PLAINTIFFS-APPELLEES' APPENDIX
VOLUME I

Exhibit	Description
1	Opinion and Order Granting Temporary Injunction, *EMW Women's Surgical Center v. Cameron*, Case No. 22-SC-3225, filed July 22, 2022 (Jefferson Circuit Court)
2	Verified Complaint for Injunctive and Declaratory Relief, *EMW Women's Surgical Center v. Cameron*, Case No. 22-SC-3225, filed June 27, 2022 (Jefferson Circuit Court)
3	Kentucky Annual Abortion Report for 2020 –Exhibit 3 from July 6, 2022 Temporary Injunction Hearing, *EMW Women's Surgical Center v. Cameron*, Case No. 22-SC-3225, filed July 7, 2022 (Jefferson Circuit Court)
4	Transcript of July 6, 2022 Temporary Injunction Hearing, *EMW Women's Surgical Center v. Cameron*, Case No. 22-SC-3225, filed July 19, 2022 (Jefferson Circuit Court)

EXHIBIT 1

NO. 22-CI-3225

JEFFERSON CIRCUIT COURT
DIVISION THREE
JUDGE MITCH PERRY

EMW WOMENS
SURGICAL CENTER, et al. PLAINTIFFS

v.

DANIEL CAMERON, et al. DEFENDANTS

OPINION & ORDER GRANTING TEMPORARY INJUNCTION

Introduction

This matter comes before the Court on Plaintiffs' Motion for a Temporary Injunction. The Court held a Hearing on July 6, 2022 where the parties presented expert witness testimony. Both parties have filed proposed Findings of Fact and Conclusions of Law. After careful consideration of the record and the memoranda of the parties, as well as the applicable law, the Court determines that the Temporary Injunction should be granted.

The Plaintiffs have sustained their burden of demonstrating substantial questions on the merits regarding the constitutionality of the challenged laws. As discussed further below, the Court finds that there is a substantial likelihood that these laws violate the rights to privacy and self-determination as protected by Sections 1 and 2 of the Kentucky Constitution, the right to equal protection in Sections 1, 2, and 3, the right to religious freedom in Section 5, and that additionally KRS 311.772 is both an unconstitutional delegation of legislative authority and unconstitutionally vague. For all of these reasons, the Plaintiffs are entitled to injunctive relief pending full resolution of this matter on the merits.

Findings of Fact

I. Procedural Background

On June 24, 2022, the United States Supreme Court issued its opinion in *Dobbs v. Jackson Women's Health Organization*, 142 S.Ct. 2228 (2022). The Supreme Court in *Dobbs* entirely overruled *Roe v. Wade*, 410 U.S. 113 (1973), and returned the issue of abortion to the states. The Attorney General contended that KRS 311.772 ("Trigger Ban") was thereby triggered and became effective on June 24, 2022. On June 27, 2022, the Plaintiffs, two clinics that provide abortions, among other medical services, and the doctor-owner of one of the clinics, filed this lawsuit challenging the constitutionality of the Trigger Ban and KRS 311.7701-7711 ("Six Week Ban"), and seeking a Temporary Restraining Order ("TRO") pending a hearing and ruling on a Temporary Injunction.

The Court held a hearing on June 29, 2022 to consider the TRO. After hearing arguments of all parties, the Court reviewed the filings and subsequently granted the TRO. The Court then held a full evidentiary hearing for the Temporary Injunction on July 6, 2022. Each side presented two expert witnesses. Dr. Ashlee Bergin and Dr. Jason Lindo testified for the Plaintiffs, while Dr. Monique Wubbenhorst and Professor O. Carter Snead testified for the Defendants. After the hearing was concluded, the Court requested the parties file proposed Findings of Fact & Conclusions of Law.

II. Factual Findings

The Plaintiffs are healthcare providers who also provide abortions in Kentucky. Prior to *Dobbs*, EMW Women's Surgical Center ("EMW") provided medication abortion up to 10 weeks from the last menstrual period ("LMP"), and procedural abortion through 21 weeks and 6 days from the LMP. Since entry of the TRO, EMW provides medication abortion up to 10 weeks from the LMP and procedural abortion up to 15 weeks.

The second Plaintiff, Planned Parenthood Great Northwest, Hawai'i, Alaska, Indiana, and Kentucky ("Planned Parenthood"), provides a variety of medical services to patients, and has also been providing abortion services in Louisville, Kentucky since 2020. Before *Dobbs*, Planned Parenthood provided medication abortion up to 10 weeks from LMP, and procedural abortion up to 13 weeks and 6 days from the LMP. After entry of the TRO, Planned Parenthood resumed abortion services as before *Dobbs*.

The final Plaintiff is Dr. Ernest Marshall, a board-certified obstetrician-gynecologist ("OBGYN") who performs abortions at EMW, and is also the owner of EMW.

Defendant Daniel Cameron is the Attorney General of Kentucky. In this role, he has the statutory authority, and duty to ensure proper enforcement and compliance with the laws of the Commonwealth. Defendant Eric Friedlander is the Secretary of the Cabinet for Health and Family Services ("the Cabinet"). In that role, he is responsible for the oversight and licensing of facilities that provide abortions to ensure they comply with applicable state laws. Defendant Michael Rodman is the Executive Director of the Kentucky Board of Medical Licensure ("the Board"). The Board possesses the authority to pursue disciplinary actions against Kentucky physicians for violations of state law. Finally, Defendant Thomas Wine is the Commonwealth's Attorney for the 30th Judicial Circuit. In this capacity, he has authority to pursue criminal prosecutions for crimes committed in Jefferson County.

At the July 6th Hearing, the Plaintiffs first called Dr. Ashlee Bergin. Dr. Bergin is a board-certified OBGYN who provides care at EMW, as well as teaching at the University of Louisville Medical School. Dr. Bergin testified at length regarding the complications that can arise from pregnancy, the relative safety of abortions, and the harms that can result from lack of access to abortions. Video Record ("VR") 10:12:21-10:13:04; 10:13:35-10:13:55; 10:15:50-10:16:15; 10:17:04-10:17:16. The latest records from the Kentucky Department of Public Health Office of Vital Statistics show that of the 4,104 abortions provided in Kentucky in 2020, there were only 30 complications, the majority of which were minor. Pls.' Ex. 3 at 12. Further, there were zero recorded deaths from abortion complications in Kentucky in 2020, whereas there were 16.6 per 100,000 pregnancy-related deaths in 2018, the last year data is available. Pls.' Ex. 3 at 12; Pls.' Ex. 10 at 10. Dr. Bergin testified that at the date of the hearing, EMW had turned away approximately 200 patients, before the TRO was entered. VR 10:20:25-10:20:41. Dr. Bergin also testified that the narrow medical emergency exceptions in the laws at issue are insufficient because it is medically and ethically unacceptable to force a patient deteriorate to the point at which she would become clearly eligible for the exception. VR 10:18:10-10:18-38.

The Plaintiffs next called Dr. Jason Lindo, an economist and causal effects expert. Dr. Lindo testified about the impacts abortion bans have on people, and the likely impact if these abortion bans take effect. Dr. Lindo testified that prenatal care and childbirth are very costly, even to those with medical insurance. VR 12:05:34-12:06:23. Further, these costs are not limited

to purely monetary ones. Pregnancy can lead to significant disruptions to a woman's education and career[1]. VR 12:07:31-12:08:04. Not all Kentuckians are legally protected from pregnancy discrimination in the workplace, or entitled to the reasonable accommodations needed to perform their jobs while pregnant. KRS 344.030(2) (exempting employers with fewer than 15 employees from pregnancy discrimination laws). Additionally, many Kentuckians are not entitled to paid time off for pregnancy, delivery, or recovery. U.S. Dep't of Labor, National Compensation Survey: Employee Benefits in the United States, March 2021, Table 33.

Dr. Lindo further testified that while some Kentuckians will be able to travel to other states to access abortions, not all will be able to afford to, and others will be prevented by the similarly restrictive policies of surrounding states. VR 12:16:19-12:16:41; 12:23:16-12:27:40.

The Defendants first called Dr. Monique Wubbenhorst, an OBGYN and research fellow at the University of Notre Dame de Nicola Center for Ethics and Culture. Dr. Wubbenhorst testified that she questioned the accuracy of abortion statistics in general, but was unable to provide any evidence to support her criticism. VR 2:18:46-2:20:14; 3:01:17-3:01:46. She further challenged the accuracy of maternal mortality statistics, but again was unable to provide any evidence to support her criticisms. VR 2:16:12-2:18-45.

The Defendants also called O. Carter Snead, a professor at the University of Notre Dame Law School and the Director of the de Nicola Center for Ethics and Culture at Notre Dame. Professor Snead has contributed significantly to the field of public bioethics. Professor Snead testified about the ethical concerns of the data indicating that many women who receive abortions are poorer, minorities, or experiencing some sort of life disruption. VR 3:59:15-4:01:29. He expressed concern that these women lacked a real choice, and were likely coerced into obtaining abortions by outside factors. *Id.*

Both Defense witnesses generally expressed views that mirrored the positions of their institutional employer, namely that abortion should have no place in the practice of medicine and should not be provided even in the cases of fatal fetal anomalies, rape, or incest. VR 2:44:37-2:46:09. In a recent statement, the de Nicola Center reaffirmed that position: "The University of Notre Dame is institutionally committed to 'to the defense of human life in all its stages,' recognizing and upholding the sanctity of human life from conception to natural death (cf.,

[1] The Court recognizes that these laws will also impact members of the LGBTQ community. Accordingly, "woman" is used in this Order to refer to all people affected by these laws.

https://news.nd.edu/news/notre-dame-adopts-new-statement-and-principles-in-support-of-life/). For our part, the de Nicola Center is proud to advance that commitment through our own efforts and programming." de Nicola Center Director's Statement on Dobbs v. Jackson Women's Health Organization, June 24, 2022, https://ethicscenter.nd.edu/news/dcec-directors-statement-on-dobbs-v-jackson-womens-health-organization/.

Conclusions of Law

I. Statutory Review

KRS 311.772 ("Trigger Ban") and KRS 311.7701-7711 ("Six Week Ban") were both passed by the General Assembly in 2019. The Trigger Ban prohibits all abortions except in extremely limited medical situations "to prevent the death or substantial risk of death due to a physical condition, or to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman." KRS 311.772(4)(a). The Trigger Ban makes it a Class D felony for anyone to knowingly provide an abortion. KRS 311.772(3)(b). KRS 311.772 is referred to as a trigger law because it would only become effective by the issuance of a U.S. Supreme Court decision "which reverses, in whole or in part, *Roe v. Wade*, 410 U.S. 113 (1973)." KRS 311.772(2)(a).

The Six Week Ban criminalizes abortion once embryonic or fetal cardiac activity is detectable. KRS 311.7704(1); KRS 311.7706(1). This is activity usually detectable around the six week mark of pregnancy, as measured from the first day of the patient's last menstrual period. Like the Trigger Ban, the Six Week Ban provides only very limited medical exceptions, preventing the woman's death or substantial and irreversible impairment of major bodily function. KRS 311.7706(2)(a). A violation of the Six Week Ban is also a Class D felony. KRS 311.990(21)-(22); KRS 532.060(2)(d). Neither the Trigger Ban nor the Six Week Ban contain exceptions for cases of rape or incest.

II. Standing

Kentucky courts have "the constitutional duty to ascertain the issue of constitutional standing ... to ensure that only justiciable causes proceed in court." *Commonwealth, Cabinet for Health & Fam. Servs., Dep't for Medicaid Servs. v. Sexton by & through Appalachian Reg'l Healthcare, Inc.*, 566 S.W.3d 185, 192 (Ky. 2018) (emphasis omitted). In *Sexton*, the Kentucky Supreme Court adopted the federal standard for standing as set forth in *Lujan v. Defenders of Wildlife*, 504 U.S. 555 (1992), holding that "for a party to sue in Kentucky, the initiating party

must have the requisite constitutional standing to do so, defined by three requirements: (1) injury, (2) causation, (3) redressability. In order words, [a] plaintiff must allege personal injury fairly traceable to the defendant's allegedly unlawful conduct and likely to be redressed by the requested relief." *Sexton*, 566 S.W.3d at 196.

Here, the Attorney General claims the Plaintiffs lack the standing to bring this suit because the facilities do not have third party standing to represent the rights of their patients. However, the Court finds that the Plaintiffs do have standing to proceed with this suit. While not binding, since Kentucky adopted the federal standing guidelines, federal cases provide persuasive authority. Federal courts have long allowed for third party standing in situations where "enforcement of the challenged restriction against the litigant would result indirectly in the violation of third parties' rights." *Warth v. Seldin*, 422 U.S. 490, 510 (1975). Third party standing should be allowed when: "(1) the interests of the litigant and the third party are aligned, and (2) there is an obstacle to the third party asserting her own rights." *Singleton v. Wulff*, 428 U.S. 106, 114-18 (1976).

Recently, the Supreme Court reaffirmed the practicality of third party standing for abortion providers in *June Medical Services LLC v. Russo*, 140 S.Ct. 2103, 2118 (2020). The Supreme Court concluded that abortion providers had third party standing to assert claims on behalf of their patients because the challenged laws regulated their conduct, including by threat of sanctions, the providers had every incentive to resist efforts at restricting their operations, and the providers were far better positioned than their patients to challenge the restrictions. *Id.* at 2119[2].

Turning then to the standing analysis. The challenged statutes directly prohibit the Plaintiffs from lawfully engaging in both medication and procedural abortions. The Attorney General is attempting to enforce these statutes against the Plaintiffs. An order of this Court preventing enforcement of these statutes would provide the Plaintiffs with adequate relief. Therefore, the Plaintiffs have satisfactorily established all the required elements of standing and can proceed with this suit.

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[2] The Defendants contend that the United States Supreme Court undermined third party standing in *Dobbs* to the point it can no longer be relied upon. While the United States Supreme Court expressed displeasure with how abortion related litigation had proceeded with the doctrine of third party standing, this comment came in dicta, and is therefore not binding upon this Court. *Dobbs*, 142 S.Ct. at 2276.

Relatedly, the other Defendants, the Kentucky Board of Medical Licensure, The Cabinet for Health and Family Services, and the Commonwealth's Attorney, have taken the position that relief should not be granted against them because the Plaintiffs' claims are purely speculative as they have not yet taken any enforcement actions against the Plaintiffs. For the same reasons, this argument is unpersuasive. The Plaintiffs have been forced to modify their medical services and practices in order to avoid the harm and sanctions envisioned by these statutes. The Commonwealth's Attorney could bring criminal prosecutions against the facilities and their practitioners. The Board of Medical Licensure and the Cabinet would then be empowered to bring administrative actions against the facilities and practitioners to prevent them from operating or even practicing medicine again in the state. The relief Plaintiffs seek would merely maintain the long-standing status quo while this litigation proceeds. With that context in mind, the Court concludes that all Defendants are properly before the Court and subject to the relief sought by the Plaintiffs.

III. Injunction Analysis

The standard for a temporary injunction is well established in Kentucky. The party moving for injunctive relief must show: (1) irreparable injury is probable if injunctive relief is not granted; (2) the equities – including the public interest, harm to the defendant, and preservation of the status quo – weigh in favor of the injunction; and (3) there is a "serious question warranting a trial on the merits." *Maupin v. Stansbury*, 575 S.W.2d 695, 699 (Ky. Ct. App. 1978). The Court will examine each of these factors.

A. Irreparable Harm

A party must first show that it will suffer irreparable harm if injunctive relief is not granted. An injury is irreparable if "there exists no certain pecuniary standard for the measurement of the damages." *Cyprus Mountain Coal Corp. v. Brewer*, 828 S.W.2d 642, 645 (Ky. 1992) (quoting *United Carbon Co. v. Ramsey*, 350 S.W.2d 454 (Ky. 1961). The Plaintiffs have demonstrated that they will indeed suffer irreparable harm without injunctive relief.

At the July 6th hearing, Dr. Bergin testified about the harms the Plaintiffs will suffer if injunctive relief is not provided. From the time when the Supreme Court's decision in *Dobbs* was handed down on June 24th to June 30th when the TRO was granted, EMW turned away almost 200 patients. These patients were denied previously scheduled medical care because of the legal uncertainty that resulted from the Trigger Ban and the Six Week Ban. Some of these women may

be able to reschedule their procedures, but others may not. Dr. Bergin testified that EMW has stopped providing abortions after 15 weeks.

Dr. Bergin also testified extensively to the harms and risks that can result from, and be exacerbated by, pregnancy. She testified that the risks presented by abortions are much lower, but do increase the later in the pregnancy the procedure is performed. Thus any delays in scheduling and performing an abortion comes with more serious risks.

Finally, waiting until final judgment on the issues presented here, without injunctive relief, would be effectively meaningless to many people because they would either be past gestational age restrictions or would have been forced to carry their pregnancy to term. Therefore, the Plaintiffs have demonstrated that they would suffer irreparable harm if injunctive relief is not provided.

B. Balance of Equities

Next the Court must consider whether the balance of equities weighs in favor of injunctive relief. This factor includes several components for courts to analyze. Courts balancing the equities of injunctive relief should consider "possible detriment to the public interest, harm to the defendant, and whether the injunction will merely preserve the status quo." *Maupin*, 575 S.W.2d at 699. The Court will examine each of the factors in order.

Public health concerns carry great weight in the public interest analysis. *Beshear v. Acree*, 615 S.W.3d 780, 830 (Ky. 2020). Plaintiffs assert, and this Court agrees, that abortion is a form of healthcare. It is provided by licensed medical professionals in licensed medical facilities, just like many other medical procedures. As such, the denial of this healthcare procedure is detrimental to the public interest.

Additionally, Dr. Lindo testified at length about the economic harms that Kentuckians would suffer under the laws at issue. Dr. Lindo noted that the burden of abortion bans falls hardest on poorer and disadvantaged members of society. By contrast the Defendants presented a baseless claim that the Plaintiffs are essentially advocating for eugenics and fewer minorities in Kentucky. This is a tired and repeatedly discredited claim[3]. It has no legal basis, and the Court disregards it as such.

[3] See further Melissa Murphy, *Race-ing Roe: Reproductive Justice, Racial Justice, and the Battle for Roe v. Wade*, 134 HARV. L. REV. 2025 (April 12, 2021).

Dr. Lindo also testified that these abortion bans will impose not just serious financial costs, but also educational and professional harms on Kentuckians. Pregnancy, childbirth, and the resulting raising of a child are incredibly expensive. Adding another child can put exponential strain on an already struggling family and lead to detrimental outcomes for all involved. An unplanned pregnancy can also derail a woman's career or educational trajectory. Across the United States, approximately 72% of women obtaining abortions are under the age of 30. Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 101 AM.J.PUB.HEALTH 1904, 1907 (2017). This is the stage of life where people are completing their education and establishing a career. All of this is not to say, as the Defendants' witness Professor Snead contends, that all young women who get abortions are financially coerced to do so. Indeed, quite the contrary. This is a decision that has perhaps the greatest impact on a person's life and as such is best left to the individual to make, free from unnecessary governmental interference. In the Court's view, denial of this healthcare option will have a detrimental impact on the public interest, satisfying the first prong of the injunctive relief analysis.

The Court must next consider if the Defendants will suffer any harm by the requested injunctive relief. The Court finds any harm the Defendants may suffer is outweighed by the interests of the Plaintiffs. At the outset, the Court notes the Supreme Court's opinion in *Dobbs* does not become final until 25 days after it was issued on June 24, 2022. Sup. Ct. R 45. Judge Glenn Acree noted in the related appellate court proceedings, 2022-CA-0780, the Defendants will at most suffer the harm of delayed enforcement, as the earliest this law became enforceable was July 19, 2022. This harm, when balanced against the harms of the Plaintiffs, is not sufficient to preclude injunctive relief.

Further, as long recognized, the state has no interest in enforcing an unconstitutional law. *See Harrod v. Whaley*, 239 S.W.2d 480, 482 (Ky. 1951). As the Court will explain further below, the Plaintiffs have established significant doubt as to the constitutionality of the laws at issue. Accordingly, the state's interest in enforcing these laws is uncertain at this stage.

Finally, the requested injunctive relief will merely restore the status quo that has existed in Kentucky for nearly fifty years. This factor weighs strongly in favor of granting the injunctive relief. Based on all of these considerations, the Court finds the balance of equities weighs in favor of granting injunctive relief.

C. Serious Questions Raised

The final factor courts must examine when considering injunctive relief is whether there are serious questions presented that warrant trial on the merits. For the reasons stated below in Section IV, the Court concludes that the Plaintiffs have identified, and sufficiently supported, serious questions such that injunctive relief is warranted.

IV. Constitutional Analysis

At the outset, the Court notes that, despite what some suggest, the inquiry does not end simply because the word "abortion" is not found in the Kentucky Constitution. The Constitution must protect more than just the words explicitly enumerated on the page in order for the purpose behind the words to have effect. To hold otherwise ignores the realities of how constitutions, and laws more generally, are written. It is impossible for any legislative or constitutional body to enumerate every possible future scenario and application. Instead, bodies craft broad sentiments, ideas, and rights they value and choose to protect. It is then the role of the judiciary to interpret the enumerated words and give effect to the meaning behind them. Indeed, "to declare the meaning of constitutional provisions is a primary function of the judicial branch in the scheme of checks and balances that has protected freedom and liberty in this country and in this Commonwealth for more than two centuries. The power of judicial review is an integral and indispensable piece of the separation of powers doctrine. To desist from declaring the meaning of constitutional language would be an abdication of our constitutional duty." *Bevin v. Commonwealth ex rel. Beshear*, 563 S.W.3d 74, 83 (Ky. 2018).

The Court further recognizes that while the parties did not raise every argument analyzed below, it is the duty of courts to consider all legal aspects when evaluating cases. *Community Financial Services Bank v. Stamper*, S.W.3d 737, 740-41 (Ky. 2019). This is so because "applicable legal authority is not evidence and can be resorted to at any stage of the proceedings whether cited by the litigants or simply applied, *sua sponte*, by the adjudicator(s). Nor is legal research a matter of judicial notice, for the issue is one of law, not evidence." *Burton v. Foster Wheeler Corp.*, 72 S.W.3d 925, 930 (Ky. 2002); *see also Mitchell v. Hadl*, 816 S.W.2d 183, 185 (Ky. 1991) ("When the facts reveal a fundamental basis for decision not presented by the parties, it is our duty to address the issue to avoid a misleading application of the law."). That is what this Court will endeavor to do below.

A. Trigger Ban

The Trigger Ban is an arguably unconstitutional delegation of legislative authority, not just to a different branch of government, but to a different jurisdictional body entirely. Since the law was drafted to take effect at a later time if the United States Supreme Court made a certain decision, it violates Sections 27, 28, and 29 of the Kentucky Constitution.

Kentucky is a strict adherent to the separation of powers. "The General Assembly cannot delegate any portion of the legislative function to another authority." *Diemer v. Commonwealth*, 786 S.W.2d 861, 864 (Ky. 1990). The Trigger Ban would create criminal penalties for abortions. Criminal laws fall directly under the umbrella of legislative and nondelegable functions. "What conduct shall in the future constitute a crime in Kentucky or be subject to severe penalties is a matter for the Kentucky legislature to determine in view of the *then existing conditions when the need for such a statute arises*. It is not a matter that may be delegated." *Dawson v. Hamilton*, 314 S.W.2d 532, 536 (Ky. 1958) (emphasis added). The Kentucky Supreme Court held that adopting prospective federal legislation or rules into state statute constituted an impermissible delegation of legislative authority. *Id.* at 535. This is precisely the action the General Assembly took with the Trigger Ban. It impermissibly delegated its legislative authority to a federal body (the United States Supreme Court) in violation of the Kentucky Constitution.

The Plaintiffs also contend the Trigger Ban is unconstitutionally vague. Kentucky laws must be sufficiently clear that a person ordinarily disposed to obey the law is able to "determine whether the contemplated conduct would amount to a violation." *State Bd. for Elementary & Secondary Educ. v. Howard*, 834 S.W.2d 657, 662 (Ky. 1992). The test to determine whether a statute is unconstitutionally vague contains two separate elements: first, does the statute place someone to whom it applies on actual notice as to what conduct is prohibited; and second, is it written in a manner that encourages arbitrary and discriminatory enforcement. *Id.* (citing *Musselman v. Commonwealth*, 705 S.W.2d 476, 478 (Ky. 1986)).

The Trigger Ban does not adequately give actual notice because the date upon which it becomes effective is at best unclear. The General Assembly stated that the Trigger Ban was to take effect "immediately upon ... the occurrence of ... [a]ny decision of the United States Supreme Court which reverses, in whole or in part *Roe v. Wade*, 410 U.S. 113 (1973)." KRS 311.772(2)(a). On its face this might seem clear enough, but upon closer examination problems arise. Unless specifically stated otherwise in the opinion, United States Supreme Court opinions

do not become final until twenty-five days after the opinion is announced. Sup. Ct. R. 45. Since the opinion in *Dobbs* was announced on June 24, 2022, the opinion did not become final until July 19, 2022. Defendant Cameron however, contends the Trigger Ban became effective immediately on June 24th. Attorneys general in other states with trigger laws have failed to reach a consensus on this matter as well[4]. This uncertainty is sufficient to satisfy the first prong of the analysis.

Secondly, the lack of clarity regarding the date of enforceability creates the risk of arbitrary and discriminatory enforcement because prosecutors across the Commonwealth could reach different conclusions as to when they may begin enforcing the Trigger Ban. Indeed, Defendant Cameron insisted that he has the authority to begin enforcing the law immediately. Defendant Wine has not given any indication when, or if, his office intends to enforce the law. A situation where the Attorney General and Commonwealth's Attorney could be at odds over the enforceability of a criminal law is undesirable for all involved. Accordingly, this second factor of the analysis is met as well. The Plaintiffs have presented serious questions as to the constitutionality of the Trigger Ban.

B. Six Week Ban

Unlike the Trigger Ban, the Six Week Ban does not rely on a decision of the U.S. Supreme Court to become effective. As such, the Six Week Ban and its constitutionality must be examined separately. For the reasons stated below, the Court concludes that the Six Week Ban implicates Sections 1, 2 and 5 of the Kentucky Constitution. The Court will separately examine the Plaintiffs' likelihood of success in Section C.

1. Right to Privacy

Sections 1 and 2 of the Kentucky Constitution broadly protect an individual's rights to liberty and self-determination. The liberty right protected in Sections 1 and 2 have been interpreted to include a similar right to privacy as recognized in the federal Constitution.

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[4] See Advisory from Tex. Att'y Gen. Ken Paxton on Texas Law upon Reversal of *Roe v. Wade* (June 24, 2022), https://www.texasattorneygeneral.gov/sites/default/files/images/executive-management/Post-Roe%20Advisory.pdf, *and* Kelcie Moseley-Morris, *Idaho Attorney General Says Abortion Ban Likely to Take Effect in Late August After SCOTUS Decision*, Idaho Capitol Sun (June 24, 2022) https://idahocapitalsun.com/2022/06/24/idahos-trigger-law-will-abolish-abortions-30-days-after-scotus-ruling-overturning-roe-v-wade/

Commonwealth v. Wasson, 842 S.W.2d 487 (Ky. 1992)[5]. Indeed, the Kentucky Constitution has been held to "offer greater protection for the right of privacy than provided by the Federal Constitution as interpreted by the United States Supreme Court." *Id.* at 491. The right of privacy has been consistently recognized as an integral part of the guarantee of liberty in the 1891 Kentucky Constitution since its inception. *Id.* at 495. The Kentucky Supreme Court has held that the 1891 Constitution prohibits state action "thus intruding upon the inalienable rights possessed by the citizens" of Kentucky. *Commonwealth v. Campbell*, 117 S.W. 383, 385 (Ky. 1909).

The constitutional privacy right protects individuals "against the intrusive police power of the state." *Wasson*, 842 S.W.2d at 492[6]. The Kentucky Supreme Court has recognized that "Kentucky has a rich and compelling tradition of recognizing and protecting individual rights from state intrusion." *Id.* The Defendants here placed great emphasis on the importance of the history and precedent of laws outlawing abortion in the mid to late nineteenth century. However, conduct is "not beyond the protections of the guarantees of individual liberty in our Kentucky Constitution simply because 'proscriptions against that conduct have ancient roots.' Kentucky constitutional guarantees against government intrusion address substantive rights." *Id.* at 493 (quoting *Bowers v. Hardwick*, 478 U.S. 186, 192 (1986)).

Additionally, the history the Defendants rely on is less clear than they contend, and actually tends to potentially weaken their case. At common law, abortion with the consent of the woman was not a crime before quickening[7]. *Mitchell v. Commonwealth*, 78 Ky. 204, 210 (1879). Ten years after the ratification of the current Kentucky Constitution, the Kentucky Supreme Court again held that "[t]here is no statute in this state changing the common-law rule" that "it was not ... a punishable offense to produce with the consent of the mother an abortion prior to

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[5] The Court recognizes that *Wasson* was revisited by the Kentucky Supreme Court in *Calloway Cnty. Sheriff's Dept. v. Woodall*, 607 S.W.3d 557 (Ky. 2020). However, *Calloway County* merely modified the analysis courts use for evaluating special legislation. The privacy analysis of *Wasson* was untouched and remains the law of Kentucky.

[6] The Court acknowledges the Defendants' contention that *Wasson* is limited to the context of private sexual activity between consenting adults. The Court is unpersuaded however that *Wasson* is, or should be, limited to that narrow context. The privacy analysis in *Wasson* discusses a much broader and more fundamental right than Defendants acknowledge. As such, the reasoning of the Kentucky Supreme Court in *Wasson* is directly applicable to this context as well.

[7] Quickening is recognized as the moment when a woman first feels fetal movement. This is generally understood not to occur until late in the fourth month or early in the fifth month of gestation. Reva Siegal, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STANFORD L. REV. 261, 281-82 (1992).

the time when she became quick with child." *Wilson v. Commonwealth*, 60 S.W. 400, 401 (Ky. 1901). The Six Week Ban intercedes well before the point of quickening. Contrary to the Defendants' contention, history demonstrates that pre-quickening abortions were permissible. Defendants' reliance on the history and traditions of Kentucky law are therefore misplaced.

Furthermore, the laws that the Defendants seek to enforce would at the very least potentially obligate the state to investigate the circumstances and conditions of every miscarriage that occurs in Kentucky. This would lead to an unprecedented level of intrusion and invasiveness, rarely seen before in this state. Kentucky has a long and proud history of limiting governmental intrusion and overreach. The Six Week Ban flies directly in the face of that tradition.

The Six Week Ban will have wide ranging effects on family planning decisions that are traditionally protected from governmental imposition. It not only compromises a woman's right to self-determination protected in Section 2 of the Kentucky Constitution by taking away the choice to have an abortion in many instances, but also undercut a woman's choice to have children at all. Many people are justifiably concerned about having children now due to a very real fear around many of the complications that may arise during the pregnancy, as outlined by Dr. Bergin in her testimony. Women have legitimate concerns about their ability to receive adequate care, and the possibility their health and safety will be deemed subordinate to the life of a fetus. Already, laws similar to the ones at issue here, are creating confusion and concern in healthcare settings as doctors, in order to avoid incurring civil and criminal liability, are forced to wait until women are in dire medical conditions before interceding[8]. There is further uncertainty regarding the future legality and logistics of In Vitro Fertilization. The implications of constitutional protections beginning from the very moment of fertilization raises a whole host of concerns for the continued legal feasibility of IVF.

These laws intrude into the traditionally protected familial sphere, and as such require exceedingly compelling justifications in order to pass constitutional muster.

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[8] Arey, et al., *A Preview of the Dangerous Future of Abortion Bans – Texas Senate Bill 8*, NEW ENGLAND JOURNAL OF MEDICINE, June 22, 2022, (last visited July 12, 2022), https://www.nejm.org/doi/full/10.1056/NEJMp2207423

2. Equal Protection

Furthermore, Sections 1, 2, and 3 of the Kentucky Constitution function much the same way as the Equal Protection Clause of the 14th Amendment of the Federal Constitution. *D.F. v. Codell*, 127 S.W.3d 571, 575 (Ky. 2003). The goal of Equal Protection is to ensure that similarly situated persons are treated alike. *Vision Mining, Inc. v. Gardner*, 364 S.W.3d 455, 465 (Ky. 2011). The challenged statutes may run afoul of this protection by imposing obligations, restrictions, and penalties on the woman, and possibly physicians, but not on the man. As defined by statute, the man is at least 50% responsible for the creation of the fetus, yet contrary to the woman, he bears no legal consequences for his contribution. As similarly situated parties to the creation of life, the woman and the man must be treated equal under the law.

Additionally, there is no other context in which the law dictates that a person's body must be used against her will, even to aid or save the life of another. Section 2 of the Kentucky Constitution grants a right to self-determination that protects people from "absolute and arbitrary power over [their] lives, liberty, and property." Ky. Const. § 2. People cannot be legally coerced into giving blood or donating organs. Bone marrow transplants are not compulsory. When a person dies, their organs can be utilized only if they consent to being an organ donor. These laws grant less bodily autonomy to pregnant women than in any of these other instances, or at any other time in the woman's life. Only in the context of pregnancy is a woman's bodily autonomy taken away from her. This is a burden that falls directly, and only, on females. It is inescapable, therefore, that these laws discriminate on the basis of sex.

3. Religious Freedom

Section 5 of the Kentucky Constitution protects both the free exercise of religion and prohibits the establishment of a state religion. The Six Week Ban infringes upon those rights as well, but primarily upon the prohibition on the establishment of religion. Defendants' witnesses at the July 6th hearing advocated for, and agreed with what the General Assembly essentially established in these laws, independent fetal personhood[9]. They argue that life begins at the very moment of fertilization and as such is entitled to full constitutional protection at that point. However, this is a distinctly Christian and Catholic belief. Other faiths hold a wide variety of views on when life begins and at what point a fetus should be recognized as an independent

[9] The General Assembly uses the term "unborn human beings" to refer to fetal personhood.

human being[10]. While numerous faith traditions embrace the concept of "ensoulment," or the acquisition of personhood, there are myriad views on when and how this transformation occurs[11]. The laws at issue here, adopt the view embraced by some, but not all, religious traditions, that life begins at the moment of conception.

The General Assembly is not permitted to single out and endorse the doctrine of a favored faith for preferred treatment. By taking this approach, the bans fail to account for the diverse religious views of many Kentuckians whose faith leads them to take very different views of when life begins. There is nothing in our laws or history that allows for such theocratic based policymaking. Both the Trigger Ban and the Six Week Ban implicate the Establishment and Free Exercise Clauses by impermissibly establishing a distinctly Christian doctrine of the beginning of life, and by unduly interfering with the free exercise of other religions that do not share that same belief.

All of these considerations together stand for the proposition that governmental intrusion into the fundamentally private sphere of self-determination as contemplated by these laws is to be prohibited. Having recognized that the Six Week Ban necessarily involves several fundamental rights, the Court will next analyze whether the law withstands constitutional scrutiny.

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[10] David Masci, *Where Major Religious Groups Stand on Abortion*, PEW RESEARCH CENTER, June 21, 2016, (last visited Jul 11, 2022), https://www.pewresearch.org/fact-tank/2016/06/21/where-major-religious-groups-stand-on-abortion/

[11] See Vatican Sacred Congregation for the Doctrine of the Faith, Declaration on Procured Abortion, at n.19 (Nov. 18, 1974), available at https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19741118_declarationabortion_en.html; Presbyterian Church (U.S.A.), Abortion/ Reproductive Choice Issues ("We may not know exactly when human life begins[.]"), available at https://www.presbyterianmission.org/what-we-believe/socialissues/abortion-issues/; United Church of Christ, Statement on Reproductive Health and Justice (noting the "many religious and theological perspectives on when life and personhood begin"), available at https://d3n8a8pro7vhmx.cloudfront.net/unitedchurchofchrist/le gacy_url/455/reproductive-health-and-justice.pdf?1418423872; Evangelical Lutheran Church in America, Social Statement on Abortion at 1, 3 n.2 (1991) (explaining that embryology provides insight into the "complex mystery of God's creative activity" but that individual interpretation of the scientific information leads to various understandings of when life begins), available at http://download.elca.org/ELCA%20Resource%20Repository/Abo rtionSS.pdf; National Council of Jewish Women, Abortion and Jewish Values Toolkit at 16 (2020), available at https://www.ncjw.org/wpcontent/uploads/2020/05/NCJW_ReproductiveGuide_Final.pdf.

C. Constitutional Scrutiny Analysis

As established in Section B above, the Six Week Ban implicates numerous fundamental rights protected by the Kentucky Constitution. Strict scrutiny is the highest level of scrutiny courts apply. It applies to analysis of statutes that "impact a fundamental right or liberty explicitly or implicitly protected by the Constitution." *Beshear v. Acree*, 615 S.W.3d 780, 816 (Ky. 2020). To survive strict scrutiny, "the government must prove that the challenged action furthers a compelling governmental interest and is narrowly tailored to that interest." *Id.* The seldom used intermediate scrutiny is generally used when evaluating discrimination based on gender. *D.F. v. Codell*, 127 S.W.3d 571, 575 (Ky. 2003). Intermediate scrutiny requires the government to "prove its action is substantially related to a legitimate state interest." *Id.* (citing *Steven Lee Enters v. Varney*, 36 S.W.3d 391, 394). Under either standard, the Plaintiffs have demonstrated serious questions regarding the validity of the Six Week Ban.

It is well established in statutory interpretation that courts must always presume the legislature did not intend for a statute to produce absurd results. *Beshear v. Acree*, 615 S.W.3d 780, 804 (Ky. 2021), citing *Layne v. Newberg*, 841 S.W.2d 181, 183 (Ky. 1992). However, followed to its logical conclusions, the theory of "independent fetal personhood" that is created by both the Trigger Ban and the Six Week Ban would have far-ranging implications and could lead to unintended consequences and absurd results. For instance, do child support obligations now begin from the moment of fertilization? Does a fetus gain a legal claim as an heir to the father's estate at the moment of fertilization? Would a pregnant woman be able to claim her fetus as a dependent on her tax returns? Would a company that schedules a pregnant woman to work be in violation of child labor laws? Or, if a pregnant woman commits a crime and is sentenced to serve time in prison, would the rights of the fetus be violated by sharing the same confinement as the woman? The answer to all of these is surely "no."[12] With these considerations in mind, the Court will now evaluate the previously identified constitutional provisions.

[12] A further example of the unintended chaos these laws will bring comes from a pregnant woman in Texas who recently received a ticket for driving in a High-Occupancy Vehicle (HOV) lane. She is currently challenging the ticket in court arguing that since Texas has recognized independent fetal personhood, the two-person minimum occupancy to use the HOV Lane was satisfied. https://www.cnn.com/2022/07/11/us/pregnant-woman-hov-lane/index.html

1. Right to Privacy

The Defendants argue that the state has a compelling interest in protecting what it calls "unborn human beings." As established at the July 6th Hearing, a fetus cannot survive on its own outside of the womb until it has reached a gestational age between twenty and twenty-five weeks. The Six Week Ban intercedes well before the point of viability, indeed at a point before many women even know they are pregnant. The state's interest in protecting potential fetal life before the point of viability has traditionally been viewed as insufficient to justify total or near total bans on abortion in courts across the country[13]. While the decisions of other states are not binding upon this Court, the reasoning behind those decisions is both informative and persuasive. This Court agrees with many other courts that the state's purported interest in protecting potential fetal life pre-viability is not a compelling enough state interest to justify such an unparalleled level of intrusion and invasiveness into the fundamental area of choosing whether or not to bear a child. The fundamental right for a woman to control her own body free from governmental interference outweighs a state interest in potential fetal life before viability. As the Court has previously recounted, Kentucky has a prodigious history of protecting privacy at a greater level than the federal Constitution. See *Wasson*, 842 S.W.2d at 491. Surely, if this heightened privacy right stands for anything, it stands for the proposition that Kentuckians should have control over basic family planning choices, free from governmental interference.

2. Equal Protection

Next, the Court turns to the Equal Protection analysis. There are two equally necessary parties to the creation of human life, a male and a female. As established above in Section IV(B), these laws impose unilateral obligations and responsibilities on only the female, and none on the male. Laws that discriminate on the basis of sex are not unconstitutional per se, but must pass intermediate scrutiny in order to be constitutional. *Codell*, 127 S.W.3d at 575. This requires the government to show that its action is substantially related to a legitimate state interest. *Id.* The Defendants again argue that the state has a legitimate interest in protecting fetal life, and that by

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[13] *Valley Hosp. Ass'n v. Mat-Su Coal. for Choice*, 948 P.2d 963, 971 (Alaska 1997); *Comm. to Def. Reprod. Rts. v. Myers*, 625 P.2d 779, 793-797 (Cal. 1981); *In re T.W.*, 551 So.2d 1186, 1192-94 (Fla. 1989); *Women of Minn. v. Gomez*, 542 N.W.2d 17, 31-32 (Minn. 1995); *Armstrong v. State*, 989 P.2d 364, 380-384 (Mont. 1999); *Planned Parenthood of Middle Tenn. v. Sundquist*, 38 S.W.3d 1, 18 (Tenn. 2000); *Right to Choose v. Byrne*, 450 A.2d 925, 934-37 (N.J. 1982); *Hodes & Nauser, MDs, P.A. v. Schmidt*, 440 P.3d 461, 496 (Kan. 2019).

nearly banning all abortions these laws will achieve that goal. However, the Defendants have again failed to meet their burden. The Defendants have proffered no legitimate reason why the woman must bear all the burdens of these laws while the man carries none. As similarly situated parties, they must be treated equally under the law. These laws fail to do that, and therefore the Plaintiffs have established a substantial question as to the merits.

3. Religious Freedom

Turning finally to the analysis of Section 5 of the Kentucky Constitution, Kentucky courts have consistently held that the purpose of Section 5 is to guarantee religious freedom. *Lawson v. Commonwealth*, 164 S.W.2d 972, 975-76 (Ky. 1942). The Kentucky Constitution states that "no preference shall ever be given by law to any religious sect, society or denomination." Ky. Const. § 5. This provision mandates "a much stricter interpretation than the Federal counterpart found in the First Amendment's 'Establishment of Religion clause.'" *Neal v. Fiscal Court, Jefferson County.*, 986 S.W.2d 907, 909-10 (Ky. 1999), citing *Fiscal Court of Jefferson County. v. Brady*, 885 S.W.2d 681 (Ky. 1994).

This is not a particularly close call. As discussed above, by ordaining that life begins at the very moment of fertilization, the General Assembly has adopted the religious tenets of specific sects or denominations. The General Assembly ignored the contending positions of other faiths regarding the origins and beginnings of life. It is true that the General Assembly has sweeping authority to legislate for the public good, but expressly encasing the doctrines of a preferred faith, while eschewing the competing views of other faiths, is an arguable violation of Section 5's prohibition on the establishment of religion[14]. Section 5 protects Kentuckians in their choice to worship, how they worship, and to be free from the imposition of a particular faith by the government. As Kentucky courts have long held, "under our institutions there is no room for that inquisitorial and protective spirit which seeks to regulate the conduct of men." *Campbell*, 117 S.W. at 387. For all of these reasons, the Plaintiffs have again at the very least established a substantial question as to the merits of this law.

[14] It is further notable that the two witnesses the Defendants called to testify at the July 6th Hearing were both affiliated with a religious institution that expressly promotes and advocates the view adopted by the General Assembly, further deepening the implicit connection between the state and a favored faith.

Conclusion

The Court here is tasked not with finding whether the Kentucky Constitution explicitly contains the right to an abortion, but rather with discerning whether the laws at issue constituting near total bans on abortion violate the rights of privacy, self-determination, equal protection, and religious freedom guaranteed by the Kentucky Constitution. The Plaintiffs have demonstrated at the very least a substantial question as to the merits regarding the constitutionality of both the Trigger Ban and the Six Week Ban. As such, they are entitled to injunctive relief until the matter can be fully resolved on the merits. Therefore, with the Court being sufficiently advised;

IT IS ORDERED THAT Plaintiffs' Motion for a Temporary Injunction is **GRANTED**. The Defendants are enjoined from enforcing KRS 311.772 and KRS 311.7701-7711, pending full resolution of this matter on the merits, until further order of this Court. The previously filed bond is continued. Accordingly, the Temporary Restraining Order issued on June 30, 2022 is hereby dissolved pursuant to CR 65.03(5).

ENTERED IN COURT
DAVID L. NICHOLSON, CLERK
JUL 22 2022
BY _____ DEPUTY CLERK

HON. MITCH PERRY, JUDGE

Date: July 22, 2022

Time: 10:00 am

CC:

Hon. Michele Henry
Counsel for Plaintiffs

Hon. Heather Gatnarek
Counsel for Plaintiffs

Hon. Carrie Flaxman
Counsel for Plaintiffs

Hon. Hana Bajramovic
Counsel for Plaintiffs

Hon. Brigitte Amiri
Hon. Chelsea Tejada
Hon. Faren Tang
Counsel for Plaintiffs

Hon. Leah Goesky
Hon. Kendall Turner
Counsel for Plaintiffs

Hon. Victor Maddox
Hon. Christopher Thacker
Hon. Lindsey Keiser
Counsel for Daniel Cameron

Hon. Leanne Diakov
Counsel for Kentucky Board of Medical Licensure

Hon. Wesley Duke
Counsel for Office of the Secretary of Kentucky's Cabinet for Health and Family Services

Hon. Jason Moore
Counsel for the Office of the Commonwealth's Attorney, 30th Judicial Circuit

EXHIBIT 2

NO. _____

22CI-3225

JEFFERSON CIRCUIT COURT
DIVISION _____ (__)
JUDGE _____

EMW WOMEN'S SURGICAL CENTER, P.S.C., on behalf of itself, its staff, and its patients; ERNEST MARSHALL, M.D., on behalf of himself and his patients; and PLANNED PARENTHOOD GREAT NORTHWEST, HAWAI'I, ALASKA, INDIANA, AND KENTUCKY, INC., on behalf of itself, its staff, and its patients

PLAINTIFFS

v.

VERIFIED COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF

DANIEL CAMERON, in his official capacity as Attorney General of the Commonwealth of Kentucky;

SERVE: Office of the Attorney General
700 Capitol Avenue, Suite 118
Frankfort, KY 40601
servethecommonwealth@ky.gov

ERIC FRIEDLANDER, in his official capacity as Secretary of Kentucky's Cabinet for Health and Family Services;

SERVE: Office of the Secretary
275 E. Main St. 5W-A
Frankfort, KY 40621
WesleyW.Duke@ky.gov

MICHAEL S. RODMAN, in his official capacity as Executive Director of the Kentucky Board of Medical Licensure;

SERVE: Board of Medical Licensure
310 Whittington Pkwy, Suite 1B
Louisville, KY 40222
kbml@ky.gov
Leanne.diakov@ky.gov

and

DEFENDANTS

THOMAS B. WINE, in his official capacity
as Commonwealth's Attorney for the 30th
Judicial Circuit of Kentucky

SERVE: Office of the Commonwealth's Attorney
30th Judicial Circuit
514 West Liberty Street
Louisville, KY 40202
tbwine@louisvilleprosecutor.com

* * * * *

PRELIMINARY STATEMENT

1. Abortion is a critical component of reproductive healthcare and crucial to the ability of Kentuckians to control their lives. Pregnancy and childbirth impact an individual's health and well-being, finances, and personal relationships. Whether to take on the health risks and responsibilities of pregnancy and parenting is a personal and consequential decision that must be left to the individual to determine for herself without governmental interference. Pregnant Kentuckians have the right to determine their own futures and make private decisions about their lives and relationships. Access to safe and legal abortion is essential to effectuating those rights.

2. Guided by their individual health, values, and circumstances, Kentuckians seek abortions for a variety of deeply personal reasons, including medical, familial, and financial concerns. Some recent Kentucky patients have shared their reasons for deciding to have an abortion, including to preserve their health, to protect their ability to care and provide for their existing children, because of financial concerns about the ability to work or go to school while pregnant or parenting, or because of complicated family circumstances. Without the ability to decide whether to continue a pregnancy, Kentuckians will lose the right to make critical decisions about their health, bodies, lives, and futures.

3. Plaintiffs are two abortion clinics and a physician who has dedicated his career to providing abortions and OB/GYN care to Kentuckians. Plaintiffs sue on behalf of themselves, their staff, and their patients, seeking declaratory and injunctive relief to prevent Defendants from enforcing the challenged laws which, collectively, eliminate access to abortion in the Commonwealth and are inflicting acute and irreparable harm on Kentuckians.

4. Plaintiffs challenge two separate Kentucky abortion bans (collectively, the "Bans") under the Kentucky Constitution: KRS 311.772 (the "Trigger Ban") (attached as Exhibit A) and KRS 311.7701–11 (the "Six-Week Ban") (attached as Exhibit B). Following the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, No. 19-1392, 2022 WL 2276808 (U.S. June 24, 2022), the threat of enforcement of the Trigger Ban is preventing the provision of *any* abortions in Kentucky except in very narrow emergency circumstances. The Six-Week Ban would make it a crime to provide an abortion after embryonic cardiac activity becomes detectable, which generally occurs around six weeks of pregnancy, as measured from the first day of the patient's last menstrual period ("LMP"). The Six-Week Ban was previously enjoined in federal court under then-existing federal constitutional law, but with the U.S. Supreme Court's decision in *Jackson Women's Health*, the law will likely soon take effect.[1] As a result, absent relief from this Court, abortion will be outlawed in the Commonwealth.

5. At this moment, Plaintiffs' patients are suffering medical, constitutional, and irreparable harm because they are denied the ability to obtain an abortion. The threat of criminal penalties from the Trigger Ban has forced Plaintiffs to cancel the appointments of patients

[1] On June 24, 2022, Plaintiffs filed a motion to dismiss the federal case without prejudice in light of the U.S. Supreme Court's decision.

seeking this time-sensitive healthcare and, unless this Court grants a restraining order and/or temporary injunction, Plaintiffs will be forced to continue restricting their operations by turning away all patients seeking abortion in Kentucky.

6. The Bans and the irreparable harms they inflict are an affront to the health and dignity of all Kentuckians. The inability to access abortion in the Commonwealth forcibly imposes the health risks and physical burdens of continued pregnancy on all Kentuckians who would otherwise choose to access safe and legal abortion. For many individuals, the Bans will altogether foreclose the ability to access abortion, thus forcing them to carry their pregnancies to term and give birth, which carries a risk of death up to fourteen times higher than that associated with abortion. These individuals will be made to suffer the life-altering physical, emotional, and economic consequences of unexpected pregnancy, childbirth, and parenting. Others, pushed by the Bans to travel out of state for legal care, will bear the burdens both of increased health risks from being pushed later into pregnancy and of the cost and logistical difficulties of long-distance travel. The Bans will also harm those who seek to terminate their unwanted pregnancies outside a clinical setting, which could put them at medical or legal risk. The Bans harm all Kentuckians, but are an attack on Kentuckians with low incomes and Black Kentuckians in particular, as they are among the least able to readily access medical care and the most vulnerable to dying from pregnancy-related causes.

7. The Bans violate Sections One and Two of the Commonwealth's Constitution by infringing on Plaintiffs' patients' rights to privacy and self-determination. Additionally, the Trigger Ban unlawfully (i) delegates legislative power in violation of Sections 27, 28, and 29 of the Constitution, and (ii) takes effect upon the authority of an entity other than the General Assembly in violation of Section 60 of the Constitution. The Trigger Ban is also

unconstitutionally vague in violation of Section Two of the Constitution and unintelligible in violation of Sections 27, 28, and 29 of the Constitution.

8. To protect the constitutional rights of Plaintiffs and their patients, this Court must issue an emergency restraining order followed by a temporary injunction prohibiting Defendants from enforcing the Bans. In addition, this Court should declare the Bans unconstitutional and permanently enjoin their enforcement.

JURISDICTION AND VENUE

9. This Court has jurisdiction over this action pursuant to Sections 109 and 112 of the Kentucky Constitution and KRS 23A.010.

10. Plaintiffs' claims for declaratory and injunctive relief are authorized by KRS 418.040, KRS 418.045, Ky. R. Civ. P. 57, Ky. R. Civ. P. 65.01, and the general legal and equitable powers of this Court.

11. Venue is appropriate in this Court pursuant to KRS 452.005 because this is a civil action that challenges the constitutionality of Kentucky statutes and that seeks declaratory and injunctive relief against individual state officials in their official capacities, and all three Plaintiffs reside in Jefferson County.

12. Pursuant to KRS 418.075(1) and KRS 452.005(3), notice of this action challenging the constitutionality of enactments of the General Assembly is being provided to the Attorney General, who is also a defendant in this action, by serving copies of the Complaint upon him.

PARTIES

Plaintiffs

13. Plaintiff EMW Women's Surgical Center, P.S.C. ("EMW") is a Kentucky corporation located in Louisville that is licensed under state law to provide abortion care. EMW has been providing reproductive healthcare, including abortion, since the 1980s. Before the U.S. Supreme Court's decision in *Jackson Women's Health*, EMW provided medication abortion up to 10 weeks LMP, and procedural abortion up to 21 weeks and 6 days LMP. EMW sues on behalf of itself, its staff, and its patients.

14. Plaintiff Ernest Marshall, M.D. ("Dr. Marshall"), is a board-certified obstetrician-gynecologist who provides abortions to patients at EMW. Dr. Marshall also owns EMW. Dr. Marshall sues on behalf of himself and his patients.

15. Plaintiff Planned Parenthood Great Northwest, Hawai'i, Alaska, Indiana, and Kentucky, Inc., is a nonprofit organization incorporated under Washington law that operates two health centers in Kentucky, one of which, in Louisville ("Planned Parenthood Louisville"), offers abortion. Planned Parenthood Louisville provides a variety of medical services to its patients, including birth control, pregnancy testing, and sexually transmitted infection testing and treatment, and has been providing abortion in Kentucky since it became a Commonwealth-licensed abortion provider in 2020. Before the U.S. Supreme Court's decision in *Jackson Women's Health*, Planned Parenthood Louisville offered medication abortion up to 10 weeks LMP, and procedural abortion up to 13 weeks and 6 days LMP. Planned Parenthood Louisville sues on behalf of itself, its staff, and its patients.

Defendants

16. Defendant Daniel Cameron is the Attorney General of the Commonwealth of Kentucky and, as such, is the Commonwealth's chief law-enforcement officer. In his capacity as Attorney General, Defendant Cameron "may seek injunctive relief as well as civil and criminal penalties in courts of proper jurisdiction to prevent, penalize, and remedy violations of . . . KRS 311.710 to 311.830," which includes the Bans. KRS 15.241(1)(b). Defendant Cameron is likewise charged with "seek[ing] injunctive relief as well as civil and criminal penalties" against "abortion facilities" to prevent violations of the provisions of KRS Chapter 216B regarding abortion facilities or the administrative regulations promulgated in furtherance thereof. KRS 15.241(1)(a). Those regulations include the requirement that all abortion facilities ensure "compliance with . . . state . . . laws," including the Bans. 902 K.A.R. 20:360 § 5(1)(a). Additionally, Defendant Cameron may initiate or participate in criminal prosecutions for violations of the Bans at the request of, *inter alia*, the Governor, any court of the Commonwealth, or local officials. KRS 15.190; KRS 15.200. Defendant Cameron is sued in his official capacity.

17. Defendant Eric Friedlander is the secretary of the Cabinet for Health and Family Services ("the Cabinet")—an agency of the Commonwealth of Kentucky. In his capacity as secretary of the Cabinet, Defendant Friedlander is charged with, *inter alia*, oversight and licensing of abortion providers and the regulatory enforcement of those facilities. KRS 216B.0431(1); 902 KAR 20:360 § 5(1)(a). The Cabinet's regulations include the requirement that all abortion facilities ensure "compliance with . . . state . . . laws," including the Bans. 902 KAR 20:360, § 5(1)(a). Defendant Friedlander is sued in his official capacity.

18. Defendant Michael S. Rodman serves as Executive Director of the Kentucky Board of Medical Licensure ("the Board"). Defendant Rodman and the Board possess authority to pursue disciplinary action up to and including license revocation against Kentucky physicians for violating the Bans. *See* KRS 311.565; KRS 311.606. Defendant Rodman is sued in his official capacity.

19. Defendant Thomas B. Wine serves as the Commonwealth's Attorney for the 30th Judicial Circuit of Kentucky. In this capacity, Defendant Wine has authority to enforce the Bans' criminal penalties in Jefferson County, where Plaintiffs are located. *See* KRS 15.725(1); KRS 23A.010(1). Defendant Wine is sued in his official capacity.

APPLICABLE CONSTITUTIONAL LAW

20. Section One of the Kentucky Constitution provides, in relevant part: "All men[2] are, by nature, free and equal, and have certain inherent and inalienable rights, among which may be reckoned: First: The right of enjoying and defending their lives and liberties. . . . Third: The right of seeking and pursuing their safety and happiness."

21. Section Two of the Kentucky Constitution provides: "Absolute and arbitrary power over the lives, liberty and property of freemen exists nowhere in a republic, not even in the largest majority."

22. Section 27 of the Kentucky Constitution provides: "The powers of the government of the Commonwealth of Kentucky shall be divided into three distinct departments, and each of them be confined to a separate body of magistracy, to wit: Those which are

[2] As used in the Kentucky Bill of Rights, "men" is a generic term encapsulating all people, including women. *Official Report of the Proceedings and Debates in the Convention,* 1890, Ky. Vol. I, 817–18 (discussing proposed amendment to Section 1 to change "men" to "persons" and receiving explanation that "men" is generic and applies to all, including women); *Posey v. Commonwealth*, 185 S.W.3d 170, 200 (Ky. 2006) (Scott, J., concurring in part) ("Nor did the word 'men,' in the first section of the Bill of Rights, limit the enjoyment of those Rights to males, as some might suggest.").

legislative, to one; those which are executive, to another; and those which are judicial, to another."

23. Section 28 of the Kentucky Constitution provides: "No person or collection of persons, being of one of those departments, shall exercise any power properly belonging to either of the others, except in the instances hereinafter expressly directed or permitted."

24. Section 29 of the Kentucky Constitution provides: "The legislative power shall be vested in a House of Representatives and a Senate, which, together, shall be styled the 'General Assembly of the Commonwealth of Kentucky.'"

25. Section 60 of the Kentucky Constitution provides, in relevant part: "No law . . . shall be enacted to take effect upon the approval of any other authority than the General Assembly, unless otherwise expressly provided in this Constitution."

STATUTORY FRAMEWORK

Trigger Ban

26. The Trigger Ban prohibits anyone from either knowingly "[a]dminister[ing] to, prescrib[ing] for, procur[ing] for, or sell[ing] to any pregnant woman any medicine, drug, or other substance" or knowingly "[u]s[ing] or employ[ing] any instrument or procedure upon a pregnant woman" if those actions are done "with the specific intent of causing or abetting the termination of the life of an unborn human being." KRS 311.772(3)(a)(1)–(2).

27. The Trigger Ban was enacted to "become effective immediately upon, and to the extent permitted, by the occurrence of . . . [a]ny decision of the United States Supreme Court which reverses, in whole or in part, *Roe v. Wade*, 410 U.S. 113 (1973), thereby restoring to the Commonwealth of Kentucky the authority to prohibit abortion." KRS 311.772(2)(a).

28. It is unclear whether the Trigger Ban is now in effect as a result of the Supreme Court's decision in *Jackson Women's Health*, or whether it will become effective once the U.S. Supreme Court transmits a certified copy of the judgement and opinion, likely on July 19, 2022, which is 25 days from issuance of the opinion, *see* U.S. Sup. Ct. R. 45. However, Defendant Cameron has made public statements indicating that he believes the Trigger Ban is in effect.[3]

29. Because of the Trigger Ban's serious criminal penalties, the threat of enforcement of the Trigger Ban following the *Jackson Women's Health* decision has stopped the provision of abortion in Kentucky, except in very narrow circumstances. KRS 311.772(3)(a)(1)–(2).

30. The Trigger Ban's extremely limited medical emergency exception permits abortion only "to prevent the death or substantial risk of death due to a physical condition, or to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman." KRS 311.772(4)(a). The Trigger Ban contains no exceptions for cases of rape or incest.

31. Under the Trigger Ban, any person who knowingly provides an abortion to someone who is pregnant would be guilty of a Class D felony, KRS 311.772(3)(b), punishable by imprisonment of one to five years, KRS 532.060(2)(d).

Six-Week Ban

32. The Six-Week Ban requires the doctor who intends to terminate an intrauterine pregnancy to first determine whether there is embryonic or fetal cardiac activity. KRS 311.7704(1); KRS 311.7705(1). If such activity is detected, the Six-Week Ban makes it a felony to "caus[e] or abet[] the termination of" the pregnancy. KRS 311.7706(1).

[3] Advisory from Ky. Att'y Gen. Daniel Cameron on The Effect and Scope of the Human Life Protection Act in Light of *Dobbs v. Jackson Women's Health Organization* (June 24, 2022), https://ag.ky.gov/Press%20Release%20Attachments/Human%20Life%20Protection%20Act%20Advisory.pdf.

33. Detectable cardiac activity generally occurs around six weeks LMP, when the cells that form the basis for development of the heart later in gestation generally begin producing pulsations that are detectable by vaginal ultrasound. Many patients do not yet know they are pregnant at this early stage, and even for patients with highly regular, four-week menstrual cycles, six weeks LMP will be just two weeks after they have missed their first period. By banning abortion at this early point in pregnancy, the Six-Week Ban would prohibit the vast majority of abortions currently provided in the Commonwealth.

34. The Six-Week Ban has only a very limited emergency exception. It permits abortion after detection of cardiac activity only if the abortion is necessary to 1) prevent the pregnant patient's death, or 2) to prevent a "substantial and irreversible impairment of a major bodily function." KRS 311.7706(2)(a). The Six-Week Ban contains no exceptions for cases of rape or incest.

35. A violation of the Six-Week Ban is a Class D felony, which is punishable by imprisonment of one to five years. KRS 311.990(21)–(22); KRS 532.060(2)(d). Additionally, a patient who receives an abortion may bring a civil action for violation of the Six-Week Ban. KRS 311.7709.

36. The Six-Week Ban has been temporarily enjoined since its passage under then-existing U.S. Supreme Court precedent. *See EMW Women's Surgical Ctr., P.S.C. v. Beshear*, No. 3:19-CV-178-DJH, 2019 WL 1233575 (W.D. Ky. Mar. 15, 2019). A motion to dismiss that lawsuit without prejudice is pending before the federal court. ECF No. 92. When the court dismisses the case, the Six-Week Ban will immediately go into effect.

FACTUAL ALLEGATIONS

Pregnancy Has Significant Medical, Financial, and Personal Consequences

37. People experience their pregnancies in a range of different ways. While pregnancy can be a celebratory and joyful event for many families, even an uncomplicated pregnancy challenges the pregnant individual's entire physiology. For many, pregnancy can be a period of physical and personal distress.

38. Every pregnancy necessarily involves significant physical change. A typical pregnancy lasts roughly 40 weeks. During that time, the body experiences a dramatic increase in blood volume, a faster heart rate, increased production of clotting factors, breathing changes, digestive complications, and a growing uterus.

39. As a result of these changes and others, pregnant individuals are more prone to blood clots, nausea, hypertensive disorders, and anemia, among other complications. Many of these complications are mild and resolve without the need for medical intervention. Some, however, require evaluation and occasionally urgent or emergent care to preserve the patient's health or save their life.

40. Pregnancy may aggravate preexisting health conditions such as hypertension and other cardiac disease, diabetes, kidney disease, autoimmune disorders, obesity, asthma, and other pulmonary disease.

41. Other health conditions such as preeclampsia, deep-vein thrombosis, gestational diabetes, and cardiomyopathy may arise for the first time during pregnancy. Patients who develop certain pregnancy-induced medical conditions are at a higher risk of developing the same condition in a subsequent pregnancy.

42. Patients face mental health risks as well. For example, mental health is a contributing factor to almost 40% of maternal deaths in Kentucky.[4] Additionally, approximately 15% of patients suffer from post-partum depression, which if left untreated can lead to guilt, anxiety, suicidal ideation, and inability to care for oneself and/or for the baby.

43. Pregnancy also increases the risk of intimate partner violence, with the severity sometimes escalating during or after pregnancy. Homicide has been reported as a leading cause of maternal mortality, the majority caused by an intimate partner.[5]

44. Separate from pregnancy, childbirth itself is a significant medical event. Even a normal pregnancy can suddenly become life-threatening during labor and delivery. During labor, increased blood flow to the uterus places the patient at risk of hemorrhage and, in turn, death.

45. People who undergo labor and delivery can experience other unexpected adverse events such as infection or hemorrhage.

46. Vaginal delivery can lead to injury, including pelvic floor injury, such as tearing of the perineum, which is painful and requires time to heal. More extensive tears can lead to problems with a patient's bowel and bladder function

47. A substantial proportion of deliveries now occur by cesarean section (C-Section), abdominal surgery requiring hospitalization for at least a few days. While common, C-sections carry risks of hemorrhage, infection, damage to surrounding organs, and in some cases hysterectomy.

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[4] Ky. Dept. for Pub. Health, Maternal Mortality Review: 2020 Annual Report at 10 (2020), https://chfs.ky.gov/agencies/dph/dmch/Documents/MMRAnnualReport.pdf.

[5] Am. Coll. Obstetricians & Gynecologists, *Committee Opinion 518: Intimate Partner Violence* (Feb. 2012), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2012/02/intimate-partner-violence.

48. Pregnancy and childbirth are expensive. Pregnancy-related healthcare and childbirth are some of the costliest hospital-based health services, particularly for complicated or higher-risk pregnancies. These expenses are not always covered by insurance, so even insured patients may pay for significant labor and delivery costs out of pocket.

49. The financial burdens of pregnancy and childbirth weigh even more heavily on patients without insurance, who are disproportionately people of color, and on people with unintended pregnancies, who may not have sufficient savings to cover the unexpected pregnancy-related expenses. A costly pregnancy, particularly for people already facing an array of economic hardships, could have long-term and severe impacts on a family's financial security.

50. According to the Centers for Disease Control and Prevention, pregnancy is becoming more dangerous, with pregnancy-related deaths on the rise across the United States.[6] This unfortunate trend is occurring in Kentucky, with experts identifying a "startling increase" in maternal deaths between 2014 and 2018.[7]

51. Kentuckians face one of the highest pregnancy-related death rates in the nation,[8] and pregnancy is more than twice as deadly for Black Kentuckians as it is for white Kentuckians.[9] As the Kentucky Department for Public Health has recognized, the Commonwealth could do a great deal to drive down these regrettable statistics and save lives: indeed "78% of [Kentucky's] maternal mortality cases were deemed to be preventable."[10]

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[6] Ctrs. for Disease Control & Prevention, *Pregnancy Mortality Surveillance System*, https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm (last updated Apr. 13, 2022).

[7] Ky. Dept. for Pub. Health, *supra* note 4, at 4.

[8] United Health Found., America's Health Rankings: Health of Women and Children Report 34 (2021), https://assets.americashealthrankings.org/app/uploads/state-summaries-healthofwomenandchildren-2021.pdf (rate of 37.7 maternal deaths per 100,000 live births in Kentucky as compared to 20.1 nationwide).

[9] Ky. Dept. for Pub. Health, *supra* note 4, at 5.

[10] *Id.* at 2.

52. Regardless of an individual's plans for after birth, the pregnancy, delivery, and recovery will impact and potentially imperil her ability to find or maintain employment, provide for her family, and care for any existing children. Many Kentuckians lack basic legal protections against pregnancy discrimination, or paid or even unpaid leave for pregnancy-related medical reasons, labor and delivery, and recovery. Kentuckians whose primary responsibilities include unpaid work, such as caring for young children or elderly or disabled loved ones, have no safety net at all for pregnancy and childbirth.

53. Given the impact of pregnancy and childbirth on a person's health and well-being, finances, and personal relationships, whether to become or remain pregnant is one of the most personal and consequential decisions a person will make in their lifetime. Certainly, many people decide that adding a child to their family is well worth all of these risks and consequences. But if abortion is unavailable in the Commonwealth, thousands of Kentuckians will be forced to assume those risks involuntarily.

Abortion Is Safe, Common, and Essential Healthcare

54. Legal abortion is one of the safest procedures in contemporary medical practice in the United States. A Committee of the National Academies of Sciences, Engineering, and Medicine previously issued a report concluding that abortion in the United States is safe; serious complications are rare; and abortion does not increase the risk of long-term physical or mental health disorders.[11]

[11] Nat'l Acad. Of Scis., Eng'g & Med., The Safety & Quality of Abortion Care in the United States 77, 161–62 (2018), https://nap.nationalacademies.org/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-united-states.

55. In Kentucky in 2020, over 99% of abortions in the Commonwealth involved no complications at all, and of the less than 1% that did, nearly all were minor, such as retained tissue treatable by an additional dose of medication.[12]

56. Abortion entails significantly less medical risk than carrying a pregnancy to term and giving birth. Overall, the risk of death from carrying a pregnancy to term is up to fourteen times higher than that from having an abortion, and every pregnancy-related complication is more common among people giving birth than among those having abortions.[13]

57. There are two primary methods of abortion: medication abortion and procedural abortion. Both methods are safe and effective in terminating a pregnancy.

58. Medication abortion involves a combination of two medications, mifepristone and misoprostol, which expel the contents of the uterus in a manner similar to a miscarriage. The passing of the pregnancy takes place after the patient has left the clinic, in a location of their choosing, typically their own home.

59. Procedural abortion involves the use of gentle suction, and in some instances, other instruments, to empty the contents of the patient's uterus. Even though procedural abortions are sometimes referred to as "surgical abortions," it is not what is commonly understood to be "surgery" because it involves no incisions.

60. Abortion is common: Approximately one in four women in this country will have an abortion by age forty-five.

61. Nationwide, a majority of women having abortions (61%) already have at least one child, while most (66%) also plan to have a child or additional children in the future.

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[12] Office of Vital Stat., Ky. Dept. for Pub. Health, Kentucky Annual Abortion Report for 2020, at 12.

[13] Elizabeth G. Raymond & David A. Grimes, The Comparative Safety of Legal Induced Abortion and Childbirth in the United States, 119 Obstetrics & Gynecology 215, 216–17 (2012).

Likewise, in Kentucky, approximately 66% of abortion patients in 2020 already had at least one child.[14]

62. Three-quarters of U.S. abortion patients have low incomes, with nearly half living below the federal poverty level.

63. In the United States, more than 60% of abortion patients are people of color, including 28% who are Black.[15] In Kentucky, nearly 35% of abortion patients identified as Black in 2020, despite comprising only around 9% of the Commonwealth's population.

64. Plaintiffs EMW and Planned Parenthood Louisville are the only two outpatient healthcare centers in Kentucky that are licensed to provide abortion care. Both are located in Louisville. In 2020, Plaintiffs provided 99.7% of all abortions in the Commonwealth.[16]

65. Prior to the threat of enforcement of the Trigger Ban, Plaintiff EMW offered abortion through 21 weeks and 6 days of pregnancy and Plaintiff Planned Parenthood Louisville offered abortion up to 13 weeks and 6 days of pregnancy.

66. For the past several years, Plaintiffs have collectively provided abortions to around 3,000 to 4,000 patients per year.[17]

67. Like in the United States as a whole, approximately half of all abortions in Kentucky are medication abortions, and the other half are procedural abortions.

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[14] *See* Office of Vital Stat., *supra* note 12, at 9.

[15] Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, at 5 (May 2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[16] Office of Vital Stat., *supra* note 12, at 2.

[17] *See id.*; Office of Vital Stat., Ky. Dept. for Pub. Health, Kentucky Annual Abortion Report for 2019, at 2; Office of Vital Stat., Ky. Dept. for Pub. Health, Kentucky Annual Abortion Report for 2018, at 2; Office of Vital Stat., Ky. Dept. for Pub. Health, Kentucky Annual Abortion Report for 2017, at 2.

68. In 2020, only 4% of abortions in Kentucky occurred prior to six weeks of pregnancy, while 28% occurred in the sixth week when cardiac activity typically becomes detectable and the remaining 68% of abortions occurred after six weeks LMP.[18]

Lack of Access to Abortion in the Commonwealth Harms Pregnant Kentuckians and Their Families

69. Kentuckians need access to safe and legal abortion in the Commonwealth in order to exercise autonomy over their lives and to engage fully and equally in society. Everyone who can become pregnant has a right to determine their own future and to make decisions about their relationships and life opportunities without government interference that puts their health and well-being at risk.

