p> <p>11 Q. And what about complication rates? You said</p> <p>12 you may have looked at some other articles with respect</p> <p>13 to complication rates. What might those have been?</p> <p>14 A. I also do a lot of research on maternal</p> <p>15 mortality, so there have been some other articles. There</p> <p>16 are some very informative articles out of Finland, and I</p> <p>17 think I may have probably documented at least one of</p> <p>18 those in my references, but -- Gissler and colleagues.</p> <p>19 There's probably about five articles that talk about</p> <p>20 mortality rates. I believe the other Finish researchers</p> <p>21 I quoted in the references already.</p> <p>22 Q. Okay. So other Finish studies.</p> <p>23 Any other documents that you reviewed in</p> <p>24 preparation for today's deposition?</p> <p>25 A. I believe that's it.</p>	16
15	<p>1 Q. Okay. Did you -- just to confirm, did you</p> <p>2 review any of the other expert reports in this case?</p> <p>3 A. No, I have not.</p> <p>4 Q. Have you reviewed any other case documents</p> <p>5 in this case since you submitted your expert report?</p> <p>6 A. You know, I take it back. The only other</p> <p>7 expert report that I have seen is Byron Calhoun's. And I</p> <p>8 don't know why, but that ended up in the packet that you</p> <p>9 guys sent me yesterday. But I had not seen it before</p> <p>10 then, and I have not really reviewed it extensively</p> <p>11 because I thought it probably got sent as an accident.</p> <p>12 Q. Okay. So just to confirm -- and perhaps</p> <p>13 this wasn't conveyed to you. Have you opened the packet</p> <p>14 from yesterday, Dr. Skop?</p> <p>15 A. Yes.</p> <p>16 Q. You've opened it. Okay.</p> <p>17 A. Was I not supposed to?</p> <p>18 Q. You weren't supposed to, no. That was part</p> <p>19 of the court's order, actually, that you were provided by</p> <p>20 Mr. Sorenson.</p> <p>21 A. Oh, I'm sorry. I --</p> <p>22 Q. And so it sounds like, in addition to</p> <p>23 opening the article, you must have opened packets inside</p> <p>24 the article that were sealed themselves. Is that</p> <p>25 accurate?</p>	17

September 02, 2020

18	<p>1 abortion and maternal mortality.</p> <p>2 Q. Okay. Have you worked on any other</p> <p>3 materials that AAPLOG has provided to the public?</p> <p>4 A. Yes, I was involved in writing several of</p> <p>5 their practice bulletins and committee opinions.</p> <p>6 Q. Okay. What about their fact sheets? AAPLOG</p> <p>7 provides fact sheets to the public, correct?</p> <p>8 A. That is correct. I believe that the fact</p> <p>9 sheets were written before I joined the board.</p> <p>10 Q. Okay. So you wouldn't have had any role</p> <p>11 working on those fact sheets?</p> <p>12 A. No, I don't think so.</p> <p>13 Q. No, so not on maternal mortality?</p> <p>14 A. I believe that one was already written.</p> <p>15 Q. What about fetal pain?</p> <p>16 A. No, I did not write that one.</p> <p>17 Q. Okay. Do you also have any association with</p> <p>18 the Charlotte Lozier Institute?</p> <p>19 A. I am one of their associate scholars.</p> <p>20 Q. What does that mean; what are your</p> <p>21 responsibilities in that capacity?</p> <p>22 A. There's not really any set responsibilities</p> <p>23 and it is not a paid position. Occasionally they'll</p> <p>24 reach out to me for my opinions on issues, and I've</p> <p>25 written one paper for them.</p>	20
19	<p>1 Q. Okay. And which paper was that?</p> <p>2 A. The paper was called No-Test Medical</p> <p>3 Abortion.</p> <p>4 Q. Okay. Is that identified in your -- well,</p> <p>5 we can talk about it in a moment.</p> <p>6 So you mentioned the Charlotte Lozier</p> <p>7 Institute and AAPLOG. Do you know, do either of those</p> <p>8 organizations provide training for expert witness</p> <p>9 testimony for individuals in the pro-life community?</p> <p>10 MR. SORENSON: Objection, foundation.</p> <p>11 A. -- it is Charlotte Lozier.</p> <p>12 Q. I'm sorry, ma'am, I couldn't hear you.</p> <p>13 MR. SORENSON: Let me put my objection on</p> <p>14 the record.</p> <p>15 Objection, foundation.</p> <p>16 Q. Could you answer the question, Dr. Skop?</p> <p>17 A. Yes. Charlotte Lozier does.</p> <p>18 Q. So you're aware of that training?</p> <p>19 A. Yes.</p> <p>20 Q. How did you become aware of that training?</p> <p>21 A. I participated in the training.</p> <p>22 Q. You participated in the training. When was</p> <p>23 that?</p> <p>24 A. It was probably last year, last fall.</p> <p>25 Q. Last fall. So around the time that you knew</p>	21
20	<p>1 you would be an expert witness in this case?</p> <p>2 A. No. It was before I knew about this case.</p> <p>3 Q. Okay. Do you recall which month that was?</p> <p>4 A. Probably September.</p> <p>5 Q. And what did that training entail?</p> <p>6 A. It involved a number of things. There was</p> <p>7 some media training: how to be interviewed and get your</p> <p>8 points across. There was a small amount of expert</p> <p>9 witness training, but it wasn't really the focus of the</p> <p>10 training event.</p> <p>11 Q. Do you remember what it was called?</p> <p>12 A. I do not remember.</p> <p>13 Q. Who presented on the expert witness</p> <p>14 testimony; do you recall that?</p> <p>15 A. I do not recall. I'm really bad with names.</p> <p>16 It was a woman I had not ever met.</p> <p>17 Q. Okay. And no one else, to your</p> <p>18 recollection?</p> <p>19 A. I'm sorry. I didn't understand the</p> <p>20 question.</p> <p>21 Q. There was no one else who presented on</p> <p>22 expert testimony training to your recollection?</p> <p>23 A. I believe there was just one presenter.</p> <p>24 Q. Okay. All right. And do you have any</p> <p>25 materials from that training?</p>	22
21	<p>1 A. Not with me.</p> <p>2 Q. But do you have them in your possession?</p> <p>3 A. I may. I would probably have to look back</p> <p>4 through handouts and stuff that I have. I don't remember</p> <p>5 if I kept them or not.</p> <p>6 Q. Would you have kept notes?</p> <p>7 A. Possibly.</p> <p>8 Q. Do you remember who else was at the training</p> <p>9 with you?</p> <p>10 A. There were probably about twelve Charlotte</p> <p>11 Lozier scholars there.</p> <p>12 Q. Any other names that you recall?</p> <p>13 A. Let's see. I think Kate Carnahan, Christina</p> <p>14 Francis, Donna Harrison. . . The others I don't recall.</p> <p>15 Q. Do you know who the experts in this case</p> <p>16 are, Dr. Skop?</p> <p>17 A. Who the --</p> <p>18 Q. Sorry, I apologize.</p> <p>19 A. Other expert witnesses?</p> <p>20 Q. Yes. The other expert witnesses; do you</p> <p>21 know any of them?</p> <p>22 A. Do I know them personally?</p> <p>23 Q. Uh-huh.</p> <p>24 A. I know Byron.</p> <p>25 Q. Byron Calhoun?</p>	23

September 02, 2020

22	<p>1 A. Uh-huh.</p> <p>2 Q. And what about Anthony Levatino?</p> <p>3 A. Oh, I'd forgotten that he was one. Yes, I</p> <p>4 know Anthony.</p> <p>5 Q. What about Maureen Condic?</p> <p>6 A. I don't know her personally.</p> <p>7 Q. What about Priscilla Coleman?</p> <p>8 A. I don't know Priscilla personally.</p> <p>9 Q. And Farr Curlin?</p> <p>10 A. I believe I met him once.</p> <p>11 Q. So you said you did a training from the</p> <p>12 Charlotte Lozier Institute. Have you spoken or done any</p> <p>13 other trainings with individuals or groups in order to</p> <p>14 prepare to give expert witness testimony?</p> <p>15 A. No, I have not.</p> <p>16 Q. Okay. So have you now told me everything</p> <p>17 you've done to prepare for today's testimony?</p> <p>18 A. Yes.</p> <p>19 Q. In total, how much time would you say you</p> <p>20 spent preparing to be deposed today?</p> <p>21 A. Probably an additional 20 hours.</p> <p>22 Q. Okay. And what's your hourly rate for</p> <p>23 compensation in this case?</p> <p>24 A. I believe it is 300.</p> <p>25 Q. \$300 per hour?</p>	24	<p>1 written agreement with the state with respect to your</p> <p>2 expert testimony in this case?</p> <p>3 A. I believe I do.</p> <p>4 Q. And is that -- to your knowledge, does the</p> <p>5 compensation you receive in this case depend in any way</p> <p>6 on the outcome?</p> <p>7 A. No.</p> <p>8 Q. Have you been told -- or to your knowledge,</p> <p>9 is there a limit to the number of hours that you can</p> <p>10 spend on this case that the state would compensate you</p> <p>11 for?</p> <p>12 A. I'm not aware of a limit.</p> <p>13 Q. Okay. Outside of the compensation that you</p> <p>14 anticipate receiving from the state in this case, is</p> <p>15 there any other entity or individual who is paying you</p> <p>16 for your time as an expert witness in this case?</p> <p>17 A. No.</p> <p>18 Q. Okay. All right. Well, with that, I think</p> <p>19 it would be helpful to switch gears a little bit to the</p> <p>20 substance. And so I wanted to start just by asking you</p> <p>21 about the law challenge in this case.</p> <p>22 Are you familiar with HB136, the law at</p> <p>23 issue in this case?</p> <p>24 A. Yes, I am.</p> <p>25 Q. And what is your understanding of what this</p>
23	<p>1 A. Uh-huh.</p> <p>2 Q. Is that different for time spent providing</p> <p>3 deposition or trial testimony?</p> <p>4 A. Is the rate --</p> <p>5 Q. Yeah, do you have a different -- yes. Is</p> <p>6 your rate different for time spent preparing trial or</p> <p>7 deposition testimony as opposed to, for example, time</p> <p>8 spent preparing a report?</p> <p>9 A. The rate for deposition and trial is 350.</p> <p>10 Q. \$350 per hour, okay. Do you have any idea</p> <p>11 how much time you spent on this case to date?</p> <p>12 A. You know, I really don't. I think about it</p> <p>13 a lot, but I don't charge for that. I don't recall how</p> <p>14 much time I spent when I was preparing the report.</p> <p>15 Q. So do you keep track of your hours?</p> <p>16 A. I do. Like I say, I don't charge every time</p> <p>17 I'm thinking about it, so . . .</p> <p>18 Q. Have you received any payment to date,</p> <p>19 Dr. Skop from the state?</p> <p>20 A. I need to check my records.</p> <p>21 Q. Okay. And you don't have any idea how many</p> <p>22 hours you've spent on the case to date, correct?</p> <p>23 A. No, I do not. No.</p> <p>24 Q. Okay. One moment. And do you -- in</p> <p>25 addition to -- well, let me ask this. Do you have a</p>	25	<p>1 law would do if it takes effect?</p> <p>2 A. It would not allow a woman to have an</p> <p>3 elective abortion after 18 weeks gestation. It does</p> <p>4 allow exceptions for life of the mother for a -- the</p> <p>5 possibility for a severe physical outcome for the mother,</p> <p>6 the case of rape, if it's been reported to law</p> <p>7 enforcement, a uniformly lethal diagnosed condition in</p> <p>8 the fetus, or a severe fetal brain malformation.</p> <p>9 Q. And when you say 18 weeks gestation, does</p> <p>10 that mean 18 weeks as dated from the first day of a</p> <p>11 patient's last menstrual period?</p> <p>12 A. That's correct.</p> <p>13 Q. Okay. So if -- throughout the day today, to</p> <p>14 make sure that we're talking about the same way of dating</p> <p>15 a pregnancy, if I say 18 weeks LMP, you would understand</p> <p>16 that to mean 18 weeks as dated from the first day of a</p> <p>17 patient's last menstrual period, correct?</p> <p>18 A. That's correct.</p> <p>19 Q. Okay. Would you agree throughout the day,</p> <p>20 as we talk about different points in pregnancy, that if</p> <p>21 you do not use LMP -- if you mean something other than</p> <p>22 LMP that you'll say that throughout the day --</p> <p>23 A. Yes.</p> <p>24 Q. -- when referring to points in pregnancy.</p> <p>25 That would be helpful. Thank you.</p>

26	<p>1 Okay. So do you know any of the defendants</p> <p>2 in this case?</p> <p>3 A. No.</p> <p>4 Q. What about any members of the Utah</p> <p>5 legislation?</p> <p>6 A. No.</p> <p>7 Q. So not representative Cheryl Acton?</p> <p>8 A. No.</p> <p>9 Q. Senator Deidre Henderson?</p> <p>10 A. No.</p> <p>11 Q. Did you play any role in the development of</p> <p>12 HB136?</p> <p>13 A. No.</p> <p>14 Q. Have you ever played any role in the</p> <p>15 development of other legislation in Utah or other states</p> <p>16 related to abortion?</p> <p>17 A. No.</p> <p>18 Q. Okay. So no drafting of other</p> <p>19 legislation?</p> <p>20 A. No.</p> <p>21 Q. No input to legislators who are considering</p> <p>22 such legislation?</p> <p>23 A. No.</p> <p>24 Q. No testimony of any kind?</p> <p>25 A. Not prior to the legislation being written.</p>	28	<p>1 safety for women.</p> <p>2 Q. Okay. And you mentioned that you had done</p> <p>3 testimony in Texas. Have you ever provided testimony</p> <p>4 with respect to any other legislation elsewhere in the</p> <p>5 United States involving abortion?</p> <p>6 A. Verbal testimony?</p> <p>7 Q. Testimony of any kind, Doctor. So verbal,</p> <p>8 written.</p> <p>9 A. I've written one other expert witness</p> <p>10 report.</p> <p>11 Q. Okay. And where would that have been</p> <p>12 submitted?</p> <p>13 A. Georgia.</p> <p>14 Q. Georgia. What was the legislation that</p> <p>15 pertained to?</p> <p>16 A. The legislation that has been put on hold</p> <p>17 that prohibits abortion after a fetal heart beat can be</p> <p>18 detected.</p> <p>19 Q. And when does a fetal heart beat</p> <p>20 generally -- when can it generally be detected?</p> <p>21 A. It can generally be detected between six and</p> <p>22 seven weeks post LMP.</p> <p>23 Q. At that point is it medically accurate to</p> <p>24 refer to the product of conception as a fetus, or is it</p> <p>25 an embryo?</p>
27	<p>1 Q. But after the legislation was written, you</p> <p>2 might have provided testimony?</p> <p>3 A. I provided testimony on several occasions in</p> <p>4 2013 in Texas for HB2.</p> <p>5 Q. And for the record, HB2 is what?</p> <p>6 A. HB2 was a legislation that had four parts:</p> <p>7 It prohibited elected abortion after 20 weeks. It</p> <p>8 required that medical abortion be done as required by the</p> <p>9 FDA. It mandated that abortion providers have hospital</p> <p>10 privileges within 30 miles. And it mandated that</p> <p>11 abortion facilities meet the criteria of ambulatory</p> <p>12 surgery centers.</p> <p>13 Q. So you provided testimony to the legislature</p> <p>14 while it was considering that legislation, correct?</p> <p>15 A. Yes, I did.</p> <p>16 Q. Did you support the legislation?</p> <p>17 A. I did for reasons of safety.</p> <p>18 Q. Can you explain that? Safety with respect</p> <p>19 to what?</p> <p>20 A. Many abortionists do not take care of their</p> <p>21 complications. I've seen that as a private OB/GYN for 25</p> <p>22 years. I have seen many women in the emergency room when</p> <p>23 their abortion providers were not willing to care for</p> <p>24 them. So I testified because I felt the hospital</p> <p>25 admitting privilege was an important way to improve</p>	29	<p>1 A. The -- there's not a very clear definition</p> <p>2 between the transition between embryo and fetus, but most</p> <p>3 would refer to it as a fetus at that point.</p> <p>4 Q. At six weeks of pregnancy?</p> <p>5 A. Uh-huh.</p> <p>6 Q. Okay. All right. So Georgia. Any other</p> <p>7 states?</p> <p>8 A. No.</p> <p>9 Q. Okay. All right. So let's go to -- let's</p> <p>10 go to your professional training before we get into the</p> <p>11 details of your expert report. I'd like to get a</p> <p>12 sense -- a little bit better sense of your professional</p> <p>13 background. So with that, I want to introduce -- if you</p> <p>14 can turn to Tab A.</p> <p>15 MS. MURRAY: And, Ms. Marchant, I think this</p> <p>16 will be Exhibit 1.</p> <p>17 (Discussion held off the record.)</p> <p>18 (Exhibit No. 1 was marked.)</p> <p>19 Q. Dr. Skop, Tab A, is this your CV,</p> <p>20 Exhibit 1?</p> <p>21 A. Yes.</p> <p>22 Q. Okay. And did you prepare it?</p> <p>23 A. Yes.</p> <p>24 Q. Does it include a current and accurate list</p> <p>25 of your credentials?</p>

<p style="text-align: right;">30</p> <p>1 A. Yes.</p> <p>2 Q. Okay. Are there any inaccuracies on the CV</p> <p>3 that you want to point out?</p> <p>4 A. No.</p> <p>5 Q. Anything missing on the CV?</p> <p>6 A. I mean, I think you can always add more</p> <p>7 things to a CV, but I don't see anything substantial</p> <p>8 missing.</p> <p>9 Q. So nothing that you would imagine would be</p> <p>10 relevant to this case?</p> <p>11 A. No.</p> <p>12 Q. So I see you're trained as an OB/GYN; is</p> <p>13 that correct?</p> <p>14 A. That is correct.</p> <p>15 Q. Can you describe the nature of your</p> <p>16 practice?</p> <p>17 A. I'm in a group practice of about 20 OB/GYNs,</p> <p>18 and I work full time. I probably deliver 15 babies a</p> <p>19 month. I see 25 to 30 patients a day in the office, take</p> <p>20 call along with the rest of my group. Since there is a</p> <p>21 lot of us, it is usually about two 24-hour calls a month.</p> <p>22 Q. Okay. And when you say you take call, what</p> <p>23 does that mean?</p> <p>24 A. Due to the size of our group, it means that</p> <p>25 I come to the hospital, I pack a bag, and I do nothing</p>	<p style="text-align: right;">32</p> <p>1 setting?</p> <p>2 A. Do you mean like a public clinic or --</p> <p>3 because we would call our office a clinic, our private</p> <p>4 practice.</p> <p>5 Q. Right. Sure. My apologies. I'm referring</p> <p>6 to a public clinic or sometimes, for example, hospitals</p> <p>7 will have outpatient clinics of different types that are</p> <p>8 located near but not necessarily within the hospital.</p> <p>9 A. No, it is within my practice.</p> <p>10 Q. I'm sorry, what was that?</p> <p>11 A. All of my clinical work is done within my</p> <p>12 private OB/GYN practice.</p> <p>13 Q. Okay. And you've been doing that since</p> <p>14 1996; is that correct?</p> <p>15 A. Yes.</p> <p>16 Q. Okay. And what's the hospital that you</p> <p>17 practice in?</p> <p>18 A. North Central Baptist.</p> <p>19 Q. I saw at one point that you were the -- am I</p> <p>20 getting this correct, that you were the chair of the</p> <p>21 Baptist Hospital Systems, or the chair of the department</p> <p>22 of OB/GYN; is that correct?</p> <p>23 A. I was just the chair of the department at</p> <p>24 one point.</p> <p>25 Q. Of the department for Baptist Hospital</p>
<p style="text-align: right;">31</p> <p>1 but manage labor and deliver babies on labor and</p> <p>2 delivery.</p> <p>3 Q. Okay. So during a month, you would probably</p> <p>4 have two days like that, where you're doing labor and</p> <p>5 delivery work at the hospital?</p> <p>6 A. Yes.</p> <p>7 Q. Are there other days of the month that you</p> <p>8 are doing labor and delivery at the hospital?</p> <p>9 A. If I have a patient that comes in in labor</p> <p>10 or a scheduled C-section or induction, I will do those</p> <p>11 deliveries even if I'm not the call doctor.</p> <p>12 Q. Okay. So if it is one of your patients, you</p> <p>13 would go into the hospital for that in addition to the</p> <p>14 days that you're on call; is that correct?</p> <p>15 A. Yes.</p> <p>16 Q. So you work in a private practice. How many</p> <p>17 people are in your practice?</p> <p>18 A. Twenty.</p> <p>19 Q. Sorry. I should say how many physicians.</p> <p>20 Is it 20?</p> <p>21 A. There's 20 physicians, yes.</p> <p>22 Q. Twenty physicians, okay. Are they all</p> <p>23 OB/GYNs?</p> <p>24 A. Yes.</p> <p>25 Q. What about -- do you do any work in a clinic</p>	<p style="text-align: right;">33</p> <p>1 Systems, right?</p> <p>2 A. For -- at the time I was at a different</p> <p>3 Baptist hospital. Northeast Baptist, and I was the chair</p> <p>4 of the OB/GYN department for that time period.</p> <p>5 Q. Okay. So you were at the Northeast Baptist</p> <p>6 Central Hospital, and now you're at the North Central</p> <p>7 Baptist Hospital?</p> <p>8 A. Yeah. I was at Northeast Baptist for</p> <p>9 probably about 15 years, and then we moved our practice</p> <p>10 to North Central Baptist for the last, probably, nine</p> <p>11 years.</p> <p>12 Q. Okay. And are those -- are both of those</p> <p>13 hospitals affiliated with Baptist Hospital Systems in</p> <p>14 Texas?</p> <p>15 A. Yes. Yes, they are.</p> <p>16 Q. Okay. So what is -- you said that you work</p> <p>17 full time. What does a normal week look like for you in</p> <p>18 terms of the kinds of care that you provide?</p> <p>19 A. I take one day off a week, Wednesday. The</p> <p>20 other four days I work -- two days a week I work from</p> <p>21 7:45 to 3:15. The other two days I see patients from</p> <p>22 9:00 until 5:00, and sometimes I have surgeries or</p> <p>23 C-sections scheduled before or during lunch periods.</p> <p>24 Q. Okay. How many -- do you have a sense of</p> <p>25 how many patients you have, your overall patient</p>

September 02, 2020

<p style="text-align: right;">34</p> <p>1 caseload?</p> <p>2 A. I don't know how many active patients I have</p> <p>3 because many of them just come to see me once a year for</p> <p>4 their annuals. I would say, in an average week, I</p> <p>5 probably see 100 to 110 patients in the office.</p> <p>6 Q. Okay. Do you have a sense of how that</p> <p>7 caseload would break down between patients seeing you for</p> <p>8 obstetrical care as opposed to gynecological care?</p> <p>9 A. Probably 20 percent obstetric and 80 percent</p> <p>10 gynecologic.</p> <p>11 Q. And some of the gynecologic visits could be</p> <p>12 women who are between pregnancies, correct?</p> <p>13 A. Yes.</p> <p>14 Q. Okay. And then how would you describe the</p> <p>15 patient population that you serve in your private</p> <p>16 practice?</p> <p>17 A. Of our OB patients, probably about 40</p> <p>18 percent have Medicaid funding. The rest are privately</p> <p>19 funded -- or private insurance. Demographics, probably</p> <p>20 10 percent black women, 50 to 60 percent Hispanic, and</p> <p>21 most of the rest are white, occasional Indian or Pacific</p> <p>22 Islander.</p> <p>23 Q. Sorry. You said 50 to 60 percent Hispanic,</p> <p>24 and what share would you estimate are black?</p> <p>25 A. About 10 percent.</p>	<p style="text-align: right;">36</p> <p>1 Q. And do you have any sense of when they do</p> <p>2 come in, that third?</p> <p>3 A. I would say it is probably only about 10 or</p> <p>4 15 percent that come in after the first trimester.</p> <p>5 Q. Okay. What's the latest you've seen someone</p> <p>6 come in?</p> <p>7 A. Well, I've delivered women at the hospital</p> <p>8 that didn't know they were pregnant, so all the way to</p> <p>9 delivery, but typically it is much earlier.</p> <p>10 Q. How often has that happened that you've had</p> <p>11 deliveries from women who didn't know they were</p> <p>12 pregnant?</p> <p>13 A. No very often. Most women know.</p> <p>14 Q. Would it be more than five?</p> <p>15 A. More than five women?</p> <p>16 Q. Uh-huh.</p> <p>17 A. I'd say probably about five women that went</p> <p>18 all the way to term without knowing they were pregnant.</p> <p>19 Q. And the people who come to see you, you say</p> <p>20 about 10 to 15 percent will come in after the first</p> <p>21 trimester. Do you have a sense of when those people</p> <p>22 learned they were pregnant?</p> <p>23 A. My sense is that it is rare for a woman not</p> <p>24 to know or suspect that she's pregnant and get halfway</p> <p>25 through her pregnancy before she knows. I think most</p>
<p style="text-align: right;">35</p> <p>1 Q. What about the -- how -- for patients who</p> <p>2 come to see you for obstetrical care, how early do</p> <p>3 patients typically come in for their first prenatal</p> <p>4 visit?</p> <p>5 A. If they're not having any problems, we</p> <p>6 generally try to bring them in by about seven weeks.</p> <p>7 Q. Okay. So is that the recommendation for</p> <p>8 standard prenatal care?</p> <p>9 A. It -- it works out well because at that</p> <p>10 visit we can generally document the fetal cardiac motion</p> <p>11 by ultrasound, so we can give them reassurance about the</p> <p>12 viability of their pregnancy. If they're bleeding or</p> <p>13 having pain, of course we get them in earlier.</p> <p>14 Q. Uh-huh. And do you -- do you see -- I mean,</p> <p>15 I imagine on some occasions you must see people who come</p> <p>16 in later for care than seven weeks; is that correct?</p> <p>17 A. That is correct.</p> <p>18 Q. Who come in for their first visit?</p> <p>19 A. That's correct.</p> <p>20 Q. How -- can you estimate how often that</p> <p>21 happens among your patient population, that people come</p> <p>22 in after the recommended seven-week visit for their first</p> <p>23 prenatal appointment?</p> <p>24 A. Probably about a third of them come in after</p> <p>25 seven weeks.</p>	<p style="text-align: right;">37</p> <p>1 women who present for late prenatal care, they are either</p> <p>2 in denial about the pregnancy or, perhaps,</p> <p>3 procrastinating. Sometimes there's Medicaid funding</p> <p>4 issues too.</p> <p>5 Q. Can you explain the Medicaid funding</p> <p>6 issue?</p> <p>7 A. If a woman doesn't have insurance, in order</p> <p>8 to get Medicaid funding, she needs to -- sorry, there's</p> <p>9 some noise.</p> <p>10 -- she needs to apply for Medicaid. And for</p> <p>11 some women, that can take a little bit of time to do</p> <p>12 that.</p> <p>13 Q. I see. Okay. So you said you think it is</p> <p>14 rare. Would you say, based on your experience, that it</p> <p>15 happens in 5 percent of cases that women don't know until</p> <p>16 after the first trimester?</p> <p>17 A. I think it would be less than 5 percent.</p> <p>18 Q. Actually, if we could back up. I believe</p> <p>19 you said you thought it was rare that people don't know</p> <p>20 they're pregnant until after the first half of pregnancy.</p> <p>21 Is that what you said, Dr. Skop?</p> <p>22 A. I think that might have been what I said.</p> <p>23 Q. Okay. But just for -- to be clear, though,</p> <p>24 the second half -- the first half of pregnancy would end</p> <p>25 after what week?</p>

September 02, 2020

<p style="text-align: right;">38</p> <p>1 A. You know, I think what I said was a little 2 imprecise. Let me back up. 3 I think it is very rare for women not to 4 know that they're pregnant until the gestational age that 5 we're discussing in this legislation. 6 Q. Meaning 18 weeks -- 7 A. Eighteen weeks. 8 Q. -- plus? Okay. 9 And with respect to those people, would you 10 say that's maybe 5 percent of your patient population 11 doesn't learn that they're pregnant until 18 weeks of 12 pregnancy or more? 13 A. I think it is far less than that. 14 Q. Less. What about the share of your pregnant 15 population who learn that they're pregnant after the 16 first trimester, so after -- let me ask you. What would 17 you say -- when does the first trimester end, what week 18 LMP? 19 A. Typically we think 12 and 13 weeks. 20 Q. What share of your patient population would 21 you say learns that they're pregnant after 12 to 13 weeks 22 of pregnancy? 23 A. Although some present later than that for 24 various reasons, I think it would probably only be 2, 3 25 percent that don't know that they're pregnant after that</p>	<p style="text-align: right;">40</p> <p>1 induction? 2 A. Possibly a third. 3 Q. Okay. And why would you induce labor? What 4 are the reasons that a patient might have induction? 5 A. Some patients want to do it for social 6 reasons. They may have other children at home that 7 they'd like to arrange child care for, perhaps to arrange 8 their work leave. That's an elective induction. There 9 are specific criteria we use to determine whether it is 10 appropriate to induce that labor. 11 We manage a very high risk patient 12 population. The rate of obesity, diabetes, and 13 hypertension are quite high in San Antonio, and many 14 times women who have those problems require delivery due 15 to worsening severity of their underlying medical 16 problems. 17 Q. I see. So when you say that they may 18 require delivery, you mean they might require delivery 19 before their bodies would naturally go into labor; is 20 that correct? 21 A. That is correct. 22 Q. So you would induce labor, in those 23 circumstances, to deliver the baby other than might 24 otherwise occur? 25 A. If appropriate. Sometimes they need a</p>
<p style="text-align: right;">39</p> <p>1 time. 2 Q. In your practice. Is that what you're 3 testifying to? 4 A. In my practice, uh-huh. 5 Q. All right. So in terms of -- you mentioned 6 you do about 20 percent obstetrical care in a given week 7 and 80 percent gynecological care, correct? 8 A. Correct. 9 Q. Of the gynecological care that you provide, 10 what kinds of procedures do you do? What are the most 11 common ones? 12 A. Probably the most common are minor 13 procedures such as an endometrial ablation, which is for 14 dysfunctional uterine bleeding or a laparoscopic tubal 15 ligation. 16 Q. Okay. What else? 17 A. Those are the most common that I do. 18 Q. Okay. What about for obstetrical care? You 19 mentioned that you deliver babies. Do you have a sense 20 of how those deliveries break down in terms of vaginal 21 versus caesarean section birth? 22 A. Probably about a quarter caesarean section 23 and three-quarter vaginal. 24 Q. Okay. What about -- among the vaginal 25 births that you do, what share would you say begin with</p>	<p style="text-align: right;">41</p> <p>1 C-section for obstetric indications. 2 Q. You mentioned the possibility of elective 3 inductions and that there was some criteria you use in 4 determining when that might be appropriate. What are 5 those criteria? 6 A. They need to be at least 39 weeks 7 gestational age. 8 Q. Okay. 9 A. And I prefer to deliver them when they have 10 a favorable cervix, meaning that they're a little bit 11 dilated. There are various criteria, but usually about 12 two centimeters dilated. Because in that scenario, I 13 don't think we're raising the risk of C-section by 14 inducing labor. 15 Q. Okay. Because if it is what you might 16 consider an unfavorable cervix, induction can increase 17 the risk of -- 18 A. Yes. 19 Q. -- the C-section? 20 And in your practice, would you say that 21 that is, to your knowledge, your colleagues' practices? 22 Is that the point at which an OB/GYN might induce labor 23 for an elective induction in pregnancy, at that point in 24 pregnancy; does that vary by doctor? 25 A. So you're asking if the criteria of 39 weeks</p>

42	<p>1 and a favorable cervix vary by doctor?</p> <p>2 Q. Not the 39 weeks but the favorable cervix.</p> <p>3 You said that you like to see two centimeters dilation.</p> <p>4 Would you say that is individual preference, or would you</p> <p>5 say that is true across your practice?</p> <p>6 A. I think my partners practice in a very</p> <p>7 similar way to the way I do. Sometimes if a woman has</p> <p>8 gone past the due date, we may induce with an unfavorable</p> <p>9 cervix. But that's generally because, at that point,</p> <p>10 we're starting to have obstetric indications, concerns</p> <p>11 for the well-being of the fetus by going post dates.</p> <p>12 Q. Okay. And you mentioned the unfavorable</p> <p>13 cervix. What do you have to do with an unfavorable</p> <p>14 cervix to make the possibility of induction -- to make it</p> <p>15 realistically possible for someone to have an</p> <p>16 induction?</p> <p>17 A. In our hospital, we generally use a</p> <p>18 prostaglandin called Cervidil.</p> <p>19 Q. Cervidil. How is that administered?</p> <p>20 A. It is a vaginal insert.</p> <p>21 Q. Are there other ways you can deal with an</p> <p>22 unfavorable cervix --</p> <p>23 A. Yes.</p> <p>24 Q. -- to cause dilation?</p> <p>25 A. Some obstetricians will use a balloon</p>	44	<p>1 Q. And do you do them when patients request</p> <p>2 elective C-sections?</p> <p>3 A. I will do them after extensive counseling.</p> <p>4 There's higher risk of morbidity after a C-section, and</p> <p>5 so I make sure that the patients are aware of that.</p> <p>6 Q. Okay. So you would do them with appropriate</p> <p>7 counseling with respect to the risks; is that accurate?</p> <p>8 A. Yes.</p> <p>9 Q. Okay. One of the -- let's see. What are</p> <p>10 the risks of C-sections?</p> <p>11 A. There can be risk for anesthesia, aspiration</p> <p>12 if a woman vomits or has an overdose or a reaction.</p> <p>13 There can be risk of bleeding. There can be risk of</p> <p>14 infection in the abdomen, in the uterus, or the incision</p> <p>15 itself can become infected and can sometimes open. There</p> <p>16 can be risk of damage to other organs, particularly the</p> <p>17 bladder.</p> <p>18 Q. Anything else?</p> <p>19 A. Not that I can think of right offhand.</p> <p>20 Q. When you say bleeding, is there bleeding</p> <p>21 after any pregnancy separation?</p> <p>22 A. Generally, yes.</p> <p>23 Q. So what kind of bleeding would be a</p> <p>24 concern?</p> <p>25 A. Bleeding that results in blood loss that</p>
43	<p>1 catheter that they'll place in the cervix.</p> <p>2 Q. Okay.</p> <p>3 A. And there's -- we'll use misoprostol.</p> <p>4 Q. How is that administered?</p> <p>5 A. It is usually administered vaginally as</p> <p>6 well.</p> <p>7 Q. Okay. And the balloon is actually a --</p> <p>8 well, how would you describe a balloon?</p> <p>9 A. Well, it is actually a Foley catheter, and a</p> <p>10 Foley has a balloon that is blown up on the tip. When it</p> <p>11 is placed in the bladder, that holds it in the bladder.</p> <p>12 But we'll use the same device to place it through the</p> <p>13 cervix, blow the balloon up to hold it in place, and then</p> <p>14 a little bit of traction is then applied to the cervix.</p> <p>15 Q. I see. Okay. And what about the C-sections</p> <p>16 that you perform; would you say any of those are elective</p> <p>17 C-sections?</p> <p>18 A. On a rare occasion a patient will request an</p> <p>19 elective C-section.</p> <p>20 Q. Uh-huh.</p> <p>21 A. But that's fairly rare. Most of the</p> <p>22 C-sections that we do are for obstetric indications.</p> <p>23 Q. And you say that some patients will request</p> <p>24 one. How often does that happen in your practice?</p> <p>25 A. Far less than one a year.</p>	45	<p>1 causes severe anemia or hemodynamic compromise. Bleeding</p> <p>2 can occur due to a flaccid uterus. So a uterus that does</p> <p>3 not contract and shut off the flow of blood. Bleeding</p> <p>4 can occur because there's large uterine vessels that can</p> <p>5 sometimes be lacerated during the surgery. Bleeding can</p> <p>6 occur outside of the uterus on the rectus muscles. It</p> <p>7 can occur in the subcutaneous space. Basically anywhere</p> <p>8 you cut, there is a potential for bleeding there.</p> <p>9 Q. So you mentioned the possibility of anemia</p> <p>10 or hemodynamic -- sorry can you say that one again?</p> <p>11 A. A hemodynamic compromise.</p> <p>12 Q. Hemodynamic compromise.</p> <p>13 A. Where she has trouble keeping her blood</p> <p>14 pressure up or her circulatory system starts to be</p> <p>15 compromised.</p> <p>16 Q. I see. With respect to bleeding, how would</p> <p>17 you define hemorrhage?</p> <p>18 A. There are actually several categories of</p> <p>19 hemorrhage depending on the amount of blood that is</p> <p>20 estimated to be lost and how the woman's heart rate and</p> <p>21 blood pressure and urine output respond to it. Typically</p> <p>22 an early hemorrhage is, you know, more than about 500</p> <p>23 cc's, about half a liter.</p> <p>24 Q. All right. And then what about the</p> <p>25 complications or risks from inductions; how would you</p>

<p style="text-align: right;">46</p> <p>1 describe those?</p> <p>2 A. Well, I've mentioned that particularly with</p> <p>3 an unfavorable cervix it may raise the risk of requiring</p> <p>4 a C-section. A long induction may raise the woman's risk</p> <p>5 of infection. An induction may lead to fetal intolerance</p> <p>6 of labor that might require a caesarean section for the</p> <p>7 indications for the baby. In rare occasions people can</p> <p>8 have adverse reactions to the medications that are used:</p> <p>9 the Pitocin or Cervidil or Cytotec.</p> <p>10 Q. What about uterine rupture; does that</p> <p>11 happen?</p> <p>12 A. It can happen. The most -- it doesn't --</p> <p>13 fortunately, it doesn't happen often and generally</p> <p>14 happens in the setting of a woman trying to have a</p> <p>15 vaginal birth after she's had a prior C-section or other</p> <p>16 uterine surgery. Sometimes women have uterine fibroids</p> <p>17 removed, and that's a situation where they also might be</p> <p>18 at risk for uterine rupture.</p> <p>19 In third world countries, fortunately I've</p> <p>20 never seen it, but uterine ruptures can occur from</p> <p>21 obstructive labors, where there is not the ability to do</p> <p>22 a caesarean section to get the baby safely out if the</p> <p>23 baby is unable to deliver vaginally.</p> <p>24 Q. But in a U.S. setting, uterine rupture does</p> <p>25 happen on occasion from inductions, correct?</p>	<p style="text-align: right;">48</p> <p>1 extremely rare occasions, has resulted in maternal death</p> <p>2 as well.</p> <p>3 Q. So to be clear, hypothetically, if you had a</p> <p>4 patient who is pregnant and has had one prior C-section,</p> <p>5 would you -- if she wanted to have another C-section,</p> <p>6 would you perform a C-section in those circumstances?</p> <p>7 A. I would after counseling on the options.</p> <p>8 Q. Okay. And in that circumstance, you would</p> <p>9 classify that as a C-section performed for maternal</p> <p>10 indication, correct?</p> <p>11 A. Yes.</p> <p>12 Q. Okay. All right. What about -- do you</p> <p>13 handle miscarriage management?</p> <p>14 A. I do.</p> <p>15 Q. And can you describe the miscarriage</p> <p>16 management care that you provide?</p> <p>17 A. Most miscarriages are in the first</p> <p>18 trimester. And on diagnosis, there are three options</p> <p>19 that I'll offer a patient and, obviously, counsel about</p> <p>20 the pros and cons of each of the options. We can do a --</p> <p>21 a dilation and suction curettage. That's a surgical</p> <p>22 management that removes the fetus and the placenta and</p> <p>23 the pregnancy tissue.</p> <p>24 We can wait. The body generally will</p> <p>25 recognize a miscarriage and eventually she will pass the</p>
<p style="text-align: right;">47</p> <p>1 A. Well, we -- as a rule, we do not induce</p> <p>2 women who have had a prior C-section. So it -- I</p> <p>3 wouldn't say that it can't happen from an induction</p> <p>4 without a prior C-section, but most of the time, when</p> <p>5 that happens, it is in that setting of a uterus that has</p> <p>6 a scar on it.</p> <p>7 Q. Right. Actually, that brings me back to one</p> <p>8 question I had. With respect to C-sections, you said you</p> <p>9 do some elective ones but they're very rare, and then you</p> <p>10 do others for maternal indication. Is a prior history of</p> <p>11 C-section a maternal indication for another C-section?</p> <p>12 A. It doesn't have to be. This is a situation</p> <p>13 where we will spend quite a bit of time counseling a</p> <p>14 woman on the risk. There is risk either way when a woman</p> <p>15 has had a caesarean. Repeating the caesarean has the</p> <p>16 risk of the C-section itself, and the more C-sections a</p> <p>17 woman has, her risk goes up of having an abnormal</p> <p>18 placenta, possibly an invasive placenta in a subsequent</p> <p>19 pregnancy, scar tissue, the technical complexity of the</p> <p>20 surgery can get more difficult if a woman has had a lot</p> <p>21 of C-sections.</p> <p>22 But the -- the risk to her and the baby of</p> <p>23 attempting a VBAC, vaginal birth after caesarean, is</p> <p>24 the -- obviously the most catastrophic thing would be a</p> <p>25 uterine rupture that can result in fetal death and, on</p>	<p style="text-align: right;">49</p> <p>1 tissue. Sometimes that's psychologically hard because it</p> <p>2 can take a little while. Sometimes it is weeks before</p> <p>3 the body recognizes it. And the third option that we</p> <p>4 will offer is misoprostol to help the body begin the</p> <p>5 process of contractions and expressing the pregnancy</p> <p>6 tissue.</p> <p>7 Q. So you would provide misoprostol alone; is</p> <p>8 that correct?</p> <p>9 A. That is correct.</p> <p>10 Q. Okay. What about for individuals who have a</p> <p>11 miscarriage after the point at which dilation and suction</p> <p>12 curettage is no longer available? How do you handle a</p> <p>13 miscarriage in those circumstances?</p> <p>14 A. Fortunately, those are rare. I will tell</p> <p>15 you honestly that even after 25 years of an obstetrician,</p> <p>16 I am very respectful of doing a D&E in that situation. A</p> <p>17 D&E, which is the most common method of pregnancy</p> <p>18 termination after about 14 weeks, requires more dilation</p> <p>19 than an early procedure does. It requires, often, the</p> <p>20 doctor to introduce grasping instruments into a</p> <p>21 distended, soft uterus. The risk of perforation is high.</p> <p>22 The risk of incomplete evacuation of the tissue is high.</p> <p>23 It is a procedure that OB/GYNs take very</p> <p>24 seriously. When I have occasion to do that, I will</p> <p>25 usually have one of my partners assist me, and I will</p>

September 02, 2020

50	<p>1 always do it under ultrasound guidance. Even later</p> <p>2 miscarriages, I would say 16, 18 weeks and beyond, we</p> <p>3 often -- we also may offer the patient induction in the</p> <p>4 hospital with misoprostol.</p> <p>5 Q. Okay. So just so that I'm clear. At the</p> <p>6 point at which, in your practice, dilation and suction</p> <p>7 curettage would no longer be available to someone</p> <p>8 experiencing a miscarriage is approximately 14 weeks; is</p> <p>9 that correct?</p> <p>10 A. Well, the -- the transition from a dilation</p> <p>11 and suction curettage to a dilation and evacuation is --</p> <p>12 I don't think there is a hard line at 14 weeks. The D&E</p> <p>13 is required when the fetal bones are calcified and the</p> <p>14 fetus has reached a size that he cannot be easily</p> <p>15 extracted with the suction tubing. And -- so it can</p> <p>16 depend on the situation.</p> <p>17 If you have a fetus that's been dead,</p> <p>18 perhaps for a couple of weeks before it was recognized,</p> <p>19 that fetus may be soft enough that you can extract him</p> <p>20 completely with the suction. But if he's bigger or</p> <p>21 recently died and has not begun the process of</p> <p>22 maceration, then many times multiple passes with the</p> <p>23 graspers to disarticulate the fetus are required. And</p> <p>24 that's the definition of a D&E.</p> <p>25 Q. And how many D&Es for miscarriage management</p>	52	<p>1 involved in something called The Contraceptive</p> <p>2 Initiative; is that right -- or institute?</p> <p>3 A. That was a nonprofit that I founded about</p> <p>4 five years ago.</p> <p>5 Q. And is it still in operation?</p> <p>6 A. It is not because I joined the board of</p> <p>7 another organization that does similar work, and so I</p> <p>8 rolled the assets of The Contraceptive Initiative into</p> <p>9 the board of The Source -- or into the organization</p> <p>10 called The Source.</p> <p>11 Q. What is The Source?</p> <p>12 A. The Source is a clinic model -- currently it</p> <p>13 is eight clinics in Texas that are based on a pregnancy</p> <p>14 resource center model of giving women options other than</p> <p>15 abortion or unintended pregnancies. They also do free</p> <p>16 STI testing, and they -- this particular group of clinics</p> <p>17 are beginning to offer whole women's health including</p> <p>18 contraception.</p> <p>19 Q. So The Contraceptive Institute -- or</p> <p>20 Initiative when you were working on that and, I guess, it</p> <p>21 sounds like, into The Source, is one of the forms of</p> <p>22 contraception that you provide long-acting reversible</p> <p>23 contraceptives?</p> <p>24 A. Yes, it is.</p> <p>25 Q. And those are sometimes call LARCs, correct?</p>
51	<p>1 have you performed during your career?</p> <p>2 A. Maybe about one a year.</p> <p>3 Q. And how long have you been practicing?</p> <p>4 A. Twenty-five years.</p> <p>5 Q. So maybe about 25 in your whole career?</p> <p>6 A. Uh-huh.</p> <p>7 Q. What about D&Es after 18 weeks of pregnancy;</p> <p>8 have you ever performed one of those?</p> <p>9 A. I have never performed one that late. When</p> <p>10 a patient loses a baby at that gestational age, we</p> <p>11 generally will do a medical induction. In addition to</p> <p>12 being safer for a woman, I believe that it is emotionally</p> <p>13 better for her to be able to hold her intact fetus and</p> <p>14 grieve, take pictures if she desires, bury the baby if</p> <p>15 she desires, have an autopsy to determine the cause of</p> <p>16 death if desired than to do an D&E, which will not leave</p> <p>17 the fetus in a condition that she can see.</p> <p>18 Q. Okay. But just to be clear, you've never</p> <p>19 performed a D&E for miscarriage management at 18 weeks or</p> <p>20 beyond in pregnancy; is that correct?</p> <p>21 A. That is correct.</p> <p>22 Q. Do you recall what the latest D&E is that</p> <p>23 you've ever performed for miscarriage management?</p> <p>24 A. Probably around 16 weeks.</p> <p>25 Q. Okay. I see on your resume that you're</p>	53	<p>1 A. Yes.</p> <p>2 Q. Do LARCs reduce, in your view -- do they</p> <p>3 reduce the incidences of unintended pregnancy?</p> <p>4 A. I believe they do.</p> <p>5 Q. Do you think they reduce reliance on</p> <p>6 abortion?</p> <p>7 A. Yes, I do.</p> <p>8 Q. Are they more effective than other types of</p> <p>9 contraceptives at reducing unintended pregnancy?</p> <p>10 A. I think there are some good studies out of</p> <p>11 Colorado and St. Louis and elsewhere that show that they</p> <p>12 do.</p> <p>13 Q. In your experience, why do some women not</p> <p>14 use LARCs who want to use contraception but do not use</p> <p>15 LARCs?</p> <p>16 A. Sometimes they have heard stories or have</p> <p>17 looked on the internet and have read things that make</p> <p>18 them nervous. Sometimes they're afraid of the pain of</p> <p>19 insertion of an IUD. I use all methods of contraception.</p> <p>20 But I've discovered that there is no one method that fits</p> <p>21 every woman. And so -- but I really like LARCs. I think</p> <p>22 they're very, very effective.</p> <p>23 Q. Do some patients not use them because of the</p> <p>24 expense?</p> <p>25 A. Oh, certainly.</p>

September 02, 2020

54	<p>1 Q. How expensive are IUDs, on average, would 2 you say, in your experience? 3 A. They -- they're about 600 to 700 dollars a 4 unit. 5 Q. Okay. And are they covered by Medicaid? 6 A. Yes. They're currently covered by all 7 insurances. So it is rare that we find a woman who can't 8 get coverage for it. 9 Q. But if you don't have Medicaid or insurance 10 of some kind, you would not be able to get coverage for 11 it; is that correct? 12 A. That's correct. 13 Q. Do you imagine among the patient population 14 that you see that relies on Medicaid, so is income 15 eligible for Medicaid, do you think an expense of -- did 16 you say 500 to 700 dollars? 17 A. That's a good range. 18 Q. Would you say 500 to 700 dollars would be a 19 barrier to getting a LARC in those circumstances without 20 insurance? 21 A. Certainly. Certainly. 22 Q. Okay. So I have just a couple more 23 questions on this, but I'm wondering, how are you doing? 24 Do you want to take a break, or do you want to go a 25 little longer and then break in maybe 15 minutes?</p>	56	<p>1 Q. What do you mean by abortion advocacy? That 2 they're an abortion advocacy organization? 3 A. To my knowledge, they have never submitted 4 an amicus brief or a statement opposing any restriction 5 on abortion. So they -- they promote abortion in any 6 circumstance for any reason at any time in pregnancy. 7 Q. And what about AAPLOG, the organization that 8 you are a member of? That's the American Association of 9 Pro-Life Obstetricians and Gynecologists, correct? 10 A. Yes. 11 Q. Are they an advocacy organization, 12 Dr. Skop? 13 A. Well, of course they are. It is in their 14 name. 15 Q. A pro-life advocacy organization? 16 A. They used to be a subgroup of ACOG until 17 ACOG kicked them out. But they represent another -- 18 Q. Ma'am, could -- are they a pro-life advocacy 19 organization? 20 A. Yes, ma'am, they are. 21 Q. Okay. So you mentioned ACOG does put out 22 some useful information in obstetrics and gynecology. Do 23 you rely on their practice bulletins in your practice at 24 all? 25 A. I have been known to consult their practice</p>
55	<p>1 A. I can go longer, but if anybody else needs a 2 break, I'm happy to take one now. 3 Q. So it is okay. All right. Let's finish 4 this line, and then we'll take a mid-morning break. 5 All right. So I see on your CV that you're 6 a fellow of the American College of Obstetricians and 7 Gynecologists, right? 8 A. Yes. 9 Q. And that's known as ACOG? 10 A. Yes. 11 Q. What is ACOG? 12 A. ACOG is a professional society of OB/GYNs. 13 Membership is voluntary, but it is somewhat prestigious 14 to be a member. It offers a lot of good advice on 15 general obstetric and gynecologic topics. Unfortunately, 16 it is an abortion advocacy organization as well. 17 Q. But you're a part of it, correct; you're a 18 member? 19 A. I am a part. I do not agree with their 20 abortion advocacy, and I've let them know. But I -- 21 there are a lot of good things about being a member, so I 22 am still a member. They, incidentally, have never asked 23 their membership -- whether the membership feels they 24 should be abortion advocates. Just the leadership has 25 decided to do that.</p>	57	<p>1 bulletins, yes. 2 Q. Okay. What about their ethics committee 3 opinions; do you ever use those to guide your practice 4 with tricky ethical issues? 5 A. I'm familiar with their ethics opinion that 6 says it is unethical not to provide or refer for 7 abortions. 8 Q. And do you agree with that opinion? 9 A. No. 10 Q. Do you provide abortions, Dr. Skop? 11 A. No. 12 Q. So if a patient comes to you and is pregnant 13 and would like to terminate a pregnancy, what do you tell 14 her? 15 A. I -- as I do in every situation with my 16 patients, I talk to her about the -- the altern -- the 17 risk, benefits, and alternatives of all of the available 18 options. 19 Q. So you'll discuss the risks and benefits of 20 abortion? 21 A. In my opinion, there are no benefits to 22 abortion. 23 Q. Okay. And if after your counseling she 24 still wants an abortion and asks you for a referral, what 25 will you tell her?</p>

58	<p>1 A. A referral is not necessary. Abortions are 2 paid for by private funds in Texas, and I believe 3 everybody knows who the largest abortion provider is. So 4 it is not necessary for me to give her a referral. That 5 is not a barrier to her ability to get an abortion if she 6 wants it.</p> <p>7 Q. With respect, Dr. Skop, that is not 8 responsive to my question. My question is what would you 9 tell the patient if she asked for a referral for an 10 abortion; what would you tell her?</p> <p>11 A. I would show her the baby on ultrasound; I 12 would tell her about the option of continuing the 13 pregnancy. If she's unable to care for the child, I 14 would tell her that there are many families in this 15 country that would like to adopt a baby. I would 16 introduce her to some of the resources available in our 17 area, many of which, incidentally, provide couples 18 counseling.</p> <p>19 And I think it is pretty clear in 20 Guttmacher's literature that many of the women who choose 21 abortion do so because of lack of support from their 22 partner and because of the perceived lack of resources. 23 So I will tell her what resources are available. If she 24 continues to express a desire to have an abortion, of 25 course, I will tell her about the potential risk from</p>	60
59	<p>1 abortion, which can include physical damage, that can 2 include mental health complications, even years later. 3 The possibility that when she does desire a pregnancy 4 that the baby could be born prematurely.</p> <p>5 If she wants an abortion, she can have one. 6 I'm not going to stop her. But, like I said, she doesn't 7 need a referral from me to get one.</p> <p>8 Q. Okay. So is it accurate to say, then, 9 Doctor, that you would never provide a patient with 10 information about where to obtain an abortion if they 11 expressed a desire to have one?</p> <p>12 A. I don't think it is necessary for me to do 13 that. Everybody knows that your position -- you work 14 for --</p> <p>15 Q. With respect, Doctor, is it accurate to say 16 that you would not provide a referral for an abortion to 17 a patient who expresses a desire to have one?</p> <p>18 A. A referral for abortion is not necessary.</p> <p>19 Q. So the answer is yes; that's accurate?</p> <p>20 A. What do you mean by referral? Do you want 21 me to tell her the name of a specific abortionist?</p> <p>22 Q. Sure. If she asks for a name and 23 information about who she can contact to obtain an 24 abortion, would you provide that?</p> <p>25 A. I'm not going to -- I'm not going to choose</p>	61
	<p>1 who she goes to. There are several different clinics she 2 could go to. I could refer her to the Yellow Pages -- or 3 to the internet to discover where a clinic is.</p> <p>4 Q. And if she says that she's interested in 5 adoption, would you refer her to the Yellow Pages?</p> <p>6 A. I could, but I also know some adoption 7 agencies.</p> <p>8 Q. Do you?</p> <p>9 A. I usually have a specific place that I can 10 send her.</p> <p>11 Q. And if a patient -- well, let's -- let me 12 back up.</p> <p>13 If a patient expresses an interest of having 14 an abortion to you, do you refer her to a colleague, 15 perhaps, who would advise her with respect to her options 16 with respect to abortion who might actually provide a 17 referral?</p> <p>18 MR. SORENSON: Objection, asked and 19 answered.</p> <p>20 Q. I'm asking here, Dr. Skop, about whether you 21 would refer a patient to one of your colleagues who does 22 provide referrals for all sorts of options, either full 23 term pregnancy, adoption, or abortion?</p> <p>24 A. I don't believe any of my colleagues would 25 refer her for an abortion either.</p>	

62

1 **question that you don't understand?**
 2 A. Yes, I think there is.
 3 So you're asking me to recall something that
 4 I said seven years ago, and I don't recall if I said that
 5 or not. I think your follow-up question was: If I said
 6 that, was it untrue --
 7 **Q. Would that have been untrue?**
 8 **Well, why don't I rephrase it this way: Do**
 9 **you provide abortion referrals where there is a need?**
 10 MR. SORENSON: Objection, vague.
 11 A. I think I would need to understand what you
 12 mean by need.
 13 **Q. Okay.**
 14 A. If a woman's life is in danger from her
 15 pregnancy, and that happens sometimes, as her doctor, I
 16 care for her, and I deliver her. So I can't think of a
 17 situation where I would need to refer her to an
 18 abortionist to be cared for.
 19 **Q. Okay. That's fair.**
 20 **All right. What about -- we talked a little**
 21 **bit about ACOG. Are there any other professional**
 22 **organizations in the medical community that you look to**
 23 **for guidance in your practice?**
 24 A. I don't think so.
 25 **Q. What about the American Medical**

63

1 **Association?**
 2 A. I'm not a member of the AMA.
 3 **Q. Okay. Well, whether or not you're a member,**
 4 **do you ever rely on their materials to guide your**
 5 **practice?**
 6 A. No.
 7 **Q. What about journals; are there particular**
 8 **medical journals that you turn to for reliable research**
 9 **and information in the fields of obstetrics and**
 10 **gynecology?**
 11 A. There are a number of medical journals that
 12 I will reference.
 13 **Q. Which ones?**
 14 A. Most commonly, "The Green Journal."
 15 **Q. What is that?**
 16 A. It is called Obstetrics and Gynecology. It
 17 is ACOG's journal.
 18 **Q. And what about -- isn't there something**
 19 **called "The Gray Journal"?**
 20 A. Yes. The American Journal on Obstetrics and
 21 Gynecology.
 22 **Q. Do you rely on that as well?**
 23 A. I have read articles from there. I no
 24 longer subscribe to it, so I don't have as ready access
 25 to it as I do. . .

64

1 **Q. Would you describe those as the leading**
 2 **journals in the obstetrics and gynecology field?**
 3 A. They're well regarded journals.
 4 **Q. Okay. So generally viewed as authoritative**
 5 **in the field?**
 6 A. They're peer reviewed. They have published
 7 articles that I have found lacking in data and substance.
 8 So I wouldn't call them perfect or always
 9 authoritative.
 10 **Q. Sure. But in terms of among the journals**
 11 **that people might consult in the field of obstetrics and**
 12 **gynecology, would you view them as the two leading**
 13 **ones?**
 14 A. They're up there, yes. They are some of the
 15 better ones.
 16 **Q. All right. And what about -- are there any**
 17 **textbooks or treatises that you turn to for information**
 18 **on the practice of the obstetrics and gynecology?**
 19 A. There used to be. When I was a resident, I
 20 had and still have copies of the textbooks in my
 21 possession. But with the way that people do research
 22 today, I do not have any updated textbooks that I rely
 23 upon.
 24 **Q. All right.**
 25 MS. MURRAY: So I think that's probably a

65

1 good spot for us to stop. Do you all want to break for
 2 ten minutes?
 3 MR. SORENSON: Yes. Should we break until
 4 9:45, Mountain time, quarter to the hour?
 5 MS. MURRAY: Sure that works. Sounds very
 6 good.
 7 (Recess from 9:33 a.m. to 9:48 a.m.)
 8 **Q. (By Ms. Murray) Welcome back from the**
 9 **break, Dr. Skop. Is there anything from your prior**
 10 **testimony that you would like to add to or correct at**
 11 **this time?**
 12 A. No.
 13 **Q. Did you speak with anyone other than**
 14 **Mr. Sorenson during the break?**
 15 A. No.
 16 **Q. So you intend to offer expert opinion in**
 17 **this case, correct?**
 18 A. Yes.
 19 **Q. And what areas in the field of obstetrics**
 20 **and gynecology do you consider yourself an expert in?**
 21 A. I would consider myself an expert in
 22 pregnancy management, in gynecologic preventive treatment
 23 as well as treatment of pathology within the field of
 24 gynecology. Specific to this case, I have cared for many
 25 women in the emergency room who have had complications

66

1 from abortions.

2 **Q. Okay. So that's your experience. What do**

3 **you think you're in an expert in with something specific**

4 **to this case?**

5 A. I think I'm an expert now, after having

6 cared for many women who had complications that were not

7 cared for by the provider who performed the procedure. I

8 began extensive research to discover why I was seeing so

9 many complications when the literature tells me that

10 there are rarely complications. I have discussed --

11 **Q. Dr. Skop, I just -- I do want to make sure**

12 **that we're able to move along today. I'm sorry to**

13 **interrupt you, but I do want you to answer my question,**

14 **which is, specific to this case, what areas of obstetrics**

15 **or gynecology do you feel that you are an expert in?**

16 A. I am an expert in obstetric management.

17 Eighteen to twenty-two weeks is an area that I have

18 extensive experience in caring for mothers and fetuses.

19 And -- yeah, so I think I've cared for complications. I

20 have done extensive research to know how poor the data on

21 complications and mortality is related to abortion in the

22 United States.

23 **Q. So do you consider yourself an expert on the**

24 **safety of pregnancy and childbirth?**

25 A. As much as you can be after delivering 6,000

67

1 babies and working in the field for 25 years -- 29 years

2 including residency.

