APPENDIX A

Affidavit of Dr. Priscilla K. Coleman

STATE OF OHIO	§	KNOW ALL MEN BY
	§	
COUNTY OF WOOD	§	THESE PRESENTS

BEFORE ME, the undersigned authority on this day personally appeared Dr. Priscilla K. Coleman, Ph.D. who is personally known to me, and after being by me first duly sworn according to law on her oath did depose and say that:

I. Introduction and Professional Background

1. "My name is Dr. Priscilla K. Coleman. I am over the age of eighteen (18) years of age and I am fully competent to make this Affidavit. I reside in Wood County, Ohio. I have personal knowledge of the facts stated herein and the following is true and correct.

2. I am providing opinions on the National Academy of Sciences' (NAS) 2018 report titled, "The Safety and Quality of Abortion Care in the United States" for *June Medical Services LLC v. Gee*. In this Affidavit, the following topics are addressed: 1) history of the NAS, focusing on allegations of bias and conflicts of interest; 2) bias and conflicts of interest specific to the report on abortion; 3) an overview of the abortion and mental health literature in the NAS report; and 4) scientific evidence indicating abortion increases risk for mental health declines.

3. I am a developmental psychologist and a Professor of Human Development and Family Studies (HDFS) at Bowling Green State University (BGSU) in Ohio. I have been a full-time employee at BGSU for 17 years. I received promotion to Associate Professor with tenure in 2005 and promotion to Professor in 2010. I am responsible for teaching the following undergraduate courses: Adolescent Development, Child Development, Life-Span Development, Parenting Processes, and Research Methods. I also advise approximately 50-100 students enrolled in the HDFS major each year, and I serve on various committees at the program, school, college, and university levels at BGSU. I have a B.A. in Psychology, an M.A. in General Psychology, and a Ph.D. in Life-Span Developmental Psychology.

4. I have published over 55 peer-reviewed scientific articles, with the majority related to the psychology of abortion (reproductive decision-making, psychological outcomes associated with abortion, and risk factors that increase the probability of women experiencing post-abortion mental health declines.) Based on my expertise, I often serve as a content expert in state and civil cases involving abortion. I have given presentations in parliament houses in Great Britain, Northern Ireland, New South Wales, and Queensland, and I have testified before state legislative bodies and before a U.S. Congressional committee.

5. Trained as a developmental research psychologist, I have the requisite skills to evaluate the methodological strengths and weaknesses of studies across various disciplines, and it is for this area of expertise, in

addition to my extensive content research on the psychology of abortion, that I have served as an expert witness. I have extensive professional experiences relevant to my expertise as a methodologist. Among the most significant are doctoral level methodology training, extensive editorial board experience (currently 5 international psychology and medicine journals), two decades as a reviewer for dozens of journals, reviewer for the American Psychological Association Task Force Report on Abortion and Mental Health, published in 2008, and teaching undergraduate and graduate research methods courses dating back to 1993.

6. I hold the opinions expressed in this Affidavit to be true to a reasonable degree of scientific and medical certainty. My education, professional experience, research, and extensive and ongoing review of the abortion literature have formed the basis of my opinions. The references to peer-reviewed publications provided in this report have been formative in shaping my opinions, as have other publications too numerous to mention in my ongoing review of the scientific literature.

7. The NAS is a private, non-profit society comprised of scholars founded 155 years ago during the Civil War. A great deal of policy-oriented work is conducted through the NAS, with thousands of experts providing volunteer service on hundreds of committees convened to examine pressing social issues. The reports generated have often formed the basis of public policy.

8. In March of 2018, the NAS Committee report on the quality and safety of abortion was released and within months the over 200-page document had quickly made its way into the reports of experts hired to assist with challenges of various state-level restrictions on abortion services throughout the U.S. As indicated on page S-12 of the report, "The committee concludes that legal abortions are safe and effective. Safety and quality are optimized when the abortion is performed as early in pregnancy as possible. Quality requires that care be respectful of individual patient preferences, needs, and values so that patient values guide all clinical decisions. The committee did not identify gaps in research that raise concerns about these conclusions . . . "

9. A careful examination of the report reveals large segments of the peer-reviewed literature are ignored, notably studies revealing heightened physical and mental health risks associated with abortion. Further, the NAS Committee generally failed to provide clear information regarding the standards employed to select and evaluate individual studies in formulating general conclusions.

III. The History of the NAS, Conflicts of Interest, and Allegations of Bias

10. The bill for the incorporation of the NAS was signed by President Lincoln, with service to the nation identified as its primary purpose. Throughout the years, the NAS has provided scientific and technological

information from members elected by their peers for distinguished achievement in their respective fields.

11. The NAS' guidebook to best practices titled "On Being a Scientist," admonishes that "even the appearance of a financial conflict of interest can seriously harm a researcher's reputation as well as public perceptions of science." Ethical handling of potential conflicts of interest as explicated in the NAS guidebook is as follows: "In some cases, the conflict cannot be allowed, and other ways must be found to carry out the research. Other financial conflicts of interest are managed through a formal review process in which potential conflicts are identified, disclosed, and discussed." More generally, in the online overview of the guidebook the societal implications of scientific integrity are described, "The scientific research enterprise is built on a foundation of trust. Scientists trust that the results reported by others are valid. Society trusts that the results of research reflect an honest attempt by scientists to describe the world accurately and without bias. But this trust will endure only if the scientific community devotes itself to exemplifying and transmitting the values associated with ethical scientific conduct."

12. Despite articulating the dangers inherent to science when conflicts of interest are present, the work of the NAS has raised questions of conflict of interest for decades, largely due to continued recruitment of scientists with financial interests in the field studied by committees on which they serve. The Center for Science in the Public Interest (CSPI) conducted one of the

most comprehensive analyses of conflict of interest within the NAS.

13. CSPI is a consumer advocacy organization launched nearly 50 years ago to conduct innovative research and advocacy programs in health and nutrition, and to provide consumers with current scientific information about health and well-being. CSPI represents the citizens' interests before regulatory, judicial, and legislative bodies on food, alcohol, health, environmental, and other issues to ensure science and technology are applied to the public good and to encourage scientists to engage in public-interest activities.

14. The CSPI published a document in 2006 titled, "Are the National Academies Fair and Balanced?" The conclusions of the CSPI report revealed significant problems with the NAS process for formulating committees stating: "Unfortunately, we found serious deficiencies in the NAS's committee-selection process that could jeopardize the quality of future NAS reports. The NAS has allowed numerous scientists (and others) with blatant conflicts of interest to sit on committees. Compounding that problem, those conflicts of interest usually are not disclosed to the public."

15. Two years ago, similar allegations were raised against the National Academies of Science, Engineering, and Medicine (NASEM) in the highly respected journal, PLOS ONE by Krimsky and Schwab (2017). In the abstract of their article, these researchers reported: "This study examines whether there were any financial conflicts of interest (COIs) among the twenty

invited committee members who wrote the 2016 report on genetically engineered (GE) crops. Our results showed that six panel members had one or more reportable financial COIs, none of which were disclosed in the report. We also report on institutional COIs held by the NASEM related to the report."

16. Toward the end of the article they state, "It is notable that the committee members we identified as having financial COIs comprised all of the committee's expertise on key topics, including plant biotechnology, molecular biology, plant breeding, weed science and food science. Presumably, committee members were asked to author the sections of the report relevant to their expertise, meaning entire chapters may have been written by committee members with financial COIs" and "Just as the NASEM did not disclose any financial COIs among its committee members, it also did not disclose institutional COIs. At the time the NASEM was developing its 2016 GE crop report, it was receiving money from agricultural biotechnology companies that have a financial interest in the study. The organization's annual financial reports do not give exact figures but note that three leading agricultural biotechnology companies (Monsanto, Dupont and Dow) have given up to $5 million dollars each to the NASEM." The authors point out that their analysis, "showed that the omitted disclosures may not have met the standards established by The Academies' own guidelines or by contemporary standards of financial COI disclosure."

IV. Evidence of Bias and Conflicts of Interest in the NAS Report on the Safety of Abortion

17. Close examination of the 2018 NAS report titled "The Safety and Quality of Abortion Care in the United States" reveals blatant conflicts of interest in the tradition described above. Contracts between the NAS and several foundations with strong commitments to reproductive rights supported the undertaking and most of the committee members and reviewers of the document have ideological and/or financial ties to the abortion industry.

18. Moreover, as described in the NAS report, the impetus for a review of evidence on the safety of abortion did not originate with the NAS, but with the funding sources. The report stated: "In 2016, six private foundations came together to ask the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine to conduct a comprehensive review of the state of the science on the safety and quality of legal abortion services in the United States. The sponsors—The David and Lucile Packard Foundation, The Grove Foundation, The JPB Foundation, The Susan Thompson Buffett Foundation, Tara Health Foundation, and William and Flora Hewlett Foundation—asked that the review focus on the eight research questions listed in Box S-1. The Committee on Reproductive Health Services: Assessing the Safety and Quality of Abortion Care in the U.S. was appointed in December 2016 to conduct the study and prepare this report." (p S-1).

19. Each of the funding agencies, which together formed the driving force behind the NAS Committee report have provided significant financial support to abortion providers and/or donated large sums of money to pro-abortion/population control initiatives. Examples are provided below.

20. The Susan Thompson Buffett Foundation (STBF) is the largest financial supporter of pro-abortion activities and population control. In fact, STBF is described by Callahan (2017) as the largest non-governmental funder of reproductive health and family planning, including extensive investments in abortion and contraceptives, worldwide. The Media Research Center (2017) estimated that STBF gave over $1.2 billion to organizations that advocate for pro-abortion policy, perform abortions, or assisted with the development of medication abortion. The Center further reported that as of 2012, STBF had provided nearly $300 million to Planned Parenthood clinics and to its national headquarters, Planned Parenthood Federation of America.

