IN THE SUPERIOR COURT OF FULTON COUNTY
STATE OF GEORGIA

SISTERSONG WOMEN OF COLOR REPRODUCTIVE JUSTICE COLLECTIVE, on behalf of itself and its members; FEMINIST WOMEN'S HEALTH CENTER, PLANNED PARENTHOOD SOUTHEAST, INC., ATLANTA COMPREHENSIVE WELLNESS CLINIC, ATLANTA WOMEN'S MEDICAL CENTER, FEMHEALTH USA d/b/a CARAFEM, and SUMMIT MEDICAL ASSOCIATES, P.C., on behalf of themselves, their physicians and other staff, and their patients; CARRIE CWIAK, M.D., M.P.H., LISA HADDAD, M.D., M.S., M.P.H., and EVA LATHROP, M.D., M.P.H., on behalf of themselves and their patients; and MEDICAL STUDENTS FOR CHOICE, on behalf of itself, its members, and their patients, Plaintiffs, v. STATE OF GEORGIA, Defendant.	Case No. 2022CV367796

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

INTRODUCTION

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

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

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

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

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

ARGUMENT

I. Sovereign Immunity Is Waived.

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

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

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

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

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

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

II. Plaintiffs Are Likely to Succeed on the Merits

A. HB 481 Is Void *Ab Initio*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Moreover, the Court distinguished the source of individual freedoms under Georgia's Constitution—"the Roman's conception of justice" and natural law," *id.* at 329 (quoting *Pavesich*, 122 Ga. at 194), from the narrower liberty protections of the U.S. Constitution, which encompass "only those matters 'deeply rooted in this Nation's history and tradition,'" *id.* at 330 (quoting *Bowers v. Hardwick*, 478 U.S. 186 (1986)). As the dissent in *Powell* points out, "[s]odomy was a criminal offense at common law," 270 Ga. 338 (Carley, J., dissenting) (quoting *Bowers*, 478 U.S. at 192)—yet the majority held Georgia's sodomy ban unconstitutional nonetheless. The State's reliance on *Dobbs*'s historical framework is wholly misplaced. *See* State's Br. 2–4, 6, 17, 27.[3]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Plaintiffs Have Standing to Challenge the Records Access Provision

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

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

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

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

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

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

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

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

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

3. The Records Access Provision Threatens Irreparable Harm.

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

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

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

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

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

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

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**Pro hac vice application pending*

CERTIFICATE OF SERVICE

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

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

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This 8th day of August, 2022.

/s/ Julia Blackburn Stone
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Attorney for All Plaintiffs

EXHIBIT A

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

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

Plaintiffs,

v.

STATE OF FLORIDA, *et al.*,

Defendants.

Case No. 2022 CA 912

Judge Cooper

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

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

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

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

OVERVIEW

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

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

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

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

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

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

PROCEDURAL BACKGROUND

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

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

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

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

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

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

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

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

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

FINDINGS OF FACT

I. HB 5's Provisions

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

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

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

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

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

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

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

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

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

II. Abortions in Florida After 15 Weeks LMP

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

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

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

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

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

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

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

A. Dr. Tien's Qualifications.

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

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

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

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

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

B. Reasons Women Seek Abortions.

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

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

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

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

C. Reasons Abortions May Be Sought After 15 Weeks LMP

1. Delay in Identifying the Pregnancy

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

2. Poverty and Financial Challenges

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

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

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

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

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

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

3. Intimate Partner Violence

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

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

4. Young Patients

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

5. Substance Abuse

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

6. Changed Life Circumstances

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

7. Health Conditions Caused or Exacerbated by Pregnancy

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

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

8. Diagnoses of Serious Fetal Conditions

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

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

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

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

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

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

9. Pregnancy Complications

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

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

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

D. Likelihood Women Will Seek Earlier Abortions Under HB 5

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

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

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

III. Abortion and Maternal Health

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

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

A. Safety of Abortion Procedures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Abortion and Mental Health

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

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

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

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

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

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

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

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

C. The Act's Effect on Maternal Health

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

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

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

IV. Abortion and Fetal Pain

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. Effects on Plaintiffs If HB 5 Is in Effect

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

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

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

CONCLUSIONS OF LAW

I. Standing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. Temporary Injunction Factors

A. Standard

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

B. Substantial Likelihood of Success on the Merits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Adequate Remedy at Law and Irreparable Harm

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

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

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

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

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

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

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

D. Public Interest

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

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

III. Scope of Relief and Bond

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

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

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

INJUNCTION & BOND ORDER

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

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

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

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

JOHN COOPER
CIRCUIT COURT JUDGE

cc Attorneys of Record

APPENDIX

Filing # 152051308 E-Filed 06/23/2022 11:43:35 AM

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

PLANNED PARENTHOOD OF SOUTHWEST AND CENTRAL FLORIDA, on behalf of itself, its staff, and its patients, *et al.*, Plaintiffs, v. STATE OF FLORIDA, *et al.*, Defendants.	**Case No. 2022 CA 912**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Findings of scientific reviews

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

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

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[2] Nada L. Stotland, *Induced Abortion and Adolescent Mental Health*, 23 Current Opinion. Obstetrics and Gynecology 340, 341 (2011a).
[3] APA Task Force Report 2008, at 5.
[4] *See id.* at 21–22.

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

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

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

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[5] *Id.* at 21.
[6] *Id.*
[7] *Id.* at 88.
[8] *Id.* at 92.
[9] Dr. Skop's critique of the APA Task Force Report's finding is unfounded. Skop Decl. ¶ 41. Her complaint that the Task Force should have made a broader conclusion ignores that it would have been inappropriate for the Task Force to do so given the state of literature at the time of the review.
[10] Charles et al. (2008), *supra* note 1.

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

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

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[11] Major et al. (2009), *supra* note 1.
[12] *Id.* at 885.
[13] *Id.* at 868–69, 884–85.
[14] Jenneke van Ditzhuijzen et al., *Psychiatric History of Women Who Have Had an Abortion*, 47 J. Psychiatric Res. 1737, 1741 (2013); Anne C. Gilchrist et al., *Termination of Pregnancy and Psychiatric Morbidity*, 167 Brit. J. Psychiatry 243, 247 (1995); Brenda Major et al., *Psychological Responses of Women After First-Trimester Abortion*, 57 Archives Gen. Psychiatry 777, 781 (2000); Julia R. Steinberg et al., *Psychosocial Factors and Pre-Abortion Psychological Health: The Significance of Stigma*, 150 Soc. Sci. & Med. 67, 73 (2016); Julia R. Steinberg & Nancy F. Russo, *Abortion and Anxiety: What's the Relationship?*, 67 Soc. Sci. & Med. 238, 245 (2008); Julia R. Steinberg et al., *Abortion and Mental Health: Findings from the National Comorbidity Survey-Replication*, 123 Obstetrics & Gynecology 263, 267 (2014); *see also* Jenneke van Ditzhuijzen et al., *Correlates of Common Mental Disorders Among Dutch Women Who Have Had an Abortion: A Longitudinal Cohort Study*, 49 Persp. on Sexual & Reprod. Health 123, 129 (2017); Trine Munk-Olsen et al., *Induced First-Trimester Abortion and Risk of Mental Disorder*, 364 N. Eng. J. Med. 332, 336 (2011).

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

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

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

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[15] Major et al. (2009), *supra* note 1, at 884.
[16] Gail Robinson et al., *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Brit. J. Psych. 78 (2012); Gail Robinson et al., *Is There an "Abortion Trauma Syndrome"? Critiquing the Evidence*, 17 Harv. Rev. Psych. 268 (2009); Nada L. Stotland, *The Myth of the Abortion Trauma Syndrome*, 268 JAMA 2078 (1992); Nada L. Stotland, *Assessing the Mental Health Impact of Induced Abortion*, 1 Medscape Women's Health 1 (1996); Nada L. Stotland, *Psychosocial Aspects of Induced Abortion*, 40 Clinical Obstetrics & Gynecology 673 (1997); Nada L. Stotland, *Abortion: Social Context, Psychodynamic Implications*, 155 Am. J. Psych. 964 (1998a); Nada L. Stotland, *Comments on Abortion*, 155 Am. J. Psych. 1305 (1998b); Nada L. Stotland, *Psychiatric Issues Related to Infertility, Reproductive Technologies, and Abortion*, 29 Primary Care: Clinics in Off. Prac. 13 (2002); Nada L. Stotland, *Abortion and Psychiatric Practice*, 9 J. Psych. Prac. 139 (2003); Nada L. Stotland, *Psychiatric Aspects of Induced Abortion*, 199 J. Nervous & Mental Disease 568 (2011b).
[17] Nada L. Stotland, *Induced Abortion and Adolescent Mental Health*, 23 Current Opinion, Obstetrics and Gynecology 340, 341 (2011a).
[18] Julia R. Steinberg, *Later Abortions and Mental Health: Psychological Experiences of Women Having Later Abortions—A Critical Review of Research*, 21 Womens Health Issues S44 (2011a).
[19] Lawrence B. Finer et al. *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334, 335 (2006).

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

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

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

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[20] Steinberg (2011a), *supra* note 14, at S46.
[21] *Id.* at S47.
[22] About Us, Academy of Medical Royal Colleges, https://www.aomrc.org.uk/about-us/ (last accessed June 23, 2022).
[23] National Academies Report at 150 (citing NCCMH Report).
[24] NCCMH Report at 8.

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

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

[26] National Academies Report at 149.

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

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

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

[27] Skop Decl. at ¶48.
[28] National Academies Report at 150.
[29] *Id.* at 150–51.

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

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

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

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

[31] Skop Decl. ¶ 48.

Indeed, our rate of attrition of about five percent from wave to wave represents excellent participant retention compared to other research in the field and is, in fact, a study strength. Furthermore, the lack of differential loss to follow-up[32] based on mental health history as well as our ability to control for history of mental health conditions, child abuse and neglect, and substance use mitigates concerns of bias. Concern about bias due to low study participation is further lessened by the consistent findings in our sensitivity analyses restricted to sites with more than 50% participation. To take into account missing observations that naturally occur from longitudinal designs, we used mixed effects regression models, which protect against bias owing to loss to follow up that is predictable from previously measured factors.

b. Findings of high-quality individual studies

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

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

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

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

- ***Suicidal ideation and behaviors.*** Recent high-quality evidence shows that having an abortion does not increase women's risk of suicidal thoughts.[35] Nevertheless, Dr. Skop's assertion[36] that those who have had an abortion have an increased risk of death from suicide disregards the fact that the only studies showing that abortion increases the risk of suicide or suicidal ideation have neglected to account for pre-existing mental health conditions, thereby rendering their results meaningless.[37]
- ***Alcohol use.*** Prospective studies indicate that induced abortion is not associated with an increase in subsequent alcohol use or alcohol use disorders.[38] Moreover, analyses of Turnaway Study data find that having an abortion does not lead to increases in heavy episodic drinking or potentially problematic alcohol use over five years after having an abortion, and that women with more problematic alcohol use are in fact unable to reduce their drinking when they are unable to obtain an abortion.[39]
- ***Drug use.*** The strongest evidence suggests that having an abortion does not increase women's risk of using illicit drugs.[40] Although Dr. Skop suggests that mental health issues stemming from abortion "may contribute to drug overdoses," she provides no

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

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

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

[36] Skop Decl. at ¶¶ 27, 41, 48.

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

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

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

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

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

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

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

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[41] Skop Decl. ¶ 27.

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

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

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

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

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

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

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

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

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

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

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

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

[49] Lauren J. Ralph et al., *Measuring Decisional Certainty Among Women Seeking Abortion*, 95 Contraception 269, 276 (2017)
[50] *Id.* at 276.
[51] Skop Decl. ¶¶ 27, 41, 42, 44, 48

and pointing to serious methodological concerns that rendered her conclusions meaningless.[52] [53]

30. Another serious methodological flaw with many of the studies Dr. Skop cites is use an inappropriate comparator group. As previously noted, in order to assess whether abortion impacts mental health outcomes, it is important to utilize comparison groups, and to ensure that they are as similar as possible to the group of women obtaining an abortion. It is scientifically unsound to rely on lower-quality studies that compare women who have abortions to women who have never been pregnant[54] or to women with intended pregnancies that are carried to term[55], as Dr. Skop does, when we have more rigorous studies with appropriate comparison groups, such as the Turnaway Study, available.

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

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

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

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

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

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

[56] Coleman et al. (2002a), *supra* note 42, at 1674; Coleman et al. (2002b), *supra* note 55, at 144; Cougle et al. (2003), *supra* note 55, at 159; Gissler et al. (2005), *supra* note 55, at 459;.
[57] Major et al. (2009), *supra* note 1, at 868–69, 884–85.
[58] Fergusson et al. (2008), *supra* note 42..
[59] Fergusson et al. (2008), *supra* note 42. The study explains that at the time, abortion in New Zealand was only allowed if the following conditions were met: Two certifying consultants must then agree: 1) that the pregnancy would seriously harm the life, physical or mental health of the woman or baby; or 2) that the pregnancy is the result of incest; or 3) that the woman is severely mentally handicapped.
[60] *Id.*
[61] *Id.*

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

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

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

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[62] *See, e.g.*, Coleman et al. (2002a), *supra* note 42, at 1674; Coleman et al. (2005), *supra* note 42, at 260; Priscilla K. Coleman, *Resolution of Unwanted Pregnancy During Adolescence Through Abortion Versus Childbirth: Individual and Family Predictors and Psychological Consequences*, 35 J. Youth & Adolescence 903, 906 (2006); Cougle et al. (2003), *supra* note 55, at 159.
[63] Coleman (2006), *supra* note 55, at 906.
[64] Radha Jagannathan, *Relying on Surveys to Understand Abortion Behavior: Some Cautionary Evidence*, 91 Am. J. Pub. Health 1825 (2001).
[65] Coleman et al. (2002a), *supra* note 42, at 1674; Coleman (2006), *supra* note 62; Cougle et al. (2003), *supra* note 55.
[66] Skop Decl. ¶ 48.
[67] *See e.g.*, Coleman et al. (2002a), *supra* note 42; Coleman et al. (2002b), *supra* note 55; Cougle et al. (2003), *supra* note 55; Jesse R. Cougle et al., *Generalized Anxiety Following Unintended Pregnancies Resolved Through Childbirth: A Cohort Study of the 1995 National Survey of Family Growth*, 19 J. Anxiety Disorders 137 (2005).

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

35. Studies from countries where the legal status of abortion is quite different from the United States, such as Russia[69] and New Zealand,[70] cannot be presumed generalizable, although Dr. Skop nonetheless relies on such studies. This is especially important when studies include people from countries with significantly different cultural or legal contexts, or for example from countries where a person can only obtain an abortion for mental health reasons, thereby biasing conclusions.

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

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

[68] Julia R. Steinberg & Nancy Felipe Russo, *Evaluating Research on Abortion and Mental Health*, 80 Contraception 500, 502 (2009).
[69] *Id.* ¶ 41.
[70] *Id.* ¶ 48.
[71] Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions*, 108 Am. J. Pub. Health 407, 410 (2018).

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

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

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

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[72] *Id.*
[73] M. Antonia Biggs et al., *Does Abortion Reduce Self-Esteem and Life Satisfaction?*, 23 Quality Life Res. 2505, 2509 (2014); M. Antonia Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74 JAMA Psych. 169, 179 (2017).
[74] Ushma D. Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC Women's Health 102, 108–9 (2015).
[75] Sarah C.M. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Med. 144, 147 (2014b).

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

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

Dated: June 23, 2022.

Antonia Biggs, Ph.D.

Prepared: June 22, 2022

University of California, San Francisco

CURRICULUM VITAE

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EDUCATION

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

PRINCIPAL POSITIONS HELD

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

OTHER POSITIONS HELD CONCURRENTLY

2008 - 2010	University of Chile, Santiago, Chile	Consultant	Center for Adolescent Reproductive Medicine and Development

Prepared: June 22, 2022

HONORS AND AWARDS

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

KEYWORDS/AREAS OF INTEREST

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

PROFESSIONAL ACTIVITIES

Memberships

2000 - present American Public Health Association

2013 - present Society of Family Planning, Fellow

Service to Professional Organizations

2016 - 2018	Ibis Reproductive Health, OTC OC working group	Member
2019 - 2021	Society of Family Planning (SFP) grant review committee, Emerging Scholars in Family Planning	Grant reviewer
2020 - 2020	Latin American Consortium Against Unsafe Abortion (CLACAI): Evaluation committee: Initiatives to increase access to sexual and reproductive health services in the context of COVID-19	Grant reviewer

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

SERVICE TO PROFESSIONAL PUBLICATIONS

2022 - 2022	Ad hoc referee: BMC Women's Health, Contraception, Journal Adolescent Health Perspectives on Sexual and Reproductive Health
2021 - 2021	Ad hoc referee: BMC Psychiatry; BMJ; BMJ Global Health; Clinical and Experimental Obstetrics and Gynecology; Contraception; The Lancet Regional Health Americas; Journal Adolescent Health; Perspectives on Sexual and Reproductive Health; Sexual and Reproductive Health Matters; Sexuality Research and Social Policy; Social Science and Medicine; Social Science Research; Women's Health Issues.
2019 - 2019	Ad hoc referee: American Journal of Public Health; BMC Pregnancy and Childbirth; Contraception; Journal of Adolescent Health; Journal of Affective Disorders; Perspectives on Sexual and Reproductive Health; The BMJ; Social Currents; Women's Health Issues; Women and Health
2020 - 2020	Ad hoc referee: BMC Medical Education; BMJ Open; BMJ Sexual & Reproductive Health; Contraception; Current Psychology; The European Journal of Contraception and Reproductive Health Care; Journal of Happiness Studies; Journal Health Care Poor and Underserved; Politics, Groups and Identities; Sexual and Reproductive Healthcare; Sexuality, Research and Social Policy; Women's Health Issues.
2018 - 2018	Ad hoc referee: Culture, Health and Sexuality; Journal of Reproductive and Infant Psychology; Journal of Psychiatric Research; Human Reproduction; Maternal and Child Health Journal; Perspectives on Sexual and Reproductive Health; Social Science and Medicine
2017 - 2017	Ad hoc referee: American Journal of Public Health; Demography; Human Reproduction; JAMA; JAMA-Psychiatry; Obstetrics and Gynecology; Social Science and Medicine
2016 - 2016	Ad hoc referee: American Journal of Transplantation; BJOG; BMC-Women's Health; Contraception; Journal of Adolescent Health; New England Journal of Medicine; Psychological Medicine; Obstetrics and Gynecology
2013 - 2016	Associate Editor: BMC Women's Health
2015 - 2015	Ad hoc referee: American Journal of Preventive Medicine; BMC-Health Services Research; BMC Women's Health; BMJOpen; International Journal of Health Policy and Management; Obstetrics Gynecology; Women's Health Issues
2013 - 2013	Ad hoc referee: American Journal of Public Health; BMC Women's Health; Health Services Research; Hispanic Health Care International; Journal of Immigrant and Minority Health; The Lancet; PlosOne; Social Science and Medicine; Stigma, Research, and Action; Women's Health Issues
2012 - 2012	Ad hoc referee: Contraception; Women's Health Issues
2011 - 2011	Ad hoc referee: Journal of Research on Adolescence; Journal of Women's Health

INVITED PRESENTATIONS

INTERNATIONAL

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

NATIONAL

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

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

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

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

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

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

UNIVERSITY AND PUBLIC SERVICE

UNIVERSITY SERVICE

DEPARTMENTAL SERVICE

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

PUBLIC SERVICE

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

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

PEER REVIEWED PUBLICATIONS

1. Galler JR, Harrison RH, **Biggs MA**, Ramsey F, Forde V. Maternal moods predict breastfeeding in Barbados. Journal of Developmental and Behavioral Pediatrics, 1999 Apr, 20(2): 80-7.
2. Driscoll AK, **Biggs MA**, Brindis CD, Yankah E. Adolescent Latino Reproductive Health: A review of the literature. Hispanic Journal of the Behavioral Sciences, 2001 Oct, 23(3): 255-326.
3. Brindis CD, Llewelyn L, Marie K, Blum M, Biggs A, Maternowska C. Meeting the reproductive health care needs of adolescents: California's Family Planning Access, Care, and Treatment (Family PACT) Program. Journal Adolescent Health. 2003 Jun; 32(6 Suppl):79-90.
4. McConnell J, Packel L, **Biggs MA**, Chow JM, Brindis C. Integrating Chlamydia Trachomatis Control Services for Males in Female Reproductive Health Programs. Perspectives on Sexual and Reproductive Health. 2003 Sept/Oct, 35(5):226-228.
5. Foster DG, **Biggs MA**, Amaral G, Brindis C, Navarro S, Bradsberry M, Stewart F. Estimates of Pregnancies Averted Through California's Family Planning Waiver Program in 2002. Perspectives on Sexual and Reproductive Health. 2006 Sep;38(3):126-31.
6. Amaral G, Foster DG, **Biggs MA**, Jasik CB, Judd S, Brindis CD. Public Savings from the Prevention of Unintended Pregnancy: A Cost Analysis of Family Planning Services in California. Health Services Research 2007 Oct;42(5):1960-80.
7. Foster DG, **Biggs MA**, Ralph LJ, Arons A, Brindis CD. Family planning and life planning reproductive intentions among individuals seeking reproductive health care. Women's Health Issues. 2008 Sep-Oct;18(5):351-9.
8. Foster DG, Rostovtseva DP, Brindis C, **Biggs MA**, Hulett D, Darney PD. Cost-Savings from the Provision of Specific Methods of Contraception. American Journal of Public Health. 2009;99: 446-451.
9. **Biggs MA**, Ralph L, Minnis AM, Arons A, Marchi LS, Lehrer JA, Braveman PA, Brindis CD. Factors associated with delayed childbearing: from the voices of expectant Latina adults and teens in California. Hispanic Journal of Behavioral Science. 2010;32(1) 77–103.
10. Foster DG, Higgins JA, **Biggs MA**, McCain C, Holtby S, Brindis CD. Willingness to have unprotected sex. Journal of Sex Research. 2011;0(0), 1–8.
11. Schwartz SL, Brindis CD, Ralph LJ, **Biggs MA**. Latina adolescents' perceptions of their male partners' influences on childbearing: findings from a qualitative study in California. Cult Health Sex. 2011 Sep;13(8):873-86.
12. Foster DG, **Biggs MA**, Rostovtseva D, de Bocanegra HT, Darney PD, Brindis CD. Estimating the fertility effect of expansions of publicly funded family planning services in California. Women's Health Issues. 2011 Nov-Dec;21(6):418-24.
13. **Biggs MA**, Karasek D, Foster DG. Unprotected Intercourse among Women Wanting to Avoid Pregnancy: Attitudes, Behaviors, and Beliefs. Women's Health Issues. 2012 May;22(3):e311-8.
14. Minnis AM, Marchi K, Ralph L, **Biggs MA**, Combellick S, Arons A, Brindis CD, Braveman P. Limited socioeconomic opportunities and Latina teen childbearing: A qualitative study of family and structural factors affecting future expectations. J Immigr Minor Health. 2012 Jun 8.

15. Foster DG, **Biggs MA**, Grossman D, Schwarz EB. Interest in a pericoital pill among women in family planning and abortion clinics. Contraception. 2013;88(1):141–146. doi:10.1016/j.contraception.2013.01.004
16. **Biggs MA**, Combellick S, Arons A, Brindis CD. Educational barriers, social isolation, and stable romantic relationships among pregnant immigrant Latina teens. Hispanic Health Care International. 2013 Mar;11(1): 38-46.
17. **Biggs MA**, Foster DG. Misunderstanding the risk of conception from unprotected and protected sex. Women's Health Issues. 2013 Jan;23(1):e47-53.
18. Foster DG. **Biggs MA**, Malvin J, Bradsberry M, Darney PD, Brindis CD. Cost-savings from the provision of specific contraceptive methods in 2009. Women's Health Issues. 2013 Jul:23(4):e265-e271.
19. **Biggs MA**, Gould H, Foster DG. Understanding why women seek abortions in the US. BMC Women's Health. 2013, 13:29. DOI: 10.1186/1472-6874-13-29
20. **Biggs MA**, Arons A, Turner R, Brindis CD. Same-day LARC insertion attitudes and practices. Contraception. 2013 Nov;88(5):629-35.
21. Chibber K, **Biggs MA**, Roberts S, Gould H, Foster DG. The role of intimate partners in women's reasons for seeking abortion. Women's Health Issues. 2014 Jan-Feb;24(1):e131-8.
22. Harris LF, Roberts SC, **Biggs MA**, Rocca CH, Foster DG. Perceived stress and emotional social support among women who are denied or receive abortions in the United States: a prospective cohort study. BMC Women's Health. 2014; 14:76.
23. **Biggs MA**, Harper CC, Malvin J, Brindis C. California providers' attitudes and provision of long-acting reversible contraception? Obstetrics & Gynecology. 2014; 23(3):593-602.
24. **Biggs MA**, Upadhyay UD, Steinberg JR, Foster DG. Does abortion reduce self-esteem and life satisfaction? Quality of Life Research. 2014 Nov;23(9): 2505-13.
25. Roberts SCM, **Biggs MA**, Chibber KS, Gould H, Rocca CH, Foster DG. Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion. BMC Medicine. 2014 Sep 29;12(1):144.
26. **Biggs MA**, Rocca CH, Brindis CD, Hirsch H, Grossman D. Did increasing use of highly effective contraception contribute to declining abortions in Iowa? Contraception. 2015 Feb;91(2):167-73.
27. Foster DG, Roberts S, Steinberg J, Neuhaus J, **Biggs MA**. A comparison of depression and anxiety symptom trajectories between women who had an abortion and women denied one. Psychological Medicine. 2015 Jan 28;1-10.
28. Foster DG, **Biggs MA**, Phillips KA, Grindlay K, Grossman D. Potential public sector cost-savings from over-the-counter access to oral contraceptives. Contraception. 2015 May;91(5):373-9.
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Prepared: June 22, 2022

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2. Driscoll AL, **Biggs MA**, Brindis C. The influence of acculturation on Latino adolescent childbearing. NOAPPP Network. 2003, 22(4):14-15.
3. **Biggs MA**, Brindis CD, Ralph L, Santelli J. The Sexual and Reproductive Health of Young Latino Men Living in the US, In Molina-Aguirre M. (Ed) Social and Structural Factors Affecting the Health of Latino Males in the US. Published by Rutgers University Press, Newark, New Jersey (2010).

OTHER PUBLICATIONS

1. **Biggs MA**. "Women's Mental Health Suffers When They are Denied an Abortion," Op-ed featured in Cosmopolitan, Dec 15, 2016, http://www.cosmopolitan.com/politics/a8504673/womens-mental-health-suffers-if-denied-abortion/
2. "A Review of the Scientific Literature on the Effects of Abortion on Women's Mental Health and Emotional Outcomes", Amicus Brief, (lead author), submitted to Chile's constitutional tribunal to support lifting Chile's complete ban on abortion.
3. **Biggs MA**. "Chile Has Relaxed Its Abortion Ban, But Does That Go Far Enough?" Op-ed featured in Rewire magazine, Aug 29, 2017, https://rewire.news/article/2017/08/29/chile-relaxed-abortion-ban-go-far-enough/
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5. **Biggs MA** & Grossman D. "With abortion clinic restrictions tightening, women want more access at home", Op-ed featured in Salon, Nov 28, 2018, https://www.salon.com/2018/11/28/with-abortion-clinic-restrictions-tightening-women-want-more-access-at-home/

OTHER CREATIVE ACTIVITIES

1. **Biggs MA**. Puerto Rican adolescents' cultural orientation: Contextual determinants and psychosocial outcomes. Doctoral dissertation. 1998.
2. Brindis CD, Cagampang H, Biggs A, McCarter V. 2000. Report of the Evaluation Enhancement: The Community Challenge Grant Program. Prepared for the U.S. DHHS, Office of the Assistant Secretary for Planning and Evaluation, Grant 98ASPE296A.
3. Brindis CD, Driscoll AK, **Biggs MA**, Valderrama LT. 2002. Issue Brief on Latino Youth: Reproductive Health. University of California, San Francisco, Center for Reproductive Health Research and Policy, Department of Obstetrics, Gynecology and Reproductive Health Sciences and the Institute for Health Policy Studies, San Francisco, CA.
4. Brindis CD, Driscoll AK, **Biggs MA**, Valderrama LT. 2002. Series of Fact Sheets on Latino Youth: Education, Families, Health Care Access, Income and Poverty, Immigrant Generation, Sexual Behavior, & Population. University of California, San Francisco, Center for Reproductive Health Research and Policy, Department of Obstetrics, Gynecology and Reproductive Health Sciences and the Institute for Health Policy Studies, San Francisco, CA.
5. Driscoll, AK, Brindis, CD, **Biggs, MA**, & Valderrama, LT. 2004. Priorities, Progress and Promise: A Chartbook on Latino Adolescent Reproductive Health. San Francisco, CA: University of California, San Francisco, Center for Reproductive Health Research and

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6. Driscoll A, **Biggs MA**, Brindis CD. 2003. The Influence of Acculturation on Latino Adolescent Childbearing. Cultural Dimensions of Teen Pregnancy Prevention and Parenting, 22(4): 14-15.
7. Amaral G, **Biggs MA**, et al. Bixby Center for Global Reproductive Health. UCSF. April 2005. Family PACT Program evaluation: Provider referral study, San Francisco, CA. Submitted to California Department of Public Health, Office of Family Planning.
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14. A Question of Hope: Reducing Latina Teen Childbearing in California, Video produced and directed by Lynn Adler and John Rogers of Ideas In Motion, based on a report by Braveman P, Brindis C, **Biggs A**, Marchi K, Minnis A, and Ralph L. University of California, San Francisco. September 2008. http://bixbycenter.ucsf.edu/videos/video-lo-1.html
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16. **Biggs MA**, Rostovtseva D, Brindis CD. Bixby Center for Global Reproductive Health. UCSF. Findings from the 2007 Family PACT Client Exit Interviews, San Francisco, CA. Submitted to CA Department of Public Health, Office of Family Planning Division. July 2009. http://bixbycenter.ucsf.edu/publications/files/FPACT_ClientExitInterview_2007
17. **Biggs MA**, Foster DG, Hulett D, and Brindis C. Series of Cost-Benefit Fact Sheets: Is California's Family PACT Program a good investment? Findings from the 2007 Family PACT Cost-Benefit Analysis; Prevention of Unintended Pregnancies in California: California State Senate and Assembly Districts; California's Family PACT Program: County Successes & Challenges. University of California, San Francisco, Bixby Center for Global Reproductive Health, University of California, San Francisco, San Francisco, CA. October 2010.
18. **Biggs MA**, Foster DG, Hulett D, and Brindis C. Cost-Benefit Analysis of the California Family PACT Program for Calendar Year 2007. Submitted to the California Department of

Public Health, Office of Family Planning Division. Bixby Center for Global Reproductive Health, University of California, San Francisco: San Francisco, CA. April 2010.

19. Obach King A, Sadler Spencer M, Luengo Charath MX, **Biggs MA**. Adolescent Barriers to Accessing Pregnancy Prevention Services in Chile. Submitted to the Ministry of Health, Chile, March 2010. http://www.minsal.gob.cl/portal/url/item/ace74d077631463de04001011e011b94.pdf
20. Foster DG, Malvin J, **Biggs MA**, Bradsberry M, Brindis C and Darney P. Cost Benefits from the Provision of Specific Methods of Contraception in 2009. Submitted to the California Department of Public Health, Office of Family Planning Division. Bixby Center for Global Reproductive Health, University of California, San Francisco: San Francisco, CA. April 2012. http://www.familypact.org/Research/reports/FINAL_CBA-SM_ExecSummary_508.pdf
21. **Biggs MA**, Brindis C and Darney P. Delivery of Long-Acting Reversible and Permanent Contraception (LAC) Among Female Family PACT Clients.Submitted to the California Department of Public Health, Office of Family Planning Division. Bixby Center for Global Reproductive Health, University of California, San Francisco: San Francisco, CA. June 2012.
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24. **Biggs MA**. Effects of Abortion on Women's Mental Health, as part of UCSF's Bixby Center Explained video series. http://innovating-education.org/2017/01/explained-series-topics/

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

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

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

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

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

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

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

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

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

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

Board certification
Maternal-Fetal Medicine 2018
Obstetrics and Gynecology 2013

Memberships
Society for Maternal-Fetal Medicine
2012 – current
American College of Obstetricians and Gynecologists
2008 – current

Committees

Northshore University Health System Obstetric Practice Committee - Chair, 2016 – 2020
- Educational committee that creates physician guidelines and nursing protocols for obstetric care for Evanston and Highland Park hospitals.

Northshore University Health System Epic Physician builder, 2018 – 2020
- Developed and implemented obstetric clinical workflows for our Epic electronic medical record system.

Illinois Perinatal Quality Collaborative (ILPQC) - Clinical lead for the Immediate Postpartum Long Acting Reversible Contraception initiative, 2018 – 2020
- Implementation of immediate postpartum LARCs for patients at Evanston and Highland Park hospitals.
- Provision of educational support for other birthing hospitals in the state.

Maternal-Fetal Medicine Clinical Competency Committee, 2018 - 2020
- Biannual meeting and evaluation of educational progress for maternal-fetal medicine fellows.

Volunteer Experience

Medical Students for Choice (MSFC), Massachusetts, 09/2003-04/2008
Student coordinator
- Facilitated multiple lectures and workshops on reproductive education and contraception.
- Organized the 2005 regional student conference for MSFC.

Cross Cultural Solutions, Ghana, 06/2003-07/2003
Medical Volunteer
- Volunteered through the organization Cross Cultural Solutions.
- Provided immunizations to children, assisted in the local health center pharmacy, and taught women's health education in the maternity ward.

Provena Mental Health, Illinois, 04/2001-05/2002
Suicide Hotline Volunteer
- Volunteer counselor on the suicide hotline.

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

Rape Crisis Services, Illinois, 05/2000-05/2003
Medical Advocate and Hotline Volunteer

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

Publications

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

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

Tien S, Villines D, Parilla B. Gestational Weight Gain in Obese Patients and Adverse Pregnancy Events. Health 2014;6:1420-1428.

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

Publications, non-peer reviewed

Rugino A, Tien SH. Strip of the Month: Complete Heart Block Masquerading as a Reactive Nonstress Test. NeoReviews November 2018, Volume 19/Issue 11.

Rodriguez-Kovacs J, Tien SH, Plunkett BA. Selective Serotonin Reuptake Inhibitor Use in Pregnancy: Repercussions on the Oblivious Passenger. NeoReviews March 2018, Volume 19/Issue 3.

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

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

Presentations

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

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

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

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

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

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

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

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

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

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EXHIBIT B

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

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

Plaintiffs, Case No. 2022 CA 000912

v.

STATE OF FLORIDA, et al.,

Defendants.
_____/

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

DATE TAKEN: Monday, June 27, 2022

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

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

Reported by:
Doreen Mannino, Certified Court Reporter

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

P R O C E E D I N G S

(Proceedings continued from Volume I.)

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

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

MR. GUARD: Thank you, Your Honor.

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

BY MR. GUARD:

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

A. Yes.

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

A. That is correct.

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

A. Yes.

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

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

MR. GUARD: Sorry, Your Honor.

THE COURT: -- equal level.

MR. GUARD: Sure.

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

MR. GUARD: Sorry, Your Honor.

THE COURT: Okay.

BY MR. GUARD:

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

A. Yes.

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

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

MR. GUARD: Page 53, line 11.

BY MR. GUARD:

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

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

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

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

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

A. Yes.

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

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

A. I have not reviewed the charts.

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

A. I have not spoken with them.

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

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

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

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

BY MR. GUARD:

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

A. Yes.

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

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

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

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

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

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

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

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

Arizona is 200,000.

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

A. Yes.

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

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

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

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

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

A. I have never testified in a court setting.

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

THE COURT: That's a very broad question. Lawyers understand what you mean. When you say has she ever offered an opinion that could be the next door neighbor. I understand what you mean. You're limiting it to as expert witness.

BY MR. GUARD:

Q. In a court case, Dr. Tien?

THE COURT: Okay.

BY MR. GUARD:

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

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

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

A. Yes.

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

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

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

A. I consider that being pro-choice.

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

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

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

THE COURT: Sure.

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

THE COURT: Thank you, Counselor. Redirect.

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

REDIRECT EXAMINATION

BY MS. SANDMAN:

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

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

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

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

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

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

BY MS. SANDMAN

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

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

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

A. Yes.

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

A. No.

Q. Why not?

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

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

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

A. No.

Q. Why is that?

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

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

A. Yes.

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

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

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

A. It does not.

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

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

MS. SANDMAN: No further questions.

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

Call your next witness.

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

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

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

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

THE COURT: No.

MS. WHITE: Thank you.

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

MS. WHITE: Understood.

THE COURT: Defense Counsel.

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

THE COURT: Thank You. All right.

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

All right. Who's next? Witness?

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

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

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

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

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

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

DR. CONDIC: I do.

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

THEREUPON,

MAUREEN CONDIC,

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

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

BY MR. FARUQUI:

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

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

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

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

Q. In what subject matter are you a professor?

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

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

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

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

A. Since 1997.

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

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

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

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

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

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

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

of specific systems?

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

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

A. Oh, yes.

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

A. Yes.

Q. Have you refereed any scientific journals?

A. Yes.

Q. Have you won any awards in your field?

A. Yes, I have.

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

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

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

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

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

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

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

BY MR. FARUQUI:

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

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

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

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

BY MR. FARUQUI:

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

A. Yes, I have.

Q. Do you recall how many times?

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

Q. And your court testimony what was the subject

matter of the testimony at those times?

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

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

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

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

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

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

MR. FARQUI: Thank you, Your Honor.

BY MR. FARQUI:

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

A. Yes, it does.

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

A. I was contacted by the attorneys representing

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

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

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

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

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

THE COURT: You may proceed.

MR. FARQUI: May it please the Court.

THE COURT: Yes.

BY MR. FARQUI:

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

A. Yes, I am.

Q. And are those rates specified in your declaration?

A. Yes, they are.

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

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

Q. What did you consider in formulating your opinions?

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. FARUQUI: Thank you, Your Honor.

BY MR. FARUQUI:

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

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

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

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

A. Yes.

Q. And could you briefly explain why?

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

Q. Is the zygote considered a new human being?

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

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

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

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

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

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

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

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

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

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

THE WITNESS: 12 to 18 weeks.

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

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

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

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

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

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

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

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

THE COURT: So are some IUDs abortions then?

THE WITNESS: Some IUDs could be considered

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

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

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

THE COURT: That would be prelife then.

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

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

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

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

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

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

THE WITNESS: Typically less than 15 weeks.

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

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

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

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

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

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

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

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

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

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

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

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

BY MR. FARUQUI:

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

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

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

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

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

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

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

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

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

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

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

consciously perceiving pain?

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

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

A. No.

Q. And why not?

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

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

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

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

A. Yes. In my report I outline 12 independent

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COURT: 2005.

THE WITNESS: 2005.

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

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

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

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

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

third trimester is that the essential?

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

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

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

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

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

THE WITNESS: Yes, sir.

THE COURT: Does it have position on these issues?

THE WITNESS: On fetal pain?

THE COURT: Yes, ma'am.

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

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

MS. CHRISTMAS: They do.

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

MS. SANDMAN: Objection, Your Honor.

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

MS. SANDMAN: Objection to Counsel.

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

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

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

MR. FARUQUI: May it please the Court?

THE COURT: Yes.

BY MR. FARUQUI:

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

THE COURT: Page 39. Okay.

THE WITNESS: Paragraph 85?

BY MR. FARUQUI:

Q. Yes.

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

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

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

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

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

Q. And is there really a consensus in the

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

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

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

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

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

THE COURT: Okay. Cross.

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

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

THE COURT: Okay. Thank you.

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

BY MS. SACERDOTE:

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

A. Yes.

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

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

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

A. Yes.

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

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

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

A. Correct.

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

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

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

A. Correct.

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

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

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

A. Correct.

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

A. Correct.

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

A. Other than my own children, no.

Q. So no clinical care?

A. No clinical care.

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

A. No professional experience, correct.

Q. And no professional experience observing newborns?

A. Correct.

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

A. Correct.

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

A. Yes.

Q. And that's an important distinction?

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

Q. A reflex response does not necessarily mean

there is a conscious awareness of pain, correct?

A. Correct.

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

A. Hormonal stress response does not require consciousness.

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

A. That is generally accepted.

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

A. Correct.

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

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

place between 12 and 18 weeks.

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

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

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

A. Correct.

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

A. I will trust you on that, yes.

Q. Your testimony in that deposition was under oath?

A. Correct.

Q. So you understood that you were required to

tell the truth?

A. Yes.

Q. And you did in fact tell the truth?

A. Yes.

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

A. Yes.

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

A. It appears to be, yes.

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

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

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

THE COURT: I do, too.

BY MS. SACERDOTE:

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

A. Correct.

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

A. Correct.

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

A. Yes.

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

A. Yes.

Q. So starting at 118 line 22.

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

Answer: Correct.

Question: Okay.

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

Did you I read that correctly?

A. You did.

BY MS. SACERDOTE:

Q. You can set that document aside. So you

would agree that if the cortex is necessary to have a conscious awareness of pain then such an awareness would not be possible until 24 weeks LMP, correct?

A. With the caveat that I've already noted depending on how you view this transient subplate structure whether it's cortical or not cortical. So with the definition of cortex as being the cells that currently reside within your cortex today as an adult human, yes, I would agree.

Q. So setting aside the subcortical structures you just referenced?

A. The subplate structures.

Q. Thank you. I'll start again. Setting aside the subplate structures you just referenced you would agree that if the cortex is necessary to have a conscious awareness of pain then such an awareness would not be possible until 24 weeks LMP, correct?

A. If the cortex was necessary, yes.

Q. It is your opinion that it is difficult to make a clear, unambiguous case that the neurocircuitry for a fetus to have a conscious awareness of pain is in place by 18 weeks LMP; is that right?

A. It is my opinion that it is difficult to make a clear, unambiguous judgment on internal experience of any other human at any stage in life. And that

would include a fetus at any stage of development not because of the uncertainty of the data, but because of our inability to query the fetus regarding its experience.

Q. So it would be accurate to say it is your opinion that it is difficult to make a clear, unambiguous case that the neurocircuitry for a fetus to have a conscious awareness of pain is in place by 18 weeks LMP, correct?

A. No.

Q. So I'll ask you to turn to that Utah deposition again. The case is Planned Parenthood Association of Utah versus Miner, and this time I'll ask you to turn to page 268.

A. I'm there.

Q. Okay. I'll ask you to look at line 5. I'll read from there and ask you to follow along.

Question: So, Dr. Condic, would you say that 18 weeks LMP it's hard to make a clear, solid, unambiguous case that we have the neurocircuitry in place for a fetus to have a conscious awareness of pain?

Answer: Clear and unambiguous, yes, I would say it's difficult to make that case.

Question: At 18 weeks LMP, correct?

Answer: Yes.

Did I read that correctly?

