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.

<u>ARGUMENT</u>

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, \P V(b)(4) ("No damages, attorney's fees, or costs of litigation shall be awarded in an action filed pursuant to this Paragraph, unless specifically authorized by Act of the General Assembly."). But the waiver does not exclude interlocutory relief, so such relief is permitted. *Couch*, 295 Ga. at 476–79.

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

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

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

II. Plaintiffs Are Likely to Succeed on the Merits

A. HB 481 Is Void Ab Initio

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

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

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

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

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

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

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

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

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

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

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

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

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

The State raises two meritless counterarguments. *See* State's Br. 24–29. *First*, the State asserts that forced pregnancy and childbirth do not trigger heightened scrutiny because an individual's privacy rights may be cabined to avoid "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 1/10th of one inch in size and entirely subsumed by, and attached to, the body of the pregnant person. Badell Aff. **(P)** 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; *see also id.* at 33 ("[T]he Court found Dr. Skop's testimony to be unsupported," including, *inter alia*, when she asserted "her belief that the risks [of abortion] are higher than" rates reported in a comprehensive study by a leading medical authority, but could identify no studies supporting her contrary view);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Plaintiffs Have Standing to Challenge the Records Access Provision

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

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

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

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

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

The State's cramped reading of King v. State ("King I") turns the Georgia Supreme Court's precedent on its head. See State's Br. 37–38. While the health records at issue in King I were those of a criminal defendant, the Court held, as a general matter, that "the personal medical records of this state's citizens . . . are protected by [the right to privacy] as guaranteed by our constitution" and that "the constitutional right of privacy protects the initial unauthorized disclosure of [personal] medical records to anyone, including the prosecutor." 272 Ga. at 790 (emphasis original). Indeed, Georgia courts have repeatedly recognized the "right to medical privacy" and enforced protections for patients' personal health records in other contexts. See, e.g., Baker v. Wellstar Health Sys., Inc., 288 Ga. 336, 338 (2010); Usserv 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.

/s/ Julia Blackburn Stone

Julia Blackburn Stone Georgia Bar No. 200070 Sarah Brewerton-Palmer Georgia Bar No. 589898 Katie W. Gamsey Georgia Bar No. 817096 **CAPLAN COBB LLC** 75 Fourteenth Street, NE, Suite 2700 Atlanta, Georgia 30309 Tel: (404) 596-5600 Fax: (404) 596-5604 jstone@caplancobb.com spalmer@caplancobb.com

Attorneys for All Plaintiffs

<u>/s/ Nneka Ewulonu</u> Nneka Ewulonu Georgia Bar No. 373718 **AMERICAN CIVIL LIBERTIES UNION FOUNDATION OF GEORGIA, INC.** P.O. Box 570738 Atlanta, Georgia 30357 Tel: (770) 303-8111 newulonu@acluga.org

Attorney for Plaintiffs SisterSong, ACWC, AWMC, carafem, Summit, and Drs. Cwiak, Haddad, & Lathrop

Carrie Y. Flaxman* **PLANNED PARENTHOOD FEDERATION OF AMERICA** 1110 Vermont Avenue, NW Suite 300 Washington, District of Columbia 20005 Tel: (202) 973-4800

/s/ Tiana S. Mykkeltvedt Tiana S. Mykkeltvedt Georgia Bar No. 533512 Jane D. Vincent Georgia Bar No. 380850 Laurie Ann Taylor Georgia Bar No. 452926 **BONDURANT MIXSON & ELMORE** LLP 1201 West Peachtree Street NW, Suite 3900 Atlanta, Georgia 30309 Tel: (404) 881-4100 Fax: (404) 881-4111 mykkeltvedt@bmelaw.com vincent@bmelaw.com ltaylor@bmelaw.com

Attorneys for All Plaintiffs

Julia Kaye* Rebecca Chan* Brigitte Amiri* Johanna Zacarias* **AMERICAN CIVIL LIBERTIES UNION FOUNDATION, INC.** 125 Broad Street, 18th Floor New York, New York 10004 Tel: (212) 549-2633 jkaye@aclu.org rebeccac@aclu.org bamiri@aclu.org jzacarias@aclu.org

Attorneys for Plaintiffs SisterSong, ACWC, AWMC, carafem, Summit, and Drs. Cwiak, Haddad, & Lathrop

Jiaman ("Alice") Wang* Cici Coquillette* **CENTER FOR REPRODUCTIVE RIGHTS** 199 Water Street, 22nd Floor New York, New York 10038 carrie.flaxman@ppfa.org

Susan Lambiase* **PLANNED PARENTHOOD FEDERATION OF AMERICA** 123 William Street, Floor 9 New York, New York 10038 Tel: (212) 541-7800 susan.lambiase@ppfa.org

Attorneys for PPSE

Tel: (917) 637-3670 awang@reporights.org ccoquillette@reporights.org

Attorneys for Plaintiffs Feminist and MSFC

*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:

> Stephen Petrany Drew Waldbeser Office of the Attorney General 40 Capitol Square, SW Atlanta, Georgia 30334 spetrany@law.ga.gov dwaldbeser@law.ga.gov

This 8th day of August, 2022.

/s/ Julia Blackburn Stone

Julia Blackburn Stone Georgia Bar No. 200070

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

E-Filed and E-Served by SB on __JUL 0 5 2022 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.

Specifically, Dr. Tien testified as an expert on behalf of Plaintiffs, both 5. 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/Trimester ByReason_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 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.* \P 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 secondtrimester 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/Trimester ByReason_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

Nearly 5,000 patients obtained abortion care in Florida in the second 43. 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, Trimester, by 2021 Year Date (May to 9, 2022), https://ahca.myflorida.com/mchq/central services/training support/docs/Trimester ByReason_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 from abortions from abortions abortion abortions abortion abortion abortion abortion abortions is more robust than reporting in other areas of medicine, and that the literature showing low rates

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.* \P 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.* \P 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 firsthand knowledge of fetal surgery and intrauterine fetal procedures. In contrast, the Court gives no weight to Dr. Condic's opinions because Dr. Condic has no clinical experience with humans and conceded that her estimation of when fetal pain perception occurs differs from the "generally [accepted]" view among mainstream medical organizations. *Id.* at 147:7-10 [Condic].

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

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

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

V. Effects on Plaintiffs If HB 5 Is in Effect

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

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

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

CONCLUSIONS OF LAW

I. Standing

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

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

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

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

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

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

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

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

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

101. The State conceded the second prong of the standing inquiry—that Plaintiffs have a sufficiently close relation to their patients for the purposes of thirdparty 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) (nonabortion 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 distancesincluding travel in excess of 1,000 miles, round-trip-to access those services outof-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 previability 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.

PER CIRCUIT COURT JUD

af Resord

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, $\P 27$, 28, 39, 41-49, particularly for those patients seeking abortion in the second trimester who face an elevated risk of psychological harms, $\P 27$, 39, 41; (2) patients who have abortions experience decisional uncertainty and regret regarding the decision to terminate their pregnancy, $\P 43$, 44; and (3) HB 5's mandate will provide mental health benefits to patients, $\P 29$, 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,

about:blank

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

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

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

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

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

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

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

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

a. Findings of scientific reviews

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

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

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

³ APA Task Force Report 2008, at 5.

⁴ See id. at 21-22.

The study focused on induced abortion [those that focused solely on 'spontaneous' abortions (miscarriages) or that did not differentiate miscarriage from induced abortion were omitted].¹⁵ 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.¹⁷

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

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

⁵ Id. at 21.

⁶ Id.

⁷ Id. at 88.

⁸ Id. at 92.

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

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

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

¹¹ Major et al. (2009), supra note 1.

¹² Id. at 885.

¹³ Id. at 868-69, 884-85.

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

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

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

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

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

¹⁶ Gail Robinson et al., Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored, 200 Brit. J. Psych. 78 (2012); Gail Robinson et al., Is There an "Abortion Trauma Syndrome"? Critiquing the Evidence, 17 Harv. Rev. Psych. 268 (2009); Nada L. Stotland, The Myth of the Abortion Trauma Syndrome, 268 JAMA 2078 (1992); Nada L. Stotland, Assessing the Mental Health Impact of Induced Abortion, 1 Medscape Women's Health I (1996); Nada L. Stotland, Psychosocial Aspects of Induced Abortion, 40 Clinical Obstetrics & Gynecology 673 (1997); Nada L. Stotland, Abortion: Social Context, Psychodynamic Implications, 155 Am. J. Psych. 964 (1998a); Nada L. Stotland, Comments on Abortion, 155 Am. J. Psych. 1305 (1998b); Nada L. Stotland, Psychiatric Issues Related to Infertility, Reproductive Technologies, and Abortion, 29 Primary Care: Clinics in Off. Prac. 13 (2002); Nada L. Stotland, Abortion and Psychiatric Practice, 9 J. Psych. Prac. 139 (2003); Nada L. Stotland, Psychiatric Aspects of Induced Abortion, 199 J. Nervous & Mental Disease 568 (2011b). ¹⁷ Nada L. Stotland, Induced Abortion and Adolescent Mental Health, 23 Current Opinion, Obstetrics and

Gynecology 340, 341 (2011a).

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

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

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

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

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

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

²¹ Id. at S47.

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

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

²⁴ NCCMH Report at 8.

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

²⁵ Though Dr. Skop critiques NASEM at length in her declaration, her criticisms are meritless and irrelevant. Skop Decl. 1 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 reporductive 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.

³¹ Skop Decl. ¶48.

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, e00970-08 (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).

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

b. Findings of high-quality individual studies

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

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

14 of 47

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

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

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

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:

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.

^{10.1176/}appi.ajp.2018.18010091. Epub 2018 May 24. PMID: 29792049.

³⁶ Skop Decl. at ¶¶ 27, 41, 48.

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

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

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

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

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

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

25. High quality research shows both that (1) women are more likely to experience

positive than negative emotions in response to abortion, including "relief," and (2) the vast

majority of women seeking abortion have high levels of decision certainty and high levels of

decision rightness after obtaining an abortion, including those who describe a primarily

negative emotional response.⁴³ The most rigorous studies, including findings from the

Turnaway Study,44 demonstrate that positive emotions, including relief, are the most common

emotions expressed in the short and long term and that the intensity of both positive and

negative emotions decline over time.45 The study also found that emotions did not differ

⁴¹ Skop Decl. ¶ 27.

⁴² Skop Decl. ¶ 27. Studies attributing higher rates of drug use to the experience of having an abortion are rife with methodological problems such as use of inappropriate comparison groups (women who have never been pregnant or had an intended pregnancy) and failure to account for pre-pregnancy drug use and other risk factors. See, e.g., Priscilla K. Coleman et al., Substance Use Among Pregnant Women in the Context of Previous Reproductive Loss and Desire for Current Pregnancy, 10 Brit. J. Health Psych. 255 (2005); Priscilla K. Coleman et al., A History of Induced Abortion in Relation to Substance Use During Subsequent 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.

⁴³Corinne 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

⁵⁰ Id. at 276.

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

⁵¹ Skop Decl. M 27, 41, 42, 44, 48

30.

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

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

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

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

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

⁵⁵ Coleman et al. (2002a), supra note 42, at 1675; Priscilla K. Coleman et al., State-Funded Abortions Versus Deliveries: A Comparison of Outpatient Mental Health Claims Over 4 Years, 72 Am. J. Orthopsychiatry 141, 144 (2002b); Jesse R. 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).

Multiple studies cited by Dr. Skop also fail to take pregnancy intention or 31. 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

61 Id.

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.

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

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

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

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

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

⁶⁴ Radha Jagannathan, Relving 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.

⁶⁷See 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 Russia⁶⁹ and New Zealand,⁷⁰ cannot be presumed generalizable, although Dr. Skop nonetheless relies on such studies. This is especially important when studies include people from countries with significantly different cultural or legal contexts, or for example from countries where a person can only obtain an abortion for mental health reasons, thereby biasing conclusions.

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

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

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

⁶⁹ Id. ¶ 41.

⁷⁰ Id. ¶ 48.

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

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

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

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

¹³ 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).

⁷² Id.

¹⁴ 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.

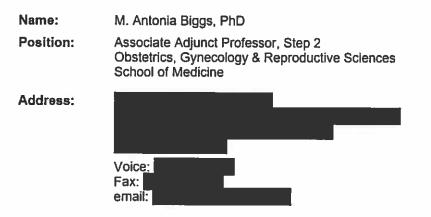
39. I declare under penalty of perjury that the foregoing is true and correct.

Dated: June <u>23</u>, 2022.

Antonia Biggs, Ph.D.

24

University of California, San Francisco CURRICULUM VITAE



EDUCATION

DATES	INSTITUTION		DEGREE	FIELD OF STUDY
1987 - 1991 1989 - 1990	University of Wisconsin-Madia Universite Aix-en-Provence, F		BA	Psychology Psychology
1994 - 1998	Boston University		PhD	Psychology
	OSITIONS HELD			
1998 - 2013	University of California, San Francisco	Analyst V	Reproduct	er for Global ve Health ite for Health Policy
2013 - 2015	University of California, San Francisco	Associate Researcher		New Standards in ve Health (ANSIRH)
2015 - 2020	University of California, San Francisco	Full Researche		New Standards in ve Health (ANSIRH)
2020 - present	University of California, San Francisco	Associate Professor		New Standards in ve Health (ANSIRH)
OTHER POSIT	TIONS HELD CONCURRENT	_Y		

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

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 Grant reviewer committee, Emerging Scholars in Family Planning
- 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

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

SERVICE TO PROFESSIONAL PUBLICATIONS

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

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
NATION	IAL	
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

	P	repared: June 22, 2022
1999	Maternal moods predict infant cognitive development in Barbados, Society for Research on Child Development, Albuquerque, NM	Oral presentation, lead author
2000	Community Challenge Grant: A successful teen pregnancy prevention model for high-risk youth? American Public Health Association, Boston, MA	Poster presentation, lead author
2001	Client satisfaction with California's Family PACT Program, American Public Health Association, Atlanta, GA	Oral presentation, lead author
2001	Reproductive Health Needs of the Latino Population, National Organization on Adolescent Pregnancy, Parenting and Prevention, Inc., Arlington, VA.	Oral presentation, co-author
2001	Acculturation and Latino Adolescent Sexual Behavior: Establishing a Research Agenda for the 21st Century, American Public Health Association, Atlanta, GA.	Oral presentation, co-author
2002	Combined pregnancy prevention approaches are associated with lower teen-birth rates at the zip code level, American Public Health Association, Philadelphia, PA	Oral presentation, lead author
2003	Meeting the reproductive health care needs of adolescents, American Public Health Association, San Francisco, CA	Oral presentation, lead author
2004	The Role of Community Based Organizations in Increasing Access to Family Planning/Reproductive Health (FP/RH) Services in California, American Public Health Association, Washington, DC	Oral presentation, lead author
2004	Adolescents' awareness of family planning policies and services in California's teen pregnancy hot spots, American Public Health Association, Washington DC.	Poster presentation (co- author)
2005	Public savings from averting unintended pregnancy: Cost-benefit analysis of California's family planning program presentation, American Public Health Association, New Orleans, LA	Oral presentation, co-author
2005	Meeting the reproductive health care needs of adolescents: California's Family PACT Program, Teen Pregnancy Prevention Annual Meeting, Burlingame, CA	Oral presentation, lead author
2006	American Evaluation Association Annual Conference, Portland, OR	Oral presentation, lead author
2007	Teens reaching teens, Use of peer outreach workers in family planning clinics, American Public Health Association, Washington, DC	Oral presentation, co-author
2008	Pregnancy intendedness and decision-making among young Latinas: Findings from a qualitative study, American Public Health Association, San Diego, CA	Oral presentation, lead author
2009	Discussing intrauterine contraception at the family planning visit: A (missed) opportunity for client education, American Public Health Association, Philadelphia, CA	Oral presentation, co-author
2009	They'll use it if it's free, Contraceptive choices among uninsured low-income women, with Rostovtseva, American Public Health Association, Philadelphia, CA	Oral presentations,co- author

	F	repared: June 22, 2022
2011	A Question of Hope, American Public Health Association, Washington, DC	Film screening
2012	Mental health and physical health consequences of abortion compared to unwanted birth, with Foster, Dobkin, Roberts, and Steinberg, American Public Health Association, San Francisco, CA	Oral presentation, lead author
2012	Misunderstanding the risk of conception from unprotected sex and contraceptive use, with Foster, American Public Health Association, San Francisco, CA	Poster presentation, lead author
2013	Emotional and mental health outcomes from the Turnaway study, National Abortion Federation, New York, NY	Oral presentation, lead author
2013	Pregnancies and Health Expenditures from Dispensing up to a One-Year Supply of Hormonal Contraception, Population Association of America, Annual Meeting, New Orleans, LA	Oral presentation, Co-author
2013	How many visits does it take to provide long-acting reversible contraception (LARC)? Provider perspectives from Colorado and lowa; 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

Prepared: June 22, 2022

2019	Women's five-year anticipated abortion stigma trajectories after receiving or being denied an abortion', North American Forum on Family Planning, Los Angeles, CA	Poster presentation, lead author
2019	Attitudes about self-managed abortion legality in the United States: results from a nationally representative survey, North American Forum on Family Planning, Los Angeles, CA	Oral presentation, co-author
2019	Minors' reasons for and experience with obtaining judicial bypass for abortion in Illinois, North American Forum on Family Planning, Los Angeles, CA (received the 2nd place best poster award).	Poster presentation, senior author
2019	Understanding young women's preferences for lower-efficacy contraceptive methods: A mixed-methods study, America Public Health Association, Philadelphia, PA (received the SRH section poster award).	Poster presentation, senior author
2020	Young Women's Preferences for Lower Efficacy Contraceptive Methods: Balancing Reproductive Autonomy and Pregnancy Prevention Goals, Society of Adolescent Health and Medicine (SAHM) Annual Meeting, San Diego, CA (Conference cancelled due to COVID-19).	Oral presentation, senior author
2020	Barriers accessing abortion care and their association with psychological well-being, has been selected for oral presentation at the National Abortion Federation (NAF) Annual Meeting, Washington, DC (Conference cancelled due to COVID-19).	Oral presentation, lead author
2020	Consequences of abortion received and denied: The Turnaway study). American Public Health Association, Annual Meeting, Remote meeting due to COVID-19.	Oral presentation, co-author
2020	Consideration of self-managed abortion among people seeking facility-based care in three haven states. Society of Family Planning (SFP) Annual Meeting, Remote meeting due to COVID-19.	Poster presentation, senior author
2020	Abortion patients' interest in obtaining medication abortion over the counter (OTC). Society of Family Planning (SFP) Annual Meeting, Remote meeting due to COVID-19.	Poster presentation, lead author
2020	Development and validation of a new scale to measure the psychosocial burden of accessing abortion care. Society of Family Planning (SFP) Annual Meeting, Remote meeting due to COVID- 19.	Poster presentation, lead author
2021	Feasibility, acceptability, and effectiveness of mail-order pharmacy dispensing of mifepristone for medication abortion. Society of Family Planning (SFP) Annual Meeting, Remote meeting due to COVID-19.	Poster presentation, co- author
2021	"Absolutely horrific." Attitudes towards self-managed abortion legality and criminalization: A qualitative study. Society of Family Planning (SFP) Annual Meeting, Remote meeting due to COVID-19.	Poster presentation, co- author
	8 of 17	

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 Standar Reproductive Health, University of California, San F		Member
2018 - 2018	Resource Allocation Program (RAP), Request for A (RFA) planning team, Bixby Center for Global Repr Health, University of California, San Francisco	pplications oductive	Member
2019 - 2020	Internal Collaboration Workgroup, Bixby Center for Reproductive Health, University of California, San F	Global Francisco	Member
2019 - present	Faculty DEI Hiring Workgroup, Advancing New Sta Reproductive Health, University of California, San F	ndards in Francisco	Member
2019 - present	Culture and Inclusion Workgroup, Advancing New S Reproductive Health, University of California, San F	Standards in Francisco	Member
2019 - present	Steering Committee for Research in Ob/Gyn at ZSF of California, San Francisco	G, University	Member
2020 - present	DEI post-doctoral search committee, Advancing Ne Reproductive Health, University of California, San F		Member
2020 - present	DEI liaison group, Advancing New Standards in Re Health, University of California, San Francisco	productive	Member
2021 - present	Research Strategy Committee, Department of Obst Gynecology and Reproductive Sciences, University San Francisco		Member
PUBLIC SERV	ICE		
2010 - 2018	Escuela Bilingüe Internacional, Emeryville, CA	Class Parent	
2014 - 2019	Emeryville-4H Club	Co-Founder; Tre	easurer
	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	Expert witness	

- 2017 2017 Provided expert testimony to Chile's Constitutional Expert witnes Court in support of lifting Chile's complete ban on abortion, Santiago, Chile
- 2014 2019 Glide Memorial Church Volunteer

Expert witness

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

PEER REVIEWED PUBLICATIONS

- 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.

Firefox

- 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
- 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.
- 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.
- 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.
- 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.
- 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.
- Foster DG, Biggs MA, Phillips KA, Grindlay K, Grossman D. Potential public sector costsavings from over-the-counter access to oral contraceptives. Contraception. 2015 May;91(5):373-9.
- 29. Biggs MA, Neuhaus J, Foster DG. Mental health diagnoses after receiving or being denied an abortion in the US. American Journal of Public Health. 2015 Dec;105(12):2557-63.
- Biggs MA, Harper CC, Brindis C. California family planning health care providers' challenges to same-day long-acting reversible contraception provision. Obstetrics & Gynecology. 2015 Aug; 126(2):338-45.
- 31. Foster DG, Barar R, Gould H, Gomez I, Nguyen D, Biggs MA. Projections and opinions from 100 experts in long-acting reversible contraception. Contraception. 2015 Oct 24.
- 32. Upadhyay UD, Biggs MA, Foster DG. The effect of abortion on having and achieving aspirational one-year plans. BMC Women's Health 2015 Nov 11;15(1):102.
- Biggs MA, Rowland B, McCulloch CE, Foster DG. Does abortion increase women's risk for post-traumatic stress? Findings from a prospective longitudinal cohort study. BMJ Open 2016 Feb 1;6(2):e009698.
- 34. Biggs MA, Upadhyay UD, McCulloch CE, Foster DG. Women's mental health and wellbeing 5 Years after receiving or being denied an abortion: A prospective, longitudinal cohort study. JAMA Psychiatry. 2017 Feb 01; 74(2):169-178.

- 35. Biggs MA, Upadhyay UD, Foster DG. Mental health outcomes after having or being denied an abortion-Reply. JAMA Psychiatry. 2017 Jun 01; 74(6):654.
- 36. Cockrill K, Biggs MA. Can stories reduce abortion stigma? Findings from a longitudinal cohort study. Culture, Health, and Sexuality. 2017 Jul 14; 1-16. PMID: 28705119
- 37. Biggs MA, Roberts SCM. Fatal flaws in recent analysis on the risk of premature death following teenage abortion and childbirth. European Journal of Public Health. 2017 Oct 01; 27(5):794. PMID: 28957488
- Block A, Dehlendorf C, Biggs MA, McNeil S, Goodman S. Postgraduate experiences with an advanced reproductive health and abortion training and leadership program. Family Medicine. 2017 Oct;49(9):706-713.
- 39. Yarger J, Daniels S, **Biggs MA**, Malvin J, Brindis CD. The role of family planning program sites in health insurance enrollment. Perspectives on Sexual and Reproductive Health 2017 Jun;49(2):103-109.
- 40. Biggs MA, Taylor D, Upadhyay UD. Role of insurance coverage in contraceptive use after abortion. Obstetrics and Gynecology. 2017 Dec;130(6):1338-1346.
- 41. Mirzazadeh A, Biggs MA, Viitanen A, Horvath H, Wang LY, Dunville R, Barrios LC, Kahn JG, Marseille E. Do school-based programs prevent HIV and other sexually transmitted infections in adolescents? A systematic review and meta-analysis. Prevention Science 2018 May; 19(4):490-506. PMID: 28786046
- 42. Ralph LJ, King E, Belusa E, Foster DG, Brindis CD, Biggs MA. The impact of a parental notification requirement on Illinois minors' access to and decision-making around Abortion. Journal of Adolescent Health. 2018 Mar; 62(3):281-287. PMID: 29248391
- McCarthy M, Upadhyay U, Biggs MA, Anthony R, Holl J, Roberts SCM. Predictors of timing of pregnancy discovery. Contraception. 2018 Apr;97(4):303-308.
- Foster DG, Biggs MA, Ralph L, Gerdts C, Roberts S, Glymour MM. Socioeconomic outcomes of women who receive and women who are denied wanted abortions in the United States. American Journal of Public Health. 2018 Mar; 108(3):407-413. PMID: 29345993. PMCID: PMC5803812
- 45. Marseille E, Mirzazadeh A, Biggs MA, Miller AP, Horvath H, Lightfoot M, Malekinejad M, Kahn JG. Effectiveness of school-based teen pregnancy prevention programs in the USA: A systematic review and meta-analysis. Prevention Science. 2018 May;19(4):468-489. PMID: 29374797
- 46. Battistelli MF, Magnusson S, Biggs MA, Freedman L. Expanding the abortion provider workforce: a qualitative study of organizations implementing a new California policy. Perspect Sex Reprod Health. 2018 Feb 14. PMID: 29443434
- 47. Biggs MA, Kaller S, Harper CC, Freedman L, Mays AR. "Birth control can easily take a back seat": Challenges providing IUDs in community health care settings. Journal Health Care Poor and Underserved. 2018 Feb; 29(1): 228-244.
- Roberts SCM, Foster DG, Gould H, Biggs MA. Changes in alcohol, tobacco, and drug use over five years after receiving versus being denied a pregnancy termination. Journal of Studies on Alcohol and Drugs. 2018 Mar;79(2):293-30.
- 49. Woodruff K, **Biggs MA**, Gould H, Foster DG. Attitudes toward abortion after receiving vs. being denied an abortion in the U.S. Sexuality Research and Social Policy. 2018; 15: 452.
- 50. Biggs MA, Barar, R, Gould H, Foster DG. Five-year suicidal ideation trajectories among women receiving versus being denied an abortion. American Journal of Psychiatry. 2018 Sep 1;175(9):845-852.
- 51. Foster DG, Biggs MA, Raifman S, Gipson J, Kimport K, Rocca CH. Comparison of Health, Development, Maternal Bonding, and Poverty Among Children Born After Denial of Abortion vs After Pregnancies Subsequent to an Abortion. JAMA Pediatr. 2018 11 01; 172(11):1053-1060. PMID: 30193363. PMCID: PMC6248140

- Foster DG, Raifman SE, Gipson JD, Rocca CH, Biggs MA. Effects of carrying an unwanted pregnancy to term on women's existing children. J Pediatr. 2019 02; 205:183-189.e1. PMID: 30389101
- 53. Biggs MA, Casas L, Ramm A, Baba CF, Correa SV, Grossman D. Future health providers' willingness to provide abortion services following decriminalisation of abortion in Chile: a cross-sectional survey. BMJ Open. 2019 Oct 30; 9(10):e030797.
- 54. Biggs MA, Kimport K, Mays A, Kaller S, Berglas NF. Young women's perspectives about the contraceptive counseling received during their emergency contraception visit. Women's Health Issues. 2019;29(2):170-175.
- 55. Biggs MA, Ralph L, Raifman S, Foster DG, Grossman D. Support for and interest in alternative models of medication abortion provision among a national probability sample of U.S. women. Contraception. 2019 Feb;99(2):118-124.
- Ralph L, Mauldon J, Biggs MA, Foster DG. A prospective cohort study of the effect of receiving versus being denied an abortion on educational attainment Women's Health Issues. 2019 Nov-Dec;29(6):455-464.
- 57. Baba CF, Casas L, Ramm A, Correa S, Biggs MA. Medical and midwifery student attitudes toward moral acceptability and legality of abortion, following decriminalization of abortion in Chile, Sexual & Reproductive Healthcare, 2020 Jun;24:100502.
- Biggs MA, Brown K, Foster DG. Perceived abortion stigma and psychological well-being over five years after receiving or being denied an abortion. PLoS One. 2020; 15(1):e0226417. PMID: 31995559. PMCID: PMC6988908
- Kaller S, Mays A, Freedman L, Harper CC, Biggs MA. Exploring young women's reasons for adopting intrauterine or oral emergency contraception in the United States: a qualitative study. BMC Women's Health. 2020;20(1):15.
- 60. Biggs MA, Casas L, Ramm A, Baba CF, Correa SP. Medical and midwifery students' views on the use of conscientious objection in abortion care, following legal reform in Chile: a cross-sectional study. BMC Med Ethics. 2020 May 24; 21(1):42.
- Cheeks M, Kaller S, Mays A, Biggs MA. Provider practices and young women's experiences with provider self-disclosure during emergency contraceptive visits. Women's Health Issues. 2020 Jul - Aug; 30(4):277-282. PMID: 32507617
- 62. McCarthy MA, Upadhyay U, Ralph L, Biggs MA, Foster DG. The effect of receiving versus being denied an abortion on making and achieving aspirational 5-year life plans. BMJ Sexual & Reproductive Health. 2020.
- 63. Ramm A, Casas L, Baba CF, Correa S, Biggs MA. "Obviously there is a conflict between confidentiality and what you are required to do by law": Chilean university faculty and student perspectives on reporting unlawful abortions. Social Science & Medicine. 2020 09; 261:113220.
- 64. Jones RK, Foster DG, Biggs MA. Fertility intentions and recent births among US abortion patients. Contraception. 2020 Nov 21:S0010-7824(20)30417-0.
- 65. Biggs MA, Tome L, Mays A, Kaller S, Harper CC, Freedman L. The Fine Line Between Informing and Coercing: Community Health Center Clinicians' Approaches to Counseling Young People About IUDs. Perspectives on Sexual and Reproductive Health. 2020, 52(4):TK, doi:10.1363/psrh.12161
- 66. Ralph L, Foster DG, Ralfman S, Biggs MA, Samari G, Upadhyay U, Gerdts C, Grossman D. Prevalence of Self-Managed Abortion Among Women of Reproductive Age in the United States. JAMA Netw Open. 2020 Dec 01; 3(12):e2029245. PMID: 33337493. PMCID: PMC7749440
- 67. Biggs MA, Neilands TB, Kaller S, Wingo E, Ralph LJ. Developing and validating the Psychosocial Burden among people Seeking Abortion Scale (PB-SAS). PLoS One. 2020; 15(12):e0242463. PMID: 33301480. PMCID: PMC7728247
- Casas L, Freedman L, Ramm A, Correa S, Baba CF, Biggs MA. Chilean Medical and Midwifery Faculty's Views on Conscientious Objection for Abortion Services. Int Perspect Sex Reprod Health. 2020 Dec 14; 46(Suppl 1):25-34. PMID: 33326397

- Berglas NF, Kimport K, Mays A, Kaller S, Biggs MA. "It's Worked Well for Me": Young Women's Reasons for Choosing Lower-Efficacy Contraceptive Methods. J Pediatr Adolesc Gynecol. 2020 Dec 23.
- 70. Wingo E, Ralph L, Kaller S, Biggs MA. Abortion method preference among people presenting for abortion care. Contraception. 2020 Dec 26. PMID: 33373612
- Ralph LJ, Chaiten L, Werth E, Daniel S, Brindis CD, Biggs MA. Reasons for and Logistical Burdens of Judicial Bypass for Abortion in Illinois. J Adolesc Health. 2021 Jan; 68(1):71-78. PMID: 33041202
- 72. Ehrenreich K, Biggs MA, Grossman D. Making the case for advance provision of mifepristone and misoprostol for abortion in the United States. BMJ Sex Reprod Health. 2021 Dec 03. PMID: 34862207
- 73. Grossman D, Baba CF, Kaller S, Biggs MA, Raifman S, Gurazada T, Rafie S, Averbach S, Meckstroth KR, Micks EA, Berry E, Raine-Bennett TR, Creinin MD. Medication Abortion with Pharmacist Dispensing of Mifepristone. Obstet Gynecol. 2021 04 01; 137(4):613-622. PMID: 33706339. PMCID: PMC7984759
- 74. Kaller S, Daniel S, Raifman S, Biggs MA, Grossman D. Pre-Abortion Informed Consent Through Telemedicine vs. in Person: Differences in Patient Demographics and Visit Satisfaction. Women's Health Issues. 2021 May-Jun; 31(3):227-235. PMID: 33832830
- 75. Raifman S, Ralph L, Biggs MA, Grossman D. "I'll just deal with this on my own": a qualitative exploration of experiences with self-managed abortion in the United States. Reprod Health. 2021 May 4;18(1):91.
- 76. Raifman S, Biggs MA, Ralph L, Ehrenreich K, Grossman D. Exploring Attitudes About the Legality of Self-Managed Abortion in the US: Results from a Nationally Representative Survey. Sexuality Research and Social Policy. 2021 Apr 1:1-4.
- 77. Berglas NF, Kaller S, Mays A, Biggs MA. The Role of Health Care Providers in Young Women's Attitudes about and Willingness to Use Emergency Contraceptive Pills. Women's Health Issues. 2021 May-Jun;31(3):286-293.
- 78. Kaller S, Morris N, Biggs MA, Baba CF, Rafie S, Raine-Bennett TR, Creinin MD, Berry E, Micks EA, Meckstroth KR, Averbach S, Grossman D. Pharmacists' knowledge, perspectives, and experiences with mifepristone dispensing for medication abortion. J Am Pharm Assoc (2003). 2021 Jun 18:S1544-3191(21)00285-5.
- 79. Foster DG, Gould H, Biggs MA. Timing of pregnancy discovery among women seeking abortion. Contraception. 2021 Aug 4:S0010-7824(21)00344-9.
- Ehrenreich K, Biggs MA, Grossman D. Making the case for advance provision of mifepristone and misoprostol for abortion in the United States. BMJ Sex Reprod Health. 2021 Dec 3:bmjsrh-2021-201321.
- 81. Ralph LJ, Ehrenreich K, Barar R, Biggs MA, Morris N, Blanchard K, Kapp N, Moayedi G, Perritt J, Raymond EG, White K, Grossman D. Accuracy of self-assessment of gestational duration among people seeking abortion. Am J Obstet Gynecol. 2021 Dec 17:S0002-9378(21)02683-1.
- Grossman D, Raifman S, Morris N, Arena A, Bachrach L, Beaman J, Biggs MA, Hannum C, Ho S, Schwarz EB, Gold M. Mail-order pharmacy dispensing of mifepristone for medication abortion after in-person clinical assessment. Contraception. 2022 Mar;107:36-41. doi: 10.1016/j.contraception.2021.09.008. Epub 2021 Sep 20. PMID: 34555420.
- Biggs MA, Ralph L, Morris N, Ehrenreich K, Perritt J, Kapp N, Blanchard K, White K, Barar R, Grossman D. A cross-sectional survey of U.S. abortion patients' interest in obtaining medication abortion over the counter. Contraception. 2022 Jan 23:S0010-7824(22)00007-5.
- 84. Biggs MA, Ehrenreich K, Morris N, Blanchard K, Bustamante C, ...Grossman D. Comprehension of an over-the-counter drug facts label prototype for a mifepristone and misoprostol medication abortion product. Obstet Gynecol. 2022 Jun 1;139(6):1111-1122. doi: 10.1097/AOG.000000000004757. Epub 2022 May 2.PMID: 35675608

BOOK CHAPTERS

- 1. Balter L and McCall RB. Parenthood in America: An Encyclopedia ABC-CLIO, Incorporated, 2000. Book Contributor.
- 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

- 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-deniedabortion/
- "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.
- 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/chilerelaxed-abortion-ban-go-far-enough/
- Biggs MA, Roberts SCM. Fatal flaws in recent analysis on the risk of premature death following teenage abortion and childbirth. European Journal of Public Health. 2017;27:794.
- 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-tighteningwomen-want-more-access-at-home/

OTHER CREATIVE ACTIVITIES

- 1. Biggs MA. Puerto Rican adolescents' cultural orientation: Contextual determinants and psychosocial outcomes. Doctoral dissertation. 1998.
- 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.
- 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.
- 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

Policy, Department of Obstetrics, Gynecology and Reproductive Sciences, and the Institute for Health Policy Studies.

- 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.
- 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.
- Berglas N, Biggs A. Key findings from the survey of organizations serving populations in need of low-cost health services, UCSF: San Francisco, CA. June 2005. Submitted to the California Department of Public Health, Office of Family Planning.
- Biggs A, Brown, A and Brindis C. 2005. Family PACT Program evaluation: Summary findings from client exit interviews, UCSF: San Francisco, CA, June 2005. Submitted to the California Department of Public Health, Office of Family Planning.
- Biggs A, Foster DG, Evaluation of the Cost-Effectiveness of Chlamydia Testing Among Women and Men Seeking Care in Family PACT, CY 2005. UCSF: San Francisco, CA, June 2007.
- Braveman P, Brindis C, Biggs A, Marchi K, Minnis A, Ralph L, Arons A. Latina Voices: Findings from a Study of Latina Teen Childbearing in the Fresno and Los Angeles Areas. UCSF: San Francisco, CA, July 2007. http://bixbycenter.ucsf.edu/publications/files/Latina_Teen_Childbearing_March_20 11
- Berglas N, Biggs A. Clinical Linkages between Family PACT Providers and Teen Pregnancy Prevention (TPP) Programs: Increasing youth-friendliness, understanding successes and challenges, and measuring impact on youth client enrollment. UCSF: San Francisco, CA. June 2008.
- Berglas N, Ralph L, Schwartz S, Biggs A, Brindis CD. Innovative Outreach: Findings from the TeenSMART Outreach Evaluation. San Francisco, CA: Bixby Center for Global Reproductive Health. University of California, San Francisco. April, 2008.
- 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
- 15. Takahashi ER, Florez CJ, Biggs A, Ahmad S, Brindis CD. Teen Births in California: A Resource for Planning and Policy. Sacramento, CA: California Department of Public Health, Maternal, Child and Adolescent Health Program and the Office of Family Planning, and the University of California, San Francisco, CA. January 2009. http://www.cdph.ca.gov/programs/mcah/Documents/MO-TeenBirthsinCalifornia.pdf
- 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.

 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

- 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
- 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.
- 22. Biggs MA, Daniel S, Lewis S, Chow J, Malvin J, Brindis CD. Findings from the 2012 Family PACT Client Exit Interviews, San Francisco, CA: Bixby Center for Global Reproductive Health, University of California, San Francisco, CA, 2014. http://www.familypact.org/Research/reports/10-27-15-CEI%20Report_ADA.pdf
- Yarger J, Daniel S, Biggs MA, Malvin J, & Brindis CD. Family PACT Providers and Health Care Reform Implementation, San Francisco, CA: Bixby Center for Global Reproductive Health, University of California, San Francisco, 2015. http://www.familypact.org/Research/reports/10-29-15HealthCareReformImplementationReport.pdf
- 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-seriestopics/

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



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

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

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

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

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

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

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

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

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

Board certification Maternal-Fetal Medicine 2018 Obstetrics and Gynecology 2013 Memberships Society for Maternal-Fetal Medicine 2012 – current American College of Obstetricians and Gynecologists 2008 – current

Committees

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

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

Northshore University Health System Epic Physician builder, 2018 - 2020

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

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

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

Maternal-Fetal Medicine Clinical Competency Committee, 2018 - 2020

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

Volunteer Experience

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

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

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

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 B-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.

Grimes K, Mullin B, Lehar S, Schulz M, Creeden M, Tien S. (2008, February). "Strength in Numbers: Using Concurrent Measurement to Guide Quality." Poster presentation at: Research and Training Center for Children's Mental Health, Tampa, FL.

EXHIBIT B

95 1 IN THE CIRCUIT COURT OF THE SECOND CIRCUIT IN AND FOR LEON COUNTY, FLORIDA 2 PLANNED PARENTHOOD OF SOUTHWEST 3 AND CENTRAL FLORIDA, on behalf of itself, its staff, and its patients, et al., 4 Case No. 2022 CA 000912 Plaintiffs, 5 v. 6 STATE OF FLORIDA, et al., 7 Defendants. 8 9 10 HEARING BEFORE THE HONORABLE JOHN C. COOPER VOLUME II 11 (Pages 95 to 267) 12 DATE TAKEN: Monday, June 27, 2022 13 Commenced at 12:57 p.m. TIME: 14 Concluded at 5:30 p.m. 15 Leon County Courthouse PLACE: Courtroom 3G 16 301 South Monroe Street Tallahassee, Florida 32301 17 18 19 20 21 22 23 Reported by: 24 Doreen Mannino, Certified Court Reporter 25

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

1	APPEARANCES
2	On Behalf of Plaintiffs:
3	WHITNEY LEIGH WHITE, ESQUIRE American Civil Liberties Union Foundation
4	125 Broad Street New York, New York 10004-2400
5	Phone: (212) 549-2690
6	JENNIFER RUTH SANDMAN, ESQUIRE Planned Parenthood
7	123 William Street New York, New York 10038-3804
8	Phone: (347) 432-5998 Email: Jennifer.sandman@ppfa.org
9	CAROLINE MARIE SACERDOTE, ESQUIRE
10	Center for Reproductive Rights 199 Water Street, Floor 22
11	New York, New York 10038-3533 Phone: (917) 637-3646
12	SHOBA PILLAY, EQUIRE
13	TASSITY S. JOHNSON, ESQUIRE Jenner & Block, LLP
14	353 N. Clark Street Chicago, Illinois 60654-3456
15	Phone: (312) 222-9350 Email: Spillay@jenner.com
16	Tjohnson@jenner.com
17	On Behalf of Defendants:
18	JOHN MATTHEW GUARD, ESQUIRE BILAL AHMED FARUQUI, EQUIRE
19	NATALIE PAIGE CHRISTMAS, EQUIRE JAMES HAMILTON PERCIVAL, II, ESQUIRE
20	Office of Attorney General The Capitol PL-01
21	Tallahassee, FL 32399-0001 Phone: 850-245-0140
22	Email: John.guard@myfloridalegal.com Bilal.faruqui@myfloridalegal.com
23	James.percival@myfloridalegal.com Natalie.christmas@myfloridalegal.com
24	
25	

96 _{II}

1	INDEX VOLUMEII	97
2		
3	Witnesses for Plaintiffs: Shelly Hsiao-Ying Tien Continued Cross-Examination by Mr. Guard9	3
4	Redirect Examination by Ms. Sandman10 Witnesses for Defendants:	
5	Maureen Condic Direct Examination by Mr. Faruqui11	
6	Cross-Examination by Ms. Sacerdote 14 Ingrid Skop	
7	Direct Examination by Mr. Faruqui	
8	State Rests	
9	Shelly Hsiao-Ying Tien Direct Examination by Ms. Sandman	>
10	Cross-Examination by Mr. Guard	7
11	Certificate of Oath	
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		

1	PROCEEDINGS 98
2	(Proceedings continued from Volume I.)
3	THE BAILIFF: All rise. Court is back in
4	session.
5	THE COURT: Everybody have a seat. You may
6	continue cross.
7	MR. GUARD: Thank you, Your Honor.
8	CONTINUED CROSS-EXAMINATION
9	BY MR. GUARD:
10	Q. Before we took a break, Dr. Tien, I had asked
11	you of the 67 abortions in 2021 that Planned
12	Parenthood of Southeast and North Florida performed
13	after 15 weeks of LMP how many of them would have been
14	subject to an exemption pertaining to HB5; do you
15	recall being asked that question?
16	A. Yes.
17	Q. Your answer was none. Did I get that right,
18	ma'am?
19	A. That is correct.
20	Q. And you were deposed just a few days ago,
21	correct?
22	A. Yes.
23	Q. And you were under oath in that deposition,
24	right?
25	THE COURT: Let's keep the tone of voice
	FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

99 1 Sorry, Your Honor. MR. GUARD: 2 THE COURT: -- equal level. 3 MR. GUARD: Sure. THE COURT: We're not on TV. Well, we are on 4 Let's keep the tone of voice level. 5 TV. 6 MR. GUARD: Sorry, Your Honor. 7 THE COURT: Okay. BY MR. GUARD: 8 9 And you were asked that question in the Q. 10 deposition, right? 11 Α. Yes. You were asked and of those 67 abortions that 12 Q. were performed after 15 weeks of LMP --13 14 MS. SANDMAN: I'm sorry. Counselor, can you 15 give me a page number? 16 MR. GUARD: Page 53, line 11. BY MR. GUARD: 17 18 If you want to get the deposition, ma'am, you Ο. 19 can get the deposition. 20 Ouestion: And of those 67 abortions that 21 were performed after 15 weeks of LMP, how many of the 22 67 would have been subject to exemption pertaining to 23 HB5? Answer: I would have to look at each 24 25 specific clinical chart for those numbers. As I

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

5 Question: Sitting here dot dot dot women have abortions for lots of reasons and per our Florida 6 7 state required web based reporting, we do document those reasons. One of the limitations of the 8 9 reporting is that staff was inputting numbers and can 10 only select one reason. And so the reasons that are 11 listed included elective abortion, emotional reasons, 12 financial hardship, health concerns, fetal conditions. 13 There are patients that likely have multiple reasons 14 for seeking abortion. And as the staff input this 15 information there is only one option allowed. And so 16 the elective option is chosen most frequently because 17 these patients are here of their own volition at the 18 clinic. Without looking at each particular patient's 19 chart I would not be able to tell you specifically. 20 And actually without reviewing each patient's chart in 21 detail or speaking with each patient I would not be 22 able to tell you specifically how many of those would 23 meet the very narrow exceptions within HB5. Correct? 24 Α. Yes.

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

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

1 two or three days ago each chart in detail, right? 2 Α. I have not reviewed the charts. 3 And you didn't speak with each one of those Ο. 67 patients; did you? 4 5 I have not spoken with them. Α. 6 Okay. Would you agree medical science has Ο. 7 made huge leaps forward since Roe versus Wade was decided? 8 9 THE COURT: This is not about Roe versus 10 Wade. This is about Florida's right of privacy. 11 MR. GUARD: Your Honor, I'm just trying to put forward that medical science has made advances 12 in the past 30 or 50 years. 13 14 THE COURT: You can ask that question, but 15 Roe versus Wade is not relevant in this case. 16 BY MR. GUARD: 17 All right. Dr. Tien, in the last 30 to Q. 18 50 years would you agree that medical science has made 19 huge leaps forward? 20 Yes. Α. 21 In the last 50 years what we know -- strike Ο. 22 that. 23 In the last 50 years we now know more about 24 reproductive health than we did then, correct? 25 Yes. Α.

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

102 1 Medical technology has made great leaps Q. 2 forward in the last 50 years as well, right? 3 Α. Yes. For example, ultrasounds, right, have made 4 Ο. 5 progress in the last 50 years? 6 Α. Yes. 7 Ultrasounds 50 years ago would be gray scaled Ο. and pixillated; would they not? 8 9 Α. Yes, the image quality was poor compared to 10 what it can be today. And today you can get a 3D image from an 11 Ο. 12 ultrasound, right? Yes. Though 3D imaging is used for specific 13 Α. 14 anatomic concerns. It's not used to evaluate detailed 15 internal anatomy. 16 Okay. Doctor, you were paid under your Ο. initial contract with Planned Parenthood Southeast and 17 18 North Florida almost \$300,000 a year, correct? 19 That is correct. My salary when I was a Α. 20 full-time physician there was 285,000. 21 Ο. And this year you have contracts to make almost \$400,000 a year, right? 22 23 As a part-time physician at Planned Α. 24 Parenthood my salary was adjusted to 185,000. Μv 25 salary as a maternal-fetal medicine physician in

1 Arizona is 200,000. 2 Ο. And you're a party in this case, correct? 3 Α. Yes. And you've been an expert or served as an 4 Ο. 5 expert before in another case, right? 6 Α. In a deposition. It did not go to trial. 7 That is right. That was in another abortion restriction 8 Q. 9 case, correct? 10 It was in the 24-hour mandated delay, yes. Α. And you've never testified on behalf of a 11 Ο. 12 government entity in support of an abortion restriction; have you? 13 14 I have never testified in a court setting. Α. 15 Never offered an opinion in any kind of a Q. 16 abortion restriction case in favor of an abortion 17 restriction; have you? 18 THE COURT: That's a very broad question. 19 Lawyers understand what you mean. When you say 20 has she ever offered an opinion that could be the 21 next door neighbor. I understand what you mean. 22 You're limiting it to as expert witness. 23 BY MR. GUARD: 24 Q. In a court case, Dr. Tien? THE COURT: Okay. 25

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

1 BY MR. GUARD: You have never offered an opinion in support 2 Ο. 3 of an abortion restriction; have you? In a court setting I have never offered an 4 Α. 5 opinion in support of an abortion restriction. 6 And earlier on you testified that you are Ο. 7 pro-choice, correct? 8 Α. Yes. 9 But you're a little bit more than just Ο. pro-choice, right? 10 11 A. Can you define a little bit more than 12 pro-choice? You've actually advocated to the legislature 13 Q. 14 regarding abortion restrictions, correct? 15 I consider that being pro-choice. Α. 16 Okay. But you have you actually advocated Ο. 17 against HB5, right? 18 I, myself and other physicians did sign a Α. 19 letter in response to learning of HB5 being passed in 20 the State of Florida, yes. 21 MR. GUARD: If I can have a moment, Your 22 Honor. 23 THE COURT: Sure. 24 MR. GUARD: I pass the witness, Your Honor. 25 THE COURT: Thank you, Counselor. Redirect.

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

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

3 REDIRECT EXAMINATION
4 BY MS. SANDMAN:

1

2

5 Dr. Tien, opposing counsel asked you some Ο. 6 questions from your deposition testimony about fetal 7 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 8 9 clear. And it said, And so you discussed fetal pain 10 and offered some information about whether it might or 11 might not be present. And then you said, and so in 12 recognition of this I provide abortions in the second trimester. I do not provide abortions after 24 weeks. 13

14 Can you explain what you meant in that 15 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 24 weeks.

106 1 MS. SANDMAN: Thank you, Your Honor. After 2 24 weeks. BY MS. SANDMAN 3 Is fetal pain the reason that you don't 4 Ο. provide after 24 weeks? 5 6 No, I do not provide after 24 weeks because I Α. 7 do not have the technical expertise and because it is illegal. 8 9 Ο. And, Dr. Tien, do you recall opposing counsel 10 asked you some questions about deposition testimony 11 that you gave about whether some patients in Texas 12 were able to get abortions earlier than six weeks after Texas's abortion ban went into effect? 13 14 Α. Yes. 15 Do you think the same thing would happen in Ο. 16 Florida if a 15-week ban went into effect? 17 Α. No. 18 Why not? Ο. 19 The type of patients who need abortions after Α. 20 15 weeks are inherently a different population of 21 patients than those who have abortions prior to six 22 weeks. 23 Ο. And, Dr. Tien, the State also asked some 24 questions about the overall relatively low number of 25 abortions after 15 weeks compared to abortions even

107 1 earlier in pregnancy. The State asked you some 2 questions about Planned Parenthood Central and Northeast Florida's relatively low number. I think it 3 was 67 after 15 weeks. Is that number representative 4 5 of the percentage of abortions that are after 15 weeks in the state as a whole? 6 7 Α. No. Why is that? 8 Q. 9 Α. Planned Parenthood is only one small picture 10 of the provision of abortion care in the entire state of Florida. 11 12 Do you know whether certain other abortion Q. providers in the state provide services to a later 13 14 gestational age than Planned Parenthood Southeast and North Florida do? 15 16 Α. Yes. 17 And you've been focussing on Planned Ο. 18 Parenthood Southeast and North Florida. Do you know 19 if that number would be similar for this year than it 20 was for last year? 21 I would not know specifically without Α. 22 reviewing their numbers; however, I am aware that there are other clinics in the entire State of Florida 23 24 that offer services past 15 weeks not just our 25 Jacksonville location.

Q. The State asked you a lot of questions about ¹⁰⁸ 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?

6

A. It does not.

Does anything about the questions they asked 7 Ο. you help patients who need abortions after 15 weeks? 8 9 Α. It does not. The data that was presented was 10 It was compiled by the Centers for Disease excellent. 11 Control and data that I'm familiar with. Again, it 12 does not affect the patients who need abortions after 13 15 weeks because they're a separate population. And 14 it also does not affect every woman and girl who 15 becomes pregnant in Florida and develops a 16 complication after 15 weeks. 17 MS. SANDMAN: No further questions. 18 THE COURT: Thank you, Doctor. You may step 19 I'm assuming no other party on the down. 20 Plaintiff's side have question for her. You may 21 step down. 22 Call your next witness. 23 MS. WHITE: Your Honor, before I proceed I

24 have one question for clarification based on some 25 procedural issues that came up earlier today. You

mentioned the possibility of continuing the trial ¹⁰⁹ 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.

1

2

3

4

5

6

7

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

13 MS. WHITE: Excellent. Thank you for 14 clarifying that, Your Honor. We just wanted to 15 make sure that wouldn't affect your availability. THE COURT: 16 No. 17 MS. WHITE: Thank you. 18 THE COURT: Unrelated to this case. It was 19 this is 1 of 800 plus cases I have. 20 Understood. MS. WHITE: 21 THE COURT: Defense Counsel. 22 MR. GUARD: Your Honor, over the lunch break 23 we did file an errata sheet. I've got a courtesy 24 copy if I may approach. It's very limited. 25 THE COURT: Thank You. All right.

110 1 Excellent. Appreciate it. The orders that I signed earlier should have been eserved to both 2 3 your mailboxes by now. All right. Who's next? Witness? 4 MS. WHITE: Plaintiffs have no further 5 witnesses in the case in chief. 6 THE COURT: State, do you want to take a 7 break before you call your next witness for 8 9 anything? 10 MR. FARQUI: I think we're fine, Your Honor. The state will call Dr. Condic first. 11 12 Your Honor, the witness has a copy of her declaration and the exhibit. I've already 13 14 conferred with counsel. THE COURT: Raise your right hand. 15 The clerk 16 will place you under oath. 17 THE CLERK: Do you solemnly swear or affirm 18 the testimony you shall give in this issue will be 19 the truth, the whole truth, and nothing but the 20 truth? 21 DR. CONDIC: I do. 22 THE COURT: Have a seat. Speak up so the 23 court reporter and I can hear you and also 24 moderately slow. 25 THEREUPON,

1	MAUREEN CONDIC, 113
2	having been first duly sworn by the Clerk, was
3	examined and testified upon her oath as follows:
4	DIRECT EXAMINATION
5	BY MR. FARUQUI:
6	Q. Good afternoon, Dr. Condic. Can you state
7	and spell your name for the record, please?
8	A. My name is Maureen Condic, C-O-N-D-I-C.
9	Q. And can you please tell the Court what you do
10	for a living?
11	A. I'm faculty at the University of Utah School
12	of Medicine.
13	Q. In what subject matter are you a professor?
14	A. I'm a professor of neurobiology at the
15	university and my training is in neuroscience.
16	Q. And have you ever had positions in other
17	departments at the university?
18	A. I have an adjunct appointment in the
19	Department of Pediatrics.
20	Q. And how many years have you been a university
21	professor?
22	A. Since 1997.
23	Q. Could you just briefly tell me your duties
24	and functions as a university professor in your
25	current position?

A. Running a research laboratory, competing for ¹¹ 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?

7

8

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

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

1 of specific systems?

1	or specific systems:
2	A. My two areas of specialization are early
3	human development, preimplantation development, and
4	development of the nervous system.
5	Q. Have you taught or given any presentations
6	outside of your duties as a professor in this field?
7	A. Oh, yes.
8	Q. And have you published peer-reviewed papers
9	in these fields?
10	A. Yes.
11	Q. Have you refereed any scientific journals?
12	A. Yes.
13	Q. Have you won any awards in your field?
14	A. Yes, I have.
15	Q. Are you affiliated with any government
16	agencies dedicated to research?
17	A. Yes. I was pointed as a member of the
18	National Science Board, and I've served the National
19	Institute Health Research Ethics Panel.
20	Q. Dr. Condic, are you affiliated with any
21	organizations that would be fairly characterized as
22	pro-life?
23	A. I'm a fellow of the Charlotte Lozier
24	Institute.
25	THE COURT: I'm sorry. I didn't hear that.
I	n de la constante de

114 THE WITNESS: I'm a scientific fellow of the 1 2 Charlotte Lozier Institute. 3 THE COURT: Okay. You are going to ask her what that is; aren't you? 4 BY MR. FARUQUI: 5 6 Can you please explain what the Charlotte Q. 7 Lozier Institute is? Charlotte Lozier Institute is an institute 8 Α. 9 dedicated to providing educational materials. And 10 it's a wing of the Susan B. Anthony group, which is 11 hoping to put forth pro-life candidates for public office. 12 THE COURT: Ask her to please speak up. I 13 14 heard it's a pro-life political group best I could 15 hear. 16 THE WITNESS: Yes, that's a fair characterizations and political and educational. 17 BY MR. FARUOUI: 18 19 Q. Okay. Have you ever testified in court as an 20 expert witness? 21 Yes, I have. Α. 22 Do you recall how many times? Ο. 23 Α. I've testified in court twice and I've testified by deposition a fair number of times. 24 25 Q. And your court testimony what was the subject

1 matter of the testimony at those times? 2 In one case it was regarding when does human Α. 3 life begin from a scientific perspective. And in one case it was the scientific basis for understanding the 4 5 experience of fetal pain. 6 THE COURT: I'm sorry. I just can't hear her 7 or understand what she's saying. THE COURT REPORTER: I need her to speak up, 8 9 Your Honor. 10 THE COURT: Yes. She's a soft-spoken person, 11 which lots of people are. Court tends to make you 12 speak softer sometimes. 13 THE WITNESS: I will do my best to speak up. 14 Is that better, sir? 15 THE COURT: Yes. Just if I can hear her I 16 guarantee you the court reporter can. 17 MR. FARQUI: Thank you, Your Honor. 18 BY MR. FAROUI: 19 So you've attached your CV to your expert Q. 20 declaration. Does the CV contain a more thorough 21 summary of your qualifications and experience? 22 Α. Yes, it does. 23 Dr. Condic, can you tell the Court how you Q. became involved in this case? 24 25 I was contacted by the attorneys representing Α.

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

the State of Florida and asked whether I would provide 1 2 expert testimony on topics of when human life begins 3 and on the topic of fetal pain. THE COURT: Can I have sidebar with counsel? 4 5 I don't think we need the court reporter. (An off-the-record discussion was held out of 6 7 the presence of the court reporter.) THE COURT: We're going to take a ten-minute 8 9 break. 10 (A recess was taken from 1:34 p.m. to 1:45 11 p.m.) 12 THE COURT: You may proceed. 13 MR. FARQUI: May it please the Court. 14 THE COURT: Yes. 15 BY MR. FARQUI: 16 Dr. Condic, we left off talking about how you Ο. got involved in this case. Are you being compensated 17 18 for your time working on this case? 19 Yes, I am. Α. 20 Ο. And are those rates specified in your 21 declaration? 22 Yes, they are. Α. 23 What were you asked to do for this case? Q. 24 Α. I was asked to provide expert testimony on 25 when human life begins and on fetal pain.

1 What did you consider in formulating your Ο. 2 opinions? 3 I considered my own personal experience, my Α. research experience, my teaching over 25 years in the 4 5 medical school, and the current scientific literature. 6 Okay. Let's talk about when life begins. Ο. 7 What is your opinion on when life begins scientifically? 8 9 Α. I think the conclusion that life begins at 10 the instant of sperm-egg fusion is scientifically 11 incontrovertible. 12 I'm sorry, but how is that THE COURT: relevant to this case? 13 14 MR. FARQUI: Your Honor, we'll reserve --15 THE COURT: I'm not here to litigate 16 abortion. I'm here to litigate the right of 17 privacy in Florida. I'm not here to litigate Roe 18 versus Wade. But what is -- what's the relevancy 19 of that issue here because Florida says under HB5 20 that abortions can be decisions can be made to 21 receive an abortion up to 15 weeks without using 22 any of the exceptions post 15 weeks. Does the 23 decision on when life begins does that enter into 24 does the State of Florida say life begins at the 25 moment the sperm meets the egg, or does the State

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

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.

1

2

3

4

5

6

7

8

17

18

19

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

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

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?

20 MR. FARQUI: I was hoping to get that done in 21 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.

7 MR. FARUQUI: Thank you, Your Honor.8 BY MR. FARUQUI:

1

2

3

4

5

6

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

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

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

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.

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

A. Yes.

9

8

Q. And could you briefly explain why?

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

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

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

121 1 used to be in both the egg and the sperm and very 2 rapidly it enters into within one or two minutes of 3 sperm-egg fusion into a novel pattern of behavior that is never seen in either an egg or a sperm cell. 4 So it 5 is clearly a new cell. Your question is whether it's 6 also a new human being and the scientific criteria to 7 distinguish between cells and human beings is also very well agreed upon. A living being is an entity 8 9 that consists of parts and all of those parts work 10 together to autonomously direct maturation and 11 continued health of the entity as a whole. So we 12 distinguish between collection of cells or a clump of cells and a living human being by examining how do the 13 14 cells of that entity interact with each other. And based on an enormous body of data from the one-cell 15 16 stage forward the human embryo behaves in an 17 integrated self-regulating manner to direct its own 18 It's unambiguously an organism or a development. 19 human being.

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

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

122 1 certainly a fact of evolution that has given us a 2 million creatures like ourselves that for a brief 3 period of our life we are dependant upon resources supplied by a mother, oxygen, food, waste removal to 4 5 continue in healthy form. But the mother does not 6 provide any instructed information to the embryo. The 7 mother doesn't direct the development of the embryo or determine other than by perhaps limiting nutritional 8 9 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?

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

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

1 It's difficult to determine what the Α. 2 psychological and mental state of a fetus might be 3 because we can't communicate effectively with a fetus. What I can tell you is we know from Neural Development 4 5 a number of facts about what structures are in place 6 when and we know what those structures do at more 7 mature stages of human life. So based on that evidence the circuitry that exists within the 8 9 subcortical regions of the brain particularly in the 10 thalamus appear to be sufficient for a fetus to have 11 self-awareness and consciousness and to experience 12 pain in a manner that reflects an understanding of pain at the level of awareness or self-consciousness 13 14 and that would happen between 12 to 18 weeks of life or 14 to 20 weeks LMP. 15 16 THE COURT: I'm going to have to ask the 17 witness some questions. So, Doctor, that was 12 18 to 16 weeks; is that right? 19 THE WITNESS: 12 to 18 weeks. 20 THE COURT: So it's your testimony that the State of Florida has decided to allow abortions 21 22 when the fetus had the ability for self-awareness, 23 consciousness and awareness of pain because 24 15 weeks is within your time frame? It's three 25 weeks past 12 weeks. Is that your position?

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

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

1

2

3

4

5

6

7

8

9

10

11

12

13

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?

14THE WITNESS: So it's a difficult question.15I'm not an obstetrician or a gynecologist. I do16know a fair amount about the mechanism of action17for IUDs and they are different depending on the18type of IUD employed.

19THE COURT: But don't most IUDs operate by20separating a fertilized egg from the uterine wall?21Person back there the blond person says no.

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

24THE COURT: So are some IUDs abortions then?25THE 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.

1

2

3

4

5

6

7

8

9

10

11

12

16

17

18

19

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?

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

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.

18 MR. FARQUI: I have not researched the19 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 part¹² 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.

1

2

3

4

5

6

7

8

9

10

11

12

13

14

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.

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

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

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

129 1 quickly decelerates, and then touches its face 2 very gently. When it's making a movement towards 3 mom, it couldn't care less. It slams full force into mom with no deceleration. And in twin 4 5 gestations when a fetus is making a movement towards its co-twin it treats the co-twin as if it 6 7 was itself. So they are both aware of their own 8 bodies, aware that poking themselves in the eye is 9 not a good thing to do, and also show some degree of social awareness that this other co-resident of 10 11 the womb is a person like myself or an entity like 12 myself who can experience the same kind of 13 negative feelings I get when I poke myself in the 14 So I'm extrapolating here quite a bit, but eve. the observation of intentional behavior on behalf 15 of the fetus is pretty strong evidence for 16 consciousness and self-awareness. 17

18 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.

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

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

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

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?

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

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

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 suggestregarding the question of when a fetus is capable of

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

1 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?

10 A. No.

11

25

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.

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

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

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

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

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

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

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

1

2

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

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.

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

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

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

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

1

2

So the next four lines of evidence have to do 3 Α. with what we know about the normal circuitry of the 4 5 brain and what it does. So as you can already see, 6 I'm relying on evidence that comes from animal 7 studies, animal evolution, human medical studies, studies of people with disorders of consciousness. 8 So 9 these are very independent areas of research and yet 10 they all support the same conclusion that the cortex 11 is not required for consciousness and for pain.

12 So I'm going to turn to the next four lines of evidence to what we know about a normal function of 13 14 the nervous system. So many, many independent lines of work show that emotional feelings including 15 16 suffering or emotional response to pain, emotional 17 awareness of pain do not require the cortex but are in 18 fact supported by circuits in many different regions 19 of the brain. So it's a very diffuse activity of the 20 nervous system to have emotions. And we share our 21 emotions with animals that have very primitive nervous 22 systems. We know that from about 150 years of 23 research on anesthesia that when an anesthesiologist will knock someone out to cause them to lose 24 25 consciousness loss of consciousness is associated with

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

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

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

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

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

16 THE WITNESS: One of them is a review written 17 by a committee from the Royal College of 18 Obstetricians and Gynecologists in the United 19 Kingdom, often referred to as the RCOG review, the 20 That was written in 2010. And the initials. 21 other one is a review published in the Journal of 22 the American Medical Association. First author is 23 Lee. 24 THE COURT: 2005.

THE WITNESS: 2005.

25

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

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

1

2

3

4

5

6

7

8

9

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.

10THE COURT: So the AMA Journal article what11did it conclude?

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

24THE COURT: Is this where they said that pain25perception probably doesn't function before the

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

third trimester is that the essential?

1

2

3

4

5

6

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?

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

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

141 1 sensitive to pain stimulus, ten volunteers who 2 were relatively incentive. All of them 3 experienced pain. And then they gave them a painful input and recorded where their nervous 4 5 system was active. And what they found is all of the subjects who experienced pain had activity in 6 7 the thalamus, and only the subjects who were very 8 sensitive to pain had activity in the cortex. Α 9 result that directly proves you do not need cortical activation in order to experience pain. 10 11 So it does suggests that for people who are very 12 sensitive to pain the cortex is doing something to 13 enhance that pain experience. Perhaps making associations with bad experiences or fear or bad 14 15 memories that they have regarding pain. But it is certainly not a necessary piece of circuitry in 16 17 order to experience pain. 18 The group that you are affiliated THE COURT: with is one of many I'm sure not the only is it 19

Charlotte Lozier Institute?

20

21

THE WITNESS: Yes, sir.

22 THE COURT: Does it have position on these 23 issues? 24 THE WITNESS: On fetal pain?

25 THE COURT: Yes, ma'am.

142 THE WITNESS: Help me out here. I think no. 1 2 I don't think they have an official position, no. 3 THE COURT: They don't have a fact sheet that 4 states what you just told me. 5 MS. CHRISTMAS: They do. THE WITNESS: They do. Okay. I'm sure I --6 7 MS. SANDMAN: Objection, Your Honor. THE COURT: On what? What I asked or what? 8 9 MS. SANDMAN: Objection to Counsel. 10 MR. GUARD: I've instructed the witness not 11 to answer. 12 THE COURT: Okay. She's fine. Overruled. She didn't say anything that you know this is 13 14 nonjury so I understand. Go ahead, Counsel. I 15 think we interrupted you, Doctor, a little bit, so 16 I apologize for that. You can complete any 17 thoughts you want. 18 That's perfectly fine. THE WITNESS: I'm 19 asked by Charlotte Lozier very rarely to provide 20 scientific data or analysis of information they 21 present to me. I've never been involved in 22 writing material for their public release. 23 MR. FARUQUI: May it please the Court? THE COURT: Yes. 24 25 BY MR. FARUQUI:

Forgive me, Dr. Condic, if I'm retreading old 1 Q. ground, but I wasn't sure if you concluded your last 2 3 answer from a couple questions ago. Would you mind taking a look on page 39 at paragraph 85 of your 4 report and explain that line of research as well? 5 6 THE COURT: Page 39. Okay. 7 THE WITNESS: Paragraph 85? BY MR. FARUQUI: 8 9 Ο. Yes. So this was simply the last line of evidence 10 Α. 11 that I was noting that professional anesthesiologists 12 who are providing in utero surgery for fetuses recommend fetal pain relief not only due to the 13 14 desirability of keeping the fetus from moving during surgery, which is certainly one of the reasons that 15 16 fetuses are anesthetized, but many of the expert reviews from anesthesiologists in this field 17 18 specifically cite the need to prevent a fetal 19 experience of pain because it's well-understood that 20 early painful experiences can impact subsequent 21 development of the nervous system. 22 And I just have a couple more questions, Ο. 23 Dr. Condic, but you may have sort of partially 24 addressed some of them. Is there empirical evidence 25 of fetal consciousness in the second trimester?

144 I've already mentioned several of the 1 Α. Yes. 2 studies that have to do with observing fetal behavior. 3 They're believed to distinguish between similar kinds of sensory input. Their ability to recognize the 4 5 difference between their faces and mom's uterine wall 6 or their face and their co-twin's face. So they show 7 intentional behavior. They show self-awareness and clear consciously mediated behavior that is not 8 9 consistent with it being simple reflex or with the 10 fetus not having consciousness. Can you just describe the sorts of tests that 11 Ο. 12 research derives from? Typically, these are studies looking with 3D 13 Α. 14 ultrasound, so you've got a surface view of the 15 fetus's face. It's well-established throughout early 16 infancy and childhood that increases in activity or 17 changes in activity can detect or illustrate when an 18 individual sees something as different. So a startle, 19 an increase in facial movement, eye movement, other 20 types of activity will show when a fetus thinks it's 21 hearing something different or experiencing something 22 different. And they use those kinds of readouts to 23 see if fetuses recognize the difference between noise 24 and music for example.

Q. And is there really a consensus in the

25

scientific community that fetuses cannot consciously 1 2 experience pain until after the second trimester? 3 I think the answer is no. There is not a Α. consensus that they cannot. 4 5 And can you explain why you believe there's Ο. 6 not a consensus? 7 I believe there's not a consensus because Α. modern reviews of literature have clearly drawn 8 9 different conclusions. As recently as 2022 there was 10 a review by two authors, Derbyshire and Brockman. 11 Derbyshire was actually one of the main neuroscientific authors of the RCOG review in 2010. 12 And at that time he strongly supported the conclusion 13 14 that a fetus could not experience pain prior to 24 weeks, but in 2022 he reversed his position. 15 He's 16 still strongly pro-choice, but his conclusions on fetal pain experience is that the evidence and a 17 18 balanced reading of the evidence supports the 19 conclusion that a fetus experiences pain as early as 20 12 weeks. MR. FARQUI: Your Honor, I do not have any 21 22 additional questions for this witness. 23 THE COURT: Okay. Cross. 24 MS. SACERDOTE: For the record, Your Honor, 25 my name is Caroline Sacerdote. I'm with the

145

146 Center for Reproductive Rights, and I'm here for 1 2 the Plaintiffs. 3 THE COURT: Okay. Thank you. C R O S S-E X A M I N A T I O N 4 BY MS. SACERDOTE: 5 Q. Good afternoon, Dr. Condic. You testified in 6 7 direct that you have testified in other cases, correct? 8 9 Α. Yes. 10 This isn't the first time you've testified in Ο. support of a law that regulates abortion or abortion 11 12 providers, correct? This is not the first time I have been asked 13 Α. 14 to testify and have testified, yes. 15 In fact, you've testified in multiple other Q. 16 cases concerning abortion restrictions in the past 17 four years, right? 18 Α. Yes. 19 And in each of those cases you provided Q. 20 testimony on the topic of fetal pain? 21 Within the last four years, I believe that's Α. 22 correct. 23 Ο. You haven't published any peer-reviewed 24 articles on the topic of human fetal pain, correct? 25 Correct. Α.

And none of the research and review articles 1 Q. 2 that you list on your CV are on the topic of human 3 fetal pain? I'm an animal biologist. I do not work on 4 Α. 5 humans. 6 Ο. So none of the books or book chapters that 7 you list on your CV have a primary focus on the topics of human fetal pain either? 8 9 Α. Correct. 10 So it's fair to say that the vast majority of Ο. 11 your research is not on the topic of human fetal pain? That is correct. My academic research that 12 Α. has been published is not on the topic of human fetal 13 14 pain. 15 And the vast majority of everything that you Q. 16 have written on this topic has been in response to 17 requests for expert reports and testimony in legal 18 proceedings? 19 Correct. Α. 20 Q. Dr. Condic, you testified on direct that you're not a physician, correct? 21 22 Α. Correct. 23 Ο. You've never provided clinical care to either adults or babies? 24 25 Other than my own children, no. Α.

148 1 So no clinical care? Q. 2 Α. No clinical care. 3 And you have no professional experience Ο. working directly with newborns? 4 5 No professional experience, correct. Α. And no professional experience observing 6 Ο. 7 newborns? Correct. 8 Α. 9 On direct I believe you describe nociception Ο. as the most basic ability to detect and respond to 10 11 painful or a noxious stimulus; is that correct? 12 Α. Correct. 13 Q. And you say that there is a distinction between nociception and the conscious awareness of 14 15 pain? 16 Α. Yes. 17 And that's an important distinction? Ο. 18 From the perspective of science and the Α. 19 behavior of the nervous system, the response to pain 20 exists pretty much in a continuum, so it's an 21 important conceptual distinction and to some extent 22 it's an important physiologic distinction. But would 23 I call it in a global term an important distinction, 24 it depends on what your question is. A reflex response does not necessarily mean 25 Ο.

1 there is a conscious awareness of pain, correct? 2 Α. Correct. 3 And consciousness is not required for a Ο. 4 hormonal stress response? 5 Hormonal stress response does not require Α. 6 consciousness. 7 You testified also on direct that the neuro Ο. connections between the thalamus and the cortex don't 8 9 develop until 24 to 26 weeks LMP, correct? 10 That is generally accepted. Α. And you understand LMP to be short for last 11 Ο. 12 menstrual period? Correct. 13 Α. 14 The earliest point at which cells within the Ο. 15 cortex could be responsive to noxious stimuli would be 24 to 26 weeks LMP, correct? 16 17 I have to qualify my answer just a tiny bit Α. 18 because there is a structure below the cortex known as 19 the subplate and the function and development of that 20 region has not been well-appreciated until recently. 21 And in fact, the main basis for Derbyshire changing 22 his opinion on fetal pain was the early development of 23 the subplate structures which are considered a 24 transient cortical structure. So that region of the 25 nervous system develops very early and is certainly in

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

1 place between 12 and 18 weeks.

My question, Dr. Condic, is whether the 2 Ο. 3 earliest point at which cells within the cortex could be responsive to noxious stimuli? 4 5 If you consider cells of the subplate to be Α. 6 cortical cells, which is one of the definitions of 7 that region of the nervous system, then, no, you're wrong. The earliest point at which cells within the 8 9 cortex could be responsive to pain would be 12 weeks. 10 If you consider as some people do the subplate to be a structure that is a precursor to the cortex because 11 12 it's transient, it does not persist into adult stages, 13 then cells that are currently in your cortex, yes, the 14 earliest time point at which those cells could be responsive would be about 24 weeks. 15 16 You were deposed in a Utah case regarding Ο. 17 abortion restrictions in September of 2020, correct? 18 Α. Correct. 19 That was for a case called Planned Parenthood Q. Association of Utah versus Miner? 20 21 I will trust you on that, yes. Α. 22 Your testimony in that deposition was under Ο. 23 oath? 24 Α. Correct. 25 So you understood that you were required to Ο.

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

1	tell the truth?
2	A. Yes.
3	Q. And you did in fact tell the truth?
4	A. Yes.
5	Q. So I'm going to ask Plaintiff's counsel to
6	hand you what's been marked Condic 3. So I'd like you
7	to start by taking a look at page 1 of this document.
8	A. Yes.
9	Q. This is the transcript of the deposition I
10	just referenced, correct?
11	A. It appears to be, yes.
12	Q. Page 1 has a caption that says Kaitlyn
13	excuse me. It think I might have pulled up the wrong
14	document. One moment, please.
15	A. The document I have says, Planned Parenthood
16	Association of Utah versus Joseph.
17	Q. Well, that's great. So you have the right
18	document, I don't.
19	THE COURT: I do, too.
20	BY MS. SACERDOTE:
21	Q. Okay. So this document states, Planned
22	Parenthood Association of Utah versus Miner, correct?
23	A. Correct.
24	Q. And it reflects that you were deposed on
25	September 14, 2020?

1	A. Correct.
2	Q. So now I'll ask you to turn to page 119?
3	A. Yes.
4	Q. So I'll direct your attention to line 3 and
5	I'll read starting from there and I'll ask that you
6	follow along with me. Excuse me. I should start at
7	line 22 on page 118 right above there.
8	A. Yes.
9	Q. So starting at 118 line 22.
10	Question: So the 24 to 26 weeks that what
11	does that represent in terms of cortical development?
12	Is that sort of the earliest point at which there is
13	some connection between the thalamus and the cortex?
14	Answer: Correct.
15	Question: Okay.
16	Answer: So what I said originally is that if
17	if you are asking me what is the earliest point in
18	time at which cells within the cortex could be
19	responsive to noxious stimuli, the earliest point
20	in time where that could occur would be 24 to
21	26 weeks.
22	Did you I read that correctly?
23	A. You did.
24	BY MS. SACERDOTE:
25	Q. You can set that document aside. So you

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.

10 Q. So setting aside the subcortical structures 11 you just referenced?

7

12

18

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

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

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.

10

15

25

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 19 18 weeks LMP it's hard to make a clear, solid, 20 unambiguous case that we have the neurocircuitry in 21 place for a fetus to have a conscious awareness of 22 pain? 23 Answer: Clear and unambiguous, yes, I would 24 say it's difficult to make that case.

Question: At 18 weeks LMP, correct?

155 1 Answer: Yes. 2 Did I read that correctly? 3 You did. Α. BY MS. SACERDOTE: 4 You can set that aside for now. So on direct 5 Ο. 6 you addressed ACOG's views on the issue of human fetal 7 pain, correct? 8 RCOG's views, yes. Α. 9 Excuse me. So in your declaration you Ο. 10 addressed ACOG's views on the issue of human fetal 11 pain, correct? 12 I believe in my declaration I noted that ACOG Α. has reiterated the conclusions of RCOG and has 13 14 published an opinion piece without evidence. But I 15 did not discuss ACOG's position beyond the fact that 16 they reference RCOG. In your declarations you characterize ACOG's 17 Q. 18 conclusions regarding human fetal pain as perplexing, 19 correct? 20 I believe so. Α. 21 So you disagree with ACOG's views on human 0. 22 fetal pain? In light of substantial evidence that I 23 Α. 24 present in my declaration, I believe their conclusion 25 is perplexing because it relies on no evidence.

156 THE COURT: I know what ACOG is, but I want 1 2 to make sure we have this on the record. ACOG is American College of Obstetricians and 3 Gynecologists, correct? 4 5 THE WITNESS: Correct. THE COURT: And most board certified OB-GYNs 6 7 are members of ACOG? I say most. I can't say all about anything. 8 9 THE WITNESS: I am not an obstetrician or 10 gynecologist. I'm not familiar with what level of 11 representation they have. 12 THE COURT: That's fine. RCOG again is the 13 British version of ACOG because it's Royal 14 College. 15 THE WITNESS: Yes. 16 THE COURT: Thanks. BY MS. SACERDOTE: 17 18 It's your view that ACOG likely has a Ο. 19 significant conflict of interest on the topic of fetal 20 pain? 21 No, I believe it's possible they have a Α. conflict of interest. 22 23 Ο. Dr. Condic, I asked if it's your view that ACOG likely has a significant conflict of interest on 24 25 the topic of fetal pain, and did I hear you say that

157 1 your answer to that question is no? 2 May I consult my report to see exactly how I Α. 3 worded it? Let's all take a look at your report. 4 Ο. 5 THE COURT: I think she said, no, it's possible they have a conflict of interest. 6 7 THE WITNESS: Yes, that was certainly my intention. 8 9 THE COURT: I don't know what the report says 10 on that specific point, but that is what she 11 answered here. 12 MS. SACERDOTE: Thank you, Your Honor. BY MS. SACERDOTE: 13 14 So let's all take a look at the declaration Ο. 15 that you submitted in this case. So please turn to 16 page 25, paragraph 62. Looking at paragraph 62 I'll read starting at the first sentence. 17 18 In considering this paradox, it's important 19 to note that RCOG and ACOG represent the primary 20 providers of abortion services both in the United 21 States and the United Kingdom, and therefore the views 22 of these societies are likely to entail significant conflicts of interest. Did I read that correctly? 23 A. You did. 24 25 You can set that aside. And so it is also Ο.

your view that RCOG likely has a conflict of interest 1 2 as well? 3 Based on my understanding of a conflict of Α. interest, the type of conflict of interest statements 4 5 I'm required to make as a professor in the University 6 of Utah, this would certainly constitute a likely 7 conflict of interest. On direct you discussed three studies cited 8 Q. 9 by RCOG, correct? 10 Α. Yes. 11 Ο. And you still have your declaration in front 12 of you, right? Yes. 13 Α. 14 So now I'd like to turn to page 25, paragraph Ο. 15 65. 16 Yes. Α. 17 So in this paragraph you talk about three Ο. 18 studies, correct? 19 Α. Yes. 20 Q. And the second study and I'll read from this 21 paragraph. The declaration states, The second study, conducted in adults, demonstrates that multiple 22 23 non-cortical regions are involved in pain perception. 24 There is a parenthetical and then the sentence goes 25 on. And provides no evidence that the cortex is

159 1 critically required for pain perception, correct? 2 Α. Yes. 3 Ο. There is a footnote 70 there, correct? Yes. 4 Α. 5 And the article referenced or cited in Ο. 6 footnote 70 is Rosen, S.D. and Camici PG, The 7 Brain-Heart Axis in the Perception of Cardiac Pain. Is that correct? 8 9 Α. Yes. 10 I'm going to ask Plaintiff's counsel to again Ο. 11 hand you a document. This time it's what's been marked Condic 14. 12 13 THE COURT: Let me guess. That's Rosen and 14 Camici's article. 15 MS. SACERDOTE: Yes. Excellent guess. 16 BY MS. SACERDOTE: So I'll ask the witness, looking at the first 17 Ο. 18 page of the document that's now before you it's 19 titled, The Brain-Heart Axis in the Perception of 20 Cardiac Pain The Elusive Link Between Ischaemia and 21 Pain, correct? 22 Α. Yes. 23 Ο. And this is the Rosen article that we just referenced? 24 25 Yes. Α.

160 So if you turn to page 362, under the heading 1 Q. of Unified Perspective, which is in the left column. 2 3 Excuse me. I'll ask you to look in the left column under the heading Unified Perspective? 4 5 Α. Yes. 6 So I'm looking at the third line from the Ο. 7 bottom and I'm going to read from that article. The thalamus may have a key role in the perception of pain 8 9 from the heart acting as a gate to afferent pain 10 signals with cortical activation being necessary for 11 the sensation of pain. Did I read that correctly? 12 Α. You did. You can set that aside. 13 Ο. In your direct 14 testimony you also discussed an article published in 15 Jama authored by Lee and other authors, correct? 16 Α. Yes. And the Lee review's conclusion was that 17 Ο. 18 certain functional regions in the cortex are required 19 to experience pain, correct? 20 Α. I will assume that they said that at some 21 place in their article. That is their general 22 conclusion, yes. 23 And it's your view that the authors of the 0. 24 Lee review also likely have a significant conflict of 25 interest?

1	A. Some of the authors, yes.
2	Q. You're familiar with the Society for
3	Maternal-Fetal Medicine?
4	A. Yes.
5	Q. You are aware that the Society for
6	Maternal-Fetal Medicine has a view on the potential
7	for fetal awareness of pain?
8	A. Yes. Recently published, yes.
9	Q. But you disagree with that view?
10	A. I disagree with that view, yes.
11	Q. And you chose not to include the Society for
12	Maternal-Fetal Medicine's view in your declaration?
13	A. I made the judgment that my declaration was
14	already quite long. Yes, so I did omit that
15	particular paper. I believe that it is I address it
16	that the reasons I do not find that argument
17	persuasive are very similar if not identical.
18	Q. And you did not cite to the Society for
19	Maternal-Fetal Medicine document in your declaration,
20	correct?
21	A. I did not.
22	Q. You aren't aware of any medical or scientific
23	professional organizations that have concluded that a
24	fetus has a capacity to consciously experience pain
25	prior to 24 weeks gestation; are you?

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.
9 I'm not familiar with positions of all medical
10 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 thatprovide 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

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

163 pain prior to 24 weeks agree with your conclusion on 1 2 that point? 3 Α. I have no idea what the author's saying. Ι know what they've written. 4 5 THE COURT: What page are we on on her 6 report? 7 MS. SACERDOTE: Your Honor, I am not referring to a specific page. The question I'm 8 9 asking relates to the 12 lines of evidence cited 10 within her declaration. THE COURT: Okay. 11 12 MS. SACERDOTE: And throughout the portions 13 of her declaration that discuss these 12 lines of 14 evidence a number of articles are cited. 15 THE COURT: Okay. I understand. 16 BY MS. SACERDOTE: It's your view that the kind of proof needed 17 Ο. 18 to prove a fetus experiences pain is not possible with 19 any scientific evidence? 20 Α. It's my opinion that it is impossible with 21 scientific evidence to prove that any human experiences pain including a human fetus. 22 23 Ο. You discussed on direct a Derbyshire and Brockman article, correct? 24 25 Α. Yes.

164 And is that an article titled, Reconsidering 1 Q. 2 Fetal Pain? 3 Α. Correct. In that article the authors question the 4 Ο. 5 necessity of the cortex for the apprehension of pain, 6 correct? 7 Α. Yes. And Derbyshire and Brockman do not state in 8 Ο. 9 their article that this immediate apprehension has a 10 conscious component, correct? 11 Α. The term apprehension is used in neuroscience 12 to refer to a conscious emotional awareness that does not necessarily reflect a cognitive component. 13 So 14 they're making no assertion regarding whether or not a fetus thinks about painful experiences, but they are 15 16 asserting that the fetus apprehends pain which means it has a conscious emotional awareness of pain. 17 18 I understand that that's your conclusion, Ο. 19 Dr. Condic. What I'm asking is whether Derbyshire and 20 Brockman state that this immediate apprehension that 21 they discussed has a conscious component? 22 Α. That is what the meaning of the term apprehension is when it's used in scientific context. 23 24 Ο. Do the authors say that this immediate 25 apprehension has a conscious component? FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

165 The authors do not need to define a cognitive 1 Α. 2 neuroscientific term within the context of the 3 published article. They simply use it with the assumption that the reader will understand what it 4 5 means. 6 Ο. So they don't say that an immediate 7 apprehension of pain has a conscious component? They do not define the word apprehension, 8 Α. 9 yes. 10 You testified on direct that you're Ο. affiliated with the Charlotte Lozier Institute? 11 12 Α. Yes. 13 The Charlotte Lozier Institute's stated Ο. 14 mission is to diminish and ultimately overcome what 15 its mission characterizes as the scorch of abortion; 16 is that correct? I will trust that that is their mission. 17 Α. 18 You testified on direct that you characterize Ο. 19 yourself as pro-life? 20 I don't believe I testified to that. Α. 21 Excuse me. You would characterize yourself Ο. 22 as pro-life? 23 Α. I would characterize myself as a scientist and the scientific evidence has lead me to conclude 24 25 that a human being exists from sperm-egg fusion and is

166 capable of pain experience. And those two conclusions 1 2 have lead to me a position that protecting life is an 3 important interest. It is your view that abortion should not be 4 Ο. 5 legal except when a pregnant person's life is at 6 stake? No. 7 Α. Okay. You were deposed in a North Carolina 8 Q. 9 case regarding abortion in September of 2017, correct? 10 I will trust you on that. Α. Well, let's see. Plaintiff's counsel is 11 Ο. 12 going to hand you what's been marked Condic 15, so 13 I'll ask you to look on the first page in the top left 14 corner of the document that you were just handed. 15 Α. Yes. 16 The first page states that this is a Ο. deposition of Maureen Condic, correct? 17 18 Α. Yes. 19 In a case captioned Amy Bryant versus Jim Q. 20 Little, correct? 21 Yes. Α. 22 And it's dated September 13, 2017? Ο. 23 Α. Yes. And I should specify the document reflects 24 Q. 25 that the deposition was taken on September 13, 2017,

1 correct?

2

A. Yes.

3 So please turn to page 198. Ο. Which page number are you referring to? 4 Α. 5 MS. SACERDOTE: Sure. This is one of the four panel deposition transcripts. Apologies to 6 7 the court. THE COURT: That's okay. 8 9 BY MS. SACERDOTE: 10 So I am looking at within the four squares Ο. 11 the page numbers listed in those four squares and 12 we're turning to page 198. 13 Yes, I'm here. Α. 14 So I'll start reading at line 4 and then I'll Ο. 15 skip some lines where the attorney and reporter are 16 speaking and start again at line 12, and I'll ask that 17 you follow along. 18 So line 4, Question: Well, do you think that 19 abortion should ever be legal when a woman's life 20 isn't at stake? 21 Line 12: The Witness: Excuse me while I try 22 to run through all possible circumstances under which 23 that situation could occur. 24 Question: Please take your time. 25 Answer: With a caveat in the absence of

167

168 1 extremely extenuating circumstances that I cannot 2 imagine that might alter my opinion, I would say, no, 3 abortion should not be legal in situations where a woman's life is not threatened immediately. 4 5 Did I read that correctly? Yes, you did. 6 Α. 7 And you can set that aside. You believe that Ο. abortion is the killing of a living human being? 8 9 Α. Yes. 10 And you believe that abortion is the killing Ο. 11 of a full and complete human being? 12 Full and complete albeit in the immature Α. 13 stage of the life span. 14 MS. SACERDOTE: Your Honor, may have a moment to confer with my colleagues? 15 THE COURT: Sure. 16 MS. SACERDOTE: So one clarification for the 17 18 record. The Condic declaration is Joint Exhibit 5 19 for the record, and with that I'll pass the 20 witness. 21 THE COURT: Could I ask just a couple 22 questions, Doctor? I think I read this right. 23 Your opinion on fetal pain does it differ from the 24 RCOG, ACOG and Society of Maternal-Fetal Health 25 position? That's what my notes say. I want to

see if I'm right on that.

1

2

9

10

11

23

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.

12 THE COURT: Okay. And you were asked about 13 IVF, which is in vitro fertilization, short 14 nonmedical term test-tube babies, but that's 15 probably not approved as correct. But do you -you were asked if you opposed the availability of 16 17 procedures for women to get pregnant, and I'm not 18 sure whether you said you opposed it or not. Could you just tell me what your opinion was then 19 20 and is it the same now?

THE WITNESS: Well, I'm referring to my
testimony on page 200.

THE COURT: Yes, ma'am.

24THE WITNESS: And I did state at that time25back in 2017 that IVF is largely an unregulated

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

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.

1

2

3

4

5

6

7

8

9

10

11

12

13

THE COURT: Does in vitro fertilization does that in your opinion include the issues of abortion or termination of pregnancy?

14 THE WITNESS: I think they're quite different 15 topics. I think that obviously they have some 16 relationship to each other, but I believe that 17 there are many different kinds of issues that face 18 both those general areas.

19THE COURT: I didn't hear part of your answer20so I want to make sure. Do you still believe that21IVF -- for some reason I have trouble saying those22few letters -- IVF presents significant health23consequences for women and the children conceived,24or have you changed your opinion on that? That's25what I didn't pick up.

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

THE WITNESS: I believe that today five years 1 2 later I'm only more convinced that IVF practices 3 as they are conducted in the United States have significant health consequences for some women and 4 5 have significant health consequences for many if not all of the children conceived. 6 7 THE COURT: Okay. Thanks. That's all I had. Does that raise anything that Plaintiff's counsel 8 9 wishes to go into? 10 MS. SACERDOTE: No, Your Honor. 11 THE COURT: Defense counsel is on redirect 12 now. Do you have anything? MR. FARQUI: No, Your Honor, we don't have 13 any redirect. 14 15 THE COURT: Thank you, Doctor. I appreciate 16 you coming all the way from Utah. Do we have another witness? 17 18 MR. GUARD: Yes, Your Honor. I was going to 19 suggest Dr. Skop has to go back home today so we 20 were going to just try to power through if we can. 21 THE COURT: Let's have a ten-minute break. 22 We'll back at 15 after and your next witness we'll 23 get her in and out today. Thank you, we'll be back in ten minutes. 24 25 (A recess was taken from 3:05 p.m. to 3:24

p.m.)

1

2

3

4

5

6

7

8

9

10

11

12

13

14

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.

15 Exhibit 2 is Exhibit B to the State's
16 response, which is the Tien export report for the
17 Gainesville Woman Care case.

18 Exhibit 3 is Exhibit C to the State's
19 response, which is the CDC Abortion Surveillance
20 Data from 2019.

Exhibit 4 is going to be the Skop declaration
including the two attachments which are listed as
A and B.

24 Exhibit 5 is the Condic declaration including 25 the attachment, which is her CV, which is

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

1 Exhibit A to Exhibit 5 now. 2 Exhibit 6 is the Tien declaration including 3 the CV, which is attached as Exhibit A to 6. Exhibit 7 is the Biggs declaration including 4 the attached CV. 5 6 Exhibit 8 is going to be the Biggs 7 deposition. Exhibit 9 is going to be the Skop deposition 8 9 transcript, which you already have. 10 And there is an agreement that all those are 11 admissible and admitted. 12 MR. PERCIVAL: Have we explained to Your Honor yet the issues with Biggs's deposition? 13 14 MS. CHRISTMAS: I thought we'd do that after. 15 MR. PERCIVAL: I just don't want the Judge to 16 think we're blind siding him with another 17 deposition transcript. 18 THE COURT: I like reading deposition 19 transcripts. 20 MR. GUARD: So I guess we will go into it 21 now. We were trying to keep -- well, she can't come back on Thursday, so Dr. Biggs who traveled 22 23 here from California, we put in her declaration. 24 And then we're putting in the deposition 25 transcript of what is mostly my cross, which is

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

174 54 pages long, which is a pretty short deposition. 1 2 So that's my way of selling it to you. We're 3 doing that in lieu of trying to make her come back from California, which she can't. 4 5 THE COURT: So we're putting in Dr. Biggs's declaration. Does she have a deposition, too? 6 7 MR. GUARD: Yes, I took a deposition of her and basically her cross. 8 9 THE COURT: Okay. That's fine. If possible 10 I'd like to get that tonight. 11 MR. GUARD: Your clerk has it. He's doing 12 his thing and then you can get it. THE COURT: So Dr. Biggs can't be here. 13 Your 14 second witness will finish today. 15 MR. GUARD: Yes. 16 THE COURT: And so are there any other witnesses? 17 18 MR. GUARD: Dr. Tien is going to testify as a 19 rebuttal witness my understanding is, and I don't 20 think I'm going to have much cross because I've 21 already done the cross once. 22 THE COURT: So Dr. Tien. Okay. 23 MR. GUARD: And then we're done. 24 THE COURT: All right. Then we have 25 argument.

1 MR. GUARD: Yes, Your Honor. 2 THE COURT: Okay. All right. Do you all 3 want to try to do that all today? 4 MS. PILLAY: As much as possible, Your Honor. 5 If it's possible to get it all done today, great. MR. GUARD: If we get everything done other 6 7 than argument. Most of these lawyers are from places other than Florida. We'll be happy to if 8 9 Your Honor would allow us to allow them to do it by Zoom or however Your Honor would like to do it, 10 11 or if you prefer it here in-person, we'll do it 12 in-person. 13 THE COURT: I hate making you come in-person, 14 but I rather not do closing argument or ruling by 15 Zoom. I'd rather do it in-person. Obviously, the 16 media is certainly invited and it's not just a 17 spur of the moment thing. I think it's better if 18 we handle this case the way did before COVID. And 19 we can talk about when that is whether it -- it 20 depends. It could be tomorrow, but I will be 21 under the influence of novocaine for a couple 22 hours afterwards if that creates any concern for 23 As far as I know the only thing it does anyone. 24 is keep me from drinking anything I mean like 25 liquid without spilling it. I could probably

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

shuffle some stuff around tomorrow afternoon if you want to do that. I certainly know I can do it Thursday.

1

2

3

4

5

6

24

25

MR. GUARD: We obviously don't want to inconvenience anyone. I was trying to be as kind as I can.