21. Examination of tax records by the Center for Medical Progress revealed that the STBF was by far the largest donor to Planned Parenthood in America, contributing $230,915,706 to Planned Parenthood between 2010 and 2013. In an article for Inside Philanthropy, titled "Long Distance Funders: The Money Behind the Endless Abortion Battles" Marek noted that "The foundation named after Warren Buffett's late wife and bankrolled by Buffet family wealth is the most important player by far in the abortion space. STBF has given tens of millions of dollars to the

Planned Parenthood Federation of America, as well [as] state affiliates, since 2010. The foundation gave over $35 million in 2014 alone." Marek further noted that STBF is the single largest funder of the National Abortion Federation, the professional association of abortion providers. In 2014, it gave the group $23 million to support its national telephone hotline. STBF has supported an array of other pro-choice groups that engaged in policy fights over abortion restrictions, including NARAL and the National Women's Law Center.

22. According to an article by Martin (2016), Warren Buffett donated at least $88 million from 2001 to 2014 to the University of California-San Francisco, a medical research institution with a strong reproductive health infrastructure. Martin (2016) interviewed Tracy Weitz, former director of UCSF's Advancing New Standards in Reproductive Health project (ANSIRH), who commented: "there's been recognition in the philanthropic community that in order to make progress, either culturally or politically or in the service-delivery arena, there are research questions that we need to answer." Martin notes: "The ANSIRH program was established in 2002 as pmi of UCSF's Bixby Center for Global Reproductive Health and lists more than two dozen separate abortion-related initiatives on its website on everything from mandatory ultrasound-viewing laws to abortion in movies and TV to reproductive health access for women in the military. The funder and recipient have been closely intertwined; Weitz left UCSF to become the Buffett Foundation's director of US programs in 2014."

23. Martin further commented that for several years now, foundation-backed researchers have churned out studies aimed at debunking common justifications for abortion restrictions including "that clinics were teeming with incompetent and unscrupulous doctors; that injured, abandoned patients were flooding emergency rooms; that the psychological damage caused by grief and regret after abortions often persists for years and ruins women's lives." Not surprisingly the primary focus of the review of literature on abortion and mental health in the NAS Report involves many studies published using the same data set, the UCSF Turnaway Study.

24. Although examination of all the NAS report funding organizations is beyond the scope of this Affidavit, a second example, the David and Lucille Packard Foundation is provided. On their website, the Population and Reproductive Health Program is described as "committed to promoting reproductive health and rights, with a focus on high quality information and services." Examination of tax records by the Center for Medical Ethics revealed that the David and Lucile Packard Foundation gave $14.7 million to Planned Parenthood's "Population and Reproductive Health" between 2010 and 2013. In the article referenced above, Marek noted that the Packard Foundation gave over $7 million to Planned Parenthood since 2011, noting the Packard Foundation also backed the National Abortion Federation with donations of approximately $2.2 million in the past few years. Other recent recipients of Packard funds noted by Marek included

NARAL ($400,000 in the past few years) and The Center for Reproductive Rights (over $2 million since 2011).

25. Several NAS Committee members have associations with organizations that have supported unrestricted access to abortion, such as the Kaiser Family Foundation and the Reproductive Health Program at the Bill & Melinda Gates Foundation. Notably, none of the Committee members appear to have a research program specifically related to abortion safety. Many of the reviewers of the NAS report are directly involved in provision of abortion services or have connections to pro-choice organizations revealing significant conflicts of interest.

V. The NAS Committee Ignored a Vast Literature on Abortion and Mental Health

26. In the section of the NAS Committee report on the association between abortion and women's mental health, the authors ignored the majority of published scientific studies, focusing nearly exclusively on the seriously flawed Turnaway Study (Biggs, 2016) and two literature reviews produced by professional organizations.

A. The Turnaway Study

27. The Turnaway Study results suggested serious consequences to denial of a wanted abortion relative to women's health and wellbeing. Described below are the

most egregious methodological flaws of the study that render the results completely unreliable.

a) Only 37.5% of women invited to take part in the study actually participated, and across the study period 42% dropped out, rendering the final sample consisting of a mere 22% of those eligible for inclusion. The women whose voices are not included were likely those who had the most serious post-abortion psychological complications (Soderberg, Andersson, Janzon, & Sjoberg, 1998).

b) The authors failed to reveal the specific consent to participate rates for each group. Second trimester abortions have been established as potentially more traumatizing than first trimester procedures (Brewer, 1978; Coleman, Coyle, & Rue, 2010; Soderberg, Janzon, & Slosberg, 1998); therefore, it is likely that a significantly higher percentage of women in the first-trimester group, compared to those in the second trimester group, consented to participate. If the rates were comparable, they should have been provided, as failure to report critical information increases suspicion that the second trimester "near limit' group was in no way representative.

c) In the Turnaway Study, women who secured abortions near the gestational limits combined women for whom the legal cut off ranged from 10 to 27 weeks, ignoring the fact that women's reasons for choosing abortion and their emotional responses to the procedure differ greatly at varying points of pregnancy. Women aborting at such widely disparate gestational ages should therefore

not be combined, particularly when the information is available in the data.

d) The Turnaway Study authors did not provide sampling information. Specifically, they do not explain how the sites located in various cities were selected, nor do they explain the overall type of sampling plan.

e) All primary outcome measures are simplistic with two variables containing only six items. This is inexcusable given the many psychometrically sound multiple item surveys available in the professional literature. Further, there is no theoretical basis for the cut-score employed to determine clinically relevant cases of depression or anxiety.

f) The authors suggest that later abortions are healthier for women than childbirth when women seek abortions, obscuring the well-documented risks of late abortions to women's physical well-being in addition to the elevated psychological risks. For example, using national data, Bartlett and colleagues reported in 2004 that the relative risk of abortion-related mortality per 100,000 was 14.7 at 13 to 15 weeks of gestation, 29.5 at 16 to 20 weeks, and 76.6 at or after 21 weeks.

B. The APA and NCCMH Reports Relied Upon in the NAS Report

28. The NAS Committee briefly described previously published systematic reviews of the literature, citing the conclusions of the American Psychological Association (APA) Task Force on Mental Health and Abortion (TFMHA) and the U.K. National Collaborating Center

for Mental Health (NCCMH). The APA Task Force and the NCCMH Committee concluded that rates of mental health problems for women with an unwanted pregnancy were the same for abortion and birth. However, close examination of the protocols for selecting and analyzing individual studies utilized by researchers affiliated with these two professional organizations reveals substantial evidence of bias and inappropriate scientific methods.

29. The APA, which published their literature review in 2008, now has a nearly 50-year history of taking a political stance on abortion, advocating it as a civil right since 1969; therefore, basic precautions should have been followed to assure the work of the Task Force was done in an objective, scientifically defensible manner. The Task Force had no call for nominations and the final make-up of the Task Force was comprised of individuals who have been public advocates of the pro-choice view. Several additional problems with the conduct of the APA review are described below.

30. There was a claim that three literature reviews (Coleman et al., 2005; Coleman, 2006; Thorp, Hartmann & Shadigian, 2003) were incorporated into the APA report; however the conclusions of these reviews are entirely ignored, and no explanation is provided. For example, Thorp et al. (2003) concluded that induced abortion increased the risk for "mood disorders substantial enough to provoke attempts of self-harm"; this is not alluded to whatsoever in the APA Task Force report. The APA Task Force did cite the review by Bradshaw and Slade (2003); however the choice of

information to report was highly selective. For example, they noted: "The conclusions drawn from the recent longitudinal studies looking at long-term outcomes following abortion, as compared to childbirth, mirror those of earlier reviews (e.g., Adler et al., 1992; Wilmoth et al., 1992), with women who have abortions doing no worse psychologically than women who give birth to wanted or unwanted children." The Task Force ignored a central statement from the abstract of the Bradshaw and Slade review pertaining to more immediate mental health implications of abortion: "up to around 30% of women are still experiencing emotional problem after a month." Also ignored from the Bradshaw and Slade article is the following statement: "The proportion of women with high levels of anxiety in the month following abortion ranged from 19-27%, with 3-9% reporting high levels of depression. The better quality studies suggested that 8-32% of women were experiencing high levels of distress."

31. The APA Task Force did not perform a meta-analysis; therefore, the strength of abortion-mental health associations across studies was not quantified in the 2008 report. In the report, the authors noted: "Given the state of the literature, a simple calculation of effect sizes or count of the number of studies that showed an effect in one direction versus another was considered inappropriate." From the authors' perspective, there are too few studies to quantify effects yet a sweeping definitive statement indicating an absence of ill-effects is considered justified.

32. According to the APA report, the Task Force "evaluated all empirical studies published in English in peer-reviewed journals post-1989 that compared the mental health of women who had an induced abortion to the mental health of comparison groups of women (N=50) or that examined factors that predict mental health among women who have had an elective abortion in the United States (N=23)." Note the second type of study is restricted to the U.S., resulting in elimination of at least 40 studies. Introduction of this exception allowed the Task Force to ignore studies, such as a large Swedish study of 854 women one year after an abortion, incorporating a semi-structured interview methodology requiring 45-75 minutes to administer (Soderberg et al., 1998). Rates of negative experiences were considerably higher than in previously published studies relying on superficial assessments. Specifically, 50-60% of the women sampled experienced emotional distress of some form (e.g., mild depression, remorse or guilt feelings, a tendency to cry without cause, discomfort upon meeting children); 16.1% experienced serious emotional distress (needing help from a psychiatrist or psychologist or being unable to work because of depression); and 76.1% said that they would not consider abortion again, suggesting it was not a very positive experience.

33. The APA Task Force did not select studies based on methodological criteria, but instead included all studies with empirical data related to induced abortion and at least one mental health measure published in peer-reviewed journals in English on U.S. and non-U.S.

samples. Sample size, characteristics, and representativeness, type of design, and employment of control techniques should have been the minimum foundation for selecting studies to include in the review.