A. You did.

BY MS. SACERDOTE:

Q. You can set that aside for now. So on direct you addressed ACOG's views on the issue of human fetal pain, correct?

A. RCOG's views, yes.

Q. Excuse me. So in your declaration you addressed ACOG's views on the issue of human fetal pain, correct?

A. I believe in my declaration I noted that ACOG has reiterated the conclusions of RCOG and has published an opinion piece without evidence. But I did not discuss ACOG's position beyond the fact that they reference RCOG.

Q. In your declarations you characterize ACOG's conclusions regarding human fetal pain as perplexing, correct?

A. I believe so.

Q. So you disagree with ACOG's views on human fetal pain?

A. In light of substantial evidence that I present in my declaration, I believe their conclusion is perplexing because it relies on no evidence.

THE COURT: I know what ACOG is, but I want to make sure we have this on the record. ACOG is American College of Obstetricians and Gynecologists, correct?

THE WITNESS: Correct.

THE COURT: And most board certified OB-GYNs are members of ACOG? I say most. I can't say all about anything.

THE WITNESS: I am not an obstetrician or gynecologist. I'm not familiar with what level of representation they have.

THE COURT: That's fine. RCOG again is the British version of ACOG because it's Royal College.

THE WITNESS: Yes.

THE COURT: Thanks.

BY MS. SACERDOTE:

Q. It's your view that ACOG likely has a significant conflict of interest on the topic of fetal pain?

A. No, I believe it's possible they have a conflict of interest.

Q. Dr. Condic, I asked if it's your view that ACOG likely has a significant conflict of interest on the topic of fetal pain, and did I hear you say that

your answer to that question is no?

A. May I consult my report to see exactly how I worded it?

Q. Let's all take a look at your report.

THE COURT: I think she said, no, it's possible they have a conflict of interest.

THE WITNESS: Yes, that was certainly my intention.

THE COURT: I don't know what the report says on that specific point, but that is what she answered here.

MS. SACERDOTE: Thank you, Your Honor.

BY MS. SACERDOTE:

Q. So let's all take a look at the declaration that you submitted in this case. So please turn to page 25, paragraph 62. Looking at paragraph 62 I'll read starting at the first sentence.

In considering this paradox, it's important to note that RCOG and ACOG represent the primary providers of abortion services both in the United States and the United Kingdom, and therefore the views of these societies are likely to entail significant conflicts of interest. Did I read that correctly?

A. You did.

Q. You can set that aside. And so it is also

your view that RCOG likely has a conflict of interest as well?

A. Based on my understanding of a conflict of interest, the type of conflict of interest statements I'm required to make as a professor in the University of Utah, this would certainly constitute a likely conflict of interest.

Q. On direct you discussed three studies cited by RCOG, correct?

A. Yes.

Q. And you still have your declaration in front of you, right?

A. Yes.

Q. So now I'd like to turn to page 25, paragraph 65.

A. Yes.

Q. So in this paragraph you talk about three studies, correct?

A. Yes.

Q. And the second study and I'll read from this paragraph. The declaration states, The second study, conducted in adults, demonstrates that multiple non-cortical regions are involved in pain perception. There is a parenthetical and then the sentence goes on. And provides no evidence that the cortex is

critically required for pain perception, correct?

A. Yes.

Q. There is a footnote 70 there, correct?

A. Yes.

Q. And the article referenced or cited in footnote 70 is Rosen, S.D. and Camici PG, The Brain-Heart Axis in the Perception of Cardiac Pain. Is that correct?

A. Yes.

Q. I'm going to ask Plaintiff's counsel to again hand you a document. This time it's what's been marked Condic 14.

THE COURT: Let me guess. That's Rosen and Camici's article.

MS. SACERDOTE: Yes. Excellent guess.

BY MS. SACERDOTE:

Q. So I'll ask the witness, looking at the first page of the document that's now before you it's titled, The Brain-Heart Axis in the Perception of Cardiac Pain The Elusive Link Between Ischaemia and Pain, correct?

A. Yes.

Q. And this is the Rosen article that we just referenced?

A. Yes.

Q. So if you turn to page 362, under the heading of Unified Perspective, which is in the left column. Excuse me. I'll ask you to look in the left column under the heading Unified Perspective?

A. Yes.

Q. So I'm looking at the third line from the bottom and I'm going to read from that article. The thalamus may have a key role in the perception of pain from the heart acting as a gate to afferent pain signals with cortical activation being necessary for the sensation of pain. Did I read that correctly?

A. You did.

Q. You can set that aside. In your direct testimony you also discussed an article published in Jama authored by Lee and other authors, correct?

A. Yes.

Q. And the Lee review's conclusion was that certain functional regions in the cortex are required to experience pain, correct?

A. I will assume that they said that at some place in their article. That is their general conclusion, yes.

Q. And it's your view that the authors of the Lee review also likely have a significant conflict of interest?

A. Some of the authors, yes.

Q. You're familiar with the Society for Maternal-Fetal Medicine?

A. Yes.

Q. You are aware that the Society for Maternal-Fetal Medicine has a view on the potential for fetal awareness of pain?

A. Yes. Recently published, yes.

Q. But you disagree with that view?

A. I disagree with that view, yes.

Q. And you chose not to include the Society for Maternal-Fetal Medicine's view in your declaration?

A. I made the judgment that my declaration was already quite long. Yes, so I did omit that particular paper. I believe that it is I address it that the reasons I do not find that argument persuasive are very similar if not identical.

Q. And you did not cite to the Society for Maternal-Fetal Medicine document in your declaration, correct?

A. I did not.

Q. You aren't aware of any medical or scientific professional organizations that have concluded that a fetus has a capacity to consciously experience pain prior to 24 weeks gestation; are you?

A. I am not a physician and I'm not familiar with the positions of all medical professional organizations.

Q. And you can't identify a single medical or scientific professional organization that has concluded that a fetus has a capacity to consciously experience pain prior to 24 weeks LMP, correct?

A. As I stated I'm not a medical professional. I'm not familiar with positions of all medical organizations that I am not familiar with anyhow.

Q. On direct you discussed 12 lines of evidence that you say clearly indicate that the cortex is not required for consciousness, correct?

A. I identified 12 lines of evidence that provide support for that conclusion, yes.

Q. But you don't assert that the authors of each of those studies in these 12 lines of evidence reach the same conclusion that you do, correct?

A. May I ask for a clarification? Are you asking me whether I assert the authors make a statement within the papers to the effect that the cortex is not required for fetal pain?

Q. I'm asking you whether the authors of the sources that you cite in your declaration or your proposition that a fetus can consciously experience

pain prior to 24 weeks agree with your conclusion on that point?

A. I have no idea what the author's saying. I know what they've written.

THE COURT: What page are we on on her report?

MS. SACERDOTE: Your Honor, I am not referring to a specific page. The question I'm asking relates to the 12 lines of evidence cited within her declaration.

THE COURT: Okay.

MS. SACERDOTE: And throughout the portions of her declaration that discuss these 12 lines of evidence a number of articles are cited.

THE COURT: Okay. I understand.

BY MS. SACERDOTE:

Q. It's your view that the kind of proof needed to prove a fetus experiences pain is not possible with any scientific evidence?

A. It's my opinion that it is impossible with scientific evidence to prove that any human experiences pain including a human fetus.

Q. You discussed on direct a Derbyshire and Brockman article, correct?

A. Yes.

Q. And is that an article titled, Reconsidering Fetal Pain?

A. Correct.

Q. In that article the authors question the necessity of the cortex for the apprehension of pain, correct?

A. Yes.

Q. And Derbyshire and Brockman do not state in their article that this immediate apprehension has a conscious component, correct?

A. The term apprehension is used in neuroscience to refer to a conscious emotional awareness that does not necessarily reflect a cognitive component. So they're making no assertion regarding whether or not a fetus thinks about painful experiences, but they are asserting that the fetus apprehends pain which means it has a conscious emotional awareness of pain.

Q. I understand that that's your conclusion, Dr. Condic. What I'm asking is whether Derbyshire and Brockman state that this immediate apprehension that they discussed has a conscious component?

A. That is what the meaning of the term apprehension is when it's used in scientific context.

Q. Do the authors say that this immediate apprehension has a conscious component?

A. The authors do not need to define a cognitive neuroscientific term within the context of the published article. They simply use it with the assumption that the reader will understand what it means.

Q. So they don't say that an immediate apprehension of pain has a conscious component?

A. They do not define the word apprehension, yes.

Q. You testified on direct that you're affiliated with the Charlotte Lozier Institute?

A. Yes.

Q. The Charlotte Lozier Institute's stated mission is to diminish and ultimately overcome what its mission characterizes as the scorch of abortion; is that correct?

A. I will trust that that is their mission.

Q. You testified on direct that you characterize yourself as pro-life?

A. I don't believe I testified to that.

Q. Excuse me. You would characterize yourself as pro-life?

A. I would characterize myself as a scientist and the scientific evidence has lead me to conclude that a human being exists from sperm-egg fusion and is

capable of pain experience. And those two conclusions have lead to me a position that protecting life is an important interest.

Q. It is your view that abortion should not be legal except when a pregnant person's life is at stake?

A. No.

Q. Okay. You were deposed in a North Carolina case regarding abortion in September of 2017, correct?

A. I will trust you on that.

Q. Well, let's see. Plaintiff's counsel is going to hand you what's been marked Condic 15, so I'll ask you to look on the first page in the top left corner of the document that you were just handed.

A. Yes.

Q. The first page states that this is a deposition of Maureen Condic, correct?

A. Yes.

Q. In a case captioned Amy Bryant versus Jim Little, correct?

A. Yes.

Q. And it's dated September 13, 2017?

A. Yes.

Q. And I should specify the document reflects that the deposition was taken on September 13, 2017,

correct?

A. Yes.

Q. So please turn to page 198.

A. Which page number are you referring to?

MS. SACERDOTE: Sure. This is one of the four panel deposition transcripts. Apologies to the court.

THE COURT: That's okay.

BY MS. SACERDOTE:

Q. So I am looking at within the four squares the page numbers listed in those four squares and we're turning to page 198.

A. Yes, I'm here.

Q. So I'll start reading at line 4 and then I'll skip some lines where the attorney and reporter are speaking and start again at line 12, and I'll ask that you follow along.

So line 4, Question: Well, do you think that abortion should ever be legal when a woman's life isn't at stake?

Line 12: The Witness: Excuse me while I try to run through all possible circumstances under which that situation could occur.

Question: Please take your time.

Answer: With a caveat in the absence of

extremely extenuating circumstances that I cannot imagine that might alter my opinion, I would say, no, abortion should not be legal in situations where a woman's life is not threatened immediately.

Did I read that correctly?

A. Yes, you did.

Q. And you can set that aside. You believe that abortion is the killing of a living human being?

A. Yes.

Q. And you believe that abortion is the killing of a full and complete human being?

A. Full and complete albeit in the immature stage of the life span.

MS. SACERDOTE: Your Honor, may have a moment to confer with my colleagues?

THE COURT: Sure.

MS. SACERDOTE: So one clarification for the record. The Condic declaration is Joint Exhibit 5 for the record, and with that I'll pass the witness.

THE COURT: Could I ask just a couple questions, Doctor? I think I read this right. Your opinion on fetal pain does it differ from the RCOG, ACOG and Society of Maternal-Fetal Health position? That's what my notes say. I want to

see if I'm right on that.

THE WITNESS: Yes, it does.

THE COURT: In looking at this deposition that was just cited here on page 199 it says you were asked if you had an opinion on contraception and you said you did not have an opinion on whether contraception should be legal. Is that still your opinion today?

THE WITNESS: I don't have that opinion.

THE COURT: You still have no opinion on it?

THE WITNESS: No opinion.

THE COURT: Okay. And you were asked about IVF, which is in vitro fertilization, short nonmedical term test-tube babies, but that's probably not approved as correct. But do you -- you were asked if you opposed the availability of procedures for women to get pregnant, and I'm not sure whether you said you opposed it or not. Could you just tell me what your opinion was then and is it the same now?

THE WITNESS: Well, I'm referring to my testimony on page 200.

THE COURT: Yes, ma'am.

THE WITNESS: And I did state at that time back in 2017 that IVF is largely an unregulated

medical practice that is legal in the United States. I think it has some very significant negative health consequences for women. I would qualify that today by saying for some women. And it clearly has negative medical consequences for children who are conceived, and I think that evidence has only grown stronger in the last five years. I think all of those things should be taken into consideration by anyone who's considering regulating the IVF industry.

THE COURT: Does in vitro fertilization does that in your opinion include the issues of abortion or termination of pregnancy?

THE WITNESS: I think they're quite different topics. I think that obviously they have some relationship to each other, but I believe that there are many different kinds of issues that face both those general areas.

THE COURT: I didn't hear part of your answer so I want to make sure. Do you still believe that IVF -- for some reason I have trouble saying those few letters -- IVF presents significant health consequences for women and the children conceived, or have you changed your opinion on that? That's what I didn't pick up.

THE WITNESS: I believe that today five years later I'm only more convinced that IVF practices as they are conducted in the United States have significant health consequences for some women and have significant health consequences for many if not all of the children conceived.

THE COURT: Okay. Thanks. That's all I had. Does that raise anything that Plaintiff's counsel wishes to go into?

MS. SACERDOTE: No, Your Honor.

THE COURT: Defense counsel is on redirect now. Do you have anything?

MR. FARQUI: No, Your Honor, we don't have any redirect.

THE COURT: Thank you, Doctor. I appreciate you coming all the way from Utah.

Do we have another witness?

MR. GUARD: Yes, Your Honor. I was going to suggest Dr. Skop has to go back home today so we were going to just try to power through if we can.

THE COURT: Let's have a ten-minute break. We'll back at 15 after and your next witness we'll get her in and out today. Thank you, we'll be back in ten minutes.

(A recess was taken from 3:05 p.m. to 3:24

p.m.)

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

THE COURT: Everybody have a seat. You may call your next witness.

MR. GUARD: Before we do that, Your Honor, just some housekeeping. At the request of the Clerk we've cleaned up the exhibits, and so I was going to read out exhibit numbers and what they are just so the record is clear.

THE COURT: All right. Go for it.

MR. GUARD: Exhibit 1 is going to be Exhibit A to the State's response, which is AHCA ITOP reports.

Exhibit 2 is Exhibit B to the State's response, which is the Tien export report for the Gainesville Woman Care case.

Exhibit 3 is Exhibit C to the State's response, which is the CDC Abortion Surveillance Data from 2019.

Exhibit 4 is going to be the Skop declaration including the two attachments which are listed as A and B.

Exhibit 5 is the Condic declaration including the attachment, which is her CV, which is

Exhibit A to Exhibit 5 now.

Exhibit 6 is the Tien declaration including the CV, which is attached as Exhibit A to 6.

Exhibit 7 is the Biggs declaration including the attached CV.

Exhibit 8 is going to be the Biggs deposition.

Exhibit 9 is going to be the Skop deposition transcript, which you already have.

And there is an agreement that all those are admissible and admitted.

MR. PERCIVAL: Have we explained to Your Honor yet the issues with Biggs's deposition?

MS. CHRISTMAS: I thought we'd do that after.

MR. PERCIVAL: I just don't want the Judge to think we're blind siding him with another deposition transcript.

THE COURT: I like reading deposition transcripts.

MR. GUARD: So I guess we will go into it now. We were trying to keep -- well, she can't come back on Thursday, so Dr. Biggs who traveled here from California, we put in her declaration. And then we're putting in the deposition transcript of what is mostly my cross, which is

54 pages long, which is a pretty short deposition. So that's my way of selling it to you. We're doing that in lieu of trying to make her come back from California, which she can't.

THE COURT: So we're putting in Dr. Biggs's declaration. Does she have a deposition, too?

MR. GUARD: Yes, I took a deposition of her and basically her cross.

THE COURT: Okay. That's fine. If possible I'd like to get that tonight.

MR. GUARD: Your clerk has it. He's doing his thing and then you can get it.

THE COURT: So Dr. Biggs can't be here. Your second witness will finish today.

MR. GUARD: Yes.

THE COURT: And so are there any other witnesses?

MR. GUARD: Dr. Tien is going to testify as a rebuttal witness my understanding is, and I don't think I'm going to have much cross because I've already done the cross once.

THE COURT: So Dr. Tien. Okay.

MR. GUARD: And then we're done.

THE COURT: All right. Then we have argument.

MR. GUARD: Yes, Your Honor.

THE COURT: Okay. All right. Do you all want to try to do that all today?

MS. PILLAY: As much as possible, Your Honor. If it's possible to get it all done today, great.

MR. GUARD: If we get everything done other than argument. Most of these lawyers are from places other than Florida. We'll be happy to if Your Honor would allow us to allow them to do it by Zoom or however Your Honor would like to do it, or if you prefer it here in-person, we'll do it in-person.

THE COURT: I hate making you come in-person, but I rather not do closing argument or ruling by Zoom. I'd rather do it in-person. Obviously, the media is certainly invited and it's not just a spur of the moment thing. I think it's better if we handle this case the way did before COVID. And we can talk about when that is whether it -- it depends. It could be tomorrow, but I will be under the influence of novocaine for a couple hours afterwards if that creates any concern for anyone. As far as I know the only thing it does is keep me from drinking anything I mean like liquid without spilling it. I could probably

shuffle some stuff around tomorrow afternoon if you want to do that. I certainly know I can do it Thursday.

MR. GUARD: We obviously don't want to inconvenience anyone. I was trying to be as kind as I can.

THE COURT: I understand. It's probably hotter in Tallahassee than it is in some of the places Plaintiff's counsel are from, but it was quite cool this morning when I got up. But I do want to have time to give justice to these depositions and to think through where we are on everything, so let me think about it. We can talk about it some more today. I don't want to delay your other witness.

MS. PILLAY: Thank you very much, Your Honor.

THE COURT: Do you swear or affirm the testimony you're about to give will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: I do.

THE COURT: Have a seat.

MR. FARQUI: Your Honor, would it make it easier if we give you an extra courtesy copy of Dr. Biggs's transcript so you don't have to rely on the Clerk's copy?

THE COURT: Yes. Thank you. That would be good if you have it. If you don't, I will not mark on the Clerk's copy. If I have my own, I can mark.

MR. GAURD: May I approach, Your Honor?

THE COURT: So I have Dr. Skop's deposition.

MR. GAURD: There's Dr. Biggs.

THE COURT: And this is Dr. Biggs's deposition, so I will reread her statement and her deposition.

MS. PILLAY: For the record, the extra copy was a rough copy that we received Friday and then we received the final one this morning that was delivered to the Clerk in case there is any we haven't had a chance to look for discrepancies.

THE COURT: If there are, we can talk about them. I don't mind taking the Clerk's home. Usually, with a rough copy you can get about 99% of what it says, but I don't mind reading both. So we've placed this witness under oath.

THEREUPON,

INGRID SKOP,

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

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

BY MR. FARUQUI:

Q. Dr. Skop, can you please state your name and spell it for the record?

A. My name is Ingrid Skop, I-N-G-R-I-D, S-K-O-P.

Q. And I'm just going to these microphones are a little bit weird I'm going to ask you to not lean too far in.

Can you please tell the Court what your occupation is?

A. I'm a board-certified obstetrician-gynecologist in Texas, and I've been practicing for 30 years.

Q. And where are you currently employed?

A. I am currently working full time for the Charlotte Lozier Institute as their senior fellow and Director of Medical Affairs. In addition, I'm working part time as an obstetrics hospitalist at a hospital in San Antonio.

Q. How long have you had this position with the Charlotte Lozier Institute?

A. I began this position on April 1st of this year. Prior to that I was in the same group practice in San Antonio for 25 years.

Q. And just to make this short is the Charlotte Lozier Institute is this the same organization that

was referenced in Dr. Condic's testimony?

A. It is. If I can clarify, Susan B. Anthony Pro-Life America is a lobbying firm. Charlotte Lozier Institute is their research arm. We are a nonprofit. We are not a lobbying group. Similar to the relationship between Planned Parenthood and Guttmacher Institute prior to the two of them separating.

Q. Do you agree that the Charlotte Lozier Institute would be fairly characterized as a pro-life organization?

A. Yes. It was mentioned earlier that our mission is to support life in the womb.

Q. Do you hold any hospital appointments?

A. Yes, sir, I do. I'm on staff at the Baptist Hospital System in San Antonio.

Q. And how long have you been on staff there?

A. 26 years.

Q. Have you ever had any leadership positions on staff?

A. Yes, sir. I was the chairman of the department of OB-GYN for a couple of years.

Q. Can you quickly walk us through your academic and training background before you -- well, walk us through your academic and training background, please.

A. Sure. I received a Bachelor's of Science in

Physiology from Oklahoma State University. I received Medical Doctorate from Washington University in St. Louis. I did my obstetric gynecology residency training with the University of Texas Health Science Center at San Antonio.

Q. Did you hold any leadership positions during your residency?

A. I was the chief resident my final year.

Q. Where are you licensed?

A. I'm licensed in Texas.

Q. And licensed as a medical doctor, correct?

A. Yes, sir.

Q. And how long have you been a licensed medical doctor?

A. I have had my medical doctorate for 30 years.

Q. Do you have any professional certifications in that field?

A. My membership in professional organizations I'm a fellow of the American College of Obstetricians and Gynecologists. In addition, I am a member of the American Association of Pro-Life Obstetricians and Gynecologists.

Q. Are you board certified in obstetrics and gynecology?

A. Yes, sir.

Q. And is that field -- can you explain what the field of obstetrics and gynecology is?

A. Sure. Obstetrics refers to the prenatal care and the delivery of babies. Gynecology refers to more general women's reproductive issues relating to menstruation, other non-pregnancy events.

Q. Have you published any peer-reviewed papers in the field of obstetrics or gynecology?

A. Yes, sir, I have.

Q. Have you given any oral presentations in the field?

A. Yes, sir, I have.

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

A. Not on this topic. I have testified as a defense witness in a medical malpractice case.

Q. Was that within the field of obstetrics and gynecology?

A. Yes. Specifically, it was a gynecologic case.

Q. And you've provided a CV; does that CV contain within there some of your qualifications and experience?

A. I believe it does.

Q. I do have one question about your CV. What

is the San Antonio Maternal Morbidity and Mortality Task Force?

A. That was a task force that was put together by the city department of health, and we spent about three years reviewing and forming protocols to assist with the problem of maternal mortality in our county.

Q. What did that review entail?

A. Unfortunately, it was not as thorough as I would have liked it to have been. We had difficulty getting the State Maternal Morbidity and Mortality Committee to share information with us due to privacy concerns.

Q. When did you become involved in this case?

A. I believe that one of the State's attorneys reached out to me. He had received information about me from Alliance Defending Freedom.

Q. And what is the Alliance Defending Freedom?

A. It is a legal nonprofit that works on issues of life and conscious protection.

Q. And is that also characterized as a pro-life organization?

A. Probably.

Q. Are you being compensated for your time in this case?

A. I'm a full-time salary position at Charlotte

Lozier Institute. Our mission is education. This falls within the context of our mission, and I'm not receiving any additional compensation other than my salary and expenses for travel.

Q. What were you asked by the State to do for this case?

A. I was asked to give my expert testimony regarding the issues of safety in later abortion.

Q. And what did you consider in formulating your opinions?

A. I considered my 30 years of clinical experience as an obstetrician-gynecologist as well as an extensive review of the literature.

Q. Have you ever performed an abortion yourself?

A. No, sir, I have not.

Q. Why is that?

A. As an obstetrician I feel that I have an ethical responsibility to both of my patients, the woman and her unborn child.

Q. Have you ever received training on how to perform an abortion?

A. Yes, sir, I have as a standard part of an obstetrics and gynecology residency, we participate in pre and post-abortion care. For those who wish they can perform the procedure, but all of us see

procedures, receive lectures on how to do the procedures. And in fact, every abortion procedure there is a similar procedure that can be done for reasons that are not related to ending the life of a fetus and so I have vast clinical experience in performing those types of surgical procedures.

Q. Have you ever worked at a Planned Parenthood facility?

A. Yes, sir, I have. I worked as a resident providing contraceptive services and general gynecologic care, but not abortions.

Q. In your career, have you ever provided care to women who previously had abortions?

A. Many times.

Q. Have you ever provided care to women who had complications from abortions?

A. Yes, sir. I've seen many women who have suffered complications of abortion. I've seen many physical complications including significant injuries that require surgery. I've cared for two patients who died of sepsis after surgical abortion; one in the first trimester, one in the second trimester. And I've cared for many women in my clinical setting who have been injured emotionally by abortion.

Q. Let's talk about your opinions in this case.

Briefly, what is your opinion regarding the Florida statutes challenged in this case?

A. I believe that setting an abortion limit at 15 weeks will significantly improve the safety for women undergoing abortion. I believe that there is significant data to indicate that abortions become substantially more difficult and dangerous after the 15th week of gestation.

Q. You believe that the -- what is your opinion on whether the challenged statute would impede the access to abortion for women?

A. As discussed earlier, I think a limitation may cause some women to seek earlier abortions which would be safer for them. The interpretation of the literature that discusses the reasons that women obtain later abortions, which is primarily from abortion providers such as Guttmacher Institute, tell me unequivocally that many women who seek these very late abortions do so under coercion. They do so under indecision. And I have seen and cared for many women who initially had unintended and sometimes unwanted pregnancies. If they encounter barriers and continue through the pregnancy to term, 100% of the time I have seen them love and cherish and value their child at the time they deliver.

Q. What is the earliest a pregnancy can be detected with over-the-counter tests?

A. Over-the-counter urine tests are so sensitive that many times HCG can be detected even before the period is missed. So two weeks after fertilization. Four weeks by last menstrual period.

Q. And that would be almost three months before abortions would be restricted under the new Florida law, correct?

A. That is correct.

Q. Are there any options available for women who seek an abortion during the first trimester?

A. Yes. The traditional procedural is called a suction, a dilation and suction. But increasingly I believe more than 50% of abortions in our country are performed by medical abortion up until 10 weeks gestation.

Q. What abortion procedures are commonly performed after 10 weeks?

A. So the dilation and suction continues to occur, but of course we all know the fetus gets bigger, there's more placental tissue, there's more amniotic fluid. At about -- ACOG tells us that around 13 to 14 weeks the procedure changes to what's called a dilation and extraction. Essentially, it's a

continuum of the same procedure, but around that gestational age the fetal bones have calcified so he cannot be removed through suction alone. He must be removed in a dismemberment procedure. This procedure becomes significantly more dangerous for a woman because it is necessary for the abortion provider to introduce instruments blindly multiple times into the uterus to extract the portions of the fetus. It is possible to incompletely extract the tissue. It is possible to leave fetal parts behind, and those parts that are calcified can puncture the uterus. They could lead to infection or even infertility if left for too long. And so the procedure becomes more difficult as we have to convert to the D&E procedure. And particularly beyond about 15 weeks the literature tells us that it probably triples in the number of complications and the risk to maternal mortality.

Q. Have you ever performed a dilation and extraction procedure?

A. I have. The same procedure is used when a woman has a late miscarriage at these gestational ages. So in that situation when the baby is deceased, I have performed that procedure.

Q. Are there any differences between performing a D&E for a miscarriage versus an abortion?

A. Technically the procedure is the same, but there are some significant differences. When a pregnancy passes away, the body starts to recognize it. The cervix becomes softer. It's a little easier to dilate the cervix to introduce instruments. In addition, the fetus is softer, so it's easier to remove him. Contrast that to a D&E on a living fetus this is a fetus who is going to actively move away from the instruments. And of course, he's going to be a firmer. And it's going to be more difficult for the abortion provider to grasp and remove his parts than with a deceased baby.

Q. You may have mentioned this, but can you let me know the sort of the range of time during which a D&E procedure can be performed?

A. Like I say it's a little bit of a continuum, but between 13 and 15 weeks. That's when it starts to be performed. Essentially, the difference is that the fetus is firm and cannot be suctioned out solely, so he has to be removed in apiece meal fashion. I believe that different abortion providers have different comfort levels with how far into a pregnancy that they will do. I believe Dr. Tien said her comfort level was at about 24 weeks. Obviously, the bigger the baby gets the more solid, the more fully

formed the joints and the bones are, the more difficult it is going to be to disarticulate him to remove him from the uterus. There is a point at which many abortion providers will switch to an induction abortion due to that difficulty and to the risk to the woman.

Q. Can you explain what potential complications can occur from a D&E procedure?

A. Sure. The first problem is that the cervix, which is designed to hold the baby in until full term, when there is 10 to 15 pounds of baby and fluid and placenta in the uterus this muscle is very strong. And so in order to enter the muscle to dilate the cervix several things must be done. There are osmotic that is water absorbing dilators. There are pharmacologic dilators. We can use mechanical dilators. Each of those if the cervix is resistant has the possibility that damage could occur to the cervix. Even instruments can be misdirected into the cervical blood flow or through the back of the uterus. Once inside of the uterus instruments are placed. And again, particularly as you get into the further the more higher gestational ages, the uterine muscle is quite thin at that point so it is easy for an abortionist to accidently puncture through the uterus.

And sometimes this can happen in such a way that it causes a very large tear in the uterus. At that point you have the problem not only of fetal parts being extruded into the abdominal cavity, but you also have the potential for abdominal contents to be inadvertently grasped and to be brought into the uterus. Things such as bowel, bladder's in the area, blood vessels. So it's a blind procedure and it does have the risk particularly in inexperienced hands or potentially a poor quality abortion provider horrendous complications have happened and I have seen this.

Q. Exhibit B to your declaration is an emergency suspension order from the Florida Agency for Health Care Administration. Did you review that before preparing your declarations?

A. I did review it. It's not part of the declaration I have because this is my personal copy, but I recall it well enough. I think I can discuss it.

Q. Okay. And did you consider those incidents described in that order in formulating your opinions?

A. I did. As I discussed in my deposition, our country does not mandate on a federal level reporting of complications. Some states do, but in general even

if they do mandate it there's frequently little oversight and little supervision of those reportings, so I think a lot of times complications are not accurately reported. And I feel that the complications that we see listed in the literature are a vast underestimation.

Pensacola is an example of things that can happen when providers are poor quality. There were two complications that were described in the report. One woman was 19 and six weeks along, so further than we would allow an abortion if this legislation were to go into effect. Although she had her abortion at 10 in the morning, she did not leave the abortion facility until midnight. During that time it was documented that she was bleeding heavily. In fact, they gave her seven doses of Misoprostol, which is a medication you use to stop bleeding. Clearly, if they had to give her seven doses there was something else going on other than a mild bleed. She spent part of the time unsupervised in the car with her husband. There was very little documentation of vital signs, estimated blood loss. And eventually, the abortionist told the husband to take her across the state border to Alabama for care despite the fact that by Florida law that facility had an agreement with a local

hospital for admission. I think that was probably because he was trying to avoid detection of his complication. And that women ended up having an exploratory laparotomy, a massive transfusion protocol. She was responsive only to pain on evaluation in the emergency room, and she had to have part of her bowel removed and a colostomy.

The second patient a very similar situation. She was 20 weeks and two days. She had an abortion. She was at the clinic being largely unsupervised despite bleeding until midnight. When she left the clinic and went to the nearby hospital, she had 10 units of blood transfusion there. Her blood pressure was not detectable at the time that she was admitted to the emergency room, and she required a total abdominal histonectomy and removal of her ovaries from her complications. The provider said that he didn't know that there was a protocol. That's hard for me to believe that any doctor in this country would not know if they had that much of a horrendous complication that they needed to facilitate transfer of that patient immediately to an emergency facility and that they needed to get on the phone and call that facility and let them know what was coming.

So that's the kind of stuff that can happen

and does happen in this country. It's been documented many times.

Q. And both of those examples the provider that treated the complication was someone other than the abortion provider, correct?

A. That is the case and that is frequently the case.

Q. And that was going to be my next question. Is there any data on how many women seek treatment of their complications from abortion from their abortion provider versus someone else?

A. There is. There is -- for one thing, there is actually a study of abortion providers in Florida that documented that only half of them have hospital admitting privileges, so in my cases these doctors could not care for a serious complication even if they wanted to. Regarding medical abortion I was involved in a study that purchased Medicaid data from 17 states that paid for abortions. And we were able to document that about 5% of women did present to an emergency room within 30 days for complications related to abortion. And of those women, 60% were cared for by and received surgery by someone other than the abortion provider. Similarly, FDA data documents similar numbers of the women who are actually cared

for for the complications of abortions.

Q. Could encouraging women to perform abortions before 15 weeks post LMP decrease maternal mortality rates?

A. I believe that it could. The CDC -- well, similar to abortion complication data I believe that the data related to abortion mortality is underestimated in our country. There are various reasons for that. Again, largely because they're often taken care of by someone other than the abortion provider.

I was not aware until just a couple of years ago after 30 years of practice that if I as the provider did not take the initiative to get on the state department of health website and report a complication I was not aware that there was no system in place to detect that complication. And I think that is the case for many providers. They may care for these complications, but they may have no idea that if they are not the one that reports it that nobody will know about it and that the CDC ultimately will not know about it if it results in a death. It's been documented in various venues that many, many maternal death certificates do not record the pregnancy that preceded the death even if the

pregnancy was the cause of the death. The CDC primarily analyzes death certificate data, and so it's highly possible that they are missing a lot of deaths that occur.

Q. Are you familiar with the literature that suggests that abortions are safer than childbirth?

A. I'm familiar with that study. I think the study compares compromised data. And in fact, it does not even have the same denominators, so to me it's not a valid comparison. And again, the CDC data is undercounted. Better studies are obtained in the Scandinavian countries. They have single parent health care. They know every pregnancy event. They know every medical event. And what we see over there unlike the CDC's data is that a woman is six times as likely to die of a suicide in the year following an abortion. She is two to three times as likely to die of any cause following an abortion than if she had carried the child and given birth.

Q. Are you familiar with the American Psychological Association's statement on mental health consequences of abortion?

A. I am familiar with that statement and I think that this an example of how often statements that sound reassuring are made. But if you look at them in

some detail, you can recognize that they're not giving you all the information. The APA statement said that there is no evidence that a single elective abortion in an adult woman carries with it mental health consequences. But what they left out is the caveats that there are many subgroups of women that we know and the literature is quite clear on this that are at high-risk for mental health complications. That is those that have had multiple abortions and that's 40 to 50% of our country. Teenagers that's 20% of the women obtaining abortions. Elective although it's often assumed that everybody who chooses an abortion did not want that pregnancy, data tells us otherwise. Many times these are initially desired pregnancies that women have and yet they find themselves in a situation either financially or socially where they don't feel they have the support to carry the baby. So that is a woman who wants her baby and yet doesn't feel like she can do it. And many times there is not the support of a man.

Second trimester later abortions are well-known to be associated with more mental health consequences, too. So the APA put out a statement that sounds reassuring on the surface, but when we dig deeper we discover that it actually does not include

the vast majority of women who have abortions.

Q. So in your opinion, there are mental health consequences of obtaining an abortion, right?

A. There certainly can be and I've seen many of them in my 30-year career. What happens with the mental health literature particularly is it's extraordinarily difficult to design a good study. The gold standard for studies in medicine and in research in general is what's called a randomized placebo controlled study where you take people and you give one an intervention, give the other no intervention, you try to control for as many factors as possible to make them as alike as possible and then you see what the outcomes are. Well, clearly we couldn't do that with abortion. That would be unethical. And so what we see is that there's quite a few studies that indicate mental health problems. There's also studies, and I think some of these will be discussed in this room, that seem to indicate no mental health problems, but many times when you look at the study design you see some significant problems.

One of the big problems with a study that's called the Turnaway that's been widely reported is that there is almost certainly selection bias. 30 abortion clinics over a three-year period of time

encompassing probably at least 100,000 abortions, 7,500 women were screened as possible participants. About 3,000 were approached. Of the women who were approached even though they were offered money to participate in the surveys of those only a little over 1,000 were willing to participate. Of those women who did participate, the vast majority of them dropped out throughout the planned five years. And in fact, at the end of the five years only 516 women were participating out of a potential pool of 100,000 women. So I think we can all see intuitively that the researchers may have either intentionally or inadvertently chosen women who would be more secure in their abortion decision. And the women might have anticipated that they would have mental health consequences would be the women who would choose not to participate in that study. I think just -- I'm sorry. As a thought experiment we can see that a woman who is a professional woman perhaps in her 30s who never desired children perhaps a secular woman might have an unintended pregnancy and have an abortion and not have issues. I mean certainly most women who have abortions don't have issues that we can see externally, but then we can also see perhaps a 16-year-old who is a religious young girl who perhaps

has very poor self-image or poor home life who becomes pregnant and initially is excited she's going to get the chance to be a mother. It's what she's always wanted to do. If that young woman is coerced by her boyfriend or by her parents into an abortion, I think we can all see intuitively that is someone who may have some mental health problems. So a study that looks very broadly at the population particularly if it's not a well-designed study, may not indicate mental health problems. But we see them. I work closely with some crisis pregnancy centers. And one of the things that we see is that many women after their abortions come to us for counseling. And they will tell me my abortion caused me to have anxiety, depression, substance abuse, self-harm. And I'm inclined to believe women when they tell me that their abortion caused those things to them.

Q. Do you know whether the risk of mental health complications from an abortion can increase based on what point in the pregnancy the abortion is elected?

A. Yes, I believe so. Like I said, there is significant data that the later abortions are more difficult emotionally for women. And this makes sense. I've seen on a number of occasions women who maybe the situation was complex but they did desire

their baby, but they kept that knowledge hidden from their parents or from the boyfriend under the impression that when the information came out that they were pregnant that there would be pressure on them to have an abortion. And so a young girl who is in that situation who now is clearly pregnant, in that situation if she is coerced into an abortion after she's felt the baby move, after she's began to bond with the baby I mean to me that seems very clear that that could result in mental health complications. So from a mental health perspective, I think limiting abortion at 15 weeks allows plenty of time for women who desire abortion to get one in general, but it does not allow nine months of coercion for a woman who is vulnerable to that pressure to be pushed into ending a pregnancy that she desires.

Q. Turning away from mental health for a second, can abortions or excuse me. Can the D&E procedure cause complications in subsequent pregnancies?

A. I believe there's good data for that. Any type of surgery it is well-known can cause damage to the lining of the uterus. We do a lot of c-sections in this country. This is something that definitely leads to it. But also you know particularly a surgical procedure that might require scrapping of the

uterus what's called a uterine curettage can cause damage to the uterus. In a subsequent pregnancy the placenta may attach tenuously because of that damage and it could separate prematurely. That's called a placental abruption. That will lead to premature delivery. It can lead to terrible outcomes for the baby, but in addition it can lead to women having hemorrhage and there have been maternal deaths from that. The flip side is that sometimes the placenta attaches too strongly. It invades into the uterus or into the cervix or into the bladder. And at the time of delivery it's very, very difficult to separate the placenta and women have died. That's called placenta accreta spectrum disorder and women have died from that. Both of those things are associated with prior uterine surgery which does include surgical abortion.

Additionally, there is compelling data that particularly a later abortion that is dilating that strong cervix that we talked about can damage the cervix. And so then subsequently as the uterus enlarges and the pressure inside increases that can cause a woman to go into preterm labor or sometimes have preterm rupture of membranes. And those are situations that of course can lead to terrible outcomes for the babies, but also for the mother. As

we're trying to stop the labor and give her magnesium sulfate sometimes that leads to toxicity. So yes, there are definitely things that happen in subsequent pregnancies that can be related to an abortion. But again at this time we don't have the ability to detect those complications to prove that that's happening, but I have no doubt that it does happen.

Q. I just have a few more questions, Dr. Skop. About how much time did you have to prepare your expert declaration?

A. It was probably two to three weeks ago that you guys reached out to me, so I've been working on it in the midst of my other responsibilities since then.

Q. And given the short time frame is it possible that there may be some typographical errors or citation errors because of that time period?

A. I think that is certainly possible.

Q. And would corrections of any of these drafting errors change the substance of your opinion?

A. No, it would not.

MR. FARQUI: May I just have a moment?

THE COURT: Sure.

MR. FARQUI: I have no additional questions, Your Honor.

THE COURT: Let's go to cross.

MS. PILLAY: May it please the Court. Shoba Pillay from Jenner & Block for the Plaintiffs.

THE COURT: Thank you.

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

BY MS. PILLAY:

Q. Good afternoon, Dr. Skop.

A. Hello.

Q. You mentioned that you've been an OB and an MD for approximately 30 years; is that right?

A. Yes, ma'am.

Q. But you've never performed an abortion; is that right?

A. That is correct.

Q. You never actually recommended an abortion to any of your patients; is that right?

A. I have not.

Q. And you have no formal training in mental health counseling outside of your time in medical school; is that fair?

A. That is true. My husband's a psychiatrist so I get a little peripherally from him, but no formal training.

Q. But you don't consider yourself an expert in mental health; is that fair?

A. I would say I'm not an expert in mental

health, but I do think I have expertise based on my 30 years of experience of understanding mental health concerns for women related to pregnancy issues.

Q. You don't consider yourself an expert in epidemiology; is that right?

A. No. I've read quite about it, but I am certainly nowhere close to an expert.

Q. You don't perform intrauterine fetal surgery; is that right?

A. No. That's correct.

Q. You don't consider yourself an expert in neonatology; is that right?

A. No. That's a pediatrician who does specialized training after residency.

Q. And it's fair to say you've never obtained informed consent from a patient to perform a D&E abortion; is that right?

A. I don't believe that that is correct. Like I mentioned earlier, as a resident even if we didn't perform the abortions we were involved in the pre and the post-abortion care. And we did perform abortions at the hospital, so I believe I probably was involved in care surrounding that which would have included informed consent.

Q. So that was over 25 years ago?

A. That's true.

Q. And you mentioned on direct that you are currently employed with the Charlotte Lozier Institute; is that right?

A. Yes, ma'am.

Q. Since April?

A. Yes.

Q. As part of your employment it's expected that you provide expert testimony in furtherance of the Charlotte Lozier Institute's research and the Susan B. Anthony Pro-Life America's policies; is that right?

A. We're an education arm and I am willing to follow the evidence where it goes, so it is not anticipated that I will gear my testimony toward promoting the pro-life desires of Susan B. Anthony List, but in the course of my research and clinical experience I feel very comfortable saying that I do not believe that there are compelling medical reasons that women need abortions.

Q. You've received training from the CLI in furtherance of that expert testimony; is that right?

A. I have received some training about testimony, yes.

Q. And that's most recently in May of 2022?

A. That's correct.

Q. Providing advice on how to formulate your message?

A. That's true.

Q. You've actually previously testified as an expert either orally or written testimony in multiple other court matters; isn't that right?

A. That is correct.

Q. So in about four other cases; does that sounds fair?

A. I believe I've done written testimony probably six or seven.

Q. And some of that written testimony is also in state legislatures?

A. That's correct.

Q. As well as oral testimony?

A. Yes, ma'am.

Q. And you're sometimes paid for that work; isn't that right?

A. I have been in the past, yes.

Q. But you're currently not paid for this engagement because you're actually salaried by the Charlotte Lozier Institute because it's expected of you as part of that role among other things to do research, provide education, and to testify in matters like this; is that right?

A. It is part of my job to do all of that you just mentioned, but the opinions are my own and I feel comfortable with them based on the literature that I've read and all my clinical experience.

