Exhibit B

NO. _____

JEFFERSON CIRCUIT COURT
DIVISION _____ (__)
JUDGE _____

EMW WOMEN'S SURGICAL CENTER, P.S.C., *et al.*,

PLAINTIFFS

v.

DANIEL CAMERON, *et al.*,

DEFENDANTS.

AFFIDAVIT OF ASHLEE BERGIN, M.D., M.P.H.

I, Ashlee Bergin, M.D., M.P.H., swear and state the following:

1. I am a board-certified obstetrician-gynecologist (OB/GYN) licensed to practice in Kentucky and one of the physicians who works at EMW Women's Surgical Center ("EMW"). I submit this declaration in support of Plaintiffs' motion for a restraining order and or temporary injunction.

2. I graduated from Reed College, in Oregon, in 1999 and from George Washington University School of Medicine, in Washington, D.C., in 2006; completed my residency in OB/GYN at the University of Chicago, in Illinois, in 2010; and completed a family planning fellowship at the University of Illinois College of Medicine at Chicago, in 2015. I also earned a Master of Public Health from the University of Illinois at Chicago. I am a fellow of the American Congress of Obstetricians and Gynecologists and a Junior Fellow of the Society of Family Planning. A copy of my curriculum vitae is attached.

3. In addition to providing abortion care at EMW, I am currently an Assistant Professor and the Assistant Director of the Ryan Residency Program in the Department of Obstetrics, Gynecology and Women's Health at the University of Louisville School of Medicine. I am also the Section Chair of the American Congress of Obstetricians and Gynecologists' Kentucky Section. I am participating in this action as an individual and not on behalf of any institution or association other than EMW.

4. As an OB/GYN, I provide the full spectrum of obstetric and gynecological care including inpatient and outpatient care, surgery, labor and delivery, miscarriage management, abortion, and contraception. I am dedicated to providing high-quality, patient-centered health care to all of my patients, including those who decide to terminate their pregnancies. I am challenging Kentucky's abortion bans because they are forcing me to violate not only my medical and ethical obligations as a physician, but my personal obligation to ensure that those who decide to terminate their pregnancies can obtain safe, legal, and compassionate abortion care.

5. I have been providing reproductive health services, including abortion care, at EMW for almost seven years. EMW is one of the two outpatient abortion clinics in the Commonwealth of Kentucky.

6. The information provided in this declaration is based on my personal knowledge. The opinions in this declaration are my expert opinions as an OB/GYN and an abortion provider. My expert opinions are based on my education, training, professional experience, and review of relevant medical literature. All of my opinions in this declaration are expressed to a reasonable degree of medical certainty.

7. The ability to control whether to carry a pregnancy to term, or to terminate a pregnancy, is essential to a woman's overall health. Pregnancy and childbirth are major medical events that

carry risks, particularly for people with underlying health conditions, that could lead to hospitalization, life-long complications, or death. Compared to childbirth, abortion is very safe – one of the safest medical procedures in the United States.[1] If Kentuckians are prohibited from obtaining an abortion because of Kentucky's laws, and instead are forced carry their pregnancies to term and give birth against their will, the consequences will be dire.

8. A typical pregnancy is about 40 weeks long as dated from last menstrual period to delivery. Pregnancy inherently causes major physiological changes to a person's body. One of the biggest changes involves increased intravascular (blood) volume. This can have several consequences including making patients more vulnerable to anemia, which is a condition that develops when the patient's blood has a lower amount of red blood cells. Anemia can increase risks for preterm labor and delivery as well as need for a blood transfusion following delivery. During pregnancy, the heart rate increases and with increased blood volume, the heart is forced to do more work than usual. The cardiac output increases 30-60% during pregnancy.[2] While most people can tolerate increases in cardiac output, these changes can lead to complications in patients with a history of cardiac disease.

