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MONTANA THIRTEENTH JUDICIAL DISTRICT COURT,
YELLOWSTONE COUNTY

PLANNED PARENTHOOD OF MONTANA, and JOEY BANKS, M.D., on behalf of themselves and their patients, Plaintiffs, vs. STATE OF MONTANA, by and through AUSTIN KNUDSEN, in his official capacity as Attorney General, Defendant.	Cause No. DV21-00999 Judge: Jessica T Fehr **AFFIDAVIT OF JOEY BANKS**

STATE OF MONTANA)
: ss.
County of MISSOULA)

I, Joey Banks, being first duly sworn upon her oath, state as follows:

1. I am currently a contract physician and Laboratory Director at Planned Parenthood of Montana ("PPMT").

2. My responsibilities at PPMT involve providing primary care and abortion care, ensuring compliance with PPMT protocols and practices and providing clinical guidance, training residents and staff, and working with PPMT senior leadership on State-wide initiatives.

3. I have reviewed the challenged laws (HB 136, 171, and 140). As I explain below, I believe that each will increase the burden on women's access to abortion in a state where access is already limited.[1] In my opinion, the challenged laws impose medically unnecessary hurdles to Montanans' ability to access a pre-viability abortion, interfere with Montanans' right to make their own medical decisions in consultation with their providers, impede providers' ability to properly counsel patients consistent with best practices, and seek to stigmatize women who seek abortions. The cumulative effect of these laws will ultimately be to deny abortion to some women and then force them to carry their pregnancy to term against their will.

4. This declaration is based upon my personal knowledge, the knowledge I have acquired in the course of my duties with PPMT, and my decades of experience in primary and reproductive health care, including my experience providing, teaching, and supervising abortions. If called and sworn as a witness, I could and would testify competently thereto.

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[1] I use "women" as shorthand for people who are or may become pregnant, but people of other gender identities, including transgender men and gender-diverse individuals, may also become pregnant, seek abortion services, and be harmed by the laws.

Experience and Background

5. I received my medical degree from Indiana University School of Medicine and am board-certified as a family physician by the American Board of Family Medicine. I completed my residency in family medicine at the Alaska Family Medicine Residency in Anchorage, Alaska, where I also served as chief resident. I have previously been a faculty member at the Alaska Family Medicine Residency and the Central Maine Medical Center Family Medicine Residency, as well as a community preceptor for Family Medicine Residency Western Montana. I am currently licensed to practice medicine in Montana, Oklahoma, and Idaho.

6. I have more than 20 years' experience providing primary care and reproductive health care, and have been performing and supervising abortions for more than 15 years. I currently perform procedural and medication abortions for PPMT, and previously served as the Chief Medical Officer of PPMT. In addition to my work with PPMT, I also provide abortion services as a contract physician at Tulsa Women's Clinic in Tulsa, Oklahoma approximately three days a month. Prior to joining PPMT, I worked as a family practice physician for nine years at Blue Mountain Clinic in Missoula, providing full primary care, and sexual and reproductive health care, including abortions. I still provide abortion services at Blue Mountain Clinic on a contract basis. I have also worked and performed abortions for Planned Parenthood of Northern New England, Planned Parenthood of Alaska, and Central Maine Family Medicine Residency Family Practice Clinic.

Abortion Services at PPMT

7. PPMT offers medication abortion ("MAB") and procedural abortion. MAB is performed by administering two medications (mifepristone and misoprostol), typically 24 to 48 hours apart. Procedural abortion, sometimes called surgical abortion (although no incisions are

made), generally uses a suction device to empty the uterus, although techniques differ depending on the gestational age of the fetus.

8. PPMT provides MAB through 77 days (11 weeks) from the first day of the woman's last menstrual period ("LMP") and procedural abortion up to 21.6 weeks LMP. I personally provide MAB through 77 days LMP and procedural abortion up to 21.6 weeks LMP.

