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. EGGELSTON, 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; JONATHAN HAUG, M.D.; GENEVIEVE GOVEN, 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

DECLARATION OF JOHN THORP, JR., M.D., M.H.S.

John Thorp, Jr., M.D., M.H.S. declares and states the following:

I. QUALIFICATIONS.

1. I received my M.D. degree from East Carolina University Medical School in 1983. My residency training took place at the University of North Carolina (Chapel Hill) School of Medicine in general obstetrics and gynecology (1983-1987). I also completed my fellowship in Maternal-Fetal Medicine at the University of North Carolina (Chapel Hill) School of Medicine

in 1989. I received my Master's of Health Sciences in Clinical Leadership from Duke University School of Medicine in 2009.

2. Since 1991 I have been a board-certified obstetrician/gynecologist and since 1992 I have also had a certification in the sub-specialty of Maternal-Fetal medicine. I am a Fellow of the American Gynecological and Obstetrics Society and a member of the American College of Obstetricians and Gynecologists.

3. I am the Hugh McAllister Distinguished Professor of Obstetrics and Gynecology at the University of North Carolina (Chapel Hill) School of Medicine. I am also a Professor in the Department of Maternal and Child Health, School of Public Health at the University of North Carolina at Chapel Hill. In those roles I teach both medical students and residents in Obstetrics and Gynecology. Up until very recently, I had administrative oversight of the Family Planning Fellowship and Residency training programs at UNC.

4. I am the Deputy Director of the Center for Women's Health Research, at the University of North Carolina School of Medicine and School of Public Health (Department of Obstetrics and Gynecology and Department of Epidemiology, respectively).

5. I am also the Vice Chair for Research and Division Director of Women's Primary Healthcare, University of North Carolina School of Medicine.

6. In addition, I am a Fellow of the Carolina Population Center and have been the Director of the Biomedical Core of the Carolina Population Center of the University of North Carolina at Chapel Hill since 2003.

7. I have authored 21 book chapters and serve as a journal referee (reviewer) for 39 different medical journals, including *The New England Journal of Medicine, Mayo Clinic Proceedings, Obstetrics & Gynecology, The American Journal of Obstetrics and Gynecology,*

British Journal of Obstetrics and Gynecology, *Lancet*, *Journal of Perinatal Medicine* and *Journal of the American Medical Association - Archives of General Psychiatry*. I am currently the deputy editor-in-chief of the *British Journal of Obstetrics & Gynecology*, an international journal which is considered one of the most prestigious in my field. I also serve on the Editorial Board of the *Obstetrics and Gynecological Survey*.

8. I have written or co-written 317 peer-reviewed articles in the professional literature, 157 abstracts discussing medical research, and 39 non-peer reviewed articles.

9. Other professional activities of mine include being an oral examiner for the American Board of Obstetrics and Gynecology, and a member of the science and grant review panels for the National Center for Research and the National Institute for Child and Human Development, National Institutes of Health. My research responsibilities include administrative and scientific leadership in multiple active grants exceeding $12 million.

10. For a complete listing of my professional background, experience, responsibilities, and publications, please see my attached Curriculum Vitae (Exhibit A).

11. The opinions I express herein are to a reasonable degree of medical certainty, and are based upon my medical education, training and thirty years of clinical experience, as well as my familiarity with the medical literature. As Division Director of UNC's Women's Primary Healthcare, which up until recently included abortion and reproductive health services, I oversee and guide the credentialing process for 12 Obstetrician-Gynecologists, 3 Fellows, and 3 Advanced Practice Nurses. Throughout this declaration, I may sometimes refer to an abortion, as that term is defined at North Dakota Century Code §14-02.1-02(1), as "TOP" (which is an acronym for "termination of pregnancy") in this declaration. The opinions I express herein are my own and do not represent the institutions with which I am affiliated.

12. I provide these opinions in opposition to Plaintiffs' Motion for Summary Judgment against enforcement of North Dakota House Bill 1456, now codified at North Dakota Century Code Sections 14-02.1-05.1 14-02.1-05.2 and 43-17-31, referred to herein as "the Act." I understand, among other provisions of the Act, that before a TOP may be performed on a pregnant woman, an individual is required to determine, in accordance with standard medical procedure, if the unborn child[1] the pregnant woman is carrying has a detectable heartbeat. If the individual determines, in accordance with standard medical procedure, the unborn child the pregnant woman has a detectable heartbeat, then a TOP may not be performed, unless the individual performs a medical procedure designed to or intended, in that individual's reasonable medical judgment, to prevent the death of a pregnant woman, to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman, or to save the life of an unborn child. However, the Act permits a TOP if the individual has performed an examination for the presence of a heartbeat in the unborn child, utilizing standard medical procedures, and that examination does not reveal a heartbeat in the unborn child or the individual has been informed by a physician who has performed the examination for the unborn child's heartbeat that the examination did not reveal a heartbeat in the unborn child. In my opinion these requirements are reasonable and medically necessary to protect women from the adverse consequences of a TOP, promote and protect the health, safety and well-being of women and their families, and the protection of every human life, whether unborn or aged, healthy or sick.

[1] I may sometimes refer to the term "unborn child," which shall have the same meaning as that term is defined in N.D.C.C. § 14-02.1-02(18) to mean the offspring of human beings from conception until birth.

II. THE UNIQUENESS OF TOP IN MEDICINE

13. Numerous factors are illustrative as to why TOP services are unlike any others in the provision of medical care and thus require special statutory safeguards to protect mothers from increased risks of harm:

a. The relationship between a TOP provider and a pregnant woman begins and ends on the same day of the TOP procedure, there generally being no prior physician-patient relationship;
b. Pre-TOP counseling at these clinics is generally not provided by a licensed health care or mental health professional
c. Often screening for risk factors for adverse post-TOP outcomes is not provided;
d. Pre-TOP counseling is often deficient, excessively time-constrained, minimal or non-existent thereby reducing the likelihood of providing high quality counseling and meeting the needs of the pregnant woman
e. In the absence of a physician-patient relationship and given the poor quality of pre-TOP counseling, the likelihood of exploring the unique circumstances of the mother is minimal, increasing the risk that coercion or pressure in her decision-making will go unaddressed;
f. The patient is unlikely to be counseled on pregnancy outcome options other than TOP as this is optional or not provided;
g. Because the physician provides diagnosis, counseling and surgery on the same day when the patient presents for treatment, the pregnant woman is at increased risk for being "rushed" into treatment;
h. Not being able to obtain the patient's fully informed consent is more likely given the above circumstances;
i. TOP services generally require payment prior to being rendered, thus inducing pressure to proceed which can override patient ambivalence or contraindications
j. The procedure is intended to terminate the life of the mother's child resulting in the deliberate death by the physician by his or her other patient to whom he owes a legal and professional duty
k. TOP intentionally ends the legally protected relationship of a mother and her child which has life-long consequences
l. The physical and psychological health risks of TOP are serious and significant;
m. Due to the scenarios described above, the likelihood of physician bias and conflict of interest with TOP is more than in any other field of medicine;

14. Considering the above, the need for state regulation is paramount to protect the unique nature of the mother's special interests, to protect her health, safety and well-being, and

to decrease the risks of injury and harm to these pregnant women from the possible adverse affects of and consequences of a TOP. In my opinion, the Act does that and is a medically and scientifically reasonable and necessary regulation that protect women from the adverse consequences from TOP, and in turn protects and promotes women's health, safety and well being.

III. THE DUAL PATIENT OF THE OB-GYN

15. It is incontrovertible in obstetrics that the physician has two separate patients: the mother and her unborn child. As an OB-GYN, I have a professional and a legal duty to both patients, including the obligation to inform the mother of the risks and impact of a particular procedure on each of these patients. The physician owes a duty of care to *both* of these patients. In compliance with this ethical and legal duty, I inform the mother of the risks the procedure poses for the unborn child and I inform the mother of the risks to her. My duty to the unborn child is discharged by advising the pregnant mother of the risks to the unborn child. The mother then becomes the informed decision maker for both herself and her unborn child, weighing the various risks and benefits to both of them. This dual duty of care is applicable in every situation where a pregnant woman is under a physician's care. Therefore, in contradiction of the duty of care and ethical responsibilities, a physician who proposes to perform a TOP is then proposing to terminate the life of one of his patients to whom he owes a duty of care.

16. In addition, there is the reality of the *relationship* between the pregnant woman and her unborn child. Irrespective of the wantedness or unexpectedness of the pregnancy, the biological and psychological connection between the mother and her unborn child cannot be denied, minimized or dismissed. This connection or relationship is not some biological potential, nor is it just something that could occur in the future. It already exists and will be ended in a

TOP. If TOP is elected, the mother loses her lifelong relationship with her child which has the potential to bring satisfaction, new meaning, and happiness to her.

17. It is also incontrovertible that when a woman elects to terminate her pregnancy, she is terminating the life of a whole, separate, unique, living human being, a member of the species Homo sapiens, as enumerated in North Dakota law (N.D.C.C. § 14-021-02(9). This is an accurate statement of scientific and medical fact, and it is a fact that is generally known and accepted among medical providers and scientists, and was legally recognized in *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724, 735–36 (8th Cir. 2008) (en banc).

18. The fact that the unborn child is a distinct, and therefore separate, human being from his or her mother, makes it clear that there exists a unique relationship between a mother and a child. This unique relationship continues throughout their lives. The fact that it takes on a different character at different moments in the life does not alter the fact that the relationship exists during the pregnancy. There is substantial evidence in the medical literature that there is not only a relationship, but an attachment between mother and unborn child. Early on, maternal-fetal attachment (MFA) was defined as the extent to which women engage in behaviors that represent an affiliation and interaction with their unborn child. Twenty years ago critical attributes of MFA were identified: *cognitive attachment*, i.e., the desire to know the baby, *affective attachment*, i.e., the pleasure related to interactions with the unborn child, and *altruistic attachment*, i.e., the desire to protect the fetus (Yarcheski et al., 2009). MFA helps explain how a mother seeks to know, be with, to avoid separation or loss, to protect, and to identify the needs of the fetus, occurring independent of whether the pregnancy is wanted and irrespective of the intention to terminate the pregnancy.

19. The biological status of the human unborn child as patient is now well established in medicine. The treatment of this patient has and continues to be based upon the ever growing ability to assess, diagnose and treat the human unborn child during pregnancy. Over the past 30 years, fetal surgery for congenital disease has evolved from fanciful concepts to an evidenced based treatment. Major advances in understanding fetal pathophysiology, fetal imaging and diagnosis, anesthesia, and tocolysis (delaying delivery) have spawned new approaches and innovative fetal interventions in this fast-moving frontier of medicine (Jancelewicz & Harrison, 2009).

20. Maternal fetal medicine (MFM) is a subspecialty of obstetrics that focuses on identified risk pregnancies. The specialty of MFM has emerged as a result of the high value we place on children (Chescheir, 2009), the long-standing duty of the Ob-Gyn to treat both of his/her patients, and the confluence of improved assessment and intervention modalities. The role includes obstetric ultrasound for fetal assessment and diagnosis of anomalies, prenatal diagnosis, and management of pregnancies complicated by maternal medical disorders, multiple fetuses and the antenatal management of extreme prematurity. Skills within MFM includes fetal interventions such as fetal shunting procedures, intrauterine transfusion, fetoscopic laser photocoagulation of anastomotic vessels for twin to twin transfusion syndrome and ex utero intrapartum treatment.

21. In summary, it is my opinion a physician or any other clinician who proposes to perform a TOP to terminate the life of an unborn child, violates his or her duty of care to the unborn child – the physician's or clinician's patient – along with violating his or her ethical duties and responsibilities. Therefore, in my opinion, the Act is a reasonable and necessary regulation of TOP procedures to promotes the State of North Dakota's substantial interest,

recognized by the United States Supreme Court, of protecting the integrity and ethics of the medical profession and ensuring the medical profession and its members "be viewed as healers, sustained by a compassionate and rigorous ethic and cognizant of the dignity and value of human life, even life which cannot survive without the assistance of others." Stenberg v. Carhart, 530 U.S. 914, 962 (2000).

IV. TOP MORBIDITY AND MORTALITY & COMPARISONS TO CHILDBIRTH TO DECLARE TOP IS SAFE IS SCIENTIFICALLY WITHOUT MERIT

22. Plaintiffs alleged in their Complaint the following:

> Legal abortion is one of the safest medical procedures in the United States. The risk of carrying a pregnancy to term carries much higher risks of both morbidity and mortality than does obtaining an abortion through around twenty weeks. The mortality rate associated with pregnancy in the United States is approximately fifteen times higher than the risks associated with abortion. Access to safe and legal abortion benefits the health and wellbeing of women and their families.

Plaintiffs' Complaint, ¶ 32 (Court Doc. 1). Plaintiff Kathryn L. Eggleston stated the following regarding the safety of a TOP:

> Abortion is one of the safest medical procedures in the United States. A recent study found that the prevalence of any complication of first-trimester surgical abortion performed by physicians was 0.89%; the prevalence of major complications requiring treatment at a hospital was 0.05%. Carrying a pregnancy to term carries much higher risks of both morbidity and mortality than does obtaining an abortion through around twenty weeks lmp. The mortality rate associated with continuing a pregnancy in the United States is approximately fifteen times higher than that associated with abortion.

See Eggleston June 20, 2013 Declaration ¶ 19 (Court Doc. 3-1). These allegations found in Plaintiffs' complaint and in Eggleston's declaration are unfounded, and lack scientific rigor and reality.

23. These unfounded allegations and statements are based upon a 2012 report by Raymond and Grimes[2] that was provided by Plaintiffs in response to discovery in this case. The Raymond and Grimes report had similar unfounded conclusions as is now being asserted by the Plaintiffs in this case. There are multiple methodological weaknesses abound in this Raymond and Grimes research: (a) reliance on voluntary and incomplete state reporting of TOP; (b) data misclassification, i.e., deaths are reported by complication (e.g., infection or hemorrhage) and not from the procedure (e.g., TOP); (c) suicide deaths are rarely if ever linked back to TOP and are thus unreported; (d) failure to include TOP related deaths beyond the first trimester where TOP mortality risks equal and exceed childbirth; and (e) failure to account for evidence that childbirth is protective in the immediate and long-term against death from non-obstetrical causes including natural causes (e.g., breast cancer) and unnatural causes (e.g., suicide).[3]

24. As far back as 1998, long-time Guttmacher Institute researcher, Stanley Henshaw, concluded: "reporting of abortions is incomplete in most states."[4] Thus, if the data is incomplete, i.e., the incidence of the number of TOPs and the number of complications are either not reported or unreliable, statements about TOP safety are questionable and in turn lack credibility.

25. Two of the major issues confounding any valid comparison between maternal and TOP mortality are measurement and data quality. Without agreement about what is being

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[2] Raymond, E., Grimes, D. The Comparative Safety of Legal Induced Abortion and Childbirth in the United States. *Obstetrics & Gynecology* 2012. 119:215-9.

