CAUSE NO. D-1-GN-23-000968

AMANDA ZURAWSKI *et al.*,

***Plaintiffs*,**

v.

STATE OF TEXAS *et al.*,

Defendants.

In the District Court of
Travis County, Texas

353RD JUDICIAL DISTRICT

PLAINTIFFS' APPLICATION FOR TEMPORARY INJUNCTION

Plaintiffs' Original Petition describes the devastating and ongoing public health crisis that the confusion and uncertainty around the exception to Texas's abortion bans is causing statewide. It told the stories of five women with obstetrical complications denied timely abortion care in Texas and two obstetrician-gynecologists, all of whom describe widespread confusion and fear regarding the enforcement of the medical exception to Texas's abortion bans. Their stories were just the tip of the iceberg. Since filing the Original Petition, many Texans have reached out to Plaintiffs and/or Plaintiffs' counsel to say, in the words of one, "your story is my story." Eight additional women join the lawsuit today and Plaintiffs collectively submit this application for temporary injunctive relief while litigation proceeds.

Plaintiffs are Amanda Zurawski, Lauren Miller, Lauren Hall, Ashley Brandt, Anna Zargarian, Kylie Beaton, Jessica Bernardo, Samantha Casiano, Austin Dennard, M.D., Taylor Edwards, Kiersten Hogan, Lauren Van Vleet, and Elizabeth Weller (the "Patient Plaintiffs"), and Judy Levison, M.D., M.P.H and Damla Karsan, M.D. on behalf of themselves and their patients

(the "Physician Plaintiffs"). Their stories, told in the Amended Verified Petition and the accompanying affidavits to this Application, prove the merits of Plaintiffs' original claims: Texas's abortions bans are preventing pregnant people statewide from receiving necessary and routine health care, an abortion, from their Texas medical professionals in times of medical crisis because doctors fear the stiff penalties imposed by Texas's abortion bans. Use of nonmedical terminology and inconsistences between different provisions of the medical exception have led to uncertainty throughout the medical community regarding the scope of Texas's medical exception and put patient lives and physicians' liberty at grave risk. A declaratory judgment would prevent further harm by giving physicians the clarity they need to provide essential abortion care to their patients—without fear that providing necessary medical treatment under the standards of care will land them in prison or jeopardize their license. The collective stories of the thirteen Patient Plaintiffs show that without immediate relief enjoining enforcement of the abortion bans as applied to patients like them, pregnant people will not be assured that their physicians can provide medically necessary care and thus that their health and lives are safe in Texas.

The only *constitutional* interpretation of the medical exception to Texas's abortion bans is that physicians may provide a pregnant person with abortion care when the physician determines, in their good faith judgment and in consultation with the pregnant person, that continuing the pregnancy poses a risk of death or a risk to their health—including their fertility. Defendants have avoided offering any contrary interpretation of the exception, and repeated requests from medical associations, medical professionals, and members of the public for guidance have been met with silence. To the extent Defendants disagree with Plaintiffs' interpretation of the medical exception, the abortion bans are unconstitutional as applied to pregnant people in medical crises, and any enforcement of them violates the Texas constitution.

A temporary injunction is necessary to stop the ongoing public health crisis caused by the confusion and uncertainty around the medical exception to Texas's abortion bans, which has and is continuing to cause irreparable harm to Plaintiffs, pregnant people, and physicians across Texas.

BACKGROUND

A. The Patient Plaintiffs Suffered Catastrophic Harms Because of the Confusion and Uncertainty Regarding the Medical Exception to Texas's Abortion Bans.

Each Patient Plaintiff was denied timely abortion care in Texas while experiencing medical conditions during their pregnancies that risked their life and/or health (including their fertility). Some of these women are pregnant again now, and all are fearful of being pregnant in Texas due to the confusion and uncertainty around the medical exception to the state's abortion bans. Briefly, their stories are as follows:

- Amanda's water broke prematurely and she was forced to wait until she was septic to receive abortion care, causing one of her fallopian tubes to become permanently closed. Amanda Aff. ¶¶ 5-16.
- Anna was forced to fly across multiple states after her water broke prematurely, risking that she would go into labor or septic shock on the journey. Anna Aff. ¶¶ 10-15.
- Kiersten's water broke prematurely, and she was told she would need to wait until she was sicker for the hospital to provide abortion care. She was also told that if she tried to leave the hospital to seek care elsewhere, she could be arrested for trying to kill her baby. Kiersten Aff. ¶ 10.
- Elizabeth's water broke prematurely, and she went home to wait until she became infected. Only after she returned to the hospital with evidence of her infected discharge did the hospital deem her eligible for abortion care. Elizabeth Aff. ¶¶ 5, 10-13.
- Lauren M. was suffering from severe hyperemesis gravidarum when she learned one of her twins had trisomy 18 and was not viable. She was forced to travel out of state for the abortion she needed to save her and her other baby's life. Pregnant at the time this lawsuit was filed, Lauren M. has since delivered a healthy baby. Lauren M. Aff. ¶¶ 6, 9, 15.
- Lauren M.'s obstetrician, Dr. Austin Dennard, was inspired to share her own story about having to travel out of state after receiving a non-viable fetal diagnosis of anencephaly only after her patient joined this lawsuit. Dr. Dennard is pregnant again

now and continues to fear for her safety as a pregnant woman in Texas. Austin Aff. ¶¶ 4-11.

- Ashley learned one of her twins was not viable due to acrania and had to travel out of state for an abortion to save the life of her other twin. Afterwards, fearful of documenting Ashley's abortion, her Texas physician instead described her condition as "vanishing twin syndrome." Ashley Aff. ¶¶ 6-10, 14.
- Lauren H. received a non-viable fetal diagnosis of anencephaly and was forced to travel to Seattle for an abortion. Pregnant again now, Lauren H. fears that Texas is not safe for her or her family. Lauren H. Aff. ¶¶ 5-12.
- Jessica received a fetal diagnosis of Down Syndrome but knew she would love her baby no matter what. However, when she learned her baby was unlikely to survive to birth due to fetal anasarca and other structural and cardiac conditions, and that she was at risk of developing a deadly condition called Mirror Syndrome, she was forced to travel to Seattle for abortion care. She is now undergoing IVF. Jessica Aff. ¶¶ 4-12, 14.
- Taylor received a non-viable fetal diagnosis of encephalocele and was advised that continuing the pregnancy posed increasing risks to her health; she was forced to travel to Colorado for an abortion. She is now undergoing IVF. Taylor Aff. ¶¶ 4-10, 12.
- Lauren V. received a non-viable fetal diagnosis of anencephaly and was forced to travel to Maryland for an abortion, even while the risks to her own health increased. Lauren V. Aff. ¶¶ 4-9.
- Samantha received a non-viable fetal diagnosis of anencephaly and was forced to carry the pregnancy to term. Samantha's daughter died a few hours after birth, and she was only able to afford a headstone for her daughter after NPR wrote a story about her and members of the public contributed to her GoFundMe. Samantha Aff. ¶¶ 3-6, 14, 17-18.
- Finally, Kylie received a non-viable fetal diagnosis of alobar holoprosencephaly and was forced to carry the pregnancy to term. After emergency cesarian surgery, her son lived for only 4 days. Kylie Aff. ¶¶ 3-6, 13-19.

These are only the patients who were willing and able to tell their stories publicly. Countless other Texas women have and will suffer because of the confusion and uncertainty around the medical exception to Texas's extreme abortion bans. *See* Am. Pet. ¶¶ 365-71, 398-419.

B. Physicians Have Been Chilled From Providing Medically Necessary Abortions.

The Physician Plaintiffs have a combined forty-five years' experience practicing obstetrics and gynecology in Texas. D. Karsan Aff. ¶ 3; J. Levison Aff. ¶ 3. Before Texas's first abortion

ban took effect, Dr. Karsan routinely provided abortions to her patients as part of their comprehensive reproductive health care needs, D. Karsan Aff. ¶ 4, while Dr. Levison for many years counseled patients on abortion care where medically indicated. J. Levison Aff. ¶ 3. They both continue to actively participate in the care of patients treated for emergent health conditions during their pregnancies. *Id.* ¶ 4; D. Karsan Aff. ¶ 6. In the months since Texas's abortion bans took effect, both physicians have personally experienced and observed widespread fear and confusion throughout Texas's medical community regarding the scope of the medical exception to the abortion bans.

Specifically, both doctors have seen and consulted with colleagues regarding patient cases that arguably fall under the medical exception to Texas's abortion bans. J. Levison Aff. ¶ 8; Karsan Aff. ¶ 7. These patients included patients carrying pregnancies with lethal fetal conditions, those who needed treatment for complications like kidney stones, bipolar disorder, and hemorrhage, D. Karsan Aff. ¶ 11, as well as patients whose water broke prematurely, who have cancer, diabetes, hypertension, suicidal ideation, and who need fetal reduction procedures, J. Levison Aff. ¶ 8. But neither Physician Plaintiff nor their colleagues have felt free to provide the standard of care they were trained to provide. J. Levison Aff. ¶ 5; D. Karsan Aff. ¶ 8. They fear providing necessary abortion care to pregnant people with emergent medical conditions will make them targets of civil and criminal prosecution and have observed similar fear throughout the medical community in Texas. J. Levison Aff. ¶ 5; D. Karsan Aff. ¶ 7.

C. Abortion Is Essential Healthcare.

While Texas has created its own legal definition of abortion, the *medical* definition of abortion is clear: An abortion is the expulsion from the uterus of an embryo or fetus, as well as the

products of conception, before viability.[1] Mainstream medical professionals, like the Physician Plaintiffs and the maternal fetal medicine expert, Dr. Aaron B. Caughey, who submit affidavits in support of this application, all understand that patients in any number of circumstances need abortions. D. Karsan Aff. ¶ 7; A. Caughey Aff. ¶¶ 29-31. It is practically impossible to compile an exhaustive list of every emergency situation or medical condition that may become urgent if abortion care is denied or delayed, as the leading medical organization on obstetrical care has stated.[2] But there are, at a minimum, several established categories of health risks caused by medical conditions during pregnancy that are considered "emergent," meaning the "[p]atient presents with symptoms of an illness or injury that may progress in severity or result in complications with a high probability for morbidity if treatment is not begun quickly." *See* Am. Pet. ¶¶ 274-99; A. Caughey Aff. ¶¶ 31, 33.

These "emergent medical conditions" include medical conditions where, in the physician's good faith judgment and in consultation with the pregnant person, a pregnant person has: (1) a complication of pregnancy that poses a risk of infection, bleeding, or otherwise makes continuing a pregnancy unsafe for the pregnant person; (2) a condition exacerbated by pregnancy, that cannot be effectively treated during pregnancy, or that requires recurrent invasive intervention; and/or (3) a fetal condition where the fetus is unlikely to survive the pregnancy and sustain life after birth. *See* Am. Pet. ¶ 444.

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[1] *See, e.g.*, *Abortion*, Taber's Med. Dictionary, https://www.tabers.com/tabersonline/view/Tabers-Dictionary/766365/all/abortion#:~:text=abortion%20is%20a%20topic%20covered,fetus%20reaches%20a%20viable%20age.

[2] *Understanding and Navigating Medical Emergency Exceptions in Abortion Bans and Restrictions*, ACOG (Aug. 15, 2022), https://www.acog.org/news/news-articles/2022/08/understanding-medical-emergency-exceptions-in-abortion-bans-restrictions

D. The Texas Abortion Bans Use Nonmedical and Inconsistent Terminology.

Texas has defined abortion as "the act of using or prescribing an instrument, a drug, a medicine, or any other substance, device, or means with the intent to cause the death of an unborn child of a woman known to be pregnant," but excludes acts "done with the intent to: (A) save the life or preserve the health of an unborn child; (B) remove a dead, unborn child whose death was caused by spontaneous abortion; or (C) remove an ectopic pregnancy." Tex. Health & Safety Code § 245.002(1); *see* Am. Pet. ¶¶ 301-05. A 6-week abortion ban with civil penalties ("S.B. 8") has been in effect since September of 2021, and a complete abortion ban with civil and criminal penalties for doctors has been in effect since *Roe v. Wade* was overturned in the summer of 2022. *See* Am. Pet. ¶¶ 306-17. The only exception to these bans is for certain medical conditions.

Lack of clarity regarding the scope of this exception, however, has chilled the provision of medically necessary abortion care in Texas. The Texas Health and Safety Code chapter on Abortion, which has long recognized an exception for providing abortion care to pregnant people with emergent medical conditions, *see* Am. Pet. ¶ 321-22, defines "medical emergency" as "a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed." Tex. Health & Safety Code § 171.002(3); *see also* § 170A.002(b). Yet nowhere in the code does Texas law define any of the following distinctions: "risk" versus "serious risk"; "insubstantial impairment" versus "substantial impairment"; "minor bodily function" versus "major bodily function." Nor does Texas law define what it means to have "a serious risk of a substantial impairment" or "a substantial impairment of a major bodily function." None of this terminology has standardized meaning in the medical profession, leaving physicians to guess at how to translate it into clinical practice. A. Caughey Aff. ¶¶ 18-28. Notably, however, the provision does *not* require that health risks be

imminent and is relatively broad when compared to abortion bans in other states with similar exceptions. *See* Am. Pet. ¶¶ 340, 344.

As a matter of statutory interpretation, the best reading of the statute is that it creates an exception to the state's abortion bans for emergent medical conditions, as determined by the good faith of the treating physician in consultation with their patient. *See* Am. Pet. ¶¶ 334-45; A. Caughey Aff. ¶¶ 58-61.

E. Defendants Enforce the Abortion Bans.

Defendants are responsible for civil enforcement of the abortion bans. This encompasses, civil suits brought by Defendant Paxton against Texas physicians who perform an unlawful abortion, TMB's authority to discipline or revoke the license of Texas physicians, and civil suits under S.B. 8 brought by private citizens. *See* Am. Pet. ¶¶ 254-57.

LEGAL STANDARD

A temporary injunction may be granted if the applicant establishes three elements: "(1) a cause of action against the defendant; (2) a probable right to the relief sought; and (3) a probable, imminent, and irreparable injury in the interim." *Butnaru v. Ford Motor Co.*, 84 S.W.3d 198, 204 (Tex. 2002). The purpose of a temporary injunction is to "preserve the status quo of the litigation's subject matter pending a trial on the merits." *Butnaru*, 84 S.W.3d at 204. The status quo to be preserved is the "last, actual, peaceable, noncontested status which preceded the pending controversy." *Texas Aeronautics Comm'n v. Betts*, 469 S.W. 2d 394, 398 (Tex. 1971) (internal citation omitted).

ARGUMENT

I. Plaintiffs Have a Cause of Action Against Defendants.

Plaintiffs are Texans who have been denied or delayed abortion care in the past, are pregnant now, could become pregnant in the future, and/or who provide OB/GYN care to pregnant

Texans. Plaintiffs bring claims against Defendants under the Texas Uniform Declaratory Judgment Act (the "UDJA"). "A person . . . whose rights, status, or other legal relations are affected by a statute . . . may have determined any question of construction or validity arising under the . . . statute . . . and obtain a declaration of rights, status, or other legal relations thereunder." Tex. Civ. Prac. & Rem. Code § 37.004(a). Plaintiffs seek a declaration clarifying the scope of the medical exception to Texas's abortion bans, or, alternatively, that the abortion bans as applied to pregnant persons with emergent medical conditions and Texas-licensed physicians treating such patients are unconstitutional. The UDJA is designed to resolve such uncertainty and confusion over the validity and construction of a state statute. *Id.* Further, the UDJA "allows for injunctive relief ancillary to a declaration of rights" provided such relief is "necessary and proper." *Tex. Dep't of Pub. Safety v. Moore*, 985 S.W.2d 149, 156 (Tex. Ct. App.—Austin 1998); *see* Tex. Civ. Prac. & Rem. Code. § 37.011 ("Further relief based on a declaratory judgment or decree may be granted whenever necessary or proper.").

Plaintiffs adequately allege that injunctive relief is "necessary and proper" here to prevent any enforcement of Texas's abortion bans as applied to a pregnant person with an emergent medical condition for whom an abortion would prevent or alleviate a risk of death or risk to their health (including their fertility); such injunctive relief is also proper because enforcement to prevent such patients from accessing abortion would be inconsistent with the rights afforded to pregnant people and their physicians under Article I, §§ 3, 3a, and/or 19. And, where, as here, parties seek a "declaratory judgment action that challenges the validity of a statute," the UDJA waives sovereign immunity in suits against the state and its political divisions. *Tex. Dep't of Transp. v. Sefzik*, 355 S.W.3d 618, 622 (Tex. 2011) ("[T]he state may be a proper party to a

declaratory judgment action that challenges the validity of a statute."); *City of El Paso v. Heinrich*, 284 S.W.3d 366, 373 n.6 (Tex. 2009).

Alternatively, Plaintiffs have brought claims under the *ultra vires* doctrine. The *ultra vires* doctrine permits claims brought against state officials for nondiscretionary acts unauthorized by law. *See* Tex. Civ. Prac. & Rem. Code §§ 37.003, 37.004, 37.006; *Tex. Lottery Comm'n v. First State Bank of DeQueen*, 325 S.W.3d 628, 634-635 (Tex. 2010); *Sefzik*, 355 S.W.3d at 621–22. That is because a state office may not act without legal authority. *See, e.g., Heinrich*, 284 S.W.3d at 372, 374; *Sefzik*, 355 S.W.3d at 621 ("[*ultra vires*] lawsuits are not against the state and thus are not barred by sovereign immunity"). A party who "who successfully proves an *ultra vires* claim is entitled to prospective injunctive relief, as measured from the date of injunction." *Heinrich*, 284 S.W.3d at 374–76; *State v. Hollins*, 620 S.W.3d 400, 410 (Tex. 2020) (providing that the "remedies available in an *ultra vires* action are injunctive and declaratory relief" and remanding the case to the trial court for an entry of a temporary injunction). Here, Plaintiffs adequately allege that enforcement of Texas's abortion bans, as applied to pregnant people with emergent medical conditions and Texas-licensed physicians treating such patients, would either violate the law or be unconstitutional and thus be *ultra vires*. Am. Pet. ¶¶ 446-49.

II. Plaintiffs Have a Strong Probability of Right to the Relief Sought.

Plaintiffs are likely to prevail on the merits of this case and receive the requested declaratory judgment, as well as equitable relief.

There is ample evidence establishing that the abortions bans have caused "uncertainty and insecurity" with respect to patient and physician rights and liabilities, and that a declaratory judgment will "afford relief." Tex. Civ. Prac. & Rem. Code § 37.002. Plaintiffs attest that medical professionals statewide are reluctant to perform an abortion under even the most pressing circumstances. This is due to many factors including: understandable confusion regarding

physicians' level of discretion under Texas's abortion bans; fear for the legal consequences if they are wrong; Defendants' threats to "strictly enforce" the bans;[3] and Defendants complete silence on the meaning of the bans' medical exception. *See* D. Karsan Aff. ¶¶ 7-11; J. Levison Aff. ¶¶ 5-8; A. Caughey Aff. ¶¶ 19, 25-28; Am. Pet. ¶¶ 346-64, 399-420. As Plaintiffs' experiences show, because of the laws' uncertainty and failure of the state to provide clarification, physicians are over-complying with the laws to the detriment of their patients' lives and health statewide. *See* Am. Pet. ¶¶ 399-420.

And it is not just Plaintiffs' say-so. The lead author of S.B. 8 wrote Defendant TMB explaining the confusion and demanding clarification. *Id.* ¶¶ 354-357. Governor Abbott acknowledged the confusion and expressed that "something that really does need to be done and that is clarify what it means to protect the life of the mother." *Id.* ¶ 361. The leading medical association in Texas, the Texas Medical Association, has demanded clarification. *Id.* ¶ 352. And multiple academic articles have described the consequences of the uncertainty. *Id.* ¶¶ 400-17. A declaratory judgment would prevent further harm by providing physicians with the clarity they need to provide essential abortion care to their patients—without fear that providing necessary medical treatment under the prevailing standards of care will land them in prison or jeopardize their license.

There are multiple reasons why Plaintiffs' requested declaration would best fill the gaps left by the state's failures. *First*, nowhere in the text does the exception require that any of the risks to the pregnant person be imminent. Thus, a declaration could properly clarify that acute risk need not be already present or imminent. *Second*, although "major bodily function" is not defined in the Texas Health and Safety Code, elsewhere Texas law defines the term to include "reproductive

[3] Ken Paxton, Tex. Att'y Gen., *Advisory on Texas Law Upon Reversal of* Roe v. Wade (June 24, 2022), https://www.texasattorneygeneral.gov/sites/default/files/images/executive-management/Post-Roe%20Advisory.pdf.

functions." *See* Tex. Labor Code § 21.002(11-a) ("[M]ajor bodily function, includ[es], but [is] not limited to, . . . reproductive functions."). Impairment of a "major bodily function" is thus best read to include harm to reproductive functions and fertility, such as impairment of the patient's uterus, ovaries, or fallopian tubes.

Third, the plain text of the statute leaves measurement of risk to physician judgment, as legislators intended. Senator Angela Paxton, primary sponsor of the Trigger Ban, explained on the Senate floor that the ban makes it "the determination of the physician and the woman" whether the woman has "a physical condition" that meets the requirements of the exception.[4] "Good faith" is a critical component of physician discretion to ensure that physicians understand they have wide discretion to determine the appropriate course of treatment, including abortion care, for their patients who present with emergent medical conditions—without being second guessed by the Attorney General, the Texas Medical Board, a prosecutor, or a jury. *See Colautti v. Franklin*, 439 U.S. 379, 395-96 (1979); Am. Pet. ¶¶ 325-33. Accordingly, Plaintiffs' requested declaration would make clear that it is when the "physician determines [sufficient risk is present], in their good faith judgment and in consultation with the pregnant person," that the exception is met. Am. Pet. ¶ 443.

Fourth, notwithstanding the term "emergency," the language of the exception is much broader than what the medical community understands as "emergencies." The full language of the exception permits abortions if the patient's condition would pose a serious risk to her health (specifically, a "serious risk of substantial impairment of a major bodily function") if left untreated. *See, e.g.*, Tex. Health & Safety Code § 170A.002. Giving meaning to that terminology requires a

[4] *Senate Session*, 87th Leg., Reg. Sess. (Tex. Mar. 29, 2021) (floor debate on Senate Bill 9, the companion bill to House Bill 1280, the Trigger Ban), https://tlcsenate.granicus.com/MediaPlayer.php?view_id=49&clip_id=15566 (beginning at 4:47:18).

declaration that describes the broad categories of health risks that stem from emergent medical conditions in pregnancy, as described further above. *Supra* at 6-7.

Alternatively, if the Court disagrees with all or part of Plaintiffs' construction of the statute, Plaintiffs are likely to prevail on their constitutional claims. *See* Am. Pet. ¶¶ 450-80. The Texas Constitution protects Texas residents from any deprivation of their "life, liberty, property, privileges or immunities . . . except by the due course of the law of the land." Tex. Const. art. I, § 19; *see, e.g.*, *Patel v. Tex. Dep't of Licensing & Reg.*, 469 S.W.3d 69, 80-81 (Tex. 2015). This provision must mean that the State cannot deny patients their fertility, let alone their lives. Further, to deny a "woman known to be pregnant" equal access to life-saving and health-preserving medical care, simply because she is pregnant, would violate the Texas Constitution's guarantees of equality. Tex. Const. art. I, §§ 3, 3a. Such fundamental rights are subject to the highest level of constitutional scrutiny, but the medical exception to Texas's abortion bans would fail even the most basic level of constitutional review. Abortion bans that force pregnant people with emergent medical conditions to surrender their lives, health, and/or fertility cannot be said to bear any rational relationship to protecting life, health, or any other legitimate state interest. *See Roe v. Wade*, 410 U.S. 113, 173 (1973) (Rehnquist, J., dissenting) ("If the Texas [pre-*Roe* ban] statute were to prohibit an abortion even where the mother's life is in jeopardy, I have little doubt that such a statute would lack a rational relation to a valid state objective under the test stated in *Williamson* . . . ."). Finally, threatened enforcement of the abortion bans against physicians who in good faith provide abortions for pregnant people suffering emergent medical conditions infringes Physician's Section 19 constitutional guarantees who have property rights in their licenses to practice medicine consistent with their profession's ethical guidelines.

III. Plaintiffs Will Suffer Probable, Imminent, and Irreparable Harm Without a Temporary Injunction.

Defendants' threatened enforcement of Texas's abortion bans is causing well-documented, imminent, and irreparable injury to Plaintiffs, and should be restrained by the Court. Harm is imminent if it is relatively certain to occur rather than being remote and speculative. *Limon v. State*, 947 S.W.2d 620, 625 (Tex. Ct. App.—Austin 1997, no writ). Here, the Patient Plaintiffs have already suffered injury because of the confusion and uncertainty caused by threatened enforcement of the abortion bans. They would like to get pregnant again, but fear irreparable injuries—including loss of fertility or death—unless the Court clarifies the medical exception and blocks its enforcement against patients with pregnancy complications. That harm is imminent and irreparable. The Plaintiff Physicians, meanwhile, try every day to provide the best care they can to their patients while operating within an unworkable legal regime.

As the new Plaintiffs added to the Amended Petition show, the situation is dire and ongoing and continues to impact pregnant people in Texas for whom an abortion would prevent or alleviate a risk of death or risk to their health (including their fertility). For example, among the new plaintiffs are two women who, in just the last two months and at risk to their own health, were forced to carry nonviable pregnancies to term. Unless an injunction is issued by the Court in connection with Plaintiffs' request for declaratory relief, the Physician Plaintiffs and other physicians throughout Texas will have no choice but to continue barring or delaying the provision of abortion care to pregnant persons in Texas for whom an abortion would prevent or alleviate a risk of death or risk to their health (including their fertility) for fear of liability under Texas's abortion bans, and the Patient Plaintiffs and those like them will continue to suffer.

Plaintiffs have no adequate remedy at law. It is appropriate to maintaining the status quo for pregnant people in medical crises as it existed before the abortion bans took effect while this

suit is fully litigated; otherwise, the physical harm that will flow to pregnant persons with obstetrical complications will be irreparable harm that cannot be adequately measured and for which Plaintiffs will receive no remedy. It is impossible to fully quantify the potential damage that will be caused if the injunction does not issue as requested. There are no money damages that can remedy Plaintiffs' injuries with reasonable certainty. Defendants will not be harmed if the Court restrains enforcement of Texas's abortion bans as applied to the provision of necessary abortion care to a pregnant person in Texas for whom an abortion would prevent or alleviate a risk of death or risk to their health (including their fertility). The threatened injury to Plaintiffs far outweighs any possible damages to Defendants. Indeed, Defendants are not harmed in any sense by maintenance of the status quo that prevailed for pregnant people in medical crises before the abortion bans took effect—the availability of abortions to patients when necessary to prevent or alleviate a risk of death or risk to their health (including their fertility).

CONCLUSION

For the foregoing reasons, the Court should enter a temporary injunction against Defendants pursuant to Texas Civil Practice and Remedies Code Section 65.001 *et seq.*, as set forth in the accompanying proposed Temporary Injunction Order.

Plaintiffs are willing to post a bond for any temporary injunction if ordered to do so by the Court, but request that the bond be minimal because Defendants are acting in a governmental capacity, have no pecuniary interest in the suit, and no monetary damages can be shown. Tex. R. Civ. P. 684.

Dated: May 22, 2023

Respectfully submitted,

<u>/s/ Austin Kaplan</u>

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In the District Court of
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353RD JUDICIAL DISTRICT

Affidavit of Plaintiff Amanda Zurawski in Support of Application for Temporary Injunction

BEFORE ME, the undersigned authority, on this day personally appeared Amanda Zurawski, who, first being duly sworn by me, deposed and stated under oath as follows:

1. My name is Amanda Zurawski. I am 35 years old and am fully competent to make this affidavit. I have personal knowledge of the facts stated herein and they are true and correct.

2. My husband and I have known each other since preschool and got married in 2019. We have long wanted to have children, but when we started trying for a baby, I learned I was not ovulating. After a year and a half of fertility treatments—which included exploratory procedures, use of multiple medications, one misdiagnosis, and treatment with intrauterine insemination or IUI—I finally got pregnant for the first time. We were obviously thrilled.

3. My pregnancy proceeded without incident until, at 17 weeks, 6 days, I was diagnosed with an "incompetent cervix"—what I understood was a weakening of the cervical tissue that causes premature dilation of the cervix. Because my pregnancy was still so many weeks before viability, I was told that my baby would not survive.

4. My husband and I were devastated and we kept asking if there was something, anything, my doctors could do. I specifically asked if I could get a cerclage procedure to stitch

close my cervix to prevent preterm birth. My doctors told me that my membranes were already prolapsing, meaning that a cerclage procedure would be too risky and, in any event, would not be successful.

5. I was sent home, and that night, my water broke. I went back to the emergency room on Tuesday, August 23, 2022.

6. At the emergency room, I was diagnosed with preterm prelabor rupture of membranes ("PPROM"). Because all my amniotic fluid drained when my water broke, the emergency room kept me overnight in hopes that I would go into labor on my own. But I still had not gone into labor by the morning, my baby still had cardiac activity, and my vitals were still "stable," meaning I was not yet showing signs of acute infection.

7. I was told that under Texas's abortion bans, there was no other medical care the hospital could provide because the hospital was concerned that providing an abortion without signs of acute infection might not fall within the Texas abortion bans' medical exceptions for abortion. Even though I didn't have signs of acute infection yet, the specialist urged me to stay within a 15-minute drive of the hospital in case my health deteriorated quickly.

8. The specialist told me that delivery could take hours, days, or weeks. Once I heard it could take hours, I realized there was not enough time to travel to another state for an abortion. I looked it up, and the drive to the closest abortion provider, in Albuquerque, New Mexico, would be 11 hours.

9. On Wednesday morning, I was sent home with instructions to monitor myself for signs of infection. I spent Wednesday and Thursday at home, grieving my inevitable loss of my baby while also worrying about my own health.

10. On Thursday morning, Texas's Trigger Ban went into effect.

11. On Friday morning, I went to my obstetrician's office for a check-up. At the appointment, I was told my vitals were still "stable." When driving home from my doctor's office, however, I developed chills and started shivering.

12. By the time I got home, I had a temperature of 101 degrees and was not responding to my husband's questions. My husband called my obstetrician's office and, while he was waiting for a call-back, decided he couldn't wait any longer and needed to take me to the emergency room immediately.

13. By the time I was admitted to the labor and delivery unit, my temperature was 102 degrees and my medical team confirmed I was septic and put me on antibiotics. My temperature peaked at 103.2 degrees and the hospital finally agreed I was sick enough that inducing labor would clearly not violate Texas's abortion bans. I delivered my baby, Willow, who did not survive.

14. That night, Friday, my fever subsided but my blood pressure and platelet levels remained abnormally low. I was told that while my first infection had cleared, I had developed a secondary infection, chorioamnionitis, and septic shock.

15. I was then transferred to the intensive care unit ("ICU") where they treated my septic infection for three days. My family flew to Austin from across the country because they worried it would be the last time they would see me.

16. Eventually I was discharged and went home. I have continued, however, to suffer from serious health issues that have impacted my fertility as a result of my experience. The infections caused such severe scar tissue to develop in my uterus and on my fallopian tubes that it obscured x-ray imaging of my reproductive organs. I had a procedure to attempt to remove the

scar tissue, and while my physicians were able to clear the scar tissue from my uterus and one of my fallopian tubes, the other fallopian tube remains permanently closed.

17. After my husband and I tried to have children for years, I learned it would now be even more difficult, if not impossible to get pregnant again. I was informed that once a pregnant person has been diagnosed with an incompetent cervix in one pregnancy, the risk is high that they will develop the same condition in future pregnancies.

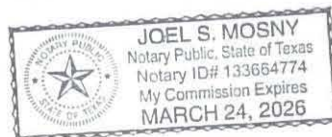
18. My reproductive specialist advised me that to get pregnant again, I should start in vitro fertilization ("IVF"), which involves its own invasive procedures and uncertain success. I have already completed three unsuccessful cycles of IVF treatments. But, after losing Willow and almost dying myself in the process, I am extremely scared to be pregnant in Texas again.

19. Further Affiant sayeth not.

Amanda Zurawski

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by the said Amanda Zurawski to certify which witness my hand and seal of the office of this the 1 day of May 2023.

NOTARY PUBLIC in and
for the STATE OF TEXAS



CAUSE NO. D-1-GN-23-000968

AMANDA ZURAWSKI, *et al.*,	
Plaintiffs,	In the District Court of Travis County, Texas
v.	
STATE OF TEXAS, *et al.*,	
Defendants.	353RD JUDICIAL DISTRICT

Affidavit of Plaintiff Anna Zargarian in Support of Application for Temporary Injunction

BEFORE ME, the undersigned authority, on this day personally appeared Anna Zargarian, who, first being duly sworn by me, deposed and stated under oath as follows:

1. My name is Anna Zargarian. I am 33 years old, live in Texas, and am fully competent to make this affidavit. I have personal knowledge of the facts stated herein and they are true and correct.

2. In September 2021, just a few weeks after Senate Bill 8 ("S.B. 8") took effect, I realized my period was two weeks late.

3. My now-husband and I were surprised to learn I was pregnant but we were excited about having a baby. I remember feeling relieved that I did not want an abortion because, I may have already been past the cutoff for abortion care under S.B. 8.

4. My pregnancy proceeded without incident until, at 19 and a half weeks, I felt a sensation like something was starting to come out of my body. I also had some cramping, but I tried to put it out of my mind. Some hours later, I felt a gush of liquid leave my body, then a second gush that left a puddle on the floor. I knew something was very wrong.

5. My husband and I went to the emergency room that night, where I was told by emergency room doctors that my water had broken prematurely and my cervix had started dilating. I was diagnosed with preterm prelabor rupture of membranes ("PPROM"), and the doctors told me that because the amniotic fluid had drained when my water broke, my baby would not survive to birth.

6. The doctors in the emergency room told me that for patients in my situation, they would usually recommend termination of the pregnancy. They explained that if I continued the pregnancy, I was at high risk of developing a septic infection or hemorrhaging. I work in the healthcare industry, as soon as I heard that I was at risk of sepsis, I panicked.

7. The doctors told me that the safest treatment was a dilation and evacuation ("D&E") abortion. But the doctors informed me that, because of S.B.8, so long as my baby had detectable cardiac activity, Texas law barred them performing an abortion unless and until my life was in imminent danger.

8. I did not want to risk my life and tried to reason with the doctors in the emergency room. I asked if, instead of a D&E abortion, they could induce labor. The doctors explained to me that an induction at this stage was also an abortion prohibited by law. I asked the medical staff for additional guidance, but they were scared to give me any information on abortion care. Instead, one of the doctors took her personal cell phone and showed me a generic abortion finder webpage.

