IN THE UNITED STATES DISTRICT FOR THE DISTRICT OF NORTH DAKOTA SOUTHWESTERN DIVISION

MKB MANAGEMENT CORP, d/b/a RED RIVER WOMEN'S CLINIC, and KATHRYN L. EGGELSTON, M.D., Plaintiffs, -vs- WAYNE STENEHJEM, in his official capacity as Attorney General for the State of North Dakota; et al., Defendants.	Civil No. 1:13-CV-071 **AFFIDAVIT OF RONALD F. FISCHER IN SUPPORT OF REPLY BRIEF IN SUPPORT OF THE DEFENDANTS' APPEAL OF MAGISTRATE MILLER'S DISCOVERY ORDER**

STATE OF NORTH DAKOTA)
)SS
COUNTY OF GRAND FORKS)

Ronald F. Fischer, being first duly sworn, on oath deposes and states the following:

1. I am one of the attorneys for Defendants Wayne Stenehjem, Attorney General, Larry Johnson, M.D., Robert Tanous, D.O., Kate Larson, P.A.C., Norman Byers, M.D., Cory Miller, M.D., Kayleen Wardner, Gaylord Kavlie, M.D., Kent Martin, M.D., Kent Hoerauf, M.D., Burt Riskedahl, Jonathan Haug, M.D., Genevieve Goven, M.D., Robert J. Olson, M.D. (hereinafter collectively referred to as "State Defendants") in the above-entitled matter and am familiar with all the pleadings and proceedings herein.

2. Attached hereto as Exhibit A is a true and correct copy of the transcript of Kathryn Eggleston's deposition taken November 26, 2013.

3. Attached hereto as Exhibit B is a true and correct copy of the transcript of Tammi Kromenaker's deposition taken November 26, 2013.

Dated this 24th day of December, 2013.

/s/ Ronald F. Fischer
Ronald F. Fischer

Subscribed and sworn to before me in Grand Forks County, State of North Dakota by Ronald F. Fischer this 24th day of December, 2013.

/s/ Illa Engel
Illa Engel
Notary Public for the State of North Dakota
My Commission Expires: Sept. 30, 2016

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
SOUTHWESTERN DIVISION

MKB MANAGEMENT CORP, D/B/A RED RIVER WOMEN'S CLINIC, AND KATHRYN L. EGGLESTON, M.D.,	)	Civil No: 1:13-CV-071
Plaintiffs,	)	
-vs-	)	
BIRCH BURDICK, in his official capacity as State Attorney for Cass County; WAYNE STENEHJEM, in his official capacity as Attorney General for the State of North Dakota; and LARRY JOHNSON, M.D.; ROBERT TANOUS, D.O.; KATE LARSON, P.A.C.; NORMAN BYERS, M.D.; CORY MILLER, M.D.; KAYLEEN WARDNER; GAYLORD KAVLIE, M.D.; KENT MARTIN, M.D.; KENT HOERAUF, M.D.; BURT RISKEDAHL; JOHNATHAN HAUG, M.D.; AND ROBERT J. OLSON, M.D., in their official capacities as members of the North Dakota Board of Medical Examiners,	)	
Defendants.		

D E P O S I T I O N

of

KATHRYN EGGLESTON M.D.

November 26, 2013

8:30 p.m.

Taken at: JOE TURMAN OFFICES
505 North Broadway, Suite 207
Fargo, North Dakota

REPORTER: KRISTEN M. KEEGAN

(PURSUANT TO NOTICE)

APPEARANCES

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COUNSEL FOR PLAINTIFFS

Also Present: Tammi Kromenaker

INDEX

EXHIBITS

WHEREUPON,
the following proceedings were had to-wit:
KATHRYN L. EGGLESTON, a witness, called by the State Defendants, being first duly sworn, testified on her oath as follows:
BY MR. GAUSTAD: EXAMINATION

Q. Why don't you just state your name, please.
A. Kathryn Eggleston.
Q. Dr. Eggleston is that the way you want to be referred to?
A. Sure.
Q. My name is Dan Gaustad. I represent, what I refer to as, the state defendants.
A. Okay.
Q. I know that Birch Burdick is a defendant, but I don't represent him, okay. But basically all the other defendants in this case.
A. Okay.
Q. Okay. Have you ever been deposed before?
A. No, I have not.
Q. Okay. Couple of things that we need to probably make sure that we understand here today, some rules of engagement.

A. Okay.
Q. One is, you're doing very well so far, is, you need to enunciate your answers so that the court reporter can take them down. Nodding the head and hand gestures, just don't do it --
A. Okay.
Q. -- 'cause she can't get that down. Another rule is, and I know I'm gonna break this 'cause I -- sometimes I get so darn excited that I speak over people, but let's try not to speak over one another -- I -- 'cause it's hard for her to take down two people talking at once. So, I will try to finish my question, I'll hopefully allow you to finish your answer without talking over each other. I'm sure she'll let us know if we're violating that rule.
A. Okay.
Q. If, at any time, you need a break, let me know. Use the restroom, whatever you need just let me know and we can take a break at any time, okay? The other thing is, I'm not the best question formulator on the face of the earth. I'm gonna be candid with you on that. So, to the extent that you don't understand a question, let

Page 6

me know that --
A. Okay.
Q. -- and I'll try to rephrase it so that you do understand it. Okay? But to the extent that you answer the question, it will be assumed that you understood; is that fair?
A. Yes.
Q. Okay. Are you under any medical condition or medication that would preclude you from being able to answer fully and truthfully here today?
A. No.
Q. Okay. What did you do to prepare for today? Did you review anything?
A. No. Just talked with the -- my lawyers here.
Q. Okay. And I don't want to talk about your communication with your attorneys 'cause you're one of the named plaintiffs, correct?
A. Yes.
Q. Okay. Other than talking to your attorney, did you speak to anybody else in preparation for today's deposition?
A. No, I did not.
Q. Did you review any documents?

Page 7

A. No, I did not.
Q. Have you ever been involved in any prior litigation? Like a malpractice action?
A. I was involved in a malpractice action many years ago in Minnesota.
Q. In Minnesota?
A. Uh-huh.
Q. And were you a defendant? A plaintiff? What were you?
A. So, I would have been a defendant. I had a patient -- a patient's husband, essentially, had claimed that I had provided inadequate care and went through the process. It went to mediation, and I was found that I provided very good medical care and it was dropped.
Q. So when was this litigation roughly?
A. It would have been '98 I bet.
Q. And this was in Minnesota?
A. Yes. No, I'm sorry -- I'm sorry. This is Wisconsin. I was in my residency so this was in Wisconsin.
Q. Okay. And was there an actual lawsuit that was started then in Wisconsin? Do you know what I mean? Like you got a complaint

Page 8

that was handed to you or something like that?
A. Well, we went to -- I'm not familiar with -- I'm assuming -- when people ask me, "Have you been sued for malpractice?" My answer is yes.
Q. Okay.
A. It went to mediation, and I was found to provide good medicine, there was no -- you know, it was dropped.
Q. Okay.
A. So that's as far as it went.
Q. Okay. Do you know --
A. So I'm assuming they went through the pro- -- those legal maneuvers.
Q. Do you remember what the names of the parties were? The plaintiffs?
A. Yes. I don't know if I -- do I -- who sued me? My patient?
Q. Yes.
A. Yes. I'm assuming that I'm not breaking any HIPAA violations by talking about a patient's name?
Q. Well, that was the question. If they brought an action, did they actually serve? Did it get into a court system type situation?

Page 9

A. Yes.
Q. Okay. So tell me the --
A. So then it's public.
Q. -- name.
A. Platt, P-L-A-T-T.
Q. P-L-A-T-T?
A. I believe.
Q. Were you the only defendant?
A. The residency program was named.
Q. Which one? What was that called?
A. Eau Claire Family Medicine Residency.
Q. Anybody else?
A. I do not believe so.
Q. And that's the only other -- that's the only medical malpractice action you've been involved in?
A. That's the only medical malpractice I've been involved in.
Q. Even as a witness or anything like that?
A. I was involved in the medical -- the trial last year in April here.
Q. Okay. But that doesn't -- that didn't necessarily relate to a malpractice action?

A. Exactly. This is the only malpractice.
Q. Okay. Even as a witness in any kind of --
A. Correct.
Q. Okay. The other litigation you've been involved in, you were in the case -- the state court case that's kinda still pending, right?
A. Yeah.
Q. Okay. Any other litigation that you've been involved in? Not just malpractice, anything else?
A. A divorce.
Q. When was that?
A. '99. I don't even -- I'm not even 100 percent sure.
Q. Okay. Are you single now?
A. No. I'm married.
Q. Okay. What's your husband's name?
A. I'm -- I don't feel comfortable answering that question.
Q. Well, what's your husband's name?
A. I don't feel comfortable answering that.

Q. I understand that, but what's your husband's name?
MS. CREPPS: I --
MR. GAUSTAD: I'm just asking. I'm just trying to get some background information.
MS. CREPPS: I know, but that's completely irrelevant and I think well beyond the scope of what the Magistrate has authorized even as background. So I -- if she's not comfortable answering a question and we have other incidents like this, I think we should just make a list of the questions that we don't think she needs to answer and we can get the Magistrate on the phone towards the end and have him sort this out.
MR. GAUSTAD: It's just background information. I think he allowed context and background information. If you're not going to answer the question, just tell me that.
THE WITNESS: I'm not gonna answer the question.
Q. So you're divorced in '99. Any other litigation?
A. No.

Q. And I'm not talking about whether you were a party to it, I'm talking as a witness. Anything?
A. No.
Q. Have you been involved in any type of complaints to like a medical board?
A. No.
Q. Do you serve on any professional boards?
A. Serve on professional boards? No.
Q. Are you a member of any type of -- and I don't know how to -- if you understand what I'm -- like professional --
A. I'm board certified --
Q. Yeah.
A. -- in American Board of Family Medicine.
Q. Okay.
A. I'm a member of the American Academy of Family Physicians, I'm a member of -- for Physicians of Reproduction Health.
Q. Okay. But do you see -- these must have some sort of overseeing board. Those, that you've just described, you don't serve on any of those boards, correct?

A. No.
Q. How about any type of professional societies? Any maybe there's a distinction if you understand what I'm asking? Do you serve on any -- or a member of any type of professional society?
A. The ones I just listed.
Q. Okay. You're a member of it but you don't serve in any like leadership capacity; is that fair?
A. Correct.
MR. GAUSTAD: Would you mark this.
(Deposition Exhibit No. 1 was marked for identification.)
Q. Dr. Eggleston, I'm showing you what's been marked as Deposition Exhibit Number 1.
A. Okay.
Q. Do you have that in front of you?
A. I do.
Q. Okay. And it's about the, I guess, it's the fourth page in, it says Page 5 of 8 at the top.
A. Yes.
Q. Is that your signature?

Page 14

A. Yes.
Q. And, as I understand, this was a declaration that has been submitted to the Court for the Plaintiff's Summary Judgment Motion, and attached to it was your CV?
A. Yes.
Q. Are there any -- and I -- I don't want to go through, I mean, I think it speaks for itself. But, are there any changes since this thing was submitted? This CV.
A. The -- the only thing, I have been promoted to -- the first listing with Planned Parenthood. I'm the Medical Director of Family Planning in addition to the Associate Medical Director and that was since October of 2012. Other than that --
Q. What's the --
A. -- that's the only update.
Q. So there's some additional responsibilities then I presume as a Medical Director of Family Planning?
A. Yes.
Q. Okay. Can you tell me what they are in comparison to what I've got?
A. It's very -- very similar position

Page 15

there. It was more of a reorganization delineation of responsibilities. So, I still think the description is very accurate, and no significant changes in the description.
Q. But you serve in both capacities?
A. Correct.
Q. As the Associate Medical Director and Medical Director of Family Planning?
A. Correct.
Q. But the responsibilities are generally what's described?
A. Yes.
Q. In the CV?
A. Yes.
Q. Okay. Any other changes?
A. No.
Q. And I know I probably asked you this already and I apologize for that. These professional memberships, those are the ones you just described, the American Academy of Family Medicine?
A. Right. I listed -- when I listed it, the American -- the first one, the American Board of Family Medicine, that's under Licensure and Certification.

Page 16

Q. Okay.
A. So, it's a little different than the Professional Membership. That's why it's listed here separately.
Q. I see. And the American Board, you don't serve in any type of leadership position in that organization, correct?
A. Correct.
Q. And you don't serve in any leadership position with respect to American Academy of Family Medicine, correct?
A. Correct.
Q. And that's the same with Physicians for Reproductive Choice?
A. Yeah.
Q. Okay.
A. The Physicians for Reproductive Choice, it used to be Physicians for Reproductive Health and Choice. Now it's Physicians for Reproductive Health.
Q. Just changed the name?
A. I just saw that. Yeah. So, I just saw that correction.
Q. Oh, okay. So that should be changed to just the name --

Page 17

A. They just changed the name.
Q. Okay. How about with Abbott Northwestern, any leadership capacity there?
A. No.
Q. And as I understand, you're a family medicine physician?
A. Yes.
Q. And I'm trying to get a sense as to what that is in comparison to an OB/GYN. What distinctions are there? What can you -- well maybe it's -- an OB/GYN probably takes more years of education; is that fair --
A. No.
Q. -- or not?
A. No. It's a different residency program.
Q. Okay.
A. That's the main difference. And then who you're certified -- to be board certified in family medicine, you need to go to an approved family medicine residency to be board certified. With ACOG, you would need to go to an OB/GYN residency program.
Q. Okay. Are there things that an OB/GYN can do -- some procedures an OB/GYN can do

Page 18

that you can't do as a family medicine physician?
A. Not -- there isn't a list of things that can't be done. It's all about training and being able to provide those procedures safety to patients and have -- be able to prove you that you can do that.
Q. Have you ever been in a situation where you have been asked to perform a procedure and have not been able to because you don't have -- I'm not OB/GYN, and I'm not qualified to do that type of procedure?
A. No. The -- for instance C-sections, I don't -- I was never trained to do C-sections but some family medicines are -- physicians are. And when they're taking care of their labor and delivery patients, they could do their own C-section. And, when I was delivering and doing full, essentially, OB/GYN -- or full OB for my family medicine patients, I would consult or refer for an OB- -- an OB/GYN would do the C-section. I would not do that.
Q. Okay. But generally speaking then, an OB/GYN can do C-sections; is that fair? And a family medicine physician needs to be trained in that particular procedure?

Page 19

A. In that particular example, true. So, a lot of the focus for OB/GYN is more surgical based, you know, hysterectomy, you know, bladder slings, pelvic reconstructive surgery, that type of thing.
Q. Okay.
A. That is more -- that -- their scope is more surgical versus a lot of family medicine is, you know, outpatient procedures, more outpatient care.
Q. Okay. So, have you ever been trained to do a C-section?
A. I have never tried to do a C-section.
Q. What other surgical procedures then do you then refer to an OB/GYN?
A. Oh, I can't even --
Q. There's a number of them?
A. A number of them.
Q. Do you do any type of surgical procedures?
A. I do quite a few outpatient surgical procedures.
Q. Okay. Just give me some examples of, you know, patients that you have -- abortions I know you do --

Page 20

A. Uh-hum.
Q. -- that would be described as an outpatient surgical procedure?
A. Uh-hum. D&Cs, endometrial biopsies, colposcopy, wart removal, lesion --
Q. You might have to slow down for the court reporter.
A. Sure. Skin lesion, toenail removal, stitches, casting, I could -- I would need time, but I could probably keep going for some time.
Q. Okay. And, the C-section is something you would refer on to an OB/GYN. Can you give me another example of a surgical procedure that you would refer on to an OB/GYN?
A. For -- like -- so something that I'm -- first of all, when you do a referral, it's up to the physician to do the -- to make the decision whether that needs to be done. You know, so I'm not going to tell the OB/GYN, you know, this patient needs a C-section. I would say I suspect and it's going to be up to that physician to, essentially, give a second opinion and do the procedure that they think is appropriate.
Q. And that's fair. What I was asking

Page 21

was: You identified C-sections as something --
A. Oh, sure.
Q. -- you're not qualified to do.
A. Sure.
Q. I'm just trying to --
A. Tubal ligation.
Q. Okay. That would be something that, if the patient needed it, that would be something that --
A. Right.
Q. -- would be something you couldn't do?
A. Exactly. That's not an outpatient procedure. Well, there's a new procedure that's an outpatient procedure but typically the straight for- -- which has been done for many, many years tubal ligation is done in the OR. It is not an outpatient procedure.
Q. Okay. Are there different rules of standards that you have to follow versus an OB/GYN has to follow? You follow like -- your -- like the American Board of Family Medicine, if an OB/GYN is involved in that or your various licensing from various states, are there different rules for you as a family medicine

Ex. A

Page 22

physician?
A. No. I could be trained. I could be trained to do C-sections, I could be trained to do tubal ligations. If I lived in a very rural community, maybe that would be something that would be worth while but from where I have practiced and now, I don't need those skills, so I wouldn't do that. So, there's not a -- there's not a rule that a family physician can or cannot do this.
Q. Okay.
A. And typically, there are not rules from, you know, ACOG or other groups that say their physicians can or cannot do this.
Q. And I'm just talking, you know, I mean for example, the state board for North Dakota, I presume, issues rules and regulations that apply to the practice of medicine. Would that be a fair -- I mean generally?
A. They -- they licensed -- they are confirming that you are licensed to practice. And there are certain, you know, rules and regulations that are from the federal level and lots of them but they're not specific to you -- you as this specialty can or cannot do this, this

Page 23

specialty can or cannot do that.
Q. Okay. But what I'm trying to get at is: If a rule is say promulgated by the state board, for example, there are the -- you don't practice under a different set of, like, ethical rules or standards of care rules that an OB/GYN would -- would be practicing under --
A. Correct.
Q. -- with the exception that I might not be able to perform a certain procedure?
A. Correct. We're all under the same requirements of standard of care and ethical and HIPAA and all that.
Q. Okay. And I'm looking at your CV, it looks like, from what I can tell, you're -- you've been engaged in or performing either medical or surgical abortions since about 2000; is that about --
A. Yes. I was trained in 1999.
Q. Okay. So I was pretty good on my -- on my evaluation of your CV here. How much of your practice, percentage wise, is dealing with either medical or surgical abortion versus, you know, the stitching that you talked about earlier?

