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**Application for Admission Pro Hac Vice Forthcoming*

MONTANA THIRTEENTH JUDICIAL DISTRICT COURT
YELLOWSTONE COUNTY

PLANNED PARENTHOOD OF MONTANA and JOEY BANKS, M.D., on behalf of themselves and their patients, Plaintiffs, v. STATE OF MONTANA, by and through AUSTIN KNUDSEN, in his official capacity as Attorney General, Defendants.	DV-21-00999 Hon. Gregory R. Todd **DECLARATION OF INGRID SKOP, M.D. IN OPPOSITION TO THE MOTION FOR PRELIMINARY INJUNCTION**

I, Ingrid Skop, declare:

1. I am at least 18 years of age and am competent to testify. I have personal knowledge of the statements contained in this declaration.

Basis for my opinions:

2. I have been asked by the Defendants in this matter to offer my professional opinion regarding the medical implications of the Montana statutes challenged in this matter. I have reviewed Plaintiffs' Complaint and the affidavits of Plaintiffs' experts. The opinions I express herein are based upon my medical education, training, research, and over 25 years of clinical experience as an obstetrician and gynecologist, as well as my familiarity with the medical literature. These opinions are my own and do not represent those of the institutions with which I am affiliated.

Professional background and experience:

3. I have been a board-certified obstetrician and gynecologist since 1998. I received a Bachelor of Science in physiology from Oklahoma State University, and a Doctorate of Medicine from Washington University School of Medicine. I completed a residency in obstetrics and gynecology at the University of Texas Health Science Center at San Antonio.

4. I am in a group practice in San Antonio where I have practiced Obstetrics and Gynecology since 1996. In my clinical work as an obstetrician/gynecologist, I have delivered over five thousand babies, including many at the threshold of viability. I have also evaluated and treated thousands of women who have had

abortions, and many women who have carried unplanned pregnancies to term. This clinical experience, as well as familiarity with the relevant research literature, informs my opinions herein regarding the physical and psychological effects of the experiences of abortion and of carrying unwanted or unintended pregnancies to term.

5. For a complete listing of my professional background, experience, research, responsibilities, and publications, please see my Curriculum Vitae, which is attached to this declaration as Exhibit A.

Summary of opinions:

6. In my professional opinion, the Montana requirements for abortion including, among other elements, (1) prohibiting abortion after 20 weeks gestational age (with exceptions for life and health of the mother), (2) regulating medical abortion provision as recommended by the FDA's Risk Evaluation and Mitigation Strategy enforced until 2016, (3) offering a pregnant woman considering abortion an opportunity to view her unborn child on ultrasound or listen to the heart tones; are medically appropriate and justified. These regulations enhance rather than detract from the safety of abortion, without unduly impeding access to available procedures or introducing unnecessary risks.

7. The Plaintiffs and their expert witnesses are incorrect in their assessment of these laws as they relate to access to medical or surgical abortion. They overestimate the safety of abortion due to known limitations in data collection and underestimate the potential for severe pain to an unborn member of the human

species. By doing so, they risk the health of women, and violate the rights of humans not yet born.

Regarding HB 136, Montana Pain-Capable Unborn Child Protection Act limiting abortion if gestational age > 20 weeks post LMP:

8. Any abortion can result in complications, particularly if performed by a poorly skilled or compromised abortionist. Misdirection of cervical dilators or accidental insertion of suction curettes or grasping forceps into the soft, gravid uterine wall may cause injury to adjacent major blood vessels and/or gynecologic, genitourinary or gastrointestinal organs, which may require emergency abdominal surgical exploration to perform a hysterectomy, bowel resection, bladder repair, or other repairs.[1] Maternal death can occur due to hemorrhage, sepsis, thrombotic emboli, intravascular amniotic or air emboli, complications of anesthesia and cardiac or cerebrovascular events.[2]

9. The American College of Obstetricians and Gynecologists reports the risks of hemorrhage and cervical laceration from abortion are 3.3%, retained products of conception, 1% for surgical abortion, and 8% for medical abortion, 0.2% serious infection and 0.5% uterine perforation, and 0.28% uterine rupture if the patient had

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[1] Niinimaki M, Pouta A, Bloigu A, Gissler M, Hemminki E, Suhonen S, Heinkinheimo O. 2009. Immediate complications after medical compared with surgical termination of pregnancy. Obstet Gynecol. 114:795–804. Available from: doi: 10.1097/AOG.0b013e3181b5ccf9; Autry A, Hayes E, Jacobson G, Kirby R. 2002. A comparison of medical induction and dilation and evacuation for second-trimester abortion. Am J Obstet Gyn 187:393–397.

[2] Cunningham F, Mac-Donald P, Gant N, Leveno K, Gilstrap L. Williams Obstetrics. 19th edition. Norwalk, CT: Appleton & Lange; 1993. 81–246; Lalitkumar S, Bygdeman M, Gemzell-Danielsson K. 2007. Mid-trimester induced abortion: a review. Hum Reprod Update 13:37–52.

a prior C-section, 0.04% without.[3] Due to the voluntary nature of complication reporting in many U.S. states, the real complication rates are undoubtedly much higher.[4]

10. It is important to consider the increasing danger of abortion to a woman as the gestational age increases. An abortion performed after the early second trimester (beyond about 14 weeks gestation) is more complicated and must be performed in one of the following ways: A Dilation and Extraction (D&X, non-intact D&E or "partial- birth" abortion) can be performed by delivering the fetus as a breech to the level of his head, then crushing his skull to assist removal, but this method is illegal under federal law. Another rarely performed method is hysterotomy, which involves performing feticide to kill the baby and then performing a C-section to deliver the dead baby, but this procedure is used only in extraordinary circumstances.[5]

11. The most commonly performed later abortion procedure is Dilation and Evacuation (D&E), accounting for about 95% of abortions after the early second trimester. In a healthy pregnancy the cervix is strong and difficult to dilate, and thus cervical ripening (usually with a water-absorbing laminaria) is performed for one to three days prior to the abortion. If dilation remains difficult, cervical damage can occur or a false channel can be created, possibly leading to laceration of cervical

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[3] Practice Bulletin 135: Second Trimester Abortion. Obstet & Gynecol. 2013 Jun;121(6):1394-1406.
[4] Abortion reporting requirements. Guttmacher Institute; 2021 Sept 1 (cited 2021 Sept 7]. Available from: https://www.guttmacher.org/state-policy/explore/abortion-reporting-requirements.
[5] Practice Bulletin 135: Second Trimester Abortion, *supra* note 3.