Q. You mentioned I think on direct that you're a member of the American Association of Pro-Life Obstetricians and Gynecologists; is that right?

A. Yes, ma'am.

Q. That's AAPLOG for short?

A. Yes, ma'am.

Q. And you have been a member about seven years; is that fair?

A. That's about right, yes.

Q. In fact, you've worked with them to update their practice bulletins and committee opinions?

A. Yes.

Q. In furthering a number of opinions that are now published on their website?

A. Yes.

Q. Typically providing pro-life perspective of OB-GYN practices; is that fair?

A. That is correct.

Q. In fact, you served on the board of AAPLOG for a couple of years; is that right?

A. Yes, I did.

Q. You understand and I think you've acknowledged before that AAPLOG has a bias against abortion; is that fair?

A. Yes.

Q. And you even admitted that you yourself have a bias against abortion in light of your views?

A. Well, morally as a Christian I believe that every human life is made in the image of God and is valuable. As an obstetrician I believe that the unborn human is my patient and I should advocate for that patient. But based on my years of experience and research, I have not found any medical reasons that women must have this procedure. I think it is used for social indications, but I think it is extraordinarily rare to be used for an actual medical indication. If a woman's life is at risk because of her complicated pregnancy, she can be separated from her baby in a way that is not an abortion. The purpose of an abortion is to end the fetal life.

Q. Dr. Skop, your opinion that testimony you just provided it's actually inconsistent with the findings of number of medical associations; isn't that right?

A. That is correct. Many of the medical associations that I assume you're going to mention

right now have well-documented to have a pro-choice bias.

Q. So you consider their positions to be bias; is that fair?

A. Yes.

Q. So let's start with American College of Obstetricians and Gynecologists. The Court has referenced this before as ACOG; is that right?

A. That is correct.

Q. And it's the largest professional association of physicians providing women's health care in the country; is that right?

A. They are the largest association of OB-GYNs. I am a member. And just for the record, they actually don't ask their memberships what we feel about their abortion advocacy. They have been advocates for abortion since the 1960s. And in fact, studies show that only 7 to 14% of OB-GYNs will perform an abortion if requested by their patient. So even though they represent us, they do not represent in my opinion the views of most OB-GYNs --

Q. Well --

A. -- regarding abortion.

Q. -- represent your view?

A. Well, that is my view. But when you look at

the statistic that's only 7 to 14% do abortions, they've never told us they've never asked us what we think about that.

Q. Well, you can't speak for every physician in the country; is that right?

A. Well, you're right. I can't.

Q. But you also rely on the materials and that education that's provided by ACOG, don't you, in your regular practice?

A. I do. Interestingly, when it's not related to abortion I think they give pretty good advice. And even related to abortion I think there can be utility in reading what they say. For example, I did reference their second trimester abortion bulletin in my expert witness testimony. But I have to read that in light of what I also know from other sources.

Q. They also publish a journal, isn't that right, what's known as the Green Journal or Obstetrics & Gynecology?

A. Yes, ma'am.

Q. And you also believe that the Green Journal is useful in your everyday practice; is that fair?

A. That is correct.

Q. It's peer-reviewed?

A. Yes.

Q. But just like ACOG, it's your view that the Green Journal has a pro-abortion ideology and is therefore bias; is that fair?

A. That is what I have noticed.

Q. Likewise, the American Medical Association that's the largest professional association of physicians in the country; is that correct?

A. Probably. The case law though it's my understanding that that they now represent only about 20% of physicians.

Q. Are you a member?

A. No, I am not.

Q. And on non-abortion medical topics, would you consider the AMA general trustworthy?

A. To tell the truth I don't think I reference their material very much.

Q. Just ACOG like you believe the AMA is an abortion advocacy organization?

A. They have become that.

Q. So suffer from the same bias that you perceive in ACOG and in the Green Journal?

A. Based on their recent statements, I think that is obvious.

Q. What about the American Psychological Association; you were testifying about that on direct?

Do you consider APA to be an abortion advocacy organization and therefore bias?

A. Just like ACOG, the APA has had abortion advocacy as a central component of their mission since the 1960s. They said at that time that they considered abortion to be a civil right of a pregnant woman, so I think again many of these organizations advocate for abortion for social reasons. But I think that's inappropriate, because they should be medical organizations sticking to medicine.

Q. But you've testified that you also have a personal objection to abortion; is that fair?

A. Yes.

Q. So APA is the largest professional association of psychologists and it's weighed in on the topic of mental health and abortion, and you had deemed their conclusions untrustworthy because they have a bias; is that accurate?

A. Well, as we discussed a few minutes ago on that APA statement, they made a statement to try to reassure people. But when you dig into the statement, you see that actually it does not refer to most women having abortion. So I think that's just kind of a demonstration of how some of these organizations are falsely trying to reassure the American public and

understanding that most people don't have the knowledge to dig into their statements and understand what's really being said.

Q. So these large medical organizations are engaging in false messaging; is that what you're saying?

A. I wouldn't say that. I would just say that they have demonstrated themselves to have a pro-choice position, and I think that many times they create publications to promote that.

Q. So the National Academies of Sciences, Engineering, and Medicine, that's an institution that's supposed advise the country on matters of health and medicine among other things; is that fair?

A. That is their stated purpose, yes.

Q. And in 2018, and I think Counsel referenced this on direct that they issued a consensus study on the quality and safety of abortion here in the United States; are you familiar with that study?

A. Yes, I am.

THE COURT: Which association?

MS. PILLAY: The National Academies of Sciences, Engineering, and Medicine.

THE COURT: Okay.

MS. PILLAY: And I will refer to it going

forward as the National Academy if that's helpful.

THE COURT: Okay. All right.

BY MS. PILLAY:

Q. And we were just talking about a consensus study that they issued in 2018 entitled The Quality and Safety of Abortion Care in the United States, and it's your opinion that that study is likewise influenced by pro-abortion bias; is that right?

A. When you look at the funding sources, you will see that all of the funders are organizations that have been known for abortion advocacy.

Q. So just like CLI is funded by SBA which is a pro-life organization, that's a similar concept?

A. Yes.

Q. So in fact, you believe the National Academies cherry picked data to reach a conclusion that would promote abortion; isn't that fair?

A. For some of the topics that they looked at, they looked at between 3 and 5 studies. When in fact for these particular topics that I'm thinking of, preterm birth, breast cancer, and mental health issues, there were between 75 and 160 peer-reviewed studies available many of which showed positive correlation. So I think that what they did is that they set their standards and their restrictions in

such a way that they were able to find just a few studies that showed what they would like them to say.

Q. And we're talking about this 208 page study, right, this is the one you're saying that does not have sufficient information or data to rely on?

A. The booklet from NAS, yes. But there's long-term complications that I just mentioned. On the short-term complications, if you look at who they quote most of the time they are studies out of abortion advocacy organizations, University of California at San Francisco, Advancing New Standards in Reproductive Health, Bixby Center.

And going back to the problem with complications reporting in our country, many times they have studies that show that supposedly show low levels of complications. And I would say that they are not picking up all the complications, and that's why they are showing such low numbers. In the study that I was involved in where we bought the data from 17 states that paid for Medicaid abortions, we actually did a very similar study to what Upadhyay did and we found significantly higher abortion related complications.

Q. So all of these medical associations, the National Academies they're all these large

organizations they do not have correct data and are biased according to you, Dr. Skop, am I getting that right?

A. Well, let me just say this because they have gone on the record as feeling that abortion is a social good, so I think they have that motivation. And in the United States we have very, very poor quality data regarding complications because we do not mandate reporting, and so we are vastly underestimating complications. When we can do records linkage studies we discover consistently far more complications than we do than when we just randomly look at emergency room data.

Q. You also find many of the US government agencies to struggle from the same bias; is that fair?

A. I think you'd have to give me some more specifics.

Q. Like the CDC?

A. The CDC again possibly collects information regarding maternal mortality, and I think that they could more actively look for data regarding that.

Q. So you had mentioned, let's talk about the data from the CDC. You acknowledge that you have scepticism of the CDC's data because they're passive; is that right?

A. Well, I have skepticism of the CDC's death certificate data because it's been proven in a number of articles unrelated to abortion even and unrelated to the whole political issue of abortion that death certificate data across the board is poor.

Q. And you've actually not noted a lot of the DCD data is actually utilized in that National Academies report that we were talking about, The Safety of Abortion; isn't that right?

A. I believe they do reference some CDC data.

Q. And you take the position I believe that a lot of these authors of studies that come out of that National Academies report are also hiding data or limiting data based on their knowledge for their bias for pro-abortion like Dr. Grimes you've mentioned that before; is that right?

A. What I said in terms of Dr. Grimes he was the head of the CDC Abortion Surveillance Division, and he if I can see as an outside observer how limited the data is I would have assumed that he also would see that and yet he published a study comparing data with two different denominators alleging that abortion was 14 times safer than child birth. And it wasn't even comparing apples and oranges. It was different denominators. And I don't have time to go into it

all, but there were so many methodological problems with that data collection that I just wonder what was his, you know, one has to ask what was the point of publishing when you knew the data was so poor.

Q. Let 's talk about that data. On direct you testified that the rate of mortality is significantly higher in second trimester abortions, right, did I get that right?

A. It is higher.

Q. Bu isn't it true you even cited the Zane study, which actually reports at a 14 to 17-week gestation it's 2.5 deaths out of 100,000 legal abortion procedures; isn't that right?

A. That is based on the data that the CDC has collected passively from death certificates. I think that if our country cared to know the real answers, we would mandate reporting of complications, we would mandate reporting of all pregnancy events, so that we can have clear and consistent data with which to work.

Q. But, dr. Skop, the CDC doesn't just passively collect data, I mean you've seen the reports that the CDC says we also search LexisNexis for information, we got information from private abortion clinics and public abortion clinics, we got it from the states, we have epidemiologists analyze it, all of that is

reported in the studies, so it's not passive?

A. Well, they do say they have a couple of additional ways of getting information. It's not clear because it's not reported how many additional deaths they pick up that way. As we discussed in the deposition, one way they could find more complications in deaths would be to do a public search of medical malpractice claims. And a researcher did that and he as able to document in a given year that based only on medical malpractice claims he found 30% more deaths than the CDC had documented. So I think that if they really had a strong desire to get every death, I think there are additional things that they could be doing.

Q. Okay. So CDC's data is not sufficient, the National Academies's reporting is not sufficient if I understand your testimony today, Doctor. Let's talk about another study that you referenced on direct examination. The Turnaway Study are you familiar with what I'm talking about?

A. Yes, ma'am.

Q. You mentioned that The Turnaway Study has deep flaws; is that correct?

A. Well, I think it is subject to significant selection bias.

Q. Would you agree though that in the medical

community including the American Psychiatric Association that you mentioned earlier it is widely accepted within that medical community?

A. Certainly I think that many medical organizations with a pro-choice idealogic backing have been happy to see the conclusions that have been generated by the Turnaway.

Q. And you mentioned you were troubled by the attrition rate. So this Turnaway Study employed a Longitudinal Perspective Cohort Study and they interviewed all of these 1,000 women that were included from 30 abortion facilities in 21 states every six months over five years and there was a 5% attrition rate every year over that time in the various waves, and it's your testimony that that's really high and therefore invalid, it invalidates the data, that attrition rate is so high it invalidates the data. That's what I believe you testified on direct; is that right.

A. Yes, I mean the attrition I'd like to expand a little bit. They asked 3,000 women. Only about 1,100 were willing to participate. And then at the end of the time period only 516 were left. So they actually ended up with about 17% of what they had initially planned. And I think that intuitively we

can recognize that because we do know that sometimes women do feel immediate relief in the week after their abortion and I think that they one of the studies indicated that there was more anxiety in the women who had not receive the abortion, but what they actually do tell us is that over the five-year time period women are pretty equivalent on the real health outcomes at the end of the five years. It should be noted that there has never ever been a study that showed improvement in mental health after an abortion. So the best the studies can show us is that it didn't hurt the woman potentially. But you know when it was the companion case to Roe v. Wade, Doe v. Bolton was all about allowing abortion for mental health reasons for the health of the woman so.

Q. Dr. Skop.

A. Go ahead.

Q. You mentioned that people you've talked to. You didn't participate in the Turnaway Study; isn't that right?

A. No.

Q. And you actually haven't engaged if your own mental health study per se? In other words, you haven't engaged in any kind of study to analyze the mental health impact of abortion; is that fair?

A. I have not been a researcher in a study like that. I'm working on getting some stuff together, but I do have 30 years of clinical experience talking to women who tell me that they have suffered from their abortion and I trust them.

Q. So speaking of your patients, you've mentioned that on direct that an over-the-counter pregnancy test can detect even before a woman misses her period. Did I get that correct?

A. That is true. They are that sensitive.

Q. So how would the woman know to go get that pregnancy test?

A. Well, I mean many women that are seeking pregnancy are excited to find out as early as they can so.

Q. So we're just talking about the women that are actually trying to get pregnant?

A. Right.

Q. The rest of the women you're not suggesting they should go every week now to make sure early --

A. That's not the point. The point is by the time she misses a period it's readily it's easily provable that she's pregnant.

Q. I'd like to turn now to some of the literature we were talking about earlier. You had

mentioned we were talking about ACOG. Is it fair to say that ACOG has weighed in on second trimester abortions in a practice bulletin?

A. Yes, they have.

Q. And they have determined that D&E abortions are safe and effective; is that right?

A. ACOG has never submitted any sort of testimony in favor of any restriction on abortion. And surely with all the restrictions that are out there, there are some that can improve safety for women. So I think the fact that they're promoting second trimester abortion is just consistent with their idealogy.

Q. You testified that there are a lot of risk of complications as a result of abortion; is that right?

A. Yes, ma'am.

Q. So while hemorrhage is a potential complication, ACOG concludes that serious hemorrhage occurs in less than 1% of D&E abortions; is that right?

A. They did report that in their 2013 practice bulletin. There was actually a recent study out of University of California at San Francisco where they were looking at using a medication called Methergine after an abortion to decrease blood loss. And

interestingly they didn't find an improvement with the medication, but what they did document was that 50% of the women obtaining D&Es at the San Francisco Hospital with experienced clinicians met their criteria for excessive hemorrhage 50%, 1 out of 2.

Q. What's the name of that report?

A. I believe the author was Kerns, K-E-R-N-S.

Q. Is that report cited in your declaration?

A. It is not. I just found it recently.

Q. You also mentioned and we were talking about the National Academies. The National Academies is also concluded in that Safety of Abortion paper that the evidence clearly shows again that D&E abortions are safe and effective and you reject that again in light of your concerns of the National Academies's bias; is that right?

A. Not so much the bias, although there may be a component of that. But just the flaws in our data collection, so that we are undoubtedly underreporting. But even the CDC's data tells us that when we go from the 13 to 15 week D&E to the 16 to 20 week D&E that there is about triple the complications. And, in fact, Bartlett and Berg in their CDC study tell us that there is a 38% increase in the risk of maternal mortality for every week past eight weeks that a

termination is performed. In the early second trimester, there is a 15-fold increase in maternal mortality. In the mid-second trimester which is the gestational age that we're discussing related to this legislation, there is a 30-fold increase in maternal mortality. And after viability after approximately 21 weeks, there is a 76-fold increase in maternal mortality and death from a D&E procedure. Again, I'm not saying every provider does dangerous D&Es. But I'm just saying since we do not supervise abortion providers very well in this country, the providers like whoever was in Pensacola at that clinic are hurting women. And there is a smattering of news releases or news reports around the country, New Mexico, Maryland. There are late-term abortion providers who do not provide good care and they are hurting women.

Q. And the Bartlett and Berg study that you cite that's from 2004, right?

A. It is an old study, yes.

Q. Right. So a lot of the data that you're referencing and support your conclusion that D&E abortions are unsafe, are actually quite outdated at this point. The reports that we've talked about today are actually relatively recent; isn't that fair?

A. That is true that it's an older study. I think what's helpful about that study is to show that as the gestational age increases the risk increases sometimes in an expediential way. I think that's the key take-home point. I'm not saying that I necessarily feel that the CDC numbers reported at that time or even now accurately reflect the deaths, but the increase that we see I think is probably an accurate reflection of how much more dangerous they get as the pregnancy increases.

Q. So the accurate reflection from 20 years ago?

A. Well, I mean just the you know again 20 years ago a 20-week fetus was the same size that a 20-week fetus is now. 20 years ago the uterus had the same degree of thin muscle that it has know. So even though there'd been some small changes in the procedure notably cervical ripening agents that make it a little easier to get into the uterus, the procedure itself has not changed significantly so that we would expect a 20-week D&E to be so much more safe than it was 20 years ago because it's essentially the same procedure.

Q. But you can't cite to any current data that supports the conclusion that you're making which is that D&E abortions are not safe; is that right?

A. Well --

Q. Yes or no question at this point, Dr. Skop?

A. If we collected accurate data, we would probably see that.

MS. PILLAY: Nothing further, Your Honor.

THE COURT: Doctor, a couple things. Is there data that you're familiar with, if this is not part of your testimony let me know, but is there data that you are aware of that compares mortality and morbidity of full term where the woman carries full term versus abortion in the first 15 weeks? Are they compared in mortality and morbidity?

THE WITNESS: Well, the CDC again they're data reflects what comes to their attention, which I think is probably not complete. We can look at the record linkage studies that I mentioned in Finland and Denmark and other countries and actually see the likelihood that a woman dies within a year of her pregnancy outcome, and we see the exact opposite of what the CDC tells us that she's much more likely to die after an abortion procedure. And that's several things. That's both the physical risk, but it's also mental health risk which we have no way of detecting

either.

THE COURT: What does the CDC does it give mortality of women after full-time delivery versus abortion; what do they say about it?

THE WITNESS: You mean what are the numbers?

THE COURT: Yes, ma'am.

THE WITNESS: Right now they are reporting higher numbers after a term pregnancy, but there's been a lot in the literature independent of abortion. The CDC in 2016 some researchers at University of Maryland told us that you know what we have not the United States didn't even release a maternal mortality statistic for about 15 years because they knew the data was so bad. And I don't think we've corrected all those data problems yet. It's on everybody's radar screen, but even in regards to a term pregnancy we're missing a lot. 50% is the number that several studies have shown, but we miss 50% of the deaths even in a term pregnancy.

THE COURT: In a delivery on a term pregnancy, there are doctors that commit malpractice in those also just like they do in abortions, right?

THE WITNESS: Well, certainly it can happen,

yes, but I think that hospitals have committees in place monitoring physician quality.

THE COURT: Well, doctors have severely injured babies through improper use of forceps in delivery, correct?

THE WITNESS: That can happen, yes.

THE COURT: Babies have been severely injured or died because of an umbilical cord compression that's not picked up correctly on fetal heart monitor or fetal heart monitor sheets?

THE WITNESS: Yes, I mean certainly medical malpractice can occur, but I think when it occurs related to a term pregnancy it's almost certain going to become a medical practice case. But I would say that because of the stigma and the embarrassment of abortion, many times when that medical practice occurs the woman or her family do not sue.

THE COURT: Breech delivery, mishandling breech delivery is another common potential negligence area.

THE WITNESS: It can happen.

THE COURT: Okay. I think that's all I have, so thank you.

THE WITNESS: Thank you.

THE COURT: Does anyone else have anyone more questions?

MR. FARQUI: No redirect, Your Honor.

MS. PILLAY: No, Your Honor.

THE COURT: Thank you very much and good luck on your I assume it's a flight back.

So are we done except for a rebuttal witness and then I have to read two depositions and then we have -- frankly, I think I'd like to read the declarations again before we do closing arguments. You all could put them in context. So how long is the rebuttal witness going to take?

MS. SANDMAN: I anticipate about 20 minutes, Your Honor.

THE COURT: Including cross?

MR. GUARD: I'll try to be brief, Your Honor.

THE COURT: So here's what I think. Whether we do the rebuttal witness today or not and I can go after 5 if we can do the rebuttal witness in 20 to 30 minutes, but I need time to read these things, these things, the exhibits, the depositions and to consider what I've heard. I want to take a look at the Florida Supreme Court cases again and then I want to consider your closing arguments. And I just don't think I can

do it justice by doing that tomorrow. I think I need to do that Thursday and I think I need to do this live and in court. Now, that doesn't mean -- I mean obviously the press has a right to be here and is invited to be here. And I understand that creates a certain amount of inconvenience, but I want to do the best I can do before this case if it does go someplace else I want to do my job the best I can do. Probably half the people will agree with me and half will disagree with me in this courtroom regardless of what I finally determine. But since I've not read these depositions and I want to read these declarations again, I just don't think I can do it justice until Thursday. I think we can have closing argument Thursday. I can then consider what you've said and then give you a verbal ruling. Can I give verbal ruling that you can put down exactly in writing, no, but I can cover the areas that you have covered in the case and rule that way. So Dr. Tien if she needs for her convenience to have her testimony heard today I'd be glad to hear that, but at that point I think I'd like to reconvene on Thursday. You want to call Dr. Tien?

MS. SANDMAN: I would appreciate that if

that's possible, Your Honor.

THE COURT: Sure.

MR. GUARD: Your Honor, the State rests.

THE COURT: All right. Thank you.

(State rests.)

THE COURT: Dr. Tien, can we just have her still be under oath from this morning. Dr. Tien, you're still under oath. If you'll have a seat. We're not so rushed that anybody has to talk fast.

MS. SANDMAN: I'll try to suppress the New Yorker in me.

THE COURT: All right. Thank you. You may proceed.

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

BY MS. SANDMAN:

Q. Dr. Tien, are abortion facilities in Florida required to be licensed?

A. Yes.

Q. Are they inspected by a Florida State agency to maintain that licensure?

A. Yes.

Q. Do you know how often those inspections happen?

A. I don't. I know that they happen. I know that care coordination occurs with our chief operating

officer.

Q. And do you know whether Florida State law imposes a requirement to report abortion complications to the State?

A. Yes.

Q. And if Florida had a concern that an abortion facility was providing unsafe services, could they revoke its license?

A. Yes.

Q. Dr. Tien, when you became credentialed as an abortion provider at Planned Parenthood Southeast and North Florida, what did you have to do to become credentialed?

A. Aside from interviews with the chief medical officer, interviews with the chief operating officer, I had to submit proof of my training, my expertise, procedures I have performed in other settings. I also had to undergo additional educational training specific to the clinic in regards to HIPAA, OSHEA, and that's actually an annual training.

Q. And do you know whether Planned Parenthood tracks your complication rates as part of its quality control process?

A. Yes, it does.

Q. If you know, do you know from your

professional experience is that process of tracking complication rates and credentialing process before providing services, is that typical of the way that abortion providers are typically credentialed?

A. Yes, absolutely.

Q. If an abortion provider had an excessive number of credentials, do you know whether the State of Florida could revoke their medical license?

A. Yes.

Q. And is that true for physicians other than abortion providers as well?

A. Yes, absolutely.

Q. Is there anything that's different about how issues of quality and care are handled in the context of abortion than other areas of medicine?

A. No.

Q. You've heard some testimony today about the American Family Planning Clinic; are you familiar with the reports of what happened there?

A. I heard initially what happened through media reports. Prior to the media reports I was not aware of that clinic's existence.

Q. And since that time have you become broad strokes familiar with the claims?

A. Yes.

Q. And if those allegations are true, are they typical of the way that abortion care is provided?

A. No.

Q. Do you have any idea how often serious complications occur such as what happened to the patients at issue in those charges?

A. Extremely rarely, less than .5% both documented in the literature and in my clinical experience.

Q. To be clear, the less than .5% statistic that you're giving that's a general statistic for complications, right?

A. Correct.

Q. Not for the specific series of events that are claimed to have happened at that clinic?

A. That's correct.

Q. Doctor, the State thinks that a subpar or dangerous provider sort of that one occurrence supports their idea of a ban on abortion after 15 weeks. In your view, is that a basis to ban abortions?

A. No. I'm not familiar with this clinic. I don't know who works there. Clearly some very dangerous things occurred and clearly the State detected it as that clinic was shut down.

Q. Doctor, I'd like to ask you some general questions about abortion procedures, the way that they're performed in this country in modern medicine. What are the basic types of procedures that can be used after 15 weeks for in clinic abortion?

A. After 15 weeks an in clinic suction procedure is most commonly done. Every abortion procedure after 15 weeks requires some amount of preparing or dilating the cervix, suction to empty the uterus, and later in pregnancy it may require additional instruments to enter the uterus.

Q. Would you normally use forceps at 15 weeks?

A. I do not.

Q. You heard Dr. Skop's testimony about what she considers to be the dangers of a D&E procedure. Did anything in that testimony change your opinion on abortion safety?

A. No, it did not.

Q. And why not?

A. The dangers described are absolutely real complications that can occur when caring for a pregnant woman. And in discussing informed consent and the procedure that is absolutely part of the discussion. The expectation as a physician is that if you are offering these procedures you have a

tremendous and stellar level of expertise prior to doing so as is the case for any area of medicine. So it does not change my opinion because that is part of the informed consent process. It is something that should only be offered by appropriately trained physicians. And overall abortion complications are very, very low.

Q. Is a D&E procedure a dangerous procedure?

A. No.

Q. Does it have a high complication rate just to be clear?

A. No, it does not.

Q. Now, you also heard Dr. Skop's testimony that abortion complication rates are I believe she said vastly underreported. Do you agree with that testimony?

A. No, I do not.

Q. Why not?

A. In every state that I have provided abortion care and also in the context of providing pregnancy care, there has been a requirement for reporting of complications. And specifically in the hospital setting, every pregnancy-related event is reported, recorded, and evaluated.

Q. How does that reporting obligation compare to

reporting complications in other areas of medicine?

A. I actually believe specific to pregnancy it's tremendously robust. We track and report pregnancy outcomes much more carefully and in much more detail than for example other nonmedical areas.

Q. I'm sorry. Could you clarify other nonmedical areas?

A. For example, general surgery, removal of the appendix. Our tracking of pregnancy related events is very detailed. And yes, it varies from state to state because we are a large country, we are heterogenous country, but we do an excellent job of tracking outcomes of pregnancy-related events.

Q. Dr. Tien, how do you open the cervix to perform abortion?

A. There are several options. Medication, mostly Misoprostol can be used to soften and open the cervix. The cervix could also be opened with dilators. And then there can be dilators that are either synthetic or natural that are placed in the cervix the day prior to a procedure.

Q. Dr. Skop testified that the cervix is resistant to being dilated and roughly speaking that complications are common as a result. Do you agree with that testimony?

A. No, I do not.

Q. And why not?

A. It is understood that in the provision of a safe abortion procedure the cervix needs to be gently dilated, so it is done so. And so that it is done via medication or mechanical dilators, or for a patient who's farther in pregnancy and requires more cervical dilation with dilators that are placed overnight to slowly absorb the moisture of the cervix and open the cervix.

Q. Does this process weaken the cervix and make premature birth more likely in the future?

A. There is some literature suggesting that there may be a weak association; however, overall it is not something that on the very long list of risk factors for preterm birth is as markedly strong as prior preterm birth, multiple gestation, poverty, being young, being black.

Q. Can prior pregnancies that are carried to term also result in an increased risk of premature birth?

A. Absolutely.

Q. Dr. Tien, what is -- I'm let me try that again. Can having an abortion increase the risk for placental abruption in future pregnancies?

A. No.

Q. You heard Dr. Skop's testimony that placental abruption occurs as a result of sharp curettage. How common is sharp curettage in contemporary provision of abortion care?

A. It is never performed.

Q. You also heard Dr. Skop's testimony that the CDC does an inadequate job of evaluating whether a death is related to abortion; do you agree?

A. I do not.

Q. And why not?

A. The CDC has scientists and epidemiologists who are trained specifically to evaluate complications and look for root cause of death.

Q. And in doing that does the CDC, and I'm doing my best to quote from Dr. Skop's testimony, just report the data that comes to it? Is that how the CDC data collection process functions?

A. No. The CDC is quite proactive, so the data sources are multiple. They can be submitted by the state. They can be submitted by multiple maternal morbidity review committees, which are state and local committees convening looking at maternal mortality and safety. And they can also be proactive evaluating additional patient surveillance and patient surveys.

Q. As a result of those multiple processes in your expert opinion, how would you evaluate the quality of the CDC data in this area?

A. I feel that it is excellent.

Q. You also heard Dr. Skop's testimony that the CDC data comparing abortion-related deaths to deaths from pregnancy and childbirth makes an inaccurate comparison because the numerators and denominators are inconsistent; do you agree with that criticisms?

A. I do not agree.

Q. And why not?

A. The data looking at abortion mortality looks at abortion mortality per legal induced abortion procedures. The data looking at maternal mortality looks at maternal mortality for women who have continued pregnancies against 100,000 live births. So those denominators are comparable and appropriate for the numerators.

Q. Dr. Tien, can you explain what is ACOG briefly?

A. ACOG is the American College of Obstetricians and Gynecologists. It is the largest educational and women's health professional association in this country specific for OB-GYNs. When I last looked, there is over 58,000 members of

obstetrician-gynecologist. They are responsible for reviewing the literature and publishing guidelines on education and clinical guidance both for clinicians and also for patients.

Q. Would you consider ACOG to biased in connection with abortion?

A. No.

Q. It doesn't have a conflict of interest?

A. It does not.

Q. Is there any serious debate on that topic in mainstream medicine?

A. No.

Q. What is the Royal College of Obstetrics and Gynecology?

A. It is a comparable association in the United Kingdom.

Q. I won't ask you to describe it in more detail, but would you consider it to be a biased organization?

A. No.

Q. And the Society for Maternal-Fetal Medicine?

A. The Society for Maternal-Fetal Medicine is the leading organization for professionals who provide care for high-risk pregnancies such as myself.

Q. And within your field what degree of weight

are conclusions from the Society for Maternal-Fetal Medicine afforded?

A. Tremendous weight.

Q. And what is the Green Journal?

A. The Green Journal is the title is Obstetrics and Gynecology. It is the well-known published peer-reviewed journal of ACOG.

Q. And what are the National Academies of Medicine and Engineering? I think I got that wrong.

A. National Academies of Sciences, Engineering, and Medicine. Similarly they used to be known as the Institute of Medicine, but similarly they are a committee of researchers, scientists, physicians, and experts in policy and law that review the evidence and make guidelines.

Q. What kind of weight are their conclusions afforded?

A. Tremendous.

Q. And in mainstream medicine are any of those organizations we've been discussing understood to be biased organizations?

A. No.

MR. PERCIVAL: Your Honor, objection. Scope. The doctor did not submit a declaration on any of these testimony that she's given and she did not

disclose it in her deposition that I took.

THE COURT: Sustained.

BY MS. SANDMAN:

Q. Dr. Tien, does the morning-after pill cause abortions?

A. It does not. The primary function of the morning after pill is similar to taking a large dose of birth control pills. It prevents ovulation. It can in some circumstances prevent a fertilized egg from implanting, but the most common mechanism is that it prevents ovulation or release of the egg from the ovary.

Q. Do IUDs cause abortions?

A. No.

Q. Do birth control pills cause abortions?

A. No.

Q. Is there any dispute on this in mainstream medicine for any of those items?

A. No.

Q. I'm going to turn now to the testimony that you've heard from Dr. Condic in connection with fetal pain. First, Dr. Tien, is knowledge of fetal development important to your work as an MFM?

A. Yes.

Q. Can you explain how?

A. A lot of what I do for maternal-fetal medicine is care for pregnant women. And that also includes performing their ultrasounds at different stages of pregnancy as well as performing what we in medicine call fetal testing, so ultrasounds to ensure that the baby is healthy and developing well or fetal testing which is monitoring of the fetal heart readout on the monitor. So in all of these settings, I need to be able to discuss with patients what I am seeing on ultrasound during their prenatal care and also on fetal testing.

Q. If a fetus could feel pain, would that be relevant to any clinical decisions that you're involved in in your role as an MFM?

A. If a fetus could feel pain, because I as an MFM care for high-risk pregnant women, it would be a part of every discussion. However because it cannot, it is not a part of my discussion with my patients.

Q. And, Dr. Tien, just to be clear, what is your opinion on whether a fetus at 15 weeks can feel pain in utero?

A. A fetus at 15 weeks cannot feel pain in utero.

Q. And how do you know that?

A. I know that it has been alluded to that the

perception of pain requires several factors. It requires the establishment of building blocks for pathways to interpret the pain from the external environment, carry the signals through the spinal cord into multiple portions of the brain including the thalamus and the cortex, so there needs to be an establishment of the building blocks or the basic circuitry. In addition, there needs to be a higher level of cortical processing recognition and awareness of pain.

Q. And when are those pathways formed?

A. The early absorption of environmental stimuli is present very early in pregnancy from 8 to 15 weeks. The beginnings of the pathways up through the spinal cord to the brain are present between 20 to 22 weeks. And when I say weeks, I speak by gestational age by LMP as I'm clinician and not an embryologist. So the basic fundamental building blocks are in place by 24 to 26 weeks, but the higher level cortical processing recognition and awareness is not in place until later in pregnancy in the third trimester.

Q. Dr. Tien, what is intrauterine surgery? Can you explain for the Court?

A. Intrauterine surgery is a procedure performed on a fetus on a pregnant woman.

Q. What are the types of situations where the need for intrauterine surgery would arise?

A. Sometimes during a routine ultrasound there can be a lesion or birth defect that is detected. A good example is neural tube defect where the spine is open. And in certain select scenarios the patient can be offered in utero fetal surgery to help optimize the outcomes for that pregnancy and that baby.

Q. Is intrauterine surgery an area that you studied as part of your MFM training?

A. Yes.

Q. Are MFMs involved in the care team providing surgeries in utero?

A. MFMs are integral to the care team.

Q. Tell the Court about how that care team functions and what the MFM --

MR. GUARD: Again, Your Honor, we've wandered way outside the scope of any testimony that's been disclosed in the declaration or that was testified to in her deposition that I took three days ago.

MS. SANDMAND: Your Honor, she disclosed --

THE COURT: I think she's -- go ahead.

MS. SANDMAND: I apologize, Your Honor.

THE COURT: I think this is a proper area of rebuttal testimony. She's an MFM. I'm saying all

these acronyms. She's an MFM. And yes, Counsel.

MR. GUARD: But, Your Honor, we had a procedure where they were supposed to disclose the expert testimony and this was not disclosed. I inquired in a deposition about the kinds of testimony she was going to offer as rebuttal and she did not disclose this testimony. So I'm impeded in my cross-examination because it was not disclosed.

MS. SANDMAN: Your Honor, we disclosed that she would be a rebuttal witness including on the topic of fetal pain. And very shortly I'll be transferring this area of my testimony to the part of the basis for the conclusion that she's offering on fetal pain, which is that it cannot be perceived prior to 24 weeks.

THE COURT: Overruled. I think this is related to the issue of fetal pain because there was testimony that in fetal surgery there is anesthesia given to the fetus, so I think it's related to the fetal pain. Go ahead.

BY MS. SANDMAN:

Q. So I believe that I'll ask the question again. Could you tell the Court about the care team that's involved in fetal surgery and what the role of

an MFM is in that team?

A. So the MFM is usually the one making the diagnosis of the fetal structural defect usually on ultrasound. So in making that diagnosis in that setting the MFM is the one that counsels the patient on the finding, counsels them on the options, and counsels them on the care moving forward. The MFM is responsible for care coordination including neonatology, making sure that the delivery occurs at a hospital that has a tertiary level of care to be able to care for a neonate with such anatomic concern as well as whatever necessary pediatric subspecialists are required as well as an anesthesia team that is familiar with obstetric anesthesia in particular.

Q. Dr. Tien, just to make sure that we're all straight in terms what is anesthesia?

A. Anesthesia is a general term that covers a broad area of medications that can be used to sedate a patient, treat pain, cause amnesia, or also relieve anxiety. It's a broad term for medication.

Q. What is analgesia?

A. Analgesia is a board term for medication used to treat pain.

Q. Do you know if anesthesia or analgesia are ever used for fetal pain in the setting of fetal

surgery?

A. They are used in the setting of in utero surgery not for fetal pain.

Q. What are they used for?

A. So there are four very important things that need to be considered to make these very delicate surgeries successful. I'm going to use the example of spina bifida or open neural tube defect. So a woman is in the operating room, an OB usually MFM makes the initial incision to open the skin and then open the uterus. The baby is then delivered to the level of the anatomic defect of concern. The surgeon repairs that defect. The fetus is returned into the uterus and the uterus is then closed. The hope then of course is that the woman remains pregnant for many, many more weeks. So you can imagine there are lots of things that need to be balanced carefully for the best outcome. So analgesia and anesthesia has four essentially roles in this setting.

No. 1, maximum uterine relaxation. The uterus must stay relaxed during this procedure. If there's contractions, it can preempt a preterm birth and that's obviously not the goal. It can also preempt what's called a placental abruption where the placenta tears off the uterus again promoting a

preterm birth which is not what we want.

The second role is a paralytic. So we want the fetus to not be moving, to be still. And the reason is that primarily we want it to be an optimal surgical space for the operating surgeon so that he or she can do his or her best job repairing the lesion of concern.

The third role is to blunt fetal physiological response. So not to treat fetal pain, but to blunt physiological response. Anytime we are exposed to something in the environment we have a response. Heart rate changes, our blood pressure changes. It does not necessarily mean that we are perceiving pain, but that we have a response. And what we don't want to happen for one of the physiological responses is what's called fetal bradycardia where the heart rate drops. If that happens that can also prompt a premature delivery and that is not what we want.

And the fourth important part is what we say in medicine is monitoring of maternal and fetal hemodynamics, and so that's just a fancy way of saying the maternal and fetal unit are one and we need to make sure that both are staying safe. And so the role of the MFM, who is actually scrubbed into operative

field along with the pediatric surgeon, is to monitor the tone of the uterus, the heart rate of the fetus, and then also communicate with the anesthesia team to make sure that from the operative field those goals are being met and the anesthesia team is also making sure that the woman is safe.

Q. So if fetal pain was what the care team was trying to address, would the team do something different in administering medications during the surgery?

A. Yes.

Q. Say more about that.

A. If the focus was treating fetal pain then we would be treating the fetus like we do an adult who needs pain medicine, so giving pain medicine by pills, starting an IV and giving pain medicine through the IV, injecting pain medicine into the muscle. Pain control can include a spinal, which is numbing medicine in the back or an epidural that's used during labor. So we would be acting on the fetus directly to administer pain control.

Q. Just to be clear is it the standard of care in medicine to do any of those things in intrauterine surgery?

A. It is not.

Q. On a slightly different topic, if the care team is doing a procedure on the fetus that does not require an incision in the uterus, so a different type of procedure, no incision, in that type of procedure is anesthesia or analgesia required?

A. No.

Q. Is there a medical consensus that anesthesia and analgesia are not required for that type of procedure?

A. Yes.

Q. Despite the fact that certain interventions are being done in the fetus?

A. That is correct.

Q. At what gestational ages have you been involved in intrauterine surgeries?

A. It depends on the lesion of concern, but most commonly this is later in the second trimester.

Q. So later than the time that we're talking about with the 15-week abortion ban for example?

A. Yes.

Q. Just a few more questions in this area. You heard Dr. Condic testify that a cortex in her view is not necessary for a fetus to feel pain; is that accurate?

A. Yes.

Q. Let me ask it a different way. Do you agree with the statement that it's not necessary for the fetus to have a cortex in order to feel pain?

A. I do not agree.

Q. Why is that?

A. I think there is good scientific literature that is based on histopathological studies, so studies of tissues, studies evaluated in the laboratory setting establishing our fundamental understanding of pain pathways.

Q. Is there a controversy in mainstream medicine as to whether a fetus at 24 weeks in utero can feel pain?

A. No.

Q. Are there medical associations that have given analysis on this question?

A. Yes.

Q. Are you familiar with the Society for Maternal-Fetal Medicine report on the use of analgesia and anesthesia for maternal-fetal procedures?

A. Yes.

Q. Did that come out in 2021?

A. Yes.

Q. And what did it conclude in regard to fetal pain?

A. It had three general conclusions based on their review of the literature. The first is that paralytics can be used in fetal procedures if needed to decrease fetal movement to help with the success of a procedure.

The second conclusion was that analgesia and anesthesia may be used in in utero fetal procedures for the reasons that I just stated.

And the third was that due to lack of good data they recommended against the use of analgesia for the purpose of any concerns for fetal pain in the setting of pregnancy termination.

Q. And did it include a conclusion that the connections to the cortex prior to 24 weeks are not present -- excuse me -- prior to the late second or early third trimester?

A. Yes.

Q. And do you agree with that conclusion?

A. Yes.

Q. Are you familiar with Royal College's fetal awareness review of research and recommendation for practice from 2010?

A. Yes.

Q. What weight would you give its conclusions?

A. I would give it tremendous weight.

Q. And do you know what it concluded with regard to fetal pain?

A. A very, very similar conclusion that the basic fundamental building blocks for pain are not present until after 24 weeks and the higher level cortical processing recognition and interpretation is not present until much later in the third trimester.

Q. Are you familiar with the ACOG gestational development and capacity for pain statement?

A. Yes.

Q. What did it conclude?

A. Similarly that the fundamental building blocks are present at 24 weeks and beyond, but that additional higher lever processing was not present until later in the third trimester.

Q. Dr. Tien, are you aware of any leading medical association at all that supports Dr. Condic's view?

A. No.

Q. My last question, Dr. Tien, is there anything else that you would want the Court to understand about fetal pain?

MR. GUARD: Objection. Calls for a narrative.

THE COURT: Sustained.

BY MS. SANDMAN:

Q. Dr. Tien, is there anything from your perspective as a maternal-fetal medicine doctor, do you have any additional views on fetal pain?

MR. GUARD: Objection. Calls for a narrative.

THE COURT: I think I know where she is on this topic. Sustained.

MS. SANDMAN: I'll pass the witness.

THE COURT: Okay. Cross.

MR. GUARD: Yes, Your Honor.

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

BY MR. GUARD:

Q. I apologize, Dr. Tien, since you did not disclose that you were going to testify on some of this information I don't actually have hardcopies of documents. Doctor, you talked about a few minutes ago the Society for Maternal-Fetal Medicine's report on the use of analgesia and anesthesia for maternal-fetal procedures?

A. Yes.

Q. And that was based largely on a paper whose primary author was a Dr. Chatterjee; are you familiar with Dr. Chatterjee's paper?

A. That consult series was based on several

studies.

Q. But one of the studies that it was primarily based on is one by Dr. Chatterjee, correct?

A. Yes.

Q. And Dr. Chatterjee on page 1167 of that consult said pain is a subjective phenomena that is difficult to assess, right?

A. Yes.

Q. It also said because it remains uncertain exactly when a fetus has the capacity to feel pain, it is best to administer adequate fetal anesthesia in all invasive maternal-fetal procedures to inhibit the humoral -- I said that wrong -- stress response, decrease fetal movement, and blunt any perception of pain as has been the standard practice since the start of maternal-fetal surgery in the early 1980s, correct?

A. Yes.

Q. So it's been the standard of care and the standard practice for maternal-fetal surgery since the '80s to administer adequate anesthesia to fetuses, correct?