34. In the APA Task Force Report, there are shifting standards of evaluation based on congruence with a pro-choice agenda. There are numerous examples in the APA report of studies with results suggesting no negative association between abortion and mental health being reviewed less extensively and stringently than studies indicating adverse relationships between abortion and mental health. Positive features of the studies suggesting abortion is a benign experience for most women are highlighted, while the positive features of the studies revealing negative outcomes are downplayed or ignored. All the studies showing adverse outcomes associated with abortion were published in peer-reviewed journals, many in very prestigious journals with low acceptance rates. A few examples of this bias are detailed below.

> a) The Medi-Cal studies (Coleman, Reardon, Rue, & Cougle, 2002; Reardon et al., 2003) are sharply criticized for insufficient controls; however, with the use of a large socio-demographically homogeneous sample many differences are likely distributed across the groups. Moreover, the strengths of the study include use of actual claims data (diagnostic codes assigned by trained professionals), which eliminate the problems of simplistic measurement, concealment, recruitment, and retention, which all are serious shortcomings of many post-abortion studies. The authors of the

Medi-Cal studies also removed all cases with previous psychological claims and analyzed data using an extended time frame, with repeated measurements enabling more confidence in the causal question.

b) Fergusson and colleagues' 2006 study had numerous positive methodological features yet it is denounced by the APA as flawed. Among the positive features of this study are the following: 1) longitudinal design, tracking women over several years, 2) comprehensive mental health assessments employing standardized diagnostic criteria of DSM III-R disorders, 3) considerably lower estimated abortion concealment rates than found in previously published studies, and 4) the sample represented between 80% and 83% of the original cohort of 630 females, and the study used extensive controls. Variables that were statistically controlled in the primary analyses included maternal education, childhood sexual abuse, physical abuse, child neuroticism, self-esteem, grade point average, child smoking, history of depression, anxiety, suicidal ideation, living with parents, and living with a partner. Very little discussion in the APA report is devoted to the positive features of this study and the limitations, which are few compared to most published studies on the topic, are emphasized.

c) Sample attrition as a methodological weakness is downplayed in the APA report. The studies with the highest attrition rates, conducted by Majors and colleagues provided little evidence of negative effects; these studies are embraced as high quality investigations despite attrition rates as

> high as 60%. Common sense suggests that those who are most adversely affected are the least likely to want to think about the experience and respond to a questionnaire. Research indicates that women who decline to participate or neglect to provide follow-up data are more likely to be negatively-impacted by an abortion than women who continue participating (Soderberg, Anderson, Janzon, & Sjoberg, 1998).

35. Cultural stigmatization as a primary variable related to whether or not negative post-abortion emotional outcomes are experienced is a theme that factors heavily into the APA report. However, there are few well-designed studies, that have been conducted to support the claim that any ill effects of abortion are culturally constructed. In fact, many studies have shown that internalized beliefs regarding the humanity of the fetus, moral, religious, and ethical objections to abortion, and feelings of bereavement/loss often distinguish between those who suffer and those who do not (see Coleman et al., 2005 for a review).

36. Perhaps most egregious is the fact that the final conclusion in the APA Task Force report did not follow from the literature reviewed, and it inappropriately rested on one study by Gilchrist et al. (1995) published in the U.K. that has a number of ignored methodological flaws. The authors of the report concluded: "The best scientific evidence published indicates that among adult women who have an unplanned pregnancy the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion

than if they deliver that pregnancy." Reliance on one study to draw a definitive conclusion stands in direct contrast to accepted scientific protocol as described by Wilkinson and the Task Force on Statistical Inference affiliated with the APA Board of Scientific Affairs. Wilkinson and colleagues (1999) specifically stated in the American Psychologist: "Do not interpret a single study's results as having importance independent of the effects reported elsewhere in the relevant literature. The thinking presented in a single study may turn the movement of the literature, but the results in a single study are important primarily as one contribution to a mosaic of study effects." Several flaws of the Gilchrist study were overlooked by the APA Task Force. These are detailed below.

a) Very few controls for confounding 3rd variables were employed, meaning the comparison groups may very well have differed systematically with regard to income, relationship quality including exposure to domestic violence, social support, and other potentially critical factors.

b) The authors report retaining only 34.4% of the termination group and only 43.4% of the group that did not request a termination at the end of the study. The attrition rate is highly problematic as are the differential rates of attrition across the comparison groups. Logically, those traumatized are less likely to continue in a study.

c) No standardized measures for mental health diagnoses were employed and evaluation of the psychological state of patients was reported by general practitioners, not psychiatrists. The GPs

were volunteers and no attempt was made to control for selection bias.

d) The response rate was not provided, meaning it is impossible to know if the sample was representative of women in the U.K. or not.

37. Within weeks of the release of the APA Task Force Report, the late Dr. David Fergusson, a self-proclaimed pro-choice New Zealand researcher with an extensive publication record (over 500 peer-reviewed articles) and I drafted a petition letter to Dr. Alan Kazdin, President of the APA. The interest in writing a petition letter originated with Dr. Fergusson, who served as an official reviewer for the Task Force Report. I too served as a reviewer of the Task Force report and we were both distressed by how the Task Force ignored ours and the other reviewers' feedback. Together Dr. Fergusson and I drafted the letter and then we solicited support from other well-published researchers, and compiled an extensive list of articles authored by the signatories. The letter was submitted to Dr. Kazdin on September 1, 2008, and the key points we raised are summarized below. At the end of our letter, we requested that the APA revisit this issue and seriously consider a retraction or revision; however, no action occurred.

a) Wholesale dismissal of most of the evidence in the field was unacceptable.

b) In no other area of public health research has a highly contested issue been resolved on the basis of a single out-of-date research study in the way that occurred in the APA Task Force report.

c) The APA Task Force report was not an impartial assessment of the mental health risks of abortion and its conclusions were unduly colored by the views of its authors.

38. The review relied upon most heavily by the NAS team was published in 2011 by the National Collaborating Centre for Mental Health (NCCMH) within the Royal College of Psychiatrists. The NCCMH review incorporates four types of studies: 1) reviews of the literature; 2) empirical studies addressing the prevalence of post-abortion mental health problems; 3) empirical studies identifying risk factors for post-abortion mental health problems; and 4) empirical studies comparing mental health outcomes between women who choose abortion and delivery. In each category, there are studies that are ignored and large numbers of studies that are entirely dismissed for vague and/or inappropriate reasons. With regard to the first type of study, only three reports are considered (APA Task Force Report, 2008; Charles et al., 2008; Coleman, 2011). The authors of the NCCMH report "missed" 19 reviews of the literature (listed below), published between 1990 and 2011. Moreover, no criteria were identified for selection of particular reviews. Narrative reviews not addressed included the following:

1. Adler NE, David HP, Major BN, Roth SH, Russo NF, Wyatt GE. Psychological responses after abortion. Science 1990 6; 248(4951):41-4.

2. Adler NE, David HP, Major BN, Roth SH, Russo NF, Wyatt GE. Psychological factors in

abortion. A review. Am Psychol. 1992; 47(10): 1194-204.

3. Adler NE, Ozer EJ, Tschann J. Abortion among adolescents. Am Psychol. 2003; 58(3): 211-7.

4. Allanson S, Astbury JJ. The abortion decision: reasons and ambivalence. Psychosom Obstet Gynaecol. 1995; 16(3):123-36.

5. Bhatia MS, Bohra N. The other side of abortion. Nurs J India. 1990; 81(2):66, 70.

6. Cameron S. Induced abortion and psychological sequelae. Best Practice & Research. Clinical Obstetrics & Gynaecology 2010; Vol. 24(5): 657-65.

7. Coleman PK, Reardon DC, Strahan T, Cougle R. The psychology of abortion: A review and suggestions for future research. Psychology & Health 2005; 20(2): 237-271.

8. Dagg PK. The psychological sequelae of therapeutic abortion—denied and completed. Am J Psychiatry. 1991; 148(5): 578-85.

9. Harris AA. Supportive counseling before and after elective pregnancy termination. Midwifery Women's Health. 2004; 49(2): 105-12.

10. Lie ML, Robson SC, May CR. Experiences of abortion: a narrative review of qualitative studies. BMC Health Serv Res. 2008; 8:150.

11. Lipp A. Termination of pregnancy: a review of psychological effects on women. Nursing Times 2009; 105(1): 26-9.

12. Major B, Appelbaum M, Beckman L, Dutton MA, Russo NF, West C. Abortion and mental health: Evaluating the evidence. Am Psychol. 2009; 64(9):863-90.

13. Major B, Cozzarelli C. Psychosocial Predictors of Adjustment to Abortion. Journal of Social Issues 1992; 48(3): 121-142.

14. Robinson GE, Stotland NL, Russo NF, Lang JA, Occhiogrosso M. Is there an “abortion trauma syndrome"? Critiquing the evidence. Harvard Review of Psychiatry 2009; 17(4): 268-90.

15. Rosenfeld JA. Emotional responses to therapeutic abortion. Am Fam Physician. 1992; 45(1):137-40.

16 Speck land A, Rue V. Complicated Mourning: Dynamics of Impacted Pre and Post-Abortion Grief,” Pre and Perinatal Psychology Journal 1993; 8(1):5-32.

17. Stotland NL. Clin Obstet Gynecol. Psychosocial aspects of induced abortion. 1997 Sep; 40(3):673-86.

18. Turell SC, Armsworth MW, Gaa JP. Emotional response to abortion: a critical review of the literature. Women Ther. 1990; 9(4):49-68.

19. Zolese G, Blacker CV. The psychological complications of therapeutic abortion. Br J Psychiatry. 1992; 160:742-9.

39. In relation to the third type of study (addressing risk factors for post-abortion psychological problems),

only 27 studies are included in the NCCMH report. Below are citations to 20 relevant and unmentioned articles published in highly respected peer reviewed journals. They are not listed in Appendix 7 of the NCCMH report, which contains all included and excluded studies.

1. Allanson S. Abortion decision and ambivalence: Insights via an abortion decision balance sheet. Clinical Psychologist 2007; 11(2): 50-60.

2. Brown D, Elkins TE, Larson DB. Prolonged grieving after abortion: a descriptive study. J Clin Ethics 1993; 4(2):118-23.

