IN THE SUPERIOR COURT OF FULTON COUNTY
STATE OF GEORGIA

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

Plaintiffs,

v.

STATE OF GEORGIA,

Defendant.

Case No. 2022CV367796

PLAINTIFFS' POST-TRIAL BRIEF

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The State has neither the law nor the facts on its side. The Georgia Constitution's strong protections against government interference with Georgians' bodies, health, and lives cannot abide a law that forces pregnancy, childbirth, and parenthood on Georgians against their will. And the State's theory that individual rights evaporate with pregnancy finds no support in precedent.

Plaintiffs' expert witnesses—a preeminent obstetrician-gynecologist ("OBGYN") in Georgia with extensive expertise in abortion care; a leading national expert in high-risk pregnancies serving patients in Georgia; the Georgia-based Director of the Center for Reproductive Health Research in the Southeast; and one of the foremost experts in reproductive psychiatry in the world—testified credibly about the devastation the Ban is causing. As explained by these experts, and by an ultrasound technician who must now inform patients from the earliest weeks of pregnancy that they are already barred from obtaining an abortion in Georgia, the Ban's harms include, *inter alia*: subjecting countless Georgians to the profound medical risks of pregnancy and childbirth, including psychiatric risks; dooming families to a life of poverty; tethering women to abusive partners; impeding doctors from providing medically appropriate care for pregnancy complications; forcing sexual assault victims to carry and deliver their rapist's pregnancy; and undermining Georgia's ability to recruit competitive medical students and residents to help mitigate its OBGYN shortage crisis. By contrast, the testimony from the State's uniformly out-of-state, largely discredited experts is plagued by poor methodology and religious bias, and it runs counter to the opinions of not only Plaintiffs' experts, but virtually every legitimate medical and mental health association in Georgia and the nation. This Court should declare unconstitutional and enjoin both the Ban and the intrusive Records Access Provision.

ARGUMENT

I. The Ban Violates Georgia's Right to Privacy.

The Georgia Constitution's robust protection of Georgians' fundamental right to privacy—

the right "to be let alone" in their personal decisions, to the "legal and uninterrupted enjoyment of [their] life . . . body, [and] health," and "to be protected in the exclusive use and enjoyment of that which is [their] own"—plainly precludes forced pregnancy, childbirth, and parenthood. *Pavesich v. New Eng. Life Ins. Co.*, 122 Ga. 190, 190, 50 S.E 68, 70–71, 78 (1905) (internal quotation marks omitted).[1] There are three pieces to this inquiry. ***First***, whether a "reasonable person[]" would view the decision whether to undergo full-term pregnancy, labor, delivery, and parenthood as a "private matter" that "falls within the area protected by the right of privacy." *Powell v. State*, 270 Ga. 327, 332 (1998). Just as refusing medical treatment, engaging in consensual sexual conduct, and preventing the unauthorized publication of a photograph of one's body all fall within the Georgia Constitution's sphere of protection, so too must an intrusion of the magnitude of forced pregnancy. *See* Pls.' Opp'n Mot. to Dismiss ("MTD Opp'n") 14–17. ***Second***, whether a woman's[2] privacy rights evaporate upon the existence of a fertilized egg (or a six-week embryo), automatically justifying the Ban's grave interference with Georgians' "life . . . body, [and] health." *Pavesich*, 50 S.E. at 70. Nothing in fact or law supports such a constitutional loophole. ***Third***, whether the State can meet its

[1] In addition, because the Ban was plainly unconstitutional under "court interpretations of th[e] period" when adopted, *Adams v. Adams*, 249 Ga. 477, 479 (1982), it is void and unenforceable. *See generally* Pls.' Mot. for Partial J. on the Pleadings ("MPJOP"); Pls.' Reply in Support of MPJOP. *Sherman v. Atlanta Indep. Sch. Sys.*, 293 Ga. 268 (2013), and *Grayson-Robinson Stores, Inc. v. Oneida, Ltd.*, 209 Ga. 613 (1953), illustrate the principle of democratic accountability underlying this doctrine. In *Sherman*, the Court held that the people of Georgia can revive a law that was void *ab initio*, if that is their will, by ratifying a constitutional amendment to specifically permit such laws both prospectively and retroactively. 293 Ga. at 275–78. By contrast, if there is a change in the constitutional landscape that was not initiated by the people—as in *Grayson-Robinson Stores, Inc.*, 209 Ga. at 617, and as here—then the Legislature can take advantage of the changed landscape by reenacting the void law, again if that is the people's will. But, under the Georgia Constitution, the U.S. Supreme Court's revocation of an established federal constitutional right is not enough to revive a state law that was unconstitutional when enacted—because it is "the people" of Georgia who "have ultimate control over the law under which they live." *Sherman*, 293 Ga. at 275–76 (Nahmias, J.). The Legislature is free to enact a new abortion ban now that *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228, 2242 (2022), has reversed 50 years of constitutional precedent, if doing so reflects the will of the people in 2022 in this dramatically changed federal constitutional environment. But the 2019 statute was void on arrival.

[2] Plaintiffs generally use "women" to refer to people who are pregnant and seeking abortion care, but note that "not all persons who may become pregnant identify as female," and that transgender and gender non-binary people also need abortion care. *Reprod. Health Servs. v. Strange*, 3 F.4th 1240, 1246 n.2 (11th Cir. 2021), *reh'g en banc granted, opinion vacated on other grounds sub nom. Reprod. Health Servs. ex rel. Ayers v. Strange*, 22 F.4th 1346 (11th Cir. 2022) (mem.).

burden under strict scrutiny to justify this intrusion. *Powell*, 270 Ga. at 333. The State cannot possibly meet that test when the Ban prohibits abortion before many even know they are pregnant, with exceptions so narrow, inscrutable, and cruel as to only underscore its constitutional deficiencies.

A. Forced Pregnancy Infringes Georgians' Right to Be Let Alone and to the Uninterrupted Enjoyment of Their Life, Body, and Health.

1. The Medical Impacts of Forced Pregnancy Are Severe.

It is difficult to imagine state action more invasive of a woman's life, body, and health than a mandate that she carry a pregnancy to term; undergo labor and delivery; and, in most cases, parent a child. Even an uncomplicated pregnancy imposes heavy burdens and significant medical risks. PX002 (Badell Aff.) ¶ 13; Tr. 1 99:11–101:5 (Cwiak). Increased demand for blood flow and plasma volume requires higher cardiac output. Tr. 1 100:3–11 (Cwiak); *see also* DX022 (Wright Aff.) ¶ 44. And in order to "deliver[] oxygen to the uterus and the placenta and the fetus," pregnant people's "lungs need to work harder." Tr. 1 100:14–16 (Cwiak); *see also* PX002 (Badell Aff.) ¶ 13. Due to these and myriad other physical impacts, "even people without a preexisting medical condition may develop" conditions like high blood pressure, diabetes, and venous thromboembolism, simply by virtue of being pregnant. *See* Tr. 1 102:3–10, 103:24–104:15 (Cwiak); *see also* PX002 (Badell Aff.) ¶¶ 14–15. These risks increase over the duration of pregnancy and can continue even after delivery. Tr. 1 99:17–101:05, 102:7–10 (Cwiak). Individuals who develop medical conditions during pregnancy remain at elevated risk for those conditions later in life. Tr. 1 102:7–10; *see also* PX002 (Badell Aff.) ¶ 19.

When a woman has underlying conditions or faces a complication, the risks are that much greater. Pregnancy can worsen preexisting conditions by, for instance, straining the cardiovascular system; as another example, increased insulin resistance during pregnancy can exacerbate diabetes. Tr. 1 101:8–16 (Cwiak); PX002 (Badell Aff.) ¶ 16. Hypertension "can develop to severe hypertension, stroke, heart attack," as well as preeclampsia and eclampsia, which can lead to seizures. Tr. 1 101:15–

23 (Cwiak); PX002 (Badell Aff.) ¶ 16. In addition, labor and delivery carry their own risks. PX002 (Badell Aff.) ¶ 17. "Severe maternal morbidity," defined by the U.S. Centers for Disease Control and Prevention ("CDC") as an "unexpected outcome at the time of labor and delivery with negative consequences on the pregnant women," affects 1,400 people per 100,000 live births. Tr. 2 22:2–7 (Badell); PX002 (Badell Aff.) ¶ 14. One "large-scale study of pregnancies among Georgians enrolled in a managed care plan showed that at least one complication occurred in approximately half of all pregnancies," with higher prevalence among Black Georgians. PX002 (Badell Aff.) ¶ 18.

In some cases, pregnancy is deadly. In Georgia, between 2018 and 2020, the maternal mortality rate was 28.8 per 100,000 live births. PX008 (Rice Aff.) ¶ 21. The State attempts to downplay this crisis. *See, e.g.*, Tr. 2 61:23–62:3 ("[I]t seems here that we've got a relatively small number" of maternal deaths). But its protestations are at odds with not only the testimony of Plaintiffs' experts, but also the Georgia House of Representatives' ***own findings***. *See* H.R. 589 (2019) (resolving that "women in the United States are more likely to die from childbirth or pregnancy-related causes than women in other high-income countries" and that "Georgia is among the top ten states with the highest maternal death rate," and establishing committee to study the problem).

There are significant racial disparities in Georgia in both maternal morbidity and mortality. Tr. 1 223:13–24 (Rice); PX008 (Rice Aff.) ¶ 22; PX002 (Badell Aff.) ¶¶ 18, 32. Indeed, Black Georgians are more than twice as likely as white Georgians to die from pregnancy-related causes. Tr. 1 217:8–11 (Rice); PX008 (Rice Aff.) ¶¶ 22, 48. Georgia's maternal health crises impact Black Georgians particularly severely, due to, *inter alia*, systemic discrimination both within and without the healthcare system, "disproportionate experiences of poverty," and being more likely to "liv[e] in rural areas in which access to care is more limited," especially access to OBGYNs. Tr. 1 217:22–218:12 (Rice); *see also* PX002 (Badell Aff.) ¶ 28; Tr. 1 220:9–222:3 (Rice). Given that the population

of Georgians who seek abortion care is disproportionately Black and low-income, and that these same communities face heightened medical risks from pregnancy, it is clear they are bearing the brunt of the Ban's harms. Tr. 1 224:21–225:2, 241:22–242:4 (Rice).

The Ban also condemns Georgians experiencing a psychiatric emergency to increased suffering and, in some cases, death. As Plaintiffs' expert Dr. Samantha Meltzer-Brody, who has cared for thousands of pregnant women in her career, Tr. 1 309:6–9, testified: "For some women, pregnancy is particularly devastating to their mental health," Tr. 1 312:7–313:1, because it "is a time of very high risk for mental health conditions," Tr. 1 310:10–13. This includes both the relapse or worsening of preexisting psychiatric symptoms, as well as the onset of new conditions, Tr. 1 312:7–313:1, such as depression; anxiety disorders, including generalized anxiety, panic attacks, panic disorder, posttraumatic stress disorder, and obsessive-compulsive disorder; and mood disorders such as bipolar disorder and postpartum psychosis, Tr. 1 311:19–312:6. The impact of pregnancy on mental health "can be devastating and, at worst, it can end someone's life." Tr. 1 315:3–6.

2. Forced Pregnancy Irreparably Impacts Georgians' Families and Futures.

As Plaintiffs' witnesses explain, "there are compelling reasons," and typically "more than one reason," why people choose to end a pregnancy. Tr. 1 107:11–108:3 (Cwiak). "[I]t's not a decision that they take lightly." Tr. 1 107:11–13 (Cwiak); *see also* Tr. 2 329:3–6 (Nesmith) ("It's a pretty complex issue, and women come to us with a variety of reasons; so tears are normal, but I see a whole lot more lately because of the ban."). Some seek abortion care "for their own health." Tr. 1 107:13–14 (Cwiak). For instance, Feminist Women's Health Center ultrasound technician Gloria Nesmith testified about caring for "an ovarian cancer patient" who recently sought an abortion "because she needed lifesaving treatment" and "being pregnant would have been an issue with her continuing her treatment." *See* Tr. 2 334:21–335:25. Others seek abortion care for "a number of familial, financial,

social situations that lead someone to determine that they—that it's best for them to pursue abortion," including, for instance, the "economic stability" of "the children that they already have." Tr. 1 107:14–21 (Cwiak); *see also* PX005 (Cwiak Aff.) ¶¶ 9–10 (reasons people decide to have an abortion); PX008 (Rice Aff.) ¶ 29 (most abortion patients are low-income and already parents). One in four women of reproductive age in the United States has had an abortion. Tr. 1 105:1–3 (Cwiak); PX014 at 1907.

Being denied a wanted abortion has significant negative implications. The groundbreaking "Turnaway Study" followed nearly 1,000 people who sought abortion care at clinics across the U.S. over the course of five years and found that those denied abortions (because they were past the clinic's limit) suffered worse outcomes across a range of measures when compared to those able to access care. Tr. 1 234:17–235:2 (Rice); PX008 (Rice Aff.) ¶ 46. The Study's data have resulted in the publication of over fifty papers in peer-reviewed, high-impact journals, reflecting the consensus view that it is a "gold standard" in social science research. Tr. 1 235:3–17 (Rice); PX009 (Rice Rebuttal Aff.) ¶ 7.[3] Its findings indicate that the Ban will increase poverty among Georgia women and families: people "denied a wanted abortion" are at "increased risk[] of experiencing things like eviction and other income-related . . . disparities," as well as "falling below the poverty line," relative to those able to obtain an abortion. Tr. 1 233:15–24, 240:12–20 (Rice); PX008 (Rice Aff.) ¶¶ 46–47;

[3] While acknowledging that the Turnaway Study is a "good idea," Tr. 2 206:7–9, Defendant's witness Priscilla Coleman, PhD, asserts that the study is of no value because its methodology is flawed. Tr. 2 205:6–206:2. To the contrary, "the Turnaway Study's methodological strengths" are why its results have been published so widely. PX009 (Rice Rebuttal Aff.) ¶ 7; Tr. 1 235:3–239:10 (discussing study's methodology). Dr. Coleman's criticisms of the Turnaway Study are "unfounded," PX009 (Rice Rebuttal Aff.) ¶ 8; *see also id.* ¶¶ 9–10—and they have gained no traction among credible scientific researchers. Dr. Coleman's recent publication critiquing the Turnaway Study is steeped in bias. Her editor, who is affiliated with a university whose motto is "passionately Catholic," selected as reviewers: two individuals affiliated with the anti-abortion Charlotte Lozier Institute (including one listing only that affiliation); one reviewer identifying the American Association of Pro-Life Obstetricians and Gynecologists ("AAPLOG") as his only affiliation; and a final reviewer whose testimony on the purported dangers of abortion care has been discredited by multiple courts. Tr. 2 227:24–233:7 (Coleman); *Planned Parenthood of Wis., Inc. v. Van Hollen*, 94 F. Supp. 3d 949, 967 n.16, 969–70 (W.D. Wis. 2015); *Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1371–72 & n.24 (M.D. Ala. 2014). When pressed about these overtly political affiliations, Dr. Coleman claimed, "this is the first time I've really looked at – at the reviewers" on her own study, Tr. 2 228:24–25, then later acknowledged that she had in fact seen their affiliations earlier and thought, "that might not look too great," yet did nothing, Tr. 2 231:13–25.

see also Tr. 2 326:8–15 (Nesmith) ("I would probably have gotten stuck in that small town that I was in and never been able to just advance my life and my career and my—you know, stretch my eyes and arms and go to college and have those opportunities that I've had."). Study participants denied an abortion faced more challenges providing for their existing children. Tr. 1 240:2–11 (Rice); PX008 (Rice Aff.) ¶ 46. They were "more likely to stay in a relationship" despite a "history of intimate partner violence." Tr. 1 234:1–11; PX008 (Rice Aff.) ¶ 53. And reinforcing the life-threatening risks of pregnancy, there were two maternal deaths among participants denied a wanted abortion. Tr. 1 241:8–20 (Rice).

Dr. Cwiak testifies that "what continues to sustain me in providing abortion care" is the "gratitude that people have when they . . . tell you how much you've changed their life and saved their life." Tr. 1 142:11–15. In violation of Georgia's right to privacy, the Ban strips Georgians of the freedom to make this deeply personal decision for themselves, their families, and their futures.

B. A Fertilized Egg or Six-Week Embryo Is Not a "Neighbor" or "Third Party" Whose Existence Nullifies the Pregnant Woman's Rights.

1. Georgia Precedent Does Not Support the State's Nullification Theory.

The State argues that the vast impact of forced pregnancy on Georgians' lives, bodies, and health is irrelevant under the Constitution, because as soon as there is a fertilized egg,[4] the pregnant woman's right to privacy evaporates. *See, e.g.*, Tr. 1 27:23–25 (State's attorney) ("[T]he legal point is that because this affects another, privacy rights don't even apply in the first place."). To support this sweeping attempt at a constitutional loophole, the State relies on language in Georgia case law

[4] The State's position is that there is ***no*** point in pregnancy at which the Constitution prohibits forced pregnancy, because (in the State's view) "unborn children are human beings, from conception onward." Mot. to Dismiss 23 (emphasis omitted); *accord id.* at 3, 24–25; H.B. 481 § 3 (Legislature defining "unborn child" as a human being "at any stage of development who is carried in the womb."), so "abortion ***always*** harms an 'innocent third party,'" Mot. to Dismiss 20 (emphasis added). Thus, while the question of whether six weeks is a constitutionally permissible line comes into play later in applying strict scrutiny, on the threshold question of whether the Georgia Constitution is apathetic to government-mandated pregnancy and childbirth, it is the moment of fertilization that is central to the State's theory.

providing that an individual's privacy rights may be cabined to avoid "invad[ing] the rights of [their] neighbor" or those of "other individuals." *Pavesich*, 50 S.E. at 70–71; *accord Powell*, 270 Ga. at 330 (quoting *Pavesich*). The State asserts that it is "absolutely clear . . . . that if it's affecting some third-party . . . . that's really just the end of the case," Tr. 1 20:1–12 (State's attorney).

The State relies on *State v. McAfee*, 259 Ga. 579, 580 (1989), for the notion that a zygote is a "third party" whose existence defeats the pregnant person's privacy right. Mot. to Dismiss 20, 22–23, 27. But the State misapprehends that case. In *McAfee*, the Supreme Court prohibited the State from forcing a prisoner to undergo medical treatment, "not[ing] that we do not have before us a case where the State's interest is in preserving the life of an innocent third party, such as the unborn child of a woman who wishes to refuse medical treatment." 259 Ga. at 580 (citing *Jefferson v. Griffin Spalding Cnty. Hosp. Auth.*, 247 Ga. 86 (1981), in which a 39-week fetus had no chance of survival absent a C-section delivery).[5] *McAfee* in no way holds—as the State mistakenly argues—that a fertilized egg or six-week embryo is a "third party" whose presence nullifies the pregnant woman's privacy rights, eliminating the need for any balancing. *McAfee* holds precisely the opposite: the "protection of innocent third parties" is a "generally recognized interest[] of the state ***which must be balanced against*** a competent, adult patient's right to refuse medical treatment." *Id.* Thus, *McAfee* reinforces ***Plaintiffs'*** position, not the State's. And, in any event, because the State in *McAfee* "concede[d]" that its interest in preserving the prisoner's life did not outweigh the prisoner's privacy right to refuse medical treatment, the Court's observation that that case did not involve a "third party" was dicta. *Id.*

The State also asserts that, because the General Assembly issued legislative findings that a fertilized egg is a person, that is the end of the constitutional inquiry: no privacy right is implicated

[5] Plaintiffs mistakenly referred at oral argument to *Zant v. Prevatte*, 248 Ga. 832 (1982), as the source of the "third party" language and corresponding citation to *Jefferson*; Plaintiffs clarify here that the correct source was *McAfee*.

by forced pregnancy. Tr. 1 18:14–18, 20:5–12, 68:10–15 (State's attorney). But this, too, is wrong: the Legislature does not get to dictate the meaning or confines of the Georgia Constitution—that is the judiciary's sole prerogative. *In re Jud. Qualifications Comm'n Formal Advisory Opinion No. 239*, 300 Ga. 291, 298–99 (2016) (citing *Marbury v. Madison*, 5 U.S. 137, 177 (1803)). And *Pavesich* expressly entrusted to "the wisdom and integrity of the judiciary" the task of resolving "the perplexing question to determine where this liberty [of privacy] ended, and the rights of others and of the public began." 50 S.E. at 72. As detailed further in Plaintiffs' response to Defendant's Motion to Dismiss (at 14–18), nothing in Georgia precedent suggests that a zygote or embryo is *Pavesich*'s "neighbor."

2. The Record Does Not Support the State's Nullification Theory.

The record likewise does not support a finding that a six-week embryo is a person with legal rights that subsume those of the pregnant woman. It is undisputed that, at six weeks of pregnancy[6] an embryo is at least ***four months away*** from potential survival outside the pregnant woman's body, even with the most advanced medical technologies. Tr. 2 23:10–24:23 (Badell); PX002 (Badell Aff.) ¶ 23; PX005 (Cwiak Aff.) ¶ 20. Until viability—by definition—a fetus is and must be a part of the pregnant woman's body. Common sense tells us that is very far from a "neighbor."

The State nonetheless argues that human life begins at conception, and thus a fertilized egg must be a person whose existence nullifies the pregnant woman's right to privacy. But when life begins is "a religious and philosophical question" that is "not . . . taught in medical school" nor grounded in "medical expertise." Tr. 2 49:3–6 (Badell). The scientific fact that, "at the moment of fertilization, cells begin dividing to develop into an embryo," Tr. 2 49:19–20 (Badell), does not resolve the existential question of whether those cells have the moral status of a person.

The State's witnesses argue otherwise, attempting to mask their religious and philosophical

[6] As dated from the first day of the last menstrual period ("LMP"). Tr. 1 94:11–23 (Cwiak); PX005 (Cwiak Aff.) ¶ 17.

beliefs as medical and scientific facts. Dr. Ingrid Skop, a member of the anti-abortion advocacy group AAPLOG, Tr. 2 168:15–18, 20–23, testifies that "the fetus is a living human being. That is scientific," Tr. 2 163:14–15. What Dr. Skop did not tell the Court is that, in addition to being the Director of Medical Affairs at the anti-abortion Charlotte Lozier Institute, she is also the medical director of two anti-abortion clinics with religious missions: Any Woman Can, "a Christ-Centered ministry,"[7] and The Source, "a consortium of full-service women's centers with a Christian worldview."[8] Dr. Jeffrey Wright, another State witness and also an AAPLOG member, presented his "medical opinion" that life begins at "the moment of conception," Tr. 2 350:10–15, but the only support he could find was from the American College of Pediatricians, an anti-abortion advocacy group.[9] Tr. 2 388:20–22 ("[R]egardless of who they are, they wrote a nice paragraph, and I thought it sounded good; so I put it in the report."); *see also* DX22 (Wright Aff.) ¶ 13. Everyone is entitled to their own religious and philosophical beliefs, but those beliefs should not be disguised as scientific fact in court testimony.

As its primary expert on when human life begins, the State presented Dr. Farr Curlin, a member of the Christian Medical and Dental Associations (CMDA)[10]—which considers abortion as "contrary to respect for the sanctity of human life as taught in the revealed written word of God"[11]—

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[7] *See* Any Woman Can, *About Us*, https://www.anywomancansa.com/about-us (last visited Nov. 3, 2022), attached hereto as Ex. A.

[8] *See* Charlotte Lozier Inst., *Ingrid Skop, M.D., F.A.C.O.G.,* https://lozierinstitute.org/team-member/ingrid-skop-m-d-f-a-c-o-g/ (last visited Nov. 3, 2022), attached hereto as Ex. B.

[9] *See* S. Poverty L. Ctr., *American College of Pediatricians,* https://www.splcenter.org/fighting-hate/extremist-files/group/american-college-pediatricians (last visited Nov. 3, 2022), attached hereto as Ex. C ("The American College of Pediatricians (ACPeds) is a fringe anti-LGBTQ hate group that masquerades as the premier U.S. association of pediatricians to push anti-LGBTQ junk science, primarily via far-right conservative media . . . ."); *see also* Am. Coll. of Pediatricians, *About*, https://acpeds.org/about (last visited Nov. 3, 2022), attached hereto as Ex. D ("Of particular importance to the founders were (as it is today) the sanctity of human life from conception to natural death and the importance of the fundamental mother-father family unit in the rearing of children.").

[10] *EMW Women's Surgical Center, P.S.C. v. Meier* (W.D. Ky. 2018), Trial Tr. at 25–27, attached hereto as Ex. E.

[11] *Id.* at 26. Other CMDA positions include the belief that "[t]herapy can be given to avoid pregnancy after a rape," and that, in the case of fatal fetal anomalies, "[i]t is much better to bear the child with a fatal illness and let him or her die than to kill the child." *See* Christian Med. & Dental Ass'ns, *Standards4Life: Abortion* 8

and the recipient of its 2022 Educator of the Year Award.[12] In a publication absent from his CV, Dr. Curlin provided guidance on "ways a faithful Christian can respond when professional expectations limit the ability to apply Christian teachings." PX149 at 2. One of Dr. Curlin's suggestions was "to stay in the profession but ignore those professional guidelines that encroach on religious teachings." *Id*. Another was "to stay in the profession but promote Christian teachings discreetly so as not to cause friction with supervisors who would disapprove if they knew." *Id*.

Dr. Curlin seems to have attempted those discreet tactics for promoting Christian teachings in presenting his testimony as informed solely by science and academic endeavors. Tr. 2 279:17–23; *accord* Tr. 2 314:22–24. Only after significant questioning did Dr. Curlin finally acknowledge that he also has a "religious belief" that a zygote "is deserving of that basic moral regard that we owe to all human beings." Tr. 2 316:10–15. In truth, Dr. Curlin's opinions on medical ethics are inseparable from his faith. In a lecture entitled "What Does Medicine Have to Do with the Healing Ministry of Jesus Christ?," Dr. Curlin opined: "Christians, we hope, refuse to worship idols, including the idols we make out of medicine. Christians, we hope, refuse to violate God's law in service to any other end, including the patient's autonomy."[13] And Dr. Curlin reaffirmed before this Court that he "tr[ies] hard to carry [his] religious beliefs over into all of [his] other dealings in life." Tr. 2 305:11–306:18.

Dr. Curlin's view that a fertilized egg holds the moral status of a full human being—and that abortions both after ***and*** before six weeks are therefore unethical, Tr. 2 316:16–317:4—is not universal across religions or even across all Christian denominations. Judaism, for example, has a

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https://app.box.com/shared/static/2c9i315a8jhizgxdfyyozkq1cbp2w3a7.pdf, attached hereto as Ex. F.

[12] *See* Christian Med. & Dental Ass'ns, *Member Awards*, https://cmda.org/member-awards (last visited Nov. 3, 2022), attached hereto as Ex. G.

[13] Farr Curlin, M.D., Lecture at Loma Linda University Center for Christian Bioethics: What Does Medicine Have to Do with the Healing Ministry of Jesus Christ? (Mar. 2, 2018), https://myllu.llu.edu/learnllu/main/courses/144 (9:53-10:08), attached hereto as Ex. H.

different understanding of when human life begins. The Talmud considers a fetus as having the status of "mere fluid" until forty days after conception—approximately seven or eight weeks LMP.[14] Beyond forty days, the fetus still does not have the moral status of a human being; the fetus "gains 'full human status at birth only.'"[15] Because of the fetus's lesser status, the pregnant person's life, physical, and mental health are primary.[16] As other examples, the Presbyterian Church (U.S.A.) acknowledges "[w]e may not know exactly when human life begins,"[17] and the United Church of Christ notes the "many religious and theological perspectives on when life and personhood begin."[18]

The State's evidence does not support treating a zygote or embryo as an "other individual[]" with rights that override those of a pregnant Georgian. *Pavesich*, 50 S.E. at 71. To the contrary, the existential nature of this question underscores that whether to continue a pregnancy is a profoundly private matter for Georgians to decide for themselves, or in consultation with loved ones, doctors, and spiritual advisors. *See* PX005 (Cwiak Aff.) ¶¶ 9–11; Tr. 1 326:25–327:4 (Meltzer-Brody).

C. The State Does Not Have a Sufficiently Compelling Interest at Six Weeks of Pregnancy to Justify Forced Pregnancy.

1. The Ban Does Not Further "Maternal Health and Safety."

Abortion Safety: The American Medical Association, American College of Obstetricians &

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[14] Rabbi Danya Ruttenberg, *The Torah of Reproductive Justice*, Sefaria (citing Yevamot 69b), https://www.sefaria.org/sheets/234926.8?lang=bi (last visited Nov. 3, 2022), attached hereto as Ex. I; *accord* Joseph G. Schenker, *The Beginning of Human Life: Status of Embryo*. *Perspectives in Halakha (Jewish Religious Law)*, 25 J. Assist. Reprod. Genet. 276 (2008), at *2, https://ncbi.nlm.nih.gov/pmc/articles/PMC2582082/, attached hereto as Ex. J.

[15] Schenker, *supra* n.14, at *5; *see also id.* at 2.

[16] *See, e.g.*, Benjamin Hassan, *Abortion in Jewish Law*, Sefaria, (citing Tzitz Eliezer, 13:102 (R. Eliezer Waldenberg)), https://www.sefaria.org/sheets/392339?lang=bi (last visited Nov. 3, 2022), attached hereto as Ex. K ("[I]t doesn't matter what type of pain and suffering is endured, physical or emotional, as emotional pain and suffering is to a large extent much greater than physical pain and suffering[.]").

[17] Presbyterian Church (U.S.A.), *Abortion/Reproductive Choice Issues*, https://www.presbyterianmission.org/what-we-believe/social-issues/abortion-issues/ (last visited Nov. 3, 2022), attached hereto as Ex. L.

[18] United Church of Christ, *Reproductive Health and Justice*, https://d3n8a8pro7vhmx.cloudfront.net/unitedchurchofchrist/legacy_url/455/reproductive-health-and-justice.pdf?1418423872 (last visited Nov. 3, 2022), attached hereto as Ex. M.

Gynecologists ("ACOG"), and more than 75 other leading health care associations agree that "[a]bortion care is safe and essential reproductive health care." PX021; *accord, e.g.*, Br. for ACOG et al. as Amici Curiae Supporting Pls., *Sistersong et al. v. State of Georgia*, (2022CV367796) (Aug. 8, 2022) [hereinafter "ACOG et al. Amicus Br."], at 5–6; PX022 at 77 (National Academies of Science, Engineering, and Medicine 2018 report on the science of abortion safety, concluding that all methods legally available in the U.S. are safe and effective);[19] PX008 (Rice Aff.) ¶ 49. Indeed, "abortion is one of the safest outpatient medical procedures in the United States." PX005 (Cwiak Aff.) ¶ 15. For instance, one study following all patients who obtained abortions billed to Medi-Cal (California's Medicaid program) in 2009–2010—comprehensively capturing data from over 50,000 abortions, including follow-up visits to emergency departments—found a major complication rate of just 0.23%. PX027 at 181; *see also* PX006 (Cwiak Rebuttal Aff.) ¶ 13. Even the State's witness, Dr. Wright, concedes that abortions are "reasonably safe." Tr. 2 382:11–15.

Whereas the most recent maternal mortality rate in Georgia is 28.8 per 100,000 live births, PX008 (Rice Aff.) ¶ 21, the fatality rate for abortion is less than 1 per 100,000 abortions, Tr. 1 111:14–25 (Cwiak). "Every pregnancy-related complication is more common among women giving birth than among those having abortions." PX005 (Cwiak Aff.) ¶ 16; PX024 at 215; *accord* ACOG et al. Amicus Br. 14; *see supra* 3–5, 7 (discussing medical risks of forced pregnancy).

Standing alone against all the weight of this medical authority is the State's witness Dr. Skop, a Texas OBGYN who has never performed an abortion. Tr. 2 139:24–140:1. Dr. Skop conceded in a 2020 deposition that she is "not a really good researcher." Tr. 2 145:15–23. Indeed, Dr. Skop has

[19] The National Academies is an independent, non-governmental institution established by Congress in 1863 to inform the public on matters of science and medicine. PX022 at iii–iv. The individuals tasked with reviewing the National Academies' abortion report were highly esteemed national experts chosen for their "diverse perspectives and technical expertise" to provide "critical comments" and ensure compliance with the academies' "institutional standards for quality, objectivity, evidence, and responsiveness." *Id.* at vii.

never held an academic position, and between the late 1990s and 2018, did not author any publications or make any public presentations. Tr. 2 143:25–144:2; Dep. Ingrid Skop, M.D., *Planned Parenthood Ass'n of Utah v. Miner* ("Skop Utah Dep.") 220:7–12, attached hereto as Ex. N. Although Dr. Skop now works at an anti-abortion research organization and has published several articles on abortion safety, she admitted in 2020 that portions of her articles were "lift[ed]" from another author's work—a practice more commonly known as plagiarism. Skop Utah Dep. 257:20–258:8 ("I thought that if the ideas were unique that I didn't realize that it was a problem to lift a couple of sentences here and there."); *see also id.* at 245:19–256:17 (admitting portions of her publications are "identical" or "nearly identical" to an expert report by a defense witness in another abortion case). Dr. Skop conceded that all of her publications in the field might suffer from this flaw, *id.* at 258:20–259:4, and professed not to know whether "identical republication of material from another author without attribution is consistent with standards of academic integrity" in her field, *id.* at 251:18–24.

Dr. Skop testified that her opinions are not "solitary," finding company in (1) AAPLOG, (2) two explicitly Christian medical associations, and (3) the American Association of Physicians and Surgeons, an advocacy group masquerading as a medical authority which, among many fringe stances,[20] accuses former President Barack Obama of hypnotizing listeners with his speeches. DX020 (Skop Aff.) ¶ 102; Tr. 2 179:13–180:7. Dr. Skop's theories hinge principally on criticism of the CDC's abortion data collection methods, which she recycles from past testimony despite having been presented with information contradicting her. Tr. 2 149:8–153:18; 159:11–162:9. She asks the Court to rely instead on 25-year-old data from Finland that she admits is overinclusive because it connects any death in the year following an abortion regardless of any causal relationship. Tr. 2 161:21–24.

[20] Olga Khazan, *The Opposite of Socialized Medicine*, The Atlantic (Feb. 25, 2020), https://www.theatlantic.com/health/archive/2020/02/aaps-make-health-care-great-again/607015, attached as Ex. O ("fringe views" include "mandatory vaccination is 'equivalent to human experimentation'" and "Medicare is 'evil.'").

Just five months ago, a Florida circuit court rejected as not credible Dr. Skop's testimony on topics nearly identical to those on which she opined in this case. *Planned Parenthood of Sw. & Cent. Fla. v. State of Fla.*, No. 2022 CA 912, 2022 WL 2436704, at *13 (Fla. Cir. Ct. July 05, 2022), *rev'd on other grounds*, 344 So. 3d 637 (Fla. 1st Dist. Ct. App. 2022), *pet. for review docketed*, No. SC2022-1127 (Fla. Aug. 31, 2022). As that court concluded:

> Dr. Skop has no experience in performing abortions; admitted that her testimony on the risks of certain abortion complications was inaccurate and overstated, or based on data from decades ago; admitted that her views on abortion safety are out of step with mainstream medical organizations; and provided no credible scientific basis for her disagreement with recognized high-level medical organizations in the United States.

Id. Likewise here, this Court should find Dr. Skop's testimony unsupported and not credible, and give no weight to Dr. Skop's unsupported theories that forced pregnancy and childbirth will result in *better* health outcomes for Georgians. The evidence overwhelmingly shows that the opposite is true.

Mental Health: The State fares no better in attempting to show that banning abortion from the earliest weeks of pregnancy will mean that "fewer [women] will suffer psychologically." Tr. 2 204:18–24 (Coleman). To support this theory, Defendant relies exclusively[21] on testimony from Dr. Coleman, a retired professor of developmental psychology and researcher with no clinical training or experience. Tr. 2 182:3–24; 218:20–219:3; 219:18–20. Dr. Coleman has testified in more than a dozen abortion-related lawsuits, always in favor of upholding the abortion restriction. Tr. 2 216:6–13. She believes that "abortion is never the right decision for a woman unless her life is in imminent danger" and that abortion should be illegal even in cases of rape. Tr. 2 216:14–217:23.

Dr. Coleman is a self-described "methodologist" and boasts that her expertise in research

[21] While Dr. Skop briefly opines that abortion causes mental health issues, *see* DX020 ¶ 76, she admits she is not an expert in mental health. Tr. 2 146:3–15.

methods means she can evaluate research in "virtually" any field to assess a study's strength. Tr. 2 223:11–22. Yet Dr. Coleman's approach to research is famously unreliable, both in her underlying work and in her legal testimony. Tr. 1 323:5–11 (Meltzer-Brody); *see infra*. And her conclusion that abortion increases the risk of mental health problems has been rejected by leading authorities including the National Academies, the American Psychological Association ("APA"),[22] and the United Kingdom's Royal College of Psychiatrists,[23] following exhaustive scientific reviews. PX012 (Meltzer-Brody Rebuttal Aff.) ¶¶ 2–3; Tr. 1 323:5–11 (Meltzer-Brody).

In concluding that abortion does ***not*** adversely affect mental health, these leading health associations have raised serious methodological concerns about Dr. Coleman's research. For instance, the Royal College stated that "[a] number of methodological problems with the meta-analysis conducted in the Coleman review have been identified, which brings into question both the results and conclusions." PX112 at 18; *see also* PX012 ¶ 3. Among the studies authored or co-authored by Dr. Coleman that the Royal College considered, it rated most methodologically "poor" or "very poor." PX112 at 226–29. The APA Report similarly found that at least eleven of Dr. Coleman's studies suffer from methodological shortcomings. PX110 at 16–19.

Yet Dr. Coleman presents herself to this Court as an expert in methodology and continues to rely upon these and other similarly flawed studies. *See, e.g.*, DX069, DX073, DX074, DX078, DX088, DX120, DX121, DX243 (examples of studies excluded by Royal College for inappropriate controls, comparators, and/or mental health measures); *see also, e.g.*, DX191, DX042, Tr. 2 223:11–

[22] A task force of the APA, the U.S.'s leading scientific and professional organization of psychologists, conducted a comprehensive, two-year review of the scientific literature "to critically and objectively evaluate the quality of the scientific evidence without regard to the direction of its findings in order to draw conclusions about the mental health implications of abortion." PX110 at 6; *see also id.* at 21–22 (detailing methodology).

[23] The Royal College of Psychiatrists, the United Kingdom's professional and educational body for psychiatrists, partnered with the British Psychological Society and established the National Collaborating Centre for Mental Health ("NCCMH") to develop "evidence-based mental health reviews and clinical guidelines." PX112 at 2. In 2011, it published a systematic review of the literature on abortion, and like the APA, included a thorough description of its methodology. *Id.* at 21–35.

225:17, 239:5–251:1. That is because, in Dr. Coleman's opinion, all of these medical associations are "arrogantly seeking to distort th[e] scientific literature" in service of a pro-abortion agenda. Tr. 2 268:17–25. Indeed, she believes "scores of scientists have suspended personal and professional ethics in order to advance abortion rights" and be "politically correct." Tr. 2 268:12–16, 269:19–25. Dr. Coleman asks the Court to trust her scientific judgment over that of leading mental health authorities—and even to ignore the limitations identified by ***the authors of the very studies*** on which she relies, because she knows better. *See, e.g.*, Tr. 2 246:2–248:5 ("So an author's particular assessment—and I don't necessarily agree with their commentary that relates to the data cited."); *id.* ("Sometimes the commentary that's provided might not line up with my view on the data . . . .").

Dr. Coleman's testimony is so misleading and riddled with errors that it does not merit this Court's consideration. For instance, Dr. Coleman admits that she does not read every article before citing it: sometimes she just "skim[s]" a study before including it in a sworn affidavit if she "read it six or [she] read it eight years ago." Tr. 2 225:22–226:14. After all, "[t]here's only so many hours in the day," Tr. 2 226:3–4, and she "wrote this [40-page, single-spaced] report in a week," Tr. 2 263:12–15. Dr. Coleman also omits crucial context for the studies she cites if, in her view, it's not "relevant to the point [she's] trying to make." Tr. 2 255:6–14. For instance, Dr. Coleman's affidavit states that "Allanson and Astbury (1996) reported some startling statistics conveying women's emotional conflict prior to having a first-trimester abortion"—but does not say that these "startling statistics" were drawn from a total of ***20 women*** (in Australia). DX015 ¶ 36; DX031 at 160; Tr. 2 253:1–20. Similarly, Dr. Coleman's affidavit reports that a study she published in 1998 "found 38.7% of female college students voiced regret in the first few years following an abortion," DX015 ¶ 42—nowhere revealing that this statistic is drawn from ***just 31 female college students*** who had abortions, DX073 at 429. When asked whether the Court "would have to review all 250 references in [her] affidavit to

understand whether something [Dr. Coleman] refer[s] to as a 'startling statistic' might in fact be drawn from a pool of 20 people," she answered: "I supposed they would." Tr. 2 255:15–20.