A. As I previously discussed, the purposes of analgesia and anesthesia in in utero fetal surgery is several fold. Blunting fetal physiologic response is one of them.

Q. So it's the standard practice to use anesthesia since the 1980s with fetuses having surgery, right?

A. In the setting of in utero surgery where there is an incision required on the uterus it is the standard to offer analgesia and anesthesia for the reasons I previously alluded to and to blunt fetal physiologic response. For procedures that do not involve an incision on the uterus, it is not the standard.

Q. Maybe this goes to the category of things that are understated but would you agree with me, Doctor, that abortion is a politically charged issue in this country?

THE COURT: I --

MR. GUARD: I'll withdraw.

THE COURT: Okay. Thank you.

BY MR. GUARD:

Q. You are not a neurologist, right?

A. I'm not a neurologist.

Q. You are not an embryologist, right?

A. I'm not an embryologist.

Q. You're a doctor who spends 70% of her time providing abortion services, right?

A. As part of my expertise in obstetrics,

gynecology and maternal-fetal medicine a large part of that is a provision of abortion services.

MR. GUARD: Your Honor, would you instruct the witness to answer the question.

THE COURT: I think she just answered it. I mean you haven't asked her anything she hasn't answered already a couple times today.

BY MR. GUARD:

Q. You've not done any research on fetal pain yourself, correct?

A. Correct.

Q. And you've never been part of a fetal pain study, right?

A. That is correct.

Q. And you're not a university professor, correct?

A. That is correct.

Q. And you've never been a university professor, right?

A. That is correct.

Q. On your direct testimony you made a whole bunch of statements and testified about being a Florida medical doctor; do you recall that?

A. Yes, I am a physician who works in Florida.

Q. Your experience as a doctor in Florida is

extremely limited, right?

A. Can you clarify limited?

Q. Well, you've been a licensed doctor in Florida for 19 months, right?

A. So I've had an active medical license in Florida for 19 months, but I've been caring for pregnant women for many more years than that.

Q. You've actually been a practicing doctor in Florida for 15 months, right?

THE COURT: How long have your witnesses been licensed in Florida and practiced in Florida, Counsel?

MR. GUARD: I did not have them testify about being a Florida doctor.

THE COURT: I know. We're getting into the weeds here. She's a licensed doctor in Florida. You've got one who's a professor. You've got one who is a practicing physician for 30 years. Each has their differences. I've listened to all of it.

MR. GUARD: All right. Your Honor, I'll move on.

THE COURT: Okay.

BY MR. GUARD:

Q. You've only performed abortions in Florida

for one provider, right?

A. Yes.

Q. And almost all of those abortions have been performed at a single location in Jacksonville, Florida, correct?

A. Yes.

Q. Before you became an expert or while you were an expert in this case or before, you didn't speak to any other providers in any other part of Florida as part of your getting ready to be an expert, right?

A. Correct.

Q. And you're not familiar with any clinics other than how Planned Parenthood Southeast and North Florida performs abortions, right?

A. Not in Florida.

Q. All right. Now, you made some statements about ACOG. Have you ever been to ACOG's website?

A. Yes.

Q. On its website doesn't it have advocacy papers and even letters for doctors to sign advocating against abortion restrictions?

A. There is an area for advocacy, yes.

Q. So ACOG does have as part of its mission to advocate for abortion against abortion restrictions, right?

A. As part of its mission for patient advocacy ACOG advocates for patient health based on the science. Abortion is one of those issues. It's not the only one.

Q. I'm just going to move on. I don't think that really answers the question but.

THE COURT: I thought it did.

MR. GUARD: Okay. Well, I respectfully disagree with that. If I could just have a minute.

THE COURT: Sure.

MR. GUARD: Nothing further, Your Honor.

THE COURT: Any redirect?

MS. SANDMAN: No, Your Honor.

THE COURT: Thank you, Doctor. You can step down.

I have Dr. Skop's transcript. Dr. Biggs. The only thing I didn't have was a corrected copy of Dr. Biggs's deposition, so I'm going to borrow that from the Clerk. I have all the declarations already in the file. I'm going to take home Exhibit 8 and give the Clerk back the rest of the exhibits.

MR. GUARD: Your Honor, most of those depositions were also notices of filing on the

docket, so if you have trouble.

THE COURT: I can look them up. All right. I'll do that. Do you all want to start at 8:30 on Thursday morning instead of 9:00? I've got a couple of hearings around 10 or so.

MR. GUARD: Yes, Your Honor.

THE COURT: So Thursday at 8:30. Same place. Same courtroom.

MS. SANDMAN: Your Honor, for the record, I'll rest our rebuttal case.

(Plaintiffs rest.)

THE COURT: Okay. Thank you. Thursday at 8:30, Courtroom 3G. Okay. Anything else before we go?

MR. GUARD: No, Your Honor.

THE COURT: I'm aware that July 1st is on Friday, but all I can do is what I can do. So I'm going to be honest with you when I hear closing argument and if I make a ruling on Thursday, I don't think it's going to be reduced in writing by Friday because I'm going to give whoever is not the prevailing party 24 hours to review. I would just say the thing we can do to make it fastest is both sides, you may already have done this, both sides be working on orders which can easily be

modified depending upon the ruling as quickly as possible. In some cases where I've had a little bit more time, I've asked lawyers to send me competing orders beforehand, but we just didn't have the time to do that here.

Anything else from Plaintiff?

MS. PILLAY: Yes, Your Honor. Thank You. We understand that your judicial assistant is out this week.

THE COURT: Yes, she is.

MS. PILLAY: We apologize for the difficulty for you, but if there is a way that the parties can contact chambers if necessary with any scheduling issues or any follow-up questions.

THE COURT: Okay. See this is difficult because I don't know what my email address is. I'll tell you the way that you can contact me is she's going to love that I do this, but Paula Watkins at Court Administration. She doesn't know I've just given her name out. And Court Administration, the Clerk can tell you how to get through them. And if I had a little bit more time, I'd go down and get my email address. But I never email myself. And usually I think I know what it is, but I'm not exactly sure I do know

what it is. I will have it by Thursday for sure. We can go off the record. Let's go off the record.

(Hearing concluded at 5:30 p.m.)

CERTIFICATE OF REPORTER

STATE OF FLORIDA)
COUNTY OF LEON)

I, Doreen M. Mannino, Court Reporter, do hereby certify that I was authorized to and did report in stenotypy and electronically the foregoing proceedings and evidence and the captioned case, and that the foregoing pages constitute a true and correct transcription of my recording thereof.

IN WITNESS WHEREOF, I have hereunto affixed my hand the 4th day of July 2022 at Tallahassee, Leon County, Florida.

Doreen M. Mannino
Doreen M. Mannino

EXHIBIT C

PLANNED PARENTHOOD ASSOCIATION OF UTAH

vs

MINER

INGRID SKOP, M.D.

September 02, 2020

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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,	Case No. 2:19-cv-00238
vs.	Deposition of:
JOSEPH MINER, in his official capacity as Executive Director of the Utah Department of Health, et al.,	INGRID SKOP, M.D.
Defendants.	COPY

* * *

September 2, 2020
8:03 a.m.

Via Web Conference

Kristin Marchant
- Registered Professional Reporter -

A P P E A R A N C E S

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Also present: Genevieve B. Delapena

* * *

I N D E X

I N D E X (Cont.)

I N D E X (Cont.)

P R O C E E D I N G S

INGRID SKOP, M.D.,

called as a witness, being duly sworn, was examined and testified as follows:

EXAMINATION

BY MS. MURRAY:

Q. Well, good morning, Dr. Skop. I know we met right before we went on the record, but so we have it straight on the record, my name is Julie Murray. I represent the plaintiff in this case, Planned Parenthood of Utah.

Can you state your full name for the record?

A. Ingrid Fansteel Skop.

Q. Okay. And you'll be advised by Mr. Sorenson; is that correct?

A. That is correct.

Q. Okay. Have you ever had your deposition taken, Doctor?

A. Yes, I have.

Q. Okay. How many times?

A. I believe two or three.

Q. Okay. What were the cases where you had your deposition taken?

A. One was as a defendant in a medical

6

malpractice case and the other is as an expert witness in a medical malpractice case.

Q. What -- so the case that you were a defendant, do you recall the name of that case?

A. To tell you the truth, I don't.

Q. What did it involve; what kind of procedure or care?

A. It was after a delivery where the baby had some problems.

Q. What kind of problems?

A. He had seizures.

Q. Okay. And then was that in Texas, I assume?

A. It was in Texas -- it was about 24 years ago.

Q. Okay. So it's been a while.

A. Yes.

Q. What about the other case you mentioned where you had been a expert witness?

A. It was also in Texas, probably about two years ago, and it was a surgical complication.

Q. Okay.

A. I was the expert witness for the defense.

Q. Okay. Was that in your report? I don't recall seeing that one. So two years ago for the

7

defense. And what kind of complication was that, again? I'm sorry.

A. It was a woman who had a hysterectomy and she had a bladder injury afterwards that required surgery to repair it.

Q. Okay. And you were testifying that the care provided was within the standard of care, is that --

A. That is correct.

Q. Okay. And then you said maybe --

MS. MURRAY: Sorry, does -- I'm getting some feedback.

Q. (By Ms. Murray) You said there may have been a third case in which you were deposed; is that correct?

A. There was another medical malpractice case, again, probably 15 to 20 years ago. Now that I think about it, I don't think there was a deposition in that case.

Q. Okay. So it sounds like, then, that this is the first kind of case where you've been deposed that involves abortion; is that correct?

A. That is correct.

Q. All right. So it sounds like based on what you've described, you have some experience with having your deposition taken, correct?

8

A. A little.

Q. A little bit. Some of it has been a while. But just so that we're all on the same page today, I want to go over some ground rules for today's deposition.

First, you understand that you're testifying under oath today and that your answers are subject to the penalties of perjury?

A. Yes.

Q. And do you understand that this is the same -- the oath that you took this morning is the same oath that you would take in court if you were testifying at trial?

A. Yes.

Q. Do you understand that today I'll ask questions, you'll provide answers, and the court reporter will take down the questions and answers verbatim and put them in a written transcript?

A. Yes.

Q. Okay. So we're interested in finding out everything you know and think about the opinions that you intend to offer as an expert witness in this case. So we want your answers to be as complete and accurate as possible. Is that fair?

A. Yes.

Q. Okay. So it is my job to ask understandable

9

questions. If at some point during the day I ask a question and you don't understand it, which is probably likely to happen despite my best efforts, if you could just flag that for me, I would be happy to rephrase. But if you don't flag a question for me as something you don't understand, I'll assume that you do understand it. Okay?

A. Okay.

Q. And then the other ground rule, I'm guilty of this quite a bit as well, it is very important for the court reporter that she be able to get full answers from both -- and record things accurately. So if you could try to wait until I finish my question to provide your answer, and I'll try to wait until you finish answering before I start talking again, just so we can keep things straight on the record.

A. Okay.

Q. Okay. So let's talk about breaks. I'll plan -- and Mr. Sorenson may have told you this. I'll plan to stop at least once every hour to every hour and a half so we can take a break. You can get up and stretch; you can get food, whatever you need. But if you feel like you need a break in between those points in the deposition today, you know, please flag them for me or Mr. Sorenson, and I would be happy to take a break. So

10

one thing I would ask, however, is that if there is a question pending at the time you would like to take a break that you provide an answer to that question before we break. Okay?

A. Okay.

Q. So sometimes it happens during a deposition that you'll remember later in the day that there are things that you forgot to say or documents that you remembered that might help refresh your recollection to respond to one of my questions. If that happens, will you let me know?

A. Yes.

Q. Okay. It may be that we have some of the documents, and I can send them along. Certainly, if there is anything you want to get corrected on the record today as we go along, just flag that.

So because we're doing this deposition remotely, the judge has put in place special rules for conducting a remote deposition. Did Mr. Sorenson share with you the judge's order about remote depositions?

A. Yes, he did.

Q. Okay. So you understand that today during the deposition, you're barred from using notes or any other materials that I have not provided to you?

A. Yes.

11

Q. Okay. And do you understand that under the court's order you're also barred from having any communication with anyone other than Mr. Sorenson via chat, text, or any other way of communication?

A. Yes.

Q. Do you agree to comply with those rules, Dr. Skop?

A. Yes.

Q. So because it is critical that we get your full and accurate answers today, I have to ask, is there any reason why you would be unable to provide full and accurate answers in response to my questions today?

A. No.

Q. Okay. All right. So in the Notice of Deposition, we had asked for some documents from you, and I appreciate you sending along some of your articles and materials. Is there anything else in response to that request that you brought with you to share today?

A. No.

Q. All right. So let's talk a little bit about how you came to serve as an expert in this case. Can you tell me when you first learned that you might be an expert in this case?

A. I believe it was probably last fall that -- I don't recall exactly who I heard from or the circumstances. It may have been because I have some friends who also do expert witness -- on cases like this.

12

Q. So would it be accurate to say that you first learned about the case and the opportunity to be an expert from someone other than Mr. Sorenson?

A. That is possible. I don't recall who reached out to me first, if it was Mr. Sorenson or someone else.

Q. Are there any documents that might refresh your recollection in that respect: emails, letters?

A. Possibly.

Q. Do you have any sense of who else might have contacted you to provide an opportunity to act as an expert in this case?

A. I don't remember who contacted me, no.

Q. Okay. What have you done to prepare for this deposition?

A. I have reread the -- many of the articles that I cited in my expert witness report.

Q. Anything else?

A. I think I've looked on the internet a little bit to find out about abortion in Utah.

Q. And what would you -- what did you read on the internet?

A. I looked at the information through Guttmacher.

13

Q. Anything else that you looked at online to prepare for the deposition?

A. I don't think so.

Q. Okay. And you said you reviewed articles that you cited in your expert report, correct?

A. Yes.

Q. Had you read all of those articles previously?

A. Yes.

Q. Okay. Did you review anything else in preparation for today's deposition?

A. Possibly some other articles that I have not cited.

Q. And what might those articles be?

A. Other articles related to the topic abortion complications, some articles about the reasons that women choose abortions late in pregnancy.

Q. Do you have the authors of those articles or any information that might help identify them?

A. The reasons -- there are a couple of -- or researchers associated with Guttmacher that do a lot of publishing on that: Finer, Foster, Jones. So I've looked at several articles from that group of researchers.

Q. Uh-huh. And would say -- you mentioned

14

Foster. Would that have been Diana Greene Foster?
A. Yes.
Q. Would that have been an article with respect to findings from the Turnaway studies; do you recall?
A. I have looked at some of the Turnaway studies, yes.
Q. But you're not sure if it is what you looked at with respect to reasons for abortion?
A. It is likely, but I don't recall specifically.
Q. And what about complication rates? You said you may have looked at some other articles with respect to complication rates. What might those have been?
A. I also do a lot of research on maternal mortality, so there have been some other articles. There are some very informative articles out of Finland, and I think I may have probably documented at least one of those in my references, but -- Gissler and colleagues. There's probably about five articles that talk about mortality rates. I believe the other Finish researchers I quoted in the references already.
Q. Okay. So other Finish studies.
Any other documents that you reviewed in preparation for today's deposition?
A. I believe that's it.

15

Q. Okay. Did you -- just to confirm, did you review any of the other expert reports in this case?
A. No, I have not.
Q. Have you reviewed any other case documents in this case since you submitted your expert report?
A. You know, I take it back. The only other expert report that I have seen is Byron Calhoun's. And I don't know why, but that ended up in the packet that you guys sent me yesterday. But I had not seen it before then, and I have not really reviewed it extensively because I thought it probably got sent as an accident.
Q. Okay. So just to confirm -- and perhaps this wasn't conveyed to you. Have you opened the packet from yesterday, Dr. Skop?
A. Yes.
Q. You've opened it. Okay.
A. Was I not supposed to?
Q. You weren't supposed to, no. That was part of the court's order, actually, that you were provided by Mr. Sorenson.
A. Oh, I'm sorry. I --
Q. And so it sounds like, in addition to opening the article, you must have opened packets inside the article that were sealed themselves. Is that accurate?

16

A. Yes.
Q. Yes. All right. Well, we'll reflect -- let the record reflect that the witness has apparently had access to the exhibits for -- how many hours would you say, Dr. Skop?
A. I opened them, looked through them and saw that most of them were things that I had provided to you. So I haven't really been looking at them, I just reviewed. . .
Q. Okay. All right. So you said that you had reviewed the expert report of Byron Calhoun. Was that just last night, or had you reviewed that before yesterday?
A. No, I had never seen it before. I just received the packet yesterday.
Q. So that was the first time that you had ever seen that expert report?
A. Yes.
Q. Okay. Anything else that you've reviewed in preparation for today's deposition?
A. No.
Q. What about people you've talked to in preparation for today's deposition? Have you spoken with anyone about today's deposition other than Mr. Sorenson?

17

A. No.
Q. Have you spoken with anyone, irrespective of whether it was related to this case, about tips or approaches to responding in depositions?
A. Well, I spoke with Mr. Sorenson.
Q. Other than Mr. Sorenson?
A. No.
Q. So you're associated or affiliated with an organization called AAPLOG; is that correct?
A. I'm a member of AAPLOG, yes.
Q. You are a member. And are you also the chair of their board?
A. I was a board member. I'm not a board member any longer.
Q. Okay. So what is your -- do you have any affiliation with AAPLOG other than as a member?
A. Currently, not really.
Q. What does that mean?
A. Well, I'm the -- I'm still the chairman of their maternal morbidity and mortality committee. But we -- we wrote a practice bulletin that's been on the website, and since that time, we have not done any further work.
Q. Okay. What is that practice bulletin?
A. It is on their website. There's one about

18

abortion and maternal mortality.
Q. Okay. Have you worked on any other materials that AAPLOG has provided to the public?
A. Yes, I was involved in writing several of their practice bulletins and committee opinions.
Q. Okay. What about their fact sheets? AAPLOG provides fact sheets to the public, correct?
A. That is correct. I believe that the fact sheets were written before I joined the board.
Q. Okay. So you wouldn't have had any role working on those fact sheets?
A. No, I don't think so.
Q. No, so not on maternal mortality?
A. I believe that one was already written.
Q. What about fetal pain?
A. No, I did not write that one.
Q. Okay. Do you also have any association with the Charlotte Lozier Institute?
A. I am one of their associate scholars.
Q. What does that mean; what are your responsibilities in that capacity?
A. There's not really any set responsibilities and it is not a paid position. Occasionally they'll reach out to me for my opinions on issues, and I've written one paper for them.

19

Q. Okay. And which paper was that?
A. The paper was called No-Test Medical Abortion.
Q. Okay. Is that identified in your -- well, we can talk about it in a moment.
So you mentioned the Charlotte Lozier Institute and AAPLOG. Do you know, do either of those organizations provide training for expert witness testimony for individuals in the pro-life community?
MR. SORENSON: Objection, foundation.
A. -- it is Charlotte Lozier.
Q. I'm sorry, ma'am, I couldn't hear you.
MR. SORENSON: Let me put my objection on the record.
Objection, foundation.
Q. Could you answer the question, Dr. Skop?
A. Yes. Charlotte Lozier does.
Q. So you're aware of that training?
A. Yes.
Q. How did you become aware of that training?
A. I participated in the training.
Q. You participated in the training. When was that?
A. It was probably last year, last fall.
Q. Last fall. So around the time that you knew

20

you would be an expert witness in this case?
A. No. It was before I knew about this case.
Q. Okay. Do you recall which month that was?
A. Probably September.
Q. And what did that training entail?
A. It involved a number of things. There was some media training: how to be interviewed and get your points across. There was a small amount of expert witness training, but it wasn't really the focus of the training event.
Q. Do you remember what it was called?
A. I do not remember.
Q. Who presented on the expert witness testimony; do you recall that?
A. I do not recall. I'm really bad with names. It was a woman I had not ever met.
Q. Okay. And no one else, to your recollection?
A. I'm sorry. I didn't understand the question.
Q. There was no one else who presented on expert testimony training to your recollection?
A. I believe there was just one presenter.
Q. Okay. All right. And do you have any materials from that training?

21

A. Not with me.
Q. But do you have them in your possession?
A. I may. I would probably have to look back through handouts and stuff that I have. I don't remember if I kept them or not.
Q. Would you have kept notes?
A. Possibly.
Q. Do you remember who else was at the training with you?
A. There were probably about twelve Charlotte Lozier scholars there.
Q. Any other names that you recall?
A. Let's see. I think Kate Carnahan, Christina Francis, Donna Harrison. . . The others I don't recall.
Q. Do you know who the experts in this case are, Dr. Skop?
A. Who the --
Q. Sorry, I apologize.
A. Other expert witnesses?
Q. Yes. The other expert witnesses; do you know any of them?
A. Do I know them personally?
Q. Uh-huh.
A. I know Byron.
Q. Byron Calhoun?

22

A. Uh-huh.
Q. And what about Anthony Levatino?
A. Oh, I'd forgotten that he was one. Yes, I know Anthony.
Q. What about Maureen Condic?
A. I don't know her personally.
Q. What about Priscilla Coleman?
A. I don't know Priscilla personally.
Q. And Farr Curlin?
A. I believe I met him once.
Q. So you said you did a training from the Charlotte Lozier Institute. Have you spoken or done any other trainings with individuals or groups in order to prepare to give expert witness testimony?
A. No, I have not.
Q. Okay. So have you now told me everything you've done to prepare for today's testimony?
A. Yes.
Q. In total, how much time would you say you spent preparing to be deposed today?
A. Probably an additional 20 hours.
Q. Okay. And what's your hourly rate for compensation in this case?
A. I believe it is 300.
Q. $300 per hour?

23

A. Uh-huh.
Q. Is that different for time spent providing deposition or trial testimony?
A. Is the rate --
Q. Yeah, do you have a different -- yes. Is your rate different for time spent preparing trial or deposition testimony as opposed to, for example, time spent preparing a report?
A. The rate for deposition and trial is 350.
Q. $350 per hour, okay. Do you have any idea how much time you spent on this case to date?
A. You know, I really don't. I think about it a lot, but I don't charge for that. I don't recall how much time I spent when I was preparing the report.
Q. So do you keep track of your hours?
A. I do. Like I say, I don't charge every time I'm thinking about it, so. . .
Q. Have you received any payment to date, Dr. Skop from the state?
A. I need to check my records.
Q. Okay. And you don't have any idea how many hours you've spent on the case to date, correct?
A. No, I do not. No.
Q. Okay. One moment. And do you -- in addition to -- well, let me ask this. Do you have a

24

written agreement with the state with respect to your expert testimony in this case?
A. I believe I do.
Q. And is that -- to your knowledge, does the compensation you receive in this case depend in any way on the outcome?
A. No.
Q. Have you been told -- or to your knowledge, is there a limit to the number of hours that you can spend on this case that the state would compensate you for?
A. I'm not aware of a limit.
Q. Okay. Outside of the compensation that you anticipate receiving from the state in this case, is there any other entity or individual who is paying you for your time as an expert witness in this case?
A. No.
Q. Okay. All right. Well, with that, I think it would be helpful to switch gears a little bit to the substance. And so I wanted to start just by asking you about the law challenge in this case.
Are you familiar with HB136, the law at issue in this case?
A. Yes, I am.
Q. And what is your understanding of what this

25

law would do if it takes effect?
A. It would not allow a woman to have an elective abortion after 18 weeks gestation. It does allow exceptions for life of the mother for a -- the possibility for a severe physical outcome for the mother, the case of rape, if it's been reported to law enforcement, a uniformly lethal diagnosed condition in the fetus, or a severe fetal brain malformation.
Q. And when you say 18 weeks gestation, does that mean 18 weeks as dated from the first day of a patient's last menstrual period?
A. That's correct.
Q. Okay. So if -- throughout the day today, to make sure that we're talking about the same way of dating a pregnancy, if I say 18 weeks LMP, you would understand that to mean 18 weeks as dated from the first day of a patient's last menstrual period, correct?
A. That's correct.
Q. Okay. Would you agree throughout the day, as we talk about different points in pregnancy, that if you do not use LMP -- if you mean something other than LMP that you'll say that throughout the day --
A. Yes.
Q. -- when referring to points in pregnancy. That would be helpful. Thank you.

26

Okay. So do you know any of the defendants in this case?
A. No.
Q. What about any members of the Utah legislation?
A. No.
Q. So not representative Cheryl Acton?
A. No.
Q. Senator Deidre Henderson?
A. No.
Q. Did you play any role in the development of HB136?
A. No.
Q. Have you ever played any role in the development of other legislation in Utah or other states related to abortion?
A. No.
Q. Okay. So no drafting of other legislation?
A. No.
Q. No input to legislators who are considering such legislation?
A. No.
Q. No testimony of any kind?
A. Not prior to the legislation being written.

27

Q. But after the legislation was written, you might have provided testimony?
A. I provided testimony on several occasions in 2013 in Texas for HB2.
Q. And for the record, HB2 is what?
A. HB2 was a legislation that had four parts: It prohibited elected abortion after 20 weeks. It required that medical abortion be done as required by the FDA. It mandated that abortion providers have hospital privileges within 30 miles. And it mandated that abortion facilities meet the criteria of ambulatory surgery centers.
Q. So you provided testimony to the legislature while it was considering that legislation, correct?
A. Yes, I did.
Q. Did you support the legislation?
A. I did for reasons of safety.
Q. Can you explain that? Safety with respect to what?
A. Many abortionists do not take care of their complications. I've seen that as a private OB/GYN for 25 years. I have seen many women in the emergency room when their abortion providers were not willing to care for them. So I testified because I felt the hospital admitting privilege was an important way to improve safety for women.

28

Q. Okay. And you mentioned that you had done testimony in Texas. Have you ever provided testimony with respect to any other legislation elsewhere in the United States involving abortion?
A. Verbal testimony?
Q. Testimony of any kind, Doctor. So verbal, written.
A. I've written one other expert witness report.
Q. Okay. And where would that have been submitted?
A. Georgia.
Q. Georgia. What was the legislation that pertained to?
A. The legislation that has been put on hold that prohibits abortion after a fetal heart beat can be detected.
Q. And when does a fetal heart beat generally -- when can it generally be detected?
A. It can generally be detected between six and seven weeks post LMP.
Q. At that point is it medically accurate to refer to the product of conception as a fetus, or is it an embryo?

29

A. The -- there's not a very clear definition between the transition between embryo and fetus, but most would refer to it as a fetus at that point.
Q. At six weeks of pregnancy?
A. Uh-huh.
Q. Okay. All right. So Georgia. Any other states?
A. No.
Q. Okay. All right. So let's go to -- let's go to your professional training before we get into the details of your expert report. I'd like to get a sense -- a little bit better sense of your professional background. So with that, I want to introduce -- if you can turn to Tab A.
MS. MURRAY: And, Ms. Marchant, I think this will be Exhibit 1.
(Discussion held off the record.)
(Exhibit No. 1 was marked.)
Q. Dr. Skop, Tab A, is this your CV, Exhibit 1?
A. Yes.
Q. Okay. And did you prepare it?
A. Yes.
Q. Does it include a current and accurate list of your credentials?

30

A. Yes.
Q. Okay. Are there any inaccuracies on the CV that you want to point out?
A. No.
Q. Anything missing on the CV?
A. I mean, I think you can always add more things to a CV, but I don't see anything substantial missing.
Q. So nothing that you would imagine would be relevant to this case?
A. No.
Q. So I see you're trained as an OB/GYN; is that correct?
A. That is correct.
Q. Can you describe the nature of your practice?
A. I'm in a group practice of about 20 OB/GYNs, and I work full time. I probably deliver 15 babies a month. I see 25 to 30 patients a day in the office, take call along with the rest of my group. Since there is a lot of us, it is usually about two 24-hour calls a month.
Q. Okay. And when you say you take call, what does that mean?
A. Due to the size of our group, it means that I come to the hospital, I pack a bag, and I do nothing

31

but manage labor and deliver babies on labor and delivery.
Q. Okay. So during a month, you would probably have two days like that, where you're doing labor and delivery work at the hospital?
A. Yes.
Q. Are there other days of the month that you are doing labor and delivery at the hospital?
A. If I have a patient that comes in in labor or a scheduled C-section or induction, I will do those deliveries even if I'm not the call doctor.
Q. Okay. So if it is one of your patients, you would go into the hospital for that in addition to the days that you're on call; is that correct?
A. Yes.
Q. So you work in a private practice. How many people are in your practice?
A. Twenty.
Q. Sorry. I should say how many physicians. Is it 20?
A. There's 20 physicians, yes.
Q. Twenty physicians, okay. Are they all OB/GYNs?
A. Yes.
Q. What about -- do you do any work in a clinic

32

setting?
A. Do you mean like a public clinic or -- because we would call our office a clinic, our private practice.
Q. Right. Sure. My apologies. I'm referring to a public clinic or sometimes, for example, hospitals will have outpatient clinics of different types that are located near but not necessarily within the hospital.
A. No, it is within my practice.
Q. I'm sorry, what was that?
A. All of my clinical work is done within my private OB/GYN practice.
Q. Okay. And you've been doing that since 1996; is that correct?
A. Yes.
Q. Okay. And what's the hospital that you practice in?
A. North Central Baptist.
Q. I saw at one point that you were the -- am I getting this correct, that you were the chair of the Baptist Hospital Systems, or the chair of the department of OB/GYN; is that correct?
A. I was just the chair of the department at one point.
Q. Of the department for Baptist Hospital

33

Systems, right?
A. For -- at the time I was at a different Baptist hospital. Northeast Baptist, and I was the chair of the OB/GYN department for that time period.
Q. Okay. So you were at the Northeast Baptist Central Hospital, and now you're at the North Central Baptist Hospital?
A. Yeah. I was at Northeast Baptist for probably about 15 years, and then we moved our practice to North Central Baptist for the last, probably, nine years.
Q. Okay. And are those -- are both of those hospitals affiliated with Baptist Hospital Systems in Texas?
A. Yes. Yes, they are.
Q. Okay. So what is -- you said that you work full time. What does a normal week look like for you in terms of the kinds of care that you provide?
A. I take one day off a week, Wednesday. The other four days I work -- two days a week I work from 7:45 to 3:15. The other two days I see patients from 9:00 until 5:00, and sometimes I have surgeries or C-sections scheduled before or during lunch periods.
Q. Okay. How many -- do you have a sense of how many patients you have, your overall patient

34

caseload?
A. I don't know how many active patients I have because many of them just come to see me once a year for their annuals. I would say, in an average week, I probably see 100 to 110 patients in the office.
Q. Okay. Do you have a sense of how that caseload would break down between patients seeing you for obstetrical care as opposed to gynecological care?
A. Probably 20 percent obstetric and 80 percent gynecologic.
Q. And some of the gynecologic visits could be women who are between pregnancies, correct?
A. Yes.
Q. Okay. And then how would you describe the patient population that you serve in your private practice?
A. Of our OB patients, probably about 40 percent have Medicaid funding. The rest are privately funded -- or private insurance. Demographics, probably 10 percent black women, 50 to 60 percent Hispanic, and most of the rest are white, occasional Indian or Pacific Islander.
Q. Sorry. You said 50 to 60 percent Hispanic, and what share would you estimate are black?
A. About 10 percent.

35

Q. What about the -- how -- for patients who come to see you for obstetrical care, how early do patients typically come in for their first prenatal visit?
A. If they're not having any problems, we generally try to bring them in by about seven weeks.
Q. Okay. So is that the recommendation for standard prenatal care?
A. It -- it works out well because at that visit we can generally document the fetal cardiac motion by ultrasound, so we can give them reassurance about the viability of their pregnancy. If they're bleeding or having pain, of course we get them in earlier.
Q. Uh-huh. And do you -- do you see -- I mean, I imagine on some occasions you must see people who come in later for care than seven weeks; is that correct?
A. That is correct.
Q. Who come in for their first visit?
A. That's correct.
Q. How -- can you estimate how often that happens among your patient population, that people come in after the recommended seven-week visit for their first prenatal appointment?
A. Probably about a third of them come in after seven weeks.

36

Q. And do you have any sense of when they do come in, that third?
A. I would say it is probably only about 10 or 15 percent that come in after the first trimester.
Q. Okay. What's the latest you've seen someone come in?
A. Well, I've delivered women at the hospital that didn't know they were pregnant, so all the way to delivery, but typically it is much earlier.
Q. How often has that happened that you've had deliveries from women who didn't know they were pregnant?
A. No very often. Most women know.
Q. Would it be more than five?
A. More than five women?
Q. Uh-huh.
A. I'd say probably about five women that went all the way to term without knowing they were pregnant.
Q. And the people who come to see you, you say about 10 to 15 percent will come in after the first trimester. Do you have a sense of when those people learned they were pregnant?
A. My sense is that it is rare for a woman not to know or suspect that she's pregnant and get halfway through her pregnancy before she knows. I think most

37

women who present for late prenatal care, they are either in denial about the pregnancy or, perhaps, procrastinating. Sometimes there's Medicaid funding issues too.
Q. Can you explain the Medicaid funding issue?
A. If a woman doesn't have insurance, in order to get Medicaid funding, she needs to -- sorry, there's some noise.
-- she needs to apply for Medicaid. And for some women, that can take a little bit of time to do that.
Q. I see. Okay. So you said you think it is rare. Would you say, based on your experience, that it happens in 5 percent of cases that women don't know until after the first trimester?
A. I think it would be less than 5 percent.
Q. Actually, if we could back up. I believe you said you thought it was rare that people don't know they're pregnant until after the first half of pregnancy. Is that what you said, Dr. Skop?
A. I think that might have been what I said.
Q. Okay. But just for -- to be clear, though, the second half -- the first half of pregnancy would end after what week?

38

A. You know, I think what I said was a little imprecise. Let me back up.
I think it is very rare for women not to know that they're pregnant until the gestational age that we're discussing in this legislation.
Q. Meaning 18 weeks --
A. Eighteen weeks.
Q. -- plus? Okay.
And with respect to those people, would you say that's maybe 5 percent of your patient population doesn't learn that they're pregnant until 18 weeks of pregnancy or more?
A. I think it is far less than that.
Q. Less. What about the share of your pregnant population who learn that they're pregnant after the first trimester, so after -- let me ask you. What would you say -- when does the first trimester end, what week LMP?
A. Typically we think 12 and 13 weeks.
Q. What share of your patient population would you say learns that they're pregnant after 12 to 13 weeks of pregnancy?
A. Although some present later than that for various reasons, I think it would probably only be 2, 3 percent that don't know that they're pregnant after that

39

time.
Q. In your practice. Is that what you're testifying to?
A. In my practice, uh-huh.
Q. All right. So in terms of -- you mentioned you do about 20 percent obstetrical care in a given week and 80 percent gynecological care, correct?
A. Correct.
Q. Of the gynecological care that you provide, what kinds of procedures do you do? What are the most common ones?
A. Probably the most common are minor procedures such as an endometrial ablation, which is for dysfunctional uterine bleeding or a laparoscopic tubal ligation.
Q. Okay. What else?
A. Those are the most common that I do.
Q. Okay. What about for obstetrical care? You mentioned that you deliver babies. Do you have a sense of how those deliveries break down in terms of vaginal versus caesarean section birth?
A. Probably about a quarter caesarean section and three-quarter vaginal.
Q. Okay. What about -- among the vaginal births that you do, what share would you say begin with

40

induction?
A. Possibly a third.
Q. Okay. And why would you induce labor? What are the reasons that a patient might have induction?
A. Some patients want to do it for social reasons. They may have other children at home that they'd like to arrange child care for, perhaps to arrange their work leave. That's an elective induction. There are specific criteria we use to determine whether it is appropriate to induce that labor.
We manage a very high risk patient population. The rate of obesity, diabetes, and hypertension are quite high in San Antonio, and many times women who have those problems require delivery due to worsening severity of their underlying medical problems.
Q. I see. So when you say that they may require delivery, you mean they might require delivery before their bodies would naturally go into labor; is that correct?
A. That is correct.
Q. So you would induce labor, in those circumstances, to deliver the baby other than might otherwise occur?
A. If appropriate. Sometimes they need a

41

C-section for obstetric indications.
Q. You mentioned the possibility of elective inductions and that there was some criteria you use in determining when that might be appropriate. What are those criteria?
A. They need to be at least 39 weeks gestational age.
Q. Okay.
A. And I prefer to deliver them when they have a favorable cervix, meaning that they're a little bit dilated. There are various criteria, but usually about two centimeters dilated. Because in that scenario, I don't think we're raising the risk of C-section by inducing labor.
Q. Okay. Because if it is what you might consider an unfavorable cervix, induction can increase the risk of --
A. Yes.
Q. -- the C-section?
And in your practice, would you say that that is, to your knowledge, your colleagues' practices? Is that the point at which an OB/GYN might induce labor for an elective induction in pregnancy, at that point in pregnancy; does that vary by doctor?
A. So you're asking if the criteria of 39 weeks

42

and a favorable cervix vary by doctor?
Q. Not the 39 weeks but the favorable cervix. You said that you like to see two centimeters dilation. Would you say that is individual preference, or would you say that is true across your practice?
A. I think my partners practice in a very similar way to the way I do. Sometimes if a woman has gone past the due date, we may induce with an unfavorable cervix. But that's generally because, at that point, we're starting to have obstetric indications, concerns for the well-being of the fetus by going post dates.
Q. Okay. And you mentioned the unfavorable cervix. What do you have to do with an unfavorable cervix to make the possibility of induction -- to make it realistically possible for someone to have an induction?
A. In our hospital, we generally use a prostaglandin called Cervidil.
Q. Cervidil. How is that administered?
A. It is a vaginal insert.
Q. Are there other ways you can deal with an unfavorable cervix --
A. Yes.
Q. -- to cause dilation?
A. Some obstetricians will use a balloon

43

catheter that they'll place in the cervix.
Q. Okay.
A. And there's -- we'll use misoprostol.
Q. How is that administered?
A. It is usually administered vaginally as well.
Q. Okay. And the balloon is actually a -- well, how would you describe a balloon?
A. Well, it is actually a Foley catheter, and a Foley has a balloon that is blown up on the tip. When it is placed in the bladder, that holds it in the bladder. But we'll use the same device to place it through the cervix, blow the balloon up to hold it in place, and then a little bit of traction is then applied to the cervix.
Q. I see. Okay. And what about the C-sections that you perform; would you say any of those are elective C-sections?
A. On a rare occasion a patient will request an elective C-section.
Q. Uh-huh.
A. But that's fairly rare. Most of the C-sections that we do are for obstetric indications.
Q. And you say that some patients will request one. How often does that happen in your practice?
A. Far less than one a year.

44

Q. And do you do them when patients request elective C-sections?
A. I will do them after extensive counseling. There's higher risk of morbidity after a C-section, and so I make sure that the patients are aware of that.
Q. Okay. So you would do them with appropriate counseling with respect to the risks; is that accurate?
A. Yes.
Q. Okay. One of the -- let's see. What are the risks of C-sections?
A. There can be risk for anesthesia, aspiration if a woman vomits or has an overdose or a reaction. There can be risk of bleeding. There can be risk of infection in the abdomen, in the uterus, or the incision itself can become infected and can sometimes open. There can be risk of damage to other organs, particularly the bladder.
Q. Anything else?
A. Not that I can think of right offhand.
Q. When you say bleeding, is there bleeding after any pregnancy separation?
A. Generally, yes.
Q. So what kind of bleeding would be a concern?
A. Bleeding that results in blood loss that

45

causes severe anemia or hemodynamic compromise. Bleeding can occur due to a flaccid uterus. So a uterus that does not contract and shut off the flow of blood. Bleeding can occur because there's large uterine vessels that can sometimes be lacerated during the surgery. Bleeding can occur outside of the uterus on the rectus muscles. It can occur in the subcutaneous space. Basically anywhere you cut, there is a potential for bleeding there.
Q. So you mentioned the possibility of anemia or hemodynamic -- sorry can you say that one again?
A. A hemodynamic compromise.
Q. Hemodynamic compromise.
A. Where she has trouble keeping her blood pressure up or her circulatory system starts to be compromised.
Q. I see. With respect to bleeding, how would you define hemorrhage?
A. There are actually several categories of hemorrhage depending on the amount of blood that is estimated to be lost and how the woman's heart rate and blood pressure and urine output respond to it. Typically an early hemorrhage is, you know, more than about 500 cc's, about half a liter.
Q. All right. And then what about the complications or risks from inductions; how would you

46

describe those?
A. Well, I've mentioned that particularly with an unfavorable cervix it may raise the risk of requiring a C-section. A long induction may raise the woman's risk of infection. An induction may lead to fetal intolerance of labor that might require a caesarean section for the indications for the baby. In rare occasions people can have adverse reactions to the medications that are used: the Pitocin or Cervidil or Cytotec.
Q. What about uterine rupture; does that happen?
A. It can happen. The most -- it doesn't -- fortunately, it doesn't happen often and generally happens in the setting of a woman trying to have a vaginal birth after she's had a prior C-section or other uterine surgery. Sometimes women have uterine fibroids removed, and that's a situation where they also might be at risk for uterine rupture.
In third world countries, fortunately I've never seen it, but uterine ruptures can occur from obstructive labors, where there is not the ability to do a caesarean section to get the baby safely out if the baby is unable to deliver vaginally.
Q. But in a U.S. setting, uterine rupture does happen on occasion from inductions, correct?

47

A. Well, we -- as a rule, we do not induce women who have had a prior C-section. So it -- I wouldn't say that it can't happen from an induction without a prior C-section, but most of the time, when that happens, it is in that setting of a uterus that has a scar on it.
Q. Right. Actually, that brings me back to one question I had. With respect to C-sections, you said you do some elective ones but they're very rare, and then you do others for maternal indication. Is a prior history of C-section a maternal indication for another C-section?
A. It doesn't have to be. This is a situation where we will spend quite a bit of time counseling a woman on the risk. There is risk either way when a woman has had a caesarean. Repeating the caesarean has the risk of the C-section itself, and the more C-sections a woman has, her risk goes up of having an abnormal placenta, possibly an invasive placenta in a subsequent pregnancy, scar tissue, the technical complexity of the surgery can get more difficult if a woman has had a lot of C-sections.
But the -- the risk to her and the baby of attempting a VBAC, vaginal birth after caesarean, is the -- obviously the most catastrophic thing would be a uterine rupture that can result in fetal death and, on

48

extremely rare occasions, has resulted in maternal death as well.
Q. So to be clear, hypothetically, if you had a patient who is pregnant and has had one prior C-section, would you -- if she wanted to have another C-section, would you perform a C-section in those circumstances?
A. I would after counseling on the options.
Q. Okay. And in that circumstance, you would classify that as a C-section performed for maternal indication, correct?
A. Yes.
Q. Okay. All right. What about -- do you handle miscarriage management?
A. I do.
Q. And can you describe the miscarriage management care that you provide?
A. Most miscarriages are in the first trimester. And on diagnosis, there are three options that I'll offer a patient and, obviously, counsel about the pros and cons of each of the options. We can do a -- a dilation and suction curettage. That's a surgical management that removes the fetus and the placenta and the pregnancy tissue.
We can wait. The body generally will recognize a miscarriage and eventually she will pass the

49

tissue. Sometimes that's psychologically hard because it can take a little while. Sometimes it is weeks before the body recognizes it. And the third option that we will offer is misoprostol to help the body begin the process of contractions and expressing the pregnancy tissue.
Q. So you would provide misoprostol alone; is that correct?
A. That is correct.
Q. Okay. What about for individuals who have a miscarriage after the point at which dilation and suction curettage is no longer available? How do you handle a miscarriage in those circumstances?
A. Fortunately, those are rare. I will tell you honestly that even after 25 years of an obstetrician, I am very respectful of doing a D&E in that situation. A D&E, which is the most common method of pregnancy termination after about 14 weeks, requires more dilation than an early procedure does. It requires, often, the doctor to introduce grasping instruments into a distended, soft uterus. The risk of perforation is high. The risk of incomplete evacuation of the tissue is high.
It is a procedure that OB/GYNs take very seriously. When I have occasion to do that, I will usually have one of my partners assist me, and I will

50

always do it under ultrasound guidance. Even later miscarriages, I would say 16, 18 weeks and beyond, we often -- we also may offer the patient induction in the hospital with misoprostol.