9. Pregnancy also changes lung functioning. The diaphragm elevates, which decreases the overall lung capacity. As a patient's uterus increases in size, patients cannot take as deep of breaths, which causes them to experience shortness of breath.[3]

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[1] National Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States* (2018), https://doi.org/10.17226/24950.

[2] Pascual, Zoey, et al., *Physiology, Pregnancy*, StatPearls [Internet] (last updated May 8, 2022), https://www.ncbi.nlm.nih.gov/books/NBK559304.

[3] *Id.*

10. Approximately a third of patients with asthma experience a worsening of asthma during pregnancy. Although most patients with asthma remain stable during their pregnancy, some can require an inhaled steroid, and if the condition worsens, the patient must be hospitalized to help manage her breathing. Poorly controlled asthma can increase both maternal and fetal morbidity and mortality. For example, patients are at higher risk for developing high blood pressure during pregnancy, and the risk for preterm labor and premature birth is also increased.[4]

11. A number of preexisting conditions can increase the morbidity or mortality associated with pregnancy, including sickle cell disease, lupus and collagen vascular diseases, epilepsy, substance use disorder, and infectious diseases such as HIV or hepatitis.[5]

12. Many patients experience nausea and vomiting during pregnancy due to the pregnancy hormone, beta hCG, and elevated levels of estrogen and progesterone. Some patients experience vomiting so severe that they cannot tolerate food, which leads to weight loss.[6] It can also lead to electrolyte changes, and, if these are not corrected, heart rhythm abnormalities can occur. A patient could also lose key nutrients, such as thiamine. If there is prolonged nausea and vomiting, it can lead to Wernicke's Encephalopathy, which is a neurological disorder typically associated with alcoholism and malnutrition.

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[4] Shebl, Eman, *et al.*, *Asthma In Pregnancy*, StatPearls [Internet] (last updated April 25, 2022), https://www.ncbi.nlm.nih.gov/books/NBK532283.

[5] Blackwell, Sean, *et al.*, *Reproductive services for women at high risk for maternal mortality: a report of the workshop of the Society for Maternal-Fetal Medicine, the American College of Obstetricians and Gynecologists, the Fellowship in Family Planning, and the Society of Family Planning*, Am. J. Obstet. Gynecol., April 2020.

[6] Pascual, Zoey, *et al.*, *Physiology, Pregnancy*, StatPearls [Internet] (last updated May 8, 2022), https://www.ncbi.nlm.nih.gov/books/NBK559304.

13. Furthermore, pregnancy increases clotting factors present in the blood, and in conjunction with compression of the inferior vena cava by the gravid uterus, there is an increased risk of developing blood clots during pregnancy. In fact, pregnancy increases the risk of developing blood clots by fivefold. Deep vein thrombosis ("DVT") is also a risk. DVT involves a blood clot that forms in one's veins and that clot can migrate into the lungs, potentially causing death. Blood clots can also form in arteries and lead to heart attack or stroke during pregnancy. The increased risk for blood clot formation exists throughout pregnancy and delivery but is highest after delivery in the post-partum period.[7]

14. Patients who have Type 2 diabetes or develop gestational diabetes because of the pregnancy also face greater risks. The risks of developing pre-eclampsia and needing cesarean section to achieve delivery are increased. Diabetes during pregnancy can lead to complications during delivery including fetal shoulder dystocia (where the fetus's shoulders get stuck during delivery), fetal nerve palsies (nerve damage), and oxygen deprivation to the fetus, which could lead to fetal brain injury or even fetal demise.

15. Preterm premature rupture of the membranes (where the patient's "water breaks" too early) can occur during pregnancy and puts patients at risk for infection and placental abruption (where the placenta separates from the uterine wall, which can cause serious fetal complications, including fetal death). If a patient experiences placental abruption, the patient's risk for life-threatening hemorrhage is increased.[8]

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[7] *ACOG Practice Bulletin No. 196: Thromboembolism in Pregnancy*, Obstetrics & Gynecology, July 2018; Walker, Isobel D., *Venus and arterial thrombosis during pregnancy: epidemiology, Seminars In Vascular Medicine* (Feb. 2003), https://pubmed.ncbi.nlm.nih.gov/15199490.