3 **Q. Uh-huh. Do you consider yourself an expert**

4 **on the safety of abortion?**

5 A. I do.

6 **Q. Do you consider yourself an expert on the**

7 **safety of abortion at or after 18 weeks of pregnancy?**

8 A. I am as much of an expert as there is

9 because I know how scanty the literature is on this

10 gestational age.

11 **Q. So would you say that you're a leading**

12 **expert on the safety of abortion after 18 weeks of**

13 **pregnancy, Dr. Skop?**

14 A. I'm not sure how you're defining expert. I

15 have written several peer reviewed papers on this topic.

16 **Q. Well, you said I am as much of an expert as**

17 **there is, so I'm asking you, does that mean that you**

18 **believe you are a leading expert on the safety of**

19 **abortion at and after 18 weeks of pregnancy?**

20 MR. SORENSON: Objection. Vague as to

21 leading, the word leading.

22 **Q. Dr. Skop, is there anything about that**

23 **question that you don't understand?**

24 A. I agree that I'm not sure what you mean by

25 leading expert. I've cared --

68

1 **Q. How would you -- how would you define**

2 **leading expert?**

3 A. Well, as I just mentioned to you, I have

4 published peer reviewed papers on it, and I have cared

5 for women who have experienced complications related to

6 abortions in this gestational age. I don't provide them.

7 As I told you earlier, I am healthfully respectful of the

8 D&E procedure because I think it is a very complicated

9 procedure. I think the American Board of Medical

10 Specialties agrees with me. They just created a two-year

11 fellowship, Complex Family Planning --

12 **Q. Dr. Skop -- objection, nonresponsive.**

13 A. -- to do D&E procedures --

14 **Q. Dr. Skop, could you please respond to my**

15 **question. How do you define the term leading expert?**

16 **How would you define that?**

17 A. I have read -- so backing up.

18 Yes, I would consider myself an expert. I

19 have read the available papers that address this topic.

20 I have cared for it in my clinical practice, and I have

21 written peer reviewed papers on it.

22 **Q. You said you've written several. How many?**

23 **More than five?**

24 A. Regarding the safety of abortion --

25 **Q. At and after 18 weeks of pregnancy.**

69

1 A. I've written two that addressed that

2 specific range. I've written two others on abortion

3 complications that are not specific to 18 to 22 weeks.

4 **Q. Would you agree that someone who has written**

5 **four articles total about abortion is as good an expert**

6 **as there is on the topic?**

7 A. Again, I'm not sure what you mean "as good

8 an expert as there is."

9 **Q. Those are your words, Doctor.**

10 A. Certainly there are doctors that have

11 written more.

12 **Q. And you said earlier you don't perform**

13 **abortions. Have you ever been trained with respect to**

14 **how to perform an abortion at or after 18 weeks of**

15 **pregnancy?**

16 A. I know how to perform them. I just don't do

17 them.

18 **Q. Have you been trained to perform them at or**

19 **after --**

20 A. Yes, that was part of the training in my

21 residency, but I did not perform them then either. I saw

22 them performed.

23 **Q. I'm sorry?**

24 A. I saw them performed. I was trained in the

25 procedure.

70	<p>1 Q. Okay. How many abortions at or after 18</p> <p>2 weeks of pregnancy have you seen performed?</p> <p>3 A. Probably 20.</p> <p>4 Q. And when was the last one that you saw</p> <p>5 performed?</p> <p>6 A. In residency, 25 years ago.</p> <p>7 Q. And what share of those would have been</p> <p>8 performed by a D&E?</p> <p>9 A. At that time, the preferred technique was</p> <p>10 prostaglandin induction. I believe most of those were</p> <p>11 done that way.</p> <p>12 Q. So have you ever observed an abortion at or</p> <p>13 after 18 weeks of pregnancy performed by a D&E?</p> <p>14 A. Not on a living fetus, but I have seen and</p> <p>15 have performed D&Es on deceased fetuses.</p> <p>16 Q. To be clear, if you are performing a D&E on</p> <p>17 a deceased fetus, is it an abortion in your view?</p> <p>18 A. No. An abortion is the intentional</p> <p>19 destruction of a living fetus.</p> <p>20 Q. So you've never performed an abortion at or</p> <p>21 after 18 weeks of pregnancy, correct?</p> <p>22 A. No, I have not.</p> <p>23 Q. And you have never seen one performed at or</p> <p>24 after 18 weeks of pregnancy by way of D&E; is that</p> <p>25 correct?</p>	72	<p>1 illness, and I treat it through medication and referral</p> <p>2 to counseling.</p> <p>3 Q. Okay. So you don't provide counseling</p> <p>4 yourself, though, correct, what would be considered</p> <p>5 mental health counseling?</p> <p>6 A. Well, it would be ongoing therapeutic</p> <p>7 relationship that I don't have time to do while seeing 30</p> <p>8 OB/GYN patients daily. That's not to say I don't counsel</p> <p>9 women when I discuss this problem with them. I do. But</p> <p>10 I don't do it for a prolonged period of time.</p> <p>11 Q. Is there anything other than what you've</p> <p>12 just described in terms of treating patients with the</p> <p>13 depression that you believe qualifies you as an expert on</p> <p>14 the identification and treatment of depression?</p> <p>15 A. I've cared for a number of post-aborted</p> <p>16 women over my career who have had depression that they</p> <p>17 have attributed to their abortion. In addition, the Any</p> <p>18 Woman Can, that I am the board chairman of, provides free</p> <p>19 mental health counseling for women who have sequelae,</p> <p>20 psychiatric sequelae of their abortions.</p> <p>21 Q. And the activities of Any Woman Can, why are</p> <p>22 they relevant to your expertise?</p> <p>23 A. I am the board chairman, so --</p> <p>24 Q. Do you oversee the --</p> <p>25 A. -- I'm involved in the protocols and</p>
71	<p>1 A. That is correct.</p> <p>2 Q. And with respect to miscarriage management,</p> <p>3 I believe you testified earlier, Doctor, that you have</p> <p>4 never performed, even for miscarriage management, a D&E</p> <p>5 past 16 weeks of pregnancy; is that correct?</p> <p>6 A. That is correct.</p> <p>7 Q. Do any of the doctors in your practice</p> <p>8 perform D&E abortions?</p> <p>9 A. No.</p> <p>10 Q. Okay. What about -- do you consider</p> <p>11 yourself an expert in mental health?</p> <p>12 A. I wouldn't say I'm an expert, but I'm</p> <p>13 married to a psychiatrist. I know a lot about it.</p> <p>14 Q. Expertise by osmosis.</p> <p>15 Would you consider yourself an expert in the</p> <p>16 identification and treatment of depression?</p> <p>17 A. It is something that I manage clinically</p> <p>18 frequently.</p> <p>19 Q. So would you consider yourself an expert in</p> <p>20 it?</p> <p>21 A. Sure. It is my professional -- part of my</p> <p>22 job.</p> <p>23 Q. And so when you say you manage it, what do</p> <p>24 you mean by that?</p> <p>25 A. I identify the symptoms, I diagnose the</p>	73	<p>1 expediting the counseling.</p> <p>2 Q. Okay. You've talked about your experience</p> <p>3 seeing women who have had abortions in the past. Let's</p> <p>4 talk about women who have had complications from</p> <p>5 abortion. How many women would you estimate you have</p> <p>6 treated for a complication of abortion during your</p> <p>7 career?</p> <p>8 A. It's probably too numerous to count the</p> <p>9 women who have presented to the emergency room</p> <p>10 hemorrhaging after medical abortions who have required a</p> <p>11 D&E or a suction D&C. I have -- in residency, I had one</p> <p>12 patient that I readmitted to the ICU in sepsis after a</p> <p>13 mid tri -- I believe after a 20 or 22 week abortion, and</p> <p>14 she died. I also know of a patient within my practice</p> <p>15 who died of septicemia after a first trimester suction</p> <p>16 abortion.</p> <p>17 Q. Okay. So just to go back through those.</p> <p>18 You said you think it is too numerous to count the number</p> <p>19 of women you've seen who have presented to the hospital</p> <p>20 after a medication abortion with a hemorrhage; is that</p> <p>21 correct?</p> <p>22 A. That's correct.</p> <p>23 Q. A medication abortion, how late is that</p> <p>24 available in the state of Texas?</p> <p>25 A. Until 2016, it was available until seven</p>

74	<p>1 weeks. Since that time, it is available until ten</p> <p>2 weeks.</p> <p>3 Q. Until ten weeks. So not an abortion that</p> <p>4 would be at issue in this case, correct?</p> <p>5 A. That's correct. Right.</p> <p>6 Q. And not a method of abortion that you could</p> <p>7 use at or after 18 weeks of pregnancy, correct?</p> <p>8 A. Abortions can be performed through medical</p> <p>9 induction --</p> <p>10 Q. But through the same medication abortion</p> <p>11 regimen that you were describing for first trimester</p> <p>12 abortions?</p> <p>13 A. They can be. They're not done frequently</p> <p>14 that way.</p> <p>15 Q. Just to be clear that I'm understanding you</p> <p>16 correctly: Are you saying that the regimen to do a</p> <p>17 medication abortion early in pregnancy in the first</p> <p>18 trimester could be used to do a medication abortion later</p> <p>19 in pregnancy, for example, at 18 to 20 weeks?</p> <p>20 A. The same medications, mifepristone and</p> <p>21 misoprostol, can be used. The dosing may be different,</p> <p>22 but the same medications can be used.</p> <p>23 Q. Do you know whether it is different?</p> <p>24 A. I don't because it is done so infrequently.</p> <p>25 I don't know that I know what standard dosing is for</p>	76	<p>1 years ago, our group stopped covering the emergency room.</p> <p>2 Just prior to that, we had a month where we had three</p> <p>3 women admitted for post-abortive complications. One was</p> <p>4 in the ICU, one required a blood transfusion, and one</p> <p>5 required surgery to complete her abortion. It was at</p> <p>6 that time that I realized that there was not a system in</p> <p>7 place that would automatically record these</p> <p>8 complications.</p> <p>9 I tried to report them to the state of</p> <p>10 Texas, which is one of the states that has a law</p> <p>11 requiring providers to report the complications, and I</p> <p>12 found it to be a very difficult process, including --</p> <p>13 they wanted the forms sent by certified mail, and it was</p> <p>14 de-identified, which, in my mind, would be very hard to</p> <p>15 discover duplicates or pull charts and find the</p> <p>16 situation. So that helped me to understand that --</p> <p>17 Q. Wait. With respect, Doctor, my question</p> <p>18 was, can you recall the most recent instance in which you</p> <p>19 have treated someone for a hemorrhage after medication</p> <p>20 abortion who specifically told you that they obtained</p> <p>21 their abortion at Planned Parenthood?</p> <p>22 A. Two to three years ago during that month,</p> <p>23 Yes.</p> <p>24 Q. One of those women identified Planned</p> <p>25 Parenthood as the place where she had her abortion?</p>
75	<p>1 that.</p> <p>2 Q. Uh-huh. So you said too numerous to count.</p> <p>3 Would you estimate that you've seen more than 20 of those</p> <p>4 patients who have had hemorrhages after medication</p> <p>5 abortions in the first trimester?</p> <p>6 A. Yes.</p> <p>7 Q. More than 30?</p> <p>8 A. Probably over the years that I've been</p> <p>9 covering the emergency room, I'll say 50.</p> <p>10 Q. Okay. And are these cases that you're</p> <p>11 describing, are they instances in which you confirmed</p> <p>12 that the person obtained a legal abortion in the United</p> <p>13 States?</p> <p>14 A. They generally tell me that they came from</p> <p>15 Planned Parenthood.</p> <p>16 Q. How many times do you think that has</p> <p>17 happened, Doctor?</p> <p>18 A. That they came from -- that they were</p> <p>19 telling me the truth --</p> <p>20 Q. That they had specifically referred to</p> <p>21 Planned Parenthood?</p> <p>22 A. When I ask, almost always.</p> <p>23 Q. Can you recall the most recent incidence</p> <p>24 that that happened, Doctor?</p> <p>25 A. I can recall -- probably about two or three</p>	77	<p>1 A. Yes, and I've tried --</p> <p>2 Q. Can you recall any other --</p> <p>3 A. -- response --</p> <p>4 Q. Doctor, if you could listen to my question.</p> <p>5 A. Okay.</p> <p>6 Q. Do you recall any other specific instance of</p> <p>7 someone identifying Planned Parenthood as the place that</p> <p>8 they had their abortion?</p> <p>9 A. Yes, it happens frequently.</p> <p>10 Q. Can you recall another instance? When did</p> <p>11 that happen?</p> <p>12 A. Like I say, I've managed probably 50 of</p> <p>13 these women over the years. And many times when I ask,</p> <p>14 that is -- I mean, probably some were also Whole Women's</p> <p>15 Health, which closed. But most of time when they name an</p> <p>16 abortion clinic, it is usually Planned Parenthood.</p> <p>17 Q. Could it also have been women who</p> <p>18 self-managed their own abortions using drugs that they</p> <p>19 may have obtained outside of the medical community?</p> <p>20 A. I know that that is something you guys</p> <p>21 are -- well, not you, but abortion advocates are starting</p> <p>22 to promote, particularly in Texas, because they're</p> <p>23 concerned that women have to drive. I've seen a number</p> <p>24 of articles asking women to go across the border to</p> <p>25 Mexico to get misoprostol, which doesn't work as well.</p>

September 02, 2020

78	<p>1 It fails about 20 percent of the time.</p> <p>2 So I can't say that there aren't women who</p> <p>3 are following that advice and trying to self-manage their</p> <p>4 abortion. Women may do it for reasons of finance because</p> <p>5 you guys charge about \$500 for the medical abortion</p> <p>6 regimen. But -- so I can't say for sure that that</p> <p>7 doesn't happen, but I also know that I've seen a number</p> <p>8 of patients who have reported that they received their</p> <p>9 medication in a Planned Parenthood clinic.</p> <p>10 Q. You mentioned going to Mexico. Is it your</p> <p>11 understanding that you can obtain a medication abortion</p> <p>12 regimen in Mexico without a prescription?</p> <p>13 A. That is true.</p> <p>14 Q. How long does it take to drive to the</p> <p>15 border, Dr. Skop, from where you are?</p> <p>16 A. It is about three hours.</p> <p>17 Q. Okay. So -- okay. So we talked about the</p> <p>18 women that you said that you've seen in the emergency</p> <p>19 room. It sounded like you could only recall specifically</p> <p>20 one instance in which that has happened; is that correct?</p> <p>21 Are there any other specific patients you can recall?</p> <p>22 A. Can you repeat the question? That reported</p> <p>23 Planned Parenthood, or have had abortion that's required</p> <p>24 surgical treatment?</p> <p>25 Q. Any other patients who you have treated post</p>	80
79	<p>1 medication abortion for hemorrhage; can you recall any</p> <p>2 other specific patients?</p> <p>3 A. I can -- I can think of some faces, yes.</p> <p>4 Q. How many?</p> <p>5 A. I don't know.</p> <p>6 Q. More than five?</p> <p>7 A. Yes. It happens frequently. It happens</p> <p>8 frequently enough that I don't recall everybody's face</p> <p>9 that I've managed through this complication.</p> <p>10 Q. You mentioned you tried to make a report of</p> <p>11 this to the state authorities; is that correct?</p> <p>12 A. That is correct.</p> <p>13 Q. So they would have -- well, did you send the</p> <p>14 report to the state authorities?</p> <p>15 A. Yes.</p> <p>16 Q. Okay. What about -- you also mentioned that</p> <p>17 you had seen, during your residency, someone who had died</p> <p>18 from septicemia after an abortion at 20 to 22 weeks; is</p> <p>19 that correct?</p> <p>20 A. That's correct.</p> <p>21 Q. When did you do your residency?</p> <p>22 A. '92 to '96.</p> <p>23 Q. So do you know whether that was a D&E</p> <p>24 abortion?</p> <p>25 A. No. I believe it was a prostaglandin.</p>	81

82	<p>1 think that studies show that there is a correlation with 2 early delivery, particularly extremely early delivery, 3 after cervical abortions. 4 Q. So setting aside the studies, Doctor, I'm 5 asking about your experience. Can you -- sticking on the 6 preterm birth. What about the histories or circumstances 7 of these patients has caused you to conclude that it is a 8 post-abortion complication that they're having preterm 9 birth? 10 Is there any -- let me ask it this way: Is 11 there anything other than the fact that these patients 12 had an abortion at an earlier -- for an earlier pregnancy 13 that you are relying on to make that connection between 14 the abortion history and the preterm birth? 15 A. I would acknowledge that there are other 16 things that can lead to preterm shortening. However, it 17 is physiological plausible that mechanically dilating an 18 unripe cervix may cause damage to that cervix, which 19 relies on its intact musculature to hold a pregnancy to 20 term, and I think there is data to support that. 21 Q. Dr. Skop, let me ask it again. Is there 22 anything other than the prior history of abortion with 23 respect to these patients' circumstances or their 24 specific histories that you are relying on to make a 25 connection between their abortion and their later preterm</p>
83	<p>1 birth? 2 A. I'm not sure of your question because I 3 think I've already answered that. There's studies that 4 show that this can happen, and, with that history, it is 5 certainly plausible that that could be the reason. 6 Q. It is plausible. Is it plausible that that 7 is not the reason? 8 A. It is possible. 9 Q. Do people have preterm births with no 10 history of abortion? 11 A. Certainly, they do. 12 Q. Would you say the majority of women who have 13 preterm births have no history of abortion? 14 A. You know, it is now estimated that -- as you 15 probably know, that one out of three to one out of four 16 American women have had abortions. I think that there is 17 not a lot of interest on the part of most academicians to 18 sort through that. We -- our data is very incomplete. 19 Many women don't admit to abortions. Most of the people 20 publishing papers on abortion complications and safety 21 right now are doing so while affiliated with an abortion 22 advocacy group, such as Advancing New Standards in 23 Reproductive Health, Guttmacher Institute. 24 I think that there is a vast need to look 25 into this subject, but there has not been a desire on the</p>
84	<p>1 part of most academic physicians in America to look into 2 this, although -- 3 Q. Dr. Skop, let me ask it another way because 4 I do want to keep us on track, and I would like you to 5 respond to my specific question. So let me ask it a 6 different way that might be helpful. 7 Of the people you have seen going into 8 preterm labor, how -- what share of them would you say 9 report that they have a history of abortion? 10 A. You know, I -- I can't really answer that 11 question. Many of them have been managed by my partners 12 and not me, and so I don't know the abortion history on a 13 lot of them. 14 Q. So you're speculating as to the cause of 15 their preterm birth; is that correct? 16 A. I'm speculating because there is no data. 17 Q. Okay. So setting aside -- so we've talked 18 about the preterm birth. Are there any other 19 complications from abortion that you believe you have 20 treated in patients that you have seen during your 21 career? 22 A. There's another serious long-term 23 complication that is also quite hard to quantify. 24 There's a situation called placenta accreta spectrum 25 disorder, which is where a placenta is abnormally</p>
85	<p>1 invasive. The incidence of that has increased 110 fold 2 in the past 50 years, and it is associated with 3 catastrophic bleeding at the time of delivery. Women 4 have died, even when they've been at a level 3 facility 5 that was prepared for hemorrhage, because they can lose 6 so much blood so quickly that they can overwhelm the 7 blood bank. It is associated with -- 8 Q. Can you answer my question? 9 A. Yeah, I'm sorry. I was giving you some 10 background. 11 Q. Yeah, if I want background, I will certainly 12 ask for it. At this point, I want to focus on: What are 13 the other complications that you believe you've seen? 14 So am I understanding you correctly that 15 placenta accreta spectrum is a complication of abortion? 16 Is that your position? 17 A. It can be a complication of surgical 18 instrumentation, which surgical abortions certainly do. 19 Q. Can it be a complication of a prior history 20 of C-section? 21 A. Of course it can. 22 Q. And you said earlier that in some cases you 23 will perform a C-section electively, correct? 24 A. That's one of the things I will counsel a 25 patient about.</p>

86	<p>1 Q. Uh-huh. That it will have -- or could</p> <p>2 potentially have an impact on the placement of the</p> <p>3 placenta in a later pregnancy?</p> <p>4 A. That's correct.</p> <p>5 Q. So when you cite the 110-fold increase in</p> <p>6 abnormal placentation, could that also be attributable to</p> <p>7 C-sections?</p> <p>8 A. It can.</p> <p>9 Q. Do you know what share of births ended in</p> <p>10 C-section in, let's say, the 1950s?</p> <p>11 MR. SORENSON: Objection, foundation.</p> <p>12 Q. Do you know what share of --</p> <p>13 A. It was far smaller than it is today. Today</p> <p>14 it is about probably about 30 percent. But just having</p> <p>15 another reason doesn't mean that we shouldn't be curious</p> <p>16 as to whether we're allowing women to undergo elective</p> <p>17 procedures that may increase their risk --</p> <p>18 Q. Dr. Skop --</p> <p>19 A. -- (inaudible) of possible death.</p> <p>20 Q. Dr. Skop, please focus you on my question.</p> <p>21 Provide an answer to the question. And if I want</p> <p>22 additional information, I will follow up with you. I'm</p> <p>23 sorry to interrupt you. But I do want to keep us on</p> <p>24 track.</p> <p>25 So you said it is possible that that</p>	88	<p>1 have had no C-sections and in woman who have abnormal</p> <p>2 placentation but not at the area of the prior uterine</p> <p>3 scar. There are, clearly, other reasons women get that</p> <p>4 other than having a prior C-section.</p> <p>5 Q. All right. So we've talked about -- I</p> <p>6 believe -- I just want to go back through. We talked</p> <p>7 about women hemorrhaging after medication abortion, a</p> <p>8 patient who died of septicemia after a later medication</p> <p>9 abortion. I believe you said it was a prostaglandin</p> <p>10 induction; is that correct?</p> <p>11 A. It was an amniocentesis. People don't do it</p> <p>12 so much anymore, but they used the do an amniocentesis</p> <p>13 and inject the prostaglandin directly into the uterine</p> <p>14 cavity --</p> <p>15 Q. Okay.</p> <p>16 A. -- to help induce labor, and it is a</p> <p>17 situation that is high risk for infection.</p> <p>18 Q. Okay. So that was one. And there was a</p> <p>19 patient who died in the first trimester after a first</p> <p>20 trimester surgical abortion, so not a D&E?</p> <p>21 A. Right. Likely that was a uterine</p> <p>22 perforation into the bowel to introduce that infection.</p> <p>23 Q. But it was not a D&E abortion, correct?</p> <p>24 A. No, it was not. It should be a safer</p> <p>25 procedure.</p>
87	<p>1 increase in placenta accreta spectrum is due to the</p> <p>2 increase in C-sections, correct?</p> <p>3 A. There is a correlation, yes.</p> <p>4 Q. And just for the record, a C-section</p> <p>5 actually involves -- every C-section involves a cut into</p> <p>6 the uterus; is that correct?</p> <p>7 A. That's correct.</p> <p>8 Q. Does every abortion or even D&E abortion</p> <p>9 involve a cut into the uterus?</p> <p>10 A. We don't know what kind of damage --</p> <p>11 Q. What about cervical damage?</p> <p>12 A. Cervical -- the cervix is stretched open in</p> <p>13 every surgical abortion.</p> <p>14 Q. So it could actually tear?</p> <p>15 A. It can, yes.</p> <p>16 Q. It can. Does it? Is that a normal part of</p> <p>17 the procedure of a surgical abortion?</p> <p>18 A. It is a complication of the surgical</p> <p>19 abortion.</p> <p>20 Q. It would be a complication, that's correct.</p> <p>21 But for a C-section, is that -- is a cut into the uterus</p> <p>22 a complication of a C-section or is it the definition of</p> <p>23 the procedure?</p> <p>24 A. The cut into the uterus is the method of</p> <p>25 entering the uterus. However, PAS occurs in women who</p>	89	<p>1 Q. But it was not a D&E abortion; is that</p> <p>2 correct?</p> <p>3 A. That is correct. Some of these abortions</p> <p>4 have more --</p> <p>5 Q. In terms of the long-term effects of</p> <p>6 abortion, or effects you attribute to abortion -- you</p> <p>7 said that you have treated patients who have had preterm</p> <p>8 abortions, and based on their abortion history, you've</p> <p>9 concluded that the preterm birth was a consequence of the</p> <p>10 abortion?</p> <p>11 A. It is possible.</p> <p>12 Q. It is possible.</p> <p>13 A. Data backs that up.</p> <p>14 Q. Is it possible that it was not; is that</p> <p>15 correct?</p> <p>16 A. Well, certainly. But there are large</p> <p>17 studies, large review studies that show higher incidence</p> <p>18 of early delivery after abortions.</p> <p>19 Q. And then with respect to -- you also</p> <p>20 mentioned the patients that you had seen with abnormal</p> <p>21 placentation; is that correct?</p> <p>22 A. That is correct.</p> <p>23 Q. And what are you relying on to connect the</p> <p>24 prior abortion history to the abnormal placentation? Is</p> <p>25 it just studies, or is there anything particular to the</p>

90

1 circumstances of the patient that have allowed you to
2 make that causal connection?
 3 A. Well, the plausibility is that if you have
 4 an invasive placenta -- and I neglected to mention the
 5 converse can also happen. You can have a placental
 6 abruption, an abnormally -- a placenta that does not
 7 adhere well, and that can separate spontaneously in a
 8 subsequent pregnancy. So, again, I don't -- nobody has
 9 the data that looks at every pregnancy outcome in
 10 America. Nobody is interested in that data; nobody is
 11 collecting it -- the CDC, nobody. So we don't know
 12 everybody's history. Where, it would be nice if we
 13 did --
14 Q. So is your answer, Dr. Skop, that you don't
15 know of any data specific to those individual's history
16 that allows you to make that causal connection between
17 the prior abortion history and the placental --
 18 A. No, no. There are studies that correlate
 19 surgical instrumentation with these abnormal placentas.
 20 And, yes, C-section can be a surgical instrumentation,
 21 but if that's the case, the placenta --
22 Q. It is always a surgical instrumentation,
23 isn't it?
 24 A. It is a surgical scar, okay? And there are
 25 women who have PAS where it is not in the surgical scar.

91

1 It is placenta previa. It can be up here. You know, so
 2 in those cases you say to yourself, What else could have
 3 happened that would make this uterus weak in the area of
 4 placental implantation so that the placenta invades? And
 5 I think that we have to ask our ourselves, is it the one
 6 out of three, one out of four women who have abortions --
 7 I know we're not doing as many surgical abortions as we
 8 used to, but we were, in the past, doing a lot of
 9 surgical abortions.
 10 It would -- it is not good care for women to
 11 ignore the possibility that that could be a door -- that
 12 could be the cause.
13 Q. You're saying that there is a possibility
14 that the prior abortion history is the cause?
 15 A. Yes. Yes.
16 Q. Okay. What about any other complications
17 that you've seen from a D&E abortion at and after 18
18 weeks?
 19 A. I have not, personally, cared for women who
 20 have had perforated uteruses, but I have read a number of
 21 reports --
22 Q. I'm asking you about who you've cared for,
23 Dr. Skop, because you've mentioned multiple times you are
24 drawing on your experience of treating women after
25 abortions who are suffering from complications. So in

92

1 your experience, what other complications have you
2 treated post abortion that we have not spoken of today?
 3 A. Well, those are physical, right? I've cared
 4 for a lot of women with emotional and psychological
 5 problems post abortion.
6 Q. Can we -- sorry. Can we pause there? So
7 have you now told me every physical complication that you
8 believe you have treated for an abortion -- for a patient
9 after an abortion that you're -- let me rephrase that.
10 Have you now told me every physical
11 complication that you have treated for a patient that you
12 believe was a physical complication of the abortion?
 13 A. I've also cared for women with Asherman's
 14 syndrome, which is scarring within the uterus. That also
 15 is linked to prior instrumentation, and many times it is
 16 a cause of infertility.
17 Q. And in those instances where you have cared
18 for people with Asherman's syndrome, have you ever
19 confirmed that those individuals had a history of
20 abortion?
 21 A. Sometimes they have.
22 Q. How many times?
 23 A. I don't know, but I know that I've gotten
 24 that history from some women.
25 Q. More than one?

93

1 A. Yes.
2 Q. More than five?
 3 A. Probably.
4 Q. More than ten?
 5 A. Possibly.
6 Q. And Asherman's syndrome can be caused from
7 other kinds of instrumentation, correct?
 8 A. That's correct.
9 Q. So even a woman with a history of abortion,
10 she could have Asherman's syndrome that is unrelated to
11 the abortion history, correct?
 12 A. That's possible.
13 Q. Okay. So have you now told me all the
14 physical complications that you have treated that you
15 would attribute to a patient's prior history of
16 abortion?
 17 A. I mentioned the lady in the ICU a couple of
 18 years ago. Transfusions, it is not uncommon to need to
 19 transfuse someone. IV antibiotics.
20 Q. So you mentioned a teenager in the ICU after
21 a first trimester. Is that what you're referring to?
 22 A. She died, but I have also cared for patients
 23 who have gone to the ICU who lived.
24 Q. Who needed the transfusions after
25 abortion?

September 02, 2020

94	<p>1 A. Yes.</p> <p>2 Q. How many?</p> <p>3 A. Probably five or ten.</p> <p>4 Q. How many after a D&E abortion after 18 weeks</p> <p>5 of pregnancy would you say?</p> <p>6 A. Well, I'm happy to say that I have not cared</p> <p>7 for women who have had complications from D&E abortions</p> <p>8 after 18 weeks. And I think the -- one of the major</p> <p>9 reasons for that is that Texas has a law against it.</p> <p>10 Yeah, we still have a law against it.</p> <p>11 So I don't think they happen very often, but</p> <p>12 they're an extremely difficult procedure to perform, and</p> <p>13 if a physician does not have a lot of experience</p> <p>14 performing them, then there is high likelihood they could</p> <p>15 perforate the uterus, lacerate vessels, leave fetal parts</p> <p>16 inside. It is a very difficult procedure, a D&E.</p> <p>17 Q. So have you now told me all of the physical</p> <p>18 complications you believe you've treated from patients</p> <p>19 after an abortion?</p> <p>20 A. I believe so.</p> <p>21 Q. Okay. And we'll get to the mental health</p> <p>22 issues later, but I do -- I do want to move on.</p> <p>23 Something you just said triggered something. With</p> <p>24 respect to the D&E, would you consider yourself to have</p> <p>25 the clinical competency to perform a D&E abortion?</p>	96	<p>1 expert. I certainly have cared for people who have had</p> <p>2 normal grief responses.</p> <p>3 Q. What about -- do you consider yourself an</p> <p>4 expert with respect to patients' decisional certainty</p> <p>5 when making health care decisions?</p> <p>6 MR. SORENSON: Objection, vague.</p> <p>7 Q. Is there anything about that question you</p> <p>8 don't understand, Dr. Skop?</p> <p>9 A. Yeah, I'm not sure what you're asking. I --</p> <p>10 Q. Are you familiar with the -- I'm sorry?</p> <p>11 A. I said I do my best to make sure that they</p> <p>12 have all the information they need to make a decision,</p> <p>13 but I don't know that that makes me an expert.</p> <p>14 Q. So are you familiar with literature about</p> <p>15 decisional certainty with respect to health care</p> <p>16 decisions?</p> <p>17 A. I don't think I've read any of that</p> <p>18 literature.</p> <p>19 Q. Okay. Do you consider yourself an expert</p> <p>20 with respect to fetal pain capacity. The capacity of a</p> <p>21 fetus to experience pain?</p> <p>22 A. I have done a lot of research on that issue.</p> <p>23 Q. Do you consider yourself an expert with</p> <p>24 respect to the capacity of a fetus to experience pain?</p> <p>25 A. Sure.</p>
95	<p>1 A. No.</p> <p>2 Q. And to perform a D&E miscarriage management</p> <p>3 at and after 18 weeks of pregnancy?</p> <p>4 A. I do them when I need to. I'm not</p> <p>5 comfortable --</p> <p>6 Q. At and after 18 weeks of pregnancy?</p> <p>7 A. Oh. Yeah, usually I'll induce those.</p> <p>8 Q. Usually or always?</p> <p>9 A. Well, I told you earlier I have not done</p> <p>10 one, so things wouldn't change in the future --</p> <p>11 Q. So do you believe you have the clinical</p> <p>12 competency to perform miscarriage management by way of</p> <p>13 D&E at and after 18 weeks of pregnancy?</p> <p>14 A. I would be uncomfortable doing that</p> <p>15 procedure because it is very complicated.</p> <p>16 Q. So would you not do it because of that</p> <p>17 discomfort?</p> <p>18 A. I would -- I would bring another partner</p> <p>19 alongside me to do it.</p> <p>20 Q. Do you believe that you are an expert</p> <p>21 in grief responses?</p> <p>22 A. Excuse me?</p> <p>23 Q. Do you consider yourself an expert in grief</p> <p>24 responses?</p> <p>25 A. Grief responses? I wouldn't say I'm an</p>	97	<p>1 Q. And what -- what would you say you base your</p> <p>2 expertise on?</p> <p>3 A. I base my expertise on the research that</p> <p>4 I've done in the neurologic literature as documented in</p> <p>5 my expert report, and also the fact that I have delivered</p> <p>6 many living babies in the gestational age that we're</p> <p>7 discussing. And I have seen responses from those babies</p> <p>8 that are identical to the responses that you and I would</p> <p>9 have if we were experiencing pain.</p> <p>10 Q. Okay. Anything else that you would base</p> <p>11 your expertise on in that area?</p> <p>12 A. No, I think clinical expertise and research</p> <p>13 is it.</p> <p>14 Q. Okay. Are you -- do you have training in</p> <p>15 neurology?</p> <p>16 A. No, I -- well, other than what we got in</p> <p>17 medical school.</p> <p>18 Q. Do you have a specialization in maternal</p> <p>19 fetal medicine?</p> <p>20 A. No, I do not.</p> <p>21 Q. Do you perform intrafetal surgeries -- is</p> <p>22 that what it is called? Intrauterine fetal surgeries?</p> <p>23 A. Nobody in San Antonio does. We send them to</p> <p>24 Houston and Dallas.</p> <p>25 Q. Okay. Do you consider yourself an expert in</p>

98	<p>1 neonatology?</p> <p>2 A. No.</p> <p>3 Q. What about epidemiology?</p> <p>4 A. I've learned a lot of epidemiology in my</p> <p>5 abortion and maternal research, but I don't consider</p> <p>6 myself an expert.</p> <p>7 Q. What about in medical ethics?</p> <p>8 A. I'm interested in medical ethics, but I'm</p> <p>9 certainly not an expert.</p> <p>10 Q. Try to adhere to them, but not an expert.</p> <p>11 So at this point, I want to introduce -- if</p> <p>12 you could turn to Tab B. This is your -- so this would</p> <p>13 become Exhibit 2. This is your expert report that you</p> <p>14 submitted in this case. Is that accurate?</p> <p>15 (Exhibit No. 2 was marked.)</p> <p>16 Q. If I can make a note because we may refer</p> <p>17 back to this expert report throughout today's deposition.</p> <p>18 So if you could, at this point, just number -- the pages</p> <p>19 aren't numbered and the paragraphs aren't numbered</p> <p>20 either. So to make sure we're all looking at the same</p> <p>21 pages, I want to note that my page numbering will start</p> <p>22 with page 1 of the cover page. So if you want to number</p> <p>23 the pages, you're welcome to take a couple of seconds for</p> <p>24 that. But I did -- in looking back through my notes, I</p> <p>25 realized that that might be a stumbling block.</p>	100
99	<p>1 So this is the expert report in the case.</p> <p>2 Does this appear complete, Dr. Skop?</p> <p>3 A. Yes, it does.</p> <p>4 Q. And did you prepare this document?</p> <p>5 A. Yes, I did.</p> <p>6 Q. Can you tell me everything -- can you tell</p> <p>7 me how the document was prepared?</p> <p>8 A. I -- for a long time, as I've done research</p> <p>9 on particular topics, I've made notes to myself, and I've</p> <p>10 written papers, essentially for my own consumption. And</p> <p>11 when I determined the topics that I wanted to address, I</p> <p>12 referred to those notes and incorporated them into the</p> <p>13 paper.</p> <p>14 Q. Okay. You said that these are personal</p> <p>15 notes; is that right?</p> <p>16 A. Yes.</p> <p>17 Q. What about any other documents that you</p> <p>18 referred to and incorporated into the expert report?</p> <p>19 A. Well, I've referred to other documents.</p> <p>20 I've referred to some of the ACOG literature on fetal</p> <p>21 pain. I -- you know, I believe that there is -- there</p> <p>22 are various papers available on the internet that I've</p> <p>23 looked at. When I've gone to a source like that, then</p> <p>24 I've subsequently gone to the references to verify the</p> <p>25 accuracy of those papers.</p>	101
100	<p>1 Q. To make sure that I understand, when you</p> <p>2 were preparing this, did you cite every document that you</p> <p>3 relied on in the expert report, or were there other</p> <p>4 documents that you reviewed that you didn't cite?</p> <p>5 A. It's hard to say. I do a lot of reading.</p> <p>6 So it is very possible that there are things that I read</p> <p>7 and ideas that I incorporated in this report that I did</p> <p>8 not specifically cite, but I tried my best to go to the</p> <p>9 source of the statements when I prepared the references.</p> <p>10 Q. Okay. And do you -- is there any way that</p> <p>11 you would be able to identify, at this point, which</p> <p>12 documents you considered for incorporation in the report</p> <p>13 but you ultimately excluded?</p> <p>14 A. I don't recall, to tell you the truth. I</p> <p>15 mean, I could certainly provide you with those later if</p> <p>16 you want to know additional resources that I looked at.</p> <p>17 Q. Well, I'm asking whether there is any way</p> <p>18 that you can identify those now? Do you have any notes</p> <p>19 as to what you reviewed and excluded?</p> <p>20 A. No. I think that -- it looks pretty</p> <p>21 thorough in terms of the -- you know, many times review</p> <p>22 papers will summarize statements, but I tried to go to</p> <p>23 the source of the facts and not necessarily reference the</p> <p>24 review paper that was referencing another paper. I felt</p> <p>25 like it would be more accurate to go to the source, to go</p>	101
101	<p>1 to the neurologic literature that I've quoted and that</p> <p>2 I've referenced.</p> <p>3 Q. You tried not to rely on how other</p> <p>4 researchers or doctors might describe the literature; is</p> <p>5 that correct?</p> <p>6 A. I tried not to. Like I say, I probably did</p> <p>7 get some of this off the AAPLOG website, which you guys</p> <p>8 have probably looked at.</p> <p>9 Q. And which parts --</p> <p>10 A. But I verified the references beyond that.</p> <p>11 Q. Which part would that be, Dr. Skop?</p> <p>12 A. Excuse me?</p> <p>13 Q. Which parts of the report would that be?</p> <p>14 A. Well, I think -- are we talking specifically</p> <p>15 about fetal pain?</p> <p>16 Q. About any -- we're talking about your report</p> <p>17 generally.</p> <p>18 A. Okay. I think the fetal pain -- possibly</p> <p>19 that began by referencing AAPLOG's fetal pain practice</p> <p>20 bulletin, and then I went from there and pulled the</p> <p>21 individual studies.</p> <p>22 Q. Okay. The fetal pain practice bulletin.</p> <p>23 Are there any other documents -- but that wasn't cited in</p> <p>24 your expert report, correct?</p> <p>25 A. Probably not. It doesn't look like it. I</p>	102

102

1 think I went straight to the -- to the neurologic
 2 literature.
 3 **Q. Okay. Any other documents from AAPLOG that**
 4 **you can recall relying on to draft the report?**
 5 A. I don't think so. I've been involved in
 6 drafting a lot of that their practice bulletins and
 7 committee opinions. So there may be similar wording, but
 8 I -- this report essentially relies upon my own
 9 research.
 10 **Q. Okay. What about -- did anyone other than**
 11 **Mr. Sorenson provide documents to you to consider with**
 12 **respect to this -- drafting this report?**
 13 A. No.
 14 **Q. And have you discussed the report with**
 15 **anyone other than Mr. Sorenson?**
 16 A. No.
 17 **Q. Did you have any role in drafting expert**
 18 **reports for any other experts in this case?**
 19 A. No.
 20 **Q. Did you review any expert reports from other**
 21 **cases?**
 22 A. No.
 23 **Q. Were you asked by anyone to make any factual**
 24 **assumptions?**
 25 A. I'm not sure that I know what you mean by

103

1 that.
 2 **Q. Did Mr. Sorenson provide any facts or data**
 3 **to you to use in drafting your opinions for this**
 4 **report?**
 5 A. No. The statements are my own.
 6 **Q. And any idea how many hours you spent**
 7 **drafting the report itself?**
 8 A. It is hard to say because I took it from
 9 papers I had already written. Probably five or six for
 10 the actual report, but a lot more time went into the
 11 research for the original papers.
 12 **Q. Sorry. Just to make sure that I understand.**
 13 **I thought that you said that you relied on personal notes**
 14 **for the report but not public papers. Is that --**
 15 A. Oh, I'm sorry. I said papers, but they're
 16 my papers. Nobody else has seen them.
 17 **Q. I see. They are not things you published**
 18 **somewhere?**
 19 A. Yeah.
 20 **Q. Got it. All right. But would you have --**
 21 **did you keep records of time that you spent on the report**
 22 **itself?**
 23 A. I did. I submitted that, but it was -- I
 24 believe it was late in 2019 that I wrote all of this, so
 25 I did not review my -- the hours. I apologize.

104

1 **Q. Do you recall, ballpark, how much you were**
 2 **paid for drafting this report?**
 3 A. I don't recall.
 4 **Q. Would it have been more than a thousand**
 5 **dollars?**
 6 A. I think so.
 7 **Q. More than \$5,000?**
 8 A. Possibly.
 9 **Q. More than \$10,000?**
 10 A. No.
 11 **Q. Okay. So somewhere between a thousand to**
 12 **\$10,000.**
 13 **And you would have records, though, that**
 14 **were submitted for that, correct?**
 15 A. Yeah, there are records.
 16 **Q. Okay. And then so your report lists certain**
 17 **opinions that you intend to testify about in this case,**
 18 **correct?**
 19 A. Yes.
 20 **Q. And are the opinions listed in the report**
 21 **all the expert opinions to which you intend to testify?**
 22 A. Are you asking if I have other opinions that
 23 aren't in the report?
 24 **Q. Well, I'm asking whether you intend to**
 25 **provide other opinions in your testimony about this**

105

1 **case?**
 2 A. I don't think so.
 3 **Q. Okay. Have you changed any of your opinions**
 4 **since you signed this report, Dr. Skop?**
 5 A. No.
 6 **Q. Did you make an effort to include in your**
 7 **report all the relevant facts and data on which your**
 8 **opinions are based?**
 9 A. Yes.
 10 **Q. Did you prepare the report -- actually, let**
 11 **me skip over that.**
 12 **Apart from your expert report, have you**
 13 **created any other documents in connection with this**
 14 **case?**
 15 A. No.
 16 **Q. And have you discussed the case with anyone**
 17 **besides Mr. Sorenson?**
 18 A. No.
 19 **Q. So at this point, I would like to turn to**
 20 **your report itself. You talk in your report about the**
 21 **reasons that individuals might have abortions later in**
 22 **pregnancy. And then the very top of page 4, very top**
 23 **paragraph, do you see the part that starts with, "One**
 24 **large study"?**
 25 A. Yes.

106

1 **Q. So it says, "One large study examining**
 2 **reasons for later abortions found that: 'not knowing**
 3 **about the pregnancy,' 'trouble deciding about the**
 4 **abortion,' and 'disagreeing about the abortion with the**
 5 **man involved' were commonly reported."**
 6 **Later in that paragraph you say, "With all**
 7 **this indecision, it is likely that another change of mind**
 8 **could occur for the woman after going through with the**
 9 **abortions, and the choice could be regretted." Did I get**
 10 **that right?**
 11 A. Yes.
 12 **Q. Okay. And in footnote 2, there, you're**
 13 **relying on an article by Jones and Finer, correct? Those**
 14 **are the researchers you mentioned earlier?**
 15 A. Yes.
 16 **Q. And you said that you had read this article**
 17 **before you drafted your report, correct?**
 18 A. I've read it. It is possible that some of
 19 that data came through the third Finer article as well.
 20 **Q. Okay. But you believe that you cited the**
 21 **Jones and Finer -- the article that you cite in**
 22 **footnote 2 you read before you cited, correct?**
 23 A. Yes.
 24 **Q. And do you consider the analysis in that**
 25 **article reliable?**

107

1 **And I should say one note, Dr. Skop: If you**
 2 **want to refer to other parts of the binder, that's fine.**
 3 **But we should make sure that we're introducing them as**
 4 **exhibits along the way so they are part of the record.**
 5 A. Okay. So when you say analysis, are you
 6 talking about results or discussion, or are you just
 7 talking about the general -- the paper itself?
 8 **Q. Well, I'm asking -- you cited it in your**
 9 **report, so I'm asking you whether you believed it to be**
 10 **an article of good quality?**
 11 A. Almost all of the literature regarding
 12 reasons for abortions comes from Guttmacher Institute
 13 researchers and it comes through the journal
 14 Contraception. And I think it is accurate, but I also
 15 think that it is -- I think that there could be more to
 16 the story on some of these reasons. I think that it is
 17 often presented in such a way as to justify abortion.
 18 **Q. But --**
 19 A. And it is -- it is the best data we have.
 20 It is the only data, really, that we have, is what the
 21 abortion clinics put out for us to see.
 22 **Q. Are you saying that this article is being**
 23 **authored by an abortion clinic, Doctor?**
 24 A. No, I'm not saying it is being altered. I'm
 25 saying it is being put out by researches --

108

1 **Q. No, offered or authored.**
 2 A. Well, they get their data -- Guttmacher gets
 3 their data directly from abortion clinics. That is not
 4 data that is available to most Americans. When you look
 5 at the numbers of abortions, you see that Guttmacher
 6 reports 30 percent more than the CDC does. So Guttmacher
 7 has a special relationship with the abortion industry.
 8 **Q. Do you actually -- can I ask you a quick**
 9 **question about that?**
 10 A. Yes, ma'am.
 11 **Q. Because I assume you would agree that no**
 12 **data is perfect, correct?**
 13 A. Absolutely.
 14 **Q. So as between the CDC data about the number**
 15 **of abortions there are in a given year in the United**
 16 **States and the Guttmacher data, do you consider one to be**
 17 **more reliable than the other?**
 18 A. I think the Guttmacher is probably more
 19 reliable. California does an extraordinary large number
 20 of abortions. They don't report anything to the CDC.
 21 That reporting is voluntary. Also, Maryland has a
 22 late-term abortionist who does a lot of really, really
 23 late procedures, and they don't report data either.
 24 So I think the CDC's data, just like it is
 25 for complications and just like it is for maternal

109

1 mortality, is seriously flawed and underestimates the
 2 extent of the problem.
 3 **Q. So as between those two sources, you would**
 4 **say that the Guttmacher source is the -- as to the number**
 5 **of abortions performed annually is the more reliable of**
 6 **the two?**
 7 A. That is probably the case.
 8 **Q. Would you say that it is the best data we**
 9 **have available right now as to the number of annual**
 10 **abortions that occur in the United States?**
 11 A. I think it is the best data.
 12 **Q. Okay. And to the extent that it is not**
 13 **entirely accurate, do you -- is it your opinion that the**
 14 **actual number is lower or higher than the Guttmacher**
 15 **data?**
 16 A. Are you asking about the number of abortions
 17 or complications?
 18 **Q. The number of abortions.**
 19 A. Guttmacher is probably reasonably accurate
 20 because they get their data directly from the abortion
 21 providers. But if there are abortions being performed by
 22 private doctors, they may not be reported.
 23 **Q. Doesn't Guttmacher have a way of sampling**
 24 **private doctors as well, Dr. Skop?**
 25 A. I don't know. I don't know how that works.

110

1 **Q. You don't know the methodology of how they**
 2 **identify abortion providers; is that correct?**
 3 A. No, I don't.
 4 **Q. Okay. So if we can turn back to the part of**
 5 **your report about reason for an abortion. My question**
 6 **was, do you consider the article to be of good quality.**
 7 **So setting aside -- I know that there are no perfect**
 8 **data. But citing this article, am I assuming correctly**
 9 **that you believe this is a good study?**
 10 A. I think it is accurate as far as it can be
 11 on this demographic data.
 12 **Q. Okay. Okay. And are you looking at the**
 13 **article now, Dr. Skop?**
 14 A. Yes, ma'am.
 15 **Q. Okay. So why don't we go ahead and**
 16 **introduce that into the record. This is Tab C, as in**
 17 **cat.**
 18 (Exhibit No. 3 was marked.)
 19 **Q. And what I'm showing you is "Who Has**
 20 **Second-Trimester Abortions in the United States?" by**
 21 **Jones and Finer; is that correct, Dr. Skop?**
 22 A. Yep.
 23 **Q. Okay. And does this appear complete?**
 24 A. The article?
 25 **Q. Yes.**

111

1 A. It is complete. I'm wondering if I might
 2 have gotten some of the reasons data from another one of
 3 their articles because I don't see that here, but I --
 4 **Q. Okay.**
 5 A. I believe there is a chart in one of the
 6 other articles that talks specifically about reasons.
 7 **Q. What about -- you mentioned the journal**
 8 **Contraception. Do you consider that to be a reliable**
 9 **source of information in the gynecological field?**
 10 A. Contraception, I believe, is published by
 11 the Guttmacher Institute, and it very much works hard to
 12 paint abortion in a favorable light. So I am skeptical
 13 sometimes with the data they put forward.
 14 **Q. Skeptical about the quality of the data or**
 15 **the conclusions they draw from that data or both?**
 16 A. Well, for example, if we're looking at
 17 reasons that women have abortions, they don't seem
 18 particularly curious about things like coercion. And I
 19 think they ask one question that was, like, did someone
 20 else other than you -- you know -- they don't ask a lot
 21 of questions that I would like to see asked. But I don't
 22 have any -- you know, I don't work in an abortion clinic,
 23 so I don't have the ability to get there and ask these
 24 questions. The -- you know, I --
 25 **Q. I understand that they could certainly ask**

112

1 **other questions. I guess my question is -- and it sounds**
 2 **like you're talking about this article in particular.**
 3 A. Uh-huh.
 4 **Q. My question is, with respect to**
 5 **Contraception. Do you believe -- is it your opinion that**
 6 **the quality of the research coming out of Contraception**
 7 **is of high quality?**
 8 A. I -- I believe it is -- well, regarding
 9 these reasons, I have no reason to doubt that they are
 10 taking the answers they've been given by women in
 11 abortion clinics and reporting them.
 12 **Q. Okay.**
 13 A. If we're talking about complications, I -- I
 14 don't think that the data on complications in the United
 15 States is accurate no matter who is reporting it.
 16 **Q. Okay. So we'll get to complications.**
 17 A. Okay.
 18 **Q. Let's talk about it a little later.**
 19 **So if I could take you back to that quote**
 20 **from your expert report where you said, "With all this**
 21 **indecision, it is likely another change of mind could**
 22 **occur for the woman after going through with the abortion**
 23 **and the choice could be regretted." How did you conclude**
 24 **that the incision prior to having an abortion makes it**
 25 **likely that the woman will change her mind again after**

113

1 **having the abortion?**
 2 A. I base that on my clinical experience both
 3 in the office and through my work with Any Woman Can.
 4 There are women who regret their abortions.
 5 **Q. There are women. Would you say --**
 6 A. And the less confident they are in their
 7 decision -- I mean, somebody who waits until the second
 8 trimester when they're feeling that baby move before they
 9 decide to terminate, to me, that just -- that reeks of
 10 coercion. And I -- I don't think that there is good data
 11 coming out of Guttmacher, coming out of Contraception
 12 that addresses that.
 13 **Q. So how did you -- to make sure I understand**
 14 **your position, then, the way you concluded that prior**
 15 **indecisional -- prior uncertainty before the abortion is**
 16 **likely to lead to another change of mind after the**
 17 **abortion is based on your clinical experience and**
 18 **encountering some women who regret their abortions at Any**
 19 **Woman Can; is that correct?**
 20 A. That is correct.
 21 **Q. You said earlier, though, that you're not**
 22 **familiar with the literature decisional certainty with**
 23 **respect to health care decisions?**
 24 A. I'm not familiar with the specific
 25 literature, but I do know what I've seen of women's

September 02, 2020

114	<p>1 decision making in my 25 years of private practice. And</p> <p>2 I've -- I've had patients, a number of patients who have</p> <p>3 told me, I didn't want -- often it is a young woman who</p> <p>4 keeps the pregnancy secret from her parents until they</p> <p>5 can no longer, you know, not see it, and often it is a</p> <p>6 woman who keeps it secret from her partner because she</p> <p>7 doesn't think he will support her decision. And in both</p> <p>8 of those cases, I think that they are often coerced by</p> <p>9 the parent or coerced by the partner to have a late</p> <p>10 abortion.</p> <p>11 I think that this uncertainty category</p> <p>12 probably encompasses a lot of that based on what I've</p> <p>13 seen of my own patients and what I've heard them say.</p> <p>14 Q. Dr. Skop, have you ever obtained an informed</p> <p>15 consent from a patient to perform an abortion?</p> <p>16 A. No.</p> <p>17 Q. So in terms of the kind of counseling that</p> <p>18 goes along with the informed consent process for</p> <p>19 abortion, you have never participated in that; is that</p> <p>20 correct?</p> <p>21 A. I mean, it is possible in residency that I</p> <p>22 might have been involved in that, but that's been more</p> <p>23 than 25 years. I'm concerned about the informed consent</p> <p>24 that does occur. You know, I'm sure you're aware of your</p> <p>25 annual report at Planned Parenthood; 96 percent of the</p>
115	<p>1 pregnancy services are abortions. Knowing the real world</p> <p>2 and knowing the decisional uncertainty in women, I find</p> <p>3 it hard to believe that 96 percent of them wouldn't have</p> <p>4 chosen something else had they had full informed consent.</p> <p>5 Q. Let me ask you this: Do you think -- you</p> <p>6 mentioned earlier that you think sometimes patients hold</p> <p>7 back things about their history when they see a doctor</p> <p>8 later, correct?</p> <p>9 A. Yes.</p> <p>10 Q. They not might not reveal --</p> <p>11 A. That can happen.</p> <p>12 Q. Do you think patients would feel comfortable</p> <p>13 about how they feel about prior abortions with a doctor</p> <p>14 who believes there are no benefits with abortion?</p> <p>15 A. I think that people often feel uncomfortable</p> <p>16 talking about abortions no matter who they're discussing</p> <p>17 it with. It is an area that a lot of women feel shame,</p> <p>18 and a lot of women feel that it is a -- that it is</p> <p>19 murder. I mean, a lot of women who have abortions,</p> <p>20 nonetheless, feel that they are committing an unethical</p> <p>21 and immoral act. And so, undoubtedly, there are women</p> <p>22 that no matter who they're talking to they don't want to</p> <p>23 discuss it with somebody else.</p> <p>24 I have never given anyone -- tried to give</p> <p>25 anyone a feeling of guilt if they discuss an abortion</p>
116	<p>1 with me. And I don't think there is any reason that they</p> <p>2 would feel that they couldn't share that with me just</p> <p>3 based on who I am and what they know about my practice.</p> <p>4 Q. Do you believe that patients -- you</p> <p>5 mentioned shame and stigma. Where did that shame and</p> <p>6 stigma come from? Do you find that it comes from your</p> <p>7 patients' own reactions to abortions or from the</p> <p>8 reactions of other individuals either in their family or</p> <p>9 community or friends?</p> <p>10 A. Well, I think, in this day and age, almost</p> <p>11 everyone has seen an ultrasound picture of a friend,</p> <p>12 perhaps, posted on Facebook. Everyone who has bothered</p> <p>13 to pay attention knows that an abortion is ending the</p> <p>14 life of a living human being. Now, you know different</p> <p>15 people will justify it in different ways and say, My</p> <p>16 circumstance is rough, or whatever. And a woman may be</p> <p>17 in a situation where she does not feel she has another</p> <p>18 option. But she also knows that she is ending the life</p> <p>19 of her own biologic child, and I -- I don't think it is</p> <p>20 necessarily a religious thing. I know our society has a</p> <p>21 lot of --</p> <p>22 Q. Dr. Skop, can you answer my question?</p> <p>23 A. I think --</p> <p>24 Q. I'm asking you about the source of shame and</p> <p>25 stigma. Do you believe it is all coming from the</p>
117	<p>1 patients that you encounter, or from their community,</p> <p>2 family, or friends, or both?</p> <p>3 A. Well, I think we'll all agree that abortion</p> <p>4 is a nuclear issue. It comes from many different</p> <p>5 directions.</p> <p>6 Q. Okay. Actually, let me now ask you: How</p> <p>7 many patients would you say you encounter in a month who</p> <p>8 talk about their decision with you to have an abortion?</p> <p>9 A. Probably not that many.</p> <p>10 Q. Two?</p> <p>11 A. I don't -- it is --</p> <p>12 Q. One?</p> <p>13 A. It is rare for me to see a patient who</p> <p>14 says -- you know, that I see for an annual one year and</p> <p>15 see for an annual the next year and have them say, Oh, by</p> <p>16 the way, my birth control failed, and I had an abortion</p> <p>17 in July. It is actually not that common for them to</p> <p>18 report it. And sometimes they do, and if they do, you</p> <p>19 know, I will talk to them about it. But it is not</p> <p>20 something that I necessarily will ask.</p> <p>21 Q. So if they don't report it, is that -- I</p> <p>22 mean, presumably, do you think it is fair to assume that</p> <p>23 that's because they had no complications from the</p> <p>24 procedure?</p> <p>25 A. We're talking emotional complications?</p>

118	<p>1 Q. Of any kind. That they don't perceive it as</p> <p>2 being relevant to their annual checkup?</p> <p>3 A. Well, they may not perceive it as being</p> <p>4 relevant, and it may just be something that they don't</p> <p>5 want to talk about.</p> <p>6 Q. Okay. So if I could go back to my question.</p> <p>7 Maybe let's think of it in terms of a year. How often</p> <p>8 would you say that you have a conversation with a patient</p> <p>9 who describes her decision making with a prior -- with</p> <p>10 respect to a prior abortion?</p> <p>11 A. Maybe once a month.</p> <p>12 Q. Okay, maybe 12 times a year. And of those,</p> <p>13 how many would you say express regret for having the</p> <p>14 procedure?</p> <p>15 A. It is complicated because some of them will</p> <p>16 affirm that they feel it was the best decision for them.</p> <p>17 But, inevitably, they also will affirm that they wish</p> <p>18 that they had not done it, if that makes sense. They</p> <p>19 wish they had not been in a situation where that was the</p> <p>20 decision they had to make.</p> <p>21 Q. They regret the situation but not the</p> <p>22 outcome?</p> <p>23 A. They're glad they're not pregnant anymore,</p> <p>24 but they regret that they had to choose an abortion.</p> <p>25 Q. When you're using regret in that way, do you</p>	120	<p>1 regretted making that decision.</p> <p>2 Q. Or that they were sad that they had to make</p> <p>3 the decision to place a baby for adoption?</p> <p>4 A. Well, certainly, I think a lot of them are</p> <p>5 sad, to be perfectly honest. I don't have that</p> <p>6 conversation very often. Very, very few women will give</p> <p>7 birth to an unwanted pregnancy and place it for adoption</p> <p>8 because abortion is so easy to obtain.</p> <p>9 Q. Okay. Let's see. Let me make sure -- so</p> <p>10 later -- if you can turn back to page 4 of your report,</p> <p>11 that same paragraph that we were just looking at --</p> <p>12 towards the end of the paragraph you discuss Florida</p> <p>13 statistics on reasons that a patient might have an</p> <p>14 abortion, correct?</p> <p>15 A. Yes.</p> <p>16 Q. And to support those data you cite a website</p> <p>17 called Abort73.com; is that right?</p> <p>18 A. Yes.</p> <p>19 Q. What is that?</p> <p>20 A. It is an organization that puts out some</p> <p>21 information about abortion. I couldn't find the -- the</p> <p>22 Florida source, but I've seen that statistics from a</p> <p>23 couple of different website, so I considered it to be</p> <p>24 accurate.</p> <p>25 Q. So you couldn't find any original data that</p>
119	<p>1 mean that they're sad that they had to have an</p> <p>2 abortion?</p> <p>3 A. Sometimes. A lot of them cry when they talk</p> <p>4 about it.</p> <p>5 Q. Have you ever had patients who tell you that</p> <p>6 they regret having children?</p> <p>7 A. No, I don't think anyone has ever told me</p> <p>8 that. Kids are hard at times, but nobody has ever wished</p> <p>9 they didn't have their child. I've never seen that.</p> <p>10 Q. There would probably be a lot of stigma</p> <p>11 attached to that, correct?</p> <p>12 MR. SORENSON: Objection, foundation.</p> <p>13 Q. Let me ask it this way. Have you ever</p> <p>14 encountered patients who have indicated that they are sad</p> <p>15 because they're parents?</p> <p>16 A. Told me they are sad because they were a</p> <p>17 parent?</p> <p>18 Q. Uh-huh, that they have children?</p> <p>19 A. No. No, I haven't.</p> <p>20 Q. Have you ever had patients who have told you</p> <p>21 that they regretted the decision to have a baby and place</p> <p>22 it for adoption?</p> <p>23 A. Placing for adoption is very complicated.</p> <p>24 It is very, very hard for a woman to do that. But I</p> <p>25 don't think I've ever had anybody who said that they</p>	121	<p>1 would support this finding with respect to Florida; is</p> <p>2 that correct?</p> <p>3 A. I did not find the Florida source, no.</p> <p>4 Q. And did you look for it?</p> <p>5 A. Yes, but I'm not a really good researcher,</p> <p>6 so it is possible that it was easy to find and I just</p> <p>7 didn't find it, but. . .</p> <p>8 Q. Okay. Did you consult the Florida state</p> <p>9 government's website?</p> <p>10 A. I don't recall where I looked for it, to</p> <p>11 tell you the truth.</p> <p>12 Q. Do you consider Abort73 a reliable source in</p> <p>13 your field?</p> <p>14 A. I'm not that familiar with who does the</p> <p>15 research for that website. But based on numbers I've</p> <p>16 seen on a number of sources, I think that these</p> <p>17 statistics are probably fairly accurate. And even</p> <p>18 Guttmacher tells us that 97 percent of abortions are done</p> <p>19 for social, financial -- not hard cases, not life and</p> <p>20 health of the mother, not fetal anomalies.</p> <p>21 Q. I'm just trying to understand your process</p> <p>22 of drafting the report, Dr. Skop. So you're not</p> <p>23 familiar, you said, with who compiles the numbers on the</p> <p>24 website Abort73; is that right?</p> <p>25 A. That's correct.</p>