Page 24

A. The -- currently, my practice is 100 percent reproductive healthcare.
Q. Okay.
A. And of that, approximately 50 percent is directly related to medical and surgical abortion related.
Q. And when you -- and I'm trying to get a sense what you meant my directly related to. Are you actually --
A. Well, performing the procedure, follow-up appointments, that type of patient -- patient care.
Q. Okay. So when you say "directly related" it's performing the procedure and/or following up afterwards?
A. Yes.
Q. Okay. Anything else when you say 50 percent is directly related to medical or surgical abortions?
A. Continually, you know, continually, we are making sure that -- as you can see from my CV, I have a lot of medical director and associate medical director, so we work on protocols, we make sure things are up to date, but I think in general, still 50 percent is --

Page 25

it's hard for me to say if you're -- I guess are you asking patient contact or just time?
Q. Well, tell me --
A. It's very close -- I think it's very close to 50 percent. Most of that would be patient -- direct patient care.
Q. Okay.
A. And a small portion would be related to reviewing charts and reviewing blood test results, et cetera --
Q. And that's all --
A. -- related to abortion.
Q. -- and that's all related to the procedure itself --
A. Yes.
Q. Right? Okay. How much of your time then is spent for these protocols?
A. Different capacity with each -- each job. It's more of a continual. I feel like we're always working on wether it'd be protocols or improving patient flow, paperwork, and making sure that things are running efficiently whether it's the clinic or, you know, whether it's the clinic here or where I work in Minnesota and South Dakota.

Page 26

Q. Kind of management type of stuff?
A. Yeah. Exactly.
Q. How much is that? Do you -- you've got 50 percent actually involved in the procedure, how much is quote "management"?
A. Management. 30- --
Q. I'm not trying to --
A. Off the top of my head, 35 percent --
Q. Yeah, and I'm --
A. -- and probably 15 percent of other direct patient contact, family planning.
Q. That's not an abortion procedure or abortion protocol, right?
A. Right.
Q. The locations -- and I didn't -- the first one, this -- that you're now the Director of Family Planning, it says, "Planned Parenthood MN, ND, SD." Where is that? I mean is there a clinic -- for example in your second line of your CV, it says, "Medical Director present Women's Clinic in Fargo." I know where that's at.
A. Uh-hum.
Q. And then Women's Health Center, Duluth. So you've identified particular spots. I'm trying to figure out where this Planned

Page 27

Parenthood MN, ND, SD is?
A. Planned Parenthood has different affiliates. So, our Planned Parenthood affiliate involves Minnesota, North Dakota, South Dakota. We do not have a clinic in the State of North Dakota but an advocacy office, and there's two clinics in South Dakota and 20 clinics in the State of Minnesota. I'm not exact on the number of clinics in Minnesota. There's been a few changes.
Q. Do you then go to these two locations in South Dakota to perform abortions?
A. I have. Abortions are performed at the Sioux Falls Clinic not at the Rapid City, so I've been to both clinics.
Q. Okay.
A. But abortions are provided at Sioux Falls.
Q. Okay. And do you then go to -- are you the one that goes to the Sioux Falls Clinic to perform the abortions?
A. I'm one of the physicians.
Q. Okay. And there is no clinic in North Dakota for Planned Parenthood, correct?
A. There's no -- right.

Page 28

Q. But you mentioned a patient advocacy. What's that?
A. A med patient advocacy --
Q. I may have miss heard you. I'm sorry.
A. There's an office --
Q. Okay.
A. -- in -- in North Dakota.
Q. Okay. Are you involved in that office?
A. I'm not.
Q. What does that office do? Do you know?
A. That office works on -- for instance, the Planned Parenthood and, this is not my area of expertise, but Planned Parenthood and NDSU are working on teaching sex ed, and so that office helps promote that program or give support when needed.
Q. Okay. But your time isn't -- the time that was just gone through isn't committed to any of that, correct?
A. Correct.
Q. And then you're in the -- you're in the Fargo office. As I understand, you come here

Page 29

one day a week?
A. Approximately.
Q. Approximately. And how many days are you in Duluth?
A. One to two times per month.
Q. Okay. And when you're in the Fargo clinic, how many abortions are you performing when you're here on a daily basis? And I'm talking both medical and surgical.
A. And surgical. I don't -- I don't have the -- I can know approximately, but I don't -- I'm sure other people at this table know more about that number than I do.
Q. I don't though.
A. I would -- I would say probably right around 20 to 22.
Q. Okay. Are you the only one that performs the abortion procedure in the Fargo clinic?
A. I'm not -- when I -- physicians provide the abortion. I'm not the only physician.
Q. Okay. There are other physicians that perform abortions?
A. Correct.

Page 30

Q. Okay. I'm not asking just -- do you know how many?
A. Other physicians?
Q. Yeah.
A. There are three of us.
Q. Okay. Are they also located -- do they come from the Minneapolis -- or come from outside the Fargo area and --
A. They -- neither one of them live in North Dakota.
Q. Okay. And that's done once per week, correct? So all three of you come together one day a week or do each one of you come on different days?
A. Different days.
Q. Okay. Do you know how many abortions those other physicians are performing when they come?
A. I would believe it's very similar.
Q. 20 to 22?
A. Yes. And I -- I'm not saying that I know that number exact. That's my estimate.
Q. I'm not trying to lock you into a precise number --
A. Right.

Page 31

Q. -- I'm just trying to get a sense.
A. Okay.
Q. And are you -- what days do you come up?
A. I'm here typically on Wednesdays.
Q. Okay. Except for today, it's a Tuesday. What about the other physicians? Do you know what days they usually --
A. Their schedule is more variable.
Q. Okay. But they come up once a week too, correct?
A. No.
Q. Okay. How often?
A. So typically --
Q. Let me step back. You're coming up once a week, Wednesdays?
A. Not 100 percent, but generally.
Q. And I thought I read something it was like 50, 45 to 50 weeks per year?
A. Correct.
Q. Okay. These other physicians, how often do they come up then? Do they come up --
A. So, our clinic is typically opened one day a week for providing abortion services.
Q. Okay.

Page 32

A. And I'm the main -- I'm here the most.
Q. Okay.
A. And so they -- when they come, I'm not in the clinic, it's on at different day. Some days -- some weeks it does work out -- on occasion, it works out that we have two clinics in the same week but the majority of the time, it's one clinic.
Q. Okay. So those weeks that you're not here, one of these other physicians come in and kind of fill in for you. Is that kinda the way it works?
A. Yes.
Q. I probably should ask you this: Do you perform any type of, you know -- and I've read research upon research upon research and data in this case and, you know, have you done any type of research as far as reproductive -- published any type or articles or --
A. I've never published. I've -- I see patients. I'm not one of the -- the researchers, so I've not been published.
Q. Okay.
A. But I keep up to date on journal --

Page 33

you know, journal articles, that type -- attend conferences and speak with colleagues and speak with people who are researchers.
Q. Sure. Who -- what type of people -- do you have a name of a researcher that you speak to often?
A. No. But -- I mean at conferences. So, for instance, they would give a talk and if I had a question, I'd go up and talk to them afterwards type of thing.
Q. Are those conferences usually done by Planned Parenthood or --
A. There are some Planned Parenthood conferences. The National Abortion Federation has a conference a couple times a year.
Q. Do you go to that regularly?
A. Once a year usually.
Q. And do you -- you usually attend that?
A. Yes.
Q. Okay. Have you ever presented at the National Abortion Federation conference?
A. I have not.
Q. Have you ever been involved in any type of teaching?

Page 34

A. I teach medical students and residents on a regular basis.
Q. Is that -- is that teaching done in the Fargo clinic?
A. No.
Q. Where is that teaching done?
A. That's done at the -- when I work with Planned Parenthood either, essentially, at the Vandalia, the main clinic. It's in St. Paul.
Q. How long have you been doing that?
A. Ever since I started there. So, October of 2010.
Q. Oh, for the last about three years or so?
A. Yeah. And actually, I have worked -- when I was with Midwest Health Center for Women, we had students and residents come through us. And, at -- on occasion, the other two. But, essentially, I've always been involved with students and residents.
(A brief break was taken.)
Q. All right. Dr. Eggleston, we're back on the record. You understand you're still under oath?
A. Yes.

Page 35

Q. Okay. One of the things that I noted is: Under your -- in your CV, that you develop and implement clinical oversight of patient care and medical protocols, ensuring adherence to NAF standards of care. Do you see that?
A. Uh-hum.
Q. Is that the National Abortion Federation?
A. National Abortion Federation.
MR. GAUSTAD: Would you mark this.
(Deposition Exhibit No. 2 was marked for identification.)
Q. Showing you what has been marked as Exhibit Number 2, do you have that in front of you, Dr. Eggleston?
A. Yes.
Q. And it's the -- reads, "2013 Clinical Policy Guidelines, The National Abortion Federation?
A. Correct.
Q. Have you seen this document before?
A. Yes.
Q. Were you involved in preparing any of this?

Page 36

A. No.
Q. And referring back then to your CV, is this the type of standards of care that you're implementing or --
A. Correct.
Q. -- assuring adherences to this? Is this the standard of care that you're referring to in your CV?
A. Yeah. So, these are used as a guideline to help make sure that protocols at individual clinics are meeting the recommendations, policies, and requirements.
Q. Okay. And you use these as guidelines for protocols for the Fargo clinic, correct?
A. Correct.
Q. And, as I understand it, if there's a standard that's issued in these guidelines, that's something that is required to be incorporated within your protocols. Is that your understanding?
A. I can read the definition of the standards.
Q. Where are you referring to?
A. Three. The --

Page 37

Q. What page?
A. I, three I's.
MS. CREPPS: Three little I's.
THE WITNESS: Yeah.
Q. Okay.
A. "Standards are intended to be applied rigidly. They must be followed in virtually all cases. Exceptions will be rare and difficult to justify."
Q. And do your protocols then follow these standards?
A. Yes.
Q. And then the recommendations are quote "steering in nature," correct?
A. Correct.
Q. Is there -- so that gives you some discretion as to whether you're going to follow the recommendation or not?
A. Correct.
Q. Can you recall a recommendation that you haven't followed within this?
A. I would have to go through them individually.
Q. Okay.
A. I do not know the answer.

Q. But are there some? I'm not asking --
A. I'm not aware that we are out- -- I think we are -- we follow the standard of care, and I'm not aware off hand of an exception to that --
Q. Okay. You --
A. -- but I would need to go through them individually to be able to answer that question.
Q. Okay. You use the word "standard of care."
A. Yes.
Q. Is that different than standards that are in this clinic guideline?
A. So, when I say "standard of care," what I'm referring to is what -- any kind of medicine, what is typical for a disease or an illness, you know, for instance pneumonia, there's -- in certain areas of the nation, this is what they do. This is -- doesn't mean you have to do it but the majority of the time, that's what is recommended in the -- and people have agreed to that.
Q. Okay. But a standard would have to

be a standard of care, correct? A standard that's set forth in this National Abortion Federation?
A. Standards of care are not -- this is a very focused document --
Q. Uh-hum.
A. -- on standards related to NAF clinics or to be certified at a NAF clinic.
Q. Okay.
A. Standard of care is a much more broad definition that all of medicine uses.
Q. Sure.
A. And I wouldn't say is written down or defined like that.
Q. Okay. But if -- in -- and I'm just trying to get my mind around because it says, "standards are to be applied rigidly." Do you see that?
A. Uh-hum.
Q. And as I understand, your protocols follow those standards, correct?
A. Yes.
Q. Okay. So with respect to abortion procedures, wouldn't the standards be the standard of care?

A. I suspect, yes.
Q. Okay. And the recommendations are something then that you get to -- you guys have some discretion as to whether this is something we're going to follow or not?
A. Correct.
Q. And options are even more discretionary?
A. Correct.
Q. Okay. Are there any other guidelines or standards that you're referring to here in this adherence to NAF standards of care? Other than what's been marked as Exhibit Number 2?
A. No. That would be it.
Q. And this also deals with the clinical quality standards as well, correct? Exhibit Number 2?
A. Where are you?
Q. I'm looking at your CV. You're saying that part of your job duties with this Fargo clinic is to ensure adherence to NAF standards of care, correct?
A. Correct.
Q. And adherence to clinical quality standards?

A. Yes.
Q. Are -- let me ask the question.
A. Okay.
Q. As I understand, Exhibit Number 2 sets forth the standard -- NAF standards of care, correct?
A. Correct.
Q. Does Exhibit Number 2 also set forth the clinical quality standards?
A. True. I think this is part of that but there's more that goes into clinical quality standards. For instance, we have certain -- when you have a -- he have a hemoglobin machine that checks your blood level and there's -- it comes with expectation that this is how you're going to use it and it's gonna be, you know, evaluated on x many months, so those type of -- so there's more that goes into that.
Q. That's kind of like a manufacturer saying, hey, we can change --
A. True. But --
Q. -- batteries periodically, right?
A. True. But in lab and medicine, those are more important then just changing a battery.
Q. And it was an analogy, but it's a

Ex. A

Page 42

manufactures type of, here you've got this piece of equipment, these are the things you need to do to make sure it works properly?
A. We have a lab that goes through the proper evaluations. So, there is more standards related to that.
Q. Okay. And who does the lab evaluations?
A. We have a physician who's -- is the lab director.
Q. Of the clinic?
A. Yes.
Q. And that's not within the confines of your job duty?
A. Correct.
Q. You don't oversee -- is he your peer then? Or is it somebody that you oversee to make sure that they're meeting these quality standards?
A. More of a peer.
Q. Okay. He's not an outside consultant though, is he? And I refer to him as he, I don't know if it's a he or she?
A. It's a he. And I don't know the specifics of that arrangement, whether he's a

Page 43

consultant or salaried.
Q. Is he one of the physicians that performs the abortions?
A. No.
Q. Okay. And again I -- I'll have to apologize, I've got a few things on my mind, but I think I may have already asked you this: This Exhibit 2, is the NAF standards of care that you refer to in your CV?
A. That's what I was referring to.
Q. And the clinical quality standards you refer to, some may be in Exhibit Number 2 but there's some others that exist because of the -- the labs or equipment that you've got? Things like that.
A. Correct.
MR. GAUSTAD: Would you mark this.
(Deposition Exhibit No. 3 was marked for identification.)
Q. Dr. Eggleston, I'm showing you what's been marked as Deposition Exhibit Number 3. Do you have that in front of you?
A. Yes.
Q. Okay. And it's a, looks like a, four

Page 44

page document. As I understand, this was introduced as an exhibit during the State Court action that it must have occurred about in April of this year. Have you seen this document before?
A. Yes.
Q. Is this something -- the protocols that you prepare as part of your job duties with the clinic --
A. Yes.
Q. -- here in Fargo? Okay. And these protocols then meet the standard of care that's marked as Exhibit 2, correct?
A. Yes.
Q. And I should have asked you this: Other than Exhibit 2, are there other National Abortion Federation standards that you're aware of? Other than these clinical policy guidelines that you used to develop your protocols?
A. No. Not that I'm aware of.
Q. Okay. Exhibit 2 is what you use to prepare your protocols, correct?
A. Correct.
Q. And I didn't -- I don't have an abortion or surgical abortion protocol. This is

Page 45

for your medication abortions, correct? Exhibit Number 3.
A. Correct.
Q. Is there a surgical abortion protocol similar to Exhibit Number 3?
A. Yes.
Q. And you're the one that's charged with preparing these type of protocols like Exhibit Number 3, the surgical protocols?
A. Well, they were first developed prior to me being the medical director.
Q. Before you became medical director?
A. Right.
Q. Okay.
A. And so they were developed by somebody else and they are periodically reviewed and updated.
Q. Okay. And that's your job is to review them to make sure, geez, are we meeting the standard of care that the National Abortion Federation wants us to meet?
A. Right. And usually -- yeah. I'll just say yes.
Q. How often do you go through your protocols?