3. Fielding SL, Schaff EA. Social context and the experience of a sample of U.S. women taking RU-486 (mifepristone) for early abortion. Qualitative Health Research 2004; 14(5): 612-27.

4. Hill RP, Patterson MJ, Maloy K. Women and abortion: a phenomenological analysis. Adv Consum Res. 1994; 21:13-4.

5. Kero A, Laios A. Ambivalence—a logical response to legal abortion: a prospective study among women and men. J Psychosom Obstet Gynaecol. 2000; 21(2):81-91.

6. Linares LO, Leadbeater BJ, Jaffe L, Kato PM, Diaz A. Predictors of repeat pregnancy outcome among black and Puerto Rican adolescent mothers. J Dev Behav Pediatr. 1992; 13(2):89-94.

7. Mufel N, Speckhard AC, Sivuha S. Predictors of posttraumatic stress disorder following abortion in a former Soviet Union country. Journal of Prenatal & Perinatal Psychology & Health 2002; 17(1): 41-61.

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40. The NCCMH authors stated that, "Because the review aimed to assess mental health problems and substance use and not transient reactions to a stressful event, negative reactions and assessments of mental state confined to less than 90 days following the

abortion were excluded from the review." This is highly problematic for the following reasons:

> a) Elimination of studies that only measured women's mental health up to 90 days, does not effectively remove cases of transient reactions. Just because the authors of these dozens of studies did not follow the women long-term, it does not mean that the women were not still suffering quite significantly beyond the early assessment.
>
> b) When investigating the mental health implications of an event, it is logical to measure outcomes soon after the event has occurred as opposed to waiting months or years to gather data. As more time elapses between the stressor and the outcome(s), healing may naturally occur, there may be events that moderate the effects, and more confounding variables may be introduced.
>
> c) Finally, focusing only on mental health events that occur later in time effectively misses the serious and more acute episodes that are effectively treated soon after exposure. Many of the studies removed from the analyses due to the abbreviated length of follow-up, had incorporated controls for prior psychological history and other study strengths.

41. The samples of studies included in each section of the NCCMH review were not representative of the best available evidence and many of the eliminated effects coincidentally revealed adverse post-abortion consequences. In the category wherein the authors sought to derive prevalence estimates, only 34 studies were retained, including a majority without controls

for previous mental health. In contrast, in my meta-analytic review, 14 out of the 22 included studies had controls for psychological history.

42. The NCCMH review has numerous factual errors. Specifically, in "Section 1.4.4: Summary of Key Findings from the APA, Charles, and Coleman Reviews," the first 6 points are not reflective of the conclusions derived from the Coleman review and the 7th and final point in this section wrongly states, with reference to the Coleman review that "previous mental health problems were not controlled for within the review." In fact, the Coleman review incorporated more studies into the final analyses with controls for prior psychological problems than the NCCMH Review. Moreover, the conclusions derived from the Coleman review were based on more studies with controls for prior psychological history than the Charles and the APA reviews as well.

43. The NCCMH review was pitched as methodologically superior to all previously conducted reviews, largely because of the criteria employed to critique individual studies and to rate the overall quality of evidence. However, the quality scales employed to rate each individual study are not well-validated and require a significant level of subjective interpretation, opening the results to considerable bias.

44. The NCCMH quality scales used to rate studies were problematic for the following reasons: 1) the categories missed key methodological features, such as initial consent to participate rates; 2) the relative

importance assigned to criteria is not based on scientific consensus; 3) requirements for assigning a "+" or "–" within categories are not provided; and 4) no explanation is given for how combinations of pluses and minuses add up to overall ratings ranging from "Very Poor" to "Very Good."

45. Similarly, when it came to evaluating the quality of evidence associated with specific outcomes, such as anxiety, depression, suicide ideation, drug or alcohol abuse, psychiatric treatment, etc. with regard to the comparative studies, the GRADE (Grading of Recommendations, Assessment, Development, and Evaluation), was inappropriately employed by the NCCMH. The GRADE system was not designed for use with individual studies, but for analysis of systematic reviews (Burford, Rehfuess, & Schunemann, et al., 2012). The anchors on this scale are vague and oftentimes only one reason is identified by the NCCMH as the basis for a "Very Low" rating. For example, in the category of Any Psychiatric Treatment," which actually only included the Munk-Olsen et al. study, the basis for the "Very Low" (very uncertain about the estimate) rating was for not having controlled for pregnancy intention. When the study is again evaluated later in the report, it is rated as "Good" in the comparison category. There are loose, poorly conceived rationales with inconsistencies like this throughout the report.

46. Each section in the NCCMH report includes conclusions that are based on a very small number of studies that are not properly rated for quality. For example, relative to the risk factors for mental health problems

category, the authors state (based on 27 studies) that: "The most reliable predictor of post-abortion mental health problems is having a history of mental health problems prior to abortion" and "A range of other factors produced more mixed results, although there is some suggestion that life events, pressure from a partner to have an abortion, and negative attitudes towards abortion in general and towards a woman's personal experience of the abortion, may have a negative impact on mental health." In reality, however, the literature on risk-factors is not mixed and professionals, both practitioners and academics alike are in agreement regarding the specific variables that operate as robust predictors of post-abortion mental health problems.

47. An extensive 40-year history of peer-reviewed research has definitively shown that when specific physical, demographic, psychological, and situational factors are present, women are at an elevated risk for post-abortion mental health problems. Many of the risk factors have been known to the research community for decades and have been recognized and affirmed by professional organizations. There is undisputed opinion among researchers and practitioners alike that pressure to abort, coercion, commitment to the pregnancy, decision difficulty/ambivalence, conflict with personal values, pre-existing mental health problems, and young maternal age, among other factors, place women at increased risk for mental health problems, including depression, anxiety, suicide ideation, suicide, and substance abuse (e.g., Baker, et al, 2009; Coleman, 2005; Ely et al., 2009; Franco et al.,

1989; Hern, 1990; Mufel et al. 2002; Paul et al. 2009; Pope et al., 2001; Soderberg et al., 1998; Urquhart & Templeton, 1991).

V. Increased Risk for Mental Health Problems Associated with Abortion

48. For a significant number of women, abortion initiates powerful negative feelings and alienation from others (Kero, Hogberg, & Laios, 2004; Kero & Laios, 2000; Kero, Wulff, & Laios, 2009; Kimport, 2012; Kimport, Foster, & Weitz, 2011; Soderberg, Janzon, & Sjoberg, 1998). A Clinician's Guide to Medical and Surgical Abortion is a textbook written by leading abortion providers (Paul, et al., 1999) for training abortion providers. The chapter on counseling in this text outlines several negative reactions that women may experience after abortion, including depression, severe guilt, shame, and unresolved grief (Baker et al., 1999). According to the Clinician's Guide, symptoms of depression include the following: crying, suicidal ideation, poor performance in school or work, loss of interest in enjoyable activities, and feelings of worthlessness. Symptoms of severe guilt entail the following: 1) self-punishing behaviors such as substance abuse or indiscriminate sex; 2) nightmares about killing or saving babies; 3) blocking out the experience; 4) avoiding anything that triggers memories of the event; 5) fearing God's punishment; and 6) interpreting misfortune, illness, or accident as signs of God's punishment. Symptoms of shame include the following: I) relentless thoughts of being a bad person; 2) engaging in self-destructive

behaviors; 3) fear of anyone finding out about the abortion. Finally, symptoms of unresolved grief, according to the authors of the abortion text involve engaging in thoughts and behaviors that perpetuate a strong emotional investment in the pregnancy, or that prevent the redirection of emotional energy into moving forward with life.

49. Over the past several decades, the number of peer-reviewed studies identifying adverse mental health outcomes associated with abortion have increased dramatically, as has the scientific rigor of research on this topic. The literature base, comprised of hundreds of studies, has revealed that women who choose abortion experience increased risk of mental health problems, including substance abuse, anxiety, depression, suicidal ideation and suicide, among other conditions and symptoms (e.g., Bradshaw & Slade, 2003; Coleman et al., 2002a, 2002b; Coleman, 2005, 2006; Cougle et al., 2003, 2005; Dingle, 2008; Fergusson et al., 2006, 2008; Gissler et al., 2005; 2015; McCarthy, 2015; Mota et al., 2010; Pedersen, 2007, 2008; Rees & Sabia, 2007; Sullins, 2016).

50. The scientific evidence linking abortion to increased rates of mental health problems is published in leading peer-reviewed journals in psychology and medicine. There are now dozens of large-scale prospective studies with 1 OOO's of participants incorporating different types of comparison groups and other control techniques, effectively fortifying the level of confidence in the results derived. Potentially confounding variables, controlled in the various studies, include prior

mental health, reproductive history, experience of abuse of various forms, and several demographic variables thereby increasing the reliability and validity of the findings.

51. In a 2013 narrative review of literature published between 1995 and 2011, incorporating 30 peer-reviewed journal articles by Italian researchers Bellieni and Buonocore, the authors concluded "The studies analyzed here show that abortion is a risk factor for mental illness when compared to childbirth."

52. In 2011, I published a meta-analysis titled "Abortion and Mental Health: A Quantitative Synthesis and Analysis of Research Published from 1995-2009" in the British Journal of Psychiatry. A meta-analysis is a specific form of systematic literature review wherein quantitative data from multiple published studies are converted to a common metric and combined statistically to derive an overall measure of the effect of an exposure such as abortion. This methodology gives the results more statistical power and much more credibility than the results of any individual empirical study or narrative review. In a meta-analysis, the contribution or weighting of any particular study to the final result is based on objective scientific criteria (sample size and strength of effect), as opposed to an individual's opinion of what constitutes a strong study.

53. My review offers the largest quantitative estimate of mental health risks associated with abortion available in the world. After applying methodologically-based selection criteria and extraction rules to

minimize bias, the sample consisted of 22 studies, 36 measures of effect, and 877,297 participants (163,880 of whom experienced an abortion). Results revealed that women who aborted compared to women who had not, experienced an 81% increased risk for mental health problems. When compared specifically to unintended pregnancies delivered, abortions were associated with a 55% increased risk of mental health problems.