vessels or injury to adjacent organs such as bladder, ureter, or bowel. Once dilation has been completed, the surgeon introduces a suction curette into the uterus to vacuum out amniotic fluid and soft tissue such as the placenta. At this late gestational age, the fetal bones are calcified, and must be removed in a piecemeal fashion with grasping clamps, hence the layman's description "dismemberment abortion." Multiple passes are required to remove all the fetal tissue, as each pass may yield an arm, leg, or section of torso. The cranium is often the most difficult portion of tissue to remove as it may require crushing in order to fit through the incompletely dilated cervix. Complications which may occur with this operation include instrumental perforation of the soft, distended uterus, with injury to surrounding bowel or vasculature, potentially leading to sepsis or uncontrollable bleeding; or the incomplete removal of all the fetal tissue which may lead to hemorrhage, infection, chronic pain, or future infertility. Additional surgery may be needed to correct these damages.[6]

12. As the fetus becomes bigger, D&E becomes harder to perform due to the difficulty of eviscerating and disarticulating the fetus, so the abortionist may choose to perform an induction abortion. He may induce labor with vaginal prostaglandins, intravenous pitocin or, rarely, saline or prostaglandin intraamniotic infusion. Infection, hemorrhage or retained tissue often require a surgical dilation and sharp

[6] Paul M, Lichenberg E, Borgatta L, Grimes D, Stubblefied P. A Clinician's Guide to Medical and Surgical Abortion. New York: Churchill Livingston; 1999. 197–216.

or suction curettage afterward to treat these complications (affecting about one in three women)[7]. Saline can also cause life-threatening electrolyte imbalances.

13. To avoid the need to commit infanticide if a fetus is born alive (which European studies have documented occurs more than half of the time between 20-24 weeks when feticide is not used)[8], the abortionist should kill the fetus before labor induction. This is usually done with intraamniotic or fetal intracardiac potassium chloride or digoxin injection but entails additional risks to the woman if these potent cardiotoxic medications should enter her bloodstream.[9]

14. In 2018, the National Academies of Sciences, Engineering and Medicine (NASEM) published a book: The Safety and Quality of Abortion Care in the United States, which made the assertion that abortion is extremely safe.[10] The researchers' bias is immediately apparent, because the study was commissioned and funded by six outspoken abortion advocacy organizations: the David and Lucile Packard Foundation, the Grove Foundation, the JPB Foundation, the Tara Health Foundation, the William and Flora Hewlett Foundation, and the Susan Thompson Buffett Foundation.[11]

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[7] Mentula M, Niinimäki M, Suhonen S, Hemminki E, Gissler M, Heikinheimo O. Immediate adverse events after second trimester termination of pregnancy: results of a nationwide registry study. Human Reproduction. 2011;26(4):927–32.
[8] Springer S, Gorczyca M, Arzt J, Pils S, Bettelheim D, Ott J. Fetal survival in second-trimester termination of pregnancy without feticide. Obstet Gynecol. 2018;131(3):575–579.
[9] Molaei M, Jones H, Weiselberg T, McManama M, Bassell J, Westhoff C. Effectiveness and safety of digoxin to induce fetal demise prior to second trimester abortion. Contraception. 2008;77(3):223.
[10] The National Academies of Science, Engineering and Medicine: The safety and quality of abortion care in the United States. Washington (DC): The National Academies Press; 2018.
[11] Novielli C. Study claiming abortion is safe was funded by those who profit from it and the media fails to investigate [Internet]. National Right to Life News Today, 2019 Aug 5 [cited

15. These researchers (none of which have specific research experience with abortion safety, but many of whom have connections to pro-choice organizations or are abortion providers themselves) performed an extensive literature review but excluded an extraordinary number of studies for perceived defects. Not surprisingly, by primarily utilizing studies performed by fellow abortion advocates, they concluded what their funders hoped they would conclude: that serious complications or long-term physical or mental health effects are virtually non-existent. In fact, they reported abortion is so safe, that the only deterrent to its safety is legislative restrictions enacted by the states that may prevent a woman from accessing an abortion immediately, "creating barriers to safe and effective care." They concluded that abortions can be performed safely in an office-based setting or by telemedicine without the need for the provider to have hospital admitting privileges. No special equipment or emergency arrangements are required for medical abortions. It does not need to be performed by physicians; it can safely be performed by trained certified nurse midwives, nurse practitioners, and physician assistants.

16. They reported that abortion has no long-term adverse effects, and it specifically does not increase the risk of preterm delivery, mental health disorders, or breast cancer. However, when one examines the research studies they used for their conclusions, the poor quality of the literature regarding long-term complications becomes apparent. For many questions, there were very few or no

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2021 Sept 7]. Available from: https://www.nationalrighttolifenews.org/2019/08/study-claiming-abortion-is-safe-was-funded-by-those-who-profit-from-it-and-the-media-fails-to-investigate/.

studies that met their stringent criteria, and they disqualified many studies due to perceived study defects. For example, they considered only five studies examining a link between abortion and preterm birth (even though seventy peer-reviewed studies documented an increased risk exist in the literature since 2000 (the arbitrary date they set for inclusion) and 163 studies exist in total); three studies examining a link between abortion and breast cancer (even though seventy-six peer-reviewed studies exist in the literature, sixty showing a positive correlation, and thirty-six showing statistically significant increased risk); and considered only seven studies examining a link between abortion and mental health disorders (four were drawn from the same study group, the Turnaway cohort, and thus should have been counted only once). Seventy-five peer-reviewed studies exist in the literature from the past twenty-five years, two-thirds (forty-nine) showing statistically significant increased risk of mental health disorders after abortion. Thus, in all cases, there were less than five study groups on which the NASEM committee based their definitive conclusion of "no long-term impact" when there were hundreds of studies they could have evaluated.

17. A consumer watchdog group, the Center for Science in the Public Interest, in their 2006 report, "Are the National Academies Fair and Balanced?", stated, "Unfortunately, we found serious deficiencies in the NASEM's committee selection process that could jeopardize the quality of future NAS reports. The NAS has allowed numerous scientists and others with blatant conflicts of interests to sit on committees. Compounding that problem, those conflicts of interest usually are not

disclosed to the public."[12] Similar allegations were made by other researchers in 2017 when they discovered that financial and institutional conflicts were not disclosed by NASEM committee members even though they stood to profit financially from their committee's report.[13]

18. When considering the safety of abortion in the U.S., it is important to be aware of the many data limitations affecting the accuracy of abortion statistics. Due to privacy concerns and out-of-pocket payment for most abortions, there is no accurate central governmental database that tracks the numbers and complications of this voluntarily reported procedure. For example, in the most recent year calculated (2017), the U.S. Centers for Disease Control (CDC), the state health departments reported 612,719 abortions, whereas the Guttmacher Institute, aligned with the abortion industry, reported 862,300.[14] Some states (28) require abortion providers to report their complications, but there is rarely an enforced penalty for noncompliance. Even fewer states (12) require other physicians, coroners, or emergency rooms to report abortion-related complications or deaths for investigation.[15] Recent studies documenting apparent low complication rates have been performed by high-volume abortionists and do not reflect the quality of all

[12] Ensuring independence and objectivity at the National Academies [PDF]. Washington (DC): Center for Science in the Public Interest; 2006 [cited 2021 Sept 7]. Available from: https://cspinet.org/sites/default/files/attachment/nasreport.pdf.
[13] Krimsky S, Schwab T. Conflicts of interest among committee members in the National Academies' genetically engineered crop study. Plos One; 2017 Feb 28 [cited 2021 Sept 7]. Available from: https://doi.org/10.1371/journal.pone.0172317.
[14] Abortion Statistics in the United States. Wikipedia. [cited 2021 Sept 7]. Available from: https://en.wikipedia.org/wiki/Abortion_statistics_in_the_United_States.
[15] An overview of abortion laws. Guttmacher Institute. 2021 Sept 1 [cited 2021 Sept 7]. Available from: https://www.guttmacher.org/state-policy/explore/overview-abortion-laws.

abortion providers in the U.S. A close analogy would be if the U.S. had allowed the tobacco industry to control the studies and narrative regarding the safety of smoking. The data regarding abortion-related complications and maternal mortality is similarly compromised.