122	<p>1 Q. Can you think of any colleague who would</p> <p>2 agree that this is a reliable source of information?</p> <p>3 A. I can't say. I haven't discussed this</p> <p>4 report with anybody.</p> <p>5 Q. Would you agree that in medical and social</p> <p>6 science research, it is better to site primary sources?</p> <p>7 A. Yes, I've tried to do that, but in this case</p> <p>8 I was not able to find it.</p> <p>9 Q. And to your knowledge, is the Abort73</p> <p>10 website, is that associated with a -- it is called</p> <p>11 Loxafamosity Ministries? Does that sound familiar?</p> <p>12 A. I don't know. I don't know who puts out</p> <p>13 that website.</p> <p>14 Q. So you don't know where this information</p> <p>15 originally came from; is that correct, with respect to</p> <p>16 the Florida statistics?</p> <p>17 A. Well, ultimately it came from the State of</p> <p>18 Florida, but I did not find the specific --</p> <p>19 Q. How do you know that, Doctor?</p> <p>20 A. Because I believe that they were telling me</p> <p>21 the truth when they said they got it from Florida.</p> <p>22 Q. And you believe that they're telling the</p> <p>23 truth, this website; is that accurate? You believe the</p> <p>24 website is telling you the truth?</p> <p>25 A. Yes.</p>	124	<p>1 Q. If we don't know where the source is coming</p> <p>2 from, I'd rather not go down that route. Certainly if</p> <p>3 there are materials that you relied on in drafting the</p> <p>4 report that you recall you did rely on, you know, we can</p> <p>5 talk about a process for submitting additional</p> <p>6 information, but if we could table that for now, that</p> <p>7 would be good.</p> <p>8 Okay. So moving on, again, to page 4.</p> <p>9 Later in that page you refer to a study that, you said,</p> <p>10 shows that abortions later in pregnancy are more</p> <p>11 frequently covered by health insurance than earlier</p> <p>12 abortions; is that correct?</p> <p>13 A. Yes, I did write that.</p> <p>14 Q. Okay. And can you describe why you think</p> <p>15 that information is relevant to this case?</p> <p>16 A. Well, later abortions are much more</p> <p>17 expensive. And so if a woman doesn't have an early</p> <p>18 abortion -- well, let me back up.</p> <p>19 There are, I believe, 13 states that will</p> <p>20 cover abortions through Medicaid. And so it is likely</p> <p>21 that if a woman is poor and doesn't get an abortion</p> <p>22 early, if she's not in one of those states and not under</p> <p>23 Medicaid coverage, it is very likely that she does not</p> <p>24 get the money together -- which, your average first</p> <p>25 trimester abortion is about \$500, later run from</p>
123	<p>1 Q. But you don't know who created the</p> <p>2 website?</p> <p>3 A. No.</p> <p>4 Q. Or who supplies the numbers?</p> <p>5 A. It is in line with other statistics that</p> <p>6 I've seen about how infrequent it is that women really</p> <p>7 have abortions for life -- serious illness, fetal</p> <p>8 anomalies, rape, incest. Those statistics are widely</p> <p>9 available and they are all the same number range.</p> <p>10 Q. So based on what you just said, would you</p> <p>11 agree, then, that HB136, as you understand it, is likely</p> <p>12 to affect the majority of abortions at and after 18 weeks</p> <p>13 of pregnancy that occur currently in the state of Utah?</p> <p>14 A. You know, the Utah statistics are difficult</p> <p>15 to interpret. After I have drafted this report, I found</p> <p>16 some more data about Utah that seems to indicate that</p> <p>17 two-thirds of their abortions are for therapeutic</p> <p>18 reasons. The problem --</p> <p>19 Q. Where did you find that data?</p> <p>20 A. I don't remember where I found it. Do you</p> <p>21 think it is true? Have you read that?</p> <p>22 The problem with therapeutic -- therapeutic</p> <p>23 to the layman sounds like those would be indicated,</p> <p>24 right? But therapeutic does not have a specific</p> <p>25 definition. The Roe versus --</p>	125	<p>1 anywhere, depending on the gestational age -- 1,500 to</p> <p>2 10,000, I've heard. So if she's not -- if she doesn't</p> <p>3 have a funding source, then, very likely, she's going to</p> <p>4 carry that pregnancy to term. So probably many of the</p> <p>5 later ones are covered by Medicaid in those states that</p> <p>6 will cover them.</p> <p>7 Q. So in other words -- as understood this</p> <p>8 statistic that you were citing about health insurance, it</p> <p>9 seemed to me -- well, let me ask it this way. Were you</p> <p>10 suggesting that it would actually be easier to get an</p> <p>11 abortion in the second trimester than the first?</p> <p>12 A. No. No.</p> <p>13 Q. Okay. So do you believe that one potential</p> <p>14 driver of higher rate of insurance in the second</p> <p>15 trimester is that the people without insurance are,</p> <p>16 essentially, priced out of being able to afford the</p> <p>17 care?</p> <p>18 A. That could be the case, yes.</p> <p>19 Q. That could be one explanation.</p> <p>20 Have you considered whether Utah permits</p> <p>21 coverage of abortions in private or public insurance</p> <p>22 plans?</p> <p>23 A. I don't know what Utah does there.</p> <p>24 Q. Okay. So you haven't done any research in</p> <p>25 that respect?</p>

126	<p>1 A. I don't know the answer to that question, 2 no. 3 Q. Okay. Would you agree -- I think that 4 you -- that you refer to the cost between 1,500 and 5 10,000 dollars. Would you agree that that expense 6 without insurance would be a barrier to obtaining an 7 abortion? 8 A. It would be a barrier. It is not an 9 absolute barrier. 10 Q. For a woman living in poverty, would it be a 11 barrier? 12 A. Possibly. 13 Q. Possibly. Okay. What about a woman with 14 moderate income? 15 A. I mean, we -- 16 Q. Based on your experience with your 17 patients? 18 A. It is hard to say. 19 Q. What about -- if I could take you back to 20 our conversation earlier about LARCs. You said that 21 those were between 500 and 700 dollars; is that right? 22 A. That's correct. 23 Q. And I think with respect to those you said 24 if someone didn't have insurance coverage -- I believe I 25 asked whether that would be a barrier to obtaining a</p>	128	<p>1 guess what I'm asking is how would you define a later 2 D&E, as you've used that term in that sentence? 3 A. Probably 18 weeks and beyond. 4 Q. And then -- let's see. We had talked 5 earlier about the counseling that you might provide to a 6 patient who is interested in abortion, and you, I 7 believe, indicated that you would talk to her about the 8 risks of abortion, correct? 9 A. Yes. 10 Q. And would one of those risks be a risk of 11 breast cancer? 12 A. The -- the literature on breast cancer is 13 controversial, but there is one thing that is not 14 controversial. If she -- if this is her first pregnancy 15 and she chooses to terminate the pregnancy and does not 16 go to term and does not get the protective effect of the 17 full maturation of her breast type 3 and 4 lobules, her 18 risk of breast cancer is increased. That is since 19 1970 -- 20 Q. Do you tell that information to your 21 patients? Do you tell that information to your 22 patients? 23 A. Yes. 24 Q. You provide that? 25 A. Uh-huh.</p>
127	<p>1 LARC. Do you remember that question? 2 A. Yes. 3 Q. And you said, Oh, certainly. Right? 4 A. It is a barrier. It is not -- it doesn't 5 mean that they won't get one, but it is a barrier. It is 6 a substantial amount of money. 7 Q. So 1,500 to 10,000 dollars, would you say, 8 would be a more substantial barrier to obtain care? 9 A. Yes. 10 Q. Can you -- let's see. 11 All right. So if you could turn to page 5 12 of your expert report. Are you there? 13 A. Yes, ma'am. 14 Q. It says -- you say, "While few OB/GYNs other 15 than high volume abortionists have the clinical skills to 16 perform a later D&E, due to its complexity and high 17 incidence of complications, all OB/GYNs can perform 18 inductions or C-sections." Did I get that right? 19 A. Yes. 20 Q. And what do you mean by "later D&E" in the 21 sentence? 22 A. Well, as we discussed earlier, I have not 23 performed a D&E after 18 weeks. And I doubt whether my 24 partners have much experience in that. 25 Q. Sorry. What do you mean by "later D&E"? I</p>	129	<p>1 Q. And let me break that down a little bit. So 2 do you believe that there is a causal connection between 3 an abortion and an increased risk of breast cancer? 4 A. I think that there is physiologic 5 plausibility that that could be the case. I realize it 6 is extremely controversial in the literature for reasons 7 that have more to do with the way the studies have been 8 conducted. When a woman has a normal -- 9 Q. Dr. Skop, I would like you to answer my 10 question. And my question to you is not about 11 physiological plausibility but whether, in your expert 12 opinion, there is a causal connection between abortion 13 itself and a heightened risk of breast cancer later in 14 life? 15 A. Ending a normal pregnancy before the breasts 16 have matured at term is linked to an increase risk of 17 breast cancer. 18 Q. Relative to a woman who carried to term, 19 correct? 20 A. Exactly. 21 Q. Okay. Let me give you this hypothetical. 22 Imagine that you have two patients who come 23 to you and they are identical in every respect. One of 24 them is not pregnant, but she's thinking about getting 25 pregnant. And one of them is pregnant and thinking about</p>

130	<p>1 having an abortion. Would you tell the patient who is</p> <p>2 thinking about getting pregnant that she should get</p> <p>3 pregnant to reduce her risk of breast cancer later in</p> <p>4 life?</p> <p>5 A. That is a true fact. I don't know that I</p> <p>6 necessarily tell everybody that who is coming in for a --</p> <p>7 Q. Do you tell anyone that?</p> <p>8 A. Yeah, if somebody had high risk for breast</p> <p>9 cancer, I would certainly tell them that.</p> <p>10 Q. You would suggest they might want to get</p> <p>11 pregnant?</p> <p>12 A. That a term pregnancy would be protective,</p> <p>13 yes.</p> <p>14 Q. And do you -- as between those two</p> <p>15 patients -- let's say those two patients, the one who is</p> <p>16 not pregnant and is thinking about getting pregnant</p> <p>17 decides not to get pregnant at that time, and the one who</p> <p>18 is pregnant and thinking about an abortion has an</p> <p>19 abortion. Do those two individuals have any different</p> <p>20 risk in later likelihood of breast cancer?</p> <p>21 A. Yes, because the one who had the normal</p> <p>22 pregnancy has stimulation of the type 1 and type 2</p> <p>23 immature lobules in the breasts. That what happens in</p> <p>24 early pregnancy. And to cut off the hormones and leave</p> <p>25 them in that state does make them more likely to form</p>	132
131	<p>1 breast cancer.</p> <p>2 Q. Makes them more likely to develop breast</p> <p>3 cancer --</p> <p>4 A. Yes.</p> <p>5 Q. -- than someone who had never been</p> <p>6 pregnant?</p> <p>7 A. They're in an undifferentiated state. And</p> <p>8 so some other driver of breast cancer could drive them</p> <p>9 into the state of cancer. Not having gone through that</p> <p>10 stimulation that resulted in all those immature lobules</p> <p>11 in the woman who never became pregnant makes her risk</p> <p>12 lower compared to the woman who did have the pregnancy</p> <p>13 that stimulated the immature cells.</p> <p>14 Q. All right. I think I understand what your</p> <p>15 position is in that respect.</p> <p>16 But it is your testimony that you would --</p> <p>17 if someone is considering an abortion, you would counsel</p> <p>18 them about the risks of breast cancer with respect to</p> <p>19 ending the pregnancy, correct?</p> <p>20 A. I would talk to them about that, yes.</p> <p>21 Q. And just to make sure that I understand. Is</p> <p>22 it your opinion that there is a causal connection between</p> <p>23 the abortion and the heightened risk of breast cancer</p> <p>24 later in life?</p> <p>25 A. Yes, by leaving those immature cells without</p>	133
130	<p>1 maturation.</p> <p>2 Q. Okay. What about -- the hospitals -- you</p> <p>3 mentioned that you work in the Baptist Health System,</p> <p>4 correct?</p> <p>5 A. Yes.</p> <p>6 Q. And have worked at one of two hospitals in</p> <p>7 your prior experience, correct?</p> <p>8 A. Yes.</p> <p>9 Q. And does the Baptist Health System where you</p> <p>10 work provide abortions?</p> <p>11 A. No.</p> <p>12 Q. None, ever?</p> <p>13 A. Not that I'm aware of.</p> <p>14 Q. Okay.</p> <p>15 A. Occasionally someone requires delivery</p> <p>16 before the time of full viability and it doesn't require</p> <p>17 an abortion, it doesn't require intentionally destroying</p> <p>18 the fetus in order to deliver the woman. The woman can</p> <p>19 be delivered in other ways and the baby can be evaluated</p> <p>20 for maturity and given hospice care. That's a different</p> <p>21 scenario than electively ending the life of that child.</p> <p>22 Q. So to make sure that I understand what the</p> <p>23 practice would be. If, for example, a patient came in at</p> <p>24 18 weeks of pregnancy with premature rupture of</p> <p>25 membranes, at that point there is no possibility of</p>	133
131	<p>1 continuing the pregnancy until viability, is that</p> <p>2 correct?</p> <p>3 A. It is a very low possibility. It has</p> <p>4 happened, but the odds are not good for that baby.</p> <p>5 Q. And so in those circumstances you might</p> <p>6 induce delivery, correct?</p> <p>7 A. After counseling with the patient, if that's</p> <p>8 what she wanted, that might be done. And --</p> <p>9 Q. And -- go ahead.</p> <p>10 A. I was going to say, we have a system in</p> <p>11 place. It is -- generally we have a three doctors</p> <p>12 recommend -- you know, saying this is reasonable; we have</p> <p>13 a chaplain. There is a protocol that we follow prior to.</p> <p>14 Q. But at that point, what would be the chance</p> <p>15 of survival for an 18-week-old fetus?</p> <p>16 A. If it is truly an 18-week fetus, the chance</p> <p>17 of survival is probably zero.</p> <p>18 Q. I'm sorry. Probably zero or zero?</p> <p>19 A. If it is truly an 18-week, it can be zero.</p> <p>20 Sometimes ifs --</p> <p>21 Q. I'm sorry. Can we go back? Is it, can it</p> <p>22 be zero? Let me rephrase the question.</p> <p>23 Have you ever seen an 18 -- a true 18-week</p> <p>24 fetus delivered and survive more than a day?</p> <p>25 A. No.</p>	133

134	<p>1 Q. Okay. So the -- in your -- your</p> <p>2 understanding is that the hospital will perform induction</p> <p>3 deliveries in cases where there is a maternal indication</p> <p>4 that one is needed even if those -- those deliveries are</p> <p>5 performed at a point where there is a zero percent chance</p> <p>6 of survival of the fetus; is that correct?</p> <p>7 A. That is correct. And the Utah law allows</p> <p>8 that.</p> <p>9 Q. That's your understanding of the Utah law;</p> <p>10 is that correct?</p> <p>11 A. Uh-huh, yes.</p> <p>12 Q. And if the Utah law did not allow that,</p> <p>13 would you think that that was problematic?</p> <p>14 A. I haven't heard of any laws anywhere that</p> <p>15 will not allow a woman's life to be saved if her</p> <p>16 pregnancy poses a risk to her life.</p> <p>17 Q. At the Baptist Health System -- so said</p> <p>18 you -- generally, you don't perform -- well, it sounds</p> <p>19 like, in your view, they don't perform abortions ever.</p> <p>20 Do you -- let's see.</p> <p>21 Actually, could I take you back to your</p> <p>22 chair position? You said you were the chair of the</p> <p>23 department of the OB/GYN at the Northeast Baptist</p> <p>24 Hospital. Did I get that right?</p> <p>25 A. Yes, ma'am.</p>	136	<p>1 readmission to the hospital, requiring a transfusion,</p> <p>2 requiring a repeat surgery, requiring IV antibiotics, ICU</p> <p>3 admission, thromboembolic event, a pulmonary embolism, a</p> <p>4 stroke, death, obviously.</p> <p>5 Q. And do you have a sense of what the -- in</p> <p>6 your practice currently what the complication rates are</p> <p>7 for those kinds of major morbidities in pregnancy or in</p> <p>8 labor and delivery -- during or after labor and</p> <p>9 delivery?</p> <p>10 A. I mean, I'd probably say the most common of</p> <p>11 those things would be a blood transfusion. That happens</p> <p>12 on occasion. Maybe 2 to 3 percent.</p> <p>13 Q. So 2 to 3 percent major morbidity?</p> <p>14 A. Uh-huh.</p> <p>15 Q. Okay. And -- but you wouldn't -- it sounds</p> <p>16 like you would not include a C-section within major</p> <p>17 morbidity, correct?</p> <p>18 A. No.</p> <p>19 Q. Okay. Even though that would involve a</p> <p>20 surgical procedure and cutting into the uterus, right?</p> <p>21 A. Right. Right. If she had a C-section and</p> <p>22 had to go back to the operating room because of</p> <p>23 complication -- then that would count, but not the</p> <p>24 initial.</p> <p>25 Q. What about minor complications or nonmajor</p>
135	<p>1 Q. And did you have any role in overseeing or</p> <p>2 tracking complications for care provided in the</p> <p>3 department during your tenure as chair?</p> <p>4 A. That's one of the jobs the chair has, yes.</p> <p>5 Q. What did you track?</p> <p>6 A. There was a quality committee that the chair</p> <p>7 is on, and so if there were -- there's kind of a list of,</p> <p>8 you know, adverse outcomes, and those will be evaluated</p> <p>9 by the quality committee.</p> <p>10 Q. Okay. So those would be adverse outcomes</p> <p>11 based on care that was provided in the hospital,</p> <p>12 correct?</p> <p>13 A. Well, sometimes there is just adverse</p> <p>14 outcomes in OB. Sometimes bad things happen even though</p> <p>15 nobody did anything wrong. But there's certain</p> <p>16 indicators where if it happened, we would review to make</p> <p>17 sure it had not been a quality issue.</p> <p>18 Q. Okay. And do you recall what the overall</p> <p>19 complication was from childbirth -- or labor and</p> <p>20 delivery?</p> <p>21 A. At the hospital -- that's been a long time.</p> <p>22 I don't think I know the overall complication rate.</p> <p>23 Q. Okay. I mean -- what about -- how would you</p> <p>24 define major morbidity from pregnancy or in childbirth?</p> <p>25 A. Yeah, so major morbidity would be requiring</p>	137	<p>1 indicators of morbidity? Are there things that you think</p> <p>2 of as a complication that you wouldn't consider major</p> <p>3 morbidity from labor and delivery or pregnancy?</p> <p>4 A. Sure. You know, sometimes women, after a</p> <p>5 C-section, can have a superficial skin infection.</p> <p>6 Sometimes, particularly if they're obese, they may have a</p> <p>7 fluid collection that occurs where their incision opens a</p> <p>8 little bit. You know, occasionally they have a fever</p> <p>9 that requires, you know, a single dose of IV antibiotics.</p> <p>10 So, yeah, those kind of mild</p> <p>11 complications -- endometritis where the uterus has an</p> <p>12 infection after a vaginal or C-section delivery.</p> <p>13 Q. What about vaginal tearing; how often does</p> <p>14 that happen during vaginal deliveries?</p> <p>15 A. I'd say maybe about 50 percent of the time</p> <p>16 there will be a small tear or --</p> <p>17 Q. Okay. I'm sorry. What was that?</p> <p>18 A. I mean, most of them are small, but</p> <p>19 sometimes they can have a tear that reaches to the rectum</p> <p>20 or a more significant tear.</p> <p>21 Q. So the -- if I understand correctly, vaginal</p> <p>22 tearing could be -- they're labeled in degrees: first,</p> <p>23 second, third, and fourth; is that right?</p> <p>24 A. That's correct.</p> <p>25 Q. And would you -- are any of those considered</p>

138	<p>1 major morbidity from childbirth?</p> <p>2 A. I don't know that any of them are considered</p> <p>3 major morbidity, but our hospital does keep records on</p> <p>4 the more extensive tears, the fourth degree tears.</p> <p>5 Q. Fourth degree. And what does a fourth</p> <p>6 degree tear involve?</p> <p>7 A. That is where the tear goes through the</p> <p>8 vagina and through the rectum and the rectal muscles.</p> <p>9 Q. Okay. And that can result in fecal</p> <p>10 incontinence, correct?</p> <p>11 A. It is possible.</p> <p>12 Q. Urinary incontinence?</p> <p>13 A. Uh-huh.</p> <p>14 Q. Does it require surgery?</p> <p>15 A. No. Generally we repair it at the time of</p> <p>16 delivery, but it is rare for it to require other</p> <p>17 surgery.</p> <p>18 Q. But it is a surgical procedure to repair it,</p> <p>19 correct?</p> <p>20 A. I guess --</p> <p>21 Q. You sew it up, right?</p> <p>22 A. Yeah, I guess -- if you consider surgery</p> <p>23 when you do stitches.</p> <p>24 Q. Well, if you had, like, a vaginal tear that</p> <p>25 required you to throw a couple of stitches to fix, what</p>	140	<p>1 Q. Uh-huh, from a medical perspective, are the</p> <p>2 most serious complications.</p> <p>3 A. Yeah. I mean, that's why we track them</p> <p>4 because we want. . .</p> <p>5 Q. Okay. So I think you said that you thought</p> <p>6 the rate of complication for major morbidity would be 2</p> <p>7 to 3 percent of the deliveries that you do or that your</p> <p>8 practice does?</p> <p>9 A. I'm thinking my practice.</p> <p>10 Q. Okay. And what about any -- anything that</p> <p>11 you would consider a complication of pregnancy -- or,</p> <p>12 perhaps, anything that your practice tracks as a</p> <p>13 complication of either labor and delivery or labor and</p> <p>14 delivery and pregnancy combined, what is the rate of</p> <p>15 those complications?</p> <p>16 A. You know, we may -- I'm going to say it is</p> <p>17 probably still in the 2 to 3 percent range. We talk about</p> <p>18 them, but they don't happen very often considering there</p> <p>19 are 20 doctors.</p> <p>20 Q. So it would be 2 to 3 percent major</p> <p>21 morbidity and another 2 to 3 percent other</p> <p>22 complications?</p> <p>23 A. So of the ones we track, I would consider</p> <p>24 all of those to be major morbidity.</p> <p>25 Q. And do you have a list of the ones that you</p>
139	<p>1 kind of tear would that be in terms of degree?</p> <p>2 A. Probably most commonly a second degree.</p> <p>3 Q. If you use stitches?</p> <p>4 A. Yeah. First or second degree are the common</p> <p>5 ones.</p> <p>6 Q. Okay. So some tears can repair -- they'll</p> <p>7 essentially repair themselves, you don't have to actually</p> <p>8 add stitches; is that correct?</p> <p>9 A. It is possible to have a very small tear</p> <p>10 that doesn't require stitches.</p> <p>11 Q. Okay. What about cervical tearing; does</p> <p>12 that happen during childbirth, vaginal delivery?</p> <p>13 A. It can. It doesn't happen often.</p> <p>14 Q. How do you repair those?</p> <p>15 A. You visualize the cervix and find the tear</p> <p>16 and place the stitch there.</p> <p>17 Q. Would you consider that a major morbidity?</p> <p>18 A. I don't know that we track it, but that's a</p> <p>19 pretty significant morbidity.</p> <p>20 Q. Okay. Would you say that the types of</p> <p>21 complications that you track in your practice are ones</p> <p>22 that are of most serious concern, from a medical</p> <p>23 perspective?</p> <p>24 A. So you're asking if the ones we keep track</p> <p>25 of are serious?</p>	141	<p>1 track? Does that come from somewhere, or is it just</p> <p>2 something that your practice has made up?</p> <p>3 A. The hospital has their own list, and I</p> <p>4 believe our practice follows that pretty well and discuss</p> <p>5 those among ourselves.</p> <p>6 Q. Okay. So would you track, for example, an</p> <p>7 infection that requires one dose of antibiotics?</p> <p>8 A. No.</p> <p>9 Q. What about something that requires a couple</p> <p>10 of stitches?</p> <p>11 A. No.</p> <p>12 Q. What about something that requires any</p> <p>13 reversal of sedation? Like any time you're using a</p> <p>14 medication to reverse sedation.</p> <p>15 A. Can you give me an example of what you mean?</p> <p>16 Q. I mean, I'm not a doctor. My understanding</p> <p>17 is that there are circumstances in which -- where a</p> <p>18 patient is sedated that, for one reason or another, you</p> <p>19 may want to try to minimize the sedation and you can</p> <p>20 administer other drugs that would have that effect. Am I</p> <p>21 wrong about that?</p> <p>22 A. Yeah, I can't really think of a scenario</p> <p>23 where that would happen.</p> <p>24 Q. Okay.</p> <p>25 A. If someone had an overdose of a narcotic,</p>

September 02, 2020

<p style="text-align: right;">142</p> <p>1 you might need to give them narcan which reverses it, but 2 I can't recall having seen that. 3 Q. Okay. And what about a uterine perforation; 4 would that be something that you would necessarily 5 track? 6 A. That would be a major complication because 7 it would require additional surgery. 8 Q. So any kind of uterine perforation. And 9 then what about any kind of pelvic floor injury? How 10 often does that happen after a -- let me ask specifics of 11 vaginal deliveries. 12 A. You're asking how often does a woman develop 13 prolapse later in life? 14 Q. Well, prolapse is one type of pelvic floor 15 injury, correct? But there could be others that happen; 16 is that correct? 17 A. Well, we talked about the different degrees 18 of laceration. 19 Q. So you would include the vaginal tearing in 20 that. There are some women who require physical therapy 21 after a vaginal delivery, correct? 22 A. There can be -- 23 Q. For incontinence? 24 A. -- yeah, incontinence and things like 25 that.</p>	<p style="text-align: right;">144</p> <p>1 A. Yes, ma'am. 2 Q. Have you ever seen any statistics on 3 abortion complications that approach a one in three 4 outcome per abortions? 5 A. You mean, like, an abortion complication 6 that occurs one out of three times? 7 Q. Yes. Have you ever seen any data to that 8 effect? 9 A. I have not, but I would back up and say that 10 we do not do a good job of collecting and analyzing 11 abortion complications in our country because -- because 12 it is not tracked by insurance. Most of them are not 13 voluntarily reported by abortionists. I don't know of 14 any that occurs that often, but, again, I think our data 15 is compromised. 16 Q. What is the highest -- as we talked about 17 earlier, no data is perfect. What is the highest rate of 18 complications from abortion that you have seen in 19 literature that you would consider reliable or among the 20 best data that we have? What's the highest rate? 21 A. There are some studies out of Europe that 22 see a one out of five complication rate, typically 23 related to medical abortions requiring surgery. There is 24 a -- medical abortions in the second trimester which, 25 again, we don't do that here, but that one has about a</p>
<p style="text-align: right;">143</p> <p>1 Q. How often does that happen? 2 A. You know, I don't know. I don't know that 3 I've ever seen a study that looks at that. 4 Q. Okay. So we talked a little bit about the 5 risks of C-sections. Earlier we talked about placenta 6 accreta spectrum. I want to keep call it placenta 7 accreta syndrome, but. . . 8 Okay. We talked about that. We talked 9 about, you know, potential blood loss complications. You 10 know, infection. Am I missing any risks of C-sections 11 that you would describe as common? 12 A. I think those are the common ones, yeah. 13 Q. Okay. But then if you could turn to page 4 14 of your report. On page 4 you say, "With modern surgical 15 techniques" -- oh, this is in the last paragraph kind of 16 midway down. Do you see that, the sentence starting with 17 "modern surgical"? 18 A. Let me make sure I'm on the right page. 19 Q. Yeah, I'm counting the cover page. 20 A. Okay. 21 Q. So you say, "With modern surgical 22 techniques, a C-section delivery is usually very safe, 23 even in an extremely sick woman. (One out of three 24 pregnancies in our country are delivered this way.)" Did 25 I get that right?</p>	<p style="text-align: right;">145</p> <p>1 two out of five complication rate requiring surgery. 2 Q. Let me back up. Can we look at page 6 of 3 your report? 4 A. Okay. 5 Q. The first full paragraph there in the 6 middle, you say, "Compared to an abortionist performed at 7 eight weeks gestation" -- and I'm skipping over a little 8 bit, but you quote a rate of -- well, sorry. I realize 9 you don't have the complication rates in here. 10 So you mentioned a one out of -- what is the 11 highest rate of complications from abortion that you have 12 seen in the United States for D&E abortions, any 13 complication? 14 A. I think the Autry study says 4 percent. 15 Q. Four percent. So to get from 4 percent to 16 33 percent, which is what you say is roughly the share of 17 deliveries that end in C-section, on what magnitude of a 18 change would you need, in terms of identifying 19 complications of abortion, to approach the one in three 20 statistics for C-section? 21 A. Can I ask a question? Are you assuming for 22 this discussion that a C-section is a complication? 23 Q. I'm not. 24 A. Because in many cases -- in probably most 25 cases, the reason for the C-section is to get a live,</p>

September 02, 2020

146	<p>1 healthy baby out. So this doesn't apply to abortion 2 because abortion has no desire to get a live, healthy 3 baby out. So I think -- 4 Q. I'm simply -- Dr. Skop, I'm asking because 5 you have indicated that you believe a C-section, which is 6 a surgical procedure that requires a full cut into the 7 uterus, is usually a very safe procedure for someone to 8 have. And so I'm asking, for an abortion, which I 9 recognize is a different procedure -- have you seen any 10 complication from an abortion that would approach a 11 33 percent rate? Setting aside whether it is a 12 complication that requires another surgery and a cut into 13 the uterus, have you seen any complication that 14 approaches a 33 percent rate? 15 A. Well, the Europe study that I mentioned 16 in -- 17 Q. In the U.S. In the United States with a 18 D&E. 19 A. I have not seen it because we do not track 20 D&E complications. We don't track them. 21 Q. And do you think -- do you think, based on 22 your expert opinion from -- well, there are studies that 23 talk about complication rates from abortions in the 24 United States, correct? 25 A. There certainly are. There is very little</p>	148	<p>1 didn't. Let me ask you. Have you reviewed the National 2 Academy of Sciences report on the safety of abortion? 3 A. I'm very familiar with that study. 4 Q. Okay. 5 A. Do you know -- 6 Q. Okay. Excuse me, Dr. Skop, if you can 7 please respond to my questions. 8 Are you aware of data presented in that 9 study about the incidence of particular complications 10 with respect to D&E abortions? 11 A. I think that's in here. I can look for it. 12 I can't tell you right offhand, but I think that is a 13 compromised study because it was commissioned by six 14 outspoken abortion advocacy organizations. 15 Q. Okay. 16 MS. MURRAY: So I think this would probably 17 be a good time to take a break? What do you think? I 18 guess it is my lunchtime, but I recognize. I guess we're 19 getting on close to your lunchtime, too. Would you all 20 like to take a short break or would you like to take a 21 lunch break. 22 MR. SORENSON: I would suggest a lunch 23 break, if that's all right. More for my dog than me. 24 MS. MURRAY: That's good. Do you want to 25 say half hour, 45 minutes?</p>
147	<p>1 that addresses complications from D&Es. 2 Q. And what would you say the most reliable 3 source is for complication rates from D&E abortions in 4 the United States, recognizing that there is no perfect 5 data? What is the best data on that? 6 A. I don't think there is any good data; the 7 CDC does not have good data. I don't -- allowing the 8 physicians who work for Danco and work for Genuity and 9 work for the Bixby Center for Reproductive Rights to 10 write the articles about abortion complications is 11 equivalent to allowing the tobacco industry to tell us 12 that tobacco smoking is safe. 13 Q. So am I understanding you, Dr. Skop, that at 14 this point in time, as you sit here today, you cannot 15 identify any specific data on complications from an 16 abortion that you would like the court to refer to in 17 this case? 18 A. The only study that I know of is by Autry, 19 and it found a 4 percent complication rate on D&E. 20 Q. Okay. 21 A. But that -- several doctors, Grossman and 22 Grimes, tried to do meta-analyses; they just could not 23 find studies. If it is something we think we should be 24 doing, perhaps we should be studying it. 25 Q. You mentioned, I think, earlier -- maybe you</p>	149	<p>1 THE WITNESS: Half hour is fine. 2 MR. SORENSON: How about we just put it at 3 half past the hour, just to make it easy to remember when 4 to come back. So that is 12:30 Mountain, and then you 5 can do the math where you are. 6 MS. MURRAY: Yes. Sounds good. 7 (Recess from 11:49 a.m. to 12:33 p.m.) 8 MS. MURRAY: Welcome back from the break. 9 Q. (By Ms. Murray) Dr. Skop, is there anything 10 from your testimony that you would like to update or add 11 to? 12 A. I did realize there is a study that is not 13 in my bibliography by Diana Greene Foster that is reasons 14 for late abortions. Some of that data may have come from 15 there that we were discussing. 16 Q. And which study is that? 17 A. I think it is called "Who Has Abortions at 18 or After 20 Weeks." 19 Q. Okay. All right. We can definitely take a 20 look at that one if we haven't already. Anything else? 21 A. I think that's all. 22 Q. Did you speak with anyone other than 23 Mr. Sorenson during the break? 24 A. Just my children at lunch but not about 25 this.</p>

September 02, 2020

150	<p>1 Q. Well, it sounds like you had a good lunch</p> <p>2 then.</p> <p>3 Okay. Let's get started then. I wanted to</p> <p>4 take you back to close to where we left off. When we</p> <p>5 left off, we had been talking about the National</p> <p>6 Academies of the Sciences' report, and, you know, I take</p> <p>7 it from your response that you -- well, let me just put</p> <p>8 it this way.</p> <p>9 In your view, what is the best source of</p> <p>10 data on abortion-related mortality and morbidity rates in</p> <p>11 the United States?</p> <p>12 A. We don't have the desire as a country to</p> <p>13 keep accurate data on that. I don't think that there is</p> <p>14 any good source of data. It's well documented that many</p> <p>15 abortion-related deaths are not documented on death</p> <p>16 certificates.</p> <p>17 Q. So, ma'am, I will say -- and I should</p> <p>18 probably just make this statement early on. I want to</p> <p>19 make sure we're able to get through the questions that I</p> <p>20 have today. So I would ask that you stick to responding</p> <p>21 to my specific questions in your answers so we can stay</p> <p>22 on track. Okay? Is that fair?</p> <p>23 A. Yes.</p> <p>24 Q. So my question to you is what is the best</p> <p>25 source of data available on abortion-related mortality</p>	152
151	<p>1 and morbidity rates in the United States?</p> <p>2 A. The CDC is the only place collecting that.</p> <p>3 Q. Okay. With respect to abortion-related</p> <p>4 mortality rates, do you believe that those rates should</p> <p>5 be calculated based on the number of abortions reported</p> <p>6 by the CDC or based on the number of abortions reported</p> <p>7 by Guttmacher?</p> <p>8 A. As we discussed earlier, I think</p> <p>9 Guttmacher's data is more accurate on the numbers.</p> <p>10 Q. I understand your position to be that you</p> <p>11 don't think there is good data, but the most reliable or</p> <p>12 the best data out there, if I understand you correctly,</p> <p>13 on mortality rates from abortions is based on the CDC</p> <p>14 maternal surveillance data, and you would use that</p> <p>15 combined with a number of abortions reported by</p> <p>16 Guttmacher. Do I have that correct?</p> <p>17 A. In terms of as good of accuracy that we</p> <p>18 have --</p> <p>19 Q. Yes.</p> <p>20 A. -- but it is still very inaccurate.</p> <p>21 Q. But that's your position as to the best data</p> <p>22 available currently?</p> <p>23 A. Yes.</p> <p>24 Q. Okay.</p> <p>25 A. Kept -- if we kept data on pregnancy</p>	153

September 02, 2020

154	<p>1 the pregnancy, would be from maternal morbidity and</p> <p>2 mortality review committees where they look at, if I have</p> <p>3 this correctly, death certificates, fetal death</p> <p>4 certificates, and a woman's medical records; is that</p> <p>5 correct?</p> <p>6 A. Well, the -- they're looking at both live</p> <p>7 births after 20 weeks and death of neonatal stillbirths</p> <p>8 after 20 weeks and connecting those to maternal death</p> <p>9 certificates.</p> <p>10 Q. Okay. So --</p> <p>11 A. They make that connection and then pull the</p> <p>12 woman's records. And if they could get ahold of the</p> <p>13 records from the abortion clinics, which, apparently,</p> <p>14 they cannot, that would be a complete way to do it.</p> <p>15 Q. Are you familiar with the review committee</p> <p>16 that operates in Utah to study the morbidity and</p> <p>17 mortality?</p> <p>18 A. Not specifically.</p> <p>19 Q. But every state has one, correct?</p> <p>20 A. Uh-huh.</p> <p>21 Q. And do you have any knowledge with respect</p> <p>22 to how they calculate the maternal mortality or</p> <p>23 pregnancy-related mortality rates in the state of Utah?</p> <p>24 A. Do you I know what the committee does</p> <p>25 specifically or how --</p>	156	<p>1 leaves a very big gap in our understanding of what</p> <p>2 happens that causes women to die.</p> <p>3 Q. Okay. So -- but that is true with respect</p> <p>4 to pregnancy-related deaths and with respect to</p> <p>5 abortion-related deaths, correct? That there is a gap in</p> <p>6 information as to -- there could be some people who do</p> <p>7 have those related deaths but are not identified,</p> <p>8 correct?</p> <p>9 A. That's correct. We know that with term</p> <p>10 deaths, even those, 40 to 50 percent are missed on death</p> <p>11 certificates. In the Finnish studies, when they look at</p> <p>12 death certificates, it missed 94 percent of deaths</p> <p>13 related to abortions. So there's a possibility of data</p> <p>14 there.</p> <p>15 Q. To be precise, Dr. Skop, didn't you say that</p> <p>16 the Finnish studies on which you rely do not assess</p> <p>17 whether a death is pregnancy related. They only identify</p> <p>18 pregnancy-associated deaths. Correct?</p> <p>19 A. Right. But the difference is that they can</p> <p>20 pick up every death associated with pregnancy because</p> <p>21 they have a single payer health care. They know about</p> <p>22 every pregnancy that enters the health care system even</p> <p>23 if it ends in abortion, we don't.</p> <p>24 Q. Right. But they're not pregnancy related --</p> <p>25 they are not assessing pregnancy-related deaths,</p>
155	<p>1 Q. Yes.</p> <p>2 A. No, I'm not familiar with the committee.</p> <p>3 Q. You're not familiar, okay. But if they</p> <p>4 looked at death certificates for women to see if they</p> <p>5 were noted to be pregnancy-related fetal death</p> <p>6 certificates and the medical records of women who the</p> <p>7 certificates identify as potentially having died from</p> <p>8 pregnancy, would you agree that that's the best kind of</p> <p>9 information that you're describing on pregnancy-related</p> <p>10 mortality rates?</p> <p>11 A. Only for deaths that occur after a 20-week</p> <p>12 pregnancy. We have no way of identifying women who have</p> <p>13 a pregnancy that ends before 20 weeks who then die within</p> <p>14 the year, because there is no -- there are no</p> <p>15 certificates at all given related to abortions or</p> <p>16 miscarriages, ectopic pregnancies.</p> <p>17 Q. Right. But that would be a limitation of</p> <p>18 the available data for both pregnancy ending in abortion</p> <p>19 and pregnancy ending at the time of the person's death</p> <p>20 unrelated to abortion; is that correct?</p> <p>21 A. Well, two-thirds of deaths are related to</p> <p>22 those late outcomes, a third, that we know of, to the</p> <p>23 early outcomes, but we don't -- unless it is specifically</p> <p>24 documented on the death certificate, we don't have any</p> <p>25 way at all of gathering information on those. And so it</p>	157	<p>1 correct?</p> <p>2 A. They are -- they are assessing -- they're</p> <p>3 collecting pregnancy-associated deaths, but they are</p> <p>4 not -- they're not giving us data with specific chart</p> <p>5 reviews to say which ones were caused be the pregnancy or</p> <p>6 its treatment or which ones just happened in that time</p> <p>7 interval within a year of pregnancy.</p> <p>8 Q. Okay. Can you turn to -- let's see. Can</p> <p>9 you turn to Tab K?</p> <p>10 (Exhibit No. 4 was marked.)</p> <p>11 Q. Are you there?</p> <p>12 A. Just about.</p> <p>13 Q. So I'm showing you a printout of a web page</p> <p>14 from the Utah Department of Health entitled "Complete</p> <p>15 Health Indicator Report of Maternal Mortality." Do you</p> <p>16 see that?</p> <p>17 A. Yes, I do.</p> <p>18 Q. Have you ever looked at this page before?</p> <p>19 A. I flipped over it when I accidentally looked</p> <p>20 at the folder last night, but I didn't look at it in</p> <p>21 depth.</p> <p>22 Q. Did you read any of it?</p> <p>23 A. No, I -- I glanced at it, and it looked like</p> <p>24 what I've seen on other M and M committees.</p> <p>25 Q. And when you -- I wanted to draw your</p>

September 02, 2020

158	<p>1 attention to the second paragraph on here that has</p> <p>2 definitions, and it says, "Pregnancy-related deaths." I</p> <p>3 just wanted to make sure that we're using terminology</p> <p>4 that is consistent with how the Utah Department of Health</p> <p>5 is using it, or make sure, if you disagree with it --</p> <p>6 MS. MURRAY: This is Tab K, Darcy.</p> <p>7 Q. -- that I understand what the disagreement</p> <p>8 is.</p> <p>9 So the Utah Department of Health defines</p> <p>10 pregnancy-related deaths as, "The death of a woman during</p> <p>11 pregnancy or within one year of the end of pregnancy from</p> <p>12 a pregnancy complication, a chain of events initiated by</p> <p>13 pregnancy or the aggravation of an unrelated condition by</p> <p>14 the physiological effects of pregnancy." Is that how you</p> <p>15 understand pregnancy-related deaths, Dr. Skop?</p> <p>16 A. Yes, it is.</p> <p>17 Q. And a pregnancy-associated death here, they</p> <p>18 would define, if it is not related, as, "The death of one</p> <p>19 during pregnancy or within one year of the end of</p> <p>20 pregnancy from a cause that is not related to pregnancy."</p> <p>21 Is that your understanding as well?</p> <p>22 A. No. That is a definition I have not seen</p> <p>23 before. The one that I used, I believe it is WHO and</p> <p>24 CDC, they don't have the part that says "but not</p> <p>25 related." They say a pregnancy-associated death, and I</p>	160	<p>1 is -- I know the CDC collects that information, but I</p> <p>2 don't know how they do it. I don't know if they require</p> <p>3 hospitals to report sentinel events or if that is</p> <p>4 voluntary. They do say there's probably a hundred times</p> <p>5 as much, you know, morbidity as mortality, but I would</p> <p>6 assume that's something we don't have a lot of great data</p> <p>7 on either.</p> <p>8 Q. And so if a patient -- let me ask you, has a</p> <p>9 patient ever asked you about the risk of dying from</p> <p>10 pregnancy and childbirth?</p> <p>11 A. On occasion somebody will ask me about that</p> <p>12 Raymond and Grimes study, and I will explain to them that</p> <p>13 it is based on noncomparable denominators, and we don't</p> <p>14 really know the answer to which is safer. I will</p> <p>15 reassure them that the MacDorman study that has been</p> <p>16 widely quoted in the news, many of the deaths that were</p> <p>17 picked up were due to increased documentation rather than</p> <p>18 actually increasing number of deaths.</p> <p>19 Q. So I do want to keep us on track. So if a</p> <p>20 patient asked you -- you've had patients ask about the</p> <p>21 Raymond and Grimes study; is that correct?</p> <p>22 A. Yes.</p> <p>23 Q. And would you give them any information that</p> <p>24 you considered to be the best data, or is your answer</p> <p>25 that there are no good data in the area?</p>
159	<p>1 believe they define it as a death within a year</p> <p>2 irrespective of the cause.</p> <p>3 So in other words, it includes women who</p> <p>4 died because of an adverse event related to pregnancy and</p> <p>5 it also includes those women who died by we don't know.</p> <p>6 Q. For example, if a woman left the hospital</p> <p>7 and was, you know, hit by a car, say, on the road outside</p> <p>8 of the hospital; had nothing to do with the fact that she</p> <p>9 had just had a baby. That would still be identified as a</p> <p>10 pregnancy-associated death, correct?</p> <p>11 A. Right.</p> <p>12 Q. Because she died within one year of having</p> <p>13 the child, okay. And so those are the deaths that you</p> <p>14 are referring to that -- let me put it another way.</p> <p>15 The Finnish studies that you rely on in your</p> <p>16 expert report -- those would include the patient who gets</p> <p>17 hit by a car outside of the hospital as a</p> <p>18 pregnancy-associated death, correct?</p> <p>19 A. That -- yes, it includes all deaths.</p> <p>20 Q. All right. Thank you for that</p> <p>21 clarification. That's helpful.</p> <p>22 So what about pregnancy-related morbidity</p> <p>23 rates in the U.S.; what is the best source of data on</p> <p>24 those?</p> <p>25 A. I don't know because I don't know that there</p>	161	<p>1 A. There's no good data. When we look at what</p> <p>2 the CDC does have documented, we discover that,</p> <p>3 particularly regarding this legislation, an 18-week</p> <p>4 abortion has double the mortality risk of a term, normal</p> <p>5 vaginal delivery.</p> <p>6 Q. I'm sorry. Can you -- where are you getting</p> <p>7 that data?</p> <p>8 A. It comes from the CDC. If you look</p> <p>9 specifically at 18 weeks and you break down the --</p> <p>10 Q. Oh, you're comparing it just to vaginal</p> <p>11 births; is that correct?</p> <p>12 A. Uh-huh.</p> <p>13 Q. And why do you think it would be appropriate</p> <p>14 to exclude all of the deaths related to C-sections?</p> <p>15 A. Because abortions are not performed by</p> <p>16 C-section, so we're comparing comparable procedures.</p> <p>17 Q. They could be performed by hysterotomy,</p> <p>18 correct?</p> <p>19 A. Right, but they rarely are.</p> <p>20 Q. But they could be?</p> <p>21 A. Sure.</p> <p>22 Q. But -- so -- I guess I'm not following that.</p> <p>23 Why would an appropriate comparator for the death rate of</p> <p>24 birth at and after 18 weeks -- of the death -- the</p> <p>25 mortality rate for abortions at and after 18 weeks be</p>

162	<p>1 mortality rate for pregnancies ending in a vaginal birth?</p> <p>2 A. Because you're comparing similar procedures.</p> <p>3 So, in other words --</p> <p>4 Q. Well, let me ask you this. Do women who</p> <p>5 have C-sections, on average, do they have higher risk</p> <p>6 pregnancies?</p> <p>7 A. Sometimes they do.</p> <p>8 Q. On average do they?</p> <p>9 A. Probably in my patient population, yes.</p> <p>10 Q. Right. And so they are, even before the</p> <p>11 C-section, on average, at higher risk of mortality and</p> <p>12 morbidity from pregnancy and childbirth, correct?</p> <p>13 A. Many -- many of the women who have</p> <p>14 C-sections do so because -- due to failed induction</p> <p>15 because of hypertension, diabetes; other high risk</p> <p>16 conditions place them at higher risk for C-section. If</p> <p>17 that makes sense. Yeah, they're higher risk women to</p> <p>18 start with.</p> <p>19 Q. And so what you're advocating would be to</p> <p>20 compare abortion to childbirth but exclude what would</p> <p>21 effectively be the highest risk population, correct, of</p> <p>22 those women who have a child?</p> <p>23 A. I want to compare similar procedures, right?</p> <p>24 So your procedure does not involve an incision on the</p> <p>25 uterus. It involves the introduction of instruments into</p>	164	<p>1 having a discussion about killing a human being in order</p> <p>2 to mildly reduce a woman's risk of going through a term</p> <p>3 pregnancy.</p> <p>4 Q. I certainly didn't write HB136. The State's</p> <p>5 position here is one of the bases for HB136 is to protect</p> <p>6 the health and safety of patients in Utah. So my</p> <p>7 question to you is do you believe or can you think of</p> <p>8 anyone else in your field who would agree with you that a</p> <p>9 pregnancy mortality rate based only on vaginal birth is</p> <p>10 an appropriate comparator to the pregnancy-related --</p> <p>11 abortion-related mortality rate?</p> <p>12 A. I don't know that I've had that discussion</p> <p>13 with many people.</p> <p>14 Q. Okay.</p> <p>15 A. It's a similar procedure. I considered it</p> <p>16 to be an appropriate comparison.</p> <p>17 Q. On page 5 of your report, if you can turn to</p> <p>18 that. That is Exhibit 2. Are you there?</p> <p>19 A. Yes, I'm here.</p> <p>20 Q. So at the very end of the first full</p> <p>21 paragraph, you say, "Complications unique to this</p> <p>22 operation may include instrumental perforation of the</p> <p>23 soft, distended uterus, with injury to surrounding bowel</p> <p>24 or vasculature, potentially leading to sepsis; or the</p> <p>25 incomplete removal of all the fetal tissue which may lead</p>
163	<p>1 the uterus to remove the child, and that has double the</p> <p>2 risk than if she went to term and had a normal delivery.</p> <p>3 Now, obviously, we don't know in advance who is going to</p> <p>4 need a C-section, but there's so much that is more</p> <p>5 important here than is just being concerned about the</p> <p>6 mortality particularly when we don't have good</p> <p>7 information on mortality.</p> <p>8 Q. Let me back up. This comparison between</p> <p>9 abortion mortality rates and vaginal-birth mortality</p> <p>10 rates, that's not in your expert report, correct?</p> <p>11 A. I don't think so.</p> <p>12 Q. You don't compare them. And do you have any</p> <p>13 cites in your expert report that describes your opinion</p> <p>14 in this respect?</p> <p>15 A. It's included in the paper that I wrote:</p> <p>16 Abortion and Maternal Mortality. That's in the CV but</p> <p>17 was published after I submitted this report.</p> <p>18 Q. Has that been peer reviewed?</p> <p>19 A. Yes.</p> <p>20 Q. Can you think of any other colleagues whose</p> <p>21 work you respect in the area -- anyone else in the field</p> <p>22 who believes that it would be appropriate to compare the</p> <p>23 mortality rate from abortion to the mortality rate only</p> <p>24 of vaginal births -- after vaginal births?</p> <p>25 A. I think it is disingenuous that we're even</p>	165	<p>1 to hemorrhage, infection, of chronic pain, or future</p> <p>2 infertility. Additional surgery may be needed to correct</p> <p>3 these damages."</p> <p>4 Did I get that right?</p> <p>5 A. Yes, ma'am.</p> <p>6 Q. What do you mean by "Complications" -- well,</p> <p>7 first of all, let me ask: When you say "this operation,"</p> <p>8 what do you mean by that? What is "this operation"</p> <p>9 here?</p> <p>10 A. Well, I'm specifically referring to a D&E.</p> <p>11 Q. Okay.</p> <p>12 A. Now, obviously, what I am not saying is that</p> <p>13 only a D&E can give these complications because, as I</p> <p>14 mentioned earlier, I know of a young woman who died of a</p> <p>15 first trimester surgical abortion from these type of</p> <p>16 complications.</p> <p>17 But Creanga, Berg, Zane -- the CDC</p> <p>18 researches who do the -- who look at the statistics on</p> <p>19 the maternal mortality that we have, have documented that</p> <p>20 early in the second trimester a D&E has 15-fold increased</p> <p>21 risk of mortality, 30-fold in the mid, 76-fold at the end</p> <p>22 of the second trimester. So it is well documented that</p> <p>23 when complications occur that they're more serious and</p> <p>24 they're more frequent in D&Es than in early first</p> <p>25 trimester surgical abortions.</p>

September 02, 2020

166	<p>1 Q. Okay. I'm going to stop you there because</p> <p>2 we will get to that, but we're going to get to that</p> <p>3 later.</p> <p>4 When you say, "Complications unique to this</p> <p>5 operation," what do you mean by the word unique there?</p> <p>6 A. Again, I'm not saying that it can only</p> <p>7 happen --</p> <p>8 Q. Let me ask it a different way. That might</p> <p>9 be more helpful. Are you saying that these complications</p> <p>10 are not complications that would occur in any other</p> <p>11 pregnancy separation besides abortion?</p> <p>12 A. As far as perforating through the uterus</p> <p>13 from the inside, that is -- unless you had a uterus that</p> <p>14 ruptured, which, as we've discussed, can happen with a</p> <p>15 C-section scar, doesn't happen very often.</p> <p>16 Q. But let me ask this: Can it happen with</p> <p>17 instruments if you have a -- I'm sorry, I'm forgetting</p> <p>18 the medical terminology. But if you have a delivery</p> <p>19 where instruments are used, could there be uterine</p> <p>20 perforation in that instance?</p> <p>21 A. There could be. It would be medical</p> <p>22 malpractice.</p> <p>23 Q. But it wouldn't be unique to an abortion; is</p> <p>24 that correct?</p> <p>25 A. Right. So it --</p>	168	<p>1 Q. And you could have uterine rupture during</p> <p>2 childbirth, correct?</p> <p>3 A. You can.</p> <p>4 Q. What about a surrounding -- what about a</p> <p>5 bowel injury; could that happen during childbirth?</p> <p>6 A. It could. It is very unusual. That would,</p> <p>7 you know, potentially be a situation where you had a</p> <p>8 surgical misadventure during a C-section. Again, it is</p> <p>9 not very likely.</p> <p>10 Q. Vasculature injury, could that happen in</p> <p>11 childbirth?</p> <p>12 A. That can happen with any --</p> <p>13 Q. What about infection leading to sepsis?</p> <p>14 A. That can happen.</p> <p>15 Q. And does that happen sometimes because of a</p> <p>16 retained placenta after delivery?</p> <p>17 A. It can.</p> <p>18 Q. What about -- well, you said incomplete</p> <p>19 removal of all the fetal tissue. So there could be</p> <p>20 incomplete removal of the placenta after childbirth,</p> <p>21 correct?</p> <p>22 A. With a D&E or with a term delivery?</p> <p>23 Q. With a term delivery.</p> <p>24 A. Yes, that can happen.</p> <p>25 Q. And is it accurate that after a term</p>
167	<p>1 Q. What about --</p> <p>2 A. Complications commonly with this procedure.</p> <p>3 Q. I'm sorry?</p> <p>4 A. Maybe I should rephrase it as complications</p> <p>5 that can happen commonly with this procedure.</p> <p>6 Q. And how would you define the word commonly</p> <p>7 there?</p> <p>8 A. That's a very good question. You know, in</p> <p>9 medicine in general, a common complication is one that's</p> <p>10 in the, you know, 5 to 10 percent range. You know, a lot</p> <p>11 of times abortionists tell us that complications are</p> <p>12 uncommon, and yet they do document, for example, failed</p> <p>13 medical abortions in the 5 percent range.</p> <p>14 Q. So you're saying commonly there you would</p> <p>15 mean 5 to 10 percent?</p> <p>16 A. No. I don't know how often that happens</p> <p>17 because we don't keep good data on those type of</p> <p>18 complications.</p> <p>19 Q. Okay. But just to be clear, instrumental</p> <p>20 perforation of the uterus -- that could occur during</p> <p>21 childbirth, correct?</p> <p>22 A. If it did, it would be a really, really bad</p> <p>23 doctor because you don't put forceps on until the child</p> <p>24 is in the vagina. You don't put the forceps on when the</p> <p>25 kid is still in the uterus.</p>	169	<p>1 delivery, you would actually examine the placenta to make</p> <p>2 sure that it is whole?</p> <p>3 A. Typically we do, yes.</p> <p>4 Q. What about the hemorrhage; that can happen</p> <p>5 after childbirth, correct?</p> <p>6 A. Yes.</p> <p>7 Q. Infection?</p> <p>8 A. Yes.</p> <p>9 Q. Chronic pain?</p> <p>10 A. Yes.</p> <p>11 Q. Future infertility?</p> <p>12 A. Yes.</p> <p>13 Q. Okay. So it is not accurate to say that</p> <p>14 these complications are unique to the D&E, is it?</p> <p>15 A. Instrumental perforation of the soft,</p> <p>16 distended uterus does not occur in normal childbirth.</p> <p>17 That's what I'm referring to, and that can lead to all of</p> <p>18 those other things, which, of course, like infection and</p> <p>19 hemorrhage can occur in other types of procedures. But</p> <p>20 the instrumental perforation is pretty much unique to a</p> <p>21 D&C, a D&E.</p> <p>22 Now, sometimes the D&C can be related to a</p> <p>23 miscarriage, so it is not always a live birth. But a D&E</p> <p>24 has a much higher incidence of these type of things</p> <p>25 happening, particularly if it is done by an inexperienced</p>

170

1 abortionist.

2 **Q. We'll get to that.**

3 **So if I could have you look at -- I just**

4 **want to make sure that we have a few things in the record**

5 **here. If I could have you look at the -- if I could have**

6 **you look at Tab G -- actually, you know what? Let's go**

7 **somewhere else first.**

8 MR. SORENSON: While you're doing that,

9 Julie or Kristin, did we mark Tab K as an exhibit? I

10 can't remember.

11 MS. MURRAY: We did.

12 MR. SORENSON: Can you remind me what

13 exhibit that was?

14 MS. MURRAY: I think it is Exhibit No. 4.

15 (Discussion held off the record.)

16 **Q. (By Ms. Murray) So if you could move to**

17 **Tab D?**

18 (Exhibit No. 5 was marked.)

19 **Q. So I'm showing you, Dr. Skop, Tab D, what**

20 **has been marked as Exhibit 5. Do you recognize this**

21 **document?**

22 A. Yes, I do.

23 **Q. And this is cited in the clinician guides to**

24 **medical and surgical, correct?**

25 A. Yes.

171

1 **Q. And it is cited in your report?**

2 A. Possibly.

3 **Q. Why don't you take a look at footnote 9.**

4 A. Okay. Yes, it is.

5 **Q. Okay. Do you consider this guide a reliable**

6 **source on abortion practice?**

7 A. I think there is some good information in

8 here. It is authored by at least one physician that is a

9 well-known abortion advocate, but I think it does have

10 some interesting information in here about complications.

11 **Q. About complications?**

12 A. Uh-huh.

13 **Q. And so what about abortion practice**

14 **generally?**

15 A. This particular chapter -- I believe this

16 comes from a book that is more specific about abortion

17 practice, but this particular chapter is about

18 complications.

19 **Q. That's correct. And do you find -- do you**

20 **believe that this is a reliable description of**

21 **complications related to abortion?**

22 A. I think that it gives a good description of

23 the complications that can occur. I would disagree with

24 the numbers for the reasons that I've mentioned earlier

25 that we do not detect all complications.