7 THE COURT: I understand. It's probably hotter in Tallahassee than it is in some of the 8 9 places Plaintiff's counsel are from, but it was 10 quite cool this morning when I got up. But I do 11 want to have time to give justice to these 12 depositions and to think through where we are on everything, so let me think about it. We can talk 13 14 about it some more today. I don't want to delay 15 your other witness.

MS. PILLAY: Thank you very much, Your Honor. 16 17 THE COURT: Do you swear or affirm the 18 testimony you're about to give will be the truth, 19 the whole truth, and nothing but the truth? 20 THE WITNESS: I do. 21 THE COURT: Have a seat. 22 MR. FARQUI: Your Honor, would it make it 23 easier if we give you an extra courtesy copy of

Dr. Biggs's transcript so you don't have to rely on the Clerk's copy?

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

177 THE COURT: Yes. Thank you. That would be 1 2 good if you have it. If you don't, I will not 3 mark on the Clerk's copy. If I have my own, I can mark. 4 5 MR. GAURD: May I approach, Your Honor? THE COURT: So I have Dr. Skop's deposition. 6 7 MR. GAURD: There's Dr. Biggs. THE COURT: And this is Dr. Biggs's 8 9 deposition, so I will reread her statement and her 10 deposition. 11 MS. PILLAY: For the record, the extra copy 12 was a rough copy that we received Friday and then we received the final one this morning that was 13 14 delivered to the Clerk in case there is any we haven't had a chance to look for discrepancies. 15 16 THE COURT: If there are, we can talk about 17 them. I don't mind taking the Clerk's home. 18 Usually, with a rough copy you can get about 99% 19 of what it says, but I don't mind reading both. 20 So we've placed this witness under oath. 21 THEREUPON, 22 INGRID SKOP, 23 having been first duly sworn by the Court, was 24 examined and testified upon her oath as follows: 25 DIRECT EXAMINATION

178 1 BY MR. FARUQUI: 2 Dr. Skop, can you please state your name and Ο. 3 spell it for the record? My name is Ingrid Skop, I-N-G-R-I-D, S-K-O-P. 4 Α. 5 And I'm just going to these microphones are a Ο. 6 little bit weird I'm going to ask you to not lean too 7 far in. Can you please tell the Court what your 8 9 occupation is? 10 I'm a board-certified Α. 11 obstetrician-gynecologist in Texas, and I've been 12 practicing for 30 years. And where are you currently employed? 13 Ο. 14 I am currently working full time for the Α. 15 Charlotte Lozier Institute as their senior fellow and Director of Medical Affairs. In addition, I'm working 16 17 part time as an obstetrics hospitalist at a hospital 18 in San Antonio. 19 How long have you had this position with the Q. 20 Charlotte Lozier Institute? 21 I began this position on April 1st of this Α. 22 Prior to that I was in the same group practice year. 23 in San Antonio for 25 years. 24 Ο. And just to make this short is the Charlotte 25 Lozier Institute is this the same organization that

179 1 was referenced in Dr. Condic's testimony? 2 It is. If I can clarify, Susan B. Anthony Α. 3 Pro-Life America is a lobbying firm. Charlotte Lozier Institute is their research arm. We are a nonprofit. 4 5 We are not a lobbying group. Similar to the 6 relationship between Planned Parenthood and Guttmacher Institute prior to the two of them separating. 7 Do you agree that the Charlotte Lozier 8 Ο. 9 Institute would be fairly characterized as a pro-life 10 organization? 11 Α. Yes. It was mentioned earlier that our 12 mission is to support life in the womb. Do you hold any hospital appointments? 13 Q. 14 Yes, sir, I do. I'm on staff at the Baptist Α. 15 Hospital System in San Antonio. 16 And how long have you been on staff there? Ο. 26 years. 17 Α. 18 Have you ever had any leadership positions on 0. 19 staff? 20 Α. Yes, sir. I was the chairman of the 21 department of OB-GYN for a couple of years. 22 Can you quickly walk us through your academic Ο. 23 and training background before you -- well, walk us 24 through your academic and training background, please. Sure. I received a Bachelor's of Science in 25 Α.

Physiology from Oklahoma State University. I received 1 2 Medical Doctorate from Washington University in St. I did my obstetric gynecology residency 3 Louis. training with the University of Texas Health Science 4 5 Center at San Antonio. 6 Ο. Did you hold any leadership positions during 7 your residency? I was the chief resident my final year. 8 Α. 9 Where are you licensed? Ο. 10 I'm licensed in Texas. Α. 11 And licensed as a medical doctor, correct? Ο. 12 Yes, sir. Α. And how long have you been a licensed medical 13 Q. 14 doctor? 15 I have had my medical doctorate for 30 years. Α. 16 Do you have any professional certifications Ο. in that field? 17 18 My membership in professional organizations Α. 19 I'm a fellow of the American College of Obstetricians 20 and Gynecologists. In addition, I am a member of the American Association of Pro-Life Obstetricians and 21 22 Gynecologists. 23 Ο. Are you board certified in obstetrics and 24 gynecology? 25 Yes, sir. Α.

Q. And is that field -- can you explain what the 1 2 field of obstetrics and gynecology is? 3 Sure. Obstetrics refers to the prenatal care Α. and the delivery of babies. Gynecology refers to more 4 5 general women's reproductive issues relating to 6 menstruation, other non-pregnancy events. 7 Q. Have you published any peer-reviewed papers in the field of obstetrics or gynecology? 8 9 A. Yes, sir, I have. Have you given any oral presentations in the 10 Ο. 11 field? 12 A. Yes, sir, I have. Have you ever testified in court as an expert 13 Q. 14 witness? Not on this topic. I have testified as a 15 Α. defense witness in a medical malpractice case. 16 Q. Was that within the field of obstetrics and 17 18 gynecology? 19 A. Yes. Specifically, it was a gynecologic 20 case. 21 Q. And you've provided a CV; does that CV 22 contain within there some of your qualifications and 23 experience? A. I believe it does. 24 25 I do have one question about your CV. What 0.

1 is the San Antonio Maternal Morbidity and Mortality 2 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.

7

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?

Α.

22

25

A. Probably.

23 Q. Are you being compensated for your time in 24 this case?

A. I'm a full-time salary position at Charlotte

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

Lozier Institute. Our mission is education. 1 This falls within the context of our mission, and I'm not 2 3 receiving any additional compensation other than my salary and expenses for travel. 4 5 What were you asked by the State to do for Ο. 6 this case? 7 I was asked to give my expert testimony Α. regarding the issues of safety in later abortion. 8 9 And what did you consider in formulating your Ο. 10 opinions? 11 Α. I considered my 30 years of clinical 12 experience as an obstetrician-gynecologist as well as an extensive review of the literature. 13 14 Have you ever performed an abortion yourself? Ο. 15 No, sir, I have not. Α. 16 Why is that? Ο. As an obstetrician I feel that I have an 17 Α. 18 ethical responsibility to both of my patients, the 19 woman and her unborn child. 20 Q. Have you ever received training on how to perform an abortion? 21 22 Yes, sir, I have as a standard part of an Α. 23 obstetrics and gynecology residency, we participate in 24 pre and post-abortion care. For those who wish they 25 can perform the procedure, but all of us see

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

184 1 procedures, receive lectures on how to do the 2 procedures. And in fact, every abortion procedure 3 there is a similar procedure that can be done for reasons that are not related to ending the life of a 4 5 fetus and so I have vast clinical experience in 6 performing those types of surgical procedures. 7 Have you ever worked at a Planned Parenthood 0. facility? 8 9 Α. Yes, sir, I have. I worked as a resident 10 providing contraceptive services and general 11 gynecologic care, but not abortions. 12 In your career, have you ever provided care Q. to women who previously had abortions? 13 14 Many times. Α. 15 Have you ever provided care to women who had Ο. 16 complications from abortions? 17 Yes, sir. I've seen many women who have Α. 18 suffered complications of abortion. I've seen many 19 physical complications including significant injuries 20 that require surgery. I've cared for two patients who 21 died of sepsis after surgical abortion; one in the 22 first trimester, one in the second trimester. And 23 I've cared for many women in my clinical setting who have been injured emotionally by abortion. 24 25 Let's talk about your opinions in this case. Ο.

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.

9 Q. You believe that the -- what is your opinion 10 on whether the challenged statute would impede the 11 access to abortion for women?

12 As discussed earlier, I think a limitation Α. may cause some women to seek earlier abortions which 13 14 would be safer for them. The interpretation of the 15 literature that discusses the reasons that women 16 obtain later abortions, which is primarily from 17 abortion providers such as Guttmacher Institute, tell 18 me unequivocally that many women who seek these very 19 late abortions do so under coercion. They do so under 20 indecision. And I have seen and cared for many women 21 who initially had unintended and sometimes unwanted 22 pregnancies. If they encounter barriers and continue 23 through the pregnancy to term, 100% of the time I have seen them love and cherish and value their child at 24 25 the time they deliver.

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

1 What is the earliest a pregnancy can be Q. 2 detected with over-the-counter tests? 3 Over-the-counter urine tests are so sensitive Α. that many times HCG can be detected even before the 4 5 period is missed. So two weeks after fertilization. Four weeks by last menstrual period. 6 7 And that would be almost three months before Ο. abortions would be restricted under the new Florida 8 9 law, correct? 10 That is correct. Α. 11 Are there any options available for women who Ο. 12 seek an abortion during the first trimester? Yes. The traditional procedural is called a 13 Α. 14 suction, a dilation and suction. But increasingly I believe more than 50% of abortions in our country are 15 performed by medical abortion up until 10 weeks 16 gestation. 17 18 What abortion procedures are commonly Ο. 19 performed after 10 weeks? 20 So the dilation and suction continues to Α. 21 occur, but of course we all know the fetus gets 22 bigger, there's more placental tissue, there's more 23 amniotic fluid. At about -- ACOG tells us that around 24 13 to 14 weeks the procedure changes to what's called 25 a dilation and extraction. Essentially, it's a

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

187 1 continuum of the same procedure, but around that gestational age the fetal bones have calcified so he 2 3 cannot be removed through suction alone. He must be removed in a dismemberment procedure. This procedure 4 5 becomes significantly more dangerous for a woman 6 because it is necessary for the abortion provider to introduce instruments blindly multiple times into the 7 uterus to extract the portions of the fetus. 8 It is 9 possible to incompletely extract the tissue. It is 10 possible to leave fetal parts behind, and those parts 11 that are calcified can puncture the uterus. Thev 12 could lead to infection or even infertility if left for too long. And so the procedure becomes more 13 14 difficult as we have to convert to the D&E procedure. 15 And particularly beyond about 15 weeks the literature tells us that it probably triples in the number of 16 17 complications and the risk to maternal mortality. 18 Have you ever performed a dilation and Ο. 19 extraction procedure? 20 Α. I have. The same procedure is used when a 21 woman has a late miscarriage at these gestational

ages. So in that situation when the baby is deceased,
I have performed that procedure.
Are there any differences between performing

Q. Are there any differences between performing
a D&E for a miscarriage versus an abortion?

1 Technically the procedure is the same, but Α. 2 there are some significant differences. When a 3 pregnancy passes away, the body starts to recognize The cervix becomes softer. It's a little easier 4 it. 5 to dilate the cervix to introduce instruments. Ιn 6 addition, the fetus is softer, so it's easier to 7 remove him. Contrast that to a D&E on a living fetus this is a fetus who is going to actively move away 8 9 from the instruments. And of course, he's going to be 10 a firmer. And it's going to be more difficult for the 11 abortion provider to grasp and remove his parts than 12 with a deceased baby.

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?

Like I say it's a little bit of a continuum, 16 Α. but between 13 and 15 weeks. That's when it starts to 17 18 be performed. Essentially, the difference is that the 19 fetus is firm and cannot be suctioned out solely, so 20 he has to be removed in apiece meal fashion. Ι 21 believe that different abortion providers have 22 different comfort levels with how far into a pregnancy 23 that they will do. I believe Dr. Tien said her 24 comfort level was at about 24 weeks. Obviously, the 25 bigger the baby gets the more solid, the more fully

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

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 complications8 can occur from a D&E procedure?

9 Α. Sure. The first problem is that the cervix, 10 which is designed to hold the baby in until full term, when there is 10 to 15 pounds of baby and fluid and 11 12 placenta in the uterus this muscle is very strong. And so in order to enter the muscle to dilate the 13 14 cervix several things must be done. There are osmotic 15 that is water absorbing dilators. There are 16 pharmacologic dilators. We can use mechanical dilators. Each of those if the cervix is resistant 17 18 has the possibility that damage could occur to the 19 Even instruments can be misdirected into the cervix. 20 cervical blood flow or through the back of the uterus. 21 Once inside of the uterus instruments are placed. And 22 again, particularly as you get into the further the 23 more higher gestational ages, the uterine muscle is 24 quite thin at that point so it is easy for an 25 abortionist to accidently puncture through the uterus.

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

190 1 And sometimes this can happen in such a way that it 2 causes a very large tear in the uterus. At that point 3 you have the problem not only of fetal parts being extruded into the abdominal cavity, but you also have 4 5 the potential for abdominal contents to be 6 inadvertently grasped and to be brought into the 7 Things such as bowel, bladder's in the area, uterus. blood vessels. So it's a blind procedure and it does 8 9 have the risk particularly in inexperienced hands or 10 potentially a poor quality abortion provider 11 horrendous complications have happened and I have seen 12 this.

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

1 if they do mandate it there's frequently little 2 oversight and little supervision of those reportings, 3 so I think a lot of times complications are not 4 accurately reported. And I feel that the 5 complications that we see listed in the literature are 6 a vast underestimation.

7 Pensacola is an example of things that can 8 happen when providers are poor quality. There were 9 two complications that were described in the report. 10 One woman was 19 and six weeks along, so further than 11 we would allow an abortion if this legislation were to 12 go into effect. Although she had her abortion at 10 in the morning, she did not leave the abortion 13 14 facility until midnight. During that time it was 15 In fact, documented that she was bleeding heavily. 16 they gave her seven doses of Misoprostol, which is a 17 medication you use to stop bleeding. Clearly, if they 18 had to give her seven doses there was something else 19 going on other than a mild bleed. She spent part of 20 the time unsupervised in the car with her husband. 21 There was very little documentation of vital signs, 22 estimated blood loss. And eventually, the abortionist 23 told the husband to take her across the state border 24 to Alabama for care despite the fact that by Florida 25 law that facility had an agreement with a local

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

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.

8 The second patient a very similar situation. 9 She was 20 weeks and two days. She had an abortion. 10 She was at the clinic being largely unsupervised 11 despite bleeding until midnight. When she left the 12 clinic and went to the nearby hospital, she had 10 units of blood transfusion there. Her blood pressure 13 14 was not detectable at the time that she was admitted 15 to the emergency room, and she required a total 16 abdominal histonectomy and removal of her ovaries from 17 her complications. The provider said that he didn't 18 know that there was a protocol. That's hard for me to 19 believe that any doctor in this country would not know 20 if they had that much of a horrendous complication 21 that they needed to facilitate transfer of that 22 patient immediately to an emergency facility and that 23 they needed to get on the phone and call that facility 24 and let them know what was coming.

So that's the kind of stuff that can happen

25

and does happen in this country. It's been documented 1 2 many times.

3 And both of those examples the provider that Ο. treated the complication was someone other than the 4 5 abortion provider, correct?

6 Α. That is the case and that is frequently the 7 case.

And that was going to be my next question. 8 Ο. 9 Is there any data on how many women seek treatment of 10 their complications from abortion from their abortion 11 provider versus someone else?

12 There is. There is -- for one thing, there Α. is actually a study of abortion providers in Florida 13 14 that documented that only half of them have hospital admitting privileges, so in my cases these doctors 15 16 could not care for a serious complication even if they wanted to. Regarding medical abortion I was involved 17 18 in a study that purchased Medicaid data from 17 states 19 that paid for abortions. And we were able to document 20 that about 5% of women did present to an emergency 21 room within 30 days for complications related to abortion. And of those women, 60% were cared for by 22 23 and received surgery by someone other than the abortion provider. Similarly, FDA data documents 24 25 similar numbers of the women who are actually cared

for for the complications of abortions.

1

Q. Could encouraging women to perform abortions before 15 weeks post LMP decrease maternal mortality rates?

5 Α. I believe that it could. The CDC -- well, 6 similar to abortion complication data I believe that 7 the data related to abortion mortality is underestimated in our country. There are various 8 9 reasons for that. Again, largely because they're 10 often taken care of by someone other than the abortion 11 provider.

12 I was not aware until just a couple of years ago after 30 years of practice that if I as the 13 14 provider did not take the initiative to get on the 15 state department of health website and report a 16 complication I was not aware that there was no system 17 in place to detect that complication. And I think 18 that is the case for many providers. They may care 19 for these complications, but they may have no idea 20 that if they are not the one that reports it that 21 nobody will know about it and that the CDC ultimately 22 will not know about it if it results in a death. It's 23 been documented in various venues that many, many maternal death certificates do not record the 24 25 pregnancy that preceded the death even if the

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

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?

5

6

7 I'm familiar with that study. I think the Α. study compares compromised data. And in fact, it does 8 9 not even have the same denominators, so to me it's not 10 a valid comparison. And again, the CDC data is 11 undercounted. Better studies are obtained in the 12 Scandinavian countries. They have single parent 13 health care. They know every pregnancy event. They 14 know every medical event. And what we see over there 15 unlike the CDC's data is that a woman is six times as 16 likely to die of a suicide in the year following an 17 abortion. She is two to three times as likely to die 18 of any cause following an abortion than if she had 19 carried the child and given birth.

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

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

196 some detail, you can recognize that they're not giving 1 you all the information. The APA statement said that 2 3 there is no evidence that a single elective abortion in an adult woman carries with it mental health 4 5 consequences. But what they left out is the caveats 6 that there are many subgroups of women that we know 7 and the literature is quite clear on this that are at high-risk for mental health complications. 8 That is 9 those that have had multiple abortions and that's 40 10 to 50% of our country. Teenagers that's 20% of the 11 women obtaining abortions. Elective although it's 12 often assumed that everybody who chooses an abortion did not want that pregnancy, data tells us otherwise. 13 14 Many times these are initially desired pregnancies that women have and yet they find themselves in a 15 16 situation either financially or socially where they 17 don't feel they have the support to carry the baby. 18 So that is a woman who wants her baby and yet doesn't 19 feel like she can do it. And many times there is not 20 the support of a man.

21 Second trimester later abortions are 22 well-known to be associated with more mental health 23 consequences, too. So the APA put out a statement 24 that sounds reassuring on the surface, but when we dig 25 deeper we discover that it actually does not include

1

2

3

the vast majority of women who have abortions.

Q. So in your opinion, there are mental health consequences of obtaining an abortion, right?

There certainly can be and I've seen many of 4 Α. 5 them in my 30-year career. What happens with the 6 mental health literature particularly is it's 7 extraordinarily difficult to design a good study. The gold standard for studies in medicine and in research 8 9 in general is what's called a randomized placebo 10 controlled study where you take people and you give one an intervention, give the other no intervention, 11 12 you try to control for as many factors as possible to 13 make them as alike as possible and then you see what 14 the outcomes are. Well, clearly we couldn't do that That would be unethical. And so what 15 with abortion. we see is that there's quite a few studies that 16 17 indicate mental health problems. There's also 18 studies, and I think some of these will be discussed 19 in this room, that seem to indicate no mental health 20 problems, but many times when you look at the study 21 design you see some significant problems.

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

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

1 encompassing probably at least 100,000 abortions, 7,500 women were screened as possible participants. 2 3 About 3,000 were approached. Of the women who were 4 approached even though they were offered money to 5 participate in the surveys of those only a little over 6 1,000 were willing to participate. Of those women who 7 did participate, the vast majority of them dropped out throughout the planned five years. And in fact, at 8 9 the end of the five years only 516 women were 10 participating out of a potential pool of 100,000 11 So I think we can all see intuitively that the women. 12 researchers may have either intentionally or 13 inadvertently chosen women who would be more secure in 14 their abortion decision. And the women might have 15 anticipated that they would have mental health 16 consequences would be the women who would choose not 17 to participate in that study. I think just -- I'm 18 sorry. As a thought experiment we can see that a woman who is a professional woman perhaps in her 30s 19 20 who never desired children perhaps a secular woman 21 might have an unintended pregnancy and have an 22 abortion and not have issues. I mean certainly most 23 women who have abortions don't have issues that we can 24 see externally, but then we can also see perhaps a 25 16-year-old who is a religious young girl who perhaps

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

199 has very poor self-image or poor home life who becomes 1 2 pregnant and initially is excited she's going to get 3 the chance to be a mother. It's what she's always wanted to do. If that young woman is coerced by her 4 5 boyfriend or by her parents into an abortion, I think 6 we can all see intuitively that is someone who may 7 have some mental health problems. So a study that looks very broadly at the population particularly if 8 9 it's not a well-designed study, may not indicate 10 mental health problems. But we see them. I work 11 closely with some crisis pregnancy centers. And one 12 of the things that we see is that many women after their abortions come to us for counseling. And they 13 14 will tell me my abortion caused me to have anxiety, depression, substance abuse, self-harm. 15 And I'm 16 inclined to believe women when they tell me that their abortion caused those things to them. 17

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

206 their baby, but they kept that knowledge hidden from 1 2 their parents or from the boyfriend under the 3 impression that when the information came out that they were pregnant that there would be pressure on 4 5 them to have an abortion. And so a young girl who is 6 in that situation who now is clearly pregnant, in that 7 situation if she is coerced into an abortion after she's felt the baby move, after she's began to bond 8 9 with the baby I mean to me that seems very clear that 10 that could result in mental health complications. So 11 from a mental health perspective, I think limiting 12 abortion at 15 weeks allows plenty of time for women who desire abortion to get one in general, but it does 13 14 not allow nine months of coercion for a woman who is 15 vulnerable to that pressure to be pushed into ending a 16 pregnancy that she desires.

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

1 uterus what's called a uterine curettage can cause 2 damage to the uterus. In a subsequent pregnancy the 3 placenta may attach tenuously because of that damage and it could separate prematurely. That's called a 4 5 placental abruption. That will lead to premature 6 delivery. It can lead to terrible outcomes for the 7 baby, but in addition it can lead to women having hemorrhage and there have been maternal deaths from 8 9 that. The flip side is that sometimes the placenta 10 attaches too strongly. It invades into the uterus or 11 into the cervix or into the bladder. And at the time 12 of delivery it's very, very difficult to separate the placenta and women have died. That's called placenta 13 14 accreta spectrum disorder and women have died from 15 Both of those things are associated with prior that. uterine surgery which does include surgical abortion. 16

17 Additionally, there is compelling data that 18 particularly a later abortion that is dilating that 19 strong cervix that we talked about can damage the 20 cervix. And so then subsequently as the uterus 21 enlarges and the pressure inside increases that can 22 cause a woman to go into preterm labor or sometimes 23 have preterm rupture of membranes. And those are situations that of course can lead to terrible 24 25 outcomes for the babies, but also for the mother. As

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

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.
9 About how much time did you have to prepare your
10 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.

17

25

Q. And would corrections of any of these
drafting errors change the substance of your opinion?
A. No, it would not.

21 MR. FARQUI: May I just have a moment?
22 THE COURT: Sure.
23 MR. FARQUI: I have no additional questions,
24 Your Honor.

THE COURT: Let's go to cross.

203 1 MS. PILLAY: May it please the Court. Shoba Pillay from Jenner & Block for the Plaintiffs. 2 3 THE COURT: Thank you. C R O S S-E X A M I N A T I O N 4 5 BY MS. PILLAY: 6 Q. Good afternoon, Dr. Skop. 7 Hello. Α. You mentioned that you've been an OB and an 8 Ο. 9 MD for approximately 30 years; is that right? 10 Yes, ma'am. Α. 11 Ο. But you've never performed an abortion; is 12 that right? That is correct. 13 Α. 14 You never actually recommended an abortion to Ο. any of your patients; is that right? 15 I have not. 16 Α. And you have no formal training in mental 17 Q. 18 health counseling outside of your time in medical 19 school; is that fair? 20 Α. That is true. My husband's a psychiatrist so 21 I get a little peripherally from him, but no formal 22 training. 23 Q. But you don't consider yourself an expert in mental health; is that fair? 24 25 I would say I'm not an expert in mental Α.

health, but I do think I have expertise based on my 1 30 years of experience of understanding mental health 2 3 concerns for women related to pregnancy issues. You don't consider yourself an expert in 4 Ο. 5 epidemiology; is that right? 6 Α. No. I've read quite about it, but I am 7 certainly nowhere close to an expert. You don't perform intrauterine fetal surgery; 8 Ο. 9 is that right? 10 No. That's correct. Α. 11 Ο. You don't consider yourself an expert in 12 neonatology; is that right? No. That's a pediatrician who does 13 Α. 14 specialized training after residency. 15 And it's fair to say you've never obtained Ο. 16 informed consent from a patient to perform a D&E abortion; is that right? 17 I don't believe that that is correct. 18 Α. Like I 19 mentioned earlier, as a resident even if we didn't 20 perform the abortions we were involved in the pre and 21 the post-abortion care. And we did perform abortions 22 at the hospital, so I believe I probably was involved 23 in care surrounding that which would have included informed consent. 24 25 So that was over 25 years ago? Ο.

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

205 1 That's true. Α. 2 And you mentioned on direct that you are Q. 3 currently employed with the Charlotte Lozier Institute; is that right? 4 5 Yes, ma'am. Α. Q. Since April? 6 7 Α. Yes. As part of your employment it's expected that 8 Ο. 9 you provide expert testimony in furtherance of the 10 Charlotte Lozier Institute's research and the Susan B. 11 Anthony Pro-Life America's policies; is that right? 12 We're an education arm and I am willing to Α. 13 follow the evidence where it goes, so it is not 14 anticipated that I will gear my testimony toward 15 promoting the pro-life desires of Susan B. Anthony 16 List, but in the course of my research and clinical 17 experience I feel very comfortable saying that I do 18 not believe that there are compelling medical reasons 19 that women need abortions. 20 Ο. You've received training from the CLI in 21 furtherance of that expert testimony; is that right? 22 Α. I have received some training about 23 testimony, yes. 24 Ο. And that's most recently in May of 2022? 25 That's correct. Α.

206 1 Providing advice on how to formulate your Q. 2 message? 3 Α. That's true. You've actually previously testified as an 4 Ο. 5 expert either orally or written testimony in multiple 6 other court matters; isn't that right? 7 That is correct. Α. So in about four other cases; does that 8 Q. 9 sounds fair? 10 I believe I've done written testimony Α. 11 probably six or seven. 12 And some of that written testimony is also in Q. state legislatures? 13 14 That's correct. Α. 15 As well as oral testimony? Q. 16 Yes, ma'am. Α. And you're sometimes paid for that work; 17 Ο. 18 isn't that right? 19 I have been in the past, yes. Α. 20 Q. But you're currently not paid for this 21 engagement because you're actually salaried by the 22 Charlotte Lozier Institute because it's expected of 23 you as part of that role among other things to do research, provide education, and to testify in matters 24 25 like this; is that right?

207 1 It is part of my job to do all of that you Α. 2 just mentioned, but the opinions are my own and I feel comfortable with them based on the literature that 3 I've read and all my clinical experience. 4 5 You mentioned I think on direct that you're a Ο. member of the American Association of Pro-Life 6 7 Obstetricians and Gynecologists; is that right? Yes, ma'am. 8 Α. 9 Ο. That's AAPLOG for short? 10 Yes, ma'am. Α. 11 And you have been a member about seven years; Ο. 12 is that fair? That's about right, yes. 13 Α. 14 In fact, you've worked with them to update Ο. their practice bulletins and committee opinions? 15 16 Α. Yes. In furthering a number of opinions that are 17 Ο. 18 now published on their website? 19 Yes. Α. 20 Typically providing pro-life perspective of Q. 21 OB-GYN practices; is that fair? That is correct. 22 Α. 23 Q. In fact, you served on the board of AAPLOG for a couple of years; is that right? 24 25 Yes, I did. Α.

1 You understand and I think you've Ο. 2 acknowledged before that AAPLOG has a bias against abortion; is that fair? 3 Α. 4 Yes. 5 And you even admitted that you yourself have Ο. 6 a bias against abortion in light of your views? 7 Well, morally as a Christian I believe that Α. every human life is made in the image of God and is 8 9 valuable. As an obstetrician I believe that the 10 unborn human is my patient and I should advocate for 11 that patient. But based on my years of experience and 12 research, I have not found any medical reasons that women must have this procedure. I think it is used 13 14 for social indications, but I think it is 15 extraordinarily rare to be used for an actual medical 16 indication. If a woman's life is at risk because of 17 her complicated pregnancy, she can be separated from 18 her baby in a way that is not an abortion. The 19 purpose of an abortion is to end the fetal life. 20 Ο. Dr. Skop, your opinion that testimony you 21 just provided it's actually inconsistent with the 22 findings of number of medical associations; isn't that 23 right? 24 Α. That is correct. Many of the medical 25 associations that I assume you're going to mention

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

209 1 right now have well-documented to have a pro-choice 2 bias. 3 So you consider their positions to be bias; Ο. is that fair? 4 5 Yes. Α. 6 So let's start with American College of Ο. 7 Obstetricians and Gynecologists. The Court has referenced this before as ACOG; is that right? 8 9 Α. That is correct. 10 And it's the largest professional association Ο. 11 of physicians providing women's health care in the 12 country; is that right? They are the largest association of OB-GYNs. 13 Α. 14 I am a member. And just for the record, they actually don't ask their memberships what we feel about their 15 16 abortion advocacy. They have been advocates for abortion since the 1960s. And in fact, studies show 17 18 that only 7 to 14% of OB-GYNs will perform an abortion 19 if requested by their patient. So even though they 20 represent us, they do not represent in my opinion the 21 views of most OB-GYNs --22 Ο. Well --23 Α. -- regarding abortion. 24 Ο. -- represent your view? 25 Well, that is my view. But when you look at Α.

1 the statistic that's only 7 to 14% do abortions, 2 they've never told us they've never asked us what we 3 think about that.

Q. Well, you can't speak for every physician in the country; is that right?

6

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?

10 I do. Interestingly, when it's not related Α. 11 to abortion I think they give pretty good advice. And 12 even related to abortion I think there can be utility 13 in reading what they say. For example, I did 14 reference their second trimester abortion bulletin in 15 my expert witness testimony. But I have to read that 16 in light of what I also know from other sources.

Q. They also publish a journal, isn't that right, what's known as the Green Journal or Obstetrics Gynecology?

20

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?

25 A. Yes.

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

211 But just like ACOG, it's your view that the 1 Q. 2 Green Journal has a pro-abortion ideology and is therefore bias; is that fair? 3 That is what I have noticed. 4 Α. 5 Likewise, the American Medical Association Ο. that's the largest professional association of 6 7 physicians in the country; is that correct? Probably. The case law though it's my 8 Α. 9 understanding that that they now represent only about 10 20% of physicians. 11 Ο. Are you a member? 12 No, I am not. Α. And on non-abortion medical topics, would you 13 Q. 14 consider the AMA general trustworthy? To tell the truth I don't think I reference 15 Α. their material very much. 16 Just ACOG like you believe the AMA is an 17 Ο. 18 abortion advocacy organization? 19 They have become that. Α. 20 Ο. So suffer from the same bias that you 21 perceive in ACOG and in the Green Journal? 22 Α. Based on their recent statements, I think 23 that is obvious. 24 Q. What about the American Psychological 25 Association; you were testifying about that on direct?

1 Do you consider APA to be an abortion advocacy organization and therefore bias? 2

3 Just like ACOG, the APA has had abortion Α. advocacy as a central component of their mission since 4 5 the 1960s. They said at that time that they 6 considered abortion to be a civil right of a pregnant 7 woman, so I think again many of these organizations advocate for abortion for social reasons. But I think 8 9 that's inappropriate, because they should be medical 10 organizations sticking to medicine.

But you've testified that you also have a 11 Ο. 12 personal objection to abortion; is that fair? 13 Yes.

Α.

14 So APA is the largest professional Ο. 15 association of psychologists and it's weighed in on 16 the topic of mental health and abortion, and you had 17 deemed their conclusions untrustworthy because they 18 have a bias; is that accurate?

19 Well, as we discussed a few minutes ago on Α. 20 that APA statement, they made a statement to try to 21 reassure people. But when you dig into the statement, 22 you see that actually it does not refer to most women 23 having abortion. So I think that's just kind of a 24 demonstration of how some of these organizations are 25 falsely trying to reassure the American public and

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850, 222, 5491

1 understanding that most people don't have the 2 knowledge to dig into their statements and understand 3 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?

20 A. Yes, I am.

15

21 THE COURT: Which association?
22 MS. PILLAY: The National Academies of
23 Sciences, Engineering, and Medicine.
24 THE COURT: Okay.
25 MS. PILLAY: And I will refer to it going

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

forward as the National Academy if that's helpful. 1 2 THE COURT: Okay. All right. 3 BY MS. PTLLAY: And we were just talking about a consensus 4 Ο. 5 study that they issued in 2018 entitled The Quality 6 and Safety of Abortion Care in the United States, and 7 it's your opinion that that study is likewise influenced by pro-abortion bias; is that right? 8 9 Α. When you look at the funding sources, you 10 will see that all of the funders are organizations 11 that have been known for abortion advocacy. 12 So just like CLI is funded by SBA which is a Ο. 13 pro-life organization, that's a similar concept? 14 Α. Yes. So in fact, you believe the National 15 Ο. 16 Academies cherry picked data to reach a conclusion that would promote abortion; isn't that fair? 17 18 For some of the topics that they looked at, Α. 19 they looked at between 3 and 5 studies. When in fact 20 for these particular topics that I'm thinking of, 21 preterm birth, breast cancer, and mental health 22 issues, there were between 75 and 160 peer-reviewed 23 studies available many of which showed positive 24 correlation. So I think that what they did is that 25 they set their standards and their restrictions in

such a way that they were able to find just a few studies that showed what they would like them to say.

1

2

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 13 14 complications reporting in our country, many times 15 they have studies that show that supposedly show low 16 levels of complications. And I would say that they 17 are not picking up all the complications, and that's 18 why they are showing such low numbers. In the study 19 that I was involved in where we bought the data from 20 17 states that paid for Medicaid abortions, we 21 actually did a very similar study to what Upadhyay did 22 and we found significantly higher abortion related 23 complications.

Q. So all of these medical associations, theNational Academies they're all these large

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

1 organizations they do not have correct data and are 2 biased according to you, Dr. Skop, am I getting that 3 right?

Well, let me just say this because they have 4 Α. 5 gone on the record as feeling that abortion is a 6 social good, so I think they have that motivation. 7 And in the United States we have very, very poor quality data regarding complications because we do not 8 9 mandate reporting, and so we are vastly 10 underestimating complications. When we can do records 11 linkage studies we discover consistently far more 12 complications than we do than when we just randomly look at emergency room data. 13

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 morespecifics.

18

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?

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

1 Well, I have skepticism of the CDC's death Α. certificate data because it's been proven in a number 2 3 of articles unrelated to abortion even and unrelated to the whole political issue of abortion that death 4 5 certificate data across the board is poor.

6 And you've actually not noted a lot of the Ο. 7 DCD data is actually utilized in that National Academies report that we were talking about, The 8 9 Safety of Abortion; isn't that right?

10

Α.

I believe they do reference some CDC data. 11 Ο. And you take the position I believe that a 12 lot of these authors of studies that come out of that 13 National Academies report are also hiding data or 14 limiting data based on their knowledge for their bias 15 for pro-abortion like Dr. Grimes you've mentioned that 16 before; is that right?

What I said in terms of Dr. Grimes he was the 17 Α. 18 head of the CDC Abortion Surveillance Division, and he 19 if I can see as an outside observer how limited the 20 data is I would have assumed that he also would see 21 that and yet he published a study comparing data with 22 two different denominators alleging that abortion was 23 14 times safer than child birth. And it wasn't even 24 comparing apples and oranges. It was different 25 denominators. And I don't have time to go into it

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850, 222, 5491

1 all, but there were so many methodological problems 2 with that data collection that I just wonder what was 3 his, you know, one has to ask what was the point of 4 publishing when you knew the data was so poor.

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?

9

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?

14 That is based on the data that the CDC has Α. 15 collected passively from death certificates. I think 16 that if our country cared to know the real answers, we 17 would mandate reporting of complications, we would 18 mandate reporting of all pregnancy events, so that we 19 can have clear and consistent data with which to work. 20 Q. But, dr. Skop, the CDC doesn't just passively 21 collect data, I mean you've seen the reports that the 22 CDC says we also search LexisNexis for information, we

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

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

reported in the studies, so it's not passive?

2 Well, they do say they have a couple of Α. 3 additional ways of getting information. It's not clear because it's not reported how many additional 4 5 deaths they pick up that way. As we discussed in the 6 deposition, one way they could find more complications 7 in deaths would be to do a public search of medical malpractice claims. And a researcher did that and he 8 9 as able to document in a given year that based only on 10 medical malpractice claims he found 30% more deaths 11 than the CDC had documented. So I think that if they 12 really had a strong desire to get every death, I think there are additional things that they could be doing. 13

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?

20

25

1

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 significantselection bias.

Q. Would you agree though that in the medical

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

1 community including the American Psychiatric
2 Association that you mentioned earlier it is widely
3 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.

And you mentioned you were troubled by the 8 Q. 9 attrition rate. So this Turnaway Study employed a 10 Longitudinal Perspective Cohort Study and they interviewed all of these 1,000 women that were 11 included from 30 abortion facilities in 21 states 12 every six months over five years and there was a 5% 13 14 attrition rate every year over that time in the various waves, and it's your testimony that that's 15 16 really high and therefore invalid, it invalidates the 17 data, that attrition rate is so high it invalidates 18 That's what I believe you testified on the data. 19 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

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

221 can recognize that because we do know that sometimes 1 2 women do feel immediate relief in the week after their 3 abortion and I think that they one of the studies 4 indicated that there was more anxiety in the women who 5 had not receive the abortion, but what they actually 6 do tell us is that over the five-year time period 7 women are pretty equivalent on the real health 8 outcomes at the end of the five years. It should be 9 noted that there has never ever been a study that 10 showed improvement in mental health after an abortion. 11 So the best the studies can show us is that it didn't 12 hurt the woman potentially. But you know when it was 13 the companion case to Roe v. Wade, Doe v. Bolton was 14 all about allowing abortion for mental health reasons for the health of the woman so. 15 Dr. Skop. 16 Ο. Go ahead. 17 Α. 18 You mentioned that people you've talked to. Ο. 19 You didn't participate in the Turnaway Study; isn't 20 that right? 21 Α. No. 22 And you actually haven't engaged if your own Ο.

23 mental health study per se? In other words, you 24 haven't engaged in any kind of study to analyze the 25 mental health impact of abortion; is that fair?

1 I have not been a researcher in a study like Α. 2 that. I'm working on getting some stuff together, but 3 I do have 30 years of clinical experience talking to women who tell me that they have suffered from their 4 abortion and I trust them. 5 6 So speaking of your patients, you've Ο. 7 mentioned that on direct that an over-the-counter pregnancy test can detect even before a woman misses 8 9 her period. Did I get that correct? 10 That is true. They are that sensitive. Α. 11 Ο. So how would the woman know to go get that 12 pregnancy test? Well, I mean many women that are seeking 13 Α. 14 pregnancy are excited to find out as early as they can 15 so. 16 So we're just talking about the women that Ο. 17 are actually trying to get pregnant? 18 Α. Right. 19 The rest of the women you're not suggesting Ο. 20 they should go every week now to make sure early --21 That's not the point. The point is by the Α. 22 time she misses a period it's readily it's easily 23 provable that she's pregnant. I'd like to turn now to some of the 24 0. 25 literature we were talking about earlier. You had

223 1 mentioned we were talking about ACOG. Is it fair to 2 say that ACOG has weighed in on second trimester 3 abortions in a practice bulletin? Yes, they have. 4 Α. 5 And they have determined that D&E abortions Ο. 6 are safe and effective; is that right? ACOG has never submitted any sort of 7 Α. testimony in favor of any restriction on abortion. 8 9 And surely with all the restrictions that are out 10 there, there are some that can improve safety for 11 women. So I think the fact that they're promoting 12 second trimester abortion is just consistent with their idealogy. 13 14 You testified that there are a lot of risk of Ο. 15 complications as a result of abortion; is that right? 16 Yes, ma'am. Α. 17 So while hemorrhage is a potential Ο. 18 complication, ACOG concludes that serious hemorrhage 19 occurs in less than 1% of D&E abortions; is that 20 right? 21 Α. They did report that in their 2013 practice 22 bulletin. There was actually a recent study out of 23 University of California at San Francisco where they 24 were looking at using a medication called Methergine 25 after an abortion to decrease blood loss. And

224 interestingly they didn't find an improvement with the 1 2 medication, but what they did document was that 50% of 3 the women obtaining D&Es at the San Francisco Hospital with experienced clinicians met their criteria for 4 5 excessive hemorrhage 50%, 1 out of 2. 6 Q. What's the name of that report? 7 I believe the author was Kerns, K-E-R-N-S. Α. Is that report cited in your declaration? 8 Q. 9 It is not. I just found it recently. Α. 10 You also mentioned and we were talking about Ο. 11 the National Academies. The National Academies is 12 also concluded in that Safety of Abortion paper that the evidence clearly shows again that D&E abortions 13 14 are safe and effective and you reject that again in 15 light of your concerns of the National Academies's 16 bias; is that right?

17 Not so much the bias, although there may be a Α. 18 component of that. But just the flaws in our data 19 collection, so that we are undoubtedly underreporting. 20 But even the CDC's data tells us that when we go from the 13 to 15 week D&E to the 16 to 20 week D&E that 21 22 there is about triple the complications. And, in 23 fact, Bartlett and Berg in their CDC study tell us that there is a 38% increase in the risk of maternal 24 25 mortality for every week past eight weeks that a

1 termination is performed. In the early second trimester, there is a 15-fold increase in maternal 2 3 mortality. In the mid-second trimester which is the 4 gestational age that we're discussing related to this 5 legislation, there is a 30-fold increase in maternal 6 mortality. And after viability after approximately 7 21 weeks, there is a 76-fold increase in maternal 8 mortality and death from a D&E procedure. Again, I'm 9 not saying every provider does dangerous D&Es. But 10 I'm just saying since we do not supervise abortion providers very well in this country, the providers 11 12 like whoever was in Pensacola at that clinic are 13 hurting women. And there is a smattering of news 14 releases or news reports around the country, New 15 Mexico, Maryland. There are late-term abortion 16 providers who do not provide good care and they are 17 hurting women.

18 Q. And the Bartlett and Berg study that you cite 19 that's from 2004, right?

20

A. It is an old study, yes.

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?

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

226 1 That is true that it's an older study. Α. Ι 2 think what's helpful about that study is to show that 3 as the gestational age increases the risk increases sometimes in an expediential way. I think that's the 4 5 key take-home point. I'm not saying that I 6 necessarily feel that the CDC numbers reported at that 7 time or even now accurately reflect the deaths, but the increase that we see I think is probably an 8 9 accurate reflection of how much more dangerous they 10 get as the pregnancy increases. So the accurate reflection from 20 years ago? 11 Ο. 12 Well, I mean just the you know again 20 years Α. ago a 20-week fetus was the same size that a 20-week 13 14 20 years ago the uterus had the same fetus is now.

degree of thin muscle that it has know. 15 So even 16 though there'd been some small changes in the 17 procedure notably cervical ripening agents that make 18 it a little easier to get into the uterus, the 19 procedure itself has not changed significantly so that 20 we would expect a 20-week D&E to be so much more safe 21 than it was 20 years ago because it's essentially the 22 same procedure.

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 --

1

2

3

4

Q. Yes or no question at this point, Dr. Skop? A. If we collected accurate data, we would probably see that.

5 MS. PILLAY: Nothing further, Your Honor. THE COURT: Doctor, a couple things. 6 Ιs 7 there data that you're familiar with, if this is 8 not part of your testimony let me know, but is 9 there data that you are aware of that compares mortality and morbidity of full term where the 10 11 woman carries full term versus abortion in the 12 first 15 weeks? Are they compared in mortality 13 and morbidity?

14 THE WITNESS: Well, the CDC again they're 15 data reflects what comes to their attention, which I think is probably not complete. We can look at 16 17 the record linkage studies that I mentioned in 18 Finland and Denmark and other countries and actually see the likelihood that a woman dies 19 20 within a year of her pregnancy outcome, and we see 21 the exact opposite of what the CDC tells us that 22 she's much more likely to die after an abortion 23 procedure. And that's several things. That's 24 both the physical risk, but it's also mental 25 health risk which we have no way of detecting

either.

1

2

3

4

5

6

25

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.

7 THE WITNESS: Right now they are reporting higher numbers after a term pregnancy, but there's 8 9 been a lot in the literature independent of 10 abortion. The CDC in 2016 some researchers at 11 University of Maryland told us that you know what 12 we have not the United States didn't even release 13 a maternal mortality statistic for about 15 years 14 because they knew the data was so bad. And I 15 don't think we've corrected all those data 16 problems yet. It's on everybody's radar screen, 17 but even in regards to a term pregnancy we're 18 missing a lot. 50% is the number that several 19 studies have shown, but we miss 50% of the deaths 20 even in a term pregnancy.

21 THE COURT: In a delivery on a term 22 pregnancy, there are doctors that commit 23 malpractice in those also just like they do in 24 abortions, right?

THE WITNESS: Well, certainly it can happen,

yes, but I think that hospitals have committees in place monitoring physician quality.

1

2

3

4

5

6

7

8

9

10

22

25

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?

11 THE WITNESS: Yes, I mean certainly medical 12 malpractice can occur, but I think when it occurs related to a term pregnancy it's almost certain 13 14 going to become a medical practice case. But I 15 would say that because of the stigma and the 16 embarrassment of abortion, many times when that 17 medical practice occurs the woman or her family do 18 not sue.

19THE COURT: Breech delivery, mishandling20breech delivery is another common potential21negligence area.

THE WITNESS: It can happen.

23THE COURT: Okay. I think that's all I have,24so thank you.

THE WITNESS: Thank you.

236 THE COURT: Does anyone else have anyone more 1 2 questions? 3 MR. FARQUI: No redirect, Your Honor. MS. PILLAY: No, Your Honor. 4 5 Thank you very much and good luck THE COURT: on your I assume it's a flight back. 6 7 So are we done except for a rebuttal witness and then I have to read two depositions and then 8 9 we have -- frankly, I think I'd like to read the declarations again before we do closing arguments. 10 11 You all could put them in context. So how long is 12 the rebuttal witness going to take? MS. SANDMAN: I anticipate about 20 minutes, 13 14 Your Honor. 15 THE COURT: Including cross? I'll try to be brief, Your Honor. 16 MR. GUARD: So here's what I think. 17 THE COURT: Whether 18 we do the rebuttal witness today or not and I can go after 5 if we can do the rebuttal witness in 20 19 20 to 30 minutes, but I need time to read these 21 things, these things, the exhibits, the 22 depositions and to consider what I've heard. Ι 23 want to take a look at the Florida Supreme Court 24 cases again and then I want to consider your closing arguments. And I just don't think I can 25

231 do it justice by doing that tomorrow. 1 I think I 2 need to do that Thursday and I think I need to do 3 this live and in court. Now, that doesn't mean --4 I mean obviously the press has a right to be here 5 and is invited to be here. And I understand that creates a certain amount of inconvenience, but I 6 7 want to do the best I can do before this case if 8 it does go someplace else I want to do my job the 9 best I can do. Probably half the people will agree with me and half will disagree with me in 10 11 this courtroom regardless of what I finally 12 determine. But since I've not read these 13 depositions and I want to read these declarations 14 again, I just don't think I can do it justice 15 until Thursday. I think we can have closing 16 argument Thursday. I can then consider what 17 you've said and then give you a verbal ruling. 18 Can I give verbal ruling that you can put down exactly in writing, no, but I can cover the areas 19 20 that you have covered in the case and rule that 21 way. So Dr. Tien if she needs for her convenience 22 to have her testimony heard today I'd be glad to 23 hear that, but at that point I think I'd like to 24 reconvene on Thursday. You want to call Dr. Tien? 25 I would appreciate that if MS. SANDMAN:

232 1 that's possible, Your Honor. 2 THE COURT: Sure. 3 MR. GUARD: Your Honor, the State rests. 4 THE COURT: All right. Thank you. 5 (State rests.) THE COURT: Dr. Tien, can we just have her 6 7 still be under oath from this morning. Dr. Tien, you're still under oath. If you'll have a seat. 8 9 We're not so rushed that anybody has to talk fast. MS. SANDMAN: I'll try to suppress the New 10 11 Yorker in me. 12 THE COURT: All right. Thank you. You may 13 proceed. 14 DIRECT EXAMINATION BY MS. SANDMAN: 15 Dr. Tien, are abortion facilities in Florida 16 Ο. required to be licensed? 17 18 Α. Yes. 19 Are they inspected by a Florida State agency Ο. to maintain that licensure? 20 21 Α. Yes. 22 Do you know how often those inspections Ο. 23 happen? 24 Α. I don't. I know that they happen. I know 25 that care coordination occurs with our chief operating

officer.

1

5

9

25

Q. And do you know whether Florida State law imposes a requirement to report abortion complications to the State?

A. Yes.

6 Q. And if Florida had a concern that an abortion 7 facility was providing unsafe services, could they 8 revoke its license?

A. Yes.

10 Q. Dr. Tien, when you became credentialed as an 11 abortion provider at Planned Parenthood Southeast and 12 North Florida, what did you have to do to become 13 credentialed?

14 Aside from interviews with the chief medical Α. 15 officer, interviews with the chief operating officer, 16 I had to submit proof of my training, my expertise, 17 procedures I have performed in other settings. I also 18 had to undergo additional educational training 19 specific to the clinic in regards to HIPAA, OSHEA, and 20 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

234 professional experience is that process of tracking 1 2 complication rates and credentialing process before 3 providing services, is that typical of the way that abortion providers are typically credentialed? 4 5 Yes, absolutely. Α. 6 If an abortion provider had an excessive Ο. 7 number of credentials, do you know whether the State of Florida could revoke their medical license? 8 9 Α. Yes. 10 And is that true for physicians other than Ο. 11 abortion providers as well? 12 Yes, absolutely. Α. Is there anything that's different about how 13 Q. 14 issues of quality and care are handled in the context of abortion than other areas of medicine? 15 16 Α. No. 17 You've heard some testimony today about the Ο. 18 American Family Planning Clinic; are you familiar with 19 the reports of what happened there? 20 Α. I heard initially what happened through media 21 reports. Prior to the media reports I was not aware of that clinic's existence. 22 23 Ο. And since that time have you become broad strokes familiar with the claims? 24 25 Yes. Α.

235 And if those allegations are true, are they 1 Q. 2 typical of the way that abortion care is provided? 3 Α. No. Do you have any idea how often serious 4 Ο. 5 complications occur such as what happened to the 6 patients at issue in those charges? Extremely rarely, less than .5% both 7 Α. documented in the literature and in my clinical 8 9 experience. 10 To be clear, the less than .5% statistic that Ο. you're giving that's a general statistic for 11 12 complications, right? 13 Α. Correct. 14 Not for the specific series of events that Ο. are claimed to have happened at that clinic? 15 16 Α. That's correct. 17 Doctor, the State thinks that a subpar or Ο. 18 dangerous provider sort of that one occurrence 19 supports their idea of a ban on abortion after 20 15 weeks. In your view, is that a basis to ban 21 abortions? 22 No. I'm not familiar with this clinic. Α. Ι 23 don't know who works there. Clearly some very dangerous things occurred and clearly the State 24 25 detected it as that clinic was shut down.

236 1 Doctor, I'd like to ask you some general Q. 2 questions about abortion procedures, the way that 3 they're performed in this country in modern medicine. What are the basic types of procedures that can be 4 5 used after 15 weeks for in clinic abortion? 6 After 15 weeks an in clinic suction procedure Δ 7 is most commonly done. Every abortion procedure after 8 15 weeks requires some amount of preparing or dilating 9 the cervix, suction to empty the uterus, and later in 10 pregnancy it may require additional instruments to 11 enter the uterus. 12 Would you normally use forceps at 15 weeks? Q. I do not. 13 Α. 14 You heard Dr. Skop's testimony about what she Ο. 15 considers to be the dangers of a D&E procedure. Did anything in that testimony change your opinion on 16 17 abortion safety? 18 No, it did not. Α. 19 And why not? Ο. 20 Α. The dangers described are absolutely real 21 complications that can occur when caring for a 22 pregnant woman. And in discussing informed consent 23 and the procedure that is absolutely part of the 24 discussion. The expectation as a physician is that if 25 you are offering these procedures you have a

1 tremendous and stellar level of expertise prior to 2 doing so as is the case for any area of medicine. So 3 it does not change my opinion because that is part of the informed consent process. It is something that 4 5 should only be offered by appropriately trained 6 physicians. And overall abortion complications are 7 very, very low. Is a D&E procedure a dangerous procedure? 8 Ο. 9 Α. No. Does it have a high complication rate just to 10 Ο. 11 be clear? 12 No, it does not. Α. Now, you also heard Dr. Skop's testimony that 13 Q. 14 abortion complication rates are I believe she said 15 vastly underreported. Do you agree with that 16 testimony? 17 No, I do not. Α. 18 Why not? Ο. 19 In every state that I have provided abortion Α. 20 care and also in the context of providing pregnancy 21 care, there has been a requirement for reporting of 22 complications. And specifically in the hospital 23 setting, every pregnancy-related event is reported, recorded, and evaluated. 24 25 How does that reporting obligation compare to Ο.

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

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.

6 Q. I'm sorry. Could you clarify other 7 nonmedical areas?

1

2

3

4

5

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.

14 Q. Dr. Tien, how do you open the cervix to 15 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?

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

1 A. No, I do not.

2

Q. And why not?

3 It is understood that in the provision of a Α. safe abortion procedure the cervix needs to be gently 4 5 dilated, so it is done so. And so that it is done via 6 medication or mechanical dilators, or for a patient 7 who's farther in pregnancy and requires more cervical 8 dilation with dilators that are placed overnight to 9 slowly absorb the moisture of the cervix and open the 10 cervix.

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?

22

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?

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

240 1 Α. No. 2 You heard Dr. Skop's testimony that placental Q. 3 abruption occurs as a result of sharp curettage. How 4 common is sharp curettage in contemporary provision of abortion care? 5 It is never performed. 6 Α. 7 You also heard Dr. Skop's testimony that the Ο. CDC does an inadequate job of evaluating whether a 8 9 death is related to abortion; do you agree? 10 Α. I do not. 11 And why not? Ο. 12 The CDC has scientists and epidemiologists Α. 13 who are trained specifically to evaluate complications 14 and look for root cause of death. 15 And in doing that does the CDC, and I'm doing Ο. my best to quote from Dr. Skop's testimony, just 16 17 report the data that comes to it? Is that how the CDC 18 data collection process functions? 19 The CDC is quite proactive, so the data Α. No. 20 sources are multiple. They can be submitted by the 21 state. They can be submitted by multiple maternal 22 morbidity review committees, which are state and local 23 committees convening looking at maternal mortality and 24 safety. And they can also be proactive evaluating 25 additional patient surveillance and patient surveys.

1 As a result of those multiple processes in Q. 2 your expert opinion, how would you evaluate the 3 quality of the CDC data in this area? I feel that it is excellent. 4 Α. 5 You also heard Dr. Skop's testimony that the Ο. 6 CDC data comparing abortion-related deaths to deaths 7 from pregnancy and childbirth makes an inaccurate comparison because the numerators and denominators are 8 9 inconsistent; do you agree with that criticisms? 10 Α. I do not agree. 11 Ο. And why not? 12 Α. The data looking at abortion mortality looks at abortion mortality per legal induced abortion 13 14 The data looking at maternal mortality procedures. looks at maternal mortality for women who have 15 16 continued pregnancies against 100,000 live births. So 17 those denominators are comparable and appropriate for 18 the numerators. 19 Dr. Tien, can you explain what is ACOG Q. 20 briefly? 21 ACOG is the American College of Obstetricians Α. 22 and Gynecologists. It is the largest educational and 23 women's health professional association in this 24 country specific for OB-GYNs. When I last looked, 25 there is over 58,000 members of

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

obstetrician-gynecologist. They are responsible for 1 reviewing the literature and publishing guidelines on 2 education and clinical guidance both for clinicians 3 and also for patients. 4 5 Would you consider ACOG to biased in Ο. connection with abortion? 6 7 Α. No. It doesn't have a conflict of interest? 8 Q. 9 Α. It does not. 10 Is there any serious debate on that topic in Ο. 11 mainstream medicine? 12 Α. No. What is the Royal College of Obstetrics and 13 Q. 14 Gynecology? It is a comparable association in the United 15 Α. 16 Kingdom. I won't ask you to describe it in more 17 Ο. 18 detail, but would you consider it to be a biased 19 organization? 20 Α. No. 21 And the Society for Maternal-Fetal Medicine? Ο. 22 The Society for Maternal-Fetal Medicine is Α. 23 the leading organization for professionals who provide care for high-risk pregnancies such as myself. 24 25 And within your field what degree of weight Ο.

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

1 are conclusions from the Society for Maternal-Fetal
2 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 of9 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.

16 Q. What kind of weight are their conclusions 17 afforded?

18

22

3

4

A. Tremendous.

19 Q. And in mainstream medicine are any of those 20 organizations we've been discussing understood to be 21 biased organizations?

A. No.

23 MR. PERCIVAL: Your Honor, objection. Scope. 24 The doctor did not submit a declaration on any of 25 these testimony that she's given and she did not

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

243

1	244 disclose it in her deposition that I took.
2	THE COURT: Sustained.
3	BY MS. SANDMAN:
4	Q. Dr. Tien, does the morning-after pill cause
5	abortions?
6	A. It does not. The primary function of the
7	morning after pill is similar to taking a large dose
8	of birth control pills. It prevents ovulation. It
9	can in some circumstances prevent a fertilized egg
10	from implanting, but the most common mechanism is that
11	it prevents ovulation or release of the egg from the
12	ovary.
13	Q. Do IUDs cause abortions?
14	A. No.
15	Q. Do birth control pills cause abortions?
16	A. No.
17	Q. Is there any dispute on this in mainstream
18	medicine for any of those items?
19	A. No.
20	Q. I'm going to turn now to the testimony that
21	you've heard from Dr. Condic in connection with fetal
22	pain. First, Dr. Tien, is knowledge of fetal
23	development important to your work as an MFM?
24	A. Yes.
25	Q. Can you explain how?

245 1 A lot of what I do for maternal-fetal Α. 2 medicine is care for pregnant women. And that also 3 includes performing their ultrasounds at different stages of pregnancy as well as performing what we in 4 5 medicine call fetal testing, so ultrasounds to ensure 6 that the baby is healthy and developing well or fetal 7 testing which is monitoring of the fetal heart readout on the monitor. So in all of these settings, I need 8 9 to be able to discuss with patients what I am seeing 10 on ultrasound during their prenatal care and also on 11 fetal testing. 12 If a fetus could feel pain, would that be Q. relevant to any clinical decisions that you're 13 14 involved in in your role as an MFM? If a fetus could feel pain, because I as an 15 Α. 16 MFM care for high-risk pregnant women, it would be a 17 part of every discussion. However because it cannot, 18 it is not a part of my discussion with my patients. 19 And, Dr. Tien, just to be clear, what is your Ο. 20 opinion on whether a fetus at 15 weeks can feel pain 21 in utero? 22 Α. A fetus at 15 weeks cannot feel pain in 23 utero. 24 Ο. And how do you know that? 25 I know that it has been alluded to that the Α.

246 perception of pain requires several factors. 1 Ιt 2 requires the establishment of building blocks for 3 pathways to interpret the pain from the external 4 environment, carry the signals through the spinal cord 5 into multiple portions of the brain including the 6 thalamus and the cortex, so there needs to be an 7 establishment of the building blocks or the basic circuitry. In addition, there needs to be a higher 8 9 level of cortical processing recognition and awareness 10 of pain.

11

Q. And when are those pathways formed?

12 The early absorption of environmental stimuli Α. 13 is present very early in pregnancy from 8 to 15 weeks. 14 The beginnings of the pathways up through the spinal 15 cord to the brain are present between 20 to 22 weeks. And when I say weeks, I speak by gestational age by 16 17 LMP as I'm clinician and not an embryologist. So the 18 basic fundamental building blocks are in place by 24 19 to 26 weeks, but the higher level cortical processing 20 recognition and awareness is not in place until later 21 in pregnancy in the third trimester.

Q. Dr. Tien, what is intrauterine surgery? Canyou explain for the Court?

A. Intrauterine surgery is a procedure performedon a fetus on a pregnant woman.

1 What are the types of situations where the Ο. 2 need for intrauterine surgery would arise? 3 Sometimes during a routine ultrasound there Α. can be a lesion or birth defect that is detected. 4 А 5 good example is neural tube defect where the spine is 6 And in certain select scenarios the patient can open. 7 be offered in utero fetal surgery to help optimize the outcomes for that pregnancy and that baby. 8 9 Ο. Is intrauterine surgery an area that you studied as part of your MFM training? 10 11 Α. Yes. 12 Q. Are MFMs involved in the care team providing surgeries in utero? 13 14 MFMs are integral to the care team. Α. Tell the Court about how that care team 15 Ο. functions and what the MFM --16 17 MR. GUARD: Again, Your Honor, we've wandered 18 way outside the scope of any testimony that's been 19 disclosed in the declaration or that was testified 20 to in her deposition that I took three days ago. 21 Your Honor, she disclosed --MS. SANDMAND: 22 THE COURT: I think she's -- go ahead. 23 MS. SANDMAND: I apologize, Your Honor. 24 THE COURT: I think this is a proper area of 25 rebuttal testimony. She's an MFM. I'm saying all

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

247

248 these acronyms. She's an MFM. And yes, Counsel. 1 But, Your Honor, we had a 2 MR. GUARD: 3 procedure where they were supposed to disclose the expert testimony and this was not disclosed. 4 Ι 5 inquired in a deposition about the kinds of 6 testimony she was going to offer as rebuttal and 7 she did not disclose this testimony. So I'm impeded in my cross-examination because it was not 8 9 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.

17 THE COURT: Overruled. I think this is 18 related to the issue of fetal pain because there 19 was testimony that in fetal surgery there is 20 anesthesia given to the fetus, so I think it's 21 related to the fetal pain. Go ahead. 22 BY MS. SANDMAN:

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?

1

2 Α. So the MFM is usually the one making the 3 diagnosis of the fetal structural defect usually on ultrasound. So in making that diagnosis in that 4 5 setting the MFM is the one that counsels the patient 6 on the finding, counsels them on the options, and 7 counsels them on the care moving forward. The MFM is responsible for care coordination including 8 9 neonatology, making sure that the delivery occurs at a 10 hospital that has a tertiary level of care to be able 11 to care for a neonate with such anatomic concern as 12 well as whatever necessary pediatric subspecialists are required as well as an anesthesia team that is 13 14 familiar with obstetric anesthesia in particular. 15 Dr. Tien, just to make sure that we're all Ο. 16 straight in terms what is anesthesia? Anesthesia is a general term that covers a 17 Α. 18 broad area of medications that can be used to sedate a 19 patient, treat pain, cause amnesia, or also relieve 20 anxiety. It's a broad term for medication. 21 Ο. What is analgesia? Analgesia is a board term for medication used 22 Α. 23 to treat pain. 24 Ο. Do you know if anesthesia or analgesia are 25 ever used for fetal pain in the setting of fetal

surgery?

1

4

A. They are used in the setting of in utero3 surgery not for fetal pain.

Q. What are they used for?

5 So there are four very important things that Α. 6 need to be considered to make these very delicate 7 surgeries successful. I'm going to use the example of spina bifida or open neural tube defect. So a woman 8 9 is in the operating room, an OB usually MFM makes the 10 initial incision to open the skin and then open the 11 The baby is then delivered to the level of uterus. 12 the anatomic defect of concern. The surgeon repairs The fetus is returned into the uterus 13 that defect. 14 and the uterus is then closed. The hope then of 15 course is that the woman remains pregnant for many, 16 many more weeks. So you can imagine there are lots of 17 things that need to be balanced carefully for the best 18 So analgesia and anesthesia has four outcome. 19 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.

1

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 8 9 physiological response. So not to treat fetal pain, 10 but to blunt physiological response. Anytime we are exposed to something in the environment we have a 11 12 Heart rate changes, our blood pressure response. 13 changes. It does not necessarily mean that we are 14 perceiving pain, but that we have a response. And 15 what we don't want to happen for one of the 16 physiological responses is what's called fetal 17 bradycardia where the heart rate drops. If that 18 happens that can also prompt a premature delivery and 19 that is not what we want.

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

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

251

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.

11

12

Q. Say more about that.

If the focus was treating fetal pain then we 13 Α. 14 would be treating the fetus like we do an adult who needs pain medicine, so giving pain medicine by pills, 15 16 starting an IV and giving pain medicine through the IV, injecting pain medicine into the muscle. Pain 17 18 control can include a spinal, which is numbing 19 medicine in the back or an epidural that's used during 20 labor. So we would be acting on the fetus directly to 21 administer pain control.

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.

253 1 Q. On a slightly different topic, if the care 2 team is doing a procedure on the fetus that does not 3 require an incision in the uterus, so a different type of procedure, no incision, in that type of procedure 4 5 is anesthesia or analgesia required? 6 Α. No. 7 Is there a medical consensus that anesthesia Ο. and analgesia are not required for that type of 8 9 procedure? 10 Α. Yes. 11 Ο. Despite the fact that certain interventions 12 are being done in the fetus? That is correct. 13 Α. 14 At what gestational ages have you been Ο. involved in intrauterine surgeries? 15 16 It depends on the lesion of concern, but most Α. commonly this is later in the second trimester. 17 18 So later than the time that we're talking Ο. 19 about with the 15-week abortion ban for example? 20 Α. Yes. 21 Just a few more questions in this area. You Ο. 22 heard Dr. Condic testify that a cortex in her view is 23 not necessary for a fetus to feel pain; is that 24 accurate? 25 Yes. Α.

1	Q. Let me ask it a different way. Do you agree
2	with the statement that it's not necessary for the
3	fetus to have a cortex in order to feel pain?
4	A. I do not agree.
5	Q. Why is that?
6	A. I think there is good scientific literature
7	that is based on histopathological studies, so studies
8	of tissues, studies evaluated in the laboratory
9	setting establishing our fundamental understanding of
10	pain pathways.
11	Q. Is there a controversy in mainstream medicine
12	as to whether a fetus at 24 weeks in utero can feel
12	pain?
13	A. No.
15	Q. Are there medical associations that have
16	given analysis on this question?
17	A. Yes.
18	Q. Are you familiar with the Society for
19	Maternal-Fetal Medicine report on the use of analgesia
20	and anesthesia for maternal-fetal procedures?
21	A. Yes.
22	Q. Did that come out in 2021?
23	A. Yes.
24	Q. And what did it conclude in regard to fetal
25	pain?

255 1 It had three general conclusions based on Α. The first is that 2 their review of the literature. 3 paralytics can be used in fetal procedures if needed to decrease fetal movement to help with the success of 4 5 a procedure. 6 The second conclusion was that analgesia and 7 anesthesia may be used in in utero fetal procedures for the reasons that I just stated. 8 9 And the third was that due to lack of good 10 data they recommended against the use of analgesia for 11 the purpose of any concerns for fetal pain in the 12 setting of pregnancy termination. And did it include a conclusion that the 13 Ο. 14 connections to the cortex prior to 24 weeks are not 15 present -- excuse me -- prior to the late second or early third trimester? 16 17 Α. Yes. 18 And do you agree with that conclusion? Ο. 19 Α. Yes. 20 Q. Are you familiar with Royal College's fetal 21 awareness review of research and recommendation for 22 practice from 2010? 23 Α. Yes. 24 Ο. What weight would you give its conclusions? 25 I would give it tremendous weight. Α.

Q. And do you know what it concluded with regard to fetal pain? A. A very, very similar conclusion that the

4 basic fundamental building blocks for pain are not 5 present until after 24 weeks and the higher level 6 cortical processing recognition and interpretation is 7 not present until much later in the third trimester. 8 Q. Are you familiar with the ACOG gestational 9 development and capacity for pain statement?

A. Yes.

10

11

25

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?

19 A. No.

20 Q. My last question, Dr. Tien, is there anything 21 else that you would want the Court to understand about 22 fetal pain?

23 MR. GUARD: Objection. Calls for a 24 narrative.

THE COURT: Sustained.

BY MS. SANDMAN:

1

2 Dr. Tien, is there anything from your Q. 3 perspective as a maternal-fetal medicine doctor, do you have any additional views on fetal pain? 4 5 MR. GUARD: Objection. Calls for a narrative. 6 7 THE COURT: I think I know where she is on 8 this topic. Sustained. 9 MS. SANDMAN: I'll pass the witness. 10 THE COURT: Okay. Cross. 11 MR. GUARD: Yes, Your Honor. CROSS-EXAMINATION 12 BY MR. GUARD: 13 14 I apologize, Dr. Tien, since you did not Ο. disclose that you were going to testify on some of 15 16 this information I don't actually have hardcopies of 17 documents. Doctor, you talked about a few minutes ago 18 the Society for Maternal-Fetal Medicine's report on 19 the use of analgesia and anesthesia for maternal-fetal 20 procedures? 21 Yes. Α. 22 And that was based largely on a paper whose Q. 23 primary author was a Dr. Chatterjee; are you familiar 24 with Dr. Chatterjee's paper? 25 That consult series was based on several Α.

studies.

1

4

8

17

Q. But one of the studies that it was primarilybased 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.

9 It also said because it remains uncertain Ο. exactly when a fetus has the capacity to feel pain, it 10 11 is best to administer adequate fetal anesthesia in all 12 invasive maternal-fetal procedures to inhibit the 13 humoral -- I said that wrong -- stress response, 14 decrease fetal movement, and blunt any perception of 15 pain as has been the standard practice since the start 16 of maternal-fetal surgery in the early 1980s, correct?

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 --

15

25

16 MR. GUARD: I'll withdraw. THE COURT: 17 Okay. Thank you. BY MR. GUARD: 18 19 You are not a neurologist, right? Q. 20 Α. I'm not a neurologist. 21 You are not an embryologist, right? Ο. 22 I'm not an embryologist. Α. 23 Ο. You're a doctor who spends 70% of her time 24 providing abortion services, right?

A. As part of my expertise in obstetrics,

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

259

gynecology and maternal-fetal medicine a large part of 1 2 that is a provision of abortion services. 3 MR. GUARD: Your Honor, would you instruct the witness to answer the question. 4 5 THE COURT: I think she just answered it. Ι mean you haven't asked her anything she hasn't 6 7 answered already a couple times today. BY MR. GUARD: 8 9 You've not done any research on fetal pain Ο. yourself, correct? 10 11 Α. Correct. 12 And you've never been part of a fetal pain Q. 13 study, right? 14 That is correct. Α. And you're not a university professor, 15 Ο. 16 correct? That is correct. 17 Α. 18 And you've never been a university professor, Ο. 19 right? 20 That is correct. Α. 21 On your direct testimony you made a whole Ο. 22 bunch of statements and testified about being a 23 Florida medical doctor; do you recall that? 24 Α. Yes, I am a physician who works in Florida. 25 Your experience as a doctor in Florida is Ο.

261 1 extremely limited, right? 2 Α. Can you clarify limited? 3 Well, you've been a licensed doctor in Ο. Florida for 19 months, right? 4 So I've had an active medical license in 5 Α. 6 Florida for 19 months, but I've been caring for 7 pregnant women for many more years than that. You've actually been a practicing doctor in 8 Q. 9 Florida for 15 months, right? 10 THE COURT: How long have your witnesses been 11 licensed in Florida and practiced in Florida, 12 Counsel? 13 MR. GUARD: I did not have them testify about 14 being a Florida doctor. 15 THE COURT: I know. We're getting into the 16 weeds here. She's a licensed doctor in Florida. 17 You've got one who's a professor. You've got one 18 who is a practicing physician for 30 years. Each 19 has their differences. I've listened to all of 20 it. 21 MR. GUARD: All right. Your Honor, I'll move 22 on. 23 THE COURT: Okay. 24 BY MR. GUARD: 25 You've only performed abortions in Florida Ο.

262 1 for one provider, right? 2 Α. Yes. And almost all of those abortions have been 3 Ο. performed at a single location in Jacksonville, 4 Florida, correct? 5 6 Α. Yes. 7 Before you became an expert or while you were 0. an expert in this case or before, you didn't speak to 8 9 any other providers in any other part of Florida as 10 part of your getting ready to be an expert, right? 11 Α. Correct. 12 And you're not familiar with any clinics Q. other than how Planned Parenthood Southeast and North 13 14 Florida performs abortions, right? 15 Not in Florida. Α. 16 All right. Now, you made some statements Ο. 17 about ACOG. Have you ever been to ACOG's website? 18 Α. Yes. 19 On its website doesn't it have advocacy Q. 20 papers and even letters for doctors to sign advocating 21 against abortion restrictions? 22 Α. There is an area for advocacy, yes. 23 Ο. So ACOG does have as part of its mission to 24 advocate for abortion against abortion restrictions, 25 right?

263 1 As part of its mission for patient advocacy Α. 2 ACOG advocates for patient health based on the science. Abortion is one of those issues. It's not 3 the only one. 4 5 I'm just going to move on. I don't think Ο. that really answers the question but. 6 7 THE COURT: I thought it did. MR. GUARD: Okay. Well, I respectfully 8 9 disagree with that. If I could just have a 10 minute. 11 THE COURT: Sure. 12 MR. GUARD: Nothing further, Your Honor. THE COURT: Any redirect? 13 14 MS. SANDMAN: No, Your Honor. 15 THE COURT: Thank you, Doctor. You can step 16 down. 17 I have Dr. Skop's transcript. Dr. Biggs. 18 The only thing I didn't have was a corrected copy 19 of Dr. Biggs's deposition, so I'm going to borrow 20 that from the Clerk. I have all the declarations 21 already in the file. I'm going to take home 22 Exhibit 8 and give the Clerk back the rest of the 23 exhibits. 24 MR. GUARD: Your Honor, most of those 25 depositions were also notices of filing on the

docket, so if you have trouble.

1

2 THE COURT: I can look them up. All right. 3 I'll do that. Do you all want to start at 8:30 on Thursday morning instead of 9:00? I've got a 4 5 couple of hearings around 10 or so. MR. GUARD: Yes, Your Honor. 6 7 THE COURT: So Thursday at 8:30. Same place. Same courtroom. 8 9 MS. SANDMAN: Your Honor, for the record, I'll rest our rebuttal case. 10 11 (Plaintiffs rest.) THE COURT: Okay. Thank you. Thursday at 12 8:30, Courtroom 3G. Okay. Anything else before 13 14 we qo? 15 MR. GUARD: No, Your Honor. THE COURT: I'm aware that July 1st is on 16 17 Friday, but all I can do is what I can do. So I'm 18 going to be honest with you when I hear closing argument and if I make a ruling on Thursday, I 19 20 don't think it's going to be reduced in writing by 21 Friday because I'm going to give whoever is not 22 the prevailing party 24 hours to review. I would 23 just say the thing we can do to make it fastest is 24 both sides, you may already have done this, both 25 sides be working on orders which can easily be

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

264

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.

1

2

3

4

5

6

7

8

9

10

11

12

13

14

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.

15 THE COURT: Okay. See this is difficult 16 because I don't know what my email address is. 17 I'll tell you the way that you can contact me is 18 she's going to love that I do this, but Paula 19 Watkins at Court Administration. She doesn't know 20 I've just given her name out. And Court 21 Administration, the Clerk can tell you how to get 22 through them. And if I had a little bit more 23 time, I'd go down and get my email address. But I 24 never email myself. And usually I think I know 25 what it is, but I'm not exactly sure I do know

FOR THE RECORD REPORTING TALLAHASSEE FLORIDA 850.222.5491

265

1	what it is. I will have it by Th	ursday	for	sure.	266
2	We can go off the record. Let's	go off	the		
3	record.				
4	(Hearing concluded at 5:30 p	.m.)			
5					
6					
7	,				
8					
9					
10					
11					
12					
13					
14					
15					
16	;				
17	,				
18					
19					
20					
21					
22					
23					
24					
25					

1	CERTIFICATE OF REPORTER 267
2	
3	STATE OF FLORIDA)
4	COUNTY OF LEON)
5	
6	I, Doreen M. Mannino, Court Reporter, do hereby
7	certify that I was authorized to and did report in
8	stenotypy and electronically the foregoing proceedings
9	and evidence and the captioned case, and that the
10	foregoing pages constitute a true and correct
11	transcription of my recording thereof.
12	IN WITNESS WHEREOF, I have hereunto affixed my
13	hand the 4^{th} day of July 2022 at Tallahassee, Leon
14	County, Florida.
15	
16	
17	
18	
19	
20	Doreen M. Mannino
21	Doreen M. Mannino
22	
23	
24	
25	

EXHIBIT C

PLANNED PARENTHOOD ASSOCIATION OF UTAH

VS

MINER

INGRID SKOP, M.D.

September 02, 2020



333 South Rio Grande Salt Lake City, Utah 84101 www.DepoMaxMerit.com Toll Free 800-337-6629 Phone 801-328-1188 Fax 801-328-1189 DI ANNED PARENTHOOD ASSOCIATION OF UTAH VS MINER

September 02, 2020	Ingrid Skop, M.D.
	1
IN THE UNITED STAT	'ES DISTRICT COURT
FOR THE DISTRICT OF UT	AH, 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

Kri	lstin	Marchant	-	
Registered	Profe	essional	Reporter	-

September 02, 2020

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

Ingrid Skop, M.D.

· ·	· · · · ·		~			4
			2			4
1	A P 1	PEARANCES		1	I N D E X (Cont.)	
2	Den the Disintiff			2		
3	For the Plaintiff:	Julie Murray PLANNED PARENTHOOD FEDERATIO	N	3	EXHIBITS	PAGE
4		OF AMERICA	514	4		-
		1110 Vermont Avenue, NW				
5		Suite 300		5	No. 9 Practice Bulletin - Second-Trimester	181
		Washington, DC 20005		6	Abortion	
6		Leah Farrell		7		
		AMERICAN CIVIL LIBERTIES UN	ION	8	No. 10 AAPLOG Fact Sheet - Fetal Pain	234
8		OF UTAH FOUNDATION, INC.				
		355 North 300 West		9		
9		Salt Lake City, Utah 84103		10	No. 11 Comparison of Excerpts	238
10	For the Defendants:	Lance Sorenson		11		
11	For the berendants:	ASSISTANT ATTORNEYS GENERAL		12	No. 12 Practice Bulletin - Fetal Pain	238
		OFFICE		13		
12		160 East 300 South			No. 10 UM-dical Blanchiana Mat Discriptions No.	3 045
		Sixth Floor		14	No. 13 "Medical Abortions: What Physicians New	ed 245
13 14		Salt Lake City, Utah 84111		15	to Know"	
14		Darcy Goddard OFFICE OF THE SALT LAKE		16		
15		COUNTY DISTRICT ATTORNEY		17	No. 14 Expert Report of Dr. Byron C. Calhoun	246
		35 East 500 South		18		
16		Salt Lake City, Utah 84111				
17				19	No. 15 Any Woman Can printout of website	268
18	Also present:	Genevieve B. Delapena		20		
19		* * *		21	No. 16 The Source - printout of website	273
20				22		
21		I N D E X		23		
22						
23 24	EXAMINATION		PAGE	24		
25	By Ms. Murray		5	25		
			3			5
1	I	N D E X (Cont.)		1	PROCEEDINGS	
2				2		
					INGRID SKOP, M.D.,	
3	EXHIBITS		PAGE	3	called as a witness, being duly sworn, was examin	ed and
4				4	testified as follows:	
5	No. 1 Curriculum V	Vitae - Dr. Skop	29	5	EXAMINATION	
6				6	BY MS. MURRAY:	
7	No. 2 Expert Repo	rt of Dr. Skop	98	7	Q. Well, good morning, Dr. Skop. I know	No mot
				-		
8				8	right before we went on the record, but so we h	
9	No. 3 Contraceptio	on article - "Who has second-	110	9	straight on the record, my name is Julie Murray	. I
10	trimester al	bortions in the United States?"		10	represent the plaintiff in this case, Planned Par	enthood
11				11	of Utah.	
12					UI UTATI.	
	No. 4 Public Healt	th Indicator Based Information	157	1		
		th Indicator Based Information	157	12	Can you state your full name for the	
13	No. 4 Public Healt System	th Indicator Based Information	157	12 13	Can you state your full name for the record?	
13 14	System			12 13 14	 Can you state your full name for the record? A. Ingrid Fansteel Skop. 	
13	System	th Indicator Based Information ns' Guide to Medical and	157 170	12 13	 Can you state your full name for the record? A. Ingrid Fansteel Skop. 	
13 14	System	ns' Guide to Medical and		12 13 14	 Can you state your full name for the record? A. Ingrid Fansteel Skop. Q. Okay. And you'll be advised by 	
13 14 15	System No. 5 "A Clinician	ns' Guide to Medical and		12 13 14 15 16	 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? 	
13 14 15 16 17	System No. 5 "A Clinician Surgical Abo	ns' Guide to Medical and ortion"	170	12 13 14 15 16 17	 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. 	tion
13 14 15 16 17 18	System No. 5 "A Clinician Surgical Abo No. 6 "Abortion-Re	ns' Guide to Medical and ortion" elated Mortality in the		 12 13 14 15 16 17 18 	 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 deposite 	tion
13 14 15 16 17 18 19	System No. 5 "A Clinician Surgical Abo	ns' Guide to Medical and ortion" elated Mortality in the	170	 12 13 14 15 16 17 18 19 	 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? 	tion
13 14 15 16 17 18	System No. 5 "A Clinician Surgical Abo No. 6 "Abortion-Re	ns' Guide to Medical and ortion" elated Mortality in the	170	 12 13 14 15 16 17 18 	 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? 	tion
13 14 15 16 17 18 19	System No. 5 "A Clinician Surgical Abo No. 6 "Abortion-Re United State	ns' Guide to Medical and ortion" elated Mortality in the	170	 12 13 14 15 16 17 18 19 	 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. 	tion
13 14 15 16 17 18 19 20	System No. 5 "A Clinician Surgical Abo No. 6 "Abortion-Ro United State No. 7 "Risk Factor	ns' Guide to Medical and ortion" elated Mortality in the es"	170 172	 12 13 14 15 16 17 18 19 20 21 	 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? 	tion
13 14 15 16 17 18 19 20 21 22	System No. 5 "A Clinician Surgical Abo No. 6 "Abortion-Ro United State No. 7 "Risk Factor	ns' Guide to Medical and ortion" elated Mortality in the es" rs for Legal Induced Abortion-	170 172	 12 13 14 15 16 17 18 19 20 21 22 	 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. 	
13 14 15 16 17 18 19 20 21 22 23	System No. 5 "A Clinician Surgical Abo No. 6 "Abortion-Re United State No. 7 "Risk Factor Related Mort	ns' Guide to Medical and ortion" elated Mortality in the es" rs for Legal Induced Abortion- tality in the United States"	170 172 172	 12 13 14 15 16 17 18 19 20 21 22 23 	 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 	
13 14 15 16 17 18 19 20 21 22 23 24	System No. 5 "A Clinician Surgical Abo No. 6 "Abortion-Re United State No. 7 "Risk Factor Related Mort	ns' Guide to Medical and ortion" elated Mortality in the es" rs for Legal Induced Abortion-	170 172	 12 13 14 15 16 17 18 19 20 21 22 23 24 	 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? A. Yes, I have. Q. Okay. How many times? A. I believe two or three. Q. Okay. What were the cases where you your deposition taken? 	
13 14 15 16 17 18 19 20 21 22 23	System No. 5 "A Clinician Surgical Abo No. 6 "Abortion-Re United State No. 7 "Risk Factor Related Mort	ns' Guide to Medical and ortion" elated Mortality in the es" rs for Legal Induced Abortion- tality in the United States"	170 172 172	 12 13 14 15 16 17 18 19 20 21 22 23 	 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? A. Yes, I have. Q. Okay. How many times? A. I believe two or three. Q. Okay. What were the cases where you your deposition taken? 	

September 02, 2020

	tember 02, 2020		Ingrid Skop, M.D.
	6		8
1	malpractice case and the other is as an expert witness in	1	A. A little.
2	a medical malpractice case.	2	Q. A little bit. Some of it has been a while.
3	Q. What so the case that you were a	3	But just so that we're all on the same page today, I want
	defendant, do you recall the name of that case?	4	to go over some ground rules for today's deposition.
4		5	First, you understand that you're testifying
5	A. To tell you the truth, I don't.	6	
6	Q. What did it involve; what kind of procedure	7	under oath today and that your answers are subject to the
7	or care?		penalties of perjury?
8	A. It was after a delivery where the baby had	8	A. Yes.
9	some problems.	9	Q. And do you understand that this is the
10	Q. What kind of problems?	10	same the oath that you took this morning is the same
11	A. He had seizures.	11	oath that you would take in court if you were testifying
12	Q. Okay. And then was that in Texas, I	12	at trial?
13	assume?	13	A. Yes.
14	A. It was in Texas it was about 24 years	14	Q. Do you understand that today I'll ask
15	ago.	15	questions, you'll provide answers, and the court reporter
16	Q. Okay. So it's been a while.	16	will take down the questions and answers verbatim and put
17	A. Yes.	17	them in a written transcript?
18	Q. What about the other case you mentioned	18	A. Yes.
19	where you had been a expert witness?	19	Q. Okay. So we're interested in finding out
20	A. It was also in Texas, probably about two	20	everything you know and think about the opinions that you
21	years ago, and it was a surgical complication.	21	intend to offer as an expert witness in this case. So we
22	Q. Okay.	22	want your answers to be as complete and accurate as
23	 I was the expert witness for the defense. 	23	possible. Is that fair?
24	Q. Okay. Was that in your report? I don't	24	A. Yes.
25	recall seeing that one. So two years ago for the	25	Q. Okay. So it is my job to ask understandable
	7		9
1	7 defense. And what kind of complication was that, again?	1	questions. If at some point during the day I ask a
1 2		1 2	questions. If at some point during the day I ask a question and you don't understand it, which is probably
	defense. And what kind of complication was that, again?		questions. If at some point during the day I ask a
2	defense. And what kind of complication was that, again? I'm sorry.	2	questions. If at some point during the day I ask a question and you don't understand it, which is probably
2 3	defense. And what kind of complication was that, again?I'm sorry.A. It was a woman who had a hysterectomy and	2 3	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
2 3 4	defense. And what kind of complication was that, again?I'm sorry.A. It was a woman who had a hysterectomy andshe had a bladder injury afterwards that required surgery	2 3 4	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
2 3 4 5	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.	2 3 4 5	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
2 3 4 5 6	 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 	2 3 4 5 6	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.
2 3 4 5 6 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 	2 3 4 5 6 7	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?
2 3 4 5 6 7 8	 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. 	2 3 4 5 6 7 8	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.
2 3 4 5 6 7 8 9	 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 	2 3 4 5 6 7 8 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
2 3 4 5 6 7 8 9 10	 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 	2 3 4 5 6 7 8 9 10	 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
2 3 4 5 6 7 8 9 10 11	 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. 	2 3 4 5 6 7 8 9 10 11	 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
2 3 4 5 6 7 8 9 10 11 12	 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 	2 3 4 5 6 7 8 9 10 11 12	 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
2 3 4 5 6 7 8 9 10 11 12 13	 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 	2 3 4 5 6 7 8 9 10 11 12 13	 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
2 3 4 5 6 7 8 9 10 11 12 13 14	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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, 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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.
 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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. Q. Okay. So let's talk about breaks. I'll
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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
 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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;
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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
 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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

September 02, 2020

Ingrid Skop, M.D. 10 12 1 one thing I would ask, however, is that if there is a 1 circumstances. It may have been because I have some 2 question pending at the time you would like to take a 2 friends who also do expert witness -- on cases like this. 3 break that you provide an answer to that question before 3 Q. So would it be accurate to say that you 4 we break. Okay? 4 first learned about the case and the opportunity to be an 5 A. Okay. 5 expert from someone other than Mr. Sorenson? 6 6 Q. So sometimes it happens during a deposition A. That is possible. I don't recall who 7 7 that you'll remember later in the day that there are reached out to me first, if it was Mr. Sorenson or things that you forgot to say or documents that you 8 8 someone else. 9 Q. Are there any documents that might refresh 9 remembered that might help refresh your recollection to 10 10 your recollection in that respect: emails, letters? respond to one of my questions. If that happens, will 11 you let me know? 11 A. Possibly. 12 A. Yes. 12 Q. Do you have any sense of who else might have 13 Q. Okay. It may be that we have some of the 13 contacted you to provide an opportunity to act as an 14 documents, and I can send them along. Certainly, if 14 expert in this case? 15 there is anything you want to get corrected on the record 15 A. I don't remember who contacted me, no. 16 today as we go along, just flag that. 16 Q. Okay. What have you done to prepare for 17 So because we're doing this deposition 17 this deposition? 18 remotely, the judge has put in place special rules for 18 A. I have reread the -- many of the articles 19 conducting a remote deposition. Did Mr. Sorenson share 19 that I cited in my expert witness report. 20 with you the judge's order about remote depositions? 20 Q. Anything else? 21 A. Yes, he did. 21 A. I think I've looked on the internet a little 22 Q. Okay. So you understand that today during 22 bit to find out about abortion in Utah. 23 the deposition, you're barred from using notes or any 23 Q. And what would you -- what did you read on 24 other materials that I have not provided to you? 24 the internet? 25 A. Yes. 25 A. I looked at the information through 11 13 Q. Okay. And do you understand that under the 1 1 Guttmacher. 2 court's order you're also barred from having any 2 Q. Anything else that you looked at online to 3 communication with anyone other than Mr. Sorenson via 3 prepare for the deposition? chat, text, or any other way of communication? 4 4 A. I don't think so. 5 A. Yes. 5 Q. Okay. And you said you reviewed articles 6 Q. Do you agree to comply with those rules, 6 that you cited in your expert report, correct? 7 Dr. Skop? 7 A. Yes. Q. Had you read all of those articles 8 A. Yes. 8 9 Q. So because it is critical that we get your 9 previously? 10 full and accurate answers today, I have to ask, is there 10 A. Yes. any reason why you would be unable to provide full and 11 11 Q. Okay. Did you review anything else in 12 accurate answers in response to my questions today? 12 preparation for today's deposition? 13 A. No. 13 A. Possibly some other articles that I have not 14 Q. Okay. All right. So in the Notice of 14 cited. 15 Deposition, we had asked for some documents from you, and 15 Q. And what might those articles be? 16 I appreciate you sending along some of your articles and 16 Other articles related to the topic abortion A. 17 materials. Is there anything else in response to that 17 complications, some articles about the reasons that women request that you brought with you to share today? 18 18 choose abortions late in pregnancy. 19 A. No. 19 Q. Do you have the authors of those articles or 20 Q. All right. So let's talk a little bit about 20 any information that might help identify them? 21 how you came to serve as an expert in this case. Can you 21 A. The reasons -- there are a couple of -- or 22 tell me when you first learned that you might be an 22 researchers associated with Guttmacher that do a lot of 23 expert in this case? 23 publishing on that: Finer, Foster, Jones. So I've looked 24 A. I believe it was probably last fall that --24 at several articles from that group of researchers. 25 I don't recall exactly who I heard from or the 25 Q. Uh-huh. And would say -- you mentioned

Ingrid Skop, M.D.