9. The doctors informed me that I could only be admitted to the hospital for "expectant management"—where I would wait either to go into labor naturally, or for my health to deteriorate sufficiently for the hospital to be able to intervene. I was also told that I could

wait until the morning to speak to a maternal-fetal medicine ("MFM") specialist, but that the MFM would not be able to offer any different treatment.

10. My husband and I feared for my life and decided I should seek abortion care out of state. We left the emergency room and went home so we could begin researching abortion options on our own. It was important to me to make sure that the state I chose did not have a mandatory waiting period that would delay my care further. Our research indicated that the closest states where I could seek abortion care and not be subject to mandatory waiting periods were New Mexico and Colorado. My husband and I then debated what seemed less risky—an 11 hour drive to New Mexico or a 2 hour flight to Colorado? That night, I continued to leak amniotic fluid and experience cramping.

11. The next morning, I spoke to my longtime OB/GYN about the health risks associated with traveling to New Mexico or Colorado for abortion care. Based on our conversation, I was concerned that if I went into labor while driving through rural Texas to New Mexico, there would be no hospital where I could access care. We discussed that while it was possible that I might go into labor or septic shock on the plane to Colorado as well, at least the trip would be shorter, and I could get to a doctor more quickly.

12. My OB/GYN and I agreed: the best option given the circumstances was for me to leave Texas for an abortion, and that a short flight was less risky than a long drive.

13. I called several clinics in Colorado, but many told me they were still being inundated by the influx of patients from Texas. To my relief, a clinic I called in Denver was able to squeeze me in for an appointment once I explained my life-threatening health condition and why I would not be able to wait weeks for an appointment.

14. I bought a plane ticket to Denver and paid extra for a seat at the front of the plane near the bathroom. It was an incredibly uncomfortable experience and I feared for my life during the entire flight but, thankfully, I arrived safely.

15. The morning of my procedure, I had a fever of 101 degrees, but I received an abortion and recovered well.

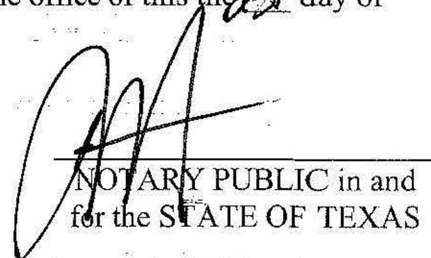
16. Since my experience, however, I have suffered from stress and anxiety, specifically related to the fear I felt during my flight to Denver. I also deeply grieve the loss of my pregnancy and I cannot help but continually relive the trauma of being forced to leave Texas in the middle of a medical emergency.

17. I would still like to have children, but I am fearful of being pregnant again in Texas. My doctors have told me that I will be at high risk for developing conditions associated with PPROM in future pregnancies.

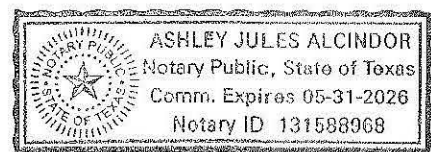
18. Further Affiant sayeth not.

Anna Zargarian

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by the said Anna Zargarian to certify which witness my hand and seal of the office of this the 25th day of April 2023.



NOTARY PUBLIC in and for the STATE OF TEXAS



CAUSE NO. D-1-GN-23-000968

AMANDA ZURAWSKI, *et al.*,	
Plaintiffs,	In the District Court of Travis County, Texas
v.	
STATE OF TEXAS, *et al.*,	353RD JUDICIAL DISTRICT
Defendants.	

Affidavit of Plaintiff Ashley Brandt in Support of Application for Temporary Injunction

BEFORE ME, the undersigned authority, on this day personally appeared Ashley Brandt, who, first being duly sworn by me, deposed and stated under oath as follows:

1. My name is Ashley Brandt. I am 31 years old, live in Texas, and am fully competent to make this affidavit. I have personal knowledge of the facts stated herein and they are true and correct.

2. My husband and I got married in 2018 and have a 3-year-old child. We love being parents and I have always wanted to have three children. When I learned in May of 2022 that I was pregnant with twins, my husband and I were thrilled.

3. During early prenatal visits, I was told I was having identical twin girls, and that each had their own placenta and amniotic sac—Twin A, which was located closer to my cervix, and Twin B. We were so excited and began to tell our friends and family.

4. At my 12-week ultrasound, however, I was told that Twin A's skull was much smaller than Twin B's, and Twin A did not appear to be developing normally. My OB/GYN explained that Twin A with the smaller skull likely had acrania, a condition where the fetus does

not develop a skull, and referred me to a maternal-fetal medicine ("MFM") specialist for further testing.

5. For over a week, I waited for my insurance to approve a visit with the MFM. I spent most of that that week crying in bed. Still reeling from the news, and frustrated by the lack of guidance from my Texas physicians, I started researching my options online and calling doctors in other states. A doctor in Colorado I spoke with explained to me what a selective fetal reduction was, and I realized that an abortion of the twin who was not developing a skull could help me save Twin B and myself.

6. When I finally had my appointment, the MFM confirmed that Twin A's skull was not properly developing and that the acrania had progressed to exencephaly, a precursor to anencephaly, which I understand is a condition where the baby does not develop a skull and has a severely underdeveloped brain. My MFM warned me that as long as Twin A continued growing, my chances of miscarriage or premature labor were high. Twin A's amniotic fluid would continue to break down brain tissue until I went into labor, at which point, I could lose both babies. I was told Twin B might survive if born prematurely, but she would require intensive neonatal care for months or longer. And if Twin A continued growing, there was also a risk of polyhydramnios, or excessive accumulation of amniotic fluid, which put Twin B at risk for fetal growth restriction.

7. I did not want one stillborn, but I definitely did not want two.

8. I also learned there were significant health risks for me as well, particularly because I had a cesarian delivery with my first pregnancy. My MFM told me that polyhydramnios can lead to preterm premature rupture of membranes ("PPROM") and/or placental abruption, meaning that I was at risk of infection, bleeding, and hemorrhage. These

risks were especially high because the twin whose skull was not developing was the twin closest to my cervix.

9. I asked my MFM about selective fetal reduction. My MFM said that in another world, it would be simple, but this was Texas. And in Texas, abortion is illegal even if it means saving the life of a healthy baby. She explained that if I wanted to go out of state for an abortion, that was my right and my MFM would send my medical records. But in Texas, all my physicians could do was monitor me at weekly appointments. At that point, I knew I was on my own.

10. I made an appointment with the doctor in Colorado, and my husband and I arranged for childcare, took time off work, and took a flight to Colorado. My abortion procedure went smoothly, and we flew home.

11. The day I returned home, however, Twin A's amniotic sac ruptured in the middle of the night and the bleeding and leaking fluid sent me to the emergency room. I was terrified that I would lose both babies and that I would somehow be in trouble for going out of state for the fetal reduction procedure. Thankfully, Twin B had a separate amniotic sac which was still intact.

12. In the emergency room, I felt a distinct uneasiness and confusion. It appeared that the medical staff thought they were not supposed to know about my abortion or discuss it with me. Everything felt secretive and icky.

13. The remainder of my pregnancy was plagued by fear and stress. My physicians recommended pelvic rest until my third trimester, as well as weekly ultrasounds that I had to pay for out of pocket. My husband and I kept extra money in savings in case we would have to leave the state again for medical care.

14. When I reviewed my medical records, I noticed an absence of documentation of my abortion. My MFM's records contained no reference to our conversations about fetal reduction and, in reference to an appointment after the abortion, stated simply "SAB of Twin A," meaning "spontaneous abortion." At every one of my regular appointments with my OB/GYN following the abortion, my OB/GYN's records listed my diagnosis as "vanishing twin syndrome." It was not until I was a few weeks from my due date that my OB/GYN added the following note to my chart: "one twin with acrania and was electively terminated."

15. At 38 weeks, I gave birth to a healthy baby.

16. I feel fortunate that I could leave Texas for an abortion and thankful for the support of my family and friends. While I had always planned to have more children, Texas's abortion bans make it hard for me to imagine getting pregnant again.

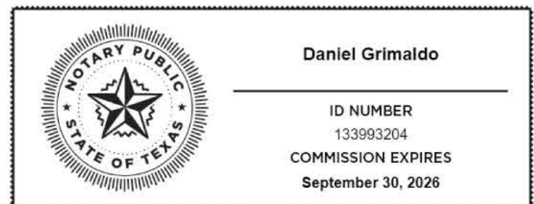
17. Further Affiant sayeth not.

Ashley Miller Brandt

Ashley Brandt

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by the said Ashley Brandt to certify which witness my hand and seal of the office of this the 6th day of May 2023.

NOTARY PUBLIC in and for the STATE OF TEXAS



Notarized online using audio-video communication

CAUSE NO. D-1-GN-23-000968

AMANDA ZURAWSKI, *et al.*,

Plaintiffs,

v.

STATE OF TEXAS, *et al.*,

Defendants.

In the District Court of
Travis County, Texas

353RD JUDICIAL DISTRICT

Affidavit of Plaintiff Austin Dennard, D.O., in Support of Application for Temporary Injunction

BEFORE ME, the undersigned authority, on this day personally Austin Dennard who, first being duly sworn by me, deposed and stated under oath as follows:

1. My name is Austin Dennard. I am 38 years old and live in Dallas, Texas.

2. I am a doctor of osteopathic medicine (D.O.) and work in general obstetrics and gynecology. I am trained to provide miscarriage care in the first trimester. I also specialize in obstetrics, robotic gynecology surgery, and pelvic floor dysfunction.

3. My husband, who is also an OB/GYN, and I have two children, and have always wanted a third. In July of 2022, I was excited to be pregnant, particularly because before this pregnancy, I had had a miscarriage.

4. At my 11-week ultrasound visit, however, my baby was diagnosed with anencephaly. I knew immediately the prognosis for both me and my baby. My doctor confirmed that the condition was not compatible with my baby's survival. As soon as I got the diagnosis, I immediately felt silenced and marginalized. Because we were in Texas, all they could offer me were additional ultrasound scans. I decided I wanted an abortion.

5. This was not the first time I had to, with my husband, make a difficult decision to end a wanted pregnancy. In my first pregnancy, my baby was diagnosed at 18 weeks with a rare genetic condition associated with heart disorders and other medical comorbidities—and my husband and I made the decision to end the pregnancy. At the time, abortion was legal in the state of Texas, and I was able to get the abortion at a clinic in my home community.

6. This time, however, I knew that due to Texas's abortion bans, I would need to travel out of state. I immediately started researching my options and calling friends and colleagues for advice. I decided to travel to the east coast for my care.

7. I felt like I was in an alternate universe, as a 6th generation Texan, fleeing my own state for basic medical care which I used to provide professionally until that year. I paid out of pocket for my abortion procedure, as well as my travel expenses. Family stayed at home with my children. Colleagues covered my shifts at the hospital. While traveling out of state was traumatic, I was relieved I had the resources to access the care I needed.

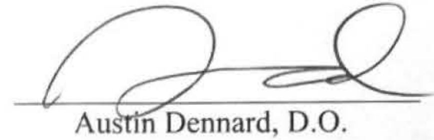
8. Months later, one of my patients faced a similar devastating diagnosis. I watched that patient go through exactly the same experience I just had—researching abortion providers out of state on her own, traveling to get care, finding childcare, and more. Just like me, she was trying to grieve while being plagued by medical trauma, fear and confusion.

9. After my abortion experience, I considered sharing my story publicly, but I was nervous to do so. My colleagues in family planning warned me of the political consequences associated with being outspoken on abortion.

10. When this lawsuit was filed, and I saw that one of my patients was one of the plaintiffs, I knew this was the moment for me to tell my story as well. I reached out to Plaintiffs' counsel.

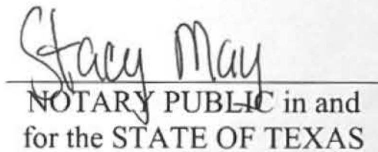
11. I am pregnant again now with my long awaited third child and I am due in the fall. I fear for my safety being a pregnant woman in Texas.

12. Further Affiant sayeth not.

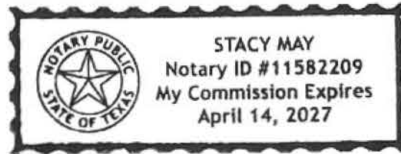


Austin Dennard, D.O.

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by the said Austin Dennard to certify which witness my hand and seal of the office of this the 17 day of May 2023.



NOTARY PUBLIC in and for the STATE OF TEXAS



CAUSE NO. D-1-GN-23-000968

AMANDA ZURAWSKI, *et al.*,	
Plaintiffs,	In the District Court of Travis County, Texas
v.	
STATE OF TEXAS, *et al.*,	353RD JUDICIAL DISTRICT
Defendants.	

Affidavit of Plaintiff Dr. Damla Karsan, M.D. in Support of Application for Temporary Injunction

BEFORE ME, the undersigned authority, on this day personally appeared Dr. Damla Karsan, M.D. who, first being duly sworn by me, deposed and stated under oath as follows:

1. My name is Dr. Damla Karsan, M.D. I am fully competent to make this affidavit. I have personal knowledge of the facts stated herein and they are true and correct.

2. I am a board-certified OB/GYN in private practice at Comprehensive Women's Healthcare in Houston, Texas. I am licensed to practice medicine in the state of Texas.

3. I have practiced obstetrics and gynecology in Houston since 2001. As part of my practice, I provide gynecological care, prenatal care, and obstetric care to my patients and to my colleagues' patients when I am on call at the hospital where I have admitting privileges.

4. I am trained to provide abortion care, and before Senate Bill 8 ("S.B. 8"), I routinely provided abortions to my patients as part of their comprehensive reproductive health care needs.

5. For over two decades, I have treated pregnant patients with a wide variety of obstetrical and other health complications that develop during pregnancy. These include, in no particular order miscarriage; ectopic pregnancy; management of fetal demise; complications of

pregnancy, including cervical insufficiency, preterm prelabor rupture of membranes ("PPROM"), bleeding, preeclampsia, hyperemesis gravidarum; maternal comorbidities such as diabetes, heart disease, hypertension, kidney disease, cancer, rheumatologic disorders, psychiatric conditions (some of which may lead to suicide); complicated twin pregnancies; lethal fetal anomalies; various genetic diagnoses, such as trisomy 13, 18, and 21; structural fetal abnormalities; and molar pregnancy.

6. I consult with specialists in the care of such patients—including but not limited to emergency medicine hospitalists, cardiologists, oncologists, anesthesiologists, and maternal fetal medicine doctors—and actively participate in the care of my patients who are treated for emergent health conditions during their pregnancies. I intend to continue providing the full scope of care to my pregnant patients in the future.

7. Over the last few years, Texas's increasingly restrictive abortion bans have gravely affected not only my medical practice, but also the practice of my colleagues and other doctors I've spoken with throughout Texas. There is a consistent theme: given the vagueness of the medical exceptions to Texas's abortion bans and the strong rhetoric surrounding their passage, we are confused and scared of liability, prosecution, and persecution. We do not want to be dragged into court or the subject of attack ads, nor do we want our practices or the hospitals we work at to suffer or lose funding, because we provide necessary abortion care to patients with life-threatening emergent medical conditions.

8. This uncertainty regarding Texas's abortion bans has delayed or barred the provision of important obstetric care—including abortion care for our patients and put our patients' lives and health (including their fertility) at risk. It has also led to many doctors choosing to remain silent for fear of retaliation by prosecutors and politicians in Texas.

9. I am lucky: I work in a private clinic and not directly for a state-funded hospital, and thereby do not have institutional constraints that restrain me from speaking out publicly. I speak on behalf of my many colleagues and acquaintances who would like to share their experiences but have been told by their employers that they are not to draw attention and are unable to risk the financial consequences that might result from speaking out.

10. I have also personally treated pregnant patients with emergent medical conditions since S.B. 8 took effect and consulted with colleagues about the care of such patients. In my experience, an emergent condition or emergency situation cannot be formulaically defined and will always depend on the patient's unique situation.

11. Since *Roe v. Wade* was overturned, I have treated patients with emergent medical conditions, including patients carrying pregnancies with lethal fetal conditions who needed treatment for complications like kidney stones, bipolar disorder, and hemorrhage. Before S.B. 8, I would have offered abortion care to these patients. Now, I instead have to give them information about where to seek abortion care out of state. I fear for my patients who have to travel long distances out of state for necessary abortion care while suffering from emergent medical conditions that present a grave risk to their health.

12. Further Affiant sayeth not.

Dr. Damla Karsan, M.D.

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by the said Dr. Damla Karsan, M.D. to certify which witness my hand and seal of the office of this the 2nd day of May 2023.

NOTARY PUBLIC in and
for the STATE OF TEXAS

CAUSE NO. D-1-GN-23-000968

AMANDA ZURAWSKI, *et al.*,

Plaintiffs,

v.

STATE OF TEXAS, *et al.*,

Defendants.

In the District Court of
Travis County, Texas

353RD JUDICIAL DISTRICT

Affidavit of Plaintiff Elizabeth Weller in Support of Application for Temporary Injunction

BEFORE ME, the undersigned authority, on this day personally appeared Elizabeth Weller who, first being duly sworn by me, deposed and stated under oath as follows:

1. My name is Elizabeth Weller. I am 27 years old and live in Kingwood, Texas.

2. My husband and I learned I was pregnant at the beginning of 2022. We had just started trying for a baby, so we were both taken aback and excited. We immediately started planning everything, from our pregnancy announcement to designing the nursery.

3. My husband and I opted not to do any genetic testing during my pregnancy since I knew I would want to continue the pregnancy even if our baby had a disability. I, myself, was born with a physical disability, brachial plexus Erb's palsy, which causes partial paralysis of my right arm.

4. I was diagnosed with gestational diabetes and began taking medication to control my blood sugar. Otherwise, my pregnancy progressed relatively smoothly. My anatomy scan revealed no issues. We learned the baby was a girl.

5. But on May 10, 2022, when I was 19 weeks pregnant, my water broke. Immediately, I knew what it meant. Shocked and terrified, we rushed to the emergency room.

Once at the hospital, I was told that while my cervix was still closed, I had lost a lot of amniotic fluid.

6. I was admitted to the hospital but felt extremely uneasy. Hospital staff told me: "At this point, we just have to hope and pray that it all comes together." They told me to pray as well. I felt like I was not getting information about the true severity of my situation and that some staff might even be lying to me.

7. I called my OB/GYN who explained that at 19 weeks, the baby was not developed enough to survive and that if I chose to remain pregnant, the baby's chances of survival were almost zero. My OB/GYN also told me that if I did not terminate the pregnancy, I could get an infection that could cause me to lose my uterus or even my life.

8. That night, my husband and I talked at length and decided we wanted to terminate the pregnancy. There was no reason to prolong our suffering and risk my health when our baby would never survive.

9. The next morning, my OB/GYN visited me in the hospital, and I confirmed that I wanted to terminate the pregnancy. My OB/GYN said that I needed to clear the procedure with the hospital administration. At this point, I was already passing blood clots and had begun taking a course of prophylactic antibiotics prescribed by the doctor.

10. But hours later, my OB/GYN returned and gave me the bad news: I wasn't sick enough to get an abortion. Specifically, because I had started antibiotics that were already fending off any infection, I had put myself in a legal grey area. I was told that I could either discontinue antibiotics and stay in the hospital to wait to develop an infection and get sicker; or I could go home and look out for signs of infection. I chose to go home.

11. For the next three days, my physical, mental, and emotional health deteriorated. I was vomiting constantly and had abdominal pain. Amniotic fluid would not stop leaking out of my body. I checked my temperature every hour and obsessively monitored the color and smell of my vaginal discharge. I was in a terrible mental state, grappling with the fact that my daughter was dying inside of me.

12. On May 13, I went to my OB/GYN's office for an ultrasound to determine if the baby still had a heartbeat. The baby did. I asked if I should leave the state to seek care, and my doctor said I could leave if I felt comfortable doing so, but that I might bleed out and risk death on the way. Dejected, I was leaving my doctor's office when I felt another gush of liquid. This time, my discharge was finally yellow and foul smelling. I collected a sample to bring to the hospital as proof.

13. That night, I was admitted again and diagnosed with chorioamnionitis. A medical board reviewed my case and finally approved my abortion. I was given the medication to induce labor. My daughter did not survive.

14. While I recovered physically, I was outraged about what happened to me. I reached out to lawyers, reporters, and even the Texas Medical Board for help. The Texas Medical Board told me that I could submit a formal complaint against my doctor. But I did not blame my doctor—to the contrary, I felt my doctor was my only advocate throughout the traumatic incident. Ultimately, the complaint went nowhere.

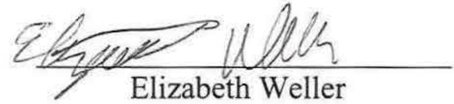
15. My experience made me feel like I was getting punished and specifically, that the state of Texas wanted me to suffer. I felt emotionally traumatized, depressed, and inadequate. It was as though because I had failed to carry a wanted pregnancy to term, I deserved to be slowly

tortured. This feeling of punishment only made the process of healing worse. It felt like a cruel and unusual reminder by Texas that I was inadequate, and therefore deserved this punishment.

16. I thought: if I don't speak out, who will? But after telling my story to a reporter at NPR, I was inundated with other media requests and decided it was all too much. At the time, I was finishing graduate school and had to focus on healing and my graduate studies. However, when I saw news reports about this lawsuit, I knew I wanted to do something more and I reached out to Plaintiffs' counsel.

17. My husband and I still want children, but we struggle to grapple with the idea and serious risks associated with being pregnant again in Texas.

18. Further Affiant sayeth not.



Elizabeth Weller

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by the said Elizabeth Weller to certify which witness my hand and seal of the office of this the 12 day of May 2023.

NOTARY PUBLIC in and
for the STATE OF TEXAS

CAUSE NO. D-1-GN-23-000968

AMANDA ZURAWSKI, *et al.*,

Plaintiffs,

v.

STATE OF TEXAS, *et al.*,

Defendants.

In the District Court of
Travis County, Texas

353RD JUDICIAL DISTRICT

Affidavit of Plaintiff Jessica Bernardo in Support of Application for Temporary Injunction

BEFORE ME, the undersigned authority, on this day personally Jessica Bernardo who, first being duly sworn by me, deposed and stated under oath as follows:

1. My name is Jessica Bernardo. I am 38 years old and live near Frisco, Texas.

2. I met my now husband in 2011 and we got married in 2018. In 2020, we started trying to get pregnant but ran into challenges, so I started seeing a reproductive specialist. I went through extensive testing and even a medical procedure to improve our chances of conceiving.

3. I finally got pregnant in July of 2022. My husband and I were ecstatic about our pregnancy, and we shared the news with our family around the world.

4. At around 14 weeks, I received the results from my non-invasive prenatal blood testing ("NIPT") genetic testing and learned that there was a high likelihood that our baby had trisomy 21, Down Syndrome. My husband and I were in disbelief, but we both agreed that we would love the baby no matter what. I began researching how to support a baby with a disability, including special schools. I also started reading about and supporting small businesses started by adults with Down Syndrome.

5. We learned the baby was a girl and decided to name her Emma, meaning "whole." We believed that she would be whole, with or without Down Syndrome. We also started telling our friends and family the exciting news.

6. Due to our baby's NIPT screening results, my OB/GYN referred me to a maternal-fetal medicine ("MFM") specialist and advised me to make an appointment as soon as possible. When making the appointment, I believe I was told about the option of having an amniocentesis. I researched amniocentesis and determined that I would not elect to have the testing performed because of the small risk of miscarriage. I knew I would keep the baby no matter what.

7. At the visit with the MFM in October 2022, we received devastating news. The scan revealed that Emma had fetal anasarca, which is the end stages of hydrops fetalis otherwise known as extreme full body edema signifying end of life; other structural abnormalities; and was already showing signs of significant heart failure. Our MFM specialist told me that the baby would not survive to birth. The MFM instructed me to monitor myself for complications like coughing, swelling, and high blood pressure, which could be signs of Mirror syndrome. I had already developed a cough since week seven of my pregnancy and my blood pressure had also increased. The MFM did not mention abortion.

8. Afterwards, I did my own research to understand what Mirror syndrome meant and how serious it was. I came to understand that Mirror syndrome is a severe condition where a pregnant person and fetus both experience severe fluid retention that can lead to the death of both the mother and the fetus, and I realized I was at a high risk for developing it. I realized just how risky it would be for me to continue my pregnancy.

9. That same day, my OB/GYN called me to follow up. I told my doctor I did not want to be left waiting for my baby's heart to stop on its own, that it was cruel and would be detrimental to my mental health, and that I was also scared of my health deteriorating. I wanted to be able to grieve, start healing, and ultimately, try to get pregnant again. My OB/GYN told me that before Texas's new laws, she would have been able to provide a "therapeutic birthing" to induce me in the hospital but could no longer do so. She contacted the ethics committee at her hospital for an exclusion but was not granted one.

10. I felt that my doctor was hesitant to tell me what my options were, other than to talk in code. I told my doctor that we had a residence in Colorado and asked my doctor if we should go there. My doctor responded that yes, I should go to Colorado. My doctor never mentioned the word abortion.

11. Unfortunately, the clinics in Colorado were all booked—the soonest appointment was two months away. I started looking for other options. I used private browser mode out of fear that I would be prosecuted for looking for abortion services out of state. I was eventually able to get an appointment for an abortion in Seattle, and we booked expensive, last-minute flights and a hotel room.

12. At the clinic in Seattle, I was told I was the third patient from Texas that week alone. One of my doctors told me that she had moved away from Texas due to its restrictive laws. At 16 weeks and six days, and on the same day the nursery furniture was supposed to be delivered, I received an abortion. I wished I could have been at home while I was going through the worst trauma of my life.

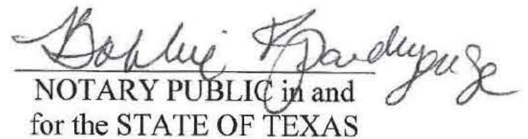
13. After this lawsuit was filed, I reached out to Plaintiffs' counsel because I wanted to tell my story and be part of changing the law. I want people to know that abortion is healthcare and that these laws are not protecting women.

14. I continue to grieve, and I am terrified to get pregnant naturally again in Texas. Because my husband and I still really want a child, I have started IVF.

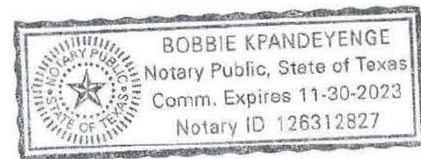
15. Further Affiant sayeth not.

Jessica Bernardo

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by the said Jessica Bernardo to certify which witness my hand and seal of the office of this the 17 day of MAY 2023.



NOTARY PUBLIC in and
for the STATE OF TEXAS



CAUSE NO. D-1-GN-23-000968

AMANDA ZURAWSKI, *et al.*,

Plaintiffs,

v.

STATE OF TEXAS, *et al.*,

Defendants.

In the District Court of
Travis County, Texas

353RD JUDICIAL DISTRICT

Affidavit of Plaintiff Judy Levison, M.D., M.P.H. in Support of Application for Temporary Injunction

BEFORE ME, the undersigned authority, on this day personally appeared Judy Levison, M.D., M.P.H. who, first being duly sworn by me, deposed and stated under oath as follows:

1. My name is Judy Levison, M.D., M.P.H. I am fully competent to make this affidavit. I have personal knowledge of the facts stated herein and they are true and correct.

2. I am a board-certified OB/GYN licensed to practice medicine in the state of Texas. I am also a professor in the Department of Obstetrics and Gynecology at Baylor College of Medicine in Houston, Texas.

3. During my career, I have worked in private practice and in educational settings in Washington, California, and Texas providing obstetrical and gynecological care, including abortion, as well as teaching medical students, residents, and fellows. For the last 23 years, I have practiced obstetrics and gynecology in Houston and taught at Baylor College of Medicine, developing internationally recognized expertise in the treatment of pregnant people with HIV.

4. Over my career, I have personally treated pregnant patients and consulted with relevant specialists regarding many different emergent conditions that arise during pregnancy, including, but not limited to: miscarriage; management of fetal demise; ectopic pregnancy;

infections during pregnancy, including as a result of preterm prelabor rupture of membranes ("PPROM"); bleeding and hemorrhage; comorbidities such as hypertension and diabetes; preeclampsia; hyperemesis gravidarum; heart conditions, including pulmonary hypertension and valve replacement; kidney disease; cancer, including cervical and breast cancer; rheumatological problems like lupus or Sjogren's Syndrome; psychological conditions, including those that may lead to suicide; and various fetal diagnoses including trisomy 13, 18, and 21, neural tube defects like anencephaly, gastric and cardiac defects, Potter Syndrome (where the baby does not properly develop kidneys), and molar pregnancy.

5. Since Senate Bill 8 ("S.B. 8") took effect, I have seen the devastating impact of Texas's abortion bans on my practice and on that of my colleagues. In my experience, widespread fear and confusion regarding the scope of Texas's abortion bans has chilled the provision of the standard of practice of obstetric care, including counseling patients about the options for genetic screening for chromosomal diagnoses or neural tube defects and the options for abortion if a lethal fetal diagnosis was found. My colleagues and I fear that prosecutors and politicians will target us personally and threaten the state funding of the hospitals if we provide abortion care to pregnant people with emergent medical conditions.

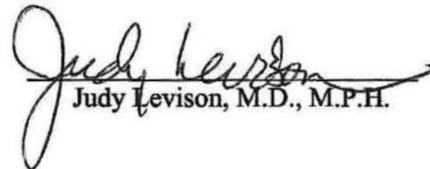
6. I have seen that physicians in Texas are even afraid to speak out publicly about this issue for fear of retaliation. I feel I am only able to speak out publicly because I am in the process of retiring.

7. I partially retired from the practice of medicine in July 2022, in part because after the Supreme Court overturned *Roe v. Wade* and abortion became nearly completely banned in Texas, I felt I could no longer practice medicine the way I was trained and consistent with my ethical obligations as a physician. Texas's abortion bans have made it impossible for me to

provide comprehensive, high quality reproductive care to my patients. Based on my conversations with colleagues, I also fear that other OB/GYNs will similarly discontinue their practices or leave Texas for fear that they will not be able to give patients the obstetric care they need in light of Texas's ambiguous abortion bans.

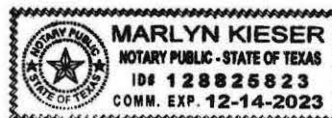
8. While I am partially retired, I can still see patients and regularly consult with colleagues regarding a wide array of pregnancy complications necessitating abortion care, including various specialists. I regularly consult with OB/GYN and Maternal Fetal Medicine ("MFM") colleagues regarding the care of pregnant patients under Texas's abortion bans. Specifically, since S.B. 8 went into effect, I have consulted with and assisted colleagues regarding patient cases that arguably fall under the emergent medical condition exception of Texas's abortion ban, including patients with PPROM, cancer, diabetes, hypertension, suicidal ideation, and who need fetal reduction procedures. I plan to continue to consult with my colleagues on these cases in the future.

9. Further Affiant sayeth not.



Judy Levison, M.D., M.P.H.

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by the said Judy Levison, M.D., M.P.H. to certify which witness my hand and seal of the office of this the 8th day of May 2023.



NOTARY PUBLIC in and for the STATE OF TEXAS

CAUSE NO. D-1-GN-23-000968

AMANDA ZURAWSKI, *et al.*,

Plaintiffs,

v.

STATE OF TEXAS, *et al.*,

Defendants.

In the District Court of
Travis County, Texas

353RD JUDICIAL DISTRICT

Affidavit of Plaintiff Kiersten Hogan in Support of Application for Temporary Injunction

BEFORE ME, the undersigned authority, on this day personally appeared Kiersten Hogan who, first being duly sworn by me, deposed and stated under oath as follows:

1. My name is Kiersten Hogan. I am 30 years old and I live in the Dallas-Fort Worth area.

2. I was living in Oklahoma in June 2021 when I found out I was pregnant. I had long-ago been diagnosed with polycystic ovary syndrome ("PCOS"), had a history of miscarriages, and had been told when I was a teenager that I could not have children. So, after I missed my period and got a positive pregnancy test, I was surprised but excited.

3. Soon after learning I was pregnant, however, I started bleeding. I went to the emergency room at a hospital near my home in Oklahoma. After an ultrasound, I was told that everything looked normal, and that I should rest and abstain from sexual activity. I was relieved.

4. I lived with my boyfriend, who was physically and emotionally abusive. When he found out I was pregnant, he became violent with me and told me we would have to leave the state for me to get an abortion. I did not want an abortion. I wanted the baby. So I decided to wait until my boyfriend was traveling for work, then packed up my things and left.

5. After staying with family briefly, I came to Waco, Texas, to stay with a friend. I immediately started looking for a job and a place to live. Things were looking up.

6. In August 2021, when I was around 13 weeks pregnant, I started bleeding again, this time passing large clots. I rushed to the emergency room and explained that I had a history of miscarriages and bleeding during this pregnancy. Once again, I was told that everything looked normal, and that I should go home, rest, and abstain from sexual activity.

7. Over the next several weeks, I tried to take it easy, though I continued to experience bleeding and cramping. I found a new job and a place to live and moved all my possessions. Shortly after, I started my new job.

8. On September 30, 2021, just weeks after S.B. 8 had taken effect, and days after I had settled into my new life, I thought my water broke. I was only around 19 weeks pregnant and panicked.

9. I was rushed to the hospital and admitted where I learned that my amniotic sac was protruding out of my cervix. The diagnosis was cervical insufficiency, and I was told that if it had been diagnosed earlier, I could have had what's called a cerclage procedure to prevent my cervix from dilating prematurely. Now it was too late. While I would likely lose the pregnancy, I was told that there was a small chance the sac would recede. In the meantime, they would keep me in the hospital for monitoring.

10. But my water broke a few hours after arriving at the hospital. I asked what my options were and was told that because of the new Texas law, as long as my baby had a heartbeat, I did not have any options. I would need to stay in the hospital on bedrest until I either went into labor or got sick enough for the hospital to give me an abortion. I was told that if I tried

to leave the hospital, it would be used as evidence that I was trying to kill my baby. I was told that if I tried to do anything to end my pregnancy, criminal charges could be brought against me.

11. On multiple occasions, religious counselors came to visit me, even though I had declined pastoral care. One nurse told me that because of the hospital's religious affiliation, they cared more about fetuses than pregnant women.

12. I was terrified and felt trapped inside the hospital walls. I was afraid to even go to the bathroom for fear that I would cause myself to go into labor and be arrested. Four days later, on the afternoon of October 4, I went into labor in the hospital bathroom and delivered my son stillborn.