[3] *See:* Appleby, L. Suicide after Pregnancy and the First Postnatal Year. *British Medical Journal*, 1991. 302: 137–140**;** Carroll, P. S. The Breast Cancer Epidemic: Modeling and Forecasts Based on Abortion and Other Risk Factors. *Journal of American Physicians and Surgeons*, 2007, 12: 72-78; Daling, J. R., Malone, K.E., Voigt, L., White, E. & Weiss, N. S. (1994). Risk of Breast Cancer among Young Women: Relationship to Induced Abortion. *Journal of the National Cancer Institute*, 1994, 86: 1584-1592.; Marzuk, P. M., et al. Lower Risk of Suicide during Pregnancy. *American Journal of Psychiatry*, 1997, 154: 122-123; Thorp, J., Hartmann, K., & Shadigan, E. Long-term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence. *Obstetrical and Gynecological Survey*, 2002, 58: 67-79.

[4] Henshaw, S. Abortion Incidence and Services in the United States, 1995-1996. *Family Planning Perspectives.* 1998, 30: 263.

measured, how, when and on what basis any conclusions are drawn is meaningless. Because the data are so incomplete, the World Health Organization (WHO) has used seven different methods to estimate maternal death.[5] This is indeed the case here. Consider the following:

a. According to the World Health Organization, "[m]easuring maternal mortality accurately is difficult except where comprehensive registration of deaths and of causes of death exists" (WHO, 2013). Since the US does not possess this capacity, the basis of our information about maternal mortality and TOP mortality is severely limited.

b. Accurate capture of the precise number of maternal deaths is further compounded by multiple variations in definitions and usage of these terms. For example:

> ''*Maternal deaths*'' are defined by the World Health Organization as ''the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.''
>
> ''*Late maternal deaths*'' are defined as ''the deaths of a woman from direct or indirect obstetric causes more than 42 days but less than one year after termination of pregnancy.''
>
> ''*Pregnancy-related deaths*'' are defined as ''the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death.''
>
> ''*Direct obstetric deaths*: those resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.''
>
> ''*Indirect obstetric deaths*: those resulting from previous existing disease or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by physiologic effects of pregnancy.'' (ICD-10, Hoyert, 2007:8)

[5] World Health Organization, *Maternal Mortality in 2005—Estimates Developed by WHO, UNICEF, UNFPA, and the World Bank*. Geneva, Switzerland: Department of Reproductive Health & Research, 2007.

Therefore, the estimative nature of the data and the use of differential definitions severely limit the conclusions drawn and the generalizability of any findings. Implicit in any discussion about TOP safety is the presumption that the data upon which this assertion rests are reliable and complete. This is not insignificant as there are only two primary sources of data for TOP: the Centers for Disease Control and Prevention[6] (CDC) and the Guttmacher Institute (GI).[7] The former does not provide surveillance data of non-fatal TOP complications, only mortality. The latter does not systematically gather this data either, but instead relies upon non-GI individual studies.[8] Even so, GI acknowledges: "Additionally, much of what is known about women having abortions is incomplete or out of date."[9]

26. Up until recently, but throughout its history, GI has been affiliated with and/or funded by the largest TOP provider in the U.S., Planned Parenthood Federation of America. This conflict of interest has created a systematic information bias which should not be

[6] The CDC obtains its TOP data from state health departments. Beginning in 1969, state health departments have voluntarily provided annual reports on TOP procedures and patients. These data are incomplete due to the wide variability in state requirements for reporting of TOP procedures, the voluntary nature of participation with some states choosing to not do so periodically, marked variation in the information each state obtains, and the lack of specific funding for TOP data accumulation. For instance, the sizable State of California has not reported in the past decade. Thus, any report on TOP epidemiology from the US is fraught with numerous assumptions and lack of any clear standardization. *See*: Cates, W., Grimes, D. & Schulz, F. Abortion Surveillance at CDC. Creating Public Health Light Out of Political Heat. 19 *American Journal of Preventative Medicine* 2000, 12-17; Pazol, K., Creanga, A., & Zane, S. Trends In Use of Medical Abortion in the United States: Reanalysis of Surveillance Data from the Centers for Disease Control and Prevention, 2001-2008. 86(6) *Contraception* 2012, 746-751.; Pazol, K., Zane, S., Parker, W., et al., Abortion Surveillance in the United States, 2008. 60(15) *MMWR Surveillance Summaries* 2011, 1-41.; Pazol,K., Zane, S., Parker, W., et al., Abortion Surveillance-United States, 2007. 60(1) *Morbidity and Mortality Weekly Report* 2011, 1-39.; Pazol, K., Zane, S., Parker, W., et al. Erratum: Abortion Surveillance-United States, 2007. 60(10) *MMWR Surveillance Summaries* 2011, 315.

[7] GI obtains its estimated number of TOP procedures from periodic surveys of all known US TOP providers. Reporting is voluntary and the surveys are done at irregular intervals up to five years apart. *See:* Jones, R. & Kooistra, K. Abortion Incidence and Access to Services in the United States, 2008. 43(1) *Perspectives on Sexual and Reproductive Health* 2011, 41-50.; Jones, R., Kost, K., Singh, S., Henshaw, S., & Finer, L. Trends in Abortion in the United States. 52(2) *Clinical Obstetrics and Gynecology* 2009, 119-129.

[8] For example, see Boonstra, H. et al. The Long-Term Safety of Abortion in Boonstra, Ch. 4 in *Abortion in Women's Lives,* Guttmacher Institute, 2006. Available at: http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf.

[9] Jones, R., Finer, L. & Singh, S. *Characteristics of U.S. Abortion Patients, 2008.* N.Y.: Guttmacher Institute, 2010, p. 2.

discounted. GI has a TOP advocacy agenda that is evident to any reasonable reader reviewing their website.[10] On the other hand, the CDC relies upon state health department data which is subject to considerable underreporting by TOP providers due to the voluntary nature of the reporting and obvious conflict of interests. Likewise, GI's TOP reporting is based upon periodic provider estimates and is also subject to provider conflict of interests. In the U.S., it is estimated that only one-third to one-half of TOP patients return to the clinic for their follow-up care.[11] Accordingly, many complications delayed or otherwise, are unlikely to even be known to the TOP provider. Moreover, there is no national mandatory registry or reporting of the incidence of elective TOP or its complications. It is my understanding that North Dakota is one only a handful of states that does require TOP providers to report complications of terminations.[12] However, even when TOP complications are required to be reported, in my opinion, significant underreporting occurs due to provider conflict of interests.

27. Given the inherent weaknesses of TOP mortality and morbidity data, it is inconceivable to me how TOP safety can be alleged with any reasonable degree of epidemiological certainty.

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[10] "The Institute works to protect, expand and equalize universal access to information, services and rights that will enable women and men to exercise the right to choose safe, legal abortion . . ." and "The Institute also recognizes a responsibility to document, and address through policy advocacy, the disparities in sexual and reproductive health and rights between and within countries across the globe, and to support the efforts of colleagues advocating for enlightened policies in their own countries and internationally." Mission of Guttmacher Institute, 2013. Available at: http://www.guttmacher.org/about/mission.html

[11] *See:* Picker Institute, *From the Patient's Perspective: Quality of Abortion Care*, 1999 at 33, and Grossman, D. et al., Routine Follow-up Visits after First-Trimester Induced Abortion. *Obstetrics & Gynecology* 2004, 103: 738-745.

[12] According to a recent nationwide survey, there are only 16 states that require reporting of TOP complications, and only 8 states that publish summary information which includes abortion complications in their annual report. See: Donovan C & Sullivan N. *Abortion Reporting: Tears in the Fabric*. 2013, Washington, D.C.: Charlotte Lozier Institute, Table 5, available at: http://www.lozierinstitute.org/abortionreporting/. According to another report, only 27 states have mandated TOP complications reporting. See: Guttmacher Institute, Abortion Reporting Requirements, *State Policies in Brief*. August 1, 2013, available at: http://www.guttmacher.org/statecenter/spibs/spib_ARR.pdf

28. Furthermore, the paucity of good data on the serious complications of TOP does not warrant the manufacturing of medical "certainty" based upon a self-citing cycle of institutional informational bias. Dr. Stephen Henshaw, a long time Guttmacher researcher, who has repeatedly testified in opposition to any regulation of TOP and has concluded in a 1999 published chapter that the risk of women expiring complication requiring hospitalization from a first trimester abortion is 0.3%. Coincidentally, the book in which Dr. Henshaw's chapter appears is a clinical text of the National Abortion Federation.[13] In that chapter, Dr. Henshaw bases his estimate on his own 1986 report co-written with Dr. Tietze, a Planned Parenthood biostatistician who received their annual Margaret Sanger Award in 1973, which examined data that is 38 years old.[14] The 1986 Henshaw & Tietze report was published by Guttmacher. It is difficult if not impossible to draw valid conclusions about contemporary TOP practices based upon data nearly four decades old, and it is certainly questionable for public policy to rely upon Plaintiff Planned Parenthood's employees for conclusive scientific evidence as to the safety of TOP.

29. Existing and scientifically valid research demands revisiting this issue. Two Canadian articles produced population-based maternal mortality rates[15] (MMR) from a developed country in "healthy women." Though neither controlled for age, their findings are illustrative here. One focused on excess risk associated with elective abdominal delivery and

[13] Henshaw, SK. Unintended pregnancy and abortion: a public health perspective. In: Paul M, Lichtenberg ES, Borgatta L, Grimes DA, Stubblefield, PG, eds, *A Clinician's Guide to Medical and Surgical Abortion*. New York: Churchill Livingston;1999:11-22.

[14] Tietze, C. & Henshaw, SH. *Induced Abortion: A World Review*. Alan Guttmacher Institute, 1986.

[15] The maternal mortality rate (MMR) is the annual number of female deaths per 100,000 live births for a specified geographical area from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes). The MMR includes deaths during pregnancy, childbirth, or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, for a specified year, and for a specified geographical area.

found an MMR of 1.2/100,000.[16] The other focused on vaginal birth after caesarean section which is a higher risk condition due to uterine scarring and found a risk of 1.6/100,000.[17] One can safely speculate that this number would be lower in women with an unscarred uterus. Both of these MMRs are well within the 1-2/100,000 quoted for TOP in the US with all its limitations. In my epidemiological opinion, it is misleading to assert that TOP is safer than pregnancy in low risk, healthy women. An additional factor that should be considered is age and maternal mortality. Younger women between the ages of 20 – 39 are generally healthier than older women and thus less likely to die from uncomplicated pregnancy and childbirth, which is a normal and natural process. In developing countries when direct obstetric deaths which are largely preventable are excluded, a "healthy pregnant woman effect" has been reported in which women currently or recently pregnant were up to five times less likely to die than women who had not been recently pregnant.[18]

30. Given the poor ascertainment and reporting of deaths after TOP in the US due to insufficient administrative oversight and subsequent inability to link TOP occurrence to death certificates,[19] it is imprecise at best to compare TOP-related deaths to pregnancy-related deaths and claim TOP is one of the safest medical procedures in the United States, and much more safe than childbirth. Pregnancy related deaths are systematically sought and investigated by state

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[16] *See: Wen, S. et al.* Comparison of Maternal Mortality and Morbidity between Trial of Labor and Elective Cesarean Section among Women with Previous Cesarean Delivery, *American Journal of Obstetrics & Gynecology,* 2004, 191: 1263-1269).

[17] Liu, S et al. Maternal Mortality and Severe Morbidity Associated with Low-risk Planned Cesarean Delivery versus Planned Vaginal Delivery at Term. *Canadian Medical Association Journal,* 2007, 176, 455-460.

[18] Ronsmans, C. et al. Evidence for a "Healthy Pregnant Woman Effect" in Niakkar, Senegal. *International Journal of Epidemiology*, 2001, 30, 467-473.

[19] Reardon, D., Strathan, J. Thorp, J. & Shuping, M. Deaths Associated with Abortion Compared to Childbirth – A Review of New and Old Data and the Medical and Legal Implications. *Journal of Contemporary Health Law & Policy*, 2004, 20: 279-327.

government sponsored commissions and the majority of states formally link birth certificates to death certificates. These efforts, which cannot currently be done for TOP, *double* the number of pregnancy related deaths discovered. Moreover, deaths after pregnancy cover an interval from conception to 42 days after delivery while TOP covers a much shorter window. An analogy would be comparing a full length film to a snapshot. For these reasons, comparing death rates and their derivative, safety claims, are inaccurate and imprecise. Such claims are not supported by adequate epidemiological methods and at this time, the comparative differences in the U.S. cannot be quantified with precision.

31. The U.S. has no national health registry identifying and linking all individual healthcare interventions, diagnoses, hospitalizations, births, deaths and other vital statistics, unlike Scandinavian countries. Accordingly, epidemiological studies using these national data sets from abroad are methodologically superior to U.S. data. In a recently published study of 463,473 women using Danish linked birth and death registry records for an epoch of 25 years, when compared to women who delivered, women with TOP < 12 weeks gestation had higher cumulative mortality rates from 180 days to 10 years later.[20] In a second study using the same national registries, the researchers again found increased risks of death for women electing abortion compared to childbirth.[21] Record linkage studies of the population of Finland and of low income women in California have also reported higher death rates associated with abortion than childbirth.[22]

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[20] Reardon, D. & Coleman, P. Short and Long Term Mortality Rates Associated with First Pregnancy Outcome: Population Register Based Study for Denmark 1980 – 2004. *Medical Science Monitor*, 2012, 18: PH71—Ph76.

[21] Coleman, P. Reardon, D. & Calhoun, B. Reproductive History Patterns and Long-term Mortality Rates: A Danish, Population-Based Record Linkage Study. *European Journal of Public Health* (September 5, 2012, Epub ahead of print).

[22] Post-pregnancy death rates within one year were nearly 4 times greater among women who had an induced abortion (100.5 per 100,000) compared to women who carried to term (26.7 per 100,000). Gissler, M. et al.

32. Indeed, large-scale studies based on data linkage from the US, Britain, Denmark and Finland, have shown that women who undergo induced abortion have a sharply increased death rate compared to women who give birth. Having TOP also greatly increases a woman's chance of later attempting or committing suicide, while carrying a baby to term greatly reduces that likelihood. As two recent researchers write, "pregnant women considering their options deserve accurate information about comparative risks."[23] Yet, as already noted above, purporting to show that induced abortion is safer than childbirth is based on faulty methodology and incomplete data, and is in any case limited to the period immediately after childbirth or termination of pregnancy. It completely ignores four data-linkage studies, which are based on a far more objective and neutral methodology, as well as complete and reliable data. Those and other studies effectively explode the myth that abortion is safer for a woman than childbirth.

33. Yet, Plaintiffs argue that TOP is safe despite the lack of valid scientific evidence. No evidence is presented or exists to corroborate this extreme position. After reviewing such opinions and allegations comparing the relative safety of childbirth to TOP, one could reasonably draw the conclusion that human pregnancy and delivery is a disease state that is unsafe and should be managed by the safer choice of pregnancy termination, notwithstanding common sense and conventional medical science. Indeed, such a one-sided view would seemingly question why a woman would ever choose conception and childbirth.