9. PPMT provides MAB through in-person appointments and via telehealth visits. For telehealth MABs, PPMT offers site-to-site visits, where a patient who is physically located at one PPMT health center meets via teleconference with an abortion provider who is physically located at another PPMT health center, and direct-to-patient visits, where a patient in Montana consults with a PPMT provider via teleconference from wherever she is located and then receives abortion medication by mail from PPMT to a Montana address. During the telehealth visit, a provider reviews the patient's medical history and explains the options that are available to the patient. If the patient is eligible for direct-to-patient MAB, the provider then instructs the patient on when to take the mifepristone and misoprostol and counsels the patient on potential side effects or complications. The patient is then mailed the medication, which the patient takes in accordance with the provider's instructions. The patient signs consent forms electronically and is not required to have an ultrasound or blood work unless medically necessary.

Impact on PPMT of Challenged Legislation

10. Despite the demonstrated safety and efficacy of abortions, Montanans already face significant hurdles in accessing abortion. It is my understanding that, including PPMT health centers, there are only seven generally available abortion facilities in the State, and even fewer than that are able to provide procedural abortion after 14 weeks LMP. Accordingly, even

slight changes to the availability of providers can result in women losing the ability to access abortion care.

11. Additionally, the State's large geographic size and rural nature means that the nearest abortion provider may be several hours away from the woman seeking an abortion. An in-person abortion appointment therefore may require a woman to spend hours traveling to a health center and a substantial amount of money on travel or lodging, on top of the costs of the abortion procedure itself. A delay in abortion care may force patients out of the window during which they are eligible for MAB, and may even push patients out of the time frame where abortion is available in Montana at all. This can be particularly problematic for women who need to take time off from school or work, who have mobility limitations that prevent them from leaving their homes, who are at risk of or currently experience intimate partner violence, or who need to arrange for care of children or other family members.

20-Week Ban on Abortion

12. I understand that HB 136 largely bans abortion beginning at 20 weeks, which is pre-viability.

13. HB 136 provides only limited exceptions to the ban on abortion beginning at 20 weeks LMP, allowing abortions that are necessary to prevent a "serious health risk" to the woman or "in the case of a medical emergency." The law defines "serious health risk" as one that "in reasonable medical judgment . . . so complicates the mother's medical condition that it necessitates the abortion of the mother's pregnancy to avert the mother's death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function." Likewise, a "medical emergency" is a condition that, "in reasonable medical judgment, so complicates the medical condition of a pregnant woman that it necessitates the immediate abortion of the

woman's pregnancy without first determining gestational age in order to avert the woman's death or for which the delay necessary to determine gestational age will create serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions." A "medical emergency" also does "not include a condition that is based on a claim or diagnosis that the woman will engage in conduct that the woman intends to result in the woman's death or in substantial and irreversible physical impairment of a major bodily function."

14. HB 136's definitions of a "serious health risk" and a "medical emergency" do not make clear to me or other providers when a patient qualifies for these exceptions. What constitutes a "serious risk of substantial and irreversible physical impairment of a major bodily function" and whether a condition "*so* complicates" the woman's medical condition that "it *necessitates*" the abortion are unclear, and I believe would be subject to disagreement among reasonable health care providers. It is not clear to me whose "reasonable medical judgment" will determine whether a woman meets one of these exceptions.

15. HB 136 imposes severe criminal penalties. If HB 136 goes into effect, I will be very concerned about providing abortion care to women between 20 and 21.6 weeks LMP (up until when PPMT provides abortion care) who have serious but arguably not life-threatening medical conditions (such as blood clotting disorders, a history of uterine rupture, lupus, or ovarian cancer). If I perform the abortion and the State determines the health condition was not immediately life-threatening, or would not irreversibly impair one of the patient's major bodily functions, I could be sent to prison. But if I do not perform an abortion on a woman because I am not certain whether she has a "serious health risk" or is experiencing a "medical emergency,"

as defined by the law, the patient could suffer serious adverse health consequences. HB 136 thus will put me in a terrible ethical bind.

