Exhibit A

IN THE DISTRICT COURT

FOR THE NINTH JUDICIAL DISTRICT OF WYOMING

RENE HINKLE, M.D.; GIOVANNINA ANTHONY M.D.; KATHLEEN DOW; DANIELLE JOHNSON; CHELSEA'S FUND; CIRCLE OF HOPE, d/b/a Wellspring Health Access; Plaintiffs, v. STATE OF WYOMING; MARK GORDON, Governor of Wyoming; BRIDGET HILL, Attorney General for the State of Wyoming; MATTHEW CARR, Sheriff Teton County, Wyoming; and MICHELLE WEBER, Chief of Police, Town of Jackson, Wyoming, Defendants.	)	Case No. 18853

EXPERT REPORT OF GHAZALEH KINNEY MOAYEDI, DO, MPH, FACOG

I, Ghazaleh Kinney Moayedi, declare as follows:

1. The facts and opinions I state here are based on my eleven years of medical practice, my review of medical and scientific literature, and my own research as a physician scientist. A copy of my *curriculum vitae* is attached as **Exhibit A.**

2. I submit this declaration in support of Plaintiff's Motion for Preliminary Injunction to prevent enforcement of Wyoming's Criminal Abortion Ban ("The Abortion Ban") and Wyoming's Criminal Medication Abortion Ban ("The Medication Ban"). I understand that the

Wyoming Abortion Ban prohibits abortion at any point in pregnancy with extremely narrow exceptions, and exposes any person who violates it to a felony punishable by a prison sentence, and that the Wyoming Medication Abortion Ban prohibits prescribing or dispensing abortion medication at any point in pregnancy with extremely narrow exceptions and exposes any person who violates it to a misdemeanor.

I. My Background

3. I am a practicing physician based in the State of Texas. I also have an active medical license and treat patients in: Alabama, Colorado, Georgia, Hawai'i, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Nevada, New Hampshire, Oklahoma, Vermont, Washington, and Wisconsin. I am Board Certified in Obstetrics and Gynecology ("Ob-Gyn") and Board Certified in Complex Family Planning by the American Board of Obstetrics and Gynecology. I am also a Nationally Certified Menopause Practitioner by The Menopause Society. I am a Fellow of the American College of Obstetricians and Gynecologists.

4. I received a degree in Biology and American Studies from the University of Texas at Austin in 2004. I received a Doctor of Osteopathic Medicine degree from the University of North Texas in 2012. I completed an Ob-Gyn residency program at Texas Tech Health Sciences Center El Paso in 2016. I completed my subspecialty training in Complex Family Planning at the University of Hawai'i in 2018. Complex Family Planning is advanced Ob-Gyn subspecialty training in contraception, early pregnancy evaluation and management, abortion care, public health, health policy, and research. I also completed a Master of Public Health with a focus on Health Policy and Management from the University of Hawai'i in 2018.

5. I provide full spectrum Ob-Gyn care in a diversity of settings, using diverse modalities across the country. I have a Complex Family Planning private practice where I provide telemedicine consultations and second opinions for birth control, early pregnancy options, abortion (where legally allowed), miscarriage management, and general gynecology. I provide telemedicine menopause diagnosis, treatment, and management for women across the country. I provide in-person clinical care for both medication and procedural abortion to 24+ weeks (where legally allowed) and my clinical focus is on abortion care for people with a medically complex diagnosis in pregnancy. I provide in-person clinical care as an Ob-Gyn hospitalist with an OB/GYN residency program and I'm the Chair of the Ob-Gyn department of the hospital I work at. In my role as an Ob-Gyn hospitalist, I deliver babies and provide emergency gynecologic surgery. I have delivered more than 1,000 babies, with many of those pregnancies and births complicated by maternal or fetal conditions. I have provided emergency obstetric care in a variety of catastrophic clinical scenarios, and I have seen the broad spectrum of human complications during pregnancy and childbirth. I have a deep understanding of the myriad of complications that can cause disability and death during pregnancy and childbirth.