172

1 **Q. Okay. And are you familiar with -- well,**

2 **let's leave that.**

3 **So then I would like you to turn to Tab H.**

4 (Exhibit No. 6 was marked.)

5 **Q. This an article called "Abortion-Related**

6 **Mortality in the United States" by Susan Zane and**

7 **coauthors. Do you recognize this document?**

8 A. Yes, I do.

9 **Q. Was this the Zane article that you were**

10 **referring to earlier when you talked about what you**

11 **believe was the best available data on abortion-related**

12 **deaths?**

13 A. Zane's article and Bartlett and Berg are two

14 that I use.

15 **Q. Okay.**

16 A. But, again, I -- it is CDC data and we know

17 that CDC is incomplete, but this is (inaudible) we get

18 from the CDC.

19 **Q. But in terms of the best available data, you**

20 **would rely on this Zane article; is that correct?**

21 A. It's the best available, yeah.

22 **Q. Okay. And then if you could turn to**

23 **Tab G?**

24 (Exhibit No. 7 was marked.)

25 **Q. I'll show you what's being marked as**

173

1 **Exhibit 7. This is an article entitled "Risk Factors for**

2 **Legal Induced Abortion-Related Mortality in the United**

3 **States" by Linda Bartlett and coauthors. Is this the**

4 **Bartlett article that you're referring to as among the**

5 **best available data on abortion-related mortality?**

6 A. This is the article that I referred to, and

7 it is the best based upon the limited data that the CDC

8 has.

9 **Q. Okay. Is it the best data available right**

10 **now with respect to abortion-related mortality in the**

11 **United States?**

12 A. Probably, that I'm aware of. Some of the

13 maternal mortality committees may be coming up with some

14 better data.

15 **Q. Okay.**

16 A. But I'm not familiar with any studies that I

17 can refer you to. But hopefully they'll have better data

18 in the future.

19 **Q. Okay. So if you could turn to page 6 of**

20 **your report now. Toward the end of the first full**

21 **paragraph -- this is Exhibit 2.**

22 A. Okay.

23 **Q. You say, "Compared to an abortion performed**

24 **at eight weeks gestation" -- and I'm going to leave out**

25 **what is in the -- well, we'll read it: "Compared to an**

174	<p>1 abortion performed at eight weeks gestation (0.7/100,000</p> <p>2 abortions maternal mortality rate), there is a 15 percent</p> <p>3 increase in maternal mortality when a woman has an</p> <p>4 abortion early in the second trimester (1.7/100,000), 30</p> <p>5 percent increase in the mid-second trimester</p> <p>6 (3.4/100,000), and 76 percent increase after viability</p> <p>7 (8.9/100,000)."</p> <p>8 And then two sentences down you say, "Thus,</p> <p>9 if this 18-week restriction is not enforced, Utah women</p> <p>10 will experience a 30 to 76 percent increased risk of</p> <p>11 dying from a complication of the late abortion."</p> <p>12 Did I read that correctly?</p> <p>13 A. You read it correctly. What was insinuated</p> <p>14 was compared to an eight-week abortion.</p> <p>15 Q. That's right. So just to -- just to be</p> <p>16 clear, then, the statement that "if this 18-week</p> <p>17 restriction is not enforced, Utah women will experience a</p> <p>18 30 to 76 percent increased risk of dying from a</p> <p>19 complication of the late abortion" -- that assertion is</p> <p>20 based on the assumption that women will have an abortion</p> <p>21 not at 18 weeks but at eight weeks; is that correct?</p> <p>22 A. It is actually based on the assumption that</p> <p>23 if they don't get it by 18 weeks, they won't have an</p> <p>24 abortion. They'll carry the baby to term. But the</p> <p>25 number does compare it to an eight-week abortion.</p>	176	<p>1 and they're allowed to have the abortions between 18 and</p> <p>2 22 weeks, then the Bartlett and Berg studies tell us</p> <p>3 that, compared to those early abortions, that's the</p> <p>4 increase in mortality that they would be expected to</p> <p>5 experience.</p> <p>6 Q. But if it is enforced, do you think people</p> <p>7 will react to the law by having an abortion at eight</p> <p>8 weeks or earlier?</p> <p>9 A. Perhaps.</p> <p>10 Q. Do you think that's the most plausible</p> <p>11 outcome from enforcement of the law?</p> <p>12 A. It may make people make decisions earlier.</p> <p>13 It may --</p> <p>14 Q. Ten weeks earlier?</p> <p>15 A. It may cause the abortion clinics to, you</p> <p>16 know, have outreach to patients. And it may allow some</p> <p>17 women, especially those that are indecisive or being</p> <p>18 coerced by their partners, it may allow them to have</p> <p>19 their children, which, as I've remarked earlier, I have</p> <p>20 never delivered a woman who has not been happy that she</p> <p>21 had that baby.</p> <p>22 So taking away that opportunity for coercion</p> <p>23 and indecision in order to commit a dangerous procedure</p> <p>24 in order to kill her baby, that does get taken out of the</p> <p>25 options.</p>
175	<p>1 Q. Okay. Let me -- I have a couple of</p> <p>2 questions on that. So is your assumption, then, that for</p> <p>3 women -- that the effect of HB136 would be to prevent</p> <p>4 women from having abortions altogether?</p> <p>5 A. No. Is that yours? I mean, they can have</p> <p>6 them before 18 weeks. It just prohibits it after 18</p> <p>7 weeks when it is very dangerous for the woman and when</p> <p>8 the baby can feel pain.</p> <p>9 Q. My question is for a particular woman --</p> <p>10 you're saying that there is an increased risk of death to</p> <p>11 have an abortion at or after 18 weeks. And my question</p> <p>12 to you is -- let me put it this way. Increased risk of</p> <p>13 death relative to what? The 30 to 76 percent increase</p> <p>14 risk of dying is relative to what?</p> <p>15 A. Those numbers are relative to an eight-week</p> <p>16 abortion. But I think we should care about the increased</p> <p>17 risk of death of women in this category of very late</p> <p>18 abortions.</p> <p>19 Q. I don't disagree with you, Dr. Skop. The</p> <p>20 numbers that you cite here, if this 18-week restriction</p> <p>21 is not enforced, Utah women will experience a 30 to 76</p> <p>22 percent increased risk of dying from a complication of a</p> <p>23 late abortion, that's not accurate, is it?</p> <p>24 A. It depends on how you're reading it.</p> <p>25 Compared to an eight-week abortion, if it is not enforced</p>	177	<p>1 Q. Let me ask my question another way,</p> <p>2 Dr. Skop. If a judge were to read -- or if someone were</p> <p>3 to read, "If this restriction -- 18-week restriction is</p> <p>4 not enforced, Utah women will experience a 30 to 76</p> <p>5 percent increased risk of dying from a complication of a</p> <p>6 late abortion." For that 30 to 76 number that you</p> <p>7 provide there to be true, would the reader have to</p> <p>8 believe that a person will respond to HB -- that women</p> <p>9 will respond to HB136 by getting abortions not at 17</p> <p>10 weeks, not at 16, not at 15, at 8 weeks of pregnancy or</p> <p>11 earlier?</p> <p>12 A. I don't know what they're going to need to</p> <p>13 assume. But I think the way that this paragraph is</p> <p>14 written, it is pretty clear that that is comparing it to</p> <p>15 an eight-week abortion. It is making the point that the</p> <p>16 earlier the woman gets an abortion, the better, if she's</p> <p>17 going to get an abortion. And there comes a time when we</p> <p>18 need to take into account the woman's safety and, as</p> <p>19 we'll discuss, fetal pain, in determining when our</p> <p>20 society should allow elective abortions.</p> <p>21 Q. Okay. I would like to move on. Can you</p> <p>22 turn to -- so Tab -- so we don't have it in yet. Tab E,</p> <p>23 and we'll mark this as Exhibit 8.</p> <p>24 (Exhibit No. 8 was marked.)</p> <p>25 A. Yes.</p>

178	<p>1 Q. So this is an article entitled "Abortion</p> <p>2 Safety: At Home and Abroad" and it is by you. Is that</p> <p>3 correct, Dr. Skop?</p> <p>4 A. That's correct.</p> <p>5 Q. Does it appear complete?</p> <p>6 A. Yes, it does.</p> <p>7 Q. If you can turn to page 57 of Exhibit 8, the</p> <p>8 second full paragraph.</p> <p>9 A. Okay.</p> <p>10 Q. As I understand it, this paragraph is a</p> <p>11 criticism of the National Academies of Sciences' report</p> <p>12 on abortion safety; is that correct?</p> <p>13 A. That is correct.</p> <p>14 Q. Okay. And you say in the middle of the</p> <p>15 paragraph: "The only conclusion that can reasonably be</p> <p>16 drawn from this report regarding abortion complications</p> <p>17 is that extremely high volume providers have low</p> <p>18 complication rates, not that every single abortion</p> <p>19 provider does it well."</p> <p>20 Did I get that right?</p> <p>21 A. That is correct.</p> <p>22 Q. Is it your opinion that with proper training</p> <p>23 and routine performance of abortion procedures that</p> <p>24 abortion providers can have low complication rates?</p> <p>25 A. I think it is the case in medicine that the</p>	180	<p>1 A. In terms of the D&E, what I've read about</p> <p>2 Utah is that you guys did about -- I don't know, about</p> <p>3 130 to 300 in this age range over a ten-year period of</p> <p>4 time. I would consider that to be fairly low volume for</p> <p>5 the complexity of this procedure. And that is part of</p> <p>6 why I have a concern about Utah's performance of</p> <p>7 abortions in this age range because it doesn't sound like</p> <p>8 that is a high volume.</p> <p>9 Q. And when you say from what you've read,</p> <p>10 there is nothing in your expert report that indicates</p> <p>11 you've read about specific abortion procedures in Utah,</p> <p>12 correct?</p> <p>13 A. I do believe in my report I did some</p> <p>14 extrapolating based on the numbers that Guttmacher gives</p> <p>15 us nationwide. I believe that Utah does about 3,000</p> <p>16 abortions throughout the state in a year. And if we took</p> <p>17 the number of 4 percent after 16 weeks -- I have some</p> <p>18 discussion of this in the first page -- it ends up being,</p> <p>19 you know, a little over a hundred procedures. And, like</p> <p>20 I say -- I've read elsewhere, but it was afterwards, so I</p> <p>21 didn't include it in this report. But I read elsewhere</p> <p>22 there were, I believe, 134 abortions performed at greater</p> <p>23 than 20 weeks in Utah over a ten-year period of time,</p> <p>24 which makes a little more than one a month, which is not</p> <p>25 a high volume.</p>
179	<p>1 more frequently one performs a procedure the more skilled</p> <p>2 one becomes at it. I think that that would probably</p> <p>3 apply to abortion providers. The problem is we have</p> <p>4 no -- no standards, no abortion certification, no way to</p> <p>5 know who is a good provider and who is not, and the women</p> <p>6 of America don't know that either.</p> <p>7 Q. What do you consider an extremely high</p> <p>8 volume provider? What do you mean by that?</p> <p>9 A. Well, I would say Planned Parenthood of Los</p> <p>10 Angeles fits the bill. They're the one that did the</p> <p>11 study of 30,000 abortions in two years in a single city.</p> <p>12 Q. Would you consider any number fewer than</p> <p>13 that to be an extremely high volume abortion provider?</p> <p>14 A. I suppose it is all relative. When you</p> <p>15 consider that these are living human beings -- certainly</p> <p>16 I could draw the line much lower. I understand that.</p> <p>17 Q. Let me ask you this. Would 2,000 per year</p> <p>18 be an extremely high volume abortion provider?</p> <p>19 A. If that was a single provider doing that?</p> <p>20 Is that what you're asking?</p> <p>21 Q. Sure. Or you referred before to the -- to</p> <p>22 an affiliate of Planned Parenthood in Los Angeles. So</p> <p>23 let's imagine an affiliate of Planned Parenthood that</p> <p>24 performs 2,000 abortions a year, would that be an</p> <p>25 extremely high volume abortion provider?</p>	181	<p>1 Q. You would agree, though, a 20-plus week</p> <p>2 abortion is less common than 18-plus, correct?</p> <p>3 A. I don't know the numbers. You're asking how</p> <p>4 many are between 18 and 20 in Utah and how many are</p> <p>5 between 20 and 22. I would have no way to know how</p> <p>6 that --</p> <p>7 Q. Would you have any way to know that</p> <p>8 nationally?</p> <p>9 A. Well, what we do know is that, and I believe</p> <p>10 this is from Guttmacher and it is in ACOG's practice</p> <p>11 bulletin as well, that 4 percent are performed after 16</p> <p>12 weeks, and then I believe it is 1.3 that are performed</p> <p>13 after 20 to 22 weeks. But I don't have it narrowed down</p> <p>14 to 18 and 20.</p> <p>15 Q. And because you referred to it, if we can</p> <p>16 mark Tab I as Exhibit 9. This is the practice bulletin</p> <p>17 from ACOG Number 135.</p> <p>18 (Exhibit No. 9 was marked.)</p> <p>19 Q. Is this the practice bulletin you were just</p> <p>20 referring to, Dr. Skop?</p> <p>21 A. Yes. It is in that first paragraph, the</p> <p>22 statistics.</p> <p>23 Q. Great. And do you find -- again,</p> <p>24 recognizing that no data is perfect, would you consider</p> <p>25 this practice bulletin a reliable source with respect to</p>

September 02, 2020

182	<p>1 the best available data about second trimester abortion</p> <p>2 in the United States?</p> <p>3 A. It's a good source. I mentioned earlier</p> <p>4 that Planned Parenthood does not -- I'm sorry, that</p> <p>5 California does not report any numbers. I've heard</p> <p>6 anecdotally that California, in addition to extremely</p> <p>7 large volume of abortions, also does a lot of late-term</p> <p>8 abortions. Additionally, Maryland does a lot of very</p> <p>9 late-term abortions, and they don't provide numbers</p> <p>10 either. So I don't know how accurate these numbers are</p> <p>11 in terms of percentages.</p> <p>12 Q. Okay. Let me -- because I do want to make</p> <p>13 sure that we're clear on this. The -- your</p> <p>14 understanding -- you've referred a least a couple of</p> <p>15 times to California and Maryland, and you say they don't</p> <p>16 provide any numbers. But they do provide numbers of</p> <p>17 abortions performed to Guttmacher, correct?</p> <p>18 A. Yeah, but not to the CDC.</p> <p>19 Q. Right. But doesn't the CDC, in the Zane</p> <p>20 analysis -- yes, in the Zane analysis, they use</p> <p>21 Guttmacher data as the denominator for the number of</p> <p>22 abortions performed, correct?</p> <p>23 A. That may be the case. I haven't looked at</p> <p>24 that recently.</p> <p>25 Q. But that would be important, correct, in</p>	184	<p>1 no. of abortions distributed by CDC gestational age</p> <p>2 proportion," and below that it says, "GI, Guttmacher</p> <p>3 Institute"?</p> <p>4 A. Yes.</p> <p>5 Q. That's referring to Guttmacher Institute</p> <p>6 data about the number of abortions performed, correct?</p> <p>7 A. Yes.</p> <p>8 Q. So you cited this in your report, and you</p> <p>9 didn't know what the source of the denominator was in the</p> <p>10 mortality rates reported, correct, at the time you wrote</p> <p>11 your report?</p> <p>12 A. You know, to tell you the truth, I probably</p> <p>13 had just not thought about it. But it is interesting</p> <p>14 that the CDC is putting these numbers out and not even</p> <p>15 using their own numbers.</p> <p>16 Q. Well, it would certainly support your view</p> <p>17 that the Guttmacher data is likely to be more reliable,</p> <p>18 correct?</p> <p>19 A. And the CDC is --</p> <p>20 Q. As far as the number of abortions?</p> <p>21 A. Uh-huh, yeah.</p> <p>22 Q. Okay. So let's see.</p> <p>23 All right. If you can turn to -- actually,</p> <p>24 we don't need the report for now. So you address in your</p> <p>25 report the relationship between abortion and mental</p>
183	<p>1 determining what would be the most reliable -- or whether</p> <p>2 data is reliable with respect to the mortality rate?</p> <p>3 A. Yeah, I think -- I think that -- obviously</p> <p>4 we want to have the denominator as close as possible</p> <p>5 to a --</p> <p>6 THE WITNESS: Sorry. I'm walking to where I</p> <p>7 have a cord because the computer is running low.</p> <p>8 MS. MURRAY: No worries. Take your time.</p> <p>9 If you want to plug in, that's fine.</p> <p>10 A. Yeah, it is important, but it begs the</p> <p>11 question of why the CDC can't get high volume abortion</p> <p>12 providing states to give them information.</p> <p>13 Q. Well, that's not my question, Dr. Skop. If</p> <p>14 I could have you look at page 259 of Exhibit 9, this Zane</p> <p>15 study, I would like you to look at table 1. And look at</p> <p>16 the bottom --</p> <p>17 A. One second.</p> <p>18 Q. Oh.</p> <p>19 A. Sorry about that.</p> <p>20 Q. Don't be sorry.</p> <p>21 A. What page?</p> <p>22 Q. So page 259 of the Zane study. Look at the</p> <p>23 bottom of table 1.</p> <p>24 A. Let's see. Okay, table 1. I'm looking.</p> <p>25 Q. Do you see at the bottom it says, "GI total</p>	185	<p>1 illness. And at some point, I think, today you've</p> <p>2 acknowledged that, in your view, the relationship between</p> <p>3 those two things is debated. But you said at page 6 of</p> <p>4 your report that there are subsets of women at higher</p> <p>5 risk of mental illness after an abortion. Is that your</p> <p>6 opinion?</p> <p>7 A. It is my opinion, but it is also the opinion</p> <p>8 of psychological societies as well.</p> <p>9 Q. Dr. Skop, I do want to remind you to please</p> <p>10 stick to responses to my questions because I --</p> <p>11 A. Okay.</p> <p>12 Q. I have a limited amount of time, and I want</p> <p>13 to make sure we get through my questions. Okay?</p> <p>14 A. Okay.</p> <p>15 Q. So do you believe there is a causal</p> <p>16 relationship between having had an abortion and suffering</p> <p>17 from depression?</p> <p>18 A. There can be.</p> <p>19 Q. Do you believe there is?</p> <p>20 A. Well, it is just like anything else. There</p> <p>21 are some women who have abortions who don't suffer from</p> <p>22 depression and others who do suffer from depression and</p> <p>23 acknowledge that it was the abortion that caused the</p> <p>24 depression.</p> <p>25 Q. I see. So the opinion that you're offering</p>

September 02, 2020

186	<p>1 is that although some women will have abortions and not</p> <p>2 have any -- not become depressed after the abortion,</p> <p>3 there are some women who become depressed and there is a</p> <p>4 causal relationship between their depression and the</p> <p>5 abortion; is that correct?</p> <p>6 A. Yes.</p> <p>7 Q. Okay. What about with respect to anxiety;</p> <p>8 do you believe that some women have anxiety that is</p> <p>9 directly caused by having an abortion?</p> <p>10 A. Yes.</p> <p>11 Q. Okay. What about suicidality?</p> <p>12 A. Yes.</p> <p>13 Q. And then at the bottom of page 6 of your</p> <p>14 report, you cite to a number of -- let's see. This is</p> <p>15 Exhibit 2, bottom of page 6. You have -- starting here</p> <p>16 with "an eight-year retrospective study." Do you see</p> <p>17 that part of your report?</p> <p>18 A. Yes.</p> <p>19 Q. So the citations for footnotes 18 through</p> <p>20 22, are these the Finnish studies that we were just</p> <p>21 talking about earlier today?</p> <p>22 A. Eighteen is from a California record linkage</p> <p>23 study. The Gissler, Karalis, and then the additional two</p> <p>24 Gisslers are all from Finland, yes.</p> <p>25 Q. But the -- so to start with, 18 -- the</p>	188	<p>1 term. As you pointed out, they're -- they're not able to</p> <p>2 prove causality. But the fact that the deaths increase</p> <p>3 so substantially raises the question of let's look into</p> <p>4 causality, and no one has done that.</p> <p>5 Q. Okay. If we can stop right there.</p> <p>6 So just to be clear, you acknowledge that</p> <p>7 the studies 18 through 22 are not measuring causality</p> <p>8 between abortion and whatever outcome they're looking at,</p> <p>9 correct?</p> <p>10 A. That is correct.</p> <p>11 Q. Okay. And the -- do any of these studies</p> <p>12 control for preexisting mental health conditions that</p> <p>13 you're citing in 18 through 22?</p> <p>14 A. They're just an observational study. So I</p> <p>15 think they're just looking at women who have pregnancy</p> <p>16 outcomes documented in their single payer system, and</p> <p>17 then they're looking at women who die. And they're</p> <p>18 looking to see, you know, who had a pregnancy and how did</p> <p>19 the outcome correlate with the likelihood of death.</p> <p>20 They're not chart reviews, so -- and the</p> <p>21 numbers are tremendous. It would take a lot to go</p> <p>22 through each of those individual charts, but these are</p> <p>23 not chart reviews. So they don't know the woman's</p> <p>24 preexisting mental health.</p> <p>25 Q. Right. Would you agree, though, based on</p>
187	<p>1 Reardon study, footnote 18, when you say that's from a</p> <p>2 record linkage study, that would have been performed in</p> <p>3 the same way as the Finnish studies, right? It would</p> <p>4 look at any deaths after an abortion and not</p> <p>5 necessarily -- not necessarily identify abortion-related</p> <p>6 deaths; is that correct?</p> <p>7 A. Right. Right. So it is identifying</p> <p>8 abortion-associated deaths.</p> <p>9 Q. Okay. So that would be any -- that could</p> <p>10 include, you know, a woman who might be hit by a car as</p> <p>11 she leaves the abortion clinic; is that correct?</p> <p>12 A. That's correct.</p> <p>13 Q. Okay. Do you -- let's see.</p> <p>14 And you had mentioned, I believe, that</p> <p>15 you're comparing here to -- page 6, you're comparing</p> <p>16 women who have an abortion to women who carry to term</p> <p>17 when you're discussing these studies at paragraph -- or</p> <p>18 at footnotes 19, 20, 21, and 22, correct?</p> <p>19 A. That's correct.</p> <p>20 Q. Why do you think that women carrying to term</p> <p>21 would be an appropriate comparator?</p> <p>22 A. In these particular studies they actually</p> <p>23 look at all pregnancy outcomes. So they're looking at</p> <p>24 women who miscarry, they're looking at women who have</p> <p>25 abortions, and they're looking at women who carry to</p>	189	<p>1 your experience with dealing with patients with mental</p> <p>2 health illness or mental illness, that a prior history of</p> <p>3 mental illness is a predictor of potential future mental</p> <p>4 illness -- or let me put it a different way because I</p> <p>5 think that was imprecise.</p> <p>6 Would you agree a prior history of mental</p> <p>7 illness is a variable that makes someone more likely to</p> <p>8 suffer from mental illness in the future?</p> <p>9 A. That is one of the categories that was</p> <p>10 documented as making a woman more likely to have a</p> <p>11 problem as was late-term abortions and as was --</p> <p>12 Q. That's not my question, Dr. Skop. If you</p> <p>13 can please focus on my question and answer it. That's</p> <p>14 all I'm asking you to do because I do want to make sure</p> <p>15 that we are able to get through my questions today in the</p> <p>16 hours that we have allotted.</p> <p>17 A. Yes.</p> <p>18 Q. Okay. So they don't control for preexisting</p> <p>19 mental health conditions, correct, these studies --</p> <p>20 A. That's correct.</p> <p>21 Q. -- 18 through 22?</p> <p>22 And they couldn't, could they?</p> <p>23 A. Not the way they were designed.</p> <p>24 Q. Right. What about -- do they control for</p> <p>25 other measures of risk-taking behavior?</p>

<p style="text-align: right;">190</p> <p>1 A. It is purely observational. So I don't 2 think they know anything about the women. 3 Q. So if it happened that women who had 4 abortions were more likely to use drugs before the time 5 that they had abortion and later died of a drug overdose, 6 there would be no way to control for that difference 7 between women who had abortion than carried to term -- 8 there would be no way to control for the difference at 9 baseline? 10 Sorry. Does that make sense? I know that 11 was a lot. 12 A. Your questions are good. And we should ask 13 those questions in the study. We should be curious. 14 Q. But my question is these studies that you're 15 relying on and pointing the court to, these do not 16 control for those differences at baseline between a 17 person who has an abortion and a person who carries to 18 term, correct? 19 A. That is correct. 20 Q. Do these studies control for the wantonness 21 of a pregnancy? 22 A. Again, no. 23 Q. So if it happened that someone -- well, you 24 agree, right, that many women who give birth at term have 25 wanted pregnancies, correct?</p>	<p style="text-align: right;">192</p> <p>1 hard to know whether the beneficial effect is more 2 related to the first trimester abortions if they're 3 overrepresented. 4 There are some other concerns with that 5 study. I'm not sure how much they break out specific 6 mental health -- you know, it would be nice if they'd ask 7 a few more questions about mental health than they do. 8 It is a start. I mean, I appreciate that they're trying 9 to do this, but I wish they would have had a better 10 participation rate. 11 Q. Well, again, taking -- no data is perfect. 12 Would you say that among the studies that you have 13 reviewed with respect to the potential physical and 14 mental -- well, let's focus on mental health impact of 15 abortion. Do you believe the Turnaway study is the best 16 among them? 17 A. I'm not aware of any other prospective 18 studies. If I say it is the best, I'm going to have to 19 say that because it is the only one. 20 Q. Okay. 21 A. I think it has some deficiencies. 22 Q. But you would say it is the only prospective 23 longitudinal study, correct, of the mental health 24 impact? 25 A. It is the only -- it is the only one that</p>
<p style="text-align: right;">191</p> <p>1 A. Yes. And many who initially don't want the 2 pregnancies love their babies when they come. 3 Q. So that might be an important difference 4 between women who give birth at term as opposed to women 5 who have abortions, correct, when analyzing outcomes? 6 A. Yes and no. I think you might be referring 7 to the Turnaway study, which had very, very poor 8 participation, and it's been acknowledged that the women 9 who chose to participate were more likely to be secure in 10 their decision. So there have been criticisms about that 11 study. 12 Yes, you're right. If we could do a study 13 where we really could determine that, it would be a very 14 helpful study. 15 Q. And so in your review, the Turnaway study 16 and the articles based on it, the design -- well, let me 17 ask it a different way. 18 Do you believe -- setting aside your 19 criticism of the participation rate in the study, do you 20 believe the study is otherwise well designed? 21 A. No. There's a lot of questions in the 22 study. They say they're looking at women who were close 23 to the gestational age of the cutoff. And also they're 24 looking at first trimester, and they don't really tell us 25 what the numbers are in those two categories. So it is</p>	<p style="text-align: right;">193</p> <p>1 I'm aware of. It would be nice if they also broke it 2 down by the known high risk categories. 3 Q. What do you mean by that? 4 A. Well, like I mentioned earlier -- the ones 5 that we know are at higher risk for mental health adverse 6 outcomes are teenagers, those who have a desired 7 pregnancy and either terminate because of fetal 8 anomalies, maternal health, coercion, those who terminate 9 late, those who have multiple abortions. So there's -- 10 there's many categories that we know that those women are 11 at our priority a higher risk, and I don't think that the 12 Turnaway study looked specifically at some of those 13 categories. That would have been useful information to 14 have. 15 When you guys, when you do your 16 counseling -- because if somebody comes in and they check 17 the box for three out of seven risk factors, do you guys 18 tell them, You may be at higher risk to have a mental 19 health adverse outcome? 20 Q. Dr. Skop, Let me remind you of our roles 21 here today. My job is to ask the questions, and your job 22 is to answer them. 23 A. Okay. 24 Q. So in terms of the Turnaway study, then, it 25 sounds like, from your perspective, it is the best</p>

194	<p>1 available study with respect to the impact of mental</p> <p>2 health -- the impact of abortion on mental health</p> <p>3 outcomes? Is that fair to say?</p> <p>4 A. There is another one by David Ferguson in</p> <p>5 New Zealand that is also a good study. Again, because of</p> <p>6 my concerns about the selection for the Turnaway study, I</p> <p>7 don't think I would call it the best.</p> <p>8 Q. Okay. And is that Ferguson study cited in</p> <p>9 your expert report?</p> <p>10 A. I don't remember.</p> <p>11 Q. Why don't you take a look.</p> <p>12 A. I don't -- I don't believe it is.</p> <p>13 Q. Okay. And can you provide the cite to that?</p> <p>14 I think we'll talk about cleanup of documents later on.</p> <p>15 But I think if there is an article that you're relying</p> <p>16 on -- well, let me ask it this way. Are you saying today</p> <p>17 that the Ferguson study is, you think, the best study</p> <p>18 with respect to the impact of abortion on mental health</p> <p>19 outcomes?</p> <p>20 A. I think it has -- it is a longitudinal; it</p> <p>21 is a 30-year study. And I think it has -- I think it is</p> <p>22 better designed than the Turnaway.</p> <p>23 Q. And so would you say it is the best</p> <p>24 available study on the impact of abortion on mental</p> <p>25 health outcomes then?</p>	196	<p>1 Q. I'm not asking about participation. I'm</p> <p>2 asking what were the findings; do you recall?</p> <p>3 A. The abortion advocates who wrote the study</p> <p>4 report that the outcomes were better for those who had</p> <p>5 the abortion. But I think it is a nonrepresentative</p> <p>6 study, and I don't think it can be relied upon for all</p> <p>7 women.</p> <p>8 Q. Just to make sure I understand. So you said</p> <p>9 that the -- I'll call them authors. The authors who</p> <p>10 wrote the study found that abortion -- people who had</p> <p>11 abortions fared better, is that what you said, than women</p> <p>12 who carried to term?</p> <p>13 A. That was their report.</p> <p>14 Q. Better in what respect?</p> <p>15 A. In regards to the mental health outcomes.</p> <p>16 Q. Okay. All right. Why don't we go to --</p> <p>17 well, let me ask you this --</p> <p>18 MS. MURRAY: How are folks doing on breaks?</p> <p>19 Do we need a break? We've been going a little over an</p> <p>20 hour, an hour and ten minutes. Would you like a break,</p> <p>21 Dr. Skop?</p> <p>22 THE WITNESS: I'm okay. If you guys need</p> <p>23 one. . .</p> <p>24 MS. MURRAY: Anybody else? Speak now or</p> <p>25 forever hold your peace. Not forever. Like, 20 minutes</p>
195	<p>1 A. I don't know that I would say it is the</p> <p>2 best. There are some other good ones as well.</p> <p>3 Q. What are those?</p> <p>4 A. Well, I think you're going to talk to</p> <p>5 Priscilla Coleman. She's done some of them.</p> <p>6 Q. So you would rely on Dr. Coleman's work?</p> <p>7 A. Uh-huh.</p> <p>8 Q. All right. Well, that's -- that's helpful.</p> <p>9 Actually, just to make sure I understand your</p> <p>10 perspective. So the Turnaway study -- I believe you</p> <p>11 mentioned earlier that you've read a number of articles</p> <p>12 based on that study, correct?</p> <p>13 A. Yes.</p> <p>14 Q. And is it your understanding that the turn</p> <p>15 away study found that after an abortion, women -- well,</p> <p>16 it said in the months after having had an abortion that</p> <p>17 women who had an abortion had fewer incidences of mental</p> <p>18 health issues than women who carried to term.</p> <p>19 A. That's what they report.</p> <p>20 Q. Okay. And then long-term, what -- do you</p> <p>21 recall what the finding was with respect to the impact of</p> <p>22 abortion and being turned away and carrying term were on</p> <p>23 mental health outcomes?</p> <p>24 A. It -- it had a 27 percent participation</p> <p>25 rate at the --</p>	197	<p>1 or so.</p> <p>2 Q. (By Ms. Murray) If you can go to page 7 of</p> <p>3 Exhibit 2. This is your expert report.</p> <p>4 A. Okay.</p> <p>5 Q. And you say -- this is the first full</p> <p>6 paragraph on Page 7. You state, "The International</p> <p>7 Association for the Study of Pain defines pain as an</p> <p>8 'unpleasant sensory and emotional experience associated</p> <p>9 with actual or potential tissue damage.'" Did I read</p> <p>10 that correctly?</p> <p>11 A. Yes.</p> <p>12 Q. Is -- in your opinion, is that the best</p> <p>13 definition of pain?</p> <p>14 A. That's a good definition. I don't know that</p> <p>15 we need to include emotional as -- in that definition,</p> <p>16 but it is -- I think a lot of societies have trouble</p> <p>17 defining pain.</p> <p>18 Q. So let me ask my question again. Is it your</p> <p>19 opinion that this is the best available definition of</p> <p>20 pain?</p> <p>21 A. Probably not. It is just one definition.</p> <p>22 Q. Then why did you include it in your expert</p> <p>23 report?</p> <p>24 A. Because it is a starting point to discuss</p> <p>25 what might be going on with the fetus that could result</p>

September 02, 2020

<p style="text-align: right;">198</p> <p>1 in pain.</p> <p>2 Q. Would you agree that the International</p> <p>3 Association for the Study of Pain is the leading</p> <p>4 professional organization regarding the study of pain in</p> <p>5 the United States?</p> <p>6 A. I'm not that familiar with their reputation.</p> <p>7 I don't know if there is -- if they're considered leading</p> <p>8 or if someone else is.</p> <p>9 Q. So you're not familiar with any</p> <p>10 organizations that study pain?</p> <p>11 A. Not intimately, no.</p> <p>12 Q. Okay. So you said you thought that this</p> <p>13 probably wasn't the best definition of pain, the one that</p> <p>14 you included in your expert report. What is the best</p> <p>15 definition of pain?</p> <p>16 A. Well, I think it depends on what you're</p> <p>17 trying to justify. The -- pain is the sensory -- I think</p> <p>18 this is a good definition that -- like I said, I don't</p> <p>19 think it has to include the emotional component. But it</p> <p>20 is the tissue damage that causes the sensory neurons to</p> <p>21 relay to the brain that the tissue damage is occurring,</p> <p>22 and then the brain responds with withdrawal movements,</p> <p>23 with --</p> <p>24 Q. So I -- I want to keep us on track,</p> <p>25 Dr. Skop. I'm not asking you describe processes. I'm</p>	<p style="text-align: right;">200</p> <p>1 you would ascribe to in this case is, quote, an</p> <p>2 unpleasant sensory experience associated with actual or</p> <p>3 potential tissue damage; is that correct?</p> <p>4 A. Yes.</p> <p>5 Q. For an 18-week fetus, okay.</p> <p>6 And then under that definition, in your</p> <p>7 professional opinion, what is the earliest point in</p> <p>8 pregnancy at which a fetus has the capacity to experience</p> <p>9 pain?</p> <p>10 A. The sensory neurons begin developing at</p> <p>11 seven weeks gestational age. But I think that sometime</p> <p>12 between 14 and -- 14 and 20 weeks the complete system is</p> <p>13 functioning to the level of the thalamus. That's the</p> <p>14 lower portion of the brain. And that is clearly a time</p> <p>15 that pain can be sensed.</p> <p>16 Q. Okay. So under the definition that you just</p> <p>17 agreed was the best definition of pain -- I just want to</p> <p>18 make sure that I'm understanding you correctly -- is it</p> <p>19 your position that the earliest point in pregnancy that</p> <p>20 that could be experienced by a fetus is between 14 and 20</p> <p>21 weeks?</p> <p>22 A. Again, it depends on what we're calling</p> <p>23 pain.</p> <p>24 Q. Well, I'm asking you based on this</p> <p>25 definition.</p>
<p style="text-align: right;">199</p> <p>1 asking you -- you said you think this is not the best</p> <p>2 definition of pain. What is the definition that you</p> <p>3 believe is the best as an expert in this case?</p> <p>4 A. I think that I would use this definition but</p> <p>5 omit the emotional experience part of it.</p> <p>6 Q. Okay. So your -- do you think it is</p> <p>7 possible to have an unpleasant sensory experience if</p> <p>8 there is no emotional context?</p> <p>9 A. It is not possible for me or for you, but it</p> <p>10 is possible for an 18-week fetus.</p> <p>11 Q. And how do you know that?</p> <p>12 A. Well, there's quite a bit of histologic</p> <p>13 evidence that show us that the pain system in the fetus</p> <p>14 at this age works all the way up to the thalamus. What</p> <p>15 the JAMA study that I reference tried to do is say it</p> <p>16 doesn't count as pain unless the organism has the ability</p> <p>17 to think about it and be horrified by the fact that the</p> <p>18 leg is being pulled off. And, as I mentioned, I think</p> <p>19 that is a very extreme definition of pain. We don't</p> <p>20 apply that standard to a lab rat; we don't apply that</p> <p>21 standard to someone who is in a persistent vegetative</p> <p>22 state, and I don't think we should apply that standard to</p> <p>23 a fetal human being.</p> <p>24 Q. Okay. Just to make sure I understand. Your</p> <p>25 definition, your best definition of pain, the one that</p>	<p style="text-align: right;">201</p> <p>1 A. Uh-huh.</p> <p>2 Q. You are opining on fetal pain in this case.</p> <p>3 So I've asked you what your best definition is. Using</p> <p>4 that definition, what is the earliest point in pregnancy</p> <p>5 at which a fetus could experience pain?</p> <p>6 A. I would say in the 14-plus range, 14 weeks.</p> <p>7 Q. And that's because of the level of</p> <p>8 development in this thalamus; is that correct?</p> <p>9 A. That's because the pain arch goes completely</p> <p>10 from the sensory neurons to the spinal cord to the brain;</p> <p>11 the brain can then send signals that cause withdrawal of</p> <p>12 the limb that cause endogenous opioids to be released to</p> <p>13 moderate that pain. It causes the heart rate to go up.</p> <p>14 It causes the fetal breathing motions.</p> <p>15 Q. I'm not asking about effects. I'm asking</p> <p>16 you about what is the -- the reason or the difference</p> <p>17 between a fetus at 13 weeks and a fetus, say, at 14</p> <p>18 weeks, in terms of development, that allows all of those</p> <p>19 parts, in your view, to come into place. Is it the</p> <p>20 development of the thalamus?</p> <p>21 A. The thalamus, yes.</p> <p>22 Q. Okay. So, in your view, what is the</p> <p>23 earliest point in pregnancy at which there is a fully</p> <p>24 formed connection between the thalamus and the cerebral</p> <p>25 cortex?</p>

September 02, 2020

<p style="text-align: right;">202</p> <p>1 A. We don't know the answer to that. The JAMA 2 study set a very high bar, and they didn't think it 3 counted unless they saw fully formed neurologic pathways. 4 I believe they said between 26 and 30 weeks. I know from 5 having delivered live babies at 22 weeks and having seen 6 them, how they behave in the NICU, I know that at 22 7 weeks there is an intact pain system in those babies. 8 Q. So I'm -- that's not my question. My 9 question is, what is your expert opinion as to the 10 earliest point in pregnancy when there is a fully formed 11 connection between the thalamus and the cerebral cortex 12 of the fetus? 13 A. It is probably between 20 and 30 weeks that 14 that forms. 15 Q. Okay. So would you agree, then, that if a 16 connection, a fully formed connection between the 17 thalamus and the cerebral cortex is necessary to 18 experience pain that that could not occur in 18 weeks of 19 pregnancy? 20 A. I'm not agreeing that that is necessary to 21 create pain. 22 Q. I'm saying if it were necessary, would you 23 agree that it can't happen at 18 weeks? I understand you 24 believe it is unnecessary. If it were necessary, would 25 you agree that it cannot happen at 18 weeks of</p>	<p style="text-align: right;">204</p> <p>1 in the fetus, correct? 2 A. I believe that there is not documentation of 3 that. Correct. 4 Q. All right. And then do you believe it is 5 appropriate when providing an opinion on fetal perception 6 of pain to rely on studies involving adults? 7 A. You know, I think all of your experts are 8 going to have to rely on studies of something other than 9 a fetus because there have been no studies done on a 10 fetus. 11 Q. Can you answer my question, please, Dr. 12 Skop? I'm asking what you believe. I'm not asking about 13 my experts; I'm asking what you believe. 14 A. Sometimes when you can't study the specific 15 organism at the specific time you want to study, you have 16 to rely on other studies that are near but not completely 17 the same. So I think it is appropriate to look at adult 18 neurologic studies. I also think it is appropriate to 19 look at neonatal studies. 20 Q. What about animal studies? 21 A. Animal studies can be helpful. 22 Q. Which animals are most comparable to humans 23 in terms of neurological development and pain perception 24 in your opinion? 25 A. I don't know that I know the answer to that.</p>
<p style="text-align: right;">203</p> <p>1 pregnancy? 2 A. I don't think that there is histologic 3 evidence that the connection exists that early. 4 Q. So there is no evidence that an 18-week 5 fetus could experience pain, if a fully formed connection 6 between the thalamus and the cerebral cortex is required 7 to experience pain? 8 A. The -- the requirement for the cerebrum is 9 the assumption that the cerebrum is required to 10 emotionally process the pain. 11 Q. Dr. Skop, I want to get us back onto my 12 question. My question is, if -- do you agree that an 13 18-week fetus could not experience pain as you have 14 defined it if a fully formed connection between the 15 thalamus and the cerebral cortex is required to 16 experience pain? 17 A. I can't agree with the wording because you 18 said as I've defined it. And as I've defined it, it 19 doesn't require the emotional component. So pain, as 20 I've defined it, does not require a connection to the 21 cerebral cortex. A functioning thalamus is sufficient to 22 document pain in a fetus. 23 Q. But to be clear, it is your opinion that at 24 18 weeks of pregnancy there is not a fully formed 25 connection between the thalamus and the cerebral cortex</p>	<p style="text-align: right;">205</p> <p>1 I would assume probably a primate, but I don't know for 2 certain that that's the case. 3 Q. Have you ever looked into the issue? 4 A. No. 5 Q. Okay. So you also mentioned in your report 6 that it is the standard of care to give analgesia to 7 premature neonate who is undergoing a potentially painful 8 procedure; is that correct? 9 A. That's correct. 10 Q. And what is the gestational age that you're 11 referring to there, or that you have in mind of the 12 neonate at the time of birth? 13 A. Conversations with my neonatology peers -- 14 any live baby in the NICU is going to get analgesia if 15 needed. There are neonatal surgeries that are done even 16 prior to the age of viability, and it is my understanding 17 that analgesia is given in those situations as well. 18 Q. But you don't perform those intrauterine 19 fetal surgeries, correct? 20 A. No. 21 Q. And it sounds like you don't actually 22 administer analgesia to neonates, correct? 23 A. No. Those are both outside of my 24 specialty. 25 Q. Outside of your expertise?</p>

206	<p>1 A. Exactly.</p> <p>2 Q. Okay. And then you mentioned something, a</p> <p>3 term I've never heard of it. What is intrahepatic vein</p> <p>4 needling?</p> <p>5 A. So sometimes they need to collect blood from</p> <p>6 the fetus, maybe an Rh isoimmunization situation to</p> <p>7 determine, you know, anemia, things like that. They need</p> <p>8 direct fetal blood. And so they can -- they can get it</p> <p>9 from the cord sometimes, and I can't really tell you</p> <p>10 exactly which situations, but they may need to go</p> <p>11 directly into the big vessel that feeds the liver. That</p> <p>12 is what that is.</p> <p>13 Q. So it is not a procedure that you perform,</p> <p>14 then?</p> <p>15 A. No.</p> <p>16 Q. And at what gestational age would you do it;</p> <p>17 do you know?</p> <p>18 A. I don't know. I think that would probably</p> <p>19 be a mid-second-trimester procedure. But, again, it is</p> <p>20 generally done by a specialist. Usually in Texas it is</p> <p>21 Houston or Dallas that does those.</p> <p>22 Q. Have you ever observed it?</p> <p>23 A. It is possible that I may have during my</p> <p>24 residency.</p> <p>25 Q. But you don't recall any --</p>	208	<p>1 which a neonate born before 21 weeks and six days of</p> <p>2 pregnancy survived long term?</p> <p>3 A. I have seen reports on that. Again, they're</p> <p>4 anecdotal reports, and I don't have the specific</p> <p>5 information.</p> <p>6 Q. You mentioned a study out of the University</p> <p>7 of Iowa. Is it your understanding that the people in the</p> <p>8 study would have received -- well, what is your</p> <p>9 understanding of what traditional treatment would be for</p> <p>10 a neonate born at 22 weeks?</p> <p>11 A. Well, if possible we tend to give antenatal</p> <p>12 steroids. I don't know specifically of those babies</p> <p>13 which did and which didn't. Many times at those</p> <p>14 gestational ages the neonatologist will attend the</p> <p>15 delivery, evaluate the baby to see if the baby is trying</p> <p>16 to breathe. I mean, there are some 22-weekers that</p> <p>17 aren't healthy enough to be resuscitated. But in those</p> <p>18 situations, when the baby appears to be fighting, they</p> <p>19 try to resuscitate, and those are the outcomes they have</p> <p>20 gotten.</p> <p>21 Q. So you mentioned antenatal steroids. So in</p> <p>22 layman's terms, that is an instance where the pregnant</p> <p>23 patient would actually take steroids in advance of the</p> <p>24 birth to bolster the lung capacity of the fetus; is that</p> <p>25 correct?</p>
207	<p>1 A. I don't recall.</p> <p>2 Q. -- particular --</p> <p>3 A. Maybe they weren't that sophisticated</p> <p>4 then.</p> <p>5 Q. Okay. And, actually, if we can back up to</p> <p>6 my earlier question about the neonates. I think you</p> <p>7 mentioned it was your understanding that any living baby</p> <p>8 in the NICU would, where appropriate in the treating</p> <p>9 physician's view, would receive analgesia for a potential</p> <p>10 painful procedure; is that right?</p> <p>11 A. That's correct.</p> <p>12 Q. When you say any living baby, what point in</p> <p>13 pregnancy would you say that is the earliest point that</p> <p>14 you're going to see living babies who make it into the</p> <p>15 NICU after birth?</p> <p>16 A. Viability is actually an ever decreasing</p> <p>17 standard. Currently 22-week neonates -- the University</p> <p>18 of Iowa just released a study that two-thirds of those</p> <p>19 lived until hospital discharge and, of those, two-thirds</p> <p>20 have no to minimal neurologic impairment. So the</p> <p>21 22-weekers are doing well. And there have been some 20-</p> <p>22 to 21-week fetuses that have been saved. So we -- we</p> <p>23 think of 22 weeks, but I think that our viability is</p> <p>24 decreasing even further.</p> <p>25 Q. Are you saying you're aware of instances in</p>	209	<p>1 A. That is correct.</p> <p>2 Q. So without that kind of steroid treatment</p> <p>3 how --</p> <p>4 A. That's felt to improve the odds. But,</p> <p>5 again, babies have survived without the steroids.</p> <p>6 Q. And -- okay. So you mentioned steroids.</p> <p>7 And, also, do you know whether the Iowa program was a</p> <p>8 Level 4 NICU.</p> <p>9 A. I would assume it must be to have</p> <p>10 22-weekers.</p> <p>11 Q. So for the record, a Level 4 NICU would be</p> <p>12 the highest -- how would you describe a Level 4 NICU?</p> <p>13 A. Yeah, it would be the highest acuity, the</p> <p>14 ones most likely to have the machinery that's needed to</p> <p>15 support a baby that young, his respiratory system.</p> <p>16 Q. And there are very few of those, correct?</p> <p>17 A. I don't know the number. You know, teaching</p> <p>18 hospitals tend to be the ones with the best NICUs.</p> <p>19 Q. So what about the -- does a pre-viable fetus</p> <p>20 have the capacity for directional movement?</p> <p>21 A. I think, undoubtedly, they do. I mean,</p> <p>22 that's been demonstrated in babies as young as 14 weeks,</p> <p>23 maybe earlier. We don't know what's going on in their</p> <p>24 minds. I mean, certainly sometimes they do look like</p> <p>25 they're doing things intentionally, but 14 I think.</p>

210	<p>1 Q. When I say directional movement, what do you 2 take that to mean? 3 A. Movement that looks like it is not just 4 random, but for a purpose. 5 Q. Okay. But moving -- do they have the 6 capacity to move in one direction as opposed to 7 another? 8 A. Certainly. 9 Q. Okay. So when you see a fetus on 10 ultrasound, would a fetus move directionally upon 11 pressure to the stomach to the pregnant patient? 12 A. They can do that as well. 13 Q. Okay. Why might you do that during an 14 ultrasound? 15 A. Well, sometimes you'll do it to get them to 16 expose themselves better to their father and they can see 17 the face, look between the legs, that type of stuff. If 18 you're doing a procedure, amniocentesis, you may want to 19 nudge them so that they give you a clear spot to get 20 amniotic fluid without the baby at risk. 21 Q. So what -- what happens when you do that? 22 You kind of nudge them to try to get them to move in a 23 way that you want. And would they have a directional 24 movement then? 25 A. Well, I mean a directional -- obviously</p>	212	<p>1 meant to put some pressure and to see the fetus move in 2 response to that. 3 Q. But in your view, that is not pain that 4 you're inflicting on the fetus; is that correct? 5 A. Right. There's other ways you can measure 6 pain. I mean, when we experience pain, our adrenaline 7 rises, our heart rate rises, it is the fight or flight. 8 Right? We want to get away. And we see that same thing 9 happening in a fetus. If we're measuring blood, we can 10 see the catecholamines, we can see the endorphins rise, 11 we can see the heart rate rise, you know, all of that in 12 conjunction with the withdrawal of the fetal parts 13 getting away from whatever that painful stimulus is. 14 Q. I'm sorry to go back. You mentioned the 15 endorphins. What else did you say? 16 A. Catecholamines. So endorphins are 17 endogenous painkillers. Catecholamines would be, like, 18 the adrenalin to make your heart race and stuff. 19 Q. Okay. Could you see a change in those in 20 the absence of what might be perceived as a painful 21 stimuli? 22 A. Well, I mean, certainly you can. You know, 23 movement, you know -- just as our heart rate rises when 24 we exercise, you know, we will see babies' heart rates 25 rise when they exercise. But the constellation of things</p>
211	<p>1 that's a responsive movement; you push them, and they 2 move away from you. I interpret directional to mean that 3 there is -- that it is more than just random, that it is 4 either some neurologic control that is causing it to 5 happen. I assume you might be responding to what I put 6 in there about the twins. Twins as early as 14 weeks, 7 you know, they can see them reaching for each other. 8 Obviously, we don't know what capacity causes them to do 9 that, but it seems to be the case that they do. 10 Q. I wasn't referring to the twin reference, 11 actually. I'm just curious, if you nudge a fetus during 12 a ultrasound, you -- it sounds like the fetus will move 13 away, correct? 14 A. Correct. 15 Q. And that's how you would be able to see 16 between the legs or you would be able to show the 17 ultrasound to someone in different view; is that correct? 18 A. That can be one way, yes. 19 Q. And do you think that you're hurting the 20 fetus when you do that? 21 A. No. 22 Q. Is that common to do during an ultrasound, 23 to nudge the fetus in ways to get it to move? 24 A. You end up putting a little bit of pressure 25 with the ultrasound transducer, so I would say it is</p>	213	<p>1 happen at the time of the pain -- of the painful 2 stimulus, and -- 3 Q. Right. But my question to you is could 4 those things that you've outlined as rising for a fetus, 5 could those happen in the absence of a painful stimuli as 6 well? 7 A. I don't know that they would release 8 endorphins if they weren't having pain because those are 9 to modulate pain. Those are to decrease the pain. 10 Q. So you believe that that would be an 11 indicator that there actually is the a pain response -- 12 A. I think all of it together tells me there is 13 a painful transmission to the fetus. 14 Q. Okay. But to go back to our earlier 15 discussion, you've never performed an abortion at or 16 after 18 weeks, correct? 17 A. That's correct. 18 Q. So you've never observed what a fetus might 19 do during an abortion at or after 18 weeks, correct? 20 A. I've seen videos. 21 Q. Where did you find the videos, Dr. Skop? 22 A. Oh, those were from Bernard Nathanson, who 23 was one of the guys who helped to override Roe. And then 24 as he -- he performed a lot of abortions and, ultimately, 25 had a change of heart and -- based on what he saw on</p>

214

1 ultrasound on how he saw those babies reacting. And he's
 2 put out a couple of videos that show the responses to
 3 babies during abortions.
 4 **Q. But you have no firsthand experience of**
 5 **observing an abortion at or after 18 weeks, correct?**
 6 A. That's correct.
 7 **Q. Okay.**
 8 MS. MURRAY: So I think this might be a good
 9 time to stop and take a break.
 10 (Recess from 2:11 p.m. to 2:34 p.m.)
 11 MS. MURRAY: Welcome back from the break.
 12 **Q. (By Ms. Murray) Dr. Skop, is there anything**
 13 **you would like to amend or add to your earlier testimony**
 14 **at this point?**
 15 A. I don't think so.
 16 **Q. Okay. Before we get started, I have --**
 17 **well, I had some -- some questions on other issues, but I**
 18 **wanted to go back to the discussion this morning about**
 19 **the exhibits in this case. When did you receive the**
 20 **package of exhibits yesterday, Dr. Skop?**
 21 A. Toward the end of the day.
 22 **Q. What time, approximately?**
 23 A. I'll say about 6:00.
 24 **Q. Okay. And when did you receive the court**
 25 **order in this case governing the depositions?**

215

1 A. Maybe a week or so ago.
 2 **Q. Okay. And then there was -- the court order**
 3 **was actually included with the exhibits, correct?**
 4 A. Yes.
 5 **Q. To be clear, was it your understanding when**
 6 **you received the packet that you were not supposed to**
 7 **open it until we had our deposition today?**
 8 A. That was totally my fault. If it was in the
 9 information that was provided before, I didn't -- I
 10 didn't remember. I didn't pay attention to it when I
 11 received the package yesterday. I didn't know what it
 12 was, and I opened it and then saw that it was these
 13 papers, and I flipped through it. But I didn't spend an
 14 extensive amount of time because I thought that -- pretty
 15 much everything I saw was the stuff I had submitted to
 16 you guys.
 17 **Q. Just to make clear, when you received the**
 18 **package, it did have a return address on it, correct?**
 19 A. Probably.
 20 **Q. And it would have had my name, Julie Murray?**
 21 A. Probably.
 22 **Q. Did you know my name last night?**
 23 A. I don't recall paying attention to who it
 24 was from.
 25 **Q. I'm asking you a different question. Did**

216

1 **you know my name last night at 6:00 p.m.?**
 2 A. I've heard your name before, yes.
 3 **Q. Okay. So you did know my name. And, I'm**
 4 **sorry, did you say that there was a return address with**
 5 **my name on it?**
 6 A. I don't recall. I've thrown the package
 7 away, but I can find out. I didn't pay attention to
 8 that.
 9 **Q. So if you didn't know who the package was**
 10 **from, would you have -- normally would you look at the**
 11 **return address to figure it out?**
 12 A. To tell you the truth, we're getting a lot
 13 of packaging right now. My son is working from home too,
 14 and so I've kind of gotten into the habit of opening
 15 packages, seeing what is in them, and then sending them
 16 to the appropriate person. I think that's why I didn't
 17 pay attention to who it was from.
 18 **Q. So you had not been advised before receiving**
 19 **the package not to open it?**
 20 A. If I was, I neglected to pay attention. So
 21 it is my fault I'm sure.
 22 **Q. Do you recall being advised about a**
 23 **package?**
 24 A. I don't recall, but I probably -- I mean, it
 25 was probably in some of the papers that I --

217

1 **Q. Did you read the court order that**
 2 **Mr. Sorenson provided to you?**
 3 A. Did I read it? I looked at it about a week
 4 ago.
 5 **Q. And did he tell you to expect a package last**
 6 **night?**
 7 A. I don't remember.
 8 **Q. So you didn't know yesterday whether you**
 9 **would be receiving documents in this case?**
 10 A. No.
 11 **Q. So they came out of the blue?**
 12 A. Yes.
 13 **Q. Okay. And then when you opened them, what**
 14 **was inside -- well, let me ask you this: How did the**
 15 **documents arrive; in what kind of container?**
 16 A. They were in a FedEx envelope.
 17 **Q. An envelope or a box?**
 18 A. It was a box.
 19 **Q. A box. And then what was inside of the**
 20 **sealed box?**
 21 A. An envelope.
 22 **Q. And was that envelope sealed?**
 23 A. Yes.
 24 **Q. And then what was inside of that sealed**
 25 **envelope?**

September 02, 2020

218	<p>1 A. The three-ring binder.</p> <p>2 Q. The three-ring binder. And did you open up</p> <p>3 the three-ring binder and look at the -- what did you do</p> <p>4 when you saw the three-ring binder?</p> <p>5 A. I opened it up and saw that it was the</p> <p>6 documents that I had previously provided.</p> <p>7 Q. And then were there four or five envelopes</p> <p>8 at the end of the binder?</p> <p>9 A. Yes.</p> <p>10 Q. And how were those marked?</p> <p>11 A. They have letters on them.</p> <p>12 Q. And what did you do with -- well, were those</p> <p>13 envelopes sealed as well?</p> <p>14 A. Yes.</p> <p>15 Q. And you opened each one of those last</p> <p>16 night?</p> <p>17 A. Yes.</p> <p>18 Q. Did it occur to you after seeing the binder</p> <p>19 that had been sealed that perhaps you were not supposed</p> <p>20 to open the envelopes?</p> <p>21 A. No, it didn't occur to me. I figured I was</p> <p>22 being sent it for use today.</p> <p>23 Q. And so you didn't reach out to counsel for</p> <p>24 any advice?</p> <p>25 A. No.</p>	220	<p>1 would you say you spent preparing the deposition between</p> <p>2 then and when the deposition began this morning?</p> <p>3 A. Really, at that point, only 15 minutes. I</p> <p>4 made dinner. I was on a conference call, watched TV, and</p> <p>5 went to bed. I didn't spend any additional time after</p> <p>6 that preparing.</p> <p>7 Q. Okay. All right. With that, let's talk a</p> <p>8 little bit about publications. If I understood your CV</p> <p>9 correctly, it looks like you didn't publish any articles</p> <p>10 or do any presentations between the late 1990s and 2018.</p> <p>11 So approximately 20 years. Is that correct?</p> <p>12 A. That's correct.</p> <p>13 Q. And the first one you published something</p> <p>14 about abortion was in 2018; is that correct?</p> <p>15 A. I believe so.</p> <p>16 Q. How many articles have you published in a</p> <p>17 peer review journal?</p> <p>18 A. I believe there have been four or five.</p> <p>19 Q. Okay. And of those -- am I correct you said</p> <p>20 there were two or three that related to abortion?</p> <p>21 A. They've all related to -- well, the recent</p> <p>22 ones all related to abortion. It looks like there have</p> <p>23 been five peer reviewed; three of them have specific</p> <p>24 information about abortion safety.</p> <p>25 Q. Uh-huh. And you said that -- earlier that</p>
219	<p>1 Q. Okay. And once you received the packages</p> <p>2 last night, did you -- have you -- did you speak to</p> <p>3 Mr. Sorenson between the time that you received the</p> <p>4 package and this morning when the deposition began?</p> <p>5 A. I don't think that we spoke.</p> <p>6 Q. Did you email or communicate in writing?</p> <p>7 A. No.</p> <p>8 Q. So you didn't have any communication with</p> <p>9 him between the time the package arrived and when you got</p> <p>10 on the deposition this morning?</p> <p>11 A. No.</p> <p>12 Q. Okay. How much time would you say you spent</p> <p>13 looking at the documents last night that were provided to</p> <p>14 you?</p> <p>15 A. I just flipped through them. Probably less</p> <p>16 than 15 minutes because I had read them all before.</p> <p>17 Q. And did you spend any other time looking at</p> <p>18 documents last night related to --</p> <p>19 A. Regarding this case --</p> <p>20 Q. -- in preparation for this deposition?</p> <p>21 A. Yeah, over the past couple of days, I've</p> <p>22 read -- reread some of the papers.</p> <p>23 Q. I'm asking about the time between when you</p> <p>24 received the packet last night, you said around 6 p.m.,</p> <p>25 and this morning when the deposition began, how much time</p>	221	<p>1 you had been -- had been deposed in two lawsuits; one as</p> <p>2 a defendant and one as an expert a couple of years ago in</p> <p>3 a medical malpractice case; is that correct?</p> <p>4 A. That is correct.</p> <p>5 Q. Was the name of that case Bates v. Smith; do</p> <p>6 you recall?</p> <p>7 A. Smith?</p> <p>8 Q. Actually, that one would have been around</p> <p>9 2005. Is that the medical malpractice case that you were</p> <p>10 referring to, Bates v. Smith?</p> <p>11 A. What was the first name?</p> <p>12 Q. Bates, B-A-T-E-S?</p> <p>13 A. I don't recall that, no.</p> <p>14 Q. Okay. What was the -- and you said you</p> <p>15 don't recall the name of the case that you were involved</p> <p>16 in a couple of years ago, right?</p> <p>17 A. The recent one was -- Carolina Praderio was</p> <p>18 the doctor. I've forgotten the plaintiff's name.</p> <p>19 Q. So Carolina Praderio would have been a</p> <p>20 defendant in the case?</p> <p>21 A. Right. Yes.</p> <p>22 Q. To your knowledge, have you ever been</p> <p>23 subject to a challenge to disqualify you from serving as</p> <p>24 an expert witness in court?</p> <p>25 A. Not that I know of.</p>