70. When individuals seek but are unable to access abortion, they are forced to take on the health risks, physical burdens, and other life-altering consequences of continued pregnancy and childbirth, outlined *supra* ¶¶ 37–53.

71. Further, those who are forced to give birth and add a child to their household when they were not prepared to do so face wide-reaching economic and family consequences.

72. The costs related to parenting a child resulting from an unexpected pregnancy could have severe negative impacts on an individual and her family's well-being. For example, those who seek but are denied an abortion often face years of economic hardship and financial insecurity, as compared with those who were able to access abortion.

73. Children in a family affected by abortion denial are likely to experience a decrease in resources, including both increased rates of poverty and less available parental time,

[18] *See* Office of Vital Stat., *supra* note 12, at 7.

which may have significant impacts on the children's lifelong educational and economic outcomes.

74. Families affected by abortion denial may also be more prone to experiencing violence at home. For example, individuals who sought but were unable to access abortion have been found to be more likely to experience physical violence from the man involved in the pregnancy, even years after being denied the wanted abortion.

75. Some Kentuckians who seek but are unable to access abortion in the Commonwealth will attempt to travel to access this healthcare in another state. Even for those who are able to find the time and resources to travel, not being able to access abortion in Kentucky causes significant harm.

76. Any delays in accessing a wanted abortion expose the abortion seeker to increased health risks, both as a result of the inherent risks of pregnancy and by pushing the procedure later in pregnancy, when there is a higher risk of complications and when a more complex and expensive procedure may be required.

77. Kentuckians forced to travel will be exposed to these risks and burdens due to delays associated with accessing abortion in another state, including from the need to raise additional funds, make travel arrangements, and the time it takes to travel.

78. Given the U.S. Supreme Court's recent decision finding no federal constitutional right to abortion, there are fewer places to access abortion, and the providers in states where abortion remains available likely do not currently have capacity to meet the increased demand for their services from out-of-state patients. As a result, Kentuckians will both have to travel longer distances and wait longer for an available appointment.

79. For most individuals, traveling long distances to access time-sensitive abortion care in another state is extremely difficult, and in many cases the burdens of travel—including travel expenses, finding childcare, and arranging time off work or school— will make it impossible to obtain the desired abortion at all.

80. Some Kentuckians who are denied clinical care because of the Bans may attempt to end their pregnancies on their own, outside the medical system. While safe and effective methods to induce abortion outside clinical settings with medication exist, attempts to access and use these abortion-inducing drugs, often from unlicensed sources, can put patients at serious legal risk. Others without the resources to access medically safe though legally risky methods of self-managed abortion may resort to dangerous tactics to try to terminate an unwanted pregnancy, such as throwing themselves down the stairs or ingesting poison. These attempts to access healthcare criminalized by Kentucky force individuals to take on added legal and medical risks, and may jeopardize pregnant Kentuckians' lives, safety, health, future, and their families' welfare.

The Bans are Causing Irreparable Harm

81. At this moment, Plaintiffs' patients are suffering medical, constitutional, and irreparable harm as a result of being denied the ability to obtain an abortion.

82. Those in need of abortion services are currently unable to access care in the Commonwealth. The threat of criminal penalties from the Trigger Ban has forced Plaintiffs to cancel the appointments of patients seeking this time-sensitive healthcare, and, unless this Court grants relief, will force Plaintiffs to continue turning away all patients seeking abortion.

83. In addition, in the near future when the federal court lifts the injunction currently preventing enforcement of the Six-Week Ban, the threat of additional criminal penalties from

that Ban will similarly force Plaintiffs to turn away patients seeking abortion at or after approximately six weeks, even if the Trigger Ban is enjoined.

84. The inability to access abortion in Kentucky causes irreparable harm to Plaintiffs' patients, including by forcibly imposing the physical burdens and health risks of continued pregnancy and childbirth. Those who seek an abortion but are unable to access that healthcare because of the Bans will be forced to suffer the life-altering physical, emotional, economic, and family consequences of unexpected pregnancy and childbirth. These consequences can be particularly acute for patients who are pregnant as a result of rape, experiencing domestic violence, or facing fetal diagnoses incompatible with sustained life after birth.

85. Kentuckians experiencing pregnancy risks or complications that may seriously and permanently impair their health, but in a way that does not meet the Bans' limited emergency exceptions, will be forced to remain pregnant and suffer serious and potentially life-long harms to their health. Even those whose dire situations may technically qualify for one or both of the Bans' varying emergency exceptions may still be refused care out of hospitals' or providers' fears of being held criminally liable under one or both of the Bans. This is already happening in Texas, where emergency room physicians are afraid to terminate patients' pregnancies because they fear being sued for violating Texas's law banning abortion at roughly six weeks LMP.[19]

86. Even those patients who may be able to arrange for out-of-state abortions will suffer the harms associated with the delay, expense, and additional burdens of long-distance

[19] For example, despite the Texas law having an emergency exception, one woman reported that after her membranes ruptured at 19 weeks—putting her at risk of life-threatening infection or hemorrhage—her doctors sent her via plane to Colorado rather than risk the potential legal consequences of terminating her pregnancy in Texas. Sarah McCammon & Lauren Hodges, *Doctors' Worst Fears About the Texas Abortion Law Are Coming True*, NPR News (Feb. 28, 2022), https://www.wbur.org/npr/1083536401/texas-abortion-law-6-months.

travel, as well as the increased medical risk that comes with delaying care until later in pregnancy.

87. Still other Kentuckians who are denied clinical care due to the Bans may attempt to end their pregnancies on their own, outside the medical system, which may entail legal and/or medical risks that could jeopardize their lives, health, safety, and welfare.

88. In addition to the irreparable harms outlined above, Plaintiffs and Plaintiffs' patients are also suffering the irreparable harm that results from the violation of their constitutional rights.

89. Plaintiffs and Plaintiffs' patients have no adequate remedy at law.

90. Absent an injunction, the Bans provide Plaintiffs no choice but to continue turning away patients in need of abortion in Kentucky, which harms all patients' health and well-being.

CLAIMS FOR RELIEF

Count I:
Violation of Kentucky Constitution §§ 1 & 2 (Right to Privacy) – Trigger Ban

91. The allegations in each of the foregoing paragraphs are incorporated as though fully set forth herein.

92. The guarantees of individual liberty provided in Sections One and Two of the Kentucky Constitution, *see* Ky. Const. §§ 1(1), 1(3) & 2, protect the right to privacy.

93. The constitutional right to privacy protects against the intrusive police power of the state, putting personal and private decision-making related to sexual and reproductive matters beyond the reach of the state. The right to privacy thus protects the right of a pregnant individual to access abortion if they decide to terminate their pregnancy.

94. The right to privacy is a fundamental liberty and inalienable right to which strict scrutiny applies. To survive strict scrutiny, the government must prove that the challenged action furthers a compelling governmental interest that is narrowly tailored to that interest.

95. The Trigger Ban does not further any compelling governmental interest. Even if it did, the law is not narrowly tailored.

96. By imposing a total prohibition on abortion, the Trigger Ban infringes Kentuckians' ability to decide to terminate a pregnancy, in violation of Plaintiffs' patients' right to privacy as guaranteed by Sections One and Two of the Kentucky Constitution.

Count II:
Violation of Kentucky Constitution §§ 1 & 2 (Right to Self-Determination) – Trigger Ban

97. The allegations in each of the foregoing paragraphs are incorporated as though fully set forth herein.

98. The guarantees of individual liberty provided in Sections One and Two of the Kentucky Constitution, *see* Ky. Const. §§ 1(1), 1(3) & 2, protect the right to self-determination and personal autonomy.

99. The constitutional right to self-determination guards every Kentuckian's ability to possess and control their own person and to determine the best course of action for themselves and their body. An individual who is required by the government to remain pregnant against her will— a significant physiological process affecting one's health for 40 weeks and culminating in childbirth—experiences interference of the highest order with her right to possess and control her own person. The right to self-determination thus protects Kentuckians' power to control whether to continue or terminate their own pregnancy.

100. The right to self-determination as protected by the constitutional right to liberty is a fundamental and inalienable right. Any statute that inhibits such a fundamental right is subject

to strict scrutiny and cannot stand unless the government can prove that the statute furthers a compelling governmental interest that is narrowly tailored to that interest.

101. The Trigger Ban does not further any compelling governmental interest. Even if it did, it is not narrowly tailored.

102. By imposing a total ban on abortion, the Trigger Ban infringes on Kentuckians' ability to decide to terminate a pregnancy, in violation of Plaintiffs' patients' right to self-determination as guaranteed by Sections One and Two of the Kentucky Constitution.

Count III:
Violation of Kentucky Constitution §§ 27, 28, & 29 (Unlawful Delegation) – Trigger Ban

103. The allegations in each of the foregoing paragraphs are incorporated as though fully set forth herein.

104. Section 29 of the Kentucky Constitution vests legislative power in the General Assembly. Sections 27 and 28 establish and enforce the separation of powers within the Kentucky government.

105. What conduct will in the future constitute a crime or be subject to severe penalties in Kentucky is a matter for the Kentucky General Assembly to determine in view of the conditions existing when the need for such a statute arises. It is not a matter that may be delegated to the federal government.

106. The Trigger Ban does not specify a point in pregnancy when its ban on abortion becomes operative. Rather, the General Assembly left it to the U.S. Supreme Court to determine the point at which abortion becomes a crime under Kentucky law: The law's prohibition is effective "to the extent permitted" by a U.S. Supreme Court decision "which reverses, in whole or in part, *Roe v. Wade*, 410 U.S. 113 (1973)." KRS 311.772(2)(a)

107. By leaving the future delineation of what conduct constitutes a crime in Kentucky in the hands of the U.S. Supreme Court, the Trigger Ban improperly delegates the nondelegable legislative duty of the General Assembly to define the scope of Kentucky criminal law, in violation of Sections 27, 28, and 29 of the Kentucky Constitution.

Count IV:
Violation of Kentucky Constitution § 60 (Approval of Authority Other Than General Assembly) – Trigger Ban

108. The allegations in each of the foregoing paragraphs are incorporated as though fully set forth herein.

109. Section 60 of the Kentucky Constitution provides that "No law . . . shall be enacted to *take effect* upon the approval of any authority other than the General Assembly, unless otherwise expressly provided in this Constitution" (emphasis added). This means that the General Assembly cannot make a law's life and vitality depend upon the affirmative act of another.

110. The General Assembly did not enact the Trigger Ban to take effect upon its own authority. Instead, it enacted it to "*become* effective immediately upon, and to the extent permitted by . . . [a]ny decision of the United States Supreme Court which reverses, in whole or in part, *Roe v. Wade*, 410 U.S. 113 (1973)." KRS 311.772(2)(a) (emphasis added). The General Assembly plays no role in the determination of when the Trigger Ban takes effect; its effectiveness depends upon the affirmative acts of the U.S. Supreme Court and Kentucky's Attorney General and other prosecutors, who will take affirmative actions to begin effectuating the Trigger Ban.

111. Because the Trigger Ban takes effect only upon the approval of the authority of the United States Supreme Court and Kentucky's Attorney General, the Trigger Ban violates Section 60 of the Kentucky Constitution.

Count V:
Violation of Kentucky Constitution § 2 (Vagueness) – Trigger Ban

112. The allegations in each of the foregoing paragraphs are incorporated as though fully set forth herein.

113. Section Two of the Kentucky Constitution provides due process rights that protect against laws so vague that a reasonable person cannot determine what conduct is prohibited.

114. The General Assembly passed the Trigger Ban in 2019, but the law would only "become effective immediately upon . . . the occurrence of . . . [a]ny decision of the United States Supreme Court which reverses, in whole or in part *Roe v. Wade*, 410 U.S. 113 (1973), thereby restoring to the Commonwealth of Kentucky the authority to prohibit abortion." KRS 311.772(2)(a).

115. The General Assembly did not specify whether "the occurrence" of a U.S. Supreme Court decision "which reverses, in whole or in part *Roe v. Wade*, 410 U.S. 113 (1973), thereby restoring to the Commonwealth of Kentucky the authority to prohibit abortion" means the issuance of an opinion articulating reversal of *Roe* or the transmission of a certified copy of the judgment in the case reversing *Roe*, which is what would authorize the state from which such a case originated to enforce its abortion prohibition.

116. On June 24, 2022, the U.S. Supreme Court entered judgment in *Dobbs v. Jackson Women's Health Organization*, No. 19-1392, 2022 WL 2276808 (U.S. June 24, 2022). In that decision, the Court explicitly and entirely overruled the federal constitutional right to abortion

recognized in *Roe*. The certified copy of the Supreme Court's judgment in that case is expected to be transmitted on July 19, 2022, which is 25 days after the entry of judgment. *See* Sup. Ct. R. 45.

117. The language of the Trigger Ban leaves it unclear whether it is now in effect, or will go into effect on July 19, 2022, when the mandate issues. Because of the criminal penalties for violating the Trigger Ban, Plaintiffs have been forced to stop providing abortion entirely, even though it is not clear whether the law is actually yet in effect.

118. By imposing serious criminal and licensure penalties while failing to give Plaintiffs fair notice of whether the abortion ban takes effect before or after the Supreme Court's mandate issues, the Trigger Ban violates Plaintiffs' right to due process as guaranteed by Section Two of the Kentucky Constitution.

Count VI:
Violation of Kentucky Constitution §§ 27, 28, & 29 (Unintelligibility) – Trigger Ban

119. The allegations in each of the foregoing paragraphs are incorporated as though fully set forth herein.

120. The Kentucky Constitution's separation of powers principles, embodied in Sections 27, 28, and 29, provide an independent constitutional protection against unintelligible laws of all kinds. This is so because courts cannot "conjecture" about the meaning of a facially unintelligible statute without "allocat[ing] to itself legislative functions." *Id.*

121. For the reasons set forth above, *supra* ¶¶ 114–17, the Trigger Ban does not intelligibly define the time at which a decision by the U.S. Supreme Court would "restor[e]to the Commonwealth of Kentucky the authority to prohibit abortion." KRS 311.772(2)(a).

122. Because it is unintelligible, the Trigger Ban cannot be enforced without violating Sections 27, 28, and 29 of the Kentucky Constitution.

Count VII:
Violation of Kentucky Constitution §§ 1 & 2 (Right to Privacy) – Six-Week Ban

123. The allegations in each of the foregoing paragraphs are incorporated as though fully set forth herein.

124. The Kentucky Constitution protects the fundamental right to privacy, which encompasses the right to abortion. *See supra* ¶¶ 92–96.

125. Statutes impacting fundamental rights can only stand if they survive strict scrutiny. *See supra* ¶ 94. The Six-Week Ban cannot survive strict scrutiny because it does not further any compelling governmental interest and, even if it did, the law is not narrowly tailored.

126. By imposing a ban on abortion upon detection of any embryonic cardiac activity, the Six-Week Ban violates Plaintiffs' patients' right to privacy as guaranteed by Sections One and Two of the Kentucky Constitution.

Count VIII:
Violation of Kentucky Constitution §§ 1 & 2 (Right to Self-Determination) – Six-Week Ban

127. The allegations in each of the foregoing paragraphs are incorporated as though fully set forth herein.

128. The Kentucky Constitution protects the fundamental right to self-determination, which encompasses the right to abortion. *See supra* ¶¶ 98–102.

129. Statutes impacting fundamental rights must be reviewed under strict scrutiny. *See supra* ¶ 100. The Six-Week Ban cannot survive strict scrutiny because it does not further any compelling governmental interest and, even if it did, the law is not narrowly tailored.

130. By imposing a ban on abortion upon detection of any embryonic cardiac activity, the Six-Week Ban violates Plaintiffs' patients' right to self-determination as guaranteed by Sections One and Two of the Kentucky Constitution.

Count IX:
Claim for Injunctive Relief Against Defendants (All Claims)

131. The allegations in each of the foregoing paragraphs are incorporated as though fully set forth herein.

132. Plaintiffs' claims for injunctive relief are authorized by Kentucky Rule of Civil Procedure 65.

133. As described *supra* in Counts I to VIII, the Trigger Ban and Six-Week Ban are violating the constitutional rights of Plaintiffs and their patients.

134. Plaintiffs and their patients are suffering, and will continue to suffer, immediate and irreparable injury in the absence of injunctive relief preventing Defendants from enforcing the Bans.

135. Plaintiffs have no adequate remedy at law or otherwise to address this injury, save in a court of equity.

136. The balance of the equities weighs in favor of granting injunctive relief because an injunction would restore the status quo, and serve the public interest in protecting public health and stopping constitutional violations.

137. Plaintiffs have presented a substantial question as to the merits of their claims.

138. Plaintiffs are entitled to injunctive relief, both temporary and permanent, restraining and enjoining Defendants and their agents, attorneys, representatives, and any other person in active concert or participation with them, from enforcing the Bans.

139. No court has refused a previous application for a restraining order or injunction in this matter.

Count X:
Claim for Declaratory Judgment (All Claims)

140. The allegations in each of the foregoing paragraphs are incorporated as though fully set forth herein.

141. Plaintiffs' claims for declaratory relief are authorized by Kentucky Rule of Civil Procedure 57 and KRS 418.040–45.

142. This is an actual and justiciable controversy with respect to the constitutionality of the Trigger Ban and Six-Week Ban.

143. The Bans violate the Kentucky Constitution, as described *supra* in Counts I to VIII.

144. Plaintiffs therefore are entitled to a declaratory judgment that the Bans violate the Kentucky Constitution and are void pursuant to Section 26 of the Kentucky Bill of Rights. Ky. Const. § 26 ("[A]ll laws … contrary to this Constitution, shall be void.").

145. The court may order a speedy hearing of an action for declaratory judgment. Ky. R. Civ. P. 57.

PRAYER FOR RELIEF

Accordingly, Plaintiffs respectfully request the Court grant the following relief:

a. Declare the Trigger Ban, KRS 311.772, and the Six-Week Ban, KRS 311.7701–11, unconstitutional and unenforceable.

b. Enjoin Defendants, their employees, agents, and successors in office from enforcing the Trigger Ban and Six-Week Ban.

c. Grant Plaintiffs costs herein expended.

d. Grant such other and further relief as this Court may deem just, proper, and equitable.

DATE: June 27, 2022

Respectfully submitted,

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**pro hac vice motions forthcoming*

VERIFICATION

I, Ernest Marshall, as an abortion provider at and owner of EMW Women's Surgical Center. P.S.C., verify that the foregoing facts are true and accurate to the best of my knowledge, information, and belief.

Ernest Marshall, M.D.

COMMONWEALTH OF KENTUCKY)
)
COUNTY OF JEFFERSON)

Subscribed, sworn, and acknowledged before me by Ernest Marshall on this 21th day of June, 2022.

NOTARY PUBLIC TRACY MARTIN-WEBB

My commission expires:
Oct 6, 2025

Commission number:
KYNP35554

VERIFICATION

I, Rebecca L. Gibron, as Acting CEO of Planned Parenthood Great Northwest, Hawai'i, Alaska, Indiana, and Kentucky, Inc., verify that the foregoing facts related to Plaintiff Planned Parenthood Great Northwest. Hawai'i, Alaska, Indiana and Kentucky, Inc., are true and accurate to the best of my knowledge, information, and belief.

Rebecca L. Gibron

State of Idaho)
)
County of Ada)

Subscribed, sworn, and acknowledged before me by Rebecca L. Gibron on this 27th day of June, 2022.

LISA R. MILLER NOTARY PUBLIC Comm. No. 64196 STATE OF IDAHO

NOTARY PUBLIC
My commission expires: 9/3/26
Commission number: 64196

Exhibit A

311.772 Prohibition against intentional termination of life of an unborn human being -- Definitions -- When section takes effect -- Penalties not to apply to pregnant woman -- Contraception -- Appropriation of Medicaid funds.

(1) As used in this section:

(a) "Fertilization" means that point in time when a male human sperm penetrates the zona pellucida of a female human ovum;

(b) "Pregnant" means the human female reproductive condition of having a living unborn human being within her body throughout the entire embryonic and fetal stages of the unborn child from fertilization to full gestation and childbirth; and

(c) "Unborn human being" means an individual living member of the species homo sapiens throughout the entire embryonic and fetal stages of the unborn child from fertilization to full gestation and childbirth.

(2) The provisions of this section shall become effective immediately upon, and to the extent permitted, by the occurrence of any of the following circumstances:

(a) Any decision of the United States Supreme Court which reverses, in whole or in part, Roe v. Wade, 410 U.S. 113 (1973), thereby restoring to the Commonwealth of Kentucky the authority to prohibit abortion; or

(b) Adoption of an amendment to the United States Constitution which, in whole or in part, restores to the Commonwealth of Kentucky the authority to prohibit abortion.

(3) (a) No person may knowingly:

1. Administer to, prescribe for, procure for, or sell to any pregnant woman any medicine, drug, or other substance with the specific intent of causing or abetting the termination of the life of an unborn human being; or

2. Use or employ any instrument or procedure upon a pregnant woman with the specific intent of causing or abetting the termination of the life of an unborn human being.

(b) Any person who violates paragraph (a) of this subsection shall be guilty of a Class D felony.

(4) The following shall not be a violation of subsection (3) of this section:

(a) For a licensed physician to perform a medical procedure necessary in reasonable medical judgment to prevent the death or substantial risk of death due to a physical condition, or to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman. However, the physician shall make reasonable medical efforts under the circumstances to preserve both the life of the mother and the life of the unborn human being in a manner consistent with reasonable medical practice; or

(b) Medical treatment provided to the mother by a licensed physician which results in the accidental or unintentional injury or death to the unborn human being.

(5) Nothing in this section may be construed to subject the pregnant mother upon

whom any abortion is performed or attempted to any criminal conviction and penalty.

(6) Nothing in this section may be construed to prohibit the sale, use, prescription, or administration of a contraceptive measure, drug, or chemical, if it is administered prior to the time when a pregnancy could be determined through conventional medical testing and if the contraceptive measure is sold, used, prescribed, or administered in accordance with manufacturer instructions.

(7) The provisions of this section shall be effective relative to the appropriation of Medicaid funds, to the extent consistent with any executive order by the President of the United States, federal statute, appropriation rider, or federal regulation that sets forth the limited circumstances in which states must fund abortion to remain eligible to receive federal Medicaid funds pursuant to 42 U.S.C. secs. 1396 et seq.

Effective: June 27, 2019

History: Created 2019 Ky. Acts ch. 152, sec. 1, effective June 27, 2019.

Legislative Research Commission Note (6/27/2019). 2019 Ky. Acts ch. 152, sec. 2 provides that 2019 Ky. Acts ch. 152 may be cited as the "Human Life Protection Act." This statute was created in Section 1 of that Act.

Exhibit B

311.7701 Definitions for KRS 311.7701 to 311.7711.

As used in KRS 311.7701 to 311.7711:

(1) "Conception" means fertilization;

(2) "Contraceptive" means a drug, device, or chemical that prevents conception;

(3) "Fertilization" has the same meaning as in KRS 311.781;

(4) "Fetal heartbeat" means cardiac activity or the steady and repetitive rhythmic contraction of the fetal heart within the gestational sac;

(5) "Fetus" means the human offspring developing during pregnancy from the moment of conception and includes the embryonic stage of development;

(6) "Frivolous conduct" has the same meaning as in KRS 311.784;

(7) "Gestational age" means the age of an unborn human individual as calculated from the first day of the last menstrual period of a pregnant woman;

(8) "Gestational sac" means the structure that comprises the extraembryonic membranes that envelop the fetus and that is typically visible by ultrasound after the fourth week of pregnancy;

(9) "Intrauterine pregnancy" means a pregnancy in which the fetus is attached to the placenta within the uterus of the pregnant woman;

(10) "Medical emergency" has the same meaning as in KRS 311.781;

(11) "Physician" has the same meaning as in KRS 311.720;

(12) "Pregnancy" means the human female reproductive condition that begins with fertilization, when the woman is carrying the developing human offspring, and that is calculated from the first day of the last menstrual period of the woman;

(13) "Serious risk of the substantial and irreversible impairment of a major bodily function" has the same meaning as in KRS 311.781;

(14) "Spontaneous miscarriage" means the natural or accidental termination of a pregnancy and the expulsion of the fetus, typically caused by genetic defects in the fetus or physical abnormalities in the pregnant woman;

(15) "Standard medical practice" means the degree of skill, care, and diligence that a physician of the same medical specialty would employ in like circumstances. As applied to the method used to determine the presence of a fetal heartbeat for purposes of KRS 311.7704, "standard medical practice" includes employing the appropriate means of detection depending on the estimated gestational age of the fetus and the condition of the woman and her pregnancy; and

(16) "Unborn child" and "unborn human individual" have the same meaning as "unborn child" has in KRS 311.781.

Effective: March 15, 2019

History: Created 2019 Ky. Acts ch. 20, sec. 1, effective March 15, 2019.

311.7702 Findings and declarations.

The General Assembly finds and declares, according to contemporary medical research, all of the following:

(1) As many as thirty percent (30%) of natural pregnancies end in spontaneous miscarriage;

(2) Less than five percent (5%) of all natural pregnancies end in spontaneous miscarriage after detection of fetal cardiac activity;

(3) Over ninety percent (90%) of intrauterine pregnancies survive the first trimester if cardiac activity is detected in the gestational sac;

(4) Nearly ninety percent (90%) of in vitro pregnancies do not survive the first trimester where cardiac activity is not detected in the gestational sac;

(5) Fetal heartbeat, therefore, has become a key medical predictor that an unborn human individual will reach live birth;

(6) Cardiac activity begins at a biologically identifiable moment in time, normally when the fetal heart is formed in the gestational sac;

(7) The Commonwealth of Kentucky has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of an unborn human individual who may be born; and

(8) In order to make an informed choice about whether to continue her pregnancy, the pregnant woman has a legitimate interest in knowing the likelihood of the fetus surviving to full-term birth based upon the presence of cardiac activity.

Effective: March 15, 2019

History: Created 2019 Ky. Acts ch. 20, sec. 2, effective March 15, 2019.

311.7703 Application of KRS 311.7704, 311.7705, and 311.7706.

KRS 311.7704, 311.7705, and 311.7706 apply only to intrauterine pregnancies.

Effective: March 15, 2019

History: Created 2019 Ky. Acts ch. 20, sec. 3, effective March 15, 2019.

311.7704 Determination of fetal heartbeat -- Medical records -- Option to view or hear heartbeat -- Administrative regulations -- Persons not in violation.

(1) (a) A person who intends to perform or induce an abortion on a pregnant woman shall determine whether there is a detectable fetal heartbeat of the unborn human individual the pregnant woman is carrying. The method of determining the presence of a fetal heartbeat shall be consistent with the person's good-faith understanding of standard medical practice, provided that if administrative regulations have been promulgated under subsection (2) of this section, the method chosen shall be one that is consistent with the regulations.

(b) The person who determines the presence or absence of a fetal heartbeat shall record in the pregnant woman's medical record the estimated gestational age of the unborn human individual, the method used to test for a fetal heartbeat, the date and time of the test, and the results of the test.

(c) The person who performs the examination for the presence of a fetal heartbeat shall give the pregnant woman the option to view or hear the fetal heartbeat.

(2) The secretary of the Cabinet for Health and Family Services may promulgate administrative regulations specifying the appropriate methods of performing an examination for the purpose of determining the presence of a fetal heartbeat of an unborn human individual based on standard medical practice. The regulations shall require only that an examination shall be performed externally.

(3) A person is not in violation of subsection (1) or (2) of this section if:

(a) The person has performed an examination for the purpose of determining the presence of a fetal heartbeat of an unborn human individual utilizing standard medical practice;

(b) The examination does not reveal a fetal heartbeat or the person has been informed by a physician who has performed the examination for a fetal heartbeat that the examination did not reveal a fetal heartbeat; and

(c) The person notes in the pregnant woman's medical records the procedure utilized to detect the presence of a fetal heartbeat.

Effective: March 15, 2019

History: Created 2019 Ky. Acts ch. 20, sec. 4, effective March 15, 2019.

311.7705 Prohibition against performing or inducing abortion before determining whether fetal heartbeat exists -- Exceptions -- Written notation -- Persons not in violation.

(1) Except as provided in subsection (2) of this section, no person shall intentionally perform or induce an abortion on a pregnant woman before determining in accordance with KRS 311.7704(1) whether the unborn human individual the pregnant woman is carrying has a detectable fetal heartbeat.

(2) (a) Subsection (1) of this section shall not apply to a physician who performs or induces the abortion if the physician believes that a medical emergency exists that prevents compliance with subsection (1) of this section.

(b) A physician who performs or induces an abortion on a pregnant woman based on the exception in paragraph (a) of this subsection shall make written notations in the pregnant woman's medical records of both of the following:

1. The physician's belief that a medical emergency necessitating the abortion existed; and
2. The medical condition of the pregnant woman that prevented compliance with subsection (1) of this section.

The physician shall maintain a copy of the notations in the physician's own records for at least seven (7) years from the date the notations were made.

(3) A person is not in violation of subsection (1) of this section if the person acts in accordance with KRS 311.7704(1) and the method used to determine the presence of a fetal heartbeat does not reveal a fetal heartbeat.

(4) A pregnant woman on whom an abortion is intentionally performed or induced in violation of subsection (1) of this section is not guilty of violating subsection (1) of this section or of attempting to commit, conspiring to commit, or complicity in committing a violation of subsection (1) of this section. In addition, the pregnant woman is not subject to a civil penalty based on the abortion being performed or induced in violation of subsection (1) of this section.

Effective: March 15, 2019

History: Created 2019 Ky. Acts ch. 20, sec. 5, effective March 15, 2019.

311.7706 Prohibition against performing or inducing abortion if fetal heartbeat detected -- Exceptions -- Written declaration -- Persons not in violation.

(1) Except as provided in subsection (2) of this section, no person shall intentionally perform or induce an abortion on a pregnant woman with the specific intent of causing or abetting the termination of the life of the unborn human individual the pregnant woman is carrying and whose fetal heartbeat has been detected in accordance with KRS 311.7704(1).

(2) (a) Subsection (1) of this section shall not apply to a physician who performs a medical procedure that, in the physician's reasonable medical judgment, is designed or intended to prevent the death of the pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman.

(b) A physician who performs a medical procedure as described in paragraph (a) of this subsection shall, in writing:

1. Declare that the medical procedure is necessary, to the best of the physician's reasonable medical judgment, to prevent the death of the pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman; and

2. Specify the pregnant woman's medical condition that the medical procedure is asserted to address and the medical rationale for the physician's conclusion that the medical procedure is necessary to prevent the death of the pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman.

(c) The physician shall place the written document required by paragraph (b) of this subsection in the pregnant woman's medical records. The physician shall maintain a copy of the document in the physician's own records for at least seven (7) years from the date the document is created.

(3) A person is not in violation of subsection (1) of this section if the person acts in accordance with KRS 311.7704(1) and the method used to determine the presence of a fetal heartbeat does not reveal a fetal heartbeat.

(4) A pregnant woman on whom an abortion is intentionally performed or induced in violation of subsection (1) of this section is not guilty of violating subsection (1) of this section or of attempting to commit, conspiring to commit, or complicity in committing a violation of subsection (1) of this section. In addition, the pregnant woman is not subject to a civil penalty based on the abortion being performed or induced in violation of subsection (1) of this section.

(5) Subsection (1) of this section shall not repeal or limit any other provision of the Kentucky Revised Statutes that restricts or regulates the performance or inducement of an abortion by a particular method or during a particular stage of a pregnancy.

Effective: March 15, 2019

History: Created 2019 Ky. Acts ch. 20, sec. 6, effective March 15, 2019.

311.7707 Written document regarding purpose of abortion -- Retention of records.

(1) The provisions of this section are independent of the requirements of KRS 311.7704, 311.7705, and 311.7706.

(2) A person who performs or induces an abortion on a pregnant woman shall:

(a) If the reason for the abortion purported is to preserve the health of the pregnant woman, specify in a written document the medical condition that the abortion is asserted to address and the medical rationale for the person's conclusion that the abortion is necessary to address that condition; or

(b) If the reason for the abortion is other than to preserve the health of the pregnant woman, specify in a written document that maternal health is not the purpose of the abortion.

(3) The person who specifies the information in the document described in subsection (2) of this section shall place the document in the pregnant woman's medical records. The person who specifies the information shall maintain a copy of the document in the person's own records for at least seven (7) years from the date the document is created.

Effective: March 15, 2019

History: Created 2019 Ky. Acts ch. 20, sec. 7, effective March 15, 2019.

311.7708 Drugs, devices, and chemicals designed for contraceptive purposes.

Nothing in KRS 311.7701 to 311.7711 prohibits the sale, use, prescription, or administration of a drug, device, or chemical that is designed for contraceptive purposes.

Effective: March 15, 2019

History: Created 2019 Ky. Acts ch. 20, sec. 8, effective March 15, 2019.

311.7709 Civil action for wrongful death of unborn child -- Damages, costs, fees -- Defense.

(1) A woman on whom an abortion was performed or induced in violation of KRS 311.7705(1) or 311.7706(1) may file a civil action for the wrongful death of her unborn child.

(2) A woman who prevails in an action filed under subsection (1) of this section shall receive from the person who performed or induced the abortion:

(a) Damages in an amount equal to ten thousand dollars ($10,000) or an amount determined by the trier of fact after consideration of the evidence at the mother's election at any time prior to final judgment subject to the same defenses and requirements of proof, except any requirement of live birth, as would apply to a suit for the wrongful death of a child who had been born alive; and

(b) Court costs and reasonable attorney's fees.

(3) A determination that KRS 311.7705(1) or 311.7706(1) is unconstitutional shall be a defense to an action filed under subsection (1) of this section alleging that the defendant violated the subsection that was determined to be unconstitutional.

(4) If the defendant in an action filed under subsection (1) of this section prevails and:

(a) The court finds that the commencement of the action constitutes frivolous conduct;

(b) The court's finding in paragraph (a) of this subsection is not based on that court or another court determining that KRS 311.7705(1) or 311.7706(1) is unconstitutional; and

(c) The court finds that the defendant was adversely affected by the frivolous conduct;

the court shall award reasonable attorney's fees to the defendant.

Effective: March 15, 2019

History: Created 2019 Ky. Acts ch. 20, sec. 9, effective March 15, 2019.

311.7710 Inspection of facilities to determine compliance with reporting requirements.

The Cabinet for Health and Family Services shall inspect the medical records from any facility that performs abortions to ensure that the physicians or other persons who perform abortions at that facility are in compliance with the reporting requirements under KRS 213.101. The facility shall make the medical records available for inspection to the Cabinet for Health and Family Services but shall not release any personal medical information in the medical records that is prohibited by law.

Effective: March 15, 2019

History: Created 2019 Ky. Acts ch. 20, sec. 10, effective March 15, 2019.

311.7711 Effect of court order suspending enforcement -- Application to court concerning constitutionality or injunction -- Severability.

(1) It is the intent of the General Assembly that a court judgment or order suspending enforcement of any provision of KRS 311.7701 to 311.7711 is not to be regarded as tantamount to repeal of that provision.

(2) (a) After the issuance of a decision by the Supreme Court of the United States overruling Roe v. Wade, 410 U.S. 113 (1973), the issuance of any other court order or judgment restoring, expanding, or clarifying the authority of states to prohibit or regulate abortion entirely or in part, or the effective date of an amendment to the Constitution of the United States restoring, expanding, or clarifying the authority of states to prohibit or regulate abortion entirely or in part, the Attorney General may apply to the pertinent state or federal court for either or both of the following:

1. A declaration that any one (1) or more sections specified in subsection (1) of this section are constitutional; or
2. A judgment or order lifting an injunction against the enforcement of any one (1) or more sections specified in subsection (1) of this section.

(b) If the Attorney General fails to apply for the relief described in paragraph (a) of this subsection within thirty (30) days of an event described in paragraph (a) of this subsection, any Commonwealth or county attorney may apply to the appropriate state or federal court for such relief.

(3) If any provision of KRS 311.7701 to 311.7711 is held invalid, or if the application of such provision to any person or circumstance is held invalid, the invalidity of that provision does not affect any other provisions or applications of KRS 311.7701 to 311.7711 that can be given effect without the invalid provision or application, and to this end the provisions of KRS 311.7701 to 311.7711 are severable as provided in KRS 446.090. In particular, it is the intent of the General Assembly that:

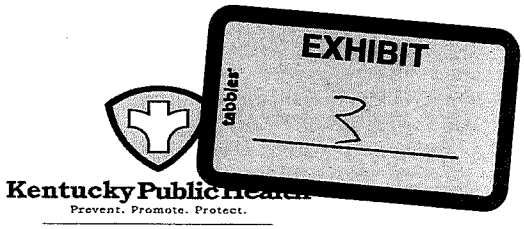
(a) Any invalidity or potential invalidity of a provision of KRS 311.7701 to 311.7711 is not to impair the immediate and continuing enforceability of the remaining provisions; and

(b) The provisions of KRS 311.7701 to 311.7711 are not to have the effect of repealing or limiting any other laws of this state, except as specified by KRS 311.7701 to 311.7711.

Effective: March 15, 2019

History: Created 2019 Ky. Acts ch. 20, sec. 11, effective March 15, 2019.

EXHIBIT 3



Kentucky Annual Abortion Report for 2020

Department for Public Health

The Office of Vital Statistics

KRS 213.101 (4) states... *"By September 30 of each year, the Vital Statistics Branch shall issue a public report that provides statistics on all data collected, including the type of abortion procedure used, for the previous calendar year compiled from all of the reports covering that calendar year submitted to the cabinet in accordance with this section for each of the items listed in subsections (1) and (2) of this section. Each annual report shall also provide statistics for all previous calendar years in which this section was in effect, adjusted to reflect any additional information from late or corrected reports. The Vital Statistics Branch shall ensure that none of the information included in the report could reasonably lead to the identification of any pregnant woman upon whom an abortion was performed or attempted. Each annual report shall be made available on the cabinet's Web site."*

Abortion Cases by Facility in KY, 2020*

	Termination Year
Name of Facility	2020
EMW WOMEN'S SURG CNTR - LOU	3,724
NORTON HOSPITAL	1
NORTON WOMEN'S AND CHILDREN'S HOSPITAL	1
PLANNED PARENTHOOD OF THE GREAT NORTHWEST HI, AK, IN, KY	368
UK HEALTH CARE	1
UNIVERSITY OF LOUISVILLE	9
TOTAL	**4,104**

*Abortion data displayed includes the events which occurred in the state, regardless of place of residence.

Abortion Cases by Month of Termination in KY, 2020*

	Termination Year
Termination Month	2020
JANUARY	367
FEBRUARY	340
MARCH	362
APRIL	358
MAY	358
JUNE	322
JULY	346
AUGUST	362
SEPTEMBER	309
OCTOBER	362
NOVEMBER	285
DECEMBER	333
TOTAL	**4,104**

*Abortion data includes events that occurred in the state, regardless of the place of residence.

Abortion Cases by State of Residence in KY, 2020*

State of Residence	Termination Year 2020
FLORIDA	1
ILLINOIS	1
INDIANA	401
KENTUCKY	3,487
LOUISIANA	2
MARYLAND	1
MISSISSIPPI	3
MISSOURI	1
NEVADA	1
NEW JERSEY	1
OHIO	31
TENNESSEE	153
TEXAS	1
VIRGINIA	4
WEST VIRGINIA	16
TOTAL	**4,104**

*Abortion data displayed includes the events which occurred in the state, regardless of place of residence.

Abortion Cases by Age in KY, 2020*

	Termination Year
Age	2020
Under 15	13
15 - 19	353
20 - 24	1,192
25 - 29	1,229
30 - 34	779
35 - 39	399
40 +	139
TOTAL	**4,104**

*Abortion data displayed includes the events which occurred in the state, regardless of place of residence.

Abortion Cases by Marital Status in KY, 2020*

	Termination Year
Marital Status	2020
Married	523
Unmarried	3,581
TOTAL	**4,104**

*Abortion data displayed includes the events which occurred in the state, regardless of place of residence.

Abortion Cases by Ethnicity in KY, 2020*

	Termination Year
Ethnicity	2020
Hispanic	310
Non-Hispanic	3,777
Unknown	17
TOTAL	**4,104**

*Abortion data displayed includes the events which occurred in the state, regardless of place of residence.

Abortion Cases by Hispanic Origin in KY, 2020*

		Termination Year
Ethnicity	Hispanic Origin	2020
Hispanic	BOLIVIAN	1
	COLOMBIAN	2
	CUBAN	91
	DOMINICAN REPUBLICAN	1
	ECUADORIAN	1
	GUATEMALAN	11
	HONDURAN	12
	MEXICAN	126
	NICARAGUAN	1
	PANAMANIAN	2
	PERUVIAN	2
	PUERTO RICAN	12
	SALVADORAN	9
	VENEZUELAN	2
	UNKNOWN	37
Non-Hispanic		3,777
Unknown	UNKNOWN	17
TOTAL		**4,104**

*Abortion data displayed includes the events which occurred in the state, regardless of place of residence.

Abortion Cases by Race in KY, 2020*

Race	Termination Year 2020
American Indian	5
Black	1,418
White	2,227
Other	448
Unknown	6
TOTAL	**4,104**

*Abortion data displayed includes the events which occurred in the state, regardless of place of residence.

Abortion Cases by Education in KY, 2020*

Education	Termination Year 2020
Elementary (0-12)	1,880
College (1-4)	2,199
College (5+)	3
Unknown	22
TOTAL	**4,104**

*Abortion data displayed includes the events which occurred in the state, regardless of place of residence.

Abortion Cases by Clinical Estimate of Gestation (Weeks) in KY, 2020*

	Termination Year
Gestation Weeks	2020
4	1
5	163
6	1,156
7	778
8	631
9	364
10	201
11	167
12	136
13	86
14	77
15	70
16	49
17	55
18	59
19	33
20	43
21	34
23	1
TOTAL	**4,104**

*Abortion data displayed includes the events which occurred in the state, regardless of place of residence.

Abortion Cases by Probable Post-Fertilization Weeks in KY, 2020*

	Termination Year
Prob-Post-Fert-Weeks	2020
3	135
4	1,091
5	709
6	580
7	363
8	252
9	226
10	180
11	114
12	89
13	79
14	56
15	58
16	61
17	33
18	43
19	34
23	1
TOTAL	**4,104**

*Abortion data displayed includes the events which occurred in the state, regardless of place of residence.

Abortion Reporting - Previous Live Births in KY, 2020*

Termination Year: 2020					
Previous Live Births Now Living€	Counts€	Previous Live Births Now Dead€	Counts€	Previous Live Births Total¥	Counts¥
0	1,387	0	4,074	0	1,379
1	1,092	1	25	1	1,091
2	931	2	5	2	932
3	426	3	0	3	426
4	179	4	0	4	185
5	52	5	0	5	54
6	19	6	0	6	19
7	8	7	0	7	8
8	6	8	0	8	6
9	1	9	0	9	1
10	3	10	0	10	3
TOTAL	**4,104**	**TOTAL**	**4,104**	**TOTAL**	**4,104**

*Abortion data displayed includes the events which occurred in the state, regardless of place of residence.

€ Counts included in these columns are not mutually exclusive. Individuals added to Births Living column may be added to the Births Dead column and vice-versa.

¥ In this table are included the total number of Previous Live Births Living AND Dead.

Abortion Reporting - Previous Pregnancies Resulting in Terminations in KY, 2020*

Termination Year: 2020					
Other Spontaneous Terminations[¥]	Counts[¥]	Other Induced Terminations[¥]	Counts[¥]	Other Terminations Total[£]	Counts[£]
0	3,249	0	2,685	0	2,215
1	648	1	925	1	1,061
2	147	2	310	2	471
3	39	3	108	3	195
4	12	4	34	4	71
5	3	5	21	5	41
6	3	6	12	6	28
7	1	7	3	7	10
8	0	8	1	8	4
9	0	9	1	9	1
10	1	10	3	10	5
11	0	11	0	11	0
12	0	12	1	12	1
13	1	13	0	13	0
14	0	14	0	14	1
TOTAL	**4,104**	**TOTAL**	**4,104**	**TOTAL**	**4,104**

*Abortion data displayed includes the events which occurred in the state, regardless of place of residence.

[¥]Counts included in these columns are not mutually exclusive. Individuals added to Spontaneous Terminations column may be added to the Induced Terminations column and vice-versa.

[£]In this table are included the total number of Other Terminations Spontaneous AND Induced.

Abortion Cases by Termination Necessary Status in KY, 2020*£

Termination Necessary Status£	Termination Year 2020
No or Unknown	4,103
Yes	1
TOTAL	**4,104**

*Abortion data displayed includes the events which occurred in the state, regardless of place of residence.

£The question related to "Termination Necessary Status" Status is for abortion patients with a post-fertilization fetus age higher than 20 weeks.

Abortion Cases by Termination Provided Best Chance for Unborn Child Survival in KY, 2020*£

Termination Chance Unborn Child Survival	Termination Year 2020
No or Unknown	4,103
Yes	1
TOTAL	**4,104**

*Abortion data displayed includes the events which occurred in the state, regardless of place of residence.

£It was determined based on age of fetus as more than 20 weeks and if the attending physician certifies that the pregnancy was terminated in a way that provided the best chance for the unborn child to survive.

Abortion Cases by Abortion Procedure Type in KY, 2020*

			Termination Year
Termination Procedure	Other Procedure	Attending Physician Written Certification >20 wks[£]	2020
Dilation and Evacuation (D&E)			283
Medical_Non_Surgical			2,085
Medical_Non_Surgical		CYTOTEC	1
Other/Abortion Drug (Specify)	CYTOTEC		1
Sharp Curettage (D&E)			1
Suction Curettage			1,733
Intra-Uterine Instillation (Saline or Prostaglandin)			0
TOTAL			**4,104**

*Abortion data displayed includes the events which occurred in the state, regardless of place of residence.

[£]It was determined based on age of fetus as more than 20 weeks and a certification from the attending physician for the methods chosen for aborting the pregnancy.

Abortion Cases by Abortion Complications in KY, 2020*

		Termination Year
Abortion Complications	Complication Description	2020
0	NO COMPLICATIONS REPORTED	4,074
1	INCOMPLETE ABORTION OR RETAINED TISSUE	18
1	CERVICAL LACERATION	1
1	FAILURE TO TERMINATE THE PREGNANCY	1
1	HEAVY BLEEDING THAT CAUSES SYMPTOMS OF HYPOVOLEMIA OR THE NEED FOR A BLOOD TRANSFUSION	2
1	UTERINE LACERATION	1
1	ANY OTHER ADVERSE EVENT AS DEFINED BY CRITERIA PROVIDED IN THE FOOD AND DRUG ADMINISTRATION SAFETY INFORMATION AND ADVERSE EVENT REPORTING PROGRAM	1
1	UNKNOWN KIND OF COMPLICATION	6
7	**TOTAL**	**4,104**

*Abortion data displayed includes the events which occurred in the state, regardless of place of residence.

EXHIBIT 4

NO. 22-CI-003225 JEFFERSON CIRCUIT COURT
ELECTRONICALLY FILED DIVISION THREE (3)
JUDGE MITCH PERRY

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

v.

DANIEL CAMERON, in his official capacity as
Attorney General of the Commonwealth of Kentucky, *et al.* DEFENDANTS

ATTORNEY GENERAL DANIEL CAMERON'S
NOTICE OF FILING OF TRANSCRIPT

On July 6, 2022, this Court held a hearing on Plaintiffs' Motion for a Temporary Injunction. To facilitate review of the Court's official video record, the Attorney General obtained a transcript of the official video record from Kentuckiana Court Reporters and cited to the transcript in his 7/18/2022 filings. The Attorney General hereby gives notice of his filing of the transcript in this Court's record and attaches the same hereto.

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CASE NO. 22-CI-3225

EMW WOMEN'S SURGICAL CENTER, ET AL.

V.

DANIEL CAMERON, ET AL.

HEARING

JEFFERSON CIRCUIT COURT

HON. JUDGE MITCH PERRY

CASE NO. 22-CI-3225

EMW WOMEN'S SURGICAL CENTER, ET AL.,

Plaintiffs

V.

DANIEL CAMERON, ET AL.,

Defendants

HEARING

INDEX

	Page
PROCEEDINGS	3
DR. ASHLEE BERGIN	
DIRECT EXAMINATION BY MS. AMIRI	18
CROSS EXAMINATION BY MR. MADDOX	42
REDIRECT EXAMINATION BY MS. AMIRI	78
JASON LINDO	
DIRECT EXAMINATION BY MS. TAKAKJIAN	89
CROSS EXAMINATION BY MR. MADDOX	133
DR. MONIQUE CHIREAU WUBBENHORST	
DIRECT EXAMINATION BY MS. KEISER	176
CROSS EXAMINATION BY MS. AMIRI	213
CARTER SNEED	
DIRECT EXAMINATION BY MR. THACKER	243
CROSS EXAMINATION BY MS. GATNAREK	270
REDIRECT EXAMINATION BY MR. THACKER	287

PROCEEDINGS

JUDGE PERRY: All right. Good morning, and welcome. This is 22-CI-3325, EMW Women's Surgical Center et al. versus Daniel Cameron et al. First, let's go back through it. We did it last week, but let's do it again. First for the plaintiff, who's with you? Announce yourself for the record.

MS. GATNAREK: Good morning, Your --

JUDGE PERRY: And who's the primary speaker? Help me with that.

MS. GATNAREK: Good morning, Your Honor. Heather Gatnarek from ACLU of Kentucky, on behalf of Plaintiffs. I will be preliminarily speaking, although others will be participating in the questioning of witnesses.

JUDGE PERRY: Okay.

MS. GATNAREK: And if it's all right, Judge, I'll let my co-counsel introduce themselves on the record.

JUDGE PERRY: Sure.

MS. AMIRI: Good morning, Your Honor. Brigitte Amiri for the plaintiffs EMW and Dr. Ernest Marshall from the ACLU, and I will be handling some of the witnesses today.

JUDGE PERRY: Okay.

MS. TAKAKJIAN: Good morning, Your Honor. Katherine Takakjian from O'Melveny & Myers, also for the plaintiffs, and I'll also be handling one of the witnesses today.

JUDGE PERRY: All right. Let's cross over, on behalf of the general.

MR. MADDOX: Good morning, Your Honor, Victor Maddox on behalf of Attorney General Daniel Cameron. I'll be dealing with some of the witnesses as well my co-counsel.

JUDGE PERRY: Okay.

MR. THACKER: Christopher Thacker, Assistant Deputy Attorney General for General Cameron.

MS. KEISER: I'm Lindsey Keiser, I'm Assistant Attorney General, and I'll also be handling one of the witnesses.

AUTOMATED: The conference will automatically end in 30 seconds.

JUDGE PERRY: All right.

MR. DUKE: Good morning. Wesley Duke, General Counsel for the Academy for Health and Family Services. I also have with me my Deputy General Counsel Jessica Williamson. As we discussed last week, the Commonwealth does not plan on -- the

cabinet does not plan on presenting any proof here today.

JUDGE PERRY: Okay. Next to you?

MR. MOORE: Your Honor, Jason Moore, Assistant Commonwealth's Attorney on behalf of Tom Wine, Commonwealth's Attorney.

JUDGE PERRY: Okay.

MS. DIAKOV: Your Honor, Leanne Diakov on behalf of the defendant, Michael Rodman --

AUTOMATED: Conference ending. Goodbye.

MS. DIAKOV: -- for the Kentucky Board of Medical Licensure.

JUDGE PERRY: Okay, good morning. And back over here.

MS. TURNER: Your Honor, I'm Kendall Turner, also representing the plaintiffs, and also from O'Melveny & Myers.

MS. BAJRAMOVIC: Your Honor, I'm Hana Bajramovic from Planned Parenthood Federation of America representing Plaintiff Planned Parenthood.

JUDGE PERRY: Okay.

MS. HENRY: I'm Michele Henry, representing the plaintiffs.

JUDGE PERRY: All right. As you can hear -- a little housekeeping -- we have a way to effectively

broadcast this through a telephone system. Was anybody expecting -- Counsel, were you expecting people to call in to listen today?

MR. MADDOX: We are not, Your Honor.

JUDGE PERRY: Anybody?

MS. GATNAREK: I had several folks ask me about it, Your Honor, but I think it's -- no, I don't think anyone's counting on it.

JUDGE PERRY: And I can tell if there are people on the line and currently there are not. But it's -- it can be disruptive as you just heard. Sorry about that. All right. Well, speaking of etiquette, let me give a couple preambles. Number one: Our friends in the press are welcome, but here in this courtroom -- so welcome -- but we'd like to keep one camera. And those that are doing other types of reporting are welcome, as long as you're not disruptive. I would ask you to be still and quiet while we're doing whatever we do here today. But you're welcome. Those in the gallery are also welcome. Courtrooms are public spaces. You're welcome to be here as long as you're simply bearing witness and not disruptive. So that's my expectation. With regard to the pandemic, many of you are wearing masks, which is great. Currently,

the Court of Justice controls our own buildings and there is no mask mandate over the building itself, but in the Courtroom, in this division, I leave it to the individuals. This Court has been vaxxed and boosted multiple times -- or all that I could legally do. I'll leave it to you whether you do that or not, but I do know that there's current -- there's a mini outbreak going on in our community and around the state. So if you choose to wear a mask, great. I don't require that of lawyers. I'll leave that to you. And with regard to witnesses, if when we get there, if they want to wear one, as long as I can hear them, that's fine, too. So that's the overview with regard to that. I had -- since we last -- gentle reminder, this case is only nine days old and I saw you seven days ago. Mr. Maddox, good to see you. Hope you feel better. And we set this today to begin the initiation of taking the proof with regard to the matter. I had asked the lawyers to meet and confer somehow, some way, this past Friday. Did you do that? Were you able to do that?

MR. MADDOX: We did, Your Honor.

JUDGE PERRY: For the purpose of informing the Court of your expectation in terms of how many

witnesses, how long this is going to take. So I can make schedule arrangements if necessary. So Plaintiff, you first. What's your expectation for today and the following days, if necessary?

MS. GATNAREK: Thank you, Judge. We were able to meet and confer with Defense Counsel on Friday. At that time, we let them know that we would be planning to call two witnesses today.

JUDGE PERRY: Okay.

MS. GATNAREK: Both of which the length sort of depends, of course, on the cross.

JUDGE PERRY: Sure.

MS. GATNAREK: But I think could probably conclude by roughly lunchtime or early afternoon.

JUDGE PERRY: Okay.

MS. GATNAREK: Again, depending on the cross. My understanding is Defense Counsel from the Attorney General's Office plans to call two witnesses as well. I wanted to just raise, Judge, another question or issue, which is, on our call on Friday, we had discussed whether it might be possible to stipulate to any particular facts, just to sort of get the record clear if there's nothing -- if there are facts, not in dispute. We proposed last night -- yesterday evening, to Defense Counsel

and asked whether they would stipulate to the fact that -- I could identify the particular paragraphs in the verified complaint, but to the fact that EMW Women's Surgical Center and the Planned Parenthood affiliate here are similarly situated as far as standing as abortion providers. We understand, of course, Defense Counsel does not agree that they have third party standing to raise claims on behalf of their patients, but simply the question of whether they are similarly situated to raise these claims as abortion providers. We heard from Defense Counsel last night, that they are not able to stipulate to that fact. In which case we may then need to add a very short witness to our list, which we could maybe schedule that for tomorrow to give Defense Counsel adequate notice, but it would just be a Planned Parenthood representative to testify that they are who they are and that they do in fact provide abortions in Kentucky.

JUDGE PERRY: So two witnesses, possibly three?

MS. GATNAREK: Yes, Your Honor.

JUDGE PERRY: All right. On behalf of Defendant?

MR. MADDOX: Your Honor, we intend to call two witnesses as well, both expert witnesses.

JUDGE PERRY: Okay.

MR. MADDOX: We had -- it was our understanding from our Friday conversation that the plaintiff's case might be finished this morning or early afternoon, and that we would then go on afterwards. We expect that our proof would be possible to begin and conclude this afternoon as well --

JUDGE PERRY: Okay.

MR. MADDOX: -- if that, in fact, is the way the plaintiff's proof goes in.

JUDGE PERRY: All right. Well, it's, as I tell juries, it's a marathon, not a sprint. So I've cleared today for you. And I can clear tomorrow. I for sure have cleared tomorrow afternoon, but my colleagues have been helpful. I have a criminal docket that will last two or three hours, but I can get that either covered or resolved some other way. So effectively, we have two whole days if we need it. So it's the Court's expectation, once the proof is in, to invite you to file proposed findings of fact and law. That'll be simultaneous, and I'll, at some point, if you don't agree on time and timing of when to do that, I'll give direction. And then after that, take the whole thing under advisement. So with regard to stipulations, it's the Court's

expectation that, regardless of what I do, which is unknown at this point, somebody will appeal this to get it to the appellate courts. So I'd rather you fully develop the record. Whatever you want to be reviewed, my preference would be to fully develop it. If it's a type of stipulation that's obvious on its face, great, if it's not, or even a close call, let's create the proof in the record, okay?

MR. MADDOX: Your Honor, just on that point, I would just suggest that from the Attorney General Cameron's perspective, the shortest possible briefing schedule after today's hearing would be what we would request.

JUDGE PERRY: Sure.

MR. MADDOX: And we believe that both sides have a pretty good idea, I think, what the proof will be. The plaintiffs have submitted affidavits that, I think, outline the proof that is likely the bulk of it at least. And I think that the rebuttal is not going to be terribly surprising. So --

JUDGE PERRY: Sure.

MR. MADDOX: We would think that the shortest possible schedule either this Friday or Monday at the latest, because, as you know, the laws are currently enjoined or at least a restraining order

is in place. On that front, we would of course move that the restraining order be dissolved and I think by operation of Rule 65, it is dissolved unless there is a temporary injunction entered after today's hearing. Of course, at the end of the proof, we would ask that injunction be denied.

MS. GATNAREK: Your Honor, it's my understanding that the temporary restraining order will remain in place until the Court decides -- makes a decision on our motion for temporary injunction, which does not have to be after today's hearing, as Your Honor has indicated. You've asked for briefing. And I think I -- even potential oral arguments, but at some point in the future, there would be a decision on the temporary injunction, which only at that point would dissolve the RO.

JUDGE PERRY: All right. Well, three things. I'm going to respectfully decline to sua sponte or upon motion, dissolve the restraining order. I will consider that in the full panoply of whatever you invite me to consider. With regard to briefing schedule, we hadn't got there yet. And even though I probably forecasted oral arguments last week, and the more I thought about it and in light of how the issues are fully made known already, obviously

there's been two writs filed over the weekend. I read everything that was filed. So you've clearly thought about it before today. So we'll go as quickly as we can. How about that? All right. Anything else from other parties in the back? And help me out, if you ever want to engage on an issue, get my attention, raise your hand or something. Otherwise, I'm going to assume I'm mostly talking with folks at the front table. Fair enough? Okay. Are you ready to proceed?

MS. GATNAREK: Your Honor, almost.

JUDGE PERRY: Okay.

MS. GATNAREK: I just have a few more things I wanted to state on the record, Judge. Of course, we are here on Plaintiff's motion for temporary injunction. I think everybody here is familiar with that standard and we intend to prove that we meet that standard both through live witness testimony today, as well as the verified complaint and affidavits that have been submitted in the case to this date. The civil rule here, Judge, clearly indicates that a temporary injunction may be granted upon a showing of verified complaint, affidavit, or other evidence. And that's what we intend to prove today, Your Honor. We have submitted over the

weekend, Judge, pro hac vice motions for the out-of-town Counsel that appears today.

JUDGE PERRY: Right.

MS. GATNAREK: Along with the certification receipt from the Kentucky bar, they've all paid the dues that is due for pro hac vices.

JUDGE PERRY: And are they here back there? Are they behind you? Is that who that is? I didn't see a -- any --

MS. GATNAREK: Yes.

JUDGE PERRY: -- rebuttal to that. So I assumed that was proper or you -- or there was no objection. Is that fair, Mr. Maddox?

MR. MADDOX: I'm sorry. We do object to the introduction of the affidavits, Your Honor.

JUDGE PERRY: No, the pro hac vice.

MR. MADDOX: Oh no, we have no objection to those.

JUDGE PERRY: Yes.

MR. MADDOX: Sorry.

MS. GATNAREK: That's fine.

JUDGE PERRY: And is that who's behind you?

MS. GATNAREK: Yes, Your Honor. Everyone here with the exception of Ms. Henry, who's local counsel, and Ms. Tahada, who was here last week --

her pro hac vice has been granted.

JUDGE PERRY: Yeah. I signed those. Pro hac vice, to the crowd, or to the gallery, just simply means limited ability and the Court's knowledge that they're practicing law with the permission of the Court. So that's fine.

MS. GATNAREK: Great. Thank you, Judge. And then one final note is just that we wanted to put on the record that Plaintiffs are not invoking the rule against witnesses. I understand that Defendant's witnesses are in the Courtroom as well, so I assume they are not either.

JUDGE PERRY: Do you agree?

MR. MADDOX: That's fine.

JUDGE PERRY: Okay. All right.

MS. GATNAREK: Thank you, Your Honor.

JUDGE PERRY: With that, I typically, in this type of setting wouldn't invite opening statements, because I'm the fact finder, so that's not helpful. Really, it's more helpful to hear the proof, whatever that is, okay.

MS. GATNAREK: Thank you, Judge. I'll make a brief opening and then we can get to the witnesses.

JUDGE PERRY: Right. Well, I'm basically saying I don't need one, but if you want to do one,

let's keep it as brief as possible or overview. Were you prepared to do that as well, Mr. Maddox?

MR. MADDOX: I will respond, Your Honor, to the opening if need be.

MS. GATNAREK: I'm sorry, Your Honor. I misunderstood. I don't think it's necessary at this point. We can just call our first witness.

JUDGE PERRY: Yeah, I'd rather do that.

MS. GATNAREK: Great. Then in that case, Plaintiffs call Dr. Ashlee Bergin.

JUDGE PERRY: Okay.

MS. GATNAREK: And I wonder, Your Honor, for questioning, if it's all right, that we use the podium?

JUDGE PERRY: Let the sheriff help you. Yes. And if you would, to complete the record, stay as close as you can to the mic, which is on the thing there. We'll put it right in the middle. Pull it back.

SHERIFF: Pull it back? There you go.

MS. GATNAREK: Okay.

JUDGE PERRY: If you would, ma'am, stand by just for a second.

SHERIFF: You're good, just face -- face the judge and raise your right hand.

JUDGE PERRY: All right. Good morning. Do you swear or affirm the testimony you are about to give will be the truth, the whole truth?

THE WITNESS: I do.

JUDGE PERRY: All right. Welcome. If you'll have a seat. Spell your last name for me -- help me with something, Mike. Spell your last name for me.

THE WITNESS: B-E-R-G-I-N.

JUDGE PERRY: All right. What I'm doing, Counsel, is making sure, since I'm confident this will be reviewed. To the gallery, courts in Kentucky no longer have court reporters. We have a video record. And it's important that the witness be un-obscured in the video record. And right now, that needs to go that way just a little bit. The camera watching the witnesses on the wall behind you.

SHERIFF: So you need --

JUDGE PERRY: That way just a little bit.

SHERIFF: A little farther back?

JUDGE PERRY: Yeah. That's perfect right there. And Counsel, or both Counsel, if you would, stay at the lectern that way you're not obscuring the witness, so whoever's watching this in the future can see it. All right. The witness is under

oath, you can proceed.

DIRECT EXAMINATION

BY MS. AMIRI:

Q Good morning, Dr. Bergin. Could you please introduce yourself to the Court?

A Yes. My name is Ashlee Bergin and I'm a practicing obstetrician-gynecologist here in Louisville, Kentucky.

Q Can you please summarize your educational background?

A Yes. I graduated with a BA in biology from Reed College in 1999. Worked for several years and then matriculated from medical school at the George Washington University School of Medicine in 2006. From there, I went to the University of Chicago for my residency in obstetrics and gynecology, which I then completed in 2010. I then proceeded to work for a few years and then returned to complete a fellowship in complex family planning at the University of Illinois at Chicago in 2015. While I was completing that fellowship in complex family planning, I also earned my Master of Public Health degree.

Q Can you please summarize your professional history?

A So after I graduated from residency in 2010,

I worked for a hospital-based practice in the Chicago suburbs for about three years and then completed my fellowship in 2015 and subsequently moved here to Louisville to take the position that I am currently in.

Q And what is that position?

A I am currently an assistant professor at the University of Louisville School of Medicine.

Q Do you have --

A In the Department of Obstetrics, Gynecology, and Women's Health.

Q Do you have another position here in Louisville?

A So I also provide care at EMW Women's Surgical Center.

Q And what kind of care is that?

A I provide abortion care as well as contraceptive services.

Q As an OB-GYN at U of L, what are your primary day-to-day activities?

A Since I am in an academic medical center, I am responsible for supervising and teaching both medical students and residents. And I provide care in both the outpatient setting, where I see patients for a variety of issues, including contraception, gynecologic issues, prenatal care. I also take care of patients in the

in-patient setting on labor and delivery at the hospital, where I provide, basically, care for patients who are delivering. And I also provide miscarriage management to both, in the office and at the hospital.

Q Do you train residents?

A I do train residents.

Q Do you train residents in all aspects of OB-GYN care and abortion care?

A Yes, I do.

Q Are medical residents required to be trained in abortion care?

A Yes. Per the ACGME, obstetrics and gynecology residents are required to be at least offered the training in abortion care and it is up to the resident if they wish to participate.

Q Do you hold any board certifications?

A I do. I am certified by the American Board of Obstetrics and Gynecology.

Q Are you a member of any professional organizations?

A I am. I am a member of the American College of Obstetricians and Gynecologists. I am also a member of the Society of Family Planning and the European Society of Family Planning.

MS. AMIRI: Your Honor, may I approach the

witness and the bench to hand up an exhibit?

JUDGE PERRY: Yes, ma'am.

BY MS. AMIRI:

Q Dr. Bergin, I've handed you what has been marked as Exhibit 1.

MR. MADDOX: Excuse me.

MS. AMIRI: I'm sorry? Oh, sorry. Yes, you already have this Exhibit, but I will give one to you as well.

MR. MADDOX: Thank you.

BY MS. AMIRI:

Q Dr. Bergin, I've handed you what has been marked as Exhibit 1. Is this a copy of the affidavit that you provided in this case?

A It is.

Q If you flip to the back, is this your CV that's been attached?

A It is my CV.

MS. AMIRI: I'd like to move to admit Exhibit 1 into evidence.

MR. MADDOX: Your Honor, we don't object to the CV. We do object to the affidavit. It's hearsay evidence. It's not admissible.

MS. AMIRI: Your Honor, an affidavit is a sworn statement under the temporary injunction rules. An

affidavit is admissible. It goes to the weight in terms of the affidavit versus live testimony.

JUDGE PERRY: Was it your intent to do both?

MS. AMIRI: Yes, Your Honor. We are going to proceed with the direct examination, summarizing the information in the affidavit.

JUDGE PERRY: Okay.

MS. AMIRI: But I think it's helpful for the Court and parties to have the affidavit in evidence as well.

JUDGE PERRY: Let's go ahead and do that and I'll defer on ruling until I hear it all.

MR. MADDOX: Thank you.

JUDGE PERRY: Okay. Go ahead.

MS. AMIRI: At this time, I'd also like to tender Dr. Bergin as an expert in obstetrics of gynecology and abortion care.

MR. MADDOX: No objection.

JUDGE PERRY: So moved.

BY MS. AMIRI:

Q Dr. Bergin, why do you provide abortion care?

A Abortion is essential medical care and people have the right to determine whether or not they wish to bear children and the number and the spacing of those children. And to that end, they deserve access to

information, education, and access to the full spectrum of reproductive healthcare in order to make those decisions for themselves. I believe it's very important for me to provide comprehensive reproductive healthcare to my patients morally and ethically. And it, as part of that care, it's also my responsibility to be able to provide patients with safe and legal abortion care.

Q Do you also provide care to patients who carry their pregnancies to term?

A I do.

Q And what is that care?

A I see patients in the office setting during the course of their pregnancy and provide them with prenatal care.

Q If a patient decides to carry a pregnancy to term, what is the duration of that pregnancy?

A Usually a pregnancy lasts approximately 40 weeks as dated from the first day of the last menstrual period to the time of the delivery.

Q Does a pregnancy change a person's body?

A A pregnancy has -- exerts many changes on a person's body.

Q Can you please explain some of those changes?

A Sure. So one of the main changes that occurs is there is an increase in blood volume that occurs

during the pregnancy and specifically the watery part of the blood does increase, as well as the red blood cell mass. That also increases, but not in proportion to the amount that the watery portion of the blood does. So people who are pregnant are often at risk for anemia during pregnancy, and in addition, iron is needed to make those red blood cells. Pregnancy requires a large portion of iron just from a nutritional perspective. And so if a patient is not getting enough iron during the pregnancy, that also puts them at risk for anemia. When people are anemic, that does put them at risk for pre-term labor or delivery, and it also, potentially, puts them at risk for needing a blood transfusion at some point, following delivery. There are also changes in cardiac output that occur. And the cardiac output in pregnancy increases by about 30 to 60 percent. And so while most people can tolerate these changes that occur during pregnancy, if a patient is -- becomes pregnant, who already has underlying heart conditions, such as congenital heart conditions or acquired heart conditions, say like an arrhythmia or something, it does put them at increased risk for complications to occur during the pregnancy. Moving on to other systems that are affected. Because of the -- because the uterus does grow during pregnancy, it exerts -- it pushes the

diaphragm upward, and patients do experience a decrease in overall lung capacity during the pregnancy. People often feel short of breath. And if a patient enters pregnancy with an underlying condition such as asthma, they are at -- a third of patients with asthma may experiencing -- may experience worsening of their condition during the pregnancy. This could require the addition of an inhaled steroid, or even worsen to the point where a patient needs to be admitted to the hospital to help improve their breathing. People who have asthma are also at -- and complications with their asthma, are also at increased risk for pre-term labor and delivery, as well as potentially developing high blood pressure during the pregnancy as well, which can be dangerous.

Q Are there other pre-existing conditions that could be exacerbated by pregnancy?

A So there are pre-existing conditions that can cause pregnancy to be more dangerous for -- for some people. Those conditions can include things like sickle cell disease, lupus, or other collagen vascular diseases. It can include things like substance use disorder or infectious diseases such as HIV or hepatitis or even epilepsy.

Q I'm sorry if I missed it. Do you mention

anything about diseases related to the liver? Can pregnancy affect diseases related to the liver?

A So if -- if a person has hepatitis, it is potential -- it is possible that a pregnancy could cause worsening with that condition. Pregnancy can also affect the kidneys. If a patient comes into a pregnancy already with pre-existing chronic kidney disease, for example, it puts them at risk for developing anemia during the pregnancy, also puts them at risk for the development of higher blood pressures during the pregnancy. And sometimes, kidney function can worsen during a pregnancy, or the pregnancy could cause kidney function to be worsened following delivery, and it stays that way. And in some instances, patients may even require dialysis during the pregnancy or after delivery.

Q I believe you'd mentioned blood clotting, clotting factors. Can you talk a little bit about how that might manifest in a dangerous way in pregnancy?

A So when -- when people are pregnant, the body produces more pro-clotting factors in the blood and a person who is pregnant also experiences -- so the increase in the clotting factors, as well as the enlarging uterus, which compresses the inferior vena cava, which is a large blood vessel that kind of helps blood flow through the lower half of the body, those two

conditions, the increase in clotting factors, as well as the compression of the inferior vena cava put people at risk for developing blood clots. In fact, pregnant patients are at five-fold risk as compared to the general population for developing these blood clots. Blood clots can include something called deep vein thrombosis, which is a blood clot that oftentimes occurs in the legs. Blood thinners can be given to treat that condition. However, the clot may also move from the legs to the lungs, and if that were to happen, in some instances that can be fatal. Patients also are at risk for developing blood clots in arteries. And when that occurs, patients are at risk for having heart attack or stroke. The risk for these increased complications with -- potentially with clotting occur most prominently right after delivery, but are present throughout all of pregnancy.

Q And are there complications if a patient's water breaks too early?

A So patients whose water breaks before it's time to -- it's before it's safe to consider delivering the baby, if at all possible, are at increased risk for infection primarily. Once the bag of water has broken, that exposes the inside of the uterus to all the bacteria that are present in the vagina. And so

patients whose water breaks early are at increased risk for infection. That infection can sometimes spread to the bloodstream and cause something called sepsis. Patients are also at risk for abruption to occur in that scenario, which is where the placenta separates from the wall of the uterus causing bleeding and/or even fetal demise.