19. It is well established that the CDC has incomplete statistics regarding abortion-related maternal mortality because most of their data is obtained from maternal death certificates, and maternal death certificates are often incomplete, especially regarding early pregnancy events.[16] Even if related to a term pregnancy, at least 50% of maternal deaths are not reported as pregnancy-related on death certificates.[17] Mortality from events in the first half of pregnancy, which are unable to be linked to a birth certificate, are even more difficult to detect, but reliable records-linkage studies from Finland document that 94% of abortion-related deaths are not documented as such on the maternal death certificate.[18]

20. Thus, the frequent assertion that legal abortion is fourteen times safer than childbirth is based on conjecture by researchers associated with the abortion industry. The authors of a misleading study making this claim are vocal abortion

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[16] Gissler M, Berg C, Bouvier-Colle M-H, Buekens P. Pregnancy associated mortality after birth, spontaneous abortion, or induced abortion in Finland, 1987-2000. Am J Obstet Gynecol. 2004;190:422–427; Horon I. Underreporting of maternal deaths on death certificates and the magnitude of the problem of maternal mortality. Am J Pub Health. 2005;95:478–82.

[17] Horon I, *supra* note 16; Deneux-Tharaux C, Berg C, Bouvier-Colle M-H, Gissler M, Harper M, Nannini A, Alexander S, Wildman K, Breart G, Buekens P. Underreporting of pregnancy related mortality in the U.S. and Europe. Obstet Gynecol. 2005;106(4):684–92.

[18] Gissler M, Berg C, Bouvier-Colle M-H, Buekens P. Methods for identifying pregnancy associated deaths: Population based data from Finland 1987-2000. Paediatric and Perinatal Epidemiology. 2004;18:448-455. Available from: doi: 10.1111/j.1365-3016.2004.00591.x

advocates who knew how limited the CDC data drawn primarily from death certificates was, because one of the authors was the former Chief of the CDC Abortion-Surveillance Branch.[19] The study used four disparate and difficult to calculate numbers with non-comparable denominators. Abortion-related deaths were compared to the number of legal abortions. Maternal deaths were compared to the number of live births.[20] Only live births can be accurately measured due to mandated birth certificates. Yet only two-thirds of maternal deaths occur in association with a live birth.[21]

21. The limited data about abortion-related mortality in the U.S. demonstrates that abortion becomes much more dangerous as gestational age progresses. Compared to an abortion performed at eight weeks gestation, there is a 15-fold increase in maternal mortality when a woman has an abortion early in the second trimester, 30-fold increase in the mid-second trimester, and 76-fold increase when the baby has the ability to survive separated from its mother, possibly as early as 22 weeks gestation. The risk of death increases by 38% for each week beyond eight weeks.[22]

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[19] Raymond E, Grimes D. The comparative safety of legal induced abortion and childbirth in the United States. Obstet Gynecol. 2012;119:215–19; David A Grimes. HuffPost; [cited 2021 Sept 7]. Available from: https://www.huffpost.com/author/david-a-grimes.

[20] Pregnancy mortality surveillance system. Centers for Disease Control and Prevention; [cited 2021 Sept 7]. Available from: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm.

[21] Zane S, Creanga A, Berg C, Pazol K, Suchdev D, Jamieson D, Callaghan W. Abortion related mortality in the U.S.:1998-2010. Obstet Gynecol. 2015;126:(2)258–265.

[22] Bartlett L, Berg C, Shulman H, Zane S, Green C, Whitehead S, Atrash H. Risk factors for legal induced abortion related mortality in the U.S. Obstet Gynecol. 2004;103:(4)729–737.

22. Additionally, it should be noted that the definition of maternal mortality encompasses all deaths that occur up to a year from the end of the pregnancy. While catastrophic complications directly related to the pregnancy separation event are more likely to be detected, mental health complications remote from the event are likely not to be detected or attributed to the method in which the pregnancy was resolved. One unexpected finding in the investigation of recent increases in U.S. maternal mortality is the increase in "deaths of despair" - substance abuse and overdose, suicides, homicides, and excessive risk-taking behavior.[23]

23. An eight-year retrospective California study showed that women who aborted had significantly higher age-adjusted risks of death from all causes (162%) and suicide (254%) compared to those who continued the pregnancy to childbirth.[24] Comprehensive record linkage studies from Finland found that following an abortion, a woman was two to four times as likely to die within a year, six times as likely to commit suicide, four times as likely to die from an accident, and fourteen times as likely to be murdered, compared with a woman who carried to term.[25]

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[23] MacDorman M, Declercq E, Cabral H, Morton C. Recent increases in the U.S. maternal mortality rate: Disentangling trends from measurement issues. Obstet Gynecol. 2016;128:447–455.
[24] Reardon D, Ney P, Scheuren F, Cougle J, Coleman P, Strahan T. Deaths associated with pregnancy outcome: a record linkage study of low-income women. South Med J. 2002;95:834–841.
[25] Gissler M, Hemminki E, Lonnqvist J. Suicides after pregnancy in Finland, 1987-94: register linkage study. British Med J. 1996;313:1431–34; Karalis E, Ulander V-M, Tapper A-M, Gissler M. Decreasing mortality during pregnancy and for a year after while mortality after termination of pregnancy remains high: a population-based register study of pregnancy associated deaths in Finland 2001-2012. BJOG. 2017;124:1115–21; Gissler M, Berg C, Bouvier-Collie M-H, Buekens P. Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000. Eur J Public Health. 2005;15:459–63; Gissler M, Kauppila R, Meriläinen J, Toukomaa H, Hemminki E. Pregnancy-associated deaths in

Similar results have been documented in Danish studies, with a 39% increased risk of death after first-trimester abortions and a 341% increased risk after later abortions.[26] Mental health issues may contribute to drug overdoses, suicides, homicides or even accidents due to risk-taking behavior, but our current system of data collection is not capable of linking these events to induced abortion. The state of Montana can justify limiting later abortions in the interest of protecting a woman's mental health and protecting her from a death of despair.