As another example, Dr. Coleman cited a 2008 study by Fergusson et al. in which the authors described their results as "consistent with the view that exposure to abortion has a small ***causal effect*** on the mental health of women" and listed findings "support[ing] a ***causal conclusion***" between abortion and adverse mental health. DX102 at 449 (emphasis added). But Dr. Coleman nowhere cited a subsequent piece by Fergusson et al. reanalyzing those 2008 data, in which the authors now caution that, "it would be premature to conclude emphatically that this evidence is sufficient grounds for believing that abortion has adverse effects on mental health," and advise that "further and better research is needed before strong conclusions can be ventured about this topic." DX619 at 826.[24]

As the U.S. District Court for the Southern District of Indiana found, Dr. Coleman's research on abortion has "been almost uniformly rejected by other experts in the field." *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r, Ind. State Dep't of Health*, 273 F. Supp. 3d 1013, 1036 (S.D. Ind. 2017). The Seventh Circuit affirmed, finding "no reason to disturb [the district court's] thoroughly reasoned findings" regarding Coleman's "much maligned" research. *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r of Ind. State Dep't of Health*, 896 F.3d 809, 826, 830 (7th Cir. 2018), *cert. granted, judgment vacated sub nom. Box v. Planned Parenthood of Ind. & Ky., Inc.*, 141 S. Ct. 184 (2020). In *Whole Woman's Health Alliance v. Rokita*, the Southern District of Indiana excluded Dr.

[24] While Fergusson et al. found in 2013 that there "was suggestive but not completely consistent evidence of modestly elevated rates of mental health problems in women having abortion compared with women having unwanted or unintended pregnancy," DX619 at 824, even that tentative conclusion relied on studies plagued by the same methodological flaws infecting Dr. Coleman's analysis. For instance, Fergusson et al. considered a 2006 study by Dr. Coleman despite acknowledging that it was excluded from the Royal College's NCCMH 2011 analysis due to Dr. Coleman's failure to control for "pre-abortion mental health data." DX619 at 821. As another example, Fergusson et al. relied on a 2005 piece by Cougle, Reardon, and Coleman (DX079) purporting to showing heightened rates of anxiety following abortion. DX619 at 821. But a 2008 re-analysis of the dataset used by Cougle et al. found *no* difference in rates of anxiety following pregnancy or birth after controlling for additional variables available in the dataset, such as preexisting anxiety symptoms. *See* Julia R. Steinberg & Nancy F. Russo, *Abortion and Anxiety: What's the Relationship?*, 67 Soc. Sci. & Med. 238 (2008), attached hereto as Ex. P.

Coleman's testimony regarding studies "infect[ed]" with methodological errors, finding it "insufficiently reliable to become evidence at trial that will inform the Court's decision-making." No. 118CV01904SEBMJD, 2021 WL 650589, at *6–7 (S.D. Ind. Feb. 19, 2021). And in *Adams & Boyle, P.C. v. Slatery*, the Tennessee district court found that "Dr. Coleman's testimony [is] not credible and not worthy of serious consideration." 494 F. Supp. 3d 488, 538 (M.D. Tenn. 2020), *hearing en banc ordered sub nom. Bristol Reg'l Women's Ctr., P.C. v. Slatery*, 993 F.3d 489 (6th Cir. 2021), *and rev'd and remanded on other grounds*, 7 F.4th 478 (6th Cir. 2021). This Court should reject both Dr. Coleman's testimony and the State's disproven interest in protecting mental health through this Ban.

2. The Ban Does Not "Safeguard[] the Ethics and Integrity of the Medical Profession."

The State's asserted "ethics and integrity" defense turns reality on its head. The American Medical Association and more than 75 other leading medical professional associations oppose abortion bans like H.B. 481 precisely because, *inter alia*, they "***impair*** the integrity of the medical profession." PX021 (emphasis added); *accord* ACOG et al. Amicus Br. 18–20. While Dr. Curlin testifies that abortion "undermines" a physician's allegiance to the Hippocratic oath, the opposite is true. Tr. 2 296:18. Georgia physicians—which Dr. Curlin is not—can no longer abide by their ethical obligation to *do no harm* when the Ban "threatens criminal prosecution against physicians" who act "within their scope of practice." PX016 (Medical Association of Georgia ("MAG") opposing the Ban); Tr. 2 96:12–96:24 (Badell); PX003 (Badell Rebuttal Aff.) ¶ 25. The Ban has not changed medical standards of care, which recommend abortion as treatment in many circumstances. *See, e.g.*, Tr. 2 30:23–31:10, 67:7-68:11 (Badell); PX002 (Badell Aff.) ¶ 29; Tr. 2 392:18–393:3, 395:17–397:17 (Wright). But Georgia doctors must now discount those standards and instead, because of the statute's convoluted and non-medical terminology, "balance the risk of criminal prosecution" when determining treatment options for a potentially life-threatening or health-impairing condition. Tr. 2

31:6–8 (Badell); PX002 (Badell Aff.) ¶ 29. Loath to face such a choice, competitive applicants are already canceling interviews and withdrawing applications to training programs at Georgia medical schools and hospitals, which is likely to exacerbate Georgia's existing OBGYN shortage. Tr. 1 139:14–141:14 (Cwiak); PX016 (MAG letter opposing Ban).

Dr. Curlin may believe that abortion is "morally reprehensible," and some members of the medical profession may share that view. *Powell*, 270 Ga. at 335. But "this repugnance alone does not create a compelling justification for state regulation of the activity," particularly when Dr. Curlin's opinion is opposed by virtually every leading state and national medical association. *Id.*

3. The State's Asserted Interest in Embryonic and Fetal Life Is Not Sufficiently Compelling Until Viability to Justify This Intrusion.

While the Georgia Supreme Court has recognized a legitimate interest in protecting potential life, the case law reflects that viability, not embryonic cardiac activity,[25] is the critical milestone at which that interest becomes sufficiently compelling to potentially "outweigh" a competing right to privacy. *McAfee*, 259 Ga. at 580; *see also* MTD Opp'n 18, 20–21. Critically, when *McAfee* discussed the balance of interests between the State's "protection of innocent third parties" and Georgians' right to privacy, it cited to *Jefferson*. 259 Ga. at 580. And in *Jefferson*, the fact that the 39-week fetus was "viable and fully capable of sustaining life independent of the mother" was critical to the Court's holding that the hospital could require a C-section delivery to save the life of the fetus as well as, likely, the pregnant woman herself. *See* MTD Opp'n 18. If viability had not been central to *Jefferson*'s holding, there would have been no reason for the Court to cite *Roe v. Wade*—which held that, "[w]ith respect to the State's important and legitimate interest in potential life, the 'compelling' point is at

[25] Moreover, the State's reliance on an embryonic "heartbeat" at approximately six weeks LMP as the key marker of its compelling interest is inconsistent with science. PX002 (Badell Aff.) ¶¶ 26–27; *see* ACOG et al. Amicus Br. 7–8 (explaining that "[a]s a matter of medical science, a true fetal heartbeat exists only after the chambers of the heart have developed and can be detected via ultrasound, which typically occurs around 17-20 weeks of gestation").

viability." 410 U.S. 113, 163 (1973), *overruled by Dobbs*, 142 S. Ct. 2228.

Additionally, the evidence shows that the Ban is "unduly oppressive" by prohibiting abortions at just six weeks LMP, *Powell*, 270 Ga. at 334, a cut-off so early that it is simply impossible for many Georgians to meet, PX008 (Rice Aff.) ¶¶ 33–34; PX005 (Cwiak Aff.) ¶ 38. Before the Ban took effect, the Georgia Department of Public Health ("GDPH") reported that a minority of abortions (43%) occurred at or before six weeks of gestation. Tr. 1 105:8–25 (Cwiak); PX008 (Rice Aff.) ¶ 33.[26] Similarly, Dr. Cwiak testified that in her personal experience, the number of abortions occurring now in Georgia is "50 percent or less" than before the Ban took effect. Tr. 1 149:2–9. Ms. Nesmith testified that Plaintiff Feminist Women's Health Center has reduced its business days from five to three because so many fewer patients are eligible for care. Tr. 2 329:10–12. Even so, and despite pre-screening patients by phone, "every clinic day, typically, we turn women away [because they are ineligible under the Ban] . . . at least one or two a day, sometimes more." Tr. 2 334:9–14 (Nesmith).

It is undisputed that many patients ***do not even know*** they are pregnant by six weeks LMP. Tr. 1 95:11–96:9 (Cwiak). Six weeks LMP is only two weeks after a first missed period for people with regular four-week cycles—which many do not have. Tr. 1 94:8–96:4 (Cwiak); PX008 (Rice Aff.) ¶ 33. For instance, a 35-day (five-week) menstrual cycle is still considered within the range of normalcy, leaving only a week or less between a missed period and the Ban's deadline; others with irregular cycles may not have any signs of pregnancy before the six-week cut-off. Tr. 1 95:11–96:4 (Cwiak). As Dr. Rice explained, for many people seeking abortions—who are disproportionately low-income—obtaining the necessary funds and making arrangements for transportation, childcare, and

[26] Moreover, this figure likely overestimates the percentage of patients able to access an abortion in Georgia under the Ban—*i.e.*, able to access an abortion before the point of cardiac activity. That is because the CDC relies on data about abortions collected by the GDPH, and in collecting such data, GDPH classifies as "at or before 6 weeks" any abortion occurring up to six weeks *and six days* of pregnancy. Tr. 1 106:5–23 (Cwiak). In most cases, cardiac activity is detectable by six weeks, zero days—or even slightly beforehand. Tr. 1 105:15–25. Thus, some number of abortions classified by the CDC as "at or before 6 weeks" would also be prohibited under the Ban.

time off work (in most cases unpaid) is not possible before six weeks LMP. Tr. 1 226:14–227:22 (Rice); Tr. 1 117:18 (Cwiak); PX008 ¶¶ 34–36 (Rice). Missing an appointment due to lack of childcare, Tr. 2 331:24–333:12 (Nesmith), or taking a few days to reflect further on their abortion decision, Tr. 2 333:7–334:3 (Nesmith), now makes the difference between being able to have an abortion in Georgia and being turned away. For example, Ms. Nesmith described a patient who left the clinic after her initial ultrasound, wanting more time to think about her decision. When she returned to the clinic for her abortion appointment, not only was there fetal cardiac activity, but she also learned that she was carrying a twin pregnancy. Tr. 2 333:7–334:3.[27]

Patients who miss the Ban's extreme cut-off are "inconsolable" and "devastated" such that Ms. Nesmith has heard "audible wailing" from "three rooms down." Tr. 2 332:12–18. Ms. Nesmith recalled one patient who was so "nervous" about the prospect of being denied abortion care due to the possible presence of cardiac activity that she was "disheveled" and "physically shaking" so much that Ms. Nesmith "had to take the things from her hand and put them on the table" to proceed with the ultrasound. Tr. 2 334:21–335:15. In the face of these significant intrusions on Georgians' privacy and the risks that forced pregnancy poses to Georgians' health, lives, and futures, the State's interests are not sufficiently compelling to justify the Ban's prohibition on abortion at just six weeks LMP.

D. The Ban Is Not the Least Restrictive Means.

1. The Narrow and Inscrutable Medical Emergency Exception Is Impeding Care for Pregnancy Complications.

The "medical emergency" exception does not save the Ban. To the contrary, the exception is

[27] In the context of multifetal reductions (offered for higher-order multiple pregnancies—*i.e.*, three or more, PX002 (Badell Aff.) ¶ 4), the State's asserted interests in both fetal life and maternal safety are particularly incoherent. Multifetal reductions are offered to patients as a means to improve health outcomes for both the remaining fetus(es) and for the pregnant woman and to increase the likelihood of at least one successful delivery. Tr. 2 16:23–18:1 (Badell). But, under the Ban, Georgia physicians like Dr. Badell can no longer offer that standard-of-care option to patients carrying multi-fetal pregnancies. Tr. 2 19:17–20:20; PX002 (Badell Aff.) ¶¶ 42–45.

drawn so narrowly that it undermines the State's asserted interest in protecting the health and lives of people in Georgia. The "medical emergency" exception allows an abortion only when the abortion "is necessary in order to prevent the death of the pregnant woman or the substantial and irreversible physical impairment of a major bodily function of the pregnant woman." PX001 at 4 (O.C.G.A. § 16-12-141(a)(3)). As multiple medical experts testified, "major bodily function" and "substantial and irreversible physical impairment" are not medical terms that are taught in medical school or with which doctors are generally familiar. Tr. 1 125:2–126:12 (Cwiak); Tr. 2 26:6–27:4 (Badell). This has left doctors treating patients in Georgia "feel[ing] hand-tied" as they attempt to navigate care for patients facing pregnancy complications. Tr. 2 25:20–26:5, 32:17–21 (Badell).

This feeling of uncertainty is especially true for maternal-fetal medicine specialists like Dr. Badell, who treat high-risk pregnancies. Tr. 2 25:20–26:5 (Badell); PX002 (Badell Aff.) ¶ 29. All parties agree that when a pregnant person presents with, for instance, serious kidney or cardiac conditions, it is the standard of care to offer abortion as a potential treatment option. Tr. 2 27:8–28:12, 45:23–46:1 (Badell), 397:10–14 (Wright). Dr. Wright, who does not practice medicine in Georgia and has no plans to do so, Tr. 2 385:14–22, posits that the exception's use of the word "prevent" still allows doctors to appropriately and timely intervene with abortion care under such circumstances, Tr. 2 400:13–401:12. But the exception applies only if an abortion is "***necessary to*** prevent" death or substantial physical impairment of a major bodily function. Tr. 2 26:11–20 (Badell), 64:24–65:18 (Badell); PX003 (Badell Rebuttal Aff.) ¶ 3. As Dr. Badell queried, "is that a death that we think is one percent likely, ten percent likely, 20 percent? . . . [I]t's unclear at what risk of death to the pregnant person would qualify as necessary." Tr. 2 65:4–9; *see also* Tr. 2 27:8–30:22 (Badell).

As a result, Georgia doctors are left to wait until pregnant people get "sick enough" before they can intervene. Tr. 1 133:1–4 (Cwiak); Tr. 2 33:15–34:18, 70:3–20, 96:12–96:22 (Badell); PX003

(Badell Rebuttal Aff.) ¶ 4.[28] As Dr. Cwiak testified, it is a doctor's job "to prevent complications," and waiting to provide care until a predictable emergency arises is contrary to medical ethics and guidelines. Tr. 1 132:17–25; *see also* ACOG et al. Amicus Br. 19; PX002 (Badell Aff.) ¶ 33.

Delay also carries devastating consequences. A recent study analyzed the impact of two 2021 Texas laws with emergency exceptions similar to the Ban. *See* PX144.[29] The study observed 28 patients who presented with a serious medical condition and fetal cardiac activity. PX144 at 3. All patients received expectant management (*i.e.*, wait and see) until a "medical emergency" arose. *Id.* at 3–4. As a result, 57% of the patients experienced a serious maternal morbidity, compared with 33% who chose to end their pregnancy under similar clinical circumstances in states without abortion bans. *Id.* at 4. All but one patient lost their fetus or infant, and the only surviving infant remained admitted to the hospital at the time the study was published. *Id.* at 3. Similarly dire outcomes occurred in Ireland when doctors felt constrained to wait to treat pregnant people facing serious medical complications, ultimately prompting Ireland to pull back on its restrictive abortion law. Tr. 2 43:23–44:9 (Badell).

Dr. Wright opines that Georgia doctors need not worry because they are permitted to use their "reasonable medical judgment" in determining whether the exception applies. Tr. 2 373:7–14. But a doctor who violates the Ban faces criminal penalties.[30] If a district attorney or a jury disagrees with a

[28] Georgia-based doctors also testified to the confusion they are facing with respect to miscarriage care, underscoring the need for a binding interpretation from this Court. Tr. 1 120:17–121:15 (Cwiak); Tr. 2 95:12–96:22 (Dr. Badell explaining the lack of clarity about whether an abortion can be performed for premature rupture of membranes with ongoing cardiac activity before "someone has gotten infected or bled enough that we can agree that it's an immediate threat to their life.").

[29] Tex. Health & Safety Code Ann. § 171.205(a) (permitting an abortion after detection of fetal heartbeat if "a physician believes a medical emergency exists"); *id.* § 171.002(3) (defining "[m]edical 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").

[30] O.C.G.A. § 16-12-140(b) (violations of the Ban "shall be punished by imprisonment for not less than one nor more than ten years"). Violation of the Ban also creates a risk that those doctors will lose their medical licenses. O.C.G.A. § 31-9B-2(b) (failure to comply with the Ban constitutes "unprofessional conduct" as used in medical licensing sanctions); O.C.G.A. § 43-34-8(7) (granting the Georgia Composite Medical Board authority to discipline a licensed physician for "unprofessional conduct" even if it results in no actual injury to a person).

doctor's "reasonable medical judgment" that an abortion was "***necessary***" to prevent death or "***substantial*** and irreversible" physical impairment of a "***major*** bodily function," the doctor risks imprisonment and loss of their medical license. Tr. 1 127:19–128:4 (Cwiak); Tr. 2 30:23–31:10, 42:9–43:3, 65:10–18 (Badell); PX003 (Badell Rebuttal Aff.) ¶ 2. And the fact that doctors often criticize each other, as Dr. Wright himself emphasized, only underscores the likelihood that a physician's judgment may be second-guessed by an expert for the State. Tr. 2 374:14–25.

2. The State Cannot Justify Its Exclusion of Life-Threatening Psychiatric Conditions from Its Medical Emergency Exception.

The Ban's carveout for psychiatric conditions disregards the evidence that pregnancy has a dire psychiatric impact on some patients, such that termination is the only course of action to alleviate symptoms and prevent death. Tr. 1 326:15–24 (Meltzer-Brody); PX011 (Meltzer-Brody Aff.) ¶ 38. As Dr. Meltzer-Brody explained based on decades of treating pregnant patients, there is no legitimate reason for excluding psychiatric conditions from the medical emergency exception. Tr. 1 316:8–320:5; PX011 (Meltzer-Brody Aff.) ¶ 43. "The brain is an organ" like any other, and psychiatric conditions are "medical conditions." Tr. 1 316:8–21. Banning abortions even in the case of a psychiatric emergency is "an enormous injustice that will result in women dying." Tr. 1 317:3–6.

The State's attempt to justify its arbitrary bifurcation of physical and psychiatric illnesses based on junk science on the mental health harms of abortion fails. *See supra* 15–19. And the State's distinction between physical and psychiatric illness conflicts with the unanimously passed 2022 Mental Health Parity Act, which found "a significant need for greater parity of treatment of [mental health and substance use] disorders with other health insurance needs[.]" H.B. 1013, Ga. L. 2022.

Although it is undisputed that suicide is "one of the greatest causes of maternal mortality in the world," Tr. 1 317:1–2 (Meltzer-Brody); PX011 (Meltzer-Brody Aff.) ¶ 12; PX095 at 5, the State tries to minimize the absolute number of maternal suicides as "almost infinitesimal," Tr. 1 351:4

(State's attorney); *see also* Tr. 2 213:4–17 (Dr. Coleman suggesting no exception is necessary for patients likely to kill themselves because that's "anecdotal"). And Dr. Coleman—who has never treated or counseled any patient, much less performed a psychiatric evaluation of a pregnant patient, Tr. 2 218:23–219:3—goes so far as to suggest that a suicidal patient be told she will "feel better" if she continues the pregnancy and that abortion will not "fix [her] problem." Tr. 2 212:21–213:3. But the record reflects real-life examples of mentally ill patients who likely would have killed themselves had they been subject to the Ban, but instead were able to end their pregnancies—and uniformly saw relief from symptoms as a result. Tr. 1 317:21–320:5, 326:15–327:25 (Meltzer-Brody); PX011 (Meltzer Brody Aff.) ¶¶ 38–43. A law that sentences Georgians experiencing a psychiatric emergency to death is plainly not the least restrictive means of advancing state interests.[31]

3. The Medical Futility Exception Is Narrow, Confusing, and Cruel.

Under the Ban, an abortion is permitted when the pregnancy is "medically futile," meaning that "an unborn child has a profound and irremediable congenital or chromosomal anomaly that is incompatible with sustaining life after birth." PX001 at 4 (O.C.G.A. § 16-12-141(a)(4)). There are numerous fetal anomalies that can occur during pregnancy, such as anencephaly, Trisomy 13, and Trisomy 18, Tr. 2 36:24–37:4, 37:8–38:2 (Badell). These conditions have a high risk for stillbirth, and if the infant survives birth, he or she will have severe neural developmental disabilities. Tr. 2

[31] Notably, many other states with abortion bans do ***not*** exclude psychiatric conditions from medical emergency exceptions. Ala. Code § 26-23H-4(b) (ban); Ala. Code § 26-23H-3(4), (6) (definitions); *see also* Ala. Code § 13A-13-7 (pre-*Roe* ban); Ariz. Rev. Stat. § 36-2322(B) (ban); Ariz. Rev. Stat. § 36-2321(6)-(7) (definitions); *see also* Ariz. Rev. Stat. § 13-3603 (enjoined pre-*Roe* ban); Ark. Code Ann. § 5-61-304(a) (ban); Ark. Code Ann. § 5-61-303(3) (definitions); Ky. Rev. Stat. Ann. § 311.772(3)–(4) (ban and definitions); Mich. Comp. Laws § 750.14 (enjoined pre-*Roe* ban); Miss. Code. Ann. § 41-41-45(2) (ban); Miss. Code. Ann. § 41-41-37 (requirements for emergency exception); Miss. Code. Ann. § 41-41-31(b) (definitions); *see also* Miss. Code. Ann. § 97-3-3(1) (pre-*Roe* ban); Mo. Ann. Stat. § 188.017(2) (ban); Mo. Ann. Stat. § 188.015(7) (definitions); Ohio Rev. Code Ann. § 2919.195(A)–(B) (ban and definitions) (enjoined); S.D. Codified Laws § 22-17-5.1 (ban and exception); Utah Code Ann. § 76-7-302.5 (ban); Utah Code Ann. § 76-7-302(3)(b) (definitions); Utah Code Ann. § 76-7a-201(1)(a) (ban and exceptions) (enjoined); Utah Code Ann. § 76-7a-101(7) (definitions); Wis. Stat. § 940.04(1), (5) (pre-*Roe* ban and exception); *cf.* N.D. Cent. Code § 12.1-31-12(2)-(3)(a) (ban and affirmative defense) (enjoined).

37:14–38:19 (Badell). Most pregnant patients who receive such a genetic diagnosis have highly desired pregnancies and are devastated when they learn of the diagnosis. Tr. 2 39:12–22 (Badell); PX002 (Badell Aff.) ¶ 40. Patients who consider the risks and benefits of continuing the pregnancy and ultimately decide on abortion take that personal decision very seriously. Tr. 2 40:1–6 (Badell).

Now with the Ban in place, that power to decide is stripped from them, as doctors in Georgia struggle to apply the exception. Tr. 2 36:5–13 (Badell); PX002 (Badell Aff.) ¶ 38. Fetal anomalies cannot be diagnosed before six weeks, so any decision to terminate must fall within this exception. Tr. 2 38:20–39:11 (Badell). And it is not clear when a fetal anomaly qualifies as "incompatible with sustaining life after birth." Tr. 2 36:5–19 (Badell); PX003 (Badell Rebuttal Aff.) ¶ 15. Must the baby die "immediately" after birth? "In a week? In a month? In a year?" Tr. 2 36:15–17 (Badell). It is equally unclear whether the exception applies where survival may be possible only with aggressive medical intervention, Tr. 2 36:17–19 (Badell); PX003 (Badell Rebuttal Aff.) ¶ 15—which a patient may or may not be able to afford, and which, for many Georgians, is unlikely to be available where they live, Tr. 1 220:4–8, 12–18 (Dr. Rice discussing physician shortage); PX008 (Rice Aff.) ¶¶ 9, 18.

Dr. Wright confidently asserts without support that Trisomy 13 falls within the medical futility exception because only about 10% of infants with Trisomy 13 survive beyond one year of life and "the vast majority [of fetuses and infants with Trisomy 13] have passed away by . . . one year of age." Tr. 2 405:20–24, 406:7–22; DX22 (Wright Aff.) ¶¶ 51–53. But doctors in Georgia who face potential criminal prosecution are fearful. Tr. 2 36:20–37:4 (Badell). As Dr. Badell explains, Georgia doctors are not sure whether prosecutors and juries will agree that conditions with a similar survival rate are "incompatible with sustaining life after birth" because some infants do survive, if only a small number and only for a short period of time. Tr. 2 37:5–38:1; PX002 (Badell Aff.) ¶¶ 38–39. Dr. Wright offers no explanation for why a fetal anomaly from which the "majority" of infants die within a year is sure

to be considered incompatible with sustaining life after birth. Tr. 2 406:23–407:9.

4. Requiring Rape and Incest Survivors to Report Their Abuse to Police Before They Can Access Abortion Compounds the Ban's Privacy Intrusion and Harm.

The Ban compounds rape survivors' trauma by conditioning their access to health care on a police report.[32] As explained by Plaintiffs' experts who have treated patients seeking health care following a rape or incest, "most cases of rape or incest are never reported to the police." Tr. 1 315:23–316:6 (Meltzer-Brody); *see also* Tr. 1 134:9–135:25 (Cwiak). Some survivors "are in a state of trauma so that they really feel like it's – it's important for them to accomplish one thing at a time," Tr. 1 135:21–23 (Cwiak)—*i.e.*, to end the pregnancy before tackling the next trauma. Other patients may "themselves feel threatened by the idea of . . . involving law enforcement, either because of the perpetrator or perhaps because of the judgment they may feel from family or friends around them." Tr. 1 135:16–23 (Cwiak). Dr. Coleman herself acknowledges that survivors "face many barriers to reporting," DX015 at ¶ 134, citing Lemaigre et al., who explain that "the second most commonly identified barrier" to police reporting by child sex abuse survivors is fear of negative consequences, including losing familial support, their family breaking up, or "being killed." DX173 at 17–18.

In short, it is undisputed that survivors of sexual abuse have varied and deeply personal reasons why reporting their assault to law enforcement is very difficult, if not impossible or deadly. While the State's witnesses believe the moral choice is to force a rape victim, no matter the age, to carry any resulting pregnancy to term, *see* Tr. 2 321:14–322:8 (Curlin); 216:18–217:23 (Coleman), a

[32] Dr. Coleman asserts that rape is less likely to result in pregnancy than consensual intercourse, a theory that only reinforces Dr. Coleman's lack of any medical expertise. DX015 (Coleman Aff.) ¶ 150. Of course, the "physiologic steps" of pregnancy "do not change based on the intention of one of the participants in the act itself." Tr. 1 133:10–134:8 (Cwiak). In any event, the State cannot excuse the inadequacy of the Ban's rape exception by arguing that only a small number of Georgians will be forced to carry their rapist's pregnancies to term against their will. Under strict scrutiny, it is the ***State's*** burden to show that there was no less restrictive means of furthering its compelling interest or else the Ban is facially unconstitutional—and the State's failure to show that the Act is narrowly tailored with respect to rape and incest survivors is fatal, even setting aside the Ban's other deficiencies. *See Powell*, 270 Ga. at 333 & n.5; MTD Opp'n 23–24.

law that subjects a 13-year-old incest survivor who cannot report her rape to further assault on her body, health, and life plainly is not the least restrictive means of furthering the State's interest.

II. The Ban Violates Equal Protection.

The Ban violates Georgia's equal protection clause requiring "'that the State treat similarly situated individuals in a similar manner.'" *Bell v. Austin*, 278 Ga. 844, 846 (2005) (quoting *City of Atlanta v. Watson*, 267 Ga. 185, 187 (1996)). Strict scrutiny is the appropriate constitutional test when a statute "interferes with the exercise of a fundamental right[,]" and applies to this Court's analysis of the Ban. *Ambles v. State*, 259 Ga. 406, 407 (1989). By affording pregnant people who seek to continue their pregnancy the right to be free from State intrusion into their "life . . . body . . . [and] health," while denying that right to pregnant people who seek to terminate their pregnancy, the Ban discriminates based on how the pregnant person chooses to exercise their fundamental rights to liberty and privacy. *Pavesich*, 50 S.E. at 70. Because the State cannot meet its burden under strict scrutiny, *see supra* 12–29, the Ban is facially invalid under equal protection as well as privacy.

But even under rational basis review, at minimum, the Ban's exclusion of psychiatric emergencies would still fail. Where a statute creates a "distinction [that] is arbitrarily drawn . . . the statute is an unconstitutional denial of equal protection" under rational basis review. *Love v. State*, 271 Ga. 398, 402 (1999). Just so here. "The brain is an organ" like any other, Tr. 1 316:12-21 (Meltzer-Brody), and the Ban's "medically unfounded" distinction between physical and mental health—which violates state policy—"will result in wholly preventable deaths of pregnant people in Georgia," PX011 (Meltzer-Brody Aff.) ¶ 36, thus failing even rational basis. *See supra* 25–26.

III. The Records Access Provision Violates Georgia's Right to Privacy.

Finally, the Records Access Provision, which provides law enforcement with seemingly unrestricted access to the deeply personal information in patients' medical records, PX005 (Cwiak

Aff.) ¶¶ 63–66, runs roughshod over patients' privacy interests in a manner squarely foreclosed by *King v. State*, 272 Ga. 788, 790 (2000). *See* MTD Opp'n 27–28. Unable to explain how this intrusion squares with the Georgia Constitution, the State instead launches procedural attacks. *See, e.g.*, Tr. 1 33:21–34:16 (State's attorney) (admitting "there are some kind of weird issues around [the Records Access Provision]"). The State ***concedes*** that patients have no way of knowing if their records are shared with law enforcement and thus may not be able to bring as-applied challenges, but nevertheless protests that the law is not facially invalid because "I think most of the time, the medical provider" would not share patient records with law enforcement without due process—despite the fact that that is precisely what the statute purports to require. Tr. 1 33:21–34:16 (State's attorney). Indeed, the State cannot point to ***any*** safeguards in the statute, admitting that "we don't really know how this is going to be rolled out in practice," but nevertheless postulates that, probably, it will all be fine. *See* Tr. 1 31:20–22 (State's attorney noting that he "thinks" "the DA would have to [ ] subpoena the records," but citing no law); Tr.1 35:14–17 (stating that "I think [the Records Access Provision] has to be just about abortions," but citing no statutory limitation on disclosure of patients' non-abortion health records); Tr. 1 35:5–11 (suggesting that perhaps some patients would not mind having their intimate medical histories shared with the State without their knowledge, and speculating that a DA "might" only request records anonymously). The Georgia Constitution does not leave Georgians' most personal medical information so vulnerable to prosecutorial whims.

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that the Court declare unconstitutional Sections 4, 10, and 11 of H.B. 481 (codified at O.C.G.A. §§ 16-12-141, 31-9B-2, 31-9B-3), and O.C.G.A. § 16-12-141(f), and enjoin any enforcement thereof.

Respectfully submitted this 4th day of November, 2022.

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CERTIFICATE OF SERVICE

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

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

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This 4th day of November, 2022.

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Dr. Ingrid Skop

Dr. Ingrid Skop, MD, FACOG serves as Any Woman Can's Medical Director. She has been practicing in the field of obstetrics and gynecology for nearly 25 years. Dr. Skop is a Fellow of the American College of Obstetrics and Gynecology. She is also a member of the American Association of Pro-Life Obstetricians and Gynecologists, and an Associate Scholar of the Charlotte Lozier Institute. She serves on the board of The Source for Women, Texas, a consortium of full-service women's health clinics that counsel women on God's plan for sexuality while helping to prevent unintended pregnancies, and caring for pregnancies already conceived.

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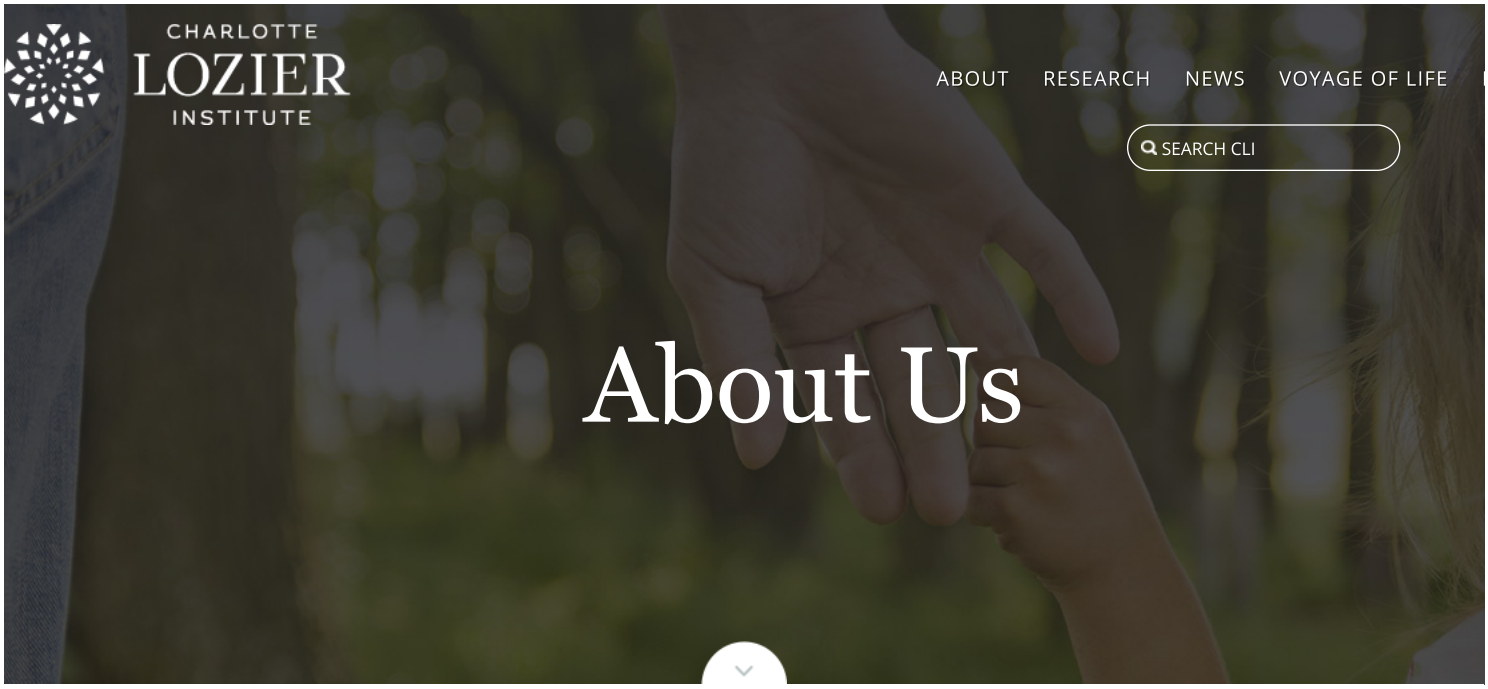

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Ingrid Skop, M.D., F.A.C.O.G.

Senior Fellow and Director of Medical Affairs

Ingrid Skop, M.D., F.A.C.O.G., is Senior Fellow and Director of Medical Affairs for Charlotte Lozier Institute, leveraging more than 25 years' experience as a practicing obstetrician-gynecologist to support research and policies that respect the dignity of every human life.

Dr. Skop received her Bachelor of Science in physiology from Oklahoma State University and her medical doctorate from Washington University School of Medicine. She completed her residency in obstetrics and gynecology at the University of Texas Health Science Center at San Antonio. Dr. Skop is a Fellow of the American College of Obstetricians and Gynecologists, where she uses science and statistics to counter pro-abortion agendas, and is a lifetime member of the American Association of Pro-Life Obstetricians and Gynecologists.

Prior to joining Charlotte Lozier Institute, Dr. Skop served for over 25 years in private practice in San Antonio, where she delivered more than 5,000 babies and personally cared for many women who had been harmed, physically and emotionally, from complications due to abortion. She continues to serve as Medical Director of Any Woman Can, a pregnancy resource center that provides support and free counseling to women in crisis. She also serves as medical director and board member of The Source in Austin and Houston, a consortium of full-service women's centers with a Christian worldview.

Dr. Skop's research on maternal mortality, abortion, and women's health has been published in multiple peer-reviewed journals. Additionally, she has provided expert testimony at both the state and federal levels on legislation related to

abortion, including standing firm against prominent pro-abortion politicians who choose not to follow the science regarding fetal heartbeat and development.

Dr. Skop is married to a physician and is the proud mother of two sons and a daughter.

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By: David C. Reardon, Ph.D., Donna J. Harrison M.D., Ingrid Skop M.D. Maka Tsulukidze, M.D., Ph.D, M.P.H.,Christina A. Cirucci, M.D., James Studnicki, Sc.D., M.P.H. M.B.A This is issue 20 of CLI's American Report Series. To View this Report as a PDF, see: Overlooked Dangers of Mifepristone, the FDA's Reduced REMS, and Self-Managed Abortion Policies: [...]

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EXHIBIT C

SPLC Southern Poverty Law Center

AMERICAN COLLEGE OF PEDIATRICIANS

The American College of Pediatricians (ACPeds) is a fringe anti-LGBTQ hate group that masquerades as the premier U.S. association of pediatricians to push anti-LGBTQ junk science, primarily via far-right conservative media and filing amicus briefs in cases related to gay adoption and marriage equality.

EXTREMIST GROUP INFO:

SPLC DESIGNATED HATE GROUP

Date Founded: 2002

Location: Gainesville, Florida

Ideology: Anti-LGBTQ

ACPeds opposes adoption by LGBTQ couples, links homosexuality to pedophilia, endorses so-called reparative or sexual orientation conversion therapy for homosexual youth, believes transgender people have a mental illness and has called transgender health care for youth child abuse.

In its own words

"Your public library may have a drag queen story hour where books like I am Jazz are read to children by trans activists eager to groom the next generation of victims."— *Andre Van Mol, co-chair of ACPeds' Committee on Adolescent Sexuality, "Reinforcing Children's Sexual Identity: A Review of Ellie Klipp's 'I Don't Have to Choose,' Aug. 27, 2019*

"The transgender movement is an opening for a totalitarian government." — *Michelle Cretella, ACPeds executive director, speaking at Illinois Family Institute Worldview Conference, Oct. 2019*

"Transgenderism is a belief system that increasingly looks like a cultish religion – a modern day Gnosticism denying physical reality for deceived perceptions – being forced on the public by the state in violation of the establishment clause of the First Amendment."