14 14 16 2 Foster. Would that have been Dana Greene Foster? 1 A. Yes. 0. Yes. All right. Well, we'll reflect let 3 0. Would that have been an article with resport 1 the record reflect that the witness has apparently had access to the whiths of - how many hours would you say, Dr. Skop? 2 A. Yes. 1 5 A. I have locked at some of the Tumaway studies; do you real? 4. I have locked at some of the Tumaway studies; do you real? 5 A. I cleaned them, locked through them and saw 7 0. But you're not sure if it is what you locked at with resport to a some of the Tumaway studies; do you real? 7 A. I cleaned them, locked through them and saw 8 at with resport to reasons for articles with resport of Byron Calhoun. Was that 10 9 9 9 specifically. 10 0. Okay. All right. So you said that you had 11 12 you may have looked at some other articles with resport of Byron Calhoun. Was that 10 10 0. Okay. All right. So you said that you had 13 mortality, rakes. I believe theores 11 6 So thawer the spect report of Byron Calhoun. Was that 10 14 A. No, 1 had never seen it before. I just 11 11 11 15 There's probably				ingha enop, inib.
2 A. Yes. 2 Q. Yes. All right. Well, well reflect left 3 Q. Would that have been an article with respect 3 the rescord reflect that the witness has apparently had 4 to findings from the Turnaway studies; do you recail? 4 access to the axhibits for - how many hours would you 5 A. I have looked at some of the Turnaway 5 access to the axhibits for - how many hours would you 5 at with respect to reasons for abortion? 6 A. I posed them, looked through them and saw 6 A. It is likely, but I don't recail 9 reviewed So I haven thealy been looking at throug Jours and that you had 10 as don't may have looked at some other articles with respect 10 Q. Okay. All right. You you asid that you had 12 you may have looked at some other articles. with respect 12 just last light, or had you reviewed that before 12 you may have looked at some other articles. with respect 12 just last light, or had you reviewed hat before 13 those inm yreferences. blaw end to char final d, and 1 16 A. No, I had never seen it before. I just 14 those inm yreferences. blaw end to ther finith studies. 2 Q. What about popoly over vereweed in 15		14		16
3 O. Would that have been an article with respect to findings from the Turnaway studies; do you recail? 3 the record reflect that the witness has apapently had access to the sublits for how many hours would you say, Dr. Skop? 6 tabiles, yes. A. It have looked at some of the Turnaway at with respect to reasons for abortion? A. It opened them, looked through them and saw that most of them were things that had provideed to you. 8 at with respect to reasons for abortion? A. It opened them, looked at hom you things that had provideed to you. 9 A. It is likely, but i don't recail you may have looked at some other articles with respect to complication rates. What might those have been? O. Okay. All right. So you said that you had 11 O. And what about complication rates? You said I you service with about complication rates? I you service with about the earcer is one ther articles out of infinand, and I 11 thake do a kid of research on materials, and I Is a reserve ther the references. I access to both was the first time that you had ever 11 there's probably about five articles at the finah researchers I proparation for today's deposition? A. No. 12 There's probably about five articles that tak about I proparation for today's deposition? A. No. 12 Q. Okay. So other Finish tsudies. I proparation for today's depos	1	Foster. Would that have been Diana Greene Foster?	1	A. Yes.
4 to findings from the Turnaway studies; do you recail? 4 access to the exhibits for - how many hours would you 5 A. I have looked at some of the Turnaway 5 say, Dr. Skop? 7 A. But you're not sure if it is what you looked 7 A. I opened them, looked through them and saw 7 A. But you're not sure if it is what you looked 7 A. I opened them, looked through them and saw 8 A. It is likely, but idon't recail 7 So I haven't really been tooking at them, I just 9 A. It is likely, but idon't recail 7 So I haven't really been tooking at them, I just 11 Quart way have looked at some other articles with respect 10 O. Okay, All right. So you said that you had 12 you may have looked at some other articles with respect 13 I sear some very informative articles not realizes. Theile the some some other articles. Theile with articles. Theile with a strop treports A. No, I had new's ean It before. I just 16 are some very informative articles and colleagues. A. Yas. Q. Okay. So ther have bearches? 17 think I may have lookaby documented at least one of 14 A. Yas. Q. Okay. So ther have bearches? 11 quoted in t	2	A. Yes.	2	Q. Yes. All right. Well, we'll reflect let
5 A. Thave looked at some of the Turnaway 5 say, Dr. Skop? 6 Studies, yes. A. Lopened them, looked through them and saw 7 A. But you're not sure if it is what you looked The times of them were things that I had provided to you. 8 at with respect to reasons for abortion? So I haven't really been looking at them. I just 10 specifically. O. Okay, All right. So you said that you had 11 Q. And what about complication rates. What might those have been? I yus and have not other articles. There 11 are some very informative articles out of Finand, and I I coexist articles out of Finand, and I 12 There's probably documented at least one of I So that was the first time that you had ever 13 those in my references, but – Gisler and colleagues. B. A. Yes. 14 there inthe references already. G. Okay. Arything else that you 've reviewed in preparation for today's deposition? 14 preparation for today's deposition? A. No. 15 A. I believe that's it. So May was the first time that you seque with a saw were not have seen is Byon Calhous. 16 Q. Kay. So other Finish studies. C. A. No. 17 think intereferences already. So may was t	3	Q. Would that have been an article with respect	3	the record reflect that the witness has apparently had
is studies, yes. 6 A. Topened them, looked through them and saw 7 Q. But you're not sure if it is why tou looked at with respect to reasons for abortion? So I haven't really been looking at them. I just 9 A. It is likely, but id on't recall 9 Feriod Science 11 Q. And what about complication rates? You said 10 Q. Okay. All right. So you said that you had 12 you may have looked at some other articles. Wher expent 12 just ast night, or had you reviewed that before 13 to complication rates. What might those have been? 14 A. No. I had never seen it before. I just 14 a raise do a lot of research on maternal 14 There's probably documented at least one off 16 mortality, so there have been some other acticles. There specifies 18 A. Yes. 17 There's probably about five articles schere specifies 18 A. Yes. 18 hover in the references already. 20 Q. Okay. So other Finish researchers 20 21 I quoted in the references already. 21 21 Proparation for today's deposition? 23 A. No, have not. 25 Mary other documents that you reviewed in preparation for today's deposition?	4	to findings from the Turnaway studies; do you recall?	4	access to the exhibits for how many hours would you
7 Q. but you're not sure if it is what you looked 7 that most of them were things that Indeprovided to you. 8 at with respect to reasons for abortion? 8 So I haven't really been looking at them, I just 0 9 A. It is likely, but I don't recall 9 10 specifically. 0. Okay. All right. So you said that you had 11 ocomplication rates. What might those have been? 14 12 you may have looked at some other articles. With respect 13 13 to complication rates. What might those have been? 14 A. No. I had never seen it before. I just 14 A. I also do a lot of research on maternal 14 A. No. I had never seen it before. I just 15 mortally, so ther have been some other articles. There 16 Q. So that was the first time that you had ever 16 these in my references, but - Gissler and colleagues. 18 A. Ves. 11 quoted the references already. 20 Okay. Anything else that you 've reviewed in 12 nortality rates. I believe the other Finish researchers 20 Q. What about people you've talked to in 21 any othe documents that you reviewed in 21 preparation for today's deposition?	5	A. I have looked at some of the Turnaway	5	say, Dr. Skop?
s at with respect to reasons for abortion? s So I haven't really been looking at them, I just 9 A. It is likely, but I don't recall specifically. 0. Okay. All right. So you said that you had 11 Q. And what about complication rates? You said 11 reviewed the expert report of Byron Calhoun. Was that 12 you may have looked at some other articles. With reside ween traced of the expert report of Byron Calhoun. Was that 12 13 reviewed the expert report of Byron Calhoun. Was that 12 14 A. I also do a lot of research on matemal 14 16 are some very informative articles with reside. 13 16 are some very informative articles that talk about 19 17 those in my references, but Gissler and colleagues. 18 A. Yes. 19 There's probably about five articles that talk about 19 G. Okay. Anything else that you've reviewed in 19 mortality trates. I believe the obre Finish researchers 21 A. No. 2 Q. What about people you've talked to in 27 Q. Okay. So other Finish studies. 22 Q. What about people you've talked to in 27 28 A. I believe that's it. 10 A. No.	6	studies, yes.	6	A. I opened them, looked through them and saw
9 A. It is likely, but I don't recall 9 reviewed.the export report of Byron Calhoun. Was that 10 specifically. 0 Q. Okay. All right. So you said that you had 11 or provided the export report of Byron Calhoun. Was that just last night, or had you reviewed the export report of Byron Calhoun. Was that 11 or proteins A. A dwhat about complication rates? You said if we weed the export report of Byron Calhoun. Was that 12 you may have looked at some other articles. There 13 complication rates. What might hose have been some other articles. There 13 those in my references, but – Gisser and colleagues. 14 A. No. I had never seen it before. I just 14 There's probably documented at least one of 17 seen that export report? 15 There's probably documented at least one of 17 seen that export report? 16 those in my references, but – Gisser and colleagues. 19 or Okay. So other Finish researchers 11 uptoted in the references already. 20 Q. What about people you've talked to in 27 A. No, Iawe not. 21 A. No. 28 A. No, Iawe not. 21 A. No. 29 review any of the other expor	7	Q. But you're not sure if it is what you looked	7	that most of them were things that I had provided to you.
10 specifically. 10 0. Okay. All right. So you said that you had 11 0. And what about complication rates? You said 11 reviewed the expert report of Byron Calhoun. Was that 13 to complication rates. What might those have been? 13 you may have looked at some other articles with respect 13 yesterday? 14 A. I also do a lot of research on matemal 14 A. No. Ihad never seen it before. I just 15 mortality, so there have been some other articles. There 15 received the packet yesterday. 16 are some very informative articles that talk about 19 A. No. Ihad never seen ithe toyor treport? 16 those in my references, but – Gissier and colleagues. 18 A. Yes. 17 There's probably about five articles that talk about 19 O. Okay. So other hinis hresearchers 12 quoted in the references already. 21 A. No. 22 21 Quotay. So dyou – just to confirm, did you 22 A. No. Ihave not. 23 23 A. No. Ihave not. 34 A. No. Ihave not. 34 24 preparation for today's deposition? 44 A. No. Ihave not. 34 24<	8	at with respect to reasons for abortion?	8	So I haven't really been looking at them, I just
11 Q. And what about complication rates? You said 11 reviewed the expert report of Byron Calhoun. Was that 12 you may have looked at some other articles with respect 12 just last night, or had your reviewed that before 14 A. Lake do a lot of research on maternal 14 A. No, I had never seen it before. I just 15 mortality, so there have been some other articles. There 14 A. No, I had never seen it before. I just 16 more some very informative articles out of Finland, and I 15 A. No, I had never seen it before. I just 17 think I may have probably documented at least one of 17 Seen that expert report? A. Yes. 19 There's probably about five articles that tak about 19 Q. Okay. So other Finish researchers 20 21 Q. Okay. So other Finish studies. 22 Q. Okay. So other finish studies. 23 23 A. Yes. 15 A. No. 24 anyone about today's deposition? 24 Q. Okay. Did you just to confirm, did you 12 A. No. 24 approaches to responding in depositions? 3 In thic case since you subitted your expert report? 1 A. No. 25 A. Wel. I spoke with Mr. Sorenson.	9	A. It is likely, but I don't recall	9	reviewed
12 you may have looked at some other articles with respect 13 iust last night, or had you reviewed that before 13 13 to complication rates. What might those have been? 14 14 A. I also do a lot of research on maternal 14 15 mortality, so there have been some other articles. There 15 16 are some very informative articles out of Finland, and 1 16 A. No. I had never seen it before. 1 just received the packet yesterday. 16 think in wy have probably about five articles that talk about 17 seen that expart report? 17 There's probably about five articles that talk about 19 Q. Okay. Anything else that you verelewed in preparation for today's deposition? 12 Iquoted in the references already. 21 A. No. 21 Iquoted in the references already. 22 Q. Okay. So other Finish studies. 23 23 A. y other documents that you reviewed in preparation for today's deposition? 24 Preparation for today's deposition? 24 Q. Okay. Did you – just to confirm, did you 1 A. No. 2 25 A. No, Ihave not. 3 approaches to responding in deposition? 3 35 In thic scase since you submitted your expe	10	specifically.	10	Q. Okay. All right. So you said that you had
13 to complication rates. What might those have been? 13 yesterday? 14 A. I also do a lot of research on maternal A. No, I had never seen it before. I just 14 A. I also do a lot of research on maternal A. No, I had never seen it before. I just 16 are some very informative articles out of Finland, and I 16 A. So that was the first time that you had ever 17 think I may have probably documented at least one of 17 So that was the first time that you've reviewed in 17 think I may have probably about five articles that talk about 19 A. Yes. 19 There's probably about five articles that talk about 19 Co Kay. Anything else that you've reviewed in 21 I quoted in the references already. 21 A. No. 22 Q. Okay. So other Finish studies. 22 Q. What about people you've talked to in 23 Any other documents that you reviewed in preparation for today's deposition other than 23 24 Q. Okay. Did you – just to confirm, did you 15 I A. No. 24 25 A. No, I have not: 25 I have sour erviewed any other case documents 3 approaches to responding in depositions? 3	11	Q. And what about complication rates? You said	11	reviewed the expert report of Byron Calhoun. Was that
14 A. I also do a lot of research on maternal 14 A. No, I had never seen it before. I just 15 mortality, so there have been some other articles. There 15 16 mortality, so there have been some other articles. There 15 17 think I may have probably documented at least one of 16 18 those in my references, but - Gissier and colleagues. 17 19 There's probably about five articles at talk about 19 20 O. Kay. So ther Finish studies. 20 21 quoted in the references already. 21 A. No. 22 Q. Okay. So ther finish studies. 21 A. No. 23 Any other documents that you reviewed in preparation for today's deposition? Have you spoken with anyone, irrespective of 24 preparation for today's deposition? 24 Wr. Sorenson? 25 A. No. Ihave not. 25 A. No. 26 Was you spoken with anyone, irrespective of whether it was related to this case, about tips or approaches to responding in deposition? 3 3 A. No. 2 A. No. 2 4 Ou know, thake it back. The only other 6 A. Vol. Ihave n	12	you may have looked at some other articles with respect	12	just last night, or had you reviewed that before
15 mortality, so there have been some other articles. There 15 received the packet yesterday. 16 are some very informative articles out of Finland, and I 16 0. So that was the first time that you had ever 17 think I may have probably documented at least one of rot orday's deposition? 18 A. Yes. 19 There's probably about five articles that talk about 19 0. Okay. Anything else that you've reviewed in preparation for today's deposition? 21 I quoted in the references already. 21 A. No. 22 0. Okay. So other Finish studies. 23 Any other documents that you reviewed in preparation for today's deposition? 14 24 preparation for today's deposition? 21 A. No. 22 0. What about peopie you've talked to in 25 A. I believe that's it. 25 Mr. Sorenson? 17 14 D. Kay. Did you – just to confirm, did you 1 A. No. 17 15 In this case since you submitted your expert report? 1 A. No. 26 Have you spoken with anyone, irrespective of whether it was related to this case, about tips or apporting in depositions? 3 3 In this case sinco you submitted you respert report? A. W	13	to complication rates. What might those have been?	13	yesterday?
16 are some very informative articles out of Finland, and I 16 Q. So that was the first time that you had ever 17 think I may have probably documented at least one of 17 seen that expert report? 18 those in my references, but – Gissler and colleagues. 18 A. Yes. 19 There's probably about five articles that talk about 19 Q. Okay. Anything else that you've reviewed in 20 mortality rates. I believe the other Finish researchers 20 proparation for today's deposition? 21 I quoted in the references already. 21 A. No. 22 Q. Okay. So other Finish studies. 22 Q. What about people you've talked to in 23 Any other documents that you reviewed in proparation for today's deposition? A. anyone about today's deposition? 24 Proparation for today's deposition? 24 anyone about today's deposition? A. No. 25 A. I believe that's it. 25 Mr. Sorenson? 17 2 Q. Okay. Did you – just to confirm, did you 1 A. No. 20 Have you spoken with anyone, irrespective of 3 A. No, Ihave not. 30 seent report that I have seen is Byron Calhouris. And I 7<	14	A. I also do a lot of research on maternal	14	A. No, I had never seen it before. I just
17 think I may have probably documented at least one of 17 seen that expert report? 18 those in my references, but - Gissler and colleagues. 18 A. Yes. 10 mortality rates. I believe the other Finish researchers 19 O. Okay. Anything else that you've reviewed in 20 mortality rates. I believe the other Finish researchers 19 O. Okay. Anything else that you've reviewed in 21 I quoted in the references already. 20 What about people you've talked to in 22 Q. Okay. So other Finish studies. 20 What about people you've talked to in 23 Any other documents that you reviewed in preparation for today's deposition? Have you spoken with anyone about today's deposition? 24 Q. Okay. Did you - just to confirm, did you 1 A. No. 17 15 15 17 4 A. No. 17 16 A. No, have not. 10 1 A. No. 17 17 A. No, have not. 3 whether it was related to this case, about tips or approaches to responding in depositions? 16 16 A. You know, Itake it back. The only other 7 A. No. 0. Okay. So you're associated or affiliated wit	15	mortality, so there have been some other articles. There	15	received the packet yesterday.
18 those in my references, but – Gissler and colleagues. 18 A. Yes. 19 There's probably about five articles that talk about 19 Q. Okay. Anything else that you've reviewed in 20 mortality rates. I believe the other Finish researchers 19 A. No. 21 Q. Okay. So other Finish studies. 20 What about people you've talked to in 23 Any other documents that you reviewed in preparation for today's deposition? Have you spoken with anyone about today's deposition other than 25 A. I believe that's it. 20 What about people you've talked to in 26 O. Kay. Did you – just to confirm, did you 1 A. No. 27 Q. Okay. Did you – just to confirm, did you 1 A. No. 28 A. No, Ihave not. 3 whether it was related to this case, about tips or approaches to responding in depositions? 3 A. Now, I take it back. The only other 6 Q. Other than Mr. Sorenson. 4 O. Vay know, I take it back. The only other 6 Q. So you're associated or affiliated with an organization called AAPLOG; is that correct? 6 the way of how only appresent report and I have not really reviewed in textensively 10 A. I was a board member. I'm not a board member any longer	16	are some very informative articles out of Finland, and I	16	Q. So that was the first time that you had ever
19 There's probably about five articles that talk about 19 Q. Okay. Anything else that you've reviewed in 20 mortality rates. I believe the other Finish researchers 20 preparation for today's deposition? 21 I quoted in the references already. 21 A. No. 22 Q. Okay. So other Finish studies. 22 Q. What about people you've talked to in 23 preparation for today's deposition? Have you spoken with 24 any other documents that you reviewed in 23 25 A. I believe that's it. 24 26 What about today's deposition? Have you spoken with 27 Q. Okay. Did you – just to confirm, did you 1 26 A. No, I have not. 15 27 A. No, I have not. 16 37 A. No, I have not. 17 4 A. No, I have not. 19 5 in this case since you subitted your expert report? A. Well, I spoke with Mr. Sorenson? 6 A. You know, Itake it back. The only other 6 Q. Other than Mr. Sorenson? 7 A. No. 30 Q. So you're associated or affiliated with an 9 or	17	think I may have probably documented at least one of	17	seen that expert report?
20mortality rates. I believe the other Finish researchers I quoted in the references already.20preparation for today's deposition? 2.1A. No.22Q. Okay. So other Finish studies. Any other documents that you reviewed in preparation for today's deposition? A. I believe that's it.21A. No.25A. I believe that's it.25What about people you've talked to in preparation for today's deposition? Have you spoken with anyone about today's deposition other than 2.52726A. I believe that's it.25What about people you've talked to in preparation for today's deposition other than 2.527A. I believe that's it.26What about people you've talked to in preparation for today's deposition other than 2.527A. I believe that's it.26What about people you've talked to in preparation for today's deposition? 2.61A. Okay. Did you – just to confirm, did you review any of the other expert reports in this case? 31A. No.2Q. Have you spoken with anyone, irrespective of whether it was related to this case, about tips or approaches to responding in depositions? 533In this case since you submitted your expert report? 6A. You know, Itake it back. The only other 694Q. Other than Mr. Sorenson?7A. No.5about the yesterday. But I had not seen it before 	18	those in my references, but Gissler and colleagues.	18	A. Yes.
21I quoted in the references already.21A. No.22Q. Okay. So other Finish studies.21A. No.23Any other documents that you reviewed in23preparation for today's deposition?23A. I believe that's it.2525A. I believe that's it.251Q. Okay. Did you just to confirm, did you1A. No.21A. No.171Q. Okay. Did you just to confirm, did you1A. No.21A. No.171Q. Okay. Did you just to confirm, did you1A. No.21A. No.171Q. Okay. Did you just to confirm, did you1A. No.21A. No.171Q. Okay. Our eviewed any other case documents105in this case since you submitted your expert report?1A. No.6A. You know, Itake it back. The only other6Q. Osy ou're associated or affiliated with an9guys sent me yesterday. But I had not seen it before9organization called AAPLOG; is that correct?10then, and I have not really reviewed it extensively10A. I was a board member. And are you also the11because I thought it probably got sent as an accident.11Q. You're opened it. Okay.13this wash't conveyed to you. Have you opened the packet13A. I was a board member. I'm not a board14therewert's supposed to, no. That was part13A. I was a board member. I'm not a bo	19	There's probably about five articles that talk about	19	Q. Okay. Anything else that you've reviewed in
22Q. Okay. So other Finish studies. Any other documents that you reviewed in preparation for today's deposition? Have you spoken with anyone about today's deposition? Have you spoken with anyone about today's deposition other than anyone about today's deposition other than2Q. What about people you've talked to in preparation for today's deposition? A i believe that's it.151517A. No, have not.2Q. Have you spoken with anyone, irrespective of whether it was related to this case, about tips or approaches to responding in depositions?3A. No, have not.4Q. Have you spoken with anyone, irrespective of whether it was related to this case, about tips or approaches to responding in depositions?5A. You know, I take it back. The only other expert report that I have seen is Byron Calhoun's. And I guys sent me yesterday. But I had not seen it before 10 then, and I have not really reviewed it extensively010because I thought it probably got sent as an accident.11 or Source as an accident.11 or Source as any accident.15A. Yes.0Okay. So just to confirm — and perhaps this wasn't conveyed to you. Have you opened the packet from yesterday, Dr. Skop?1A. I was a board member. I'm not a board member any longer.16Q. You've opened it. Okay	20	mortality rates. I believe the other Finish researchers	20	preparation for today's deposition?
23Any other documents that you reviewed in preparation for today's deposition?23 any other documents that you reviewed in preparation for today's deposition?23 any one about today's deposition? Have you spoken with anyone about today's deposition other than 24 anyone about today's deposition other than 2525A. Ibelieve that's it.15171Q. Okay. Did you just to confirm, did you review any of the other expert reports in this case? 3. A. No, I have not.1A. No.2review any of the other expert reports in this case? 4. No, I have not.2Q. Have you spoken with anyone, irrespective of whether it was related to this case, about tips or approaches to responding in depositions?5in this case since you submitted your expert report? expert report that I have seen is Byron Calhoun's. And I a don't know why, but that ended up in the packet that you guys sent me yesterday. But I had not seen it before 93A. Well, I spoke with Mr. Sorenson.12Q. Okay. So just to confirm - and perhaps 1111Q. You are a member. And are you also the chair of their board?13this wasn't conveyed to you. Have you opened the packet 1417A. I'm a member of AAPLOG, yes.13this wasn't conveyed to you. Have you opened the packet 141714Q. You've opened it. Okay.16A. I'was a board member. I'm not a board member any longer.15A. Yes.15Q. Okay. So what is your do you have any affiliation with AAPLOG other than as a member?17A. Was I not supposed to?17A. Currently, not really.18<	21	I quoted in the references already.	21	A. No.
24preparation for today's deposition?24anyone about today's deposition other than25A. I believe that's it.15171Q. Okay. Did you – just to confirm, did you1A. No.2review any of the other expert reports in this case?2Q. Have you spoken with anyone, irrespective of3A. No, Ihave not.3whether it was related to this case, about tips or4Q. Have you reviewed any other case documents3whether it was related to this case, about tips or5A. No, Ihave not.3whether it was related to this case, about tips or6A. You know, I take it back. The only other6Q. Other than Mr. Sorenson?7expert report that I have seen is Byron Calhouris. And I7A. No.8don't know why, but that ended up in the packet that you90So you're associated or affiliated with an9guys sent me yesterday. But I had not seen it before9organization called AAPLOG; is that correct?10he., and I have not really reviewed it extensively10A. I'm a member of AAPLOG; ses.11because I thought it probably got sent as an accident.10A. I was a board member. I'm not a board17A. Yes.15Q. Okay. So what is your do you have any16Q. You've opened it. Okay.16affiliation with AAPLOG other than as a member?17A. Was I not supposed to?17A. Well, I'm the I'm still the chairman of19Mr. Sorenson.18Q. What does that mean?	22	Q. Okay. So other Finish studies.	22	Q. What about people you've talked to in
25 A. I believe that's it. 25 Mr. Sorenson? 15 15 17 1 Q. Okay. Did you just to confirm, did you 1 A. No. 2 review any of the other expert reports in this case? 1 A. No. 3 A. No, I have not. 3 whether it was related to this case, about tips or 4 Q. Have you reviewed any other case documents approaches to responding in depositions? 6 A. You know, I take it back. The only other 6 Q. Other than Mr. Sorenson? 7 expert report that I have seen is Byron Calhoun's. And I 7 A. No. 8 Q. So you're associated or affiliated with an organization called AAPLOG; is that correct? 11 because I thought it probably got sent as an accident. 11 Q. You are a member. And are you also the 12 Q. Okay. So just to confirm - and perhaps 13 A. I was a board member. I'm not a board 13 this wasn't conveyed to you. Have you opened the packet 16 Q. Okay. So what is your do you have any 14 from yesterday, Dr. Skop? 17 A. I was a board member. I'm not a board 14 from yesterday, Dr. Skop? 17 A. Currently	23	Any other documents that you reviewed in	23	preparation for today's deposition? Have you spoken with
15 15 17 1 Q. Okay. Did you just to confirm, did you 1 A. No. 2 review any of the other expert reports in this case? 2 Q. Have you spoken with anyone, irrespective of 4 Q. Have you reviewed any other case documents 3 whether it was related to this case, about tips or 5 In this case since you submitted your expert report? 5 A. Well, I spoke with Mr. Sorenson. 6 A. You know, I take it back. The only other 6 Q. Other than Mr. Sorenson? 7 expert report that I have seen is Byron Calhour's. And I 7 A. No. 9 guys sent me yesterday. But I had not seen it before 9 organization called AAPLOG; is that correct? 10 then, and I have not really reviewed it extensively 10 A. I'm a member of AAPLOG, yes. 11 Q. Okay. So just to confirm and perhaps 11 Q. You are a member. And are you also the 12 Q. Okay. So just to confirm and perhaps 15 A. I was a board member. I'm not a board 14 from yesterday, Dr. Skop? 16 A. Okay. So what is your do you have any 15 A. Yes. 16 Q. Okay. So what is your do you have any <tr< th=""><th>24</th><th>preparation for today's deposition?</th><th>24</th><th>anyone about today's deposition other than</th></tr<>	24	preparation for today's deposition?	24	anyone about today's deposition other than
1Q. Okay. Did you just to confirm, did you1A. No.2review any of the other expert reports in this case?2Q. Have you spoken with anyone, irrespective of3A. No, I have not.3whether it was related to this case, about tips or4Q. Have you reviewed any other case documents3whether it was related to this case, about tips or5in this case since you submitted your expert report?5A. Well, I spoke with Mr. Sorenson.6A. You know, I take it back. The only other6Q. Other than Mr. Sorenson?7expert report that I have seen is Byron Calhour's. And I7A. No.8don't know why, but that ended up in the packet that you8Q. So you're associated or affiliated with an9guys sent me yesterday. But I had not seen it before9organization called AAPLOG; is that correct?10then, and I have not really reviewed it extensively10A. I'm a member of AAPLOG, yes.11Decause I thought it probably got sent as an accident.11Q. You are a member. And are you also the12O. Nay. So just to confirm and perhaps15Q. Okay. So what is your do you have any14from yesterday, Dr. Skop?16A. I was a board member. I'm not a board15A. Yes.15Q. Okay. So what is your do you have any16A. You weren't supposed to, no. That was part18Q. What does that mean?19of the court's order, actually, that you were provided by19A. Well, I'm the I'm still the chairman of <th>25</th> <th>A. I believe that's it.</th> <th>25</th> <th>Mr. Sorenson?</th>	25	A. I believe that's it.	25	Mr. Sorenson?
1Q. Okay. Did you just to confirm, did you1A. No.2review any of the other expert reports in this case?2Q. Have you spoken with anyone, irrespective of3A. No, I have not.3whether it was related to this case, about tips or4Q. Have you reviewed any other case documents3whether it was related to this case, about tips or5in this case since you submitted your expert report?5A. Well, I spoke with Mr. Sorenson.6A. You know, I take it back. The only other6Q. Other than Mr. Sorenson?7expert report that I have seen is Byron Calhour's. And I7A. No.8don't know why, but that ended up in the packet that you8Q. So you're associated or affiliated with an9guys sent me yesterday. But I had not seen it before9organization called AAPLOG; is that correct?10then, and I have not really reviewed it extensively10A. I'm a member of AAPLOG, yes.11Decause I thought it probably got sent as an accident.11Q. You are a member. And are you also the12O. Nay. So just to confirm and perhaps15Q. Okay. So what is your do you have any14from yesterday, Dr. Skop?16A. I was a board member. I'm not a board15A. Yes.15Q. Okay. So what is your do you have any16A. You weren't supposed to, no. That was part18Q. What does that mean?19of the court's order, actually, that you were provided by19A. Well, I'm the I'm still the chairman of <th></th> <th>1 -</th> <th></th> <th>1.0</th>		1 -		1.0
2review any of the other expert reports in this case?2Q. Have you spoken with anyone, irrespective of3A. No, I have not.3whether it was related to this case, about tips or4Q. Have you reviewed any other case documents4approaches to responding in depositions?5in this case since you submitted your expert report?5A. Well, I spoke with Mr. Sorenson.6A. You know, I take it back. The only other6Q. Other than Mr. Sorenson?7expert report that I have seen is Byron Calhoun's. And I7A. No.8don't know why, but that ended up in the packet that you9Q. So you're associated or affiliated with an9guys sent me yesterday. But I had not seen it before9organization called AAPLOG; is that correct?10then, and I have not really reviewed it extensively10A. I'm a member of AAPLOG, yes.11because I thought it probably got sent as an accident.11Q. You are a member. And are you also the12Q. Okay. So just to confirm - and perhaps12chair of their board?13this wasn't conveyed to you. Have you opened the packet13A. I was a board member. I'm not a board14from yesterday, Dr. Skop?16affiliation with AAPLOG other than as a member?15A. Yes.16Q. What does that mean?16Q. You weren't supposed to?17A. Currently, not really.17A. Was I not supposed to?17A. Currently, not really.18Q. What does that mean?19A.	1		1	
 A. No, I have not. M. No, I have not. 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. Yes. Q. You've opened it. Okay. A. Yes. Q. You weren't supposed to? A. Was I not supposed to? A. Oh, I'm sorry. 1 Q. And so it sounds like, in addition to opening the article, you must have opened packets inside d. And so it sounds like, in addition to opening the article, you must have opened packets inside M. Barticle that were sealed themselves. Is that 				
4Q. Have you reviewed any other case documents in this case since you submitted your expert report?4approaches to responding in depositions?5in this case since you submitted your expert report?5A. Well, I spoke with Mr. Sorenson.6A. You know, I take it back. The only other6Q. Other than Mr. Sorenson?7expert report that I have seen is Byron Calhoun's. And I7A. No.8don't know why, but that ended up in the packet that you8Q. So you're associated or affiliated with an9guys sent me yesterday. But I had not seen it before9organization called AAPLOG; is that correct?10then, and I have not really reviewed it extensively10A. I'm a member of AAPLOG, yes.11because I thought it probably got sent as an accident.11Q. You are a member. And are you also the12Q. Okay. So just to confirm and perhaps11A. I was a board member. I'm not a board14from yesterday, Dr. Skop?14member any longer.15A. Yes.15Q. Okay. So what is your do you have any16Q. You've opened it. Okay.16affiliation with AAPLOG other than as a member?17A. Was I not supposed to?17A. Currently, not really.18Q. You weren't supposed to, no. That was part18Q. What does that mean?19of the court's order, actually, that you were provided by19A. Well, I'm theI'm still the chairman of21A. Oh, I'm sorry. 121we we wrote a practice bulletin that's been on the				
5in this case since you submitted your expert report?5A. Well, I spoke with Mr. Sorenson.6A. You know, I take it back. The only other6Q. Other than Mr. Sorenson?7expert report that I have seen is Byron Calhoun's. And I7A. No.8don't know why, but that ended up in the packet that you8Q. So you're associated or affiliated with an9guys sent me yesterday. But I had not seen it before9Organization called AAPLOG; is that correct?10then, and I have not really reviewed it extensively10A. I'm a member of AAPLOG, yes.11because I thought it probably got sent as an accident.11Q. You are a member. And are you also the12Q. Okay. So just to confirm and perhaps13A. I was a board member. I'm not a board14from yesterday, Dr. Skop?15Q. Okay. So what is your do you have any16Q. You've opened it. Okay.16affiliation with AAPLOG other than as a member?17A. Was I not supposed to?17A. Currently, not really.19of the court's order, actually, that you were provided by19A. Well, I'm the I'm still the chairman of11Mr. Sorenson.20Mr. Sorenson.2021A. Oh, I'm sorry. I21We we wrote a practice bulletin that's been on the22Q. And so it sounds like, in addition to22wesite, and since that time, we have not done any23opening the article, you must have opened packets inside23further work.24the arti			-	
6A. You know, I take it back. The only other6Q. Other than Mr. Sorenson?7expert report that I have seen is Byron Calhoun's. And I7A. No.8don't know why, but that ended up in the packet that you8Q. So you're associated or affiliated with an9guys sent me yesterday. But I had not seen it before9organization called AAPLOG; is that correct?10then, and I have not really reviewed it extensively10A. I'm a member of AAPLOG, yes.12Q. Okay. So just to confirm and perhaps11Q. You are a member. And are you also the13this wasn't conveyed to you. Have you opened the packet13A. I was a board member. I'm not a board14from yesterday, Dr. Skop?14member any longer.15A. Yes.15Q. Okay. So what is your do you have any16Q. You weren't supposed to; no. That was part18Q. What does that mean?19of the court's order, actually, that you were provided by19A. Well, I'm the I'm still the chairman of21A. Oh, I'm sorry. I21We we wrote a practice bulletin that's been on the22Q. And so it sounds like, in addition to22website, and since that time, we have not done any23opening the article, you must have opened packets inside23further work.24the article that were sealed themselves. Is that24Q. Okay. What is that practice bulletin?				
 7 expert report that I have seen is Byron Calhoun's. And I 7 A. No. 8 don't know why, but that ended up in the packet that you 9 guys sent me yesterday. But I had not seen it before 9 then, and I have not really reviewed it extensively 10 then, and I have not really reviewed it extensively 10 because I thought it probably got sent as an accident. 11 Q. You are a member. And are you also the 12 O. Okay. So just to confirm and perhaps 13 this wasn't conveyed to you. Have you opened the packet 14 from yesterday, Dr. Skop? 15 A. Yes. 16 Q. You've opened it. Okay. 17 A. Was I not supposed to? 18 Q. You weren't supposed to? 17 A. Was I not supposed to? 18 Q. You weren't supposed to, no. That was part 19 of the court's order, actually, that you were provided by 19 A. Oh, I'm sorry. I 20 And so it sounds like, in addition to 21 Q. Okay. What is that practice bulletin? 22 What is that practice bulletin? 				-
8don'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 extensively8Q. So you're associated or affiliated with an organization called AAPLOG; is that correct?10then, and I have not really reviewed it extensively10A. I'm a member of AAPLOG; is that correct?11because I thought it probably got sent as an accident.11Q. You are a member. And are you also the chair of their board?12Q. Okay. So just to confirm and perhaps12chair of their board?13this wasn't conveyed to you. Have you opened the packet from yesterday, Dr. Skop?13A. I was a board member. I'm not a board14from yesterday, Dr. Skop?14member any longer.15A. Yes.15Q. Okay. So what is your do you have any16Q. You weren't supposed to?17A. Currently, not really.17A. Was I not supposed to, no. That was part of the court's order, actually, that you were provided by19A. Well, I'm the I'm still the chairman of20Mr. Sorenson.20their maternal morbidity and mortality committee. But21A. Oh, I'm sorry. I21we we wrote a practice bulletin that's been on the22Q. And so it sounds like, in addition to opening the article, you must have opened packets inside the article that were sealed themselves. Is that24Q. Okay. What is that practice bulletin?		-		
9guys 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.9organization called AAPLOG; is that correct?11because I thought it probably got sent as an accident.10A. I'm a member of AAPLOG, yes.12Q. Okay. So just to confirm and perhaps11Q. You are a member. And are you also the13this wasn't conveyed to you. Have you opened the packet from yesterday, Dr. Skop?11A. I was a board member. I'm not a board14from yesterday, Dr. Skop?13A. I was a board member. I'm not a board15A. Yes.15Q. Okay. So what is your do you have any16Q. You've opened it. Okay.16affiliation with AAPLOG other than as a member?17A. Was I not supposed to?17A. Currently, not really.18Q. What does that mean?19A. Well, I'm the I'm still the chairman of20Mr. Sorenson.20their maternal morbidity and mortality committee. But21A. Oh, I'm sorry. I21we we wrote a practice bulletin that's been on the22Q. And so it sounds like, in addition to opening the article, you must have opened packets inside the article that were sealed themselves. Is that24Q. Okay. What is that practice bulletin?				
10then, and I have not really reviewed it extensively because I thought it probably got sent as an accident.10A. I'm a member of AAPLOG, yes.11Q. Okay. So just to confirm and perhaps this wasn't conveyed to you. Have you opened the packet from yesterday, Dr. Skop?10A. I'm a member of AAPLOG, yes.12Q. Okay. So just to confirm and perhaps this wasn't conveyed to you. Have you opened the packet from yesterday, Dr. Skop?11Q. You are a member. And are you also the chair of their board?14from yesterday, Dr. Skop?13A. I was a board member. I'm not a board member any longer.15A. Yes.15Q. Okay. So what is your do you have any affiliation with AAPLOG other than as a member?16Q. You weren't supposed to?17A. Currently, not really.18Q. What does that mean?19of the court's order, actually, that you were provided by Mr. Sorenson.19A. 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 opening the article, you must have opened packets inside the article that were sealed themselves. Is that24Q. Okay. What is that practice bulletin?			-	-
11because I thought it probably got sent as an accident.11Q. You are a member. And are you also the12Q. Okay. So just to confirm and perhaps12chair of their board?13this wasn't conveyed to you. Have you opened the packet13A. I was a board member. I'm not a board14from yesterday, Dr. Skop?14member any longer.15A. Yes.15Q. Okay. So what is your do you have any16Q. You've opened it. Okay.16affiliation with AAPLOG other than as a member?17A. Was I not supposed to?17A. Currently, not really.18Q. You weren't supposed to, no. That was part18Q. What does that mean?19of the court's order, actually, that you were provided by19A. Well, I'm the I'm still the chairman of20Mr. Sorenson.20their maternal morbidity and mortality committee. But21A. Oh, I'm sorry. I21we we wrote a practice bulletin that's been on the22Q. And so it sounds like, in addition to22website, and since that time, we have not done any23opening the article, you must have opened packets inside23further work.24the article that were sealed themselves. Is that24Q. Okay. What is that practice bulletin?				•
12Q. Okay. So just to confirm and perhaps12chair of their board?13this wasn't conveyed to you. Have you opened the packet13A. I was a board member. I'm not a board14from yesterday, Dr. Skop?13A. I was a board member. I'm not a board15A. Yes.15Q. Okay. So what is your do you have any16Q. You've opened it. Okay.16affiliation with AAPLOG other than as a member?17A. Was I not supposed to?17A. Currently, not really.18Q. You weren't supposed to, no. That was part18Q. What does that mean?19of the court's order, actually, that you were provided by19A. Well, I'm the I'm still the chairman of20Mr. Sorenson.20their maternal morbidity and mortality committee. But21A. Oh, I'm sorry. I21we we wrote a practice bulletin that's been on the22Q. And so it sounds like, in addition to22website, and since that time, we have not done any23opening the article, you must have opened packets inside23further work.24the article that were sealed themselves. Is that24Q. Okay. What is that practice bulletin?			-	-
13this wasn't conveyed to you. Have you opened the packet from yesterday, Dr. Skop?13A. I was a board member. I'm not a board member any longer.14from yesterday, Dr. Skop?14member any longer.15A. Yes.15Q. Okay. So what is your do you have any affiliation with AAPLOG other than as a member?16Q. You've opened it. Okay.1617A. Was I not supposed to?17A. Currently, not really.18Q. You weren't supposed to, no. That was part of the court's order, actually, that you were provided by19A. Well, I'm the I'm still the chairman of19Mr. Sorenson.20their maternal morbidity and mortality committee. But we we wrote a practice bulletin that's been on the21A. Oh, I'm sorry. I21we we wrote a practice bulletin that's been on the23opening the article, you must have opened packets inside the article that were sealed themselves. Is that24Q. Okay. What is that practice bulletin?			1	-
14from yesterday, Dr. Skop?14member any longer.15A. Yes.15Q. Okay. So what is your do you have any16Q. You've opened it. Okay.16affiliation with AAPLOG other than as a member?17A. Was I not supposed to?17A. Currently, not really.18Q. You weren't supposed to, no. That was part18Q. What does that mean?19of the court's order, actually, that you were provided by19A. Well, I'm the I'm still the chairman of20Mr. Sorenson.20their maternal morbidity and mortality committee. But21A. Oh, I'm sorry. I21we we wrote a practice bulletin that's been on the22Q. And so it sounds like, in addition to22website, and since that time, we have not done any23opening the article, you must have opened packets inside24Q. Okay. What is that practice bulletin?			1	
15A. Yes.15Q. Okay. So what is your do you have any16Q. You've opened it. Okay.16affiliation with AAPLOG other than as a member?17A. Was I not supposed to?17A. Currently, not really.18Q. You weren't supposed to, no. That was part18Q. What does that mean?19of the court's order, actually, that you were provided by19A. Well, I'm the I'm still the chairman of20Mr. Sorenson.20their maternal morbidity and mortality committee. But21A. Oh, I'm sorry. I21we we wrote a practice bulletin that's been on the22Q. And so it sounds like, in addition to22website, and since that time, we have not done any23opening the article, you must have opened packets inside23further work.24the article that were sealed themselves. Is that24Q. Okay. What is that practice bulletin?			1	
16Q. You've opened it. Okay.16affiliation with AAPLOG other than as a member?17A. Was I not supposed to?17A. Currently, not really.18Q. You weren't supposed to, no. That was part18Q. What does that mean?19of the court's order, actually, that you were provided by19A. Well, I'm the I'm still the chairman of20Mr. Sorenson.20their maternal morbidity and mortality committee. But21A. Oh, I'm sorry. I21we we wrote a practice bulletin that's been on the22Q. And so it sounds like, in addition to22website, and since that time, we have not done any23opening the article, you must have opened packets inside23further work.24the article that were sealed themselves. Is that24Q. Okay. What is that practice bulletin?			1	, ,
17A. Was I not supposed to?17A. Currently, not really.18Q. You weren't supposed to, no. That was part18Q. What does that mean?19of the court's order, actually, that you were provided by19A. Well, I'm the I'm still the chairman of20Mr. Sorenson.20their maternal morbidity and mortality committee. But21A. Oh, I'm sorry. I21we we wrote a practice bulletin that's been on the22Q. And so it sounds like, in addition to22website, and since that time, we have not done any23opening the article, you must have opened packets inside24Q. Okay. What is that practice bulletin?				
18Q. You weren't supposed to, no. That was part18Q. What does that mean?19of the court's order, actually, that you were provided by19A. Well, I'm the I'm still the chairman of20Mr. Sorenson.20their maternal morbidity and mortality committee. But21A. Oh, I'm sorry. I21we we wrote a practice bulletin that's been on the22Q. And so it sounds like, in addition to22website, and since that time, we have not done any23opening the article, you must have opened packets inside24Q. Okay. What is that practice bulletin?				
19of the court's order, actually, that you were provided by Mr. Sorenson.19A. 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 we builte and since that time, we have not done any opening the article, you must have opened packets inside the article that were sealed themselves. Is that19A. 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.23opening the article, you must have opened packets inside the article that were sealed themselves. Is that24Q. Okay. What is that practice bulletin?				
20Mr. Sorenson.20their maternal morbidity and mortality committee. But21A. Oh, I'm sorry. I21we we wrote a practice bulletin that's been on the22Q. And so it sounds like, in addition to22website, and since that time, we have not done any23opening the article, you must have opened packets inside2324the article that were sealed themselves. Is that2424Q. Okay. What is that practice bulletin?				
21A. Oh, I'm sorry. I21we we wrote a practice bulletin that's been on the22Q. And so it sounds like, in addition to22we we wrote a practice bulletin that's been on the23opening the article, you must have opened packets inside23further work.24the article that were sealed themselves. Is that24Q. Okay. What is that practice bulletin?				
22Q. And so it sounds like, in addition to22website, and since that time, we have not done any23opening the article, you must have opened packets inside23further work.24the article that were sealed themselves. Is that24Q. Okay. What is that practice bulletin?			1	
 23 opening the article, you must have opened packets inside 24 the article that were sealed themselves. Is that 23 further work. 24 Q. Okay. What is that practice bulletin? 		-	1	-
24the article that were sealed themselves. Is that24Q.Okay. What is that practice bulletin?			1	-
			1	
			25	

18 20 1 abortion and maternal mortality. 1 you would be an expert witness in this case? 2 Q. Okay. Have you worked on any other 2 A. No. It was before I knew about this case. 3 materials that AAPLOG has provided to the public? 3 Q. Okay. Do you recall which month that was? A. Yes, I was involved in writing several of 4 A. Probably September. 4 5 their practice bulletins and committee opinions. 5 Q. And what did that training entail? 6 Q. Okay. What about their fact sheets? AAPLOG 6 A. It involved a number of things. There was 7 7 provides fact sheets to the public, correct? some media training: how to be interviewed and get your points across. There was a small amount of expert 8 A. That is correct. I believe that the fact 8 9 sheets were written before I joined the board. 9 witness training, but it wasn't really the focus of the 10 Q. Okay. So you wouldn't have had any role 10 training event. working on those fact sheets? Q. Do you remember what it was called? 11 11 12 A. No, I don't think so. 12 A. I do not remember. Q. Who presented on the expert witness 13 Q. No, so not on maternal mortality? 13 14 A. I believe that one was already written. 14 testimony; do you recall that? 15 Q. What about fetal pain? 15 A. I do not recall. I'm really bad with names. 16 A. No, I did not write that one. 16 It was a woman I had not ever met. 17 Q. Okay. Do you also have any association with 17 Q. Okay. And no one else, to your 18 the Charlotte Lozier Institute? 18 recollection? 19 A. I am one of their associate scholars. 19 A. I'm sorry. I didn't understand the 20 Q. What does that mean; what are your 20 auestion. 21 responsibilities in that capacity? 21 Q. There was no one else who presented on 22 A. There's not really any set responsibilities 22 expert testimony training to your recollection? 23 and it is not a paid position. Occasionally they'll 23 A. I believe there was just one presenter. 24 reach out to me for my opinions on issues, and I've Q. Okay. All right. And do you have any 24 25 written one paper for them. 25 materials from that training? 19 21 Q. Okay. And which paper was that? 1 1 Α. Not with me. A. The paper was called No-Test Medical 2 2 Q. But do you have them in your possession? 3 Abortion. 3 A. I may. I would probably have to look back 4 Q. Okay. Is that identified in your -- well, 4 through handouts and stuff that I have. I don't remember 5 5 we can talk about it in a moment. if I kept them or not. 6 So you mentioned the Charlotte Lozier 6 Q. Would you have kept notes? 7 Institute and AAPLOG. Do you know, do either of those 7 A. Possibly. 8 organizations provide training for expert witness 8 Q. Do you remember who else was at the training 9 testimony for individuals in the pro-life community? 9 with you? 10 10 MR. SORENSON: Objection, foundation. A. There were probably about twelve Charlotte 11 A. -- it is Charlotte Lozier. 11 Lozier scholars there. 12 Q. I'm sorry, ma'am, I couldn't hear you. 12 Q. Any other names that you recall? MR. SORENSON: Let me put my objection on 13 13 A. Let's see. I think Kate Carnahan, Christina 14 the record. 14 Francis, Donna Harrison. . . The others I don't recall. 15 Objection, foundation. 15 Q. Do you know who the experts in this case Q. Could you answer the question, Dr. Skop? 16 16 are, Dr. Skop? 17 A. Yes. Charlotte Lozier does. 17 A. Who the --18 Q. So you're aware of that training? 18 Q. Sorry, I apologize. 19 A. Yes. 19 A. Other expert witnesses? 20 Q. How did you become aware of that training? 20 Q. Yes. The other expert witnesses; do you 21 21 I participated in the training. know any of them? Α. 22 A. Do I know them personally? 22 Q. You participated in the training. When was 23 that? 23 Q. Uh-huh. 24 A. It was probably last year, last fall. 24 I know Byron. A. 25 Q. Last fall. So around the time that you knew 25 Q. Byron Calhoun?

Ingrid	Skop,	M.D

Sep			ingha Skop, M.D
	22		24
1	A. Uh-huh.	1	written agreement with the state with respect to your
2	Q. And what about Anthony Levatino?	2	expert testimony in this case?
3	A. Oh, I'd forgotten that he was one. Yes, I	3	A. I believe I do.
4	know Anthony.	4	Q. And is that to your knowledge, does the
5	Q. What about Maureen Condic?	5	compensation you receive in this case depend in any way
6	A. I don't know her personally.	6	on the outcome?
7	Q. What about Priscilla Coleman?	7	A. No.
8	A. I don't know Priscilla personally.	8	Q. Have you been told or to your knowledge,
9	Q. And Farr Curlin?	9	is there a limit to the number of hours that you can
10	A. I believe I met him once.	10	spend on this case that the state would compensate you
11	Q. So you said you did a training from the	11	for?
12	Charlotte Lozier Institute. Have you spoken or done any	12	A. I'm not aware of a limit.
13	other trainings with individuals or groups in order to	13	Q. Okay. Outside of the compensation that you
14	prepare to give expert witness testimony?	14	anticipate receiving from the state in this case, is
15	A. No, I have not.	14	there any other entity or individual who is paying you
16	Q. Okay. So have you now told me everything	16	for your time as an expert witness in this case?
17	you've done to prepare for today's testimony?	17	A. No.
18	A. Yes.	18	Q. Okay. All right. Well, with that, I think
19	Q. In total, how much time would you say you	19	it would be helpful to switch gears a little bit to the
20	spent preparing to be deposed today?	20	substance. And so I wanted to start just by asking you
21	A. Probably an additional 20 hours.	21	about the law challenge in this case.
22	Q. Okay. And what's your hourly rate for	22	Are you familiar with HB136, the law at
23	compensation in this case?	23	issue in this case?
24	A. I believe it is 300.	24	A. Yes, I am.
25	Q. \$300 per hour?	25	Q. And what is your understanding of what this
	23		25
1	A. Uh-huh.	1	law would do if it takes effect?
2	Q. Is that different for time spent providing	2	A. It would not allow a woman to have an
3	deposition or trial testimony?	3	elective abortion after 18 weeks gestation. It does
4	A. Is the rate	4	allow exceptions for life of the mother for a the
5	Q. Yeah, do you have a different yes. Is	5	possibility for a severe physical outcome for the mother,
6	your rate different for time spent preparing trial or	6	the case of rape, if it's been reported to law
7	deposition testimony as opposed to, for example, time	7	enforcement, a uniformly lethal diagnosed condition in
8	spent preparing a report?	8	the fetus, or a severe fetal brain malformation.
9	A. The rate for deposition and trial is 350.	9	Q. And when you say 18 weeks gestation, does
10	· · · · · · · · · · · · · · · · · · ·	10	that mean 18 weeks as dated from the first day of a
1			-
11	how much time you spent on this case to date?	11	patient's last menstrual period?
12	A. You know, I really don't. I think about it	12	A. That's correct.
13	a lot, but I don't charge for that. I don't recall how	13	Q. Okay. So if throughout the day today, to
14	much time I spent when I was preparing the report.	14	make sure that we're talking about the same way of dating
15	Q. So do you keep track of your hours?	15	a pregnancy, if I say 18 weeks LMP, you would understand
16	A. I do. Like I say, I don't charge every time	16	that to mean 18 weeks as dated from the first day of a
17	I'm thinking about it, so	17	patient's last menstrual period, correct?
	Q. Have you received any payment to date,	18	A. That's correct.
18		19	Q. Okay. Would you agree throughout the day,
19	Dr. Skop from the state?		
19 20	A. I need to check my records.	20	as we talk about different points in pregnancy, that if
19 20 21		20 21	you do not use LMP if you mean something other than
19 20	A. I need to check my records.	20	
19 20 21	A. I need to check my records.Q. Okay. And you don't have any idea how many	20 21	you do not use LMP if you mean something other than
19 20 21 22	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?	20 21 22	you do not use LMP if you mean something other than LMP that you'll say that throughout the day

Ingrid Skop, M.D.

1 Okay. So do you know any of the defendants 1 safety for women. 2 in this case? 2 Q. Okay. And you mentioned that you had done testimony in Texas. Have you ever provided testimony in Texas. Have you ever provided testimony in Texas. Have you ever provided testimony with respect to any other legislation elsewhere in the testimony in Texas. Have you ever provided testimony in Texas. Have you ever provided testimony in Texas. Have you ever provided testimony with respect to any other legislation elsewhere in the testimony in Texas. Have you ever provided testimony in Texas. Have you ever provided testimony. 6 A. No. 5 United States involving abortion? 6 A. No. 6 A. Verbal testimony? 7 Q. So not representative Cheryl Acton? 7 Q. Testimony of any kind, Doctor. So verbal, wiritten. 9 Q. Senator Deidre Henderson? 9 A. I've written one other expert witness 10 A. No. 10 report. 11 11 Q. Okay. And where would that have been submitted? 13 A. Georgia. 12 HB136? 13 A. Georgia. 14 13 A. No. 13 A. Georgia. 14 14 Q. Okay. So no drafting of other 16 A. No. 17 15 developm			1	0 17
2 in this case? 2 0. Okay. And you mentioned that you had done of the summer of the registation elsewhere in the summer of the registation elsewhere in the summer of the registation? 3 A. No. 3 this sepect to any other legistation elsewhere in the summer of the registation elsewhere in the summer of the registation? 6 A. No. 6 A. Verbal testimony? 7 Q. So not representative Cheryl Acton? 7 Q. Testimony of any kind, Doctor. So verbal, writtens. 9 A. No. 9 A. Ive written one other expert witness 10 A. No. 10 Okay. And where would that have been summer of other legistation in Utah or other statists 11 B. Did you play any role in the development of the registation in Utah or other statists 10 A. No. 12 HB136? 3 A. Georgia. 14 Q. Georgia, What was the legislation that bas been put on hold 14 A. No. 11 D. Okay. So no drafting of other 19 A. Ano. 15 related to abortion? 19 A. Ano. 20 A. No. 21 24 A. No. 21 A. No. 21 A. No. 22 A. No. 25 A. No. 2		26		28
3 A. No. 3 testimory in Texas. Have you over provided testimony 4 Q. What about any members of the Utah 4 with respect to any other legislation elsewhere in the 6 A. No. 6 United States involving abortion? 6 A. No. 6 A. Verbal testimony? 7 Q. So not representative Cheryl Acton? 6 A. Verbal testimony? 9 Q. Senator Deidre Henderson? 9 A. I've written one other expert witness 10 A. No. 10 report. 11 Q. Okay. And where would that have been 11 A. No. 13 A. Georgia. 4 Georgia. 14 Q. Have you over played any role in the 13 A. Georgia. 14 Georgia. 15 development of other legislation in Utah or other states 16 A. No. 13 Georgia. 16 related to abortion? 10 14 Georgia. 14 Georgia. 17 Q. No input to legislators who are considering 21 A. No. 23 A. No. 23 Seven weeks post LMP. 24 20 A. No. 23	1	Okay. So do you know any of the defendants	1	safety for women.
4 Q. What about any members of the Utah 4 with respect to any other legislation elsewhere in the involving abortion? 5 legislation? 5 United States Involving abortion? 7 Q. So not representative Cheryl Acton? 7 Q. Tostimony of any kind, Doctor. So verbal, 8 9 Q. Senator Doidre Henderson? 9 A. I ve written one other expert witness 10 A. No. 9 A. No. 9 11 Q. Did you play any role in the development of 11 9 A. Georgia. 12 HB1367 13 A. Georgia. 14 Q. Georgia. What was the legislation that have been 13 A. No. 13 A. Georgia. 16 related to abortion? 16 A. The unit of the regislation in Utah or other states 16 related to abortion? 16 A. No. 17 16 A. No. 10 17 14 O. Okay. So no drafting of other 18 detected. 10	2	in this case?	2	Q. Okay. And you mentioned that you had done
5 legislation? 5 United States involving abortion? 6 A. No. 6 A. Verbal testimony? 7 Q. Son or tepresentative Cheryl Acton? 7 Q. Testimony of any kind, Doctor. So verbal, written. 8 A. No. 9 Q. Senator Doirlo Honderson? 9 A. Inc. 10 A. No. 10 Testimony of any kind, Doctor. So verbal, written. 11 Q. Didyou play any role in the development of other legislation in Utah or other states 10 C. Okay. And where would that have been 12 HB136? 13 A. Georgia. A. The legislation that has been put on hold 16 related to abortion? 16 A. The legislation after a fetal heart beat can be 19 legislation? 17 A. The legislation? 18 20 A. No. 20 A. No. 21 A. It can generally be detected? 23 A. No. 23 A. No. 23 A. No. 24 24 O. No testimony of any kind? 24 7 A. The - there's not a very clear definition 24 a. Not prior to the legislation was written, you 1 A. The - there's not a very c	3		3	testimony in Texas. Have you ever provided testimony
6 A. Varbal testimony? 7 Q. So not representative Cheryl Acton? 7 Q. Tostimony of any kind, Doctor. So varbal, 8 9 Q. Senator Deidre Henderson? 9 A. No. 9 Q. Did you play any role in the development of 11 Q. Okay. And where would that have been submitted? 11 Q. Did you play any role in the development of 11 Q. Okay. And where would that have been submitted? 12 HB136? 13 A. Georgia. 14 Q. Georgia. 14 Q. Nay. So no drafting of other 16 A. No. 17 14 G. Georgia. 16 related to abortion? 16 A. No. 17 16 A. No. 19 legislation? 19 Q. And when does a fatal heart beat georgia. 20 20 21 A. It can generally be detected? 21 A. It can generally - when can it generally be detected? 21 A. No. 23 A. No. 23 A. No. 23 24 refer to the so the	4	-	4	
7 Q. Son ot representative Cheryl Acton? 7 Q. Testimony of any kind, Doctor. So verbal, 8 A. No. 8 written. 10 A. No. 10 report. 11 Q. Did you play any role in the development of other legislation in Utah or other states 10 C. Okay. And where would that have been used that have been put on hold 13 A. No. 13 A. Georgia. 14 Q. Have you ever play any role in the 14 Q. Georgia. What was the legislation that has been put on hold 15 related to abortion? 16 A. The legislation that has been put on hold 17 A. No. 17 that prohibits abortion after a fetal heart beat can be 18 evelopment of other legislations who are considering 20 A. No. 21 19 A. No. 21 A. No. 23 A. No. 23 21 A. No. 23 A. No. 23 Q. No testimony of any kind? 24 refer to the product of conception as a fetus, or is it an embryo? 22 Q. No testimony on several occasions in A. Toprovided testimony? 24 A. No. 25 23 A. Infor the record, HB2 is what?	5	legislation?	5	-
8 A. No. 8 written. 9 Q. Senator Deidre Henderson? 9 A. I've written one other expert witness 11 Q. Did you play any role in the development of 11 Q. Okay. And where would that have been 13 A. No. 13 A. Georgia. 14 HB1367 3 A. Georgia. 15 repartinet 07 14 Q. Okay. And where would that have been 16 related to abortion? 16 A. Georgia. 17 A. No. 13 A. Georgia. 18 development of other legislation in Utah or other states 16 19 legislation? 19 Q. And when does a fetal heart beat 20 A. No. 20 generally - when can it generally be detected? 21 A. No. 21 A. No. 23 22 A. No. torior to the legislation being written. 24 refer to the point is it medically accurate to 24 Q. Not input to legislation was written, you 27 A. The - there's not a very clear definition 21 M. But after the legislation mas written, you 27 A. The - there's not a very clear definition	6		6	•
9 Q. Senator Deidre Henderson? 9 A. Ive written one other expert witness 10 A. No. 10 Billing 11 Q. Did you play any role in the development of 11 C. Okay. And where would that have been 12 HB1367 13 A. No. 13 A. Georgia. 13 A. No. 13 A. Georgia. A. The legislation that has been put on hold 15 development of other legislation in Utah or other states 16 A. The legislation that has been put on hold 16 A. No. 20 Carogengia. A. The legislation that has been put on hold 18 Q. Okay. So no drafting of other 19 Q. And when does a fetal heart beat 20 21 Q. No input to legislators who are considering 21 A. No. 23 A. It can generally be detected? 23 A. No. 23 But after the legislation being written. 25 an dor the record, HB2 is what? 25 3 A. Iprovided testimony on several occasions in 20 A. that sweeks of pregnancy? 26 4 D. The where's not a very clear definition between the transition between embryo and fetus, but mos 30	7	Q. So not representative Cheryl Acton?	7	
10 A. No. 10 report. 11 Did you play any role in the development of 11 G. Okay. And where would that have been submitted? 13 A. No. 13 A. Georgia. 14 G. Have you ever played any role in the development of other legislation in Utah or other states 13 A. Georgia. 16 related to abortion? 16 A. The legislation that has been put on hold 17 A. No. 17 that prohibits abortion after a fetal heart beat 18 Q. Okay. So no drafting of other 18 A. No. 19 legislation? 19 Q. And when does a fetal heart beat 20 A. No. 20 A. No. 21 21 A. No. 23 A. No. 23 22 a. No tepisto to the legislation being written. 24 Q. At that point is it medically accurate to 24 A. Not pror to the legislation being written. 25 1 A. The there's not a very clear definition 21 B. But after the legislation being written. 27 25 2 26 22 Q. And for the record, HB2 is what? 3 Q. At tark weeks of pregnan			-	
11 0. Did you play any role in the development of 11 0. Okay. And where would that have been submitted? 12 HB136? 13 A. No. 13 A. Georgia. 14 0. Have you ever played any role in the 14 0. Georgia. What was the legislation that thas been put on hold 15 development of other legislation in Utah or other states 16 A. No. 17 The legislation that has been put on hold 17 A. No. 17 The legislation that has been put on hold that prohibits abortion after a fetal heart beat can be 19 legislation? 19 Q. And when does a fetal heart beat 20 A. No. 20 A. It can generally be detected? A. It can generally be detected between six and seven weeks post LMP. 23 A. No. 22 Q. No testimony of any kind? 24 A. The - there's not a very clear definition 24 Q. No trast for the legislation was written, you 1 A. The - there's not a very clear definition 25 A. Iprovided testimony on several occasions in 3 A. Uh-huh. 4 A. Oko. 3 A. Iprovided testimony on several occasions in 4 A. Max as legislation that had four parts: 6			-	-
12 HB136? 12 submitted? 13 A. No. 13 A. Georgia. 14 Q. Have you ever played any role in the 14 Q. Georgia. What was the legislation that 15 development of other legislation in Utah or other states 16 A. The legislation that has been put on hold 16 related to abortion? 16 A. The legislation that has been put on hold 17 A. No. 17 that prohibits abortion after a fetal heart beat 20 18 Q. Okay. So no drafting of other 18 detected. 18 19 legislation? 19 Q. And when does a fetal heart beat 20 21 A. No. 20 A. thar generally be detected? A. It can generally be detected? 23 A. No. 21 A. The legislation six and seven weeks post LMP. 22 23 A. Not prior to the legislation was written, you 1 A. The - there's not a very clear definition 2013 Traces for HB2. 24 A. The - there's not a very clear definition 2013 Theraw for the record, HB2 is what? 6 A. HB2 was a legislation that had four parts: 7 1 <td></td> <td></td> <th>1</th> <td>-</td>			1	-
13 A. No. 13 A. Georgia. 14 Q. Have you ever played any role in the 14 Q. Georgia. What was the legislation that 15 development of other legislation in Utah or other states 16 A. The legislation that has been put on hold 17 A. No. 17 that prohibits abortion after a fetal heart beat can be 18 Q. Okay. So no drafting of other 18 detected. 19 legislation? 19 Q. And when does a fetal heart beat 20 A. No. 10 A. It can generally be detected? 21 Q. No input to legislators who are considering 23 A. No. 23 23 A. No. 23 Q. No testimony of any kind? 24 A. It can generally be detected between six and seven weeks post LMP. 25 24 Q. No testimony of any kind? 24 The refor to the product of conception as a fetus, or is it an embryo? 27 25 A. Not prior to the legislation was written, you 1 A. The - there's not a very clear definition 2 timpt have provided testimony on several occasions in a required that medical abortion be done as required by the geislation that had four parts: 6 A. Okay. All right. So Georgia. Any other			1	-
14 Q. Have you ever played any role in the development of other legislation in Utah or other states related to abortion? 14 Q. Georgia. What was the legislation that pertained to? 15 related to abortion? 16 A. The legislation that has been put on hold that prohibits abortion after a fetal heart beat can be detected. 18 Q. Okay. So no drafting of other 18 detected. 19 legislation? 19 Q. And when does a fetal heart beat detected. 20 A. No. 20 generally - when can it generally be detected? 21 A. No. 20 A. No. 20 23 A. No. 23 Q. At that point is it medically accurate to ever weeks post LMP. 23 24 Q. But after the legislation being written. 25 4. No triptor to the legislation was written, you might have provided testimony? 2 2 Q. But after the legislation was written, you 1 A. The - there's not a very clear definition 2 Provided testimony on several occasions in might have provided testimony? 2 2 4. Uh-huh. 2 Q. And for the record, HB2 is what? 5 A. Uh-huh. 3 4. Okay. All right. So let's go to - let's go to your professional training before we get into the details of your export				
15 development of other legislation in Utah or other states 15 pertained to? 16 related to abortion? 16 A. The legislation that has been put on hold 18 Q. Okay. So no drafting of other 18 A. No. 19 19 legislation? 19 Q. And when does a fetal heart beat 20 21 Q. No input to legislators who are considering 21 A. No. 20 A. It can generally be detected? 22 such legislation? 20 A. It hat point is it medically accurate to refer to the product of conception as a fetus, or is it 23 A. No. 27 A. The - there's not a very clear definition between the transition between embryo and fetus, but most 24 Q. But after the legislation was written, you 1 A. The - there's not a very clear definition 25 Q. And for the record, HB2 is what? 5 A. Uh-huh. 29 3 A. I provided testimony on several occasions in 3 would refer to it as a fetus at that point. 29 3 A. It provided testimony on several occasions in 3 Would refer to it as a fetus at that point. 5 4 Q. At six weeks of Pregnancry? 5			-	5
16 related to abortion? 16 A. The legislation that has been put on hold 17 A. No. 17 that prohibits abortion after a fetal heart beat can be 19 legislation? 19 Q. And when does a fetal heart beat 20 A. No. 20 A. No. 20 21 Q. No input to legislators who are considering 21 A. It can generally be detected? 23 A. No. 23 A. No. 23 24 Q. Not testimony of any kind? 23 Q. At that point is it medically accurate to 25 A. Not prior to the legislation being written. 25 26 Q. But after the legislation was written, you 1 A. The - there's not a very clear definition 27 Q. But after the legislation being written. 26 A. Uh-huh. 27 3 A. I provided testimony? 3 3 would refer to it as a fetus at that point. 2013 In Texas for HB2. 4 Q. At is ix weeks of pregnancy? 5 A. Uh-huh. 6 Q. Okay. All right. So let's go to - let's 9 Q. Okay. All right. So let's go to - let's 10 privileges within 30 miles. And it mandated that				
17 A. No. 17 that prohibits abortion after a fetal heart beat can be detected. 18 Q. Okay, So no drafting of other 18 detected. 19 Image: Comparison of the second			1	•
18 Q. Okay. So no drafting of other 18 detected. 19 legislation? Q. And when does a fetal heart beat 20 A. No. 20 21 Q. No input to legislators who are considering 21 A. It can generally be detected between six and seven weeks post LMP. 23 A. No. 20 A. Nto prior to the legislation being written. 21 A. Thethere's not a very clear definition 25 A. Not prior to the legislation was written, you 1 A. The there's not a very clear definition 2 might have provided testimony? 20 between the transition between embryo and fetus, but mos 2 no can drift the legislation was written, you 1 A. The there's not a very clear definition 2 might have provided testimony? 2 between the transition between embryo and fetus, but mos 3 A. Iprovided testimony? 2 between the transition between embryo and fetus, but mos 4 Q. And for the record, HB2 is what? 5 A. Uh-huh. 6 A. HB2 was a legislation that had four parts: 7 states? 7 got our professional training before we get into the 9 Q. Okay. All right. So feergia. Any other <td></td> <td></td> <th>1</th> <td></td>			1	
19 legislation? 19 Q. And when does a fetal heart beat generally when can it generally be detected? 21 Q. No input to legislators who are considering such legislation? 21 A. No. 23 A. No. 23 Q. No testimony of any kind? 23 25 A. Not prior to the legislation being written. 23 Q. At that point is it medically accurate to refer to the product of conception as a fetus, or is it an embryo? 26 A. Not prior to the legislation was written, you 1 A. The there's not a very clear definition 27 Q. But after the legislation was written, you 1 A. The there's not a very clear definition 28 A. I provided testimony? 2 A. It provided testimony? 2 3 A. I provided testimony on several occasions in 3 would refer to it as a fetus at that point. 4 Q. And for the record, HB2 is what? 6 Q. Okay. All right. So Georgia. Any other 5 required that medical abortion be done as required by the 8 A. No. 9 Q. Okay. All right. So Georgia. Any other 1 details of your repressional training before we get into the details of your represt report. I'd like to get a 10 privileges within 30 miles. And it mandated that				•
20 A. No. 20 generally - when can it generally be detected? 21 Q. No input to legislators who are considering 21 A. It can generally be detected between six and 22 such legislation? 22 A. No. 23 23 A. No. 23 Q. At that point is it medically accurate to 24 Q. No testimony of any kind? 24 an embryo? 25 A. Not prior to the legislation being written, would the the product of conception as a fetus, or is it an embryo? 27 27 Q. But after the legislation was written, you 1 A. The - there's not a very clear definition 26 D. It and ated that four parts: 1 A. The - there's not a very clear definition 2013 in Texas for HB2. Q. At six weeks of pregnancy? A. Uh-huh. Q. Okay. All right. So Georgia. Any other 7 It prohibited elected abortion after 20 weeks. It Required that medical abortion providers have hospital 9 Q. Okay. All right. So let's go to let's 10 privileges within 30 miles. And it mandated that 10 go to your professional training before we get into the 11 abortion facilities meet the criteria of ambulatory 13 background. So with that, I want to introduce if you			-	
21 Q. No input to legislators who are considering 21 A. It can generally be detected between six and seven weeks post LMP. 23 A. No. 23 Q. At that point is it medically accurate to 24 Q. No testimony of any kind? 23 Q. At that point is it medically accurate to 25 A. Not prior to the legislation being written. 27 Q. At that point is it medically accurate to 27 Q. But after the legislation was written, you 1 A. The - there's not a very clear definition 2013 in Texas for HB2. 1 A. The - there's not a very clear definition 2013 in Texas for HB2. 4 Q. At six weeks of pregnancy? 5 Q. And for the record, HB2 is what? 5 A. Uh-huh. 6 Q. Okay. All right. So Georgia. Any other states? 7 It prohibited elected abortion after 20 weeks. It 7 states? 8 A. No. 9 Q. Okay. All right. So let's go to let's 9 privileges within 30 miles. And it mandated that 10 go to your professional training before we get into the 11 abortion facilities meet the criteria of ambulatory 11 details of your expert report. I'd like to get a 12 <t< td=""><td></td><td>•</td><th>-</th><td></td></t<>		•	-	
22 such legislation? 22 seven weeks post LMP. 23 A. No. Q. No testimony of any kind? 24 24 Q. No testimony of any kind? 24 25 A. Not prior to the legislation being written. 27 26 Q. But after the legislation was written, you 1 A. The there's not a very clear definition 26 M. The there's not a very clear definition 26 27 A. I provided testimony on several occasions in 3 would refer to it as a fetus at that point. 4 2013 in Texas for HB2. 4 Q. At six weeks of pregnancy? 5 3 A. HB2 was a legislation that had four parts: 6 Q. Okay. All right. So Georgia. Any other 1 Iprovided testimony providers have hospital 9 Q. Okay. All right. So let's go to let's 10 privileges within 30 miles. And it mandated that 10 go to your professional training before we get into the 11 abortion facilities meet the criteria of ambulatory 11 details of your export report. I'd like to get a 12 surgery centers. 12 Sense a little bit better sense of your professional 13 Q. Can you explain that? Safety with r			1	
23 A. No. 23 Q. At that point is it medically accurate to 24 Q. No testimony of any kind? 24 refer to the product of conception as a fetus, or is it 25 A. Not prior to the legislation being written. 27 29 1 Q. But after the legislation was written, you 1 A. The there's not a very clear definition 2 might have provided testimony? 2 29 3 A. I provided testimony on several occasions in 3 would refer to it as a fetus at that point. 4 2013 in Texas for HB2. 4 Q. At six weeks of pregnancy? 5 5 Q. And for the record, HB2 is what? 6 Q. Okay. All right. So Georgia. Any other 5 6 A. Throught and four parts: 6 Q. Okay. All right. So let's go to let's 9 9 FDA. It mandated that abortion be done as required by the 9 A. No. 9 9 1 abortion facilities meet the criteria of ambulatory 11 details of your expert report. I'd like to get a sense a little bit better sense of your professional 13 Q. So you provided testimony to the legislation? 16 MS. MURRAY: And, MS. Marchant, I think this <t< td=""><td></td><td></td><th></th><td></td></t<>				
24 Q. No testimony of any kind? 24 refer to the product of conception as a fetus, or is it an embryo? 27 27 29 1 Q. But after the legislation being written. 27 2 A. Not prior to the legislation being written. 27 2 A. Not prior to the legislation was written, you 1 A. The there's not a very clear definition 2 might have provided testimony on several occasions in 3 4 3 A. I provided testimony on several occasions in 3 would refer to it as a fetus at that point. 4 2013 in Texas for HB2. 4 Q. At six weeks of pregnancy? 5 4 A. HB2 was a legislation that had four parts: 6 Q. Okay. All right. So Georgia. Any other 5 It mandated that abortion providers have hospital 9 Q. Okay. All right. So let's go to let's 10 privileges within 30 miles. And it mandated that 10 go to your professional training before we get into the 11 abortion facilities meet the criteria of ambulatory 11 aberloin facilities meet the criteria of ambulatory 12 12 surgery centers. 12 sense - a little bit better sense of your professional		-	1	-
25 A. Not prior to the legislation being written. 25 an embryo? 29 1 Q. But after the legislation was written, you 1 A. The there's not a very clear definition 2 might have provided testimony? 2 between the transition between embryo and fetus, but most would refer to it as a fetus at that point. 3 A. I provided testimony on several occasions in 3 would refer to it as a fetus at that point. 4 2013 in Texas for HB2. 4 Q. At six weeks of pregnancy? 5 A. And for the record, HB2 is what? 5 A. Uh-huh. 6 A. H22 was a legislation that had four parts: 6 Q. Okay. All right. So Georgia. Any other 7 It prohibited elected abortion providers have hospital 9 Q. Okay. All right. So let's go to let's 9 FDA. It mandated that abortion providers have hospital 9 Q. Okay. All right. So let's go to let's 11 abortion facilities meet the criteria of ambulatory 11 details of your expert report. I'd like to get a 12 surgery centers. 12 sense - a little bit better sense of your professional 13 Q. So you provided testimony to the legislature? 16 14 Mile it	-		-	
27 1 A. But after the legislation was written, you 1 A. The there's not a very clear definition 2 might have provided testimony? 1 A. The there's not a very clear definition 2 between the transition between embryo and fetus, but most would refer to it as a fetus at that point. 2 4 2013 in Texas for HB2. 4 Q. At six weeks of pregnancy? 5 Q. And for the record, HB2 is what? 5 A. Uh-huh. 6 A. HB2 was a legislation that had four parts: 6 Q. Okay. All right. So Georgia. Any other 7 It prohibited elected abortion after 20 weeks. It 7 states? 8 required that medical abortion be done as required by the 9 Q. Okay. All right. So let's go to let's 9 FDA. It mandated that abortion providers have hospital 9 Q. Okay. All right. So let's go to let's 11 abortion facilities meet the criteria of ambulatory 11 details of your expert report. I'd like to get a 12 surgery centers. 12 sense a little bit better sense of your professional 13 O. Did you support the legislation? 16 MS. MURRAY: And, Ms. Marchant, I think this 16 Q. Did you support t				
1Q. But after the legislation was written, you1A. The there's not a very clear definition2might have provided testimony?2between the transition between embryo and fetus, but most3A. I provided testimony on several occasions in3would refer to it as a fetus at that point.42013 in Texas for HB2.4Q. At six weeks of pregnancy?5Q. And for the record, HB2 is what?5A. Uh-huh.6A. HB2 was a legislation that had four parts:6Q. Okay. All right. So Georgia. Any other7It prohibited elected abortion after 20 weeks. It7states?8required that medical abortion providers have hospital9Q. Okay. All right. So let's go to let's9FDA. It mandated that abortion providers have hospital9Q. Okay. All right. So let's go to let's10privileges within 30 miles. And it mandated that10go to your professional training before we get into the11abortion facilities meet the criteria of ambulatory11background. So with that, I want to introduce if your13Q. So you provided testimony to the legislature13background. So with that, I want to introduce if your14while it was considering that legislation, correct?14MS. MURRAY: And, Ms. Marchant, I think this16Q. Did you support the legislator?16Will be Exhibit 1.17A. I did for reasons of safety.17Q. Dr. Skop, Tab A, is this your CV,18Q. Can you explain that? Safety with respect18Q. Okay. And	25	A. Not phot to the legislation being written.	25	
2might have provided testimony?2between the transition between embryo and fetus, but most3A. I provided testimony on several occasions in3would refer to it as a fetus at that point.42013 in Texas for HB2.4Q. At six weeks of pregnancy?5Q. And for the record, HB2 is what?5A. Uh-huh.6A. HB2 was a legislation that had four parts:6Q. Okay. All right. So Georgia. Any other7It prohibited elected abortion after 20 weeks. It7states?8required that medical abortion be done as required by the9Q. Okay. All right. So let's go to let's9FDA. It mandated that abortion providers have hospital9Q. Okay. All right. So let's go to let's10privileges within 30 miles. And it mandated that10go to your professional training before we get into the11abortion facilities meet the criteria of ambulatory11details of your expert report. I'd like to get a12surgery centers.12sense a little bit better sense of your professional13Q. So you provided testimony to the legislature13background. So with that, I want to introduce if you14while it was considering that legislation, correct?14MS. MURRAY: And, Ms. Marchant, I think this16Q. Did you support the legislation?16will be Exhibit 1.17A. I did for reasons of safety.17(Discussion held off the record.)18Q. Can you explain that? Safety with respect18Q. Dr. Skop, Tab A, is this your CV, </th <th></th> <th>27</th> <th></th> <th>29</th>		27		29
3A. I provided testimony on several occasions in3would refer to it as a fetus at that point.42013 in Texas for HB2.4Q. At six weeks of pregnancy?5Q. And for the record, HB2 is what?5A. Uh-huh.6A. HB2 was a legislation that had four parts:6Q. Okay. All right. So Georgia. Any other7It prohibited elected abortion after 20 weeks. It7states?8required that medical abortion providers have hospital9Q. Okay. All right. So let's go to let's9FDA. It mandated that abortion providers have hospital9Q. Okay. All right. So let's go to let's10privileges within 30 miles. And it mandated that10go to your professional training before we get into the11abortion facilities meet the criteria of ambulatory11details of your expert report. I'd like to get a12surgery centers.12sense a little bit better sense of your professional13Q. So you provided testimony to the legislature1314while it was considering that legislation, correct?1415A. Yes, I did.1516Q. Did you support the legislation?1617A. I did for reasons of safety.1718Q. Can you explain that? Safety with respect1810complications. I've seen that as a private OB/GYN for 252121A. Yes.2022years. I have seen many women in the emergency room when2223their abortion providers were not willing to ca	1		1	A. The there's not a very clear definition
42013 in Texas for HB2.4Q. At six weeks of pregnancy?5Q. And for the record, HB2 is what?5A. Uh-huh.6A. HB2 was a legislation that had four parts:6Q. Okay. All right. So Georgia. Any other7It prohibited elected abortion after 20 weeks. It7states?8required that medical abortion be done as required by the8A. No.9FDA. It mandated that abortion providers have hospital9Q. Okay. All right. So let's go to let's10privileges within 30 miles. And it mandated that10go to your professional training before we get into the details of your expert report. I'd like to get a11abortion facilities meet the criteria of ambulatory11background. So with that, I want to introduce if your14while it was considering that legislation, correct?14can turn to Tab A.15A. Yes, I did.15MS. MURRAY: And, Ms. Marchant, I think this16Q. Did you support the legislation?16will be Exhibit 1.17A. I did for reasons of safety.17(Discussion held off the record.)18Q. Can you explain that? Safety with respect18(Exhibit No. 1 was marked.)19to what?19Q. Okay. And did you prepare it?20A. Many abortionists do not take care of their20A. Yes.21complications. I've seen that as a private OB/GYN for 2521A. Yes.22years. I have seen many women in the emergency room when22Q. Okay. And did you prepare it? <td>2</td> <td></td> <th>2</th> <td>between the transition between embryo and fetus, but most</td>	2		2	between the transition between embryo and fetus, but most
5Q. And for the record, HB2 is what?5A. Uh-huh.6A. HB2 was a legislation that had four parts:6Q. Okay. All right. So Georgia. Any other7It prohibited elected abortion after 20 weeks. It7states?8required that medical abortion be done as required by the8A. No.9FDA. It mandated that abortion providers have hospital9Q. Okay. All right. So let's go to let's10privileges within 30 miles. And it mandated that10go to your professional training before we get into the11abortion facilities meet the criteria of ambulatory11details of your expert report. I'd like to get a12surgery centers.12sense a little bit better sense of your professional13Q. So you provided testimony to the legislature13background. So with that, I want to introduce if you14while it was considering that legislation, correct?14can turn to Tab A.15A. Yes, I did.15MS. MURRAY: And, Ms. Marchant, I think this16Q. Did you support the legislation?16will be Exhibit 1.17A. I did for reasons of safety.17(Discussion held off the record.)19to what?19Q. Dr. Skop, Tab A, is this your CV,20A. Many abortionists do not take care of their2021years. I have seen many women in the emergency room when2222years. I have seen many women in the emergency room when2223their abortion providers were not willing to care for <td></td> <td></td> <th>3</th> <td></td>			3	
6A. HB2 was a legislation that had four parts:6Q. Okay. All right. So Georgia. Any other7It prohibited elected abortion after 20 weeks. It7states?8required that medical abortion be done as required by the8A. No.9FDA. It mandated that abortion providers have hospital9Q. Okay. All right. So let's go to let's10privileges within 30 miles. And it mandated that10go to your professional training before we get into the11abortion facilities meet the criteria of ambulatory11details of your expert report. I'd like to get a12surgery centers.12sense a little bit better sense of your professional13Q. So you provided testimony to the legislature13background. So with that, I want to introduce if you14while it was considering that legislation, correct?14can turn to Tab A.15A. Yes, I did.15MS. MURRAY: And, Ms. Marchant, I think this16Q. Did you support the legislation?16will be Exhibit 1.17A. I did for reasons of safety.17(Discussion held off the record.)18Q. Can you explain that? Safety with respect18Q. Dr. Skop, Tab A, is this your CV,20A. Many abortionists do not take care of their20Kay. Yes.21complications. I've seen that as a private OB/GYN for 2521A. Yes.22years. I have seen many women in the emergency room when22Q. Okay. And did you prepare it?23their abortion providers were not wil			4	Q. At six weeks of pregnancy?
7It prohibited elected abortion after 20 weeks. It7states?8required that medical abortion be done as required by the8A. No.9FDA. It mandated that abortion providers have hospital9Q. Okay. All right. So let's go to let's10privileges within 30 miles. And it mandated that10go to your professional training before we get into the11abortion facilities meet the criteria of ambulatory11details of your expert report. I'd like to get a12surgery centers.12sense a little bit better sense of your professional13Q. So you provided testimony to the legislature13background. So with that, I want to introduce if you14while it was considering that legislation, correct?14can turn to Tab A.15A. Yes, I did.15MS. MURRAY: And, Ms. Marchant, I think this16Q. Did you support the legislation?16will be Exhibit 1.17A. I did for reasons of safety.17(Discussion held off the record.)18Q. Can you explain that? Safety with respect18(Exhibit No. 1 was marked.)19Q. Dr. Skop, Tab A, is this your CV,20A. Many abortionists do not take care of their2021years. I have seen many women in the emergency room when2222years. I have seen many women in the emergency room when2224them. So I testified because I felt the hospital2424Q. Does it include a current and accurate list		·	-	
8required that medical abortion be done as required by the8A. No.9FDA. It mandated that abortion providers have hospital9Q. Okay. All right. So let's go to let's10privileges within 30 miles. And it mandated that10go to your professional training before we get into the11abortion facilities meet the criteria of ambulatory11details of your expert report. I'd like to get a12surgery centers.12sense a little bit better sense of your professional13Q. So you provided testimony to the legislature13background. So with that, I want to introduce if you14while it was considering that legislation, correct?14can turn to Tab A.15A. Yes, I did.15MS. MURRAY: And, Ms. Marchant, I think this16Q. Did you support the legislation?16will be Exhibit 1.17A. I did for reasons of safety.17(Discussion held off the record.)18Q. Can you explain that? Safety with respect18(Exhibit No. 1 was marked.)19Q. Dr. Skop, Tab A, is this your CV,20A. Many abortionists do not take care of their20Exhibit 1?21complications. I've seen that as a private OB/GYN for 2521A. Yes.22years. I have seen many women in the emergency room when23A. Yes.23their abortion providers were not willing to care for23A. Yes.24them. So I testified because I felt the hospital24Q. Does it include a current and accurate list			-	
9FDA. It mandated that abortion providers have hospital privileges within 30 miles. And it mandated that abortion facilities meet the criteria of ambulatory9Q. 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 background. So with that, I want to introduce if you can turn to Tab A.14while it was considering that legislation, correct?14background. So with that, I want to introduce if you can turn to Tab A.15A. Yes, I did.15MS. MURRAY: And, MS. Marchant, I think this16Q. Did you support the legislation?16will be Exhibit 1.17A. I did for reasons of safety.17(Discussion held off the record.)18Q. Can you explain that? Safety with respect18(Exhibit No. 1 was marked.)19Q. Dr. Skop, Tab A, is this your CV,20A. Many abortionists do not take care of their2021years. I have seen many women in the emergency room when2222years. I have seen many women in the emergency room when2223their abortion providers were not willing to care for2324them. So I testified because I felt the hospital24		1		
10privileges within 30 miles. And it mandated that abortion facilities meet the criteria of ambulatory surgery centers.10go to your professional training before we get into the details of your expert report. I'd like to get a 			-	
11abortion facilities meet the criteria of ambulatory surgery centers.11details 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.13Q. So you provided testimony to the legislature while it was considering that legislation, correct? A. Yes, I did.13background. So with that, I want to introduce if you can turn to Tab A.14while it was considering that legislation, correct? A. Yes, I did.14MS. MURRAY: And, Ms. Marchant, I think this16Q. Did you support the legislation? A. I did for reasons of safety.16Will be Exhibit 1. (Discussion held off the record.) (Exhibit No. 1 was marked.)19Q. Can you explain that? Safety with respect to what?19Q. Dr. Skop, Tab A, is this your CV,20A. 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 a their abortion providers were not willing to care for their abortion providers were not willing to care for care for20A. Yes.24them. So I testified because I felt the hospital24Q. Does it include a current and accurate list			1	
12surgery centers.12sense a little bit better sense of your professional13Q. So you provided testimony to the legislature13background. So with that, I want to introduce if you14while it was considering that legislation, correct?14can turn to Tab A.15A. Yes, I did.15MS. MURRAY: And, Ms. Marchant, I think this16Q. Did you support the legislation?16will be Exhibit 1.17A. I did for reasons of safety.17(Discussion held off the record.)18Q. Can you explain that? Safety with respect18(Exhibit No. 1 was marked.)19Q. Dr. Skop, Tab A, is this your CV,20A. Many abortionists do not take care of their20Exhibit 1?21complications. I've seen that as a private OB/GYN for 2521A. Yes.22years. I have seen many women in the emergency room when22Q. Okay. And did you prepare it?23their abortion providers were not willing to care for23A. Yes.24them. So I testified because I felt the hospital24Q. Does it include a current and accurate list		· -		
13Q. So you provided testimony to the legislature while it was considering that legislation, correct?13background. So with that, I want to introduce if you can turn to Tab A.15A. Yes, I did.14can turn to Tab A.16Q. Did you support the legislation?15MS. MURRAY: And, Ms. Marchant, I think this17A. I did for reasons of safety.17(Discussion held off the record.)18Q. Can you explain that? Safety with respect18(Exhibit No. 1 was marked.)19D. Dr. Skop, Tab A, is this your CV,20A. Many abortionists do not take care of their20Exhibit 1?21complications. I've seen that as a private OB/GYN for 2521A. Yes.22years. I have seen many women in the emergency room when22Q. Okay. And did you prepare it?23their abortion providers were not willing to care for23A. Yes.24them. So I testified because I felt the hospital24Q. Does it include a current and accurate list		-		
14while it was considering that legislation, correct?14can turn to Tab A.15A. Yes, I did.15MS. MURRAY: And, Ms. Marchant, I think this16Q. Did you support the legislation?16will be Exhibit 1.17A. I did for reasons of safety.17(Discussion held off the record.)18Q. Can you explain that? Safety with respect18(Exhibit No. 1 was marked.)19Q. Dr. Skop, Tab A, is this your CV,20A. Many abortionists do not take care of their20Exhibit 1?21complications. I've seen that as a private OB/GYN for 2521A. Yes.22years. I have seen many women in the emergency room when22Q. Okay. And did you prepare it?23their abortion providers were not willing to care for23A. Yes.24them. So I testified because I felt the hospital24Q. Does it include a current and accurate list				
15A. Yes, I did.15MS. MURRAY: And, Ms. Marchant, I think this16Q. Did you support the legislation?16will be Exhibit 1.17A. I did for reasons of safety.17(Discussion held off the record.)18Q. Can you explain that? Safety with respect18(Exhibit No. 1 was marked.)19D. Dr. Skop, Tab A, is this your CV,20A. Many abortionists do not take care of their20Exhibit 1?21complications. I've seen that as a private OB/GYN for 2521A. Yes.22years. I have seen many women in the emergency room when22Q. Okay. And did you prepare it?23their abortion providers were not willing to care for23A. Yes.24them. So I testified because I felt the hospital24Q. Does it include a current and accurate list			1	
16Q. Did you support the legislation?16will be Exhibit 1.17A. I did for reasons of safety.17(Discussion held off the record.)18Q. Can you explain that? Safety with respect18(Exhibit No. 1 was marked.)19to what?19Q. Dr. Skop, Tab A, is this your CV,20A. Many abortionists do not take care of their20Exhibit 1?21complications. I've seen that as a private OB/GYN for 2521A. Yes.22years. I have seen many women in the emergency room when22Q. Okay. And did you prepare it?23their abortion providers were not willing to care for23A. Yes.24them. So I testified because I felt the hospital24Q. Does it include a current and accurate list				
17A. I did for reasons of safety.17(Discussion held off the record.)18Q. Can you explain that? Safety with respect18(Exhibit No. 1 was marked.)19to what?19Q. Dr. Skop, Tab A, is this your CV,20A. Many abortionists do not take care of their20Exhibit 1?21complications. I've seen that as a private OB/GYN for 2521A. Yes.22years. I have seen many women in the emergency room when22Q. Okay. And did you prepare it?23their abortion providers were not willing to care for23A. Yes.24them. So I testified because I felt the hospital24Q. Does it include a current and accurate list			1	
18Q. Can you explain that? Safety with respect18(Exhibit No. 1 was marked.)19to what?19Q. Dr. Skop, Tab A, is this your CV,20A. Many abortionists do not take care of their20Exhibit 1?21complications. I've seen that as a private OB/GYN for 2521A. Yes.22years. I have seen many women in the emergency room when22Q. Okay. And did you prepare it?23their abortion providers were not willing to care for23A. Yes.24them. So I testified because I felt the hospital24Q. Does it include a current and accurate list			1	
19to what?19Q.Dr. Skop, Tab A, is this your CV,20A. Many abortionists do not take care of their20Exhibit 1?21complications. I've seen that as a private OB/GYN for 2521A.Yes.22years. I have seen many women in the emergency room when22Q.Okay. And did you prepare it?23their abortion providers were not willing to care for23A.Yes.24them. So I testified because I felt the hospital24Q.Does it include a current and accurate list		-		
20A. Many abortionists do not take care of their20Exhibit 1?21complications. I've seen that as a private OB/GYN for 2521A. Yes.22years. I have seen many women in the emergency room when22Q. Okay. And did you prepare it?23their abortion providers were not willing to care for23A. Yes.24them. So I testified because I felt the hospital24Q. Does it include a current and accurate list			1	
21complications. I've seen that as a private OB/GYN for 2521A.Yes.22years. I have seen many women in the emergency room when22Q.Okay. And did you prepare it?23their abortion providers were not willing to care for23A.Yes.24them. So I testified because I felt the hospital24Q.Does it include a current and accurate list	1		1	
22years. I have seen many women in the emergency room when22Q.Okay. And did you prepare it?23their abortion providers were not willing to care for23A.Yes.24them. So I testified because I felt the hospital24Q.Does it include a current and accurate list		-	1	
23their abortion providers were not willing to care for23A. Yes.24them. So I testified because I felt the hospital24Q. Does it include a current and accurate list				
24them. So I testified because I felt the hospital24Q.Does it include a current and accurate list				
25 admitting privilege was an important way to improve 25 of your credentials?				
	25	admitting privilege was an important way to improve	25	of your credentials?

Ingrid Skop, M.D.

	•		0
	30		32
1	A. Yes.	1	setting?
2	Q. Okay. Are there any inaccuracies on the CV	2	A. Do you mean like a public clinic or
3	that you want to point out?	3	because we would call our office a clinic, our private
4	A. No.	4	practice.
5	Q. Anything missing on the CV?	5	Q. Right. Sure. My apologies. I'm referring
6	A. I mean, I think you can always add more	6	to a public clinic or sometimes, for example, hospitals
7	things to a CV, but I don't see anything substantial	7	will have outpatient clinics of different types that are
8	missing.	8	located near but not necessarily within the hospital.
9	Q. So nothing that you would imagine would be	9	A. No, it is within my practice.
10	relevant to this case?	10	Q. I'm sorry, what was that?
11	A. No.	11	A. All of my clinical work is done within my
12	Q. So I see you're trained as an OB/GYN; is	12	private OB/GYN practice.
13	that correct?	13	Q. Okay. And you've been doing that since
14	A. That is correct.	14	1996; is that correct?
15	Q. Can you describe the nature of your	15	A. Yes.
16	practice?	16	Q. Okay. And what's the hospital that you
17	A. I'm in a group practice of about 20 OB/GYNs,	17	practice in?
18	and I work full time. I probably deliver 15 babies a	18	A. North Central Baptist.
19	month. I see 25 to 30 patients a day in the office, take	19	Q. I saw at one point that you were the am I
20	call along with the rest of my group. Since there is a	20	getting this correct, that you were the chair of the
21	lot of us, it is usually about two 24-hour calls a month.	21	Baptist Hospital Systems, or the chair of the department
22	Q. Okay. And when you say you take call, what	22	of OB/GYN; is that correct?
23	does that mean?	23	A. I was just the chair of the department at
24	A. Due to the size of our group, it means that	24	one point.
25	I come to the hospital, I pack a bag, and I do nothing	25	Q. Of the department for Baptist Hospital
	31		33
1	but manage labor and deliver babies on labor and	1	Systems, right?
2	delivery.	2	A. For at the time I was at a different
3	Q. Okay. So during a month, you would probably	3	Baptist hospital. Northeast Baptist, and I was the chair
4	have two days like that, where you're doing labor and	4	of the OB/GYN department for that time period.
5	delivery work at the hospital?	5	Q. Okay. So you were at the Northeast Baptist
6	A. Yes.	6	Central Hospital, and now you're at the North Central
7	Q. Are there other days of the month that you	7	Baptist Hospital?
8	are doing labor and delivery at the hospital?	8	A. Yeah. I was at Northeast Baptist for
9	A. If I have a patient that comes in in labor	9	probably about 15 years, and then we moved our practice
10	or a scheduled C-section or induction, I will do those	10	to North Central Baptist for the last, probably, nine
11	deliveries even if I'm not the call doctor.	11	years.
12	Q. Okay. So if it is one of your patients, you	12	Q. Okay. And are those are both of those
13	would go into the hospital for that in addition to the	13	hospitals affiliated with Baptist Hospital Systems in
14	days that you're on call; is that correct?	14	Texas?
15	A. Yes.	15	A. Yes. Yes, they are.
16	Q. So you work in a private practice. How many	16	Q. Okay. So what is you said that you work
17	people are in your practice?	17	full time. What does a normal week look like for you in
18	A. Twenty.	18	terms of the kinds of care that you provide?
19	Q. Sorry. I should say how many physicians.	19	A. I take one day off a week, Wednesday. The
20	ls it 20?	20	other four days I work two days a week I work from
21	A. There's 20 physicians, yes.	21	7:45 to 3:15. The other two days I see patients from
1		00	
22	Q. Twenty physicians, okay. Are they all	22	9:00 until 5:00, and sometimes I have surgeries or
22 23	Q. Twenty physicians, okay. Are they all OB/GYNs?	22	C-sections scheduled before or during lunch periods.
			-
23	OB/GYNs?	23	C-sections scheduled before or during lunch periods.

34 36 1 caseload? 1 Q. And do you have any sense of when they do 2 A. I don't know how many active patients I have 2 come in. that third? because many of them just come to see me once a year for 3 3 A. I would say it is probably only about 10 or 4 their annuals. I would say, in an average week, I 4 15 percent that come in after the first trimester. 5 probably see 100 to 110 patients in the office. 5 Q. Okay. What's the latest you've seen someone 6 Q. Okay. Do you have a sense of how that 6 come in? 7 7 caseload would break down between patients seeing you for A. Well, I've delivered women at the hospital 8 obstetrical care as opposed to gynecological care? 8 that didn't know they were pregnant, so all the way to 9 A. Probably 20 percent obstetric and 80 percent 9 delivery, but typically it is much earlier. 10 10 gynecologic. Q. How often has that happened that you've had 11 Q. And some of the gynecologic visits could be deliveries from women who didn't know they were 11 12 women who are between pregnancies, correct? 12 pregnant? 13 A Yes 13 Α. No very often. Most women know. 14 Q. Okay. And then how would you describe the 14 Would it be more than five? Q. patient population that you serve in your private 15 15 A. More than five women? 16 practice? 16 Q. Uh-huh. 17 A. Of our OB patients, probably about 40 17 A. I'd say probably about five women that went 18 percent have Medicaid funding. The rest are privately 18 all the way to term without knowing they were pregnant. funded -- or private insurance. Demographics, probably 19 19 Q. And the people who come to see you, you say 10 percent black women, 50 to 60 percent Hispanic, and 20 20 about 10 to 15 percent will come in after the first 21 most of the rest are white, occasional Indian or Pacific 21 trimester. Do you have a sense of when those people 22 Islander 22 learned they were pregnant? Q. Sorry. You said 50 to 60 percent Hispanic, 23 23 A. My sense is that it is rare for a woman not 24 and what share would you estimate are black? 24 to know or suspect that she's pregnant and get halfway 25 A. About 10 percent. 25 through her pregnancy before she knows. I think most 35 37 Q. What about the -- how -- for patients who 1 1 women who present for late prenatal care, they are either come to see you for obstetrical care, how early do 2 2 in denial about the pregnancy or, perhaps, patients typically come in for their first prenatal 3 3 procrastinating. Sometimes there's Medicaid funding issues too. 4 visit? 4 5 A. If they're not having any problems, we 5 Q. Can you explain the Medicaid funding 6 generally try to bring them in by about seven weeks. 6 issue? Q. Okay. So is that the recommendation for 7 7 A. If a woman doesn't have insurance, in order 8 standard prenatal care? 8 to get Medicaid funding, she needs to -- sorry, there's 9 A. It -- it works out well because at that 9 some noise. visit we can generally document the fetal cardiac motion 10 -- she needs to apply for Medicaid. And for 10 some women, that can take a little bit of time to do 11 by ultrasound, so we can give them reassurance about the 11 12 viability of their pregnancy. If they're bleeding or 12 that. 13 having pain, of course we get them in earlier. 13 Q. I see. Okay. So you said you think it is 14 Q. Uh-huh. And do you -- do you see -- I mean, 14 rare. Would you say, based on your experience, that it 15 I imagine on some occasions you must see people who come 15 happens in 5 percent of cases that women don't know until 16 in later for care than seven weeks; is that correct? 16 after the first trimester? 17 A. That is correct. 17 A. I think it would be less than 5 percent. Q. Actually, if we could back up. I believe 18 Q. Who come in for their first visit? 18 19 A. That's correct. 19 you said you thought it was rare that people don't know they're pregnant until after the first half of pregnancy. 20 Q. How -- can you estimate how often that 20 21 happens among your patient population, that people come 21 Is that what you said, Dr. Skop? 22 in after the recommended seven-week visit for their first 22 A. I think that might have been what I said. 23 prenatal appointment? 23 Q. Okay. But just for -- to be clear, though, 24 A. Probably about a third of them come in after 24 the second half -- the first half of pregnancy would end 25 seven weeks. 25 after what week?