September 02, 2020

<p style="text-align: right;">222</p> <p>1 Q. Okay. And is there any other prior 2 testimony that you've provided in any type of proceeding 3 that we haven't talked about today? 4 A. I don't think so. 5 Q. So I believe you mentioned there was some 6 testimony to the Texas state legislation, correct? 7 A. Correct. 8 Q. And that wasn't on your CV, correct? 9 A. I don't believe so. 10 Q. What about testimony to the Vermont 11 legislature, have you ever done that? 12 A. I wrote a -- I wrote a report at the request 13 of Vermont Right to Life. 14 Q. And you don't know what happened to it? 15 A. It got ignored, apparently. 16 Q. Was the purpose of the report to submit to 17 the legislature? 18 A. I believe so. 19 Q. And that wasn't on your CV, correct? 20 A. I had forgotten about that. 21 Q. So it wasn't on your CV? 22 A. That's correct. 23 Q. And you didn't mention it this morning? 24 A. No. I'd forgotten about it until just 25 now.</p>	<p style="text-align: right;">224</p> <p>1 Q. And you opposed it? 2 A. Yes, I did. 3 Q. So just to make sure that I understand. In 4 Texas, Georgia, and Vermont, all of the testimony you 5 have provided has been to support greater regulation of 6 abortion as opposed to less regulation; is that correct? 7 A. In the interest of safety, yes. 8 Q. Or to ban it outright, correct? 9 A. No, I haven't supported anything that would 10 ban it outright. 11 Q. The Georgia ban at six weeks, you don't 12 consider a ban on abortion outright? 13 A. No. Women can get abortions -- it is 14 possible to know you are pregnant prior to the fetal 15 heartbeat. 16 Q. When is a home pregnancy test accurate? How 17 many weeks LMP? 18 A. It can pick up as early as three weeks LMP, 19 about a week after the conception occurs. 20 Q. So, at best, three weeks. And when is it 21 most reliable? Does it start being very reliable at 22 three weeks? 23 A. Depending on the test. It is almost 24 always -- even with a low sensitivity test, it is always 25 going to be positive around the time of the missed</p>
<p style="text-align: right;">223</p> <p>1 Q. Is there any other testimony that you have 2 ever provided that you haven't told me so far in any type 3 of proceeding? 4 A. It's hard to say. Not that I can recall. 5 But some of these things are fairly minor, so I may be 6 forgetting something. 7 Q. What about any letters to the editor or 8 newspaper articles about abortions -- actually, can we 9 back up? 10 So you told me what the Texas and Georgia 11 testimony was about. What was the Vermont testimony 12 about, to your recollection? 13 A. Well, this was at the time that Vermont took 14 away all restrictions on the procedure of abortion, and 15 so I wasn't paid for that testimony. They just asked 16 me -- I don't remember how they found me, but they asked 17 me to write a -- you know, a report about the dangers, 18 which I did. 19 Q. The dangers of abortion? 20 A. The dangers of abortion, yes. 21 Q. So you were opposing legislation that would 22 have removed some regulation of abortion; is that 23 correct? 24 A. That legislation removed all regulation of 25 the abortion in the state of Vermont.</p>	<p style="text-align: right;">225</p> <p>1 menstrual period. 2 Q. So when would that be? 3 A. Around four weeks. 4 Q. Four weeks. So in your view, it is not an 5 outright ban on abortion if a woman can get an abortion 6 between four weeks, when it will be reliably diagnosed by 7 a home pregnancy test, and six weeks; is that correct? 8 A. Yes. There's certainly time to get an 9 abortion there. And sometimes we don't see the heartbeat 10 until seven or eight weeks depending on the sensitivity 11 of the ultrasound. 12 Q. Have you also advocated waiting periods, 13 Dr. Skop, between the time that a woman is provided 14 informed consent papers for abortion and when she can 15 actually obtain one? 16 A. I don't recall if I've done anything 17 specific in writing or in testing, but I think that is a 18 reasonable restriction. 19 Q. Do you know what the waiting period is in 20 Utah? 21 A. I believe I read 72 hours. 22 Q. Seventy-two hours. So -- okay. 23 So we talked about the Vermont testimony. 24 What about any letters to the editor or newspaper 25 articles about abortion that didn't appear on your CV?</p>

September 02, 2020

<p style="text-align: right;">226</p> <p>1 A. I've had a few letters to the editor, local 2 op-eds. I've had a few op-eds published in more national 3 magazines. I had a joint op-ed with a congressman on the 4 hill. There's been a few others. I don't think those 5 were important to put on the CV, but . . .</p> <p>6 Q. Are you referring to the op-ed that you did 7 with Representative Kevin Brady of Texas with respect to 8 federal legislation on abortion?</p> <p>9 A. Yeah. The legislation, as I recall, was 10 about supporting babies that are born alive.</p> <p>11 Q. After an abortion?</p> <p>12 A. It doesn't actually limit abortion. It just 13 ask that you save the infant.</p> <p>14 Q. But it was an op-ed with respect to 15 abortion, correct, with a congressman?</p> <p>16 A. Yes.</p> <p>17 Q. And did any of the other letters or op-eds 18 that you mentioned pertain to abortion?</p> <p>19 A. Probably most of them did.</p> <p>20 Q. Okay. But none of them appeared on your CV, 21 correct?</p> <p>22 A. Yeah, I didn't put any of those on.</p> <p>23 Q. Okay. What about -- have you ever been 24 denied a license to practice medicine in any state?</p> <p>25 A. No.</p>	<p style="text-align: right;">228</p> <p>1 Q. Do you have -- are there any circumstances 2 in which you believe abortion should be available in the 3 United States?</p> <p>4 A. I think -- I don't think it is necessary for 5 women's health. If a woman needs to be separated from 6 her baby to preserve her health, that can be done without 7 intentionally performing an abortion.</p> <p>8 Q. And how would that be done, so that I 9 understand?</p> <p>10 A. Labor can be induced or, you know, as we 11 discussed earlier, caesarean if indicated.</p> <p>12 Q. And in those circumstances, how would you 13 describe when you think abortion should be legal to 14 protect a woman's health?</p> <p>15 A. Well, abortion --</p> <p>16 Q. Would any health risk be a sufficient basis 17 for performing an abortion?</p> <p>18 A. Doe v. Bolton defined a health risk as 19 emotional, psychological, physical, age, social. So many 20 times things that are defined as for the health of the 21 mother are not life-threatening. I don't -- I can't 22 think of a time that a pregnancy has posed a risk to the 23 life of a patient that I've cared for that I have not 24 been able to take care of the mother with either 25 induction or C-section.</p>
<p style="text-align: right;">227</p> <p>1 Q. Have you ever had your license revoked or 2 suspended?</p> <p>3 A. No.</p> <p>4 Q. Has a patient or a former patient ever filed 5 a complaint against you with any disciplinary body?</p> <p>6 A. No.</p> <p>7 Q. Have you ever been named as a defendant in 8 any lawsuit that we haven't discussed today?</p> <p>9 A. No. There were two medical malpractice 10 suits, one of them did not do a deposition.</p> <p>11 Q. Okay. And when did that happen?</p> <p>12 A. Oh, it was quite some time ago; 15 years 13 maybe.</p> <p>14 Q. Okay. Have you ever been fired from any 15 position?</p> <p>16 A. No.</p> <p>17 Q. Have you ever been asked to resign or leave 18 a job or professional position?</p> <p>19 A. No.</p> <p>20 Q. Have you ever resigned from a position while 21 an investigation was ongoing against your conduct?</p> <p>22 A. No.</p> <p>23 Q. Have you ever been accused of professional 24 misconduct?</p> <p>25 A. No.</p>	<p style="text-align: right;">229</p> <p>1 Q. Do you believe that abortion should be legal 2 in the United States if there is a threat to the 3 mother -- or the woman's health but not to her life?</p> <p>4 A. Well, like I mentioned, the health exception 5 is very broad. In some states she says she feels 6 depressed about the pregnancy; they consider that a 7 health exception.</p> <p>8 Q. Not asking you what the law is. I'm asking 9 you, in your view, are there any circumstances in which 10 abortion should be legal to preserve the health of the 11 pregnant patient if her life is not threatened?</p> <p>12 A. I have not come across a circumstance like 13 that.</p> <p>14 Q. So you can't think of any circumstances in 15 which you think abortion should be legal to preserve the 16 health of a pregnant patient but not her life; is that 17 right?</p> <p>18 A. My goal is not to make abortion illegal. My 19 goal is to make it unnecessary by providing contraception 20 for women who need it, by providing support --</p> <p>21 Q. Dr. Skop, I do want you to be responsive to 22 my question. And my question is about what you believe 23 should be legal. Let me ask it this way.</p> <p>24 You have testified about the circumstances 25 or the points in pregnancy at which abortion should be</p>

September 02, 2020

<p style="text-align: right;">230</p> <p>1 legal, correct?</p> <p>2 A. Specifically regarding this legislation,</p> <p>3 I've said I don't think it is necessary after 18 weeks.</p> <p>4 Q. Or at six weeks, you have testified that it</p> <p>5 should be -- six to eight weeks, you have testified that</p> <p>6 it shouldn't be legal, correct?</p> <p>7 A. I submitted an expert witness report to the</p> <p>8 State of Georgia that is unrelated to this legislation</p> <p>9 with some reasons that it is reasonable for them to make</p> <p>10 the ban where they have.</p> <p>11 Q. And if you were making the ban, where would</p> <p>12 you put the point in pregnancy at which abortion should</p> <p>13 no longer be available?</p> <p>14 A. Well, morally, since it is the taking of a</p> <p>15 human life, I think that that is a discussion our society</p> <p>16 should have. My goal is not legislation --</p> <p>17 Q. I'm not asking about your goals. I'm asking</p> <p>18 about your personal beliefs, Dr. Skop.</p> <p>19 A. I don't -- I don't care where the law falls</p> <p>20 on it, but I think it is certainly reasonable for us to</p> <p>21 put limitations, and 18 weeks is certainly a good place</p> <p>22 to put a limitation. I'm not out trying to make abortion</p> <p>23 illegal in every situation.</p> <p>24 Q. I'm asking you what you believe should be</p> <p>25 legal. Do you believe that it should be legal for a</p>	<p style="text-align: right;">232</p> <p>1 correct?</p> <p>2 A. That's correct.</p> <p>3 Q. Okay. Have you ever advocated the closure</p> <p>4 of Planned Parenthood?</p> <p>5 A. I don't think so.</p> <p>6 Q. Have you ever advocated for legislation that</p> <p>7 would prevent Planned Parenthood affiliates from</p> <p>8 obtaining any funding for nonabortion-related work that</p> <p>9 they do?</p> <p>10 A. The -- I think I may have written an op-ed</p> <p>11 about Title X.</p> <p>12 Q. And, for the record, what is Title X?</p> <p>13 A. Title X is unrestricted government funds</p> <p>14 that Planned Parenthood gets -- used to get a lot of that</p> <p>15 they would use to support other services --</p> <p>16 Q. I'm not -- sorry. Let me back up. I'm not</p> <p>17 asking about Planned Parenthood. I'm asking you, what is</p> <p>18 your understanding of the Title X program. What does it</p> <p>19 fund?</p> <p>20 A. It funds women's health, but it doesn't fund</p> <p>21 specific -- like, it is not to pay for a particular</p> <p>22 procedure. But it is a block grant that goes to family</p> <p>23 planning agencies. And the current regulations say that</p> <p>24 there needs to be brick and mortar separation between an</p> <p>25 organization that accepts that money and provides</p>
<p style="text-align: right;">231</p> <p>1 patient to obtain an abortion where her health is</p> <p>2 threatened but her life is not threatened?</p> <p>3 A. It depends on the definition of health. If</p> <p>4 she is just depressed about being pregnant, I don't think</p> <p>5 that that should be legal.</p> <p>6 Q. Can you imagine any other circumstances</p> <p>7 where the health could be threatened but the life would</p> <p>8 not be where you believe that abortion should be legal?</p> <p>9 A. I think that no matter how we legislate it</p> <p>10 we're going to have exceptions for that. So I'm not sure</p> <p>11 how that applies to a case where we're talking about a</p> <p>12 very late abortion for elective reasons.</p> <p>13 Q. I'm asking about abortion generally,</p> <p>14 Dr. Skop. Can you think of any circumstances where the</p> <p>15 pregnant patient's health would be threatened but her</p> <p>16 life would not be where you believe abortion should be</p> <p>17 legal, any circumstance?</p> <p>18 A. There may be some.</p> <p>19 Q. Can you think of any as you sit here</p> <p>20 today?</p> <p>21 A. Not that can be taken care of with other</p> <p>22 procedures.</p> <p>23 Q. With induction, is that what you mean?</p> <p>24 A. Uh-huh.</p> <p>25 Q. Induction of a pre-viable fetus; is that</p>	<p style="text-align: right;">233</p> <p>1 abortions.</p> <p>2 Q. And so you said you've written an op-ed</p> <p>3 about Title X funding?</p> <p>4 A. I did.</p> <p>5 Q. Would it have mentioned Planned Parenthood</p> <p>6 in it?</p> <p>7 A. Possibly because they were the big topic of</p> <p>8 conversation about the Title X.</p> <p>9 Q. And was that on your CV?</p> <p>10 A. No.</p> <p>11 Q. No, it wasn't.</p> <p>12 You know the plaintiff in this case is</p> <p>13 Planned Parenthood Association of Utah, correct?</p> <p>14 A. Yes.</p> <p>15 Q. And so you didn't think that would be</p> <p>16 relevant to the case, to include on your CV?</p> <p>17 A. Truthfully, it never crossed my mind that</p> <p>18 people put op-eds on their CVs. I thought you wanted the</p> <p>19 big stuff.</p> <p>20 Q. All right. Have you ever participated in a</p> <p>21 protest outside of a Planned Parenthood health center?</p> <p>22 A. No.</p> <p>23 Q. What about another abortion provider?</p> <p>24 A. No.</p> <p>25 Q. Are you a member of any pro-life</p>

September 02, 2020

234	<p>1 organizations not listed on your CV?</p> <p>2 A. No.</p> <p>3 Q. Are you familiar with a fact sheet published</p> <p>4 by AAPLOG that focuses on fetal pain?</p> <p>5 A. Yes.</p> <p>6 Q. Let me go ahead and -- I think that is</p> <p>7 Tab N. So this will be -- we'll mark this as Exhibit 10.</p> <p>8 (Exhibit No. 10 was marked.)</p> <p>9 Q. And for the record, this is titled "AAPLOG</p> <p>10 Fact Sheet Fetal Pain," release date, February 13, 2019.</p> <p>11 Is that correct, Dr. Skop?</p> <p>12 A. Which tab was that?</p> <p>13 Q. Sorry. It is Tab N. N as in Nancy.</p> <p>14 A. Okay. I've got it.</p> <p>15 Q. Okay. And have you seen this document</p> <p>16 before?</p> <p>17 A. Yes.</p> <p>18 Q. Is it the fact sheet that AAPLOG has</p> <p>19 published?</p> <p>20 A. Yes.</p> <p>21 Q. Does it appear complete?</p> <p>22 A. Yes, it does.</p> <p>23 Q. Okay. And we've talked some about the</p> <p>24 portion of your expert report that deals with fetal pain</p> <p>25 today, correct?</p>	236	<p>1 opinion on fetal pain, do you believe that it reflects</p> <p>2 this same information?</p> <p>3 A. It probably does. It's been a while since</p> <p>4 I've looked at it, so I don't know if it is word for word</p> <p>5 what I wrote here or if it is -- it may -- it may be more</p> <p>6 comprehensive. It may have what other people have</p> <p>7 written too. I haven't looked at it.</p> <p>8 Q. So you've -- you didn't realize that you had</p> <p>9 authored this fact sheet; is that your testimony?</p> <p>10 A. I -- during the two years that I was</p> <p>11 involved on the board of AAPLOG, I wrote a number of</p> <p>12 statements. I lead the effort to produce practice</p> <p>13 bulletins and committee opinions and position statements</p> <p>14 because ACOG does that, and I thought that was a good</p> <p>15 format. So I was involved in several of those.</p> <p>16 The fact sheets, I thought that most of</p> <p>17 those were previous information, but, apparently, some of</p> <p>18 them are some of the new information as well.</p> <p>19 Q. Okay. So I just sent you a document -- are</p> <p>20 you able to access email right now?</p> <p>21 A. Uh-huh.</p> <p>22 Q. Can you check your email?</p> <p>23 MS. MURRAY: And I've actually sent this</p> <p>24 along to everyone else. My apologies it wasn't in the</p> <p>25 binder. Have you all received it?</p>
235	<p>1 A. Yes.</p> <p>2 Q. And if I recall what you said earlier,</p> <p>3 correct me if I'm wrong, the preparation of your expert</p> <p>4 report, you might have, you said, relied on some other</p> <p>5 personal notes that you have taken -- or, sorry, personal</p> <p>6 notes of yours that are not public in drafting it and</p> <p>7 potentially other AAPLOG policy statements or bulletins;</p> <p>8 is that correct?</p> <p>9 A. Just to clarify, this is what I wrote.</p> <p>10 AAPLOG had -- they had previous fact sheets that I drew</p> <p>11 information from, but clearly this is -- this is what is</p> <p>12 in the expert witness report because this -- when I was</p> <p>13 involved in updating stuff, I was thinking that it made</p> <p>14 it to the -- to the committee opinions, but apparently</p> <p>15 this -- what I wrote has also made it to this fact sheet.</p> <p>16 Q. So just to make sure that I understand. So</p> <p>17 I think you had said earlier that you didn't have</p> <p>18 involvement with any fact sheets; is that correct?</p> <p>19 A. I wasn't aware that they put what I wrote on</p> <p>20 a fact sheet as well, but it appears that they did.</p> <p>21 Q. And what was your understanding of what you</p> <p>22 wrote; where did that go?</p> <p>23 A. There's a committee opinion on fetal pain,</p> <p>24 and I think some of it is there as well.</p> <p>25 Q. And if we were to look at the committee</p>	237	<p>1 Actually, while we're waiting on that, I'm</p> <p>2 going to send something else.</p> <p>3 MR. SORENSON: I've received it Julie.</p> <p>4 MS. MURRAY: Okay. Great.</p> <p>5 Q. (By Ms. Murray) So the document that you</p> <p>6 were referring to, Dr. Skop, that you thought you were</p> <p>7 drafting language for, you thought that was the fetal</p> <p>8 pain practice bulletin; is that correct?</p> <p>9 A. It probably would have been a committee</p> <p>10 opinion.</p> <p>11 Q. Committee opinion, okay. But you don't have</p> <p>12 a copy of that?</p> <p>13 A. No.</p> <p>14 Q. I'm going to go ahead -- and since it sounds</p> <p>15 like you don't entirely recall what you thought you were</p> <p>16 drafting for, I am going to send -- I'm going to drop a</p> <p>17 link into the chat. And if -- that has a PDF that we can</p> <p>18 view as an exhibit.</p> <p>19 Okay. If we could go to this link, and</p> <p>20 we'll mark this -- so the last document -- let's see.</p> <p>21 The one that I just sent you by email let's mark as</p> <p>22 Exhibit 10. And then the document that I've sent through</p> <p>23 the chat, let's mark as Exhibit 11.</p> <p>24 And with respect --</p> <p>25 MS. FARRELL: Just one clarification. I</p>

September 02, 2020

<p style="text-align: right;">238</p> <p>1 have Tab N as Exhibit 10. 2 MS. MURRAY: Okay. So Exhibit 11 will be 3 the document I just sent by email, and Exhibit 12 will be 4 the link that I just dropped into the chat. 5 Q. (By Ms. Murray) So with respect to the 6 document that I just dropped into the chat, Dr. Skop, 7 have you been able to pull that up? 8 A. Yes. That is the practice bulletin. 9 (Exhibit No. 11 was marked.) 10 (Exhibit No. 12 was marked.) 11 Q. Is that -- now that you look at the 12 document, this is the practice bulletin from AAPLOG 13 called Evidence -- let's see. It is dated November 2017 14 on Fetal Pain; is that correct? 15 A. Yes. 16 Q. And this is the document you thought you 17 were drafting? 18 A. I didn't write this. 19 Q. Okay. So this is not your work? 20 A. Correct. 21 Q. And then the document that I just sent you 22 by email, I'll represent to you that that is a document 23 created by my office to compare the material in your 24 expert report to the material in the AAPLOG fact sheet, 25 so the material in Tab N that we've marked as Exhibit 10.</p>	<p style="text-align: right;">240</p> <p>1 Q. Not the research. The writing, Dr. Skop, is 2 it yours? 3 A. I believe it is. It looks like my 4 writing. 5 Q. In your expert report? 6 A. Yes. 7 Q. All of this is your writing? 8 A. I believe so. 9 Q. Did you draft every word of it? 10 A. You know, I can't recall. Like I say, I've 11 been making notes to myself for probably five to ten 12 years on different topics, so it is possible that I did 13 take some of this from someone's statement at some point. 14 I can't say that is not possible, but it is -- you know, 15 I just don't recall whether some of it came from another 16 researcher or not. 17 Q. But it is your testimony that you didn't 18 rely on this fact sheet when you were drafting your 19 expert report in this case; is that correct? 20 A. Again, I had this on documents that were my 21 private documents. I don't recall. I know I've done a 22 lot of writing for AAPLOG on a lot of these sheets. So I 23 don't recall if this all originated specifically with me. 24 Q. Do you believe that you're able to offer an 25 independent opinion in this case separate from the views</p>
<p style="text-align: right;">239</p> <p>1 Is that right? Yes. 2 That's a red line. Does that look correct 3 based on your review of your report and the AAPLOG fact 4 sheet provided to you? 5 A. So you're asking me if the email that you 6 sent which is very similar to mine with a few additions 7 and subtractions -- you're asking me if this is what I 8 wrote? 9 Q. Yes. 10 A. This is very similar -- 11 Q. And just for the record, is it your 12 testimony, then, that this language on fetal pain is 13 yours? 14 A. I believe so. You know, I may have gotten 15 some of the these statements from other places as well. 16 Like I say, what I've tended to do you is right notes to 17 myself, write papers, you know, to help myself 18 understand. And then when the opportunities came to do 19 expert witness, I would bring that information into the 20 expert witness report. 21 Q. So is it your testimony, then, that the 22 material on fetal pain in your expert report may not have 23 originated with you? 24 A. Well, a lot of it did originate with other 25 experts, yeah. I mean, I didn't do this research myself.</p>	<p style="text-align: right;">241</p> <p>1 of AAPLOG? 2 A. Yes, I've done a lot of independent 3 research. 4 Q. And throughout the day, you've referred, 5 sometimes, to authors or researchers who perform 6 abortions. Is it your view that individuals who perform 7 abortions are inherently biased as experts? 8 A. It is my view that that is the case. I will 9 acknowledge that AAPLOG also has a bias. I would love it 10 if a nonbiased organization wanted to dig into the truth 11 of abortion, but there doesn't really seem to be anybody 12 who is interested in doing that in a nonbiased way. 13 Q. To be clear, the document that I just sent 14 you, Exhibit 11, the compare document between your expert 15 report and the AAPLOG fact sheet, would you say that the 16 vast majority of this language is identical in the two 17 documents? 18 A. It is very similar, yes. 19 Q. So your view and AAPLOG's view are one with 20 in the same? 21 A. AAPLOG is where I got a lot of my 22 information. 23 Q. But you didn't cite it in your expert 24 report, correct? 25 A. I didn't cite AAPLOG -- well, I mean, it was</p>

September 02, 2020

<p style="text-align: right;">242</p> <p>1 in my CV that I was a member.</p> <p>2 Q. No. But in your expert report, it was not a</p> <p>3 source that you cited, correct?</p> <p>4 A. Well, remember I said that when I -- I did</p> <p>5 look at some intermediate documents that were -- but then</p> <p>6 I went to the neurologic literature to cite where those</p> <p>7 statements actually came from.</p> <p>8 Q. But it is not -- in terms of what you</p> <p>9 revealed in your CV that you had considered in</p> <p>10 preparation of your expert report, you didn't cite</p> <p>11 AAPLOG, did you?</p> <p>12 A. I guess not.</p> <p>13 Q. No. And I asked you earlier whether you had</p> <p>14 made every effort to include in your expert report the</p> <p>15 facts and data that you relied upon, correct?</p> <p>16 A. That's correct.</p> <p>17 Q. Would you say you overlooked this one?</p> <p>18 A. I did overlook this one, yeah, because I</p> <p>19 thought it would be more important to go directly to the</p> <p>20 studies.</p> <p>21 Q. Do you think a court might consider -- as</p> <p>22 you said, AAPLOG has a bias. Would you be concerned that</p> <p>23 a reader might believe your expert report is less</p> <p>24 reliable if you relied on AAPLOG?</p> <p>25 A. Not necessarily, if they go to the</p>	<p style="text-align: right;">244</p> <p>1 Q. What other projects have you done for the</p> <p>2 Charlotte Lozier Institute?</p> <p>3 A. I did some -- I did a statement on maternal</p> <p>4 mortality that was presented at a congressional</p> <p>5 briefing.</p> <p>6 Q. Okay. Is that on your CV?</p> <p>7 A. No.</p> <p>8 Q. Okay. Did you think that that might be</p> <p>9 relevant to this case the in the scope of your expert</p> <p>10 testimony?</p> <p>11 A. Well, I thought that the CV just wanted</p> <p>12 publications that were peer reviewed. I didn't</p> <p>13 intentionally leave those off. But, you know, like I</p> <p>14 said, I didn't think it was important enough to put on</p> <p>15 here.</p> <p>16 Q. Okay. Do you -- you mentioned that you have</p> <p>17 been paid by the Charlotte Lozier Institute, and is that</p> <p>18 affiliated with AAPLOG?</p> <p>19 A. No.</p> <p>20 Q. Is it affiliated with any other pro-life</p> <p>21 organizations?</p> <p>22 A. I believe it is affiliated with Susan B.</p> <p>23 Anthony List.</p> <p>24 Q. All right. Any other projects that you've</p> <p>25 done for the Charlotte Lozier Institute that you can</p>
<p style="text-align: right;">243</p> <p>1 neurologic literature.</p> <p>2 Q. Okay. And then the document that I just</p> <p>3 dropped into the chat, have you -- let's see. We've</p> <p>4 introduced that one. That was Exhibit 12.</p> <p>5 A. That was the practice bulletin.</p> <p>6 Q. Okay. And that, you said, was not your</p> <p>7 work, correct?</p> <p>8 A. That's correct.</p> <p>9 Q. Okay. What about -- do you have any prior</p> <p>10 existing contracts with AAPLOG for any services of any</p> <p>11 kind?</p> <p>12 A. No, I have not received any money or</p> <p>13 contribution.</p> <p>14 Q. Do you have money from any other pro-life</p> <p>15 organizations?</p> <p>16 A. On occasion I will be paid for work that</p> <p>17 I've done for Charlotte Lozier, but it is usually on a</p> <p>18 project basis.</p> <p>19 Q. Okay. And what kind of projects do you do</p> <p>20 for them.</p> <p>21 A. I wrote a paper on "No Test Medical</p> <p>22 Abortion."</p> <p>23 Q. And just to confirm, that is not in your CV,</p> <p>24 correct?</p> <p>25 A. Yes, it is not in my CV.</p>	<p style="text-align: right;">245</p> <p>1 recall?</p> <p>2 A. No.</p> <p>3 Q. Okay. So you've now told me all the</p> <p>4 projects you've done for them. There were two?</p> <p>5 A. Those are the only two things I've been paid</p> <p>6 for. Oh, I -- you know, two of these articles, the two</p> <p>7 that were written by Studnicki, those are some Charlotte</p> <p>8 Lozier researchers as well. So I collaborated on those</p> <p>9 two papers.</p> <p>10 Q. Okay. Were you paid for those?</p> <p>11 A. No.</p> <p>12 Q. And can we go to Tab O?</p> <p>13 Before we go on, you mentioned you looked at</p> <p>14 these documents for about 15 minutes last night, the</p> <p>15 documents I sent as exhibits. Did you look at this</p> <p>16 AAPLOG fact sheet last night?</p> <p>17 A. I glanced and saw it was in there. I didn't</p> <p>18 reread it.</p> <p>19 Q. Okay. So Tab O I will mark as Exhibit 13.</p> <p>20 This is entitled "Medical Abortion: What Physicians Need</p> <p>21 to Know" authored by you.</p> <p>22 A. That is correct.</p> <p>23 (Exhibit No. 13 was marked.)</p> <p>24 Q. Does it appear complete?</p> <p>25 A. Yes, it does.</p>

246	<p>1 Q. And is this one of the articles that was</p> <p>2 peer reviewed?</p> <p>3 A. Yes, this was -- this was peer reviewed.</p> <p>4 Q. Okay. And then if we could go to --</p> <p>5 actually, let's stay with this. So did you author this</p> <p>6 article, Dr. Skop?</p> <p>7 A. Yes, I did.</p> <p>8 Q. You wrote all of it?</p> <p>9 A. Yes.</p> <p>10 Q. Can we go to Tab P, please? Are you</p> <p>11 there?</p> <p>12 A. Yes.</p> <p>13 Q. So we'll mark Tab P as Exhibit 14.</p> <p>14 (Exhibit No. 14 was marked.)</p> <p>15 Q. And Tab P is the expert report of Byron C.</p> <p>16 Calhoun and this case, correct?</p> <p>17 A. Yes.</p> <p>18 Q. And you said you had seen this last night</p> <p>19 for the first time is that correct?</p> <p>20 A. That's correct.</p> <p>21 Q. Can you look at paragraph 73 and 74? It</p> <p>22 says, "However, when one examines the research studies,</p> <p>23 NAS, the National Academies of Sciences, used for their</p> <p>24 conclusions, the poor quality of the literature regarding</p> <p>25 long-term complications becomes apparent.</p>	248	<p>1 Q. These passages are identical, aren't they?</p> <p>2 A. They sound identical, yes.</p> <p>3 Q. It is your testimony that you wrote this?</p> <p>4 A. You know, I don't recall if I wrote that</p> <p>5 statement or if maybe I got it from something I read that</p> <p>6 Byron wrote. It is hard to know, or possibly we both got</p> <p>7 it from a statement that someone else wrote. I don't</p> <p>8 recall exactly.</p> <p>9 Q. Would you agree that at least one of you</p> <p>10 must have taken someone else's work and presented it as</p> <p>11 your own?</p> <p>12 A. I mean, certainly it is the same couple of</p> <p>13 sentences. I don't think that this means that either one</p> <p>14 of us did not come to this conclusion independently.</p> <p>15 Q. Okay. Why don't we -- let's see.</p> <p>16 Can you actually take a look at the</p> <p>17 exhibit --</p> <p>18 MS. MURRAY: Leah, can you correct me? Is</p> <p>19 Exhibit O the Medical Abortion -- or Exhibit 13 is</p> <p>20 Medical abortion?</p> <p>21 MS. FARRELL: That is correct. Tab O or</p> <p>22 Exhibit 13.</p> <p>23 Q. (By Ms. Murray) If you look at Exhibit 13</p> <p>24 down there on the bottom, it says the name of the</p> <p>25 journal, and it says Number 4 Winter 2019; is that</p>
247	<p>1 "For many questions, there were very few or</p> <p>2 no studies that met their criteria, and they disqualified</p> <p>3 many studies (especially those regarding mental health)</p> <p>4 due to perceived study defects. Thus, in all cases,</p> <p>5 there were fewer than a handful of studies on which they</p> <p>6 based their definitive conclusion of 'no long-term</p> <p>7 impact.' The sparse selection of studies does not</p> <p>8 support conclusions as definite as those drawn by the</p> <p>9 NAS."</p> <p>10 Did I read that correctly?</p> <p>11 A. Yes, ma'am.</p> <p>12 Q. And now can we look back at your medical</p> <p>13 abortion article on page 110, the last full paragraph on</p> <p>14 the left column? And I'll read that there. At the very</p> <p>15 end of the paragraph, it says, "However, when one</p> <p>16 examines the research studies they used for their</p> <p>17 conclusions, poor quality of the literature regarding</p> <p>18 long-term complications becomes apparent. For many</p> <p>19 questions, there were very few or no studies that met</p> <p>20 their stringent criteria, and they disqualified many</p> <p>21 studies to perceived study defects. Thus, in all cases,</p> <p>22 there were less than five studies on which they based</p> <p>23 their definitive conclusion of 'no long-term impact.'"</p> <p>24 Did I read that correctly?</p> <p>25 A. Yes, ma'am.</p>	249	<p>1 correct?</p> <p>2 A. Yes.</p> <p>3 Q. Do you think that means that it is the</p> <p>4 fourth issue in the year 2019?</p> <p>5 A. That's probable.</p> <p>6 Q. So this would have come out after the expert</p> <p>7 reports in this case were submitted, correct?</p> <p>8 A. I -- it may have been concordant with the</p> <p>9 report. This article I wrote based on a talk that I gave</p> <p>10 at their conference in September of last year.</p> <p>11 Q. Okay. Do you expect this journal would have</p> <p>12 published something it knew to be identical to another</p> <p>13 source from a different author?</p> <p>14 A. You mean that a two sentence identical --</p> <p>15 Q. Three sentences. And I will represent to</p> <p>16 you I haven't actually pulled all of the examples. But</p> <p>17 assuming it is three sentences, do you think this journal</p> <p>18 would have published something that it knew to be</p> <p>19 identical to another source from a different author?</p> <p>20 A. I don't know. The content in the article is</p> <p>21 unique.</p> <p>22 Q. These three sentences are unique?</p> <p>23 A. Admittedly, they're the same as what Byron</p> <p>24 has in his report, but the article itself, I have not</p> <p>25 seen anything that brings all this information together</p>

September 02, 2020

250	<p>1 in a similar sort of article.</p> <p>2 Q. Dr. Skop, do you believe that articles need</p> <p>3 to be identical in order for one author to have</p> <p>4 plagiarized from another?</p> <p>5 A. No, but I guess I'm questioning what -- what</p> <p>6 the concern about plagiarism is.</p> <p>7 Q. Because you think plagiarism is not a --</p> <p>8 well, you say you're questioning that. Why?</p> <p>9 A. Well, can you explain to me your concern?</p> <p>10 Q. Let me ask the question a different way. Do</p> <p>11 you have any concerns about plagiarism in your work?</p> <p>12 A. I haven't, no.</p> <p>13 Q. You haven't had any concerns to date. Do</p> <p>14 you believe within the medical research community that</p> <p>15 plagiarism is a -- well, let me ask you this: Within the</p> <p>16 medical research community, do you believe that</p> <p>17 plagiarism is an accepted practice among authors?</p> <p>18 A. I wouldn't think so.</p> <p>19 Q. And would you expect that a peer reviewed</p> <p>20 article would want only material that is original to the</p> <p>21 author whose publication is being published?</p> <p>22 A. Yes, I would assume that they do want that.</p> <p>23 Q. Okay.</p> <p>24 A. I'm just not sure what this small portion --</p> <p>25 what you think it represents. Do you think it makes the</p>
251	<p>1 article not useful or informative if there is a small --</p> <p>2 I mean, probably what happened --</p> <p>3 Q. Dr. Skop, because I know we do have a</p> <p>4 limited amount of time, do you believe that identical</p> <p>5 republishing of material from another author without</p> <p>6 attribution is consistent with standards of academic</p> <p>7 integrity in your field?</p> <p>8 A. I did not intentionally reproduce anybody</p> <p>9 else's work.</p> <p>10 Q. That's not my question. My question is, do</p> <p>11 you believe that identical republication of material from</p> <p>12 another author without attribution is consistent with</p> <p>13 standards of academic integrity in your field?</p> <p>14 A. I don't consider this plagiarism.</p> <p>15 Q. Dr. Skop, you paused there, didn't you?</p> <p>16 A. Well, I'm just thinking it all through,</p> <p>17 but. . .</p> <p>18 Q. So let the record reflect there was a long</p> <p>19 pause. I'll ask my question again. Do you believe that</p> <p>20 identical republication of material from another author</p> <p>21 without attribution is consistent with standards of</p> <p>22 academic integrity in your field?</p> <p>23 A. I need to -- I need to research that. I'm</p> <p>24 not sure what -- what the standards say about that.</p> <p>25 Q. Okay. And do you -- where would you turn to</p>
252	<p>1 figure out what the standards are? What do you consider</p> <p>2 standards of academic integrity in your field?</p> <p>3 A. I'll have to do some research.</p> <p>4 Q. Okay. All right. Can we go back to Tab E?</p> <p>5 So this would be Exhibit 8, your article, "Abortion</p> <p>6 Safety: At Home and Abroad."</p> <p>7 A. Which tab did you say that was again?</p> <p>8 Q. It is Tab E, as in elephant.</p> <p>9 A. Okay.</p> <p>10 Q. Are you there?</p> <p>11 A. Uh-huh.</p> <p>12 Q. I believe it was your testimony earlier,</p> <p>13 Dr. Skop, that you wrote this entire article, correct?</p> <p>14 A. That's correct.</p> <p>15 Q. And you're the only author listed,</p> <p>16 correct?</p> <p>17 A. That is correct.</p> <p>18 Q. Okay. Can we take a look at page 50, the</p> <p>19 first full paragraph? There's a sentence in there. It</p> <p>20 says, "Instrumental trauma of the uterus may result in</p> <p>21 faulty adherence of the placenta in subsequent</p> <p>22 pregnancies, resulting in chronic abruption or placenta</p> <p>23 previa/accreta/increta (invasion of the placenta into the</p> <p>24 cervix, uterine wall, or other adjacent organs)." Is</p> <p>25 that correct?</p>
253	<p>1 A. That's correct.</p> <p>2 Q. Can we now take a look at Exhibit P --</p> <p>3 Exhibit 14, Tab P. This is the Calhoun report. Can you</p> <p>4 take a look at paragraph 52.</p> <p>5 Are you there?</p> <p>6 A. Not quite. Fifty-two you said?</p> <p>7 Q. Uh-huh.</p> <p>8 A. Okay.</p> <p>9 Q. Are you there now?</p> <p>10 A. Yes, ma'am.</p> <p>11 Q. And it says, "Instrumental trauma to the</p> <p>12 uterus in a surgical abortion may lead to faulty</p> <p>13 adherence of the placenta in subsequent pregnancies.</p> <p>14 That, in turn, may result in chronic abruption or</p> <p>15 placenta previa/accreta/increta (invasion of the placenta</p> <p>16 into the cervix, uterine wall, or other adjacent</p> <p>17 organs)."</p> <p>18 Those are nearly identical, aren't they?</p> <p>19 A. Yes.</p> <p>20 Q. Now can you turn back to your article? So</p> <p>21 this would be Exhibit 8, Tab E, on page 50, the second</p> <p>22 full paragraph.</p> <p>23 A. We're going back to the safety article?</p> <p>24 Q. Yes. Tab E, page 50.</p> <p>25 A. Okay.</p>

September 02, 2020

<p style="text-align: right;">254</p> <p>1 Q. And the second full paragraph says, "One 2 meta-analysis found that there was a 25 percent increased 3 risk of premature birth in a subsequent pregnancy after 4 one abortion, 32 percent after more than one, and 5 51 percent after more than two abortions. Likewise, 6 another meta-analysis found a 35 percent increased risk 7 of delivery of a very low birthweight infant after one 8 abortion and 72 percent after two or more abortions." 9 Did I read that correctly? 10 A. Yes. 11 Q. And now can we go to the Calhoun report? So 12 this would be Exhibit P -- sorry, Tab P, Exhibit 14, 13 paragraph 50. 14 A. Okay. 15 Q. It says, midway down the paragraph, "One 16 meta-analysis found that there was a 25 percent increased 17 risk of premature birth in a subsequent pregnancy after 18 one abortion, 32 percent after more than one, and 51 19 percent after more than two abortions." Citing Swingle 20 et al., 2019. "Likewise, another meta-analysis found a 21 35 percent increased risk of delivery of a very low 22 birthweight infant after one abortion, and 72 percent 23 after two or more abortions." Citing Liao et al., 2011. 24 Did I read that correctly? 25 A. Yes, ma'am.</p>	<p style="text-align: right;">256</p> <p>1 "Joyful events (such as the birth of a child) are 2 associated with improvement in health and well-being. 3 Stress and guilt accompanying voluntary or spontaneous 4 pregnancy loss may adversely impact a woman's health and 5 well-being. In addition, motherhood may have a 6 protective emotional effect, whereas an abortion may have 7 a deleterious emotional effect, leading to greater 8 risk-taking activities. The phenomenon of abortion 9 patients committing suicide on anniversaries connected to 10 the abortion is well-documented as well. It is evident 11 that a suicide on the anniversary of an abortion should 12 be linked to that pregnancy outcome, but none of the 13 maternal mortality categories allow that late 14 connection." 15 Those are nearly identical, correct? Those 16 two passages? 17 A. Yes, they are. 18 Q. Dr. Skop, who wrote these two passages -- 19 who wrote these passages that we've been discussing in 20 your article and in Dr. Calhoun's report? 21 A. I believe that the part about the placenta 22 accreta came from my article on maternal mortality. It 23 is -- I think some of these others probably came from 24 different papers on the AAPLOG website. 25 Q. Okay. In terms of who wrote these passages,</p>
<p style="text-align: right;">255</p> <p>1 Q. And with the exception of the citations, 2 those are identical, correct? 3 A. Yes. 4 Q. Okay. And then let's go back to your 5 report. This would be Exhibit 8, Tab E, page 56. 6 A. Okay. 7 Q. And you say, in the second full paragraph -- 8 the second sentence starts, "Joyous events (such as the 9 birth of a child) have been associated with improvement 10 in health and well-being, and likewise the stress and 11 guilt that can accompany a pregnancy loss may adversely 12 impact a woman's health. In addition, motherhood may 13 have protective emotional effect, whereas an abortion may 14 have a deleterious emotional effect, leading to greater 15 risk-taking activities. It is evident that a suicide on 16 the anniversary of a coerced abortion or stillbirth 17 should be linked to that pregnancy outcome, but none of 18 these definitions will make that connection." 19 Did I read that correctly? 20 A. Yes, ma'am. 21 Q. And then if we could go back to Exhibit 14, 22 Tab P, paragraph 56 of Dr. Calhoun's report. 23 Are you there? 24 A. Yes, ma'am. 25 Q. So the third sentence in this one says,</p>	<p style="text-align: right;">257</p> <p>1 your best guess would be neither of you; is that correct? 2 A. I don't recall to tell you the truth. I've 3 written a lot. I may have written some of these; I may 4 have taken them from something somebody else wrote. You 5 know, I don't -- I can't tell you for sure where they all 6 came from. 7 Q. Would you agree that one of you must have 8 copied them from the other or someone else? 9 A. Well, clearly they -- because they're 10 written -- or they're worded identically, they came from 11 the same source, whether, you know, I took it from him, 12 he took it from me, or we both took it from another 13 source. I don't know. The -- you know, the wording, 14 obviously, is identical. But I think that we all have 15 had our independent reports looking at these issues. 16 Q. And just to ask you -- with respect to the 17 "Abortion Safety: At Home and Broad," so that's Tab E, 18 Exhibit 8. 19 A. Uh-huh. 20 Q. To confirm, I may have asked you this, and 21 if so, I apologize. This also is in a peer-reviewed 22 publication; is that correct? 23 A. Yes. 24 Q. And do you expect that this publication 25 would have published something that they knew to include</p>

September 02, 2020

258	<p>1 language that originated with another author without</p> <p>2 attribution?</p> <p>3 A. You know, again, I guess it's been a long</p> <p>4 time since I've dealt with the definition. I thought</p> <p>5 that if the ideas were unique that I didn't realize that</p> <p>6 it was a problem to lift a couple of sentences here and</p> <p>7 there. I don't know what the rules are for these</p> <p>8 journals, how they feel about that.</p> <p>9 Q. If I were to tell you that the definition of</p> <p>10 plagiarism is the practice of taking someone else's work</p> <p>11 or ideas and passing them off as one's own, would you</p> <p>12 agree that either you, Dr. Calhoun, or both of you</p> <p>13 engaged in plagiarism?</p> <p>14 A. These are a couple of sentences at a time.</p> <p>15 I thought that plagiarism meant that you'd taken, like, a</p> <p>16 work, like, you know, a unique idea and said, I had this</p> <p>17 idea. I didn't realize that, you know, using wording</p> <p>18 from a paper that you agreed with qualified as</p> <p>19 plagiarism.</p> <p>20 Q. So is it possible that all of your</p> <p>21 publications include sentences or paragraphs that</p> <p>22 originated from someone else that are not attributed to</p> <p>23 them?</p> <p>24 A. It is possible that is the case. When I</p> <p>25 write, I make notes to myself. Sometimes I do take down</p>	260	<p>1 A. Yes, ma'am.</p> <p>2 Q. And you're affiliated with them?</p> <p>3 A. Yes.</p> <p>4 Q. And what's your role, again, there?</p> <p>5 A. I'm the chairman of the board.</p> <p>6 Q. Okay. And was it Any Woman Can that you</p> <p>7 mentioned as evidence of your expertise with respect to</p> <p>8 mental health issues or was that The Source?</p> <p>9 A. It was Any Women Can in my clinical</p> <p>10 experience.</p> <p>11 Q. Any Woman Can. Is it "any women" or "any</p> <p>12 woman"?</p> <p>13 A. "Woman," singular.</p> <p>14 Q. Okay. Any Woman Can. So would you agree</p> <p>15 that you're closely involved with the activities of Any</p> <p>16 Woman Can?</p> <p>17 A. Yes.</p> <p>18 Q. Okay. So is Any Woman Can located near a</p> <p>19 clinic that provides abortions --</p> <p>20 A. No, it is not.</p> <p>21 Q. -- To your knowledge?</p> <p>22 Does it employ medical professionals?</p> <p>23 A. Yes, we have two nurses.</p> <p>24 Q. Any doctors?</p> <p>25 A. We have a medical director, but they're</p>
259	<p>1 a sentence or two word for word if I think it is written</p> <p>2 well. And then when I've put papers together, I've</p> <p>3 probably forgot that I was not the original author of</p> <p>4 that. It was certainly not intentional.</p> <p>5 Q. So do you believe that taking sentences</p> <p>6 directly from someone else's work or from someone else's</p> <p>7 publication constitutes taking someone else's work?</p> <p>8 A. I never really thought about it in the</p> <p>9 context of a sentence or two.</p> <p>10 Q. Now that you are thinking about it, do you</p> <p>11 think it constitutes the taking of someone else's work if</p> <p>12 you copy entire sentences from other authors?</p> <p>13 A. I mean, certainly it is the taking of a</p> <p>14 sentence, but I don't know how serious that is.</p> <p>15 Q. And would you agree that a written sentence</p> <p>16 that you create is your work?</p> <p>17 A. Well, if it is a written sentence that I've</p> <p>18 written it is my work, yes.</p> <p>19 Q. Okay.</p> <p>20 MS. MURRAY: Do you feel like you need a</p> <p>21 break?</p> <p>22 THE WITNESS: I'm okay. I can keep going.</p> <p>23 Q. (By Ms. Murray) So you're affiliated -- I</p> <p>24 believe you talked earlier about an organization called</p> <p>25 Any Woman Can, correct?</p>	261	<p>1 not -- he's not employed.</p> <p>2 Q. So you have volunteers?</p> <p>3 A. Right.</p> <p>4 Q. Is he on site?</p> <p>5 A. You know, we have two other physician</p> <p>6 volunteers, so we frequently have physicians on site.</p> <p>7 Q. How often would you say that happens?</p> <p>8 A. Probably several times a week.</p> <p>9 Q. Okay. And does Any Woman Can confirm</p> <p>10 pregnancy?</p> <p>11 A. Yes.</p> <p>12 Q. Does it -- how does it confirm pregnancy;</p> <p>13 what kind of tests?</p> <p>14 A. Urine pregnancy test and ultrasound.</p> <p>15 Q. So urine pregnancy test. Is that, like, the</p> <p>16 kind of test you would get from a drugstore?</p> <p>17 A. I don't know if it is. It is probably a</p> <p>18 higher sensitivity, but similar.</p> <p>19 Q. So you don't know whether they use any -- a</p> <p>20 pregnancy test that's any different from what you would</p> <p>21 buy in a drugstore?</p> <p>22 A. I don't know which one they use</p> <p>23 specifically, no.</p> <p>24 Q. Okay. So it could be the same kind of</p> <p>25 pregnancy test that you could get in a drugstore; is that</p>

September 02, 2020

<p style="text-align: right;">262</p> <p>1 correct?</p> <p>2 A. It could be.</p> <p>3 Q. Okay. And you said that they do ultrasounds</p> <p>4 as well?</p> <p>5 A. Yes.</p> <p>6 Q. What's the purpose of the ultrasound?</p> <p>7 A. To document the pregnancy.</p> <p>8 Q. Okay. Can they date pregnancies?</p> <p>9 A. Yes.</p> <p>10 Q. How do they date them?</p> <p>11 A. Generally pregnancy dating is based upon the</p> <p>12 last menstrual period and correlation with the</p> <p>13 ultrasound. If there's a discrepancy between the two,</p> <p>14 then sometimes the dating changes to correspond to the</p> <p>15 ultrasound.</p> <p>16 Q. Sorry, I should have been more specific.</p> <p>17 What kind of measurements do they use to</p> <p>18 date the ultrasound? Is it the same -- do they rely on</p> <p>19 the same measurements that you would use in your private</p> <p>20 practice?</p> <p>21 A. Yes, they do.</p> <p>22 Q. Okay. The same exact ones?</p> <p>23 A. Yes.</p> <p>24 Q. Okay. What about the -- are they able to</p> <p>25 diagnose ectopic pregnancies?</p>	<p style="text-align: right;">264</p> <p>1 like, an ectopic pregnancy; is that correct?</p> <p>2 A. That would be our recommendation.</p> <p>3 Q. So if you had a patient who came to you with</p> <p>4 an ultrasound from Any Woman Can, would you rely on it in</p> <p>5 your practice for the first prenatal visit?</p> <p>6 A. I generally repeat it myself. Not because I</p> <p>7 don't trust Any Woman Can ultrasounds. I feel that</p> <p>8 they're well trained, but I generally do it mostly as a</p> <p>9 bonding experience with the patient.</p> <p>10 Q. Uh-huh. And are there -- is that true of</p> <p>11 all ultrasounds that patients bring to you in your</p> <p>12 private practice; do you always repeat them anyway?</p> <p>13 A. Yeah, I probably do. Depending on their</p> <p>14 gestational age, I may wait. If they bring me an</p> <p>15 ultrasound and they arrive to me at the point where I can</p> <p>16 hear the baby's heart beat, I may document it that way</p> <p>17 and then do the next indicated ultrasound at the time it</p> <p>18 is due.</p> <p>19 Q. And would you say you are more likely to</p> <p>20 rely on that ultrasound if it has come from another</p> <p>21 doctor?</p> <p>22 A. Not necessarily. I think the ultrasounds</p> <p>23 that Any Woman Can does are well done. Some of the</p> <p>24 physicians that volunteer do the ultrasounds, and the</p> <p>25 nurses that do them have been well trained by a</p>
<p style="text-align: right;">263</p> <p>1 A. They know what to look for. If there was a</p> <p>2 suspicion of an ectopic pregnancy, they would have it</p> <p>3 confirmed with a doctor.</p> <p>4 Q. When a patient comes to your private</p> <p>5 practice for their first prenatal care appointment, do</p> <p>6 you do an ultrasound at that time?</p> <p>7 A. I generally do.</p> <p>8 Q. Uh-huh, and are you able to diagnose ectopic</p> <p>9 pregnancies?</p> <p>10 A. Generally, yes.</p> <p>11 Q. At the time of the appointment, correct?</p> <p>12 A. Uh-huh.</p> <p>13 Q. What about molar pregnancies?</p> <p>14 A. They have a characteristic appearance on</p> <p>15 ultrasound, so often we can diagnose it with ultrasound</p> <p>16 and sometimes blood -- or pathology is needed.</p> <p>17 Q. What about Any Woman Can, are they able to</p> <p>18 diagnose molar pregnancies?</p> <p>19 A. They are trained to recognize abnormalities.</p> <p>20 And, again, they would have it verified with a</p> <p>21 physician.</p> <p>22 Q. So if you saw them and you had an ultrasound</p> <p>23 that looked irregular, they could can confirm your</p> <p>24 pregnancy, but you would have to go see someone else to</p> <p>25 actually get a confirmation of a problematic pregnancy,</p>	<p style="text-align: right;">265</p> <p>1 physician.</p> <p>2 Q. Can you ever recall relying on an ultrasound</p> <p>3 from Any Woman Can in your private practice instead of</p> <p>4 repeating it yourself?</p> <p>5 A. There have been occasions where I have not</p> <p>6 repeated it right away.</p> <p>7 Q. The majority of the time, would you say that</p> <p>8 you repeat it?</p> <p>9 A. Ultimately they get a repeat ultrasound, but</p> <p>10 maybe not necessarily on the first visit.</p> <p>11 Q. Okay. Can Any Woman Can draw blood?</p> <p>12 A. They don't draw blood right now. We have a</p> <p>13 partnership with the Metropolitan Health Department, and</p> <p>14 Metro Health comes up periodically to draw HIV, syphilis,</p> <p>15 some of the STI labs.</p> <p>16 Q. So they'll come on site to Any Woman Can, or</p> <p>17 do individuals who seek care at Any Woman Can have to go</p> <p>18 to another location to obtain a blood draw?</p> <p>19 A. They come on site they also have a mobile</p> <p>20 van.</p> <p>21 Q. I see. But the staff -- I'm sorry?</p> <p>22 A. I said everything slowed down with COVID but</p> <p>23 they have had --</p> <p>24 Q. And the staff with Any Woman Can, they,</p> <p>25 though, are not able to draw blood; is that correct?</p>

September 02, 2020

<p style="text-align: right;">266</p> <p>1 A. We don't do that currently.</p> <p>2 Q. Okay.</p> <p>3 A. As we expand our services, we may.</p> <p>4 Q. Uh-huh. So if someone came in to Any Woman</p> <p>5 Can on a day when Metro Health wasn't present and wanted</p> <p>6 to obtain STI testing, what would Any Woman Can tell</p> <p>7 them? Would it be able to do full STI testing that day?</p> <p>8 A. We can do the gonorrhea and chlamydia,</p> <p>9 detected in the urine, and we'd bring them back on a day</p> <p>10 we were drawing blood.</p> <p>11 Q. So they would have to come in twice for a</p> <p>12 full STI screening?</p> <p>13 A. If they wanted all that. A lot of them</p> <p>14 don't necessarily want the blood.</p> <p>15 Q. In your private office, are you able to do a</p> <p>16 full STI screening on a single appointment?</p> <p>17 A. We have a full-time lab, yes.</p> <p>18 Q. Okay. If individuals who suspect or know</p> <p>19 they're pregnant when they call Any Woman Can to ask --</p> <p>20 if they ask whether they can obtain an abortion there,</p> <p>21 does Any Woman Can tell them no?</p> <p>22 A. We tell them, No, we do not perform or refer</p> <p>23 for abortions.</p> <p>24 Q. And do you tell them that at the time of the</p> <p>25 call?</p>	<p style="text-align: right;">268</p> <p>1 A. It is generally very quick. I believe we</p> <p>2 can get them in that day. We usually have staff there to</p> <p>3 do that.</p> <p>4 Q. Okay. Let me ask you -- can we turn to --</p> <p>5 this is going to be Tab L, and we'll mark it as</p> <p>6 Exhibit 15.</p> <p>7 (Exhibit No. 15 was marked.)</p> <p>8 A. Okay.</p> <p>9 Q. So on page -- let's see. On page 4 of 7,</p> <p>10 and the page numbering on this is kind of small. It</p> <p>11 says, "Free first trimester ultrasound"?</p> <p>12 A. Uh-huh.</p> <p>13 Q. It says, "An ultrasound can answer several</p> <p>14 questions that may give you some clarity if you're</p> <p>15 considering having an abortion"; is that correct?</p> <p>16 A. Yes.</p> <p>17 Q. Did I read that correctly?</p> <p>18 A. Yes.</p> <p>19 Q. But you testified earlier that typically if</p> <p>20 someone obtains an ultrasound at Any Woman Can, if they</p> <p>21 then go for another abortion -- sorry, if they then see a</p> <p>22 doctor in your private practice that you would typically</p> <p>23 perform the ultrasound over again, correct?</p> <p>24 A. That's what I would typically do, but not</p> <p>25 necessarily all the time.</p>
<p style="text-align: right;">267</p> <p>1 A. If they ask, yes.</p> <p>2 Q. So if a patient called Any Woman Can and</p> <p>3 said, Can you provide an abortion, the staff would</p> <p>4 directly tell them, No, we don't provide abortion here,</p> <p>5 or would you have to come in for an appointment to obtain</p> <p>6 that information?</p> <p>7 A. I think if they asked them straight out they</p> <p>8 would tell them that we don't do them.</p> <p>9 Q. Okay. And if someone called and said, I'm</p> <p>10 interested -- I'm thinking about having an abortion; I</p> <p>11 think I'm pregnant, would Any Woman Can tell the</p> <p>12 individual that an abortion could not be received at Any</p> <p>13 Woman Can?</p> <p>14 A. I think what we would do is tell them that</p> <p>15 we can offer options, counseling, and schedule them for</p> <p>16 an appointment.</p> <p>17 Q. But you wouldn't tell them at the time of</p> <p>18 the call, unless they directly asked, that Any Woman Can</p> <p>19 does not provide abortion, correct?</p> <p>20 A. I believe that that is not the policy, to</p> <p>21 offer that information if they don't ask.</p> <p>22 Q. If they don't ask, okay.</p> <p>23 And when you -- do you know what the wait</p> <p>24 time is to get an appointment for a pregnancy test at Any</p> <p>25 Woman Can?</p>	<p style="text-align: right;">269</p> <p>1 Q. But typically you would perform the</p> <p>2 ultrasound again, correct?</p> <p>3 A. Uh-huh.</p> <p>4 Q. Is that correct?</p> <p>5 A. That's correct. Not because I don't trust</p> <p>6 Any Woman Can's ultrasound; because I like to do ultra</p> <p>7 sounds with my patients on their first visit.</p> <p>8 Q. I understand.</p> <p>9 A. They get to see the baby, and I think it is</p> <p>10 a nice kind of way to bond with them.</p> <p>11 Q. So you would typically perform the</p> <p>12 ultrasound again?</p> <p>13 A. Yes.</p> <p>14 Q. Well, let me ask this not specific to you.</p> <p>15 But are OB/GYNs competent to provide options, counseling,</p> <p>16 to patients about their options if they have an unplanned</p> <p>17 pregnancy?</p> <p>18 A. I think so.</p> <p>19 Q. So they could get the services of Any Woman</p> <p>20 Can with respect -- patients could get the services of</p> <p>21 Any Woman Can with respect to a first trimester</p> <p>22 ultrasound from an OB/GYN in private practice, correct?</p> <p>23 A. They can. Everything Any Woman Can does is</p> <p>24 free.</p> <p>25 Q. But they could get those services elsewhere,</p>