16. I am also concerned that HB 136's exceptions categorically exclude all mental health issues from constituting a "serious health risk" or "medical emergency" that qualifies for an abortion beginning at 20 weeks LMP. Serious mental health conditions, such as suicidal thoughts, obsessive compulsive disorder, substance use disorder, and severe bipolarity, can be just as damaging to a woman as certain physical conditions. They can also impact a woman's physical health, as well as her pregnancy. In my experience, denying a woman access to an abortion and forcing her to continue a pregnancy that she is not prepared to handle (mentally, emotionally, or otherwise) can have serious detrimental effects on the woman's mental and physical health and, in some cases, could lead her to commit suicide or other self-harm. However, HB 136 prohibits me from considering mental health conditions when assessing the risk to the woman's health, including self-harm. This could further put the health or life of the woman in jeopardy.

17. Finally, even when the "serious health risk" exception applies, providers are required to end the pregnancy in a way that provides "the best opportunity" for the fetus to survive. As a healthcare provider, I have serious concerns about the lack of clarity of this provision and its impact. There is no method of ending a pregnancy at or around 20 weeks, or up until the 21.6 weeks LMP when PPMT provides abortion care, that will provide a meaningful opportunity for survival. I do not know how providers can comply with this requirement.

18. If providers do not know how to perform an abortion that someone could later argue would have provided the "best opportunity" for the fetus to survive, they may decide not to perform the abortion at all. Exacerbating this risk is the fact that HB 136 threatens providers

with felony charges and civil penalties. In short, this law would replace the ability of trained medical providers to perform the procedure we believe will be the most effective in saving the pregnant woman's life and accounting for her health with confusing dictates that could end up seriously harming her.

19. Providers should not be put in the untenable position of choosing between providing the right medical care for our patients or the threat of imprisonment for failing to follow a vague, scientifically unjustified law.

20. The availability of abortions beginning at 20 weeks is critical to those who need them. Women who come to PPMT seeking abortion care beginning at 20 weeks LMP often do so as a last resort, for example, after learning that the fetus would suffer from debilitating congenital defects such as hydranencephaly, infantile polycystic kidneys, VATER syndrome, or trisomy 13. In some cases, women decide that they do not want to carry a pregnancy to term because the child would not survive beyond a few months. In the past, maternal fetal medicine doctors have referred patients to me for abortion care because they have recommended their patients not continue the pregnancy due to such congenital defects but were unable to complete the abortions themselves due to hospital protocols.

21. If providers, including PPMT, are no longer able to provide abortions beginning at 20 weeks LMP, Montanans would be forced either to travel (usually at significant cost) to another state to obtain an abortion, to seek an abortion outside the medical system, or to carry out a pregnancy that they are not prepared to undertake (because, for example, it would affect the woman's ability to care for children at home) or which could harm the woman's health.

Omnibus MAB Restrictions Law

22. HB 171 imposes medically unnecessary limitations on MAB that may actually increase the risk to a pregnant woman's health by delaying or blocking entirely her ability to access an MAB and by substituting the judgment of experienced medical providers with State-mandated information about MAB that is not supported by medical evidence.

23. MAB is preferred by or medically indicated for some patients.

a. Mandatory Delay and Multiple-Trip Requirements

24. HB 171 imposes a 24-hour mandatory delay and requires patients to make multiple trips to obtain MABs. The law requires the abortion provider who prescribes the MAB to conduct an extensive, in-person examination of the patient and obtain the patient's "informed consent" using a State-mandated form at least 24 hours before providing the MAB. This means that patients have to make one in-person appointment for the ultrasound and to sign the "informed consent" forms, and a second in-person appointment with the same provider at least 24 hours later to obtain the medication for the MAB. HB 171 also mandates that providers "make all reasonable efforts" to ensure that patients return for a (third) follow-up appointment seven to 14 days after the MAB.

25. These requirements will impose significant burdens on pregnant women who cannot afford the time or expense needed to make multiple, unnecessary trips to a health center. These burdens are especially pronounced in Montana, where—given its large rural population, expansive geographic footprint, and few abortion providers—some of my patients have had to travel five hours one way to reach the nearest providing health center.

26. Moreover, given the scarcity of abortion providers in Montana, it is very unlikely that the same abortion provider will be able to meet in person with the same patient twice within

24 hours. It could even take weeks before a patient is able to see the same abortion provider a second time, which could force patients to undergo a procedural abortion when MAB would have sufficed and/or was preferred. Although abortion is extremely safe, the risk of a serious complication associated with abortion increases as a patient's pregnancy advances.