38 40 1 1 induction? A. You know, I think what I said was a little 2 2 imprecise. Let me back up. A. Possibly a third. Q. Okay. And why would you induce labor? What 3 I think it is very rare for women not to 3 4 are the reasons that a patient might have induction? 4 know that they're pregnant until the gestational age that 5 we're discussing in this legislation. 5 A. Some patients want to do it for social Q. Meaning 18 weeks --6 6 reasons. They may have other children at home that 7 7 A. Eighteen weeks. they'd like to arrange child care for, perhaps to arrange 8 Q. -- plus? Okay. 8 their work leave. That's an elective induction. There 9 9 And with respect to those people, would you are specific criteria we use to determine whether it is 10 10 say that's maybe 5 percent of your patient population appropriate to induce that labor. 11 doesn't learn that they're pregnant until 18 weeks of 11 We manage a very high risk patient 12 pregnancy or more? 12 population. The rate of obesity, diabetes, and 13 13 hypertension are quite high in San Antonio, and many A. I think it is far less than that. 14 Q. Less. What about the share of your pregnant 14 times women who have those problems require delivery due 15 population who learn that they're pregnant after the 15 to worsening severity of their underlying medical 16 first trimester, so after -- let me ask you. What would 16 problems. 17 you say -- when does the first trimester end, what week 17 Q. I see. So when you say that they may LMP? 18 18 require delivery, you mean they might require delivery 19 A. Typically we think 12 and 13 weeks. 19 before their bodies would naturally go into labor; is 20 Q. What share of your patient population would 20 that correct? 21 21 you say learns that they're pregnant after 12 to 13 weeks A. That is correct. 22 of pregnancy? 22 Q. So you would induce labor, in those 23 A. Although some present later than that for 23 circumstances, to deliver the baby other than might 24 24 various reasons, I think it would probably only be 2, 3 otherwise occur? 25 percent that don't know that they're pregnant after that 25 A. If appropriate. Sometimes they need a 39 41 1 time. 1 C-section for obstetric indications. 2 2 Q. You mentioned the possibility of elective Q. In your practice. Is that what you're 3 testifying to? 3 inductions and that there was some criteria you use in 4 A. In my practice, uh-huh. 4 determining when that might be appropriate. What are 5 5 Q. All right. So in terms of -- you mentioned those criteria? you do about 20 percent obstetrical care in a given week A. They need to be at least 39 weeks 6 6 and 80 percent gynecological care, correct? 7 7 gestational age. 8 A. Correct. 8 Q. Okay. 9 Q. Of the gynecological care that you provide, 9 A. And I prefer to deliver them when they have what kinds of procedures do you do? What are the most 10 10 a favorable cervix, meaning that they're a little bit 11 common ones? 11 dilated. There are various criteria, but usually about 12 A. Probably the most common are minor 12 two centimeters dilated. Because in that scenario, I 13 procedures such as an endometrial ablation, which is for 13 don't think we're raising the risk of C-section by 14 dysfunctional uterine bleeding or a laparoscopic tubal 14 inducing labor. 15 ligation. 15 Q. Okay. Because if it is what you might 16 consider an unfavorable cervix, induction can increase 16 Q. Okay. What else? 17 A. Those are the most common that I do. 17 the risk of --18 Q. Okay. What about for obstetrical care? You 18 A. Yes. 19 mentioned that you deliver babies. Do you have a sense 19 Q. -- the C-section? 20 of how those deliveries break down in terms of vaginal 20 And in your practice, would you say that 21 versus caesarean section birth? 21 that is, to your knowledge, your colleagues' practices? 22 22 Is that the point at which an OB/GYN might induce labor A. Probably about a quarter caesarean section 23 23 for an elective induction in pregnancy, at that point in and three-quarter vaginal. 24 Q. Okay. What about -- among the vaginal 24 pregnancy; does that vary by doctor? 25 births that you do, what share would you say begin with 25 A. So you're asking if the criteria of 39 weeks

Seh	tember 02, 2020		Ingrid Skop, M.D.
	42		44
1	and a favorable cervix vary by doctor?	1	Q. And do you do them when patients request
2	Q. Not the 39 weeks but the favorable cervix.	2	elective C-sections?
3	You said that you like to see two centimeters dilation.	3	A. I will do them after extensive counseling.
4	Would you say that is individual preference, or would you	4	There's higher risk of morbidity after a C-section, and
5	say that is true across your practice?	5	so I make sure that the patients are aware of that.
6	A. I think my partners practice in a very	6	Q. Okay. So you would do them with appropriate
7	similar way to the way I do. Sometimes if a woman has	7	counseling with respect to the risks; is that accurate?
8	gone past the due date, we may induce with an unfavorable	8	A. Yes.
9	cervix. But that's generally because, at that point,	9	Q. Okay. One of the let's see. What are
10	we're starting to have obstetric indications, concerns	10	the risks of C-sections?
11	for the well-being of the fetus by going post dates.	11	A. There can be risk for anesthesia, aspiration
12	Q. Okay. And you mentioned the unfavorable	12	if a woman vomits or has an overdose or a reaction.
13	cervix. What do you have to do with an unfavorable	12	There can be risk of bleeding. There can be risk of
14	-	14	-
14	cervix to make the possibility of induction to make it realistically possible for someone to have an	14	infection in the abdomen, in the uterus, or the incision
16	induction?	16	itself can become infected and can sometimes open. There
17		17	can be risk of damage to other organs, particularly the bladder.
	A. In our hospital, we generally use a		
18	prostaglandin called Cervidil.	18	Q. Anything else?
19	Q. Cervidil. How is that administered?	19	A. Not that I can think of right offhand.
20	A. It is a vaginal insert.	20	Q. When you say bleeding, is there bleeding
21	Q. Are there other ways you can deal with an	21	after any pregnancy separation?
22	unfavorable cervix	22	A. Generally, yes.
23	A. Yes.	23	Q. So what kind of bleeding would be a
24	Q to cause dilation?A. Some obstetricians will use a balloon	24	concern?
25	A. Some obstetricians will use a balloon	25	A. Bleeding that results in blood loss that
	43		45
1		1	
1	catheter that they'll place in the cervix.	1	causes severe anemia or hemodynamic compromise. Bleeding
2	catheter that they'll place in the cervix. Q. Okay.	2	causes severe anemia or hemodynamic compromise. Bleeding can occur due to a flaccid uterus. So a uterus that does
2 3	catheter that they'll place in the cervix.Q. Okay.A. And there's we'll use misoprostol.	2 3	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
2 3 4	 catheter that they'll place in the cervix. Q. Okay. A. And there's we'll use misoprostol. Q. How is that administered? 	2 3 4	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
2 3 4 5	 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 	2 3 4 5	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
2 3 4 5 6	 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. 	2 3 4 5 6	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
2 3 4 5 6 7	 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 	2 3 4 5 6 7	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
2 3 4 5 6 7 8	 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? 	2 3 4 5 6 7 8	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.
2 3 4 5 6 7 8 9	 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 	2 3 4 5 6 7 8 9	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
2 3 4 5 6 7 8 9 10	 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 	2 3 4 5 6 7 8 9 10	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?
2 3 4 5 6 7 8 9 10	 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. 	2 3 4 5 6 7 8 9 10 11	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.
2 3 4 5 6 7 8 9 10 11 12	 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 	2 3 4 5 6 7 8 9 10 11 12	 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.
2 3 4 5 6 7 8 9 10 11 12 13	 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 	2 3 4 5 6 7 8 9 10 11 12 13	 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
2 3 4 5 6 7 8 9 10 11 12 13 14	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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-section. Q. Uh-huh. 	2 3 4 5 6 7 8 9 10 11 11 12 13 14 15 16 17 18 19 20	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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-section. Q. Uh-huh. A. But that's fairly rare. Most of the 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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
 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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 compromise. A. A hemodynamic compromise. A. Mere 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
 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 	 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-sections. 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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. Mhere she has trouble keeping her blood pressure up or her circulatory system starts to be compromised. 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.
 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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 compromise. A. A hemodynamic compromise. A. Mere 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

	46		48
1	describe those?	1	extremely rare occasions, has resulted in maternal death
2	A. Well, I've mentioned that particularly with	2	as well.
3	an unfavorable cervix it may raise the risk of requiring	3	Q. So to be clear, hypothetically, if you had a
4	a C-section. A long induction may raise the woman's risk	4	patient who is pregnant and has had one prior C-section,
5	of infection. An induction may lead to fetal intolerance	5	would you if she wanted to have another C-section,
6	of labor that might require a caesarean section for the	6	would you perform a C-section in those circumstances?
7	indications for the baby. In rare occasions people can	7	A. I would after counseling on the options.
8	have adverse reactions to the medications that are used:	8	Q. Okay. And in that circumstance, you would
9	the Pitocin or Cervidil or Cytotec.	9	classify that as a C-section performed for maternal
10	Q. What about uterine rupture; does that	10	indication, correct?
11	happen?	11	A. Yes.
12	A. It can happen. The most it doesn't	12	Q. Okay. All right. What about do you
13	fortunately, it doesn't happen often and generally	13	handle miscarriage management?
14	happens in the setting of a woman trying to have a	14	A. I do.
15	vaginal birth after she's had a prior C-section or other	15	Q. And can you describe the miscarriage
16	uterine surgery. Sometimes women have uterine fibroids	16	management care that you provide?
17	removed, and that's a situation where they also might be	17	A. Most miscarriages are in the first
18	at risk for uterine rupture.	18	trimester. And on diagnosis, there are three options
19	In third world countries, fortunately I've	19	that I'll offer a patient and, obviously, counsel about
20	never seen it, but uterine ruptures can occur from	20	the pros and cons of each of the options. We can do a
21	obstructive labors, where there is not the ability to do	21	a dilation and suction curettage. That's a surgical
22	a caesarean section to get the baby safely out if the	22	management that removes the fetus and the placenta and
23	baby is unable to deliver vaginally.	23	the pregnancy tissue.
24	Q. But in a U.S. setting, uterine rupture does	24	We can wait. The body generally will
25	happen on occasion from inductions, correct?	25	recognize a miscarriage and eventually she will pass the
	47		49
1	47 A Well we as a rule, we do not induce	1	4.9 tissue. Sometimes that's psychologically hard because it
1	A. Well, we as a rule, we do not induce	1	tissue. Sometimes that's psychologically hard because it
2	A. Well, we as a rule, we do not induce women who have had a prior C-section. So it I	2	tissue. Sometimes that's psychologically hard because it can take a little while. Sometimes it is weeks before
2 3	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	2 3	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
2 3 4	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	2 3 4	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
2 3	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	2 3	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
2 3 4 5	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.	2 3 4 5	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.
2 3 4 5 6	 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 	2 3 4 5 6	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
2 3 4 5 6 7	 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 	2 3 4 5 6 7	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
2 3 4 5 6 7 8	 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 	2 3 4 5 6 7 8	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?
2 3 4 5 6 7 8 9	 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 	2 3 4 5 6 7 8 9	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.
2 3 4 5 6 7 8 9 10	 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 	2 3 4 5 6 7 8 9 10	 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
2 3 4 5 6 7 8 9 10 11	 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? 	2 3 4 5 6 7 8 9 10 11	 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
2 3 4 5 6 7 8 9 10 11 12	 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 	2 3 4 5 6 7 8 9 10 11 12	 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
2 3 4 5 6 7 8 9 10 11 12 13	 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 	2 3 4 5 6 7 8 9 10 11 12 13	 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,
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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. It is a procedure that OB/GYNs take very
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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.

	50		52
1	always do it under ultrasound guidance. Even later	1	involved in something called The Contraceptive
2	miscarriages, I would say 16, 18 weeks and beyond, we	2	Initiative; is that right or institute?
3	often we also may offer the patient induction in the	3	A. That was a nonprofit that I founded about
4	hospital with misoprostol.	4	five years ago.
5	Q. Okay. So just so that I'm clear. At the	5	Q. And is it still in operation?
6	point at which, in your practice, dilation and suction	6	A. It is not because I joined the board of
7	curettage would no longer be available to someone	7	another organization that does similar work, and so I
8	experiencing a miscarriage is approximately 14 weeks; is	8	rolled the assets of The Contraceptive Initiative into
9	that correct?	9	the board of The Source or into the organization
10	A. Well, the the transition from a dilation	10	called The Source.
11	and suction curettage to a dilation and evacuation is	11	Q. What is The Source?
12	I don't think there is a hard line at 14 weeks. The D&E	12	A. The Source is a clinic model currently it
13	is required when the fetal bones are calcified and the	13	is eight clinics in Texas that are based on a pregnancy
14	fetus has reached a size that he cannot be easily	14	resource center model of giving women options other than
15	extracted with the suction tubing. And so it can	15	abortion or unintended pregnancies. They also do free
16	depend on the situation.	16	STI testing, and they this particular group of clinics
17	If you have a fetus that's been dead,	17	are beginning to offer whole women's health including
18	perhaps for a couple of weeks before it was recognized,	18	contraception.
19	that fetus may be soft enough that you can extract him	19	Q. So The Contraceptive Institute or
20	completely with the suction. But if he's bigger or	20	Initiative when you were working on that and, I guess, it
21	recently died and has not begun the process of	21	sounds like, into The Source, is one of the forms of
22	maceration, then many times multiple passes with the	22	contraception that you provide long-acting reversible
23	graspers to disarticulate the fetus are required. And	23	contraceptives?
24	that's the definition of a D&E.	24	A. Yes, it is.
25	Q. And how many D&Es for miscarriage management	25	Q. And those are sometimes call LARCs, correct?
	51		53
1	51	1	53
1	have you performed during your career?	1	A. Yes.
2	have you performed during your career? A. Maybe about one a year.	2	 A. Yes. Q. Do LARCs reduce, in your view do they
2 3	have you performed during your career?A. Maybe about one a year.Q. And how long have you been practicing?	2 3	 A. Yes. Q. Do LARCs reduce, in your view do they reduce the incidences of unintended pregnancy?
2 3 4	 have you performed during your career? A. Maybe about one a year. Q. And how long have you been practicing? A. Twenty-five years. 	2 3 4	 A. Yes. Q. Do LARCs reduce, in your view do they reduce the incidences of unintended pregnancy? A. I believe they do.
2 3 4 5	 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? 	2 3 4 5	 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
2 3 4	 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. 	2 3 4 5 6	 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?
2 3 4 5 6	 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. 	2 3 4 5	 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.
2 3 4 5 6 7	 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; 	2 3 4 5 6 7	 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.
2 3 4 5 6 7 8	 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? 	2 3 4 5 6 7 8	 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
2 3 4 5 6 7 8 9	 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 	2 3 4 5 6 7 8 9	 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?
2 3 4 5 6 7 8 9 10	 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 	2 3 4 5 6 7 8 9 10	 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
2 3 4 5 6 7 8 9 10 11	 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 	2 3 4 5 6 7 8 9 10 11	 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
2 3 4 5 6 7 8 9 10 11 12	 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 	2 3 4 5 6 7 8 9 10 11 12	 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.
2 3 4 5 6 7 8 9 10 11 12 13	 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 	2 3 4 5 6 7 8 9 10 11 12 13	 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
2 3 4 5 6 7 8 9 10 11 12 13 14	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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

	54		56
1	Q. How expensive are IUDs, on average, would	1	Q. What do you mean by abortion advocacy? That
2	you say, in your experience?	2	they're an abortion advocacy organization?
3	A. They they're about 600 to 700 dollars a	3	A. To my knowledge, they have never submitted
4	unit.	4	an amicus brief or a statement opposing any restriction
5	Q. Okay. And are they covered by Medicaid?	5	on abortion. So they they promote abortion in any
6	A. Yes. They're currently covered by all	6	circumstance for any reason at any time in pregnancy.
7	insurances. So it is rare that we find a woman who can't	7	Q. And what about AAPLOG, the organization that
8	get coverage for it.	8	you are a member of? That's the American Association of
9	Q. But if you don't have Medicaid or insurance	9	Pro-Life Obstetricians and Gynecologists, correct?
10	of some kind, you would not be able to get coverage for	10	A. Yes.
11	it; is that correct?	11	
12	A. That's correct.	12	Q. Are they an advocacy organization, Dr. Skop?
		13	-
13	Q. Do you imagine among the patient population		A. Well, of course they are. It is in their
14	that you see that relies on Medicaid, so is income	14	name.
15	eligible for Medicaid, do you think an expense of did	15	Q. A pro-life advocacy organization?
16	you say 500 to 700 dollars?	16	A. They used to be a subgroup of ACOG until
17	A. That's a good range.	17	ACOG kicked them out. But they represent another
18	Q. Would you say 500 to 700 dollars would be a	18	Q. Ma'am, could are they a pro-life advocacy
19	barrier to getting a LARC in those circumstances without	19	organization?
20	insurance?	20	A. Yes, ma'am, they are.
21	A. Certainly. Certainly.	21	Q. Okay. So you mentioned ACOG does put out
22	Q. Okay. So I have just a couple more	22	some useful information in obstetrics and gynecology. Do
23	questions on this, but I'm wondering, how are you doing?	23	you rely on their practice bulletins in your practice at
24	Do you want to take a break, or do you want to go a	24	all?
25	little longer and then break in maybe 15 minutes?	25	A. I have been known to consult their practice
	55		57
4	55	1	57
1	A. I can go longer, but if anybody else needs a	1	bulletins, yes.
2	A. I can go longer, but if anybody else needs a break, I'm happy to take one now.	2	bulletins, yes. Q. Okay. What about their ethics committee
2 3	 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 	2 3	bulletins, yes. Q. Okay. What about their ethics committee opinions; do you ever use those to guide your practice
2 3 4	 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. 	2 3 4	bulletins, yes. Q. Okay. What about their ethics committee opinions; do you ever use those to guide your practice with tricky ethical issues?
2 3 4 5	 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 	2 3 4 5	 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
2 3 4 5 6	 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 	2 3 4 5 6	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
2 3 4 5 6 7	 A. I can go longer, but if anybody else needs a break, l'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? 	2 3 4 5 6 7	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.
2 3 4 5 6 7 8	 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. 	2 3 4 5 6 7 8	 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?
2 3 4 5 6 7 8 9	 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? 	2 3 4 5 6 7 8 9	 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.
2 3 4 5 6 7 8 9 10	 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. 	2 3 4 5 6 7 8 9 10	 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?
2 3 4 5 6 7 8 9 10 11	 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? 	2 3 4 5 6 7 8 9 10 11	 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.
2 3 4 5 6 7 8 9 10 11 12	 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. 	2 3 4 5 6 7 8 9 10 11 12	 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
2 3 4 5 6 7 8 9 10 11 12 13	 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 	2 3 4 5 6 7 8 9 10 11 12 13	 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
2 3 4 5 6 7 8 9 10 11 12 13 14	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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, 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

Ingrid Skop, M.D.

Sep	otember 02, 2020		Ingria Skop, IVI.D.
	58		60
1	A. A referral is not necessary. Abortions are	1	who she goes to. There are several different clinics she
2	paid for by private funds in Texas, and I believe	2	could go to. I could refer her to the Yellow Pages or
3	everybody knows who the largest abortion provider is. So	3	to the internet to discover where a clinic is.
4	it is not necessary for me to give her a referral. That	4	Q. And if she says that she's interested in
5	is not a barrier to her ability to get an abortion if she	5	adoption, would you refer her to the Yellow Pages?
6	wants it.	6	A. I could, but I also know some adoption
7	Q. With respect, Dr. Skop, that is not	7	agencies.
8	responsive to my question. My question is what would you	8	Q. Do you?
9	tell the patient if she asked for a referral for an	9	A. I usually have a specific place that I can
10	abortion; what would you tell her?	10	send her.
11	A. I would show her the baby on ultrasound; I	11	Q. And if a patient well, let's let me
12	would tell her about the option of continuing the	12	back up.
13	pregnancy. If she's unable to care for the child, I	13	If a patient expresses an interest of having
14	would tell her that there are many families in this	14	an abortion to you, do you refer her to a colleague,
15	country that would like to adopt a baby. I would	15	perhaps, who would advise her with respect to her options
16	introduce her to some of the resources available in our	16	with respect to abortion who might actually provide a
17	area, many of which, incidentally, provide couples	17	referral?
18	counseling.	18	MR. SORENSON: Objection, asked and
19	And I think it is pretty clear in	19	answered.
20	Guttmacher's literature that many of the women who choose	20	Q. I'm asking here, Dr. Skop, about whether you
21	abortion do so because of lack of support from their	21	would refer a patient to one of your colleagues who does
22	partner and because of the perceived lack of resources.	22	provide referrals for all sorts of options, either full
23	So I will tell her what resources are available. If she	23	term pregnancy, adoption, or abortion?
24	continues to express a desire to have an abortion, of	24	A. I don't believe any of my colleagues would
25	course, I will tell her about the potential risk from	25	refer her for an abortion either.
	59		61
1	abortion, which can include physical damage, that can	1	Q. Okay. So you think, throughout your
2	include mental health complications, even years later.	2	practice, none of your colleagues would give the name and
3	The possibility that when she does desire a pregnancy	3	contact information of an abortion provider?
4	that the baby could be born prematurely.	4	A. It is not
5	If she wants an abortion, she can have one.	5	MR. SORENSON: Objection, foundation.
6	I'm not going to stop her. But, like I said, she doesn't	6	A. It is not necessary.
7	need a referral from me to get one.	7	Q. Okay. Let me ask you this: Dr. Skop, have
8	Q. Okay. So is it accurate to say, then,	8	you ever indicated that you do provide or sorry. Let
9	Doctor, that you would never provide a patient with	9	me rephrase.
10	information about where to obtain an abortion if they	10	Have you ever stated that you do refer for
11	expressed a desire to have one?	11	abortion where there is a need?
12	A. I don't think it is necessary for me to do	12	MR. SORENSON: Objection, vague.
13	that. Everybody knows that your position you work	13	A. What do you mean by a need?
14	for	14 15	Q. Dr. Skop, in testimony you gave to the Texas
15	Q. With respect, Doctor, is it accurate to say		State Legislature in a committee hearing you mentioned
16	that you would not provide a referral for an abortion to	16 17	that you gave such testimony earlier to the Texas State
17	a patient who expresses a desire to have one?	17	Legislature. Did you ever indicate to the one of the legislators that you did provide referrals to abortion
18	 A referral for abortion is not necessary. So the answer is yes: that's accurate? 	18 19	where there was need?
19	Q. So the answer is yes; that's accurate?	20	A. I don't recall that I said that.
20	A. What do you mean by referral? Do you want	20 21	
21 22	me to tell her the name of a specific abortionist? Q. Sure. If she asks for a name and	21	Q. And if you would have said that, it would have been untrue; is that correct?
22	Q. Sure. If she asks for a name and information about who she can contact to obtain an	23	MR. SORENSON: Objection, vague.
	mornation about who she can contact to obtain an	20	wirk. OUTENOUN. Objection, Vague.
21	abortion, would you provide that?	24	Ο Could you answer the question Doctor
24 25	abortion, would you provide that? A. I'm not going to I'm not going to choose	24 25	Q. Could you answer the question, Doctor well, let me ask you this: Is there anything about my

62 64 1 question that you don't understand? 1 Q. Would you describe those as the leading 2 A. Yes, I think there is. 2 journals in the obstetrics and gynecology field? So you're asking me to recall something that 3 3 A. They're well regarded journals. I said seven years ago, and I don't recall if I said that 4 Okay. So generally viewed as authoritative 4 **Q**. 5 or not. I think your follow-up question was: If I said 5 in the field? that. was it untrue --6 6 A. They're peer reviewed. They have published 7 Q. Would that have been untrue? 7 articles that I have found lacking in data and substance. So I wouldn't call them perfect or always 8 Well, why don't I rephrase it this way: Do 8 you provide abortion referrals where there is a need? authoritative. 9 9 10 MR. SORENSON: Objection, vague. 10 Q. Sure. But in terms of among the journals A. I think I would need to understand what you 11 11 that people might consult in the field of obstetrics and 12 mean by need. 12 gynecology, would you view them as the two leading 13 13 Q. Okay. ones? A. If a woman's life is in danger from her 14 A. They're up there, yes. They are some of the 14 15 pregnancy, and that happens sometimes, as her doctor, I 15 better ones. 16 care for her, and I deliver her. So I can't think of a 16 Q. All right. And what about -- are there any 17 situation where I would need to refer her to an 17 textbooks or treatises that you turn to for information 18 abortionist to be cared for. 18 on the practice of the obstetrics and gynecology? 19 Q. Okay. That's fair. 19 A. There used to be. When I was a resident, I 20 All right. What about -- we talked a little 20 had and still have copies of the textbooks in my 21 bit about ACOG. Are there any other professional 21 possession. But with the way that people do research organizations in the medical community that you look to 22 22 today, I do not have any updated textbooks that I rely 23 for guidance in your practice? 23 upon. A. I don't think so. 24 24 Q. All right. 25 Q. What about the American Medical 25 MS. MURRAY: So I think that's probably a 63 65 1 Association? 1 good spot for us to stop. Do you all want to break for 2 2 ten minutes? A. I'm not a member of the AMA. 3 Q. Okay. Well, whether or not you're a member, 3 MR. SORENSON: Yes. Should we break until 4 do you ever rely on their materials to guide your 4 9:45, Mountain time, quarter to the hour? 5 5 MS. MURRAY: Sure that works. Sounds very practice? 6 6 A. No. good. 7 7 Q. What about journals; are there particular (Recess from 9:33 a.m. to 9:48 a.m.) 8 medical journals that you turn to for reliable research 8 Q. (By Ms. Murray) Welcome back from the 9 and information in the fields of obstetrics and 9 break, Dr. Skop. Is there anything from your prior 10 testimony that you would like to add to or correct at 10 gynecology? 11 A. There are a number of medical journals that 11 this time? 12 I will reference. 12 A. No. 13 Q. Did you speak with anyone other than 13 Q. Which ones? 14 A. Most commonly, "The Green Journal." 14 Mr. Sorenson during the break? 15 Q. What is that? 15 A. No. 16 A. It is called Obstetrics and Gynecology. It 16 Q. So you intend to offer expert opinion in 17 is ACOG's journal. 17 this case, correct? 18 Q. And what about -- isn't there something 18 A. Yes. called "The Gray Journal"? 19 Q. And what areas in the field of obstetrics 19 20 A. Yes. The American Journal on Obstetrics and 20 and gynecology do you consider yourself an expert in? 21 A. I would consider myself an expert in 21 Gynecology. 22 22 Q. Do you rely on that as well? pregnancy management, in gynecologic preventive treatment 23 as well as treatment of pathology within the field of 23 A. I have read articles from there. I no 24 longer subscribe to it, so I don't have as ready access 24 gynecology. Specific to this case, I have cared for many 25 women in the emergency room who have had complications 25 to it as I do. . .

			· · · ·
	66		68
1 fro	om abortions.	1	Q. How would you how would you define
2	Q. Okay. So that's your experience. What do	2	leading expert?
3 yo	ou think you're in an expert in with something specific	3	A. Well, as I just mentioned to you, I have
4 to	this case?	4	published peer reviewed papers on it, and I have cared
5	A. I think I'm an expert now, after having	5	for women who have experienced complications related to
6 ca	red for many women who had complications that were not	6	abortions in this gestational age. I don't provide them.
7 ca	red for by the provider who performed the procedure.	7	As I told you earlier, I am healthfully respectful of the
8 be	gan extensive research to discover why I was seeing so	8	D&E procedure because I think it is a very complicated
9 ma	any complications when the literature tells me that	9	procedure. I think the American Board of Medical
	ere are rarely complications. I have discussed	10	Specialties agrees with me. They just created a two-year
11	Q. Dr. Skop, I just I do want to make sure	11	fellowship, Complex Family Planning
	hat we're able to move along today. I'm sorry to	12	Q. Dr. Skop objection, nonresponsive.
	iterrupt you, but I do want you to answer my question,	13	A to do D&E procedures
	hich is, specific to this case, what areas of obstetrics	14	Q. Dr. Skop, could you please respond to my
	r gynecology do you feel that you are an expert in?	15	question. How do you define the term leading expert?
16 0	A. I am an expert in obstetric management.	16	How would you define that?
	ighteen to twenty-two weeks is an area that I have	17	A. I have read so backing up.
	xtensive experience in caring for mothers and fetuses.	18	Yes, I would consider myself an expert. I
	nd yeah, so I think I've cared for complications. I	19	
	ave done extensive research to know how poor the data on		have read the available papers that address this topic.
		20 21	I have cared for it in my clinical practice, and I have
	omplications and mortality is related to abortion in the nited States.	21 22	written peer reviewed papers on it.
-			Q. You said you've written several. How many?
23	Q. So do you consider yourself an expert on the	23	More than five?
	afety of pregnancy and childbirth?	24	A. Regarding the safety of abortion
25	A. As much as you can be after delivering 6,000	25	Q. At and after 18 weeks of pregnancy.
	67		69
1 b:		1	
	abies and working in the field for 25 years 29 years	1	A. I've written two that addressed that
2 in	abies and working in the field for 25 years 29 years cluding residency.	2	A. I've written two that addressed that specific range. I've written two others on abortion
2 in 3	abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert	2 3	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.
2 in 3 4 or	abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert n the safety of abortion?	2 3 4	 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
2 in 3 4 or 5	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert n the safety of abortion? A. I do. 	2 3 4 5	 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
2 in 3 4 or 5 6	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert n the safety of abortion? A. I do. Q. Do you consider yourself an expert on the 	2 3 4 5 6	 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?
2 in 3 4 or 5 6 7 sa	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert n the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? 	2 3 4 5 6 7	 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
2 in 3 4 or 5 6 7 sa 8	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert n the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? A. I am as much of an expert as there is 	2 3 4 5 6 7 8	 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."
2 in 3 4 or 5 6 7 sa 8 9 be	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert n the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? A. I am as much of an expert as there is ecause I know how scanty the literature is on this 	2 3 4 5 6 7 8 9	 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.
2 in 3 4 or 5 6 7 sa 8 9 be 10 g	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert n the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? A. I am as much of an expert as there is ecause I know how scanty the literature is on this estational age. 	2 3 4 5 6 7 8 9 10	 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
2 in 3 4 or 5 6 7 sa 8 9 be 10 g 11	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert n the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? A. I am as much of an expert as there is ecause I know how scanty the literature is on this estational age. Q. So would you say that you're a leading 	2 3 4 5 6 7 8 9 10 11	 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.
2 in 3 4 or 5 6 7 sa 8 9 be 10 g 11 12 e	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert in the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? A. I am as much of an expert as there is exause I know how scanty the literature is on this estational age. Q. So would you say that you're a leading xpert on the safety of abortion after 18 weeks of 	2 3 4 5 6 7 8 9 10 11 12	 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
2 in 3 4 or 5 6 7 sa 8 9 be 10 g 11 12 e 13 p	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert in the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? A. I am as much of an expert as there is exause I know how scanty the literature is on this estational age. Q. So would you say that you're a leading xpert on the safety of abortion after 18 weeks of pregnancy, Dr. Skop? 	2 3 4 5 6 7 8 9 10 11 12 13	 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
2 in 3 4 or 5 6 7 sa 8 9 be 10 g 11 12 e 13 p 14	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert in the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? A. I am as much of an expert as there is ecause I know how scanty the literature is on this restational age. Q. So would you say that you're a leading xpert on the safety of abortion after 18 weeks of pregnancy, Dr. Skop? A. I'm not sure how you're defining expert. I 	2 3 4 5 6 7 8 9 10 11 12 13 14	 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
2 in 3 4 or 5 6 7 sa 8 9 be 10 g 11 12 e 13 p 14 15 h	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert in the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? A. I am as much of an expert as there is exause I know how scanty the literature is on this estational age. Q. So would you say that you're a leading xpert on the safety of abortion after 18 weeks of pregnancy. A. I'm not sure how you're defining expert. I ave written several peer reviewed papers on this topic. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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?
2 in 3 4 or 5 6 7 sa 8 9 be 10 g 11 12 e 13 p 14 15 h 16	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert in the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? A. I am as much of an expert as there is exause I know how scanty the literature is on this estational age. Q. So would you say that you're a leading xpert on the safety of abortion after 18 weeks of pregnancy. A. I'm not sure how you're defining expert. I ave written several peer reviewed papers on this topic. Q. Well, you said I am as much of an expert as several peer to the safety of an expert as the sure of an expert of abortion after 18 weeks of the sure how you're defining expert. I ave written several peer reviewed papers on this topic. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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
2 in 3 4 or 5 6 7 sa 8 9 be 10 g 11 12 e 13 p 14 15 h 16 17 tl	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert in the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? A. I am as much of an expert as there is exause I know how scanty the literature is on this estational age. Q. So would you say that you're a leading xpert on the safety of abortion after 18 weeks of oregnancy, Dr. Skop? A. I'm not sure how you're defining expert. I ave 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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.
2 in 3 4 or 5 6 7 sa 8 9 be 10 g 11 12 e 13 p 14 15 h 16 17 til 18 b	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert in the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? A. I am as much of an expert as there is excause I know how scanty the literature is on this estational age. Q. So would you say that you're a leading xpert on the safety of abortion after 18 weeks of oregnancy, Dr. Skop? A. I'm not sure how you're defining expert. I ave 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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
2 in 3 4 or 5 6 7 sa 8 9 be 10 g 11 12 e 13 p 14 15 h 16 17 tl 18 b 19 a	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert an the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? A. I am as much of an expert as there is excause I know how scanty the literature is on this estational age. Q. So would you say that you're a leading xpert on the safety of abortion after 18 weeks of oregnancy, Dr. Skop? A. I'm not sure how you're defining expert. I ave 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 bortion at and after 18 weeks of pregnancy? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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
2 in 3 4 or 5 6 7 sa 8 9 be 10 g 11 12 e 13 p 14 15 h 16 17 tl 18 b 19 a 20	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert in the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? A. I am as much of an expert as there is ecause I know how scanty the literature is on this testational age. Q. So would you say that you're a leading xpert on the safety of abortion after 18 weeks of pregnancy. A. I'm not sure how you're defining expert. I ave 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 bortion at and after 18 weeks of pregnancy? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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
2 in 3 4 or 5 6 7 sa 8 9 be 10 g 11 12 e 13 p 14 15 h 16 17 til 18 b 19 a 20 21 le	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert in the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? A. I am as much of an expert as there is exause I know how scanty the literature is on this testational age. Q. So would you say that you're a leading xpert on the safety of abortion after 18 weeks of pregnancy, Dr. Skop? A. I'm not sure how you're defining expert. I ave 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 bortion at and after 18 weeks of pregnancy? MR. SORENSON: Objection. Vague as to eading, the word leading. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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
2 in 3 4 or 5 6 7 sa 8 9 be 10 g 11 12 e 13 p 14 15 h 16 17 tl 18 b 19 a 20 21 le 22	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert in the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? A. I am as much of an expert as there is excause I know how scanty the literature is on this estational age. Q. So would you say that you're a leading xpert on the safety of abortion after 18 weeks of oregnancy, Dr. Skop? A. I'm not sure how you're defining expert. I ave written several peer reviewed papers on this topic. Q. Well, you said I am as much of an expert as here is, so I'm asking you, does that mean that you relieve you are a leading expert on the safety of bortion at and after 18 weeks of pregnancy? MR. SORENSON: Objection. Vague as to eading, the word leading. Q. Dr. Skop, is there anything about that 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 20 21 22	 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.
2 in 3 4 or 5 6 7 sa 8 9 be 10 g 11 12 e 13 p 14 15 h 16 17 til 18 b 19 a 20 21 le 22 23 q	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert an the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? A. I am as much of an expert as there is excause I know how scanty the literature is on this estational age. Q. So would you say that you're a leading xpert on the safety of abortion after 18 weeks of oregnancy, Dr. Skop? A. I'm not sure how you're defining expert. I ave written several peer reviewed papers on this topic. Q. Well, you said I am as much of an expert as here is, so I'm asking you, does that mean that you believe you are a leading expert on the safety of bortion at and after 18 weeks of pregnancy? MR. SORENSON: Objection. Vague as to eading, the word leading. Q. Dr. Skop, is there anything about that you don't understand? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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?
2 in 3 4 or 5 6 7 sa 8 9 be 10 g 11 12 e 13 p 14 15 h 16 17 tl 18 b 19 a 20 21 le 23 q 24	 abies and working in the field for 25 years 29 years cluding residency. Q. Uh-huh. Do you consider yourself an expert in the safety of abortion? A. I do. Q. Do you consider yourself an expert on the afety of abortion at or after 18 weeks of pregnancy? A. I am as much of an expert as there is excause I know how scanty the literature is on this estational age. Q. So would you say that you're a leading xpert on the safety of abortion after 18 weeks of oregnancy, Dr. Skop? A. I'm not sure how you're defining expert. I ave written several peer reviewed papers on this topic. Q. Well, you said I am as much of an expert as here is, so I'm asking you, does that mean that you relieve you are a leading expert on the safety of bortion at and after 18 weeks of pregnancy? MR. SORENSON: Objection. Vague as to eading, the word leading. Q. Dr. Skop, is there anything about that 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 20 21 22	 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.

		-	ingita ettop, m.b.
	70		72
1	Q. Okay. How many abortions at or after 18	1	illness, and I treat it through medication and referral
2	weeks of pregnancy have you seen performed?	2	to counseling.
3	A. Probably 20.	3	Q. Okay. So you don't provide counseling
4	Q. And when was the last one that you saw	4	yourself, though, correct, what would be considered
5	performed?	5	mental health counseling?
6	A. In residency, 25 years ago.	6	A. Well, it would be ongoing therapeutic
7	Q. And what share of those would have been	7	relationship that I don't have time to do while seeing 30
8	performed by a D&E?	8	OB/GYN patients daily. That's not to say I don't counsel
9	A. At that time, the preferred technique was	9	women when I discuss this problem with them. I do. But
10	prostaglandin induction. I believe most of those were	10	I don't do it for a prolonged period of time.
11	done that way.	11	Q. Is there anything other than what you've
12	Q. So have you ever observed an abortion at or	12	just described in terms of treating patients with the
13	after 18 weeks of pregnancy performed by a D&E?	13	depression that you believe qualifies you as an expert on
14	A. Not on a living fetus, but I have seen and	14	the identification and treatment of depression?
15	have performed D&Es on deceased fetuses.	15	A. I've cared for a number of post-aborted
16	Q. To be clear, if you are performing a D&E on	16	women over my career who have had depression that they
17	a deceased fetus, is it an abortion in your view?	17	have attributed to their abortion. In addition, the Any
18	A. No. An abortion is the intentional	18	Woman Can, that I am the board chairman of, provides free
19	destruction of a living fetus.	19	mental health counseling for women who have sequelae,
20	Q. So you've never performed an abortion at or	20	psychiatric sequelae of their abortions.
21	after 18 weeks of pregnancy, correct?	21	Q. And the activities of Any Woman Can, why are
22	A. No, I have not.	22	they relevant to your expertise?
23	Q. And you have never seen one performed at or	23	A. I am the board chairman, so
24	after 18 weeks of pregnancy by way of D&E is that	24	Q. Do you oversee the
25	correct?	25	A I'm involved in the protocols and
	71		73
1	A. That is correct.	1	expediting the counseling.
2	Q. And with respect to miscarriage management,	2	Q. Okay. You've talked about your experience
3	I believe you testified earlier, Doctor, that you have	3	seeing women who have had abortions in the past. Let's
4	never performed, even for miscarriage management, a D&E	4	talk about women who have had complications from
5	past 16 weeks of pregnancy; is that correct?	5	abortion. How many women would you estimate you have
6	A. That is correct.	6	treated for a complication of abortion during your
7	Q. Do any of the doctors in your practice	7	career?
8	perform D&E abortions?	8	A. It's probably too numerous to count the
9	A. No.	9	women who have presented to the emergency room
10	Q. Okay. What about do you consider	10	hemorrhaging after medical abortions who have required a
11	yourself an expert in mental health?	11	D&E or a suction D&C. I have in residency, I had one
12	A. I wouldn't say I'm an expert, but I'm	12	patient that I readmitted to the ICU in sepsis after a
13	married to a psychiatrist. I know a lot about it.	13	mid tri I believe after a 20 or 22 week abortion, and
14	Q. Expertise by osmosis.	14	she died. I also know of a patient within my practice
15	Would you consider yourself an expert in the	15	who died of septicemia after a first trimester suction
16	identification and treatment of depression?	16	abortion.
17	A. It is something that I manage clinically	17	Q. Okay. So just to go back through those.
18	frequently.	18	You said you think it is too numerous to count the number
19	Q. So would you consider yourself an expert in	19	of women you've seen who have presented to the hospital
20	it?	20	after a medication abortion with a hemorrhage; is that
21	A. Sure. It is my professional part of my	21	correct?
22	job.	22	A. That's correct.
23	Q. And so when you say you manage it, what do	23	Q. A medication abortion, how late is that
24	you mean by that?	24	available in the state of Texas?
24 25	you mean by that? A. I identify the symptoms, I diagnose the	24 25	A. Until 2016, it was available until seven

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

Ingrid Skop,	M.	D.
--------------	----	----

	74		76
1	weeks. Since that time, it is available until ten	1	years ago, our group stopped covering the emergency room.
2	weeks.	2	Just prior to that, we had a month where we had three
3	Q. Until ten weeks. So not an abortion that	3	women admitted for post-abortive complications. One was
4	would be at issue in this case, correct?	4	in the ICU, one required a blood transfusion, and one
5	A. That's correct. Right.	5	required surgery to complete her abortion. It was at
6	Q. And not a method of abortion that you could	6	that time that I realized that there was not a system in
7	use at or after 18 weeks of pregnancy, correct?	7	place that would automatically record these
8	A. Abortions can be performed through medical	8	complications.
9	induction	9	I tried to report them to the state of
10	Q. But through the same medication abortion	10	Texas, which is one of the states that has a law
11	regimen that you were describing for first trimester	11	requiring providers to report the complications, and I
12	abortions?	12	found it to be a very difficult process, including
13	A. They can be. They're not done frequently	13	they wanted the forms sent by certified mail, and it was
14	that way.	14	de-identified, which, in my mind, would be very hard to
15	Q. Just to be clear that I'm understanding you	15	discover duplicates or pull charts and find the
16	correctly: Are you saying that the regimen to do a	16	situation. So that helped me to understand that
17	medication abortion early in pregnancy in the first	17	Q. Wait. With respect, Doctor, my question
18	trimester could be used to do a medication abortion later	18	was, can you recall the most recent instance in which you
19		19	have treated someone for a hemorrhage after medication
20	in pregnancy, for example, at 18 to 20 weeks? A. The same medications, mifepristone and	20	-
	•	20	abortion who specifically told you that they obtained their abortion at Planned Parenthood?
21	misoprostol, can be used. The dosing may be different,		
	but the same medications can be used.	22	A. Two to three years ago during that month,
23	Q. Do you know whether it is different?	23	Yes.
24	A. I don't because it is done so infrequently.	24	Q. One of those women identified Planned
25	I don't know that I know what standard dosing is for	25	Parenthood as the place where she had her abortion?
	75		77
1	75 that.	1	
	that.		A. Yes, and I've tried
2	that. Q. Uh-huh. So you said too numerous to count.	2	A. Yes, and I've triedQ. Can you recall any other
	that. Q. Uh-huh. So you said too numerous to count. Would you estimate that you've seen more than 20 of those		 A. Yes, and I've tried Q. Can you recall any other A response
2 3	that. Q. Uh-huh. So you said too numerous to count.	2 3	 A. Yes, and I've tried Q. Can you recall any other A response Q. Doctor, if you could listen to my question.
2 3 4 5	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?	2 3 4 5	 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.
2 3 4 5 6	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.	2 3 4 5 6	 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
2 3 4 5 6 7	 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? 	2 3 4 5 6 7	 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
2 3 4 5 6 7 8	 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 	2 3 4 5 6 7 8	 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?
2 3 4 5 6 7 8 9	 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. 	2 3 4 5 6 7 8 9	 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.
2 3 4 5 6 7 8 9 10	 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 	2 3 4 5 6 7 8 9 10	 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
2 3 4 5 6 7 8 9 10 11	 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 	2 3 4 5 6 7 8 9 10 11	 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?
2 3 4 5 6 7 8 9 10 11 12	 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 	2 3 4 5 6 7 8 9 10 11 12	 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
2 3 4 5 6 7 8 9 10 11 12 13	 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? 	2 3 4 5 6 7 8 9 10 11 12 13	 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,
2 3 4 5 6 7 8 9 10 11 12 13 14	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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

Sep	otember 02, 2020		Ingrid Skop, M.D.
	78		80
1	It fails about 20 percent of the time.	1	Q. Okay. It was not a D&E. And then you also
2	So I can't say that there aren't women who	2	mentioned I believe there was one other that you
3	are following that advice and trying to self-manage their	3	talked about. Which one am I not recalling; do you
4	abortion. Women may do it for reasons of finance because	4	remember?
5	you guys charge about \$500 for the medical abortion	5	A. That had died?
6	regimen. But so I can't say for sure that that	6	Q. Uh-huh, or any other type of complication.
7	doesn't happen, but I also know that I've seen a number	7	
8	of patients who have reported that they received their	8	A. There was a teenager who died after a first
9	medication in a Planned Parenthood clinic.	0 9	trimester surgical abortion.
10		9 10	Q. Right. First trimester surgical abortion. And what did she die from?
11	Q. You mentioned going to Mexico. Is it your	-	
	understanding that you can obtain a medication abortion	11	A. Overwhelming sepsis.
12	regimen in Mexico without a prescription?	12	Q. And when did that happen?
13	A. That is true.	13	A. Maybe 15 years ago.
14	Q. How long does it take to drive to the	14	Q. Do you know what point you said it is a
15	border, Dr. Skop, from where you are?	15	first trimester abortion. So is it your understanding
16	A. It is about three hours.	16	that was not a D&E abortion, correct?
17	Q. Okay. So okay. So we talked about the	17	A. That's correct.
18	women that you said that you've seen in the emergency	18	Q. So have you ever seen a complication from a
19	room. It sounded like you could only recall specifically	19	D&E abortion, Dr. Skop?
20	one instance in which that has happened; is that correct?	20	A. I have seen women have cervical incompetence
21	Are there any other specific patients you can recall?	21	and deliver babies extremely early after a history of a
22	A. Can you repeat the question? That reported	22	mid-trimester abortion. I would consider damage to the
23	Planned Parenthood, or have had abortion that's required	23	cervix resulting in the inability to hold a pregnancy to
24	surgical treatment?	24	term in a subsequent pregnancy to be a complication of
25	Q. Any other patients who you have treated post	25	D&E, and I have seen that occur on more than one
	79		81
	medication abortion for hemorrhage; can you recall any	1	occasion.
1	other specific patients?		
3	A. I can I can think of some faces, yes.	2 3	Q. Okay. So let me just break that down.
4	Q. How many?	3 4	So you're talking about women who have
5	A. I don't know.	4 5	preterm birth in subsequent births after an abortion, correct?
6	Q. More than five?	-	
7		6 7	A. Right.
8	A. Yes. It happens frequently. It happens frequently enough that I don't recall everybody's face		Q. And so the connection that you're making
9	that I've managed through this complication.	8	between the preterm birth and the earlier birth or the
		9	earlier abortion is the fact that uterine damage could
10	Q. You mentioned you tried to make a report of	10	cause later preterm birth; is that correct?
11	this to the state authorities; is that correct? A. That is correct.	11	A. That's correct, a cervical damage.
12		12	Q. Cervical damage. My apologies. Cervical
13	Q. So they would have well, did you send the	13	damage.
14	report to the state authorities?	14	How many times would you say you have seen
15	A. Yes.	15	that?
16	Q. Okay. What about you also mentioned that	16	A. I've seen a tendency toward early cervical
17	you had seen, during your residency, someone who had died	17	shortening become more pronounced throughout my career.
18	from septicemia after an abortion at 20 to 22 weeks; is	18	We at times, my group has had three or four women
19	that correct?	19	hospitalized on the antepartum service with this
20	A. That's correct.	20	premature shortening and dilation at very early
21	Q. When did you do your residency?	21	gestational ages 22, 24 weeks. So it is a trend that
22	A. '92 to '96.	22	I'm seeing a lot. I don't know that in all of those
23	Q. So do you know whether that was a D&E	23	situations they have a prior history of an abortion.
24	abortion?	24	As you may be aware, it is sometimes
25	A. No. I believe it was a prostaglandin.	25	difficult to get women to give you that history. But I
			1

			ingita ettep, inibi
	82		84
1	think that studies show that there is a correlation with	1	part of most academic physicians in America to look into
2	early delivery, particularly extremely early delivery,	2	this, although
3	after cervical abortions.	3	Q. Dr. Skop, let me ask it another way because
4	Q. So setting aside the studies, Doctor, I'm	4	I do want to keep us on track, and I would like you to
5	asking about your experience. Can you sticking on the	5	respond to my specific question. So let me ask it a
6	preterm birth. What about the histories or circumstances	6	different way that might be helpful.
7	of these patients has caused you to conclude that it is a	7	Of the people you have seen going into
8	post-abortion complication that they're having preterm	8	preterm labor, how what share of them would you say
9	birth?	9	report that they have a history of abortion?
10	Is there any let me ask it this way: Is	10	A. You know, I I can't really answer that
11	there anything other than the fact that these patients	11	question. Many of them have been managed by my partners
12	had an abortion at an earlier for an earlier pregnancy	12	and not me, and so I don't know the abortion history on a
13	that you are relying on to make that connection between	13	lot of them.
14	the abortion history and the preterm birth?	14	Q. So you're speculating as to the cause of
15	A. I would acknowledge that there are other	15	their preterm birth; is that correct?
16	things that can lead to preterm shortening. However, it	16	A. I'm speculating because there is no data.
17	is physiological plausible that mechanically dilating an	17	Q. Okay. So setting aside so we've talked
18	unripe cervix may cause damage to that cervix, which	18	about the preterm birth. Are there any other
19	relies on its intact musculature to hold a pregnancy to	19	complications from abortion that you believe you have
20	term, and I think there is data to support that.	20	treated in patients that you have seen during your
21	Q. Dr. Skop, let me ask it again. Is there	21	career?
22	anything other than the prior history of abortion with	22	A. There's another serious long-term
23	respect to these patients' circumstances or their	23	complication that is also quite hard to quantify.
24	specific histories that you are relying on to make a	24	There's a situation called placenta accreta spectrum
25	connection between their abortion and their later preterm	25	disorder, which is where a placenta is abnormally
	83		85
1	birth?	1	invasive. The incidence of that has increased 110 fold
2	A. I'm not sure of your question because I	2	in the past 50 years, and it is associated with
3	think I've already answered that. There's studies that	3	catastrophic bleeding at the time of delivery. Women
4	show that this can happen, and, with that history, it is	4	have died, even when they've been at a level 3 facility
5	certainly plausible that that could be the reason.	5	that was prepared for hemorrhage, because they can lose
6	Q. It is plausible. Is it plausible that that	6	so much blood so quickly that they can overwhelm the
7	is not the reason?	7	blood bank. It is associated with
8	A. It is possible.	8	Q. Can you answer my question?
9	Q. Do people have preterm births with no	9	A. Yeah, I'm sorry. I was giving you some
10	history of abortion?	10	background.
1		i 1	5
11	-	11	Q. Yeah, if I want background. I will certainly
11 12	A. Certainly, they do.	11 12	Q. Yeah, if I want background, I will certainly ask for it. At this point, I want to focus on: What are
12	A. Certainly, they do.Q. Would you say the majority of women who have		ask for it. At this point, I want to focus on: What are
	A. Certainly, they do.	12	ask for it. At this point, I want to focus on: What are the other complications that you believe you've seen?
12 13	 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 	12 13	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
12 13 14	A. Certainly, they do.Q. Would you say the majority of women who have preterm births have no history of abortion?	12 13 14	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
12 13 14 15	 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 	12 13 14 15	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?
12 13 14 15 16	 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 	12 13 14 15 16	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?
12 13 14 15 16 17	 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 	12 13 14 15 16 17	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
12 13 14 15 16 17 18	 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. 	 12 13 14 15 16 17 18 	 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.
12 13 14 15 16 17 18 19	 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 	 12 13 14 15 16 17 18 19 	 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
12 13 14 15 16 17 18 19 20	 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 	 12 13 14 15 16 17 18 19 20 	 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?
12 13 14 15 16 17 18 19 20 21	 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 	 12 13 14 15 16 17 18 19 20 21 	 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.
12 13 14 15 16 17 18 19 20 21 22	 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 	 12 13 14 15 16 17 18 19 20 21 22 	 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

Ingrid Skop, M.D. 86 88 1 Q. Uh-huh. That it will have -- or could 1 have had no C-sections and in woman who have abnormal 2 potentially have an impact on the placement of the 2 placentation but not at the area of the prior uterine 3 placenta in a later pregnancy? 3 scar. There are, clearly, other reasons women get that 4 A. That's correct. 4 other than having a prior C-section. 5 Q. So when you cite the 110-fold increase in 5 Q. All right. So we've talked about -- I abnormal placentation, could that also be attributable to 6 6 believe -- I just want to go back through. We talked 7 7 C-sections? about women hemorrhaging after medication abortion, a 8 A. It can. 8 patient who died of septicemia after a later medication Q. Do you know what share of births ended in 9 abortion. I believe you said it was a prostaglandin 9 10 10 C-section in, let's say, the 1950s? induction; is that correct? MR. SORENSON: Objection, foundation. 11 A. It was an amniocentesis. People don't do it 11 12 Q. Do you know what share of --12 so much anymore, but they used the do an amniocentesis 13 A. It was far smaller than it is today. Today 13 and inject the prostaglandin directly into the uterine 14 it is about probably about 30 percent. But just having 14 cavity --15 another reason doesn't mean that we shouldn't be curious 15 Q. Okay. 16 as to whether we're allowing women to undergo elective 16 A. -- to help induce labor, and it is a 17 procedures that may increase their risk --17 situation that is high risk for infection. 18 18 Q. Dr. Skop --Q. Okay. So that was one. And there was a A. -- (inaudible) of possible death. patient who died in the first trimester after a first 19 19 20 Q. Dr. Skop, please focus you on my question. 20 trimester surgical abortion, so not a D&E? 21 21 Provide an answer to the question. And if I want A. Right. Likely that was a uterine 22 additional information, I will follow up with you. I'm 22 perforation into the bowel to introduce that infection. 23 sorry to interrupt you. But I do want to keep us on 23 Q. But it was not a D&E abortion, correct? 24 24 A. No, it was not. It should be a safer track. 25 So you said it is possible that that 25 procedure. 87 89 Q. But it was not a D&E abortion; is that 1 increase in placenta accreta spectrum is due to the 1 2 2 correct? increase in C-sections, correct? 3 A. There is a correlation, yes. 3 A. That is correct. Some of these abortions 4 Q. And just for the record, a C-section 4 have more --5 5 actually involves -- every C-section involves a cut into Q. In terms of the long-term effects of the uterus; is that correct? 6 abortion, or effects you attribute to abortion -- you 6 7 said that you have treated patients who have had preterm 7 A. That's correct. 8 Q. Does every abortion or even D&E abortion 8 abortions, and based on their abortion history, you've 9 9 concluded that the preterm birth was a consequence of the involve a cut into the uterus? 10 abortion? 10 A. We don't know what kind of damage --11 Q. What about cervical damage? 11 A. It is possible. A. Cervical -- the cervix is stretched open in 12 Q. It is possible. 12 13 every surgical abortion. A. Data backs that up. 13 14 Q. So it could actually tear? 14 Q. Is it possible that it was not; is that A. It can, yes. 15 correct? 15 16 A. Well, certainly. But there are large 16 Q. It can. Does it? Is that a normal part of 17 the procedure of a surgical abortion? 17 studies, large review studies that show higher incidence 18 A. It is a complication of the surgical 18 of early delivery after abortions. 19 19 Q. And then with respect to -- you also abortion. 20 Q. It would be a complication, that's correct. 20 mentioned the patients that you had seen with abnormal 21 21 placentation; is that 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 22 22 A. That is correct. 23 Q. And what are you relying on to connect the 23 the procedure? 24 24 A. The cut into the uterus is the method of prior abortion history to the abnormal placentation? Is 25 entering the uterus. However, PAS occurs in women who 25 it just studies, or is there anything particular to the

Ingrid Skop, M.D. 90 92 1 circumstances of the patient that have allowed you to 1 your experience, what other complications have you 2 2 make that causal connection? treated post abortion that we have not spoken of today? 3 A. Well, those are physical, right? I've cared 3 A. Well, the plausibility is that if you have 4 for a lot of women with emotional and psychological 4 an invasive placenta -- and I neglected to mention the 5 converse can also happen. You can have a placental 5 problems post abortion. 6 6 abruption, an abnormally -- a placenta that does not Q. Can we -- sorry. Can we pause there? So 7 7 adhere well, and that can separate spontaneously in a have you now told me every physical complication that you 8 subsequent pregnancy. So, again, I don't -- nobody has 8 believe you have treated for an abortion -- for a patient 9 after an abortion that you're -- let me rephrase that. 9 the data that looks at every pregnancy outcome in 10 10 America. Nobody is interested in that data; nobody is Have you now told me every physical collecting it -- the CDC, nobody. So we don't know 11 complication that you have treated for a patient that you 11 12 everybody's history. Where, it would be nice if we 12 believe was a physical complication of the abortion? 13 did --13 A. I've also cared for women with Asherman's Q. So is your answer, Dr. Skop, that you don't 14 14 syndrome, which is scarring within the uterus. That also 15 15 know of any data specific to those individual's history is linked to prior instrumentation, and many times it is 16 that allows you to make that causal connection between 16 a cause of infertility. 17 the prior abortion history and the placental --17 Q. And in those instances where you have cared 18 18 A. No, no. There are studies that correlate for people with Asherman's syndrome, have you ever 19 surgical instrumentation with these abnormal placentas. 19 confirmed that those individuals had a history of 20 20 And, yes, C-section can be a surgical instrumentation, abortion? 21 21 but if that's the case, the placenta --A. Sometimes they have. 22 22 Q. It is always a surgical instrumentation, Q. How many times? 23 isn't it? 23 Α. I don't know, but I know that I've gotten 24 24 A. It is a surgical scar, okay? And there are that history from some women. 25 women who have PAS where it is not in the surgical scar. 25 Q. More than one? 91 93 1 It is placenta previa. It can be up here. You know, so 1 A. Yes. Q. More than five? 2 2 in those cases you say to yourself, What else could have 3 happened that would make this uterus weak in the area of 3 Α. Probably. 4 placental implantation so that the placenta invades? And 4 Q. More than ten? 5 I think that we have to ask our ourselves, is it the one 5 Possibly. Α. 6 6 And Asherman's syndrome can be caused from out of three, one out of four women who have abortions --Q. 7 I know we're not doing as many surgical abortions as we 7 other kinds of instrumentation, correct? 8 used to, but we were, in the past, doing a lot of 8 A. That's correct. 9 surgical abortions. 9 So even a woman with a history of abortion, Q. 10 It would -- it is not good care for women to 10 she could have Asherman's syndrome that is unrelated to 11 ignore the possibility that that could be a door -- that 11 the abortion history, correct? 12 could be the cause. 12 A. That's possible. 13 13 Q. You're saying that there is a possibility Q. Okay. So have you now told me all the 14 that the prior abortion history is the cause? 14 physical complications that you have treated that you 15 A. Yes. Yes. 15 would attribute to a patient's prior history of 16 Q. Okay. What about any other complications 16 abortion? that you've seen from a D&E abortion at and after 18 17 17 A. I mentioned the lady in the ICU a couple of 18 weeks? 18 years ago. Transfusions, it is not uncommon to need to 19 A. I have not, personally, cared for women who 19 transfuse someone. IV antibiotics. 20 have had perforated uteruses, but I have read a number of 20 Q. So you mentioned a teenager in the ICU after 21 reports --21 a first trimester. Is that what you're referring to? 22 22 Q. I'm asking you about who you've cared for, A. She died, but I have also cared for patients 23 Dr. Skop, because you've mentioned multiple times you are 23 who have gone to the ICU who lived. 24 drawing on your experience of treating women after 24 Q. Who needed the transfusions after 25 abortions who are suffering from complications. So in 25 abortion?

94 96 1 A. Yes. 1 expert. I certainly have cared for people who have had 2 Q. How many? 2 normal grief responses. 3 A. Probably five or ten. 3 Q. What about -- do you consider yourself an expert with respect to patients' decisional certainty 4 Q. How many after a D&E abortion after 18 weeks 4 5 of pregnancy would you say? 5 when making health care decisions? MR. SORENSON: Objection, vague. 6 A. Well, I'm happy to say that I have not cared 6 7 7 for women who have had complications from D&E abortions Q. Is there anything about that question you 8 after 18 weeks. And I think the -- one of the major 8 don't understand, Dr. Skop? 9 9 reasons for that is that Texas has a law against it. A. Yeah, I'm not sure what you're asking. I --10 10 Yeah, we still have a law against it. Q. Are you familiar with the -- I'm sorry? A. I said I do my best to make sure that they 11 So I don't think they happen very often, but 11 12 they're an extremely difficult procedure to perform, and 12 have all the information they need to make a decision, 13 if a physician does not have a lot of experience but I don't know that that makes me an expert. 13 14 performing them, then there is high likelihood they could 14 Q. So are you familiar with literature about 15 perforate the uterus, lacerate vessels, leave fetal parts 15 decisional certainty with respect to health care 16 inside. It is a very difficult procedure, a D&E. 16 decisions? 17 Q. So have you now told me all of the physical 17 A. I don't think I've read any of that 18 complications you believe you've treated from patients 18 literature. 19 after an abortion? 19 Q. Okay. Do you consider yourself an expert 20 A. I believe so. 20 with respect to fetal pain capacity. The capacity of a 21 Q. Okay. And we'll get to the mental health 21 fetus to experience pain? 22 issues later, but I do -- I do want to move on. 22 A. I have done a lot of research on that issue. 23 Something you just said triggered something. With 23 Q. Do you consider yourself an expert with 24 respect to the D&E, would you consider yourself to have 24 respect to the capacity of a fetus to experience pain? 25 the clinical competency to perform a D&E abortion? 25 A. Sure. 95 97 1 A. No. 1 Q. And what -- what would you say you base your 2 Q. And to perform a D&E miscarriage management 2 expertise on? 3 at and after 18 weeks of pregnancy? 3 A. I base my expertise on the research that A. I do them when I need to. I'm not 4 4 I've done in the neurologic literature as documented in 5 comfortable --5 my expert report, and also the fact that I have delivered Q. At and after 18 weeks of pregnancy? 6 6 many living babies in the gestational age that we're A. Oh. Yeah, usually I'll induce those. 7 7 discussing. And I have seen responses from those babies 8 Q. Usually or always? 8 that are identical to the responses that you and I would 9 A. Well, I told you earlier I have not done 9 have if we were experiencing pain. 10 one, so things wouldn't change in the future --10 Q. Okay. Anything else that you would base 11 Q. So do you believe you have the clinical 11 your expertise on in that area? 12 competency to perform miscarriage management by way of 12 A. No, I think clinical expertise and research D&E at and after 18 weeks of pregnancy? 13 13 is it. A. I would be uncomfortable doing that 14 14 Q. Okay. Are you -- do you have training in 15 procedure because it is very complicated. 15 neurology? 16 Q. So would you not do it because of that 16 A. No, I -- well, other than what we got in 17 discomfort? 17 medical school. A. I would -- I would bring another partner 18 18 Q. Do you have a specialization in maternal 19 alongside me to do it. 19 fetal medicine? 20 Q. Do you believe that you are an expert 20 A. No, I do not. 21 in grief responses? 21 Q. Do you perform intrafetal surgeries -- is A. Excuse me? 22 22 that what it is called? Intrauterine fetal surgeries? 23 Q. Do you consider yourself an expert in grief 23 A. Nobody in San Antonio does. We send them to 24 responses? 24 Houston and Dallas. 25 A. Grief responses? I wouldn't say I'm an 25 Q. Okay. Do you consider yourself an expert in

Ingrid Skop, M.D.

		1	ingita ettep, M.B.
	98		100
1	neonatology?	1	Q. To make sure that I understand, when you
2	A. No.	2	were preparing this, did you cite every document that you
3	Q. What about epidemiology?	3	relied on in the expert report, or were there other
4	A. I've learned a lot of epidemiology in my	4	documents that you reviewed that you didn't cite?
5	abortion and maternal research, but I don't consider	5	A. It's hard to say. I do a lot of reading.
6	myself a expert.	6	So it is very possible that there are things that I read
7	Q. What about in medical ethics?	7	and ideas that I incorporated in this report that I did
8	A. I'm interested in medical ethics, but I'm	8	not specifically cite, but I tried my best to go to the
9	certainly not an expert.	9	source of the statements when I prepared the references.
10	Q. Try to adhere to them, but not an expert.	10	Q. Okay. And do you is there any way that
11	So at this point, I want to introduce if	11	you would be able to identify, at this point, which
12	you could turn to Tab B. This is your so this would	12	documents you considered for incorporation in the report
13	become Exhibit 2. This is your expert report that you	13	but you ultimately excluded?
14	submitted in this case. Is that accurate?	14	A. I don't recall, to tell you the truth. I
		15	-
15	(Exhibit No. 2 was marked.)		mean, I could certainly provide you with those later if
16	Q. If I can make a note because we may refer	16	you want to know additional resources that I looked at.
17	back to this expert report throughout today's deposition.	17	Q. Well, I'm asking whether there is any way
18	So if you could, at this point, just number the pages	18	that you can identify those now? Do you have any notes
19	aren't numbered and the paragraphs aren't numbered	19	as to what you reviewed and excluded?
20	either. So to make sure we're all looking at the same	20	A. No. I think that it looks pretty
21	pages, I want to note that my page numbering will start	21	thorough in terms of the you know, many times review
22	with page 1 of the cover page. So if you want to number	22	papers will summarize statements, but I tried to go to
23	the pages, you're welcome to take a couple of seconds for	23	the source of the facts and not necessarily reference the
24	that. But I did in looking back through my notes, I	24	review paper that was referencing another paper. I felt
25		25	like it would be more accurate to go to the source, to go
25	realized that that might be a stumbling block.	25	like it would be more accurate to go to the source, to go
	99		
	22		101
1		1	101
1	So this is the expert report in the case.	1	to the neurologic literature that I've quoted and that
2	So this is the expert report in the case. Does this appear complete, Dr. Skop?	2	to the neurologic literature that I've quoted and that I've referenced.
2 3	So this is the expert report in the case. Does this appear complete, Dr. Skop? A. Yes, it does.	2 3	to the neurologic literature that I've quoted and that I've referenced. Q. You tried not to rely on how other
2 3 4	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?	2 3 4	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
2 3	So this is the expert report in the case. Does this appear complete, Dr. Skop? A. Yes, it does.	2 3	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?
2 3 4	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?	2 3 4	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
2 3 4 5	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.	2 3 4 5	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?
2 3 4 5 6	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	2 3 4 5 6	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
2 3 4 5 6 7 8	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	2 3 4 5 6 7	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
2 3 4 5 6 7 8 9	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	2 3 4 5 6 7 8 9	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
2 3 4 5 6 7 8 9 10	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	2 3 4 5 6 7 8 9 10	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.
2 3 4 5 6 7 8 9 10 11	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	2 3 4 5 6 7 8 9 10 11	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?
2 3 4 5 6 7 8 9 10 11 12	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	2 3 4 5 6 7 8 9 10 11 12	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?
2 3 4 5 6 7 8 9 10 11 12 13	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.	2 3 4 5 6 7 8 9 10 11 12 13	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?
2 3 4 5 6 7 8 9 10 11 12 13 14	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	2 3 4 5 6 7 8 9 10 11 12 13 14	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
2 3 4 5 6 7 8 9 10 11 12 13 14 15	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?	2 3 4 5 6 7 8 9 10 11 12 12 13 14 15	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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	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.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	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	2 3 4 5 6 7 8 9 10 11 12 12 13 14 15	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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	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.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	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	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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.
 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 	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?	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	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	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	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	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	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	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	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	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	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	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	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	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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.

Ingrid Skop, M.D.

_			
	102		104
1	think I went straight to the to the neurologic	1	Q. Do you recall, ballpark, how much you were
2	literature.	2	paid for drafting this report?
3	Q. Okay. Any other documents from AAPLOG that	3	A. I don't recall.
4	you can recall relying on to draft the report?	4	Q. Would it have been more than a thousand
5	A. I don't think so. I've been involved in	5	dollars?
6	drafting a lot of that their practice bulletins and	6	A. I think so.
7	committee opinions. So there may be similar wording, but	7	Q. More than \$5,000?
8	I this report essentially relies upon my own	8	A. Possibly.
9	research.	9	Q. More than \$10,000?
10	Q. Okay. What about did anyone other than	10	A. No.
11	Mr. Sorenson provide documents to you to consider with	11	Q. Okay. So somewhere between a thousand to
12	respect to this drafting this report?	12	\$10,000.
13	A. No.	13	And you would have records, though, that
14	Q. And have you discussed the report with	14	were submitted for that, correct?
15	anyone other than Mr. Sorenson?	15	A. Yeah, there are records.
16	A. No.	16	Q. Okay. And then so your report lists certain
17	Q. Did you have any role in drafting expert	17	opinions that you intend to testify about in this case,
18	reports for any other experts in this case?	17	correct?
19	A. No.	19	A. Yes.
	Q. Did you review any expert reports from other		
20	cases?	20	Q. And are the opinions listed in the report
21 22		21	all the expert opinions to which you intend to testify?
	A. No.	22	A. Are you asking if I have other opinions that
23	Q. Were you asked by anyone to make any factual	23	aren't in the report?
24	assumptions?	24	Q. Well, I'm asking whether you intend to
25	A. I'm not sure that I know what you mean by	25	provide other opinions in your testimony about this
	103		
	TO2		105
1	that.	1	105 case?
1 2		1 2	
	that. Q. Did Mr. Sorenson provide any facts or data		case? A. I don't think so.
2	that.	2	case?A. I don't think so.Q. Okay. Have you changed any of your opinions
2 3	that. Q. Did Mr. Sorenson provide any facts or data to you to use in drafting your opinions for this report?	2 3	case? A. I don't think so.
2 3 4	 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. 	2 3 4	 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.
2 3 4 5	 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 	2 3 4 5	 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
2 3 4 5 6	 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? 	2 3 4 5 6	 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
2 3 4 5 6 7	 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 	2 3 4 5 6 7	 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?
2 3 4 5 6 7 8	 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 	2 3 4 5 6 7 8	 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.
2 3 4 5 6 7 8 9	 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 	2 3 4 5 6 7 8 9 10	 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
2 3 4 5 6 7 8 9 10 11	 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. 	2 3 4 5 6 7 8 9 10 11	 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.
2 3 4 5 6 7 8 9 10 11 12	 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. 	2 3 4 5 6 7 8 9 10 11 12	 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
2 3 4 5 6 7 8 9 10 11 12 13	 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 	2 3 4 5 6 7 8 9 10 11 12 13	 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
2 3 4 5 6 7 8 9 10 11 12 13 14	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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.
 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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.
 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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

106 108 1 1 Q. So it says, "One large study examining Q. No, offered or authored. 2 2 reasons for later abortions found that: 'not knowing A. Well, they get their data -- Guttmacher gets 3 about the pregnancy,' 'trouble deciding about the 3 their data directly from abortion clinics. That is not 4 data that is available to most Americans. When you look 4 abortion,' and 'disagreeing about the abortion with the 5 man involved' were commonly reported." 5 at the numbers of abortions, you see that Guttmacher 6 reports 30 percent more than the CDC does. So Guttmacher 6 Later in that paragraph you say, "With all 7 7 this indecision, it is likely that another change of mind has a special relationship with the abortion industry. 8 could occur for the woman after going through with the Q. Do you actually -- can I ask you a quick 8 9 abortions, and the choice could be regretted." Did I get 9 question about that? 10 10 that right? A. Yes, ma'am. 11 A. Yes. 11 Q. Because I assume you would agree that no 12 Q. Okay. And in footnote 2, there, you're 12 data is perfect, correct? 13 relying on an article by Jones and Finer, correct? Those 13 A. Absolutely. are the researchers you mentioned earlier? 14 Q. So as between the CDC data about the number 14 15 A. Yes. 15 of abortions there are in a given year in the United 16 Q. And you said that you had read this article 16 States and the Guttmacher data, do you consider one to be 17 before you drafted your report, correct? 17 more reliable than the other? A. I've read it. It is possible that some of 18 A. I think the Guttmacher is probably more 18 19 that data came through the third Finer article as well. 19 reliable. California does an extraordinary large number 20 20 Q. Okay. But you believe that you cited the of abortions. They don't report anything to the CDC. Jones and Finer -- the article that you cite in 21 That reporting is voluntary. Also, Maryland has a 21 22 footnote 2 you read before you cited, correct? 22 late-term abortionist who does a lot of really, really 23 A. Yes. 23 late procedures, and they don't report data either. 24 So I think the CDC's data, just like it is 24 Q. And do you consider the analysis in that 25 article reliable? 25 for complications and just like it is for maternal 107 109 1 And I should say one note, Dr. Skop: If you 1 mortality, is seriously flawed and underestimates the 2 want to refer to other parts of the binder, that's fine. 2 extent of the problem. 3 But we should make sure that we're introducing them as 3 Q. So as between those two sources, you would 4 exhibits along the way so they are part of the record. 4 say that the Guttmacher source is the -- as to the number 5 5 of abortions performed annually is the more reliable of A. Okay. So when you say analysis, are you 6 talking about results or discussion, or are you just 6 the two? 7 A. That is probably the case. 7 talking about the general -- the paper itself? 8 Q. Well, I'm asking -- you cited it in your 8 Q. Would you say that it is the best data we 9 report, so I'm asking you whether you believed it to be 9 have available right now as to the number of annual 10 an article of good quality? 10 abortions that occur in the United States? 11 A. Almost all of the literature regarding 11 A. I think it is the best data. 12 reasons for abortions comes from Guttmacher Institute 12 Q. Okay. And to the extent that it is not 13 researchers and it comes through the journal 13 entirely accurate, do you -- is it your opinion that the 14 Contraception. And I think it is accurate, but I also 14 actual number is lower or higher than the Guttmacher 15 think that it is -- I think that there could be more to 15 data? the story on some of these reasons. I think that it is 16 16 A. Are you asking about the number of abortions 17 often presented in such a way as to justify abortion. 17 or complications? 18 Q. But --18 Q. The number of abortions. 19 A. And it is -- it is the best data we have. 19 A. Guttmacher is probably reasonably accurate 20 It is the only data, really, that we have, is what the 20 because they get their data directly from the abortion 21 21 providers. But if there are abortions being performed by abortion clinics put out for us to see. 22 22 Q. Are you saying that this article is being private doctors, they may not be reported. 23 authored by an abortion clinic, Doctor? 23 Q. Doesn't Guttmacher have a way of sampling 24 24 A. No, I'm not saying it is being altered. I'm private doctors as well, Dr. Skop? 25 saying it is being put out by researches --25 A. I don't know. I don't know how that works.

Sep	otember 02, 2020		Ingrid Skop, M.D.
	110		112
1	Q. You don't know the methodology of how they	1	other questions. I guess my question is and it sounds
2	identify abortion providers; is that correct?	2	like you're talking about this article in particular.
3	A. No, I don't.	3	A. Uh-huh.
4	Q. Okay. So if we can turn back to the part of	4	Q. My question is, with respect to
5	your report about reason for an abortion. My question	5	Contraception. Do you believe is it your opinion that
6	was, do you consider the article to be of good quality.	6	the quality of the research coming out of Contraception
	So setting aside I know that there are no perfect	7	is of high quality?
7	data. But citing this article, am I assuming correctly		
8		8 9	A. I I believe it is well, regarding
9	that you believe this is a good study?		these reasons, I have no reason to doubt that they are
10	A. I think it is accurate as far as it can be	10	taking the answers they've been given by women in
11	on this demographic data.	11	abortion clinics and reporting them.
12	Q. Okay. Okay. And are you looking at the	12	Q. Okay.
13	article now, Dr. Skop?	13	A. If we're talking about complications, I I
14	A. Yes, ma'am.	14	don't think that the data on complications in the United
15	Q. Okay. So why don't we go ahead and	15	States is accurate no matter who is reporting it.
16	introduce that into the record. This is Tab C, as in	16	Q. Okay. So we'll get to complications.
17	cat.	17	A. Okay.
18	(Exhibit No. 3 was marked.)	18	Q. Let's talk about it a little later.
19	Q. And what I'm showing you is "Who Has	19	So if I could take you back to that quote
20	Second-Trimester Abortions in the United States?" by	20	from your expert report where you said, "With all this
21	Jones and Finer; is that correct, Dr. Skop?	21	indecision, it is likely another change of mind could
22	A. Yep.	22	occur for the woman after going through with the abortion
23	Q. Okay. And does this appear complete?	23	and the choice could be regretted." How did you conclude
24	A. The article?	24	that the incision prior to having an abortion makes it
25	Q. Yes.	25	likely that the woman will change her mind again after
	111		110
	111		113
1	A. It is complete. I'm wondering if I might	1	having the abortion?
2	have gotten some of the reasons data from another one of	2	A. I base that on my clinical experience both
3	their articles because I don't see that here, but I	3	in the office and through my work with Any Woman Can.
4	Q. Okay.	4	There are women who regret their abortions.
5	A. I believe there is a chart in one of the	5	Q. There are women. Would you say
6	other articles that talks specifically about reasons.	6	A. And the less confident they are in their
7	Q. What about you mentioned the journal	7	decision I mean, somebody who waits until the second
8	Contraception. Do you consider that to be a reliable	8	trimester when they're feeling that baby move before they
9	source of information in the gynecological field?	9	decide to terminate, to me, that just that reeks of
10	A. Contraception, I believe, is published by	10	coercion. And I I don't think that there is good data
11	the Guttmacher Institute, and it very much works hard to	11	coming out of Guttmacher, coming out of Contraception
12	paint abortion in a favorable light. So I am skeptical	12	that addresses that.
13	sometimes with the data they put forward.	13	Q. So how did you to make sure I understand
14	Q. Skeptical about the quality of the data or	14	your position, then, the way you concluded that prior
15	the conclusions they draw from that data or both?	15	indecisional prior uncertainty before the abortion is
16	A. Well, for example, if we're looking at	16	likely to lead to another change of mind after the
17	reasons that women have abortions, they don't seem	17	abortion is based on your clinical experience and
18	particularly curious about things like coercion. And I	18	encountering some women who regret their abortions at Any
19	think they ask one question that was, like, did someone	19	Woman Can; is that correct?
20	else other than you you know they don't ask a lot	20	A. That is correct.
1			Q. You said earlier, though, that you're not
21	of questions that I would like to see asked. But I don't	21	a. Tou salu earlier, though, that you're not
	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,	21 22	familiar with the literature decisional certainty with
21	-		
21 22	have any you know, I don't work in an abortion clinic,	22	familiar with the literature decisional certainty with
21 22 23	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	22 23	familiar with the literature decisional certainty with respect to health care decisions?

	tember 02, 2020		Ingrid Skop, M.D.
	114		116
1	decision making in my 25 years of private practice. And	1	with me. And I don't think there is any reason that they
2	I've I've had patients, a number of patients who have	2	would feel that they couldn't share that with me just
3	told me, I didn't want often it is a young woman who	3	based on who I am and what they know about my practice.
4	keeps the pregnancy secret from her parents until they	4	Q. Do you believe that patients you
5	can no longer, you know, not see it, and often it is a	5	mentioned shame and stigma. Where did that shame and
6	woman who keeps it secret from her partner because she	6	stigma come from? Do you find that it comes from your
7	doesn't think he will support her decision. And in both	7	patients' own reactions to abortions or from the
8	of those cases, I think that they are often coerced by	8	reactions of other individuals either in their family or
9	the parent or coerced by the partner to have a late	9	community or friends?
10	abortion.	10	A. Well, I think, in this day and age, almost
11	I think that this uncertainty category	11	everyone has seen an ultrasound picture of a friend,
12	probably encompasses a lot of that based on what I've	12	perhaps, posted on Facebook. Everyone who has bothered
13	seen of my own patients and what I've heard them say.	13	to pay attention knows that an abortion is ending the
14	Q. Dr. Skop, have you ever obtained an informed	14	life of a living human being. Now, you know different
15	consent from a patient to perform an abortion?	15	people will justify it in different ways and say, My
16	A. No.	16	circumstance is rough, or whatever. And a woman may be
17	Q. So in terms of the kind of counseling that	17	in a situation where she does not feel she has another
18	goes along with the informed consent process for	18	option. But she also knows that she is ending the life
19	abortion, you have never participated in that; is that	19	of her own biologic child, and I I don't think it is
20	correct?	20	necessarily a religious thing. I know our society has a
21	A. I mean, it is possible in residency that I	21	lot of
22	might have been involved in that, but that's been more	22	Q. Dr. Skop, can you answer my question?
23	than 25 years. I'm concerned about the informed consent	23	A. I think
24	that does occur. You know, I'm sure you're aware of your	24	Q. I'm asking you about the source of shame and
25	annual report at Planned Parenthood; 96 percent of the	25	stigma. Do you believe it is all coming from the
1			
	115		117
1	pregnancy services are abortions. Knowing the real world	1	patients that you encounter, or from their community,
2	pregnancy services are abortions. Knowing the real world and knowing the decisional uncertainty in women, I find	2	patients that you encounter, or from their community, family, or friends, or both?
2 3	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	2 3	patients that you encounter, or from their community, family, or friends, or both? A. Well, I think we'll all agree that abortion
2 3 4	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.	2 3 4	patients that you encounter, or from their community,family, or friends, or both?A. Well, I think we'll all agree that abortionis a nuclear issue. It comes from many different
2 3 4 5	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	2 3 4 5	patients that you encounter, or from their community,family, or friends, or both?A. Well, I think we'll all agree that abortionis a nuclear issue. It comes from many differentdirections.
2 3 4 5 6	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	2 3 4 5 6	 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
2 3 4 5	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	2 3 4 5	 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
2 3 4 5 6	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	2 3 4 5 6 7 8	 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?
2 3 4 5 6 7 8 9	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.	2 3 4 5 6 7 8 9	 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.
2 3 4 5 6 7 8 9 10	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	2 3 4 5 6 7 8 9 10	 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?
2 3 4 5 6 7 8 9 10 11	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.	2 3 4 5 6 7 8 9 10 11	 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
2 3 4 5 6 7 8 9 10 11 12	 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 	2 3 4 5 6 7 8 9 10 11 12	 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?
2 3 4 5 6 7 8 9 10 11 12 13	 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 	2 3 4 5 6 7 8 9 10 11 12 13	 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
2 3 4 5 6 7 8 9 10 11 12 13 14	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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, 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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, 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 20 21	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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

118 120 1 Q. Of any kind. That they don't perceive it as 1 regretted making that decision. 2 being relevant to their annual checkup? 2 Q. Or that they were sad that they had to make A. Well, they may not perceive it as being 3 3 the decision to place a baby for adoption? 4 relevant, and it may just be something that they don't 4 A. Well, certainly, I think a lot of them are 5 want to talk about. 5 sad, to be perfectly honest. I don't have that 6 Q. Okay. So if I could go back to my question. 6 conversation very often. Very, very few women will give 7 Maybe let's think of it in terms of a year. How often 7 birth to an unwanted pregnancy and place it for adoption 8 would you say that you have a conversation with a patient 8 because abortion is so easy to obtain. who describes her decision making with a prior -- with 9 9 Q. Okay. Let's see. Let me make sure -- so 10 respect to a prior abortion? 10 later -- if you can turn back to page 4 of your report, A. Maybe once a month. that same paragraph that we were just looking at --11 11 12 Q. Okay, maybe 12 times a year. And of those, 12 towards the end of the paragraph you discuss Florida 13 how many would you say express regret for having the 13 statistics on reasons that a patient might have an 14 procedure? 14 abortion, correct? 15 A. It is complicated because some of them will 15 A. Yes. 16 affirm that they feel it was the best decision for them. 16 Q. And to support those data you cite a website 17 But, inevitably, they also will affirm that they wish 17 called Abort73.com; is that right? 18 that they had not done it, if that makes sense. They 18 A. Yes. 19 wish they had not been in a situation where that was the 19 Q. What is that? 20 decision they had to make. 20 Α It is an organization that puts out some 21 Q. They regret the situation but not the 21 information about abortion. I couldn't find the -- the 22 outcome? 22 Florida source, but I've seen that statistics from a 23 A. They're glad they're not pregnant anymore, 23 couple of different website, so I considered it to be 24 but they regret that they had to choose an abortion. 24 accurate. 25 Q. When you're using regret in that way, do you 25 Q. So you couldn't find any original data that 119 121 mean that they're sad that they had to have an 1 1 would support this finding with respect to Florida; is 2 2 that correct? abortion? 3 A. Sometimes. A lot of them cry when they talk 3 A. I did not find the Florida source, no. about it. 4 4 Q. And did you look for it? 5 Q. Have you ever had patients who tell you that 5 A. Yes, but I'm not a really good researcher, 6 they regret having children? 6 so it is possible that it was easy to find and I just 7 didn't find it, but. . . 7 A. No, I don't think anyone has ever told me 8 that. Kids are hard at times, but nobody has ever wished 8 Q. Okay. Did you consult the Florida state 9 they didn't have their child. I've never seen that. 9 government's website? 10 10 Q. There would probably be a lot of stigma A. I don't recall where I looked for it, to 11 attached to that, correct? 11 tell you the truth. 12 MR. SORENSON: Objection, foundation. 12 Q. Do you consider Abort73 a reliable source in your field? 13 13 Q. Let me ask it this way. Have you ever 14 encountered patients who have indicated that they are sad 14 A. I'm not that familiar with who does the 15 because they're parents? 15 research for that website. But based on numbers I've 16 A. Told me they are sad because they were a 16 seen on a number of sources, I think that these 17 parent? 17 statistics are probably fairly accurate. And even 18 Q. Uh-huh, that they have children? 18 Guttmacher tells us that 97 percent of abortions are done 19 A. No. No, I haven't. 19 for social, financial -- not hard cases, not life and 20 Q. Have you ever had patients who have told you 20 health of the mother, not fetal anomalies. 21 that they regretted the decision to have a baby and place 21 Q. I'm just trying to understand your process 22 it for adoption? 22 of drafting the report, Dr. Skop. So you're not 23 A. Placing for adoption is very complicated. 23 familiar, you said, with who compiles the numbers on the 24 24 It is very, very hard for a woman to do that. But I website Abort73; is that right? 25 don't think I've ever had anybody who said that they 25 A. That's correct.

122 124 1 Q. Can you think of any colleague who would 1 Q. If we don't know where the source is coming 2 agree that this is a reliable source of information? 2 from, I'd rather not go down that route. Certainly if A. I can't say. I haven't discussed this 3 3 there are materials that you relied on in drafting the 4 4 report that you recall you did rely on, you know, we can report with anybody. 5 Q. Would you agree that in medical and social 5 talk about a process for submitting additional 6 science research, it is better to site primary sources? 6 information, but if we could table that for now, that 7 7 A. Yes, I've tried to do that, but in this case would be good. 8 8 I was not able to find it. Okay. So moving on, again, to page 4. 9 9 Q. And to your knowledge, is the Abort73 Later in that page you refer to a study that, you said, 10 10 website, is that associated with a -- it is called shows that abortions later in pregnancy are more Loxafamosity Ministries? Does that sound familiar? 11 frequently covered by health insurance than earlier 11 12 A. I don't know. I don't know who puts out 12 abortions; is that correct? 13 that website. 13 A. Yes, I did write that. Q. So you don't know where this information 14 Q. Okay. And can you describe why you think 14 15 originally came from; is that correct, with respect to 15 that information is relevant to this case? 16 the Florida statistics? 16 A. Well. later abortions are much more A. Well, ultimately it came from the State of 17 expensive. And so if a woman doesn't have an early 17 18 18 Florida, but I did not find the specific -abortion -- well, let me back up. 19 Q. How do you know that, Doctor? 19 There are, I believe, 13 states that will 20 A. Because I believe that they were telling me 20 cover abortions through Medicaid. And so it is likely 21 21 the truth when they said they got it from Florida. that if a woman is poor and doesn't get an abortion 22 Q. And you believe that they're telling the 22 early, if she's not in one of those states and not under 23 truth, this website; is that accurate? You believe the 23 Medicaid coverage, it is very likely that she does not 24 website is telling you the truth? 24 get the money together -- which, your average first 25 A. Yes. 25 trimester abortion is about \$500, laters run from 125 123 Q. But you don't know who created the 1 1 anywhere, depending on the gestational age -- 1,500 to website? 2 2 10,000, I've heard. So if she's not -- if she doesn't 3 A. No. 3 have a funding source, then, very likely, she's going to 4 Q. Or who supplies the numbers? 4 carry that pregnancy to term. So probably many of the 5 5 A. It is in line with other statistics that later ones are covered by Medicaid in those states that I've seen about how infrequent it is that women really 6 6 will cover them. have abortions for life -- serious illness, fetal 7 7 Q. So in other words -- as understood this 8 anomalies, rape, incest. Those statistics are widely 8 statistic that you were citing about health insurance, it 9 available and they are all the same number range. 9 seemed to me -- well, let me ask it this way. Were you 10 Q. So based on what you just said, would you 10 suggesting that it would actually be easier to get an 11 agree, then, that HB136, as you understand it, is likely 11 abortion in the second trimester than the first? 12 to affect the majority of abortions at and after 18 weeks 12 A. No. No. 13 of pregnancy that occur currently in the state of Utah? 13 Q. Okay. So do you believe that one potential 14 A. You know, the Utah statistics are difficult 14 driver of higher rate of insurance in the second 15 to interpret. After I have drafted this report, I found 15 trimester is that the people without insurance are, some more data about Utah that seems to indicate that 16 16 essentially, priced out of being able to afford the 17 two-thirds of their abortions are for therapeutic 17 care? 18 reasons. The problem --18 A. That could be the case, yes. 19 Q. Where did you find that data? 19 Q. That could be one explanation. 20 A. I don't remember where I found it. Do you 20 Have you considered whether Utah permits 21 21 think it is true? Have you read that? coverage of abortions in private or public insurance 22 22 The problem with therapeutic -- therapeutic plans? 23 to the layman sounds like those would be indicated, 23 A. I don't know what Utah does there. 24 24 right? But therapeutic does not have a specific Q. Okay. So you haven't done any research in 25 definition. The Roe versus --25 that respect?