24. It is misleading to say that late-term abortions are necessary to save a woman's life. High-risk obstetricians are very skilled at helping a mother and her child make it safely through a complicated pregnancy. In the rare event that a pregnancy poses an immediate risk to a mother's life, her obstetrician can deliver her in a medically standard way, usually by induced labor or C-section, so that she and usually her baby can survive. Neonatologists have successfully saved babies born a little over halfway through a pregnancy. Medically indicated delivery does not require intentionally killing the child in an abortion.

25. Although it is often assumed that late-term abortions are only performed for severe fetal abnormalities or to save the mother's life, the reality is that most are performed for elective reasons, just as early abortions are. Reasons frequently given

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Finland 1987-1994—definition problems and benefits of record linkage. Acta Obstet Gynecol Scand. 1997;76:651–57.

[26] Reardon D, Coleman P. Short and long term mortality rates associated with first pregnancy outcome: Population register based study for Denmark 1980-2004. Med Sci Monit. 2012;18(9):71–76; Coleman P, Reardon D, Calhoun B. Reproductive history patterns and long-term mortality rates: a Danish population-based record linkage study. Eur J Public Health. 2013;23(4):569–74.

for later abortions are: "not knowing about the pregnancy," "trouble deciding about the abortion," and "disagreeing about the abortion with the man involved." It appears that indecision, partner abandonment and coercion are far more common reasons for the elective killing of pain-capable fetal humans than the truly heart-breaking situations.[27]

26. There is a maternal mortality crisis in our country and widespread abortion access is often recommended as the solution to this problem. Yet, the U.S. abortion rate is already one of the highest in the world, and we are one of only seven countries that allow elective abortion after viability, when the fetus experiences excruciating pain while being killed.[28] Black women are experiencing maternal mortality at a rate 3.3 times that of white women, but their abortion rate is also disproportionately 3.7 times higher.[29] Abortion is not the solution. It is part of the problem.

27. Abortion is known to lead to mental health disorders in some women.[30] Twenty percent of maternal deaths in Texas were due to "deaths of despair"-

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[27] Jones R, Finer L. Who Has Second Trimester Abortions in the United States? Contraception. 2012;85(6):544–51; Finer L, Frohwirth L, Dauphinee L, Singh S, Moore A. Timing of steps and reasons for delays in obtaining abortions in the United States. Contraception. 2006;74(4):334–44.
[28] Gestational limits on abortion in the United States compared to international norms. Charlotte Lozier Institute; 2014 Feb 1 [cited 2021 Sept 7]. Available from: https://lozierinstitute.org/internationalabortionnorms/.
[29] Marmion P, Skop I. Induced abortion and the increased risk of maternal mortality. Linacre Quarterly. 2020;87(3):302–10.
[30] Reardon D. The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities. SAGE Open Med. 2018 Oct 29;6:2050312118807624. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6207970/ doi: 10.1177/2050312118807624.

overdose, suicide and homicide.[31] Thirteen percent of maternal deaths in Illinois were due to homicide, usually by a woman's intimate partner.[32] A study in Minnesota demonstrated that a teenager was ten times as likely to commit suicide after an abortion than her non-pregnant peers.[33]

28. Abortion can be associated with an abnormal placental attachment in a subsequent pregnancy due to instrumental damage of the uterus. Placental abruption (premature separation) or Placenta Acreta Spectrum disorder (invasive placenta) can lead to catastrophic hemorrhage and are associated with twenty-five percent of the maternal deaths due to hemorrhage.[34]

29. Abortion is associated with an increased risk of preterm delivery of a subsequent pregnancy. Interventions related to premature rupture of membranes and preterm labor can raise a woman's risk of maternal mortality from infection and medication side effects.[35]

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[31] Baeva S, Saxton D, Ruggiero K, Jormondy M, Hollier L, Hellerstedt J, Hall M, Archer N. Identifying maternal deaths in Texas using an enhanced method, 2012. Obstet Gynecol. 2018;131:762–69.
[32] Koch A, Rosenberg D, Geller S. Higher risk of homicide among pregnant and postpartum females aged 10-29 years in Illinois, 2002-2011. Obstet and Gynecol. 2016;128:440–46.
[33] Garfinkel B, et al. Stress, depression and suicide: a study of adolescents in Minnesota. Univ of Minnesota Extension Service.1986.
[34] Mogos M, Salemi J, Ashley M, Witeman V, Salihu H. Recent trends in placenta accreta in the United States and its impact on maternal-fetal morbidity and healthcare-associated costs, 1998-2011. J Matern Fetal Neonatal Med. 2015;29:1077; Baldwin H, Patterson J, Nippita T, Torvaldsen S, Ibiebele I, Simpson J, Ford J. Antecedents of abnormally invasive placenta in primiparous women: risk associated with gynecologic procedures. Obstet Gynecol. 2018;131:227-233. Available from: doi: 10.1097/AOG.0000000000002434.
[35] Swingle H, Colaizy R, Zimmerman M, Morriss F. Abortion and the risk of subsequent preterm birth: a systematic review and meta-analysis. J Reprod Med. 2009;54:95-108; Liao H, Wei Q, Ge J, Zhou Y, Zeng W. Repeated medical abortions and the risk of preterm birth in the subsequent pregnancy. Arch Gynecol Obstet. 2011;284:579–86.

30.Asserting "viability doesn't occur until 24 weeks" is a misrepresentation of the ever-lowering gestational age at which modern medicine and technology have been able to save the lives of premature babies, and in many cases, give them a long, high-quality life.

31.The plaintiff's expert, Dr. McNicholas, and I are both alumni of Washington University School of Medicine, whose world-renowned Fetal Care Center routinely performs intrauterine fetal surgery with anesthesia for pain control and rescues babies born at the edge of viability (twenty-one weeks, not twenty-four).[36]

32.The youngest known preterm birth survivor was born at 21 4/7 weeks gestation.[37]

33. A large, multi-center cohort demonstrated recently improved survival of infants born between twenty-two and twenty-four weeks, often without long-term neurologic impairment.[38]

34.Obstetric sonogram in the second trimester estimates gestational age with a margin of error between one and two weeks, so setting a gestational age cutoff of twenty weeks is a conservative measure, as many babies at this estimated

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[36] Fetal Care Center. Washington University School of Medicine in St. Louis, Department of Obstetrics and Gynecology, [cited 2021 Sept 7]. Available from: https://obgyn.wustl.edu/patients/high-risk-pregnancy/fetal-care-center/.

[37] Pawlawski A. 'Miracle baby': Born at 21 weeks, she may be the most premature surviving infant. Today, 2017 Nov 9, updated 2018 Nov 21 [cited 2021 Sept 7]. Available from: https://www.today.com/health/born-21-weeks-she-may-be-most-premature-surviving-baby-t118610.