54. Separate effects were calculated based on the type of mental health outcome, with the results revealing the following increased risks: anxiety disorders 34%; depression 37%; alcohol use/abuse 110%; marijuana use/abuse 220%; and suicide behaviors 155%. Calculation of a composite Population Attributable Risk (PAR) statistic revealed that nearly 10% of the incidence of mental health problems was directly attributable to abortion.

55. On April 8, 2015, Dr. Elizabeth Suhay challenged readers in U.S. News to recognize the dangers of agenda-driven science and work to reverse an inherently formidable trend: "Right now, too many people are willing to accept the scientific process only when it leads to conclusions that bolster their political, economic and religious outlooks. This leads to a dangerous distortion of scientific understanding. It inhibits our ability to see the world clearly, to formulate science-based policy to meet important challenges and to reach across the political aisle to implement that policy A critical first step in combating this all too human prejudice is simply to recognize its existence and commit

to overcoming it." Ironically and sadly, the NAS originated out of strong interest in preventing what is now a widespread political orientation to use of scientific data in pursuit of socio-political agendas. The NAS report on the safety of abortion constitutes a repudiation of the NAS founding ideals.

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Further Affiant sayeth not."

/s/ Priscilla K. Coleman
Dr. Priscilla K. Coleman

SWORN TO AND SUBSCRIBED BEFORE ME, the undersigned authority, on this 16 day of Dec, 2019.

/s/ Melissa Baker
NOTARY PUBLIC IN AND FOR
Notary Public, Wood County, Ohio

[SEAL] MELISSA BAKER
Notary Public, State of Ohio
My Comm. Expires 05/19/2024
Recorded in Lucas County

APPENDIX B

Affidavit of Carol Everett

STATE OF TEXAS	§	KNOW ALL MEN BY
	§	
COUNTY OF WILLIAMSON	§	THESE PRESENTS

BEFORE ME, the undersigned authority on this day personally appeared Carol Everett who is personally known to me, and after being by me first duly sworn according to law on her oath did depose and say that:

1. "My name is CAROL EVERETT. I am over the age of eighteen (18) years of age and I am fully competent to make this Affidavit. I reside in Round Rock, Texas. I have personal knowledge of the facts stated herein and the following is true and correct.

2. I know firsthand about abortion and the abortion industry. I have been both a consumer and provider. I was involved in the operation of abortion facilities from 1977 to 1983, overseeing 35,000 abortions. I was formerly part owner of Dallas' largest abortion chain.

3. Since leaving the abortion industry, I have been committed to safeguarding the health of women and their babies all over this nation. I speak to the men and women who have experienced an abortion to offer a message of healing and hope.

4. I formed The Heidi Group to help girls and women in unplanned pregnancies make positive, life-affirming choices for themselves and their babies.

Our role is to connect girls and women to the best resources available. At the Heidi Group, we affirm the dignity and value of girls, women, and families. It is our goal to make sure that before a girl or a woman walks through the door of an abortion facility, she sees the full picture of the resource community waiting to embrace her and her unborn baby.

My Abortion Experience

5. I was married, had an 8 year-old daughter and a 10 year-old son when I found myself pregnant again. When I excitedly told my husband of the pregnancy, his initial reaction was, "You'll just have to have an abortion."

6. Searching for help, I went to my doctor and told him that my husband didn't want me to have this baby. Without discussion, he offered an illegal abortion. I was looking for someone to tell me not to have the abortion, but I ran into an abortion salesman. And that is what happens in our nation today as employees of abortion facilities may earn a higher rate per hour or a commission for abortion appointments completed. Every physician performs abortions on a straight commission. Abortion physicians are only paid for their services after the abortion procedure is complete. Abortion physicians strive to perform ten to twelve first trimester abortions per hour, paid approximately one-third of the total fee. Second and third trimester abortions require more of the physician's time because the baby's muscle structure is more strongly developed and takes longer to

remove. Second and third trimester physician procedure fees are approximately fifty percent of the total cost. A late term physician specialist strives to perform two to three second and third trimester abortions per hour.

7. When I woke from my abortion, I picked up the telephone, and literally started working from my hospital bed, not realizing that I was already running from that decision. I know first-hand the devastation of abortion – my life rapidly went downhill. Within a month, I was having an affair which I had never done before. Very soon I started drinking; another new factor in my life. Shortly thereafter, my marriage broke up.

8. Then I started seeing a psychiatrist daily. At the rate of $125.00 an hour, I could not go on with this very long. So, I decided to do what I called, "get hold of myself." I changed everything I could in my life, except my children. I got away from the job I'd had; now away from my husband, and decided I would make it on my own. What I'm telling you is the story about how my life went along at a pretty good level for a while, and the moment I had that abortion, it went straight downhill. I think that is what happens to every woman who has an abortion.

9. Abortion is devastating to women and babies, but it also has very negative consequences for fathers. My former husband now struggles with our abortion.

The Abortion Business

10. When I did "get hold of myself", I went to work for a man who had a medical supply business. At about this time, abortion became legal in the State of Texas, and very soon we had a new account that was very profitable. The medical supply company was making thousands of dollars a month from this one account. My employer determined to understand exactly what sort of business this new account was and found it to be an abortion facility. This man who told me he never wanted to see an abortion, never wanted to know what an abortion really was, opened his first abortion clinic, and soon he had four abortion facilites.

11. All this time he kept inviting me to join him. He said that with my daily contact with physicians, I was in a perfect position to sell abortions for him. He would pay $25 per completed abortion. I kept selling medical supplies and sold a few abortions along the way. But the day came when I needed to make more money. So, I told him that I was quitting my job; I wanted to go with another company. So, he got me on the fringe of the abortion industry by asking me to set up referral clinics all over Texas, Oklahoma and Louisiana. And I did that for a while and it was quite profitable.

12. Then he asked me to work at one of the clinics for a month. I immediately recognized ways to sell more abortions. With just a very few small changes, in one of his clinics, abortions went from 190 to 195 per month to over 400 per month. Our telephone counselors booked abortions for both the Dallas and Fort Worth clinics. The last month I

was with him in those two clinics, he was doing something over 800 abortions a month. I personally participated in approximately 10% of the abortion procedures performed at the two facilities.

13. In addition to other duties, I was in charge of training employees we called "counselors." These counselors were not trained to counsel a woman about her options or to provide accurate, truthful information about an abortion. Information about fetal development or the risks of abortion was not provided. We did not counsel our patients as to the potential physical and emotional consequences of having an abortion. What we did could not be considered counseling. Our people were trained as telemarketers. We learned how to exploit the fears of our callers. We sold abortions. I believe that states should require full and accurate informed consent counseling and should require statistical reporting to compile data for accurate informed consent forms.

14. The strategy of the abortion industry is to gain the trust of young people by offering secrecy and promiscuity via free and inexpensive birth control, and then banking on their inevitable return when pregnancy occurs. We deliberately prescribed low-dosage birth control to help ensure that pregnancies occurred. The goal was three to five abortions from girls between the ages of 13 and 18. The record was nine from one girl.

15. It has been my experience that when a woman or a young girl learns that she is pregnant, she may not want an abortion. She may only want

information. The person who answers the phone in an abortion facility is paid and trained to be her friend. Her job is to sell her an abortion by asking questions and leading her to believe an abortion is her only option – the answer to every question.

16. Since I had doubled his business, I asked for an equity interest in the business. He said no. I placed my Yellow Page ad to come out in six months for my own abortion clinic. We opened the first clinic. And then I opened a second clinic in the Dallas area. We did over 500 abortions a month in those two clinics. I was compensated at the rate of $25.00 per case, plus one-third of the clinics, so you can imagine what my motivation was. I sold abortions. I had made $150,000; was on target in 1983 to make about $260,000; and my goal when we opened our five clinics was to complete 40,000 abortions annually. I would have been making a million dollars a year.

17. Abortion is a very lucrative business. Abortion facilities sell abortions. They don't sell keeping the baby. They don't sell placing the baby for adoption. The only "choice" offered by the abortion industry is abortion.

18. It is becoming more lucrative with the RU-486 regimen. These medical abortions sell pills with minimal oversight and follow-up. The potential of an RU-486 abortion is that if the pill does not completely abort the baby, the woman may be subjected to a second procedure – a surgical abortion in some cases for a second full fee.

19. Since 2000 when the FDA approved the RU-486 regimen, I have met with women who have taken

RU-486. They have had more severe physical and psychological complications than women who have had surgical abortions. For example, the physical issues include severe hemorrhaging and pain from RU 486. In addition, some of the most severe post-abortion syndrome occurs because the women actually see the baby after it is expelled.

20. Abortion facilities do not discuss the baby in accurate terms. Even when the woman asks if it is a baby, abortion clinic employees answer "No, it's a product of conception"; "It's a blood clot"; "It's a piece of tissue". They do not even really tell them it's a fetus because that almost humanizes it too much. It is never a baby. We never explained that every baby had to be reconstructed in the Central Supply room to be certain all parts had been removed. If a body part is not present, the woman may have to return to the procedure room to complete removal of the baby body parts and thus prevent infection.

21. This is what causes such psychological trauma certainly with RU-486 because the woman sees for herself that she was lied to and it really is a baby that she has just expelled in the toilet or shower.

22. They also mislead women as to what will occur. For example, women ask if it will hurt. They say no and explain that the uterus is a muscle and it is cramp to open it; a cramp to close it; it is a slight cramping sensation. Because every woman has had cramps, they think that it is like what they have experienced before. But women who have taken RU-486 state that it is severe cramping like they have never experienced before.

23. I have worked with a Houston woman who was given RU-486. Ten weeks later, she thought she was pregnant again, but when she went to the abortion facility, she learned she had an incomplete abortion. This time, for a second fee, a surgical abortion was performed and she was sent home with an IV in her arm. When she called the abortion facility, she was told to meet facility personnel in a park and they would take it out. Recognizing this was substandard medical care, the woman went to an Emergency Room where a physician removed the IV.