12of your expert report. Are you there?12opinion, there is a causal connection between abortion13A. Yes, ma'am.13itself and a heightened risk of breast cancer later in14Q. It says you say, "While few OB/GYNs other141315than high volume abortionists have the clinical skills to1416perform a later D&E, due to its complexity and high15A. Ending a normal pregnancy before the breasts17incidence of complications, all OB/GYNs can perform16breast cancer.18inductions or C-sections." Did I get that right?18Q. Relative to a woman who carried to term,19A. Yes.19correct?20Q. And what do you mean by "later D&E" in the20A. Exactly.21Sentence?21Q. Okay. Let me give you this hypothetical.22A. Well, as we discussed earlier, I have not23performed a D&E after 18 weeks. And I doubt whether my23performed a D&E after 18 weeks. And I doubt whether my23to you and they are identical in every respect. One of				
2 no. D&E, as you've used that term in that sentence? 3 Q. Okay. Would you agree1 think that 4 you - that you refer to the cost between 1,500 and A. Probably 18 weeks and beyond. 5 10.000 dollars. Would you agree that that expense A. And then - let's see. We had talked 6 abortion? A. It would be a barrier. It is not an believe, indicated that you would talk to her about 7 absolute barrier. A. Possibly. Q. And would one of those risks be a risk of 10 D. For a woman living in poverty, would it be a in the sentence? 11 barrier? A. Possibly. C. And would one of those risks be a risk of 12 A. Possibly. C. And would one of those set is be a risk of 14 moderate income? A. Imean, we - 15 A. Imean, we - 10 16 Based on your experience with your 17 17 patients? 19 O. What about - iff could take you back to 20 our conversation earlier about LARCS. You said that 10 12 A. That's correct. 1970 - 23 A. And I think with respect to those you said 1970 -		126		128
2 no. D&E, as you'vu used that term in that isentence? 3 Q. Kay. Would you agree – I think that 4 you – that you refer to the cost between 1,500 and A. Probably 18 weeks and beyond. 5 M. Invould be a barrier to obtaining an abortion? A. Ind then – lef's see. We had talked 6 A. Invould be a barrier. It is not an abortion, and you, I Delievy, indicated that you would talk to her about arisks of abortion, correct? 9 A. For a woman living in poverty, would it be a larrier? A. Possibly. C. And would one of those risks be a risk of the barst cancer? 10 D. For a woman living in poverty, would it be a larrier? A. Possibly. C. And would one of thoses risks be a risk of the set cancer? 11 Darter? A. Inean, we – This is her first pregnancy and doe abarrier to those you sail 10 Decayse A. Intalk is not The presentop and all tholues, her presentop and all tholues, her and the would be a barrier to obtain ang at the foreast cancer? 11 LARC. Do you remember that question? A. A res. 2 A. And I think with respect to those you sail The aster first presentop. 3 A. Jobio to 10.000 dollars, would you say. A. Yes. 2 A. Yes. A. Yes. 3	1	A. I don't know the answer to that question.	1	quess what I'm asking is how would you define a later
3 A. Probably 18 weeks and beyond. 4 you that you refer to the cost between 1,500 and G. And then let's see. We had talked 6 without insurance would be a barrier to obtaining an G. And then let's see. We had talked 7 absolute barrier. It would be a barrier to obtaining an 9 absolute barrier. It is not an 9 absolute barrier. It is not an 9 A. It would be a barrier to obtaining an A. 10 D. For a woman living in poverty, would it be a It is barrier? 11 Desite by. A. 12 A. Possibly. Okay. What about a woman with It moderate income? 14 moderate income? A. 15 A. It is hard to say. It is a bartier to abut - if I could take you back to 10 Our conversation earlier about LARCs. You said tat If is oneone didn't have insurance coverage - I believel 12 A. And you said, Oh, certainly. Right? A. It is a barrier. It is not - it doesn't 1 LARC. Do you remember that question? A. It is abarrier. It is not - it doesn't 1 LARC. Do you remember that quest				
4 Qu - that you refer to the cost between 1,500 and 5 4 Q. And then - let's see. We had talked earlier about the counseling that you might provid patient who is interested in abortion, and you, I 7 abortion? A. It would be a barrier to obtaining an absolute barrier. 5 abortion? 9 absolute barrier. 10 A. It would be a barrier. It is not an absolute barrier. 9 10 Q. For a woman living in poverty, would it be a in barrier? 10 7 believe, indicated that you would talk to her about the is one thing that is not controversial. 11 barrier. 12 A. Possibly. Okay. What about a woman with 4 0. And would one of those at cancer is controversial. 13 A. Yes. 14 moderate income? 14 14 controversial. 15 16 15 A. Imaan. we - 16 0. What about - if I could tak you back to our conversation acrine about LARC. You said the bas at regime asked whether that would be a barrier to obtaining a 19 0. Do you tell that information to your patients? 16 A. It is a barrier. It is not - it doesn't 5 a. Mal think with respect to those you said a subsantial amount of money. 1227 1 LARC. Do you remember that question? 2 A. Yes. 2 A. Uh-huh.				
5 10,000 dollars. Would you agree that that expanse 5 earlier about the counseling that you might provid 6 without insurance would be a barrier to obtaining an 5 earlier about the counseling that you might provid 8 A. It would be a barrier. It is not an 8 A. It would be a barrier. It is not an 9 A. It would be a barrier. It is not an 8 A. Tes. 10 Q. For a woman living in poverty, would it be a 7 believe, indicated that you would that to her about 11 barrier? A. Possibly. C. And would one of those risks be a risk of 11 barrier? A. The - the literature on breast cancer is 12 A. Possibly. C. And would one of those risks be a risk of 14 moderate income? 10 15 A. Time - the literature on breast cancer is 11 16 Q. Based on your experience with your 17 16 A. It is hard to say. 19 17 Q. Mhat about - If could take you back to 10 20 our conversation earlier about tARCs. You said 12 21 for some officit have instrue resport to those you said 22 24			-	
6 without insurance would be a barrier to obtaining an 7 7 abortion? 6 8 A. It would be a barrier. It is not an 8 9 absolute barrier. 9 10 Q. For a woman living in poverty, would it be a 7 11 barrier? 0 Q. And would one of those risks be a risk of 11 barrier? 0 Q. Possibly. 12 A. Possibly. 0 Q. And would one of those risks be a risk of 14 moderate income? 11 breast cancer? 15 A. Imean, we - 12 A. The - the literature on breast cancer is 16 Q. Based on your experience with your 16 go term and does not get the protective effect of th 16 Q. What about - if I could take you back to 10 1070 - 100 ou tell that information to your 122 A. That's correct. 23 Q. You patients? Quo you tell that information to your 123 Q. And think with respect to those you said 11 1070 - 100 ou tell that information to your 124 if someone didn't have insurance coverage - I believe I 23 A. Yes.				
7 abortion? 7 believe, indicated that you would talk to her about a sound talk to her about a solute barrier. 10 0. For a woman living in poverty, would it be a liberarier? 9 A. Yes. 11 barrier? 12 A. Possibly. Okay. What about a woman with moderate income? 9 A. The the literature on breast cancer is controversial. In there is not hing that is not threast income? 12 A. Imean, we - 16 0. Based on your experience with your patients? 13 A. It is and to say. 19 1970 14 controversial. In there is not ensead. That is since 1970 0. Do you tell that information to your patients? 14 for some didn't have insurance coverage believe! 22 A. That's correct. 12 A. The's correct. 23 A. Yes. 23 A. And let me break that down a little bit. So do you believe that there is a causal connection belw 23 12 A. So of ,500 to 10,000 dollars, would you say. 1 0. And let me break that down a little bit. So do you believe that there is a causal connection belw 14 con you remember that question? 1 0. So f,500 to 10,000 dollars, would you say. 15 mean tha t				
8 A. It would be a barrier. It is not an 8 risks of abortion, correct? 9 absolute barrier. 0 A. For a woman living in poverty, would it be a 11 barrier? 0 A. A dwould one of those risks be a risk of 12 A. Possibly. 0 A. The - the literature on breast cancer is 13 C. Possibly. 12 A. The - the literature on breast cancer is 14 moderate income? 13 Controversial. If she - if this is her first pregnancy and doe 16 A. Imean, we - 16 and she chooses to terminate the pregnancy and doe 17 patients? 17 fill maturation of her breast type 3 and 4 lobules, her 18 A. It is hard to say. 18 is for breast cancer is increased. That is since 19 O. What about - if I could take you back to 20 0. Do you tell that information to your 21 Those were between 500 and 700 dollars; is that right? 21 22 A. Yes. 22 A. It hink hink with respect to those you said 22 A. Yes. 22 A. Yes. 22 A. And I think with respect to those you said 3 A. Yes. 22 A. Yes. <th></th> <td></td> <th></th> <td></td>				
9 absolute barrier. 9 A. Yes. 10 Q. For a woman living in poverty, would it be a 9 A. Yes. 11 barrier? 12 A. Possibly. 0 Q. And would one of those risks be arisk of breast cancer? 12 A. Possibly. Okay. What about a woman with moderate income? 11 A. The - the ilterature on breast cancer is controversial. If she – if this is her first pregnancy and does not get the protective effect of th full maturation of her breast type 3 and 4 lobules, her risk of breast cancer is increased. That is since 19 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? 1970 - 2 A. Andy to may the insurance coverage - I believel a saked whether that would be a barrier to obtaining a the abarrier. It is a barrier. It is a barrier to obtain care? 1 LARC. Do you remember that question? 1 Q. And let me break that down a little bit. So that have more to do with heway the studies have been conducted. When a woman has a n				•
10 Q. For a woman living in poverty, would it be a sarrier? 11 barrier? 12 A. Possibly. 13 Q. Possibly. Okay. What about a woman with moderate income? 14 moderate income? 15 A. Imean, we – 16 Q. Based on your experience with your 17 patients? 18 A. It is hard to say. 19 Q. What about - if I could take you back to 20 our conversation earlier about LARGs. You said that 21 those were between 500 and 700 dollars; is that right? 23 Q. And I think with respect to those you said 24 ff someone didn't have insurance coverage – I believel 22 A. That's correct. 23 Q. And you said, Oh, certainly. Right? 4 A. Yes. 2 A. Yes. 3 a. Sol 500 to 10,000 dollars, would you say, 4 M. Solo 1,500 to 10,000 dollars, would you say, 7 Q. Sol 1,500 to 10,000 dollars, would you say, 7 Q. Sol 1,500 to 10,000 dollars, would you say, 7 Q. Can you - let's see. 11 A. It says - you say, "While f				
11 barrier? 11 breast cancer? 12 A. Possibly. Okay. What about a woman with 11 breast cancer? 12 A. The - the literature on breast cancer is controversial, but there is one thing that is not controversial, but there is one thing that is not controversial. If she if this is her first pregnancy and obes not get the predetive effect of th full maturation of her breast type 3 and 4 lobules, her is one thing that is not conversation earlier about LARCs. You said that 21 13 Q. What about if I could take you back to our conversation earlier about LARCs. You said that 21 1970 14 Mose we between 500 and 700 dollars; is that right? 20 A. The's correct. 14 G. And I think with respect to those you said 41 1970 Q. Do you tell that information to your 21 15 mean that they won't get one, but it is a barrier. It is a saked whether that would be a barrier to obtaining a 127 14 LARC. Do you remember that question? 1 Q. And let me break that down a little bit. So 2 2 A. Yes. 1 Q. And let me break that down a little bit. So 2 3 a abortion and an increased risk of breast cancer? 4 4 A. The awards abarrier. It is a barrier. It is a saturel. The weak that down a little bit. So 2 1 5 meanthat they won't get one, b			1	
12 A. Possibly. 12 A. The the literature on breast cancer is controversial, but three is one thing that is not controversial. If she if this is her first prepancy and doe go term and does not get the protective effect of th full maturation of her breast type 3 and 4 bloubles, her first or porceive and she chooses to terminate the pregnancy and doe go term and does not get the protective effect of th full maturation of her breast type 3 and 4 bloubles, her first or porceive and she chooses to terminate the pregnancy and doe go term and does not get the protective effect of th full maturation of her breast type 3 and 4 bloubles, her first pregnancy and doe go term and does not get the protective effect of th full maturation of her breast type 3 and 4 bloubles, her first pregnancy and doe go term and does not get the protective effect of th full maturation of her breast type 3 and 4 bloubles, her first pregnancy and doe go term and does not get the protective effect of th full maturation of her breast type 3 and 4 bloubles, her first pregnancy and doe go term and does not get the protective effect of th full maturation of the breast type 3 and 4 bloubles, her first pregnancy and doe go term and does not get the protective effect of th full maturation of the preserves about the three is a causal connection between the traits is not increased. That is since 11 227 1 LARC. Do you remember that question? 2 A. Yes. 2 A. Ares. 12 C. You provide that? 3 A. And I think with respect to tobasi neare? 1 C. And lea more substantial barrier to obtain care? 4 A. It is a barrier. It is not - it doesn't 1 A. I think that there is a causal			-	
13 Q. Possibly. Okay. What about a woman with moderate income? 13 controversial, but there is one thing that is not moderate income? 14 moderate income? and she chooses to terming that is not controversial. If she the prepanety and doe shooses to term and does not get the protective effect of th full maturation of herbars type 3 and 4 lobules, her risk of breast cancer is increased. That is since 17 patients? and she chooses to term and does not get the protective effect of th full maturation of herbars type 3 and 4 lobules, her risk of breast cancer is increased. That is since 19 Q. What about - if I could take you back to our conversation earlier about LARCs. You said that if someone didn't have insurance coverage - I believel 21 A. That's correct. 23 A. Yes. 23 Q. And I think with respect to those you said 24 Q. You provide that? 24 G. You provide that? 25 A. Uh-huh. 127 1 LARC. Do you remember that question? 1 Q. And let me break that down a little bit. So 3 Q. And you said, Oh, certainly. Right? 4 Uh-huh. 3 4 N res. 3 anotion and an increased risk of breast cancer? 4 A. Us as substantial amount of money. 7 Q. So 1,500 to 10,000 dollars, would you say, 5 <th></th> <td></td> <th></th> <td></td>				
14 moderate income? 14 moderate income? 15 A. I mean, we 16 Q. Based on your experience with your 17 patients? 18 A. It is hard to say. 19 Q. What about - if I could take you back to 20 our conversation earlier about LARCs. You said that 21 those were between 500 and 700 dollars; is that right? 22 A. That's correct. 23 Q. And I think with respect to those you said 24 if someone didn't have insurance coverage I believel 25 A. Yes. 26 A. Yes. 30 And you said, Oh, certainly. Right? 4 A. Yes. 3 Q. And you said, Oh, certainly. Right? 4 A. Yes. 3 asubstantial amount of money. 7 Q. So 1,500 to 10,000 dollars, would you say, 8 would be a more substantial barrier to obtain care? 9 A. Yes. 10 Can you let's see. 11 All right. So if you could turn to page 5 12 of your expert report. Are you there?		•	1	
15 A. I mean, we 15 and she chooses to terminate the pregnancy and doe 16 Q. Based on your experience with your 16 go to term and does not get the protective effect of th 17 patients? 17 17 16 Go to term and does not get the protective effect of th 18 A. It is hard to say. 17 17 10 1			1	-
16 Q. Based on your experience with your 16 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 17 full maturation of her breast type 3 and 4 lobules, her risk of breast cancer is increased. That is since 20 Our conversation earlier about LARCs. You said that 21 those were between 500 and 700 dollars; is that right? 23 Q. And I think with respect to those you said 24 if someone didn't have insurance coverage – I bellevel 25 asked whether that would be a barrier to obtaining a 127 LARC. Do you remember that question? 2 A. Yes. 3 Q. And you said, Oh, certainly. Right? 4 A. It is a barrier. It is not – it doesn't 5 mean that they work get one, but it is a barrier. It is 6 a substantial amount of money. 7 Q. So 1,500 to 10,000 dollars, would you say, 8 would be a more substantial barrier to obtain care? 9 A. Yes. 11 All right. So if you could turn to page 5 12 optionion, there is a causal connection between aborti 13 A. Yes, ma'am. 1			1	
17 patients? 17 full maturation of her breast type 3 and 4 lobules, her risk of breast cancer is increased. That is since 18 A. It is hard to say. 19 0. What about - if I could take you back to 19 0. What about - if I could take you back to 1970 - 10 0. rowersation earlier about LARCs. You said that 1970 - 21 A. That's correct. 20 Do you tell that information to your 22 A. That's correct. 21 patients? 23 O. And I think with respect to those you said 22 A. Yes. 24 D. you rell that information to your patients? 25 asked whether that would be a barrier to obtaining a 12.27 1 LARC. Do you remember that question? 2 A. Yes. 3 Q. And you said, Oh, certainly. Right? 1 Q. And you said, Oh, certainly. Right? 4 A. It is a barrier. It is a barrier. It is a a substantial amount of money. 7 A. Ithink that there is physiologic 7 Q. So 1,500 to 10,000 dollars, would you say, 8 would be a more substantial barrier to obtain care? 9 Q. Dr. Skop, I would like you to answer my 10 Q. Can you let's see.				
18 A. It is hard to say. 18 risk of breast cancer is increased. That is since 19 Q. What about if I could take you back to 1970 20 our conversation earlier about LARCs. You said that 1970 21 those were between 500 and 700 dollars; is that right? 2 Q. Do you tell that information to your 23 A. That's correct. 20 Yes. 23 A. Yes. 24 if is omeone didn't have insurance coverageI believel 23 A. Yes. 24 Q. You provide that? 25 asked whether that would be a barrier to obtaining a 25 A. Uh-huh. 26 1 LARC. Do you remember that question? 1 Q. And let me break that down a little bit. So 26 2 A. Yes. 3 an abortion and an increased risk of breast cancer? 4 A. Uh-huh. 3 a substantial amount of money. 3 an abortion and an increased risk of breast cancer? 4 4 A. So 1,500 to 10,000 dollars, would you say, that have more to do with the way the studies have been 5 plausibility that that could be the case. I realize it is is extremely controversial in the literature for reasons 7 Q. Can you			16	
19 Q. What about if I could take you back to our conversation earlier about LARCs. You said that 19 1970 21 those were between 500 and 700 dollars; is that right? Q. Do you tell that information to your patients? Do you tell that information to your patients? 23 Q. And I think with respect to those you said if someone didn't have insurance coverageI believel 23 24 Q. You provide that? 24 if someone didn't have insurance coverageI believel 25 24 Q. And I think with respect to those you said 26 25 asked whether that would be a barrier to obtaining a 25 A. Yes. 1 LARC. Do you remember that question? 1 Q. And let me break that down a little bit. So 2 2 A. Yes. 1 Q. And let me break that down a little bit. So 40 you believe that there is a causal connection betw 3 3 Q. And you said, Oh, certainly. Right? 4 A. Ithink that there is physiologic 5 mean that they won't get one, but it is a barrier. It is 3 a substantial barrier to obtain care? 5 4 A. Its a barrier. It is not it doesn't 5 is extremely controversial in the literature for reasons 4 7 Q. Can you let's see. 10 Q. Dr. Skop, I would like you to answer my 9 Q. Dr. Skop, I would like you to answe		•		
20 our conversation earlier about LARCs. You said that 20 Q. Do you tell that information to your 21 those were between 500 and 700 dollars; is that right? 21 patients? Do you tell that information to your 22 A. That's correct. 23 A. Yes. 23 D. And I think with respect to those you said 24 Q. You provide that? 24 asked whether that would be a barrier to obtaining a 23 A. Yes. 1 LARC. Do you remember that question? 1 Q. And let me break that down a little bit. So 2 A. Yes. 1 Q. And you said, Oh, certainly. Right? 3 A. It is a barrier. It is not it doesn't 3 an abortion and an increased risk of breast cancer? 4 A. It is a barrier. It is not it doesn't 4 A. I think that there is a causal connection betw 5 mean that they won't get one, but it is a barrier. It is 5 plausibility that that could be the case. I realize it 6 a substantial amount of money. 7 A. Yes. 9 C. Dr. Skop, I would like you to answer my 10 Q. Can you - let's see. 11 11 physiological plausibility but whether, in your expert 13	18		1	
21 those were between 500 and 700 dollars; is that right? 21 patients? Do you tell that information to your patients? 23 A. That's correct. 22 A. That's correct. 23 A. Yes. 24 if someone didn't have insurance coverage – I believel 24 Q. You provide that? 25 asked whether that would be a barrier to obtaining a 1 C. And let me break that down a little bit. So 25 A. Yes. 2 A. Uh-huh. 1 LARC. Do you remember that question? 1 Q. And you said, Oh, certainly. Right? 3 Q. And you said, Oh, certainly. Right? 3 a abortion and an increased risk of breast cancer? 4 A. It is a barrier. It is not it doesn't 5 plausibility that that there is physiologic 5 mean that they won't get one, but it is a barrier. It is 5 plausibility that that could be the case. I realize it 6 6 a substantial amount of money. 7 A. I think that there is physiologic 5 plausibility that that way the studies have been conducted. When a woman has a normal - 9 Q. Dr. Skop, I would like you to answer my 0 Q. Dr. Skop, I would like you to answer my 10 question. And my question to you is not about physiologi	19		19	1970
22 A. That's correct. 22 patients? 23 G. And I think with respect to those you said 23 A. Yes. 24 if someone didn't have insurance coverage I believel 23 A. Yes. 25 asked whether that would be a barrier to obtaining a 24 Q. You provide that? 2 A. Yes. 25 A. Uh-huh. 1 LARC. Do you remember that question? 1 Q. And you said, Oh, certainly. Right? 3 Q. And you said, Oh, certainly. Right? 3 an abortion and an increased risk of breast cancer? 4 A. It is a barrier. It is not it doesn't 5 plausibility that that could be the case. I realize it 5 a substantial amount of money. 6 is extremely controversial in the literature for reasons 7 Q. So 1,500 to 10,000 dollars, would you say, 8 would be a more substantial barrier to obtain care? 9 Q. Dr. Skop, I would like you to answer my 10 Q. Can you let's see. 10 question. And my question to you is not about 11 A. Yes, ma'am. 11 itself and a heightened risk of breast cancer later in is inked to an increase risk of 16 perform a later D&E, due to its complexity and h	20			
23 Q. And I think with respect to those you said 23 A. Yes. 24 if someone didn't have insurance coverage I believel asked whether that would be a barrier to obtaining a 24 Q. You provide that? 25 A. Uh-huh. 25 A. Uh-huh. 1 LARC. Do you remember that question? 1 Q. And let me break that down a little bit. So 2 A. Yes. 2 do you believe that there is a causal connection betw 3 Q. And you said, Oh, certainly. Right? A. It is a barrier. It is not it doesn't 4 5 mean that they won't get one, but it is a barrier. It is 6 is extremely controversial in the literature for reasons 7 Q. So 1,500 to 10,000 dollars, would you say, 8 would be a more substantial barrier to obtain care? 9 9 A. Yes. 9 Q. Dr. Skop, I would like you to answer my 10 Q. Can you let's see. 10 physiological plausibility but whether, in your expert 11 A. Yes, ma'am. 11 11 Belfort an a high volume abortionists have the clinical skills to 16 perform a later D&E, due to its complexity and high 11 Iife? A. Ending a normal pregnancy before the breasts	21	those were between 500 and 700 dollars; is that right?	21	patients? Do you tell that information to your
24 if someone didn't have insurance coverage I believe I 24 Q. You provide that? 25 asked whether that would be a barrier to obtaining a 25 A. Uh-huh. 1 LARC. Do you remember that question? 1 Q. And let me break that down a little bit. So 2 A. Yes. 2 do you believe that there is a causal connection betw 3 Q. And you said, Oh, certainly. Right? 3 an abortion and an increased risk of breast cancer? 4 A. It is a barrier. It is not it doesn't 5 plausibility that that there is physiologic 5 mean that they won't get one, but it is a barrier. It is a substantial amount of money. 6 7 Q. So 1,500 to 10,000 dollars, would you say, 8 would be a more substantial barrier to obtain care? 9 Q. Dr. Skop, I would like you to answer my 10 Q. Can you let's see. 10 question. And my question to you is not about 11 A. Yes. 11 A. Yes, ma'am. 13 12 of your expert report. Are you there? 15 A. Yes, ma'am. 14 life? 13 A. Yes, ma'am. 13 itself and a heightened risk of breast cancer. 16	22	A. That's correct.	22	patients?
25 asked whether that would be a barrier to obtaining a 25 A. Uh-huh. 1 LARC. Do you remember that question? 1 Q. And let me break that down a little bit. So 2 A. Yes. 2 do you believe that there is a causal connection betwat an abortion and an increased risk of breast cancer? 4 A. It is a barrier. It is not it doesn't 3 abortion and an increased risk of breast cancer? 5 mean that they won't get one, but it is a barrier. It is 6 is extremely controversial in the literature for reasons 6 a substantial amount of money. 7 Q. So 1,500 to 10,000 dollars, would you say, 8 8 would be a more substantial barrier to obtain care? 9 Q. Dr. Skop, I would like you to answer my 10 Q. Can you let's see. 10 question. And my question to you is not about 11 All right. So if you could turn to page 5 10 physiological plausibility but whether, in your expert 13 A. Yes, ma'am. 14 life? 14 14 Q. It says you say, "While few OB/GYNs other 15 have matured at term is linked to an increase risk of 16 perform a later D&E, due to its complexity and high 11 incidence of complic	23	Q. And I think with respect to those you said	23	A. Yes.
1 LARC. Do you remember that question? 1 Q. And let me break that down a little bit. So 2 A. Yes. 2 do you believe that there is a causal connection betw 3 Q. And you said, Oh, certainly. Right? 3 an abortion and an increased risk of breast cancer? 4 A. It is a barrier. It is not it doesn't 5 plausibility that there is physiologic 5 mean that they won't get one, but it is a barrier. It is 6 is extremely controversial in the literature for reasons 7 Q. So 1,500 to 10,000 dollars, would you say, 7 that have more to do with the way the studies have been 8 would be a more substantial barrier to obtain care? 9 Q. Dr. Skop, I would like you to answer my 9 A. Yes. 9 Q. Dr. Skop, I would like you to answer my 10 Q. Can you let's see. 11 physiological plausibility but whether, in your expert 11 A. Yes, ma'am. 13 itself and a heightened risk of breast cancer later in 14 Q. It says you say, "While few OB/GYNs other 14 life? 15 A. Mes. 10 Q. Relative to a woman who carried to term, correct? 12 Q. And what do you mean by "later D&E" in the	24	if someone didn't have insurance coverage I believe I	24	Q. You provide that?
1LARC. Do you remember that question?1Q. And let me break that down a little bit. So2A. Yes.2do you believe that there is a causal connection betw3Q. And you said, Oh, certainly. Right?an abortion and an increased risk of breast cancer?4A. It is a barrier. It is not	25	asked whether that would be a barrier to obtaining a	25	A. Uh-huh.
1LARC. Do you remember that question?1Q. And let me break that down a little bit. So2A. Yes.2do you believe that there is a causal connection betw3Q. And you said, Oh, certainly. Right?an abortion and an increased risk of breast cancer?4A. It is a barrier. It is not		1.00		100
2A. Yes.2do you believe that there is a causal connection between an abortion and an increased risk of breast cancer?4A. It is a barrier. It is not it doesn't4A. I think that there is physiologic5mean that they won't get one, but it is a barrier. It is5plausibility that that could be the case. I realize it6a substantial amount of money.6is extremely controversial in the literature for reasons7Q. So 1,500 to 10,000 dollars, would you say,7that have more to do with the way the studies have been8would be a more substantial barrier to obtain care?9Q. Dr. Skop, I would like you to answer my9A. Yes.9Q. Dr. Skop, I would like you to answer my10Q. Can you let's see.1111All right. So if you could turn to page 51112of your expert report. Are you there?1213A. Yes, ma'am.1314Q. It says you say, "While few OB/GYNs other1415than high volume abortionists have the clinical skills to16perform a later D&E, due to its complexity and high17incidence of complications, all OB/GYNs can perform18inductions or C-sections." Did I get that right?19A. Yes.20Q. And what do you mean by "later D&E" in the21A. Well, as we discussed earlier, I have not22A. Well, as we discussed earlier, I have not23performed a D&E after 18 weeks. And I doubt whether my23performed a D&E after 18 weeks. A				129
3Q. And you said, Oh, certainly. Right?3an abortion and an increased risk of breast cancer?4A. It is a barrier. It is not it doesn't4A. I think that there is physiologic5mean that they won't get one, but it is a barrier. It is6I think that there is physiologic6a substantial amount of money.7A. I think that there is physiologic7Q. So 1,500 to 10,000 dollars, would you say,6is extremely controversial in the literature for reasons8would be a more substantial barrier to obtain care?9A. Yes.9A. Yes.9Q. Dr. Skop, I would like you to answer my10Q. Can you let's see.1011All right. So if you could turn to page 51112of your expert report. Are you there?1213A. Yes, ma'am.1314Q. It says you say, "While few OB/GYNs other1415than high volume abortionists have the clinical skills to16perform a later D&E, due to its complexity and high1617incidence of complications, all OB/GYNs can perform1718inductions or C-sections." Did I get that right?1819A. Yes.1920Q. And what do you mean by "later D&E" in the21A. Well, as we discussed earlier, I have not2222A. Well, as we discussed earlier, I have not2223performed a D&E after 18 weeks. And I doubt whether my2323performed a D&E after 18 weeks. And I doubt whether my <th></th> <td></td> <th></th> <td></td>				
4A. It is a barrier. It is not it doesn't4A. I think that there is physiologic5mean that they won't get one, but it is a barrier. It is5plausibility that that could be the case. I realize it6a substantial amount of money.6is extremely controversial in the literature for reasons7Q. So 1,500 to 10,000 dollars, would you say,7that have more to do with the way the studies have been8would be a more substantial barrier to obtain care?9Q. Dr. Skop, I would like you to answer my9A. Yes.9Q. Dr. Skop, I would like you to answer my10Q. Can you let's see.10question. And my question to you is not about11All right. So if you could turn to page 511physiological plausibility but whether, in your expert12of your expert report. Are you there?12opinion, there is a causal connection between aborti13A. Yes, ma'am.13itself and a heightened risk of breast cancer later in14Q. It says you say, "While few OB/GYNs other14life?15than high volume abortionists have the clinical skills to15A. Ending a normal pregnancy before the breasts16perform a later D&E, due to its complexity and high16A. Yes.017A. Yes.19A. Yes.1920Q. And what do you mean by "later D&E" in the20A. Exactly.21sentence?21Q. Okay. Let me give you this hypothetical.22A. Well, as we discussed earlier, I have not <td< td=""><th></th><td></td><th></th><td>-</td></td<>				-
5mean that they won't get one, but it is a barrier. It is5plausibility that that could be the case. I realize it6a substantial amount of money.is extremely controversial in the literature for reasons7Q. So 1,500 to 10,000 dollars, would you say,is extremely controversial in the literature for reasons8would be a more substantial barrier to obtain care?99A. Yes.910Q. Can you let's see.1011All right. So if you could turn to page 51012of your expert report. Are you there?1113A. Yes, ma'am.1314Q. It says you say, "While few OB/GYNs other1415than high volume abortionists have the clinical skills to1516perform a later D&E, due to its complexity and high1617incidence of complications, all OB/GYNs can perform1818inductions or C-sections." Did I get that right?1819A. Yes.1920Q. And what do you mean by "later D&E" in the2021A. Well, as we discussed earlier, I have not2322A. Well, as we discussed earlier, I have not2323performed a D&E after 18 weeks. And I doubt whether my23			-	
6a substantial amount of money.6is extremely controversial in the literature for reasons7Q. So 1,500 to 10,000 dollars, would you say,7that have more to do with the way the studies have been8would be a more substantial barrier to obtain care?9A. Yes.9A. Yes.9Q. Dr. Skop, I would like you to answer my10Q. Can you let's see.10question. And my question to you is not about11All right. So if you could turn to page 511physiological plausibility but whether, in your expert12of your expert report. Are you there?12opinion, there is a causal connection between abortion13A. Yes, ma'am.13itself and a heightened risk of breast cancer later in14Q. It says you say, "While few OB/GYNs other14life?15than high volume abortionists have the clinical skills to15A. Ending a normal pregnancy before the breasts16perform a later D&E, due to its complexity and high16have matured at term is linked to an increase risk of17incidence of complications, all OB/GYNs can perform18Q. Relative to a woman who carried to term,19A. Yes.19Correct?20Q. And what do you mean by "later D&E" in the20A. Exactly.21Sentence?21Q. Okay. Let me give you this hypothetical.22A. Well, as we discussed earlier, I have not2223performed a D&E after 18 weeks. And I doubt whether my2324byou and they are ide				
7Q. So 1,500 to 10,000 dollars, would you say, 87that have more to do with the way the studies have been conducted. When a woman has a normal9A. Yes.9Q. Dr. Skop, I would like you to answer my question. And my question to you is not about11All right. So if you could turn to page 510question. And my question to you is not about12of your expert report. Are you there?12opinion, there is a causal connection between aborti opinion, there is a causal connection between aborti13A. Yes, ma'am.13itself and a heightened risk of breast cancer later in14Q. 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 perform14life?17incidence of complications, all OB/GYNs can perform17breast cancer.18inductions or C-sections." Did I get that right?18Q. Relative to a woman who carried to term, to rect?20Q. And what do you mean by "later D&E" in the 22A. Well, as we discussed earlier, I have not 2320A. Exactly.21Q. Okay. Let me give you this hypothetical. Imagine that you have two patients who complexity a D&E after 18 weeks. And I doubt whether my23to you and they are identical in every respect. One of to you and they are identical in every respect. One of				
8would be a more substantial barrier to obtain care?8conducted. When a woman has a normal9A. Yes.9Q. Dr. Skop, I would like you to answer my10Q. Can you let's see.10question. And my question to you is not about11All right. So if you could turn to page 511physiological plausibility but whether, in your expert12of your expert report. Are you there?12opinion, there is a causal connection between aborti13A. Yes, ma'am.13itself and a heightened risk of breast cancer later in14Q. It says you say, "While few OB/GYNs other14life?15than high volume abortionists have the clinical skills to15A. Ending a normal pregnancy before the breasts16perform a later D&E, due to its complexity and high16have matured at term is linked to an increase risk of17incidence of complications, all OB/GYNs can perform17breast cancer.18inductions or C-sections." Did I get that right?18Q. Relative to a woman who carried to term, correct?20Q. And what do you mean by "later D&E" in the 2220A. Well, as we discussed earlier, I have not 232223performed a D&E after 18 weeks. And I doubt whether my23to you and they are identical in every respect. One of	6			
9A. Yes.9Q. Dr. Skop, I would like you to answer my10Q. Can you let's see.10question. And my question to you is not about11All right. So if you could turn to page 511physiological plausibility but whether, in your expert12of your expert report. Are you there?12opinion, there is a causal connection between abortion13A. Yes, ma'am.13itself and a heightened risk of breast cancer later in14Q. It says you say, "While few OB/GYNs other14life?15than high volume abortionists have the clinical skills to15A. Ending a normal pregnancy before the breasts16perform a later D&E, due to its complexity and high16have matured at term is linked to an increase risk of17incidence of complications, all OB/GYNs can perform18Q. Relative to a woman who carried to term,19A. Yes.19Q. And what do you mean by "later D&E" in the20A. Exactly.21Sentence?21Q. Okay. Let me give you this hypothetical.22A. Well, as we discussed earlier, I have not23performed a D&E after 18 weeks. And I doubt whether my2323performed a D&E after 18 weeks. And I doubt whether my23to you and they are identical in every respect. One of		,	6	is extremely controversial in the literature for reasons
10Q. Can you let's see.10question. And my question to you is not about11All right. So if you could turn to page 511physiological plausibility but whether, in your expert12of your expert report. Are you there?12opinion, there is a causal connection between abortion13A. Yes, ma'am.13itself and a heightened risk of breast cancer later in14Q. It says you say, "While few OB/GYNs other14life?15than high volume abortionists have the clinical skills to15A. Ending a normal pregnancy before the breasts16perform a later D&E, due to its complexity and high16have matured at term is linked to an increase risk of17incidence of complications, all OB/GYNs can perform17breast cancer.18inductions or C-sections." Did I get that right?18Q. Relative to a woman who carried to term,19A. Yes.19A. Exactly.20Q. And what do you mean by "later D&E" in the20A. Exactly.21sentence?21Q. Okay. Let me give you this hypothetical.22A. Well, as we discussed earlier, I have not22Imagine that you have two patients who complexity on operational performed a D&E after 18 weeks. And I doubt whether my2323performed a D&E after 18 weeks. And I doubt whether my23to you and they are identical in every respect. One operational performed and the pare identical in every respect. One operational performed and the pare identical in every respect.	7	,	6	is extremely controversial in the literature for reasons
11All right. So if you could turn to page 511physiological plausibility but whether, in your expert12of your expert report. Are you there?11physiological plausibility but whether, in your expert13A. Yes, ma'am.12opinion, there is a causal connection between abortion14Q. It says you say, "While few OB/GYNs other141315than high volume abortionists have the clinical skills to16perform a later D&E, due to its complexity and high16perform a later D&E, due to its complexity and high15A. Ending a normal pregnancy before the breasts17incidence of complications, all OB/GYNs can perform17breast cancer.18inductions or C-sections." Did I get that right?18Q. Relative to a woman who carried to term,19A. Yes.19A. Exactly.20Q. And what do you mean by "later D&E" in the20A. Exactly.21Sentence?21Q. Okay. Let me give you this hypothetical.22A. Well, as we discussed earlier, I have not23performed a D&E after 18 weeks. And I doubt whether my23performed a D&E after 18 weeks. And I doubt whether my23to you and they are identical in every respect. One of		Q. So 1,500 to 10,000 dollars, would you say,	6 7	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
12of your expert report. Are you there?12opinion, there is a causal connection between abortion13A. Yes, ma'am.13itself and a heightened risk of breast cancer later in14Q. It says you say, "While few OB/GYNs other141315than high volume abortionists have the clinical skills to15A. Ending a normal pregnancy before the breasts16perform a later D&E, due to its complexity and high15A. Ending a normal pregnancy before the breasts17incidence of complications, all OB/GYNs can perform16breast cancer.18inductions or C-sections." Did I get that right?18Q. Relative to a woman who carried to term,19A. Yes.19Correct?20Q. And what do you mean by "later D&E" in the20A. Exactly.21Sentence?21Q. Okay. Let me give you this hypothetical.22A. Well, as we discussed earlier, I have not23performed a D&E after 18 weeks. And I doubt whether my23performed a D&E after 18 weeks. And I doubt whether my23to you and they are identical in every respect. One of	8	Q. So 1,500 to 10,000 dollars, would you say, would be a more substantial barrier to obtain care?	6 7 8	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
13A. Yes, ma'am.13itself and a heightened risk of breast cancer later in 1414Q. It says you say, "While few OB/GYNs other 1514Iife?15than 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 1813itself and a heightened risk of breast cancer later in 1418incidence of complications, all OB/GYNs can perform 1816have matured at term is linked to an increase risk of breast cancer.19A. Yes.18Q. Relative to a woman who carried to term, correct?20Q. And what do you mean by "later D&E" in the sentence?20A. Exactly.21A. Well, as we discussed earlier, I have not performed a D&E after 18 weeks. And I doubt whether my23Okay. Let me give you this hypothetical.23performed a D&E after 18 weeks. And I doubt whether my23to you and they are identical in every respect. One of	8 9	 Q. So 1,500 to 10,000 dollars, would you say, would be a more substantial barrier to obtain care? A. Yes. 	6 7 8 9	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
14Q. 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?14life?18inductions or C-sections." Did I get that right? A. Yes.18Q. Relative to a woman who carried to term, correct?20Q. And what do you mean by "later D&E" in the sentence?20A. Exactly.21Sentence?21Q. Okay. Let me give you this hypothetical.22A. Well, as we discussed earlier, I have not performed a D&E after 18 weeks. And I doubt whether my23to you and they are identical in every respect. One of	8 9 10 11	 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. 	6 7 8 9 10	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
 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 A. Bending a normal pregnancy before the breasts have matured at term is linked to an increase risk of breast cancer. B. Relative to a woman who carried to term, correct? Q. And what do you mean by "later D&E" in the performed a D&E after 18 weeks. And I doubt whether my Correct? C. Okay. Let me give you this hypothetical. Imagine that you have two patients who complexities of to you and they are identical in every respect. One of 	8 9 10 11	 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 	6 7 8 9 10 11	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
16perform 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?16have matured at term is linked to an increase risk of breast cancer.18inductions or C-sections." Did I get that right?18Q. Relative to a woman who carried to term, correct?20Q. And what do you mean by "later D&E" in the sentence?20A. Exactly.21sentence?21Q. Okay. Let me give you this hypothetical.22A. Well, as we discussed earlier, I have not performed a D&E after 18 weeks. And I doubt whether my23to you and they are identical in every respect. One of	8 9 10 11 12	 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? 	6 7 8 9 10 11 12	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
 incidence of complications, all OB/GYNs can perform inductions or C-sections." Did I get that right? A. Yes. 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 	8 9 10 11 12 13	 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. 	6 7 9 10 11 12 13	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
 17 incidence of complications, all OB/GYNs can perform 18 inductions or C-sections." Did I get that right? 19 A. Yes. 20 Q. And what do you mean by "later D&E" in the 21 sentence? 22 A. Well, as we discussed earlier, I have not 23 performed a D&E after 18 weeks. And I doubt whether my 	8 9 10 11 12 13 14	 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 	6 7 9 10 11 12 13 14	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?
18inductions or C-sections." Did I get that right?18Q. Relative to a woman who carried to term,19A. Yes.19correct?20Q. And what do you mean by "later D&E" in the20A. Exactly.21sentence?21Q. Okay. Let me give you this hypothetical.22A. Well, as we discussed earlier, I have not22Imagine that you have two patients who come23performed a D&E after 18 weeks. And I doubt whether my23to you and they are identical in every respect. One of	8 9 10 11 12 13 14 15	 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 	6 7 8 9 10 11 12 13 14 15	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
19A. Yes.19correct?20Q. And what do you mean by "later D&E" in the sentence?20A. Exactly.21sentence?21Q. Okay. Let me give you this hypothetical.22A. Well, as we discussed earlier, I have not performed a D&E after 18 weeks. And I doubt whether my2223D&E after 18 weeks. And I doubt whether my2324DD25DD26DD27DD28DD29DD20DD21DD22DD23DD24DD25DD26DD27DD28DD29DD20DD21DD22DD23DD24DD25DD26DD27DD28DD29DD29DD29DD29DD20DD20DD21DD22DD23DD24DD25DD26DD27DD2	8 9 10 11 12 13 14 15 16	 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 	6 7 8 9 10 11 12 13 14 15 16	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
20Q. And what do you mean by "later D&E" in the sentence?20A. Exactly.21sentence?21Q. Okay. Let me give you this hypothetical.22A. Well, as we discussed earlier, I have not performed a D&E after 18 weeks. And I doubt whether my22Imagine that you have two patients who come to you and they are identical in every respect. One of	8 9 10 11 12 13 14 15 16 17	 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 	6 7 8 9 10 11 12 13 14 15 16 17	 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.
21sentence?21Q.Okay. Let me give you this hypothetical.22A.Well, as we discussed earlier, I have not22Imagine that you have two patients who come23performed a D&E after 18 weeks. And I doubt whether my23to you and they are identical in every respect. One of	8 9 10 11 12 13 14 15 16 17 18	 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? 	6 7 8 9 10 11 12 13 14 15 16 17 18	 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,
22A. Well, as we discussed earlier, I have not22Imagine that you have two patients who come23performed a D&E after 18 weeks. And I doubt whether my23to you and they are identical in every respect. One of	8 9 10 11 12 13 14 15 16 17 18 19	 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. 	6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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?
23 performed a D&E after 18 weeks. And I doubt whether my 23 to you and they are identical in every respect. One of	8 9 10 11 12 13 14 15 16 17 18 19 20	 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 	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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.
	8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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? 	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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.
24 $ 24 $ $ 101 2 3 24 21 21 21 21 21 21 21 21 21$	8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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 	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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
	8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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 	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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
	8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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 	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 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

Ingrid Skop, M.D.

	130		132
1	having an abortion. Would you tell the patient who is	1	maturation.
2	thinking about getting pregnant that she should get	2	Q. Okay. What about the hospitals you
3	pregnant to reduce her risk of breast cancer later in	3	mentioned that you work in the Baptist Health System,
4	life?	4	correct?
5	A. That is a true fact. I don't know that I	5	A. Yes.
6	necessarily tell everybody that who is coming in for a	6	Q. And have worked at one of two hospitals in
7	Q. Do you tell anyone that?	7	your prior experience, correct?
8	A. Yeah, if somebody had high risk for breast	8	A. Yes.
9	cancer, I would certainly tell them that.	9	Q. And does the Baptist Health System where you
10	Q. You would suggest they might want to get	10	work provide abortions?
11	pregnant?	11	A. No.
12	A. That a term pregnancy would be protective,	12	Q. None, ever?
13	yes.	13	A. Not that I'm aware of.
14	Q. And do you as between those two	14	Q. Okay.
15	patients let's say those two patients, the one who is	15	A. Occasionally someone requires delivery
16	not pregnant and is thinking about getting pregnant	16	before the time of full viability and it doesn't require
17	decides not to get pregnant at that time, and the one who	17	an abortion, it doesn't require intentionally destroying
18	is pregnant and thinking about an abortion has an	18	the fetus in order to deliver the woman. The woman can
19	abortion. Do those two individuals have any different	19	be delivered in other ways and the baby can be evaluated
20	risk in later likelihood of breast cancer?	20	for maturity and given hospice care. That's a different
21	A. Yes, because the one who had the normal	21	scenario than electively ending the life of that child.
22	pregnancy has stimulation of the type 1 and type 2	22	Q. So to make sure that I understand what the
23	immature lobules in the breasts. That what happens in	23	practice would be. If, for example, a patient came in at
24	early pregnancy. And to cut off the hormones and leave	24	18 weeks of pregnancy with premature rupture of
25	them in that state does make them more likely to form	25	membranes, at that point there is no possibility of
	131		133
1	breast cancer.	1	continuing the pregnancy until viability, is that
2	Q. Makes them more likely to develop breast	2	correct?
3	cancer	3	A. It is a very low possibility. It has
4	A. Yes.	4	happened, but the odds are not good for that baby.
5	Q than someone who had never been	5	Q. And so in those circumstances you might
6	pregnant?	6	induce delivery, correct?
7	A. They're in an undifferentiated state. And	7	A. After counseling with the patient, if that's
8	so some other driver of breast cancer could drive them	8	what she wanted, that might be done. And
9	into the state of cancer. Not having gone through that	9	Q. And go ahead.
10	stimulation that resulted in all those immature lobules	10	A. I was going to say, we have a system in
11	in the woman who never became pregnant makes her risk	11	place. It is generally we have a three doctors
12	lower compared to the woman who did have the pregnancy	12	recommend you know, saying this is reasonable; we have
13	that stimulated the immature cells.	13	a chaplain. There is a protocol that we follow prior to.
14	Q. All right. I think I understand what your	14	Q. But at that point, what would be the chance
15	position is in that respect.	15	of survival for an 18-week-old fetus?
16	But it is your testimony that you would	16	A. If it is truly an 18-week fetus, the chance
17	if someone is considering an abortion, you would counsel	17	of survival is probably zero.
18	them about the risks of breast cancer with respect to	18	Q. I'm sorry. Probably zero or zero?
19	ending the pregnancy, correct?	19	A. If it is truly an 18-week, it can be zero.
20	A. I would talk to them about that, yes.	20	Sometimes ifs
21	Q. And just to make sure that I understand. Is	21	Q. I'm sorry. Can we go back? Is it, can it
22	it your opinion that there is a causal connection between	22	be zero? Let me rephrase the question.
23	the abortion and the heightened risk of breast cancer	23	Have you ever seen an 18 a true 18-week
24	later in life?	24	fetus delivered and survive more than a day?
25	A. Yes, by leaving those immature cells without	25	A. No.
		1	

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER Ingrid Skop, M.D.

Deh	tember 02, 2020		Ingrid Skop, M.D.
	134		136
1	Q. Okay. So the in your your	1	readmission to the hospital, requiring a transfusion,
2	understanding is that the hospital will perform induction	2	requiring a repeat surgery, requiring IV antibiotics, ICU
3	deliveries in cases where there is a maternal indication	3	admission, thromboembolic event, a pulmonary embolism, a
4	that one is needed even if those those deliveries are	4	stroke, death, obviously.
			· · · · · ·
5	performed at a point where there is a zero percent chance	5	Q. And do you have a sense of what the in
6	of survival of the fetus; is that correct?	6	your practice currently what the complication rates are
7	A. That is correct. And the Utah law allows	7	for those kinds of major morbidities in pregnancy or in
8	that.	8	labor and delivery during or after labor and
9	Q. That's your understanding of the Utah law;	9	delivery?
10	is that correct?	10	A. I mean, I'd probably say the most common of
11	A. Uh-huh, yes.	11	those things would be a blood transfusion. That happens
12	Q. And if the Utah law did not allow that,	12	on occasion. Maybe 2 to 3 percent.
13	would you think that that was problematic?	13	Q. So 2 to 3 percent major morbidity?
14	A. I haven't heard of any laws anywhere that	14	A. Uh-huh.
15	will not allow a woman's life to be saved if her	15	Q. Okay. And but you wouldn't it sounds
16	pregnancy poses a risk to her life.	16	like you would not include a C-section within major
17	Q. At the Baptist Health System so said	17	morbidity, correct?
18	you generally, you don't perform well, it sounds	18	A. No.
19	like, in your view, they don't perform abortions ever.	19	Q. Okay. Even though that would involve a
20	Do you let's see.	20	surgical procedure and cutting into the uterus, right?
21	Actually, could I take you back to your	21	A. Right. Right. If she had a C-section and
22	chair position? You said you were the chair of the	22	had to go back to the operating room because of
23	department of the OB/GYN at the Northeast Baptist	23	complication then that would count, but not the
24	Hospital. Did I get that right?	24	initial.
25	A. Yes, ma'am.	25	Q. What about minor complications or nonmajor
	105		
	135		137
1	Q. And did you have any role in overseeing or	1	indicators of morbidity? Are there things that you think
1 2	Q. And did you have any role in overseeing or tracking complications for care provided in the	1 2	indicators of morbidity? Are there things that you think of as a complication that you wouldn't consider major
	Q. And did you have any role in overseeing or tracking complications for care provided in the department during your tenure as chair?		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?
2	Q. And did you have any role in overseeing or tracking complications for care provided in the	2	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
2 3	Q. And did you have any role in overseeing or tracking complications for care provided in the department during your tenure as chair?	2 3	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?
2 3 4	 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. 	2 3 4	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
2 3 4 5	 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, 	2 3 4 5 6 7	 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
2 3 4 5 6	 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 	2 3 4 5 6	 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
2 3 4 5 6 7	 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, 	2 3 4 5 6 7	 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
2 3 4 5 6 7 8	 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 	2 3 4 5 6 7 8	 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
2 3 4 5 6 7 8 9	 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. 	2 3 4 5 6 7 8 9	 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.
2 3 4 5 6 7 8 9 10	 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 	2 3 4 5 6 7 8 9 10	 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
2 3 4 5 6 7 8 9 10 11	 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, 	2 3 4 5 6 7 8 9 10 11	 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
2 3 4 5 6 7 8 9 10 11 12	 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? 	2 3 4 5 6 7 8 9 10 11 12	 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.
2 3 4 5 6 7 8 9 10 11 12 13	 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 	2 3 4 5 6 7 8 9 10 11 12 13	 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
2 3 4 5 6 7 8 9 10 11 12 13 14	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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 	2 3 4 5 6 7 8 9 10 11 12 12 13 14 15	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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
 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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?
 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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
 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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.
 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 20 21	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 20 21 22	 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,
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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?
 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 20 21 22	 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,

Ingrid Skop, M.D.

	138		140
1	major morbidity from childbirth?	1	Q. Uh-huh, from a medical perspective, are the
2	A. I don't know that any of them are considered	2	most serious complications.
3	major morbidity, but our hospital does keep records on	3	A. Yeah. I mean, that's why we track them
4	the more extensive tears, the fourth degree tears.	4	because we want
5	Q. Fourth degree. And what does a fourth	5	Q. Okay. So I think you said that you thought
6	degree tear involve?	6	the rate of complication for major morbidity would be 2
7	A. That is where the tear goes through the	7	to 3 percent of the deliveries that you do or that your
8	vagina and through the rectum and the rectal muscles.	8	practice does?
9	Q. Okay. And that can result in fecal	9	A. I'm thinking my practice.
10	incontinence, correct?	10	Q. Okay. And what about any anything that
11	A. It is possible.	11	you would consider a complication of pregnancy or,
12	Q. Urinary incontinence?	12	perhaps, anything that your practice tracks as a
13	A. Uh-huh.	13	complication of either labor and delivery or labor and
14	Q. Does it require surgery?	14	delivery and pregnancy combined, what is the rate of
15	A. No. Generally we repair it at the time of	15	those complications?
16	delivery, but it is rare for it to require other	16	A. You know, we may I'm going to say it is
17		17	probably still in the 2 to 3 percent rage. We talk about
18	surgery. Q. But it is a surgical procedure to repair it,	18	them, but they don't happen very often considering there
19	correct?	19	are 20 doctors.
20	A. I guess	20	Q. So it would be 2 to 3 percent major
20	Q. You sew it up, right?	20	morbidity and another 2 to 3 percent other
22	A. Yeah, I guess if you consider surgery	22	complications?
23	when you do stitches.	23	A. So of the ones we track, I would consider
23 24	Q. Well, if you had, like, a vaginal tear that	23	all of those to be major morbidity.
24	required you to throw a couple of stitches to fix, what	24	Q. And do you have a list of the ones that you
25	required you to throw a couple of stitches to fix, what	23	Q. And do you have a list of the offes that you
	139		141
1	139 kind of tear would that be in terms of degree?	1	141 track? Does that come from somewhere, or is it just
1 2		1 2	
	kind of tear would that be in terms of degree?		track? Does that come from somewhere, or is it just
2	kind of tear would that be in terms of degree? A. Probably most commonly a second degree.	2	track? Does that come from somewhere, or is it just something that your practice has made up?
2 3	kind of tear would that be in terms of degree?A. Probably most commonly a second degree.Q. If you use stitches?	2 3	track? Does that come from somewhere, or is it justsomething that your practice has made up?A. The hospital has their own list, and I
2 3 4	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	2 3 4	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
2 3 4 5	 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. 	2 3 4 5	 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.
2 3 4 5 6	 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 	2 3 4 5 6	 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
2 3 4 5 6 7	 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 	2 3 4 5 6 7	 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?
2 3 4 5 6 7 8	 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? 	2 3 4 5 6 7 8	 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.
2 3 4 5 6 7 8 9	 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 	2 3 4 5 6 7 8 9	 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
2 3 4 5 6 7 8 9 10	 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. 	2 3 4 5 6 7 8 9 10	 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?
2 3 4 5 6 7 8 9 10 11	 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 	2 3 4 5 6 7 8 9 10 11	 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.
2 3 4 5 6 7 8 9 10 11 12	 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? 	2 3 4 5 6 7 8 9 10 11 12	 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
2 3 4 5 6 7 8 9 10 11 12 13	 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. 	2 3 4 5 6 7 8 9 10 11 12 13	 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
2 3 4 5 6 7 8 9 10 11 12 13 14	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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?

Ingrid Skop, M.D.

			ingita ettep; in.e.
	142		144
1	you might need to give them narcan which reverses it, but	1	A. Yes, ma'am.
2	I can't recall having seen that.	2	Q. Have you ever seen any statistics on
3	Q. Okay. And what about a uterine perforation;	3	abortion complications that approach a one in three
4	would that be something that you would necessarily	4	outcome per abortions?
5	track?	5	A. You mean, like, an abortion complication
6	A. That would be a major complication because	6	that occurs one out of three times?
7	it would require additional surgery.	7	Q. Yes. Have you ever seen any data to that
8	Q. So any kind of uterine perforation. And	8	effect?
9	then what about any kind of pelvic floor injury? How	9	A. I have not, but I would back up and say that
10	often does that happen after a let me ask specifics of	10	we do not do a good job of collecting and analyzing
11	vaginal deliveries.	11	abortion complications in our country because because
12	A. You're asking how often does a woman develop	12	it is not tracked by insurance. Most of them are not
13	prolapse later in life?	13	voluntarily reported by abortionists. I don't know of
14	Q. Well, prolapse is one type of pelvic floor	14	any that occurs that often, but, again, I think our data
15	injury, correct? But there could be others that happen;	15	is compromised.
16	is that correct?	16	Q. What is the highest as we talked about
17	A. Well, we talked about the different degrees	17	earlier, no data is perfect. What is the highest rate of
18	of laceration.	18	complications from abortion that you have seen in
19	Q. So you would include the vaginal tearing in	19	literature that you would consider reliable or among the
20	that. There are some women who require physical therapy	20	best data that we have? What's the highest rate?
21	after a vaginal delivery, correct?	21	A. There are some studies out of Europe that
22	A. There can be	22	see a one out of five complication rate, typically
23	Q. For incontinence?	23	related to medical abortions requiring surgery. There is
24	A yeah, incontinence and things like	24	a medical abortions in the second trimester which,
25	that.	25	again, we don't do that here, but that one has about a
			again, no aoirt ao anathoro, but anatorio nao about a
	143		145
1	Q. How often does that happen?	1	two out of five complication rate requiring surgery.
2	A. You know, I don't know. I don't know that	2	Q. Let me back up. Can we look at page 6 of
3	I've ever seen a study that looks at that.	3	your report?
4	Q. Okay. So we talked a little bit about the	4	A. Okay.
5	risks of C-sections. Earlier we talked about placenta	5	Q. The first full paragraph there in the
6	accreta spectrum. I want to keep call it placenta	6	middle, you say, "Compared to an abortionist performed at
7	accreta syndrome, but	7	eight weeks gestation" and I'm skipping over a little
8	Okay. We talked about that. We talked	8	bit, but you quote a rate of well, sorry. I realize
9	about, you know, potential blood loss complications. You	9	you don't have the complication rates in here.
10	know, infection. Am I missing any risks of C-sections	10	So you mentioned a one out of what is the
11	that you would describe as common?	11	highest rate of complications from abortion that you have
12	A. I think those are the common ones, yeah.	12	seen in the United States for D&E abortions, any
13	Q. Okay. But then if you could turn to page 4	13	complication?
14	of your report. On page 4 you say, "With modern surgical	14	A. I think the Autry study says 4 percent.
15	techniques" oh, this is in the last paragraph kind of	15	Q. Four percent. So to get from 4 percent to
16	midway down. Do you see that, the sentence starting with	16	33 percent, which is what you say is roughly the share of
17	"modern surgical"?	17	deliveries that end in C-section, on what magnitude of a
18	A. Let me make sure I'm on the right page.	18	change would you need, in terms of identifying
19	Q. Yeah, I'm counting the cover page.	19	complications of abortion, to approach the one in three
20	A. Okay.	20	statistics for C-section?
21	Q. So you say, "With modern surgical	21	A. Can I ask a question? Are you assuming for
22	techniques, a C-section delivery is usually very safe,	22	this discussion that a C-section is a complication?
23	even in an extremely sick woman. (One out of three	23	Q. I'm not.
24		1	
27	pregnancies in our country are delivered this way.)" Did	24	A. Because in many cases in probably most
25	pregnancies in our country are delivered this way.)" Did I get that right?	24 25	 A. Because in many cases in probably most cases, the reason for the C-section is to get a live,

	146		148
1	healthy baby out. So this doesn't apply to abortion	1	didn't. Let me ask you. Have you reviewed the National
2	because abortion has no desire to get a live, healthy	2	Academy of Sciences report on the safety of abortion?
3	baby out. So I think	3	A. I'm very familiar with that study.
4	Q. I'm simply Dr. Skop, I'm asking because	4	Q. Okay.
5	you have indicated that you believe a C-section, which is	5	A. Do you know
6	a surgical procedure that requires a full cut into the	6	Q. Okay. Excuse me, Dr. Skop, if you can
7	uterus, is usually a very safe procedure for someone to	7	please respond to my questions.
8	have. And so I'm asking, for an abortion, which I	8	Are you aware of data presented in that
9	recognize is a different procedure have you seen any	9	study about the incidence of particular complications
10	complication from an abortion that would approach a	10	with respect to D&E abortions?
11	33 percent rate? Setting aside whether it is a	11	A. I think that's in here. I can look for it.
12	complication that requires another surgery and a cut into	12	I can't tell you right offhand, but I think that is a
13	the uterus, have you seen any complication that	13	compromised study because it was commissioned by six
14	approaches a 33 percent rate?	14	outspoken abortion advocacy organizations.
15	A. Well, the Europe study that I mentioned	15	Q. Okay.
16	in	16	MS. MURRAY: So I think this would probably
17	Q. In the U.S. In the United States with a	17	be a good time to take a break? What do you think? I
18	D&E.	18	guess it is my lunchtime, but I recognize. I guess we're
19	A. I have not seen it because we do not track	19	getting on close to your lunchtime, too. Would you all
20	D&E complications. We don't track them.	20	like to take a short break or would you like to take a
21	Q. And do you think do you think, based on	21	lunch break.
22	your expert opinion from well, there are studies that	22	MR. SORENSON: I would suggest a lunch
23	talk about complication rates from abortions in the	23	break, if that's all right. More for my dog than me.
24	United States, correct?	24	MS. MURRAY: That's good. Do you want to
25	A. There certainly are. There is very little	25	say half hour, 45 minutes?
			1.4.0
	147		149
1	that addresses complications from D&Es.	1	THE WITNESS: Half hour is fine.
2	that addresses complications from D&Es. Q. And what would you say the most reliable	2	THE WITNESS: Half hour is fine. MR. SORENSON: How about we just put it at
2 3	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	2 3	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
2 3 4	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	2 3 4	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
2 3 4 5	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?	2 3 4 5	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.
2 3 4 5 6	 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 	2 3 4 5 6	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.
2 3 4 5 6 7	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	2 3 4 5 6 7	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.)
2 3 4 5 6 7 8	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	2 3 4 5 6 7 8	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.
2 3 4 5 6 7 8 9	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	2 3 4 5 6 7 8 9	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
2 3 4 5 6 7 8 9 10	 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 	2 3 4 5 6 7 8 9 10	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
2 3 4 5 6 7 8 9 10 11	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	2 3 4 5 6 7 8 9 10 11	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?
2 3 4 5 6 7 8 9 10 11 12	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.	2 3 4 5 6 7 8 9 10 11 12	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
2 3 4 5 6 7 8 9 10 11 12 12 13	 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 	2 3 4 5 6 7 8 9 10 11 12 13	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
2 3 4 5 6 7 8 9 10 11 12 13 14	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14	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
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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, 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	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."
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	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

	150		152
1	Q. Well, it sounds like you had a good lunch	1	outcomes, all of them, we might be able to obtain better
2	then.	2	data.
3	Okay. Let's get started then. I wanted to	3	Q. And what about the pregnancy-related
4	take you back to close to where we left off. When we	4	mortality rate for pregnancies that end in a live birth;
5	left off, we had been talking about the National	5	what do you think the best data available is to calculate
6	Academies of the Sciences' report, and, you know, I take	6	those rates?
7	it from your response that you well, let me just put	7	A. The best data and some of the state level
8	it this way.	8	maternal morbidity and mortality committees are doing
9	In your view, what is the best source of	9	this would be to look at maternal death certificates
10	data on abortion-related mortality and morbidity rates in	10	along with the fetal live birth or death certificate,
11	the United States?	11	which are given after 20 weeks with the exception of
12	A. We don't have the desire as a country to	12	abortion, which does not have to have a certificate, and
13	keep accurate data on that. I don't think that there is	13	then to pull all of that woman's medical records to
14	any good source of data. It's well documented that many	14	determine causation. That would be the best.
15	abortion-related deaths are not documented on death	15	It's not been done here; it's been done in
16	certificates.	16	Finland and Denmark. And when it is done with complete
17	Q. So, ma'am, I will say and I should	17	records, the risk of death following abortion is far
18	probably just make this statement early on. I want to	18	higher than the risk of death within a year following a
19	make sure we're able to get through the questions that I	19	term birth.
20	have today. So I would ask that you stick to responding	20	Q. I noticed that you relied on the Finnish
21	to my specific questions in your answers so we can stay	21	studies in your report. Those studies are based on vital
22	on track. Okay? Is that fair?	22	records data, correct?
23	A. Yes.	23	A. That's correct.
24	Q. So my question to you is what is the best	24	Q. And so they don't measure pregnancy-related
25	source of data available on abortion-related mortality	25	outcomes to the extent pregnancy related means there is
	151		153
1	and morbidity rates in the United States?	1	some causal nexus between the pregnancy and the outcome;
2	A. The CDC is the only place collecting that.		
			IS that correct?
3			A. They are looking at all deaths, so they are
3	Q. Okay. With respect to abortion-related	3	A. They are looking at all deaths, so they are
4	Q. Okay. With respect to abortion-related mortality rates, do you believe that those rates should	3	A. They are looking at all deaths, so they are actually looking at pregnancy-associated deaths.
4 5	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	3 4	 A. They are looking at all deaths, so they are actually looking at pregnancy-associated deaths. Q. And pregnancy-associated deaths, to make
4	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	3 4 5 6	 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
4 5 6	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	3 4 5 6	 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?
4 5 6 7	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?	3 4 5 6 7	 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
4 5 6 7 8	 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 	3 4 5 6 7 8	 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
4 5 6 7 8 9	 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. 	3 4 5 6 7 8 9	 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
4 5 6 7 8 9 10	 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 	3 4 5 6 7 8 9 10	 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.
4 5 6 7 8 9 10 11	 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 	3 4 5 6 7 8 9 10 11	 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
4 5 6 7 8 9 10 11 12	 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, 	3 4 5 6 7 8 9 10 11	 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.
4 5 6 7 8 9 10 11 12 13	 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 	3 4 5 6 7 8 9 10 11 12 12 13	 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
4 5 6 7 8 9 10 11 12 13 14	 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 	3 4 5 6 7 8 9 10 11 12 13 14	 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
4 5 7 8 9 10 11 12 13 14 15	 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 	3 4 5 6 7 8 9 10 11 12 13 14 15	 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
4 5 7 8 9 10 11 12 13 14 15 16	 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? 	3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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
4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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 	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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;
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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 	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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?
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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. 	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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.
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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. 	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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. 	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 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. 	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 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
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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. 	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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

Sep	tember 02, 2020		Ingrid Skop, M.D.
	154		156
1	the pregnancy, would be from maternal morbidity and	1	leaves a very big gap in our understanding of what
2	mortality review committees where they look at, if I have	2	happens that causes women to die.
3	this correctly, death certificates, fetal death	3	Q. Okay. So but that is true with respect
4	certificates, and a woman's medical records; is that	4	to pregnancy-related deaths and with respect to
5	correct?	5	abortion-related deaths, correct? That there is a gap in
6	A. Well, the they're looking at both live	6	information as to there could be some people who do
7	births after 20 weeks and death of neonatal stillbirths	7	have those related deaths but are not identified,
	after 20 weeks and connecting those to maternal death	8	correct?
8	certificates.	-	
9		9	A. That's correct. We know that with term
10	Q. Okay. So	10	deaths, even those, 40 to 50 percent are missed on death
11	A. They make that connection and then pull the	11	certificates. In the Finnish studies, when they look at
12	woman's records. And if they could get ahold of the	12	death certificates, it missed 94 percent of deaths
13	records from the abortion clinics, which, apparently,	13	related to abortions. So there's a possibility of data
14	they cannot, that would be a complete way to do it.	14	there.
15	Q. Are you familiar with the review committee	15	Q. To be precise, Dr. Skop, didn't you say that
16	that operates in Utah to study the morbidity and	16	the Finnish studies on which you rely do not assess
17	mortality?	17	whether a death is pregnancy related. They only identify
18	A. Not specifically.	18	pregnancy-associated deaths. Correct?
19	Q. But every state has one, correct?	19	A. Right. But the difference is that they can
20	A. Uh-huh.	20	pick up every death associated with pregnancy because
21	Q. And do you have any knowledge with respect	21	they have a single payer health care. They know about
22	to how they calculate the maternal mortality or	22	every pregnancy that enters the health care system even
23	pregnancy-related mortality rates in the state of Utah?	23	if it ends in abortion, we don't.
24	A. Do you I know what the committee does	24	Q. Right. But they're not pregnancy related
25	specifically or how	25	they are not assessing pregnancy-related deaths,
	1 5 5		1 5 7
	155		157
1	Q. Yes.	1	correct?
2	Q. Yes.A. No, I'm not familiar with the committee.	2	correct? A. They are they are assessing they're
2 3	Q. Yes.A. No, I'm not familiar with the committee.Q. You're not familiar, okay. But if they	2 3	correct? A. They are they are assessing they're collecting pregnancy-associated deaths, but they are
2 3 4	 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 	2 3 4	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
2 3 4 5	 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 	2 3 4 5	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
2 3 4 5 6	 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 	2 3 4 5 6	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
2 3 4 5 6 7	 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 	2 3 4 5 6 7	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.
2 3 4 5 6 7 8	 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 	2 3 4 5 6 7 8	 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
2 3 4 5 6 7 8 9	 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 	2 3 4 5 6 7 8 9	 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?
2 3 4 5 6 7 8 9 10	 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 	2 3 4 5 6 7 8	 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.)
2 3 4 5 6 7 8 9 10 11	 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 	2 3 4 5 6 7 8 9 10 11	 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?
2 3 4 5 6 7 8 9 10 11 12	 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 	2 3 4 5 6 7 8 9 10 11 12	 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.
2 3 4 5 6 7 8 9 10 11 12 13	 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 	2 3 4 5 6 7 8 9 10 11	 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
2 3 4 5 6 7 8 9 10 11 12	 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 	2 3 4 5 6 7 8 9 10 11 12	 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
2 3 4 5 6 7 8 9 10 11 12 13	 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 	2 3 4 5 6 7 8 9 10 11 12 13	 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
2 3 4 5 6 7 8 9 10 11 12 13 14	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

Ingrid Skop, M.D.

· · ·		1	
	158		160
1	attention to the second paragraph on here that has	1	is I know the CDC collects that information, but I
2	definitions, and it says, "Pregnancy-related deaths." I	2	don't know how they do it. I don't know if they require
3	just wanted to make sure that we're using terminology	3	hospitals to report sentinel events or if that is
4	that is consistent with how the Utah Department of Health	4	voluntary. They do say there's probably a hundred times
5	is using it, or make sure, if you disagree with it	5	as much, you know, morbidity as mortality, but I would
6	MS. MURRAY: This is Tab K, Darcy.	6	assume that's something we don't have a lot of great data
7	Q that I understand what the disagreement	7	on either.
8	is.	8	Q. And so if a patient let me ask you, has a
9	So the Utah Department of Health defines	9	patient ever asked you about the risk of dying from
10	pregnancy-related deaths as, "The death of a woman during	10	pregnancy and childbirth?
11	pregnancy or within one year of the end of pregnancy from	11	A. On occasion somebody will ask me about that
12	a pregnancy complication, a chain of events initiated by	12	Raymond and Grimes study, and I will explain to them that
13	pregnancy or the aggravation of an unrelated condition by	13	it is based on noncomparable denominators, and we don't
14	the physiological effects of pregnancy." Is that how you	14	really know the answer to which is safer. I will
15	understand pregnancy-related deaths, Dr. Skop?	15	reassure them that the MacDorman study that has been
16	A. Yes, it is.	16	widely quoted in the news, many of the deaths that were
17	Q. And a pregnancy-associated death here, they	17	picked up were due to increased documentation rather than
18	would define, if it is not related, as, "The death of one	18	actually increasing number of deaths.
19	during pregnancy or within one year of the end of	19	Q. So I do want to keep us on track. So if a
20	pregnancy from a cause that is not related to pregnancy."	20	patient asked you you've had patients ask about the
21	Is that your understanding as well?	21	Raymond and Grimes study; is that correct?
22	A. No. That is a definition I have not seen	22	A. Yes.
23	before. The one that I used, I believe it is WHO and	23	Q. And would you give them any information that
24	CDC, they don't have the part that says "but not	23	you considered to be the best data, or is your answer
25	related." They say a pregnancy-associated death, and I	25	that there are no good data in the area?
20	Tolated. They buy a pregnancy accounted death, and t	20	that there are no good data in the area i
	159		161
1	159 believe they define it as a death within a year	1	161 A. There's no good data. When we look at what
1		1 2	
	believe they define it as a death within a year		A. There's no good data. When we look at what
2	believe they define it as a death within a year irrespective of the cause.	2	A. There's no good data. When we look at what the CDC does have documented, we discover that,
2 3	believe they define it as a death within a year irrespective of the cause. So in other words, it includes women who	2 3	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
2 3 4	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	2 3 4	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
2 3 4 5	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.	2 3 4 5	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.
2 3 4 5 6	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	2 3 4 5 6	 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
2 3 4 5 6 7	 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 	2 3 4 5 6 7	 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?
2 3 4 5 6 7 8	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	2 3 4 5 6 7 8	 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
2 3 4 5 6 7 8 9	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	2 3 4 5 6 7 8 9	 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
2 3 4 5 6 7 8 9 10	 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? 	2 3 4 5 6 7 8 9 10	 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
2 3 4 5 6 7 8 9 10 11	 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. 	2 3 4 5 6 7 8 9 10 11	 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?
2 3 4 5 6 7 8 9 10 11 12	 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 	2 3 4 5 6 7 8 9 10 11 12	 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.
2 3 4 5 6 7 8 9 10 11 12 13	 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 	2 3 4 5 6 7 8 9 10 11 12 13	 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
2 3 4 5 6 7 8 9 10 11 12 13 14	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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,
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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.

Ingrid Skop, M.D. 162 164 1 mortality rate for pregnancies ending in a vaginal birth? 1 having a discussion about killing a human being in order 2 A. Because you're comparing similar procedures. 2 to mildly reduce a woman's risk of going through a term So, in other words --3 3 pregnancy. 4 4 Q. I certainly didn't write HB136. The State's Q. Well, let me ask you this. Do women who 5 have C-sections, on average, do they have higher risk 5 position here is one of the bases for HB136 is to protect 6 6 pregnancies? the health and safety of patients in Utah. So my 7 7 question to you is do you believe or can you think of A. Sometimes they do. 8 anyone else in your field who would agree with you that a 8 Q. On average do they? 9 9 A. Probably in my patient population, yes. pregnancy mortality rate based only on vaginal birth is 10 10 Q. Right. And so they are, even before the an appropriate comparator to the pregnancy-related --C-section, on average, at higher risk of mortality and 11 abortion-related mortality rate? 11 12 morbidity from pregnancy and childbirth, correct? 12 A. I don't know that I've had that discussion 13 13 A. Many -- many of the women who have with many people. 14 C-sections do so because -- due to failed induction 14 Q. Okay. because of hypertension, diabetes; other high risk 15 15 A. It's a similar procedure. I considered it 16 conditions place them at higher risk for C-section. If 16 to be an appropriate comparison. 17 that makes sense. Yeah, they're higher risk women to 17 Q. On page 5 of your report, if you can turn to 18 start with. 18 that. That is Exhibit 2. Are you there? 19 Q. And so what you're advocating would be to 19 A. Yes, I'm here. 20 compare abortion to childbirth but exclude what would 20 Q. So at the very end of the first full 21 21 effectively be the highest risk population, correct, of paragraph, you say, "Complications unique to this 22 22 those women who have a child? operation may include instrumental perforation of the 23 A. I want to compare similar procedures, right? 23 soft, distended uterus, with injury to surrounding bowel 24 So your procedure does not involve an incision on the 24 or vasculature, potentially leading to sepsis; or the 25 uterus. It involves the introduction of instruments into 25 incomplete removal of all the fetal tissue which may lead 163 165 1 the uterus to remove the child, and that has double the 1 to hemorrhage, infection, of chronic pain, or future 2 risk than if she went to term and had a normal delivery. 2 infertility. Additional surgery may be needed to correct 3 Now, obviously, we don't know in advance who is going to 3 these damages." 4 need a C-section, but there's so much that is more 4 Did I get that right? 5 5 important here than is just being concerned about the A. Yes, ma'am. 6 mortality particularly when we don't have good 6 Q. What do you mean by "Complications" -- well, 7 information on mortality. 7 first of all, let me ask: When you say "this operation," 8 Q. Let me back up. This comparison between 8 what do you mean by that? What is "this operation" 9 abortion mortality rates and vaginal-birth mortality 9 here? 10 10 rates, that's not in your expert report, correct? A. Well, I'm specifically referring to a D&E. 11 A. I don't think so. 11 Q. Okay. 12 Q. You don't compare them. And do you have any 12 A. Now, obviously, what I am not saying is that cites in your expert report that describes your opinion 13 13 only a D&E can give these complications because, as I 14 in this respect? 14 mentioned earlier, I know of a young woman who died of a 15 A. It's included in the paper that I wrote: 15 first trimester surgical abortion from these type of Abortion and Maternal Mortality. That's in the CV but 16 16 complications. was published after I submitted this report. 17 17 But Creanga, Berg, Zane -- the CDC 18 Q. Has that been peer reviewed? 18 researches who do the -- who look at the statistics on 19 A. Yes. 19 the maternal mortality that we have, have documented that 20 Q. Can you think of any other colleagues whose 20 early in the second trimester a D&E has 15-fold increased 21 work you respect in the area -- anyone else in the field 21 risk of mortality, 30-fold in the mid, 76-fold at the end 22 who believes that it would be appropriate to compare the 22 of the second trimester. So it is well documented that 23 mortality rate from abortion to the mortality rate only 23 when complications occur that they're more serious and 24 of vaginal births -- after vaginal births? 24 they're more frequent in D&Es than in early first 25 A. I think it is disingenuous that we're even 25 trimester surgical abortions.

Set			
	166		168
1	Q. Okay. I'm going to stop you there because	1	Q. And you could have uterine rupture during
2	we will get to that, but we're going to get to that	2	childbirth, correct?
3	later.	3	A. You can.
4	When you say, "Complications unique to this	4	Q. What about a surrounding what about a
5	operation," what do you mean by the word unique there?	5	bowel injury; could that happen during childbirth?
6	A. Again, I'm not saying that it can only	6	A. It could. It is very unusual. That would,
7	happen	7	you know, potentially be a situation where you had a
8	Q. Let me ask it a different way. That might	8	surgical misadventure during a C-section. Again, it is
	· ·	9	
9	be more helpful. Are you saying that these complications		not very likely.
10	are not complications that would occur in any other	10	Q. Vasculature injury, could that happen in
11	pregnancy separation besides abortion?	11	childbirth?
12	A. As far as perforating through the uterus	12	A. That can happen with any
13	from the inside, that is unless you had a uterus that	13	Q. What about infection leading to sepsis?
14	ruptured, which, as we've discussed, can happen with a	14	A. That can happen.
15	C-section scar, doesn't happen very often.	15	Q. And does that happen sometimes because of a
16	Q. But let me ask this: Can it happen with	16	retained placenta after delivery?
17	instruments if you have a I'm sorry, I'm forgetting	17	A. It can.
18	the medical terminology. But if you have a delivery	18	Q. What about well, you said incomplete
19	where instruments are used, could there be uterine	19	removal of all the fetal tissue. So there could be
20	perforation in that instance?	20	incomplete removal of the placenta after childbirth,
21	A. There could be. It would be medical	21	correct?
22	malpractice.	22	A. With a D&E or with a term delivery?
23	Q. But it wouldn't be unique to an abortion; is	23	Q. With a term delivery.
24	that correct?	24	A. Yes, that can happen.
25	A. Right. So it	25	Q. And is it accurate that after a term
	1 (7		1.00
	167		169
1	Q. What about	1	delivery, you would actually examine the placenta to make
2	A. Complications commonly with this procedure.	2	sure that it is whole?
3	Q. I'm sorry?	3	A. Typically we do, yes.
4	A. Maybe I should rephrase it as complications	4	Q. What about the hemorrhage; that can happen
5	that can happen commonly with this procedure.	5	after childbirth, correct?
6	Q. And how would you define the word commonly	6	A. Yes.
7	there?	7	Q. Infection?
8	A. That's a very good question. You know, in	8	A. Yes.
9	medicine in general, a common complication is one that's	9	Q. Chronic pain?
10	in the, you know, 5 to 10 percent range. You know, a lot	10	A. Yes.
11	of times abortionists tell us that complications are	11	Q. Future infertility?
12	uncommon, and yet they do document, for example, failed	12	A. Yes.
13	medical abortions in the 5 percent range.	13	Q. Okay. So it is not accurate to say that
14	Q. So you're saying commonly there you would	14	these complications are unique to the D&E, is it?
15	mean 5 to 10 percent?	15	A. Instrumental perforation of the soft,
16	A. No. I don't know how often that happens	16	distended uterus does not occur in normal childbirth.
17	because we don't keep good data on those type of	17	That's what I'm referring to, and that can lead to all of
18	complications.	18	those other things, which, of course, like infection and
19	Q. Okay. But just to be clear, instrumental	19	hemorrhage can occur in other types of procedures. But
20	perforation of the uterus that could occur during	20	the instrumental perforation is pretty much unique to a
21	childbirth, correct?	21	D&C, a D&E.
22	A. If it did, it would be a really, really bad	22	Now, sometimes the D&C can be related to a
23	doctor because you don't put forceps on until the child	23	miscarriage, so it is not always a live birth. But a D&E
24	is in the vagina. You don't put the forceps on when the	24	has a much higher incidence of these type of things
24	kid is still in the uterus.	25	happening, particularly if it is done by an inexperienced
120		20	happoning, particularly in it is done by an inexperienced

Sep	tember 02, 2020		Ingrid Skop, M.D.
	170		172
1	abortionist.	1	Q. Okay. And are you familiar with well,
2	Q. We'll get to that.	2	let's leave that.
3	So if I could have you look at I just	3	So then I would like you to turn to Tab H.
4	want to make sure that we have a few things in the record	4	(Exhibit No. 6 was marked.)
5	here. If I could have you look at the if I could have	5	Q. This an article called "Abortion-Related
6	you look at Tab G actually, you know what? Let's go	6	Mortality in the United States" by Susan Zane and
7	somewhere else first.	7	coauthors. Do you recognize this document?
8	MR. SORENSON: While you're doing that,	8	A. Yes, I do.
9	Julie or Kristin, did we mark Tab K as an exhibit? I	9	Q. Was this the Zane article that you were
10	can't remember.	10	referring to earlier when you talked about what you
11	MS. MURRAY: We did.	11	believe was the best available data on abortion-related
12	MR. SORENSON: Can you remind me what	12	deaths?
13	exhibit that was?	13	A. Zane's article and Bartlett and Berg are two
14	MS. MURRAY: 1 think it is Exhibit No. 4.	14	that I use.
15	(Discussion held off the record.)	15	Q. Okay.
16	Q. (By Ms. Murray) So if you could move to	16	2
17	Tab D?	17	A. But, again, I it is CDC data and we know that CDC is incomplete, but this is (inaudible) we get
18	(Exhibit No. 5 was marked.)	17	from the CDC.
10	Q. So I'm showing you, Dr. Skop, Tab D, what	10 19	Q. But in terms of the best available data, you
20	has been marked as Exhibit 5. Do you recognize this	20	would rely on this Zane article; is that correct?
20	document?	20	A. It's the best available, yeah.
22	A. Yes, I do.	21	Q. Okay. And then if you could turn to
22	Q. And this is cited in the clinician guides to	22	Tab G?
23	medical and surgical, correct?	23 24	(Exhibit No. 7 was marked.)
25	A. Yes.	24 25	Q. I'll show you what's being marked as
20	A. 163.	23	Q. This now you what's being marked as
	171		173
1	Q. And it is cited in your report?	1	Exhibit 7. This is an article entitled "Risk Factors for
2	A. Possibly.	2	Legal Induced Abortion-Related Mortality in the United
3	Q. Why don't you take a look at footnote 9.	3	States" by Linda Bartlett and coauthors. Is this the
4	A. Okay. Yes, it is.	4	Bartlett article that you're referring to as among the
5	Q. Okay. Do you consider this guide a reliable	5	best available data on abortion-related mortality?
6	source on abortion practice?	6	A. This is the article that I referred to, and
7	A. I think there is some good information in	7	it is the best based upon the limited data that the CDC
8	here. It is authored by at least one physician that is a	8	has.
9	well-known abortion advocate, but I think it does have	9	Q. Okay. Is it the best data available right
10	some interesting information in here about complications.	10	now with respect to abortion-related mortality in the
11	Q. About complications?	11	United States?
12	A. Uh-huh.	12	A. Probably, that I'm aware of. Some of the
13	Q. And so what about abortion practice	13	maternal mortality committees may be coming up with some
14	generally?	14	better data.
15	A. This particular chapter I believe this	15	Q. Okay.
16	comes from a book that is more specific about abortion	16	A. But I'm not familiar with any studies that I
17	practice, but this particular chapter is about	17	can refer you to. But hopefully they'll have better data
18	complications.	18	in the future.
19	Q. That's correct. And do you find do you	19	Q. Okay. So if you could turn to page 6 of
20	believe that this is a reliable description of	20	your report now. Toward the end of the first full
	-	24	paragraph this is Exhibit 2.
21	complications related to abortion?	21	
	A. I think that it gives a good description of	22	A. Okay.
21	-		
21 22	A. I think that it gives a good description of	22	A. Okay.
21 22 23	A. I think that it gives a good description of the complications that can occur. I would disagree with	22 23	A. Okay.Q. You say, "Compared to an abortion performed

25

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

Ingrid Skop, M.D. 174176 1 abortion performed at eight weeks gestation (0.7/100,000 1 and they're allowed to have the abortions between 18 and 2 abortions maternal mortality rate), there is a 15 percent 2 22 weeks, then the Bartlett and Berg studies tell us 3 increase in maternal mortality when a woman has an 3 that, compared to those early abortions, that's the 4 abortion early in the second trimester (1.7/100,000), 30 4 increase in mortality that they would be expected to 5 percent increase in the mid-second trimester 5 experience. 6 (3.4/100,000), and 76 percent increase after viability 6 Q. But if it is enforced, do you think people 7 (8.9/100,000)." 7 will react to the law by having an abortion at eight 8 And then two sentences down you say, "Thus, 8 weeks or earlier? 9 if this 18-week restriction is not enforced, Utah women 9 A. Perhaps. 10 will experience a 30 to 76 percent increased risk of 10 Q. Do you think that's the most plausible dying from a complication of the late abortion." outcome from enforcement of the law? 11 11 12 Did I read that correctly? 12 A. It may make people make decisions earlier. 13 A. You read it correctly. What was insinuated 13 It may --14 was compared to an eight-week abortion. 14 Q. Ten weeks earlier? 15 Q. That's right. So just to -- just to be 15 A. It may cause the abortion clinics to, you 16 clear, then, the statement that "if this 18-week 16 know, have outreach to patients. And it may allow some 17 restriction is not enforced, Utah women will experience a 17 women, especially those that are indecisive or being 18 30 to 76 percent increased risk of dying from a 18 coerced by their partners, it may allow them to have 19 complication of the late abortion" -- that assertion is 19 their children, which, as I've remarked earlier, I have 20 based on the assumption that women will have an abortion 20 never delivered a woman who has not been happy that she 21 not at 18 weeks but at eight weeks; is that correct? 21 had that baby. 22 22 A. It is actually based on the assumption that So taking away that opportunity for coercion 23 if they don't get it by 18 weeks, they won't have an 23 and indecision in order to commit a dangerous procedure 24 abortion. They'll carry the baby to term. But the 24 in order to kill her baby, that does get taken out of the number does compare it to an eight-week abortion. 25 25 options. 175 177 1 Q. Okay. Let me -- I have a couple of 1 Q. Let me ask my question another way, 2 questions on that. So is your assumption, then, that for 2 Dr. Skop. If a judge were to read -- or if someone were 3 women -- that the effect of HB136 would be to prevent 3 to read, "If this restriction -- 18-week restriction is 4 women from having abortions altogether? 4 not enforced, Utah women will experience a 30 to 76 5 5 A. No. Is that yours? I mean, they can have percent increased risk of dying from a complication of a them before 18 weeks. It just prohibits it after 18 6 6 late abortion." For that 30 to 76 number that you 7 weeks when it is very dangerous for the woman and when 7 provide there to be true, would the reader have to 8 the baby can feel pain. 8 believe that a person will respond to HB -- that women 9 Q. My question is for a particular woman --9 will respond to HB136 by getting abortions not at 17 10 you're saying that there is an increased risk of death to 10 weeks, not at 16, not at 15, at 8 weeks of pregnancy or 11 have an abortion at or after 18 weeks. And my question 11 earlier? 12 to you is -- let me put it this way. Increased risk of 12 A. I don't know what they're going to need to 13 death relative to what? The 30 to 76 percent increase 13 assume. But I think the way that this paragraph is 14 risk of dying is relative to what? 14 written, it is pretty clear that that is comparing it to 15 A. Those numbers are relative to an eight-week 15 an eight-week abortion. It is making the point that the abortion. But I think we should care about the increased 16 16 earlier the woman gets an abortion, the better, if she's 17 risk of death of women in this category of very late 17 going to get an abortion. And there comes a time when we 18 abortions. 18 need to take into account the woman's safety and, as 19 Q. I don't disagree with you, Dr. Skop. The 19 we'll discuss, fetal pain, in determining when our 20 numbers that you cite here, if this 18-week restriction 20 society should allow elective abortions. 21 21 is not enforced, Utah women will experience a 30 to 76 Q. Okay. I would like to move on. Can you 22 22 percent increased risk of dying from a complication of a turn to -- so Tab -- so we don't have it in yet. Tab E, 23 23 and we'll mark this as Exhibit 8. late abortion, that's not accurate, is it? 24 A. It depends on how you're reading it. 24 (Exhibit No. 8 was marked.)

Kristin Marchant, RPR

Compared to an eight-week abortion, if it is not enforced

DepomaxMerit Litigation Services

25

A. Yes.

25

extremely high volume abortion provider?

Ingrid Skop, M.D.

Sep	otember 02, 2020		Ingrid Skop, M.D.
	178		180
1	Q. So this is an article entitled "Abortion	1	A. In terms of the D&E, what I've read about
2	Safety: At Home and Abroad" and it is by you. Is that	2	Utah is that you guys did about I don't know, about
3	correct, Dr. Skop?	3	130 to 300 in this age range over a ten-year period of
4	A. That's correct.	4	
		5	time. I would consider that to be fairly low volume for
5	Q. Does it appear complete?		the complexity of this procedure. And that is part of
6	A. Yes, it does.	6	why I have a concern about Utah's performance of
7	Q. If you can turn to page 57 of Exhibit 8, the	7	abortions in this age range because it doesn't sound like
8	second full paragraph.	8	that is a high volume.
9	A. Okay.	9	Q. And when you say from what you've read,
10	Q. As I understand it, this paragraph is a	10	there is nothing in your expert report that indicates
11	criticism of the National Academies of Sciences' report	11	you've read about specific abortion procedures in Utah,
12	on abortion safety; is that correct?	12	correct?
13	A. That is correct.	13	A. I do believe in my report I did some
14	Q. Okay. And you say in the middle of the	14	extrapolating based on the numbers that Guttmacher gives
15	paragraph: "The only conclusion that can reasonably be	15	us nationwide. I believe that Utah does about 3,000
16	drawn from this report regarding abortion complications	16	abortions throughout the state in a year. And if we took
17	is that extremely high volume providers have low	17	the number of 4 percent after 16 weeks I have some
18	complication rates, not that every single abortion	18	discussion of this in the first page it ends up being,
19	provider does it well."	19	you know, a little over a hundred procedures. And, like
20	Did I get that right?	20	I say I've read elsewhere, but it was afterwards, so I
21	A. That is correct.	21	didn't include it in this report. But I read elsewhere
22	Q. Is it your opinion that with proper training	22	there were, I believe, 134 abortions performed at greater
23	and routine performance of abortion procedures that	23	than 20 weeks in Utah over a ten-year period of time,
24	abortion providers can have low complication rates?	24	which makes a little more than one a month, which is not
25	A. I think it is the case in medicine that the	25	a high volume.
	179		181
1	more frequently one performs a procedure the more skilled	1	Q. You would agree, though, a 20-plus week
2	one becomes at it. I think that that would probably	2	abortion is less common than 18-plus, correct?
3	apply to abortion providers. The problem is we have	3	A. I don't know the numbers. You're asking how
4	no no standards, no abortion certification, no way to	4	many are between 18 and 20 in Utah and how many are
5	know who is a good provider and who is not, and the women	5	between 20 and 22. I would have no way to know how
6	of America don't know that either.	6	that
7	Q. What do you consider an extremely high	7	Q. Would you have any way to know that
8	volume provider? What do you mean by that?	8	nationally?
9	A. Well, I would say Planned Parenthood of Los	9	A. Well, what we do know is that, and I believe
10	Angeles fits the bill. They're the one that did the	10	this is from Guttmacher and it is in ACOG's practice
11	study of 30,000 abortions in two years in a single city.	11	bulletin as well, that 4 percent are performed after 16
12	Q. Would you consider any number fewer than	12	weeks, and then I believe it is 1.3 that are performed
13	that to be an extremely high volume abortion provider?	13	after 20 to 22 weeks. But I don't have it narrowed down
14	A. I suppose it is all relative. When you	14	to 18 and 20.
15	consider that these are living human beings certainly	15	Q. And because you referred to it, if we can
16	I could draw the line much lower. I understand that.	16	mark Tab I as Exhibit 9. This is the practice bulletin
17	Q. Let me ask you this. Would 2,000 per year	17	from ACOG Number 135.
18	be an extremely high volume abortion provider?	18	(Exhibit No. 9 was marked.)
19	A. If that was a single provider doing that?	19	Q. Is this the practice bulletin you were just
20		20	referring to, Dr. Skop?
	Is that what you're asking? Q. Sure. Or you referred before to the to	21	A. Yes, It is in that first paragraph, the
21 22	Q. Sure. Or you referred before to the to	21 22	A. Yes. It is in that first paragraph, the statistics.
21 22	Q. Sure. Or you referred before to the to an affiliate of Planned Parenthood in Los Angeles. So	22	statistics.
21	Q. Sure. Or you referred before to the to		

Kristin Marchant, RPR DepomaxMerit Litigation Services

25

this practice bulletin a reliable source with respect to

		1	
	182		184
1	the best available data about second trimester abortion	1	no. of abortions distributed by CDC gestational age
2	in the United States?	2	proportion," and below that it says, "GI, Guttmacher
3	A. It's a good source. I mentioned earlier	3	Institute"?
4	that Planned Parenthood does not I'm sorry, that	4	A. Yes.
5	California does not report any numbers. I've heard	5	Q. That's referring to Guttmacher Institute
6	anecdotally that California, in addition to extremely	6	data about the number of abortions performed, correct?
7	large volume of abortions, also does a lot of late-term	7	A. Yes.
8	abortions. Additionally, Maryland does a lot of very	8	Q. So you cited this in your report, and you
9	late-term abortions, and they don't provide numbers	9	didn't know what the source of the denominator was in the
10	either. So I don't know how accurate these numbers are	10	mortality rates reported, correct, at the time you wrote
11	in terms of percentages.	11	your report?
12	Q. Okay. Let me because I do want to make	12	A. You know, to tell you the truth, I probably
13	sure that we're clear on this. The your	13	had just not thought about it. But it is interesting
14	understanding you've referred a least a couple of	14	that the CDC is putting these numbers out and not even
15	times to California and Maryland, and you say they don't	15	using their own numbers.
16	provide any numbers. But they do provide numbers of	16	Q. Well, it would certainly support your view
17	abortions performed to Guttmacher, correct?	17	that the Guttmacher data is likely to be more reliable,
18	A. Yeah, but not to the CDC.	18	correct?
19	Q. Right. But doesn't the CDC, in the Zane	19	A. And the CDC is
20	analysis yes, in the Zane analysis, they use	20	Q. As far as the number of abortions?
21	Guttmacher data as the denominator for the number of	21	A. Uh-huh, yeah.
22	abortions performed, correct?	22	Q. Okay. So let's see.
23	A. That may be the case. I haven't looked at	23	All right. If you can turn to actually,
24	that recently.	24	we don't need the report for now. So you address in your
25	Q. But that would be important, correct, in	25	report the relationship between abortion and mental
	102		105
	183		185
1	determining what would be the most reliable or whether	1	illness. And at some point, I think, today you've
2	determining what would be the most reliable or whether data is reliable with respect to the mortality rate?	2	illness. And at some point, I think, today you've acknowledged that, in your view, the relationship between
2 3	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	2 3	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
2 3 4	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	2 3 4	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
2 3 4 5	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	2 3 4 5	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
2 3 4 5 6	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	2 3 4 5 6	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?
2 3 4 5 6 7	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.	2 3 4 5 6 7	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
2 3 4 5 6 7 8	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.	2 3 4 5 6 7 8	 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.
2 3 4 5 6 7 8 9	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.	2 3 4 5 6 7 8 9	 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
2 3 4 5 6 7 8 9 10	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	2 3 4 5 6 7 8 9 10	 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
2 3 4 5 6 7 8 9 10 11	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	2 3 4 5 6 7 8 9 10 11	 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.
2 3 4 5 6 7 8 9 10 11 12	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.	2 3 4 5 6 7 8 9 10 11 12	 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
2 3 4 5 6 7 8 9 10 11 12 12 13	 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 	2 3 4 5 6 7 8 9 10 11 12 13	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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. Sorry about that. Q. Don't be sorry. A. What page? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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. 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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. Sorry about that. Q. Don't be sorry. A. What page? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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

Sept

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

ptember 02, 2020 PLANNED PAF	KEN	THOOD ASSOCIATION OF UTAH vs MINER Ingrid Skop, M.D.
186		188
is that although some women will have abortions and not	1	term. As you pointed out, they're they're not able to
have any not become depressed after the abortion,	2	prove causality. But the fact that the deaths increase
there are some women who become depressed and there is a	3	so substantially raises the question of let's look into
causal relationship between their depression and the	4	causality, and no one has done that.
abortion; is that correct?	5	Q. Okay. If we can stop right there.
A. Yes.	6	So just to be clear, you acknowledge that
Q. Okay. What about with respect to anxiety;	7 8	the studies 18 through 22 are not measuring causality
do you believe that some women have anxiety that is	0 9	between abortion and whatever outcome they're looking at, correct?
directly caused by having an abortion? A. Yes.	10	A. That is correct.
Q. Okay. What about suicidality?	11	Q. Okay. And the do any of these studies
A. Yes.	12	control for preexisting mental health conditions that
Q. And then at the bottom of page 6 of your	12	you're citing in 18 through 22?
report, you cite to a number of let's see. This is	14	A. They're just an observational study. So I
Exhibit 2, bottom of page 6. You have starting here	14	think they're just looking at women who have pregnancy
with "an eight-year retrospective study." Do you see	16	outcomes documented in their single payer system, and
that part of your report?	17	then they're looking at women who die. And they're
A. Yes.	18	looking to see, you know, who had a pregnancy and how did
Q. So the citations for footnotes 18 through	19	the outcome correlate with the likelihood of death.
22, are these the Finnish studies that we were just	20	They're not chart reviews, so and the
talking about earlier today?	20	numbers are tremendous. It would take a lot to go
A. Eighteen is from a California record linkage	22	through each of those individual charts, but these are
study. The Gissler, Karalis, and then the additional two	23	not chart reviews. So they don't know the woman's
Gisslers are all from Finland, yes.	24	preexisting mental health.
Q. But the so to start with, 18 the	25	Q. Right. Would you agree, though, based on
1.07		
187		189
Reardon study, footnote 18, when you say that's from a	1	your experience with dealing with patients with mental
Reardon study, footnote 18, when you say that's from a record linkage study, that would have been performed in	2	your experience with dealing with patients with mental health illness or mental illness, that a prior history of
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	2 3	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
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	2 3 4	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
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	2 3 4 5	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.
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?	2 3 4 5 6	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
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	2 3 4 5 6 7	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
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.	2 3 4 5 6 7 8	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?
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	2 3 4 5 6 7 8 9	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
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	2 3 4 5 6 7 8 9 10	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
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?	2 3 4 5 6 7 8 9 10 11	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
 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. 	2 3 4 5 6 7 8 9 10 11 12	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
 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. 	2 3 4 5 6 7 8 9 10 11 12 13	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
 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 	2 3 4 5 6 7 8 9 10 11 12 13 14	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
 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	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
 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	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.
 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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.
 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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
 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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
 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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.
 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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?
 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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?
 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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.
 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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?