[38] Younge N, et al. Survival and neurodevelopmental outcomes among periviable infants. New Engl J Med. 2017;376:617–28.

gestational age may actually be older and may have the ability to survive separated from their mothers.[39]

35. Fetal pain perception occurs much earlier than many realize. The first requirement for fetal pain perception is the presence of cutaneous sensory receptors, which begin to develop in the peri-oral area at seven weeks, spread to the palms and soles by eleven weeks, to trunk and proximal limbs by fifteen weeks, and are present throughout the fetus's entire body by twenty weeks.[40] As these sensory neurons develop, the unborn child begins to react to touch.[41] Early in the process, the pain system is relatively primitive,[42] but the part of the central nervous system leading from the peripheral nerves to the brain starts developing in the dorsal horn of the spinal cord at thirteen weeks.[43] Connection is made to the brain's thalamus (midbrain) between fourteen to twenty weeks.[44]

36. Early in the second trimester, the fetus reacts to stimuli that would be recognized as painful if applied to an adult human, in much the same ways as an

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[39] Skupski D, Owen J, Kim S, Fuchs K, Albert P, Grantz K. Estimating gestational age from ultrasound fetal biometrics. Obstet Gynecol. 2017;130(2):433–41.
[40] Anand K, Hickey P. Pain and its effects in the human neonate and fetus. New Engl J Med. 1987;317(21):1321–29. Available from: https://www.ncbi.nlm.nih.gov/pubmed/3317037.
[41] Myers L, Bulich L, Hess P, Miller N. Fetal endoscopic surgery: indications and anesthetic management. Best Pract Res Clin Anesthesiol. 2004;18(2):231–58. Available from: https://www.ncbi.nlm.nih.gov/pubmed/15171502.
[42] Derbyshire S. Foetal Pain? Best Practices and Research. Clinical Obstet Gynecol 2010;24(5):647–55. Available from: https://www.researchgate.net/publication/42806276_Foetal_pain.
[43] Gupta R, Kilby M, Cooper G. Fetal surgery and anesthetic implications. Continuing Education in Anesthesia, Critical Care & Pain. 2008;8(2):71–75. Available from https://academic.oup.com/bjaed/article/8/2/71/338464.
[44] Lee S, Ralston H, Drey E, Partidge J, Rosen M. Fetal pain: a systematic, multidisciplinary review of the evidence. JAMA. 2005;294(8):947–54. Available from: https://www.ncbi.nlm.nih.gov/pubmed/16118385.

adult, for example, by recoiling.[45] Fetuses can be seen reacting to intra-hepatic vein needling with vigorous body and breathing movements, increased heart rate, and increased blood flow to the brain.[46] Increases in levels of circulating stress hormones and endogenous opioids can also be measured.[47] The neurons of the cerebral cortex begin development at 8 weeks, and are complete by twenty weeks. It appears that neural connections between the thalamus and the cerebral cortex are made starting at seventeen weeks and are fully functional by twenty-six to thirty weeks.[48]

37. Abortion advocates argue that these responses do not qualify as pain because the fetus cannot yet experience an emotional response to the pain. This argument is based upon an extreme interpretation of what constitutes pain. They support their position with an oft quoted study which states: "Pain is an emotional and psychological experience that requires conscious recognition of noxious stimulus." This study lacks credibility because author Susan Lee previously practiced as a National Abortion Rights Action League attorney, and author Eleanor Drey, M.D. was the medical director of an abortion clinic at the University of California, San Francisco. The intent of the study is readily apparent from the first paragraph,

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[45] Lowery C, Hardman M, Manning N, Hall R, Anand K, Clancy B. Neurodevelopmental changes of fetal pain. Semin Perinatol. 2007;31(5):275–82. Available from: https://www.ncbi.nlm.nih.gov/pubmed/17905181.
[46] Giannakoulopoulos X, Sepulveda W, Kourtis P, Glover V, Fisk N. Fetal plasma cortisol and b-endorphin response to intrauterine needling. Lancet. 1994;344:77–81. Available from: https://www.ncbi.nlm.nih.gov/pubmed/7912391.
[47] Gitau R, Fisk N, Teixeira J, Cameron A, Glover V. Fetal hypothalamic-pituitary-adrenal stress responses to invasive procedures are independent of maternal responses. J Clin Endocrinol Metab 2001;86(1):104–9. Available from: https://www.ncbi.nlm.nih.gov/pubmed/11231985.
[48] Glover V, Fisk N. Fetal pain: implications for research and practice. Br J Obstet Gynecol. 1999;106(9):881–86. Available from: https://www.ncbi.nlm.nih.gov/pubmed/10492096.

where the authors discuss legislative limitations on mid-trimester abortions and discount any concern for the fetus, as they attempt to systematically dismantle all of the observed fetal physiologic responses and attempt to explain how that does not actually represent pain as we know it.[49]

38. There are many instances in our society in which we take extra precautions to prevent pain even though we do not know whether the recipient is capable of fully experiencing pain. When organs are harvested from a person who has experienced brain death, we administer anesthesia. Prior to undergoing a painful procedure, a person in a persistent vegetative state is given anesthesia. When a convicted murderer is given the death penalty, there is a long list of safeguards to make sure that he dies as quickly and painlessly as possible. We have many laws that monitor how animals raised to provide meat should be treated when they are butchered, and many more laws to tell us how we should interact with pets so that they do not experience pain. A conference on pain in laboratory animals noted that "it is imperative to acknowledge that unless it is established to the contrary, we should assume that those procedures that produce pain in us might also produce pain in animals," and proposes preemptive analgesia in those situations.[50]

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[49] Lee S, Ralston H, Drey E, Partidge J, Rosen M. Fetal pain: a systematic, multidisciplinary review of the evidence. JAMA. 2005;294(8):947–54. Available from: https://www.ncbi.nlm.nih.gov/pubmed/16118385.

[50] Gebhart G. Scientific issues of pain and distress. In: Definition of pain and distress and reporting requirements for laboratory animals: proceedings of the workshop held June 22, 2000. Washington (DC): National Academies Press; 2000. Available from: https://www.ncbi.nlm.nih.gov/books/NBK99533/.

39. One of the most frequent myths about abortion is that it may be necessary to save a woman's life. It is clearly the standard of care for any physician to intervene in a pregnancy that presents a risk to the mother's life. However, these life-threatening situations occur far less commonly than one may assume. Medically indicated separation of the fetus from his mother is more correctly termed "premature parturition." In these cases, the purpose of delivery is not to directly kill the fetus, as in elective abortion, but to save the life of the mother, and the life of the fetus, or to save the life of at least one of them. This can be done in such a way, induction or C-section, that the baby can be saved if possible. With modern surgical techniques, a C-section delivery is usually very safe, even in an extremely sick woman. One out of three pregnancies in our country are delivered this way. In the event that a baby is too immature or sick to survive, perinatal hospice is a loving and life-affirming way to care for the infant and his family.