13. Early the next morning, on October 5, I was discharged.

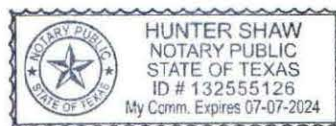
14. Texas law caused me to be detained against my will for four days and made to feel like a criminal, all during the biggest emergency of my life.

15. When I saw news reporting about this lawsuit, I reached out to Plaintiffs' counsel because I wanted to tell my story too.

16. Further Affiant sayeth not.

Kiersten Hogan

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by the said Kiersten Hogan to certify which witness my hand and seal of the office of this the 18 day of May 2023.



NOTARY PUBLIC in and
for the STATE OF TEXAS

CAUSE NO. D-1-GN-23-000968

AMANDA ZURAWSKI, *et al.*,

Plaintiffs,

v.

STATE OF TEXAS, *et al.*,

Defendants.

In the District Court of
Travis County, Texas

353RD JUDICIAL DISTRICT

Affidavit of Plaintiff Kylie Beaton in Support of Application for Temporary Injunction

BEFORE ME, the undersigned authority, on this day personally Kylie Beaton who, first being duly sworn by me, deposed and stated under oath as follows:

1. My name is Kylie Beaton. I am 33 years old and live near Fort Worth, Texas.

2. My husband and I have a four-and-a-half-year-old and we have wanted to have more children for years. But it has not been easy. I have a history of polycystic ovary syndrome ("PCOS"), a condition which interferes with ovulation. Also, my husband was hospitalized for four months in 2021 with COVID pneumonia. When he recovered, we immediately started trying to get pregnant again but faced challenges. After trying several different fertility medications, I was thrilled to learn I was pregnant.

3. At my 20-week anatomy scan in early January of 2023, however, my obstetrician told me that something did not look right with the baby's head. My obstetrician diagnosed the baby with alobar holoprosencephaly, a condition in which the brain does not develop into two hemispheres as it normally would, and the major structures of the brain remain fused in the middle. He referred me to a specialist.

4. The next week, a maternal-fetal medicine specialist ("MFM") confirmed the diagnosis and explained that my baby would likely only survive for several days or weeks past birth, if at all. In the meantime, my baby's head would continue to be abnormally large for its gestational age. The specialist told me that due to Texas's abortion laws, there was nothing he could do unless I became severely ill or my baby's heart stopped. He told me I would either have to carry to term or look for care outside of Texas. Before the law changed, my doctors would have been able to perform a D&E or an induction abortion before the baby's head got too big, but that was no longer legally possible.

5. Unsure what to do or where to go, my husband and I began researching our options. We called a couple abortion clinics and made an appointment at a clinic in New Mexico for the beginning of February. The procedure would cost $3,500. In advance of traveling to New Mexico, however, an ultrasound revealed that my baby's head was already measuring at close to 24 weeks, abnormally large, meaning its size was past the gestational cutoff for the New Mexico clinic. We were devastated.

6. We quickly learned that very few clinics in the country provide abortions past this cutoff. I called a few of those clinics but the procedure would cost between $10,000 and $15,000, which was far beyond our means. I realized that I would have no choice but to continue the pregnancy.

7. At an ultrasound appointment in early March, the baby's head was measuring at 39 weeks even though I was only 28 weeks. I was told this would be the last point at which I would be able to deliver vaginally. I begged the doctors to induce me. My doctor told me that if not for Texas's abortion bans, he would induce me for a vaginal delivery that day. But because of the law, I was told that no doctor could induce me until 37 weeks.

8. I preferred to deliver vaginally, so my specialist called other doctors to make sure there was nothing more they could do. But my specialist was told that my baby's large head size alone was not enough of a reason to justify an induction abortion under Texas law.

9. I was scheduled for a Cesarean section in early May, when I would be 37 weeks.

10. When I was 35 weeks pregnant, however, I started having horrible pain in the right side of my abdomen. It did not feel like labor contractions and I knew something was wrong. After speaking with my OB/GYN, I decided to go to the hospital to get checked out. We live an hour from the hospital, and my husband was at work, but another family member was able to drive me. I was in excruciating pain for the entire drive.

11. At the hospital, the medical staff could not determine if I was experiencing unusual labor pains due to the size of my baby's head or if the pain was originating from my gallbladder, appendix, or some other internal organ. I was told that before they could induce me, they would need to rule out my gallbladder and appendix as the source of my pain.

12. By this point, my baby's head circumference was measuring at 49cm. I understand that the average head circumference for a newborn is 35cm.

13. Tests of my gallbladder and appendix came back normal. I was only a couple centimeters dilated and, due to the size of my baby's head, the staff did not believe I would dilate further. Finally, the hospital agreed to send me for an emergency Cesarean.

14. My OB/GYN performed the Cesarean section surgery, making a larger incision than normal to accommodate the baby's head. The baby was born at the end of April.

15. My husband and I wanted to donate our baby's heart valves. We named our son Grant, hoping that he could grant other children life.

16. The first day in the hospital, Grant ate relatively well and at times, almost seemed normal. But over the next three days, his condition deteriorated. He cried constantly. He stopped eating. His core temperature gradually decreased. He could not be held upright or it would put too much pressure on his head. The medical staff was unsure if he was experiencing pain but gave him morphine. I understood he was slowly dying, day by day.

17. On day 4, my insurance required me to be discharged from the hospital. My husband and I set up hospice care to meet them at home.

18. We were discharged in the early afternoon. The medical staff told me that Grant could not sit in a car-seat because it would put too much pressure on his head. So I held Grant in my arms for the hour long car ride home.

19. My daughter wanted to have a movie night with her brother, so we all watched movies together for a few hours. After my daughter went to bed, however, Grant's breathing became more labored. A hospice nurse came to establish care. For hours, my husband and I watched as our son grew cold in our arms. Late that night, Grant passed.

20. We are still waiting for Grant's cremated ashes to be returned to us, and we plan to plant a tree outside our house along with the ashes.

21. Many challenges remain for our family. My milk came in while I was at the hospital and it took weeks to dry up, long after Grant was gone. I am still recovering from the Cesarean section surgery and struggle to resume normal physical activity. The hardest part, however, is explaining to my daughter what happened and why. She still says she misses her brother and draws him pictures. Each time, it brings my husband and I a new wave of grief.

22. I will need to wait many months before trying to get pregnant again. Doctors have recommended that I wait at least 12-18 months after my Cesarean section to get pregnant

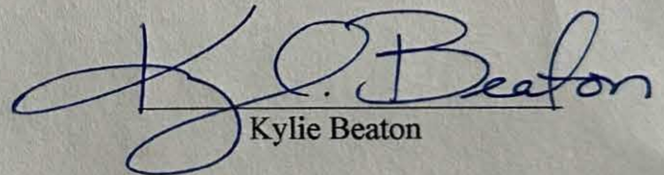
again to give the uterus time to heal. I do not want to have another Cesarean delivery, but doctors have told me it will be challenging to deliver vaginally in the future, and the risk of another Cesarean section is higher the sooner I gets pregnant again.

23. When I read about this lawsuit in the news in March of 2023, I decided I wanted to tell my story too, so I contacted a reporter and connected with Plaintiffs' counsel.

24. I believe that the government should not dictate the choices families like mine have to make. Having to go through the birth and death of Grant made losing him so much harder. I want to fight for other women, so they do not have to experience the same grief and pain.

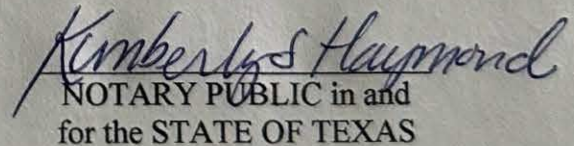
25. I fear for my health and safety and my ability to get pregnant again in the future. I also fear for my safety as a pregnant woman in Texas if I get pregnant again.

26. Further Affiant sayeth not.

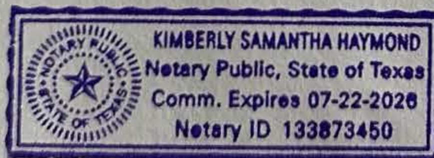


Kylie Beaton

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by the said Kylie Beaton to certify which witness my hand and seal of the office of this the 19th day of May 2023.



NOTARY PUBLIC in and
for the STATE OF TEXAS



CCAUSE NO. D-1-GN-23-000968

AMANDA ZURAWSKI, *et al.*,

Plaintiffs,

v.

STATE OF TEXAS, *et al.*,

Defendants.

In the District Court of
Travis County, Texas

353RD JUDICIAL DISTRICT

Affidavit of Plaintiff Lauren Hall in Support of Application for Temporary Injunction

BEFORE ME, the undersigned authority, on this day personally appeared Lauren Hall, who, first being duly sworn by me, deposed and stated under oath as follows:

1. My name is Lauren Hall. I am 28 years old, live in Texas, and am fully competent to make this affidavit. I have personal knowledge of the facts stated herein and they are true and correct.

2. My husband and I were thrilled when we found out I was pregnant. At my first ultrasound at around 8 weeks, everything looked great. Because my pregnancy was uncomplicated, my doctor did not schedule me for another ultrasound until my anatomy scan with a maternal-fetal medicine ("MFM") specialist, which would be at around 18 weeks.

3. In the meantime, I started planning for the baby, telling friends and family the news, buying baby clothes and furniture, and even selected a name—Amelia.

4. Two weeks after *Roe v. Wade* was overturned, I went to my appointment for my anatomy scan. I was about 18 weeks' pregnant. I am a nurse, and as the ultrasound began, I knew immediately that something was wrong.

5. I was told that my baby had anencephaly, which I understand to be a condition where the baby does not develop a skull and has a severely underdeveloped brain. I knew that with this diagnosis, the baby had no chance of survival. My MFM specialist told me that anencephaly is incompatible with life.

6. I was told that there were many physical and mental risks to me if I continued the pregnancy, including hemorrhage and preterm birth. I didn't want to end up bleeding to death on the bathroom floor. I was scared that when something inevitably went wrong, I wouldn't get proper care for this pregnancy in Texas. So I decided that I wanted an abortion.

7. My MFM specialist said she couldn't help me and was scared of giving me information about my options. *Roe* had just been overturned and everyone I encountered was terrified. My MFM urged me to go out of state and tell no one—not my family, not anyone at the airport—where I was going or what I was doing. My MFM said she couldn't provide me with a referral or even transfer my medical records to an abortion provider. No one I spoke with knew how far the politicians in Texas would go to prosecute people involved in abortion care.

8. My husband and I were grieving. We were desperate for help, and we were made to feel like everything we needed was illegal.

9. I tried to get an appointment with my OB/GYN, but he was out of town, and no one from the office was responding. I even drove to the OB/GYN's office to ask for help in person, but no one would see me. I had known my OB/GYN was opposed to abortion, but until then it hadn't felt like a big deal. Eventually someone from the office called back but only offered me information about support groups for patients who give birth to babies with anencephaly. That's when I realized I was on my own in figuring out what to do.

10. I called clinics in Colorado and New Mexico. Because *Roe* had just been overturned and abortion bans were taking effect in states throughout the South, the Colorado and New Mexico clinics told me they were inundated with patients and didn't have appointments.

11. I have struggled with depression in the past, and the stress of searching for care took a major toll on me. My mental health spiraled to the point that I considered checking myself into the hospital. But I was afraid to tell anyone what was going on because I was worried what would happen to me if people knew I wanted an abortion.

12. Because I was already 18 weeks pregnant, I worried that I was too far along to be seen by most clinics. Eventually, I got an appointment at a clinic in Seattle, Washington that specializes in cases like mine. My family and my husband's family sent us money to help pay for the extremely expensive last-minute trip. On my way into the clinic for my appointment, protesters shouted at me that I was a baby killer.

13. My family and I grieved our loss. We are still processing the trauma of what happened to me and needing to travel so far from home during such a time of chaos and confusion just to receive necessary healthcare.

14. I am now pregnant again and due in September. I am excited, but also scared because it does not feel safe for me or anyone to be pregnant in Texas.

15. Further Affiant sayeth not.

Lauren Renee Hall

State of Virginia, County of Virginia Beach

____
Lauren Hall

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by the said Lauren Hall to certify which witness my hand and seal of the office of this the 6th day of May 2023.

Reginald Renard Barnes

____
NOTARY PUBLIC in and
for the STATE OF ~~TEXAS~~ Virginia

Notarized online using audio-video communication

CAUSE NO. D-1-GN-23-000968

AMANDA ZURAWSKI, *et al.*,

Plaintiffs,

v.

STATE OF TEXAS, *et al.*,

Defendants.

In the District Court of
Travis County, Texas

353RD JUDICIAL DISTRICT

Affidavit of Plaintiff Lauren Miller in Support of Application for Temporary Injunction

BEFORE ME, the undersigned authority, on this day personally appeared Lauren Miller, who, first being duly sworn by me, deposed and stated under oath as follows:

1. My name is Lauren Miller. I am 35 years old, live in Texas, and am fully competent to make this affidavit. I have personal knowledge of the facts stated herein and they are true and correct.

2. I first learned I was pregnant from a pharmacy urine test in July 2022. I quickly realized the first day of my last menstrual period was June 24, 2022, the same day *Roe v. Wade* was overturned.

3. At the time, I already had a one-year-old son. My husband and I were excited to have another child join our family. I started keeping a pregnancy journal to document the details of my pregnancy and my emotions about my pregnancy.

4. I scheduled my first prenatal visit for approximately 8 weeks.

5. Before my first prenatal visit, I began experiencing horrible nausea and vomiting. I could not keep food or water down. After 36 hours of continuous vomiting, I went to the

emergency room for treatment for dehydration. At the emergency room, I had my first ultrasound and learned I was pregnant with twins. My husband and I were shocked, but thrilled.

6. At the emergency room, I was also diagnosed with hyperemesis gravidarum. This is a severe form of persistent nausea that can last throughout pregnancy and cause significant risks for me and my twins.

7. I began treatment for hyperemesis gravidarum but did not respond to medications and continued to struggle with nausea and vomiting as my pregnancy progressed.

8. At my 12-week ultrasound appointment, I learned that one of my twins—who my doctors referred to as Baby B because it was farther away from my cervix—was not growing as fast as the other—who my doctors referred to as Baby A because it was closer to my cervix. I learned that, because of this potential concern, obtaining a diagnosis would require additional monitoring and testing. I provided a blood sample for noninvasive prenatal blood testing (known as "NIPT"). While I was waiting for the NIPT results, I returned a week later for another ultrasound and learned that Baby B had developed two cystic hygromas, which I understand are fluid filled sacs, near the brain. My physicians still could not diagnose Baby B's medical condition and recommended additional testing—specifically chorionic villus sampling ("CVS") or amniocentesis.

9. Several days later, I received the results of my NIPT, which indicated that Baby B likely had trisomy 18. I understood that this condition came with a very high likelihood of miscarriage or stillbirth and low survival rates beyond the first few days of life.

10. I met with a genetic counselor who appeared to struggle with giving me clear information regarding what the NIPT result meant for my pregnancy under Texas's new abortion

bans. After, I received a referral to a maternal-fetal medicine ("MFM") specialist who could perform CVS testing, I scheduled the first appointment available, which was the following day.

11. The following day, I visited the MFM specialist who performed a high-resolution ultrasound and attempted CVS testing. The MFM confirmed via ultrasound that Baby B had multiple fetal structural abnormalities—cystic hygromas where much of the brain should have been developing, a single artery umbilical cord, incomplete abdominal wall, abnormal heart, abnormal nuchal translucency—and told me and my husband that Baby B would likely not survive to birth. Because the ultrasound alone was so conclusive, and because my uterus was contracting and preventing the needle from reaching Baby B's placenta, the MFM did not ultimately complete the CVS test.

12. The MFM told me and my husband that, previously, he would have been able to offer me a single fetal reduction—an abortion of Baby B—to give Baby A and myself the best chance to avert a health crisis. If it weren't for Texas's abortion bans, I would have gotten a single fetal reduction. Since passage of the abortion bans, all the MFM could do was suggest that I travel out of state.

13. In every interaction with our medical team in Texas, my husband and I felt confused and frustrated. We could not get direct answers. It was apparent to us that our doctors, nurses, and counselors were all fearful of speaking directly and openly about abortion for fear of liability under Texas's abortion bans. Many—including genetic counselors who do not even provide abortion services—apologized for not being able to say more.

14. A few days after my visit with the MFM, I was hospitalized again with complications from hyperemesis gravidarum. I was vomiting so violently that I was unable to

drive myself to the emergency room and had debilitating chills and severe dehydration requiring hospitalization.

15. My husband and I remained deeply concerned about my health and the health of Baby A. We decided to travel out of state to receive a selective fetal reduction abortion procedure. We named our son, Baby B, "Thomas" and started to say goodbye.

16. At 15 weeks at a clinic in Colorado, I underwent the selective reduction procedure. The procedure was quick, taking approximately 15 minutes, and uncomplicated. But the procedure, plus the associated travel, cost thousands of dollars and required me and my husband to be away from our son for two days.

17. After the procedure, my hyperemesis gravidarum symptoms immediately subsided. I had lost so much weight from hyperemesis gravidarum that I did not return to my pre-pregnancy weight until 29 weeks gestation.

18. After the procedure, my pregnancy with Baby A progressed without complications. I gave birth in late March to a healthy baby boy who we named Henry.

19. I am thankful I had the funds and support from family, friends, and employers to allow me and my husband to travel for the health care that I needed. I have friends in the medical field who helped connect me with doctors out of state. I know that many other pregnant people have not been so fortunate.

20. I was overjoyed to discover I was pregnant with twins, but after suffering from extreme hyperemesis gravidarum and a devastating fetal diagnosis for Thomas, I believe Texas's abortion laws made it less likely that both Henry and I would survive my pregnancy.

21. Although Henry was born without complications, I feared for my and his safety while I was pregnant, and I fear my safety should I get pregnant in the future.

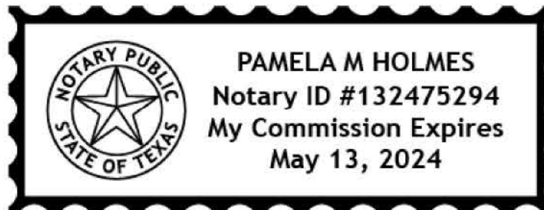
22. I am personally aware that others share my experience with Texas's abortion laws. My OB/GYN, Austin Dennard, told me that she had a similarly devastating diagnosis with a pregnancy after *Roe* was overturned and went through the same experience I did—researching abortion providers out of state on her own, traveling to get care, finding childcare, and more. Just like me, she had grieved while being plagued by trauma, fear, and confusion.

23. Further Affiant sayeth not.

State of Texas
County of Fort Bend

Lauren Miller

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by the said Lauren Miller to certify which witness my hand and seal of the office of this the 17th day of May 2023.



Pamela M. Holmes

NOTARY PUBLIC in and
for the STATE OF TEXAS

Disclosure - This notarial act was completed as an online notarization via two-way audio/video recording. Lauren Miller provided a State of Texas DL as identification and was approved with multi-factor KBA authentication.

CAUSE NO. D-1-GN-23-000968

AMANDA ZURAWSKI, *et al.*,

Plaintiffs,

v.

STATE OF TEXAS, *et al.*,

Defendants.

In the District Court of
Travis County, Texas

353RD JUDICIAL DISTRICT

Affidavit of Plaintiff Lauren Van Vleet in Support of Application for Temporary Injunction

BEFORE ME, the undersigned authority, on this day personally appeared Lauren Van Vleet who, first being duly sworn by me, deposed and stated under oath as follows:

1. My name is Lauren Van Vleet. I am 27 years old and live in Jarrell, Texas.

2. My husband and I have always wanted children, so we were excited when I got pregnant in October 2022. My initial bloodwork and ultrasounds were all normal. We learned the baby was a boy and named him Rowan.

3. I was scheduled to have my anatomy scan at 20 weeks. However, there was a terrible snow and ice storm that caused widespread power outages and several deaths throughout Texas. My anatomy scan was rescheduled for two weeks later.

4. At my anatomy scan in February 2023, I learned that my baby's skull was not developing properly. My OB/GYN said it was anencephaly.

5. I had an appointment with a high-risk specialist the next day who confirmed the diagnosis and told me that my baby would not survive. I was advised that I could either continue the pregnancy or I could go to Colorado or New Mexico for an abortion. My doctor told me that

due to Texas's laws, there was nothing we could do but wait for the baby's heart to stop beating or for me to carry the pregnancy to term.

6. I was devastated and had a sudden and suffocating feeling of guilt. I feared that I had done something wrong. Nonetheless, I knew that I wanted an abortion.

7. Due to the delay in getting my anatomy scan, I was already 23 weeks pregnant and concerned that I would have trouble finding a clinic, even one out of state, with appointments and the ability to provide me with abortion care.

8. My aunt lives in Maryland, so I looked for a provider there. My family helped me with the logistics, and I got financial support for the procedure. All the while, I was terrified about legal liability and avoided texting anyone about my plans.

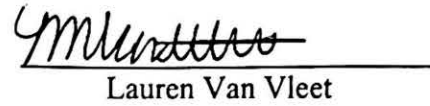
9. By the time I arrived at the clinic for my abortion, I was 24 weeks pregnant. I received the abortion and have spent the last several months trying to heal.

10. When this lawsuit was filed, I read about the case and was very interested in it, especially because one of the plaintiff's story, Lauren Hall, was so similar to my own.

11. I wrote a letter to Lauren Hall, sent it to Plaintiffs' counsel, and asked them to pass it on for me. My letter said, in part: "[I]t wasn't until I read your story on the news and then again in the lawsuit that I actually felt like I had made the right choice. I am so sorry for your loss but I am also very happy to see you fighting for our rights as mothers to make informed decisions about our own bodies and health without feeling like we are committing a terrible crime. Know that you have so many people in your corner and I will be cheering you on as loudly as I can."

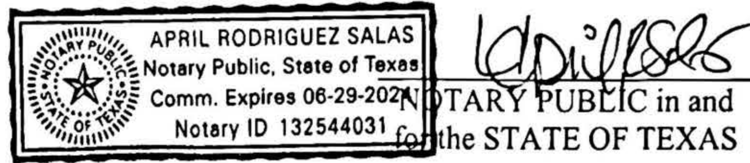
12. I decided to join this lawsuit because I still want to have children but am scared to be pregnant again in Texas.

13. Further Affiant sayeth not.



Lauren Van Vleet

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by the said Lauren Van Vleet to certify which witness my hand and seal of the office of this the 15 day of May 2023.



NOTARY PUBLIC in and for the STATE OF TEXAS

CAUSE NO. D-1-GN-23-000968

AMANDA ZURAWSKI, *et al.*,	
Plaintiffs,	In the District Court of Travis County, Texas
v.	
STATE OF TEXAS, *et al.*,	353RD JUDICIAL DISTRICT
Defendants.	

Affidavit of Plaintiff Samantha Casiano in Support of Application for Temporary Injunction

BEFORE ME, the undersigned authority, on this day personally Samantha Casiano who, first being duly sworn by me, deposed and stated under oath as follows:

1. My name is Samantha Casiano. I am 29 years old and live in East Texas.

2. I live with my partner and our four children and our goddaughter in a mobile home. I'm a busy working mom, with a large extended family.

3. My youngest child was only around 3 months old when I found out I was pregnant again. I was initially excited, but at my 20-week anatomy scan in December of 2022, everything changed. After a long pause during my ultrasound, the doctor entered the room. Without providing me with much explanation of the condition, my doctor told me that the baby had anencephaly and that the condition was incompatible with life. I was devastated.

4. I immediately asked what my options were. But my doctor's response was, "You have no options. You will have to go through with your pregnancy." My doctor gave me a prescription for an anti-depressant.

5. My doctor did not mention the option of leaving the state for abortion care. I assumed the doctor was legally prohibited from doing so. My partner and I investigated our

options and called clinics in New Mexico and Arizona, but quickly realized it would be financially impossible to make the trip. I would need somewhere to stay, a car, and a way to pay for the procedure, none of which we had. Our family only has one car that my partner uses to drive an hour and a half to work every day. I also could not miss work or find childcare for our five children.

6. I realized I would have to carry the pregnancy to term.

7. In January, my doctor wrote my employer a letter, saying that I would need to work from home until I delivered. The doctor's letter said that my baby had been diagnosed with anencephaly, which is incompatible with life, and that my pregnancy was high risk. I was relieved. It was excruciating to have people congratulating my, rubbing my belly, and asking questions about my plans for the new baby. Repeatedly having to tell people the baby would not survive made everything worse.

8. As the months wore on, I tried to focus on something positive. I wanted to donate my baby's organs because then there might be a purpose to this pregnancy. But I learned that babies with anencephaly are not eligible for donation.

9. Eventually, all I could think about was that my partner and I needed to bury our daughter and I did not know how we would be able to afford a funeral. I reached out to a Christian pro-life non-profit that paid for professional maternity photos and said they would help me raise the money. They generated almost no donations. I also started a GoFundMe to pay for the funeral, but that too did not yield much money either. I started my own fundraising campaign, including selling *menudo*, a spicy Mexican soup, by the bowl.

10. I grew weary of hearing the phrase "I'm sorry."

11. I read about this lawsuit after it was filed, and I reached out to both a reporter and Plaintiffs' counsel. I wanted people to know my story.

12. At the end of March, I went into labor several weeks early and panicked. I had not had enough time to raise the money I needed for the funeral.

13. At the hospital, I learned my baby was breech so it was positioned backwards for delivery. As I understand it, because vaginal delivery can be complicated and dangerous and risk injuring the baby, Cesarean section is recommended for a breech baby. But there was no talk of a Cesarean that day. It was not lost on me the hypocrisy of treating my daughter like a healthy baby only while she was in utero.

14. I gave birth to my daughter and named her Halo. Halo only lived for four hours. She was given morphine, though my doctors told me she was not in pain. During those hours, as I watched my daughter gasp for air, I knew for sure I wanted to tell my story publicly.

15. After Halo passed, my milk came in.

16. I received multiple calls from Texas Women, Infants, and Children ("WIC") to congratulate me on the birth of my baby and update my Medicaid. Each time, I had to tell them that Halo had passed.

17. When I was planning Halo's funeral, my partner and I got multiple quotes for thousands of dollars. We found a simple graveside service that we could afford and scheduled it for a Friday morning. When the funeral home tried to charge us an additional $1,100 because it was Good Friday, I cried. They eventually agreed to waive the extra fee.

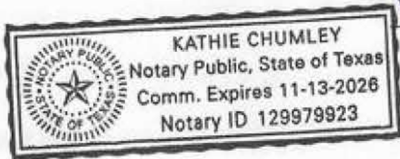
18. I connected with an NPR reporter, and after they published a story about me, people donated to the GoFundMe I'd set up. By then, the funeral was already over, but now I'll be able to buy a headstone for Halo.

19. I should have had the choice and the right over my body and Halo's body. I wanted to be able to put my daughter to rest earlier, since she was going to have to rest either way. I hope that the law will change and no one, including my children, will have to go through this again.

20. Further Affiant sayeth not.

Samantha Casiano

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by the said Samantha Casiano to certify which witness my hand and seal of the office of this the 16th day of May 2023.



NOTARY PUBLIC in and for the STATE OF TEXAS

CAUSE NO. D-1-GN-23-000968

AMANDA ZURAWSKI, *et al.*,	
Plaintiffs,	In the District Court of Travis County, Texas
v.	
STATE OF TEXAS, *et al.*,	353RD JUDICIAL DISTRICT
Defendants.	

Affidavit of Plaintiff Taylor Edwards in Support of Application for Temporary Injunction

BEFORE ME, the undersigned authority, on this day personally appeared Taylor Edwards who, first being duly sworn by me, deposed and stated under oath as follows:

1. My name is Taylor Edwards. I am 30 years old and live in Austin, Texas.

2. My husband and I have always wanted to have kids but struggled to get pregnant. I have polycystic ovary syndrome ("PCOS"), which interferes with ovulation, so we began fertility treatments and in vitro fertilization ("IVF"). After two years of treatments, I finally got pregnant in November 2022.

3. At first, everything was fine. I had some bleeding at 12 weeks, but ultrasounds showed that the pregnancy was developing normally. My husband and I learned we were having a girl and named her Phoebe. I did noninvasive prenatal genetic testing ("NIPT") that came back normal.

4. Because I had conceived with IVF, my doctor recommended that I do my anatomy scan early, at 17 weeks. That is when everything changed. In February 2023, my maternal-fetal medicine specialist ("MFM") told me that the baby was measuring unusually small and diagnosed the baby with encephalocele, which I was told is a bubble-like protrusion on

the base of the skull that causes the brain matter to herniate out of the skull. My MFM told me that no fetal surgery could correct the issue and that my baby would die at birth and may not even survive the pregnancy. The MFM gave me the name of an abortion clinic in New Mexico but could not advise me further.

5. I sought a second opinion from another MFM who confirmed the diagnosis. I also spoke to my OB/GYN, who said the baby would never be able to breathe on her own.

6. My doctors counseled me that there was a high risk my baby would not survive to birth and that continuing the pregnancy carried risks for me. I decided I needed an abortion. My doctors told me that if this had happened a year and a half ago, they could have offered me the care I needed in Texas, but not anymore.

7. The logistics were daunting. I could not use my medical insurance to pay for the abortion. We had to sort out flights, hotels, and transfer of medical records. My husband and I felt like we were completely on our own.

8. I made an appointment at the clinic in New Mexico recommended by my doctor, and my husband and I booked plane tickets. But three hours before our flight was scheduled to leave, the clinic called to say that due to a shortage of medication needed for the procedure, they had to cancel my appointment. I was shocked. I tried to get an appointment at another clinic in New Mexico, but none were available.

9. I started to panic. I worried that by the time I got an appointment, I would be too far along to get an abortion. I started vomiting every day and struggled with the physical and emotional weight of my situation. I also felt like a fraud, walking around pregnant with a baby that would never live.

10. I searched for help online and eventually found a clinic in Colorado with appointments. I traveled to Colorado to receive my abortion.

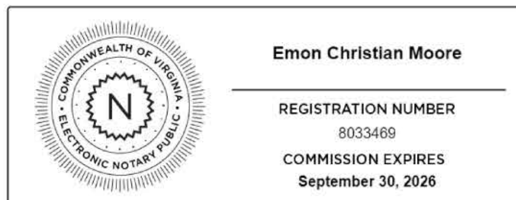
11. When I returned from Colorado, I saw news about this lawsuit. I was connected to a reporter and Plaintiffs' counsel and decided I needed to tell my story too.

12. Now, I am back at square one with IVF. My husband and I still want a child, but trying again is complex, especially in Texas, where I fear being pregnant again.

13. Further Affiant sayeth not.

Taylor Marie Edwards
Taylor Edwards

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by the said Taylor Edwards to certify which witness my hand and seal of the office of this the 13th day of May 2023.



Commonwealth of Virginia, County of Prince William
Notarized online using audio-video communication

NOTARY PUBLIC in and ECM
for the STATE OF ~~TEXAS~~ Virginia

CAUSE NO. D-1-GN-23-000968

AMANDA ZURAWSKI, et al.,	IN THE DISTRICT COURT OF
Plaintiffs,	TRAVIS COUNTY, TEXAS
v.	
STATE OF TEXAS, et al.,	353RD JUDICIAL DISTRICT
Defendants.	

AFFIDAVIT OF AARON CAUGHEY, M.D., M.P.P., M.P.H., PH.D. IN SUPPORT OF PLAINTIFFS' APPLICATION FOR TEMPORARY INJUNCTION

BEFORE ME, the undersigned authority, on this day personally appeared Aaron Caughey, M.D., M.P.P., M.P.H., Ph.D. who, first being duly sworn by me, deposed and stated under oath as follows:

1. My name is Aaron Caughey, M.D., M.P.P., M.P.H., Ph.D. and I am fully competent to make this affidavit. I have personal knowledge of the facts stated herein and they are true and correct. The opinions expressed in this affidavit are based upon my 28 years of medical practice treating and consulting with patients, and the knowledge that I have obtained through my education, training, teaching experience, clinical research, attendance at professional conferences, discussions with colleagues, and ongoing review of the relevant professional literature and research in my fields.

2. I am a board-certified obstetrician/gynecologist ("OB/Gyn") and maternal-fetal medicine ("MFM") specialist. I currently practice in Portland, Oregon, and am licensed to practice medicine in the states of Oregon and Washington, and was previously licensed in California, where I practiced from 1999 to 2010.

3. Currently, I serve as Chair of the Department of Obstetrics & Gynecology and Associate Dean for Women's Health Research and Policy at Oregon Health & Science University's School of Medicine ("OHSU"). Educational programs within the OHSU's Ob/Gyn Department overseen by me include the Ob/Gyn residency program, as well as fellowship programs in Complex Family Planning, Reproductive Endocrinology & Infertility, Female Pelvic Medicine & Reconstructive Surgery, and Maternal-Fetal Medicine. In addition to these educational programs, I supervise and coordinate clinical care and research projects focused on advancing pregnant people's and women's healthcare across several disciplines. I also supervise students, residents, fellows, and attending physicians within the Department, and oversee all outpatient and inpatient obstetrical services, including the treatment of medically complicated pregnancies, fetal reductions in pregnancies of multiple gestations, and critically ill patients referred to OHSU from throughout Oregon and Washington.

4. Prior to becoming Chair of OHSU's Ob/Gyn Department, I served as the Director of the Center for Clinical and Policy Perinatal Research, the Medical Director of the Diabetes and Pregnancy Program, and the Fellowship Program Director of Maternal-Fetal Medicine of the Ob/Gyn Department at the University of California San Francisco.

5. I received my medical degree from Harvard Medical School as well as a graduate degree in public policy from the Harvard Kennedy School of Government in 1995, and completed my residency in Ob/Gyn at the Brigham & Women's and Massachusetts General Hospitals in Boston, in 1999. Subsequently, I completed fellowships in obstetric ultrasound and maternal-fetal medicine at UCSF. Additionally, I earned graduate degrees in public health, epidemiology, biostatistics, and health economics from the University of California, Berkeley.

6. My current medical association memberships include the American College of Obstetrics and Gynecology ("ACOG"), where I sit on the Committee for Obstetric Clinical Practice Guidelines and serve as an abstract reviewer; the Society for Maternal Fetal Medicine, where I serve as a senior abstract reviewer and as a member of the Resident Scholars Committee; the Pacific Coast Obstetric and Gynecologic Society, where I serve as Scientific Editor and Program Chair; and the American Gynecological and Obstetrical Society. I am also a Board Examiner for the American Board of Obstetrics and Gynecology, and currently serve as an Editor or on the editorial board for several medical journals.

7. I conduct original clinical research that is supported by grants from federal agencies and private foundations. I have authored or co-authored medical textbooks, book chapters, and over 650 articles published in peer-reviewed journals. The topics on which I publish have been primarily focused on the following four areas: prenatal screening and diagnosis of fetal disorders and anomalies; the risks and benefits of various modes of obstetrical delivery, with a particular focus on evidence-based approaches to reducing the cesarean delivery rate; the interaction between gestational age, mode of delivery, and pregnancy outcomes; and management of diabetes and other complications during pregnancy.