Page 46

A. We don't have a set schedule.
Q. Generally? I mean sometimes I've got books that I put on the shelf and I never look at again. I presume you look at these?
A. We -- because I attend conferences and involved with, whether it's a NAF conference or Planned Parenthood, we commonly learn new things and update our practice everyday, you know, I mean, regularly. Whether the paperwork is updated, there's definitely a lag and sometimes it -- we may change something and it's lag before the paperwork is updated.
Q. Okay. Is there -- in looking at Exhibit Number 3 -- is there a lag? Is there something in Exhibit Number 3 that's --
A. I've not looked at it since April and since that in detail, so I can read it right now.
Q. Sure.
A. (Reviewing document.)
MR. GAUSTAD: We can go off the record.
(A discussion was held off the record.)
Q. Dr. Eggleston, you understand you're still under oath?

Page 47

A. Correct.
Q. Okay. And you had an opportunity to review Exhibit Number 3?
A. Yes.
Q. Okay. And I think the question was: Is there something in here that is -- is there some procedure that's lag? That's not noted in Exhibit Number 3?
A. So, these are just the -- on the last page, it refers to a follow-up visit. There was something -- hold on a minute, sorry.
Q. You're reading under the conclusion of treatment?
A. And I'm just gonna scratch that. I don't have a comment, it was more of a typo and it's fine. There is a lot of reference in here to ultrasound, it's in a couple different locations and different type of wording is used. So, to make it -- I could make edits to this to make it a little bit more clear, but I feel overall this is accurate.
Q. Give me an example of where you would make an edit to make it more clear?
A. So, on 1B should have gestation no more than 63 days from the first day of the last

Page 48

menstrual period with concordant clinical examination. Conformation by ultrasound may be used routinely and conformation by ultrasound is used routinely. So, I wouldn't say it's an error, but that is what is routine in practice.
Q. Anything else?
A. The same thing. There was another reference to ultrasound. For instance, ultrasound examination will be used routinely.
Q. Where are you reading?
A. Under -- page 2, ultrasound examination.
Q. Okay.
A. So just to make sure that those two are consistent.
Q. But that's what it reads.
A. Right.
Q. It says, "ultrasound will be used to obtain," there shouldn't be a change with that?
A. Correct.
Q. Any other change that you would -- to make it more clear?
A. No. I believe that -- I believe that there was a few changes made to this within the last one year, and I can't pick them out, and I

Page 49

think they were small changes. It's hard for me to concentrate to read through it -- every -- but this, overall --
Q. Do you -- are you having difficulty concentrating? 'Cause if you are, let me know if you need a break or --
A. Well, in general, this document is correct.
Q. Okay. And there is a protocol for surgical procedures similar to what we've got here for medical abortions?
A. Similar, yes.
Q. Okay. And I want to kind of go through and make sure that conceptionally 'cause I don't have that document, and I apologize for that, and I'm trying to utilize your memory as best as you can for the surgical procedure to go through these.
Is there -- in the surgical abortion protocol, is there an eligibility section do you know? This one is pretty detailed as far as medical abortions are concerned. Is there an eligibility --
A. Yes. And I'm not -- I can't comment whether it is as detailed but there is an

Page 50

eligibility. Whether it's separated out under eligibility, I can't remember the layout.
Q. Sure. But there's an eligibility --
A. Correct.
Q. -- component to the surgical abortion?
A. Correct.
Q. Can you tell me what those eligibility components are for a surgical abortion?
A. I can tell you more what they are in practice. I can't verbatim give you our surgical --
Q. And I'm not asking -- that wouldn't be a fair question. I'm just -- generally from your knowledge what the eligibility components are?
A. So, we -- the eligibility that the women desires an abortion, has met -- is not being forced to be there, that the decision is her own, that she's been informed and consented to the procedure, we evaluate -- from an exam perspective, we evaluate their hemoglobin to make sure it's safe, vital signs, general nature, that they are, essentially, have stable vitals and are

Page 51

in good health. To -- essentially, to confirm that it's safe for them to have an outpatient surgical abortion. We use ultrasound to confirm an intrauterine pregnancy and evaluate the gestational age.
Q. How do you determine if they want -- first, that they desire to have an abortion and are not forced? How do you make that assessment?
A. By talking with the woman by herself without other people around and --
Q. Do you do that?
A. I do that at the time -- yes. When I speak with the patient, I confirm that, and it is also done -- that question is asked prior to them seeing me.
Q. And do you ask that question?
A. I'm sorry?
Q. Do you ask the question whether they desire to have an abortion?
A. Yes.
Q. And when does that -- when does that happen?
A. Prior to the abortion.
Q. Are they in the exam room then with you or is there a separate room?

Page 52

A. They're either in the exam room or a separate room.
Q. Generally, are you asking this question in the examination room or in the separate room?
A. Most of the time it is in the exam room.
Q. Who else is in the exam room?
A. Frequently there is another staff member.
Q. Anybody else? And the patient?
A. And the patient.
Q. And you?
A. Uh-hum.
Q. Anybody else?
A. No. Possibly an additional staff member but no other partner or family members are not present.
Q. Why?
A. A variety of reasons. Number one, to confirm this is her decision without feeling pressured by other friends, partners, family; second of all, we want to focus on the patient rather than having extra people that we need to focus on.

Page 53

Q. How do you determine whether this other staff person is going to be in the exam room when you're performing an abortion?
A. It just has to do with timing. So, the other staff member is in the room during the abortion. Whether they are in the room when I -- prior to the abortion, when I'm speaking with the patient.
Q. And then the informed consent, that's by state they have to sign off on something, correct?
A. Uh-hum.
Q. Anything else with the -- that you can recall as far as eligibility for a surgical abortion other than what we just went through? We went through I think seven of them. Is that you're not being forced, informed consent, you do their vital signs, hemoglobin, their general nature of their health.
A. So, similar -- there are medical -- if they have a bleeding disorder, it may or may not be safe for them to have an outpatient procedure so we would do, you know, further evaluation.
Q. You were referring to -- you're

Page 54

pointing to Exhibit Number 3. Is there something in Exhibit Number 3 that would --
A. Well, hemorrhagic --
Q. -- explain why?
A. -- Number 1, a hemorrhagic disorder, or concurrent anticoagulant therapy.
Q. Okay.
A. So that can be a contraindication to surgical or medical abortion.
Q. Okay. Anything else?
A. Very -- a very similar list. If they had a -- if we could not -- like I had told you before, we need to confirm it's an intrauterine pregnancy so that would -- that's in reference to Number 1.A.4.
Number 6 there, an IUD in place. That is a contraindication for medical abortion. That is not a contraindication for a surgical abortion.
Q. Okay.
A. And then Number 7: History of allergy to mifepristone, misoprostol or other prostaglandin. That would be not a contraindication to a surgical abortion.
Q. 6 and 7 are not issues with respect

Page 55

to surgical abortion?
A. Correct.
Q. Okay. And looking at the Counseling, Education, and Informed Consent in Exhibit Number 3.
A. Uh-hum.
Q. Is this generally what you go through with respect to a surgical abortion?
A. Number 1, yes. Number 2, so, that's not -- discussion of non-surgical and suction abortion alteratives; so, essentially when someone has a medical abortion, we also talk about if it does not work, we would need a surgical so would have to educate them both.
Q. Okay.
A. So that would limit the education portion. So we would not talk about the side effects of mife and miso, and so, that whole Number 3 section is not related. Number 4, that would not be discussed. Number 5, we do talk about what to expect afterwards and how long the procedure is. Number 6, we give the patient typically 800 milligrams of Ibuprofen before the procedure, so that's discussed. It's a little different -- the -- when you do a -- when they

Page 56

talk about Number 8, it's about what to expect at home.
Q. Number 7 is probably not something you discuss in a surgical abortion?
A. Only if the patient is receiving misoprostol.
Q. Okay.
A. So some surgical patients do receive misoprostol.
Q. Okay.
A. Number 8, what to expect at home after their -- after the surgical abortion. We review that. And there's not a medication guide, Number 9. Number 10, we're in compliance. I'm not sure how that's necessarily discussed but we're in compliance. And confidentiality is discussed and after care instructions, 24-hour emergency contact is discussed and contraception is discussed.
Q. How about under the Medical History and Physical Examination. Are these, the four items there listed, generally what is the protocol for a surgical abortion as well?
A. Correct. Once again, being consistent with ultrasound is used routinely.

Page 57

Q. Where are you referring?
A. So, Number 4. It says, "ultrasound exam when indicated."
Q. Okay. So when it said indicated it should say ultrasound examination routinely?
A. Yes.
Q. Is what it should read?
A. Right. And the sentence below it does say that.
Q. And so then my next question is: The ultrasound examination, does this, items 1 through 4 under that section -- I don't know why they're missing number two. Two is not missing and it is missing for some reason, but I got the same pages -- is the ultrasound examination -- there must be a misprint or something.
A. Yeah.
Q. Does that kind of set out the ultrasound examination for a surgical abortion as well?
A. Yes. The ultrasound examination is, essentially, the same whether you're having a surgical or a medical abortion.
Q. Okay. So what I'm showing here is marked as Exhibit Number 3 under Ultrasound

Examination, that's the protocol for a surgical abortion as well, correct?
A. Correct. There's just some reference to the mifepristone and misoprostol. Number 4 so -- Number 4 --
Q. With the exception of the -- those medications -- those references to the medication, I can't pronounce them very well so I'm not gonna try, but with respect to those references the rest of it, under the ultrasound section --
A. Correct. I'm sorry.
Q. -- is the same protocol for a surgical abortion?
A. Correct.
Q. And then the Laboratory Evaluation. Is that the same protocol that's used with respect to a surgical abortion as well?
A. Correct.
Q. And Medication and Follow-up. There must be some differences between the medication and the surgical abortion?
A. Yes.
Q. This sets out the follow up for medical abortion, correct? Medication abortion.

A. Correct.
Q. What's the follow up for a surgical abortion?
A. We offer patients a follow-up appointment but the follow-up appointment is not required.
Q. Not required by who?
A. Not required by us. By the clinic.
Q. How often do they come back? How often in your experience does an abortion patient come back?
A. If we have a -- so, on occasion we do recommend it or require it but typically it's not required. Of our surgical patients, I would say less than ten percent come back for a follow-up appointment.
Q. Out of the patients that you see that have either a medication or surgical abortion, how many come back to -- for further care by you?
A. For the follow-up appointment?
Q. Any type of -- any type of care.
A. I believe our follow-up -- our follow-up rate for medical abortion is around 75 percent or so and then the follow up for surgical, it's just a rough guesstimate because I

don't keep track of that, but less than ten percent and then a very rare patient do we see for -- at a later time for whether it's a physical or an IUD placement or other health care. Our clinic is mainly an abortion clinic and so those appointments are few and far between.
Q. When you're doing those examinations, when a woman has an abortion, is that the first time you've met the patient?
A. The day of their abortion is the first time I've met them, yes.
Q. Have they -- do you know do they come in before the abortion to kinda do some prep work and do any of this stuff as far as the desire and things like that?
A. Well, the -- their appointment is a few hours in length and during that time, they're receiving this care but it's all in one day.
Q. How many hours does it take?
A. For an --
Q. Do you know? From the time the woman walks in until the time she walks out.
A. I work at a couple different clinics and some of them quote different hours so I can't

quote you what Red River Women's Clinic tells the patient on the phone, but anywhere from three to six hours would be typical.
Q. Okay. And that's what you think they tell them, what actually happens? Do you know?
A. I think it's very -- very close to that.
Q. So you're between three and six hours -- you're -- the woman walks in, gets this -- all this testing that we just talked about, protocols, the examination, and there's a -- how long is she in a recovery room?
A. The recovery room is usually about 20 minutes.
Q. And then she's free to go?
A. Correct.
Q. Okay. The -- you talked about surgical abortions. You sometimes say we don't require but sometimes we do?
A. Require?
Q. A follow-up examination.
A. Correct.
Q. Tell me why that would be. Give me an example of why they would be required when generally it's not, correct?

A. Sure. When we do an abortion, afterwards we examine the tissue, the pregnancy tissue, and if there's any concern whether we're concerned we may not see enough tissue and we want to make sure that she's fine. Or if a patient is in the recovery room having maybe more pain or more bleeding then we like, we would -- we may require that.

Q. But you still let her go?

A. If she's stable, uh-hum.

Q. And percentage wise, how many do you think you require to come back from a surgical abortion?

A. I would say maybe one or two percent and usually it would be because of the tissue examination.

Q. And how many actually follow your directive?

A. Of those? Most. The majority. Because they want to make sure that the pregnancy is ended.

Q. And I probably should have asked this: The -- the Counseling component, the protocol, the education. I understand you do some of that when they get into the exam room,

ask them whether they want to have this abortion. Who else does that type of counseling?

A. We have staff that meet individually with the patient and we also have group education in a variety of different ways we interact with the patient. There's also some education going on during the ultrasound, so it's sort of throughout the day.

Q. Is there like a counselor or somebody that's licensed -- licensed counselor on staff that does this -- this work?

A. No. It's more of a patient educator.

Q. Okay. And the -- in the Medical History and Physical Examination, do you do -- are you involved in any of that?

A. The patient completes that prior to meeting with me and then I review that --

Q. Okay.

A. -- prior to and ask questions and review it with the patient, essentially.

Q. Anybody else involved in this Medical History and Physical Examination we're talking about?

A. There -- when somebody makes an appointment, we ask them if they have a bleeding

disorder and so those things can get flagged ahead of time or brought to my attention ahead of time, and so on occasion, it's brought to my attention ahead of time.

Q. And who does the ultrasound examination? Are you involved in that?

A. I'm -- occasionally I am when it's a -- if it's a difficult or there's a question, that type of thing.

Q. Would you have a staff person that takes care of that?

A. Correct.

Q. Is there -- 'cause my niece is thinking about becoming a sonographer. Is that the correct term that performs ultrasounds?

A. Lots of people perform ultrasounds.

Q. Okay. You don't have to have a particular license or --

A. Correct.

Q. Okay. Do you have to have a particular degree in anything?

A. No. Not that I'm aware of.

Q. All right. Well, I'm gonna tell her maybe she doesn't have to go on to school. The lab evaluations, who -- are you involved in --

A. What lab evaluations are you referring to?

Q. Well, under your protocol here?

A. Like the hemoglobin?

Q. Any type of --

A. So, I review -- I review the lab results prior to performing an abortion.

Q. Okay. And who actually takes the or does the blood draw and things like this? Is there somebody on staff that does that?

A. Yes.

Q. Do they have any particular -- is there an RN or somebody like that?

A. I don't know that -- she is licensed to do that. Whether it's a lab technician or phlebotomist, I can't quote what -- but she has training.

Q. She has some licensing or training in doing the lab work that's required -- that's necessary?

A. Right. And sometimes RNs can do it also, and I can do it. So --

Q. How many RNs do you have on staff? Do you know?

A. Quite a few. I don't -- I don't know

Ex. A

Page 66

the number.
Q. During this counseling, does some women that come in decide not to have an abortion?
A. True.
Q. What's the percentage of that?
A. Less than five percent.
Q. Do you know why?
A. A variety of reasons.
Q. Can you give me some examples of why.
A. They may decide after the ultrasound that maybe they thought they were earlier and they're father then they thought they were, they may have been somewhat undecided and came in and decided that they needed more time, or may have just changed their mind, and we also, maybe someone was forcing them to have an abortion and we talked with them and asked, you know, do you want to be -- do you want to have an abortion and they said no someone is forcing me to be here, we would send those patients home.
Q. Do you -- I mean, when you do this counseling, I presume you take records and take notes of the communications that occur, correct?
A. Not verbatim.