[8] *ACOG Practice Bulletin No. 217: Prelabor Rupture of Membranes*, Obstetrics & Gynecology, March 2020.

16. Hypertensive disorders are also a significant concern in pregnancy. Preeclampsia is a condition characterized by high blood pressure during pregnancy, which puts the patient at risk for many things, including stroke, seizure, and placental abruption. Furthermore, patients can also experience headaches or altered consciousness. The patient's lungs could retain fluid decreasing a patient's oxygen saturation. Preeclampsia can also lead to impaired liver and kidney function. There are also risks to the fetus including growth restriction. If a patient experiences preeclampsia in one pregnancy she is at a greater risk for developing it in subsequent pregnancies.[9]

17. Patients with renal disease also face risks from pregnancy, and their renal function can worsen after delivery given pregnancy's effect on the kidneys. Renal disease can lead to anemia and put a patient at risk for preterm birth and even pregnancy loss. People with renal disease can also develop high blood pressure during pregnancy. Some patients will require dialysis.[10]

18. Approximately 10-15% of pregnancies will end in miscarriage. Most people will pass the products of conception without issue, but some people will have complications such as hemorrhage that will require an emergency procedure (dilation and curettage) to empty the uterus, and possibly a blood transfusion. If the fetus or the placental tissue doesn't pass on its own, infection including sepsis can result, requiring hospitalization.

19. In patients who carry their pregnancies to term, there are risks associated with the labor and delivery process. For example, during the labor process, patients are at risk of developing

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[9] *ACOG Practice Bulletin No. 222: Gestational Hypertension and Preeclampsia*: Obstetrics & Gynecology, June 2020.

[10] Gonzalez Suarez, Maria L., *et al.*, *Renal Disorders in Pregnancy: Core Curriculum 2019*, American Journal of Kidney Diseases (Aug. 16, 2018), https://doi.org/10.1053/j.ajkd.2018.06.006.

infection in the uterus, or chorioamnionitis, also known as intrauterine infection or inflammation (Triple I Infection).

20. Patients who deliver by cesarean section (C-section), when an incision is made on the lower abdomen, face additional risks, as with any surgery. These risks increase for patients who are immunocompromised, such as those with diabetes, or who are significantly obese. Risks include skin infection, hemorrhage (especially given the increased blood flow to the uterus during pregnancy), inflammation of the lining of the uterus, abscesses in the abdomen, and damage to surrounding organs (uterus, bladder, bowels). Those who have repeat C-sections face additional risks including morbidly adherent placenta (such as placenta accreta where the placenta does not detach because it has grown into the uterine wall), and risk of hysterectomy (removal of the uterus). Patients who have a C-section also face risks from complications of the anesthesia. People who have C-sections are also at higher risk for blood clots compared to those who deliver vaginally.

21. Patients who deliver vaginally also face risks, including pelvic floor injury, such as tearing of the perinium, which is painful and requires time to heal. More extensive tears can lead to problems with a patient's bowel and bladder function. Furthermore, given the increased blood flow to the uterus, there is a risk of hemorrhage from vaginal delivery as well as C-section.

