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**Application for Admission Pro Hac Vice
 Forthcoming*

MONTANA THIRTEENTH JUDICIAL DISTRICT COURT
 YELLOWSTONE COUNTY

<p>PLANNED PARENTHOOD OF MONTANA and JOEY BANKS, M.D., on behalf of themselves and their patients,</p> <p style="text-align: center;">Plaintiffs,</p> <p style="text-align: center;">v.</p> <p>STATE OF MONTANA, by and through AUSTIN KNUDSEN, in his official capacity as Attorney General,</p> <p style="text-align: center;">Defendants.</p>	<p>DV-21-00999</p> <p>Hon. Gregory R. Todd</p> <p>DECLARATION OF GEORGE MULCAIRE-JONES, M.D. IN OPPOSITION TO THE MOTION FOR PRELIMINARY INJUNCTION</p>
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I, George Mulcaire-Jones, declare:

1. I am over the age of eighteen and competent to testify, and I make this declaration based on my personal knowledge.

Professional Qualifications and Experience

2. I am a board-certified family medicine physician who practiced obstetrics, pediatrics and primary care in Butte, Montana from October 1991 till July 20th, 2021. My CV is attached as Exhibit A.

3. In addition to my family medicine residency, I completed an obstetrical fellowship, and my practice over the past 29 years has included management of both low and high-risk pregnancies.

4. On average, I have delivered between 60 and 100 babies a year. My practice includes Cesarean sections, care of miscarriages/fetal demise, external cephalic version, repair of 3rd and 4th degree lacerations and assisted vaginal deliveries with vacuum extraction.

5. I am skilled and experienced in the management of obstetrical emergencies including shoulder dystocia, obstructed labor, fetal distress, and postpartum hemorrhage.

6. I have considerable experience in developing safe birth training programs for midwives, nurses, and physicians in low resource settings in Africa.

7. I have been the physician lead in implementing a perinatal behavioral health and support program (A Healthy 1st Thousand Days of Life) for pregnant

women with substance use and mental health conditions at SCL Health St. James. The 1000 Day model has also been adapted for use at other Montana hospital sites.

8. As part of my family medicine and obstetrical practice, I have provided holistic care for women and families. As part of that holistic care, I have a deep awareness of the social determinants of health and the impact of adverse childhood experiences, mental illness, unemployment, domestic violence, substance use and dysfunctional intimate partner relationships have on the health and well-being of women.

9. As a part of my obstetrical practice, I manage miscarriages (spontaneous abortion), fetal demise, stillbirth, retained products of conception and retained placenta. In so doing, I perform the same procedures as do abortion providers with two exceptions:

a. When I perform a surgical evacuation of the uterus or medical induction of a miscarriage or stillbirth the fetus is already dead or the embryo/fetus never developed (i.e. an anembryonic pregnancy or a molar pregnancy). Thus, I am well-acquainted with techniques, risks and complications inherent with both surgical and medical evacuation of the uterus.

b. I perform dilation and curettage of the uterus and induction of later fetal demise and stillbirths in a hospital setting which is fully equipped and capable of responding to any complications including management of hemorrhage, shock, retained placenta, retained products of conception and any complications related to anesthesia. While the vagina and cervix cannot be made bacteria or pathogen free

by antiseptic preparation or prophylactic antibiotics, a sterile, well lighted operating room and field reduces the risk of complications and also reduces operating time which in turn reduces risk of infection.

10. As a part of my obstetrical care, I have cared for patients who have had hemorrhage, shock and complications of both spontaneous and induced miscarriages as well as women who have had secondary infertility and ectopic pregnancies as a sequelae of pelvic inflammatory disease – including several cases which occurred after an elective abortion.

11. As a part of the standard care for pregnant patients I routinely obtain an ultrasound for dating pregnancies, for insuring there is an intrauterine pregnancy and not an ectopic pregnancy, for managing antepartum bleeding and for screening for fetal anatomy. I also routinely use ultrasound at the time of a dilation and curettage for an incomplete miscarriage to ensure complete removal of the fetus and placenta and insure there are no retained products.

12. As part of my practice I have managed early pregnancy losses with embryonic/fetal demise and/or an anembryonic pregnancy with misoprostol – which is part of the standard medication protocol for chemical termination of pregnancy, While I am inducing a non-viable fetus or an anembryonic pregnancy, an elective chemical abortion is used to terminate a live embryo/fetus. According to ACOG, “A misoprostol-only regimen is an acceptable alternative” for inducing uterine evacuation when mifepristone is not available.¹ Thus, there is little difference

¹ American Academy of Obstetrics and Gynecology, *Medication Abortion Up to 70 Days of Gestation. Practice Bulletin*, ACOG PRACTICE BULLETIN No. 225, 1 (2020), <https://bit.ly/3DRqo7j>.

between regimens used for medical treatment of a miscarriage/fetal demise and termination of a viable pregnancy as is done with chemical abortion. However, neither regimen – misoprostol alone, or misoprostol with mifeprax – is appropriate treatment for ectopic pregnancy.

13. When I care for a patient with a fetal demise I present options of expectant management, medical induction with misoprostol or surgical evacuation with ultrasound guidance. If they meet gestational age requirements for medical induction (which can only be accurately determined by ultrasound), I administer misoprostol in the office if that is their choice. Every patient is counseled about side effects and warning signs inherent in a medically induced miscarriage. Every patient is counseled about my immediate availability to manage any complications and is given both my phone number and if I am not available, the phone number for the obstetrical provider on call. If I know I am not going to be available, I contact the obstetrical provider on-call notifying them of the patient who has had misoprostol administered. Every patient is given instructions to go the Emergency Room if they have heavy bleeding, worsening abdominal or pelvic pain, fever, worsening diarrhea or vomiting or any other symptoms that are concerning for them.

