IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION

COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, et al. Plaintiffs, v. PETER LYSKOWSKI, in his official capacity as Director of the Missouri Department of Health and Senior Services, et al. Defendants.	)	Case No. 2:16-cv-04313-HFS

PLAINTIFFS' SUR-SURREPLY SUGGESTIONS IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Apparently unsatisfied with their original briefing and evidence, Defendants Hawley and Lyskowski (the "State Defendants") filed Surreply Suggestions in Opposition to Plaintiffs' Motion for Preliminary Injunction ("Surreply"), ECF No. 56, along with two new declarations, Declaration of Priscilla Coleman, ECF no. 56-1, and Supplemental Declaration of Tulumesh Solanky, ECF No. 56-2. The new declarations both cite to new evidence, and one is from an entirely new witness. But this belated effort by the State Defendants to buttress their defense is to no avail because, at their core, these new filings largely repeat the same unavailing arguments the State Defendants had already raised in their response briefing.

First, the State Defendants repeat their prior incorrect argument that abortion has a higher complication rate than that shown by the widely accepted medical literature relied upon by Plaintiffs' medical expert Dr. Eisenberg. Surreply at 1–2. Apparently unhappy with their original witnesses' responses to Dr. Eisenberg, the State Defendants submit a declaration by a new witness, Professor Priscilla Coleman, but she is an anti-abortion activist who is not a

medical doctor and whose research has been discredited by both courts and the mainstream scientific community. *See Planned Parenthood of Wisconsin, Inc. v. Schimel*, 806 F.3d 908, 922 (7th Cir. 2015), *cert. denied*, 136 S. Ct. 2545, 195 L. Ed. 2d 869 (2016) (noting methodological flaws with a Coleman study of longevity following abortion); Eisenberg Supp. Rebuttal Decl. in Supp. of Pls.' Mot. for Prelim. Inj. ("Eisenberg Supp. Rebuttal"), attached hereto as Exhibit A, ¶ 4 n. 1 (collecting scientific critiques of Professor Coleman's research finding that it is methodologically flawed and that the data do not support Coleman's conclusions). Professor Coleman attempts to show that the studies relied upon by Dr. Eisenberg are unreliable and that abortion complications are common; however, Professor Coleman's declaration does not undermine the consensus in the literature, recognized by the Supreme Court in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2311 (2016), that abortion is extremely safe. As Dr. Eisenberg explains in his Supplemental Rebuttal Declaration, Professor Coleman's critiques of the studies Dr. Eisenberg relies upon are unfounded. Eisenberg Supp. Rebuttal ¶ 6–15. Furthermore, the studies cited by Professor Coleman in an attempt to show that abortion is unsafe show no such thing. Eisenberg Supp. Rebuttal ¶¶ 16–23.

Notably, neither the State Defendants in their surreply, nor Professor Coleman, even attempt to show that the Restrictions at issue in this case do anything to either reduce the rate of complications from abortion or improve the way complications are treated. Nor could they—as Dr. Eisenberg has explained, and as the Supreme Court has held, ambulatory surgical center and hospital privilege requirements do not affect the quality of patient care. Whole Woman's Health, 136 S. Ct. at 2311, 2315–16; Decl. of David L. Eisenberg in Supp. of Pls.' Mot. for Prelim. Inj., ECF No. 15-3, ¶¶ 13–14; 30–34, 38, 39–49; Rebuttal Decl. of David L. Eisenberg in Supp. of Pls.' Mot. for Prelim. Inj., ECF No. 42-1, ¶¶ 19–24, 27–28. Therefore, even if the

State Defendants' attempts to dispute the safety of abortion had merit (which they do not), that would not change the fact that the Restrictions do not further the state's interest in women's health.

Second, the State Defendants in their surreply continue to rely upon Dr. Solanky's arguments regarding the overall abortion rate in Missouri to attempt to show that the Restrictions do not impose a burden on Missouri women. But, as Plaintiffs have previously explained, Pls.' Reply Suggestions in Supp. of Mot. for Prelim. Inj., ECF No. 42, at 8-9, this argument applies the wrong legal analysis. Under clear Supreme Court precedent, the Court's analysis of the burdens the Restrictions impose must focus on their impact on those women for whom the laws are "an actual rather than an irrelevant restriction"–which, in this case, means women who live in or near communities in Missouri that would have an abortion provider but for the Restrictions, and not all women seeking abortion in the state. *Whole Woman's Health*, 136 S. Ct. at 2320 (explaining "large fraction" refers to "a large fraction of cases in which [the provision at issue] is *relevant*," a class narrower than "all women," "pregnant women," or even "the class of *women seeking abortions* identified by the State") (internal quotations omitted).

The literature relied upon by Dr. Henshaw in his Rebuttal Declaration in Support of Plaintiffs' Motion for Preliminary Injunction, ECF No. 42-3, properly focuses on women *actually affected* by abortion restrictions and shows that, when women are forced to travel long distances to reach an abortion provider, a significant portion are preventing from accessing abortion services and still more are delayed. *Id.* ¶¶ 18-24, 26. Contrary to the State Defendants' assertions that this literature is methodologically flawed, as Dr. Henshaw explains in his Supplemental Rebuttal Declaration in Support of Plaintiffs' Motion for Preliminary Injunction, attached hereto as Exhibit B, those studies are reliable and control very well for factors other

than driving distance. Henshaw Supp. Rebuttal ¶¶ 5-8.

