STATE OF NORTH DAKOTA | IN DISTRICT COURT

COUNTY OF CASS | EAST CENTRAL JUDICIAL DISTRICT

MKB MANAGEMENT CORP, dba RED RIVER WOMEN'S CLINIC, KATHRYN L. EGGLESTON, M.D.,

Plaintiffs,

vs.

BIRCH BURDICK, in his official capacity as State Attorney for Cass County, TERRY DWELLE, M.D., in his official capacity as the chief administrator of the North Dakota Department of Health,

Defendants.

AFFIDAVIT OF DONNA HARRISON

Civil No. 09-2011-CV-02205

DONNA HARRISON, M.D., swears or affirms the following:

1. I provide the following opinions as an expert in obstetrics, gynecology, and the United States Food and Drug Administration (FDA) drug approval process. A copy of my curriculum vitae summarizing my background, experience, and publications is attached as Exhibit A.

2. I have reviewed HB 1297 as well as affidavits submitted by Plaintiffs MKB Management Corp., d/b/a Red River Women's Clinic, et al. I submit this affidavit in support of the Motion for Summary Judgment made by defendant Terry Dwelle, M.D., in his official capacity, and in opposition to Plaintiffs Motion for Summary Judgment.

3. The opinions expressed below are based on my years of experience in the field of obstetrics and gynecology as well as extensive research into reproductive issues.

4. In summary, HB 1297 provides needed regulation to ensure, as much as is possible, the safety of women pursuing abortions in North Dakota.

5. The affidavits provided by the Plaintiffs are rife with erroneous claims and mischaracterizations regarding medical issues, FDA drug approval, and the potential effects of HB 1297. I address my concerns in summary below.

6. Attached to this affidavit as Exhibit B are true and correct copies of reports I have authored responding to Plaintiff's proffered affidavits in more detail and with references, when appropriate, to competent sources.

Response to Affidavit of Kathryn L. Eggleston.

7. Eggleston claims that compliance with the FDA protocol will result in worse outcome for her medical abortion patients than the current protocol that she follows. However, she provides no data from her clinic to support this incredible claim.

8. The protocol Eggleston claims she uses is not mentioned in the American Congress of Obstetricians and Gynecologists (ACOG) Clinical Management Guidelines Practice Bulletin "Medical Management of Abortion", which outlines guidelines for medical abortion care, and discusses alternative regimens.

9. Further, Eggleston provides no evidence that in her clinic population, her use of a non-FDA approved medical abortion regimen confers any advantage to women over the FDA protocol. She provides no details of rate of hemorrhage, rate of surgical re-evacuation, rate of emergency room visits, rate of transfusion, rate of infection, rate of failed procedures, rate of adverse events, or any other objective parameter in her

clinic population which would justify her claim that her protocol offers an advantage over the FDA approved regimen. Without such objective data, her claim is unsupported.

10. Eggleston makes general erroneous claims about the safety of medical abortions compared with surgical abortions without substantiation of these claims.

11. Contrary to her claims, there have actually been very few randomized controlled trials comparing medical and surgical abortion outcomes. Most recent studies have clearly demonstrated that Mifeprex abortions create a greater risk of hemorrhage, infection, continued pregnancies, retained tissue and need for emergency reoperation than surgical abortions.

12. In addition, the Center for Disease Control (CDC) reviewed statistics on the maternal mortality rate from surgical abortion in the first trimester and compared that with the mortality rate of medical abortion from infection with C. sordelli bacteria. The death rate from C. sordelli infection alone in medical abortion is ten times the death rate from all causes in surgical abortion at a comparable gestational age.

13. Eggleston erroneously claims that Mifeprex abortions can be safely performed in patients who are not candidates for surgical abortion.

14. ACOG practice guidelines state that approximately 1 out of every 100 women who undergo mifepristone abortions will require emergency surgery for hemorrhage. This 1% does not include women who will need surgery for incomplete abortion, continuing pregnancy and other indications. According to one paper, 5.9% of women required surgery after medical abortion up to 63 days gestation.

15. The common and predictable need for surgical completion led both the WHO and ACOG to state that surgical backup must be available on a 24 hour basis.

16. Eggleston states that certain women have circumstances which make surgical abortion more difficult. However, she erroneously claims that these circumstances constitute an "indication" for medical abortion over surgical abortion. It is exactly these women who are at highest risk if a failed medical abortion requires emergency surgery for completion. These are exactly the women who should have their abortions performed under closely monitored circumstances in a setting where the woman would have immediate access to surgical services capable of handling complex surgical cases and familiar with her case, since emergency curettage will be exceptionally difficult.