— Andre Van Mol, co-chair of ACPeds' Committee on Adolescent Sexuality, in "Transgenderism: A State-Sponsored Religion?" Jan. 24, 2018

"Homosexual men and women are reported to be promiscuous, with serial sex partners, even within what are loosely-termed "committed relationships. Individuals who practice a homosexual lifestyle are more likely than heterosexuals to experience mental illness, substance abuse, suicidal tendencies and shortened life spans."
—"Homosexual Parenting: Is It Time for A Change?" updated July 2017, available on ACPeds website

"Driving in this morning I began to wonder. Why isn't the movement of LGBT not the PLGBT movement: 'P' for pedophile? ...In one sense, it could be argued that the LGBT movement is only tangentially associated with pedophilia. I see that argument, but the pushers of the movement, the activists, I think have pedophilia intrinsically woven into their agenda. It is they who need to be spoken to and against."
—Blog post on ACPeds website, July 15, 2015

"I truly believe that when we are practicing a sexual act that goes against our natural design, it's going to be very harmful to us emotionally, physically and, in the situation with AIDS, even infectious consequences will occur."
—Former ACPeds President Den Trumbull on VCY America's "Crosstalk," May 2015

"[T]here is sound evidence that children exposed to the homosexual lifestyle may be at increased risk for emotional, mental, and even physical harm."
—"Homosexual Parenting: Is It Time For Change?" ACPeds article, January 22, 2004

"For unwanted sexual attractions, therapy to restore heterosexual attraction has proven effective and harmless."
—Facts About Youth website, 2010

"Gay, lesbian, and bisexual students are not born that way. The most recent, extensive, and scientifically sound research finds that the primary factor in the development of homosexuality is environmental not genetic."
—Facts About Youth website, 2010

"School officials are being increasingly pressured by pro-homosexual organizations to integrate homosexual education into school curricula. These organizations recommend promoting homosexuality as a normal, immutable trait that should be validated during childhood, as early as kindergarten. These organizations also condemn all efforts to provide treatment to gender confused students, advocating instead the creation of student groups that affirm homosexual attractions and behaviors."
—Facts About Youth website, 2010

"In dealing with adolescents experiencing same-sex attraction, it is essential to understand there is no scientific evidence that an individual is born 'gay' or 'transgender.'"
—ACPEds letter to 14,800 school superintendents, March 31, 2010

"Conditioning children into believing a lifetime of chemical and surgical impersonation of the opposite sex is normal and healthful is child abuse."
—"Gender Ideology Harms Children," ACPeds article, March 2016

"We at the American College of Pediatricians, and also I have many colleagues on the left, also insist that those solutions be rooted in reality, and transgender ideology is not. Sex is hard-wired from before birth, and it cannot change. And that's why we had actually called this child abuse, because by feeding children and families these lies, children are having their normal psychological development interrupted... Our job as parents and physicians is to help children embrace their healthy bodies. And when this is done, once they get past puberty into late adolescence, as many as 95 percent will come to embrace their bodies and identify with their biological sex."
—Michelle Cretella, former president of ACPeds, "Tucker Carlson Tonight," July 24, 2017
(Cretella became ACPeds' first executive director in 2018)

Background

Though it sounds official, ACPeds is not the leading organization for U.S. pediatricians; That designation goes to the 67,000-member American Academy of Pediatrics (AAP). ACPeds was founded in 2002 when a small number of socially conservative AAP

members broke away from AAP after it endorsed adoption by same-sex couples. ACPeds subsequently issued its own report stating that gay parenting puts children's health and development at high risk.

ACPeds supports "reparative" or sexual orientation conversion therapy (also known as "ex-gay" therapy) for LGBTQ juveniles, advances the debunked theory that being LGBTQ can be "cured" through therapy and has encouraged the practice in communication with schools nationwide. ACPeds has also called being transgender a mental illness, and opposes families' support of their transgender children, calling such support "child abuse." Though membership is believed to be just a few hundred, ACPeds spreads its falsehoods by acting as a go-to authority for far-right media outlets such as Breitbart and the Daily Caller, and right-wing Christian publications and websites.

In 2002, AAP released a policy statement in support of second-parent adoptions by same-sex parents. Its newsletter stated, "Pediatricians should support the legal adoption of children by co-parents or second parents because it provides permanency and stability to children of gay and lesbian parents." In response, approximately 60 of the AAP's 60,000 members broke off, forming ACPeds.

ACPeds' founder, Dr. Joseph Zanga, described it as a "Judeo-Christian, traditional values" organization, "open to pediatric medical professionals of all religions who hold true to the group's core beliefs: that life begins at conception; and that the traditional family unit, headed by an opposite-sex couple, poses far fewer risk factors in the adoption and raising of children."

ACPeds claims more than 500 members, though its former president, Dr. Michelle Cretella (she became executive director in 2018), wouldn't answer a direct question about its membership numbers in 2016. In 2012, ACPeds was estimated to have no more than 200 members. AAP currently has more than 67,000 members.

Yet ACPeds has continued to be a far-right media favorite and prominent voice in anti-LGBT circles. On the July 24, 2017 episode of "Tucker Carlson Tonight" on Fox News, then-ACPeds president Cretella continued her attack on "transgender ideology." "Sex is hard-wired from before birth, and it cannot change," Cretella said. "And that's why we have actually called this child abuse, because by feeding children and families these lies, children are having their normal psychological development interrupted ... This is child abuse. It's not health care."

She also made misleading and false claims about hormone treatments for transgender children and adolescents in the 2017 appearance, claiming that 95% of transgender children will eventually "embrace" their "biological sex" as long as they are forced to reject their trans identity.

The so-called "desistance" myth (whose numbers range from 80-95%) has been promoted for years by anti-trans groups and individuals, and derives from a 1995 study of 45 gender nonconforming children that conflated children who exhibited gender nonconforming behaviors with children who insisted they are a different gender; that is, transgender children. Most of the children who desisted were never transgender to begin with.

ACPeds responded to AAP's endorsement of adoption by gay couples with its own policy statement in January 2004 (re-posted in July 2017), titled "Homosexual Parenting: Is It Time For Change?" Among its false claims: "research has demonstrated considerable risks to children exposed to the homosexual lifestyle. Violence between same-sex partners is two to three times more common than among married heterosexual couples;" "[h]omosexual men and women are reported to be promiscuous, with serial sex partners, even within what are loosely-termed 'committed relationships;'" and to excuse its bunk science, "[a]lthough some would claim that these dysfunctions are a result of societal pressures in America, the same dysfunctions exist at inordinately high levels among homosexuals in cultures where the practice is more widely accepted."

The statement concludes, "Given the current body of evidence, the American College of Pediatricians believes it is inappropriate, potentially hazardous to children, and dangerously irresponsible to change the age-old prohibition on same-sex parenting, whether by adoption, foster care, or reproductive manipulation."

In 2008, AAP, along with 12 other leading national organizations including the American Psychological Association and the National Association of Social Workers, released a pamphlet titled "Just the Facts About Sexual Orientation and Youth." Distributed to school administrators nationwide, the pamphlet declared, "The idea that homosexuality is a mental disorder or that the emergence of same-sex attraction and orientation among some adolescents is in any way abnormal or mentally unhealthy has no support among any

mainstream health and mental health professional organizations." It also warned against efforts to change sexual orientation through reparative or conversion therapy, stating, "such efforts have serious potential to harm young people because they present the view that the sexual orientation of lesbian, gay, and bisexual youth is a mental illness or disorder, and they often frame the inability to change one's sexual orientation as a personal and moral failure," and clearly specifying that "homosexuality is not a mental disorder and thus is not something that needs to or can be 'cured.'"

In response, ACPeds joined with the reparative therapy organization the National for Research and Therapy of Homosexuality (NARTH, now the NARTH Institute, which was folded into the Alliance for Therapeutic Choice) to attack "Facts About Sexual Orientation and Youth," calling it "biased and grossly misleading," and published an online rebuttal called "Facts About Youth" in 2010.

"Facts About Youth" contains a slew of false assertions, among them that "[h]omosexual attraction of young students is usually temporary (if not encouraged) and may be unwanted," "[t]he homosexual lifestyle carries grave health risks, especially for males," and "[f]or unwanted sexual attractions, therapy to restore heterosexual attraction has proven effective and harmless."

"Facts About Youth" also includes a page called "Health Risks of the Homosexual Lifestyle" which links LGBTQ people to disease and uses a legitimate Canadian study conducted in 1996 to claim that being LGBTQ shortens lifespans. The authors of that study blasted anti-LGBTQ groups for distorting their data, stating that "... it appears that our research is being used by select groups in US and Finland to suggest that gay and bisexual men live an unhealthy lifestyle that is destructive to themselves and to others. These homophobic groups appear more interested in restricting the human rights" of LGBTQ people "rather than promoting their health and wellbeing."

The aim of their research, the paper's writers stated, "was to assist health planners with the means of estimating the impact of HIV infection on groups, like gay and bisexual men, not necessarily captured by vital statistics data and not to hinder the rights of these groups worldwide." The writers concluded that they do not condone the use of their work in a manner that restricts political and human rights of gay and bisexual men or any other group.

On March 31, 2010 ACPeds sent a letter to 14,800 school superintendents across the country endorsing reparative therapy and directing school administrators to its "Facts About Youth" website.

One of the names on the masthead of the ACPeds letter endorsing sexual orientation conversion therapy was George Rekers. Rekers was a married Baptist minister and clinical psychologist who vocally advocated "curing" homosexuality. Just two weeks after the ACPeds letter was distributed, Reker was caught returning from a European vacation with a 20-year-old male escort he'd met on Rentboy.com.

The genuine leading pediatrics association, the AAP, issued a statement saying ACPeds' Facts About Youth "campaign does not acknowledge the scientific and medical evidence regarding sexual orientation, sexual identity, sexual health, or effective health education."

Indeed, several medical sources cited prominently by ACPeds to support "Facts About Youth" immediately rebutted ACPeds' assertions. Dr. Francis S. Collins, the director of the National Institute of Health, wrote, "The American College of Pediatricians pulled language out of context from a book I wrote in 2006 to support an ideology that can cause unnecessary anguish and encourage prejudice. The information they present is misleading and incorrect, and it is particularly troubling that they are distributing it in a way that will confuse school children and their parents."

Dr. Gary Remafedi, a University of Minnesota researcher also cited by ACPeds to support "Facts About Youth," strenuously objected to the misrepresentation of his research, demanding a retraction.

Dr. Remafedi wrote to ACPeds, "this episode is especially troubling and egregious because it is led by colleagues within my own profession, who certainly have the ability, education, and experience to access, review, and accurately summarize the Pediatric scientific literature." He continued, "Implicating me in this chicanery is doubly damaging to my professional reputation and career by holding me accountable for misstatements and by associating me with a cause that most ethical Pediatricians will recognize as misguided and hurtful to an entire class of children and families."

Therapist Warren Throckmorton, who specializes in sexual orientation issues, was also cited by ACPeds. "The [ACPeds] letter and [Facts About Youth] website are just disingenuous," Throckmorton told City Pages. "They say they're impartial and not motivated by

political or religious concerns, but if you look at who they're affiliated with and how they're using the research, that's just obviously not true."

While ACPeds may sound sufficiently marginalized within the medical and mental health professional communities, that hasn't stopped the far-right from using its debunked pseudo-science to back anti-LGBTQ agendas.

In a debate between the Family Research Council's Tony Perkins and the Southern Poverty Law Center's Mark Potok on the November 30, 2010 edition of MSNBC's "Hardball with Chris Matthews," Perkins said, "If you look at the American College of Pediatricians, they say the research is overwhelming that homosexuality poses a danger to children."

Evangelical anti-LGBTQ extremist and pseudo-historian David Barton cited ACPeds on his WallBuilders Live radio program in August 2011, falsely calling it "the leading pediatric association in America," to claim schools are using "indoctrination" to make students LGBTQ. "If you'll just let this develop naturally, they'll end up being heterosexual unless you force them to be homosexual," Barton paraphrased ACPeds.

In June 2013, the conservative Washington Times quoted then-president of ACPeds Den Trumbull's continued endorsement of reparative therapy for LGBTQ teens: "'Spontaneous and assisted change is possible,' and if a teen's sexual-orientation confusion is not encouraged or validated, in the vast majority of cases, he or she 'will return to heterosexual orientation,' said Dr. Trumbull, who has a pediatrics practice in Alabama."

In May 2015, Trumbull appeared on VCY America's "Crosstalk" program, where he disparaged preventative methods of arresting the spread of HIV, saying, "yet the push is more to find a vaccine, to use condoms, to — but I truly believe that when we are practicing a sexual act that goes against our natural design, it's going to be very harmful to us emotionally, physically and, in the situation with AIDS, even infectious consequences will occur."

Later in 2015, then-president of ACPeds, Dr. Michelle Cretella, decried the Supreme Court's decision to legalize same-sex marriage, calling it "a tragic day for America's children," which was touted by Breitbart.

ACPeds also engages in court cases and files amicus briefs often filled with pseudoscientific claims and research. For example, it filed an amicus brief with the Alabama Supreme Court on November 6, 2015, urging the state court to defy the U.S. Supreme Court's earlier decision legalizing same-sex marriage in the United States. The brief cited discredited anti-LGBTQ research while attacking legitimate research by professional organizations like the American Psychological Association.

In March 2016 (updated in September 2017), ACPeds published an anti-transgender position statement titled " Gender Ideology Harms Children," falsely alleging that gender dysphoria "is a recognized mental disorder" in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). The statement called it "abusive" to support gender dysphoric children, and using twisted statistics alleged that "as many as 98% of gender confused boys and 88% of gender confused girls eventually accept their biological sex after naturally passing through puberty."

Far-right conservative media outlets and commentators including Glenn Beck, the Christian Broadcasting Network, the Daily Caller and Breitbart parroted ACPeds' false claim that being transgender is a mental illness and "gender ideology" is child abuse.

Meanwhile, the legitimate leading association of pediatricians, the American Academy of Pediatricians, joined the Human Rights Campaign along with other leading mental health and educational organizations in April 2016 to issue a statement opposing "needless and mean-spirited legislation" targeting transgender students.

Still, Louisiana Attorney General Jeff Landry felt comfortable citing "the American Pediatrics" (he got ACPeds' name wrong), stating "transgender identity is a mental illness" on the Family Research Council's "Washington Watch" radio program in May 2016.

The magazine Psychology Today's website called out ACPeds in May 2017, quoting Dr. Scott Leibowitz, medical director of the THRIVE program at Nationwide Children's Hospital and chair of the sexual orientation and gender identity issues committee for the American Academy of Child & Adolescent Psychiatry. Dr. Leibowitz said of ACPeds, "It can hardly be a credible medical organization when it consistently chooses to ignore science and the growing evidence base that clearly demonstrates the benefits of affirmative care with LGBT youth across all ages."

Dr. Jack Turban, the author of the Psychology Today article, concluded, "I urge news organizations and individuals to stop propagating these false claims from the ACP. The health of LGBT youth depends on it."

Yet ACPeds continues to be a far-right media favorite and prominent voice in anti-LGBTQ circles. On the July 24, 2017 episode of "Tucker Carlson Tonight" on Fox News, ACPeds then-president Cretella continued her attack on "transgender ideology." "Sex is hard-wired from before birth, and it cannot change," Cretella said. "And that's why we have actually called this child abuse, because by feeding children and families these lies, children are having their normal psychological development interrupted ... This is child abuse. It's not health care."

Additionally, Cretella was the keynote speaker at the reparative therapy organization NARTH Institute's training institute in October 2017, and presented an anti-transgender session at the Minnesota Catholic Conference in December 2017. Cretella served as a board member (2010-2015) for NARTH (National Association for Research and Therapy of Homosexuality), which changed its name to NARTH Institute in 2014.

In an anti-trans Daily Signal piece posted in July 2017, Cretella claimed that medial professionals are "using the myth that people are born transgender to justify engaging in massive, uncontrolled, and unconsented experimentation on children" who, she further claimed, "have a psychological condition that would otherwise resolve after puberty in the vast majority of cases."

The Society for Adolescent Health and Medicine issued a point-by-point rebuttal of Cretella's July 2017 Daily Signal claims, noting that her post is "littered with correlation without causation references." One cannot claim to be an unbiased medical professional writing for the greater good, SAHM states, "when one's entire article is predicated upon gender dysphoria as a choice."

Nevertheless, ACPeds continues to falsely claim that gender-affirming care for transgender children somehow "harms" children, and also falsely claims that the medical establishment is forcing transgender children to undergo transition surgeries.

In reality, gender-affirming care for youth involves following developmentally appropriate established guidelines put out by the Endocrine Society, the World Professional Association of Transgender Health and American Academy of Pediatrics to ensure the safety and well-being transgender youth and adults.

The rise of anti-trans sentiment among anti-LGBTQ groups has fueled a cottage industry of anti-trans research that in turn is promoted by anti-LGBTQ groups, including ACPeds, which has become a go-to for expertise in anti-trans pseudoscience.

One such study ACPeds has promoted is one published in August 2018 that makes unfounded claims about so-called "rapid onset gender dysphoria," which posits that gender dysphoria seemingly appears abruptly during or after puberty as a result of peer pressure or "social contagion." That is, youth are "pressured" into being trans and can therefore "change" into not being trans.

The study, by Brown University researcher Lisa Littman, appeared in August 2018 in the pay-to-publish journal PLOS ONE that dealt with what she called "rapid onset gender dysphoria" (ROGD), which is promoted on anti-trans message boards.

Littman's dubious data collection focused on a questionnaire to parents who frequented anti-trans websites and did not involve any trans-identified youth or controls. Also, she did not account for how using anti-trans subjects might skew her data, nor did she question the parents' claims. Her study's flawed methodology and conclusions were immediately critiqued, and Brown University ceased disseminating it via news distribution the same month it was published.

PLOS ONE conducted a post-publication reassessment of the piece, and in March 2019 announced revisions to it that ostensibly address the concerns that were raised.

Regardless, anti-LGBTQ media circulated the study widely, and ACPeds' Cretella touted the study at the 2018 Values Voter gathering (sponsored by anti-LGBTQ hate group Family Research Council). The ACPeds website also promotes anti-trans parenting sites as "resources," including Kelsey Coalition and Parents of ROGD Kids. The Kelsey Coalition, which offers little to no information about permanent staff, incorporation or tax status, solicits anonymous anti-trans personal testimonies from parents and advocates against protections from conversion therapy for trans youth.

The ROGD Parents site, like Kelsey Coalition, offers little information about who they are and claims that transgender youth are merely "confused" and have been somehow talked into being trans and wanting to transition because of social media and peers. The site also

attempts to link gender dysphoria to several things including borderline personality disorder, autism, Munchausen Syndrome, and being bullied for "being too butch."

The ACPeds site also warns parents to "Avoid 'Gender therapists,' 'Gender-Affirming' therapists, 'LGBT-affirming' therapists, and 'Gender clinics'" because, according to ACPeds, "These are all titles of therapists who seek to validate and affirm your child's gender disturbance as normal."

In September 2018, Joseph Zanga, an ACPeds founder and past president (also a past president of AAP), wrote an opinion piece in the *Bulletin* of the Muscogee County Medical Society (Columbus, Georgia) that ACPeds promoted on its website.

Zanga seems to claim that children are forced to be transgender by their parents: "But children's brains are plastic and can be molded by experience, by parents dressing them as the opposite sex, calling them an opposite sex name, and insisting that all others do the same." Children thus become, Zanga continued, "the sex others create for them," and claims that children are "incapable of making those decisions." In the op-ed, Zanga referenced the desistance myth, claiming that the "condition" usually "cures itself" by late adolescence.

In March 2019, ACPeds executive director Cretella and anti-trans activist Walt Heyer went to Capitol Hill at the invitation of FRC to address members of Congress about the alleged dangers of the Federal Equality Act, which would include sexual orientation and gender identity in the Civil Rights Act. Heyer claims to have been previously trans but says he was misdiagnosed. Heyer peddles the "transgender regret" myth, which claims that the majority of people who transition end up regretting their decision.

After the Capitol Hill meetings, Cretella participated in two interviews with FRC president Tony Perkins following the introduction of the Equality Act. In those interviews, she discussed meeting with members of Congress and their staffs and referred to being transgender as being in a cult. "Transgender belief is in the mind," she said the interviews. "It's a cult that is telling us that children are born with the belief that they are trapped in the wrong body, and it's simply not true."

In July of 2019, ACPeds, the Association of American Physicians and Surgeons, the Catholic Medical Association and the Alliance for Therapeutic Choice and Scientific Integrity (which supports conversion therapy), sent a letter to U.S. Surgeon General Jerome Adams asking him not to support affirming care for gender dysphoric children. They also asked Adams to issue a warning with regard to medical intervention for gender dysphoric children. The letter claims that health professionals who don't engage in affirmative care for gender dysphoric children are at risk for discrimination and marginalization.

In October 2019, Cretella spoke at anti-LGBTQ hate group Illinois Family Institute's Worldview Conference. Her talk was titled "Transgender Ideology: Child Abuse and the Erasure of Human Rights." In that talk, she claimed that "we are actually manufacturing transgender children in this country and around the world" and pushed a conspiracy theory that the transgender movement "is an opening for a totalitarian government."

During that conference, she also referred to intersex people as "having birth defects" (being intersex is not considered a defect); touted Littman's study; and repeated several anti-trans conspiracy theories, including that social media is making children transgender. She claimed falsely that New York City fines people $250,000 for not using someone's preferred gender pronouns.

ACPeds president Quentin van Meter, who is based in Atlanta, was quoted in a November 2019 press release from Georgia state Rep. Ginny Ehrhart (R-Marietta) regarding her sponsorship of an anti-trans bill that would criminalize gender-affirming healthcare for transgender youth. In the release, Van Meter said children need to be protected from "medical experimentation based on wishful social theory." He added: "These children are suffering from a psychological condition without biologic [sic] basis."

Van Meter, who is popular on the anti-LGBTQ circuit, touts the discredited practice of conversion therapy in addition to anti-trans pseudoscience. The Ohio Department of Health hired him in early 2020 to serve as an expert witness in a civil rights lawsuit against the state, which is refusing to change the sex on birth certificates of four transgender people. Such a move could put them in danger of being outed as trans.

In addition, Van Meter testified to the Alabama state legislature in early 2020 in favor of legislation that would criminalize gender-affirming healthcare for children. He went on Tony Perkins' radio show March 5 to discuss his testimony and gender dysphoria. Van Meter referred to the latter as "gender confusion," a right-wing term used to denigrate transgender people. Van Meter claimed that "gender confusion" is "sort of a cult phenomenon" influenced by "internet access and hysteria."

* * *

EXHIBIT D

The American College of Pediatricians is a national organization of pediatricians and other healthcare professionals dedicated to the health and well-being of children.

Who is the American College of Pediatricians?

ACPeds

00:57

Our Mission is to enable all children to reach their optimal physical and emotional health and well-being.

Our Vision is to promote a society where all

Our vision is to promote a society where all children, from the moment of their conception, are valued unselfishly. We encourage mothers, fathers and families to advance the needs of their children above their own.

Objectives

1. To foster and stimulate improvements in all aspects of healthcare of infants, children, and adolescents;
2. To promote the basic father-mother family unit as the optimal setting for childhood development, while pledging to support all children, regardless of their circumstances;
3. To affirm that parents have the inalienable right and responsibility to educate and rear their children;
4. To advocate for children at all stages of development, from conception to young adulthood;
5. To cultivate and encourage parental responsibility for and involvement in the child's life;
6. To engender the honest interpretation of scientific pediatric research, without deference to current political persuasions;
7. To promote the highest standards of medical practice among its Members and within the field of pediatrics;
8. To encourage and support sound, ethical scientific research in all aspects of healthcare for infants, children, and adolescents; and
9. To cooperate with other organizations having similar purposes and standards.

Principles

The American College of Pediatricians:

1. Recognizes that there are absolutes and scientific truths that transcend relative social considerations of the day.

2. Recognizes that good medical science cannot exist in a moral vacuum and pledges to promote such science.
3. Recognizes the fundamental mother-father family unit, within the context of marriage, to be the optimal setting for the development and nurturing of children and pledges to promote this unit.
4. Recognizes the unique value of every human life from the time of conception to natural death and pledges to promote research and clinical practice that provides for the healthiest outcome of the child from conception to adulthood.
5. Recognizes the essential role parents play in encouraging and correcting the child and pledges to protect and promote this role.
6. Recognizes the physical and emotional benefits of sexual abstinence until marriage and pledges to promote this behavior as the ideal for adolescence.
7. Recognizes that health professionals caring for children must maintain high ethical and scientific standards and pledges to promote such practice.

History of the American College of Pediatricians

The American College of Pediatricians (ACPeds) is a national organization of pediatricians and other healthcare professionals dedicated to the health and well-being of children. It was founded by a group of concerned physicians who saw the need for a pediatric organization that would not be influenced by the politically driven pronouncements of the day. The ACPeds bases its policies and positions upon scientific truth within a framework of ethical absolutes. Of particular importance to the founders were (as it is today) the sanctity of human life from conception to natural death and the importance of the fundamental mother-father family unit in the rearing of children. The first official meeting of the newly formed college was held in Boston in October 2002.

The ACPeds is committed to fulfilling its mission by producing sound policy, based upon the best available research, to assist parents and to influence society in the endeavor of childrearing. Membership is open to qualifying healthcare professionals who share the ACPeds' Mission, Vision and Values. The ACPeds currently has members in 47 states, and several countries outside of the US. The ACPeds is a not-for-profit corporation organized for scientific and educational purposes, exempt from taxation under Section 501(c)(3) of the U.S. Internal Revenue Code. The home office is in Gainesville, Florida.

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EXHIBIT E

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION

EMW WOMEN'S SURGICAL CENTER, P.S.C., et al.,	)	
Plaintiffs,	)	Case No. 3:18-CV-00224-JHM
v.	)	
ADAM W. MEIER, Secretary of Kentucky's Cabinet for Health and Family Services, et al.,	)	
Defendants.	)	November 19, 2018 Louisville, Kentucky

* * * * *

VOLUME 5-B
TRANSCRIPT OF BENCH TRIAL
BEFORE HONORABLE JOSEPH H. MCKINLEY, JR.
UNITED STATES DISTRICT JUDGE

* * * * *

APPEARANCES:
For Plaintiffs: Alexa Kolbi-Molinas
Elizabeth K. Watson
Esha Bhandari
Susan Talcott Camp
American Civil Liberties Union Foundation
125 Broad Street, 18th Floor
New York, NY 10004

April R. Dowell, RMR, CRR
Official Court Reporter
232 U.S. Courthouse
Louisville, KY 40202
(502) 625-3778

Proceedings recorded by mechanical stenography, transcript produced by computer.

A. I do, yes.
Q. And in your ethics opinion, Dr. Curlin, this is an inappropriate position for the AMA to take; is that right?
A. Yes. I mean, this is a position that contradicts the AMA's prior position up until it switched to this -- till it -- it opposed abortion from its outset and then went neutral. I forget what year the policy was changed to this kind of statement of neutrality.

It contradicts 2000 years of medical tradition regarding this area and it I believe is not to the credit of the AMA. I mean, it -- the notion that the regard we owe to another human being is something that we just each decide individually and it's up to our personal values seems to me unreasonable.

Q. You, Dr. Curlin, are a member of the Christian Medical and Dental Associations; is that right?
A. Yes.
Q. And, Dr. Curlin, the stated mission of the CMDA is to motivate, educate, and equip Christian health care professionals to glorify God; is that right?
A. I don't know, but I'll take your word for it.
Q. It sounds right?
A. It doesn't sound contradictory to them.
Q. And you agree that motivating, educating and equipping Christian health care professionals to glorify God is a

worthwhile mission or you wouldn't be in the group, right?
A. Well, there are a variety of reasons why I'm a member of CMDA, but I don't think equipping people to glorify God is a bad thing.
Q. Have you ever reviewed the CMDA's position statement on abortion, Dr. Curlin?
A. I don't believe I have.
MS. GODESKY: If we could look at PX 394.
Q. Dr. Curlin, does PX 394 appear to be a copy of the CMDA position statements?
A. That's the title I read across the front of it.
Q. I'd like to take a look at page four or five. Thank you. And there's a header on this page that says abortion, correct?
A. Correct.
Q. And the CMDA writes in paragraph 2 that (Reading) The practice of abortion is contrary to respect for the sanctity of human life as taught in the revealed written word of God and traditional historical and Judeo-Christian medical ethics. Do you see that?
A. Yes.
Q. And do you generally agree with those statements, Dr. Curlin?
A. I wouldn't say them in exactly that way, but I do, as I said before, believe that the practice of abortion -- well, it contradicts respect for the sanctity of human life. As that

is revealed I think in the world as we find it and in -- in our access to reasonable judgments about what's required of us. It's also traditionally opposed by Christian teaching as well as by of course the traditional medical ethics as I've said before.

Q. And so the Christian Medical and Dental Association is referring to traditional medical ethics which I believe you discussed on your direct with Mr. Meredith, right?

A. I don't know exactly what they're referring to here, but I wouldn't be surprised if that's the case.

Q. You use the term of art traditional medical ethics during your direct?

A. Yeah, I did.

Q. Okay. And then you contrasted that with what you termed conventional medical ethics, right?

A. Right. That's my term for principlism combined with consequentialism, yes.

Q. And I believe you testified on direct that there's been a quote, unquote persistent criticism of conventional medical ethics and that it's very novel. Do you remember saying that?

A. Yes.

Q. But you would agree that conventional medical ethics refers to the way that medical ethics is customarily done in today's health care institutions and among health care professionals, correct?

EXHIBIT F

STANDARDS 4 LIFE
Abortion

Christian Medical & Dental Associations®
Changing Hearts in Healthcare

P.O. Box 7500
Bristol, TN 37621
888-230-2637
www.cmda.org

Christian Medical & Dental Associations serves as a voice and ministry for Christian healthcare professionals. Its vision is to "transform doctors to transform the world." Founded in 1931, CMDA currently serves more than 16,000 members and coordinates a network of Christian healthcare professionals for personal and professional growth; sponsors student ministries in medical and dental schools; conducts overseas healthcare projects for underserved populations; addresses policies on healthcare, medical ethics and bioethical and human rights issues; distributes educational and inspirational resources; provides missionary doctors with continuing education resources; and conducts international academic exchange programs.

1. What is Abortion?

Abortion: The premature expulsion of the human fetus. It usually refers to an artificially induced abortion caused by surgical or chemical means. A spontaneous abortion is often called a miscarriage.

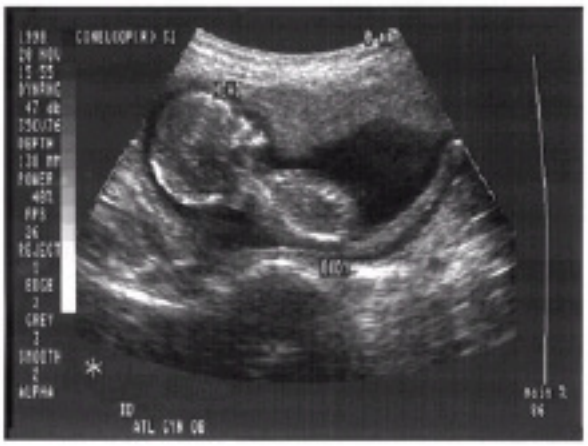
Abortion in America stops beating hearts more than 1.2 million times each year [1]—our nation's most common surgical procedure. This tragedy is a symptom of the corruption of the gifts and stewardship responsibilities God has given us.

First Trimester Development (0-12 Weeks)

Days after last menstrual period	Development of embryo/fetus
18-21	Heart beats[1]
32	Eyes are formed[2]
38	Upper lip formed[2]
40	Brain waves are measurable[3]
44	Arms and legs formed[4]
48	Beginnings of all internal structures present; baby is moving[5]
56	Embryo now called a fetus[5]
63	Sucking thumb, teeth forming[6]
84	Cries, feels pain

****Most surgical abortions occur between 49 to 70 days****[6]

Abortion Methods: First Trimester



- **Dilation and Curettage**
  The cervix is dilated with metal dilators to allow the insertion of a loop-shaped steel knife. The developing baby is dismembered by the knife and the placenta is scraped off the inner wall of the uterus. This method is more likely to leave behind tissue and blood clots, which increases the risk of subsequent infection. There is also a higher incidence of blood loss and uterine perforation.
- **Suction Aspiration or "Vacuum Curettage"**
  The most common method used in the first trimester. The cervix is dilated and a plastic suction tube with a sharp cutting edge just behind its tip is inserted into the uterus. The suction curette is connected via a plastic tube to a suction machine. The fetus is dismembered and the placenta is scraped off. The placenta, fetus, amniotic fluid and blood are suctioned out of the uterus.
- **RU-486**
  Also called the "French Abortion Pill" since it was first developed there. It is a two- stage procedure using two synthetic hormones - mifepristone (RU-486) and misoprostol. It is used for abortions between the 5th and 7th week and requires multiple trips to the doctor. During the first visit, if the woman has no contra-indications (smoking, asthma, high blood pressure, obesity, etc.), she swallows the RU-486. It blocks the actions of naturally occurring progesterone in the woman's body that sustains the rich nutrient-filled lining of the uterus. This causes the uterine lining, the endometrium, to disintegrate and the baby dies. At a second visit, 36-48 hours later, the woman is given a powerful prostaglandin, misoprostol, which starts uterine contractions to expel the baby and the placenta. Many women abort during a four-hour stay at the clinic. About 30 percent abort up to five days later. If the abortion has not occurred by a third visit, a surgical abortion is required. Side effects are severe: prolonged bleeding, nausea, vomiting, pain and rarely death. Long-term side effects have not been sufficiently studied.

- **Methotrexate**
  This is an anticancer drug that attacks fast growing cells in the body by neutralizing folic acid, the vitamin needed for cell division. The embryo and the trophoblast, the tissue around the embryo that becomes the placenta, are rapidly growing. The methotrexate chokes its growth and causes it to disintegrate and kill the growing child. Methotrexate must be injected and also requires giving misoprostol three to seven days afterward to cause the uterus to contract and expel its contents. This is not a popular method because of the time required and the woman may abort days to weeks later. One out of every 25 women requires surgical abortion after methotrexate fails. There is a risk of death even with smaller doses that are used.

Second Trimester Development[7]

Weeks of age	Development of fetus
13	3 inches long, weighs half oz., reflexes active
14	Fingerprints present
15	Has ability to grasp, smile, grimace, squint
16	6 inches long, weighs 6 oz., somersaults, mother feels movement
17	Gets hiccups, plays with umbilical cord
18	Hair and eyebrows are growing
20	Hears, recognizes mother's voice
22	Responds to stories, music, etc.
24	Weighs 1 lb., has 85 percent survival rate
26	Responds to light, weighs 1.5 to 2 lbs.

Third Trimester Development[7]

Weeks of age	Development of fetus
24	Weighs 2 lbs. and is practicing breathing
30	Grows rapidly, sleeps 90 percent of time, has dreams
32	Weighs 4 lbs., urinates
34	Weighs 5 lbs., 19.5 in. long, head begins to drop into mother's pelvis
36	Now has 99 percent survival rate
38	Is 1,000 times its original size, gains an ounce a day
40	Average weight: 7.5 lbs.

Abortion Methods: Second & Third Trimesters

- **Saline Abortion**

Also called "saline amniocentesis," "salting out" and "hypertonic saline" abortion, this method is used after 16 weeks of pregnancy because there needs to be enough amniotic fluid to enable the doctor to get a needle into the amniotic sac. The doctor withdraws 50 to 250 cc of amniotic fluid and injects a concentrated solution of salt. The baby breathes in and swallows the salt, which is poisonous. The baby's skin is burned by the salt as it draws water out of the baby's body. The baby dies within one to two hours, often after violent movements. The mother goes into spontaneous labor in 36 to 72 hours and delivers her shriveled baby. Complications include the salt getting drawn into the mother's circulation and causing widespread blood clotting and then uncontrollable bleeding. If the salt solution is injected directly into the mother's circulation, it can cause seizures, coma or death. This method is not used much due to its dangers.

- **Urea**
  Urea, a concentrated compound of mammalian urine commercially used in the creation of plastics, fertilizers and animal food, is injected. This method is not as effective as saline in killing the baby. Often something must be given to cause the uterus to contract and even so it has a higher incidence of requiring the additional risk of surgery. Side effects include nausea, vomiting and injuries to the cervix.

- **Prostaglandins**
  Can be used alone; often results in baby being born alive but too young to survive. It is often used with saline or urea to kill the baby. Risks include a retained placenta, cervical trauma, later infection, bleeding, asthma or hyperthermia (becoming dangerously hot). The most serious complications are a ruptured uterus and cardiac arrest.

- **D & E, or Dilation and Evacuation**
  A popular method for second trimester abortions, the cervix is dilated, forceps with sharp metal jaws are inserted and the child is torn apart limb by limb. The head is the largest part of the baby and if it is too large to be pulled through the cervix, it must be crushed. This is a dangerous form of abortion due to the risk of uterine perforation or laceration of the uterus or cervix by sharp bone ends. Bleeding may be severe as well.

- **D & X, or Dilation and Extraction (Partial Birth Abortion)**
  Usually done between the 20th and 32nd weeks, which is the period that the child can survive outside the womb. The cervix is dilated with a laminara (dehydrated sea weed) overnight and then the doctor, using ultrasound to visualize the baby, grabs the baby's legs with forceps and pulls it out through the cervix and vaginal canal except for the large after-coming head, which is kept in the uterus. The abortionist then sticks scissors into the base of the baby's head and spreads the tips to kill the baby. The scissors are removed and a suction tip is inserted to suck out the baby's brains, collapse the skull and allow the baby to be delivered dead. This is a safer procedure than a D&E but borders on infanticide.

- **Hysterotomy**
  This method is similar to a C-section and is generally used if chemical methods such as salt poisoning or prostaglandins fail. Incisions are made in the abdomen and uterus and the baby, placenta, and amniotic sac are removed. Babies are sometimes born alive during this procedure, raising questions as to how and when these infants are killed and by whom. This method offers the highest risk to the health of the mother, because the potential for rupture during subsequent pregnancies is appreciable. In the first two years of legal abortion in New York State, the death rate from hysterotomy was 271.2 deaths per 100,000 cases.[8]

"It's hard for most doctors to deliver babies and do abortions. It also has to do with the fact that to almost everyone else the pregnancy is just a blob of tissue, but the abortionist knows exactly what he is doing because he has to count all the parts after each abortion. I never had any doubt that I was killing little people, but somehow I was able to justify and compartmentalize that." —Kathi Aultman, CMDA member and former abortion provider, before a Senate Judiciary Committee on the "Partial-Birth Abortion Ban Act of 2002"

2. What You Should Know

Abortion in the USA

♦ 48 percent of pregnancies among American women are unintended; half of these are terminated by abortion.
♦ In 1997, 1.33 million abortions took place, down from an estimated 1.61 million in 1990. From 1973 through 1997, more than 35 million legal abortions occurred.
♦ Each year, two out of every 100 women aged 15-44 have an abortion; 47 percent of them have had at least one previous abortion and 55 percent have had a previous birth.
♦ An estimated 43 percent of women will have at least one abortion by the time they are 45 years old.
♦ Each year, an estimated 46 million abortions occur worldwide. Of these, 20 million procedures are obtained illegally.

Who's Having Abortions?

♦ 52 percent of U.S. women obtaining abortions are younger than 25. Women aged 20-24 obtain 32 percent of all abortions, and teenagers obtain 20 percent.
♦ Black women are more than three times as likely as white women to have an abortion, and Hispanic women are roughly two times as likely.
♦ Catholic women are 29 percent more likely than Protestants to have an abortion, but are about as likely as all women nationally to do so.
♦ Two-thirds of all abortions are among never-married women.

Who's Having Abortions? cont'd

- On average, women give at least three reasons for choosing abortion: three-fourths say that having a baby would interfere with work, school or other responsibilities; about two-thirds say they cannot afford a child; and half say they do not want to be a single parent or are having problems with their husband or partner.
- About 13,000 women have abortions each year following rape or incest. (This is less than one percent of all abortions.)

It's the Law[9]

- In the 1973 *Roe* v. *Wade* decision, the Supreme Court ruled that women, in consultation with their physician, have a constitutionally protected right to have an abortion in the early stages of pregnancy—that is, before viability—free from government interference.
- In 1992, the Court upheld the right to abortion in *Planned Parenthood v. Casey.* However, the ruling significantly weakened the legal protections previously afforded women and physicians by giving states the right to enact restrictions that do not create an "undue burden" for women seeking abortion.
- In *Steinberg v. Carhart* in 2000, the Court declared Nebraska's law criminalizing so-called partial birth abortion unconstitutional because it lacked an exception to protect the woman's health. The court also found that the law imposed an undue burden on women because it was written so broadly as to ban not only dilation and extraction (D & X) procedures, but also dilation and evacuation (D & E) procedures.
- In 2000, the U.S. Food and Drug Administration approved the abortion drug mifepristone to be marketed in the United States as an alternative to surgical abortion.
- In 2002, President Bush signed into law legislation ensuring that every infant born alive is considered a person under federal law, a measure designed to prevent mistreatment of infants who survive abortions or are too underdeveloped to live long-term.
- The Child Custody Protection Act (H.R. 476) passed the House April 17, 2002 by a vote of 260-161. Would "prohibit taking minors across State lines in circumvention of laws requiring the involvement of parents in abortion decisions."
- The Partial-Birth Abortion Ban Act of 2002 (H.R. 4965) was passed on July 24 by the House of Representatives, 274-151. This bill clearly distinguishes Partial-Birth Abortion from other abortion procedures, while protecting women from being subjected to a dangerous unproven experimental procedure.