For the foregoing reasons, and the reasons stated in Plaintiffs' Suggestions in Support of Motion for Preliminary Injunction, ECF No. 15, and Reply Suggestions in Support of Motion for Preliminary Injunction, ECF No. 42, Plaintiffs respectfully request that their Motion for Preliminary Injunction, ECF No. 14, be granted.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on March 20, 2017 a copy of the foregoing has been served upon all counsel of record in this action by electronic service through the Court's CM/ECF system.

/s/ Melissa A. Cohen
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EXHIBIT A

IN THE UNITED STATES DISTRICT COURT FOR THE
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COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, et al. Plaintiffs, v. PETER LYSKOWSKI, in his official capacity as Director of the Missouri Department of Health and Senior Services, et al. Defendants.	)	Case No. 2:16-cv-04313-HFS

SUPPLEMENTAL REBUTTAL DECLARATION OF DAVID L. EISENBERG IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

David L. Eisenberg declares the following:

1. I previously submitted two declarations in this case entitled "Declaration of David L. Eisenberg in Support of Plaintiffs' Motion for a Preliminary Injunction" ("Initial Decl."), ECF No. 15-3, dated December 12, 2016 and "Rebuttal Declaration of David L. Eisenberg in Support of Plaintiffs' Motion for a Preliminary Injunction" ("Rebuttal Decl."), ECF No. 42-1, dated January 31, 2017. A copy of my curriculum vitae was attached to my initial declaration as Exhibit A. I submit this supplemental rebuttal in my personal capacity, and hold the opinions in this declaration to a reasonable degree of medical certainty. My rebuttal represents my opinions alone. I do not speak for or serve as an authorized representative of Washington University School of Medicine or Barnes-Jewish Hospital.

2. I have reviewed the Declaration of Priscilla Coleman ("Coleman Decl."), ECF No. 56-1, submitted by the State Defendants. I offer my opinion on certain assertions in that

declaration. The fact that I do not address a particular statement or assertion in the declaration does not necessarily mean that I agree with the statement or assertion.

3. The Coleman Declaration does not effectively contradict the scholarly research from prestigious peer reviewed journals I cited in my initial report that shows that abortion is one of the safest medical procedures in the United States with an extremely low risk of complications and death. Indeed, Professor Coleman repeats many of the erroneous assertions made by Defendants' prior witnesses Dr. Andrew Steele and Tumulesh Solanky, and relies upon many of the same unreliable studies as those prior witnesses, in order to conclude, entirely without evidentiary support, that "abortion-related physical complication rates are a minimum of 5 to 10 times greater than the Plaintiffs' experts contend, and the risk of death resulting from abortion compared to childbirth is a minimum of 2 to 4 times greater." Coleman Decl. Section IV ¶ 9. As I explain below, Professor Coleman is simply incorrect.

4. Professor Coleman is not an abortion provider, or even a medical doctor, but a developmental psychologist who focuses primarily on mental health. Furthermore, Professor Coleman's work on abortion as been widely discredited (and refuted) as agenda-driven and seriously deficient in methodological rigor.[1]

[1] Julia R. Steinberg & Lawrence B. Finer, *Examining the Association of Abortion History and Current Mental Health: A Reanalysis of the National Comorbidity Survey Using a Common-Risk-Factors Model*, 72 Soc. Sci. & Med. 72 (2011); Julia R. Steinberg et al., *Fatal Flaws in a Recent Meta-Analysis on Abortion and Mental Health*, 86 Contraception 430 (2012); Tim Kendall et al., *To Meta-Analyse or Not to Meta-Analyse: Abortion, Birth and Mental Health*, 200 Br. J. Psychiatry 12 (2012); Louise M. Howard et al., Correspondence: *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Br. J. Psychiatry 74 (2012); Kathryn M. Abel et al., Correspondence: *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Br. J. Psychiatry 75 (2012); Julia H. Littell & James C. Coyne, Correspondence: *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Br. J. Psychiatry 76 (2012); Chelsea B. Polis et al., Correspondence: *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Br. J. Psychiatry 77 (2012); Ben Goldacre & William Lee, Correspondence: *Abortion and Mental Health: Guidelines*

5. As an initial matter, Professor Coleman claims that studies regarding the frequency of complications from abortion show that "the ASC and Hospital Relationship Restriction are prudent and necessary," Coleman Decl. Section I ¶ 3, but she nowhere explains why she believes this to be the case. Her entire declaration is focused on trying unsuccessfully to undermine the significant body of data that shows the safety of abortion; however, she never connects her position on that research with the actual issues in this case. She does not even attempt to show, nor could she, that the already extremely low rate of complications from abortion has been lowered by the Restrictions at issue in this case,[2] or that the Restrictions improve the way that complications from abortion are treated. Coleman Decl. Section I ¶ 8. This is not surprising since, as I have explained in my prior declarations, the Restrictions have no effect on the incidence or treatment of complications. Initial Decl. ¶¶ 13–14; 30–34, 38, 39–49; Rebuttal Decl. ¶¶ 19–24, 27–28.