14. Every patient with a medically induced miscarriage has ongoing careful follow up. (The same applies to women who are being followed for expectant management of a fetal demise or women who have had a surgical evacuation for a fetal demise). As a part of this follow up, the patient is called by my nurse the next

day to assess the patient's status and if the miscarriage is completed or not. In cases of continued bleeding or pain, the patient is seen and a repeat ultrasound done to determine if there has been a complete evacuation or not. In cases where there is an incomplete evacuation and ongoing bleeding, I perform a surgical evacuation with suction under ultrasound guidance.

15. Patients are seen again in follow up 1 to 2 weeks after the miscarriage is completed. At that time, we assess the patient's medical and obstetrical/reproductive health status and needs. At that time, patients who have a history of depression, mental illness, substance use, domestic violence and may have compromised housing and living situations are seen not only by myself, but also by a social worker and/or counselor. Frequently patients will be seen at another post-miscarriage visit, especially if there are concerns about depression and/or ongoing grief following the pregnancy loss. At these follow up visits we also address family planning, pre-conception care and in the case of recurrent pregnancy loss, options for further testing and referral.

16. During the course of my career, I have served as a supervising physician and consultant to certified nurse-midwives who have practiced at St. James Health Care in Butte, Montana.

17. I have been a part of a collaborative call group of obstetricians and family medicine physicians with Cesarean-section privileges which provide backup for a nurse midwife as well as call coverage for the nurse midwife.

Safety of Abortion versus Childbirth

18. The National Abortion Federation's 2015 *Clinical Policy Guidelines* term both first and second trimester procedures as "surgical."² Of note, the National Abortion Federations 2020 Clinical Policy Guidelines has changed the term "surgical abortion" to "aspiration abortion," even though the procedure is exactly the same as in 2015. A surgical abortion is a more precise clinical term; the term aspiration abortion is misleading to patients. A 16 week old fetus undergoing a dilation and evacuation is not "aspirated," it is surgically removed with instruments and suction. Notably, the misleading term of "aspiration abortion" was not used in a 2021 study of 1st trimester abortions published in a leading peer-reviewed Ob/Gyn Publication.³

19. Maternal mortality and abortion mortality are subject to both bias and misinterpretation. They cannot be accurately compared because abortion related mortality is subject to a completely different standard whereby accurate statistics in regard to abortions are not reported or analyzed.

20. More than 99% of births in the United States are registered⁴ and 98% of live births occurred in a hospital.⁵ Because birth certificates require maternal

² National Abortion Federation, *2015 Clinical Policy Guidelines*, 18 (2015), <https://bit.ly/3h5YevO>.

³ Naima Hamdaoui, et. al., *Pain Associated with Cervical Priming for First-Trimester Surgical Abortion: A Randomized Controlled Trial*, NATIONAL LIBRARY OF MEDICINE, (2021), <https://pubmed.ncbi.nlm.nih.gov/33957651/>.

⁴ Joyce A. Martin, et. al., *Births: Final Data for 2018*, NATIONAL LIBRARY OF MEDICINE, (2019), <https://pubmed.ncbi.nlm.nih.gov/32501202/>.

⁵ Gregory Lang, et. al., *Out-of-Hospital Birth*, National Library of Medicine (2021), <https://pubmed.ncbi.nlm.nih.gov/34060788/>.

identification, maternal deaths can be linked to live birth data.⁶ This link allows states and public health organizations such as the Center for Disease Control to investigate maternal deaths through maternal mortality review committees. For example, the State of California has put in place an outstanding model for improving obstetrical outcomes and reducing maternal death (California Maternal Health Quality Care Collaborative).⁷ Thus, in California, if a maternal death should occur, it will be reported and tracked, and an institutional or state inquiry into the maternal death will be conducted. In contrast, abortion related statistics do not have to be reported and thus fetal losses through abortion cannot be linked to maternal deaths.

21. The CDC explicitly states the following in regard to the question, “Are states required to report their abortion statistics to CDC?”

No, states and areas voluntarily report data to CDC for inclusion in its annual Abortion Surveillance Report. CDC’s Division of Reproductive Health prepares surveillance reports as data become available. There is no national requirement for data submission or reporting.⁸

Because reporting to CDC is voluntary and reporting requirements vary by the individual reporting areas , CDC is unable to report the total number of abortions performed in the United States.⁹

⁶ National Academies of Sciences, Engineering, and Medicine, *Maternal and Newborn Care in the United States*, (2020), <https://www.ncbi.nlm.nih.gov/books/NBK555484/>.

⁷ Maternal Data Center, <https://www.cmqcc.org/>. (last accessed Sept. 7, 2021).

⁸ Centers for Disease Control and Prevention, *CDCs Abortion Surveillance System FAQs*, https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm. (last accessed Sept. 7, 2021)

⁹ Katherine Kortsmitt, et. al., *Abortion Surveillance – United States, 2018*, National Library of Medicine, (2020), <https://pubmed.ncbi.nlm.nih.gov/33237897/>.

22. Because of the haphazard and “voluntary” nature of abortion reporting, it is not possible to determine the number of abortions, or the number of deaths or injuries caused by abortion. As the CDC notes, “Moreover, even in states that legally require clinicians to submit a report for every abortion they perform, enforcement of this requirement varies.”¹⁰

23. The cause of death in an abortion may be attributed on a death certificate to bleeding or infection and the underlying reason – an abortion complication – is not identified.

24. Abortion is underreported in the United States with less than half of all abortions reported by women in face-to-face interviews.¹¹

25. Women are more likely to report their smoking history than having had an abortion.¹²

26. As many as two out of three women do not return to the abortion clinic for complications or follow up care.¹³

27. Two landmark studies from Denmark and Norway which have complete follow up noted complication rates of 6.1% and 7.2% for abortions.