3. What You Can Do

I. Expose Abortion Fallacies

Abortion Fallacy #1: Abortion is Painless

The majority of women report moderate to severe pain during an abortion, according to a Planned Parenthood study from 1997.[10]

No pain	1.8%
Hardly any	4.8%
A little	11.1%
Medium	20.8%
Quite a bit	34.2%
Severe	27.4%

Abortion Fallacy #2: Abortion is Safer than Childbirth

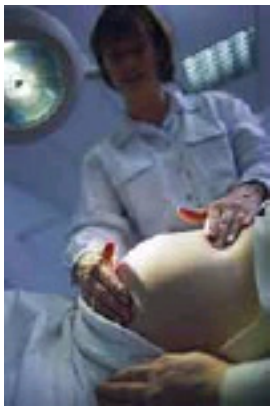
Complications that can arise:

- Perforated Uterus[11]
- Pelvic Inflammatory Disease[12]
- Future miscarriages[13]
- Placenta previa: condition where the placenta implants in the lower part of the uterus and obstructs the cervical opening to the vagina, or birth canal.[14]
- Breast cancer risk increase: twice the risk of breast cancer.[15]

- Ectopic pregnancy increase: 50 percent increased risk for tubal pregnancies.[16]
- Death: Finnish study showed that risk of dying from suicide, risky behavior, homicide and natural causes is several times higher the year after an abortion.[17]

Abortion complications are underreported. There is no requirement to report complications and most women do not return to their abortion clinic for the complications they have.

Abortion Fallacy #3: Every Child is a Wanted Child



Proponents implied that legalization of abortion in America would reduce child abuse, illegitimate births and unplanned pregnancies. Instead:

- ♦ Child abuse quadrupled between 1977 and 1993.[18]
- ♦ Illegitimacy tripled between 1970 and 1993.[19]
- ♦ The number of abortions doubled between 1972 and 1993.[20]
- ♦ 43 percent of women will have an abortion by the time they are 45 years old.[21]

Abortion Fallacy #4: There is no Post-Abortion Syndrome

In a study published in the *Archives of General Psychiatry* (8/2000), pro-choice advocates minimized the negatives in the study.

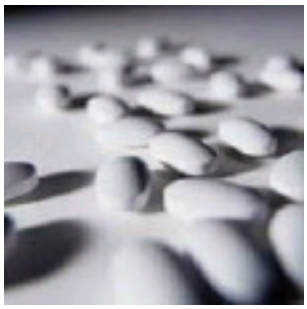
- ♦ 1.4 percent of women reported symptoms within two years of their abortion. 1.4 percent may seem like a small number, but it equals 560,000 women since 1972.

- ♦ 20 percent reported clinical depression. Depression correlated with those who had depression before their abortion, but abortion increased the severity and the number of women with this problem.

- ♦ 31 percent would not do it again. When asked if they would do it all over again, the response was that they would not or were ambivalent, which is a good predictor of post-abortion syndrome.

- ♦ Women paid to participate in this study: 15 percent wouldn't participate and 50 percent wouldn't allow follow-up interview. Studies show that women with post-abortion syndrome are the least likely to participate in research. Their comments were most often, "I do not want to talk about it. I just want to forget." Paying participants distorted this study's validity; also, the high rate of refusal and dropout is very problematic.

- ♦ During the one-year follow up interview:
  - 60 percent had "experienced emotional distress" after their abortions.
  - 16 percent said it was severe distress.
  - 70 percent said they would never consider abortion again if they faced an unwanted pregnancy.
  - Negative feelings increased with time.
  - 17 percent experienced physical problems such as bleeding and pelvic infections due to the abortion. That is a much higher rate than abortion providers admit.



"As abortifacient procedures go, RU-486 is not at all easy to use. In fact it is much more complex to use than the technique of vacuum extraction. True, no anesthetic is required. But a woman who wants to end her pregnancy has to live with her abortion for at least a week using this technique. It's an appalling psychological ordeal."

-Edouard Sakiz, former chairman and CEO of RU-486 manufacturer Roussel Uclaf, in French newspaper Le Monde

II. Know What the Bible Says

1. Children are a blessing from God:

   - "Behold, children are a gift of the LORD; The fruit of the womb is a reward." --Psalm 127:3

2. Each of us has been created by and known by God—even before our earthly parents knew us:

   - "Before I formed you in the womb I knew you, and before you were born I consecrated you; I have appointed you a prophet to the nations." --Jeremiah 1:5
   - "In his hand is the life of every creature and the breath of all mankind." --Job 12:10
   - "And he is not served by human hands, as if he needed anything, because he himself gives all men life and breath and everything else. 'For in him we live and move and have our being.' As some of your own poets have said, 'We are his offspring.'" --Acts 25:17

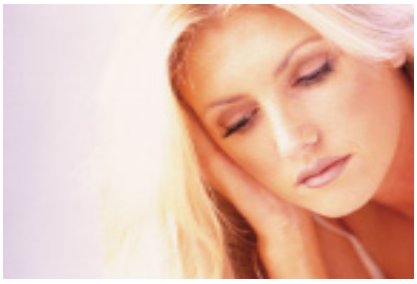
3. God alone has authority over life and death, and He condemns those who warrant such power as their own:

   - "See now that I myself am He! There is no god besides me. I put to death and I bring to life, I have wounded and I will heal, and no one can deliver out of my hand." --Deuteronomy 32:39

4. The Old Testament states that there is punishment for someone who causes a miscarriage intentionally:

   - "If men who are fighting hit a pregnant woman and she gives birth prematurely but there is no serious injury, the offender must be fined whatever the woman's husband demands and the court allows. But if there is serious injury, you are to take life for life, eye for eye, tooth for tooth, hand for hand, foot for foot, burn for burn, wound for wound, bruise for bruise." --Exodus 21:22-25

III. Answer the Arguments



1. "Abortion is the answer to overpopulation."
   - In 1957 there were 3.7 children born per woman. It takes 2.1 children per woman to maintain population. Between 1973 and 1988, the average dropped to 1.8 children per woman. Increases in population in the U.S. have been due to immigration.[22]
   - There were 6.5 million fewer school children in 1980 than in 1973, resulting in the closure of 9,000 elementary schools.[23]

2. "Abortion will reduce child abuse."
   - "Recent evidence indicates many women harbour strong guilt feelings long after their abortions. Guilt is one important cause of child battering and infanticide. Abortion lowers women's self-esteem and there are studies reporting a major loss of self-esteem in battering parents...."[24]
   - The first ten years after abortion, child abuse increased 500 percent.[25]

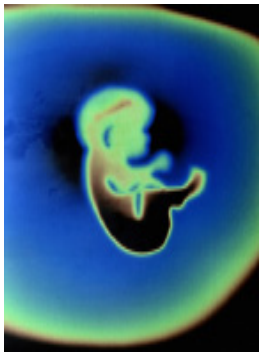
3. “If abortion is legal, it will be safer.”

- 90 percent of abortions occurred in doctor’s offices before it was legalized.[26]
- Women still die of legal abortions and before it was legal, fewer than 400 women died a year.[27]

4. “If I don’t have an abortion, the doctors say my baby will be deformed or disabled.”

- Doctors’ diagnoses can be wrong and the deformity is often minor (for example, a hair lip) and correctable. Even when it is not, it does not justify killing the child before birth when it is illegal to discriminate against the disabled after they are born.
- Many abortions are for handicaps that are not life threatening - Down’s Syndrome. These children are happy and delightful to be around.
- It is much better to bear the child with a fatal illness and let him or her die than to kill the child.[28]

5. “Abortion is okay in cases of rape and incest.”



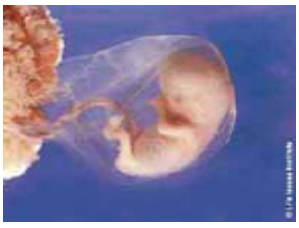
- There are less than 16,000 cases of abortion from rape or incest per year. This is less than one percent of all abortions.[29]
- Less than 3 percent chance of getting pregnant after one unprotected intercourse. Most of these cases are incest.
- Does the child deserve to die because of what the father did? “Fathers shall not be put to death for their children, nor children put to death for their fathers;” Deuteronomy 24:16
- Adoption is the proper option. We shouldn’t put the punishment for rape on the woman (she is spoiled goods) or the child. Ethel Waters was the product of a rape.
- Adding the trauma and guilt of abortion to the rape is not the solution.
- Therapy can be given to avoid pregnancy after a rape.

6. “If I don’t have an abortion, my life will be in danger.”

- Extremely rare – in only one out of 10,000 pregnancies or less is the mother’s life in danger.
- In those situations, it is moral to save one life rather than lose two. Sometimes this is the baby and sometimes the mother.
- Even before *Roe v. Wade*, abortion to save the life of the mother was legal.

7. “It is unfair to minorities to restrict abortion.”

- Abortion’s greatest support is among white women, though there is a higher abortion rate among minorities who favor it less.[30]
- No one has a greater right to kill children.



8. “Every child should be a wanted child.”

- Many children not wanted early in a pregnancy are wanted later.
- There is always someone who wants a child. More than two million couples are infertile in the U.S.
- A child’s worth is not based on whether he or she is wanted before birth or after birth.

9. “You can’t legislate morality.”

- Much of legislation is about morality - not stealing, killing, bearing false witness, etc.
- Just because legislation doesn’t stop all bad behavior doesn’t mean it doesn’t deter it.

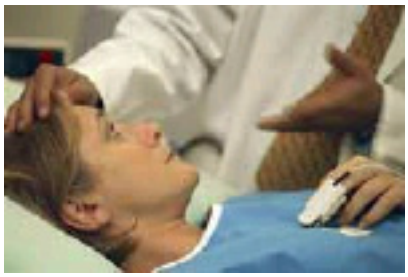
10. “It’s okay because it is legal.”

- Slavery was once legal, but it wasn’t right even though the Supreme Court endorsed it in the Dred Scott decision in the 1840s.

11. “Abortion is a decision between a woman and her doctor.”

- There is no constitutional right to complete privacy. This new right was established in *Roe v. Wade* though it is never mentioned in the Constitution.
- Privacy is important but it is not an absolute right. It can be overridden by more important things. A father does not have the right to privacy when he beats his wife or has incest with his female daughters. The so-called right to privacy does not give a woman the right to kill her child.
- Having a doctor involved in the abortion decision does not give it legitimacy. Fewer than 2,500 doctors do most of the abortions in the U.S. and they are ostracized by their medical colleagues. Doctors perform abortions because they can make lots of money doing it. Their average fee is $100 per abortion so they can make over $3,000 a day.

IV. Help Women Who Have Aborted



• If you are pregnant, choose life. You can trust God to care for the precious life He is developing within you.

• Make a commitment to stand against abortion. Ask God to work in the hearts of those who are making the choice.

• Study the Scriptures and other educational tools to help you prepare to give an answer.

• Donate time. Consider volunteering at Crisis Pregnancy Centers. You can donate a lifetime of love by adopting a child.

• Above all, pray that God will end this tragedy—and restore to each of us and to our nation a commitment to the sanctity of human life.

• Learn from the past. One of the mistakes of the pro-life movement in the early days of abortion was to demand a complete ban or nothing. It is clear now that a complete ban is unrealistic at this time. We should incrementally try to limit the number of abortions done through: a) Trying to eliminate second and third trimester abortions; b) Making abortion more expensive by requiring generally accepted health standards in abortion clinics; and c) Working to recognize the unborn as persons before the law.

• Know the alternatives. Crisis pregnancy centers provide more than counseling. They provide emotional support and practical assistance to women who want to keep their children.

• Love abortion victims and providers. They should know we are Christians by our love. We need to accept those who have aborted into our churches and our hearts, giving them permission to share their pain. We also need to love abortion providers because they are loved by God.

The remedy for guilt is forgiveness. We must enter into a personal relationship with Christ who can forgive our wrongdoing and pay for the price for it.

We have all sinned. Romans 3:23: “All have sinned and come short of the glory of God.” Isaiah 59:2: “But your iniquities have separated you from your God; your sins have hidden his face from you, so that he will not hear.”

The penalty for unforgiven sin is death. Proverbs 14:12: “There is a way that seems right to a man, but in the end it leads to death.” Romans 6:23: “For the wages of sin is death, but the gift of God is eternal life in Christ Jesus our Lord.”

Jesus Christ paid the penalty for our sin. John 3:16: “For God so loved the world that he gave his only son that whosoever believeth in him, should not perish but have everlasting life.”

God forgives every sin if we repent. 1 John 1:9: “If we confess our sins, he is faithful and just and will forgive us our sins and purify us from all unrighteousness.” Romans 8:1 - “Therefore, there is now no condemnation for those who are in Christ Jesus.”

Our duty is to accept God’s forgiveness. Luke 7:47-50 (Story of woman caught in adultery): “Therefore, I tell you, her many sins have been forgiven—for she loved much. But he who has been forgiven little loves little. Then Jesus said to her, ‘Your sins are forgiven.’ The other guests began to say among themselves, ‘Who is this who even forgives sins?’ Jesus said to the woman, ‘Your faith has saved you; go in peace.’”

Forgiveness must be followed by doing the right thing. Matthew 6:14-15 - “For if you forgive men when they sin against you, your heavenly Father will also forgive you. But if you do not forgive men their sins, your Father will not forgive your sins.”

4. Resources

For more detailed information on abortion, including legislation, congressional testimony and commentaries, please visit *www.cmda.org/washington*.

Pro-Life Organizations

The Center for Bioethics & Human Dignity
2065 Half Day Road
Bannockburn, IL 60015
847-317-8180
info@cbhd.org

Christian Legal Society
4208 Evergreen Lane,
Suite 222
Annandale, VA 22003
703-642-1070
www.clsnet.org

Life Issues Institute
1821 W. Galbraith Road
Cincinnati, OH 45239
513-729-3600
513-729-3636
www.lifeissues.org

Family Research Council
801 G. Street NW
Washington, DC 20001
202-393-2100
800-225-4008
www.frc.org

Focus on the Family
8605 Explorer Drive
Colorado Springs, CO 80902
719-531-3328
800-A-FAMILY
www.family.org

Concerned Women for America
1015 Fifteenth St. NW
Suite 1100
Washington, DC 20005
202-488-7000
www.cwfa.org

Helpful Links

www.babycenter.com
www.bethany.org
www.hopeafterabortion.com
www.optionline.org

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EXHIBIT G

Member Awards

One of the highlights each year during the CMDA National Convention (../../events/detail/national-convention.html) is the presentation of the Servant of Christ, Educator, Missionary and President's Heritage Awards. You are invited to nominate CMDA colleagues for three of these four awards, while the Missionary of the Year Award is selected by the CMDE Commission.

A one-page summary of the person's achievements and why they should be considered can be submitted to CMDA's Board of Trustees (mailto:board@cmda.org), by fax to 423-844-1017 (Attn: Board of Trustees) or mailed to CMDA, Attn: Board of Trustees, P.O. Box 7500, Bristol, TN 37621.

Nomination Criteria

+ Servant of Christ Award

+ Educator of the Year Award

+ President's Heritage Award

+ Missionary of the Year Award

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2022 CMDA Member Awards

2022 Servant of Christ Award

Alva Weir, III, MD, FACP

"The greatest among you shall be your servant. Whoever exalts himself will be humbled, and whoever humbles himself will be exalted" (Matthew 23:11-12, ESV).

Established in 1972, the Servant of Christ Award honors those whose careers exemplify commitment to medical excellence along with a stalwart faith in Jesus Christ. The Christian Medical & Dental Associations is honored to present the 2022 Servant of Christ Award to Dr. Al Weir.

Al was raised by a Christian physician father and a Bible teaching mother in Memphis, Tennessee. He can't remember when he gave his life to Christ but came to love Jesus deeply as a boy and continues to do so. Growing up with a physician father, Al knew he wanted to follow in his footsteps and become a doctor. He graduated from University of Tennessee Medical School, completed internal medicine residency at both Washington University in St. Louis, Missouri and University of Tennessee in Memphis, and was board certified in internal medicine with certifications in hematology and oncology. He married his life-long love, Becky, in medical school. After a few years of practice, God called Al and Becky to international missions. They began serving at Eku Baptist Hospital in Eku, Nigeria in 1983, along with 5-year-old daughter Jennifer and 6-week-old daughter Catherine. Their plan for career international missions was cut short by family health issues, so they returned to the U.S. where their son Bowen was born. After a few years on the University of Tennessee faculty, Dr. Weir entered private practice, while also continuing as adjunct faculty at the medical school.

In his own words, Al said, "For most of my youth, my goal was to become a Christian doctor, like my father. When I finally got there, I realized I did not know what that meant. After a few years of practice, God called my family to foreign missions and we were able to serve Him in Nigeria for the two hardest and most fun years of my life. When we had to return for my wife's health, I was stuck again trying to figure out what it means to be a Christian doctor. I have been on that path of discovery ever since."

For a few years, Al felt lost without his mission life, but one morning after a long run, God clearly spoke to him and said, "I have a mission for you if you really want one. I want you to learn how to become a Christian doctor and then be one." He took this calling seriously, and he became plugged into CMDA as a campus advisor and later as the leader of CMDA's Memphis local council. In addition, Dr. Bill Johnson tapped Dr. Weir on the shoulder in need of an oncologist to work with him, and many others, as part of the Albanian Health Fund, an educational evangelism mission. He has now been serving with that mission for 29 years. He received an honorary doctorate from the medical university in Tirana, Albania for his educational work. More importantly, he developed many long-term relationships with faculty and students with the very deliberate goal of leading them to Christ.

Al continued to grow his involvement with CMDA and became a state representative for the House of Representatives, then a member of CMDA's Board of Trustees and then he served as president from 2001 to 2003. In 2005, God again asked Al to focus on occupational ministry and brought him to Bristol, Tennessee to serve as CMDA's Vice President for Campus & Community Ministries, where he served until 2008. He later served a second term as president from 2017 to 2019. During that time, he began to write a weekly devotional for CMDA that continues today. Dr. Weir has written and contributed to several books published by CMDA, including *Practice by the Book* with Dr. Gene Rudd, *When Your Doctor Has Bad News, Decisions* and *Whispers*, a daily devotional book for Christian healthcare professionals. He also edited *The Doctor's Bible* with CMDA for Holman Publishing and contributed chapters for *The Handbook of Medicine for Developing Countries.*

Currently, Dr. Weir serves as professor of medicine at University of Tennessee Health Science Center, section chief for hematology and oncology at the VA Medical Center in Memphis and Program Director for the hematology and oncology fellowship at the University of Tennessee. Al and Becky will be celebrating their 49th wedding anniversary this year. When there is time, Al likes to run and read a bit, but his greatest joys are Jesus, Becky, his children and his grandchildren. His greatest sources of strength are Jesus and Becky.

In recognition of a life focused on serving God no matter where His call leads, we proudly present the 2022 Servant of Christ Award to Dr. Al Weir.

2022 Educator of the Year Award

Farr Curlin, MD

"I sensed early in my medical training that something had gone wrong at the heart of our profession. I came to medical training confident that caring for those who are sick would readily fit into my vocation as a Christian. In seven years of medical school and residency training, I do not recall a medical educator ever encouraging me or my fellow trainees to consider how the substance of our faith informs the practice of medicine."
—Farr Curlin, MD

The Educator of the Year Award is presented to Christian healthcare professionals who are exceptionally dedicated to using healthcare education to change the world. These devoted individuals strive to provide the best education to their students, taking time to share their knowledge, integrity and compassion. Undeniably, they are committed to God and living out their faith. It is due to his dedication to educating and inspiring others that the Christian Medical & Dental Associations is proud to present the 2022 Educator of the Year Award to Dr. Farr Curlin.

Farr Curlin is the fourth of seven children born to John and Leeba Curlin of Jackson, Tennessee. Farr was introduced to Jesus primarily through the faithful witness of his parents and grandparents, and he was baptized at an early age. He also was introduced to CMDA at a young age, because his faither John is a retired obstetrician gynecologist and a longtime CMDA member. Farr's brother Howard, also a longtime CMDA member, is on the OB/Gyn faculty at Vanderbilt University, and Howard's wife Michelle was once on staff at CMDA.

Farr was "baptized" twice as a North Carolina Tarheel, completing both his bachelor's degree and his medical degree at the University of North Carolina, where he also met his wife Kimberly. Farr and Kimberly spent the first 14 years of their marriage in Chicagoland, and most of those years they were part of the community surrounding the Lawndale Christian Health Center. That community, and particularly those who were part of the church Nueva Vida La Villita, deeply shaped Farr and Kimberly. Meanwhile, their four

children, David, Andrew, Caroline and Gigi were all born at the University of Chicago's Lying-in Hospital. At the University of Chicago, Farr completed internal medicine residency and fellowships in health services research and clinical ethics. He joined the faculty in 2003 and went on to found and co-direct the University of Chicago's Program on Medicine and Religion, while also founding, with colleagues, the annual Conference on Medicine and Religion, now in its 11th year. In 2014, Dr. Curlin accepted an offer from Duke University to become the Josiah Trent Professor of Medical Humanities in the Trent Center for Bioethics, Humanities and History of Medicine.

Farr's studies of Christian tradition regarding health and medicine led him to grapple with the history of the church and its witness in the world. Since moving to North Carolina, Farr and Kimberly have been members of Church of the Apostles in Raleigh, where they appreciate being part of the Anglican tradition shared by Farr's intellectual hero, C.S. Lewis. At Duke, Farr holds joint appointments in the School of Medicine, where he teaches medical ethics and practices hospice and palliative medicine, and also the Divinity School, where with his friend Dr. Warren Kinghorn, he co-directs the Theology, Medicine and Culture Initiative (or "TMC"). The TMC initiative offers in-depth Christian theological training for those with vocations in healthcare. The initiative has trained more than 70 fellows and now includes a hybrid track for practicing clinicians who want deeper theological training regarding medicine but cannot relocate to North Carolina.

Dr. Curlin has authored more than 130 articles and book chapters dealing with the moral and spiritual dimensions of medical practice, and he is also co-author of *The Way of Medicine: Ethics and the Healing Profession* (released by Notre Dame in 2021). *The Way of Medicine* articulates and defends an account of medicine and medical ethics meant to challenge the reigning provider of services model, in which clinicians eschew any claim to know what is good for a patient and instead offer an array of "health care services" for the sake of the patient's subjective well-being. Through his work with this book, Farr is committed to contending for good medicine in our time.

In recognition of a life of godly service and academic achievement, CMDA proudly presents the 2022 Educator of the Year Award to Dr. Farr Curlin.

2022 Missionary of the Year Award

Dr. Harry and Mrs. Echo VanderWal

"His master replied, 'Well done, good and faithful servant! You have been faithful with a few things; I will put you in charge of many things. Come and share your master's happiness!'" —Matthew 25:21, NIV

The CMDA Missionary of the Year Award exists to honor outstanding missionary healthcare professionals who give countless hours to bring healing and God's light to those who are suffering. The missionaries we recognize each year have been instruments of God to inspire others to develop a heart for missions. It is an honor for the Christian Medical & Dental Associations to present the 2022 Missionary of the Year Award to Dr. Harry and Mrs. Echo VanderWal.

Long before meeting each other, Harry and Echo VanderWal each sensed God's call to serve as healthcare missionaries in Africa. Both Harry and Echo grew up in Christ-centered families, where listening for and responding to God's voice was practiced and encouraged. For Harry, the call came at age 17. Following a love for mathematics, Harry had considered becoming a calculus professor. While browsing through the university course catalog as a college freshman, Harry saw the course offerings for the pre-med track and thought, "That makes sense. I could serve God as a doctor." For Echo, the call came even earlier in life—in a church service at the age of 8. In that service, she had a distinct sense God was inviting her to join in what He was already doing in Africa. She shared the experience with her parents, who encouraged her to pursue that calling. In turn, she pursued a pre-med track in college, where she sought out the smartest person in the room to be her lab partner. That person was Harry.

Harry and Echo fell in love in two senses: they fell in love with the idea of serving God together, and they also fell in love with each other. The two married shortly after graduation and devoted themselves to preparing to respond to God's call. Harry trained at Boonshoft School of Medicine in Dayton, Ohio, specializing in internal medicine and pediatrics. Echo trained as a physician assistant at Kettering College of Medical Arts, then joined a surgical practice.

In Harry's third year of medical school, the VanderWals welcomed triplets, Luke, Zebadiah and Jacob, to their family. With the blessing of triplets, the Vanderwals quickly learned to take challenges in stride and not worry about the little things—helpful training for eventually serving in a resource-limited country. In 2004, the VanderWals visited Eswatini, a country of just over one million people in southern Africa, for the first time. Then, as it still does today, Eswatini had the highest prevalence of HIV/AIDS in the world. Seeing the devastation of the HIV/AIDS pandemic, the VanderWals soon realized the magnitude of the health crisis could only be solved by a God-sized solution. When they returned for a second visit in 2005, God affirmed their call to Eswatini. After Harry completed his medical training, the couple and their family (then four children, with the addition of son Zion) moved to Eswatini in 2006 to serve the most isolated and underserved populations. There, they founded The Luke Commission and began growing the team. The name represents a deep conviction to treat both the medical and the spiritual, highlighting the importance of treating the whole person—body, mind and spirit—with compassionate and tender loving care.

From the earliest days of The Luke Commission, the VanderWals were advised to follow an African proverb: "If you want to go fast, go alone. If you want to go far, go together." Working with local staff, the VanderWals began conducting mobile medical outreaches in rural and isolated communities. Local staff translated for them, offered cultural guidance and connected them to community leaders and traditional leadership structures. In 2013, God provided an opportunity to purchase a piece of property in central Eswatini, and generous donors from around the world united to raise the funds needed to purchase the property. A year later, an adjacent farm was also purchased to extend access to the largest river in Eswatini. As a constant reminder of God's faithfulness, The Luke Commission team affectionately named the new property the

Miracle Campus. Since 2013, the team has expanded its compassionate reach through the addition of 21 buildings to support increased medical and logistical capacity. Between the second and third waves of COVID-19 in Eswatini, God paved the way to build Eswatini's first-ever oxygen production plant. At the height of the third wave in August 2021, the plant served a daily inpatient census of 138 COVID-19 inpatients, producing the equivalent of 700 cylinders of oxygen per day.

As TLC's staff and impact grew over the years, the VanderWal family welcomed two more children, Hosanna in 2012, Gilead in 2015, and Ncamile in 2020, their daughter-in-love who married their son Luke. Today, The Luke Commission team serves patients 24 hours a day, seven days a week, 365 days a year at the fixed-site Miracle Campus in central Eswatini and at hundreds of outreaches across the country each year. With more than 650 staff members, 38 departments and multi-disciplinary teams supporting on-site construction, supply chain logistics, meal preparation, medical care, engineering, systems, agriculture and hospitality, the Miracle Campus resembles a small town and serves as a hub of operations and the heartbeat of compassionate care throughout Eswatini.

Harry and Echo thank God for His invitation to serve in Eswatini, which they have called home for 16 years. For the many miracles to date and the ones yet to come, may they serve as a testament to God's faithfulness as they seek to expand His kingdom through the ministry of compassionate medicine. In recognition of their devotion to cross-cultural service and their service as healthcare missionaries, the Christian Medical & Dental Associations proudly presents the 2022 Missionary of the Year Award to Dr. Harry and Mrs. Echo VanderWal.

2022 President's Heritage Award

Regina Frost, MD

"Our faith encompasses every aspect of our lives. My convictions, my faiths and my beliefs are much more important to me than what the government or my employer say. I have to answer to God. I will not allow them to force me to do anything that I felt was morally or ethically wrong. In fact, if they did that, I would be willing to leave medicine altogether if I had to. And that would be unfortunate, but I just cannot go against what I believe." —Dr. Regina Frost

The Christian Medical & Dental Associations is honored to present the 2022 President's Heritage Award to Dr. Regina Frost. This award is given to individuals whose lives and work support the mission of CMDA.

Regina grew up in a single-parent home in Detroit, Michigan, and Detroit has been her home for her entire life. She realized at a young age that she wanted to be a doctor, and she credits that to God and His all-knowing plans for her life. Regina's experiences as a young patient hit home for her, when she felt like she was just a number to her doctor, and it became her personal goal to treat her patients with compassion and to get to know them on a personal basis. As she grew in her faith, this became even more important to her.

Dr. Frost began her education in 1996 at the University of Michigan in Ann Arbor, receiving a bachelor's degree in psychology. Subsequently, she earned her medical degree at the Wayne State University School of Medicine in Detroit, Michigan, and then she performed her residency in obstetrics and gynecology at St. John Hospital and Medical Center also in Detroit. After beginning her career in 2008 with a medical group and in a hospital, Regina started her own private practice for women's healthcare, while also teaching part-time at St. John Hospital and Medical Center. Furthering her experience in teaching from 2011 to 2017, Regina was a clinical assistant professor for Michigan State University in the Department of Osteopathic Surgical Specialties. In 2012, she became board certified by the American Board of Obstetrics and Gynecology.

Today, she is an is an OB/Gyn with Ascension St. John Hospital in Detroit, Michigan. Regina has also been an active member of CMDA, where she is the current Chair of CMDA's Women Physicians and Dentists in Christ, as well as a past speaker at their annual conference, and she is an elder at Detroit World Outreach Church. In addition, Dr. Frost has served abroad in mission trips to Jamaica, Brazil, Kenya and Uganda. She enjoys educating women about their health and seeing God work in the lives of her patients. She is married to Darren Clark, and they look forward to seeing how God will use them together to advance His kingdom.

In 2019, Dr. Frost was involved in a federal court case in which she was a named defendant, along with CMDA and the U.S. Department of Health and Human Services. Health and Human Services bravely released a new conscience rule enforcing existing laws that allow religious healthcare professionals to continue their important work in caring for patients without having to perform certain procedures that would be inconsistent with their beliefs or their conscience. However, several states sued to block this rule, which would have forced Dr. Frost and other healthcare professionals to either violate their conscience or end their practice. By agreeing to participate and be named a defendant in this case, Dr. Frost willingly stepped into the fray and testified in court on behalf of religious healthcare professionals nationwide. In this case, the Becket Fund for Religious Liberty defended medical conscience rights so healthcare professionals just like Dr. Frost can continue their ministry providing compassionate care to their patients.

In her own words, Dr. Frost said, "I feel very uneasy and unsettled about the fact that there could be a court order that could cause me or other physicians to perform procedures such as abortions that we feel are morally wrong. That would cause me to want to leave healthcare altogether, which would be very unfortunate because I have a love for what I am doing. That's why I am thankful for this opportunity to stand up and stand for our rights as physicians, as other healthcare professionals, and stand up for what is true."

We are thankful for modern day Esthers just like Dr. Frost, who took a courageous stand for faith just as the biblical heroine did. In an age of increasing hostility toward believers in the healthcare arena on issues including abortion, assisted suicide, sex and gender, the faith community needs more Esthers and Daniels

to stand up and speak out. In recognition of her dedicated support of CMDA and her courage in standing up for truth in the public square and in the courts to protect the right of conscience for healthcare professionals around the country, we are pleased to present the 2022 President's Heritage Award to Dr. Regina Frost.

+ 2021 Award Winners

+ 2020 Award Winners

+ 2019 Award Winners

+ 2018 Award Winners

+ 2017 Award Winners

+ 2016 Award Winners

+ 2015 Award Winners

+ 2014 Award Winners

+ 2013 Award Winners

+ 2012 Award Winners

+ 2011 Award Winners

+ 2010 Award Winners

+ 2009 Award Winners

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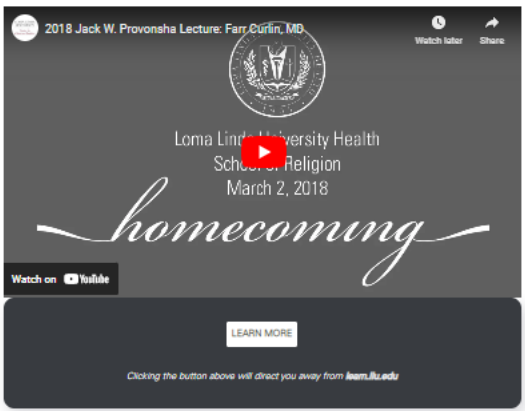
EXHIBIT H

What Does Medicine Have to Do with the Healing Ministry of Jesus Christ?

Bioethics



START DATE
3/2/2018

END DATE
3/2/2018

Description

This lecture will be part of the 98th Annual Alumni Postgraduate Convention (APC)

Presented by

Farr Curlin, MD

Professor of Medicine and Medical Humanities Duke University School of Medicine

Organized by

LLU | Center for Christian Bioethics

Located in the School of Religion at Loma Linda University, the Center brings together ethics scholars from Loma Linda University Health's eight schools and six hospitals. The Center sponsors programs focused on ethical and social issues from the perspective of the Christian faith. We also serve the various Adventist health systems by continuing to develop a highly effective network of bioethics resources.

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2018 Jack W. Provonsha Lecture: Farr Curlin, MD

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2018 Jack W. Provonsha Lecture

Transcript

family - and refusing to

9:47 go along with the powers and principalities that structure and down in our world Christians we hope refuse

9:54 to worship idols including the idols we make out medicine Christians we hope

10:00 refused to violate God's law in service to other end including the patient's

10:07 autonomy Christians we hope have learned to think soberly in Paul's language

English (auto-generated)

EXHIBIT I

The Torah of Reproductive Justice (Annotated Source Sheet)


By Rabbi Danya Ruttenberg

NCJW™

National Council of Jewish Women

This learning is part of the work of NCJW, the National Council of Jewish Women. Learn more and get involved at NCJW.org.

Abortion is one of the more charged topics in American political discourse.

Proposals to limit or block access to reproductive health care in most states reflect a specific Christian definition of the beginning of life, and limit the termination of pregnancy even in instances where Jewish law not only permits, but even requires it. Learning the sources that undergird Judaism's approach to reproductive rights can help illuminate one of the major struggles of our day in new and, sometimes, surprising ways.

(One content note: These texts talk, not surprisingly, about pregnant women. In the context of our contemporary gender categories, it might be useful to remember that, while many (but not all) cisgender women can get pregnant, so too can some non-binary people, some trans men, and some other people whose identities are not reflected in the framework of binary gender.)

Let's begin by looking at the question of the personhood of a fetus:

1

שמות כ״א:כ״ב-כ״ה

(כב) וְכִי־יִנָּצוּ אֲנָשִׁים וְנָגְפוּ אִשָּׁה הָרָה וְיָצְאוּ יְלָדֶיהָ וְלֹא יִהְיֶה אָסוֹן עָנוֹשׁ יֵעָנֵשׁ כַּאֲשֶׁר יָשִׁית עָלָיו בַּעַל הָאִשָּׁה וְנָתַן בִּפְלִלִים: (כג) וְאִם־אָסוֹן יִהְיֶה וְנָתַתָּה נֶפֶשׁ תַּחַת נָפֶשׁ: (כד) עַיִן תַּחַת עַיִן שֵׁן תַּחַת שֵׁן יָד תַּחַת יָד רֶגֶל תַּחַת רָגֶל: (כה) כְּוִיָּה תַּחַת כְּוִיָּה פֶּצַע תַּחַת פָּצַע חַבּוּרָה תַּחַת חַבּוּרָה: (ס)

Exodus 21:22-25

(22) When men fight, and one of them pushes a pregnant woman and a miscarriage results, but no other damage ensues, the one responsible shall be fined according as the woman's husband may exact from him, the payment to be based on reckoning. (23) But if other damage ensues, the penalty shall be life for life, (24) eye for eye, tooth for tooth, hand for hand, foot for foot, (25) burn for burn, wound for wound, bruise for bruise.

In other words, if someone accidentally causes a miscarriage to take place, they are obligated to pay financial damages only; the case is not treated as manslaughter or murder, which would demand the death penalty. The "other damage" that would demand the death penalty ("life for life") would be the death of the pregnant person herself (or some other serious punishment relating to the damage caused--"eye for eye, tooth for tooth…") In other words, causing the termination of a pregnancy is not, in the Torah, considered murder. As the Talmud puts it:

סנהדרין פ״ז ב:י׳

דיני נפשות בפלוגתא דרבי ורבנן דתניא רבי אומר (שמות כא, כג) ונתת נפש תחת נפש ממון

Sanhedrin 87b:10

In cases of **capital law,** the dispute concerning such a prohibition is **with regard to** the issue that is the subject of **the dispute** between **Rabbi** Yehuda HaNasi **and the Rabbis, as it is taught** in a *baraita* that **Rabbi** Yehuda HaNasi **says** with regard to that which is written: "If men struggle and they hurt a pregnant woman…and if there shall be a tragedy **you shall give a life for a life"** (Exodus 21:22–23), the reference is to **a monetary payment** for the life that he took. The tragedy referenced is the unintentional killing of the mother.

Interestingly, a major factor in some Christian views on abortion were developed through a mistranslation of this passage. In the Greek translation of the Hebrew Bible (known as the Septuagint, completed in 132 BCE), they translated ason, damage or tragedy in these Exodus verses, to exeikonismenon, "from the image," making the verse seem to be about whether or not the fetus is "perfectly formed," rather than whether or not the pregnant person dies. That is, the question of whether one pays mere damages or incurs the death penalty would then depend on whether the fetus is "formed," or sufficiently developed in terms of gestational stages, to warrant a harsher punishment. Notably, the Septuagint translated the word ason in a different, more accurate,

way (as malakia, affliction) in the Book of Genesis. There are a few theories as to why this happened, but the ramifications of this poor translation choice continue to this day.

The next few sources look more closely at the status of the fetus:

3

יבמות ס״ט ב

אי מיעברא עד ארבעים מיא בעלמא היא

Yevamot 69b

If she is found pregnant, until the fortieth day it is mere fluid.

That is to say, the fetus has basically no status whatsoever for the forty days of pregnancy. It is like water--a thing of no legal significance. Was this because of the prevalence of miscarriages? Was it a larger philosophical claim? Regardless, this text is a clear assertion that life does not begin at conception.

It may be worth noting that modern decisors of Jewish law count the 40 days as beginning from conception. Given that contemporary medical practice is to count pregnancy gestation from the last menstrual period--not conception--the end of those 40 days lands at about 7 or 8 weeks of pregnancy, by our current accounting.

4

גיטין כ״ג ב

מאי טעמא דרבי בהא קסבר עובר ירך אמו הוא

Gittin 23b

What is the reason for Rabbi Yehuda HaNasi's position [in the above conversation]? He holds that a fetus is considered as its mother's thigh [that is, as part of its mother's body].

In the middle of a Talmudic debate about whether a fetus is considered separate from the pregnant person, we see a clear statement by Rabbi Yehuda HaNasi who, as redactor of the Mishnah, holds great authority. His statement, in fact, closes the debate and lends credence to the discussion at hand (about the status of a fetus if its mother is liberated from bondage.) A fetus is not an independent being; it is part of the body of the person carrying it.

Now, a few sources on ending pregnancies:

5

משנה אהלות ז׳:ו׳

(ו) הָאִשָּׁה שֶׁהִיא מַקְשָׁה לֵילֵד, מְחַתְּכִין אֶת הַוָּלָד בְּמֵעֶיהָ וּמוֹצִיאִין אוֹתוֹ אֵבָרִים אֵבָרִים, מִפְּנֵי שֶׁחַיֶּיהָ קוֹדְמִין לְחַיָּיו. יָצָא רֻבּוֹ, אֵין נוֹגְעִין בּוֹ, שֶׁאֵין דּוֹחִין נֶפֶשׁ מִפְּנֵי נֶפֶשׁ:

Mishnah Oholot 7:6

(6) If a woman is having trouble giving birth, they cut up the child in her womb and brings it forth limb by limb, because her life comes

> before the life of [the child]. But if the greater part has come out, one may not touch it, for one may not set aside one person's life for that of another.

In a situation in which the pregnant person's life is in danger from the pregnancy or labor, Jewish law is abundantly clear: The adult's life takes precedence. The only situation in which that comes into question is if the birth is already more than half completed--only then does the life of the birthing baby come into consideration. As Rabbi David Felman put it, "Implicit in [this] Mishnah is the teaching that the rights of the fetus are secondary to the rights of the mother all the way up until the moment of birth."

This principle is cited elsewhere in the Talmud in a conversation about self-defense; the Gemara there asserts that abortion to save the pregnant person's life should be considered self-defense, that the fetus in this case is a rodef, a "pursuer" attempting to kill the pregnant person. Rashi--Rabbi Shlomo Yitzhaki, the important 11th century French commentator addresses that discussion. The word nefesh in classical Jewish literature refers both to a "soul" and a "life."