Pregnancy Associated Deaths in Finland 1987-1994: Definition Problems and Benefits of Record Linkage. 76 *A Acta Obstetricia et Gynecologica Scandinavica*. 1997, 76: 651-7; mortality was significantly lower after a birth (28.2 per 100,000) than after an induced abortion (83.1 per 100,000). Gissler, M., Berg, C., Bouvier-Colle, M., Buekins, P. Pregnancy-associated mortality after birth, spontaneous abortion, or induced abortion in Finland, 1987-2000. *American Journal of Obstetrics and Gynecology*, 2004, 190: 422-427; women who aborted, when compared to women who delivered, were 62% more likely to die over an 8 year period from any cause after adjustments were made for age. Reardon, D. et al. Deaths Associated with Pregnancy Outcome: A Record Linkage Study of Low Income Women. *Southern Medical Journal*, 2002, 95: 834-841.

[23] Raymond, E., Grimes, D. The Comparative Safety of Legal Induced Abortion and Childbirth in the United States. *Obstetrics & Gynecology* 2012. 119:215-9, pp. 187-91

34. In summary, there are numerous and complex methodological factors that make a valid scientific assessment of TOP mortality and morbidity impossible: incomplete reporting, definitional incompatibilities of measures, voluntary data collection, investigator bias, reliance upon estimations, inaccurate and/or incomplete death certificate completion, incomparability with maternal mortality statistics, and failing to include other causes of death such as suicides. Numerous other methodological issues abound in TOP epidemiology. Further discussion of this is presented in my 2012 article in *Scientifica* entitled: Public Health Impact of Legal Termination of Pregnancy in the US: 40 Years Later. Therefore, in my opinion any assertion that TOP is safer than childbirth lacks medical and scientific merit – it is not and any contention otherwise is misleading.

V. ADVERSE CONSEQUENCES TO WOMEN FROM TOP: SHORT & LONG TERM RISKS OF TOP

35. With the caveats identified above, and acknowledging the weaknesses of existing epidemiological research on TOP outcomes, in my opinion, there are significant risks from surgical TOP, which include bleeding, infection, and damage to bowel, bladder, or upper genital tract. The risks from medical TOP include failed abortion, incomplete abortion, bleeding, and infection which are greater than for surgical TOP, according to existing research.[24] Heavier bleeding and more severe cramping are more common in medical TOP. Off-label use of medical TOP is inadvisable given the number of adverse event reports and deaths.[25] Complication rates

[24] Similar to the findings of other studies, the incidence of hemorrhage is 15.6 percent following medical abortions, compared to 5.6 percent for surgical abortions; 6.7 percent of medical abortions result in incomplete abortion, compared to 1.6 percent of surgical abortions; and the rate of need for surgery following medical abortion is 5.9 percent. M. Niinimaki, et al., Immediate Complications after Medical Compared with Surgical Termination of Pregnancy, *Obstetrics & Gynecology*. 2009,114:795-799 (2009). For a discussion of complications associated with medical TOP <49 weeks gestation versus 49>, see: Amici Curiae Brief of Dr. John Thorp et al., *Cline, et al. v. Oklahoma Coalition for Reproductive Justice, et al.,* U.S. Supreme Court, No. 12-1094, 2013.

[25] The FDA relies on "adverse event reports" as one method to determine whether to remove a drug from the market after approval. An FDA report in 2011 acknowledged at least 2,207 cases of severe adverse events, including

range from 1-10% and most complications can be managed without major surgery. While TOP complication rates tend to increase proportionately with gestational age, based upon the limited and incomplete data available, and while the magnitude of risk remains small, after 16 weeks, risks from TOP may exceed the risks of carrying a pregnancy to term and certainly do so by 20 weeks.

36. While there have been numerous claims that TOP has no long-term health consequences beyond the immediate complications identified above, these assertions are based upon the data limitations previously discussed, particularly lack of completeness and the sole use of observational data generated by self-report of TOP exposure. Methodologically sound research has, however, indicated significant associations between TOP and preterm birth that appear to be causal and association with placenta previa, breast cancer, and mental health problems, i.e., mood disorders, substance abuse and suicide, that are suggestive of causality.[26]

37. When one reviews countries where TOP is freely available, like in certain Latin American, African and European countries, there is next-to-no evidence to support the proposition that legalizing abortion leads to improved maternal and infant health. On the contrary, we find that those countries which do not permit abortion, or which have banned it in the past two decades, have a consistently better record in caring for mothers and newborns. This is clearly evident in Chile, Poland and Ireland. What is beyond dispute is that countries that have made strides in improving the education of women, in emergency obstetric care (such

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hemorrhaging, blood loss requiring transfusion, serious infection, and 14 deaths. U.S. Food & Drug Administration. *Mifepristone U.S. Postmarketing Adverse Events Summary Through 04/30/2011*. RCM 2007-525 (July 2011) available at: http://www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM263353.pdf.

[26] Thorp, J. *Scientifica*, 2012, op. cit.; Thorp, J. Hartman, K. & Shadigian, E. *Obstetrical & Gynecological Survey*, 2004, op. cit.

as caesarean sections), in skilled attendance at birth, as well as community outreach, improved referral systems and transportation for emergency care - most notably Chile, Uganda and Egypt -- have been rewarded with greatly improved maternal and infant health.

38. A woman who is pregnant will increase her risk of breast cancer if she aborts that pregnancy, given the protective effect of delivery on breast cancer risk. The woman who does have a TOP procedure will either remain childless, which in itself increases breast cancer risk, or she will delay her first full-term pregnancy, another known risk for breast cancer. The woman having a TOP procedure is also deprived of breastfeeding her baby, which would further reduce her breast cancer risk. By the end of a full-term pregnancy, a woman will cause 85 percent of the Type 1 and 2 breast lobules she developed at puberty (where ductal and lobular cancers start respectively) to mature to Type 4 lobules which are cancer-resistant. There are documented changes in the breast cells' genomes which have been studied and provide the known molecular basis for the protective effect of a full-term pregnancy.

39. The rate of infection for women undergoing a TOP ranges from <1% to as high as 10%. Pelvic inflammatory disease (PID) is a consequence both of sexually transmitted infections (STIs) and medical procedures like a surgical TOP that introduces bacteria from the vagina or cervix into the uterus, uterine tubes or ovaries. Women with an STI who procure an induced TOP are therefore up to 72 percent more likely to contract PID; this association is most commonly seen among women with Chlamydia. Even with the administration of antibiotics prior to a TOP, women still risk the sequelae of infection. The consequences most discussed in the literature are subfertility, infertility, and ectopic pregnancy. Studies also show that PID can cause tubal pathology that renders a woman infertile. Ectopic pregnancy is one of the leading causes of pregnancy-related deaths, and because of the scarring caused by PID, the risk of

ectopic pregnancy rises seven- to ten-fold in infected women. There is a correlation between abortion and subsequent ectopic pregnancy. In my opinion a women that has a TOP significantly increases her risk of PID and a subsequent ectopic pregnancy that is itself life threatening.

40. In the past fifteen to twenty years the medical literature has increasingly documented the immediate hazards of a surgical TOP: perforation of the uterus, causing scarring, which in turn can result in Asherman's syndrome and infertility. The risk of placenta previa in a subsequent pregnancy may also be increased. The necessity to force open the cervix (dilation) during a surgical TOP can weaken the cervix and render it incapable of performing its primary function during pregnancy: holding in the baby. A weakened or "incompetent" cervix will mean a higher rate of miscarriage and premature births. In my opinion, these are very real hazards stemming from a surgical TOP, which are significantly increased when a woman has a TOP.

41. TOP greatly elevates the subsequent risk of bearing a premature baby. Two systematic reviews published in the British Journal of Obstetrics and Gynaecology and the Journal of Reproductive Medicine, as well as two recently completed, massive studies from Scandinavia and Britain have established that preterm and low-birth-weight children have a much greater chance of dying in childhood.[27] These unfortunate children also have a much higher incidence of medical disabilities, most notably cerebral palsy and mental retardation. They fare worse in the educational system, on the job market, and in finding a life partner. Furthermore, four studies have documented a link between autism and prior abortions. The

[27] Shah, PS, Zao J. Induced termination of pregnancy and low birth rate and preterm birth: a systematic review and meta-analysis. BJOG: An International Journal of Obstetrics & Gynecology, May 2009; 116(1): 1425-42. Swingle, HM, Colaizy, TT, Zimmerman MB, Morriss, FH. Abortion and the risk of subsequent pre-term birth. The Journal of Reproductive Medicine 2009, February; 54(2): pp. 95-108.

association between having one or more TOP procedures and later giving birth to a premature child has also been clearly established, most recently by two major Canadian studies this year. The more TOP procedures a woman has, the greater her chances of later delivering a preterm or low-birth-weight child. Surgical TOP procedures also elevate the risk of uterine scar tissue (also known as adhesions) and cervical insufficiency (also called incompetent cervix), both of which raise the risk of a future premature delivery. An "incompetent cervix" raises cerebral palsy risk, as do maternal infections. Consequently, it is fair to say that TOP is producing a medical and social disaster in those countries where it is freely available. Writing in the Journal of Reproductive Medicine, a group of researchers has estimated that in the United States in one year alone, prior induced abortions caused at least 1096 cases of cerebral palsy in very low birth weight newborns. Globally this translates into well over 15,000 cases of cerebral palsy annually attributable to prior induced abortions. It is interesting to compare this with the birth of an estimated 10,000 babies with serious defects in the late 1950s as a consequence of thalidomide use. This personal and collective tragedy was then greeted with universal horror. A glimpse of the benefits that might accrue from reducing the number of induced abortions is furnished by the experience of Poland. Twenty-three years ago the new democratic regime took the drastic step of banning almost all TOP procedures in that country. As we have seen, this action was followed by a more than 70 percent drop in the deaths of children under the age of five from cerebral palsy in the succeeding fifteen years. Moreover, in the three-year period from 1995 to 1997 Poland's extreme preterm birthrate dropped by 21 percent, while the total of all births declined by only five percent. No other country has achieved such a dramatic reduction in extremely preterm births in such a short time. By contrast, both the US and Canada, where TOP is freely available, experienced a rise in preterm births during the same period.

VI. ADVERSE CONSEQUENCES TO WOMEN FROM TOP: COERCION, PRESSURE AND UNDUE INFLUENCE IN TOP DECISION-MAKING

42. Current research informs and alerts ob-gyns to the importance of screening for intimate partner violence and reproductive coercion (Miller & Silverman, 2010). The American College of Obstetricians and Gynecologists has issued Committee Opinion #554 on reproductive and sexual coercion indicating: "Obstetrician-gynecologists are in a unique position to address reproductive and sexual coercion and provide screening and clinical interventions to improve health outcomes" (ACOG, 2013). Forcing a female partner to terminate a pregnancy when she does not want to is reproductive coercion according to ACOG and others (Chamberlain & Levenson, 2012). Research indicates that past year prevalence of physical and sexual intimate partner violence (IPV) among abortion-seeking women is estimated to be 14% to 25.7% for sexual intimate partner violence. This estimate is more than 6 times the estimated national prevalence of 3.7% among US women who continue their pregnancy; accordingly, women in violent relationships are much more likely to seek TOP services (Saftlas et al, 2010; Woo, Fine & Goetzl, 2005). Men who perpetrate IPV are more likely to report conflicts with pregnant female partners regarding TOP decisions (Silverman et al., 2011), and thus these women are in danger of being coerced.

43. Teens and women seeking terminations of pregnancy are 3 times more likely to be victims of partner violence (Chamberlain & Levenson, 2012; Taft & Watson (2007), and women presenting for a third or subsequent abortion were more than 2.5 times as likely as those seeking a first abortion to report a history of physical abuse by a male partner or a history of sexual abuse/violence (Fisher et al, 2005). The association between TOP and sexual coercion reflects a situation of gender vulnerability and reveals young women's precariousness in sex negotiation and reproduction (Pilecco, Knauth & Vigo, 2011).

44. While estimates vary according to the study, coercion or pressure among women seeking TOP ranges between 11% - 64%. Even the National Abortion [providers] Federation identifies "perceived coercion to have the abortion" as a risk factor for negative postabortion emotional sequelae (Baker & Beresford, 2009: 57). Given the nature, gravity and prevalence of IPV, and the common association between IPV and TOP, coercion or pressure prior to the termination of pregnancy occurs with frequency.

45. An associated factor with coercion, pressure and undue influence is the age of the father of the unborn child. For pregnant adolescents, the majority of these pregnancies are fathered by older, adult men (Males and Chew, 1996), and these men are in a position to exert an inordinate and potentially unhealthy influence over pregnant girls resulting in STIs, non-marital births, and TOPs. Half of the births to teen mothers involve men who are 20 – 24 years old, and an additional one-sixth are over age 25; teens who date older partners have a lower likelihood of consistent contraceptive use and for each year a partner is older than the teen, the likelihood of always using contraception decreased by 11 percent (Males, 2004). Adolescent girls with older male partners are more likely to have earlier sexual debut, multiple sexual partners, unprotected and non-voluntary sex, non-marital births, high-risk partners, STIs, and experience IPV (Manlove et al., 2006). Low relationship power can be one explanation, i.e., an adolescent girl's ability to act independently of her partner's control is compromised, and his influence and dominance in decision-making is prevalent. A noteworthy example of this occurred in Cincinnati, Ohio where a 22 year old soccer coach impregnated a 14 year old girl who subsequently went to Planned Parenthood for an abortion and did not tell her parents. Planned Parenthood did not inform the parents nor the authorities of this statutory rape and ongoing sexually abusive relationship. The fact that adolescents are exposed to so many individuals and

forces outside the family makes them particularly vulnerable to undue influence, pressure and even coercion. Clearly, "Clinicians need to screen for partner age differences and recognize the possible association between partner age differences and IPV" (Volpe et al., 2013:14).

46. Abortionists, like Plaintiffs, all too often focus on decisional certainty, without examining those risk factors that may predispose pregnant women to postabortion emotional injury, including coercion. A pregnant woman's decision can indeed be certain but also be coerced at the same time. Dr. Eggleston comes in from out of state and is paid only if sufficient numbers of women consent to abortion. This pressure, combined with the above, in my medical opinion, constitutes a serious conflict of interest that in turn harms women.

VII. SUMMARY

47. It is my opinion that TOP has a significant and profoundly adverse effect on the physical health, safety and well-being of women. Further, it is my opinion that a physician or any other clinician who performs a TOP to terminate the life of an unborn child, violates his or her duty of care to the unborn child – the physician's or clinician's patient – along with violating his or her ethical duties and responsibilities. Therefore in my opinion the Act protects women from the adverse effects of a TOP and in turn promotes the health, safety and well-being of women and their families, and the protection of every human life, whether unborn or aged, healthy or sick, protects and promotes the integrity and ethics of the medical profession, and is medically and scientifically sound and reasonable.

VIII. LIST OF ALL CASES IN WHICH, DURING THE PAST FOUR YEARS, I HAVE TESTIFIED AS AN EXPERT AT TRIAL OR BY DEPOSITION.

A. Constitutional Cases in Which I Have Provided Testimony:

- *Planned Parenthood of Arizona, Inc. v. Goddard et. al*., Case No.: CV2009-029110. Superior Court of Arizona, County of Maricopa. Provided declaration 9/25/09.