8. I am frequently invited to give presentations and lectures across the United States on a wide range of topics related to maternal and fetal health, including diabetes care in pregnancy, prenatal diagnosis, elective induction of labor, cesarean rates and outcomes, and the relationship between cost-effectiveness, diagnosis, and treatment of pregnancy complications.

9. I have received several awards and honors for teaching, writing, and research over the course of my career. I was named as one of Portland's "Top Doctors" in 2010, 2011, and

2016, and received a U.S. News and World Report "Top Doctor's Award" in 2011 and the "Best Doctors in America Award" in 2012, 2013, and 2014.

10. A copy of my curriculum vitae, which provides a full description of my education, experience, professional activities and leadership positions, publications, and research activities, is attached hereto as Exhibit A.

11. I have reviewed Texas' definition for abortion, the abortion Trigger Ban, and Senate Bill 8 of 2021, as well as the pleadings relating to Plaintiffs' First Amended Verified Petition for Declaratory Judgment and Application for Temporary and Permanent Injunction.

12. I understand that Texas has created a legal definition for abortion which is: "'Abortion' means the act of using or prescribing an instrument, a drug, a medicine, or any other substance, device, or means with the intent to cause the death of an unborn child of a woman known to be pregnant. The term does not include birth control devices or oral contraceptives. An act is not an abortion if the act is done with the intent to: (A) save the life or preserve the health of an unborn child; (B) remove a dead, unborn child whose death was caused by spontaneous abortion; or (C) remove an ectopic pregnancy."[1]

13. While Texas law does not define what it means to be "alive" or "dead," I understand that legal definitions of abortion are generally interpreted to apply wherever a pregnancy has a detectible heartbeat or cardiac activity.

14. I understand that Texas' Trigger Ban and Senate Bill 8 of 2021 largely prohibit physicians from providing an abortion in Texas. I further understand that both laws have a medical exception to their respective bans for "a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places the woman in

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[1] Tex. Health & Safety Code § 245.002(1). Texas law defines "ectopic pregnancy" as "the implantation of a fertilized egg or embryo outside of the uterus." Tex. Health & Safety Code § 245.002(4-a).

danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed."[2]

15. I further understand that violation of Texas' abortion bans carries many severe penalties for physicians, including loss of medical license, up to 99 years in prison, and exorbitant monetary penalties, but these penalties do not attach if the medical exception applies.

16. I also understand that the abortion ban at issue in *Roe v. Wade* is still technically on the books in Texas. My understanding is that courts have concluded that this law has been repealed by implication and thus, it is not in effect.

A. Texas' Abortion Bans Fail to Provide Sufficient Guidance to Physicians

17. It is my medical opinion that the language of the exception to Texas' abortion bans does not provide sufficient clarity to physicians to discern whether providing an abortion would be a crime.

18. As a preliminary matter, Texas' definition of abortion does not conform to medical terms. Correct terminology would refer to stopping the growth of the fetus or embryo or interrupting the growth or function of the placenta—not the death of an "unborn child."[3] Under Texas' law, it is assumed that whether an "unborn child" is "dead" is based on the presence of cardiac activity or a fetal heartbeat, but as physicians, we don't focus only on cardiac activity to assess whether a pregnancy is viable or not (meaning that it is developing normally and can result in a live birth). Cardiac activity is only one measure of a potentially growing embryo and even with cardiac activity, there is no guarantee of a viable pregnancy.

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[2] Tex. Health & Safety Code §§ 171.002(3), 171.205, 171A.002(b).
[3] The law also defines an abortion based on whether there is a "woman known to be pregnant." But there are many patients who are pregnant and are not women.

19. Texas' definition of abortion thus creates confusion for physicians. As an illustration, there are pregnancies where there is cardiac activity, but the embryo is not actually developing in a healthy way; pregnancies where there is no observable cardiac activity, but the pregnancy may be viable; and pregnancies where there is no cardiac activity because there are no embryonic cells despite growing trophoblastic cells, which develop into a large part of the placenta, in the uterus or adnexa. In the case of pregnancies where there is no cardiac activity, there is no way of knowing with certainty whether the pregnancy is actually viable, a spontaneous abortion (an exception to Texas' abortion bans), or an ectopic pregnancy (an exception to Texas' abortion bans). A physician in Texas would need to wait to see if they can identify cardiac activity over time to assess whether the pregnancy is viable. Unfortunately, for an ectopic pregnancy, waiting leads to increased risk of intra-abdominal bleeding and mortality. It is unclear how long a physician would have to wait to see if it is a viable pregnancy to meet the letter of the law. This causes a delay in care, which can impact a pregnant person's health.

20. The exceptions to the abortion bans are likewise confusing. First, given that there is no definition of a "life-threatening physical condition", it is unclear how "life threatening" a risk must be. In medical terms, life-threatening often means that someone may die in the next brief period of time, but it can also mean a condition that may lead to a mortality in the future such as cancer or another terminal illness. Similarly in pregnancy, some conditions may be imminently life threatening; others can become life-threatening as the pregnancy progresses. In many cases, it is impossible to predict whether or when a condition will threaten the pregnant person's life. There are conditions such as previable preterm premature rupture of membranes ("PPROM"), or severe preeclampsia, where the person's health is stable, but the condition

becomes life-threatening in a short period of time.[4] It is impossible to predict whether and when the condition will deteriorate to the point where it becomes life-threatening. Thus, such conditions, themselves, should probably be considered life-threatening, but the guidance on this is unclear.

21. Second, the condition must place the pregnant person in danger of death or a serious risk. It is unclear how imminent the risk must be, the risk itself is not quantified, and the types of risks are not well explained. The types of risk, the acuity of the risk, and the degree of risk all vary from situation to situation. Pregnancy poses different types of risk, which vary from pregnancy to pregnancy and depend on baseline medical conditions. Each pregnancy needs to be considered on its own. The timing of the risk of morbidity and mortality may vary based on baseline medical conditions, and often, not intervening in a pregnancy leads to increased risk over time.

22. Third, serious risk of substantial impairment of a major bodily function is not defined. It is unclear how serious and certain the health risk must be. But given the language of the law, physicians may reasonably conclude that they must be 100% certain to not commit a crime. Different doctors may have different assessments of the certainty and probability of the risk of a condition for a given patient. Further, when one considers the degree of risk, there is the quantitative amount of risk, which in many conditions is higher with an ongoing pregnancy as compared to having an abortion, and there is the particular type of risk of different morbidities or mortality (*e.g.*, risk of infection, hemorrhage, injury to an internal organ).

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[4] *See*, *e.g.*, Sarah K. Dotters-Katz, et al., *Maternal Morbidity After Previable Prelabor Rupture of Membranes*, 129 Obstetrics & Gynecology 101, 103-04 (2017), https://pubmed.ncbi.nlm.nih.gov/27926655/ (finding that "nearly one in seven women with previable PROM who did not have contraindications to expectant management experienced maternal morbidity.").

23. The meaning of "substantial impairment of a major bodily function" is also not defined. This is not a phrase in common usage in medicine. There is no guidance regarding the difference between a substantial and insubstantial impairment, no guidance of how serious the risk should be, and no guidance regarding the difference between a major and minor bodily function. It is also unclear whether the physician, the patient, or both decide whether the risk is serious or substantial.

24. Take for example a pregnant person who has a chronic disease or condition. As physicians, it is not always possible to predict whether or when the patient will experience a serious worsening of the disease. Patients with chronic conditions or illnesses do not necessarily follow a linear path of deteriorating health—a diabetic patient may be fine one day and in a coma the next. As a result, it is unlikely that a physician will be able to accurately predict, at any given time, whether the condition has progressed to the point that it is life-threatening or poses a serious risk of substantial impairment of a major bodily function, in time to provide medically-necessary abortion care to prevent progression of disease.

25. Doctors cannot be faced with professional and financial ruin as well as jailtime if their medical judgment is second guessed. Abortion providers are operating in an environment today that is even more politically hostile than it was before *Roe v. Wade* was overturned. It is my medical opinion that, without further guidance, physicians will be disinclined to provide appropriate care with the medical exception as written because it is unclear and invites legal interpretation that may overrule prior medical interpretation.

26. I understand that abortion bans in various states use similar language. I have spoken with colleagues across the country about the problems with these medical exceptions and I have learned that the exceptions are so confusing that providers are inclined to withhold

abortion care or refer for abortion care for fear of prosecution. This is the case even in cases where an abortion is medically indicated. A recent "simulated patient" study in Oklahoma, where there is a total abortion ban, revealed health care providers' confusion.[5] The study found that the ban's life exception was so unclear that not a single hospital in Oklahoma was able to articulate clear, consistent policies for emergency obstetric care.[6] In response to questions about hospital's procedures in the case of a life-threatening medical emergency while pregnant, staff at 22 hospitals (65% of the 34 out of 37 hospitals offering obstetric care across the state of Oklahoma that were reached) were unable to provide information about procedures, policies, or support provided to doctors when the clinical decision was that it was necessary to terminate a pregnancy to save the life of a pregnant patient.[7]

27. Concerns about lack of clarity in medical exceptions to abortion bans are not isolated to a couple of doctors. Mainstream medical professional organizations have condemned the fear that doctors live in when providing care to pregnant people and the problems with medical exceptions generally.[8]

28. Without clear guidance, physicians are afraid their good faith medical judgment will be questioned later on by prosecutors, law enforcement, or the state. It is no surprise that

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[5] Physicians for Human Rights et al., *No One Could Say: Accessing Emergency Obstetrics Information as a Prospective Prenatal Patient in Post-*Roe *Oklahoma* 1 (2023), https://reproductiverights.org/wp-content/uploads/2023/04/OklahomaAbortionBanReport_Full_SinglePages-NEW-4-27-23.pdf; *see also* Michele Heisler et al., *US Abortion Bans Violate Patients' Right to Information and to Health*, 401 Lancet 1480, 14 (2023), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)00808-5/fulltext (discussing how the Oklahoma study shows that abortion bans "have impaired the ability of hospital staff to respect" patients' right to information).
[6] Physicians for Human Rights et al., *supra* note 5, at 12.
[7] *Id*. at 1.
[8] *See*, *e.g.*, Society for Maternal-Fetal Medicine et al., *Society for Maternal-Fetal Medicine Special Statement: A Critical Examination of Abortion Terminology as it Relates to Access and Quality of Care*, 228 Am. J. Obstetrics & Gynecology B2, B4 (2023), https://www.ajog.org/action/showPdf?pii=S0002-9378%2822%2902580-7 ("Legal, institutional, and insurance policies are often written in concrete terms that demand diagnostic or prognostic certainty at odds with medicine, which is appropriately accustomed to probabilities and uncertainty. Such restrictions fail to account for the range of prognoses that accompany many fetal diagnoses and maternal medical conditions, and the complexities of mental health, psychosocial circumstances, and disparities in access to care.").

physicians would err on the side of caution in deciding when to provide abortion care. The consequences are too high and may destroy a physician's life and career. In turn, a physician's ability to provide the medical care that he or she believes to be most appropriate for a particular patient based on his or her expertise and training, and as supported by evidence-based medicine and clinical guidelines, is limited.

B. Physicians Should be Able to Offer Abortions to Patients with Certain Pregnancy Complications Without Fear of Prosecution

29. Abortion is an integral part of the standard of care for many pregnant people. The consideration of when abortion is medically indicated should include patient preferences and risk tolerances for medical risks and allow physicians to engage in appropriate shared medical decision making with patients regarding the risks, benefits, and/or alternatives of health care, including abortion care.

30. In almost all cases, continuing a pregnancy presents a higher risk of morbidity and mortality for the patient than getting an abortion. The risk of maternal mortality has doubled in the United States over the past two decades to about 1 in 5,000 pregnancies; the risk is even higher for non-white populations or those who do not have ready access to health care.[9] For patients with pre-pregnancy medical conditions (*e.g.* chronic kidney disease, diabetes, chronic hypertension) or increased risks of pregnancy complications, this risk difference of dying with pregnancy continuation versus having an abortion is even greater. As such, determining the best course of treatment throughout a patient's pregnancy and during labor and delivery (if she chooses to continue the pregnancy) requires consideration of a wide range of factors and probabilities.

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[9] Ryan S. Huang, et al., *Racial Disparities in National Maternal Mortality Trends in the United States from 2000 to 2019: A Population-Based Study on 80 Million Live Births*, Archives of Gynecology and Obstetrics (2023), https://pubmed.ncbi.nlm.nih.gov/36933039/.

31. For patients with certain serious, urgent, or emergent medical conditions, the standard of care is to offer the patient an abortion as part of the care plan. These conditions include those that may necessitate emergency abortion care (*e.g.*, chorioamnionitis), conditions that may become emergencies if not treated promptly (*e.g.*, previable preterm premature rupture of membranes ("PPROM"), preeclampsia, molar pregnancy), severe medical disorders (*e.g.*, Type 1 diabetes, chronic kidney disease, chronic hypertension, cardiac disease, asthma, lupus, and sickle cell disease), and conditions that may significantly increase the patient's health risks if they remain pregnant (*e.g.*, certain cancers and non-viable pregnancies).

32. ACOG has declared that there is no comprehensive list of medical conditions that ought to qualify for a health exception under an abortion ban. As they explained: "it is dangerous to attempt to create a finite list of conditions to guide the practice of clinicians attempting to navigate their state's abortion restrictions." This is true for many reasons, including: "The practice of medicine is complex and requires individualization—it cannot be distilled down to a one-page document or list that is generalizable for every situation; No single patient's condition progresses at the same pace; A patient may experience a combination of medical conditions or symptoms that, together, become life-threatening; Pregnancy often exacerbates conditions or symptoms that are stable in nonpregnant individuals; There is no uniform set of signs or symptoms that constitute an 'emergency'; Patients may be lucid and appear to be in stable condition but demonstrate deteriorating health."[10] I agree with this opinion, and highlight that acting before the risky health condition progresses is critical in reducing maternal morbidity and mortality.

[10] *Understanding and Navigating Medical Emergency Exceptions in Abortion Bans and Restrictions*, ACOG (Aug. 15, 2022), https://www.acog.org/news/news-articles/2022/08/understanding-medical-emergency-exceptionsin-abortion-bans-restrictions.

33. Nonetheless, it is my medical opinion that there are several broad categories of patient health risks for which, under the standard of care, abortion should be offered: i) medical conditions arising during pregnancy that pose a risk of infection, hemorrhage, or other health risk that makes continuing a pregnancy unsafe for the pregnant person; ii) medical conditions that can be exacerbated by pregnancy, cannot be effectively treated during pregnancy, or that require recurrent invasive intervention; and iii) instances where there is a fetal condition that makes the fetus unlikely to survive the pregnancy or sustain life after birth.

i. Conditions arising during pregnancy that pose a risk of infection, hemorrhage, or other health risk

34. There are many health conditions that develop in pregnancy that can be worsened by continuing a pregnancy. In these situations, it is not possible to know how and when the condition will worsen such that a threshold of no return for morbidity or mortality is crossed. Some examples of conditions are previable PPROM, preeclampsia, dilation of the cervix prior to viability of the pregnancy, hyperemesis gravidarum, and placental conditions such as placenta previa or accreta with bleeding or placental abruption. These examples are all common scenarios I have taken care of multiple times over the past 28 years and having access to safe abortion care was critical in preserving life and quality of life for patients.

35. Previable PPROM is the rupture of the membranes that contain the amniotic fluid prior to viability of the pregnancy. When this occurs, the probability of a successful pregnancy is low, but the health risks to the pregnant person are high. One of the most common treatments for previable PPROM is abortion, as the chances of the pregnant person becoming infected during expectant management of the pregnancy are very high. If the infection progresses to sepsis (infection in the bloodstream), the risk of severe morbidity (loss of fingers, toes, limbs, or neurologic injury), need for hysterectomy, or mortality becomes quite high. In my experience,

patients who are managed expectantly can progress from asymptomatic and seemingly uninfected to floridly septic within a few hours. As such, it is critical to act prior to the development of these infections.

36. Abortion is a critical component of previable preeclampsia as well. Preeclampsia is a condition that some pregnant people may develop during pregnancy characterized by high blood pressure and a high level of protein in the urine. Other symptoms and problems may develop as a result of the progression of preeclampsia that include pulmonary edema, liver failure, hemolytic anemia, thrombocytopenia, acute renal disease, and heart failure. If undiagnosed or untreated, preeclampsia can lead to severe preeclampsia or eclampsia, which is characterized by seizures, and can cause both maternal and fetal mortality. Preeclampsia can develop in any person during pregnancy, even those with no known risk factors.

37. Pregnancies with preeclampsia diagnosed prior to 23 weeks' gestation, known as previable preeclampsia, have not been shown to benefit from expectant management, though it is a shared medical decision between a patient and their physician. If a pregnancy is prior to viability, because of the risk to the mother and the poor chance of achieving a viable gestational age, the most common management is abortion. And, at the very least, abortion should be offered to the patient.

38. Similarly, with dilation of the cervix prior to viability of the pregnancy, either by preterm labor or cervical insufficiency, the chance of a successful pregnancy is low, but the risks of the mother developing a uterine infection or even sepsis, are high. Medically, it is critical to act prior to the development of these infections that can lead to morbidity, future infertility, and even death.

39. Hyperemesis gravidarum is a condition where the pregnant patient is unable to maintain adequate nutrition in pregnancy, characterized by severe weight loss (often 10% or more of pre-pregnancy body weight). It is common that this is treated with abortion, which leads to rapid resolution of the symptoms. The medical management in patients who desire to continue the pregnancy includes intravenous feeding and prolonged hospitalization, both of which carry increased risk of morbidity and mortality.

40. There are several pregnancy conditions that place a patient at high risk of hemorrhage including placenta previa, placenta accreta, and placenta abruption. Placenta previa is a condition where the placenta lies low in the uterus and partially or completely covers the cervix, and the placenta may separate from the uterine wall as the cervix begins to dilate during labor. Placenta accreta occurs when the placenta attaches too deeply to the uterine wall. As such, the placenta cannot normally deliver after birth, and attempts to remove the placenta can lead to heavy bleeding and require hysterectomy. Placenta abruption is the separation of the placenta from the uterine lining, which necessitates premature delivery of the fetus and can lead to heavy bleeding in the pregnant person. These conditions impact the health of both the pregnant person and the fetus. If these occur in a previable pregnancy, the appropriate management is often abortion to avoid ongoing risk of hemorrhage. If one waits until bleeding is severe, it may be too late to save a patient's life.

ii. Conditions exacerbated by pregnancy or where pregnancy limits their ability to be effectively treated for the condition

41. There are many medical conditions that impact, and are impacted by, pregnancy. As explained above, creating an exhaustive list of conditions is impossible, but some examples of such medical conditions include cancer, chronic renal disease, psychiatric conditions, Type 1 and 2 diabetes, heart disease, and autoimmune disorders. Some of these conditions are chronic

and tend to increase in severity over time, even when patients and their physicians carefully monitor and control the disease. Because such conditions may worsen during pregnancy, it is important that pregnant people have the option to terminate the pregnancy before progressing to a more severe health state, as the disease progression may become irreversible.

42. Cancer diagnosed and managed in pregnancy is commonly treated with chemotherapy, radiation therapy or major surgery. These treatments carry a range of risks to the developing fetus and can be challenging in the pregnant individual. Thus, it is common that patients choose to have an abortion before embarking on cancer treatment. For instance, the medication for breast cancer, which is one of the most common cancers in people who are pregnant, is embryotoxic, can lead to damage to the embryo in the first trimester, and impacts fetal development during the pregnancy. It is often unknown whether the most effective drugs to treat cancer are safe for the fetus, so physicians do not offer them to pregnant people, reducing the ability to optimally treat the cancer in pregnancy.

43. A range of psychiatric conditions such as bipolar disorder, schizophrenia, major depressive disorder, anxiety disorders, and psychotic disorders cannot be optimally treated during pregnancy because the medication of choice may impact the developing fetus. For example, one of the most effective medications to treat bipolar disorder is lithium, but this medication is associated with the development of congenital heart disease in the developing fetus, thus the medication is stopped during pregnancy. This commonly leads to resumption of symptoms of bipolar and precipitating life-threatening manic or depressive episodes. These conditions are among the leading causes of maternal mortality; thus, optimal treatment is essential to reducing morbidity and mortality.

44. Chronic renal (kidney) disease tends to worsen during pregnancy. This disease is characterized by damage to the kidneys that impairs filtering blood appropriately. A substantial proportion of pregnant people with this disease will cross the threshold requiring dialysis.[11] Dialysis is usually for 3-6 hours per day 4-6 days per week and its need commonly persists beyond pregnancy. In my experience, there are no warning signs of this progression, it occurs during pregnancy and is not preventable except by abortion of the pregnancy. Once such an individual goes on dialysis, their annual risk of mortality is approximately between 2% and 10%.[12]

45. Type 1 diabetes is quite challenging to manage during pregnancy. Type 1 diabetes occurs when the pancreas makes no or little insulin such that the body is unable to properly metabolize blood sugar for energy. Type 1 diabetes is treated with injectable insulin, usually given several times per day or continuously via an insulin pump. The placental hormones, which change throughout pregnancy, impair sugar metabolism, so insulin requirements increase throughout pregnancy. At the end of the second trimester and beginning of the third trimester, the need for insulin can increase so rapidly that is particularly hard to keep up with the demand. This rapidly changing physiology increases the probability for patients to go into diabetic ketoacidosis ("DKA"). This life-threatening condition is more challenging to manage in pregnancy and increases risks to the patient and the developing fetus. Again, the transition to

[11] David C. Jones & John P. Hayslett, *Outcome of Pregnancy in Women with Moderate or Severe Renal Insufficiency*, 335 N. Engl. J. Med. 226 (1996), https://www.nejm.org/doi/full/10.1056/NEJM199607253350402.
[12] Benedikt Kolbrink et al., *Patient-Focused Outcomes After Initiation of Dialysis for ESRD: Mortality, Hospitalization, and Functional Impairment*, Nephrology Dialysis Transplantation (2023), https://doi.org/10.1093/ndt/gfad099; Maurizio Bossola et al., *Trend and Determinants of Mortality in Incident Hemodialysis Patients of the Lazio Region*, 24 BMC Nephrology 111 (2023), https://pubmed.ncbi.nlm.nih.gov/37101132/.

DKA is not predictable or foreseeable and prevention would be solely by providing abortion in the second trimester or earlier.[13]

46. Pregnant people with heart valve abnormalities, pulmonary hypertension, Eisenmenger's syndrome, or other forms of maternal heart disease face an increased risk of complications during pregnancy.[14] Pregnancy puts an added strain on the heart muscle due to the dramatic increase in blood volume over the course of pregnancy; thus, most pregnant people with preexisting heart conditions will experience an exacerbation of symptoms during pregnancy. Labor and delivery, which involve abrupt changes in blood flow and pressure, puts even more strain on the heart. As such, maternal heart disease carries a very high risk of maternal mortality that even with the best medical care is only preventable by abortion of the pregnancy. Pregnant people with congenital heart defects are more likely to give birth to a child with a heart defect and are at higher risk for preterm birth. Furthermore, the optimal medical treatment for patients with heart conditions often involves the use of drugs that pose a risk to the fetus, such as angiotensin-converting enzyme ("ACE") inhibitors (Class C during the first trimester, and Class D in the second and third trimesters), which are medications used to treat and manage hypertension.[15]

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[13] Keenan E. Yanit, et al., *The Impact of Chronic Hypertension and Diabetes on Pregnancy Outcomes*, 207 Am. J. Obstetrics & Gynecology 333.e1 (2012), https://pubmed.ncbi.nlm.nih.gov/22892187/.

[14] Rafael Alonso-Gonzalez & Lorna Swan, *Treating Cardiac Disease in Pregnancy*, 10 Women's Health 79, 80 (2014), https://pubmed.ncbi.nlm.nih.gov/24328600/; Kathleen Stergiopoulos et al., *Pregnancy in Patients with Pre-Existing Cardiomyopathies*, 58 J. Am. Coll. Cardiology 337, 337 (2011), https://pubmed.ncbi.nlm.nih.gov/21757110/.

[15] Kasper Meidahl Petersen et al., *Beta-Blocker Treatment During Pregnancy and Adverse Pregnancy Outcomes: A Nationwide Population-Based Cohort Study*, 2:e001185 BMJ Open 1, 1-2 (2012), https://pubmed.ncbi.nlm.nih.gov/22815467/.

47. Of maternal cardiac diseases, maternal pulmonary hypertension or Eisenmenger's syndrome carry the highest rate of mortality.[16] Much of the morbidity and mortality occur during the intrapartum period, the period spanning childbirth, from the onset of labor through delivery of the placenta, and the postpartum period, the first six weeks after birth, so is not preventable or foreseeable until it occurs.

48. Hypertension, also known as high blood pressure, is a fairly common condition that can complicate pregnancies.[17] Pregnant people with chronic hypertension can experience an exacerbation of the condition during pregnancy, although hypertension with superimposed preeclampsia (*i.e.*, pregnant people with chronic hypertension who develop protein in the urine) does not usually develop until the third trimester. The risks of severe hypertension in pregnancy include stroke, cerebral hemorrhage, hypertensive encephalopathy (a condition where dangerously high blood pressure causes brain swelling), congestive heart failure, renal failure, and death.[18] For the fetus, the risks include premature birth, placental abruptions, restricted fetal growth, low birth weight, and death. Mild hypertension in pregnancy is associated with an elevated risk of adverse maternal, fetal, and neonatal outcomes.[19]

49. Two types of drugs most commonly prescribed to control hypertension, angiotensin receptor blockers (ARBs) and ACE inhibitors, have been linked to adverse fetal and

[16] Nivedita Jha et al., *Management and Outcomes of Pulmonary Artery Hypertension and Eisenmenger Syndrome During Pregnancy: A Prospective Observational Cohort Study*, British Journal of Obstetrics and Gynecology 1, 1-2 (2023), https://obgyn.onlinelibrary.wiley.com/doi/abs/10.1111/1471-0528.17474; Qian Zhang et al., *Maternal Outcomes Among Pregnant Women with Congenital Heart Disease-Associated Pulmonary Hypertension*, 147 Circulation 549 (2023), https://pubmed.ncbi.nlm.nih.gov/36780387.
[17] William M. Gilbert et al., *Pregnancy Outcomes in Women with Chronic Hypertension: A Population-Based Study*, 52 J. Reprod. Med., 1046, 1046 (2007), https://pubmed.ncbi.nlm.nih.gov/18161404/.
[18] Adel M. Bassily-Marcus et al. *Pulmonary Hypertension in Pregnancy: Critical Care Management*, 2012 Pulmonary Med. 1, 1-2 (2012), https://pubmed.ncbi.nlm.nih.gov/22848817/.
[19] Robert L. Ferrer, et al., *Management of Mild Chronic Hypertension During Pregnancy: A Review*, 96 Obstetrics & Gynecology 849, 849 (2000), https://pubmed.ncbi.nlm.nih.gov/11094241/.

neonatal outcomes, especially when used in the latter part of pregnancy.[20] Both ARBs and ACE inhibitors are designated as Class C in the first trimester and Class D in the second and third trimesters, and have been associated with congenital defects and death. Thus, pregnant women are faced with the decision to utilize less appropriate medications or risk injury to their fetus. For this reason, abortion care should be offered to such patients.

50. Sickle cell disease worsens in pregnancy, particularly the risk of sickle cell crisis, which are episodes of intense pain and carry a risk of mortality. Sickle cell disease is a group of inherited red blood cell disorders. For patients with these disorders, the hemoglobin, a protein that carries oxygen, is abnormal, which causes the red blood cells that carry oxygen to all parts of the body to become hard and sticky. The sickle cells die early, which causes a constant shortage of red blood cells. Also, when they travel through small blood vessels, they get stuck and clog the blood flow. This can cause pain and other serious complications such as infection, acute chest syndrome, and stroke. The risk of sickle cell crisis is increased during pregnancy, and these crises are not preventable or foreseeable, and only by a safely provided abortion, may the risk be decreased.

51. Patients who suffer from autoimmune disorders, including lupus, Grave's disease, and rheumatoid arthritis, which are more common among women, may cause complications for them during pregnancy such as kidney damage, hypertension, or preeclampsia, as well as complications for the fetus, including restricted fetal growth, preterm birth, and low birth

[20] Jennifer Fu, *Increased Risk of Major Congenital Malformations in Early Pregnancy Use of Angiotensin-Converting-Enzyme Inhibitors and Angiotensin-Receptor-Blockers: A Meta-Analysis*, 37 Diabetes Metabolism Research and Reviews 1-3 (2021), https://onlinelibrary.wiley.com/doi/10.1002/dmrr.3453.

weight.[21] Although the research is somewhat limited in this area, many of the drugs used to treat these autoimmune disorders are contraindicated in pregnancy:

- methotrexate is a known abortifacient with teratogenic effects and is classified by the FDA as Class X;
- leflunomide is likewise categorized as Class X;
- mycophenolate and azathioprine are categorized as Class D medications;
- non-steroidal anti-inflammatory drugs (NSAIDs), that are commonly prescribed to treat a variety of conditions including autoimmune disorders, are categorized as Class C during the first and second trimester and Class D during the third trimester, because they can lead to complications such as fetal pulmonary hypertension, decreased renal function, and oligohydramnios (low amniotic fluid);[22]
- Corticosteroids are designated Class B medications, but may increase the risk of hypertension, gestational diabetes, early miscarriage, and premature rupture of membranes for pregnant people, and the risk of cleft palate and fetal growth restriction for the fetus.

As with cancer, chronic renal condition, psychiatric conditions, Type 1 diabetes, heart disease, and autoimmune disorders, and other medical conditions arising during pregnancy, patients and physicians must carefully weigh the risks and benefits of altering or stopping drug treatment to reduce the risk of adverse fetal outcomes.

52. Patients who have a prior history of developing complications during pregnancy but who have not yet reached the stage of pregnancy where the condition manifests itself to impose a serious health risk, should also have the option of terminating the pregnancy to protect their health. A physician's fundamental duties are to provide patients with the standard of care and to not expose patients to unnecessary risks to their health. Neither physicians nor their

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[21] *See*, *e.g.*, Shagufta Yasmeen et al., *Pregnancy Outcomes in Women with Systemic Lupus Erythematosus*, 10 J. Maternal Fetal Med. 91, 91 (2001), https://pubmed.ncbi.nlm.nih.gov/11392599/.
[22] *See*, *e.g.*, Monika Ostensen, et al., *Anti-inflammatory and Immunosuppressive Drugs and Reproduction*, 8 Arthritis Rsch. Therapy 209 (2006), https://pubmed.ncbi.nlm.nih.gov/16712713/.

patients should be forced to delay treatment to wait until a patient's medical condition escalates out of control.

iii. Fetal conditions where the pregnancy is unlikely to result in a child with sustained life

53. As explained above, continuing a pregnancy leads to greater risk of morbidity and mortality than abortion. Thus, in cases where the fetus either will not survive delivery or likely will not survive more than a few hours or days after birth, the patient, with the support of their physician, should decide how best to manage the pregnancy.

54. There are fetal or pregnancy conditions where the pregnancy is unlikely to result in a child with sustained life, including partial molar and molar pregnancies, which are pregnancies where there is an imbalance in the number of chromosomes supplied from both of the parents such that a healthy fetus does not develop; anencephaly, a neurological disorder that involves a defect in the closure of the neural tube during fetal development, resulting in the absence of a major portion of the brain, skull, and scalp; certain trisomies (the presence of an extra chromosome) like trisomy 13, characterized by having three copies of chromosome 13 in cells of the body, instead of the usual two copies, causing severe intellectual and physical disabilities, and trisomy 18, characterized by having three copies of chromosome 18 instead of the usual two copies, causing severe intellectual disabilities, congenital heart defects, and various issues with other organs; triploidy (the presence of an extra set of chromosomes), which causes a variety of birth defects; and other congenital issues including severe cardiac defects and Potter Sequence (insufficient amniotic fluid in the uterus), which may cause underdevelopment of the lungs, eye malformations, and heart defects.

55. Forcing a person to carry a pregnancy to term where the fetus is unlikely to survive or likely to survive more than a few hours or days after birth, increases the health risks of

the pregnant person and in some cases, can be especially dangerous. For example, molar pregnancies and certain cases of trisomy increase the risk of preeclampsia and hemorrhage, as well as the risk of cancer.[23]

56. In the case of a multiple gestation, where more than one fetus develops in the uterus, offering fetal reduction (abortion of that fetus) is common for pregnancies where one fetus has a severe congenital condition. In these circumstances, the chances of survival for the other fetus(es) improve if the fetus(es) with fetal diagnoses are aborted.

57. In addition to the medical risk of carrying a pregnancy that has little chance of meaningful survival, forcing pregnant people to carry to term against their will can have devastating psychological impact on the patient, including depression, anxiety, and post-traumatic stress disorder.

C. To protect Texans, physicians must be able to use their good faith judgment to determine whether an abortion is medically-indicated

58. Without further clarity, the exception to Texas' abortion bans restricts a physician's ability to provide abortion care based on their good faith judgment that the pregnancy places the person at risk of death or poses a serious risk of substantial impairment of a major bodily function.

59. Interference with physicians' good faith judgment is at odds with policies of leading medical groups. A physician's role is to "present relevant information accurately and sensitively" and "[p]atients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care."[24]

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[23] *See*, *e.g.*, Valena Soto-Wright, et al., *The Changing Clinical Presentation of Complete Molar Pregnancy*, 86 Obstetrics & Gynecology 775, 776 (1995).

[24] Am. Med. Ass'n ("AMA"), Code of Medical Ethics, 2.1.1 Informed Consent, https://code-medical-ethics.ama-assn.org/sites/default/files/2022-08/2.1.1.pdf.

Specifically, for abortion care, the American Medical Association ("AMA") Code of Medical Ethics provides that "a physician [is not prohibited] from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law."[25] Further, the decision to have an abortion should be made privately within the relationship of trust between patient and physician in keeping with "physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare."[26]

60. Physicians have an ethical duty to act in the best interests of their patients, and to minimize any threats to their health and well-being. Forcing patients to continue pregnancies against their will that pose risks to their health, with no corresponding medical benefit, is fundamentally at odds with the ethical duties and obligations of physicians. Indeed, the AMA "strongly condemn[s] any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient."[27] In any other context, forcing patients to continue a medical condition that does not confer any medical benefits but poses increased risks would be rejected as inappropriate and antithetical to the practice of medicine.