Page 67

Q. Sure.
A. But the -- there's a form that the patients complete and if there's anything unusual or outstanding, we would write that down, yes.
Q. Okay. But with respect to these protocols, as you go through, you must keep some record of yes, we went through this protocol and this is how we did it and this was the result of what we found?
A. What are you in reference -- referencing to?
Q. Well, I'm trying to, you know, for example, you go through your protocols. It says Counseling, Education, and Informed Consent --
A. Yes.
Q. -- right? And so I -- what I'm trying to get a sense of: You must keep some records of we went through this protocol with this particular patient?
A. Correct. We have -- for instance, when they sign the consent for a surgical or medical abortion, that is laid out and that's reviewed with them and then they sign it and I sign it.
Q. Okay. I just want to briefly just

Page 68

talk about, because I'm not that familiar with the procedure itself, the medication procedure, just -- if you could briefly describe to me medication abortion?
A. So --
Q. I don't need you to go through each of the protocols. I'm just tying to get a sense of what happens.
A. So day one they take the mifepristone and that's the pill that stops the pregnancy from growing. 24 to 48 hours later, they take the misoprostol which causes the pregnancy to expel. That's when they have the heavy bleeding, and we review when to call and what's normal and what's not normal. There's antibiotics given whether it's before, after, during that's in flux a little bit, and then a follow-up appointment is made to confirm that the pregnancy is passed and that is done usually anywhere from one to three weeks --
Q. Is that some sort of --
A. -- after.
Q. -- vaginal examination then?
A. It is a vaginal ultrasound.
Q. Okay. Is it the vaginal ultrasound

Page 69

that you use? Maybe I misheard you.
A. We use a vaginal ultrasound for the follow-up on medication abortion I would say 99 percent of the time.
Q. And so they take the first medication at your facility the day they come in?
A. Correct.
Q. And they take the second medication 24 hours later?
A. 24 to 48 hours later.
Q. Okay. And do they then call you? Is that kind of the procedure? Hey, I have expelled this unborn child. Is that what happens?
A. No. We tell them what to expect as far as bleeding and cramping. And if anything is unusual, then they should contact us and they have our number, 24 contact, you know, that kind of thing.
Q. Okay. So the next time that you -- unless there's something that they -- happens during that expelling, the next time you see them is that follow-up visit?
A. Correct.
Q. Assuming that they show up?
A. Correct.

Q. Surgical abortion. Walk me through that process.
A. So --
Q. Not the -- I don't need the protocol. Just when you're in that examination room.
A. So, the procedure itself takes usually about five to ten minutes. After my review of their history and discussion and asking all -- making sure that they're confident in their decision, the next step is a pelvic exam. Then, speculum is placed in the vagina to view the cervix, local anesthetic is given around the cervix, and the cervix is dilated and the pregnancy is removed by, it's called, suction, and the whole procedure is usually five to ten minutes and then it's confirmed that -- the equipment is taken out and confirmed that the pregnancy has been removed.
Q. And then they go into the exam room -- do the medication abortions, do they go into a recovery room?
A. The way our facility works, they do actually go to the recovery room to kind of get a final -- antibiotics, contraceptive prescriptions, that's where those are given at

that point. So, they are in the recovery room but it could easily have been done in a different room. It just logistically works out.
Q. Just -- this just happens to be the room we use for the --
A. Correct.
Q. So there -- the surgical abortion takes about five to ten minutes and that's for the -- is that for the entire time they're in that examination room with you?
A. It's probably closer to 15 minutes would be typical.
Q. So anywhere from 5 to 15 minutes?
A. That they're --
Q. Is 15 minutes the top end?
A. The 15 -- I'm in the room with them, I would say very close to 15 minutes.
Q. Okay.
A. The procedure, itself, is five to ten.
Q. Okay. And then once they're done with the procedure, itself, do you stay in the room with them or do you just move on to the next patient?
A. We have a staff member stay in with

them. I make sure they're stable before I leave and they're helped to get dressed and brought to the recovery room.
Q. Okay. And so -- but you're -- once the procedure is done, then you leave the examination room; is that fair?
A. Yes.
Q. Do you ever see them again unless they come back?
A. I frequently -- the way our clinic is set up, the recovery room is very convenient so -- and I'm walking by it throughout the day, so I'm frequently popping my head in and probably, most of the time, end up communicating with the patient again just how are you doing or see them in the hallway.
Q. And how long is that interchange usually per patient in the recovery room?
A. So, they're in the recovery room with a nurse for 20 minutes.
Q. Okay.
A. And then just a very brief -- unless there's a concern, then I'm called to the recovery room.
Q. How often does that happen?

A. Not very often at all. Typically, it's more like this patient needs a work note can you sign this work note or, you know, that type of --
Q. What's a work note?
A. For instance, if they -- were -- miss that day of work --
Q. Oh.
A. -- and needed doctor verification.
Q. Okay. It's not something internal with you? They just had to take time off?
A. Right.
Q. Okay.
MR. GAUSTAD: I've finished off quite a bit of water here. I need to -- I need to take a break to use the restroom.
MS. CREPPS: No. No. It's good. Okay. How long would you like?
MR. GAUSTAD: Doesn't take me very long to use the restroom. Maybe five or ten minutes?
MS. CREPPS: Okay.
(A brief break was taken.)
Q. All right. Dr. Eggleston, you understand you're still under oath?

Ex. A

Page 74

A. Yes.
Q. And am I pronouncing your name right? Eggleston?
A. Yes.
Q. If you could pull out Exhibit Number 1, it should be your declaration. Do you have that in front -- yeah, Exhibit Number 1. Do you have that?
A. Yes.
Q. Okay. And as I understand, and I'm looking at paragraph 8, where it says, "the protocols include an ultrasound for all abortion patients, which is important for dating the pregnancy and determining where the pregnancy is located within the uterus." And those are the protocols we just went through --
A. Correct.
Q. -- correct? And you go on to say, "A physician needs to confirm an intrauterine pregnancy and gestational age in order to safely provide an abortion." Do you see that?
A. Yes.
Q. Okay. And you use the term "pregnancy." What do you mean by that? In this declaration? You say, "determining where the

Page 75

pregnancy is located." What do you mean when you use the word "pregnancy"?
A. The gestational sac where it is located to confirm it's not an atopic or --
Q. What do you mean "it"? What do you mean by "where it is located"? What are you referring to?
A. So the --the sac, the gestational sac, is a fluid filled sac and the -- depending on gestational age, the embryo or fetus is inside that sac.
Q. Okay.
A. So it depends on what we're looking -- depending on the gestational age, is what we're looking at to confirm where the pregnancy is.
Q. Okay. And that's the purpose of the ultrasound, right? You need to find out that it's not -- that it's a normal intrauterine pregnancy and you need to know the age of this unborn child, correct?
A. We need to know the location -- yes, of the pregnancy and the gestational age.
Q. And those are the two things that you need to know in order to perform an abortion,

Page 76

right? From the ultrasound?
A. Correct. That's the point of the ultrasound.
Q. Precisely. Okay. And as I understand, the gestational age -- if it's less then five weeks lmp -- am I saying that right?
A. Yes.
Q. They're not eligible for an abortion?
A. Correct.
Q. Okay. And --
A. That's not a hard-and-fast rule, but in general, that is correct.
Q. Okay. And in general, what's the latest that the Fargo clinic performs an abortion as far as gestational age?
A. We go through 16 weeks.
Q. And so as long as it's an intrauterine pregnancy and it's within those perimeters, the gestational age perimeters, they're eligible for an abortion aside from the health and the other aspects?
A. The only exception to that is at the beginning because five weeks we may or may not see a gestational sac. We may or may not see a yoke sac. So, some women are eligible to have an

Page 77

abortion as early as five weeks but it depends on what we see on ultrasound.
Q. Sure. And depending on what you see on ultrasound, as long as it's an intrauterine pregnancy and you, in your medical judgement, has determined the gestational age fits within those perimeters, they're eligible for an abortion?
A. Correct.
Q. And one of the by-products is -- of the ultrasound is also you detect a heartbeat too, correct?
A. If we see an embryo or fetus, we evaluate whether we see cardiac motion.
Q. But that's not necessary to determine whether they're eligible for an abortion, correct?
A. It is necessary --
Q. Go ahead. I'm sorry. I didn't mean to interrupt.
A. Can you ask me the question again?
Q. Yeah. The detection of a heartbeat through the ultrasound, that doesn't -- does that affect where the -- whether it's an intrauterine pregnancy or not?
A. If we are -- if we are questioning

what we are seeing on the ultrasound, the cardiac motion can help us to confirm that it is an intrauterine pregnancy.

Q. Okay. And does the detection of a heartbeat, does that affect the gestational age? That component of --

A. It is typically seen about six weeks.

Q. Okay.

A. So when we determine gestational age, we can do different types of measurements, and if that's noted, then that can -- can influence in those very early gestational age -- that can influence whether we would call it five weeks or six weeks.

MR. GAUSTAD: Would you mark this for me.

(Deposition Exhibit No. 4 was marked for identification.)

Q. Dr. Eggleston, I'm showing you what has been marked as Deposition Exhibit Number 4. Do you have that in front of you?

A. Yes.

Q. And the last page of that, is that your signature?

A. Yes.

Q. Okay. And in turning to paragraph 10, of Exhibit Number 4, you made reference, "In early pregnancy, the location and gestational age of the embryo, as well as the presence or absence of cardiac activity is usually determined by vaginal ultrasound, rather than by any other method." Do you see that?

A. Yes.

Q. What is the percentage of vaginal ultrasound versus the other method of ultrasound that you maybe use? Do you know?

A. I don't know.

Q. Usually? I'm just trying to figure out --

A. In early pregnancy, that's what it's referring to.

Q. Okay.

A. It is used the majority of the time.

Q. More then 50 percent?

A. Well more, yes.

Q. More then 75 percent?

A. Yes.

Q. Is it used 100 percent of the time?

A. In early pregnancy -- no. It is not used 100 percent of the time.

Q. When you say "early pregnancy," what do you mean?

A. Well, I didn't define that in this. But, at the -- we were talking about cardiac motion at six weeks. At that gestational age, vaginal ultrasound, I suspect, is used 99 percent.

Q. Do you know or are you guessing?

A. I'm using my experience.

Q. And so the early pregnancy, you're referring to early pregnancy as somebody that comes in at a gestational age of six weeks? Six weeks lmp?

A. Six weeks lmp or earlier. I -- very close to 100 percent are going to be having a vaginal ultrasound done.

Q. Okay. When is it that you're beyond the early pregnancy period? I'm trying to figure out what you -- you said you didn't define it, so I'm trying to get you to tell me what you meant by early pregnancy? The timeline here. I get it's six weeks --

A. Everybody has a different opinion of what an early pregnancy --

Q. But you said that in your

declaration --

A. Yeah.

Q. -- doctor, so I want you to tell me what you meant by early pregnancy?

A. So I would say six weeks.

Q. Okay. And then anything after that six weeks is no longer an early pregnancy as you've defined it?

A. In reference to vaginal ultrasound, early pregnancy is right around six weeks.

Q. Okay.

A. But early pregnancy in other references, would be much more broad. For instance, first trimester.

Q. When you're using it in reference to this paragraph 10, what did you mean by early pregnancy, Dr. Eggleston?

A. I would say somewhere around six weeks gestational age.

Q. And so under this early pregnancy as you've just defined, it's 99 percent of the time we're using the vaginal ultrasound?

A. Correct.

Q. And how is it that you know they're at six weeks lmp before you do the ultrasound?

Page 82

A. Number one, we ask them their lmp when we make the appointment. We would hate for someone to drive and be 18 weeks, for instance. We need to make sure that we're letting them know our gestational age limits.
Q. Okay.
A. So, we have an idea of their lmp, gestational age. Then, the patient has the -- the typical patient, will have an ultrasound and that is initially done abdominally, and if we do not see -- we cannot confirm those things we've already discussed, then they would have a vaginal ultrasound.
Q. Okay. So even in early pregnancy, starts out with the abdominal. Is that what you're saying?
A. In most circumstances, yes.
Q. Okay. And then if you -- so what then prompts you to go to the next step and say geez, now we need to do a vaginal ultrasound?
A. Because of determining the location of the pregnancy and confirming it's an intrauterine pregnancy.
Q. Okay. Because the abdominal ultrasound doesn't confirm those or doesn't --

Page 83

A. It is much less clear. And so, at that gestational age, it's frequent that we don't see adequate visualization of the gestational sac or the yoke sac, so that's why we need to do vaginal.
Q. Okay. So you, as I understand then, you are, even in the early pregnancy, you're gonna start out with an abdominal ultrasound, correct?
A. Correct.
Q. And if you're able to locate the location and the gestational age on that, that's good enough? You don't -- you don't have to go on and do the vaginal ultrasound, right?
A. If we're able to confirm that it's an intrauterine pregnancy and confirm the gestational age by abdominal, we do not do a transvaginal ultrasound.
Q. So in those instances, well, let's start out with the early pregnancy. What's the percentage of just the abdominal ultrasound being -- whether you just -- you're able to figure out the location and the gestational age just the abdominal, in your experience?
A. So, six weeks -- that's what you're

Page 84

referring to?
Q. Early pregnancy. Yup.
A. I suspect 90 percent would need a vaginal.
Q. And how about for those that are beyond this early pregnancy stage?
A. Maybe 20 percent would require vaginal.
Q. In your experience?
A. In my experience.
Q. Okay. And, as I understand then, that if you don't detect cardiac activity, you inform the patient of that, correct?
A. If --
Q. Through this ultrasound process?
A. Sometimes we don't see the embryo. And so if we don't see the embryo, we're not going to see the cardiac motion. So in that instance, we would not necessarily inform the patient, but if the patient is eight weeks gestational age and there's an empty sac or an embryo without cardiac motion, we inform the patient of what the ultrasound find is.
Q. And why do you do that?
A. Because it's important to communicate

Page 85

with the patient. In this particular -- what we're discussing is likely a miscarriage, and so I want to make sure the patient is aware of that. It also gives them more options for more care.
Q. Getting back to the vaginal ultrasound, is that something that the National Abortion Federation -- is that required under these policy guidelines that are marked as Exhibit Number 2? Do you know?
A. I don't believe it is required, but I would have to --
Q. Probably wrong word. It should be: Is it a standard of care under their policy guidelines, right?
A. I -- so what's the question?
Q. Is a vaginal ultrasound, is that a standard set forth in --
A. I do not believe so.
Q. I'm looking for Exhibit Number 1, Dr. Eggleston. We can probably keep 1 and 4 close by. Exhibit Number 1, I'm looking at paragraph 11. You've got that in front of you?
A. Yes.
Q. Okay. And in that paragraph, you define viability "as the ability" and there's

Page 86

some words missing "to live outside the mother's womb albeit with artificial aid." Do you see that?
A. Yes.
Q. Okay. And then you cite to the Century Code Statute, right?
A. Yes.
Q. And I want to make sure because --
MR. GAUSTAD: Would you mark that.
(Deposition Exhibit No. 5 was marked for identification.)
Q. Dr. Eggleston, I'm showing you what's been marked as Exhibit Number 5.
A. Okay.
Q. You have that in front of you?
A. Yes.
Q. And I'll represent to you that this is the Century Code Statute that you've cited in your declaration.
A. Okay.
Q. 14-02.1-02.
A. Okay.
Q. And it's on page 3 subsection 14. You see that? It says "Viable means the ability

Page 87

of an unborn child to live outside the mother's womb, albeit with artificial aid."
A. Yes.
Q. Do -- is that -- I presume that's the same statute you are referring to in your declaration, correct?
A. Yes.
Q. Okay.
MR. GAUSTAD: Would you mark this also.
(Deposition Exhibit No. 6 was marked for identification.)
Q. And I'll represent to you that -- what's been marked, and I should have said this in advance, as Exhibit 5 is the Statute as through the 2011 session. And I just want to get clarity that kinda is to the current statute that exists.
You've got Exhibit Number 6 in front of you?
A. 6. Yeah.
Q. And I'll represent to you that is the same statute except it's through the 2013 session for North Dakota. And here, it's on page 3, again, and it defines -- under subsection 19 it

Page 88

defines viable and it has the same definition as the 2011 that you're referring to; is that correct?
A. Yes.
Q. Okay. In looking at paragraph number 11, again, Dr. Eggleston, after reciting the definition of -- you say viability but I think it's the definition viable, correct?
A. True. Yes.
Q. The statute says viable --
A. Viable.
Q. -- and you use the term viability.
A. Correct.
Q. Okay. And in the second sentence of paragraph 11 you say, "A fetus does not become viable until approximately twenty-four weeks lmp." Do you see that?
A. Yes.
Q. The term "viable" in that sentence, you're referring to that statutory definition, correct? When you say "fetus does not become viable," are you using the same definition that's in the statutes?
A. Correct.
Q. And, as I understand then, your

Page 89

opinion as to -- is the second sentence your opinion? "The fetus does not become viable until approximately twenty-four weeks lmp?
A. That's my opinion and my medical knowledge, yes.
Q. Okay. And that's based upon -- your medical knowledge based upon applying the definition of viable in the statutes, correct?
A. Correct.
Q. And I'm showing you it's Exhibit Number 4, in particular the paragraph 9. Do you see that?
A. Yes.
Q. And in there you use -- you say, "The presence of cardiac activity is an important indicator that a pregnancy retains potential for viability." Do you see that?
A. Uh-hum.
Q. The term "viability" when you use that in your declaration, is that the same as viable that's set out in the statues?
A. No.
Q. What is -- what do you mean by viability in that sentence then?
A. So, when we evaluate for cardiac

Page 90

motion, we're evaluating whether it is -- the term used there is a "viable pregnancy," that without intervention, it would continue -- the pregnancy would continue. So we -- the medical term for instance a "nonviable pregnancy" if the woman didn't have -- if the pregnancy didn't have the cardiac motion but you would expect it at eight weeks, then we would inform the woman that she has a nonviable pregnancy.