6. In addition to my clinical expertise, I am a physician-scientist with seven years of experience in critically reviewing scientific literature, serving as a junior-editor and as a reviewer for peer-reviewed medical journals, and conducting my own scientific research. I have designed, managed, and served as a co-investigator in many well-designed, grant funded Ob-Gyn research studies. One research study I helped design and have been working on for several years with The Texas Policy Evaluation Project is a study evaluating how abortion bans impact the healthcare of pregnant people who experience medical complications during their pregnancies. Approximately four years ago, we designed a qualitative research study to interview clinicians, and subsequently

patients, across Texas to document the ways abortion bans had resulted in delayed care or denial of care when pregnant patients were confronted with a complex medical diagnosis – whether for the pregnant person or for the fetus. We have finished data collection and analysis from this project – findings from our study were published in two peer reviewed journals: *The New England Journal of Medicine*[1] in August 2022 and *Obstetrics & Gynecology*[2] in May of 2023. I have also co-authored another publication in *Obstetrics & Gynecology*[3] in March of 2023, which describes the experiences of real pregnant patients diagnosed with severe, life-limiting fetal conditions, navigating care through abortion bans in Texas.

II. My Opinions on The Abortion Ban

A. The "exception" language of The Abortion Ban invents medical terminology in an attempt to falsely assert that abortion care is not healthcare. Without using legitimate medical terminology, healthcare providers cannot follow the law because it is unclear when exceptions to The Abortion Ban would be allowed.

7. In Section 35-6-124(a)(1) of The Abortion Ban, an exception to The Abortion Ban is made for a "pre-viability separation procedure necessary in the physician's reasonable medical judgment to prevent the death of the pregnant woman...". As an expert in Ob-Gyn care and one of

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[1] Arey W, Lerma K, Beasley A, Harper L, Moayedi G, White K. A Preview of the Dangerous Future of Abortion Bans - Texas Senate Bill 8. N Engl J Med. 2022 Aug 4;387(5):388-390. doi: 10.1056/NEJMp2207423. Epub 2022 Jun 22. PMID: 35731914.

[2] Arey W, Lerma K, Carpenter E, Moayedi G, Harper L, Beasley A, Ogburn T, White K. Abortion Access and Medically Complex Pregnancies Before and After Texas Senate Bill 8. Obstet Gynecol. 2023 May 1;141(5):995-1003. doi: 10.1097/AOG.0000000000005153. Epub 2023 Apr 5. PMID: 37023461; PMCID: PMC10214013.

[3] Baker CC, Smith E, Creinin MD, Moayedi G, Chen MJ. Texas Senate Bill 8 and Abortion Experiences in Patients With Fetal Diagnoses: A Qualitative Analysis. Obstet Gynecol. 2023 Mar 1;141(3):602-607. doi: 10.1097/AOG.0000000000005071. Epub 2023 Feb 2. PMID: 36735418.

the few Board-Certified Subspecialists in Complex Family Planning in the United States, I am unclear what a "separation procedure" is or how to perform one. No legitimate Ob-Gyn textbook I have ever read or taught students from describes a "separation procedure." None of the major textbooks in Ob-Gyn surgery describe a "separation procedure". The American College of Obstetricians and Gynecologists does not describe a "separation procedure" in any of the hundreds of clinical guidelines it publishes. The American Board of Obstetrics and Gynecology does not include "separation procedure" as a required skill or required knowledge for the Qualifying Exam,[4] nor does it include "separation procedure" as an exam topic as part of the Certifying Exam.[5] The Accreditation Council for Medical Education does not list "separation procedure" as required knowledge in any of the required Milestones for Ob-Gyn graduate education, nor does it list "separation procedure" as a tracked procedure with minimum required numbers for graduation.[6] Furthermore, "separation procedure" is not a procedure code described in the Center for Medicare and Medicaid Services tenth revision of the International Classification of Diseases.[7] Given that a "separation procedure" is not a medical procedure that is taught, tracked, described, or able to be coded, it's unclear how physicians can safely comply with this exception in The Abortion Ban in order to save someone's life. I assume "separation procedure" means induced abortion, however, I personally would not risk my career or freedom on an assumption about invented terminology.

B. The "exception" language of The Abortion Ban is too vague to allow physicians to use their medical judgment to prevent serious harm for people with pregnancy complications.

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[4] https://www.abog.org/specialty-certification/qualifying-exam/exam-preparation
[5] https://www.abog.org/specialty-certification/certifying-exam/exam-preparation
[6] https://www.acgme.org/specialties/obstetrics-and-gynecology/milestones/
[7] https://www.cms.gov/Medicare/Coding/ICD10

8. Assuming "separation procedure" means induced abortion, The Abortion Ban allows an abortion when, "in the physician's reasonable medical judgment to prevent the death of the pregnant woman, a substantial risk of death for the pregnant woman because of a physical condition or the serious and permanent impairment of a life-sustaining organ of a pregnant woman..." As with the term "separation procedure," there is no medical definition or guidance for the terms "substantial risk of death," "serious and permanent impairment," or "life-sustaining organ." The meaning and application of these phrases do not appear in textbooks, are not taught in medical school, and are not part of the training or certification of Ob-Gyn's.