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for Proper Scientific Conduct Ignored, 200 Br. J. Psychiatry 77 (2012); Gail Erlick Robinson, Nada L. Stotland, & Carol C. Nadelson., Correspondence: *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Br. J. Psychiatry 78 (2012); Toine Lagro-Janssen et al., Correspondence: *Abortion And Mental Health: Guidelines for Scientific Conduct Ignored*, 200 Br. J. Psychiatry 78 (2012); Helene H. Thygesen, E-Letter, *Shortcomings in the Data Analysis in Coleman (2011 199)*, Br. J. Psychiatry (Nov. 2, 2011), http://bjp.rcpsych.org/content/199/3/180.e-letters#shortcomings-in-the-data-analysis-in-coleman-2011-199; James C. Coyne, E-Letter, *Coleman Article Should Be Retracted, Not Debated in a Subsequent Issue of BJP*, Br. J. Psychiatry (Nov. 4, 2011), http://bjp.rcpsych.org/content/199/3/180.e-letters#coleman-article-should-be-retracted-not-debated-in-a-subsequent-issue-of-bjp; Gregory L. Kinney, E-Letter, *Re:Re: Abortion and Mental Health*, Br. J. Psychiatry (Nov. 29, 2011), http://bjp.rcpsych.org/content/199/3/180.e-letters#rere-abortion-and-mental-health; Royal College of Obstetricians & Gynaecologists, *RCOG Statement on BJPsych Paper on Mental Health Risks and Abortion* (Sept. 1, 2011), https://www.rcog.org.uk/en/news/rcog-statement-on-bjpsych-paper-on-mental-health-risks-and-abortion/.

[2] Mo. Ann. Stat. §197.200 (Ambulatory Surgical Center Restriction); Mo. Ann. Stat. §§ 197.215, 188.080, and 188.027 and Mo. Code Regs. Ann. tit. 19, § 30-30.060(1)(C)4 (Hospital Relationship Restriction).

Abortion-Related Deaths are Extraordinarily Rare

6. Much of Professor Coleman's declaration focuses on her argument that deaths from abortion are underreported. She attempts to imply that abortion is less safe than childbirth, but she bases these arguments on a number of erroneous conjectures for which she provides no actual evidence. To take just two examples, Professor Coleman argues, citing no evidence whatsoever, that abortion providers under-report data to state health departments and to the CDC in part because "many abortion providers do not offer after hours contact numbers," and that therefore abortion mortality is underreported. Coleman Decl. Section II ¶ 6. This is entirely untrue. In fact, both Planned Parenthood Federation of America and the National Abortion Federation, of which the vast majority of abortion providers nationally are members, require that after-hours contact information be given to patients. And, as I have previously explained, in my experience physicians who provide abortion become aware of most complications, especially serious complications, that arise post-procedure because their patients or other treating physicians or hospitals report them either at a follow-up visit or by a separate phone call. Rebuttal Decl. ¶ 4.

7. Similarly, Coleman states, again providing zero evidence, that "[t]he majority of deaths due to childbirth are the result of conditions and age that do not apply to the average young healthy pregnant women [sic], who most typically present for abortions." Coleman Decl. Section II ¶ 9. This statement is belied by the literature. For example, the Raymond and Grimes study comparing mortality from abortion and childbirth found that patients undergoing abortion were at higher underlying risk than women who opted for delivery.[3] Coleman criticizes the CDC

[3] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*. 119 Obstetrics & Gynecology 215, 218 (2012) (noting that women who had abortions were more likely to have demographic characteristics strongly

data relied upon in that study, but as I have already explained in my Rebuttal Declaration, the CDC's data collection process is rigorous and reliable. Rebuttal Decl. ¶ 10. Furthermore, Coleman states that the Raymond and Grimes study looked only at first-trimester abortions, but this is just wrong.[4]

8. Indeed, the only study Professor Coleman relies upon, by Bartlett et al., regarding abortion-related mortality[5] actually supports the evidence I presented in my initial report.[6] Coleman misleadingly provides information about the "relative risk" of death from abortion at various gestational ages, but the figures she provides do not reflect the actual risk of death from abortion, but rather differences in the risk at different points in pregnancy. Coleman Decl. Section III ¶ 12. While Professor Coleman is correct that the risk of death from abortion increases as gestational age increases, the overall risk of death from abortion is extremely low. In fact, the Bartlett study notes that for the period from 1988-1997 (the most recent 10-year period for which the study presents data) the overall risk of death from abortion was 0.7 in 100,000,[7] and the risk during the first trimester, when most abortions in Missouri are performed, is even

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associated with increased mortality and that, because comorbidities are sometimes the motivation for abortion, the underlying medical risk of patients who have abortions may be higher than patients who carry pregnancies to term).

[4] Coleman also argues that Raymond and Grimes ignore that women who give birth are less likely to die from causes unrelated to pregnancy than women who have not given birth, Coleman Decl. Section III ¶ 13, but this fact has absolutely nothing to do with the relative safety of abortion vs. childbirth.

[5] As I explain in detail below, other studies Coleman cites that she says show mortality from abortion in fact show no such thing, but rather show long term death rates for any reason for women with various reproductive histories.

[6] Bartlett et al. *Risk Factors for Legal Induced Abortion-Related Mortality in the United States.* 103 Obstetrics & Gynecology 729 (2004)

[7] The Grimes study I cite in my opening declaration found a similar risk of death of less than 0.6 per 100,000 procedures. Initial Decl. ¶ 7, n. 4. Coleman criticizes the Grimes study, citing several of the study's limitations, Coleman Decl. Section III ¶ 14, but all studies have some limitations and those of the Grimes study do not render its results invalid. In any event, the fact that the very study Coleman relies upon regarding abortion-related mortality reached comparable results reinforces the reliability of the Grimes study.

lower: 0.1 in 100,000 abortions that occurred at 8 weeks gestation or less, 0.2 in 100.000 for abortions that occurred at 9-10 weeks gestation, and 0.4 in 100,000 for abortions that occurred at 11-12 weeks gestation, according to Bartlett. As I have explained in my prior declarations, this increased risk at later gestational ages is precisely why medically unnecessary restrictions on abortion that delay women in accessing abortion care actually harm women's health by pushing abortions later in pregnancy. Initial Decl. ¶¶ 59–64; Rebuttal Decl. ¶ 14.