Q. And what would nonviable pregnancy -- would it be viable as the statute is defined it? Do you know? Is -- you said a non- -- if you don't have detectible cardiac activity, it's a nonviable pregnancy, correct?

A. If -- if the cardiac activity is expected at that gestational age and it is not present, then that is most likely a nonviable pregnancy, and I would have a discussion about that with the -- with the woman.

Q. Okay. And under those set of circumstances then, when it's a nonviable pregnancy, does it then have the ability to live outside the mother's womb albeit with artifical aid?

A. No.

Page 91

Q. So, then it would not be viable as the statutes defined it?

A. Correct.

Q. And then when it does have the presence of cardiac activity --

A. Uh-hum.

Q. -- then there is a potential for viability, correct?

A. No. That would be a viable pregnancy.

Q. Okay. And I'm referring to paragraph 9 of Exhibit Number 4. Where you say, "The presence of cardiac activity is an important indictor that a pregnancy retains the potential for viability."

A. Yes.

Q. Okay.

A. That's what it says.

Q. It does. And I'm trying to get a sense as to what you meant by then viability in that sentence?

A. So, viable pregnancy versus nonviable pregnancy means that the pregnancy will continue or at this point is continuing to grow and develop, versus a nonviable pregnancy is not

Page 92

continuing to grow and develop as expected.

Q. Okay.

A. And then -- yeah.

Q. And so the presence of cardiac activity may or may not then be viable as defined in the statute. Is that --

A. Right. When I'm referencing in Number 9, what I'm referencing is whether this is a viable pregnancy or nonviable pregnancy at that gestational age.

Q. And when you say viable pregnancy, you mean it will continue -- the unborn child will continue to grow?

A. The pregnancy will, without intervention, the pregnancy at this point is -- appears to be continuing to grow, a viable pregnancy.

Q. Okay. But that doesn't mean it's necessarily viable as the statute defines it?

A. Correct. Viable is used in different --

Q. Context?

A. Context, yes.

Q. Now turning to your opinion, and if you've got Exhibit Number 1 in front of you, do

Page 93

you have that in front of you?

A. Yep.

Q. And it's paragraph 11. Do you have that?

A. Number 11?

Q. Yes.

A. Yes.

Q. Okay. As I understand, your opinion is that a viability doesn't commence until approximately 24 weeks lmp, correct?

A. A fetus does not become viable until approximately 24 weeks lmp.

Q. In that context, you're using the definition of viable in the statute?

A. Correct.

Q. Okay. What attributes or characteristics does an unborn child have that is viable?

A. So --

Q. As your -- in your opinion?

A. So with medical intervention, at 24 weeks lmp, medical intervention is needed but the fetus would be able to survive after delivery.

Q. How long do they have to survive?

A. How long -- I don't -- I'm not sure

Page 94

your question.
Q. Well, you said they have to survive after delivery. How long? What's the length of time they have to survive to be viable?
A. Is -- I'm not sure if you're asking me from a medical/legal perspective or what --
Q. I'm asking from based upon your opinion that you say they're viable at 24 weeks.
A. So, the majority of -- well, most -- I'm not sure -- I'm not an expert at preterm delivery. If a woman was pregnant at 24 weeks and went into labor, the physician would, on that -- based on that individual pregnancy and her history, they would decide an individual nature how likely is it that this fetus can survive outside after delivery and use medical interventions to assist that.
Q. Okay. And, as I understand, this was -- this opinion that you rendered was based upon a reasonable degree of medical certainty, correct?
A. Correct.
Q. And so based upon that, Dr. Eggleston, I'm asking: How long does that fetus, for it to be viable, as you've opined here, at 24

Page 95

weeks, how long does that fetus have to survive after birth to be viable? Is it days? Years? What it is?
A. I -- it would be -- it could be -- unfortunately, it could be only minutes. But, there is a reasonable -- I mean, medical interventions have been successful that it's much longer. Hopefully a lifetime.
Q. Do you know what type of characteristics a viable child has? Do they have circulatory, respiratory functions? Does it -- viable --
A. Yeah.
Q. -- as you've defined it? Respiratory?
A. Yes.
Q. Circulatory function?
A. Yes.
Q. Does it have brain function?
A. Yes.
Q. How about pain? Is it capable of feeling pain?
A. The studies that I'm aware of, are -- the most recent studies that I've looked at, 26 to 28 weeks --

Page 96

Q. That's when a viable fetus or unborn child has to -- I'm asking what characteristics and you said a viable --
A. So with medical intervention, that the circulatory system is keeping the -- the brain alive, the heart alive, the lungs working, the kidneys, the liver, there has to be circulation to keep those organs working and alive.
Q. Okay. So all of those body functions need to -- those characteristics exist for a viable child, correct?
A. Correct.
Q. As you've defined it here --
A. Correct.
Q. -- at 24 weeks lmp, a viable unborn child of 24 weeks lmp, has a circulatory function, correct?
A. Yeah. I -- my --
Q. And I'm not asking about the -- I understand that it may require some artificial aid to -- but with that artificial aid, it would have circulatory function, correct?
A. That's my understanding.
Q. And is that your understanding when

Page 97

you issued this opinion, correct?
A. So my opinion is not based on my personal medical knowledge. I do not take care of kids in the neonate. Okay? This statement is in reference to my medical knowledge of what I read, of what I -- in the medical literature.
Q. Okay. So you don't know what functions -- your own personal experience, you don't know what functions a viable unborn child has to have? Unborn child has to have to be viable?
A. Other than some basic functions, that's all I can comment on.
Q. What basic functions does a viable unborn child have to have?
A. Circulation, oxygen --
Q. Respiratory, right?
A. Right. With medical intervention frequently.
Q. Anything else? Pain? Does a viable unborn child -- is it capable of feeling pain?
A. I have no medical knowledge.
Q. Don't know?
A. Don't know.
Q. Any other characteristics or

functions or attributes of a viable unborn child?
A. I don't take care of those patients.
Q. Don't know?
A. So I don't feel comfortable answering.
Q. If you don't know, that's fine. Just don't know?
A. Personally, I don't know what you're asking.
Q. Fair.
A. And partially, I don't know the answer to that combination.
Q. This is where we get into if you don't understand, let me know. Okay? My -- what I'm trying to get at is: What type of characteristics, based upon your understanding, your knowledge, does a viable unborn child have? And you talked about brain function.
A. Yeah. I don't know the answer to that question.
Q. Okay. And what did you rely upon then to make your determination in paragraph 11 that viability commences at 24 weeks lmp?
A. Well, the literature and -- I'm involved in abortion care so you read lots of

articles about limits and different state limits and frequently those articles are referencing what is the current medical expectation of fetal viability.
Q. Okay.
A. So --
Q. Is there -- is it a medical judgement call as to whether an unborn child is viable or not?
A. The physician would make that determination case by case. But in general, it is approximately 24 weeks lmp, my understanding.
Q. Does it take some medical judgement to determine whether or not a child is viable or not?
A. Yes.
Q. Okay. Is -- do you know whether -- if whether an unborn child is viable or not, does it actually have to survive?
A. I don't know.
Q. And in your paragraph 11, you pulled out the statute as far as what viable is and you say uses with artificial aid, right?
A. Uh-hum.
Q. Is there a time period that, you

know, artificial aid -- if you're continuing to apply artifical aid, this unborn child won't be viable no matter how long -- as long as you keep the brain function going and the circulatory function going and the respiratory function going with artificial aid, it could be years. It is still a viable unborn child?
A. I don't know -- I don't know that answer.
MR. GAUSTAD: Would you mark this.
(Deposition Exhibit No. 7 was marked for identification.)
Q. Dr. Eggleston, I'm showing you what's been marked as Exhibit Number 7.
A. Okay.
Q. Have you seen this document before?
A. No.
Q. Then I won't ask you anything because you don't know anything about it, do you? You don't know anything about what's contained in Exhibit Number 7 if you've never reviewed it?
A. Right. I could review it now, but no, I've not reviewed it prior to this or not seen it.

Q. Why don't you go ahead and review it.
A. Okay. Well --
Q. Go ahead.
A. Okay.
MS. CREPPS: We might as well go off the record.
MR. GAUSTAD: Sure.
MS. CREPPS: It will probably be 10 or 15 minutes.
(A brief break was taken.)
Q. Dr. Eggleston, you understand you're still under oath?
A. Yes.
Q. Have you had an opportunity to review Exhibit Number 7? Did you want --
A. Initial -- yes.
Q. Okay. And do you have any dispute with the findings that were made in this article?
A. I don't have anything -- no.
Q. Turning to Exhibit Number 1, Dr. Eggleston, it's paragraph 13. Do you have that in front of you?
A. Yes.
Q. Okay. You've already testified to this that abortions are performed only one day

Ex. A

Page 102

per week at the Fargo clinic, and "The bill will effectively limit women's ability to obtain an abortion to a single day during their pregnancy's fifth week." Do you see that?

A. Yes.

Q. Okay. And the bill you're referring to is the, I think, it's H.B. 1456, or Heartbeat Detection Statute?

A. Yes. That seems right.

Q. There's nothing in the statute though that precludes the clinic from being open -- doing abortions more then one day a week, is there?

A. Correct.

Q. And then turning to paragraph 14 of Exhibit Number 1. You made reference to, "Most of the women who currently receive abortions from the clinic at or after six weeks would probably be unable to schedule their abortions early enough to avoid the ban," due to a combination of a number of factors listed -- various -- it looks like about five factors here.

A. Uh-hum.

Q. Is this based -- I mean, is there some data that the clinic retains or you retain?

Page 103

Where would I look to find this type of data? Is there medical records or something like that that says this is the reasons why women wouldn't be able to get an abortion six weeks or later?

A. I think you could look at the clinics statistics on the percentage of patients we see that are earlier then six weeks.

Q. So they -- the clinic's stats?

A. Right. Stats.

Q. That would -- that's what you're relying upon for these statements?

A. No. That would be one factor.

Q. Okay. What are the other factors?

A. Talking to patients, and having knowledge of their -- difficult traveling, the work, like I had mentioned before, the notes for work, work release, medical, taking time off work.

Patients frequently share, you know, I have to be back by this time, I couldn't come last week because of this, you know, they share those experiences with us, so this is based on my experience, the stats, the -- the waiting, and delays imposed by the laws.

Q. The discussions you have with the

Page 104

patients, is that something you record then in some sort of record to say geez, the patient told me this, I should write this down in some fashion?

A. It may be when -- the patient completes some forms about why they're having an abortion, it may be in that, written down. But, when I have that discussion, I personally do not write that down.

Q. Okay. So to the extent that the patient completes that information, that would be with the medical records for that particular patient?

A. Correct. Sometimes we may elaborate and write additional notes.

Q. Okay. That's where I'd be looking for that type -- this type of information? Those medical records? Give me an example --

A. What type of information?

Q. The information about these factors that you've elicited in paragraph 14.

A. I wouldn't -- I think it could be in there on occasion but these are discussions we're having with women on the phone when we're making their appointment. I'm not on the phone, but I

Page 105

overhear. I hear patient concerns or staff discussing how can they get here and with my own discussion with the patients.

Q. What delays are you referring to -- you're referring to delays imposed by laws of the State of North Dakota. What are you referring to there?

A. They need to call and receive the information, the 24 hour reading at least 24 hours prior to the abortion.

Q. And then turning to paragraph 15, you made several references to factors women rely upon or utilize in deciding whether or not to have an abortion, and you've listed a number of them.

A. (Witness nods head.)

Q. Where would I look to -- I mean, I can read it on your Affidavit but is there somewhere else that would, a list of this information, medical records or the information the patient gives you?

A. When I have discussions with a patient, that frequently comes up, but there is a form that they complete and they may or may list their reasons for having an abortion.

Page 106

Also, I believe there's been some studies, I can't specifically mention them, but in -- seems to me I remember being at a conference and they discussed reasons why women had abortions and it was an actual study about it, but I don't know that study and can't name the conference. But in general, that type of material is discussed.

Q. Okay. So I'd look at these forms that the women fill out? May contain this type of information?

A. It may contain this.

Q. And then some studies that are out there is what you're relying upon to make this type of --

A. In my experience talking with women.

Q. Okay. Has there been a study done of this Fargo clinic?

A. Not that I'm aware of.

Q. Okay. And paragraph 14 and 15, really are directed at, as I understand, the harm that this statute would have on women, the patients for the clinic. Is -- your position on it anyway, is to the harm that this statue would have on women generally?

Page 107

A. So, what's the question?

Q. Poorly, poorly worded question. I'm sorry. What I'm trying to get at as: As I understand, paragraph 14 and 15 -- ah, strike that.

Do you know what -- I mean you've listed the factors as to why women have an abortion, do you know what factors women consider when they don't have an abortion? Or they come into your clinic and -- you've listed them as to why they'd have an abortion.

A. Uh-hum. You mean for the patients who come in and then leave?

Q. Yes.

A. They, I think we went over that earlier, but they changed their mind for a variety of reasons. I don't know that -- I think there's similar reasons and they may change their mind, maybe they were undecided and they changed their mind and that's the time -- that's when you have to make a decision is on that day, at least initially, women make a decision not to go ahead with an abortion, they may come back but there's some discussion and maybe they thought about something that they hadn't thought of before.

Page 108

Q. And do you have -- I mean, you listed the reasons why. Do you -- can you -- in your experience, in your discussion with those women that don't go forward with the abortion, do they describe to you why?

A. Some women may just leave and so we wouldn't know, some women may have a discussion with the front desk, some may have a discussion with me. And, typically, if they meet with me and I'm reviewing their history and ask them if they're confident in their decision, if they say no, I -- then we have discussion but I also document that.

Q. Okay. That would be in the medical records?

A. Yes. If I -- if at that point -- yes.

Q. Outside of those -- I resume you've talked with folks within the Fargo Clinic about this case?

A. Tammi Kromenaker, yes.

Q. And you've talked to others within the clinic about this case? I'm not asking for names. Just generally? Or not?

A. No.

Page 109

Q. How about -- and not your attorneys, have you talked to others outside of the clinic about this case?

A. Yes. Many people know I'm here today 'cause it changed my scheduled and a lot of people were involved.

Q. And I want to thank you for that --

A. That's fine.

Q. -- I apologize for having to reschedule, and I do appreciate it. But aside from having to reschedule, have you talked to anybody outside of the clinic about this case? And I'm not talking about your attorneys.