Q I think you also mentioned blood pressure increase. Can you talk a little bit about the risks of increase in blood pressure during pregnancy?

A Yes. So people are at risk for the development of high blood pressures and a condition that's referred to as pre-eclampsia. Pre-eclampsia is defined as elevated blood pressures and spilling protein into the urine. When a patient develops pre-eclampsia, it puts them at risk for having seizures or even stroke, possibly. If pre-eclampsia progresses into the severe form, it can also put patients at risk for retaining fluid on the lungs, making it difficult for a patient to maintain their oxygen saturation. It can also put patients at risk for complications with their liver and renal function. It can also cause people to develop severe headaches and alter consciousness, and it can also adversely affect fetal growth. If a patient develops pre-eclampsia in one pregnancy, that person is

at risk for developing it again in a subsequent pregnancy. Patients who also have diabetes or develop gestational diabetes prior to the pregnancy are also at risk for developing -- are at higher risk for developing pre-eclampsia. And if a patient's blood glucose levels are not properly controlled, they are at risk for complications, which can include fetal macrosomia, meaning the fetus is larger than expected at a particular gestational age, which can then cause things such as shoulder dystocia at the time of the delivery. If the fetus does get entrapped, nerve damage can occur as well as oxygen deprivation, which may lead to damage to the brain and/or even fetal demise.

Q What are the risks of miscarriage in a pregnancy?

A So approximately ten to 15 percent, meaning ten to 15 out of every 100 people that become pregnant will experience miscarriage. And most of the time patients will pass the products of conception without issue. However, in some instances, patients don't -- their bodies don't pass all of the -- all of the pregnancy tissue. And in those instances, that puts people at risk for developing infection. And again, that is a sort of infection that can potentially enter the bloodstream and cause sepsis. Patients are also at

risk for increased bleeding if there are retained products of conception. And so if you have increased bleeding, that puts a person at risk for hemorrhage, which can require either an emergency procedure to evacuate the uterine contents, and/or a blood transfusion if they do hemorrhage, and/or IV antibiotics.

Q What is sepsis?

A Sepsis is a condition where bacteria is in the bloodstream. And basically it interferes with the ability of tissues to receive adequate oxygen and can cause like organ malfunction.

Q Does childbirth carry risks?

A Childbirth does carry risks.

Q And can you talk about some of those risks, please?

A So basically there's issues with -- there can -- issues can arise, sorry, during the labor and delivery process. So for example, in patients who have diabetes or develop gestational diabetes, those folks are at increased risk for possibly needing delivery at -- via Cesarean section. Patients are also at risk for developing infection during the process of their labor. And that is a condition known as intrauterine inflammation and infection, or chorioamnionitis. And if

a patient needs a C-section -- delivery via C-section, there are obviously risks associated with that, which include bleeding, infection, injury to surrounding organs such as the bowel or the bladder, development of abscesses, potentially skin infections afterwards. And also, not to mention it puts the patient at risk for developing complications from anesthesia. Patients are also, if they end up delivering via C-section -- are also at risk for -- higher risk for developing a blood clot after delivery, the DVT that I referred to earlier. Patients who end up having multiple Cesarean sections are also at risk because they could develop something called morbidly adherent placenta, which is where the placenta grows into the prior uterine scar, into the muscular wall of the uterus, and then at the time of the delivery, the placenta does not want to detach and that can put the patient at risk for bleeding and hemorrhage and even necessitate, following delivery, a hysterectomy. Patients who deliver vaginally are also at risk, too. They are -- they are at risk for sustaining significant perineal tears that potentially can go on to cause problems with bowel and bladder function, and given that there is, overall, an increased amount of blood flow to the uterus, patients who deliver regardless of mode of delivery, vaginal versus Cesarean

section, they are at increased risk for hemorrhage from those deliveries.

Q Do patients take time to recover after childbirth, whether it's vaginal delivery or Cesarean delivery?

A So most often, patients do take time to recover. And, I guess, stepping back a little bit, there is something that can occur around the time of delivery or after delivery called peripartum cardiomyopathy. That is a weakening of the heart muscle, and basically can lead to problems with the amount of blood that the heart is able to pump to the rest of the body. Blood carries oxygen to the tissues, so if the heart is not pumping as effectively and the blood carrying that oxygen is not getting to those tissues, then patients can potentially experience complications with organ function. Some people recover from peripartum cardiomyopathy. Some people do not recover from peripartum cardiomyopathy, but regardless, they are increased risk for complications from this, with any subsequent pregnancy. Patients also face --

MR. MADDOX: Your Honor, I'm sorry. The witness seems to be reading her testimony. Not -- I've objected to the introduction of the affidavit. I don't know if she's reading from the

affidavit.

JUDGE PERRY: She is not.

MS. AMIRI: She's not reading. She's allowed to refresh her recollection. You have an exhibit in front of you. It's been filed with the Court.

MR. MADDOX: Your Honor, I -- just note my objection.

JUDGE PERRY: Understand. Thank you.

MS. AMIRI: I'm sorry, Dr. Bergin.

JUDGE PERRY: Go ahead.

BY MS. AMIRI:

Q Please -- please continue.

A Okay. So one of the other things that patients can face following delivery are mental health issues, specifically postpartum depression. Approximately 15 percent of all patients will experience postpartum depression, which is most commonly treated with therapy and/or medications. If a patient experiences postpartum depression, it does put them at risk for increased feelings of anxiety, guilt, possibly suicidal ideation. It also puts patient at risk of being unable to care for oneself or unable to care for the -- for the neonate. And it can also cause problems with bonding between the neonate and the mother, and also potentially even result in failure to thrive.

Q I'm sorry, Dr. Bergin, not meaning to cut you off. I was going to ask you, in terms of childbirth and risks to childbirth whether there is a disparity between Black and White patients in terms of mortality.

A There is a disparity.

Q And what is that disparity?

A Black women are two times higher -- two times more likely, than their White counterparts to experience morbidity and mortality from childbirth.

Q And why is that?

A It's due to the structural racism that exists within the medical system, as well as the inequitable distribution of resources, as well as unequal access to care.

Q I'd like to turn now to abortion. I'm sorry. I feel like I cut you off. So if there's something more you wanted to say about pregnancy in response to one of my questions. If not, we, well, we can move on to abortion safety.

A No, I think basically just to summarize and say that there is recovery time that is needed for individuals following delivery.

Q Yes, I'm sorry. I did forget that, to follow-up on that question. Is the length of time for recovery more for Cesarean patients than it is for

vaginal patients?

A So oftentimes patients do, who -- who deliver via Cesarean section do require a bit more time to recover. And you know, when -- obviously if there are complications during pregnancy, this can affect a person's ability to take care of their other children or even interfere with their ability to return to work or school.

Q I'd like to turn to abortion. And I'm going to hand you what's been marked as Exhibit 2, if I may approach the witness and bench, Your Honor.

JUDGE PERRY: Yes. And a copy for the defense, okay?

MS. AMIRI: Yes, sir. I won't forget that again.

JUDGE PERRY: Did you get it?

MR. MADDOX: Yeah.

BY MS. AMIRI:

Q Dr. Bergin, have you had a chance to look at what is marked as Exhibit 2?

A Yes.

Q Is this -- do you recognize this study or a chapter from this study?

A I do recognize this.

Q And what is it?

A This is a chapter from the National Academies of Sciences, Engineering, and Medicines report on the safety and quality of abortion care in the United States.

Q Is it cited in your affidavit?

A It is cited in my affidavit.

Q Is the National Academies -- can we call them, for short, the National Academies? Are they considered a reliable entity in your field of medicine?

A Yes, they are. They were actually created by an act of Congress in 1863, that was signed by President Lincoln. And basically they were created as a private, non-governmental organization with their -- their role defined as advising the nation on science and technology.

Q I'd like to draw your attention to pages 38 and 39 to discuss abortion safety. Under "Mortality" heading, could you please read the first two sentences?

A "Death associated with a legal abortion in the United States is an exceedingly rare event. As table 2-4 shows, the risk of death subsequent to a legal abortion (0.7 per 100,000) is a small fraction of that for childbirth (8.8 per 100,000)."

Q Thank you. If you could please continue reading to -- finish that paragraph please.

A Oh, sure.

Q Sorry.

A "Abortion related mortality is also lower than that for colonoscopies (2.9 per 100,000), plastic surgery (0.8 to 1.7 per 100,000), dental procedures (0 to 1.7 per 100,000), and adult tonsillectomies (2.9 to 6.3 per 100,000). Comparable data for other common medical procedures are difficult to find."

Q Thank you, Dr. Bergin.

MS. AMIRI: I'd like to move for the admission of Exhibit 2 into evidence.

JUDGE PERRY: Any objection?

MR. MADDOX: No objection, Your Honor.

JUDGE PERRY: So be it.

(PLAINTIFF'S EXHIBIT 2 ADMITTED INTO EVIDENCE)

BY MS. AMIRI:

Q Generally speaking, why do you -- oh, sorry. Let me start that again. Generally speaking, why do your patients seek abortion care?

A Patients often seek abortion care for a myriad of reasons, which can be financial reasons in that they're financially unable to care for, perhaps, an additional child. It could be social reasons that they don't have partner support, or it could be, you know,

some other sort of social issue. Patients also seek it because they experience contraceptive failure, or they are unable to access contraception. It could be the situation of rape, incest, or there could be intimate partner violence. Patients seek abortion care for fetal anomalies, potentially when they experience an exposure to teratogenic medications, or if a patient were to develop a medical condition such as pre-eclampsia, or -- like hemorrhage or abruption, things like that. Those might cause patients to seek abortion care.

Q What are the medical consequences of being unnecessarily -- I'm sorry. What are the medical consequences if someone is denied abortion?

A So if a patient is denied an abortion, then they are, in essence, forced to carry a pregnancy to term and that includes all of the risks that I previously mentioned. So it puts them, you know, at risk for all of those complications.

Q What are the medical consequences of someone being unnecessarily delayed in accessing abortion?

A So if someone is unnecessarily delayed, there is increasing risk associated with abortion care, with increased weeks in gestational age.

Q If I could have you look at Exhibit 2 and turn your attention to page 42. Oh, sorry. I think I'm not

on the right page. Oh yes, I am. If you could please read that first paragraph.

A Sure. "The clinical evidence makes clear that legal abortions in the United States, whether by medication, aspiration, D&E, or induction are safe and effective. Serious complications are rare. In the vast majority of studies, they occur in fewer than 1 percent of abortions, and they do not exceed 5 percent in any of the studies the committee identified. However, the risk of a serious complication increases with weeks' gestation. As the number of weeks increases, the invasiveness of the required procedure and the need for deeper levels of sedation also increase, thus delaying the abortion increases the risk of harm to the woman."

Q Thank you. Can we talk about the exceptions to the two bans that we have challenged? What do you understand those exceptions to be? Not -- I know you're a doctor, not an attorney. Just from your medical perspective, in terms of the exceptions.

A As I -- as I read it and understand it, it sounds like abortion care could only be provided in the situation where maternal life is at risk or where there's risk of impairment of like a major bodily function or organ.

Q Do you see patients that are so sick that they

would meet the definition of the medical emergency exception in the bans that we've challenged?

A We -- I think overall the vast majority of patients won't necessarily meet that criteria and to let someone to deteriorate to that level of, you know, seriousness, I think is, like, ethically unacceptable.

Q So you think there's a point at which a sick patient would not yet be eligible for that medical emergency exception?

A It would all -- it would all depend on how the state chooses to interpret the reading in that -- in that law. And I think it's very vague and confusing to a lot of people, and also very scary to be faced with, you know, you are doing your best as a medical professional to provide your patient with the highest level of care, and in medicine, we are taught to do no harm. And so watching someone suffer unnecessarily goes against all medical principles. But I worry because in that law also contains a provision that we could be charged with a felony for providing that care potentially if it was deemed that we did not meet the criteria as outlined.

Q Did EMW stop providing abortions after Roe versus Wade was overturned?

A Yes, they did.

Q And why? Why did EMW stop?

A So because it was our understanding that this trigger ban immediately went into effect and the Attorney General indicated that he would enforce that trigger ban now that the Supreme Court decision had been issued.

Q Did EMW turn patients away after the decision overturning Roe versus Wade was announced?

A EMW did Turnaway the patients that were in the office on the day the decision was announced. And in addition, we took many phone calls and unfortunately had to tell those patients as well that we could not see them for care.

Q Between the patients in the office and the phone calls in the days between Roe being overturned and the restraining order granted in this case, do you know approximately how many patients had been turned away?

A It is my understanding approximately 200 patients.

MS. AMRI: Your Honor, if I may confer with co-counsel before I pass the witness.

JUDGE PERRY: Sure.

MS. AMIRI: All right. I will pass the witness, Your Honor.

JUDGE PERRY: Cross.

CROSS EXAMINATION

BY MR. MADDOX:

Q Good morning, Dr. Bergin. My name is Victor Maddox. I'm representing Attorney General Cameron today. We've never met before, correct?

A Not to my knowledge.

Q Dr. Bergin, are you affiliated with Planned Parenthood in any way?

A I am not affiliated with Planned Parenthood.

Q Are you affiliated with the ACLU in any way?

A The ACLU provides us with representation in my capacity of work at EMW.

Q Okay. And you would consider yourself, I guess, pro-choice in the sort of great debate that goes on in this country about pro-life versus pro-choice, correct?

A Well, I prefer not to use labels, but I guess if you want me to pick a label, then pro-choice seems --

Q Sure.

A -- fine.

Q Right. In looking at your CV that was introduced as part of Exhibit number 1 for the plaintiffs, I noticed that you do not list any work at EMW, the abortion clinic here in town; is that correct?

A That is correct.
Q Okay. Is there -- are you an employee there?
A At?
Q EMW?
A I do provide services there. Yes.
Q Right. But are you an employee there?
A So my employment is through the University of Louisville. So as part of my position at University of Louisville, part of my -- my job is to also provide care at EMW.
Q So if I understand it correctly, you've been at the University of Louisville since the fall of 2015; is that correct?
A That is correct.
Q And when you were interviewed for that position, you understood that part of your job as a member of the faculty at the University of Louisville would be to provide abortions at the EMW facility, correct?
A So --
Q Is that correct?
A I was hired because of my training in complex family planning. And as part of the training, as I mentioned previously, residents need to be offered the opportunity to provide abortion care. So to meet that

ACGME requirement for OB-GYN resident training, yes, I did accept the position at University of Louisville with the -- like, I guess as part of that, my work was to include work at EMW where I would also train residents.

Q And perform abortions?

A Correct.

Q And you've described that relationship between EMW and the University of Louisville as sort of a joint venture, haven't you?

A So -- yes.

MS. AMIRI: Your Honor, I'm going to object at this point. This is beyond the scope of the direct. It's not relevant to the proceedings. I'm going to object to this line of questioning.

MR. MADDOX: Your Honor, I don't think I'm limited to specifically the scope of her direct.

JUDGE PERRY: I agree. Let's move on.

BY MR. MADDOX:

Q So now, you've indicated in the affidavit that we -- I guess, has been marked for identification as Plaintiff's Exhibit number 1, that you are challenging the trigger law and the heartbeat law, the two laws in front of the Court today, because you feel like it's sort of your moral and personal duty to do so; is that right?

A Yes.
Q Okay. Now, you're not a plaintiff in this case, are you?
A I am not.
Q Okay. And you're not an employee of EMW. I think we just established that, correct?
A So, no.
Q Okay. You don't have a contract with EMW, for instance, to perform abortions, do you?
A I signed no specific contract with EMW.
Q Okay. So can you really speak for EMW today?
A I mean, I can speak to my capacity in which I work and provide care there.
Q Right, but you're not a member of the board of EMW, correct?
A I am not a member of the board.
Q You're not a shareholder?
A I am not a shareholder.
Q And you're not an employee?
A So EMW does provide some salary support for me. So --
Q I see. So when you say "salary support," do you mean they give you a paycheck?
A So no. They provide the University of Louisville.

Q I see.
A For my time.
Q Okay. So then the University pays you for your time at EMW. EMW reimburses the University for that?
A So -- yes.
Q Okay. Now, you've indicated that you believe it's important that the laws that were passed by the Commonwealth of Kentucky's General Assembly -- and those, I believe, are KRS 311.772 -- that's the trigger law, and KRS 311 7701 through 011, I believe -- that's the heartbeat law. You believe that it's important that those laws be enjoined effectively because your patients have a right to have an abortion, correct?
A Yes.
Q Okay. You don't believe that you have a personal or legal right to provide abortions if state law prohibits it, do you?
MS. AMIRI: Your Honor, I'm going to object to the extent it calls for a legal answer. This -- this client -- this witness is not an attorney. She's a doctor.
MR. MADDOX: I'm just exploring her testimony, Your Honor.
JUDGE PERRY: I'll give you a little room.

MR. MADDOX: Thank you.

THE WITNESS: Can you please repeat your question?

BY MR. MADDOX:

Q Yeah. You're not testifying to the Court today that you as a doctor have a personal right, whether it's under the Constitution or somewhere else, to provide abortions if the state law prohibits it, correct?

A I guess I'm still unclear as to what -- what you're trying to get at.

Q Well, you've read the complaint in this case, correct?

A Correct.

Q Okay. And it invokes the rights of your patients, doesn't it?

A Yes.

Q Okay. And what I'm asking you is can you confirm for the Court that you are not asserting a personal right to provide abortions under the Constitution or any -- anything else if state law prohibits it.

MS. AMIRI: Your Honor, I'm going to object again in terms of this is a legal argument related to standing. I don't think it's fair to ask the

doctor these questions.

MR. MADDOX: I'm just asking if she's asserting that -- you know -- in this case, Your Honor.

JUDGE PERRY: And she's pretty clear she's not a plaintiff. So let's move on.

MR. MADDOX: Okay. Thank you, Your Honor.

BY MR. MADDOX:

Q Let me make sure I understand the process at EMW, Doctor. So you provide what's called medical abortions, correct, those are basically drug-induced?

A Yes.

Q Okay. And you provide what's called D&E abortions, dilation and extraction, is that -- evacuation; is that right?

A Dilation and evacuation.

Q Evacuation, correct. And that's -- the dilation and evacuation abortion is where -- first of all, you do that typically in the second trimester, correct?

A Yes.

Q So after 14 weeks -- or beginning at 14 weeks last menstrual period, correct?

A Approximately.

Q Okay. And in that procedure, if I understand it, an instrument of some sort is used -- first of all,

the amniotic fluid is removed, correct?

A Yes.

Q And then some instrument, forceps or some other instrument is used to basically remove the limbs of the fetus, correct?

A So tissue separation does occur.

Q And that involves removing the arms and legs of the fetus, correct?

MS. AMIRI: Your Honor, I'm going to object for a couple of reasons. First of all, I don't see how this is relevant to the proceedings. This is certainly designed to invoke an emotional response, but it is not relevant to the testimony today. We're not challenging the 15-week abortion ban or the D&E ban in this case. We're solely challenging the six-week ban and the trigger ban.

MR. MADDOX: The trigger ban, Your Honor, involves the prohibition on any abortion, and that includes the D&E procedure.

JUDGE PERRY: I'm --

MR. MADDOX: She's also testified, Your Honor, that, you know, she's concerned for the health and wellbeing of her patients and she doesn't like to see anyone suffer. I think we'll be able to establish that she actually sees the fetus in the

process of the D&E extraction on ultrasound.

JUDGE PERRY: I'm going to give you a little room.

MR. MADDOX: Thank you, Your Honor.

JUDGE PERRY: Just be mindful that we're here talking about the law.

MR. MADDOX: Thank you, Your Honor.

JUDGE PERRY: Once you Provoke the procedure, that should be good enough.

BY MR. MADDOX:

Q All right. So just to be clear, the D&E procedure involves dismembering the fetus, correct?

A Tissue separation, yes.

Q So I know you call it tissue separation. The law calls it dismemberment and --

MS. AMIRI: Your Honor, objection again. This is not about the D&E law. We're not here on the D&E law. Whether the law calls it a dismemberment ban is not a question for this court even, because we're not challenging that law. And it's certainly not a question for -- for Dr. Bergin in terms of what the law says.

MR. MADDOX: Your Honor, she -- she's challenging the ban on abortion. And she's just testified that one of the procedures she uses is

D&E.

JUDGE PERRY: I'm going to allow you to do it.

MR. MADDOX: Thank you.

JUDGE PERRY: But let's do it in a less graphic way if that's possible.

MR. MADDOX: I -- thank you, Your Honor.

BY MR. MADDOX:

Q So you've read the statute, correct, on dismemberment?

A Yes.

Q And when the statute says "dismemberment," you use the term "tissue separation," correct?

A Yes.

Q But it's the same thing, right? It's the same physical procedure?

A Yes.

Q Okay. Now, you -- is it fair to say that EMW is a profit-making corporation?

MS. AMIRI: Objection, Your Honor. Their profits don't have anything to do with this proceeding. It's irrelevant --

MR. MADDOX: Your Honor, I'm trying to understand the relationship between Dr. Bergin and the plaintiff in this case as it relates to the rights of the patients she claims to be

representing.

JUDGE PERRY: She just testified that she's not an employee. So I assume another witness will be here on behalf of EMW. If she knows the answer to that, she can answer it. If not, let's move on. She's very clearly, and the Court accepts, she's not employed by --

MR. MADDOX: I'm not aware of any other EMW representative who will testify, Your Honor.

JUDGE PERRY: Then only if she knows.

BY MR. MADDOX:

Q Dr. Bergin, do you know if EMW provides -- requires payment in advance of providing any abortion?

MS. AMIRI: Objection again, Your Honor.

JUDGE PERRY: She can answer.

MS. AMIRI: I don't really understand what this is about.

JUDGE PERRY: Overruled. She can answer. If she knows.

THE WITNESS: Yes. Patients are required to submit payment prior to being seen and evaluated.

BY MR. MADDOX:

Q And a few years ago, it was anywhere from $800 to $2,000, correct?

A So, yes, it's roughly between $750 to $2,000.

Q And if a patient shows up at the clinic and hasn't paid or can't pay, you don't provide the abortion, correct?

A It -- it's a little bit more nuanced than that.

Q Okay. They have to make arrangements to pay in advance, correct?

A So -- yes.

Q Thank you. And just to be clear, at least in 2017, those were the last statistics I had available. EMW did about 1,489 medical abortions; is that right?

A I -- I'd have to probably look at the statistic you're referring to as I don't know that number off the top of my head.

Q Okay. Let me show you your deposition from October 11, 2018. And ask you to turn to page --

MR. MADDOX: Your Honor, may I approach?

JUDGE PERRY: Uh-huh.

BY MR. MADDOX:

Q I don't have another copy of this for Counsel, but I'm not introducing it. I ask you, Dr. Bergin, to turn to page 55 of that deposition. First of all, you remember giving that deposition, correct?

A I do.

Q And it was October 11, 2018, and you were

under oath, correct?

A Yes.

Q Okay. And I -- if you look there on page 55, beginning at about line 11, you were asked about the number of medical, non-surgical procedures, and you were asked if 1,489 was the number. And you said that, "I guess I don't really have a good sense of, you know, how many patients we see that request medical abortion, but if that's what's listed here, then I trust that that number is correct." Do you see that?

A I do.

Q Does that refresh your recollection about the testimony you gave?

A Yes.

Q Okay. Now, on page 57 of that deposition, I believe you were asked about the number of D&E, or dilation and evacuation abortions. And you agreed that 523 such procedures were done in 2017, correct?

A Yes.

Q Okay. And then the final number was suction curettage. Is that -- have I pronounced that correctly?

A Usually we say curettage.

Q Curettage. Thank you. Suction curettage procedures, 1,168 in 2017, correct?

A Yes.

Q Have the number of abortions changed in any appreciable way that you do on an annual basis since then?

A I'm not sure, as I have not reviewed those numbers recently.

Q Okay. You can keep that. We may use it again, if you don't mind.

A Okay.

Q Now, you testified during your direct examination that -- you were asked if residents are required to be trained in abortion, and you said yes. But then you said they can opt out of that, correct?

A Yes. They can opt out. We do want them to get the experience of providing counseling to patients on their options. But as far as actually, like, providing abortion care, like directly, they are not required to do that.

Q Okay. So a resident at U of L in obstetrics and gynecology can go through the entire program and successfully complete it without being required to do abortion work, correct?

A So if that -- if that is their desire. However, they are also required to be able to manage complications, should any arise, from patients that present to the hospital.

Q All right. You know, on that front, you testified at length about the risks of pregnancy effectively, right? You -- I think your testimony stands for the proposition that pregnancy entails a number of risks, correct?

A Yes.

Q Okay. By and large, you didn't quantify those risks, did you?

A Do you mean, like with percentages?

Q Yes, yes, sir -- yes, ma'am.

A Well, I tried to include the relevant numbers when I remembered them.

Q Okay. How many abortions, if you know, do you do each year?

A I'm not certain of exact numbers.

Q Can you give us your best estimate?

A I -- as I am one of three providers that works in the clinic, then I guess we could estimate that I provide roughly a third of the total number.

Q Okay. So if there were roughly 4,000 abortions, then you're doing maybe 1,200 to 1,400 a year?

A Yes.

Q Okay. Now, how many babies do you deliver, Doctor?

A I'm not sure of that statistic.

Q Okay. Do you have any idea?

A No. I -- I really don't because it's kind of just dependent on what happens when I'm there.

Q Okay. Do you think you deliver as many babies as you provide abortions?

A I'm not sure.

Q Okay. Do you have any experience in your own practice with the relative risks of abortion versus a live birth? In other words, have you experienced higher morbidity rates and higher rates of serious complications of pregnancy and childbirth than from abortion?

A I've seen many complex, complicated sick pregnant patients.

Q Okay. And you're trained as an OB-GYN to manage and deal with those complications, correct?

A Yes.

Q Okay. And I think you indicated in the -- I think what this is called, Exhibit 2, the National Academies study --

JUDGE PERRY: Correct.

Q You indicated that childbirth is relatively riskier than abortion, I think, would be the essence of it, right?

A Excuse me. Yes.

Q Okay. But that as the gestation age increases, the risk of abortion increases, correct?

A That is correct.

Q In fact, on page 39 of Exhibit 2, it says that after 17 weeks -- and this is in the bottom paragraph, Doctor, the very bottom paragraph. About third line down. After 17 weeks, the death rate for abortion was 6.7 per 100,000, correct?

A Correct.

Q So then that compares to 0.7 per 100,000 overall, correct?

A I'm sorry, could you repeat what you just said?

Q Yeah, I was just comparing that number to the number on page 38 at the beginning of the mortality section. 0.7 percent -- or 0.7 per 100,000 overall, correct?

A I'm sorry, can you just, like, repeat your question or your statement again?

Q Sure. Let me start over. I think your Exhibit 2 says that the risk of death from legal abortion, overall, is 0.7 per 100,000, whereas the risk when the gestation age is 17 weeks or greater is 6.7 per 100,000, correct?

A Yes.

Q And you do a lot of abortions at EMW at the 17 week or later age, don't you, Doctor?

MS. AMIRI: Objection, Your Honor. She did not testify that she provides a lot of abortions after 17 weeks.

MR. MADDOX: Well --

JUDGE PERRY: Overruled. She can answer.

BY MR. MADDOX:

Q Yeah. Could you -- I don't mean to put words in your mouth, Doctor. You do abortions after 17 weeks at EMW, correct?

A So I did. I don't know that -- what I will say is I don't know the exact numbers and just generally speaking, the proportion of abortions that are provided -- you know -- at that gestational age are, like, by and large vary -- like, the numbers of those are, like, very small. So the bulk of all abortions are provided prior -- like 90 percent of all abortions are provided prior to 13 weeks.

Q 90 percent at EMW, is that what you're saying?

A Just generally speaking --

Q Right.

A -- national statistic.

Q But we saw in 2017 that 523 out of about 4,000

at EMW were D&E, correct?

A So --

Q That's on page 55 -- or page 57.

A So yes, there were 523.

MS. AMIRI: Objection.

Q Okay. And --

MS. AMIRI: Objection, Your Honor. He's conflating D&E with 17 weeks. D&E --

MR. MADDOX: Well, I'm getting there, Your Honor.

JUDGE PERRY: I think the witness understands.

BY MR. MADDOX:

Q Yeah. And the D&E procedure is a procedure you do beginning at about 14 weeks, correct?

A Correct.

Q And that -- so that then goes up until the legal limit in Kentucky, which is what, 22 weeks, I believe, LMP?

A So the -- like prior to all of this happening, it was 21 weeks and six days from first day of last menstrual period.

Q Okay, so very close to 22 weeks, right? Okay. And you continue to do those procedures at EMP today -- I'm sorry, at EMW today, up until that legal cutoff date, correct?

A No, we are not currently providing care beyond 15 weeks at this time.

Q I see. And how long has that been the case?

A Since -- actually, I'm sorry. I don't know for how long.

Q Okay.

A Specifically.

Q Okay. You mentioned another condition that is a risk of childbirth, and I think you called it morbidly adherent placenta; is that right?

A Correct.

Q Can you tell us what the placenta is and what it does?

A So the placenta is basically a structure that forms and it's kind of like a big filtration system. It is connected to the fetus via an umbilical cord and then adherent to the -- the uterine surface, and basically acts to exchange nutrients and like, blood flow between fetus and maternal circulation. Filters out waste, brings in oxygen and nutrients.

Q Okay. And so the placenta is an organ that's actually generated during pregnancy, right?

A It develops during pregnancy.

Q So a non-pregnant woman typically doesn't have a placenta, right?

A Correct.

Q And I think you just indicated that it's an organ that sort of acts as a filter and an exchange of oxygen, blood stream, filters of waste, and the like between the mother and the fetus, correct?

A Correct.

Q Okay. And is it fair to say that the fetus is effectively protected from the mother's immune system by the placenta?

A It plays a role in that, but it's a very complex system.

Q Right. So the placenta helps protect the fetus -- the unborn child from the mother's immune system, among other things, because otherwise it might be attacked as a foreign body, correct?

A There are alterations that do take place during pregnancy so that the maternal immune system does not attack the fetus.

Q Right, right. Now, we can agree, can't we, that the fetus from the moment of fertilization has its own unique DNA compared to its mother or anyone else on the planet, right?

A Sure.

Q Okay. And the developing fetus has its own blood supply, blood system separate from its mother's,

correct?

A Yes.

Q Okay. And I think you've said in the past, and you would agree today wouldn't you, that by about eight weeks, and certainly by ten weeks, the baby has developed its own heartbeat, right?

A There is, generally speaking, a heartbeat unless there's a miscarriage.

Q Right. But a live fetus that's developing towards full term has a heartbeat by the eighth week or so?

A Yes.

Q Okay. And that's its own heartbeat, right? It's not its mother's heartbeat, right?

A Yes.

Q So would you agree with me that an abortion is a procedure that ends pregnancy?

A Yes, abortion does end a pregnancy.

Q And so if that abortion is done after the eighth week or so when the baby has developed a heartbeat, you would agree that abortion in every case actually stops a beating heart, wouldn't you?

A So I don't really view it in those terms. I think that's how some people view it. But that's not how I've really -- how I really view it.

Q But scientifically and biologically, that's the only way to view it --

MS. AMIRI: Your Honor, asked and answered.

JUDGE PERRY: She can answer. Go ahead.

A Could you please --

Q Biologically, that's the only way, right? You've just testified that the fetus has its own heartbeat at about eight weeks, that abortion ends that pregnancy, and the end of the pregnancy stops that beating heart of the baby in every case, right?

A So -- yes.

Q Okay. Now, you -- I think you've indicated that you believe that your patients are entitled to have an abortion because it's an important part of their healthcare. You don't consider the human fetus, the unborn child, to be a patient of yours; is that correct?

A So when a patient presents to me seeking abortion care, I do my best to provide safe and compassionate care to that patient. And part of providing patient-centered care is to -- listening to what it is the patient is wanting and, you know, making sure that the patient is fully informed of all of her options.

Q Right. And so my question, again, was in that context where you're providing care to the woman who is

pregnant, you don't consider the unborn child, or the fetus she's carrying, to be a patient of yours, right?

A I just don't think of it in those terms.

Q Right. Now, I think when we looked at Exhibit 1, your resume, you indicated that you are actually on the Medical Ethics Committee at the University of Louisville, correct?

A So yes, I participate when -- when I am able.

Q And as part of your medical ethics role, have you come across the school of thought, the published literature suggesting that the fetus is actually a patient and should be treated as a patient by the OB-GYN?

A I have not come across that.

Q Okay. Have you ever had circumstances where your patient, the pregnant mother, effectively considers the fetus to be a patient as well?

A So I think patients who seek prenatal care feel that way.

Q Okay, but not in the abortion context?

A So I think -- you know -- it just really depends on the patient and I kind of mirror and follow the patient as to their -- the language they use, the considerations, all of those sorts of things.

Q Right. And I guess as a matter of medical

ethics, you mentioned the Hippocratic Oath earlier. I guess as a matter of medical ethics, you -- it follows from your testimony today that you don't consider a previable unborn child or human fetus to be a human being; is that right?

A I think I've already answered that question.

MR. MADDOX: I don't remember asking the question, Your Honor.

MS. AMIRI: It was asked and answered, Your Honor.

JUDGE PERRY: You can answer.

A Again for -- I don't really think of it in those terms when I'm taking care of patients seeking abortion care.

BY MR. MADDOX:

Q Right. So you don't think of the previable -- and that's to say before 24 weeks, in your view -- you don't believe that the unborn child or the fetus is a human being, correct?

MS. AMIRI: Your Honor, asked and answered.

JUDGE PERRY: She can answer.

A So, again, I don't think of it in those terms. That's just not how I approach my patients when they come to me seeking abortion care.

BY MR. MADDOX:

Q Okay. When you do the D&E procedure, you use the ultrasound to help guide you, correct?

A Typically procedures are performed under ultrasound guidance.

Q Is that all procedures or just the D&E procedure?

A So usually primarily D&Es. If there's a more complicated case earlier, we may use the ultrasound.

Q But certainly after 14 weeks, if you're doing an abortion, it's typically a D&E and you're using the ultrasound, correct?

A Sometimes, but not always.

Q And --

A But -- yeah.

Q Is it more common than not that you would use the ultrasound?

A It -- it would be more common than not. It -- a lot of it depends on gestational age, specifically in weeks.

Q And I believe by certainly 15 weeks LMP that the fetus is quite active in the uterus, in the womb, correct?

A I -- I guess I'm not sure of your question there.

Q There's a lot of fetal movement at 15 weeks

and beyond?

A So you can potentially appreciate movement with ultrasound.

Q Okay. And when you do the D&E and you use the ultrasound, have you seen the baby that's about to be aborted moving away from the instruments?

A So I don't really look at the ultrasound for that purpose.

Q Okay. If you did look at it for that purpose, you could see the baby moving away from the instruments.

MS. AMIRI: Objection, Your Honor. She answered the question.

MR. MADDOX: It's a different question, Your Honor.

JUDGE PERRY: She can answer.

MR. MADDOX: Thank you.

BY MR. MADDOX:

Q If you did look at the ultrasound for that purpose, you'd be able to see the baby recoiling from the instruments that are approaching it, correct?

A I don't know that I would see that.

Q Okay. Is that because you haven't looked?

A So I haven't -- I haven't -- I guess I've never taken notice of that particular thing that you're asking me about when I use ultrasound guidance.

Q And when you are using the ultrasound guidance, can you tell us what it is you are looking for?

A So basically just to make sure that we are being as safe as possible as we are performing the procedure.

Q Okay. So that -- so as to not injure the mother, the uterus, or any other organ?

A That is correct.

Q Okay. Now, Dr. Bergin, you had indicated in your direct examination that -- I believe you indicated that child -- pregnancy or childbirth is substantially more risky than abortion, correct?

A So that is the statistic that's widely quoted.

Q Okay. Do you -- are you aware of any research suggesting that the statistical data underlying the risks of abortion is subject to question?

A I'm not sure what you mean by that.

Q Well, there are a number of factors that go into assessing the risk of mortality from abortion, would you agree?

A I guess -- what do you mean by that?

Q Well, it's all based on data, right?

A Correct.

Q And that's the amalgamation of data across a

very large country, right?

A Right.

Q Involving a lot of doctors, of -- a large number of doctors, correct?

A Yes.

Q And it involves data that perhaps is self-reported from a large number of patients, right?

A I don't know that patients make reports.

Q Okay. Is it fair to say that a woman who has an abortion, that the record of her abortion often doesn't get into her official medical record?

A I think it just depends on where that patient seeks care.

Q Okay. So a doctor who sees a woman who's had an abortion a year later, may not know that she's had that abortion based on her medical records. Is that fair to say?

A I think it just depends on where that person seeks abortion care.

Q Right.

A And if it's within the same medical facility, then a provider may have access to that.

Q Right.

A If it's not within the same medical, you know, system, then a provider may not be able to see those

records.

Q So EMW doesn't share its records with the University of Louisville, does it?

A It does not.

Q Okay. Or with any other healthcare provider, correct?

A It does not.

Q Okay. Are you aware of any concern for incomplete reporting in the numbers regarding abortion mortality?

A Could you please ask the question again to make sure I'm understanding you?

Q Well, there's an article by someone named Brian Calhoun, who did an article called The Maternal Mortality Myth in the context of legalized abortion. Are you familiar with that?

A I am not familiar with that.

Q He suggests that there are risks of incomplete reporting, definitional incompatibilities, voluntary data collection, research bias, reliance upon estimates, political correctness, inaccurate or incomplete death certificate completion, incomparability with maternal mortality statistics, and failure to include other causes of death. Are you familiar with any of the research on that?

A I am not.

Q Okay. Now, I think you also testified that the mortality risks -- and correct me in this, I may have misunderstood your testimony, Doctor -- you testified that -- I believe you said Black women, African American women, are twice as likely to die from -- I'm sorry, it was either childbirth or from abortion. And I can't recall what you said. Can you help me?

A Sure. So basically --

Q You're looking at your affidavit to refresh your recollection?

A Yeah, just to -- just to refresh my recollection. Just to make sure that --

Q If there's a paragraph -- if there is a paragraph that you have in mind, please let me know.

A Oh yes. I just am trying to find it so that I can make sure that I say things --

Q Was it paragraph 24?

A It is 24, yes. So the complications for pregnancy, including death, are twice as high for Black women --

Q Right.

A -- in their risk of dying during childbirth, as compared to their White counterparts.

Q And you said that was due to structural

racism, correct?

A That's correct.

Q Now, you're not an expert on sociology or racial influences in American society. You're not offering an expert opinion to the Court on that, are you?

A I am not.

Q Okay. And when you say "structural racism in our healthcare system," you don't mean to say that you're a racist, do you?

A So I do not consider myself to be a racist, no.

Q And nobody at EMW is a racist, are they?

A So -- no.

Q And none of your colleagues at the University of Louisville Faculty of Obstetrics and Gynecology are racists, are they?

A No.

Q And the administration certainly isn't, is it?

MS. AMIRI: Objection, Your Honor. I don't think she can speak for the entire administration of U of L.

MR. MADDOX: Well, I'll take that back, Your Honor.

JUDGE PERRY: You've --

MR. MADDOX: I'll withdraw that question.

JUDGE PERRY: You've made your point. Thank you.

BY MR. MADDOX:

Q So my question is, to summarize it, Doctor, what is -- you can't say that the differences in the mortality rate for Black or African American women or any other minority group are due to structural racism, can you?

A So I can tell you what I've read in the literature, which is that -- that disparity is due to structural racism.

Q Okay.

A And that's --

Q But you certainly provide --

A -- what I've read.

Q You certainly provide the best medical care you can to all of your patients, regardless of race, right?

A I do the best that I can, but I am sure that, you know, in some regards, I --

Q Right.

A -- you know, may inadvertently not always provide the best care. But that is always what I strive to do.

Q Sure. And all of your colleagues do as far as you know, right?

A Yes.

Q And let me just add one element to this. We've talked about EMW and the University of Louisville. You also engage in practice at University -- what is it? ULP? University of Louisville? What -- what's the name of that outfit?

A University of Louisville Physicians.

Q Physicians. And that's where you do, sort of, your direct care with patients, correct?

A Yeah. That's kind of the umbrella under which the outpatient care is provided.

Q Right. And the people there are University of Louisville physicians who are providing medical care to people in the community, right?

A Yes.

Q And they're not racist, are they?

A So, I can't answer that question.

Q Okay. Doctor, I think I have one, perhaps two more questions. You agree that sort of the -- when a human egg is fertilized, it creates basically a zygote, right -- in biology?

A Yes.

Q Okay. And would you agree that a human's life

begins at fertilization, the process during which a male gamete unites with a female gamete to form a single cell called a zygote?

A I'm sorry, what is your question there?

Q Yeah. Would you agree that a human life begins with the fertilization, which is the process I've just described of the male and female gametes forming a zygote?

A I know that some people feel that way.

Q But you don't agree with that?

A So again, I never have really given the matter much -- that much thought.

Q And I think you've indicated earlier, Doctor, that you don't agree with the definition of human life beginning at fertilization that's found in our statutes, correct?

A I'm sorry. Can you -- can you say that again?

Q You don't agree with the definition of human being beginning at fertilization, correct?

A So I think that's a matter of debate and people have different feelings on the matter.

Q And can I just ask you this -- and it'll be my last question, I think. Do you agree that a human being becomes human through a gradual process that evolves as the woman's gestational period advances?

A Sorry. Just to make sure that I'm understanding you, can you please repeat your question?

Q Right. One of the Kentucky statutes defines a human being as a human being from fertilization until birth, right? So the law protects the human being from fertilization until birth. And I would ask you if you agree with the definition as it is laid out that way?

A I'm -- so I got the fertilization to birth.

Q Right. Do you agree that's -- that defines a human being?

A So again, I -- you know, I haven't really given this matter much thought. I probably need to think on it and could tell you specifically what I think.

Q Right. In 2018, when you gave your deposition, you said that you didn't think that a fetus is a human being at fertilization, "You know, it's sort of a gradual process that evolves as the pregnant woman advances in gestational age." That's at page 66 of your deposition. That was your testimony then, wasn't it?

A Yes. That is what I testified at that time.

Q And that's your testimony today?

A So --

Q Or has it changed?

A So no, I -- I agree with that statement.

Q Okay. So if, in your view, a human being gains human status at some point in the gestational period, and you're concerned with medical ethics, do you have any concern that when you're performing an abortion at 15 weeks or 18 weeks, that fetus has already gained its human status and you are terminating that life?

A Again, I don't really think of the abortion care that I provide in -- in that context or in those terms.

MR. MADDOX: Okay. That's all I have, Your Honor.

JUDGE PERRY: All right. Anything else for the plaintiff?

MS. AMIRI: A very quick redirect, Your Honor.

MR. MADDOX: Thank you, Doctor. I'm sorry. Let me -- if I could get --

THE WITNESS: Oh.

MR. MADDOX: Thank you.

THE WITNESS: You're welcome.

REDIRECT EXAMINATION

BY MS. AMIRI:

Q Dr. Bergin, how many days a week do you provide reproductive healthcare at EMW?

A It usually averages two to three days per week.

Q Do you -- does -- sorry, let me back up. Who's the owner of EMW?

A Dr. Ernest Marshall.

Q Does Dr. Marshall know that you're testifying here today?

A He does know.

Q Does Dr. Marshall approve of your testimony today?

A As far as I know.

Q Are you -- do you make any decisions at EMW about overall policies? Running the clinic?

A No. If there are things that I think we should address, I bring them to the attention of the -- to Dr. Marshall's attention, and then we kind of talk about it. But ultimately he makes the final decision.

Q And just to be clear, you are not here in your capacity as a doctor at U of L hospital, correct?

A I am not.

Q Does EMW report abortions to the Commonwealth of Kentucky?

A Yes. We're required to report via, like, the Vital Statistics -- to the Vital Statistics, I think it's Department. We're required to report.

Q Do you know what categories that you are

required to report, including complications, demographic information, things of that nature?

A You're -- you're meaning, like what -- what the information that is on the form that we submit includes?

Q Yes.

A Yeah. So it includes like location, some demographic information, which includes race, ethnicity, age, gestational age, highest level of education completed, I believe, and also prior pregnancy history as well.

Q Do you know what happens to that information after you report it?

A I know that the Vital Statistics Department, I assume, like collates it and analyzes it.

MS. AMIRI: Your Honor, may I approach --

JUDGE PERRY: Yes.

MS. AMIRI: For an exhibit. Let me hand you what's been marked as Exhibit 3.

MR. MADDOX: Thank you.

BY MS. AMIRI:

Q And when you had mentioned a report to the Vital Statistics, does this look like what you were talking about?

A I don't believe I've seen this actual report,

but I -- but the information in it looks like the information I know that we submit.

MS. AMIRI: Your Honor, I'd like to move for the admission of Exhibit 3.

MR. MADDOX: No objection.

JUDGE PERRY: So moved.

(PLAINTIFF'S EXHIBIT 3 ADMITTED INTO EVIDENCE)

BY MS. AMIRI:

Q Dr. Bergin, what is defined as the first trimester in pregnancy?

A Most people consider the first trimester to be the start of the pregnancy through like 13 weeks, 6 days.

Q And what abortion procedures do you do in that first trimester?

A In the first trimester, they're all suction curettage.

Q And medication abortion?

A Oh, yes. We also provide medication abortion up to ten weeks.

Q At what point do -- in terms of week of pregnancy, do you switch to D&E abortion?

A So I -- the way that I was trained in my education, we were -- we defined dilation and evacuation

to start at gestational age of 14 weeks, zero days and greater.

Q I think I have nothing further, Your Honor. Oh, I'm sorry. I do. We talked a little bit about delaying access to abortion unnecessarily and the consequences. Could you go to Exhibit 2, please? And page 42. I believe there's a paragraph a little further down that starts with "Financial burdens."

A Oh, yes. I see it.

Q Could you please read that into the record, please?

A Sure. "Financial burdens and difficulty obtaining insurance are frequently cited by women as reasons for delay in obtaining an abortion. As noted in Chapter 1, 33 states prohibit public payers from paying for abortions. And other states have laws that either prohibit health insurance exchange plans (25 states), or private insurance plans (11 states) sold in the state from covering or paying for abortions, with few exceptions."

MS. AMIRI: That -- that's fine. Thank you. Your Honor, if I may confer with co-counsel. I may be --

JUDGE PERRY: Yes.

MS. AMIRI: -- done with this witness. Nothing

further, Your Honor.

JUDGE PERRY: Anything else?

MR. MADDOX: Nothing, Your Honor.

JUDGE PERRY: All right. Can this witness be excused?

MS. AMIRI: Yes. Thank you.

JUDGE PERRY: All right, ma'am. You can step back. And leave those there on the table.

THE WITNESS: Oh. Leave these here?

JUDGE PERRY: Just leave them right there -- uh-huh.

THE WITNESS: Okay.

JUDGE PERRY: Counsel, I was prepared to work through lunch. I don't know if you are or not, but it's going to matter on how -- we're about to take a break, just a matters of how long. So I didn't know what your intent was, if you want to press through? If anybody needs to take a lunch break --

MR. MADDOX: Your Honor, I would prefer that we press through after a break, if that suits the plaintiffs?

MS. GATNAREK: That's fine with us, Judge.

JUDGE PERRY: All right. Then let's do this: Let's take about 15 and break until 11:30, and then we'll come back for the plaintiff's next witness,

okay?

MS. AMIRI: Thank you, Your Honor.

JUDGE PERRY: All right. All right.

BAILIFF: All rise.

JUDGE PERRY: We're in recess.

(OFF THE RECORD)

JUDGE PERRY: All right. We're back on the record in the plaintiff's case. By the way, I forgot, but let me circle back and rule on Exhibit number 1. I'm going to allow that. The affidavit completes her testimony, so that's permissible and is now Exhibit number 1. And we're ready to proceed to the plaintiff. You can call your next witness.

(PLAINTIFF'S EXHIBIT 1 ADMITTED INTO EVIDENCE)

MS. GATNAREK: Your Honor, we'd actually like to recall Dr. Bergin for a very quick moment to clarify something on the record.

JUDGE PERRY: Okay. Is she still here?

MS. GATNAREK: Yes.

MR. MADDOX: Your Honor, I object.

JUDGE PERRY: I'm going to allow it. I want to complete whatever you want to offer within reason and permissible. I want to hear it. Dr. Bergin, you're still under oath. You're still under oath,

if you'll have a seat and answer the questions that are asked at this time. Go ahead.

BY MS. AMIRI:

Q Dr. Bergin, as soon as we stepped out, you mentioned that you misunderstood or -- a question or misspoke. Could you please clarify the point that you wanted to make -- clarify the point you wanted to make about the paycheck that you received?

A Oh, I believe earlier I had indicated I receive salary support from EMW which goes to the University of Louisville, but what I -- what I meant to also say was that I also do receive a paycheck from EMW that compensates me for overnight and weekend call that I take as well as time that I spend in the clinic and compensates me for the number of patients that I see and the type of procedures that are performed.

MS. AMIRI: Thank you, Dr. Bergin. That's all. We just wanted to clarify that.

JUDGE PERRY: All right. Anything? Okay. All right, Dr. Bergin, you can step back.

THE WITNESS: Okay.

JUDGE PERRY: All right. Next for the plaintiff.

MS. GATNAREK: Thank you, Your Honor. Plaintiffs call Jason -- Dr. Jason Lindo.

JUDGE PERRY: Dr. Jason Lindo.

MS. GATNAREK: And Your Honor, before Dr. Lindo takes the witness stand, we just had a few logistical matters to go through --

JUDGE PERRY: Sure.

MS. GATNAREK: -- regarding his testimony. The first, as Your Honor can see, we've prepared some slides as demonstrative aids to use while Dr. Lindo delivers his testimony today. We shared these slides with Defense Counsel --

JUDGE PERRY: Okay.

MS. GATNAREK: -- last night, and we haven't received any objection to their use.

MR. MADDOX: Your Honor, I don't object to these slides per se, and in light of your ruling, I'll make the same objection with respect to the affidavit, but I understand the ruling. I think there are some portions of the affidavit that Dr. Lindo, as an economist, does not qualify to offer the Court. They amount to medical opinions. And I think I would -- I think it's important that those be stricken if the Court's going to accept the affidavit and if they're included in this slide, I don't -- or this slide show --

JUDGE PERRY: Okay.

MR. MADDOX: -- I don't think that they're appropriate either.

JUDGE PERRY: Number one, I haven't seen it yet. Number two, I'm going to allow you to vigorously cross examine --

MR. MADDOX: Thank you.

JUDGE PERRY: -- him on those. So if they seem not properly admissible, I'll consider that once I hear it. And with any demonstrable evidence, again, I'm the fact finder. So this isn't evidence nor are your questions, it's what the witness says. So if it's helping him -- or the witness or you proceed, that's fine, but just be clear, this isn't the evidence, it's the sworn testimony, which --

MS. GATNAREK: Absolutely.

JUDGE PERRY: Is the doctor here?

MS. GATNAREK: He is, Your Honor.

JUDGE PERRY: Okay.

MS. GATNAREK: We do have one more logistical matter to attend to.

JUDGE PERRY: Oh, okay. Sure.

MS. GATNAREK: To keep things moving along here, Your Honor, we've prepared binders of the different exhibits to which Dr. Lindo will be referring.

JUDGE PERRY: Okay.
MS. GATNAREK: We have copies that we can provide to Your Honor and to Defense Counsel as well, if you'd like me to distribute those now.
JUDGE PERRY: That would be great. Go ahead.
MR. MADDOX: Thank you.
MS. GATNAREK: And just so Your Honor knows, copies of the slides are in here as well.
JUDGE PERRY: Perfect. Thank you. All right. Anything else?
MS. GATNAREK: No, Your Honor, with that Plaintiffs are ready to proceed.
JUDGE PERRY: All right. Dr. Lindo.
BAILIFF: Sir, if you could go on and raise your right hand.
JUDGE PERRY: Good morning, sir. Doctor, do you swear or affirm the testimony you're about to give will be the truth and the whole truth?
THE WITNESS: Yes, I do.
JUDGE PERRY: All right, welcome. Have a seat there. This is the mic in front of you, and you're invited to wear your mask if you feel it's necessary unless I can't hear you.
THE WITNESS: I'll take it off if you want.
JUDGE PERRY: And the record needs to hear you,

okay?

THE WITNESS: Okay.

JUDGE PERRY: All right. Whenever you're ready.

MS. TAKAKJIAN: Thank you, Your Honor.

DIRECT EXAMINATION

BY MS. TAKAKJIAN:

Q Good morning.

A Good morning.

Q Dr. Lindo, could you please introduce yourself to the Court?

A I'm Jason Lindo, a professor of economics at Texas A&M.

Q And what is your educational background?

A I received my bachelor's degree in economics at UC Davis in 2004, my master's degree in economics at UC Davis in 2005, and my PhD in economics at UC Davis in 2009.

Q And what have you done since obtaining your PhD in 2009?

A I've been an academic professor since, starting as an assistant professor at University of Oregon in 2009. Subsequently, was an associate professor with tenure at Texas A&M for four years. And since then, I've been a full professor of economics at

Texas A&M.

Q And if you --

MR. MADDOX: Your Honor, I'm sorry to interrupt. I -- it may be the plexiglass that's sort of deadening the sound. I'm having a hard time hearing the end of sentences.

JUDGE PERRY: Okay. Just so this witness and all witnesses are clear, you don't have to turn to me. I'm actually watching you on the live feed for me, closed circuit. And if you'll stay close to the mic so everybody can hear you, that would be helpful, okay?

THE WITNESS: Sure.

JUDGE PERRY: Go ahead.

BY MS. TAKAKJIAN:

Q Dr. Lindo, how long have you been a professor at Texas A&M?

A Full professor? For five years.

Q And what kind of courses do you teach there?

A I teach courses on evaluating causal effects at both the undergraduate and PhD levels.

Q To what extent, if any, do those courses focus on or address literature relating to the economic impact of laws regulating or restricting abortion?

A They do cover how to evaluate the causal

effects of such laws.

Q Dr. Lindo, are you involved with any peer-reviewed journals or publications?

A Yes, I am extensively involved. I am a specialized co-editor at Economic Inquiry, where I handle papers that are submitted in health economics and evaluating policies. And there in my role as a specialized co-editor, I determine whether papers should be published or not. In addition to that, I review papers extensively for other journals in the profession to advise editors at those journals as to whether or not papers should be published or not.

Q Do you have any research or academic affiliations other than with Texas A&M and the Journal for Economic Inquiry?

A I am also a research associate at the National Bureau of Economic Research.

Q And what is the National Bureau of Economic Research, Doctor?

A It -- it's the leading nonprofit economic research organization in the United States.

Q Do you have a particular field of research in which you specialize?

A I specialize in health economics and issues concerning youth, particularly reproductive healthcare.

Q In your career, Dr. Lindo, have you published any peer-reviewed articles or studies?

A Yes.

Q Roughly how many would you say?

A Close to 30.

Q Have you received any awards or commendations in the course of your work?

A I have multiple times been awarded for graduate student advising and teaching.

Q Dr. Lindo, have you ever been accepted by a court before as an expert witness in the field of economics and policy evaluation, particularly as it relates to laws on abortion?

A Yes, I have.

Q What court was that?

A That was in Arkansas.

Q Plaintiffs in this case are challenging certain abortion restrictions that the Commonwealth has proposed and put forward. Have you ever been an expert witness who was retained by a party seeking to enforce laws restricting abortion access?

A Yes, I have.

Q And what case was that?

A That was Doe versus Minnesota.

MS. TAKAKJIAN: Your Honor, based on his

qualifications, Plaintiffs now tender Dr. Lindo as an expert in economics and policy evaluation.

JUDGE PERRY: Any objection?

MR. MADDOX: No objection.

JUDGE PERRY: So moved.

BY MS. TAKAKJIAN:

Q Dr. Lindo, could you tell the Court what your assignment in this case was?

A It was to generally evaluate the effects that can be expected from a ban on abortion in the Commonwealth.

Q And could you please tell us how you approached that assignment?

A I drew upon my education, my research, you know, beginning from my dissertation research, I have been working on issues related to the family and -- and children, and I have read extensively and done research extensively in literatures that are closely related to this topic. So I was able to draw upon that in order to draw conclusions to the specific task, in addition to doing some specific analyses to -- to get a better sense of the setting in Kentucky.

Q And that approach you just described, Doctor, is that a -- an approach that you consider to be reliable and would allow you to reach conclusions in

this case?

A Yes.

Q After reviewing the literature that you did, did you find that you had sufficient facts and data to form those conclusions?

A Yes.

Q And did you prepare an affidavit for the Court's review, Dr. Lindo?

A I did.

Q If you wouldn't mind turning please to tab 1 in your binder, which Plaintiffs will mark as Exhibit 4. Dr. Lindo, does that look to be a fair and accurate copy of the affidavit you prepared in this case?

A It does.

Q And if I could direct your attention to page 38. Is that your signature?

A Yes, it is.

Q And is your CV appended to this affidavit, Dr. Lindo?

A Yes, it is.

MS. TAKAKJIAN: Your Honor, at this time, Plaintiffs offer Dr. Lindo's Affidavit as Exhibit 4.

MR. MADDOX: With the same objections I've made previously.

JUDGE PERRY: But just the affidavit?

MS. TAKAKJIAN: The affidavit and the CV attached to it, Your Honor.

MR. MADDOX: No objection to the CV.

JUDGE PERRY: Right. Okay. CV, so moved. The affidavit, let me hear the testimony further.

BY MS. TAKAKJIAN:

Q Dr. Lindo, have you rendered certain expert conclusions in this case?

A Yes, I have.

Q And have you prepared a few slides to help walk us through that?

A Yes.

Q Dr. Lindo, did you prepare these slides on your own, or did you work with Counsel to prepare them?

A We workshopped them together.

Q And did you review and have final approval over the content of each and every slide?

A Yes.

MS. TAKAKJIAN: Your Honor, purely now for logistical purposes and for the record, we'd like to mark the slides that Dr. Lindo will be using as Plaintiff's Exhibit S-1 through 19. These won't be evidence, as Your Honor already noted, but these will just be so we can refer to them in the record.

JUDGE PERRY: 1 through what?

MS. TAKAKJIAN: 19.

JUDGE PERRY: For purposes of eliciting the testimony?

MS. TAKAKJIAN: And for identification purposes in the record, Your Honor.

JUDGE PERRY: Any objection to that? Okay, go ahead.

(PLAINTIFF'S EXHIBIT S1-19 MARKED FOR IDENTIFICATION)

BY MS. TAKAKJIAN:

Q Dr. Lindo, we're looking at slide 1 right now. Could you tell us at a high level what we're looking at here?

A These are the main conclusions from my work on this case.

Q We'll get into each of those conclusions in more detail shortly, but can you tell us from a high level of what your conclusions were here?

A Yes. The bans on abortion will significantly reduce access to abortion for Kentuckians. Some folks won't be able to access care at all, others will travel outside of the state to access care. Some of those will be delayed in their ability to access care as a result of needing to -- to travel outside of the state. Secondly, there will be serious costs for Kentuckians,

including financial hardship, educational and professional harms, physical and emotional harms -- excuse me, psychological harms, and -- and finally, these costs will be disproportionately borne by vulnerable populations, in particular, low-income people and people of color.

Q Dr. Lindo, you made reference to the Commonwealth bans. What do you understand the bans to be?

A I understand them to ban abortion in all cases, except perhaps in some cases where the pregnant person's life might be in danger.

Q Doctor, before we get into the details of your conclusions, I'd like to talk a bit about the demographics of patients seeking abortions, both in the United States and in the Commonwealth more specifically. Is that something that you've studied in the course of your work in this field?

A Yes.

Q If we could put up slide 2, please. Dr. Lindo, before we get into what's on this slide, could you tell us the source of the data depicted here?

A Yes. It's from a Jones and German paper published in 2017.

Q And the paper was published in 2017. Do you

know when the data itself comes from?

A The data are from 2014.

Q And why 2014, Dr. Lindo?

A That was the most up-to-date data that could be relied upon.

Q And as far as you're aware, is that data from 2014 still reliable?

A Yes.

Q Is this a source, the Jones and German study that you've cited, on which you typically rely on and consider rigorous in the course of your work as an economist?

A Yes.

Q Now, Doctor, taking a look at what's actually on the slide, can you tell us how common is it for a woman to get an abortion or to obtain abortion care in America?

A It is sufficiently common such that, based on abortion rates observed in 2014, we would expect 23.7 percent of women to obtain an abortion during their reproductive years, if -- if those abortion rates were to continue.

Q So is that roughly one in four women?

A Yes.

Q Could we put up slide 5, please -- or slide 3.

I'm so sorry. Dr. Lindo, is the data depiction on this slide from that same Jones and German study?

A Yes.

Q And can you tell us what the data here indicate?

A The data indicate that 12 percent of people seeking abortion are younger than 20 years old, 60 percent are 20 to 29 years old, and 28 percent are 30 or older.

Q Could we put up slide 4, please? Again, Dr. Lindo, is the source of this data the same as the previous two slides?

A Yes.

Q And what are we looking at here?

A This is the share of women seeking abortions who have incomes that put them below the federal poverty line on the -- in the bar on the left, and the share whose income would put them below 200 percent of the federal poverty line on the right. And so these statistics indicate that 50 percent of women obtaining abortions are officially in poverty and 75 percent would generally be considered to have low incomes.

Q And just to put it in context for the Court, what does it mean for someone to be living below the federal poverty level?

A Typically that would mean that their incomes relative to their needs is -- is low, and so having -- it -- they would struggle to meet the needs of their -- their particular household type.

Q Can we have slide 5, please? Again, Dr. Lindo, we've looked at some of these findings already, but is this -- is the data depicted on this slide from that same study?

A Yes.

Q And could you tell us, based on the data in that study, if there's any significant finding regarding the race or ethnicity of patients obtaining abortion care?

A Yes, it's -- it is the case that Black and Hispanic people are over-represented among individuals obtaining abortions.

Q And of those individuals obtaining abortions, Dr. Lindo, do you know roughly how many had already given birth before they got -- they obtained abortion care?

A 59 percent had already given birth.

Q And does the data tell us anything about whether those patients obtaining abortions were married or were living with a partner?

A Yes. And the -- 55 percent were neither

married nor cohabitating.

Q And what, if anything, is the significance of whether someone is married or co-habitating on their economic health?

A It would mean there's likely to be one fewer adult who can provide income for the members of the household.

Q Could we please move to slide 6? Before we jump into the data here, Dr. Lindo, could you tell us what source you relied upon to form your conclusions on this slide?

A This is also a Jones and German study from 2017, but -- but it -- it's a different one, the title listed at the bottom.

Q Dr. Lindo, at a high level, what are we looking at on this slide?

A This is, at a high level, information surrounding the -- or contextual information surrounding the circumstances that people seeking abortion have faced in the year prior to doing so.

Q And it says, "Disruptive life events." Can you tell us what constitutes a disruptive life event?

A Yeah. In -- in this research study, the authors defined disruptive life events as the death of a close friend or family member, having a household member

with serious health problems, having a baby, unemployed -- being unemployed for at least one month, separating from a partner, having a partner arrested or incarcerated, being behind on rent or mortgage payments, or moving two or more times. And these are all things that would typically involve economic strain and -- and probably psychological strain as well.

Q Can we move to slide 7, please? Dr. Lindo, we've been talking about statistics and data as related to the United States at large. I'd like to focus and drill down on the Commonwealth now. So speaking from an economic standpoint, how does Kentucky compare to the rest of the country?

A Their poverty rates are higher.

Q And could you tell us, looking at this slide that you've prepared, is there any significant finding regarding female-headed households with children and no spouse living there?

A Their poverty rates are especially high, and in addition, the poverty rates in Kentucky for that group is higher than the US average.

Q Why have you identified that group as a particularly notable demographic?

A Because we would expect that group to be disproportionately affected by a ban on abortion.

Q Can we please put up slide 8? Dr. Lindo, could you tell us what the source of the data is that appears on this slide?

A Yes. This is based on reports -- Kentucky's annual abortion report from 2020, which is available from Kentucky's Public Health Department's website.

Q And is data from the Kentucky Public Health Department considered to be a reliable data for experts in your field?

A Yes, I -- I think it should be reliable.

Q And I think you may have already mentioned this, but what years are covered by this data?

A These statistics are for 2020.

Q Dr. Lindo, what do we see on this slide at a very high level?

A Characteristics of patients obtaining abortions in the Commonwealth.

Q I'd like to walk through each of these. So does the data that you reviewed indicate anything about the age of patients who obtain abortion care in Kentucky?

A A majority were under age 30.

Q And is there any relevance of that finding on the education or careers of those patients?

A Yes, it -- it implies that many of these

individuals are going to be continuing to pursue their education or early in their careers and we know that investments in education and early career investments have substantial payoffs that sort of extend throughout an entire -- a person's entire lifetime and -- and also affect their -- their children's lives as well.

Q Dr. Lindo, does the data indicate whether Kentuckians who obtained abortion care in 2020 already had children?

A Yes. There is information on that.

Q And roughly what percent of patients had previously given birth?

A Roughly 66.3 percent.

Q Now, I'd like to go to slide 9, if you don't mind. Dr. Lindo, is this data on the -- on slide 9 from the same source we just discussed?

A Yes. In addition to data from the US Census Bureau on the right.

Q And is the US Census Bureau typically considered a reliable source?

A Absolutely.

Q Dr. Lindo, what does the data that you reviewed tell us about whether there are any populations that would be disproportionately impacted by the Commonwealth's bans?

A These statistics in particular demonstrate that Black patients are substantially over-represented among those obtaining abortions in the Commonwealth. If they were proportionally represented, we would expect the number on the left to be 8.5 percent, and it's many times that. And so that implies that Black Kentuckians will be disproportionately affected by a ban on abortion.

Q Dr. Lindo, what percent of patients obtaining abortion care in Kentucky are Black?

A 34.5 percent.

Q Can we go to slide 10, please? Is this data on this slide, Dr. Lindo, from the same sources we've been discussing?

A Yes, it is.

Q And could you tell us, at a high level, what we're looking at?

A This is the share of individuals who are unmarried in different groups.

Q And what does this tell us about whether unmarried individuals are seeking access to abortion care in Kentucky?

A It -- it tells us that unmarried individuals are -- are disproportionately represented among those obtaining abortions in Kentucky and that is clearly true

when compared against Kentucky residents as a whole, and sort of that -- that gap in representation is even larger and more stark when compared against Kentucky residents giving birth.

Q Just to illustrate those gaps, Dr. Lindo, could you tell us what percent of Kentucky residents are unmarried?

A 49.4 percent.

Q And what percent of those people were unmarried and giving birth in 2020?

A 34.5 percent.

Q Dr. Lindo, what percent of those unmarried individuals obtaining abortion in Kentucky -- or sorry. I should say, what percentage of individuals obtaining abortion care in Kentucky were unmarried in 2020?

A 87.2 percent.

Q I'd like to go ahead now, Dr. Lindo, and talk about your specific opinions regarding the economic impact of the Commonwealth's bans. To begin, did you distinguish between the likely effects on different groups of people?

A Yes.

Q Could we please put up slide 11? What are those groups, Dr. Lindo?

A Those groups are people who will have no

access to abortion, that is who will not access abortion in the state or outside of the state, individuals who will access abortion by traveling to another state, but who will be delayed in their ability to obtain an abortion as a result of that additional travel requirement, and finally, those who will now have to travel outside of the state to obtain an abortion, but who will not be delayed in obtaining an abortion by that extra travel.

Q So I'd like to go ahead and take those groups one at a time here. If we could go to slide 12, please. Let's start with groups of people, Kentuckians, who will have no access to abortion care if the bans go into effect. Dr. Lindo, are there any reliable empirical studies that you used in your work in this case to determine the effects on this group?

A Yes, absolutely.

Q And if you wouldn't mind, please, turning to tab two in your binder. What are we looking at here, Doctor?

A This is a recently published paper on the economic consequences of being denied an abortion.

Q Who was the author of this paper?

A Sarah Miller, Laura Wary, and Diana Green Foster are the authors.

Q So we'll just call this the Miller et al. for short. Dr. Lindo, is there a particular data set on which the Miller et. al paper relied?

A Yes. It relies on the Turnaway dataset.

Q From a very high level, could you tell us, what is that dataset?

A Yes. It was a dataset where they collected -- researchers collected information on individuals presenting at abortion providers across the United States, some of whom were -- had a gestational age just before the provider's gestational age limit, and thus, they were able to obtain an abortion and others were at a gestational age that put them just beyond the provider's gestational age cutoff and as a result, they were denied from having an abortion at that provider.

Q Dr. Lindo, has the Miller et. al paper been published and peer-reviewed?

A Yes.

Q Is this something that an economist working in your field would consider to be both rigorous and reliable?

A Yes.

MS. TAKAKJIAN: Your Honor, at this time Plaintiffs offer the Miller et al. study as Exhibit 5 into evidence.

MR. MADDOX: No objection.

JUDGE PERRY: So moved.

(PLAINTIFF'S EXHIBIT 5 ADMITTED INTO EVIDENCE)

BY MS. TAKAKJIAN:

Q Before we go into discussing some of the findings in the Miller et al. paper that informed your conclusions, Dr. Lindo, I want to talk about how studies like this one are typically designed. So what can you tell us about that?

A Yeah, the -- the methodology that these authors use is called a "Difference in differences" research design, which is a very commonly used method for estimating causal effects in the context of what we call natural experiments, where institutions, or forces of nature, or random chance, or policy makers determine who is treated and who is not treated as opposed to say, a researcher conducting a -- a randomized control trial. In the most applications, causal effect is estimated by measuring how outcomes change after treatment for the treatment group relative to how outcomes change over the same period of time for some untreated comparison group, which we would often call the control group.

Q And just speaking in general terms, Dr. Lindo you've talked about treatment and a treatment group.

Do you mean by that medical treatment or -- or something else?

A It -- it could be any type of treatment.

Q And is the difference in differences model considered to be a rigorous and reliable way to conduct studies?

A It -- it absolutely -- yes. Yes, it is.

Q Let's return to Miller et al. if you don't mind, Doctor. I think you already told us, but could you remind us about the two groups of patients that were primarily studied by Miller et al?

A Yes. The -- the first group, which we might think of as the control group is those who presented at the abortion provider before it's gestational age threshold, who are able to obtain an abortion. And the treatment group is those who presented at the provider after its threshold and who are thus denied from having an abortion by that provider.

Q Does the data that's set out in Miller et al. tell us anything about how many of those patients who were denied abortion care ultimately carried the pregnancy to term?

A Two-thirds -- roughly two-thirds.

Q Dr. Lindo, if I could draw your attention to page 4 of this paper, please. Could you please read out

loud, starting with the second paragraph on page 4, beginning with the third sentence. It starts with, "We find," and then ending with a sentence that concludes, "For which we observe the women."

A It says, "We find that abortion denial resulted in increases in the amount of debt 30 days or more past due of $1,750, an increase of 78 percent relative to their pre-birth mean. And in negative public records on the credit reports, such as bankruptcy, evictions, and tax liens of about 0.07 additional records. Or an increase of 81 percent. These effects are persistent over time with elevated rates of financial distress observed the year of the birth and for the entire five subsequent years, for which we observed the women."

Q Dr. Lindo, what's the significance of that finding, if any, on your conclusions in this case, regarding the laws that ban access to abortion in Kentucky?

A It supports the conclusion that there will be economic harms from people being unable to access abortion.

Q Doctor, if I could draw your attention now to page 37 of the Miller et al. paper. I'm going to ask you to look at the first partial paragraph on that page.

And if you could please read aloud for the Court the final sentence in that paragraph. It begins with the words "In some."

A "In some while women's family obligations in need for resources increased the abortion denial. They did not appear to experience increases in support from male partners, adult family, or the government to sufficiently offset these responsibilities, possibly driving the inability to meet financial obligations documented in our credit report analysis."

Q Doctor, what impact, if any, does that finding have on your conclusions in this case regarding the economic impact of the Commonwealth's proposed bans?

A It supports the conclusion that there will be additional economic strain resulting from the ban.

Q I know we've been talking about Miller et al, Doctor. Are there other studies or empirical literature on which you relied to form your conclusions about Kentuckians who will not have access to abortion if the bans are allowed to go into effect?