22. Some patients experience cardiomyopathy (weakness of the heart muscle) at the time of delivery or afterward. This weakness results in a lower percentage of blood that gets pumped out with every beat. If the heart is not pumping as much blood as it should, it means the heart is not meeting the body's demand for oxygen, which can adversely affect the lungs and liver, and other body systems. Some people will recover but some will have permanent reduced cardiac

function. If a patient has experienced it in one pregnancy, there is a greater risk she will experience it in a subsequent one.[11]

23. Patients face mental health risks as well. Approximately 15% of patients suffer from post-partum depression, which will necessitate counseling and/or medication. If post-partum depression goes untreated, it can lead to guilt, anxiety, suicidal ideation, inability to care for oneself and/or for the baby. It can also affect the bonding between the patient and the baby, which can lead to the baby's failure to thrive and overall poor health of the baby.[12]

24. These serious complications from pregnancy, including death, are higher if you are Black due to structural racism and inequities in our health care system. For example, a Black woman's risk of dying during pregnancy or childbirth is about two times higher than her white counterpart.

25. Complications from pregnancy and childbirth not only affect the physical and mental health of the patient but can also interfere with her ability to care for her children or go to work or school if she is debilitated or hospitalized. The time to recover from childbirth can also affect a patient's life, including recovery from abdominal surgery (C-section) and injury during vaginal delivery, discussed above.

26. If Kentucky's abortion bans are permitted to stand, our patients will face all of the risks discussed above because they will be forced to carry a pregnancy to term against their will.

27. Although the Trigger Ban contains a medical emergency exception, it is very limited – it applies to prevent the death or to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman. The Six Week Ban's exception is similar – to prevent the woman's

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[11] Arany, Zolt, *et al.*, *Peripartum cardiomyopathy*, Circulation (April 2016), https://www.ahajournals.org/doi/10.1161/CIRCULATIONAHA.115.020491.

[12] Pearlstein, Teri, *et al.*, *Postpartum depression*, American Journal of Obstetrics and Gynecology, https://doi.org/10.1016/j.ajog.2008.11.033

death or prevent a substantial and irreversible impairment of a major bodily function. As discussed above, many patients will get sick but not sick enough to meet this definition. Others may eventually get sick enough to meet the definition, but it is cruel to require them to deteriorate until the point where the exception applies. Moreover, because the law carries felony penalties, myself and other doctors and health care staff members are going to be very nervous relying on the exception in case the Attorney General disagrees with our medical assessment of the emergency.

28. Abortion is one of the safest medical procedures in the United States and is substantially safer for a woman than childbirth. A woman's risk of death associated with childbirth is approximately 10-14 times higher than her risk of death associated with abortion.

29. One in four women will have an abortion in their lifetime. Every person has their own deeply personal reason for seeking an abortion, including reasons based on familial, medical, or financial circumstances. Some have abortions because they decide it is not the right time in their lives to have children or to add to their families because they need to pursue their education, they feel they lack the resources or partner support to raise a child, they face onset of intimate partner violence (IPV) or intensified levels of IPV, or they are concerned that adding another child will make it harder to care for their existing children. Some decide to have an abortion because of risks to their health, including the risks of pregnancy and childbirth discussed above.

30. Some patients decide to have an abortion after receiving a diagnosis of a fetal anomaly. When patients receive a diagnosis of a fetal anomaly, they can experience stress and anxiety, and some decide to terminate the pregnancy while others decide to carry the pregnancy to term. In cases of lethal fetal anomalies, while some patients continue the pregnancy, most find that the prospect of continuing a pregnancy to term and giving birth to an infant who will not survive is

extremely distressing and decide to terminate the pregnancy, especially given the risks of pregnancy and delivery discussed above.

31. Furthermore, a number of my patients seeking abortion care have been sexually assaulted, and if these patients were forced to carry their pregnancies to term and give birth against their will, they would possibly face additional trauma by constantly being reminded of the violation committed against them.

32. Although people can travel to another state to get an abortion, many of our patients are low-income and will not have the ability or resources to travel. Those that are able to travel will also face risks to their health if they have to delay their abortion while they raise funds to travel and make arrangements. Although abortion is extremely safe, and safer than remaining pregnant and giving birth, delay increases risks by forcing the patient to remain pregnant, which is risky itself, and by necessitating a procedure later in pregnancy, when the complication rate is greater.