- *Stuart et al., v. Huff., et al.* CV No.: 1:11-cv-804-CCE. U.S. District Court, Greensboro, North Carolina. Provided declaration and deposition. 2011-12.

- *Planned Parenthood of the Great Northwest, et al., v. State of Alaska*. Case No.: 3AN-10-12279 CI. Superior Court in Anchorage, Alaska, 2012.

- *Planned Parenthood of Greater Texas Surgical Health Services, et al*. v. Abbott, et. al. Case No. 1:13-cv-862 U.S. District Court, Middle District of Alabama.

- *Planned Parenthood Southeast, Inc*., et. al. v. Bentley, et. al. Case NO. 2:13-cv-00405. U.S. District Court, Western District of Texas.

- *Planned Parenthood v*. Daugaard, et. al. Case No. 11-4071-KES, U.S. District Court, South Dakota

B. Medical Malpractice Cases in Which I Have Provided Testimony:

I do not maintain records that will allow me to provide names of cases and courts for the medical malpractice cases listed below. I maintain only contact information regarding the attorneys and law firms that I provided expert witness assistance to and the dates of my work.

- Trial testimony on 3/1/13, 1/28/11; Deposition testimony on 3/22/10, 2/19/10, 10/9/09, 8/21/09, 6/9/09, Shumaker, Loop & Kendrick, Charlotte NC.

- Deposition testimony on 10/11/12, Heath & Carcioppolo, Ft. Lauderdale FL

- Trial testimony on 8/24/12; Deposition testimony on 4/7/11, 3/7/09, Huff, Powell & Bailey, Atlanta GA.

- Trial testimony on 7/23/12, Tharrington & Smith, Raleigh NC

- Trial testimony on 5/21/12; Deposition testimony on 12/22/11, Wilson Helms & Cartledge, Winston-Salem NC

- Deposition testimony on 4/30/12, Mundy Rogers & Assoc., Roanoke VA

- Deposition testimony on 3/20/12, 1/27/11, 1/3/09, 7/28/09, Haliczer, Pettis & Schwamm, Ft. Lauderdale FL.

- Deposition testimony on 3/15/12, 9/3/10, Wilson, Elser, Moskowitz, Edelman & Dicker, Washington DC.

- Trial testimony on 3/9/12, 4/4/11, 5/13/10; Deposition testimony on 5/6/09, Walker, Allen, Grice, Ammons & Foy, Goldsboro NC.

- Deposition testimony on 3/2/12, Hamilton, Altman, Canale, & Dillon, Fairfax VA

- Trial testimony on 1/25/12, Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, Raleigh NC.

- Trial testimony on 1/20/12, Adams Coogler, West Palm Beach FL.

- Deposition testimony on 1/17/12, Law Office of Michael Goodman, Englewood CO

- Deposition testimony on 11/3/11, Cecily E. Steele, Cary NC.

- Deposition testimony on 9/1/11, Shuttleworth & Ingersoll, Cedar Rapids IA.

- Deposition testimony on 7/8/11, 6/3/11, 1/3/11, Baker & Whitt, Memphis TN.

- Deposition testimony on 6/1/11, 5/10/1, Feldman Shepherd, Philadelphia PA.

- Deposition testimony on 5/16/11, Owen, Gleaton, Egan, Jones & Sweeney, Atlanta GA.

- Deposition testimony on 5/13/11, 12/18/09, 10/15/09, 7/10/09, 5/26/09, 4/22/08, 1/24/08; Trial testimony on 1/26/11, Cranfill, Sumner & Hartzog, Raleigh NC.

- Deposition testimony on 1/4/10, Parker Poe, Charlotte NC.
- Deposition testimony on 12/2/10, 10/25/10, Yates, McLamb & Weyher, Raleigh NC.

- Deposition testimony on 11/19/10, Harris, Ward & Blackerby, New Bern NC.

- Trial testimony on 9/24/10, Dameron Burgin, Parker, Lorenz & Jackson, Marion NC.

- Deposition testimony on 1/4/10, 6/25/09, Parker Poe, Adams & Bernstein, Charlotte NC.

- Deposition testimony on 12/4/09, Forrester & Brim, Gainesville GA.
- Trial testimony on 10/20/09; Deposition testimony on 5/29/09, Goodell, DeVries, Leech & Dann, Baltimore MD
- Deposition testimony on 9/29/09, 6/9/09, Rodney Dickanson, Sloan, Akin & Robb, Albuquerque NM.
- Deposition testimony on 9/4/09, Leech & Dann, Baltimore MD.
- Deposition testimony on 9/1/09, Daniel Weinstock, Feldman Shepherd, Philadelphia PA.
- Deposition testimony on 9/1/09, Paralegal to Rishard Ramsey, Wicker, Smith, O'Hara, McCoy & Ford, Jacksonville FL.
- Deposition testimony on 8/28/09, Adams & Bernstein, Charlotte NC.
- Deposition testimony on 8/28/09, Nancy E. Carr Claims and Risk Management Services, Miami FL.
- Deposition testimony on 7/23/09. The Keenan Law Firm, Atlanta GA.
- Deposition testimony on 7/20/09, 5/27/09, 1/22/08, 12/21/07, Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, Raleigh NC.
- Deposition testimony on 7/12/09, Dickie, McCamey & Chilcote, Pittsburg PA.
- Deposition testimony on 6/31/09, Matthew W. Sowell, Jacksonville FL.
- Deposition testimony on 3/12/09, 6/20/08, 1/29/08; Trial testimony on 11/18/08, Wilson & Coffey, Winston-Salem NC.
- Deposition testimony on 3/3/09, 4/17/08, Upton & Hatfield, Concord NH.
- Deposition testimony on 2/2/09, 1/22/08, 12/11/07, Hood Law Firm, Charleston SC.

IX. COMPENSATION.

I will be compensated at the rate of $500 per hour for work performed in this case. I charge $500 per hour for time spent testifying either in deposition or at trial, and it is also my understanding that if travel is required, that all of these expenses will also be paid in conjunction with my testifying.

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

Dated: December 10, 2013

/s/ John Thorp, Jr., MD
John Thorp, Jr., M.D., M.H.S.

EXHIBIT A

EXHIBIT A

CURRICULUM VITAE
JOHN M. THORP, JR., M.D.

Personal Information

Name	John M. Thorp, Jr., M.D.
	Department of Obstetrics and Gynecology 3027 Old Clinic Building CB # 7570 Chapel Hill, NC 27599-7570
Telephone	(919) 843 7852
Fax	(919) 966-6001
E-mail	thorp@med.unc.edu

Education

Master's	Duke University School of Medicine Master of Health Sciences in Clinical Leadership	2009
Fellowship	University of North Carolina School of Medicine Chapel Hill, North Carolina Fellowship in Maternal-Fetal Medicine Fellowship Director: J.W. Seeds	1987 – 1989
Residency	University of North Carolina School of Medicine Chapel Hill, North Carolina Residency in Obstetrics & Gynecology Program Director: W.C. Fowler	1983 – 1987
Medical School	East Carolina University Medical School, M.D. Greenville, North Carolina	1979 – 1983
College	University of North Carolina at Chapel Hill B.A. Zoology	1975 – 1979

Certification:

Licensure	Medical Council of Malawi	2012
Board Certification	Obstetrics and Gynecology	1991 – annually to present

Sub-Specialty	Maternal-Fetal Medicine	1992 – annually to present

Professional Experience

Vice Chair	Research	February 2013
Division Director	Women's Primary Healthcare	July 2006 – present
Program Director	Women's Reproductive Health Research Scholars Program	July 2006 – present
Research Core Co-Director	Women's Reproductive Health Research Scholars Program	July 2006 – present
Interim Director	Center for Women's Health Research Cecil G. Sheps Center For Health Services Research Department of Epidemiology School of Public Health Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	July 2006 – present
Professor	Department of Maternal and Child Health School of Public Health University of North Carolina, Chapel Hill, NC	July 2005 – present
Adjunct Professor	Department of Epidemiology School of Public Health University of North Carolina, Chapel Hill, NC	July 2004 – present
Director	Biomedical Core Carolina Population Center University of North Carolina, Chapel Hill, NC	July 2004 – present
Deputy Director	Center for Women's Health Research Cecil G. Sheps Center For Health Services Research Department of Epidemiology School of Public Health Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	July 2004 – present
Adjunct Professor	Department of Epidemiology School of Public Health and Tropical Medicine Tulane University	July 2003 – present

Fellow	Carolina Population Center University of North Carolina, Chapel Hill, NC	July 2003 – present
Hugh McAllister Distinguished Professor Ob & Gyn	Department of Obstetrics and Gynecology School of Medicine University of North Carolina, Chapel Hill, NC	July 2001 – present
Professor	Department of Obstetrics and Gynecology School of Medicine University of North Carolina, Chapel Hill, NC	July 2000 – present
Co-Director	North Carolina Program for Women's Health Research, Cecil G. Sheps Center For Health Services Research Department of Epidemiology School of Public Health Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	July 1999 – June 2004
Senior Research Fellow	Cecil G. Sheps Center for Health Services Research University of North Carolina, Chapel Hill, NC	July 1999 – present
Co-Director	Institute Generalist Physician School of Medicine University North Carolina-Chapel Hill	July 1999 – June 2000
Adjunct Associate Professor	Department of Epidemiology School of Public Health University of North Carolina, Chapel Hill, NC	July 1999 – June 2004
Associate Professor	Division of Maternal-Fetal Medicine Department of Obstetrics and Gynecology School of Medicine University of North Carolina, Chapel Hill, NC	July 1995 – June 2000
Associate Chair	Department of Obstetrics and Gynecology School of Medicine University of North Carolina, Chapel Hill, NC	July 1995 – June 1999
Medical Director	HORIZONS Perinatal Substance Abuse Program School of Medicine University North Carolina-Chapel Hill	July 1993 – present
Assistant Professor	Division of Maternal-Fetal Medicine Department of Obstetrics and Gynecology School of Medicine	July1990 – June 1995

	University of North Carolina, Chapel Hill, NC	
Clinical Assistant Professor	Division of Maternal-Fetal Medicine Department of Obstetrics and Gynecology School of Medicine University of North Carolina, Chapel Hill, NC	July 1989 – June 1990

Honors

Substance Abuse and Mental Health Services Administration (SAMHSA) Science and Service Awards	2013
Golden Tarheel Award for Medical Student Education	2012
University of Rochester School of Medicine Teaching Fellow	2010
Golden Tar Heel Medical Student Teaching Award	2005, 2006
Robert C. Cefalo Excellence in Teaching Professors Award	2004 – 2005
Hugh McAllister Distinguished Professorship in Obstetrics and Gynecology	2002
Professor Teaching Award Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	1993, 2000
Perinatal Health Model of Excellence North Carolina Department of Health and Human Services in Conjunction with the March of Dimes	1999
North Carolina Division of Mental Health Developmental Disabilities and Substance Abuse Services Recognition Award for Outstanding Service to Women and Children	1999
APGO/CREOG Departmental Teaching Award Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	1992, 1995
Junior Faculty Teaching Award Department of Obstetrics & Gynecology School of Medicine	1990, 1992, 1995

University North Carolina-Chapel Hill

Family Medicine Teaching Award — 1989
Department of Family Practice
School of Medicine
University North Carolina-Chapel Hill

American Journal of Obstetrics & Gynecology — 2006 – 2007
One of the top 100 reviewers for the academic year

Memberships

Fellow, American Gynecological and Obstetrical Society — 2004 – present

Vice President, Southern OBG Seminar — 2003 – present

Southern Obstetrics & Gynecologic Seminar — 1994 – present

South Atlantic Association of Obstetrics and Gynecology — 1994 – present

Society for Gynecologic Investigation — 1993 – present

Association of Professors of Gynecology and Obstetrics — 1993 – present

Society for Maternal-Fetal Medicine — 1984 – present

American College of Obstetricians and Gynecologists — 1983 – present

Administrative Accomplishments

Four of six clinicians in Women's Primary Care Division were cited for excellence in graduate and postgraduate medical education — 2005

Four of seven clinicians in Women's Primary Care Division were cited for excellence in resident Medical education

Bibliography

Book Chapters

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2. **Thorp JM** Listeriosis: a treatable cause of intrapartum fever. In *Clinical Decisions in Obstetrics and Gynecology*. Cefalo RC (ed). Rockville, MD: Aspen Publishers, 48-9, 1990.

3. **Thorp JM** , Herbert WNP. Pancreatitis in pregnancy. In *Clinical Decisions in Obstetrics and Gynecology*. Cefalo RC (ed). Rockville, MD: Aspen Publishers, 60-2, 1990.

4. **Thorp JM** Maternal-fetal physiologic interactions in the critically ill pregnant patient. *Critical Care Obstetrics* 2/E:102-11, May 1990.

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6. **Thorp JM** Pasteur, Charles. In *Dictionary of North Carolina biography.* Powell WS (ed). U of North Carolina P. Vol 5: p28, 1994.

7. **Thorp JM** Pasteur, Thomas. In *Dictionary of North Carolina Biography.* Powell WS (ed). U of North Carolina P. Vol 5: p28, 1994.

8. **Thorp JM** Pasteur, William. In *Dictionary of North Carolina Biography.* Powell WS (ed). U of North Carolina P. Vol 5: p28, 1994.

9. **Thorp, JM** Management of Drug Dependency, Overdose, and Withdrawal in the Obstetrical Patient. *Obstetrics and Gynecology Clinics of North America,* Accepted 7/94*,* 14 pages.

10. **Thorp JM**, Episiotomy, Clinical Management of Labor, *Churchill Livingstone*, Accepted, 11/94, 20 pages.

11. **Thorp JM** Episiotomy. in Intrapartum Obstetrics, John T. Repke, MD (ed). Churchill Livingstone: New York, 1995.

12. **Thorp, JM**, Prenatal Diagnosis and Therapy. in New Issues in Medical Ethics, Jay Hollman, MD (ed). Christian Medical and Dental Society, Bristol, TN, 1995.

13. Feilder M, **Thorp JM** Radiologic Examinations During Pregnancy. In Drug Therapy in Pregnancy, Third Edition. Jerome Yankowitz & Jennifer R. Niebyl (eds.). Lippincott Williams & Wilkins: Philadelphia PA, 2001.

14. Gwyther RE, **Thorp JM**. Substance Abuse. Netter's Internal Medicine. Marschall Runge & M. Andrew Greganti (eds.). Icon Learning Systems: Teterboro, NJ, 2003.

15. Wilson JK, **Thorp JM**. Substance Abuse in Pregnancy. Clinical Obstetrics, Volume 2, Chapter 33.

16. **Thorp JM**. Clinical Aspects of Normal and Abnormal Labor. Maternal-Fetal Medicine; Principles and Practice, sixth edition, Chapter 36. Robert Creasy and Robert Resnik (eds.): The Curtis Center, Philadelphia, PA, 2007.

17. Garbutt JE, Gwyther RE, **Thorp JM**. Alcohol and Substance Dependence and Abuse. Netter's Internal Medicine 2nd Edition. Marschall S. Runge & M. Andrew Greganti (eds.). Saunders Elsevier, Philadelphia PA, 2009.