A There are many, many studies and many literatures that I would say contributed to this conclusion.

Q If we could go to slide 13, please. We'll go category by category in a moment, Doctor, but if you

could tell us from a high level, what are we looking at here?

A This is the costs that will be borne by individuals who are unable to access an abortion as a result of the ban.

Q Let's start with the first category, which you've identified as direct financial costs. Could you tell the Court why you've identified financial costs as an economic outcome of the Commonwealth's proposed bans?

A I'm -- I'm not sure. I -- under -- I guess that was part of the task that I was assigned to do is to try to document the costs in their totality.

Q Of course. Could you tell us what the data says about those financial costs?

A Sure. Well, and this won't come as a surprise for folks who have had children. Pregnancy itself can be very expensive. It could involve parenting classes, it could involve prenatal care. It can involve expenditures preparing to have a child and to raise a child. All of these things can involve substantial expenditures. Additionally, childbearing itself can involve substantial expenditures, particularly for households or for people who don't have insurance. But even -- for even people who do have insurance, they still could face substantial costs of having a child.

And then finally, raising a child is extremely expensive as well, which I think most parents can appreciate.

Q Could you tell us, Doctor, roughly how much does it cost for an average family to raise a child in this country?

A On -- on average households, and just to be a little more specific to the -- the group who would be disproportionately affected by the bans, low-income households in the United States spend approximately $10,000 a year raising children throughout their lives.

Q Dr. Lindo, you also indicated that there would be reduced resources for household members. Can you explain that finding?

A Yeah. And -- and this is consistent with what the Miller et al study was finding. And the idea here of course, is that income is, if anything, going to be reduced for these households and they had -- now have an additional member to care for. And so that means the resources are going to be spread more thinly across all of the household members.

Q I want to talk about that second category that you've identified, which is work and education costs. Dr. Lindo, what did your review tell you about the costs to people's work and education if they don't have access to abortion care?

A Yeah. And these costs can start with pregnancy in terms of people needing to interrupt or discontinue altogether their investments in their education or in their careers. And as I mentioned before, those disruptions are costly, both in the short-run and in the long-run because the returns to early career investments are lifelong. And actually they span generations.

Q Focusing now on schooling, Dr. Lindo, did you review any literature in the course of your work in this case that documents non-financial or non-pecuniary benefits of education?

A I did.

Q Could I draw your attention to tab five of your binder with -- apologies for going out of order here. Dr. Lindo, what are we looking at here?

A This is a paper titled "Priceless: The Nonpecuniary Benefits of Schooling," by Phil Oreopoulos and Kjell Salvanes published in 2011.

Q You said this paper was published. Do you know if it's been peer-reviewed?

A It has.

Q And is this a source on which you would typically rely on and consider rigorous in your work as an economist?

A Yes, it is.

MS. TAKAKJIAN: Your Honor, at this time, Plaintiffs would move to admit the Oreopoulos paper into evidence as Exhibit 6.

MR. MADDOX: No objection.

JUDGE PERRY: So moved.

(PLAINTIFF'S EXHIBIT 6 ADMITTED INTO EVIDENCE)

BY MS. TAKAKJIAN:

Q Dr. Lindo, could I draw your attention please to page 179 of the Oreopoulos article? I'm going to ask if you could please read aloud for me, starting with the last paragraph on page 79 and running onto page 180 with the sentence that begins, "Gains from school," through the end of the paragraph.

A "Gains from school occur from being in a job that not only pays more, but also offers more opportunities for self-accomplishment, social interaction, and independence. Schooling generates occupational prestige. It reduces the chance of ending up on welfare or unemployed. It improves success in the labor market and the marriage market. That our decision-making skills learned in school also lead to better health, happier marriages, and more successful children. Schooling also encourages patience in

long-term thinking. Teen fertility, criminal activity, and other risky behaviors decrease with it. Schooling promotes trust and civic participation. It teaches students how to enjoy a good book and manage money. And for many, schooling has consumption value, too."

Q Dr. Lindo, what importance, if any, do those non-pecuniary benefits that you've just identified have on a person's economic outcomes and wellbeing?

A I -- sorry, could you repeat the question?

Q Certainly. I'll rephrase. What importance, if any, do the non-pecuniary benefits that you've just identified have on your conclusions in this case regarding the economic impact of patients who cannot access abortion care in Kentucky?

A It -- it suggests that the -- the effect generally on wellbeing would go beyond the economic effects.

Q I want to draw your attention back to the slides that you've prepared and talk about that final category you've identified of costs for patients who can't access abortion care, psychological and health costs. Dr. Lindo, I see on the slide that you've included a finding about intimate partner violence. Could you tell us about that?

A Yes. Surveys of individuals obtaining

abortions indicate that a reason for obtaining abortions is concerns about having a -- an abusive partner. Moreover, there is research demonstrating that an inability to obtain an abortion increases victimization.

Q If I could draw your attention to what's been marked as Exhibit 5, which is the Miller paper, tab 2. And it'll be page 11 of the Miller paper. Dr. Lindo, could you please read aloud for the Court the second paragraph of that page ending with the sentence that concludes, "Four years later"?

A Starting at the beginning of the paragraph?

Q Yes. So starting with a sentence that begins, "Using the survey data."

A "Using the survey data, the team documented important differences in the wellbeing of women in the Turnaway group, compared to the near-limit group. Many of which persisted over the study period. This body of work finds that women who were turned away by the abortion clinics experienced worse mental health in the short-run, poorer physical health among those who gave birth, including two maternal deaths, and increased risk of physical violence from the man involved in the pregnancy when compared to women in the near-limit group who received abortions. Researchers also documented worse economic outcomes following the abortion denial

for women in the Turnaway group, including higher rates of poverty, lower employment, and greater use of public assistance, both in the short-term, six months following the service denial, and over a longer time horizon, four years later."

Q Dr. Lindo, what significance, if any, of those findings that are detailed in Miller et al. have on your conclusions regarding the likely impact of a ban on abortion in Kentucky?

A They generally support the conclusion of harms beyond economic outcomes.

Q And I want to go back to the slide now. You've also identified risks of pregnancy and childbirth as a potential cost. Can you tell us from an economic perspective why you've included those costs on this slide?

A Yes. It's well appreciated and accepted that the risks associated with continuing a pregnancy and bearing a child are smaller than the effect -- the risks associated with obtaining an abortion.

Q And looking at these effects on this slide, Dr. Lindo, are there any populations of people in Kentucky who will be disproportionately impacted by these costs?

A Low-income individuals and people of color.

Q Doctor, as a practical matter, how do you know that there will be patients in this group -- people who can't access abortion care at all in Kentucky?

A There's extensive research showing that limiting access to abortion reduces the number of people who obtain abortions and increases childbearing. Including the Turnaway Study that we've talked about already.

Q I'd like to talk about another study. So if you could turn to tab 3 of your binder. What are we looking at here, Dr. Lindo?

A This is a paper that I have published with co-authors titled "How Far is Too Far? New evidence on abortion clinic closures, access, and abortions."

Q Dr. Lindo, was your paper peer-reviewed before it was published?

A Yes.

Q And is it broadly considered to be a rigorous and reliable study?

A Yes.

Q What can you tell me about the circumstances that you studied and documented in this paper?

A The -- the general circumstances surrounding the study was the very large natural experiment, is what economists would call it, that resulted from Texas HB2.

Where in 2013, nearly half of the clinics in the state were forced to cease operations resulting in substantial increases in the distance that people had to travel to obtain abortions, and also substantially reducing the number of clinics that were available to provide for those who were still seeking abortions.

MS. TAKAKJIAN: Your Honor, at this time, Plaintiffs would offer the Lindo paper as Exhibit 7 into evidence.

MR. MADDOX: No objection.

JUDGE PERRY: So moved.

(PLAINTIFF'S EXHIBIT 7 ADMITTED INTO EVIDENCE)

BY MS. TAKAKJIAN:

Q So, can you tell us, Dr. Lindo, what did studying, what you called that natural experiment where half of the clinics in Texas shut down, what conclusions did that yield?

A We found significant decreases in abortion rates and also evidence of delayed abortions.

Q And did travel or transportation have any effect on those findings?

A Yes. And perhaps I should have been clearer before. We found that increasing the distance that a person has to travel in order to reach a provider

substantially reduces the number of people obtaining abortions.

Q Were there any other groups who were studying that same natural experiment?

A Yes. There were three research teams sort of independently evaluating the causal effect of this natural experiment.

Q And do you know if those other teams arrived at the same conclusions that you and your colleagues did?

A They arrived at the same general conclusions.

Q Now, Dr. Lindo, what significance, if any, does the literature documenting the effects of the natural experiment of HB2 in Texas have on your conclusions in this case, regarding the likely economic impacts of patients seeking abortion care in Kentucky?

A It -- it supports that conclusion by demonstrating that there will be reductions in the number of abortions, and thus -- and also increases in births as a result.

Q Speaking slightly more broadly, Doctor, is there any other literature that speaks to the effects of needing to travel or obtain transportation on access to healthcare?

A There are many, many, many studies on the

effects of needing to travel on healthcare access and utilization.

Q If you wouldn't mind turning to tab 3 of your binder, please. Or tab 4, I'm so sorry. Dr. Lindo, what are we looking at in tab 4?

A This is a report. It's the 2021 needs assessment report produced by the Kentucky Department of Public Health's primary care office.

Q And are reports like this one produced by the Kentucky Department of Public Health considered to be reliable sources for experts working in your field?

A Yes.

MS. TAKAKJIAN: Your Honor, at this time, Plaintiffs move to admit this report from the Kentucky Department of Public Health as Exhibit 8.

MR. MADDOX: No objection.

(PLAINTIFF'S EXHIBIT 8 ADMITTED INTO EVIDENCE)

BY MS. TAKAKJIAN:

Q Dr. Lindo, if I could ask you to turn to page 20, and if we could put up slide 14, please. Looking at figure 14, Doctor, what are we seeing here?

A We are seeing statistics based on a survey where people were asked, what were the greatest barriers for patients accessing primary care in Kentucky.

Q And what findings the Kentucky Department of Public Health have on the impact of transportation as a barrier to access for healthcare?

A Overwhelmingly and -- and -- and substantial magnitude relative to any other category. 64 percent of respondents indicated that transportation was one of the greatest barriers for patients in accessing care. And the second closest category to that folks selected was indicating that their patients couldn't afford primary care. And -- and 31 percent of respondents indicated that as one of the greatest barriers to primary care.

Q And Doctor, how does this finding from the Kentucky Department of Public Health study impact your conclusions in this case, on the likely economic effects of the Commonwealth's bans?

A It provides further support for the conclusion that being required to travel out of state will be a barrier to accessing abortion for people who desire an abortion.

Q If we could go onto slide 15, please. Dr. Lindo, if you could turn to page 19 -- well, I actually don't know if you need to turn, and direct your attention to figure 13. What are we looking at?

A Here, this is statistics based on respondents, their responses to a question asking about groups

with -- who are -- with particularly -- who are particularly disadvantaged in terms of their health, relative to the general population of Kentucky.

Q And could you tell us what percent of respondents said that people or patients who had low incomes were being disproportionately impacted?

A 28 percent indicated that low-income individuals were disadvantaged in their health relative to the Kentucky average.

Q And what about people who are part of a racial or ethnic minority?

A 21 percent of respondents indicated that that was a population group with a disadvantage in terms of their health.

Q So, Doctor, what do these responses from Kentucky healthcare providers tell you when it comes to forming your conclusions about the likely economic impact of the bans we've been talking about?

A They provide further support for the conclusion that low-income individuals and people of color will be disproportionately affected by the ban.

Q We -- we've just been talking a lot about travel and transportation barriers, Doctor. So I'd like to talk about those other two groups of people that you identified in your affidavit. Could we please put up

slide 16? Could you remind the Court, Doctor, of the other two groups of people that you assessed in your work in this case?

A Yes. One group is folks who will travel outside of the state to obtain abortion care. But as a result of needing to travel, they will have their -- that care delayed. And the third group is folks who will have -- who will travel outside of the state to have an abortion, and who will not have their care delayed by the need to travel.

Q Could we please have slide 17? From a high level, what are we looking at here?

A From a high level, this is the set of costs that we can expect for these individuals.

Q Doctor, I note that the categories of costs, as it were, are very similar to the categories that we looked at with respect to that first group of patients, the ones who won't be able to obtain abortion care at all. So starting with the patients who are forced to travel out of state to obtain abortion care, but won't delay their care, could you tell us if there are any notable differences between the costs that those patients will face and the costs we've already discussed today?

A Yes. Well, they won't have such the same --

they won't have pregnancy costs and childbearing and child rearing costs. But as a result of having to travel outside of the state instead of obtaining an abortion inside the state, they will now face greater transportation costs and lodging costs and potentially childcare costs. In addition, many people will have to take time off of work in order to make this travel possible. All of that involves a direct economic impact.

Q And Doctor, now talking about the group that have to travel out of state, but are delayed in accessing their abortion care as a result of doing so, could you tell us if there are any notable differences for those group -- people?

A I'm sorry, is that a question about the direct financial cost or -- or generally about all of the group?

Q Generally about all of them.

A In terms of all of the costs, we would expect them to be exacerbated. And I think it's important to keep in mind in this context that the logistic -- logistical issues often come up as a challenge for people who are seeking abortions, particularly low-income populations who are seeking abortions.

And as a result of trying to figure out how to travel, that's sort of how a delay can -- can happen. And then once the delay starts to -- to happen, well, the types of procedures that might be available to an individual can become more limited. And there's a possibility that sort of things spiral, such that eventually a person may not be able to obtain an abortion at all. But the process of this delay can exacerbate the direct financial costs, the costs associated with missing work and/or missing school, and also all of the health and psychological costs.

Q Doctor we've just been talking about patients who will have to travel out of state to obtain abortion care. And I'd like to talk more about travel as a practical matter. So if we could please put up slide 18. And Dr. Lindo, if you could turn to tab six in your binder. Looks like our slide isn't working right. Oh, there it goes. Dr. Lindo, what are we looking at here?

A This is a map produced by the Guttmacher Institute showing the relative restrictiveness of abortion policies in effect across the United States as of June 9th, 2022.

Q What is the Guttmacher Institute?

A It's a -- an organization that does extensive research on abortion, both in terms of policies that are

in effect and patients who are seeking abortion and providers who are providing abortion.

Q Is the Guttmacher Institute's work generally considered to be reliable by experts working in your field?

A Yes.

MS. TAKAKJIAN: Your Honor, at this time, Plaintiffs move to admit this graphic, which has been identified as Exhibit 9 into evidence.

MR. MADDOX: No objection.

JUDGE PERRY: So moved.

(PLAINTIFF'S EXHIBIT 9 ADMITTED INTO EVIDENCE)

BY MS. TAKAKJIAN:

Q Looking at this map, Dr. Lindo, how, if at all, does it impact your conclusions about the likely ability of Kentuckians to travel out of state to obtain abortion care?

A Well, this graphic highlights that the -- the general context with states surrounding Kentucky mostly having restrictive abortion policies in effect, that is going -- that means that the expected effects of Kentucky's ban will be especially large. Or -- or those effects will be magnified by the fact that all the states surrounding Kentucky also have restrictive

policies that will make it harder for individuals to travel to obtain abortions.

Q Now, Dr. Lindo, we've focused so far today on the effects on patients. So I want to talk now about the effects on the children of Kentucky. Earlier today you told us that nearly two-thirds of Kentuckians who obtain abortion care already had a child, or have given birth to at least one child. Could we please put up slide 19? What are we looking at here?

A This is a broad overview of the effect that we can expect to result from the ban on abortion, on the children of people who are seeking abortion. And just to be clear, these are the children that they already had prior to having sought an abortion.

Q So let's take these one at a time, Doctor, starting with financial costs. What can you tell us about the likely economic impact on children with respect to financial costs from the Commonwealth's bans?

A Yeah, as -- as we were talking about earlier, we know that having an additional person in the household and no additional resources in the household means that resources are going to be spread more thinly across the members of the household. So these children will be growing up in households with more limited resources relative to needs.

Q What about the next category, health costs? What can you tell us about the impact on children's health of the Commonwealth's bans?

A Yeah, I -- I -- I think I would say there is extensive research on, generally, the effects of growing up in a more impoverished household. And that research shows that it can lead to poorer health at birth. So here we're talking about children who would possibly be born later on to patients seeking abortion. It -- also growing up in a more impoverished household impairs cognitive skills of children. It reduces their life expectancy as well.

Q What about education costs, Dr. Lindo?

A We see that growing up in a more impoverished household causes poorer test scores, more behavioral issues in school, an increased likelihood of repeating a grade, and reduced educational attainment.

Q And what about any other costs that the Commonwealth bans would be likely to have on the children of Kentucky?

A As a result of growing up in a more impoverished household, we would expect these children to be at a heightened risk of involvement in crime, and to generally have poor living conditions as adults.

Q Thank you. We could take the slides down.

Dr. Lindo, just to wrap things up here. You've talked about an array of literature today, informing your expert conclusions. How would you characterize the breadth and the depth of the available literature when it comes to the evaluation of the economic harms from the Commonwealth's bans?

A I would say the rigor, the breadth, and the depth of not just the literature, but the literatures that informed my conclusions on this case are all extremely impressive. This is not the sort of situation where there are some studies that might find positive effects and some studies find negative effects, and we're not sure what to make of it and we're trying to weigh the evidence. Here it's very clear that there will be economic harms imposed by a ban like this.

Q Would you say that there's a consensus on this issue, Doctor?

A I would say there is as -- would be as close to a consensus as is possible.

Q Thank you.

MS. TAKAKJIAN: Your Honor, if I could have a moment to confer with co-Counsel before I pass the witness? Your Honor, I have no further questions at this time and can pass the witness to Defense Counsel. Thank you, Dr. Lindo.

JUDGE PERRY: Cross?

CROSS EXAMINATION

BY MR. MADDOX:

Q Good afternoon, Professor Lindo. My name is Victor Maddox, and I am Counsel for Attorney General Daniel Cameron here in today's proceeding. We've never met before, correct?

A Correct.

Q Okay. And if I understand it, you're not a medical doctor, you're an economist, right? You have a PhD in economics; is that right?

A It is correct that I have a PhD in economics, and I consider myself a health economist.

Q And, so we're clear, you are not a medical doctor, correct?

A I'm -- I am not a medical doctor.

Q Okay. You -- your testimony, I think stands for the proposition that Kentucky's laws restricting or banning abortion will lead to fewer abortions; is that right?

A Sorry. Could you repeat the question?

Q Your testimony today stands for the proposition that Kentucky's laws restricting or banning abortions will lead to fewer abortions in the Commonwealth, correct?

A Yes.

Q Okay. And you don't need a rigorous academic study to understand that, do you?

A It's helpful to know that numerous academic studies have documented that to be the case.

Q Okay.

A In my opinion.

Q That's actually the point of the laws, isn't it? To limit or eliminate abortions where at all possible?

MS. TAKAKJIAN: Objection, Your Honor. Dr. Lindo didn't draft these laws. Asking him to state what the point of them is -- isn't proper.

JUDGE PERRY: Overruled. This is --

MR. MADDOX: Thank you, Judge.

JUDGE PERRY -- cross examination.

MR. MADDOX: Thank you, Judge.

THE WITNESS: I'm -- I'm -- I'm -- I'm not sure. I -- I -- my understanding is that sometimes in cases like these health issues related to the mother is cited as another reason for laws like this. But I -- that -- that -- I'm -- I'm not a political economist. I think a political economist would maybe be better situated to offer an expert opinion on something like that.

BY MR. MADDOX:

Q Okay. So were you involved in any way in the legislation that was enacted that is involved here today?

A No.

Q Did Planned Parenthood or EMW ask you to provide expert testimony to the Kentucky General Assembly along the lines of the testimony you provided the Court today?

A No.

Q Okay. Were you available to provide that testimony to the Kentucky General Assembly, if they had asked you?

A I'm -- I'm not sure.

Q Well, were you -- could you have come to Kentucky between January of 2021 and, say, April 15th of 2021?

A Maybe. I'm -- I'm not sure.

Q Okay.

A I -- I -- I -- my primary occupation -- I -- I mean, I'm a -- I'm a professor. I have to teach classes --

Q Right.

A -- so I can't just travel any time.

Q But you found time to testify in Arkansas,

right?

A I sometimes can -- can find time. Yeah.

Q And you found time to come here today, right?

A I did not have to cancel any classes. It is the summer. I don't teach classes during the summer.

Q But, for whatever reason, you weren't asked and you didn't provide any of the testimony you gave here today to the Kentucky General Assembly when they were considering the policy behind these laws, correct?

A I -- I was not asked. Correct.

Q Okay. Do you agree with me, sir, that the testimony you're -- you've given here is basically a matter of good or bad public policy?

A I -- I would absolutely object to that characterization.

Q Why is that?

A Because, as an economist, I -- I don't -- I don't determine policy. I -- it's not me to say what is good policy and what is bad policy. It's for me to do research, and to understand the way the world works, and to provide that information.

Q And it's your view that laws that limit abortions, therefore lead to more child births, correct?

A Research -- substantial research demonstrates that restrictions on abortion lead to additional child

birth.

Q And those child births cause the deleterious or damaging economic effects that you've testified about today, correct?

A Generally, people having more children than they plan to, or having children earlier than they plan to reduces incomes and education. So I think -- I think the answer to -- to your question is, yes.

Q You talked about the Miller study. That was tab 2 in the notebook the counsel for the plaintiffs has distributed. "The Economic Consequences of Being Denied an Abortion." Would you look to page 38, please? Tab 2.

A Sorry, what page?

Q Page 38. So the first full paragraph on page 38, even the authors of the Miller study acknowledge that what they're talking about in their study is public policy, don't they? They say, "There are several implications for public policy. If policy makers wish to avoid the adverse economic consequences documented here, one option would be to relax laws that impose a gestational limit for abortion." Correct?

A I would emphasize here -- and -- actually, this --

Q First of all, have I read that correctly?

A Oh, yes.
Q Okay.
A I -- sorry. I thought you asked two questions.
Q Oh, I did, so go ahead and explain.
A Okay, got you. So an -- it's typical in economics for working papers to be released and then researchers to get feedback possibly, and then the late -- paper is later published. This paper was actually released as an NBER working paper prior to its publication. The NBER, by policy, does not publish working papers that make policy recommendations. This is not a policy recommendation. This is saying policy makers can take or leave this evidence. Like -- if you want to do this, if this is -- if it is the policy maker's desire, then they can consider this. But they're not telling the policy makers that they ought to consider this, in my opinion. And so I think this is the sort of thing that absolutely would go straight through NBER policy with no problem, because the researchers are not advocating in this statement. Not -- not in my opinion.
Q So even though they say there are implications for public policy and they suggest ways that policy makers may want to avoid, may follow to avoid the

economic consequences you've testified about, that's not a policy recommendation. Is that your testimony?

A Particularly because it says, "If policy makers wish to avoid these adverse economic consequences." Policy makers probably will be considering many other factors when they're making these decisions.

Q Okay. Now, you testified at some length about the Miller study and I believe it features prominently in your affidavit, correct?

A That's correct.

Q Okay. Now, there are a number of limitations to the data and the research presented in that study, wouldn't you agree?

A I don't -- I don't -- I wouldn't agree to that characterization. I think it's an extraordinarily high-quality study with -- that's very credible.

Q So on page 32, they talk about exploring mechanisms from the Turnaway Study follow-up surveys, and they talk about their methodology of interviewing women. And they say in the second -- in the first full paragraph, "However, in contrast to the credit report data, we are not able to evaluate whether pre-birth trends are similar across the near limit and Turnaway since we are limited to one observation period prior to

the birth. In addition, a fairly large percentage of respondents in our survey, 24 percent at baseline, did not provide household income information resulting in smaller sample sizes for this outcome. Because of these limitations, we consider our analysis in this subsection to be exploratory." That's what it says, right?

A Yes. You read that correctly.

Q Okay. Lower on that page, the last paragraph, they talk about changes in household income from being turned away from abortion and having had a child. And you suggested to the Court that when you have a child and you don't have any additional resources, that has negative consequences, right?

A Correct.

Q In fact, women who have children do get additional resources, don't they?

A Could you clarify?

Q Well, in tab 2, the Miller study, they say, "We do not find an evidence of changes in employment, but do find an increase in the receipt of public benefits." And later they say, "In addition, we are unable to examine changes in benefit amounts with the data available." So that's a significant limitation in the study's analysis and methodology, wouldn't you say, Doctor?

A No.
Q No?
A No.
Q Okay.
A Look, researchers always want more data. This is exploratory analysis. This is secondary to their main findings were about -- which were about the economic outcomes, and which were about financial distress.
Q Then the next page, page 33 of tab 2, Professor Lindo, they say, "Finally, we do not find a significant change in the share of women reporting that they do not have enough money 'most of the time' although the point estimate is positive, indicating an increase in this measure." You see that?
A I see that.
Q Okay. In the next section, page 36, and under "Conclusion," they say, "We find little evidence that the amount borrowed measured by credit card balance, number of auto loans, and presence of a mortgage changed following the abortion denial." So there are plenty of limitations on the data and the analysis in this report, wouldn't you say?
A It's always the case that a researcher wants to have more data and wants to be able to answer more

questions than they're able to. In terms of the main question of, "Does financial distress increase as a result of being denied an abortion?" These results are extremely strong and, actually, all of the results that you're describing as being limited also generally support that conclusion.

Q Let me go back to your slide deck, your key conclusions. I think we agreed that your first proposition for the Court is that the laws in question will result in fewer abortions and more childbirth, and that's a bad thing, correct?

A No.

Q Okay. How is it incorrect?

A I have not said that's a bad thing. I said there will be economic -- there will be a reduction in economic circumstances, or in incomes, and a reduction in education. As to whether that's a good thing or a bad thing, I'll leave that to you.

Q Okay. Now, in the second key conclusion, you say that, "It will impose serious costs on Kentuckians including financial hardship, educational and professional harms, and physical and psychological harms." I just want to make clear: you don't have any expertise regarding physical and psychological harms, do you? You're not a psychologist, you're not a

psychiatrist, you're not a doctor. You --

A In the course of my research, I look at these as outcomes.

Q So you're saying you've read things that suggest that to be the case; is that right?

A And I have also conducted research where health outcomes are the primary outcome, where I'm evaluating the effects of policies and treatments.

Q Let me ask you about your research, Professor. Looking at, I think it's Exhibit -- I've forgotten, Your Honor, what exhibit it is.

JUDGE PERRY: Which one?

MR. MADDOX: The -- the CV.

JUDGE PERRY: His? 4.

MS. TAKAKJIAN: The CV is Exhibit 4, Your Honor.

MR. MADDOX: Thank you.

BY MR. MADDOX:

Q Exhibit 4, Professor Lindo, and that's the CV that's attached to your affidavit. Am I correct that you don't show any research interest in abortion, or any publications regarding abortion in an academic setting before 2020; is that correct?

A I'm -- I'm sorry. I'd -- I -- I -- can you direct me to my --

Q Yeah --

A I think I found the vitae that you're referring to. I have it as attachment 1 --

Q Correct.

A -- here to -- okay.

Q Attachment 1. And I'm just looking at the publication section. So you have your positions, your education, et cetera, and then you have your publications. And the first one I see that has anything to do with abortion is in the year 2020. Is that fair to say?

A No, I wouldn't say that's true. I mean, I've been working on issues related to infant health and childbearing since the very beginning of my career, and all is very closely related, of course, to abortion. In terms of papers specifically evaluating the effects of abortion policy, or an abortion policy, then I think your statement would be correct.

Q Okay. So the first one I see is in the Journal of Human Resources, along with some others, and that was published in 2020, correct?

A I don't -- I don't know which of these you're referring to.

Q It's the fourth one under your publications.

A But -- I'm sorry, can you clarify the question

for me?

Q Right. I'm just asking you if that's the first publication you have that addresses abortion in your professional work?

A And, as I said before, I've been working on issues related to childbearing. If you look at the very first publication of -- on my vitae in 2010, it was a paper looking at fertility. And for -- of course, an important determinant of whether or not someone is observed as having a child or not is whether or not they had an abortion. So I've been working on related topics since I was working on my PhD dissertation --

Q Okay.

A -- as a grad student.

Q Let me ask you about some of the slides. Now, the first -- what -- so slide 2, 3, 4, 5, 6 -- slides 2 through 6, those are all based on the Jones and German study, correct?

A I believe so. I don't remember the exact slides, but yeah, there were several slides --

Q Right.

A -- referring to that study.

Q And you didn't do the work that Jones and German did. You simply read what they did, right?

A That -- that's correct. I wouldn't have had

the ability to do that work because I wouldn't have had access to those data.

Q Okay. So to the extent that the Jones and German study has value for the Court today, it's really, you're just sort of relaying the message that they provided in those articles, right?

A No. I -- I would say I'm drawing on my general expertise for having worked extensively in this area. And those statistics are consistent with what we see in the Commonwealth, and they're also consistent with what we see in virtually every US state.

Q Okay. Let me ask you about slide number 8, "Patients obtaining abortions in Kentucky." You indicated that the majority of the people obtaining abortions in Kentucky are under the age of 30. And you said, "This implies that they are developing their career." Did you do any study to look into that, to determine to what extent abortion recipients in Kentucky are developing their careers and are somehow impeded in that process?

A I think it is a fair assertion to make given the extensive research that exists outside of Kentucky.

Q Okay. So it's an implication, which means you don't have direct data to support that, correct?

A As a professor, I see people in their teens

and 20s, that they are investing in their education. I know that to be the case in Kentucky as well. I -- I -- I'm -- I'm sorry if I'm not following the point you're making.

Q So you teach at the -- at Texas A&M University?

A Yes, I do.

Q Okay. And is it your view that's a representative sample of the population of Kentucky under 30 who seek abortions?

A I think the types of people who I see at Texas A&M in terms of the age distribution is probably very similar to the age distribution that you would see at major universities --

Q Right.

A -- in Kentucky.

Q So age distribution, sure. What about career tracks?

A We know in virtually every single state, there are people in their 20s who are making substantial investments in their careers.

Q So a woman in Kentucky who's 25 years old and obtains abortion, do you have any basis for telling the Court that her -- in her career -- excuse me, her career trajectory, or development of her career has been

negatively impacted?

A There is substantial evidence that policies that restrict access to abortion lead to reduced income. Partially, as a result of reduced earnings, there -- it leads to reduced employment. And that happens over a long time horizon.

Q And you haven't given us any of that data today though, have you?

A I -- I've cited papers in my affidavit.

Q Okay. Now, you -- say on that same slide, and this is a -- I think a substantial part of your opinion, in fact, it's number three, I think, that Black and Hispanic patients are disproportionately represented in the population of Kentucky women who seek abortion, correct?

A Yes.

Q Okay. And in fact, it's about four times greater than their percentage of the population in the case of the Black population, correct?

A Roughly, yes.

Q Okay. So is the implication then, of what you're saying, that if the bans that EMW and Planned Parenthood, the laws that they're trying to have invalidated are in fact invalidated, that there would be substantially fewer African American and Hispanic babies

born in the Commonwealth in the coming years than would otherwise be the case?

A If fewer of these people are able to access abortion, fewer of them will have children, yes.

Q And these people are Black women and Hispanic women, correct?

A Correct.

Q And in your view, that's a good thing?

A I am not making any value judgements here today.

Q Okay. You suggested that the laws in question here are going to eliminate abortion. Isn't it a fact that you previously asserted that if abortion is made illegal in Kentucky, that the incidence of abortion will be reduced by between 30 percent and 40 percent in the state?

A I don't recall saying that.

Q Okay. Do you recall signing on to a brief that was submitted to the United States Supreme Court in the Dobbs versus Jackson Women's Health case?

A Yes, I do.

Q Okay. And that's called, "The Economist Brief." Correct?

A Correct.

Q It's a -- friend of the court brief that you

and a number of other economists submitted to the United States Supreme Court, correct?

A That is correct.

MR. MADDOX: Your Honor, may I just refresh your recollection?

Q And I think if we look at page 15A of Exhibit A, we'll see that that's your name there. Correct, sir?

A That is correct. That is my name there.

Q Okay. So you reviewed this before it was submitted to the Court, didn't you?

A I did.

Q Okay. So on page 32 of this brief, it says, "Under this scenario" -- and that is if Roe and Casey were overturned or limited, "nationwide clinic-based abortion rates are predicted to fall by 14 percent in the year following any change."

A I'm sorry to interrupt. Can you point me to the page? I'm -- I'm not able to follow because --

Q Yeah. I'm sorry. It's page 32.

A Okay.

Q And I'll start over. The brief you submitted to the United States Supreme Court says that if Roe and Casey were overturned or limited, "Nationwide clinic-based abortion rates are predicted to fall by 14 percent in the year following any change, equating to

approximately 120,000 women who want to obtain an abortion, but are unable to reach a provider in just that first year alone." Correct?

A That is what this says, correct.

Q Okay. And if you'll look to the next page --

MR. MADDOX: Do we have the brief -- do we have the brief to this?

MS. TAKAKJIAN: Your Honor, could I ask Mr. Maddox for a copy of the exhibit to which he's referring?

MR. MADDOX: I was really refreshing his recollection with it, Counsel. And let me do this, Your

Honor: I will offer as Exhibit 1 for the -- for Attorney General Cameron, a map from page 33 of Professor Lindo's Supreme Court Brief in the Dobbs case.

JUDGE PERRY: Show it to the --

MS. TAKAKJIAN: And Your Honor, just as a point of clarification, I -- don't believe Professor -- or Dr. Lindo authored this brief, I think he signed on to it.

MR. MADDOX: Yeah.

MS. TAKAKJIAN: And also, Your Honor, I just object to this. Defense Counsel did not provide us

with any exhibits in advance. We haven't had notice of this.

JUDGE PERRY: Do you have one now?

MS. TAKAKJIAN: I do have a copy of this particular page now. We also add an objection as to the lack of the full exhibit.

JUDGE PERRY: Well, let's prove that the foundation -- it's not clear it's his brief, it's a brief. So let's prove that up a little more.

MR. MADDOX: Right.

MS. GATNAREK: And just -- I'm sorry, Your Honor, just to be clear, during Counsel's meet and confer on Friday, we did discuss exhibits. We let Defense Counsel know which we would intend to use. Defense Counsel on Monday alerted us that they were calling witnesses and did not identify any exhibits. So we would just note an objection generally about not having notice of any exhibits that they used today.

JUDGE PERRY: That's why we may not get finished today. If it --

MR. MADDOX: And my only response to that, Your Honor, is I did not need or intend to offer this as an exhibit. I was going to use it to refresh his recollection, and I can do that if the Court

prefers.

JUDGE PERRY: Understand. But as you know, there's a difference between refreshing the --

MR. MADDOX: Right.

JUDGE PERRY: -- recollection and offering something as an exhibit --

MR. MADDOX: Right.

JUDGE PERRY: -- and I didn't hear the foundation for the exhibit.

MR. MADDOX: Right.

MS. TAKAKJIAN: Your Honor, I'm sorry, just as a point of clarification: Is this page 33 the sole piece of the Brief that's being offered --

MR. MADDOX: Yes.

MS. TAKAKJIAN: -- as an exhibit?

JUDGE PERRY: It's what I'm gently trying to suggest. It's not clear to me yet, so I'm sure Mr. Maddox will prove that up.

MS. TAKAKJIAN: Very good, Your Honor.

BY MR. MADDOX:

Q Okay. Professor, you've got the full brief there in front of you, correct?

A I -- I believe so. Yes.

Q Okay. If you'll look to the first page, the cover page. It's in case number 19-1392, Dobbs versus

Jackson Women's Health Organization, United States Supreme Court, correct?

A Correct.

Q And it says, "Brief of amicus curiae economists in support of respondents." Correct?

A Correct.

Q So this is the brief that you authorized the lawyers who filed this to file with the United States Supreme Court on your behalf, correct?

A Yes. Along with many other economists.

Q Right.

A Yes.

Q And if you look to the interest of the amicus curiae, this is after the table of contents. It's on the first page of the brief, which actually does not have a number on it. "Interest of amicus curiae." Do you see that?

A Yes.

Q And then in the first full paragraph it says, "Amici," that means you, "submit this brief to assist this court in understanding the developments in causal inference methodologies over the last three decades." Correct?

A I'm -- I'm -- I'm sorry. I'm not -- I don't see where you're reading that.

Q It was the third sentence, the middle of that first full paragraph.

A Yes. That is -- that sentence appears there. Yes.

Q Okay. So is there any doubt in your mind that the brief that you have in front of you is the brief that you authorized lawyers to file with the US Supreme Court on your behalf?

A I have -- I have no reason to believe that --

Q Okay.

A -- you would be dishonest in that way in court today.

Q Now, Your Honor, I really just wanted to refresh his recollection about Kentucky statistics. I can withdraw Exhibit 1 if that's preferable.

JUDGE PERRY: I want you to develop the record that you're --

MR. MADDOX: All right.

JUDGE PERRY: -- choosing to defend later. So it's up to you.

MR. MADDOX: In that case, if -- despite the objection, I would like to offer General Cameron's Exhibit number 1.

JUDGE PERRY: Is just that one page?

MR. MADDOX: That one page.

JUDGE PERRY: Okay. All right. Over objection, so moved.

(DEFENSE EXHIBIT 1 ADMITTED INTO EVIDENCE)

BY MR. MADDOX:

Q Professor, what I've called Exhibit 1 is page 33 of the brief we've just discussed. Do you see that?

A Yes.

Q Okay. And it's got figure 3, and it says, "Predicted decline in abortion rates if Roe and Casey were overturned or limited." Do you see that?

A I do.

Q And Kentucky is in the area of the country that Figure 3, in your Supreme Court brief, shades in various colors of, you know, fuchsia or purple or light blue. Do you see that?

A I do see that.

Q Okay. And the lighter the color, the bluer the color, the lower the predicted reduction in abortion rate in the area involved, correct?

A Correct.

Q And the more red or violet the color, the higher the predicted reduction in abortion rate, correct?

A Sorry. The -- the -- the more intensely red, the high --

Q Yes.
A -- the larger the expected reduction.
Q Right. And the chart, the scale of predicted reduction, runs from 40, maybe -- what is that? Maybe 50 percent down to zero percent?
A Yes.
Q Okay. Now, eastern and western Kentucky appear to be in the blue-ish areas, correct?
A Yes.
Q Okay. And then the middle of the state, in particular the Louisville metro area and the northern Kentucky area, and perhaps the Fayette County area, that's Lexington, are in the redder areas, correct?
A I'll -- I'll take you -- yes. Yes.
Q Okay.
A That's -- that's true.
Q I mean, I don't -- it --
A My -- my knowledge of geography around Kentucky is not perfect. But yeah, I -- I -- I -- yes, I see that.
Q Okay. I think the Court can probably take notice of the fact that my -- my geography lesson is accurate.
A Sounds good.
Q So is it fair to say that, in -- in eastern

and western parts of the state, the predicted reduction in abortion because of a ban or the elimination of Roe and Casey, which would allow Kentucky's trigger law to go into effect, is in the five to ten percent range?

MS. TAKAKJIAN: Your Honor, just an objection to clarify the record. This figure 3, to which Mr. Maddox is referring, predicts the decline in abortion rates if Roe and Casey were overturned or limited. Presenting it as equivalent to a ban is misleading, Your Honor.

MR. MADDOX: Well, I didn't present it as a ban.

JUDGE PERRY: Do you have an extra copy?

MR. MADDOX: Oh, I do, Your Honor. I'm sorry. I didn't present it as a ban. I said that if Roe or Casey is limited or overturned, as the brief suggests, then Kentucky's trigger law would go into effect.

JUDGE PERRY: Do this for me: As the fact finder, I'll eventually decide some -- something along those lines. Get him to prove up what it is you're -- you're fussing about in terms --

MR. MADDOX: Thank you.

JUDGE PERRY: -- of what does he think it means.

MR. MADDOX: Thank you.

BY MR. MADDOX:

Q And so, Professor, in those areas of the state where your figure 3 shows the redder or more intense color, you would agree with me, wouldn't you, that it suggests that the reduction in abortion rates, if Roe and Casey were overturned, would be in the 30 to 50 percent range?

A Yeah. Sorry. I think you asked a couple questions leading up to that. And I want to make sure that I answer precisely because there's something that I -- is often confusing, is reductions versus percent reductions. And so there can be large percent reductions versus small percent reductions. And there can be large numbers of reductions that are determined both by the pre-existing number of abortions and the percent change. So if there's an area that has a small percent reduction, but there are a large number of people who are typically obtaining abortions there, we would still expect there to be far fewer abortions. So I -- I -- I just wanted to cover all of the questions I think you asked. So I hope I did.

Q Well, I just want to make sure I understand what you're saying now. So your brief says that you expect nationwide a 14 percent drop in clinic-based

abortion rates, correct. And that's on page 32 of the brief in front of you.

A Yeah. So again, I didn't author this brief. And I didn't do the statistical analysis to produce this figure. But I did sign this, along with 150-odd other economists. And that is what we wrote. We would, indeed expect to see substantial percent reductions in abortion rates as a result of bans on abortion.

Q Right. Now, I'm just trying to understand if we can agree on what those reduction rates are. Nationwide, you think, you've told the Supreme Court, that it would be 14 percent, correct?

A Yes. And that is based on the research done --

Q Okay.

A -- on Texas.

Q Right. And you've told the Court, based on the data that we can infer or deduce from figure 3, that in Kentucky, it would be five to ten percent in the eastern and western part of the state, and 30 to 50 percent in the other areas of the state, correct?

A You know, honestly, I don't know. These colors are kind of blending together for me. It -- it does seem to range from roughly ten percent in some parts of the state, to up to maybe 40 percent in other

parts of the state.

Q Okay.

A But it -- it's hard to tell from this figure.

Q Okay. So in any event, you would agree based on what you told the United States Supreme Court, and now this court, that abortion is not going to be eliminated in Kentucky even when the trigger ban or the trigger law and the heartbeat law go into effect, correct?

A Ah. I -- there's -- my understanding is that there will still be some people who are able to obtain abortions in Kentucky in situations where the person's life is at risk. But otherwise, my understanding is that no more abortions will be obtained in the State of Kentucky.

Q But your brief says that the expected reduction in abortion rates in Kentucky would be five percent to 40 percent, not 100 percent, correct?

MS. TAKAKJIAN: Objection, Your Honor. Asked and answered. I think Counsel's conflating this figure which talks about different scenarios in which Roe or Casey were either limited or overturned. And Dr. Lindo's opinions in this case are predicated on what would happen if the Commonwealth banned abortion.

MR. MADDOX: Your Honor.
JUDGE PERRY: Go ahead.
MR. MADDOX: Our trigger law, which is in front of the Court today, says that in the event Roe is overturned, in whole or in part, then the law banning abortion, except in the case of the life of the mother --
JUDGE PERRY: Right.
MR. MADDOX: -- goes into effect immediately. So I think Counsel's, you know, argument is, you know, grasping at straws here.
JUDGE PERRY: Well, I -- I'm not the witness. This person is. So overruled. Let's ask the question.
MR. MADDOX: Thank you.
JUDGE PERRY: Let's move on.
MR. MADDOX: Thank you, Your Honor.
THE WITNESS: Yeah. I -- I -- I understand. I think I -- I think I see the confusion now. When we talk about abortion rates, sometimes we talk about abortion rates based on the number of abortions obtained within state boundaries. And sometimes we talk about abortion rates based on the number of residents obtaining abortions. And as I said earlier, some residents of Kentucky will be

able to obtain abortions by traveling outside of the state. And so that's why we don't see this number going to zero here. And perhaps for lay readers, this figure should have clarified that this abortion rate here is referring to the abortion rate in terms of the number of residents of each county obtaining an abortion.

BY MR. MADDOX:

Q Right. Right. So abortion's not going to be eliminated according to the data you've submitted to the Court, correct?

A It -- it depends on what you mean by "eliminated."

Q Okay. Now, one of the things you mentioned, Professor, was the cost of child rearing. Do you recall that?

A Yes.

Q And that was a significant part of the, I think you called it, "deleterious economic consequences of not being able to obtain an abortion," correct?

A I don't know if I would say it was a significant portion. It was one among many.

Q Okay. Are you familiar with Kentucky's Safe Haven law?

A I -- I am not familiar with that law.

Q Okay. For that matter, have you read the Kentucky constitution, are you familiar with that?

A I have not read the Kentucky constitution.

Q Okay. So you know what a safe haven law is, don't you?

A Generally, but I would appreciate it if you would tell me so I understand what you mean when you are describing it for me here today.

Q I mean by that a law like KRS 216B.190, which provides that anyone who has a newborn child and doesn't want that child can drop it off at any number of locations, and do so anonymously, and have no more responsibility for raising that child. Are you familiar with that?

A I'm familiar with that type of law.

Q Okay.

A Yes.

Q Now, to what extent did you include the economic consequences of that law in the analysis you've provided the Court?

A Right. I think the totality of evidence includes people who have had opportunities to give their children up for adoption. Very -- very few do, empirically. And we see these economic harms as a

result of people having more children. So I -- I think I don't explicitly address that, but it wouldn't alter any of the conclusions that I -- I -- came from my report in my affidavit.

Q So would you consider that a rigorous opinion, given that you haven't considered it and you haven't apparently included any quantitative effect of the ability to avoid the cost of child rearing if you're denied an abortion?

A Sorry. I think that was maybe a multi -- multiple part question. I'm going to mix up the answers. Could you --

Q You haven't made any quantitative analysis of the impact of the option a woman has to invoke her rights under KRS 216B.190, and leave her child for others to raise, have you?

A I guess I would -- I would say that is incorporated in the analyses that I refer to in my affidavit.

Q Okay.

A There are these economic costs, despite the fact that people have this opportunity to give their --

Q But --

A -- the children up for adoption.

Q But at the point that they choose not to leave

their child as the law allows, then they voluntarily decided to keep the child, right?

A I -- I think that -- I think that's tricky. I think it depends on it what means by voluntary. These things are really tricky and hard. And as I noted before, a lot of these people are in abusive relationships. So I don't -- I don't know how to answer that question. I am not an expert in domestic violence. So I -- yeah, I'll -- I'll leave it at that.

Q Okay. On the point that you just made that a lot of women seeking abortion are in abusive relationships, you're not an expert in that sort of thing, right? Domestic violence, social welfare. You're just not an expert in that, are you?

A I mean, I -- I would say I do research that is closely related to these topics. I've published papers on sexual assault, for example. But I don't do qualitative research examining the detailed circumstances surrounding individuals' decisions on whether or not to give a child up for adoption and people's sort of more intimate experiences with domestic violence.

Q Okay. In one of your slides you talked about women obtaining abortions having disruptive life events. I believe that was slide 6. Do you recall that?

A Yes.

Q Do you have any ability or basis for an opinion concerning the extent to which women in those disruptive life events, say for instance an abusive spouse, are voluntarily choosing to get an abortion?

A My understanding, from having read the medical literature regarding abortion care, is that a patient would typically be asked if that sort of thing is happening. That -- that's my understanding from -- from reading this literature, that they would be asked whether or not they feel they're being pressured by anyone, or if they have an abusive partner before they receive any care. And -- and if they answer yes, they would be counseled accordingly.

Q So that's really just based on your reading of other literature, correct?

A Yes. That is based on my -- my understanding of medical practice.

Q Okay. I guess one other question I have for you, Professor, is you indicated in one of your slides that roughly 23.7 percent of women are expected to seek an abortion, women between 15 and 45, by the time they reach the age of 45, if the abortion rates that were in effect in 2014 continue, correct?

A Correct.

Q Now, you know that the Dobbs decision has come out, and your own brief suggested that the rates that were in effect in 2013 or 2014 would drop by at least 14 percent nationwide, correct?

A Correct.

Q So do we need then to take your 23.7 percent number and reduce that number by 14 percent?

A No. That was to provide context for historically how many people obtain abortions. Of course we expect fewer people to obtain abortions in a world in which abortion procedures are banned. I mean, I think I've stated that several times.

Q But it's fair to say that, based on the Dobbs decision, the abortion rates that you use for your own analysis are not going to continue; isn't that right? So the assumption of your analysis, that slide, was incorrect, correct?

A There was no assumption there. That was just providing a statistic to characterize historically, you know, what -- how many people have obtained abortions. Or how many people would we expect to obtain abortions based on the rates that were observed in 2014.

Q Okay. Finally, in your affidavit, sir, there are references to sort of a comparison, I think you called it a natural experiment, between abortion rates

that were in effect in what you called the five legal states from 1970 to 1973 before Roe versus Wade, and the rest of the country. Do you recall that?

A Yes. I recall that.

Q And I think you indicated that the abortion rates in those five states, and I -- going from memory I think it was Hawaii, Alaska, California, and New York and Illinois, but I could be wrong. That the birth rate in those states dropped by five percent relative to the rest of the country, correct?

A This can be hard to talk about because there's sort of two natural experiments here. One, where the five "early repeal states," is what they're referred to, made abortion legal. And when they did make abortion legal, birth rates in those states fell relative to the rest of the US. And then when the rest of the US legalized, that gap subsequently closed. So it was generally supporting the same conclusion that I've stated many times, which is that when access to abortion is limited, there are more children who are born.

Q Okay. And you said in your affidavit that once Roe versus Wade was passed by the Supreme Court, issued by the Supreme Court, by 1976 the national birth rate had dropped to the same birth rate as those other five states from 1970 to 1973, correct?

A That's not quite correct. It's that the gap that existed prior to those early repeal states repealing early, it went to its preexisting gap.

Q Right. So you said in paragraph 32, you said, "After Roe versus Wade made abortion legal in the other states, their birth rates fell relative to the repeal states. Such that repeal states minus other states' difference that emerged from 1971 to 1973 had vanished by 1976." Correct?

A That -- that sounds correct. If it would be helpful, I -- maybe I should turn to my affidavit to make sure that we're -- but --

Q Paragraph --

A -- it depends how long we're going to be talking about this.

Q It's paragraph 32. Page 12.

A Thank you.

Q So you indicated there that the birth rates in the rest of the country, the other 45 states, fell after the issuance of Roe versus Wade, to reach the same level as the states that had previously legalized abortion. And that gap was closed by 1976, just three years, correct?

A It -- it's -- it's -- it's not correct. And I'm sorry, this is why difference and differences can be

a little bit tricky. It's -- it's that they fell relative to those states. So falling versus falling relative to the comparison group are two different things. So I just want to make sure that I'm -- I'm clear about that.

Q Sure. And your conclusion in that paragraph is, "The evidence can be thought of as indicating that birth rates are increased if abortion is illegal." Correct?

A Yes.

MR. MADDOX: Okay. Your Honor, that's all I have for this witness.

JUDGE PERRY: Okay. All right. Redirect anything?

MS. TAKAKJIAN: No, Your Honor. Plaintiffs don't have any further questions for Dr. Lindo.

JUDGE PERRY: All right. So with regard to -- first, Dr. Lindo, you're excused. You can step back. And we're about to take a break. With regard to the Exhibit 4, the affidavit, and -- CV over objection, I'm going to allow it to supplement what we've done here. You'd indicated earlier today -- this morning, that there might be a third witness. Have you talked about that, the lawyers, yet?

(PLAINTIFF'S EXHIBIT 4 ADMITTED INTO EVIDENCE)

MR. MADDOX: We have not, Your Honor.

JUDGE PERRY: Why don't we do this: Let's take about a 20-minute break, 'til 1:45, and talk about that. And either keep your case open to do it, or we'll talk scheduling as to when. And if not, we'll come back. Are you prepared to proceed?

MR. MADDOX: We are.

JUDGE PERRY: Then we'll come back here in about 20 minutes, okay?

MS. TAKAKJIAN: Very good, Your Honor. One more thing as a housekeeping matter for the Court. If you don't mind, I'll collect the binder of exhibits from Doctor -- from the witness stand. I'll apply --

JUDGE PERRY: Sure, sure.

MS. TAKAKJIAN: -- labels and return to the stand.

JUDGE PERRY: Okay.

MS. TAKAKJIAN: Thank you, Your Honor.

JUDGE PERRY: All right. Anything else? All right. We're in recess.

(OFF THE RECORD)

JUDGE PERRY: All right. We're back on the

record in 22-CI-3225. And we have just finished a witness on behalf of the plaintiff. Let me -- the Court asks though, is that the case for the plaintiff?

MS. GATNAREK: Your Honor, that is the culmination of the live witness testimony that we intend to introduce. Again, as we mentioned at the top, we will also be relying on the verified complaints and sworn -- complaint and sworn affidavits.

JUDGE PERRY: And the parties have agreed upon some stipulation; is that accurate?

MR. MADDOX: That's accurate, Your Honor, we've agreed to the -- to the averments of fact in paragraph 13 through 15 of the complaint.

JUDGE PERRY: Right.

MR. MADDOX: Paragraph 15 addresses the Planned Parenthood's --

JUDGE PERRY: Right. Sure.

MR. MADDOX: -- status, and its relationship to the clinic.

JUDGE PERRY: And at this point, no need to explain it. I just want to make sure you both record that -- memorialize that, rather, in a written way and then attach it to whatever your

ultimate request for finding and conclusions are.

MS. GATNAREK: Yes.

JUDGE PERRY: So with that, is that the case for the plaintiff?

MS. GATNAREK: Yes. That's it, Your Honor.

JUDGE PERRY: All right. Then let's cross the "D," as it's told -- or called and ask Defendant if you're ready to proceed. If so, who's your first witness?

MR. MADDOX: Your Honor, I just want to note for the record that we would renew our motion that the temporary injunction motion be denied. We don't believe that there's been a factual foundation, and obviously there's no legal basis for their claim. I don't want to argue that now, but I do want it on the record.

JUDGE PERRY: I usually don't hear that in these matters, but I'll accept it as consistent with the rules. Any comment, Plaintiff, one way or the other?

MS. TAKAKJIAN: No, Your Honor. Of course we would ask that the restraining order remain in place while we continue presenting our case for the temporary injunction.

JUDGE PERRY: Yes. I would respectfully deny

that at this time. And of course, consider that to be your ultimate request when we get down to that. All right. Who's the first witness?

MS. KEISER: We'll be calling Dr. Wubbenhorst.

JUDGE PERRY: Okay. Is that person available?

MS. KEISER: Yes, she is.

JUDGE PERRY: Okay.

BAILIFF: Watch the -- turn around, face the judge and raise your right hand and he'll swear you in.

THE WITNESS: Yes.

JUDGE PERRY: Good afternoon. Ma'am, do you swear or affirm the testimony you're about to give the Court will be the truth and the whole truth?

THE WITNESS: Yes, sir.

JUDGE PERRY: All right. Welcome. Be seated.

THE WITNESS: Thank you.

JUDGE PERRY: If you heard me earlier, if not, let me remind you, you have to stay close to the mic so the record hears you.

THE WITNESS: That's right.

JUDGE PERRY: I'll both watch you around my monitor and watch you on my monitor.

THE WITNESS: Okay, good.

JUDGE PERRY: So if you'll answer the question

to Counsel, it'll look like you're talking to me.

THE WITNESS: Okay. Thank you, sir.

JUDGE PERRY: Uh-huh.

DIRECT EXAMINATION

BY MS. KEISER:

Q Good afternoon, Dr. Wubbenhorst. Would you please state your full name for the Court?

A Yes, I am Dr. Monique Chireau Wubbenhorst.

Q Thank you. And would you please tell the Court your profession?

A I'm an obstetrician-gynecologist and researcher.

Q Okay. And what kind of academic training did you undergo to become an obstetrician-gynecologist?

A You mean in general?

Q Yes. You can just go through your academic background.

A Okay. I completed -- I went to -- completed college at Mount Holyoke College. Went on to graduate from Brown Medical School. Concurrently did a master's in public health at Harvard University. Did my obstetrics and gynecology residency at Yale University. And then subsequently went on to do a health services research fellowship at University of North Carolina at Chapel Hill.

Q Okay. And do you have any board certifications?

A Yes, ma'am. I'm board certified in OB-GYN.

Q Okay. And how long have you been practicing?

A Since 1991.

Q Okay. And are you currently practicing at the moment?

A I'm taking sabbatical.

Q Okay. But are you intending to practice again?

A Yes. Starting in the fall.

Q Okay. Great. And during your time during clinical work, has your clinical work had a particular focus?

A Yes. My focus of my clinical work has been in underserved populations. Specifically African American women, inner city women, women in Appalachia, women in Native American reservations, and also globally, especially in Sub-Saharan Africa.

Q Okay. And then the --

A And the -- and the Caribbean.

Q Oh, I'm sorry. Yes. And in the Caribbean. That's what you said?

A Uh-huh.

Q And beyond your clinical work, are -- have you

also taught courses as well?

A Yes, ma'am. When I was at Harvard during the first few years after I finished residency, I taught the first and second -- first year introduction to clinical medicine course, which dealt with both clinical medicine and ethics in medicine. And then also when I was at Duke University, I taught the -- both -- I taught residents in clinic and medical students in clinic, as well as nurse practitioner and physician assistants. And also -- (coughs) excuse me -- taught the second year students going into their third year basics of clinical OB-GYN.

Q Okay. And what is your current position?

A I'm a senior research associate at the de Nicola Center for Ethics and Culture at Notre Dame University -- (coughs) sorry.

Q And have --

A Can I get some water?

Q Oh, that's okay. Have you written any peer-reviewed articles or papers on pregnancy risks or maternal mortality?

A Yes, ma'am. We completed a study while I was at Duke University, looking at something called the Hispanic paradox. And what the Hispanic paradox is that if you look at pregnancy outcomes for Black, White, and

Hispanic women, despite similar levels of socioeconomic status and really racism against Hispanic women, they have better outcomes. So we explored what were possibly some of the reasons for that. I've also published on pre-eclampsia, high blood pressure in pregnancy, and risk of stroke and mortality in women as well.

Q Okay. When you're talking about that Hispanic paradox, I think you mentioned, and correct me if I'm wrong, but you created the database that went with the -- in the data that you used for that study. You helped create that database while you were at Duke?

A Yeah, actually I did create it. So what we did was to look at administrative data -- actual charts and administrative data for all women who'd given birth at Duke from 1978 to about 2007, which was tens of thousands of women. And then we were able to pull charts on those women, as well as to analyze trends, what their outcomes were, what their mortality was. And because we're actually working from patient charts, we could look at variables like race -- race and ethnicity, and so on and so forth.

Q Okay. In general, can you give an estimate of how many peer-reviewed articles or papers you have written during your career?

A I think it's 20, maybe 21.

Q Okay. When you're writing your research and you're writing these papers, what scientific or technical principles do you rely on to reach your conclusions?

A I think it depends on the study design. So for primary data collection, for example, when I was studying patterns of protein expression in placenta, I actually collected placentas and then subjected them to various analyses to see what types of gene and protein expression were going on to try to understand whether there was a difference between placentas from pregnancies complicated by pre-eclampsia, versus normal ones. In a secondary data analysis, as I described when I was at Duke, we were looking at large database studies. And then for literature reviews, there are a couple of specific techniques that we use. One is to just -- you search the five major databases. That'd be Medline, CINAHL, we cheat and use Google Scholar, and a couple of others. And Embase -- you're so kind. Thank you so much. Thank you. I was getting cottonmouth here -- and what you do is you pull -- you search on specific search terms. Then after you've looked at search terms, you pull each paper and look at the bibliography. It's called the snowball technique.

Q Okay. Thank you.

MS. KEISER: Your Honor, may I approach the witness?

JUDGE PERRY: Okay.

BY MS. KEISER:

Q So Dr. Wubbenhorst, do you recognize what is in front of you?

A Yes, ma'am.

Q Can you tell the Court what it is?

A It's my curriculum vitae.

Q Okay. And does it appear to be an accurate reflection of your CV?

A Yes.

Q Okay. And is it -- is the information in that CV up to date?

A Yes, ma'am.

MS. KEISER: Wonderful. Your Honor, I'd like to move to introduce this as Attorney General Exhibit 2.

MS. GATNAREK: No objection.

JUDGE PERRY: So moved.

(DEFENSE EXHIBIT 2 ADMITTED INTO EVIDENCE)

BY MS. KEISER:

Q Dr. Wubbenhorst, as to your testimony today, what did you do to prepare?

A I reviewed medical literature. I did searches

using the tech -- methodology that I mentioned earlier to you, and I also looked at professional recommendations and guidelines.

Q Okay. And did you read the complaint in this case?

A Yes, ma'am.

Q Okay. And some of the laws that are at issue?

A Yes, ma'am.

Q Okay. And why were you retained in this case?

A To provide expert witness testimony.

Q Thank you. And Dr. Wubbenhorst, would you identify as pro-life?

A Yes.

Q Okay. And will your personal views affect your expert opinion that you are offering today?

A My -- as I see it, my role is to provide a reasoned scientific perspective.

MS. KEISER: Thank you. Your Honor, at this time, I'd like to tender this witness as an expert in the field of medicine, specifically obstetrics-gynecology, and women's health.

MS. AMIRI: I don't have any objection, Your Honor, to the tender of the expert for obstetrics and gynecology. But the field of medicine is quite broad as is women's health, but obstetrics and

gynecology is fine with me.

JUDGE PERRY: I'll allow it.

MS. KEISER: Okay, thank you.

JUDGE PERRY: Over objection.

BY MS. KEISER:

Q Thank you. Now, Dr. Wubbenhorst, I'd like to start talking with you about some of the medical and scientific facts that are concerned in this case. So Kentucky Law, as you are aware from your preparation, in KRS 311.772 defines a human -- an unborn human being -- and I'll just read what it says for you -- and it is: "an individual living member of the species Homo sapiens, throughout the entire embryonic and fetal stages of the unborn child, from fertilization to full gestation and childbirth." Is that definition consistent with the opinion of the medical community?

A Yes.

Q Okay. And in the field of obstetrics and gynecology, who do you consider to be the patient?

A I would consider actually that we have two patients. That's the art and the science of obstetrics -- obstetrics and gynecology. We know this because we take steps to try to protect the fetus, for example, from women who are working in the hospital, we protect them from teratogenic medications, from

radiation, from teratogenic -- by teratogenic, I'm sorry, I mean medications that can cause birth defects in the baby. And in addition to that, we give women prenatal vitamins, which are fortified folic acid to prevent neural tube defects. So even at the earliest ages, we're treating the fetus as a patient.

Q Okay. And does that change if -- throughout the pregnancy? Or is that the same at all times during the pregnancy?

A If anything, our ability to intervene on behalf of the fetus as a patient increases. The field of -- what we call the perinatal revolution has been going on. And the field of fetal surgery, for example, and fetal treatment has really exploded, I would say, over -- definitely over the last 20 -- 30 years since I've been in medicine. A little bit more than 30 years that I've been in medicine, has really exploded. Now we have fetal surgery for spina bifida. We have the ability to treat some types of congenital heart defects and other defects in ways that were just not possible before. And I think that's only going to continue to happen. There's very good early animal evidence that -- for prenatal nutritional treatments for Down Syndrome -- to potentially prevent Down Syndrome. So I think seeing the fetus as a patient is really how

we need to visualize the maternal-fetal dyad as including that member of the family.

Q Yes. And when -- I think you mentioned there some of the surgeries that they can now perform in utero on the fetus. When they do that, is there anesthesia given to the fetus -- how is the fetus treated when they're undergoing those types of surgery?

A Right. The standard of care actually for the anesthesiologist is to provide fetal anesthesia. And in addition, insurance companies reimburse for the cost of that anesthesia.

Q Okay. So we -- in the definition that I read, the General Assembly uses the term "fertilization." So I just want to kind of talk about that term a little bit. What do members of the scientific community mean when they say "fertilization"?

A So fertilization is the process by which a male gamete, a sperm cell, penetrates the zone of pellucida, or the outer transparent layer of the -- of the female gamete, the egg, resulting in conception, which is the merging of the two pronuclei into one nucleus, creating a new human being. That's evidenced by the fact that DNA is distinct. The -- there's actually energy emitted upon fertilization and conception. There's a zinc spark that occurs, and

people observe this in -- in -- in vitro. In addition, the zygote at that point as it's called, is self-organizing. So the zygote begins to organize along a detailed pattern towards becoming more and more developed as it goes along.

Q Okay. And when does fertilization occur? You know, we talk about -- a lot about the gestational weeks. So when does fertilization occur in that timeline?

A So typically when a woman -- and again, us obstetricians use a little bit different terminology. But typically once ovulation occurs, the egg floats -- is in transit for a couple of days, then begins to make its way into the fallopian tube. Under optimal conditions, fertilization occurs within the fallopian tube after a few days, and then the -- not the fertilized egg because there's no such thing. It -- it is an -- it's a zygote, and then it's an embryo, and then it's a fetus.

Q Uh-huh.

A Then kind of bumps along the tube and goes into -- enters the uterus where following a specific series of developmental stages, it requires the ability to attach.

Q Okay. So let's -- so it happens very early in

terms of -- what you're saying is, it happens very early in terms of the gestational period?

A Right. Uh-huh.

Q Okay. Let's talk about some of those other developmental stages that are going to occur throughout, afterwards, if you wouldn't mind.

A Uh-huh.

Q So would you mind walking us through some other key embryonic and fetal developmental phases, and when they occur?

A Sure. So I think that one of the earliest systems to develop is the cardiovascular system. So as the -- the zygote moves towards being an embryo, there are distinct cell layers within the embryo, which begin to differentiate into different types of cells and eventually into organs and systems. The cardiovascular system, as I just said, is one of the first to develop. So by about four weeks, the primordial cells that will eventually make up the cardiovascular system begin to separate from the connection with the -- between the fetal membranes and the placenta, and begin to organize themselves. By about -- between four and five weeks, they form a tube, which then over the next few weeks begins to fold and differentiate. In the meantime, the specific cells cardiomyocytes, which are the progenitors

of cardiac cells, begin to -- they form out of the inner cell mass of the embryo. And they begin to contract. And that occurs usually around five weeks.

Q Okay.

A Then by about seven weeks, that -- the tube, as I'm calling it -- I'm just using general terms.

Q That's okay.

A As it folds begins to differentiate into an organ which has four apertures, which represent the great vessels that will eventually form. The cardiac valves begin to form around eight weeks. And by nine to ten weeks, pretty much the entire pattern is laid down. And the fetal heart functions as it will in the adult. In addition, some other markers are that around five weeks, the first -- the beginnings -- the nervous system begins to differentiate. By seven weeks, the first synapses are observable in the spine. By about eight to nine weeks, electrical activity is detectable in the brain. By about ten weeks, fingerprints are discernible. The hand develops -- begins to develop after the limb buds developed around four weeks, and then continues to extend around six weeks.

Q Okay, great. Great. I'm going to focus on a couple of those just to follow-up with you. So when you started talking about the circulatory system and the

cardiovascular system, we're referring to the blood that's going to be pumping through the baby's body.

A Right.

Q So is the blood that's in the fetus or the embryo's body, the same as the blood that is pumping through the mother's body or the woman's body?

A No, it's quite distinct. And that's a very important clinical situation. Because the -- the placenta, which is a very unique organ, has the ability to bring the maternal blood in proximity to the baby's blood, but there is no mixing. When that mixing occurs, and that can occur through different situations, it's a situation we deal with a lot in obstetrics. Early in pregnancy, it can occur when a woman has bleeding. It can occur if she has a miscarriage, a spontaneous abortion, or a termination of pregnancy. And if she is RH negative, she becomes sensitized to those antigens. And that can cause major problems in the future. And again, after a woman gives birth and that barrier is breached, that's another -- another situation where a woman can become RH sensitized. And that's why we give -- we have specific treatment protocols for present -- preventing that kind of sensitization.

Q Okay. So by the time the -- it's an embryo, as you classify it, it has its own distinct DNA, its own

distinct blood. And then from what I understand, by the time the heart starts beating, which you said starts pumping around five weeks, or the -- at least starts --

A The cardiomyocytes are -- they can already contract. Yes.

Q Contracting. Thank you. So are the heartbeats that are measurable when you detect a heartbeat in the unborn child, are they the same as the woman's heartbeat?

A No, they're distinct. Just as fetal brain wave activity, which is able to be seen around, I think, eight weeks, is distinct from the mother -- from the mother's. Yeah.

Q Great. Thank you. So let's talk specifically about the heart a little bit more since that's an issue in one of the laws that's being challenged here.
So specifically in that law, which is KRS 311 and the definitions are in .7701, fetal heartbeat, and again, I'll read it for you, is defined as, "Cardiac activity, or the steady and repetitive rhythmic contraction of the fetal heart within the gestational sac." So would you just tell us whether that definition is consistent with what you and the medical community mean when you say "heartbeat"?

A I think it's a good -- it's a good lay

definition. Because cardiac activity and heartbeat are two different things. As I was saying, the valves -- heart valves are really not really -- I'm not -- redundant, sorry about that. Are not fully developed, or beginning to be developed rather, until between eight and ten weeks. And when we use the fetal Doppler, you know, that's the microphone we put on a mom's tummy to hear the whoosh-whoosh-whoosh sound (sound effect). That's really detecting -- depending on how you're listening, it can be detecting the sound of the valves as they're opening and closing. But if you listen in other parts, it's -- it's placental blood flow. But when you're looking on ultrasound, one reason that you can see fetal cardiac activity early, is because as the cardiomyocytes contract, as they're undergoing with rhythm -- rhythmic contraction, you can see it as a twinkle in -- on an ultrasound.

Q Okay. Now, if -- you kind of started to tell us some of the methods of looking, or --

A Well --

Q -- detecting a heartbeat. And no, that's fine. So would you just mind expanding a bit on that, and explaining what are the common methods that are used for detecting a -- an unborn child's heartbeat?

A Sure. So typically transvaginal ultrasound

and transabdominal ultrasound are two of the methods that are used. Transvaginal ultrasound, because the probe is right up against the uterus, allows you to see very, very early. Often as early as five weeks when you can -- can see that twinkle. And whereas with transabdominal ultrasound, there's some technical limitations because of the mother's tissue, because -- if she's heavier, it may be more difficult. Tissue characteristics actually vary. There's a lot of discussion of this in the radiology literature, that tissue characteristics vary from one woman to another, as you can imagine. And then the fetal Doppler, which is what most women hear when they go into the doctor's office and get really excited about hearing is a microphone that really, as I said, can start picking up around eight to ten weeks. The caveat is that, again, because of the differences between different women -- and the radiology literature, as I've said, spends a lot of time talking about this. It's possible to not be able to detect a fetal heartbeat even until later on in gestation because of technical limitations, as well as the skill of the operator.

Q Okay. And why is it important for doctors to monitor and check the baby's heartbeat?

A Because the presence of a fetal heartbeat at

eight weeks is associated with approximately ten percent pregnancy loss rate over the rest of the pregnancy, whereas at ten weeks it's a three percent pregnancy loss rate. I think from the woman's perspective, from the patient's perspective, it's very reassuring to her to hear the -- or see the baby's heartbeat. And I will tell you from scanning literally thousands of women, it's a magical moment for a lot of women to see their baby's heartbeat for the first time.

Q Okay. So what I hear you saying, too, is that by monitoring the baby's heartbeat, you have an indicator of whether that child will live to term --

A Yes.

Q -- as well.

A And also if you do see a slow heartbeat, that's cause for concern. Some fetuses do have slower heartbeats, but there are gestational age thresholds below which if you see abnormalities, you get concerned that something's wrong and you want to investigate further.

Q Okay. We'll probably discuss that a little bit more when we talk about risks, but just as a -- before we get there, are you familiar with the Miller study that was discussed earlier by Professor Lindo? And then there's the Turnaway Study that's referenced in

that Miller study. Are you familiar with that?

A I'm only peripherally familiar with the Miller study. I am fairly familiar with the Turnaway studies as a series.

Q Okay. And have you looked at those studies enough that you could give an opinion as to whether you consider them to be reliable?

A I think that they're -- they not just by myself, but they've been widely critiqued in the literature. I think Priscilla Coleman this year, 2022, wrote a very detailed critique of the studies. I think the studies were extremely well designed, but one of the problems is that by the time they got to the end of their ascertainment period -- and this is a problem with all surveys. That's why surveys in a sense are some of the weaker forms of data. We have to -- they give us information we can't get any other way. But the problem is that the loss to follow-up rate in the study is very high. And so if you go through and calculate numbers for at least some of the outcomes they were studying, the response rate was only 17 percent. So it's very difficult with a sample size like that, even if you start with a fairly large number of patients, which they did, it's very difficult to make generalizable conclusions. And again, it -- this is -- this is a

difficult problem with surveys, especially one being conducted over five years. And I will add that it's also difficult because I find for many women it's difficult to talk about their abortions.