17. Eggleston's affidavit contains an admission that when the clinic administers mifepristone to a high risk patient, if the patient later experiences a known complication such as excessive hemorrhage, Eggleston's clinical setting does not provide optimum conditions under which to handle such a high risk emergency treatment.

18. Eggleston indicates she has no formal arrangements with a competent surgeon who could handle such a high risk emergency situation.

19. It is medically irresponsible and adverse to patient interests to begin a mifepristone abortion process in a woman who is a high risk surgical candidate, knowing that up to 6% of mifepristone abortions will require surgical completion, and that many of those surgeries will have to be completed on an emergency basis, compounding the risks of surgery to the woman.

20. Without any data on her clinic patients, any information on the number of patients who take the mifepristone, but fail to take the misoprostol, or take the misoprostol at a time outside of the 24-48 hour window, without any information on complete and incomplete abortion rate, hemorrhage rate and timing of hemorrhage, without any information on rate of adverse events or loss to follow-up, or any other meaningful data, Ms. Eggleston states that "this protocol has worked well for our patients." Without data, the statement "worked well" is incoherent.

21. It is true that the majority of women will pass the fetus and placenta within 6 hours of ingestion of misoprostol. Thus for patient safety and wellbeing, it is in the patient's best interest that she be in a place where her physical needs can be addressed, and she can have access to adequate pain control, as well as be monitored for excessive bleeding, low blood pressure or other complications that can arise during the passage of tissue. This is the proper role of the clinic, not of the patient who is isolated from care.

22. It is incoherent to think that a woman would be able to work or care for children while she is in the process of passing tissue during the medical abortion procedure. Her need for childcare or leave from work will be equivalent, regardless of the location of her passage of tissue. Similarly, although women in abusive relationships deserve help and sympathy, an abusive relationship is even more likely to result in a woman being isolated and without care at the point of tissue passage, when she is most in need of a competent caregiver to assess her for pain control and hemorrhage.

23. HB 1297 requires that medicine abortion providers provide a patient with the name of a physician qualified and privileged to care for her should an emergency arise. Eggleston, by her own admission does not reside in the state of N.D., nor is she physically available on a 24-hour basis. Thus, she is not available to provide surgical curettage on a 24 hour basis, which is the standard recommended by ACOG for both surgical and medical abortion patients.

24. Without such coverage, patients experiencing hemorrhage or other emergency are left to find their own coverage when they are least capable of doing so: in the midst of a medical emergency. Most women do not have any relationship with their local emergency room doctor. And most ER physicians are not familiar with the management of medical abortions or their complications. Neither do most emergency room doctors have access to critically important patient records. And women may not be able or willing to give the information critically important to their care in the midst of a medical emergency.

25. It is irresponsible for a physician to provide medical abortions without a seamless system to handle the known and common complications that result from such abortions. It is inadequate to have a phone system staffed by "trained clinic personnel" to handle routine questions.

26. HB 1298 seeks to provide patients with timely and adequate information about physicians capable of managing the complications inherent in medical abortion in the initial physician's physical absence. This is in the best interests of patient care.

27. The State of North Dakota is acting with concern for the well-being of the women of North Dakota in requiring that the abortion providers supply patients with the

names of physicians qualified to care for medical and surgical abortion patients in the initial physician's absence, as evidenced by the body of malpractice law concerning patient abandonment.

28. Eggleston's claimed inability to find physicians willing to cover her patients is incoherent. Eggleston's claim that patients will use the physician's contact information to harass him or her is inconceivable.

29. Both surgical and medical abortion are significant interventions. The state of North Dakota not only has the right, but also the responsibility, to regulate medical care within the state in the best interests of the women of North Dakota.

30. HB 1297 provides for the very minimal actions necessary on the part of a physician to minimize the inherent risks of medical and surgical abortion to women. Failure to comply with these minimal provisions calls into question the safety of the facility and practitioner providing abortion services.

Response to Affidavit of Tammi Kromenaker.

31. Kromenaker, with a Bachelor's degree in social work, appears to be performing duties that should be conducted by trained medical personnel. Both conducting patient education sessions and providing patient information for purposes of informed consent requires a high level of medical understanding.

32. Kromenaker's admission that the Red River Clinic has been unable to find a physician willing to provide surgical back-up for patients in case of an emergency raises significant concerns about the safety of patients treated at the clinic.