9. Professor Coleman also attempts, as did Drs. Steele and Solanky, to undermine my statement in my initial declaration that the risk of death from childbirth is approximately 14 times higher than that associated with abortion by arguing that abortion mortality data cannot be accurately compared with data regarding mortality from childbirth because different methods of data collection are utilized for the two sets of data.[8] Coleman Decl. Section II ¶ 7-11. But, as I explained in my Rebuttal Declaration, even if Professor Coleman were correct that such comparisons are imperfect, the data would have to be extraordinarily flawed to account for a 14-fold increase in death risk. Rebuttal Decl. ¶ 12. Even if differences in data collection methods caused minor issues with the data, that would not even come close to altering the fact that abortion is considerably safer than carrying a pregnancy to term.

[8] Professor Coleman also oddly states both that maternal deaths are underreported, Coleman Decl. Section II ¶ 1, and that the maternal mortality rate is over-inflated, *Id.* ¶ 10. At any rate, her argument that maternal mortality is over-inflated because some deaths (such as from molar and ectopic pregnancies) are included in the numerator but not in the denominator of maternal mortality data, *Id.*, applies to a different data set than the one on which I rely. My conclusion that abortion is fourteen times safer than childbirth is based on a Raymond and Grimes study, which looked at mortality for only women who carried a viable pregnancy to term and gave birth, and compared that data to data regarding women who had abortions. Raymond and Grimes, *supra* n. 3 at 215.

The Studies I Rely Upon to Show that Abortion is Extremely Safe Are Reliable

10. Professor Coleman also critiques the methodology of the studies I rely upon in my initial declaration for the proposition that abortion is extremely safe, but her arguments do not undermine my conclusions. Each of the studies I rely upon is valid and reliable and, to the extent they have certain limitations, such as loss of some patients to follow up, as I have previously explained, these kinds of limitations are inherent to all medical research and do not render studies unreliable. Rebuttal Decl. ¶ 4.

11. First, Coleman argues that the 2013 study by Weitz and colleagues that I rely upon is unreliable because, she claims, the study had a high attrition rate. Coleman Decl. Section III ¶ 3–4. But Professor Coleman entirely misrepresents the actual percentage of patients for whom follow-up data were available and who were therefore included in the final analysis—the study authors accurately reported that that number was 69.5%,[9] not the 46.6% number inaccurately cobbled together by Professor Coleman.[10] Coleman relies upon the Amico study regarding attrition rates to argue that the Weitz study is unreliable, Coleman Decl. Section III ¶

[9] Tracy A. Weitz, et al. *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. J. of Pub. Health 454, 456 (2013)

[10] For example, Professor Coleman misleadingly states that 30% of women "did not participate in after-abortion follow-up" and incorrectly states that these patients were not included in the study. Coleman Decl. Section III ¶ 4, but this entirely misrepresents the truth—patients who declined to fill out a follow up survey were still included in the study data, since complication information was collected in other ways. Weitz et al. at 456. In fact, the study itself directly contradicts Coleman's incorrect and wholly unsupported statement that women do not return to providers for treatment when they are experiencing an incomplete abortion, since it states that patients contacted the facility when they experienced a complication. *Id.* This is consistent with my experience as an abortion provider, as I have previously explained. Rebuttal Decl. ¶ 4. Coleman also argues that it was improper to exclude procedures performed by non-physicians during the training phase of the study, but this was entirely proper, since the purpose of the study was to compare trained non-physician providers with physicians. In any event, Coleman is incorrect that these training-phase procedures were higher risk, given the close physician supervision during training of non-physicians.

5–6, but the entire thrust of the Amico study is that Coleman's approach of simply looking at a study's overall attrition rate is improper and that it is necessary to look at other indicators to assess the validity of a study. Indeed, Amico states, "A given rate of attrition in and of itself does not equate to bias, nor does it confer methodological flaws or, conversely, integrity."[11] The quote Coleman pulls out of the Amico study noting that high attrition rates equal fatal flaws in a study is actually an approach that Amico *criticizes.*[12] Indeed, following Amico's approach and looking at indicators of validity other than raw attrition rates, the Weitz study is strong. For example, the study's follow-up rates were "nondifferential" between the physician and non-physician groups studied, which means that attrition affected the study groups equally and therefore would not reduce the validity of the study's results.[13] Professor Coleman also argues that patients lost to follow up are likely to have had complications (citing no evidence at all for this conjecture), but in fact, in my experience, the exact opposite is true—women who do not return for follow up after an abortion usually do not do so because their procedure was routine and they are not experiencing any symptoms, whereas patients who are experiencing symptoms of a potential complication return for follow up. The Weitz study also found this to be true, since even patients who did not fill out the follow up survey called the provider when they were experiencing symptoms of a complication. *See Supra* n. 9.