6

רש"י על סנהדרין ע"ב ב:י"ד

יצא ראשו - באשה המקשה לילד ומסוכנת וקתני רישא החיה פושטת ידה וחותכתו ומוציאתו לאברים דכל זמן שלא יצא לאויר העולם לאו נפש הוא וניתן להורגו ולהציל את אמו אבל יצא

> ראשו אין נוגעים בו להורגו דהוה ליה כילוד ואין דוחין נפש מפני נפש

Rashi on Sanhedrin 72b:14

its head came out: With a women that is experiencing difficulty giving birth and is in [mortal] danger. And it is taught in the first section [of this teaching], "the midwife extends her hand and cuts it up and extracts [the pieces];" as the entire time that that it has not gone out into the air of the world, it is not [considered] a soul, and [so] it is possible to kill it and to save its mother. But when its head came out, we cannot touch it to kill it, as it is like a born [baby]; and we do not push off one soul for the sake of another.

Notably, Rashi defines a nefesh--a life--as taking place at birth, as the head emerges from the birth canal. A fetus does not have this status before then. Rashi may be referencing Genesis 2:7: "Then God formed man of the dust of the ground, and breathed into his nostrils the breath of life; and man became a living soul." That is, regarding life as taking place with the first breath, and not before.

Here are a couple more recent texts that show some of the ways in which these texts above have been applied:

7

> אמנם נדון השואל בא"א שזנתה שאלה הגונה היא. וקרוב בעיני להתירה...וגם בעובר כשר הי' צד להקל לצורך גדול. כל כמה

דלא עקר. אפי' אינו משום פקוח נפש אמו. אלא להציל לה מרעתו. שגורם לה כאב גדול וצ"ע.

Rabbi Jacob Emden, Responsa She'elat Ya"vetz 1:43 (1739-1759)

The questioner asks about an adulterous married woman (who is pregnant) is a good question. It appears to me to permit her (to abort)...And even in the case of a legitimate fetus there is reason to be lenient if there is a great need, as long as the fetus has not begun to emerge; even if the mother's life is not in jeopardy, but only so as to save her from woe associated with it that would cause her great pain...

Here, abortion is permitted in situations where carrying the fetus to term would cause "woe" and "great pain." One might wonder if any situation in which one is forced to carry an unwanted pregnancy would not cause such things.

8

ברור ופשוט הדבר בהלכה דישראל אינו נהרג על העוברין, ומלבד דעה יחידית סוברים הפוסקים שאיסור מיהא ישנו, אבל דעת הרבה מהפוסקים שהאיסור אינו אלא מדרבנן, או הוא רק משום גדר בנינו של עולם, אבל מחמת איבוד נפשות אין נדנוד כלל, ומשום כך מתיר בשו"ת מהרי"ט ט:צ"ז–צ"ט לסדר בישראלית הפלת ולד בכל היכא שהדבר נחוץ משום רפואת אמו, אפילו באין סיבה של פקו"נ לאם... ובכזאת, ויותר מזאת,

צידד להתיר בהדיא בשו"ת שאילת יעב"ץ א:מג, וכותב בלשון: "וגם בעובר כשר יש צד להקל לצורך גדול כל כמה דלא עקר אפילו אינו משום פקוח נפש אמו, אלא להציל לה מרעתו שגורם לה כאב גדול." הרי בהדיא שדבר הצעת ההיתר בזה של היעב"ץ הוא אפילו כשליכא בכאן שאלת פקו"נ של האם, והמדובר רק כדי להצילה מכאב גדול שיש לה בגללו, ושבכלל יש להקל בזה לצורך גדול.... ויסורים וכאבים נפשיים המה במדה מרובה הרבה יותר גדולים ויותר מכאיבים מיסורים גופיים.

Rabbi Eliezer Waldenberg, Tzitz Eliezer 13:102 (1978)

It is clear and obvious as law that a Jew is not killed for a fetus. Aside from one view, the authorities rule that there is a prohibition, but many authorities believe that this prohibition is rabbinic, or it is under "building the world." But there is no concern for destroying a life, and therefore Maharit 1:97-99 permits arrangement for a Jewish woman to abort a fetus where it is needed for the mother's health, even without it being a matter of saving the mother's life… And in such a case, and beyond this, Rabbi Yaakov Emden permitted, writing, "And even with a legitimate fetus, there is room to be lenient for great need, so long as it has not been uprooted [for birth], even without a need to save the mother's life, but only to save her from her evil, which causes her great pain." We see clearly that this permission of Rabbi Yaakov Emden is even when it is not a matter of saving the

> mother's life, and it is only to save her from great pain because of the child, and that in general there is room to be lenient for great need. ...And suffering and emotional pain in great measure are greater and more painful than physical pain.

Here, Rabbi Waldenberg is talking about the great emotional pain a pregnant person might experience knowing that the fetus has been diagnosed with a disease like Tay-Sachs, but the larger legal framework stands: There is room in the tradition to permit abortion in order to relieve someone who is pregnant from "great emotional pain." And, again, one might speculate that any person who is forced to carry to term an unwanted pregnancy could, indeed, experience exactly that.

Rabbi Aharon Lichtenstein, "Abortion: A Halakhic Perspective," Tradition 25:4 (1991)

Here it is clear that saving a life is not the only sanction for permitting an abortion. This is evident from the Talmudic passage that permits a nursing mother to cohabitate using a mokh (a barrier of cotton or wool) to prevent pregnancy… Since this prohibition is waived to facilitate normal family relations (which is why the emission in this context is not "wasteful"), it would follow that other ethical and humane factors may also be taken into account. It would seem to me that issues such as kevod ha-beriyot (dignity of persons), shalom bayit (domestic peace) and tza'ar (pain), which all carry significant halakhic weight in other contexts, should be considered in making these decisions.

Many Jewish values can and should factor in to our understanding of the importance of abortion access for all. Dignity, avoiding pain, valuing relationships, and other factors--including also, perhaps, our Jewish mandate to pursue the creation of a more just society--should be present as we consider both individual cases (and remember that not everyone has the same privileges, or the same choices) and larger systems.

Abortion is not only permitted in Jewish law, but it is required when the life of the pregnant person is in danger.

Our access to reproductive health care is guaranteed not only by the Fourteenth Amendment — the right to equality and privacy — but also by the First Amendment's guarantee that no one religion or religious interpretation will be enshrined in law or regulation.

We must not remain idle while barriers to health care place any individual's health, well-being, autonomy, or economic security at risk.

Reproductive justice is a Jewish issue.

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EXHIBIT J

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The beginning of human life

Status of embryo. Perspectives in Halakha (Jewish Religious Law)

Joseph G. Schenker

Abstract

Introduction

The Jewish religion is characterized by a strict association between faith and practical precept. Jewish law has two sections, the written and the oral tradition. The foundation of the written law and the origin of authority is the Torah, the first five books of the Scripture. It is an expression of God's revelation, teaching and guiding humanity. The oral laws interpret, expand, and elucidate the written Torah and behavior patterns regulate new rules and customs. The main parts of the oral law are as follows: the Mishnah, the Talmud, Post-Talmudic Codes and. Responsa Literature.

Discussion

Life is a process that has a beginning and an end. The consensus about the time when human life really begins is still not reached among scientists, philosophers, ethicists, sociologists and theologizes. The scientific data suggested that a single developmental moment marking the beginning of human life does not exist. Current biological perspectives on when human life begins range through fertilization, gastrulation, to birth and even after. The development of a newborn is a smoothly continuous process.

Results

Procreation is acknowledged in the Bible to be the gift of God. The (Halachic) Jewish interpretation of when human life begins is extracted predominantly from procreation is acknowledged in the Bible to be the gift of God. The Jewish interpretation of when human life begins is extracted predominantly from The Halachic sources. The Bible does not make any other direct references regarding the beginning of human life.

Conclusion

While the Talmud gives the full status of humanness to a child at birth, the rabbinical writings have partially extended the acquisition of humanness to the 13th postnatal day of life for full-term infants. The Babylonian Talmud Yevamot 69b states that: "*the embryo is considered to be mere water until the fortieth day*." Afterwards, it is considered subhuman until it is born. The issues of abortion, embryo research, multifetal reduction and cloning will be discussed according to Jewish Law perspectives. Life is a process that has a beginning and an end. The consensus about the time when human life really begins is still not reached among scientists, philosophers, ethicists, sociologists and theologizes. The scientific data suggested that a single developmental moment marking the beginning of human life does not exist. Current biological perspectives on when human life begins range through fertilization, gastrulation, to birth and even after. The development of a newborn is a smoothly continuous process.

Keywords: Embryo, Human life, Cloning, Preembryo, Jewish religion

Jewish Religious Law (Halakha)

The Jewish religion is characterized by a strict association between faith and practical precept. Jewish law has two sections, the written and the oral tradition [1].

The foundation of the written law and the origin of authority is the Torah, the first five books of the Scripture. It is an expression of God's revelation, teaching and guiding humanity.

The Torah is viewed as a single unit a divine text that obligates moral values as well as practical laws. The oral laws interpret, expand, and elucidate the written Torah and behavior patterns regulate new rules and customs. The authority is derived from the written Torah. The main parts of the oral law are as follows:

1. The Mishnah. This early textbook was compiled systematically by numerous scholars over a few centuries. Its final form was established early in the third century. The Mishnah includes early traditional and original interpretations of the written Torah, ancient regulations that are not written in the Torah, and post-Biblical regulations.
2. The Talmud. For approximately three centuries after the final compilation of the Mishnah, the great interpreters studied the six orders of the Mishnah contributed to a monumental composition know as the Talmud. The great interpreters (Amoraim) included in the Talmud commentaries and interpretative studies of the Mishnah and Midrashim and established regulations and new customs.
3. Post-Talmudic codes. An enormous amount of Talmudic knowledge was essential for accurate ruling. These post-Talmudic codes were compiled with the intention of assisting access to the laws, regulations, and customs of the Talmudic Halakha. Different scholars until the 16th century summarized and reviewed the Halakhic conclusions of the Talmud in the post-Talmudic codes. Among the scholars were Rashi (1040–1105), Rabbi Moshe Ben Nachman (1195–1270), and Rabbi Menachem Ben Shlomo Hameiri (1249–1316). The most prominent post-Talmudic codes are Sheilot, Halakhot, Maimonides, Piskey Harosh, Shulhan Arukh.

4. Responsa. The various attitudes of rabbinic scholars about the way Halakha should be applied in a changing world is analyzed and discussed with regard to the legal codes, and written opinion has been given by qualified authorities throughout ages to questions about aspects of Jewish law.

Responsa is a term usually confined to written replies given to questions on all aspects of Jewish law by qualified authorities from the time of the later Geonim to the present day. About 1,000 volumes, containing more than half a million separate Responsa, have appeared in print. Contemporary rabbinic scholars deal with new problems that arise in the wake of scientific advancement. Moreover, the Responsa of later rabbinic authorities are often short monographs in which every text remotely relevant to the point at issue is quoted or discussed.

Procreation is acknowledged in the Bible to be the gift of God. The (Halachic) Jewish interpretation of when human life begins is extracted predominantly from following sources: the Torah, the Talmud, and the Responsa (rabbinical writings). A basic biblical identification of life with breath is pointed in Torah and other books of Tanach (Bible).

Torah

The first detailed description of the creation of a human being by God points to the moment when human life begins. “Yahveh God formed the man from the dust of the earth and breathed into his nostrils the breath of life and the man became a living nefesh” (the first breath). Life began for human being when God breathed breath into him (Genesis 2.7).

Additional Statements in the Torah demonstrate that breath is understood to be essential to life; and that when the breathing stops, life ends. “And all flesh that moved on the earth perished, birds, cattle, wild animals all swarming creatures that swarm upon the earth and all human beings. Everything which had the nishmat (breath) of life in its nostrils, all that were on dry land died” (Genesis 7.21–22).

The Bible does not make any other direct references regarding the beginning of human life. The conclusion as to when human life begins can be obtained from the Torah’s stated position on the issue of abortion.

> *And if men strive together, and hurt a woman with a child, so that her fruit depart (if she miscarries) and yet no harm follow, he shall be surely fined, according as the woman’s husband shall lay upon him; and he shall pay as the judges determine. But if any harm follow, then shalt thou give life for life… (Exodus 21: 22–23)*

According to the Jewish interpretation,” if no harm follow the hurt to the *woman* resulting in the loss of her fruit refers to the survival of the woman following her miscarriage; in that case there is no capital guilt involved, and the attacker is merely liable to pay compensation for the loss of her unborn child. “But if any harm follow,” i.e., the woman is fatally injured, then the man responsible for her death has to give “life for life”. In that event the capital charge of murder exempts him from

any monetary liability for the aborted fruit [2]. From the interpretation of this passage it can be inferred that the killing of an unborn child is not considered murder punishable by death in Jewish law. What is explicitly stated in the Jewish law is that murder is an offense that is punishable by death: “He that smiteth a man, so that he dieth, shall surely be put to death” (Exodus 21:12).

The Responsa literature reached from these two passages the conclusion that the capital charge of murder should be used for death of “a man, but not a fetus”. It means that complete human life does not begin at the embryonic or fetal stage of development.

The Septuagint—the translation of the Hebrew Bible into Greek by 72 Jewish Scholars, 270 BC—renders the word *ason* not as ‘casualty’ or ‘serious injury’ but as ‘form.’ This gives a completely different meaning to the passage. The first verse, in which there is a liability, compensation, refers to the miscarriage of an ‘unformed’ fetus. The second, which speaks of a capital crime, refers to a ‘formed’ fetus, in other words one sufficiently developed to have a recognizably human shape. [This, is the source of the teaching of the Church, from Tertullian who was ignorant of Hebrew onwards through later church fathers, that at a certain stage the fetus is a person and that abortion is a form of homicide.

This position was further reinforced by the belief that the “animation” (entry of the soul) of a fetus occurred on the fortieth or eightieth day after conception for males and females respectively, an idea first expressed by Aristotle and by the doctrine, firmly enunciated by Saint Augustine and other early Christian authorities, that the unborn child was included among those condemned to eternal perdition if he died un-baptized. Some even regarded the death or murder of an unborn child as a greater calamity than that of a baptized person.

Eventually the distinction between animate and inanimate fetuses was lost; and since 1588, the Catholic Church has considered as murder the killing of any human fetus from the moment of conception.

This position is maintained to the present day. It assumes that potential life, even in the earliest stages of gestation, enjoys the same value as any existing adult life. Hence, the Catholic Church never tolerates any direct abortion, even when, by allowing the pregnancy to continue, both mother and child will perish; following the principle two deaths are better than one murder].

Talmud

The Jewish Talmudic Law assumes that the full title to life arises only at birth. Accordingly, the Talmud rules (Talmud, Tohoroth II Oholoth 7:6). A passage from the Mishna describes the situation in which a woman’s life is endangered during childbirth.

> *If a woman is in hard labor {and her life cannot otherwise be saved}, one cuts up the child within her womb and extracts it member by member, because her life comes before that of the child. But if the greater part {or the head} was delivered, one may not touch it, for one may not set aside one person’s life for the sake of another.*

The legal text states that the fetus must be dismembered and removed limb by limb. However, if "the greater part" of the fetus had already been delivered, then the fetus should not be killed. This is based on the belief that the fetus only becomes a person when most of its body emerges from the birth canal. Before personhood has been reached, it may be necessary to "sacrifice a potential life in order to save a fully existent human life, i.e. the pregnant woman in labor." After the forehead has emerged from the birth canal, the fetus is regarded as a person. Neither the baby nor the mother can be killed to save the life of the other.

A second consideration is the principle of self-defense. Some Jewish authorities have asserted that if the fetus placed its mother's life at risk, then the mother should be permitted to kill the fetus to save herself, even if the "greater portion [of its body] had already emerged" from the birth canal.

This ruling, sanctioning embryotomy to save the mother in her mortal conflict with her unborn child, is also the sole reference to abortion in the principal codes of Jewish law. They add only the further argument that such a child, being in "pursuit" of the mother's life, may be destroyed as an "aggressor" following the general principle of self-defense.

This formulation of the attitude toward abortion in the classic sources of Jewish law implies:

1. That the only indication considered for abortion is a hazard to the mother's life.
2. That, otherwise, the destruction of an unborn child is a grave offence, although not murder.
3. That it can be viewed that the fetus is granted some recognition of human life, but it does not equal that of the mother's, and can be sacrificed if her life is in danger.

While the Talmud gives the full status of humanness to a child at birth, the rabbinical writings have partially extended the acquisition of humanness to the thirteenth postnatal day of life for full-term infants. This designation is based on the viability of the infant, so the acquisition of humanness occurs later for premature infants, because the viability of premature infants is still questionable after thirteen days.

Rashi, the great twelfth century commentator on the Bible and Talmud, states clearly of the fetus 'lav nefesh hu—It is not a person.'

Objection to abortion in Jewish Law is thus strong but not absolute. It is not permitted even if the fetus carries a genetic conditions or other congenital malformation; nor for social reasons. Abortions are not permitted for economic reasons, to avoid career inconveniences, or because the woman is unmarried. However, some Rabbinical authorities have been known to approve abortion in the early stages of gestation, within the first forty days, during which it is, according to one talmudic statement, 'mere water'. The Babylonian Talmud Yevamot 69b states that: "the embryo is considered to be mere water until the fortieth day." Afterwards, it is considered subhuman until it is born.

The fetus has great value because it is potentially a human life. It gains "full human status at birth only."

Each case of abortion must be decided individually by a rabbi well-versed in Jewish law.

Israel State legislation [3], the Criminal Law Amendment (Interruption of Pregnancy) of 31 January 1977 increased the circumstances under which abortions could be legally performed. It permitted abortions if the continuation of the pregnancy was likely to endanger the woman's life or cause her physical or mental harm, if the woman was under the age of marriage or over 40 years of age, if the pregnancy resulted from a sexual offence, incest or extramarital sexual intercourse, or if the child was likely to have a physical impairment. The penalty imposed on a person performing an illegal induced abortion is imprisonment to up to 5 years.

Performance of an abortion required the approval of a three-member committee consisting of a social worker and two medical practitioners, one of whom was an obstetrician/gynaecologist. The committee was required to give its approval in writing and to set out the grounds justifying the abortion. The pregnant woman was required to give her written consent, after the physical and mental risks and consequences involved in the procedure had been explained to her. The consent of a minor did not require the approval of her representative. An abortion had to be performed by a physician in a recognized medical institution. According to Israel State legislation, the Criminal Law feticide can be carried out at any stage of pregnancy until birth as is mention in Mishna based on the belief that the fetus only becomes a person after most of its body emerges from the birth canal.

Multiple pregnancy reduction

In recent years, there has been a dramatic increase in multiple pregnancies throughout the world. Undoubtedly, the main factor has been the use of ovulation inducing drugs and of multiple embryo transfer in the treatment of infertility. Multiple pregnancy has very serious implications for the mother and for her offspring, for the family, community, and for health service resources. Multifetal pregnancy reduction was initially used selectively to terminate a fetus affected by a genetic disorder.

This procedure of multifetal pregnancy reduction (MFPR) is now considered an efficient and safe way to improve the outcome. According to Jewish law the fetus is regarded as a part of the mother's body and not as a separate being until it begins to egress from the womb during parturition, and attains the status of 'nefesh,' which means soul in Hebrew.

Abortion on demand is repulsive to the ethics of the Halakha; however as we have seen, in some situations a pregnancy may be terminated. If, for 'example, the mother's life is in danger, as in sometime the case is in multiple pregnancy a fetus is a *Rodef*; an aggressor who may even or must be killed in order to save the individual in danger. Most rabbis permit and even mandate abortion when the health or life of the mother is threatened. Some authorities are stringent and require the mother's life to be in actual danger, however remote that danger, whereas others permit abortion for a serious threat to the mother's health.

The question of multifetal pregnancy reduction was debated in the Responsa literature by rabbinical authorities. If the mother's life is in danger, each fetus is a *rodef* and can be killed to save the mother. But if the danger is to the fetuses and not to the mother, each fetus is an aggressor and victim with equal status. In this case, it might not be permissible to put aside one soul for the sake of another. Searching for a legal analogy for this situation, some Rabbis focused on the case of a group of people who are in mortal danger and who can be saved by sacrificing one innocent member of the group. Most Halakhic authorities agree that in such a case all must allow themselves to die rather than sacrifice an innocent person. If, however, it is absolutely certain that all would be lost unless one is forfeited, these same authorities would allow some innocent people to be selected randomly and sacrificed to save the others. This conclusion is applicable to cases of a viable person. In the case of fetuses who are already condemned to death, multifetal reductions might well be allowed. The number of fetuses to be destroyed is a medical question that should be decided by the doctors involved, who must determine the minimum number that need to be reduced to ensure a good prognosis for the mother and remaining fetus.

Human embryo and assisted reproduction

The development of assisted reproductive technologies has made it necessary to consider the question of the beginning of life and the moral status of the embryo from different perspectives.

Many forms of infertility treatment consist precisely of producing embryos outside the woman's body by in vitro fertilization with a view to subsequently implanting them in the uterus, where they have the opportunity to develop into full-term children. The fact that this is even feasible shows that the embryos have not taken on a different character by being created outside the woman's body.

The basic fact that allows IVF-ET to be considered in the rabbinical literature at all is that the oocyte and the sperm originate from the wife and husband based on the commandment of procreation stated in the Bible (Old Testament, Genesis 1:18). The Jewish majority's religious point of view, however, as formulated by the chief rabbis of Israel, supports both IVF and ET [4, 5].

Embryo research

Various criteria exist in Jewish law which determine the status of a fetus or an embryo. One fundamental principle that is agreed upon by all branches of the Jewish faith and that is that full human status is not acquired until birth. Thus, until then, the destruction of a product of conception does not constitute homicide culpable as murder. Although the Jewish law refuses to grant a full human inviolability to the unborn child from conception, it is clearly agreed that the potentiality for life must not be compromised except for the most substantial medical reasons. Man's creation "in the image of G-d" confers infinite value on every human life and renders its destruction a capital offence. Since the pre-implantation pre- embryo carries a low probability of reaching the neonate stage, and achieving full human status, it does not enjoy the same sacred title to life as the fetus or embryo, and its status is similar to that of human semen. Nevertheless the destruction of human seed or embryo is considered a grave violation of the law.

According to the Talmud, during the first 41 days from fertilization until the completion of organogenesis, the embryo is defined as “plain water”, for the purpose of certain laws. Pre-embryo research may be therefore permissible if it is carried out in order to enable the sperm owner to have his own child. It is prohibited to use a pre-implantation pre-embryo for research, unless specific medical research. The destruction or use of a pre-implantation pre-embryo for research is forbidden, as long as it has the potential to implant. It is permitted to create In vitro pre-implantation pre-embryos for research if there are real chances that the sperm owner may benefit and have a child as a result of this research. When this does not apply, then the creation of a pre-embryo for research purposes is strictly forbidden.

Cryo-preservation

Cryopreservation of pre-embryos is routinely practiced in IVF programmes. Because cryo-preservation stops the development and growth of the embryo, it raises the basic question of whether it cancels all rights of the pre-embryo’s father. As far as the mother is concerned, the difficulty is removed, since the pre-embryo is transferred into her uterus. As for the father, whose main function is to fertilize the oocyte to form the pre-embryo, the period of freezing may sever his relationship with the child. Freezing the spermatozoa and pre-embryo is permitted in Judaism only when all measures are taken to ensure that the father’s identity will not be lost.

Cloning

Animal models have demonstrated that in several mammalian species, such as mice, sheep and cows, SCNT has resulted in live births that developed into healthy adult animals. This would suggest that reproductive cloning could be achieved in humans.

Perspectives for applying cloning technology to human reproduction have generated much controversy. Worldwide legislations has banned reproductive cloning.

The Jewish religion takes the position that reproductive human cloning could conceivably be justified in some circumstances. This view is largely based on historical tradition and sacred writings, which largely focus on human destiny. The Jewish tradition emphasizes that man is in partnership with God. Some Jewish thinkers find justification for this view in the story of Genesis, which says that Adam and Eve were ‘to work it [the garden] and to preserve it’ (Old Testament, Genesis 2). Jewish scholars do not believe that potential violations of human dignity are reason enough to prohibit human cloning. They believe that the potential benefits of developing cloning technology outweigh the potential risks, provided man fulfils his obligation to minimize violations of human dignity. Some Jewish thinkers fear that cloning human beings might harm the family by changing the roles and relationships between family members that define their responsibilities to one another and patterns of inheritance. In Judaism religious status is passed down through the mother and tribal designation is passed down through the father. Thus, a child needs both a mother and a father. However, many regard cloning of a family member as more acceptable than donor insemination or egg donation.

Jewish Law is squarely situated on the side of medical research that has potential to save and preserve life. Given this presumptive duty, it is possible to support therapeutic cloning as a remedy for diseases. Since Jewish law does not grant full moral status to the human embryo, therapeutic cloning research conducted on the early human embryo may be acceptable.

Definitions of a human embryo normally include those entities created by the fertilization of a human oocyte by a human sperm. However, there have been a number of recent technological developments that have made it possible to create entities called embryos by other means, such as somatic cell nuclear transfer (SCNT) and induced parthenogenesis [6]. Applying such new technology will likely be prohibited by Rabbinical Authorities.

The development in future of such new “entities”, embryos which might result in live births when transfer to women uterus will even more confuse the issue when human life begins.

Footnotes

Capsule Presented at the International Symposium on “Beginning of Human Life,” Zagreb, September 2007.

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EXHIBIT K

Abortion in Jewish Law

By Benjamin Hassan

1

שמות כ״א:כ״ב-כ״ג

(כב) וְכִי־יִנָּצוּ אֲנָשִׁים וְנָגְפוּ אִשָּׁה הָרָה וְיָצְאוּ יְלָדֶיהָ וְלֹא יִהְיֶה אָסוֹן עָנוֹשׁ יֵעָנֵשׁ כַּאֲשֶׁר יָשִׁית עָלָיו בַּעַל הָאִשָּׁה וְנָתַן בִּפְלִלִים: (כג) וְאִם־אָסוֹן יִהְיֶה וְנָתַתָּה נֶפֶשׁ תַּחַת נָפֶשׁ:

Exodus 21:22-23

(22) When [two or more] parties fight, and one of them pushes a pregnant woman and a miscarriage results, but no other damage ensues, the one responsible shall be fined according as the woman's husband may exact, the payment to be based on reckoning. (23) But if other damage ensues, the penalty shall be life for life,

Septuagint, *Shemot* 21:22-23 (NETS translation)

Now if two men fight and strike a pregnant woman and her child comes forth not fully formed, he shall be punished with a fine. According as the husband of the woman might impose, he shall pay with judicial assessment. But if it is fully formed, he shall pay life for life.

Philo, Special Laws III

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(108) But if any one has a contest with a woman who is pregnant, and

strike her a blow on her belly, and she miscarries, if the child which was conceived within her is still unfashioned and unformed, he shall be punished by a fine… But if the child which was conceived had assumed a distinct Shape in all its parts, having received all its proper connective and distinctive qualities, he shall die; (109) for such a creature as that is a man…requiring nothing more than to be released and sent out into the world.

2

משנה נדה ה׳:ג׳

תִּינוֹק בֶּן יוֹם אֶחָד... וְנוֹחֵל וּמַנְחִיל. וְהַהוֹרְגוֹ, חַיָּב. וַהֲרֵי הוּא לְאָבִיו וּלְאִמּוֹ וּלְכָל קְרוֹבָיו כְּחָתָן שָׁלֵם:

Mishnah Niddah 5:3

A one day old baby boy… inherits and transmits; one who kills him is guilty of murder, and he counts to his father, to his mother and to all his relatives as a fully grown man

3

סנהדרין צ״א ב:ו׳

וא״ל אנטונינוס לרבי נשמה מאימתי ניתנה באדם משעת פקידה או משעת יצירה א״ל משעת יצירה א״ל אפשר חתיכה של בשר עומדת שלשה ימים בלא מלח ואינה מסרחת אלא משעת פקידה אמר רבי דבר זה למדני אנטונינוס ומקרא מסייעו שנאמר (איוב י, יב) ופקודתך שמרה רוחי

Sanhedrin 91b:6

And Antoninos said to Rabbi Yehuda HaNasi: **From when is** the **soul placed in a person?** Is it **from the moment of conception or from the moment of** the **formation** of the embryo, forty days after conception? Rabbi Yehuda HaNasi **said to him:** It is **from the moment of** the **formation** of the embryo. Antoninos **said to him:** That is inconceivable. Is it **possible** that **a piece of meat** could **stand** for even **three days without salt** as a preservative **and** would **not rot?** The embryo could not exist for forty days without a soul. **Rather,** the soul is placed in man **from the moment of conception. Rabbi** Yehuda HaNasi **said: Antoninos taught me this matter, and** there is **a verse** that **supports him, as it is stated: "And Your Providence** [***pekudatekha***] **has preserved my spirit"** (Job 10:12) indicating that it is from the moment of conception [*pekida*] that the soul is preserved within a person.

4

משנה אהלות ז׳:ו׳

(ו) הָאִשָּׁה שֶׁהִיא מַקְשָׁה לִיֵּלֵד, מְחַתְּכִין אֶת הַוָּלָד בְּמֵעֶיהָ וּמוֹצִיאִין אוֹתוֹ אֵבָרִים אֵבָרִים, מִפְּנֵי שֶׁחַיֶּיהָ קוֹדְמִין לְחַיָּיו. יָצָא רֻבּוֹ, אֵין נוֹגְעִין בּוֹ, שֶׁאֵין דּוֹחִין נֶפֶשׁ מִפְּנֵי נֶפֶשׁ:

Mishnah Oholot 7:6

A woman who was having trouble giving birth, they abort the fetus inside her and take it out limb by limb, because her life comes before

its life. If most of he had come out already they do not touch it because we do not push off one life for another.

5

משנה תורה, הלכות רוצח ושמירת נפש א׳:ט׳

(ט) אַף זוֹ מִצְוַת לֹא תַעֲשֶׂה שֶׁלֹּא לָחוּס עַל נֶפֶשׁ הָרוֹדֵף. לְפִיכָךְ הוֹרוּ חֲכָמִים שֶׁהָעֻבָּרָה שֶׁהִיא מַקְשָׁה לֵילֵד מֻתָּר לַחְתֹּךְ הָעֻבָּר בְּמֵעֶיהָ בֵּין בְּסַם בֵּין בְּיָד מִפְּנֵי שֶׁהוּא כְּרוֹדֵף אַחֲרֶיהָ לְהָרְגָהּ. וְאִם מִשֶּׁהוֹצִיא רֹאשׁוֹ אֵין נוֹגְעִין בּוֹ שֶׁאֵין דּוֹחִין נֶפֶשׁ מִפְּנֵי נֶפֶשׁ וְזֶהוּ טִבְעוֹ שֶׁל עוֹלָם:

Mishneh Torah, Murderer and the Preservation of Life 1:9

This, indeed, is one of the negative mitzvot - not to take pity on the life of a rodef. On this basis, our Sages ruled that when complications arise and a pregnant woman cannot give birth, it is permitted to abort the fetus in her womb, whether physically or with drugs. For the fetus is considered a rodef of its mother. If the head of the fetus emerges, it should not be touched, because one life should not be sacrificed for another. Although the mother may die, this is the nature of the world.

6

חושן משפט תכ״ה:ב׳

(ב) לפיכך העוברת שהיא מקשה לילד מותר לחתוך העובר במעיה בין בסם בין ביד מפני שהוא כרודף אחריה להרגה ואם הוציא ראשו אין נוגעין בו שאין דוחין נפש מפני נפש וזהו טבעו של עולם:

Shulchan Arukh, Choshen Mishpat 425:2

Therefore, in a case of a pregnant woman who is having difficulty in childbirth--it is permissible to abort the fetus inside her either with drugs or physically since the fetus is considered to be a *rodef* (pursuer) chasing her in order to kill her. Yet, if his head has breached then we do not harm him since we do not save one life by ending another. This is the nature of the world.

7

סנהדרין ע״ב ב:י״ד

איתיביה רב חסדא לרב הונא יצא ראשו אין נוגעין בו לפי שאין דוחין נפש מפני נפש ואמאי רודף הוא שאני התם דמשמיא קא רדפי לה

Sanhedrin 72b:14

Rav Ḥisda raised an objection to Rav Huna from a *baraita*: If a woman was giving birth and her life was being endangered by the fetus, the life of the fetus may be sacrificed in order to save the mother. But once **his head has emerged** during the birthing process, **he may not be harmed** in order to save the mother, **because** one **life**

may not be pushed aside to save another **life.** If one is permitted to save the pursued party by killing the minor who is pursuing him, **why** is this so? The fetus **is a pursuer** who is endangering his mother's life. The Gemara answers: This is not difficult, as **it is different there,** with regard to the woman giving birth, **since she is being pursued by Heaven.** Since the fetus is not acting of his own volition and endangering his mother of his own will, his life may not be taken in order to save his mother.

8

סנהדרין נ״ז ב:ה׳

משום רבי ישמעאל אמרו אף על העוברין מאי טעמיה דרבי ישמעאל דכתיב (בראשית ט, ו) שופך דם האדם באדם דמו ישפך איזהו אדם שהוא באדם הוי אומר זה **עובר שבמעי אמו**

בן נח – ליכא מידעם

Sanhedrin 57b:5

It is stated in that book of *Aggadot* that the Sages **said in the name of Rabbi Yishmael:** A descendant of Noah is executed **even for** killing **fetuses.** The Gemara asks: **What is the reason** for the opinion **of Rabbi Yishmael?** The Gemara answers: It is derived from that **which is written: "One who sheds the blood of a person, by a person** [***ba'adam***] **his blood shall be shed"** (Genesis 9:6). The word *ba'adam* literally means: In a person, and is interpreted homiletically:

What is a person that is in a person? You must say: This is a fetus that is in its mother's womb. Accordingly, a descendant of Noah is liable for killing a fetus.

9

ערכין ז׳ א:י״א

מתני׳ האשה שיצאה ליהרג אין ממתינין לה עד שתלד האשה שישבה על המשבר ממתינין לה עד שתלד.

Arakhin 7a:11

MISHNA: In the case of a pregnant **woman who is taken** by the court **to be executed,** the court **does not wait to** execute **her until she gives birth.** Rather, she is killed immediately. But with regard to **a woman** taken to be executed **who sat on the travailing chair** in the throes of labor, the court **waits to** execute **her until she gives birth.**

10

ערכין ז׳ א:ט״ו

ישבה על המשבר וכו׳: מ״ט כיון דעקר גופא אחרינא הוא:

Arakhin 7a:15

What is the reason for delaying the execution in this case? The Gemara answers: **Once** the fetus **uproots** from its place and begins to

leave the woman's body, **it is** considered **an independent body** and may not be killed together with the mother.

11

ערכין ז׳ א:כ״א

א״ר נחמן אמר שמואל האשה שישבה על המשבר ומתה בשבת מביאין סכין ומקרעים את כריסה ומוציאין את הוולד

Arakhin 7a:21

§ **Rav Naḥman says** that **Shmuel says:** In the case of **a woman who sat on the travailing chair** in the throes of labor, **and died on Shabbat, one brings a knife, and tears** open **her abdomen, and removes the fetus,** as it might still be alive, and it could be possible to save its life.

12

תוספות חולין דף לג עמוד א ד"ה אחד

משמע דטעמא משום דליכא מידי דלישראל שרי ולעובד כוכבים אסור... ואע"ג דבן נח נהרג על העוברים כדאמר התם וישראל אינו נהרג נהי דפטור מ"מ לא שרי

This Gemara implies that there is nothing that is permissible to a Jew that is forbidden to a non-Jew… Although a Noahide is executed for killing a fetus, and a Jew is not executed, although he is exempt, nevertheless it is not permissible to do so.

13

תוס' נדה (מד.) ד"ה איהו

וא"ת אם תמצי לומר דמותר להורגו בבטן אפי' מתה אמו ולא הוי כמונח בקופסא אמאי מחללין עליו את השבת שמביאין סכין דרך ר"ה לקרוע האם כדמוכח בפ' קמא דערכין (דף ז:) וי"ל דמכל מקום משום פקוח נפש מחללין עליו את השבת אף ע"ג דמותר להרגו דהא גוסס בידי אדם ההורגו פטור... ומחללין את השבת עליו...

Now, were you to ask – if it is permissible to kill a fetus in the mother's womb [even after the mother has died], and it is not considered to just be placed in a box, then why can we violate Shabbat for him? For we bring a knife by way of the public domain to surgically remove him from the mother, as it is stated in Arakhin (7a). One can say: that nevertheless, for the sake of saving a life, we violate Shabbat even though it is permissible to kill him. For behold for a gosses by human hands, one who kills him is exempt… and we can nevertheless violate Shabbat to save his life…

14

תורת האדם שער המיחוש – ענין הסכנה

ואע"ג דתנן (אהלות פ"ז) האשה המקשה לילד מביאין סכין ומחתכין אותו אבר אבר יצא ראשו אין נוגעין בו שאין דוחין נפש מפני נפש, דאלמא מעיקרא לית ביה משום הצלת נפשות, ותנן

נמי (נדה מ"ד א') גבי תינוק בן יום אחד וההורגו חייב, ודוקא בן יום אחד אבל עובר לא, וקרא נמי כתיב דמשלם דמי ולדות, אפילו הכי לענין שמירת מצות מחללין עליה, אמרה תורה חלל עליו שבת אחת שמא ישמור שבתות הרבה. הלכך אפי' בהצלת עובר פחות מבן ארבעים יום שאין לו חיות כלל מחללין עליו כדעת בעל הלכות.

ואיכא דסבירא ליה שאין מחללין משום נפלים...

The Mishna in Ohalot however states (7:6), 'If a woman is in hard travail, one cuts up the child in her womb and brings it forth member by member, because her life comes before that of [the child]. But if the greater part has proceeded forth, one may not touch it, for one may not set aside one person's life for that of another'. Now this implies that beforehand [before birth] there is no concept of 'saving of a life'. Similarly the Mishna states (Niddah 44a) that if a person murders a one day old child he is liable the death penalty – that is, only a one day old child, not a fetus – and the verse also states that one pays monetary compensation for [causing a miscarriage] of a fetus. Nevertheless, regarding the issue of mitzvah observance, we can violate Shabbat for a fetus. The Torah says: violate one Shabbat for him, for perhaps he might keep many Shabbats. Therefore, even to save a fetus less than 40 days old, which has no [current] viability, we would desecrate Shabbat according to Hilkhot Gedolot.

> There are those who are of the opinion that we do not violate Shabbat for fetuses…

15

> **תוספות נדה דף מד עמוד א ד"ה איהו**
>
> וא"ת אם תמצי לומר דמותר להורגו בבטן אפי' מתה אמו ולא הוי כמונח בקופסא אמאי מחללין עליו את השבת... וי"ל דמכל מקום משום פקוח נפש מחללין עליו את השבת אף ע"ג דמותר להרגו...

> According to the possibility that it is permitted to kill it (the fetus) in the womb, even if the mother has already died, and it is not considered to be merely residing in a box, then we can ask – why should it be permissible to violate the Shabbat for its sake? And one can answer that nevertheless for the sake of preserving a life one can violate the Shabbat even though it is permissible to kill it…

Responsa of *Maharit*, 1:97

Rabbi Joseph ben Moses Trani (Maharit), the son of Mabit (q.v.), was born in Safed in 1568, and died in Constantinople in 1639.

Question. Regarding a fetus which is considered the thigh of its mother… In the second chapter of Hullin… Tosafot wrote that while one is exempt from killing a fetus, it is nevertheless not permitted to do so… [The

reason is] that it is forbidden on the basis of bodily injury.
The Mishna in chapter 7 of Ohalot states… And it is only because the mother's life takes precedence that we can abort it, but were it not that there was a risk to her life, there is a matter of concern regarding [taking] the life of a fetus. So how then can we say in Arakhin that we would kill the fetus directly (lit., with our hands) because of concern of disfigurement of the mother? And an additional question, for in that very sugya in Arakhin, it quotes the case of the women who sits on the birthing stool on Shabbat… From this it is clear that it is considered a risk of life and it overrides Shabbat…. And Tosafot also wrote the a non-Jew is liable for killing a fetus, and a Jew is exempt, but although he is exempt, it is not permissible. We see that there is a prohibition in this matter.
And we can answer – that the case of being taken out to be executed is different, since the fetus will be executed together with the mother, since a fetus is a thigh of the mother…

Responsa of *Maharit*, 1:99

And from the fact that the *Gemara (Arakhin 7a)* says, "It is obvious!" [that we can abort the fetus of the woman who is condemned], it implies that as far as taking a [fetal] life is concerned, there is not the slightest issue of concern… Therefore, regarding a Jewish woman, in a case of the mother's need, it would appear that it is permissible to assist them to have an abortion, since it is for the sake of the mother's health.