Q Okay. So let's transition a bit and let's talk about some of the risks during pregnancy and abortion. So Ms. Bergin spoke earlier in her testimony about some of the risks that come up during pregnancy. And we noted in your background that you've done some research on health risks that arise during pregnancy like pre-eclampsia, et cetera. So based on your clinical experience and the research that you've done, would you agree with her assessment of the risks that are there during pregnancy?

A I think that we can look at actual numbers. So for example, I think Dr. Begin mentioned blood clots in pregnancy. Those occur in 0.05 percent to 0.3 percent of pregnancies. Gestational diabetes occurs in about seven percent of pregnancy. Hypertension pregnancy, about 0.3 percent to three percent of pregnancies. Abruption, postpartum cardiomyopathy is somewhere in the range of one in -- I think it's -- no, I'm sorry. It's four per 10,000. So these risks are very significant because we value the life of the mom and we value the life of the child. And it's very

interesting because if you look at -- I was looking at a paper not long ago from 1951. Since earlier in the -- in the 20th century, there's been a 99 percent reduction in maternal mortality. And so it's important to keep in mind that mortality in a mom -- when a mom dies, it is a tragedy. It's a tragedy for families, it's a tragedy for community. But these are still relatively rare outcomes. And many of these other issues in pregnancy are not only relatively uncommon, but they're often treatable.

Q Is there also some risk of there being an overstated risk of pregnancy due to reporting inaccuracies or just under-reporting of both maternal mortality as well as abortion?

A Sure. So for maternal mortality, I think we have come a long way, even since I've been in medicine. I think that there are numerous problems. One is that, how do you define maternal mortality? Do you define it as a woman died as a result of a pregnancy complication or she died and she was pregnant? Those are two very, very different issues. And depending on how you define it, you may or may not include problems like homicide. Many collections -- data collections on maternal mortality don't include homicide. They don't do -- include trauma. They don't include car accidents.

They don't include drug overdoses. I think the second problem is that the best -- only about the last I heard -- let me just back up for a second. So the gold standard for ascertaining maternal mortality is to collect data and then have a state level group of obstetricians and epidemiologists review every case. Those are called maternal mortality review committees. But unfortunately, not every state uses those. And a third problem or a fourth problem is that when the -- when you sign a death certificate for maternal mortality, the check boxes vary from state to state. So what you -- the way you can ascertain what caused the death varies. For example, you can say, "This patient died as a result of stroke as a result of hypertension as a result of pre-eclampsia associated with pregnancy." But another state may have a totally different way of categorizing that. So when it comes time to actually collect those statistics, it's very difficult. So the -- one of the questions that has come up, I think, over the last five years is recently, there's a question as to whether maternal mortality to actually increase dramatically or whether it was due to better ascertainment. It seems as though in some jurisdictions or some states, there is under-reporting. In general, maternal mortality is going to be under-reported because

if a woman dies in a car crash and no one decides to do a post-mortem, you won't know that she was pregnant. From another perspective, it's slightly -- because different pregnancy outcomes -- for example, pregnancy related mortality can bundle in death from abortion, as well as death from childbirth, and whether she had a live birth or not. This makes it very complicated. I think that the abortion reporting statistics are uniformly, even admittedly by CDC, very problematic. Even to this day, four states don't report. California doesn't report, New Hampshire doesn't, New Jersey, and Washington D.C. don't report any of their statistics. The other problem is that -- and for that reason, when CDC reports their mortality statistics, they say, "You cannot use these." You can read it in their discussion. They say, "You cannot use these statistics to make decisions or make conclusions about abortion-related mortality." I also think that abortion-related mortality is under-reported because some women won't disclose that they've had an abortion. They come in septic. And I've had women come in very septic after an abortion and had to take care of them. There's injury to the bowel, there's injury the other organs. And if the woman says, "Well, I had a miscarriage," then it's very difficult to ascertain

that. So I think abortion reporting statistics are inherently very limited. Alan Guttmacher does maintain their survey of abortion providers. But my understanding from Brian Calhoun's paper, which I think was cited earlier, is that under oath, they said that CDC's statistics are the ones that we should rely on. But then CDC says their own statistics are not entirely reliable.

Q Okay.

A Did that answer your question?

Q Yes. Yes. That was very helpful. Thank you. And so when we talk about risks during pregnancy, are there comparable risks that exist during abortion? We've heard a little bit of discussion about that already. But so if you wouldn't mind just talking about the risks to the woman that are present during an abortion as well, and kind of how that changes over time in comparison with pregnancy over time.

A Sure. So I think that one problem on -- and the statistics that is frequently cited is that the abortion mortality rate is 0.7. I don't think that's an accurate statistic. It doesn't accurately reflect the real question, which is: Is the mortality rate from either from abortion the same as the mortality rate from a miscarriage going by gestational week or trimester,

however you want to slice it up? Is it the same? And it's not. We know that at earlier gestational ages, the risk of miscarriage is slightly lower or the same as the risk of -- do you understand why I'm making a comparison?

Q Yes.

A You can't compare a pregnancy at eight weeks where the baby is a couple of centimeters long versus a pregnancy at term where the baby is six to eight pounds or larger, where there's tremendous blood flow, where the placenta is large. You can't say that an abortion done at that age is the same as childbirth done at that age. And so if you look at abortion and spontaneous -- induced abortion and spontaneous abortion, which is miscarriage, you find that pretty much at all gestational ages spontaneous abortion is slightly less risky or has similar risk. And this was shown in a study by Barrett and her colleagues. I believe it was from 2007 where they looked at several years, I think decades of abortion mortality. What they found was that for each week of gestation, the risk of death -- not the risk of injury, but the risk of death increased by 38 percent. And that for greater than 21 weeks, gestations at greater than 21 weeks, the risk compared to the risk in the first trimester was 76

times. And that's for mortality. That's not -- that's not for morbidity. If you extrapolate her model out to getting closer and closer to term, by the time you get to about 25 weeks, you have already greatly exceeded maternal mortality rates. So I don't think that you can say that abortion is safer than childbirth when comparatively doing an abortion at a later gestational age, we've heard, is more risky. There is solid evidence to back that up. You can't say that doing an abortion at 32 weeks, 28 weeks, 32 weeks or later is safer than giving birth.

Q Okay, thank you. Let's go back to talking a little bit about the risks during pregnancy, because I want to specifically talk about -- and since you've done some research on this, how does race impact the risks during pregnancy?

A So it's very significant. Excuse me. For both abortion and for childbirth, Black women have -- for abortion black women have three times the mortality rate for White women. For childbirth, it varies and -- typically two and a half to three times. Now, what's very interesting about that statistic is that if you look at younger age -- not younger gestational ages, but younger women, that difference is about 1.5. Once you get up into women who are in their 30s and 40s and

giving birth, that difference is much higher. It's about 4.8. So what that is saying is that a lot of the risk -- the risk differential is concentrated in older women. And that brings me to the essential, you know, why is it that Black women have more -- have higher rates of mortality? The -- a lot of the thinking when you sit down and review these data is that it's underlying cardiovascular risk factors. We know that Black women are higher risk for hypertension, coronary artery disease. And what it looks like is that that process starts earlier in Black women. I will say from a clinical experience in the Caribbean, majority Black nations in west Africa, majority Black nations other parts of Sub-Saharan Africa, that is also true. Rates of pre-eclampsia, hypertension were astronomically higher in these -- in these parts of the world. And it's because of these undiagnosed risk factors. What's also interesting is that if you look at causes of mortality, they vary very significantly. For example, among American Indian women, I remember it was not -- it was very routine to have terrible hemorrhage postpartum. And -- but that's less true -- that's -- it's less of a cause of death among Black and White women. Black women are more likely to die from cardiomyopathy and venous thromboembolism, but less likely to die from stroke.

So there's some significant differences here, I think, based on genetics and vascular biology that I think don't allow you to lump things together. And that lead to us -- lead us to understand that the real key to addressing all of this is prevention. When people have looked at preventability -- because there's something called preventability index. And what the preventability index does, is it enables you to look at what factors could have been controlled. And again, that's why these maternal review committees where people sit and look at charts, and they -- and they look at everything that happened and who said what, and who did what, preventability index helps you to assess was this a preventable bad outcome? And what they find is the preventability index is not that different between Black and White women. Now, preventability, only about 60 percent of maternal mortality is considered to be preventable. It's the non-preventable that we need to devote the most research effort and others. And I think that some of the research that has been -- Peterson has done a couple of really excellent papers on -- over the past couple of years, actually one in 2021 and one in 2020, looking at racial disparities. And there are community level factors such as transportation and stable housing would also contribute as well. I'm

sorry. I went on a little bit of a tangent.

Q No, no, that's perfectly fine. I'm going to circle back to a couple things you said. So you, at one point, mentioned that for Black women, it seems to be heart issues or cardio issues. And then I think you mentioned stroke. But is that for the White population?

A White women seem to be more -- stroke seems to be a much more significant cause of mortality. There are statistically significant differences between mortality from stroke in Black or White women, with White women having higher risk.

Q Okay. And so -- and when you were talking about the risks that occur for mortality during pregnancy, I believe you said it was for Black women for pregnancy, it's two and a half to three times more -- they're more likely than their White counterparts to die.

A Again, depending on the age group.

Q Depending on the age group. And then you said for abortion, though, Black women are four times more likely to die. Is that correct?

A It's three to four times. And again, that breaks down to a couple of statistics. Partly that's because Black women not only have the highest rates of abortion, but they tend to have higher rates of abortion

in the second trimester where the procedure is riskier. So I think that contributes to the mortality difference. But even if you look back at origin data from the 1970s, there -- this has been the major difference -- major racial disparity in abortion has been in mortality. And in fact, Bartlett -- and that's -- did I say Barrett? It's Bartlett.

Q Bartlett.

A May I correct myself? It's Bartlett. In her study said that after gestational age, race is the biggest predictor of mortality from abortion.

Q Okay. That's good. Now, on Ms. Bergin's direct, they mentioned a National Academies -- (coughs) excuse me -- a National Academies study that was called "The Safety and Quality of Current Abortion Methods," and introduced it into -- as an exhibit. Are you familiar with this study as well?

A Yes.

Q Okay. And are you familiar with the assertion that it makes, as it's one of the propositions that abortion is safer than childbirth? Are you familiar with that assertion?

A Yes.

Q Okay. In your opinion, based on your clinical experience as well as your research, including the

literature reviews that you've done, is there reliable, scientific evidence for that assertion?

A I don't think so, based on what I was just saying. I think that you have to look at -- if you're going to be honest about that comparison, you have to look at abortion at each gestational period, in which case it's clearly -- it's not. I think that the other way to look at it, and as I've seen in the literature, is that by doing an abortion, you somehow prevent, you know, that woman from having gone into pregnancy. Risk is a population attribute. Risk is not in -- we can -- we can calculate individual risk. But a risk and a probability are two -- and a likelihood are two entirely different things. We can say if you have hypertension, high blood pressure prior to pregnancy, you have a greater risk of going on to develop -- developing pre- eclampsia. We can't tell which pre-eclamptic woman is going to die and which is not. So it's not possible to say that if you do an abortion you're going to prevent that woman from having some kind of a life threatening complication, because you can't predict who is and who's not. You can assess risk. You can say there's a higher or lower likelihood that this woman might undergo that. Does that answer the question?

Q Yes. Yes. That's very --

A And then the other piece that I think comes in here is that, again, Black women have the highest rates of abortion, highest rates of maternal mortality. How do you reconcile those two facts?

Q Yes.

A Yeah.

Q Let's talk about that a little more, then. So if a woman would come into you when you're doing your clinical work and she is concerned about potential risks during her pregnancy, you know, what is your professional advice? Or how should the medical community handle a woman who's concerned about risks appearing during pregnancy?

A So I think there's two windows of opportunities. And again, risk -- as I said, there's different ways to look at risk apart from the statistical and epidemiologic way of looking at it. Risk is a very individual thing. You know, what I consider to be -- I may have -- be very risk averse. And I may say, "Well, such and such is not a risk that I want to do." But I think that for optimal care of both the mother and the baby, we would want to see women preconceptually. And would want -- would want to assess, do you have cardiovascular factors? Do you have

diabetes? Gestational diabetes is -- and many diabetologists really consider it to be what's called a forme fruste. It's just a form of diabetes that manifests in pregnancy, but the woman already had probably subclinical diabetes. So you would want to be able to assess them. Barring that, because it's hard to get healthy women who are not pregnant -- you know, very busy -- so they don't necessarily come in for care. You try to make an assessment as early on in pregnancy as you can, of what these lady's potential risk factors are. And then you treat appropriately. For example, when I was working on the reservation, typically we screen for gestational diabetes, you know, getting towards 18 to 20 weeks. Because their risk is so high, we would screen them very early. We'd screen them about 12 to 14 weeks in a very culturally sensitive way. We'd have them come and sit -- sit and eat a traditional breakfast at a certain number of calories, and then check their blood sugar. So these are the types of things you do to minimize maternal and fetal risk, is -- is with good care. Is that helpful?

Q Yeah. That's very helpful. Yes. Yes. And so if they would present pre-eclampsia or something like that, what is your -- you know, what's your path of taking care? Since you -- you've said that they're both

your patient. So if they come with one of these, you know, that has a high mortality rate or could potentially result in mortality or morbidity, you know, what are your steps as a medical professional?

A Well, I would say a lot of these gray hairs are from pre-eclampsia, I have to say. I think pre-eclampsia is -- is a real problem, because having been deeply immersed in research and potentially going back to it -- it comes from the Greek root is eclampsia, which means lightning. Because you do have women who have hypertension go on to develop pre-eclampsia. But much more often, you just don't see it coming. And women are perfectly healthy, doing fine, come in, and have sky-high blood pressures, renal failure, starting to get liver involvement. In those situations, especially pre-term, what you're faced with is taking care of both the mother and the baby. And so what you'll try to do is temporize a little bit, get her blood pressure under control, make sure that she's not going into renal failure. But you will do what obstetricians have been doing, really, for -- for decades, which is to do the best thing. And if she -- if her condition appears to be deteriorating, you're going to go ahead and do a delivery even if the baby is not viable or is peri-viable. And in those

circumstances, the differences between that, and I think this is an important -- it's an important question of terminology. You are going to do that delivery in such a way that it does not destroy or injure the fetus. And that's distinct. That's -- I would call that a termination of pregnancy, which is distinct from an abortion, whose goal is to kill the baby. And we know that because when you have a live birth after an abortion procedure, that's a failed abortion. So the goal of an abortion is to kill -- is to kill the fetus. The goal of terminations of pregnancy -- and, you know, people may disagree with me on terminology, and that's fine. But intent is -- matters very much here. And obstetricians will do what we have always done, which is the best thing for the mother. Sometimes, that results in a poor outcome for the baby. But we have to try to optimize things. Again, that's the art and science of obstetrics, is that you have two patients.

Q Right. And if it is possible to save the baby, there can be steps like we talked about with the in-utero surgeries and that type of thing. So is that part of the consideration of -- of how you might treat a patient or might treat a woman if she's presenting with risks, you know, if you could -- if you know that you can potentially undergo some of these new surgeries

and -- or care that might be available at a later gestation?

A So if I'm understanding what you're saying, you're saying is that -- let's say, again, the pre-eclamptic woman who is at, say, 28 weeks or 26 weeks or 24 weeks?

Q Right.

A What would be the -- what would you do?

Q Uh-huh.

A So again, your initial idea would be to stabilize her, hydrate her, control her blood pressure, assess fetal status. If she's getting sicker, and I've been in this situation hundreds of times, then you would deliver her. If your hospital is not equipped to have a -- doesn't have a NICU, can't get surfactant for the baby's lungs, I have called helicopters and planes and ambulances plenty of times to do that. And -- and then you try to get them to a center that can provide appropriate care for that baby. Sometimes, you have to do a delivery then and there and do the best you can with what you have. And I've been in that situation, too.

Q Okay. And just as, like, a final thing, because you didn't submit any written documentation for this. So when you were preparing, were there any

conclusions that you made that you feel we haven't already discussed or ones that you would like to reiterate that we have discussed?

A I do think that it's important to, you know, express my opinion, which is that abortion is not healthcare. Healthcare is defined as procedures and care that palliate, prevent, or treat a disease. And abortion does none of those things. It's a procedure that has the intent to destroy a human being. The fact that the -- the embryo and the fetus is a human being is clear, because the -- as we discussed, we all started that way. That's where we all came from. And I think that, just to come back to something that you mentioned earlier, which was life beginning at conception, fertilization, conception -- and there are shades of difference there. Steve Jacobs, who is a -- at the University of Chicago did a study -- did a survey of 5,500 biologists. And 96 percent of them -- and about half of -- half of them were pro-choice -- 96 percent of them agreed that life begins at conception. And so I think that there's -- the embryology books that I studied in medical school, that was the -- the consensus, as well.

Q Thank you.

A Okay.

MS. KEISER: Your Honor, I'm just going to confer for a second. Okay. All right, then. I'm ready to pass the witness.

JUDGE PERRY: All right. Cross?

CROSS EXAMINATION

BY MS. AMIRI:

Q Okay. Good afternoon.

A Yes.

Q Dr. Wubbenhorst? Am I pronouncing that correctly?

A Yes. Yes. Good afternoon.

Q Hi. I'm Brigitte Amiri. I'm one of the attorneys for the plaintiffs. Nice to meet you today.

A Nice to meet you, as well.

Q When were you contacted by the Attorney General to participate in this case?

A Oh. It was last week, but I cannot tell you the exact day.

Q Okay. And what, specifically, did they ask you to testify about today?

A They asked me to provide expert testimony regarding the -- the two bills.

Q And what expertise did they ask you to lend?

A My obstetrics and gynecology expertise.

Q In the course of preparing for this hearing,

you mentioned a few things that you reviewed, the statutes that we're challenging, the complaint in this case. Anything else that you reviewed? Oh, I think you said some studies. Anything else that you reviewed in preparation for today's hearing that you haven't already discussed?

A I reviewed some professional guidelines. And I looked at some previous presentations that I had done.

Q What professional guidelines did you look at?

A ACOG's guidelines, and also -- I think that was it. Just ACOG's.

Q So ACOG has a number of different bulletins. For example, were there specific bulletins, the Practice Bulletins, or something along those lines that you were looking at?

A Yes.

Q And which were they?

A I think I looked at their Bulletin on Gestational Diabetes. I couldn't tell you the exact ones, because I -- I look at them all the time.

Q So you frequently reference ACOG's materials in the course of your work?

A I don't reference it. But in different situations, I will look at their guidelines.

Q So do you consider ACOG a reliable source of information?

A Not always.

Q In the context of the things that you've relied on, though, you do?

A On -- in specific issues, yes.

Q Did you speak to anyone besides the Attorney General's Office in preparation for your testimony today?

A No.

Q Didn't speak with Mr. Snead, who's going to testify later today?

A No. I -- he gave me a ride down here.

Q You didn't speak about your testimony?

A No.

Q Have you looked at the abortion-related mortality or pregnancy-related rates specific to Kentucky?

A No, I have not.

Q Have you looked at the abortion-related complication rates specific to Kentucky?

A No.

Q Have you looked to the way in which Kentucky requires reporting for abortion writ large in Kentucky?

A I looked at the -- I looked very briefly at

the guidelines for reporting, yes.

Q Okay. And did you form an opinion as to those, as to the guidelines for reporting?

A No. They're similar to other states.

Q So before when you were talking about the other states, four states don't require reporting at all. Kentucky's not one of them, correct?

A That's correct.

Q Correct, Kentucky does require a fair amount of reporting in terms of complication, demographic information, age of gestation, age of patient. Does that sound right to you?

A Uh-huh. I'm sorry. Yes.

Q Yes? Okay. If you could look at Exhibit 3 that's in a pile there, please? Should be the Kentucky Vital Statistics?

A Uh-huh.

Q Do you have any reason to believe that these specific statistics are unreliable?

A I haven't had a chance to review them, so I can't say one way or another.

MS. AMIRI: Permission to approach, Your Honor?

JUDGE PERRY: Yes.

MS. AMIRI: Marked Exhibit 10. Sorry. Only have one of these.

MR. MADDOX: Thank you.
MS. AMIRI: I'm sorry.
MS. KEISER: Thank you.
BY MS. AMIRI:
Q This is a Report from this -- the Commonwealth of Kentucky about maternal mortality in Kentucky. Have you reviewed this Report?
A No.
Q So you don't have any reason to believe that the statistics and discussion in this Report are true or not true?
A I can't say one way or the other.
MS. AMIRI: Okay. I'd like to move Exhibit 10 into evidence, Your Honor.
MS. KEISER: No objection.
JUDGE PERRY: So admitted.
(PLAINTIFF'S EXHIBIT 10 ADMITTED INTO EVIDENCE)
BY MS. AMIRI:
Q You're not a social scientist, correct?
A Ma'am?
Q You're not a social scientist?
A No, I am not.
Q You're a medical doctor?
A And researcher, yes.

Q Okay. Research in -- but you -- the research that you do is medical research?

A It's medical research, but I do quite a lot that overlaps with social science research. Plus, I work with social scientists.

Q But you yourself are not a social scientist?

A No.

Q You had mentioned something about the difficulty of women talking about their abortions. In what context are you speaking to women about their abortions?

A Well, over the course of my career, I've taken care of probably tens of thousands of women. And a routine question that we ask women is -- in terms of their reproductive history -- is have you ever had an abortion? That has important implications in a variety of ways. And I find that to a woman -- every woman that I've ever asked that question, there have been a lot of them, most of them have regret. Most of them have pain. And so that's the context. I'm speaking out of my own experience, as well as data in the field that shows that women have difficulty disclosing their abortions.

Q What data do you rely on for that?

A I don't rely on any data. I'm just talking about having seen studies in the social science

literature that talk about women's feeling -- and there's a lot of data out there discussing how women feel a range of emotions. But one of them -- one of the consistent themes that emerges is that they have difficulty discussing their abortions.

Q But you're not citing a specific study at this present moment?

A No.

Q I see on your CV that you list your association with the American Association of Pro-Life Obstetricians and Gynecologists; Is that correct?

A Yes.

Q The organization is opposed to abortion?

A I think that the organization would not characterize itself that well -- that way. I think that the organization puts forth the premise that in obstetrics, we have two patients, that we want to adhere to Hippocratic medicine tradition.

Q Well, let me read the mission statement to you. It's "To inform and enable the public to better understand the medical and biological fact that life begins at fertilization, and that the willful destruction of innocent human lives have no place in the practice of medicine."

A That is correct. But I don't think in that

statement they've said, "We oppose abortion."

Q That is an accurate statement of their mission, though?

A Yes.

Q Okay. I also see that you're a board member of Americans United for Life, correct?

A Yes.

Q And you've been on that board for about a decade?

A No. I was on. I rotated off. I rotated on again.

Q So what is the status of now? Are you on that board or not?

A Uh-huh. I just rejoined.

Q Okay. You're personally opposed to abortion, correct?

A Yes.

Q You believe that all, "elective abortion should be illegal in all cases"?

A Yes.

Q Do you support abortion in the context of a fatal fetal anomaly?

A No.

Q Rape?

A Are we talking -- oh, I'm sorry. Rape? No.

Q Incest?

A No. And if I can elaborate on that point -- will you allow me to elaborate on that point?

Q Sure.

A I got some very interesting insight into the question of incest, having taken care of patients who have been raped and impregnated by their fathers. And one patient in particular was pushed by her father to have an abortion, and she declined to do so. So in caring for her, I said, you know, "What was your thought process? You could have had an abortion." She said, "There were two reasons I chose not to have an abortion. The first was that by having an abortion, there would be no evidence that he did it. And he consistently refused to admit that he did it." The second thing that she said, which was really quite amazing to me, was that this baby is the best thing that came out of years of abuse and rape.

Q That's an individual's decision to make, though, correct?

A Excuse me?

Q That individual made the decision to carry her pregnancy to term. She was able to make that decision, correct?

A Yes.

Q If an abortion is banned in the case of rape or incest, an individual who's pregnant as a result of those circumstances cannot make that individual's -- individual decision to terminate her pregnancy?

A That's correct.

Q Have you read the exceptions in the statutes here?

A Yes.

Q Life endangerment?

A Yes.

Q So do you support an exception for an abortion ban in the case of life endangerment?

A As I said earlier, I think that terminology and intent are very important in any discussion about life endangerment. The issue at hand is what is the intent of -- of that termination of pregnancy? If the intent of that termination of pregnancy is to kill the fetus, which is the definition of abortion, then that's -- then I'm opposed to that. If the intent is to potentially deliver a fetus who may not be viable or may not survive, but in a way that does not necessarily result in its death, then I think that's the acceptable alternative.

Q If a fetus is delivered before viability, it will inevitably die, though, correct?

A It depends. Viability -- the pediatricians are pushing viability further and further. When I first started in medicine, viability was 29 weeks. Now, it's 22 weeks. And they're still pushing it.

Q Regardless of the debate about viability, though, if a fetus is born before the point at which it can live outside of the womb, it will inevitably die, correct?

A That's not the point. I think the point is that --

Q But --

A -- if we say -- if we say viability, and viability changes, then what we've done is to say -- we've set some gestational age, arbitrary gestational age limit. And I don't think that's what we want to do.

Q I'm going to ask the question again. And, Your Honor, if I need an instruction, I'd appreciate one. If a fetus is delivered before the point of viability and has no ability to survive outside the womb, the fetus will inevitably die, correct?

A That's correct.

Q Okay. Thank you. So you talk about the difference between termination of pregnancy and abortion. What is your understanding of what the bans

challenged here do? Let's just focus on the trigger ban. Is it your understanding that in the circumstance that you're talking about, that a doctor could still deliver in a situation where the fetus will inevitably die, and that would not be considered an abortion under the trigger ban?

A That's correct, because it's -- it's intent. An abortion by definition is a procedure that does not result in a live birth. That's a -- that's a WHO and CDC definition.

Q So at any gestational age before the ability of the -- the fetus to live outside the womb, a doctor could induce pre-labor before term, and that would not be considered an abortion under the statute?

A What's the indication?

Q I'm just -- I'm not talking about indications yet. I'm just talking about whether that's even included under the definition in general of the trigger statute.

A But the trigger statute relies on -- on an indication for -- are you talking about ending the pregnancy for the life of the mother?

Q No. No. I'm sorry. Perhaps this is the confusion. I'm just talking generally, like, starting with the ban itself. So let me just read you the

trigger ban statute. It says, "No person may knowingly administer to, prescribe for, procure for, or sell to any pregnant woman any medicine, drug, or other substance with the specific intent of causing or abating the termination of the life of an unborn human being, or use or employ any instrument or procedure upon a pregnant woman with the specific intent of causing or abating the termination of the life of an unborn human being." So starting with that definition, is inducing labor before viability an abortion under that definition in your mind?

A No. It's -- again, I think intent is everything. What is the intent of the medical intervention? The law can only provide -- in my opinion. In my opinion. I'm not a lawyer. But as I understand it, the interaction between law and medical practice, the law can only provide guidelines. Clinicians make an individual judgment about if a -- if a -- now, are we talking about before current standards of viability? Or after current standards of viability?

Q I'm talking about before viability, before the ability of the fetus to live outside the womb.

A Okay. So again, what would the indication be for an induction of labor?

Q Well, I think that those are two different

questions. My first question is just whether induction of labor would fit within -- pre-viability, would fit within this definition?

A In other words, do -- I'm -- I'm just trying to understand it because I'm not a lawyer.

Q Yeah.

A In other words, if you -- if I as a clinician was inducing labor, would I be running afoul of the ban?

Q Correct.

A Again, it -- it has to do with intent. If I am inducing labor as to effect an abortion, then that's clearly in violation of the ban. Maybe I'm not understanding what you're saying.

Q I think maybe we're also using different terminology. So maybe we'll move to the exceptions. So let's assume that the Attorney General takes the position that induction of labor pre-viability is an abortion under the trigger ban. But there are exceptions to save the life of the woman or for --

MS. KEISER: Your Honor, I'll just -- could we potentially get the -- a copy of the statute in front of her --

MS. AMIRI: Sure.

MS. KEISER: -- so she has a chance to look at again if you're going to --

MS. AMIRI: Absolutely.

THE WITNESS: Yeah. That would be really helpful. Thank you. So which section are you --

BY MS. AMIRI:

Q So it's -- this is -- Section 3 is the broad ban part of it. That's what I just read to you, 3A1 and 2?

A Right.

Q But I was going to move on from there, assuming that the Attorney General takes the position that induction of labor pre-viability is an abortion under this Section 3, but that there are exceptions further down in Section 4. And so to draw your attention to those in terms of those exceptions and the -- whether you agree with an exception for an abortion ban for -- to prevent the death or the substantial risk of death due to a physical condition or to prevent the serious permanent impairment of a life-sustaining organ of a pregnant woman?

A I'm sorry, what's the exact question? Do I agree with that?

Q Oh. Would you agree that those exceptions should be permitted --

A Yes.

Q -- for an abortion ban?

A Yes.

Q Okay. In terms of the substantial impairment of a major bodily function or major organ system, have you seen circumstances in your clinical practice where a patient has become so sick that you think that she might meet that definition?

A Yes.

Q And can you talk about some of those circumstances?

A I would say the major ones are complications of pregnancy, such as pre-eclampsia with uncontrollable blood pressure or multi-working involvement or infection. I think those would be two out of a long list of those.

Q You've never performed an abortion yourself, correct?

A No, I have cared for women in the process of an abortion, but I've never performed one.

Q I'm sorry, I just didn't hear that.

A I've cared for women in the process of an abortion, but I have never performed one.

Q And you've never supervised residents in your -- performing abortion in your career?

A No.

Q Abortion is not the focus of your research,

correct?

A Actually it is one of the foci of my research.

Q It's not the primary focus, correct?

A No, but --

Q How many articles have you written on abortion?

A One, looking at the association between abortion legislation and maternal mortality.

Q You mentioned the Turnaway Study earlier. If I heard you correctly, I believe you said that it was not a reliable study in your opinion because the participation rate decreased to 15 percent. Did I hear that correctly?

A No, I don't think I said that it's not a reliable study. I think I said -- and if I did, then that was an error. I think that what I said or meant to say was that there's significant statistical and other issues with the study, which are very well-described in Dr. Coleman's paper from this year.

Q Did I hear you correctly, though, about the return rate was about 15 percent at the conclusion of the study. Is that what you had said?

A I think that to be a little bit more nuanced with that, when you look at specific outcomes that they were interested in measuring in the study, and you

calculate the number of patients over the five years that you come to number, you come to a realization that about 17 percent of the -- of patients remained in the study through to the end of the study, for specific outcomes that they were looking at. And again, I -- I would -- I would direct you to her critique because it's excellent and very comprehensive.

Q All right. Well, her critique is not in evidence, but one of the studies about the Turnaway Study is if you could turn to Exhibit 5, please, that should be in the stack in front of you.

A I don't see --

Q Oh, sorry. It's in the binder. Can I approach, Your Honor? It's in the binder -- it's in the binder. I'll give you a minute to take a look, but I want to draw your attention specifically to the concluding paragraph that begins with, "Finally and specifically" -- towards the end of the paragraph, about the end of the five-year study period and the percent response rate.

A Yeah. I have not reviewed this study, so I am not comfortable making any assessments of it. Typically when I review a study at this level, I look at the statistical methods, I look at the sample size, I look at what the particular outcomes were, the sample

population, and I -- I -- I'm not able to do that right now.

Q I understand that, but you testified that there were 17 percent respondents left at the end of the five-year study, at the Turnaway Study, and I'm drawing your attention to the paragraph here, where it says that at the end of the five-year study, about 58 percent response was left.

A Well, again, I have not looked at this. I cannot because the way that I arrived at that particular number was to go through the paper and to calculate. And again, it was for different outcomes. So I'm not saying that for every iteration of the Turnaway Study, that was what they ended up with. So I really can't comment on this paper.

Q You talked a little bit about the National Academies Study, which is Exhibit 2, I believe, on the pile.

A Yes, I have it.

Q Draw your attention to page 39. You testified about the death rate for abortion later in gestation. Here it says that the -- "After 17 weeks, the rate was 6.7 per 100,000." Do you disagree with that statistic?

A I'm sorry, which page? And which paragraph?

Q Page 39. It's the last full paragraph. The

paragraph starts with, "The researchers found" -- the paragraphs are at the bottom. I'm sorry, I just want to make sure I have the right exhibit -- Exhibit 2?

A Right here?

Q Yeah.

MS. KEISER: I'm sorry. Can you tell us which --

MS. AMIRI: It's the National Academies Study. It's not in the binder. It's the --

MS. KEISER: The one you gave out, the first one.

MS. AMIRI: -- the first one. I -- or second one. He's with Dr. Bergin. Yeah.

MS. KEISER: Okay. Okay.

A Yes, what's the question?

BY MS. AMIRI:

Q The question is the statistic about 17 -- as after 17 weeks, the rate of death for an abortion was 6.7 per 100,000. Do you disagree with that statistic?

A I think I do disagree with it because I'm relatively familiar with Zane's study. I looked at it not long ago, and if I recall correctly -- and I can't -- I can't really go very far with this -- the -- I'm trying to remember this study, and I just don't -- that they did not -- I'd have to have the study

in front of me.

Q Okay. Earlier, when you ticked off some statistics about risks during pregnancy for blood clots, for other -- I think it was, cardiomyopathy -- where did those statistics come from?

A Some of them came from ACOG's practice guidelines. Some came from research studies.

Q Do you remember the title of the research studies?

A No, I'd be happy to dig them up for you, but I've looked at a variety of different data sources to try to get consensus on what the relative risks were of these outcomes of pregnancy.

Q Earlier, we were talking about risk and the risk assessment that doctors make in terms of their patients when there is a condition that develops, especially in your case, during pregnancy. Who makes the risk assessment about whether to continue with the pregnancy or to terminate the pregnancy, ultimately?

A So can you clarify? Do you mean a patient who is admitted sick to hospital? Is that what you're referring to?

Q Yes, I am asking the question of if a patient is facing risks in her pregnancy, and she has the decision to carry that pregnancy further and assume

those risks, or to terminate the pregnancy to avoid the risks, who makes that decision?

A I don't think that clinicians make a decision to terminate a pregnancy just based on risk. I think that, again, getting back to what I was saying, when we make a decision to terminate a pregnancy, it's because a patient is ill for some reason. I don't think that -- I think that we would look at, for example, in a patient who has a very serious -- I'm just trying to think of, like, pulmonary hypertension is very good example. You know, there's a 50 percent mortality risk associated with that. I think that in that situation, the -- if a woman is becoming ill, then a decision is made that she -- that you would terminate that pregnancy in order to save her life. I'm not sure if that's what you're asking.

Q Well, some women may decide to assume the risks associated with the pregnancy, and some may decide that the risks are too much, and she would like to terminate the pregnancy. And so my question is have you seen -- we'll take it in pieces -- have you seen situations where patients, even though there is great risk to their life or health, they have decided to continue a pregnancy and assume those risks?

A I would say that's the majority of cases that

I'm seeing. And again, I want to emphasize there's a difference between an abortion and termination of pregnancy when a woman is ill to save her life.

Q I understand that, but I'm just focusing in general on the risk assessment that's made and who gets to make that decision. If an abortion is banned in Kentucky, if these laws take effect, the risk assessment will ultimately not be the patient's anymore, unless she's eligible for one of the exceptions under the ban. Is that correct?

A I don't think that's correct. I think that if patient has a life-threatening episode during her pregnancy, obstetricians would do what they have always done. They would intervene to save the life of the mother. If that resulted in the death of the fetus, because the fetus was not 22 weeks or beyond, then that -- that would be what would happen. If the situation was happening post-viability at, you know, 24 weeks, 25 weeks, you would perform the induction of labor in a way that would give you the best chance of having a live baby and a healthy mom.

Q Yes, and I specifically put aside the exceptions in the statute. So aside from life endangerment or substantial impairment and irreversible substantial impairment of a major bodily function,

putting those exceptions aside, unless a patient is eligible for one of those exceptions, and she faces risks in her pregnancy, she is not able to make the decision to have an abortion if these laws take effect?

A I think the question really comes down to what is the value of fetal life. If the value of fetal life is -- and I think I -- I want to say this, if the value of fetal life is -- if there is value to fetal life, then its destruction is problematic.

Q That is your moral belief, correct?

A No, I think that -- that we are not talking about the fetus as a person. We are talking about the fetus as a human being. And I think that it's generally a situation where the destruction of a human being is -- is -- is something that is not considered a societal good.

Q So I'm going to try the question again. In the circumstance that we're talking about here, we're here today because Kentucky is banning abortion, absent relief from this court, absent the exceptions, which are life endangerment or substantially irreversible of an impairment of a major bodily function. If a patient develops a condition that doesn't meet the -- that criteria and decides that she wants to terminate her pregnancy, perhaps she doesn't share your view of

destruction of life -- and -- as you just put it, she is not able to make the decision to have an abortion under this law?

A I think you're asking me for a hypothetical, and I'm -- I'm not sure what you mean. If you can give me a specific example of she -- her developing a condition, then I can talk about a clinical pathway, but I -- I don't have a way to respond to a hypothetical.

Q Okay. So let's say there's a patient. I mean, I'm sure you see patients all the time that develop health conditions that are short of life endangerment or --

A But specifically what?

Q I promise I will finish my question.

A Okay.

Q And then I promise to give you an opportunity to answer.

A Okay.

Q So let's say that a patient has a health condition that begins to deteriorate as the pregnancy progresses, and she had wanted to carry the pregnancy term, but was -- to term, but was not able to, because the diabetes was getting so severe, her renal disease was getting severe. She might need to be on dialysis if the pregnancy continued, and she makes the decision that

to have an abortion, because she doesn't want to get so sick that she needs to be on dialysis, in this circumstance, she would not be able to make the decision if these laws took effect.

A But as a clinician -- and -- and again, I've -- I've dealt with this situation where a patient had worsening renal failure, hepatic failure. And you don't wait until they need dialysis. You intervene early on in the pregnancy.

Q So you think that she would meet an -- the definition for an abortion under these laws that's substantial and irreversible of impairment of a major bodily function?

A I think renal failure is -- is a substantial impairment. And we see this in people with certain types of collagen vascular disease. I mean, pregnancy causes some diseases to get better. Rheumatoid arthritis, multiple sclerosis, other diseases get better, but lupus either stays the same or can get worse. And those patients can become extremely sick, but you don't wait until a patient has irreversible damage -- you -- where she's going to need to go on dialysis. You intervene at what you believe to be a clinically appropriate time.

Q And do you think that these exceptions in the

statute give clinicians the ability to make a determination to intervene, as you put it, before a patient gets so sick that she is going to face substantial and irreversible impairment of a major bodily function?

A Yes, I do. Because for a hundred years when abortion was a felony in all states, clinicians terminated a pregnancy to save the life of a mother. They didn't wait until someone became irreversibly ill or had a stroke. Sometimes you can't prevent that, but -- but you didn't wait to intervene until her blood pressure was so out of control that she would have a stroke. You took action, and that was something that happened in the generation of physicians that trained me, who largely practiced when abortion was illegal. They did what they needed to do.

Q Do you ever use the term "patient-centered care"?

A Yes.

Q What does that term mean to you?

A I think it means creating what we would call -- and -- and there are different definitions, but there, it means creating a clinical ecosystem which offers the patient the best care. It -- it may not always be the care that they want to get or that they

like to get, but it offers them the best care and the best chance for healing or rehabilitation or whatever it is that they need.

Q And in that patient-centered model, does the patient make the decision about the course of action to pursue?

A No, not always. I have had patients in my career who demanded narcotics. I said, "No, that's not an appropriate intervention for you."

Q Among appropriate interventions, is it the patient's decision which intervention to pursue?

A I think that we have a phrase called "shared decision making," where we present the best possible options or set of options to a patient, knowing that we have a fiduciary relation -- fiduciary responsibility to patients, to present the best -- the best care or the best plan of care. And again, that may involve saying no to specific interventions, and we have to be comfortable with doing that.

Q You talked about prevention methods. You don't believe, though, that contraception is a method to prevent unintended pregnancy, do you?

A I don't believe that contraception prevents unintended pregnancy?

Q No, you don't support access to contraception,

do you?

A I have -- my positions on contraception have definitely evolved. I think that women should be aware, in terms of their use of contraception, that it has benefits and problems. I think there are situations, as I mentioned earlier, of women with pulmonary hypertension, where it's very important to them to not get pregnant because mortality rate is so high. The -- what it comes down to really, again, is shared decision making with the patient, helping them understand the risks, and also that there are numerous methods that don't necessarily involve contraceptive technology and helping the patient to really choose what's -- what's going to work.

Q Have you prescribed contraceptives to your patients?

A Yes.

MS. AMIRI: Your Honor, if I may take a minute? Thank you. And no more questions for this witness, Your Honor.

JUDGE PERRY: All right. Anything else?

MS. KEISER: No, we're fine.

JUDGE PERRY: All right. Can this witness be excused?

THE WITNESS: Thank you.

JUDGE PERRY: All right. As she steps back -- leave that up there, Doctor. Yeah, please. Thank you.

THE WITNESS: Uh-huh.

JUDGE PERRY: All right. You have one more witness for the defense?

MR. THACKER: We do, Your Honor.

JUDGE PERRY: All right. Let's take an afternoon -- or another break before we do that. We've been at it all day, so let's take a -- let's break until 3:30. How about that? And we'll come back for your final witness. The court is in recess.

(OFF THE RECORD)

JUDGE PERRY: All right. We're back on the record in 22-CI-3223 -- 5, rather. Still in the defendant's case. I'm advised to prepare to call the next witness. So Counsel, who's your next witness?

MR. THACKER: Yes, Your Honor. Christopher Thacker for Attorney General Cameron. Attorney General calls O. Carter Snead.

JUDGE PERRY: Sir?

THE WITNESS: May I bring the water?

JUDGE PERRY: You can.

THE WITNESS: Thank you.
JUDGE PERRY: Snead is the last name?
THE WITNESS: Snead.
BAILIFF: Turn and face the judge. Raise your right hand, he'll swear you in.
JUDGE PERRY: Good afternoon, sir. Sir, do you swear or affirm the testimony you're about to give the Court will be the truth and the whole truth?
THE WITNESS: Yes, sir.
JUDGE PERRY: All right. Thank you. You may be seated. As a reminder, this is the microphone right here.
THE WITNESS: Thank you.
JUDGE PERRY: Whenever you're ready.
THE WITNESS: Yes, sir.

DIRECT EXAMINATION

BY MR. THACKER:

Q Professor Snead, could I ask you just to, again, introduce yourself again for the Court?

A Sure. My name is Professor Carter Snead.

Q And Professor Snead, what do you do for a living?

A I'm a professor of law at the University of Notre Dame, where I'm also a concurrent professor of political science and I'm the Director of the de Nicola

Center for Ethics and col -- and Culture in the College of Arts and Letters at Notre Dame.

Q What kind of courses do you teach at the university?

A I teach law and bioethics to law students. I teach health law to law students. I teach torts to our first-year law students and I teach -- occasionally I'll teach undergraduates. I taught a course to a group of undergraduate political science students this past spring semester as well. It was called Law Bioethics and the Human Person.

Q Can you tell me a little bit about your educational and academic background?

A Sure. I attended college at St. John's College in Annapolis, Maryland, where it's a great books curriculum. So every -- it's an all-required curriculum, but if you were to analogize what our major and minor would be, it'd be a double major in philosophy in history and philosophy of science and a double minor in comparative literature and classics. And then I studied law at Georgetown University.

Q What would you consider your area of academic expertise to be?

A My area of academic expertise is public bioethics. I -- my teaching, my research is in the area

of public bioethics, which is -- I define as the governance of science medicine and biotechnology in the name of ethical goods. It's an interdisciplinary field of inquiry that involves, of course, the law, but also involves philosophy, especially ethics, bioethics, and other related disciplines also.

Q Have you conducted research in the area of public bioethics?

A Yes. I conduct research both in my capacity as a faculty member at the University of Notre Dame, and prior to that, I served as general counsel to the president's council on bioethics, which was a White House advisory committee, and I did a great deal of research in -- in my capacity in that role also, prior to joining the faculty of the University of Notre Dame.

Q And have you published scholarly papers in the area of public bioethics?

A Yes, I have.

Q Can you talk to us about your publications?

A Sure. I have -- I have scholarly publications in law review journals. Most recently, and probably most significantly I -- in 2020, I published a book called -- it -- it -- it's -- "What it Means to be Human: The Case for the Body in Public Bioethics," published by Harvard University Press in

2020, but also a number of -- of essays, law review articles and other scholarly contributions to various journals and -- and outlets.

Q Can you talk a little bit about the reception of your recent book, "What it Means to be Human"? I mean, has it been cited by other -- the media, other academics?

A Yeah, and I've been very grateful by the reception. It was named one of the ten best books of 2020 by the Wall Street Journal. More recently in the New York Times, it was listed as one of ten books that are essential to understand American abortion -- the debate on abortion in America. It's been reviewed in multiple publications and in a favorable way. One -- one review in the Wall Street Journal described it as one of the most important contributions to moral philosophy thus far in this century.

Q And you mentioned when you were talking about your prior experience, your service in the president's counsel and bioethics, were you also involved in the United Nations, in connection of public bioethics, anyway?

A Yes, I was. I -- I led the US delegation for, for the negotiation of the universal declaration on bioethics and human rights at UNESCO, the United Nations

Education Science and Cultural Organization headquartered in Paris. I -- I led that negotiation. I served as the -- the -- US government's representative on the International Bioethics Governing Committee. I was an independent expert appointed by the director general of UNESCO on the International Bioethics Governing Committee, which is an independent body that advises member states on the different ethical and public policy questions associated with the issues under consideration. And I was also the permanent observer for the United States government to the Counsel of Europe's steering committee on -- on bioethics in Strasbourg, France.

Q Have you presented expert testimony in any other courts on the issue of public bioethics and particularly the kinds of topics that this case involves?

A Yes, sir. I've been an expert witness in federal court only. I've never testified in a trial court before. Two times in federal district court in the state of Texas involving different matters relating to bioethics and the bioethical questions that related to the abortion disputes that were at issue in those cases. And also here in Kentucky, in the federal Court, ex -- I was an expert witness in that case. I also

provided an expert report in a case in the trial court in Tennessee, federal trial court as well and advised. Yeah, so that's -- so yes, the answer is yes. I have experience as an expert witness.

MR. THACKER: Your Honor, may I approach?

JUDGE PERRY: Uh-huh.

Q I will hand you what we will at the moment are going to be marked as Attorney General's Exhibit 3. Professor Snead, if you could take a moment to review that and tell me if you recognize that document.

A Yes. This is my CV.

Q And can -- tell me, is this a current and accurate version of your CV?

A It is. It -- I -- looking at it now, it occurs to me that there may be some recent commentaries. Op-ed in the Washington Post recently, that's not here. In the past couple of weeks, I've been pretty busy and so I've not had the opportunity to update it, but it's only a handful of op-eds and commentaries that are missing. All the scholarship is -- is current.

Q And what is here is correct?

A Yes, it's accurate. Yeah.

MR. THACKER: And Your Honor, again, I move to admit into the record Professor Snead's CV as Attorney General's Exhibit 3.

MS. GATNAREK: No objection, Your Honor.

JUDGE PERRY: It's admitted.

(DEFENSE EXHIBIT 3 ADMITTED INTO EVIDENCE)

BY MR. THACKER:

Q Before moving on to talk about your -- the expert opinion that you're going to offer in this case, I wanted to ask you: Are you personally pro-life? Would you identify that way?

A Yes. Well, let me explain what I mean by that. In the context of abortion -- abortion is a sometimes tragic conflict between competing goods and values that are in some cases incommensurable. On the one side, you have this very significant burden that a woman faces with an unplanned pregnancy, the physical burdens, the psychic burdens, as well as the burdens of unplanned parenthood, on the one side of the question. On the other side of the question you have of fundamentally the question of the moral status and eventually the legal status of the unborn child, the human being in utero, as well as the state's interest in promoting the integrity -- ethical integrity of the medical profession, as well as promoting maternal health, as well as promoting respect for life more generally. So in the context of abortion, those are the issues that you -- that are held in balance. And those

-- the debate is about how to reconcile or to compare those things. And my -- I -- my view is that -- that the unborn human being from conception forward, being that it's the same biological organism at all stages of development, that there are no meaning -- meaningful moral distinctions bet- [sic] or ethical distinctions between the different stages of development. And therefore, that human being is entitled to moral respect throughout his or her stages of development and that -- and those interests and those -- and the dignity and intrinsic equal value of those human beings need to be compared as such to all the burdens on the other side of the equation. So I -- I -- I believe that all of the arguments against the so-called personhood of the unborn child or arguments are -- are unpersuasive. So my view is that every human being born, unborn, mothers, babies, families, are all intrinsically equal and valuable. And the -- our -- we have ethical obligations that flow from that. And I think that the law should -- should reflect that as well.

Q Are you -- have you been asked today to testify about your personal views on abortion?

A No. No, not at all. I've been asked to offer a -- a scholarly opinion regarding the questions that you're -- you're going to ask me.

Q And you're confident that you can distinguish between your personally held views, whatever their multifaceted origins they may be, from talking about the scholarly perspectives and issues involved in the academic field of public bioethics?

A Absolutely. I -- I strive to be fair and balanced in my presentation to my students. My goal is for them not to know what my views are. I try to hold those in advance and simply focus on helping them to understand the field of inquiry and the disputes therein.

MR. THACKER: Okay. Your Honor, this time, I'd like to tender this witness as an expert in the field of public bioethics.

MS. GATNAREK: No objection, Your Honor, to the witness being tendered as expert in bioethics. I want to make sure that he's not tendered as an expert in other things he's mentioned such as states, et cetera.

JUDGE PERRY: Correct.

MS. GATNAREK: Thank you.

JUDGE PERRY: So moved as to that. Let's proceed.

BY MR. THACKER:

Q And -- okay. And again, you've

probably -- you've already, I think, touched on this and answered to a different question, but can you explain a bit for the Court your understanding of why you've been retained in this case?

A My understanding for the reason for my testimony is to try to offer a sort of a -- an account of why the -- the -- it's ethically defensible to take the position that the unborn child should be protected in the law as is the case and the legal questions that are at issue in this matter. To give a kind of ethical analysis, I suppose, of the state's interest in promoting these laws as that matters for the questions that are before the Court right now.

Q Okay. And to get right at, I guess, the central issue, what is the bioethical argument or arguments for -- that would be offered for protecting prenatal human organism from private legal violence from the moment of conception on?

A Yeah. And it's -- it rests on two premises. One premise is it has already been discussed today. The premise is involving the biological identity of the unborn child. That is a -- a living individual member of the human species. The debate over abortion is not about the biological status of the unborn child. It's about the moral status and ultimately the legal status

of the unborn child. And so if you begin with the premise that at every gestational stage, we're talking about the same organism, you can rely on a sort of principle of equality or -- or principle of justice that suggests that it's unjust, it's a form of unjust discrimination to ignore the moral standing of that being when you are asked to balance those interests against the other interests that are at issue in the context of abortion involving the burdens that a woman faces.

Q Earlier in -- again, in the -- actually our previous witness' testimony, there was a distinction that was made in one of the answers between a human being versus a person. Can you explain --

A Sure.

Q -- ethically what the significance of that statement is?

A Yeah, there -- there's an ethical debate over the moral standing of human life, not just by the way, prenatally, but even at later stages of development. There are ethical debates about the moral standing of the newborn. There are ethical debates about people who suffer from dementia or other cognitive disabilities. Whether or not there's a sliding scale of value of persons depending on capacities that they have as

established by those in power who wish to divide the world up into persons and non-persons according to their own interests. And so in the ethical debates, there are those who make the argument that not every human being is a person, that is, you're not a person, unless you can meet certain criteria, again, that are set by the folks that are setting the criteria. Sometimes that criteria is cognitive. You can't be a person unless you can formulate future directed desires and therefore be a bearer of human rights. That's on the one side of the argument, that those are so-called personhood arguments. The counterpoint to that in the literature and in the ethical debate is that there is -- there should be no moral distinction between human beings and persons. There are no pre-personal human beings. There are no post-personal human beings. All that matters for a person's basic human rights, moral regard, and the protection of the law is whether or not they're living members of the human species. And that life begins at conception. And so that's the argument on, you know, as far as the debate unfolds.

Q Okay. Professor Snead, in preparation for today's hearing, have you had an opportunity to review the two statutes at issue, the Human Life Protection Act or so -- so-called trigger ban, and the

Kentucky's -- the Heartbeat Bill?

A Yes.

MR. THACKER: Your Honor, just as -- I don't need to make this exhibit, but as an aid, I would like to approach the witness and give him a copy of the Human Life Protection Act, if that's okay.

JUDGE PERRY: Uh-huh, yes.

BY MR. THACKER:

Q I'd like to draw your attention -- and I've handed you a copy of KRS 311.772. And I'd like to draw your attention to subsection -- section 1, subsection C.

A Uh-huh.

Q And that's a definition for this particular statute. And could you read that definition?

A Sure. It says, "Unborn human being means an individual living member of the species Homo sapiens throughout the entire embryonic and fetal stages of the unborn child from fertilization to full gestation and childbirth."

Q Is that a definition that is within the mainstream of generally discussed and accepted bioethical principles?

A Well, of course there's dispute, as I mentioned about -- about the moral status of the unborn human being, but this definition is easily recognizable

as one of the positions in the debate over the question of the moral status of the unborn child. It -- as I say, it's contested, of course, by those who disagree and take the view that unborn human beings are not entitled to moral respect or perhaps a -- a different position that they're -- they have gradual moral respect as they become stronger and more independent. But this is a -- a fairly standard definition that represents one perspective in the mainstream of the debate about the moral standing of the unborn human being.

Q Does this deposition -- definition require you to reconcile or to reach a definite conclusion about whether or not a human being is also a human person?

A Well, this -- this defines human being, it seems to me, as coextensive. This -- this -- it seems to me that this is reflective of the view that I described a moment ago, that there should be no distinction between persons and human beings. This represents a very robust, almost a rejection of personhood theory, insofar as personhood theory is a theory of exclusion, meaning it's a theory that seeks to define narrowly those human beings that count as persons and exclude those that don't. This seems like a very robust and inclusive definition, as opposed to the narrow or an exclusive definition that you see also in

these debates.

Q Okay. Would another way to say what you were just expressing be that the statute reflects the General Assembly's conclusion that if you're a -- biologically a member of the human family, human species, you're going to be worthy of protection of law?

A I think that's a fair -- a fair summary of what this appears to reflect. Namely, this reflects the view, a capacious view of the human family that includes all human beings, born and unborn. It doesn't make distinctions between human beings on the grounds of their location, their size, their state of dependence, or how other people view them, which is a hallmark of personhood theory, which seeks to divide the world up into a narrower framework of persons.

Q And having reviewed Kentucky's statutes, are there ethical interests, other than the protection of the unborn human being, that could support this kind of legislation?

MS. GATNAREK: I'm going to object, Your Honor, that this calls for speculation, unless the witness has some personal knowledge about the drafting of the law at issue here. It seems to me irrelevant otherwise.

MR. THACKER: Your Honor, again, the question

was not whether what the General Assembly was motivated by. It's as a matter of public bioethics, are there other recognized ethical principles that --

JUDGE PERRY: Right.

MR. THACKER: -- would provide a rational basis?

JUDGE PERRY: Second part is fair. First part is not. He doesn't speak for the General Assembly.

MR. THACKER: Correct.

JUDGE PERRY: So the second part, yes, he could answer.

BY MR. THACKER:

Q So just as a matter of --

A As a --

Q -- public bioethics, are there --

A Are there ethically defensible reasons why you would adopt a law like this beyond the protection of the individual prenatal human being?

Q Correct.

A And the answer is -- and this, again, this is -- this is reflected both in the literature, it's reflected actually in the Supreme Court jurisprudence also, that the justifications for this sort of a law relate to promotion of maternal health, the protection

of the integrity of the medical profession, as well as promotion more broadly as a societal good, respect for human life more generally.

Q Again, I think you testified a moment ago that you've had the opportunity to review the plaintiff's complaint in this matter, and in so doing, you -- did you note that one of the bases of the claim that's being brought here is section 1 of the Constitution's provision that -- of the State Constitution's provision that all men are by nature free and equal and have certain inherent inalienable rights and goes on to cite, in particular, the right to liberty in section 1 and later the right to privacy that, you know, sort of summarized --

A I recall seeing that in --

Q -- the high level?

A Yes, sir.

Q Again, as a matter of bioethics, do the concepts of privacy and liberty settle the question of how or whether a state should regulate abortion?

A As an ethical matter, privacy and liberty are important goods. They're important goods to be protected and -- and embraced. However, as I said before, the question of abortion is a -- is a question of reconciling or evaluating the contending goods,

privacy and liberty on the one side, of course, as well, alongside the interest of the inviolability or the moral standing of the prenatal human being. Traditionally speaking, privacy and liberty in -- in the literature and in the -- in the Western tradition frequently are invoked, but some -- the limiting principle of privacy and liberty is the point at which -- and this is clear in John Stuart Mills' "On Liberty" -- that generally speaking privacy and liberty stop where it begins -- where one's freely undertaken actions adversely affect other people or third parties, when one -- one's liberty ends where another person's bodily integrity or dignity or other interests begin, so to speak.

Q And I think a very similar question, again, I believe you were in the Courtroom earlier and heard the witnesses presented by Plaintiff, correct?

A I did. I heard -- I heard the testimony of the plaintiff's experts,

Q Dr. Bergin and Dr. Lindo?

A Yes.

Q Much of that testimony, if -- well, at least some of what we heard, and I will say the -- again, the complaint seems to discuss at length the burdens or the alleged burdens of pregnancy and parenthood on a

pregnant woman. Do -- does that -- is the discussion of burdens alone sufficient from the general public bioethics analysis?

A So -- so again, the discussion of burdens on a woman, the physical burdens, the psychic burdens, the other burdens of unplanned pregnancy, unwanted pregnancy, unplanned parenthood, unwanted parenthood, are very significant and need to be considered very carefully and -- and taken very seriously because they're very serious things, indeed. However, the -- that's -- that's half of the calculus. That's -- that's one side of the equation for evaluating the ethical standing of a -- a proposed approach to abortion. You have to consider the other side as well, which is, as I say, the moral status, the interests of the prenatal human being who is destroyed in an abortion, alongside the other goods that I mentioned a moment ago involving maternal health, the integrity of the medical profession, and promoting life more generally. So I would say, to answer your question more directly, it was a -- the presentation that I listened to seemed to be a very granular and an important accounting of -- of burdens that need to be taken seriously, but that they - - without a discussion and reflection on the other side of the ledger, if you will,

we wouldn't be able to responsibly resolve the question of abortion.

Q We'll take each in turn, but, again, I do want to just invite you to, again, I -- you heard this one, I believe you also had the opportunity to review both the affidavits of --

A Yes, yes.

Q -- Dr. Bergin and Dr. Lindo. Sticking first with, I guess, Dr. Lindo's testimony regarding the economic impacts of abortion, from, again, the perspective of public bioethics. Do you have any critiques or response to that testimony?

A Well, insofar as the -- so -- so as I understood it, the -- the argument in -- in the affidavit and the -- and the statements that were made today relate to the proposition that a -- bans on abortion limit abortion. That seems to be a truism in a way, if the law is enforced. But then the second point is that bans on abortion threaten the economic wellbeing of women, both in terms of the costs associated with unplanned pregnancy, but also the cost associated with unplanned parenthood. In other words, the presence of an unwanted child in a family -- and he said, I think, this very directly, causes significant -- the words in the affidavit were "deleterious and disadvantageous

consequences." And -- and there were certain consequences that were spelled out that I think are objectively -- objectively bad things, like involvement in criminality, cognitive impairments, and so on, other -- exacerbation of poverty. So as a description, I don't know enough to have an opinion about whether or not the causal relationships in that account are true or false, but if I take them at face value and assume for the sake of argument that they're true, they don't tell me enough about -- about the calculus for whether or not abortion is a legitimate solution to dealing with those problems. There are a lot of things we could do that are illegal in order -- that would alleviate the presence of unwanted children. And so -- and that would therefore have a positive impact on a person's economic wellbeing. But no one would propose such a thing because they have an ex ante sense that certain kinds of interventions are -- we shouldn't pursue because they're wrong. And if one were to take the account that Dr. Lindo gave as the only argument in favor of abortion, you would have to say, "Well, I don't know enough. I need to know more about the moral standing of the unborn child to know if destroying the unborn child is a legitimate means of pursuing those economic goods." We routinely restrain ourselves from doing things that

are unethical or illegal in the name of pursuing economic goods. And so simply saying that abortion promotes economic goods is not sufficient to tell me if abortion is legitimate or illicit or should be pursued as a -- as a policy.

Q And I'd invite you basically the same question with respects to Dr. Bergin. Was there anything in her testimony that, again, you believe, again, from the perspective of public bioethics, sort of warrants critique or further consideration?

A Well, insofar as -- again, insofar as that is marshaled as an argument that -- that she -- she pointed to -- to what appeared to be -- again, I'm not an expert. I can't assess the validity of the clinical assertions that were made in that -- in her -- in her testimony. But again, taking them at face value, the idea of certain health risks that are associated with pregnancy and childbirth, that tells us something important to plug into the calculus. But -- but again, in that -- if that's the only information that you have, and you're trying to think through this question, the unborn child is -- is invisible in that conversation, in the -- in those -- in both of those statements. Both affidavits, the unborn child doesn't seem -- the question of the moral standing of the unborn child is

not engaged as a serious question, which I think is a serious -- it means that those pieces of information are incomplete in -- in terms of us trying to assemble a full landscape to understand whether or not abortion is legitimate or not. Perhaps, I mean, one could -- and I don't know if this is -- was the intention, but the idea that -- I mean, if -- if you assume without stating that the unborn child is not worth protecting in the law, or is -- has a sub-personal status or categorically, the interest of the unborn child are subordinate to that of the woman's health risks, no matter which kind they are, or her economic interests, no matter what kind they are, then you might be persuaded by those arguments. But they didn't make the case that the unborn child has no interest or have interests that are not worthy of pursuing or protecting. And therefore, if they're meant to promote a -- an argument in favor of abortion, they -- they're guilty of the sort of fallacy of question begging. They assume the thing that they -- that is necessary to the analysis, namely the moral standing of the unborn child, which they don't address and they don't -- and they don't describe. And -- and they certainly don't engage Kentucky's decision to -- to define the protected class of individuals as unborn human beings, as defined in this statute.

Q In I think both Dr. Bergin's and Dr. Lindo's testimony, in particular, Dr. Lindo's, there were several statistics about women who were more likely to seek abortion. In particular, I believe there was a -- you -- do you recall testimony to the effect of -- something along the effect of that African American women in Kentucky are as compared to the overall percentage population about four times more likely to seek an abortion. Do you remember that testimony?

A I do. I do remember that testimony.

Q From -- again, from the perspective of public bioethics, is that statistic clearly one that argues in favor of abortion?

A So there are a couple things I would say in response. First of all, the category of individuals who seek abortions, according to the testimony, as I recall, many of them had what was described as a disruptive life event in the year leading up to it, which made me worry that the import of that data is not -- it implicates the question of the genuine voluntariness of seeking an abortion. If a person is suffering under the duress of economic ruin or the likes of which was described, or -- or let's put it more gently, the failure to pursue educational attainment, and the problems for one's, you

know, pre-existing postnatal children, that makes me worry that those aren't free and equal decisions that are being made. Those are decisions that being made under duress and the appropriate --

MS. GATNAREK: Your Honor, I'm going to object to this line of questioning and our witness's continued explanation here because I think it goes outside the scope of what he has been tendered as an expert for. We did hear testimony from doctors who speak to the experience of counseling patients through those decisions. But I don't believe that this expert's testimony is appropriate for talking about whether patients are making decisions freely and of their own choice. There's no -- there's certainly no evidence to the contrary in the record here, and I think it's improper for the witnesses speculate on this in his testimony.

MR. THACKER: Your Honor, the witness is -- I've asked him to draw inferences from the testimony they've offered. The testimony they've offered is that the reason these women are seeking abortions are all these horrible life events that make them feel compelled to. And if that's the case, is there an ethical concern that would perhaps push back against the argument the plaintiffs are

trying to make?

JUDGE PERRY: My only concern is he's offering in the context of rebutting somebody who was offered as an economics expert. So let's keep it to this tiny little area. And I'm curious about this response, so overruled, but let's keep it to that and let's go forward. So you can answer.

A Thank you, sir. So as -- the argument, the ethical argument, cited for abortion rights, which we read in the complaint, and we hear in the literature is reproductive autonomy and reproductive freedom, the exercise of choice. The phrase "pro-choice" reflects that good, the good of choice, reproductive choice. And if there is evidence that suggests that -- that people who -- a large percentage of people who choose abortion are operating under duress, that calls into question the ethical norm that anchors the entire theory of reproductive rights in the first instance, it seems to me. And it also suggests that we have an ethical obligation as fellow citizens, fellow members of the human family, to come to the aid of those women, to help alleviate those burdens, rather than simply give them a path of least resistance to terminate their pregnancy. And the fact that they -- they focus on women of color and people in poverty worries me, too. I don't -- I'm

very uncomfortable as an ethical matter with arguments that focus on disparate impact and interventions into the reproductive health of minorities, who have a very, very tortured and shameful history in this country of forced sterilization, of systematically deceiving the African American community in Tuskegee. That was one of the -- something I wrote about at length in my book. It's a -- it's a shameful moment of systemic American racism at the hands of the government itself, deceiving African American sharecroppers and their families about the fact that they had syphilis. We have a history of forced sterilization, especially of women of color to intervene in their reproductive health. And -- and I would say also, that if you think about civil rights icons like Fannie Lou Hamer from -- from -- from Mississippi, she regarded abortion as a tool of white supremacy for precisely that reason. George Wallace supported abortion. She opposed abortion. These are the kinds of things that we have an ugly history of racism in America. We have an ugly history of racism as it plays out in a bioethical context. And when we start talking about the harms of too many unwanted minority and poor children as causing economic harms, my worries are compounded and aggravated.

MR. THACKER: Your Honor, if I may consult with

co-counsel for a moment, we may be finished. I have no further questions at this time for this witness.

JUDGE PERRY: All right, cross.

CROSS EXAMINATION

BY MS. GATNAREK:

Q Thank you, Judge. Good afternoon.

A Hi.

Q Professor Snead, my name is Heather Gatnarek. I represent the plaintiffs in this case. I'm not sure that we've met before, but I was present at one of the trials where you testified --

A Okay. Nice to see you.

Q -- here in Kentucky in 2018. It's nice to see you as well. Professor Snead, can you tell us when you were contacted by the Attorney General's Office to participate in this case?

A I think it was last week. Yeah.

Q And what did they ask you to testify about?

A They asked if I would testify about the ethical justifications for the laws at issue in this case.

Q And you spoke previously about having reviewed some of the pleadings in the case, the complaints and the affidavits. Did you do anything else to prepare for your testimony today?

A No.

Q Have you looked at abortion related mortality rates specific to Kentucky?

A No.

Q Or complication rates specific to Kentucky?

A No.

Q Who did you speak with besides the Attorney General in preparation for today's testimony? I'm sorry, the Attorney General's Office. Let me clarify.

A Oh, the only people I spoke with in preparation of my testimony were the folks that represent the Attorney General.

Q Did you speak with Dr. Wubbenhorst regarding your testimony today?

A Not regard -- no, not regarding my testimony. I did not.

Q And are you being compensated for your testimony today?

A Yes.

Q How much are you being compensated?

A It's the same rate as the Kentucky AG's Office in the previous representation, $550 an hour.

Q Okay. And you stated on direct examination that you are appearing here as an expert. I'm sorry, that you're appearing here with your expertise in public

bioethics. That's not the same thing as medical ethics, is it?

A So it depends. Medical ethics has a clinical dimension to it. And so insofar as I write and teach about clinical questions, especially involving -- that is involving the clinical setting, end of life decision-making, you could say that my expertise includes medical ethics. Bioethics is in some ways broader, at least in the American tradition. Bioethics includes any ethical question that arises from advances in biomedical science and biotechnology. Insofar as abortion relates to the clinical setting, one could say that I write about medical ethics, insofar as I write about abortion. In Europe, bioethics is defined in a much broader way. It includes the natural environment, as well as merely human questions.

Q Understanding that public bioethics may touch on these other realms, you yourself are not though an expert in medical ethics?

A No, I think I am an expert in medical ethics. I've published peer-reviewed books in Elite University Press on medical ethics question. My book was briefly number one book in medical ethics, and according to amazon.com, which was gratifying. So no, I think I am an expert in medical ethics.

Q You are not though testifying here today about a doctor's ethical obligations regarding caring for their patients?

A Not specifically, no.

Q And you yourself are not a medical doctor?

A I'm not a medical doctor.

Q You've not been to medical school?

A No.

Q And you're not offering --

A Not as a student.

Q You're not offering a medical opinion?

A No, absolutely not.

Q Because you're not a doctor and have not been to medical school, I assume you also have never practiced medicine?

A That would be illegal. No, I've never done that.

Q And you've never performed an abortion?

A No, I've not done that.

Q And you're not testifying about the safety of abortion?

A No.

Q Is that correct? And you're not opining here today about medical schools' obligation to provide access to training for abortion care for medical

residents?

A No, I'm not.

Q You're also -- my understanding is you're also not offering here today information on -- I'm sorry. Let me rephrase that. You are also not offering information or data regarding patients' decisions for obtaining an abortion; is that right?

A That's correct.

Q You testified previously about your concerns regarding some of Dr. Lindo's slides. And I think you referenced a large percentage of patients who had experienced certain life events.

A Uh-huh.

Q But that's not based on any data that you're offering the Court here today?

A No, my reaction was if taking his presentation as face value, if it is true that a significant percentage of people in have life disruptions and face significant risks to themselves economically and choose and -- and choose abortion, I worry about the causal relationship between the duress and the choice.

Q But again, your testimony here today is in response to Dr. Lindo's slides rather than being based on your own --

A Absolutely. Yes.

Q -- data or --
A Yes.
Q Thank you.
A Uh-huh.
Q Professor Snead, you -- prior to Friday, June 24th, you had argued for the reversal of Roe v. Wade; is that correct?
A That is correct.
Q And you did so in a number of contexts, for instance, and I think you may have mentioned this earlier, you have published various op-eds.
A Uh-huh.
Q One of those somewhat recently was in the, I think you mentioned, the Washington Post.
A Washington Post, yeah.
Q That -- does September 6, 2021, does it sound about when that op-ed was published?
A So I've written several op-eds in the Washington Post. The most recent was about a week ago. It was shortly after the decision in Dobbs, and it was about the obligation of the pro-life community to come to the aid of women and children and families, both politically and in their own personal lives.
Q Do you recall an op-ed that you wrote in the Washington Post in September of 2021, that was titled

"Critics of Texas's Convoluted Abortion Law Have a Point: The Solution Is to Overturn Roe v. Wade"?

A Yes, I do remember that. Yep.

Q And do you recall describing in that op-ed, describing Roe v. Wade and the jurisprudence related to it as "a tortured and shifting cluster of normative rationales, rules, and standards of judicial review"?

A Yes, absolutely. I do remember that.

Q And on June 24th, you also published an op-ed in CNN -- I'm actually --

A Yep, cnn.com.

Q CNN.com. And you remember writing in that op-ed that Roe and its progeny have been very bad for America?

A Yes, I did write that.

Q You also, I think you were in the courtroom to hear my opposing counsel question Dr. Lindo regarding an amicus brief that he signed onto in the Dobbs case. You yourself submitted an amicus brief in that case?

A I did, yes.

Q And in that amicus brief, which -- I'm sorry. Your law firm paid for the printing of that amicus brief; is that correct?

A Yes, that's correct.

Q And in that amicus brief, you describe abortion as lethal violence?

A Yes.

Q And again, you describe the history of Roe v. Wade as the story of American abortion jurisprudence as "a tortured narrative of successive failed attempts to justify the invention of a near absolute right to abortion."

A Yeah, just to -- just to enlarge or to explain that. The argument is that from the -- from 1973 until like very recently, the jurisprudence of abortion in America began with the right to privacy, shifted to the right to liberty in 1992. It had a trimester framework in '73, which gave way to a binary undue burden analysis in 1992. Basically the argument is there's been shifting standards, rationales, rules, such that the jurisprudence has been quite unstable, which is relevant to the analysis of stare decisis, which we talk about in the brief also.