33. These conditions of administration of mifepristone abortions at Red River are in sharp contrast to the requirements for provision of medical abortion stated by

both the World Health Organization (WHO) and ACOG. For example, the unavailability of surgical curettage on a 24 hour basis is adverse to WHO and ACOG provisions.

34. The Red River Clinic's directions to patients who experience adverse effects may subject patients to emergency room delay. Furthermore, emergency room personnel may not be prepared the emergency situation without access to the patient's medical records. Furthermore, most emergency room physicians are not trained in medical abortion. This can result in a dangerous delay in care, especially if the patient is bleeding profusely, or in need of surgery, as happens to between 1 and 5% of mifepristone abortion patients.

35. Thus the State of North Dakota has taken into consideration the best health interests of the women of North Dakota, in accordance with WHO and ACOG guidelines for provision of medical abortion, by requiring that Red River make a contractual arrangement with a physician or physicians capable of providing emergency coverage for medical abortion patients in the predictable event of massive hemorrhage or other need for emergency surgery. Simply providing a phone number, without real prearranged access to emergency care does not meet the criteria outlined by WHO or by ACOG.

36. The North Dakota law does not forbid the provision of medication abortions. Nor does it forbid the provision of surgical abortions, which in fact are safer. The North Dakota law requires physicians providing medical abortion to provide that abortion in the way deemed at this point in time to be the safest by the State of North Dakota, in accordance with objective parameters set by the FDA.

37. Kromenaker correctly claims that women who currently have abortions between 50 and 63 days would not be able to have medical abortions. However, she fails to note that surgical abortion is still available to such women. Indeed, she also fails to note the increase of failures and adverse events which occur in gestations older than 49 days, providing good reason for the State of North Dakota to require adherence to the 49 day limit as set by the FDA.

38. Patients with transportation difficulties, or who are unable to comply with the intense patient participation necessary for medical abortion have a relative contraindication for medical abortion. For those patients, surgical abortion is the most appropriate method.

39. Kromenaker's statement that requiring women to return to the clinic for ingestion of misoprostol will necessarily result in expulsions in the car on the way home from the clinic. Kromenaker's argument is incoherent and fails to address the two significant realities behind the second visit requirement: 1) the observation period during the second visit and 2) the patient safety and comfort reasons behind the requirement for observation. The WHO notes that most medical abortion protocols require a 4-6 hour observation period after ingestion of the misoprostol. The reason for this observation period is both patient safety and compassion. The most painful and difficult time in the mifepristone abortion process is during the expulsion. This is the time when women should be in a place where their bleeding can be monitored, their vital signs can be observed by a trained medical personnel, and they can receive sufficient pain medication during the most difficult part of the expulsion.

40. Leaving medically untrained patients to self-monitor their own bleeding and vital signs, and make medical decisions while going through the agony of expelling the fetus and placenta shows a callous disregard of the difficulty of this process of expulsion for women, and the conditions under the risks inherent in the expulsion could be minimized. This requires the clinic take responsibility for ensuring the safety and comfort of patients during the abortion, which is something that, according to staff admissions, Red River protocols avoid.

41. Kromenaker's claim that Red River Clinic is unable to find physicians willing to provide coverage for Red River patients may be due to malpractice concerns. If a particular physician manages their patient in a way which incurs high risk of malpractice, that physician often finds difficulty in obtaining cross-coverage, since the doctor who cross-covers will share in the malpractice risk. Since Red River is already providing abortions outside of the standard of care described in the ACOG practice bulletin, it is not surprising that other physicians would be unwilling to assume such risk.

Response to Affidavit of Daniel A. Grossman, M.D.

42. Grossman, like Eggleston, erroneously claims, without any evidence from Red River Clinic patients with respect to rate of adverse events, rate of hemorrhage, rate of ongoing pregnancy, rate of emergency surgical curettage, rate of admission to hospitals or any other objective data, that requiring Red River clinic to follow FDA protocol will result in worse outcome for patients than the current untested protocol followed by Red River clinic.

43. Grossman erroneously implies that women with cervical stenosis, uterine anomalies, obesity, fibroids, genital tract malformations constitute a special indication

for medical abortion as administered by Red River clinic, when in fact such women should only have medical abortion under the closest possible scrutiny, as an adverse event such as hemorrhage requiring emergency curettage will be much more dangerous in these women than curettage under controlled conditions in a hospital. Further the lack of follow-up and lack of guarantee that such women can rapidly access qualified emergency curettage makes administration of mifepristone and misoprostol abortions under the Red River protocol especially dangerous in these patients.

44. Grossman erroneously claims that the Red River protocol for administration of mifepristone and misoprostol, and the conditions of lack of physician coverage and lack of adequate measures to ensure follow-up of patients is supported by "sound medical evidence."