***Responsa* of *Havot Yair*, 31**

Rabbi Yair Chaim ben Moses Samson Bachrach, Germany, 1638-1702.

Regarding your question of a married woman who became pregnant through adultery… and the question is whether she is permit to swallow some medicine that will cause her to abort. And you wanted to know my opinion regarding this matter…

And it seems that your question is whether in general there is a sin of destroying a life in this case. Now, it would be possible to make a number of distinctions, such as whether 40 days have passed – for before this time it is "mere water", as is stated in Yevamot and Kriot – or whether three months have passed which is the time when the pregnancy is visible, or if she sensed in her womb the movement of the infant, which occurs a brief time after the 3 months, nevertheless it is not our interest to decide based on how we would be inclined to think or the "logic of the gut", but only according to Torah law.

The Mishnah in Niddah states that only one who murders a one day old child is liable for execution, but not for a fetus…

Nevertheless, before the fetus has detached, it would seem that it is permitted to abort it according to everyone, based on the Talmud in Arakhin, where a condemned woman can be hit so that the fetus' death will not lead to her disgrace…

And you cannot ask from the fact that we violate Shabbat to save the life of a fetus… for perhaps that is really because of the life of the mother, for any danger to the fetus is a danger to the mother…

And you cannot say [that if it is permitted,] why did the Gemara imply that were it not for the principle of it being part of her body [which is

condemned to death] we would wait for the child to be born, how much more so not to cause it death. For it certainly is forbidden ab initio. For it is no better than a case of masturbation, which is considered to be a "slaughtering of children." And masturbation is considered a grave offense, and the reason is because every drop of semen has the potential to create holy progeny. And one cannot say that the prohibition of masturbation is because of auto-eroticism… Thus even women are prohibited from wasting seed [and destroying potential life]…

Therefore, based on what we have written, it would be completely permissible in your case according to Torah law, were it not for the widespread practice amongst us and amongst them [not to abort], because of a safeguard against fornicators and those who fornicate after them…

Nonetheless, in Hullin 33, Tosafot wrote as a matter of obvious fact that "while one is exempt [who aborts], nevertheless it is not permissible to do so"…

This is implicit in the Gemara's discussion, that had it not been for the reason that "the fetus is her body," [and can be executed with her], there would be a logic to wait to save the fetus, and how much more so should we not cause its death at the outset. The reason for this is that to do so is no better than those who "inflame themselves under every leafy tree and slaughter (or 'squeeze out' children" (Niddah 13a based on Isa. 57:5), and the Rabbis spoke in extreme terms regarding the prohibition to waste semen, and the reason is because it is possible that a holy life (lit., seed) will be created from every drop. One cannot say that the reason for all these problems is because of provoking the evil inclination, for if that were the case, there would be no need to bring a proof from the verses.. And

this prohibition of wasting semen applies even to women (to destroy the man's semen in their body), and is only permitted in three special cases of women…

We see that it is also Rashi's opinion that regarding other women (not the special cases), the problem is only regarding the man to waste his seed, and it is not a problem for the women, thus there is no inherent problem to destroy the semen after it has been "absorbed" (i.e., possibly caused conception). Nevertheless, just because we can make an argument does not mean that we can make a ruling tht is should be allowed for a woman (to destroy the semen in her body), and how much more so after the semen has been "absorbed". Thus, one who assists in this is aiding those who are sinning…

Thus, anyone who is involved in this act, or who causes it, I fear that he may be deserving a sin offering… Although we have made arguments, to actually act on it, we cannot permit. And no more needs to be said about this. Now, please, my brother, do not burden me any more with questions such as these, for it is only with difficulty that I answered you this time.

Rabbi Jacob Emden, Responsa Shelat Yavetz, I 43

Rabbi Jacob ben Tzvi Emden was born in 1697 and died in 1776, in Germany.

Question: Regarding what you asked – is there a violation to destroy a fetus in the womb of a mother who is pregnant due to fornication, both in the case of a single woman and the case of a married woman.

Response: In the book Havot Yair (following responsum 31) I have found

that the author was asked about a married woman who became pregnant due to adultery, and after the act she had regret, etc., if she is allowed to swallow some medicine that will cause her to abort (lit., destroy the corrupt seed within her)…

Now it would seem to me that there is reason to be lenient since she has committed adultery and there is blood on her hands. Therefore, she is now deserving of death according to the Torah. Although her life is not in ur hands to execute her, nevertheless, by law of Heaven she is deserving of death… Although a mamzer once he is born has the status of a "kosher" person, for whom it would be murder to kill, nevertheless, now, that he is still a limb of his mother, and if her life were in our hands we would execute her with her unborn child… it is obvious to me that there is no prohibition in destroying it, even if his mother remains alive…

Now, regarding the author's attempt to demonstrate in that responsum that there was there was an element of violation based on the sin of wasting of seed. This can be rejected, for one can say that this (wasting potential life) is not the reason for the prohibition, but rather because one "spills into the dung heep" and gives power to the demonic powers and weakens the supernal forces, as is known from the masters of Kabbalah… One can thus see that it is not considered to be "for waste" except when it is wasted on the ground (as a result of masturbation), based on the reason given above… Thus, regarding a fetus, since it is not a life it is a doubt if it will ever become a full life, as discussed, the matter is still doubtful. Thus even for a "kosher" fetus (not the result of adultery) there would be reason to be lenient for a great need, until the point when it has "become uprooted" (childbirth has begun). Even when the mother's life is not at

risk, but it is just to save the fetus from the evil that will befall it, that it will cause significant pain to the mother. And this requires further investigation.

Knowledge is easy to he who understands it, that there is nevertheless a prohibition at the outset to destroy a fetus based on the simple sense of the Talmud, although one is not liable for murder regarding fetuses. And similarly [it is prohibited] to destroy semen that has been absorbed into a woman's body, although she has not yet conceived as a result. All of this is definitely forbidden without a reason, as is clear from the discussion that women who may not use a mokh, save for three special cases. In truth, however, for a (legitimate) purpose it is permissible, even to "waste seed" and to spill it on the ground, as we see in the case of the testing of the genitals (Yevamot 76a). From this we see that this serious prohibition is permitted in the case of the mitzvah need, as I have written elsewhere, and there is no need to write at more length.

Tzitz Eliezer 9: 51 (R. Eliezer Waldenberg)

Summary of the halakhot that emerge from the preceding section:

1. A Noahide is executed for aborting a fetus. There is an opinion that he is not executed.
2. A Jew is not executed for aborting a fetus.
3. When there is a need, and the law determines that it is allowed to arrange for an abortion, it is preferable to have it done by a Jewish doctor.
4. One should be stricter regarding arranging an abortion for non-Jews than for Jews, since they are prohibited regarding aborting a fetus and one would transgress putting a stumbling block before the blind if there is no

one else to do the abortion… Similarly, when there is a need to arrange for an abortion for a non-Jew, one should attempt to have a Jewish doctor perform it.

5. Some are of the opinion that even though a Jew is not executed for aborting a fetus, there is nevertheless a Biblical prohibition against him doing such.

6. Others hold that there is no Biblical prohibition, only a Rabbinic one.

7. Still others hold that even Rabbinically, the prohibition is a weak one.

8. Kabalistically, the prohibition regarding aborting a fetus is very severe.

9. When there is a danger to the mother in continuing the pregnancy, one can allow an abortion easily.

10. Even when there is no danger, but the mother's health is very delicate, and for the sake of her health or to relieve her of severe pain, it is advised to perform an abortion, even though there is no real risk of life, even here one can allow this, according to the judgment of the decisor, as he sees the case.

11. One can also allow, as above, when the woman is nursing.

12. A married woman who committed adultery or was raped and became pregnant, even from a non-Jew, where the child would not be a mamzer, and she has now repented (in the case of adultery), a number of great decisors are inclined to allow for an abortion, either because of her shame or because of desecration of the divine name, and the shame and stigma to the family [and other reasons, as mentioned above].

13. To have an abortion before 40 days from conception, and also before 3 months from conception, is much more lenient than to do so after these periods. It is thus preferable to arrange for the abortion prior to these

periods, while the fetus has not begun to stir, when there is a well-based concern that the fetus that will be born deformed and beset by afflictions.
14. At the other extreme, to kill a fetus once the woman is in the process of giving birth and the fetus has already been "uprooted to emerge", it is much stricter than before this moment, and one cannot allow in such a case, save when there is a direct threat to the mother's life.
15. Even in cases where the law would allow for an abortion, nevertheless, one should get the husband's permission, since it is his property.
16. It is also preferable to have an abortion by drinking a medicine than by direct surgical means.
17. A woman who has a terminal illness, and if she continues her pregnancy continues it will hasten her death, and the woman is beseeching not to have the abortion, and she does not care that the pregnancy will hasten her death, as long as she leaves behind a child, one can allow such a pregnancy to continue, on the basis of "sit and be passive."
18. All Jews are commanded with a strict decree not to deal lightly regarding ending a pregnancy, and there is a great responsibility in such a case, both on the one asking to have the abortion and on the decisor being asked. Not to mention that there is in such decisions the fencing in of the breaches made by the wanton women and those who would fornicate after them , that even the nations of the world have fenced themselves regarding this, and established laws and strict punishments on the violators and those who assist them, and behold Israel are a holy people.

Tzitz Eliezer, 13:102 (R. Eliezer Waldenberg)

The question is regarding terminating a pregnancy because of the Tay-Sachs disease… The technology today which allows testing for this disease cannot giver reliable results prior to three months into the pregnancy. Thus his question is if one can view such a disease with such severe and certain consequences, sufficient severity to allow for a termination of the pregnancy even after three months, or if the period of three months is absolute, and there is no justification, short of direct risk to the life to the mother, that would allow for a termination of pregnancy after three months.

Behold after investigation into the matter with great seriousness, and with consideration of all the relevant circumstances, it seems in my humble opinion, on the basis of the analysis that I wrote in my responsa, 9:51.3… that in a case such as this, in which the consequences are so grave if the pregnancy and childbirth are allowed to continue, it is permissible to terminate the pregnancy until 7 months have elapsed, and in a way in which no danger will befall the mother. Beyond 7 months the issue is more serious (and the stringency here is more based on how the matter seems and the "knowledge of the gut", to use the phrase of the Havot Yair) since at the end of 7 months the fetus is often fully developed.

It is clear that capital punishment is not prescribed for abortion, and with the exception of a single opinion, the decisors conclude that there is nevertheless some form of a prohibition. But the opinion of most rabbis is that the prohibition is only of Rabbinic origin, or that it is in the category of the well-being of the world, but that there is not even the slightest element of destroying a life. Therefore, Maharit, in his responsum, permitted abortion for a Jewish woman whenever the matter was

necessary for her health even when her life was not at stake.
Like this, and even to a greater degree, was it argued to be permissible in Responsa Yavet, 1:43… And therefore ask yourself where is there a great need regarding pain and suffering greater than the woman in our case which will be inflicted upon her if she gives birth to such a creature whose very being is one of pain and suffering and his death is certain within a few years… and added to that is the pain and suffering of the infant. This would seem to be the classic case in which abortion may be permitted, and it doesn't matter what type of pain and suffering is endured, physical or emotional, as emotional pain and suffering is to a large extent much greater than physical pain and suffering…
(2) And you should know that in the words of Maharit and Yavetz, there is not mentioned at all that there should be a distinction between within 3 months and after 3 months. And the clear distinction given is only regarding once it has been "uprooted to emerge" and beforehand. To the contrary, Yavetz writes thusly: "As long as it has not uprooted to emerge," and from this we can infer that as long as this is not the case, there is no distinction regarding what month it is in…
(4) Also in Responsa Havot Yair, 31, where he raises the possibility of distinguishing between before and after 40 days, or before and after 3 months, he expresses in passing his reservations about such distinctions, and he writes thusly: "Nevertheless, it is not our desire to make a decision based on what seems, and a knowledge of the gut"…
(6) Thus, as I have indicated at the outset, it would seem in my humble opinion that one can allow in a case such as ours to arrange for a termination of the pregnancy immediately once the test results are

definitive that the child has this disease, even up to 7 months of pregnancy, provided that there is no risk to the mother…
(7) I will add that, to do it in the best possible way, it would be ideal if the operation could be performed by a woman doctor, for in such a case there would be another aspect of leniency, according to Havot Yair and Yavetz in their responsa. For they are of the opinion that the prohibition for a Jew to kill a fetus is because of wasting of seed, see there, and women are not prohibited in doing such according to most decisors.

Tzitz Eliezer, 14:102 (R. Eliezer Waldenberg)

Regarding checking the amniotic fluid to detect if the fetus has Mongoloidism (Down's syndrome), and terminating a pregnancy under such circumstances.
March 19, 1978To his honor, haRav haGaon, Rabbi Eliezer Waldenberg, shlita, head of the Rabbinical Court, Jerusalem…
Among those who give birth over the age of 37, the frequency of such cases is approximately 1%, and amongst those who give birth over the age of 40, the frequency of occurrence is approximately 2%. The Ministry of Health will implement an amniocentesis screening program to be done at a time that will enable the detection of the embryos with this syndrome and the decision to terminate the pregnancy. This syndrome cannot be detected within the first three months of pregnancy. There is thus in this case a halakhic question similar to the one regarding pregnancy with a child who has Tay-Sachs disease.
As is known to his honor, a child who suffers from Down's syndrome is

completely different from one who suffers from Tay-Sachs. Down's syndrome is a very undesirable disease accompanied by physical changes and mental retardation that sometimes requires institutional care and is linked to a shortened life expectancy. But, one should not compare a child with this disease to a child with Tay-Sachs who will surely die. It seems to me that the permission to terminate the pregnancy in a case of Tay-Sachs is based mainly on how such a case will impact the mental state of the parents, especially the mother, and it is for this reason that the rabbi (you) ruled that it is possible to terminate the pregnancy up through the seventh month of pregnancy. The harsh impact of a case of Tay-Sachs on the parents is clear and straightforward. On the other hand, although it is possible that Down's syndrome will have such a negative effect, at the same time I am familiar with families who love their children who suffer from Down's syndrome.

I am sure that I will soon be faced with inquiries from mothers of thirty-seven to forty years who will have two concerns: (a) Is it permissible to perform amniocentesis in order to discover cases of Down's syndrome? (b) Requests for termination of pregnancy in such cases.**Response.** March 26, 1978. Jerusalem. To the honorable Prof. Dr. M. Meir, the executive director of Shaarei Tzedek Hospital in Jerusalem.

… Let us turn to second and main problem, if it is permissible to terminate pregnancy in the event that the examination shows 100% (as I was told in a verbal conversation) that the fetus suffers from Down's syndrome, given that we are talking about doing this after three months of pregnancy.

Now, as his honor himself senses and emphasizes in his letter, one cannot

compare the case of a child with this disease to a child with Tay-Sachs who will definitely die.

Similarly, a child who suffers from Down's syndrome is very different from one who suffers from Tay-Sachs.

Therefore, it would seem that we cannot issue a general permission to terminate a pregnancy in a case of Tay-Sachs. However, when the results of the examination are known, the doctor must send the woman (and the hospital administration must issue an order in this regard) to a posek, providing the specifics of the results of the test, and the rabbi who is a posek will pay close attention to the emotional state of the couple in regards to this, and will decide with his halakhic judgment whether to allow the termination of the pregnancy. Only upon receipt of a qualified posek permit may the hospital management agree to do so in its facility.

I have emphasized that it is impossible issue a general permission… for according to the halachic sources and arguments that I have detailed and explained in my two previous responsa, in the course of my discussion of termination of pregnancy in the case of Tay-Sachs disease, there is a wide space (a strong basis) to conclude that it is permitted based on those same sources and reasons, even in the case of a fetus with Down's syndrome. For in the final analysis, as his honor as described in his letter, it is also a very undesirable disease accompanied by physical changes and mental retardation that sometimes requires institutional care and is linked to a shortened life span. These realities have the ability, in many cases, to destroy the emotional/mental state of both the wife and the husband, including the ability to cause them to come down with a serious or not-so-serious illness, and also to destroy the health of the couple's family life.

Let me give an example from a case that came before me in a couple of ultra-Orthodox Jews (from the old yishuv) who had already been born to them – it shouldn't happen to us – two children who had Down's syndrome who died a little more than a year after their birth. As a result, the wife was struck with an anxiety attack, and this expressed itself in her refusal to have marital relations with her husband for fear of becoming pregnant and again becoming pregnant with such a fetus. The husband waited a year, then two, and frequently implored his wife to return to a normal marital life, and the woman turned her back to him and remained adamant in her refusal. The situation came to my attention when they were already on the verge of divorce. When I saw what the situation was, I gave the woman permission to undergo the appropriate tests in case she got pregnant. She resumed martial relations with her husband, she became pregnant, she underwent the test, the test showed that everything was fine, and she gave birth to a sound and healthy child. Peace in their house was restored to its proper place, and they continue to live a happy life together.

In another case, I was asked by a certain Torah-scholar – scientist, regarding his wife, who was over forty and pregnant, and the doctor advised her to do the test. I tried to influence him that there was no need for an examination and to behave like our forbearers did who had faith in God that everything would turn out alright. He responded to me that from the moment his wife learned from the doctor about the concern (regarding Down's syndrome) and the possibility to determine this through this recently developed test, she is not able to sleep at night, and she is deeply distressed to the point that he fears for her health. In this

way, this knowledge has brought women into a state of "one who adds knowledge adds pain."

Therefore, regarding such cases, and similar ones, it seems that we can certainly base a permission (for termination of pregnancy) one the rulings of the great poskim that we cited in our earlier writings (see Tztitz Eliezer, vol. 9, 13:102, and the previous responsum in this volume). In other words, whether based on the opinion of many poskim who hold that the prohibition against abortion for a Jew is only a rabbinic violation, for a fetus is not considered a life; or based on the opinions of the poskim who believe that it is not even an appurtenance to the sin of murder, but rather an offense like any other offense, add to this the fact that we don't even violate Shabbat to save such a fetus (according to these opinions) as long as the woman is not in active childbirth; or based on Maharit and the many who are in his camp who permit an abortion whenever it is required for the health of the mother, even when there is no risk to life, and this is even if the prohibition is a Biblical one inasmuch as the fetus does not yet have a presumption of being alive; or based on the opnions that are mentioned in Havot Yair; or based on Yavetz and those in his camp who are of the opinion that there is a basis to be lenient as long as the child has not begun to leave the mother's womb, even if there is no risk to life of the mother, but only to save her from the fact that the child will cause her great pain; or based on the author of Rav Paalim who is of the opinion that when dealing with these cases, a great need is defined not only in terms of one's physical health needs, but also in terms of one's spiritual and emotional needs, in accordance with how I explained and gave backing to this position; or explain and substantiate this; and so on,

everything as I wrote and explained with great depth with God's help in our earlier writings.

(D) I would also add that in a case where an abortion is permitted, in addition to the need and obligation to obtain the consent of the woman to terminate the pregnancy (as his honor wrote in his letter, which is included in the standard that you have prepared in this regard), there is also a need and an obligation to receive the husband's consent, in accordance with the well-known halakha regarding damages when someone causes a woman to miscarry, that such damages are paid to the husband (Shemot 21:22, Baba Kama 42 and 49, Rambam, Hovel u'Mazik 5:1-2, and Hoshen Mishpat 423:1).

In conclusion:

(a) It is permitted to conduct an amniocentesis for the purpose of making a decision regarding termination of pregnancy due to mental retardation in a case of Down's syndrome.

(b) In the event that the examination shows, with confidence, that the fetus has Down's syndrome, a permissive ruling must be obtained from a qualified rabbi to perform a termination of pregnancy.

(c) An additional consideration to permit such an abortion would be if there was the possibility to terminate the pregnancy through drinking some medicine or through giving an injection (i.e., non-surgical means).

(d) In addition to the need to obtain the consent of the woman to terminate the pregnancy, the consent of the husband must also be obtained.With great honor and blessing, Eliezer Yehuda Waldenberg

Tzitz Eliezer 14:10 – excerpt on amniocentesis

Regarding the first matter (of the permissibility of undergoing an amniocentesis), there are two questions: (a) Whether it is permissible to conduct such an examination? and (b) Even if it is permitted on its own terms, is it permissible in cases where it will lead to a transgressing a prohibition? Because this will lead to causing the woman to stumble (in sin), for when she learns at that hospital the results of the examination, and when the hospital, which follows Torah law, will refuse to terminate the pregnancy, she will go to a different hospital or doctor who will agree to go against Torah law and carry out the termination of pregnancy.

Let me explain. The question regarding the intrinsic permissibility of the procedure, is because to do this test – as your honor has explained it to me in our oral conversation – it is necessary to insert a needle through the walls of the woman's body and into her uterus (and this is done under local anesthesia) and the needle reaches the uterine cavity and draws a quantity of fluid from it … Sometimes it can happen (even if this is rare) that such an examination cause real harm and damage, such as bleeding and the like.

And examining the matter, it seems that despite this we can permit the act itself of performing a test … As far as the possibility that this will cause some injury to the woman as a result of this, behold this is it only a doubt (i.e., a small risk), and for this the woman's consent suffices. For they do not perform such procedures without the woman's consent to that, The permission to do this is certainly true given that they do not perform such a procedure for the purposes of inflicting injury, but for the sake of benefit.

The second question is that, as a result of the examination, the woman

will be informed that the defect has been discovered in the fetus, and will arrange for the termination of pregnancy even in the case where the halakhic ruling is to forbid it. As a result of which, by administering the test we are transgressing the prohibition of putting a stumbling block before the blind, This can be an even greater concern if the woman who is undergoing the test is not religious, for in such a case the stumbling block is more real and anticipatable.

However, after looking into this matter, it appears that even the concern for this prohibition (of placing a stumbling block) does not exist, For we do not transgress the prohibition of placing a stumbling block before the blind except in cases where it is clear that the other person will transgress as a result of the first person's actions. But wherever there is room to argue that the first person's actions will possibly not lead to sin, then he does not transgress placing a stumbling block before the blind…

Now, in our case, we have all of these factors (of leniency regarding placing a stumbling block before the blind), and even more than them, For we are not handing the person the forbidden thing, for the test itself is not a violation, as stated above. It is also not clear whether this will even lead to a transgression, for in our case there are many many doubts regarding this. First, perhaps the test will be negative, which is what occurs in the vast majority of cases (the occurrence of Down's syndrome in this population is only 1-2%), Second, who is to say that the woman will consent afterwards to undergo a termination of pregnancy. Thirdly, perhaps according to the circumstances of the case, she will receive a halakhic ruling permitting her to terminate her pregnancy from a rabbi who is a posek who will permit this according to Torah law…

Iggrot Moshe, Choshen Mishpat, 2:69

Rabbi Moshe Feinstein, 1895-1986, was the leading halachic authority of American Jewry.

Day after Sukkot. 1976.

Regarding Killing a fetus…
And in Maimonides it is even more explicit that killing a fetus is actual murder…
Therefore, regarding the law, it is prohibited under the prohibition of "Thou shalt not murder" to abort a fetus, with the single exception that one who kills it is exempt from the death penalty… And because of this I ruled that even if the doctors are saying that there is a possibility that the mother may die if the fetus is not killed – although for desecrating Shabbat and violating other commandments one would do so in such a case, even for a small concern of life – nevertheless, to kill a fetus it would be forbidden until the doctors assess that the likelihood of her death is almost definite…
And even if the doctor is being forced by threat of death to perform an abortion, it would appear that he must give up his life rather than do so [although an argument could be made to the contrary]… Therefore, this ruling requires greater thought, whether one must give up his life rather than perform an abortion…
I have written all this because of the great calamity in the world that many governments have allowed the killing of fetuses, among them political leaders in the State of Israel, and countless of fetuses have already been

killed, and in these days the greatest need is to make a fence around the Torah, how much more so not to make leniencies regarding the prohibition of murder that is so severe. Thus, I was appalled by the responsa of a learned man in Israel written to the director of Shaarei Tzedek Hospital who permits the abortion of a Tay-Sachs fetus even beyond 3 months. And he ruled such by prefacing that the prohibition was, according to many decisors, only rabbinic… It is clear and simple as I wrote, the law which is made clear by the early rabbis and the decisors of Jew law, that abortion is prohibited as it is considered actual murder, whether the fetus is legitimate or illegitimate, regular fetuses or those which are suffering from Tay-Sachs. It is strictly prohibited, and do not err and rely on the responsum of that learned man…

Tzitz Eliezer, 20:2

1993.

The case is of a certain woman who is pregnant with quadruplets, and after a medical exam the doctors have determined that it is necessary to kill one fetus, and then the other three will definitely live, but without this, all of them will die. I was asked by her husband, who is a talmid chakham, if it is permissible by law to kill one of them so that his siblings live, or if this is similar to the law that is ruled in Rambam, Foundations of Torah 5:5, that if non-Jews tell you to give us one person to be killed, or else we will kill all of you, that you must let everyone die rather than giving over one Jewish soul…

Now, we have shown, that one who kills a fetus is not considered a murdered, and that this is not included in the three cardinal sins for

which it is said that one must die rather than transgressing, one of which is murder, and on this point no one argues. The only debate is which negative prohibition applies to this case, whether the prohibition of wounding or that of wasting seed, or something similar, but that this is not even in the category of appurtenances to murder. And the majority of the decisors are of the opinion that it is only a Rabbinic violation, and some frame it merely as "a minor violation"…

Based on all the above, it appears to me, in my humble opinion, that the ruling regarding our question is, that it is permissible to kill one fetus so that more than three fetuses (each one of whom is in the category of a pursuer of the other) will survive…

Dr. Avraham Steinberg, The Beginning of Life – Jewish Perspectives, 2005.

PRE-IMPLANTATION EMBRYO

This entity deserves dignity and respect as a human part and as a potential for future life, but it is not considered as life. The potential for future life of this entity is still very low and very remote. It also requires further unnatural human intervention in order to continue its existence and to enable it to become a human being. Hence, this entity has no humanhood status.

One of the basic sources for the Jewish position designating an inherent different legal and moral status to a pre-implanted embryo as compared with an in-utero embryo is the following:

The Bible states "One who spills the blood of a human, in a human, his

blood shall be spilled". This verse teaches us that the prohibition of murder applies exclusively to a human formed within another human, i.e., a fetus within its mother's womb. Hence, a pre-implanted fertilized ovum does not have the status of a human being regarding the prohibition of murder. Pre-implanted zygotes or blastocytes, as such, are entitled to full protection and dignity. However, when these rights come into conflict with other values one ought to weigh the relevant merits and rights and balance between them. One of the consequences of such a balance is the permission to perform a pre-implantation genetic diagnosis and to discard defective pre-embryos. The potential damage of giving birth to a seriously defective child overrides the minimal dignity that the zygote deserves and the remote potential of life of a pre-implanted fertilized egg. This is a critical issue about maternal care that we must not forget.

Rav Yitzhak Zilberstein: "The Evaluation of the Pre-embryo Before Implantation for Prevention of Defective Embryos and Gender Determination," Assia, Iyar 5752

And since most great authorities hold that there is no law of loss of life with regard to abortions, it is clear that it is possible to rule leniently in this case and in the matter under discussion, where the questioner wrote that even if the fetuses survived, they'd be born with serious mental and physical defects, it's clear that one should follow the lenient ruling and say that it is permissible to kill some of the fetuses so that the remaining ones will be born healthy.

EXHIBIT L

Presbyterian Church (U.S.A.)
Presbyterian Mission

Abortion/Reproductive Choice Issues

Presbyterians have struggled with the issue of abortion for more than 30 years, beginning in 1970 when the General Assembly, the national governing body of the Presbyterian Church (U.S.A.), declared that "the artificial or induced termination of a pregnancy is a matter of careful ethical decision of the patient . . . and therefore should not be restricted by law . . ."[1] (#1) In the years that followed this action, the General Assembly has adopted policy and taken positions on the subject of abortion.

In 2006, the 217th General Assembly approved language that clarified the Presbyterian Church (U.S.A.) position on problem pregnancies.

When an individual woman faces the decision whether to terminate a pregnancy, the issue is intensely personal, and may manifest itself in ways that do not reflect public rhetoric, or do not fit neatly into medical, legal or policy guidelines. Humans are empowered by the spirit prayerfully to make significant moral choices, including the choice to continue or end a pregnancy. Human choices should not be made in a moral vacuum, but must be based on Scripture, faith and Christian ethics. For any choice, we are accountable to God; however, even when we err, God offers to forgive us.[2] (#2)

The 217th General Assembly (2006) reiterated the role of the church in individual and families lives as they face problem pregnancy issues.

The church has a responsibility to provide public witness and to offer guidance, counsel and support to those who make or interpret laws and public policies about abortion and problem pregnancies. Pastors have a duty to counsel with and pray for those who face decisions about problem pregnancies. Congregations have a duty to pray for and support those who face these choices, to offer support for women and families to help make unwanted pregnancies less likely to occur, and to provide practical support for those facing the birth of a child with medical anomalies, birth after rape or incest, or those who face health, economic, or other stresses.[3] (#3)

The church also affirms the value of children and the importance of nurturing, protecting and advocating their well-being. The church, therefore, appreciates the challenge each woman and family face when issues of personal well-being arise in the later stages of a pregnancy.[4] (#4)

"In life and death, we belong to God." Life is a gift from God. We may not know exactly when human life begins, and have but an imperfect understanding of God as the giver of life and of our own human existence, yet we recognize that life is precious to God, and we should preserve and protect it. We derive our understanding of human life from Scripture and the Reformed Tradition in light of science, human experience and reason guided by the Holy Spirit. Because we are made in the image of God, human beings are moral agents, endowed by the Creator with the capacity to make choices. Our Reformed Tradition recognizes that people do not always make moral choices, and forgiveness is central to our faith. In the Reformed Tradition, we affirm that God is the only Lord of conscience — not the state or the church. As a community, the church challenges the faithful to exercise their moral agency responsibly.[5] (#5)

In regard to problems that arise in late pregnancies, the 217th General Assembly (2006) adopted the following position:

> We affirm that the lives of viable unborn babies — those well-developed enough to survive outside the womb if delivered — ought to be preserved and cared for and not aborted. In cases where problems of life or health of the mother arise in a pregnancy, the church supports efforts to protect the life and health of both the mother and the baby. When late-term pregnancies must be terminated, we urge decisions intended to deliver the baby alive. We look to our churches to provide pastoral and tangible support to women in problem pregnancies and to surround these families with a community of care. We affirm adoption as a provision for women who deliver children they are not able to care for, and ask our churches to assist in seeking loving, Christian, adoptive families.[6] (#6)

This General Assembly holds this statement as its position on a Christian response to problems that arise late in pregnancies. We find it to be consistent with current General Assembly policy on Problem Pregnancies and Abortion (1992), and supersedes General Assembly statements of 2002 and 2003 on late-term pregnancies and abortion.[7] (#7)

The 204th General Assembly (1992) adopted the most comprehensive policy statement on pregnancy and abortion. The "Report of the Special Committee on Problem Pregnancy" addressed a myriad of issues in order to help guide individuals and families who face problem pregnancies and abortion. The following are excerpts from the 1992 policy:

> There is [both] agreement and disagreement on the basic issue of abortion. The committee [on problem pregnancies and abortion] agreed that there are no biblical texts that speak expressly to the topic of abortion, but that taken in their totality the Holy Scriptures are filled with messages that advocate respect for the woman and child before and after birth. Therefore the Presbyterian Church (U.S.A.) encourages an atmosphere of open debate and mutual respect for a variety of opinions concerning the issues related to problem pregnancies and abortion.[8] (#8)

Areas of Substantial Agreement on the Issue of Abortion

The church ought to be able to maintain within its fellowship those who, on the basis of a study of Scripture and prayerful decision, come to diverse conclusions and actions.

Problem pregnancies are the result of, and influenced by, so many complicated and insolvable circumstances that we have neither the wisdom nor the authority to address or decide each situation.

We affirm the ability and responsibility of women, guided by the Scriptures and the Holy Spirit, in the context of their communities of faith, to make good moral choices in regard to problem pregnancies.

We call upon Presbyterians to work for a decrease in the number of problem pregnancies, thereby decreasing the number of abortions.

The considered decision of a woman to terminate a pregnancy can be a morally acceptable, though certainly not the only or required, decision. Possible justifying circumstances would include medical indications of severe physical or mental deformity, conception as a result of rape or incest, or conditions under which the physical or mental health of either woman or child would be gravely threatened.

We are disturbed by abortions that seem to be elected only as a convenience or ease embarrassment. We affirm that abortion should not be used as a method of birth control.

Abortion is not morally acceptable for gender selection only or solely to obtain fetal parts for transplantation.

We reject the use of violence and/or abusive language either in protest of or in support of abortion.

The strong Christian presumption is that since all life is precious to God, we are to preserve and protect it. Abortion ought to be an option of last resort.

The Christian community must be concerned about and address the circumstances that bring a woman to consider abortion as the best available option. Poverty, unjust societal realities, sexism, racism, and inadequate supportive relationships may render a woman virtually powerless to choose freely.[9] (#9)

The previous excerpts and the areas of substantial agreement on the issue of abortion have been the cornerstone for "the atmosphere of open debate and mutual respect for a variety of opinions" during the past 30 years.

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(1) Minutes of the 182nd General Assembly (1970), United Presbyterian Church in the U.S.A., p. 891
(2) Minutes of the 217th General Assembly (2006), Presbyterian Church (U.S.A.), p. 905
(3) Minutes of the 217th General Assembly (2006), Presbyterian Church (U.S.A.), p. 905
(4) Minutes of the 217th General Assembly (2006), Presbyterian Church (U.S.A.), p. 905
(5) Minutes of the 217th General Assembly (2006), Presbyterian Church (U.S.A.), p. 905
(6) Minutes of the 217th General Assembly (2006), Presbyterian Church (U.S.A.), p. 905
(7) Minutes of the 217th General Assembly (2006), Presbyterian Church (U.S.A.), p. 905
(8) Minutes of the 204th General Assembly (1992), Presbyterian Church (U.S.A.), pp. 367-368, 372-374
(9) Minutes of the 204th General Assembly (1992), Presbyterian Church (U.S.A.), pp. 367-368, 372-374

Other resources of interest

Presbyterian Church (U.S.A.) General Assembly Resolution on Reproductive Health (2012) (https://www.presbyterianmission.org/wp-content/uploads/1-res_on_reproductive_health_care_access-2012.pdf)

The Covenant of Life and The Caring Community & Covenant and Creation: Theological Reflections on Contraception and Abortion (1983; biomedical ethics) (https://www.presbyterianmission.org/wp-content/uploads/8-covenant-of-life-and-covenant-and-creation-1993.pdf)

"I do not cease to give thanks for you as I remember you." — Ephesians 1:16

Contact Us

EXHIBIT M

Reproductive Health and Justice

Why the UCC is a leader in this area

God has given us life, and life is sacred and good. God has also given us the responsibility to make decisions which reflect a reverence for life in circumstances when conflicting realities are present. Jesus affirmed women as full partners in the faith, capable of making decisions that affect their lives.

There are many justice issues related to reproductive health, including access to pre- and post-natal care for all women, equal access to the full range of legal reproductive health services including abortion, the right of women to determine when, if and how many children she should have, access to emergency contraception and other family planning services and information, the right not to be sterilized against one's wishes, and the ability of women to negotiate safe sexual practices and non-coercive sexual experiences.

The United Church of Christ has affirmed and re-affirmed since 1971 that access to safe and legal abortion is consistent with a woman's right to follow the dictates of her own faith and beliefs in determining when and if she should have children, and it has supported comprehensive sexuality education as one measure to prevent unwanted or unplanned pregnancies, and to create healthy and responsible sexual persons and relationships. (General Synods VIII, IX, XI, XII, XIII, XVI, XVII, and XVIII)

We have also supported that women with limited financial means should be able to receive public funding in order to exercise her legal right to the full range of reproductive health services. What is legally available to women must be accessible to all women.

The United Church of Christ is one of the founding faith groups of the Religious Coalition for Reproductive Choice, formed in 1973 as the Religious Coalition for Abortion Rights. Over the years, RCRC has continued to bring a strong voice of faith on the moral and religious issues that swirl around public debate over abortion, contraception and pregnancy prevention. Because there are many religious and theological perspectives on when life and personhood begin, the UCC joins others in advocating that public policy must honor this rich religious diversity. Our position is not a pro-abortion position but a pro-faith, pro-family and pro-woman position.

RCRC has resources to train clergy and others in a counseling position in All Options Counseling which is centered on what is best for the individual woman and supports her decision-making. It also has a pro-choice religious leadership network, specific resources for African American and Latina/o church communities, a Spiritual Youth for Reproductive Freedom network active on college and university campuses, many state affiliates, resources for post-abortion counseling, a Theologies of Choice course for seminaries, and a Seminarians for Choice network. For more information, visit www.rcrc.org.

EXHIBIT N

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF UTAH, CENTRAL DIVISION

* * *

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

* * *

September 2, 2020
8:03 a.m.

Via Web Conference

Kristin Marchant
- Registered Professional Reporter -

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EXHIBIT O

The Atlantic

HEALTH

The Opposite of Socialized Medicine

A small, litigious group has spent decades trying to stop the government from telling doctors what to do. What happens if it succeeds?

By Olga Khazan

Bettmann / Getty / Katie Martin / The Atlantic

FEBRUARY 25, 2020

SHARE

When the vaccine crackdown came, it was the doctors, of all people, who felt censored. It all started last year, when Adam Schiff, a Democratic representative from California, sent letters to Amazon and other tech giants expressing concern that the companies feature anti-vaccine videos and information on their platforms. Schiff cited a report by CNN that found that many searches on Amazon related to vaccines led to anti-vax content. The first listing, for instance, was a sponsored post for the book *Vaccines on Trial*, which is dedicated to "children who had to suffer due to adverse vaccine reactions."

Amazon removed anti-vaccine movies like *Vaxxed: From Cover-Up to Catastrophe* from its Prime streaming service, incensing advocates opposed to mandatory vaccines and leading to a lawsuit that was filed against Schiff a few weeks ago. The lawsuit came from a New York woman who wants more information about vaccines, alongside an organization that, on the surface, seems counterintuitive: a group of doctors called the Association of American Physicians and Surgeons.

The lawsuit alleges that Schiff's actions are tantamount to censorship. As a result of his letters, the suit says, Amazon kicked AAPS out of an affiliate network through which the organization had earned commissions. According to the group, searches on Facebook for AAPS vaccine articles instead yielded links to the World Health Organization, the National Institutes of Health, and the Centers for Disease Control and Prevention. One of the AAPS articles that was allegedly suppressed states, "Measles is a vexing problem, and more complete, forced vaccination will likely not solve it." (Schiff's office did not respond to a request for comment.)

Read: The new measles

The Association of American Physicians and Surgeons might sound like another boring doctors' group politely debating telehealth legislation. But AAPS is a small yet vociferous interest group. Like Zelig with a stethoscope, it has popped up in nearly every major health-care debate for decades, including the Affordable Care Act and opioids, and it wields a surprising amount of influence. Senator Rand Paul of Kentucky was outed as a member in 2010. (A Paul spokesperson told me that while

the senator is no longer a member, he is supportive of AAPS's fight against Obamacare.) When Representative Tom Price of Georgia was nominated to lead President Donald Trump's Department of Health and Human Services, several newspapers pointed out that he, too, was a member. (At the time, an HHS spokesperson said that not all doctors in a group believe the same thing.)

Though AAPS often takes positions that are associated with conservative groups, it sometimes goes even further, pushing fringe views that most mainstream conservatives do not endorse, such as the belief that mandatory vaccination is "equivalent to human experimentation" and that Medicare is "evil." Over the years, the group seems to have coalesced around an ethos of radical self-determination and a belief that mainstream science isn't always trustworthy. It's the most curious of medical organizations: a doctors' interest group that seems more invested in the interests of doctors, rather than public health.