26			Inghu Skop, M.D.	_
	190		192	
1	A. It is purely observational. So I don't	1	hard to know whether the beneficial effect is more	
2	think they know anything about the women.	2	related to the first trimester abortions if they're	
3	Q. So if it happened that women who had	3	overrepresented.	
4	abortions were more likely to use drugs before the time	4	There are some other concerns with that	
5	that they had abortion and later died of a drug overdose,	5	study. I'm not sure how much they break out specific	
6	there would be no way to control for that difference	6	mental health you know, it would be nice if they'd ask	
7	between women who had abortion than carried to term	7	a few more questions about mental health than they do.	
8	there would be no way to control for the difference at	8	It is a start. I mean, I appreciate that they're trying	
9	baseline?	9	to do this, but I wish they would have had a better	
10	Sorry. Does that make sense? I know that	10	participation rate.	
11	was a lot.	11	Q. Well, again, taking no data is perfect.	
12	A. Your questions are good. And we should ask	12	Would you say that among the studies that you have	
13	those questions in the study. We should be curious.	13	reviewed with respect to the potential physical and	
14	Q. But my question is these studies that you're	14	mental well, let's focus on mental health impact of	
15	relying on and pointing the court to, these do not	15	abortion. Do you believe the Turnaway study is the best	
16	control for those differences at baseline between a	16	among them?	
17	person who has an abortion and a person who carries to	17	A. I'm not aware of any other prospective	
18	term, correct?	18	studies. If I say it is the best, I'm going to have to	
19	A. That is correct.	19	say that because it is the only one.	
20	Q. Do these studies control for the wantonness	20	Q. Okay.	
21	of a pregnancy?	21	A. I think it has some deficiencies.	
22	A. Again, no.	22	Q. But you would say it is the only prospective	
23	Q. So if it happened that someone well, you	23	longitudinal study, correct, of the mental health	
24	agree, right, that many women who give birth at term have	24	impact?	
25	wanted pregnancies, correct?	25	A. It is the only it is the only one that	
	191		193	1
1	A. Yes. And many who initially don't want the	1	I'm aware of. It would be nice if they also broke it	
2 3	pregnancies love their babies when they come. Q. So that might be an important difference	2 3	down by the known high risk categories.Q. What do you mean by that?	
4	between women who give birth at term as opposed to women	4	A. Well, like I mentioned earlier the ones	
5	who have abortions, correct, when analyzing outcomes?	5	that we know are at higher risk for mental health adverse	
6	A. Yes and no. I think you might be referring	6	outcomes are teenagers, those who have a desired	
7	to the Turnaway study, which had very, very poor	7	pregnancy and either terminate because of fetal	
8	participation, and it's been acknowledged that the women	8	anomalies, maternal health, coercion, those who terminate	
9	who chose to participate were more likely to be secure in	9	late, those who have multiple abortions. So there's	
10	their decision. So there have been criticisms about that	10	there's many categories that we know that those women are	
11	study.	11	at our priority a higher risk, and I don't think that the	
12	Yes, you're right. If we could do a study	12	Turnaway study looked specifically at some of those	
13	where we really could determine that, it would be a very	13	categories. That would have been useful information to	
14	helpful study.	14	have.	
15	Q. And so in your review, the Turnaway study	15	When you guys, when you do your	
16	and the articles based on it, the design well, let me	16	counseling because if somebody comes in and they check	
17	ask it a different way.	17	the box for three out of seven risk factors, do you guys	
18	Do you believe setting aside your	18	tell them, You may be at higher risk to have a mental	
19	criticism of the participation rate in the study, do you	19	health adverse outcome?	
20	believe the study is otherwise well designed?	20	Q. Dr. Skop, Let me remind you of our roles	
21	A. No. There's a lot of questions in the	21	here today. My job is to ask the questions, and your job	
22	study. They say they're looking at women who were close	22	is to answer them.	
23	to the gestational age of the cutoff. And also they're	23	A. Okay.	
24	looking at first trimester, and they don't really tell us	24	Q. So in terms of the Turnaway study, then, it	
25	what the numbers are in those two categories. So it is	25	sounds like, from your perspective, it is the best	

			підпа экор, ім.д.
	194		196
1	available study with respect to the impact of mental	1	Q. I'm not asking about participation. I'm
2	health the impact of abortion on mental health	2	asking what were the findings; do you recall?
3	outcomes? Is that fair to say?	3	A. The abortion advocates who wrote the study
4	A. There is another one by David Ferguson in	4	report that the outcomes were better for those who had
5	New Zealand that is also a good study. Again, because of	5	the abortion. But I think it is a nonrepresentative
6	my concerns about the selection for the Turnaway study, I	6	study, and I don't think it can be relied upon for all
7	don't think I would call it the best.	7	women.
		8	
8	Q. Okay. And is that Ferguson study cited in		Q. Just to make sure I understand. So you said
9	your expert report?	9	that the I'll call them authors. The authors who
10	A. I don't remember.	10	wrote the study found that abortion people who had
11	Q. Why don't you take a look.	11	abortions fared better, is that what you said, than women
12	A. I don't I don't believe it is.	12	who carried to term?
13	Q. Okay. And can you provide the cite to that?	13	A. That was their report.
14	I think we'll talk about cleanup of documents later on.	14	Q. Better in what respect?
15	But I think if there is an article that you're relying	15	A. In regards to the mental health outcomes.
16	on well, let me ask it this way. Are you saying today	16	Q. Okay. All right. Why don't we go to
17	that the Ferguson study is, you think, the best study	17	well, let me ask you this
18	with respect to the impact of abortion on mental health	18	MS. MURRAY: How are folks doing on breaks?
19	outcomes?	19	Do we need a break? We've been going a little over an
20	A. I think it has it is a longitudinal; it	20	hour, an hour and ten minutes. Would you like a break,
21	is a 30-year study. And I think it has I think it is	21	Dr. Skop?
22	better designed than the Turnaway.	22	THE WITNESS: I'm okay. If you guys need
23	Q. And so would you say it is the best	23	one
24	available study on the impact of abortion on mental	24	MS. MURRAY: Anybody else? Speak now or
25	health outcomes then?	25	forever hold your peace. Not forever. Like, 20 minutes
	195		197
1	A. I don't know that I would say it is the	1	197 or so.
1		1 2	
	A. I don't know that I would say it is the		or so.
2	A. I don't know that I would say it is the best. There are some other good ones as well.	2	or so. Q. (By Ms. Murray) If you can go to page 7 of
2 3	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?	2 3	or so. Q. (By Ms. Murray) If you can go to page 7 of Exhibit 2. This is your expert report.
2 3 4	 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 	2 3 4	or so. Q. (By Ms. Murray) If you can go to page 7 of Exhibit 2. This is your expert report. A. Okay.
2 3 4 5	 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. 	2 3 4 5	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
2 3 4 5 6	 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? 	2 3 4 5 6	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
2 3 4 5 6 7	 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. 	2 3 4 5 6 7	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
2 3 4 5 6 7 8	 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. 	2 3 4 5 6 7 8	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
2 3 4 5 6 7 8 9	 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 	2 3 4 5 6 7 8 9	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
2 3 4 5 6 7 8 9 10	 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 	2 3 4 5 6 7 8 9 10	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?
2 3 4 5 6 7 8 9 10 11	 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 	2 3 4 5 6 7 8 9 10 11	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
2 3 4 5 6 7 8 9 10 11 12	 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. 	2 3 4 5 6 7 8 9 10 11 12	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?
2 3 4 5 6 7 8 9 10 11 12 13 14	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14	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
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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, 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	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,
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	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. Q. Then why did you include it in your expert
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	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?

198 you would ascribe to in this case is, quote, an 2 Q. Would you agree that the International you would ascribe to in this case is, quote, an 4 professional organization regarding the study of pain in and the under that correct? 4 professional organization regarding the study of pain in and then under that definition, in your 5 the United States? a. Im not that familiar with their reputation. and then under that definition, in your 7 I don't know if there is – if they're considered leading or if someone else is. and then under that definition, in your 9 organization that study pain? a. Ares. and then under that definition, in your 9 organizations that study pain? a. The semsory neurons begin developing at 11 A. Not intimately, no. the they you included in your expert report. What is the best 15 they would be thain that the sole of the thains. the they you power report. What is the sensory neurons begin developing at 16 A. Well, think it depends on what you'e the they in the the sole of the thains. the they and the and a 14 and 20 weeks the best definition that you you set definition of pain. 16 A. Well, there sou she they on track, you they on the they in the they			1	
2 Q. Would you agree that the International 2 unpleasant sensory experience associated with actual or 3 Association for the Study of Pain is the leading professional organization regarding the study of pain in potential lissue damage; is that correct? 4 A. The information of the Study of Pain is the leading A. Yes. Q. For an 18-week fetus, okay. 7 I don't know if there is – if they're considered leading To ris Moment that definition, in your 7 ord in Some else is. To ron 18-week fetus, okay. 9 O. So you're not familiar with way To ron 18-week fetus, okay. 9 organizations that study pain? A. The sensory neurons begin developing at 11 A. Not infunately, no. The sensory neurons begin developing at 12 O. Okay. So you said you thought that the The sensory neurons begin developing at 13 functioning to the level of the thalamus. That's the 14 you included in your expert report. What is the beat The sensory neurons begin developing at 15 functioning to the invel of the thalamus. That's the The definition of pain. 16 A. Well, think it depends on what you're The definitititi on of pain. The		198		200
3 Association for the Study of Pain is the leading professional organization regarding the study of pain in the United States? A. Yes. 6 A. Trm not that familiar with their reputation. A. Or or an 18-week focus, okay. 7 A. Trm not that familiar with their reputation. For an 18-week focus, okay. 8 or if someone else is. G. So you're not familiar with any organizations that study pain? A. The sensory neurons begin developing at the voluncided in your export report. What is the best definition of pain? A. The sensory neurons begin developing at that dot in the sensory neurons begin developing at that dot in the sensory neurons begin of the issue damage that causes the sensory neurons begin - 1 just want to relay to the brain that the issue damage that causes the sensory neurons to relay to the brain that the issue damage that causes the sensory neurons to relay to the brain that the issue damage that causes the sensory neurons to relay to the brain that the issue damage that causes the sensory neurons to relay to the brain that the issue damage that causes the sensory neurons to relay to the brain that the issue damage that causes the sensory neurons to relay to the brain that the issue damage that causes the sensory neurons to relay to the brain that the issue damage that causes the sensory neurons to relay to the brain that the issue damage that causes. The sposible to have an unpleasant sensory experiment that definition of pain. What is the definition that you set when the neutonal context? A. Quh-huh. 19 1.99 1.91 A. Uh-huh. 201 A. Would say in the 14-bits reage. <t< th=""><th> 1</th><th>in pain.</th><th>1</th><th>you would ascribe to in this case is, quote, an</th></t<>	1	in pain.	1	you would ascribe to in this case is, quote, an
4 Professional organization regarding the study of pain in 4 A. Yes. 5 the United States? 6 A. Tm not that familiar with their reputation. 6 G. For an 18-week fetus, okay. 7 I don't know if their is if they're considered leading 6 A. At then under that definition, in your 9 G. So you're not familiar with any 7 professional opinion, what is the earliest point in 10 A. Not intimately, no. 0 A. The sensory neurons begin developing at 11 A. Not intimately, no. 10 A. The sensory neurons begin developing at 11 A. Not intimately, no. 10 A. The sensory neurons begin developing at 12 Device of the brain at the sole complete system is 5 finition of pain. 14 you included in your export report. What is the best 10 and then the brain responde number on what you're 15 this is a good definition that like I said, I don't 18 your position that the carliest point in prognancy that 19 thick has to include the emotional component. Buil to 18 the arrise sone what we're calling 23 and then the brain responds with withread any ope sone what we're calling 20	2	Q. Would you agree that the International	2	unpleasant sensory experience associated with actual or
5 the United States? 5 0. For an 18-week fetus, oky. 6 A. I'm not that familiar with heir reputation. 7 A then under that definition, in your 7 I don't know if there is - if they're considered leading 7 professional oplinion, what is the earliest point in progranzations that study pain? 10 organizations that study pain? 7 professional oplinion, what is the earliest point in programacy at which a fetus has the capacity to experience by pain? 11 A. Not intimately, no. 10 A. The sensory neurons begin developing at successing probably wasn't the best definition of pain, the one that is update pain can be sensed. 11 12 12 O. Cokay. So you said you thought that is the definition of pain. 11 12 12 12 13 probably wasn't the best definition of pain, the one that is the is ad, don't this is a good definition that - like is ad. I don't this is a ood definition that - like is ad. I don't this is a good definition that - like is ad. I don't this is a good definition that with drawal movements, with - 16 0. Okay. So update the definition that you just is the definition of pain. 11 this is a good definition that with drawal movements, with with a size damage that causes the senory neurons begin be that definition of pain. 19 0. Okay. So upare calling is ada is a sequer to it. If is ada is	3	Association for the Study of Pain is the leading	3	potential tissue damage; is that correct?
6 A. Trim not that familiar with heir reputation. 7 7 I don't know if there is – if they're considered leading 7 9 0. So you're not familiar with any 7 10 0. So you're not familiar with any 7 11 A. Not infimately, no. 9 12 0. Okay. So you're not familiar with any 9 13 probably wasn't the best definition of pain, the one that 11 14 you included in your expert report. What is the best 11 14 you included in your expert report. What is the best 11 15 definition of pain. 14 16 A. Well, think it depends on what you're 15 17 trying to justify. The p- pain is the sensory neurons. 16 18 this is a good definition that - like I said, I don't 18 19 this kit has to include the emotional component. But it 19 20 and then brain responds with withdrawal movement, 19 21 relay to the brain that the lissue damage is occurring, and then brain responds y with any ou pous ali you think this is not the best 23 believe Is the best as an expert in this case? 20 </th <th>4</th> <th>professional organization regarding the study of pain in</th> <th>4</th> <th>A. Yes.</th>	4	professional organization regarding the study of pain in	4	A. Yes.
6 A. I'm not that familiar with heir reputation. 6 And then under that definition, in your 7 I don't know if there is – if they're considered leading 7 professional oplinon, what is the earliest point in 9 0. So you're not familiar with any 7 professional oplinon, what is the earliest point in 11 A. Not infimately, no. 10 A. The sensory neurons begin developing at 12 0. Okay. So you're not familiar with the thest 11 seven weeks gestalional age. But think that sometime 13 probably wasn't the best definition of pain, the one that 11 seven weeks gestalional age. But think that sometime 14 you included in your expert report. What is the best 14 14 14 14 14 you included in your expert report. What is the best 15 that and 20 weeks the complete system is 15 think it has to include the emotional component. But it 13 guard mether brain responds with withdrawal movement. 12 eaking you – you said you think this is not the best 19 14 A. Un-huh. 12 acking you – you said you think this is not the best 19 1 A. Un-huh. 13 asking you – you said you think this is not the b	5	the United States?	5	Q. For an 18-week fetus, okay.
7 I don't know if there is – if they're considered leading 7 professional opinion, what is the sartiest point in 8 or if someone else is. 9 0. So you're not familiar with any 9 10 organizations that study pain? 10 A. The sensory neurons begin developing at 11 A. No linitimately, no. 11 Serve meeks gestational age. But I think that sometime 12 O. Okay. So you said you thought that this 13 bower notion (the brain, And that is dearly a time 15 definition of pain? 6 O. Okay. So under the definition that you just 16 A. Well, I think it depends on what you're 16 O. Okay. So under the definition that you just 17 trying to justify. The - pain is the sensory - I think 16 O. Okay. So under the definition that you just 18 the brain that the dissue damage is occurring, with - 20 A. Again, it depends on what were calling 24 O. So I - I want to keep us on track, 2 20 A. Again, it depends on what were calling 25 pr. Skop. I'm not asking you describe processes. I'm 109 1 A. Uh-huh. 2 Q. Well, I'm asking you based on this 201 3 possible t	6	A. I'm not that familiar with their reputation.	6	-
8 or if someone else is. 9 pregnancy at which a fetus has the capacity to experience 9 9 C. So you're not familiar with any 9 pregnancy at which a fetus has the capacity to experience 9 11 A. Not infimately, no. 10 A. The sensory neurons begin developing at serve weeks gestational age. But I think that someline 12 O. Okay. So you said you thought that this 11 Serve weeks gestational age. But I think that someline 13 probably wasn't the best definition of pain, the one that 14 you included in your expert report. What is the best 14 you included in your expert report. What is the best 16 A. Well, think it depends on what your 16 A. Well, think it depends on what your best definition of pain. The is assory neurons to 17 regreaves the best definition of pain. The is assory neurons to 11 is the tissue damage that causes the sensory neurons to 18 vour position that the earliest point in pregnancy that 12 and then the brain responds with withdrawal movements, 19 10 A. Again, it depends on what we're calling 23 works. 11 12 14 2011 13 asking you – you said you think it is is n	7		7	professional opinion, what is the earliest point in
9 Q. So yov're not familiar with any 9 pain? 10 organizations that study pain? 10 A. Not initimately, no. 12 Q. Okay. So you said you thought that this seven weeks gestational age. But I think that someline 14 you included in your expert report. What is the best 10 seven weeks gestational age. But I think that someline 15 definition of pain? 0. Okay. So used you thought that this 10 O. Okay. So under the definition of pain. The sensory - I think 16 A. Well, I think it depends on what your 10 O. Okay. So under the definition of painI Just want to 17 trying to justify. The - pain is the sensory - I think 11 seven weeks gestational age. But I think that you just 16 A. Well, I think that the issue damage is occurring, 10 Weeks? 22 A. So I - I want to keep us on track, 20 A. Ush-thu. 24 Q. So I - I want to keep us on track, 21 Weeks? 23 believe is the best as an expert in this case? 4. A. Uh-huh. 2 G. Okay. So your - do you think it is 5o I've asked you what your best definition the suisa 3 believe is the best as an expert in this case? 4. Lis huck hat	8		8	
10 organizations that study pain? 1.1 A. Not intimately, no. 11 A. Not intimately, no. 1.1 seven weeks gestational age. But I think that sometime 12 O. Okay. So you said you thought that this seven weeks gestational age. But I think that sometime 13 probably wasn't the best definition of pain, the one that seven weeks gestational age. But I think that sometime 14 you included in your export report. What is the best fination of pain and that is deendy a time 15 A. Well, I think it depends on what you're this is a good definition that	9	Q. So you're not familiar with any	9	
11A. Not intimately, no.11seven weeks gestational age. But I think that sometime12Q. Okay, So you said you thought that this11iseven weeks gestational age. But I think that sometime12between 14 and - 14 and 20 weeks the complete system is14you included in your export report. What is the best1115definition of pain?0. Okay. So under the definition that - ike a sid, I don't16A. Well, I think it depends on what you're1617trying to justfy. The - pain is the sensory - I think1818this is a good definition that - ike is a kid, I don't1819is the tissue damage that causes the sensory neurons to1811is the tissue damage that causes the sensory neurons to1812and then the brain responds with withdrawal movements,1914 0. So I - I want to keep us on track,1915 Dr. Skop. I'm not asking you describe processes. Tm1991asking you you said you think this is not the best116 0. Okay. So your - do you think It is1991asking you you said you think this is not the best215believe is the best as an expert in this case?32A. Ithink that I would use this definition but116Q. Okay. So your - do you think It is17Q. And how do you know that?18there is no emotional context?19A. It in not passible for na 1-week fetus.11A. Mell, there's quite a bit of histologic			10	A. The sensory neurons begin developing at
12 Q. Okay. So you said you thought that this 12 between 14 and - 14 and 20 weeks the complete system is 13 probably wasn't the best definition of pain, the ore that 13 inducioning to the level of the brain. And that is clearly a time 14 you included in your expert report. What is the best 16 A. Well, I think it depends on what you're 15 definition of pain? 16 A. Well, I think it depends on what you're 16 A. Well, I think it depends on what you're 17 agreed was the best definition that - uou you sate sensory - I think 18 this is a good definition that - like I said, I don't 18 make sure that I'm understanding you correctly - is it 19 that the insue damage is occurring, and then the brain responds with withdrawal movements, 19 21 relay to the brain that the itsue damage is occurring, A. Again, it depends on what we're calling 22 a. So I - I want to keep us on track, 22 A. Again, it depends on what we're calling 23 believe is the best as an expert in this case? 4 A. Uh-huh. 2 0. Vell, I'm asking you based on this 24 A. So J - I want to keep us on track, 25 5 0're saked you what your best definition is. Using 3		• • • •	11	
13 probably wasn't the best definition of pain, the one that you included in your export report. What is the best definition of pain? 13 functioning to the level of the brain. And that is clearly a time that pain can be sensed. 14 you included in your export report. What is the best definition of pain? 0. Okay. So under the definition that you just 16 A. Well, I blink it depends on what you're 16 0. Okay. So under the definition that you just 17 trying to justify. The - pain is the sensory - I blink 18 make sure that I'm understanding you correctly - is it 19 think it has to include the emotional component. But it 18 make sure that I'm understanding you correctly - is it 2 and then the brain responds with withdrawal movements, 19 10 14 Our explain ach you 2 A. Sol I - I want to keep us on track, 22 A. Again, it depends on what we're calling 23 3 with - 199 201 3 A. Uh-huh. 2 2 14 4 that tend pain in this case. 35 O I'was and that is bearles to point in pregnancy 4 4 4 4 5 Dr. Skop, I'm not asking you describe processes. I'm 199 1 A. Uh-huh. 2			12	
14 you included in your expert report. What is the best 14 lower portion of the brain. And that is clearly a time 15 definition of pain? 15 that pain can be sensed? 17 trying to justify. The - pain is the sensory - 1 think 16 0. Okay. So under the definition that you just 18 this is a good definition that - like I said, I don't 18 make sure that I'm understanding you correctly - ls it 19 think it has to include the emotional component. But it 18 make sure that I'm understanding you correctly - ls it 20 is the fissue damage that causes the sensory neurons to 14 A. Qain, it depends on what we're calling 23 with - 2 A. Again, it depends on what we're calling 23 with - 2 A. Again, it depends on what we're calling 24 Q. So I - I want to keep us on track, 25 25 Dr. Skop. I'm not asking you escribe processes. I'm 201 14 A. Uh-huh. 2 Q. You are opining on fetal pain in this case. 2 So Ive asked you what your best definition, sub ig 5 3 believe is the best as an expert in this case? 3 4 4 Think that I would use			1	
15 definition of pain? 16 A. Well, 1 think it depends on what you're 17 trying to jusitfy. The - pain is the sensory - I think 18 this is a good definition that - like I said, I don't 19 think it has to include the emotional component. But it 19 think it has to include the emotional component. But it 19 think it has to include the emotional component. But it 19 this is a good definition that - like I said, I don't 11 that size damage is occurring, 2 and then the brain responds with withdrawal movements, 28 Dr. Skop. I'm not asking you describe processes. I'm 19 10 11 asking you - you said you think this is not the best 29 1 14 A. Ithink that I would use this definition but 15 that earlow could experience pain? 16 that size ound a pain in this case? 20 A. It is not possible for an er for you, but it 19 possible to have an unpleasant sensory experience 10 is possible for an 18-week fetus. 11 Q. And how do you know that? 12 A. Well, there's quite a bit of hist		· · ·	1	5
16 A. Well, 1 think it depends on what you're 16 Q. Okay. So under the definition that you just 17 trying to justify. The - pain is the sensory - I think 11 agreed was the best definition of pain - 1 just want to 18 this is a good definition that - like I said, 1 don't make sure that Tm understanding you correctly - is it 19 this is to include the emotional component. But it is the tissue damage that causes the sensory neurons to 10 relay to the brain rhat the tissue damage is occurring, A. Again, it depends on what we're calling 23 and then the brain responds with withdrawal movements, 20 24 Q. Sol - I want to keep us on track, 21 25 Dr. Skop. I'm not asking you describe processes. I'm 199 1 asking you - you said you think this is not the best 20. You are opining on fetal pain in this case. 3 So I've asked you what your best definition is. Using 4 A. I think that I would use this definition but 2 5 or. Okay. So your - do you think it is 7 7 Dosliber to have an unpleasant sensory experience fit 7 8 there is no emotional context? 9 A. It thin the fersulit and beroge sompletely				
17 trying to justify. The – pain is the sensory – I think 17 agreed was the best definition of pain – 1 just want to 18 this is a good definition that – like I said, I don't 18 make sure that Tm understanding you correctly – is it 10 think it has to include the emotional component. But it 19 your position that the earliest point in pregnancy that 21 relay to the brain that the tissue damage is occurring, 10 14 that could be experienced by a fetus is between 14 and 20 22 and then the brain responds with withdrawal movements, 12 A. Again, it depends on what we're calling 23 and then the brain responds with withdrawal movements, 20 A. Again, it depends on what we're calling 24 Q. Sol – I want to keep us on track, 22 A. Again, it depends on what we're calling 25 Dr. Skop. I'm not asking you exercise processes. I'm 199 201 1 A. Uh-huh. 2 Q. You are opining on fetal pain in this case. 3 bolieve is the best as an expert in this case? 3 So I've asked you what your best definition is. Using 4 that the tail to wold use this definition that you 5 So I've asked you what your best definition is. Using 5 the the		-	-	
18 this is a good definition that – like I said, I don't 18 make sure that I'm understanding you correctly – is it 19 think it has to include the emotional component. But it 19 your position that the earliest point in pregnancy that 18 this is a good definition that – like I said, I don't 19 your position that the earliest point in pregnancy that 19 think it has to include the emotional component. But it 10 your position that the earliest point in pregnancy that 21 relay to the brain that the tissue damage is occurring, and then the brain responds with withdrawal movements, 201 24 Q. So I – I want to keep us on track, 20 A. Again, it depends on what we're calling 25 Dr. Skop. I'm not asking you describe processes. I'm 209 1 A. Making you – you said you think this is not the best 2 definition of pain. What is the definition that you 3 So I've asked you what your best definition is. Using 4 A. I think that I would use this definition but 5 No. Kay, So your – do you think it is 7 A. Uh-huh. 2 0. And that's because of the level of 8 there is no emotional context? 9 A. That's because of the level of 6 A. I would say in the 14-plus range, 14			-	
 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 20 asking you you said you think this is not the best 2 definition of pain. What is the definition that you 30 believe is the best as an expert in this case? A. I think that I would use this definition but 5 omit the emotional experience part of it. 6 Q. Okay. So your - do you think it is definition but 5 omit the emotional context? A. I think that I would use this definition but 5 omit the emotional context? A. I think that I would use this definition but 5 omit the emotional context? A. I think that I would use this definition but 5 omit the emotional context? A. It is not possible for me or for you, but it is possible for me or for you, but it this age works all the way up to the thalamus. What 1t his dabut it and be horrified by the fact that the leg is being pulled off. And, as I mentioned, I think about it and be horrified by the fact that the 18 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 a lab rat: we don't apply that standard to a lab rat: we don't apply that standard to a lab rat: we don't apply that standard to a lab rat: we don't apply that standard to a lab rat: we don't apply that standard to a lab rat: we don't apply that standard to a lab rat: we don't apply that standard to a lab rat: we don't apply that standard to a lab rat: we don't apply that standard to a lab rat: we don't apply that standard to a lab rat: we don't apply that standard to a lab rat: we don't apply that standard to a lab rat: we don't apply that standard to a lab rat: we don't apply that standard to a				- · · ·
 20 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 - 21 and then the brain responds with withdrawal movements, with - 22 and then the brain responds with withdrawal movements, with - 23 and then the brain responds with withdrawal movements, with - 24 Q. So I - I want to keep us on track, Dr. Skop. I'm not asking you describe processes. I'm 29 1 20 1 20 201 21 asking you you said you think this is not the best a gray of the best as an expert in this case? 20 A. I think that I would use this definition but 5 omit the emotional experience pat of it. 31 Q. Okay. So your do you think it is 7 possible to have an unpleasant sensory experience if 8 there is no emotional context? 32 A. Well, there's quite a bit of histologic 32 evidence that show us that the pain system in the fetus 14 at this age works all the way up to the thalamus. What is the JAMA study that I reference tried to do is say it 44 this age works all the way up to the thalamus. What is the JAMA study that I reference tried to do is say it 45 to think about it and be horrified by the fact that the 18 is being unleds of . And, as I mentioned, I think 18 that asse is of evelopment of the talamus end signals that cause with drawal of 14 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 a lab rat, we don't apply that standard to a lab rat, we don't apply that standard to a lab rat, we don't apply that standard to a lab rat, we don't apply that standard to a lab rat, we don't apply that standard to a lab rat, we don't apply that standard to a lab rat, we don't apply that standard to a lab rat, we don't apply that standard to a lab rat, we don't apply that standard to a lab rat, we don't apply that standard to a lab rat, we don't apply that standard t			1	
21relay to the brain that the tissue damage is occurring, and then the brain responds with withdrawal movements,21weeks?23withQ. Sol - I want to keep us on track, Dr. Skop. I'm not asking you describe processes. I'm201asking 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?4Q. Well, I'm asking you based on this definition.110. Well, I'm asking you based on this definition.2011asking 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?34A. I think that I would use this definition but omit the emotional experience part of it. for not support - do you think it is possible to have an unpleasant sensory experience if there is no emotional context?6A. Iwould say in the 14-plus range, 14 weeks.7Q. And how do you know that? the JAMA study that I reference tried to do is say it the JAMA study that I reference tried to do is say it the bank about it and be horrified by the fact that the leg is being pulled off. And, as I mentioned, 1 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 a lab r		•	1	
 and then the brain responds with withdrawal movements, with - a. So I - I want to keep us on track, Dr. Skop. I'm not asking you describe processes. I'm 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 context? A. It is not possible for an 18-week fetus. C. And how do you know that? A. Well, here'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 the JAMA study that I reference tried to do is say it the JAMA study that I reference tried to do is asy it the JAMA study that I reference tried to do is an yit 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 a fet human being. Q. Okay. Just to make sure I understand. Your 			1	
 with 24 Q. So I I want to keep us on track, 25 Dr. Skop. I'm not asking you describe processes. I'm 26 asking you you said you think this is not the best 27 definition of pain. What is the definition that you 29 believe is the best as an expert in this case? 4 A. I think that I would use this definition but 5 omit the emotional experience part of it. 6 Q. Okay. So your do you think it is 7 possible to have an unpleasant sensory experience if 8 there is no emotional context? 9 A. It is not possible for an 18-week fetus. 11 Q. And how do you know that? 12 A. Well, there's quite a bit of histologic evidence that show us that the pain system in the fetus 14 at this age works all the way up to the thalamus. What 15 the JAMA study that I reference tried to do is say it 16 doesn't count as pain unless the organism has the ability 16 that is a very extreme definition of pain. We don't apply that standard to a lab rat; we don't apply that tstandard to someone who is in a persistent vegetative 23 standard to someone who is in a persistent vegetative 24 Q. Okay. Just to make sure I understand. Your 23 earliest point in pregnancy at which there is a fully 44 formed connection between the thalamus and the cerebral 				
24Q. Sol-I want to keep us on track, 2524Q. Well, I'm asking you based on this definition.25112011asking you you said you think this is not the best 21A. Uh-huh.22Q. You are opining on fetal pain in this case.3believe is the best as an expert in this case?34A. I think that I would use this definition but 5 omit the emotional experience part of it.Q. You are opining on fetal pain in this case.6Q. Okay. So your do you think it is possible for have an unpleasant sensory experience if 8 there is no emotional context?So I've asked you what your best definition is. Using 4 that definition, what is the earliest point in pregnancy 4 that definition, what is the arriest point in pregnancy at which a fetus sould experience pain?6A. I would say in the 14-plus range, 14 weeks.7D. And how do you know that?11A. Well, there's quite a bit of histologic13evidence that show us that the pain system in the fetus at this age works all the way up to the thalamus. What16doesn't count as pain unless the organism has the ability 1717to think about it and be horrified by the fact that the leg is being pulled off. And, as I mentioned, 1 think that is a very extrem definition of pain. We don't apply that standard to a lab rat; we don't apply that state, and I don't think we should apply that standard to a fetal human being.24Q. Okay. Just to make sure I understand. Your24Q. Okay. Just to make sure I understand. Your24Q. Okay. Just to make sure I understand. Your </th <th></th> <th>-</th> <th>1</th> <th></th>		-	1	
25Dr. Skop. I'm not asking you describe processes. I'm25definition.119911asking you you said you think this is not the best12definition of pain. What is the definition that you33believe is the best as an expert in this case?34A. I think that I would use this definition but45omit the emotional experience part of it.66Q. Okay. So your do you think it is7possible to have an unpleasant sensory experience if78A. It is not possible for me or for you, but it510is possible for an 8-week fetus.711Q. And how do you know that?712A. Well, there's quite a bit of histologic113evidence that show us that the pain system in the fetus114the JAMA study that I reference tried to do is say it615being pulled off. And, as I mentioned, I think16being pulled off. And, as I mentioned, I think17ta this a very extreme definition of pain. We don't18tat and ard to alab rat; we don't apply that20A. Okay. Just to make sure I understand. Your24Q. Okay. Just to make sure I understand. Your			1	
119911asking you you said you think this is not the best22definition of pain. What is the definition that you23believe is the best as an expert in this case?34A. I think that I would use this definition but215omit the emotional experience part of it.3So I've asked you what your best definition is. Using6Q. Okay. So your do you think it is4Hould say in the 14-plus range, 14 weeks.7possible to have an unpleasant sensory experience if6A. I would say in the 14-plus range, 14 weeks.7A. It is not possible for me or for you, but it9A. That's because the pain arch goes completely10is possible for an 18-week fetus.10For the sensory neurons to the spinal cord to the brain;11Q. And how do you know that?1112A. Well, there's quite a bit of histologic1214at this age works all the way up to the thalamus. What1515the JAMA study that I reference tried to do is say it1616doesn't count as pain unless the organism has the ability1717to hink about it and be horrified by the fact that the1818leg is being pulled off. And, as I mentioned, I think1819that is a very extreme definition of pain. We don't202apply that standard to a lab rat; we don't apply that212a fetal human being.2124Q. Okay. Just to make sure I understam. Your21		-		
1asking you you said you think this is not the best2definition of pain. What is the definition that you3believe is the best as an expert in this case?4A. I think that I would use this definition but5omit the emotional experience part of it.6Q. Okay. So your do you think it is7possible to have an unpleasant sensory experience if8there is no emotional context?9A. It is not possible for me or for you, but it10is possible for an 18-week fetus.11Q. And how do you know that?12A. Well, there's quite a bit of histologic13evidence that show us that the pain system in the fetus14the jAMA study that I reference tried to do is say it16doesn't count as pain unless the organism has the ability17to think about it and be horrified by the fact that the18that is a very extreme definition of pain. We don't19that is a very extreme definition of pain. We don't20apply that standard to a lab rat; we don't apply that21Q. Okay. Just to make sure I understand.22Q. Okay. Just to make sure I understand. Your24Q. Okay. Just to make sure I understand. Your	25	Di. Skop. Thi not asking you describe processes. Thi	25	demitton.
1asking you you said you think this is not the best2definition of pain. What is the definition that you3believe is the best as an expert in this case?4A. I think that I would use this definition but5omit the emotional experience part of it.6Q. Okay. So your do you think it is7possible to have an unpleasant sensory experience if8there is no emotional context?9A. It is not possible for me or for you, but it10is possible for an 18-week fetus.11Q. And how do you know that?12A. Well, there's quite a bit of histologic13evidence that show us that the pain system in the fetus14the jAMA study that I reference tried to do is say it16doesn't count as pain unless the organism has the ability17to think about it and be horrified by the fact that the18that is a very extreme definition of pain. We don't19that is a very extreme definition of pain. We don't20apply that standard to a lab rat; we don't apply that21Q. Okay. Just to make sure I understand.22Q. Okay. Just to make sure I understand. Your24Q. Okay. Just to make sure I understand. Your		199		201
2definition of pain. What is the definition that you2Q. You are opining on fetal pain in this case.3believe is the best as an expert in this case?3So I've asked you what your best definition is. Using4A. I think that I would use this definition but4that definition, what is the earliest point in pregnancy5ornit the emotional experience part of it.5at which a fetus could experience pain?6Q. Okay. So your do you think it is6A. I would say in the 14-plus range, 14 weeks.7possible to have an unpleasant sensory experience if7Q. And that's because of the level of8there is no emotional context?9A. It is not possible for me or for you, but it910is possible for an 18-week fetus.10from the sensory neurons to the spinal cord to the brain;11Q. And how do you know that?11the brain can then send signals that cause withdrawal of12A. Well, there's quite a bit of histologic12the limb that cause endogenous opioids to be released to13evidence that show us that the pain system in the fetus13moderate that pain. It causes the heart rate to go up.14at this age works all the way up to the thalamus. What16Q. I'm not asking about effects. I'm asking16doesn't count as pain unless the organism has the ability16you about what is the - the reason or the difference17to think about it and be horrified by the fact that the19parts, in your view, to come into place. Is it the19that is a very	1	asking you you said you think this is not the best	1	A Uh-huh
 3 believe is the best as an expert in this case? 4 A. I think that I would use this definition but 5 omit the emotional experience part of it. 6 Q. Okay. So your do you think it is 7 possible to have an unpleasant sensory experience if 8 there is no emotional context? 9 A. It is not possible for me or for you, but it 10 is possible for an 18-week fetus. 11 Q. And how do you know that? 12 A. Well, there's quite a bit of histologic at this age works all the way up to the thalamus. What 14 at this age works all the way up to the thalamus. What 15 the JAMA study that I reference tried to do is say it 16 doesn't count as pain unless the organism has the ability 17 to think about it and be horrified by the fact that the 18 leg is being pulled off. And, as I mentioned, I think 19 that is a very extreme definition of pain. We don't 20 apply that standard to a lab rat; we don't apply that 21 standard to someone who is in a persistent vegetative 22 state, and I don't think we should apply that standard to a fetal human being. 24 Q. Okay. Just to make sure I understand. Your 3 believe is the best as an expert in this case? 3 believe is the sub to make sure I understand. Your 3 believe is the sub to thalamus and the cerebral 3 believe is the sub to the sub of the thalamus and the cerebral 				
 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 sandard to a lab rat; we don't apply that standard to someone who is in a persistent vegetative standard to someone who is in a persistent vegetative a fetal human being. Q. Okay. Just to make sure I understand. Your A. Not the definition, what is the earliest point in pregnancy at which there is a fully format connection between the thalamus, and the cerebral 				
 5 omit the emotional experience part of it. 6 Q. Okay. So your do you think it is 7 possible to have an unpleasant sensory experience if 8 there is no emotional context? 9 A. It is not possible for me or for you, but it 10 is possible for an 18-week fetus. 11 Q. And how do you know that? 12 A. Well, there's quite a bit of histologic 13 evidence that show us that the pain system in the fetus 14 at this age works all the way up to the thalamus. What 15 the JAMA study that I reference tried to do is say it 16 doesn't count as pain unless the organism has the ability 17 to think about it and be horrified by the fact that the 18 that is a very extreme definition of pain. We don't 19 that is a very extreme definition of pain. We don't 19 that is a very extreme definition of pain. We don't 19 that is a very extreme definition of pain. We don't 10 a fetal human being. 24 Q. Okay. Just to make sure I understand. Your 5 down it the mate sure I understand. Your 5 down it in pregnancy at which there is a fully 6 ormed connection between the thalamus and the cerebral 		•	-	
6Q. Okay. So your do you think it is6A. I would say in the 14-plus range, 14 weeks.7possible to have an unpleasant sensory experience if7Q. And that's because of the level of8there is no emotional context?9A. It is not possible for me or for you, but it9A. That's because the pain arch goes completely9A. It is not possible for an 18-week fetus.9A. That's because the pain arch goes completely10is possible for an 18-week fetus.10from the sensory neurons to the spinal cord to the brain;11Q. And how do you know that?1111the brain can then send signals that cause withdrawal of12A. Well, there's quite a bit of histologic12the brain can then send signals that cause withdrawal of13evidence that show us that the pain system in the fetus13moderate that pain. It causes the heart rate to go up.14at this age works all the way up to the thalamus. What14It causes the fetal breathing motions.15the JAMA study that I reference tried to do is say it16Q. I'm not asking about effects. I'm asking16doesn't count as pain unless the organism has the ability17to think about it and be horrified by the fact that the18leg is being pulled off. And, as I mentioned, I think18weeks, in terms of development, that allows all of those19that is a very extreme definition of pain. We don't20A. The thalamus?21standard to someone who is in a persistent vegetative21A. The thalamus?22 <t< th=""><th></th><th></th><th></th><th></th></t<>				
7possible to have an unpleasant sensory experience if there is no emotional context?7Q. And that's because of the level of development in this thalamus; is that correct?9A. It is not possible for me or for you, but it is possible for an 18-week fetus.9A. 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.11Q. And how do you know that?1212A. Well, there's quite a bit of histologic evidence that show us that the pain system in the fetus the JAMA study that I reference tried to do is say it to think about it and be horrified by the fact that the leg is being pulled off. And, as I mentioned, I think 191619that is a very extreme definition of pain. We don't can apply that standard to a lab rat; we don't apply that standard to someone who is in a persistent vegetative can a fetal human being.21A. The thalamus, yes.24Q. Okay. Just to make sure I understand. Your24Q. Okay. Just to make sure I understand. Your24		· ·	-	
 8 there is no emotional context? 9 A. It is not possible for me or for you, but it 10 is possible for an 18-week fetus. 11 Q. And how do you know that? 12 A. Well, there's quite a bit of histologic 13 evidence that show us that the pain system in the fetus 14 at this age works all the way up to the thalamus. What 15 the JAMA study that I reference tried to do is say it 16 doesn't count as pain unless the organism has the ability 17 to think about it and be horrified by the fact that the 18 leg is being pulled off. And, as I mentioned, I think 19 that is a very extreme definition of pain. We don't 20 apply that standard to a lab rat; we don't apply that 21 standard to someone who is in a persistent vegetative 22 state, and I don't think we should apply that standard to 23 a fetal human being. 24 Q. Okay. Just to make sure I understand. Your 			-	
 9 A. It is not possible for me or for you, but it 10 is possible for an 18-week fetus. 11 Q. And how do you know that? 12 A. Well, there's quite a bit of histologic 13 evidence that show us that the pain system in the fetus 14 at this age works all the way up to the thalamus. What 15 the JAMA study that I reference tried to do is say it 16 doesn't count as pain unless the organism has the ability 17 to think about it and be horrified by the fact that the 18 leg is being pulled off. And, as I mentioned, I think 19 that is a very extreme definition of pain. We don't 20 apply that standard to a lab rat; we don't apply that 21 standard to someone who is in a persistent vegetative 22 state, and I don't think we should apply that standard to 23 a fetal human being. 24 Q. Okay. Just to make sure I understand. Your 4. It is not possible for me or for you, but it 4. That's because the pain arch goes completely 6. That's because the pain arch goes completely 7. That's because the pain arch goes completely 7. A. That's because the pain arch goes completely 7. A. That's because the pain arch goes completely 7. That 's because the pain arch goes completely 7. That 's because the pain arch goes completely 7. The thalamus, yes. 7. Okay. Just to make sure I understand. Your 24 0. Okay. Just to make sure I understand. Your 		possible to have an unpleasant sensory experience in		
 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 format can the sensory neurons to the spinal cord to the brain; the brain can then send signals that cause withdrawal of the brain can then send signals that cause withdrawal of 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. U. 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 		there is no amotional context?		Q. And that's because of the level of
11Q. And how do you know that?11the brain can then send signals that cause withdrawal of12A. Well, there's quite a bit of histologic12the brain can then send signals that cause withdrawal of13evidence that show us that the pain system in the fetus13moderate that pain. It causes the heart rate to go up.14at this age works all the way up to the thalamus. What14the JAMA study that I reference tried to do is say it1515the JAMA study that I reference tried to do is say it16Q. I'm not asking about effects. I'm asking17to think about it and be horrified by the fact that the16you about what is the the reason or the difference18leg is being pulled off. And, as I mentioned, I think18weeks, in terms of development, that allows all of those19that is a very extreme definition of pain. We don't19parts, in your view, to come into place. Is it the20apply that standard to a lab rat; we don't apply that20A. The thalamus?21standard to someone who is in a persistent vegetative21A. The thalamus, yes.22state, and I don't think we should apply that standard to23a fetal human being.24Q. Okay. Just to make sure I understand. Your24formed connection between the thalamus and the cerebral	-		8	Q. And that's because of the level of development in this thalamus; is that correct?
 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 	9	A. It is not possible for me or for you, but it	8 9	Q. And that's because of the level ofdevelopment in this thalamus; is that correct?A. That's because the pain arch goes completely
 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. 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 	9 10	A. It is not possible for me or for you, but it is possible for an 18-week fetus.	8 9 10	 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;
14at this age works all the way up to the thalamus. What14It causes the fetal breathing motions.15the JAMA study that I reference tried to do is say it14It causes the fetal breathing motions.16doesn't count as pain unless the organism has the ability16Q. I'm not asking about effects. I'm asking17to think about it and be horrified by the fact that the16you about what is the the reason or the difference18leg is being pulled off. And, as I mentioned, I think17between a fetus at 13 weeks and a fetus, say, at 1418leg is being pulled off. And, as I mentioned, I think18weeks, in terms of development, that allows all of those19that is a very extreme definition of pain. We don't19parts, in your view, to come into place. Is it the20apply that standard to a lab rat; we don't apply that20A. The thalamus, yes.21standard to someone who is in a persistent vegetative21A. The thalamus, yes.23a fetal human being.22Q. Okay. So, in your view, what is the24Q. Okay. Just to make sure I understand. Your24formed connection between the thalamus and the cerebral	9 10 11	 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? 	8 9 10 11	 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 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. 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. Just to make sure I understand. Your G. Okay. Just to make sure I understand. Your 	9 10 11 12	 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 	8 9 10 11 12	 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
 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 doesn't count as pain unless the organism has the ability to think about it and be horrified by the fact that the 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. Just to make sure I understand. Your 	9 10 11 12 13	 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 	8 9 10 11 12 13	 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.
 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 to think about it and be horrified by the fact that the 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. Just to make sure I understand. Your 	9 10 11 12 13 14	 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 	8 9 10 11 12 13 14	 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.
 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 	9 10 11 12 13 14 15	 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 	8 9 10 11 12 13 14 15	 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
 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 that is a very extreme definition of pain. We don't 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 	9 10 11 12 13 14 15 16	 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 	 8 9 10 11 12 13 14 15 16 	 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
 20 apply that standard to a lab rat; we don't apply that 21 standard to someone who is in a persistent vegetative 22 state, and I don't think we should apply that standard to 23 a fetal human being. 24 Q. Okay. Just to make sure I understand. Your 20 development of the thalamus? 21 A. The thalamus, yes. 22 Q. Okay. So, in your view, what is the 23 earliest point in pregnancy at which there is a fully 24 formed connection between the thalamus and the cerebral 	9 10 11 12 13 14 15 16 17	 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 	 8 9 10 11 12 13 14 15 16 17 	 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
 21 standard to someone who is in a persistent vegetative 22 state, and I don't think we should apply that standard to 23 a fetal human being. 24 Q. Okay. Just to make sure I understand. Your 21 A. The thalamus, yes. 22 Q. Okay. So, in your view, what is the 23 earliest point in pregnancy at which there is a fully 24 formed connection between the thalamus and the cerebral 	9 10 11 12 13 14 15 16 17 18	 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 	 8 9 10 11 12 13 14 15 16 17 18 	 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
 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 Q. Okay. Just to make sure I understand. Your 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 	9 10 11 12 13 14 15 16 17 18 19	 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 	 8 9 10 11 12 13 14 15 16 17 18 19 	 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
23a fetal human being.23earliest point in pregnancy at which there is a fully24Q. Okay. Just to make sure I understand. Your24formed connection between the thalamus and the cerebral	9 10 11 12 13 14 15 16 17 18 19 20	 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 	8 9 10 11 12 13 14 15 16 17 18 19 20	 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?
24 Q. Okay. Just to make sure I understand. Your 24 formed connection between the thalamus and the cerebral	9 10 11 12 13 14 15 16 17 18 19 20 21	 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 	 8 9 10 11 12 13 14 15 16 17 18 19 20 21 	 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.
	9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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 	8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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
25 definition, your best definition of pain, the one that 25 cortex?	9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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 a fact that the standard to a fact the standard to a fact that the standard to a fact the standard to a fact the standard to a fact that the standard to a fact the standard	8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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
	9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 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 a lab rat; we don't apply that standard to a fetal human being. Q. Okay. Just to make sure I understand. Your 	8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 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

202 204 1 A. We don't know the answer to that. The JAMA 1 in the fetus, correct? 2 study set a very high bar, and they didn't think it 2 A. I believe that there is not documentation of 3 counted unless they saw fully formed neurologic pathways. 3 that. Correct. 4 I believe they said between 26 and 30 weeks. I know from 4 Q. All right. And then do you believe it is 5 having delivered live babies at 22 weeks and having seen 5 appropriate when providing an opinion on fetal perception 6 of pain to rely on studies involving adults? 6 them, how they behave in the NICU, I know that at 22 7 weeks there is an intact pain system in those babies. 7 A. You know, I think all of your experts are 8 Q. So I'm -- that's not my question. My 8 going to have to rely on studies of something other than 9 question is, what is your expert opinion as to the 9 a fetus because there have been no studies done on a 10 earliest point in pregnancy when there is a fully formed 10 fetus 11 connection between the thalamus and the cerebral cortex 11 Q. Can you answer my question, please, Dr. 12 of the fetus? 12 Skop? I'm asking what you believe. I'm not asking about 13 A. It is probably between 20 and 30 weeks that 13 my experts; I'm asking what you believe. 14 that forms. 14 A. Sometimes when you can't study the specific 15 15 Q. Okay. So would you agree, then, that if a organism at the specific time you want to study, you have 16 connection, a fully formed connection between the 16 to rely on other studies that are near but not completely 17 thalamus and the cerebral cortex is necessary to 17 the same. So I think it is appropriate to look at adult experience pain that that could not occur in 18 weeks of 18 neurologic studies. I also think it is appropriate to 18 19 pregnancy? 19 look at neonatal studies. 20 A. I'm not agreeing that that is necessary to 20 Q. What about animal studies? 21 21 A. Animal studies can be helpful. create pain. 22 Q. I'm saying if it were necessary, would you 22 Q. Which animals are most comparable to humans 23 agree that it can't happen at 18 weeks? I understand you 23 in terms of neurological development and pain perception 24 24 believe it is unnecessary. If it were necessary, would in your opinion? 25 you agree that it cannot happen at 18 weeks of 25 A. I don't know that I know the answer to that. 203 205 1 pregnancy? 1 I would assume probably a primate, but I don't know for 2 A. I don't think that there is histologic 2 certain that that's the case. 3 evidence that the connection exists that early. 3 Q. Have you ever looked into the issue? 4 Q. So there is no evidence that an 18-week 4 A. No. 5 Q. Okay. So you also mentioned in your report 5 fetus could experience pain, if a fully formed connection 6 between the thalamus and the cerebral cortex is required that it is the standard of care to give analgesia to 6 7 to experience pain? 7 premature neonate who is undergoing a potentially painful 8 A. The -- the requirement for the cerebrum is 8 procedure; is that correct? 9 the assumption that the cerebrum is required to 9 A. That's correct. 10 10 emotionally process the pain. Q. And what is the gestational age that you're 11 Q. Dr. Skop, I want to get us back onto my 11 referring to there, or that you have in mind of the 12 question. My question is, if -- do you agree that an 12 neonate at the time of birth? 13 13 18-week fetus could not experience pain as you have A. Conversations with my neonatology peers --14 defined it if a fully formed connection between the 14 any live baby in the NICU is going to get analgesia if 15 thalamus and the cerebral cortex is required to 15 needed. There are neonatal surgeries that are done even 16 prior to the age of viability, and it is my understanding 16 experience pain? 17 A. I can't agree with the wording because you 17 that analgesia is given in those situations as well. 18 said as I've defined it. And as I've defined it, it 18 Q. But you don't perform those intrauterine 19 doesn't require the emotional component. So pain, as 19 fetal surgeries, correct? 20 I've defined it, does not require a connection to the 20 A. No. 21 21 Q. And it sounds like you don't actually cerebral cortex. A functioning thalamus is sufficient to 22 22 document pain in a fetus. administer analgesia to neonates, correct? 23 Q. But to be clear, it is your opinion that at 23 A. No. Those are both outside of my 24 18 weeks of pregnancy there is not a fully formed 24 specialty. 25 connection between the thalamus and the cerebral cortex 25 Q. Outside of your expertise?

206 208 1 A. Exactly. 1 which a neonate born before 21 weeks and six days of 2 Q. Okay. And then you mentioned something, a 2 pregnancy survived long term? 3 term I've never heard of it. What is intrahepatic vein 3 A. I have seen reports on that. Again, they're needling? 4 anecdotal reports, and I don't have the specific 4 5 A. So sometimes they need to collect blood from 5 information. 6 6 the fetus, maybe an Rh isoimmunization situation to Q. You mentioned a study out of the University 7 7 determine, you know, anemia, things like that. They need of lowa. Is it your understanding that the people in the 8 direct fetal blood. And so they can -- they can get it 8 study would have received -- well, what is your 9 understanding of what traditional treatment would be for 9 from the cord sometimes, and I can't really tell you 10 10 exactly which situations, but they may need to go a neonate born at 22 weeks? directly into the big vessel that feeds the liver. That A. Well, if possible we tend to give antenatal 11 11 12 is what that is. 12 steroids. I don't know specifically of those babies 13 13 which did and which didn't. Many times at those Q. So it is not a procedure that you perform, then? 14 gestational ages the neonatologist will attend the 14 15 15 A. No. delivery, evaluate the baby to see if the baby is trying 16 Q. And at what gestational age would you do it; 16 to breathe. I mean, there are some 22-weekers that 17 17 aren't healthy enough to be resuscitated. But in those do you know? 18 18 A. I don't know. I think that would probably situations, when the baby appears to be fighting, they 19 be a mid-second-trimester procedure. But, again, it is 19 try to resuscitate, and those are the outcomes they have 20 20 generally done by a specialist. Usually in Texas it is gotten. 21 21 Houston or Dallas that does those. Q. So you mentioned antenatal steroids. So in 22 22 layman's terms, that is an instance where the pregnant Q. Have you ever observed it? 23 It is possible that I may have during my 23 patient would actually take steroids in advance of the Α. 24 24 birth to bolster the lung capacity of the fetus; is that residency. 25 Q. But you don't recall any --25 correct? 207 209 1 A. I don't recall. 1 Α. That is correct. 2 2 Q. -- particular --Q. So without that kind of steroid treatment 3 A. Maybe they weren't that sophisticated 3 how --4 then. 4 A. That's felt to improve the odds. But, 5 5 Q. Okay. And, actually, if we can back up to again, babies have survived without the steroids. 6 my earlier question about the neonates. I think you Q. And -- okay. So you mentioned steroids. 6 7 mentioned it was your understanding that any living baby 7 And, also, do you know whether the lowa program was a 8 in the NICU would, where appropriate in the treating 8 Level 4 NICU. 9 physician's view, would receive analgesia for a potential 9 A. I would assume it must be to have 10 painful procedure; is that right? 10 22-weekers. 11 A. That's correct. 11 Q. So for the record, a Level 4 NICU would be 12 Q. When you say any living baby, what point in 12 the highest -- how would you describe a Level 4 NICU? 13 13 pregnancy would you say that is the earliest point that A. Yeah, it would be the highest acuity, the 14 you're going to see living babies who make it into the 14 ones most likely to have the machinery that's needed to 15 NICU after birth? 15 support a baby that young, his respiratory system. 16 16 Q. And there are very few of those, correct? A. Viability is actually an ever decreasing standard. Currently 22-week neonates -- the University 17 17 A. I don't know the number. You know, teaching 18 of lowa just released a study that two-thirds of those 18 hospitals tend to be the ones with the best NICUs. 19 lived until hospital discharge and, of those, two-thirds 19 Q. So what about the -- does a pre-viable fetus have no to minimal neurologic impairment. So the 20 20 have the capacity for directional movement? 21 22-weekers are doing well. And there have been some 20-21 A. I think, undoubtedly, they do. I mean, 22 22 to 21-week fetuses that have been saved. So we -- we that's been demonstrated in babies as young as 14 weeks, 23 think of 22 weeks, but I think that our viability is 23 maybe earlier. We don't know what's going on in their 24 decreasing even further. 24 minds. I mean, certainly sometimes they do look like 25 Q. Are you saying you're aware of instances in 25 they're doing things intentionally, but 14 I think.

		1	
	210		212
1	Q. When I say directional movement, what do you	1	meant to put some pressure and to see the fetus move in
2	take that to mean?	2	response to that.
3	A. Movement that looks like it is not just	3	Q. But in your view, that is not pain that
4	random, but for a purpose.	4	you're inflicting on the fetus; is that correct?
5	Q. Okay. But moving do they have the	5	A. Right. There's other ways you can measure
6	capacity to move in one direction as opposed to	6	pain. I mean, when we experience pain, our adrenaline
7	another?	7	rises, our heart rate rises, it is the fight or flight.
8	A. Certainly.	8	Right? We want to get away. And we see that same thing
9	Q. Okay. So when you see a fetus on	9	happening in a fetus. If we're measuring blood, we can
10	ultrasound, would a fetus move directionally upon	10	see the catecholamines, we can see the endorphins rise,
11	pressure to the stomach to the pregnant patient?	11	we can see the heart rate rise, you know, all of that in
12	A. They can do that as well.	12	conjunction with the withdrawal of the fetal parts
13	Q. Okay. Why might you do that during an	13	getting away from whatever that painful stimulus is.
14	ultrasound?	14	Q. I'm sorry to go back. You mentioned the
15	A. Well, sometimes you'll do it to get them to	15	endorphins. What else did you say?
16	expose themselves better to their father and they can see	16	A. Catecholamines. So endorphins are
17	the face, look between the legs, that type of stuff. If	17	endogenous painkillers. Catecholamines would be, like,
18	you're doing a procedure, amniocentesis, you may want to	18	the adrenalin to make your heart race and stuff.
19	nudge them so that they give you a clear spot to get	19	Q. Okay. Could you see a change in those in
20	amniotic fluid without the baby at risk.	20	the absence of what might be perceived as a painful
21	Q. So what what happens when you do that?	21	stimuli?
22	You kind of nudge them to try to get them to move in a	22	A. Well, I mean, certainly you can. You know,
23	way that you want. And would they have a directional	23	movement, you know just as our heart rate rises when
24	movement then?	24	we exercise, you know, we will see babies' heart rates
25	A. Well, I mean a directional obviously	25	rise when they exercise. But the constellation of things
	,		
	211		213
1	that's a responsive movement; you push them, and they	1	happen at the time of the pain of the painful
2	move away from you. I interpret directional to mean that	2	stimulus, and
3	there is that it is more than just random, that it is	3	Q. Right. But my question to you is could
4	either some neurologic control that is causing it to	4	those things that you've outlined as rising for a fetus,
5	happen. I assume you might be responding to what I put	E	could these hannen in the channes of a nainful stimuli so
6		5	could those happen in the absence of a painful stimuli as
7	in there about the twins. Twins as early as 14 weeks,	6	well?
1	in there about the twins. Twins as early as 14 weeks, you know, they can see them reaching for each other.		
8		6	well?
	you know, they can see them reaching for each other.	6 7	well? A. I don't know that they would release
8	you know, they can see them reaching for each other. Obviously, we don't know what capacity causes them to do	6 7 8	well? A. I don't know that they would release endorphins if they weren't having pain because those are
8 9	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.	6 7 8 9	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.
8 9 10	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,	6 7 8 9 10	 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
8 9 10 11	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	6 7 8 9 10 11	 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
8 9 10 11 12	 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 	6 7 8 9 10 11 12	 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
8 9 10 11 12 13	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	6 7 8 9 10 11 12 13	 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.
8 9 10 11 12 13 14	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	6 7 8 9 10 11 12 13 14	 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?
8 9 10 11 12 13 14 15	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	 6 7 8 9 10 11 12 13 14 15 16 17 	 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
8 9 10 11 12 13 14 15 16	 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. 	6 7 8 9 10 11 12 13 14 15 16	 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?
8 9 10 11 12 13 14 15 16 17	 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? 	 6 7 8 9 10 11 12 13 14 15 16 17 	 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.
8 9 10 11 12 13 14 15 16 17 18 19 20	 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? 	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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.
8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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. 	 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 	 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?
8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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, 	 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 	 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
8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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? 	 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 	 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
8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 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 	 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 	 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,
8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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? 	 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 	 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

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

Ingrid Skop, M.D.

	214		216
1	ultrasound on how he saw those babies reacting. And he's	1	you know my name last night at 6:00 p.m.?
2	put out a couple of videos that show the responses to	2	A. I've heard your name before, yes.
3	babies during abortions.	3	Q. Okay. So you did know my name. And, I'm
4	Q. But you have no firsthand experience of	4	sorry, did you say that there was a return address with
5	observing an abortion at or after 18 weeks, correct?	5	my name on it?
6	A. That's correct.	6	A. I don't recall. I've thrown the package
7	Q. Okay.	7	away, but I can find out. I didn't pay attention to
8	MS. MURRAY: So I think this might be a good	8	that.
9	time to stop and take a break.	9	Q. So if you didn't know who the package was
10	(Recess from 2:11 p.m. to 2:34 p.m.)	10	from, would you have normally would you look at the
11	MS. MURRAY: Welcome back from the break.	11	return address to figure it out?
12	Q. (By Ms. Murray) Dr. Skop, is there anything	12	A. To tell you the truth, we're getting a lot
13	you would like to amend or add to your earlier testimony	13	of packaging right now. My son is working from home too,
14	at this point?	14	and so I've kind of gotten into the habit of opening
15	A. I don't think so.	15	packages, seeing what is in them, and then sending them
16	Q. Okay. Before we get started, I have	16	to the appropriate person. I think that's why I didn't
17	well, I had some some questions on other issues, but I	17	pay attention to who it was from.
18	wanted to go back to the discussion this morning about	18	Q. So you had not been advised before receiving
19	the exhibits in this case. When did you receive the	19	the package not to open it?
20	package of exhibits yesterday, Dr. Skop?	20	A. If I was, I neglected to pay attention. So
21	A. Toward the end of the day.	21	it is my fault I'm sure.
22	Q. What time, approximately?	22	Q. Do you recall being advised about a
23	A. I'll say about 6:00.	23	package?
24	Q. Okay. And when did you receive the court	24	A. I don't recall, but I probably I mean, it
25	order in this case governing the depositions?	25	was probably in some of the papers that I
	215		217
1	A. Maybe a week or so ago.	1	Q. Did you read the court order that
2	Q. Okay. And then there was the court order	2	Mr. Sorenson provided to you?
3	was actually included with the exhibits, correct?	3	A. Did I read it? I looked at it about a week
4	A. Yes.	4	ago.
5	Q. To be clear, was it your understanding when	5	Q. And did he tell you to expect a package last
6	you received the packet that you were not supposed to	6	night?
7	open it until we had our deposition today?	7	A. I don't remember.
8	A. That was totally my fault. If it was in the	8	Q. So you didn't know yesterday whether you
9	information that was provided before, I didn't I	9	would be receiving documents in this case?
10	didn't remember. I didn't pay attention to it when I	10	A. No.
11	received the package yesterday. I didn't know what it	11	Q. So they came out of the blue?
12	was, and I opened it and then saw that it was these	12	A. Yes.
13	papers, and I flipped through it. But I didn't spend an	13	Q. Okay. And then when you opened them, what
14	extensive amount of time because I thought that pretty	14	was inside well, let me ask you this: How did the
15	much everything I saw was the stuff I had submitted to	15	documents arrive; in what kind of container?
16	you guys.	16	A. They were in a FedEx envelope.
17	Q. Just to make clear, when you received the	17	Q. An envelope or a box?
18	package, it did have a return address on it, correct?	18	A. It was a box.
19	A. Probably.	19	Q. A box. And then what was inside of the
20	Q. And it would have had my name, Julie Murray?	20	sealed box?
21	A. Probably.	21	A. An envelope.
22	Q. Did you know my name last night?	22	Q. And was that envelope sealed?
23	A. I don't recall paying attention to who it	23	A. Yes.
24	was from.	24	Q. And then what was inside of that sealed
25	Q. I'm asking you a different question. Did	25	envelope?
L			

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

Ingrid Skop, M.D.

Seh			ingria Skop, M.D.
	218		220
1	A. The three-ring binder.	1	would you say you spent preparing the deposition between
2	Q. The three-ring binder. And did you open up	2	then and when the deposition began this morning?
3	the three-ring binder and look at the what did you do	3	A. Really, at that point, only 15 minutes. I
4	when you saw the three-ring binder?	4	made dinner. I was on a conference call, watched TV, and
5	A. I opened it up and saw that it was the	5	went to bed. I didn't spend any additional time after
6	documents that I had previously provided.	6	that preparing.
7	Q. And then were there four or five envelopes	7	Q. Okay. All right. With that, let's talk a
8	at the end of the binder?	8	little bit about publications. If I understood your CV
9	A. Yes.	9	correctly, it looks like you didn't publish any articles
10	Q. And how were those marked?	10	or do any presentations between the late 1990s and 2018.
11	A. They have letters on them.	11	So approximately 20 years. Is that correct?
12	Q. And what did you do with well, were those	12	A. That's correct.
13	envelopes sealed as well?	13	Q. And the first one you published something
14	A. Yes.	14	about abortion was in 2018; is that correct?
15	Q. And you opened each one of those last	15	A. I believe so.
16	night?	16	Q. How many articles have you published in a
17	A. Yes.	17	peer review journal?
18	Q. Did it occur to you after seeing the binder	18	A. I believe there have been four or five.
19	that had been sealed that perhaps you were not supposed	19	Q. Okay. And of those am I correct you said
20	to open the envelopes?	20	there were two or three that related to abortion?
21	A. No, it didn't occur to me. I figured I was	21	A. They've all related to well, the recent
22	being sent it for use today.	22	ones all related to abortion. It looks like there have
23	Q. And so you didn't reach out to counsel for	23	been five peer reviewed; three of them have specific
24	any advice?	24	information about abortion safety.
25	A. No.	25	Q. Uh-huh. And you said that earlier that
	219		221
4		1	
1	Q. Okay. And once you received the packages last night, did you have you did you speak to	2	you had been had been deposed in two lawsuits; one as a defendant and one as an expert a couple of years ago in
3	Mr. Sorenson between the time that you received the	3	a medical malpractice case; is that correct?
4	package and this morning when the deposition began?	4	A. That is correct.
5	A. I don't think that we spoke.	5	Q. Was the name of that case Bates v. Smith; do
6	Q. Did you email or communicate in writing?	6	vou recall?
7	A. No.	7	A. Smith?
8	Q. So you didn't have any communication with	8	Q. Actually, that one would have been around
9	him between the time the package arrived and when you got	9	2005. Is that the medical malpractice case that you were
10	on the deposition this morning?	10	referring to, Bates v. Smith?
11	A. No.	11	A. What was the first name?
12	Q. Okay. How much time would you say you spent	12	Q. Bates, B-A-T-E-S?
13	looking at the documents last night that were provided to	13	A. I don't recall that, no.
14	you?	14	Q. Okay. What was the and you said you
15	A. I just flipped through them. Probably less	15	don't recall the name of the case that you were involved
16	than 15 minutes because I had read them all before.	16	in a couple of years ago, right?
17	Q. And did you spend any other time looking at	17	A. The recent one was Carolina Praderio was
18	documents last night related to	18	the doctor. I've forgotten the plaintiff's name.
19	A. Regarding this case	19	Q. So Carolina Praderio would have been a
20	Q in preparation for this deposition?	20	defendant in the case?
21	A. Yeah, over the past couple of days, I've	21	A. Right. Yes.
22	read reread some of the papers.	22	Q. To your knowledge, have you ever been
23	Q. I'm asking about the time between when you	23	subject to a challenge to disqualify you from serving as
24	received the packet last night, you said around 6 p.m.,	24	an expert witness in court?
25	and this morning when the deposition began, how much time	25	A. Not that I know of.

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

Ingrid Skop, M.D.

Ser			ingnu Skop, w.D.
	222		224
1	Q. Okay. And is there any other prior	1	Q. And you opposed it?
2	testimony that you've provided in any type of proceeding	2	A. Yes, I did.
3	that we haven't talked about today?	3	Q. So just to make sure that I understand. In
4	A. I don't think so.	4	Texas, Georgia, and Vermont, all of the testimony you
5	Q. So I believe you mentioned there was some	5	have provided has been to support greater regulation of
6	testimony to the Texas state legislation, correct?	6	abortion as opposed to less regulation; is that correct?
7	A. Correct.	7	A. In the interest of safety, yes.
8	Q. And that wasn't on your CV, correct?	8	Q. Or to ban it outright, correct?
9	A. I don't believe so.	9	A. No, I haven't supported anything that would
10	Q. What about testimony to the Vermont	10	ban it outright.
11	legislature, have you ever done that?	11	Q. The Georgia ban at six weeks, you don't
12	A. I wrote a I wrote a report at the request	12	consider a ban on abortion outright?
13	of Vermont Right to Life.	13	A. No. Women can get abortions it is
14	Q. And you don't know what happened to it?	14	possible to know you are pregnant prior to the fetal
15	A. It got ignored, apparently.	15	heartbeat.
		16	
16 17	Q. Was the purpose of the report to submit to		Q. When is a home pregnancy test accurate? How
17 18	the legislature? A. I believe so.	17 18	many weeks LMP? A. It can pick up as early as three weeks LMP,
		-	
19	Q. And that wasn't on your CV, correct?	19	about a week after the conception occurs.
20	A. I had forgotten about that.	20	Q. So, at best, three weeks. And when is it
21	Q. So it wasn't on your CV?	21 22	most reliable? Does it start being very reliable at
22	A. That's correct.		three weeks?
23	Q. And you didn't mention it this morning?	23	A. Depending on the test. It is almost
24	A. No. I'd forgotten about it until just	24	always even with a low sensitivity test, it is always
25	now.	25	going to be positive around the time of the missed
	223		225
1	Q. Is there any other testimony that you have	1	menstrual period.
2	ever provided that you haven't told me so far in any type	2	Q. So when would that be?
3	of proceeding?	3	A. Around four weeks.
4	A. It's hard to say. Not that I can recall.	4	Q. Four weeks. So in your view, it is not an
5	But some of these things are fairly minor, so I may be	5	outright ban on abortion if a woman can get an abortion
6	forgetting something.	6	between four weeks, when it will be reliably diagnosed by
7	Q. What about any letters to the editor or	7	a home pregnancy test, and six weeks; is that correct?
8	newspaper articles about abortions actually, can we	8	A. Yes. There's certainly time to get an
9	back up?	9	abortion there. And sometimes we don't see the heartbeat
10	So you told me what the Texas and Georgia	10	until seven or eight weeks depending on the sensitivity
11	testimony was about. What was the Vermont testimony	11	of the ultrasound.
12	about, to your recollection?	12	Q. Have you also advocated waiting periods,
13	A. Well, this was at the time that Vermont took	13	Dr. Skop, between the time that a woman is provided
	,	14	informed consent papers for abortion and when she can
14	away all restrictions on the procedure of abortion, and		
14 15	away all restrictions on the procedure of abortion, and so I wasn't paid for that testimony. They just asked		
15	so I wasn't paid for that testimony. They just asked	15	actually obtain one?
15 16	so I wasn't paid for that testimony. They just asked me I don't remember how they found me, but they asked	15 16	A. I don't recall if I've done anything
15 16 17	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,	15 16 17	A. I don't recall if I've done anything specific in writing or in testing, but I think that is a
15 16 17 18	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.	15 16 17 18	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.
15 16 17 18 19	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?	15 16 17 18 19	 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
15 16 17 18 19 20	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.	 15 16 17 18 19 20 	 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?
15 16 17 18 19 20 21	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	 15 16 17 18 19 20 21 	 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.
15 16 17 18 19 20 21 22	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	 15 16 17 18 19 20 21 22 	 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.
15 16 17 18 19 20 21 22 23	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?	 15 16 17 18 19 20 21 22 23 	 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.
15 16 17 18 19 20 21 22	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	 15 16 17 18 19 20 21 22 	 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.

			Ingria Skop, M.D.
	226		228
1	A. I've had a few letters to the editor, local	1	Q. Do you have are there any circumstances
2	op-eds. I've had a few op-eds published in more national	2	in which you believe abortion should be available in the
3	magazines. I had a joint op-ed with a congressman on the	3	United States?
4	hill. There's been a few others. I don't think those	4	A. I think I don't think it is necessary for
5	were important to put on the CV, but	5	women's health. If a woman needs to be separated from
6	Q. Are you referring to the op-ed that you did	6	her baby to preserve her health, that can be done without
7	with Representative Kevin Brady of Texas with respect to	7	intentionally performing an abortion.
8	federal legislation on abortion?	8	Q. And how would that be done, so that I
9	A. Yeah. The legislation, as I recall, was	9	understand?
10	about supporting babies that are born alive.	10	A. Labor can be induced or, you know, as we
11	Q. After an abortion?	11	discussed earlier, caesarean if indicated.
12			
	A. It doesn't actually limit abortion. It just	12	Q. And in those circumstances, how would you
13	ask that you save the infant.	13	describe when you think abortion should be legal to
14	Q. But it was an op-ed with respect to	14	protect a woman's health?
15	abortion, correct, with a congressman?	15	A. Well, abortion
16	A. Yes.	16	Q. Would any health risk be a sufficient basis
17	Q. And did any of the other letters or op-eds	17	for performing an abortion?
18	that you mentioned pertain to abortion?	18	A. Doe v. Bolton defined a health risk as
19	A. Probably most of them did.	19	emotional, psychological, physical, age, social. So many
20	Q. Okay. But none of them appeared on your CV,	20	times things that are defined as for the health of the
21	correct?	21	mother are not life-threatening. I don't I can't
22	A. Yeah, I didn't put any of those on.	22	think of a time that a pregnancy has posed a risk to the
23	Q. Okay. What about have you ever been	23	life of a patient that I've cared for that I have not
24	denied a license to practice medicine in any state?	24	been able to take care of the mother with either
25	A. No.	25	induction or C-section.
	227		229
4		4	
1	Q. Have you ever had your license revoked or	1 2	Q. Do you believe that abortion should be legal in the United States if there is a threat to the
2	suspended?		
	A N		
3	A. No.	3	mother or the woman's health but not to her life?
4	Q. Has a patient or a former patient ever filed	3 4	mother or the woman's health but not to her life?A.Well, like I mentioned, the health exception
4 5	Q. Has a patient or a former patient ever filed a complaint against you with any disciplinary body?	3 4 5	mother or the woman's health but not to her life?A. Well, like I mentioned, the health exceptionis very broad. In some states she says she feels
4 5 6	 Q. Has a patient or a former patient ever filed a complaint against you with any disciplinary body? A. No. 	3 4 5 6	mother or the woman's health but not to her life?A. Well, like I mentioned, the health exceptionis very broad. In some states she says she feelsdepressed about the pregnancy; they consider that a
4 5 6 7	 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 	3 4 5 6 7	 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.
4 5 6 7 8	 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? 	3 4 5 6 7 8	 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
4 5 6 7 8 9	 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 	3 4 5 6 7 8 9	 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
4 5 6 7 8 9	 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. 	3 4 5 6 7 8 9 10	 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
4 5 7 8 9 10 11	 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? 	3 4 5 6 7 8 9 10 11	 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?
4 5 7 8 9 10 11 12	 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 	3 4 5 6 7 8 9 10 11 12	 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
4 5 6 7 8 9 10 11 12 13	 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. 	 3 4 5 6 7 8 9 10 11 12 13 	 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.
4 5 6 7 8 9 10 11 12 13 14	 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 	 3 4 5 6 7 8 9 10 11 12 13 14 	 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
 4 5 6 7 8 9 10 11 12 13 14 15 	 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? 	 3 4 5 6 7 8 9 10 11 12 13 14 15 	 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
 4 5 6 7 8 9 10 11 12 13 14 15 16 	 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. 	 3 4 5 6 7 8 9 10 11 12 13 14 15 16 	 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 abortion should be legal to preserve the health of preserve the health of a pregnant patient but not her life; is that
 4 5 6 7 8 9 10 11 12 13 14 15 16 17 	 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 	 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 	 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 reserve the health of a pregnant patient but not her life; is that right?
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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? 	 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 	 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 the pregnant patient patient but not her life; is that right? A. My goal is not to make abortion illegal. My
 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 	 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. 	 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 	 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
 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 	 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 	 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 	 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 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
 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 	 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. 	 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 	 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 vou 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
 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 	 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. 	 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 	 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 vou 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
 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 	 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 	 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 	 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.
 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 	 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. 	 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 	 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 vou 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
 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 	 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 	 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 	 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.

	230		232
1	legal, correct?	1	correct?
2	A. Specifically regarding this legislation,	2	A. That's correct.
3	I've said I don't think it is necessary after 18 weeks.	3	Q. Okay. Have you ever advocated the closure
4	Q. Or at six weeks, you have testified that it	4	of Planned Parenthood?
5	should be six to eight weeks, you have testified that	5	A. I don't think so.
6	it shouldn't be legal, correct?	6	Q. Have you ever advocated for legislation that
7	A. I submitted an expert witness report to the	7	would prevent Planned Parenthood affiliates from
8	State of Georgia that is unrelated to this legislation	8	obtaining any funding for nonabortion-related work that
9	with some reasons that it is reasonable for them to make	9	they do?
10	the ban where they have.	10	A. The I think I may have written an op-ed
11	Q. And if you were making the ban, where would	11	about Title X.
12	you put the point in pregnancy at which abortion should	12	Q. And, for the record, what is Title X?
13	no longer be available?	13	A. Title X is unrestricted government funds
14	A. Well, morally, since it is the taking of a	14	that Planned Parenthood gets used to get a lot of that
15	human life, I think that that is a discussion our society	15	they would use to support other services
16	should have. My goal is not legislation	16	Q. I'm not sorry. Let me back up. I'm not
17	Q. I'm not asking about your goals. I'm asking	17	asking about Planned Parenthood. I'm asking you, what is
18	about your personal beliefs, Dr. Skop.	18	your understanding of the Title X program. What does it
19	A. I don't I don't care where the law falls	19	fund?
20	on it, but I think it is certainly reasonable for us to	20	A. It funds women's health, but it doesn't fund
21	put limitations, and 18 weeks is certainly a good place	21	specific like, it is not to pay for a particular
22	to put a limitation. I'm not out trying to make abortion	22	procedure. But it is a block grant that goes to family
23	illegal in every situation.	23	planning agencies. And the current regulations say that
24	Q. I'm asking you what you believe should be	24	there needs to be brick and mortar separation between an
25	legal. Do you believe that it should be legal for a	25	organization that accepts that money and provides
	231		222
1		1	233
1	patient to obtain an abortion where her health is	1	abortions.
2	patient to obtain an abortion where her health is threatened but her life is not threatened?	2	abortions. Q. And so you said you've written an op-ed
2 3	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	2 3	abortions. Q. And so you said you've written an op-ed about Title X funding?
2 3 4	patient to obtain an abortion where her health isthreatened but her life is not threatened?A. It depends on the definition of health. Ifshe is just depressed about being pregnant, I don't think	2 3 4	abortions. Q. And so you said you've written an op-ed about Title X funding? A. I did.
2 3 4 5	patient to obtain an abortion where her health isthreatened but her life is not threatened?A. It depends on the definition of health. Ifshe is just depressed about being pregnant, I don't thinkthat that should be legal.	2 3 4 5	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
2 3 4 5 6	 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 	2 3 4 5 6	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?
2 3 4 5 6 7	 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 	2 3 4 5 6 7	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
2 3 4 5 6 7 8	 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? 	2 3 4 5 6	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.
2 3 4 5 6 7	 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 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 	2 3 4 5 6 7 8	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?
2 3 4 5 6 7 8 9	 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 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 	2 3 4 5 6 7 8 9	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.
2 3 4 5 6 7 8 9 10	 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 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 	2 3 4 5 6 7 8 9 10	 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.
2 3 4 5 6 7 8 9 10	 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 	2 3 4 5 6 7 8 9 10 11	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.
2 3 4 5 6 7 8 9 10 11 12	 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. 	2 3 4 5 6 7 8 9 10 11 12	 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
2 3 4 5 6 7 8 9 10 11 12 13	 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, 	2 3 4 5 6 7 8 9 10 11 12 13	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?
2 3 4 5 6 7 8 9 10 11 12 13 14	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14	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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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 be where you believe abortion should be 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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?
 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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?

Ingrid Skop, M.D. 234 236 1 organizations not listed on your CV? 1 opinion on fetal pain, do you believe that it reflects 2 A. No. 2 this same information? 3 Q. Are you familiar with a fact sheet published 3 A. It probably does. It's been a while since 4 by AAPLOG that focuses on fetal pain? 4 I've looked at it, so I don't know if it is word for word 5 A. Yes. 5 what I wrote here or if it is -- it may -- it may be more 6 Q. Let me go ahead and -- I think that is 6 comprehensive. It may have what other people have 7 7 Tab N. So this will be -- we'll mark this as Exhibit 10. written too. I haven't looked at it. 8 (Exhibit No. 10 was marked.) 8 Q. So you've -- you didn't realize that you had 9 Q. And for the record, this is titled "AAPLOG 9 authored this fact sheet; is that your testimony? Fact Sheet Fetal Pain," release date, February 13, 2019. 10 10 A. I -- during the two years that I was Is that correct, Dr. Skop? 11 11 involved on the board of AAPLOG, I wrote a number of 12 A. Which tab was that? 12 statements. I lead the effort to produce practice 13 13 Q. Sorry. It is Tab N. N as in Nancy. bulletins and committee opinions and position statements 14 A. Okay. I've got it. 14 because ACOG does that, and I thought that was a good 15 Q. Okay. And have you seen this document 15 format. So I was involved in several of those. 16 before? 16 The fact sheets, I thought that most of 17 those were previous information, but, apparently, some of 17 A. Yes. 18 Q. Is it the fact sheet that AAPLOG has 18 them are some of the new information as well. published? 19 19 Q. Okay. So I just sent you a document -- are 20 A. Yes. 20 you able to access email right now? 21 Q. Does it appear complete? 21 A. Uh-huh. 22 A. Yes, it does. 22 Q. Can you check your email? 23 Q. Okay. And we've talked some about the 23 MS. MURRAY: And I've actually sent this 24 portion of your expert report that deals with fetal pain 24 along to everyone else. My apologies it wasn't in the 25 today, correct? 25 binder. Have you all received it? 235 237 1 A. Yes. 1 Actually, while we're waiting on that, I'm going to send something else. 2 2 Q. And if I recall what you said earlier, correct me if I'm wrong, the preparation of your expert 3 3 MR. SORENSON: I've received it Julie. 4 report, you might have, you said, relied on some other 4 MS. MURRAY: Okay. Great. 5 5 Q. (By Ms. Murray) So the document that you personal notes that you have taken -- or, sorry, personal notes of yours that are not public in drafting it and 6 were referring to, Dr. Skop, that you thought you were 6 7 potentially other AAPLOG policy statements or bulletins; 7 drafting language for, you thought that was the fetal 8 is that correct? 8 pain practice bulletin; is that correct? 9 9 A. Just to clarify, this is what I wrote. A. It probably would have been a committee 10 opinion. 10 AAPLOG had -- they had previous fact sheets that I drew 11 information from, but clearly this is -- this is what is 11 Q. Committee opinion, okay. But you don't have 12 in the expert witness report because this -- when I was 12 a copy of that? 13 A. No. 13 involved in updating stuff, I was thinking that it made 14 it to the -- to the committee opinions, but apparently 14 Q. I'm going to go ahead -- and since it sounds 15 this -- what I wrote has also made it to this fact sheet. 15 like you don't entirely recall what you thought you were Q. So just to make sure that I understand. So 16 drafting for, I am going to send -- I'm going to drop a 16 17 link into the chat. And if -- that has a PDF that we can 17 I think you had said earlier that you didn't have 18 involvement with any fact sheets; is that correct? 18 view as an exhibit. 19 19 A. I wasn't aware that they put what I wrote on Okay. If we could go to this link, and 20 a fact sheet as well, but it appears that they did. 20 we'll mark this -- so the last document -- let's see. 21 The one that I just sent you by email let's mark as 21 Q. And what was your understanding of what you 22 22 wrote; where did that go? Exhibit 10. And then the document that I've sent through 23 A. There's a committee opinion on fetal pain, 23 the chat. let's mark as Exhibit 11. 24 24 and I think some of it is there as well. And with respect --25 Q. And if we were to look at the committee 25 MS. FARRELL: Just one clarification. I

Ingrid Skop, M.D.

	238		240
1	have Tab N as Exhibit 10.	1	Q. Not the research. The writing, Dr. Skop, is
2	MS. MURRAY: Okay. So Exhibit 11 will be	2	it yours?
3	the document I just sent by email, and Exhibit 12 will be	3	A. I believe it is. It looks like my
4	the link that I just dropped into the chat.	4	writing.
5	Q. (By Ms. Murray) So with respect to the	5	Q. In your expert report?
6	document that I just dropped into the chat, Dr. Skop,	6	A. Yes.
7	have you been able to pull that up?	7	Q. All of this is your writing?
8	A. Yes. That is the practice bulletin.	8	A. I believe so.
9	(Exhibit No. 11 was marked.)	9	Q. Did you draft every word of it?
10	(Exhibit No. 12 was marked.)	10	A. You know, I can't recall. Like I say, I've
11	Q. Is that now that you look at the	11	been making notes to myself for probably five to ten
12	document, this is the practice bulletin from AAPLOG	12	years on different topics, so it is possible that I did
13	called Evidence let's see. It is dated November 2017	13	take some of this from someone's statement at some point.
14	on Fetal Pain; is that correct?	14	I can't say that is not possible, but it is you know,
15	A. Yes.	15	I just don't recall whether some of it came from another
16	Q. And this is the document you thought you	16	researcher or not.
17	were drafting?	17	Q. But it is your testimony that you didn't
18	A. I didn't write this.	18	rely on this fact sheet when you were drafting your
19	Q. Okay. So this is not your work?	19	expert report in this case; is that correct?
20	A. Correct.	20	A. Again, I had this on documents that were my
21	Q. And then the document that I just sent you	21	private documents. I don't recall. I know I've done a
22	by email, I'll represent to you that that is a document	22	lot of writing for AAPLOG on a lot of these sheets. So I
23	created by my office to compare the material in your	23	don't recall if this all originated specifically with me.
24	expert report to the material in the AAPLOG fact sheet,	24	Q. Do you believe that you're able to offer an
25	so the material in Tab N that we've marked as Exhibit 10.	25	independent opinion in this case separate from the views
	239		241
1	Is that right? Yes.	1	of AAPLOG?
2	That's a red line. Does that look correct		A. Yes, I've done a lot of independent
		Z	
3	based on your review of your report and the AAPLOG fact	2	research.
3	based on your review of your report and the AAPLOG fact sheet provided to you?		research.
	sheet provided to you?	3	research. Q. And throughout the day, you've referred,
4	sheet provided to you?A.So you're asking me if the email that you	3 4	research.
4 5	sheet provided to you?	3 4 5	research. Q. And throughout the day, you've referred, sometimes, to authors or researchers who perform
4 5 6	sheet provided to you?A. So you're asking me if the email that yousent which is very similar to mine with a few additions	3 4 5 6	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
4 5 6 7	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	3 4 5 6 7	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?
4 5 6 7 8	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?	3 4 5 6 7 8	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
4 5 6 7 8 9	 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. 	3 4 5 6 7 8 9	 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
4 5 6 7 8 9 10	 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 	3 4 5 6 7 8 9 10	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
4 5 6 7 8 9 10 11	 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 	3 4 5 6 7 8 9 10 11	 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
4 5 7 8 9 10 11 12	 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 	3 4 5 6 7 8 9 10 11 12	 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.
4 5 6 7 8 9 10 11 12 13	 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? 	3 4 5 6 7 8 9 10 11 12 13	 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
4 5 6 7 8 9 10 11 12 13 14	 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 	3 4 5 6 7 8 9 10 11 12 13 14	 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
 4 5 6 7 8 9 10 11 12 13 14 15 	 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. 	3 4 5 6 7 8 9 10 11 12 13 14 15	 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
 4 5 6 7 8 9 10 11 12 13 14 15 16 	 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 	3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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
 4 5 6 7 8 9 10 11 12 13 14 15 16 17 	 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 	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	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?
 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 	 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 	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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.
 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 	 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 	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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
 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 	 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. 	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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?
 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 	 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 report. Q. So is it your testimony, then, that the material on fetal pain in your expert report may not have originated with you? 	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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
 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 	 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 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 	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 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?
 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 	 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 report. Q. So is it your testimony, then, that the material on fetal pain in your expert report may not have originated with you? 	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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

Set			
	242		244
1	in my CV that I was a member.	1	Q. What other projects have you done for the
2	Q. No. But in your expert report, it was not a	2	Charlotte Lozier Institute?
3	source that you cited, correct?	3	A. I did some I did a statement on maternal
4	A. Well, remember I said that when I I did	4	mortality that was presented at a congressional
5	look at some intermediate documents that were but then	5	briefing.
6	I went to the neurologic literature to cite where those	6	Q. Okay. Is that on your CV?
7	statements actually came from.	7	A. No.
8	Q. But it is not in terms of what you	8	Q. Okay. Did you think that that might be
9	revealed in your CV that you had considered in	9	relevant to this case the in the scope of your expert
10	preparation of your expert report, you didn't cite	10	testimony?
11	AAPLOG, did you?	11	A. Well, I thought that the CV just wanted
12	A. I guess not.	12	publications that were peer reviewed. I didn't
13	Q. No. And I asked you earlier whether you had	13	intentionally leave those off. But, you know, like I
14	made every effort to include in your expert report the	14	said, I didn't think it was important enough to put on
15	facts and data that you relied upon, correct?	15	here.
16	A. That's correct.	16	Q. Okay. Do you you mentioned that you have
17	Q. Would you say you overlooked this one?	17	been paid by the Charlotte Lozier Institute, and is that
18	A. I did overlook this one, yeah, because I	18	affiliated with AAPLOG?
19	thought it would be more important to go directly to the	19	A. No.
20	studies.	20	Q. Is it affiliated with any other pro-life
21	Q. Do you think a court might consider as	20	organizations?
22	you said, AAPLOG has a bias. Would you be concerned that	22	A. I believe it is affiliated with Susan B.
23	a reader might believe your expert report is less	23	Anthony List.
24	reliable if you relied on AAPLOG?	23 24	Q. All right. Any other projects that you've
25	A. Not necessarily, if they go to the	24	done for the Charlotte Lozier Institute that you can
	243		245
1	neurologic literature.	1	recall?
2	Q. Okay. And then the document that I just	2	A. No.
3	dropped into the chat, have you let's see. We've	3	Q. Okay. So you've now told me all the
4	introduced that one. That was Exhibit 12.	4	projects you've done for them. There were two?
5	A. That was the practice bulletin.	5	A. Those are the only two things I've been paid
6	Q. Okay. And that, you said, was not your	6	for. Oh, I you know, two of these articles, the two
7	work, correct?	7	that were written by Studnicki, those are some Charlotte
8	A. That's correct.	8	Lozier researchers as well. So I collaborated on those
9	Q. Okay. What about do you have any prior	9	two papers.
10	existing contracts with AAPLOG for any services of any	10	Q. Okay. Were you paid for those?
11	kind?	11	A. No.
12	A. No, I have not received any money or	12	Q. And can we go to Tab O?
13	contribution.	13	Before we go on, you mentioned you looked at
14	Q. Do you have money from any other pro-life	14	these documents for about 15 minutes last night, the
15	organizations?	15	documents I sent as exhibits. Did you look at this
16	A. On occasion I will be paid for work that	16	AAPLOG fact sheet last night?
17	I've done for Charlotte Lozier, but it is usually on a	17	A. I glanced and saw it was in there. I didn't
18	project basis.	18	reread it.
19	Q. Okay. And what kind of projects do you do	19	Q. Okay. So Tab O I will mark as Exhibit 13.
20	for them.	20	This is entitled "Medical Abortion: What Physicians Need
21	A. I wrote a paper on "No Test Medical	21	to Know" authored by you.
		22	A. That is correct.
22	Abortion."	22	
22 23		22	
22 23 24	Abortion." Q. And just to confirm, that is not in your CV, correct?		(Exhibit No. 13 was marked.)
23	Q. And just to confirm, that is not in your CV,	23	

September 02, 2020 Ingrid Skop, M.D. 246 248 1 Q. And is this one of the articles that was 1 Q. These passages are identical, aren't they? 2 peer reviewed? 2 A. They sound identical, yes. 3 A. Yes, this was -- this was peer reviewed. 3 Q. It is your testimony that you wrote this? 4 4 Q. Okay. And then if we could go to --A. You know, I don't recall if I wrote that 5 actually, let's stay with this. So did you author this 5 statement or if maybe I got it from something I read that 6 article, Dr. Skop? 6 Byron wrote. It is hard to know, or possibly we both got 7 7 it from a statement that someone else wrote. I don't A. Yes, I did. Q. You wrote all of it? 8 8 recall exactly. 9 9 A. Yes. Q. Would you agree that at least one of you 10 Q. Can we go to Tab P, please? Are you 10 must have taken someone else's work and presented it as 11 there? 11 your own? 12 A. Yes. 12 A. I mean, certainly it is the same couple of 13 Q. So we'll mark Tab P as Exhibit 14. 13 sentences. I don't think that this means that either one 14 (Exhibit No. 14 was marked.) 14 of us did not come to this conclusion independently. 15 15 Q. And Tab P is the expert report of Byron C. Q. Okay. Why don't we -- let's see. 16 Calhoun and this case, correct? 16 Can you actually take a look at the 17 A. Yes. 17 exhibit --Q. And you said you had seen this last night 18 18 MS. MURRAY: Leah, can you correct me? Is 19 for the first time is that correct? 19 Exhibit O the Medical Abortion -- or Exhibit 13 is 20 A. That's correct. 20 Medical abortion? 21 Q. Can you look at paragraph 73 and 74? It 21 MS. FARRELL: That is correct. Tab O or 22 says, "However, when one examines the research studies, 22 Exhibit 13. 23 NAS, the National Academies of Sciences, used for their 23 Q. (By Ms. Murray) If you look at Exhibit 13 24 24 conclusions, the poor quality of the literature regarding down there on the bottom, it says the name of the 25 long-term complications becomes apparent. 25 journal, and it says Number 4 Winter 2019; is that 247 249 1 "For many questions, there were very few or 1 correct? 2 no studies that met their criteria, and they disqualified 2 A. Yes. 3 many studies (especially those regarding mental health) 3 Q. Do you think that means that it is the 4 due to perceived study defects. Thus, in all cases, 4 fourth issue in the year 2019? 5 5 there were fewer than a handful of studies on which they A. That's probable. 6 based their definitive conclusion of 'no long-term 6 Q. So this would have come out after the expert impact.' The sparse selection of studies does not 7 7 reports in this case were submitted, correct? 8 support conclusions as definite as those drawn by the 8 A. I -- it may have been concordant with the 9 NAS." 9 report. This article I wrote based on a talk that I gave 10 Did I read that correctly? 10 at their conference in September of last year. 11 A. Yes, ma'am. 11 Q. Okay. Do you expect this journal would have 12 Q. And now can we look back at your medical 12 published something it knew to be identical to another 13 abortion article on page 110, the last full paragraph on 13 source from a different author? 14 the left column? And I'll read that there. At the very 14 A. You mean that a two sentence identical --15 end of the paragraph, it says, "However, when one 15 Q. Three sentences. And I will represent to 16 examines the research studies they used for their 16 you I haven't actually pulled all of the examples. But 17 conclusions, poor quality of the literature regarding 17 assuming it is three sentences, do you think this journal 18 long-term complications becomes apparent. For many 18 would have published something that it knew to be 19 questions, there were very few or no studies that met 19 identical to another source from a different author? 20 their stringent criteria, and they disqualified many 20 A. I don't know. The content in the article is 21 21 studies to perceived study defects. Thus, in all cases, unique. 22 22 there were less than five studies on which they based Q. These three sentences are unique? 23 their definitive conclusion of 'no long-term impact." 23 A. Admittedly, they're the same as what Byron 24 Did I read that correctly? 24 has in his report, but the article itself, I have not 25 A. Yes, ma'am. 25 seen anything that brings all this information together

	250		252
1	in a similar sort of article.	1	figure out what the standards are? What do you consider
2	Q. Dr. Skop, do you believe that articles need	2	standards of academic integrity in your field?
3	to be identical in order for one author to have	3	A. I'll have to do some research.
4	plagiarized from another?	4	Q. Okay. All right. Can we go back to Tab E?
5	A. No, but I guess I'm questioning what what	5	So this would be Exhibit 8, your article, "Abortion
6	the concern about plagiarism is.	6	Safety: At Home and Abroad."
7	Q. Because you think plagiarism is not a	7	A. Which tab did you say that was again?
8	well, you say you're questioning that. Why?	8	Q. It is Tab E, as in elephant.
9	A. Well, can you explain to me your concern?	9	A. Okay.
10	Q. Let me ask the question a different way. Do	10	Q. Are you there?
11	you have any concerns about plagiarism in your work?	11	A. Uh-huh.
12	A. I haven't, no.	12	Q. I believe it was your testimony earlier,
13	Q. You haven't had any concerns to date. Do	13	Dr. Skop, that you wrote this entire article, correct?
14	you believe within the medical research community that	14	A. That's correct.
15	plagiarism is a well, let me ask you this: Within the	15	Q. And you're the only author listed,
16	medical research community, do you believe that	16	correct?
17	plagiarism is an accepted practice among authors?	17	A. That is correct.
18	A. I wouldn't think so.	18	Q. Okay. Can we take a look at page 50, the
19	Q. And would you expect that a peer reviewed	19	first full paragraph? There's a sentence in there. It
20	article would want only material that is original to the	20	says, "Instrumental trauma of the uterus may result in
21	author whose publication is being published?	21	faulty adherence of the placenta in subsequent
22	A. Yes, I would assume that they do want that.	22	pregnancies, resulting in chronic abruption or placenta
23	Q. Okay.	23	previa/acreta/increta (invasion of the placenta into the
24	A. I'm just not sure what this small portion	24	cervix, uterine wall, or other adjacent organs)." Is
25	what you think it represents. Do you think it makes the	25	that correct?
	0.51		252
	251		253
1	article not useful or informative if there is a small	1	A. That's correct.
2	I mean, probably what happened	2	Q. Can we now take a look at Exhibit P
3	Q. Dr. Skop, because I know we do have a	3	Exhibit 14, Tab P. This is the Calhoun report. Can you
4	limited amount of time, do you believe that identical	4	take a look at paragraph 52.
5	republication of material from another author without	5	Are you there?
6	attribution is consistent with standards of academic	6	A. Not quite. Fifty-two you said?
7	integrity in your field?	7	
8			Q. Uh-huh.
	A. I did not intentionally reproduce anybody	8	A. Okay.
9	else's work.	9	A. Okay.Q. Are you there now?
10	else's work. Q. That's not my question. My question is, do	9 10	A. Okay.Q. Are you there now?A. Yes, ma'am.
10 11	else's work. Q. That's not my question. My question is, do you believe that identical republication of material from	9 10 11	 A. Okay. Q. Are you there now? A. Yes, ma'am. Q. And it says, "Instrumental trauma to the
10 11 12	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	9 10 11 12	 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
10 11 12 13	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?	9 10 11 12 13	 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.
10 11 12 13 14	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.	9 10 11 12 13 14	 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
10 11 12 13 14 15	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?	 9 10 11 12 13 14 15 	 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
10 11 12 13 14 15 16	 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, 	 9 10 11 12 13 14 15 16 	 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
10 11 12 13 14 15 16 17	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	 9 10 11 12 13 14 15 16 17 	 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)."
 10 11 12 13 14 15 16 17 18 	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	 9 10 11 12 13 14 15 16 17 18 	 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?
 10 11 12 13 14 15 16 17 18 19 	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	 9 10 11 12 13 14 15 16 17 18 19 	 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.
 10 11 12 13 14 15 16 17 18 19 20 	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	 9 10 11 12 13 14 15 16 17 18 19 20 	 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
 10 11 12 13 14 15 16 17 18 19 20 21 	 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 	 9 10 11 12 13 14 15 16 17 18 19 20 21 	 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
 10 11 12 13 14 15 16 17 18 19 20 21 22 	 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? 	 9 10 11 12 13 14 15 16 17 18 19 20 21 22 	 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.
 10 11 12 13 14 15 16 17 18 19 20 21 22 23 	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	 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 	 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?
 10 11 12 13 14 15 16 17 18 	 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? 	 9 10 11 12 13 14 15 16 17 18 19 20 21 22 	 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.