27. HB 171's requirement that providers schedule an in-person follow-up visit may also have a chilling effect on MABs by turning a convenient, efficient process into a prolonged, time- and resource-intensive one—without any medical justification. Prior to providing MABs, PPMT providers counsel patients on when to take the drug(s), the risks, what side effects to expect, and when to seek emergency medical attention. This information is also provided in writing. Additionally, PPMT protocol already provides that our nurses or medical assistants follow up with our patients after an MAB to check on the patient. This provides patients an opportunity to discuss contraception options and any concerns or issues that arose with the MAB and, if necessary, make plans to see a provider. Typically, however, there is no need for a patient to go for an in-person follow-up visit after an MAB. Patients have several options to confirm that an MAB was successful that do not require them to return to a PPMT health center. These include using at-home urine pregnancy tests or getting blood work done by a provider in the patient's community.

28. I am not aware of non-abortion providers being required to wait 24 hours before providing other, riskier procedures, such as vasectomies, circumcision, colonoscopies, or elective plastic surgery.

b. Biased Counseling Requirements

29. HB 171 requires providers to tell patients false information about so-called abortion "reversals" and the need to receive Rh immunoglobulin ("Rhogam") in all instances,

and misleading information about MAB "complications" (for example, that MAB may cause breast cancer, which is false). It requires providers to do so using a State-created form, which means that providers have no control over how that information is provided to their patients. It is unconscionable and dangerous for the State to interfere in the patient-provider relationship and require providers to tell patients something that is not true.

30. HB 171 puts providers in the untenable position of having to choose between upholding our ethical obligation to provide accurate medical advice to patients and exposing ourselves to criminal and civil penalties for failing to provide this inaccurate information. I should not be put to the choice of following my ethical obligation to provide my patients with accurate, sound medical advice, or risk my liberty, livelihood, and my family's cohesion, safety, and reputation.

31. Moreover, the severity of HB 171's potential penalties may lead some providers to stop providing MAB altogether, thereby denying some pregnant women access to MAB.

32. Consistent with my ethical obligations, I always counsel my patients on the abortion process and make sure they are confident in their decision to have an abortion. It will *undermine* the informed consent process if I am required to falsely tell patients that they are able to reverse an abortion, for example, and it may actually result in some patients choosing to go forward with the abortion—on the false assumption that it is reversible—when they have not come to a full decision about whether they want to abort their pregnancy.

33. HB 171 also requires providers to tell patients that, if they have an Rh negative blood type, they "should receive an injection of Rh immunoglobulin at the time of the abortion to prevent Rh incompatibility in future pregnancies, which can lead to complications and miscarriage in future pregnancies." This requirement is unnecessary and will impose additional

burdens on Montanans' access to pre-viability abortions. If the blood of an Rh-positive fetus crosses into the bloodstream of a pregnant woman who is Rh negative, it can lead to a condition called "Rh incompatibility," which may cause complications in subsequent pregnancies for the pregnant woman. However, the risk of fetal blood crossing into the pregnant woman's bloodstream below eight weeks LMP is very low. Accordingly, PPMT does not recommend Rh testing or treatment with Rhogam for patients who are less than eight weeks LMP. In addition, patients who are at or over eight weeks LMP may still sign a waiver and decline Rh testing and treatment.

34. Additionally, HB 171 requires providers to document "the gestational age and intrauterine location of the pregnancy" prior to an MAB. This provision may be impossible to comply with in certain situations because a fetus or gestational sac may not be visible on an ultrasound in early pregnancies.

c. **Ban on MAB by Telemedicine**

35. I am not aware of any medical justification for requiring in-person medical exams for all MABs or for distributing the medication for MABs in person. For over four years, PPMT has safely provided hundreds of MABs for eligible patients using telehealth and the mail without any difference in complication rates from women who have been provided MAB in person.

36. PPMT has used site-to-site and direct-to-patient MABs to significantly expand access to abortion care in areas where the number of abortion providers is limited. With site-to-site MABs, patients can meet with a provider who is physically located at another site and still be prescribed the medications for the MAB in one visit. And with direct-to-patient MABs, eligible patients can access abortion from the comfort of their own homes.