Q And it's safe to say though, that you have long advocated for the reversal of Roe v. Wade --

A Yes. That's -- yes, of course. Yeah.

Q And Professor Snead, you've previously testified in another matter that you think abortion is a kind of injustice?

A Well, so the intentional killing of an unborn human being without justification, without necessity, excuse, and without justification is an injustice. I mean, as I said, it's a balance. The question is how do you reconcile the competing interests on the one side, the burdens that the mother faces, which are very serious burdens that need to be responded to, versus the intrinsic equal value of every human being born and unborn, as well as the other issues. And so I would say that to make a blanket statement that abortion is always an injustice depends on, I suppose, how you define it, abortion. You guys talked about that with the previous witness. If there's no -- I would say -- I'd put it this way. Without duly considering the moral standing of the unborn human being as an equal human member of the human family, and acting on that failure to consider that, is a kind of injustice. It's a kind of discrimination.

Q You also previously testified that abortion, if the person seeking the abortion is doing so because the pregnancy is a result of rape is in injustice as well?

A I don't quite -- I may have said that. I think that as a defensible point of view, to argue that taking the life of an innocent human being, even

for the -- out of the motivation, the very understandable and human and admirable motivation to alleviate the burden on a woman who's been criminally and grotesquely violated is nevertheless as an ethical matter, compounding one injustice with another injustice. Now it's a different question as to whether or not people should support bans that have rape and incest exceptions. That's a question of pragmatic decision making about what is possible and what's not, but as a purely ethical matter, if one takes the view, as I do, that the unborn human being is a living member of the human family with human rights, the intentional killing of that being for the sake of, even for very good motivations, is -- is -- is a kind of compounding of the original horrific injustice of rape.

Q Thank you. That was -- there was a lot there and I just want to make sure that you agree with me that you previously testified, and I'll quote it for you --

A Sure, please. Yeah, thank you.

Q You previously testified, "The intentional killing of an unborn child because he or she was conceived by rape is an injustice."

A Yeah, I -- yes, I -- yes, I think that's -- yeah.

Q And the testimony that I just read for you,

Professor Snead, was your testimony in -- we mentioned a federal case here in Kentucky --

A Uh-huh.

Q -- where you testified at a bench trial in 2018, you recall that?

A I do remember that, yes.

Q And in that particular case, you were offering an opinion that a particular abortion procedure --

A Right.

Q -- should be outlawed.

A Yes, I was testifying about the ethical standing of a particular method of abortion and offering a kind of account of the rich ethical tradition of taking seriously the -- the mode in which an abortion is performed and -- and that the -- the way in which an abortion performed is ethically significant in itself and -- and worth considering.

Q And the federal district court in that case, ultimately, struck down that law, permanently enjoined that law?

A That's correct.

Q And the Sixth Circuit Court of Appeals affirmed that?

A I think that's right.

Q You talked a little bit about -- not a little,

you talked about your work at Notre Dame where you are the director of the Notre Dame Center for Ethics and Culture?

A Uh-huh.

Q One of the issues that center is concerned with is the injustice -- "Injustice perpetrated against unborn children," is that correct?

A We have -- one of the things that we work on, we call our -- is a culture of life dimension of what we do, research and teaching and -- and -- and student formation. We have a program called the Women and Children First initiative, which is about trying to get care to moms and babies and families in a post-Roe landscape that will need the kinds of care to alleviate the burdens that we've been talking about today and the concerns we've been talking about today. But yes, there -- Notre Dame -- University of Notre Dame is institutionally committed to building a culture of life. It's -- there are statements from our president to that effect and the de Nicola Center stands in that tradition.

Q And as director of the center, you run the Notre Dame Vita Institute; is that correct?

A Yeah, the center runs the Vita Institute. I'm the director of the center. We have a staff member who

manages it on a day-to-day basis, but that is a -- that is an initiative of de Nicola Center for Ethics and Culture, which I serve as director. Absolutely.

Q And the witness that testified just prior to you, Dr. Wubbenhorst, is currently a research associate at the Vita Institute?

A No, she's a research associate of the de Nicola Center more generally, where she conducts research and works on -- she works on different kinds of scholarly publications. But she is a faculty member in our Vita Institute, which is a week-long kind of -- it's like a -- it's like a -- it's a -- an abbreviated course, an intensive course on the different subject matters that relate to culture of life. We have a day on embryology, we have a day on law, a day on social science, and Dr. Wubbenhorst frequently gives a presentation that is very similar to the one that she gave today, which is about the relative safety of abortion versus childbirth and the -- and whether or not that's been empirically demonstrated.

Q The Vita Institute has been described as, essentially, an intellectual boot camp for leaders of the pro-life movement; is that --

A Yeah, I think that's a fair -- a fair description. It's an intensive course. The people who

apply to come to the Vita Institute tend to be leaders of -- of the pro-life movement, meaning not just advocates, but people who work -- who run maternal group homes, people who do post-abortive healing initiatives, people who run crisis resource centers -- pregnancy resource centers, I should say, as well as academics, medical doctors, leaders of nonprofits from around the world, Africa, Latin America. So we -- we have a broad -- a broad spectrum of participants that come all -- but I'd say the common thread is that they all are committed to building a culture of life in which mothers and babies, born and unborn, in families are protected.

Q And at that Institute, you prepare participants to be "even more effective advocates on behalf of the unborn"?

A Yeah, we think that people who are out there advocating for a culture of life need to be informed, they need to have the best learning in terms of the science and the law and the public policy questions, as well as understanding in a very deep way the arguments in favor of abortion, the arguments in favor of -- of -- of these different kinds of practices, so that they can better assess their own point of view and be more effective in the public square if they choose to advocate for a culture of life.

Q And in your role, you are -- you select faculty for the Vita Institute?

A In collaboration with my staff, we do, yeah.

Q And you organize lectures, you organize the types of educational opportunities you were just describing?

A Yeah, and again, it's a much -- very much a collaborative enterprise. We have a staff, we have a dedicated staff member who runs all of our pro-life -- our culture of life programming, and -- and we've been doing it -- and this Vita Institute predates my assumption of the directorship. The Vita Institute was started before I became director and a lot of the faculty and a lot of the subject matters are -- you know, are -- have been consistent over the years. Same social scientists, same -- you know, we rotate to keep it interesting and fresh, but -- but yeah, we have a stable of -- of elite experts who -- who are -- who -- who teach the -- the participants.

Q One of the activities of the Vita Institute is that you organize site visits to crisis pregnancy centers?

A So we -- this year we didn't do that, but in the -- because we -- we've -- we've -- we -- again, we mix up the curriculum just to kind of keep it fresh. But

in the past, there's a very successful crisis pregnancy center called the Women's Care Center in South Bend. It's one of the most successful in the country, does amazing things for moms and babies and families. And so some of the people in the -- and the participants work in that field and so we do a site visit to see what best practices are, how best to care for those families and those babies before, during, and after the child is born, as well as to a maternal group home, I think called Hannah's House, where they care for moms in -- in difficult situations. And again, it's to -- it's to see best practices from people who are succeeding at caring for people.

Q Professor Snead, you were asked several questions on your direct about the Kentucky statutes that issue in this case.

A Uh-huh.

Q Do you recall that conversation?

A I do, yes.

Q And you were asked questions regarding considerations of privacy and liberty that might be invoked --

A Yes.

Q -- in a case such as this?

A Uh-huh.

Q But just to be clear, you're not here testifying as an expert about the Kentucky constitution; is that right?

A No, not -- not about the constitution, no.

Q And you're not offering any sort of legal opinion about the Kentucky constitution?

A No, that -- of course not. No, I'm simply talking about the -- the ethical balancing of privacy and liberty and reproductive freedom on the one hand versus the inviolability of human life at its various stages on the other.

Q And it -- during that conversation on your direct examination, I think you referred to the position taken by the trigger ban, in particular KRS 311.772, as ethically defensible. Do you recall that?

A Yes.

Q But that's not the only ethically defensible position to take on this issue?

A There's a broad disagreement about -- about what the appropriate ethical solution is to the problem, the human problems that -- which abortion is proposed as an option.

MS. GATNAREK: If I may have just one moment, Your Honor, to confer with co-counsel. I'm not going to ask that kind of question. We have no

further questions, Your Honor. Thank you.

THE WITNESS: Thank you so much.

MR. THACKER: Just a sec.

THE WITNESS: Yes, sir.

MR. THACKER: Just one quick matter in redirect, if I could, Your Honor?

JUDGE PERRY: Okay.

REDIRECT EXAMINATION

BY MR. THACKER:

Q You were asked by opposing counsel just a moment ago about the prior case in which you testified here in Kentucky, involving Kentucky's dismemberment statute, HB 454 --

A Uh-huh.

Q -- and I believe opposing Counsel asked you whether you were aware that the -- that statute was enjoined both by the district court and then that decision was affirmed by the Sixth Circuit. Do you know what's happened with that case since then?

A No, I do not.

MR. THACKER: Okay. We'll advise the Court of that in writing. Thank you.

JUDGE PERRY: All right. Recross, anything?

MS. GATNAREK: No, Your Honor. Thank you.

JUDGE PERRY: All right. Now, can the witness

be excused? All right, Dr. Snead, thank you.

THE WITNESS: Do I leave these papers --

JUDGE PERRY: Yes, please.

THE WITNESS: -- up here?

JUDGE PERRY: Uh-huh.

THE WITNESS: Okay, great.

JUDGE PERRY: All right. Anything else for the defendants?

MR. MADDOX: Nothing, Your Honor.

JUDGE PERRY: Okay. Any of the defendant wishing to offer anything today? Okay. Let's do this, let's take a tiny, short break and let me see what else is going on in terms of preparation of the record, what tomorrow might look like. You two talk. I know Mr. Maddox suggested a one-day briefing schedule. It'll be much more than that, but it can be a handful of days. I don't have an opinion about that yet. I want to hear what your thoughts are. You folks talk for a second and let me check on what else is going on and I'll be right back. Say ten minutes, and we'll come back, okay? All right. We're in recess.

(OFF THE RECORD)

JUDGE PERRY: All right. Welcome back. We're back on the record in 22-CI-3225. Before we

talk about logistics, let me just ensure, for all parties, you presented the proof you intend. So first, on behalf of the plaintiff, anything else you want to add, or have you told me or shown me what you intend to?

MS. TAKAKJIAN: We have put forth all the evidence we intend to, Your Honor. And again, I've mentioned that that includes live witness testimony today, as well as the verified complaints and sworn affidavits.

JUDGE PERRY: Okay. And you two are -- the parties are working on the stipulation that you'll embed into, ultimately, our briefing schedule which we'll talk about in a minute. All right. On behalf of the defendant, Daniel Cameron, anything -- have you told me all that you're going to tell me?

MR. MADDOX: We've completed our proof, Your Honor.

JUDGE PERRY: Okay. And then, although you didn't do it, anybody in the back, do you want offer anything we haven't talked about?

MR. MADDOX: No, Your Honor.

JUDGE PERRY: All right. Any motions before we start talking about briefing schedules?

MR. MADDOX: Your Honor, the only motion that I

would make is, again, the motion I made earlier today, and I think we'll encompass that in the discussion of our briefing --

JUDGE PERRY: And to be specific, I'll understand that Counsel, Mr. Maddox, to -- that you're moving to dissolve the restraining order.

MR. MADDOX: Yes, Your Honor.

JUDGE PERRY: I'm going to respectfully decline to do that and consider that inside the concept -- or the context of the relief sought from the plaintiff. So let's talk so politely. I respectfully decline to do that. So let's talk about next steps and how to both be expeditious, but responsible with what my job is now, which is decide the issue. I've just confirmed with my staff of what needs to be done. The record is right here underneath my feet, literally. That needs to be copied. The keeper of the record is always, in every county, the circuit court clerk. And in this county, that's David Nicholson. He doesn't have that yet until my staff gives that to him. I can't do that until in the morning, sometime between 9:00-- before 9:00 to 9:30. And then once the clerk has it, the media room, and you folks may know these folks dealing with them already -- it's an

individual named Steven Rush, who's the director of media relations even for our friends in the press or for the parties -- and you know where the media room is, I hope, downstairs. That's where you would ask for the record. Not here in Division 3. Does that make sense to everybody? Once -- and this happens every day, by the way, nothing different for the record purposes between today and just a normal miscellaneous docket. It happens every day. We copy it. We never copy it on the day of, unless we're in trial and then it's unique. But we're going to copy this one tomorrow morning between 9:00 and 9:30. So after that, I do not know how long it takes to turn around then to make copies for you. Whether it's the parties or press requests, I don't know. But I'd asked you to contact the office or the clerk to make that inquiry. My sense is it'll be sometime after we get it to them, probably between 10:00 and noon, something like that. So, to that end, to the extent I'm going to consider the filings, the affidavits, and the record, I want you to be in a position to comment on the record in whatever you eventually tender to the court. So that's, thinking out loud for you, my intent on what I'm about to do, which is to now talk about your proposed findings of

fact of law to support your specific request. I want you to be in a position to fully and thoughtfully consider the record today. And to me, that's going to take at least a couple days. So I don't know if you'll have a chance to chat about a proposed briefing schedule, or better question is, do you agree on anything?

MR. MADDOX: You won't be surprised to know, Your Honor, we do not agree.

MS. TAKAKJIAN: That's right, Your Honor. We would be requesting at least two weeks for the purpose of briefing. I also don't want to forget to ask the Court for -- within the briefing schedule, a deadline for amicus briefs if there are interested parties.

JUDGE PERRY: The -- I'm confident-- well, I know they are, because we've been getting them all day from folks that want to offer input. So you're asking for two weeks. Counsel, you're asking for less than that, I assume.

MR. MADDOX: Yes, Your Honor. We -- if the record's available tomorrow, we would be prepared to submit our brief, our response to the motion for a

temporary injunction, proposed findings of fact and conclusions of law on Monday. And I understand that would involve working over the weekend. We're certainly prepared to do that. We think that the issues are vitally important.

JUDGE PERRY: They -- no question, it's an important case, but also be mindful, I'm only one circuit judge with a small staff, and I have hundreds of cases on my docket. This is going to the top of the list, but that doesn't mean everything else goes away. So if you want to work over the weekend, great, but I'm not going to set it at Monday. I suspected that was your request. But I would think two weeks is a touch long. So what I'm really thinking through is when I want to start working on it, because as soon as I pick it up, that would become the most important thing on the Court's docket. So let me find a balance and suggest -- you suggested this Monday. I'm going to suggest the following Monday. And I'm specifically picking a work day so I don't get it on Friday afternoon to start my clock, if that makes sense to you. So whatever that is.

MR. MADDOX: So, that's July 18th, Your Honor.

JUDGE PERRY: That sounds right. Yeah. So

let's do that. That gives everyone plenty of time to get the record, to thoughtfully peruse it and how you want to use it. That gives you ten days or so at a minimum. And then I need to prepare myself for this Court's docket, to take it and be able to consider it and go as fast as I can go to get you a final opinion in order that I'm confident will reach other appellate courts. So I want to do my part in a thoughtful way. So I'd like to have it -- or receive your comments, on a Monday. I've thought about it all day. I don't think I need further comment. I mean, today's really been a real high level presentation of proof. I see your case. I see both sides. I haven't decided yet, obviously. And frankly, oral argument would simply slow that part down. I'd rather just have what you think and then go do my part. If you object to that and make a motion or tell me otherwise, I'm going to say I don't need an oral argument.

MR. MADDOX: No. We -- I have no objection to that, Your Honor.

MS. TAKAKJIAN: That's fine with us, Judge.

MR. MADDOX: I do wonder, do -- would Your Honor like to have the materials on the 18th at a particular time?

JUDGE PERRY: Well, I want it to be simultaneous. What I don't want is to build in a time gap so you somehow are responding to one another as if you're writing a response to a dissent. That -- we're not at that level yet. I want to know what you think. So, why don't we just say 12:00 on that Monday?

MR. MADDOX: Very well.

JUDGE PERRY: Assuming you will work over that weekend, Vic, and both you, and we'll have it on then. All right. Any questions about anything? And what we're going to do is publish a small scheduling order. My staff will do that probably tomorrow, to say what I've just said out loud, which is the record will be available tomorrow sometime in the a.m., simultaneous briefs by 12:00 on the 18th of July. And it'll be taken under submission for the court to rule as expeditiously as possible.

MS. TAKAKJIAN: Okay. Thank you, Your Honor. And just to clarify, would the July 18th date be the same deadline for any potential amicus parties?

JUDGE PERRY: Sure. I mean, if -- I'm frankly not sure how much -- amicus, for me, at the trial level, the rules don't even contemplate that. If it jumps off the page as something I want to read,

I will. But I'll tell you in advance, I probably won't. The -- that'll be saved for another level on another day. But if they want to make it part of the record, that's fine too.

MS. TAKAKJIAN: Thank you, Your Honor.

JUDGE PERRY: All right. Anything from anybody? And the parties that did not participate in the presentation of proof, you're welcome to file a pleading. Head nod. I don't expect it from you. Anybody expecting to file anything on behalf of their clients? Okay. All right. Well, let me commend everybody for today. It's been a really a great exercise in our constitutional democracy on how we resolve disputes, and so, well done. And you'll hear from me in the appropriate time. By the way, I've got a full miscellaneous criminal docket in the morning. I will be here. I don't expect to entertain anything, but if something comes up and you need to be heard, tell one another. Don't just wander in by yourself. But if something happens, I'll be here. All right? All right.

MS. TAKAKJIAN: Thank you, Judge.

JUDGE PERRY: We're adjourned.

(TRIAL ADJOURNED AT 4:42 P.M.)

CERTIFICATE OF REPORTER

COMMONWEALTH OF KENTUCKY AT LARGE

I do hereby certify that the said matter was reduced to type written form under my direction, and constitutes a true record of the recording as taken, all to the best of my skill and ability. I certify that I am not a relative or employee of either counsel, and that I am in no way interested financially, directly or indirectly, in this action.

SHAFAQ SAMEEN SHABBIR,
COURT REPORTER/NOTARY
COMMISSION EXPIRES ON: 01/07/2023
SUBMITTED ON: 07/15/2022

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$1,750 111:7

$10,000 114:10

$2,000 52:24, 25

$550 271:22

$750 52:25

$800 52:23

0

0 37:6

0.05 195:17

0.07 111:10

0.3 195:17,20

0.7 36:22 58:11, 17,23 199:21

0.8 37:5

011 46:11

1

1 21:5,13,19 39:7 42:23 44:21 65:5 82:15 84:10,12, 14 94:10 95:25 96:11 144:3,6 151:14 155:15, 23 156:3,5 255:11 259:8, 12

1,168 54:24

1,200 56:21

1,400 56:21

1,489 53:11 54:6

1.5 201:24

1.7 37:5,6

10 105:12 216:24 217:13, 17

10,000 195:23

100 29:17 161:18

100,000 36:22, 23 37:4,5,6,7 58:9,11,17,23, 25 231:23 232:19

10:00 291:18

11 53:16,25 54:4 82:18 106:23 118:7

11:30 83:24

12 99:6 107:11 170:16 208:16

120,000 151:1

12:00 295:7,16

13 59:20 81:13 112:24 124:23 173:15

14 48:21 60:14 67:9 82:1 123:21,22 150:15,24 159:25 160:12 168:3,7 208:16

15 29:16,17 33:16 61:2 67:20,25 78:5 83:24 124:20 167:22 173:15, 17 229:12,21

15-week 49:14

150-odd 160:5

15A 150:6

15th 135:16

16 126:1

17 58:6,8,24 59:2,6,11 60:8 126:11 194:21 230:3 231:4,22 232:17,18

179 116:11

18 78:5 128:16 208:14

180 116:13

1863 36:11

18th 293:24 294:24 295:16, 20

19 95:22 96:1 124:21 130:9

19-1392 153:25

1951 196:2

1970 169:2,25

1970s 205:3

1971 170:8

1973 169:2,25 170:8 277:10

1976 169:23 170:9,22

1978 179:15

1991 177:5

1992 277:13,15

1999 18:12

1:45 172:5

2

2 35:10,20 37:11,15 38:24 57:20 58:5,22 82:6 97:20 118:6 137:10, 13 140:18 141:10 145:16 181:18,21 227:7 231:17 232:3

2-4 36:21

2.9 37:4,6

20 99:7,8 123:21 172:11 179:25 184:15 208:14

20-minute 172:5

200 41:18 99:18

2004 89:16

2005 89:17

2006 18:14

2007 179:15 200:19

2009 89:18,20, 23

2010 18:17,25 145:7

2011 115:19

2013 121:1 168:3

2014 98:2,3,7, 19 167:24 168:3,22

2015 18:20 19:3 43:12

2017 53:10 54:18,24 59:25 97:24,25 101:13

2018 53:16,25 77:15 270:13 280:5

2020 103:5,13 104:8 106:10, 15 143:23 144:10,21 203:23 245:22 246:1,10

2021 123:6 135:16,17 203:22 275:16, 25

2022 128:22 194:10

20s 147:1,20

20th 196:3

21 60:20 125:12 179:25 200:23, 24

216B.190 164:10 165:15

22 60:17,22 223:4 235:16

22-CI-3223 242:16

22-CI-3225 173:1 288:25

22-CI-3325 3:4

23.7 98:19 167:21 168:6

24 66:17 72:18, 19 140:2 211:6 235:18

24th 275:6 276:10

25 82:17 147:22 201:4 235:18

26 211:5

28 99:8 125:7 201:10 211:5

29 99:8 223:3

3

3 80:19 81:4,7 98:25 120:10 123:3 145:16 156:8,13 158:6 159:4 160:18 216:14 227:5, 12 248:8,25 249:3 291:5

30 4:19 24:16 92:5 99:8 103:22 111:6 146:15 147:10 149:15 159:7 160:20 184:15, 16

30s 201:25

31 124:10

311 46:11 190:17

311.772 46:10 183:10 255:10 286:14

32 139:18 150:12,19 160:1 170:4,16

201:10

33 82:15 141:10 151:15 153:12 156:6

34.5 105:11 106:11

36 141:17

37 111:24

38 36:16 58:16 94:16 137:12, 15,16 200:23

39 36:17 58:5 231:20,25

3:30 242:11

3A1 227:6

4

4 94:11,22 99:10 110:25 111:1 123:4,5 143:14,15,19 145:16 171:20 172:1 227:13

4,000 56:20 59:25

4.8 202:2

40 23:17 149:15 157:4 160:25 161:18

40s 201:25

42 38:25 82:7

45 167:22,23 170:19

454 287:13

49.4 106:8

4:42 296:24

5

5 39:8 98:25 100:5 108:25 109:3 118:6 145:16 230:10 242:16

5,500 212:18

50 99:20 157:5 159:7 160:20 234:11

523 54:18 59:25 60:4

55 53:22 54:3 60:3 100:25

57 54:15 60:3

58 231:7

59 100:21

6

6 81:13 101:8 116:4,7 145:16, 17 166:25 275:16

6.3 37:7

6.7 58:9,25 231:23 232:19

60 24:16 99:7 203:16

64 124:5

65 12:3

66 77:19

66.3 104:13

7

7 102:8 121:8, 12

73 277:14

75 99:21

76 200:25

7701 46:11 190:18

78 111:7

79 116:13

8

8 103:1 123:15, 17 146:12

8.5 105:5

8.8 36:23

81 111:11

87.2 106:16

9

9 104:14,15 129:9,12

90 59:19,21

96 212:18,19

99 196:3

9:00 290:23 291:12

9:00- 290:22

9:30 290:23 291:12

9th 128:22

A

A&m 89:13,24 90:1,17 91:14 147:5,12

a.m. 295:16

abating 225:4, 8

abbreviated 282:12

ability 15:4 30:11 35:6,7 96:23 107:4 129:17 146:1 165:8 167:2 184:10,19 186:23 189:9 223:20 224:11 225:22 239:1

abnormalities 193:18

aborted 68:6

abortion 9:6, 11 19:16 20:8, 11,14 22:17,21, 22 23:7 34:15, 19 35:9 36:3, 17,19,22 37:3, 20,21 38:5,10, 13,14,20,22 39:14,21 42:25 43:25 46:14 48:17 49:14,18 50:24 52:13 53:3 54:8 55:11,16,21 57:9,13,24 58:3,8,23 63:16,18,19,21 64:8,14,18 65:20 66:14,24 67:10 69:13,17, 20 70:10,15,16, 19 71:9,15 72:7 78:4,7 81:15, 19,20,23 82:5, 14 90:24 92:13, 18,21 93:10 96:19,20 97:10 98:16,19,20,21 99:7 100:12,19 101:19 102:25 103:5,20 104:8 105:8,10,21 106:13,15 107:1,3,5,7,8, 13,22 108:9,12, 15 110:14,15, 18,21 111:5,18, 22 112:5,19 113:4 114:25 117:14,21 118:4,19,25 119:9,20 120:3, 5,14 121:19 122:16 124:18, 19 126:5,9,18, 20 127:4,12 128:7,13,21,25 129:1,2,18,21 130:7,11,12,14 131:9 133:19 136:25 137:12, 22 140:10 141:21 142:3 143:21,22 144:10,15,17 145:3,11 146:18 147:23 148:3,14 149:4, 12,13,14 150:15,24 151:2 156:9,18, 22 158:2,8 159:6 160:1,8 161:6,17,25 162:6,20,21,23 163:4,5,7,20 165:9 166:11 167:5,7,22,23 168:11,14,25 169:5,14,19 170:5,21 171:8 189:16 195:7 196:14 198:6,8, 20,22 199:1,3, 13,16,21,24 200:11,13,14, 15,16,20 201:6, 7,10,18,19 204:20,25 205:5,11,15,21 206:6,9,20 207:4 210:7,9, 10 212:5,8 215:24 218:16 219:13 220:1, 15,18,21 221:9, 11,12,13 222:1, 11,18 223:25 224:5,8,14 225:10 226:11, 18 227:11,15, 25 228:15,18, 21,23,25 229:6, 8 231:21 232:18 235:2,6 236:4,19 237:2 238:1,11 239:7, 15 246:12,13 247:23 249:10, 24 250:22 252:23 253:9 259:20,24 261:14,17 262:2,10,17,19 263:11,21 264:2,4 265:4, 17 266:4,9,14, 22 268:9,16 269:16,18 271:2 272:12, 14 273:18,21, 25 274:7,20 276:1 277:2,5, 8,11,24 278:10, 12,19,20 280:8,

12,14,16 282:19 283:21 286:21

abortion's 163:9

abortion-related 198:18, 19 215:16,20

abortions 9:19 39:4,8 40:23 43:18 44:5 45:9 46:17 47:8,20 48:10,13 53:11 54:17 55:1 56:13,21 57:6 59:2,5,11,15, 18,19 79:20 82:16,19 97:15 99:15,21 100:16,17,23 103:17 105:3, 25 118:1,24 120:6,14 121:4, 6,20 122:2,19 127:23,25 130:2 133:19, 24 134:9 136:23 142:10 146:13,15 147:10 159:16, 19,20 161:12, 14 162:22,24 163:1 166:24 168:9,10,20,21 195:4 218:9,11, 22 219:5 266:17 267:22

abruption 28:4 38:9 195:21

abscesses 31:5

absent 236:19, 20

absolute 277:7

absolutely 87:15 104:21 107:17 110:7 136:14 138:19 227:1 251:6 273:12 274:25 276:9 282:3

abuse 221:18

abusive 118:2 166:6,11 167:4, 12

academic 19:20 89:21 91:13 134:2,4 143:22 176:13, 16 244:13,22, 24 251:5

academics 246:7 283:6

Academies 36:1,7,8 57:21 205:13,14 231:17 232:8

Academy 4:22

accept 44:2 86:22 174:18

acceptable 222:22

accepted 92:10 119:17 255:21

accepts 52:6

access 22:25 23:1 34:13 38:3 70:22 82:5 92:21 96:20,21, 22,23 105:21 107:1,3,13 111:18,21 112:19 113:4 114:24 117:14, 21 120:3,5,14 122:23 123:1 124:3 146:2 148:3 149:3 169:19 240:25 273:25

accessing 38:20 123:25 124:7,18 127:12

accidents 196:25

account 252:6 263:7,19 280:13

accounting 261:23

accurate 94:12 157:23 173:12, 13 181:10 199:22 220:2 248:13,22

accurately 199:22

ACGME 20:12 44:1

acid 184:4

acknowledge 137:16

ACLU 3:13,24 42:10,11

ACOG 214:13 215:1

ACOG's 214:11,12,22 233:6

acquired 24:20

act 36:11 254:25 255:6

acting 278:16

action 239:13 240:5

actions 260:10

active 67:21

activities 19:19 284:20

activity 117:1 188:18 190:11, 19 191:1,14

acts 61:18 62:3

actual 80:25 179:13 195:15

add 9:14 75:4 152:5 195:2 289:4

addition 24:6 25:8 41:11 91:9 93:20 102:20 104:17 127:6 140:1,21 184:3 185:10 186:1 188:14

additional 37:24 107:5 111:11 112:15 114:18 130:20, 21 136:25 140:12,16

Additionally 113:21

address 79:13 90:23 165:2 265:21

addresses 145:3 173:17

addressing 203:5

adequate 9:16 30:11

adhere 219:17

adherent 31:13 61:10,17

adjourned 296:23,24

administer 225:2

administration 73:19,21

administrative 179:13,14

admirable 279:2

admissible 21:23 22:1 87:8

admission 37:10 81:4

admit 21:19 116:3 123:14 129:8 221:15 248:24

admitted 25:9 37:15 81:7 84:14 109:3 116:7 121:12 123:17 129:12 156:3 172:1 181:21 217:16, 17 233:21 249:2,3

admittedly 198:9

adopt 258:18

adoption 164:24 165:24 166:20

adult 37:6 101:6 112:7 188:13

adults 131:24

advance 52:13 53:7 152:1 251:9 296:1

advances 76:25 77:19 272:10

adverse 137:20 139:4

adversely 28:24 260:11

advice 207:12

advise 91:11 287:21

advised 242:17 248:2

advisement 10:24

advises 247:8

advising 36:14 92:9

advisory 245:13

advocate 283:25

advocated 277:21

advocates 283:3,14

advocating 138:21 283:17

affect 26:2,6 28:24 35:5

104:6 182:14 260:11

affected 24:24 102:25 105:7 114:8 125:21

affidavit 13:23 21:13,22,24 22:1,2,6,9 32:25 33:1 36:5,6 44:19 72:10 84:10 86:17,18,23 94:7,13,18,22, 25 95:1,5 125:25 139:10 143:20 148:9 165:4,19 168:23 169:21 170:11 171:20 262:15,25

affidavits 11:17 13:20 14:15 173:10 262:6 264:24 270:24 289:10 291:21

affiliate 9:5

affiliated 42:7, 9,10

affiliations 91:14

affirm 17:2 88:17 175:13 243:7

affirmed 280:23 287:18

afford 124:9

afoul 226:8

Africa 177:19 202:13,14 283:8

African 72:6 74:7 148:25 177:16 266:6 269:6,10

afternoon 8:14 10:5,7,14 133:4 175:12 176:6 213:7,11 242:9 243:6 270:6 293:22

AG's 271:21

age 29:9 38:23 58:2,24 59:3,16 67:18 77:19 80:9 82:1 103:20,22 108:10,11,13, 14 110:14 146:15 147:12, 13,17 167:23 193:17 200:12, 13 201:8,23 204:18,19 205:10 216:11 223:14,15 224:11

ages 184:6 200:2,16 201:23

aggravated 269:24

agree 9:7 10:22 15:13 44:17 62:19 63:4,16,21 69:21 75:21,25 76:5,10,14,18, 23 77:7,9,25 136:11 139:14, 15 159:5 160:10 161:4 195:13 227:15, 21,22 279:17 292:7,9

agreed 54:17 142:8 173:11, 14 212:20

ahead 22:11,14 33:10 64:4 85:2 88:5 90:14 96:7 106:17 107:10 138:5 162:2 209:24

aid 255:4 268:21 275:22

aids 86:8

Alan 199:2

Alaska 169:7

alerted 152:15

all-required 244:16

alleged 260:25

alleviate 263:13 268:22 279:3 281:14

allowed 33:3 112:20

alongside 260:2 261:17

aloud 112:1 116:12 118:8

alter 28:23 165:2

alterations 62:16

alternative 222:23

altogether 115:3

amalgamation 69:25

amazing 221:16 285:4

amazon.com 272:24

ambulances 211:17

America 5:20 98:17 246:13 269:20 276:15 277:12 283:8

American 20:17,21 72:6 73:4 74:7 148:25 177:16, 18 202:20 219:10 246:12 266:7 269:6,8, 10 272:9 277:5

Americans 220:6

Amici 154:20

amicus 154:4, 13,16 276:19, 20,22,23 277:1 292:16 295:21, 23

Amiri 3:22,23 18:3 20:25 21:3,7,11,19,24 22:4,8,15,20 33:3,9,11 35:14,18 37:10, 17 41:23 44:11 46:19 47:23 49:9 50:16 51:19 52:14,16 59:4 60:5,7 64:3 66:9,20 68:11 73:20 78:14,21 80:16, 18,21 81:3,9 82:21,25 83:6 84:2 85:3,17 182:22 213:6, 12 216:22,24 217:2,4,13,19 226:23 227:1,4 232:8,12,16 241:18

amniotic 49:1

amount 24:4 31:24 32:12 86:20 111:6 141:19 216:9

amounts 140:22

AMRI 41:20

analogize 244:17

analyses 93:21 165:18 180:9

analysis 112:10 140:5, 24 141:6,22 160:4 164:20 165:13 168:15, 16 180:13 252:11 261:3 265:20 277:14, 18

analyze 179:17

analyzes 80:15

anchors 268:17

and/or 28:6 29:13 30:5,6 33:18 128:10

anemia 24:5, 10 26:8

anemic 24:11

anesthesia 31:7 185:5,9,11

anesthesiologist 185:9

animal 184:22

Annapolis 244:15

Announce 3:8

announced 41:8,10

annual 55:2 103:5

anomalies 38:6

anomaly 220:22

anonymously 164:13

answers 165:12 253:13

ante 263:17

antibiotics 30:7

antigens 189:17

anxiety 33:20

anymore 235:8

anyone's 6:8

apertures 188:9

apologies 115:15

Appalachia 177:17
apparently 165:7
appeal 11:2
Appeals 280:22
appeared 264:13
appearing 207:14 271:24, 25
appears 14:2 103:3 155:3 209:23 257:8
appellate 11:3 294:8
appended 94:18
applications 109:19
apply 172:16 283:1
appointed 247:5
appreciable 55:2
appreciated 119:17
approach 20:25 35:11 53:17 66:23 80:16 93:23,24 181:1 216:22 230:14 248:5 255:5 261:13
approached 93:13
approaching 68:20
appropriately 208:11
approval 95:16
approve 79:7
approximately 23:17 29:16 33:16 41:17,18 48:23 114:9 151:1 193:1
April 135:16
arbitrary 223:14
area 146:9 156:12,19 157:11,12 159:17 244:22, 24,25 245:7,17 268:5
areas 157:8,13 159:3 160:21
argue 174:15 278:24
argued 275:6
argues 266:13
argument 47:24 162:10 252:15 254:4, 11,20 262:14 263:9,20 264:12 265:17 267:25 268:8,9 277:10,15 294:15,19
arguments 12:14,23 250:14,15 252:16 254:11 265:13 269:1 283:20,21
arise 30:18 55:24 195:10
arises 272:10
Arkansas 92:16 135:25
arms 49:7
arrangements 8:2 53:6
array 132:2
arrested 102:3
arrhythmia 24:21
arrived 122:8, 11 231:10
art 183:21 210:17
arteries 27:12
artery 202:10
arthritis 238:18
article 71:13, 14 116:11
articles 92:2 146:6 178:20 179:23 229:5 246:2
Arts 244:2
ascertain 197:12 198:25
ascertaining 197:4
ascertainment 194:14 197:23
Ashlee 16:10 18:6
asks 173:3
aspects 20:7
aspiration 39:5
assault 166:17
assemble 265:3
Assembly 46:9 135:8,12 136:8 185:13 258:1,9
Assembly's 257:4
asserted 149:13
asserting 47:19 48:2
assertion 146:21 205:19, 22 206:2
assertions 264:15
assess 203:13 206:22 207:25 208:6 211:12 264:14 283:23
assessed 126:2
assessing 69:20
assessment 123:7 195:13 208:9 233:15, 18 235:5,7
assessments 230:22
assigned 113:11
assignment 93:8,13
assist 154:20
assistance 119:3
assistant 4:13, 15 5:4 19:6 89:22
assistants 178:9
associate 89:23 91:16 178:14 282:5,7
association 219:10 229:7
assume 13:8 15:11 52:3 80:15 226:16 233:25 234:17, 24 263:8 265:7, 19 273:14 292:22
assumed 14:12
assuming 227:10 295:9
assumption 168:16,18 284:12
asthma 25:4,5, 11,12
astronomically 202:15
attach 173:25 186:24
attached 21:17 95:2 143:20
attachment 144:3,6
attack 27:13 62:18
attacked 62:15
attainment 131:17 266:25
attempts 277:6
attend 87:20
attended 244:14
attention 13:7 36:16 38:25 79:13,14 94:15 110:24 111:23 115:14 116:10 117:18 118:5 124:23 227:14 230:16 231:6, 20 255:9,11
attorney 4:9, 14,16 5:5,6 8:18 11:10 39:18 41:4 42:4 46:21 133:5 151:15 181:17 213:15 215:7 226:16 227:10 242:21 248:8, 25 270:15 271:7,9,12
attorneys 213:13
attribute 206:11
author 107:23 160:3
authored 151:21

authorized 154:7 155:7
authors 101:24 107:25 109:12 137:16
auto 141:20
AUTOMATED 4:18 5:10
automatically 4:18
autonomy 268:11
average 102:21 114:4,6 125:9
averages 78:24
averments 173:14
averse 207:20
avoid 137:20 138:25 139:4 165:8 234:1
awarded 92:8
awards 92:6
aware 52:8 69:15 71:8 98:6 183:9 241:3 287:16

B

B-E-R-G-I-N 17:8
BA 18:11
babies 56:24 57:5 148:25 250:16 281:13 283:12 285:4,8
baby 27:22 63:5,20 64:10 68:5,10,19 102:1 184:3 200:8,9 207:23 209:17,25 210:7,16,20 211:19 221:17 235:21
baby's 189:2, 10 192:24 193:6,9,11 211:16
bachelor's 89:15
back 3:6 5:13 13:5 14:7 16:19,20 17:20 21:16 32:7 73:23 79:1 83:8,25 84:7,9 85:20 117:18 119:12 142:7 171:19 172:8, 10,25 197:3 201:9,12 204:3 205:3 209:9 212:13 234:5 242:1,12,15 267:25 288:21, 24,25 289:20
background 18:10 89:14 176:17 195:9 244:13
bacteria 27:25 30:9
bad 136:13,19 142:11,14,18 203:14 263:3 276:14
bag 27:23
BAILIFF 84:4 88:14 175:8 243:4
Bajramovic 5:18,19
balance 141:19 249:25 253:7 278:4 293:18
balanced 251:7
balancing 286:8
ban 41:3,5 49:14,15,16,17 50:19,24 93:10 97:10 102:25 105:7 111:18 112:15 113:5 119:8 125:21 129:23 130:11 132:15 158:2,9, 12,15 161:7 222:12 224:2,6, 25 225:1 226:8, 12,18 227:6,16, 25 235:9 254:25 286:14
bankruptcy 111:10
banned 161:25 168:11 222:1 235:6
banning 133:19,23 162:6 236:19
bans 39:16 40:2 96:19 97:8 104:25 106:19 107:13 112:13, 20 113:9 114:8 124:15 125:18 130:18 131:3, 19 132:6 148:22 160:8 223:25 262:16, 19 279:7
bar 14:5 99:17
Barrett 200:18 205:7
barrier 124:3, 18 189:19
barriers 123:24 124:7, 11 125:23
Barring 208:6
Bartlett 205:6, 7,8,9
based 69:23 70:16 92:25 98:18 100:10 103:4 123:23 124:24 145:17 150:24 160:13, 17 161:4 162:21,23 167:15,17 168:13,22 195:11 203:2 205:24 206:3 234:4 274:14, 23
baseline 140:2
bases 259:7
basic 254:17
basically 15:24 20:2 30:10,17 32:11 34:20 36:12 48:10 49:4 61:14,18 69:4 72:9 75:22 136:12 264:6 277:15
basics 178:11
basis 55:2 147:23 167:2 174:14 258:7 282:1
bear 22:24
bearer 254:10
bearing 6:22 119:19
beating 63:22 64:10 190:2
began 277:12
begging 265:19
begin 7:18 10:6 106:19 187:14,19,21 188:1,2,11 195:16 253:1 260:13
beginning 48:21 54:4 58:16 60:14 76:15,19 93:15 111:2 118:11 144:14 191:5 212:14
beginnings 188:15
begins 76:1,6 112:2 116:14 118:12 186:3, 14 187:24 188:8,16,20 212:20 219:22 230:17 237:20 254:19 260:10
behalf 3:13 4:7,9 5:5,9 9:8, 22 52:4 154:9 155:8 173:2 184:11 283:15 289:3,14 296:10
behavioral 131:15
behaviors 117:2
beings 250:11 254:14,15,16 256:4,18,22 257:10,11 265:25
belief 236:10
bench 21:1 35:11 280:4
Bend 285:2
benefit 140:22
benefits 115:12,18 117:7,11 140:21 241:5
Bergin 16:10 18:4,6 21:4,12 22:16,21 33:9 34:1 35:19 37:9 42:3,7 50:21 51:23 52:12 53:21 69:10 78:22 81:10 84:17,24 85:4, 17,20 195:7 232:13 260:20 262:8 264:7
Bergin's 205:12 266:1
bet- 250:6

bias 71:20
bibliography 180:23
bifida 184:18
big 61:15
biggest 205:11
Bill 255:1
bills 213:22
binary 277:14
binder 94:11 107:19 115:15 120:10 123:4 128:17 172:14 230:13,14,15 232:9
binders 87:23
bioethical 247:22 252:15 255:22 269:21
bioethics 244:5,10,25 245:1,5,8,12, 17,25 246:20, 21,25 247:4,6, 12,15,22 251:5, 14,17 258:2,16 259:18 261:3 262:11 264:9 266:13 272:1,8, 9,14,17
biological 219:21 250:4 252:21,24
biologically 64:1,6 257:4
biologists 212:18
biology 18:11 75:23 203:2
biomedical 272:11
biotechnology 245:2 272:11
birth 57:10 77:5,6,8 100:19,21 104:12 106:4, 10 111:13 118:21 130:8 131:7 137:1 140:1 169:8,15, 23,24 170:6,18 171:8 179:14 184:2 189:19 198:7 201:11 202:1 210:8 224:9
births 122:20 136:23 137:2
bit 17:15,19 26:17 28:9 32:7 35:3 53:4 82:4 97:14 171:1 184:16 185:15 186:11 190:15 191:22 193:22 195:5 199:14 201:13 204:1 209:18 229:23 231:16 244:12 246:4 252:3 280:25
black 34:4,7 72:5,20 74:7 100:14 105:2,6, 10 148:12,19 149:5 178:25 201:18,19 202:5,9,11,12, 13,23 203:15 204:4,10,14,20, 24 207:3
bladder 31:4, 22
blanket 278:10
bleeding 28:6 30:1,3 31:3,17 189:14
blending 160:23
blood 23:25 24:2,4,7,13 25:14 26:10,16, 20,24,25 27:3, 5,6,7,8,12 28:8, 10,12,14 29:5 30:5 31:9,24 32:12,13,15 61:18 62:4,25 179:5 189:1,4, 5,10,11 190:1 191:13 195:16 200:10 206:15 208:19 209:14, 19 211:11 228:12 233:3 239:11
bloodstream 28:3 29:25 30:10
blue 156:15
blue-ish 157:8
bluer 156:17
board 5:11 20:16,17 45:14, 16 177:1,3 220:5,8,13
bodies 29:21
bodily 39:23 228:3 235:25 236:22 238:13 239:5 260:12
body 23:20,22 26:19,25 32:13 62:15 118:18 189:2,5,6 245:24 247:7
bonding 33:24
book 117:4 245:22 246:5 269:7 272:22, 23
books 212:21 244:15 246:9, 11 272:21
boosted 7:5
boot 282:22
born 131:9 149:1 169:20 223:6 250:16 257:10 278:8 283:12 285:9
borne 97:4 113:3
borrowed 141:19
bottom 58:6,7 101:14 232:2
boundaries 162:22
bowel 31:4,22 198:23
boxes 197:11
brain 29:13 188:19 190:10
breached 189:20
breadth 132:4, 7
break 83:16, 18,20,24 171:19 172:5 242:9,11 288:12
breakfast 208:18
breaks 27:19, 20 28:1 204:23
breath 25:3
breathing 25:10
Brian 71:14 199:4
briefing 11:12 12:13,21 288:16 289:13, 24 290:3 292:6, 14,15
briefly 215:25 272:22
briefs 292:16 295:16
Brigitte 3:22 213:12
bring 79:13 189:10 242:24
brings 61:20 202:4
broad 130:10 182:25 227:5 283:8,9 286:19
broadcast 6:1
broader 272:9, 15
broadly 120:18 122:21 259:2
broken 27:23
brought 259:8
Brown 176:20
buds 188:21
build 295:2
building 7:2 281:18 283:11
buildings 7:1
bulk 11:19 59:18
Bulletin 214:19
bulletins 214:13,14,15
bumps 186:21
bundle 198:5
burden 249:13 277:14 279:3
burdens 82:8, 12 249:15 250:12 253:9 260:24,25 261:2,4,5,6,23 268:22 278:6,7 281:15
Bureau 91:17, 18 104:18,19
busy 208:8 248:17

C

C-SECTION 31:1,8
cabinet 5:1
calculate 194:19 206:12 230:1 231:12

calculus 261:11 263:10 264:19
Calhoun 71:14
Calhoun's 199:4
California 169:7 198:11
call 6:3 8:8,18, 20 9:24 11:7 16:7,10 36:7 50:14 84:13 85:13,25 108:1 109:15,23 120:25 184:12 210:5 239:22 242:17 281:9
called 27:6 28:3 31:13 32:9 48:9,12 57:20 61:9 71:14 76:3 109:12 121:16 149:22 156:5 163:19 168:25 169:1 174:7 178:23 180:24 186:2 197:7 203:7 205:14 208:2 211:16 240:12 244:10 245:23 281:11 285:2,10
calling 152:16 175:4 188:6
calls 41:11,15 46:20 50:15,18 242:22 257:21 268:16
calories 208:18
camera 6:16 17:16
Cameron 3:5 4:9,14 42:4 133:6 151:15 242:21 289:15
Cameron's 11:11 155:22
camp 282:22
cancel 136:4
capacious 257:9
capacities 253:25
capacity 25:2 42:12 45:12 79:18 245:9,14
car 196:25 198:1
card 141:19
cardiac 24:15 188:1,10 190:19 191:1, 14
cardio 204:5
cardiomyocytes 187:25 190:4 191:15
cardiomyopathy 32:10,18,19 195:21 202:24 233:4
cardiovascular 187:12,16,19 189:1 202:8 207:25
care 19:13,15, 16,22,25 20:2, 8,11,14 22:17, 21,22 23:6,7,8, 11,14 33:22 34:14 35:6 36:3 37:20,21,23 38:5,10,22 39:21 40:16,20 41:13 43:9,25 45:13 55:16 61:1 64:18,19, 20,25 65:18 66:13,14,24 70:13,19 74:17, 24 75:11,13,15 78:8 96:21,22, 23 98:16 100:13,20 103:20 104:8 105:10,22 106:15 107:13 110:21 113:18 114:18,25 117:14,21 120:3 122:16 123:8,25 124:7, 10,11 126:5,7, 9,18,20,21 127:12 128:14 129:18 130:7 167:7,13 185:8 198:22 207:22 208:8,21,25 209:17 211:1, 19 212:7 218:13 221:6 239:18,24,25 240:1,16,17 273:25 281:13, 14 285:2,7,10
cared 228:17, 20
career 92:1 104:3 115:7 144:14 146:17 147:17,24,25 179:24 218:12 228:23 240:8
careers 103:24 104:2 115:4 146:19 147:21
carefully 261:9
Caribbean 177:21,22 202:12
caring 221:10 273:2 285:12
Carolina 176:24
carried 110:22
carries 32:13
carry 23:8,15 30:13,14 38:15 221:22 233:25 237:21
carrying 32:15 65:2
Carter 242:22 243:20
case 7:15 9:13 10:4 13:20 16:9 21:14 41:16 45:3 47:12 48:3 49:15 51:24 61:3 63:21 64:10 67:8 84:8 92:17,23 93:8 94:1,13 95:8 96:15 100:14 107:15 111:17 112:12 115:11 117:12 122:15 124:14 126:3 132:9 134:5 141:24 143:5 147:2 148:19 149:2,20 151:17 153:25 155:21 161:23 162:6 172:6 173:3 174:3,23 182:5,9 183:8 197:6 206:7 213:16 214:3 222:1,12 233:17 242:17 245:24 247:16, 25 248:1 249:6 252:4,9 265:14 267:24 270:9, 16,21,23 276:19,20 280:2,7,18 285:16,24 287:11,19 293:7 294:13
cases 97:11 134:20 220:19 234:25 247:24 249:12 293:9
Casey 150:13, 23 156:9 158:3, 8,16 159:7 161:22
categorically 265:9
categories 79:25 126:15, 16
categorizing 197:17
category 112:25 113:6 114:21 117:20 124:5,8 131:1 266:16
causal 90:20, 25 109:14,19 122:6 154:21 263:7 274:20
caused 197:12
causing 28:6 225:4,7 269:23
cava 26:24 27:2
caveat 192:16
CDC 198:9,14 199:7 224:10
CDC's 199:6
cease 121:2
cell 24:2 25:21 76:2 185:18 187:14 188:2
cells 24:7 187:15,18,25 188:1
Census 104:17,19
center 3:5 9:4 19:14,20 178:15 211:18 244:1 281:2,5, 20,22,24,25 282:2,8 285:2
centers 283:5, 6 284:22
centimeters 200:8
central 252:15
century 196:3 246:17
certificate 71:22 197:10
certification 14:4
certifications 20:16 177:2
certified 20:17 177:3

Cesarean 30:22 31:11,25 32:4 34:25 35:3
cetera 144:8 195:11 251:19
challenge 127:23
challenged 39:16 40:2 190:16 224:1
challenging 44:21 49:14,15 50:20,24 92:17 214:2
chance 35:19 109:16 116:20 216:20 226:24 235:20 240:2 292:5
change 23:20 109:20,21 141:12 150:16, 25 159:17 184:7
changed 55:1 77:24 141:20
Chapel 176:25
chapter 35:23 36:1 82:15
characteristics 103:16 192:9, 11
characterization 136:15 139:16
characterize 132:3 168:19 219:15
charged 40:20
chart 157:3
charts 179:13, 17,19 203:11
chat 292:5
cheat 180:18
check 192:24 197:11 208:19 288:20
Chicago 18:15,20 19:1 212:17
child 37:24 62:13 64:16 65:1 66:4,18 69:12 113:19, 20,25 114:1,4 119:19 127:2 130:7,8 136:23, 25 137:2 140:10,11 145:10 163:15 164:11,12,14 165:8,15 166:1, 2,20 183:14 190:8 193:12 195:25 249:19 250:15 252:8, 22,24 253:1 255:18 256:2 262:23 263:23 264:22,24,25 265:8,10,14,21 279:21 285:8
child's 191:24
childbearing 113:21 120:6 127:1 144:14 145:6
childbirth 30:13,14 32:4 34:2,3,9 36:23 57:12,23 61:9 69:12 72:7,23 119:13 142:10 183:15 198:6 200:12 201:6, 18,20 205:21 255:19 264:18 282:19
childcare 127:6
children 22:24, 25 35:6 93:17 102:17 104:9 113:16 114:10 116:25 130:5, 12,13,17,23 131:8,11,20,22 137:5,6 140:15 149:4 164:24 165:1,24 169:20 263:14 267:1 269:23 275:22 281:7, 12
children's 104:6 131:2
Chireau 176:8
choice 267:14 268:12,13 274:21
choose 7:9 165:25 241:13 268:15 274:19, 20 283:24
chooses 40:11
choosing 155:19 167:5
chorioamnionitis 30:25
chose 221:12
Christopher 4:13 242:20
chronic 26:7
CINAHL 180:18
circle 84:9 204:3
circuit 90:10 280:22 287:18 290:19 293:8
circulation 61:19
circulatory 188:25
circumstance 224:2 236:18 238:3
circumstances 65:15 101:19 120:21,23 142:16 166:19 210:1 222:3 228:4,9
cite 259:11
cited 36:5,6 82:13 98:10 134:21 148:9 199:5,20 246:6 268:9
citing 219:6
citizens 268:20
city 177:17
civic 117:3
civil 13:21 269:14
claim 174:14 259:7
claims 9:8,11 51:25
clarification 151:20 153:12
clarified 163:4
clarify 84:18 85:6,7,18 140:17 144:25 158:6 233:20 271:9 295:20
class 265:24
classes 113:17 135:22 136:4,5
classics 244:20
classify 189:25
clear 8:23 10:13 39:3 48:4 50:11 53:9 79:17 87:13 90:8 130:13 132:14 133:14 142:23 152:8, 12 153:17 171:5 212:11 260:7 286:1
cleared 10:13, 14
clearer 121:23
clerk 290:19,23 291:16
client 46:21
clients 296:11
clinic 42:25 53:1 56:18 79:11 85:14 120:14 173:21 178:8
clinic- 150:23
clinic-based 150:14 159:25
clinical 39:3 177:13,15,25 178:4,5,11 189:8 195:12 202:12 205:24 207:10 228:4 237:7 239:23 264:14 272:3,5, 6,12
clinically 238:24
clinician 226:7 238:5
clinicians 225:18 234:3 239:1,7
clinics 118:19 121:1,5,17
clock 293:22
close 11:7 16:17 60:22 90:10 92:5 101:25 132:18 175:19
closed 90:10 169:17 170:22
closely 93:18 144:15 166:16
closer 201:3
closest 124:8
closing 191:11
closures 120:14
clot 27:7,9 31:10

clots 27:3,5,6, 12 195:16 233:3
clotting 26:16, 17,22 27:1,15
cluster 276:7
CNN 276:11
cnn.com. 276:12,13
co-authors 120:13
co-counsel 3:19 4:11 41:21 82:22 132:22 270:1 286:24
co-editor 91:5, 8
co-habitating 101:3
coextensive 256:15
cognitive 131:11 253:23 254:8 263:4
cohabitating 101:1
col 244:1
Coleman 194:10
Coleman's 229:19
collaboration 284:3
collaborative 284:8
collagen 25:21 238:16
collates 80:15
colleagues 10:15 73:15 75:1 122:9 200:18
collect 172:14 197:5,18
collected 108:7,8 180:8
collection 71:20 180:6
collections 196:23
college 18:12 20:21 176:19 244:1,14,15
colonoscopies 37:4
color 97:6 119:25 125:21 156:17,18,21 159:5 268:24 269:12
colors 156:14 160:23
comfortable 230:22 240:19
commend 296:12
commendations 92:6
comment 174:19 231:15 291:22 294:12
commentaries 248:15,19
comments 294:10
committed 281:18 283:10
committee 39:9 65:6 245:13 247:4,7, 12
committees 197:7 203:10
common 37:7 67:15,17 98:15, 18 191:23 283:10
commonly 33:17 109:13
Commonwealth 4:25 46:9 79:20 92:18 93:11 97:8,16 102:11 103:17 105:3 131:19 133:25 146:10 149:1 161:25 217:5
Commonwealth's 5:5,6 104:25 106:19 112:13 113:9 124:15 130:18 131:3 132:6
community 7:9 75:16 183:16 185:15 190:23 196:7 203:24 207:13 269:6 275:21
companies 185:10
comparable 37:7 199:13
comparative 244:20
comparatively 201:7
compare 102:12 200:7 250:1
compared 27:4 62:21 72:24 106:1,3 118:16,23 200:25 250:12 266:7
compares 58:11
comparing 58:15
comparison 109:22 168:24 171:3 199:18 200:5 206:5
compassionate 64:19
compelled 267:23
compensated 271:17,20
compensates 85:13,15
competing 249:11 278:5
complaint 9:3 13:19,23 47:12 173:9,15 182:4 214:2 259:6 260:24 268:10
complaints 173:9 270:23 289:9
complete 16:16 18:18 55:20 84:23
completed 18:17 19:2 80:10 176:18 178:22 289:17
completes 84:11
completing 18:20
completion 71:22
complex 18:19,21 43:22 57:14 62:11
complicated 57:14 67:8 180:12 198:8
complication 39:10 196:19 206:21 215:21 216:10 271:5
complications 24:22 25:11 27:14,18 28:21 29:7 31:7 32:17,20 35:5 38:18 39:6 55:24 57:12,17 72:19 80:1 228:10
compounded 269:24
compounding 279:5,14
comprehensive 23:4 230:7
compresses 26:23
compression 27:2
conceived 279:22
concentrated 202:3
concept 290:10
conception 29:19 30:2 185:20,25 212:14,15,20 250:3 252:18 254:20
concepts 259:19
concern 71:8 78:4 193:16 267:24 268:2
concerned 49:22 78:3 183:8 193:18 207:10,13 281:5
concerns 118:2 274:9 281:16
conclude 8:14 10:7
concludes 111:3 118:10
concluding 230:17
conclusion 111:20 112:14, 23 119:10 122:17 124:16 125:20 141:18 142:6,19

169:18 171:6 229:21 256:12 257:4

conclusions 93:20,25 94:5 95:8 96:14,16, 18 97:14 101:10 109:8 111:17 112:12, 18 117:12 119:8 121:17 122:9,11,15 124:14 125:17 129:16 132:3,9 142:8 165:3 174:1 180:4 194:25 198:17 212:1 293:2

concurrent 243:24

Concurrently 176:20

condition 25:4,7 26:5 27:9 28:12 30:9,24 38:8 61:8 209:23 227:17 233:16 236:23 237:7, 20

conditions 24:19,20,21 25:16,18,20 27:1 131:24 186:15 237:11

conduct 110:5 245:9

conducted 143:6 195:2 245:7

conducting 109:18

conducts 282:8

confer 7:20 8:6 41:20 82:22 132:22 152:13 213:2 286:24

conference 4:18 5:10

confident 17:10 251:1 294:7

confident-- 292:18

confirm 47:19

confirmed 290:15

conflating 60:8 161:20

conflict 249:11

confusing 40:12 159:12

confusion 162:19 224:24

congenital 24:20 184:19

Congress 36:11

connected 61:16

connection 187:20 246:21

consciousness 28:23

consensus 132:16,19 212:23 233:12

consequences 38:11,13,19 82:6 107:22 137:11,20 139:1,5 140:13 163:20 164:20 263:1,2

consideration 210:22 247:10 264:10

considerations 65:24 285:21

considered 36:8 99:22 103:8 104:20 110:5 120:18 123:10 129:4 165:6 203:17 224:5,14 236:15 261:8

considers 65:16

consistent 114:14 146:9, 10 174:18 183:16 190:22 219:4 284:15

consistently 221:14

constitutes 101:22

constitution 47:7,21 164:3,4 286:2,4,6

Constitution's 259:8,9

constitutional 296:13

consult 269:25

consumption 117:5

contact 291:16

contacted 213:15 270:15

contemplate 295:24

contending 259:25

content 95:17

contents 30:5 154:14

contested 256:3

context 64:25 65:20 71:15 78:8 99:23 109:14 127:21 129:20 168:8 215:4 218:10, 20 220:21 249:10,24 253:9 268:3 269:21 290:10

contexts 275:9

contextual 101:18

continue 33:12 36:24 60:23 98:22 167:24 168:15 174:23 184:21 233:18 234:24

continued 237:25 267:7

continues 188:22

continuing 104:1 119:18

contraception 19:24 38:3 240:21,23,25 241:2,4

contraceptive 19:17 38:2 241:12

contraceptives 241:15

contract 45:8, 10 188:2 190:5 191:15

Contracting 190:6

contraction 190:20 191:16

contrary 267:15

contrast 139:22

contribute 203:25

contributed 112:22

contributes 205:2

contributions 246:2,16

control 109:18, 23 110:13 209:19 211:11 239:12

controlled 29:6 203:9

controls 7:1

conversation 10:3 264:22 285:18 286:12

Convoluted 276:1

copied 290:18

copies 88:2,8 291:14

copy 21:13 35:12 53:20 94:12 151:9 152:4 158:13 226:21 255:5, 10 291:9,10,11

cord 61:16

coronary 202:9

corporation 51:18

correct 42:5, 16,25 43:1,13, 14,19,21 44:6 45:6,15 46:14 47:9,13,14 48:10,16,19,22 49:1,5,8 50:12 51:8,12 52:24 53:3,7,23 54:1, 10,18,24 55:12, 21 56:5 57:17, 22 58:3,4,9,10, 12,18,25 59:12 60:1,14,15,25 61:11 62:1,5,6, 15 63:1 64:16 65:7 66:19 67:2,11,22 68:20 69:9,13, 24 70:4 71:6 72:3 73:1,2 75:11 76:16,19 79:18 133:7,8, 12,15,25 136:9, 10,23 137:4,22 139:10,11 140:14 142:11 143:20,23

144:4,18,21 145:18,25 146:24 148:15, 19 149:6,7,23, 24 150:2,3,7,8 151:3,4 153:22 154:2,3,5,6,9, 23 156:19,20, 23 157:8,13 160:1,12,21 161:9,18 163:11,21 167:16,24,25 168:4,5,17 169:10,25 170:1,9,10,23, 24 171:9 179:8 204:21 205:9 216:7,8,9 217:20 219:11, 25 220:6,16 221:20,24 222:5,25 223:8, 21,22 224:7 226:9 228:16 229:1,3 235:10, 11 236:10 248:21 251:20 258:10,20 260:17 273:23 274:8 275:7,8 276:24,25 280:21 281:7, 23

correctly 43:11 54:21 137:25 140:7 213:10 229:10, 13,20 232:22

correctness 71:21

cost 114:4 119:14 127:16 163:15 165:8 185:10 262:21

costly 115:5

costs 96:25 97:4 113:3,7,8, 12,14,25 114:22,23 115:1 117:20, 22 119:15,24 126:13,15,22, 23 127:1,2,5,6, 19 128:9,11 130:16,18 131:1,13,18 142:20 165:21 262:20

cottonmouth 180:20

coughs 178:10,16 205:13

council 245:12

counsel 4:22, 24 6:2 8:6,17, 25 9:7,12,16 14:2,25 17:10, 22 53:20 83:13 86:10 88:3 95:14 132:25 133:5 137:10 151:12,25 152:14,15 176:1 242:18 245:11 246:20 247:11 276:18 287:10,15 290:5 292:21

Counsel's 152:12 161:20 162:10

counseled 167:14

counseling 55:14 267:10

count 256:22

counterparts 34:8 72:24 204:17

counterpoint 254:12

counting 6:8

country 42:15 70:1 102:13 114:5 156:12 169:3,10 170:19 269:4 285:3

county 157:12 163:6 290:19, 20

couple 6:13 49:10 159:9 180:16,19 186:13 188:24 200:8 203:21, 22 204:3,23 248:17 266:15 292:4

courses 90:19, 20,22 178:1 244:3

court 7:1,4,25 12:9 15:6 17:12 18:5 22:9 33:5 41:5 44:23 47:5,19 50:19 52:6 73:5 86:20 89:11 92:11,15 93:7 99:23 112:1 113:8 118:8 126:1 135:9 140:11 142:9 146:4 147:24 149:19, 25 150:2,10,22 151:16 152:25 154:2,9,21 155:8,11 156:13 157:21 160:11,17 161:5,6 162:4 163:11 164:21 169:22,23 172:14 173:3 175:14 176:7, 10 181:8 236:20 242:12 243:8,19 247:19,20,24 248:1,2 252:3, 13 258:23 274:15 280:18, 22 287:17,21 290:19 291:23 292:15 295:18

Court's 10:19, 25 15:4 86:22 94:8 293:18 294:5

courtroom 6:15 7:3 15:11 260:16 276:17

Courtrooms 6:21

courts 11:3 17:11 247:15 294:8

cover 90:25 153:25 159:21

covered 10:17 103:12

covering 82:19

crash 198:1

create 11:8 179:11,12

created 36:10, 12 179:9

creates 75:22

creating 185:22 239:21, 23

credible 139:17

credit 111:9 112:10 139:22 141:19

crime 131:23

criminal 10:15 117:1 296:16

criminality 263:4

criminally 279:3

crisis 283:5 284:21 285:1

criteria 40:4,22 236:24 254:6,7, 8

Critics 276:1

critique 194:11 230:6,8 264:10

critiqued 194:9

critiques 262:12

cross 4:6 8:11, 16 41:25 42:1 87:5 133:1,2 134:16 174:6 213:4,5 270:3,4

crowd 15:3

culmination 173:6

Cultural 247:1

culturally 208:16

culture 178:15 244:1 281:3,9, 18 282:3,14 283:11,17,25 284:10

curettage 54:21,22,23 81:18

curiae 154:4, 14,16

curious 268:5

current 7:8 178:13 205:15 225:19,20 248:12,20

curriculum 181:9 244:16, 17 284:25

cut 34:1,16

cutoff 60:24 108:14

CV 21:16,18,22 42:22 94:18 95:1,3,4 143:13,15,19 171:20 181:11, 14 219:9 248:11,13,24

D

D&e 39:5 48:12 49:15,19 50:1, 11,17,18 51:1 54:16 60:1,8,13 67:1,5,10 68:4 81:23

D&es 67:7
D.C. 198:12
damage 29:11, 12 238:22
damaging 137:3
Dame 178:15 243:24 244:2 245:10,15 281:1,2,17,23
danger 97:12
dangerous 25:15,19 26:18
Daniel 3:5 4:9 133:6 289:15
data 37:7 69:16,23,25 70:6 71:20 94:4 97:22 98:1,2,4, 6 99:1,4,6,11 100:7,10,22 101:9 102:9 103:2,7,8,12,19 104:7,15,17,22 105:12 108:2 110:19 113:13 118:13,14 139:13,23 140:23 141:5, 22,25 146:2,24 148:7 160:18 163:10 179:10, 13,14 180:6,13 194:16 196:23 197:5 202:7 205:3 218:21, 23,24 219:2 233:11 266:20 274:6,14 275:1
database 179:9,11 180:14
databases 180:17
dataset 108:4, 6,7
date 13:21 60:25 181:14 295:20
dated 23:18
David 290:20
Davis 89:16,17
day 23:18 41:10 60:20 198:10 213:18 242:10 282:14, 15 291:7,9,10 292:20 293:21 294:11 296:3
day-to-day 19:19 282:1
days 7:16 8:4 10:18 41:15 60:20 78:22,24 81:14 82:1 111:6 186:13, 16 288:17 292:4 294:3
de 178:14 243:25 281:20 282:2,7
deadening 90:5
deadline 292:16 295:21
deal 57:17 189:13 245:13
dealing 4:10 263:11 290:25
dealt 178:5 238:6
death 36:19,21 58:8,22 71:21, 24 72:20 101:24 197:10, 13 198:5,6 200:22 202:23 222:22 227:16, 17 231:21 232:18 235:15
deaths 118:21
debate 42:14 76:20 223:5 246:13 250:1 252:23 253:18 254:13,21 256:1,9
debates 253:21,22 254:3 257:1
debt 111:6
decade 220:9
decades 154:22 200:20 209:22
deceiving 269:5,9
decide 158:20 234:17,18 290:14
decided 166:2 234:23 294:14
decides 12:9 23:15 198:1 236:24
decision 12:10,15 41:5, 7,10 79:16 168:1,14 221:19,22,23 222:4 233:25 234:2,3,6,13 235:6 236:4 237:2,25 238:3 240:5,11,13 241:10 265:23 275:20 279:9 287:18
decision-making 116:23 272:7
decisions 23:3 79:10 139:7 166:19 198:17 267:2,3,11,13 274:6
decisis 277:18
deck 142:7
declaration 246:24
decline 12:18 156:9 158:7 290:9,12
declined 221:9
decrease 25:1 117:2
decreased 229:12
decreases 121:19
dedicated 284:9
deduce 160:18
deemed 40:21
deep 27:6 283:20
deeper 39:13
deeply 209:8
defects 184:2, 5,19,20
defend 155:19
defendant 5:9 9:23 174:7 288:10 289:15
defendant's 15:10 242:17
defendants 288:8
defense 8:6, 17,25 9:7,11,16 35:12 86:10 88:3 132:24 151:25 152:14, 15 156:3 181:21 242:6 249:3
defensible 252:7 258:17 278:24 286:15, 17
defer 22:12
define 196:18, 21 245:1 256:22 265:24 278:11
defined 28:14 36:14 81:10,25 101:24 190:19 212:6 265:25 272:14
defines 77:3,9 183:10 256:14
definite 256:12
definition 40:1 76:14,18 77:7 183:15 185:12 190:22 191:1 222:18 224:8, 10,18 225:9,10 226:3 228:6 238:11 255:13, 14,20,25 256:8, 11,24,25
definitional 71:19
definitions 190:18 239:22
degree 18:22 89:15,16
delay 82:14 126:21 128:2,3, 8
delayed 38:20, 21 96:23 107:4, 8 121:20 126:7, 10 127:11
delaying 39:13 82:5
delegation 246:23
deleterious 137:2 163:19 262:25
deliver 31:19, 24 35:2 56:24 57:5 211:14 222:20 224:4
delivered 222:24 223:19
deliveries 32:2
delivering 20:3 27:21 31:8
delivers 86:9
delivery 20:1 23:19 24:12,14 25:13 26:13,15 27:16 29:10