At a time when doctors are facing scorching levels of burnout, health-care costs are soaring, and seemingly everyone is frustrated with the status quo, AAPS seems to have come up with an unusual answer: to turn back the clock. AAPS sees its vision as forward-looking and modern, but the group's rhetoric recalls an era when a doctor would treat you for just a few bucks. No insurance deductible would need to be met first, and no intimidating vaccine schedule had been mandated from above.

AAPS has been called the Tea Party's favorite doctors, but it's actually a more fitting health-care group for the Trump era. As Trump has contributed to sowing doubt about the scientific consensus, AAPS is seizing the moment. The group just wants to make health care great again—even if that means tearing it apart.

AAPS was founded in 1943 in opposition to an early effort to provide universal health care to Americans. It first shot to fame half a century later, when it sued then–first lady Hillary Clinton to gain access to the records of her Task Force on National Health Care Reform. (Though the Clinton administration was initially ordered to pay AAPS's lawyer fees and other costs, eventually a federal appeals court ruled in its favor.)

RECOMMENDED READING

The Shadow Network of Anti-Vax Doctors

OLGA KHAZAN

What Hardcore Conservatives Really Want for Health Care

OLGA KHAZAN

The Doctors Who Bill You While You're Unconscious

OLGA KHAZAN

Today, the group has moved beyond simply opposing health-care reform, with the apparent intent to throw sand in any and all government gears. It seems most invested in protecting doctors from regulations. "We believe in private medicine," Jane Orient, AAPS's longtime executive director and primary spokesperson, told me in a phone interview. "We have opposed attempts to intrude government and other third parties between the patients and the physicians."

Read: When the religious doctor refuses to treat you

Orient said that AAPS's membership consists of "under 5,000" of the country's million or so doctors. She is a physician herself, based in Tucson and licensed by the Arizona Medical Board. According to AAPS's tax forms, Orient makes $181,000 a year from the group, though she said in an email that much of this goes toward running the office, such as IT support and office supplies, and that her salary is $48,000. On Facebook, someone named Jane Orient from Tucson posts AAPS press releases on her feed, along with ads for radiation detectors, conspiracy theories about vaccines, and inspirational posts from Littlethings.com. Orient would not confirm whether this was her Facebook page.

During our call, Orient was down on insurance companies, as well as electronic health records and anyone or anything that might tell a doctor what to do, ever. In 2005, Orient backed doctors who prescribe lots of opioids, telling a newspaper that doctors were being "imprisoned for prescribing in good faith with the intention of relieving pain." (The opioid epidemic has claimed 700,000 American lives.) In 2007, AAPS sued the Texas Medical Board to stop it from relying on anonymous complaints to retaliate against doctors suspected of wrongdoing. (AAPS lost.) Later, AAPS

became the first medical society to sue to overturn the Affordable Care Act, saying that it "spells the end of freedom in medicine as we know it."

During the 2018 election cycle, AAPS donated $16,000 to federal political candidates, all of them Republicans, according to the Center for Responsive Politics. Orient herself has consistently donated small amounts of money to candidates, almost exclusively Republicans, since 1998. But the group drifts from the Republican establishment in many ways. Orient said she opposes some traditionally conservative health-care policies, such as the Massachusetts predecessor to the Affordable Care Act devised by the conservative Heritage Foundation. Regarding Trump, Orient said he has been "a disappointment in some ways," but that AAPS is "very glad for some of the things that he has done," such as continuing to oppose Obamacare.

Several mainstream conservatives I reached out to declined to speak with me about AAPS. When I finally got one right-leaning health wonk, Joe Antos, on the phone, he said he had been thinking of the wrong AAPS and did not know much about the group.

Meanwhile, a media-relations representative at the American Medical Association, the main doctors' group in America, mentioned that he'd expect the AAPS to accuse the AMA of having a 'fascist' relationship with the government. Orient told me that AAPS does not consider the AMA fascist, "although we certainly criticize many of their policies. We think it is important to define terms precisely and not to indulge in name-calling."

Perhaps the only thing Americans agree on when it comes to health care today is that something's gotta give. Electronic records are a nightmare for many doctors, and patients hate fighting with insurers as much as doctors do. It's natural to want to just nuke it all. AAPS presents an extreme vision of that: What would happen if the government didn't make doctors do, well, anything? I've met with some doctors who see anti-vaccine patients and who also don't accept insurance, and I was taken by how

free, self-actualized, and otherwise perky they were. Many doctors might readily swap an overcrowded primary-care practice for a concierge gig like that.

AAPS seems to have pushed this vision of the unfettered doctor too far, though. Over time, it has taken a puzzling turn toward unconventional medical views, as exemplified by its legal tangle with Schiff. To Orient, the government should not even dictate essential medications that protect public health. Asked whether vaccines increase the risk of autism, she said, "I think that the definitive research has not been done." (The overwhelming scientific consensus is that vaccines do not cause autism.)

In 2015, after measles broke out at Disneyland, AAPS put out a press release questioning the safety of vaccines. The group has suggested that women who have abortions are at a higher risk of breast cancer, though mainstream scientists say this is false. In 2008, an article on AAPS's website suggested that President Barack Obama was covertly hypnotizing people with his speeches, and that this might explain why Jews voted for him. AAPS's journal, the *Journal of American Physicians and Surgeons*, has published articles raising doubts that HIV causes AIDS and questioning the wisdom of urging people to quit smoking, according to the *Louisville Courier Journal*.

Orient told me that the articles in the group's journal don't necessarily represent the official policy of AAPS. She called the story from the *Louisville Courier Journal* a "hit piece," saying that the smoking article was arguing simply that "constantly telling [people] that nicotine is addictive might give them an excuse not to try" to quit. Regarding the abortion–breast cancer link, she said in an email that "there is a large and growing number of articles supporting this, although 'mainstream' American researchers deny it and focus on a small number of articles with negative findings." She denied the suggestion about Jews and said that the entire AAPS article was referencing an article from another source.

Read: What the measles epidemic really says about America

Orient disagrees with the premise of *this* article, too. She said that AAPS cares most about patients, not doctors. Rather than being backwards-looking, she said, the group is "looking forward to a future in which there's more innovation and more freedom, instead of one in which there's tighter government control." With such freedom, Orient told me, "we could have a thriving, innovative, friendly medical practice where

when you call the doctor's office on the phone, instead of saying, 'What insurance do you have?' the doctor's office will say, 'How can we help you?'"

AAPS's apparent yearning for patients to pay with cash and for doctors to do as they please has historical precedent. Medicare only arrived in 1966. Before that, the options for seniors were to, as *PolitiFact* notes, "spend their savings, rely on funding from their children … hope for charity from the hospitals or avoid care altogether." In the early 1970s, only certain states had school vaccination laws—and their measles rates were 40 to 51 percent lower than in schools without such laws.

There were indeed fewer rules and less paperwork back then. But the AAPS doesn't seem to offer a solution for the fact that these days, a single "How can we help you?" from a doctor can result in a five-figure bill. In recent years, the group has focused on opposing calls for single-payer health care, and it even came out against surprise-billing legislation, which would protect patients from out-of-network hospital bills and has garnered bipartisan support in several states. (Orient dismissed these measures as "price controls imposed on physicians.")

In our conversation, Orient did say that physicians should strive to help people who can't pay, that hospitals should charge more reasonable and transparent prices, and that patients are often able to reduce their hospital bills through negotiation. But in 2016, Orient wrote in an op-ed that some people might simply sell their belongings to pay their medical bills. "Consider this," she wrote. "Would you rather buy a nice car and risk having to sell it to pay a bill, or pay the insurance company the same amount and never get to drive the car?" (Orient stands by this, writing in an email, "If you lived beyond your means and bought a car that you couldn't afford, and did not provide for future medical costs, how much sympathy should you receive?")

Most health groups today have a specific idea for how to reform medical care, whether through single-payer health care or Netflix for doctors. The trouble with AAPS's vision for America is that it exhibits a nostalgia for a past that never existed. Measles killed hundreds of Americans a year before the vaccine became available. Americans

are drowning in medical debt that kindly doctors haven't successfully eliminated, and selling our cars to pay for medical care would strike few people as the right answer. The idea that doctors always do right by patients, and that patients always have the money to pay, and that no one ever gets measles at Disneyland, is a tempting dream. The problem is, it's just that.

EXHIBIT P

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Abortion and anxiety: What's the relationship?

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ABSTRACT

Using data from the United States National Survey of Family Growth (NSFG) and the National Comorbidity Survey (NCS), we conducted secondary data analyses to examine the relationship of abortion, including multiple abortions, to anxiety after first pregnancy outcome in two studies. First, when analyzing the NSFG, we found that pre-pregnancy anxiety symptoms, rape history, age at first pregnancy outcome (abortion vs. delivery), race, marital status, income, education, subsequent abortions, and subsequent deliveries accounted for a significant association initially found between first pregnancy outcome and experiencing subsequent anxiety symptoms. We then tested the relationship of abortion to clinically diagnosed generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), and social anxiety disorder, using NCS data. Contrary to findings from our analyses of the NSFG, in the NCS analyses we did not find a significant relationship between first pregnancy outcome and subsequent rates of GAD, social anxiety, or PTSD. However, multiple abortions were found to be associated with much higher rates of PTSD and social anxiety; this relationship was largely explained by pre-pregnancy mental health disorders and their association with higher rates of violence. Researchers and clinicians need to learn more about the relations of violence exposure, mental health, and pregnancy outcome to avoid attributing poor mental health solely to pregnancy outcomes.

Abortion is a common life circumstance for women, with an estimated 1 in 5 women experiencing at least 1 abortion in their lifetime (Henshaw, 1998). Recently, concerns have been raised about the impact of having an abortion on women's risk for anxiety as well as other mental health outcomes. A number of researchers have reported an association between pregnancy outcome and anxiety (Bradshaw & Slade, 2003; Cougle, Reardon, & Coleman, 2005; Fergusson, Horwood, & Ridder, 2006; Major, Richards, Cooper, Cozzarelli, & Zubek, 1998; Russo & Denious, 2001).

Compared to men, women have higher rates of anxiety (Somers, Goldner, Waraich, & Hsu, 2006). Given that an estimated 43% of females will experience at least one anxiety disorder in their lifetime (Breslau, Schultz, & Peterson, 1995), it is not surprising that some women who have had an abortion also report having anxiety symptoms. The questions addressed here are do women who have abortions have higher rates of anxiety than other women, and if so, how might this abortion–anxiety relationship be understood?

Answering these questions is difficult because abortion is confounded with many life events that have been associated with negative mental health outcomes, in particular unintended pregnancy. An estimated 92% of the pregnancies ending in abortion are unintended (Finer & Henshaw, 2006), compared to 31% of all births (Henshaw, 1998). Differences between women who have an abortion and other groups of women must be interpreted in light of this fact. One way to address the association of pregnancy outcome and pregnancy intention is to examine pregnancy outcome among groups of women who have had unintended pregnancies. Another is to control for experiences that are associated with anxiety and with unintended pregnancy or

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abortion. In this article we use both strategies and present two studies that examine the relationship of abortion to anxiety symptoms and disorders. Our goal is to ascertain whether the relationship of abortion to anxiety can be explained by pre-existing anxiety, violence exposure, and other relevant covariates.

Abortion and anxiety

Several studies have examined the relationship between abortion and anxiety in samples of patients (for a review see Bradshaw & Slade, 2003) as well as non-patients (Cougle et al., 2005; Fergusson et al., 2006). Although some women do experience post-abortion anxiety, the prevalence of post-abortion anxiety is low, and generally lower than that found pre-abortion. For instance, Lowenstein et al. (2006) found that women's anxiety significantly declined after having an abortion. In a review of the post-1990 literature on abortion and mental health, Bradshaw and Slade (2003) concluded that most studies found a decrease in anxiety or distress after having an abortion. More recently, however, two studies have been used as evidence that abortion increases risk for subsequent anxiety.

In the first study, studying only women whose first pregnancy was unintended, Cougle et al. (2005) hypothesized a relationship between having an abortion on the first pregnancy and subsequent generalized anxiety among women who reported no pre-pregnancy generalized anxiety. Using data from the United States National Survey of Family Growth (NSFG), they reported that abortion on the first pregnancy was related to subsequent generalized anxiety, controlling for race and age at interview. Unfortunately differential exclusion of women with subsequent abortions only from the delivery group renders the interpretation of that study's findings problematic. Further, some important variables that were available in the data set – rape experience and socioeconomic status – that have been found previously to be associated with both mental health and having an abortion were not included in their model. As the authors themselves pointed out, "the association between anxiety and abortion could be the result of many other variables that differentiate women likely to opt for abortion from their peers who decide to carry an unintended pregnancy to term" (p. 142).

Finally, rather than controlling for pre-pregnancy anxiety, women who had such anxiety were excluded from the analyses, limiting the appropriate generalization of findings only to women with no pre-existing generalized anxiety experience. This limitation becomes a serious deficiency given that one of the most consistent findings in the literature is that the strongest predictor of mental health after an abortion is mental heath before the abortion (Adler et al., 1990, 1992; Gilchrist, Hanaford, Frank, & Kay, 1995). For instance, Major et al. (2000) found that a history of depression consistently predicted a range of negative post-abortion outcomes, including higher depression scores, lower self-esteem, and greater likelihood of post-traumatic stress disorder. Indeed, for most psychiatric disorders, the strongest risk factor for the onset of an episode is whether or not the individual has a history of previous episodes (American Psychiatric Association [APA], 2000; Kessler & Magee, 1994). The fact that the women most at risk for anxiety after an abortion are those who experience anxiety beforehand attests to the importance of including women with pre-existing anxiety in the sample if the relation of abortion to subsequent anxiety is to be fully understood. In the research reported here, we examine the relation of abortion to subsequent anxiety controlling for pre-pregnancy anxiety.

In the second study that examined the relation between abortion and anxiety, Fergusson et al. (2006) analyzed data collected in a longitudinal study of a cohort of New Zealand children, including 630 females, followed through young adulthood. They examined the relationship of pregnancy history (never pregnant, pregnant and 0 abortions, or ever had an abortion) to mental health outcomes at age 25. A large number of covariates related to socioeconomic background, family functioning (including childhood physical abuse and childhood contact sexual abuse), conduct problems, educational achievement, personality, adolescent adjustment, and lifestyle factors were controlled. Correlational analyses revealed that the abortion group was significantly more likely to have an anxiety disorder than the delivery group, but did not significantly differ from the never pregnant group.

Several factors limit the conclusions of the Fergusson et al. (2006) study, however. First, it did not have an appropriate comparison group of women who delivered an unintended pregnancy. Second, small numbers precluded conducting prospective analyses specifically on anxiety or separating out the 21.6% of the sample who reported having multiple abortions. Third, the data were not broken out by specific disorder. Unfortunately the pathways from abortion to anxiety disorder may differ depending on the disorder, and the definition of anxiety disorder used in the study encompassed generalized anxiety disorder, social anxiety disorder, specific phobia, panic disorder, and agoraphobia. Finally, New Zealand's legal requirements use mental health grounds for screening women who have abortions. These laws require that women must first be referred to two certifying specialist consultants who must agree that (1) the pregnancy would seriously harm the life, physical or mental health of the woman or baby; or (2) the pregnancy is the result of incest; or (3) the woman is severely mentally handicapped. An abortion will also be considered on the basis of age, or when the pregnancy is the result of rape (Fergusson et al., 2006, p. 17). Given that mentally healthy women are less able to obtain abortions in this legal context, it is not surprising to find higher rates of mental disorders in the abortion group. Thus, the Fergusson et al. (2006) study does not provide strong evidence for an abortion–anxiety relationship.

Violence, unintended pregnancy, and anxiety

A substantial body of research has established that the rates of violence in the lives of women who have unintended pregnancies – whether or not those pregnancies end in abortion – are higher than rates for other women (Campbell, Pugh, Campbell, & Visscher 1995; Coker, 2007; Dietz et al., 2000; Fisher et al., 2005; Gazmararian et al., 1995, 2000; Gissler, Berg, Bouvier-Colle, & Buekens, 2004;

Glander, Moore, Michielutte, & Parsons, 1998; Goodwin, Gazmararian, Johnson, Gilbert, Saltzman, & The PRAMS Working Group, 2000; Pallitto, Campbell, & O'Campo, 2005; Russo & Denious, 1998, 2001).

For instance, of 39,348 women in 14 states, Goodwin et al. (2000) found that among mothers of newborns, women with unintended pregnancies were 2.5 times more likely to experience physical abuse compared to women whose pregnancies were intended. Additionally, in a meta-analysis of the relation of intimate partner violence and sexual health, Coker (2007) found that intimate partner violence was associated with unwanted pregnancy in 3 of 4 studies. Intimate partner violence was associated with abortion in 6 of 8 studies that addressed this association. Two studies also noted an association between abortion and both physical and sexual abuse. Finally, in a multi-national population-based study of 10 countries, Garcia-Moreno, Jansen, Ellsberg, Heise, and Watts (2005) found that in 8 of the countries, compared to women who had not experienced violence, women who had experienced some violence in their lives were more likely to have had an abortion. Hence, research consistently finds a relationship of violence with unintended pregnancy, whether terminating in delivery or abortion.

There is also empirical research to support the relation of violence and anxiety. First, violence is a known cause of post-traumatic stress disorder (APA, 2000). Second, studies show that both childhood sexual and physical abuse are associated with anxiety disorders such as post-traumatic stress disorder (PTSD) or generalized anxiety disorder (Adams & Bukowski, 2007; Briere & Runtz, 1988; Cuffe et al., 1998; Fergusson, Lynskey, & Horwood, 1996; Kendall Tackett, Williams, & Finkelhor, 1993; MacMillan et al., 2001; Molnar, Buka, & Kessler, 2001; Springer, Sheridan, Kuo, & Carnes, 2007; Widom, 1999). Given violence is strongly and consistently related to both abortion and anxiety, controlling for violence when investigating the relationship of abortion and anxiety is warranted.

To date, only one study has examined the extent to which violence explains the relationship of abortion to anxiety. Russo and Denious (2001) analyzed responses of 2525 women participating in the Commonwealth Fund's Women's Health Survey in which 324 women reported having had at least 1 abortion. They found small but significant correlations between having an abortion and scores on several mental health outcomes, including being told by a doctor they had "anxiety/depression" ($r = 0.08$). Abortion also was significantly correlated with experiencing rape (0.06), childhood physical ($r = 0.15$) and sexual ($r = 0.18$) abuse, having a violent partner ($r = 0.11$) and having a partner who refused to use a condom ($r = 0.06$). When race, education, number of children living at home, marital status, partner characteristics, and history of abuse were controlled, however, abortion was no longer significantly related to any outcome variable, including being told by a doctor they had anxiety/depression. The data supported the hypothesis that exposure to violence in the lives of women who have abortions accounts for the association of abortion with negative mental health outcomes, including being given a diagnosis of anxiety/depression. This study had several limitations, including ambiguity in the timing of the abortion with respect to the diagnosis of anxiety/depression and experience of violence. Moreover, pre-abortion distress was not assessed. Thus, the finding that abortion did not independently contribute to variation in mental health outcomes when controlling for violence and other covariates, needs to be investigated more thoroughly. Consequently, we hypothesize that violence, pre-pregnancy anxiety, and other covariates will account for the higher rate of anxiety among women who have abortions, compared to other women.

Violence and specific anxiety disorders

Previous studies of post-abortion mental health outcomes have not separately and specifically assessed clinically diagnosed anxiety disorders (Cougle et al., 2005; Major et al., 2000; Russo & Denious, 2001). Thus, we test whether abortion leads to clinically diagnosed anxiety disorders. Based on previous research and theory regarding the causes of specific anxiety disorders (e.g., fear of public embarrassment – social anxiety; violence – PTSD), we tested whether first pregnancy outcome was related to generalized anxiety disorder (GAD), social anxiety, and PTSD.

Generalized anxiety disorder (GAD). Selection of GAD (hereafter "anxiety disorder") for this study was in response to research reporting a correlation between abortion on first unintended pregnancy and subsequent generalized anxiety (Cougle et al., 2005). The information in the NSFG, however, is not sufficient to conclude the presence of clinically diagnosed general anxiety disorder (APA, 2000). Therefore, we refer to the anxiety measure in our first study using the NSFG as experience of anxiety symptoms (EAS or anxiety symptoms). In our second study, using NCS data, the variable GAD is based on DSM-IIIR criteria.

Social anxiety. Social anxiety disorder is the most prevalent anxiety disorder (13.3% lifetime; Kessler et al., 1994). There are also theoretical reasons to postulate a relationship between abortion and social anxiety. Because experiencing intimate violence or abortion may be stigmatizing (Ely, Dulmus, & Wodarski, 2004; Major & Gramzow, 1999), women who have such experiences might be expected to be at higher risk for social anxiety disorder, which represents "a marked and persistent fear of social or performance situations in which embarrassment may occur" (APA, 2000, p. 411).

Indirect findings in support of this conceptualization come from Major and Gramzow (1999) who examined the psychological implications of the stigma of abortion. They hypothesized that "secrecy [of abortion] inhibits disclosure of emotion and generates cognitive processes of suppression and intrusion that are detrimental to mental health" (p. 736; see Pennebaker, 1989, 1997 for reviews of the disclosure literature). Intrusive thoughts may be associated with social anxiety among women who have abortions. Women who have such intrusive thoughts may fear social situations because they believe this secret will be discovered by others. Major and Gramzow (1999) indeed found that intrusive thoughts post-abortion predicted scores on the depression, anxiety, and hostility subscales of the Brief Symptom Inventory (BSI; Derogatis, 1993). The more a woman had intrusive thoughts after an

abortion the more distress she experienced. The clinical implications of Major and Gramzow's (1999) findings are limited. First, only 3.4% of women reported experiencing intrusive thoughts "quite a bit" or "a great deal," and 35% of the women reported experiencing no intrusive thoughts at all. Additionally, they did not measure social anxiety. So while an association between abortion and intrusive thoughts is suggestive, direct examination of the relation between abortion and social anxiety disorder is warranted.

PTSD. Researchers have suggested that abortion can function as a traumatic stressor capable of causing PTSD symptoms (Rue, Coleman, Rue, & Reardon, 2004, p. 15; Speckhard & Rue, 1992). However, an alternate explanation for an association between abortion and PTSD may be found in the higher rates of intimate violence—a known cause of traumatic stress (APA, 2000)—in the lives of women who have abortions. Given the relation of violence to abortion (e.g., Coker, 2007; Garcia-Moreno et al., 2005) and to PTSD (APA, 2000), when violence variables are not controlled an association between abortion and PTSD would be expected. This would be congruent with the findings of Russo and Denious (2001).

In summary, previous research suggests an association between abortion and anxiety, but assessment of anxiety symptoms vs. a specific diagnosis (GAD, social anxiety, PTSD) is lacking. We hypothesize that the relation of anxiety symptoms or disorders and abortion can be explained by pre-pregnancy anxiety and the higher rates of violence in the lives of women who have abortions.

The case of multiple abortions

Most sexually active women are at risk for having an unintended pregnancy, with the risk for more than one such pregnancies increasing over her lifetime. However, researchers have found that the more severe the adversity in childhood, the greater the likelihood of unintended pregnancy (Dietz et al., 2000; Roosa, Tien, Reinholtz, & Angelini, 1997). Further, there is evidence that a history of childhood physical or sexual abuse is associated with repeat abortion, which is an indicator of repeated unintended pregnancy (Fisher et al., 2005). Thus, we hypothesize that the experience of repeat abortions is related to higher rates of violence in women's lives, which in turn puts a woman at greater risk for anxiety.

Research goals and approach

Our primary goal was to examine the relation of anxiety after first pregnancy outcome (abortion vs. delivery) controlling for pre-pregnancy anxiety, violence exposure, and other relevant covariates. Further, in investigating the relations of pre-pregnancy anxiety, violence, and abortion to post-pregnancy anxiety, we examined whether these relations differed with type of anxiety disorder. We also examined the interrelations among having repeat abortions, violence exposure, and anxiety disorders as a foundation for future research. We did this in two independent studies. In the first study we investigated the relation of abortion to anxiety symptoms in the NSFG data set. In the second study we examined the relation of abortion to clinically diagnosed GAD, social anxiety, and PTSD in the National Comorbidity Survey (NCS) data set.

Study 1: the National Survey of Family Growth (NSFG)

Study 1 involved two sets of analyses for two different samples of women. The first sample consisted of women who had unintended first pregnancies ending in abortion or delivery of a live birth, and they provide a basis for comparison with findings from Cougle et al. (2005) as well as other studies that examined the relation of unintended first pregnancy outcome to mental health variables (e.g., Reardon & Cougle, 2002; Schmiege & Russo, 2005). The second sample consisted of all women who had a first pregnancy ending in abortion or delivery of a live birth, regardless of pregnancy intention. They provide a basis for comparison with the NCS analyses presented below and with findings from studies where pregnancy intention is not identified (e.g., Cougle, Reardon, & Coleman, 2003; Fergusson et al., 2006).

The first set of analyses focused on the relation of first pregnancy outcome to post-pregnancy anxiety symptoms in each sample and addressed two initial questions:

(1) Do women who terminate a first pregnancy outcome have significantly higher rates of anxiety symptoms than women who deliver a first pregnancy?
(2) If post-pregnancy anxiety symptoms differ by first pregnancy outcome, to what extent is this explained by pre-pregnancy anxiety symptoms, rape experience, and demographic characteristics known to co-vary with anxiety and abortion?

The second set of analyses examined the relation of repeat abortion and anxiety in both samples and addressed two additional questions:

(3) Is there a relationship of abortion status (0, 1, or repeat abortions) to rates of anxiety symptoms after first pregnancy?
(4) If there is a relationship of abortion status and anxiety after the first pregnancy, to what extent is this explained by pre-pregnancy anxiety symptoms, rape experience, and demographic characteristics known to co-vary with anxiety and abortion?

Method

Survey design

The NSFG is administered by the National Center for Health Statistics (NCHS) of the U.S. Centers for Disease Control and Prevention. The NSFG Cycle V sample used for the secondary analyses in this study was initially drawn from a national probability sample of households with civilian non-institutionalized women ages 15–44 that responded to the National Health Interview Survey (NHIS, Abma, Chandra, Mosher, Peterson, & Piccinino, 1997; Potter, Iannacchione, Mosher, Mason, & Kavee, 1998). Respondents were interviewed in their homes between January and October 1995 by trained female interviewers using a computer-

assisted personal interviewing approach technique. An audio computer-assisted self-interviewing technique was also used to collect additional data in a short self-administered interview in which each respondent heard the questions over headphones and entered her own answers into a notebook computer. The response rate of the NSFG was 78.6%.

The sampling design of the NSFG is complex; the sample was formed using a stratified multistage design with individual sampling rates (Potter et al., 1998). In order to obtain unbiased estimates of parameters and sampling variances, the complex nature of the design and the sampling weights must be taken into account when analyzing the data. Consequently, sampling weights, stratification, and clustering variables provided in the NSFG by the NCHS were used in all analyses. We used the complex sample design feature of SPSS version 14.0.2 to conduct analyses (SPSS Inc. 2001, Release 14.0.2). The complex sample analysis module in SPSS uses the Taylor series linearization method to estimate sampling variances. Unless otherwise stated, all parameter estimates (except unweighted *n*s) and standard errors are based on analysis taking the complex sample design into account. Potter et al. (1998) provided detailed information on how sampling weights were derived and what variables to use for sampling weights, stratification, and clustering.

Sample

Of 10,847 women interviewed in the 1995 NSFG Cycle V, 7761 (66.6%, weighted percent) had been pregnant at least once; 3981 of these women (50.1%, weighted percent) reported their first pregnancies were unintended. Two overlapping samples were drawn from the survey population. The *unintended first pregnancies* sample ($n = 3496$) was comprised of all women having an *unintended* first pregnancy ending in either induced abortion ($n = 1175$) or a live birth ($n = 2321$). The *all first pregnancies* sample ($n = 6714$) was comprised of all women having a first pregnancy ending in induced abortion ($n = 1244$) or a live birth ($n = 5470$).

Fourteen women were excluded from all analyses in the *unintended first pregnancies* sample and 20 from the analyses in the *all first pregnancies* sample because they did not report (1) the age of their earliest period of anxiety, or (2) when their anxiety ended or how long it lasted, or because (3) they reported their most recent period ended before their first period of anxiety and a pregnancy event occurred in-between. This left an unweighted sample size of 3482 women (1167 abortion group; 2315 delivery group) in the *unintended first pregnancies* sample and 6694 women (1236 abortion group; 5458 delivery group) in the *all first pregnancies* sample. Table 1 reports descriptive statistics for demographic characteristics and major variables of the final samples used in the data analyses.

For the *unintended first pregnancies* sample, compared to women in the delivery group, women in the abortion group were more likely to be White ($t = 6.80, p < 0.0005$) and never married ($t = 5.81$, $p < 0.0005$), but less likely to be Black ($t = -5.96, p < 0.0005$), Hispanic ($t = -3.12, p = 0.002$), or divorced ($t = -4.19, p < 0.0005$). They were also more likely to have experienced rape ($t = 2.57, p = 0.01$) and have a significantly higher income ($t = 15.06$, $p < 0.0005$), have more years of education ($t = 13.479$, $p < 0.0005$), have a larger number of subsequent abortions ($t = 10.07$, $p < 0.0005$), and have fewer subsequent births ($t = -4.43, p < 0.0005$).

The characteristics of *all first pregnancies* sample were similar to that of the *unintended first pregnancies* sample, except that women in the abortion group were more likely to be younger at age of first pregnancy outcome ($t = -16.68$, $p < 0.0005$), less likely to be married at time of interview ($t = -9.28$, $p < 0.0005$), and equally likely to be Black ($t = -0.93$, $p = 0.35$) compared to women in the delivery group.

Measures

First pregnancy. Participants were asked about their intention of each pregnancy. First pregnancies that were described as not wanted by the woman at the time (mistimed/too soon) or unwanted at any time were classified as unintended. Only women with first pregnancies identified as ending in either an abortion or live birth were included in the analyses. For *unintended first pregnancies*, there were 2316 and 1166 in the delivery and abortion groups, respectively. For *all first pregnancies*, there were 5458 and 1235 in the delivery and abortion groups, respectively.

Abortion status. This variable was created by classifying women into three categories on the basis of number of abortions reported: 0, 1, and 2 or more (repeat) abortions.

Pre- and post-pregnancy experience of anxiety symptoms (EAS). Individuals answered a sequence of questions about their anxiety experiences. If they reported having experienced a period in their lifetime lasting 6 months or longer when most of the time they felt worried or anxious, they were then asked if the anxiety had ended and 3 'screener' questions. If they passed the screener questions they were asked if they experienced 7 other symptoms related to anxiety (feeling restless, keyed up or on the edge, irritable, heart pounding, easily tired, trouble falling or staying asleep, or feeling faint or unreal). Finally, they were asked questions about the length and endpoint of the period of anxiety, whether it occurred more than once, and if so, what age they first remembered experiencing a period of anxiety.

To repeat, we label our outcome variable *experience of anxiety symptoms* (EAS) or simply *anxiety symptoms* to emphasize that the symptoms assessed are not identical to those listed in the criteria for a GAD diagnosis in either the DSM-IV or DSM-IV-TR (APA, 1994, 2000). However, in keeping with GAD criteria for DSM-IV or DSM-IV-TR, to be identified as having anxiety symptoms, a woman had to experience at least 3 symptoms for at least 6 months. Women who reported a period of anxiety as lasting less than 6 months or accompanied by less than 3 symptoms were not coded as having anxiety symptoms regardless of whether they reported an earlier experience of anxiety. When a woman reported she had anxiety for as long as she could remember, she was included in the anxiety symptom group, provided she experienced at least 3 symptoms. Thus, women who reported their most recent period of anxiety as lasting less than 6 months or as experiencing less than 3 symptoms were coded as never experiencing anxiety; 64 and 98 women in the *unintended first pregnancies* and *all first pregnancies* samples, respectively, were coded this way.

In contrast to the approach of Cougle et al. (2005), which excluded women who had anxiety before their first

Table 1
NSFG descriptive statistics for demographic characteristics and major variables for unintended first pregnancies and all first pregnancies ending in a live birth or abortion

	Unintended first pregnancies		All first pregnancies	
	Abortion	Delivery	Abortion	Delivery
Unweighted *n*	1167	2315	1236	5458
Race				
White	**73.8% (1.5%)[a]**	**59.6% (1.5%)[b]**	**73.5% (1.5%)[a]**	**66.9% (1.1%)[b]**
Black	**14.4% (1.1%)[a]**	**23.6% (1.4%)[b]**	14.3% (1.0%)	15.4% (0.8%)
Hispanic	**8.0% (1.1%)[a]**	**13.0% (1.0%)[b]**	**8.3% (1.1%)[a]**	**13.6% (0.8%)[b]**
Other[a]	4.0% (0.7%)	3.8% (0.5%)	3.9% (0.7%)	4.1% (0.4%)
Marital status				
Married	51.9% (1.6%)	55.8% (1.3%)	**52.1% (1.6%)[a]**	**68.0% (0.8%)[b]**
Divorced/separated	**14.2% (1.2%)[a]**	**20.9% (0.9%)[b]**	14.5% (1.2%)	17.3% (0.6%)
Never married	**33.2% (1.5%)[a]**	**22.4% (1.2%)[b]**	**32.7% (1.5%)[a]**	**13.6% (0.6%)[b]**
Widowed	0.7% (0.3%)	0.9% (0.2%)	0.7% (0.2%)	1.1% (0.2%)
Rape experience	**33.3% (1.4%)[a]**	**28.5% (1.3%)[b]**	**33.6% (1.4%)[a]**	**21.0% (0.7%)[b]**
EAS				
Before	7.8 (0.8)	6.3 (0.6)	**7.8 (0.8)[a]**	**5.6 (0.4)[b]**
After	**20.2 (0.8)[a]**	**15.2 (0.9)[b]**	**20.0 (1.4)[a]**	**13.6 (0.6)[b]**
Income as percent of poverty level	**385.2 (7.1)[a]**	**252.0 (4.7)[b]**	**383.7 (6.9)[a]**	**289.9 (3.7)[b]**
Age at first pregnancy outcome	19.4 (0.12)	19.3 (0.08)	**19.4 (0.12)[a]**	**21.9 (0.08)[b]**
Education	**13.6 (0.11)[a]**	**11.9 (0.06)[b]**	**13.6 (0.10)[a]**	**12.5 (0.05)[b]**
Subsequent abortions	**0.56 (0.03)[a]**	**0.27 (0.02)[b]**	**0.55 (0.03)[a]**	**0.19 (0.01)[b]**
Subsequent births	**1.10 (0.04)[a]**	**1.32 (0.03)[b]**	**1.11 (0.04)[a]**	**1.19 (0.02)[b]**

For categorical variables, percents (standard error) are reported; for continuous variables, means (standard error) are reported.
Marital status, income as percent of poverty level, and education were at time of interview.
Different superscripts represent a statistically significant ($p < 0.05$) difference between abortion and delivery groups (2-tailed). Rows containing significant differences are in bold.
NSFG: National Survey of Family Growth; EAS = experience of anxiety symptoms.

pregnancy event, we controlled for whether women reported experiencing a period of anxiety prior to or during their first pregnancy event. Women were coded as experiencing anxiety before their first pregnancy event if they reported having a period of anxiety beginning at the same time as or before the month and year or age of their first pregnancy outcome.

Violence exposure. Three questions were used to code rape experience, the only form of violence measured in the NSFG. Women were identified as having experienced rape (yes/no) if they reported that their first intercourse was involuntary, their first intercourse was a rape, or they reported at some time in their life they had been forced by a man to have sex against their will. Thus, a rape experience may have occurred before or after a woman's first pregnancy outcome or experience of anxiety symptoms. Data obtained from both previously described computer-assisted techniques were used to determine whether a woman had ever been raped.

Demographic covariates. Marital status (married, separated or divorced, widowed, or never married), income as a percentage of poverty level, and educational level at time of interview and Race (White, Black, Hispanic, Other), age at first pregnancy outcome (in years), number of subsequent abortions, and number of subsequent births were controlled in the multivariate analyses. Data obtained from both computer-assisted techniques were used to calculate the number of subsequent abortions.

Procedure

For both samples, in our first model we investigated the bivariate relation of first pregnancy outcome and subsequent experience of anxiety symptoms. In the second model, we controlled for pre-existing anxiety symptoms, rape experience, and the other covariates listed above. We then examined whether women having 0, 1, or multiple abortions differed in rates of anxiety symptoms after first pregnancy outcome. Finally, we analyzed this relationship in the context of previous anxiety symptoms, rape experience, and the other covariates.

Results

Do women who terminate a first pregnancy have significantly higher rates of experiencing anxiety symptoms (EAS) compared to women who deliver a first pregnancy?

The answer is yes. Table 2 contains the results from logistic regression analyses that used first pregnancy outcome to predict subsequent anxiety symptoms among *unintended first pregnancies* and among *all first pregnancies*, respectively, with no covariates controlled. For this model, in both samples pregnancy outcome was significant, with abortion found to be associated with a greater likelihood of having subsequent anxiety symptoms.

To what extent are differences in post-pregnancy rates of anxiety symptoms explained by pre-pregnancy anxiety symptoms, rape experience, and demographic characteristics known to co-vary with anxiety and abortion?

Controlling for pre-pregnancy anxiety symptoms, rape experience and the other covariates was sufficient to explain the relationship of pregnancy outcome to anxiety symptoms; abortion was no longer found to be associated with increased risk for anxiety symptoms in either sample.

Table 2
NSFG first model: logistic regression coefficients for first pregnancy outcome (abortion versus delivery) predicting post-first pregnancy EAS for unintended first pregnancies and for all first pregnancies, no covariates controlled

Sample	*B*	SE *B*	*t*	*p*	Odds ratio (95% CI)
Unintended first pregnancies	**0.347**	**0.11**	**3.03**	**0.003**	**1.42 (1.13–1.77)**
All first pregnancies	**0.463**	**0.10**	**4.63**	**<0.0005**	**1.59 (1.31–1.94)**

Positive *B* and *t* = women who have abortions on first pregnancy are more likely to have post-pregnancy EAS; negative *B* and *t* = women who have deliveries on first pregnancy are more likely to have post-pregnancy EAS. Odds ratio = exp (*B*); CI = confidence interval; EAS = experience of anxiety symptoms. Rows containing significant differences are in bold.

Table 3 presents the results of the second logistic regression predicting anxiety symptoms from pregnancy outcome for the *unintended first pregnancies* and *all first pregnancies* samples, controlling for pre-existing anxiety, rape experience, race, marital status, age of first pregnancy outcome, income as a percent of poverty level and education at time of interview, number of subsequent abortions, and number of subsequent births. In sum, when these key covariates known to be associated with experience of anxiety and unintended pregnancy were controlled, differences between the abortion and delivery groups disappeared in both samples.

What does predict anxiety symptoms? As seen in Table 3, for the *unintended first pregnancies* sample, women who experienced pre-pregnancy anxiety and were White as opposed to Black, divorced vs. married at time of interview, raped at some point in their lives, and younger at age of first pregnancy outcome were all more likely to experience anxiety symptoms. For the *all first pregnancies* sample, the pattern of findings was similar to that of the *unintended first pregnancies* sample, except being Hispanic vs. White and having a higher income and more subsequent births were also associated with a higher likelihood of experiencing anxiety symptoms. Also, the significance of the association of rape experience with anxiety symptoms only approached statistical significance ($p < 0.07$).

In the *all first regnancy* sample, we did not control for pregnancy intention, in order to be able to compare these findings to those of Study 2. However, using logistic regression, we examined a model in which we regressed post-pregnancy anxiety symptoms on pre-pregnancy anxiety, first pregnancy intention, and first pregnancy outcome, with nothing else controlled. Although pre-pregnancy anxiety emerged as the strongest predictor of the 3 variables ($B = 3.30$, $p < 0.0005$, OR = 27.2), each variable made significant independent contributions to post-pregnancy anxiety symptoms when the others were controlled (pregnancy outcome $B = 0.337$, $p = 0.004$, OR = 1.40; pregnancy intention $B = 0.205$, $p = 0.026$, OR = 1.23).

Is there a significant relationship of abortion status (0, 1, or repeat abortion) to rates of anxiety symptoms after first pregnancy?