61. Decision-making during pregnancy is particularly nuanced because it involves the delicate balance between maternal and fetal risk and benefit, and each individual patient's threshold for risk to herself and to the fetus must inform the final decision. When patients play an active role in the medical decision-making process, they report lower levels of anxiety about

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[25] AMA, Code of Medical Ethics, 4.2.7 Abortion, https://code-medical-ethics.ama-assn.org/sites/default/files/2022-08/4.2.7.pdf.
[26] AMA, Code of Medical Ethics, Opinion 1.1.1 Patient-Physician Relationships, https://code-medical-ethics.ama-assn.org/sites/default/files/2022-08/1.1.1.pdf.
[27] AMA, *Freedom of Communication Between Physicians and Patients H-5.989*, (2013), https://policysearch.ama-assn.org/policyfinder/detail/Freedom%20of%20Communication%20?uri=%2FAMADoc%2FHOD.xml-0-4540.xml.

their condition, a greater sense of control, less discomfort and, most importantly, greater improvement in their medical condition. Patients and physicians must carefully weigh the risks and benefits of a particular treatment and choose the most appropriate option for each individual patient, as supported by evidence-based medicine and clinical guidelines.[28]

62. For most of the conditions discussed above, expectant management of the pregnancy increases patient's risk of infertility, infection, hemorrhage, and/or death. Waiting for a patient's health to deteriorate may have a devastating psychological impact on the patient.

63. Several studies have documented the devastating impact of abortion bans on maternal health care. A study at two large hospitals in Dallas County after Texas' Senate Bill 8 took effect found a significant increase in maternal morbidity among patients with preterm labor.[29] The study followed 28 patients (26 with PPROM, 2 with pregnancy tissue prolapsed into the vagina). Patients were not offered abortion care until physicians were able to determine that a condition posed "an immediate threat to maternal life," resulting in a lapse of nine days on average between first diagnosis and the development of "complications that qualified as an immediate threat to maternal life."[30] Among these patients, 43% (12 of 28) experienced infection or hemorrhage and one patient required a hysterectomy—other maternal morbidities included intensive care unit admissions, blood transfusions, postpartum emergency room visits, and postpartum readmission.[31]

64. Another study, based on fifty submissions from health care providers in states with abortion bans, found that the bans altered the standard of care for obstetric complications in the

[28] Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 Am. J. L. and Med. 429, 469-470 (2006), https://pubmed.ncbi.nlm.nih.gov/17240730/.
[29] Anjali Nambiar, et al., *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less with Complications in Two Texas Hospitals After Legislation on Abortion*, 227 Am. J. Obstetrics & Gynecology 648 (2022), https://doi.org/10.1016/j.ajog.2022.06.060.
[30] *Id.*
[31] *Id.*

second trimester, ectopic pregnancies, underlying medical conditions that made continuing a pregnancy dangerous, fetal diagnoses, and early miscarriages.[32] Patients had a range of different backgrounds, but a notable proportion involved Black or Latine patients. Deviations of the standard of care contributed to delays, worsened health outcomes, and increased the cost and logistic complexity of care. Delays in care created preventable complications, such as severe infection or having the placenta grow deep into the uterine wall and surrounding structures. One physician narrated how a patient who was denied an abortion even though their membranes ruptured at 16-18 weeks' gestation, was sent home, and developed a severe infection requiring management in the intensive care unit. The patient subsequently delivered her fetus but required a surgical procedure to remove her placenta.

65. Providing abortion care in all the circumstances outlined above conforms with the standard of care and could truncate the increased risks of morbidity and mortality. Because abortion care is time-sensitive, failing to give physicians security that they will not be prosecuted or lose their license if they provide this care, places physicians in the untenable situation of having to wait for the patient to get sicker to perform an abortion.

66. Further Affiant sayeth not.

[32] Daniel Grossman et al., *Care Post-*Roe*: Documenting Cases of Poor-Quality Care Since the* Dobbs *Decision* 4 (2023), https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf.

Aaron Caughey, M.D., M.P.P., M.P.H., Ph.D.

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by the said Aaron Caughey, M.D., M.P.P., M.P.H., P.H.D. to certify which witness my hand and seal of the office of this the 18th day of May 2023.

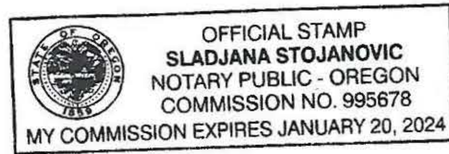

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EXHIBIT A

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2001	University of California, Berkeley School of Public Health	MPH	Epidemiology
2006	University of California, Berkeley Health Services and Policy Analysis Program	PhD	Health Economics

POSTDOCTORAL TRAINING

1995-1998	Resident in Obstetrics & Gynecology	Brigham & Women's Hospital Massachusetts General Hospital
1998-1999	Chief Resident in Obstetrics & Gynecology	Brigham & Women's Hospital Massachusetts General Hospital
1999	ORACLE Program in Clinical Research	UCSF – Dept of Epi & Biostats
1999-2002	Fellow in Maternal-Fetal Medicine	UCSF – Dept of OB/Gyn
1999-2000	Fellow in Obstetric Ultrasound	UCSF – Dept of Radiology
2001-2002	AHRQ Fellow in Health Policy	UC Berkeley, School of Public Health
2002	Summer Institute in Behavioral Economics	Russell Sage Foundation, Berkeley, CA
2008	Mentorship Development Program	UCSF – Clinical and Translational Sciences Institute
2013	Leadership Development for Chiefs of Clinical Services	Harvard School of Public Health
2013	Lean training – OHSU Performance Excellence (OPEx)	OHSU

ACADEMIC APPOINTMENTS

1995-1999 Clinical Fellow in Obstetrics, Gynecology & Reproductive Biology, Harvard Medical School
1999-2002 Postdoctoral Fellow in Obstetrics & Gynecology, UCSF
2002-2003 Clinical Instructor, Obstetrics, Gynecology & Reproductive Sciences, UCSF
2003-2007 Assistant Professor in Residence, Department of Obstetrics, Gynecology & Reproductive Sciences, UCSF
2007-2010 Associate Professor in Residence, Department of Obstetrics, Gynecology & Reproductive Sciences, UCSF
2010-present Professor with tenure, Department of Obstetrics & Gynecology, OHSU
2011-present Professor, Department of Public Health and Preventative Medicine, OHSU
2011-present Professor, Division of Midwifery, School of Nursing, OHSU
2011-present Professor, Division of Management, OHSU
2011-present Professor, Department of Pediatrics, OHSU

SCHOOL / DEPARTMENTAL / DIVISION TITLES

2002-2010 Director, Perinatal Data Collection, UCSF
2002-2007 Women's Reproductive Health Research Scholar, UCSF
2003-2010 Medical Director, Diabetes and Pregnancy Program, UCSF
2007-2010 Director, Clinical Perinatal Research, UCSF
2007-2008 Associate Program Director, Maternal-Fetal Medicine Fellowship, UCSF
2008-2010 Program Director, Maternal-Fetal Medicine Fellowship, UCSF
2009-2010 Director, Center for Clinical and Policy Perinatal Research (C^2P^2R), UCSF
2010-present Chair, Department of Obstetrics & Gynecology, OHSU
2010-2013 Director, Center for Women's Health, OHSU
2010-2013 Associate Program Director, Maternal-Fetal Medicine Fellowship, OHSU
2012-2013 Director, Quality for Obstetrics & Gynecology
2013-2014 Interim Division Director, Reproductive Endocrinology & Infertility, OHSU
2013-present Associate Dean for Women's Health Research and Policy, OHSU
2015-2022 Interim Division Director, Reproductive Endocrinology & Infertility, OHSU
2022-2023 Interim Division Director, Reproductive Psychiatry & Behavioral Health, OHSU

HOSPITAL APPOINTMENTS

1999-2002 Dept. of Obstetrics & Gynecology, Kaiser Permanente, Hayward
1999-2010 Dept. of Obstetrics & Gynecology, St. Luke's Hospital
1999-2010 Dept. of Obstetrics & Gynecology, San Francisco General Hospital
1999-2010 Dept. of Obstetrics & Gynecology, UCSF – Moffitt-Long Hospital
2000-2002 Dept. of Obstetrics & Gynecology, Marin General Hospital
2001-2004 Dept. of Obstetrics & Gynecology, Santa Clara Valley Medical Center
2005-2010 Dept. of Obstetrics & Gynecology, California Pacific Medical Center
2010-present Obstetrician-in-Chief, Dept. of Obstetrics & Gynecology, OHSU
2014-2022 Salem Hospital, Dept. of Obstetrics & Gynecology
2020-present Hillsboro Medical Center, Dept. of Obstetrics & Gynecology

LICENSES and CERTIFICATION

1999-present DEA License # BC6411235 Federal DEA

1999-2011	Medical License # A68905 State of California
2004-present	Diplomate, American Board of Obstetrics & Gynecology
2007-present	Diplomate, American Board of Obstetrics & Gynecology, Maternal-Fetal Medicine
2010-present	Medical License MD152183 State of Oregon
2013-present	Medical License MD60321425 State of Washington

AWARDS and HONORS

1989	Magna Cum Laude, University of Washington
1991-1993	Joseph Collins Scholarship, Harvard Medical School
1993-1995	Agassiz Fellowship in Health Policy, Kennedy School of Government
1996	Outstanding Teacher of Obstetrics & Gynecology, Harvard Medical School
1997	Resident Reporter, American Professors of Gynecology & Obstetrics
1997	Outstanding Teacher of Obstetrics & Gynecology, Harvard Medical School
1998	Winner Resident Writing Contest, Parke-Davis/ACOG
1998	Outstanding Teacher of Obstetrics & Gynecology, Harvard Medical School
1999	Junior Fellow in Health Policy, Wyeth-Ayerst / ACOG
2000	Excellence in Clinical Education Award, Harvard Medical School
2000-2001	Public Health Trainee Scholarship, UC Berkeley, School of Public Health
2001-2002	AHRQ Postdoctoral Training Fellowship, UC Berkeley, School of Public Health
2002-2007	Women's Reproductive Health Research Scholar, Department of OB/Gyn, UCSF
2003-2009	NIH Loan Repayment Program for Clinical Researchers
2003	Lee B. Lusted Research Award, First Place – Society for Medical Decision Making
2004	Outstanding Graduate Student Instructor, School of Public Health, UC Berkeley
2004	Outstanding Academic Faculty, Department of OB/Gyn, UCSF
2005	Outstanding Resident Teaching Award, Department of OB/Gyn, UCSF
2006	Best Poster, Session 2, co-author, Society of Maternal-Fetal Medicine Annual Meeting
2006	President's Award, Society for Gynecologic Investigation, senior author
2005-2006	Excellence in Medical Student Teaching Award, Department of OB/Gyn, UCSF
2006	Outstanding Resident Teaching Award, Department of OB/Gyn, UCSF
2006	Essential Core Teaching Award - Best Small Group Instructor, UCSF School of Medicine
2007	Best Poster, Session 1, co-author, Society of Maternal-Fetal Medicine Annual Meeting
2007-2010	Robert Wood Johnson Physician Faculty Scholars Program
2007	Outstanding Resident Teaching Award, Department of OB/Gyn, UCSF
2007-10	Selected to Best Doctors in America, 2007, 2008, 2009, 2010
2007	Frank Lynch Memorial Essay, Pacific Coast Obstetric and Gynecologic Society Annual Meeting, senior author
2007	Charles Kimball Award for Best Poster, Pacific Coast Obstetric and Gynecologic Society, senior author
2008	Outstanding Academic Faculty, Department of OB/Gyn, UCSF
2008	Frank Lynch Memorial Essay, Pacific Coast Obstetric and Gynecologic Society Annual Meeting, senior author
2008	Charles Kimball Award for Best Poster, Pacific Coast Obstetric and Gynecologic Society, senior author

2009	Henry J. Kaiser Excellence in Teaching Award - Best Clinical Instructor in an Ambulatory Care Setting, UCSF School of Medicine
2009	Roy M. Pitkin Award for Outstanding Research Paper – The Journal *Obstetrics and Gynecology*, co-author
2009	Frank Lynch Memorial Essay, Pacific Coast Obstetric and Gynecologic Society Annual Meeting, senior author
2009-2010	Excellence in Medical Student Teaching Award, Department of OB/Gyn, UCSF
2010	Dru Carlson Award for the Best Abstract in Genetics/Ultrasound, Society for Maternal-Fetal Medicine, senior author
2010	Bay Area's Top Doctors and Dentists Award
2010	Grammy Award – Best Choral Performance, Mahler 8 with San Francisco Symphony, member San Francisco Symphony Chorus
2010	Award for Best Research Abstract, Oral Plenary Session 2, Society for Maternal-Fetal Medicine, senior author
2010	Award for Best Poster, Royal Australian New Zealand College of Obstetrics and Gynecology (RANZCOG) Annual Research Conference, senior author
2010	Outstanding Article Award from the journal Contraception, co-author
2010	Charles Kimball Award for Best Poster, Pacific Coast Obstetric and Gynecologic Society, senior author
2010	Portland's Top Doctors Award
2011	Award for Best Research Abstract, Poster Session 4, Society for Maternal-Fetal Medicine, senior author
2011	President's Award, Society for Gynecologic Investigation, co-author
2011	Portland's Top Doctors Award
2011	U.S. News and World Report - Top Doctor's Award
2012	Best Doctors in America Award
2013	Award for Best Research Abstract, Oral Presentation Session 7, Society for Maternal-Fetal Medicine, senior author
2013	U.S. News and World Report – Department of Obstetrics & Gynecology named in Top 50 Hospitals in the Nation
2013	Best Doctors in America Award
2014	First Place Prize Paper – American College of Obstetricians & Gynecologists Annual Meeting, senior author
2014	Best Doctors in America Award
2014	Faculty Speaker – Selected by the graduating class of 2014 at OHSU
2014	American College of Nurse-Midwives Best Poster Award, co-author
2015	Nominated, Clinician of the Year, OHSU, Department of Obstetrics & Gynecology
2015	Faculty Award – OHSU Student Council
2015	Frank Lynch Memorial Essay, Pacific Coast Obstetric and Gynecologic Society Annual Meeting, co-senior author
2016	Best Doctors in America Award
2016	Award for top-cited paper in Am J Obstet Gynecol at the Society for Maternal-Fetal Medicine
2016	Portland's Top Doctors Award
2017	Award for Best Research Abstract, Oral Presentation Session 6, Society for Maternal-Fetal Medicine, senior author

2017	Award for top-cited paper in Am J Obstet Gynecol at the Society for Maternal-Fetal Medicine
2017	Ivory Tower Award – OHSU, Department of Obstetrics & Gynecology
2017	Chief Pro Tempore at Brown University, Department of Obstetrics & Gynecology
2017	Albert Nelson Marquis Lifetime Achievement Award, Who's Who in America
2017	Charles Kimball Award best poster, Pacific Coast Obstetric and Gynecologic Society Annual Meeting, senior author
2017	Colleges Impact Award, OHSU School of Medicine
2017	Portland's Top Doctors Award
2018	Roy M. Pitkin Award for OB/Gyn Department with Outstanding Research Excellence – The Journal *Obstetrics and Gynecology*
2018	Portland's Top Doctors Award
2018	Honored CME Educator Award - OHSU
2018	Award for Overall Best Paper published in the Journal Annals of Epidemiology
2018	Best Doctors in America Award
2019	Campbell Award for Contributions to Pediatric Surgery, OHSU
2019	Award for Best Research Abstract, Oral Presentation Session 2, Society for Maternal-Fetal Medicine, Annual Meeting, senior author
2019	Second Place Award for Best Research Abstract, Oral Presentation, American College of Obstetricians and Gynecologists, Annual Meeting, senior author
2019	Best Doctors in America Award
2019	Honored CME Educator Award – OHSU
2019	Black Belt, First Degree, Tae Kwon Do, World Champion Tae Kwon Do
2020	Best Doctors in America Award
2020	Honored CME Educator Award – OHSU
2020	Milton Weinstein Award for Outstanding Presentation in Applied Health Economics, Senior Author, Society for Medical Decision Making
2020	Lee B. Lusted Award, Senior Author – Society for Medical Decision Making
2020	Medical Research Foundation of Oregon Mentor Award
2021	Roy M. Pitkin Award for OB/Gyn Department with Outstanding Research Excellence – The Journal *Obstetrics and Gynecology*
2021	Black Belt, Second Degree, Tae Kwon Do, World Champion Tae Kwon Do
2022	Best research abstract, American Society of Addiction Medicine (senior author)
2022	Award for Best Research Abstract, Oral Presentation Session 7, Society for Maternal-Fetal Medicine, Annual Meeting, co-author
2023	Roy M. Pitkin Award for OB/Gyn Department with Outstanding Research Excellence – The Journal *Obstetrics and Gynecology*

KEYWORDS / AREAS of INTEREST

Mode of delivery, operative vaginal delivery, cesarean delivery, vaginal birth after cesarean, induction of labor, prenatal diagnosis, diabetes in pregnancy, gestational age, complications of term pregnancies, cost-effectiveness analysis, quality of life metrics, patient preferences, time preferences, discounting, decision analysis, perinatal epidemiology, quality of care

PROFESSIONAL ACTIVITIES

Clinical Service:

2002-2010 Attending, Obstetrics Service – 6 weeks per year, responsible for the inpatient obstetrics service including all high-risk patients and extramural transports at UCSF

2003-2010 Medical director of the Diabetes and Pregnancy Program at UCSF - responsible for all pregnant women with pregestational or gestational diabetes at UCSF and from a number of referring clinics throughout Northern California; Comprehensive Perinatal Service Providers clinic at UCSF – responsible for care provided to Medicaid patients at UCSF

2010-present Attending, Obstetrics and Maternal-Fetal Medicine Services – Responsible for the inpatient obstetrics service including all patients on labor and delivery as well as the antepartum service with high-risk patients and extramural transports at OHSU; attending in maternal-fetal medicine clinic, diabetes and pregnancy clinic, and resident clinics

Professional Service:

Professional Organizations

1991-1999 Massachusetts Medical Society

1991-2006 American Medical Association

1995-present American College of Obstetricians & Gynecologists
- Elected Fellow, 2005
- Committee on Obstetric Practice, 2011-2014
- Abstract reviewer, 2011, 2012, 2014, 2015, 2016, 2017, 2018, 2019, 2020
- Content Expert – Patient Safety and Quality Improvement Committee, 2012
- Speaker, Annual Meeting – 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, (scheduled 2020)
- Obstetric Care Consensus Writing Group, 2013-2014
- Committee on Practice Bulletins, Obstetrics, 2014-2021
  - Vice Chair 2017-2021
- Committee on Diversity, 2016-2018
- Evidence-Based Medicine Expert Work Group, 2016-present
- Committee on Clinical Practice Guidelines - Obstetrics, 2021-present

1999-present Society for Maternal-Fetal Medicine
- Vice-President of Associate Members of SMFM, 2000-2001
- President of Associate Members of SMFM, 2001-2002
- Paper Reviewer, 2005-present
- Perinatal Epidemiology Scientific Forum, Vice-Chair, 2007-08
- Perinatal Epidemiology Scientific Forum, Chair, 2008-10
- Course Speaker – 2008, 2009, 2012, 2013, 2014, 2015, 2016, 2019, 2020, 2021
- Abstract Reviewer, 2008-present
- Course Director, 2010, 2011, 2016
- Oral Presentation Moderator, 2010, 2014, 2015, 2018, 2021
- Judge, 2012, 2013, 2017, 2019
- Publications Committee, 2013-2017
- NICHD/SMFM/ACOG Speaker/Moderator, 2013, 2014, 2016, 2018, 2019
- Quilligan Scholar Mentor, 2014, 2015, 2016, 2017, 2018, 2019, 2020

Senior abstract reviewer, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021
Research Committee, Chair, 2014-2018, Prior Chair, 2018-2020
Board member, 2014-2018
Fellows Education Committee, 2014-2017
Health Policy and Advocacy Committee, 2016-2019
Nominating Committee, 2016-2017, 2020-21
Fellowship Retreat Faculty, 2015, 2016, 2018, 2020, 2021
Cesarean prevention toolkit Committee, 2017-2018
Task Force on Value-based Healthcare Models, 2018-2020
Editorial Review Committee for SMFM / AJOG 2020-
Vice Chair 2020-

2001-present Academy of Health Services Research
Panel Speaker, 2016

2002-present Society for Medical Decision Making
Abstract reviewer, 2006, 2007, 2008, 2009, 2010, 2011, 2015, 2016, 2018, 2019

2007-present Society for Gynecologic Investigation / Society for Reproductive Investigation
Abstract reviewer, 2007, 2008, 2009, 2010, 2015, 2016, 2017, 2018, 2019, 2020, 2021
Oral Presentation Moderator, 2011

2007-present Pacific Coast Obstetric and Gynecologic Society
Paper Discussant, 2009, 2011
Board Member, 2010-2013
Audit Committee, 2010-2014
Scientific Editor, 2013-present
Presidential Speaker, 2015
Program Committee, 2018-present
Poster Chair, 2020
Program Chair, 2021, COVID-19 Task Force, 2021

2007-2010 Robert Wood Johnson Physician Faculty Scholars Program
Program Committee, 2008, 2009
Keynote Panelist, 2011

2007-present American Board of Obstetrics and Gynecology
Question author, 2010-present
Board Examiner, Maternal-Fetal Medicine, 2012-present
Oral Board Case Author, 2021-present

2010-present American Gynecological and Obstetrical Society
2016-present – Candidate reviewer
2019-present – Nominating committee

2010-present Council of University Chairs in Obstetrics and Gynecology

2011-present Portland Obstetricians and Gynecologists Society

2015-present Pacific Northwest Obstetric and Gynecologic Association – Honorary Member

Service to Professional Publications:

Leadership Positions at Journals

2003-2005, 2014-present Journal of Perinatology – Editorial Board

2004-2015 Current Women's Health Reviews – Editorial Board
2005-2014 Journal of Perinatology - Associate Editor for Obstetrics and Maternal-Fetal Medicine
2006-present UpToDate Peer Reviewer – Obstetrics and Maternal-Fetal Medicine
2007-present Reviews in Obstetrics and Gynecology – Editorial Board
2007-2014 Clinical Medicine: Pediatrics – Editorial Board
2009-2014 F1000 Medicine Reports Advisory Board for Women's Health
2010-present Obstetrics and Gynecology Survey – Editor-in-Chief for Obstetrics
2011-2017 World Diabetes Journal – Editorial Board
2012-present Journal of Maternal-Fetal and Neonatal Medicine – Editorial Board
2015-2019 Acta Obstetricia et Gynecologica Scandinavica – Editorial Board
2018-present American Journal of Obstetrics and Gynecology – Associate Editor
2020- SMFM Editor

Ad Hoc Referee

Ad hoc referee for: Acta Obstetricia and Gynecologica, Acta Paediatrica, American Journal of Epidemiology, American Journal of Obstetrics and Gynecology, American Journal of Perinatology, American Journal of Public Health, Anesthesia & Analgesia, Annals of Family Medicine, Annals of Medicine and Surgery, Archives of Internal Medicine, Archives of Gynecology and Obstetrics, BMC Genetics, BMC Pregnancy and Childbirth, BMJ, BMJ Online, British Journal of Obstetrics and Gynaecology, Canadian Medical Association Journal, Circulation, Contraception, Current Diabetes Reviews, Current HIV Research, Current Medical Research and Opinion, Current Women's Health Reviews, Diabetologia, Diabetes Care, Diabetes Research and Clinical Practice, Diabetic Medicine, Endocrine Practice, Endocrine Reviews, European Journal of Obstetrics and Gynaecology, Evidence Based Journals, Expert Review of Obstetrics and Gynecology, F1000 Medicine Reports, Health Economics, Health Policy, Health Services Research, Hypertension in Pregnancy, International Journal of Women's Health, JAMA, JAMA Pediatrics, The Journal of Obstetrics and Gynaecology Research, Journal of Maternal-Fetal and Neonatal Medicine, Journal of Perinatology, Journal of Reproductive Medicine, The Journal of Urology, Journal of Women's Health, The Lancet, Lancet Global Health, Lancet Pediatrics and Adolescent Medicine, Medical Decision Making, The New England Journal of Medicine, Obstetrics and Gynecology, The Obstetrics and Gynecology Survey, Paediatric and Perinatal Epidemiology, Pediatrics, Pharmacist's Letter, Pharmacological Reports, PLOS One, Prenatal Diagnosis, Public Health Genomics, Quality of Life Research, Reproductive Biology and Endocrinology, Reproductive Sciences, Reviews in Obstetrics and Gynecology, Saudi Medical Journal, UpToDate, Women's Health, Women and Health

Referee Recognition

American Journal of Obstetrics and Gynecology
Top 5% Reviewer – 2006, 2007, 2009, 2010, 2011, 2012
Obstetrics and Gynecology
Top 5% Reviewer – 2006, 2007, 2009, 2010, 2011, 2014, 2015, 2018, 2019, 2020
British Journal of Obstetrics and Gynaecology
Top 25 (2.5%) Reviewer – 2008, 2009, 2010, 2011

Public Service - State, Regional, National, and International Organizations and Committees

2003-2010 Founding Co-Director, Bay Area Perinatal Research Consortium (BARC)
2005-2014 Director, Decision and Economic Analysis in Reproductive Sciences Group (DEAR)

2008-2010	California Dental Association – Perinatal Oral Health Advisory Committee
2008-2011	California Maternal Quality Care Collaborative – Data Committee
2008-2011	California Health Benefits Review Program – Content Expert
2009-2012	California Sweet Success Program Guidelines For Care Committee
2011	NICHD – Group Leader for Vision Conference on Developmental Origins of Adult Disease
2010-present	Founding member, Oregon Perinatal and Neonatal Network
2011	Founding member, Babies are Worth the Wait Initiative, Oregon
2012	NIH Study Section, Patient Centered and Outcomes Research Institute (PCORI)
2012	Center for Medicare and Medicaid Services Strong Start Grant Review Panelist
2012	Speaker, 39+ Weeks Quality Improvement Initiative, March of Dimes
2012-present	Chair, Oregon Perinatal Collaborative
2012-2017	Board of Directors, Oregon Symphony
2012	Member of the Expert Panel on the Availability of Care for the High Risk Obstetrical Patient - The Joint Commission and the Mount Sinai Collaboration to Advance Pediatric Quality Measures (CAPQuaM) project
2013	Speaker – NICHD review of Periviable Birth
2013	Speaker/Panel Member – NICHD review of Gestational Diabetes
2014	NICHD Perinatal and Neonatal Study Section
2014-2018	The Collaborative Improvement & Innovation Network (**COIIN**) to Reduce Infant Mortality – Oregon representative
2015-2017	Committee member, Project Nurture, Alternative Payment Mechanisms, Health Share of Oregon
2016	External Advisory Board, Mt. Sinai Icahn School of Medicine, Department of Obstetrics & Gynecology
2017-2020	Member of Advisory Council for development of cesarean toolkit, Ariadne Labs, Harvard School of Public Health, Boston, MA
2017-2020	International ERAS Society C/S Guideline group
2018-2022	United States Preventive Services Task Force, Member Women's and Children's Health Committee Methods Committee Prioritization Committee Systemic Racism Workgroup Lead, Inclusion of Gender and Sex in Recommendations Committee
2019-present	Board Chair, Oregon March of Dimes
2022	Special Emphasis Panel/Scientific Review Group - Population Sciences and Epidemiology, National Institutes of Health
2022	Consultant to Patient Centered Outcomes Research Institute, Maternal Morbidity and Mortality Committee
2022	U.S. Food & Drug Administration Advisory Committee on 17-hydroxyprogesterone
2022-	Hassenfeld Child Health Innovation Institute, Brown University - Advisory Council
2022-2023	National Academy of Science, Engineering and Medicine - Committee on the Identification and Prognosis of Low Birth Weight Babies in Disability Determinations

University/Departmental/Campus Wide Service

1997-1999	Faculty Education and Training Committee, Brigham & Women's Hospital
1998-1999	Residency Governance Committee, Brigham & Women's Hospital

1997-1999	Residency Admissions Committee, Brigham & Women's Hospital
1995-1999	Medical Student Education Committee, Brigham & Women's Hospital
1998-1999	Administrative Chief in Obstetrics & Gynecology Brigham & Women's Hospital / Massachusetts General Hospital
1999-2010	Maternal-Fetal Medicine Fellowship Admissions Committee, UCSF, Division of MFM
1999-2010	Residency Admissions Committee, UCSF – Dept. of Ob/Gyn
2002-2006	PCRC Committee, UCSF
2002-2010	Perinatal Database Committee, UCSF - Chair
2002-2004	HSPA Admissions Committee, School of Public Health, UC, Berkeley
2003-2010	Residency Advisory Council, UCSF – Dept. of OB/Gyn
2004-2005	Information Technology Committee, UCSF- Dept. of OB/Gyn
2004-2010	Hospital Ethics Committee, UCSF
2005-2010	Perinatal Research Committee, UCSF Director, 2007-2010
2005-2007	Labor and Delivery Focus Committee, UCSF
2005-2009	Hospital Information Technology Committee, UCSF
2006-2010	OB/Gyn Residency PGY1 Class Mentor
2007-2010	Clinical Infrastructure Pre-Award Committee, UCSF
2007-2009	Pisces Medical Student Preceptor, UCSF
2007-2009	Mission Bay Hospital Working Group
2007	Maternal-Fetal Medicine Candidate Search Committee
2007-2010	Diabetes in Pregnancy Management Committee
2007-2010	Antepartum and Intrapartum Management CME Course, Course Co-Director, UCSF-Dept. of OB/Gyn
2008-2010	Diabetes Management Committee, UCSF
2008-2010	UCSF Risk Management Committee
2009	UCSF RWJF Physician Faculty Scholar Review and Nomination Committee
2009	UCSF Building Research Careers in Women's Health (BIRCWH) K-12 Program – Resource Faculty
2009-2010	UCSF Henry J. Kaiser Award for Excellence in Teaching Award Committee
2010-2017	Faculty Practice Plan Committee, OHSU
2010-2011	Professional Board, OHSU
2010-2013	Women in Academic Medicine Committee, OHSU
2010-present	Doernbecher Children's Hospital Expansion Planning Committee, OHSU
2010-present	Obstetrics & Gynecology Quality Executive Committee
2010-2011	Meaningful Use Task Force of Faculty Practice Plan, OHSU
2010-2012	Program Development Committee, Pediatric and Congenital Cardiac Program, OHSU
2010	Architect Selection Committee, Doernbecher Expansion Project, OHSU
2010-2015	Clinical Executive Committee, Knight Cancer Institute, OHSU
2010-2011	LCME Task Force for Medical Student Teaching, OHSU
2010-2011	Clinical Research Management System Advisory Committee for OCTRI, OHSU
2011-present	Perinatal Best Practice Committee
2011-2016	OHSU Building Research Careers in Women's Health (BIRCWH) K-12 Program – Selection Committee
2011-2014	OHSU Hospital Capital Committee
2011-2019	OHSU Center for Health Systems Evaluation, Steering Committee

2011-present OHSU Bob and Charlee Moore Center for Wellness and Nutrition, Steering Committee
2011-2016 Oregon Clinical and Translational Research Institute (OCTRI) Internal Advisory Board on Human Investigations
2011-2013 OHSU/PSU School of Public Health Visioning Committee
2012-2014 Research Roadmap Blueprint Advisory Committee
2012-2013 OHSU School of Medicine Families Advisory Group Leader
2012-2014 OHSU/PSU School of Public Health Steering Committee
2012-2015 OHSU Professional Board
2012-2014 Management Committee, Faculty Practice Plan, OHSU
2012-2013 Department of Medicine Review Committee
2013-2014 Oregon Performance Excellence (OPEx) Training
2013-2017 OHSU Surgical Subspecialties College Lead
2015-2017 OHSU Partners – Salem Health Transition Committee
2016-present OHSU NICU, L&D Design Committee
2016-2017 OHSU Faculty First Steering Committee
2016-2017 OHSU, Interim Director, Women's & Children's Outreach
2016-2017 OHSU, Executive Management Team – Doernbecher Children's Hospital
2017-2022 OHSU Hospital Capital Council
2017-present OHSU Practice Plan Board
2019-present OHSU Hospital Leadership Committee
2019-present OHSU Hillsborough Medical Center Women's and Childrens' Service Line Executive Committee
2020-present OHSU Health Finance Committee
2021-present OHSU Fetal Therapy Program Executive Committee
2021-2022 OHSU Faculty Compensation Committee
2021-present OHSU Professional Board
2021-2023 OHSU Clinical Leadership Council

INVITED PRESENTATIONS:

1997 Peripartum Cardiomyopathy: Diagnosis & Treatment; Grand Rounds - Brigham & Women's Hospital, Dept of OB/GYN; Boston, MA
1998 Management of Mullerian Anomalies; Grand Rounds - Massachusetts General Hospital Dept of OB/GYN; Boston, MA
1998 Non-Hodgkin's Lymphoma In Pregnancy; Grand Rounds - Brigham & Women's Hospital, Dept of OB/GYN; Boston, MA
1998 Trial of labor after cesarean: Predictors of success; Grand Rounds - Salem Hospital Dept of OB/GYN; Salem, MA
1999 Rate of uterine rupture during a trial of labor in women with one and two prior cesarean deliveries. Oral presentation at the Society for Maternal-Fetal Medicine, Annual Meeting; San Francisco, CA
1999 Decision Analysis in Obstetrics & Gynecology: When to Offer Amniocentesis; Grand Rounds - Brigham & Women's Hospital; Boston, MA
1999 Predictors and Outcomes Related to a Trial of Labor After Cesarean. Resident Research Day – Brigham & Women's and Massachusetts General Hospital; Boston, MA