I have reviewed the facts contained in this affidavit and they are true and correct to the best of my knowledge.

Ashlee Bergin, MD, MPH

Ashlee Bergin, M.D. M.P.H.

COMMONWEALTH OF KENTUCKY)
)
COUNTY OF JEFFERSON)

Subscribed, sworn, and acknowledged before me by Ashlee Bergin this 26th day of June, 2022.

Notary Public TRACY MORTIN-WILEY

My commission expires: Oct 16, 2025

Kentucky NP ID: KYNP 35554

Attachment 1

ASHLEE BERGIN

Louisville, KY

EDUCATION

MPH	University of Illinois at Chicago, School of Public Health Chicago, IL	May 2015
	Family Planning Fellowship University of Illinois at Chicago Chicago, IL	June 2015
	Obstetrics and Gynecology Residency University of Chicago Hospitals Chicago, IL	June 2010
MD	The George Washington University School of Medicine Washington, D.C.	June 2006
BA	Reed College, Biology Portland, OR	May 1999

CURRENT POSITIONS

Assistant Medical Student Clerkship Director 2019 - present
Department of Obstetrics, Gynecology, & Women's Health
University of Louisville School of Medicine
Louisville, KY

Assistant Director, Ryan Residency Training Program 2015 - present
Department of Obstetrics, Gynecology, & Women's Health
University of Louisville School of Medicine
Louisville, KY

ACADEMIC APPOINTMENT

Assistant Professor 2015 - present
Department of Obstetrics, Gynecology, & Women's Health
University of Louisville School of Medicine
Louisville, KY

OTHER POSITIONS AND EMPLOYMENT

Staff Obstetrician/Gynecologist 2010 – 2013
Little Company of Mary Hospital
Evergreen Park, IL

Embryologist, IVF Laboratory Technician 2000 - 2002
George Washington University Medical Faculty Associates
Washington, D.C.

Laboratory Technician 1999 - 2000
Gamma-A Technologies, Inc.
Herndon, VA

CERTIFICATION AND LICENSURE

Diplomate, American Board of Obstetrics and Gynecology 2012

Colorado Medical License 2022

Kentucky Medical License 2015 - present

Illinois Medical License 2009 - present

DEA Registration 2009 - present

PROFESSIONAL MEMBERSHIPS AND ACTIVITIES

Fellow, Cefalo National Leadership Institute 2022
American College of Obstetricians and Gynecologists

Chair, Kentucky Section 2020 - present
American College of Obstetricians and Gynecologists

Vice Chair, Kentucky Section 2017 - 2020
American College of Obstetricians and Gynecologists

Secretary, Kentucky Section 2015 - 2017
American College of Obstetricians and Gynecologists

Elected Fellow 2013 - present
American College of Obstetricians and Gynecologists

Junior Fellow in Practice, District VI 2010 - 2012
American College of Obstetricians and Gynecologists
Group Leader for Mentorship Task Force

Junior Fellow 2006 - 2012
American College of Obstetricians and Gynecologists

Member 2014 - present
European Society of Contraception and Reproductive Health

Junior Fellow 2013 - present
Society of Family Planning

Member 2008 - 2019
Association of Reproductive Health Professionals

Fellow, Leadership Training Academy 2014 - 2015
Physicians for Reproductive Health

Student Teacher, MSII Physical Diagnosis Class 2004 - 2005
George Washington University School of Medicine

President, Beaumont Research Society 2004 - 2005
George Washington University School of Medicine

HONORS AND AWARDS

Chicago Lying-In Hospital Excellence in Student Teaching Award 2007

Alpha Omega Alpha National Medical Honor Society 2006

President, Kane-King-Dodek Obstetrical Honor Society 2006

Rachel Morris Dominick Award in Obstetrics and Gynecology 2006

Recipient, Charles Iber Memorial Scholarship 2003

Reed College Presidential Commendation for Academic Excellence 1998 - 1999

COMMITTEE ASSIGNMENTS AND ADMINISTRATIVE SERVICES

Ethics Committee Member 2021- present
University of Louisville School of Medicine