<p style="text-align: right;">270</p> <p>1 correct?</p> <p>2 A. Sure. Yes.</p> <p>3 Q. And if they eventually -- let me ask this.</p> <p>4 Does Any Woman Can provide prenatal care?</p> <p>5 A. No, they do not.</p> <p>6 Q. Okay. So, eventually, someone who is</p> <p>7 pregnant and is not planning to end the pregnancy will</p> <p>8 have to go to another provider for prenatal care; is that</p> <p>9 correct?</p> <p>10 A. That is correct.</p> <p>11 Q. So what is the value of the first trimester</p> <p>12 ultrasound that Any Woman Can provides?</p> <p>13 A. It helps them to see the humanity of their</p> <p>14 baby. It does provide confirmation and viability when we</p> <p>15 see the heartbeat.</p> <p>16 Q. And to be clear, you've used that term,</p> <p>17 viability, multiple times today. Went you say viability,</p> <p>18 you don't mean ability to survive outside of the uterus</p> <p>19 for a sustained period of time, right?</p> <p>20 A. Right. In that context, I'm referring to a</p> <p>21 heartbeat and evidence that it is not a miscarriage.</p> <p>22 Q. So they can see the fetus; they can</p> <p>23 determine whether there's a heartbeat. Anything else?</p> <p>24 A. It gives us an opportunity to provide the</p> <p>25 support that many of them are looking for, counseling,</p>	<p style="text-align: right;">272</p> <p>1 Q. Would you say you're intimately involved</p> <p>2 with their affairs?</p> <p>3 A. On the state level, yes.</p> <p>4 Q. What other level would there be?</p> <p>5 A. It consists currently of eight functioning</p> <p>6 clinics, and I'm not involved in the day-to-day affairs</p> <p>7 of the individual clinics.</p> <p>8 Q. I see. And all of the clinics are in Texas;</p> <p>9 is that right?</p> <p>10 A. That is correct.</p> <p>11 Q. Okay. To your knowledge, are any of The</p> <p>12 Source locations located near clinics that provide</p> <p>13 abortion?</p> <p>14 A. It is possible. I don't know how close they</p> <p>15 are.</p> <p>16 Q. Would you see that as a -- I'll leave that.</p> <p>17 What about The Source; does it employ</p> <p>18 medical professionals?</p> <p>19 A. Yes, it does.</p> <p>20 Q. What kind?</p> <p>21 A. Several of the clinics, not all of them, but</p> <p>22 several provide women's health care and employ OB/GYNs</p> <p>23 and nurse practitioners.</p> <p>24 Q. Okay. And the others, who do they employ?</p> <p>25 A. Some of them are working their way up to</p>
<p style="text-align: right;">271</p> <p>1 resources, relationship counseling.</p> <p>2 Q. Okay. Are you aware of any information or</p> <p>3 data with respect to the number of women who come to Any</p> <p>4 Woman Can with an unplanned pregnancy and who ask for</p> <p>5 referrals to abortion providers?</p> <p>6 A. I'm not aware of data. But, again, in San</p> <p>7 Antonio, you don't need a referral to go to an abortion</p> <p>8 provider.</p> <p>9 Q. Does it happen that patients come to Any</p> <p>10 Woman Can and ask for referrals to abortion providers</p> <p>11 with names, contact information of local abortion</p> <p>12 providers?</p> <p>13 A. I don't know. It is possible.</p> <p>14 Q. And it is -- okay.</p> <p>15 Do you know whether Any Woman Can has been</p> <p>16 the subject of complaints to the Texas Medical Board, the</p> <p>17 Board of Nursing or the Better Business Bureau?</p> <p>18 A. I'm not aware of that.</p> <p>19 Q. Any other licensing or regulatory body?</p> <p>20 A. No.</p> <p>21 Q. You're also affiliated with The Source,</p> <p>22 correct?</p> <p>23 A. That's correct.</p> <p>24 Q. What is your role there?</p> <p>25 A. I'm a board member.</p>	<p style="text-align: right;">273</p> <p>1 that. The goal is that all of them are going to provide</p> <p>2 those services as well as contraception, but it is a work</p> <p>3 in progress. Some of them are not there yet.</p> <p>4 Q. Would you consider the facilities that The</p> <p>5 Source and Any Woman Can runs, would you consider those</p> <p>6 crisis pregnancy centers?</p> <p>7 A. That's a name that some would give them,</p> <p>8 yes.</p> <p>9 Q. But they don't -- The Source doesn't provide</p> <p>10 abortions either, correct?</p> <p>11 A. That's correct.</p> <p>12 Q. Can we turn to Tab M in what I'll mark as</p> <p>13 Exhibit 16?</p> <p>14 (Exhibit No. 16 was marked.)</p> <p>15 Q. Is this the -- does this appear to be from</p> <p>16 the website of The Source, Dr. Skop?</p> <p>17 A. Yes, it does.</p> <p>18 Q. Do you see that on the first page it says --</p> <p>19 this is a printout -- I'll say Exhibit 16 is a printout</p> <p>20 of the welcome page from The Source. On the front page</p> <p>21 it says, "Your place for women's health. The Source is a</p> <p>22 full-service women's health clinic empowering women with</p> <p>23 better choices."</p> <p>24 A. Yes.</p> <p>25 Q. You mentioned earlier about the statistics</p>

September 02, 2020

274	<p>1 about the share of women in the United States who have</p> <p>2 abortions. What are those?</p> <p>3 A. It is estimated that one out of four to one</p> <p>4 out of three women have had abortions?</p> <p>5 Q. By the age of 45, correct?</p> <p>6 A. Yes.</p> <p>7 Q. Do you think it is accurate to say a women's</p> <p>8 health clinic is full service when it does not offer a</p> <p>9 gynecological service that one in four women will use?</p> <p>10 A. In my opinion, abortion is not women's</p> <p>11 health care. It is disrupting a normal, physiological</p> <p>12 process.</p> <p>13 Q. But it is provided by gynecologists,</p> <p>14 correct?</p> <p>15 A. It is generally provided by abortion</p> <p>16 specific doctors. Most OB/GYNs in private practice do</p> <p>17 not do abortions.</p> <p>18 Q. But many OB/GYNs do do abortions, correct?</p> <p>19 A. The OB/GYNs who perform abortions,</p> <p>20 typically, that is their career. They don't -- it is</p> <p>21 rare to find an abortion provider who also does a full</p> <p>22 obstetric -- has a full obstetric practice.</p> <p>23 Q. Dr. Skop, how many abortion providers would</p> <p>24 you say that you know well?</p> <p>25 A. I don't know any well. I -- yeah.</p>	276	<p>1 you don't know any abortion providers well, correct?</p> <p>2 A. But -- I don't know them personally, but I</p> <p>3 know of them. And there are three clinics in town. And,</p> <p>4 to my knowledge, none of those doctors have -- offer full</p> <p>5 gynecologic services.</p> <p>6 Q. If we can get back to my question.</p> <p>7 Do you -- I take it your position is</p> <p>8 full-service women's health clinic is accurate because</p> <p>9 abortion is not a service. Do you think that your</p> <p>10 understanding of what the term full-service women's</p> <p>11 health clinic is consistent with the expectations of what</p> <p>12 your patients, for example, would interpret that term to</p> <p>13 mean?</p> <p>14 A. I do. I think it also is consistent with</p> <p>15 what most OB/GYNs in this country believe. If this was a</p> <p>16 needed medical service, every OB/GYN would do it. There</p> <p>17 have not been --</p> <p>18 Q. Can you provide -- I'm sorry. You mentioned</p> <p>19 earlier that you can't provide abortions in your</p> <p>20 hospital, correct?</p> <p>21 A. Right.</p> <p>22 Q. If someone wanted to provide abortions in</p> <p>23 your practice, could they do it?</p> <p>24 A. No.</p> <p>25 Q. No. Okay. What about -- if we can look at</p>
275	<p>1 Q. Okay. So your information about the careers</p> <p>2 of abortion providers is coming from where?</p> <p>3 A. One of the papers that's included in my CV</p> <p>4 is a paper that looked specifically at all the</p> <p>5 abortionists in Florida.</p> <p>6 Q. I've read it.</p> <p>7 A. Yeah.</p> <p>8 Q. But you didn't look in that -- in that</p> <p>9 study, as to whether the individuals involved provided</p> <p>10 services other than abortion, did you?</p> <p>11 A. We actually did. We looked at did they have</p> <p>12 hospital privileges, and about half did. And we looked</p> <p>13 at did they admit patients to the hospital. About a</p> <p>14 third had admissions, but only --</p> <p>15 Q. But those are different considerations,</p> <p>16 correct, than whether someone does additional</p> <p>17 gynecological or obstetrical services besides abortion,</p> <p>18 correct?</p> <p>19 A. Well, only a quarter of those doctors ever</p> <p>20 delivered a live baby, and very few of them -- granted</p> <p>21 this is not my state but this is a state -- very few of</p> <p>22 them had a very busy obstetric practice. That has been</p> <p>23 my experience. Most abortion providers work for abortion</p> <p>24 clinics.</p> <p>25 Q. But your experience -- you indicated that</p>	277	<p>1 this -- the Tab M, Exhibit 16 again. On page 3, it says,</p> <p>2 "If you're facing a pregnancy you didn't intend and are</p> <p>3 considering abortion, our counselors can provide the</p> <p>4 information you're looking for." Did I read that</p> <p>5 correctly?</p> <p>6 A. Yes, ma'am.</p> <p>7 Q. But if someone is looking for the phone</p> <p>8 number and address of where she can obtain an abortion,</p> <p>9 does The Source provide that?</p> <p>10 A. No. We provide them information about</p> <p>11 abortion, but we don't refer them for abortion.</p> <p>12 Q. You wouldn't provide them information about</p> <p>13 where they could find an abortion.</p> <p>14 What about if individuals who suspect or</p> <p>15 know they are pregnant when they call The Source ask</p> <p>16 whether they can obtain an abortion there; does The</p> <p>17 Source tell them no?</p> <p>18 A. I assume that they tell them no.</p> <p>19 Q. But you don't know?</p> <p>20 A. I'm not involved in the day-to-day running</p> <p>21 of the clinics, but I would assume that they would tell</p> <p>22 them no.</p> <p>23 Q. Do you have any role in providing advice as</p> <p>24 to medical standards there?</p> <p>25 A. We're working on that. The Source is</p>

September 02, 2020

278	<p>1 creating a model that can be replicated to create more</p> <p>2 clinics like this that are -- that take into account</p> <p>3 women's emotional and mental health, spiritual health, as</p> <p>4 well as physical health.</p> <p>5 Q. What's your role in that?</p> <p>6 A. I'm -- well I'm a board member, but I'm sort</p> <p>7 of the medical consultant on that.</p> <p>8 Q. You're the medical consultant. But you</p> <p>9 don't know whether the clinics are up front with people</p> <p>10 that they do not provide abortion if someone asks over</p> <p>11 the phone?</p> <p>12 A. I would assume that they are. I haven't</p> <p>13 checked that out myself, but I would assume that they</p> <p>14 are.</p> <p>15 Q. And do you know whether there is any data</p> <p>16 information about the number of patients or the number of</p> <p>17 individuals who come to The Source for services and</p> <p>18 believe they might be able to obtain an abortion there?</p> <p>19 A. I don't know any data on that.</p> <p>20 Q. Does it happen?</p> <p>21 A. It probably does. Probably people go to</p> <p>22 Planned Parenthood and think they can get prenatal care</p> <p>23 too; they are wrong.</p> <p>24 Q. That is not responsive to my question,</p> <p>25 Dr. Skop. If we can stick to the questions.</p>	280	<p>1 today that you would like to amend or add to?</p> <p>2 A. No.</p> <p>3 Q. And during the break, did you have any</p> <p>4 conversations with anyone other than Mr. Sorenson?</p> <p>5 A. No.</p> <p>6 Q. Okay. Before -- I have some wrap-up</p> <p>7 questions, but I guess one question I did want to return</p> <p>8 to that we had talked about this morning -- I asked you,</p> <p>9 if you recall, how you came to be an expert in this case,</p> <p>10 and you indicated, at the time, that you didn't have any</p> <p>11 recollection as to who contacted you about the case; is</p> <p>12 that correct?</p> <p>13 A. That is correct.</p> <p>14 Q. And at this point in time, now that you've</p> <p>15 had a few hours -- since then have you recalled any</p> <p>16 information about how you found out about this case?</p> <p>17 A. I don't remember for sure. As we discussed,</p> <p>18 the expert witness training that I had with Charlotte</p> <p>19 Lozier, it may have been Charlotte Lozier.</p> <p>20 Q. So you did the training with Charlotte</p> <p>21 Lozier, and then, perhaps, they reached out to you to be</p> <p>22 an expert after that?</p> <p>23 A. I think that might have been the case.</p> <p>24 Q. Okay. Do you recall who at Charlotte Lozier</p> <p>25 reached out to you?</p>
279	<p>1 So is it your testimony that -- I think you</p> <p>2 said both with respect to The Source and Any Woman Can</p> <p>3 that you're not certain where -- it could happen that</p> <p>4 people come to the clinics and believe that they might be</p> <p>5 able to obtain abortions there, correct?</p> <p>6 A. It is possible that people do.</p> <p>7 Q. Have you ever confirmed that people have?</p> <p>8 A. No. I haven't asked that specific question.</p> <p>9 Q. Okay. Do you know whether The Source has</p> <p>10 ever been the subject of complaints to the Texas Medical</p> <p>11 Board, the Board of Nursing, or the Better Business</p> <p>12 Bureau?</p> <p>13 A. I'm not aware of any complaints.</p> <p>14 Q. And any other licensing or oversight body?</p> <p>15 A. Not that I know of.</p> <p>16 Q. Okay.</p> <p>17 MS. MURRAY: I think that is probably close</p> <p>18 to the end. Can we take a quick break just to make sure</p> <p>19 that everything is set, and then I think we're getting</p> <p>20 close to the end? Why don't we break for ten minutes,</p> <p>21 and come back.</p> <p>22 (Recess from 4:14 p.m. to 4:28 p.m.)</p> <p>23 MS. MURRAY: Welcome back from the break.</p> <p>24 Q. (By Ms. Murray) Before we get started again,</p> <p>25 Dr. Skop, is there anything from your prior testimony</p>	281	<p>1 A. No.</p> <p>2 Q. When you did the training at Charlotte</p> <p>3 Lozier, was that because you were hoping to become an</p> <p>4 expert in abortion cases?</p> <p>5 A. As I mentioned, the training also</p> <p>6 incorporated media training. And, at that point, I was</p> <p>7 getting some opportunities to speak to reporters, and I</p> <p>8 think -- I was interested to learn all of it, but,</p> <p>9 primarily, I was interested in learning how to give good</p> <p>10 interviews.</p> <p>11 Q. That actually reminds me of something else.</p> <p>12 Are you on a national fetal tissue research board of some</p> <p>13 kind, Dr. Skop?</p> <p>14 A. Yes. There was an NIH Fetal Tissue Research</p> <p>15 Ethics Review Board, and I was a member of that.</p> <p>16 Q. Are you a member still?</p> <p>17 A. Yes, if it meets again.</p> <p>18 Q. And that wasn't on your CV, correct?</p> <p>19 A. I believe it was.</p> <p>20 Q. Oh, maybe I missed it. I apologize.</p> <p>21 A. It wasn't on the initial CV you got, but I</p> <p>22 added. It is under professional --</p> <p>23 Q. Oh, I see. Okay. All right. I skimmed too</p> <p>24 quickly.</p> <p>25 Okay. With that -- so we're getting close</p>

282

1 to the end. Before we wrap up, are there any answers to
 2 my questions that you want to change before we close the
 3 deposition?
 4 A. I don't think so.
 5 **Q. And is there any information I asked you**
 6 **about that you remember now that you didn't recall when I**
 7 **asked a question about it?**
 8 A. No. Just the discussion about the sentences
 9 that were -- that were the same. I still cannot tell you
 10 if I wrote those, but I thought that I did.
 11 **Q. All of them?**
 12 A. Well, I think the Fetal Pain possibly came
 13 from somewhere else, but, like I say, the way that I do
 14 research, I write stuff down, and then later on I put
 15 together papers and articles. And I think I may have
 16 inadvertently taken wording that I thought I wrote that,
 17 in retrospect, I may have just used from someone else.
 18 **Q. Uh-huh. And earlier, though, you testified**
 19 **that you didn't see it -- and I don't remember your exact**
 20 **words, but that you were uncertain why there would be a**
 21 **concern about taking sentences from someone else's**
 22 **publication; is that correct?**
 23 A. Yeah, I -- yes.
 24 **Q. Is that still your position?**
 25 A. Well, obviously I would not have done it

283

1 knowingly, but I think in all of these reports and
 2 articles that I've written, they've been primarily my
 3 thoughts and my reports.
 4 **Q. When you say that you wouldn't have done it**
 5 **knowingly, why not?**
 6 A. Well, I would have just reworded it in my
 7 own words, had I recognized that it was from someone
 8 else.
 9 **Q. Because you think there's some problem with**
 10 **taking full sentences from other authors?**
 11 A. I don't think that's particularly
 12 problematic, assuming one has done the research. But,
 13 obviously, your line of questioning seems to indicate
 14 that there is an appearance of impropriety of that.
 15 **Q. So it is your testimony that you don't think**
 16 **it is problematic --**
 17 A. I don't think it is problematic --
 18 **Q. -- to take whole sentences from other**
 19 **authors?**
 20 A. Right. Because I've gone to the source;
 21 I've verified the information. And what's included in
 22 the expert witness report is my well-researched expert
 23 witness testimony.
 24 **Q. Okay. So -- I think we'll leave it at that.**
 25 **Is there anything that you would like to add**

284

1 to what you've told us so that we can understand your
 2 perspective or viewpoint more clearly?
 3 A. I think that my expert witness report
 4 clarifies my position on all of this. I don't think
 5 there is anything additional.
 6 **Q. Okay. So when I asked you earlier whether**
 7 **all of the opinions that you intend to testify to are**
 8 **contained in your expert report, is that still your**
 9 **answer that, yes, they are?**
 10 A. Yes, they are.
 11 **Q. Okay. Anything else that you want to add?**
 12 A. No.
 13 **Q. So with that, I think this deposition is**
 14 **concluded, subject to the right to re-call the witness**
 15 **for further questioning should that be required.**
 16 MS. MURRAY: I will say, Lance, I think
 17 we're going to follow up with a letter requesting
 18 documents -- some documents that have been discussed
 19 today. I can follow up in writing. I know it's been a
 20 long day.
 21 MR. SORENSON: Okay.
 22 MS. MURRAY: All right. We have nothing
 23 further. Thanks everyone.
 24 (Signature requested.)
 25 (Whereupon the taking of this deposition was

285

1 concluded at 4:37 p.m.)
 2 * * *
 3 A reading copy of the Original transcript
 4 was submitted to Mr. Sornesen for witness review.
 5 Original transcript filed with Ms. Murray.
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September 02, 2020

<p style="text-align: center;">Exhibits</p> <hr/> <p>Skop Exhibit 01 29:16, 18,20</p> <p>Skop Exhibit 02 98:13,15 164:18 173:21 186:15 197:3</p> <p>Skop Exhibit 03 110:18</p> <p>Skop Exhibit 04 157:10 170:14</p> <p>Skop Exhibit 05 170:18, 20</p> <p>Skop Exhibit 06 172:4</p> <p>Skop Exhibit 07 172:24 173:1</p> <p>Skop Exhibit 08 177:23, 24 178:7 252:5 253:21 255:5 257:18</p> <p>Skop Exhibit 09 181:16, 18 183:14</p> <p>Skop Exhibit 10 234:7,8 237:22 238:1,25</p> <p>Skop Exhibit 11 237:23 238:2,9 241:14</p> <p>Skop Exhibit 12 238:3,10 243:4</p> <p>Skop Exhibit 13 245:19, 23 248:19,22,23</p> <p>Skop Exhibit 14 246:13, 14 253:3 254:12 255:21</p> <p>Skop Exhibit 15 268:6,7</p> <p>Skop Exhibit 16 273:13, 14,19 277:1</p> <hr/> <p style="text-align: center;">\$</p> <hr/> <p>\$10,000 104:9,12</p> <p>\$300 22:25</p> <p>\$350 23:10</p> <p>\$5,000 104:7</p> <p>\$500 78:5 124:25</p> <hr/> <p style="text-align: center;">0</p> <hr/> <p>0.7/100,000 174:1</p> <hr/> <p style="text-align: center;">1</p> <hr/> <p>1 29:16,18,20 98:22 130:22 183:15,23,24</p> <p>1,500 125:1 126:4 127:7</p> <p>1.3 181:12</p> <p>1.7/100,000 174:4</p>	<p>10 34:20,25 36:3,20 167:10,15 234:7,8 237:22 238:1,25</p> <p>10,000 125:2 126:5 127:7</p> <p>100 34:5</p> <p>11 237:23 238:2,9 241:14</p> <p>110 34:5 85:1 247:13</p> <p>110-fold 86:5</p> <p>11:49 149:7</p> <p>12 38:19,21 118:12 238:3, 10 243:4</p> <p>12:30 149:4</p> <p>12:33 149:7</p> <p>13 38:19,21 124:19 201:17 234:10 245:19,23 248:19, 22,23</p> <p>130 180:3</p> <p>134 180:22</p> <p>135 181:17</p> <p>14 49:18 50:8,12 200:12,20 201:6,17 209:22,25 211:6 246:13,14 253:3 254:12 255:21</p> <p>14-plus 201:6</p> <p>15 7:16 30:18 33:9 36:4,20 54:25 80:13 174:2 177:10 219:16 220:3 227:12 245:14 268:6,7</p> <p>15-fold 165:20</p> <p>16 50:2 51:24 71:5 177:10 180:17 181:11 273:13,14, 19 277:1</p> <p>17 177:9</p> <p>18 25:3,9,10,15,16 38:6,11 50:2 51:7,19 67:7,12,19 68:25 69:3,14 70:1,13,21, 24 74:7,19 91:17 94:4,8 95:3,6,13 123:12 127:23 128:3 132:24 133:23 161:9,24,25 174:21,23 175:6,11 176:1 181:4,14 186:19,25 187:1 188:7,13 189:21 202:18,23,25 203:24 213:16,19 214:5 230:3,21</p> <p>18-plus 181:2</p> <p>18-week 133:16,19,23 161:3 174:9,16 175:20 177:3 199:10 200:5 203:4, 13</p> <p>18-week-old 133:15</p> <p>19 187:18</p> <p>1950s 86:10</p> <p>1970 128:19</p> <p>1990s 220:10</p>	<p>1996 32:14</p> <hr/> <p style="text-align: center;">2</p> <hr/> <p>2 38:24 98:13,15 106:12,22 130:22 136:12,13 140:6, 17,20,21 164:18 173:21 186:15 197:3</p> <p>2,000 179:17,24</p> <p>20 7:16 22:21 27:7 30:17 31:20,21 34:9 39:6 70:3 73:13 74:19 75:3 78:1 79:18 140:19 149:18 152:11 154:7,8 155:13 180:23 181:4,5,13,14 187:18 196:25 200:12,20 202:13 220:11</p> <p>20- 207:21</p> <p>20-plus 181:1</p> <p>20-week 155:11</p> <p>2005 221:9</p> <p>2011 254:23</p> <p>2013 27:4</p> <p>2016 73:25</p> <p>2017 238:13</p> <p>2018 220:10,14</p> <p>2019 103:24 234:10 248:25 249:4 254:20</p> <p>21 187:18 208:1</p> <p>21-week 207:22</p> <p>22 69:3 73:13 79:18 81:21 176:2 181:5,13 186:20 187:18 188:7,13 189:21 202:5,6 207:23 208:10</p> <p>22-week 207:17</p> <p>22-weekers 207:21 208:16 209:10</p> <p>24 6:14 81:21</p> <p>24-hour 30:21</p> <p>25 27:21 30:19 49:15 51:5 67:1 70:6 114:1,23 254:2, 16</p> <p>259 183:14,22</p> <p>26 202:4</p> <p>27 195:24</p> <p>29 67:1</p> <p>2:11 214:10</p> <p>2:34 214:10</p> <hr/> <p style="text-align: center;">3</p> <hr/> <p>3 38:24 85:4 110:18 128:17 136:12,13 140:7,17,20,21 277:1</p>	<p>3,000 180:15</p> <p>3.4/100,000 174:6</p> <p>30 27:10 30:19 72:7 75:7 86:14 108:6 174:4,10,18 175:13,21 177:4,6 202:4, 13</p> <p>30,000 179:11</p> <p>30-fold 165:21</p> <p>30-year 194:21</p> <p>300 22:24 180:3</p> <p>32 254:4,18</p> <p>33 145:16 146:11,14</p> <p>35 254:6,21</p> <p>350 23:9</p> <p>39 41:6,25 42:2</p> <p>3:15 33:21</p> <hr/> <p style="text-align: center;">4</p> <hr/> <p>4 105:22 120:10 124:8 128:17 143:13,14 145:14, 15 147:19 157:10 170:14 180:17 181:11 209:8,11,12 248:25 268:9</p> <p>40 34:17 156:10</p> <p>45 148:25 274:5</p> <p>4:14 279:22</p> <p>4:28 279:22</p> <hr/> <p style="text-align: center;">5</p> <hr/> <p>5 37:15,17 38:10 127:11 164:17 167:10,13,15 170:18,20</p> <p>50 34:20,23 75:9 77:12 85:2 137:15 156:10 252:18 253:21,24 254:13</p> <p>500 45:22 54:16,18 126:21</p> <p>51 254:5,18</p> <p>52 253:4</p> <p>56 255:5,22</p> <p>57 178:7</p> <p>5:00 33:22</p> <hr/> <p style="text-align: center;">6</p> <hr/> <p>6 145:2 172:4 173:19 185:3 186:13,15 187:15 219:24</p> <p>6,000 66:25</p> <p>60 34:20,23</p> <p>600 54:3</p> <p>6:00 214:23 216:1</p>
---	--	--	--

7	Abort73.com 120:17	abortion,' 106:4	accreta 84:24 85:15 87:1 143:6,7 256:22
7 172:24 173:1 197:2,6 268:9	abortion 7:21 12:22 13:16 14:8 18:1 19:3 25:3 26:16 27:7,8,9,11,23 28:5,17 52:15 53:6 55:16,20,24 56:1,2,5 57:20,22,24 58:3, 5,10,21,24 59:1,5,10,16, 18,24 60:14,16,23,25 61:3, 11,18 62:9 66:21 67:4,7, 12,19 68:24 69:2,5,14 70:12,17,18,20 72:17 73:5, 6,13,16,20,23 74:3,6,10, 17,18 75:12 76:5,20,21,25 77:8,16,21 78:4,5,11,23 79:1,18,24 80:8,9,15,16, 19,22 81:4,9,23 82:12,14, 22,25 83:10,13,20,21 84:9, 12,19 85:15 87:8,13,17,19 88:7,9,20,23 89:1,6,8,10, 24 90:17 91:14,17 92:2,5, 8,9,12,20 93:9,11,16,25 94:4,19,25 98:5 106:4 107:17,21,23 108:3,7 109:20 110:2,5 111:12,22 112:11,22,24 113:1,15,17 114:10,15,19 115:14,25 116:13 117:3,8,16 118:10, 24 119:2 120:8,14,21 124:18,21,25 125:11 126:7 128:6,8 129:3,12 130:1,18, 19 131:17,23 132:17 144:3,5,11,18 145:11,19 146:1,2,8,10 147:10,16 148:2,14 152:12,17 153:7, 12,17 154:13 155:18,20 156:23 161:4 162:20 163:9,16,23 165:15 166:11,23 171:6,9,13,16, 21 173:23 174:1,4,11,14, 19,20,24,25 175:11,16,23, 25 176:7,15 177:6,15,16, 17 178:1,12,16,18,23,24 179:3,4,13,18,25 180:11 181:2 182:1 183:11 184:25 185:5,16,23 186:2,5,9 187:4,11,16 188:8 190:5,7, 17 192:15 194:2,18,24 195:15,16,17,22 196:3,5, 10 213:15,19 214:5 220:14,20,22,24 223:14, 19,20,22,25 224:6,12 225:5,9,14,25 226:8,11,12, 15,18 228:2,7,13,15,17 229:1,10,15,18,25 230:12, 22 231:1,8,12,13,16 233:23 241:11 243:22 245:20 247:13 248:19,20 252:5 253:12 254:4,8,18, 22 255:13,16 256:6,8,10, 11 257:17 266:20 267:3,4, 10,12,19 268:15,21 271:5, 7,10,11 272:13 274:10,15, 21,23 275:2,10,17,23 276:1,9 277:3,8,11,13,16 278:10,18 281:4	abortion-associated 153:21 187:8	accuracy 99:25 151:17
700 54:3,16,18 126:21	abortionist 59:21 62:18 108:22 145:6 170:1	abortion-related 150:10, 15,25 151:3 156:5 164:11 172:5,11 173:2,5,10 187:5	accurate 8:22 11:10,12 12:3 15:25 28:23 29:24 44:7 59:8,15,19 98:14 100:25 107:14 109:13,19 110:10 112:15 120:24 121:17 122:23 150:13 151:9 168:25 169:13 175:23 182:10 224:16 274:7 276:8
72 225:21 254:8,22	abortionists 27:20 127:15 144:13 167:11 275:5	abortionist 59:21 62:18 108:22 145:6 170:1	accurately 9:12
73 246:21	abortions 13:18 57:7,10 58:1 66:1 68:6 69:13 70:1 71:8 72:20 73:3,10 74:8,12 75:5 77:18 82:3 83:16,19 85:18 89:3,8,18 91:6,7,9, 25 94:7 105:21 106:2,9 107:12 108:5,15,20 109:5, 10,16,18,21 110:20 111:17 113:4,18 115:1,13,16,19 116:7 121:18 123:7,12,17 124:10,12,16,20 125:21 132:10 134:19 144:4,23,24 145:12 146:23 147:3 148:10 149:14,17 151:5,6, 13,15 155:15 156:13 161:15,25 165:25 167:13 174:2 175:4,18 176:1,3 177:9,20 179:11,24 180:7, 16,22 182:7,8,9,17,22 184:1,6,20 185:21 186:1 187:25 189:11 190:4 191:5 192:2 193:9 196:11 213:24 214:3 223:8 224:13 233:1 241:6,7 254:5,8,19,23 260:19 266:23 273:10 274:2,4,17,18,19 276:19, 22 279:5	abortionist 59:21 62:18 108:22 145:6 170:1	accused 227:23
74 246:21	Abroad 178:2 252:6	abortionists 27:20 127:15 144:13 167:11 275:5	acknowledge 82:15 185:23 188:6 241:9
76 174:6,10,18 175:13,21 177:4,6	abruption 90:6 252:22 253:14	abortionists 27:20 127:15 144:13 167:11 275:5	acknowledged 185:2 191:8
76-fold 165:21	absence 212:20 213:5	abortionists 27:20 127:15 144:13 167:11 275:5	ACOG 55:9,11,12 56:16, 17,21 62:21 99:20 181:17 236:14
7:45 33:21	absolute 126:9	abortionists 27:20 127:15 144:13 167:11 275:5	ACOG's 63:17 181:10
8	Absolutely 108:13	abortionists 27:20 127:15 144:13 167:11 275:5	act 12:13 115:21
8 177:10,23,24 178:7 252:5 253:21 255:5 257:18	academic 84:1 251:6,13, 22 252:2	abortionists 27:20 127:15 144:13 167:11 275:5	active 34:2
8.9/100,000 174:7	academicians 83:17	abortionists 27:20 127:15 144:13 167:11 275:5	activities 72:21 255:15 256:8 260:15
80 34:9 39:7	Academies 150:6 178:11 246:23	abortionists 27:20 127:15 144:13 167:11 275:5	Acton 26:7
9	Academy 148:2	abortionists 27:20 127:15 144:13 167:11 275:5	actual 103:10 109:14 197:9 200:2
9 171:3 181:16,18 183:14	accepted 250:17	abortionists 27:20 127:15 144:13 167:11 275:5	acuity 209:13
92 79:22	accepts 232:25	abortionists 27:20 127:15 144:13 167:11 275:5	add 30:6 65:10 139:8 149:10 214:13 280:1 283:25 284:11
94 156:12	access 16:4 63:24 236:20	abortionists 27:20 127:15 144:13 167:11 275:5	added 281:22
96 79:22 114:25 115:3	accident 15:11	abortionists 27:20 127:15 144:13 167:11 275:5	addition 15:22 23:25 31:13 51:11 72:17 182:6 255:12 256:5
97 121:18	accidentally 157:19	abortionists 27:20 127:15 144:13 167:11 275:5	additional 22:21 86:22 100:16 124:5 142:7 153:14 165:2 186:23 220:5 275:16 284:5
9:00 33:22	accompany 255:11	abortionists 27:20 127:15 144:13 167:11 275:5	Additionally 182:8
9:33 65:7	accompanying 256:3	abortionists 27:20 127:15 144:13 167:11 275:5	additions 239:6
9:45 65:4	account 177:18 278:2	abortionists 27:20 127:15 144:13 167:11 275:5	address 68:19 99:11 184:24 215:18 216:4,11 277:8
9:48 65:7		abortionists 27:20 127:15 144:13 167:11 275:5	addressed 69:1
A		abortionists 27:20 127:15 144:13 167:11 275:5	addresses 113:12 147:1
a.m. 65:7 149:7		abortionists 27:20 127:15 144:13 167:11 275:5	adhere 90:7 98:10
AAPLOG 17:9,10,16 18:3, 6 19:7 56:7 101:7 102:3 234:4,9,18 235:7,10 236:11 238:12,24 239:3 240:22 241:1,9,15,21,25 242:11,22,24 243:10 244:18 245:16 256:24		abortionists 27:20 127:15 144:13 167:11 275:5	adherence 252:21 253:13
AAPLOG's 101:19 241:19		abortionists 27:20 127:15 144:13 167:11 275:5	adjacent 252:24 253:16
abdomen 44:14		abortionists 27:20 127:15 144:13 167:11 275:5	administer 141:20 205:22
ability 46:21 58:5 111:23 199:16 270:18		abortionists 27:20 127:15 144:13 167:11 275:5	administered 42:19 43:4, 5
ablation 39:13		abortionists 27:20 127:15 144:13 167:11 275:5	admission 136:3
abnormal 47:17 86:6 88:1 89:20,24 90:19		abortionists 27:20 127:15 144:13 167:11 275:5	
abnormalities 263:19		abortionists 27:20 127:15 144:13 167:11 275:5	
abnormally 84:25 90:6		abortionists 27:20 127:15 144:13 167:11 275:5	
Abort73 121:12,24 122:9		abortionists 27:20 127:15 144:13 167:11 275:5	

<p>admissions 275:14 admit 83:19 275:13 admitted 76:3 Admittedly 249:23 admitting 27:25 adopt 58:15 adoption 60:5,6,23 119:22,23 120:3,7 adrenalin 212:18 adrenaline 212:6 adult 204:17 adults 204:6 advance 163:3 208:23 Advancing 83:22 adverse 46:8 135:8,10,13 159:4 193:5,19 adversely 255:11 256:4 advice 55:14 78:3 218:24 277:23 advise 60:15 advised 5:15 216:18,22 advocacy 55:16,20 56:1,2, 11,15,18 83:22 148:14 advocate 171:9 advocated 225:12 232:3,6 advocates 55:24 77:21 196:3 advocating 162:19 affairs 272:2,6 affect 123:12 affiliate 179:22,23 affiliated 17:8 33:13 83:21 244:18,20,22 259:23 260:2 271:21 affiliates 232:7 affiliation 17:16 affirm 118:16,17 afford 125:16 afraid 53:18 age 38:4 41:7 51:10 67:10 68:6 97:6 116:10 125:1 180:3,7 184:1 191:23 199:14 200:11 205:10,16 206:16 228:19 264:14 274:5 agencies 60:7 232:23 ages 81:21 208:14 aggravation 158:13 agree 11:6 25:19 55:19 57:8 67:24 69:4 108:11 117:3 122:2,5 123:11 126:3,5 155:8 164:8 181:1 188:25 189:6 190:24 198:2</p>	<p>202:15,23,25 203:12,17 248:9 257:7 258:12 259:15 260:14 agreed 200:17 258:18 agreeing 202:20 agreement 24:1 agrees 68:10 ahead 110:15 133:9 234:6 237:14 ahold 154:12 alive 226:10 allotted 189:16 allowed 90:1 176:1 allowing 86:16 147:7,11 alongside 95:19 altered 107:24 altern 57:16 alternatives 57:17 altogether 175:4 AMA 63:2 ambulatory 27:11 amend 214:13 280:1 America 84:1 90:10 179:6 American 55:6 56:8 62:25 63:20 68:9 83:16 Americans 108:4 amicus 56:4 amniocentesis 88:11,12 210:18 amniotic 210:20 amount 20:8 45:19 127:6 185:12 215:14 251:4 analgesia 205:6,14,17,22 207:9 analysis 106:24 107:5 182:20 analyzing 144:10 191:5 anecdotal 208:4 anecdotally 182:6 anemia 45:1,9 206:7 Anesthesiology 44:11 Angeles 179:10,22 animal 204:20,21 animals 204:22 anniversaries 256:9 anniversary 255:16 256:11 annual 109:9 114:25 117:14,15 118:2 annually 109:5 annuals 34:4</p>	<p>anomalies 121:20 123:8 193:8 answering 9:14 answers 8:6,15,16,22 9:11 11:10,12 112:10 150:21 282:1 antenatal 208:11,21 antepartum 81:19 Anthony 22:2,4 244:23 antibiotics 93:19 136:2 137:9 141:7 anticipate 24:14 Antonio 40:13 97:23 271:7 anxiety 186:7,8 anymore 88:12 118:23 apologies 32:5 81:12 236:24 apologize 21:18 103:25 257:21 281:20 apparent 246:25 247:18 apparently 16:3 154:13 222:15 235:14 236:17 appearance 263:14 283:14 appeared 226:20 appears 208:18 235:20 applied 43:14 applies 231:11 apply 37:10 146:1 179:3 199:20,22 appointment 35:23 263:5, 11 266:16 267:5,16,24 approach 144:3 145:19 146:10 approaches 17:4 146:14 approximately 50:8 214:22 220:11 arch 201:9 area 58:17 66:17 88:2 91:3 97:11 115:17 160:25 163:21 areas 65:19 66:14 arrange 40:7 arrive 217:15 264:15 arrived 219:9 article 14:3 15:23,24 106:13,16,19,21,25 107:10,22 110:6,8,13,24 112:2 172:5,9,13,20 173:1, 4,6 178:1 194:15 246:6 247:13 249:9,20,24 250:1, 20 251:1 252:5,13 253:20, 23 256:20,22 articles 11:16 12:18 13:5, 8,13,15,16,17,19,24 14:12,</p>	<p>15,16,19 63:23 64:7 69:5 77:24 111:3,6 147:10 191:16 195:11 220:9,16 223:8 225:25 245:6 246:1 250:2 282:15 283:2 ascribe 200:1 Asherman's 92:13,18 93:6,10 asks 57:24 59:22 278:10 aspiration 44:11 assertion 174:19 assess 153:16 156:16 assessing 156:25 157:2 assets 52:8 assist 49:25 associate 18:19 association 18:17 56:8 63:1 197:7 198:3 233:13 assume 6:13 9:6 108:11 117:22 160:6 177:13 205:1 209:9 211:5 250:22 277:18,21 278:12,13 assuming 110:8 145:21 249:17 283:12 assumption 174:20,22 175:2 203:9 assumptions 102:24 attached 119:11 attempting 47:23 attend 208:14 attention 116:13 158:1 215:10,23 216:7,17,20 attributable 86:6 attribute 89:6 93:15 attributed 72:17 258:22 attribution 251:6,12,21 258:2 author 246:5 249:13,19 250:3,21 251:5,12,20 252:15 258:1 259:3 authored 107:23 108:1 171:8 236:9 245:21 authoritative 64:4,9 authorities 79:11,14 authors 13:19 196:9 241:5 250:17 259:12 283:10,19 automatically 76:7 autopsy 51:15 Autry 145:14 147:18 average 34:4 54:1 124:24 162:5,8,11 aware 19:18,20 24:12 44:5 81:24 114:24 132:13 148:8 173:12 192:17 193:1</p>
---	--	--	---

207:25 235:19 271:2,6,18
279:13

B

B-A-T-E-S 221:12

babies 30:18 31:1 39:19
67:1 80:21 97:6,7 191:2
202:5,7 207:14 208:12
209:5,22 214:1,3 226:10

babies' 212:24

baby 6:8 40:23 46:7,22,23
47:22 51:10,14 58:11,15
59:4 113:8 119:21 120:3
132:19 133:4 146:1,3
159:9 174:24 175:8
176:21,24 205:14 207:7,12
208:15,18 209:15 210:20
228:6 269:9 270:14 275:20

baby's 264:16

back 15:6 21:3 37:18 38:2
47:7 60:12 65:8 73:17 88:6
98:17,24 110:4 112:19
115:7 118:6 120:10 124:18
126:19 133:21 134:21
136:22 144:9 145:2 149:4,
8 150:4 163:8 203:11
207:5 212:14 213:14
214:11,18 223:9 232:16
247:12 252:4 253:20,23
255:4,21 266:9 276:6
279:21,23

background 29:13 85:10,
11

backing 68:17

backs 89:13

bad 20:15 135:14 167:22

bag 30:25

balloon 42:25 43:7,8,10,13

ballpark 104:1

ban 224:8,10,11,12 225:5
230:10,11

bank 85:7

Baptist 32:18,21,25 33:3,
5,7,8,10,13 132:3,9
134:17,23

bar 202:2

barred 10:23 11:2

barrier 54:19 58:5 126:6,8,
9,11,25 127:4,5,8

Bartlett 172:13 173:3,4
176:2

base 97:1,3,10 113:2

based 7:23 37:14 52:13
89:8 105:8 113:17 114:12
116:3 121:15 123:10
126:16 135:11 146:21
151:5,6,13 152:21 160:13

164:9 173:7 174:20,22
180:14 188:25 191:16
195:12 200:24 213:25
239:3 247:6,22 249:9
262:11

baseline 190:9,16

bases 164:5

Basically 45:7

basis 228:16 243:18

Bates 221:5,10,12

beat 28:17,19 264:16

bed 220:5

began 66:8 101:19 219:4,
25 220:2

begin 39:25 49:4 200:10

beginning 52:17

begs 183:10

begun 50:21

behave 202:6

behavior 153:10 189:25

beings 179:15

beliefs 230:18

believed 107:9

believes 115:14 163:22

beneficial 192:1

benefits 57:17,19,21
115:14

Berg 165:17 172:13 176:2

Bernard 213:22

bias 241:9 242:22

biased 241:7

bibliography 149:13

big 156:1 206:11 233:7,19

bigger 50:20

bill 179:10

binder 107:2 218:1,2,3,4,8,
18 236:25

biologic 116:19

birth 39:21 46:15 47:23
81:4,8,10 82:6,9,14 83:1
84:15,18 89:9 117:16
120:7 152:4,10,19 161:24
162:1 164:9 169:23 190:24
191:4 205:12 207:15
208:24 254:3,17 255:9
256:1

births 39:25 81:4 83:9,13
86:9 154:7 161:11 163:24

birthweight 254:7,22

bit 8:2 9:10 11:20 12:22
24:19 29:12 37:11 41:10
43:14 47:13 62:21 129:1
137:8 143:4 145:8 153:11
199:12 211:24 220:8

Bixby 147:9

black 34:20,24

bladder 7:4 43:11 44:17

bleeding 35:12 39:14
44:13,20,23,25 45:1,3,5,8,
16 85:3

block 98:25 232:22

blood 44:25 45:3,13,19,21
76:4 85:6,7 136:11 143:9
206:5,8 212:9 263:16
265:11,12,18,25 266:10,14

blow 43:13

blown 43:10

blue 217:11

board 17:12,13 18:9 52:6,9
68:9 72:18,23 236:11
260:5 271:16,17,25 278:6
279:11 281:12,15

bodies 40:19

body 48:24 49:3,4 227:5
271:19 279:14

bolster 208:24

Bolton 228:18

bond 269:10

bonding 264:9

bones 50:13

book 171:16

border 77:24 78:15

born 59:4 208:1,10 226:10

bothered 116:12

bottom 183:16,23,25
186:13,15 248:24

bowel 88:22 164:23 168:5

box 193:17 217:17,18,19,
20

Brady 226:7

brain 25:8 198:21,22
200:14 201:10,11

break 9:21,23,25 10:3,4
34:7 39:20 54:24,25 55:2,4
65:1,3,9,14 81:2 129:1
148:17,20,21,23 149:8,23
161:9 192:5 196:19,20
214:9,11 259:21 279:18,
20,23 280:3

breaks 9:18 196:18

breast 128:11,12,17,18
129:3,13,17 130:3,8,20
131:1,2,8,18,23

breasts 129:15 130:23

breathe 208:16

breathing 201:14

brick 232:24

briefing 244:5

bring 35:6 95:18 239:19
264:11,14 266:9

brings 47:7 249:25

broad 229:5 257:17

broke 193:1

brought 11:18

bulletin 17:21,24 101:20,
22 181:11,16,19,25 237:8
238:8,12 243:5

bulletins 18:5 56:23 57:1
102:6 235:7 236:13

Bureau 271:17 279:12

bury 51:14

Business 271:17 279:11

busy 275:22

buy 261:21

Byron 15:7 16:11 21:24,25
246:15 248:6 249:23

C

C-SECTION 31:10 41:1,
13,19 43:19 44:4 46:4,15
47:2,4,11,16 48:4,5,6,9
85:20,23 86:10 87:4,5,21,
22 88:4 90:20 136:16,21
137:5,12 143:22 145:17,
20,22,25 146:5 161:16
162:11,16 163:4 166:15
168:8 228:25

C-SECTIONS 33:23
43:15,17,22 44:2,10 47:8,
16,21 86:7 87:2 88:1
127:18 143:5,10 161:14
162:5,14

caesarean 39:21,22 46:6,
22 47:15,23 228:11

calcified 50:13

calculate 152:5 154:22

calculated 151:5

Calhoun 16:11 21:25
246:16 253:3 254:11
258:12

Calhoun's 15:7 255:22
256:20

California 108:19 182:5,6,
15 186:22

call 30:20,22 31:11,14 32:3
52:25 64:8 143:6 194:7
196:9 220:4 266:19,25
267:18 277:15

called 5:3 17:9 19:2 20:11
42:18 52:1,10 63:16,19
84:24 97:22 120:17 122:10
149:17 172:5 238:13
259:24 267:2,9

calling 200:22
calls 30:21
Can's 269:6
cancer 128:11,12,18
 129:3,13,17 130:3,9,20
 131:1,3,8,9,18,23
capacity 18:21 96:20,24
 200:8 208:24 209:20 210:6
 211:8
car 159:7,17 187:10
cardiac 35:10
care 6:7 7:6,7 27:20,23
 33:18 34:8 35:2,8,16 37:1
 39:6,7,9,18 40:7 48:16
 58:13 62:16 91:10 96:5,15
 113:23 125:17 127:8
 132:20 135:2,11 156:21,22
 175:16 205:6 228:24
 230:19 231:21 263:5
 265:17 270:4,8 272:22
 274:11 278:22
cared 62:18 65:24 66:6,7,
 19 67:25 68:4,20 72:15
 91:19,22 92:3,13,17 93:22
 94:6 96:1 228:23
career 51:1,5 72:16 73:7
 81:17 84:21 274:20
careers 275:1
caring 66:18
Carnahan 21:13
Carolina 221:17,19
carried 129:18 190:7
 195:18 196:12
carries 190:17
carry 125:4 174:24 187:16,
 25
carrying 187:20 195:22
case 5:10 6:1,2,3,4,18
 7:13,15,18,20 8:21 11:21,
 23 12:4,14 15:2,4,5 17:3
 20:1,2 21:15 22:23 23:11,
 22 24:2,5,10,14,16,21,23
 25:6 26:2 30:10 65:17,24
 66:4,14 74:4 90:21 98:14
 99:1 102:18 104:17 105:1,
 14,16 109:7 122:7 124:15
 125:18 129:5 147:17
 178:25 182:23 199:3 200:1
 201:2 205:2 211:9 214:19,
 25 217:9 219:19 221:3,5,9,
 15,20 231:11 233:12,16
 240:19,25 241:8 244:9
 246:16 249:7 258:24
 280:9,11,16,23
caseload 34:1,7
cases 5:23 12:2 37:15
 75:10 85:22 91:2 102:21
 114:8 121:19 134:3
 145:24,25 247:4,21 281:4

cat 110:17
catastrophic 47:24 85:3
catecholamines 212:10,
 16,17
categories 45:18 189:9
 191:25 193:2,10,13 256:13
category 114:11 175:17
catheter 43:1,9
causal 90:2,16 129:2,12
 131:22 153:1,7,16,25
 185:15 186:4
causality 188:2,4,7
causation 152:14
caused 82:7 93:6 157:5
 185:23 186:9
causing 211:4
cavity 88:14
cc's 45:23
CDC 90:11 108:6,14,20
 147:7 151:2,6,13 158:24
 160:1 161:2,8 165:17
 172:16,17,18 173:7
 182:18,19 183:11 184:1,
 14,19
CDC's 108:24
cells 131:13,25
center 52:14 147:9 233:21
centers 27:12 273:6
centimeters 41:12 42:3
Central 32:18 33:6,10
cerebral 201:24 202:11,17
 203:6,15,21,25
cerebrum 203:8,9
certainty 96:4,15 113:22
certificate 152:10,12
 155:24
certificates 150:16 152:9
 154:3,4,9 155:4,6,7,15
 156:11,12
certification 179:4
certified 76:13
cervical 80:20 81:11,12,16
 82:3 87:11,12 139:11
Cervidil 42:18,19 46:9
cervix 41:10,16 42:1,2,9,
 13,14,22 43:1,13,14 46:3
 80:23 82:18 87:12 139:15
 252:24 253:16
chain 158:12
chair 17:12 32:20,21,23
 33:3 134:22 135:3,4,6
chairman 17:19 72:18,23
 260:5

challenge 24:21 221:23
chance 133:14,16 134:5
change 95:10 106:7
 112:21,25 113:16 145:18
 212:19 213:25 282:2
changed 105:3
chaplain 133:13
chapter 171:15,17
characteristic 263:14
charge 23:13,16 78:5
Charlotte 18:18 19:6,11,
 17 21:10 22:12 243:17
 244:2,17,25 245:7 280:18,
 19,20,24 281:2
chart 111:5 157:4 188:20,
 23
charts 76:15 188:22
chat 11:4 237:17,23 238:4,
 6 243:3
check 23:20 193:16
 236:22
checked 278:13
checkup 118:2
Cheryl 26:7
child 40:7 58:13 116:19
 119:9 132:21 159:13
 162:22 163:1 167:23 255:9
 256:1
childbirth 66:24 135:19,24
 138:1 139:12 160:10
 162:12,20 167:21 168:2,5,
 11,20 169:5,16
children 40:6 119:6,18
 149:24 176:19
chlamydia 266:8
choice 106:9 112:23
choices 273:23
choose 13:18 58:20 59:25
 118:24
chooses 128:15
chose 191:9
chosen 115:4
Christina 21:13
chronic 165:1 169:9
 252:22 253:14
circulatory 45:14
circumstance 48:8 56:6
 116:16 229:12 231:17
circumstances 12:1
 40:23 48:6 49:13 54:19
 82:6,23 90:1 133:5 141:17
 228:1,12 229:9,14,24
 231:6,14
citations 186:19 255:1

cite 86:5 100:2,4,8 106:21
 120:16 175:20 186:14
 194:13 241:23,25 242:6,10
cited 12:19 13:6,14 101:23
 106:20,22 107:8 170:23
 171:1 184:8 194:8 242:3
cites 163:13
citing 110:8 125:8 188:13
 254:19,23
city 179:11
clarification 159:21
 237:25
clarifies 284:4
clarify 235:9
clarity 268:14
classify 48:9
cleanup 194:14
clear 29:1 37:23 48:3 50:5
 51:18 58:19 70:16 74:15
 167:19 174:16 177:14
 182:13 188:6 203:23
 210:19 215:5,17 241:13
 270:16
clinic 31:25 32:2,3,6 52:12
 60:3 77:16 78:9 107:23
 111:22 187:11 260:19
 273:22 274:8 276:8,11
clinical 32:11 68:20 94:25
 95:11 97:12 113:2,17
 127:15 260:9
clinically 71:17
clinician 170:23
clinics 32:7 52:13,16 60:1
 107:21 108:3 112:11
 154:13 176:15 272:6,7,8,
 12,21 275:24 276:3 277:21
 278:2,9 279:4
close 148:19 150:4 183:4
 191:22 272:14 279:17,20
 281:25 282:2
closed 77:15
closely 260:15
closure 232:3
coauthors 172:7 173:3
coerced 114:8,9 176:18
 255:16
coercion 111:18 113:10
 176:22 193:8
Coleman 22:7 195:5
Coleman's 195:6
collaborated 245:8
colleague 60:14 122:1
colleagues 14:18 60:21,
 24 61:2 163:20
colleagues' 41:21

collect 206:5
collecting 90:11 144:10
 151:2 157:3
collection 137:7
collects 160:1
College 55:6
Colorado 53:11
column 247:14
combined 140:14 151:15
comfortable 95:5 115:12
commissioned 148:13
commit 176:23
committee 17:20 18:5
 57:2 61:15 102:7 135:6,9
 154:15,24 155:2 235:14,
 23,25 236:13 237:9,11
committees 152:8 154:2
 157:24 173:13
committing 115:20 256:9
common 39:11,12,17
 49:17 117:17 136:10 139:4
 143:11,12 167:9 181:2
 211:22
commonly 63:14 106:5
 139:2 167:2,5,6,14
communicate 219:6
communication 11:3,4
 219:8
community 19:9 62:22
 77:19 116:9 117:1 250:14,
 16
comparable 161:16
 204:22
comparator 161:23
 164:10 187:21
compare 162:20,23
 163:12,22 174:25 238:23
 241:14
compared 131:12 145:6
 173:23,25 174:14 175:25
 176:3
comparing 161:10,16
 162:2 177:14 187:15
comparison 163:8 164:16
compensate 24:10
compensation 22:23
 24:5,13
competency 94:25 95:12
competent 269:15
compiles 121:23
complaint 227:5
complaints 271:16
 279:10,13
complete 8:22 76:5 99:2
 110:23 111:1 152:16

154:14 157:14 178:5
 200:12 234:21 245:24
completely 50:20 201:9
 204:16
Complex 68:11
complexity 47:19 127:16
 180:5
complicated 68:8 95:15
 118:15 119:23
complication 6:21 7:1
 14:11,13 73:6 79:9 80:6,
 18,24 82:8 84:23 85:15,17,
 19 87:18,20,22 92:7,11,12
 135:19,22 136:6,23 137:2
 140:6,11,13 142:6 144:5,
 22 145:1,9,13,22 146:10,
 12,13,23 147:3,19 158:12
 167:9 174:11,19 175:22
 177:5 178:18,24
complications 13:17
 27:21 45:25 59:2 65:25
 66:6,9,10,19,21 68:5 69:3
 73:4 76:3,8,11 83:20 84:19
 85:13 91:16,25 92:1 93:14
 94:7,18 108:25 109:17
 112:13,14,16 117:23,25
 127:17 135:2 136:25
 137:11 139:21 140:2,15,22
 143:9 144:3,11,18 145:11,
 19 146:20 147:1,10,15
 148:9 164:21 165:6,13,16,
 23 166:4,9,10 167:2,4,11,
 18 169:14 171:10,11,18,
 21,23,25 178:16 246:25
 247:18
comply 11:6
component 198:19
 203:19
comprehensive 236:6
compromise 45:1,11,12
compromised 45:15
 144:15 148:13
computer 183:7
conception 28:24 224:19
concern 44:24 139:22
 180:6 250:6,9 282:21
concerned 77:23 114:23
 163:5 242:22
concerns 42:10 192:4
 194:6 250:11,13
conclude 82:7 112:23
concluded 89:9 113:14
 284:14
conclusion 178:15 247:6,
 23 248:14
conclusions 111:15
 246:24 247:8,17
concordant 249:8

Condic 22:5
condition 25:7 51:17
 158:13
conditions 162:16 188:12
 189:19
conduct 227:21
conducted 129:8
conducting 10:19
conference 220:4 249:10
confident 113:6
confirm 15:1,12 243:23
 257:20 261:9,12 263:23
confirmation 263:25
 270:14
confirmed 75:11 92:19
 263:3 279:7
congressional 244:4
congressman 226:3,15
conjunction 212:12
connect 89:23
connected 256:9
connecting 154:8
connection 81:7 82:13,25
 90:2,16 105:13 129:2,12
 131:22 154:11 201:24
 202:11,16 203:3,5,14,20,
 25 255:18 256:14
cons 48:20
consent 114:15,18,23
 115:4 225:14
consequence 89:9
considerations 275:15
considered 72:4 100:12
 120:23 125:20 137:25
 138:2 160:24 164:15 198:7
 242:9
consistent 158:4 251:6,
 12,21 276:11,14
consists 272:5
constellation 212:25
constitutes 259:7,11
consult 56:25 64:11 121:8
consultant 278:7,8
consumption 99:10
contact 59:23 61:3 271:11
contacted 12:13,15
 280:11
contained 284:8
container 217:15
content 249:20
context 199:8 259:9
 270:20

continues 58:24
continuing 58:12 133:1
contraception 52:18,22
 53:14,19 107:14 111:8,10
 112:5,6 113:11 229:19
 273:2
Contraceptive 52:1,8,19
contraceptives 52:23
 53:9
contract 45:3
contractions 49:5
contracts 243:10
contribution 243:13
control 117:16 188:12
 189:18,24 190:6,8,16,20
 211:4
controversial 128:13,14
 129:6
conversation 118:8 120:6
 126:20 233:8
conversations 205:13
 280:4
converse 90:5
conveyed 15:13
copied 257:8
copies 64:20
copy 237:12 259:12
cord 183:7 201:10 206:9
correct 5:16,17 7:8,14,21,
 22,25 13:6 17:9 18:7,8
 23:22 25:12,17,18 27:14
 30:13,14 31:14 32:14,20,
 22 34:12 35:16,17,19 39:7,
 8 40:20,21 46:25 48:10
 49:8,9 50:9 51:20,21 52:25
 54:11,12 55:17 56:9 61:22
 65:10,17 70:21,25 71:1,5,6
 72:4 73:21,22 74:4,5,7
 78:20 79:11,12,19,20
 80:16,17 81:5,10,11 84:15
 85:23 86:4 87:2,6,7,20
 88:10,23 89:2,3,15,21,22
 93:7,8,11 101:5,24 104:14,
 18 106:13,17,22 108:12
 110:2,21 113:19,20 114:20
 115:8 119:11 120:14
 121:2,25 122:15 124:12
 126:22 128:8 129:19
 131:19 132:4,7 133:2,6
 134:6,7,10 135:12 136:17
 137:24 138:10,19 139:8
 142:15,16,21 146:24
 151:16 152:22,23 153:2,7,
 18,19,22,23 154:5,19
 155:20 156:5,8,9,18 157:1
 159:10,18 160:21 161:11,
 18 162:12,21 163:10 165:2
 166:24 167:21 168:2,21
 169:5 170:24 171:19
 172:20 174:21 178:3,4,12,

13,21 180:12 181:2
 182:17,22,25 184:6,10,18
 186:5 187:6,11,12,18,19
 188:9,10 189:19,20
 190:18,19,25 191:5 192:23
 195:12 200:3 201:8 204:1,
 3 205:8,9,19,22 207:11
 208:25 209:1,16 211:13,
 14,17 212:4 213:16,17,19
 214:5,6 215:3,18 220:11,
 12,14,19 221:3,4 222:6,7,
 8,19,22 223:23 224:6,8
 225:7 226:15,21 230:1,6
 232:1,2 233:13 234:11,25
 235:3,8,18 237:8 238:14,
 20 239:2 240:19 241:24
 242:3,15,16 243:7,8,24
 245:22 246:16,19,20
 248:18,21 249:1,7 252:13,
 14,16,17,25 253:1 255:2
 256:15 257:1,22 259:25
 262:1 263:11 264:1 265:25
 267:19 268:15,23 269:2,4,
 5,22 270:1,9,10 271:22,23
 272:10 273:10,11 274:5,
 14,18 275:16,18 276:1,20
 279:5 280:12,13 281:18
 282:22

corrected 10:15

correctly 74:16 85:14
 110:8 137:21 151:12 154:3
 174:12,13 197:10 200:18
 220:9 247:10,24 254:9,24
 255:19 268:17 277:5

correlate 90:18 188:19

correlation 82:1 87:3
 262:12

correspond 262:14

cortex 201:25 202:11,17
 203:6,15,21,25

cost 126:4

counsel 48:19 72:8 85:24
 131:17 218:23

counseling 44:3,7 47:13
 48:7 57:23 58:18 72:2,3,5,
 19 73:1 114:17 128:5
 133:7 193:16 267:15
 269:15 270:25 271:1

counselors 277:3

count 73:8,18 75:2 136:23
 199:16

counted 202:3

counting 143:19

countries 46:19

country 58:15 143:24
 144:11 150:12 276:15

couple 13:21 50:18 54:22
 93:17 98:23 120:23 138:25
 141:9 175:1 182:14 214:2
 219:21 221:2,16 248:12
 258:6,14

couples 58:17

court 8:11,15 9:11 147:16
 190:15 214:24 215:2 217:1
 221:24 242:21

court's 11:2 15:19

cover 98:22 124:20 125:6
 143:19

coverage 54:8,10 124:23
 125:21 126:24

covered 54:5,6 124:11
 125:5

covering 75:9 76:1

COVID 265:22

Creanga 165:17

create 202:21 259:16
 278:1

created 68:10 105:13
 123:1 238:23

creating 278:1

credentials 29:25

crisis 273:6

criteria 27:11 40:9 41:3,5,
 11,25 247:2,20

critical 11:9

criticism 178:11 191:19

criticisms 191:10

crossed 233:17

cry 119:3

curettage 48:21 49:12
 50:7,11

curious 86:15 111:18
 190:13 211:11

Curlin 22:9

current 29:24 232:23

cut 45:8 87:5,9,21,24
 130:24 146:6,12

cutoff 191:23

cutting 136:20

CV 29:19 30:2,5,7 55:5
 163:16 220:8 222:8,19,21
 225:25 226:5,20 233:9,16
 234:1 242:1,9 243:23,25
 244:6,11 275:3 281:18,21