37. Patients, particularly those in more rural areas of the State, have greatly appreciated the flexibility of telehealth and mailing the medications for the MAB. Patients have been able to access MABs without having to take extended time off from work, school, or other personal responsibilities, saving time and money that would have been spent on travel to and lodging near a health center. The benefit is even greater for those patients who have mobility restrictions or who are otherwise homebound. The use of telehealth and mailing mifepristone and misoprostol have been particularly impactful in Montana, with its large geographic size, large rural population, and few abortion providers. And it has been especially critical during the COVID-19 pandemic.

38. For example, I recently had a patient who was a single mother of multiple children who worked full-time as a teacher. The closest abortion provider to her was a PPMT health center four hours away. The burden on this patient of an in-person abortion would have been significant both personally and professionally: she would have had to sacrifice at least a day—and likely more, given HB 171's mandatory delay and multiple-trip requirements—of work and pay, and cover expenses for childcare, to travel to get an abortion in person, and her students would have been without their teacher. Moreover, requiring the patient to travel in person to an abortion provider during the COVID-19 pandemic would have risked exposing her—and her family and students, in turn—to the potentially life-threatening consequences of COVID-19.

d. Provider Qualifications

39. HB 171 would also likely limit the number of providers able to provide MABs. In order to be a "qualified medical practitioner" who can perform MABs under HB 171, a provider must "be credentialed and competent to handle complications management, including

emergency transfer, or must have a signed contract with an associated medical practitioner who is credentialed to handle complications and must be able to produce the signed contract on demand by the woman or by the department." The law defines "complication" to include a wide range of health conditions, including cardiac arrest, respiratory arrest, shock, coma, depression, suicidal ideation, anxiety, and death—some of which, such as breast cancer, are not risks from MAB, but rather pregnancy itself.

40. PPMT providers are all properly credentialed and trained to provide safe abortions. This includes being trained on recognizing potential health complications that require additional attention or (very rarely) emergency care. Despite our providers' qualifications and demonstrated ability to perform safe abortions and provide necessary follow-up, HB 171's definition of "qualified medical practitioner" is so restrictive that it threatens to further reduce the already scarce population of abortion providers in Montana because our providers may not meet its stringent requirements.

41. Notably, these extensive expectations are not required of other types of providers, including providers of other pregnancy-related care or other reproductive health procedures, like vasectomies. For example, doctors performing vasectomies or colonoscopies are not required to be competent to "handle" death, depression, or comas, or to contract with providers who are. Indeed, it is common sense and standard practice to direct patients to specialists or emergency care if patients develop a health condition that the original treating provider cannot treat. There is no reason to require that MAB providers, and only MAB providers, comply with additional requirements beyond this standard practice. Doing so may lead some providers to stop providing MAB altogether because they are not able to handle the unreasonably broad list of complications included in this law or locate another provider who can handle those complications and who is

willing to enter a contract. Such a result, in turn, will mean that some pregnant women will be unable to get an abortion.

42. Moreover, the provider qualifications listed in HB 171 are practically difficult for providers to comply with. HB 171's requirement that an abortion provider be "credentialed and competent" to "handle" "complications management" is extremely vague. There is no standard credential that makes a provider competent to "handle" death, and the law provides very little guidance. This requires providers to guess at whether they are complying with the law while risking severe criminal penalties.

e. **Public Reporting**

43. Finally, HB 171 § 9 sets up an onerous public reporting system for MAB, asking for information that could ultimately deter women from seeking abortions. The additional reporting requirements imposed by HB 171 are unnecessary, unduly invasive, and vague.

44. PPMT already confidentially reports each abortion it performs to the State, including information on the method of abortion (MAB or procedural) and the gestational age of the fetus. These reports are not publicly available.

45. HB 171's requirement that providers submit identifying information about their patients, including the patients' age, race, and county of residence, are invasive of patients' confidentiality. Indeed, in a state like Montana with many rural areas, this information could identify women who have abortions. The risk of identification alone could be enough to scare women into not having an abortion, even though it is their right to do so.