Review Panel Member 2018 - present
Continuing Medical Education & Professional Development Advisory Board
University of Louisville School of Medicine

Member, Passport Health Plan Women's Health Committee 2018 – 2020
Member, Residency Program Evaluation Committee 2014 - 2015
University of Illinois at Chicago Hospital

Member, Perinatal Practice Committee 2010 - 2013
Little Company of Mary Hospital

Resident Member, Graduate Medical Education Committee 2009 - 2010
University of Chicago Hospitals

EDUCATIONAL ACTIVITIES

University of Louisville, Louisville, KY 2015 - present
Presenter, MVA Workshop for Medical Students and Residents

University of Louisville, Louisville, KY 2016 - present
Medical Student Advisor for Education and Research Tracts

University of Louisville, Louisville, KY 2016 - present
Presenter, First and Second Trimester Abortion

University of Louisville, Louisville, KY 2016 - present
Resident Research Advisor

University of Louisville, Louisville, KY 2016 - present
Presenter, Professionalism Workshop

University of Louisville, Louisville, KY 2016 - 2018
Presenter, Sterilization Workshop

University of Kentucky, Lexington, KY 2016
Invited Presenter for OB/GYN Grand Rounds, Physicians as Advocates

University of Louisville, Louisville, KY 2016
Presenter for OB/GYN Grand Rounds, The Interpregnancy Interval

University of Louisville, Louisville, KY 2015
Presenter, Contraception Workshop

Loyola University, Chicago, IL 2015
Presenter for TEACH Program, First Trimester Abortion

Chicago College of Osteopathic Medicine, Chicago, IL — 2015
Presenter, Professionalism Workshop

Chicago College of Osteopathic Medicine, Chicago, IL — 2015
Presenter, First and Second Trimester Abortion

Chicago College of Osteopathic Medicine, Chicago, IL — 2014
Presenter, Contraception

University of Illinois at Chicago, Chicago, IL — 2014
Presenter for OB/GYN Grand Rounds, The Interpregnancy Interval

University of Illinois at Chicago, Chicago, IL — 2013 - 2015
Presenter, First and Second Trimester Abortion

Chicago College of Nursing, Chicago, IL — 2014
Presenter, First and Second Trimester Abortion

University of Illinois at Chicago, Chicago, IL — 2013 - 2015
Presenter, Contraception

Medical Council of Guyana, Georgetown, Guyana — 2014
Invited Presenter, Family Planning Considerations

Georgetown Public Hospital Dept. OB/GYN, Georgetown, Guyana — 2014
Invited Presenter, Ectopic Pregnancy

Georgetown Public Hospital Dept. OB/GYN, Georgetown, Guyana — 2014
Assistant Course Director, Safe Abortion Training

Georgetown Public Hospital Dept. OB/GYN, Georgetown, Guyana — 2014
Invited Presenter, Contraception

Georgetown Public Hospital Dept. OB/GYN, Georgetown, Guyana — 2014
Invited Presenter, Basic Ultrasound

Georgetown Public Hospital Dept. OB/GYN, Georgetown, Guyana — 2014
Invited Presenter, Pregnancy Termination

University of Illinois at Chicago, Chicago, IL — 2013 - 2014
Presenter, Basic Ultrasound

University of Illinois at Chicago, Chicago, IL — 2013
Presenter, Ectopic Pregnancy

Loyola University, Chicago, IL — 2013
Presenter for TEACH Program, Estrogen-Containing Contraception

Chicago College of Osteopathic Medicine, Chicago, IL 2011
Presenter, Options for Abortion and Early Pregnancy Failure in the First Trimester

University of Chicago Hospitals, Chicago, IL 2010
Presented for OB/GYN Grand Rounds, Birth Spacing