12. Furthermore, the Weitz study has external indicators of validity, including its consistency with other studies. For example, it looked at complication rates for first-trimester

[11] K.R. Amico, *Percent Total Attrition: A Poor Metric for Study Rigor in Hosted Intervention Design*. 99 Am. J. of Pub. Health 1567, 1568 (2009)
[12] *Id.* at 1569.
[13] *Id.* at 1568.

surgical abortions in California and found an overall complication rate of 1.32%.[14] The Upadhyay study introduced in this case by Defendants' witness Dr. Steele (and cited by Professor Coleman, Coleman Decl. Table 1) found a nearly identical complication rate for first trimester surgical abortion in California of 1.3%.[15]

13. With respect to the Cleland study, Professor Coleman correctly identified a math error in my initial declaration, which I regret, and I will submit to the Court a corrected version of my initial declaration. The Cleland study in fact reports a rate of treatment in an emergency room of 0.1% and a rate of hospital admission of 0.06%.[16] These rates, however, are still extremely low and do nothing to change the fact that the consensus in the literature is that legal abortion is extremely safe.

14. Furthermore, Coleman's methodological critiques of the Cleland study are unavailing. Coleman first argues that the fact that the Cleland study tracked only more serious complications renders the study unreliable, but the study does not purport to study less serious outcomes, nor did I state in my initial report that it did. Coleman also criticizes the study for failing to analyze complications according to patient demographics and argues that this means the patients studied may not have been representative of abortion patients generally. Coleman Decl. Section III ¶ 10. This critique is without basis. First, the Cleland study has a very large sample size of 233,805 medication abortions, which makes it very unlikely that the patients studied were not representative of patients generally. Second, there is no evidence in the

[14] The Weitz study's finding that procedures performed by non-physician practitioners have a slightly higher (but still very low) complication rate than procedures performed by physicians is not relevant to Missouri where there is a statutory prohibition against non-physicians performing abortions. Mo. Ann. Stat. §§ 188.080, 334.245.
[15] Ushma D. Uphadhyay, et al. *Incidence of Emergency Department Visits and Complications After Abortion*. 125 Obstetrics & Gynecology 175, 175 (2015).
[16] Kelly Cleland et al.,*Significant Adverse Events and Outcomes After Medical Abortion*. 121 Obstetrics & Gynecology 166 (2013).

literature that complications from abortion disproportionately affect certain demographic groups, nor does Coleman provide any—her statements about what these patients' life situations "may" have been like are nothing more than conjecture. In any event, such conjecture does nothing to undermine the fact that overall rates of complications from abortion are extremely low.

15. Coleman finally states that I do not provide evidence for the low rates of incomplete abortion and ongoing pregnancy following medication abortion. In fact, the Cleland study found that an ongoing pregnancy was present following 0.5% of medication abortions. The low rates of incomplete abortion are also well-documented. In fact, the Upadhyay study cited by Defendant's witness Dr. Steele found that 0.87% of medication abortions were incomplete.

The Studies Cited by Defendants' Witnesses Do Not Undermine The Safety of Abortion

16. Professor Coleman also makes a failed attempt to bolster the studies relied upon by Drs. Steele and Solanky, which I have already explained in my Rebuttal Declaration do nothing to undermine my opinion or the consensus in the literature that abortion is extremely safe, and certainly do not show that the ASC and Hospital Relationship Restrictions are medically necessary.

17. First, Coleman states that my rebuttal declaration was "incorrect" that the 2010 Niinimaki study from Finland included "complications" that were not complications at all, but she is wrong. As I stated in my Rebuttal, the study's authors themselves admitted that "many of the 'complications' are not really such." Rebuttal Decl. ¶ 7. Therefore there can be no dispute that the "complication" rate reported in this study is not reliable. Professor Coleman cites a second 2011 study by Niinimaki and colleagues that was not previously cited by Defendants'

experts, but the 2011 study suffers from the very same problems as the 2010, since it relies upon the same data set as the 2010 study.[17]

18. Coleman also attempts to defend the Reardon study relied upon by Dr. Steele by criticizing the conclusions of the Academy of Medical Royal Colleges and the American Psychological Association that the study was of "poor quality" and has severe methodological limitations. Even if Coleman's attack on these leading, mainstream professional bodies were credible, the Reardon study Coleman is attempting to defend has no relevance to this case, since, as I explained in my Rebuttal Declaration, it looked at death rates during a 10 year period following abortion and childbirth for *any reason*, including for example, deaths from accidents, circulatory diseases, and AIDS, and therefore sheds no light whatsoever on the safety of abortion or the relative risks of abortion vs. childbirth. Rebuttal Decl. ¶ 11.

19. Finally, Coleman introduces several new studies that she claims are "methodologically sound," but none of the new studies she cites undermine my conclusions or the fact that the consensus in the literature is that abortion is extremely safe. First, Coleman cites several studies that, similar to the Reardon study, looked at deaths for *any reason* following various pregnancy outcomes, and therefore shed no light whatsoever on the safety of abortion, the relative risks of abortion vs. childbirth, or the need for the challenged requirements. Specifically, Coleman cites two of her own studies that looked at data from Denmark.[18] Her

[17] David A. Grimes & Elizabeth G. Raymond, *Medical Abortion for Adolescents*, 342 BMJ d2185 (2011) ("The alarmingly high 'adverse event' rates in both adolescents and adults reported by Niinimäki and colleagues, which range from 20 to 100 times higher than recent large studies with more specific outcome definitions, should be interpreted with caution because the reported outcomes were mainly office visits by the worried well and not validated complications.").
[18] David C. Reardon & Priscilla K. Coleman. *Short and Long Term Mortality Rates Associated with First Pregnancy Outcome: Population Register Based Study for Denmark 1980-2004*. 18 Medical Science Monitor 71 (2012); Priscilla K. Coleman, David C. Reardon, & Byron C.