CVS 233:18

Cytotec 46:9

D

D&c 73:11 169:21,22

D&e 49:16,17 50:12,24
 51:16,19,22 68:8,13 70:8,
 13,16,24 71:4,8 73:11
 79:23 80:1,16,19,25 87:8
 88:20,23 89:1 91:17 94:4,

7,16,24,25 95:2,13 127:16,
 20,23,25 128:2 145:12
 146:18,20 147:3,19 148:10
 165:10,13,20 168:22
 169:14,21,23 180:1

D&es 50:25 51:7 70:15
 147:1 165:24

daily 72:8

Dallas 97:24 206:21

damage 44:16 59:1 80:22
 81:9,11,12,13 82:18 87:10,
 11 198:20,21 200:3

damage.' 197:9

damages 165:3

Danco 147:8

danger 62:14

dangerous 175:7 176:23

dangers 223:17,19,20

Darcy 158:6

data 64:7 66:20 82:20
 83:18 84:16 89:13 90:9,10,
 15 103:2 105:7 106:19
 107:19,20 108:2,3,4,12,14,
 16,23,24 109:8,11,15,20
 110:8,11 111:2,13,14,15
 112:14 113:10 120:16,25
 123:16,19 144:7,14,17,20
 147:5,6,7,15 148:8 149:14
 150:10,13,14,25 151:9,11,
 12,14,21,25 152:2,5,7,22
 153:24 155:18 156:13
 157:4 159:23 160:6,24,25
 161:1,7 167:17 172:11,16,
 19 173:5,7,9,14,17 181:24
 182:1,21 183:2 184:6,17
 192:11 242:15 271:3,6
 278:15,19

date 23:11,18,22 42:8
 234:10 250:13 262:8,10,18

dated 25:10,16 238:13

dates 42:11

dating 25:14 262:11,14

David 194:4

day 9:1 10:7 25:10,13,16,
 19,22 30:19 33:19 116:10
 133:24 214:21 241:4
 266:5,7,9 268:2 284:20

day-to-day 272:6 277:20

days 31:4,7,14 33:20,21
 208:1 219:21

de-identified 76:14

dead 50:17

deal 42:21

dealing 189:1

deals 234:24

dealt 258:4

death 47:25 48:1 51:16
 86:19 136:4 150:15 152:9,
 10,17,18 153:25 154:3,7,8
 155:4,5,19,24 156:10,12,
 17,20 158:10,17,18,25
 159:1,10,18 161:23,24
 175:10,13,17 188:19

deaths 150:15 153:3,4,5,6,
 10,24 155:11,21 156:4,5,7,
 10,12,18,25 157:3 158:2,
 10,15 159:13,19 160:16,18
 161:14 172:12 187:4,6,8
 188:2

debated 185:3

deceased 70:15,17

decide 113:9

decided 55:25

decides 130:17

deciding 106:3

decision 96:12 113:7
 114:1,7 117:8 118:9,16,20
 119:21 120:1,3 191:10

decisional 96:4,15 113:22
 115:2

decisions 96:5,16 113:23
 176:12

decrease 213:9

decreasing 207:16,24

defects 247:4,21

defendant 5:25 6:4 221:2,
 20 227:7

defendants 26:1

defense 6:23 7:1

deficiencies 192:21

define 45:17 68:1,15,16
 128:1 135:24 158:18 159:1
 167:6

defined 203:14,18,20
 228:18,20

defines 158:9 197:7

defining 67:14 197:17

definite 247:8

definition 29:1 50:24
 87:22 123:25 158:22
 197:13,14,15,19,21
 198:13,15,18 199:2,4,19,
 25 200:6,16,17,25 201:3,4
 231:3 258:4,9

definitions 158:2 255:18

definitive 247:6,23

degree 138:4,5,6 139:1,2,4

degrees 137:22 142:17

Deidre 26:9

deleterious 255:14 256:7

deliver 30:18 31:1 39:19

40:23 41:9 46:23 62:16
80:21 132:18
delivered 36:7 97:5
132:19 133:24 143:24
176:20 202:5 275:20
deliveries 31:11 36:11
39:20 134:3,4 137:14
140:7 142:11 145:17
delivering 66:25
delivery 6:8 31:2,5,8 36:9
40:14,18 82:2 85:3 89:18
132:15 133:6 135:20
136:8,9 137:3,12 138:16
139:12 140:13,14 142:21
143:22 161:5 163:2 166:18
168:16,22,23 169:1 208:15
254:7,21
demographic 110:11
Demographics 34:19
demonstrated 209:22
denial 37:2
denied 226:24
Denmark 152:16
denominator 182:21
183:4 184:9
denominators 160:13
department 32:21,23,25
33:4 134:23 135:3 157:14
158:4,9 265:13
depend 24:5 50:16
depending 45:19 125:1
224:23 225:10 264:13
depends 175:24 198:16
200:22 231:3
deposed 7:13,20 22:20
221:1
deposition 5:18,24 7:17,
25 8:4 9:24 10:6,17,19,23
11:15 12:17 13:3,12 14:24
16:20,23,24 23:3,7,9 98:17
215:7 219:4,10,20,25
220:1,2 227:10 282:3
284:13,25
depositions 10:20 17:4
214:25
depressed 186:2,3 229:6
231:4
depression 71:16 72:13,
14,16 185:17,22,24 186:4
depth 157:21
describe 30:15 34:14 43:8
46:1 48:15 64:1 101:4
124:14 143:11 198:25
209:12 228:13
describes 118:9 163:13
describing 74:11 75:11
155:9

description 171:20,22
design 191:16
designed 189:23 191:20
194:22
desire 58:24 59:3,11,17
83:25 146:2 150:12
desired 51:16 193:6
desires 51:14,15
destroying 132:17
destruction 70:19
details 29:11
detect 171:25
detected 28:18,20,21
266:9
determine 40:9 51:15
152:14 191:13 206:7
270:23
determined 99:11
determining 41:4 177:19
183:1
develop 131:2 142:12
developing 200:10
development 26:11,15
201:8,18,20 204:23
device 43:12
diabetes 40:12 162:15
diagnose 71:25 262:25
263:8,15,18
diagnosed 25:7 225:6
diagnosis 48:18
Diana 14:1 149:13
die 80:10 155:13 156:2
188:17
died 50:21 73:14,15 79:17
80:5,7 85:4 88:8,19 93:22
155:7 159:4,5,12 165:14
190:5
difference 156:19 190:6,8
191:3 201:16
differences 190:16
difficult 47:20 76:12 81:25
94:12,16 123:14
dig 153:11 241:10
dilated 41:11,12
dilating 82:17
dilation 42:3,24 48:21
49:11,18 50:6,10,11 81:20
dinner 220:4
direct 206:8
direction 210:6
directional 209:20 210:1,
23,25 211:2

directionally 210:10
directions 117:5
directly 88:13 108:3
109:20 186:9 206:11
242:19 259:6 267:4,18
director 260:25
disagree 158:5 171:23
175:19
disagreeing 106:4
disagreement 158:7
disarticulate 50:23
discharge 207:19
disciplinary 227:5
discomfort 95:17
discover 60:3 66:8 76:15
161:2
discovered 53:20
discrepancy 262:13
discuss 57:19 72:9
115:23,25 120:12 141:4
177:19 197:24
discussed 66:10 102:14
105:16 122:3 127:22 151:8
166:14 227:8 228:11
280:17 284:18
discussing 38:5 97:7
115:16 149:15 187:17
256:19
discussion 29:17 107:6
145:22 164:1,12 170:15
180:18 213:15 214:18
230:15 282:8
disingenuous 163:25
disorder 84:25
disqualified 247:2,20
disqualify 221:23
disrupting 274:11
distended 49:21 164:23
169:16
distributed 184:1
doctor 5:19 28:7 31:11
41:24 42:1 49:20 59:9,15
61:24 62:15 69:9 71:3
75:17,24 76:17 77:4 82:4
107:23 115:7,13 122:19
141:16 167:23 221:18
263:3 264:21 268:22
doctors 69:10 71:7 101:4
109:22,24 133:11 140:19
147:21 260:24 274:16
275:19 276:4
document 35:10 99:4,7
100:2 167:12 170:21 172:7
203:22 234:15 236:19
237:5,20,22 238:3,6,12,16,
21,22 241:13,14 243:2
262:7 264:16

documentation 160:17
204:2
documented 14:17 97:4
150:14,15 155:24 161:2
165:19,22 188:16 189:10
documents 10:8,14 11:15
12:9 14:23 15:4 99:17,19
100:4,12 101:23 102:3,11
105:13 194:14 217:9,15
218:6 219:13,18 240:20,21
241:17 242:5 245:14,15
284:18
Doe 228:18
dog 148:23
dollars 54:3,16,18 104:5
126:5,21 127:7
Donna 21:14
door 91:11
dose 137:9 141:7
dosing 74:21,25
double 161:4 163:1
doubt 112:9 127:23
draft 102:4 240:9
drafted 106:17 123:15
drafting 26:18 102:6,12,17
103:3,7 104:2 121:22
124:3 235:6 237:7,16
238:17 240:18
draw 111:15 157:25
179:16 265:11,12,14,18,25
drawing 91:24 266:10
drawn 178:16 247:8
drew 235:10
drive 77:23 78:14 131:8
driver 125:14 131:8
drop 237:16
dropped 238:4,6 243:3
drug 190:5
drugs 77:18 141:20 190:4
drugstore 261:16,21,25
due 30:24 40:14 42:8 45:2
87:1 127:16 160:17 162:14
247:4 264:18
duly 5:3
duplicates 76:15
dying 160:9 174:11,18
175:14,22 177:5
dysfunctional 39:14

E

earlier 35:13 36:9 61:16
68:7 69:12 71:3 81:8,9
82:12 85:22 95:9 106:14

<p>113:21 115:6 124:11 126:20 127:22 128:5 143:5 144:17 147:25 151:8 165:14 171:24 172:10 176:8,12,14,19 177:11,16 182:3 186:21 193:4 195:11 207:6 209:23 213:14 214:13 220:25 228:11 235:2,17 242:13 252:12 259:24 268:19 273:25 276:19 282:18 284:6</p> <p>earliest 200:7,19 201:4,23 202:10 207:13</p> <p>early 35:2 45:22 49:19 74:17 80:21 81:16,20 82:2 89:18 124:17,22 130:24 150:18 155:23 165:20,24 174:4 176:3 203:3 211:6 224:18</p> <p>easier 125:10</p> <p>easily 50:14</p> <p>easy 120:8 121:6 149:3</p> <p>ectopic 155:16 262:25 263:2,8 264:1</p> <p>editor 223:7 225:24 226:1</p> <p>effect 25:1 128:16 141:20 144:8 175:3 192:1 255:13, 14 256:6,7</p> <p>effective 53:8,22</p> <p>effectively 162:21</p> <p>effects 89:5,6 158:14 201:15</p> <p>effort 105:6 236:12 242:14</p> <p>efforts 9:3</p> <p>eight-week 174:14,25 175:15,25 177:15</p> <p>eight-year 186:16</p> <p>Eighteen 38:7 66:17 186:22</p> <p>elected 27:7</p> <p>elective 25:3 40:8 41:2,23 43:16,19 44:2 47:9 86:16 177:20 231:12</p> <p>electively 85:23 132:21</p> <p>elephant 252:8</p> <p>eligible 54:15</p> <p>else's 248:10 251:9 258:10 259:6,7,11 282:21</p> <p>email 219:6 236:20,22 237:21 238:3,22 239:5</p> <p>emails 12:10</p> <p>embolism 136:3</p> <p>embryo 28:25 29:2</p> <p>emergency 27:22 65:25 73:9 75:9 76:1 78:18</p>	<p>emotional 92:4 117:25 197:8,15 198:19 199:5,8 203:19 228:19 255:13,14 256:6,7 278:3</p> <p>emotionally 51:12 203:10</p> <p>employ 260:22 272:17,22, 24</p> <p>employed 261:1</p> <p>empowering 273:22</p> <p>encompasses 114:12</p> <p>encounter 117:1,7</p> <p>encountered 119:14</p> <p>encountering 113:18</p> <p>end 37:24 38:17 120:12 145:17 152:4 158:11,19 164:20 165:21 173:20 211:24 214:21 218:8 247:15 270:7 279:18,20 282:1</p> <p>ended 15:8 86:9</p> <p>ending 116:13,18 129:15 131:19 132:21 155:18,19 162:1</p> <p>endogenous 201:12 212:17</p> <p>endometrial 39:13</p> <p>endometritis 137:11</p> <p>endorphins 212:10,15,16 213:8</p> <p>ends 155:13 156:23 180:18</p> <p>enforced 174:9,17 175:21, 25 176:6 177:4</p> <p>enforcement 25:7 176:11</p> <p>engaged 258:13</p> <p>entail 20:5</p> <p>entering 87:25</p> <p>enters 156:22</p> <p>entire 252:13 259:12</p> <p>entitled 157:14 173:1 178:1 245:20</p> <p>entity 24:15</p> <p>envelope 217:16,17,21, 22,25</p> <p>envelopes 218:7,13,20</p> <p>epidemiology 98:3,4</p> <p>equivalent 147:11</p> <p>essentially 99:10 102:8 125:16 139:7</p> <p>estimate 34:24 35:20 73:5 75:3</p> <p>estimated 45:20 83:14 274:3</p>	<p>et al 254:20,23</p> <p>ethical 57:4</p> <p>ethics 57:2,5 98:7,8 281:15</p> <p>Europe 144:21 146:15</p> <p>evacuation 49:22 50:11</p> <p>evaluate 208:15</p> <p>evaluated 132:19 135:8</p> <p>event 20:10 136:3 159:4</p> <p>events 158:12 160:3 255:8 256:1</p> <p>eventually 48:25 270:3,6</p> <p>everybody's 79:8 90:12</p> <p>evidence 199:13 203:3,4 238:13 260:7 270:21</p> <p>evident 255:15 256:10</p> <p>exact 262:22 282:19</p> <p>EXAMINATION 5:5</p> <p>examine 169:1</p> <p>examined 5:3</p> <p>examines 246:22 247:16</p> <p>examining 106:1</p> <p>examples 249:16</p> <p>exception 152:11 229:4,7 255:1</p> <p>exceptions 25:4 231:10</p> <p>exclude 161:14 162:20</p> <p>excluded 100:13,19</p> <p>Excuse 95:22 101:12 148:6</p> <p>exercise 212:24,25</p> <p>exhibit 29:16,18,20 98:13, 15 110:18 157:10 164:18 170:9,13,14,18,20 172:4, 24 173:1,21 177:23,24 178:7 181:16,18 183:14 186:15 197:3 234:7,8 237:18,22,23 238:1,2,3,9, 10,25 241:14 243:4 245:19,23 246:13,14 248:17,19,22,23 252:5 253:2,3,21 254:12 255:5, 21 257:18 268:6,7 273:13, 14,19 277:1</p> <p>exhibits 16:4 107:4 214:19,20 215:3 245:15</p> <p>existing 243:10</p> <p>exists 203:3</p> <p>expand 266:3</p> <p>expect 217:5 249:11 250:19 257:24</p> <p>expectations 276:11</p> <p>expected 176:4</p>	<p>expediting 73:1</p> <p>expense 53:24 54:15 126:5</p> <p>expensive 54:1 124:17</p> <p>experience 7:24 37:14 53:13 54:2 66:2,18 73:2 82:5 91:24 92:1 94:13 96:21,24 113:2,17 126:16 127:24 132:7 174:10,17 175:21 176:5 177:4 189:1 197:8 199:5,7 200:2,8 201:5 202:18 203:5,7,13, 16 212:6 214:4 260:10 264:9 275:23,25</p> <p>experienced 68:5 200:20</p> <p>experiencing 50:8 97:9</p> <p>expert 6:1,19,23 8:21 11:21,23 12:2,5,14,19 13:6 15:2,5,7 16:11,17 19:8 20:1,8,13,22 21:19,20 22:14 24:2,16 28:9 29:11 65:16,20,21 66:3,5,15,16, 23 67:3,6,8,12,14,16,18,25 68:2,15,18 69:5,8 71:11, 12,15,19 72:13 95:20,23 96:1,4,13,19,23 97:5,25 98:6,9,10,13,17 99:1,18 100:3 101:24 102:17,20 104:21 105:12 112:20 127:12 129:11 146:22 159:16 163:10,13 180:10 194:9 197:3,22 198:14 199:3 202:9 221:2,24 230:7 234:24 235:3,12 238:24 239:19,20,22 240:5,19 241:14,23 242:2, 10,14,23 244:9 246:15 249:6 280:9,18,22 281:4 283:22 284:3,8</p> <p>expertise 71:14 72:22 97:2,3,11,12 205:25 260:7</p> <p>experts 21:15 102:18 204:7,13 239:25 241:7</p> <p>explain 27:18 37:5 160:12 250:9</p> <p>explanation 125:19</p> <p>expose 210:16</p> <p>express 58:24 118:13</p> <p>expressed 59:11</p> <p>expresses 59:17 60:13</p> <p>expressing 49:5</p> <p>extensive 44:3 66:8,18,20 138:4 215:14</p> <p>extensively 15:10</p> <p>extent 109:2,12 152:25</p> <p>extract 50:19</p> <p>extracted 50:15</p> <p>extraordinary 108:19</p>
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September 02, 2020

extrapolating 180:14
extreme 199:19
extremely 48:1 80:21 82:2
 94:12 129:6 143:23 178:17
 179:7,13,18,25 182:6

F

face 79:8 210:17
Facebook 116:12
faces 79:3
facilities 27:11 273:4
facility 85:4
facing 277:2
fact 18:6,7,8,11 81:9 82:11
 97:5 130:5 159:8 188:2
 199:17 234:3,10,18
 235:10,15,18,20 236:9,16
 238:24 239:3 240:18
 241:15 245:16
factors 173:1 193:17
facts 100:23 103:2 105:7
 242:15
factual 102:23
failed 117:16 162:14
 167:12
fails 78:1
fair 8:23 62:19 117:22
 150:22 194:3
fairly 43:21 121:17 180:4
 223:5
fall 11:24 19:24,25
falls 230:19
familiar 24:22 57:5 96:10,
 14 113:22,24 121:14,23
 122:11 148:3 154:15
 155:2,3 172:1 173:16
 198:6,9 234:3
families 58:14
family 68:11 116:8 117:2
 232:22
Fansteel 5:14
fared 196:11
Farr 22:9
FARRELL 237:25 248:21
father 210:16
fault 215:8 216:21
faulty 252:21 253:12
favorable 41:10 42:1,2
 111:12
FDA 27:9
February 234:10
fecal 138:9

federal 226:8
Fedex 217:16
feedback 7:11
feeds 206:11
feel 9:22 66:15 115:12,13,
 15,17,18,20 116:2,17
 118:16 175:8 258:8 259:20
 264:7
feeling 113:8 115:25
feels 55:23 229:5
fellow 55:6
fellowship 68:11
felt 27:24 100:24 209:4
Ferguson 194:4,8,17
fetal 18:15 25:8 28:17,19
 35:10 46:5 47:25 50:13
 94:15 96:20 97:19,22
 99:20 101:15,18,19,22
 121:20 123:7 152:10 154:3
 155:5 164:25 168:19
 177:19 193:7 199:23
 201:2,14 204:5 205:19
 206:8 212:12 224:14
 234:4,10,24 235:23 236:1
 237:7 238:14 239:12,22
 281:12,14 282:12
fetus 25:8 28:24 29:2,3
 42:11 48:22 50:14,17,19,
 23 51:13,17 70:14,17,19
 96:21,24 132:18 133:15,
 16,24 134:6 197:25
 199:10,13 200:5,8,20
 201:5,17 202:12 203:5,13,
 22 204:1,9,10 206:6
 208:24 209:19 210:9,10
 211:11,12,20,23 212:1,4,9
 213:4,13,18 231:25 270:22
fetuses 66:18 70:15
 207:22
fever 137:8
fewer 179:12 195:17 247:5
fibroids 46:16
field 64:2,5,11 65:19,23
 67:1 111:9 121:13 163:21
 164:8 251:7,13,22 252:2
fields 63:9
Fifty-two 253:6
fight 212:7
fighting 208:18
figure 216:11 252:1
figured 218:21
filed 227:4
finance 78:4
financial 121:19
find 12:22 54:7 76:15
 115:2 116:6 120:21,25
 121:3,6,7 122:8,18 123:19

139:15 147:23 171:19
 181:23 213:21 216:7
 274:21 277:13
finding 8:19 121:1 195:21
findings 14:4 196:2
fine 107:2 149:1 183:9
Finer 13:23 106:13,19,21
 110:21
finish 9:13,14 14:20,22
 55:3
Finland 14:16 152:16
 186:24
Finnish 152:20 153:15
 156:11,16 159:15 186:20
 187:3
fired 227:14
firsthand 214:4
fits 53:20 179:10
fix 138:25
flaccid 45:2
flag 9:4,5,24 10:16
flawed 109:1
flight 212:7
flipped 157:19 215:13
 219:15
floor 142:9,14
Florida 120:12,22 121:1,3,
 8 122:16,18,21 275:5
flow 45:3
fluid 137:7 210:20
focus 20:9 85:12 86:20
 189:13 192:14
focuses 234:4
fold 85:1
folder 157:20
Foley 43:9,10
folks 196:18
follow 86:22 133:13
 284:17,19
follow-up 62:5
food 9:22
footnote 106:12,22 171:3
 187:1
footnotes 186:19 187:18
forceps 167:23,24
forever 196:25
forgetting 166:17 223:6
forgot 10:8 259:3
forgotten 22:3 221:18
 222:20,24
form 130:25

format 236:15
formed 201:24 202:3,10,
 16 203:5,14,24
forms 52:21 76:13 202:14
fortunately 46:13,19
 49:14
forward 111:13
Foster 13:23 14:1 149:13
found 64:7 76:12 106:2
 123:15,20 147:19 195:15
 196:10 223:16 254:2,6,16,
 20 280:16
foundation 19:10,15 61:5
 86:11 119:12
founded 52:3
fourth 137:23 138:4,5
 249:4
Francis 21:14
free 52:15 72:18 268:11
 269:24
frequent 165:24
frequently 71:18 74:13
 77:9 79:7,8 124:11 179:1
 261:6
friend 116:11
friends 12:2 116:9 117:2
front 273:20 278:9
full 5:12 9:11 11:10,11
 30:18 33:17 60:22 115:4
 128:17 132:16 145:5 146:6
 164:20 173:20 178:8 197:5
 247:13 252:19 253:22
 254:1 255:7 266:7,12,16
 274:8,21,22 276:4 283:10
full-service 273:22 276:8,
 10
full-time 266:17
fully 201:23 202:3,10,16
 203:5,14,24
functioning 200:13
 203:21 272:5
fund 232:19,20
funded 34:19
funding 34:18 37:3,5,8
 125:3 232:8 233:3
funds 58:2 232:13,20
future 95:10 165:1 169:11
 173:18 189:3,8

G

gap 156:1,5
gathering 155:25
gave 61:14,16 249:9

gears 24:19
general 55:15 107:7 167:9
generally 28:20,21 35:6, 10 42:9,17 44:22 46:13 48:24 51:11 64:4 75:14 101:17 133:11 134:18 138:15 171:14 206:20 231:13 262:11 263:7,10 264:6,8 268:1 274:15
Genuity 147:8
Georgia 28:13,14 29:6 223:10 224:4,11 230:8
gestation 25:3,9 145:7 173:24 174:1
gestational 38:4 41:7 51:10 67:10 68:6 81:21 97:6 125:1 184:1 191:23 200:11 205:10 206:16 208:14 264:14
GI 183:25 184:2
Gissler 14:18 186:23
Gisslers 186:24
give 22:14 35:11 58:4 61:2 81:25 115:24 120:6 129:21 141:15 142:1 160:23 165:13 183:12 190:24 191:4 205:6 208:11 210:19 268:14 273:7 281:9
giving 52:14 85:9 157:4
glad 118:23
glanced 157:23 245:17
goal 229:18,19 230:16 273:1
goals 230:17
gonorrhea 266:8
good 5:7 53:10 54:17 55:14,21 65:1,6 69:5,7 91:10 107:10 110:6,9 113:10 121:5 124:7 133:4 144:10 147:6,7 148:17,24 149:6 150:1,14 151:11,17 160:25 161:1 163:6 167:8, 17 171:7,22 179:5 182:3 190:12 194:5 195:2 197:14 198:18 214:8 230:21 236:14 281:9
governing 214:25
government 232:13
government's 121:9
grant 232:22
granted 275:20
graspers 50:23
grasping 49:20
Gray 63:19
great 160:6 181:23 237:4
greater 180:22 224:5 255:14 256:7

Green 63:14
Greene 14:1 149:13
grief 95:21,23,25 96:2
grieve 51:14
Grimes 147:22 160:12,21
Grossman 147:21
ground 8:4 9:9
group 13:24 30:17,20,24 52:16 76:1 81:18 83:22
groups 22:13
guess 52:20 112:1 128:1 138:20,22 148:18 161:22 242:12 250:5 257:1 258:3 280:7
guidance 50:1 62:23
guide 57:3 63:4 171:5
guides 170:23
guilt 115:25 255:11 256:3
guilty 9:9
Guttmacher 13:1,22 83:23 107:12 108:2,5,6,16, 18 109:4,14,19,23 111:11 113:11 121:18 151:7,16 180:14 181:10 182:17,21 184:2,5,17
Guttmacher's 58:20 151:9
guys 15:9 77:20 78:5 101:7 180:2 193:15,17 196:22 213:23 215:16
gynecologic 34:10,11 55:15 65:22 276:5
gynecological 34:8 39:7, 9 111:9 274:9 275:17
gynecologists 55:7 56:9 274:13
gynecology 56:22 63:10, 16,21 64:2,12,18 65:20,24 66:15

H

habit 216:14
half 9:21 37:20,24 45:23 148:25 149:1,3 275:12
halfway 36:24
handful 247:5
handle 48:13 49:12
handouts 21:4
happen 9:3 43:24 46:11, 12,13,25 47:3 77:11 78:7 80:12 83:4 90:5 94:11 115:11 135:14 137:14 139:12,13 140:18 141:23 142:10,15 143:1 166:7,14, 15,16 167:5 168:5,10,12,

14,15,24 169:4 202:23,25 211:5 213:1,5 227:11 271:9 278:20 279:3
happened 36:10 75:17,24 78:20 91:3 133:4 135:16 157:6 190:3,23 222:14 251:2
happening 169:25 212:9
happy 9:4,25 55:2 94:6 176:20
hard 49:1 50:12 76:14 84:23 100:5 103:8 111:11 115:3 119:8,24 121:19 126:18 192:1 223:4 248:6
Harrison 21:14
HB 177:8
HB136 24:22 26:12 123:11 164:4,5 175:3 177:9
HB2 27:4,5,6
health 52:17 59:2 71:11 72:5,19 77:15 83:23 94:21 96:5,15 113:23 121:20 124:11 125:8 132:3,9 134:17 156:21,22 157:14, 15 158:4,9 164:6 188:12, 24 189:2,19 192:6,7,14,23 193:5,8,19 194:2,18,25 195:18,23 196:15 228:5,6, 14,16,18,20 229:3,4,7,10, 16 231:1,3,7,15 232:20 233:21 247:3 255:10,12 256:2,4 260:8 265:13,14 266:5 272:22 273:21,22 274:8,11 276:8,11 278:3,4
healthfully 68:7
healthy 146:1,2 208:17
hear 19:12 264:16
heard 11:25 53:16 114:13 125:2 134:14 182:5 206:3 216:2
hearing 61:15
heart 28:17,19 45:20 201:13 212:7,11,18,23,24 213:25 264:16
heartbeat 224:15 225:9 270:15,21,23
heightened 129:13 131:23
held 29:17 170:15
helped 76:16 213:23
helpful 24:19 25:25 84:6 159:21 166:9 191:14 195:8 204:21
helps 270:13
hemodynamic 45:1,10, 11,12
hemorrhage 45:17,19,22 73:20 76:19 79:1 85:5

165:1 169:4,19
hemorrhages 75:4
hemorrhaging 73:10 88:7
Henderson 26:9
high 40:11,13 49:21,22 88:17 94:14 112:7 127:15, 16 130:8 162:15 178:17 179:7,13,18,25 180:8,25 183:11 193:2 202:2
higher 44:4 89:17 109:14 125:14 152:18 162:5,11, 16,17 169:24 185:4 193:5, 11,18 261:18
highest 144:16,17,20 145:11 162:21 209:12,13
hill 226:4
Hispanic 34:20,23
histologic 199:12 203:2
histories 82:6,24
history 47:10 80:21 81:23, 25 82:14,22 83:4,10,13 84:9,12 85:19 89:8,24 90:12,15,17 91:14 92:19, 24 93:9,11,15 115:7 153:17 189:2,6
hit 159:7,17 187:10
HIV 265:14
hold 28:16 43:13 51:13 80:23 82:19 115:6 196:25
holds 43:11
home 40:6 178:2 216:13 224:16 225:7 252:6 257:17
honest 120:5
honestly 49:15
hoping 281:3
hormones 130:24
horrified 199:17
hospice 132:20
hospital 27:9,24 30:25 31:5,8,13 32:8,16,21,25 33:3,6,7,13 36:7 42:17 50:4 73:19 134:2,24 135:11,21 136:1 138:3 141:3 159:6,8,17 207:19 275:12,13 276:20
hospitalized 81:19
hospitals 32:6 33:13 132:2,6 160:3 209:18
hour 9:20 22:25 23:10 65:4 148:25 149:1,3 196:20
hourly 22:22
hours 16:4 22:21 23:15,22 24:9 78:16 103:6,25 189:16 225:21,22 280:15
Houston 97:24 206:21

human 116:14 164:1
179:15 199:23 230:15
humanity 270:13
humans 204:22
hundred 160:4 180:19
hurting 211:19
hypertension 40:13
162:15
hypothetical 129:21
hypothetically 48:3
hysterectomy 7:3
hysterotomy 161:17

I

ICU 73:12 76:4 93:17,20,23
136:2
idea 23:10,21 103:6
258:16,17
ideas 100:7 258:5,11
identical 97:8 129:23
241:16 248:1,2 249:12,14,
19 250:3 251:4,11,20
253:18 255:2 256:15
257:14
identically 257:10
identification 71:16 72:14
identified 19:4 76:24
156:7 159:9
identify 13:20 71:25
100:11,18 110:2 147:15
155:7 156:17 187:5
identifying 77:7 145:18
155:12 187:7
ifs 133:20
ignore 91:11
illegal 229:18 230:23
illness 72:1 123:7 185:1,5
189:2,3,4,7,8
imagine 30:9 35:15 54:13
129:22 179:23 231:6
immature 130:23 131:10,
13,25
immoral 115:21
impact 86:2 192:14,24
194:1,2,18,24 195:21
255:12 256:4
impact.' 247:7,23
impairment 207:20
implantation 91:4
important 9:10 27:25
163:5 182:25 183:10 191:3
226:5 242:19 244:14
imprecise 38:2 189:5

impropriety 283:14
improve 27:25 209:4
improvement 255:9 256:2
inability 80:23
inaccuracies 30:2
inaccurate 151:20
inadvertently 282:16
inaudible 86:19 172:17
incest 123:8
incidence 75:23 85:1
89:17 127:17 148:9 169:24
incidences 53:3 195:17
incidentally 55:22 58:17
incision 44:14 112:24
137:7 162:24
include 29:24 59:1,2 105:6
136:16 142:19 159:16
164:22 180:21 187:10
197:15,22 198:19 233:16
242:14 257:25 258:21
included 163:15 198:14
215:3 275:3 283:21
includes 159:3,5,19
including 52:17 67:2
76:12
income 54:14 126:14
incompetence 80:20
incomplete 49:22 83:18
164:25 168:18,20 172:17
incontinence 138:10,12
142:23,24
incorporated 99:12,18
100:7 281:6
incorporation 100:12
increase 41:16 86:5,17
87:1,2 129:16 153:9 174:3,
5,6 175:13 176:4 188:2
increased 85:1 128:18
129:3 160:17 165:20
174:10,18 175:10,12,16,22
177:5 254:2,6,16,21
increasing 160:18
indecision 106:7 112:21
176:23
indecisional 113:15
indecisive 176:17
independent 240:25
241:2 257:15
independently 248:14
Indian 34:21
indication 47:10,11 48:10
134:3
indications 41:1 42:10
43:22 46:7

indicator 157:15 213:11
indicators 135:16 137:1
individual 24:15 42:4
101:21 188:22 267:12
272:7
individual's 90:15
individuals 19:9 22:13
49:10 92:19 105:21 116:8
130:19 241:6 265:17
266:18 275:9 277:14
278:17
induce 40:3,10,22 41:22
42:8 47:1 88:16 95:7 133:6
induced 173:2 228:10
inducing 41:14
induction 31:10 40:1,4,8
41:16,23 42:14,16 46:4,5
47:3 50:3 51:11 70:10 74:9
88:10 134:2 162:14 228:25
231:23,25
inductions 41:3 45:25
46:25 127:18
industry 108:7 147:11
inevitably 118:17
inexperienced 169:25
infant 226:13 254:7,22
infected 44:15
infection 44:14 46:5
88:17,22 137:5,12 141:7
143:10 165:1 168:13
169:7,18
infertility 92:16 165:2
169:11
inflicting 212:4
information 12:25 13:20
56:22 59:10,23 61:3 63:9
64:17 86:22 96:12 111:9
120:21 122:2,14 124:6,15
128:20,21 155:9,25 156:6
160:1,23 163:7 171:7,10
183:12 193:13 208:5 215:9
220:24 235:11 236:2,17,18
239:19 241:22 249:25
267:6,21 271:2,11 275:1
277:4,10,12 278:16 280:16
282:5 283:21
informative 14:16 251:1
informed 114:14,18,23
115:4 225:14
infrequent 123:6
infrequently 74:24
Ingrid 5:2,14
inherently 241:7
initial 136:24 281:21
initially 191:1
initiated 158:12

Initiative 52:2,8,20
inject 88:13
injury 7:4 142:9,15 164:23
168:5,10
input 26:21
insert 42:20
insertion 53:19
inside 15:23 94:16 166:13
217:14,19,24
insinuated 174:13
instance 76:18 77:6,10
78:20 166:20 208:22
instances 75:11 92:17
207:25
institute 18:18 19:7 22:12
52:2,19 83:23 107:12
111:11 184:3,5 244:2,17,
25
instrumental 164:22
167:19 169:15,20 252:20
253:11
instrumentation 85:18
90:19,20,22 92:15 93:7
instruments 49:20 162:25
166:17,19
insurance 34:19 37:7
54:9,20 124:11 125:8,14,
15,21 126:6,24 144:12
insurances 54:7
intact 51:13 82:19 202:7
integrity 251:7,13,22
252:2
intend 8:21 65:16 104:17,
21,24 277:2 284:7
intentional 70:18 259:4
intentionally 132:17
209:25 228:7 244:13 251:8
interest 60:13 83:17 224:7
interested 8:19 60:4 90:10
98:8 128:6 241:12 267:10
281:8,9
interesting 171:10 184:13
intermediate 242:5
International 197:6 198:2
internet 12:21,24 53:17
60:3 99:22
interpret 123:15 211:2
276:12
interrupt 66:13 86:23
interval 157:7
interviewed 20:7
interviews 281:10
intimately 198:11 272:1

intolerance 46:5
intrafetal 97:21
intrahepatic 206:3
intrauterine 97:22 205:18
introduce 29:13 49:20
 58:16 88:22 98:11 110:16
introduced 243:4
introducing 107:3
introduction 162:25
invades 91:4
invasion 252:23 253:15
invasive 47:18 85:1 90:4
investigation 227:21
involve 6:6 87:9 136:19
 138:6 162:24
involved 18:4 20:6 52:1
 72:25 102:5 114:22 221:15
 235:13 236:11,15 260:15
 272:1,6 275:9 277:20
involved' 106:5
involvement 235:18
involves 7:21 87:5 162:25
involving 28:5 204:6
iowa 207:18 208:7 209:7
irregular 263:23
irrespective 17:2 159:2
Islander 34:22
isoimmunization 206:6
issue 24:23 37:6 74:4
 96:22 117:4 135:17 205:3
 249:4
issues 18:24 37:4 57:4
 94:22 195:18 214:17
 257:15 260:8
IUD 53:19
IUDS 54:1
IV 93:19 136:2 137:9

J

JAMA 199:15 202:1
job 8:25 71:22 144:10
 193:21 227:18
jobs 135:4
joined 18:9 52:6
joint 226:3
Jones 13:23 106:13,21
 110:21
journal 63:14,17,19,20
 107:13 111:7 220:17
 248:25 249:11,17
journals 63:7,8,11 64:2,3,
 10 258:8

Joyful 256:1
Joyous 255:8
judge 10:18 177:2
judge's 10:20
Julie 5:9 170:9 215:20
 237:3
July 117:17
justify 107:17 116:15
 198:17

K

Karalis 186:23
Kate 21:13
keeping 45:13
Kevin 226:7
kicked 56:17
kid 167:25
Kids 119:8
kill 176:24
killing 164:1
kind 6:6,10 7:1,20 26:24
 28:7 44:23 54:10 87:10
 114:17 118:1 135:7 137:10
 139:1 142:8,9 143:15
 153:17,25 155:8 209:2
 210:22 216:14 217:15
 243:11,19 261:13,16,24
 262:17 268:10 269:10
 272:20 281:13
kinds 33:18 39:10 93:7
 136:7
knew 19:25 20:2 249:12,18
 257:25
knowing 36:18 106:2
 115:1,2
knowingly 283:1,5
knowledge 24:4,8 41:21
 56:3 122:9 154:21 221:22
 260:21 272:11 276:4
Kristin 170:9

L

lab 199:20 266:17
labeled 137:22
labor 31:1,4,8,9 40:3,10,
 19,22 41:14,22 46:6 84:8
 88:16 135:19 136:8 137:3
 140:13 228:10
labors 46:21
labs 265:15
lacerate 94:15
lacerated 45:5

laceration 142:18
lack 58:21,22
lacking 64:7
lady 93:17
Lance 284:16
language 237:7 239:12
 241:16 258:1
laparoscopic 39:14
LARC 54:19 127:1
LARCS 52:25 53:2,14,15,
 21 126:20
large 45:4 89:16,17 105:24
 106:1 108:19 182:7
largest 58:3
late 13:18 37:1 51:9 73:23
 103:24 108:23 114:9
 149:14 155:22 174:11,19
 175:17,23 177:6 193:9
 220:10 231:12 256:13
late-term 108:22 182:7,9
 189:11
laters 124:25
latest 36:5 51:22
law 24:21,22 25:1,6 76:10
 94:9,10 134:7,9,12 176:7,
 11 229:8 230:19
laws 134:14
lawsuit 227:8
lawsuits 221:1
layman 123:23
layman's 208:22
lead 46:5 82:16 113:16
 164:25 169:17 236:12
 253:12
leadership 55:24
leading 64:1,12 67:11,18,
 21,25 68:2,15 164:24
 168:13 198:3,7 255:14
 256:7
Leah 248:18
learn 38:11,15 281:8
learned 11:22 12:4 36:22
 98:4
learning 281:9
learns 38:21
leave 40:8 51:16 94:15
 130:24 172:2 173:24
 227:17 244:13 272:16
 283:24
leaves 156:1 187:11
leaving 131:25
left 150:4,5 159:6 247:14
leg 199:18

legal 75:12 173:2 228:13
 229:1,10,15,23 230:1,6,25
 231:5,8,17
legislate 231:9
legislation 26:5,15,19,22,
 25 27:1,6,14,16 28:4,14,16
 38:5 161:3 222:6 223:21,
 24 226:8,9 230:2,8,16
 232:6
legislators 26:21 61:18
legislature 27:13 61:15,17
 222:11,17
legs 210:17 211:16
lethal 25:7
letter 284:17
letters 12:10 218:11 223:7
 225:24 226:1,17
Levatino 22:2
level 85:4 152:7 200:13
 201:7 209:8,11,12 272:3,4
Liao 254:23
license 226:24 227:1
licensing 271:19 279:14
life 25:4 62:14 116:14,18
 121:19 123:7 129:14 130:4
 131:24 132:21 134:15,16
 142:13 222:13 228:23
 229:3,11,16 230:15 231:2,
 7,16
life-threatening 228:21
lift 258:6
ligation 39:15
light 111:12
likelihood 94:14 130:20
 188:19
likewise 254:5,20 255:10
limb 201:12
limit 24:9,12 226:12
limitation 155:17 230:22
limitations 230:21
limited 173:7 185:12 251:4
Linda 173:3
link 237:17,19 238:4
linkage 186:22 187:2
linked 92:15 129:16
 255:17 256:12
list 29:24 135:7 140:25
 141:3 244:23
listed 104:20 234:1 252:15
listen 77:4
lists 104:16
liter 45:23
literature 58:20 66:9 67:9

96:14,18 97:4 99:20 101:1, 4 102:2 107:11 113:22,25 128:12 129:6 144:19 242:6 243:1 246:24 247:17
live 145:25 146:2 152:4,10 154:6 169:23 202:5 205:14 275:20
lived 93:23 207:19
liver 206:11
living 70:14,19 97:6 116:14 126:10 179:15 207:7,12,14
LMP 25:15,21,22 28:22 38:18 224:17,18
lobules 128:17 130:23 131:10
local 226:1 271:11
located 32:8 260:18 272:12
location 265:18
locations 272:12
long 46:4 51:3 78:14 99:8 135:21 208:2 251:18 258:3 284:20
long-acting 52:22
long-term 84:22 89:5 195:20 246:25 247:6,18,23
longer 17:14 49:12 50:7 54:25 55:1 63:24 114:5 230:13
longitudinal 192:23 194:20
looked 12:21,25 13:2,23 14:5,7,12 16:6 53:17 99:23 100:16 101:8 121:10 155:4 157:18,19,23 182:23 193:12 205:3 217:3 236:4, 7 245:13 263:23 275:4,11, 12
Los 179:9,22
lose 85:5
loses 51:10
loss 44:25 143:9 255:11 256:4
lost 45:20
lot 13:22 14:14 23:13 30:21 47:20 55:14,21 71:13 81:22 83:17 84:13 91:8 92:4 94:13 96:22 98:4 100:5 102:6 103:10 108:22 111:20 114:12 115:17,18, 19 116:21 119:3,10 120:4 160:6 167:10 182:7,8 188:21 190:11 191:21 197:16 213:24 216:12 232:14 239:24 240:22 241:2,21 257:3 266:13

Louis 53:11
love 191:2 241:9
low 133:3 178:17,24 180:4 183:7 224:24 254:7,21
lower 109:14 131:12 179:16 200:14
Loxafamosity 122:11
Lozier 18:18 19:6,11,17 21:11 22:12 243:17 244:2, 17,25 245:8 280:19,21,24 281:3
lunch 33:23 148:21,22 149:24 150:1
lunchtime 148:18,19
lung 208:24

M

M.D. 5:2
Macdorman 160:15
maceration 50:22
machinery 209:14
made 99:9 141:2 220:4 235:13,15 242:14
magazines 226:3
magnitude 145:17
mail 76:13
major 94:8 135:24,25 136:7,13,16 137:2 138:1,3 139:17 140:6,20,24 142:6
majority 83:12 123:12 241:16 265:7
make 25:14 42:14 44:5 53:17 66:11 79:10 82:13, 24 90:2,16 91:3 96:11,12 98:16,20 100:1 102:23 103:12 105:6 107:3 113:13 118:20 120:2,9 130:25 131:21 132:22 135:16 143:18 149:3 150:18,19 153:5 154:11 158:3,5 169:1 170:4 176:12 182:12 185:13 189:14 190:10 195:9 196:8 199:24 200:18 207:14 212:18 215:17 224:3 229:18,19 230:9,22 235:16 255:18 258:25 279:18
makes 96:13 112:24 118:18 131:2,11 162:17 180:24 189:7 250:25
making 81:7 96:5 114:1 118:9 120:1 177:15 189:10 230:11 240:11
malformation 25:8
malpractice 6:1,2 7:15 166:22 221:3,9 227:9

man 106:5
manage 31:1 40:11 71:17, 23
managed 77:12 79:9 84:11
management 48:13,16,22 50:25 51:19,23 65:22 66:16 71:2,4 95:2,12
mandated 27:9,10
Marchant 29:15
mark 170:9 177:23 181:16 234:7 237:20,21,23 245:19 246:13 268:5 273:12
marked 29:18 98:15 110:18 157:10 170:18,20 172:4,24,25 177:24 181:18 218:10 234:8 238:9,10,25 245:23 246:14 268:7 273:14
married 71:13
Maryland 108:21 182:8,15
material 238:23,24,25 239:22 250:20 251:5,11,20
materials 10:24 11:17 18:3 20:25 63:4 124:3
maternal 14:14 17:20 18:1,13 47:10,11 48:1,9 97:18 98:5 108:25 134:3 151:14 152:8,9 154:1,8,22 157:15 163:16 165:19 173:13 174:2,3 193:8 244:3 256:13,22
math 149:5
matter 112:15 115:16,22 231:9
maturation 128:17 132:1
matured 129:16
maturity 132:20
Maureen 22:5
meaning 38:6 41:10
means 30:24 152:25 153:25 248:13 249:3
meant 212:1 258:15
measure 152:24 212:5
measurements 262:17,19
measures 189:25
measuring 188:7 212:9
mechanically 82:17
media 20:7 281:6
Medicaid 34:18 37:3,5,8, 10 54:5,9,14,15 124:20,23 125:5
medical 5:25 6:2 7:15 19:2 27:8 40:15 51:11 62:22,25 63:8,11 68:9 73:10 74:8 77:19 78:5 97:17 98:7,8

122:5 139:22 140:1 144:23,24 152:13 154:4 155:6 166:18,21 167:13 170:24 221:3,9 227:9 243:21 245:20 247:12 248:19,20 250:14,16 260:22,25 271:16 272:18 276:16 277:24 278:7,8 279:10
medically 28:23
medication 72:1 73:20,23 74:10,17,18 75:4 76:19 78:9,11 79:1 88:7,8 141:14
medications 46:8 74:20, 22
medicine 97:19 167:9 178:25 226:24
meet 27:11
meets 281:17
member 17:10,11,13,14, 16 55:14,18,21,22 56:8 63:2,3 233:25 242:1 271:25 278:6 281:15,16
members 26:4
membership 55:13,23
membranes 132:25
menstrual 25:11,17 225:1 262:12
mental 59:2 71:11 72:5,19 94:21 184:25 185:5 188:12,24 189:1,2,3,6,8,19 192:6,7,14,23 193:5,18 194:1,2,18,24 195:17,23 196:15 247:3 260:8 278:3
mention 90:4 222:23
mentioned 6:18 13:25 19:6 28:2 39:5,19 41:2 42:12 45:9 46:2 56:21 61:15 68:3 78:10 79:10,16 80:2 89:20 91:23 93:17,20 106:14 111:7 115:6 116:5 132:3 145:10 146:15 147:25 153:23 165:14 171:24 182:3 187:14 193:4 195:11 199:18 205:5 206:2 207:7 208:6,21 209:6 212:14 222:5 226:18 229:4 233:5 244:16 245:13 260:7 273:25 276:18 281:5
met 5:7 20:16 22:10 247:2, 19
meta-analyses 147:22
meta-analysis 254:2,6, 16,20
method 49:17 53:20 74:6 87:24
methodology 110:1
methods 53:19

Metro 265:14 266:5
Metropolitan 265:13
Mexico 77:25 78:10,12
mid 73:13 165:21
mid-morning 55:4
mid-second 174:5
mid-second-trimester 206:19
mid-trimester 80:22
middle 145:6 178:14
midway 143:16 254:15
mifepristone 74:20
mild 137:10
mildly 164:2
miles 27:10
mind 76:14 106:7 112:21, 25 113:16 205:11 233:17
minds 209:24
mine 239:6
minimal 207:20
minimize 141:19
Ministries 122:11
minor 39:12 136:25 223:5
minutes 54:25 65:2 148:25 196:20,25 219:16 220:3 245:14 279:20
misadventure 168:8
miscarriage 48:13,15,25 49:11,13 50:8,25 51:19,23 71:2,4 95:2,12 169:23 270:21
miscarriages 48:17 50:2 155:16
miscarry 187:24
misconduct 227:24
misoprostol 43:3 49:4,7 50:4 74:21 77:25
missed 156:10,12 224:25 281:20
missing 30:5,8 143:10
mobile 265:19
model 52:12,14 278:1
moderate 126:14 201:13
modern 143:14,17,21
modulate 213:9
molar 263:13,18
moment 19:5 23:24
money 124:24 127:6 232:25 243:12,14
month 20:3 30:19,21 31:3, 7 76:2,22 117:7 118:11 180:24

months 195:16
morally 230:14
morbidity 136:7
morbidity 17:20 44:4 135:24,25 136:13,17 137:1,3 138:1,3 139:17,19 140:6,21,24 150:10 151:1 152:8 154:1,16 159:22 160:5 162:12
morning 5:7 8:10 214:18 219:4,10,25 220:2 222:23 280:8
mortality 14:15,20 17:20 18:1,13 66:21 109:1 150:10,25 151:4,13 152:4, 8 154:2,17,22,23 155:10 157:15 160:5 161:4,25 162:1,11 163:6,7,9,16,23 164:9,11 165:19,21 172:6 173:2,5,10,13 174:2,3 176:4 183:2 184:10 244:4 256:13,22
mortar 232:24
mother 25:4,5 121:20 228:21,24 229:3
motherhood 255:12 256:5
mothers 66:18
motion 35:10
motions 201:14
Mountain 65:4 149:4
move 66:12 94:22 113:8 170:16 177:21 210:6,10,22 211:2,12,23 212:1
moved 33:9
movement 209:20 210:1, 3,24 211:1 212:23
movements 198:22
moving 124:8 210:5
multiple 50:22 91:23 193:9 270:17
murder 115:19
Murray 5:6,9 7:10,12 29:15 64:25 65:5,8 148:16, 24 149:6,8,9 158:6 170:11, 14,16 183:8 196:18,24 197:2 214:8,11,12 215:20 236:23 237:4,5 238:2,5 248:18,23 259:20,23 279:17,23,24 284:16,22
muscles 45:6 138:8
musculature 82:19

N

named 227:7

names 20:15 21:12 271:11
Nancy 234:13
narcan 142:1
narcotic 141:25
narrowed 181:13
NAS 246:23 247:9
Nathanson 213:22
national 148:1 150:5 178:11 226:2 246:23 281:12
nationally 181:8
nationwide 180:15
naturally 40:19
nature 30:15
necessarily 32:8 100:23 116:20 117:20 130:6 142:4 187:5 242:25 264:22 265:10 266:14 268:25
needed 93:24 134:4 165:2 205:15 209:14 263:16 276:16
needling 206:4
neglected 90:4 216:20
neonatal 154:7 204:19 205:15
neonate 205:7,12 208:1, 10
neonates 205:22 207:6,17
neonatologist 208:14
neonatology 98:1 205:13
nervous 53:18
neurologic 97:4 101:1 102:1 202:3 204:18 207:20 211:4 242:6 243:1
neurological 204:23
neurology 97:15
neurons 198:20 200:10 201:10
news 160:16
newspaper 223:8 225:24
nexus 153:1,25
nice 90:12 192:6 193:1 269:10
NICU 202:6 205:14 207:8, 15 209:8,11,12
NICUS 209:18
night 16:12 157:20 215:22 216:1 217:6 218:16 219:2, 13,18,24 245:14,16 246:18
NIH 281:14
No-test 19:2
noise 37:9

nonabortion-related 232:8
nonbiased 241:10,12
noncomparable 160:13
nonetheless 115:20
nonmajor 136:25
nonprofit 52:3
nonrepresentative 196:5
nonresponsive 68:12
normal 33:17 87:16 96:2 129:8,15 130:21 161:4 163:2 169:16 274:11
North 32:18 33:6,10
Northeast 33:3,5,8 134:23
note 98:16,21 107:1
noted 155:5
notes 10:23 21:6 98:24 99:9,12,15 100:18 103:13 235:5,6 239:16 240:11 258:25
Notice 11:14
noticed 152:20
November 238:13
nuclear 117:4
nudge 210:19,22 211:11, 23
number 20:6 24:9 63:11 72:15 73:18 77:23 78:7 91:20 98:18,22 108:14,19 109:4,9,14,16,18 114:2 121:16 123:9 151:5,6,15 160:18 174:25 177:6 179:12 180:17 181:17 182:21 184:6,20 186:14 195:11 209:17 236:11 248:25 271:3 277:8 278:16
numbered 98:19
numbering 98:21 268:10
numbers 108:5 121:15,23 123:4 151:9 171:24 175:15,20 180:14 181:3 182:5,9,10,16 184:14,15 188:21 191:25
numerous 73:8,18 75:2
nurse 272:23
nurses 260:23 264:25
Nursing 271:17 279:11

O

oath 8:6,10,11
OB 34:17 135:14
OB/GYN 27:21 30:12 32:12,22 33:4 41:22 72:8 134:23 269:22 276:16

OB/GYNS 30:17 31:23
49:23 55:12 127:14,17
269:15 272:22 274:16,18,
19 276:15

obese 137:6

obesity 40:12

objection 19:10,13,15
60:18 61:5,12,23 62:10
67:20 68:12 86:11 96:6
119:12

observational 188:14
190:1

observed 70:12 206:22
213:18

observing 214:5

obstetric 34:9 41:1 42:10
43:22 55:15 66:16 274:22
275:22

obstetrical 34:8 35:2 39:6,
18 275:17

obstetrician 49:15

obstetricians 42:25 55:6
56:9

obstetrics 56:22 63:9,16,
20 64:2,11,18 65:19 66:14

obstructive 46:21

obtain 59:10,23 78:11
120:8 127:8 152:1 225:15
231:1 265:18 266:6,20
267:5 277:8,16 278:18
279:5

obtained 75:12 76:20
77:19 114:14

obtaining 126:6,25 232:8

obtains 268:20

occasion 43:18 46:25
49:24 81:1 136:12 160:11
243:16

occasional 34:21

occasionally 18:23
132:15 137:8

occasions 27:3 35:15
46:7 48:1 265:5

occur 40:24 45:2,4,6,7
46:20 80:25 106:8 109:10
112:22 114:24 123:13
155:11 165:23 166:10
167:20 169:16,19 171:23
202:18 218:18,21

occurring 198:21

occurs 87:25 137:7 144:6,
14 224:19

odds 133:4 209:4

offer 8:21 48:19 49:4 50:3
52:17 65:16 240:24
267:15,21 274:8 276:4

offered 108:1

offering 185:25

offers 55:14

offhand 44:19 148:12

office 30:19 32:3 34:5
113:3 238:23 266:15

omit 199:5

one's 258:11

ongoing 72:6 227:21

online 13:2

op-ed 226:3,6,14 232:10
233:2

op-eds 226:2,17 233:18

open 44:15 87:12 215:7
216:19 218:2,20

opened 15:13,16,23 16:6
215:12 217:13 218:5,15

opening 15:23 216:14

opens 137:7

operates 154:16

operating 136:22

operation 52:5 164:22
165:7,8 166:5

opining 201:2

opinion 57:5,8,21 65:16
109:13 112:5 129:12
131:22 146:22 163:13
178:22 185:6,7,25 197:12,
19 200:7 202:9 203:23
204:5,24 235:23 236:1
237:10,11 240:25 274:10

opinions 8:20 18:5,24
57:3 102:7 103:3 104:17,
20,21,22,25 105:3,8
235:14 236:13 284:7

opioids 201:12

opportunities 239:18
281:7

opportunity 12:4,13
176:22 270:24

opposed 23:7 34:8 191:4
210:6 224:1,6

opposing 56:4 223:21

option 49:3 58:12 116:18

options 48:7,18,20 52:14
57:18 60:15,22 176:25
267:15 269:15,16

order 10:20 11:2 15:19
22:13 37:7 132:18 164:1
176:23,24 214:25 215:2
217:1 250:3

organism 199:16 204:15

organization 17:9 52:7,9
55:16 56:2,7,11,15,19
120:20 198:4 232:25

241:10 259:24

organizations 19:8 62:22
148:14 198:10 234:1
243:15 244:21

organs 44:16 252:24
253:17

original 103:11 120:25
250:20 259:3

originally 122:15

originate 239:24

originated 239:23 240:23
258:1,22

osmosis 71:14

outcome 24:6 25:5 90:9
118:22 144:4 153:1,17
176:11 188:8,19 193:19
255:17 256:12

outcomes 135:8,10,14
152:1,25 153:21 155:22,23
187:23 188:16 191:5 193:6
194:3,19,25 195:23 196:4,
15 208:19

outlined 213:4

outpatient 32:7

output 45:21

outreach 176:16

outright 224:8,10,12 225:5

outspoken 148:14

overdose 44:12 141:25
190:5

overlook 242:18

overlooked 242:17

overrepresented 192:3

override 213:23

oversee 72:24

overseeing 135:1

oversight 279:14

overwhelm 85:6

Overwhelming 80:11

P

p.m. 149:7 214:10 216:1
219:24 279:22

Pacific 34:21

pack 30:25

package 214:20 215:11,18
216:6,9,19,23 217:5 219:4,
9

packages 216:15 219:1

packaging 216:13

packet 15:8,13 16:15
215:6 219:24

packets 15:23

pages 60:2,5 98:18,21,23

paid 18:23 58:2 104:2
223:15 243:16 244:17
245:5,10

pain 18:15 35:13 53:18
96:20,21,24 97:9 99:21
101:15,18,19,22 165:1
169:9 175:8 177:19 197:7,
13,17,20 198:1,3,4,10,13,
15,17 199:2,13,16,19,25
200:9,15,17,23 201:2,5,9,
13 202:7,18,21 203:5,7,10,
13,16,19,22 204:6,23
212:3,6 213:1,8,9,11
234:4,10,24 235:23 236:1
237:8 238:14 239:12,22
282:12

painful 205:7 207:10
212:13,20 213:1,5,13

painkillers 212:17

paint 111:12

paper 18:25 19:1,2 99:13
100:24 107:7 163:15
243:21 258:18 275:4

papers 67:15 68:4,19,21
83:20 99:10,22,25 100:22
103:9,11,14,15,16 215:13
216:25 219:22 225:14
239:17 245:9 256:24 259:2
275:3 282:15

paragraph 105:23 106:6
120:11,12 143:15 145:5
158:1 164:21 173:21
177:13 178:8,10,15 181:21
187:17 197:6 246:21
247:13,15 252:19 253:4,22
254:1,13,15 255:7,22

paragraphs 98:19 258:21

parent 114:9 119:17

Parenthood 5:10 75:15,21
76:21,25 77:7,16 78:9,23
114:25 179:9,22,23 182:4
232:4,7,14,17 233:5,13,21
278:22

parents 114:4 119:15

part 15:18 55:17,19 69:20
71:21 83:17 84:1 87:16
101:11 105:23 107:4 110:4
158:24 180:5 186:17 199:5
256:21

participate 191:9

participated 19:21,22
114:19 233:20

participation 191:8,19
192:10 195:24 196:1

partner 58:22 95:18 114:6,
9

partners 42:6 49:25 84:11
127:24 176:18

partnership 265:13
parts 27:6 94:15 101:9,13 107:2 201:19 212:12
PAS 87:25 90:25
pass 48:25
passages 248:1 256:16, 18,19,25
passes 50:22
passing 258:11
past 42:8 71:5 73:3 85:2 91:8 149:3 219:21
pathology 65:23 263:16
pathways 202:3
patient 31:9 33:25 34:15 35:21 38:10,20 40:4,11 43:18 48:4,19 50:3 51:10 54:13 57:12 58:9 59:9,17 60:11,13,21 73:12,14 85:25 88:8,19 90:1 92:8,11 114:15 117:13 118:8 120:13 128:6 130:1 132:23 133:7 141:18 159:16 160:8,9,20 162:9 208:23 210:11 227:4 228:23 229:11,16 231:1 263:4 264:3,9 267:2
patient's 25:11,17 93:15 231:15
patients 30:19 31:12 33:21,25 34:2,5,7,17 35:1, 3 40:5 43:23 44:1,5 53:23 57:16 72:8,12 75:4 78:8, 21,25 79:2 82:7,11 84:20 89:7,20 93:22 94:18 114:2, 13 115:6,12 116:4 117:1,7 119:5,14,20 126:17 128:21,22 129:22 130:15 160:20 164:6 176:16 189:1 256:9 264:11 269:7,16,20 271:9 275:13 276:12 278:16
patients' 82:23 96:4 116:7
pause 92:6 251:19
paused 251:15
pay 116:13 215:10 216:7, 17,20 232:21
payer 156:21 188:16
paying 24:15 215:23
payment 23:18
PDF 237:17
peace 196:25
peer 64:6 67:15 68:4,21 163:18 220:17,23 244:12 246:2,3 250:19
peer-reviewed 257:21
peers 205:13

pelvic 142:9,14
penalties 8:7
pending 10:2
people 16:22 31:17 35:15, 21 36:19,21 37:19 38:9 46:7 64:11,21 83:9,19 84:7 88:11 92:18 96:1 115:15 116:15 125:15 156:6 164:13 176:6,12 196:10 208:7 233:18 236:6 278:9, 21 279:4,6,7
perceive 118:1,3
perceived 58:22 212:20 247:4,21
percent 34:9,18,20,23,25 36:4,20 37:15,17 38:10,25 39:6,7 78:1 86:14 108:6 114:25 115:3 121:18 134:5 136:12,13 137:15 140:7, 17,20,21 145:14,15,16 146:11,14 147:19 156:10, 12 167:10,13,15 174:2,5,6, 10,18 175:13,22 177:5 180:17 181:11 195:24 254:2,4,5,6,8,16,18,19,21, 22
percentages 182:11
perception 204:5,23
perfect 64:8 108:12 110:7 144:17 147:4 181:24 192:11
perfectly 120:5
perforate 94:15
perforated 91:20
perforating 166:12
perforation 49:21 88:22 142:3,8 164:22 166:20 167:20 169:15,20
perform 43:16 48:6 69:12, 14,16,18,21 71:8 85:23 94:12,25 95:2,12 97:21 114:15 127:16,17 134:2, 18,19 205:18 206:13 241:5,6 266:22 268:23 269:1,11 274:19
performance 178:23 180:6
performed 48:9 51:1,8,9, 19,23 66:7 69:22,24 70:2, 5,8,13,15,20,23 71:4 74:8 109:5,21 127:23 134:5 145:6 161:15,17 173:23 174:1 180:22 181:11,12 182:17,22 184:6 187:2 213:15,24
performing 70:16 94:14 228:7,17
performs 179:1,24

period 25:11,17 33:4 72:10 180:3,23 225:1,19 262:12 270:19
periodically 265:14
periods 33:23 225:12
perjury 8:7
permits 125:20
persistent 199:21
person 75:12 177:8 190:17 216:16
person's 155:19
personal 99:14 103:13 230:18 235:5
personally 21:22 22:6,8 91:19 276:2
perspective 139:23 140:1 193:25 195:10 284:2
pertain 226:18
pertained 28:15
phenomenon 256:8
phone 277:7 278:11
physical 25:5 59:1 92:3,7, 10,12 93:14 94:17 142:20 192:13 228:19 278:4
physician 94:13 171:8 261:5 263:21 265:1
physician's 207:9
physicians 31:19,21,22 84:1 147:8 245:20 261:6 264:24
physiologic 129:4
physiological 82:17 129:11 158:14 274:11
pick 156:20 224:18
picked 160:17
picture 116:11
pictures 51:14
Pitocin 46:9
place 10:18 43:1,12,13 60:9 76:7,25 77:7 119:21 120:3,7 133:11 139:16 151:2 162:16 201:19 230:21 273:21
placement 86:2
placenta 47:18 48:22 84:24,25 85:15 86:3 87:1 90:4,6,21 91:1,4 143:5,6 168:16,20 169:1 252:21, 22,23 253:13,15 256:21
placental 90:5,17 91:4
placentas 90:19
placental 86:6 88:2 89:21,24
places 239:15