Q. Okay. So just so that I'm clear. At the point at which, in your practice, dilation and suction curettage would no longer be available to someone experiencing a miscarriage is approximately 14 weeks; is that correct?

A. Well, the -- the transition from a dilation and suction curettage to a dilation and evacuation is -- I don't think there is a hard line at 14 weeks. The D&E is required when the fetal bones are calcified and the fetus has reached a size that he cannot be easily extracted with the suction tubing. And -- so it can depend on the situation.

If you have a fetus that's been dead, perhaps for a couple of weeks before it was recognized, that fetus may be soft enough that you can extract him completely with the suction. But if he's bigger or recently died and has not begun the process of maceration, then many times multiple passes with the graspers to disarticulate the fetus are required. And that's the definition of a D&E.

Q. And how many D&Es for miscarriage management

51

have you performed during your career?

A. Maybe about one a year.

Q. And how long have you been practicing?

A. Twenty-five years.

Q. So maybe about 25 in your whole career?

A. Uh-huh.

Q. What about D&Es after 18 weeks of pregnancy; have you ever performed one of those?

A. I have never performed one that late. When a patient loses a baby at that gestational age, we generally will do a medical induction. In addition to being safer for a woman, I believe that it is emotionally better for her to be able to hold her intact fetus and grieve, take pictures if she desires, bury the baby if she desires, have an autopsy to determine the cause of death if desired than to do an D&E, which will not leave the fetus in a condition that she can see.

Q. Okay. But just to be clear, you've never performed a D&E for miscarriage management at 18 weeks or beyond in pregnancy; is that correct?

A. That is correct.

Q. Do you recall what the latest D&E is that you've ever performed for miscarriage management?

A. Probably around 16 weeks.

Q. Okay. I see on your resume that you're

52

involved in something called The Contraceptive Initiative; is that right -- or institute?

A. That was a nonprofit that I founded about five years ago.

Q. And is it still in operation?

A. It is not because I joined the board of another organization that does similar work, and so I rolled the assets of The Contraceptive Initiative into the board of The Source -- or into the organization called The Source.

Q. What is The Source?

A. The Source is a clinic model -- currently it is eight clinics in Texas that are based on a pregnancy resource center model of giving women options other than abortion or unintended pregnancies. They also do free STI testing, and they -- this particular group of clinics are beginning to offer whole women's health including contraception.

Q. So The Contraceptive Institute -- or Initiative when you were working on that and, I guess, it sounds like, into The Source, is one of the forms of contraception that you provide long-acting reversible contraceptives?

A. Yes, it is.

Q. And those are sometimes call LARCs, correct?

53

A. Yes.

Q. Do LARCs reduce, in your view -- do they reduce the incidences of unintended pregnancy?

A. I believe they do.

Q. Do you think they reduce reliance on abortion?

A. Yes, I do.

Q. Are they more effective than other types of contraceptives at reducing unintended pregnancy?

A. I think there are some good studies out of Colorado and St. Louis and elsewhere that show that they do.

Q. In your experience, why do some women not use LARCs who want to use contraception but do not use LARCs?

A. Sometimes they have heard stories or have looked on the internet and have read things that make them nervous. Sometimes they're afraid of the pain of insertion of an IUD. I use all methods of contraception. But I've discovered that there is no one method that fits every woman. And so -- but I really like LARCs. I think they're very, very effective.

Q. Do some patients not use them because of the expense?

A. Oh, certainly.

54

Q. How expensive are IUDs, on average, would you say, in your experience?
A. They -- they're about 600 to 700 dollars a unit.
Q. Okay. And are they covered by Medicaid?
A. Yes. They're currently covered by all insurances. So it is rare that we find a woman who can't get coverage for it.
Q. But if you don't have Medicaid or insurance of some kind, you would not be able to get coverage for it; is that correct?
A. That's correct.
Q. Do you imagine among the patient population that you see that relies on Medicaid, so is income eligible for Medicaid, do you think an expense of -- did you say 500 to 700 dollars?
A. That's a good range.
Q. Would you say 500 to 700 dollars would be a barrier to getting a LARC in those circumstances without insurance?
A. Certainly. Certainly.
Q. Okay. So I have just a couple more questions on this, but I'm wondering, how are you doing? Do you want to take a break, or do you want to go a little longer and then break in maybe 15 minutes?

55

A. I can go longer, but if anybody else needs a break, I'm happy to take one now.
Q. So it is okay. All right. Let's finish this line, and then we'll take a mid-morning break. All right. So I see on your CV that you're a fellow of the American College of Obstetricians and Gynecologists, right?
A. Yes.
Q. And that's known as ACOG?
A. Yes.
Q. What is ACOG?
A. ACOG is a professional society of OB/GYNs. Membership is voluntary, but it is somewhat prestigious to be a member. It offers a lot of good advice on general obstetric and gynecologic topics. Unfortunately, it is an abortion advocacy organization as well.
Q. But you're a part of it, correct; you're a member?
A. I am a part. I do not agree with their abortion advocacy, and I've let them know. But I -- there are a lot of good things about being a member, so I am still a member. They, incidentally, have never asked their membership -- whether the membership feels they should be abortion advocates. Just the leadership has decided to do that.

56

Q. What do you mean by abortion advocacy? That they're an abortion advocacy organization?
A. To my knowledge, they have never submitted an amicus brief or a statement opposing any restriction on abortion. So they -- they promote abortion in any circumstance for any reason at any time in pregnancy.
Q. And what about AAPLOG, the organization that you are a member of? That's the American Association of Pro-Life Obstetricians and Gynecologists, correct?
A. Yes.
Q. Are they an advocacy organization, Dr. Skop?
A. Well, of course they are. It is in their name.
Q. A pro-life advocacy organization?
A. They used to be a subgroup of ACOG until ACOG kicked them out. But they represent another --
Q. Ma'am, could -- are they a pro-life advocacy organization?
A. Yes, ma'am, they are.
Q. Okay. So you mentioned ACOG does put out some useful information in obstetrics and gynecology. Do you rely on their practice bulletins in your practice at all?
A. I have been known to consult their practice

57

bulletins, yes.
Q. Okay. What about their ethics committee opinions; do you ever use those to guide your practice with tricky ethical issues?
A. I'm familiar with their ethics opinion that says it is unethical not to provide or refer for abortions.
Q. And do you agree with that opinion?
A. No.
Q. Do you provide abortions, Dr. Skop?
A. No.
Q. So if a patient comes to you and is pregnant and would like to terminate a pregnancy, what do you tell her?
A. I -- as I do in every situation with my patients, I talk to her about the -- the altern -- the risk, benefits, and alternatives of all of the available options.
Q. So you'll discuss the risks and benefits of abortion?
A. In my opinion, there are no benefits to abortion.
Q. Okay. And if after your counseling she still wants an abortion and asks you for a referral, what will you tell her?

58

A. A referral is not necessary. Abortions are paid for by private funds in Texas, and I believe everybody knows who the largest abortion provider is. So it is not necessary for me to give her a referral. That is not a barrier to her ability to get an abortion if she wants it.

Q. With respect, Dr. Skop, that is not responsive to my question. My question is what would you tell the patient if she asked for a referral for an abortion; what would you tell her?

A. I would show her the baby on ultrasound; I would tell her about the option of continuing the pregnancy. If she's unable to care for the child, I would tell her that there are many families in this country that would like to adopt a baby. I would introduce her to some of the resources available in our area, many of which, incidentally, provide couples counseling.

And I think it is pretty clear in Guttmacher's literature that many of the women who choose abortion do so because of lack of support from their partner and because of the perceived lack of resources. So I will tell her what resources are available. If she continues to express a desire to have an abortion, of course, I will tell her about the potential risk from

59

abortion, which can include physical damage, that can include mental health complications, even years later. The possibility that when she does desire a pregnancy that the baby could be born prematurely.

If she wants an abortion, she can have one. I'm not going to stop her. But, like I said, she doesn't need a referral from me to get one.

Q. Okay. So is it accurate to say, then, Doctor, that you would never provide a patient with information about where to obtain an abortion if they expressed a desire to have one?

A. I don't think it is necessary for me to do that. Everybody knows that your position -- you work for --

Q. With respect, Doctor, is it accurate to say that you would not provide a referral for an abortion to a patient who expresses a desire to have one?

A. A referral for abortion is not necessary.

Q. So the answer is yes; that's accurate?

A. What do you mean by referral? Do you want me to tell her the name of a specific abortionist?

Q. Sure. If she asks for a name and information about who she can contact to obtain an abortion, would you provide that?

A. I'm not going to -- I'm not going to choose

60

who she goes to. There are several different clinics she could go to. I could refer her to the Yellow Pages -- or to the internet to discover where a clinic is.

Q. And if she says that she's interested in adoption, would you refer her to the Yellow Pages?

A. I could, but I also know some adoption agencies.

Q. Do you?

A. I usually have a specific place that I can send her.

Q. And if a patient -- well, let's -- let me back up.

If a patient expresses an interest of having an abortion to you, do you refer her to a colleague, perhaps, who would advise her with respect to her options with respect to abortion who might actually provide a referral?

MR. SORENSON: Objection, asked and answered.

Q. I'm asking here, Dr. Skop, about whether you would refer a patient to one of your colleagues who does provide referrals for all sorts of options, either full term pregnancy, adoption, or abortion?

A. I don't believe any of my colleagues would refer her for an abortion either.

61

Q. Okay. So you think, throughout your practice, none of your colleagues would give the name and contact information of an abortion provider?

A. It is not --

MR. SORENSON: Objection, foundation.

A. It is not necessary.

Q. Okay. Let me ask you this: Dr. Skop, have you ever indicated that you do provide or -- sorry. Let me rephrase.

Have you ever stated that you do refer for abortion where there is a need?

MR. SORENSON: Objection, vague.

A. What do you mean by a need?

Q. Dr. Skop, in testimony you gave to the Texas State Legislature in a committee hearing -- you mentioned that you gave such testimony earlier to the Texas State Legislature. Did you ever indicate to the one of the legislators that you did provide referrals to abortion where there was need?

A. I don't recall that I said that.

Q. And if you would have said that, it would have been untrue; is that correct?

MR. SORENSON: Objection, vague.

Q. Could you answer the question, Doctor -- well, let me ask you this: Is there anything about my

62

question that you don't understand?
A. Yes, I think there is.
So you're asking me to recall something that I said seven years ago, and I don't recall if I said that or not. I think your follow-up question was: If I said that, was it untrue --
Q. Would that have been untrue?
Well, why don't I rephrase it this way: Do you provide abortion referrals where there is a need?
MR. SORENSON: Objection, vague.
A. I think I would need to understand what you mean by need.
Q. Okay.
A. If a woman's life is in danger from her pregnancy, and that happens sometimes, as her doctor, I care for her, and I deliver her. So I can't think of a situation where I would need to refer her to an abortionist to be cared for.
Q. Okay. That's fair.
All right. What about -- we talked a little bit about ACOG. Are there any other professional organizations in the medical community that you look to for guidance in your practice?
A. I don't think so.
Q. What about the American Medical

63

Association?
A. I'm not a member of the AMA.
Q. Okay. Well, whether or not you're a member, do you ever rely on their materials to guide your practice?
A. No.
Q. What about journals; are there particular medical journals that you turn to for reliable research and information in the fields of obstetrics and gynecology?
A. There are a number of medical journals that I will reference.
Q. Which ones?
A. Most commonly, "The Green Journal."
Q. What is that?
A. It is called Obstetrics and Gynecology. It is ACOG's journal.
Q. And what about -- isn't there something called "The Gray Journal"?
A. Yes. The American Journal on Obstetrics and Gynecology.
Q. Do you rely on that as well?
A. I have read articles from there. I no longer subscribe to it, so I don't have as ready access to it as I do. . .

64

Q. Would you describe those as the leading journals in the obstetrics and gynecology field?
A. They're well regarded journals.
Q. Okay. So generally viewed as authoritative in the field?
A. They're peer reviewed. They have published articles that I have found lacking in data and substance. So I wouldn't call them perfect or always authoritative.
Q. Sure. But in terms of among the journals that people might consult in the field of obstetrics and gynecology, would you view them as the two leading ones?
A. They're up there, yes. They are some of the better ones.
Q. All right. And what about -- are there any textbooks or treatises that you turn to for information on the practice of the obstetrics and gynecology?
A. There used to be. When I was a resident, I had and still have copies of the textbooks in my possession. But with the way that people do research today, I do not have any updated textbooks that I rely upon.
Q. All right.
MS. MURRAY: So I think that's probably a

65

good spot for us to stop. Do you all want to break for ten minutes?
MR. SORENSON: Yes. Should we break until 9:45, Mountain time, quarter to the hour?
MS. MURRAY: Sure that works. Sounds very good.
(Recess from 9:33 a.m. to 9:48 a.m.)
Q. (By Ms. Murray) Welcome back from the break, Dr. Skop. Is there anything from your prior testimony that you would like to add to or correct at this time?
A. No.
Q. Did you speak with anyone other than Mr. Sorenson during the break?
A. No.
Q. So you intend to offer expert opinion in this case, correct?
A. Yes.
Q. And what areas in the field of obstetrics and gynecology do you consider yourself an expert in?
A. I would consider myself an expert in pregnancy management, in gynecologic preventive treatment as well as treatment of pathology within the field of gynecology. Specific to this case, I have cared for many women in the emergency room who have had complications

66

from abortions.
Q. Okay. So that's your experience. What do you think you're in an expert in with something specific to this case?
A. I think I'm an expert now, after having cared for many women who had complications that were not cared for by the provider who performed the procedure. I began extensive research to discover why I was seeing so many complications when the literature tells me that there are rarely complications. I have discussed --
Q. Dr. Skop, I just -- I do want to make sure that we're able to move along today. I'm sorry to interrupt you, but I do want you to answer my question, which is, specific to this case, what areas of obstetrics or gynecology do you feel that you are an expert in?
A. I am an expert in obstetric management. Eighteen to twenty-two weeks is an area that I have extensive experience in caring for mothers and fetuses. And -- yeah, so I think I've cared for complications. I have done extensive research to know how poor the data on complications and mortality is related to abortion in the United States.
Q. So do you consider yourself an expert on the safety of pregnancy and childbirth?
A. As much as you can be after delivering 6,000

67

babies and working in the field for 25 years -- 29 years including residency.
Q. Uh-huh. Do you consider yourself an expert on the safety of abortion?
A. I do.
Q. Do you consider yourself an expert on the safety of abortion at or after 18 weeks of pregnancy?
A. I am as much of an expert as there is because I know how scanty the literature is on this gestational age.
Q. So would you say that you're a leading expert on the safety of abortion after 18 weeks of pregnancy, Dr. Skop?
A. I'm not sure how you're defining expert. I have written several peer reviewed papers on this topic.
Q. Well, you said I am as much of an expert as there is, so I'm asking you, does that mean that you believe you are a leading expert on the safety of abortion at and after 18 weeks of pregnancy?
MR. SORENSON: Objection. Vague as to leading, the word leading.
Q. Dr. Skop, is there anything about that question that you don't understand?
A. I agree that I'm not sure what you mean by leading expert. I've cared --

68

Q. How would you -- how would you define leading expert?
A. Well, as I just mentioned to you, I have published peer reviewed papers on it, and I have cared for women who have experienced complications related to abortions in this gestational age. I don't provide them. As I told you earlier, I am healthfully respectful of the D&E procedure because I think it is a very complicated procedure. I think the American Board of Medical Specialties agrees with me. They just created a two-year fellowship, Complex Family Planning --
Q. Dr. Skop -- objection, nonresponsive.
A. -- to do D&E procedures --
Q. Dr. Skop, could you please respond to my question. How do you define the term leading expert? How would you define that?
A. I have read -- so backing up.
Yes, I would consider myself an expert. I have read the available papers that address this topic. I have cared for it in my clinical practice, and I have written peer reviewed papers on it.
Q. You said you've written several. How many? More than five?
A. Regarding the safety of abortion --
Q. At and after 18 weeks of pregnancy.

69

A. I've written two that addressed that specific range. I've written two others on abortion complications that are not specific to 18 to 22 weeks.
Q. Would you agree that someone who has written four articles total about abortion is as good an expert as there is on the topic?
A. Again, I'm not sure what you mean "as good an expert as there is."
Q. Those are your words, Doctor.
A. Certainly there are doctors that have written more.
Q. And you said earlier you don't perform abortions. Have you ever been trained with respect to how to perform an abortion at or after 18 weeks of pregnancy?
A. I know how to perform them. I just don't do them.
Q. Have you been trained to perform them at or after --
A. Yes, that was part of the training in my residency, but I did not perform them then either. I saw them performed.
Q. I'm sorry?
A. I saw them performed. I was trained in the procedure.

70

Q. Okay. How many abortions at or after 18 weeks of pregnancy have you seen performed?
A. Probably 20.
Q. And when was the last one that you saw performed?
A. In residency, 25 years ago.
Q. And what share of those would have been performed by a D&E?
A. At that time, the preferred technique was prostaglandin induction. I believe most of those were done that way.
Q. So have you ever observed an abortion at or after 18 weeks of pregnancy performed by a D&E?
A. Not on a living fetus, but I have seen and have performed D&Es on deceased fetuses.
Q. To be clear, if you are performing a D&E on a deceased fetus, is it an abortion in your view?
A. No. An abortion is the intentional destruction of a living fetus.
Q. So you've never performed an abortion at or after 18 weeks of pregnancy, correct?
A. No, I have not.
Q. And you have never seen one performed at or after 18 weeks of pregnancy by way of D&E; is that correct?

71

A. That is correct.
Q. And with respect to miscarriage management, I believe you testified earlier, Doctor, that you have never performed, even for miscarriage management, a D&E past 16 weeks of pregnancy; is that correct?
A. That is correct.
Q. Do any of the doctors in your practice perform D&E abortions?
A. No.
Q. Okay. What about -- do you consider yourself an expert in mental health?
A. I wouldn't say I'm an expert, but I'm married to a psychiatrist. I know a lot about it.
Q. Expertise by osmosis.
Would you consider yourself an expert in the identification and treatment of depression?
A. It is something that I manage clinically frequently.
Q. So would you consider yourself an expert in it?
A. Sure. It is my professional -- part of my job.
Q. And so when you say you manage it, what do you mean by that?
A. I identify the symptoms, I diagnose the

72

illness, and I treat it through medication and referral to counseling.
Q. Okay. So you don't provide counseling yourself, though, correct, what would be considered mental health counseling?
A. Well, it would be ongoing therapeutic relationship that I don't have time to do while seeing 30 OB/GYN patients daily. That's not to say I don't counsel women when I discuss this problem with them. I do. But I don't do it for a prolonged period of time.
Q. Is there anything other than what you've just described in terms of treating patients with the depression that you believe qualifies you as an expert on the identification and treatment of depression?
A. I've cared for a number of post-aborted women over my career who have had depression that they have attributed to their abortion. In addition, the Any Woman Can, that I am the board chairman of, provides free mental health counseling for women who have sequelae, psychiatric sequelae of their abortions.
Q. And the activities of Any Woman Can, why are they relevant to your expertise?
A. I am the board chairman, so --
Q. Do you oversee the --
A. -- I'm involved in the protocols and

73

expediting the counseling.
Q. Okay. You've talked about your experience seeing women who have had abortions in the past. Let's talk about women who have had complications from abortion. How many women would you estimate you have treated for a complication of abortion during your career?
A. It's probably too numerous to count the women who have presented to the emergency room hemorrhaging after medical abortions who have required a D&E or a suction D&C. I have -- in residency, I had one patient that I readmitted to the ICU in sepsis after a mid tri -- I believe after a 20 or 22 week abortion, and she died. I also know of a patient within my practice who died of septicemia after a first trimester suction abortion.
Q. Okay. So just to go back through those. You said you think it is too numerous to count the number of women you've seen who have presented to the hospital after a medication abortion with a hemorrhage; is that correct?
A. That's correct.
Q. A medication abortion, how late is that available in the state of Texas?
A. Until 2016, it was available until seven

74

weeks. Since that time, it is available until ten weeks.

Q. Until ten weeks. So not an abortion that would be at issue in this case, correct?

A. That's correct. Right.

Q. And not a method of abortion that you could use at or after 18 weeks of pregnancy, correct?

A. Abortions can be performed through medical induction --

Q. But through the same medication abortion regimen that you were describing for first trimester abortions?

A. They can be. They're not done frequently that way.

Q. Just to be clear that I'm understanding you correctly: Are you saying that the regimen to do a medication abortion early in pregnancy in the first trimester could be used to do a medication abortion later in pregnancy, for example, at 18 to 20 weeks?

A. The same medications, mifepristone and misoprostol, can be used. The dosing may be different, but the same medications can be used.

Q. Do you know whether it is different?

A. I don't because it is done so infrequently. I don't know that I know what standard dosing is for

75

that.

Q. Uh-huh. So you said too numerous to count. Would you estimate that you've seen more than 20 of those patients who have had hemorrhages after medication abortions in the first trimester?

A. Yes.

Q. More than 30?

A. Probably over the years that I've been covering the emergency room, I'll say 50.

Q. Okay. And are these cases that you're describing, are they instances in which you confirmed that the person obtained a legal abortion in the United States?

A. They generally tell me that they came from Planned Parenthood.

Q. How many times do you think that has happened, Doctor?

A. That they came from -- that they were telling me the truth --

Q. That they had specifically referred to Planned Parenthood?

A. When I ask, almost always.

Q. Can you recall the most recent incidence that that happened, Doctor?

A. I can recall -- probably about two or three

76

years ago, our group stopped covering the emergency room. Just prior to that, we had a month where we had three women admitted for post-abortive complications. One was in the ICU, one required a blood transfusion, and one required surgery to complete her abortion. It was at that time that I realized that there was not a system in place that would automatically record these complications.

I tried to report them to the state of Texas, which is one of the states that has a law requiring providers to report the complications, and I found it to be a very difficult process, including -- they wanted the forms sent by certified mail, and it was de-identified, which, in my mind, would be very hard to discover duplicates or pull charts and find the situation. So that helped me to understand that --

Q. Wait. With respect, Doctor, my question was, can you recall the most recent instance in which you have treated someone for a hemorrhage after medication abortion who specifically told you that they obtained their abortion at Planned Parenthood?

A. Two to three years ago during that month, Yes.

Q. One of those women identified Planned Parenthood as the place where she had her abortion?

77

A. Yes, and I've tried --

Q. Can you recall any other --

A. -- response --

Q. Doctor, if you could listen to my question.

A. Okay.

Q. Do you recall any other specific instance of someone identifying Planned Parenthood as the place that they had their abortion?

A. Yes, it happens frequently.

Q. Can you recall another instance? When did that happen?

A. Like I say, I've managed probably 50 of these women over the years. And many times when I ask, that is -- I mean, probably some were also Whole Women's Health, which closed. But most of time when they name an abortion clinic, it is usually Planned Parenthood.

Q. Could it also have been women who self-managed their own abortions using drugs that they may have obtained outside of the medical community?

A. I know that that is something you guys are -- well, not you, but abortion advocates are starting to promote, particularly in Texas, because they're concerned that women have to drive. I've seen a number of articles asking women to go across the border to Mexico to get misoprostol, which doesn't work as well.

78

It fails about 20 percent of the time.
So I can't say that there aren't women who are following that advice and trying to self-manage their abortion. Women may do it for reasons of finance because you guys charge about $500 for the medical abortion regimen. But -- so I can't say for sure that that doesn't happen, but I also know that I've seen a number of patients who have reported that they received their medication in a Planned Parenthood clinic.
Q. You mentioned going to Mexico. Is it your understanding that you can obtain a medication abortion regimen in Mexico without a prescription?
A. That is true.
Q. How long does it take to drive to the border, Dr. Skop, from where you are?
A. It is about three hours.
Q. Okay. So -- okay. So we talked about the women that you said that you've seen in the emergency room. It sounded like you could only recall specifically one instance in which that has happened; is that correct? Are there any other specific patients you can recall?
A. Can you repeat the question? That reported Planned Parenthood, or have had abortion that's required surgical treatment?
Q. Any other patients who you have treated post

79

medication abortion for hemorrhage; can you recall any other specific patients?
A. I can -- I can think of some faces, yes.
Q. How many?
A. I don't know.
Q. More than five?
A. Yes. It happens frequently. It happens frequently enough that I don't recall everybody's face that I've managed through this complication.
Q. You mentioned you tried to make a report of this to the state authorities; is that correct?
A. That is correct.
Q. So they would have -- well, did you send the report to the state authorities?
A. Yes.
Q. Okay. What about -- you also mentioned that you had seen, during your residency, someone who had died from septicemia after an abortion at 20 to 22 weeks; is that correct?
A. That's correct.
Q. When did you do your residency?
A. '92 to '96.
Q. So do you know whether that was a D&E abortion?
A. No. I believe it was a prostaglandin.

80

Q. Okay. It was not a D&E. And then you also mentioned -- I believe there was one other that you talked about. Which one am I not recalling; do you remember?
A. That had died?
Q. Uh-huh, or any other type of complication.
A. There was a teenager who died after a first trimester surgical abortion.
Q. Right. First trimester surgical abortion. And what did she die from?
A. Overwhelming sepsis.
Q. And when did that happen?
A. Maybe 15 years ago.
Q. Do you know what point -- you said it is a first trimester abortion. So is it your understanding that was not a D&E abortion, correct?
A. That's correct.
Q. So have you ever seen a complication from a D&E abortion, Dr. Skop?
A. I have seen women have cervical incompetence and deliver babies extremely early after a history of a mid-trimester abortion. I would consider damage to the cervix resulting in the inability to hold a pregnancy to term in a subsequent pregnancy to be a complication of D&E, and I have seen that occur on more than one

81

occasion.
Q. Okay. So let me just break that down.
So you're talking about women who have preterm birth in subsequent births after an abortion, correct?
A. Right.
Q. And so the connection that you're making between the preterm birth and the earlier birth -- or the earlier abortion is the fact that uterine damage could cause later preterm birth; is that correct?
A. That's correct, a cervical damage.
Q. Cervical damage. My apologies. Cervical damage.
How many times would you say you have seen that?
A. I've seen a tendency toward early cervical shortening become more pronounced throughout my career. We -- at times, my group has had three or four women hospitalized on the antepartum service with this premature shortening and dilation at very early gestational ages -- 22, 24 weeks. So it is a trend that I'm seeing a lot. I don't know that in all of those situations they have a prior history of an abortion.
As you may be aware, it is sometimes difficult to get women to give you that history. But I

82

think that studies show that there is a correlation with early delivery, particularly extremely early delivery, after cervical abortions.

Q. So setting aside the studies, Doctor, I'm asking about your experience. Can you -- sticking on the preterm birth. What about the histories or circumstances of these patients has caused you to conclude that it is a post-abortion complication that they're having preterm birth?

Is there any -- let me ask it this way: Is there anything other than the fact that these patients had an abortion at an earlier -- for an earlier pregnancy that you are relying on to make that connection between the abortion history and the preterm birth?

A. I would acknowledge that there are other things that can lead to preterm shortening. However, it is physiological plausible that mechanically dilating an unripe cervix may cause damage to that cervix, which relies on its intact musculature to hold a pregnancy to term, and I think there is data to support that.

Q. Dr. Skop, let me ask it again. Is there anything other than the prior history of abortion with respect to these patients' circumstances or their specific histories that you are relying on to make a connection between their abortion and their later preterm

83

birth?

A. I'm not sure of your question because I think I've already answered that. There's studies that show that this can happen, and, with that history, it is certainly plausible that that could be the reason.

Q. It is plausible. Is it plausible that that is not the reason?

A. It is possible.

Q. Do people have preterm births with no history of abortion?

A. Certainly, they do.

Q. Would you say the majority of women who have preterm births have no history of abortion?

A. You know, it is now estimated that -- as you probably know, that one out of three to one out of four American women have had abortions. I think that there is not a lot of interest on the part of most academicians to sort through that. We -- our data is very incomplete. Many women don't admit to abortions. Most of the people publishing papers on abortion complications and safety right now are doing so while affiliated with an abortion advocacy group, such as Advancing New Standards in Reproductive Health, Guttmacher Institute.

I think that there is a vast need to look into this subject, but there has not been a desire on the

84

part of most academic physicians in America to look into this, although --

Q. Dr. Skop, let me ask it another way because I do want to keep us on track, and I would like you to respond to my specific question. So let me ask it a different way that might be helpful.

Of the people you have seen going into preterm labor, how -- what share of them would you say report that they have a history of abortion?

A. You know, I -- I can't really answer that question. Many of them have been managed by my partners and not me, and so I don't know the abortion history on a lot of them.

Q. So you're speculating as to the cause of their preterm birth; is that correct?

A. I'm speculating because there is no data.

Q. Okay. So setting aside -- so we've talked about the preterm birth. Are there any other complications from abortion that you believe you have treated in patients that you have seen during your career?

A. There's another serious long-term complication that is also quite hard to quantify. There's a situation called placenta accreta spectrum disorder, which is where a placenta is abnormally

85

invasive. The incidence of that has increased 110 fold in the past 50 years, and it is associated with catastrophic bleeding at the time of delivery. Women have died, even when they've been at a level 3 facility that was prepared for hemorrhage, because they can lose so much blood so quickly that they can overwhelm the blood bank. It is associated with --

Q. Can you answer my question?

A. Yeah, I'm sorry. I was giving you some background.

Q. Yeah, if I want background, I will certainly ask for it. At this point, I want to focus on: What are the other complications that you believe you've seen?

So am I understanding you correctly that placenta accreta spectrum is a complication of abortion? Is that your position?

A. It can be a complication of surgical instrumentation, which surgical abortions certainly do.

Q. Can it be a complication of a prior history of C-section?

A. Of course it can.

Q. And you said earlier that in some cases you will perform a C-section electively, correct?

A. That's one of the things I will counsel a patient about.

86

Q. Uh-huh. That it will have -- or could potentially have an impact on the placement of the placenta in a later pregnancy?
A. That's correct.
Q. So when you cite the 110-fold increase in abnormal placentation, could that also be attributable to C-sections?
A. It can.
Q. Do you know what share of births ended in C-section in, let's say, the 1950s?
MR. SORENSON: Objection, foundation.
Q. Do you know what share of --
A. It was far smaller than it is today. Today it is about probably about 30 percent. But just having another reason doesn't mean that we shouldn't be curious as to whether we're allowing women to undergo elective procedures that may increase their risk --
Q. Dr. Skop --
A. -- (inaudible) of possible death.
Q. Dr. Skop, please focus you on my question. Provide an answer to the question. And if I want additional information, I will follow up with you. I'm sorry to interrupt you. But I do want to keep us on track.
So you said it is possible that that

87

increase in placenta accreta spectrum is due to the increase in C-sections, correct?
A. There is a correlation, yes.
Q. And just for the record, a C-section actually involves -- every C-section involves a cut into the uterus; is that correct?
A. That's correct.
Q. Does every abortion or even D&E abortion involve a cut into the uterus?
A. We don't know what kind of damage --
Q. What about cervical damage?
A. Cervical -- the cervix is stretched open in every surgical abortion.
Q. So it could actually tear?
A. It can, yes.
Q. It can. Does it? Is that a normal part of the procedure of a surgical abortion?
A. It is a complication of the surgical abortion.
Q. It would be a complication, that's correct. But for a C-section, is that -- is a cut into the uterus a complication of a C-section or is it the definition of the procedure?
A. The cut into the uterus is the method of entering the uterus. However, PAS occurs in women who

88

have had no C-sections and in woman who have abnormal placentation but not at the area of the prior uterine scar. There are, clearly, other reasons women get that other than having a prior C-section.
Q. All right. So we've talked about -- I believe -- I just want to go back through. We talked about women hemorrhaging after medication abortion, a patient who died of septicemia after a later medication abortion. I believe you said it was a prostaglandin induction; is that correct?
A. It was an amniocentesis. People don't do it so much anymore, but they used the do an amniocentesis and inject the prostaglandin directly into the uterine cavity --
Q. Okay.
A. -- to help induce labor, and it is a situation that is high risk for infection.
Q. Okay. So that was one. And there was a patient who died in the first trimester after a first trimester surgical abortion, so not a D&E?
A. Right. Likely that was a uterine perforation into the bowel to introduce that infection.
Q. But it was not a D&E abortion, correct?
A. No, it was not. It should be a safer procedure.

89

Q. But it was not a D&E abortion; is that correct?
A. That is correct. Some of these abortions have more --
Q. In terms of the long-term effects of abortion, or effects you attribute to abortion -- you said that you have treated patients who have had preterm abortions, and based on their abortion history, you've concluded that the preterm birth was a consequence of the abortion?
A. It is possible.
Q. It is possible.
A. Data backs that up.
Q. Is it possible that it was not; is that correct?
A. Well, certainly. But there are large studies, large review studies that show higher incidence of early delivery after abortions.
Q. And then with respect to -- you also mentioned the patients that you had seen with abnormal placentation; is that correct?
A. That is correct.
Q. And what are you relying on to connect the prior abortion history to the abnormal placentation? Is it just studies, or is there anything particular to the

90

circumstances of the patient that have allowed you to make that causal connection?

A. Well, the plausibility is that if you have an invasive placenta -- and I neglected to mention the converse can also happen. You can have a placental abruption, an abnormally -- a placenta that does not adhere well, and that can separate spontaneously in a subsequent pregnancy. So, again, I don't -- nobody has the data that looks at every pregnancy outcome in America. Nobody is interested in that data; nobody is collecting it -- the CDC, nobody. So we don't know everybody's history. Where, it would be nice if we did --

Q. So is your answer, Dr. Skop, that you don't know of any data specific to those individual's history that allows you to make that causal connection between the prior abortion history and the placental --

A. No, no. There are studies that correlate surgical instrumentation with these abnormal placentas. And, yes, C-section can be a surgical instrumentation, but if that's the case, the placenta --

Q. It is always a surgical instrumentation, isn't it?

A. It is a surgical scar, okay? And there are women who have PAS where it is not in the surgical scar.

91

It is placenta previa. It can be up here. You know, so in those cases you say to yourself, What else could have happened that would make this uterus weak in the area of placental implantation so that the placenta invades? And I think that we have to ask our ourselves, is it the one out of three, one out of four women who have abortions -- I know we're not doing as many surgical abortions as we used to, but we were, in the past, doing a lot of surgical abortions.

It would -- it is not good care for women to ignore the possibility that that could be a door -- that could be the cause.

Q. You're saying that there is a possibility that the prior abortion history is the cause?

A. Yes. Yes.

Q. Okay. What about any other complications that you've seen from a D&E abortion at and after 18 weeks?

A. I have not, personally, cared for women who have had perforated uteruses, but I have read a number of reports --

Q. I'm asking you about who you've cared for, Dr. Skop, because you've mentioned multiple times you are drawing on your experience of treating women after abortions who are suffering from complications. So in your experience, what other complications have you treated post abortion that we have not spoken of today?

92

A. Well, those are physical, right? I've cared for a lot of women with emotional and psychological problems post abortion.

Q. Can we -- sorry. Can we pause there? So have you now told me every physical complication that you believe you have treated for an abortion -- for a patient after an abortion that you're -- let me rephrase that.

Have you now told me every physical complication that you have treated for a patient that you believe was a physical complication of the abortion?

A. I've also cared for women with Asherman's syndrome, which is scarring within the uterus. That also is linked to prior instrumentation, and many times it is a cause of infertility.

Q. And in those instances where you have cared for people with Asherman's syndrome, have you ever confirmed that those individuals had a history of abortion?

A. Sometimes they have.

Q. How many times?

A. I don't know, but I know that I've gotten that history from some women.

Q. More than one?

93

A. Yes.

Q. More than five?

A. Probably.

Q. More than ten?

A. Possibly.

Q. And Asherman's syndrome can be caused from other kinds of instrumentation, correct?

A. That's correct.

Q. So even a woman with a history of abortion, she could have Asherman's syndrome that is unrelated to the abortion history, correct?

A. That's possible.

Q. Okay. So have you now told me all the physical complications that you have treated that you would attribute to a patient's prior history of abortion?

A. I mentioned the lady in the ICU a couple of years ago. Transfusions, it is not uncommon to need to transfuse someone. IV antibiotics.

Q. So you mentioned a teenager in the ICU after a first trimester. Is that what you're referring to?

A. She died, but I have also cared for patients who have gone to the ICU who lived.

Q. Who needed the transfusions after abortion?

94

A. Yes.
Q. How many?
A. Probably five or ten.
Q. How many after a D&E abortion after 18 weeks of pregnancy would you say?
A. Well, I'm happy to say that I have not cared for women who have had complications from D&E abortions after 18 weeks. And I think the -- one of the major reasons for that is that Texas has a law against it. Yeah, we still have a law against it.
So I don't think they happen very often, but they're an extremely difficult procedure to perform, and if a physician does not have a lot of experience performing them, then there is high likelihood they could perforate the uterus, lacerate vessels, leave fetal parts inside. It is a very difficult procedure, a D&E.
Q. So have you now told me all of the physical complications you believe you've treated from patients after an abortion?
A. I believe so.
Q. Okay. And we'll get to the mental health issues later, but I do -- I do want to move on. Something you just said triggered something. With respect to the D&E, would you consider yourself to have the clinical competency to perform a D&E abortion?

95

A. No.
Q. And to perform a D&E miscarriage management at and after 18 weeks of pregnancy?
A. I do them when I need to. I'm not comfortable --
Q. At and after 18 weeks of pregnancy?
A. Oh. Yeah, usually I'll induce those.
Q. Usually or always?
A. Well, I told you earlier I have not done one, so things wouldn't change in the future --
Q. So do you believe you have the clinical competency to perform miscarriage management by way of D&E at and after 18 weeks of pregnancy?
A. I would be uncomfortable doing that procedure because it is very complicated.
Q. So would you not do it because of that discomfort?
A. I would -- I would bring another partner alongside me to do it.
Q. Do you believe that you are an expert in grief responses?
A. Excuse me?
Q. Do you consider yourself an expert in grief responses?
A. Grief responses? I wouldn't say I'm an

96

expert. I certainly have cared for people who have had normal grief responses.
Q. What about -- do you consider yourself an expert with respect to patients' decisional certainty when making health care decisions?
MR. SORENSON: Objection, vague.
Q. Is there anything about that question you don't understand, Dr. Skop?
A. Yeah, I'm not sure what you're asking. I --
Q. Are you familiar with the -- I'm sorry?
A. I said I do my best to make sure that they have all the information they need to make a decision, but I don't know that that makes me an expert.
Q. So are you familiar with literature about decisional certainty with respect to health care decisions?
A. I don't think I've read any of that literature.
Q. Okay. Do you consider yourself an expert with respect to fetal pain capacity. The capacity of a fetus to experience pain?
A. I have done a lot of research on that issue.
Q. Do you consider yourself an expert with respect to the capacity of a fetus to experience pain?
A. Sure.

97

Q. And what -- what would you say you base your expertise on?
A. I base my expertise on the research that I've done in the neurologic literature as documented in my expert report, and also the fact that I have delivered many living babies in the gestational age that we're discussing. And I have seen responses from those babies that are identical to the responses that you and I would have if we were experiencing pain.
Q. Okay. Anything else that you would base your expertise on in that area?
A. No, I think clinical expertise and research is it.
Q. Okay. Are you -- do you have training in neurology?
A. No, I -- well, other than what we got in medical school.
Q. Do you have a specialization in maternal fetal medicine?
A. No, I do not.
Q. Do you perform intrafetal surgeries -- is that what it is called? Intrauterine fetal surgeries?
A. Nobody in San Antonio does. We send them to Houston and Dallas.
Q. Okay. Do you consider yourself an expert in

98

neonatology?
A. No.
Q. What about epidemiology?
A. I've learned a lot of epidemiology in my abortion and maternal research, but I don't consider myself a expert.
Q. What about in medical ethics?
A. I'm interested in medical ethics, but I'm certainly not an expert.
Q. Try to adhere to them, but not an expert. So at this point, I want to introduce -- if you could turn to Tab B. This is your -- so this would become Exhibit 2. This is your expert report that you submitted in this case. Is that accurate?
(Exhibit No. 2 was marked.)
Q. If I can make a note because we may refer back to this expert report throughout today's deposition. So if you could, at this point, just number -- the pages aren't numbered and the paragraphs aren't numbered either. So to make sure we're all looking at the same pages, I want to note that my page numbering will start with page 1 of the cover page. So if you want to number the pages, you're welcome to take a couple of seconds for that. But I did -- in looking back through my notes, I realized that that might be a stumbling block.

99

So this is the expert report in the case. Does this appear complete, Dr. Skop?
A. Yes, it does.
Q. And did you prepare this document?
A. Yes, I did.
Q. Can you tell me everything -- can you tell me how the document was prepared?
A. I -- for a long time, as I've done research on particular topics, I've made notes to myself, and I've written papers, essentially for my on consumption. And when I determined the topics that I wanted to address, I referred to those notes and incorporated them into the paper.
Q. Okay. You said that these are personal notes; is that right?
A. Yes.
Q. What about any other documents that you referred to and incorporated into the expert report?
A. Well, I've referred to other documents. I've referred to some of the ACOG literature on fetal pain. I -- you know, I believe that there is -- there are various papers available on the internet that I've looked at. When I've gone to a source like that, then I've subsequently gone to the references to verify the accuracy of those papers.