¹⁰ *Id.*

¹¹ Rachel K. Jones and Kathryn Kost, *Underreporting of Induced and Spontaneous Abortion in the United States: An Analysis of the 2002 National Survey of Family Growth*, National Library of Medicine, (2007), <https://pubmed.ncbi.nlm.nih.gov/17933292/>.

¹² L. B. Smith, et. al., *Underreporting Sensitive Behaviors: The Case of Young Women’s Willingness to Report Abortion*, National Library of Medicine (1999), <https://pubmed.ncbi.nlm.nih.gov/9925044/>.

¹³ Picker Institute, *From the Patient’s Perspective – Quality of Abortion Care*, (1999).

28. In a study of abortion complications in Denmark, 5,851 first trimester surgical abortions were performed. 356 of those abortions (6.1percent) were complicated by one or several of the following complications: pathologic bleeding with or without recurettage; fever; pelvic inflammatory disease (PID) requiring antibiotic therapy; uterine perforation; cervical injury requiring suture; continued pregnancy; and readmission without therapy. According to the researchers, the total complication rate of 6.1percent compares favorably with the results of recent large investigations of abortion population.¹⁴

29. In Norway, "complication rates among all 3,036 patients who had pregnancies terminated by suction techniques, under general anesthesia, at Akershus Central Hospital in Norway between 1977-80 were analyzed. Abortions performed in conjunction with sterilizations were not included in the study. Almost all of the abortions were performed during the 1st trimester. A few early second trimester suction abortions were included. Information for the analysis was obtained from medical records. Registered complication variables included prolonged hospital readmissions, perforations, cervical lacerations, blood transfusions, laparotomies, repeat curettages, temperature rises of 100.4 degrees

¹⁴ L. Heisterberg and M. Kringelbach, *Early Complications After Induced First-Trimester Abortion*, NATIONAL LIBRARY OF MEDICINE, (1987), <https://pubmed.ncbi.nlm.nih.gov/3661126/>.

Fahrenheit or more, antibiotic treatments, and infections with or without a palpable pelvic mass. . . Complications were registered for 7.1 percent of the patients.”¹⁵

30. Complications are generally cared for in the emergency room or through a woman’s primary care physician. These complications are generally not reported or considered by abortion providers.

31. Merriam Webster’s dictionary defines the word “safe” as “not able or likely to be hurt or harmed in any way: not in danger.”¹⁶

32. The claim that abortion is “safer” than childbirth is a deliberate deception. It rests on a false and misleading understanding of the meaning of “safety.”

33. With a surgical abortion, a woman is generally administered conscious sedation or a general anesthesia. If she is given conscious sedation, she is often also given a paracervical block with local anesthetic, which in itself carries a risk of anaphylaxis and death.

34. A woman’s cervix is then forcibly dilated and a series of instruments inserted into the cavity of the uterus to evacuate the “products of conception,” *i.e.*, the developing fetus and placenta.

35. Prior to the procedure, the developing fetus and placenta are protected from bacterial contamination by the surrounding amnion and chorion. Unlike the

¹⁵ B. I. Nesheim, *Induced Abortion by the Suction Method: An Analysis of Complication Rates*, NATIONAL LIBRARY OF MEDICINE, (1984), <https://pubmed.ncbi.nlm.nih.gov/6516807/>.

¹⁶ <https://www.merriam-webster.com/dictionary/safe> (last accessed Sept. 7, 2021)

interior of the uterine cavity, both the cervix itself and the surrounding vaginal tissue and perineum normally harbor bacteria and other microorganisms.

36. To perform a standard surgical abortion, the abortionist must necessarily pass the dilators, the curettes and in case of later second term abortions, large forceps through the cervix and into the uterine cavity.

37. The abortionist then removes the fetal parts and tissues as well as the placenta and reenters the uterine cavity with a different instrument.

38. Sterile precautions and antibiotics cannot completely eliminate the presence of bacteria and thus it is unavoidable that in passing surgical instruments including dilators, forceps and suction catheters from the vagina through the cervix and into the uterus, the uterine cavity can be contaminated. From this contamination, an infection can develop and ascend through the uterine cavity into the fallopian tubes and surrounding tissue.

39. When a woman develops an infection after an abortion, it is often post-abortal pelvic inflammatory disease (PID).

40. Following an episode of PID, women have a 20 percent chance of developing infertility from tubal scarring, a 9 percent chance of having an ectopic pregnancy, and an 18 percent chance of developing chronic pelvic pain.^{17 18}

¹⁷ Catherine L. Haggerty, et. al., *Risk of Sequelae after Chlamydia Trachomatis Genital Infection in Women*, NATIONAL LIBRARY OF MEDICINE, (2010), <https://pubmed.ncbi.nlm.nih.gov/20470050/>

¹⁸ Sami L. Gottlieb, *Screening and Treatment to Prevent Sequelae in Women with Chlamydia Trachomatis Genital Infection: How Much Do We Know?*, National Library of Medicine, (2010), <https://pubmed.ncbi.nlm.nih.gov/20470051/>.

41. In addition to the risks related to infection, a woman undergoing abortion also faces risks related to hemorrhage.

42. During pregnancy, maternal blood volume increases progressively from 6–8 weeks of gestation and reaches a maximum approximately at 32–34 weeks. At maximum flow, maternal blood volume is 600 to 700 ml/minute, which represents 10 to 15 percent of the total maternal blood volume.