GRANTS AND CONTRACT AWARDS

Past Grant
Primary Investigator (6 person months) 2014 – 2015
Family Planning Fellowship Research: Providers, Patients, and the Interpregnancy Interval: Knowledge, Attitudes, and Practices
Funded by the Society of Family Planning, Grant #SFPRF14-25
Award Total $69,621

PUBLICATIONS

Books

Bergin, A. (2018). A 19-year-old with Postoperative Fever and Lower Abdominal Pain. In K.V. Meriwether & J. England (Eds.), Obstetrics and Gynecology Morning Report: Beyond the Pearls (pp 265-269). Philadelphia, PA: Elsevier.

Journal Publications

Ruben LN, Johnson RO, **Bergin A**, Clothier RH. Apoptosis and the Cell Cycle in Xenopus: PMA and MPMA Exposure of Splenocytes. Apoptosis 2000; 5:225-33.

Dayal MB, Gindoff P, Dubey A, Spitzer TL, **Bergin A**, Peak D, Frankfurter D. Does ethnicity influence in vitro fertilization (IVF) outcomes? Fertility & Sterility 2009; 91:2414-8.

Bergin A, Whitaker AK, Terplan M, Gilliam M. Failure to return for intrauterine device insertion after initial clinic visit. Abstract. Contraception 2009; 80:217.

Bergin A, Tristan S, Terplan M, Gilliam ML, Whitaker AK. A missed opportunity for care: Two-visit IUD insertion protocols inhibit placement. Contraception 2012; 86: 694-7.

Bergin A, Rankin K, Stumbras K, Handler A, Haider S. Prenatal Patient Knowledge of the Interpregnancy Interval. Abstract. Obstetrics & Gynecology 2017; 129, 5 (Suppl): 18S.

Pomerantz T, Patel P, Miller K, Ziegler C, Hoffmann J, **Bergin A.** Teaching Medical Students About Abortion Through Problem-Based Learning. Abstract. Obstetrics & Gynecology 2018; 131, (Suppl): 163S.

Pomerantz T, **Bergin A**, Miller KH, Ziegler CH, Patel PD. A problem-based learning session on pregnancy options, counseling, and abortion care. *MedEdPORTAL*. 2019;15:10816.

Hoffmann, J, **Bergin, A.** Contraception, Abortion and More: Understanding Health Disparities for LBGTQ Patients in their Own Words. Abstract. Obstetrics & Gynecology: May 2019 - Volume 133 - Issue - p 76S
doi: 10.1097/01.AOG.0000558710.06533.3f

Sullivan, R, Franklin, T, **Bergin, A.** Anti-Abortion Picketing and Mental Health: Is There a Correlation Between Picketers and Post-traumatic Stress? Abstract. Obstetrics & Gynecology: May 2020 - Volume 135 - Issue - p 93S doi: 10.1097/01.AOG.0000664120.64643.c6

Posters

Bergin A, Whitaker AK, Terplan M, Gilliam M. Failure to return for intrauterine device insertion after initial clinic visit. Presented at Reproductive Health, Los Angeles, CA, September 30-October 3, 2009.

Bergin A, Rankin K, Stumbras K, Handler A, Haider S. Prenatal Patient Knowledge of the Interpregnancy Interval. Presented at the 65th Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists, San Diego, CA, May 6-9, 2017.

Pomerantz T, Patel P, Hughes Miller K, Ziegler C, Hoffmann J, **Bergin A.** Teaching Medical Students About Abortion Through Problem -Based Learning: An Evaluation of Medical Students' Knowledge and Experiences. Presented at the 66th Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists, Austin, TX, April 27-30, 2018.

Hoffmann J, **Bergin A.** Contraception, Abortion, and More: Understanding Health Disparities for LGBTQ Patients in Their Own Words. Presented at the 67th Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists, Nashville, TN, May 3-6, 2019.