46. Publicly reporting the identity of abortion providers and referring providers is also problematic. Abortion providers already face stigmatization, harassment, and even physical violence due to their association with abortion. I have personally received threats in the mail,

witnessed picketers protesting in front of the health center where I work, had protestors follow my car and take pictures of me in my car, and been subject to physical threats of violence while working at a health center. I know many abortion providers who want to stay anonymous for fear of harassment or even violence. If their identities become public, as they would under HB 171, abortion providers may become afraid to provide abortions at all.

47. The requirements that providers report on the "complications" associated with MABs or the "preexisting medical conditions" are vague, burdensome, and have no bearing on the ability of providers to ensure the safety of an MAB. The definition of "complications" is extremely broad and ambiguous in that it lists certain *expected* effects of MABs, like heavy bleeding, as well as a host of medical events that may be wholly unconnected to abortion, as "complications" from MAB. It is not clear to me whether I am supposed to report intended (or unrelated) results as "complications" of MABs. The "preexisting medical conditions" reporting requirement is also unclear. It is not clear whether providers are supposed to report common conditions like smoking or obesity, which can impact pregnancy.

48. Similarly unnecessary, burdensome, and potentially impossible to comply with is HB 171's requirement that providers submit detailed reports about the amount that other providers, hospitals, or labs bill to our patients for treatment of complications after MAB. The law requires that PPMT submit this information within 15 days after the end of the "reporting month." Our patients do not always contact their PPMT provider when they have a complication, which, as discussed above, is vaguely defined. Additionally, other providers often do not bill for their care until days or weeks after service is rendered, meaning that it could be weeks (and well after the end of the "reporting month") before PPMT could get a copy of the bill for any care rendered to a PPMT patient by the other provider.

Ultrasound "Offer"

49. HB 140 requires abortion providers to offer women the opportunity to view an "active" ultrasound and "ultrasound image," and to listen to the "fetal heart tone" of the fetus.[2] And worse, it requires providers to make patients sign a State-created form that indicates whether they chose to view or hear fetal activity.

50. PPMT does not offer every patient the opportunity to view an "active ultrasound" and "ultrasound image," and to listen to the "fetal heart tone." Rather, PPMT's providers exercise their medical judgment as to what offers are in the best interest of our patients, based on factors such as whether the patient has a history of trauma, is young, and/or is a victim of rape.

51. I am not aware of any medical justification for *requiring* providers to offer patients the opportunity to view an "active ultrasound" and "ultrasound image," and to listen to the "fetal heart tone," or for recording patients' decisions.

52. Forcing providers to ask patients if they want to view an "active ultrasound" and "ultrasound image," and to listen to the "fetal heart tone," is medically unnecessary and will just stigmatize abortion. Asking patients to sign a State-developed certification form indicating that they chose *not* to view an ultrasound or listen to fetal activity—especially given that the form will likely use stigmatizing language like "unborn child"—may further stigmatize patients with no medical reason and discourage them from seeking abortion care. In my opinion, these offer and signing requirements could make women feel pressured to view or listen to fetal activity, which may not be in the patient's best interest, or discourage them from having an abortion.

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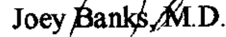
[2] The only exceptions to HB 140's requirements are for abortions performed to: (a) save the life of the woman; (b) ameliorate a serious risk of causing the woman substantial and irreversible impairment of a bodily function; or (c) remove an ectopic pregnancy.

53. Additionally, given that there have been varying literacy rates among the abortion patients I have seen, some women may not understand that they are not *required* to view or listen to fetal activity.

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

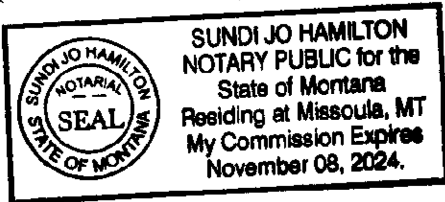
Dated: 8/12/2021



Joey Banks, M.D.

Subscribed and sworn to before me this 12 day of August, 2021.

(NOTARIAL SEAL)



Printed Name: Sundi Jo Hamilton