43. With a surgical abortion, the instrumentation of the uterus can lead to hemorrhage in one of three ways.

44. The instruments themselves may lacerate or perforate the uterus. This can lead to unintended surgery, bowel injury and hysterectomy.¹⁹

45. The fetus and placental tissues may not be completely removed and therefore the uterus cannot fully contract and will continue to bleed.

46. In later second term abortions done by a D and E technique (Dilation and Extraction), the long bones of the fetus can lacerate the uterus.

47. The potential for complications arise by the very nature of the abortion procedure. The hemorrhage may occur during or immediately after the abortion. Or the hemorrhage may be delayed and not occur for hours or even several days after the surgical termination of pregnancy.

¹⁹ P.D. Damey, et. al., *Uterine Perforation During Second-Trimester Abortion by Cervical Dilation and Instrumental Extraction: A Review of 15 Cases*, NATIONAL LIBRARY OF MEDICINE, (1990), <https://pubmed.ncbi.nlm.nih.gov/2304715/>.

48. I have seen patients who have secondary tubal-related infertility following post-abortion pelvic inflammatory disease.

49. This is not a “minor” complication. For a woman this is a major life-long complication that affects her physically, sexually and psychologically. See ¶ 39-40 above.

50. There are absolutely no long-term health benefits conferred by abortion.

51. In contrast, there are multiple health benefits of pregnancy carried to term in reducing the risk of breast, ovarian and endometrial cancer.

52. According to the National Cancer Institute,²⁰ pregnancy and breast feeding have direct effects on breast cells, causing them to differentiate in order to produce milk. These differentiated cells are more likely to be resistant to transforming into cancer cells.

53. By way of illustration, in women who have a first full term pregnancy before the age of 20, the risk of developing breast cancer is about half of that of women whose full-term pregnancy occurs after the age of 30.

54. Women who have had a full-term pregnancy also have reduced risks of endometrial cancer.²¹

²⁰NATIONAL CANCER INSTITUTE, <http://www.cancer.gov/about-cancer/causes-prevention/risk/hormones/reproductive-history-fact-sheet> (last visited Sept. 2, 2021).

²¹B. E. Henderson, et. al., *The Epidemiology of Endometrial Cancer in Young Women*, NATIONAL CENTER FOR BIOTECHNOLOGY INFORMATION, (1983), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2011352/>.

55. Ovarian cancer is also influenced by reproductive events. According to a 2015 study,²² “For ovarian cancer overall, women with one child had about a 20 per cent reduction in risk compared to women without children, and about a 40 percent reduction of endometrioid and clear cell tumors. Each additional birth then offered an estimated seven per cent reduction in the overall risk of ovarian cancer.”²³

56. A pregnancy that results in the delivery of a live fetus also allows a mother to breast feed – which offers further protection against breast cancer.

57. All of these benefits of carrying a child and multiple children to term are lost by abortion.

58. Abortion has absolutely no protective health benefits.

59. The data clearly demonstrates what is natural – to carry a baby to term – confers significant health benefits to women. The converse, to forcibly interrupt a normal, healthy pregnancy with either a surgical or medical abortion, negates these health benefits as well as exposing women to the risks and complications of induced abortion.

²² Cancer Research UK, *Different Types of Ovarian Cancer have Different Causes*, (2015), <https://bit.ly/3hbelzP>.

²³ Kezia Galtskell, et. al., *Childbearing Patterns and Ovarian Cancer in the Million Women Study: Variation by Histological Subtype*, NATIONAL CANCER RESEARCH INSTITUTE (2015), <https://bit.ly/3tp67Bd>.

20-Week Regulation

60. The world's most premature baby to survive was born at 21-weeks in Minneapolis. That baby recently turned one year old.²⁴

61. The most common fetal medical conditions are chromosomal aneuploidies (Trisomy 13, 18, and 21) which can now be detected by Non-Invasive Prenatal Screening (NIPS) using cell fetal DNA analysis at a much earlier gestational age. NIPS testing is typically offered at 9 to 12 weeks gestation and has a sensitivity rate of 98 to 99%. The American Academy of Obstetrics and Gynecology specifically notes the following in regard to fetal chromosomal aneuploidies: "Although chromosomal abnormalities occur in approximately 1 in 150 live births (1), the prevalence of chromosomal abnormalities is greater earlier in gestation because aneuploidy accounts for a large proportion of early pregnancy loss. Trisomy 21 (Down syndrome) is the most common autosomal chromosomal aneuploidy in liveborn infants, with a prevalence of approximately 1 in 700 live births. Trisomy 18 (Edward syndrome) is the second most common autosomal trisomy at the time of birth, with a prevalence of about 1 in 3,000 live births (2–4). The prevalence of trisomy 13 (Patau syndrome) at birth is approximately 1 in 6,000. The most common sex chromosome aneuploidy is 47, XXY (Klinefelter syndrome)

²⁴ Alana Elassar, *The World's Most Premature Baby has Celebrated His First Birthday After Beating 0% Odds of Surviving*, CNN (2021), <https://cnn.it/3jOCCW0>.

with a prevalence of 1 in 500 males. The only viable monosomy is 45, X (Turner syndrome), in which the birth prevalence is approximately 1 in 2,500.²⁵

62. Late term abortions have more risks and complications. “Compared with women whose abortions were performed at or before 8 weeks of gestation, women whose abortions were performed in the second trimester were significantly more likely to die of abortion-related causes. The relative risk of abortion-related mortality was 14.7 at 13-15 weeks of gestation 29.5 at 16-20 weeks and 76.6 at or after 21 weeks.”²⁶ It is safer for a woman to carry a fetus with a lethal anomaly than to have a 20-week induced abortion.