A. No. I've not talked to anyone.

Q. Looking at Exhibit Number 4, do you have it in front of you?

A. Yes.

Q. Okay. In paragraph 9, you say that, "no detectible cardiac activity after seven weeks can be a sign of a nonviable pregnancy or miscarriage." Do you see that?

A. Yes.

Q. And then you tell the patient or you inform them, as I understand it, about the fact that you can't locate a cardiac activity?

Page 110

A. Correct.
Q. Okay. And you're doing that, as I understand, because they may go out and find their own primary care physician, they may wait for the miscarriage, may not be -- the abortion is not necessary really, right?
A. Correct.
Q. What type of reaction do women have when they hear that there's no heartbeat?
A. They -- I think they're most interested in knowing, you know, what do I do from here, you know. So our discussion focuses on medical options. I think for some women, they feel a sense of relief. They don't have to go through with an abortion procedure.
Q. Why do they feel relief?
A. Well, they don't have to do anything, they can go home. They may be afraid of pain, this was -- if they're there for an abortion, at least at that point, they were considering terminating the pregnancy and didn't want to be pregnant. And so, by confirming that it's a nonviable pregnancy, they would not, essentially, be eligible for an abortion, technically an abortion.

Page 111

Q. What about when you detect a heartbeat, do you tell the women you detect a heartbeat?
A. No. Not routinely.
Q. Why not?
A. They may ask and we talk about it. But that is -- the women are coming in for an abortion and they're assuming that they have a normal pregnancy that will continue to grow and they choose to have an abortion. So, unless we see something different than that --
Q. So generally you don't tell them if you detect a heartbeat or not?
A. I don't believe so.
Q. And in those instances that you do tell them that you detect a heartbeat, what's the reaction of them?
A. I'm not -- I don't know that I can answer that question --
Q. Well, you talked about --
A. -- because I'm not having that discussion with every patient, you know, I'm not doing every patient's ultrasound.
Q. And I'm only asking about the patients that you talk to them about -- they've

Page 112

asked you -- you've detected a heartbeat, you've had this discussion. What's the reaction of the women?
A. I have not been present when a woman has asked that question. Usually, the discussion is this appears to be either a normal pregnancy or an abnormal pregnancy.
Q. And so you don't, as I'm -- If I'm hearing you correctly, you don't get into the discussion of whether there's a heartbeat detected or not with a patient?
A. Correct.
Q. And do you then tell them what you mean by an abnormal or a normal pregnancy?
A. Yes. If I'm brought in, I'm having that discussion with the patient.
Q. How often does that happen where you're brought in to talk about whether there's a normal or abnormal pregnancy?
A. Under five per- -- under five percent.
Q. And a normal is one that would be cardiac activity, correct?
A. There can be factors -- I'm brought in if there's a concern. So depending on the

Page 113

gestational age, there may or may not be expected cardiac motion.
Q. Flip it the other way then. If they don't have cardiac activity, that would be an abnormal pregnancy at seven weeks or more?
A. At seven weeks or more yes, we would expect to see cardiac motion.
Q. Okay. And if you don't have that then that, as you've defined it, is an abnormal pregnancy at that point?
A. When I use -- yeah, it would be -- there's a concern and that we need to have a discussion with the patient to make sure she understands and knows her options.
Q. Okay. And then when you detect cardiac activity at six weeks or seven weeks, that's, aside from the other, you know, the location and gestational age, that would be something that would be a normal pregnancy then, correct?
A. It's normal to have cardiac motion at six -- about six weeks gestational age and beyond.
Q. And, as I understand it, you don't have discussion with the patient whether there's

Ex. A

Page 114

cardiac activity or not? You just say there's either -- this is a normal pregnancy.
A. Correct.
Q. Okay. And then your statement that it says, "there's no detectible cardiac activity after seven weeks can be a sign of a nonviable pregnancy or miscarriage."
A. I'm sorry can you --
Q. I'm sorry.
A. -- tell me where you are?
Q. Exhibit Number 4 paragraph 9.
A. Okay.
Q. It's about halfway through. It says, "no detectable cardiac activity after seven weeks can be a sign of a nonviable pregnancy or miscarriage."
A. Uh-hum.
Q. Would the opposite be true then if there's a detectable cardiac activity after seven weeks can be a sign of a viable pregnancy?
A. Correct.
Q. Do you know who Stacey Burns is?
A. Yes.
Q. Who is she?
A. I know who she is.

Page 115

Q. And I'm showing you -- it's part of the plaintiffs discovery it's Bates number PL104 --
A. Okay.
Q. -- I don't use Twitter. I Facebook, but I don't use Twitter, and we got this from a Stacey Burns and it says @WentRogue.
A. Okay.
Q. Do you know what that means? @WentRogue?
A. No.
Q. Who is Stacey Burns?
A. She is a woman -- I know who she is, and I've met her. I do not know what her title is. I believe she did or does -- I believe she works for a pro choice organization, whether it's Pro Choice Resources, I'm not confident.
Q. Okay. Did she have any affiliation with the clinic?
A. Not that I'm aware of.
Q. Do you know if her stat is correct? 87 percent of the abortions done at the Fargo is, I don't know, @RRWomen'sClinic are at least six weeks gestation?
A. So six -- that seems pretty accurate.

Page 116

Q. And you don't know where she got her data from?
A. No, I don't not.
Q. Have you ever seen this?
A. I've never seen that.
Q. All right. There are several letters that we got as part of the discovery process. They are Bates Numbers PL624, and, I can't read the last number but I think it's gotta be, PL675 from women. Do you just want to -- so you can see them.
A. Uh-hum.
Q. Have you -- if you want to just look through them. The question I have is: Have you ever seen these before?
A. No. I'm assuming -- in our recovery room, there are notebooks for women to -- to write and this appears to be a photocopy of that notebook.
Q. Okay. You don't know?
A. I don't know.
Q. And do you have any idea how these things are created other than suspecting that they are done in this recovery room?
A. I don't know.

Page 117

Q. And do you have any idea who created them?
A. No. Create -- you mean who wrote them?
Q. Yes.
A. Oh, no.
Q. Do you know if they were actually patients that wrote them?
A. I would have no way to -- to know that. Like I said, it just looks like the notebook that's in our recovery room.
Q. But you don't know if an actual patient wrote any of those statements?
A. True.
MR. GAUSTAD: At this point, we've got a discovery dispute. We're in- -- we do intend to appeal the order. We're going to keep the deposition open to -- this is the -- I don't have any further questions today given the order, but we are going to keep the deposition open until the discovery dispute is resolved. We're limited as to the number or questions and the topics that we can discuss here today.
MS. CREPPS: So you're planning to appeal the Magistrate's order to Judge

Hovland?
MR. GAUSTAD: Yes.
MS. CREPPS: Okay.
MR. GAUSTAD: So that's it for -- for today, Dr. Eggleston. Thank you and thank you very much for rescheduling yesterday.
(The deposition was concluded at 11:20 a.m.)

NOTARY REPORTER'S CERTIFICATE
STATE OF NORTH DAKOTA
COUNTY OF CASS

I, Kristen M. Keegan, a Notary Public within and for the County of Cass and State of North Dakota do hereby certify: That the afore-named witness was by me sworn to testify the truth, the whole truth, and nothing but the truth.

That the foregoing one hundred nineteen (119) pages contain an accurate transcription of my shorthand notes then and there taken.

I further certify that I am neither related to any of the parties or counsel, nor interested in this matter directly or indirectly.

WITNESS my hand and seal this 4th day of December, 2013.

Kristen M. Keegan
Notary Public
Fargo, North Dakota

THE FOREGOING CERTIFICATION OF THIS TRANSCRIPT DOES NOT APPLY TO THE REPRODUCTION OF THE SAME BY ANY MEANS, UNLESS UNDER THE DIRECT CONTROL AND/OR DIRECTION OF THE CERTIFYING COURT REPORTER.

Ex. A

Ex. A

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
SOUTHWESTERN DIVISION

MKB MANAGEMENT CORP, D/B/A RED RIVER WOMEN'S CLINIC, AND KATHRYN L. EGGLESTON, M.D., Plaintiffs, -vs- BIRCH BURDICK, in his official capacity as State Attorney for Cass County; WAYNE STENEHJEM, in his official capacity as Attorney General for the State of North Dakota; and LARRY JOHNSON, M.D.; ROBERT TANOUS, D.O.; KATE LARSON, P.A.C.; NORMAN BYERS, M.D.; CORY MILLER, M.D.; KAYLEEN WARDNER; GAYLORD KAVLIE, M.D.; KENT MARTIN, M.D.; KENT HOERAUF, M.D.; BURT RISKEDAHL; JOHNATHAN HAUG, M.D.; AND ROBERT J. OLSON, M.D., in their official capacities as members of the North Dakota Board of Medical Examiners, Defendants.	Civil No: 1:13-CV-071

D E P O S I T I O N

of

TAMMI KROMENAKER

November 26, 2013

12:30 p.m.

Taken at: JOE TURMAN OFFICES
505 North Broadway, Suite 207
Fargo, North Dakota

REPORTER: KRISTEN M. KEEGAN

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INDEX

EXHIBITS

WHEREUPON,
the following proceedings were had
to-wit:
TAMMI KROMENAKER, a witness, called by the Defense, being first duly sworn, testified on her oath as follows:
BY MR. GAUSTAD: EXAMINATION

Q. Will you state your name.
A. Tammi Kromenaker.
Q. Okay. I may mispronounce the name --
A. That's fine.
Q. -- and I apologize for that. My name is Dan Gaustad. I represent the state defendants in this action. As I understand, you're here as the designated -- corporate designee for -- is it MKB?
A. MKB Management, yes.
Q. Yes. You were here during the deposition of Dr. Eggleston --
A. Yes.
Q. -- correct? So you kinda understand what the rules are? I don't think I need to go through them again unless there's some confusion?
A. Nope. That's fine.
Q. Have you been deposed before?

A. No, I have not.
Q. For today's deposition, what did you do to prepare? Who did you speak to?
A. My attorneys.
Q. Anybody else?
A. No.
Q. Did you review anything?
A. No, I did not.
Q. Okay. Your involvement in any other litigation and I'm talking just anything as a witness, as a plaintiff, defendant, if you've been involved in litigation before?
A. With MKB in other cases, yes.
Q. Okay. And one was a State Court case that's still going on, right?
A. Correct.
Q. Any other cases with MKB?
A. Yes. Well, that case which S.B. 2305 has been added to, and in 2001, there was a case, a false advertising case.
Q. That was brought by who?
A. A citizen of North Dakota.
Q. Do you remember who that was?
A. Amy Jo Matson.
Q. She brought it against the clinic?

Page 6

A. Yes.
Q. Tell me -- I don't understand. False advertising?
A. We had a brochure that stated an abortion does not cause breast cancer, and she disagreed with that and accused us of false advertising.
Q. Okay. What was the outcome?
A. We prevailed at the North Dakota Supreme Court.
Q. Okay. Any other -- you were -- you're the director at that time, right?
A. Yes.
Q. Okay. And so your involvement would have been kinda like a witness or representing the clinic in that case? Were you actually a named party?
A. I was not a named party.
Q. Okay. Do you know who else besides the clinic was the named party in that action?
A. No.
Q. And was Amy Jo, I didn't get the last name. I didn't write it down.
A. Matson.
Q. Matson. Was she the only plaintiff?

Page 7

A. Yes.
Q. You were successful at the North Dakota Supreme Court. What happened at the trial court level?
A. We prevailed at the trial court as well.
Q. On both levels?
A. Yes.
Q. Okay. Was there -- so you prevailed at both the Trial Court and the Supreme Court level?
A. Yes.
Q. Okay. Any other litigation you've been involved with? We've talked about this one obviously and --
A. Yes. In 2009, the State of North Dakota passed a bill regarding ultrasounds that we challenged and were able to come to a settlement, I believe is the proper term with the State on that.
Q. Okay. What was the statute that -- what was the problem in your estimation?
A. It was a confusing statute that we weren't sure how to implement at the clinic.
Q. Okay. What was the statute? I mean,

Page 8

as a result of the settlement, did you clear up -- you got some clarity?
A. Yes. We were able to clarify what the statute called for and what we were supposed to do at the clinic.
Q. Okay. And that deals with ultrasounds?
A. Correct.
Q. Tell me what it is then that you have to -- the clarity.
A. We have to offer women the opportunity to receive and view an active ultrasound of her pregnancy at least 24 hours in advance.
Q. Of the abortion?
A. Of the abortion. It's part of the informed, 24 hour informed consent process.
Q. Okay. And it is a 24 hour process, right? That before the woman can have an abortion, there's a 24 hour kinda waiting period?
A. That's correct.
Q. 'Cause I thought Dr. Eggleston thought it was 24 to 48 hours, but it is just 24 hours, right?
A. The waiting period in North Dakota is

Page 9

a 24 hour waiting period.
Q. Okay. Any other litigation that you've been involved in?
A. Not that I can recall.
Q. How about any -- have you been involved or the clinic been involved in any type of complaints with any type of medical boards?
A. No.
Q. Your education. Do you have a degree? Post high school degree?
A. Yes. I have a bachelor's degree in social work.
Q. When did you get that?
A. 1994.
Q. Where?
A. Moorhead State University.
Q. Did you ever use -- I mean, in a -- like a social services -- an agency, did you ever work for a social services agency?
A. Yes, I did.
Q. Where?
A. Becker County Social Services.
Q. And what did you do there?
A. I was a child support officer.
Q. And when was that?

Page 10

A. 1995 and 1996.
Q. So right out of college?
A. About a year later.
Q. What did you do between that year you graduated before you came to social services?
A. I worked at another -- the former abortion clinic in Fargo part time, and I also worked at the YWCA Women's Shelter part time.
Q. And that was that interim period between when you graduated from MSU and this Becker County Social Services?
A. Yes. I worked at both of those places.
Q. In that one year period of time roughly?
A. Yeah.
Q. Okay. And why did you decide to go to Becker County Social Services?
A. It was full-time employment.
Q. How long did you work there?
A. Approximately nine months.
Q. Why'd you leave?
A. I had a baby.
Q. And then what did you do after you -- Becker County?

Page 11

A. Then I became a full-time staff person at Fargo Women's Health Organization.
Q. Is that the former clinic that was before this MKB?
A. Yes.
Q. And what did you do there?
A. I was the assistant administrator.
Q. And as an assistant administrator, what did you -- what were your duties?
A. Much of what I do now just overseeing day-to-day operations.
Q. So what you did for the Fargo Women's Health Organization is similar to what you're doing today?
A. Similar, yes.
Q. Okay. Tell me a difference.
A. I had less responsibility when I first started there --
Q. Okay.
A. -- at the Fargo Women's Health Organization.
Q. How long did you work for Fargo Women's Health Organization?
A. I began part time there in November of 1993, full time 1996, and I left there in July of 1998.
Q. Why?
A. To start working at Red River Women's Clinic.
Q. And that Fargo Women's Health Organization, that doesn't exist anymore, right?
A. No. It has closed.
Q. When did it close?
A. I believe the end of January 2001.
Q. And was there a problem that you decided to go to the Fargo Women's Clinic versus the Fargo Women's Health Organization that caused you to make the transfer?
A. I liked my boss better.
Q. Over at the clinic -- the clinic you're at now?
A. Correct.
Q. It was a lateral move though wasn't it? From a professional standpoint?
A. Basically yes.
Q. And you've been at the Fargo Women's Clinic since '98 then?
A. I've been at Red River Women's --
Q. Excuse me.
A. -- Clinic since July of 1998, yes.

Page 12

Page 13

Q. Yeah. Let's talk about what your position was when you first came over in '98. What was --
A. I was the clinic director at that time and have been the clinic director since that time.
Q. Okay. So you became the clinic director all the way from '98 forward?
A. Correct.
Q. Okay. We'll get into that in a little bit. Any type of post-graduate degrees that you've got?
A. No.
Q. How about any type of licenses?
A. I had a social work license at one time, and I have not renewed it.
Q. When was it last renewed?
A. I got it right out of college, and I honestly don't remember how long they're active for. I probably renewed it -- I know I took continuing education, so I probably renewed it at least once. So it may have been a year or two or up to four. I honestly don't remember how long Minnesota licenses for.
Q. Okay. You've never been licensed in

North Dakota as a social worker?
A. No, I have not.
Q. And so it's been a number of years since you've had your social work license; is that fair?
A. Correct.
Q. Probably more then ten years?
A. Correct.
Q. Any other licenses that you -- driver's license obviously, right?
A. Yes. I have a driver's license.
Q. Any other -- and I think you understand what I'm -- any other type of --
A. I have no other professional licenses.
Q. How about any type of designations? Professional designations? Special designations that you might hold?
A. What do you mean by designations?
Q. Something more than just a licensed social worker. You've attained some board certification or anything like that?
A. No, I have not.
Q. Have you served on any type of boards or organizations?