40. By comparison, a dilation and evacuation abortion usually requires between one and three days of cervical ripening in order for the surgeon to enter the uterus. If a woman were truly sick enough to need emergent delivery, this much of a delay would only worsen her condition. In addition, a delivery by induced labor or C-section, even if the baby dies during the course of the delivery, allows the woman to mourn, hold, photograph, and bury her baby, if desired. In the event of a fetal abnormality, an autopsy can be performed to assist with counseling for future pregnancies. A dilation and evacuation (D&E) dismemberment abortion, of course, does not allow for any of that. While few OB/GYNs other than high- volume, late-

term abortionists have the clinical skills to perform a late-term D&E, due to its complexity and high incidence of complications, all OB/GYNs can perform inductions or C-sections, thus allowing the woman's own physician to care for her in her distress.

41. In my twenty-five years of obstetric practice, during which I have delivered over five thousand babies, I have occasionally encountered situations where continuing a pregnancy poses a significant risk to my patient, requiring me to separate a premature child from his mother. Yet, I have always been able to care for this woman in her distress without performing an abortion. Extreme hypertension (preeclampsia/eclampsia) and preterm premature rupture of membranes leading to infection/sepsis are two such examples. Abortion, by definition, involves intentionally ending the life of the unborn child. Depending on the circumstance, I may induce labor, or sometimes perform a C-section. But I have never considered transferring such a patient from my intensive-care hospital to a lesser quality abortion clinic (where most later abortions are performed). It would be clinical malpractice to abandon my patient to a lower level of care if I am concerned about the mother's life and health.

42. It is misleading to say that elective abortion is healthcare. Healthcare is defined as "maintenance and restoration of the health of the body or mind". Prenatal care and delivery of babies is healthcare. Disrupting the normal physiologic process of pregnancy and ending the life of an unborn human being by induced abortion is the very antithesis of healthcare. Only one in ten obstetricians

say they will perform an abortion when requested by their patient.[51] If abortion was necessary for a woman's health, every obstetrician would be willing to perform that intervention.

43. It is scientifically undeniable that abortion ends the life of a preborn human. This decision should be undertaken with a great deal of consideration to the gravity of the action weighted against the reasons for ending this fetal life.

44. It appears many abortions are not freely "chosen." Often the decision to terminate a pregnancy is influenced by partner abandonment, family pressure, or outright coercion. In one survey of post-abortive women, fifty-eight percent said that they had their abortions in order to "make others happy," with over twenty-eight percent saying they had the abortion because "they feared their partner would leave them" if they did not. Perhaps most heartbreaking is that sixty-six percent of women "said they knew in their hearts that they were making a mistake when they underwent the abortion."[52]

45. Studies confirm that most later abortions are obtained for the very same elective reasons as earlier abortions—most of those aborted are healthy babies being carried by healthy women. 10.3% of U.S. abortions are performed after the first trimester: 6.2% between thirteen to fifteen weeks, 4% at or after sixteen weeks,

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[51] Desai S, Jones R, Castle K. Estimating abortion provision and abortion referrals among United States obstetricians and gynecologists in private practice. Contraception. 2018;97:297–302; Stuhlberg D, Dude A, Dahlquist I, Curlin F. Abortion provision among practicing obstetrician-gynecologists. Obstet Gynecol. 2011;118(3):609–14. Available from: doi: 10.1097/AOG.0b013e31822ad973.

[52] Coleman P, Boswell K, Etzkorn K, Turnwald R. Women who suffered emotionally from abortion: a qualitative synthesis of their experiences. J Am Physicians and Surgeons. 2017;22(4):113–18. Available from: http://www.jpands.org/vol22no4/coleman.pdf.

including 1.3% after viability.[53] Reasons given for late abortions are: "not knowing about the pregnancy," "trouble deciding about the abortion," and "disagreeing about the abortion with the man involved." Fifty percent of women having second trimester abortions delayed the procedure due to indecision, and thirty-three percent due to the difficulty of the decision.[54] A study in England and Wales found similar reasons for later abortions: forty-one percent indecision, thirty percent procrastination and twenty-three percent relationship changed.[55] With all this indecision, it is likely that another change of mind could occur for the woman after going through with the abortion, and the choice could be regretted. These studies did not report the number of "hard cases," because apparently there were so few. The state of Florida keeps statistics on the reasons for all abortions in the state, and they found incest accounted for only 0.001% of all abortions, rape 0.085%, health of mother 0.5%, life of mother 0.065%, and serious fetal anomalies 0.66%.[56]

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[53] Jones R, Finer L. Who has second trimester abortions in the United States? Contraception. 2012;85:544–51. Available from: http://www.contraceptionjournal.org/article/S0010-7824(11)00625-1/pdf.

[54] Finer L, Frohwirth L, Dauphinee L, Singh S, Moore A. Timing of steps and reasons for delays in obtaining abortions in the United States. Contraception. 2006;74(4):334–44. Available from: https://www.guttmacher.org/sites/default/files/pdfs/pubs/2006/10/17/Contraception74-4-334_Finer.pdf.

[55] Ingham R, Lee E, Clements S, Stone N. Reasons for second trimester abortions in England and Wales. Reproductive Health Matters. 2008;16:18–29. Available from: https://www.tandfonline.com/doi/full/10.1016/S0968-8080%2808%2931375-5.

[56] Agency for Health Care Administration. Reported induced terminations of pregnancy by reason by trimester. 2020 Nov 17 [cited 2021 Sept 7]. Available from: https://ahca.myflorida.com/MCHQ/Central_Services/Training_Support/docs/TrimesterByReason_2018.pdf.

HB 171's Chemical Abortion regulations serve the valid medical purposes of ensuring informed consent and protecting the patient from known risks

46. A medical abortion is usually induced with two medications. Mifepristone, (Mifeprex or RU486) blocks progesterone receptors to cut off hormonal support for the pregnancy, which results in disruption of the implantation site and fetal death. Misoprostol (Cytotec) is consumed twenty-four to forty-eight hours later to induce contractions to expel the pregnancy tissue. This regimen is approved by the FDA until ten weeks gestational age,[57] but Planned Parenthood providers brazenly acknowledge that they distribute these medications past the recommended limit. Women in Montana are being steered toward medical abortions for reasons that benefit the abortionist rather than the woman. The cost is approximately the same, but a surgical abortion requires the abortion facility to pay a skilled surgeon, provide and sterilize surgical instruments, dispense anesthesia and incur other expenses. Medical abortion merely requires the cost of pills that a woman will use to self-manage her own abortion. The plaintiffs have acknowledged that few physicians want to perform abortions, so there are several benefits for an abortion facility when a woman chooses a medical abortion over surgery.