63. The term “serious risk” as defined by HB 136 can be reasonably applied and understood by both medical providers and patients. “Serious risk” as presented in HB 136 considers mortality (“averting the mother’s death”) as well as morbidity (compromises the mother’s medical condition as to lead to “serious risk of substantial and irreversible physical impairment of a major bodily function.”) “Serious risk” is a clear term that is used ubiquitously in the practice of medicine including in informed consent.

64. HB 136 provides guidelines that in the circumstance where an unborn child after 20 weeks is to be aborted, it is done so in a way that allows for a child at the margins of viability an opportunity to survive. At the same time, the guidelines

²⁵ ACOG, *Screening for Fetal Chromosomal Abnormalities: ACOG Practice Bulletin, No. 226*, National Library of Medicine, (2020), <https://pubmed.ncbi.nlm.nih.gov/32804883/>.

²⁶ Linda A. Bartlett, et. al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, National Library of Medicine, (2004), <https://pubmed.ncbi.nlm.nih.gov/15051566/>.

indicate that an abortion deemed safer and posing less risk to the mother takes precedence over the survival opportunity of the baby. In practical terms, reasonable medical judgement would be used for risk stratification for the mother considering whether the abortion should be performed surgically (dilation and evacuation/surgical abortion) or medication induced abortion. In the former the baby would have no chance of survival; in the latter there would be the possibility of survival if the child was born alive.

65. In Montana, as in many rural states, the majority of low-density counties do not have specialty clinics in which every type of procedure is available.

66. To have to travel to have an abortion in a safe setting where standard of care measures are more likely to be met is no different than a patient who must travel for any other type of elective surgery, which would require post-operative care and monitoring.

67. In rural states such as Montana, “Fewer than 50% of rural women have access to perinatal services within a 30-mile drive from their home and more than 10% of rural women drive 100 miles or more for these services”.²⁷

Chemical Abortion

68. I have seen many patients change their mind before a scheduled abortion and choose to continue their pregnancy. The majority of these women who decided to not terminate their pregnancy went on to deliver and parent their child.

²⁷ Centers for Medicare and Medicaid, *Improving Access to Maternal Health Care in Rural Communities*, (2019), <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/rural-maternal-health>.

Other patients have chosen to adopt. As well, I have seen many patients with an unanticipated pregnancy see their pregnancy as a turning point in which they better care for themselves as a mother-to-be. In this context, they have stopped substance use, adhered to chemical dependency treatment, pursued counseling, eliminated unhealthy lifestyle choices and often reconciled primary relationships in their lives. For them, the pregnancy – though initially unwanted – has become a new beginning in their lives.

69. Other elective procedures, such as circumcision, are sometimes discussed before delivery, giving parents time to discuss, ask questions, and assess risks and benefits of the procedure.

70. The same goes for other procedures like vasectomies, colonoscopies, or elective plastic surgery. These procedures are scheduled in advance, giving patients time to discuss and ask questions.

71. Neither a colonoscopy nor a vasectomy involve the direct violation – surgically or chemically – of an organ (the uterus) that contains a fetus and is engorged with blood.²⁸

72. It is absolutely crucial to assess gestational age via ultrasound in order to manage and care for complications in early pregnancy. An evidence-based expert commentary on the role of ultrasound notes: “Pelvic ultrasonography (US) and testing of the beta subunit of human chorionic gonadotropin (β -hCG) serum levels

²⁸ Kyle K. Jensen, et. al., *Imaging of Acute Pelvic Pain: Pregnant (Ectopic and First-Trimester Viability Updated)*, RADIOLOGIC CLINICS OF NORTH AMERICA, VOL. 58, ISSUE 2 (2020), <https://bit.ly/3yKuAC8>.

are key to diagnosis of early pregnancy and guide management of its associated complications. These tests allow distinction among the diagnostic possibilities of early pregnancy—intrauterine pregnancy (IUP) versus ectopic pregnancy, viable versus nonviable IUP, IUP of uncertain viability, and pregnancy of unknown location—and have contributed to the marked decline in mortality from ectopic pregnancy since the 1980s.”²⁹

73. Ectopic pregnancy accounts for 6% of maternal deaths and with higher rates of mortality and morbidity in African American women.³⁰

74. I only prescribe medication treatment for a fetal demise if a woman has had an ultrasound clearly demonstrating a non-viable fetus within an intrauterine gestational sac or an “empty” gestational sac and no ultrasonographic signs of an ectopic pregnancy. In cases of very early pregnancy where ultrasound cannot fully rule out an ectopic pregnancy or establish viability of the pregnancy, I also utilize serum hCG levels. If there is a fetal demise, I consider the crown lump length and gestational age of the pregnancy to ensure that medication management is appropriate.

²⁹ Shuchi K. Rodgers, et. al., *Normal and Abnormal US Findings in Early First-Trimester Pregnancy: Review of the Society of Radiologists in Ultrasound 2012 Consensus Panel Recommendations*, NATIONAL LIBRARY OF MEDICINE, (2015), <https://pubmed.ncbi.nlm.nih.gov/26562242/>.

³⁰ Erin Hendriks, et. al., *First Trimester Bleeding: Evaluation and Management*, AMERICAN FAMILY PHYSICIAN, (2019), <https://www.aafp.org/afp/2019/0201/p166.html/>.

75. Complications occur up to 10-15 percent of the time after medically induced miscarriage. Performing an ultrasound before medically inducing miscarriage allows for appropriate follow up care.

76. It is false to claim that the regimens used for chemical abortions are the same as for ectopic pregnancy and thus it is of no concern that a woman could have an ectopic pregnancy. In fact, "Mifepristone and misoprostol do not treat ectopic pregnancy and use of the medications may delay diagnosis and treatment of this life-threatening condition."³¹

77. The standard of care for treatment of diagnosed ectopic pregnancy includes medical management with intramuscular methotrexate, surgical management via salpingostomy or salpingectomy, and, in rare cases, expectant management.³²

78. While no doctor can be credentialed to handle all complications, doctors should be credentialed to handle the complications that are relevant to their scope of practice.