1999 IUGR: Diagnosis and Management, UCSF – School of Midwifery; San Francisco, CA
2000 Preeclampsia: Etiology, Diagnosis, Management & Prevention, Kaiser-Oakland Dept of OB/GYN; Oakland, CA
2000 Use of Ultrasound in Obstetrics; Kaiser-Oakland Dept of OB/GYN; Oakland, CA
2000 Vaginal Birth After Cesarean; Antepartum and Intrapartum Management CME Course, San Francisco, CA
2000 Ultrasound Use in Obstetric Care: Level I, BPP and AFI; UCSF – School of Midwifery; San Francisco, CA
2001 Operative Vaginal Delivery; Kaiser-Oakland Dept of OB/GYN; Oakland, CA
2001 Evidence-Based Management of Preeclampsia; Antepartum and Intrapartum Management CME Course, San Francisco, CA
2001 Trial of Labor after Prior Cesarean: Predictors of Outcomes; Grand Rounds, Santa Clara Valley Medical Center, Dept of OB/GYN; San Jose, CA
2002 Clinical Controversies in Obstetrics – VBAC, Preeclampsia and Prenatal Diagnosis; Contraceptive Technology, San Francisco, CA
2002 Decision Analysis and Measuring Outcomes, Utilities and QALYs; Cost-Effectiveness Analysis – PH228, School of Public Health, University of California, Berkeley; Berkeley, CA
2002 Demand for Health Insurance and Moral Hazard; Health Economics – PH226A, School of Public Health, University of California, Berkeley, CA
2002 Vaginal Birth After Cesarean – Emerging Issues; Antepartum and Intrapartum Management CME Course, San Francisco, CA
2002 Perinatal Outcomes in Patients Exposed to Environmental Smoke: TDRP Research Conference, San Jose, CA
2003 Methods for Measuring Outcomes, Utilities and QALYs; Decision and Cost-Effectiveness Analysis – Department of Epidemiology and Biostatistics, UCSF, San Francisco, CA
2003 Decision Analysis, Discounting Methods, and Methods for Measuring Outcomes, Utilities and QALYs; Cost-Effectiveness Analysis – PH228, School of Public Health, University of California, Berkeley, CA
2003 Measuring Perinatal Outcomes at Term: What denominator should be used: Women's Reproductive Health Research Scholars Presentation, UCSF; San Francisco, CA
2003 Complications in Term Pregnancies; Antepartum and Intrapartum Management CME Course, San Francisco, CA
2003 Ultrasound Use in Obstetric Care: What to Do About the Soft Markers of Aneuploidy; UCSF – School of Midwifery; San Francisco, CA
2003 Prenatal Diagnosis: Using Patient Preferences to Inform Counseling. Department of Obstetrics and Gynecology, Kaiser, SF; San Francisco, CA
2003 What Discounting Model Best Fits Differences Between Standard Gamble and Time Trade-off Metrics? Oral Plenary Presentation at the Society of Medical Decision Making, Annual Meeting; Chicago, IL
2003 Demand for Health Insurance, Moral Hazard and Other Behavioral Concerns; Health Economics – PH226A, School of Public Health, University of California, Berkeley, CA
2004 Diabetes and Pregnancy: Past, Present, and Future – What's Hot in Obstetrics & Gynecology – CME Course. Squaw Valley, CA.
2004 Vaginal Birth After Cesarean: Who is a Candidate? – Antepartum and Intrapartum Management - CME Course, SF, CA
2004 Management of Postterm Pregnancy – Ob/Gyn Update CME Course. SF, CA

2004 Ultrasound Use in Obstetric Care: What to Do About the Soft Markers of Aneuploidy; UCSF – School of Midwifery; San Francisco, CA
2005 IUGR: Etiology and Management – UCSF Dept of OB/Gyn – San Francisco, CA
2005 Diabetes and Pregnancy: Past, Present, and Future – UCSF/UC Davis CME Course. Squaw Valley, CA
2005 Vaginal Birth After Cesarean: Counseling Patients Using the Evidence – UCSF/UC Davis CME Course. Squaw Valley, CA
2005 Cost-effectiveness Analysis – PH226A Health Economics, School of Public Health, University of California, Berkeley, CA
2005 Complications in Term and Postterm Pregnancies; Antepartum and Intrapartum Management UCSF CME Course, San Francisco, CA
2005 Exponential Discounting versus Present Biased Preferences – Women's Reproductive Health Research Scholars Symposium – Cincinnati, OH
2005 Diabetes and Pregnancy: Review of the Evidence – Obstetrics & Gynecology Update – UCSF CME Course. SF, CA
2005 Postterm Pregnancy: Definitions, Complications, & Management – Obstetrics & Gynecology Update - UCSF CME Course. SF, CA
2005 Risks and Management of Pregnancies with Increasing Gestational Age – Grand Rounds, Santa Clara Valley Medical Center. Santa Clara, CA
2006 Vaginal Birth After Cesarean: Sifting Through the Evidence to Counsel Women – Antepartum and Intrapartum Management, UCSF CME Course, SF, CA
2006 Management of pregnancies at term: How to prevent postterm – Obstetrics & Gynecology Update – CME Course. SF, CA
2007 Measuring Perinatal Complications: Methodologic Issues Related to Gestational Age. – Perinatal Epidemiology Scientific Forum, Society for Maternal Fetal Medicine, SF, CA
2007 The Benefits of Vaginal Birth – Antepartum and Intrapartum Management, UCSF CME Course, San Francisco, CA
2007 Elective Induction of Labor: Outcomes and Costs - Obstetrics & Gynecology Update, UCSF CME Course, San Francisco, CA
2007 Maternity Care Costs – Forum with Michael Krasny, KQED, National Public Radio
2007 First versus Second Trimester Ultrasound: The Effect on Pregnancy Dating and Perinatal Outcomes. Pacific Coast Obstetrics and Gynecological Society Annual Meeting – Las Vegas, NV
2007 Elective vs. Preventative Induction of Labor – Kaiser Permanente Medical Center Department of Obstetrics & Gynecology Grand Rounds, San Francisco, CA
2007 Cesarean and Vaginal Delivery: Preferences, Outcomes, and Costs - The Robert Wood Johnson Foundation Physician Faculty Scholars Program Annual Meeting, San Diego, CA
2007 Prevention of Complications of Term Pregnancies: Is an Ounce of Prevention Worth a Pound of Cure? – University of California, San Francisco Department of Obstetrics & Gynecology Grand Rounds, San Francisco, CA
2007 Nurturing Your Academic Career: Gardening Tips from the Wild – Faculty Research Methods Conference, Washington University. St. Louis, MO
2007 Elective Induction of Labor: Weighing the Evidence – Grand Rounds, Washington University. St. Louis, MO
2008 Cohort Studies – Methodologic Considerations – Society for Maternal-Fetal Medicine, Perinatal Epidemiology Seminar. Dallas, TX

2008 Controversies in Preeclampsia – Society for Maternal-Fetal Medicine CME Course. Dallas, TX
2008 Universal Screening for HSV – Society for Maternal-Fetal Medicine CME Course. Dallas, TX
2008 Prenatal Care – Forum with Dave Iverson, KQED, National Public Radio
2008 Thyroid Disease in Pregnancy – Kaiser Permanente CME Course, Kauai, HI
2008 Vaginal Birth after Cesarean: Current Controversies - Kaiser Permanente CME Course, Kauai, HI
2008 Maternity Care: Use of Birth Plans to Educate Regarding Expectations - Kaiser Permanente CME Course, Kauai, HI
2008 Postterm and Prolonged Pregnancy: Counseling and Management – Home Birth Midwifery Association of the Bay Area. San Francisco, CA
2008 Elective Induction of Labor, the Importance of Considering Gestational Age – Grand Rounds, University of North Carolina. Chapel Hill, NC
2008 Resident Research Day Judge – Kaiser Permanente, Northern California. Oakland, CA
2008 Abnormal Placentation and Delivery Planning – University of California, San Francisco Grand Rounds, San Francisco, CA
2008 When to Deliver? – Antepartum and Intrapartum Management, UCSF CME Course, San Francisco, CA
2008 Postterm Pregnancy – Lecture, UC Davis Medical Center. Davis, CA
2008 Prevention of Cesarean Delivery in the Setting of Fetal Malposition – Grand Rounds, Santa Clara Valley Medical Center. Santa Clara, CA
2008 Elective Induction of Labor – Grand Rounds, University of Washington. Seattle, WA
2008 Fostering an Academic Career – Teaching Session, University of Washington. Seattle, WA
2008 Postterm and Prolonged Pregnancy: Prediction and Prevention – Obstetrics & Gynecology Update, UCSF CME Course, San Francisco, CA
2008 Who is at Risk for Prolonged and Postterm Pregnancy? – Oral presentation, PCOGS, Victoria, B.C.
2008 Elective Induction of Labor and Gestational Age – Grand Rounds, Santa Clara Valley Medical Center, Santa Clara, CA
2008 How will increases in cesarean rates affect the incidence of placenta previa, placenta accreta, and maternal death in future years? – The Robert Wood Johnson Foundation Physician Faculty Scholars Program Annual Meeting, Ft. Lauderdale, FL
2008 Elective Induction of Labor – Wayne Day Speaker, Wayne State University, Detroit, MI
2008 Term Complications of Pregnancy: Methodologic Issues Related to Gestational Age – Speaker, Perinatal Research Branch, Wayne State University, Detroit, MI
2009 Quality of Care in Obstetrics – Perinatal Epidemiology Forum, Society for Maternal-Fetal Medicine Annual Meeting, San Diego, CA
2009 Magnesium and Cerebral Palsy: Discussion of BEAM – Roundtable Discussion, Society for Maternal-Fetal Medicine Annual Meeting, San Diego, CA
2009 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions. Center for Healthcare Policy and Research, UC Davis; Sacramento, CA
2009 Resident Research Day Judge – Kaiser Permanente, Northern California. Santa Clara, CA
2009 Elective Induction of Labor and Gestational Age – Grand Rounds, St. Louis University, St. Louis, MO
2009 Resident Research Day Visiting Professor – Department of Obstetrics & Gynecology, Santa Clara Valley Medical Center, Santa Clara, CA

2009 Getting Published: The Art of Submission, Revision, and Resubmission. Department of Obstetrics, Gynecology, and Reproductive Sciences, UCSF; San Francisco, CA

2009 How can we lower the rate of cesarean delivery? American College of Nurse Midwifery Annual Meeting, Seattle, WA

2009 Resident Research Day Visiting Professor – Department of Obstetrics & Gynecology, Stanford University, Palo Alto, CA

2009 Management of GDM: Pill or Shot? Antepartum and Intrapartum Management, UCSF CME Course, San Francisco, CA

2009 What is the strongest predictor of gestational diabetes: Maternal or paternal ethnicity? Oral Presentation, Pacific Coast Obstetric and Gynecologic Society, San Diego, CA

2009 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions. Kaiser Permanente Grand Rounds; San Francisco, CA

2009 Continuing a trial of labor after 2 hours of active-phase labor arrest: is it cost effective? Oral Presentation, Society for Medical Decision Making, Hollywood, CA

2009 Prolonged and Postterm Pregnancy: An Evidence-Based Approach to Management. Midwives Alliance of North America. Asilomar, CA 2009

2009 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions. Department of Obstetrics and Gynecology, OHSU, Portland, OR

2009 Cesarean and Vaginal Delivery: Preferences, Outcomes, and Costs – The Results - The Robert Wood Johnson Foundation Physician Faculty Scholars Program Annual Meeting, San Diego, CA

2010 Methods for Measuring Outcomes in Decision and Cost-effectiveness Analysis: Utilities, QALYs, and Discounting – Department of Epidemiology and Biostatistics, UCSF, San Francisco, CA

2010 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions. Department of Obstetrics and Gynecology, University of New Mexico, Albuquerque, NM

2010 Magnesium: Friend or Foe. Midcoastal Perinatal Outreach Program Conference. Monterey, CA

2010 Racial/ethnic Disparities in Obstetrics – Perinatal Epidemiology Forum, Society for Maternal-Fetal Medicine Annual Meeting, Chicago, IL

2010 Corticosteroids for Fetal Lung Maturity Should be Given More than Once and Beyond 34 Weeks of Gestation: A Debate – Society for Maternal-Fetal Medicine Annual Meeting, Chicago, IL

2010 Magnesium for Cerebral Palsy: Is it Time? Society for Maternal-Fetal Medicine Annual Meeting, Chicago, IL

2010 Maternal Mortality – Forum with Michael Krasny, KQED, National Public Radio

2010 The Cesarean Epidemic: Etiologies and Maternal Outcomes. Sol Schnider Course by the Society for Obstetric Anesthesia, San Francisco, CA

2010 Markov Modeling – Department of Epidemiology and Biostatistics, UCSF, San Francisco, CA

2010 Evidenced-Based Management of GDM – ACOG, Indiana Section Meeting, Indianapolis, IN

2010 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions. ACOG, Indiana Section Meeting, Indianapolis, IN

2010 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions. McElin Lectureship, North Shore Hospital, Chicago, IL

2010 Operative Vaginal and Cesarean Delivery: Past, Present, and Future. American College of Obstetricians and Gynecologists; San Francisco, CA

2010 Elective Induction of Labor Debate with Bill Grobman – Antepartum and Intrapartum Management, UCSF CME Course, San Francisco, CA
2010 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – ACOG, District V Annual Meeting, Cancun, Mexico
2010 Postterm Pregnancy – ACOG, District V Annual Meeting, Cancun, Mexico
2010 Operative Vaginal and Cesarean Delivery: Past, Present, and Future. OHSU, Portland, OR
2010 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – Maternity Care, Conference Sponsored by Kaiser Permanente, Oakland, CA
2010 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – Northwest Update in OB/Gyn and Women's Health, Portland, OR
2010 Elective Induction of Labor in Early Term and Late Term Pregnancy – Northwest Update in OB/Gyn and Women's Health, Portland, OR
2010 The Department of Obstetrics & Gynecology and Center for Women's Health: Where do we go from here? – Grand Rounds, OHSU, Portland, OR
2011 Decision and Cost-effectiveness Analysis: An Overview - Society for Maternal-Fetal Medicine Research Course, San Francisco, CA
2011 How to Jump Start your Research Career - Society for Maternal-Fetal Medicine Research Course, San Francisco, CA
2011 Prolonged and Postterm Pregnancy - The USC Perinatal Meeting, Maui, HI
2011 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions - The USC Perinatal Meeting, Maui, HI
2011 Elective Induction of Labor - The USC Perinatal Meeting, Maui, HI
2011 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – American College of Obstetricians and Gynecologists District 8 meeting, Sunriver, OR
2011 Elective Induction of Labor – American College of Obstetricians and Gynecologists District 8 meeting, Sunriver, OR
2011 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – Southwest Washington Medical Center, Vancouver, WA
2011 What's New in Obstetrics? - The Society for Obstetric Anesthesia Annual Meeting, Las Vegas, NV
2011 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – San Francisco Gynecologic Society, San Francisco, CA
2011 Gestational Diabetes: Evidence-Based Diagnosis and Treatment – Grand Rounds, Kaiser Permanente Medical Center, San Francisco, CA
2011 The Cesarean Epidemic – Antepartum and Intrapartum Management, UCSF CME Course, San Francisco, CA
2011 Gestational Diabetes: Evidence-Based Diagnosis and Treatment – OHSU Endocrine Course, Ashland, OR
2011 Elective Induction of Labor – International Birth Conference – Chicago, IL
2011 Second Stage of Labor – When to begin to push – International Birth Conference – Chicago, IL
2011 Magnesium Sulfate: Friend or Foe – a debate with Yasser El-Sayed, MD – Pacific Coast Obstetric and Gynecologic Society – Sun River, OR
2011 The Cesarean Epidemic – Nineteenth Annual Martha Browning Bryant Memorial Lecture, Portland, OR

2011 Patient Preferences in the Setting of Prenatal Diagnosis – Obstetric Ultrasound CME Course – Las Vegas, NV
2011 Cost effectiveness of Prenatal Diagnosis – Obstetric Ultrasound CME Course – Las Vegas, NV
2011 The Cesarean Epidemic: Etiologies, Outcomes, and Solutions – Obstetric Ultrasound CME Course – Las Vegas, NV
2011 Medical-legal factors and the cesarean epidemic - RWJ Physician Faculty Scholars Annual Meeting, San Diego, CA
2011 Transition from Mentee to Mentor – RWJ Physician Faculty Scholars Annual Meeting, San Diego, CA
2012 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions. ALSO CME Course, Oregon Academy of Family Physicians. Bend, OR
2012 Assisted Vaginal Delivery. ALSO CME Course, Oregon Academy of Family Physicians. Bend, OR
2012 VBAC Debate – Kaiser Permanente Maternity Course, Oakland, CA
2012 Diabetes Care in Pregnancy – Outpatient to Inpatient - Kaiser Permanente Maternity Course, Oakland, CA
2012 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions. Idaho obstetric practice collaborative meeting. Boise, ID
2012 Elective Induction of Labor: The Impact of Gestational Age. Idaho obstetric practice collaborative meeting. Boise, ID
2012 Universal Labor Induction by 39 weeks Debate – SMFM CME Course, Dallas, TX
2012 Gestational Diabetes Controversies Debate – SMFM, Dallas, TX
2012 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions. ACOG Annual Meeting. San Diego, CA
2012 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – Cohen Lecture, Northwestern University, Chicago, IL
2012 The Obesity Epidemic – Effect on Obstetric Outcomes: What Can We Do? Evergreen Perinatal Conference. Bellevue, WA
2012 Elective Induction of Labor: The Effect of Gestational Age. Evergreen Perinatal Conference. Bellevue, WA
2012 Prenatal Diagnosis – Why do we do what we do? Evergreen Perinatal Conference. Bellevue, WA
2012 The Cesarean Epidemic – Grand Rounds, Tufts University, Boston, MA
2012 The Cesarean Epidemic - Safon Lecture, Brigham and Women's Hospital, Boston, MA
2012 Elective Induction of Labor – Grand Rounds, Brigham and Women's Hospital, Boston, MA
2012 Gestational Diabetes – What's New in 2012. Antepartum and Intrapartum Management, San Francisco, CA
2012 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions. American Academy of Family Physicians National Maternity Meeting. Portland, OR
2012 Quantitative evalution of maternal preferences towards mode of delivery– Pacific Coast Obstetric and Gynecologic Society, Long Beach, CA
2012 Prevention of elective induction of labor – Pacific Coast Obstetric and Gynecologic Society, Long Beach, CA
2012 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – Pacific Coast Obstetric and Gynecologic Society, Long Beach, CA

2012 The Obesity Epidemic – Effect on Obstetric Outcomes. Asbury meeting, Corvallis, OR
2012 Preterm birth prevention – Is progesterone the answer? American Academy of Pediatrics Annual Meeting. New Orleans, LA
2012 National Health Reform – OHSU Course in Health Policy – Portland, OR
2013 Induction of labor by 39 weeks of gestation: a debate – Society for Maternal-Fetal Medicine, San Francisco, CA
2013 Economic issues of Periviable Birth. NICHD, SMFM, ACOG, AAP Workshop on Periviable Birth. San Francisco, CA
2013 Expanding the diagnosis of Gestational Diabetes – Economic Implications. NICHD Consensus Conference, Bethesda, MD
2013 Study Design, Epidemiology, and Biostatistics: Practical Approaches to Answering Questions. Research Lecture, OHSU, Portland, OR
2013 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – University of Arizona, Resident Research Day, Phoenix, AZ
2013 Prevention of elective induction of labor prior to 39 weeks' gestation – Grand Rounds, Salem Hospital, Salem, OR
2013 Keys to a Successful Academic Career – Fellow lecture, University of Hawaii, Honolulu, HI
2013 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – Resident Research Day, University of Hawaii, Honolulu, HI
2013 Progesterone for preterm birth prevention: A moving target. Antepartum and Intrapartum Management Course. San Francisco, CA
2013 Intrapartum Electronic Fetal Monitoring: Embarrassment or Opportunity. Antepartum and Intrapartum Management Course. San Francisco, CA
2013 Gestational Diabetes – A 2013 Update. Grand Rounds, Multnomah County Clinics, Portland, OR
2013 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – Grand Rounds, Massachusetts General Hospital, Boston, MA
2013 Obstetric Controversies. ACOG District II, V, VIII, IX Annual Meeting. Maui, HI
2013 How to Conduct a Publishable Research Project. PCOGS Annual Meeting, Walla Walla, WA
2013 Building a Successful Research Program within an Academic Department. Reproductive Scientist Development Program Annual Retreat. Boulder, CO
2013 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – Midwifery Week, University of California, San Diego, San Diego, CA
2013 Public Health Considerations: Cost Effectiveness of Diagnosis and Treatment of GDM – Diabetes in Pregnancy Study Group of North America, Washington, DC
2013 The New Labor Curve: Evidence-based management of the First and Second Stage. Northwest Update, Portland, OR
2013 Prevention of elective induction of labor prior to 39 weeks' gestation – Washington State Obstetrical Association, Seattle, WA
2013 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – Washington State Obstetrical Association, Seattle, WA
2014 Timing and Mode of Delivery in Diabetic Pregnancy: Examining the Evidence - Society for Maternal-Fetal Medicine, New Orleans, LA
2014 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – Grand Rounds – Loma Linda University, Loma Linda, CA
2014 Term and Postterm Pregnancy – Annual Meeting of the Obstetrical and Gynecological Assembly of Southern California, Los Angeles, CA

2014 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – Annual Meeting of the Obstetrical and Gynecological Assembly of Southern California, Los Angeles, CA

2014 Applications from Behavioral and Micro Economics to your Healthcare Career – Commencement, Class of 2014, OHSU, Portland, OR

2014 Decision to Incision Timing: Is the 30-minute rule valid? Antepartum and Intrapartum Management, San Francisco, CA

2014 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – Shanghai International Conference for Obstetric Anesthesia, Shanghai, China

2014 Trial of labor after cesarean – Counseling the patient – Conference on reducing cesareans in China, Beijing, China

2014 Managing Labor in 2014 – an evidence-based approach – Zhangzhou Maternity Hospital, Zhangzhou, China

2014 Management of the Second Stage of Labor: How Long is too Long? University of Washington Resident Research Day, Seattle, WA

2014 Gestational Diabetes: How best to diagnose in 2014 – Northwest Update, Portland, OR

2014 Prevention of delivery prior to 39 weeks' gestation: What is the Impact? - The Woman's Hospital, Baton Rouge, LA

2014 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – The Woman's Hospital, Baton Rouge, LA

2014 Should all deliveries occur by 38 weeks' gestation? – Israel Perinatal Society, Tel Aviv, Israel

2014 The Obesity Epidemic: Evidence-based Obstetric Management – Israel Perinatal Society, Tel Aviv, Israel

2014 Screening for Gestational Diabetes – Old Guidelines vs. New – Northwest Update, Portland, OR

2014 Management of the Second Stage of Labor: Examining the Evidence – Anesthesia and OB/Gyn Grand Rounds, Brigham & Women's Hospital, Boston, MA

2014 The Optimal Time for Delivery at Term – The World Symposium of Perinatal Medicine, San Diego, CA

2014 Management of the Second Stage of Labor: Examining the Evidence – OB/Gyn Grand Rounds, UCLA, Los Angeles, CA

2014 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – Taiwanese Society for Maternal-Fetal Medicine Meeting – Taipei, Taiwan

2015 What is the impact of Induction of Labor on Cesareans? - Society for Maternal-Fetal Medicine, San Diego, CA

2015 Timing of Delivery in Diabetic Pregnancy: Examining the Evidence - Society for Maternal-Fetal Medicine, San Diego, CA

2015 Induction of Labor by 39 weeks for all? – Birth Conference – Fortaleza, Brazil

2015 Second Stage of Labor – When to stop and start? – Birth Conference – Fortaleza, Brazil

2015 Timing of delivery for fetuses with cardiac anomalies. American College of Cardiology, San Diego, CA

2015 Improving Maternity Care in Oregon: The Oregon Perinatal Collaborative – American College of Obstetricians and Gynecologists District VIII meeting, Portland, OR

2015 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – Grand Rounds, Christiana Care Health System – Newark, Delaware

2015 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – Grand Rounds, University of Colorado, Denver, CO

2015 The Academic Impact of a Family Planning Fellowship: The OHSU Example – Annual Meeting Family Planning, San Francisco, CA

2015 Periviable Interventions: Decision Making Under Uncertainty – San Francisco Gynecologic Society, San Francisco, CA
2015 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – ACOG Annual Meeting, San Francisco, CA
2015 Forceps Delivery – Simulation Course – ACOG Annual Meeting, San Francisco, CA
2015 Management of the Second Stage of Labor – When to stop and start – Antepartum and Intrapartum Management Conference – San Francisco, CA
2015 Periviable Pregnancies: Decision Making Under Uncertainty – Pacific Northwest OB/Gyn Association, Sun River, OR
2015 Management of the Second Stage of Labor: Examining the Evidence – Pacific Northwest OB/Gyn Association, Sun River, OR
2015 Timing of Delivery: What is Optimal? – Pacific Northwest OB/Gyn Association, Sun River, OR
2015 National Healthcare Reform – Still Crazy After All These Years! – Infectious Disease Society of Obstetrics and Gynecology, Portland, OR
2015 Periviable Pregnancies: Decision Making Under Uncertainty – Pacific Coast Obstetric and Gynecologic Society, Turtle Bay, HI
2015 Forceps Delivery – Simulation Course – FIGO Annual Meeting, Vancouver, BC
2015 Periviable Pregnancies: Decision Making Under Uncertainty – Fleury Maternal-Fetal Medicine Conference, Sao Paulo, Brazil
2015 What is the impact of Induction of Labor on Cesareans? - Fleury Maternal-Fetal Medicine Conference, Sao Paulo, Brazil
2015 Periviable Pregnancies: Decision Making Under Uncertainty – Grand Rounds, Duke University, Durham, NC
2016 Management of the Second Stage of Labor: How Long is Too Long? – Society for Maternal-Fetal Medicine, Atlanta, GA
2016 Research and Measurement of Quality and Safety Metrics within Obstetrics and Maternal-Fetal Medicine. NICHD/SMFM/ACOG Quality Symposium. SMFM, Atlanta, GA
2016 Periviable Pregnancies: Decision Making Under Uncertainty – Society for Maternal-Fetal Medicine, Atlanta, GA
2016 Obstetrics and Midwifery: No "I" in Team. Keynote Speaker – Patient Safety Symposium. University of Pittsburgh, Magee Women's Hospital. Pittsburgh, PA
2016 Management of Category II tracings – As indeterminate as the tracings themselves? Oregon ACOG Meeting, Portland, OR
2016 Periviable Pregnancies: Decision Making Under Uncertainty – Grand Rounds, University of Michigan, Ann Arbor, MI
2016 Periviable Pregnancies: Decision Making Under Uncertainty – Resident Research Day, University of Rochester, Rochester, NY
2016 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – ACOG Annual Meeting, Washington DC
2016 Periviable Pregnancies: Decision Making Under Uncertainty – Antepartum & Intrapartum Management, San Francisco, CA
2016 Advancing the Translation and Impact of Maternal Health Services Research – Perintal Collaboratives. Academy Health Annual Meeting, Boston, MA
2016 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – University of Oklahoma, Oklahoma City, OK
2016 Universal Cord Gases – A Quality Improvement Approach – ACOG District VIII and IX Meeting, Waikoloa, HI
2016 Periviability – Long-term outcomes matter most – ACOG District VIII and IX Meeting, Waikoloa, HI

2016 Neonatal acidemia – Prediction and quality improvement – PCOGS Annual Meeting, Sun Valley, ID
2016 Periviable Pregnancies: Decision Making Under Uncertainty – Visiting Professor Lectureship, Carolinska Institute, Stockholm, Sweden
2016 Preventing the First Cesarean – Freedom from the Friedman Curve – Obstetrics Update for Family Physicians, University of British Columbia, Vancouver, BC
2016 Management of the Second Stage of Labor: How Long is Too Long? Washington State Obstetric Association Annual Meeting, Seattle WA
2016 Periviable Pregnancies: Decision Making Under Uncertainty. Washington State Obstetric Association Annual Meeting, Seattle WA
2017 Management of Fetal Position With and Without Dystocia. Obstetrics, Gynecology, Perinatal Medicine, Neonatology, and the Law. Cabo San Lucas, Mexico
2017 Macrosomia and Induction: Expected Standard of Care. Obstetrics, Gynecology, Perinatal Medicine, Neonatology, and the Law. Cabo San Lucas, Mexico
2017 Prediction and Liability in the Management of Preeclampsia and Eclampsia. Obstetrics, Gynecology, Perinatal Medicine, Neonatology, and the Law. Cabo San Lucas, Mexico
2017 Managing Labor by the New ACOG Guidelines – Why and How? ACOG Recording, Las Vegas, NV
2017 National Healthcare Reform – Obamacare post Obama – Grand Rounds, University of Washintgon, Seattle, WA
2017 Economic Implications of Screening and Treating Diabetes in Pregnancy. Diabetes In Pregnancy Meeting. Barcelona, Spain
2017 Periviable Pregnancies: Decision Making Under Uncertainty – Visiting Professor, Brown University, Providence, RI
2017 Decision and Cost-effectiveness Analysis: An Overview - Visiting Professor, Brown University, Providence, RI
2017 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – The Swanman Lecture, Portland, OR
2017 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – ACOG Annual Meeting, San Diego, CA
2017 National Healthcare Reform - Obamacare Post Obama – Resident Research Day, Mt. Sinai Medical School, New York, NY
2017 Obstetricians and Midwives: No I in Team. Society for OB/Gyn Hospitalists. New Orleans, LA
2017 Forceps Delivery: Lecture and Simulation. Society for OB/Gyn Hospitalists. New Orleans, LA
2017 Physician reimbursement: You get what you incentivize – Association for Maternal-Fetal Medicine Management. Orlando, FL
2017 Improving Maternity Care in Oregon: The Oregon Perinatal Collaborative – Northwest Neonatal Collaborative Annual Summit. Salem, OR
2017 Keynote Speaker - The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions. Australia and New Zealand College of Obstetrics and Gynecology, Annual Meeting, New Zealand
2017 Second Stage of Labor: When to Start and Stop. Australia and New Zealand College of Obstetrics and Gynecology, Annual Meeting, New Zealand
2017 National Healthcare Reform - Obamacare Post Obama – Pacific Coast Obstetric and Gynecologic Society Annual Meeting. Palm Desert, CA
2017 National Healthcare Reform - Obamacare Post Obama – Washington State Obstetrical Association Meeting. Seattle, WA
2017 Periviable Pregnancies: Decision Making Under Uncertainty – William Copeland Lecture, The Ohio State University, Columbus, OH

2017 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – Frederick Zuspan Lecture, The Ohio State University, Columbus, OH
2018 Operative Vaginal Delivery. Obstetrics, Gynecology, Perinatal Medicine, Neonatology, and the Law. Maui, HI
2018 Category II Fetal Heart Rate Tracings. Obstetrics, Gynecology, Perinatal Medicine, Neonatology, and the Law. Maui, HI
2018 Universal Cord Gases – An Opportunity for Quality Improvement. Obstetrics, Gynecology, Perinatal Medicine, Neonatology, and the Law. Maui, HI
2018 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – ACOG Annual Meeting, Austin, TX
2018 Timing of Induction of Labor: Myths, Facts, and Misunderstandings – Connie and Harry Jonas, MD Clinical Seminar - ACOG Annual Meeting, Austin, TX
2018 The Obesity Epidemic – A Big Problem and Getting Bigger – AWHONN Regional Meeting, Seattle, WA
2018 National Healthcare Reform - Obamacare Post Obama – Pediatric Grand Rounds, OHSU, Portland, OR
2018 Improving Care for Moms: The Oregon Perinatal Collaborative. March for Moms, Washington, DC
2018 Screening for Preeclampsia: USPSTF Recommendations. Preeclampsia Think Tank Group. Lago Mar, FL
2018 Medical Management of GDM: An evidence-based approach. Antepartum and Intrapartum Management Course. San Francisco, CA
2018 Second Stage of Labor: When to Start and Stop. OB COAP Mtg. SeaTac, WA
2018 Category II Fetal Heart Rate Tracings. Beecher Carlson Round Table Conference, Los Angeles, CA
2018 Universal Cord Gases – An Opportunity for Quality Improvement. Beecher Carlson Round Table Conference, Los Angeles, CA
2018 Perinatal Collaboratives: Approaches to Reducing Maternal Morbidity and Mortality. PCOGS. Boise, ID
2018 Reducing Disparities in OB Outcomes. ACOG District IX Meeting. Maui, HI
2018 Disparities in GDM Diagnosis and Treatment. ACOG District IX Meeting. Maui, HI
2018 Second Stage of Labor: When to Start and Stop. T. Hart Baker Kaiser OB Conference. San Diego, CA
2018 Obesity in Pregnancy: A Big Problem and Getting Bigger. T. Hart Baker Kaiser OB Conference. San Diego, CA
2018 Protracted and Arrest of Dilatation: Diagnosis, Prognosis and Management. Birth Conference. Venice, Italy
2018 Should Every Woman be Induced at 39 Weeks of Gestation? Birth Conference. Venice, Italy
2018 Second Stage of Labor: Protracted Descent and Arrest: Diagnosis and Management. Birth Conference. Venice, Italy
2019 Second Stage of Labor: When to Start and Stop. – Grand Rounds Albert Einstein Medical School, Montefiore Hospital. Bronx, NY
2019 Periviable Pregnancies: Decision Making Under Uncertainty – NY OB Association. NY, NY
2019 Is Zhang the new Friedman? Controversies in Obstetrics. Society for Maternal-Fetal Medicine Annual Meeting. Las Vegas, NV
2019 Health Economics of GDM. Society for Maternal-Fetal Medicine Annual Meeting. Las Vegas, NV
2019 Second Stage of Labor: When to Start and Stop. USC Perinatal Course. Kuai, HI

2019 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – ACOG Annual Meeting, Nashville, TN
2019 Timing of Induction of Labor: Myths, Facts, and Misunderstandings - ACOG Annual Meeting, Nashville, TN
2019 Second Stage of Labor: When to Start and Stop. Antepartum and Intrapartum Management Course. San Francisco, CA
2019 Second Stage of Labor: When to Start and Stop. University of South Florida Grand Rounds. Tampa, FL
2019 Periviable Pregnancies: Decision Making Under Uncertainty – Washington State AWHONN Annual Conference. Bremerton, WA
2019 Second Stage of Labor: When to Start and Stop. Washington State AWHONN Annual Conference. Bremerton, WA
2020 Periviable pregnancies: Decisions and Ethical Considerations. Obstetrics, Gynecology, Perinatal Medicine, Neonatology, and the Law Conference.
2020 Challenges in the management of the second stage of labor. Obstetrics, Gynecology, Perinatal Medicine, Neonatology, and the Law Conference.
2020 Gestational diabetes: Controversies in guidelines and management. Obstetrics, Gynecology, Perinatal Medicine, Neonatology, and the Law Conference.
2020 Decision and Cost-effectiveness Analysis in MFM. Society for Maternal-Fetal Medicine, Annual Meeting. Grapevine, TX
2020 National Healthcare Reform - Obamacare in the Trump/Covid Era – OB/Gyn Grand Rounds, OHSU, Portland, OR
2020 Decision and Cost-effectiveness Analysis in Obstetrics. Society for Maternal-Fetal Medicine Fellows Retreat, Virtual Meeting
2020 The Department of Obstetrics & Gynecology: Resilience and Resolve During a Global Pandemic. OB/Gyn Grand Rounds, OHSU, Portland, OR
2020 Timing of Induction of Labor: Myths, Facts, and Misunderstandings - ACOG National Virtual Meeting
2020 Timing of Induction of Labor: Is 39 weeks the new 41? Grand Rounds, Massachusetts General Hospital. Boston, MA
2020 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – Grand Rounds, Texas Tech University Grand Rounds
2020 Second Stage of Labor: When to Start and Stop. Grand Rounds, Texas Tech University Grand Rounds
2020 Timing of Induction of Labor: Is 39 weeks the new 41? Grand Rounds, Lehigh Valley Medical Center, Allentown, PA
2020 Economic Efficiency and Cost-Effectiveness Analysis. OHSU/PSU School of Public Health, Portland, OR
2020 Fetal Monitoring in the Second Stage: Practices and Pitfalls. Washington State Obstetric and Gynecologic Association, Virtual Meeting
2021 Med Talks: Timing of Induction of Labor – What to do? Society for Maternal-Fetal Medicine Annual Conference Virtual Meeting
2021 Hypertensive Disorders of Pregnancy. Hillsboro Medical Center. Tualitin, OR
2021 Decision and Cost-effectiveness Analysis: Obstetric Considerations. Society for Maternal-Fetal Medicine Fellows Lecture. Virtual Meeting
2021 Fetal Monitoring in the Second Stage: Practices and Pitfalls. Antepartum and Intrapartum Management Course. San Francisco, CA and Virtual Meeting
2021 Second Stage of Labor: When to Start and Stop. Washington State OB COAP Annual Meeting. Seattle, WA and Virtual Meeting
2021 Fetal Monitoring in the Second Stage: Practices and Pitfalls. Philadelphia Prenatal Care Conference. Philadelphia, PA and Virtual Meeting