100

Q. To make sure that I understand, when you were preparing this, did you cite every document that you relied on in the expert report, or were there other documents that you reviewed that you didn't cite?
A. It's hard to say. I do a lot of reading. So it is very possible that there are things that I read and ideas that I incorporated in this report that I did not specifically cite, but I tried my best to go to the source of the statements when I prepared the references.
Q. Okay. And do you -- is there any way that you would be able to identify, at this point, which documents you considered for incorporation in the report but you ultimately excluded?
A. I don't recall, to tell you the truth. I mean, I could certainly provide you with those later if you want to know additional resources that I looked at.
Q. Well, I'm asking whether there is any way that you can identify those now? Do you have any notes as to what you reviewed and excluded?
A. No. I think that -- it looks pretty thorough in terms of the -- you know, many times review papers will summarize statements, but I tried to go to the source of the facts and not necessarily reference the review paper that was referencing another paper. I felt like it would be more accurate to go to the source, to go

101

to the neurologic literature that I've quoted and that I've referenced.
Q. You tried not to rely on how other researchers or doctors might describe the literature; is that correct?
A. I tried not to. Like I say, I probably did get some of this off the AAPLOG website, which you guys have probably looked at.
Q. And which parts --
A. But I verified the references beyond that.
Q. Which part would that be, Dr. Skop?
A. Excuse me?
Q. Which parts of the report would that be?
A. Well, I think -- are we talking specifically about fetal pain?
Q. About any -- we're talking about your report generally.
A. Okay. I think the fetal pain -- possibly that began by referencing AAPLOG's fetal pain practice bulletin, and then I went from there and pulled the individual studies.
Q. Okay. The fetal pain practice bulletin. Are there any other documents -- but that wasn't cited in your expert report, correct?
A. Probably not. It doesn't look like it. I

102

think I went straight to the -- to the neurologic literature.

Q. Okay. Any other documents from AAPLOG that you can recall relying on to draft the report?

A. I don't think so. I've been involved in drafting a lot of that their practice bulletins and committee opinions. So there may be similar wording, but I -- this report essentially relies upon my own research.

Q. Okay. What about -- did anyone other than Mr. Sorenson provide documents to you to consider with respect to this -- drafting this report?

A. No.

Q. And have you discussed the report with anyone other than Mr. Sorenson?

A. No.

Q. Did you have any role in drafting expert reports for any other experts in this case?

A. No.

Q. Did you review any expert reports from other cases?

A. No.

Q. Were you asked by anyone to make any factual assumptions?

A. I'm not sure that I know what you mean by

103

that.

Q. Did Mr. Sorenson provide any facts or data to you to use in drafting your opinions for this report?

A. No. The statements are my own.

Q. And any idea how many hours you spent drafting the report itself?

A. It is hard to say because I took it from papers I had already written. Probably five or six for the actual report, but a lot more time went into the research for the original papers.

Q. Sorry. Just to make sure that I understand. I thought that you said that you relied on personal notes for the report but not public papers. Is that --

A. Oh, I'm sorry. I said papers, but they're my papers. Nobody else has seen them.

Q. I see. They are not things you published somewhere?

A. Yeah.

Q. Got it. All right. But would you have -- did you keep records of time that you spent on the report itself?

A. I did. I submitted that, but it was -- I believe it was late in 2019 that I wrote all of this, so I did not review my -- the hours. I apologize.

104

Q. Do you recall, ballpark, how much you were paid for drafting this report?

A. I don't recall.

Q. Would it have been more than a thousand dollars?

A. I think so.

Q. More than $5,000?

A. Possibly.

Q. More than $10,000?

A. No.

Q. Okay. So somewhere between a thousand to $10,000.

And you would have records, though, that were submitted for that, correct?

A. Yeah, there are records.

Q. Okay. And then so your report lists certain opinions that you intend to testify about in this case, correct?

A. Yes.

Q. And are the opinions listed in the report all the expert opinions to which you intend to testify?

A. Are you asking if I have other opinions that aren't in the report?

Q. Well, I'm asking whether you intend to provide other opinions in your testimony about this

105

case?

A. I don't think so.

Q. Okay. Have you changed any of your opinions since you signed this report, Dr. Skop?

A. No.

Q. Did you make an effort to include in your report all the relevant facts and data on which your opinions are based?

A. Yes.

Q. Did you prepare the report -- actually, let me skip over that.

Apart from your expert report, have you created any other documents in connection with this case?

A. No.

Q. And have you discussed the case with anyone besides Mr. Sorenson?

A. No.

Q. So at this point, I would like to turn to your report itself. You talk in your report about the reasons that individuals might have abortions later in pregnancy. And then the very top of page 4, very top paragraph, do you see the part that starts with, "One large study"?

A. Yes.

106

Q. So it says, "One large study examining reasons for later abortions found that: 'not knowing about the pregnancy,' 'trouble deciding about the abortion,' and 'disagreeing about the abortion with the man involved' were commonly reported."

Later in that paragraph you say, "With all this indecision, it is likely that another change of mind could occur for the woman after going through with the abortions, and the choice could be regretted." Did I get that right?

A. Yes.

Q. Okay. And in footnote 2, there, you're relying on an article by Jones and Finer, correct? Those are the researchers you mentioned earlier?

A. Yes.

Q. And you said that you had read this article before you drafted your report, correct?

A. I've read it. It is possible that some of that data came through the third Finer article as well.

Q. Okay. But you believe that you cited the Jones and Finer -- the article that you cite in footnote 2 you read before you cited, correct?

A. Yes.

Q. And do you consider the analysis in that article reliable?

107

And I should say one note, Dr. Skop: If you want to refer to other parts of the binder, that's fine. But we should make sure that we're introducing them as exhibits along the way so they are part of the record.

A. Okay. So when you say analysis, are you talking about results or discussion, or are you just talking about the general -- the paper itself?

Q. Well, I'm asking -- you cited it in your report, so I'm asking you whether you believed it to be an article of good quality?

A. Almost all of the literature regarding reasons for abortions comes from Guttmacher Institute researchers and it comes through the journal Contraception. And I think it is accurate, but I also think that it is -- I think that there could be more to the story on some of these reasons. I think that it is often presented in such a way as to justify abortion.

Q. But --

A. And it is -- it is the best data we have. It is the only data, really, that we have, is what the abortion clinics put out for us to see.

Q. Are you saying that this article is being authored by an abortion clinic, Doctor?

A. No, I'm not saying it is being altered. I'm saying it is being put out by researches --

108

Q. No, offered or authored.

A. Well, they get their data -- Guttmacher gets their data directly from abortion clinics. That is not data that is available to most Americans. When you look at the numbers of abortions, you see that Guttmacher reports 30 percent more than the CDC does. So Guttmacher has a special relationship with the abortion industry.

Q. Do you actually -- can I ask you a quick question about that?

A. Yes, ma'am.

Q. Because I assume you would agree that no data is perfect, correct?

A. Absolutely.

Q. So as between the CDC data about the number of abortions there are in a given year in the United States and the Guttmacher data, do you consider one to be more reliable than the other?

A. I think the Guttmacher is probably more reliable. California does an extraordinary large number of abortions. They don't report anything to the CDC. That reporting is voluntary. Also, Maryland has a late-term abortionist who does a lot of really, really late procedures, and they don't report data either.

So I think the CDC's data, just like it is for complications and just like it is for maternal

109

mortality, is seriously flawed and underestimates the extent of the problem.

Q. So as between those two sources, you would say that the Guttmacher source is the -- as to the number of abortions performed annually is the more reliable of the two?

A. That is probably the case.

Q. Would you say that it is the best data we have available right now as to the number of annual abortions that occur in the United States?

A. I think it is the best data.

Q. Okay. And to the extent that it is not entirely accurate, do you -- is it your opinion that the actual number is lower or higher than the Guttmacher data?

A. Are you asking about the number of abortions or complications?

Q. The number of abortions.

A. Guttmacher is probably reasonably accurate because they get their data directly from the abortion providers. But if there are abortions being performed by private doctors, they may not be reported.

Q. Doesn't Guttmacher have a way of sampling private doctors as well, Dr. Skop?

A. I don't know. I don't know how that works.

110

Q. You don't know the methodology of how they identify abortion providers; is that correct?
A. No, I don't.
Q. Okay. So if we can turn back to the part of your report about reason for an abortion. My question was, do you consider the article to be of good quality. So setting aside -- I know that there are no perfect data. But citing this article, am I assuming correctly that you believe this is a good study?
A. I think it is accurate as far as it can be on this demographic data.
Q. Okay. Okay. And are you looking at the article now, Dr. Skop?
A. Yes, ma'am.
Q. Okay. So why don't we go ahead and introduce that into the record. This is Tab C, as in cat.
(Exhibit No. 3 was marked.)
Q. And what I'm showing you is "Who Has Second-Trimester Abortions in the United States?" by Jones and Finer; is that correct, Dr. Skop?
A. Yep.
Q. Okay. And does this appear complete?
A. The article?
Q. Yes.

111

A. It is complete. I'm wondering if I might have gotten some of the reasons data from another one of their articles because I don't see that here, but I --
Q. Okay.
A. I believe there is a chart in one of the other articles that talks specifically about reasons.
Q. What about -- you mentioned the journal Contraception. Do you consider that to be a reliable source of information in the gynecological field?
A. Contraception, I believe, is published by the Guttmacher Institute, and it very much works hard to paint abortion in a favorable light. So I am skeptical sometimes with the data they put forward.
Q. Skeptical about the quality of the data or the conclusions they draw from that data or both?
A. Well, for example, if we're looking at reasons that women have abortions, they don't seem particularly curious about things like coercion. And I think they ask one question that was, like, did someone else other than you -- you know -- they don't ask a lot of questions that I would like to see asked. But I don't have any -- you know, I don't work in an abortion clinic, so I don't have the ability to get there and ask these questions. The -- you know, I --
Q. I understand that they could certainly ask

112

other questions. I guess my question is -- and it sounds like you're talking about this article in particular.
A. Uh-huh.
Q. My question is, with respect to Contraception. Do you believe -- is it your opinion that the quality of the research coming out of Contraception is of high quality?
A. I -- I believe it is -- well, regarding these reasons, I have no reason to doubt that they are taking the answers they've been given by women in abortion clinics and reporting them.
Q. Okay.
A. If we're talking about complications, I -- I don't think that the data on complications in the United States is accurate no matter who is reporting it.
Q. Okay. So we'll get to complications.
A. Okay.
Q. Let's talk about it a little later.
So if I could take you back to that quote from your expert report where you said, "With all this indecision, it is likely another change of mind could occur for the woman after going through with the abortion and the choice could be regretted." How did you conclude that the incision prior to having an abortion makes it likely that the woman will change her mind again after

113

having the abortion?
A. I base that on my clinical experience both in the office and through my work with Any Woman Can. There are women who regret their abortions.
Q. There are women. Would you say --
A. And the less confident they are in their decision -- I mean, somebody who waits until the second trimester when they're feeling that baby move before they decide to terminate, to me, that just -- that reeks of coercion. And I -- I don't think that there is good data coming out of Guttmacher, coming out of Contraception that addresses that.
Q. So how did you -- to make sure I understand your position, then, the way you concluded that prior indecisional -- prior uncertainty before the abortion is likely to lead to another change of mind after the abortion is based on your clinical experience and encountering some women who regret their abortions at Any Woman Can; is that correct?
A. That is correct.
Q. You said earlier, though, that you're not familiar with the literature decisional certainty with respect to health care decisions?
A. I'm not familiar with the specific literature, but I do know what I've seen of women's

114

decision making in my 25 years of private practice. And I've -- I've had patients, a number of patients who have told me, I didn't want -- often it is a young woman who keeps the pregnancy secret from her parents until they can no longer, you know, not see it, and often it is a woman who keeps it secret from her partner because she doesn't think he will support her decision. And in both of those cases, I think that they are often coerced by the parent or coerced by the partner to have a late abortion.

I think that this uncertainty category probably encompasses a lot of that based on what I've seen of my own patients and what I've heard them say.

Q. Dr. Skop, have you ever obtained an informed consent from a patient to perform an abortion?

A. No.

Q. So in terms of the kind of counseling that goes along with the informed consent process for abortion, you have never participated in that; is that correct?

A. I mean, it is possible in residency that I might have been involved in that, but that's been more than 25 years. I'm concerned about the informed consent that does occur. You know, I'm sure you're aware of your annual report at Planned Parenthood; 96 percent of the

115

pregnancy services are abortions. Knowing the real world and knowing the decisional uncertainty in women, I find it hard to believe that 96 percent of them wouldn't have chosen something else had they had full informed consent.

Q. Let me ask you this: Do you think -- you mentioned earlier that you think sometimes patients hold back things about their history when they see a doctor later, correct?

A. Yes.

Q. They not might not reveal --

A. That can happen.

Q. Do you think patients would feel comfortable about how they feel about prior abortions with a doctor who believes there are no benefits with abortion?

A. I think that people often feel uncomfortable talking about abortions no matter who they're discussing it with. It is an area that a lot of women feel shame, and a lot of women feel that it is a -- that it is murder. I mean, a lot of women who have abortions, nonetheless, feel that they are committing an unethical and immoral act. And so, undoubtedly, there are women that no matter who they're talking to they don't want to discuss it with somebody else.

I have never given anyone -- tried to give anyone a feeling of guilt if they discuss an abortion

116

with me. And I don't think there is any reason that they would feel that they couldn't share that with me just based on who I am and what they know about my practice.

Q. Do you believe that patients -- you mentioned shame and stigma. Where did that shame and stigma come from? Do you find that it comes from your patients' own reactions to abortions or from the reactions of other individuals either in their family or community or friends?

A. Well, I think, in this day and age, almost everyone has seen an ultrasound picture of a friend, perhaps, posted on Facebook. Everyone who has bothered to pay attention knows that an abortion is ending the life of a living human being. Now, you know different people will justify it in different ways and say, My circumstance is rough, or whatever. And a woman may be in a situation where she does not feel she has another option. But she also knows that she is ending the life of her own biologic child, and I -- I don't think it is necessarily a religious thing. I know our society has a lot of --

Q. Dr. Skop, can you answer my question?

A. I think --

Q. I'm asking you about the source of shame and stigma. Do you believe it is all coming from the

117

patients that you encounter, or from their community, family, or friends, or both?

A. Well, I think we'll all agree that abortion is a nuclear issue. It comes from many different directions.

Q. Okay. Actually, let me now ask you: How many patients would you say you encounter in a month who talk about their decision with you to have an abortion?

A. Probably not that many.

Q. Two?

A. I don't -- it is --

Q. One?

A. It is rare for me to see a patient who says -- you know, that I see for an annual one year and see for an annual the next year and have them say, Oh, by the way, my birth control failed, and I had an abortion in July. It is actually not that common for them to report it. And sometimes they do, and if they do, you know, I will talk to them about it. But it is not something that I necessarily will ask.

Q. So if they don't report it, is that -- I mean, presumably, do you think it is fair to assume that that's because they had no complications from the procedure?

A. We're talking emotional complications?

118

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

119

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

120

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

121

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

122

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

123

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

124

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

125

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

126

A. I don't know the answer to that question, no.
Q. Okay. Would you agree -- I think that you -- that you refer to the cost between 1,500 and 10,000 dollars. Would you agree that that expense without insurance would be a barrier to obtaining an abortion?
A. It would be a barrier. It is not an absolute barrier.
Q. For a woman living in poverty, would it be a barrier?
A. Possibly.
Q. Possibly. Okay. What about a woman with moderate income?
A. I mean, we --
Q. Based on your experience with your patients?
A. It is hard to say.
Q. What about -- if I could take you back to our conversation earlier about LARCs. You said that those were between 500 and 700 dollars; is that right?
A. That's correct.
Q. And I think with respect to those you said if someone didn't have insurance coverage -- I believe I asked whether that would be a barrier to obtaining a

127

LARC. Do you remember that question?
A. Yes.
Q. And you said, Oh, certainly. Right?
A. It is a barrier. It is not -- it doesn't mean that they won't get one, but it is a barrier. It is a substantial amount of money.
Q. So 1,500 to 10,000 dollars, would you say, would be a more substantial barrier to obtain care?
A. Yes.
Q. Can you -- let's see.
All right. So if you could turn to page 5 of your expert report. Are you there?
A. Yes, ma'am.
Q. It says -- you say, "While few OB/GYNs other than high volume abortionists have the clinical skills to perform a later D&E, due to its complexity and high incidence of complications, all OB/GYNs can perform inductions or C-sections." Did I get that right?
A. Yes.
Q. And what do you mean by "later D&E" in the sentence?
A. Well, as we discussed earlier, I have not performed a D&E after 18 weeks. And I doubt whether my partners have much experience in that.
Q. Sorry. What do you mean by "later D&E"? I

128

guess what I'm asking is how would you define a later D&E, as you've used that term in that sentence?
A. Probably 18 weeks and beyond.
Q. And then -- let's see. We had talked earlier about the counseling that you might provide to a patient who is interested in abortion, and you, I believe, indicated that you would talk to her about the risks of abortion, correct?
A. Yes.
Q. And would one of those risks be a risk of breast cancer?
A. The -- the literature on breast cancer is controversial, but there is one thing that is not controversial. If she -- if this is her first pregnancy and she chooses to terminate the pregnancy and does not go to term and does not get the protective effect of the full maturation of her breast type 3 and 4 lobules, her risk of breast cancer is increased. That is since 1970 --
Q. Do you tell that information to your patients? Do you tell that information to your patients?
A. Yes.
Q. You provide that?
A. Uh-huh.

129

Q. And let me break that down a little bit. So do you believe that there is a causal connection between an abortion and an increased risk of breast cancer?
A. I think that there is physiologic plausibility that that could be the case. I realize it is extremely controversial in the literature for reasons that have more to do with the way the studies have been conducted. When a woman has a normal --
Q. Dr. Skop, I would like you to answer my question. And my question to you is not about physiological plausibility but whether, in your expert opinion, there is a causal connection between abortion itself and a heightened risk of breast cancer later in life?
A. Ending a normal pregnancy before the breasts have matured at term is linked to an increase risk of breast cancer.
Q. Relative to a woman who carried to term, correct?
A. Exactly.
Q. Okay. Let me give you this hypothetical.
Imagine that you have two patients who come to you and they are identical in every respect. One of them is not pregnant, but she's thinking about getting pregnant. And one of them is pregnant and thinking about

130

having an abortion. Would you tell the patient who is thinking about getting pregnant that she should get pregnant to reduce her risk of breast cancer later in life?

A. That is a true fact. I don't know that I necessarily tell everybody that who is coming in for a --

Q. Do you tell anyone that?

A. Yeah, if somebody had high risk for breast cancer, I would certainly tell them that.

Q. You would suggest they might want to get pregnant?

A. That a term pregnancy would be protective, yes.

Q. And do you -- as between those two patients -- let's say those two patients, the one who is not pregnant and is thinking about getting pregnant decides not to get pregnant at that time, and the one who is pregnant and thinking about an abortion has an abortion. Do those two individuals have any different risk in later likelihood of breast cancer?

A. Yes, because the one who had the normal pregnancy has stimulation of the type 1 and type 2 immature lobules in the breasts. That what happens in early pregnancy. And to cut off the hormones and leave them in that state does make them more likely to form

131

breast cancer.

Q. Makes them more likely to develop breast cancer --

A. Yes.

Q. -- than someone who had never been pregnant?

A. They're in an undifferentiated state. And so some other driver of breast cancer could drive them into the state of cancer. Not having gone through that stimulation that resulted in all those immature lobules in the woman who never became pregnant makes her risk lower compared to the woman who did have the pregnancy that stimulated the immature cells.

Q. All right. I think I understand what your position is in that respect.

But it is your testimony that you would -- if someone is considering an abortion, you would counsel them about the risks of breast cancer with respect to ending the pregnancy, correct?

A. I would talk to them about that, yes.

Q. And just to make sure that I understand. Is it your opinion that there is a causal connection between the abortion and the heightened risk of breast cancer later in life?

A. Yes, by leaving those immature cells without

132

maturation.

Q. Okay. What about -- the hospitals -- you mentioned that you work in the Baptist Health System, correct?

A. Yes.

Q. And have worked at one of two hospitals in your prior experience, correct?

A. Yes.

Q. And does the Baptist Health System where you work provide abortions?

A. No.

Q. None, ever?

A. Not that I'm aware of.

Q. Okay.

A. Occasionally someone requires delivery before the time of full viability and it doesn't require an abortion, it doesn't require intentionally destroying the fetus in order to deliver the woman. The woman can be delivered in other ways and the baby can be evaluated for maturity and given hospice care. That's a different scenario than electively ending the life of that child.

Q. So to make sure that I understand what the practice would be. If, for example, a patient came in at 18 weeks of pregnancy with premature rupture of membranes, at that point there is no possibility of

133

continuing the pregnancy until viability, is that correct?

A. It is a very low possibility. It has happened, but the odds are not good for that baby.

Q. And so in those circumstances you might induce delivery, correct?

A. After counseling with the patient, if that's what she wanted, that might be done. And --

Q. And -- go ahead.

A. I was going to say, we have a system in place. It is -- generally we have a three doctors recommend -- you know, saying this is reasonable; we have a chaplain. There is a protocol that we follow prior to.

Q. But at that point, what would be the chance of survival for an 18-week-old fetus?

A. If it is truly an 18-week fetus, the chance of survival is probably zero.

Q. I'm sorry. Probably zero or zero?

A. If it is truly an 18-week, it can be zero. Sometimes ifs --

Q. I'm sorry. Can we go back? Is it, can it be zero? Let me rephrase the question.

Have you ever seen an 18 -- a true 18-week fetus delivered and survive more than a day?

A. No.

134

Q. Okay. So the -- in your -- your understanding is that the hospital will perform induction deliveries in cases where there is a maternal indication that one is needed even if those -- those deliveries are performed at a point where there is a zero percent chance of survival of the fetus; is that correct?

A. That is correct. And the Utah law allows that.

Q. That's your understanding of the Utah law; is that correct?

A. Uh-huh, yes.

Q. And if the Utah law did not allow that, would you think that that was problematic?

A. I haven't heard of any laws anywhere that will not allow a woman's life to be saved if her pregnancy poses a risk to her life.

Q. At the Baptist Health System -- so said you -- generally, you don't perform -- well, it sounds like, in your view, they don't perform abortions ever. Do you -- let's see.

Actually, could I take you back to your chair position? You said you were the chair of the department of the OB/GYN at the Northeast Baptist Hospital. Did I get that right?

A. Yes, ma'am.

135

Q. And did you have any role in overseeing or tracking complications for care provided in the department during your tenure as chair?

A. That's one of the jobs the chair has, yes.

Q. What did you track?

A. There was a quality committee that the chair is on, and so if there were -- there's kind of a list of, you know, adverse outcomes, and those will be evaluated by the quality committee.

Q. Okay. So those would be adverse outcomes based on care that was provided in the hospital, correct?

A. Well, sometimes there is just adverse outcomes in OB. Sometimes bad things happen even though nobody did anything wrong. But there's certain indicators where if it happened, we would review to make sure it had not been a quality issue.

Q. Okay. And do you recall what the overall complication was from childbirth -- or labor and delivery?

A. At the hospital -- that's been a long time. I don't think I know the overall complication rate.

Q. Okay. I mean -- what about -- how would you define major morbidity from pregnancy or in childbirth?

A. Yeah, so major morbidity would be requiring

136

readmission to the hospital, requiring a transfusion, requiring a repeat surgery, requiring IV antibiotics, ICU admission, thromboembolic event, a pulmonary embolism, a stroke, death, obviously.

Q. And do you have a sense of what the -- in your practice currently what the complication rates are for those kinds of major morbidities in pregnancy or in labor and delivery -- during or after labor and delivery?

A. I mean, I'd probably say the most common of those things would be a blood transfusion. That happens on occasion. Maybe 2 to 3 percent.

Q. So 2 to 3 percent major morbidity?

A. Uh-huh.

Q. Okay. And -- but you wouldn't -- it sounds like you would not include a C-section within major morbidity, correct?

A. No.

Q. Okay. Even though that would involve a surgical procedure and cutting into the uterus, right?

A. Right. Right. If she had a C-section and had to go back to the operating room because of complication -- then that would count, but not the initial.

Q. What about minor complications or nonmajor

137

indicators of morbidity? Are there things that you think of as a complication that you wouldn't consider major morbidity from labor and delivery or pregnancy?

A. Sure. You know, sometimes women, after a C-section, can have a superficial skin infection. Sometimes, particularly if they're obese, they may have a fluid collection that occurs where their incision opens a little bit. You know, occasionally they have a fever that requires, you know, a single dose of IV antibiotics.

So, yeah, those kind of mild complications -- endometritis where the uterus has an infection after a vaginal or C-section delivery.

Q. What about vaginal tearing; how often does that happen during vaginal deliveries?

A. I'd say maybe about 50 percent of the time there will be a small tear or --

Q. Okay. I'm sorry. What was that?

A. I mean, most of them are small, but sometimes they can have a tear that reaches to the rectum or a more significant tear.

Q. So the -- if I understand correctly, vaginal tearing could be -- they're labeled in degrees: first, second, third, and fourth; is that right?

A. That's correct.

Q. And would you -- are any of those considered

138

major morbidity from childbirth?
A. I don't know that any of them are considered major morbidity, but our hospital does keep records on the more extensive tears, the fourth degree tears.
Q. Fourth degree. And what does a fourth degree tear involve?
A. That is where the tear goes through the vagina and through the rectum and the rectal muscles.
Q. Okay. And that can result in fecal incontinence, correct?
A. It is possible.
Q. Urinary incontinence?
A. Uh-huh.
Q. Does it require surgery?
A. No. Generally we repair it at the time of delivery, but it is rare for it to require other surgery.
Q. But it is a surgical procedure to repair it, correct?
A. I guess --
Q. You sew it up, right?
A. Yeah, I guess -- if you consider surgery when you do stitches.
Q. Well, if you had, like, a vaginal tear that required you to throw a couple of stitches to fix, what

139

kind of tear would that be in terms of degree?
A. Probably most commonly a second degree.
Q. If you use stitches?
A. Yeah. First or second degree are the common ones.
Q. Okay. So some tears can repair -- they'll essentially repair themselves, you don't have to actually add stitches; is that correct?
A. It is possible to have a very small tear that doesn't require stitches.
Q. Okay. What about cervical tearing; does that happen during childbirth, vaginal delivery?
A. It can. It doesn't happen often.
Q. How do you repair those?
A. You visualize the cervix and find the tear and place the stitch there.
Q. Would you consider that a major morbidity?
A. I don't know that we track it, but that's a pretty significant morbidity.
Q. Okay. Would you say that the types of complications that you track in your practice are ones that are of most serious concern, from a medical perspective?
A. So you're asking if the ones we keep track of are serious?

140

Q. Uh-huh, from a medical perspective, are the most serious complications.
A. Yeah. I mean, that's why we track them because we want. . .
Q. Okay. So I think you said that you thought the rate of complication for major morbidity would be 2 to 3 percent of the deliveries that you do or that your practice does?
A. I'm thinking my practice.
Q. Okay. And what about any -- anything that you would consider a complication of pregnancy -- or, perhaps, anything that your practice tracks as a complication of either labor and delivery or labor and delivery and pregnancy combined, what is the rate of those complications?
A. You know, we may -- I'm going to say it is probably still in the 2 to 3 percent rage. We talk about them, but they don't happen very often considering there are 20 doctors.
Q. So it would be 2 to 3 percent major morbidity and another 2 to 3 percent other complications?
A. So of the ones we track, I would consider all of those to be major morbidity.
Q. And do you have a list of the ones that you

141

track? Does that come from somewhere, or is it just something that your practice has made up?
A. The hospital has their own list, and I believe our practice follows that pretty well and discuss those among ourselves.
Q. Okay. So would you track, for example, an infection that requires one dose of antibiotics?
A. No.
Q. What about something that requires a couple of stitches?
A. No.
Q. What about something that requires any reversal of sedation? Like any time you're using a medication to reverse sedation.
A. Can you give me an example of what you mean?
Q. I mean, I'm not a doctor. My understanding is that there are circumstances in which -- where a patient is sedated that, for one reason or another, you may want to try to minimize the sedation and you can administer other drugs that would have that effect. Am I wrong about that?
A. Yeah, I can't really think of a scenario where that would happen.
Q. Okay.
A. If someone had an overdose of a narcotic,

142

you might need to give them narcan which reverses it, but I can't recall having seen that.

Q. Okay. And what about a uterine perforation; would that be something that you would necessarily track?

A. That would be a major complication because it would require additional surgery.

Q. So any kind of uterine perforation. And then what about any kind of pelvic floor injury? How often does that happen after a -- let me ask specifics of vaginal deliveries.

A. You're asking how often does a woman develop prolapse later in life?

Q. Well, prolapse is one type of pelvic floor injury, correct? But there could be others that happen; is that correct?

A. Well, we talked about the different degrees of laceration.

Q. So you would include the vaginal tearing in that. There are some women who require physical therapy after a vaginal delivery, correct?

A. There can be --

Q. For incontinence?

A. -- yeah, incontinence and things like that.

143

Q. How often does that happen?

A. You know, I don't know. I don't know that I've ever seen a study that looks at that.

Q. Okay. So we talked a little bit about the risks of C-sections. Earlier we talked about placenta accreta spectrum. I want to keep call it placenta accreta syndrome, but. . .

Okay. We talked about that. We talked about, you know, potential blood loss complications. You know, infection. Am I missing any risks of C-sections that you would describe as common?

A. I think those are the common ones, yeah.

Q. Okay. But then if you could turn to page 4 of your report. On page 4 you say, "With modern surgical techniques" -- oh, this is in the last paragraph kind of midway down. Do you see that, the sentence starting with "modern surgical"?

A. Let me make sure I'm on the right page.

Q. Yeah, I'm counting the cover page.

A. Okay.

Q. So you say, "With modern surgical techniques, a C-section delivery is usually very safe, even in an extremely sick woman. (One out of three pregnancies in our country are delivered this way.)" Did I get that right?

144

A. Yes, ma'am.

Q. Have you ever seen any statistics on abortion complications that approach a one in three outcome per abortions?

A. You mean, like, an abortion complication that occurs one out of three times?

Q. Yes. Have you ever seen any data to that effect?

A. I have not, but I would back up and say that we do not do a good job of collecting and analyzing abortion complications in our country because -- because it is not tracked by insurance. Most of them are not voluntarily reported by abortionists. I don't know of any that occurs that often, but, again, I think our data is compromised.

Q. What is the highest -- as we talked about earlier, no data is perfect. What is the highest rate of complications from abortion that you have seen in literature that you would consider reliable or among the best data that we have? What's the highest rate?

A. There are some studies out of Europe that see a one out of five complication rate, typically related to medical abortions requiring surgery. There is a -- medical abortions in the second trimester which, again, we don't do that here, but that one has about a

145

two out of five complication rate requiring surgery.

Q. Let me back up. Can we look at page 6 of your report?

A. Okay.

Q. The first full paragraph there in the middle, you say, "Compared to an abortionist performed at eight weeks gestation" -- and I'm skipping over a little bit, but you quote a rate of -- well, sorry. I realize you don't have the complication rates in here.

So you mentioned a one out of -- what is the highest rate of complications from abortion that you have seen in the United States for D&E abortions, any complication?

A. I think the Autry study says 4 percent.

Q. Four percent. So to get from 4 percent to 33 percent, which is what you say is roughly the share of deliveries that end in C-section, on what magnitude of a change would you need, in terms of identifying complications of abortion, to approach the one in three statistics for C-section?

A. Can I ask a question? Are you assuming for this discussion that a C-section is a complication?

Q. I'm not.

A. Because in many cases -- in probably most cases, the reason for the C-section is to get a live,

146

healthy baby out. So this doesn't apply to abortion because abortion has no desire to get a live, healthy baby out. So I think --

Q. I'm simply -- Dr. Skop, I'm asking because you have indicated that you believe a C-section, which is a surgical procedure that requires a full cut into the uterus, is usually a very safe procedure for someone to have. And so I'm asking, for an abortion, which I recognize is a different procedure -- have you seen any complication from an abortion that would approach a 33 percent rate? Setting aside whether it is a complication that requires another surgery and a cut into the uterus, have you seen any complication that approaches a 33 percent rate?

A. Well, the Europe study that I mentioned in --

Q. In the U.S. In the United States with a D&E.

A. I have not seen it because we do not track D&E complications. We don't track them.

Q. And do you think -- do you think, based on your expert opinion from -- well, there are studies that talk about complication rates from abortions in the United States, correct?

A. There certainly are. There is very little

147

that addresses complications from D&Es.

Q. And what would you say the most reliable source is for complication rates from D&E abortions in the United States, recognizing that there is no perfect data? What is the best data on that?

A. I don't think there is any good data; the CDC does not have good data. I don't -- allowing the physicians who work for Danco and work for Genuity and work for the Bixby Center for Reproductive Rights to write the articles about abortion complications is equivalent to allowing the tobacco industry to tell us that tobacco smoking is safe.

Q. So am I understanding you, Dr. Skop, that at this point in time, as you sit here today, you cannot identify any specific data on complications from an abortion that you would like the court to refer to in this case?

A. The only study that I know of is by Autry, and it found a 4 percent complication rate on D&E.

Q. Okay.

A. But that -- several doctors, Grossman and Grimes, tried to do meta-analyses; they just could not find studies. If it is something we think we should be doing, perhaps we should be studying it.

Q. You mentioned, I think, earlier -- maybe you

148

didn't. Let me ask you. Have you reviewed the National Academy of Sciences report on the safety of abortion?

A. I'm very familiar with that study.

Q. Okay.

A. Do you know --

Q. Okay. Excuse me, Dr. Skop, if you can please respond to my questions.

Are you aware of data presented in that study about the incidence of particular complications with respect to D&E abortions?

A. I think that's in here. I can look for it. I can't tell you right offhand, but I think that is a compromised study because it was commissioned by six outspoken abortion advocacy organizations.

Q. Okay.

MS. MURRAY: So I think this would probably be a good time to take a break? What do you think? I guess it is my lunchtime, but I recognize. I guess we're getting on close to your lunchtime, too. Would you all like to take a short break or would you like to take a lunch break.

MR. SORENSON: I would suggest a lunch break, if that's all right. More for my dog than me.

MS. MURRAY: That's good. Do you want to say half hour, 45 minutes?

149

THE WITNESS: Half hour is fine.

MR. SORENSON: How about we just put it at half past the hour, just to make it easy to remember when to come back. So that is 12:30 Mountain, and then you can do the math where you are.

MS. MURRAY: Yes. Sounds good.

(Recess from 11:49 a.m. to 12:33 p.m.)

MS. MURRAY: Welcome back from the break.

Q. (By Ms. Murray) Dr. Skop, is there anything from your testimony that you would like to update or add to?

A. I did realize there is a study that is not in my bibliography by Diana Greene Foster that is reasons for late abortions. Some of that data may have come from there that we were discussing.

Q. And which study is that?

A. I think it is called "Who Has Abortions at or After 20 Weeks."

Q. Okay. All right. We can definitely take a look at that one if we haven't already. Anything else?

A. I think that's all.

Q. Did you speak with anyone other than Mr. Sorenson during the break?

A. Just my children at lunch but not about this.

150

Q. Well, it sounds like you had a good lunch then.

Okay. Let's get started then. I wanted to take you back to close to where we left off. When we left off, we had been talking about the National Academies of the Sciences' report, and, you know, I take it from your response that you -- well, let me just put it this way.

In your view, what is the best source of data on abortion-related mortality and morbidity rates in the United States?

A. We don't have the desire as a country to keep accurate data on that. I don't think that there is any good source of data. It's well documented that many abortion-related deaths are not documented on death certificates.

Q. So, ma'am, I will say -- and I should probably just make this statement early on. I want to make sure we're able to get through the questions that I have today. So I would ask that you stick to responding to my specific questions in your answers so we can stay on track. Okay? Is that fair?

A. Yes.

Q. So my question to you is what is the best source of data available on abortion-related mortality

151

and morbidity rates in the United States?

A. The CDC is the only place collecting that.

Q. Okay. With respect to abortion-related mortality rates, do you believe that those rates should be calculated based on the number of abortions reported by the CDC or based on the number of abortions reported by Guttmacher?

A. As we discussed earlier, I think Guttmacher's data is more accurate on the numbers.

Q. I understand your position to be that you don't think there is good data, but the most reliable or the best data out there, if I understand you correctly, on mortality rates from abortions is based on the CDC maternal surveillance data, and you would use that combined with a number of abortions reported by Guttmacher. Do I have that correct?

A. In terms of as good of accuracy that we have --

Q. Yes.

A. -- but it is still very inaccurate.

Q. But that's your position as to the best data available currently?

A. Yes.

Q. Okay.

A. Kept -- if we kept data on pregnancy

152

outcomes, all of them, we might be able to obtain better data.

Q. And what about the pregnancy-related mortality rate for pregnancies that end in a live birth; what do you think the best data available is to calculate those rates?

A. The best data -- and some of the state level maternal morbidity and mortality committees are doing this -- would be to look at maternal death certificates along with the fetal live birth or death certificate, which are given after 20 weeks with the exception of abortion, which does not have to have a certificate, and then to pull all of that woman's medical records to determine causation. That would be the best.

It's not been done here; it's been done in Finland and Denmark. And when it is done with complete records, the risk of death following abortion is far higher than the risk of death within a year following a term birth.

Q. I noticed that you relied on the Finnish studies in your report. Those studies are based on vital records data, correct?

A. That's correct.

Q. And so they don't measure pregnancy-related outcomes to the extent pregnancy related means there is

153

some causal nexus between the pregnancy and the outcome; is that correct?

A. They are looking at all deaths, so they are actually looking at pregnancy-associated deaths.

Q. And pregnancy-associated deaths, to make sure I understand, those could be deaths that have no causal relationship to abortion, correct?

A. That is possible, but I think we also need to consider the increase in suicides, the increase in risk-taking behavior, and the risk in violent deaths. And we should dig into those a little bit more to see how those might be related to abortion.

Q. I understand what you're saying about additional research that could be done. But with respect to the research that has been done, the Finnish studies that you rely on do not assess a causal relationship between a history of abortion and an outcome of any kind; is that correct?

A. That is correct.

Q. Okay. So it is just pregnancy-associated or abortion-associated outcomes?

A. That is correct.

Q. That's correct. And you mentioned that the best data with respect to pregnancy-related deaths, so that means some kind of death that has a causal nexus to

154

the pregnancy, would be from maternal morbidity and mortality review committees where they look at, if I have this correctly, death certificates, fetal death certificates, and a woman's medical records; is that correct?

A. Well, the -- they're looking at both live births after 20 weeks and death of neonatal stillbirths after 20 weeks and connecting those to maternal death certificates.

Q. Okay. So --

A. They make that connection and then pull the woman's records. And if they could get ahold of the records from the abortion clinics, which, apparently, they cannot, that would be a complete way to do it.

Q. Are you familiar with the review committee that operates in Utah to study the morbidity and mortality?

A. Not specifically.

Q. But every state has one, correct?

A. Uh-huh.

Q. And do you have any knowledge with respect to how they calculate the maternal mortality or pregnancy-related mortality rates in the state of Utah?

A. Do you I know what the committee does specifically or how --

155

Q. Yes.

A. No, I'm not familiar with the committee.

Q. You're not familiar, okay. But if they looked at death certificates for women to see if they were noted to be pregnancy-related fetal death certificates and the medical records of women who the certificates identify as potentially having died from pregnancy, would you agree that that's the best kind of information that you're describing on pregnancy-related mortality rates?

A. Only for deaths that occur after a 20-week pregnancy. We have no way of identifying women who have a pregnancy that ends before 20 weeks who then die within the year, because there is no -- there are no certificates at all given related to abortions or miscarriages, ectopic pregnancies.

Q. Right. But that would be a limitation of the available data for both pregnancy ending in abortion and pregnancy ending at the time of the person's death unrelated to abortion; is that correct?

A. Well, two-thirds of deaths are related to those late outcomes, a third, that we know of, to the early outcomes, but we don't -- unless it is specifically documented on the death certificate, we don't have any way at all of gathering information on those. And so it

156

leaves a very big gap in our understanding of what happens that causes women to die.

Q. Okay. So -- but that is true with respect to pregnancy-related deaths and with respect to abortion-related deaths, correct? That there is a gap in information as to -- there could be some people who do have those related deaths but are not identified, correct?

A. That's correct. We know that with term deaths, even those, 40 to 50 percent are missed on death certificates. In the Finnish studies, when they look at death certificates, it missed 94 percent of deaths related to abortions. So there's a possibility of data there.

Q. To be precise, Dr. Skop, didn't you say that the Finnish studies on which you rely do not assess whether a death is pregnancy related. They only identify pregnancy-associated deaths. Correct?

A. Right. But the difference is that they can pick up every death associated with pregnancy because they have a single payer health care. They know about every pregnancy that enters the health care system even if it ends in abortion, we don't.

Q. Right. But they're not pregnancy related -- they are not assessing pregnancy-related deaths,

157

correct?

A. They are -- they are assessing -- they're collecting pregnancy-associated deaths, but they are not -- they're not giving us data with specific chart reviews to say which ones were caused be the pregnancy or its treatment or which ones just happened in that time interval within a year of pregnancy.

Q. Okay. Can you turn to -- let's see. Can you turn to Tab K?

(Exhibit No. 4 was marked.)

Q. Are you there?

A. Just about.

Q. So I'm showing you a printout of a web page from the Utah Department of Health entitled "Complete Health Indicator Report of Maternal Mortality." Do you see that?

A. Yes, I do.

Q. Have you ever looked at this page before?

A. I flipped over it when I accidentally looked at the folder last night, but I didn't look at it in depth.

Q. Did you read any of it?

A. No, I -- I glanced at it, and it looked like what I've seen on other M and M committees.

Q. And when you -- I wanted to draw your

158

attention to the second paragraph on here that has definitions, and it says, "Pregnancy-related deaths." I just wanted to make sure that we're using terminology that is consistent with how the Utah Department of Health is using it, or make sure, if you disagree with it --

MS. MURRAY: This is Tab K, Darcy.

Q. -- that I understand what the disagreement is.

So the Utah Department of Health defines pregnancy-related deaths as, "The death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy or the aggravation of an unrelated condition by the physiological effects of pregnancy." Is that how you understand pregnancy-related deaths, Dr. Skop?

A. Yes, it is.

Q. And a pregnancy-associated death here, they would define, if it is not related, as, "The death of one during pregnancy or within one year of the end of pregnancy from a cause that is not related to pregnancy." Is that your understanding as well?

A. No. That is a definition I have not seen before. The one that I used, I believe it is WHO and CDC, they don't have the part that says "but not related." They say a pregnancy-associated death, and I

159

believe they define it as a death within a year irrespective of the cause.

So in other words, it includes women who died because of an adverse event related to pregnancy and it also includes those women who died by we don't know.

Q. For example, if a woman left the hospital and was, you know, hit by a car, say, on the road outside of the hospital; had nothing to do with the fact that she had just had a baby. That would still be identified as a pregnancy-associated death, correct?

A. Right.

Q. Because she died within one year of having the child, okay. And so those are the deaths that you are referring to that -- let me put it another way.

The Finnish studies that you rely on in your expert report -- those would include the patient who gets hit by a car outside of the hospital as a pregnancy-associated death, correct?

A. That -- yes, it includes all deaths.

Q. All right. Thank you for that clarification. That's helpful.

So what about pregnancy-related morbidity rates in the U.S.; what is the best source of data on those?

A. I don't know because I don't know that there

160

is -- I know the CDC collects that information, but I don't know how they do it. I don't know if they require hospitals to report sentinel events or if that is voluntary. They do say there's probably a hundred times as much, you know, morbidity as mortality, but I would assume that's something we don't have a lot of great data on either.

Q. And so if a patient -- let me ask you, has a patient ever asked you about the risk of dying from pregnancy and childbirth?