79. HB 136's mandate that chemical abortion providers be able to handle "Complications management" reasonably requires the provider to treat or refer for treatment of complications arising while the drug is terminating the pregnancy and immediately afterward.

³¹ *Quality of evidence: High. Clinical Updates in Reproductive Health*, IPAS, (2021). <https://bit.ly/3ttaj36>.

³² Erin Hendriks, et. al., *Ectopic Pregnancy: Diagnosis and Management*, NATIONAL LIBRARY OF MEDICINE, (2020), <https://pubmed.ncbi.nlm.nih.gov/32412215/>.

80. It is reasonable and common to require the provider be credentialed and competent to handle those complications that are common from the intervention (provision of chemical abortion) as detailed in the prescribing information of the medication and the experience of its use. In chemical abortion this would include the following:

- a. Heavy bleeding consistent with incomplete abortion including credentialing to complete surgical evacuation of an incomplete abortion
- b. Recognition and medical management of unsuspected ectopic pregnancy (with or without rupture)
- c. Post-abortal infection including sepsis and pelvic inflammatory disease
- d. Allergic reaction to the medication
- e. Management of hypovolemic volume depletion from vomiting and diarrhea from medication

81. Chemical abortion providers should be credentialed to handle common abortion complications, just as an ob-gyn should be credentialed to handle childbirth complications.

82. The standard of care for physicians is that the treating physician or operating surgeon/proceduralist should be available for consultation, admission, and further care if a patient goes to the hospital with complications.

83. In order to uphold the standard of care, physicians should be credentialed and available to complete care at a nearby hospital.

84. Tele-abortions severely undercut the standard of care.

85. Without an in-person consultation, it can be difficult to properly assess the patient – to know the circumstances of conception, to know the patient’s support system, and, most importantly, to know the gestational age for certain.

Furthermore without an in-person consultation, sexually transmitted diseases are not screened for – including Chlamydia, Gonorrhea and emerging infections such as *Mycoplasma genitalium*. *Mycoplasma genitalium* has been associated with post-abortal pelvic inflammatory disease.³³ A prospective study for women presenting for abortion care found 8.7% of women had *Mycoplasma genitalium*.³⁴

86. A recent comprehensive study of medical abortions from Sweden found that self-administered chemical, at-home abortions are associated with an increase rate of complications.:

The rate of complications associated with medical abortions < 12 weeks has increased from 4.2% in 2008 to 8.2% in 2015. The cause of this is unknown but it may be associated with a shift from hospital to home medical abortions.³⁵

Studies such as this from Scandanavian countries are more likely to reflect the true incidence of complications as they are done within a universal health care system which has a much more reliable data base, inclusive of comprehensive patient assessment, treatment and follow-up.

³³ C. Bjartling, *The Association Between Mycoplasma Genitalium and Pelvic Inflammatory Disease After Termination of Pregnancy*, NATIONAL LIBRARY OF MEDICINE, (2009), <https://pubmed.ncbi.nlm.nih.gov/20015303/>.

³⁴ Beverley A. Lawton, *High Prevalence of Mycoplasma Genitalium in Women Presenting for Termination of Pregnancy*, NATIONAL LIBRARY OF MEDICINE, (2008), <https://pubmed.ncbi.nlm.nih.gov/18342654/>.

³⁵ Isabelle Carlsson, et. al., *Complications Related to Induced Abortion: A Combined Retrospective and Longitudinal Follow-up Study*, BMC WOMEN’S HEALTH, (2018), <https://bmcmwomenshealth.biomedcentral.com/articles/10.1186/s12905-018-0645-6>.

87. The standard of care in modern medicine requires adequate follow-up for a medical or procedural intervention. Follow-up is necessary to ensure patient safety and well-being, to provide patient education and to provide any further medical treatment. There should not be an exception for certain classes of procedures like chemical abortion which has the potential for both short and long-term side effects (from excessive bleeding to pelvic inflammatory disease). Office-based practices have in place protocols for follow up that are reasonable and understood by both staff and patients. By way of example, postpartum women are routinely seen in follow-up for care at 1 to 2 weeks (along with their newborn) and again at 6 to 8 weeks. They are seen sooner and more frequently if there are complications or concerns about postpartum depression or other medical or mental health concerns. If they do not show up for an appointment, then they are contacted by staff and inquiries made as to reasons for not following up or barriers they may have to accessing follow-up care. As part of their postpartum care, they receive information and make decisions on family planning. All visits for postpartum care are documented in the patient's medical records. This level of follow up is expected and indicated and an integral part of women's reproductive health. The same reasonable level of follow up should be provided and documented for pregnancy termination.

88. It is dangerous to chemically induce an abortion in a woman who lives a significant distance from a hospital, especially without knowing if she has the support to get to the hospital if she experiences complications.

Ultrasound

89. Informed consent is part of the standard care for patients.

90. According to the Joint Commission, informed consent is an “Agreement or permission accompanied by full notice about the care, treatment, or service that is the subject of content. A patient must be apprised by of the nature, risks and alternatives of a medical procedure or treatment before the physician or other health care professional begins any such course. After receiving the information, the patient then either consents to or refuses a procedure or treatment.”³⁶

91. In the case of informed consent for a woman choosing between continuing or terminating the pregnancy, informed consent should involve a detailed and unbiased explanation of the two choices.

92. Any medicine or procedure has a broad list of complications that patients should be aware of.

93. In many procedures an image is shared with a patient to help them understand what is going on in their body. For example, a CT scan showing the extent of a cancer or an X-ray showing pneumonia.