30:19,21 31:1, 10,16,18,25 32:4,5,9 33:14 34:22 209:24 210:3 211:20

demanded 240:8

dementia 253:23

demise 28:7 29:13

democracy 296:13

demographic 80:1,8 102:23 216:10

demographics 97:15

demonstrable 87:9

demonstrate 105:1

demonstrated 282:20

demonstrates 136:24

demonstrating 118:3 122:18

demonstrative 86:8

denial 111:5 112:5 118:25 119:4 141:21

denied 12:6 38:13,14 107:22 108:15 110:17,21 137:11 142:3 165:9 174:12

dental 37:5

deny 174:25

Department 19:9 79:24 80:14 103:8 123:7,10,15 124:1,13

Department's 103:6

depend 40:10

dependence 257:12

dependent 57:4

depending 8:16 191:10 196:21 204:18, 19 253:25

depends 8:11 65:22 67:18 70:12,18 163:12 166:4 170:14 180:5 223:1 272:3 278:11

depicted 97:22 100:7

depiction 99:1

deposition 53:15,22,23 54:15 77:16,20 256:11

depression 33:15,17,19

deprivation 29:12

depth 132:4,8

Deputy 4:14,23

describe 265:22 277:1,4

describing 142:5 164:9 276:5,6 284:6

description 263:5 282:25

deserve 22:25

design 109:13 180:5

designed 49:12 109:9 194:12

desire 55:22 124:18 138:16

desires 254:9

destroy 210:4 212:9

destroyed 261:16

destroying 263:23

destruction 219:23 236:9, 14 237:1

detach 31:16

detail 96:17

detailed 119:7 166:18 186:4 194:11

details 97:13

detect 190:7 192:20

detectable 188:18

detecting 191:9,10,21,24

deteriorate 40:5 237:20

deteriorating 209:23

determinant 145:9

determination 239:2

determine 22:23 91:8 107:16 109:16 136:18 146:18

determined 159:15

develop 11:4,5 28:22 29:2 30:20 31:12 38:8 155:16 187:12,17 188:20 206:17 209:11 237:11

developed 63:6,20 186:5 188:21 191:5

developing 25:13 26:8 27:3,5,12 29:1, 4,23 30:23 31:7,9 62:24 63:9 146:16,19 206:17 237:6

development 26:10 28:12 31:4 147:25 250:5,7,9 253:20

developmental 186:23 187:5,9

developments 154:21

develops 28:15,25 61:23 188:20 233:16 236:23

devote 203:19

diabetes 29:2, 3 30:20 195:18 208:1,3,5,13 214:20 237:23

diabetologists 208:2

Diakov 5:8,11

dialysis 26:15 237:24 238:2,8, 23

Diana 107:24

diaphragm 25:1

die 72:6 202:24,25 204:17,21 206:18 222:25 223:7,21 224:5

died 196:19,20 197:14

dies 196:6 198:1

difference 109:12 110:4 153:3 170:8,25 180:11 201:24 202:1 205:2,4 212:16 223:24 235:2

differences 74:6 109:12 110:4 118:15 126:22 127:13 170:25 192:17 203:1 204:9 210:1

differential 202:3

differentiate 187:15,24 188:8,16

difficult 28:19 37:8 192:8 194:22,24 195:1,3,4 197:18 198:25 285:11

difficulty 82:12 218:9,22 219:5

dig 233:10

dignity 250:10 260:13

dilation 48:13, 15,17 54:17 81:25

dimension 272:4 281:9

direct 18:2 22:5 44:12,16 55:9 69:11 75:11 89:6 94:15 113:7 124:22 127:8, 15 128:8 143:25 146:24 176:4 205:13 230:6 243:16 271:23 285:15 286:13

directed 254:9

direction 10:23

directly 55:16 261:21 262:24

director

243:25 247:5 281:2,22,25 282:3 284:13 291:1

directorship 284:12

disabilities 253:23

disadvantage 125:13

disadvantaged 125:2,8

disadvantageous 262:25

disagree 210:12 231:23 232:19,20 256:3

disagreement 286:19

discernible 188:20

disciplines 245:6

disclose 198:20

disclosing 218:22

discontinue 115:3

discrimination 253:6 278:18

discuss 36:17 152:13 193:21 260:24

discussed 4:24 8:21 104:16 126:23 156:6 193:24 212:2,3,11 214:6 252:20 255:21

discussing 105:14 109:6 219:2,5

discussion 192:10 198:16 199:14 217:10 222:14 261:1,4, 24 290:3

disease 25:21 26:7 202:10 212:7 237:23 238:16

diseases 25:22,23 26:1,2 238:17,18

dishonest 155:11

dismembering 50:12

dismemberment 50:15,19 51:9,11 287:12

disorder 25:23

disparate 269:2

disparities 203:23

disparity 34:3, 5,6 74:11 205:5

disproportionately 97:4 102:25 104:24 105:7,24 114:8 119:23 125:6, 21 148:13

dispute 8:24 255:23

disputes 247:23 251:10 296:14

disruptions 115:5 274:18

disruptive 6:11,18,23 101:21,22,24 166:24 167:4 266:18

dissent 295:5

dissertation 93:15 145:12

dissolve 12:16,19 290:6

dissolved 12:2,3

distance 121:3,24

distinct 185:23 187:14 189:7, 25 190:1,10,12 210:5,6

distinction 253:12 254:14 256:18

distinctions 250:6 257:11

distinguish 106:20 251:1

distress 111:13 141:9 142:2

distribute 88:4

distributed 137:11

distribution 34:13 147:12, 13,17

district 247:20 280:18 287:17

divide 254:1 257:14

division 7:3 291:5

DNA 62:21 185:23 189:25

Dobbs 149:20 151:16 153:25 168:1,13 275:20 276:19

docket 10:16 291:9 293:9,18 294:5 296:16

doctor 39:18 46:22 47:6 48:1,9 56:25 58:7 59:3,11 70:14 72:4 74:5 75:20 76:13 78:15 79:18 87:16 88:16 91:19 93:23 97:13 98:14 107:20 110:9 111:23 112:11, 17,25 114:3 120:1 122:21 123:22 124:12 125:15,23 126:1,15 127:10 128:12 130:15 132:17 133:10,15,16 140:25 143:1 172:15 217:24 224:3,12 242:2 273:5,6,13

doctor's 192:13 273:2

doctors 70:3,4 192:23 233:15 267:9 283:7

document 113:12 248:10

documentation 211:24

documented 112:10 118:14, 24 120:22 134:5 137:20

documenting 122:13

documents 115:11

Doe 92:24

domestic 166:8,13,21

Doppler 191:7 192:12

double 244:18, 19

doubt 155:5

downstairs 291:4

draft 134:12

drafting 257:22

dramatically 197:22

draw 36:16 93:19,20 110:24 111:23 115:14 116:10 117:18 118:5 227:13 230:16 231:20 255:9, 10 267:19

drawing 146:7 231:5

drew 93:14

drill 102:11

driving 112:9

drop 159:25 164:12 168:3

dropped 169:9,24

drug 197:1 225:3

drug-induced 48:10

due 14:6 34:11 72:25 74:8,11 111:7 196:12 197:22 227:17

dues 14:6

Duke 4:21 178:7,23 179:11,15 180:14

duly 278:14

duration 23:16

duress 266:22 267:4 268:16 274:21

duty 44:24

DVT 31:10

dyad 185:1

dying 72:23

dystocia 29:10

E

earlier 31:10 66:1 67:8 76:13 85:9 130:5,19 137:6 162:25 171:22 175:18 182:1 193:24 195:7 196:2 199:5 200:2 202:11 212:14 222:13 229:9 233:2,14 241:6 253:11 260:16 275:11 290:1

earliest 184:5 187:11

early 8:14 10:4 27:19 28:1 104:2,3 115:7 169:13 170:2,3 184:22 186:25 187:1 189:13 191:14 192:4 208:9,15 238:9

earned 18:21

earnings 148:4

easily 255:25

eastern 157:7, 25 160:20

eat 208:17

eclampsia 206:17 209:10

economic 90:23 91:5,15, 17,18,20 101:4 102:6,12 106:18 107:22 111:21 112:13, 15 113:9 117:8, 13,16 118:25 119:11,14 122:15 124:14 125:17 127:8 130:17 132:5, 15 137:3,11,20 139:1,4 141:8 142:15,16 163:19 164:20, 25 165:21 262:10,19 263:15,24 264:2,3 265:12 266:23 269:23

economically 274:19

economics 89:12,15,16,17, 25 91:6,24 92:12 93:2 133:11,12 138:7 268:4

economist 86:19 98:12 108:19 115:25 133:10,13 134:23 136:17 149:22

economists 120:25 150:1 154:5,10 160:6

ecosystem 239:23

editors 91:11

education 23:1 80:9 81:25 93:14 103:24 104:2,3 114:22, 24 115:4,12 131:13 137:7 142:17 144:8 147:1 247:1

educational 18:9 89:14 97:1 131:17 142:21 244:13 266:25 284:5

effect 41:3 107:14 109:19 112:20 117:15 119:19 121:22 122:6 128:21 129:1,21 130:10 158:4, 18 161:8 162:9 165:7 167:24 168:3 169:1 191:9 226:11 235:7 236:4 238:4 266:5,6 281:20

effective 39:6 283:14,24

effectively 5:25 10:18 32:14 46:13 56:3 62:8 65:16

effects 90:20 91:1 93:9 106:20 107:16 109:14 111:12 117:17 119:21 122:13,22 123:1 124:14 129:22,24 130:4,5 131:5 132:12 137:3 143:8 144:16

effort 203:19

egg 75:22 185:20 186:12, 17

eighth 63:10, 20

elaborate 221:2,3

elective 220:18

electrical 188:18

element 75:4

elevated 28:14 111:12

eliciting 96:2

eligible 40:8 235:9 236:2

eliminate 134:9 149:12

eliminated 161:7 163:10, 13

elimination 158:2

elite 272:21 284:18

Embase 180:19

embed 289:13

embraced 259:23

embryo 186:19 187:13,14 188:2 189:24 212:10

embryo's 189:5

embryology 212:21 282:15

embryonic 183:13 187:9 255:17

emerged 170:8

emergency 30:4 40:1,9

emerges 219:4

emitted 185:24

emotional 49:12 97:2

emotions 219:3

EMP 60:23

emphasize 137:23 235:1

empirical 107:14 112:17

empirically 164:25 282:20

employ 225:6

employed 52:7

employee 43:2,6 45:5,19 52:3

employment 43:7 119:2 140:19 148:5

EMW 3:4,23 9:3 19:13 40:23 41:1,7,9 42:12, 25 43:4,10,18 44:4,8 45:5,8, 10,11,15,20 46:4 48:9 51:17 52:4,8,12 53:11 59:2,12,21 60:1,24 71:2 73:13 75:5 78:23 79:2,10, 20 85:10,12 135:6 148:22

enable 219:20

enables 203:8

enacted 135:3

encompass 290:2

encourages 116:25

end 4:19 12:5 22:25 31:8,11 63:18 64:9 90:6 116:15 194:13 230:4,18,19 231:4,7 272:6 291:19

endangerment 222:9,12,15 235:24 236:21 237:12

ended 231:14

ending 5:10 111:3 116:20 118:9 224:21

ends 63:17 64:8 260:12

energy 185:24

enforce 41:4 92:20

enforced 262:18

engage 13:6 75:6 265:23

engaged 265:1

Engineering 36:2

enjoined 11:25 46:13 280:19 287:17

enjoy 117:4

enlarge 277:9

enlarging 26:23

ensure 289:1

entails 56:4

enter 29:24

entered 12:4

enterprise 284:8

enters 25:3 186:22

entertain 296:18

entire 55:19 73:21 104:5 111:14 183:13 188:12 255:17 268:17

entitled 64:13 250:8 256:5

entity 36:9

entrapped 29:11

environment 272:15

epidemiologic 207:18

epidemiologists 197:6

epilepsy 25:24

episode 235:12

equal 250:11, 17 259:10 267:2 278:8,15

equality 253:4

equating 150:25

equation 250:13 261:12

equipped 211:14

equivalent 158:9

Ernest 3:23 79:3

error 229:16

essays 246:1

essence 38:15 57:24

essential 22:22 202:4 246:12

essentially 282:22

establish 49:25

established 45:6 254:1

estimate 56:16,18 141:14 179:22

estimated 109:19

estimates 71:20

estimating 109:14

et al 3:5 108:1, 24 109:7 110:8, 11,19 111:24 112:16 114:15 119:7

ethical 245:3 247:8 249:21 250:6,18 252:10 253:18, 21,22 254:3,13 257:17 258:3 259:21 261:13 267:24 268:9, 17,19 269:1 270:20 272:10 273:2 279:4,10 280:11,13 286:8,20

ethically 23:5 40:6 252:7 253:16 258:17 280:16 286:15, 17

ethics 65:6,9 66:1,2 78:3 178:6,15 244:1 245:5 272:1,3, 8,13,19,20,22, 23,25 281:2 282:2

ethnic 125:11

ethnicity 80:8 100:12 179:20

etiquette 6:13

Europe 272:14

Europe's 247:12

European 20:23

evacuate 30:5

evacuation 48:14,15,16,17 54:17 81:25

evaluate 90:25 93:9 139:23

evaluated 52:21

evaluating 90:20 91:7 122:6 143:8 144:16 259:25 261:12

evaluation 92:12 93:2 132:5

evening 8:25

event 36:20 101:22 161:4 162:4 266:19

events 101:21, 24 166:24 167:4 267:22 274:12

eventually 128:6 158:20 187:16,19 188:10 249:19 291:23

evictions 111:10

evidence 13:24 21:20,23 22:9 37:11,16 39:3 81:8 84:15 87:9,10,14 95:23 108:25 109:4 116:4,8 120:13 121:9, 13,20 123:18 129:9,13 132:14 138:14 140:19 141:18 148:2 156:3 164:22 171:7 172:2 181:21 184:22 201:9 206:2 217:14, 18 221:14 230:9 249:3 267:15 268:14 289:7

evidenced 185:22

evolved 241:3

evolves 76:24 77:18

exacerbate 128:8

exacerbated 25:17 127:20

exacerbation 263:5

exact 56:15 59:14 145:19 213:18 214:20 227:20

examination 18:2 22:5 42:1 55:10 69:11 78:20 89:6 133:2 134:16 176:4 213:5 243:16 270:4 271:23 286:13 287:8

examine 87:5 140:22

examining 166:18

exceed 39:8

exceeded 201:4

exceedingly 36:20

excellent 203:21 230:7

exception 14:24 40:2,9 222:11 227:15

exceptions 39:15,17,19 82:20 222:6 226:15,19 227:12,14,22 235:9,23 236:1, 2,20 238:25 279:8

exchange 61:18 62:3 82:17

excited 192:14

exclude 256:23

exclusion 256:21

exclusive 256:25

excuse 21:6 58:1 97:3 147:24 178:10 201:17 205:14 221:21 278:3

excused 83:5 171:18 241:24 288:1

exercise 268:12 296:13

exerts 23:21 24:25

exhibit 21:1,5, 8,13,19 33:4 35:10,20 37:11, 15 38:24 42:23 44:21 57:20

58:5,22 65:4 80:18,19 81:4,7 82:6 84:9,12,14 94:11,22 95:22 96:8 108:24 109:3 116:4,7 118:6 121:8,12 123:15,17 129:9,12 143:10,11,15, 19 150:6 151:9, 14 152:6,24 153:6,9,15 155:15,23 156:3,5 171:20 172:1 181:18, 21 205:16 216:14,24 217:13,17 230:10 231:17 232:3 248:8,25 249:3 255:4

exhibits 87:24 152:1,13,16,18 172:15

exist 199:13

existed 170:2

exists 34:11 146:22

expanding 191:22

expect 10:6 98:19 102:24 105:4 126:14 127:19 130:11 131:22 159:20, 25 160:7 168:10,21 296:9,17

expectancy 131:12

expectation 6:24 7:25 8:3 10:19 11:1

expected 29:8 93:10 129:22 157:2 161:16 167:21

expecting 6:2 296:10

expeditious 290:13

expeditiously 295:18

expenditures 113:19,21,22

expensive 113:17 114:1

experience 25:1,6 29:18 32:16 33:16 34:8 38:2,6 55:14 57:8 112:6 195:12 202:12 205:25 218:21 246:19 248:4 267:10

experienced 57:10 118:19 274:12

experiences 26:21 33:19 166:21

experiencing 25:6

experiment 120:24 121:16 122:4,7,14 168:25

experiments 109:15 169:12

expert 9:25 22:16 73:3,5 92:11,19 93:2 95:7 132:3 134:24 135:7 166:8,12,14 182:10,15,19, 23 213:21 247:5,14,18,25 248:1,4 249:6 251:13,16,18 264:14 267:9 268:4 271:24 272:19,20,25 286:2

expert's 267:12

expertise 142:24 146:8 213:23,24 244:23,24 271:25 272:7

experts 103:8 123:11 129:4 260:19 284:18

explain 23:23 114:13 138:5 173:23 249:9 252:2 253:14 277:9

explaining 191:23

explanation 267:7

explicitly 165:2

exploded 184:14,17

exploratory 140:6 141:6

explored 179:3

exploring 46:23 139:18

exposes 27:24

exposure 38:6

express 212:5

expressing 257:3

expression 180:7,10

extend 104:4 188:22

extensive 120:4 128:24 131:5 146:22

extensively 91:4,10 93:17, 18 146:8

extent 46:20 90:22 146:3,18 164:19 167:3 291:20

extra 107:9 158:13

extraction 48:13 50:1

extraordinarily 139:16

extrapolate 201:2

extremely 114:1 132:10 142:4 194:12 238:20

F

face 11:7 16:24 32:21 33:14 113:25 126:23 127:4 175:8 239:3 243:4 263:8 264:16 274:17,18

faced 40:13 101:20 209:16

faces 236:2 249:14 253:10 278:6

facility 43:18 70:21

facing 233:24

fact 9:1,3,13,18 10:9,21 15:19 27:3 58:5 87:10 129:24 140:15 148:12,17,24 149:12 157:22 158:19 165:22 173:14 185:23 205:6 212:9 219:21 268:24 269:11 292:1 293:1

factors 26:17, 20,22 27:1 69:19 139:6 202:8,17 203:9, 24 207:25 208:10

facts 8:22,24 94:4 183:8 207:5

factual 174:13

faculty 43:17 73:16 245:10, 15 282:10 284:2,14

failed 210:9 277:6

failure 33:25 38:2 71:23 209:15,20 238:7,14 266:24 278:16

fair 13:10 14:13 47:25 51:17 62:7 70:9,17 94:12 144:10 146:21 157:25 168:13 216:9 251:6 257:7 258:8 282:24

fairly 140:1 194:3,23 256:8

fall 43:12 150:15,24 177:11

fallacy 265:18

falling 171:2

fallopian 186:14,16

false 263:8

familiar 13:16 71:16,17,24 163:24 164:1,3, 14,16 193:23 194:1,2,3 205:17,19,21 232:21

families 196:6 250:17 269:10 275:22 281:13 283:12 285:4,7

family 4:22 18:19,21 20:23, 24 43:23 93:16 101:25 112:4,7 114:4 185:2

257:5,9 262:23 268:21 278:16 279:12

Fannie 269:15

farther 17:20

fast 294:6

fatal 27:11 220:22

father 221:8

fathers 221:7

favor 263:20 265:17 266:14 283:21

favorable 246:14

Fayette 157:12

features 139:9

federal 99:16, 19,25 247:19, 20,24 248:2 280:2,18

Federation 5:19

feed 90:9

feedback 138:8

feel 7:17 25:3 34:16 44:23 65:19 76:9 88:22 167:11 212:1 219:3 267:23

feeling 219:1

feelings 33:20 76:21

feet 290:17

fell 169:15 170:6,19 171:1

fellow 268:20

fellowship 18:18,20 19:3 176:24

felony 40:20 239:7

female 76:2,7 185:20

female-headed 102:17

fertility 117:1 145:8

fertilization 62:20 76:1,6, 15,19 77:4,6,8, 17 183:14 185:13,16,17, 24 186:6,8,15 212:15 219:22 255:18

fertilized 75:22 186:17

fetal 28:6,24 29:7,13 38:5 67:25 183:13 184:13,14,18 185:9 187:9,21 188:13 190:10, 18,21 191:7,14 192:12,20,25 208:20 211:12 220:22 236:6,8 255:17

fetus 29:8,11 49:5,8,25 50:12 61:16,19 62:5, 7,13,18,20,24 63:9 64:7,15 65:2,11,17 66:4,19 67:21 77:16 78:5 183:23 184:6, 11,25 185:5,6 186:19 189:4 210:4,10 212:10 222:18, 20,24 223:6,19, 21 224:4,12 225:22 235:15, 16 236:12,13

fetuses 193:16

fewer 39:7 101:5 133:19, 24 142:10 148:25 149:3,4 159:20 168:10

fiduciary 240:15

field 36:9 91:22 92:11 97:18 103:9 108:20 123:11 129:5 182:20,24 183:18 184:11, 13 218:21 245:3 251:5,10, 14 285:6

figure 123:22 124:23 128:1 156:8,13 158:6 159:4 160:5,18 161:3,21 163:4

file 10:20 154:8 155:7 296:8,10

filed 13:1,2 33:5 154:8

filings 291:20

filter 62:3

filters 61:19 62:4

filtration 61:15

final 15:8 54:20 79:15 95:16 112:2 117:19 211:23 242:12 294:7

finally 97:4 107:6 114:1 141:11 168:23 230:17

financial 37:22 82:8,12 97:1 111:13 112:9 113:7,8,14 127:16 128:9 130:16,18 141:8 142:2,21

financially 37:23

find 37:8 72:16 94:4 111:3,5 132:11,12 136:2 140:19, 20 141:11,18 195:3 200:15 203:14 218:17 293:18

finder 15:19 87:10 158:20

finding 100:11 102:16 103:23 111:17 112:11 114:13,15 117:23 124:12 174:1

findings 10:20 100:6 109:7 119:7 121:22 124:1 141:7 291:25 293:1

finds 118:18

fine 7:13 14:21 15:6,14 42:21 82:21 83:22 87:13 183:1 191:22 204:2 209:13 210:13 241:22 294:22 296:4

fingerprints 188:19

finish 36:25 237:14

finished 10:4 152:21 173:1 178:3 270:1

firm 276:23

first-year 244:7

fit 226:2

five-fold 27:4

five-year 230:19 231:5,7

flip 21:16

floats 186:13

flow 26:25 31:24 61:19 191:13 200:10 250:18

fluid 28:19 49:1

foci 229:2

focus 90:22 102:10 177:14, 15 188:23 224:1 228:25 229:3 251:9 268:24 269:2

focused 130:3

focusing 115:9 235:4

fold 187:24

folds 188:8

folic 184:4

folks 6:6 13:9 30:20 96:20 113:16 124:8 126:4,7 254:7 271:11 288:19 290:24,25 292:20

follow 65:22 138:25 150:18

follow-up 34:24 139:19 188:24 194:18

forced 38:15 121:2 126:19 269:5,12

forceps 49:3

forces 109:15

forecasted 12:23

foreign 62:15

forget 34:23 35:14 292:14

forgot 84:9

forgotten 143:10

form 28:18 76:2 80:4 94:5 101:10 112:18 187:23 188:1, 10,11 208:3 216:2 253:5

formation 281:11

forme 208:3

forming 76:7 125:17

forms 61:15 194:16

formulate 254:9

fortified 184:4

forward 92:19 250:3 268:7

Foster 107:25

found 76:15 121:19,24 135:25 136:3 144:2 200:21 232:1

foundation 152:8 153:9 174:13

fourth 144:24 197:9

fraction 36:22

framework 257:15 277:13

France 247:13

frankly 294:15 295:22

free 259:10 267:2

freedom 268:11 286:9

freely 260:10 267:13

frequently 82:13 199:20 214:22 260:5 282:16

fresh 284:17, 25

Friday 7:21 8:6,21 10:3 11:23 152:13 275:5 293:21

friend 101:25 149:25

friends 6:14 291:2

front 12:1 13:9 33:5 44:23 56:1 88:21 153:22 155:6 160:2 162:3 181:6 226:22 230:11 233:1

fruste 208:3

fuchsia 156:14

full 12:20 23:1 63:10 89:25 90:18 137:15 139:21 152:6 153:21 154:19 155:2 176:7 183:14 231:25 255:18 265:4 296:16

fully 11:4,5 12:25 64:22 191:5 292:2

function 26:11,13 28:22 31:23 32:17 39:24 228:3 235:25 236:22 238:13 239:5

functions 188:13

fundamentally 249:18

fussing 158:22

future 12:14 17:25 189:18 254:9

G

gained 78:5

gains 78:2 116:14,16

gallery 6:20 15:3 17:11

gamete 76:2 185:18,20

gametes 76:7

gap 106:2 169:17 170:1,3, 22 295:3

gaps 106:5

Gatnarek 3:9, 12,13,18 6:6 8:5,10,13,16 9:21 12:7 13:11,13 14:4, 10,21,23 15:7, 16,22 16:5,9, 12,21 83:22 84:16,20 85:24 86:2,6,12 87:15,17,19,22 88:2,7,11 152:11 173:5 174:2,5 181:19 249:1 251:15, 21 257:20 267:5 270:5,8 286:23 287:24

gave 54:13 77:15 118:21 136:7 215:13 232:10 263:20 277:14 282:18

gene 180:9

general 4:7,9, 14,16,21,23 11:10 27:5 41:4 42:4 46:9 109:24 120:23 122:11 125:3 129:20 133:5 135:7,12 136:8 146:8 151:15 155:22 176:15 179:22 181:17 185:13 188:6 197:24 213:16 224:18 226:16 227:10 235:5 242:21,22 245:11 247:6 257:3 258:1,9 261:2 271:8,12

General's 8:18 215:8 248:8,25 270:15 271:9

generalizable 194:24

generally 37:18,19 59:14, 22 63:7 93:9 99:22 117:16 119:10 127:16, 18 129:3 131:5, 24 137:5 142:5 152:17 164:7 169:18 224:24 236:13 249:24 255:21 259:3 260:8 261:20 282:8

generated 61:22

generates 116:19

generation 239:14

generations 115:8

genetics 203:2

gentle 7:15

gently 153:16 266:24

genuine 266:21

geography 157:18,22

George 18:13 269:17

Georgetown 244:21

German 97:23 98:9 99:2 101:12 145:17, 24 146:4

gestation 39:11 58:2,24 183:15 192:21 200:21 211:2 216:11 231:21 255:18

gestational 29:3,9 30:20 38:23 59:16 67:18 76:25 77:19 78:2 80:9 82:1 108:10,11, 13,14 110:14 137:22 186:7 187:2 190:21 193:17 195:18 199:25 200:2, 16 201:7,23 205:10 206:6 208:1,13 214:20 223:14, 15 224:11 253:2

gestations 200:24

give 6:13 9:15 10:23 17:3 21:8 45:23 46:25 50:2 56:16 88:18 164:23 165:22 166:20 175:13 179:22 184:3 189:22 194:6,16 230:15 235:20 237:5,16 239:1 243:7 252:10 255:5 268:22

giving 53:23 106:4,10 201:11 202:1

globally 177:18

glucose 29:5

goal 210:7,10, 11 251:7

gold 197:4

good 3:3,9,12, 22 4:2,8,21 5:13 7:17 11:16 16:24 17:1 18:4 42:3 50:9 54:7 88:16 89:8,9 117:4 133:4 136:13,19 142:17 149:8 153:19 157:24 172:12 175:12, 24 176:6 184:22 190:25 205:12 208:21

213:7,11 234:10 236:16 243:6 259:2 268:13 270:6 279:14

Goodbye 5:10

goods 245:3 249:11 259:22, 25 261:17 263:24 264:2,3

Google 180:18

governance 245:2

Governing 247:4,7

government 112:7 247:11 269:9

government's 247:3

grad 145:14

grade 131:17

gradual 76:24 77:18 256:6

graduate 92:9 176:19

graduated 18:11,25

granted 13:22 15:1 41:16

granular 261:22

graphic 51:4 129:8,19

grasping 162:11

grateful 246:8

gratifying 272:24

gray 209:5

great 6:25 7:10 11:7 15:7 16:9 42:14 88:5 177:12 188:10, 23 190:14 234:22 244:15 245:13 288:6 293:12 296:13

greater 58:24 82:2 119:2 127:4 148:18 200:23,24 206:16

greatest 123:24 124:7, 11

greatly 201:4

Greek 209:9

Green 107:24

grotesquely 279:4

grounds 257:11

group 74:8 102:21,22,24 107:16 109:21, 22,23,25 110:12,13,16 114:7 118:16, 23 119:1 120:2 125:13 126:4,7, 17 127:10,14, 17 171:3 197:5 204:18,19 244:8 283:3 285:9

groups 105:19 106:21,24,25 107:10,12 110:10 122:3 124:25 125:24 126:2

grow 24:25

growing 130:24 131:5, 10,14,21

grows 31:14

growth 28:24

guess 32:7 42:14,18 44:3, 20 47:10 54:7 56:18 65:25 66:2 67:23 68:23 69:22 113:10 165:17 167:19 252:14 262:9

guidance 67:4 68:25 69:2

guide 67:2

guidelines 182:3 214:7,10, 11,25 216:1,3 225:17 233:7

guilt 33:20

guilty 265:18

Guttmacher 128:19,23 129:3 199:2

guys 278:12

gynecologic 19:24

Gynecologists 20:22 219:11

gynecology 18:16 19:9 20:12,18 22:17 55:19 73:16 176:22 182:24 183:1,19,22 213:24

H

hac 14:1,6,16 15:1,2

hairs 209:5

half 26:25 121:1,17 201:21 204:15 212:19 261:11

hallmark 257:13

Hamer 269:15

Hampshire 198:11

Hana 5:18

hand 13:7 16:25 21:1 35:10 80:18 88:15 175:9 188:20 222:15 243:5 248:7 286:9

handed 21:4, 12 255:10

handful 248:19 288:17

handle 91:6 207:13

handling 3:24 4:4,16

hands 269:9

Hannah's 285:10

happen 27:10 128:2,3 161:24 184:22 235:17

happened 203:12 239:14 287:19

happening 60:19 167:9 235:18

happier 116:24

happy 233:10

hard 90:5 161:3 166:5 169:11 208:6

harder 130:1

hardship 97:1 142:21

harm 39:14 40:17

harms 97:2,3 111:21 119:10 132:5,15 142:22,23,24 164:25 269:22, 23

Harvard 176:21 178:2 245:25

haven 163:25 164:5

Hawaii 169:7

HB 287:13

HB2 120:25 122:14

he'll 175:9 243:5

head 53:14 296:9

headaches 28:23

heading 36:18

headquartered 247:2

healing 240:2 283:4

health 4:22 18:22 19:10 33:14 49:22 82:17 91:6,24 101:4 102:1 103:6,7 116:24 117:21 118:19, 20 123:10,15 124:2,13 125:2, 8,14 128:10 131:1,3,7 133:13 134:20 143:7 144:13 149:20 154:1 176:21,23 182:21,25 195:10 234:23 237:11,19 244:6 249:23 258:25 261:18 264:17 265:11 269:3,13

Health's 123:8

healthcare 23:2,4 64:15 71:5 73:9 78:23 91:25 122:24 123:1 124:3 125:16 212:6

healthy 208:7 209:13 235:21

hear 5:24 7:13 15:20 22:12 84:24 87:9

88:23,25 90:11 95:5 153:8 174:17 191:8 192:13 193:6, 10 228:19 229:12,20 267:9 268:10 276:18 288:18 296:15

heard 6:11 9:11 175:18 197:3 199:14 201:8 229:10 260:16,18,23 262:4 296:19

hearing 11:12 12:5,12 90:6 192:14 213:25 214:5 254:23

hears 175:20

hearsay 21:22

heart 24:19,20 27:13 32:10,12, 14 63:22 64:10 184:19 188:13 190:2,15,21 191:3 204:5

heartbeat 44:22 46:12 63:6,7,10,13, 14,21 64:8 161:8 190:8,9, 18,24 191:1,21, 24 192:20,24, 25 193:6,9,11, 15 255:1

heartbeats 190:7 193:17

Heather 3:13 270:8

heavier 192:8

heightened 131:23

held 249:25 251:2

helicopters 211:16

helped 179:10

helpful 10:15 15:19,20 22:8 90:12 134:4 170:11 199:11 208:21,22 227:3

helping 87:12 241:10,13 251:9

helps 26:24 62:12 203:13

hemorrhage 30:3,6 31:17 32:1 38:9 202:21

Henry 5:22 14:24

hepatic 238:7

hepatitis 25:23 26:3

high 25:13 28:12 72:20 96:12,17 101:15,17 102:19 103:15 105:16 108:5 113:1 126:11, 13 156:25 179:5 194:19 206:15 208:14 209:2 241:8 259:16 294:12

high-quality 139:17

higher 26:10 29:4 31:9 34:7 57:10,11 102:14,21 119:1 156:22 202:1,5,9,16 204:11,25 206:23

highest 40:15 80:9 204:24 207:3,4

highlights 129:19

Hill 176:25

Hippocratic 66:1 219:18

hired 43:22

Hispanic 100:15 148:13, 25 149:5 178:24 179:1,2, 7

historically 168:9,19

history 18:24 80:10 218:15 244:19 269:4, 11,19,20 277:4

HIV 25:23

hold 20:16 251:8

Holyoke 176:19

home 285:9

homes 283:4

homicide 196:22,24

Homo 183:12 255:16

honest 206:5

honestly 160:22

Honor 3:12,22 4:2,8 5:4,8,15, 18 6:4,7 7:23 9:21,24 11:9 12:7,12 13:11, 25 14:15,23 15:16 16:3,5,12 20:25 21:21,24 22:4 32:22 33:6 35:11 37:13 41:20,24 44:11, 15 46:19,24 47:23 48:3,6 49:9,17,21 50:4,7,16,23 51:6,19,22 52:9,14 53:17 59:4 60:7,10 64:3 66:8,10,20 68:11,14 73:20, 24 78:11,14 80:16 81:3 82:3,22 83:1,3, 19 84:2,16,21 85:24 86:2,7,14 87:17,23 88:3, 7,11 89:5 90:3 92:25 94:21 95:2,19,23 96:5 108:23 116:2 121:7 123:13 129:7 132:21, 23 134:11 143:11,16 150:4 151:8,14, 19,24 152:12, 23 153:11,19 155:13 158:5, 10,14 161:19 162:1,17 171:11,15 172:3,12,21 173:5,13 174:5, 10,21 181:1,16 182:18,23 213:1 216:22 217:14 223:18 226:20 230:14 241:18,20 242:7,20 248:5, 23 249:1 251:12,15 255:3 257:20, 25 267:5,18 269:25 286:24 287:1,6,24 288:9 289:7,18, 22,25 290:7 292:9,12,23 293:24 294:21, 24 295:19 296:5

hope 7:17 159:22 291:4

horizon 119:4 148:6

horrible 267:22

horrific 279:15

hospital 20:2,4 25:10 55:25 79:18 183:24 211:14 233:21

hospital-based 19:1

hour 271:22

hours 10:16

House 245:13 285:10

household 100:4 101:7,25 114:12,20 130:21,23 131:6,10,15,22 140:3,9

households 102:17 113:23 114:6,9,17 130:24

housekeeping 5:25 172:13

housing 203:25

human 64:15 66:4,19 75:22 76:5,14,18,23, 24 77:4,5,10,17 78:1,2,6 144:20 183:10 185:22 212:9,10 219:23 225:5,8 236:13,14 244:11 245:24 246:5,25 249:20 250:3,8, 11,16 252:17, 23 253:13,19 254:4,10,14,15, 16,17,19,24 255:6,15,25 256:4,10,13,14, 18,22 257:5,9, 10,11,18 258:19 259:3 260:3 261:16 265:25 268:21 272:16 278:2,8, 15,16,25 279:2, 11,12 286:10, 21

human's 75:25

hundred 239:6

hundreds 211:13 293:9
hydrate 211:11
hypertension 195:19 197:14 202:9,15 206:15 209:11 234:10 241:7
hypothetical 237:4,8
hysterectomy 31:19

I

icons 269:15
idea 11:16 57:2 114:15 211:10 264:17 265:6
ideation 33:21
identification 44:20 96:4,9
identified 39:9 102:22 113:7,8 114:22 117:7, 12,20 119:13 125:25 129:9
identify 9:2 152:16 182:12 249:8
identity 252:21
ignore 253:6
ill 234:7,13 235:3 239:9
illegal 149:14 171:8 220:19 239:15 263:13 264:1 273:16
illicit 264:4
Illinois 18:19 169:8
illustrate 106:5
imagine 192:12
immediately 41:3 162:9
immersed 209:8
immune 62:8, 13,17
impact 90:23 106:19 112:11, 13 117:13 119:8 124:2,13 125:18 127:9 129:16 130:17 131:2 165:14 201:15 263:15 269:2
impacted 104:24 119:23 125:6 148:1
impacts 122:16 262:10
impairment 39:23 227:18 228:2 235:24, 25 236:22 238:12,15 239:4
impairments 263:4
impairs 131:10
impeded 146:19
implicates 266:20
implication 146:23 148:21
implications 137:19 138:23 218:16
implies 103:25 105:6 146:16
import 266:20
importance 117:6,10
important 17:13 23:3 46:8,12 64:14 86:21 118:15 127:20 145:9 189:8 192:23 196:4 210:2 212:4 218:16 222:14 241:7 246:16 259:22 261:22 264:19 293:5,7,17
impose 137:21 142:20
imposed 132:15
impoverished 131:6,10,14,22
impregnated 221:7
impressive 132:10
improper 267:16
improve 25:10
improves 116:21
in-patient 20:1
in-utero 210:21
inability 112:9 118:4
inaccuracies 196:13
inaccurate 71:21
inadvertently 74:23
inalienable 259:11
incarcerated 102:4
incest 38:4 221:1,6 222:2 279:8
incidence 149:14
include 25:20, 22 27:6 29:7 31:3 44:4 56:11 71:23 164:19 196:22,24,25 197:1
included 86:23 117:23 119:15 165:7 224:18
includes 38:16 49:19 80:5,7,8 164:23 257:9 272:8,10,15 289:8
including 19:24 72:20 80:1 97:1 118:21 119:1 120:7 142:21 185:2 205:25
inclusive 256:24
income 99:18 101:6 114:16 140:3,9 148:3
incomes 99:16,22 100:1 125:6 137:7 142:16
incommensurable 249:12
incomparability 71:22
incompatibilities 71:19
incomplete 71:9,18,21 265:3
incorporated 165:18
incorrect 142:13 168:17
increase 23:25 24:2 26:22 27:1 28:9,10 39:13 111:7,11 140:20 141:15 142:2 197:21
increased 24:22 25:12 27:14,22 28:1 30:1,2,21 31:23 32:1,20 33:20 38:23 112:5 118:21 131:16 171:8 200:23
increases 24:3,16 39:10, 11,14 58:3 111:6 112:6 118:4 120:6 121:3 122:19 184:11
increasing 38:22 121:24
independence 116:19
independent 247:5,7 256:7
independently 122:6
index 203:7,8, 13,15
Indian 202:20
indicating 124:9 141:14 171:7
indication 224:15,21 225:23
indications 224:16
indicator 193:12
individual 128:4 183:12 206:12 207:19 221:22 222:2,4 225:18 252:22 255:16 258:19 291:1
individual's 221:19 222:3
individuals 7:4 34:22 100:15,17 104:1 105:18, 21,23 106:13, 14 107:2 108:8

113:4 117:25 119:25 125:8, 20 126:14 130:1 265:24 266:16

individuals' 166:19

induce 224:13

induced 200:14

inducing 225:9 226:8,11

induction 39:5 225:24 226:1, 17 227:11 235:19

inequitable 34:12

inevitably 222:25 223:7, 21 224:4

infant 144:13

infection 27:23 28:2 29:23,24 30:23,25 31:3 228:13

infections 31:5

infectious 25:23

infer 160:18

inference 154:22

inferences 267:19

inferior 26:23 27:2

inflammation 30:25

influences 73:4

inform 219:20

information 22:6 23:1 80:2, 4,8,12 81:1,2 101:17,18 104:10 108:8 136:21 140:3 181:13 194:17 215:2 216:11 264:20 265:2 274:4,5

informed 64:22 109:7 132:9 283:17

informing 7:24 132:2

inhaled 25:8

inherent 259:11

inherently 199:2

initial 211:10

initiation 7:18

initiative 281:12 282:2

initiatives 283:4

injunction 12:4,6,11,15 13:16,22 21:25 174:12,24 293:1

injure 69:7 210:4

injury 31:3 198:23 200:22

injustice 277:25 278:3, 11,17,21 279:5, 6,15,22 281:6

innocent 219:23 278:25

input 292:20

inquiry 91:5,15 245:4 251:10 291:17

inside 27:24 127:4 290:9

insight 221:5

instance 45:9 167:4 268:18 275:10

instances 26:14 27:11 29:20,22

Institute 128:20,23 281:23,24 282:6,11,21 283:1,13 284:2, 11,12,20

Institute's 129:3

institutionally 281:18

institutions 109:15

instruction 223:18

instrument 48:25 49:3,4 225:6

instruments 68:6,10,20

insurance 82:13,17,18 113:23,24 185:10

integrity 249:21 259:1 260:13 261:18

intellectual 282:22

intend 9:24 13:17,24 152:14,23 173:7 289:2,5,7

intending 177:9

intense 159:4

intensely 156:24

intensive 282:13,25

intent 22:3 83:17 210:13 212:9 222:14, 16,17,19 224:7 225:4,7,12,13 226:10 291:24

intention 265:6

intentional 278:1 279:12, 20

interaction 116:19 225:16

interdisciplinary 245:3

interest 143:21 154:13,16 249:20 252:11 260:2 265:10, 15

interested 229:25 292:16

interesting 196:1 201:22 202:18 221:5 284:17

interests 250:10 253:7,8 254:3 257:17 260:13 261:15 265:12,15 278:5

interfere 35:7

interferes 30:10

International 247:4,6

interpret 40:11

interrupt 90:4 115:2 150:17

intervene 184:10 235:14 238:8,23 239:2, 11 269:13

intervention 225:14 240:9, 11

interventions 240:10,18 263:18 269:2

interviewed 43:15

interviewing 139:20

intimate 38:4 117:23 166:21

intrauterine 30:24

intrinsic 250:11 278:8

intrinsically 250:17

introduce 3:19 18:5 89:10 173:7 181:17 243:19

introduced 42:23 205:16

introducing 53:21

introduction 14:15 32:24 178:4

invalidated 148:24

invasiveness 39:12

invention 277:7

investigate 193:19

investing 147:1

investments 104:3 115:3,7 147:21

inviolability 260:2 286:10

invisible 264:22

invite 10:20 12:21 15:18 262:4 264:6

invited 88:22

invoke 49:12

165:14

invoked 260:6 285:22

invokes 47:15

invoking 15:9

involve 102:6 113:17,18,20, 22 240:17 241:12 293:3

involved 91:2, 4 118:22 135:2, 3 156:19 246:20 251:4

involvement 131:23 209:15 228:12 263:3

involves 49:7, 18 50:12 70:6 127:8 245:4,5 247:17

involving 70:3 247:21 252:21 253:9 261:18 272:5,6 287:12

iron 24:6,8,9

irrelevant 51:21 257:23

irreversible 235:24 236:21 238:12,21 239:4

irreversibly 239:9

issuance 170:20

issue 8:20 13:7 29:20 38:1 132:17 182:7 190:15 222:15 247:15,23 252:10,15 253:8 254:24 257:23 270:20 285:16 286:18 290:15

issued 41:6 169:23

issues 12:25 19:24 30:17,18 33:15 91:24 93:16 127:22 131:16 134:20 144:13 145:6 196:9,21 204:5 215:6 229:18 247:9 249:25 251:4 278:9 281:5 293:5

iteration 231:13

IV 30:6

J

Jackson 149:20 154:1

Jacobs 212:16

January 135:16

Jason 5:4 85:25 86:1 89:12

Jersey 198:12

Jessica 4:24

job 43:9,16 116:16 290:14

John 260:8

John's 244:14

joining 245:15

joint 44:8

Jones 97:23 98:9 99:2 101:12 145:17, 23 146:3

Journal 91:14 144:20 246:10, 15

journals 91:3, 10,11 245:21 246:3

judge 3:3,10, 17,18,21 4:1,6, 12,20 5:3,7,13, 21,24 6:5,9 7:24 8:5,9,12, 15,19 9:20,22 10:1,8,11 11:14,21 12:17 13:12,14,21 14:1,3,7,11,16, 19,22 15:2,7, 13,15,17,22,24 16:8,11,15,22, 25 17:1,5,9,19, 21 21:2 22:3,7, 11,14,19 33:2, 8,10 35:12,16 37:12,14 41:22, 25 44:17 46:25 48:4 49:20 50:2,5,8 51:2,4 52:2,10,15,18 53:18 57:22 59:8 60:11 64:4 66:11,21 68:15 73:25 74:2 78:12 80:17 81:6 82:24 83:2,4,7,10,13, 22,23 84:3,5,7, 19,22 85:19,22 86:1,5,11,25 87:3,7,16,18,21 88:1,5,9,13,16, 20,25 89:3 90:7,14 93:3,5 94:25 95:4,25 96:2,6 109:2 116:6 121:11 129:11 133:1 134:14,15,16, 17 143:12,14 151:18 152:3,7, 20 153:2,5,8,16 155:16,19,24 156:1 158:13, 19,24 162:2,8, 12,16 171:13, 17 172:4,10,17, 20,22,25 173:11,16,19, 22 174:3,6,17, 25 175:5,7,9, 12,16,18,22,25 176:3 181:3,20 183:2,4 213:4 216:23 217:16 241:21,23 242:1,5,8,15, 23,25 243:2,4, 6,10,14 248:6 249:2 251:20, 22 255:7 258:5, 8,11 268:2 270:3,6 287:7, 23,25 288:3,5, 7,10,24 289:11, 19,23 290:4,8 292:18 293:6,8, 25 294:22 295:1,9,22 296:6,22,23

judgements 149:9

judgment 225:18

judicial 276:8

July 293:24 295:17,20

jump 101:9

jumps 295:25

June 128:22 275:5 276:10

juries 10:12

jurisdictions 197:23

jurisprudence 258:23 276:6 277:5,11,17

justice 7:1 253:4

justification 278:2,3

justifications 258:24 270:20

justify 277:7

K

Katherine 4:3

keeper 290:18

Keiser 4:15 175:4,6 176:5 181:1,4,16,22 182:18 183:3,5 213:1 217:3,15 226:20,24 232:6,10,14 241:22

Kendall 5:15

Kentuckians 96:20,25 104:8 105:6 107:12 112:19 129:17 130:6 142:20

Kentucky 3:13 5:11 9:19 14:5 17:12 18:8 60:17 77:3 79:21 93:22 102:12,20 103:7,21 105:10,22,25 106:1,3,6,13,15 111:19 117:14 119:9,23 120:3 122:16 123:7, 10,15,25 124:1, 13 125:3,9,16 129:20,25 130:5 131:20 135:7,12,16 136:8 146:13, 15,18,22 147:2, 9,16,22 148:14 149:14 155:14 156:12 157:7, 12,19 160:19 161:7,12,15,17 162:25 164:3,4 183:9 215:18, 21,23,24 216:9, 15 217:6 235:7 236:19 247:24 266:7 270:13 271:3,5,21 280:2 285:15 286:2,6 287:12

Kentucky's 46:9 103:4,6 129:23 133:18, 23 158:3,17 163:24 216:7 255:1 257:16 265:23 287:12

key 142:7,19 187:9 203:4

kidney 26:7, 11,12

kidneys 26:6
kill 210:7,10 222:17
killing 278:1 279:13,21
kind 19:15 26:24 57:3 61:15 65:22 75:12 79:14 90:19 160:23 176:13 180:19 185:14 186:21 189:23 191:18 199:17 206:21 244:3 252:10 257:18 265:11, 12 277:25 278:17 279:14 280:13 282:11 284:25 286:25
kinds 247:16 263:17 269:19 281:14 282:9 283:22
Kjell 115:19
knowing 240:14
knowingly 225:1
knowledge 15:4 42:6 157:18 257:22
KRS 46:10,11 164:10 165:15 183:10 190:17 255:10 286:14

L

label 42:18
labels 42:17 172:18
labor 20:1 24:12 25:12 30:18,24 116:22 225:10, 24 226:2,8,11, 17 227:11 235:19
lack 152:6
lady's 208:10
laid 77:7 188:12
landscape 265:4 281:14
language 65:23
large 24:7 26:24 56:7 59:17 70:1,3,7 102:10 120:24 129:23 140:1 159:13,15,18 180:14 194:23 200:11 215:24 268:15 274:11
largely 239:15
larger 29:8 106:3 157:2 200:10
lasts 23:17
late 138:8
latest 11:24
Latin 283:8
Laura 107:24
law 10:21 15:5 40:12,19 44:22 46:11,12,18 47:8,21 50:6, 15,17,18,20,22 77:5 158:3,17 161:8 162:3,5 163:25 164:1,5, 10,16,20 166:1 183:9 190:17 225:14,16,17 237:3 243:23 244:5,6,7,10,21 245:4,21 246:1 250:19 252:9 254:18 257:6, 23 258:18,24 262:18 265:8 276:1,23 280:19,20 282:15 283:19 292:1 293:2
laws 11:24 44:22 46:8,13 82:16 90:24 91:1 92:13,21 111:18 133:18, 23 134:8,12,21 136:9,22 137:21 142:9 148:23 149:11 182:7 190:16 235:7 236:4 238:4,11 252:12 270:20
lawyer 225:15 226:5
lawyers 7:11, 20 154:8 155:7 171:24
lay 163:3 190:25
layer 185:19
layers 187:14
lead 29:12 32:11 116:23 131:7 133:19, 24 136:23,25 148:3 203:3,4
leaders 282:22 283:1,7
leading 91:20 159:10 266:19
leads 148:5
Leanne 5:8
learned 116:23
learning 283:18
leave 7:3,6,11 83:8,9,10 138:14 142:18 165:15,25 166:9 242:2 288:2
lectern 17:23
lectures 284:4
led 246:23 247:2
ledger 261:25
left 99:17 105:5 231:4,8
legal 23:7 36:19,21 39:4 46:17,20 47:24 58:22 60:17,24 169:1,14,15 170:5 174:14 249:19 252:9, 17,25 286:5
legalized 71:15 169:17 170:21
legally 7:6
legislation 135:3 229:8 257:19
legitimate 263:11,24 264:4 265:5
legs 27:8,10 49:7
lend 213:23
length 8:10 34:24 56:2 139:8 260:24 269:7
lesson 157:22
lethal 277:2
Letters 244:2
level 40:5,16 80:9 96:12,18 99:25 101:15, 17 103:15 105:16 108:5 113:1 126:12, 13 170:20 197:5 203:24 230:23 259:16 294:13 295:5, 24 296:2
levels 29:5 39:13 90:21 179:1
Lexington 157:13
liberty 259:12, 19,21 260:1,4, 7,8,9,12 277:13 285:21 286:9
Licensure 5:12
liens 111:10
life 39:22 75:25 76:5,14 78:6 97:12 101:21, 22,24 131:11 161:13 162:6 166:24 167:4 195:24,25 206:21 212:14, 20 219:21 220:6 222:9,12, 15 224:22 225:5,8 226:19 234:15,23 235:3,14,23 236:6,8,21 237:1,11 239:8 249:8,23 253:19 254:19, 24 255:6 259:3 261:19 266:18 267:22 272:6 274:12,18 278:25 281:9, 18 282:14 283:11,17,25 284:10 286:10
life-sustaining 227:18
life-threatening 235:12
lifelong 115:7
lifetime 104:5
light 12:24 86:15 156:14
lighter 156:17
lightning 209:10
likelihood 131:16 206:13, 23
likes 266:23

limb 188:21
limbs 49:4
limit 60:17 108:11 134:9 136:22 137:22 139:24 223:15 262:17
limitation 140:23
limitations 139:12 140:5 141:22 192:7, 21
limited 15:4 44:16 128:5 130:24 139:25 142:5 150:14, 23 156:10 158:9,16 161:22 169:20 199:2
limiting 120:5 260:6
Lincoln 36:12
Lindo 85:25 86:1,2,9,19 87:24 88:13 89:10,12 90:16 91:2 92:1,10 93:1,7 94:8,12, 19 95:7,13,21 96:11 97:7,21 98:3 99:1,11 100:6,18 101:9, 15 102:8 103:1, 14 104:7,15,22 105:9,13 106:5, 12,17,24 107:14 108:2, 16 109:8,24 110:24 111:16 114:11,23 115:9,16 116:10 117:6, 22 118:7 119:6, 22 120:11,15 121:8,15 122:12 123:4, 20 124:21 128:16,18 129:15 130:3 131:13 132:1, 25 133:4 134:12 141:11 143:19 151:21 171:16,18 193:24 260:20 262:8 263:20 276:18
Lindo's 94:22 151:16 161:23 262:9 266:1,2 274:10,23
Lindsey 4:15
lines 135:8 158:21 214:15
list 9:14 42:24 219:9 228:14 293:10
listed 54:9 101:14 246:11
listen 6:3 191:12
listened 261:21
listening 64:20 191:10
literally 193:7 290:17
literature 65:11 74:11 90:23 94:3 112:17 115:10 122:13,22 132:2,4,8 167:7,10,16 180:15 181:25 192:10,18 194:10 206:1,8 219:1 244:20 254:12 258:22 260:4 268:10
literatures 93:18 112:22 132:8
live 13:18 22:2 57:10 63:9 90:9 173:6 193:12 198:7 210:8 223:7 224:9,12 225:22 235:20 289:8
liver 26:1,2 28:21 209:15
lives 104:6 114:10 219:23 275:23
living 99:24 100:24 102:18 131:24 183:12 243:22 252:22 254:18 255:16 279:11
LMP 60:18 67:20
loans 141:20
local 14:24
location 80:7 257:12
locations 164:13
lodging 127:5
logistic 127:22
logistical 86:4 87:19 95:20 127:22
logistics 289:1
long 6:17,22 7:13 8:1 61:3,5 83:16 90:16 148:6 170:14 177:4 196:2,16 200:8 228:13 232:22 277:21 291:13 293:14
long-run 115:6
long-term 117:1
longer 17:12 119:4
looked 65:4 68:22 100:6 126:17 180:22 182:2 194:5 200:19 203:6 214:8,19 215:16,20,23, 25 231:9 232:21 233:11 271:2
loss 193:2,3 194:18
lot 40:13 59:2,5 67:18,25 70:3 125:22 166:6, 11 186:7 189:13 192:9, 19 193:8 202:2, 6 209:5 218:3, 18 219:2 263:12 279:16 284:13,14
Lou 269:15
loud 111:1 291:24 295:14
Louisville 18:7 19:4,7,12 43:8, 9,12,17 44:2,8 45:25 65:7 71:3 73:16 75:5,7,9, 15 85:11 157:11
low 99:22 100:2 125:5
low-income 97:5 114:8 119:25 125:7, 20 127:25
lower 26:25 37:3 119:2 140:8 156:18 200:3 206:23
lump 203:3
lunch 83:14,18
lunchtime 8:14
lung 25:2
lungs 27:10 28:19 211:16
lupus 25:21 238:19

M

macrosomia 29:7
Maddox 4:8,9 6:4 7:17,23 9:24 10:2,9 11:9,15,22 14:13,14,17,20 15:14 16:2,3 21:6,10,21 22:13,18 32:22 33:6 35:17 37:13 42:2,4 44:15,18 46:23 47:1,4 48:2,6,7 49:17,21 50:4, 7,10,23 51:3,6, 7,22 52:8,11,22 53:17,19 59:7,9 60:9,12 66:7, 15,25 68:13,16, 17 73:23 74:1,4 78:10,15,18 80:20 81:5 83:3,19 84:21 86:14 87:1,6 88:6 90:3 93:4 94:23 95:3 109:1 116:5 121:10 123:16 129:10 133:3,5 134:15,17 135:1 143:13, 17,18 150:4 151:6,9,11,23 152:10,22 153:4,7,10,14, 18,20 155:18, 21,25 156:4 158:7,11,14,23 159:1,2 162:1, 3,9,15,17 163:8 171:11 172:3,9 173:13,17,20 174:10 217:1 288:9,15 289:17,22,25 290:5,7 292:8, 23 293:24 294:20,23 295:8
made 12:25 74:2 94:23 97:7 149:13 165:13 166:10 169:14 170:5 212:1 221:22 234:13 235:5 253:13

262:15 264:15 266:19 267:3 290:1

magical 193:8

magnified 129:24

magnitude 124:5

main 23:24 96:14 141:7 142:1

mainstream 255:21 256:9

maintain 28:20 199:2

major 39:23 147:14 180:17 189:18 205:4 228:3,10 235:25 236:22 238:12 239:4 244:17,18

majority 39:7 40:3 103:22 146:14 202:12, 13 234:25

make 8:2 15:22 23:2 24:7 48:8 53:6 69:4 70:8 71:12 72:13,17 77:1 79:10 85:7 86:16 127:7 130:1 132:13 138:12 142:23 146:21 159:10, 23 169:14 170:12 171:4 173:23 186:14 187:19 194:24 198:17 208:9 209:19 221:19, 23 222:3 225:18 232:3 233:15 234:3,6 235:6 236:3 237:2 238:3 239:1 240:5 251:17 254:4 255:4 257:10 265:14 267:23 268:1 278:10 279:17 290:1 291:6,14,17 294:17 296:3

maker's 138:16

makers 109:16 137:19 138:14, 17,25 139:4,5

makes 12:10 39:3 79:15 198:7 205:20 233:17 234:2 237:25 267:1 293:22

making 17:10 28:19 64:21 139:6 147:4,20 149:9 200:4 230:22 240:13 241:10 267:13 279:9

male 76:1,7 112:7 185:18

malfunction 30:12

man 118:22

manage 55:23 57:17 117:4

management 20:4

manages 282:1

mandate 7:2

manifest 26:18

manifests 208:4

map 128:19 129:15 151:15

marathon 10:12

mark 94:11 95:21

marked 21:5, 13 35:10,20 44:20 80:19 96:8 118:6 216:24 248:8

markers 188:14

market 116:22

marriage 116:22

marriages 116:24

married 100:23 101:1,3

marshaled 264:12

Marshall 3:23 79:3,4,7

Marshall's 79:14

Maryland 244:15

mask 7:2,10 88:22

masks 6:25

mass 24:3 188:2

Master 18:21

master's 89:16 176:20

materials 214:22 294:24

maternal 39:22 61:19 62:17 71:14,22 118:21 178:21 189:10 196:4, 13,15,18,23 197:4,7,10,21, 25 201:5 203:10,17 207:4 208:20 217:6 229:8 249:22 258:25 261:18 283:3 285:9

maternal-fetal 185:1

matriculated 18:13

matter 7:19 65:25 66:2 76:11,20,21 77:12 83:15 87:20 120:1 128:15 136:13 164:2 172:13 252:10 258:2, 14 259:6,18,21 265:11,12 269:1 277:24 279:5,10 287:5

matters 83:16 86:4 174:18 210:13 247:21 252:12 254:16 282:14 284:14

meaning 29:8, 16 34:1 80:3 250:5 256:21 283:2

meaningful 250:5

means 15:4 114:18 129:22 130:22 146:23 154:20 158:25 166:4 209:10 239:21,23 245:23 246:5 255:15 263:24 265:2

meant 85:11 229:16 265:16

meantime 187:24

measurable 190:7

measure 141:15

measured 141:19

measuring 109:20 229:25

mechanisms 139:19

media 246:6 290:24 291:2,3

medical 5:12 18:13 19:20,21 20:10 22:22 34:12 37:8 38:8,11,12,19 39:18 40:1,8, 14,18 48:9 53:11 54:5,8 65:6,9,25 66:2 70:11,16,21,24 74:17 75:15 78:3 86:20 110:1 133:10, 14,16 167:6,18 176:20 178:8 181:25 183:7, 16 190:23 207:12 209:4 212:22 217:24 218:2,3 219:21 225:13,16 249:22 259:1 261:19 272:1,3, 8,13,19,20,22, 23,25 273:5,6, 7,11,14,24,25 283:7

medication 39:5 81:19,20

medications 33:18 38:7 183:25 184:2

medicine 18:14 19:7 36:9 40:16 178:5,6 182:20,24 184:16,17 196:16 219:18, 24 223:3 225:3 245:2 273:15

Medicines 36:2

Medline 180:18

meet 7:20 8:6 13:17 40:1,4,21 43:25 100:3 112:9 152:12 213:13,14 228:6 236:23 238:10 254:6

member 20:19, 21,22 43:17 45:14,16

101:25 114:18 183:12 185:2 220:5 245:10 247:8 252:22 255:16 257:5 278:15 279:11 281:25 282:10 284:9

members 101:6 114:12, 20 130:23 185:15 254:19 268:20

membranes 187:21

memorialize 173:24

memory 169:6

men 259:10

menstrual 23:18 48:22 60:21

mental 33:14 118:19

mention 25:25 31:6

mentioned 26:16 28:8 38:17 43:24 61:8 66:1 80:22 85:5 103:11 115:4 163:14 173:7 179:8 182:1 185:3 195:16 204:4,6 205:13 212:13 214:1 218:8 229:9 241:6 246:18 251:18 255:24 261:17 275:10,14 280:1 289:8

merging 185:21

message 146:5

met 42:5 133:7 270:10

method 109:13 240:21 280:12

methodologies 154:22

methodology 109:11 139:20 140:24 182:1

methods 191:19,23 192:1 205:15 230:24 240:20 241:12

metro 157:11

mic 16:17 88:21 90:11 175:19

Michael 5:9

Michele 5:22

microphone 191:7 192:15 243:11

middle 16:18 155:1 157:10

Mike 17:7

Miller 107:24 108:1,3,16,24 109:7 110:8,11, 19 111:24 112:16 114:15 118:6,7 119:7 137:9,16 139:9 140:18 193:23 194:1,2

Mills' 260:8

mind 55:7 72:15 94:10 104:15 107:18 110:9 123:3 127:21 155:5 172:14 187:6,8 191:22 196:5 199:15 225:11

mindful 50:5 293:7

mini 7:8

minimize 208:20

minimum 294:4

Minnesota 92:24

minor 244:18, 19

minorities 269:3

minority 74:8 125:11 269:22

minus 170:7

minute 230:15 241:18 289:14

minutes 172:11 288:21

mirror 65:22

miscarriage 20:3 29:14,18 63:8 189:15 198:25 199:25 200:3,15

miscellaneous 291:9 296:16

misleading 158:10

missed 25:25

missing 128:9, 10 248:20

mission 219:19 220:3

Mississippi 269:16

misspoke 85:6

misunderstood 16:6 72:4 85:5

mix 165:11 284:25

mixing 189:11

mode 31:25 280:14

model 110:4 201:2 240:4

mom 195:24 196:5 235:21

mom's 191:8

moment 62:20 84:17 112:25 132:22 177:7 193:8 219:7 248:7,9 252:18 256:17 259:4 261:18 269:8 270:1 286:23 287:11

moms 281:13 285:4,10

Monday 11:23 152:15 293:2, 13,19,20 294:10 295:7

money 117:4 141:13

Monique 176:8

monitor 175:23 192:24

monitoring 193:11

month 102:2

months 119:3

Moore 5:4

moral 44:24 236:10 246:16 249:18 250:6,8 252:25 253:6, 19,21 254:14, 17 255:24 256:2,5,6,10 260:2 261:15 263:22 264:25 265:20 278:14

morally 23:5

morbidity 34:9 57:11 201:2 209:3

morbidly 31:13 61:9

morning 3:3,9, 12,22 4:2,8,21 5:13 10:4 17:1 18:4 42:3 88:16 89:8,9 171:23 290:22 291:12 296:17

mortality 34:4, 9 36:17 37:3 58:16 69:20 71:10,15,23 72:3 74:7 178:21 179:6, 18 196:4,5,14, 15,18,24 197:4, 7,11,21,25 198:5,14,18,19 199:21,23,24 200:20 201:1,5, 19 202:6,19 203:17 204:8, 10,13 205:2,5, 11 207:4 209:2, 3 215:17 217:6 229:8 234:11 241:8 271:2

mortgage 102:4 141:20

mother 33:24 62:5,21 65:16 69:8 134:21 162:7 190:12 207:23 209:17 210:15 224:22 235:15 239:8 278:6

mother's 62:8, 13,25 63:14 189:6 190:13 192:7

mothers 250:16 283:11

motion 12:10, 19 13:15 174:11,12 289:25 290:1 292:25 294:18

motions 14:1 289:23

motivated 258:2

motivation 279:1,2

motivations 279:14

Mount 176:19

mouth 59:11

move 12:1 21:19 27:9 34:18 37:10 44:17 48:5 52:5 81:3 101:8 102:8 116:3 123:14 129:8 162:16 181:17 217:13 226:15 227:9 248:23

moved 19:3 22:19 81:6 93:5 95:4 109:2 116:6 121:11 129:11 156:2 181:20 251:22

movement 67:25 68:2 282:23 283:2

moves 187:13

moving 24:23 68:6,10 87:22 102:5 249:5 290:6

multi 165:11

multi-working 228:12

multifaceted 251:3

multiple 7:5 31:11 92:8 165:11 238:18 246:14

muscle 32:11

muscular 31:15

Myers 4:3 5:17

myriad 37:21

Myth 71:15

N

named 71:13 246:9 291:1

narcotics 240:8

narrative 277:6

narrow 256:25

narrower 257:15

narrowly 256:22

nation 36:14

national 36:1, 7,8 57:20 59:24 91:16,18 169:23 205:13, 14 231:16 232:8

nations 202:13 246:21,25

nationwide 150:14,23 159:25 160:11 168:4

Native 177:18

natural 109:15 120:24 121:16 122:4,7,14 168:25 169:12 272:15

nature 80:2 109:16 259:10

NBER 138:10, 11,20

near-limit 118:16,23

necessarily 40:4 208:8 222:21 241:12

necessitate 31:18

necessity 278:2

needed 24:6 34:21 239:16

needing 24:13 30:21 96:24 115:2 122:23 123:1 126:6

negative 111:8 132:12 140:13 189:17

negatively 148:1

negotiation 246:24 247:2

neonate 33:23, 24

nerve 29:11

nervous 188:15

neural 184:5

newborn 164:11 253:22

nice 213:13,14 270:12,13

Nicholson 290:20

Nicola 178:15 243:25 281:20 282:2,8

NICU 211:15

night 8:25 9:12 86:12

nod 296:9

non-financial 115:11

non-governmental 36:13

non-pecuniary 115:11 117:7, 11

non-persons 254:2

non-pregnant 61:24

non-preventable 203:18

non-surgical 54:5

Nonpecuniary 115:18

nonprofit 91:20

nonprofits 283:7

noon 291:19

norm 268:17

normal 180:12 291:8

normative 276:7

North 176:24

northern 157:11

notable 102:23 126:22 127:13

note 15:8 33:6 126:15 152:17 174:10 259:7

notebook 137:10

noted 82:14 95:23 166:5 195:9

notice 9:16 68:24 152:1,18 157:22

noticed 42:24

Notre 178:15 243:24 244:2 245:10,15 281:1,2,17,23

nuanced 53:4 229:23

nucleus 185:22

number 6:13 22:24 39:11 42:23 44:21 53:14 54:5,6, 10,16,20 55:1 56:5,19 58:15, 16 69:19 70:4,7 84:10,12 85:15 87:3,4 105:5 120:5 121:5 122:1,19 139:12 141:20 146:12 148:12 150:1 153:25 154:16 155:23 159:16,18 162:21,24 163:2,6 164:12 168:7 194:23 208:18 214:13 230:1,2 231:11 246:1 272:23 275:9

numbers 55:5 56:11,15 59:14, 17 71:9 159:15 194:19 195:15

numerous 134:4 196:17 241:11

nurse 178:9

nutrients 61:18,20

nutritional 24:8 184:23

O

O'MELVENY 4:3 5:17

oath 18:1 54:1 66:1 84:25 199:5

OB-GYN 19:18 20:8 44:1 57:16 65:13 177:3 178:12

object 14:14 21:21,22 44:11, 14 46:19 47:23 49:9 84:21 86:14 136:14 151:25 257:20 267:5 294:17

objected 32:24

objection 14:13,17 22:18 33:7 37:12,13 50:16 51:19

52:14 59:4 60:5,7 68:11 73:20 81:5 86:13,16 93:3,4 95:3 96:6 109:1 116:5 121:10 123:16 129:10 134:11 152:5, 17 155:22 156:2 158:5 161:19 171:21 181:19 182:22 183:4 217:15 249:1 251:15 294:20

objections 94:23

objectively 263:3

obligation 268:20 273:24 275:21

obligations 112:4,9 250:18 273:2

obscuring 17:23

observable 188:17

observation 139:25

observe 111:4 186:1

observed 98:19 111:13, 15 145:10 168:22

observer 247:10

obstetrician-gynecologist 18:7 176:11,14

obstetricians 20:22 186:11 197:6 209:21 210:14 219:11 235:13

obstetrics 18:16 19:9 20:12,18 22:16 55:18 73:16 176:22 182:23, 25 183:18,22 189:13 210:18 213:24 219:17

obstetrics-gynecology 182:21

obtain 98:16, 20 103:20 107:4,7 108:12 110:15 118:4 120:6 121:4 122:23 126:5, 18,20 128:7,13 129:17 130:2,7 151:1 161:11 163:1,20 168:9, 10,21

obtained 100:19 104:8 161:14 162:22 168:20

obtaining 82:13,14 89:19 99:20 100:12, 16,17,23 103:16 105:3,9, 25 106:13,14 107:8 117:25 118:1 119:20 122:1 127:3 146:13,14 159:19 162:24 163:6 166:24 274:6

obtains 147:23

obvious 11:6

occasionally 244:7

occupation 135:20

occupational 116:20

occur 24:15, 17,22 27:15 28:4 29:11 32:8 39:7 49:6 116:16 186:6,8 187:5,10 189:12,14,15 195:17 204:13

occurs 23:24, 25 27:7,13 185:25 186:12, 15 188:3 189:11 195:18 248:15

October 53:16, 25

offer 84:23 86:20 94:22 108:24 121:8 134:24 151:14 152:23 155:22 249:6 250:23 252:6 288:11 289:20 292:20

offered 20:13 43:24 153:13 252:16 267:20, 21 268:3

offering 73:5 153:5 182:15 268:2 273:9,11 274:4,5,15 280:7,12 286:5

offers 116:17 239:24 240:1

office 8:18 20:4 23:12 41:10,14 123:8 192:14 215:8 270:15 271:9, 21 291:16

official 70:11

officially 99:21

offset 112:8

oftentimes 27:7 35:2

older 99:9 202:3

one's 260:10, 12 266:25

one-day 288:15

oneself 33:22

op-ed 248:16 275:17,24 276:5,10,14

op-eds 248:19 275:11,18

open 172:6

opening 15:18, 23 16:4 191:11

operating 268:16

operation 12:3

operations 121:2

operator 192:22

opining 273:23

opinion 73:5 134:7,25 138:18,22 148:11 165:5 167:3 182:15 183:16 194:6 205:24 212:5 216:2 225:15 229:11 249:6 250:24 263:6 273:11 280:8 286:6 288:18 294:7

opinions 86:20 106:18 161:23

opportunities 116:18 164:23 207:16 284:5

opportunity 43:25 165:22 237:16 248:18 254:23 259:5 262:5

oppose 220:1

opposed 109:17 219:13 220:15 222:19 256:24 269:18

opposing 276:18 287:10, 15

opt 55:12,13

optimal 186:15 207:22

optimize 210:17

option 137:21 165:14 286:22

options 55:15 64:23 240:14

oral 12:13,23 294:15,19

order 11:25 12:2,8,19 23:2 41:16 93:19 115:15 121:25 127:7 174:22 234:14 263:13 290:6 294:7 295:13

Oregon 89:23

Oreopoulos 115:18 116:3, 11

organ 30:12 32:17 39:24 61:21 62:3 69:8 188:9 189:9 227:18 228:3

organism 250:4 252:17 253:3

organization 36:13 91:21 128:24 154:1 219:13,14,16 247:1

organizations 20:20

organize 186:3 187:21 284:4, 21

organs 31:4 187:16 198:24

origin 205:3

original 279:15

origins 251:3
out-of-town 14:2
outbreak 7:8
outcome 113:9 140:4 143:7 203:14 210:16
outcomes 109:20,21 117:8 118:25 119:11 141:8 143:3,7 178:25 179:3,18 194:20 196:8 198:4 229:24 230:5,25 231:12 233:13
outer 185:19
outfit 75:8
outlawed 280:10
outlets 246:3
outline 11:18
outlined 40:22
outpatient 19:23 75:13
output 24:15
over-represented 100:15 105:2
overdoses 197:1
overlaps 218:4
overnight 85:13
overruled 52:18 59:8 134:14 162:13 268:6
overstated 196:12
Overturn 276:2
overturned 40:24 41:15 150:14,23 156:10 158:8, 16 159:7 161:23 162:5
overturning 41:8
overview 7:14 16:1 130:10
Overwhelmingly 124:4
ovulation 186:12
owner 79:2
oxygen 28:20 29:12 30:11 32:13,15 61:20 62:4