A. On occasion somebody will ask me about that Raymond and Grimes study, and I will explain to them that it is based on noncomparable denominators, and we don't really know the answer to which is safer. I will reassure them that the MacDorman study that has been widely quoted in the news, many of the deaths that were picked up were due to increased documentation rather than actually increasing number of deaths.

Q. So I do want to keep us on track. So if a patient asked you -- you've had patients ask about the Raymond and Grimes study; is that correct?

A. Yes.

Q. And would you give them any information that you considered to be the best data, or is your answer that there are no good data in the area?

161

A. There's no good data. When we look at what the CDC does have documented, we discover that, particularly regarding this legislation, an 18-week abortion has double the mortality risk of a term, normal vaginal delivery.

Q. I'm sorry. Can you -- where are you getting that data?

A. It comes from the CDC. If you look specifically at 18 weeks and you break down the --

Q. Oh, you're comparing it just to vaginal births; is that correct?

A. Uh-huh.

Q. And why do you think it would be appropriate to exclude all of the deaths related to C-sections?

A. Because abortions are not performed by C-section, so we're comparing comparable procedures.

Q. They could be performed by hysterotomy, correct?

A. Right, but they rarely are.

Q. But they could be?

A. Sure.

Q. But -- so -- I guess I'm not following that. Why would an appropriate comparator for the death rate of birth at and after 18 weeks -- of the death -- the mortality rate for abortions at and after 18 weeks be

162

mortality rate for pregnancies ending in a vaginal birth?
A. Because you're comparing similar procedures. So, in other words --
Q. Well, let me ask you this. Do women who have C-sections, on average, do they have higher risk pregnancies?
A. Sometimes they do.
Q. On average do they?
A. Probably in my patient population, yes.
Q. Right. And so they are, even before the C-section, on average, at higher risk of mortality and morbidity from pregnancy and childbirth, correct?
A. Many -- many of the women who have C-sections do so because -- due to failed induction because of hypertension, diabetes; other high risk conditions place them at higher risk for C-section. If that makes sense. Yeah, they're higher risk women to start with.
Q. And so what you're advocating would be to compare abortion to childbirth but exclude what would effectively be the highest risk population, correct, of those women who have a child?
A. I want to compare similar procedures, right? So your procedure does not involve an incision on the uterus. It involves the introduction of instruments into

163

the uterus to remove the child, and that has double the risk than if she went to term and had a normal delivery. Now, obviously, we don't know in advance who is going to need a C-section, but there's so much that is more important here than is just being concerned about the mortality particularly when we don't have good information on mortality.
Q. Let me back up. This comparison between abortion mortality rates and vaginal-birth mortality rates, that's not in your expert report, correct?
A. I don't think so.
Q. You don't compare them. And do you have any cites in your expert report that describes your opinion in this respect?
A. It's included in the paper that I wrote: Abortion and Maternal Mortality. That's in the CV but was published after I submitted this report.
Q. Has that been peer reviewed?
A. Yes.
Q. Can you think of any other colleagues whose work you respect in the area -- anyone else in the field who believes that it would be appropriate to compare the mortality rate from abortion to the mortality rate only of vaginal births -- after vaginal births?
A. I think it is disingenuous that we're even

164

having a discussion about killing a human being in order to mildly reduce a woman's risk of going through a term pregnancy.
Q. I certainly didn't write HB136. The State's position here is one of the bases for HB136 is to protect the health and safety of patients in Utah. So my question to you is do you believe or can you think of anyone else in your field who would agree with you that a pregnancy mortality rate based only on vaginal birth is an appropriate comparator to the pregnancy-related -- abortion-related mortality rate?
A. I don't know that I've had that discussion with many people.
Q. Okay.
A. It's a similar procedure. I considered it to be an appropriate comparison.
Q. On page 5 of your report, if you can turn to that. That is Exhibit 2. Are you there?
A. Yes, I'm here.
Q. So at the very end of the first full paragraph, you say, "Complications unique to this operation may include instrumental perforation of the soft, distended uterus, with injury to surrounding bowel or vasculature, potentially leading to sepsis; or the incomplete removal of all the fetal tissue which may lead

165

to hemorrhage, infection, of chronic pain, or future infertility. Additional surgery may be needed to correct these damages."
Did I get that right?
A. Yes, ma'am.
Q. What do you mean by "Complications" -- well, first of all, let me ask: When you say "this operation," what do you mean by that? What is "this operation" here?
A. Well, I'm specifically referring to a D&E.
Q. Okay.
A. Now, obviously, what I am not saying is that only a D&E can give these complications because, as I mentioned earlier, I know of a young woman who died of a first trimester surgical abortion from these type of complications.
But Creanga, Berg, Zane -- the CDC researches who do the -- who look at the statistics on the maternal mortality that we have, have documented that early in the second trimester a D&E has 15-fold increased risk of mortality, 30-fold in the mid, 76-fold at the end of the second trimester. So it is well documented that when complications occur that they're more serious and they're more frequent in D&Es than in early first trimester surgical abortions.

166

Q. Okay. I'm going to stop you there because we will get to that, but we're going to get to that later.

When you say, "Complications unique to this operation," what do you mean by the word unique there?

A. Again, I'm not saying that it can only happen --

Q. Let me ask it a different way. That might be more helpful. Are you saying that these complications are not complications that would occur in any other pregnancy separation besides abortion?

A. As far as perforating through the uterus from the inside, that is -- unless you had a uterus that ruptured, which, as we've discussed, can happen with a C-section scar, doesn't happen very often.

Q. But let me ask this: Can it happen with instruments if you have a -- I'm sorry, I'm forgetting the medical terminology. But if you have a delivery where instruments are used, could there be uterine perforation in that instance?

A. There could be. It would be medical malpractice.

Q. But it wouldn't be unique to an abortion; is that correct?

A. Right. So it --

167

Q. What about --

A. Complications commonly with this procedure.

Q. I'm sorry?

A. Maybe I should rephrase it as complications that can happen commonly with this procedure.

Q. And how would you define the word commonly there?

A. That's a very good question. You know, in medicine in general, a common complication is one that's in the, you know, 5 to 10 percent range. You know, a lot of times abortionists tell us that complications are uncommon, and yet they do document, for example, failed medical abortions in the 5 percent range.

Q. So you're saying commonly there you would mean 5 to 10 percent?

A. No. I don't know how often that happens because we don't keep good data on those type of complications.

Q. Okay. But just to be clear, instrumental perforation of the uterus -- that could occur during childbirth, correct?

A. If it did, it would be a really, really bad doctor because you don't put forceps on until the child is in the vagina. You don't put the forceps on when the kid is still in the uterus.

168

Q. And you could have uterine rupture during childbirth, correct?

A. You can.

Q. What about a surrounding -- what about a bowel injury; could that happen during childbirth?

A. It could. It is very unusual. That would, you know, potentially be a situation where you had a surgical misadventure during a C-section. Again, it is not very likely.

Q. Vasculature injury, could that happen in childbirth?

A. That can happen with any --

Q. What about infection leading to sepsis?

A. That can happen.

Q. And does that happen sometimes because of a retained placenta after delivery?

A. It can.

Q. What about -- well, you said incomplete removal of all the fetal tissue. So there could be incomplete removal of the placenta after childbirth, correct?

A. With a D&E or with a term delivery?

Q. With a term delivery.

A. Yes, that can happen.

Q. And is it accurate that after a term

169

delivery, you would actually examine the placenta to make sure that it is whole?

A. Typically we do, yes.

Q. What about the hemorrhage; that can happen after childbirth, correct?

A. Yes.

Q. Infection?

A. Yes.

Q. Chronic pain?

A. Yes.

Q. Future infertility?

A. Yes.

Q. Okay. So it is not accurate to say that these complications are unique to the D&E, is it?

A. Instrumental perforation of the soft, distended uterus does not occur in normal childbirth. That's what I'm referring to, and that can lead to all of those other things, which, of course, like infection and hemorrhage can occur in other types of procedures. But the instrumental perforation is pretty much unique to a D&C, a D&E.

Now, sometimes the D&C can be related to a miscarriage, so it is not always a live birth. But a D&E has a much higher incidence of these type of things happening, particularly if it is done by an inexperienced

170

abortionist.
Q. We'll get to that.
So if I could have you look at -- I just want to make sure that we have a few things in the record here. If I could have you look at the -- if I could have you look at Tab G -- actually, you know what? Let's go somewhere else first.
MR. SORENSON: While you're doing that, Julie or Kristin, did we mark Tab K as an exhibit? I can't remember.
MS. MURRAY: We did.
MR. SORENSON: Can you remind me what exhibit that was?
MS. MURRAY: I think it is Exhibit No. 4.
(Discussion held off the record.)
Q. (By Ms. Murray) So if you could move to Tab D?
(Exhibit No. 5 was marked.)
Q. So I'm showing you, Dr. Skop, Tab D, what has been marked as Exhibit 5. Do you recognize this document?
A. Yes, I do.
Q. And this is cited in the clinician guides to medical and surgical, correct?
A. Yes.

171

Q. And it is cited in your report?
A. Possibly.
Q. Why don't you take a look at footnote 9.
A. Okay. Yes, it is.
Q. Okay. Do you consider this guide a reliable source on abortion practice?
A. I think there is some good information in here. It is authored by at least one physician that is a well-known abortion advocate, but I think it does have some interesting information in here about complications.
Q. About complications?
A. Uh-huh.
Q. And so what about abortion practice generally?
A. This particular chapter -- I believe this comes from a book that is more specific about abortion practice, but this particular chapter is about complications.
Q. That's correct. And do you find -- do you believe that this is a reliable description of complications related to abortion?
A. I think that it gives a good description of the complications that can occur. I would disagree with the numbers for the reasons that I've mentioned earlier that we do not detect all complications.

172

Q. Okay. And are you familiar with -- well, let's leave that.
So then I would like you to turn to Tab H.
(Exhibit No. 6 was marked.)
Q. This an article called "Abortion-Related Mortality in the United States" by Susan Zane and coauthors. Do you recognize this document?
A. Yes, I do.
Q. Was this the Zane article that you were referring to earlier when you talked about what you believe was the best available data on abortion-related deaths?
A. Zane's article and Bartlett and Berg are two that I use.
Q. Okay.
A. But, again, I -- it is CDC data and we know that CDC is incomplete, but this is (inaudible) we get from the CDC.
Q. But in terms of the best available data, you would rely on this Zane article; is that correct?
A. It's the best available, yeah.
Q. Okay. And then if you could turn to Tab G?
(Exhibit No. 7 was marked.)
Q. I'll show you what's being marked as

173

Exhibit 7. This is an article entitled "Risk Factors for Legal Induced Abortion-Related Mortality in the United States" by Linda Bartlett and coauthors. Is this the Bartlett article that you're referring to as among the best available data on abortion-related mortality?
A. This is the article that I referred to, and it is the best based upon the limited data that the CDC has.
Q. Okay. Is it the best data available right now with respect to abortion-related mortality in the United States?
A. Probably, that I'm aware of. Some of the maternal mortality committees may be coming up with some better data.
Q. Okay.
A. But I'm not familiar with any studies that I can refer you to. But hopefully they'll have better data in the future.
Q. Okay. So if you could turn to page 6 of your report now. Toward the end of the first full paragraph -- this is Exhibit 2.
A. Okay.
Q. You say, "Compared to an abortion performed at eight weeks gestation" -- and I'm going to leave out what is in the -- well, we'll read it: "Compared to an

174

abortion performed at eight weeks gestation (0.7/100,000 abortions maternal mortality rate), there is a 15 percent increase in maternal mortality when a woman has an abortion early in the second trimester (1.7/100,000), 30 percent increase in the mid-second trimester (3.4/100,000), and 76 percent increase after viability (8.9/100,000)."

And then two sentences down you say, "Thus, if this 18-week restriction is not enforced, Utah women will experience a 30 to 76 percent increased risk of dying from a complication of the late abortion."

Did I read that correctly?

A. You read it correctly. What was insinuated was compared to an eight-week abortion.

Q. That's right. So just to -- just to be clear, then, the statement that "if this 18-week restriction is not enforced, Utah women will experience a 30 to 76 percent increased risk of dying from a complication of the late abortion" -- that assertion is based on the assumption that women will have an abortion not at 18 weeks but at eight weeks; is that correct?

A. It is actually based on the assumption that if they don't get it by 18 weeks, they won't have an abortion. They'll carry the baby to term. But the number does compare it to an eight-week abortion.

175

Q. Okay. Let me -- I have a couple of questions on that. So is your assumption, then, that for women -- that the effect of HB136 would be to prevent women from having abortions altogether?

A. No. Is that yours? I mean, they can have them before 18 weeks. It just prohibits it after 18 weeks when it is very dangerous for the woman and when the baby can feel pain.

Q. My question is for a particular woman -- you're saying that there is an increased risk of death to have an abortion at or after 18 weeks. And my question to you is -- let me put it this way. Increased risk of death relative to what? The 30 to 76 percent increase risk of dying is relative to what?

A. Those numbers are relative to an eight-week abortion. But I think we should care about the increased risk of death of women in this category of very late abortions.

Q. I don't disagree with you, Dr. Skop. The numbers that you cite here, if this 18-week restriction is not enforced, Utah women will experience a 30 to 76 percent increased risk of dying from a complication of a late abortion, that's not accurate, is it?

A. It depends on how you're reading it. Compared to an eight-week abortion, if it is not enforced

176

and they're allowed to have the abortions between 18 and 22 weeks, then the Bartlett and Berg studies tell us that, compared to those early abortions, that's the increase in mortality that they would be expected to experience.

Q. But if it is enforced, do you think people will react to the law by having an abortion at eight weeks or earlier?

A. Perhaps.

Q. Do you think that's the most plausible outcome from enforcement of the law?

A. It may make people make decisions earlier. It may --

Q. Ten weeks earlier?

A. It may cause the abortion clinics to, you know, have outreach to patients. And it may allow some women, especially those that are indecisive or being coerced by their partners, it may allow them to have their children, which, as I've remarked earlier, I have never delivered a woman who has not been happy that she had that baby.

So taking away that opportunity for coercion and indecision in order to commit a dangerous procedure in order to kill her baby, that does get taken out of the options.

177

Q. Let me ask my question another way, Dr. Skop. If a judge were to read -- or if someone were to read, "If this restriction -- 18-week restriction is not enforced, Utah women will experience a 30 to 76 percent increased risk of dying from a complication of a late abortion." For that 30 to 76 number that you provide there to be true, would the reader have to believe that a person will respond to HB -- that women will respond to HB136 by getting abortions not at 17 weeks, not at 16, not at 15, at 8 weeks of pregnancy or earlier?

A. I don't know what they're going to need to assume. But I think the way that this paragraph is written, it is pretty clear that that is comparing it to an eight-week abortion. It is making the point that the earlier the woman gets an abortion, the better, if she's going to get an abortion. And there comes a time when we need to take into account the woman's safety and, as we'll discuss, fetal pain, in determining when our society should allow elective abortions.

Q. Okay. I would like to move on. Can you turn to -- so Tab -- so we don't have it in yet. Tab E, and we'll mark this as Exhibit 8.

(Exhibit No. 8 was marked.)

A. Yes.

178

Q. So this is an article entitled "Abortion Safety: At Home and Abroad" and it is by you. Is that correct, Dr. Skop?
A. That's correct.
Q. Does it appear complete?
A. Yes, it does.
Q. If you can turn to page 57 of Exhibit 8, the second full paragraph.
A. Okay.
Q. As I understand it, this paragraph is a criticism of the National Academies of Sciences' report on abortion safety; is that correct?
A. That is correct.
Q. Okay. And you say in the middle of the paragraph: "The only conclusion that can reasonably be drawn from this report regarding abortion complications is that extremely high volume providers have low complication rates, not that every single abortion provider does it well."
Did I get that right?
A. That is correct.
Q. Is it your opinion that with proper training and routine performance of abortion procedures that abortion providers can have low complication rates?
A. I think it is the case in medicine that the

179

more frequently one performs a procedure the more skilled one becomes at it. I think that that would probably apply to abortion providers. The problem is we have no -- no standards, no abortion certification, no way to know who is a good provider and who is not, and the women of America don't know that either.
Q. What do you consider an extremely high volume provider? What do you mean by that?
A. Well, I would say Planned Parenthood of Los Angeles fits the bill. They're the one that did the study of 30,000 abortions in two years in a single city.
Q. Would you consider any number fewer than that to be an extremely high volume abortion provider?
A. I suppose it is all relative. When you consider that these are living human beings -- certainly I could draw the line much lower. I understand that.
Q. Let me ask you this. Would 2,000 per year be an extremely high volume abortion provider?
A. If that was a single provider doing that? Is that what you're asking?
Q. Sure. Or you referred before to the -- to an affiliate of Planned Parenthood in Los Angeles. So let's imagine an affiliate of Planned Parenthood that performs 2,000 abortions a year, would that be an extremely high volume abortion provider?

180

A. In terms of the D&E, what I've read about Utah is that you guys did about -- I don't know, about 130 to 300 in this age range over a ten-year period of time. I would consider that to be fairly low volume for the complexity of this procedure. And that is part of why I have a concern about Utah's performance of abortions in this age range because it doesn't sound like that is a high volume.
Q. And when you say from what you've read, there is nothing in your expert report that indicates you've read about specific abortion procedures in Utah, correct?
A. I do believe in my report I did some extrapolating based on the numbers that Guttmacher gives us nationwide. I believe that Utah does about 3,000 abortions throughout the state in a year. And if we took the number of 4 percent after 16 weeks -- I have some discussion of this in the first page -- it ends up being, you know, a little over a hundred procedures. And, like I say -- I've read elsewhere, but it was afterwards, so I didn't include it in this report. But I read elsewhere there were, I believe, 134 abortions performed at greater than 20 weeks in Utah over a ten-year period of time, which makes a little more than one a month, which is not a high volume.

181

Q. You would agree, though, a 20-plus week abortion is less common than 18-plus, correct?
A. I don't know the numbers. You're asking how many are between 18 and 20 in Utah and how many are between 20 and 22. I would have no way to know how that --
Q. Would you have any way to know that nationally?
A. Well, what we do know is that, and I believe this is from Guttmacher and it is in ACOG's practice bulletin as well, that 4 percent are performed after 16 weeks, and then I believe it is 1.3 that are performed after 20 to 22 weeks. But I don't have it narrowed down to 18 and 20.
Q. And because you referred to it, if we can mark Tab I as Exhibit 9. This is the practice bulletin from ACOG Number 135.
(Exhibit No. 9 was marked.)
Q. Is this the practice bulletin you were just referring to, Dr. Skop?
A. Yes. It is in that first paragraph, the statistics.
Q. Great. And do you find -- again, recognizing that no data is perfect, would you consider this practice bulletin a reliable source with respect to

182

the best available data about second trimester abortion in the United States?

A. It's a good source. I mentioned earlier that Planned Parenthood does not -- I'm sorry, that California does not report any numbers. I've heard anecdotally that California, in addition to extremely large volume of abortions, also does a lot of late-term abortions. Additionally, Maryland does a lot of very late-term abortions, and they don't provide numbers either. So I don't know how accurate these numbers are in terms of percentages.

Q. Okay. Let me -- because I do want to make sure that we're clear on this. The -- your understanding -- you've referred a least a couple of times to California and Maryland, and you say they don't provide any numbers. But they do provide numbers of abortions performed to Guttmacher, correct?

A. Yeah, but not to the CDC.

Q. Right. But doesn't the CDC, in the Zane analysis -- yes, in the Zane analysis, they use Guttmacher data as the denominator for the number of abortions performed, correct?

A. That may be the case. I haven't looked at that recently.

Q. But that would be important, correct, in

183

determining what would be the most reliable -- or whether data is reliable with respect to the mortality rate?

A. Yeah, I think -- I think that -- obviously we want to have the denominator as close as possible to a --

THE WITNESS: Sorry. I'm walking to where I have a cord because the computer is running low.

MS. MURRAY: No worries. Take your time. If you want to plug in, that's fine.

A. Yeah, it is important, but it begs the question of why the CDC can't get high volume abortion providing states to give them information.

Q. Well, that's not my question, Dr. Skop. If I could have you look at page 259 of Exhibit 9, this Zane study, I would like you to look at table 1. And look at the bottom --

A. One second.

Q. Oh.

A. Sorry about that.

Q. Don't be sorry.

A. What page?

Q. So page 259 of the Zane study. Look at the bottom of table 1.

A. Let's see. Okay, table 1. I'm looking.

Q. Do you see at the bottom it says, "GI total

184

no. of abortions distributed by CDC gestational age proportion," and below that it says, "GI, Guttmacher Institute"?

A. Yes.

Q. That's referring to Guttmacher Institute data about the number of abortions performed, correct?

A. Yes.

Q. So you cited this in your report, and you didn't know what the source of the denominator was in the mortality rates reported, correct, at the time you wrote your report?

A. You know, to tell you the truth, I probably had just not thought about it. But it is interesting that the CDC is putting these numbers out and not even using their own numbers.

Q. Well, it would certainly support your view that the Guttmacher data is likely to be more reliable, correct?

A. And the CDC is --

Q. As far as the number of abortions?

A. Uh-huh, yeah.

Q. Okay. So let's see.

All right. If you can turn to -- actually, we don't need the report for now. So you address in your report the relationship between abortion and mental

185

illness. And at some point, I think, today you've acknowledged that, in your view, the relationship between those two things is debated. But you said at page 6 of your report that there are subsets of women at higher risk of mental illness after an abortion. Is that your opinion?

A. It is my opinion, but it is also the opinion of psychological societies as well.

Q. Dr. Skop, I do want to remind you to please stick to responses to my questions because I --

A. Okay.

Q. I have a limited amount of time, and I want to make sure we get through my questions. Okay?

A. Okay.

Q. So do you believe there is a causal relationship between having had an abortion and suffering from depression?

A. There can be.

Q. Do you believe there is?

A. Well, it is just like anything else. There are some women who have abortions who don't suffer from depression and others who do suffer from depression and acknowledge that it was the abortion that caused the depression.

Q. I see. So the opinion that you're offering

186

is that although some women will have abortions and not have any -- not become depressed after the abortion, there are some women who become depressed and there is a causal relationship between their depression and the abortion; is that correct?

A. Yes.

Q. Okay. What about with respect to anxiety; do you believe that some women have anxiety that is directly caused by having an abortion?

A. Yes.

Q. Okay. What about suicidality?

A. Yes.

Q. And then at the bottom of page 6 of your report, you cite to a number of -- let's see. This is Exhibit 2, bottom of page 6. You have -- starting here with "an eight-year retrospective study." Do you see that part of your report?

A. Yes.

Q. So the citations for footnotes 18 through 22, are these the Finnish studies that we were just talking about earlier today?

A. Eighteen is from a California record linkage study. The Gissler, Karalis, and then the additional two Gisslers are all from Finland, yes.

Q. But the -- so to start with, 18 -- the

187

Reardon study, footnote 18, when you say that's from a record linkage study, that would have been performed in the same way as the Finnish studies, right? It would look at any deaths after an abortion and not necessarily -- not necessarily identify abortion-related deaths; is that correct?

A. Right. Right. So it is identifying abortion-associated deaths.

Q. Okay. So that would be any -- that could include, you know, a woman who might be hit by a car as she leaves the abortion clinic; is that correct?

A. That's correct.

Q. Okay. Do you -- let's see.

And you had mentioned, I believe, that you're comparing here to -- page 6, you're comparing women who have an abortion to women who carry to term when you're discussing these studies at paragraph -- or at footnotes 19, 20, 21, and 22, correct?

A. That's correct.

Q. Why do you think that women carrying to term would be an appropriate comparator?

A. In these particular studies they actually look at all pregnancy outcomes. So they're looking at women who miscarry, they're looking at women who have abortions, and they're looking at women who carry to

188

term. As you pointed out, they're -- they're not able to prove causality. But the fact that the deaths increase so substantially raises the question of let's look into causality, and no one has done that.

Q. Okay. If we can stop right there.

So just to be clear, you acknowledge that the studies 18 through 22 are not measuring causality between abortion and whatever outcome they're looking at, correct?

A. That is correct.

Q. Okay. And the -- do any of these studies control for preexisting mental health conditions that you're citing in 18 through 22?

A. They're just an observational study. So I think they're just looking at women who have pregnancy outcomes documented in their single payer system, and then they're looking at women who die. And they're looking to see, you know, who had a pregnancy and how did the outcome correlate with the likelihood of death.

They're not chart reviews, so -- and the numbers are tremendous. It would take a lot to go through each of those individual charts, but these are not chart reviews. So they don't know the woman's preexisting mental health.

Q. Right. Would you agree, though, based on

189

your experience with dealing with patients with mental health illness or mental illness, that a prior history of mental illness is a predictor of potential future mental illness -- or let me put it a different way because I think that was imprecise.

Would you agree a prior history of mental illness is a variable that makes someone more likely to suffer from mental illness in the future?

A. That is one of the categories that was documented as making a woman more likely to have a problem as was late-term abortions and as was --

Q. That's not my question, Dr. Skop. If you can please focus on my question and answer it. That's all I'm asking you to do because I do want to make sure that we are able to get through my questions today in the hours that we have allotted.

A. Yes.

Q. Okay. So they don't control for preexisting mental health conditions, correct, these studies --

A. That's correct.

Q. -- 18 through 22?

And they couldn't, could they?

A. Not the way they were designed.

Q. Right. What about -- do they control for other measures of risk-taking behavior?

190

A. It is purely observational. So I don't think they know anything about the women.

Q. So if it happened that women who had abortions were more likely to use drugs before the time that they had abortion and later died of a drug overdose, there would be no way to control for that difference between women who had abortion than carried to term -- there would be no way to control for the difference at baseline?

Sorry. Does that make sense? I know that was a lot.

A. Your questions are good. And we should ask those questions in the study. We should be curious.

Q. But my question is these studies that you're relying on and pointing the court to, these do not control for those differences at baseline between a person who has an abortion and a person who carries to term, correct?

A. That is correct.

Q. Do these studies control for the wantonness of a pregnancy?

A. Again, no.

Q. So if it happened that someone -- well, you agree, right, that many women who give birth at term have wanted pregnancies, correct?

191

A. Yes. And many who initially don't want the pregnancies love their babies when they come.

Q. So that might be an important difference between women who give birth at term as opposed to women who have abortions, correct, when analyzing outcomes?

A. Yes and no. I think you might be referring to the Turnaway study, which had very, very poor participation, and it's been acknowledged that the women who chose to participate were more likely to be secure in their decision. So there have been criticisms about that study.

Yes, you're right. If we could do a study where we really could determine that, it would be a very helpful study.

Q. And so in your review, the Turnaway study and the articles based on it, the design -- well, let me ask it a different way.

Do you believe -- setting aside your criticism of the participation rate in the study, do you believe the study is otherwise well designed?

A. No. There's a lot of questions in the study. They say they're looking at women who were close to the gestational age of the cutoff. And also they're looking at first trimester, and they don't really tell us what the numbers are in those two categories. So it is

192

hard to know whether the beneficial effect is more related to the first trimester abortions if they're overrepresented.

There are some other concerns with that study. I'm not sure how much they break out specific mental health -- you know, it would be nice if they'd ask a few more questions about mental health than they do. It is a start. I mean, I appreciate that they're trying to do this, but I wish they would have had a better participation rate.

Q. Well, again, taking -- no data is perfect. Would you say that among the studies that you have reviewed with respect to the potential physical and mental -- well, let's focus on mental health impact of abortion. Do you believe the Turnaway study is the best among them?

A. I'm not aware of any other prospective studies. If I say it is the best, I'm going to have to say that because it is the only one.

Q. Okay.

A. I think it has some deficiencies.

Q. But you would say it is the only prospective longitudinal study, correct, of the mental health impact?

A. It is the only -- it is the only one that

193

I'm aware of. It would be nice if they also broke it down by the known high risk categories.

Q. What do you mean by that?

A. Well, like I mentioned earlier -- the ones that we know are at higher risk for mental health adverse outcomes are teenagers, those who have a desired pregnancy and either terminate because of fetal anomalies, maternal health, coercion, those who terminate late, those who have multiple abortions. So there's -- there's many categories that we know that those women are at our priority a higher risk, and I don't think that the Turnaway study looked specifically at some of those categories. That would have been useful information to have.

When you guys, when you do your counseling -- because if somebody comes in and they check the box for three out of seven risk factors, do you guys tell them, You may be at higher risk to have a mental health adverse outcome?

Q. Dr. Skop, Let me remind you of our roles here today. My job is to ask the questions, and your job is to answer them.

A. Okay.

Q. So in terms of the Turnaway study, then, it sounds like, from your perspective, it is the best

194

available study with respect to the impact of mental health -- the impact of abortion on mental health outcomes? Is that fair to say?

A. There is another one by David Ferguson in New Zealand that is also a good study. Again, because of my concerns about the selection for the Turnaway study, I don't think I would call it the best.

Q. Okay. And is that Ferguson study cited in your expert report?

A. I don't remember.

Q. Why don't you take a look.

A. I don't -- I don't believe it is.

Q. Okay. And can you provide the cite to that? I think we'll talk about cleanup of documents later on. But I think if there is an article that you're relying on -- well, let me ask it this way. Are you saying today that the Ferguson study is, you think, the best study with respect to the impact of abortion on mental health outcomes?

A. I think it has -- it is a longitudinal; it is a 30-year study. And I think it has -- I think it is better designed than the Turnaway.

Q. And so would you say it is the best available study on the impact of abortion on mental health outcomes then?

195

A. I don't know that I would say it is the best. There are some other good ones as well.

Q. What are those?

A. Well, I think you're going to talk to Priscilla Coleman. She's done some of them.

Q. So you would rely on Dr. Coleman's work?

A. Uh-huh.

Q. All right. Well, that's -- that's helpful. Actually, just to make sure I understand your perspective. So the Turnaway study -- I believe you mentioned earlier that you've read a number of articles based on that study, correct?

A. Yes.

Q. And is it your understanding that the turn away study found that after an abortion, women -- well, it said in the months after having had an abortion that women who had an abortion had fewer incidences of mental health issues than women who carried to term.

A. That's what they report.

Q. Okay. And then long-term, what -- do you recall what the finding was with respect to the impact of abortion and being turned away and carrying term were on mental health outcomes?

A. It -- it had a 27 percent participation rate at the --

196

Q. I'm not asking about participation. I'm asking what were the findings; do you recall?

A. The abortion advocates who wrote the study report that the outcomes were better for those who had the abortion. But I think it is a nonrepresentative study, and I don't think it can be relied upon for all women.

Q. Just to make sure I understand. So you said that the -- I'll call them authors. The authors who wrote the study found that abortion -- people who had abortions fared better, is that what you said, than women who carried to term?

A. That was their report.

Q. Better in what respect?

A. In regards to the mental health outcomes.

Q. Okay. All right. Why don't we go to -- well, let me ask you this --

MS. MURRAY: How are folks doing on breaks? Do we need a break? We've been going a little over an hour, an hour and ten minutes. Would you like a break, Dr. Skop?

THE WITNESS: I'm okay. If you guys need one. . .

MS. MURRAY: Anybody else? Speak now or forever hold your peace. Not forever. Like, 20 minutes

197

or so.

Q. (By Ms. Murray) If you can go to page 7 of Exhibit 2. This is your expert report.

A. Okay.

Q. And you say -- this is the first full paragraph on Page 7. You state, "The International Association for the Study of Pain defines pain as an 'unpleasant sensory and emotional experience associated with actual or potential tissue damage.'" Did I read that correctly?

A. Yes.

Q. Is -- in your opinion, is that the best definition of pain?

A. That's a good definition. I don't know that we need to include emotional as -- in that definition, but it is -- I think a lot of societies have trouble defining pain.

Q. So let me ask my question again. Is it your opinion that this is the best available definition of pain?

A. Probably not. It is just one definition.

Q. Then why did you include it in your expert report?

A. Because it is a starting point to discuss what might be going on with the fetus that could result

198

in pain.
Q. Would you agree that the International Association for the Study of Pain is the leading professional organization regarding the study of pain in the United States?
A. I'm not that familiar with their reputation. I don't know if there is -- if they're considered leading or if someone else is.
Q. So you're not familiar with any organizations that study pain?
A. Not intimately, no.
Q. Okay. So you said you thought that this probably wasn't the best definition of pain, the one that you included in your expert report. What is the best definition of pain?
A. Well, I think it depends on what you're trying to justify. The -- pain is the sensory -- I think this is a good definition that -- like I said, I don't think it has to include the emotional component. But it is the tissue damage that causes the sensory neurons to relay to the brain that the tissue damage is occurring, and then the brain responds with withdrawal movements, with --
Q. So I -- I want to keep us on track, Dr. Skop. I'm not asking you describe processes. I'm

199

asking you -- you said you think this is not the best definition of pain. What is the definition that you believe is the best as an expert in this case?
A. I think that I would use this definition but omit the emotional experience part of it.
Q. Okay. So your -- do you think it is possible to have an unpleasant sensory experience if there is no emotional context?
A. It is not possible for me or for you, but it is possible for an 18-week fetus.
Q. And how do you know that?
A. Well, there's quite a bit of histologic evidence that show us that the pain system in the fetus at this age works all the way up to the thalamus. What the JAMA study that I reference tried to do is say it doesn't count as pain unless the organism has the ability to think about it and be horrified by the fact that the leg is being pulled off. And, as I mentioned, I think that is a very extreme definition of pain. We don't apply that standard to a lab rat; we don't apply that standard to someone who is in a persistent vegetative state, and I don't think we should apply that standard to a fetal human being.
Q. Okay. Just to make sure I understand. Your definition, your best definition of pain, the one that

200

you would ascribe to in this case is, quote, an unpleasant sensory experience associated with actual or potential tissue damage; is that correct?
A. Yes.
Q. For an 18-week fetus, okay. And then under that definition, in your professional opinion, what is the earliest point in pregnancy at which a fetus has the capacity to experience pain?
A. The sensory neurons begin developing at seven weeks gestational age. But I think that sometime between 14 and -- 14 and 20 weeks the complete system is functioning to the level of the thalamus. That's the lower portion of the brain. And that is clearly a time that pain can be sensed.
Q. Okay. So under the definition that you just agreed was the best definition of pain -- I just want to make sure that I'm understanding you correctly -- is it your position that the earliest point in pregnancy that that could be experienced by a fetus is between 14 and 20 weeks?
A. Again, it depends on what we're calling pain.
Q. Well, I'm asking you based on this definition.

201

A. Uh-huh.
Q. You are opining on fetal pain in this case. So I've asked you what your best definition is. Using that definition, what is the earliest point in pregnancy at which a fetus could experience pain?
A. I would say in the 14-plus range, 14 weeks.
Q. And that's because of the level of development in this thalamus; is that correct?
A. That's because the pain arch goes completely from the sensory neurons to the spinal cord to the brain; the brain can then send signals that cause withdrawal of the limb that cause endogenous opioids to be released to moderate that pain. It causes the heart rate to go up. It causes the fetal breathing motions.
Q. I'm not asking about effects. I'm asking you about what is the -- the reason or the difference between a fetus at 13 weeks and a fetus, say, at 14 weeks, in terms of development, that allows all of those parts, in your view, to come into place. Is it the development of the thalamus?
A. The thalamus, yes.
Q. Okay. So, in your view, what is the earliest point in pregnancy at which there is a fully formed connection between the thalamus and the cerebral cortex?

202

A. We don't know the answer to that. The JAMA study set a very high bar, and they didn't think it counted unless they saw fully formed neurologic pathways. I believe they said between 26 and 30 weeks. I know from having delivered live babies at 22 weeks and having seen them, how they behave in the NICU, I know that at 22 weeks there is an intact pain system in those babies.

Q. So I'm -- that's not my question. My question is, what is your expert opinion as to the earliest point in pregnancy when there is a fully formed connection between the thalamus and the cerebral cortex of the fetus?

A. It is probably between 20 and 30 weeks that that forms.

Q. Okay. So would you agree, then, that if a connection, a fully formed connection between the thalamus and the cerebral cortex is necessary to experience pain that that could not occur in 18 weeks of pregnancy?

A. I'm not agreeing that that is necessary to create pain.

Q. I'm saying if it were necessary, would you agree that it can't happen at 18 weeks? I understand you believe it is unnecessary. If it were necessary, would you agree that it cannot happen at 18 weeks of

203

pregnancy?

A. I don't think that there is histologic evidence that the connection exists that early.

Q. So there is no evidence that an 18-week fetus could experience pain, if a fully formed connection between the thalamus and the cerebral cortex is required to experience pain?

A. The -- the requirement for the cerebrum is the assumption that the cerebrum is required to emotionally process the pain.

Q. Dr. Skop, I want to get us back onto my question. My question is, if -- do you agree that an 18-week fetus could not experience pain as you have defined it if a fully formed connection between the thalamus and the cerebral cortex is required to experience pain?

A. I can't agree with the wording because you said as I've defined it. And as I've defined it, it doesn't require the emotional component. So pain, as I've defined it, does not require a connection to the cerebral cortex. A functioning thalamus is sufficient to document pain in a fetus.

Q. But to be clear, it is your opinion that at 18 weeks of pregnancy there is not a fully formed connection between the thalamus and the cerebral cortex

204

in the fetus, correct?

A. I believe that there is not documentation of that. Correct.

Q. All right. And then do you believe it is appropriate when providing an opinion on fetal perception of pain to rely on studies involving adults?

A. You know, I think all of your experts are going to have to rely on studies of something other than a fetus because there have been no studies done on a fetus.

Q. Can you answer my question, please, Dr. Skop? I'm asking what you believe. I'm not asking about my experts; I'm asking what you believe.

A. Sometimes when you can't study the specific organism at the specific time you want to study, you have to rely on other studies that are near but not completely the same. So I think it is appropriate to look at adult neurologic studies. I also think it is appropriate to look at neonatal studies.

Q. What about animal studies?

A. Animal studies can be helpful.

Q. Which animals are most comparable to humans in terms of neurological development and pain perception in your opinion?

A. I don't know that I know the answer to that.

205

I would assume probably a primate, but I don't know for certain that that's the case.

Q. Have you ever looked into the issue?

A. No.

Q. Okay. So you also mentioned in your report that it is the standard of care to give analgesia to premature neonate who is undergoing a potentially painful procedure; is that correct?

A. That's correct.

Q. And what is the gestational age that you're referring to there, or that you have in mind of the neonate at the time of birth?

A. Conversations with my neonatology peers -- any live baby in the NICU is going to get analgesia if needed. There are neonatal surgeries that are done even prior to the age of viability, and it is my understanding that analgesia is given in those situations as well.

Q. But you don't perform those intrauterine fetal surgeries, correct?

A. No.

Q. And it sounds like you don't actually administer analgesia to neonates, correct?

A. No. Those are both outside of my specialty.

Q. Outside of your expertise?

206

A. Exactly.
Q. Okay. And then you mentioned something, a term I've never heard of it. What is intrahepatic vein needling?
A. So sometimes they need to collect blood from the fetus, maybe an Rh isoimmunization situation to determine, you know, anemia, things like that. They need direct fetal blood. And so they can -- they can get it from the cord sometimes, and I can't really tell you exactly which situations, but they may need to go directly into the big vessel that feeds the liver. That is what that is.
Q. So it is not a procedure that you perform, then?
A. No.
Q. And at what gestational age would you do it; do you know?
A. I don't know. I think that would probably be a mid-second-trimester procedure. But, again, it is generally done by a specialist. Usually in Texas it is Houston or Dallas that does those.
Q. Have you ever observed it?
A. It is possible that I may have during my residency.
Q. But you don't recall any --

207

A. I don't recall.
Q. -- particular --
A. Maybe they weren't that sophisticated then.
Q. Okay. And, actually, if we can back up to my earlier question about the neonates. I think you mentioned it was your understanding that any living baby in the NICU would, where appropriate in the treating physician's view, would receive analgesia for a potential painful procedure; is that right?
A. That's correct.
Q. When you say any living baby, what point in pregnancy would you say that is the earliest point that you're going to see living babies who make it into the NICU after birth?
A. Viability is actually an ever decreasing standard. Currently 22-week neonates -- the University of Iowa just released a study that two-thirds of those lived until hospital discharge and, of those, two-thirds have no to minimal neurologic impairment. So the 22-weekers are doing well. And there have been some 20- to 21-week fetuses that have been saved. So we -- we think of 22 weeks, but I think that our viability is decreasing even further.
Q. Are you saying you're aware of instances in

208

which a neonate born before 21 weeks and six days of pregnancy survived long term?
A. I have seen reports on that. Again, they're anecdotal reports, and I don't have the specific information.
Q. You mentioned a study out of the University of Iowa. Is it your understanding that the people in the study would have received -- well, what is your understanding of what traditional treatment would be for a neonate born at 22 weeks?
A. Well, if possible we tend to give antenatal steroids. I don't know specifically of those babies which did and which didn't. Many times at those gestational ages the neonatologist will attend the delivery, evaluate the baby to see if the baby is trying to breathe. I mean, there are some 22-weekers that aren't healthy enough to be resuscitated. But in those situations, when the baby appears to be fighting, they try to resuscitate, and those are the outcomes they have gotten.
Q. So you mentioned antenatal steroids. So in layman's terms, that is an instance where the pregnant patient would actually take steroids in advance of the birth to bolster the lung capacity of the fetus; is that correct?

209

A. That is correct.
Q. So without that kind of steroid treatment how --
A. That's felt to improve the odds. But, again, babies have survived without the steroids.
Q. And -- okay. So you mentioned steroids. And, also, do you know whether the Iowa program was a Level 4 NICU.
A. I would assume it must be to have 22-weekers.
Q. So for the record, a Level 4 NICU would be the highest -- how would you describe a Level 4 NICU?
A. Yeah, it would be the highest acuity, the ones most likely to have the machinery that's needed to support a baby that young, his respiratory system.
Q. And there are very few of those, correct?
A. I don't know the number. You know, teaching hospitals tend to be the ones with the best NICUs.
Q. So what about the -- does a pre-viable fetus have the capacity for directional movement?
A. I think, undoubtedly, they do. I mean, that's been demonstrated in babies as young as 14 weeks, maybe earlier. We don't know what's going on in their minds. I mean, certainly sometimes they do look like they're doing things intentionally, but 14 I think.