47. Complications occur four times more frequently from medical as compared to surgical abortions.[58] The average woman bleeds for nine to sixteen days and eight

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[57] Food and Drug Administration. Information on Mifeprex labeling changes and ongoing monitoring efforts. Government Accountability Office. Report to Requesters. 2018 [cited 2021 Sept 7]. Available from: https://www.gao.gov/assets/700/690914.pdf.
[58] Niinimaki M, Pouta A, Bloigu A, Gissler M, Hemminki E, Suhonen S, Heinkinheimo O. 2009. Immediate complications after medical compared with surgical termination of

percent will bleed longer than a month. The side effects of cramping, vaginal bleeding, hemorrhage, nausea, weakness, fever/chills, vomiting, headache, diarrhea, and dizziness occur in almost all women.[59] One percent will require hospitalization for hemorrhage or infection, one percent will have ongoing viable pregnancies (it will fail to kill the fetus), and if the pregnancy tissue is not completely expelled, surgery for incomplete abortion will be required in three to eight percent of cases.[60]

48. Recent research suggests that mifepristone itself may also cause complications of hemorrhage, infection, and mental health issues through direct pharmacologic effects. Mifepristone impairs the ability of the spiral arterioles in the uterus to contract, predisposing to excessive blood loss. It also blocks glucocorticoid receptors which may contribute to an impaired inflammatory response, increasing the risk of infection.[61] In addition, it releases inflammatory cytokines which have been implicated in causing depression. In a rat model the mifepristone termination

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pregnancy. Obstet Gynecol. 114:795–804. Available from: doi: 10.1097/AOG.0b013e3181b5ccf9.

[59] MIFEPREX™ (mifepristone) tablets, 200 mg for oral administration only. Food and Drug Administration; [cited 2021 Sept 7].
Available from: https://www.accessdata.fda.gov/drugsatfda_docs/label/2000/20687lbl.htm
FDA Mifeprex tablets label. Available at: https://www.accessdata.fda.gov/.

[60] Mentula M, Niinimäki M, Suhonen S, Hemminki E, Gissler M, Heikinheimo O. Immediate adverse events after second trimester medical termination of pregnancy: results of a nationwide registry study. Human Reproduction. 2011;26(4):937–42. Available from: doi: 10.1093/humrep/der016; Raymond E, Weaver S, Winikoff B. First trimester medical abortion with mifepristone 200 mg and misoprostol: A systemic review. Contraception. 2013;87(1):36–37; Chen M, Creinin M. Mifepristone with buccal misoprostol for medical abortion: a systemic review. Obstetrics & Gynecology, 2015;126:12–21. Available from: doi: 10.1097/AOG.0000000000000897.

[61] Fischer M, et al. Fatal toxic shock syndrome associated with Clostridium sordellii after medical abortion. N Engl J Med. 2005;353:2352–60; Miech R. Pathophysiology of mifepristone induced septic shock due to Clostridium sordellii. Ann Pharmacother 2005;39:1483–88.

group had significantly decreased body weight, food intake, locomotor-related activity, and sucrose consumption, which are all animal proxies for depression and anxiety.[62]

49. Our country has never mandated reporting of data about abortion: either its incidence, complications or deaths associated with it. The data that the CDC reports is voluntarily obtained and known to be incomplete. Even though the FDA mandated reporting of mifepristone complications, this information has been filtered through the manufacturer, and a recent analysis revealed that the data was of such poor quality that much of it could not be accurately analyzed.[63]

50. Biased studies based on poor-quality data, published by the U.S. abortion industry, report low complication rates. Better-quality international systematic reviews and records-linkage studies in countries with better record-keeping, however, demonstrate high failure rates of chemical abortion: A review of 45,000: almost five percent of failures cto kill the baby.[64] A review of 18,000: nearly eight percent failure in the first trimester and forty percent failure in the second trimester.[65] When the FDA loosened its restrictions in 2016, allowing the

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[62] Camilleri C, Beiter R, Puentes L, Scherk P, Sammut S. Biologic, behavioral and physiologic consequences of drug-induced pregnancy termination at first-trimester human equivalent in an animal model. Front Neurosci. 2019;13:544.
[63] Aultman K, Cirucci C, Harrison D, Beran B, Lockwood M, Seiler S. Deaths and severe adverse events after mifepristone for use as an abortifacient from September 2000 to February 2019. Issues Law Med. 2021;36(1):3–27.
[64] Raymond E, Weaver S, Winikoff B. First trimester medical abortion with mifepristone 200 mg and misoprostol: A systemic review. Contraception. 2013;87(1):36–37. Contraception, 87(1), 26-37. doi: 10.1016/j.contraception.2012.06.011.
[65] Mentula M, Niinimäki M, Suhonen S, Hemminki E, Gissler M, Heikinheimo O. Immediate adverse events after second trimester medical termination of pregnancy: results

gestational age limit to be extended from seven weeks to ten weeks gestation, far higher failure rates occur in the higher gestations. Review of 33,000: < two percent failures at < seven weeks, rose to seven percent by ten weeks.[66] Review of 42,000: Complications are four times more likely with a chemical than with a surgical abortion. One out of five women undergoing chemical abortion had complications, almost seven percent required surgery. [67]

51. These failure rates are not negligible, particularly when medical resources need to be conserved during a pandemic. Most of the women with failed medication abortions will present to an emergency room bleeding heavily where they will often require immediate surgery and sometimes hospitalization for blood transfusion or intravenous antibiotics. In a state such as Montana, where many women live in rural locations remote from emergency care, the toll of these complications will be much higher.

52. Recently, using the COVID-19 pandemic as an excuse, the FDA removed the in-person Risk Evaluation Mitigation Strategy (REMS) that has supervised mifepristone's use since its U.S. approval. This action will allow mifepristone

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of a nationwide registry study. Human Reproduction. 2011;26(4):937–42. Available from: doi: 10.1093/humrep/der016.

[66] Chen M, Creinin M. Mifepristone with buccal misoprostol for medical abortion: a systemic review. Obstetrics & Gynecology, 2015;126:12–21. Available from: doi: 10.1097/AOG.0000000000000897; Winikoff B, Dzuba I, Chong E. (2012). Extending outpatient medical abortion services through 70 days of gestational age. Obstet Gynecol. 2012;120(5):1070–76. Available from: doi: 10.1097/AOG.0b013e31826c315f.

[67] Niinimaki M, Pouta A, Bloigu A, Gissler M, Hemminki E, Suhonen S, Heinkinheimo O. 2009. Immediate complications after medical compared with surgical termination of pregnancy. Obstet Gynecol. 114:795–804. Available from: doi: 10.1097/AOG.0b013e3181b5ccf9.

administration without in-person examination, sonogram, or laboratory analysis. Efforts to remove the REMS restrictions reveal a cavalier approach by the abortion industry, demonstrating their prioritization of widespread abortion access over the health and safety of women and girls. These recommendations are in direct contradiction to the results of a 2017 survey of abortion providers which found that one third had seen complications as a result of "self-managed" abortion, and only half felt it was safe.[68]

53. In-person counseling ensures that mifepristone will be dispensed directly to the woman seeking abortion, and to observe that she genuinely seeks this action. Intentionally ending a preborn human life is a momentous decision—one that should not be rushed or entered into without adequate knowledge of the meaning of the action. Post-abortion regret is common, as evidenced by the proliferation of counseling programs in churches and pregnancy resource centers for suffering women.[69] Additionally, in-person counseling prevents illicit use by others who may benefit from the loss of the baby, such as sex traffickers, incestuous abusers and coercive boyfriends or husbands. It has been documented that many women experiencing sex trafficking have been forced into multiple abortions. Interaction

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[68] Kerestes C, Stockdale C, Zimmerman M, Hardy-Fairbanks A. Abortion providers' experiences and views on self-managed medication abortion: an exploratory study. Contraception. 2019;100(2):160–64. Available from: doi:10.1016/j.contraception.2019.04.006.