2021 Timing of Induction of Labor: Is 39 weeks the new 41? Society for OB/Gyn Hospitalists Annual Meeting, Chicago, IL
2021 Fetal Monitoring in the Second Stage: Practices and Pitfalls. Grand Rounds, Oregon Health & Science University, Portland, OR
2021 Universal Cord Gases – A Quality Improvement Approach. Washington State Obstetric and Gynecologic Association, Seattle, WA
2022 Periviability: What is Important to Consider? Society for Maternal-Fetal Medicine Annual Meeting, Orlando, FL (virtual)
2022 The Cesarean Epidemic: Etiologies, Outcomes, and Potential Solutions – The Tennessee Perinatal Quality Collaborative Annual Meeting, Nashville, TN
2022 Timing of Induction of Labor: Is 39 weeks the new 41? Grand Rounds, SUNY Stonybrook, Long Island, NY (virtual)
2022 Management of Category II Fetal Heart Rate Tracings. Antepartum and Intrapartum Management Course, San Francisco, CA
2023 Periviable Pregnancies: Decision Making Under Uncertainty – Grand Rounds, University of Tennessee (virtual)

CME Courses/Conferences Attended (since 2010)

2010 Society for Maternal-Fetal Medicine, Annual Meeting, Chicago, IL
2010 Antepartum and Intrapartum Management, UCSF CME Course, San Francisco, CA
2010 Pacific Coast OB/Gyn Society, Annual Meeting. HI
2010 Northwest Update, OHSU CME Course, Portland, OR
2011 Society for Maternal-Fetal Medicine, Annual Meeting, San Francisco, CA
2011 Antepartum and Intrapartum Management, UCSF CME Course, San Francisco, CA
2011 Endocrine Conference, OHSU CME Course, Ashland, OR
2011 Developmental Origins of Health and Disease, 7th World Congress, Portland, OR
2011 BIRTH Conference, Chicago, IL
2011 Pacific Coast OB/Gyn Society, Annual Meeting. San Diego, CA
2011 Northwest Update, OHSU CME Course, Portland, OR
2011 Society for Medical Decision Making, Chicago, IL
2011 Robert Wood Johnson Physician Faculty Scholars Annual Meeting, San Diego, CA
2012 Society for Maternal-Fetal Medicine, Annual Meeting, Dallas, TX
2012 Antepartum and Intrapartum Management, UCSF CME Course, San Francisco, CA
2012 American Academy of Family Practice, Portland, OR
2012 Pacific Coast OB/Gyn Society, Annual Meeting. Newport Beach, CA
2012 Northwest Update, OHSU CME Course, Portland, OR
2012 Society for Medical Decision Making, Phoenix, AZ
2013 Society for Maternal-Fetal Medicine, Annual Meeting, San Francisco, CA
2013 Antepartum and Intrapartum Management, UCSF CME Course, San Francisco, CA
2013 ACOG Districts II, V, VIII, IX Annual Meeting, Maui, HI
2013 Pacific Coast OB/Gyn Society, Annual Meeting. Walla Walla, WA
2013 Northwest Update, OHSU CME Course, Portland, OR
2014 Society for Maternal-Fetal Medicine, Annual Meeting, New Orleans, LA
2014 Antepartum and Intrapartum Management, UCSF CME Course, San Francisco, CA
2014 Pacific Coast OB/Gyn Society, Annual Meeting. Dove Mountain, AZ
2014 Northwest Update, OHSU CME Course, Portland, OR
2014 Society for Medical Decision Making, Miami, FL

2014 World Symposium in Perinatal Medicine, San Diego, CA
2015 Society for Maternal-Fetal Medicine, Annual Meeting, San Diego, CA
2015 Antepartum and Intrapartum Management, UCSF CME Course, San Francisco, CA
2015 Pacific Coast OB/Gyn Society, Annual Meeting. Turtle Bay, HI
2015 Northwest Update, OHSU CME Course, Portland, OR
2016 Society for Maternal-Fetal Medicine, Annual Meeting, Atlanta, GA
2016 Antepartum and Intrapartum Management, UCSF CME Course, San Francisco, CA
2016 Pacific Coast OB/Gyn Society, Annual Meeting. Sun Valley, ID
2016 Northwest Update, OHSU CME Course, Portland, OR
2017 Society for Maternal-Fetal Medicine, Annual Meeting, Las Vegas, NV
2017 Antepartum and Intrapartum Management, UCSF CME Course, San Francisco, CA
2017 Pacific Coast OB/Gyn Society, Annual Meeting. Palm Desert, CA
2018 Society for Maternal-Fetal Medicine, Annual Meeting, Dallas, TX
2018 Antepartum and Intrapartum Management, UCSF CME Course, San Francisco, CA
2018 Pacific Coast OB/Gyn Society, Annual Meeting. Coer D'Alene, ID
2019 Society for Maternal-Fetal Medicine, Annual Meeting, Las Vegas, NV
2019 Antepartum and Intrapartum Management, UCSF CME Course, San Francisco, CA
2019 Pacific Coast OB/Gyn Society, Annual Meeting. San Diego, CA
2020 Society for Maternal-Fetal Medicine, Annual Meeting, Grapevine, TX
2020 Pacific Coast OB/Gyn Society, Annual Meeting – Virtual Meeting
2021 Society for Maternal-Fetal Medicine, Annual Meeting, Virtual
2021 Antepartum and Intrapartum Management, UCSF CME Course, San Francisco, CA / Virtual
2021 Pacific Coast OB/Gyn Society, Annual Meeting – Virtual Meeting
2022 Society for Maternal-Fetal Medicine, Annual Meeting, Virtual
2022 Antepartum and Intrapartum Management, UCSF CME Course, San Francisco, CA

TEACHING and MENTORING
Formally Scheduled Classes for UCSF Students:

Acad Qtr	*Year*	*Number and Title*	*Nature of Contribution*	*Annual Hours*	*Class Size*
Win	2003	Dec. and Cost-Effec. Anal	Lecturer/Section Leader	60	15
Fall	2003	CNM Training Program	Lecturer	10	15
Win	2004	Life Cycle	Section Leader	10	14
Win	2004	Dec. and Cost-Effec. Anal	Section Leader	60	15
Fall	2004	U Teach – Obstetrics	Lecturer	10	50
Fall	2004	CNM Training Program	Lecturer	10	15
Win	2005	Life Cycle	Section Leader	20	14
Fall	2005	U Teach – Obstetrics	Lecturer	10	50
Fall	2005	CNM Training Program	Lecturer	10	15
Win	2006	Dec. and Cost-Effec. Anal	Section Leader	60	15
Win	2006	Life Cycle	Section Leader	40	14
Fall	2006	U Teach – Obstetrics	Lecturer	10	50
Win	2007	Life Cycle	Section Leader	40	14
Fall	2007	U Teach – Obstetrics	Lecturer	10	50
All	07-08	PISCES	Mentor / Advisor	120	2

Win	2008	Life Cycle	Section Leader	40	14
Fall	2008	U Teach – Obstetrics	Lecturer	10	50
All	08-09	PISCES	Mentor / Advisor	120	2
Win	09-10	Dec. and Cost-Effec. Anal	Course Co-Director	120	40

Formally Scheduled Classes for OHSU Students:

Fall	2011	Principles in Clinical Medicine	Discussion Leader	40	14
Win	2011	Healthcare Policy	Discussion Leader	40	11
Spr	2012	Finance 514 – Health Economics	Course Director	100	40
Win	2012	Healthcare Policy	Discussion Leader	40	15
Win	2012	Epidemiology & Biostatistics	Discussion Leader	40	14
Spr	2013	Finance 514 – Health Economics	Course Director	100	40
Win	2013	Healthcare Policy	Course Cmte / Leader	40	15
Win	2013	Epidemiology & Biostatistics	Discussion Leader	40	14
Spr	2014	Finance 514 – Health Economics	Course Director	100	35
Fall-S	2014-15	Surgical Subspecialities College	Lead	120	50
Spr	2015	Finance 514 – Health Economics	Course Director	100	40
Fall-S	2015-16	Surgical Subspecialities College	Lead	120	70
Spr	2016	Finance 514 – Health Economics	Course Director	100	40
Fall-S	2016-17	Surgical Subspecialities College	Lead	120	70
Spr	2017	Finance 514 – Health Economics	Course Director	100	40
Fall-S	2017-18	Surgical Subspecialities College	Lead emeritus	60	70
Spr	2018	Finance 514 – Health Economics	Course Director	80	40
Spr	2019	Finance 514 – Health Economics	Course Director	80	40
Spr	2020	Finance 514 – Health Economics	Course Director	80	40
Spr	2021	Finance 514 – Health Economics	Course Director	80	35
Sum	2022	Finance 514 – Health Economics	Course Director	80	35

Lecturer in Postgraduate Courses Sponsored by UCSF/OHSU:

2004 What's Hot in Ob/Gyn
2004 Antepartum and Intrapartum Management
2004 Obstetrics and Gynecology Update: What Does the Evidence Show?
2005 What's Hot in Ob/Gyn
2005 Antepartum and Intrapartum Management
2005 Obstetrics and Gynecology Update: What Does the Evidence Show?
2006 Antepartum and Intrapartum Management
2006 Obstetrics and Gynecology Update: What Does the Evidence Show?
2007 Antepartum and Intrapartum Management
2007 Obstetrics and Gynecology Update: What Does the Evidence Show?
2008 Antepartum and Intrapartum Management (Course Co-Director)
2008 Obstetrics and Gynecology Update: What Does the Evidence Show?
2009 Antepartum and Intrapartum Management (Course Co-Director)
2010 Antepartum and Intrapartum Management (Course Co-Director)
2011 Antepartum and Intrapartum Management (Course Co-Director)

2011	The Northwest Update in Obstetrics and Gynecology (Course Co-Director)
2012	Antepartum and Intrapartum Management (Course Co-Director)
2012	The Northwest Update in Obstetrics and Gynecology (Course Co-Director)
2013	Antepartum and Intrapartum Management (Course Co-Director)
2013	The Northwest Update in Obstetrics and Gynecology (Course Co-Director)
2014	Antepartum and Intrapartum Management (Course Co-Director)
2014	The Northwest Update in Obstetrics and Gynecology (Course Co-Director)
2015	Antepartum and Intrapartum Management (Course Co-Director)
2015	The Northwest Update in Obstetrics and Gynecology (Course Co-Director)
2016	Antepartum and Intrapartum Management (Course Co-Director)
2016	The Northwest Update in Obstetrics and Gynecology (Course Co-Director)
2017	Antepartum and Intrapartum Management (Course Co-Director)
2017	The Northwest Update in Obstetrics and Gynecology (Course Co-Director)
2018	Antepartum and Intrapartum Management (Course Co-Director)
2018	The Northwest Update in Obstetrics and Gynecology (Course Co-Director)
2019	Antepartum and Intrapartum Management (Course Co-Director)
2019	The Northwest Update in Obstetrics and Gynecology
2020	Antepartum and Intrapartum Management (Course Co-Director)
2020	The Northwest Update in Obstetrics and Gynecology
2021	Antepartum and Intrapartum Management (Course Co-Director)
2022	Antepartum and Intrapartum Management (Course Co-Director)
2023	Antepartum and Intrapartum Management (Course Co-Director)

Predoctoral Students Supervised in Research		*Current Position and Title*
2002-2003	Christie del Castillo, UCSF Medical Student	Assistant Professor, Emergency Medicine, UNM
2003-2006	Jeff Lee, UCSF Medical Student	Resident, Pediatrics, L.A. Children's Hospital
2004-2006	Kier Van Remoortere, UCSF Medical Student	Resident, OB/Gyn, UCSF Attending Physician
2004-2015	Sarah Little, UCSF Medical Student	Resident, OB/Gyn, Harvard Fellow, MFM, Brigham Assoc Prof, MFM, Brigham
2005-2007	Cynthia Chen, UCSF Medical Student	Resident, Derm, UCSF
2005-2010	Margaret Sullivan, UCSF Medical Student	Resident, OB/Gyn, NC Faculty, Ashville, NC
2006-2008	Amy Shah, UCSF Medical Student	Resident, OB/Gyn, UCLA REI Fellow
2006-2014	Dana Myers Henry, UCSF Medical Student	Resident, OB/Gyn, Harvard Fellow, MFM, UCSF
2006-2010	Rachel Ruskin, UCSF Medical Student	Resident, OB/Gyn, UCSF Fellow, Gyn Onc, U OK
2007-2010	Nancy Tran, Mills post-baccalaureate student	Medical Student, UVM Resident, Peds, OHSU
2007-2015	Luchin Wong, Albert Einstein Medical Student	Resident, OB/Gyn, SCVMC

		Fellow, MFM, Utah Attending MFM, Seattle
2007-2016	Jasmine Lai, UCSF Medical Student	Resident, OB/Gyn, UCSD MFM Fellow, UW Attending MFM, San Diego
2007-2010	Nina de Lacy, UCSF Medical Student	Resident, UW
2007-2018	Teresa Sparks, UCSF Medical Student	Resident, OB/Gyn, Harvard MFM-Genetics Fellow, UCSF WRHR K12 Scholar, UCSF Assoc. Prof, MFM Fellow Dir.
2008-2013	Karla Solheim, UCSF Medical Student	Resident, University of Iowa
2008-2010	Monica Young, UCSF Medical Student	Resident, UCLA
2008-2017	Marina Stasenko, Cornell Medical Student	Resident, U Michigan Gyn/Onc Fellow Cornell
2008-2017	Amanda Yeaton-Massey, UCSF Medical Student	Resident, Stanford MFM Fellow, Stanford Attending MFM, UCSF
2008-2010	Sinae Vogel, UCSF Medical Student	Resident, UCSF
2008-2011	Jillian Main, UI, Chicago Medical Student	Resident, Kaiser, SF Attending Physician, Kaiser
2008-2010	Mariam Naqvi, UCI Medical Student	Resident, Stanford MFM Fellow, MGH
2008-2010	Jed Wolpaw, UCSF Medical Student	Resident, ED
2008-2011	Stephanie Handler, SFSU post-bacc student	Medical Student, UC Davis Resident, Cedars Sinai
2008-2011	Jesus Granados, SFSU post-bacc student	Medical Student, UCSF
2008-2010	Chris Jones, UCSF Medical Student	Resident, UCSF
2009-2011	Geri Ottaviano, UCSF Medical Student	Resident, Harvard
2009-2017	Christina Penfield, UCI Medical Student UC, Berkeley, MPH	Resident, Cedars Sinai MFM Fellow, UC Irvine Attending MFM, Cedars Sinai
2009-2010	Baotram Nguyen, UCSF Medical Student	Resident, Kaiser, SF
2010-2015	Michelle Meyer, Mills post-bacc student	Medical Student, UCSF
2010-2013	Mika Ohno, UCSF Medical Student	Resident, Stanford
2010-2012	Katie Volpe, OHSU Medical Student	Resident, UNM Fellow, Uro Gyn
2011-2022	Rachel Pilliod, OHSU Medical Student	Resident, Harvard, Brigham/MGH MFM Fellow, OHSU Assistant Professor, OHSU
2011-2014	Keenan Yanit, OHSU Medical Student	Resident, OHSU Assistant Professor, OHSU
2011-2019	Jessica Page, OHSU Medical Student	Resident, University of Utah MFM Fellow, Utah Assistant Professor, U. of Utah
2011-2014	Merritt Hoover, OHSU Medical Student	Resident, Kaiser, Santa Clara
2012-2014	Jessica Fowler, OHSU Medical Student	Resident, UCLA / Physician

2012-2014	Jenna Emerson, OHSU Medical Student	Resident, Brown Gyn/Onc Fellow, Brown Assistant Professor, OHSU
2012-present	Allison Allen, OHSU Medical Student	Resident, OHSU MFM Fellow, OHSU Assistant Professor, Univ of Iowa Assistant Professor, OHSU
2012-2018	Emily Griffin, OHSU Medical Student	Resident, OHSU / Physician Assistant Professor, OHSU
2013-2018	Teresa Worstell, OHSU Medical Student	Resident, OHSU
2013-present	Brenda Niu, OHSU Medical Student	Resident, U of Wisconsin
2013-present	Vanessa Lee, OHSU Medical Student	Resident, OHSU, Fellow OHSU
2013-present	Britta Ameel, OHSU Medical Student	Resident, OHSU
2013-2015	Alison Uyemura, OHSU Medical Student	Resident, Baylor
2013-2018	Nancy Nguyen, OHSU Medical Student	Resident, Kaiser, Oakland
2013-2015	Margaret Gorman, OHSU Medical Student	Resident, Virginia Carillon
2013-2018	Amy Dorius, OHSU Medical Student	Resident, Pennsylvania Hospital
2013-2015	Joseph Kent, OHSU Medical Student	Resident, Brown Resident, Northwestern
2013-2015	Sierra Jansen, OHSU Medical Student	Resident, University of Wisconsin
2014-2022	Francis Hacker, OHSU Medical Student	Resident, UPMC – Magee Fellow, MFM - Magee
2014-2016	Phoebe Smitasin, OHSU Medical Student	Resident, U Rochester
2014-2016	Molly Wilson-Smith, OHSU Medical Student	Resident, UT San Antonio
2014-2016	Thomas Brennan, OHSU Medical Student	Resident, OHSU
2014-2018	Alexis Fields, U of O Student	Medical Student,
2014-2017	Leah Savitsky, OHSU Medical Student	Resident, UW
2014-2016	Courtney Simpson, OHSU Medical Student	Resident, U Conn
2015-2017	Lindsey Pearson, OHSU Medical Student	Resident, Fam Med, CO
2015-2017	Whitney Humphrey, OHSU Medical Student	Resident, University of Michigan
2015-2017	Kayli Senz, OHSU Medical Student	Resident, OB Gyn
2015-2016	Miranda Merrill, OHSU Medical Student	Resident, Internal Medicine, CO
2015-2023	Ashley Skeith, OHSU Medical Student	Resident, U Michigan
2015-2022	Marissa Luck, OHSU Medical Student	Resident, Northwestern Fellow, REI, OHSU
2015-present	Rosa Speranza, OHSU Medical Student	Resident, U Penn Fellow, MFM Utah
2016-present	Emily Clennon, OHSU Medical Student	Resident, Urology
2016-present	Alyssa Hersh, OHSU Medical Student	Resident, OHSU
2016-present	Karen Scrivner, OHSU Medical Student	Resident, Kaiser, SF
2016-2022	Kim Bullard, OHSU Medical Student	Resident, OHSU
2016-2021	Scott Hoffman, OHSU Medical Student	Resident, OHSU
2016-2018	Catherine John, OHSU Medical Student	Resident, U of Utah
2016-2019	Suzy Funkhouser, OHSU Medical Student	Resident, OHSU
2016-2021	Allison Walker, OHSU Medical Student	Resident, U Vermont
2016-2018	Ruth Hickok, OHSU Medical Student	Resident,

2016-2022	Louisa Chatroux, OHSU Medical Student	Resident, OHSU
2017-2019	Michelanne Shields, OHSU Medical Student	Resident, Utah
2017-present	Carmen Avram, OHSU Medical Student	Resident, Duke
2017-2021	Clarice Zhou, OHSU Medical Student	Resident, Pennsy
2017-2021	Zoe Frank, OHSU Medical Student	Resident, Maricopa, AZ
2017-present	Beth Waites, OHSU Medical Student	Resident, Kaiser, SF
2017-2022	Dagnie Howard, OHSU Medical Student	Resident, Univ. Ariz
2018-present	Claire Packer, OHSU Medical Student	Same
2018-present	Sonya Fabricant, OHSU Medical Student	Resident,
2018-present	Sarah Owens, OHSU Medical Student	Resident, Stanford
2019-present	Sarina Chaiken, OHSU Medical Student	Same
2019-present	Brooke Mischkot, OHSU Medical Student	Resident
2019-present	Marguerite Zimmerman, OHSU Medical Student	Same
2019-present	Arianna Robin, OHSU Medical Student	Same
2019-present	Eleanor Schmidt, OHSU Medical Student	Resident, OHSU
2019-2021	Gabe Franta, OHSU Medical Student	Resident, UW
2019-2022	Alicia Christenson, OHSU Medical Student	Same
2020-present	Hannah Bacheller, OHSU Medical Student	Resident,
2020-present	Uma Doshi, OHSU Medical Student	Same
2020-present	Miriam Hernandez-Zepeda, OHSU Medical Student	Resident, OHSU
2020-present	Afsoon Ghafari, OHSU Medical Student	Same
2021-present	Isabel Katlaps, OHSU Medical Student	Same
2021-present	Olivia Curl, OHSU Medical Student	Same
2021-present	Sarah Dzubay, OHSU Medical Student	Same
2022-present	Helen Samuel, OHSU Medical Student	Same
2022-present	Ava Mandelbaum, OHSU Medical Student	Same
2022-present	Lila Hawkinson, OHSU Medical Student	Same
2022-present	Megha Arora, OHSU Medical Student	Same

Postdoctoral Fellows and Residents Supervised in Research ***Current Position and Title***

2001-2005	Naomi Stotland, MD – HCP Fellow	Assistant Professor WRHR Scholar, UCSF
2002-2003	Julie Livingston, MD – OB/Gyn Resident	Attending Physician, SCVMC
2002-2006	Andrea Fick, MD – MFM Fellow	Assistant Professor University of Iowa
2003-2004	Carolyn Cruz, MD – OB/Gyn Resident	Attending Physician, SCVMC
2003-2005	Alea Angeja, MD – OB/Gyn Resident	Attending Physician, Kaiser
2003-2010	Brian Shaffer, MD – OB/Gyn Resident / MFM Fellow / Genetics Fellow	Assistant Professor, UCSF Associate Professor, OHSU
2003-2006	Linda Hopkins, MD – MFM Fellow	Assistant Professor, UCSF Private MFM, Ashland,OR
2003-2006	Yvonne Cheng, MD, MPH - MFM Fellow	Assistant Professor, UCSF WRHR Scholar, UCSF Attending Physician, CPMC
2004-2006	G. Iram Qidwai, MD – OB/Gyn Resident	Attending Physician

		Kaiser Walnut Creek
2004-2006	Gladys Ramos, MD – OB/Gyn Resident	MFM Fellow, UCSD Associate Professor, UCSD
2004-2012	Tania Esakoff, MD – OB/Gyn Resident	MFM Fellow, UCSF Assistant Professor, Cedars-Sinai
2004-2010	Katherine Bianco, MD – MFM/Genetics Fellow	Assistant Professor, UCSF Associate Professor, Stanford
2004-2010	Natali Aziz, MD, MPH – MFM/ID Fellow	Assistant Professor, Stanford
2005-2007	G. Blake McLaughlin, MD – OB/Gyn Resident	Attending Physician, Travis Air Force Base
2005-2006	Anjali Rao, MD – OB/Gyn Resident, Stanford	Attending Physician, Kaiser
2005-2007	Tina O. Tan, MD – OB/Gyn Resident	Attending Physician, Kaiser
2005-2010	Mara Greenberg, MD – OB/Gyn Resident	MFM Fellow, Stanford Attending Physician, Kaiser
2006-2010	Shani Delaney, MD – OB/Gyn Resident	MFM Fellow, UW Assistant Professor, UW
2006-2010	Sierra Washington, MD – OB/Gyn Resident	Assistant Professor, Indiana University; Albert Einstein University
2006-2012	Angie Child, MD – OB/Gyn Resident	MFM/Genetics Fellow BIRCWH K12 Scholar, Johns Hopkins
2006-2012	Anjali Kaimal, MD – MFM Fellow	Assistant Professor, Massachusetts General Hosp. MFM Division Chief, MGH
2007-2010	Lena Kim, MD – MFM Fellow	Assistant Professor, UCSF Attending Physician, CPMC
2007-2010	Ngoc Phan, MD – OB/Gyn Resident	Attending Physician, Kaiser
2007-2010	Nami Jhaveri, MD, MPH – Neonatology Fellow	Attending Physician, Kaiser
2007-2012	Tim Bruckner, PhD – Epidemiology post-doc	Assistant Professor, UCI
2008-2013	Melissa Rosenstein, MD – OB/Gyn Resident	MFM Fellow, UCSF K-12 Scholar, UCSF
2008-2010	Ayaba Worjoloh, MD – OB/Gyn Resident	Fellow, Global Health, Duke
2008-2010	Jin Chang, DO – MFM Fellow	Attending Physician, SCVMC
2009-2014	Maria Isabel Rodriguez, MD – Family Planning Fellow	Fellow, WHO; Assistant Professor, OHSU WRHR Scholar, OHSU Associate Professor, OHSU
2009-2011	Clara Ward, MD, MS – MFM Fellow	ICU Fellow, U Cincinatti Assistant Professor, UT Houston
2010-2013	Kirsten Salmeen, MD – MFM Fellow	Assistant Professor, UCSF
2010-present	Nicole Marshall, MD, MS - MFM Fellow	Assistant Professor, OHSU KL2/KO1 Scholar, OHSU Associate Professor, OHSU
2010-2013	Elizabeth Brass, MD – MFM Fellow	Attending Physician, Kaiser, NW
2010-2014	Kimberly Ma, MD - OB/Gyn Resident	MFM Fellow, UW / Attending

2010-2012	Ashlie Tronnes, MD – OB/Gyn Resident	MFM Fellow, UW / Attending Physician
2010-2017	John Mission, MD – OB/Gyn Resident	MFM Fellow, U. Pittsburgh
2010-2014	Brian Nguyen, MD – OB/Gyn Resident	Fellow, Family Planning, U. Chicago
2011-2014	Amy Doss, MD – MFM Fellow	Attending Physician, Legacy
2012-2020	Jamie Lo, MD – MFM Fellow	Associate Professor, OHSU
2013-2018	Jennifer Salati, MD – MFM Fellow	Assistant Professor, OHSU
2013-2020	Bethany Sabol, MD – OB/Gyn Resident	MFM Fellow, Wash U Assistant Professor, U Minn
2014-2018	Rita Sharshiner, MD – MFM Fellow	Assistant Professor, OHSU
2014-2018	Alyson Guillet, MD – OB/Gyn Resident	Attending Physician
2015-2019	Kelly Kuo, MD – MFM Fellow	Assistant Professor, OHSU
2015-2018	Megan Cohen, MD – OB/Gyn Resident	Global Health Fellow
2015-2019	Annessa Kernberg, MD – OB/Gyn Resident	Fellow, Washington U Fellow, OHSU
2015-2019	Ruofan Yao – MFM Fellow	Attending, Loma Linda
2016-2019	Christina Megli, OB/Gyn Resident	MFM Fellow, U. Pittsburgh
2016-2022	Rachel Pilliod, MD – MFM Fellow	Assistant Professor, OHSU
2016-2020	James Sargent, MD – MFM Fellow	Assistant Professor, UTH
2018-2021	Abbie Vinson, MD – MFM Fellow	Private Practice, Tacoma
2018-2021	Sydney Thayer, MD – OB/Gyn Resident	MFM Fellow, Wash U
2019-2022	Duncan Harmon, MD – MFM Fellow	Attending MFM, Boise, ID
2019-present	Jackie Powell, MD – OB/Gyn Resident	Same
2019-present	Osii Mbata, MD – OB/Gyn Resident	Same
2019-present	Alexis Fields, DO – MFM Fellow	Same

Faculty Mentored ***Current Position and Title***

2005-2010	Naomi Stotland, MD	WRHR Scholar, SFGH OB/Gyn Assistant Professor, UCSF
2006-2014	Yvonne Cheng, MD, MPH, PhD	Maternal-Fetal Medicine Associate Professor, UC Davis
2006-2009	Lee-May Chen, MD	Gynecologic Oncologist, Associate Clinical Professor UCSF Division Director
2007-2013	Donna Halloran, MD, MPH	General Pediatrics Assistant Professor St. Louis University
2007-2009	Sharon Knight, MD	Urogynecologist, Assistant Clinical Professor UCSF
2009-2020	Brian Shaffer, MD	Maternal-Fetal Medicine Assistant Professor OHSU

2010-2013	Erika Cottrell, MPP, PhD	Sociologist Assistant Professor OHSU
2010-present	Maria Rodriguez, MD, MPH	Family Planning Specialist WHO Fellow Assistant Professor, OHSU WRHR Scholar Associatte Professor, OHSU Professor, OHSU Director, Center for Women's Health
2011-2017	Jonathan Snowden, PhD	Epidemiologist Assistant Professor OHSU K99/R00 awardee
2011-present	Nicole Marshall, MD, MCR	Maternal-Fetal Medicine Assistant Professor OHSU K awardee Associate Professor Assistant Division Head, MFM Division Head, MFM
2012-present	Ellen Tilden, CNM, PhD	Assistant Professor, OHSU K awardee
2012- 2017	Blair Darney, MPH, PhD	Assistant Professor, OHSU Mexico, Dept of Public Health
2013-2017	Richard Burwick, MD, MPH	Assistant Professor, OHSU Assistant Professor, Cedars Si
2014-2019	Willi Horner-Johnson, PhD	Assistant Professor, OHSU K awardee
2014-2016	Janne Boone-Heinonen, PhD	Assistant Professor, OHSU K awardee
2015-2021	Kathleen Brookfield, MD, PhD	MFM Assistant Professor, OHSU
2015-present	Amanda Bruegl, MD	Gyn Oncology Assistant Professor, OHSU K Awardee
2015-present	Amy Valent, DO	MFM Assistant Professor, OHSU WRHR K12 Scholar MFM Fellowship Director Associate Professor, OHSU
2018-present	Amy Hermesch, MD, PhD	MFM Assistant Professor, OHSU Vice-Chair, OHSU
2019-present	Karen Gibbins, MD	MFM

		Assistant Professor, OHSU WRHR K12 Scholar
2021-present	Andrew Chon, MD	MFM / Fetal Surgeon Assistant Professor, OHSU
2022-present	Ross Harrison, MD	Gyn / Onc Assistant Professor, OHSU

Teaching Awards:

1996	Outstanding Teacher of Obstetrics & Gynecology, Harvard Medical School
1997	Outstanding Teacher of Obstetrics & Gynecology, Harvard Medical School
1998	Outstanding Teacher of Obstetrics & Gynecology, Harvard Medical School
2000	Excellence in Clinical Education Award, Harvard Medical School
2004	Outstanding Academic Faculty, Department of OB/Gyn, UCSF
2004	Outstanding Graduate Student Instructor, UC Berkeley, School of Public Health
2005	Nominated: Small Group Instructor Teaching Award, UCSF School of Medicine
2005	Nominated Outstanding Graduate Student Instructor, UC Berkeley
2005	Outstanding Resident Teaching Award, Department of OB/Gyn, UCSF
2006	Excellence in Medical Student Teaching Award, Department of OB/Gyn, UCSF
2006	Outstanding Resident Teaching Award, Department of OB/Gyn, UCSF
2006	Essential Core Teaching Award – Best Small Group Instructor UCSF School of Medicine
2007	Nominated: Small Group Instructor Teaching Award, UCSF School of Medicine
2007	Outstanding Resident Teaching Award, Department of OB/Gyn, UCSF
2008	Outstanding Academic Faculty, Department of OB/Gyn, UCSF
2009	Henry J. Kaiser Teaching Award – Best Teacher in Ambulatory Care Setting, UCSF
2009	Outstanding Resident Teaching Award, Department of OB/Gyn, UCSF
2010	Excellence in Medical Student Teaching Award, Department of OB/Gyn, UCSF
2010	Outstanding Resident Teaching Award, Department of OB/Gyn, UCSF
2014	Class Speaker, OHSU Medical School Graduating Class, OHSU
2015	Faculty Award – OHSU Student Council
2017	Outstanding Contribution to the Colleges, OHSU
2019	Honored CME Educator Award – OHSU
2020	Medical Research Foundation of Oregon Mentor Award

Teaching Aids:

These are formally listed below under book publications:

1. **Blueprints in Obstetrics and Gynecology (co-author)** – This book, designed for third and fourth year medical students, is a leading seller of OB/Gyn review books. It is in its seventh edition.
2. **Clinical Cases (series editor / author)**: This eight book series (Medicine, Surgery, OB/Gyn, Pediatrics, Family Medicine, Emergency Medicine, Psychiatry, and Neurology) is designed to teach clinical medicine to third and fourth year medical students using case-driven examples. The series is now in its second edition.

3. **Notes and Cases (series editor / author)**: This eight book series covers all of the basic science topics including biochemistry, physiology, pathophysiology, genetics, pharmacology, microbiology, immunology, neuroscience, psychology, epidemiology, and biostatistics. It is designed to teach the basic sciences to first and second year medical students using case-based material. This series is now in its second edition.

Teaching and Mentoring Narrative:
I continue to teach medical students, residents, and fellows in a variety of ways. These include formal education through lectures and small group learning, clinical education both on labor and delivery and in the diabetes, high-risk, and resident clinics, and through mentorship of research projects. I serve as the lead or research mentor for medical students, residents, fellows, and junior faculty across the country.

Research Support:

ACTIVE SUPPORT

5 U58 DP006358 (Caughey) 9/30/17-6/30/23 0.6 calendar months
CDC $199,938/yr direct
Role: PI
Project title: **Oregon Perinatal Collaborative**
This project is to develop and expand a state-based Perinatal Quality Collaborative in Oregon with goals to include all of the hospitals that provide obstetric care in Oregon.