18. **Thorp JM Jr**. Chapter 36: Clinical Aspects of Normal and Abnormal Labor. In: Creasy & Resnick's Maternal-Fetal Medicine: Principles and Practice. Sixth Edition. (Robert K. Creasy, Robert Resnik, Jan D. Iams, Charles J. Lockwood, Thomas R. Moore Eds.) Saunders Elsevier, Philadelphia PA, 2009, pp.691-725.

19. O'Neill E, **Thorp J**. Antepartum evaluation of the fetus and fetal well being. In: Clinical Obstetrics and Gynecology. (Roger P. Smith, Vern L. Katz Eds) Lippincott Williams & Wilkins, Philadelphia PA, 2012, pp. 722-30.

20. **Thorp JM Jr**. Chapter 36: Clinical Aspects of Normal and Abnormal Labor. In: Creasy & Resnick's Maternal-Fetal Medicine: Principles and Practice. Seventh Edition. (Robert K. Creasy, Robert Resnik, Jan D. Iams, Charles J. Lockwood, Thomas R. Moore Eds.) Saunders Elsevier, Philadelphia PA, 2012, pp.??.

21. **Thorp, JM Jr.** Prolog Task Force for *Obstetrics*, Seventh Edition 2013; The American College of Obstetricians and Gynecologists

Journal Refereeing

Reviewer *The Netherlands Organisation for Health Research and Development (ZonMw)*
Reviewer *African Journal of Reproductive Health*
Reviewer *Journal of Developmental Origins of Health and Disease*
Reviewer *The Journal of Obstetrics and Gynaecology Research*
Reviewer *Obstetrics and Gynecology International*
Reviewer *Human Reproduction*
Reviewer *British Journal of Obstetrics and Gynaecology*
Reviewer *American Family Physician*
Reviewer *Mayo Clinic Proceedings*
Reviewer *Journal of the American Women's Association*
Reviewer *International Journal of Psychophysiology*
Reviewer *Journal of the American Medical Association*
Reviewer *New England Journal of Medicine*
Reviewer *Clinical Anesthesia*
Reviewer *Preventive Medicine*
Reviewer *Journal of Maternal-Fetal Medicine*
Reviewer *Primary Care Field Reviewer's Guide to Substance Abuse Service for Primary Care Clinicians*
Reviewer *Paediatric and Perinatal Epidemiology*
Reviewer *American Journal of Perinatology*
Reviewer *Obstetrics and Gynecology*
Reviewer *American Journal of Obstetrics and Gynecology*
Reviewer *Journal of Pediatrics*
Reviewer *Journal of Perinatal Medicine*
Reviewer *Journal of Perinatology*
Reviewer *Reproductive Toxicology*

Reviewer *Southern Medical Journal*
Reviewer *International Urogynecology Journal*
Reviewer *Medscape Women's Health*
Reviewer *Evidence-Based Preventive Medicine*
Reviewer *JAMA- Archives of General Psychiatry*
Reviewer *OB/GYN Management*
Reviewer *American Family Physician*
Reviewer *Nature Clinical Practice Endocrinology & Metabolism*
Reviewer *The Lancet*
Reviewer *Journal of Psychiatric Research*
Reviewer *Early Human Development*
Reviewer *Canadian Medical Association Journal*
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Deputy Editor-in Chief	2012 – present
British Journal of Obstetrics and Gynaecology	

Abstracts and presentations:

1. Siega-Riz AM, Savitz DA, **Thorp J**, Bodnar LM. Supplementation use preconceptionally and during pregnancy: does it decrease the risk of preterm births? Poster presentation at the Annual Meeting of the American Public Health Association, Washington, DC, 1998.
2. Siega-Riz AM, Savitz DA, **Thorp JM Jr**, Herrmann T. Meal patterning during pregnancy and its association with preterm births. Oral presentation at the Annual Meeting of the American Public Health Association, Washington, DC, 1998.

3. West S, Yawn B, **Thorp JM**, Korhonen M, Savitz D, Guess H. The efficacy of tocolytic therapy for preterm labor. Presented at the Society for Gynecologic Investigation Annual meeting, Atlanta GA, March, 1999.

4. Saacks C, Wells E, **Thorp JM**. The effects of parturition on immediate puerperal bladder function. To be presented at the Society for Gynecologic Investigation Annual Meeting, Atlanta GA, March, 1999.

5. Pastore LM, Hulka B, **Thorp JM**, Wells E, Kuller J. Postmenopausal vaginal symptoms in relation to douching and smoking. Presented at the Society for Epidemiologic Research Annual Meeting, Baltimore MD, June, 1999.

6. Sayle AE, Savitz DA, **Thorp JM**, Hertz-Picciotto I, Wilcox AJ. Sexual activity during late pregnancy and preterm delivery. Oral presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Baltimore MD, June, 1999.

7. Savitz D, Dole N, Henderson L, **Thorp JM**. Socioeconomic status, race, and pregnancy outcome. Presented at the Society for Epidemiologic Research Annual Meeting, Baltimore MD, June, 1999. Am J Epidemiol 1999;149:S28 (Abstract #111).

8. Forna F, Hartmann KE, Savitz D, **Thorp J**, Buekens P. Early pregnancy bleeding and risk to preterm birth. Poster presentation at the Student National Medical Associatio9n Annual Conference (Second place Clinical Research Award), April, 1999.

9. Herrmann TS, Seiga-Riz AM, Savitz DA, **Thorp JM**. Association between prolonged periods of time without food during pregnancy and preterm birth. Poster presentation at the Society for Pediatric and Perinatal Epidemiologic Research 12th Annual Meeting, Baltimore MD, June 1999.

10. Pastore LM, Hartmann KE, **Thorp JM**, Royce RA, Savitz DA, Jackson TP. Bacterial vaginosis and cervical dilation and effacement at 24-29 weeks' gestation. Poster presentation at The Society for Pediatric and Perinatal Epidemiologic Research 12th Annual Meeting, Baltimore MD, June 1999.

11. Dole N, Savitz D, Hertz-Picciotto I, **Thorp JM**. Stress, social support and pregnancy outcome. Oral presentation at the Society for Pediatric and Perinatal Epidemiologic Research 12th Annual Meeting, Baltimore MD, June, 1999.

12. Pastore LM, **Thorp JM**, Royce RA, Savitz DA, Jackson TP. BV PIN Points: Clinical risk scoring system for antenatal bacterial vaginosis. Annual Meeting of the Society for Maternal-Fetal Medicine, San Francisco, CA, January 1999, and oral presentation at The Society of Perinatal Epidemiologic Research, Baltimore MD, June, 1999.

13. Savitz DA, Runkle ND, **Thorp JM**. Smoking and preterm birth: Evaluation of timing, dose, and etiologic pathway. Poster presentation at the International Scientific Meeting of the International Epidemiological Association, Florence, Italy, August, 1999.

14. **Thorp JM**, Berkman ND, Gavin NI, Hasselblad V, Lohr KN, Hartmann KE. Antibiotics for treatment of preterm labor—review and meta-analysis. Presented at ACOG Annual Meeting, October, 1999.

15. **Thorp JM**, Berkman ND, Gavin NI, Hasselblad V, Lohr KN, Hartmann KE. Maintenance tocolysis for treatment of preterm labor—review of the evidence and meta-analysis. Presented at ACOG Annual Meeting, October, 1999.

16. **Thorp JM**, Hartmann KE, Berkman ND, Lohr KN. Fetal fibronectin and endovaginal ultrasound in the management of preterm labor—a review of the evidence. Presented at ACOG Annual Meeting, October, 1999.

17. McPheeters M, **Thorp JM**, Gavin NI, Hasselblad V, Berkman ND, Lohr KN, Hartmann KE. Hone uterine activity monitoring in the care of preterm labor – a review of the evidence. Presented at ACOG Annual Meeting, October, 1999.

18. **Thorp JM**, Berkman ND, Gavin NI, Lohr KN, Hartmann KE. Acute tocolysis for treatment of preterm labor – review of the evidence and meta-analysis. Submitted to ACOG, October, 1999.

19. McMahon MJ, **Thorp JM**, Savitz DA, Bagchee R. Risk factors for preterm birth. Presented at the Society for Maternal-Fetal Medicine, January, 2000.

20. Strauss RA, Royce RA, Sanasuttipun W, Eucker B, **Thorp JM**. Diagnosis of bacterial vaginosis from self-obtained vaginal swabs. Poster presentation. Poster presentation at the Annual meeting of the Society for Gynecologic Investigation. Chicago IL, March 25, 2000. *J Soc Gynecol Invest* 2000; 7(1) suppl (abstract #840).

21. Pastore LM, Wells E, **Thorp JM**, Kuller J, Hulka BS. Bacterial vaginosis in postmenopausal women: prevalence, symptoms and diagnostic implications. Presented at 21st Annual Meeting of the Southern Gerontological Society, Raleigh NC, April, 2000.

22. Savitz D, Wilkins D, Rollins D, **Thorp JM**, Henderson L, Dole N. Hair as an indicator of cocaine use during pregnancy and risk of preterm birth. Poster presentation at the Annual Meeting of the Society for Epidemiologic Research, June 2000, Seattle WA. Am J Epidemiol 2000;151:S7 (abstract #25).

23. Gavin NI, **Thorp JM**. Medical care costs associated with postmenopausal hormone replacement therapy. Accepted for poster presentation at the World Congress on Osteoporosis 2000. Chicago, IL, June 15-18, 2000.

24. Pastore LM, Wells E, **Thorp JM**, Kuller J, Hulka BS. Bacterial vaginosis in postmenopausal women: prevalence, symptoms and diagnostic implications. Poster presentation at the Southern Gerontological Society, April, 2000.

25. Pastore LM, **Thorp JM**, Dawson IJ. Public health clinic use of antenatal bacterial vaginosis risk score. Accepted for poster presentation to International Federation of Gynecology and Obstetrics XVI World Congress Conference, Washington DC, September, 2000.

26. Saldana TM, Seiga-Riz AM, Adair LS, Savitz DA, **Thorp JM**. Women with impaired glucose status during pregnancy have heavier babies. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Toronto, CAN, June 2001.

27. Saldana TM, Siega-Riz AM, Adair LS, Savitz DA, **Thorp JM**. The association between impaired glucose tolerance and birth weight among black and white women in central North Carolina. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiological Research, Toronto, CAN, June, 2001.

28. Siega-Riz AM, Savitz DA, **Thorp JM Jr**, Zeisel S. Is there an association between maternal folate status in the second trimester and preterm birth? Oral presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research. Toronto, CA, June 2001

29. Connolly AM, **Thorp JM**, Pahel-Short L, Copeland K. Effects of pregnancy and childbirth on postpartum sexual function. Poster presentation. American Urogynecology Society Annual Meeting, October, 2001, Chicago, IL.

30. Connolly AM, **Thorp JM**, McMahon M, Pahel-Short L, Wells E. Pregnancy, Childbirth, and Postpartum Bladder Function. Poster presentation at the American Urogynecologic Society Annual Meeting, Hilton Head Island, SC. Oct 26-28, 2000.

31. Whitecar PW, Boggess KA, McMahon MJ, **Thorp JM**, Taylor DD. Comparison of asymmetric, non-precipitating antibodies in preeclampsia to normotensive pregnant controls. Poster presentation at the Twenty-first Annual Meeting of the Society for Maternal-Fetal Medicine, February, 2001, Reno NV.

32. Savitz DA, Terry J, Dole N, **Thorp JM,** Siega-Riz AM, Herring A. Comparison of pregnancy dating by last menstrual period, ultrasound, or their combination. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, June, 2001, Toronto ONT CAN

33. Seiga-Riz AM, Savitz DA, **Thorp JM,** Zeisel S. Is there an association between maternal folate status in the second trimester and preterm birth: Oral presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Toronto, CAN, June, 2001.

34. **Thorp JM**, Gavin NI, Ohsfeldt RL. Hormone replacement therapy in postmenopausal women: Utilization of Health Care Resources by New Users. Presented at the South Atlantic Association of Obstetricians & Gynecologists Annual Meeting, Hot Springs VA, January, 2001.

35. Yang J, Savitz DA, **Thorp JM**, Hartmann KE, Dole N. Predictors of vaginal bleeding in the first two trimesters of pregnancy. Poster presentation at the Annual Meeting of the Society for Epidemiologic Research, Toronto CAN, June, 2001.

36. Berkman ND, **Thorp JM**, Lohr KN, Carey TS, Hartmann KE, Gavin NI, Hasselblad V, Idicula AE. Tocolytic Treatment for the Management of Preterm Labor: A Review of the Evidence. To be presented at the South Atlantic Association of Obstetricians and Gynecologists 64th Annual Meeting, January, 2002.

37. Siega-Riz AM, Hartzema AG, Turnbull C, **Thorp JM**, McDonald T, Cogswell M. A trial of selective versus routine iron supplementation to prevent third trimester anemia during pregnancy. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

38. Balu R, **Thorp JM**, Savitz D, Heine P. Association between cervical length and markers of immune status of the cervico-genital tract during pregnancy. Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

39. Balu R, Savitz D, Ananth C, **Thorp JM**, Heine P, Eucker B. Bacterial vaginosis and vaginal fluid defensins during pregnancy. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

40. Balu R, Savitz D, Ananth C, **Thorp JM**, Heine P, Eucker B. Bacterial vaginosis, vaginal fluid defensins and preterm birth in a cohort of North Carolina women. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

41. Balu R, **Thorp JM**, Savitz D, McMahon M, Hartmann K, Eucker B. Cervical length and the etiologic heterogeneity of preterm birth. Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

42. Savitz D, Terry JW, Dole N, **Thorp JM**, Siega-Riz AM, Herring AH. Comparison of pregnancy dating by last menstrual period, ultrasound, or their combination. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

43. Malizia B, **Thorp JM**, Siega-Riz AM, Savitz D, Hartmann K, Eucker B. Identification of perinatal substance use in clinical care. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

44. Siega-Riz AM, Savitz D, **Thorp JM**, Zeisel S, Hartmann K, Eucker B. Is there an association between maternal folate status in the second trimester and preterm birth? Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

45. Dole N, Savitz D, Siega-Riz AM, McMahon M, **Thorp JM**, Eucker B. Psychosocial factors and preterm birth among African-American and white women in central North Carolina. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

46. Siega-Riz AM, Promislow J, Savitz D, **Thorp JM**, Hartmann K, Eucker B. Vitamin C intake and the risk of preterm birth. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA. January 17, 2002.

47. Evenson KR, Siega-Riz AM, Savitz DA, Leiferman JA, and **Thorp JM**. Vigorous leisure activity and pregnancy outcome: The Pregnancy, Infection, and Nutrition Study. Poster at the American College of Sports Medicine meeting in St. Louis, MO, May 31, 2002. Abstract in Med Sci Sport Exercise. 2002;34(5) Supplement.

48. Pompeii LA, Savitz DA, Evenson KR, Loomis D, Rogers B, **Thorp JM**. Cessation of employment and the risk of preterm delivery and small-for-gestational age birth. Third International Congress of Women, Work, and Health. Stockholm Sweden, June, 2002.