24. Many women who had abortions at my clinics had major physical complications requiring hospitalization. The last 18 months I was in the abortion business, one out of every 500 women had major surgery requiring hospitalization. (Hysterectomy, colostomies due to bowel perforation and one woman bled to death. We moved that woman from the clinic so the staff would not be aware of the death.) Patients were moved to hospitals by private car – never by ambulance. (An ambulance at an abortion facility was considered negative advertisement.) We transported patients in crisis in some cases more than 30 miles, but at the very least across town to a hospital we trusted to keep the abortion complication admission secret. Our medical director always had a hospital that he promised his private admissions in return for handling the next abortion clinic emergency. If the specialties of other physicians were required, the medical director called in favors from friendly physicians. The patient and her needs were secondary to the protection of the clinic and its reputation even to the point of falsification of medical records.

The requirement of admitting privileges for abortion physicians would have forced our abortion physicians to consider the needs of the woman in crisis before the reputation of the abortion clinic.

25. At the first trimester price of $450 for an abortion, an abortion physician performing 10 abortions is paid approximately one-third of the total fee makes $150 per procedure for an hourly rate of $1,500. Four hours nets $6,000.

    In a second trimester abortion costing $4,000, the abortion physician's fee is one-half or $2,000. At an average of three procedures per hour, the physician can net $6,000.

    The added benefit for the physician was that we did not want to be responsible for our physician's malpractice insurance. Our clinics kept two sets of books: one for the clinic and one for the abortion physicians with no bookkeeping records. Our abortion physicians were independent contractors who kept receipts from each chart to be paid at the end of the day in cash. No 1099. No reporting to Internal Revenue Service.

26. Based on my experience, I now believe that women should have been given accurate information about the physical and emotional consequences of abortion so that they could make an informed decision.

27. Some of our abortion physicians were circuit rider physicians, living some distance from our clinics. They moved from abortion clinic to abortion clinic, working for different owners.

28. Ordinary day surgery and physician's offices meet the standards of Medicare in order to be paid for services by insurance. Abortion is a cash or credit card business, thus no need to meet the minimum standards of quality health care.

29. Based on the fact that abortion physicians strive to perform a minimum of 10 to 12 abortions per hour, it is almost impossible to keep surgical instruments clean and sterile. For instance, 50 abortions are scheduled for a day. Two abortion physicians are working at a rate of 20 to 24 abortions an hour. The abortion facility only has 21 sets of surgical instruments. The physicians are each working from two rooms. The first two procedures are completed and both physicians rush across the next room to perform the second surgical procedure. The instruments and the "products of conception" are sent to Central Supply. The technician reconstructs the babies to be certain all body parts are removed. (If a baby's body part is missing, the woman may be subjected to a second abortion procedure.) The instruments are washed, placed in sterile wrap and placed in a steam sterilizer. The temperature for sterility is required to reach 270 degrees. It takes several minutes for the temperature to be reached. After holding the temperature at 270 degrees for 20 minutes for to sterilize instruments, it takes some time for the steam to release. The instruments are removed but they are far too hot to touch. By now the technician has a stack of instruments ready to go but the problem now is that the two abortion physicians are so far ahead of the sterilization process, it is humanly impossible to keep the instruments sterile. The unwritten protocol of the abortion clinic at this

point changes from complete sterilization to using a product like Cidex that is supposed to sterilize but again, the problem of time. Now the tech must wash instruments and leave in the sterilization product long enough to completely sterilize. At some point, the process is abandoned and the technician simply wants to supply the abortion physician with instruments to continue his work at 10 to 12 abortions each hour. Instruments are washed and returned to the line for procedures. I saw one abortion physician use instruments straight out of the sterilizer that were so hot, he had to use an oven mitt to insert the dilators. That woman's cervix was surely burned, even scarred. What sort of complications with future fertility?

30. I support requiring hospital admitting privileges guarantees the continuity of care when complications arise and to provide details of the care that may not be available in an emergency. Having hospital privileges at a local hospital is both reasonable and necessary for the health and safety of women.

Further Affiant sayeth not."

/s/ Carol Everett
Carol Everett

SWORN TO AND SUBSCRIBED BEFORE ME, the undersigned authority, on this 4 day of December 2019.

/s/ Michelle Renea Herrera
NOTARY PUBLIC IN AND FOR
THE STATE OF TEXAS

Notary Public, Williamson, County, Texas
My Commission Expires:

[Notary Stamp]

APPENDIX C

Affidavit of Dr. Kathi Aultman

STATE OF FLORIDA	§	KNOW ALL MEN BY
	§	
COUNTY OF CLAY	§	THESE PRESENTS

BEFORE ME, the undersigned authority on this day personally appeared Dr. Kathi A. Aultman, M.D., FACOG who is personally known to me, and after being by me first duly sworn according to law on her oath did depose and say that:

1. "My name is Dr. Kathi Aultman. I am over the age of eighteen (18) years of age and I am fully competent to make this Affidavit. I reside in Clay County, Florida. I have personal knowledge of the facts stated herein and the following is true and correct.

2. I am a Board-Certified OB/Gyn and a Life Fellow of the American College of Obstetricians and Gynecologists. I earned my medical degree at the University of Florida College of Medicine in 1977 and completed my OB/Gyn Residency at the University of Florida affiliated, Jacksonville Health Education Program in 1981. I retired in 2014 for medical reasons after 33 years in private practice in Orange Park, FL.

3. I have been an advocate for women and their health issues for my entire career. I was the co-founder and co-director of the first Rape Treatment Center in Jacksonville, Florida, and performed sexual assault exams on women and

children as a medical examiner for Duval and Clay Counties. I also served as the Medical Director for Planned Parenthood of Northeast Florida, Inc. from 1981 to 1983.

4. I testified before several state legislatures, state courts, and before Congress on the Partial Birth Abortion Ban and other issues from 1997-2002 and was a consultant for the United States Justice Department on the Partial Birth Abortion Ban from 2003-2004.

5. I am currently an Associate Scholar with the Charlotte Lozier Institute, a member of the American Association of Prolife Obstetricians and Gynecologists (AAPLOG), and a member of the Christian Medical and Dental Associations. I have testified extensively at the state and federal level on a variety of pro-life issues from 2016 to the present. I recently reviewed and coded 199 Adverse Event Reports from Mifepristone Regimens for Abortion for AAPLOG and entered the data into a spreadsheet be used for research purposes.

6. I performed 1st trimester suction D&C abortions and received special training in 2nd trimester D&E's. I have treated women with the medical, surgical, and psychological complications of abortion and pregnancy. I have performed C-sections, vaginal deliveries, and gynecological surgeries including robotic hysterectomy and laparoscopy. I have stayed current with my Continuing Education Requirements and have been continually reviewing the medical literature on abortion, especially since 2016 when I began testifying again. The opinions I express in this Affidavit are

based on my education, training and experience, in addition to my ongoing familiarity with the medical literature.

7. Based on my medical expertise and experience, I can say that the safety measures provided in H.B. 388 requiring doctor privileges at local hospitals are reasonable and necessary for the health and safety of women considering an abortion.

I. Women Suffer Serious Medical and Psychological Complications of Abortion, But They Are Significantly Under-Reported.

8. Only 28 states require providers to report post abortion complications.[1]

9. Women presenting with complications related to the abortion don't always disclose that they had an abortion.

10. The Emergency Room diagnosis does not always reflect the fact that the problem was the result of an abortion.

11. Even if a death is recorded, the cause of death may be reported as sepsis or hemorrhage and not linked to an abortion especially if the patient conceals the fact that she had an abortion.

12. I had assumed that the complications from abortion treated in the Emergency Room or admitted to the hospital were reported, but when I checked

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[1] *Abortion Reporting Requirements.* (2019, Nov 01). Retrieved Dec 01, 2019, from Guttmacher Institute: https://www.guttmacher.org/print/state-policy/explore/abortion-reporting-requirements.

our hospital's medical records department, I learned they were not. During the years I practiced medicine in Florida, I was unaware of any requirement for the hospital or a physician's office to report complications from abortion.

13. I was never required to report any of the medical or psychological complications of abortions that I treated or witnessed.

II. Abortions Are Not As Safe As Portrayed.

14. Abortions are touted as being one of the safest medical procedures and are often compared to other minor surgical procedures and childbirth however they are not as safe as they are portrayed. According to abortionist Warren Hern, "In medical practice, there are few surgical procedures given so little attention and so underrated in its potential hazard as abortion."[2]

15. Mortality from abortions increases dramatically as gestational age increases and by 21 weeks abortion has a higher mortality than delivery at term.[3]

16. Comparing the average abortion complication or mortality rate to those of a specific surgical procedure gives a false picture of safety because the majority of abortions are done at early gestational ages when the risk is lower, therefore the average is low, but the risk is still high at later

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[2] Hern, W. M. (1990). *Abortion Practice.* Boulder, CO: Alpenglo Graphic, Inc. (p.101).

[3] An Overview of Abortion in the United States. (2014, Jan). (PowerPoint Slide #19). NY: Guttmacher Institute.

gestations. Because of this, one cannot use the average risk when comparing the complication or mortality rates of abortion to other procedures. These are the rates, however, that are extensively quoted and generalized to all abortions. It would be less misleading to compare abortion at a particular gestation to another surgical procedure. The problem is exacerbated by the abysmal reporting of abortion complications.

17. Comparing induced abortion mortality rates (number of induced abortion related deaths per 100,000 induced abortions) to maternal mortality rates (number of pregnancy related deaths per 100,000 live births) is not an apples-to-apples comparison.

18. "There are numerous and complicated methodological factors that make a valid scientific assessment of abortion mortality extremely difficult. Among the many factors responsible are incomplete reporting, definitional incompatibilities, voluntary data collection, research bias, reliance upon estimations, political correctness, inaccurate and/or incomplete death certificate completion, incomparability with maternal mortality statistics, and failing to include other causes of death such as suicides."[4]

19. It is important to recognize that according to the World Health Organization, a "Maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of

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[4] Calhoun, B. (2013). Systematic Review: The maternal mortality myth in the context of legalized abortion. *The Linacre Quarterly Review*, *80*(3), 264-276.

the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes."[5] This includes deaths from abortion, ectopic pregnancy and miscarriage.