P

P.M. 296:24
pages 36:16
paid 14:5 53:2 276:23
pain 218:19
palliate 212:7
pandemic 6:24
panoply 12:20
paper 97:23,25 107:21,23 108:3,16 109:7 110:25 111:24 115:17,20 116:3 118:6,7 120:12,15,22 121:8 138:9,10 145:8 180:23 196:2 199:4 229:19 231:11, 15
papers 91:6,8, 10,12 138:7,12 144:16 148:9 166:16 178:20 179:23 180:2 203:21 245:16 288:2
paradox 178:24 179:8
paragraph 36:25 39:2 58:6,7 72:14, 15,18 82:7 111:1,25 112:2 116:13,15 118:9,11 137:15 139:22 140:8 154:19 155:2 170:4,13, 16 171:6 173:15,17 230:17,18 231:6,24,25 232:1
paragraphs 9:2 232:2
parenthood 5:19,20 9:4,17 42:8,9 135:6 148:23 249:16 260:25 261:7 262:22
Parenthood's 173:18
parenting 113:17
parents 114:2
Paris 247:2
part 23:5 24:1 42:23 43:8,9, 16,23 44:3 64:14,19 65:9 113:11 125:10 148:11 160:20 162:5 163:18 165:11 210:22 227:6 258:8,11 294:8,15,17 296:3
partial 111:25
Partially 148:4
participants 283:9,14 284:19 285:5
participate 20:15 65:8 213:16 270:16 296:7
participating 3:15
participation 117:3 229:12
parties 13:5 22:9 173:11 260:11 289:2, 12 291:3,15 292:17 295:21 296:7
Partly 204:23
partner 37:25 38:5 100:24 102:3 117:23 118:2 167:12
partners 112:7
parts 158:1 160:25 161:1 191:12 202:14, 16
party 9:8 92:20
pass 29:19,21 41:21,23 132:22,24 213:3
passed 46:8 169:22
past 7:21 63:3 111:7 203:22 244:9 248:17 285:1
path 208:24 268:23
pathway 237:7
patience 116:25
patient 23:15 24:9,18 25:3,9 26:6 28:15,19, 24 31:1,6,17 33:18,21 38:7, 14 40:8,15 53:1 64:16,17,19,21, 22 65:2,12,16, 17,22,23 70:12 167:7 179:19 183:19 184:6, 11,25 197:13 209:1 210:23 216:11 221:8 228:5 233:20, 23 234:7,8 235:12 236:1, 22 237:9,19 238:6,21 239:3, 24 240:5,14 241:10,13
patient's 27:18 29:5 193:5 235:8 240:11
patient-centered 64:20 239:17 240:4
patients 9:9 19:23,25 20:2 23:5,7,8,12 25:1,5 26:14 27:4,11,13,20 28:1,4,18,21 29:2,19,20,25 30:19,22 31:7, 11,19,24 32:3, 6,16,21 33:14, 16 34:4,25 35:1,2 37:20,21 38:1,5,10 39:25 40:4 41:7,9,12, 14,17,19 46:13 47:16 49:23 51:25 52:20 54:8 55:14,24 57:15 64:13 65:18 66:13,23 70:7,8 74:18 75:11 85:15 97:15 100:12, 23 103:16,20, 24 104:11 105:2,9 110:10, 21 117:13,20 120:2 122:16 123:25 124:7,9 125:5 126:17, 19,23 128:12 129:1 130:4 131:9 146:13 148:13 183:21 194:23 210:18 219:17 221:6

230:1,3 233:16 234:22 237:10 238:20 240:7, 16 241:16 267:10,13 273:3 274:11

patients' 274:6

pattern 186:4 188:12

patterns 180:7

pay 53:2,6

paycheck 45:23 85:8,12

payers 82:15

paying 82:15, 19

payment 52:13,21

payments 102:4

payoffs 104:4

pays 46:3 116:17

pediatricians 223:1

peer- 178:19

peer-reviewed 91:3 92:2 108:17 115:21 120:15 179:23 272:21

pellucida 185:19

penetrates 185:18

people 6:3,10 22:22 24:5,11, 17 25:2,10,20 26:19 27:2 28:11,22 29:17, 23 32:17,18 40:13 63:24 75:14,16 76:9, 21 81:12 97:5,6 99:6 100:15 101:19 106:9, 21,25 107:12 111:21 113:23, 24 115:2 119:22,25 120:2,5 121:3 122:1 123:24 124:18 125:5, 10,20,24 126:2 127:6,14,23 130:12 137:5 146:14,25 147:11,20 149:3,5 159:19 161:11 164:23 165:1,22 166:6 168:9,10,20,21 186:1 203:5,10 210:12 238:15 253:22 257:13 260:11 268:15, 25 271:10 274:18 279:7 282:25 283:3,4, 5,16 285:5,12, 13

people's 114:24 166:21

percent 24:16 29:16 33:16 39:7,8 58:17 59:19,21 98:20 99:6,8,18,20,21 100:21,25 104:11,13 105:5,9,11 106:6,8,9,11, 12,16 111:7,11 124:5,10 125:4, 7,12 140:2 149:15 150:15, 24 157:5 158:4 159:8,12,13,14, 17,18,25 160:7, 12,19,21,24,25 161:18 167:21 168:4,6,7 169:9 193:1,3 194:21 195:17,18,19, 20 196:3 200:23 203:17 212:18,19 229:12,21 230:3,19 231:4, 7 234:11

percentage 106:14 140:1 148:18 266:8 268:15 274:11, 18

percentages 56:9

perfect 17:21 88:9 157:19

perfectly 204:2 209:13

perform 44:5 45:9 185:4 235:19

performed 67:3 85:16 228:15,18,21 273:18 280:15, 16

performing 69:5 78:4 228:23

peri-viable 209:25

perinatal 184:12

perineal 31:21

period 23:19 48:22 60:21 76:25 78:3 109:22 118:17 139:25 187:2 194:14 206:6 230:19

peripartum 32:9,18,19

peripherally 194:2

permanent 227:18 247:10

permanently 280:19

permissible 84:11,24

permission 15:5 216:22

permitted 227:23

perpetrated 281:6

PERRY 3:3,10, 17,21 4:1,6,12, 20 5:3,7,13,21, 24 6:5,9 7:24 8:9,12,15 9:20, 22 10:1,8,11 11:14,21 12:17 13:12 14:3,7, 11,16,19,22 15:2,13,15,17, 24 16:8,11,15, 22 17:1,5,9,19, 21 21:2 22:3,7, 11,14,19 33:2, 8,10 35:12,16 37:12,14 41:22, 25 44:17 46:25 48:4 49:20 50:2,5,8 51:2,4 52:2,10,15,18 53:18 57:22 59:8 60:11 64:4 66:11,21 68:15 73:25 74:2 78:12 80:17 81:6 82:24 83:2,4,7,10,13, 23 84:3,5,7,19, 22 85:19,22 86:1,5,11,25 87:3,7,16,18,21 88:1,5,9,13,16, 20,25 89:3 90:7,14 93:3,5 94:25 95:4,25 96:2,6 109:2 116:6 121:11 129:11 133:1 134:14,16 143:12,14 151:18 152:3,7, 20 153:2,5,8,16 155:16,19,24 156:1 158:13, 19,24 162:2,8, 12,16 171:13, 17 172:4,10,17, 20,22,25 173:11,16,19, 22 174:3,6,17, 25 175:5,7,12, 16,18,22,25 176:3 181:3,20 183:2,4 213:4 216:23 217:16 241:21,23 242:1,5,8,15, 23,25 243:2,6, 10,14 248:6 249:2 251:20, 22 255:7 258:5, 8,11 268:2 270:3 287:7,23, 25 288:3,5,7, 10,24 289:11, 19,23 290:4,8 292:18 293:6, 25 295:1,9,22 296:6,23

persisted 118:17

persistent 111:12

person 26:3,21 28:25 30:3 70:18 121:25 128:6 130:20 162:13 175:5 225:1 236:12 244:11 253:14 254:5,8 256:13 266:22 278:20

person's 23:20,22 35:6 97:12 104:5 117:8 161:12 254:17 260:12 263:15

personal 44:24 46:17 47:6,20 182:14 250:22 257:22 275:23

personally 220:15 249:7 251:2

personhood 250:14 254:11 256:20 257:14

persons 253:25 254:2, 14 256:18,22 257:15

perspective

11:11 24:8 39:19 119:15 182:17 193:4,5 198:3 256:9 262:11 264:9 266:12

perspectives 251:4

persuaded 265:13

peruse 294:2

Peterson 203:20

phases 187:9

Phd 89:17,20 90:21 133:11, 12 145:12

Phil 115:18

philosophy 244:18,19 245:5 246:17

phone 41:11, 15

phrase 240:12 268:12

physical 51:15 97:2 118:20,22 142:22,24 227:17 249:14 261:5

physician 178:9

physicians 75:9,10,15 239:14

pick 42:18 293:16

picking 192:15 293:21

piece 153:13 207:2

pieces 234:21 265:2

pile 216:15 231:18

place 12:1,9 62:16 174:22 219:23

placenta 28:5 31:13,14,16 61:10,12,14,21, 25 62:9,12 180:7 187:21 189:9 200:11

placental 191:12

placentas 180:8,11

plaintiff 3:7 5:20 8:3 45:2 48:5 51:24 78:13 84:13 85:23 173:2,4 174:4,19 260:17 289:3 290:11

plaintiff's 10:3,10 13:15 37:15 44:21 81:7 83:25 84:8,14 95:22 96:8 109:3 116:7 121:12 123:17 129:12 172:1 217:17 259:5 260:19

plaintiffs 3:14, 23 4:4 5:16,23 11:17 15:9 16:10 42:24 83:21 85:25 88:12 92:17 93:1 94:11,22 108:24 116:3 121:8 123:14 129:8 137:10 171:15 213:13 267:25 270:9

plan 4:25 5:1 137:6 240:17

planes 211:16

planet 62:22

Planned 5:19, 20 9:4,17 42:7, 9 135:6 148:22 173:17

planning 8:8 18:19,21 20:23, 24 43:23

plans 8:18 82:17,18

plastic 37:4

plays 62:10 269:21

pleading 296:9

pleadings 270:23

plenty 141:21 211:17 294:1

plexiglass 90:4

plug 264:19

podium 16:14

point 10:22 11:2,9 12:14,16 16:7 24:14 25:9 40:7 44:12 74:2 78:2 81:22 85:6,7 134:8,13 141:14 147:4 150:17 151:19 153:12 165:25 166:10 173:22 186:2 204:4 221:2,3 223:6, 9,19 260:7 262:18 276:2 278:24 283:23

pointed 264:12

policies 79:11 91:7 128:21,25 129:21 130:1 143:8 148:2

policy 92:12 93:2 109:16 136:9,13,18,19 137:18,19 138:11,12,13, 15,17,20,24 139:2,3,5 144:17 247:9 264:5 283:19

politely 290:11

political 71:21 134:23 243:25 244:9

politically 275:23

poor 131:24 210:16 269:23

poorer 118:20 131:7,15

population 27:5 125:3,13 147:9 148:14, 18,19 204:6 206:11 231:1 266:8

populations 97:5 104:23 119:22 127:25 177:16

portion 24:4,8 163:23

portions 86:18

position 19:4, 5,11 43:8,16 44:2 178:13 226:17 227:10 252:8 256:6 286:13,18 291:22 292:2

positions 144:7 241:2 256:1

positive 132:11 141:14 263:15

possibility 128:5

possibly 9:20 28:17 30:21 33:20 112:8 131:8 138:8 179:3

Post 248:16 275:14,15,19, 25

post-abortive 283:4

post-mortem 198:2

post-personal 254:16

post-roe 281:13

post-viability 235:18

postnatal 267:1

postpartum 33:15,17,19 195:21 202:21

potential 12:13 26:4 119:14 207:10 208:10 295:21

potentially 24:12 25:13 27:15 29:24 31:5,21 32:16 33:25 38:6 40:21 68:2 127:5 184:24 209:3,8 210:25 222:20 226:21

pounds 200:9

poverty 99:16, 19,21,25 102:14,19,20 119:2 263:5 268:25

power 254:1

practical 120:1 128:15

practice 19:1 57:9 75:6 167:18 177:9 214:14 219:24 225:17 228:4 233:6

practiced 239:15 273:15

practices 283:22 285:7, 12

practicing 15:5 18:7

177:4,6
practitioner 178:9
pragmatic 279:8
pre- 206:17
pre-birth 111:8 139:23
pre-eclampsia 28:13,15,17,25 29:5 38:8 179:5 180:12 195:11 197:15 202:15 208:23 209:6,7, 12 228:11
pre-eclamptic 206:18 211:5
pre-existing 25:16,18 26:7 159:16 267:1
pre-labor 224:13
pre-personal 254:15
pre-term 24:12 25:12 209:16
pre-viability 226:2,17 227:11
preambles 6:13
precisely 159:11 269:17
preconceptually 207:24
predates 284:11
predicated 161:24
predict 206:22
predicted 150:15,24 156:9,18,22 157:3 158:1
predictor 205:11
predicts 158:7
preexisting 170:3
prefer 42:17 83:19
preferable 155:15
preference 11:5
prefers 153:1
pregnancies 23:9 180:12 195:18,21
pregnancy 23:13,15,16,17, 20,21 24:1,6,7, 10,16,18,23,25 25:2,4,7,14,17, 19 26:2,4,5,6,9, 11,12,15,18 27:17 28:10,25 29:2,3,15,22 32:21 34:17 35:5 38:15 56:2,4 57:12 61:22,23 62:17 63:17,18 64:9 69:12 72:20 80:10 81:11,13, 23 110:22 113:16 115:2 118:23 119:13, 18 127:1 178:20,25 179:5 184:8,9 189:14,16 193:2,3 195:6, 8,10,14,17,19, 20 196:9,12,19 197:15 198:4,5 199:12,18 200:7,9 201:13, 16 204:14,15 206:10,16 207:11,14 208:4,9 210:6, 11 221:23 222:4,16,17 223:24 224:22 228:11 233:3, 13,17,19,24,25 234:1,4,6,14, 18,20,24 235:3, 13 236:3,25 237:20,21,25 238:9,16 239:8 240:22,24 249:14 260:25 261:6,7 262:21 264:18 268:23 278:21 283:5 284:21 285:1
pregnancy-related 215:17
pregnant 24:5, 18 26:19,21 27:3 29:17 57:15 65:1,16 77:18 97:11 196:20 198:3 208:7 222:2 225:3,7 227:19 241:8 261:1
preliminarily 3:14
premise 219:16 252:20, 21 253:2
premises 252:19
prenatal 19:25 23:14 65:18 113:18 184:4, 23 252:17 258:19 260:3 261:16
prenatally 253:20
preparation 183:9 214:5 215:8 254:22 271:8,11 288:13
prepare 94:7 95:13,14 181:24 242:17 270:24 283:13 294:4
prepared 16:2 83:13 86:7 87:23 94:13 95:10 102:16 117:19 172:8 292:24 293:4
preparing 113:19 211:25 213:25
prescribe 225:2
prescribed 241:15
presence 141:20 192:25 262:22 263:14
present 27:16, 25 55:25 158:11,15 189:23 199:16 208:23 219:7 240:13,16 270:10
presentation 251:7 261:21 274:16 282:17 294:13 296:8
presentations 214:8
presented 110:13,16 139:13 247:14 260:17 289:2
presenting 5:1 108:9 158:9 174:23 210:23
presents 64:17
president 36:11 281:19
president's 245:12 246:19
press 6:14 83:17,20 245:25 272:22 291:2,15
pressure 25:14 28:8,10 179:5 206:15 209:19 211:11 228:12 239:12
pressured 167:11
pressures 26:10 28:12,14 209:14
prestige 116:20
pretty 11:16 48:4 188:12 200:15 248:17
prevent 184:5, 24 206:9,20 212:7 227:16, 17 239:10 240:22
preventability 203:6,7,8,13, 15,16
preventable 203:14,18
preventing 189:23
prevention 203:5 240:20
prevents 240:23
previable 66:4, 17
previous 99:12 214:8 253:12 271:22 278:12
previously 38:17 43:24 94:24 104:12 149:13 170:21 270:22 274:9 277:23 278:19 279:18,20
Priceless 115:17
primarily 27:23 67:7 110:11
primary 3:10 19:18 123:8,25 124:9,11 135:20 143:7

180:6 229:3
primordial 187:18
principle 253:4 260:6
principles 40:18 180:3 255:22 258:3
printing 276:23
prior 29:3 31:14 52:21 59:19,20 60:19 80:10 101:20 130:14 138:10 139:25 170:2 206:15 245:11, 14 246:19 275:5 282:4 287:11
Priscilla 194:10
privacy 259:13,19,21 260:1,4,6,9 277:12 285:21 286:8
private 36:12 82:18 252:17
pro 14:1,6,16 15:1,2
pro- 249:7
pro-choice 42:14,15,19 212:19 268:12
pro-clotting 26:20
pro-life 42:15 182:12 219:10 275:21 282:23 283:2 284:10
probability 206:13
probe 192:3
problem 138:20 194:14, 17 195:1 197:2, 9 198:13 199:19 209:7 286:20
problematic 198:10 236:9
problems 31:22 32:11 33:23 102:1 189:18 194:13 196:17,22 241:5 263:12 266:25 286:21
procedure 30:4 39:12 48:24 49:19 50:8,12 51:15 60:13 63:17 67:1,6 69:6 205:1 210:9 212:8 224:8 225:6 280:8
procedures 37:5,8 50:25 54:5,18,24 60:23 67:3,5 81:15 85:16 128:4 168:11 212:6
proceed 13:10 18:1 22:5 84:12 87:12 88:12 172:8 174:8 251:23
proceeded 18:17
proceeding 51:21 133:6
proceedings 3:1 44:13 49:11
process 30:19, 23 48:8 50:1 76:1,6,24 77:18 128:8 146:20 185:17 202:11 221:11 228:17, 20
procure 225:2
produce 160:4
produced 123:7,9 128:19
produces 26:20
products 29:19 30:2
profession 91:10 176:10 249:22 259:1 261:19
professional 18:23 20:19 40:15 97:2 142:22 145:4 182:2 207:12 209:4 214:7,10
professor 19:6 89:12,21,22,24, 25 90:16,18 133:4 135:21 141:11 143:9, 19 146:25 151:16,20 153:21 156:5 159:3 163:15 167:20 193:24 243:18,20,21, 23,24 248:9,24 254:22 270:8, 14 275:5 277:23 280:1 285:14
profit-making 51:18
profits 51:20
progenitors 187:25
progeny 276:14
program 55:19 281:11
programming 284:10
progresses 28:17 237:21
prohibit 82:15, 17
prohibition 49:18
prohibits 46:18 47:8,22
prominently 27:15 139:9
promise 237:14,16
promote 265:17
promotes 117:3 264:3
promoting 249:21,22,23 252:12 261:19
promotion 258:25 259:2
pronounced 54:21
pronouncing 213:9
pronuclei 185:21
proof 5:1 7:19 10:6,10,19 11:8,16,18 12:6 15:20 289:2,17 294:13 296:8
proper 14:12 134:13
properly 29:6 87:8
proportion 24:3 59:15
proportionally 105:4
propose 263:16
proposed 8:24 10:20 92:19 112:13 113:9 261:13 286:21 291:25 292:6 293:1
proposition 56:4 133:18,23 142:9 262:16
propositions 205:20
protect 62:12 183:23,25
protected 62:8 252:8 259:23 265:24 283:12
protecting 252:16 265:8, 16
protection 254:18,24 255:6 257:6,17 258:18,25
protects 77:5
protein 28:14 180:7,9
protocols 189:22
prove 13:17,24 152:7,9 153:18 158:21
provide 9:19 19:13,16,22 20:2,3 22:21 23:4,7,8,13 40:15 43:5,9, 18,25 45:13,20, 24 46:17 47:8, 20 48:9,12 53:2 56:19 57:6 64:18 74:15,17, 24 78:8,23 81:20 88:3 101:6 121:5 125:19 135:7, 11 136:7,21 140:3 151:25 168:8 182:10, 16 185:9 211:18 213:21 225:14,17 258:6 273:24
provided 21:14 39:21 59:16,19,20 75:13 135:8 146:6 164:21 248:1
provider 70:22,25 71:5

108:15 110:14, 16,18 121:25 151:2

provider's 108:11,14

providers 9:6, 11 56:17 108:9 125:16 129:2 199:3

providing 40:20,23 52:13 55:14,16 61:1 64:20,25 75:15 129:2 168:19

provision 40:19 259:9

Provoke 50:8

proximity 189:10

psychiatrist 143:1

psychic 249:15 261:5

psychological 97:3 102:7 117:21 128:11 142:22,24

psychologist 142:25

public 6:21 18:22 82:15 103:6,7 111:9 119:2 123:8,10, 15 124:2,13 136:13 137:17, 19 138:24 140:20 176:21 219:20 244:24 245:1,8,17,24 246:21 247:9, 15 251:5,14 258:2,16 261:2 262:11 264:9 266:12 271:25 272:17 283:19, 24

publication 138:11 144:7 145:3,7

publications 91:3 143:22 144:9,24 245:19,20 246:14 282:10

publish 138:11 295:12

published 65:10 91:9,12 92:1 97:24,25 107:21 108:17 115:19,20 120:12,16 138:9 144:21 166:16 179:4 245:16,22,25 272:21 275:11, 17 276:10

pull 16:18,20 179:16 180:21, 23

pulmonary 234:10 241:6

pump 32:12

pumping 32:14 189:2,5 190:3

purely 95:19 279:10

purple 156:14

purpose 7:24 68:8,9,19 292:14

purposes 95:20 96:2,4 291:8

pursue 104:1 240:6,11 263:18 266:24

pursued 264:4

pursuing 263:24 264:1 265:16

push 267:25

pushed 221:8

pushes 24:25

pushing 223:2, 4

put 15:8 16:18 24:11,22 27:2 28:18,20 31:17 33:19 59:10 92:19 97:20 98:25 99:10,16, 18,23 103:1 106:23 108:13 123:21 125:25 128:15 130:8 191:8 235:22 237:1 239:2 266:24 278:13 289:6

puts 24:10,13 26:8,9 28:16 29:22 30:3 31:6 33:21 38:17 219:16

putting 236:1

Q

qualifications 93:1

qualify 86:19

qualitative 166:18

quality 36:3 205:15

quantify 56:7

quantitative 165:7,13

question 8:20 9:9 34:24 47:3 50:19,21 58:20 64:24 66:6,8 67:23 68:12,13 69:17 71:11 74:1,5 75:19 76:4,23 77:2 85:5 117:9 124:25 127:15 133:21 137:8 142:2,9 144:25 149:11 162:14 165:11 166:8 167:19 175:25 197:20 199:10, 23 206:25 210:2 218:14, 18 221:6 223:17 226:1 227:20 232:15, 17 233:23 234:20 236:5, 17 237:14 249:16,17,18 252:2 256:1 257:25 259:19, 24 260:15 261:20 262:1 264:6,21,25 265:1,19 266:21 268:17 272:10,22 276:18 278:4 279:6,8 286:25 292:7 293:6

questioning 3:16 16:13 44:14 267:6

questions 34:18 48:1 75:21 85:1 87:11 132:23 138:4 142:1 159:10,21 171:16 197:19 226:1 241:19 247:9,22 250:24 252:9, 12 270:2 272:5, 16 283:19 285:15,20 287:1 295:11

quick 78:14 84:17 287:5

quickly 13:4

quiet 6:19

quote 279:18

quoted 69:14

R

race 74:18 80:8 100:12 179:20 201:15 205:10

racial 73:4 125:10 203:23 205:5

racism 34:11 73:1,8 74:8,12 179:2 269:9,20

racist 73:10, 11,13 75:18

racists 73:17

radiation 184:1

radiology 192:10,18

raise 8:19 9:8, 10 13:7 16:25 88:14 113:19 114:4 165:16 175:9 243:4

raising 114:1, 10 164:14

random 109:16

randomized 109:18

range 158:4 159:8 160:24 195:22 219:3

rape 38:4 220:24,25 221:18 222:1 278:21 279:7, 15,22

raped 221:7

rare 36:20 39:6 196:8

rate 58:8 74:7 156:19,22 163:5 169:8,24 193:2,4 194:18, 21 199:21,23, 24 201:20 209:2 229:12, 21 230:20 231:21,22 232:18 241:8 271:21

rates 57:11 98:19,21 102:14,19,20

111:12 119:1 121:20 150:15, 24 156:9 158:8 159:6 160:1,8, 10 161:17 162:20,21,23 167:23 168:2, 14,22,25 169:6, 15 170:6,18 171:8 201:5 202:6,14 204:24,25 207:3,4 215:17, 21 271:3,5

rational 258:6

rationales 276:8 277:16

reach 93:25 121:25 151:2 167:23 170:20 180:3 256:12 294:7

reaction 274:16

read 13:2 36:18 39:2,20 47:12 51:8 74:10,16 82:10 93:17 110:25 112:1 116:12 118:8 137:25 140:7 143:4 145:24 164:2,4 167:6 182:4 183:11 185:12 190:19 198:15 219:19 222:6 224:25 227:6 255:14 268:10 279:25 295:25

readers 163:3

reading 32:23, 25 33:3 36:25 40:11 154:25 167:10,15

ready 13:10 84:12 88:12 89:4 174:8 213:3 243:14

real 199:23 203:4 209:7 294:12

realization 230:2

realms 272:18

rearing 127:2 163:15 165:8

reason 84:23 118:1 134:21 136:6 155:9 191:14 198:14 216:18 217:9 234:7 252:5 267:21 269:17

reasoned 182:17

reasons 37:22, 24 49:10 82:14 179:4 221:12 258:17

reassuring 193:5

rebuttal 11:19 14:11

rebutting 268:3

recall 72:8 84:17 149:17, 18 163:15 166:25 169:3,4 232:22 259:15 266:5,17 275:24 276:5 280:5 285:18 286:15

receipt 14:5 140:20

receive 30:11 85:10,12 167:13 294:10

received 85:8 86:13 89:15 92:6 118:24

recent 246:5 248:15 275:19

recently 55:5 107:21 197:20 245:21 246:10 248:16 275:13 277:11

reception 246:4,9

recess 84:5 172:23 242:13 288:22

recipients 146:18

recognizable 255:25

recognize 35:22,24 181:5 248:10

recognized 258:3

recoiling 68:19

recollection 33:4 54:12 72:11,13 150:5 151:12 152:25 153:5 155:14

recommendation 138:13 139:2

recommendations 138:12 182:3

reconcile 207:5 250:1 256:12 278:5

reconciling 259:25

record 3:8,20 8:23 11:4,8 13:14 15:9 16:16 17:13,14 70:10,11 82:10 84:6,8,18 88:25 95:20,24 96:5 155:16 158:6 172:24 173:1, 24 174:11,16 175:20 242:14, 16 248:24 267:15 288:14, 23,25 290:16, 18 291:5,8,21, 22 292:3 294:2 295:15 296:4

record's 292:24

records 70:16 71:1,2 111:9,11

recover 32:3,7, 17,19 35:4

recovery 34:21,25

Recross 287:23

red 24:2,7 156:21,24

redder 157:13 159:4

redirect 78:14, 20 171:13 287:6,8

reduce 96:20 168:7

reduced 114:12,17 131:17 148:3,4, 5 149:15

reduces 116:20 120:5 122:1 131:11 137:7

reducing 121:4

reduction 142:15,16 156:18,22 157:2,4 158:1 159:6,18 160:10 161:17 196:4

reductions 122:18 159:12, 13,14,15 160:7

redundant 191:4

Reed 18:12

refer 95:24 165:18

reference 97:7 214:22,24

referenced 193:25 274:11

references 168:24

referred 28:13 31:10 169:13 286:13

referring 53:13 87:25 144:3,23 145:22 151:10 158:7 163:5 189:1 233:22

reflect 199:22 250:19 257:8

reflected 258:22,23

reflection 181:11 261:25

reflective 256:16

reflects 257:3, 8 268:12

refresh 33:4 54:12 72:10,12 150:4 152:24 155:14

refreshing 151:11 153:3

refused 221:14

regard 6:24 7:11,14,19 10:25 12:21 171:17,20 254:17 271:15

regarded 269:16

regret 218:19

regulate 259:20

regulating 90:24

rehabilitation 240:2

reimburse 185:10

reimburses 46:4
reiterate 212:3
rejection 256:19
rejoined 220:14
relate 258:25 262:16 282:14
related 26:1,2 37:3 47:24 93:16,18 102:9 134:20 144:13, 15 145:6,11 166:16 198:5 245:6 247:22 271:2 276:6
relates 51:24 92:13 272:12
relating 90:23 247:21
relation 240:15
relations 291:2
relationship 44:7 51:23 173:20 274:21
relationships 166:7,12 263:7
relative 57:9 100:2 109:21 111:8 124:5 125:3,8 128:20 130:25 169:9, 15 170:6 171:2, 3 233:12 282:18
relax 137:21
relaying 146:5
released 138:7,10
relevance 103:23
relevant 44:13 49:11,13 56:11 277:17
reliable 36:9 93:25 98:7 103:8,10 104:20 107:14 108:21 110:5 120:19 123:11 129:4 194:7 199:8 206:1 215:1 229:11, 15
reliance 71:20
relied 98:5 101:10 108:3 112:18 215:5
relief 236:20 290:10
relies 108:4 224:20
rely 98:10 115:24 180:3 199:6 218:23, 24 253:3
relying 173:8
remain 12:9 174:22
remained 230:3
remember 53:23 66:7 145:19 202:20 232:24 233:8 266:9,11 276:4, 9,13 280:6
remembered 56:12
remind 110:10 126:1 175:19
reminder 7:15 243:11
remove 49:4
removed 49:1
removing 49:7
renal 28:22 209:14,20 237:23 238:7, 14
rendered 95:7
renew 174:11
rent 102:4
repeal 169:13 170:2,6,7
repealing 170:3
repeat 47:2 58:13,19 77:2 117:9 133:21
repeating 131:16
repetitive 190:20
rephrase 117:10 274:5
report 36:2 79:20,22,24 80:1,13,22,25 103:5 112:10 123:6,7,14 139:22 141:22 165:4 198:10, 11,12 217:5,7, 10 248:1
reporters 17:12
reporting 6:17 71:9,19 141:12 196:12 198:8 199:1 215:24 216:1,3,6,10
reports 70:8 103:4 111:9 123:9 198:14
represent 188:9 270:9 271:12
representation 42:11 106:2 271:22
representative 9:17 52:9 147:9 247:3
represented 105:4,24 148:13
representing 5:16,20,22 42:4 52:1
represents 256:8,19
reproductive 23:2,4 78:23 91:25 98:21 218:15 268:11, 13,18 269:3,13 286:9
request 11:13 54:8 174:1 175:2 292:1 293:13
requesting 292:13
requests 291:15
require 7:10 25:7 26:15 30:4 35:3 216:6,9 256:11
required 20:10,13 39:12 52:20 55:11,17, 20,23 79:22,24 80:1 124:17
requirement 44:1 107:6
requires 24:7 52:13 186:23 215:24
research 69:15 71:20,25 91:13,16,17,19, 21,22 93:14,15, 17 101:23 109:13 118:3 120:4 122:5 128:25 131:5,6 136:20,24 139:13 143:2,6, 9,21 146:22 160:13 166:15, 18 176:24 178:14 180:1 195:10,12 201:15 203:19, 20 205:25 209:8 218:1,2, 3,4 228:25 229:2 233:7,8 244:25 245:7,9, 14 281:10 282:5,7,9
researcher 109:18 141:24 176:12 217:25
researchers 108:8 118:24 138:8,21 141:5 232:1
reservation 208:12
reservations 177:18
residency 18:16,25 176:22 178:3
resident 20:14 44:1 55:18
residents 19:22 20:5,6,7, 10,13 43:24 44:4 55:10 106:1,4,6 162:24,25 163:6 178:8 228:22 274:1
resistance 268:23
resolve 262:1 296:14
resolved 10:17
resource 283:5,6
resources 34:13 112:5 114:12,19 130:21,22,25 140:12,16 144:20
respect 86:16 126:17 130:18 249:23 250:8 256:5,6 259:2
respectfully

12:18 174:25 290:8,12

respects 264:7

respond 16:3 237:8

responded 278:7

respondents 124:6,10,24 125:5,12 140:2 154:5 231:4

responding 295:3

response 34:17 49:12 152:22 194:21 230:20 231:8 262:12 266:16 268:6 274:23 292:25 295:4

responses 124:25 125:15

responsibilities 112:8

responsibility 23:6 164:14 240:15

responsible 19:21 290:14

responsibly 262:1

rest 32:13 102:13 169:3, 10,16 170:19 193:2

restrain 263:25

restraining 11:25 12:2,8,19 41:16 174:22 290:6

restrict 148:3

restricting 90:24 92:21 133:18,23

restrictions 92:18 136:25

restrictive 129:21,25

restrictiveness 128:20

rests 252:19

result 33:25 96:23 107:5 108:14 113:5 122:20 126:6 127:2,12 128:1 130:11 131:21 142:3,10 148:4 160:8 165:1 196:19 197:14, 15 209:3 222:2, 22 224:9 278:21

resulted 111:6 120:25 235:15

resulting 112:15 121:2 140:3 185:20

results 142:3,4 210:15

resume 65:5

retained 30:1 92:20 182:9 252:4

retaining 28:18

return 35:7 110:8 172:18 229:21

returned 18:18

returns 115:6

reversal 275:6 277:21

review 91:9 94:8 95:16 114:23 115:10 197:6,7 202:7 203:10 216:20 230:23 245:21 246:1,15 248:9 254:23 259:5 262:5 276:8

reviewed 11:5 17:11 55:4 103:19 104:23 150:9 178:20 181:25 214:1,3, 4,7 217:7 230:21 246:13 257:16 270:22

reviewing 94:3

reviews 180:15 206:1

revolution 184:12

RH 189:17,21

Rheumatoid 238:17

rhythm 191:16

rhythmic 190:20 191:16

rich 280:13

ride 215:13

rights 47:15 51:25 165:15 246:25 254:10, 17 259:11 268:9,18 269:14 279:12

rigor 132:7

rigorous 98:11 108:20 110:5 115:24 120:18 134:2 165:5

rise 84:4

risk 24:5,10,11, 13,22 25:12 26:8,9 27:3,4, 11,13,14,22 28:1,4,11,16, 18,21 29:1,4,6, 23 30:1,3,21,22 31:6,9,12,17,20 32:1,20 33:20, 21 36:21 38:18, 22 39:9,14,22, 23 58:3,22,23 61:9 69:20 72:23 118:22 131:23 161:13 179:6 196:11, 12 200:3,4,17, 21,22,24,25 202:3,8,9,17 204:11 206:11, 12,16,23 207:16,17,18, 20,21 208:10, 14,20 227:16 233:14,15,18 234:4,11,23 235:5,7

riskier 57:24 205:1

risks 28:9 29:14 30:13,14, 15 31:2 34:3 38:16 56:2,5,8 57:9 69:17 71:18 72:3 119:13,18,19 178:20 193:22 195:6,8,10,13, 23 199:12,13, 15 201:13,15 204:13 207:10, 13 210:24 233:3,12,24 234:1,2,18,19, 24 236:3 241:11 264:17 265:11 274:19

risky 69:13 117:2 200:17 201:8

RO 12:16

robust 256:19, 24

Rodman 5:9

Roe 40:23 41:8, 15 150:13,22 156:9 158:2,8, 15 159:6 161:22 162:4 169:2,22 170:5, 20 275:6 276:3, 6,14 277:4,21

role 36:13 62:10 65:9 91:7 182:16 245:14 284:1

room 46:25 50:3 290:24 291:3

root 209:9

rotate 284:16

rotated 220:10

roughly 8:14 52:25 56:19,20 92:4 98:23 100:18 104:11, 13 110:23 114:3 148:20 160:24 167:21

routine 202:21 218:14

routinely 263:25

ruin 266:23

rule 12:3 13:21 15:9 84:9 295:18

rules 21:25 174:19 276:8 277:16 295:24

ruling 22:12 86:15,17

run 281:22 283:3,5

running 79:11 116:13 226:8

runs 157:4 281:24 284:9

Rush 291:1

S

S-1 95:22

S1-19 96:8

sabbatical 177:8

sac 190:21

safe 23:7 27:21 39:5 64:18 69:5 163:24 164:5 277:20

safer 201:6,11 205:21

safety 34:19 36:3,17 205:15 273:20 282:18
sake 263:9 279:13
salary 45:20,22 85:10
Salvanes 115:19
sample 140:4 147:9 194:22 230:24,25
sapiens 183:13 255:16
Sarah 107:24
saturation 28:20
save 210:19 226:19 234:15 235:3,14 239:8
saved 296:2
scale 157:3 253:24
scanning 193:7
scar 31:14
scary 40:13
scenario 28:5 150:13
scenarios 161:21
schedule 8:2 9:15 11:12,23 12:22 288:16 289:13 292:6, 15
schedules 289:24
scheduling 172:7 295:13
Scholar 180:18
scholarly 245:16,20 246:2 250:24 251:4 282:10
scholarship 248:20
school 18:13, 14 19:7 35:8 65:10 116:14, 16,23 128:10 131:16 176:20 212:22 273:7, 14
schooling 115:9,18 116:19,25 117:2,5
schools' 273:24
science 36:14 183:21 210:17 218:4,25 243:25 244:9, 19 245:2 247:1 272:11 282:16 283:19
Sciences 36:2
scientific 180:2 182:17 183:8 185:15 206:2
scientifically 64:1
scientist 217:20,22 218:6
scientists 218:5 284:16
sclerosis 238:18
scope 44:12,16 267:8
scores 131:15
screen 208:13, 15
search 180:17, 21,22
searches 181:25
seat 17:6 85:1 88:20
seated 175:16 243:11
sec 287:3
secondary 141:6 180:13
seconds 4:19
section 30:22 32:1 35:3 58:17 141:17 144:7 227:3,5,12,13 255:11 259:8, 12
sections 31:11
sedation 39:13
seek 37:20,21 38:1,5,10 65:18 147:10 148:14 167:21 266:4,9, 17
seeking 64:17 66:13,24 92:20 97:15 99:7,15 101:19 105:21 121:6 122:16 127:23,25 129:1 130:12 131:9 166:11 266:21 267:21 278:20
seeks 70:13,19 256:21 257:14
sees 49:25 70:14
seizures 28:16
select 284:1
selected 124:8
self-accomplishment 116:18
self-organizing 186:3
self-reported 70:7
sell 225:2
semester 244:10
senior 178:14
sense 54:7 93:21 194:15 263:17 291:6, 17 293:22
sensitive 208:16
sensitization 189:23
sensitized 189:17,21
sentence 111:2,3 112:2 116:14 118:9, 12 155:1,3
sentences 36:18 90:6
separate 62:25 187:20
separates 28:5
separating 102:2
separation 49:6 50:13,14 51:12
sepsis 28:3 29:25 30:8,9
September 275:16,25
septic 198:21, 22
series 186:23 194:4
seriousness 40:6
serve 282:3
served 245:11 247:3
service 119:4 246:19
services 4:23 19:17 43:5 176:23
set 7:18 108:2 110:19 126:13 223:14 240:14 254:6 293:12
setting 15:18 19:23 20:1 23:12 93:22 143:22 254:7 272:6,12
settle 259:19
severe 28:17, 23 237:23,24
sexual 166:17
shades 156:13 212:15
shameful 269:4,8
share 71:2 99:15,17 105:18 141:12 236:25
sharecroppers 269:10
shared 86:9 240:12 241:9
shareholder 45:17,18
sheriff 16:15, 20,24 17:18,20
shifted 277:12
shifting 276:7 277:16
short 9:14 25:3 36:8 108:2 237:11 288:12
short-run 115:6 118:20
short-term 119:3
shortest 11:11,22
shortly 96:17 275:20

shoulder 29:10
show 53:15 86:24 143:21 151:18
showing 13:23 120:4 128:20
shown 200:18 289:4
shows 36:21 53:1 131:7 159:4 218:21
shut 121:17
sic 250:6
sick 39:25 40:7 57:14 228:5 233:21 238:2, 20 239:3
sicker 211:12
sickle 25:20
side 249:13,16, 17 250:12 254:10 260:1 261:12,14,25 278:6
sides 11:15 294:14
sign 160:5 197:10
signature 94:16
signed 15:2 36:11 45:10 151:21 276:19
significance 101:2 111:16 119:6 122:12 253:16
significant 31:21 100:11 102:16 121:19 140:23 141:12 163:18,23 195:24 201:17 203:1 204:8,9 229:17 249:13 261:8 262:24 274:17,19 280:16
significantly 96:19 202:19 245:22
signing 149:18
similar 126:16 139:24 147:13 179:1 200:17 216:4 260:15 282:17
similarly 9:5, 10
simply 6:22 9:9 15:3 145:24 251:9 264:2 268:22 286:7 294:15
simultaneous 10:21 295:2,16
single 76:2 147:19
sir 35:14 56:10 88:14,16 136:11 150:7 168:23 175:15 176:2 242:23 243:6,9,15 247:18 259:17 268:8 287:4
sit 202:7 203:11 208:17
site 284:21 285:6
situated 9:5,10 134:24
situation 38:4 39:22 132:10 189:8,13,20 211:13,21 224:4 234:12 235:17 236:14 238:6
situations 161:12 189:12 209:16 214:25 234:22 241:5 285:11
six-week 49:16
Sixth 280:22 287:18
size 194:22 230:24 257:12
sizes 140:4
skill 192:22
skills 116:23 131:11
skin 31:5
sky-high 209:14
slice 200:1
slide 86:23,24 95:17 96:11 97:20,21 98:15, 25 99:2,10 100:5,8 101:8, 11,16 102:8,15 103:1,3,14 104:14,15 105:12,13 106:23 107:11 112:24 117:22 119:12,16,21 123:21 124:20 126:1,11 128:15,17 130:9 142:7 145:16 146:12 148:10 166:25 168:16
slides 86:8,10, 15 88:8 95:10, 13,21 99:12 117:19 131:25 145:15,16,20 166:23 167:20 274:10,23
sliding 253:24
slightly 122:21 198:4 200:3,17
slow 193:15 294:15
slower 193:16
small 36:22 59:18 159:14, 17 293:8 295:12
smaller 119:19 140:4
Snead 215:11 242:22 243:2,3, 18,20,21 248:9 254:22 270:8, 14 275:5 277:23 280:1 285:14 288:1
Snead's 248:24
snowball 180:24
so-called 250:14 254:11, 25
social 37:24 38:1 116:18 166:13 217:20, 22 218:4,5,6,25 282:15 284:16
societal 236:16 259:2
society 20:23, 24 73:4
socioeconomic 179:1
sociology 73:3
sold 82:18
sole 153:12
solely 49:15
solid 201:8
solution 263:11 276:2 286:20
something's 193:19
sort 8:10,23 29:24 38:1 42:14 44:8,24 48:25 62:3 75:10,21 77:17 90:5 104:4 106:2 122:5 128:2,6 132:10 138:19 146:5 166:12,21 167:8 168:24 169:12 252:6 253:3 258:24 259:13 264:9 265:18 286:5
sorts 65:24
sought 130:14 290:10
sound 90:5 191:9,11 216:12 275:16
sounds 39:21 157:24 170:10 293:25
source 97:22 98:9 99:11 101:10 103:2 104:16,20 115:23 215:1
sources 105:13 123:11 233:11
South 285:2
spaces 6:21
spacing 22:24
span 115:8
spark 185:25
speak 45:11,12 73:21 215:7,11, 14 258:9 260:14 267:10 271:7,13
speaker 3:10
speaking 3:14 6:12 37:18,19 59:15,22 63:7 102:11 109:24 122:21 218:10, 20 260:4,9
speaks 122:22
specialize 91:23,24
specialized 91:5,8

species 183:12 252:23 254:19 255:16 257:5

specific 45:10 93:20,21 106:18 114:7 180:16,21 186:22 187:25 189:22 214:14 215:6,17,21 216:19 219:6 225:4,7 229:24 230:4 237:6 240:18 271:3,5 290:4 292:1

specifically 24:1 33:15 44:16 61:7 67:19 77:13 97:16 144:16 177:16 182:20 190:14,17 201:14 213:19 230:16,18 235:22 237:13 273:4 293:20

spectrum 23:1 283:9

speculate 267:17

speculation 257:21

Spell 17:6,7

spelled 263:2

spend 85:14 114:9

spends 192:19

sperm 185:18

spilling 28:14

spina 184:18

spine 188:17

spiral 128:6

spoke 195:7 270:22 271:10

spontaneous 189:15 200:14, 16

sponte 12:18

spouse 102:18 167:5

spread 28:2 114:19 130:22

spring 244:10

sprint 10:12

square 283:24

St 244:14

stabilize 211:11

stable 203:25 284:18

stack 230:11

staff 281:25 284:3,8,9 290:15,21 293:8 295:13

stage 253:2

stages 183:14 186:23 187:5 250:4,7,9 253:20 255:17 286:11

stand 16:22 86:3 172:15,19

standard 13:17,18 185:8 197:4 256:8

standards 225:19,20 276:8 277:16

standing 9:6,8 47:25 253:6,19, 21 256:10 260:3 261:13 263:22 264:25 265:21 278:14 280:12

standpoint 102:12

stands 56:4 133:17,22 281:20

stare 277:18

stark 106:3

start 37:19 58:21 81:13 82:1 107:12 113:6 115:1 150:21 183:7 192:15 194:23 269:21 289:24 293:15,22

started 188:25 191:18 212:11 223:3 284:13

starting 89:22 111:1 116:12 118:11,12 126:19 130:16 177:11 209:15 224:24 225:9

starts 82:8 111:2 128:3 190:2,3 202:11 232:1

state 7:9 13:14 40:11 46:17 47:8,21 82:18 96:22,24 107:2, 3,7 121:1 124:17 126:5,8, 20 127:3,4,11 128:13 129:17 134:13 146:11 147:19 149:16 157:10 158:1 159:3 160:20, 21,25 161:1,14 162:22 163:2 176:7 197:5,8, 11,16 247:21 257:12 259:9, 20

state's 249:20 252:11

stated 168:12 169:19 271:23

statement 21:25 58:20 77:25 138:21 144:18 219:19 220:1,2 253:17 278:10

statements 15:18 262:15 264:23 281:19

states 36:4,20 39:4 82:15,16, 17,18 91:21 97:16 102:10 108:10 114:9 128:21 129:20, 25 149:19 150:2,22 154:1, 8 161:5 169:2, 6,9,13,15,25 170:2,6,7,19,21 171:2 197:24 198:10 216:4,6 239:7 247:8,11 251:19

states' 170:7

stating 265:7

statistic 53:13 57:1 59:24 69:14 168:19 199:22 201:22 231:23 232:17, 19 266:13

statistical 69:16 160:4 207:18 229:17 230:24

statistically 204:9

statistics 53:10 71:23 79:23 80:14,23 99:20 102:9 103:13 105:1 123:23 124:24 146:9 155:14 197:18 198:9, 13,14,17 199:1, 6,7,20 204:23 216:16,19 217:10 233:3,5 266:3

status 78:2,6 173:20 179:2 211:12 220:12 249:18,19 252:24,25 255:24 256:2 261:15 265:9

statute 51:8,11 224:14,19,20 225:1 226:21 235:23 239:1 255:14 257:3 265:25 287:13, 16

statutes 76:15 77:3 214:2 222:6 254:24 257:16 285:15

stay 16:16 17:23 90:10 175:19

stays 26:13 238:19

steady 190:20

steering 247:12

step 83:7 85:20 171:19

stepped 85:4

stepping 32:7

steps 183:23 209:4 210:20 242:1 290:13

sterilization 269:5,12

steroid 25:8

Steve 212:16

Steven 291:1

Sticking 262:8

stipulate 8:22 9:1,13

stipulation 11:6 173:12 289:12

stipulations 10:25

stop 40:23 41:1 260:9

stops 63:22 64:9

story 277:5

straight 138:19
strain 102:6,7 112:15
Strasbourg 247:13
straws 162:11
stream 62:4
Street 246:10, 15
stricken 86:22
strive 74:24 251:6
stroke 27:14 28:16 179:6 197:14 202:25 204:6,7,10 239:10,13
strong 142:4
stronger 256:7
struck 280:19
structural 34:11 72:25 73:8 74:8,12
structure 61:14
struggle 100:3
Stuart 260:8
student 92:9 145:14 273:10 281:10
students 19:22 117:4 178:8,11 244:5,6,7,9 251:7
studied 97:17 110:11 120:22 212:22 244:21
studies 39:7,9 92:2 107:15 109:8 110:6 112:17,21 122:25 132:11, 12 134:5 180:15 194:3,5, 11,12 214:4 218:25 230:9 233:7,9
study 35:22,23 57:21 98:9 99:2 100:8,11 101:12,23 108:24 114:15 118:17 120:7,9, 19,24 124:13 134:3 137:9,16, 17 139:9,13,17, 19 140:18 145:18,22 146:4,17 178:22 179:10 180:5 193:24, 25 194:1,3,18 200:18 205:10, 14,17 212:17 219:6 229:9,11, 15,18,22,25 230:4,10,19,21, 23 231:5,7,14, 17 232:8,21,24, 25
study's 140:24
studying 121:16 122:3 180:7 194:20
sua 12:18
sub-personal 265:9
Sub-saharan 177:19 202:14
subclinical 208:5
subject 69:17 282:13 284:14
subjected 180:8
submission 295:17
submit 52:21 80:4 81:2 154:20 211:24 292:25
submitted 11:17 13:20,25 91:6 149:19 150:1,10,21 163:10 276:20
subordinate 265:10
subsection 140:5 255:11
subsequent 29:1 32:21 36:21 111:14
subsequently 19:3 89:23 169:17 176:23
substance 25:22 225:4
substantial 104:4 113:20, 22,25 121:2 124:4 136:24 147:20 148:2, 11 160:7 227:16 228:2 235:24,25 238:12,14 239:4
substantially 69:12 105:2 121:4 122:1 148:25 236:21
suburbs 19:2
succeeding 285:12
success 116:21
successful 116:24 285:1,3
successfully 55:20
successive 277:6
suction 54:20, 23 81:17
suffer 40:17 49:24 253:23
suffering 266:22
sufficient 94:4 261:2 264:3
sufficiently 98:18 112:8
sugar 208:19
suggest 11:10 138:24 143:5 153:17 293:19, 20
suggested 140:11 149:11 168:2 288:15 293:19
suggesting 65:11 69:16
suggests 71:18 117:15 158:17 159:6 253:5 268:14, 19
suicidal 33:21
suits 83:20
summarize 18:9,23 34:20 74:5
summarized 259:14
summarizing 22:5
summary 257:7
summer 136:5
supervised 228:22
supervising 19:21
supplement 171:21
supply 62:25
support 37:25 45:20,22 85:10 112:6 119:10 124:16 125:19 142:6 146:24 154:5 220:21 222:11 240:25 257:18 279:7 292:1
supported 269:18
supporting 169:18
supports 111:20 112:14 122:17
suppose 252:11 278:11
supremacy 269:17
Supreme 41:5 149:19 150:2, 22 151:16 154:2,9 155:7 156:13 160:11 161:5 169:22, 23 258:23
surface 61:17
surfactant 211:15
surgeries 185:4 210:21, 25
surgery 37:5 184:13,18 185:7
Surgical 3:4 9:4 19:13
surprise 113:15
surprised 292:8
surprising 11:20
surrounding 31:3 101:18 120:23 129:20, 25 166:19
survey 118:13, 14 123:23 140:2 199:3 212:17
surveys 117:25 139:19 194:15 195:1

survive 222:21 223:20
suspected 293:13
sustaining 31:21
swear 17:2 88:17 175:9,13 243:5,7
switch 81:23
sworn 21:24 87:14 173:9 289:9
synapses 188:17
Syndrome 184:24
syphilis 269:11
system 6:1 34:12 61:15 62:8,11,14,17, 25 70:25 73:9 187:12,17,19 188:15,25 189:1 228:3
systematically 269:5
systemic 269:8
systems 24:23 187:12,16

T

tab 94:10 107:19 115:14 118:6 120:10 123:3,4,5 128:16 137:10, 13 140:18 141:10
table 13:9 36:20 83:8 154:14
Tahada 14:25
Takakjian 4:2, 3 89:5,7 90:15 92:25 93:6 94:21 95:1,6,19 96:1,4,10 108:23 109:5 116:2,9 121:7, 14 123:13,19 129:7,14 132:21 134:11 143:15 151:8, 19,24 152:4 153:11,15,19 158:5 161:19 171:15 172:12, 18,21 174:21 289:6 292:12 294:22 295:19 296:5,22
takes 86:3 226:16 227:10 279:10 291:13
taking 7:19 66:13 98:14 177:8 208:25 209:17 264:16 274:16 278:25 280:14
talk 26:17 28:9 30:15 39:15 79:15 97:14 106:17 109:8 114:21 117:19 120:9 125:24 128:14 130:4 139:18,20 140:9 162:20, 23 169:11 172:5,7 185:14 186:7 187:4 190:14 193:22 195:4,6 199:12 201:14 207:8 219:1 223:23 228:8 237:7 245:19 246:4 249:5 277:18 288:15,19 289:1,14 290:11,12 291:25
talked 75:5 82:4 109:25 120:7 132:1 137:9 166:23 171:24 210:20 231:16 240:20 278:12 280:25 281:1 289:21
talking 13:9 50:6 80:24 102:9 112:16 125:18,22 127:10 128:12 130:19 131:8 137:17 170:15 176:1 179:7 183:7 188:25 192:19 199:15 201:12 204:12 216:5 218:9,24 220:25 224:3, 16,17,21,24 225:19,21 233:14 236:11, 12,18 246:18 251:3 253:2 267:12 269:22 281:15,16 286:8 289:24
talks 161:21
tangent 204:1
task 93:20 113:11
taught 40:16 178:1,3,7,10 244:8
tax 111:10
teach 90:19,20 135:21 136:5 147:5 244:3,5, 6,7,8 272:4 284:19
teaches 117:3
teaching 19:21 92:9 244:25 281:10
team 118:14
teams 122:5,8
tears 31:21
tech 182:1
technical 180:3 192:6,21
technique 180:24
techniques 180:16
technology 36:15 241:13
Teen 117:1
teens 146:25
telephone 6:1
telling 138:17 147:23
tells 105:23 264:18
temporary 12:4,8,10,15 13:15,22 21:25 174:12,24 293:1
temporize 209:18
ten 29:16,17 63:5 81:21 158:4 160:19, 24 188:12,19 191:6 192:16 193:1,3 246:9, 11 288:21 294:3
tend 204:25 283:1
tender 22:16 93:1 182:19,23 251:13 291:23
tendered 251:16,18 267:8
Tennessee 248:2
tens 179:15 218:13
tenure 89:24
teratogenic 38:7 183:25 184:1
term 23:9,16 38:16 51:12 63:10 110:22 185:13,14 193:12 200:9 201:3 221:23 224:13 237:22 239:17,20
terminate 222:4 233:19 234:1,4,6,14,20 236:24 268:23
terminated 239:8
terminating 78:6
termination 189:16 210:6 222:16,17 223:24 225:5,8 235:2
terminations 210:11
terminology 186:11 210:3, 12 222:13 226:15
terms 7:25 22:2 34:2,4 39:19 47:24 50:22 63:23 65:3 66:13,22 78:9 81:22 109:24 115:2 125:2,13 127:19 128:25 142:1 144:16 147:12 158:22 163:5 180:22 187:1,2 188:6 216:10 218:14 227:14 228:2 233:15 241:4 262:20 265:3 283:18 288:13
terrible 202:21
terribly 11:20
test 131:15
testified 49:21 50:25 52:2 55:9 56:2 64:7 72:2, 5 77:21 137:3

139:1,8 231:3, 20 247:19 259:4 270:11 274:9 277:24 278:19 279:18, 20 280:4 282:4 287:11

testify 9:17 52:9 59:5 135:25 213:20 215:12 250:22 270:18,19

testifying 47:5 79:4 273:1,20 280:11 286:2

testimony 13:18 17:2 22:2 32:23 46:23 49:13 54:13 56:3 66:3 72:4 77:20,22 79:7 84:11 86:6,9 87:14 88:17 95:5 96:3 133:17,22 135:7,8,12 136:7,12 139:2 173:6 175:13 181:23 182:10 195:7 213:21 215:8,14 243:7 247:14 252:6 253:12 260:18, 22 262:9,12 264:8,16 266:2, 5,10,11,17 267:9,12,17,20 270:25 271:8, 11,14,15,18 274:22 279:25 280:1 289:8

Texas 89:13,24 90:1,17 91:14 120:25 121:17 122:14 147:5, 11 160:16 247:21

Texas's 276:1

Thacker 4:13 242:7,20,21 243:17 248:5, 23 249:4 251:12,24 255:3,8 257:25 258:6,10,13 267:18 269:25 287:3,5,9,21

That'd 180:17

that'll 10:21 296:2

themes 219:4

theory 256:20, 21 257:14 268:17

therapy 33:18

thing 10:24 16:17 51:14 68:24 138:19 142:11,14,17, 18 149:8 166:13 167:8 172:13 186:18 207:19 209:22 210:15,21 211:23 221:15, 17 263:16 265:19 272:1 293:17

things 12:17 13:13 25:20,22 29:9 33:13 38:9 62:14 65:24 72:17 79:12 80:2 87:22 102:5 113:20 128:6 132:1 143:4 163:14 166:5 171:4 191:2 203:3 204:3 206:14 208:20 210:17 212:8 214:1 215:4 250:2 251:18 261:10 263:3,12,25 266:15 269:19 281:8 285:4

thinking 117:1 202:6 291:23 293:15

thinly 114:19 130:22

thinners 27:8

thought 12:24 13:3 65:10 76:12 77:12 138:3 171:7 221:10 294:10

thoughtful 294:9

thoughtfully 292:3 294:2

thoughts 288:19

thousands 179:16 193:7 218:13

thread 283:10

threaten 262:19

threatening 206:21

threshold 110:15,17

thresholds 193:17

thrive 33:25

thromboembolism 202:25

thrombosis 27:7

ticked 233:2

til 172:5

time 8:7 10:22 22:15 23:19 27:21 29:10,18 31:15 32:3,6,8 34:21,24 35:3 46:2,4 61:2 77:21 85:2,14 90:5 94:21 107:11 108:23 109:22 111:12 116:2 119:4 121:7 123:13 127:7 129:7 130:15 132:24 135:24,25 136:2,3 141:13 148:6 167:22 175:1 177:12 182:19 189:24 190:2 192:19 193:9 194:13 197:17 199:17, 18 201:3 214:21 237:10 238:24 251:12 270:2 294:1,25 295:3 296:15

timeline 186:9

times 7:5 34:7 92:8 102:5 105:6 148:17 168:12 169:19 184:8 201:1,19, 21 204:15,20, 22 211:13,17 246:11 247:20 266:8

timing 10:22

tiny 268:5 288:12

tissue 29:22 49:6 50:13,14 51:12 192:7,9, 11

tissues 30:11 32:13,16

title 101:13 233:8

titled 115:17 120:13 275:25

today 3:25 4:5 5:2 6:3,19 7:18 8:4,8 10:13 13:3,19,25 14:2 42:5 44:23 45:11 47:6 49:13 60:23,24 63:4 66:3 77:22 79:5,8 86:9 126:24 130:3,5 132:2 133:22 135:4,9 136:3,8 137:4 146:4 148:8 149:10 152:19,21 155:12 162:4 164:9 171:23 181:23 182:15 213:13,20 215:9,12 236:19 250:21 252:20 262:16 270:25 271:14, 18 273:1,24 274:4,15,22 281:15,16 282:18 288:11 289:9 290:2 291:8 292:3 296:12

today's 11:12 12:5,11 133:6 214:5 254:23 271:8 294:12

told 110:9 130:6 160:11, 17 161:5 174:7 289:4,16

tolerate 24:17

Tom 5:5

tomorrow 9:15 10:13,14 288:14 291:12 292:24 295:14, 15

tonsillectomies 37:6

tool 269:16

top 53:14 173:8 293:10

topic 93:19

topics 145:11 166:16 247:16

torts 244:6

tortured 269:4 276:7 277:6

total 56:19

totality 113:12 164:22

totally 197:16

touch 272:17 293:14

touched 252:1

town 42:25

tracks 147:18
tradition 219:18 260:5 272:9 280:13 281:21
traditional 208:17
Traditionally 260:3
tragedy 196:6, 7
tragic 249:11
train 20:5,6,7 44:4
trained 20:10 55:11 57:16 81:24 239:14
training 20:14 43:22,23 44:1 176:13 273:25
trajectory 147:25
transabdominal 192:1,6
transfusion 24:13 30:6
transit 186:13
transition 195:5
transparent 185:19
transportation 121:21 122:23 124:2,6 125:23 127:5 203:24
transvaginal 191:25 192:2
trauma 196:25
travel 96:21,24 107:5,7,9 121:3,21,25 122:23 123:1 124:17 125:23 126:4,6,8,10,20 127:3,7,11 128:1,13,14 129:17 130:2 135:24
traveling 107:3 163:1
treat 27:8 184:19 208:11 210:22,23 212:7
treatable 196:10
treated 33:17 65:12 109:17 185:6
treating 184:6
treatment 109:20,21,25 110:1,3,16 184:14 189:22
treatments 143:8 184:23
tremendous 200:10
trends 139:24 179:17
trial 109:18 247:19 248:1,2 280:4 291:11 295:23 296:24
trials 270:11
tricky 166:3,5 171:1
trigger 41:3,5 44:22 46:10 49:16,17 158:3, 17 161:7,8 162:3 224:1,6, 18,20 225:1 226:18 254:25 286:14
trimester 48:18 81:11,12, 16,17 199:25 200:25 205:1 277:13
true 105:25 144:12 157:16 202:14,22 217:10,11 263:7,9 274:17
truism 262:17
trust 54:9 117:3
truth 17:3 88:18 175:14 243:8
tube 184:5 186:14,16,21 187:23 188:5
tummy 191:8
turn 34:15 35:9 38:24 41:7 53:16,22 90:8 120:10 123:20 124:21,22 128:16 170:11 175:8 230:10 243:4 262:3 291:13
Turnaway 41:9 108:4 118:16 119:1 120:7 139:19,24 193:25 194:3 229:9 230:9 231:5,13
turned 41:17 118:18 140:10
Turner 5:15
turning 94:10 107:18 123:3
Tuskegee 269:6
twinkle 191:17 192:5
two-thirds 110:23 130:6
type 11:6 15:18 85:16 100:4 110:3 164:16 210:21
types 6:17 128:3 147:11 180:9 184:19 185:7 187:15 208:19 238:16 284:5
typical 138:6
typically 15:17 48:18 61:24 67:3,10 98:10 100:1 102:6 104:19 109:9 115:24 159:19 167:8 186:10, 12 191:25 201:21 208:12 230:22

U

UC 89:16,17
ugly 269:19,20
uh-huh 53:18 83:11 176:3 177:24 186:20 187:3,7 211:9 216:13,17 220:14 242:4 248:6 255:7,12 274:13 275:4, 12 280:3 281:4 285:17,25 287:14 288:5
ULP 75:7
ultimate 174:1 175:2
ultimately 79:15 110:21 233:19 235:8 252:25 280:19 289:13
ultrasound 50:1 67:2,4,8, 11,16 68:3,5,7, 18,25 69:1 191:13,17,25 192:1,2,6
umbilical 61:16
umbrella 75:12
un-obscured 17:14
unable 33:22 37:23 38:3 111:21 113:4 140:22 151:2
unacceptable 40:6
unborn 62:13 64:16 65:1 66:4,18 183:10, 14 190:8 191:24 225:5,8 249:19 250:3, 14,16 252:8,22, 24 253:1 255:15,18,24 256:2,4,10 257:10,18 263:23 264:22, 24,25 265:8,10, 14,21,24 278:1, 9,15 279:11,21 281:7 283:12, 15
unclear 47:10
uncomfortable 269:1
uncommon 196:9
uncontrollable 228:11
under-reported 197:25 198:19
under-reporting 196:13 197:24
undergo 176:14 206:24 210:25
undergoing 185:7 191:16
undergraduate 90:21 244:9
undergraduates 244:8
underlying 24:19 25:4 69:16 202:8
underneath 290:17

underserved 177:16

understand 9:6 15:10 33:8 39:17,20 43:11 48:8,24 51:23 52:16 86:17 97:8,10 133:9 134:3 136:20 153:2 159:23 160:9 162:18 164:8 180:10 190:1 200:4 203:4 219:21 225:16 226:5 231:3 235:4 241:11 246:12 251:10 265:4 290:5 293:2

understandable 279:2

understanding 8:17 10:2 12:8 41:2,18 71:12 77:2 134:19 154:21 161:10, 13 167:6,9,17 199:4 211:3 223:25 224:2 226:13 252:3,5 272:17 274:3 283:20

understands 60:11

understood 43:16 262:14

undertaken 260:10

undiagnosed 202:17

undue 277:14

unemployed 102:1,2 116:21

unequal 34:13

UNESCO 246:25 247:6

unethical 264:1

unfolds 254:21

uniformly 198:9

unintended 240:22,24

unique 62:21 189:9 291:11

United 36:3,20 39:4 91:21 97:16 102:10 108:9 114:9 128:21 149:19 150:1,22 154:1, 8 161:5 220:6 246:21,25 247:11

unites 76:2

universal 246:24

universities 147:14

university 18:14,15,19 19:7 43:7,8,12, 17 44:2,8 45:24 46:3,4 65:6 71:3 73:15 75:5,6,7,9,14 85:11 89:22 147:6 176:21, 22,24 178:7,16, 23 212:17 243:23 244:4, 21 245:10,15, 25 272:21 281:17

unjust 253:5

unknown 11:2

unmarried 105:19,21,23 106:7,10,12,15

unnecessarily 38:12,20,21 40:17 82:5

unpersuasive 250:15

unplanned 249:14,16 261:6,7 262:21, 22

unreliable 216:19

unstable 277:17

untreated 109:22

unwanted 261:6,7 262:23 263:14 269:22

up-to-date 98:4

update 248:18

upward 25:1

urine 28:15

uterine 30:5 31:14 61:17

utero 185:4 249:20

uterus 24:24 26:23 27:24 28:6 31:15,24 67:21 69:8 186:22 192:3

utilization 123:2

V

vagina 27:25

vaginal 31:25 32:4 35:1

vaginally 31:19

vague 40:12

validity 264:14

valuable 250:17

values 249:12

valves 188:11 191:3,11

vanished 170:8

variables 179:20

varies 197:13 201:20

variety 19:23 218:16 233:11

vary 59:17 192:9,11 197:11 202:19

vascular 25:21 203:2 238:16

vast 39:6 40:3

vaxxed 7:4

vein 27:6

vena 26:23 27:2

venous 202:24

venture 44:9

verified 9:3 13:19,23 173:8 289:9

version 248:13

versus 3:5 22:2 31:25 40:24 41:8 42:15 57:9 92:24 149:20 153:25 159:12, 14 169:2,22 170:5,20 171:2 180:12 200:8 253:14 278:7 282:19 286:10

vessel 26:24

vessels 188:10

viability 222:24 223:1,2, 3,5,12,13,20 225:10,20,21

viable 209:25 222:20

Vic 295:10

vice 14:1,16 15:1,3

vices 14:6

victimization 118:4

Victor 4:8 42:3 133:5

video 17:13,14

view 63:23,24, 25 64:2 66:18 78:1 136:22 147:8 149:8 236:25 250:2, 15 256:4,16 257:9,13 278:24 279:10 283:23

views 182:14 250:22 251:2,8

vigorously 87:5

violated 279:4

violation 226:12

violence 38:5 117:23 118:22 166:8,13,22 252:17 277:2

violet 156:21

virtually 146:11 147:19

visit 285:6

visits 284:21

visualize 185:1

Vita 281:23,24 282:6,11,21 283:1 284:2,11, 12,20

vitae 144:2 145:7 181:9

Vital 79:23 80:14,23 216:16

vitally 293:5

vitamins 184:4

vitro 186:1

volume 23:25

voluntarily 166:1 167:5
voluntariness 266:21
voluntary 71:19 166:4
vulnerable 97:5

W

Wade 40:24 41:8 169:2,22 170:5,20 275:6 276:3,6 277:5, 21
wait 238:8,21 239:9,11
walk 95:11 103:18
walking 187:8
wall 17:16 28:6 31:15 246:10, 15
Wallace 269:17
wander 296:20
wanted 8:19 13:14 15:8 34:17 85:7,18 155:13 159:21 237:21 249:7
wanting 64:21
warrants 264:9
Wary 107:24
Washington 18:14 198:12 248:16 275:14, 15,19,25
waste 61:20 62:4
watch 175:8, 22,23
watching 17:16,24 40:17 90:9
water 27:19,20, 23 28:1 178:18 242:24
watery 24:1,4
wave 190:11
ways 138:24 184:20 207:17 218:17 272:8
weakening 32:10
weaker 194:16
wear 7:10,13 88:22
wearing 6:25
website 103:6
week 3:6 4:25 12:23 14:25 59:3 63:10,20 78:22,25 81:22 199:25 200:21 213:17 270:17 275:19
week-long 282:11
weekend 13:1 14:1 85:13 293:3,12 295:10
weeks 23:18 38:23 39:11 48:21 58:6,8,24 59:6,11,20 60:8,14,17,20, 22 61:2 63:5 64:8 66:17 67:9,19,20,25 78:5 81:13,21 82:1 186:8 187:18,22,23 188:3,5,11,12, 15,16,18,19,21, 22 190:3,12 191:6 192:4,16 193:1,3 200:7, 24 201:4,10 208:14,16 211:5,6 223:3,4 231:22 232:18 235:16,18,19 248:17 292:13, 21 293:14
weeks' 39:10
weigh 132:14
weight 22:1
welfare 116:21 166:13
well-described 229:18
wellbeing 49:23 117:8,16 118:15 262:19 263:16
Wesley 4:21
west 202:13
western 157:7 158:1 160:20 260:5
white 34:4,8 72:24 178:25 201:20 202:23 203:16 204:6,7, 10,11,16 245:12 269:16
who'd 179:14
whoever's 17:24
whoosh-whoosh-whoosh 191:8
widely 69:14 194:9
willful 219:22
Williamson 4:24
windows 207:15
Wine 5:5
wishing 288:11
withdraw 74:1 155:15
witness' 253:12
witness's 267:6
witnesses 3:16,25 4:5,10, 17 7:12 8:1,8, 19 9:20,25 15:10,11,23 17:16 90:8 152:16 260:17 267:16
woman 39:14 61:24 64:25 70:9,14 77:18 98:16 147:22 165:14 186:10 189:14,19,21 192:11 196:19 198:1,24 199:16 206:10, 18,20,24 207:9, 13 208:4 210:23 211:5 218:17 225:3,7 226:19 227:19 234:13 235:3 249:14 253:9 261:1,5 279:3
woman's 76:25 189:6 190:9 193:4 265:11
womb 67:21 223:7,21 224:12 225:22
women 34:7 72:5,6,21 74:7 82:13 98:20,23 99:15,20 111:4, 15 118:15,18, 23 119:1 139:21 140:15 141:12 148:14 149:5,6 151:1 166:11,24 167:3,21,22 177:17 179:1,2, 6,14,16,17 183:24 184:3 192:13,18 193:7,8 195:3 198:20,21 201:18,19,20, 24,25 202:4,5, 9,11,20,23 203:16 204:4,7, 10,11,14,20,24 207:3,23 208:7 209:11,13 218:9,10,13,14, 22 219:2 228:17,20 234:17 241:3,6 262:20 266:3,7 267:21 268:21, 24 269:12 275:22 281:11
women's 3:4 9:4 19:10,13 112:4 149:20 154:1 182:21, 25 219:1 285:2
Wonderful 181:16
words 57:10 59:10 112:3 226:4,7 262:22, 24
work 18:17 35:7 42:12,24 44:3,4 45:13 55:21 83:13 92:7 95:14 96:14 97:18 98:11 107:15 114:22,24 115:10,24 118:18 126:3 127:7 128:9 129:3 145:4,23 146:1 177:13, 15,25 207:10 214:23 218:5 241:14 281:1,8 283:3 285:5 293:11,21 295:9
worked 18:12 19:1 146:8
working 93:16 108:19 123:11 128:17 129:4 138:7,10,12 144:13 145:5, 11,12 179:19 183:24 208:12 289:12 293:3,

16
works 56:17 136:20 282:9
workshopped 95:15
world 136:20 168:11 202:16 254:2 257:14 283:8
worries 268:25 269:23
worry 40:18 266:19 267:2 274:20
worse 118:19, 25 238:20
worsen 25:8 26:11
worsened 26:13
worsening 25:6 26:5 238:7
worth 265:8 280:17
worthy 257:6 265:15
wrap 132:1
writ 215:24
write 272:4,13 276:16
writing 180:1,2 276:13 287:22 295:4
writs 13:1
written 173:25 178:19 179:24 211:24 229:5 275:18
wrong 169:8 179:9 193:19 263:19
wrote 160:6 194:11 269:7 275:24
Wubbenhorst 175:4 176:6,8 181:5,23 182:11 183:6 213:9 271:13 282:5,16

Y

Yale 176:22
year 56:14,22 70:15 101:20 111:13 114:10 144:10 150:16, 25 151:3 178:4, 10,11 194:10 229:19 266:19 284:23
years 18:12,18 19:2 52:23 89:24 90:18 98:21 99:7,8 103:12 111:14 118:10 119:5 147:22 149:1 170:22 178:3 184:15,16 195:2 197:20 200:20 203:22 221:17 230:1 239:6 284:15
yesterday 8:25
yield 121:18
York 169:7 246:11
younger 99:7 201:23,24
youth 91:25

Z

Zane's 232:21
zinc 185:25
zone 185:18
zygote 75:22 76:3,8 186:2,3, 18 187:13