A. Yes. I'm currently on the board of The Abortion Care Network.
Q. And how long have you been on that?
A. Approximately three to four years.
Q. How do you get -- does somebody nominate you or how do you get on that board?
A. You make an application and you gain board approval.
Q. How many members are on that board?
A. Approximately a dozen.
Q. Is this a national organization?
A. Yes, it is.
Q. What does it do?
A. The Abortion Care Network is an organization that represents independent abortion providers.
Q. What do you mean by independent abortion providers?
A. Independent abortion providers are providers like Red River Women's Clinic that have no national affiliate.
Q. And I'm gonna ask you: What national affiliate? Give me an example of that.
A. For an example, Planned Parenthood is part -- is a, you know, the Planned Parenthood

Clinic in Sioux Falls that Dr. Eggleston referenced, is part of the affiliate of Planned Parenthood which has a national organization Planned Parenthood Federation of America. So an independent abortion provider is a doctor in their solo practice, a clinic like Red River Women's Clinic, or a hospital that has no -- basically not Planned Parenthood.
Q. Does it belong to this National Abortion Federation though?
A. Does what?
Q. The Fargo clinic.
A. Red River Women's Clinic is a member of the National Abortion Federation, yes.
Q. Okay. And how is that different than between that Planned Parenthood and National Abortion Federation?
A. NAF is a professional membership organization and Planned Parenthood is a corporation.
Q. Okay. And so Planned Parenthood runs the clinics? Is that -- and the National Abortion --
A. I don't work for Planned Parenthood so I'm not exactly sure how that works. That's

my understanding.
Q. Okay. That's your understanding that they actually operate the clinics?
A. Yes.
Q. Okay. And the National Abortion Federation, they don't run the clinics? They evidently provide some protocol but --
A. They do not run clinics. Correct.
Q. Any other boards?
A. I'm also on the board of The North Dakota Women in Need Abortion Access Fund.
Q. And how long have you been on that?
A. 14 years.
Q. And how many board members are there?
A. Approximately a dozen.
Q. And how does one get on that board?
A. Makes an application and the board determines if that person will be on the board or not.
Q. Okay. And that's just within the State of North Dakota, right?
A. Yes.
Q. What does this organization do?
A. The North Dakota Women Abortion Access Fund is a 501c3 charitable fund that helps

women seeking reproductive healthcare services at Red River Women's Clinic afford those services.
Q. So they pay the fees then?
A. They assist with grants for services.
Q. Do they issue the grants themselves?
A. The Red River Women's Clinic bills the WIN Fund for the grants given to women.
Q. Okay. And so the funds come from this access fund organization that you're involved with, correct?
A. Yes.
Q. So there's a -- I'm gonna put it in laymen's terms. If the cost is let's say $500, the woman comes up with $200, this access fund would then make up the $300 difference?
A. Not every time.
Q. No. But to the extent that they do, is that kind of the way it works? Just as kind of an example?
A. If the woman meets the guidelines set out by the board of the WIN Fund to receive grant money, it will be designated towards her, yes.
Q. Okay. Any other boards?
A. Yes. The North Dakota Planned Parenthood Advisory Council.

Q. And what is that?
A. It is a board for the local Planned Parenthood affiliate, and we advise the Planned Parenthood public affairs office and provide support.
Q. That I don't understand. What do you mean provide support? It's a lot of words that didn't say much to me that candidly.
A. I sit on the advisory committee of somebody who is knowledgeable about reproductive health in North Dakota, and I provide that information and -- to the Planned Parenthood affiliate.
Q. And that's I think Dr. Eggleston talked about some advocacy -- Planned Parenthood advocacy that she was involved with that. Is that the Planned Parenthood you're referring to?
A. I don't think Dr. Eggleston is involved in the advocacy. There's a public affairs office of the affiliate that she works for that is located here in Fargo, North Dakota.
Q. Okay. And is this Planned Parenthood Advisory Council kinda part of the Planned Parenthood National Organization?
A. It's associated with the St. Paul

affiliate which is associated with Planned Parenthood Federation of America.
Q. So the answer is yes?
A. Yes.
Q. Okay. Any other organizations or boards you're -- you're on?
A. I was recently asked to join the Social Workers for Reproductive Justice Advisory Council. I don't think that's really considered a board though.
Q. Are you on that?
A. It's newly formed. That's all I can -- that's all I know about it at this point.
Q. Okay. You've been asked but you don't know if you're on it or not?
A. I know I'm on it. It's a very new organization. We have not even had a meeting.
Q. Okay. Do you know what the purpose of this organization is?
A. I don't think that's been -- I don't think the mission statement has been created.
Q. Okay. Any other boards?
A. Not that I can think of, no.
MR. GAUSTAD: Would you mark this, please.

(Deposition Exhibit No. 8 was marked for identification.)
Q. Ms. Kromenaker, (phonetic) did I say that right?
A. Kromenaker.
Q. Kromenaker. Sorry. You have Exhibit Number 8 in front of you?
A. Yes, I do.
Q. And looking at the last page, that's your signature?
A. It is.
Q. Okay. We talked about you becoming clinic director in 1998, and I'm looking at paragraph 3. "As director, I am responsible for overseeing the Clinic's day-to-day operations." Do you see that?
A. Yes, I do.
Q. And then you describe what that means. As I understand, it includes personnel matters?
A. Correct.
Q. Tell me what you do with personnel matters.
A. I hire and schedule staff.
Q. You schedule Dr. Eggleston?

Page 22

A. I work with Dr. Eggleston on her schedule, yes.
Q. Is that -- and what about the other physicians that perform abortions? Are they scheduled through you?
A. Yes.
Q. Are those other physicians, are they OB/GYN or are they just in the family practice that Dr. Eggleston has?
A. All of our physicians are board certified family medicine.
Q. Okay. So are they OB/GYN or not?
A. No. They are family -- they are board certified in family medicine.
Q. Okay. And then you -- part of your day-to-day operations is the clinic's business affairs. Tell me what that means.
A. It means I run the pay roll, I pay the bills, oversee ordering supplies.
Q. Anything else that would fall within that business affair?
A. No, I don't think so.
Q. And then you say, "serving patients in virtually all non-medical capacities, including education, counseling, and billing."

Page 23

Do you see that?
A. Yes.
Q. Tell me what you do as far as the non-medical education.
A. I often make appointments, and when patients are in the clinic, I answer questions and provide them information.
Q. What type of information do you provide them?
A. Information about the services that Red River Women's Clinic offers.
Q. Are patients in there for only one reason to get an abortion?
A. No.
Q. Okay. How much of your -- of the Red River Clinic is abortion? Percentage wise.
A. Over 90 percent.
Q. Would that be, you know, the revenue stream too? Is that what you're -- be 90 percent of the revenue is from abortions?
A. Yes.
Q. So tell me what the other ten percent comprises of.
A. We do walk-in pregnancy tests, sexual transmitted infection screenings, and provide

Page 24

birth control to non, you know, patients who are not having an abortion that day.
Q. And so you're providing the information primarily on the abortion services, correct?
A. No. I'm providing information on all of the services that we offer at the clinic.
Q. Okay. But if 90 percent of your services are abortion, it would be about 90 percent of the information you're providing would be about abortion?
A. That's correct.
Q. Is this information in written form or --
A. It's in various forms.
Q. Okay. Is it in written form that the State of North Dakota requires?
A. Yes.
Q. Okay. And you provide that information --
A. Yes.
Q. -- that's part of your day-to-day operations, correct?
A. Yes.
Q. Is there information that the clinic

Page 25

has prepared itself?
A. On our website we have information.
Q. But that's -- do you provide that then to the women when they come in? Is that part of your day-to-day operations?
A. Well, I maintain the clinic's website, so I believe that women receive information from us in a variety of ways --
Q. Okay.
A. -- both with the state required materials, verbally over the phone asking questions, they may visit our website ahead of time to get some of that information, and then when they're physically in the building, we provide them information both, you know, verbally, written, however they --
Q. When the patient comes in, are you the designated go-to person then to say if there's some question they have it's talk to Tammi?
A. What do you mean by when they come in?
Q. When they walk into your clinic and they're looking for information, are you the go-to person?

Page 26

A. No. We have many staff who are trained to provide information.
Q. Okay. And when you say trained, what training do they go to to provide that information?
A. We train our staff.
Q. Okay. How? Tell me what you do to train your staff.
A. We train our staff on Red River Women's Clinic protocols and how we conduct, you know, our services at our clinic. Many of our staff are also nurses so they've received training through their nursing course of -- course of education.
Q. Okay. Do they have any other special type of training that they go to so that they know what type of information, what type of responses should be given to patients?
A. Many staff go to professional conferences and we have ongoing, you know, staff meetings that Dr. Eggleston will be present at so that staff can ask questions of her.
Q. And she's the one that sets the protocols to the procedures for abortions, correct?

Page 27

A. Yes.
Q. What about as far as your non-medical counseling. What do you do there?
A. We educate --
Q. I'm asking about you. 'Cause you -- I'm talking about your day-to-day operations. And you say you serve virtually -- patients in virtually all non-medical capacities. And you've said counseling. So I'm asking about you.
A. I make many of the appointments, and I speak to many patients when they're in our building.
Q. So what is it that you do as far as counseling? I understand you make the appointments and you talk to them, but what is it that you're doing as far as this counseling is concerned?
A. It's part of our patient education process of talking with the woman about her circumstances and her situation and providing her information on what she needs from us that day.
Q. How many people are providing this non-medical counseling besides you?
A. Most of our staff are cross-trained in many areas, so it -- there's approximately

Page 28

five to seven people who, when I'm answering that question, I'm thinking of who knows how to be part of the patient education session.
Q. And these five to seven people are they -- are they all RNs? Do you know?
A. Well, I think I'm gonna -- say -- elaborate a little more that all or our staff are, you know, trained and educated to answer questions throughout the day whatever station a patient might, you know, be at at that time.
Q. And that training is through the clinic?
A. And in addition to some of our staff are nurses, part of their nursing education.
Q. How many nurses do you have on staff?
A. Approximately five to six.
Q. How many social workers do you have on staff?
A. I don't know that I can at this moment tell you every single person's educational degree. I know for a fact I have a social work degree and as I think about our staff, I don't know -- memorized what all of their, you know, degrees are.
Q. Have you ever advertised -- you're

Page 29

the clinic director, have you ever advertised saying hey we're hiring social workers?
A. No. I don't believe we've ever run a specific add for a social worker.
Q. How about like psychiatrist or a psychologist? How many are on staff?
A. Zero.
Q. Do you know if you have any licensed counselors on staff?
A. I do not have any licensed counselors on staff at this time, no.
Q. Have you ever had any licensed counselors on staff?
A. Yes, I have.
Q. When?
A. Sometime in the past decade.
Q. Okay. Do you know for a length of time they were employed?
A. I had a staff person who was getting her master's and licensing. I don't recall the exact dates when she was from master's to licensed and, you know, she worked at our clinic throughout that time.
Q. And she's no longer with the clinic, correct?

Page 30

A. Correct.
Q. Do you know why she left?
A. She needed full-time employment.
Q. The billing is pretty self-explanatory I suspect? You send out the bills and you receive payments. Or is there something more to the billing?
A. No. It's a very straight forward. We don't bill patients. The patients pay the day that they receive their services.
Q. Before --
A. But billing --
Q. -- is that before they walk in? Do they come to the desk and say here's my money?
A. No.
Q. When is it in the process that they cut the check?
A. We don't take checks. Patients pay --
Q. It's an analogy. I'm sorry.
A. -- patients pay after we've determined how far along they are, what their blood type is, if they want STI testing or not, and what method of birth control they want or not.

Page 31

Q. And -- 'cause that's all factored in to what the fees are going to be then?
A. That is correct.
Q. How much is it for an abortion?
A. An abortion in the first trimester is $550.
Q. And that's the first -- how many weeks of lmp is that?
A. Up to 12 weeks.
Q. Okay. And then after 12 weeks is it more?
A. Yes.
Q. How much?
A. 12 to 13 weeks is $600, 14 weeks is $750, 15 weeks is $850.
Q. And how long have you -- that fee structure been in place? Have there been changes?
A. There's been changes in the 15 years that we've been open. I believe the fee structure that's in place right now has been in place for at least the last -- we've not raised our prices in three to five years.
Q. Do you have any other responsibilities at the clinic other than what's

Page 32

shown in Exhibit Number 3 -- or excuse me, paragraph 3 of Exhibit Number 8?
A. No.
Q. Why is it your fees, as far as the 12 to 13, why does it go up?
A. We have to pay the physician more.
Q. Do you know why that is?
A. My understanding it's standard to pay the physician more after the first trimester.
Q. But do you know why that's standard?
A. Because of their skill and expertise and the procedure may take a little bit more of their time.
Q. Okay. Any other reason that you know as to why it costs more?
A. No.
Q. Is there -- does the National Abortion Federation kinda set the standard?
A. No, they do not.
Q. In paragraph 4, of your declaration, which is Exhibit Number 8, you say the clinic is only open one day per week, correct?
A. That's what it says, yes, and that is generally true.
Q. Is there a time when it's open more

Page 33

then one day per week? Or excuse me, performs abortions more then one day per week?
A. Yes.
Q. How often does that happen?
A. Once every couple of months.
Q. Okay. And how many days does -- every couple of months does it occur? Is it two days? Three days? Four days?
A. Two days per week.
Q. So the maximum is two days per week?
A. That is generally the practice, yes.
Q. And why is it that you're only performing abortions one day per week?
A. That's our physician availability and our patient demand.
Q. And you're talking doctor -- the three physicians that you've got? Those are -- they can only come in one day a week?
A. Correct.
Q. Have you ever advertised to bring a physician on full time?
A. No.
Q. Why not?
A. We don't have the capacity to provide a physician with full-time work.

Page 34

Q. Just not enough patients?
A. Correct.
Q. Any other reason why you wouldn't bring on a physician more then just one day per week to do abortions?
A. No.
Q. Is there any other reason why you're not open more then one day a week other than we don't have enough patients?
A. We're only open to perform abortions one day a week due to patient demand and our physician schedule.
Q. Okay. And the physician schedule, that's based upon patient demand too, isn't it?
A. Yes.
Q. So ultimately it's, we just don't have enough patients to warrant more then one day per week?
A. That's correct.
Q. Any other reason why you don't perform abortions more then one day per week?
A. None that I can think of.
Q. And there's nothing in the state statutes that you're aware of that would preclude you from being open or offering abortions more

Page 35

then one day a week, right?
MR. BROWN: I'm gonna object to that. That's a legal question. She doesn't have any familiarity. She's talking about the practices not the law.
Q. Are you -- thank you. Are you aware of anything that would preclude you from being -- from providing abortions more then one day per week?
MR. BROWN: You can answer the question.
THE WITNESS: I don't know of any law, no.
Q. How about anything that would preclude you other than the number of patients that want to have an abortion is -- are there any other reasons why you couldn't offer abortions more then one day per week?
A. None that I can think of.
Q. Then looking at paragraph 5 of your declaration. Do you have that in front of you?
A. Yes.
Q. Okay. In that paragraph you set out the reasons why women seek abortion services. Do you see that?

Page 36

A. Yes, I do.
Q. You say, "Fifty-eight percent of the clinic's patients already have children and many do not feel they can adequately parent and support additional children." Do you see that?
A. Yes.
Q. Where would I look to get this information to support that?
A. From the North Dakota Department of Health reports.
Q. And where would that show me that they do not feel they can adequately parent and support additional children?
A. That's from information that patients provide to us.
Q. And where would I look to find that type of information then?
A. Patients have a form that they fill out plus they also tell us that verbally.
Q. Okay. So I'd look to those forms, correct?
A. Yeah. There's forms that the patients tell us about their reasons plus they also, when they make their appointment, when they're at the clinic, will say why they are not

Page 37

going to continue this pregnancy.
Q. And is that type of information then put into their medical records?
A. The patient fills out a form.
Q. Okay. But when they're at the clinic does that -- do they tell you why they're seeking an abortion? Does that then show up in their medical records?
A. You know, if I'm making an appointment for somebody and she tells me her story over the phone, no, I do not write that story down on the appointment sheet.
Q. Do you know if others write this type of information in those medical records?
A. Not when a patient tells us information over the phone.
Q. How about in person?
A. There are times where a patient will tell us things that we may record but it's not -- there's not a specific form that -- I'm imagining a checkbox form where we, you know, write down this, that, or the other that the patient said.
Q. What about a non checkbox? Tell me the comments the patients made that you would include within their medical records.