Placing 119:23
plagiarism 250:6,7,11,15, 17 251:14 258:10,13,15,19
plagiarized 250:4
plaintiff 5:10 233:12
plaintiff's 221:18
plan 9:19,20
Planned 5:10 75:15,21 76:21,24 77:7,16 78:9,23 114:25 179:9,22,23 182:4 232:4,7,14,17 233:5,13,21 278:22
planning 68:11 232:23 270:7
plans 125:22
plausibility 90:3 129:5,11
plausible 82:17 83:5,6 176:10
play 26:11
played 26:14
plug 183:9
point 9:1 28:23 29:3 30:3 32:19,24 41:22,23 42:9 49:11 50:6 80:14 85:12 98:11,18 100:11 105:19 132:25 133:14 134:5 147:14 177:15 185:1 197:24 200:7,19 201:4,23 202:10 207:12,13 214:14 220:3 230:12 240:13 264:15 280:14 281:6
pointed 188:1
pointing 190:15
points 9:23 20:8 25:20,24 229:25
policy 235:7 267:20
poor 66:20 124:21 191:7 246:24 247:17
population 34:15 35:21 38:10,15,20 40:12 54:13 162:9,21
portion 200:14 234:24 250:24
posed 228:22
poses 134:16
position 18:23 59:13 85:16 113:14 131:15 134:22 151:10,21 164:5 200:19 227:15,18,20 236:13 276:7 282:24 284:4
positive 224:25
possession 21:2 64:21
possibility 25:5 41:2 42:14 45:9 59:3 91:11,13 132:25 133:3 156:13

<p>possibly 12:11 13:13 21:7 40:2 47:18 93:5 101:18 104:8 126:12,13 171:2 233:7 248:6 282:12</p> <p>post 28:22 42:11 78:25 92:2,5</p> <p>post-aborted 72:15</p> <p>post-abortion 82:8</p> <p>post-abortive 76:3</p> <p>posted 116:12</p> <p>potential 45:8 58:25 125:13 143:9 189:3 192:13 197:9 200:3 207:9</p> <p>potentially 86:2 155:7 164:24 168:7 205:7 235:7</p> <p>poverty 126:10</p> <p>practice 17:21,24 18:5 30:16,17 31:16,17 32:4,9, 12,17 33:9 34:16 39:2,4 41:20 42:5,6 43:24 50:6 56:23,25 57:3 61:2 62:23 63:5 64:18 68:20 71:7 73:14 101:19,22 102:6 114:1 116:3 132:23 136:6 139:21 140:8,9,12 141:2,4 171:6,13,17 181:10,16,19, 25 226:24 236:12 237:8 238:8,12 243:5 250:17 258:10 262:20 263:5 264:5,12 265:3 268:22 269:22 274:16,22 275:22 276:23</p> <p>practices 41:21</p> <p>practicing 51:3</p> <p>practitioners 272:23</p> <p>Praderio 221:17,19</p> <p>pre-viable 209:19 231:25</p> <p>precise 156:15</p> <p>predictor 189:3</p> <p>preexisting 188:12,24 189:18</p> <p>prefer 41:9</p> <p>preference 42:4</p> <p>preferred 70:9</p> <p>pregnancies 34:12 52:15 143:24 152:4 155:16 162:1,6 190:25 191:2 252:22 253:13 262:8,25 263:9,13,18</p> <p>pregnancy 13:18 25:15, 20,24 29:4 35:12 36:25 37:2,20,24 38:12,22 41:23, 24 44:21 47:19 48:23 49:5, 17 51:7,20 52:13 53:3,9 56:6 57:13 58:13 59:3 60:23 62:15 65:22 66:24 67:7,13,19 68:25 69:15 70:2,13,21,24 71:5 74:7,</p>	<p>17,19 80:23,24 82:12,19 86:3 90:8,9 94:5 95:3,6,13 105:22 114:4 115:1 120:7 123:13 124:10 125:4 128:14,15 129:15 130:12, 22,24 131:12,19 132:24 133:1 134:16 135:24 136:7 137:3 140:11,14 151:25 152:25 153:1 154:1 155:8, 12,13,18,19 156:17,20,22, 24 157:5,7 158:11,12,13, 14,19,20 159:4 160:10 162:12 164:3,9 166:11 177:10 187:23 188:15,18 190:21 193:7 200:8,19 201:4,23 202:10,19 203:1, 24 207:13 208:2 224:16 225:7 228:22 229:6,25 230:12 254:3,17 255:11,17 256:4,12 261:10,12,14,15, 20,25 262:7,11 263:2,24, 25 264:1 267:24 269:17 270:7 271:4 273:6 277:2</p> <p>pregnancy,' 106:3</p> <p>pregnancy-associated 153:4,5,20 156:18 157:3 158:17,25 159:10,18</p> <p>pregnancy-related 152:3,24 153:24 154:23 155:5,9 156:4,25 158:2,10, 15 159:22 164:10</p> <p>pregnant 36:8,12,18,22,24 37:20 38:4,11,14,15,21,25 48:4 57:12 118:23 129:24, 25 130:2,3,11,16,17,18 131:6,11 208:22 210:11 224:14 229:11,16 231:4,15 266:19 267:11 270:7 277:15</p> <p>premature 81:20 132:24 205:7 254:3,17</p> <p>prematurely 59:4</p> <p>prenatal 35:3,8,23 37:1 263:5 264:5 270:4,8 278:22</p> <p>preparation 13:12 14:24 16:20,23 219:20 235:3 242:10</p> <p>prepare 12:16 13:3 22:14, 17 29:22 99:4 105:10</p> <p>prepared 85:5 99:7 100:9</p> <p>preparing 22:20 23:6,8,14 100:2 220:1,6</p> <p>prescription 78:12</p> <p>present 37:1 38:23 266:5</p> <p>presentations 220:10</p> <p>presented 20:13,21 73:9, 19 107:17 148:8 244:4 248:10</p> <p>presenter 20:23</p>	<p>preserve 228:6 229:10,15</p> <p>pressure 45:14,21 210:11 211:24 212:1</p> <p>prestigious 55:13</p> <p>preterm 81:4,8,10 82:6,8, 14,16,25 83:9,13 84:8,15, 18 89:7,9</p> <p>pretty 58:19 100:20 139:19 141:4 169:20 177:14 215:14</p> <p>prevent 175:3 232:7</p> <p>preventive 65:22</p> <p>previa 91:1</p> <p>previa/accreta/increta 253:15</p> <p>previa/accreta/increta 252:23</p> <p>previous 235:10 236:17</p> <p>previously 13:9 218:6</p> <p>priced 125:16</p> <p>primarily 281:9 283:2</p> <p>primary 122:6</p> <p>primate 205:1</p> <p>printout 157:13 273:19</p> <p>prior 26:25 46:15 47:2,4,10 48:4 65:9 76:2 81:23 82:22 85:19 88:2,4 89:24 90:17 91:14 92:15 93:15 112:24 113:14,15 115:13 118:9,10 132:7 133:13 189:2,6 205:16 222:1 224:14 243:9 279:25</p> <p>priority 193:11</p> <p>Priscilla 22:7,8 195:5</p> <p>private 27:21 31:16 32:3, 12 34:15,19 58:2 109:22, 24 114:1 125:21 240:21 262:19 263:4 264:12 265:3 266:15 268:22 269:22 274:16</p> <p>privately 34:18</p> <p>privilege 27:25</p> <p>privileges 27:10 275:12</p> <p>pro-life 19:9 56:9,15,18 233:25 243:14 244:20</p> <p>probable 249:5</p> <p>problem 72:9 109:2 123:18,22 179:3 189:11 258:6 283:9</p> <p>problematic 134:13 263:25 283:12,16,17</p> <p>problems 6:9,10 35:5 40:14,16 92:5</p> <p>procedure 6:6 49:19,23 66:7 68:8,9 69:25 87:17,23 88:25 94:12,16 95:15</p>	<p>117:24 118:14 136:20 138:18 146:6,7,9 162:24 164:15 167:2,5 176:23 179:1 180:5 205:8 206:13, 19 207:10 210:18 223:14 232:22</p> <p>procedures 39:10,13 68:13 86:17 108:23 161:16 162:2,23 169:19 178:23 180:11,19 231:22</p> <p>proceeding 222:2 223:3</p> <p>process 49:5 50:21 76:12 114:18 121:21 124:5 203:10 274:12</p> <p>processes 198:25</p> <p>procrastinating 37:3</p> <p>produce 236:12</p> <p>product 28:24</p> <p>professional 29:10,12 55:12 62:21 71:21 198:4 200:7 227:18,23 281:22</p> <p>professionals 260:22 272:18</p> <p>program 209:7 232:18</p> <p>progress 273:3</p> <p>prohibited 27:7</p> <p>prohibits 28:17 175:6</p> <p>project 243:18</p> <p>projects 243:19 244:1,24 245:4</p> <p>prolapse 142:13,14</p> <p>prolonged 72:10</p> <p>promote 56:5 77:22</p> <p>pronounced 81:17</p> <p>proper 178:22</p> <p>proportion 184:2</p> <p>pros 48:20</p> <p>prospective 192:17,22</p> <p>prostaglandin 42:18 70:10 79:25 88:9,13</p> <p>protect 164:5 228:14</p> <p>protective 128:16 130:12 255:13 256:6</p> <p>protest 233:21</p> <p>protocol 133:13</p> <p>protocols 72:25</p> <p>prove 188:2</p> <p>provide 8:15 9:13 10:3 11:11 12:13 19:8 33:18 39:9 48:16 49:7 52:22 57:6,10 58:17 59:9,16,24 60:16,22 61:8,18 62:9 68:6 72:3 86:21 100:15 102:11 103:2 104:25 128:5,24 132:10 177:7 182:9,16</p>
---	--	---	--

194:13 267:3,4,19 269:15
 270:4,14,24 272:12,22
 273:1,9 276:18,19,22
 277:3,9,10,12 278:10
provided 7:7 10:24 15:19
 16:7 18:3 27:2,3,13 28:3
 135:2,11 215:9 217:2
 218:6 219:13 222:2 223:2
 224:5 225:13 239:4
 274:13,15 275:9
provider 58:3 61:3 66:7
 178:19 179:5,8,13,18,19,
 25 233:23 270:8 271:8
 274:21
providers 27:9,23 76:11
 109:21 110:2 178:17,24
 179:3 271:5,10,12 274:23
 275:2,23 276:1
providing 23:2 183:12
 204:5 229:19,20 277:23
psychiatric 72:20
psychiatrist 71:13
psychological 92:4 185:8
 228:19
psychologically 49:1
public 18:3,7 32:2,6
 103:14 125:21 235:6
publication 250:21
 257:22,24 259:7 282:22
publications 220:8
 244:12 258:21
publish 220:9
published 64:6 68:4
 103:17 111:10 163:17
 220:13,16 226:2 234:3,19
 249:12,18 250:21 257:25
publishing 13:23 83:20
pull 76:15 152:13 154:11
 238:7
pulled 101:20 199:18
 249:16
pulmonary 136:3
purely 190:1
purpose 210:4 222:16
 262:6
push 211:1
put 8:16 10:18 19:13 28:16
 56:21 107:21,25 111:13
 149:2 150:7 159:14
 167:23,24 175:12 189:4
 211:5 212:1 214:2 226:5,
 22 230:12,21,22 233:18
 235:19 244:14 259:2
 282:14
puts 120:20 122:12
putting 184:14 211:24

Q

qualified 258:18
qualifies 72:13
quality 107:10 110:6
 111:14 112:6,7 135:6,9,17
 246:24 247:17
quantify 84:23
quarter 39:22 65:4 275:19
question 9:2,5,13 10:2,3
 19:16 20:20 47:8 58:8
 61:24 62:1,5 66:13 67:23
 68:15 76:17 77:4 78:22
 83:2 84:5,11 85:8 86:20,21
 96:7 108:9 110:5 111:19
 112:1,4 116:22 118:6
 126:1 127:1 129:10 133:22
 145:21 150:24 164:7 167:8
 175:9,11 177:1 183:11,13
 188:3 189:12,13 190:14
 197:18 202:8,9 203:12
 204:11 207:6 213:3 215:25
 229:22 250:10 251:10,19
 276:6 278:24 279:8 280:7
 282:7
questioning 250:5,8
 283:13 284:15
questions 8:15,16 9:1
 10:10 11:12 54:23 111:21,
 24 112:1 148:7 150:19,21
 175:2 185:10,13 189:15
 190:12,13 191:21 192:7
 193:21 214:17 247:1,19
 268:14 278:25 280:7 282:2
quick 108:8 268:1 279:18
quickly 85:6 281:24
quote 112:19 145:8 200:1
quoted 14:21 101:1
 160:16

R

race 212:18
rage 140:17
raise 46:3,4
raises 188:3
raising 41:13
random 210:4 211:3
range 54:17 69:2 123:9
 167:10,13 180:3,7 201:6
rape 25:6 123:8
rare 36:23 37:14,19 38:3
 43:18,21 46:7 47:9 48:1
 49:14 54:7 117:13 138:16
 274:21
rarely 66:10 161:19

rat 199:20
rate 22:22 23:4,6,9 40:12
 45:20 125:14 135:22
 140:6,14 144:17,20,22
 145:1,8,11 146:11,14
 147:19 152:4 161:23,25
 162:1 163:23 164:9,11
 174:2 183:2 191:19 192:10
 195:25 201:13 212:7,11,23
rates 14:11,13,20 136:6
 145:9 146:23 147:3 150:10
 151:1,4,13 152:6 154:23
 155:10 159:23 163:9,10
 178:18,24 184:10 212:24
Raymond 160:12,21
re-call 284:14
reach 18:24 218:23
reached 12:7 50:14
 280:21,25
reaches 137:19
reaching 211:7
react 176:7
reacting 214:1
reaction 44:12
reactions 46:8 116:7,8
read 12:23 13:8 53:17
 63:23 68:17,19 91:20
 96:17 100:6 106:16,18,22
 123:21 157:22 173:25
 174:12,13 177:2,3 180:1,9,
 11,20,21 195:11 197:9
 217:1,3 219:16,22 225:21
 247:10,14,24 248:5 254:9,
 24 255:19 268:17 275:6
 277:4
reader 177:7 242:23
reading 100:5 175:24
readmission 136:1
readmitted 73:12
ready 63:24
real 115:1
realistically 42:15
realize 129:5 145:8 149:12
 236:8 258:5,17
realized 76:6 98:25
Reardon 187:1
reason 11:11 56:6 83:5,7
 86:15 110:5 112:9 116:1
 141:18 145:25 201:16
reasonable 133:12 225:18
 230:9,20
reasons 13:17,21 14:8
 27:17 38:24 40:4,6 78:4
 88:3 94:9 105:21 106:2
 107:12,16 111:2,6,17
 112:9 120:13 123:18 129:6
 149:13 171:24 230:9

231:12
reassurance 35:11
reassure 160:15
recall 6:4,25 11:25 12:6
 14:4,9 20:3,14,15 21:12,14
 23:13 51:22 61:20 62:3,4
 75:23,25 76:18 77:2,6,10
 78:19,21 79:1,8 100:14
 102:4 104:1,3 121:10
 124:4 135:18 142:2 195:21
 196:2 206:25 207:1 215:23
 216:6,22,24 221:6,13,15
 223:4 225:16 226:9 235:2
 237:15 240:10,15,21,23
 245:1 248:4,8 257:2 265:2
 280:9,24 282:6
recalled 280:15
recalling 80:3
receive 24:5 207:9 214:19,
 24
received 16:15 23:18 78:8
 208:8 215:6,11,17 219:1,3,
 24 236:25 237:3 243:12
 267:12
receiving 24:14 216:18
 217:9
recent 75:23 76:18 220:21
 221:17
recently 50:21 182:24
recess 65:7 149:7 214:10
 279:22
recognize 48:25 146:9
 148:18 170:20 172:7
 263:19
recognized 50:18 283:7
recognizes 49:3
recognizing 147:4 181:24
recollection 10:9 12:10
 20:18,22 223:12 280:11
recommend 133:12
recommendation 35:7
 264:2
recommended 35:22
record 5:8,9,13 9:12,16
 10:15 16:3 19:14 27:5
 29:17 76:7 87:4 107:4
 110:16 170:4,15 186:22
 187:2 209:11 232:12 234:9
 239:11 251:18
records 23:20 103:21
 104:13,15 138:3 152:13,
 17,22 154:4,12,13 155:6
rectal 138:8
rectum 137:19 138:8
rectus 45:6
red 239:2

reduce 53:2,3,5 130:3
164:2
reducing 53:9
reeks 113:9
refer 28:24 29:3 57:6 60:2,
5,14,21,25 61:10 62:17
98:16 107:2 124:9 126:4
147:16 173:17 266:22
277:11
reference 63:12 100:23
199:15 211:10
referenced 101:2
references 14:18,21 99:24
100:9 101:10
referencing 100:24
101:19
referral 57:24 58:1,4,9
59:7,16,18,20 60:17 72:1
271:7
referrals 60:22 61:18 62:9
271:5,10
referred 75:20 99:12,18,
19,20 173:6 179:21 181:15
182:14 241:4
referring 25:24 32:5 93:21
159:14 165:10 169:17
172:10 173:4 181:20 184:5
191:6 205:11 211:10
221:10 226:6 237:6 270:20
reflect 16:2,3 251:18
reflects 236:1
refresh 10:9 12:9
regarded 64:3
regimen 74:11,16 78:6,12
regret 113:4,18 118:13,21,
24,25 119:6
regretted 106:9 112:23
119:21 120:1
regulation 223:22,24
224:5,6
regulations 232:23
regulatory 271:19
related 13:16 17:3 26:16
66:21 68:5 144:23 152:25
153:12 155:15,21 156:7,
13,17,24 158:18,20,25
159:4 161:14 169:22
171:21 192:2 219:18
220:20,21,22
relationship 72:7 108:7
153:7,16 184:25 185:2,16
186:4 271:1
relative 129:18 175:13,14,
15 179:14
relay 198:21
release 213:7 234:10

released 201:12 207:18
relevant 30:10 72:22
105:7 118:2,4 124:15
233:16 244:9
reliable 63:8 106:25
108:17,19 109:5 111:8
121:12 122:2 144:19 147:2
151:11 171:5,20 181:25
183:1,2 184:17 224:21
242:24
reliably 225:6
reliance 53:5
relied 100:3 103:13 124:3
152:20 196:6 235:4
242:15,24
relies 54:14 82:19 102:8
religious 116:20
rely 56:23 63:4,22 64:22
101:3 124:4 153:16 156:16
159:15 172:20 195:6
204:6,8,16 240:18 262:18
264:4,20
relying 82:13,24 89:23
102:4 106:13 190:15
194:15 265:2
remarked 176:19
remember 10:7 12:15
20:11,12 21:4,8 80:4
123:20 127:1 149:3 170:10
194:10 215:10 217:7
223:16 242:4 280:17
282:6,19
remembered 10:9
remind 170:12 185:9
193:20
reminds 281:11
remote 10:19,20
remotely 10:18
removal 164:25 168:19,20
remove 163:1
removed 46:17 223:22,24
removes 48:22
repair 7:5 138:15,18 139:6,
7,14
repeat 78:22 136:2 264:6,
12 265:8,9
repeated 265:6
repeating 47:15 265:4
rephrase 9:4 61:9 62:8
92:9 133:22 167:4
replicated 278:1
report 6:24 12:19 13:6
15:5,7 16:11,17 23:8,14
28:10 29:11 76:9,11 79:10,
14 84:9 97:5 98:13,17
99:1,18 100:3,7,12 101:13,
16,24 102:4,8,12,14 103:4,

7,10,14,21 104:2,16,20,23
105:4,7,10,12,20 106:17
107:9 108:20,23 110:5
112:20 114:25 117:18,21
120:10 121:22 122:4
123:15 124:4 127:12
143:14 145:3 148:2 150:6
152:21 157:15 159:16
160:3 163:10,13,17 164:17
171:1 173:20 178:11,16
180:10,13,21 182:5 184:8,
11,24,25 185:4 186:14,17
194:9 195:19 196:4,13
197:3,23 198:14 205:5
222:12,16 223:17 230:7
234:24 235:4,12 238:24
239:3,20,22 240:5,19
241:15,24 242:2,10,14,23
246:15 249:9,24 253:3
254:11 255:5,22 256:20
283:22 284:3,8
reported 25:6 78:8,22
106:5 109:22 144:13
151:5,6,15 184:10
reporter 8:15 9:11
reporters 281:7
reporting 108:21 112:11,
15
reports 15:2 91:21 102:18,
20 108:6 208:3,4 249:7
257:15 283:1,3
represent 5:10 56:17
238:22 249:15
representative 26:7
226:7
represents 250:25
reproduce 251:8
Reproductive 83:23
147:9
republication 251:5,11,20
reputation 198:6
request 11:18 43:18,23
44:1 222:12
requested 284:24
requesting 284:17
require 40:14,18 46:6
132:16,17 138:14,16
139:10 142:7,20 160:2
203:19,20
required 7:4 27:8 50:13,23
73:10 76:4,5 78:23 138:25
203:6,9,15 284:15
requirement 203:8
requires 49:18,19 132:15
137:9 141:7,9,12 146:6,12
requiring 46:3 76:11
135:25 136:1,2 144:23
145:1

reread 12:18 219:22
245:18
research 14:14 63:8 64:21
66:8,20 96:22 97:3,12 98:5
99:8 102:9 103:11 112:6
121:15 122:6 125:24
153:14,15 239:25 240:1
241:3 246:22 247:16
250:14,16 251:23 252:3
281:12,14 282:14 283:12
researcher 121:5 240:16
researchers 13:22,24
14:20 101:4 106:14 107:13
241:5 245:8
researches 107:25 165:18
residency 67:2 69:21 70:6
73:11 79:17,21 114:21
206:24
resident 64:19
resign 227:17
resigned 227:20
resource 52:14
resources 58:16,22,23
100:16 271:1
respect 12:10 14:3,8,12
24:1 27:18 28:4 38:9 44:7
45:16 47:8 58:7 59:15
60:15,16 69:13 71:2 76:17
82:23 89:19 94:24 96:4,15,
20,24 102:12 112:4 113:23
118:10 121:1 122:15
125:25 126:23 129:23
131:15,18 148:10 151:3
153:14,24 154:21 156:3,4
163:14,21 173:10 181:25
183:2 186:7 192:13 194:1,
18 195:21 196:14 226:7,14
237:24 238:5 257:16 260:7
269:20,21 271:3 279:2
respectful 49:16 68:7
respiratory 209:15
respond 10:10 45:21
68:14 84:5 148:7 177:8,9
responding 17:4 150:20
211:5
responds 198:22
response 11:12,17 77:3
150:7 212:2 213:11
responses 95:21,24,25
96:2 97:7,8 185:10 214:2
responsibilities 18:21,22
responsive 58:8 211:1
229:21 278:24
rest 30:20 34:18,21
restriction 56:4 174:9,17
175:20 177:3 225:18
restrictions 223:14

result 47:25 138:9 197:25
252:20 253:14
resulted 48:1 131:10
resulting 80:23 252:22
results 44:25 107:6
resume 51:25
resuscitate 208:19
resuscitated 208:17
retained 168:16
retrospect 282:17
retrospective 186:16
return 215:18 216:4,11
280:7
reveal 115:10
revealed 242:9
reversal 141:13
reverse 141:14
reverses 142:1
reversible 52:22
review 13:11 15:2 89:17
100:21,24 102:20 103:25
135:16 154:2,15 191:15
220:17 239:3 281:15
reviewed 13:5 14:23 15:4,
10 16:9,11,12,19 64:6
67:15 68:4,21 100:4,19
148:1 163:18 192:13
220:23 244:12 246:2,3
250:19
reviews 157:5 188:20,23
revoked 227:1
reworded 283:6
Rh 206:6
Rights 147:9
rise 212:10,11,25
rises 212:7,23
rising 213:4
risk 40:11 41:13,17 44:4,
11,13,16 46:3,4,18 47:14,
16,17,22 49:21,22 57:17
58:25 86:17 88:17 128:10,
18 129:3,13,16 130:3,8,20
131:11,23 134:16 152:17,
18 153:10 160:9 161:4
162:5,11,15,16,17,21
163:2 164:2 165:21 173:1
174:10,18 175:10,12,14,
17,22 177:5 185:5 193:2,5,
11,17,18 210:20 228:16,
18,22 254:3,6,17,21
risk-taking 153:10 189:25
255:15 256:8
risks 44:7,10 45:25 57:19
128:8,10 131:18 143:5,10
road 159:7

Roe 123:25 213:23
role 18:10 26:11,14 102:17
135:1 260:4 271:24 277:23
278:5
roles 193:20
rolled 52:8
room 27:22 65:25 73:9
75:9 76:1 78:19 136:22
rough 116:16
roughly 145:16
route 124:2
routine 178:23
rule 9:9 47:1
rules 8:4 10:18 11:6 258:7
run 124:25
running 183:7 277:20
runs 273:5
rupture 46:10,18,24 47:25
132:24 168:1
ruptured 166:14
ruptures 46:20

S

sad 119:1,14,16 120:2,5
safe 143:22 146:7 147:12
safely 46:22
safer 51:12 88:24 160:14
safety 27:17,18 28:1 66:24
67:4,7,12,18 68:24 83:20
148:2 164:6 177:18 178:2,
12 220:24 224:7 252:6
253:23 257:17
sampling 109:23
San 40:13 97:23 271:6
save 226:13
saved 134:15 207:22
scanty 67:9
scar 47:6,19 88:3 90:24,25
166:15
scarring 92:14
scenario 41:12 132:21
141:22
schedule 267:15
scheduled 31:10 33:23
scholars 18:19 21:11
school 97:17
science 122:6
Sciences 148:2 246:23
Sciences' 150:6 178:11
scope 244:9

screening 266:12,16
sealed 15:24 217:20,22,24
218:13,19
Second-trimester 110:20
seconds 98:23
secret 114:4,6
section 39:21,22 46:6,22
secure 191:9
sedated 141:18
sedation 141:13,14,19
seek 265:17
seizures 6:11
selection 194:6 247:7
self-manage 78:3
self-managed 77:18
Senator 26:9
send 10:14 60:10 79:13
97:23 201:11 237:2,16
118:18 136:5 162:17
190:10
sensed 200:15
sensitivity 224:24 225:10
261:18
sensory 197:8 198:17,20
199:7 200:2,10 201:10
sentence 127:21 128:2
143:16 249:14 252:19
255:8,25 259:1,9,14,15,17
sentences 174:8 248:13
249:15,17,22 258:6,14,21
259:5,12 282:8,21 283:10,
18
sentinel 160:3
separate 90:7 240:25
separated 228:5
separation 44:21 166:11
232:24
sepsis 73:12 80:11 164:24
168:13
September 20:4 249:10
septicemia 73:15 79:18
88:8
sequelae 72:19,20
serve 11:21 34:15
service 81:19 274:8,9
276:9,16
services 115:1 232:15
243:10 266:3 269:19,20,25
273:2 275:10,17 276:5
278:17

serving 221:23
set 18:22 202:2 279:19
setting 32:1 46:14,24 47:5
82:4 84:17 110:7 146:11
191:18
seven-week 35:22
Seventy-two 225:22
severe 25:5,8 45:1
severity 40:15
sew 138:21
shame 115:17 116:5,24
share 10:19 11:18 34:24
38:14,20 39:25 70:7 84:8
86:9,12 116:2 145:16
274:1
sheet 234:3,10,18 235:15,
20 236:9 238:24 239:4
240:18 241:15 245:16
sheets 18:6,7,9,11 235:10,
18 236:16 240:22
short 148:20
shortening 81:17,20
82:16
show 53:11 58:11 82:1
83:4 89:17 172:25 199:13
211:16 214:2
showing 110:19 157:13
170:19
shows 124:10
shut 45:3
sick 143:23
signals 201:11
signature 284:24
signed 105:4
significant 137:20 139:19
similar 42:7 52:7 102:7
162:2,23 164:15 239:6,10
241:18 250:1 261:18
simply 146:4
single 137:9 156:21
178:18 179:11,19 188:16
266:16
singular 260:13
sit 147:14 231:19
site 122:6 261:4,6 265:16,
19
situation 46:17 47:12
49:16 50:16 57:15 62:17
76:16 84:24 88:17 116:17
118:19,21 168:7 206:6
230:23
situations 81:23 205:17
206:10 208:18
size 30:24 50:14

skeptical 111:12,14
skilled 179:1
skills 127:15
skimmed 281:23
skin 137:5
skip 105:11
skipping 145:7
Skop 5:2,7,14 11:7 15:14
 16:5 19:16 21:16 23:19
 29:19 37:21 56:12 57:10
 58:7 60:20 61:7,14 65:9
 66:11 67:13,22 68:12,14
 78:15 80:19 82:21 84:3
 86:18,20 90:14 91:23 96:8
 99:2 101:11 105:4 107:1
 109:24 110:13,21 114:14
 116:22 121:22 129:9 146:4
 147:13 148:6 149:9 156:15
 158:15 170:19 175:19
 177:2 178:3 181:20 183:13
 185:9 189:12 193:20
 196:21 198:25 203:11
 204:12 213:21 214:12,20
 225:13 229:21 230:18
 231:14 234:11 237:6 238:6
 240:1 246:6 250:2 251:3,
 15 252:13 256:18 273:16
 274:23 278:25 279:25
 281:13
slowed 265:22
small 20:8 137:16,18 139:9
 250:24 251:1 268:10
smaller 86:13
Smith 221:5,7,10
smoking 147:12
social 40:5 121:19 122:5
 228:19
societies 185:8 197:16
society 55:12 116:20
 177:20 230:15
soft 49:21 50:19 164:23
 169:15
someone's 240:13
son 216:13
sophisticated 207:3
Sorenson 5:16 9:19,25
 10:19 11:3 12:5,7 15:20
 16:25 17:5,6 19:10,13
 60:18 61:5,12,23 62:10
 65:3,14 67:20 86:11 96:6
 102:11,15 103:2 105:17
 119:12 148:22 149:2,23
 170:8,12 217:2 219:3
 237:3 280:4 284:21
sort 83:18 250:1 278:6
sorts 60:22
sound 122:11 180:7 248:2

sounded 78:19
sounds 7:19,23 15:22
 52:21 65:5 112:1 123:23
 134:18 136:15 149:6 150:1
 193:25 205:21 211:12
 237:14 269:7
source 52:9,10,11,12,21
 99:23 100:9,23,25 109:4
 111:9 116:24 120:22
 121:3,12 122:2 124:1
 125:3 147:3 150:9,14,25
 159:23 171:6 181:25 182:3
 184:9 242:3 249:13,19
 257:11,13 260:8 271:21
 272:12,17 273:5,9,16,20,
 21 277:9,15,17,25 278:17
 279:2,9 283:20
sources 109:3 121:16
 122:6
space 45:7
sparse 247:7
speak 65:13 149:22
 196:24 219:2 281:7
special 10:18 108:7
specialist 206:20
specialization 97:18
Specialties 68:10
specialty 205:24
specific 40:9 59:21 60:9
 65:24 66:3,14 69:2,3 77:6
 78:21 79:2 82:24 84:5
 90:15 113:24 122:18
 123:24 147:15 150:21
 157:4 171:16 180:11 192:5
 204:14,15 208:4 220:23
 225:17 232:21 262:16
 269:14 274:16 279:8
specifically 14:10 75:20
 76:20 78:19 100:8 101:14
 111:6 154:18,25 155:23
 161:9 165:10 193:12
 208:12 230:2 240:23
 261:23 275:4
specifics 142:10
spectrum 84:24 85:15
 87:1 143:6
speculating 84:14,16
spend 24:10 47:13 215:13
 219:17 220:5
spent 22:20 23:2,6,8,11,
 14,22 103:6,21 219:12
 220:1
spinal 201:10
spiritual 278:3
spoke 17:5 219:5
spoken 16:23 17:2 22:12
 92:2

spontaneous 256:3
spontaneously 90:7
spot 65:1 210:19
St 53:11
staff 265:21,24 267:3
 268:2
standard 7:7 35:8 74:25
 199:20,21,22 205:6 207:17
standards 83:22 179:4
 251:6,13,21,24 252:1,2
 277:24
start 9:15 24:20 98:21
 162:18 186:25 192:8
 224:21
started 150:3 214:16
 279:24
starting 42:10 77:21
 143:16 186:15 197:24
starts 45:14 105:23 255:8
state 5:12 23:19 24:1,10,
 14 61:15,16 73:24 76:9
 79:11,14 121:8 122:17
 123:13 130:25 131:7,9
 152:7 154:19,23 180:16
 197:6 199:22 222:6 223:25
 226:24 230:8 272:3 275:21
State's 164:4
stated 61:10
statement 56:4 150:18
 174:16 240:13 244:3
 248:5,7
statements 100:9,22
 103:5 235:7 236:12,13
 239:15 242:7
states 26:15 28:5 29:7
 66:22 75:13 76:10 108:16
 109:10 110:20 112:15
 124:19,22 125:5 145:12
 146:17,24 147:4 150:11
 151:1 172:6 173:3,11
 182:2 183:12 198:5 228:3
 229:2,5 274:1
statistic 125:8
statistics 120:13,22
 121:17 122:16 123:5,8,14
 144:2 145:20 165:18
 181:22 273:25
stay 150:21 246:5
steroid 209:2
steroids 208:12,21,23
 209:5,6
STI 52:16 265:15 266:6,7,
 12,16
stick 150:20 185:10 278:25
sticking 82:5
stigma 116:5,6,25 119:10

stillbirth 255:16
stillbirths 154:7
stimulated 131:13
stimulation 130:22
 131:10
stimuli 212:21 213:5
stimulus 212:13 213:2
stitch 139:16
stitches 138:23,25 139:3,
 8,10 141:10
stomach 210:11
stop 9:20 59:6 65:1 166:1
 188:5 214:9
stopped 76:1
stories 53:16
story 107:16
straight 5:9 9:16 102:1
 267:7
stress 255:10 256:3
stretch 9:21
stretched 87:12
stringent 247:20
stroke 136:4
studies 14:4,6,22 53:10
 82:1,4 83:3 89:17,25 90:18
 101:21 129:7 144:21
 146:22 147:23 152:21
 153:15 156:11,16 159:15
 173:16 176:2 186:20
 187:3,17,22 188:7,11
 189:19 190:14,20 192:12,
 18 204:6,8,9,16,18,19,20,
 21 242:20 246:22 247:2,3,
 5,7,16,19,21,22
Studnicki 245:7
study 105:24 106:1 110:9
 124:9 143:3 145:14 146:15
 147:18 148:3,9,13 149:12,
 16 154:16 160:12,15,21
 179:11 183:15,22 186:16,
 23 187:1,2 188:14 190:13
 191:7,11,12,14,15,19,20,
 22 192:5,15,23 193:12,24
 194:1,5,6,8,17,21,24
 195:10,12,15 196:3,6,10
 197:7 198:3,4,10 199:15
 202:2 204:14,15 207:18
 208:6,8 247:4,21 275:9
studying 147:24
stuff 21:4 210:17 212:18
 215:15 233:19 235:13
 282:14
stumbling 98:25
subcutaneous 45:7
subgroup 56:16
subject 8:6 83:25 221:23
 271:16 279:10 284:14

submit 222:16
submitted 15:5 28:12 56:3
 98:14 103:23 104:14
 163:17 215:15 230:7 249:7
submitting 124:5
subscribe 63:24
subsequent 47:18 80:24
 81:4 90:8 252:21 253:13
 254:3,17
subsequently 99:24
subsets 185:4
substance 24:20 64:7
substantial 30:7 127:6,8
substantially 188:3
subtractions 239:7
suction 48:21 49:11 50:6,
 11,15,20 73:11,15
suffer 185:21,22 189:8
suffering 91:25 185:16
sufficient 203:21 228:16
suggest 130:10 148:22
suggesting 125:10
suicidality 186:11
suicide 255:15 256:9,11
suicides 153:9
suits 227:10
summarize 100:22
superficial 137:5
supplies 123:4
support 27:16 58:21 82:20
 114:7 120:16 121:1 184:16
 209:15 224:5 229:20
 232:15 247:8 270:25
supported 224:9
supporting 226:10
suppose 179:14
supposed 15:17,18 215:6
 218:19
surgeries 33:22 97:21,22
 205:15,19
surgery 7:4 27:12 45:5
 46:16 47:20 76:5 136:2
 138:14,17,22 142:7 144:23
 145:1 146:12 165:2
surgical 6:21 48:21 78:24
 80:8,9 85:17,18 87:13,17,
 18 88:20 90:19,20,22,24,
 25 91:7,9 136:20 138:18
 143:14,17,21 146:6
 165:15,25 168:8 170:24
 253:12
surrounding 164:23
 168:4

surveillance 151:14
survival 133:15,17 134:6
survive 133:24 270:18
survived 208:2 209:5
Susan 172:6 244:22
suspect 36:24 266:18
 277:14
suspended 227:2
suspicion 263:2
sustained 270:19
Swingle 254:19
switch 24:19
sworn 5:3
symptoms 71:25
syndrome 92:14,18 93:6,
 10 143:7
syphilis 265:14
system 45:14 76:6 132:3,9
 133:10 134:17 156:22
 188:16 199:13 200:12
 202:7 209:15
Systems 32:21 33:1,13

T

tab 29:14,19 98:12 110:16
 157:9 158:6 170:6,9,17,19
 172:3,23 177:22 181:16
 234:7,12,13 238:1,25
 245:12,19 246:10,13,15
 248:21 252:4,7,8 253:3,21,
 24 254:12 255:5,22 257:17
 268:5 273:12 277:1
table 124:6 183:15,23,24
takes 25:1
taking 112:10 176:22
 192:11 230:14 258:10
 259:5,7,11,13 282:21
 283:10 284:25
talk 9:18 11:20 14:19 19:5
 25:20 57:16 73:4 105:20
 112:18 117:8,19 118:5
 119:3 124:5 128:7 131:20
 140:17 146:23 194:14
 195:4 220:7 249:9
talked 16:22 62:20 73:2
 78:17 80:3 84:17 88:5,6
 128:4 142:17 143:4,5,8
 144:16 172:10 222:3
 225:23 234:23 259:24
 280:8
talking 9:15 25:14 81:3
 101:14,16 107:6,7 112:2,
 13 115:16,22 117:25 150:5
 186:21 231:11
talks 111:6

teaching 209:17
tear 87:14 137:16,19,20
 138:6,7,24 139:1,9,15
tearing 137:13,22 139:11
 142:19
tears 138:4 139:6
technical 47:19
technique 70:9
techniques 143:15,22
teenager 80:7 93:20
teenagers 193:6
telling 75:19 122:20,22,24
tells 66:9 121:18 213:12
ten 65:2 74:1,3 93:4 94:3
 176:14 196:20 240:11
 279:20
ten-year 180:3,23
tend 208:11 209:18
tended 239:16
tendency 81:16
tenure 135:3
term 36:18 60:23 68:15
 80:24 82:20 125:4 128:2,
 16 129:16,18 130:12
 152:19 156:9 161:4 163:2
 164:2 168:22,23,25 174:24
 187:16,20 188:1 190:7,18,
 24 191:4 195:18,22 196:12
 206:3 208:2 270:16
 276:10,12
terminate 57:13 113:9
 128:15 193:7,8
termination 49:18
terminology 158:3 166:18
terms 33:18 39:5,20 64:10
 72:12 89:5 100:21 114:17
 118:7 139:1 145:18 151:17
 172:19 180:1 182:11
 193:24 201:18 204:23
 208:22 242:8 256:25
test 224:16,23,24 225:7
 243:21 261:14,15,16,20,25
 267:24
testified 5:4 27:24 71:3
 229:24 230:4,5 268:19
 282:18
testify 104:17,21 284:7
testifying 7:6 8:5,11 39:3
testimony 19:9 20:14,22
 22:14,17 23:3,7 24:2 26:24
 27:2,3,13 28:3,6,7 61:14,
 16 65:10 104:25 131:16
 149:10 214:13 222:2,6,10
 223:1,11,15 224:4 225:23
 236:9 239:12,21 240:17
 244:10 248:3 252:12
 279:1,25 283:15,23

testing 52:16 225:17
 266:6,7
tests 261:13
Texas 6:12,14,20 27:4
 28:3 33:14 52:13 58:2
 61:14,16 73:24 76:10
 77:22 94:9 206:20 222:6
 223:10 224:4 226:7 271:16
 272:8 279:10
text 11:4
textbooks 64:17,20,22
thalamus 199:14 200:13
 201:8,20,21,24 202:11,17
 203:6,15,21,25
therapeutic 72:6 123:17,
 22,24
therapy 142:20
thing 10:1 47:24 116:20
 128:13 212:8
things 9:12,15 10:8 16:7
 20:6 30:7 53:17 55:21
 82:16 85:24 95:10 100:6
 103:17 111:18 115:7
 135:14 136:11 137:1
 142:24 169:18,24 170:4
 185:3 206:7 209:25 212:25
 213:4 223:5 228:20 245:5
thinking 23:17 129:24,25
 130:2,16,18 140:9 235:13
 251:16 259:10 267:10
thought 15:11 37:19
 103:13 140:5 184:13
 198:12 215:14 233:18
 236:14,16 237:6,7,15
 238:16 242:19 244:11
 258:4,15 259:8 282:10,16
thoughts 283:3
thousand 104:4,11
threat 229:2
threatened 229:11 231:2,
 7,15
three-quarter 39:23
three-ring 218:1,2,3,4
thromboembolic 136:3
throw 138:25
thrown 216:6
time 10:2 16:16 17:22
 19:25 22:19 23:2,6,7,11,
 14,16 24:16 30:18 33:2,4,
 17 37:11 39:1 47:4,13 56:6
 65:4,11 70:9 72:7,10 74:1
 76:6 77:15 78:1 85:3 99:8
 103:10,21 130:17 132:16
 135:21 137:15 138:15
 141:13 147:14 148:17
 155:19 157:6 177:17
 180:4,23 183:8 184:10
 185:12 190:4 200:14
 204:15 205:12 213:1

September 02, 2020

214:9,22 215:14 219:3,9,
12,17,23,25 220:5 223:13
224:25 225:8,13 227:12
228:22 246:19 251:4
258:4,14 263:6,11 264:17
265:7 266:24 267:17,24
268:25 270:19 280:10,14
times 5:21 40:14 50:22
75:16 77:13 81:14,18
91:23 92:15,22 100:21
118:12 119:8 144:6 160:4
167:11 182:15 208:13
228:20 261:8 270:17
tip 43:10
tips 17:3
tissue 47:19 48:23 49:1,6,
22 164:25 168:19 197:9
198:20,21 200:3 281:12,14
Title 232:11,12,13,18
233:3,8
titled 234:9
tobacco 147:11,12
today 8:3,6,14 9:24 10:16,
22 11:10,12,18 22:20
25:13 64:22 66:12 86:13
92:2 147:14 150:20 185:1
186:21 189:15 193:21
194:16 215:7 218:22 222:3
227:8 231:20 234:25
270:17 280:1 284:19
today's 8:4 13:12 14:24
16:20,23,24 22:17 98:17
told 9:19 22:16 24:8 68:7
76:20 92:7,10 93:13 94:17
95:9 114:3 119:7,16,20
223:2,10 245:3 284:1
top 105:22
topic 13:16 67:15 68:19
69:6 233:7
topics 55:15 99:9,11
240:12
total 22:19 69:5 183:25
totally 215:8
town 276:3
track 23:15 84:4 86:24
135:5 139:18,21,24 140:3,
23 141:1,6 142:5 146:19,
20 150:22 160:19 198:24
tracked 144:12
tracking 135:2
tracks 140:12
traction 43:14
traditional 208:9
trained 30:12 69:13,18,24
263:19 264:8,25
training 19:8,18,20,21,22
20:5,7,9,10,22,25 21:8
22:11 29:10 69:20 97:14

178:22 280:18,20 281:2,5,
6
trainings 22:13
transcript 8:17
transducer 211:25
transfuse 93:19
transfusion 76:4 136:1,11
transfusions 93:18,24
transition 29:2 50:10
transmission 213:13
trauma 252:20 253:11
treat 72:1
treated 73:6 76:19 78:25
84:20 89:7 92:2,8,11 93:14
94:18
treating 72:12 91:24 207:8
treatises 64:17
treatment 65:22,23 71:16
72:14 78:24 157:6 208:9
209:2
tremendous 188:21
trend 81:21
tri 73:13
trial 8:12 23:3,6,9
tricky 57:4
triggered 94:23
trimester 36:4,21 37:16
38:16,17 48:18 73:15
74:11,18 75:5 80:8,9,15
88:19,20 93:21 113:8
124:25 125:11,15 144:24
165:15,20,22,25 174:4,5
182:1 191:24 192:2 268:11
269:21 270:11
trouble 45:13 106:3
197:16
true 42:5 78:13 123:21
130:5 133:23 156:3 177:7
264:10
trust 264:7 269:5
truth 6:5 75:19 100:14
121:11 122:21,23,24
184:12 216:12 241:10
257:2
Truthfully 233:17
tubal 39:14
tubing 50:15
turn 29:14 63:8 64:17
98:12 105:19 110:4 120:10
127:11 143:13 157:8,9
164:17 172:3,22 173:19
177:22 178:7 184:23
195:14 251:25 253:14,20
268:4 273:12
Turnaway 14:4,5 191:7,15

192:15 193:12,24 194:6,22
195:10
turned 195:22
TV 220:4
twelve 21:10
Twenty 31:18,22
Twenty-five 51:4
twenty-two 66:17
twin 211:10
twins 211:6
two-thirds 123:17 155:21
207:18,19
two-year 68:10
type 80:6 128:17 130:22
142:14 165:15 167:17
169:24 210:17 222:2 223:2
types 32:7 53:8 139:20
169:19
typically 35:3 36:9 38:19
45:21 144:22 169:3
268:19,22,24 269:1,11
274:20

U

U.S. 46:24 146:17 159:23
uh-huh 13:25 21:23 22:1
23:1 29:5 35:14 36:16 39:4
43:20 51:6 67:3 75:2 80:6
86:1 112:3 119:18 128:25
134:11 136:14 138:13
140:1 154:20 161:12
171:12 184:21 195:7 201:1
220:25 231:24 236:21
252:11 253:7 257:19
263:8,12 264:10 266:4
268:12 269:3 282:18
ultimately 100:13 122:17
213:24 265:9
ultra 269:6
ultrasound 35:11 50:1
58:11 116:11 210:10,14
211:12,17,22,25 214:1
225:11 261:14 262:6,13,
15,18 263:6,15,22 264:4,
15,17,20 265:2,9 268:11,
13,20,23 269:2,6,12,22
270:12
ultrasounds 262:3 264:7,
11,22,24
unable 11:11 46:23 58:13
uncertain 282:20
uncertainty 113:15
114:11 115:2
uncomfortable 95:14
115:15
uncommon 93:18 167:12
underestimates 109:1
undergo 86:16
undergoing 205:7
underlying 40:15
understand 8:5,9,14 9:2,6
10:22 11:1 20:19 25:15
62:1,11 67:23 76:16 96:8
100:1 103:12 111:25
113:13 121:21 123:11
131:14,21 132:22 137:21
151:10,12 153:6,13 158:7,
15 178:10 179:16 195:9
196:8 199:24 202:23 224:3
228:9 235:16 239:18 269:8
284:1
understandable 8:25
understanding 24:25
74:15 78:11 80:15 85:14
134:2,9 141:16 147:13
156:1 158:21 182:14
195:14 200:18 205:16
207:7 208:7,9 215:5
232:18 235:21 276:10
understood 125:7 220:8
undifferentiated 131:7
undoubtedly 115:21
209:21
unethical 57:6 115:20
unfavorable 41:16 42:8,
12,13,22 46:3
uniformly 25:7
unintended 52:15 53:3,9
unique 164:21 166:4,5,23
169:14,20 249:21,22
258:5,16
unit 54:4
United 28:5 66:22 75:12
108:15 109:10 110:20
112:14 145:12 146:17,24
147:4 150:11 151:1 172:6
173:2,11 182:2 198:5
228:3 229:2 274:1
University 207:17 208:6
unnecessary 202:24
229:19
unplanned 269:16 271:4
unpleasant 197:8 199:7
200:2
unrelated 93:10 155:20
158:13 230:8
unrestricted 232:13
unripe 82:18
untrue 61:22 62:6,7
unusual 168:6
unwanted 120:7

September 02, 2020

update 149:10
updated 64:22
updating 235:13
Urinary 138:12
urine 45:21 261:14,15 266:9
Utah 5:11 12:22 26:4,15 123:13,14,16 125:20,23 134:7,9,12 154:16,23 157:14 158:4,9 164:6 174:9,17 175:21 177:4 180:2,11,15,23 181:4 225:20 233:13
Utah's 180:6
uterine 39:14 45:4 46:10, 16,18,20,24 47:25 81:9 88:2,13,21 142:3,8 166:19 168:1 252:24 253:16
uterus 44:14 45:2,6 47:5 49:21 87:6,9,21,24,25 91:3 92:14 94:15 136:20 137:11 146:7,13 162:25 163:1 164:23 166:12,13 167:20, 25 169:16 252:20 253:12 270:18
uteruses 91:20

V

vagina 138:8 167:24
vaginal 39:20,23,24 42:20 46:15 47:23 137:12,13,14, 21 138:24 139:12 142:11, 19,21 161:5,10 162:1 163:24 164:9
vaginal-birth 163:9
vaginally 43:5 46:23
vague 61:12,23 62:10 67:20 96:6
van 265:20
variable 189:7
vary 41:24 42:1
vasculature 164:24 168:10
vast 83:24 241:16
VBAC 47:23
vegetative 199:21
vein 206:3
verbal 28:6,7
verbatim 8:16
verified 101:10 263:20 283:21
verify 99:24
Vermont 222:10,13 223:11,13,25 224:4 225:23

versus 39:21 123:25
vessel 206:11
vessels 45:4 94:15
viability 35:12 132:16 133:1 174:6 205:16 207:16,23 270:14,17
videos 213:20,21 214:2
view 53:2 64:12 70:17 134:19 150:9 184:16 185:2 201:19,22 207:9 211:17 212:3 225:4 229:9 237:18 241:6,8,19
viewed 64:4
viewpoint 284:2
views 240:25
violent 153:10
visit 35:4,10,18,22 264:5 265:10 269:7
visits 34:11
visualize 139:15
vital 152:21
volume 127:15 178:17 179:8,13,18,25 180:4,8,25 182:7 183:11
voluntarily 144:13
voluntary 55:13 108:21 160:4 256:3
volunteer 264:24
volunteers 261:2,6
vomits 44:12

W

wait 9:13,14 48:24 76:17 264:14 267:23
waiting 225:12,19 237:1
waits 113:7
walking 183:6
wall 252:24 253:16
wanted 24:20 48:5 76:13 99:11 133:8 150:3 157:25 158:3 190:25 214:18 233:18 241:10 244:11 266:5,13 276:22
wantonness 190:20
watched 220:4
ways 42:21 116:15 132:19 211:23 212:5
weak 91:3
web 157:13
website 17:22,25 101:7 120:16,23 121:9,15,24 122:10,13,23,24 123:2 256:24 273:16

Wednesday 33:19
week 33:17,19,20 34:4 37:25 38:17 39:6 73:13 181:1 215:1 217:3 224:19 261:8
weeks 25:3,9,10,15,16 27:7 28:22 29:4 35:6,16,25 38:6,7,11,19,21 41:6,25 42:2 49:2,18 50:2,8,12,18 51:7,19,24 66:17 67:7,12, 19 68:25 69:3,14 70:2,13, 21,24 71:5 74:1,2,3,7,19 79:18 81:21 91:18 94:4,8 95:3,6,13 123:12 127:23 128:3 132:24 145:7 149:18 152:11 154:7,8 155:13 161:9,24,25 173:24 174:1, 21,23 175:6,7,11 176:2,8, 14 177:10 180:17,23 181:12,13 200:11,12,21 201:6,17,18 202:4,5,7,13, 18,23,25 203:24 207:23 208:1,10 209:22 211:6 213:16,19 214:5 224:11, 17,18,20,22 225:3,4,6,7,10 230:3,4,5,21
well-being 42:11 255:10 256:2,5
well-documented 256:10
well-known 171:9
well-researched 283:22
white 34:21
widely 123:8 160:16
Winter 248:25
wished 119:8
withdrawal 198:22 201:11 212:12
witnesses 21:19,20
woman 7:3 20:16 25:2 36:23 37:7 42:7 44:12 46:14 47:14,17,20 51:12 53:21 54:7 72:18,21 88:1 93:9 106:8 112:22,25 113:3,19 114:3,6 116:16 119:24 124:17,21 126:10, 13 129:8,18 131:11,12 132:18 142:12 143:23 158:10 159:6 165:14 174:3 175:7,9 176:20 177:16 187:10 189:10 225:5,13 228:5 259:25 260:6,11,12, 13,14,16,18 261:9 263:17 264:4,7,23 265:3,11,16,17, 24 266:4,6,19,21 267:2,11, 13,18,25 268:20 269:6,19, 21,23 270:4,12 271:4,10, 15 273:5 279:2
woman's 45:20 46:4 62:14 134:15 152:13 154:4,12 164:2 177:18 188:23 228:14 229:3 255:12 256:4

women 13:17 27:22 28:1 34:12,20 36:7,11,13,15,17 37:1,11,15 38:3 40:14 46:16 47:2 52:14 53:13 58:20 65:25 66:6 68:5 72:9,16,19 73:3,4,5,9,19 76:3,24 77:13,17,23,24 78:2,4,18 80:20 81:3,18,25 83:12,16,19 85:3 86:16 87:25 88:3,7 90:25 91:6, 10,19,24 92:4,13,24 94:7 111:17 112:10 113:4,5,18 115:2,17,18,19,21 120:6 123:6 137:4 142:20 155:4, 6,12 156:2 159:3,5 162:4, 13,17,22 174:9,17,20 175:3,4,17,21 176:17 177:4,8 179:5 185:4,21 186:1,3,8 187:16,20,24,25 188:15,17 190:2,3,7,24 191:4,8,22 193:10 195:15, 17,18 196:7,11 224:13 229:20 260:9,11 271:3 273:22 274:1,4,9
women's 52:17 77:14 113:25 228:5 232:20 272:22 273:21,22 274:7,10 276:8,10 278:3
wondering 54:23 111:1
word 67:21 166:5 167:6 236:4 240:9 259:1
worded 257:10
wording 102:7 203:17 257:13 258:17 282:16
words 69:9 125:7 159:3 162:3 282:20 283:7
work 17:23 30:18 31:5,16, 25 32:11 33:16,20 40:8 52:7 59:13 77:25 111:22 113:3 132:3,10 147:8,9 163:21 195:6 232:8 238:19 243:7,16 248:10 250:11 251:9 258:10,16 259:6,7, 11,16,18 273:2 275:23
worked 18:2 132:6
working 18:11 52:20 67:1 216:13 272:25 277:25
works 35:9 65:5 109:25 111:11 199:14
world 46:19 115:1
worries 183:8
worsening 40:15
wrap 282:1
wrap-up 280:6
write 18:16 124:13 147:10 164:4 223:17 238:18 239:17 258:25 282:14
writing 18:4 219:6 225:17 240:1,4,7,22 284:19

September 02, 2020

written 8:17 18:9,14,25
 24:1 26:25 27:1 28:8,9
 67:15 68:21,22 69:1,2,4,11
 99:10 103:9 177:14 232:10
 233:2 236:7 245:7 257:3,
 10 259:1,15,17,18 283:2

wrong 135:15 141:21
 235:3 278:23

wrote 17:21 103:24 163:15
 184:10 196:3,10 222:12
 235:9,15,19,22 236:5,11
 239:8 243:21 246:8 248:3,
 4,6,7 249:9 252:13 256:18,
 19,25 257:4 282:10,16

Y

year 19:24 34:3 43:25 51:2
 108:15 117:14,15 118:7,12
 152:18 155:14 157:7
 158:11,19 159:1,12
 179:17,24 180:16 249:4,10

years 6:14,21,25 7:16
 27:22 33:9,11 49:15 51:4
 52:4 59:2 62:4 67:1 70:6
 75:8 76:1,22 77:13 80:13
 85:2 93:18 114:1,23
 179:11 220:11 221:2,16
 227:12 236:10 240:12

Yellow 60:2,5

yesterday 15:9,14 16:13,
 15 214:20 215:11 217:8

young 114:3 165:14
 209:15,22

Z

Zane 165:17 172:6,9,20
 182:19,20 183:14,22

Zane's 172:13

Zealand 194:5