[69] Coleman P. Post abortion mental health research: distilling quality evidence from a politicized professional literature. J Am Phys Surg. 2017;22(2):38–43; Coleman P. Induced abortion and anxiety, mood, and substance abuse disorders: isolating the effects of abortion in the national comorbidity survey. J Psychiatric Res. 2009;43(8):770–76; Coleman P. Induced abortion and increased risk of substance abuse: a review of the evidence. Current Women's Health Reviews. 2005;1:21–34.

with the health care system is an opportunity for these women to be identified and helped, but ready availability of abortion pills to abusers will remove this opportunity for intervention.[70]

54. An in-person examination and ultrasound ensures that the duration of pregnancy will be assessed accurately because underestimation of gestational age will lead to far higher failure rates. The Plaintiffs assume that a woman will be able to accurately determine her gestational age based on her last menstrual period, but my clinical experience suggests otherwise. Increasing obesity has led to a high incidence of polycystic ovarian syndrome causing irregular ovulation and menstruation. Implantation bleeding may lead a woman to assume she had a period when in fact she is already pregnant. Medical abortion performed < seven weeks gestation has a failure rate of < two percent, but increases to seven percent by ten

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[70] Reproductive and sexual coercion. Committee Opinion No. 554. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;121:411–5. Available from: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/02/reproductive-and-sexual-coercion; Bourassa, D, Bérubé, J. (2007). The prevalence of intimate partner violence among women and teenagers seeking abortion compared with those continuing pregnancy. J Obstet Gynecol Canada. 2007;29(5):415–23. Available from: doi: 10.1016/S1701-2163(16)35493-7; Ethical decision making in obstetrics and gynecology. Committee Opinion No. 390. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007;110:1479–87. Available from: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Ethical-Decision-Making-in-Obstetrics-and-Gynecology; Ethical principles for abortion care. National Abortion Federation; 2011 [cited 2021 Sept 7]. Available from: http://prochoice.org/wp-content/uploads/NAF_Ethical-_Principles.pdf; Hall M, Chappell L, Parnell B, Seed P, Bewley S. "Associations between intimate partner violence and termination of pregnancy: a systematic review and meta-analysis," PLOS Medicine. 2014;11(1):e1001581. Available from: doi: 10.1371/journal.pmed.1001581; Lederer L, Wetzel C. The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. Ann Health Law. 2014;23(1):61–91. Available from: http://www.annalsofhealthlaw.com/annalsofhealthlaw/vol_23_issue_1?pg=69#pg69.

weeks gestation,[71] and skyrockets to thirty-nine percent if pills are accidentally consumed in the second trimester.[72]

55. In-person examination and ultrasound are critically important because mifepristone has no effect on a tubal pregnancy, which can rupture, causing catastrophic bleeding or death. Although ectopic implantation occurs in only two percent of pregnancies, it accounts for thirteen percent of maternal deaths.[73] A woman is thirty percent more likely to die from a missed ectopic while undergoing an abortion than if she had not chosen an abortion, because she may interpret the warning signs of pain and bleeding as signs the abortion pills are working.[74] Half of women with ectopic pregnancies have no known risk factors,[75] so merely screening by history without performing ultrasound is clearly inadequate, given the great risk of morbidity and mortality to a woman from a misdiagnosed ectopic pregnancy.

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[71] Chen M. & Creinin M. (2015). Mifepristone with buccal misoprostol for medical abortion: a systemic review. Obstetrics & Gynecology, 126,12-21. doi: 10.1097/ AOG.0000000000000897; Winikoff B., Dzuba I.G., Chong E. (2012). Extending outpatient medical abortion services through 70 days of gestational age. Obstetrics & Gynecology, Nov;120(5), 1070-6. doi: 10.1097/AOG.0b013e31826c315f.

[72] Mentula M., et al. (2011). Immediate adverse events after second trimester medical termination of pregnancy: Results of a nationwide registry study. Human Reproduction, 26(4), 937-942. doi: 10.1093/humrep/der016.

[73] American College of Obstetrics and Gynecology. Practice Bulletin 193: Tubal ectopic pregnancy. Obstetrics and Gynecology. 131;3:613-614.

[74] CDC MMWR Surveillance Summaries. (1993). Surveillance for ectopic pregnancy – United States, 19701989.https://www.cdc.gov/mmwR/preview/mmwrhtml/00031632.htm#:~:text=Although%20ectopic%20pregnancies%20accounted%20for,of%20all%20pregnancy%2D%20related%20deaths; Atrash H.K., et al. (1990). Ectopic pregnancy concurrent with induced abortion: Incidence and mortality. American Journal of Obstetrics & Gynecology, 162(3), 726-730. doi: 10.1016/0002-9378(90)90995-j.

[75] https://www.acog.org/womens-health/faqs/ectopic-pregnancy?utm_source=redirect&utm_medium=web&utm_campaign=int.

56. Evaluation of Rh status and provision of Rhogam if indicated will prevent a mother from mounting an immune response to her future unborn children. In 2017, ACOG stated that "Rh D immune globulin should be given to Rh D-negative women who have a pregnancy termination, either medical or surgical." They further documented that "Rh testing is standard of care in the U.S. and Rh immunoglobulin should be administered if indicated." In their 2020 updated medical abortion recommendations, ACOG continues to recommend Rh testing and Rh immunoglobulin when indicated, but then hedges by saying, "in situations where (these) are not immediately available or would significantly delay medication abortion, shared decision making is recommended."[76] Thus, without any new clinical information, this pro-abortion medical organization is opening the door to lowering the standard of care, to the detriment of the health of women and their future children. If these recommendations are ignored and isoimmunization occurs, fourteen percent of untreated infants will be stillborn and half will suffer neonatal death or brain injury.[77]

57. Fetal survival continues in one to three percent of women consuming the medical abortion pills.[78] Prompt diagnosis that the medical abortion did not work

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[76] American College of Obstetricians and Gynecologists. (2020). Practice Bulletin 225: Medical management of first trimester abortion. Obstetrics & Gynecology. 2020;136(4):855-858.
[77] American College of Obstetricians and Gynecologists. (2017). Practice Bulletin 181: Prevention of Rh D
Alloimmunization. Obstetrics & Gynecology 130(2),481-483; American College of Obstetricians and Gynecologists. (2014). Practice Bulletin 143: Medical management of first trimester abortion. Obstetrics & Gynecology.
[78] Raymond E, Weaver S, Winikoff B. First trimester medical abortion with mifepristone 200 mg and misoprostol: A systemic review. Contraception. 2013;87(1):36-37; Winikoff B.,