2012 study looked at deaths for any reason for up to 10 years following a pregnancy outcome, whereas the 2013 study looked at deaths for any reason at any time in a woman's life during the period studied. Similarly, the two Gissler studies Coleman cites in her Table 1 looked at deaths for any reason within one year of a pregnancy outcome.[19] Furthermore, as I noted above, patients who choose abortion tend to have more pre-existing health and demographic risk factors than patients who choose to give birth, so a higher death rate over the long term for the former population is not surprising. *See Supra.* ¶ 7, n. 2.

20. Next, Coleman cites two studies that she claims show higher complication rates from abortion than the studies I cite, but both studies she relies upon look at narrow gestational age windows during which it is expected that complication rates would be higher and are consistent with my opinion that abortion is overwhelmingly safe. First, she cites a 2001 study by Paul and colleagues that looked only at surgical abortions taking place at less than 6 weeks gestation. It is expected that abortions at these very early gestational ages have a higher failure rate than later abortions because the pregnancy is so small that it can be missed during an aspiration procedure. In fact, the Paul study reported 17 failed abortions out of the 30 total complications listed. Failed abortion is a known potential outcome of very early surgical abortion and patients are appropriately counseled regarding their potentially higher rate of failed abortion and need for follow up, which would involve only a repeat aspiration procedure. Indeed, the

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Calhoun. *Reproductive History Patterns and Long-Term Mortality Rates: A Danish, Population Based Record Linkage Study*. 23 Eur. J. of Pub.Health 569 (2013).

[19]Mika Gissler, et al. *Pregnancy-Associated Deaths in Finland in 1987–1994 – Definition Problems and Benefits of Record Linkage*. 76 Acta Obstet Gynaecol Scand. 651 (1997); Mika Gissler, et al. *Pregnancy-Associated Mortality after Birth, Spontaneous Abortion, or Induced Abortion in Finland, 1987-2000*. 190 Am.J. of Obstetrics and Gynecology 422 (2004)

study's authors concluded that "[e]arly surgical abortion is safe and effective."[20] Because this study looks at only a narrow gestational age window with unique characteristics, its results do not undermine studies that find a lower overall complication rate for abortion at all gestational ages.

21. Coleman similarly cites a 2015 study by Lederle and colleagues, but this study only looked at abortions occurring at 14 weeks gestation or later. Nearly 53% of the abortions studied occurred at 20 weeks gestation or more, and more than three quarters of the complications occurred at 20 weeks gestation or more.[21] In Missouri, less than 2.0% of all abortions occur at 20 weeks gestation or later[22] and, as I have explained numerous times, abortions that occur later in pregnancy have higher complication rates than earlier abortions, so it is expected that the Lederle study, which looked at later abortions, would find a higher complication rate than studies looking at all gestational ages. Notably, despite this study population, the Lederle study found only a 1.7% rate of major complications.

22. The 2015 study by Oud and Watkins regarding deaths due to pregnancy associated severe sepsis ("PASS") similarly does not undermine any of my conclusions about the safety of abortion. Indeed, this study notes that, of 1007 PASS hospitalizations studied, only 9

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[20] Maureen E. Paul, et al. *Early Surgical Abortion: Efficacy and Safety*. 187 Am. J. of Obstetrics and Gynecology 407 (2002).

[21] Lauren Lederle, et al. *Obesity as a Risk Factor for Complications After Second-Trimester Abortions by Dilation & Evacuation*. 126 Obstetrics & Gynecology 585 (2015)

[22] Missouri Department of Health & Senior Servs. Vital Statistics Table 12A: Resident Abortions by Race, Age, and Type of Procedure by Weeks of Gestation: Missouri, 2014 http://health.mo.gov/data/vitalstatistics/mvs14/Table12A.pdf; Missouri Department of Health & Senior Servs. Vital Statistics Table 12A: Resident Abortions by Race, Age, and Type of Procedure by Weeks of Gestation: Missouri, 2013 http://health.mo.gov/data/vitalstatistics/mvs13/Table12A.pdf; Missouri Department of Health & Senior Servs. Vital Statistics Table 12A: Resident Abortions by Race, Age, and Type of Procedure by Weeks of Gestation: Missouri, 2012 http://health.mo.gov/data/vitalstatistics/mvs12/Table12A.pdf

patients had recently had an abortion, and states, "Our findings underscore the remarkable safety of contemporary legal abortion practices."[23]

23. Finally, Coleman lists in her Table 1 a 2015 study by Upadhyay and colleagues, which was a large scale study of abortion complications in California that utilized Medi-Cal billing codes to determine patient outcomes. As I have already explained in my rebuttal declaration, this study's findings are consistent with the findings of studies I cited in my initial declaration. In particular, the Upadhyay study found an extremely low major complication rate of 0.23%.[24] Furthermore, when the higher medical risks of the Medicaid population studied and the researchers' definition of complication are taken into account, the overall complication rate is also consistent with those I cited. Rebuttal Decl. ¶ 8.

24. For all these reasons, Professor Coleman's declaration does nothing to undermine my opinions, expressed in my prior declarations, that abortion is extremely safe. Furthermore, she does not even attempt to connect her erroneous arguments regarding the safety of abortion with the idea that the Restrictions at issue in this case make abortion safer. Nor could she since, as I have explained, the Restrictions at issue in this case are medically unnecessary.