94. Offering a woman an ultrasound is integral to patient safety and providing informed consent.

95. Ultrasounds provide doctors with essential information – gestational age, whether the pregnancy is ectopic, if there is placenta previa, among others.

³⁶Crossroads Hospice and Palliative Care, *Keep Patients Informed: What is True Consent*, (2018), <https://www.crossroadshospice.com/hospice-palliative-care-blog/2018/may/23/keep-patients-informed-what-is-true-informed-consent/>.

96. The only way to reliably identify and manage an ectopic pregnancy is through an ultrasound, either by itself or in combination with serum hCG hormone measurements.

97. Symptom based screening for ectopic pregnancy is not sufficient in the context of a tele-medicine visit or reliance on a clinical examination without an ultrasound. Symptoms of an ectopic pregnancy may well be the same as symptoms caused by a chemically induced abortion – vaginal bleeding and abdominal pain. These symptoms overlap with those of spontaneous abortion. By way of example, a prospective, consecutive case series found no statistically significant differences in the presenting symptoms of patients with unruptured ectopic pregnancies versus those with intrauterine pregnancies.³⁷ According to expert recommendations, “Women with abdominal pain or vaginal bleeding during early pregnancy may have an ectopic pregnancy. This systematic review of the literature and meta-analysis confirms that the patient history and clinical examination alone are insufficient to indicate or eliminate the possibility of ectopic pregnancy.”³⁸

98. In my judgement, it is malpractice not to perform an ultrasound before prescribing an abortion inducing drug, thereby willfully ignoring the gestational age of the pregnancy and failing to ensure there is not the possibility of an ectopic pregnancy. Providing an early ultrasound for pregnancy dating and ensuring an

³⁷*Ectopic Pregnancy*, MEDSCAPE, (2017), <https://emedicine.medscape.com/article/2041923-clinical>.

³⁸ John R. Crochet, et. al., *Does This Woman Have an Ectopic Pregnancy?: The Rational Clinical Examination Systemic Review*, NATIONAL LIBRARY OF MEDICINE, (2013), <https://pubmed.ncbi.nlm.nih.gov/23613077/>.

intrauterine pregnancy is essential for protecting the health of women, regardless of their choice to continue or terminate the pregnancy.

I submit this declaration pursuant to Mont. Code Ann. §§ 1-6-105 and 27-19-303, which together permit parties to present declarations for the court to consider at a preliminary injunction hearing. I hereby declare under penalty of perjury under the laws of the United States of America and the State of Montana that the foregoing is true and correct.

Dated: September 6, 2021

George Mulcaire-Jones, M.D.
George Mulcaire-Jones, M.D.

CERTIFICATE OF SERVICE

I certify a true and correct copy of the foregoing was delivered by

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ROCHELL STANDISH

EXHIBIT A

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PERSONAL

Spouse: Mary

Children: Mark, Megan, Katherine, John, Matthew, Liam

EDUCATION

1971-74: Helena High School, Helena, Montana.

1974-77: Biology Major, Carroll College, Helena, Montana.

1977-1981: University of Washington School of Medicine, Seattle, Washington

1981-1982: Flexible Internship, Deaconess Hospital, Spokane, Washington

1982-1984: Family Practice Residency, University of Minnesota Affiliated Hospitals, St. Paul, Minnesota

1989-1990: Obstetric Fellowship, Family Medicine Spokane, Deaconess and Sacred Heart Hospitals, Spokane, Washington

PROFESSIONAL EXPERIENCE

Employment

1985-1987: General Medical, Surgical and Obstetrical Practice, Shisong Hospital, Cameroon, West Africa, through Mission Doctors Association, Los Angeles, CA

1987-1988: Emergency Room Physician, Spectrum Emergency Services, Tulare, California

1988-1989: Family Practice and Obstetrics, Obstetrics Coordinator: Highpoint Clinic, West Seattle Housing Project, Puget Sound Neighborhood Health Centers, Seattle, Washington

1990-1991: Family Practice and Obstetrics: Providence Factoria, Seattle, Washington.

1991- 2010 Family Practice and Obstetrics, Rocky Mountain Clinic, Butte, Montana

2010 – 2014: Family Practice and Obstetrics, Community Health Center, Butte, Montana

2014- 2021: Family Practice and Obstetrics, St. James Health Care/Rocky Mountain Clinic, Butte, Montana

1997-present: President and Medical Director, Maternal Life International

Hospital and Community Affiliations

St. James Health Care, Member Integrated Strategic Leadership Team, 2012 to 2021

Maternal/Newborn Council Head, 2012 to 2021

Chair and founder of D.J. Memorial Ethics Conference, 2014, St. James Health Care

Founder of Butte Community Fitness Foundation and Snoflinga Winter Festival, Butte, Montana, 2015 to present

Lead Physician, Meadow Lark Initiative and 1st 1000 Days of Life Perinatal Program at SCL St. James, 2017 to 2021

2021 Physician consultant to Montana Perinatal Quality Collaborative and M.O.M.S program for development of Obstetrical Care Bundles

International Health Care Development and Training

1985-1987: General Medical, Surgical and Obstetrical Practice, St Elizabeth's Hospital, Shisong, Cameroon

1985- 1987: Training Nurses, Nurse-Midwives at Shisong Nursing and Midwifery School, Cameroon

1985- 1987: Developed training program for compound and consulting nurses; assisted in primary health care program training for village health care workers, Cameroon

1997 -1999: Developed bead system of fertility awareness with pilot training in Cameroon, Ghana and Mexico. Patent issued for bead system by National Patent Office, Washington, D.C. September 2009

2000- 2001: Developed parish nurse model for community based HIV Prevention and Care in Africa; piloted first ever parish nurse program in Africa, Swaziland.