The answer is a qualified no. Table 4 presents the percentages of women in both samples with post-pregnancy anxiety symptoms and who ever experienced rape by abortion status. Although in both samples, post-pregnancy anxiety symptoms increased with levels of abortion status, the difference in prevalence of anxiety symptoms between women having repeat (2 or more) abortions and 1 abortion is not statistically significant. Specifically, in this model where no covariates are controlled, logistic regression analyses found that women who reported having repeat abortions were significantly more likely to be identified as having anxiety symptoms than those who reported 0 abortions (*unintended first pregnancies*: $t = 3.48$, $p = 0.001$; *all first pregnancy*: $t = 4.74$, $p < 0.0005$), but not significantly more so than women who reported 1 abortion (*unintended first pregnancies*: $t = 1.40$, $p = 0.16$; *all first pregnancy*: $t = 1.70$, $p = 0.09$). Women who reported experiencing 1 abortion were also significantly more likely to be identified as having anxiety symptoms than those who reported experiencing 0 abortions (*unintended first pregnancies*: $t = 2.58$, $p = 0.01$; *all first pregnancy*: $t = 4.04$, $p < 0.0005$). Table 5 presents the coefficients and odds ratios for these regression analyses.

Also, as seen in Table 4, in both samples women who experienced repeat abortions were more likely to report

Table 3
NSFG second model: logistic regression coefficients for pregnancy outcome, pre-pregnancy anxiety, rape experience and covariates for unintended first pregnancies/all first pregnancies

	B	SE *B*	*t*	*p*-Value	Odds ratio (CI)
Abortion vs. delivery	0.22/0.20	0.15/0.12	1.45/1.65	0.15/0.10	1.24/1.23 (0.92–1.68/0.96–1.56)
Anxiety before first pregnancy	**3.77/3.45**	**0.19/0.13**	**19.81/25.71**	**<0.0005/<0.0005**	**43.5/31.3 (29.41–62.5/24.39–41.67)**
Black vs. white	**−0.83/−0.93**	**0.18/0.15**	**−4.70/−6.41**	**<0.0005/<0.0005**	**0.44/0.40 (0.31−0.62/0.30−0.53)**
Hispanic vs. white	−0.16/**−0.37**	0.18/**0.14**	−0.86/**−2.75**	0.39/**0.006**	0.86/**0.69** (0.60–1.22/**0.53–0.90**)
Other vs. white	0.17/−0.06	0.32/0.23	0.54/−0.26	0.59/0.80	1.19/0.94 (0.64–2.21/0.60–1.49)
Never married vs. married[a]	−0.29/−0.06	0.19/0.15	−1.53/−0.41	0.13/0.69	0.75/0.94 (0.52–1.09/0.70–1.27)
Divorced vs. married[a]	**0.78/0.85**	**0.15/0.12**	**5.14/7.21**	**<0.0005/<0.0005**	**2.18/2.35 (1.61–2.93/1.86–2.96)**
Widowed vs. married[a]	−0.20/0.60	0.64/0.38	−0.32/1.60	0.75/0.11	0.82/1.82 (0.23–2.89/0.87–3.82)
Raped vs. not raped[a]	0.30/0.20	0.13/0.11	2.29/1.85	0.02/0.07	1.35/1.22 (1.04–1.76/0.99–1.51)
Age at first pregnancy outcome	**−0.07/−0.06**	**0.02/0.01**	**−3.73/−4.83**	**<0.0005/<0.0005**	**0.935/0.94 (0.89–0.97/0.923–0.97)**
Income as a percent of poverty level[a]	0.0005/**0.001**	0.0003/**0.0002**	1.54/**2.42**	0.13/**0.02**	1.000/**1.001** (1.000–1.001/**1.000–1.001**)
Education[a]	0.04/0.001	0.03/0.02	1.35/0.07	0.18/0.94	1.04/1.00 (0.98–1.09/0.96–1.04)
Subsequent abortions[a]	0.07/0.10	0.07/0.06	1.08/1.77	0.28/0.07	1.08/1.11 (0.94–1.23/0.99–1.24)
Subsequent births[a]	0.02/**0.09**	0.06/**0.04**	0.33/**2.29**	0.74/**0.02**	1.02/**1.09** (0.91–1.14/**1.01–1.18**)

For categorical variables, positive *B* and *t* = first category is more likely to have EAS; negative *B* and *t* = second category is more likely to have EAS. Odds ratio = exp (*B*); CI = confidence interval. Significant differences are presented in bold.

[a] At time of interview.

Table 4
Percent (and standard error in parentheses) of women in NSFG experiencing EAS and rape by abortion status in unintended first pregnancies and all first pregnancies samples

Sample	Post-pregnancy EAS			Rape		
	0 Abortion	1 Abortion	2 Abortions	0 Abortion	1 Abortion	2+ Abortions
Unintended first pregnancies	**14.7[a] (1.0)**	**18.8[b] (1. 4)**	**22.0[b] (2.0)**	**25.8[a] (1.3)**	**32.1[b] (1.7)**	**40.9[c] (2.1)**
All first pregnancies	**13.1[a] (0.6)**	**18.0[b] (0.7)**	**21.4[b] (1.1)**	**18.9[a] (0.7)**	**31.9[b] (1.5)**	**39.4[c] (1.8)**

Within each row, frequencies with different superscripts are significantly different from one another. Rows containing significant differences are in bold.
EAS = experience of anxiety symptoms.

experiencing rape at some point in their lives than other women. Specifically, women who reported experiencing repeat abortions were significantly more likely to report experiencing rape at some time in their lives than women who reported either 1 abortion (*unintended first pregnancies*: $t = 3.44$, $p = 0.001$; *all first pregnancies*: $t = 8.76$, $p < 0.0005$) or 0 abortions (*unintended first pregnancies*: $t = 6.49$, $p < 0.0005$; *all first pregnancies*: $t = 11.37$, $p < 0.0005$). Women who reported 1 abortion were more likely to report experiencing rape at some point in their lives than women reporting 0 abortions as well (*unintended first pregnancies*: $t = 3.23$, $p = 0.001$; *all first pregnancies*: $t = 3.25$, $p = 0.001$).

To what extent is the relation of abortion status to anxiety explained by pre-pregnancy anxiety symptoms, rape experience, and demographic characteristics known to co-vary with anxiety and abortion?

In both samples, logistic regression was used to explore the relation of abortion status to anxiety symptoms controlling for pre-pregnancy anxiety, rape experience, race, marital status, age at first pregnancy outcome, current poverty level status and education, and subsequent births. In this model, for the *unintended first pregnancies* sample women who reported repeat abortion were more likely to experience anxiety than women who reported 0 abortions ($t = 2.73$, $p < 0.01$) or 1 abortion ($t = 1.96$, $p = 0.05$); women who reported 1 abortion were equally likely to experience anxiety compared to women who reported 0 abortions ($t = 1.31$, $p = 0.19$) (see Table 6). For the *all first pregnancies* sample, women who reported repeat abortion were more likely to experience anxiety than women who reported 1 abortion or 0 abortions; women who reported 1 abortion were significantly more likely to experience anxiety symptoms than women who reported 0 abortion (see Table 6).

Table 5
NSFG: logistic regression coefficients for abortion status predicting experience of anxiety symptoms (EAS) among unintended and all first pregnancies samples, no covariates controlled

Abortion status	*B*	SE *B*	*t*	*p*-Value	Odds ratio (CI)
2 vs. 0					
Unintended	**0.50**	**0.14**	**3.48**	**0.001**	**1.65 (1.24–2.18)**
All	**0.59**	**0.12**	**4.71**	**< 0.0005**	**1.80 (1.41–2.30)**
2 vs. 1					
Unintended	0.20	0.14	1.40	0.16	1.22 (0.92–1.62)
All	0.21	0.13	1.66	0.10	1.24 (0.96–1.59)
1 vs. 0					
Unintended	**0.30**	**0.12**	**2.58**	**0.01**	**1.35 (1.07–1.69)**
All	**0.37**	**0.09**	**4.09**	**< 0.0005**	**1.45 (1.21–1.74)**

Positive *B* and *t* = first category is more likely to have EAS; negative *B* and *t* = second category is more likely to have EAS.
CI = confidence interval. Rows containing significant differences are in bold.

Discussion

The finding that women who terminated a first pregnancy had a greater likelihood of subsequent anxiety symptoms than women who delivered a first pregnancy – regardless of intention – is congruent with previous research that has reported an association between abortion and anxiety when relevant variables are not controlled (e.g., Cougle et al., 2005). One contribution of this study is to show that this relation can be accounted for by other factors, particularly pre-pregnancy anxiety and violence. Similar to Major et al.'s (2000) findings, for both samples, the strongest predictor of post-pregnancy anxiety was the occurrence of pre-pregnancy anxiety. No relation between abortion on the first pregnancy and anxiety symptoms was found in either NSFG sample when pre-pregnancy anxiety, rape experience, and other relevant covariates were controlled. The significant and independent contributions of pre-pregnancy anxiety symptoms and rape experience to post-pregnancy anxiety symptoms suggest that a more fruitful line of investigation would be to focus on understanding both the pathways of pre-existing conditions and violence exposure to pregnancy outcome among women.

The findings with regard to repeat abortion are problematic due to the lack of information about the timing of

Table 6
NSFG: logistic regression coefficient for all first pregnancies group for abortion status predicting EAS, controlling for covariates

Abortion status	*B*	SE *B*	*t*	*p*-Value	Odds ratio (CI)
2 vs. 0					
Unintended	**0.52**	**0.19**	**2.73**	**0.007**	**1.69 (1.16–2.47)**
All	**0.52**	**0.16**	**3.17**	**0.002**	**1.68 (1.22–2.31)**
2 vs. 1					
Unintended	**0.33**	**0.17**	**1.96**	**0.05**	**1.40 (1.00–1.95)**
All	**0.29**	**0.15**	**1.94**	**0.05**	**1.34 (1.00–1.80)**
1 vs. 0					
Unintended	0.19	0.15	1.31	0.19	1.21 (0.91–1.61)
All	**0.22**	**0.11**	**1.98**	**0.05**	**1.25 (1.00–1.56)**

Controlling for race, age at first pregnancy outcome, number of subsequent births, rape history, and marital status, poverty status, and educational level at time of interview.
Positive *B* and *t* = first category is more likely to have EAS; negative *B* and *t* = second category is more likely to have EAS.
CI = confidence interval; EAS = experience of anxiety symptoms. Rows containing significant differences are in bold.

the predictor and outcome variables. For women having 1 abortion that occurred on their first pregnancy event, we could assess when anxiety occurred relative to that abortion. However, for women who had abortions after their first pregnancy event, we do not know the timing of those abortions with respect to post-pregnancy anxiety. Consequently, a thorough examination of the relationship of repeat abortion status to anxiety was beyond the scope of this study. Thus, in interpreting our findings with regard to repeat abortions, it must be kept in mind that lack of information about timing of the relevant variables makes speculation about causal inferences particularly inappropriate.

Keeping these caveats in mind, we can say that women who reported having repeat abortions were more likely to experience rape at some time in their lives, as predicted, and were more likely to have higher rates of anxiety symptoms than women who reported 0 abortions, even when covariates were controlled. Similarly, women who experienced 1 vs. 0 abortions were more likely to experience anxiety symptoms, even when controlling for the study variables. However, the fact that the non-significant difference between women who reported repeat abortions compared to women reporting 1 abortion emerged as significant when covariates were controlled suggests that more needs to be known about the women's characteristics to understand what is going on, and that general statements about the relation of "abortion" to mental health are not sufficiently informative to inform clinical practice or public policy. In particular, future research is needed to learn more about how women who have repeat abortions differ in experience from women who report 1 abortion, and how both groups differ from women who report 0 abortion.

The ability to identify pregnancy intention in the NSFG provided an opportunity to examine the extent to which pregnancy intention contributes independently to variation in post-pregnancy anxiety symptoms beyond that associated with pre-pregnancy anxiety and pregnancy outcome (abortion vs. delivery). The finding that pregnancy intention continued to make an independent contribution to post-pregnancy anxiety when the other 2 variables were controlled underscores the importance of controlling for pregnancy intention in studies seeking to understand the relation of abortion to mental health. If a study reports a significant correlation between abortion and a mental health outcome such as anxiety, even if pre-existing mental health factors are carefully controlled (e.g., as in Fergusson et al., 2006), unless pregnancy intention is also controlled the explanation for that correlation is problematic.

In addition to limitations common to retrospective survey research, the major limitations of this particular study include limited assessment of exposure to violence and the inability to define a clinically diagnosed anxiety disorder. Moreover, we determined that among all women, the lifetime prevalence of the variable used to assess generalized anxiety symptoms in the NSFG was more than twice as high (14.8%) as the lifetime prevalence for women in the NCS, a population survey in which a clinical diagnosis of GAD was assessed (6.6%; Kessler et al., 1994). Thus, it is likely that the anxiety symptoms in the NSFG were reflecting more than generalized anxiety. It may be that effects of pregnancy outcome may emerge for specific clinically diagnosed anxiety disorders. To investigate this possibility, as well as to provide a more thorough examination of the relation of violence exposure to pregnancy outcome, we examined the relation of abortion to selected anxiety disorders using data from the National Comorbidity Survey.

Study 2: the National Comorbidity Survey (NCS)

In some ways, the NCS is a more appropriate data set than the NSFG for investigating questions about the relation of pregnancy outcome to mental health. First, in contrast to the NSFG, in the NCS the variables constructed are more closely and accurately based on psychiatric diagnoses of clinical disorders (i.e., the DSM-III-R). Second, in the NCS, variables are constructed for several anxiety diagnoses based on the DSM-III-R, allowing separate analyses for generalized anxiety disorder (GAD or anxiety disorder), social anxiety, and PTSD. Finally, while the NSFG asked only about rape experience, in the NCS a more extensive history of physical and sexual violence was taken and can be accounted for in data analyses. The major limitation of the NCS for our purposes was that it did not assess pregnancy intention. Thus, interpreting any relationship remaining between abortion and anxiety disorder after controlling for covariates may be problematic and should be approached with caution.

The findings in Study 2 are designed to be comparable to results from analyses of the NSFG *all first pregnancies* sample, and to answer the following questions with regard to anxiety disorder, social anxiety, and PTSD, respectively:

(1) Do women who terminate a first pregnancy have significantly higher rates of anxiety disorder, social anxiety, or PTSD compared to women who deliver a first pregnancy?
(2) If rates of these anxiety disorders differ by first pregnancy outcome, to what extent are they explained by pre-pregnancy anxiety disorder, exposure to violence, and demographic characteristics known to co-vary with anxiety and abortion?
(3) Is there a significant relation between abortion status (0, 1, or repeat abortion) and prevalence of anxiety disorders after first pregnancy?
(4) If there is a relation between abortion status and prevalence of anxiety disorder, to what extent is this explained by pre-pregnancy anxiety disorder, violence exposure, and demographic characteristics known to co-vary with anxiety and abortion?

Method

Survey design

The NCS was administered by the staff of the Survey Research Center at the University of Michigan, Ann Arbor. Like the NSFG, the NCS is based on a stratified, multistage area probability sample of persons aged 15–54 years in the non-institutionalized civilian population in the 48 coterminous states (Kessler, 2002). Participants were interviewed

between September 14, 1990 and February 6, 1992 by trained lay interviewers. The structured psychiatric interview was administered face-to-face using paper and pencil interviewing. The response rate was 82.6%, and cooperation in listed households did not differ markedly by age or sex, the only 2 listing variables available for all selected respondents. The NCS was the first nationally representative survey in the United States to use a modified version of the Composite International Diagnostic Interview (CIDI; World Health Organization, 1990) to assess the prevalence and correlates of mental disorder as defined by the DSM-III-R. Again, we used the complex sample analysis feature of SPSS Version 14.0.2 to estimate parameters, and although unweighted *n*s are reported, all parameter estimates are based on complex sample analysis.

Sample

Of 8098 participants, 3054 women responded to the portions of the survey containing demographic and pregnancy variables (for more information on the survey and sample design see Kessler, 2002). Of 3054 women, 2077 (70.2%, weighted percent) had been pregnant at least once. As described below, women who did not meet criteria for pregnancy outcome were excluded.

In parallel to the second set of NSFG analyses presented above on *all first pregnancies*, the analyses reported here are based on all women whose first pregnancy ended in abortion or live birth ($n = 1823$). Table 7 presents descriptive statistics and results of logistic regression analyses that compared women who delivered with those who terminated their first pregnancy on the study variables. Compared to women in the delivery group, women in the abortion group were not significantly more likely to be White, Black, or Hispanic ($ts < 0.57$, $ps > 0.5$), but were significantly less likely to be of the Other race category. They were more likely to never be married ($t = -5.80$, $p < 0.0005$), and less likely to be married/cohabitating at time of interview ($t = -3.23$, $p < 0.01$). The abortion group was also more likely to experience any type of intimate violence ($t = 2.43$, $p < 0.05$) in general, and was specifically more likely to be raped ($t = 2.73$, $p < 0.01$) or molested ($t = 2.20$, $p < 0.05$) than the delivery group. Linear regression analyses revealed that women in the abortion group were more likely to have significantly higher personal income ($t = 3.36$, $p < 0.01$) and more education ($t = 5.47$, $p < 0.0005$), be younger at first pregnancy outcome ($t = -5.64$, $p < 0.0005$), have more subsequent abortions ($t = 3.076$, $p < 0.01$) and fewer subsequent births ($t = -2.50$, $p < 0.02$).

Table 7
NCS: descriptive statistics for demographic characteristics and major variables for all first pregnancies ending in a live birth or abortion

	Abortion	Delivery
Unweighted *n*	273	1549
Race		
White	75.4% (4.2%)	73.1% (2.7%)
Black	12.4% (3.6%)	14.7% (1.9%)
Hispanic	10.5% (3.0%)	9.1% (1.7%)
Other	**1.7% (0.5%)[a]**	**3.1% (0.8%)[b]**
Marital status		
Married/cohabitating	**64.9% (3.5%)[a]**	**76.4% (1.6%)[b]**
Divorced/separated/widowed	16.1% (2.9%)	17.4% (1.4%)
Never married	**19% (2.6%)[a]**	**6.3% (0.9%)[b]**
Violence exposure		
Rape	**15.1% (3.6%)[a]**	**7.5% (0.8%)[b]**
Molestation	**18.3% (32.%)[a]**	**11.6% (1.0)[b]**
Child physical abuse	5.3% (1.7%)	5.5% (0.7%)
Captured/kidnapped/ threatened with a weapon	11.9% (2.9%)	7.9% (1.0%)
Physically attacked	9.7% (2.3%)	7.0% (0.8%)
Any type of violence	**39.1% (5.1%)[a]**	**26.8% (1.4%)[b]**
Pre-existing disorder		
GAD	2.0% (0.7%)	3.2% (0.5%)
Social anxiety	12.6% (2.3%)	13.8% (1.1%)
PTSD	10.4% (2.6%)	7.5% (0.8%)
Post-pregnancy anxiety disorder		
GAD	6.2% (1.7%)	7.3% (0.8%)
Social anxiety	12.0% (2.4%)	13.5% (1.0%)
PTSD	10.2% (2.9%)	7.8% (0.8%)
Mean income	19,521 (1860)	13,484 (643)
Age at first pregnancy outcome	**20.02 (0.314)[a]**	**21.97 (0.185)[b]**
Education	**13.83 (0.198)[a]**	**12.78 (0.094)[b]**
Subsequent abortions	**0.23 (0.042)[a]**	**0.08 (0.015)[b]**
Subsequent children	**0.96 (0.109)[a]**	**1.29 (0.054)[b]**

For categorical variables, percents (standard errors) are reported; for continuous variables, means (standard errors) are reported.
Marital status, mean income, and education were at time of interview.
Different superscripts represent a statistically significant difference between abortion and delivery group. Rows containing significant differences are in bold.

Measures

First pregnancy outcome. In contrast to the NSFG, in the NCS the intendedness of the first pregnancy was not directly ascertained. However, women were asked about the dates of their first pregnancy, miscarriage, and abortion, making it possible to calculate first pregnancy outcome. It was not possible to compute the age of first pregnancy outcome for one women in the abortion group. Thus, analyses are based on 1822 women.

Abortion status. This variable was created by classifying women whose first pregnancy ended in abortion or delivery into 3 categories on the basis of number of abortions reported: 0, 1, and 2 or more (repeat) abortions.

Pre- and post-pregnancy generalized anxiety disorder (GAD), Social anxiety, and post-traumatic stress disorder (PTSD). The NCS was designed to construct variables representing DSM-III-R diagnoses. NCS variables representing the lifetime measures for anxiety disorder, social anxiety, and PTSD were used in the analyses presented here (see APA, 1994 for criteria). The age of first onset and most recent occurrence of each disorder were used to determine whether the disorder occurred before or after the age of first pregnancy outcome.

Violence exposure. Five categories of violence were identified in the NCS: rape, molestation, child physical abuse, held captive/kidnapped/threatened with a weapon, and physical attack. In addition to analyzing these separately, we created a sixth variable that compared women who reported any type of violence to those who did not report any violence.

Covariates. An effort was made to use the same covariates in analyses of the NCS as were used in the NSFG: race (Black, White, Hispanic, Other), marital status

(Married/cohabitating, separated/widowed/divorced, never married), annual income, age at first pregnancy outcome, years of education, number of subsequent abortions, and number of subsequent births. There were some differences in the definitions of the variables, however. In particular, note that in the NCS cohabitating and married individuals are grouped together, reducing the number of individuals in the never married category.

Procedure

Congruent with Study 1 analyses, we tested 2 models for each anxiety disorder; first we investigated the relation of first pregnancy outcome to anxiety disorder, social anxiety, and PTSD, respectively. Second, we planned to control for pre-pregnancy anxiety disorder, social anxiety, or PTSD (depending on the outcome being measured), the same demographic covariates as used in Study 1, and additional violence exposure variables.

Furthermore and also similar to the NSFG analyses, to test whether individuals who had multiple abortions were most likely to develop anxiety disorders, we tested 2 more models for each of the anxiety disorders. In the first model we examined the 3 possible 2-way comparisons between those who had 0, 1, and repeat abortions on the prevalence of generalized anxiety disorder, social anxiety disorder, and PTSD. In the second model, we controlled for the same covariates as those in the model that examined the relation of first pregnancy outcome and subsequent anxiety disorder.

Results and discussion

Do women who terminate a first pregnancy have significantly higher rates of experiencing anxiety disorder, social anxiety, or PTSD compared to women who deliver a first pregnancy?

The answer is no. Table 8 presents the percentages of women experiencing anxiety disorder, PTSD, or social anxiety before and after their first pregnancy. Although the rates of anxiety disorder and social anxiety were higher in the delivery group and the rate of PTSD was higher in the abortion group, these differences were not statistically significant; thus, only the first model is presented.

For the first model we conducted logistic regression analyses with outcome of first pregnancy (abortion vs. delivery) predicting subsequent anxiety disorder, social anxiety, and PTSD, respectively. In contrast to NSFG results, first pregnancy outcome was not related to anxiety disorder, social anxiety, or PTSD. In other words, in the NSFG there was an association between anxiety symptoms and abortion on the first pregnancy that was subsequently explained by the presence of covariates. In the NCS data, however, there was no such association to be explained.

Is there a significant relationship of abortion status (0, 1, or repeat abortion) to rates of each disorder after first pregnancy?

The answer depends on the disorder. Table 9 presents the percentage of women experiencing generalized anxiety disorder, social anxiety, and PTSD by abortion status. For generalized anxiety disorder, the answer is no. There is no relation between first pregnancy outcome and subsequent generalized anxiety disorder. For social anxiety and PTSD, the answer is yes, but the relationships differ for each disorder.

Specifically, in parallel to the approach to the NSFG analyses, a series of logistic regressions were conducted to determine the relationship of abortion status to generalized anxiety disorder, social anxiety, and PTSD. When no covariates were controlled, no relationship of abortion status to generalized anxiety disorder was found, but abortion status was related to rates of social anxiety and PTSD after first pregnancy. As seen in Table 10, in this model, women who reported repeat (2 or more) abortions had higher rates of social anxiety than those who reported 0 abortions, but the difference was not statistically significant ($p < 0.09$). However, they were significantly more likely to have social anxiety than those who reported 1 abortion ($p = 0.008$). Further, as seen in Table 11, women who had repeat abortions were significantly more likely to have PTSD than those who reported 0 abortions, but not 1 abortion. Women who reported 1 abortion did not differ significantly from women who reported 0 abortions with regard to rates of social anxiety or PTSD, respectively (social anxiety: $t = -1.01$, $p = 0.32$; PTSD: $t = 0.70$, $p = 0.49$).

To what extent is the relationship of multiple abortions to anxiety disorder explained by pre-pregnancy anxiety disorder, violence exposure, and demographic characteristics known to co-vary with anxiety and abortion?

Given the limited assessment of violence exposure in the NSFG, we were particularly interested in investigating whether relations found between abortion status and anxiety disorder could be explained with a more thorough assessment of violence exposure. Logistic regression analyses

Table 8
NCS: logistic regression coefficients for outcome of first pregnancy (abortion versus delivery) predicting subsequent GAD, social anxiety, or PTSD, no covariates controlled

Disorder	*B*	SE *B*	*t*	*p*-Value	Odds ratio (CI)
GAD	−0.175	0.312	−0.56	0.58	0.84 (0.45–1.88)
Social anxiety	−0.138	0.258	−0.54	0.60	0.87 (0.52–1.47)
PTSD	0.30	0.350	0.86	0.43	1.35 (0.67–2.73)

Positive *B* and *t* = women who have abortions on first pregnancy are more likely to have post-pregnancy disorder; negative *B* and *t* = women who have deliveries on first pregnancy are more likely to have post-pregnancy disorder.
GAD = generalized anxiety disorder; PTSD = post-traumatic stress disorder; odds ratio = exp (*B*); CI = confidence interval.

Table 9
Percent of women (who had first pregnancy outcome end in abortion or delivery) in NCS experiencing GAD, social anxiety, and PTSD by abortion status

Anxiety disorder	Abortion status		
	0 Abortions (%)	1 Abortion (%)	2+ Abortions (%)
GAD	7.4 (0.9)[a]	6.5 (1.5)[a]	3.0 (1.6)[a]
Social anxiety	**13.4 (1.1)[ab]**	**11.0 (1.8)[a]**	**21.3 (5.0)[b]**
PTSD	**7.5 (0.9)[a]**	**9.2 (2.5)[a]**	**19.0 (4.8)[b]**

Within each row, frequencies with different superscripts are significantly different from one another. Rows containing significant differences are in bold.
GAD = generalized anxiety disorder; PTSD = post-traumatic stress disorder.

Table 10
NCS: logistic regression coefficients for abortion status predicting social anxiety, with no covariates controlled

Abortion status	*B*	SE *B*	*t*	*p*-Value	Odds ratio (CI)
2 vs. 0	0.556	0.316	1.76	0.09	1.74 (0.92–3.23)
2 vs. 1	**0.786**	**0.28**	**2.79**	**0.008**	**2.20 (1.24–3.88)**
1 vs. 0	0.440	0.316	1.391	0.172	1.553 (0.820–2.940)

Positive *B* and *t* = first category is more likely to have social anxiety; negative *B* and *t* = second category is more likely to have social anxiety.
Odds ratio = exp (*B*); CI = confidence interval; PTSD = post-traumatic stress disorder. Bolded figures represent a statistically significant difference between comparison groups.

revealed that women who experienced repeat abortion were more likely to be exposed to certain forms of violence than other women. As seen in Table 12, compared to women who reported having 0 abortions, women who reported having multiple abortions were significantly more likely to report experiencing rape ($t = 3.765$, $p < 0.01$) or any type of violence ($t = 2.360$, $p < 0.05$), being held captive/kidnapped/threatened with a weapon ($t = 3.367$, $p < 0.01$), or being physically attacked ($t = 4.539$, $p < 0.0005$). They were more likely to report experiencing molestation, but the difference did not achieve conventional levels of statistical significance ($t = 1.961$, $p = 0.057$). They were equally likely to report experiencing child physical abuse ($t = 0.516$, $p = 0.609$).

Compared to women who had 1 abortion, women who reported having multiple abortions were significantly more likely to report being physically attacked ($t = 2.847$, $p < 0.01$). Although not statistically reliable, they were also more likely to report being held captive/kidnapped/threatened with a weapon ($t = 1.910$, $p < 0.08$). They were equally likely to report experiencing rape ($t = 1.346$, $p = 0.186$), molestation ($t = 0.349$, $p = 0.729$), child physical abuse ($t = 0.640$, $p = 0.526$), or any type of violence ($t = 0.489$, $p = 0.628$).

Compared to women who reported 0 abortions, women who had 1 abortion were significantly more likely to report experiencing any type of violence ($t = 2.161$, $p = 0.036$). They were more likely to report experiencing molestation, but the difference only approached significance ($t = 1.850$, $p = 0.071$); they were equally likely to report experiencing rape ($t = 1.505$, $p = 0.140$), child physical abuse ($t = 0.376$, $p = 0.709$), being held captive/kidnapped/threatened with a weapon ($t < 1.105$, $p = 0.275$), or being physically attacked ($t = 0.715$, $p = 0.478$).

Tables 13 and 14 contain the logistic regression coefficients for abortion status predicting social anxiety and PTSD, respectively, controlling for history of disorder (PTSD or social anxiety), rape, molestation, child abuse, held captive/kidnapped/threatened with a weapon, physically attacked, race, marital status, age at first pregnancy outcome, current income, current education, and subsequent births. In this model, neither the relationship of abortion status to social anxiety nor to PTSD remained statistically significant.

Specifically, women who experienced repeated, 1, or 0 abortions were all equally likely be identified as having PTSD ($ts < 0.47$, $ps > 0.63$) and social anxiety ($ts < 1.57$, $ps > 0.12$). However, women who were raped, kidnapped/held captive/threatened with a weapon or physically attacked and those with PTSD before their pregnancy were significantly more likely to have PTSD; and women who had social anxiety before their pregnancy were more likely to have social anxiety afterwards.

Thus, no evidence was found in the NCS data for the claim that abortion on the first pregnancy leads to higher risk for any of the anxiety diagnoses studied, even though it was not possible to control for unintended pregnancy. This finding underscores the importance of careful assessment of outcome variables if an accurate portrait of women's post-abortion mental health is to be developed. The strengths of this study lie in its assessment of multiple forms of violence and the measurement of 3 clinical anxiety disorders. It shares a number of problems with Study 1, however (described below), and wantedness of pregnancy was not assessed.

Table 11
NCS: logistic regression coefficients for abortion status predicting PTSD, with no covariates controlled

Abortion status	*B*	SE *B*	*t*	*p*-Value	Odds ratio (CI)
2 vs. 0	**1.065**	**0.35**	**3.05**	**0.004**	**2.90 (1.44–5.87)**
2 vs. 1	1.043	0.553	1.888	0.066	2.841 (0 0.931–11.904)
1 vs. 0	**0.84**	**0.42**	**1.99**	**0.05**	**2.31 (0.99–5.38)**

Positive *B* and *t* = first category is more likely to have disorder PTSD; negative *B* and *t* = second category is more likely to have PTSD.
Odds ratio = exp (*B*); CI = confidence interval; PTSD = post-traumatic stress disorder. Rows containing significant differences are in bold.

Table 12
Percent of women in NCS experiencing types of intimate violence by 0, 1, and repeat abortion among all women who delivered or had an abortion on the first pregnancy

Type of violence	0 Abortion (%)	1 Abortion (%)	2+ Abortions (%)
Rape	**7.5 (0.8)^{a}**	**11.5 (3.1)^{ab}**	**18.2 (3.7)^{b}**
Molestation	11.4 (1.0)^{a}	17.0 (3.1)^{a}	18.8 (4.4)^{a}
Child physical abuse	5.6 (0.8)^{a}	4.8 (1.6)^{a}	6.9 (2.7)^{a}
Held captive/kidnapped/ threatened with a weapon	**7.5 (1.0)^{a}**	**10.6 (2.7)^{ab}**	**21.8 (5.3)^{b}**
Physically attacked	**6.7 (0.7)^{a}**	**7.9 (1.8)^{a}**	**21.5 (4.9)^{b}**
Any type of violence	**26.2 (1.5)^{a}**	**37.3 (5.0)^{b}**	**41.1 (6.4)^{b}**

Within each row, frequencies with different superscripts are significantly different ($p < 0.05$) from one another. Rows containing significant differences are in bold.

General discussion

In both the NSFG and the NCS, two samples that are representative of the United States, we found that women who

Table 13
NCS: logistic regression coefficients for abortion status predicting social anxiety, controlling for covariates

Abortion status	*B*	SE *B*	*t*	*p*-Value	Odds ratio (CI)
2 vs. 0	0.50	0.38	1.31	0.20	1.65 (0.76–3.57)
2 vs. 1	0.67	0.43	1.58	0.12	1.96 (0.83–4.62)
1 vs. 0	−0.17	0.32	−0.52	0.60	0.84 (0.44–1.63)

Positive *B* and *t* = first category is more likely to have social anxiety; negative *B* and *t* = second category is more likely to have social anxiety.
Odds ratio = exp (*B*); CI = confidence interval.

Table 14
NCS: logistic regression coefficients for abortion status predicting PTSD, controlling for covariates

Abortion status	*B*	SE *B*	*t*	*p*-Value	Odds ratio (CI)
2 vs. 0	0.25	0.54	0.47	0.64	1.29 (0.43–3.84)
2 vs. 1	0.27	0.58	0.48	0.64	1.32 (0.41–4.21)
1 vs. 0	−0.02	0.30	−0.07	0.94	0.98 (0.54–1.78)

Positive *B* and *t* = first category is more likely to have PTSD; negative *B* and *t* = second category is more likely to have PTSD.
Odds ratio = exp (*B*); CI = confidence interval; PTSD = post-traumatic stress disorder.

have abortions on their first pregnancy are more likely to experience violence in their lives, congruent with other research finding an association between violence and abortion (e.g., Coker, 2007; Garcia-Moreno et al., 2005; Russo & Denious, 2001). The results also provide additional documentation of the association between violence exposure and anxiety outcomes in the lives of women regardless of pregnancy outcome (see Fisher et al., 2005; Garcia-Moreno et al., 2005; Golding, 1999).

Moreover, the congruence of the findings in the 2 separate studies provides strong support for our hypothesis that confounding factors, including pre-existing anxiety and violence exposure, can explain the abortion–anxiety relationship. The differences in the pattern of findings are informative for interpreting contradictions across studies as well, for they establish that the findings regarding the relation of abortion and mental health will depend on type of violence exposure controlled (e.g., rape vs. physical attack) and clinical significance of the outcome variable (i.e., general symptoms vs. a diagnosis) and warrant limitations on generalization.

The results do not support the use of abortion history as a marker for identifying patients at risk for GAD (e.g., Cougle et al., 2005) – women who terminated their first pregnancy were not at higher risk for having an actual diagnosis of GAD. Indeed, such a practice is ill-advised given that being raped, physically attacked, and held captive/threatened with a weapon remained significant predictors of PTSD when pregnancy outcome and other covariates were in the model. These results are congruent with those of numerous studies, including longitudinal research, that support a causative role for victimization in the development of negative mental health outcomes as well as risk for unwanted pregnancy (e.g., Dietz et al., 2000; Pallitto et al., 2005). Given the long history of invisibility for and neglect of the mental health effects of women's victimization (Koss et al., 1994), focusing on unintended pregnancy (regardless of pregnancy outcome) as a marker for violence risk would be more appropriate.

The NSFG finding that pregnancy intention continued to make an independent contribution to post-pregnancy anxiety when pre-pregnancy anxiety symptoms and pregnancy outcome (abortion vs. delivery) were controlled underscores the importance of controlling for pregnancy intention in studies seeking to understand the relationship of abortion to mental health. Indeed, research that does not control for pregnancy intention has limited clinical or public policy application if the goal is to enhance informed consent by identifying and communicating risks. Knowing that women who deliver wanted pregnancies have better mental health profiles than women who terminate unwanted pregnancies does not help a pregnant woman weigh the relative risks of terminating vs. delivering her unwanted pregnancy.

The case of multiple abortions

Consistent with NSFG findings, Study 2 found that women who reported repeat abortion were more likely to experience violence, PTSD, and social anxiety than women who reported 0 abortion or 1 abortion. Unlike the relation of abortion status to anxiety symptoms found in Study I, however, these relationships were accounted for when violence, pre-pregnancy disorder, and other relevant covariates were controlled. Notably, in the NSFG, only rape experience was assessed, and in the NCS, the strongest predictor of an anxiety disorder was being physically attacked. This suggests that a more adequate assessment of violence exposure would explain the relationship of abortion status to anxiety symptoms found in the NSFG. These findings underscore the need for research on violence in the lives of women who experience multiple unwanted pregnancies in general, and multiple abortions in particular. Such research should accurately assess various forms of violence, particularly severe forms of sexual and physical violence, when seeking to sort out the extent to which having 1 or more abortions is associated with poor mental health.

Limitations

We want to emphasize that in the repeat abortion analyses, neither the timing of the pregnancy events in which the abortions occurred nor the timing of the abortion(s) relative to post-first pregnancy anxiety was able to be specified. Future research is needed to unravel the relation of timing of unintended pregnancy outcomes and onset of anxiety for all women, regardless of their first pregnancy outcome. Such analyses could determine whether the context and outcomes surrounding an abortion on the first unintended pregnancy are similar or different from a first abortion on a later pregnancy. Meanwhile generalizing findings from research that focuses on women who terminate unintended first pregnancies to women who have their first abortion later in their life cycle after they have already borne children is unwarranted.

The use of these national data sets to study the relationship of abortion and anxiety disorders (and other measured mental health outcomes) has several limitations in addition to the standard problems associated with retrospective self-report methods, including underreporting of stigmatized conditions and unreliability of memory for timing of events. The length of time from the woman's first pregnancy outcome to the onset of anxiety symptoms (in the NSFG) or to the diagnosis of anxiety disorders (in the NCS) varied from 1 to 6 months to 20 years later. In addition to the standard issues related to reliability of memory, personal (divorce, infertility) and societal (e.g., rising influence of fundamentalist religions, stigmatization of abortion) events that occur subsequent to first pregnancy outcome (and that were not

assessed in the survey) may differentially affect anxiety experience or alter the meaning and memory of women who chose to deliver vs. terminate a previous pregnancy.

Ideally, studies of abortion's relationship to mental health should separate elective vs. therapeutic abortions (the latter performed for reasons of health or fetal anomaly), control for pregnancy intention, and use a valid diagnostic outcome measure. The NSFG did not use a valid diagnostic measure, while the NCS, which was designed to study mental health, did not control for the key covariate of pregnancy intention. With pregnancy intention uncontrolled, had we found a significant relationship of abortion to anxiety in the NCS analyses, the findings would have been problematic. The fact that we were able to control for the specific pre-existing disorder and had detailed information on violence exposure variables that predict unwanted pregnancy regardless of outcome is a likely explanation for not finding an initial difference between abortion and delivery groups in the NCS analyses.

Whether or not pregnancy intention is controlled, it should be remembered that research on pregnancy outcome, even when prospective and longitudinal, cannot determine that abortion is the *cause* of psychological disorder. This limitation is inherent in abortion outcome research because it is unethical to randomly assign women to the conditions of conceiving and then terminating vs. delivering an unintended pregnancy.

Conclusion

The body of findings reported here suggests that the associations between abortion and anxiety reported previously in the literature (Cougle et al., 2005; Fergusson, et al., 2006) may be explained by the fact that in previous research the outcome variable was not a specific clinical anxiety diagnosis, pre-pregnancy anxiety was not controlled, or that women who have unintended pregnancies have higher rates of violence exposure in their lives than women who have intended pregnancies. More theory-based research based on complex models and directed towards understanding the interrelationship among violence, unintended pregnancy, pregnancy outcome (abortion vs. delivery), and mental health is needed. For research having the goal of creating a body of knowledge that will be useful in providing informed consent to women seeking abortion, pregnancy intention should serve as a defining variable in the creation of comparison groups.

Meanwhile, given the lack of evidence that abortion increases risk for anxiety disorder, emphasizing abortion as a marker or screening factor may itself be harmful because focusing on abortion may distract attention from factors that do. The women who experience violence – regardless of pregnancy outcome – are the ones who are at higher risk and who need assistance. It is important that clinicians explore the effects of violence in women's lives to avoid misattribution of the negative mental health outcomes of victimization to having an abortion (Rubin & Russo, 2004). To do otherwise may be to impede full exploration and understanding of the origins of women's mental health problems and prolong their psychological distress.

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