20. "An abortion-related death is defined as a death resulting from a direct complication of an induced abortion, an indirect complication caused by a chain of events initiated by an abortion procedure, or the aggravation of a pre-existing condition by the physiologic or psychological effects of the abortion."[6]

21. Because certain states did not report abortion data every year, the CDC could not rely on the abortion surveillance data reported to CDC during 1998-2015 alone, to calculate the national legal induced abortion case-fatality rates (number of legal induced abortion-related deaths per 100,000 reported legal induced abortions in the United States). Therefore, "the denominator data were obtained from a published report by the Guttmacher Institute that includes estimated total numbers of abortions in the United States from a national survey of abortion-providing facilities."[7]

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[5] *Health statistics and information systems.* (2019). Retrieved Dec 1, 2019, from World Health Organization: https://www.who.int/healthinfo/statistics/indmaternalmortality/en/.

[6] Zane, S et al. (2015, Aug). Abortion-Related Mortality in the United States 1998-2010. *Obstet Gynecol, 126*(2), 258-265. doi:10.1097/A0G.0000000000000945.

[7] *MMWR: Abortion Surveillance – United States, 2016. Abortion Mortality.* (2016). Retrieved Dec 1, 2019, from CDC Centers for Disease Control and Prevention: https://www.cdc.gov/mmwevolumes/68/ss/ss6811a1.htm.

22. A Danish study found that, "Compared to women who delivered, women who had an early or late abortion had significantly higher mortality rates within 1 through 10 years post abortion. A lesser effect may also be present relative to miscarriage."[8]

III. Psychological Complications of Abortion.

23. When I began my private OB/Gyn practice, I believed that abortion was a good solution to the problem of young women's unplanned pregnancies and that abortion did not tend to cause psychological difficulties; but, in my practice, I was surprised to find that the opposite was true.

24. Although I could provide many examples, the following are representative. I provided gynecologic care to a young professional woman who confided in me that she was seeing a psychiatrist for what she described as "severe psychological problems." The young woman explained that when she found she was pregnant, her immediate reaction was to have an abortion, and she did so. But once the abortion was over, she found that the realization that she had killed her unborn child was far worse than living with an unplanned pregnancy would have been.

25. I also provided care to a woman who came to see me for continuous spotting and bleeding several

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[8] Reardon, D., & Coleman, P. (2012). Short and long term mortality rates associated with first pregnancy outcome: Population register based study for Denmark 1980-2004. *Med Sci Monit, 18*(9), 71-76. doi:DOI: 10.12659/MSM.883338.

months following an abortion. She was severely emotionally distressed as a result of her experience with her second-trimester abortion. I learned that she had been given medication and kept overnight in a cold room in an abortion clinic, without a blanket or any way to call for help. The next morning, she was given vaginal medication. After hours of painful cramping she was instructed to sit on the toilet and push. She delivered a 20+ week baby boy into the toilet. The baby drowned in the toilet water. The woman could not shake the image of the baby in the toilet, and she suffered severe emotional distress.

IV. Medical Complications of Surgical Abortions.

26. **Aspiration Abortion or Suction Curettage:** This is commonly performed up to 12-14 weeks. Aspiration abortion is an invasive surgical procedure which can have serious complications.

27. Complications: Hemorrhage (heavy bleeding), uterine atony (loss of contractility of the muscle wall leading to hemorrhage) cervical laceration, laceration of uterine arteries, uterine perforation, injury to bowel or other structures, retained products of conception (portions of the fetus and placenta are inadvertently left in the uterus) infection, pelvic inflammatory disease (which can lead to infertility[9]), DIC (Disseminated Intravascular

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[9] Infertility Workup for the Women's Health Specialist – ACOG Committee Opinion – #781. (2013, June). *Obstetrics and Gynecology*, *133*(6), p. e379. Retrieved Dec 05, 2019, from ACOG American College of Obstetricians and Gynecologists: https://www.acog.org/-

Coagulation: the clotting factors in the blood are used up and the patient begins to bleed uncontrollably), pulmonary embolus, (blood clot which lodges in the blood vessels of the lungs and is life threatening) death, sepsis (life threatening organ dysfunction caused by a dysregulated host response to infection), vasovagal reaction (pulse slows and the blood pressure drops which can lead to loss of consciousness), toxic reaction from lidocaine overdose, complications from anesthesia, allergic reactions, hematometra (post-abortal syndrome – the uterus fills with clotted blood), missed ectopic pregnancy with subsequent tubal rupture and hemorrhage, ongoing pregnancy,[10] cervical insufficiency which may lead to premature birth[11].

28. **D&E: Dilation and Evacuation (Disarticulation or Dismemberment Abortions):** This is done between 13 to 24 weeks gestation when the tissue becomes too tough to be removed with a suction curette alone.

29. Complications: Hemorrhage, uterine atony, DIC, amniotic fluid embolism, pulmonary embolus, cervical laceration, uterine perforation, laceration of uterine arteries, uterine perforation, injury to

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/media/Committee-Opinions/Committee-on-GynecologicPractice/co781.pdf?dmc=1&ts=20191205T1257296831_(p. e379).

[10] Hern, W. M. (1990). *Abortion Practice.* Boulder, CO: Alpenglo Graphic, Inc. (pp. 175-187).

[11] *Cerclage for the Management of Cervical Insufficiency – Practice Bulletin #142.* (2014 (Reaffirmed 2019), Feb). Retrieved Dec 05, 2019, from ACOG – American College of Ostetricians and Gynecologists: https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins----Obstetrics/pb142.pdf?dmc=1&ts=20191205T1226480545 (p. 1).

bowel or other structures, retained products of conception. infection, pelvic inflammatory disease (which can lead to infertility[12]), DIC, amniotic fluid embolism, (amniotic fluid enters the bloodstream, 80% mortality) pulmonary embolus, death,[13] sepsis, vasovagal reactions, toxic reaction from lidocaine overdose, complications from anesthesia, allergic reactions, hematometra, missed ectopic pregnancy, ongoing pregnancy,[14] cervical incompetence.[15]

30. One of the most frightening scenarios is profuse vaginal bleeding because there is little time to get it under control before the patient goes into shock and dies. This is one of the more serious complications of both surgical and medical abortions. Immediate transfer to a hospital is necessary in order to transfuse the patient, provide resuscitative care, and to have the availability of a board-certified

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[12] Infertility Workup for the Women's Health Specialist – ACOG Committee Opinion – #781. (2013, June). *Obstetrics and Gynecology*, *133*(6), p. e379. Retrieved Dec 05, 2019, from ACOG American College of Obstetricians and Gynecologists: https://www.acog.org/-/media/Committee-Opinions/Committee-on-GynecologicPractice/co781.pdf?dmc=1&ts=20191205T1257296831.

[13] *Second – Trimester Abortion Practice Bulletin # 135.* (2013 (reaffirmed 2019), June). Retrieved from ACOG The American College of Obstetricians and Gynecologists: https://www.acog.org/-/media/Practice-Bulletins/Committeeon-Practice-Bulletins----Gynecology/Public/pb135.pdf?dmc=1&ts=20191205T0142321508.

[14] Hern, W. M. (1990). *Abortion Practice.* Boulder, CO: Alpenglo Graphic, Inc (pp. 175-187, 201-203.

[15] *Cerclage for the Management of Cervical Insufficiency – Practice Bulletin #142.* (2014 (Reaffirmed 2019), Feb). Retrieved Dec 05, 2019, from ACOG – American College of Ostetricians and Gynecologists: https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins----Obstetrics/pb142.pdf?dmc=1&ts=20191205T1226480545.

OB/Gyn to perform laparoscopy, laparotomy, uterine artery or hypogastric artery ligation, and hysterectomy are critical.

31. Another serious complication is to see the patient's bowel in the suction tubing or to get a call a day or two after the procedure from the pathologist stating he found mature bowel (from the mother) in the specimen. At times perforation of the uterus with bowel injury goes unnoticed until the patient comes into the Emergency Room with an acute abdomen and sepsis (life threatening infection) a couple of days later. A patient with a bowel injury came into the Emergency Room when I was on call. The abortionist had perforated her uterus during a D&E and had pulled a piece of her small bowel into the vagina. I was thankful that she was immediately triaged to the general surgeons who took her to the operating room.

V. Requiring Hospital Admitting Privileges Provides a Safety Net, Protects Women from Unscrupulous Providers by Providing Oversite, and Improves Care.

32. According to the AMA Code of Medical Ethics, "the purpose of medical staff privileging is to improve the quality and efficiency of patient care in the hospital."[16] Before granting admitting privileges, hospitals review the qualifications, education, competency, and character of physicians. Physicians with hospital privileges also undergo

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[16] *Staff Privileges.* (2019). Retrieved Dec 06, 2019, from AMA: https://www.ama-assn.org/deliveringcare/ethics/staff-privileges.

ongoing peer review and must maintain their competency. They must also maintain certain ethical standards and codes of expected behavior. This safeguards patients against unqualified or unscrupulous providers like Dr. Kermit Gosnell.[17]

33. Hospitals cannot afford to have incompetent or unethical physicians on their staff.

34. Physicians have always been held to a higher standard than those in other professions because when a physician makes a mistake, his patient can die or be damaged for life. This is especially true of those who perform surgical procedures which includes abortions. As the Chairman of the OB/Gyn Department at Orange Park Medical Center, the Chairman of the QA Committee of North Florida Obstetricians and Gynecologists, and the Chairman of the Governing Board of the Orange Park Surgery Center and its Medical Board, I found that although most physicians are conscientious, ethical, competent, caring individuals, there are those who are not. These are problem physicians who put their own interests above the interests of their patients and put their patients at risk if unchecked.