Sep	tember 02, 2020	Ingrid Skop, M.D.		
	254		256	
1	Q. And the second full paragraph says, "One	1	"Joyful events (such as the birth of a child) are	
2	meta-analysis found that there was a 25 percent increased	2	associated with improvement in health and well-being.	
3	-			
	risk of premature birth in a subsequent pregnancy after	3	Stress and guilt accompanying voluntary or spontaneous	
4	one abortion, 32 percent after more than one, and	4	pregnancy loss may adversely impact a woman's health and	
5	51 percent after more than two abortions. Likewise,	5	well-being. In addition, motherhood may have a	
6	another meta-analysis found a 35 percent increased risk	6	protective emotional effect, whereas an abortion may have	
7	of delivery of a very low birthweight infant after one	7	a deleterious emotional effect, leading to greater	
8	abortion and 72 percent after two or more abortions."	8	risk-taking activities. The phenomenon of abortion	
9	Did I read that correctly?	9	patients committing suicide on anniversaries connected to	
10	A. Yes.	10	the abortion is well-documented as well. It is evident	
11	Q. And now can we go to the Calhoun report? So	11	that a suicide on the anniversary of an abortion should	
12	this would be Exhibit P sorry, Tab P, Exhibit 14,	12	be linked to that pregnancy outcome, but none of the	
13	paragraph 50.	13	maternal mortality categories allow that late	
14	A. Okay.	14	connection."	
15	Q. It says, midway down the paragraph, "One	15	Those are nearly identical, correct? Those	
16	meta-analysis found that there was a 25 percent increased	16	two passages?	
17	risk of premature birth in a subsequent pregnancy after	17	A. Yes, they are.	
18	one abortion, 32 percent after more than one, and 51	18	Q. Dr. Skop, who wrote these two passages	
19	percent after more than two abortions." Citing Swingle	19	who wrote these passages that we've been discussing in	
20	et al., 2019. "Likewise, another meta-analysis found a	20	your article and in Dr. Calhoun's report?	
21	35 percent increased risk of delivery of a very low	21	A. I believe that the part about the placenta	
22	birthweight infant after one abortion, and 72 percent	22	accreta came from my article on maternal mortality. It	
23	after two or more abortions." Citing Liao et al., 2011.	23	is I think some of these others probably came from	
24	Did I read that correctly?	24	different papers on the AAPLOG website.	
25	A. Yes, ma'am.	25	Q. Okay. In terms of who wrote these passages,	
	255		257	
1	255 Q. And with the exception of the citations,	1	257 your best guess would be neither of you; is that correct?	
1 2		1		
	Q. And with the exception of the citations,		your best guess would be neither of you; is that correct?	
2	Q. And with the exception of the citations, those are identical, correct?	2	your best guess would be neither of you; is that correct? A. I don't recall to tell you the truth. I've	
2 3	 Q. And with the exception of the citations, those are identical, correct? A. Yes. Q. Okay. And then let's go back to your 	2 3	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	
2 3 4	Q. And with the exception of the citations, those are identical, correct?A. Yes.	2 3 4	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	
2 3 4 5	 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. 	2 3 4 5	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.	
2 3 4 5 6 7	 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 	2 3 4 5 6	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	
2 3 4 5 6	 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 	2 3 4 5 6 7	 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 	
2 3 4 5 6 7 8 9	 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 	2 3 4 5 6 7 8	 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? 	
2 3 4 5 6 7 8 9 10	 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 	2 3 4 5 6 7 8 9	 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 	
2 3 4 5 6 7 8 9 10 11	 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 	2 3 4 5 6 7 8 9 10	 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 	
2 3 4 5 6 7 8 9 10 11 12	 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 	2 3 4 5 6 7 8 9 10 11	 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, 	
2 3 4 5 6 7 8 9 10 11 12 13	 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 	2 3 4 5 6 7 8 9 10 11 12	 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, 	
2 3 4 5 6 7 8 9 10 11 12 13 14	 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, leading to greater 	2 3 4 5 6 7 8 9 10 11 12 13	 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 	
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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, leading to greater risk-taking activities. It is evident that a suicide on 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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. 	
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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, leading to greater risk-taking activities. It is evident that a suicide on the anniversary of a coerced abortion or stillbirth 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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 	
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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, 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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, 	
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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, 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." 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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. 	
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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. 	
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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. 	
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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, 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, 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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 	
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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, 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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? 	
 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 	 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, 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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. 	
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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, 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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? 	

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

Ingrid Skop, M.D.

<u> </u>			
	258		260
1	language that originated with another author without	1	A. Yes, ma'am.
2	attribution?	2	Q. And you're affiliated with them?
3	A. You know, again, I guess it's been a long	3	A. Yes.
4	time since I've dealt with the definition. I thought	4	Q. And what's your role, again, there?
5	that if the ideas were unique that I didn't realize that	5	A. I'm the chairman of the board.
6	it was a problem to lift a couple of sentences here and	6	Q. Okay. And was it Any Woman Can that you
7	there. I don't know what the rules are for these	7	mentioned as evidence of your expertise with respect to
8	journals, how they feel about that.	8	mental health issues or was that The Source?
9	Q. If I were to tell you that the definition of	9	A. It was Any Women Can in my clinical
10	plagiarism is the practice of taking someone else's work	10	experience.
11	or ideas and passing them off as one's own, would you	11	Q. Any Woman Can. Is it "any women" or "any
12	agree that either you, Dr. Calhoun, or both of you	12	woman"?
13	engaged in plagiarism?	13	A. "Woman," singular.
14	A. These are a couple of sentences at a time.	14	Q. Okay. Any Woman Can. So would you agree
15	I thought that plagiarism meant that you'd taken, like, a	15	that you're closely involved with the activities of Any
16	work, like, you know, a unique idea and said, I had this	16	Woman Can?
17	idea. I didn't realize that, you know, using wording	17	A. Yes.
18	from a paper that you agreed with qualified as	18	Q. Okay. So is Any Woman Can located near a
19	plagiarism.	19	clinic that provides abortions
20	Q. So is it possible that all of your	20	A. No, it is not.
21	publications include sentences or paragraphs that	21	Q To your knowledge?
22	originated from someone else that are not attributed to	22	Does it employ medical professionals?
23	them?	23	A. Yes, we have two nurses.
24	A. It is possible that is the case. When I	24	Q. Any doctors?
25	write, I make notes to myself. Sometimes I do take down	25	A. We have a medical director, but they're
	259		261
1	a sentence or two word for word if I think it is written	1	not he's not employed.
2	well. And then when I've put papers together, I've	2	Q. So you have volunteers?
3	probably forgot that I was not the original author of	3	A. Right.
4	that. It was certainly not intentional.	4	Q. Is he on site?
5	Q. So do you believe that taking sentences	5	A. You know, we have two other physician
6	directly from someone else's work or from someone else's	6	volunteers, so we frequently have physicians on site.
7	publication constitutes taking someone else's work?	7	Q. How often would you say that happens?
8	A. I never really thought about it in the	8	A. Probably several times a week.
9	context of a sentence or two.	9	Q. Okay. And does Any Woman Can confirm
10	Q. Now that you are thinking about it, do you	10	pregnancy?
11	think it constitutes the taking of someone else's work if	11	A. Yes.
12	you copy entire sentences from other authors?	12	Q. Does it how does it confirm pregnancy;
13	A. I mean, certainly it is the taking of a	13	what kind of tests?
14	sentence, but I don't know how serious that is.	14	A. Urine pregnancy test and ultrasound.
15	Q. And would you agree that a written sentence	15	Q. So urine pregnancy test. Is that, like, the
16	that you create is your work?	16	kind of test you would get from a drugstore?
17	A. Well, if it is a written sentence that I've	17	A. I don't know if it is. It is probably a
18	written it is my work, yes.	18	higher sensitivity, but similar.
19	Q. Okay.	19	Q. So you don't know whether they use any a
20	MS. MURRAY: Do you feel like you need a	20	pregnancy test that's any different from what you would
21	break?	21	buy in a drugstore?
22	THE WITNESS: I'm okay. I can keep going.	22	A. I don't know which one they use
23	Q. (By Ms. Murray) So you're affiliated I	23	specifically, no.
24	believe you talked earlier about an organization called	24	Q. Okay. So it could be the same kind of
25	Any Woman Can, correct?	25	pregnancy test that you could get in a drugstore; is that
L		1	

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

Ingrid Skop, M.D.

	262		264
1	correct?	1	like, an ectopic pregnancy; is that correct?
2	A. It could be.	2	A. That would be our recommendation.
3	Q. Okay. And you said that they do ultrasounds	3	Q. So if you had a patient who came to you with
4	as well?	4	an ultrasound from Any Woman Can, would you rely on it in
5	A. Yes.	5	your practice for the first prenatal visit?
6	Q. What's the purpose of the ultrasound?	6	A. I generally repeat it myself. Not because I
7	A. To document the pregnancy.	7	don't trust Any Woman Can ultrasounds. I feel that
8	Q. Okay. Can they date pregnancies?	8	they're well trained, but I generally do it mostly as a
9	A. Yes.	9	bonding experience with the patient.
10	Q. How do they date them?	10	Q. Uh-huh. And are there is that true of
11	A. Generally pregnancy dating is based upon the	11	all ultrasounds that patients bring to you in your
12	last menstrual period and correlation with the	12	private practice; do you always repeat them anyway?
13	ultrasound. If there's a discrepancy between the two,	13	A. Yeah, I probably do. Depending on their
14	then sometimes the dating changes to correspond to the	14	gestational age, I may wait. If they bring me an
15	ultrasound.	15	ultrasound and they arrive to me at the point where I can
16	Q. Sorry, I should have been more specific.	16	hear the baby's heart beat, I may document it that way
17	What kind of measurements do they use to	17	and then do the next indicated ultrasound at the time it
18	date the ultrasound? Is it the same do they rely on	18	is due.
19	the same measurements that you would use in your private	19	Q. And would you say you are more likely to
20	practice?	20	rely on that ultrasound if it has come from another
21	A. Yes, they do.	21	doctor?
22	Q. Okay. The same exact ones?	22	A. Not necessarily. I think the ultrasounds
23	A. Yes.	23	that Any Woman Can does are well done. Some of the
24	Q. Okay. What about the are they able to	24	physicians that volunteer do the ultrasounds, and the
25	diagnose ectopic pregnancies?	25	nurses that do them have been well trained by a
	263		
	263		265
1	A. They know what to look for. If there was a	1	265 physician.
1		1 2	
	A. They know what to look for. If there was a		physician.
2	A. They know what to look for. If there was a suspicion of an ectopic pregnancy, they would have it	2	physician. Q. Can you ever recall relying on an ultrasound
2 3	A. They know what to look for. If there was a suspicion of an ectopic pregnancy, they would have it confirmed with a doctor.	2 3	physician. Q. Can you ever recall relying on an ultrasound from Any Woman Can in your private practice instead of
2 3 4	 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 	2 3 4	physician. Q. Can you ever recall relying on an ultrasound from Any Woman Can in your private practice instead of repeating it yourself?
2 3 4 5	 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 	2 3 4 5	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
2 3 4 5 6	 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? 	2 3 4 5 6	 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.
2 3 4 5 6 7	 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. 	2 3 4 5 6 7	 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
2 3 4 5 6 7 8	 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 	2 3 4 5 6 7 8	 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?
2 3 4 5 6 7 8 9	 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? 	2 3 4 5 6 7 8 9	 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
2 3 4 5 6 7 8 9 10	 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. 	2 3 4 5 6 7 8 9 10	 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.
2 3 4 5 6 7 8 9 10 11	 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? 	2 3 4 5 6 7 8 9 10 11	 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?
2 3 4 5 6 7 8 9 10 11 12	 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. 	2 3 4 5 6 7 8 9 10 10 11 12	 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
2 3 4 5 6 7 8 9 10 11 12 13	 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? 	 2 3 4 5 6 7 8 9 10 11 12 13 	 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
2 3 4 5 6 7 8 9 10 11 12 13 14	 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 	 2 3 4 5 6 7 8 9 10 11 12 13 14 	 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,
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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 	 2 3 4 5 6 7 8 9 10 11 12 13 14 15 	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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 have to go
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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 have to go to another location to obtain a blood draw?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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 have to go to another location to obtain a blood draw? A. They come on site they also have a mobile van.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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 have to go to another location to obtain a blood draw? A. They come on site they also have a mobile van.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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 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

			ingita ettep, m.b.
	266		268
1	A. We don't do that currently.	1	A. It is generally very quick. I believe we
2	Q. Okay.	2	can get them in that day. We usually have staff there to
3	A. As we expand our services, we may.	3	do that.
4	Q. Uh-huh. So if someone came in to Any Woman	4	Q. Okay. Let me ask you can we turn to
5	Can on a day when Metro Health wasn't present and wanted	5	this is going to be Tab L, and we'll mark it as
6	to obtain STI testing, what would Any Woman Can tell	6	Exhibit 15.
7	them? Would it be able to do full STI testing that day?	7	(Exhibit No. 15 was marked.)
8	A. We can do the gonorrhea and chlamydia,	8	A. Okay.
9	detected in the urine, and we'd bring them back on a day	9	Q. So on page let's see. On page 4 of 7,
10	we were drawing blood.	10	and the page numbering on this is kind of small. It
11	Q. So they would have to come in twice for a	11	says, "Free first trimester ultrasound"?
12	full STI screening?	12	A. Uh-huh.
13	A. If they wanted all that. A lot of them	13	Q. It says, "An ultrasound can answer several
14	don't necessarily want the blood.	14	questions that may give you some clarity if you're
15	Q. In your private office, are you able to do a	15	considering having an abortion"; is that correct?
16	full STI screening on a single appointment?	16	A. Yes.
17	A. We have a full-time lab, yes.	17	Q. Did I read that correctly?
18	Q. Okay. If individuals who suspect or know	18	A. Yes.
19	they're pregnant when they call Any Woman Can to ask	19	Q. But you testified earlier that typically if
20	if they ask whether they can obtain an abortion there,	20	someone obtains an ultrasound at Any Woman Can, if they
21	does Any Woman Can tell them no?	21	then go for another abortion sorry, if they then see a
22	A. We tell them, No, we do not perform or refer	22	doctor in your private practice that you would typically
23	for abortions.	23	perform the ultrasound over again, correct?
24	Q. And do you tell them that at the time of the	24	A. That's what I would typically do, but not
25	call?	25	necessarily all the time.
	267		269
1	A. If they ask, yes.	1	Q. But typically you would perform the
2	Q. So if a patient called Any Woman Can and	2	ultrasound again, correct?
3	said, Can you provide an abortion, the staff would	3	A. Uh-huh.
4	directly tell them, No, we don't provide abortion here,	4	Q. Is that correct?
5	or would you have to come in for an appointment to obtain	5	A. That's correct. Not because I don't trust
6	that information?	6	Any Woman Can's ultrasound; because I like to do ultra
7	A. I think if they asked them straight out they	7	sounds with my patients on their first visit.
8	would tell them that we don't do them.	8	Q. I understand.
9	Q. Okay. And if someone called and said, I'm	9	A. They get to see the baby, and I think it is
10	interested I'm thinking about having an abortion; I	10	a nice kind of way to bond with them.
11	think I'm pregnant, would Any Woman Can tell the	11	Q. So you would typically perform the
12	individual that an abortion could not be received at Any	12	ultrasound again?
13	Woman Can?	13	A. Yes.
14	A. I think what we would do is tell them that	14	Q. Well, let me ask this not specific to you.
15	we can offer options, counseling, and schedule them for	15	But are OB/GYNs competent to provide options, counseling,
16	an appointment.	16	to patients about their options if they have an unplanned
17	Q. But you wouldn't tell them at the time of	17	pregnancy?
18	the call, unless they directly asked, that Any Woman Can	18	A. I think so.
19	does not provide abortion, correct?	19	Q. So they could get the services of Any Woman
20	A. I believe that that is not the policy, to	20	Can with respect patients could get the services of
21	offer that information if they don't ask.	21	Any Woman Can with respect to a first trimester
22	Q. If they don't ask, okay.	22	ultrasound from an OB/GYN in private practice, correct?
23	And when you do you know what the wait	23	A. They can. Everything Any Woman Can does is
	at the first state of the state	0.4	for a second
24	time is to get an appointment for a pregnancy test at Any	24	free.
	time is to get an appointment for a pregnancy test at Any Woman Can?	24 25	free. Q. But they could get those services elsewhere,

Ingrid Skop, M.D.

	270		272
1	correct?	1	Q. Would you say you're intimately involved
2	A. Sure. Yes.	2	with their affairs?
3	Q. And if they eventually let me ask this.	3	A. On the state level, yes.
4	Does Any Woman Can provide prenatal care?	4	Q. What other level would there be?
5	A. No, they do not.	5	A. It consists currently of eight functioning
6	Q. Okay. So, eventually, someone who is	6	clinics, and I'm not involved in the day-to-day affairs
7	pregnant and is not planning to end the pregnancy will	7	of the individual clinics.
8	have to go to another provider for prenatal care; is that	8	Q. I see. And all of the clinics are in Texas;
9	correct?	9	is that right?
10	A. That is correct.	10	A. That is correct.
11	Q. So what is the value of the first trimester	11	Q. Okay. To your knowledge, are any of The
12	ultrasound that Any Woman Can provides?	12	Source locations located near clinics that provide
13	A. It helps them to see the humanity of their	13	abortion?
14	baby. It does provide confirmation and viability when we	14	A. It is possible. I don't know how close they
15	see the heartbeat.	15	are.
16	Q. And to be clear, you've used that term,	16	Q. Would you see that as a I'll leave that.
17	viability, multiple times today. Went you say viability,	17	What about The Source; does it employ
18	you don't mean ability to survive outside of the uterus	18	medical professionals?
19	for a sustained period of time, right?	19	A. Yes, it does.
20	A. Right. In that context, I'm referring to a	20	Q. What kind?
21	heartbeat and evidence that it is not a miscarriage.	21	A. Several of the clinics, not all of them, but
22	Q. So they can see the fetus; they can	22	several provide women's health care and employ OB/GYNs
23	determine whether there's a heartbeat. Anything else?	23	and nurse practitioners.
24	A. It gives us an opportunity to provide the	24	Q. Okay. And the others, who do they employ?
25	support that many of them are looking for, counseling,	25	A. Some of them are working their way up to
	271		273
1	resources, relationship counseling.	1	that. The goal is that all of them are going to provide
2	Q. Okay. Are you aware of any information or	2	those services as well as contraception, but it is a work
3	data with respect to the number of women who come to Any	3	in progress. Some of them are not there yet.
4	Woman Can with an unplanned pregnancy and who ask for	4	Q. Would you consider the facilities that The
5	referrals to abortion providers?	5	Source and Any Woman Can runs, would you consider those
6	A. I'm not aware of data. But, again, in San	6	crisis pregnancy centers?
7	Antonio, you don't need a referral to go to an abortion	7	A. That's a name that some would give them,
8	provider.	8	yes.
9	Q. Does it happen that patients come to Any	9	Q. But they don't The Source doesn't provide
10	Woman Can and ask for referrals to abortion providers	10	abortions either, correct?
11	with names, contact information of local abortion	11	A. That's correct.
12	providers?	12	Q. Can we turn to Tab M in what I'll mark as
13	A. I don't know. It is possible.	13	Exhibit 16?
14	Q. And it is okay.	14	(Exhibit No. 16 was marked.)
15	Do you know whether Any Woman Can has been	15	Q. Is this the does this appear to be from
16	the subject of complaints to the Texas Medical Board, the	16	the website of The Source, Dr. Skop?
17	Board of Nursing or the Better Business Bureau?	17	A. Yes, it does.
18	A. I'm not aware of that.	18	Q. Do you see that on the first page it says
19	Q. Any other licensing or regulatory body?	19	this is a printout I'll say Exhibit 16 is a printout
20	A. No.	20	of the welcome page from The Source. On the front page
21	Q. You're also affiliated with The Source,	21	it says, "Your place for women's health. The Source is a
22	correct?	22	full-service women's health clinic empowering women with
23	A. That's correct.	23	better choices."
24	Q. What is your role there?	24	A. Yes.
25	A. I'm a board member.	25	Q. You mentioned earlier about the statistics
1		1	

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

Ingrid Skop, M.D.

			lingina entop, m.b.
	274		276
1	about the share of women in the United States who have	1	you don't know any abortion providers well, correct?
2	abortions. What are those?	2	A. But I don't know them personally, but I
3	A. It is estimated that one out of four to one	3	know of them. And there are three clinics in town. And,
4	out of three women have had abortions?	4	to my knowledge, none of those doctors have offer full
5	Q. By the age of 45, correct?	5	gynecologic services.
6	A. Yes.	6	Q. If we can get back to my question.
7	Q. Do you think it is accurate to say a women's	7	Do you I take it your position is
8	health clinic is full service when it does not offer a	8	full-service women's health clinic is accurate because
9	gynecological service that one in four women will use?	9	abortion is not a service. Do you think that your
10	A. In my opinion, abortion is not women's	10	understanding of what the term full-service women's
11	health care. It is disrupting a normal, physiological	11	health clinic is consistent with the expectations of what
12	process.	12	your patients, for example, would interpret that term to
13	Q. But it is provided by gynecologists,	13	mean?
14	correct?	14	
			A. I do. I think it also is consistent with
15	A. It is generally provided by abortion	15	what most OB/GYNs in this country believe. If this was a
16	specific doctors. Most OB/GYNs in private practice do not do abortions.	16 17	needed medical service, every OB/GYN would do it. There
17			have not been
18	Q. But many OB/GYNs do do abortions, correct?	18	Q. Can you provide I'm sorry. You mentioned
19	A. The OB/GYNs who perform abortions,	19	earlier that you can't provide abortions in your
20	typically, that is their career. They don't it is	20	hospital, correct?
21	rare to find an abortion provider who also does a full	21	A. Right.
22	obstetric has a full obstetric practice.	22	Q. If someone wanted to provide abortions in
23	Q. Dr. Skop, how many abortion providers would	23	your practice, could they do it?
24	you say that you know well?	24	A. No.
25	A. I don't know any well. I yeah.	25	Q. No. Okay. What about if we can look at
	275		277
1	275 O Okay So your information about the caroors	1	277
1	Q. Okay. So your information about the careers	1	this the Tab M, Exhibit 16 again. On page 3, it says,
2	Q. Okay. So your information about the careers of abortion providers is coming from where?	2	this the Tab M, Exhibit 16 again. On page 3, it says, "If you're facing a pregnancy you didn't intend and are
2 3	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	2 3	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
2 3 4	 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 	2 3 4	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
2 3 4 5	 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. 	2 3 4 5	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?
2 3 4 5 6	 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. 	2 3 4 5 6	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.
2 3 4 5 6 7	 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. 	2 3 4 5 6 7	 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
2 3 4 5 6 7 8	 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 	2 3 4 5 6 7 8	 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,
2 3 4 5 6 7 8 9	 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 	2 3 4 5 6 7 8 9	 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?
2 3 4 5 6 7 8 9 10	 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? 	2 3 4 5 6 7 8 9 10	 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
2 3 4 5 6 7 8 9 10 11	 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 	2 3 4 5 6 7 8 9 10 11	 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.
2 3 4 5 6 7 8 9 10 11 12	 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 	2 3 4 5 6 7 8 9 10 11 12	 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
2 3 4 5 6 7 8 9 10 11 12 13	 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 	2 3 4 5 6 7 8 9 10 11 12 13	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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, 	2 3 4 5 6 7 8 9 10 11 12 13 14 15	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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? 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 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.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 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. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 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?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 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

Sep	otember 02, 2020		Ingrid Skop, M.D.
	278		280
1	creating a model that can be replicated to create more	1	today that you would like to amend or add to?
2	clinics like this that are that take into account	2	A. No.
3	women's emotional and mental health, spiritual health, as	3	Q. And during the break, did you have any
4	well as physical health.	4	conversations with anyone other than Mr. Sorenson?
5	Q. What's your role in that?	5	A. No.
6	A. I'm well I'm a board member, but I'm sort	6	Q. Okay. Before I have some wrap-up
7	of the medical consultant on that.	7	questions, but I guess one question I did want to return
8	Q. You're the medical consultant. But you	8	to that we had talked about this morning I asked you,
9	don't know whether the clinics are up front with people	9	if you recall, how you came to be an expert in this case,
10	that they do not provide abortion if someone asks over	10	and you indicated, at the time, that you didn't have any
11	the phone?	11	recollection as to who contacted you about the case; is
12	A. I would assume that they are. I haven't	12	that correct?
13	checked that out myself, but I would assume that they	13	A. That is correct.
14	are.	14	Q. And at this point in time, now that you've
15	Q. And do you know whether there is any data	15	had a few hours since then have you recalled any
16	information about the number of patients or the number of	16	information about how you found out about this case?
17	individuals who come to The Source for services and	17	A. I don't remember for sure. As we discussed,
18	believe they might be able to obtain an abortion there?	18	the expert witness training that I had with Charlotte
19	A. I don't know any data on that.	19	Lozier, it may have been Charlotte Lozier.
20	Q. Does it happen?	20	Q. So you did the training with Charlotte
21	A. It probably does. Probably people go to	21	Lozier, and then, perhaps, they reached out to you to be
22	Planned Parenthood and think they can get prenatal care	22	an expert after that?
23	too; they are wrong.	23	A. I think that might have been the case.
24	Q. That is not responsive to my question,	23	Q. Okay. Do you recall who at Charlotte Lozier
25	Dr. Skop. If we can stick to the questions.	25	reached out to you?
		20	
	279		281
1	So is it your testimony that I think you	1	A. No.
2	said both with respect to The Source and Any Woman Can	2	Q. When you did the training at Charlotte
3	that you're not certain where it could happen that	3	Lozier, was that because you were hoping to become an
4	people come to the clinics and believe that they might be	4	expert in abortion cases?
5	able to obtain abortions there, correct?	5	A. As I mentioned, the training also
6	A. It is possible that people do.	6	incorporated media training. And, at that point, I was
7	Q. Have you ever confirmed that people have?	7	getting some opportunities to speak to reporters, and I
8	A. No. I haven't asked that specific question.	8	think I was interested to learn all of it, but,
9	Q. Okay. Do you know whether The Source has	9	primarily, I was interested in learning how to give good
10	ever been the subject of complaints to the Texas Medical	10	interviews.
11	Board, the Board of Nursing, or the Better Business	11	Q. That actually reminds me of something else.
12	Bureau?	12	Are you on a national fetal tissue research board of some
13	A. I'm not aware of any complaints.	13	kind, Dr. Skop?
14	Q. And any other licensing or oversight body?	14	A. Yes. There was an NIH Fetal Tissue Research
15	A. Not that I know of.	15	Ethics Review Board, and I was a member of that.
16	Q. Okay.	16	Q. Are you a member still?
17	MS. MURRAY: I think that is probably close	17	A. Yes, if it meets again.
18	to the end. Can we take a quick break just to make sure	18	Q. And that wasn't on your CV, correct?
19	that everything is set, and then I think we're getting	19	A. I believe it was.
20	close to the end? Why don't we break for ten minutes,	20	Q. Oh, maybe I missed it. I apologize.
21	and come back.	21	A. It wasn't on the initial CV you got, but I
22	(Recess from 4:14 p.m. to 4:28 p.m.)	22	added. It is under professional
23	MS. MURRAY: Welcome back from the break.	23	Q. Oh, I see. Okay. All right. I skimmed too
24	O (De Ma Merrary) Defensive activity of easing	24	quickly.
	Q. (By Ms. Murray) Before we get started again,	24	quickly.
25	Q. (By Ms. Murray) Before we get started again, Dr. Skop, is there anything from your prior testimony	24	Okay. With that so we're getting close

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

Ingrid Skop, M.D. 282 284 1 to the end. Before we wrap up, are there any answers to 1 to what you've told us so that we can understand your 2 my questions that you want to change before we close the 2 perspective or viewpoint more clearly? deposition? 3 3 A. I think that my expert witness report 4 A. I don't think so. 4 clarifies my position on all of this. I don't think 5 Q. And is there any information I asked you 5 there is anything additional. about that you remember now that you didn't recall when I 6 6 Q. Okay. So when I asked you earlier whether 7 7 asked a question about it? all of the opinions that you intend to testify to are 8 8 A. No. Just the discussion about the sentences contained in your expert report, is that still your 9 that were -- that were the same. I still cannot tell you 9 answer that, yes, they are? 10 if I wrote those, but I thought that I did. 10 A. Yes, they are. 11 Q. All of them? 11 Q. Okay. Anything else that you want to add? 12 A. Well, I think the Fetal Pain possibly came 12 A. No. 13 Q. So with that, I think this deposition is 13 from somewhere else, but, like I say, the way that I do 14 research, I write stuff down, and then later on I put concluded, subject to the right to re-call the witness 14 15 together papers and articles. And I think I may have 15 for further questioning should that be required. 16 inadvertently taken wording that I thought I wrote that, 16 MS. MURRAY: I will say, Lance, I think 17 in retrospect, I may have just used from someone else. 17 we're going to follow up with a letter requesting 18 Q. Uh-huh. And earlier, though, you testified 18 documents -- some documents that have been discussed 19 that you didn't see it -- and I don't remember your exact 19 today. I can follow up in writing. I know it's been a 20 words, but that you were uncertain why there would be a 20 long day. 21 concern about taking sentences from someone else's 21 MR. SORENSON: Okay. 22 publication; is that correct? 22 MS. MURRAY: All right. We have nothing 23 A. Yeah, I -- yes. 23 further. Thanks everyone. 24 Q. Is that still your position? 24 (Signature requested.) 25 A. Well, obviously I would not have done it 25 (Whereupon the taking of this deposition was 283 285 concluded at 4:37 p.m.) knowingly, but I think in all of these reports and 1 1 2 * * 2 articles that I've written, they've been primarily my 3 thoughts and my reports. 3 A reading copy of the Original transcript was submitted to Mr. Sornesen for witness review. 4 Q. When you say that you wouldn't have done it 4 5 5 Original transcript filed with Ms. Murray. knowingly, why not? 6 6 A. Well, I would have just reworded it in my 7 7 own words, had I recognized that it was from someone 8 else. 8 9 Q. Because you think there's some problem with 9 10 10 taking full sentences from other authors? 11 11 A. I don't think that's particularly 12 problematic, assuming one has done the research. But, 12 13 obviously, your line of questioning seems to indicate 13 14 14 that there is an appearance of impropriety of that. 15 Q. So it is your testimony that you don't think 15 16 16 it is problematic --17 17 A. I don't think it is problematic --18 18 Q. -- to take whole sentences from other authors? 19 19 20 A. Right. Because I've gone to the source; 20 21 21 I've verified the information. And what's included in 22 22 the expert witness report is my well-researched expert 23 23 witness testimony. 24 24 Q. Okay. So -- I think we'll leave it at that. 25 25 Is there anything that you would like to add

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

Ingrid Skop, M.D.

	286	
1	CERTIFICATE	
2	STATE OF UTAH)	
)	
3	COUNTY OF SALT LAKE)	
4		
5	I HEREBY CERTIFY that I have read the	
6 7	foregoing testimony and the same is a true and correct transcription of said testimony except as I have	
8	corrected, initialed same, and indicated said changes on	
9	enclosed correction sheet.	
10		
11		
	INGRID SKOP, M.D.	
12		
13	Cubaanibad and guarm to at	
14	Subscribed and sworn to at	
11	this day of, 2020.	
15		
16		
17		
18		
	Notary Public	
19		
20 21		
21	My commission Expires:	
22		
23		
24		
25	* * *	
	287	
1		
	CERTIFICATE	
2	CERTIFICATE STATE OF UTAH)	
2	CERTIFICATE STATE OF UTAH))	
2	STATE OF UTAH))	
3	STATE OF UTAH)) COUNTY OF SALT LAKE)	
3 4	STATE OF UTAH)) COUNTY OF SALT LAKE) THIS IS TO CERTIFY that the deposition of	
3 4 5	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,	
3 4 5 6	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	
3 4 5 6 7	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.	
3 4 5 6 7 8	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	
3 4 5 7 8 9	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	
3 4 5 6 7 8 9 10	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.	
3 4 5 6 7 8 9 10 11	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	
3 4 5 6 7 8 9 10 11 12	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	
3 4 5 6 7 8 9 10 11 12 13	<pre>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</pre>	
3 4 5 6 7 8 9 10 11 12 13 14	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,	
3 4 5 6 7 8 9 10 11 12 13 14 15	<pre>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.</pre>	
3 4 5 6 7 8 9 10 11 12 13 14 15 16	<pre>STATE OF UTAM)) 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. </pre>	
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	<pre>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</pre>	
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	<pre>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</pre>	
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	<pre>STATE OF UTAM)) 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.</pre>	
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	<pre>STATE OF UTAM)) 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</pre>	
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	<pre>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.</pre>	
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	<pre>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.</pre>	
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	<pre>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.</pre>	
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	<pre>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.</pre>	
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	<pre>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.</pre>	

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

2

130:22 136:12,13 140:6,

Exhibits Skop Exhibit 01 29:16, 18,20 Skop Exhibit 02 98:13,15 164:18 173:21 186:15 197:3 Skop Exhibit 03 110:18 Skop Exhibit 04 157:10 170:14 Skop Exhibit 05 170:18, 20 Skop Exhibit 06 172:4 Skop Exhibit 07 172:24 173:1 Skop Exhibit 08 177:23, 24 178:7 252:5 253:21 255:5 257:18 Skop Exhibit 09 181:16, 18 183:14 Skop Exhibit 10 234:7,8 237:22 238:1,25 Skop Exhibit 11 237:23 238:2,9 241:14 Skop Exhibit 12 238:3,10 243:4 Skop Exhibit 13 245:19, 23 248:19,22,23 Skop Exhibit 14 246:13, 14 253:3 254:12 255:21 Skop Exhibit 15 268:6,7 Skop Exhibit 16 273:13, 14,19 277:1 \$ **\$10,000** 104:9,12 **\$300** 22:25 \$350 23:10 \$5,000 104:7 \$500 78:5 124:25 0

0.7/100,000 174:1

1

1 29:16,18,20 98:22 130:22 183:15,23,24 **1,500** 125:1 126:4 127:7 **1.3** 181:12 1.7/100,000 174:4

1996 32:14 **10** 34:20,25 36:3,20 167:10,15 234:7,8 237:22 238:1,25 **10,000** 125:2 126:5 127:7 **100** 34:5 **2** 38:24 98:13,15 106:12,22 **11** 237:23 238:2,9 241:14 **110** 34:5 85:1 247:13 110-fold 86:5 11:49 149:7 **12** 38:19,21 118:12 238:3, 10 243:4 12:30 149:4 12:33 149:7 **13** 38:19,21 124:19 201:17 234:10 245:19,23 248:19, 22,23 **130** 180:3 134 180:22 **135** 181:17 **14** 49:18 50:8,12 200:12,20 201:6,17 209:22,25 211:6 246:13,14 253:3 254:12 255:21 14-plus 201:6 **15** 7:16 30:18 33:9 36:4,20 54:25 80:13 174:2 177:10 219:16 220:3 227:12 245:14 268:6,7 15-fold 165:20 **16** 50:2 51:24 71:5 177:10 180:17 181:11 273:13,14, 19 277:1 **17** 177:9 **18** 25:3,9,10,15,16 38:6,11 50:2 51:7,19 67:7,12,19 68:25 69:3,14 70:1,13,21, 24 74:7,19 91:17 94:4,8 95:3,6,13 123:12 127:23 128:3 132:24 133:23 161:9,24,25 174:21,23 175:6,11 176:1 181:4,14 186:19,25 187:1 188:7,13 189:21 202:18.23.25 203:24 213:16,19 214:5 230:3,21 18-plus 181:2 18-week 133:16,19,23 161:3 174:9,16 175:20 177:3 199:10 200:5 203:4, 13 18-week-old 133:15 **19** 187:18 1950s 86:10 1970 128:19

1990s 220:10

130:22 136:12,13 140:6, 17,20,21 164:18 173:21 186:15 197:3	30,00
2,000 179:17,24	30-fo
20 7:16 22:21 27:7 30:17	30-y€
31:20,21 34:9 39:6 70:3	300
73:13 74:19 75:3 78:1 79:18 140:19 149:18	32 2
152:11 154:7,8 155:13	33 14
180:23 181:4,5,13,14 187:18 196:25 200:12,20	35 2
202:13 220:11	350
20- 207:21	39 4 ⁻
20-plus 181:1	3:15
20-week 155:11	
2005 221:9	
2011 254:23	4 105
2013 27:4	128:
2016 73:25	180:
2017 238:13	248:
2018 220:10,14	40 34
2019 103:24 234:10 248:25	45 14
249:4 254:20	4:14
21 187:18 208:1	4:28
21-week 207:22	
22 69:3 73:13 79:18 81:21 176:2 181:5,13 186:20	
187:18 188:7,13 189:21	5 37:
202:5,6 207:23 208:10	164:
22-week 207:17	170:
22-weekers 207:21 208:16 209:10	50 34 85:2
24 6:14 81:21	253:
24-hour 30:21	500
25 27:21 30:19 49:15 51:5	51 2
67:1 70:6 114:1,23 254:2, 16	52 2
259 183:14,22	56 2
26 202:4	57 1
27 195:24	5:00
29 67:1	——
2:11 214:10	
2:34 214:10	6 145
	186:
3	6,000
	60 34
3 38:24 85:4 110:18 128:17 136:12,13 140:7,17,20,21	600 ·
277:1	6:00

Ingrid Skop, M.D.

3,000 180:15 3.4/100,000 174:6 **30** 27:10 30:19 72:7 75:7 86:14 108:6 174:4.10.18 175:13,21 177:4,6 202:4, 13 **00** 179:11 old 165:21 ear 194:21 22:24 180:3 54:4,18 45:16 146:11,14 54:6,21 23:9 1:6,25 42:2 33:21 4 5:22 120:10 124:8 :17 143:13,14 145:14, 47:19 157:10 170:14 :17 181:11 209:8,11,12 :25 268:9 84:17 156:10 48:25 274:5 279:22 279:22 5 :15,17 38:10 127:11 :17 167:10,13,15 :18,20 4:20.23 75:9 77:12 2 137:15 156:10 252:18 :21.24 254:13 45:22 54:16,18 126:21 254:5,18 253·4 55:5.22 78:7 33:22 6 5:2 172:4 173:19 185:3 :13,15 187:15 219:24 **0** 66:25 4:20.23 54:3 214:23 216:1

7 **7** 172:24 173:1 197:2,6 268:9 700 54:3,16,18 126:21 **72** 225:21 254:8,22 **73** 246:21 **74** 246:21 76 174:6,10,18 175:13,21 177:4,6 76-fold 165:21 7:45 33:21 8 8 177:10,23,24 178:7 252:5 253:21 255:5 257:18 8.9/100.000 174:7 80 34:9 39:7 9 **9** 171:3 181:16,18 183:14 **92** 79:22 **94** 156:12 96 79:22 114:25 115:3 **97** 121:18 9:00 33:22 9:33 65:7 9:45 65:4 9:48 65:7 Α a.m. 65:7 149:7 AAPLOG 17:9,10,16 18:3, 6 19:7 56:7 101:7 102:3 234:4,9,18 235:7,10 236:11 238:12,24 239:3 240:22 241:1,9,15,21,25 242:11,22,24 243:10 244:18 245:16 256:24 AAPLOG's 101:19 241:19 abdomen 44:14 ability 46:21 58:5 111:23 199:16 270:18 ablation 39:13 abnormal 47:17 86:6 88:1 89:20.24 90:19 abnormalities 263:19 abnormally 84:25 90:6 Abort73 121:12.24 122:9

Abort73.com 120:17 abortion 7:21 12:22 13:16 14:8 18:1 19:3 25:3 26:16 27:7,8,9,11,23 28:5,17 52:15 53:6 55:16,20,24 56:1,2,5 57:20,22,24 58:3, 5,10,21,24 59:1,5,10,16, 18,24 60:14,16,23,25 61:3, 11,18 62:9 66:21 67:4,7, 12.19 68:24 69:2.5.14 70:12,17,18,20 72:17 73:5, 6,13,16,20,23 74:3,6,10, 17,18 75:12 76:5,20,21,25 77:8,16,21 78:4,5,11,23 79:1,18,24 80:8,9,15,16, 19,22 81:4,9,23 82:12,14, 22,25 83:10,13,20,21 84:9, 12,19 85:15 87:8,13,17,19 88:7,9,20,23 89:1,6,8,10, 24 90:17 91:14.17 92:2.5. 8,9,12,20 93:9,11,16,25 94:4,19,25 98:5 106:4 107:17,21,23 108:3,7 109:20 110:2,5 111:12,22 112:11,22,24 113:1,15,17 114:10,15,19 115:14,25 116:13 117:3,8,16 118:10, 24 119:2 120:8,14,21 124:18,21,25 125:11 126:7 128:6,8 129:3,12 130:1,18, 19 131:17,23 132:17 144:3,5,11,18 145:11,19 146:1,2,8,10 147:10,16 148:2,14 152:12,17 153:7, 12.17 154:13 155:18.20 156:23 161:4 162:20 163:9,16,23 165:15 166:11,23 171:6,9,13,16, 21 173:23 174:1,4,11,14, 19,20,24,25 175:11,16,23, 25 176:7,15 177:6,15,16, 17 178:1,12,16,18,23,24 179:3,4,13,18,25 180:11 181:2 182:1 183:11 184:25 185:5,16,23 186:2,5,9 187:4,11,16 188:8 190:5,7, 17 192:15 194:2,18,24 195:15,16,17,22 196:3,5, 10 213:15,19 214:5 220:14,20,22,24 223:14, 19,20,22,25 224:6,12 225:5,9,14,25 226:8,11,12, 15,18 228:2,7,13,15,17 229:1,10,15,18,25 230:12, 22 231:1,8,12,13,16 233:23 241:11 243:22 245:20 247:13 248:19,20 252:5 253:12 254:4,8,18, 22 255:13,16 256:6,8,10, 11 257:17 266:20 267:3.4. 10,12,19 268:15,21 271:5, 7,10,11 272:13 274:10,15, 21,23 275:2,10,17,23 276:1,9 277:3,8,11,13,16 278:10,18 281:4

abortion,' 106:4 abortion-associated 153:21 187:8 abortion-related 150:10. 15,25 151:3 156:5 164:11 172:5,11 173:2,5,10 187:5 abortionist 59:21 62:18 108:22 145:6 170:1 abortionists 27:20 127:15 144:13 167:11 275:5 abortions 13:18 57:7,10 58:1 66:1 68:6 69:13 70:1 71:8 72:20 73:3,10 74:8,12 75:5 77:18 82:3 83:16,19 85:18 89:3,8,18 91:6,7,9, 25 94:7 105:21 106:2,9 107:12 108:5,15,20 109:5, 10,16,18,21 110:20 111:17 113:4,18 115:1,13,16,19 116:7 121:18 123:7,12,17 124:10,12,16,20 125:21 132:10 134:19 144:4,23,24 145:12 146:23 147:3 148:10 149:14,17 151:5,6, 13,15 155:15 156:13 161:15,25 165:25 167:13 174:2 175:4,18 176:1,3 177:9,20 179:11,24 180:7, 16,22 182:7,8,9,17,22 184:1.6.20 185:21 186:1 187:25 189:11 190:4 191:5 192:2 193:9 196:11 213:24 214:3 223:8 224:13 233:1 241:6,7 254:5,8,19,23 260:19 266:23 273:10 274:2,4,17,18,19 276:19, 22 279:5 Abroad 178:2 252:6 abruption 90:6 252:22 253:14 absence 212:20 213:5 absolute 126:9 Absolutely 108:13 academic 84:1 251:6,13, 22 252:2 academicians 83:17 Academies 150:6 178:11 246:23 Academy 148:2 accepted 250:17 accepts 232:25 access 16:4 63:24 236:20 accident 15:11 accidentally 157:19 accompany 255:11 accompanying 256:3 account 177:18 278:2

accreta 84:24 85:15 87:1 143:6,7 256:22

accuracy 99:25 151:17

accurate 8:22 11:10,12 12:3 15:25 28:23 29:24 44:7 59:8,15,19 98:14 100:25 107:14 109:13,19 110:10 112:15 120:24 121:17 122:23 150:13 151:9 168:25 169:13 175:23 182:10 224:16 274:7 276:8

accurately 9:12

accused 227:23

acknowledge 82:15 185:23 188:6 241:9

acknowledged 185:2 191:8

ACOG 55:9,11,12 56:16, 17,21 62:21 99:20 181:17 236:14

ACOG's 63:17 181:10

act 12:13 115:21

active 34:2 activities 72:21 255:15 256:8 260:15

Acton 26:7

actual 103:10 109:14 197:9 200:2

acuity 209:13 add 30:6 65:10 139:8 149:10 214:13 280:1 283:25 284:11

added 281:22 addition 15:22 23:25

31:13 51:11 72:17 182:6 255:12 256:5

additional 22:21 86:22 100:16 124:5 142:7 153:14 165:2 186:23 220:5 275:16 284:5

Additionally 182:8 additions 239:6

address 68:19 99:11 184:24 215:18 216:4,11 277:8

addressed 69:1

addresses 113:12 147:1 adhere 90:7 98:10 adherence 252:21 253:13 adjacent 252:24 253:16 administer 141:20 205:22 administered 42:19 43:4,

admission 136:3

admissions 275:14 admit 83:19 275:13 admitted 76:3 Admittedly 249:23 admitting 27:25 adopt 58:15 adoption 60:5,6,23 119:22,23 120:3,7 adrenalin 212:18 adrenaline 212:6 adult 204:17 adults 204:6 advance 163:3 208:23 Advancing 83:22 adverse 46:8 135:8,10,13 159:4 193:5.19 adversely 255:11 256:4 advice 55:14 78:3 218:24 277:23 advise 60:15 advised 5:15 216:18.22 advocacy 55:16,20 56:1,2, 11,15,18 83:22 148:14 advocate 171:9 advocated 225:12 232:3.6 advocates 55:24 77:21 196:3 advocating 162:19 affairs 272:2.6 affect 123:12 affiliate 179:22,23 affiliated 17:8 33:13 83:21 244:18,20,22 259:23 260:2 271:21 affiliates 232:7 affiliation 17:16 affirm 118:16,17 afford 125:16 afraid 53:18 age 38:4 41:7 51:10 67:10 68:6 97:6 116:10 125:1 180:3.7 184:1 191:23 199:14 200:11 205:10,16 206:16 228:19 264:14 274:5 agencies 60:7 232:23 ages 81:21 208:14 aggravation 158:13 agree 11:6 25:19 55:19 57:8 67:24 69:4 108:11 117:3 122:2,5 123:11 126:3.5 155:8 164:8 181:1 188:25 189:6 190:24 198:2

202:15,23,25 203:12,17 248:9 257:7 258:12 259:15 260:14 agreed 200:17 258:18 agreeing 202:20 agreement 24:1 agrees 68:10 ahead 110:15 133:9 234:6 237:14 ahold 154:12 alive 226:10 allotted 189:16 allowed 90:1 176:1 allowing 86:16 147:7,11 alongside 95:19 altered 107:24 altern 57:16 alternatives 57:17 altogether 175:4 **AMA** 63:2 ambulatory 27:11 amend 214:13 280:1 America 84:1 90:10 179:6 American 55:6 56:8 62:25 63:20 68:9 83:16 Americans 108:4 amicus 56:4 amniocentesis 88:11,12 210:18 amniotic 210:20 amount 20:8 45:19 127:6 185:12 215:14 251:4 analgesia 205:6,14,17,22 207:9 analysis 106:24 107:5 182:20 analyzing 144:10 191:5 anecdotal 208:4 anecdotally 182:6 anemia 45:1,9 206:7 anesthesia 44:11 **Angeles** 179:10,22 animal 204:20.21 animals 204:22 anniversaries 256:9 anniversary 255:16 256:11 annual 109:9 114:25 117:14,15 118:2 annually 109:5 annuals 34:4

anomalies 121:20 123:8 193:8 answering 9:14 answers 8:6,15,16,22 9:11 11:10,12 112:10 150:21 282.1 antenatal 208:11,21 antepartum 81:19 Anthony 22:2,4 244:23 antibiotics 93:19 136:2 137:9 141:7 anticipate 24:14 Antonio 40:13 97:23 271:7 anxiety 186:7,8 anymore 88:12 118:23 apologies 32:5 81:12 236:24 apologize 21:18 103:25 257:21 281:20 apparent 246:25 247:18 apparently 16:3 154:13 222:15 235:14 236:17 appearance 263:14 283:14 appeared 226:20 appears 208:18 235:20 applied 43:14 applies 231:11 apply 37:10 146:1 179:3 199:20,22 appointment 35:23 263:5, 11 266:16 267:5,16,24 approach 144:3 145:19 146:10 approaches 17:4 146:14 approximately 50:8 214:22 220:11 arch 201:9 area 58:17 66:17 88:2 91:3 97:11 115:17 160:25 163.21 areas 65:19 66:14 arrange 40:7 arrive 217:15 264:15 arrived 219:9 article 14:3 15:23,24 106:13,16,19,21,25 107:10,22 110:6,8,13,24 112:2 172:5,9,13,20 173:1, 4,6 178:1 194:15 246:6 247:13 249:9,20,24 250:1, 20 251:1 252:5,13 253:20, 23 256:20,22 articles 11:16 12:18 13:5, 8,13,15,16,17,19,24 14:12,

15,16,19 63:23 64:7 69:5 77:24 111:3,6 147:10 191:16 195:11 220:9,16 223:8 225:25 245:6 246:1 250:2 282:15 283:2 ascribe 200:1 Asherman's 92:13,18 93.6 10 asks 57:24 59:22 278:10 aspiration 44:11 assertion 174:19 assess 153:16 156:16 assessing 156:25 157:2 assets 52:8 assist 49:25 associate 18:19 association 18:17 56:8 63:1 197:7 198:3 233:13 assume 6:13 9:6 108:11 117:22 160:6 177:13 205:1 209:9 211:5 250:22 277:18,21 278:12,13 assuming 110:8 145:21 249:17 283:12 assumption 174:20,22 175:2 203:9 assumptions 102:24 attached 119:11 attempting 47:23 attend 208:14 attention 116:13 158:1 215:10,23 216:7,17,20 attributable 86:6 attribute 89:6 93:15 attributed 72:17 258:22 attribution 251:6.12.21 258:2 author 246:5 249:13,19 250:3,21 251:5,12,20 252:15 258:1 259:3 authored 107:23 108:1 171:8 236:9 245:21 authoritative 64:4,9 authorities 79:11,14 authors 13:19 196:9 241:5 250:17 259:12 283:10,19 automatically 76:7 autopsy 51:15 Autry 145:14 147:18 average 34:4 54:1 124:24 162:5,8,11

aware 19:18,20 24:12 44:5 81:24 114:24 132:13 148:8 173:12 192:17 193:1

207:25 235:19 271:2,6,18 279:13

В **B-A-T-E-S** 221:12 babies 30:18 31:1 39:19 67:1 80:21 97:6,7 191:2 202:5,7 207:14 208:12 209:5,22 214:1,3 226:10 babies' 212:24 baby 6:8 40:23 46:7,22,23 47:22 51:10.14 58:11.15 59:4 113:8 119:21 120:3 132:19 133:4 146:1.3 159:9 174:24 175:8 176:21.24 205:14 207:7.12 208:15,18 209:15 210:20 228:6 269:9 270:14 275:20 baby's 264:16 **back** 15:6 21:3 37:18 38:2 47:7 60:12 65:8 73:17 88:6 98:17,24 110:4 112:19 115:7 118:6 120:10 124:18 126:19 133:21 134:21 136:22 144:9 145:2 149:4, 8 150:4 163:8 203:11 207:5 212:14 213:14 214:11,18 223:9 232:16 247:12 252:4 253:20,23 255:4.21 266:9 276:6 279:21.23 background 29:13 85:10, 11 backing 68:17 backs 89:13 bad 20:15 135:14 167:22 bag 30:25 balloon 42:25 43:7.8.10.13 ballpark 104:1 ban 224:8,10,11,12 225:5 230:10,11 bank 85:7 Baptist 32:18,21,25 33:3, 5,7,8,10,13 132:3,9 134:17,23 bar 202:2 barred 10:23 11:2 barrier 54:19 58:5 126:6,8, 9,11,25 127:4,5,8 Bartlett 172:13 173:3,4 176:2base 97:1,3,10 113:2 based 7:23 37:14 52:13 89:8 105:8 113:17 114:12 116:3 121:15 123:10 126:16 135:11 146:21 151:5,6,13 152:21 160:13

 Bixby 147:9
 briefing 244:5

 180:14 188:25 191:16
 black 34:20 24

195:12 200:24 213:25 239:3 247:6,22 249:9 262:11 **baseline** 190:9,16 bases 164:5 Basically 45:7 basis 228:16 243:18 Bates 221:5,10,12 beat 28:17,19 264:16 **bed** 220:5 began 66:8 101:19 219:4, 25 220:2 begin 39:25 49:4 200:10 beginning 52:17 begs 183:10 begun 50:21 behave 202:6 behavior 153:10 189:25 beings 179:15 beliefs 230:18 believed 107:9 believes 115:14 163:22 beneficial 192:1 benefits 57:17,19,21 115:14 Berg 165:17 172:13 176:2 Bernard 213:22 bias 241:9 242:22 biased 241:7 bibliography 149:13 **big** 156:1 206:11 233:7,19 **bigger** 50:20 **bill** 179:10 binder 107:2 218:1,2,3,4,8, 18 236:25 biologic 116:19 birth 39:21 46:15 47:23 81:4,8,10 82:6,9,14 83:1 84:15,18 89:9 117:16 120:7 152:4,10,19 161:24 162:1 164:9 169:23 190:24 191:4 205:12 207:15 208:24 254:3,17 255:9 256.1births 39:25 81:4 83:9,13 86:9 154:7 161:11 163:24 birthweight 254:7,22 bit 8:2 9:10 11:20 12:22 24:19 29:12 37:11 41:10

43:14 47:13 62:21 129:1 137:8 143:4 145:8 153:11 199:12 211:24 220:8

black 34:20,24 bladder 7:4 43:11 44:17 bleeding 35:12 39:14 44:13,20,23,25 45:1,3,5,8, 16 85.3 **block** 98:25 232:22 blood 44:25 45:3,13,19,21 76:4 85:6,7 136:11 143:9 206:5,8 212:9 263:16 265:11,12,18,25 266:10,14 **blow** 43:13 blown 43:10 blue 217:11 board 17:12,13 18:9 52:6,9 68:9 72:18,23 236:11 260:5 271:16,17,25 278:6 279:11 281:12.15 bodies 40:19 body 48:24 49:3,4 227:5 271:19 279:14 bolster 208:24 Bolton 228:18 bond 269:10 bonding 264:9 bones 50:13 book 171:16 border 77:24 78:15 born 59:4 208:1,10 226:10 **bothered** 116:12 **bottom** 183:16,23,25 186:13,15 248:24 bowel 88:22 164:23 168:5 **box** 193:17 217:17,18,19, 20 Brady 226:7 brain 25:8 198:21.22 200:14 201:10,11 break 9:21.23.25 10:3.4 34:7 39:20 54:24.25 55:2.4 65:1,3,9,14 81:2 129:1 148:17,20,21,23 149:8,23 161:9 192:5 196:19,20 214:9,11 259:21 279:18, 20,23 280:3

breaks 9:18 196:18

breast 128:11,12,17,18 129:3,13,17 130:3,8,20 131:1,2,8,18,23

breasts 129:15 130:23 breathe 208:16 breathing 201:14

brick 232:24

bring 35:6 95:18 239:19 264:11,14 266:9 brings 47:7 249:25 broad 229:5 257:17 broke 193:1 brought 11:18 bulletin 17:21,24 101:20, 22 181:11,16,19,25 237:8 238:8.12 243:5 bulletins 18:5 56:23 57:1 102:6 235:7 236:13 Bureau 271:17 279:12 **bury** 51:14 Business 271:17 279:11 **busy** 275:22 buy 261:21 Byron 15:7 16:11 21:24,25 246:15 248:6 249:23

С

C-SECTION 31:10 41:1, 13,19 43:19 44:4 46:4,15 47:2,4,11,16 48:4,5,6,9 85:20,23 86:10 87:4,5,21, 22 88:4 90:20 136:16,21 137:5,12 143:22 145:17, 20,22,25 146:5 161:16 162:11,16 163:4 166:15 168:8 228:25

C-SECTIONS 33:23 43:15,17,22 44:2,10 47:8, 16,21 86:7 87:2 88:1 127:18 143:5,10 161:14 162:5,14

caesarean 39:21,22 46:6, 22 47:15,23 228:11

calcified 50:13

calculate 152:5 154:22 calculated 151:5

Calhoun 16:11 21:25 246:16 253:3 254:11 258:12

Calhoun's 15:7 255:22 256:20

California 108:19 182:5,6, 15 186:22

call 30:20,22 31:11,14 32:3 52:25 64:8 143:6 194:7 196:9 220:4 266:19,25 267:18 277:15

called 5:3 17:9 19:2 20:11 42:18 52:1,10 63:16,19 84:24 97:22 120:17 122:10 149:17 172:5 238:13 259:24 267:2,9

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER Ingrid Skop, M.D.

calling 200:22 calls 30:21 Can's 269:6 cancer 128:11,12,18 129:3,13,17 130:3,9,20 131:1,3,8,9,18,23 capacity 18:21 96:20,24 200:8 208:24 209:20 210:6 211:8 car 159:7,17 187:10 cardiac 35:10 care 6:7 7:6,7 27:20,23 33:18 34:8 35:2,8,16 37:1 39:6,7,9,18 40:7 48:16 58:13 62:16 91:10 96:5,15 113:23 125:17 127:8 132:20 135:2,11 156:21,22 175:16 205:6 228:24 230:19 231:21 263:5 265:17 270:4.8 272:22 274:11 278:22 cared 62:18 65:24 66:6,7, 19 67:25 68:4,20 72:15 91:19,22 92:3,13,17 93:22 94:6 96:1 228:23 career 51:1,5 72:16 73:7 81:17 84:21 274:20 careers 275:1 caring 66:18 Carnahan 21:13 Carolina 221:17.19 carried 129:18 190:7 195:18 196:12 carries 190.17 carry 125:4 174:24 187:16, 25 carrying 187:20 195:22 case 5:10 6:1,2,3,4,18 7:13,15,18,20 8:21 11:21, 23 12:4,14 15:2,4,5 17:3 20:1.2 21:15 22:23 23:11. 22 24:2,5,10,14,16,21,23 25:6 26:2 30:10 65:17,24 66:4.14 74:4 90:21 98:14 99:1 102:18 104:17 105:1, 14.16 109:7 122:7 124:15 125:18 129:5 147:17 178:25 182:23 199:3 200:1 201:2 205:2 211:9 214:19. 25 217:9 219:19 221:3,5,9, 15.20 231:11 233:12.16 240:19,25 241:8 244:9 246:16 249:7 258:24 280:9,11,16,23 caseload 34:1.7 cases 5:23 12:2 37:15 75:10 85:22 91:2 102:21

114:8 121:19 134:3

145:24,25 247:4,21 281:4

cat 110:17 catastrophic 47:24 85:3 catecholamines 212:10, 16.17 categories 45:18 189:9 191:25 193:2,10,13 256:13 category 114:11 175:17 catheter 43:1,9 causal 90:2,16 129:2,12 131:22 153:1,7,16,25 185:15 186:4 causality 188:2,4,7 causation 152:14 caused 82:7 93:6 157:5 185:23 186:9 causing 211:4 cavity 88:14 cc's 45:23 **CDC** 90:11 108:6,14,20 147:7 151:2,6,13 158:24 160:1 161:2,8 165:17 172:16,17,18 173:7 182:18,19 183:11 184:1, 14.19 CDC's 108:24 cells 131:13,25 center 52:14 147:9 233:21 centers 27:12 273:6 centimeters 41:12 42:3 Central 32:18 33:6,10 cerebral 201:24 202:11,17 203:6,15,21,25 cerebrum 203:8,9 **certainty** 96:4,15 113:22 certificate 152:10,12 155:24 certificates 150:16 152:9 154:3,4,9 155:4,6,7,15 156:11,12 certification 179:4 certified 76:13 cervical 80:20 81:11.12.16 82:3 87:11,12 139:11 Cervidil 42:18.19 46:9 cervix 41:10,16 42:1,2,9, 13,14,22 43:1,13,14 46:3 80:23 82:18 87:12 139:15 252:24 253:16 chain 158:12 chair 17:12 32:20,21,23 33:3 134:22 135:3,4,6 chairman 17:19 72:18,23 260:5

challenge 24:21 221:23 **chance** 133:14,16 134:5 change 95:10 106:7 112:21,25 113:16 145:18 212:19 213:25 282:2 changed 105:3 chaplain 133:13 chapter 171:15,17 characteristic 263:14 charge 23:13,16 78:5 Charlotte 18:18 19:6,11, 17 21:10 22:12 243:17 244:2,17,25 245:7 280:18, 19.20.24 281:2 chart 111:5 157:4 188:20, 23 charts 76:15 188:22 chat 11:4 237:17,23 238:4, 6 243:3 check 23:20 193:16 236:22 checked 278:13 **checkup** 118:2 Cheryl 26:7 child 40:7 58:13 116:19 119:9 132:21 159:13 162:22 163:1 167:23 255:9 256:1 childbirth 66:24 135:19.24 138:1 139:12 160:10 162:12,20 167:21 168:2,5, 11,20 169:5,16 children 40:6 119:6,18 149:24 176:19 chlamydia 266:8 choice 106:9 112:23 choices 273:23 choose 13:18 58:20 59:25 118:24 chooses 128:15 chose 191:9 chosen 115:4 Christina 21:13 chronic 165:1 169:9 252:22 253:14 circulatory 45:14 circumstance 48:8 56:6 116:16 229:12 231:17 circumstances 12:1 40:23 48:6 49:13 54:19 82:6,23 90:1 133:5 141:17 228:1,12 229:9,14,24 231:6,14

citations 186:19 255:1

cite 86:5 100:2,4,8 106:21 120:16 175:20 186:14 194:13 241:23,25 242:6,10 cited 12:19 13:6,14 101:23 106:20,22 107:8 170:23 171:1 184:8 194:8 242:3 cites 163:13 citing 110:8 125:8 188:13 254:19,23 city 179:11 clarification 159:21 237:25 clarifies 284:4 clarify 235:9 clarity 268:14 classify 48:9 cleanup 194:14 clear 29:1 37:23 48:3 50:5 51:18 58:19 70:16 74:15 167:19 174:16 177:14 182:13 188:6 203:23 210:19 215:5,17 241:13 270.16**clinic** 31:25 32:2,3,6 52:12 60:3 77:16 78:9 107:23 111:22 187:11 260:19 273:22 274:8 276:8.11 clinical 32:11 68:20 94:25 95:11 97:12 113:2,17 127:15 260:9 clinically 71:17 clinician 170:23 **clinics** 32:7 52:13,16 60:1 107:21 108:3 112:11 154:13 176:15 272:6,7,8, 12,21 275:24 276:3 277:21 278:2,9 279:4 **close** 148:19 150:4 183:4 191:22 272:14 279:17,20 281:25 282:2 closed 77:15 closely 260:15 closure 232:3 coauthors 172:7 173:3 coerced 114:8,9 176:18 255:16 coercion 111:18 113:10 176:22 193:8 Coleman 22:7 195:5 Coleman's 195:6 collaborated 245:8 **colleague** 60:14 122:1 colleagues 14:18 60:21, 24 61:2 163:20

Kristin Marchant, RPR DepomaxMerit Litigation Services colleagues' 41:21

collect 206:5 **collecting** 90:11 144:10 151:2 157:3 collection 137:7 collects 160:1 College 55:6 Colorado 53:11 column 247:14 combined 140:14 151:15 comfortable 95:5 115:12 commissioned 148:13 **commit** 176:23 committee 17:20 18:5 57:2 61:15 102:7 135:6,9 154:15,24 155:2 235:14, 23,25 236:13 237:9,11 **committees** 152:8 154:2 157:24 173:13 committing 115:20 256:9 **common** 39:11,12,17 49:17 117:17 136:10 139:4 143:11,12 167:9 181:2 211:22 **commonly** 63:14 106:5 139:2 167:2.5.6.14 communicate 219:6 communication 11:3,4 219:8 **community** 19:9 62:22 77:19 116:9 117:1 250:14, 16 comparable 161:16 204:22 comparator 161:23 164:10 187:21 compare 162:20,23 163:12,22 174:25 238:23 241:14 compared 131:12 145:6 173:23,25 174:14 175:25 176:3 **comparing** 161:10,16 162:2 177:14 187:15 comparison 163:8 164:16 compensate 24:10 compensation 22:23 24:5.13 **competency** 94:25 95:12 competent 269:15 **compiles** 121:23 complaint 227:5 complaints 271:16 279:10,13 complete 8:22 76:5 99:2 110:23 111:1 152:16

154:14 157:14 178:5 200:12 234:21 245:24 completely 50:20 201:9 204:16 **Complex** 68:11 complexity 47:19 127:16 180.5complicated 68:8 95:15 118:15 119:23 complication 6:21 7:1 14:11,13 73:6 79:9 80:6, 18,24 82:8 84:23 85:15,17, 19 87:18,20,22 92:7,11,12 135:19,22 136:6,23 137:2 140:6,11,13 142:6 144:5, 22 145:1,9,13,22 146:10, 12,13,23 147:3,19 158:12 167:9 174:11.19 175:22 177:5 178:18,24 complications 13:17 27:21 45:25 59:2 65:25 66:6,9,10,19,21 68:5 69:3 73:4 76:3,8,11 83:20 84:19 85:13 91:16,25 92:1 93:14 94:7,18 108:25 109:17 112:13,14,16 117:23,25 127:17 135:2 136:25 137:11 139:21 140:2,15,22 143:9 144:3,11,18 145:11, 19 146:20 147:1,10,15 148:9 164:21 165:6,13,16, 23 166:4,9,10 167:2,4,11, 18 169:14 171:10,11,18, 21,23,25 178:16 246:25 247:18 **comply** 11:6 **component** 198:19 203:19 comprehensive 236:6 **compromise** 45:1,11,12 compromised 45:15 144:15 148:13 computer 183:7 conception 28:24 224:19 concern 44:24 139:22 180:6 250:6,9 282:21 concerned 77:23 114:23 163:5 242:22 concerns 42:10 192:4 194:6 250:11,13 conclude 82:7 112:23 concluded 89:9 113:14 284:14 conclusion 178:15 247:6, 23 248:14 conclusions 111:15 246:24 247:8.17 concordant 249:8

Condic 22:5 condition 25:7 51:17 158:13 conditions 162:16 188:12 189:19 conduct 227:21 conducted 129:8 conducting 10:19 conference 220:4 249:10 confident 113:6 confirm 15:1,12 243:23 257:20 261:9,12 263:23 confirmation 263:25 270:14 confirmed 75:11 92:19 263:3 279:7 congressional 244:4 congressman 226:3,15 conjunction 212:12 connect 89:23 connected 256:9 connecting 154:8 connection 81:7 82:13,25 90:2,16 105:13 129:2,12 131:22 154:11 201:24 202:11,16 203:3,5,14,20, 25 255:18 256:14 cons 48:20 consent 114:15,18,23 115:4 225:14 consequence 89:9 considerations 275:15 considered 72:4 100:12 120:23 125:20 137:25 138:2 160:24 164:15 198:7 242.9 consistent 158:4 251:6, 12,21 276:11,14 consists 272:5 constellation 212:25 constitutes 259:7,11 consult 56:25 64:11 121:8 consultant 278:7,8 consumption 99:10 contact 59:23 61:3 271:11 contacted 12:13,15 280:11 contained 284:8 container 217:15 content 249:20 context 199:8 259:9 270:20

continues 58:24 **continuing** 58:12 133:1 contraception 52:18,22 53:14,19 107:14 111:8,10 112:5,6 113:11 229:19 273:2 Contraceptive 52:1,8,19 contraceptives 52:23 53:9 contract 45:3 contractions 49:5 contracts 243:10 contribution 243:13 **control** 117:16 188:12 189:18,24 190:6,8,16,20 211:4 controversial 128:13,14 129:6 conversation 118:8 120:6 126:20 233:8 conversations 205:13 280:4 converse 90:5 conveyed 15:13 copied 257:8 copies 64:20 **copy** 237:12 259:12 cord 183:7 201:10 206:9 **correct** 5:16,17 7:8,14,21, 22,25 13:6 17:9 18:7,8 23:22 25:12,17,18 27:14 30:13,14 31:14 32:14,20, 22 34:12 35:16.17.19 39:7. 8 40:20,21 46:25 48:10 49:8,9 50:9 51:20,21 52:25 54:11,12 55:17 56:9 61:22 65:10,17 70:21,25 71:1,5,6 72:4 73:21,22 74:4,5,7 78:20 79:11,12,19,20 80:16,17 81:5,10,11 84:15 85:23 86:4 87:2,6,7,20 88:10,23 89:2,3,15,21,22 93:7,8,11 101:5,24 104:14, 18 106:13,17,22 108:12 110:2,21 113:19,20 114:20 115:8 119:11 120:14 121:2,25 122:15 124:12 126:22 128:8 129:19 131:19 132:4,7 133:2,6 134:6,7,10 135:12 136:17 137:24 138:10,19 139:8 142:15,16,21 146:24 151:16 152:22,23 153:2,7, 18,19,22,23 154:5,19 155:20 156:5,8,9,18 157:1 159:10,18 160:21 161:11, 18 162:12,21 163:10 165:2 166:24 167:21 168:2,21 169:5 170:24 171:19 172:20 174:21 178:3,4,12,

Index: collect-correct

13,21 180:12 181:2 182:17,22,25 184:6,10,18 186:5 187:6,11,12,18,19 188:9,10 189:19,20 190:18,19,25 191:5 192:23 195:12 200:3 201:8 204:1, 3 205:8.9.19.22 207:11 208:25 209:1,16 211:13, 14,17 212:4 213:16,17,19 214:5,6 215:3,18 220:11, 12,14,19 221:3,4 222:6,7, 8,19,22 223:23 224:6,8 225:7 226:15,21 230:1,6 232:1,2 233:13 234:11,25 235:3,8,18 237:8 238:14, 20 239:2 240:19 241:24 242:3,15,16 243:7,8,24 245:22 246:16,19,20 248:18,21 249:1,7 252:13, 14,16,17,25 253:1 255:2 256:15 257:1,22 259:25 262:1 263:11 264:1 265:25 267:19 268:15,23 269:2,4, 5,22 270:1,9,10 271:22,23 272:10 273:10,11 274:5, 14,18 275:16,18 276:1,20 279:5 280:12,13 281:18 282.22 corrected 10:15 correctly 74:16 85:14 110:8 137:21 151:12 154:3 174:12.13 197:10 200:18 220:9 247:10,24 254:9,24 255:19 268:17 277:5 correlate 90:18 188:19 correlation 82:1 87:3 262:12 correspond 262:14 cortex 201:25 202:11.17 203:6,15,21,25 cost 126:4 counsel 48:19 72:8 85:24 131:17 218:23 counseling 44:3,7 47:13 48:7 57:23 58:18 72:2,3,5, 19 73:1 114:17 128:5 133:7 193:16 267:15 269:15 270:25 271:1 counselors 277:3

count 73:8,18 75:2 136:23 199:16

counted 202:3

counting 143:19

countries 46:19 country 58:15 143:24

144:11 150:12 276:15

couple 13:21 50:18 54:22 93:17 98:23 120:23 138:25 141:9 175:1 182:14 214:2 219:21 221:2,16 248:12 258:6,14

couples 58:17 court 8:11,15 9:11 147:16 190:15 214:24 215:2 217:1 221:24 242:21 court's 11:2 15:19 cover 98:22 124:20 125:6 143:19 coverage 54:8,10 124:23 125:21 126:24 covered 54:5,6 124:11 125:5 covering 75:9 76:1 COVID 265:22 Creanga 165:17 create 202:21 259:16 278:1 created 68:10 105:13 123:1 238:23 creating 278:1 credentials 29:25 crisis 273:6 criteria 27:11 40:9 41:3,5, 11,25 247:2,20 critical 11:9 criticism 178:11 191:19 criticisms 191:10 crossed 233:17 cry 119:3 curettage 48:21 49:12 50:7,11 curious 86:15 111:18 190:13 211:11 **Curlin** 22:9 current 29:24 232:23 cut 45:8 87:5.9.21.24 130:24 146:6,12 cutoff 191:23 cutting 136:20 CV 29:19 30:2,5,7 55:5 163:16 220:8 222:8,19,21 225:25 226:5,20 233:9,16 234:1 242:1.9 243:23.25 244:6,11 275:3 281:18,21 CVS 233:18 **Cytotec** 46:9 D **D&c** 73:11 169:21,22 D&e 49:16,17 50:12,24 51:16,19,22 68:8,13 70:8, 13,16,24 71:4,8 73:11 79:23 80:1,16,19,25 87:8

88:20,23 89:1 91:17 94:4,

7,16,24,25 95:2,13 127:16, 20,23,25 128:2 145:12 146:18,20 147:3,19 148:10 165:10,13,20 168:22 169:14,21,23 180:1 D&es 50:25 51:7 70:15 147:1 165:24 daily 72:8 Dallas 97:24 206:21 damage 44:16 59:1 80:22 81:9,11,12,13 82:18 87:10, 11 198:20,21 200:3 damage.' 197:9 damages 165:3 Danco 147:8 danger 62:14 dangerous 175:7 176:23 dangers 223:17,19,20 Darcy 158:6 data 64:7 66:20 82:20 83:18 84:16 89:13 90:9,10, 15 103:2 105:7 106:19 107:19,20 108:2,3,4,12,14, 16,23,24 109:8,11,15,20 110:8,11 111:2,13,14,15 112:14 113:10 120:16,25 123:16.19 144:7.14.17.20 147:5,6,7,15 148:8 149:14 150:10,13,14,25 151:9,11, 12,14,21,25 152:2,5,7,22 153:24 155:18 156:13 157:4 159:23 160:6.24.25 161:1,7 167:17 172:11,16, 19 173:5,7,9,14,17 181:24 182:1,21 183:2 184:6,17 192:11 242:15 271:3,6 278:15.19 date 23:11,18,22 42:8 234:10 250:13 262:8,10,18 dated 25:10,16 238:13 dates 42:11 dating 25:14 262:11,14 David 194:4 day 9:1 10:7 25:10,13,16, 19,22 30:19 33:19 116:10 133:24 214:21 241:4 266:5,7,9 268:2 284:20 day-to-day 272:6 277:20 days 31:4,7,14 33:20,21 208:1 219:21 de-identified 76:14 dead 50:17 deal 42:21 dealing 189:1 deals 234:24 dealt 258:4

death 47:25 48:1 51:16 86:19 136:4 150:15 152:9, 10,17,18 153:25 154:3,7,8 155:4,5,19,24 156:10,12, 17,20 158:10,17,18,25 159:1,10,18 161:23,24 175:10.13.17 188:19 deaths 150:15 153:3,4,5,6, 10,24 155:11,21 156:4,5,7, 10.12.18.25 157:3 158:2. 10,15 159:13,19 160:16,18 161:14 172:12 187:4,6,8 188.2 debated 185:3 deceased 70:15,17 decide 113:9 decided 55:25 decides 130:17 deciding 106:3 decision 96:12 113:7 114:1,7 117:8 118:9,16,20 119:21 120:1,3 191:10 decisional 96:4,15 113:22 115:2 decisions 96:5,16 113:23 176:12 decrease 213:9 decreasing 207:16,24 defects 247:4,21 defendant 5:25 6:4 221:2, 20 227:7 defendants 26:1 defense 6:23 7:1 deficiencies 192:21 define 45:17 68:1,15,16 128:1 135:24 158:18 159:1 167:6 defined 203:14.18.20 228:18,20 defines 158:9 197:7 defining 67:14 197:17 definite 247:8 definition 29:1 50:24 87:22 123:25 158:22 197:13,14,15,19,21 198:13.15.18 199:2.4.19. 25 200:6,16,17,25 201:3,4 231:3 258:4,9 definitions 158:2 255:18 definitive 247:6.23 degree 138:4,5,6 139:1,2,4 degrees 137:22 142:17 **Deidre** 26:9 deleterious 255:14 256:7

Index: corrected-deliver

deliver 30:18 31:1 39:19

40:23 41:9 46:23 62:16 80:21 132:18 delivered 36:7 97:5 132:19 133:24 143:24 176:20 202:5 275:20 deliveries 31:11 36:11 39:20 134:3,4 137:14 140:7 142:11 145:17 delivering 66:25 delivery 6:8 31:2,5,8 36:9 40:14,18 82:2 85:3 89:18 132:15 133:6 135:20 136:8,9 137:3,12 138:16 139:12 140:13,14 142:21 143:22 161:5 163:2 166:18 168:16,22,23 169:1 208:15 254:7.21 demographic 110:11 **Demographics** 34:19 demonstrated 209:22 denial 37:2 denied 226:24 **Denmark** 152:16 denominator 182:21 183:4 184:9 denominators 160:13 department 32:21,23,25 33:4 134:23 135:3 157:14 158:4,9 265:13 depend 24:5 50:16 depending 45:19 125:1 224:23 225:10 264:13 depends 175:24 198:16 200:22 231:3 deposed 7:13,20 22:20 221.1 deposition 5:18,24 7:17, 25 8:4 9:24 10:6,17,19,23 11:15 12:17 13:3,12 14:24 16:20,23,24 23:3,7,9 98:17 215:7 219:4,10,20,25 220:1,2 227:10 282:3 284:13,25 depositions 10:20 17:4 214:25 depressed 186:2,3 229:6 231:4 depression 71:16 72:13, 14,16 185:17,22,24 186:4 depth 157:21 describe 30:15 34:14 43:8 46:1 48:15 64:1 101:4 124:14 143:11 198:25 209:12 228:13 describes 118:9 163:13 describing 74:11 75:11 155:9

description 171:20,22 design 191:16 designed 189:23 191:20 194:22 desire 58:24 59:3,11,17 83:25 146:2 150:12 desired 51:16 193:6 desires 51:14.15 destroying 132:17 destruction 70:19 details 29:11 detect 171:25 detected 28:18.20.21 266:9 determine 40:9 51:15 152:14 191:13 206:7 270:23 determined 99:11 determining 41:4 177:19 183:1 develop 131:2 142:12 developing 200:10 **development** 26:11,15 201:8,18,20 204:23 device 43:12 diabetes 40:12 162:15 diagnose 71:25 262:25 263:8,15,18 diagnosed 25:7 225:6 diagnosis 48:18 Diana 14:1 149:13 die 80:10 155:13 156:2 188:17 died 50:21 73:14,15 79:17 80:5.7 85:4 88:8.19 93:22 155:7 159:4,5,12 165:14 190:5 difference 156:19 190:6.8 191:3 201:16 differences 190:16 difficult 47:20 76:12 81:25 94:12,16 123:14 dig 153:11 241:10 dilated 41:11,12 dilating 82:17 dilation 42:3,24 48:21 49:11,18 50:6,10,11 81:20 dinner 220:4 direct 206:8 direction 210:6 directional 209:20 210:1, 23,25 211:2

directionally 210:10 directions 117:5 directly 88:13 108:3 109:20 186:9 206:11 242:19 259:6 267:4,18 director 260:25 disagree 158:5 171:23 175:19 disagreeing 106:4 disagreement 158:7 disarticulate 50:23 discharge 207:19 disciplinary 227:5 discomfort 95:17 discover 60:3 66:8 76:15 161.2 discovered 53:20 discrepancy 262:13 discuss 57:19 72:9 115:23,25 120:12 141:4 177:19 197:24 discussed 66:10 102:14 105:16 122:3 127:22 151:8 166:14 227:8 228:11 280:17 284:18 discussing 38:5 97:7 115:16 149:15 187:17 256:19 discussion 29:17 107:6 145:22 164:1,12 170:15 180:18 213:15 214:18 230:15 282:8 disingenuous 163:25 disorder 84:25 disgualified 247:2,20 disqualify 221:23 disrupting 274:11 distended 49:21 164:23 169:16 distributed 184:1 doctor 5:19 28:7 31:11 41:24 42:1 49:20 59:9,15 61:24 62:15 69:9 71:3 75:17,24 76:17 77:4 82:4 107:23 115:7,13 122:19 141:16 167:23 221:18 263:3 264:21 268:22 doctors 69:10 71:7 101:4 109:22,24 133:11 140:19 147:21 260:24 274:16 275:19 276:4 document 35:10 99:4.7 100:2 167:12 170:21 172:7

100:2 167:12 170:21 172:7 203:22 234:15 236:19 237:5,20,22 238:3,6,12,16, 21,22 241:13,14 243:2 262:7 264:16 documentation 160:17 204:2

documented 14:17 97:4 150:14,15 155:24 161:2 165:19,22 188:16 189:10

documents 10:8,14 11:15 12:9 14:23 15:4 99:17,19 100:4,12 101:23 102:3,11 105:13 194:14 217:9.15 218:6 219:13,18 240:20,21 241:17 242:5 245:14,15 284:18 **Doe** 228:18 dog 148:23 dollars 54:3,16,18 104:5 126:5,21 127:7 Donna 21:14 door 91:11 dose 137:9 141:7 dosing 74:21,25 double 161:4 163:1 doubt 112:9 127:23 draft 102:4 240:9 drafted 106:17 123:15 drafting 26:18 102:6,12,17 103:3,7 104:2 121:22 124:3 235:6 237:7,16 238:17 240:18 draw 111:15 157:25 179:16 265:11,12,14,18,25 drawing 91:24 266:10 drawn 178:16 247:8 drew 235:10 drive 77:23 78:14 131:8 driver 125:14 131:8 drop 237:16 dropped 238:4,6 243:3 drug 190:5 drugs 77:18 141:20 190:4 drugstore 261:16,21,25 **due** 30:24 40:14 42:8 45:2 87:1 127:16 160:17 162:14 247:4 264:18 duly 5:3 duplicates 76:15 dying 160:9 174:11,18 175:14,22 177:5 dysfunctional 39:14 Ε

earlier 35:13 36:9 61:16 68:7 69:12 71:3 81:8,9 82:12 85:22 95:9 106:14

Index: delivered-earlier

113:21 115:6 124:11 126:20 127:22 128:5 143:5 144:17 147:25 151:8 165:14 171:24 172:10 176:8,12,14,19 177:11,16 182:3 186:21 193:4 195:11 207:6 209:23 213:14 214:13 220:25 228:11 235:2,17 242:13 252:12 259:24 268:19 273:25 276:19 282:18 284:6 earliest 200:7.19 201:4.23 202:10 207:13 early 35:2 45:22 49:19 74:17 80:21 81:16,20 82:2 89:18 124:17,22 130:24 150:18 155:23 165:20.24 174:4 176:3 203:3 211:6 224:18 easier 125:10 easily 50:14 easy 120:8 121:6 149:3 ectopic 155:16 262:25 263:2,8 264:1 editor 223:7 225:24 226:1 effect 25:1 128:16 141:20 144:8 175:3 192:1 255:13, 14 256:6,7 effective 53:8,22 effectively 162:21 effects 89:5,6 158:14 201:15 effort 105:6 236:12 242:14 efforts 9:3 eight-week 174:14,25 175:15,25 177:15 eight-year 186:16 Eighteen 38:7 66:17 186:22 elected 27:7 elective 25:3 40:8 41:2.23 43:16,19 44:2 47:9 86:16 177:20 231:12 electively 85:23 132:21 elephant 252:8 eligible 54:15 else's 248:10 251:9 258:10 259:6,7,11 282:21 email 219:6 236:20,22 237:21 238:3,22 239:5 emails 12:10 embolism 136:3 embryo 28:25 29:2 emergency 27:22 65:25 73:975:976:178:18

emotional 92:4 117:25 197:8,15 198:19 199:5,8 203:19 228:19 255:13,14 256:6,7 278:3 emotionally 51:12 203:10 employ 260:22 272:17,22, 24 employed 261:1 empowering 273:22 encompasses 114:12 encounter 117:1,7 encountered 119:14 encountering 113:18 end 37:24 38:17 120:12 145:17 152:4 158:11,19 164:20 165:21 173:20 211:24 214:21 218:8 247:15 270:7 279:18,20 282:1 ended 15:8 86:9 ending 116:13,18 129:15 131:19 132:21 155:18,19 162:1 endogenous 201:12 212:17 endometrial 39:13 endometritis 137:11 endorphins 212:10,15,16 213:8 ends 155:13 156:23 180:18 enforced 174:9,17 175:21, 25 176:6 177:4 enforcement 25:7 176:11 engaged 258:13 entail 20:5 entering 87:25 enters 156:22 entire 252:13 259:12 entitled 157:14 173:1 178:1 245:20 entity 24:15 envelope 217:16,17,21, 22,25 envelopes 218:7,13,20 epidemiology 98:3,4 equivalent 147:11 essentially 99:10 102:8 125:16 139:7 estimate 34:24 35:20 73:5 75:3 estimated 45:20 83:14 274:3

et al 254:20,23 ethical 57:4 ethics 57:2,5 98:7,8 281:15 **Europe** 144:21 146:15 evacuation 49:22 50:11 evaluate 208:15 evaluated 132:19 135:8 event 20:10 136:3 159:4 events 158:12 160:3 255:8 256:1 eventually 48:25 270:3,6 everybody's 79:8 90:12 evidence 199:13 203:3,4 238:13 260:7 270:21 evident 255:15 256:10 exact 262:22 282:19 EXAMINATION 5:5 examine 169:1 examined 5:3 examines 246:22 247:16 examining 106:1 examples 249:16 exception 152:11 229:4,7 255:1 exceptions 25:4 231:10 **exclude** 161:14 162:20 excluded 100:13,19 Excuse 95:22 101:12 148:6 exercise 212:24,25 exhibit 29:16.18.20 98:13. 15 110:18 157:10 164:18 170:9,13,14,18,20 172:4, 24 173:1,21 177:23,24 178:7 181:16,18 183:14 186:15 197:3 234:7,8 237:18,22,23 238:1,2,3,9, 10.25 241:14 243:4 245:19,23 246:13,14 248:17,19,22,23 252:5 253:2,3,21 254:12 255:5 21 257:18 268:6,7 273:13, 14,19 277:1 exhibits 16:4 107:4 214:19,20 215:3 245:15 existing 243:10 exists 203:3 expand 266:3 expect 217:5 249:11 250:19 257:24 expectations 276:11 expected 176:4

expense 53:24 54:15 126:5 expensive 54:1 124:17 **experience** 7:24 37:14 53:13 54:2 66:2,18 73:2 82:5 91:24 92:1 94:13 96:21,24 113:2,17 126:16 127:24 132:7 174:10,17 175:21 176:5 177:4 189:1 197:8 199:5,7 200:2,8 201:5 202:18 203:5,7,13, 16 212:6 214:4 260:10 264:9 275:23.25 experienced 68:5 200:20 experiencing 50:8 97:9 expert 6:1,19,23 8:21 11:21,23 12:2,5,14,19 13:6 15:2,5,7 16:11,17 19:8 20:1,8,13,22 21:19,20 22:14 24:2,16 28:9 29:11 65:16,20,21 66:3,5,15,16, 23 67:3,6,8,12,14,16,18,25 68:2,15,18 69:5,8 71:11, 12,15,19 72:13 95:20,23 96:1,4,13,19,23 97:5,25 98:6,9,10,13,17 99:1,18 100:3 101:24 102:17,20 104:21 105:12 112:20 127:12 129:11 146:22 159:16 163:10,13 180:10 194:9 197:3,22 198:14 199:3 202:9 221:2,24 230:7 234:24 235:3,12 238:24 239:19,20,22 240:5,19 241:14,23 242:2, 10,14,23 244:9 246:15 249:6 280:9,18,22 281:4 283:22 284:3.8 expertise 71:14 72:22 97:2,3,11,12 205:25 260:7 experts 21:15 102:18 204:7,13 239:25 241:7 explain 27:18 37:5 160:12 250:9 explanation 125:19 expose 210:16 express 58:24 118:13

expediting 73:1

expressed 59:11

expressing 49:5

extensively 15:10

extent 109:2,12 152:25

extraordinary 108:19

138:4 215:14

extract 50:19

extracted 50:15

expresses 59:17 60:13

extensive 44:3 66:8.18.20

extrapolating 180:14 extreme 199:19 extremely 48:1 80:21 82:2 94:12 129:6 143:23 178:17 179:7,13,18,25 182:6 F face 79:8 210:17 **Facebook** 116:12 faces 79:3 facilities 27:11 273:4 facility 85:4 facing 277:2 fact 18:6,7,8,11 81:9 82:11 97:5 130:5 159:8 188:2 199:17 234:3.10.18 235:10,15,18,20 236:9,16 238:24 239:3 240:18 241:15 245:16 factors 173:1 193:17 facts 100:23 103:2 105:7 242:15 factual 102:23 failed 117:16 162:14 167:12 fails 78:1 fair 8:23 62:19 117:22 150:22 194:3 fairly 43:21 121:17 180:4 223:5 fall 11:24 19:24,25 falls 230:19 familiar 24:22 57:5 96:10, 14 113:22,24 121:14,23 122:11 148:3 154:15 155:2.3 172:1 173:16 198:6,9 234:3 families 58:14 family 68:11 116:8 117:2 232:22 Fansteel 5:14 fared 196:11 Farr 22:9 FARRELL 237:25 248:21 father 210:16 fault 215:8 216:21 faulty 252:21 253:12 favorable 41:10 42:1,2 111:12 **FDA** 27:9 February 234:10 fecal 138:9

federal 226:8 Fedex 217:16 feedback 7:11 feeds 206:11 feel 9:22 66:15 115:12.13. 15.17.18.20 116:2.17 118:16 175:8 258:8 259:20 264:7 feeling 113:8 115:25 feels 55:23 229:5 fellow 55:6 fellowship 68:11 felt 27:24 100:24 209:4 Ferguson 194:4,8,17 **fetal** 18:15 25:8 28:17,19 35:10 46:5 47:25 50:13 94:15 96:20 97:19,22 99:20 101:15,18,19,22 121:20 123:7 152:10 154:3 155:5 164:25 168:19 177:19 193:7 199:23 201:2,14 204:5 205:19 206:8 212:12 224:14 234:4,10,24 235:23 236:1 237:7 238:14 239:12,22 281:12.14 282:12 fetus 25:8 28:24 29:2.3 42:11 48:22 50:14,17,19, 23 51:13,17 70:14,17,19 96:21,24 132:18 133:15, 16.24 134:6 197:25 199:10.13 200:5.8.20 201:5,17 202:12 203:5,13, 22 204:1,9,10 206:6 208:24 209:19 210:9,10 211:11,12,20,23 212:1,4,9 213:4,13,18 231:25 270:22 fetuses 66:18 70:15 207:22 fever 137:8 fewer 179:12 195:17 247:5 fibroids 46:16 **field** 64:2,5,11 65:19,23 67:1 111:9 121:13 163:21 164:8 251:7,13,22 252:2 fields 63:9 Fifty-two 253:6 fight 212:7 fighting 208:18 figure 216:11 252:1 figured 218:21 filed 227:4 finance 78:4 financial 121:19 find 12:22 54:7 76:15 115:2 116:6 120:21,25

121:3,6,7 122:8,18 123:19

139:15 147:23 171:19 181:23 213:21 216:7 274:21 277:13 finding 8:19 121:1 195:21 findings 14:4 196:2 fine 107:2 149:1 183:9 Finer 13:23 106:13,19,21 110:21 finish 9:13,14 14:20,22 55:3 **Finland** 14:16 152:16 186:24 **Finnish** 152:20 153:15 156:11,16 159:15 186:20 187:3 fired 227:14 firsthand 214:4 fits 53:20 179:10 fix 138:25 flaccid 45:2 flag 9:4,5,24 10:16 flawed 109:1 flight 212:7 flipped 157:19 215:13 219:15 **floor** 142:9,14 Florida 120:12,22 121:1,3, 8 122:16,18,21 275:5 flow 45:3 fluid 137:7 210:20 focus 20:9 85:12 86:20 189:13 192:14 focuses 234:4 fold 85:1 folder 157:20 Foley 43:9,10 folks 196:18 follow 86:22 133:13 284:17,19 follow-up 62:5 food 9:22 footnote 106:12,22 171:3 187:1 footnotes 186:19 187:18 forceps 167:23,24 forever 196:25 forgetting 166:17 223:6 forgot 10:8 259:3 forgotten 22:3 221:18 222:20.24 form 130:25

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

Ingrid Skop, M.D.

format 236:15 formed 201:24 202:3,10, 16 203:5,14,24 forms 52:21 76:13 202:14 fortunately 46:13,19 49:14 forward 111:13 Foster 13:23 14:1 149:13 found 64:7 76:12 106:2 123:15,20 147:19 195:15 196:10 223:16 254:2,6,16, 20 280:16 foundation 19:10,15 61:5 86:11 119:12 founded 52:3 fourth 137:23 138:4,5 249:4 Francis 21:14 free 52:15 72:18 268:11 269:24 frequent 165:24 frequently 71:18 74:13 77:9 79:7.8 124:11 179:1 261:6 friend 116:11 friends 12:2 116:9 117:2 front 273:20 278:9 full 5:12 9:11 11:10,11 30:18 33:17 60:22 115:4 128:17 132:16 145:5 146:6 164:20 173:20 178:8 197:5 247:13 252:19 253:22 254:1 255:7 266:7,12,16 274:8,21,22 276:4 283:10 full-service 273:22 276:8, 10 full-time 266:17 fully 201:23 202:3,10,16 203:5,14,24 functioning 200:13 203:21 272:5 fund 232:19,20 funded 34:19 funding 34:18 37:3,5,8 125:3 232:8 233:3 funds 58:2 232:13,20 future 95:10 165:1 169:11 173:18 189:3,8

G

qap 156:1.5 gathering 155:25 **qave** 61:14,16 249:9

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

Ingrid Skop, M.D.

gears 24:19 general 55:15 107:7 167:9 generally 28:20,21 35:6, 10 42:9.17 44:22 46:13 48:24 51:11 64:4 75:14 101:17 133:11 134:18 138:15 171:14 206:20 231:13 262:11 263:7,10 264:6.8 268:1 274:15 **Genuity** 147:8 Georgia 28:13,14 29:6 223:10 224:4,11 230:8 gestation 25:3,9 145:7 173:24 174:1 gestational 38:4 41:7 51:10 67:10 68:6 81:21 97:6 125:1 184:1 191:23 200:11 205:10 206:16 208:14 264:14 **GI** 183:25 184:2 Gissler 14:18 186:23 **Gisslers** 186:24 give 22:14 35:11 58:4 61:2 81:25 115:24 120:6 129:21 141:15 142:1 160:23 165:13 183:12 190:24 191:4 205:6 208:11 210:19 268:14 273:7 281:9 giving 52:14 85:9 157:4 glad 118:23 glanced 157:23 245:17 goal 229:18,19 230:16 273:1 goals 230:17 gonorrhea 266:8 good 5:7 53:10 54:17 55:14,21 65:1,6 69:5,7 91:10 107:10 110:6,9 113:10 121:5 124:7 133:4 144:10 147:6,7 148:17,24 149:6 150:1,14 151:11,17 160:25 161:1 163:6 167:8, 17 171:7.22 179:5 182:3 190:12 194:5 195:2 197:14 198:18 214:8 230:21 236:14 281:9 governing 214:25 government 232:13 government's 121:9 grant 232:22 granted 275:20 graspers 50:23 grasping 49:20 Gray 63:19 great 160:6 181:23 237:4 greater 180:22 224:5 255:14 256:7

Green 63:14 Greene 14:1 149:13 grief 95:21,23,25 96:2 grieve 51:14 Grimes 147:22 160:12,21 Grossman 147:21 ground 8:4 9:9 group 13:24 30:17,20,24 52:16 76:1 81:18 83:22 groups 22:13 guess 52:20 112:1 128:1 138:20,22 148:18 161:22 242:12 250:5 257:1 258:3 280:7 guidance 50:1 62:23 guide 57:3 63:4 171:5 guides 170:23 guilt 115:25 255:11 256:3 guilty 9:9 Guttmacher 13:1,22 83:23 107:12 108:2,5,6,16, 18 109:4,14,19,23 111:11 113:11 121:18 151:7,16 180:14 181:10 182:17,21 184:2.5.17 Guttmacher's 58:20 151:9 guys 15:9 77:20 78:5 101:7 180:2 193:15.17 196:22 213:23 215:16 gynecologic 34:10,11 55:15 65:22 276:5 gynecological 34:8 39:7, 9 111:9 274:9 275:17 gynecologists 55:7 56:9 274:13 gynecology 56:22 63:10, 16,21 64:2,12,18 65:20,24 66:15 н habit 216:14 half 9:21 37:20,24 45:23 148:25 149:1,3 275:12 halfway 36:24 handful 247:5 handle 48:13 49:12 handouts 21:4

happen 9:3 43:24 46:11, 12,13,25 47:3 77:11 78:7 80:12 83:4 90:5 94:11 115:11 135:14 137:14 139:12,13 140:18 141:23 142:10,15 143:1 166:7,14, 15,16 167:5 168:5,10,12,

14,15,24 169:4 202:23,25 211:5 213:1,5 227:11 271:9 278:20 279:3

happened 36:10 75:17,24 78:20 91:3 133:4 135:16 157:6 190:3,23 222:14 251:2

happening 169:25 212:9 happy 9:4,25 55:2 94:6 176:20

hard 49:1 50:12 76:14 84:23 100:5 103:8 111:11 115:3 119:8.24 121:19 126:18 192:1 223:4 248:6

Harrison 21:14

HB 177:8

HB136 24:22 26:12 123:11 164:4,5 175:3 177:9

HB2 27:4.5.6

health 52:17 59:2 71:11 72:5,19 77:15 83:23 94:21 96:5,15 113:23 121:20 124:11 125:8 132:3,9 134:17 156:21,22 157:14, 15 158:4,9 164:6 188:12 24 189:2,19 192:6,7,14,23 193:5,8,19 194:2,18,25 195:18,23 196:15 228:5,6, 14,16,18,20 229:3,4,7,10, 16 231:1,3,7,15 232:20 233:21 247:3 255:10,12 256:2,4 260:8 265:13,14 266:5 272:22 273:21,22 274:8,11 276:8,11 278:3,4

healthfully 68:7

healthy 146:1,2 208:17

hear 19:12 264:16

heard 11:25 53:16 114:13 125:2 134:14 182:5 206:3 216:2

hearing 61:15

heart 28:17,19 45:20 201:13 212:7,11,18,23,24 213:25 264:16

heartbeat 224:15 225:9 270:15,21,23

heightened 129:13 131:23

held 29:17 170:15

helped 76:16 213:23 helpful 24:19 25:25 84:6 159:21 166:9 191:14 195:8 204:21

helps 270:13 hemodynamic 45:1,10,

11,12

hemorrhage 45:17,19,22 73:20 76:19 79:1 85:5

165:1 169:4,19

hemorrhages 75:4

hemorrhaging 73:10 88:7

Henderson 26:9

high 40:11,13 49:21,22 88:17 94:14 112:7 127:15. 16 130:8 162:15 178:17 179:7.13.18.25 180:8.25 183:11 193:2 202:2

higher 44:4 89:17 109:14 125:14 152:18 162:5,11, 16,17 169:24 185:4 193:5, 11,18 261:18

highest 144:16,17,20 145:11 162:21 209:12,13

hill 226.4

Hispanic 34:20,23

histologic 199:12 203:2

histories 82:6,24

history 47:10 80:21 81:23, 25 82:14,22 83:4,10,13 84:9,12 85:19 89:8,24 90:12,15,17 91:14 92:19, 24 93:9,11,15 115:7 153:17 189:2,6

hit 159:7,17 187:10

HIV 265:14

hold 28:16 43:13 51:13 80:23 82:19 115:6 196:25

holds 43:11

home 40:6 178:2 216:13 224:16 225:7 252:6 257:17

honest 120:5

honestly 49:15

hoping 281:3

hormones 130:24

horrified 199:17

hospice 132:20

hospital 27:9,24 30:25 31:5,8,13 32:8,16,21,25 33:3,6,7,13 36:7 42:17 50:4 73:19 134:2,24 135:11.21 136:1 138:3 141:3 159:6,8,17 207:19 275:12,13 276:20

hospitalized 81:19

hospitals 32:6 33:13 132:2.6 160:3 209:18

hour 9:20 22:25 23:10 65:4 148:25 149:1,3 196:20

hourly 22:22

hours 16:4 22:21 23:15,22 24:9 78:16 103:6,25 189:16 225:21,22 280:15

Houston 97:24 206:21

human 116:14 164:1 179:15 199:23 230:15 humanity 270:13 humans 204:22 hundred 160:4 180:19 hurting 211:19 hypertension 40:13 162:15 hypothetical 129:21 hypothetically 48:3 hysterectomy 7:3 hysterotomy 161:17

ICU 73:12 76:4 93:17,20,23 136:2 idea 23:10,21 103:6 258:16,17 ideas 100:7 258:5,11

identical 97:8 129:23 241:16 248:1,2 249:12,14, 19 250:3 251:4,11,20 253:18 255:2 256:15 257:14

identically 257:10

identification 71:16 72:14 identified 19:4 76:24 156:7 159:9

identify 13:20 71:25 100:11,18 110:2 147:15 155:7 156:17 187:5

identifying 77:7 145:18 155:12 187:7

ifs 133:20

ignore 91:11

illegal 229:18 230:23 illness 72:1 123:7 185:1,5

189:2,3,4,7,8 imagine 30:9 35:15 54:13

129:22 179:23 231:6 immature 130:23 131:10.