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

Executed on March 3, 2017

s/ David L. Eisenberg
David L. Eisenberg, MD, MPH

[23] Lavi Oud & Philip Watkins. *Evolving Trends in the Epidemiology, Resource Utilization, and Outcomes of Pregnancy Associated Severe Sepsis: A Population-Based Cohort Study.* 7 J. Clin. Med. Res. 400, 409 (2015)
[24] Ushma D. Uphadhyay, et al. *Incidence of Emergency Department Visits and Complications After Abortion*. 125 Obstetrics & Gynecology 175, 181 (2015)

EXHIBIT B

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF MISSOURI CENTRAL DIVISION

COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, et al.	)	
Plaintiffs,	)	
v.	)	Case No. 2:16-cv-04313-HFS
PETER LYSKOWSKI, in his official capacity as Director of the Missouri Department of Health and Senior Services, et al.	)	
Defendants.	)	

SUPPLEMENTAL REBUTTAL DECLARATION OF STANLEY K. HENSHAW, PH.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

Stanley K. Henshaw, Ph.D., declares the following:

1. I previously submitted a declaration in this case entitled "Rebuttal Declaration of Stanley K. Henshaw in Support of Plaintiffs' Motion for a Preliminary Injunction" ("Henshaw Rebuttal Declaration" or "Initial Declaration"), ECF No. 42-3, dated January 31, 2017. A copy of my curriculum vitae was attached to that declaration as Exhibit A.

2. I have reviewed the Supplemental Declaration of Tumulesh K. S. Solanky, ECF No. 54-3 ("Supplemental Solanky Declaration"), and I submit this Second Rebuttal Declaration in order to respond to certain assertions therein. The fact that I do not address a particular statement or assertion in the Supplemental Solanky Declaration does not necessarily mean that I agree with the statement or assertion.

3. As an initial matter, Dr. Solanky and I seem to agree that the total number of abortion clinics in a state alone does not impact the accessibility of abortion services, or the abortion rate, in a direct way. Henshaw Rebuttal Decl. ¶ 10. As I explained in my previous

declaration, this is because many facilities, including most hospitals, perform few abortions and provide accessibility to very few women, and, furthermore, changes in the number of clinics say nothing about the geographic accessibility of those clinics. In addition, as Dr. Solanky points out in his supplemental declaration, abortion rates are affected by a number of factors other than the availability of abortion services. *See* Suppl. Solanky Decl. ¶ 5–7. Thus, the 2017 Jones and Jerman study Dr. Solanky relies upon only reinforces my prior statements that reliable conclusions cannot be drawn about abortion access, or the impact on women of clinic openings or closures, by comparing overall abortion rates in a state to the total number of clinics, as Dr. Solanky does.

4. Dr. Solanky's reliance on a comparison between changes in the national abortion rate over time and changes in the Missouri statewide abortion rate over time also does not provide an accurate picture of the impact of loss of abortion providers. Such a comparison does not show that a loss of abortion providers was *not* a factor in the decline in the abortion rate in Missouri over time, as there has been a loss of providers over time both in Missouri and nationally.[1] Furthermore, as I have explained, in order to accurately assess the impact of a loss of abortion providers, one must look at the impact on women living in or near the communities that have lost providers, not at the state as a whole. *See* Henshaw Rebuttal Decl. ¶ 6. Dr. Solanky's declarations do not evaluate the impact on those women, nor does he undermine my opinion regarding that impact in any way.

5. Dr. Solanky implies that my conclusions about the percentage of women who are prevented from accessing abortion by the significant travel required to obtain an abortion in Missouri are based on changes in the overall abortion rate in Missouri, Suppl. Solanky Decl. ¶ 9,

[1] Indeed, the loss of providers in Missouri over time may well have contributed to the fact that the abortion rate in Missouri has declined more over time than the abortion rate nationally.

but this is entirely untrue. My conclusions are instead based on the studies I rely upon in my initial declaration, which look at the effects of changes in driving distances to reach abortion providers on the women who live in communities actually impacted by the changes. Contrary to Dr. Solanky's assertions, the designs of these studies carefully controlled for factors other than driving distance, including, for example, changes in contraceptive use, sexual activity, and attitudes toward abortion.[2] These factors other than driving distance affect the population generally. Therefore, a study that compares a geographic area affected by a change in abortion service availability with another contiguous area not affected by the change isolates the impact of driving distance on abortion incidence.

6. For example, the 2017 study by Grossman et al. that I rely upon in my initial declaration,[3] looked at Texas county-level data regarding abortions received by residents and analyzed that data based on the distance of each county to an abortion provider. By looking at such small and contiguous geographic areas, and comparing trends in areas where abortion services were lost with areas that retained services, this study controlled extremely well for other factors that affect abortion incidence. Factors such as contraceptive use do not vary significantly from county to county, since these factors affect the population as a whole. Indeed, even if there were minute differences from county to county in these other factors, based on my extensive

[2] Dr. Solanky also asserts that the studies I rely upon only observe correlation, but in fact the 2017 Grossman study, the Colman and Joyce study, the Shelton study and the Dobie study, for example, are natural experiments that are able to rule out factors other than driving distance because they compared changes in abortion rates after an increase or decrease in abortion access to changes in rates over the same time period in geographically similar areas where access did not change. The areas are contiguous and small enough that they are exposed to the same external influences such as changes in contraceptive use. Furthermore, the Finer and Torres studies I cite in my initial report, both of which involved interviewing women regarding the reasons they were delayed in accessing abortion clearly show causation.