35. There are physicians who do abortions who are board-certified and have hospital privileges. These physicians are held accountable by their specialty board and the hospital. There are other physicians

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[17] Hurdle, J., & Gabriel, T. (2013, May 13). Philadelphia Abortion Doctor Guilty of Murder in Late-Term Procedures. *The New York Times.* (D. Baguet, Ed.) NY, US. Retrieved July 15, 2019, from https://www.nytimes.com/2013/05/14/us/kermit-gosnell-abortion-doctor-found-guilty-of-murder.html.

who do abortions who are not board-certified nor have hospital privileges and therefore have no such accountability.[18]

36. For too long abortionists and their clinics have not been held to the same standards as other physicians and their facilities because of powerful lobbyists who have argued that we won't have enough abortionists if they are required to meet those standards. This leaves patients at their mercy. As a board-certified OB/Gyn with hospital privileges I resented being forced to handle the complications dumped on our Emergency Room by the local abortion clinic, partly because of the liability involved in taking care of someone else's complications, especially with no history on the patient or her procedure.

37. Historically regulators and law enforcement have turned a blind eye to abortion clinics and the offices of abortionists despite allegations of shoddy practices by patients and clinic staff. Despite numerous complaints, Dr Kermit Gosnell was not investigated because of his horrendous medical practices but because of a tip that he was operating an illegal prescription mill. Once authorities began investigating the clinic, however, the conditions they found were so deplorable that they could no longer look the other way.[19] Despite

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[18] Studnicki, J. (2019, April 15). Doctors Who Perform Abortions: Their Characteristics and Patterns of Holding and Using Hospital Privileges. *Health Services Research and Managerial Epidemiology*, *6*, 1-8. Retrieved Dec 02, 2019, from https://journals.sagepub.com/doi/10.1177/2333392819841211 (p.7).

[19] Hurdle, J., & Gabriel, T. (2013, May 13). Philadelphia Abortion Doctor Guilty of Murder in Late-Term Procedures. *The*

similar allegations, other abortionists have not been held accountable and have escaped prosecution for fear of losing abortion providers.[20] This is what happens when there is no accountability or oversite and it puts patients at risk.

38. Abortion is extremely lucrative. Patients pay cash up front for their procedure and yet because of this lack of oversite and accountability they are not given the same protections and quality of care as patients undergoing other surgical procedures.

VII. Requiring Hospital Privileges Facilitates Continuity of Care.

39. As an OB/Gyn in private practice, I saw many patients, who had significant complications from their abortion. Since the abortionists were not required to have hospital privileges, the clinics just told clients with complications to go to the Emergency Room or to see a Gynecologist. It was extremely frustrating and anxiety producing to be on Emergency Room call and be required to see these patients without any information. Often the patients didn't really know what had been done. These complications included life-threatening hemorrhage, retained fetal parts or placenta from

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New York Times. (D. Baguet, Ed.) NY, US. Retrieved July 15, 2019, from https://www.nytimes.com/2013/05/14/us/kermit-gosnell-abortion-doctor-found-guilty-of-murder.html.

[20] Johnson, B. (2014, 03 18). *OB/GYN: Karpen's botched abortion was 'one of the worst injuries to a uterus' she had ever seen.* Retrieved Dec 6, 2019, from Life Site News: https://www.lifesitenews.com/news/ob-gyn-karpens-botchedabortion-was-one-of-the-worst-injuries-to-a-uterus-t.

incomplete abortions, infections including life-threatening sepsis, and bowel injury.

40. It was often difficult to make a diagnosis not knowing what went on during the abortion procedure. Just as with any other surgical procedure, communication and continuity of care is critical to the health and well-being of the patient. As a surgeon, my patient's safety and well-being were my primary concern and I never told any of my patients to just go to the Emergency Room, expecting someone else to take care of them, not knowing anything about them or their procedure. It has been my experience that when patients are just dumped on the Emergency Room staff without any continuity of care, information critical to their care and well-being is unavailable, putting their lives and health at risk.

41. Having hospital privileges is especially important in urgent life-threatening emergencies where time is critical. The physician who has admitting privileges at a hospital is able to expedite transfer of the patient to the hospital where they can receive the care they need, saving valuable time and possibly saving the woman's life. The physician then has the ability to care for the patient herself, but if unable to do so, she is required to have someone who is covering for her, to whom she can pass on critical information about the patient and the procedure maintaining the continuity of care.

42. Physicians with hospital privileges are more likely to admit a high-risk patient to the hospital to do her abortion rather than risk her life by doing it in a clinic setting.

43. Requiring hospital privileges also solves the problem of itinerant surgery where the abortionist flies in from out of state, then leaves as soon as he is done, relying on the local Emergency Room to handle any problems.

44. Similar facilities, like surgery centers, are required by law to have a transfer agreement with a hospital or to ensure that all their practitioners have admitting privileges at a local hospital so that if there is a complication, the surgeon or someone he has a relationship with can handle the problem ensuring adequate care and follow-up. Patient safety and continuity of care are a priority.

45. There was a proposal to eliminate this requirement for surgery centers, but it failed for fear that patient care and safety would be compromised.

46. According to a study which looked at abortionists in Florida between 2011 and 2016, 55.3% had hospital privileges. Those with hospital privileges were significantly more likely to be board-certified and be eligible for Medicaid payments, both of which are quality indicators.[21]

47. As I was reviewing 199 Mifepristone adverse events, I was struck with the callousness of many of the abortion clinic staff when it came to handling complications. Invariably it was a non-physician who handled the call and most often the

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[21] Studnicki, J. (2019, April 15). Doctors Who Perform Abortions: Their Characteristics and Patterns of Holding and Using Hospital Privileges. *Health Services Research and Managerial Epidemiology*, *6*, 1-8. Retrieved Dec 02, 2019, from https://joumals.sagepub.com/doi/10.1177/2333392819841211.

patient was just told to go to the Emergency Room. Frequently the patient was told her complaint was nothing to worry about, but she ended up going to the Emergency Room on her own, because her symptoms were so severe. Several of these women would have died had they not gone to the Emergency Room when they did.

48. In summary, requiring hospital admitting privileges improves and safeguards patient care.

49. For all these reasons, I support the Louisiana law requiring hospital admitting privileges.

Further Affiant sayeth not."

/s/ K Aultman MD
Kathi Aultman MD, FACOG

SWORN TO AND SUBSCRIBED BEFORE ME, the undersigned authority, on this 7 day of Dec 2019.

/s/ Misty Flores
NOTARY PUBLIC IN AND FOR
THE STATE OF FLORIDA

Notary Public, Clay County, Texas
My Commission Expires: Jan 02, 2022

[Notary Stamp]

APPENDIX D

Affidavit of Dr. Anthony Levatino

STATE OF ARIZONA	§	KNOW ALL MEN BY
	§	
COUNTY OF PINAL	§	THESE PRESENTS

BEFORE ME, the undersigned authority on this day personally appeared Dr. Anthony Levatino, M.D. who is personally known to me, and after being by me first duly sworn according to law on his oath did depose and say that:

1. "My name is Dr. Anthony Levatino. I am over the age of eighteen (18) years of age and I am fully competent to make this Affidavit. I reside in Pinal County, Arizona. I have personal knowledge of the facts stated herein and the following is true and correct.

2. I graduated from Albany Medical College in 1976 and started doing abortions in 1977 in New York State during my OB residency.

3. I am a Board-Certified OB/Gyn with 43 years of medical experience. I am both a physician and lawyer. I taught as an associate professor of OB-GYN at Albany Medical Center, where I also served as the Medical Student Director and Residency Program Director. At the time, I had strong pro-choice beliefs.

4. In five years, I performed over 1,200 abortions in the first and second trimesters.

5. In 1984, however, my five-year old adopted daughter was struck by a car. She died in our arms in the ambulance on the way to the hospital. That event had a profound impact on me. Everything changed and doing abortions was too hard on me. I decided to stop doing abortions.

6. I have testified before Congress and have done videos on the abortion procedures during the first, second, and third trimesters to provide full and accurate information on these procedures.

7. I have practiced obstetrics and gynecology in Florida, New York, and I currently practice and teach in New Mexico.

8. Based on my 40 years of experience, I believe that it is important that physicians doing an abortion have hospital admitting privileges. I personally have hospital privileges and understand the criteria for privileges and the necessity for hospital admitting privileges.

9. In the early 1980s, I had a case of an 18-week D&E procedure that went wrong and illustrates the reason for needing admitting privileges.

10. I always had admitting privileges and was one of only three physicians that had experience performing D&E abortions in my city. I always performed D&E procedures in the hospital in an operating room with a qualified anesthesiologist in attendance due to the risks of this procedure.

11. Midway through such a procedure, as I was extracting fetal parts, I pulled out my Sopher clamp and instead of having more fetal parts in the clamp, I realized that I had perforated the uterus

and had the patient's intestines in my clamp that had been pulled through the uterus and vagina and were now exteriorized.

12. Uterine perforation with injury to bowel is a known complication of this procedure. This was obviously a serious emergency but care of the patient was immediate as she was in a sterile environment. I completed her abortion and a surgeon assisted me in repairing the damaged bowel.

13. If the D&E had been performed outside the hospital by a physician without admitting privileges, she would have been placed in an ambulance, dumped into a local emergency room and her care would have been left in the hands of an OB/Gyn who not only was a stranger to the patient, but likely would have NO experience in performing second-trimester D&E abortions. That physician would then be facing care of a patient who was a stranger with an incomplete 18-week abortion, a perforated uterus, and a bowel injury.

14. This is clearly not in the best interest of the patient. For the health and safety of women, individuals performing an abortion should have hospital privileges. This is a reasonable requirement for the Louisiana Legislature to enact.

Further Affiant sayeth not."

/s/ Anthony Levatino MD
Anthony Levatino MD

SWORN TO AND SUBSCRIBED BEFORE ME, the undersigned authority, on this 27th day of Dec, 2019.

/s/ Chesnie Wainscott
NOTARY PUBLIC IN AND FOR
THE STATE OF ARIZONA

Notary Public, Pinal County, Texas
My Commission Expires: Apr 6, 2023

[Notary Stamp]