210

Q. When I say directional movement, what do you take that to mean?
A. Movement that looks like it is not just random, but for a purpose.
Q. Okay. But moving -- do they have the capacity to move in one direction as opposed to another?
A. Certainly.
Q. Okay. So when you see a fetus on ultrasound, would a fetus move directionally upon pressure to the stomach to the pregnant patient?
A. They can do that as well.
Q. Okay. Why might you do that during an ultrasound?
A. Well, sometimes you'll do it to get them to expose themselves better to their father and they can see the face, look between the legs, that type of stuff. If you're doing a procedure, amniocentesis, you may want to nudge them so that they give you a clear spot to get amniotic fluid without the baby at risk.
Q. So what -- what happens when you do that? You kind of nudge them to try to get them to move in a way that you want. And would they have a directional movement then?
A. Well, I mean a directional -- obviously

211

that's a responsive movement; you push them, and they move away from you. I interpret directional to mean that there is -- that it is more than just random, that it is either some neurologic control that is causing it to happen. I assume you might be responding to what I put in there about the twins. Twins as early as 14 weeks, you know, they can see them reaching for each other. Obviously, we don't know what capacity causes them to do that, but it seems to be the case that they do.
Q. I wasn't referring to the twin reference, actually. I'm just curious, if you nudge a fetus during a ultrasound, you -- it sounds like the fetus will move away, correct?
A. Correct.
Q. And that's how you would be able to see between the legs or you would be able to show the ultrasound to someone in different view; is that correct?
A. That can be one way, yes.
Q. And do you think that you're hurting the fetus when you do that?
A. No.
Q. Is that common to do during an ultrasound, to nudge the fetus in ways to get it to move?
A. You end up putting a little bit of pressure with the ultrasound transducer, so I would say it is

212

meant to put some pressure and to see the fetus move in response to that.
Q. But in your view, that is not pain that you're inflicting on the fetus; is that correct?
A. Right. There's other ways you can measure pain. I mean, when we experience pain, our adrenaline rises, our heart rate rises, it is the fight or flight. Right? We want to get away. And we see that same thing happening in a fetus. If we're measuring blood, we can see the catecholamines, we can see the endorphins rise, we can see the heart rate rise, you know, all of that in conjunction with the withdrawal of the fetal parts getting away from whatever that painful stimulus is.
Q. I'm sorry to go back. You mentioned the endorphins. What else did you say?
A. Catecholamines. So endorphins are endogenous painkillers. Catecholamines would be, like, the adrenalin to make your heart race and stuff.
Q. Okay. Could you see a change in those in the absence of what might be perceived as a painful stimuli?
A. Well, I mean, certainly you can. You know, movement, you know -- just as our heart rate rises when we exercise, you know, we will see babies' heart rates rise when they exercise. But the constellation of things

213

happen at the time of the pain -- of the painful stimulus, and --
Q. Right. But my question to you is could those things that you've outlined as rising for a fetus, could those happen in the absence of a painful stimuli as well?
A. I don't know that they would release endorphins if they weren't having pain because those are to modulate pain. Those are to decrease the pain.
Q. So you believe that that would be an indicator that there actually is the a pain response --
A. I think all of it together tells me there is a painful transmission to the fetus.
Q. Okay. But to go back to our earlier discussion, you've never performed an abortion at or after 18 weeks, correct?
A. That's correct.
Q. So you've never observed what a fetus might do during an abortion at or after 18 weeks, correct?
A. I've seen videos.
Q. Where did you find the videos, Dr. Skop?
A. Oh, those were from Bernard Nathanson, who was one of the guys who helped to override Roe. And then as he -- he performed a lot of abortions and, ultimately, had a change of heart and -- based on what he saw on

214

ultrasound on how he saw those babies reacting. And he's put out a couple of videos that show the responses to babies during abortions.

Q. But you have no firsthand experience of observing an abortion at or after 18 weeks, correct?

A. That's correct.

Q. Okay.

MS. MURRAY: So I think this might be a good time to stop and take a break.

(Recess from 2:11 p.m. to 2:34 p.m.)

MS. MURRAY: Welcome back from the break.

Q. (By Ms. Murray) Dr. Skop, is there anything you would like to amend or add to your earlier testimony at this point?

A. I don't think so.

Q. Okay. Before we get started, I have -- well, I had some -- some questions on other issues, but I wanted to go back to the discussion this morning about the exhibits in this case. When did you receive the package of exhibits yesterday, Dr. Skop?

A. Toward the end of the day.

Q. What time, approximately?

A. I'll say about 6:00.

Q. Okay. And when did you receive the court order in this case governing the depositions?

215

A. Maybe a week or so ago.

Q. Okay. And then there was -- the court order was actually included with the exhibits, correct?

A. Yes.

Q. To be clear, was it your understanding when you received the packet that you were not supposed to open it until we had our deposition today?

A. That was totally my fault. If it was in the information that was provided before, I didn't -- I didn't remember. I didn't pay attention to it when I received the package yesterday. I didn't know what it was, and I opened it and then saw that it was these papers, and I flipped through it. But I didn't spend an extensive amount of time because I thought that -- pretty much everything I saw was the stuff I had submitted to you guys.

Q. Just to make clear, when you received the package, it did have a return address on it, correct?

A. Probably.

Q. And it would have had my name, Julie Murray?

A. Probably.

Q. Did you know my name last night?

A. I don't recall paying attention to who it was from.

Q. I'm asking you a different question. Did

216

you know my name last night at 6:00 p.m.?

A. I've heard your name before, yes.

Q. Okay. So you did know my name. And, I'm sorry, did you say that there was a return address with my name on it?

A. I don't recall. I've thrown the package away, but I can find out. I didn't pay attention to that.

Q. So if you didn't know who the package was from, would you have -- normally would you look at the return address to figure it out?

A. To tell you the truth, we're getting a lot of packaging right now. My son is working from home too, and so I've kind of gotten into the habit of opening packages, seeing what is in them, and then sending them to the appropriate person. I think that's why I didn't pay attention to who it was from.

Q. So you had not been advised before receiving the package not to open it?

A. If I was, I neglected to pay attention. So it is my fault I'm sure.

Q. Do you recall being advised about a package?

A. I don't recall, but I probably -- I mean, it was probably in some of the papers that I --

217

Q. Did you read the court order that Mr. Sorenson provided to you?

A. Did I read it? I looked at it about a week ago.

Q. And did he tell you to expect a package last night?

A. I don't remember.

Q. So you didn't know yesterday whether you would be receiving documents in this case?

A. No.

Q. So they came out of the blue?

A. Yes.

Q. Okay. And then when you opened them, what was inside -- well, let me ask you this: How did the documents arrive; in what kind of container?

A. They were in a FedEx envelope.

Q. An envelope or a box?

A. It was a box.

Q. A box. And then what was inside of the sealed box?

A. An envelope.

Q. And was that envelope sealed?

A. Yes.

Q. And then what was inside of that sealed envelope?

218

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.

219

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

220

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

221

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.

222

Q. Okay. And is there any other prior testimony that you've provided in any type of proceeding that we haven't talked about today?
A. I don't think so.
Q. So I believe you mentioned there was some testimony to the Texas state legislation, correct?
A. Correct.
Q. And that wasn't on your CV, correct?
A. I don't believe so.
Q. What about testimony to the Vermont legislature, have you ever done that?
A. I wrote a -- I wrote a report at the request of Vermont Right to Life.
Q. And you don't know what happened to it?
A. It got ignored, apparently.
Q. Was the purpose of the report to submit to the legislature?
A. I believe so.
Q. And that wasn't on your CV, correct?
A. I had forgotten about that.
Q. So it wasn't on your CV?
A. That's correct.
Q. And you didn't mention it this morning?
A. No. I'd forgotten about it until just now.

223

Q. Is there any other testimony that you have ever provided that you haven't told me so far in any type of proceeding?
A. It's hard to say. Not that I can recall. But some of these things are fairly minor, so I may be forgetting something.
Q. What about any letters to the editor or newspaper articles about abortions -- actually, can we back up?
So you told me what the Texas and Georgia testimony was about. What was the Vermont testimony about, to your recollection?
A. Well, this was at the time that Vermont took away all restrictions on the procedure of abortion, and so I wasn't paid for that testimony. They just asked me -- I don't remember how they found me, but they asked me to write a -- you know, a report about the dangers, which I did.
Q. The dangers of abortion?
A. The dangers of abortion, yes.
Q. So you were opposing legislation that would have removed some regulation of abortion; is that correct?
A. That legislation removed all regulation of the abortion in the state of Vermont.

224

Q. And you opposed it?
A. Yes, I did.
Q. So just to make sure that I understand. In Texas, Georgia, and Vermont, all of the testimony you have provided has been to support greater regulation of abortion as opposed to less regulation; is that correct?
A. In the interest of safety, yes.
Q. Or to ban it outright, correct?
A. No, I haven't supported anything that would ban it outright.
Q. The Georgia ban at six weeks, you don't consider a ban on abortion outright?
A. No. Women can get abortions -- it is possible to know you are pregnant prior to the fetal heartbeat.
Q. When is a home pregnancy test accurate? How many weeks LMP?
A. It can pick up as early as three weeks LMP, about a week after the conception occurs.
Q. So, at best, three weeks. And when is it most reliable? Does it start being very reliable at three weeks?
A. Depending on the test. It is almost always -- even with a low sensitivity test, it is always going to be positive around the time of the missed

225

menstrual period.
Q. So when would that be?
A. Around four weeks.
Q. Four weeks. So in your view, it is not an outright ban on abortion if a woman can get an abortion between four weeks, when it will be reliably diagnosed by a home pregnancy test, and six weeks; is that correct?
A. Yes. There's certainly time to get an abortion there. And sometimes we don't see the heartbeat until seven or eight weeks depending on the sensitivity of the ultrasound.
Q. Have you also advocated waiting periods, Dr. Skop, between the time that a woman is provided informed consent papers for abortion and when she can actually obtain one?
A. I don't recall if I've done anything specific in writing or in testing, but I think that is a reasonable restriction.
Q. Do you know what the waiting period is in Utah?
A. I believe I read 72 hours.
Q. Seventy-two hours. So -- okay.
So we talked about the Vermont testimony. What about any letters to the editor or newspaper articles about abortion that didn't appear on your CV?

226

A. I've had a few letters to the editor, local op-eds. I've had a few op-eds published in more national magazines. I had a joint op-ed with a congressman on the hill. There's been a few others. I don't think those were important to put on the CV, but. . .

Q. Are you referring to the op-ed that you did with Representative Kevin Brady of Texas with respect to federal legislation on abortion?

A. Yeah. The legislation, as I recall, was about supporting babies that are born alive.

Q. After an abortion?

A. It doesn't actually limit abortion. It just ask that you save the infant.

Q. But it was an op-ed with respect to abortion, correct, with a congressman?

A. Yes.

Q. And did any of the other letters or op-eds that you mentioned pertain to abortion?

A. Probably most of them did.

Q. Okay. But none of them appeared on your CV, correct?

A. Yeah, I didn't put any of those on.

Q. Okay. What about -- have you ever been denied a license to practice medicine in any state?

A. No.

227

Q. Have you ever had your license revoked or suspended?

A. No.

Q. Has a patient or a former patient ever filed a complaint against you with any disciplinary body?

A. No.

Q. Have you ever been named as a defendant in any lawsuit that we haven't discussed today?

A. No. There were two medical malpractice suits, one of them did not do a deposition.

Q. Okay. And when did that happen?

A. Oh, it was quite some time ago; 15 years maybe.

Q. Okay. Have you ever been fired from any position?

A. No.

Q. Have you ever been asked to resign or leave a job or professional position?

A. No.

Q. Have you ever resigned from a position while an investigation was ongoing against your conduct?

A. No.

Q. Have you ever been accused of professional misconduct?

A. No.

228

Q. Do you have -- are there any circumstances in which you believe abortion should be available in the United States?

A. I think -- I don't think it is necessary for women's health. If a woman needs to be separated from her baby to preserve her health, that can be done without intentionally performing an abortion.

Q. And how would that be done, so that I understand?

A. Labor can be induced or, you know, as we discussed earlier, caesarean if indicated.

Q. And in those circumstances, how would you describe when you think abortion should be legal to protect a woman's health?

A. Well, abortion --

Q. Would any health risk be a sufficient basis for performing an abortion?

A. Doe v. Bolton defined a health risk as emotional, psychological, physical, age, social. So many times things that are defined as for the health of the mother are not life-threatening. I don't -- I can't think of a time that a pregnancy has posed a risk to the life of a patient that I've cared for that I have not been able to take care of the mother with either induction or C-section.

229

Q. Do you believe that abortion should be legal in the United States if there is a threat to the mother -- or the woman's health but not to her life?

A. Well, like I mentioned, the health exception is very broad. In some states she says she feels depressed about the pregnancy; they consider that a health exception.

Q. Not asking you what the law is. I'm asking you, in your view, are there any circumstances in which abortion should be legal to preserve the health of the pregnant patient if her life is not threatened?

A. I have not come across a circumstance like that.

Q. So you can't think of any circumstances in which you think abortion should be legal to preserve the health of a pregnant patient but not her life; is that right?

A. My goal is not to make abortion illegal. My goal is to make it unnecessary by providing contraception for women who need it, by providing support --

Q. Dr. Skop, I do want you to be responsive to my question. And my question is about what you believe should be legal. Let me ask it this way.

You have testified about the circumstances or the points in pregnancy at which abortion should be

230

legal, correct?
A. Specifically regarding this legislation, I've said I don't think it is necessary after 18 weeks.
Q. Or at six weeks, you have testified that it should be -- six to eight weeks, you have testified that it shouldn't be legal, correct?
A. I submitted an expert witness report to the State of Georgia that is unrelated to this legislation with some reasons that it is reasonable for them to make the ban where they have.
Q. And if you were making the ban, where would you put the point in pregnancy at which abortion should no longer be available?
A. Well, morally, since it is the taking of a human life, I think that that is a discussion our society should have. My goal is not legislation --
Q. I'm not asking about your goals. I'm asking about your personal beliefs, Dr. Skop.
A. I don't -- I don't care where the law falls on it, but I think it is certainly reasonable for us to put limitations, and 18 weeks is certainly a good place to put a limitation. I'm not out trying to make abortion illegal in every situation.
Q. I'm asking you what you believe should be legal. Do you believe that it should be legal for a

231

patient to obtain an abortion where her health is threatened but her life is not threatened?
A. It depends on the definition of health. If she is just depressed about being pregnant, I don't think that that should be legal.
Q. Can you imagine any other circumstances where the health could be threatened but the life would not be where you believe that abortion should be legal?
A. I think that no matter how we legislate it we're going to have exceptions for that. So I'm not sure how that applies to a case where we're talking about a very late abortion for elective reasons.
Q. I'm asking about abortion generally, Dr. Skop. Can you think of any circumstances where the pregnant patient's health would be threatened but her life would not be where you believe abortion should be legal, any circumstance?
A. There may be some.
Q. Can you think of any as you sit here today?
A. Not that can be taken care of with other procedures.
Q. With induction, is that what you mean?
A. Uh-huh.
Q. Induction of a pre-viable fetus; is that

232

correct?
A. That's correct.
Q. Okay. Have you ever advocated the closure of Planned Parenthood?
A. I don't think so.
Q. Have you ever advocated for legislation that would prevent Planned Parenthood affiliates from obtaining any funding for nonabortion-related work that they do?
A. The -- I think I may have written an op-ed about Title X.
Q. And, for the record, what is Title X?
A. Title X is unrestricted government funds that Planned Parenthood gets -- used to get a lot of that they would use to support other services --
Q. I'm not -- sorry. Let me back up. I'm not asking about Planned Parenthood. I'm asking you, what is your understanding of the Title X program. What does it fund?
A. It funds women's health, but it doesn't fund specific -- like, it is not to pay for a particular procedure. But it is a block grant that goes to family planning agencies. And the current regulations say that there needs to be brick and mortar separation between an organization that accepts that money and provides

233

abortions.
Q. And so you said you've written an op-ed about Title X funding?
A. I did.
Q. Would it have mentioned Planned Parenthood in it?
A. Possibly because they were the big topic of conversation about the Title X.
Q. And was that on your CV?
A. No.
Q. No, it wasn't.
You know the plaintiff in this case is Planned Parenthood Association of Utah, correct?
A. Yes.
Q. And so you didn't think that would be relevant to the case, to include on your CV?
A. Truthfully, it never crossed my mind that people put op-eds on their CVs. I thought you wanted the big stuff.
Q. All right. Have you ever participated in a protest outside of a Planned Parenthood health center?
A. No.
Q. What about another abortion provider?
A. No.
Q. Are you a member of any pro-life

234

organizations not listed on your CV?
A. No.
Q. Are you familiar with a fact sheet published by AAPLOG that focuses on fetal pain?
A. Yes.
Q. Let me go ahead and -- I think that is Tab N. So this will be -- we'll mark this as Exhibit 10.
(Exhibit No. 10 was marked.)
Q. And for the record, this is titled "AAPLOG Fact Sheet Fetal Pain," release date, February 13, 2019. Is that correct, Dr. Skop?
A. Which tab was that?
Q. Sorry. It is Tab N. N as in Nancy.
A. Okay. I've got it.
Q. Okay. And have you seen this document before?
A. Yes.
Q. Is it the fact sheet that AAPLOG has published?
A. Yes.
Q. Does it appear complete?
A. Yes, it does.
Q. Okay. And we've talked some about the portion of your expert report that deals with fetal pain today, correct?

235

A. Yes.
Q. And if I recall what you said earlier, correct me if I'm wrong, the preparation of your expert report, you might have, you said, relied on some other personal notes that you have taken -- or, sorry, personal notes of yours that are not public in drafting it and potentially other AAPLOG policy statements or bulletins; is that correct?
A. Just to clarify, this is what I wrote. AAPLOG had -- they had previous fact sheets that I drew information from, but clearly this is -- this is what is in the expert witness report because this -- when I was involved in updating stuff, I was thinking that it made it to the -- to the committee opinions, but apparently this -- what I wrote has also made it to this fact sheet.
Q. So just to make sure that I understand. So I think you had said earlier that you didn't have involvement with any fact sheets; is that correct?
A. I wasn't aware that they put what I wrote on a fact sheet as well, but it appears that they did.
Q. And what was your understanding of what you wrote; where did that go?
A. There's a committee opinion on fetal pain, and I think some of it is there as well.
Q. And if we were to look at the committee

236

opinion on fetal pain, do you believe that it reflects this same information?
A. It probably does. It's been a while since I've looked at it, so I don't know if it is word for word what I wrote here or if it is -- it may -- it may be more comprehensive. It may have what other people have written too. I haven't looked at it.
Q. So you've -- you didn't realize that you had authored this fact sheet; is that your testimony?
A. I -- during the two years that I was involved on the board of AAPLOG, I wrote a number of statements. I lead the effort to produce practice bulletins and committee opinions and position statements because ACOG does that, and I thought that was a good format. So I was involved in several of those.
The fact sheets, I thought that most of those were previous information, but, apparently, some of them are some of the new information as well.
Q. Okay. So I just sent you a document -- are you able to access email right now?
A. Uh-huh.
Q. Can you check your email?
MS. MURRAY: And I've actually sent this along to everyone else. My apologies it wasn't in the binder. Have you all received it?

237

Actually, while we're waiting on that, I'm going to send something else.
MR. SORENSON: I've received it Julie.
MS. MURRAY: Okay. Great.
Q. (By Ms. Murray) So the document that you were referring to, Dr. Skop, that you thought you were drafting language for, you thought that was the fetal pain practice bulletin; is that correct?
A. It probably would have been a committee opinion.
Q. Committee opinion, okay. But you don't have a copy of that?
A. No.
Q. I'm going to go ahead -- and since it sounds like you don't entirely recall what you thought you were drafting for, I am going to send -- I'm going to drop a link into the chat. And if -- that has a PDF that we can view as an exhibit.
Okay. If we could go to this link, and we'll mark this -- so the last document -- let's see. The one that I just sent you by email let's mark as Exhibit 10. And then the document that I've sent through the chat, let's mark as Exhibit 11.
And with respect --
MS. FARRELL: Just one clarification. I

238

have Tab N as Exhibit 10.
MS. MURRAY: Okay. So Exhibit 11 will be the document I just sent by email, and Exhibit 12 will be the link that I just dropped into the chat.
Q. (By Ms. Murray) So with respect to the document that I just dropped into the chat, Dr. Skop, have you been able to pull that up?
A. Yes. That is the practice bulletin.
(Exhibit No. 11 was marked.)
(Exhibit No. 12 was marked.)
Q. Is that -- now that you look at the document, this is the practice bulletin from AAPLOG called Evidence -- let's see. It is dated November 2017 on Fetal Pain; is that correct?
A. Yes.
Q. And this is the document you thought you were drafting?
A. I didn't write this.
Q. Okay. So this is not your work?
A. Correct.
Q. And then the document that I just sent you by email, I'll represent to you that that is a document created by my office to compare the material in your expert report to the material in the AAPLOG fact sheet, so the material in Tab N that we've marked as Exhibit 10.

239

Is that right? Yes.
That's a red line. Does that look correct based on your review of your report and the AAPLOG fact sheet provided to you?
A. So you're asking me if the email that you sent which is very similar to mine with a few additions and subtractions -- you're asking me if this is what I wrote?
Q. Yes.
A. This is very similar --
Q. And just for the record, is it your testimony, then, that this language on fetal pain is yours?
A. I believe so. You know, I may have gotten some of the these statements from other places as well. Like I say, what I've tended to do you is right notes to myself, write papers, you know, to help myself understand. And then when the opportunities came to do expert witness, I would bring that information into the expert witness report.
Q. So is it your testimony, then, that the material on fetal pain in your expert report may not have originated with you?
A. Well, a lot of it did originate with other experts, yeah. I mean, I didn't do this research myself.

240

Q. Not the research. The writing, Dr. Skop, is it yours?
A. I believe it is. It looks like my writing.
Q. In your expert report?
A. Yes.
Q. All of this is your writing?
A. I believe so.
Q. Did you draft every word of it?
A. You know, I can't recall. Like I say, I've been making notes to myself for probably five to ten years on different topics, so it is possible that I did take some of this from someone's statement at some point. I can't say that is not possible, but it is -- you know, I just don't recall whether some of it came from another researcher or not.
Q. But it is your testimony that you didn't rely on this fact sheet when you were drafting your expert report in this case; is that correct?
A. Again, I had this on documents that were my private documents. I don't recall. I know I've done a lot of writing for AAPLOG on a lot of these sheets. So I don't recall if this all originated specifically with me.
Q. Do you believe that you're able to offer an independent opinion in this case separate from the views

241

of AAPLOG?
A. Yes, I've done a lot of independent research.
Q. And throughout the day, you've referred, sometimes, to authors or researchers who perform abortions. Is it your view that individuals who perform abortions are inherently biased as experts?
A. It is my view that that is the case. I will acknowledge that AAPLOG also has a bias. I would love it if a nonbiased organization wanted to dig into the truth of abortion, but there doesn't really seem to be anybody who is interested in doing that in a nonbiased way.
Q. To be clear, the document that I just sent you, Exhibit 11, the compare document between your expert report and the AAPLOG fact sheet, would you say that the vast majority of this language is identical in the two documents?
A. It is very similar, yes.
Q. So your view and AAPLOG's view are one with in the same?
A. AAPLOG is where I got a lot of my information.
Q. But you didn't cite it in your expert report, correct?
A. I didn't cite AAPLOG -- well, I mean, it was

242

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

243

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.

244

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

245

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.

246

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.

247

"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.

248

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

249

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

250

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

251

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

252

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?

253

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.

254

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.

255

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,

256

"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,

257

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

258

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

259

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?

260

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

261

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

262

correct?
A. It could be.
Q. Okay. And you said that they do ultrasounds as well?
A. Yes.
Q. What's the purpose of the ultrasound?
A. To document the pregnancy.
Q. Okay. Can they date pregnancies?
A. Yes.
Q. How do they date them?
A. Generally pregnancy dating is based upon the last menstrual period and correlation with the ultrasound. If there's a discrepancy between the two, then sometimes the dating changes to correspond to the ultrasound.
Q. Sorry, I should have been more specific. What kind of measurements do they use to date the ultrasound? Is it the same -- do they rely on the same measurements that you would use in your private practice?
A. Yes, they do.
Q. Okay. The same exact ones?
A. Yes.
Q. Okay. What about the -- are they able to diagnose ectopic pregnancies?

263

A. They know what to look for. If there was a suspicion of an ectopic pregnancy, they would have it confirmed with a doctor.
Q. When a patient comes to your private practice for their first prenatal care appointment, do you do an ultrasound at that time?
A. I generally do.
Q. Uh-huh, and are you able to diagnose ectopic pregnancies?
A. Generally, yes.
Q. At the time of the appointment, correct?
A. Uh-huh.
Q. What about molar pregnancies?
A. They have a characteristic appearance on ultrasound, so often we can diagnose it with ultrasound and sometimes blood -- or pathology is needed.
Q. What about Any Woman Can, are they able to diagnose molar pregnancies?
A. They are trained to recognize abnormalities. And, again, they would have it verified with a physician.
Q. So if you saw them and you had an ultrasound that looked irregular, they could can confirm your pregnancy, but you would have to go see someone else to actually get a confirmation of a problematic pregnancy,

264

like, an ectopic pregnancy; is that correct?
A. That would be our recommendation.
Q. So if you had a patient who came to you with an ultrasound from Any Woman Can, would you rely on it in your practice for the first prenatal visit?
A. I generally repeat it myself. Not because I don't trust Any Woman Can ultrasounds. I feel that they're well trained, but I generally do it mostly as a bonding experience with the patient.
Q. Uh-huh. And are there -- is that true of all ultrasounds that patients bring to you in your private practice; do you always repeat them anyway?
A. Yeah, I probably do. Depending on their gestational age, I may wait. If they bring me an ultrasound and they arrive to me at the point where I can hear the baby's heart beat, I may document it that way and then do the next indicated ultrasound at the time it is due.
Q. And would you say you are more likely to rely on that ultrasound if it has come from another doctor?
A. Not necessarily. I think the ultrasounds that Any Woman Can does are well done. Some of the physicians that volunteer do the ultrasounds, and the nurses that do them have been well trained by a

265

physician.
Q. Can you ever recall relying on an ultrasound from Any Woman Can in your private practice instead of repeating it yourself?
A. There have been occasions where I have not repeated it right away.
Q. The majority of the time, would you say that you repeat it?
A. Ultimately they get a repeat ultrasound, but maybe not necessarily on the first visit.
Q. Okay. Can Any Woman Can draw blood?
A. They don't draw blood right now. We have a partnership with the Metropolitan Health Department, and Metro Health comes up periodically to draw HIV, syphilis, some of the STI labs.
Q. So they'll come on site to Any Woman Can, or do individuals who seek care at Any Woman Can have to go to another location to obtain a blood draw?
A. They come on site they also have a mobile van.
Q. I see. But the staff -- I'm sorry?
A. I said everything slowed down with COVID but they have had --
Q. And the staff with Any Woman Can, they, though, are not able to draw blood; is that correct?

266

A. We don't do that currently.
Q. Okay.
A. As we expand our services, we may.
Q. Uh-huh. So if someone came in to Any Woman Can on a day when Metro Health wasn't present and wanted to obtain STI testing, what would Any Woman Can tell them? Would it be able to do full STI testing that day?
A. We can do the gonorrhea and chlamydia, detected in the urine, and we'd bring them back on a day we were drawing blood.
Q. So they would have to come in twice for a full STI screening?
A. If they wanted all that. A lot of them don't necessarily want the blood.
Q. In your private office, are you able to do a full STI screening on a single appointment?
A. We have a full-time lab, yes.
Q. Okay. If individuals who suspect or know they're pregnant when they call Any Woman Can to ask -- if they ask whether they can obtain an abortion there, does Any Woman Can tell them no?
A. We tell them, No, we do not perform or refer for abortions.
Q. And do you tell them that at the time of the call?

267

A. If they ask, yes.
Q. So if a patient called Any Woman Can and said, Can you provide an abortion, the staff would directly tell them, No, we don't provide abortion here, or would you have to come in for an appointment to obtain that information?
A. I think if they asked them straight out they would tell them that we don't do them.
Q. Okay. And if someone called and said, I'm interested -- I'm thinking about having an abortion; I think I'm pregnant, would Any Woman Can tell the individual that an abortion could not be received at Any Woman Can?
A. I think what we would do is tell them that we can offer options, counseling, and schedule them for an appointment.
Q. But you wouldn't tell them at the time of the call, unless they directly asked, that Any Woman Can does not provide abortion, correct?
A. I believe that that is not the policy, to offer that information if they don't ask.
Q. If they don't ask, okay.
And when you -- do you know what the wait time is to get an appointment for a pregnancy test at Any Woman Can?

268

A. It is generally very quick. I believe we can get them in that day. We usually have staff there to do that.
Q. Okay. Let me ask you -- can we turn to -- this is going to be Tab L, and we'll mark it as Exhibit 15.
(Exhibit No. 15 was marked.)
A. Okay.
Q. So on page -- let's see. On page 4 of 7, and the page numbering on this is kind of small. It says, "Free first trimester ultrasound"?
A. Uh-huh.
Q. It says, "An ultrasound can answer several questions that may give you some clarity if you're considering having an abortion"; is that correct?
A. Yes.
Q. Did I read that correctly?
A. Yes.
Q. But you testified earlier that typically if someone obtains an ultrasound at Any Woman Can, if they then go for another abortion -- sorry, if they then see a doctor in your private practice that you would typically perform the ultrasound over again, correct?
A. That's what I would typically do, but not necessarily all the time.

269

Q. But typically you would perform the ultrasound again, correct?
A. Uh-huh.
Q. Is that correct?
A. That's correct. Not because I don't trust Any Woman Can's ultrasound; because I like to do ultra sounds with my patients on their first visit.
Q. I understand.
A. They get to see the baby, and I think it is a nice kind of way to bond with them.
Q. So you would typically perform the ultrasound again?
A. Yes.
Q. Well, let me ask this not specific to you. But are OB/GYNs competent to provide options, counseling, to patients about their options if they have an unplanned pregnancy?
A. I think so.
Q. So they could get the services of Any Woman Can with respect -- patients could get the services of Any Woman Can with respect to a first trimester ultrasound from an OB/GYN in private practice, correct?
A. They can. Everything Any Woman Can does is free.
Q. But they could get those services elsewhere,

270

correct?
A. Sure. Yes.
Q. And if they eventually -- let me ask this. Does Any Woman Can provide prenatal care?
A. No, they do not.
Q. Okay. So, eventually, someone who is pregnant and is not planning to end the pregnancy will have to go to another provider for prenatal care; is that correct?
A. That is correct.
Q. So what is the value of the first trimester ultrasound that Any Woman Can provides?
A. It helps them to see the humanity of their baby. It does provide confirmation and viability when we see the heartbeat.
Q. And to be clear, you've used that term, viability, multiple times today. Went you say viability, you don't mean ability to survive outside of the uterus for a sustained period of time, right?
A. Right. In that context, I'm referring to a heartbeat and evidence that it is not a miscarriage.
Q. So they can see the fetus; they can determine whether there's a heartbeat. Anything else?
A. It gives us an opportunity to provide the support that many of them are looking for, counseling,

271

resources, relationship counseling.
Q. Okay. Are you aware of any information or data with respect to the number of women who come to Any Woman Can with an unplanned pregnancy and who ask for referrals to abortion providers?
A. I'm not aware of data. But, again, in San Antonio, you don't need a referral to go to an abortion provider.
Q. Does it happen that patients come to Any Woman Can and ask for referrals to abortion providers with names, contact information of local abortion providers?
A. I don't know. It is possible.
Q. And it is -- okay.
Do you know whether Any Woman Can has been the subject of complaints to the Texas Medical Board, the Board of Nursing or the Better Business Bureau?
A. I'm not aware of that.
Q. Any other licensing or regulatory body?
A. No.
Q. You're also affiliated with The Source, correct?
A. That's correct.
Q. What is your role there?
A. I'm a board member.

272

Q. Would you say you're intimately involved with their affairs?
A. On the state level, yes.
Q. What other level would there be?
A. It consists currently of eight functioning clinics, and I'm not involved in the day-to-day affairs of the individual clinics.
Q. I see. And all of the clinics are in Texas; is that right?
A. That is correct.
Q. Okay. To your knowledge, are any of The Source locations located near clinics that provide abortion?
A. It is possible. I don't know how close they are.
Q. Would you see that as a -- I'll leave that.
What about The Source; does it employ medical professionals?
A. Yes, it does.
Q. What kind?
A. Several of the clinics, not all of them, but several provide women's health care and employ OB/GYNs and nurse practitioners.
Q. Okay. And the others, who do they employ?
A. Some of them are working their way up to

273

that. The goal is that all of them are going to provide those services as well as contraception, but it is a work in progress. Some of them are not there yet.
Q. Would you consider the facilities that The Source and Any Woman Can runs, would you consider those crisis pregnancy centers?
A. That's a name that some would give them, yes.
Q. But they don't -- The Source doesn't provide abortions either, correct?
A. That's correct.
Q. Can we turn to Tab M in what I'll mark as Exhibit 16?
(Exhibit No. 16 was marked.)
Q. Is this the -- does this appear to be from the website of The Source, Dr. Skop?
A. Yes, it does.
Q. Do you see that on the first page it says -- this is a printout -- I'll say Exhibit 16 is a printout of the welcome page from The Source. On the front page it says, "Your place for women's health. The Source is a full-service women's health clinic empowering women with better choices."
A. Yes.
Q. You mentioned earlier about the statistics

274

about the share of women in the United States who have abortions. What are those?

A. It is estimated that one out of four to one out of three women have had abortions?

Q. By the age of 45, correct?

A. Yes.

Q. Do you think it is accurate to say a women's health clinic is full service when it does not offer a gynecological service that one in four women will use?

A. In my opinion, abortion is not women's health care. It is disrupting a normal, physiological process.

Q. But it is provided by gynecologists, correct?

A. It is generally provided by abortion specific doctors. Most OB/GYNs in private practice do not do abortions.

Q. But many OB/GYNs do do abortions, correct?

A. The OB/GYNs who perform abortions, typically, that is their career. They don't -- it is rare to find an abortion provider who also does a full obstetric -- has a full obstetric practice.

Q. Dr. Skop, how many abortion providers would you say that you know well?

A. I don't know any well. I -- yeah.

275

Q. Okay. So your information about the careers of abortion providers is coming from where?

A. One of the papers that's included in my CV is a paper that looked specifically at all the abortionists in Florida.

Q. I've read it.

A. Yeah.

Q. But you didn't look in that -- in that study, as to whether the individuals involved provided services other than abortion, did you?

A. We actually did. We looked at did they have hospital privileges, and about half did. And we looked at did they admit patients to the hospital. About a third had admissions, but only --

Q. But those are different considerations, correct, than whether someone does additional gynecological or obstetrical services besides abortion, correct?

A. Well, only a quarter of those doctors ever delivered a live baby, and very few of them -- granted this is not my state but this is a state -- very few of them had a very busy obstetric practice. That has been my experience. Most abortion providers work for abortion clinics.

Q. But your experience -- you indicated that

276

you don't know any abortion providers well, correct?

A. But -- I don't know them personally, but I know of them. And there are three clinics in town. And, to my knowledge, none of those doctors have -- offer full gynecologic services.

Q. If we can get back to my question. Do you -- I take it your position is full-service women's health clinic is accurate because abortion is not a service. Do you think that your understanding of what the term full-service women's health clinic is consistent with the expectations of what your patients, for example, would interpret that term to mean?

A. I do. I think it also is consistent with what most OB/GYNs in this country believe. If this was a needed medical service, every OB/GYN would do it. There have not been --

Q. Can you provide -- I'm sorry. You mentioned earlier that you can't provide abortions in your hospital, correct?

A. Right.

Q. If someone wanted to provide abortions in your practice, could they do it?

A. No.

Q. No. Okay. What about -- if we can look at

277

this -- the Tab M, Exhibit 16 again. On page 3, it says, "If you're facing a pregnancy you didn't intend and are considering abortion, our counselors can provide the information you're looking for." Did I read that correctly?

A. Yes, ma'am.

Q. But if someone is looking for the phone number and address of where she can obtain an abortion, does The Source provide that?

A. No. We provide them information about abortion, but we don't refer them for abortion.

Q. You wouldn't provide them information about where they could find an abortion. What about if individuals who suspect or know they are pregnant when they call The Source ask whether they can obtain an abortion there; does The Source tell them no?

A. I assume that they tell them no.

Q. But you don't know?

A. I'm not involved in the day-to-day running of the clinics, but I would assume that they would tell them no.

Q. Do you have any role in providing advice as to medical standards there?

A. We're working on that. The Source is

278

creating a model that can be replicated to create more clinics like this that are -- that take into account women's emotional and mental health, spiritual health, as well as physical health.

Q. What's your role in that?

A. I'm -- well I'm a board member, but I'm sort of the medical consultant on that.

Q. You're the medical consultant. But you don't know whether the clinics are up front with people that they do not provide abortion if someone asks over the phone?

A. I would assume that they are. I haven't checked that out myself, but I would assume that they are.

Q. And do you know whether there is any data information about the number of patients or the number of individuals who come to The Source for services and believe they might be able to obtain an abortion there?

A. I don't know any data on that.

Q. Does it happen?

A. It probably does. Probably people go to Planned Parenthood and think they can get prenatal care too; they are wrong.

Q. That is not responsive to my question, Dr. Skop. If we can stick to the questions.

279

So is it your testimony that -- I think you said both with respect to The Source and Any Woman Can that you're not certain where -- it could happen that people come to the clinics and believe that they might be able to obtain abortions there, correct?

A. It is possible that people do.

Q. Have you ever confirmed that people have?

A. No. I haven't asked that specific question.

Q. Okay. Do you know whether The Source has ever been the subject of complaints to the Texas Medical Board, the Board of Nursing, or the Better Business Bureau?

A. I'm not aware of any complaints.

Q. And any other licensing or oversight body?

A. Not that I know of.

Q. Okay.

MS. MURRAY: I think that is probably close to the end. Can we take a quick break just to make sure that everything is set, and then I think we're getting close to the end? Why don't we break for ten minutes, and come back.

(Recess from 4:14 p.m. to 4:28 p.m.)

MS. MURRAY: Welcome back from the break.

Q. (By Ms. Murray) Before we get started again, Dr. Skop, is there anything from your prior testimony

280

today that you would like to amend or add to?

A. No.

Q. And during the break, did you have any conversations with anyone other than Mr. Sorenson?

A. No.

Q. Okay. Before -- I have some wrap-up questions, but I guess one question I did want to return to that we had talked about this morning -- I asked you, if you recall, how you came to be an expert in this case, and you indicated, at the time, that you didn't have any recollection as to who contacted you about the case; is that correct?

A. That is correct.

Q. And at this point in time, now that you've had a few hours -- since then have you recalled any information about how you found out about this case?

A. I don't remember for sure. As we discussed, the expert witness training that I had with Charlotte Lozier, it may have been Charlotte Lozier.

Q. So you did the training with Charlotte Lozier, and then, perhaps, they reached out to you to be an expert after that?

A. I think that might have been the case.

Q. Okay. Do you recall who at Charlotte Lozier reached out to you?

281

A. No.

Q. When you did the training at Charlotte Lozier, was that because you were hoping to become an expert in abortion cases?

A. As I mentioned, the training also incorporated media training. And, at that point, I was getting some opportunities to speak to reporters, and I think -- I was interested to learn all of it, but, primarily, I was interested in learning how to give good interviews.

Q. That actually reminds me of something else. Are you on a national fetal tissue research board of some kind, Dr. Skop?

A. Yes. There was an NIH Fetal Tissue Research Ethics Review Board, and I was a member of that.

Q. Are you a member still?

A. Yes, if it meets again.

Q. And that wasn't on your CV, correct?

A. I believe it was.

Q. Oh, maybe I missed it. I apologize.

A. It wasn't on the initial CV you got, but I added. It is under professional --

Q. Oh, I see. Okay. All right. I skimmed too quickly.

Okay. With that -- so we're getting close

282

to the end. Before we wrap up, are there any answers to my questions that you want to change before we close the deposition?

A. I don't think so.

Q. And is there any information I asked you about that you remember now that you didn't recall when I asked a question about it?

A. No. Just the discussion about the sentences that were -- that were the same. I still cannot tell you if I wrote those, but I thought that I did.

Q. All of them?

A. Well, I think the Fetal Pain possibly came from somewhere else, but, like I say, the way that I do research, I write stuff down, and then later on I put together papers and articles. And I think I may have inadvertently taken wording that I thought I wrote that, in retrospect, I may have just used from someone else.

Q. Uh-huh. And earlier, though, you testified that you didn't see it -- and I don't remember your exact words, but that you were uncertain why there would be a concern about taking sentences from someone else's publication; is that correct?

A. Yeah, I -- yes.

Q. Is that still your position?

A. Well, obviously I would not have done it

283

knowingly, but I think in all of these reports and articles that I've written, they've been primarily my thoughts and my reports.

Q. When you say that you wouldn't have done it knowingly, why not?

A. Well, I would have just reworded it in my own words, had I recognized that it was from someone else.

Q. Because you think there's some problem with taking full sentences from other authors?

A. I don't think that's particularly problematic, assuming one has done the research. But, obviously, your line of questioning seems to indicate that there is an appearance of impropriety of that.

Q. So it is your testimony that you don't think it is problematic --

A. I don't think it is problematic --

Q. -- to take whole sentences from other authors?

A. Right. Because I've gone to the source; I've verified the information. And what's included in the expert witness report is my well-researched expert witness testimony.

Q. Okay. So -- I think we'll leave it at that. Is there anything that you would like to add

284

to what you've told us so that we can understand your perspective or viewpoint more clearly?

A. I think that my expert witness report clarifies my position on all of this. I don't think there is anything additional.

Q. Okay. So when I asked you earlier whether all of the opinions that you intend to testify to are contained in your expert report, is that still your answer that, yes, they are?

A. Yes, they are.

Q. Okay. Anything else that you want to add?

A. No.

Q. So with that, I think this deposition is concluded, subject to the right to re-call the witness for further questioning should that be required.

MS. MURRAY: I will say, Lance, I think we're going to follow up with a letter requesting documents -- some documents that have been discussed today. I can follow up in writing. I know it's been a long day.

MR. SORENSON: Okay.

MS. MURRAY: All right. We have nothing further. Thanks everyone.

(Signature requested.)

(Whereupon the taking of this deposition was

285

concluded at 4:37 p.m.)

* * *

A reading copy of the Original transcript was submitted to Mr. Sornesen for witness review.

Original transcript filed with Ms. Murray.

C E R T I F I C A T E

STATE OF UTAH)
)
COUNTY OF SALT LAKE)

I HEREBY CERTIFY that I have read the foregoing testimony and the same is a true and correct transcription of said testimony except as I have corrected, initialed same, and indicated said changes on enclosed correction sheet.

_____
INGRID SKOP, M.D.

Subscribed and sworn to at_____

this _____ day of _____, 2020.

_____
Notary Public

My commission Expires:

_____

* * *

C E R T I F I C A T E

STATE OF UTAH)
)
COUNTY OF SALT LAKE)

THIS IS TO CERTIFY that the deposition of INGRID SKOP, M.D., was taken before me, Kristin Marchant, Registered Professional Reporter and Notary Public in and for the State of Utah.

That the said witness was by me, before examination, duly sworn to testify the truth, the whole truth, and nothing but the truth in said cause.

That the testimony was reported by me in stenotype, and thereafter transcribed by computer under my supervision, and that a full, true, and correct transcription is set forth in the foregoing pages, numbered 5 through 285 inclusive.

I further certify that I am not of kin or otherwise associated with any of the parties to said cause of action, and that I am not interested in the event thereof.

WITNESS MY HAND and official seal at Salt Lake City, Utah, this 8th day of September, 2020.

Kristin Marchant, RPR

My commission expires:
17 January 2022

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