49. Savitz DA, Dole N, Herring AH, Kaczor DA, Murphy J, Siega-Riz AM, **Thorp JM Jr**. Risk factor profile of spontaneous and medically indicated preterm births. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Palm Desert CA, June, 2002.

50. Vahratian A, Siega-Riz AM, Savitz DA, **Thorp JM Jr**. Multivitamin use and the risk of preterm birth. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Palm Desert CA, June, 2002.

51. Murphy J, Dole N, Savitz DA, Herring A, Kaczor D, Siega-Riz AM, **Thorp JM**. Perinatal factors associated with both intermediate and positive bacterial vaginosis in pregnancy. Poster presentation at the 23rd Annual Meeting of the Society of Maternal-Fetal Medicine, San Francisco CA, February, 2003.

52. Murphy J, Dole N, Savitz DA, Herring A, Kaczor D, Benson A, Siega-Riz AM, **Thorp JM**. Decision to delivery in preterm preeclampsia: Maternal or fetal indications. Poster presentation at the 23rd Annual Meeting of the Society of Maternal-Fetal Medicine, San Francisco CA, February, 2003.

53. Savitz DA, Kaufman JS, Dole N, Siega-Riz AM, **Thorp JM Jr**, Kaczor DT. Poverty, education, race, and pregnancy outcome. Poster presentation at the Annual Population Association of America Meeting, Minneapolis MN, May, 2003.

54. Vahratian A, Zhang J, Hasling J, Troendle J, Klebanoff M, **Thorp JM**. Early Analgesia and Labor. Poster Presentation: Society for Pediatric and Perinatal Epidemiologic Research, Atlanta, Ga, June 10-11, 2003.

55. Yang J, Savitz DA, Dole N, Hartmann KE, Herring AH, Olshan AF, Thorp JM Jr. Predictors of vaginal bleeding during pregnancy/ poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiological Research, Atlanta GA, June, 2003.

56. Salafia C, **Thorp JM**, Maas E, Eucker B, Smith F, Savitz D. Umbilical cord insertion and timing of delivery: 3 measures of relative umbilical cord insertion account for 29% of gestational age variance. Presentation: Society for Maternal-Fetal Medicine 2004 Annual Meeting, New Orleans, LA, February 4, 2004.

57. Salafia C, **Thorp JM**, Maas E, Eucker B, Smith F, Savitz D. Measures of Relative Umbilical Cord Insertion Account for 26% of Birthweight Variance. Presentation: Society for Maternal-Fetal Medicine 2004 Annual Meeting, New Orleans LA, February 4, 2004.

58. Salafia C, Maas E, **Thorp JM**, Eucker B, Smith F, Savitz D. Chorionic Plate Measures Account for 39% of Birthweight Variance. Presentation: Society for Maternal-Fetal Medicine 2004 Annual Meeting, New Orleans LA, February 4, 2004.

59. Salafia C, Mass E, **Thorp JM**, Eucker B, Smith F, Savitz D. Measures of Chorionic Plate area Account for 45% of Gestational Age Variance. Presentation: Society for Maternal-Fetal Medicine 2004 Annual Meeting, New Orleans, LA, February 4, 2004.

60. Vahratian A, Zhang J, Hasling J, Troendle J, Klebanoff M, **Thorp JM**. Effects of Early Epidural Analgesia vs IV Analgesia on Labor Progression: A Natural Experiment. Presentation: Society for Maternal-Fetal Medicine 2004 Annual Meeting, New Orleans, LA, February 4, 2004.

61. Vahratian A, Zhang J, Troendle J, Siega-Riz AM, Savitz D, **Thorp JM**. Maternal obesity and labor progression in nulliparous Women. Poster presentation at the Annual Meeting of the Society for Maternal-Fetal Medicine. New Orleans, LA, February 4, 2004. Am J Obstet Gynecol 2003;189(6 Suppl1):S202.

62. Savitz DA, Dole N, Siega-Riz AM, Kaczor DA, Kaufman J, Herring AH, **Thorp JM**. Probability samples or clinic populations to study pregnancy and children's health? Contrasting approaches of demography and epidemiology. Oral presentation at the Annual population Association of America Meeting, Boston, MA, April, 2004.

63. Fogleman K, Herring A, Jo H, Pusek S, **Thorp JM**. Factors that influence the timing of spontaneous labor at term. Annual Clinical Meeting, Philadelphia PA, May, 2004.

64. Dole N, Herring AH, Savitz DA, **Thorp JM**. Corticotropin-releasing hormone (CRH) perceived stress, and preterm birth. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiological Research, Salt Lake City UT, June, 2004.

65. Herring Ah, Liao X, Savitz DA, Dole N, Evenson K, Thorp JM. Time-varying coefficient models for preterm birth. Oral presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiological Research, Salt Lake City UT, June, 2004.

66. Harville E, Savitz Da, Dole N, **Thorp JM**, Predictors of placenta resistance. Oral presentation at the Annual Meeting of the Society for Epidemiologic Research. Salt Lake City UT, June, 2004.

67. Harville E, Dole N, **Thorp JM**, Savitz DA. Diurnal patterns of cortisol. Poster presentation at the Annual Meeting of the Society for Epidemiologic Research, Toronto CAN, June 2005.

68. Siega-Riz AM, Savitz DA, Kaczor D, Herring A, **Thorp J**. Serum transferring receptor and preterm birth. Oral presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiological Research, Toronto, CAN, June, 2005.

69. Harville E, Dole N. **Thorp JM**, Savitz DA. Stress and uterine dopplers. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiology, Toronto CAN, June, 2005.

70. Harville E, Dole N, Savitz DA, Herring AH, **Thorp J**. Stress questionnaires and stress biomarkers during pregnancy: Do they measure the same thing? Poster presentation at the 19th Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Seattle WA, June, 2006.

71. Salafia CM, Pezzullo JC, **Thorp JM**, Eucker B. Pijnenborg R, Savitz DA. Basal plate uteroplacental vasculature in a birth cohort: measurement methods and analyses. Poster presented at 19th Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Seattle WA, June, 2006.

72. Siega-Riz AM, Howard DL, Savitz DA, **Thorp J**. The association between dyslipidemia and preterm delivery. Oral presentation at the 19th Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Seattle, WA, June, 2006.

73. Rouse, Dwight and the MFMU Network: A randomized controlled trial of magnesium sulfate for the prevention of cerebral palsy. Abstract #1. Plenary Session 1 at the 28th Annual Meeting of the Society for Maternal Fetal Medicine, Dallas TX, January 28, 2008.

74. Chireau M, Crosslin D, Hauser E, Olshan A, Zheng S, Salafia C, Thorp J. Endothelial function gene polymorphisms are associated with pregnancy outcomes, indepent of placental vascular disease. (Abstract #668). Poster presentation at the 29th Annual Meeting of the Society for Maternal Fetal Medicine, Dallas TX, January 29, 2008.

75. Rouse, D for the NICHD MFMU Network. A Randomized controlled trial of magnesium sulfate for the prevention of cerebral palsy. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

76. Tita, A for the NICHD MFMU Network. The MFMU Cesarean Registry: Impact of gestational age at elective repeat cesarean on neonatal outcomes. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

77. Harper, M for the NICHD MFMU Network. A Randomized controlled trial of Omega-3 fatty acid supplementation for recurrent preterm birth prevention. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

78. Mertz, H for the NICHD MFMU Network. Placental eNOS in multiple and single dose bethamethasone exposed pregnancies. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

79. Bakhshi, T for the NICHD MFMU Network. Maternal and neonatal outcomes of repeat cesarean delivery in women with a prior classical versus low transverse uterine incision. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

80. Rouse, D for the NICHD MFMU Network. When should labor induction be discontinued in the latent phase? Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

81. Varner, M for the NICHD MFMU Network. Can fetal oxygen saturation identify chorioamnionitis? Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

82. Contag, S for the NICHD MFMU Network. Operative vaginal delivery versus cesarean delivery in the second stage of labor. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

83. Rogers, B for the NICHD MFMU Network. Placental pathology associated with the factor V leiden mutation. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

84. Aagard-Tillery, K for the NICHD MFMU Network. Hazardous air pollutants and risk of adverse pregnancy outcomes. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

85. Joy, S for the NICHD MFMU Network. Latency and infectious complications following preterm premature rupture of the membranes: Impact of body mass index. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

86. Sciscione, A for the NICHD MFMU Network. Perinatal outcomes in women with twin gestations who conceived spontaneously versus by assisted reproductive techniques. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

87. Caritis, S for the NICHD MFMU Network. Relationship of 17? Hydroxyprogesterone Caproate (17-OHPC) Concentrations and Gestational Age at Delivery in Twins. Presented at the 55th Annual Scientific Meeting for Society of Gynecologic Investigation, San Diego, CA, March 2008.

88. Caritis, S for the NICHD MFMU Network. Impact of Body Mass Index (BMI) on Plasma Concentrations of 17 ? Hydroxyprogesterone Caproate (17-OHPC). Presented at the 55th Annual Scientific Meeting for Society of Gynecologic Investigation, San Diego, CA, March 2008.

89. Simhan, H for the NICHD MFMU Network. The Effect of 17-alpha Hydroxyprogesterone Caproate (17-OHPC) on Maternal Plasma CRP Levels in Twin Pregnancies. Presented at the 55th Annual Scientific Meeting for Society of Gynecologic Investigation, San Diego, CA, March 2008.

90. Cormier, C for the NICHD MFMU Network. Relationship between Severity of Maternal Diabetes and VBAC Success in Women Undergoing Trial of Labor. Presented at the 55th Annual Scientific Meeting for Society of Gynecologic Investigation, San Diego, CA, March 2008.

91. Rouse D, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Magnesium sulfate (MgSO4) dose and timing, and umbilical cord Mg++ concentration: Relationship to cerebral palsy (CP) Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

92. Mercer B, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Fetal thyroid function and neuro-developmental outcomes. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

93. Roberts JM, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. A randomized controlled trial of antioxidant vitamins to prevent serious preeclampsia-associated morbidity. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

94. Rouse D, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Second stage labor duration: Relationship to maternal and perinatal outcomes. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

95. Silver R, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Prothrombin gene G20210a mutation and

obstetric complications: A propsective cohort. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

96. Manuck T, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Do antiphospholipid antibodies affect pregnancy outcomes in women heterozygous for factor v leiden? Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

97. Landon MB, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. A prospective multicenter randomized treatment trial of mild gestational diabetes (GDM). Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

98. Harper M, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Effect of omega-3 supplementation on plasma fatty acid levels. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

99. Harper M, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, Maryland. Cytokine gene single nucleotide polymorphisms (SNPS) and length of gestation. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

100. Hickman A, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. The MFMU cesarean registry: Risk of rupture in women attempting VBAC with an unknown uterine scar. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

101. Hashima J, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. The effect of maternal obesity on neonatal outcome in women receiving a single course of antenatal corticosteroids. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

102. Manuck T, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. The relationship between polymorphisms in the human progesterone receptor and clinical response to 17 alpha-hydroxyprogesterone caproate for the prevention of recurrent spontaneous preterm birth. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

103. Gyamfi C, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Neonatal and developmental outcomes in children born in the late preterm period versus term. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

104. Simhan HN, Caritis SN, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. 17 alpha hydroxy-

progesterone caproate (17OHPC) and corticotropin releasing hormone (CRH) among women with twins. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

105. Durnwald C, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. The impact of cervical length on risk of preterm birth in twin gestations. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

106. Horton A, Gyamfi C, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. 17 alpha hydroxy-progesterone caproate does not increase the risk of gestational diabetes in singleton and twin pregnancies. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

107. Refuerzo J, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, Maryland. Comparison of neonatal morbidity and mortality in twin pregnancies born at moderately preterm, late preterm, and term gestation. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

108. Clark E, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Inflammation pathway gene polymorphisms are associated with neurodevelopmental delay at age 2. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

109. Gyamfi C, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Maternal and cord blood betamethasone concentrations in singleton and twin gestations. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

110. Clark E, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, Maryland. Association of repeated dose antenatal steroids and IL6 -174 genotype with neurodevelopemental outcomes at age 2. Presented at the 56th Annual Scientific Meeting for Society of Gynecologic Investigation, Glasgow, UK, March 2009.

111. Gyamfi C, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, Maryland. The rate of recurrent preterm birth analyzed by indication for prior spontaneous preterm birth. Presented at the 56th Annual Scientific Meeting for Society of Gynecologic Investigation, Glasgow, UK, March 2009.

112. Manuck T, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, Maryland. The relationship between polymorphisms in a truncated progesterone receptor (PR-M) and clinical response to 17 alpha-hydroxyprogesterone caproate for the treatment of recurrent spontaneous preterm birth. Presented at the 56th Annual Scientific Meeting for Society of Gynecologic Investigation, Glasgow, UK, March 2009.

113. Horton A, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, Maryland. The role of family history in identifying factor v leiden carriers during pregnancy. Presented at the 56th Annual Scientific Meeting for Society of Gynecologic Investigation, Glasgow, UK, March 2009.

114. Gyamfi C, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, Maryland. The MFMU cesarean registry: the effect of antenatal corticosteroids on respiratory morbidity in singletons after late preterm birth. Presented at the 56th Annual Scientific Meeting for Society of Gynecologic Investigation, Glasgow, UK, March 2009.

115. Harden C, Montouris G, Lippik I, Alekar S. for the UCB Pregnancy Registry. Poster presentation at the 62nd American Academy of Neurology Annual Meeting, Toronto Ont., April 10-17, 2010.

116. Berner M, Nappi R, Thorp JM, Jolly E, Sand M**.** Efficacy of Flibanserin in Premenopausal Women with Hypoactive Sexual Desire Disorder: Remitter Analyses. Poster presentation at European Society for Sexual Medicine.

117. Hauth JC, et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Maternal insulin resistance and preeclampsia. Oral presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 10, 2011.

118. Figueroa D, et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Relationship between the 1-hur glucose loading test results and perinatal outcomes. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 10, 2011.

119. Clark EAS, et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Maternal insulin resistance and preeclampsia. Oral presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

120. Constantine MM, Clark EAS et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Oxidative stress, neuroprotection candidate gene polymorphisms and adverse neurodevelopmental outcomes. Oral presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

121. Peaceman Al, et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Duration of latency after PPROM by gestational age at time of membrane rupture. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

122. Harper M. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Tumor necrosis factor α -308 genetic polymorphism and cytokine production. Poster

presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

123. Harper M. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Omega-3 fatty acids and cytokine production. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

124. Harper M. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Inflammatory cytokines and recurrent preterm birth. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

125. Makhlouf M. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Adverse pregnancy outcomes among women with prior spontaneous or induced abortions. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

126. Stuebe A. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Maternal BMI, glucose tolerance, and adverse pregnancy outcomes. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

127. Stuebe A. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Is there a threshold OGTT value for predicting adverse neonatal outcome? Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

128. Johnson J. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Outcomes associated with failure to achieve the 2009 Institute of Medicine (IOM) guidelines for weight gain in pregnancy. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

129. Varner M. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Influenza-like illness in hospitalized pregnancy and immediately postpartum women during the 2009-2010 H1N1 influenza pandemic. Oral presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 12, 2011.