5 U58 DP006358 Supplement (Caughey) 7/01/21-6/30/23 0.6 calendar months
CDC $140,000/yr
Role: PI
Project title: **COVID supplement to the Perinatal Quality Collaboratives**
This project is to impact the prevention and treatment of COVID in pregnancy in Oregon.

1K12HD085809 (Caughey) 7/01/20-6/30/25 1.2 calendar (WOS)
NIH/NICHD $314,000/yr direct
Role: PI
Project title: **OHSU Women's Reproductive Health Research K12 Program**
This is a career development program to develop Obstetrician/Gynecologists into career clinical and translational scientists.

R01HD055651 (Wapner) 9/1/18-8/31/23 0.60 calendar
NIH / NICHD $95,613 (OHSU Direct Costs)
Role: Co-I
Project Title**: Prenatal Genetic Diagnosis by Genomic Sequencing: A Prospective Evaluation**
The goal of this study is to conduct whole genome sequencing in a cohort of prenatally diagnosed fetuses with congenital anomalies and to examine clinical and economic outcomes of the cohort.

R01MD013648 (Rodriguez) 1/1/19-12/31/23 1.20 calendar
NIH / NIMHD $1,348,749 (OHSU Direct Costs)
Role: Co-I

Project Title**: The impact of Emergency Medicaid policy on reproductive health disparities among new immigrants**
The goal of this study is to examine the impact of changes in Medicaid policy and funding on the outcomes, particularly focused on obstetric outcomes, of immigrant populations and their offspring.

1R01DK124806 (Phelan/Redman) 5/15/20-4/30/25 0.6 calendar months
NIH/NIDDK $494,531/yr direct
Role: Co-I
Project title: **Promoting fat loss during pregnancy in women with grade 2 and 3 obesity**
The focus of this project is to examine the impact of lifestyle modifications on obese women during pregnancy in terms of fat mass, fetal growth, and other perinatal outcomes.

U01 CA232819 (Spellman) 6/30/20-7/1/25 0.6 calendar months
NHGRI $1,000,000/yr direct
Role: co-I
Project title**: Approaches to Identify and Care for Individuals with Inherited Cancer Syndromes**
This multi-center cohort study examines different screening approaches to identifying individuals with BOC or Lynch syndrome and the cost-effectiveness of these approaches.

EPC – RFTO #43 6/1/22-12/31/23 0.6 calendar months
AHRQ
Role: Co-I
Project title: **Respectful Maternity Care: Dissemination and Implementation of Perinatal Safety Culture Training to Improve Equitable Maternal Healthcare Delivery and Outcomes**
This project was designed to better understand perinatal safety culture on labor and delivery units.

AHA (Tita) 7/1/22-6/30/24 0.6 calendar months
Role: Co-I
Project title: P3 (Pregnancy and Postpartum/Preconception) EQUATE (Enhancing Access and Quality to Achieve Equitable Maternal and Infant Health Network)
This project is focused on decreasing disparities in maternal and child health.

PENDING SUPPORT

R01 (Phillipi) 9/01/21-8/31/26 1.2 calendar months
NICHD $500,000/yr direct
Role: co-I
Project title**:**
This study was designed to examine the impact of labor curves on common obstetric outcomes.

R40 (Caughey) 04/01/21–03/31/22 1.2 calendar months
Health Resources and Services Administration $100,000 direct/yr
Role: co-I
Title: **Prevention of the Primary Cesarean: Impact of a Statewide Program**
The major goals of this project are to examine the impact of a statewide program in Oregon designed to reduce the primary cesarean delivery rate.

PAST SUPPORT

5 U58 DP006358 Supplement (Caughey) 9/01/19-6/30/22 0.6 calendar months
CDC $100,000/yr
Role: PI
Project title: Opioid use disorders supplement to the Perinatal Quality Collaboratives
This project is to impact the diagnosis and management of opioid use disorders in pregnancy in Oregon.

U01 HD077384 (Cahill/Tuuli) 8/01/14-12/31/22 1.8 calendar months
NIH/NICHD $1,050,000/yr direct
Role: OHSU site PI
Project title: **Optimizing Management of the Second Stage of Labor in Nulliparous and Multiparous Women: a Multicenter Randomized Controlled Trial**
The focus of this project is to determine the impact of delayed pushing in the second stage of labor. This prospective, randomized, controlled trial has four sites and will be the largest study to examine this question.

R01 HD084282 (Phelan) 4/1/16-8/31/21 0.6 calendar months
NIH/NIDDK $500,000/yr direct
Role: Co-I
Project title: **Prevention of gestational diabetes through lifestyle modification before pregnancy**
The focus of this project is to examine the impact of lifestyle modifications on women who become pregnant and ascertain whether the rate of gestational diabetes can be reduced.

1R01HD086007-01A1 (Tuuli) 9/1/16-8/31/21 0.84 calendar
NIH / NICHD $21,613 (OHSU Direct Costs)
Role: Co-I
Project Title**: Prophylactic Negative Pressure Wound Therapy in Obese Women at Cesarean: Multicenter Randomized Trial "CS-NPWT"**
The goal of this study is high-quality evidence on the effectiveness, safety and cost-effectiveness of prophylactic NPWT in reducing SSIs after cesarean in obese women.

University Venture Development Fund (Tilden) 6/1/20-5/31/21 0.6 WOS
Role: Co-I
Project Title: **Preventing Postpartum Depression: Combining Content Delivery and Data Capture.**
The goal of this study is to examine the use of digital health technology to screen and prevent postpartum depression.

UO1 (Frias) 09/1/15-8/31/20 0.12 calendar months
NIH $756,000/yr direct
Role: Co-I
Project Title: **Non-invasive imaging tools for detecting abnormally functioning placentas**
This project has both an animal and human component to develop imaging tools to examine placental function.

R01 HD086331-01 (Frias) 9/01/15-8/31/20 0.12 calendar

NIH/NICHD $323,294
Role: Co-I
Development and validation of MR imaging methods for *in vivo* assessment of placental perfusion and oxygenation
The goal of this proposal is to develop and validate advanced noninvasive magnetic resonance imaging protocols for the *in vivo* assessment of placental perfusion and oxygenation. This imaging modality has the potential to improve the clinical management and early identification of pregnancies at-risk for placental insufficiency

1K12HD085809 (Caughey) 7/01/15-6/30/20 1.2 calendar (WOS)
NIH/NICHD $310,000/yr direct
Role: PI
Project title: **OHSU Women's Reproductive Health Research K12 Program**
This is a career development program to develop Obstetrician/Gynecologists into career clinical and translational scientists.

R01 (Newgard) 7/01/15-6/30/19 0.6 calendar months
NIH/NIA $500,000/yr direct
Role: Co-I
Project title: **Evaluating Out-of-Hospital Triage for Older Adults with Traumatic Brain Injury**
The focus of this project is to examine different pathways for trauma triage in the setting of traumatic brain injury.

5U01HG006500 (Green) 12/1/14-11/30/17 0.12 calendar
NIH/NHGRI $498,000/yr direct
Role: Co-I
Project title: **Cost Analysis of Whole Genome Sequencing in the MedSeq Project**
This project focuses on quantifying costs of whole gene sequencing for the parent cohort study.

SMFM Health Policy Award (Pilliod) 2/1/17 – 1/31/18 0.6 calendar (WOS)
Society for Maternal-Fetal Medicine $25,000 direct
Role: Co-I
Project Title: **Impact of Medicaid Expansion on Perinatal Outcomes**
The focus of this project is to examine changes in Medicaid funding changes on a state level on prenatal and postpartum care and potential downstream outcomes.

R01 (Dublin / Getahun) 8/01/13-7/31/17 1.8 calendar months
NIH/NICHD $480,000/yr direct
Role: site PI
Project title: **Elective Induction of Labor and Pregnancy Outcomes**
The focus of this project is on identifying the effect of induction of labor on mode of delivery, maternal morbidity, and neonatal outcomes utilizing the appropriate comparisons of expectant management vs. induction of labor in mature HMO populations.

Research Core Pilot Award (Caughey) 4/01/17-6/30/17 0.6 calendar months (WOS)
OHSU $5,000/yr direct
Role: PI
Project title: **Developing a Multicenter Trial for Antibiotic Prophylaxis for Cesarean Delivery**

This project is to develop an above the cap, multicenter trial to examine antibiotic prophylaxis for cesarean deliveries.

R21 (Horner-Johnson) 8/01/14-7/31/17 1.2 calendar months
NIH/NICHD $250,000/yr direct
Role: Co-I
Project title: **Examining disparities in access and outcomes of pregnancy in women with disabilities**
The aims of the project are to determine whether there appear to be disparities in access to prenatal care or outcomes in pregnancy in women with disabilities.

1 R01HG007074 (Chandrasekharan) 6/01/13-5/31/17 1.2 calendar months
NIH/NHGRI $440,000/yr direct
Role: site PI
Project title: **Intellectual Property and Access to Noninvasive Prenatal Testing**
The focus of this project is understanding the social and economic implications including impact on access to noninvasive prenatal diagnosis from the various business practices and intellectual property implications related to this technology.

R40MC26809 (Caughey) 04/01/14–03/31/16 2.4 calendar months
Health Resources and Services Administration $192,438 direct/yr
Role: PI
Title: **Prevention of Elective Induction of Labor: Impact of a Statewide Program**
The major goals of this project are to examine the impact of a statewide program in Oregon designed to prevent elective induction of labor prior to 39 weeks' gestation.

1 R40MC25694-01-00 (Caughey) 3/01/13-3/31/14 1.44 calendar months
HRSA/MCH $71,025/yr direct
Role: PI
Project title: **Elective Induction of Labor: Outcomes by Gestational Age**
The focus of this project is examining the outcomes in pregnancies subject to elective induction of labor as compared to expectant management in term gestations from 37-40 weeks in the state of California.

Contract (Caughey) 4/01/15-3/31/16 0.6 calendar months
GfK Custom Research $10,000/yr direct
Role: site PI
Project title: **Cost-effectiveness of Preterm Labor Screening Test**
The focus of this project is to examine the outcomes, costs, and cost-effectiveness of a theoretical test to identify women at risk for preterm birth.

K12 HS19456-01 (Guise) 07/01/10-6/30/13 0.24 calendar months
AHRQ
Role: Mentor/consultant
Project title: **Mentored Clinical Scientists Comparative Effectiveness Development Award**
This K12 training program will provide post-doctoral scholars with skills in conducting evidence-based, patient-centered, pragmatic, "real world" research in comparative effectiveness.

CERT Infrastructure Grant 1/1/11-6/30/12 1.2 calendar months (WOS)
PI (Dublin)
CERT Foundation $100,000 direct

Role: Co-I
Project Title: **Elective Induction of Labor**
This project is designed to elucidate outcomes and practice patterns associated with elective induction of labor in a broad group of regions across the country.

RWJF-61535 PI (Caughey) 7/1/07 – 12/31/10 3.6 calendar months (thru 6/08)
Robert Wood Johnson Foundation $100,000/yr direct 6.0 calendar months (7/08- on)
Role: Principal Investigator
Project title: **RWJ Physician Faculty Scholars Program: Cesarean and Vaginal Delivery: Preferences, Outcomes, and Costs**
This project is designed to examine outcomes in the setting of cesarean and vaginal delivery as well as estimate maternal preferences towards outcomes related to various modes of delivery as well as the associated costs.

R01 DK 58214 (Bull) 07/01/07-06/30/12 0.24 calendar months
NIH/NIDDK $240,000/yr direct
Role: Co-investigator
Project title: **The Genetic Basis of Hereditary Liver Disease**
The focus of this project is on characterization of the genetic etiology underlying two cholestatic liver disorders, lymphedema-cholestasis syndrome (LCS) and intrahepatic cholestasis of pregnancy (ICP).

P01 HD030367-14 (Hubel) 07/01/08-06/30/13 1.2 calendar months
NIH/NICHD $164,931/yr direct
UCSF PI – Fisher
Role: Co-investigator
Project title: **Placental Origins of Preeclampsia: A Global Analysis of Cytotrophoblast Defects**
The long-term goal of this project is to elucidate the molecular bases of the placental defects that occur in preeclampsia and to explain their relationship to the clinical signs of this syndrome.

RO1 PI (Swann) 9/1/09-8/31/14 0.6 calendar months
NIH/NICHD $500,000/yr direct
Role: Co-investigator
Title: **The Infant Development and the Environment Study**
This project is designed to examine the association between environmental exposures and identifiable birth anogenital birth defects

R01 HD049686-01 PI (Kuppermann) 7/1/06 – 6/30/11 0.3 calendar months
NIH/NICHD $291,232/yr direct
Role: Co-investigator
Project title: **Expanded Prenatal Testing Options and Informed Choice (EPIC)**
This project is a prospective randomized, controlled trial of having complete access to any prenatal testing as compared to usual care. The primary outcomes include use of prenatal testing and patient satisfaction with testing.

R01 HL080074 PI (Cabana) 3/01/06 – 2/28/11 0.24 calendar months
NIH/NHLBI $478,033/yr direct
Role: Co-investigator
Project title: **Trial of Infant Probiotic Supplementation to Prevent Asthma (TIPS)**

This project is a prospective, randomized, controlled trial of Probiotic dietary supplementation as compared to placebo control for the prevention of childhood asthma.

PI (Giudice) 7/1/08-6/30/10 0.6 calendar months (WOS)
March of Dimes $125,000/yr
Role: Co-investigator
Project title: **Genomics and preterm delivery**
This project will use a novel technique to characterize the vaginal flora with RNA probes and explore potential associations with bacterial flora and preterm birth.

Luminex – ACMGF Award PI (Norton) 7/1/09 – 6/30/10 0.24 calendar months (WOS)
Kaiser Permanente Research Committee $25,000
Role: Co-investigator
Project title: **Prenatal Genetic Testing: What Do Women Prefer?**
This project examines women's preferences regarding a variety of genetic syndromes and neonatal conditions using several preference metrics.

Contract – 08-9402 PI(Caughey) 06/01/09-11/30/10 1.2 calendar months
State of California
Role: Principal Investigator
Project title: **Measurement of maternal outcomes and quality of care using linked discharge and vital statistics data.**

Contract No. 290-02-0017 UCSF PI (Caughey) 3/1/07 – 6/30/08 1.2 calendar months (thru 6/07)
AHRQ / Stanford-UCSF Evidence-based Practice Center $250,000 4.2 calendar months (7/07- on)
Role: UCSF PI
Project title: **Evidence Review of Elective Induction in Labor**
This project from AHRQ was contracted out to the Stanford-UCSF EPC. The project was designed to answer clinical outcomes questions with regards to elective induction of labor.

RO1 (Padian/Dunbar) 7/01/07-6/30/09 0.24 calendar months
FHI (NIH) $500,000/yr direct
Role: Consultant
Project title: **Hormonal Contraception & the Risk of HIV Acquisition**
The focus of this project is to characterize the risks of HIV acquisition with the use of hormonal and nonhormonal contraception.

LRP L30 HD045176-03 (Caughey) 7/1/07 – 6/30/09 0.00 calendar months
NIH/LRP $20,000/yr direct
Role: Principal Investigator
Title: **Mode of Delivery: Outcomes, Preferences, and Costs**
The project examines outcomes related to varying modes and timing of delivery as well as examines women's preferences towards these outcomes and modes of delivery and the costs incurred.

REAC Award PI (Caughey) 3/1/07 – 2/29/09 1.2 calendar months (WOS)
UCSF Research Evaluation and Allocation Committee $24,336
Role: Principal investigator
Project title: **Women's Satisfaction and Attitudes Regarding Their Labor and Delivery Experience**

This project is designed to use qualitative analysis of women's stated preferences regarding aspects of the labor and delivery experience to develop an instrument to evaluate birth experience.

Community Benefits Research Grant (Kim) 1/1/08 – 12/31/08 0.24 calendar months (WOS)
Kaiser Permanente Research Committee $25,000
Role: Co-investigator
Project title: **Racial and Ethnic differences in placenta previa**
This project examines the racial/ethnic differences in previa prevalence as well as outcomes in those women with a placenta previa.

UCSF Academic Senate Grant (Joe) 2/8/06 – 3/1/08 0.24 calendar months (WOS)
Role: Co-investigator $15,966/yr
Project title: **Non-invasive evaluation of fetal lung maturity by MR spectroscopy: Ex Vivo and In Vivo Investigations**
This project uses MR spectroscopy to evaluate the NMR of protons of phospholipids in amniotic fluid specimens to assess fetal lung maturity.

LRP L30 HD045176-01/02 (Caughey) 7/1/03 – 6/30/07 0.00 calendar months
NIH/LRP $20,000/yr direct
Role: Principal Investigator
Title: **Which Complications of Pregnancy are Associated with Increased Gestational Age?**
The project proposed in particular is the examination of perinatal outcomes with respect to gestational age at term.

K12 HD001262 PI (Washington/Mellon/Giudice) 7/1/02 – 6/30/07 9.0 calendar months
NIH/NICHD $95,000/yr direct
Role: Mentored Scholar
Project title: **Women's Reproductive Health Research (WRHR)**
This K award was to fund projects in three areas: examination of perinatal outcomes with respect to gestational age at term; differences in perinatal outcomes by race/ethnicity; decision and cost-effectiveness analyses of issues in the setting of prenatal diagnosis.

Research Scholar Award (Joe) 7/1/05 – 12/30/07 0.12 calendar months (WOS)
RSNA Research and Education Foundation
Role: Co-investigator $150,000
Project title: **Non-invasive evaluation of fetal lung maturity by MR spectroscopy: Development and assessment of ex vivo and in vivo techniques**
This project uses MR spectroscopy to evaluate the NMR of protons of phospholipids in amniotic fluid specimens to assess fetal lung maturity.

REAC Award (Joe) 3/1/05 – 2/28/06 0.6 calendar months (WOS)
UCSF Research Evaluation and Allocation Committee $24,790
Role: Co-investigator
Project title: **Non-invasive evaluation of fetal lung maturity by MR spectroscopy: Development and assessment of ex vivo and in vivo techniques**
This project used MR spectroscopy to evaluate the NMR of protons of phospholipids in the amniotic fluid to assess fetal lung maturity.

AHRQ Training Grant PI (Sheffler) 9/1/01-6/30/02 10 calendar months
AHRQ
Role: Health Policy Fellow
Project title: AHRQ Fellows in Health Policy
This was a postdoctoral fellowship award that supported the first year of my doctoral degree.

5T32HD007162-27 PI (Kitterman) 7/1/99-6/30/01 12 calendar months
NICHD $45,048/yr
Role: Mentored Scholar
Project Title: Graduate Research Training in Perinatal Biology
This is an interdisciplinary post-doctoral program at the University of California San Francisco designed to provide comprehensive training in perinatal science as well as mentored career development for pediatricians and obstetricians with MD or MD, PhD degrees that are committed to academic careers with a strong research component.

PUBLICATIONS

Articles – Original Research in Peer-reviewed Journals:

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2. Zelop CM, Shipp TD, Repke JT, Cohen A, **Caughey AB**, Lieberman E. Uterine rupture during induced or augmented labor in gravid women with one prior cesarean delivery. Am J Obstet Gynecol 1999;181:882-6
3. Shipp TD, Zelop CM, Repke JT, Cohen A, **Caughey AB**, Lieberman E. Intrapartum Uterine Rupture and Dehiscence in Patients With Prior Lower Uterine Segment Vertical and Transverse Incisions. Obstet Gynecol 1999;94:735-40
4. **Caughey AB**, Shipp TD, Repke JT, Zelop CM, Cohen A, Lieberman E. Rate of uterine rupture during a trial of labor in women with one and two prior cesarean deliveries. Am J Obstet Gynecol 1999;181:872-6
5. Shipp TD, Zelop CM, Repke JT, Cohen A, **Caughey AB**, Lieberman E. Labor after previous cesarean: Influence of prior indication and parity. Obstet Gynecol 2000;95:913-6
6. Subak LL, **Caughey AB**. Measuring cost-effectiveness of surgical procedures. Clin Obstet Gynecol 2000;43(3):551-60
7. **Caughey AB**, Lyell DJ, Filly R, Washington AE, Norton ME. The impact of the use of echogenic intracardiac focus as a screen for Down syndrome in women under the age of 35. Am J Obstet Gynecol 2001;85:1021-7
8. Subak LL, **Caughey AB**, Washington AE. Cost-effectiveness analyses in Obstetrics and Gynecology: evaluation of methodological quality and trends. J Reprod Med 2002;47:631-9
9. Shipp TD, Zelop CM, Repke JT, Cohen A, **Caughey AB**, Lieberman E. The association of maternal age and symptomatic uterine rupture during a trial of labor after prior cesarean delivery. Obstet Gynecol 2002;99:585-8.
10. **Caughey AB**, Parer JT. Recommendations for Repeat Courses of Antenatal Corticosteroids: A Decision Analysis. Am J Obstet Gynecol 2002;186:1221-1229.
11. Stotland NE, Lipschitz L, **Caughey AB**. Management of patients with a prior classical cesarean section: a decision analysis. Am J Obstet Gynecol 2002;187:1203-8

12. **Caughey AB**, Kuppermann M, Norton ME, Washington AE. First vs. Second trimester screening tools for Down syndrome: A cost-effectiveness analysis. Am J Obstet Gynecol 2002 187:1239-45
13. Tran SH, **Caughey AB**, Musci TJ. Meconium stained fluid is associated with puerperal infections. Am J Obstet Gynecol 2003;189:746-50
14. **Caughey AB**, Stotland NE, Escobar G. What is the best measure of maternal complications of term pregnancy: Ongoing pregnancies or pregnancies delivered? Am J Obstet Gynecol 2003;189:1047-52
15. **Caughey AB**, Musci TJ. Complications of term pregnancies beyond 37 weeks of gestation. Obstet Gynecol 2004;103:57-62
16. Manuel MR, Chen L, **Caughey AB**, Subak LL. Cost-effectiveness analyses in gynecologic oncology: Methodological Quality and Trends. Gynecol Oncol 2004;93:1-8
17. **Caughey AB**, Washington AE, Gildengorin V, Kuppermann M. Assessment of Potential Demand for Invasive Genetic Testing Using Willingness to Pay. Obstet Gynecol, 2004;103:539-45
18. Cheng YW, Hopkins LM, **Caughey AB**. How long is too long: Is a prolonged second stage of labor associated with worse maternal and neonatal outcomes? Am J Obstet Gynecol, 2004;191:933-8
19. Stotland NE, Hopkins LM, **Caughey AB**. Gestational weight gain, macrosomia, and the risk of cesarean birth. Obstet Gynecol, 2004;104:671-7
20. Stotland NE, **Caughey AB**, Breed E, Escobar GJ. Macrosomia in a large managed care cohort: maternal risk factors and complications. Int J Gynaecol Obstet 2004;87:220-26
21. **Caughey AB**, Washington AE, Laros RK. Neonatal complications of term pregnancies: Rates increase in a continuous, not threshold fashion. Am J Obstet Gynecol 2005;192:185-90
22. Cruz C, **Caughey AB**, Jasmer R. Postpartum follow up of positive PPD among an indigent population at a county hospital. Am J Obstet Gynecol 2005;192:1455-1457
23. Musci TJ, **Caughey AB**. Cost-effectiveness analysis of prenatal population-based fragile X carrier screening. Am J Obstet Gynecol 2005;192:1905-1912
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26. Tran SH, **Caughey AB**, Norton ME. Ethnic variation in the prevalence of echogenic intracardiac foci and the association with Down syndrome. Ultrsnd Obstet Gynecol 2005;26:158-161
27. Lyell DJ, **Caughey AB**, Chu E, Daniels K. Peritoneal closure at primary cesarean delivery and adhesions. Obstet Gynecol 2005;106:275-80
28. Ramos GA, **Caughey AB.** Interrelationship Between Ethnicity and Obesity on Obstetrical Outcomes. Am J Obstet Gynecol 2005;193:1089-93
29. Little SE, **Caughey AB**. Acyclovir prophylaxis for pregnant women with a known history of herpes simplex virus: a cost-effectiveness analysis. Am J Obstet Gynecol 2005;193:1274-79
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33. Qidwai GI, **Caughey AB**, Jacoby A. Obstetric Outcomes in Women with Sonographically Identified Uterine Myomas. Obstet Gynecol, 2006;107:376-82
34. Cheng YW, Shaffer BL, **Caughey AB**. The association between persistent occiput posterior position and neonatal outcomes. Obstet Gynecol 2006;107:837-844
35. Bianco K, **Caughey AB**, Davis R, Shaffer BL, Norton ME. History of miscarriage and increased incidence of fetal aneuploidy in subsequent pregnancy. Obstet Gynecol, 2006;107:1098-1102
36. Chung JH, Voss KJ, **Caughey AB**, Wing DA, Henderson EJ, Major CA. The Role of Education Level in Predicting Macrosomia Among Women with Gestational Diabetes Mellitus. J Perinatol, 2006;26:328-32
37. Shaffer BL, Cheng YW, Vargas J, Laros RK Jr, **Caughey AB**. Manual Rotation of the Fetal Occiput: Predictors of Success and Delivery. Am J Obstet Gynecol, 2006;194:e7-9
38. Rao A, Cheng YW, **Caughey AB**. Perinatal Complications Among Different Asian-American Subgroups. Am J Obstet Gynecol, 2006;194:e39-41
39. McLaughlin GB, Cheng YW, **Caughey AB**. Women with One Elevated 3-hour Glucose Tolerance Test Value: Are They at Risk for Adverse Perinatal Outcomes? Am J Obstet Gynecol, 2006;194:e16-19
40. Fick AL, Feldstein VA, Norton ME, Fyr CW, **Caughey AB**, Machin GA. Unequal Placenta Sharing and Growth Discordance in Monochorionic Twins. Am J Obstet Gynecol, 2006;195:178-83
41. Shaffer BL, Cheng YW, Vargas J, Laros RK Jr, **Caughey AB**. Face Presentation: Predictors and Delivery Route. Am J Obstet Gynecol, 2006;194:e10-12
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43. Shaffer BL, **Caughey AB**, Norton ME. Variation in the decision to terminate pregnancy in the setting of fetal aneuploidy. Prenat Diagn. 2006;26:667-71
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CAUSE NO. D-1-GN-23-000968

AMANDA ZURAWSKI, *et al.*,

***Plaintiffs*,**

v.

STATE OF TEXAS *et al.*,

Defendants.

In the District Court of

Travis County, Texas

353RD JUDICIAL DISTRICT

[PROPOSED] TEMPORARY INJUNCTION ORDER

On the ___ day of ____ 2023, the Court considered Plaintiffs' Application for Temporary Injunction (the "Application") and Plaintiffs' First Amended Verified Petition for Declaratory Judgment and Application for Temporary and Permanent Injunction (the "Amended Petition") seeking to temporarily restrain Defendants the State of Texas, Ken Paxton, Texas Medical Board, and Stephen Brint Carlton (collectively, "Defendants"), their agents, servants, employees, attorneys, and all persons in active concert and participation with Defendants from enforcing Texas's abortion bans, as codified at 1925 Tex. Penal Code Arts. 1191–1194, 1196 (Vernon's Tex. Civ. States Civil Statutes Arts. 4512.1–4512.4, 4512.6) (the "Pre-*Roe* Ban"), Tex. Health & Safety Code §§ 170A *et seq.* (the "Trigger Ban"), and Tex. Health & Safety Code §§ 171.002, 171.203-205 ("S.B. 8"), in any manner that would prevent pregnant Texans with emergent medical conditions from receiving abortion care, while this litigation proceeds.

Plaintiffs Amanda Zurawski, Lauren Miller, Lauren Hall, Ashley Brandt, Anna Zargarian, Kylie Beaton, Jessica Bernardo, Samantha Casiano, Austin Dennard, M.D., Taylor Edwards, Kiersten Hogan, Lauren Van Vleet, and Elizabeth Weller (the "Patient Plaintiffs"), and Judy

Levison, M.D., M.P.H and Damla Karsan, M.D. on behalf of themselves and their patients (the "Physician Plaintiffs") ask for a declaratory judgment construing the "medical emergency" exception to Texas's abortion bans to allow abortion care for pregnant persons with emergent medical conditions, as defined by medical terminology, and contend that a narrower construction would be inconsistent with the rights of pregnant persons and physicians in Texas under Article I, §§ 3, 3a, and/or 19 of the Texas Constitution and therefore *ultra vires*. After consideration of the Application and the evidence attached thereto, and pursuant to Texas Rule of Civil Procedure 680 *et seq.*, the Court hereby finds:

FINDINGS

The Court finds that there is uncertainty regarding whether the medical exception to Texas's abortion bans, codified at Tex. Health & Safety Code §§ 170A.001-002, 171.002(3), 171.203-205, permits a physician to provide abortion care where, in the physician's good faith judgment and in consultation with the pregnant person, a pregnant person has a physical emergent medical condition. The Court finds that physical medical conditions include, at a minimum: a physical medical condition or complication of pregnancy that poses a risk of infection, bleeding, or otherwise makes continuing a pregnancy unsafe for the pregnant person; a physical medical condition that is exacerbated by pregnancy, cannot be effectively treated during pregnancy, or requires recurrent invasive intervention; and/or a fetal condition where the fetus is unlikely to survive the pregnancy and sustain life after birth. The Court finds that any official's enforcement of Texas's abortion bans against any physician who provides an abortion to a pregnant person who, in the physician's good faith judgment, has a physical emergent medical condition would be inconsistent with the medical exception to Texas's abortion bans, and therefore would be *ultra vires*.

The Court further finds that any official's enforcement of Texas's abortion bans as applied to a pregnant person with an emergent medical condition for whom an abortion would prevent or alleviate a risk of death or risk to their health (including their fertility) would be inconsistent with the rights afforded to pregnant people under Article I, §§ 3, 3a, and/or 19 of the Texas Constitution and therefore would be *ultra vires*. The Court also finds that any official's enforcement of Texas's abortion bans against any physician who provides an abortion to a pregnant person after determining that, in the physician's medical judgment, the pregnant person has an emergent medical condition for which abortion would prevent or alleviate a risk of death or risk to their health (including their fertility) would be inconsistent with Article I, §§ 3, 3a, and/or 19 of the Texas Constitution, and therefore would be *ultra vires*.

The Court finds that the Patient Plaintiffs each experienced emergent medical conditions during their pregnancies that risked the Patient Plaintiffs' lives and/or health (including their fertility) and required abortion care, but that Patient Plaintiffs were delayed or denied access to abortion care because of the widespread uncertainty regarding physicians' level of discretion under the medical exception to Texas's abortion bans. The Court further finds that the Patient Plaintiffs' claims are capable of repetition but evading review.

The Court further finds that the Physician Plaintiffs routinely treat and/or consult on care for patients with emergent medical conditions and the uncertainty regarding the scope of the medical exception and the related threat of enforcement of Texas's abortion bans has created an imminent risk that Physician Plaintiffs and other physicians throughout Texas will have no choice but to bar or delay the provision of abortion care to pregnant persons in Texas for whom an abortion would prevent or alleviate a risk of death or risk to their health (including their fertility) for fear of liability under Texas's abortion bans.

The Court therefore finds that all Plaintiffs, as well as other pregnant persons, physicians, and others in Texas, face a probable, irreparable and imminent injury for which they will have no adequate remedy at law unless: (*i*) the medical exception permits the Patient Plaintiffs and pregnant persons throughout Texas to receive necessary abortion care in connection with an emergent medical condition, and (*ii*) Defendants are temporarily enjoined from enforcing Texas's abortion bans in connection with any abortion care provided by the Physician Plaintiffs and physicians throughout Texas to a pregnant person where, in a physician's good faith judgment and in consultation with the pregnant person, the pregnant person has an emergent medical condition requiring abortion care.

Money damages are insufficient to remedy the injuries to Plaintiffs that will result if Defendants are not enjoined from instituting civil, criminal, or disciplinary investigations or actions under Texas's abortion bans related to any abortion care provided to pregnant persons in Texas in connection with an emergent medical condition. Conversely, Defendants will not be harmed if the Court restrains them and anyone in active concert and participation with them from enforcing Texas's abortion bans as applied to the provision of necessary abortion care to a pregnant person in Texas for whom an abortion would prevent or alleviate a risk of death or risk to their health (including their fertility).

Defendants were provided notice of the cause of action, the Application, and the hearing conducted. Unless Defendants are restrained, Plaintiffs face an imminent threat of irreparable harm under Texas's abortion bans. Judicial intervention is necessary to preserve Plaintiffs' legal right to obtain or provide abortion care in Texas in connection with emergent medical conditions under the medical exception and the Texas Constitution.

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

A. Emergent medical conditions that a physician has determined, in their good faith judgment and in consultation with the patient, pose a risk to a patients' lives and/or health (including their fertility) permit physicians to provide abortion care to pregnant persons in Texas under the medical exception to Texas's abortion bans and Article I, §§ 3, 3a, and 19 of the Texas Constitution.

B. At a minimum, Defendants are restrained from enforcing Texas's abortion bans against physicians that provide abortion care and those that aid or abet in the provision of abortion care for any pregnant person who, in the treating physician's good faith judgment and in consultation with the pregnant person, has: (1) a complication of pregnancy that poses a risk of infection, bleeding, or otherwise makes continuing a pregnancy unsafe for the pregnant person; (2) a condition exacerbated by pregnancy, that cannot be effectively treated during pregnancy, or that requires recurrent invasive intervention; and/or (3) a fetal condition where the fetus is unlikely to survive the pregnancy and sustain life after birth.

C. Until all issues in this lawsuit are finally and fully determined, a temporary injunction is entered immediately enjoining Defendants, their officers, agents, servants, employees, and attorneys, and upon those persons in active concert or participation with them, from enforcing Texas's abortion bans in any manner that: (*i*) would prevent the Patient Plaintiffs and pregnant persons throughout Texas from receiving necessary abortion care in connection with an emergent medical condition, (*ii*) would subject the Physician Plaintiffs and others in Texas to liability for providing necessary abortion care in connection with an emergent medical condition; *and* (*iii*) would be inconsistent with the rights of pregnant persons and physicians in Texas under Article I, §§ 3, 3a, and/or 19 of the Texas Constitution and therefore *ultra vires*

D. Defendants shall provide notice of this temporary injunction to their officers, agents, servants, employees, and attorneys, and those persons in active concert or participation with them.

E. Plaintiffs' bond is set at ________. A law firm check is sufficient to post the bond. Upon the filing of the bond required herein, the Clerk of this Court shall issue a Temporary Injunction in conformity with the law and the terms of this Order Granting Plaintiffs' Application for Temporary Injunction.

F. All parties may be served with notice of this Temporary Injunction in any manner provided under Rule 21a of the Texas Rules of Civil Procedure.

G. This Temporary Injunction shall not expire until judgment in this case is entered or this Case is otherwise dismissed by this Court.

Dated this ___ day of _______________, 2023.

____

PRESIDING JUDGE

Prepared by:

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