[3] Daniel Grossman, et al., Research Letter: Change in Distance to Nearest Facility and Abortion in Texas, 2012 to 2014, 317(4) JAMA 437 (2017).

experience looking at trends in reproductive health nationwide over a long period of time, such minute differences could not account for the large impact that changes in driving distance had on abortion incidence in the Grossman study. Dr. Solanky attempts to undermine this study by arguing that its results apply only to Texas, but there are no characteristics unique to Texas that prevent these data from being generalizable to other states, including Missouri. Furthermore, the fact that all of the studies I cite in my initial declaration, and indeed, all of the reliable studies I am aware of, that have examined the impact of distance on access to abortion have reached similar conclusions, regardless of what state or other geographic area was studied, reinforces that Grossman's results are accurate and generalizable. Dr. Solanky also attempts to undermine the Grossman study by pointing to overall changes in the abortion rate and the number of abortion providers in the state of Texas during the relevant time period, but as I have already explained and as Dr. Solanky seems to agree, a state's abortion rate does not provide meaningful information about the effects of changes in abortion availability on women who reside in areas that have lost access. Therefore, changes in the overall abortion rate in Texas do nothing to undermine the results of the Grossman study.[4]

7. The Shelton study criticized by Dr. Solanky, Suppl. Solanky Decl. ¶ 14, utilized similar methodology—it examined county-level data regarding abortion incidence and analyzed this data based on driving distance to Atlanta, where the vast majority of abortions in the state took place.[5] As with the Texas study, the fact that the geographic areas examined were small and contiguous means that the study controlled extremely well for factors other than driving distance

[4] Dr. Solanky similarly attempts to undermine the Grossman study by arguing that changes in the number of abortion clinics in Wisconsin from 2011–2014 did not affect the state's abortion rate. Suppl. Solanky Decl. ¶ 12. For all the reasons I have outlined above and in my initial declaration, this argument is unavailing.

[5] James D. Shelton, Edward A. Brann & Kenneth F. Schulz, *Abortion Utilization: Does Travel Distance Matter?*, 8 Fam. Plan. Persp. 260, 262 (1976).

that affect abortion incidence. Dr. Solanky criticizes this study by saying that it "disregarded" the 10% of abortions that occurred outside Atlanta at scattered small providers, but this is not true. The abortion ratios in each county *included* abortions that occurred outside Atlanta, but *excluded* the clinics that provided those abortions in the study's analysis of driving distance from each county to a provider. Because of this, the study actually under-estimated the impact of distance on abortion incidence. In other words, had the study included these smaller providers outside of Atlanta in its analysis of driving distance, it would have found an even *greater* impact of driving distance on abortion incidence because the actual driving distances were smaller than the study evaluated. Furthermore, Dr. Solanky criticizes the age of the Shelton study, saying that "a lot has changed since 1974," but while there have been some changes that may make it easier for women to travel, there have been others that have made travel more difficult for women seeking abortion, for example the fact that the population of women seeking abortion now is far more poor than in the 1970s and therefore has less access to transportation. Furthermore, similar findings in the very recent studies reinforce the continuing validity of the Shelton study.

8. Each of the other studies I cite in my report utilize similarly reliable methodology that controls for factors other than driving distance by comparing contiguous geographic areas that are subject to the same factors. The Colman and Joyce study, for example, looked at the effect of the loss of abortion services after 15 weeks' gestation in Texas by comparing the trend in second trimester abortions in Texas to that in neighboring states.[6] Because, as I have explained, factors such as trends in contraceptive use affect the population generally, this design isolates the impact of distance to abortion providers. This study has an additional control in that it also looked at trends in earlier abortions in Texas during the same time period and found no decline in

[6] Silvie Colman & Ted Joyce, *Regulating Abortion: Impact on Patients and Providers in Tex.*, 30 J. Pol'y Analysis & Mgmt. 775 (2011)

incidence. Factors such as contraceptive use have the same effect on abortions regardless of gestational age, so the fact that the incidence of abortions after 15 weeks' gestation declined dramatically, while the incidence of abortion at earlier gestational ages did not, further isolates the effect of driving distance.

9. Dr. Solanky attempts to argue that a recent policy review by Joerg Dreweke shows that abortion rates are not affected by state restrictions on abortion, Suppl. Solanky Decl. ¶ 8, but this article does not undermine my conclusions.[7] In fact, most restrictions on abortion have no effect on the distance women must travel to obtain an abortion, so this article's analysis is not relevant to my conclusions. Some restrictions, however, may force abortions providers in certain regions to shut down and therefore increase the driving distances faced by women seeking abortion. As Dreweke recognizes, "Declines in access spurred by [such] laws may have contributed to lower abortion incidence."[8] However, in order to accurately measure how a law affects women actually impacted by a resulting clinic closure, a study would have to isolate the women who live near a closed clinic in comparison with women whose access to abortion remained unchanged. The Dreweke study does not purport to do this, while the studies I rely upon do.

10. For these reasons, the studies I rely upon in my initial report provide an accurate measure of the effects of changes in driving distance on abortion access, whereas the abortion rate data relied upon by Dr. Solanky does not.

[7] Joerg Dreweke, *U.S. Abortion Rate Reaches Record Low Amidst Looming Onslaught Against Reproductive Health and Rights*, 20 Guttmacher Pol'y Rev. 15 (2017).
[8] *Id.* at 17.

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

Dated: March 3, 2017

s/ Stanley K. Henshaw
Stanley K. Henshaw