130. Graves SW, Esplin MS et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Validation of predictive preterm birth biomarkers obtained by maternal serum proteomics. Oral presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 10, 2011.

131. Carreno C. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Excessive early gestational weight gain and risks of gestational diabetes and large for gestational

age infants in nulliparous women. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 10, 2011.

132. Hauth JC. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Insulin resistance in pregnancy and maternal body mass. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 10, 2011.

133. Griffin JB, Lomboka V, Landis SH, Herring Am, Thorp JM Jr, Tshefu AK, Meshnick SR. Malaria in early pregnancy and in utero fetal growth. Presented at the Tropical Medicine conference, December, 2011.

134. Grobman W. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Can differences in obstetric outcomes be explained by differences in the care provided? Oral presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 9, 2012.

135. Bailit J. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Use of maternal and neonatal outcomes to measure quality of care: Is hospital performance consistent across outcomes? Oral presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 9, 2012.

136. Gilbert S. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. The MFMU Cesarean Registry: Propensity Score Analysis for Bias Reduction in Comparing Elective Repeat Cesarean Delivery with Trial of Labor after a Previous Cesarean. Oral presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 9, 2012.

137. Chiossi G. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Timing of delivery and adverse outcomes in term singleton repeat cesarean deliveries. Oral presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 10, 2012.

138. Grobman W. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Randomized controlled trial of progesterone treatment for preterm birth prevention in nulliparous women with cervical length less than 30 mm. Oral presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 10, 2012.

139. Silver B. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. First trimester free total and fetal DNA in the maternal circulation are not associated with preeclampsia. Oral presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 10, 2012.

140. Sutton A. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. The Impact of Delivery Timing on Cesarean Delivery Risk in Women with Mild Gestational Diabetes. Poster presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 9, 2012.

141. Grobman W. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Is an individualized growth standard better than a population-based standard at predicting cerebral palsy or death among SGA infants? Poster presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 10, 2012.

142. Tita A. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Burden of Adverse Maternal and Perinatal Outcomes by Preterm Birth Type in Nulliparas. Poster presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 10, 2012.

143. Peaceman A. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Prediction of cerebral palsy (CP) or death among preterm infants who survive the neonatal period. Poster presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 10, 2012.

144. Horton A. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. The effect of magnesium sulfate administration for neuroprotection on latency in women with preterm premature rupture of membranes. Poster presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 10, 2012.

145. Pereira L., Wilmarth P. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Prediction of preterm birth in twin gestations through analysis of maternal plasma at 24-30 weeks gestation. Poster presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 10, 2012.

146. Olson G. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. The relationship of birth weight to body mass index and blood pressure at ages 3-5 years. Poster presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 10, 2012.

147. Olson G. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Fetal growth restriction is associated with decreased developmental screening scores in childhood. Poster presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 10, 2012.

148. Gilbert S. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. The MFMU Cesarean Registry: Cost-Effectiveness of a Trial of Labor Compared with an Elective Repeat Cesarean Delivery After a Previous Cesarean in a Minimally Biased Cohort . Poster presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 10, 2012.

149. Grobman W. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. The development of risk-adjusted outcomes to be used as quality indicators for obstetric care. Poster presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 10, 2012.

150. Grobman W. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Does risk adjustment for patient characteristics affect assessment of hospital quality performance? Poster presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 10, 2012.

151. Bousleiman S. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Maternal risk factors and small for gestational age neonates. Poster presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 10, 2012.

152. Bousleiman S. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Translating research into practice in obstetrics. Poster presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 10, 2012.

153. Berggren E. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. The NICHD-MFMU GDM study: Differences in perinatal outcomes between Hispanic women and Non-Hispanic White women with and without gestational diabetes. Poster presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 10, 2012.

154. Tita A. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Maternal and Perinatal Morbidity Risks Differ by Type of Pregnancy-Associated Hypertension in Nulliparas. Poster presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 11, 2012.

155. Tita A. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Pregnancy Associated Hypertension: Cumulative risk varies by subtype, race and body mass index. Poster presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation 2012, Dallas, TX, February 11, 2012.

156. Chen H. et al. (Thorp JM) for the Xolair Pregnancy Registry (EXPECT). An observational study of the safety of amalizumab during pregnancy in women with asthma. Poster presentation at the American Thoracic Society International Annual Meeting, San Francisco, CA, May 22, 2012.

157. Connolly AM, Hong J, et al (Thorp JM) A Competency-Based Approach to Continuous Quality Improvement in the Resident Continuity Clinic CREOG/APGO Annual Meeting 2013.

158. Clark, et al. (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Genetic predisposition to adverse neurodevelopmental outcomes after pre-term birth. Poster presentation at the Society for Maternal-Fetal Medicine and Society for Gynecologic Investigation. Oral accepted 2013. Presented at the 34th Annual Meeting of the Society for Maternal-Fetal Medicine. February 3, 2014 - February 8, 2014, New Orleans, LA.

159. Saade G. et al. (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Cervical debris and adverse pregnancy outcomes in nulliparous with short cervix. Oral accepted 2013. Presented at the 34th Annual Meeting of the Society for Maternal-Fetal Medicine. February 3, 2014 - February 8, 2014, New Orleans, LA.

160. Bailit J. et al. (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Delivery for non-medical indications at <39 weeks vs expectant management. Poster accepted 2013. Presented at the 34th Annual Meeting of the Society for Maternal-Fetal Medicine. February 3, 2014 - February 8, 2014, New Orleans, LA.

161. Saade G. Blackwell S., et al. (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Computerized interpretations of intra FHR neonatal outcomes. Poster accepted 2013. Presented at the 34th Annual Meeting of the Society for Maternal-Fetal Medicine. February 3, 2014 - February 8, 2014, New Orleans, LA.

162. Constantine MM. et al. (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. The effect of cesarean delivery on the weight of the offspring. Poster accepted 2013. Presented at the 34th Annual Meeting of the Society for Maternal-Fetal Medicine. February 3, 2014 - February 8, 2014, New Orleans, LA.

163. Grobman W. et al. (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Short cervix and preterm birth. Poster accepted 2013. . Presented at the 34th Annual Meeting of the Society for Maternal-Fetal Medicine. February 3, 2014 - February 8, 2014, New Orleans, LA.

164. Weigand S. et al. (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Buprenorphone/Naloxone (B/N) and Methadone (M) Maintenance During Pregnancy: A chart Review and Comparison of Maternal and Neonatal Outcomes. Poster accepted

2013. Presented at the 34th Annual Meeting of the Society for Maternal-Fetal Medicine. February 3, 2014 - February 8, 2014, New Orleans, LA.

165. Myatt L. et al. (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Title: Placental Histology of Low Risk Nulliparous Women: Does Preeclampsia Make a Difference? A chart Review and Comparison of Maternal and Neonatal Outcomes. Poster accepted 2013. SGI 61st Annual Scientific Meeting 2014.

166. Jeyabalan A. et al. (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Title: Do differences in arginase, asymmetric dimethylarginine and nitric oxide precede the development of preeclampsia? A chart Review and Comparison of Maternal and Neonatal Outcomes. Poster accepted 2013. SGI 61st Annual Scientific Meeting 2014.

Podcasts:

International Journal of Obstetrics and Gyneacology audio podcast entitled "Termination of pregnancy and the risk of subsequent preterm birth – what is the evidence?"

Taskforce Publications:

North Carolina Institute of Medicine Task Force, funded by the Substance Abuse Prevention and Treatment Block Grant. Growing up well: Supporting young children's social-emotional development and mental health in North Carolina. Morrisville, NC: North Carolina Institute of Medicine;July 2012.

Publications

Peer Reviewed Articles

1. **Thorp JM**, Bowes WA Jr, Brame RG, Cefalo RC. Selected use of midline episiotomy: Effect on perineal trauma. *Obstet Gynecol* 1987;70:260-2. PMID: 3601289

2. Richards DS, Cefalo RC, **Thorp JM**, Salley M, Rose D. Determinants of fetal heart rate response to vibroacoustic stimulation in labor. *Obstet Gynecol* 1988;71:535-9. PMID: 3353043

3. **Thorp JM**, Bowes WA Jr. Episiotomy: can its routine use be defended? *Am J Obstet Gynecol* 1989; 160:1027. PMID: 2658595

4. **Thorp JM**, Katz VL, Campbell D, Cefalo RC. Hypersensitivity to magnesium sulfate. *Am J Obstet Gynecol* 1989;161:889-90. PMID: 2801834

5. **Thorp JM**, Katz VL, Fowler LJ, Kurtzman JT, Bowes WA Jr. Fetal Death from chlamydial infection across intact amniotic membranes. *Am J Obstet Gynecol* 1989;161:1245-6. PMID: 2589446

6. **Thorp JM**, Jordon S, Watson WJ, Bowes WA Jr. Survey of maternal transports to the North Carolina Memorial Hospital. *NC Med J* 1989; 50:423-5. PMID: 2770894

7. Katz VL, **Thorp JM**, Bowes WA Jr. Severe symmetric intrauterine growth retardation 'IUGR' associated with the topical use of triamcinalone. *Am J Obstet Gynecol* 1990; 162:396-7. PMID: 2309822

8. **Thorp JM**, White GL, Moake JL, Bowes WA Jr. Von Willebrand factor multimeric levels and patterns in patients with severe preeclampsia. *Obstet Gynecol* 1990;75:163-7. PMID: 2300343

9. Katz, VL, **Thorp JM**, Cefalo RC. Epidural analgesia and autonomic hyperreflexia: a case report. *Am J Obstet Gynecol* 1990;162:471-2. PMID: 2309831

10. Watson WJ, **Thorp JM**, Seeds JW. Familial cystic hygroma with normal karyotype. *Prenatal Dianosis* 1990;10:37-40. PMID: 2179939

11. **Thorp JM**, Wells S, Droegemueller W. Ovarian suspension in massive ovarian edema. *Obstet Gynecol* 1990; 76(s):912-4. PMID: 2216254

12. **Thorp JM**, Fowler WC, Donehoo R, Sawicki C, Bowes WA Jr. Antepartum and intrapartum events in women exposed in utero to diethylstilbesterol. *Obstet Gynecol* 1990;76(s):828-32. PMID: 2216234

13. **Thorp JM**, Spielman FJ, Valea FA, Payne FG, Mueller RA, Cefalo RC. Nifedipine enhances the cardiac toxicity of magnesium sulfate in the isolated, perfused Spraque-Dawley rat heart. *Am J Obstet Gynecol* 1990;163:655-6. PMID: 2386158

14. **Thorp JM**, Fann BB, Korb EG, Brannan WG, Pierson S, Bowes WA Jr. Establishing maternal-fetal medicine consultative services in western North Carolina (Perinatal Region 1). *NC Med J* 1990;51:266-7. PMID: 2366883

15. Neifert M, **Thorp JM**. Twins: family adjustment, parenting, and infant feeding in the fourth trimester. *Clin Obstet Gynecol* 1990;33:102-13. PMID: 2178828

16. Watson WJ, Katz VL, **Thorp JM**. Spontaneous resolution of fetal nuchal cystic hygroma. *Prenatal Diagnosis* 1990;73:862-5. PMID: 1919817

17. Watson WJ, **Thorp JM**, Miller RC, Chescheir NC, Katz VL, Seeds JW. Prenatal diagnosis of laryngeal atresia. *Am J Obstet Gynecol* 1990;163 (5):1456-7. PMID: 2240087

18. Katz VL, Rozas L, Bowes WA Jr, **Thorp JM.** The natural history of thrombocytopenia associated with preeclampsia. *Am J Obstet Gynecol* 1990;163(4):1142-3. PMID: 2220918

19. Katz, VL, **Thorp JM**, Watson WJ, Fowler L, Heine RP. Human immunoglobin therapy for preeclampsia associated with lupus anticoagulant and anticardiolipin antibody. *Obstet Gynecol* 1990;76(2):986-8. PMID: 2120649

20. **Thorp, JM**, Watson WJ, Katz VL. Effect of corpus luteum position on hyperemesis gravidarum. A case report. *J Reprod Med* 1991;36(10):761-2. PMID: 1956019

21. Katz VL, Blanchard GF, Watson WJ, Miller RC, Chescheir NC, **Thorp JM**. The clinical implications of subchorionic placental lucencies. *Am J Obstet Gynecol* 1991;164:99-100. PMID: 1986634

22. **Thorp JM**, Katz VL. Submucous myomas treated with gonadotropin releasing hormone agonist and resulting in vaginal hemorrhage. *J Reprod Med* 1991;36(8):625-6. PMID: 1941808

23. **Thorp JM**, Bowes WA Jr, Droegemueller W, Wicker H. Assessment of perineal floor function: electromyography with acrylic plug surface electrodes in nulliparous women. *Obstet Gynecol* 1991;78(1):89-92. PMID: 2047074

24. **Thorp JM**, Wells SR, Bowes WA Jr. The obfuscation continues: severe preeclampsia versus thrombotic thrombocytopenic purpura. *NC Med J* 1991;52:126-8. PMID: 2030749

25. **Thorp JM**, Jenkins T, Watson WJ. Utility of Leopold maneuvers in screening for malpresentation. *Obstet Gynecol* 1991;78(3):394-6. PMID: 1876372

26. Wells SR, **Thorp JM**, Bowes WA Jr. Management of the nonvertex second twin. *Surg Obstet Gynecol* 1991; 172:383-5. PMID : 2028373

27. Savitz DA, Blackmore CA, **Thorp JM**. Epidemiologic characteristics of preterm delivery: etiologic heterogeneity. *Am J Obstet Gynecology* 1991; 164:467-71. PMID: 1992685

28. **Thorp JM**, Bowes WA Jr. Prolife perinatologist: paradox or possibility? *New Engl J Med* 1992; 326:1217-9. PMID: 1472178

29. **Thorp JM**, Weeks M, Watson W, Bowes WA Jr, Fowler WC. Should every gravida exposed to diethylstilbesterol in utero undergo prophylactic cerclage? *J Mat-Fetal Med* 1992;1(6):300-2.