45. Grossman erroneously cites as evidence ACOG PB 67, Cochrane Review, WHO, El Rafaey, Schaff as supporting the Red River protocol, despite the fact that none of these papers even mention, much less support the protocol and conditions that Red River is using for medical abortion administration and follow-up.

46. Grossman erroneously claims that requiring a woman to take misoprostol at the clinic would necessarily result in an increased number of patients completing the abortion "in the car," completely ignoring the safety considerations surrounding such a requirement, which include an opportunity for observation of the patient under conditions meant to maximize her safety and comfort during the time when over 90% of women complete expulsion. Such a commitment to observation requires that the clinic actually care for the patient when she is most in need of pain medication, and observation for hemorrhage and other adverse events.

47. Grossman erroneously claims that Red River's protocol is safe and effective, without any data specific to Red River which would support such a claim. Data such as rates of effective expulsion, rates of surgical re-evacuation, rates of adverse events such as hemorrhage, or emergency room visits, or any other objective data are needed to substantiate the claim of safety.

48. Grossman erroneously claims that oral versus buccal administration of misoprostol "subjects women to increased risks of side effects such as nausea, vomiting, cramping and diarrhea" in direct contradiction to the study by Winikoff which he cited. In fact, the Winikoff article does not support, but rather contradicts his assertion that women will tolerate oral misoprostol less well than buccal misoprostol.

49. Grossman erroneously claims that complications due to medical abortion are rare. Several studies in the recent medical literature have allowed quantification of the risks of medical abortion. Recent studies actually indicate that in the first trimester, medical abortion with mifepristone and misoprostol result in 20 out of every 100 women experiencing a significant adverse event, 15 out of every 100 women experiencing hemorrhage, 7 out of every 100 women with tissue left inside, and 6 out of every 100 women needing surgery to complete the abortion.

50. Grossman erroneously compares Coumadin treatment with mifepristone abortions. Coumadin is used to treat patients with life threatening disease, and for whom the risk of treatment is less than the risk of untreated disease. However, mifepristone abortions are necessarily used in healthy women for whom the risk of serious adverse events is much greater in women given medical abortion than these

same risks in women who are not "treated" with a mifepristone abortion, but rather proceed to term birth.

Response to Affidavit of Lisa D. Rarick, M.D.

51. Rarick erroneously states that the FDA did not authorize any protocol for mifepristone.

52. Rarick erroneously implies by her general discussion of "off-label" use, that the FDA did not specifically intend to prohibit and discourage off label use of mifepristone due to safety considerations.

53. The FDA had serious reservations about the safety of the mifepristone abortions which resulted in the approval of mifepristone under a special section of FDA rules known as "Subpart H." The FDA chose to approve mifepristone under Subpart H in order to allow the FDA to impose post-approval restrictions on the distribution and use of the drug. The decision to impose Subpart H came after significant disagreements between the Agency and the Population Council about the lack of control over use of this drug after approval.

54. The February 2000 Approvable letter explains FDA's rationale:

> *"**Distribution Plan***
>
> *We have completed our review of this application, including the restrictions on the distribution and use of this product proposed in your January 21, 2000 submission, entitled "Distribution Plan". We have concluded that adequate information has not been presented to demonstrate that the drug, when marketed in accordance with the terms of distribution proposed, is safe and effective for use as recommended. The restrictions on distribution will need to be amended.*
>
> *We have thus considered this application under the restricted distribution regulations contained in 21 CFR 314.500 (Subpart H) and*

have concluded that restrictions as per CFR 314.520 on the distribution and use of mifepristone are needed to assure safe use of this product."

55. Section 314.520 is intended for drugs that are vitally necessary, but which may impose greater than normal risks for the patient. The FDA went to extensive lengths to specifically approve mifepristone under the restricted distribution section of Subpart H in order to explicitly control the circumstances under which mifepristone would be used. Dr. Rarick uses examples of drugs which were not approved under the restricted distribution section of Subpart H, and therefore these examples of off-label uses are not comparable to mifepristone.

Dated this 28 day of November, 2011

Donna Harrison M.D.
Donna Harrison, M.D.

STATE MI)
) ss.
COUNTY OF Berrien)

Subscribed and affirmed to before me
this 28th day of November, 2011.

Joyce M Needham
Notary Public

JOYCE M. NEEDHAM
Notary Public, State of Michigan
County of Berrien
My Commission Expires Sep. 19, 2014
Acting in the County of Berrien