Page 38

A. Yeah. We may write down some of what they share with us.
Q. So that fifty-eight percent that you're referring to in paragraph 5, that only relates to the clinic's patients having children. Does that fifty-eight percent also mean -- that's -- I'm trying to connect the dots here with the -- fifty-eight percentage is only with respect to the patients that already have children, correct?
A. Fifty-eight percent of our patients already have had at least one child, yes. That is correct.
Q. Going on in that sentence, that fifty-eight percent doesn't necessarily reflect the -- that they do not feel that they can adequately parent and support additional children. You haven't done that math calculation, have you?
A. I don't calculate or tabulate patients' reasons.
Q. Okay. But do you follow what I'm saying is you've got a 50- -- you've got a specified percentage of -- in paragraph 5. That specified percentage only relates to your patients that already have children, correct?

Page 39

A. Fifty-eight percent of the clinic's patients already have children. That is correct.
Q. Okay. And you haven't done that same type of tabulation with respect to those that do not feel they can adequately parent and support additional children, correct?
A. That is correct. I have not tabulated that.
Q. You make reference to younger patients. Do you see that in paragraph 5?
A. Yes.
Q. About their education and development and ability to provide for children in the future. Are -- what percentage of your patients are minors?
A. Approximately five percent.
Q. And you also make reference to, they seek abortions because they are pregnant as a result or rape, or domestic violence. How many of your patients do you know are pregnant because of a rape or -- do you know?
A. No. I don't tabulate that.
Q. Do you do any tabulation as to how many patients are subject to domestic violence?
A. No, I do not.

Page 40

Q. How about with respect to -- that the pregnancy threatens their health?
A. No, I do not.
Q. Does the clinic -- does the clinic calculate that at all?
A. No.
Q. But that's something as far as the pregnancy threatens their health, you would certainly see that in the medical records, wouldn't we?
A. I'm not a physician and can't -- can you rephrase the question?
Q. Well, if the pregnancy threatens the health, and they're in there -- they're seeking an abortion because -- you said it threatens their health. Wouldn't I expect to see that in their medical records?
A. It's possible.
Q. Have you ever seen -- you don't know -- poorly worded question. Are you aware of an instance where an abortion was performed because of -- the pregnancy threatens the health and it didn't appear in the medical records?
A. I have instances where patients have been recommended not to continue their pregnancy.

Page 41

And we have, at times, received records of their current health condition from their referring provider.
Q. And that -- those records would then be within your records for that patient, correct?
A. If we had -- yes. Yes.
Q. And if the patient talked to you about I've been the subject of domestic violence, you'd expect to see that in their records too, wouldn't you?
A. Not necessarily. Domestic violence is very common and we hear it many times from patients so it's not something that is -- that would always be written down or there's not a checkbox for that.
Q. Okay. How about if they were the subject of rape? Would we expect to see that in their medical records? That they've disclosed to you I was raped and I became pregnant?
A. If a patient discloses it, it's possible it would show up in her medical record.
Q. And so you're telling me it's possible it may not show up as well?
A. That is correct.
Q. And then you go on to say that

Page 42

patients are informed of the risks associated with abortion and childbirth, and this is not the only thing that women consider in deciding whether or not to have an abortion. Do you see that?
A. Yes, I do.
Q. What risks are you referring to as far as associated with abortion?
A. As part of the required 24 hour informed consent statements that we read to a woman, we list the risks of abortion.
Q. That's it? Is there anything else that you're aware of?
A. We read quite a bit to the patient as part of that informed consent process.
Q. Okay. And that's coming from the State of North Dakota?
A. It is the requirement of the State of North Dakota, yes.
Q. Other than what's in that informed consent statement, what other risks that you are aware of that are associated with abortion?
A. What risks am I aware of?
Q. Well, because you say, "while the patients are informed of the risks associated

Page 43

with abortion," is that the only thing that you talk to them about is what the State of North Dakota requires you to --
A. We read the required statements to the patients and a patient -- patients will often ask questions and we answer those questions.
Q. Concerning the risks associated with abortion?
A. Correct.
Q. And those risks associated with abortion, as I understand, those are the things that are within that informed consent from the State of North Dakota?
A. Yes.
Q. Do you know do you talk to the patients about any other risks that may not be listed in that informed consent that are associated with abortion?
A. Yes. Patients ask many questions about the risks of abortion.
Q. Give me an example of --
A. Am I going to die.
Q. Any other --
A. Will my uterus fall out.
Q. And that's all listed from that

Page 44

informed consent or is that --
A. No. We do not tell them that their uterus will not fall out.
Q. I understand.
A. That's not part of the informed consent.
Q. I understand that it's a question that they're posing after they've read that informed consent statement, correct?
A. Sometimes before.
Q. What are the risks of -- associated with childbirth that you are referencing in paragraph 5?
A. That's also required as part of the informed consent.
Q. So it's -- whatever's in that informed consent, that's what you were referencing in these risks associated with abortion or childbirth?
A. Yes.
Q. And then you've got that inform consent and you go on to say, that is not the only thing that women consider in deciding whether or not to have an abortion," and I've got some here listed in paragraph 5. Is there

Page 45

anything else that you know of as to what women consider in whether or not to have an abortion? Other than what's enumerated in paragraph 5.
A. I think it's alluded to in some younger patients but, you know, the ability to provide that's not only younger patients, so financial reasons. I believe -- I don't know that I could give you a complete list of every reason that every patient has ever, you know, told us. These are the general, sort of, most typical reasons that we hear but many -- you know, every women is unique, every women has a unique situation and will have her own reasons.
Q. And in paragraph 5, are these reasons why women would seek an abortion or actually have an abortion?
A. I believe women seek an abortion because they don't want to be pregnant for some reason.
Q. And tell me what reasons they consider not having an abortion. Do you know? If a patient comes and decides not to have an abortion, do you know what factors that --
A. Many of the same exact reasons.
Q. That are listed paragraph 5?

A. Yes.
Q. Do you need a break?
A. No, I do not. Thank you.
Q. You're statement in the last sentence of paragraph 5, you say, "women take several days or weeks to decide whether to continue the pregnancy or have an abortion." Do you see that?
A. Yes, I do.
Q. Tell me the -- when a woman first calls to schedule an appointment, what's the length of time before they're actually brought into the clinic?
A. At least 24 hours, and it can vary depending on the woman's financial situation, ability to get time off from work, provide child care if she has children she needs to, make the trip to Fargo, and our availability.
Q. And at that point when they call, have they made the decision, at least initially, that they want to seek an abortion? That's why they're trying at get an appointment at your clinic?
A. I would assume that somebody calling and saying I would like to make an appointment for an abortion has made that decision that that

is her intention.
Q. Okay. And so once that initial phone call is made, the decision has been made that she's going to seek and abortion, it's just trying to schedule things out is the problem? It could be -- it has to be at least 24 hours but if there's a longer period of time, it's just a scheduling problem then, correct?
A. Well, she, you know, has to wait at least the 24 hours required by law and then there's a variety of factors that may play into how soon she can get in. This sentence is referencing what I believe happens before she even makes the call to us.
Q. Okay. So when they make the call to you, they've already gone through this several days or weeks of deciding whether they want to continue the pregnancy or have an abortion?
A. That's my experience, yes.
Q. Have they ever told you when they call for the appointment, geez, this has taken me forever to decide?
A. Yes.
Q. And is that something that would get noted in the records somehow?

A. No.
Q. And tell me what information do you get from a woman when they call in for the appointment.
A. A lot.
Q. Tell me what's the protocol as to what the clinic requires to -- the information you're required to get.
A. We first ask her if she's confirmed the pregnancy with a pregnancy test, her name, age, date of birth, where she lives, her last period, whether or not she's been a patient at our clinic before, we ask her if she's had an ultrasound with this pregnancy, then we ask her a series of medical history questions. Would you like me to list those?
Q. Just -- go ahead. Yes.
A. We ask her what medications she's taking, we ask her if she has a history of asthma, diabetes, seizures, high blood pressure, we ask her if she has a history of heart surgery, or heart condition, we ask her if she has a -- if she's taking blood thinners or has a bleeding disorder, and we ask her if she has any other medical problems that she knows of and we also

ask her if she's been hospitalized for any reason other than childbirth.
Q. Okay. Those are things that are required by the clinic protocol, correct?
A. Dr. Eggleston has directed us to ask those questions to screen for medical situations that might require more information before the patient comes and sees us.
Q. Okay. And that would then be within their medical records? You retain that information?
A. That appointment sheet, it is part of her medical record.
Q. And to the extent that you -- is there space in that appointment sheet to add additional comments the patient may provide to you do during this communication?
A. Yes. There's spots where somebody -- if a patient tells me she's been raped, I will write rape on there because we also waive her fee at that time, so it's an indicator that this person is not going to be paying the fee.
Q. Okay. And to the extent that you might write down things like rape or domestic violence or the reasons why they're seeking an

abortion, it would be within that type of initial appointment?

A. I generally don't make those kinds of notes on the appointment sheet. I would put rape. The only other note I would put is if the patient says she has, you know, an IUD.

Q. And these -- the items in paragraph 5, as I understand it, you're trying to explain what the impact of this Heartbeat Detection Bill has on women, correct? Your patients.

A. I think paragraph 5 is just explaining why women seek abortion services.

Q. Okay. Paragraph 7 of Exhibit Number 8. You say, "it would be difficult for most patients to schedule their abortion prior to the cutoff of approximately six weeks imposed by H.B. 1456."

A. Yes, I see that.

Q. And that's the Heartbeat Detection Statute, right?

A. Yes.

Q. Does that statute actually make reference to a time period? Do you know?

A. My understanding of H.B. 1456 is that it says no abortion can be performed once a

detectable heartbeat is found.

Q. Okay. And you're assuming that that occurs at around six weeks?

A. Yes.

Q. Okay. So tell me what the purpose of paragraph 7 is. Is that then to demonstrate the impact or the harm of the women as a result of this Heartbeat Detection Statute?

A. Can you repeat the question?

Q. Yeah. You said paragraph 5 is -- your purpose was to explain why women seek abortions.

A. Yes.

Q. I'm trying to figure out what your purpose was in drafting paragraph 7. Was that to describe what the impact of the Heartbeat Detection Statute would have on your patients?

A. Yes.

Q. And I don't see anything in here about the impact, in your affidavit as part of summary judgment, the impact that 1456 would have on the clinic. Is there anything in your affidavit that makes reference to any harm or impact of 1456 has on your clinic?

A. I don't believe there's any

paragraphs that talk about the harm to Red River Women's Clinic in my affidavit.

Q. The affidavit that's marked as Exhibit Number 8?

A. Yes.

Q. Do you know what the harm to the clinic would be from 1456 that's not in your affidavit?

A. I believe the harm would be we would no longer be able to stay open.

Q. Why?

A. 'Cause the vast majority of our patients would not be able to comply with H.B. 1456.

Q. And why wouldn't they be able to comply with H.B. 1456?

A. For all the reasons I listed in paragraph 7.

Q. Okay. Any other reason?

A. No.

Q. If you're open more then one day a week providing services though, would that still be the same scenario?

A. The patient population wouldn't be any different if we were op- -- there's -- by

being open more days a week, we're not creating more women in North Dakota and the surrounding areas that we serve.

Q. Okay. But that wasn't my question. I understand that you believe that there's a limited number of customers that you've got or patients, potential patients that come in for abortion services. The question is: If you're open more days a week providing abortion services, would that still be the same? The vast majority of your patients would not be able to comply with 1456?

A. I think that's still correct, yes.

Q. Why?

A. Again, for all the reasons that are listed in 7 that it takes a woman time to find out she's pregnant, decide if she wants an abortion or not, discuss it with family members and friends, take a day off of work, provide childcare, travel to Fargo, that all takes time.

Q. Any other reason that you believe other than what you've just described there as to why they wouldn't be able -- even if you're open more then one day a week, you still believe that 1456 -- the vast majority of women would not be

Ex. B

able to comply with 1456?
A. I believe that is correct.
Q. As far as viability is concerned, whether an unborn child is viable, do you have any qualifications to make that judgment as to when an unborn child is viable?
A. No. I'm not a physician.
Q. It takes medical judgement to -- I trust, as to whether an unborn child is viable?
A. Viable -- a physician has to answer that question.
Q. You're not qualified to make that determination?
A. I am not a physician, no.
Q. So the answer is you're not qualified to make that determination?
A. To make what determination?
Q. As to whether an unborn child is viable or not?
A. No. I am not qualified to make that determination.
Q. Do you know who Stacey Burns is?
A. Yes, I do.
Q. Who is she?
A. Stacey Burns, I don't know her

official title, but she works for the National Network of Abortion Funds as their social media person.
Q. Is that one of the organizations you're involved in?
A. No. The National Network of Abortion Funds is -- no, I am not involved with The National Network of Abortion Funds other than the North Dakota WIN Abortion Access Fund is one of a member fund of the National Network of Abortion Funds.
Q. Is she on the board for the North Dakota Network of Abortion Funds?
A. Stacey Burns is not on the board of the North Dakota Women In Need Abortion Access Fund, no.
Q. Does she attend your meetings?
A. No, she does not.
Q. Do you know why she sent out this Twitter?
A. Stacey Burns is a very active reproductive justice tweeter. I cannot tell you why she sends out tweets she sends out.
Q. And then went through and -- with Dr. Eggleston, these forms that are, I think it

starts at PL 624, if my memory serves me it goes to PL 675 as part of the discovery the plaintiffs provided in this case. Do you know how those are created?
A. Yes. We ask patients to fill those -- the first forms out and the later ones are from patient journals at our clinic.
Q. So these are -- these PL 627 to 694 are patients that have already had an abortion?
A. Yes.
Q. So they're sitting in the recovery room filling this out?
A. We have patient journals throughout the clinic and patients or their support person who comes with will often be seen writing in them. The recovery room is where most of that writing occurs 'cause it's a more private space.
Q. Do you then retain these? I mean, how do you retain these journals?
A. Every patient journal that's ever been written in is within Red River Women's Clinic. They never leave the building.
Q. Do they ever go -- do you identify which patient they're from?
A. No. Unless the patient writes her

name in there, no. There's no way to know the identity of a specific patient who wrote those.
Q. MKB is a North Dakota corporation, correct?
A. That is correct.
Q. Do you know who the officers are?
A. Yes, I do.
Q. Who are they?
A. Jane Bovard, George Miks, and George Klopfer.
Q. And who are the directors?
A. Those same people.
Q. Same people serve as officers and directors?
A. They are the owners and officers of the corporation.
Q. Okay. Which one is the president?
A. Jane Bovard.
Q. And the other -- the other two people, what are their positions?
A. I don't know.
Q. Don't know. Was she affiliated with The Fargo Women's Health Organization?
A. Yes.
Q. Have they always been officers and

directors as far as you've been there?
A. Yes.
Q. Other than your attorneys, have you spoken to anybody about this case?
A. No.
MR. GAUSTAD: We will keep this deposition open as well for the same reasons that's cited in Dr. Eggleston's deposition.
THE WITNESS: Okay.
MS. CREPPS: Anything else?
MR. GAUSTAD: That's it for now.
(This deposition was concluded at 1:36 p.m.)

NOTARY REPORTER'S CERTIFICATE
STATE OF NORTH DAKOTA
COUNTY OF CASS

I, Kristen M. Keegan, a Notary Public within and for the County of Cass and State of North Dakota do hereby certify: That the afore-named witness was by me sworn to testify the truth, the whole truth, and nothing but the truth.

That the foregoing fifty-nine (59) pages contain an accurate transcription of my shorthand notes then and there taken.

I further certify that I am neither related to any of the parties or counsel, nor interested in this matter directly or indirectly.

WITNESS my hand and seal this 4th day of December, 2013.

Kristen M. Keegan
Notary Public
Fargo, North Dakota

THE FOREGOING CERTIFICATION OF THIS TRANSCRIPT DOES NOT APPLY TO THE REPRODUCTION OF THE SAME BY ANY MEANS, UNLESS UNDER THE DIRECT CONTROL AND/OR DIRECTION OF THE CERTIFYING COURT REPORTER.

Ex. B