30. **Thorp JM**, Boyette DD, Watson WJ, Cefalo RC. Elemental mercury exposure in early pregnancy. *Obstet Gynecol* 1992;79:874-6. PMID: 1565393

31. Katz VL, Watson WJ, **Thorp JM**, Hansen W, Bowes WA Jr. Treatment of persistent postpartum HELLP syndrome with plasmaphoresis. *Am J Perinatol* 1992;9(2):120-2. PMID: 1590866

32. Katz VL, Watson WJ, **Thorp JM**, Chescheir NC, Miller RC. Prenatal sonographic findings of massive lower extremity lymphangioma. *Am J Perinatol* 1992;9(2):127-9. PMID: 1590868

33. **Thorp JM**, Councell RB, Sandridge DA, Wiest HH. Antepartum diagnosis of placenta previa percreta by magnetic resonance imaging. *Obstet Gynecol* 1992;80:506-8. PMID: 1495723

34. Kurtzman JT, **Thorp JM**, Spielman FJ, Mueller RA, Cefalo RC. Do nifedipine and verapamil potentiate the cardiac toxicity of magnesium sulfate? *Am J Perinatol* 1993;10(6):450-2. PMID: 8267811

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306. **Thorp JM Jr.** International guidelines, patents and trials *Women's health – what's new worldwide* DOI: 10.1111/j.1471-0528.12114 www.bjog.org BJOG an International Journal of Obstetrics and Gynaecology

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316. Kirtley S, **Thorp J**, International guidelines, patents and trials www.bjog.org BJOG is an International Journal of Obstetrics and Gynaecology*. Women's health – what's new worldwide***.** DOI: 10.1111/1471-0528.12361

317. **Thorp J**, Editor's Choice: *Commentaries and BJOG* DOI: 10.1111/1471-0528.123662

318. **Xolair Pregnancy Registry (EXPECT): *the safety of omalizumab use during pregnancy*** Jennifer Namazy, MD[1] Michael D. Cabana, MD[2] Angela Scheuerle, MD[3] **John M. Thorp**, Jr., MD[4] Hubert Chen MD,[5] Gillis Carrigan PhD,[5] Yan Wang PhD,[5] Elizabeth B. Andrews, PhD[6]Scripps Clinic, La Jolla, California, USA; [2]Department of Pediatrics, University of California, San Francisco, California, USA; [3]Tesserae Genetics, Dallas, Texas, USA; [4]School of Medicine, University of North Carolina, Chapel Hill, North Carolina, USA; [5]Genentech, Inc., South San Francisco, California, USA; [6]RTI Health Solutions, Research Triangle Park, North Carolina, USA Submitted July 2013

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Non-Peer Reviewed Articles

1. **Thorp JM.** Should episiotomy be routine? *Current Practices* 8:3, December 1988.

2. **Thorp JM.** Should we routinely screen for toxoplasmosis? *Current Practices* 10:6, September 1990.

3. **Thorp JM**. Endovaginal sonography. *Current Practices* 12(4):1-2, December 1991.

4. **Thorp JM.** Book review. Prenatal abuse of licit and illicit drugs. Hutchings DE (ed.) *In American Scientist* 79:369, 1991.

5. Hansen WF, **Thorp JM**. Postterm pregnancy. *Current Practices* 13 (1):1-2, March 1992.

6. **Thorp JM**, Stanford D. The Horizons program: a perinatal substance abuse project. *Current Practices* 13(2):6, June, 1993.

7. Kurtzman JL, **Thorp JM**, Spielman FJ, Mueller RC, and Cefalo RC. Do Nifedipine and Verapamil Potentiate the Cardiac Toxicity of Magnesium Sulfate? *Obstetric Anesthesia Digest*, 14(2) 45-92, 1994.

8. **Thorp, JM**. Patient Autonomy, Informed Consent, and Routine Episiotomy. *Contemporary OB/GYN*, September, 1995.

9. **Thorp, JM**. Point/Counterpoint: Should physicians with strong pro-life views avoid specializing in perinatology? No. *Physicians Weekly*, 12 (23); April 19, 1995.

10. **Thorp, JM**. Challenging Cases as a preceptor. *The Front Line* 1; 3-4, Summer, 1995.

11. **Thorp, JM**. Is episiotomy necessary? *Health Confidential*, 1995.

12. **Thorp JM**, Pisano EA. Why you should read the blue handbook about breast cancer mailed to you by the NC comprehensive breast and cervical center control coalition. *Current Practices* 4;1,1995.

13. **Thorp JM**. Obstetrical Management of Alcohol and Cocaine Abuse. Horizons Professional Newsletter, April, 1996.

14. **Thorp, JM.** Should I Incorporate Fetal Fibronectin Testing into my Practice; and if so, How? *Current Practices* 16;2, 1996.

15. **Thorp JM.** New Services Offered by the Department and the End of an Era. *Current Practices* 16;1, 1996.

16. Guise J-M, **Thorp JM.** Antibiotics in the Management of Preterm Premature Rupture of Membranes. *Current Practices* 16;4, 1996.

17. **Thorp, JM.** Should I Incorporate Fetal Fibronectin into my Practice; and if so, How? *OBG Management*. Accepted, Sept, 1996.

18. **Thorp JM**, Cefalo RC, Bowes WA Jr. Court-ordered obstetrical intervention. *Contemporary OB/GYN*. June, 1997.

19. **Thorp JM**, Cefalo RC, Bowes WA Jr. Court-ordered obstetrical intervention. *Current Practices*, June, 1997

20. **Thorp JM.** Editorial Comment: Preterm Birth: The Role of Infection and Inflammation. *Medscape Women's Health*, 2(8), 1997.

21. Dorman K, **Thorp JM**. Improving Access to UNC Clinicians. *Current Practices*, September, 1998.

22. Cefalo RC, **Thorp JM.** Videotaping in Labor and Delivery. *Current Practices*, September, 1998.

23. **Thorp JM.** I Want To Be Like Watt. *Current Practices*, March, 1999.

24. **Thorp JM**. Literature Review and Study Design: Resource use associated with hormone replacement therapy. Research Triangle Institute project report funded by Eli Lilley, January 1999.

25. Gavin N, Wilson A, Greene Al, West, S, **Thorp JM**. Health Care Resource Use Associated with Hormone Replacement Therapy. Research Triangle Institute Report Project No 7203, funded by Eli Lilley, November, 1999.

26. **Thorp JM**. No role for maintenance tocolysis in preterm labour: study. Obstet & Gynaecol Canada. November, 2000, Vol 4, No. 7, p 13.

27. Ansbacher R, Creinin MD, **Thorp JM**, Nolan TE, Darney PD, Thorneycrost IH. Consensus statement: Public health considerations with therapeutic substitution of low-dose oral contraceptives. *Am J Obstet Gynecol (Clinical Opinion)*, September, 2000.

28. **Thorp JM**. Helicobacter uteri (poem). Iris: The UNC Journal of Medicine, Literature & Visual Art. 2001;5:57.

29. Payne PA, **Thorp JM**. Evaluation of The North Carolina Midwifery Grants Program 1991-2000. Cecil G. Sheps Center for Health Services Research. July, 2001.

30. Sayle A, Savitz D, **Thorp JM**. Sexual intercourse and orgasm during late pregnancy may have a protective effect against preterm delivery. Family Planning Perspective 2001;33(4):185.

31. **Thorp JM**. Integrity, Abortion, and the Pro-Life Perinatologists. Proceedings of World Federal of Catholic Medical Associations, "The Future of Obstetrics and Gynaecology: The Fundamental Human Right to be Trained and to Practice According to Conscience". Marie S.S. Bambina Institute, Rome, Italy, 2001.

32. Ansbacher R, Creinin MD, **Thorp JM**, Nolan TE, Thorneycroft IH. Therapeutic substitution of low-dose OCs. *The Female Patient* 2002;27:11-12.

33. **Thorp JM**. Predicting and preventing preterm birth. *OBG Management* 2005;17 (6):49-53.

34. **Thorp JM Jr**, Rowland Hogue CJ, Does elective abortion increase the risk of preterm delivery? *Contemporary OB/GYN: Controversies in OB/GYN* 2006(September)51(9):88-92.

35. **Thorp JM Jr**. Does cervical dysplasia raise the risk of preterm birth? Examining the Evidence (commentary). *OBG Management* 2007:19(40):20-23.

36. **Thorp JM Jr**. Can intrauterine growth restriction be present in the first trimester: Expert Commentary. *OBG Management* 2008;20(6):28.

37. **Thorp JM** and Forsythe C. A Fact Ignored by the WHO. http://www.firstthings.com/onthesquare/2012/07/a-fact-ignored-by-the-WHO

38. **Thorp JM Jr.** Does maternal exposure to magnesium sulfate affect fetal heart-rate patterns? Expert Commentary *OBG Management* 2012:24(10):17-18

39. **Thorp JM Jr,** "Public Health Impact of Legal Termination of Pregnancy in the US: 40 Years Later," Scientifica, vol. 2012, Article ID 980812, 16 pages, 2012 doi:10.6064/2012/980812; http://hindawi.com/journals/scientifica/2012/980812/

Teaching Activities

Faculty Committees	1. Tenured Medicine Council 2. Faculty Executive Committee(alternate)	2007
Liaison	Area Health Education Center Liaison School of Medicine University North Carolina-Chapel Hill	2000-2003
Member	Doctoral Dissertation Committees Department of Epidemiology School of Public Health University North Carolina-Chapel Hill	1997-present
Oral Examiner	American Board Obstetrics and Gynecology MFM Subspecialty	2005 - present
Oral Examiner	American Board Obstetrics and Gynecology	1996-present
Fellowship Director	Division of Maternal-Fetal Medicine Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	1997-2000

Grants

ACTIVE

No Number (Thorp) 01/01/1994 – present 0.45
calendar
NC DHHS $5,000,000
Model Program for Perinatal Substance Abuse

HORIZONS. This is a demonstration project of a novel paradigm to treat perinatal substance use problems by combining perinatal and mental health care. It combines an array of treatment resources including a residential program in which families can receive substance abuse treatment.

HHSN275201100005C (Entwisle) 03/1/2011 – 02/28/2013 0.71
calendar
NIH/NICHD $3,610,855
The National Children's Study – Duplin County Vanguard Center

The goal of the National Children's Study is to identify a sample of 100,000 children, as early as possible in pregnancy, and follow them for 21 years to address the causes of a variety of health problems including obesity, injuries, asthma, and developmental delays. The University of North Carolina at Chapel Hill, in collaboration with Duke University and Battelle Institute, is conducting a study in Duplin County.

U01HD044219-08 (Thorp) 07/01/2007 – 06/30/2012 1.62
calendar
NIH/NICHD $399,385
Community Child Health Network (CCHN) Phase II

This is a collaboration among the Eastern NC Baby Love Plus Consortium, East Carolina University, Cecil G. Sheps Center for Health Services Research, and the Division of Women's Primary Health at UNC to evaluate the effect of stress (allostatic load) on pregnant women and their partners in regards to pregnancy outcome and maternal and infant health. This is part of an ongoing collaboration aimed at understanding and eliminating Health disparities in rural North Carolina.

HHSN267200700049C (Entwisle) 10/01/2007 – 09/30/2012 No Salary Support–Supported on Main Grant
NIH/NICHD $3,019,699
National Children's Study ** North Carolina Study Centers

This study will measure the effects of environmental, social, biological and behavioral factors on child health. The goal is to understand causes for a range of health problems, including asthma, developmental delays, autism, and obesity. The study will collect information from families about their health, their activities, and their neighborhoods. Various biological samples, along with air and water at home and in schools will also be collected.

HHSN275200800029C (Entwisle) 09/26/2008 – 09/25/2013 No Salary Support–Supported on Main Grant
NIH/NICHD $417,669
National Children's Study Cumberland County

Cumberland County NC (population 299,060) is part of Wave 2 of the study.

3U01HD044219-07S1 (Thorp) 09/01/2010 – 08/31/2012 No Salary Support – Supported on Main Grant
NIH/NICHD $125,000
Community Child Health Network, Eastern North Carolina, Fatherhood Supplement

This supplement is to focus on recruitment of fathers to participate in the Community Child Health Network study in Eastern North Carolina. ,

RO1 HD067683-01 (Steiner) 04/15/2011– 3/31/2016 0.25 calendar
NIH/NICHD $375,915
Biomarkers of Infertility

The goal of this project is to determine the ability of markers of ovarian aging to predict infertility in the general population.

2U10HD040560-12 (Thorp) 04/18/2001 – 03/31/2016 1.20 calendar
NIH/NICHD $260,000

Cooperative Multicenter Maternal Fetal Medicine Units Networks
The Maternal-Fetal Medicine Units Network conducts clinical studies to improve maternal, fetal and neonatal health emphasizing randomized-controlled trials.

Grant Number OPP1090837 05/06/13 – 05/31/17
Bill & Melinda Gates Foundation $7,994,469.00
Global Development Malawi: Maternal Health and Safe Motherhood Initiative

Past Support

Influence of iron, zinc, and folate on preterm delivery 1999-2001
Funding Agency: NICHD/NIH
Co-Investigator
$570,000

Addiction Studies, Center for Welfare reform and perinatal substance abuse 1998-2001
Funding Agency: RW Johnson

Medical Director
$800,000

Evidence based management of Preterm Labor 1998-1999
Funding Agency: AHRQ
Scientific Director
$200,000

Perinatal iron metabolism 1996-1999
Funding Agency: CDC
Co-Principal Investigator
$386,000

Epidemiology of cocaine use 1996-1999
Funding Agency: NICHD
Co-Principal Investigator
$78,000

Perinatal HIV Prevention 1996-1997
Funding Agency: CDC
Co-Principal Investigator
$120,000

Perinatal smoking cessation 1993-1995
Funding Agency: Kate B. Reynolds
Charitable Trust
Medical Director
$109,000

Smoking cessation 1995-1997
Funding Agency: R.W. Johnson
$205,000

Psychosocial Risks and Preterm Birth in African-American Women. 1999-2002
Principal Investigator: David Savitz PhD
Funding Agency: ASPH S0807-18/20
$256,841

Drinking Water Disinfection By-Products and Spontaneous Abortion 11/15/99-06/15/02
Funding Agency: American Water Works Association
3,000,000
Direct: $1,668,000 Indirect: $1,332,000

Epidemiology of Exertion, Stress and Preterm Delivery. 12/1/99-11/30/04
Funding Agency: NICHD/NIH RO1-HD3758
$3,735,28

Epidemiologic Study of Vaginal Bleeding during Pregnancy and Preterm Birth. Funding Agency: March of Dimes $179,584	6/01/01-5/31/04
Gates Global Network to Improve Maternal Health. Funding Agency: NICHD $2,800,000	1/01/01-1/01/06
Placental Vascular Compromise and Preterm Delivery: Funding Agency: NICHD/NIH . $2,350,497	9/01/01-8/31/06
Epidemiology of Leptin Production and Fetal Growth. Funding Agency: NIH Funding: 5,500,000	9/2004 – 9/2009
Pregnancy-Related Weight Gain: A Link to Obesity. Funding Agency: NIH/NIDDK $1,749,033	8/01/02 –7/31/07

Professional Service

Specialty and Sub-Specialty Certification

	Sub-Specialty certification, Gynecology American Board of Obstetrics and Gynecology	1992-present
Diplomate	American Board of Obstetrics and Gynecology Maternal-Fetal Medicine	1991-present

Committee Assignment

University of North Carolina at Chapel Hill Appointment to Promotion with Tenure Committee Chapel Hill, NC	2003 - 2005
University of North Carolina at Chapel Hill Appointments, Promotions, and Tenure Committee	2009-present

Proposal Reviewer

Member	Study Section – Maternal & Child Health NICHD, Bethesda, MD	2002 - present
Member	Steering Committee, MFMU Network CHD, Bethesda, MD	2001 - present
Member	Expert Review Panel – Evidence report on post-term pregnancy Duke University, Durham, NC	2001 - 2002
Proposal Reviewer	Family Health International RTP, NC	2000 - present
Member	Special emphasis group on regional anesthesia NICHD, Bethesda, MD	1999

Rev: November 12, 2013