13,25 immoral 115:21

impact 86:2 192:14,24 194:1,2,18,24 195:21 255:12 256:4

impact.' 247:7,23

impairment 207:20

implantation 91:4

important 9:10 27:25 163:5 182:25 183:10 191:3 226:5 242:19 244:14

imprecise 38:2 189:5

impropriety 283:14 improve 27:25 209:4 improvement 255:9 256:2 inability 80:23 inaccuracies 30:2 inaccurate 151:20 inadvertently 282:16 inaudible 86:19 172:17 incest 123:8 incidence 75:23 85:1 89:17 127:17 148:9 169:24 incidences 53:3 195:17 incidentally 55:22 58:17 incision 44:14 112:24 137:7 162:24 include 29:24 59:1.2 105:6 136:16 142:19 159:16 164:22 180:21 187:10 197:15,22 198:19 233:16 242:14 257:25 258:21 included 163:15 198:14 215:3 275:3 283:21 includes 159:3,5,19 including 52:17 67:2 76:12 income 54:14 126:14 incompetence 80:20 incomplete 49:22 83:18 164:25 168:18,20 172:17 **incontinence** 138:10,12 142:23,24 incorporated 99:12,18 100:7 281:6 incorporation 100:12 increase 41:16 86:5,17 87:1.2 129:16 153:9 174:3. 5,6 175:13 176:4 188:2 increased 85:1 128:18 129:3 160:17 165:20 174:10,18 175:10,12,16,22 177:5 254:2,6,16,21 increasing 160:18 indecision 106:7 112:21 176:23 indecisional 113:15 indecisive 176:17 independent 240:25 241:2 257:15 independently 248:14 Indian 34:21 indication 47:10,11 48:10 134:3 indications 41:1 42:10

43:22 46:7

indicator 157:15 213:11 indicators 135:16 137:1 individual 24:15 42:4 101:21 188:22 267:12 272:7

individual's 90:15

individuals 19:9 22:13 49:10 92:19 105:21 116:8 130:19 241:6 265:17 266:18 275:9 277:14 278:17

induce 40:3,10,22 41:22 42:8 47:1 88:16 95:7 133:6

induced 173:2 228:10

inducing 41:14

induction 31:10 40:1,4,8 41:16,23 42:14,16 46:4,5 47:3 50:3 51:11 70:10 74:9 88:10 134:2 162:14 228:25 231:23,25

inductions 41:3 45:25 46:25 127:18

industry 108:7 147:11

inevitably 118:17

inexperienced 169:25 infant 226:13 254:7,22

infected 44:15

infection 44:14 46:5 88:17,22 137:5,12 141:7 143:10 165:1 168:13 169:7,18

infertility 92:16 165:2 169:11

inflicting 212:4

information 12:25 13:20 56:22 59:10,23 61:3 63:9 64:17 86:22 96:12 111:9 120:21 122:2,14 124:6,15 128:20,21 155:9,25 156:6 160:1,23 163:7 171:7,10 183:12 193:13 208:5 215:9 220:24 235:11 236:2,17,18 239:19 241:22 249:25 267:6,21 271:2,11 275:1 277:4,10,12 278:16 280:16 282:5 283:21

informative 14:16 251:1 informed 114:14,18,23 115:4 225:14

infrequent 123:6 infrequently 74:24 Ingrid 5:2,14 inherently 241:7 initial 136:24 281:21 initially 191:1 initiated 158:12

Initiative 52:2,8,20

inject 88:13

injury 7:4 142:9,15 164:23 168:5,10

input 26:21

insert 42:20

insertion 53:19 inside 15:23 94:16 166:13 217:14,19,24

insinuated 174:13

instance 76:18 77:6,10 78:20 166:20 208:22

instances 75:11 92:17 207:25

institute 18:18 19:7 22:12 52:2,19 83:23 107:12 111:11 184:3,5 244:2,17, 25

instrumental 164:22 167:19 169:15,20 252:20 253:11

instrumentation 85:18 90:19,20,22 92:15 93:7

instruments 49:20 162:25 166:17,19

insurance 34:19 37:7 54:9,20 124:11 125:8,14, 15,21 126:6,24 144:12

insurances 54:7

intact 51:13 82:19 202:7

integrity 251:7,13,22 252:2

intend 8:21 65:16 104:17, 21,24 277:2 284:7

intentional 70:18 259:4 intentionally 132:17

intentionally 132:17 209:25 228:7 244:13 251:8

interest 60:13 83:17 224:7

interested 8:19 60:4 90:10 98:8 128:6 241:12 267:10 281:8,9

interesting 171:10 184:13 intermediate 242:5

International 197:6 198:2

internet 12:21,24 53:17 60:3 99:22

interpret 123:15 211:2 276:12

interrupt 66:13 86:23 interval 157:7 interviewed 20:7 interviews 281:10 intimately 198:11 272:1

intolerance 46:5 intrafetal 97:21 intrahepatic 206:3 intrauterine 97:22 205:18 introduce 29:13 49:20 58:16 88:22 98:11 110:16 introduced 243:4 introducing 107:3 introduction 162:25 invades 91:4 invasion 252:23 253:15 invasive 47:18 85:1 90:4 investigation 227:21 involve 6:6 87:9 136:19 138:6 162:24 involved 18:4 20:6 52:1 72:25 102:5 114:22 221:15 235:13 236:11,15 260:15 272:1,6 275:9 277:20 involved' 106:5 involvement 235:18 involves 7:21 87:5 162:25 involving 28:5 204:6 lowa 207:18 208:7 209:7 irregular 263:23 irrespective 17:2 159:2 Islander 34:22 isoimmunization 206:6 **issue** 24:23 37:6 74:4 96:22 117:4 135:17 205:3 249:4 issues 18:24 37:4 57:4 94:22 195:18 214:17 257:15 260:8 IUD 53:19 **IUDS** 54:1 IV 93:19 136:2 137:9 J JAMA 199:15 202:1 **iob** 8:25 71:22 144:10 193:21 227:18 jobs 135:4 joined 18:9 52:6 ioint 226:3 Jones 13:23 106:13,21 110:21 journal 63:14,17,19,20 107:13 111:7 220:17

248:25 249:11,17 journals 63:7,8,11 64:2,3, 10 258:8

Joyful 256:1 Joyous 255:8 judge 10:18 177:2 judge's 10:20 Julie 5:9 170:9 215:20 237:3 July 117:17 justify 107:17 116:15 198:17

Κ

Karalis 186:23 Kate 21:13 keeping 45:13 Kevin 226:7 kicked 56:17 kid 167:25 **Kids** 119:8 kill 176:24 killing 164:1 kind 6:6,10 7:1,20 26:24 28:7 44:23 54:10 87:10 114:17 118:1 135:7 137:10 139:1 142:8,9 143:15 153:17,25 155:8 209:2 210:22 216:14 217:15 243:11,19 261:13,16,24 262:17 268:10 269:10 272:20 281:13 kinds 33:18 39:10 93:7 136:7 knew 19:25 20:2 249:12,18 257.25 knowing 36:18 106:2 115:1,2 knowingly 283:1,5 knowledge 24:4,8 41:21 56:3 122:9 154:21 221:22 260:21 272:11 276:4 Kristin 170:9 L lab 199:20 266:17 labeled 137:22 labor 31:1,4,8,9 40:3,10, 19,22 41:14,22 46:6 84:8

88:16 135:19 136:8 137:3 140:13 228:10 labors 46:21

labs 265:15

lacerate 94:15 lacerated 45:5

laceration 142:18 lack 58:21,22 lacking 64:7 lady 93:17 Lance 284:16 language 237:7 239:12 241:16 258:1 laparoscopic 39:14 LARC 54:19 127:1 LARCS 52:25 53:2,14,15, 21 126:20 large 45:4 89:16.17 105:24 106:1 108:19 182:7 largest 58:3 late 13:18 37:1 51:9 73:23 103:24 108:23 114:9 149:14 155:22 174:11,19 175:17,23 177:6 193:9 220:10 231:12 256:13 late-term 108:22 182:7,9 189:11 laters 124:25 latest 36:5 51:22 law 24:21,22 25:1,6 76:10 94:9.10 134:7.9.12 176:7. 11 229:8 230:19 laws 134:14 lawsuit 227:8 lawsuits 221:1 layman 123:23 layman's 208:22 lead 46:5 82:16 113:16 164:25 169:17 236:12 253:12 leadership 55:24 leading 64:1,12 67:11,18, 21,25 68:2,15 164:24 168:13 198:3,7 255:14 256:7 Leah 248:18 learn 38:11,15 281:8 learned 11:22 12:4 36:22 98:4 learning 281:9 learns 38:21 leave 40:8 51:16 94:15 130:24 172:2 173:24 227:17 244:13 272:16 283.24 leaves 156:1 187:11 leaving 131:25 left 150:4,5 159:6 247:14

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

Ingrid Skop, M.D.

legal 75:12 173:2 228:13 229:1,10,15,23 230:1,6,25 231:5,8,17

legislate 231:9

legislation 26:5,15,19,22, 25 27:1,6,14,16 28:4,14,16 38:5 161:3 222:6 223:21, 24 226:8,9 230:2,8,16 232:6

legislators 26:21 61:18

legislature 27:13 61:15,17 222:11,17

legs 210:17 211:16

lethal 25:7

letter 284:17

letters 12:10 218:11 223:7 225:24 226:1,17

Levatino 22:2 level 85:4 152:7 200:13 201:7 209:8,11,12 272:3,4

Liao 254:23

license 226:24 227:1

licensing 271:19 279:14

life 25:4 62:14 116:14,18 121:19 123:7 129:14 130:4 131:24 132:21 134:15.16 142:13 222:13 228:23 229:3,11,16 230:15 231:2, 7,16

life-threatening 228:21 lift 258:6

ligation 39:15 light 111:12

likelihood 94:14 130:20 188:19

likewise 254:5,20 255:10 limb 201:12

limit 24:9,12 226:12

limitation 155:17 230:22

limitations 230:21

limited 173:7 185:12 251:4 Linda 173:3

link 237:17,19 238:4

linkage 186:22 187:2

linked 92:15 129:16

255:17 256:12 list 29:24 135:7 140:25 141:3 244:23

listed 104:20 234:1 252:15 listen 77:4 lists 104:16 liter 45:23

literature 58:20 66:9 67:9

leg 199:18

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER Ingrid Skop, M.D.

96:14,18 97:4 99:20 101:1, 4 102:2 107:11 113:22,25 128:12 129:6 144:19 242:6 243:1 246:24 247:17 live 145:25 146:2 152:4.10 154:6 169:23 202:5 205:14 275:20 lived 93:23 207:19 liver 206:11 living 70:14,19 97:6 116:14 126:10 179:15 207:7,12,14 LMP 25:15,21,22 28:22 38:18 224:17,18 lobules 128:17 130:23 131:10 local 226:1 271:11 located 32:8 260:18 272:12 location 265:18 locations 272:12 **long** 46:4 51:3 78:14 99:8 135:21 208:2 251:18 258:3 284:20 long-acting 52:22 long-term 84:22 89:5 195:20 246:25 247:6,18,23 longer 17:14 49:12 50:7 54:25 55:1 63:24 114:5 230:13 longitudinal 192:23 194:20 looked 12:21,25 13:2,23 14:5,7,12 16:6 53:17 99:23 100:16 101:8 121:10 155:4 157:18,19,23 182:23 193:12 205:3 217:3 236:4, 7 245:13 263:23 275:4,11, 12 Los 179:9,22 lose 85:5 loses 51.10 loss 44:25 143:9 255:11 256:4 **lost** 45:20 lot 13:22 14:14 23:13 30:21 47:20 55:14,21 71:13 81:22 83:17 84:13 91:8 92:4 94:13 96:22 98:4 100:5 102:6 103:10 108:22 111:20 114:12 115:17,18, 19 116:21 119:3.10 120:4 160:6 167:10 182:7,8 188:21 190:11 191:21 197:16 213:24 216:12 232:14 239:24 240:22 241:2,21 257:3 266:13

Louis 53:11 love 191:2 241:9 low 133:3 178:17,24 180:4 183:7 224:24 254:7.21 lower 109:14 131:12 179:16 200:14 Loxafamosity 122:11 Lozier 18:18 19:6,11,17 21:11 22:12 243:17 244:2, 17,25 245:8 280:19,21,24 281:3 lunch 33:23 148:21.22 149:24 150:1 lunchtime 148:18,19 lung 208:24 Μ M.D. 5:2 **Macdorman** 160:15 maceration 50:22 machinery 209:14 made 99:9 141:2 220:4 235:13,15 242:14 magazines 226:3 magnitude 145:17 mail 76:13 major 94:8 135:24,25 136:7.13.16 137:2 138:1.3 139:17 140:6,20,24 142:6 majority 83:12 123:12 241:16 265:7 make 25:14 42:14 44:5 53:17 66:11 79:10 82:13, 24 90:2.16 91:3 96:11.12 98:16,20 100:1 102:23 103:12 105:6 107:3 113:13 118:20 120:2,9 130:25 131:21 132:22 135:16 143:18 149:3 150:18.19 153:5 154:11 158:3,5 169:1 170:4 176:12 182:12 185:13 189:14 190:10 195:9 196:8 199:24 200:18 207:14 212:18 215:17 224:3 229:18,19 230:9,22 235:16 255:18 258:25 279:18 makes 96:13 112:24 118:18 131:2,11 162:17 180:24 189:7 250:25 making 81:7 96:5 114:1 118:9 120:1 177:15 189:10 230:11 240:11 malformation 25:8 malpractice 6:1,2 7:15

166:22 221:3,9 227:9

man 106:5

manage 31:1 40:11 71:17, 23

managed 77:12 79:9 84:11

management 48:13,16,22 50:25 51:19,23 65:22 66:16 71:2,4 95:2,12

mandated 27:9,10 Marchant 29:15

mark 170:9 177:23 181:16 234:7 237:20,21,23 245:19 246:13 268:5 273:12

marked 29:18 98:15 110:18 157:10 170:18,20 172:4,24,25 177:24 181:18 218:10 234:8 238:9,10,25 245:23 246:14 268:7 273:14

married 71:13

Maryland 108:21 182:8,15 material 238:23,24,25 239:22 250:20 251:5,11,20 materials 10:24 11:17

18:3 20:25 63:4 124:3

maternal 14:14 17:20 18:1,13 47:10,11 48:1,9 97:18 98:5 108:25 134:3 151:14 152:8,9 154:1,8,22 157:15 163:16 165:19 173:13 174:2,3 193:8 244:3 256:13,22

math 149:5 matter 112:15 115:16,22 231:9 maturation 128:17 132:1 matured 129:16 maturity 132:20 Maureen 22:5 meaning 38:6 41:10 means 30:24 152:25 153:25 248:13 249:3 meant 212:1 258:15 measure 152:24 212:5 measurements 262:17,19 measures 189:25 measuring 188:7 212:9 mechanically 82:17 media 20:7 281:6 Medicaid 34:18 37:3,5,8, 10 54:5,9,14,15 124:20,23 125:5 medical 5:25 6:2 7:15 19:2 27:8 40:15 51:11 62:22,25

63:8,11 68:9 73:10 74:8

77:19 78:5 97:17 98:7,8

122:5 139:22 140:1 144:23,24 152:13 154:4 155:6 166:18,21 167:13 170:24 221:3,9 227:9 243:21 245:20 247:12 248:19,20 250:14,16 260:22,25 271:16 272:18 276:16 277:24 278:7,8 279:10

medically 28:23

medication 72:1 73:20,23 74:10,17,18 75:4 76:19 78:9,11 79:1 88:7,8 141:14

medications 46:8 74:20, 22

medicine 97:19 167:9 178:25 226:24

meet 27:11

meets 281:17

member 17:10,11,13,14, 16 55:14,18,21,22 56:8 63:2,3 233:25 242:1 271:25 278:6 281:15,16

members 26:4

membership 55:13,23

membranes 132:25

menstrual 25:11,17 225:1 262:12

mental 59:2 71:11 72:5,19 94:21 184:25 185:5 188:12,24 189:1,2,3,6,8,19 192:6,7,14,23 193:5,18 194:1,2,18,24 195:17,23 196:15 247:3 260:8 278:3

mention 90:4 222:23

mentioned 6:18 13:25 19:6 28:2 39:5,19 41:2 42:12 45:9 46:2 56:21 61:15 68:3 78:10 79:10,16 80:2 89:20 91:23 93:17,20 106:14 111:7 115:6 116:5 132:3 145:10 146:15 147:25 153:23 165:14 171:24 182:3 187:14 193:4 195:11 199:18 205:5 206:2 207:7 208:6,21 209:6 212:14 222:5 226:18 229:4 233:5 244:16 245:13 260:7 273:25 276:18 281:5

met 5:7 20:16 22:10 247:2, 19

meta-analyses 147:22

meta-analysis 254:2,6, 16,20

method 49:17 53:20 74:6 87:24

methodology 110:1 methods 53:19

Metro 265:14 266:5 Metropolitan 265:13 Mexico 77:25 78:10,12 mid 73:13 165:21 mid-morning 55:4 mid-second 174:5 mid-second-trimester 206:19 mid-trimester 80:22 middle 145:6 178:14 midway 143:16 254:15 mifepristone 74:20 mild 137:10 mildly 164:2 miles 27:10 mind 76:14 106:7 112:21, 25 113:16 205:11 233:17 minds 209:24 mine 239:6 minimal 207:20 minimize 141:19 Ministries 122:11 minor 39:12 136:25 223:5 **minutes** 54:25 65:2 148:25 196:20,25 219:16 220:3 245:14 279:20 misadventure 168:8 miscarriage 48:13,15,25 49:11,13 50:8,25 51:19,23 71:2,4 95:2,12 169:23 270:21 miscarriages 48:17 50:2 155:16 **miscarry** 187:24 misconduct 227:24 misoprostol 43:3 49:4,7 50:4 74:21 77:25 missed 156:10,12 224:25 281:20 missing 30:5,8 143:10 mobile 265:19 model 52:12,14 278:1 moderate 126:14 201:13 modern 143:14,17,21 modulate 213:9 molar 263:13,18 moment 19:5 23:24 money 124:24 127:6 232:25 243:12,14 month 20:3 30:19,21 31:3, 7 76:2,22 117:7 118:11 180:24

months 195:16 morally 230:14 morbidities 136:7 morbidity 17:20 44:4 135:24,25 136:13,17 137:1,3 138:1,3 139:17,19 140:6,21,24 150:10 151:1 152:8 154:1,16 159:22 160:5 162:12 morning 5:7 8:10 214:18 219:4,10,25 220:2 222:23 280.8 mortality 14:15,20 17:20 18:1,13 66:21 109:1 150:10,25 151:4,13 152:4, 8 154:2,17,22,23 155:10 157:15 160:5 161:4,25 162:1,11 163:6,7,9,16,23 164:9,11 165:19,21 172:6 173:2,5,10,13 174:2,3 176:4 183:2 184:10 244:4 256:13.22 mortar 232:24 mother 25:4.5 121:20 228:21,24 229:3 motherhood 255:12 256:5 mothers 66:18 motion 35:10 motions 201:14 Mountain 65:4 149:4 move 66:12 94:22 113:8 170:16 177:21 210:6,10,22 211:2,12,23 212:1 moved 33:9 movement 209:20 210:1, 3,24 211:1 212:23 **movements** 198:22 moving 124:8 210:5 multiple 50:22 91:23 193:9 270:17 murder 115:19 Murray 5:6,97:10,12 29:15 64:25 65:5,8 148:16, 24 149:6,8,9 158:6 170:11, 14,16 183:8 196:18,24 197:2 214:8,11,12 215:20 236:23 237:4.5 238:2.5 248:18,23 259:20,23 279:17,23,24 284:16,22 muscles 45:6 138:8 musculature 82:19 Ν named 227:7

names 20:15 21:12 271:11 Nancy 234:13 narcan 142:1 narcotic 141:25 narrowed 181:13 NAS 246:23 247:9 Nathanson 213:22 national 148:1 150:5 178:11 226:2 246:23 281:12 nationally 181:8 nationwide 180:15 naturally 40:19 nature 30:15 necessarily 32:8 100:23 116:20 117:20 130:6 142:4 187:5 242:25 264:22 265:10 266:14 268:25 **needed** 93:24 134:4 165:2 205:15 209:14 263:16 276:16 needling 206:4 neglected 90:4 216:20 neonatal 154:7 204:19 205:15 neonate 205:7,12 208:1, 10 neonates 205:22 207:6,17 neonatologist 208:14 neonatology 98:1 205:13 **nervous** 53:18 neurologic 97:4 101:1 102:1 202:3 204:18 207:20 211:4 242:6 243:1 neurological 204:23 neurology 97:15 neurons 198:20 200:10 201:10 news 160:16 newspaper 223:8 225:24 nexus 153:1.25 nice 90:12 192:6 193:1 269:10 NICU 202:6 205:14 207:8, 15 209:8.11.12 NICUS 209:18 night 16:12 157:20 215:22 216:1 217:6 218:16 219:2, 13,18,24 245:14,16 246:18 NIH 281:14

No-test 19:2 noise 37:9

noncomparable 160:13 nonetheless 115:20 nonmaior 136:25 nonprofit 52:3 nonrepresentative 196:5 nonresponsive 68:12 **normal** 33:17 87:16 96:2 129:8,15 130:21 161:4 163:2 169:16 274:11 North 32:18 33:6,10 Northeast 33:3,5,8 134:23 note 98:16.21 107:1 noted 155:5 **notes** 10:23 21:6 98:24 99:9,12,15 100:18 103:13 235:5,6 239:16 240:11 258:25 Notice 11:14 noticed 152:20 **November** 238:13 nuclear 117:4 nudge 210:19,22 211:11, 23 number 20:6 24:9 63:11 72:15 73:18 77:23 78:7 91:20 98:18,22 108:14,19 109:4,9,14,16,18 114:2 121:16 123:9 151:5,6,15 160:18 174:25 177:6 179:12 180:17 181:17 182:21 184:6,20 186:14 195:11 209:17 236:11 248:25 271:3 277:8 278:16 numbered 98:19 numbering 98:21 268:10 numbers 108:5 121:15,23 123:4 151:9 171:24 175:15.20 180:14 181:3 182:5,9,10,16 184:14,15 188:21 191:25 numerous 73:8,18 75:2

nonabortion-related

nonbiased 241:10,12

232.8

nurse 272:23 nurses 260:23 264:25 Nursing 271:17 279:11

0

oath 8:6,10,11 OB 34:17 135:14

OB/GYN 27:21 30:12 32:12,22 33:4 41:22 72:8 134:23 269:22 276:16

Index: Metro-OB/GYN

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER Ingrid Skop, M.D.

OB/GYNS 30:17 31:23 49:23 55:12 127:14,17 269:15 272:22 274:16,18, 19 276:15 obese 137:6 obesity 40:12 objection 19:10,13,15 60:18 61:5,12,23 62:10 67:20 68:12 86:11 96:6 119.12 observational 188:14 190.1observed 70:12 206:22 213:18 observing 214:5 obstetric 34:9 41:1 42:10 43:22 55:15 66:16 274:22 275:22 obstetrical 34:8 35:2 39:6. 18 275:17 obstetrician 49:15 obstetricians 42:25 55:6 56:9 obstetrics 56:22 63:9,16, 20 64:2,11,18 65:19 66:14 obstructive 46:21 obtain 59:10,23 78:11 120:8 127:8 152:1 225:15 231:1 265:18 266:6,20 267:5 277:8,16 278:18 279:5 obtained 75:12 76:20 77:19 114:14 obtaining 126:6,25 232:8 obtains 268:20 occasion 43:18 46:25 49:24 81:1 136:12 160:11 243.16 occasional 34:21 occasionally 18:23 132:15 137:8 occasions 27:3 35:15 46:7 48:1 265:5 occur 40:24 45:2,4,6,7 46:20 80:25 106:8 109:10 112:22 114:24 123:13 155:11 165:23 166:10 167:20 169:16,19 171:23 202:18 218:18.21 occurring 198:21 occurs 87:25 137:7 144:6, 14 224:19 odds 133:4 209:4 offer 8:21 48:19 49:4 50:3 52:17 65:16 240:24 267:15,21 274:8 276:4

offered 108:1 offering 185:25 offers 55:14 offhand 44:19 148:12 office 30:19 32:3 34:5 113:3 238:23 266:15 omit 199:5 one's 258:11 ongoing 72:6 227:21 **online** 13:2 op-ed 226:3,6,14 232:10 233:2 op-eds 226:2,17 233:18 open 44:15 87:12 215:7 216:19 218:2,20 opened 15:13,16,23 16:6 215:12 217:13 218:5,15 opening 15:23 216:14 opens 137:7 operates 154:16 operating 136:22 operation 52:5 164:22 165:7,8 166:5 opining 201:2 opinion 57:5,8,21 65:16 109:13 112:5 129:12 131:22 146:22 163:13 178:22 185:6,7,25 197:12, 19 200:7 202:9 203:23 204:5,24 235:23 236:1 237:10,11 240:25 274:10 opinions 8:20 18:5,24 57:3 102:7 103:3 104:17, 20,21,22,25 105:3,8 235:14 236:13 284:7 opioids 201:12 opportunities 239:18 281:7 opportunity 12:4,13 176:22 270:24 opposed 23:7 34:8 191:4 210:6 224:1.6 opposing 56:4 223:21 option 49:3 58:12 116:18 options 48:7,18,20 52:14 57:18 60:15,22 176:25 267:15 269:15,16 order 10:20 11:2 15:19 22:13 37:7 132:18 164:1 176:23.24 214:25 215:2 217:1 250:3

organism 199:16 204:15

organization 17:9 52:7,9 55:16 56:2,7,11,15,19 120:20 198:4 232:25

241:10 259:24 organizations 19:8 62:22 148:14 198:10 234:1 243:15 244:21 organs 44:16 252:24 253:17 original 103:11 120:25 250:20 259:3 originally 122:15

originate 239:24

originated 239:23 240:23 258:1,22

osmosis 71:14 outcome 24:6 25:5 90:9 118:22 144:4 153:1,17 176:11 188:8,19 193:19 255:17 256:12

outcomes 135:8,10,14 152:1,25 153:21 155:22,23 187:23 188:16 191:5 193:6 194:3,19,25 195:23 196:4, 15 208:19

outlined 213:4

outpatient 32:7 output 45:21

outreach 176:16

outright 224:8,10,12 225:5

outspoken 148:14 overdose 44:12 141:25 190:5 overlook 242:18

overlooked 242:17 overrepresented 192:3 override 213:23 oversee 72:24 overseeing 135:1

oversight 279:14 overwhelm 85:6 Overwhelming 80:11

Ρ

p.m. 149:7 214:10 216:1 219:24 279:22

Pacific 34:21 pack 30:25

package 214:20 215:11,18 216:6,9,19,23 217:5 219:4,

packages 216:15 219:1

packaging 216:13 packet 15:8,13 16:15 215:6 219:24

packets 15:23 pages 60:2,5 98:18,21,23

paid 18:23 58:2 104:2 223:15 243:16 244:17 245:5,10

pain 18:15 35:13 53:18 96:20,21,24 97:9 99:21 101:15,18,19,22 165:1 169:9 175:8 177:19 197:7, 13,17,20 198:1,3,4,10,13, 15,17 199:2,13,16,19,25 200:9,15,17,23 201:2,5,9, 13 202:7,18,21 203:5,7,10, 13.16.19.22 204:6.23 212:3,6 213:1,8,9,11 234:4,10,24 235:23 236:1 237:8 238:14 239:12,22 282:12

painful 205:7 207:10 212:13,20 213:1,5,13

painkillers 212:17

paint 111:12

paper 18:25 19:1,2 99:13 100:24 107:7 163:15 243:21 258:18 275:4

papers 67:15 68:4.19.21 83:20 99:10,22,25 100:22 103:9,11,14,15,16 215:13 216:25 219:22 225:14 239:17 245:9 256:24 259:2 275:3 282:15

paragraph 105:23 106:6 120:11,12 143:15 145:5 158:1 164:21 173:21 177:13 178:8,10,15 181:21 187:17 197:6 246:21 247:13,15 252:19 253:4,22 254:1,13,15 255:7,22

paragraphs 98:19 258:21

parent 114:9 119:17

Parenthood 5:10 75:15.21 76:21,25 77:7,16 78:9,23 114:25 179:9,22,23 182:4 232:4,7,14,17 233:5,13,21 278:22

parents 114:4 119:15

part 15:18 55:17,19 69:20 71:21 83:17 84:1 87:16 101:11 105:23 107:4 110:4 158:24 180:5 186:17 199:5 256:21

participate 191:9

participated 19:21,22 114:19 233:20

participation 191:8,19 192:10 195:24 196:1 partner 58:22 95:18 114:6,

9

partners 42:6 49:25 84:11 127:24 176:18

Index: OB/GYNS-partners

partnership 265:13 parts 27:6 94:15 101:9,13 107:2 201:19 212:12 PAS 87:25 90:25 pass 48:25 passages 248:1 256:16. 18,19,25 passes 50:22 passing 258:11 past 42:8 71:5 73:3 85:2 91:8 149:3 219:21 pathology 65:23 263:16 pathways 202:3 patient 31:9 33:25 34:15 35:21 38:10,20 40:4,11 43:18 48:4,19 50:3 51:10 54:13 57:12 58:9 59:9,17 60:11,13,21 73:12,14 85:25 88:8,19 90:1 92:8,11 114:15 117:13 118:8 120:13 128:6 130:1 132:23 133:7 141:18 159:16 160:8.9.20 162:9 208:23 210:11 227:4 228:23 229:11.16 231:1 263:4 264:3,9 267:2 patient's 25:11,17 93:15 231:15 patients 30:19 31:12 33:21,25 34:2,5,7,17 35:1, 3 40:5 43:23 44:1,5 53:23 57:16 72:8.12 75:4 78:8. 21,25 79:2 82:7,11 84:20 89:7,20 93:22 94:18 114:2, 13 115:6,12 116:4 117:1,7 119:5,14,20 126:17 128:21,22 129:22 130:15 160:20 164:6 176:16 189:1 256:9 264:11 269:7.16.20 271:9 275:13 276:12 278:16 patients' 82:23 96:4 116:7 pause 92:6 251:19 paused 251:15 pay 116:13 215:10 216:7. 17,20 232:21 payer 156:21 188:16 paying 24:15 215:23 payment 23:18 **PDF** 237:17 peace 196:25 peer 64:6 67:15 68:4,21 163:18 220:17,23 244:12 246:2.3 250:19 peer-reviewed 257:21 peers 205:13

pelvic 142:9,14 penalties 8:7 pending 10:2 people 16:22 31:17 35:15, 21 36:19,21 37:19 38:9 46:7 64:11,21 83:9,19 84:7 88:11 92:18 96:1 115:15 116:15 125:15 156:6 164:13 176:6,12 196:10 208:7 233:18 236:6 278:9, 21 279:4,6,7 perceive 118:1,3 perceived 58:22 212:20 247:4,21 percent 34:9,18,20,23,25 36:4,20 37:15,17 38:10,25 39:6.7 78:1 86:14 108:6 114:25 115:3 121:18 134:5 136:12,13 137:15 140:7, 17,20,21 145:14,15,16 146:11,14 147:19 156:10, 12 167:10,13,15 174:2,5,6, 10,18 175:13,22 177:5 180:17 181:11 195:24 254:2,4,5,6,8,16,18,19,21, 22 percentages 182:11 perception 204:5,23 perfect 64:8 108:12 110:7 144:17 147:4 181:24 192.11 perfectly 120:5 perforate 94:15 perforated 91:20 perforating 166:12 perforation 49:21 88:22 142:3.8 164:22 166:20 167:20 169:15.20 perform 43:16 48:6 69:12. 14,16,18,21 71:8 85:23 94:12,25 95:2,12 97:21 114:15 127:16,17 134:2, 18,19 205:18 206:13 241:5,6 266:22 268:23 269:1,11 274:19 performance 178:23 180:6 performed 48:9 51:1,8,9, 19,23 66:7 69:22,24 70:2, 5,8,13,15,20,23 71:4 74:8 109:5,21 127:23 134:5 145:6 161:15,17 173:23 174:1 180:22 181:11,12 182:17,22 184:6 187:2 213:15,24 performing 70:16 94:14 228:7,17 performs 179:1,24

period 25:11,17 33:4 72:10 **Placing** 119:23 180:3,23 225:1,19 262:12 plagiarism 250:6,7,11,15, 270:19 17 251:14 258:10,13,15,19 periodically 265:14 plagiarized 250:4 periods 33:23 225:12 **plaintiff** 5:10 233:12 perjury 8:7 plaintiff's 221:18 permits 125:20 plan 9:19,20 persistent 199:21 **Planned** 5:10 75:15,21 person 75:12 177:8 76:21,24 77:7,16 78:9,23 190:17 216:16 114:25 179:9,22,23 182:4 232:4,7,14,17 233:5,13,21 person's 155:19 278:22 personal 99:14 103:13 230:18 235:5 270:7 personally 21:22 22:6,8 91:19 276:2 perspective 139:23 140:1 193:25 195:10 284:2 176:10 pertain 226:18 play 26:11 pertained 28:15 phenomenon 256:8 plug 183:9 phone 277:7 278:11 physical 25:5 59:1 92:3,7, 10,12 93:14 94:17 142:20 192:13 228:19 278:4 physician 94:13 171:8 261:5 263:21 265:1 physician's 207:9 physicians 31:19,21,22 84:1 147:8 245:20 261:6 264:24 physiologic 129:4 physiological 82:17 129:11 158:14 274:11 229:25 pick 156:20 224:18 picked 160:17 picture 116:11 pictures 51:14 Pitocin 46:9 162:9,21 **place** 10:18 43:1,12,13 60:9 76:7,25 77:7 119:21 120:3,7 133:11 139:16 250:24 151:2 162:16 201:19 230:21 273:21 placement 86:2 placenta 47:18 48:22 84:24,25 85:15 86:3 87:1 90:4,6,21 91:1,4 143:5,6 168:16,20 169:1 252:21, 22,23 253:13,15 256:21 placental 90:5,17 91:4 placentas 90:19 placentation 86:6 88:2 89:21,24

places 239:15

planning 68:11 232:23 plans 125:22 plausibility 90:3 129:5,11 plausible 82:17 83:5,6 played 26:14 point 9:1 28:23 29:3 30:3 32:19,24 41:22,23 42:9 49:11 50:6 80:14 85:12 98:11,18 100:11 105:19 132:25 133:14 134:5 147:14 177:15 185:1 197:24 200:7,19 201:4,23 202:10 207:12,13 214:14 220:3 230:12 240:13 264:15 280:14 281:6

pointed 188:1

pointing 190:15 points 9:23 20:8 25:20,24

policy 235:7 267:20

poor 66:20 124:21 191:7 246:24 247:17

population 34:15 35:21 38:10,15,20 40:12 54:13

portion 200:14 234:24

posed 228:22

poses 134:16

position 18:23 59:13 85:16 113:14 131:15 134:22 151:10,21 164:5 200:19 227:15,18,20 236:13 276:7 282:24 284:4

positive 224:25

possession 21:2 64:21

possibility 25:5 41:2 42:14 45:9 59:3 91:11.13 132:25 133:3 156:13

possibly 12:11 13:13 21:7 40:2 47:18 93:5 101:18 104:8 126:12,13 171:2 233:7 248:6 282:12 post 28:22 42:11 78:25 92:2.5 post-aborted 72:15 post-abortion 82:8 post-abortive 76:3 **posted** 116:12 potential 45:8 58:25 125:13 143:9 189:3 192:13 197:9 200:3 207:9 potentially 86:2 155:7 164:24 168:7 205:7 235:7 poverty 126:10 practice 17:21,24 18:5 30:16,17 31:16,17 32:4,9, 12,17 33:9 34:16 39:2,4 41:20 42:5,6 43:24 50:6 56:23,25 57:3 61:2 62:23 63:5 64:18 68:20 71:7 73:14 101:19,22 102:6 114:1 116:3 132:23 136:6 139:21 140:8,9,12 141:2,4 171:6,13,17 181:10,16,19, 25 226:24 236:12 237:8 238:8,12 243:5 250:17 258:10 262:20 263:5 264:5,12 265:3 268:22 269:22 274:16,22 275:22 276:23 practices 41:21 practicing 51:3 practitioners 272:23 **Praderio** 221:17,19 pre-viable 209:19 231:25 precise 156:15 predictor 189:3 preexisting 188:12,24 189:18 prefer 41:9 preference 42:4 preferred 70:9 pregnancies 34:12 52:15 143:24 152:4 155:16 162:1,6 190:25 191:2 252:22 253:13 262:8,25 263:9.13.18 pregnancy 13:18 25:15, 20,24 29:4 35:12 36:25 37:2.20.24 38:12.22 41:23. 24 44:21 47:19 48:23 49:5, 17 51:7,20 52:13 53:3,9 56:6 57:13 58:13 59:3 60:23 62:15 65:22 66:24 67:7,13,19 68:25 69:15

70:2,13,21,24 71:5 74:7,

17,19 80:23,24 82:12,19 86:3 90:8,9 94:5 95:3,6,13 105:22 114:4 115:1 120:7 123:13 124:10 125:4 128:14,15 129:15 130:12, 22,24 131:12,19 132:24 133:1 134:16 135:24 136:7 137:3 140:11,14 151:25 152:25 153:1 154:1 155:8, 12,13,18,19 156:17,20,22, 24 157:5,7 158:11,12,13, 14,19,20 159:4 160:10 162:12 164:3,9 166:11 177:10 187:23 188:15,18 190:21 193:7 200:8,19 201:4,23 202:10,19 203:1, 24 207:13 208:2 224:16 225:7 228:22 229:6,25 230:12 254:3,17 255:11,17 256:4,12 261:10,12,14,15, 20,25 262:7,11 263:2,24, 25 264:1 267:24 269:17 270:7 271:4 273:6 277:2 pregnancy,' 106:3

pregnancy-associated 153:4,5,20 156:18 157:3 158:17,25 159:10,18

pregnancy-related 152:3,24 153:24 154:23 155:5,9 156:4,25 158:2,10, 15 159:22 164:10

pregnant 36:8,12,18,22,24 37:20 38:4,11,14,15,21,25 48:4 57:12 118:23 129:24, 25 130:2,3,11,16,17,18 131:6,11 208:22 210:11 224:14 229:11,16 231:4,15 266:19 267:11 270:7 277:15

premature 81:20 132:24 205:7 254:3,17

prematurely 59:4

prenatal 35:3,8,23 37:1 263:5 264:5 270:4,8 278:22

preparation 13:12 14:24 16:20,23 219:20 235:3 242:10

prepare 12:16 13:3 22:14, 17 29:22 99:4 105:10

prepared 85:5 99:7 100:9 preparing 22:20 23:6,8,14

100:2 220:1,6 prescription 78:12

present 37:1 38:23 266:5

presentations 220:10 presented 20:13,21 73:9, 19 107:17 148:8 244:4

248:10 presenter 20:23

preserve 228:6 229:10,15 pressure 45:14,21 210:11 211:24 212:1 prestigious 55:13 preterm 81:4,8,10 82:6,8, 14,16,25 83:9,13 84:8,15, 18 89:7.9 pretty 58:19 100:20 139:19 141:4 169:20 177:14 215.14prevent 175:3 232:7 preventive 65:22 previa 91:1 previa/accreta/increta 253:15 previa/acreta/increta 252:23 previous 235:10 236:17 previously 13:9 218:6 priced 125:16 primarily 281:9 283:2 primary 122:6 primate 205:1 printout 157:13 273:19 prior 26:25 46:15 47:2,4,10 48:4 65:9 76:2 81:23 82:22 85:19 88:2,4 89:24 90:17 91:14 92:15 93:15 112:24 113:14.15 115:13 118:9.10 132:7 133:13 189:2,6 205:16 222:1 224:14 243:9 279:25 priority 193:11 Priscilla 22:7,8 195:5 private 27:21 31:16 32:3, 12 34:15,19 58:2 109:22, 24 114:1 125:21 240:21 262:19 263:4 264:12 265:3 266:15 268:22 269:22 274:16 privately 34:18 privilege 27:25 **privileges** 27:10 275:12 pro-life 19:9 56:9,15,18 233:25 243:14 244:20 probable 249:5 problem 72:9 109:2 123:18,22 179:3 189:11 258:6 283:9 problematic 134:13 263:25 283:12,16,17 problems 6:9,10 35:5

40:14,16 92:5 procedure 6:6 49:19,23

66:7 68:8,9 69:25 87:17,23 88:25 94:12,16 95:15 117:24 118:14 136:20 138:18 146:6,7,9 162:24 164:15 167:2,5 176:23 179:1 180:5 205:8 206:13, 19 207:10 210:18 223:14 232:22 **procedures** 39:10,13 68:13 86:17 108:23 161:16

68:13 86:17 108:23 161:16 162:2,23 169:19 178:23 180:11,19 231:22

proceeding 222:2 223:3

process 49:5 50:21 76:12 114:18 121:21 124:5 203:10 274:12

processes 198:25

procrastinating 37:3

produce 236:12

product 28:24 professional 29:10,12 55:12 62:21 71:21 198:4

200:7 227:18,23 281:22 professionals 260:22

272:18

program 209:7 232:18

progress 273:3

prohibited 27:7 prohibits 28:17 175:6

project 243:18

projects 243:19 244:1,24 245:4

prolapse 142:13,14 prolonged 72:10

promote 56:5 77:22 pronounced 81:17

proper 178:22

proportion 184:2 pros 48:20

prospective 192:17,22

prostaglandin 42:18 70:10 79:25 88:9,13

protect 164:5 228:14

protective 128:16 130:12 255:13 256:6

protest 233:21

protocol 133:13

protocols 72:25

prove 188:2

provide 8:15 9:13 10:3 11:11 12:13 19:8 33:18 39:9 48:16 49:7 52:22 57:6,10 58:17 59:9,16,24 60:16,22 61:8,18 62:9 68:6 72:3 86:21 100:15 102:11 103:2 104:25 128:5,24 132:10 177:7 182:9,16

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

rat 199:20

Ingrid Skop, M.D.

194:13 267:3,4,19 269:15 270:4,14,24 272:12,22 273:1,9 276:18,19,22 277:3,9,10,12 278:10 provided 7:7 10:24 15:19 16:7 18:3 27:2,3,13 28:3 135:2,11 215:9 217:2 218:6 219:13 222:2 223:2 224:5 225:13 239:4 274:13.15 275:9 provider 58:3 61:3 66:7 178:19 179:5,8,13,18,19, 25 233:23 270:8 271:8 274:21 providers 27:9,23 76:11 109:21 110:2 178:17,24 179:3 271:5,10,12 274:23 275:2,23 276:1 providing 23:2 183:12 204:5 229:19,20 277:23 psychiatric 72:20 psychiatrist 71:13 psychological 92:4 185:8 228:19 psychologically 49:1 public 18:3,7 32:2,6 103:14 125:21 235:6 publication 250:21 257:22,24 259:7 282:22 publications 220:8 244:12 258:21 **publish** 220:9 published 64:6 68:4 103:17 111:10 163:17 220:13,16 226:2 234:3,19 249:12,18 250:21 257:25 publishing 13:23 83:20 pull 76:15 152:13 154:11 238:7 pulled 101:20 199:18 249:16 pulmonary 136:3 purely 190:1 purpose 210:4 222:16 262:6 **push** 211:1 put 8:16 10:18 19:13 28:16 56:21 107:21,25 111:13 149:2 150:7 159:14 167:23,24 175:12 189:4 211:5 212:1 214:2 226:5, 22 230:12,21,22 233:18 235:19 244:14 259:2 282:14 puts 120:20 122:12 putting 184:14 211:24

Q qualified 258:18 qualifies 72:13 **quality** 107:10 110:6 111:14 112:6,7 135:6,9,17 246:24 247:17 quantify 84:23 quarter 39:22 65:4 275:19 question 9:2,5,13 10:2,3 19:16 20:20 47:8 58:8 61:24 62:1,5 66:13 67:23 68:15 76:17 77:4 78:22 83:2 84:5,11 85:8 86:20,21 96:7 108:9 110:5 111:19 112:1,4 116:22 118:6 126:1 127:1 129:10 133:22 145:21 150:24 164:7 167:8 175:9,11 177:1 183:11,13 188:3 189:12,13 190:14 197:18 202:8,9 203:12 204:11 207:6 213:3 215:25 229:22 250:10 251:10,19 276:6 278:24 279:8 280:7 282:7 questioning 250:5,8 283:13 284:15 questions 8:15,16 9:1 10:10 11:12 54:23 111:21, 24 112:1 148:7 150:19,21 175:2 185:10,13 189:15 190:12,13 191:21 192:7 193:21 214:17 247:1.19 268:14 278:25 280:7 282:2 quick 108:8 268:1 279:18 quickly 85:6 281:24 quote 112:19 145:8 200:1 quoted 14:21 101:1 160:16 R race 212:18 rage 140:17 raise 46:3,4 raises 188:3 raising 41:13 random 210:4 211:3 range 54:17 69:2 123:9 167:10,13 180:3,7 201:6 rape 25:6 123:8 rare 36:23 37:14,19 38:3 43:18,21 46:7 47:9 48:1

49:14 54:7 117:13 138:16

rarely 66:10 161:19

274:21

rate 22:22 23:4,6,9 40:12 45:20 125:14 135:22 140:6,14 144:17,20,22 145:1,8,11 146:11,14 147:19 152:4 161:23,25 162:1 163:23 164:9,11 174:2 183:2 191:19 192:10 195:25 201:13 212:7,11,23 rates 14:11,13,20 136:6 145:9 146:23 147:3 150:10 151:1.4.13 152:6 154:23 155:10 159:23 163:9,10 178:18,24 184:10 212:24 Raymond 160:12,21 re-call 284:14 reach 18:24 218:23 reached 12:7 50:14 280:21,25 reaches 137:19 reaching 211:7 react 176:7 reacting 214:1 reaction 44:12 reactions 46:8 116:7.8 read 12:23 13:8 53:17 63:23 68:17,19 91:20 96:17 100:6 106:16,18,22 123:21 157:22 173:25 174:12,13 177:2,3 180:1,9, 11,20,21 195:11 197:9 217:1,3 219:16,22 225:21 247:10,14,24 248:5 254:9, 24 255:19 268:17 275:6 277.4 reader 177:7 242:23 reading 100:5 175:24 readmission 136:1 readmitted 73:12 ready 63:24 real 115:1 realistically 42:15 realize 129:5 145:8 149:12 236:8 258:5,17 realized 76:6 98:25 **Reardon** 187:1 reason 11:11 56:6 83:5,7 86:15 110:5 112:9 116:1 141:18 145:25 201:16 reasonable 133:12 225:18 230:9,20 reasons 13:17,21 14:8 27:17 38:24 40:4,6 78:4 88:3 94:9 105:21 106:2

107:12,16 111:2,6,17 112:9 120:13 123:18 129:6 149:13 171:24 230:9

231:12

reassurance 35:11

```
reassure 160:15
```

recall 6:4,25 11:25 12:6 14:4,9 20:3,14,15 21:12,14 23:13 51:22 61:20 62:3,4 75:23,25 76:18 77:2,6,10 78:19,21 79:1,8 100:14 102:4 104:1,3 121:10 124:4 135:18 142:2 195:21 196:2 206:25 207:1 215:23 216:6,22,24 221:6,13,15 223:4 225:16 226:9 235:2 237:15 240:10,15,21,23 245:1 248:4,8 257:2 265:2 280:9,24 282:6

recalled 280:15

recalling 80:3

receive 24:5 207:9 214:19, 24

received 16:15 23:18 78:8 208:8 215:6,11,17 219:1,3, 24 236:25 237:3 243:12 267:12

receiving 24:14 216:18 217:9

recent 75:23 76:18 220:21 221:17

recently 50:21 182:24

recess 65:7 149:7 214:10 279:22

recognize 48:25 146:9 148:18 170:20 172:7 263:19

recognized 50:18 283:7

recognizes 49:3

recognizing 147:4 181:24 recollection 10:9 12:10

20:18,22 223:12 280:11

recommend 133:12

recommendation 35:7 264:2

recommended 35:22

record 5:8,9,13 9:12,16 10:15 16:3 19:14 27:5 29:17 76:7 87:4 107:4 110:16 170:4,15 186:22 187:2 209:11 232:12 234:9 239:11 251:18

records 23:20 103:21 104:13,15 138:3 152:13, 17,22 154:4,12,13 155:6

rectal 138:8

rectum 137:19 138:8 rectus 45:6

red 239:2

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER Ingrid Skop, M.D.

reduce 53:2,3,5 130:3 164:2 reducing 53:9 reeks 113:9 refer 28:24 29:3 57:6 60:2, 5,14,21,25 61:10 62:17 98:16 107:2 124:9 126:4 147:16 173:17 266:22 277.11 reference 63:12 100:23 199:15 211:10 referenced 101:2 references 14:18,21 99:24 100:9 101:10 referencing 100:24 101:19 referral 57:24 58:1,4,9 59:7,16,18,20 60:17 72:1 271:7 referrals 60:22 61:18 62:9 271:5,10 referred 75:20 99:12,18, 19.20 173:6 179:21 181:15 182:14 241:4 referring 25:24 32:5 93:21 159:14 165:10 169:17 172:10 173:4 181:20 184:5 191:6 205:11 211:10 221:10 226:6 237:6 270:20 **reflect** 16:2,3 251:18 reflects 236:1 refresh 10:9 12:9 regarded 64:3 regimen 74:11,16 78:6,12 regret 113:4,18 118:13,21, 24,25 119:6 regretted 106:9 112:23 119:21 120:1 regulation 223:22,24 224:5.6 regulations 232:23 regulatory 271:19 related 13:16 17:3 26:16 66:21 68:5 144:23 152:25 153:12 155:15,21 156:7, 13,17,24 158:18,20,25 159:4 161:14 169:22 171:21 192:2 219:18 220:20,21,22 relationship 72:7 108:7 153:7,16 184:25 185:2,16 186:4 271:1 relative 129:18 175:13,14, 15 179:14 **relay** 198:21 release 213:7 234:10

released 201:12 207:18 relevant 30:10 72:22 105:7 118:2,4 124:15 233:16 244:9 reliable 63:8 106:25 108:17,19 109:5 111:8 121:12 122:2 144:19 147:2 151:11 171:5,20 181:25 183:1.2 184:17 224:21 242:24 reliably 225:6 reliance 53:5 relied 100:3 103:13 124:3 152:20 196:6 235:4 242:15,24 relies 54:14 82:19 102:8 religious 116:20 rely 56:23 63:4,22 64:22 101:3 124:4 153:16 156:16 159:15 172:20 195:6 204:6,8,16 240:18 262:18 264:4,20 relying 82:13,24 89:23 102:4 106:13 190:15 194:15 265:2 **remarked** 176:19 remember 10:7 12:15 20:11,12 21:4,8 80:4 123:20 127:1 149:3 170:10 194:10 215:10 217:7 223:16 242:4 280:17 282:6,19 remembered 10:9 remind 170:12 185:9 193:20 reminds 281:11 remote 10:19,20 remotely 10:18 removal 164:25 168:19,20 remove 163:1 removed 46:17 223:22.24 removes 48:22 repair 7:5 138:15,18 139:6, 7,14 repeat 78:22 136:2 264:6, 12 265:8,9 repeated 265:6 repeating 47:15 265:4 rephrase 9:4 61:9 62:8 92:9 133:22 167:4 replicated 278:1 report 6:24 12:19 13:6 15:5,7 16:11,17 23:8,14 28:10 29:11 76:9,11 79:10, 14 84:9 97:5 98:13,17 99:1,18 100:3,7,12 101:13,

16,24 102:4,8,12,14 103:4,

7,10,14,21 104:2,16,20,23 105:4,7,10,12,20 106:17 107:9 108:20,23 110:5 112:20 114:25 117:18,21 120:10 121:22 122:4 123:15 124:4 127:12 143:14 145:3 148:2 150:6 152:21 157:15 159:16 160:3 163:10,13,17 164:17 171:1 173:20 178:11,16 180:10,13,21 182:5 184:8, 11,24,25 185:4 186:14,17 194:9 195:19 196:4,13 197:3.23 198:14 205:5 222:12,16 223:17 230:7 234:24 235:4,12 238:24 239:3,20,22 240:5,19 241:15,24 242:2,10,14,23 246:15 249:9,24 253:3 254:11 255:5,22 256:20 283:22 284:3.8 reported 25:6 78:8.22 106:5 109:22 144:13 151:5,6,15 184:10 reporter 8:15 9:11 reporters 281:7 reporting 108:21 112:11, 15 reports 15:2 91:21 102:18, 20 108:6 208:3,4 249:7 257:15 283:1,3 represent 5:10 56:17 238:22 249:15 representative 26:7 226:7 represents 250:25 reproduce 251:8 Reproductive 83:23 147:9 republication 251:5,11,20 reputation 198:6 request 11:18 43:18,23 44:1 222:12 requested 284:24 requesting 284:17 **require** 40:14,18 46:6 132:16,17 138:14,16 139:10 142:7,20 160:2 203:19,20 required 7:4 27:8 50:13,23 73:10 76:4,5 78:23 138:25 203:6,9,15 284:15 requirement 203:8 requires 49:18,19 132:15 137:9 141:7,9,12 146:6,12 requiring 46:3 76:11

reread 12:18 219:22 245:18

research 14:14 63:8 64:21 66:8,20 96:22 97:3,12 98:5 99:8 102:9 103:11 112:6 121:15 122:6 125:24 153:14,15 239:25 240:1 241:3 246:22 247:16 250:14,16 251:23 252:3 281:12,14 282:14 283:12

researcher 121:5 240:16

researchers 13:22,24 14:20 101:4 106:14 107:13 241:5 245:8

researches 107:25 165:18

residency 67:2 69:21 70:6 73:11 79:17,21 114:21 206:24

resident 64:19

resign 227:17 resigned 227:20

resource 52:14

resources 58:16,22,23 100:16 271:1

respect 12:10 14:3,8,12 24:1 27:18 28:4 38:9 44:7 45:16 47:8 58:7 59:15 60:15,16 69:13 71:2 76:17 82:23 89:19 94:24 96:4,15, 20,24 102:12 112:4 113:23 118:10 121:1 122:15 125:25 126:23 129:23 131:15,18 148:10 151:3 153:14,24 154:21 156:3,4 163:14,21 173:10 181:25 183:2 186:7 192:13 194:1, 18 195:21 196:14 226:7,14 237:24 238:5 257:16 260:7 269:20,21 271:3 279:2

respectful 49:16 68:7

respiratory 209:15

respond 10:10 45:21 68:14 84:5 148:7 177:8,9

responding 17:4 150:20 211:5

responds 198:22

response 11:12,17 77:3 150:7 212:2 213:11

responses 95:21,24,25 96:2 97:7,8 185:10 214:2

responsibilities 18:21,22

responsive 58:8 211:1 229:21 278:24

rest 30:20 34:18,21

restriction 56:4 174:9,17 175:20 177:3 225:18 restrictions 223:14

145:1

135:25 136:1,2 144:23

serving 221:23

191:18

set 18:22 202:2 279:19

seven-week 35:22

severe 25:5,8 45:1

severity 40:15

sew 138:21

274:1

Seventy-two 225:22

shame 115:17 116:5.24

share 10:19 11:18 34:24

86:9,12 116:2 145:16

38:14,20 39:25 70:7 84:8

sheet 234:3,10,18 235:15,

sheets 18:6.7.9.11 235:10.

20 236:9 238:24 239:4

240:18 241:15 245:16

18 236:16 240:22

shortening 81:17,20

show 53:11 58:11 82:1

showing 110:19 157:13

83:4 89:17 172:25 199:13

short 148:20

211:16 214:2

shows 124:10

signals 201:11

signed 105:4

simply 146:4

266:16

230:23

19

signature 284:24

significant 137:20 139:19

162:2,23 164:15 239:6,10

178:18 179:11,19 188:16

site 122:6 261:4,6 265:16,

49:16 50:16 57:15 62:17

76:16 84:24 88:17 116:17

situation 46:17 47:12

similar 42:7 52:7 102:7

241:18 250:1 261:18

single 137:9 156:21

singular 260:13

sit 147:14 231:19

82:16

170:19

shut 45:3

sick 143:23

setting 32:1 46:14,24 47:5

82:4 84:17 110:7 146:11

result 47:25 138:9 197:25 252:20 253:14 resulted 48:1 131:10 resulting 80:23 252:22 results 44:25 107:6 resume 51:25 resuscitate 208:19 resuscitated 208:17 retained 168:16 retrospect 282:17 retrospective 186:16 return 215:18 216:4,11 280:7 reveal 115:10 revealed 242:9 reversal 141:13 reverse 141:14 reverses 142:1 reversible 52:22 review 13:11 15:2 89:17 100:21,24 102:20 103:25 135:16 154:2.15 191:15 220:17 239:3 281:15 **reviewed** 13:5 14:23 15:4, 10 16:9,11,12,19 64:6 67:15 68:4,21 100:4,19 148:1 163:18 192:13 220:23 244:12 246:2,3 250:19 reviews 157:5 188:20,23 revoked 227:1 **reworded** 283:6 **Rh** 206:6 **Rights** 147:9 rise 212:10.11.25 rises 212:7,23 rising 213:4 **risk** 40:11 41:13,17 44:4, 11,13,16 46:3,4,18 47:14, 16,17,22 49:21,22 57:17 58:25 86:17 88:17 128:10, 18 129:3.13.16 130:3.8.20 131:11,23 134:16 152:17, 18 153:10 160:9 161:4 162:5,11,15,16,17,21 163:2 164:2 165:21 173:1 174:10,18 175:10,12,14, 17,22 177:5 185:5 193:2,5, 11,17,18 210:20 228:16. 18,22 254:3,6,17,21 risk-taking 153:10 189:25 255:15 256:8 risks 44:7.10 45:25 57:19 128:8,10 131:18 143:5,10 road 159:7

Roe 123:25 213:23 role 18:10 26:11,14 102:17 135:1 260:4 271:24 277:23 278:5 roles 193:20 rolled 52:8 room 27:22 65:25 73:9 75:9 76:1 78:19 136:22 rough 116:16 roughly 145:16 route 124:2 routine 178:23 rule 9:9 47:1 rules 8:4 10:18 11:6 258:7 run 124:25 running 183:7 277:20 runs 273:5 rupture 46:10,18,24 47:25 132:24 168:1 ruptured 166:14 ruptures 46:20

S

sad 119:1,14,16 120:2,5 safe 143:22 146:7 147:12 **safely** 46:22 safer 51:12 88:24 160:14 safety 27:17,18 28:1 66:24 67:4,7,12,18 68:24 83:20 148:2 164:6 177:18 178:2, 12 220:24 224:7 252:6 253:23 257:17 sampling 109:23 San 40:13 97:23 271:6 save 226:13 saved 134:15 207:22 scanty 67:9 scar 47:6,19 88:3 90:24,25 166:15 scarring 92:14 scenario 41:12 132:21 141:22 schedule 267:15 scheduled 31:10 33:23 scholars 18:19 21:11 school 97:17 **science** 122:6 Sciences 148:2 246:23 Sciences' 150:6 178:11 scope 244:9

screening 266:12,16 sealed 15:24 217:20.22.24 218:13,19 Second-trimester 110:20 seconds 98:23 secret 114:4.6 section 39:21,22 46:6,22 secure 191:9 sedated 141:18 sedation 141:13,14,19 seek 265:17 seizures 6:11 selection 194:6 247:7 self-manage 78:3 self-managed 77:18 Senator 26:9 send 10:14 60:10 79:13 97:23 201:11 237:2.16 sending 11:16 216:15 sense 12:12 29:12 33:24 34:6 36:1,21,23 39:19 118:18 136:5 162:17 190.10sensed 200:15 sensitivity 224:24 225:10 261:18 sensory 197:8 198:17,20 199:7 200:2,10 201:10 sentence 127:21 128:2 143:16 249:14 252:19 255:8,25 259:1,9,14,15,17 sentences 174:8 248:13 249:15,17,22 258:6,14,21 259:5,12 282:8,21 283:10, 18 sentinel 160:3 separate 90:7 240:25 separated 228:5 separation 44:21 166:11 232:24 sepsis 73:12 80:11 164:24 168:13 September 20:4 249:10 septicemia 73:15 79:18 88:8 sequelae 72:19,20 serve 11:21 34:15 service 81:19 274:8,9 276:9.16 services 115:1 232:15 243:10 266:3 269:19,20,25

273:2 275:10,17 276:5 278:17

118:	19.2	1 168:7	206:6
------	------	---------	-------

situations 81:23 205:17 206:10 208:18

size 30:24 50:14

skeptical 111:12,14 skilled 179:1 skills 127:15 skimmed 281:23 skin 137:5 skip 105:11 skipping 145:7 Skop 5:2,7,14 11:7 15:14 16:5 19:16 21:16 23:19 29:19 37:21 56:12 57:10 58:7 60:20 61:7,14 65:9 66:11 67:13,22 68:12,14 78:15 80:19 82:21 84:3 86:18,20 90:14 91:23 96:8 99:2 101:11 105:4 107:1 109:24 110:13,21 114:14 116:22 121:22 129:9 146:4 147:13 148:6 149:9 156:15 158:15 170:19 175:19 177:2 178:3 181:20 183:13 185:9 189:12 193:20 196:21 198:25 203:11 204:12 213:21 214:12,20 225:13 229:21 230:18 231:14 234:11 237:6 238:6 240:1 246:6 250:2 251:3, 15 252:13 256:18 273:16 274:23 278:25 279:25 281.13 slowed 265:22 small 20:8 137:16.18 139:9 250:24 251:1 268:10 smaller 86:13 Smith 221:5,7,10 **smoking** 147:12 social 40:5 121:19 122:5 228:19 societies 185:8 197:16 society 55:12 116:20 177:20 230:15 **soft** 49:21 50:19 164:23 169:15 **someone's** 240:13 son 216:13 sophisticated 207:3 Sorenson 5:16 9:19,25 10:19 11:3 12:5,7 15:20 16:25 17:5,6 19:10,13 60:18 61:5,12,23 62:10 65:3,14 67:20 86:11 96:6 102:11,15 103:2 105:17 119:12 148:22 149:2,23

170:8,12 217:2 219:3 237:3 280:4 284:21 sort 83:18 250:1 278:6 sorts 60:22

sound 122:11 180:7 248:2

sounded 78:19 sounds 7:19,23 15:22 52:21 65:5 112:1 123:23 134:18 136:15 149:6 150:1 193:25 205:21 211:12 237:14 269:7 source 52:9,10,11,12,21 99:23 100:9,23,25 109:4 111:9 116:24 120:22 121:3,12 122:2 124:1 125:3 147:3 150:9.14.25 159:23 171:6 181:25 182:3 184:9 242:3 249:13,19 257:11,13 260:8 271:21 272:12,17 273:5,9,16,20, 21 277:9,15,17,25 278:17 279:2,9 283:20 sources 109:3 121:16 122:6 **space** 45:7 sparse 247:7 **speak** 65:13 149:22 196:24 219:2 281:7 **special** 10:18 108:7 specialist 206:20 specialization 97:18 Specialties 68:10 specialty 205:24 **specific** 40:9 59:21 60:9 65:24 66:3,14 69:2,3 77:6 78:21 79:2 82:24 84:5 90:15 113:24 122:18 123:24 147:15 150:21 157:4 171:16 180:11 192:5 204:14,15 208:4 220:23 225:17 232:21 262:16 269:14 274:16 279:8 **specifically** 14:10 75:20 76:20 78:19 100:8 101:14 111:6 154:18,25 155:23 161:9 165:10 193:12 208:12 230:2 240:23 261:23 275:4 specifics 142:10 spectrum 84:24 85:15 87:1 143:6 speculating 84:14,16 spend 24:10 47:13 215:13 219:17 220:5 **spent** 22:20 23:2,6,8,11, 14,22 103:6,21 219:12 220:1 spinal 201:10 spiritual 278:3

spoke 17:5 219:5 **spoken** 16:23 17:2 22:12 92:2

spontaneous 256:3 spontaneously 90:7 spot 65:1 210:19 St 53:11 staff 265:21,24 267:3 268:2 standard 7:7 35:8 74:25 199:20,21,22 205:6 207:17 standards 83:22 179:4 251:6,13,21,24 252:1.2 277:24 start 9:15 24:20 98:21 162:18 186:25 192:8 224:21 started 150:3 214:16 279:24 starting 42:10 77:21 143:16 186:15 197:24 starts 45:14 105:23 255:8 state 5:12 23:19 24:1,10, 14 61:15,16 73:24 76:9 79:11,14 121:8 122:17 123:13 130:25 131:7,9 152:7 154:19,23 180:16 197:6 199:22 222:6 223:25 226:24 230:8 272:3 275:21 State's 164:4 stated 61:10 statement 56:4 150:18 174:16 240:13 244:3 248:5.7 statements 100:9.22 103:5 235:7 236:12,13 239:15 242:7 states 26:15 28:5 29:7 66:22 75:13 76:10 108:16 109:10 110:20 112:15 124:19,22 125:5 145:12 146:17,24 147:4 150:11 151:1 172:6 173:3.11 182:2 183:12 198:5 228:3 229:2,5 274:1 statistic 125:8 statistics 120:13,22 121:17 122:16 123:5,8,14 144:2 145:20 165:18 181:22 273:25 stay 150:21 246:5 steroid 209:2 steroids 208:12,21,23 209:5,6 **STI** 52:16 265:15 266:6,7, 12,16

stick 150:20 185:10 278:25 sticking 82:5 stigma 116:5,6,25 119:10

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER Ingrid Skop, M.D.

> stillbirth 255:16 stillbirths 154:7 stimulated 131:13 stimulation 130:22 131:10 stimuli 212:21 213:5 **stimulus** 212:13 213:2 stitch 139:16 stitches 138:23,25 139:3, 8,10 141:10 stomach 210:11 stop 9:20 59:6 65:1 166:1 188:5 214:9 stopped 76:1 stories 53:16 story 107:16 straight 5:9 9:16 102:1 267:7 stress 255:10 256:3 stretch 9:21 stretched 87:12 stringent 247:20 stroke 136:4 studies 14:4,6,22 53:10 82:1,4 83:3 89:17,25 90:18 101:21 129:7 144:21 146:22 147:23 152:21 153:15 156:11.16 159:15 173:16 176:2 186:20 187:3,17,22 188:7,11 189:19 190:14,20 192:12, 18 204:6,8,9,16,18,19,20, 21 242:20 246:22 247:2.3. 5,7,16,19,21,22 Studnicki 245:7 **study** 105:24 106:1 110:9 124:9 143:3 145:14 146:15 147:18 148:3,9,13 149:12, 16 154:16 160:12.15.21 179:11 183:15,22 186:16, 23 187:1,2 188:14 190:13 191:7,11,12,14,15,19,20, 22 192:5,15,23 193:12,24 194:1,5,6,8,17,21,24 195:10,12,15 196:3,6,10 197:7 198:3,4,10 199:15 202:2 204:14,15 207:18 208:6,8 247:4,21 275:9 studying 147:24 stuff 21:4 210:17 212:18 215:15 233:19 235:13 282:14 stumbling 98:25

subcutaneous 45:7

subgroup 56:16

subject 8:6 83:25 221:23 271:16 279:10 284:14

Ingrid Skop, M.D.

submit 222:16 submitted 15:5 28:12 56:3 98:14 103:23 104:14 163:17 215:15 230:7 249:7 submitting 124:5 subscribe 63:24 subsequent 47:18 80:24 81:4 90:8 252:21 253:13 254:3,17 subsequently 99:24 subsets 185:4 substance 24:20 64:7 substantial 30:7 127:6,8 substantially 188:3 subtractions 239:7 suction 48:21 49:11 50:6. 11,15,20 73:11,15 suffer 185:21,22 189:8 suffering 91:25 185:16 sufficient 203:21 228:16 suggest 130:10 148:22 suggesting 125:10 suicidality 186:11 suicide 255:15 256:9,11 **suicides** 153:9 suits 227:10 summarize 100:22 superficial 137:5 supplies 123:4 support 27:16 58:21 82:20 114:7 120:16 121:1 184:16 209:15 224:5 229:20 232:15 247:8 270:25 supported 224:9 supporting 226:10 suppose 179:14 supposed 15:17,18 215:6 218:19 surgeries 33:22 97:21,22 205:15,19 surgery 7:4 27:12 45:5 46:16 47:20 76:5 136:2 138:14,17,22 142:7 144:23 145:1 146:12 165:2 surgical 6:21 48:21 78:24 80:8,9 85:17,18 87:13,17, 18 88:20 90:19,20,22,24, 25 91:7,9 136:20 138:18 143:14,17,21 146:6 165:15,25 168:8 170:24 253:12 surrounding 164:23 168:4

surveillance 151:14 survival 133:15,17 134:6 survive 133:24 270:18 survived 208:2 209:5 Susan 172:6 244:22 suspect 36:24 266:18 277:14 suspended 227:2 suspicion 263:2 sustained 270:19 Swingle 254:19 switch 24:19 sworn 5:3 symptoms 71:25 syndrome 92:14,18 93:6, 10 143:7 syphilis 265:14 system 45:14 76:6 132:3.9 133:10 134:17 156:22 188:16 199:13 200:12 202:7 209:15 Systems 32:21 33:1,13 Т tab 29:14,19 98:12 110:16 157:9 158:6 170:6,9,17,19 172:3,23 177:22 181:16 234:7.12.13 238:1.25 245:12,19 246:10,13,15 248:21 252:4,7,8 253:3,21, 24 254:12 255:5,22 257:17 268:5 273:12 277:1 table 124:6 183:15,23,24 takes 25:1 taking 112:10 176:22 192:11 230:14 258:10 259:5,7,11,13 282:21 283:10 284:25 talk 9:18 11:20 14:19 19:5 25:20 57:16 73:4 105:20 112:18 117:8.19 118:5 119:3 124:5 128:7 131:20 140:17 146:23 194:14 195:4 220:7 249:9 talked 16:22 62:20 73:2 78:17 80:3 84:17 88:5,6 128:4 142:17 143:4,5,8 144:16 172:10 222:3 225:23 234:23 259:24 280:8 talking 9:15 25:14 81:3 101:14.16 107:6.7 112:2.

13 115:16,22 117:25 150:5 186:21 231:11 talks 111:6

teaching 209:17 tear 87:14 137:16,19,20 138:6,7,24 139:1,9,15 tearing 137:13,22 139:11 142:19 tears 138:4 139:6 technical 47:19 technique 70:9 techniques 143:15,22 teenager 80:7 93:20 teenagers 193:6 telling 75:19 122:20,22,24 tells 66:9 121:18 213:12 ten 65:2 74:1,3 93:4 94:3 176:14 196:20 240:11 279:20 ten-year 180:3,23 tend 208:11 209:18 tended 239:16 tendency 81:16 tenure 135:3 term 36:18 60:23 68:15 80:24 82:20 125:4 128:2, 16 129:16,18 130:12 152:19 156:9 161:4 163:2 164:2 168:22,23,25 174:24 187:16,20 188:1 190:7,18, 24 191:4 195:18,22 196:12 206:3 208:2 270:16 276:10.12 terminate 57:13 113:9 128:15 193:7.8 termination 49:18 terminology 158:3 166:18 terms 33:18 39:5.20 64:10 72:12 89:5 100:21 114:17 118:7 139:1 145:18 151:17 172:19 180:1 182:11 193:24 201:18 204:23 208:22 242:8 256:25 test 224:16.23.24 225:7 243:21 261:14,15,16,20,25 267:24 testified 5:4 27:24 71:3 229:24 230:4,5 268:19 282:18 testify 104:17,21 284:7 testifying 7:6 8:5,11 39:3 testimony 19:9 20:14,22 22:14,17 23:3,7 24:2 26:24 27:2,3,13 28:3,6,7 61:14, 16 65:10 104:25 131:16 149:10 214:13 222:2,6,10 223:1,11,15 224:4 225:23 236:9 239:12,21 240:17 244:10 248:3 252:12 279:1,25 283:15,23

testing 52:16 225:17 266:6,7

tests 261:13

Texas 6:12,14,20 27:4 28:3 33:14 52:13 58:2 61:14,16 73:24 76:10 77:22 94:9 206:20 222:6 223:10 224:4 226:7 271:16 272:8 279:10

text 11:4

textbooks 64:17,20,22

thalamus 199:14 200:13 201:8,20,21,24 202:11,17 203:6,15,21,25

therapeutic 72:6 123:17, 22,24

therapy 142:20

thing 10:1 47:24 116:20 128:13 212:8

things 9:12,15 10:8 16:7 20:6 30:7 53:17 55:21 82:16 85:24 95:10 100:6 103:17 111:18 115:7 135:14 136:11 137:1 142:24 169:18,24 170:4 185:3 206:7 209:25 212:25 213:4 223:5 228:20 245:5

thinking 23:17 129:24,25 130:2,16,18 140:9 235:13 251:16 259:10 267:10

thought 15:11 37:19 103:13 140:5 184:13 198:12 215:14 233:18 236:14,16 237:6,7,15 238:16 242:19 244:11 258:4,15 259:8 282:10,16

thoughts 283:3

thousand 104:4,11

threat 229:2

threatened 229:11 231:2, 7,15

three-quarter 39:23

three-ring 218:1,2,3,4

thromboembolic 136:3

throw 138:25

thrown 216:6

time 10:2 16:16 17:22 19:25 22:19 23:2,6,7,11, 14,16 24:16 30:18 33:2,4, 17 37:11 39:1 47:4,13 56:6 65:4,11 70:9 72:7,10 74:1 76:6 77:15 78:1 85:3 99:8 103:10,21 130:17 132:16 135:21 137:15 138:15 141:13 147:14 148:17 155:19 157:6 177:17 180:4,23 183:8 184:10 185:12 190:4 200:14 204:15 205:12 213:1

Index: submit-time

214:9,22 215:14 219:3,9, 12,17,23,25 220:5 223:13 224:25 225:8,13 227:12 228:22 246:19 251:4 258:4,14 263:6,11 264:17 265:7 266:24 267:17,24 268:25 270:19 280:10.14 times 5:21 40:14 50:22 75:16 77:13 81:14,18 91:23 92:15.22 100:21 118:12 119:8 144:6 160:4 167:11 182:15 208:13 228:20 261:8 270:17 tip 43:10 tips 17:3 tissue 47:19 48:23 49:1,6, 22 164:25 168:19 197:9 198:20,21 200:3 281:12,14 **Title** 232:11,12,13,18 233:3,8 titled 234:9 tobacco 147:11,12 today 8:3,6,14 9:24 10:16, 22 11:10,12,18 22:20 25:13 64:22 66:12 86:13 92:2 147:14 150:20 185:1 186:21 189:15 193:21 194:16 215:7 218:22 222:3 227:8 231:20 234:25 270:17 280:1 284:19 today's 8:4 13:12 14:24 16:20,23,24 22:17 98:17 told 9:19 22:16 24:8 68:7 76:20 92:7,10 93:13 94:17 95:9 114:3 119:7,16,20 223:2,10 245:3 284:1 top 105:22 topic 13:16 67:15 68:19 69:6 233:7 topics 55:15 99:9,11 240:12 total 22:19 69:5 183:25 totally 215:8 town 276:3 track 23:15 84:4 86:24 135:5 139:18,21,24 140:3, 23 141:1,6 142:5 146:19, 20 150:22 160:19 198:24 tracked 144:12 tracking 135:2 tracks 140:12 traction 43:14 traditional 208:9 trained 30:12 69:13,18,24 263:19 264:8,25 training 19:8,18,20,21,22 20:5,7,9,10,22,25 21:8 22:11 29:10 69:20 97:14

178:22 280:18,20 281:2,5, trainings 22:13 transcript 8:17 transducer 211:25 transfuse 93:19 transfusion 76:4 136:1,11 transfusions 93:18,24 transition 29:2 50:10 transmission 213:13 trauma 252:20 253:11 treat 72:1 treated 73:6 76:19 78:25 84:20 89:7 92:2,8,11 93:14 94:18 treating 72:12 91:24 207:8 treatises 64:17 treatment 65:22,23 71:16 72:14 78:24 157:6 208:9 209:2 tremendous 188:21 trend 81:21 tri 73:13 trial 8:12 23:3,6,9 tricky 57:4 triggered 94:23 trimester 36:4,21 37:16 38:16,17 48:18 73:15 74:11,18 75:5 80:8,9,15 88:19.20 93:21 113:8 124:25 125:11,15 144:24 165:15,20,22,25 174:4,5 182:1 191:24 192:2 268:11 269:21 270:11 trouble 45:13 106:3 197:16 true 42:5 78:13 123:21 130:5 133:23 156:3 177:7 264:10 trust 264:7 269:5 truth 6:5 75:19 100:14 121:11 122:21,23,24 184:12 216:12 241:10 257:2 Truthfully 233:17 tubal 39:14 tubing 50:15 turn 29:14 63:8 64:17 98:12 105:19 110:4 120:10 127:11 143:13 157:8,9 164:17 172:3,22 173:19 177:22 178:7 184:23 195:14 251:25 253:14.20 268:4 273:12 **Turnaway** 14:4,5 191:7,15

192:15 193:12,24 194:6,22 195:10 turned 195:22 TV 220:4 twelve 21:10 **Twenty** 31:18.22 Twenty-five 51:4 twenty-two 66:17 twin 211:10 twins 211:6 two-thirds 123:17 155:21 207:18,19 two-year 68:10 type 80:6 128:17 130:22 142:14 165:15 167:17 169:24 210:17 222:2 223:2 types 32:7 53:8 139:20 169:19 typically 35:3 36:9 38:19 45:21 144:22 169:3 268:19,22,24 269:1,11 274:20 U U.S. 46:24 146:17 159:23 uh-huh 13:25 21:23 22:1 23:1 29:5 35:14 36:16 39:4 43:20 51:6 67:3 75:2 80:6 86:1 112:3 119:18 128:25 134:11 136:14 138:13 140:1 154:20 161:12 171:12 184:21 195:7 201:1 220:25 231:24 236:21 252:11 253:7 257:19 263:8,12 264:10 266:4 268:12 269:3 282:18 ultimately 100:13 122:17 213:24 265:9 ultra 269:6 ultrasound 35:11 50:1 58:11 116:11 210:10,14 211:12,17,22,25 214:1 225:11 261:14 262:6,13, 15,18 263:6,15,22 264:4, 15.17.20 265:2.9 268:11. 13,20,23 269:2,6,12,22 270:12 ultrasounds 262:3 264:7, 11.22.24 unable 11:11 46:23 58:13 uncertain 282:20 uncertainty 113:15 114:11 115:2 uncomfortable 95:14 115:15

uncommon 93:18 167:12 underestimates 109:1 undergo 86:16 undergoing 205:7 underlying 40:15 understand 8:5,9,14 9:2,6 10:22 11:1 20:19 25:15 62:1,11 67:23 76:16 96:8 100:1 103:12 111:25 113:13 121:21 123:11 131:14,21 132:22 137:21 151:10,12 153:6,13 158:7, 15 178:10 179:16 195:9 196:8 199:24 202:23 224:3 228:9 235:16 239:18 269:8 284:1 understandable 8:25 understanding 24:25 74:15 78:11 80:15 85:14 134:2.9 141:16 147:13 156:1 158:21 182:14 195:14 200:18 205:16 207:7 208:7,9 215:5 232:18 235:21 276:10 understood 125:7 220:8 undifferentiated 131:7 undoubtedly 115:21

209:21 unethical 57:6 115:20

unfavorable 41:16 42:8, 12,13,22 46:3

uniformly 25:7

unintended 52:15 53:3,9 unique 164:21 166:4,5,23 169:14,20 249:21,22

258:5,16 unit 54:4

United 28:5 66:22 75:12 108:15 109:10 110:20 112:14 145:12 146:17,24 147:4 150:11 151:1 172:6 173:2,11 182:2 198:5 228:3 229:2 274:1

University 207:17 208:6 unnecessary 202:24 229:19

unplanned 269:16 271:4

unpleasant 197:8 199:7 200:2

unrelated 93:10 155:20 158:13 230:8

unrestricted 232:13 unripe 82:18 untrue 61:22 62:6,7 unusual 168:6 unwanted 120:7

PLANNED PARENTHOOD ASSOCIATION OF UTAH vs MINER

update 149:10 updated 64:22 updating 235:13 **Urinary** 138:12 urine 45:21 261:14,15 266:9 Utah 5:11 12:22 26:4,15 123:13,14,16 125:20,23 134:7,9,12 154:16.23 157:14 158:4,9 164:6 174:9,17 175:21 177:4 180:2,11,15,23 181:4 225:20 233:13 Utah's 180:6 uterine 39:14 45:4 46:10, 16,18,20,24 47:25 81:9 88:2,13,21 142:3,8 166:19 168:1 252:24 253:16 uterus 44:14 45:2.6 47:5 49:21 87:6,9,21,24,25 91:3 92:14 94:15 136:20 137:11 146:7,13 162:25 163:1 164:23 166:12,13 167:20, 25 169:16 252:20 253:12 270.18 uteruses 91:20 V vagina 138:8 167:24 vaginal 39:20,23,24 42:20 46:15 47:23 137:12,13,14, 21 138:24 139:12 142:11. 19,21 161:5,10 162:1 163:24 164:9 vaginal-birth 163:9 vaginally 43:5 46:23 vague 61:12,23 62:10 67:20 96:6 van 265:20 variable 189:7 vary 41:24 42:1 vasculature 164:24 168.10vast 83:24 241:16 **VBAC** 47:23 vegetative 199:21 vein 206:3 verbal 28:6,7 verbatim 8:16 verified 101:10 263:20 283:21 **verify** 99:24 **Vermont** 222:10,13 223:11,13,25 224:4 225:23

versus 39:21 123:25 vessel 206:11 vessels 45:4 94:15 viability 35:12 132:16 133:1 174:6 205:16 207:16,23 270:14,17 videos 213:20,21 214:2 view 53:2 64:12 70:17 134:19 150:9 184:16 185:2 201:19,22 207:9 211:17 212:3 225:4 229:9 237:18 241:6.8.19 viewed 64:4 viewpoint 284:2 views 240:25 violent 153:10 visit 35:4,10,18,22 264:5 265:10 269:7 visits 34:11 visualize 139:15 vital 152:21 volume 127:15 178:17 179:8,13,18,25 180:4,8,25 182:7 183:11 voluntarily 144:13 voluntary 55:13 108:21 160:4 256:3 volunteer 264:24 volunteers 261:2,6 vomits 44:12 W wait 9:13,14 48:24 76:17 264:14 267:23 waiting 225:12,19 237:1 waits 113:7 walking 183:6 wall 252:24 253:16 wanted 24:20 48:5 76:13 99:11 133:8 150:3 157:25 158:3 190:25 214:18 233:18 241:10 244:11 266:5,13 276:22 wantonness 190:20 watched 220:4 ways 42:21 116:15 132:19 211:23 212:5 weak 91:3 web 157:13 website 17:22.25 101:7

120:16,23 121:9,15,24 122:10,13,23,24 123:2 256:24 273:16 Wednesday 33:19 week 33:17,19,20 34:4 37:25 38:17 39:6 73:13 181:1 215:1 217:3 224:19 261.8 weeks 25:3,9,10,15,16 27:7 28:22 29:4 35:6,16,25 38:6,7,11,19,21 41:6,25 42:2 49:2.18 50:2.8.12.18 51:7,19,24 66:17 67:7,12, 19 68:25 69:3,14 70:2,13, 21,24 71:5 74:1,2,3,7,19 79:18 81:21 91:18 94:4,8 95:3,6,13 123:12 127:23 128:3 132:24 145:7 149:18 152:11 154:7,8 155:13 161:9,24,25 173:24 174:1, 21,23 175:6,7,11 176:2,8, 14 177:10 180:17,23 181:12,13 200:11,12,21 201:6,17,18 202:4,5,7,13, 18,23,25 203:24 207:23 208:1.10 209:22 211:6 213:16,19 214:5 224:11, 17,18,20,22 225:3,4,6,7,10 230:3,4,5,21 well-being 42:11 255:10 256:2,5 well-documented 256:10 well-known 171:9 well-researched 283:22 white 34:21 widely 123:8 160:16 Winter 248:25 wished 119:8 withdrawal 198:22 201:11 212:12 witnesses 21:19,20 woman 7:3 20:16 25:2 36:23 37:7 42:7 44:12 46:14 47:14,17,20 51:12 53:21 54:7 72:18,21 88:1 93:9 106:8 112:22,25 113:3,19 114:3,6 116:16 119:24 124:17,21 126:10, 13 129:8,18 131:11,12 132:18 142:12 143:23 158:10 159:6 165:14 174:3 175:7,9 176:20 177:16 187:10 189:10 225:5,13 228:5 259:25 260:6,11,12, 13,14,16,18 261:9 263:17 264:4,7,23 265:3,11,16,17, 24 266:4,6,19,21 267:2,11, 13,18,25 268:20 269:6,19, 21,23 270:4,12 271:4,10, 15 273:5 279:2

woman's 45:20 46:4 62:14 134:15 152:13 154:4,12 164:2 177:18 188:23 228:14 229:3 255:12 256:4 Ingrid Skop, M.D. women 13:17 27:22 28:1 34:12,20 36:7,11,13,15,17

37:1,11,15 38:3 40:14

46:16 47:2 52:14 53:13 58:20 65:25 66:6 68:5 72:9,16,19 73:3,4,5,9,19 76:3,24 77:13,17,23,24 78:2,4,18 80:20 81:3,18,25 83:12,16,19 85:3 86:16 87:25 88:3,7 90:25 91:6, 10,19,24 92:4,13,24 94:7 111:17 112:10 113:4,5,18 115:2,17,18,19,21 120:6 123:6 137:4 142:20 155:4, 6,12 156:2 159:3,5 162:4, 13,17,22 174:9,17,20 175:3,4,17,21 176:17 177:4,8 179:5 185:4,21 186:1,3,8 187:16,20,24,25 188:15,17 190:2,3,7,24 191:4,8,22 193:10 195:15, 17,18 196:7,11 224:13 229:20 260:9,11 271:3 273:22 274:1,4,9 women's 52:17 77:14 113:25 228:5 232:20 272:22 273:21,22 274:7,10 276:8,10 278:3 wondering 54:23 111:1 word 67:21 166:5 167:6 236:4 240:9 259:1 worded 257:10 wording 102:7 203:17 257:13 258:17 282:16 words 69:9 125:7 159:3 162:3 282:20 283:7 work 17:23 30:18 31:5,16, 25 32:11 33:16,20 40:8 52:7 59:13 77:25 111:22 113:3 132:3,10 147:8,9 163:21 195:6 232:8 238:19 243:7.16 248:10 250:11 251:9 258:10,16 259:6,7, 11,16,18 273:2 275:23 worked 18:2 132:6 working 18:11 52:20 67:1 216:13 272:25 277:25 works 35:9 65:5 109:25 111:11 199:14 world 46:19 115:1 worries 183:8 worsening 40:15 wrap 282:1 wrap-up 280:6 write 18:16 124:13 147:10 164:4 223:17 238:18 239:17 258:25 282:14

writing 18:4 219:6 225:17 240:1,4,7,22 284:19

written 8:17 18:9,14,25 24:1 26:25 27:1 28:8,9 67:15 68:21,22 69:1,2,4,11 99:10 103:9 177:14 232:10 233:2 236:7 245:7 257:3, 10 259:1,15,17,18 283:2 wrong 135:15 141:21 235:3 278:23 wrote 17:21 103:24 163:15 184:10 196:3,10 222:12 235:9,15,19,22 236:5,11 239:8 243:21 246:8 248:3, 4,6,7 249:9 252:13 256:18, 19,25 257:4 282:10,16 Υ year 19:24 34:3 43:25 51:2 108:15 117:14,15 118:7,12 152:18 155:14 157:7 158:11,19 159:1,12 179:17,24 180:16 249:4,10 years 6:14,21,25 7:16 27:22 33:9,11 49:15 51:4 52:4 59:2 62:4 67:1 70:6 75:8 76:1,22 77:13 80:13 85:2 93:18 114:1,23 179:11 220:11 221:2,16 227:12 236:10 240:12 Yellow 60:2.5 yesterday 15:9,14 16:13, 15 214:20 215:11 217:8 young 114:3 165:14 209:15,22 Ζ Zane 165:17 172:6,9,20 182:19,20 183:14,22 Zane's 172:13 **Zealand** 194:5