2001-2002: Developed "Circles of Life" Program for Integration of AIDS Prevention with Fertility Awareness, piloted programs in Cameroon, Malawi, and Uganda.

2003: Started Maternal Life Uganda. Program has continued to be funded for thirteen years and has a staff of five

2003: Developed "Safe Passages: Emergency Obstetrical Care in A Time of AIDS" maternal health care training model. Piloted Safe Passages Training in collaboration with Catholic Medical Mission Board at two sites in Nigeria, August, 2003.

2003: Expanded Parish Nurse training to eight Christian denominations; developed training workshop for parish nurses and home-based providers, presented training workshop, Swaziland.

2003 –2007: Writing and Publication of quarterly "Safe Passages Bulletin" for obstetrical providers in Nigeria in collaboration with Catholic Secretariat of Nigeria

2005- present: Developed "The Faithful House" HIV Risk Avoidance Program in collaboration with Catholic Relief Services. Program operative in multiple countries in Africa.

2006: Developed South African Parish Nurse Training Manual and introduced parish nurse program in Mbupalongo and Kwa-Zulu-Natal provinces in collaboration with CATHCA (Catholic Health Care Association of South Africa)

2007: Developed, in collaboration with National Center for Health Care Informatics, AFMED (African Family Medicine Education and Development Initiative) with pilots in Jos, Nigeria (2008) and Sierra Leone (2009)

2008: Developed training manual for CRS Faithful House program for HIV Risk Avoidance for PMTCT programs

2008-2009: Adapted and introduced *The Faithful House* program and Bead System of Fertility Literacy in Haiti in collaboration with CRUDEM foundation and Archdiocese of Boston NFP office

2009: Developed training manual for Faithful House "Training of Facilitators" with multi-country training Kampala, Uganda.

2011: Developed Faithful House adaptation for couples living with HIV and for PMTCT (Prevention of Mother to Child Transmission)

2012: Began conception and design work for mobile surgical unit for Cesarean-sections in collaboration with Montana Tech University Engineering Department. Unit constructed out of 40 foot shipping container and prototype built and is now being equipped.

2012: Consultant and trainer for Catholic Relief Services for development of Faithful House adaptations for fertility education, PMTCT, Couples living with HIV. Presented training workshop for CRS program coordinators from multiple countries, Arusha, Tanzania, October 2012.

2013: Started Maternal Life Haiti affiliate with continued operations and a staff of three to present.

2014: Started Maternal Life Tanzania affiliate with continued operations and a staff of two to present.

2012-2015: Supported development of training model for Natural Family Planning for use in Somalia and adaptations of programs for Muslim beneficiaries.

2013 -2015: Revised bead method of natural family planning in collaboration with Dr. Richard Fehring (Published May 2016 as *Couple Beads: An integrated method of natural family planning*. Mulcaire-Jones, G., Fehring R., Bradshaw M., Brower K., Lubega G., Lubega P. The Linacre Quarterly 83 (1) 2016, 69-82.

2015 to present: Development and piloting of "The Journey of a Thousand Days" in Uganda and Kenya.

2016: Developed and piloted training programs for post-partum hemorrhage and infant resuscitation in collaboration with Uganda Catholic Medical Bureau. (August 2016 with pilots in Masaka and Kabuli)

2018 to present: Expanded Family Life Programs to sites and teams in Rwanda and Kenya. Ongoing program development and training in Haiti, Uganda, Kenya, Nigeria, Tanzania and Rwanda

Professional Affiliations

American Academy of Family Practice

Montana Medical Association

Mission Doctors Association, Los Angeles, California

Catholic Medical Association

American Academy of Pro-Life Obstetricians and Gynecologists (AAPLOG)

Board Certification

American Board of Family Medicine: Recertified as of November 8, 2013

PUBLICATIONS:

Safe Passages: Emergency Obstetrical Care in a Time of AIDS, A Training Manual for African Obstetrical Providers, Maternal Life International. 2003.

A New Robe: Parish Nursing in AIDS Prevention and Care, A Training Manual for Nurses in Swaziland and South Africa, Maternal Life International, 2001 and 2006.

Circles of Life: Integrating HIV Risk Avoidance and Fertility Literacy. Maternal Life International. Nujbass Press. Lagos, Nigeria, 2005.

The Faithful House: Affirming Life and Avoiding Risk; Catholic Relief Services, USAID, 2006.

The Faithful House PMTCT Training Manual; CRS, 2008

The Faithful House Training of Facilitators Manual, CRS, 2009.

The Faithful House CALL manual (Couples Affirming Live and Love) CRS 2010

Windows to Ordinary Souls: A Poetic Reflection on the Spiritual Journey, 1997.

The Bead System of Fertility Awareness, Maternal Life International, 2009.

Apparatus and Method of Fertility Awareness, US Patent Office Number 7,588,544 B2, Date of Issue September 15, 2009.

Couple Beads: An integrated method of natural family planning. Mulcaire-Jones, G., Fehring R., Bradshaw M., Brower K., Lubega G., Lubega P. The Linacre Quarterly 83 (1) 2016, 69-82.

Safe Passages, A Pro-Life Response to the Tragedy of Maternal Deaths. Mulcaire-Jones G., Scanlon R., The Linacre Quarterly 78 (2) (May 2011) : 202-210

AWARDS AND RECOGNITIONS

Carroll College Charles Borromeo Humanitarian Award, 2000

St. James Health Care Community Advocacy Award, 2001

1995 Advocate of the Year, State Award for Excellence, Montana Advanced Practice Registered Nurses Association

Finalist, Family Physician of the Year 2005, American Academy of Family Practice

Dr. George Saari Humanitarian Award, University of Washington Medical School, WWAMI Program, September 2007