9. It is my expert opinion, based on my clinical experience and supported by peer-reviewed research, that exception language like this is too vague to prevent harm to pregnant people when serious pregnancy complications arise. It is unclear from this language if care can be administered to prevent the worsening of a medical condition that will lead to death, or if care must be withheld until the patient is actively dying. Texas has very similarly worded exceptions to their abortion bans, so I have direct clinical experience with how these types of exceptions are interpreted in real life. The reality is that in the setting of abortion bans like The Abortion Ban, physicians themselves are confused by the non-medical language and they are rarely "allowed" to use their medical judgment to determine when care should be delivered to prevent death or injury. The threats of felony convictions, jail time, civil liability, and substantial fines often initiate a cascade of gatekeepers to timely medical intervention - including multiple layers of hospital leadership, "ethics committees," and legal counsel. Despite their "exceptions" for medical emergencies, abortion bans in Texas have resulted in the denial of life-saving care for people in

Texas and many women are now suing the state because of the harm they experienced from the vagueness of these laws and their "exception" language.[8]

10. During Ob-Gyn residency training in El Paso was the first time I was confronted with one of these scenarios – someone too sick to continue their pregnancy, but not sick enough to warrant an exception to our abortion ban as determined by our hospital leadership. A patient presented to our care past 20 weeks of pregnancy with heart failure so severe that she was using a wheelchair because she could not walk without becoming dangerously short of breath. Serious complications from a prior pregnancy resulted in her permanent heart failure and she was advised that another pregnancy would strain her heart so much that it would likely lead to death. She requested an abortion to save her life and allow her to live for the children she already had. We knew that as her pregnancy advanced, her heart function would continue to deteriorate, every day putting her at increased risk of death from cardiovascular collapse. Our team was ready and willing to provide her with the life-saving abortion care she requested, but because of the language of the medical emergency law in Texas, similar to The Abortion Ban language, the hospital leadership decided that she was not actively dying at the moment and therefore would not allow us to provide her the care that was needed to sustain her life and prevent further harm to her heart. It is unconscionable in modern medical practice to withhold interventions or treatments that would prevent someone from critically decompensating, until they are actively dying, but that is exactly the result of vague exception language like that found in The Abortion Ban.

11. My own research with the Texas Policy Evaluation Project demonstrates similar experiences among physicians across Texas. In our publication in *The New England Journal of*

[8] https://www.texastribune.org/2023/03/07/texas-abortion-lawsuit/

Medicine entitled, "The Dangerous Future of Abortions Bans - Texas Senate Bill 8," we describe how a near-total abortion ban in Texas with similarly narrow exceptions like those in The Abortion Ban caused a "chilling effect on a broad range of health care professionals, adversely affecting patient care and endangering people's lives".[9] We interviewed 25 clinicians from across the state to describe how the abortion ban had impacted their care of pregnant patients with desired pregnancies experiencing medical complications. Clinicians described receiving legal advice preventing them from providing information or referrals, disrupting the physician-patient relationship. Physicians also described being given legal advice that they could not provide intervention in the setting of previable rupture of membranes, and therefore "sent patients home, only to see them return with signs of sepsis." In Ob-Gyn training, we learn to intervene early in the setting of previable rupture of membranes to prevent sepsis, as sepsis is one of the leading causes of maternal death globally. Withholding treatment necessary to prevent sepsis is unethical and goes against all reasonable medical judgment, yet withholding life-saving interventions is the reality of providing healthcare in the setting of laws like The Abortion Ban.

12. A recent study conducted at two Dallas hospitals, including one of the busiest labor and delivery units in the country, also showed that the vague exception clause in the Texas abortion ban failed to protect patients with pregnancy complications and resulted in a doubling of maternal morbidity.[10] The study followed pregnant patients that presented to the hospital at < 22 weeks of pregnancy with a medical indication for urgent delivery, but also with continuing fetal cardiac

[9] Arey W, Lerma K, Beasley A, Harper L, Moayedi G, White K. A Preview of the Dangerous Future of Abortion Bans - Texas Senate Bill 8. N Engl J Med. 2022 Aug 4;387(5):388-390. doi: 10.1056/NEJMp2207423. Epub 2022 Jun 22. PMID: 35731914. https://www.nejm.org/doi/full/10.1056/NEJMp2207423

[10] Nambiar A, Patel S, Santiago-Munoz P, Spong CY, Nelson DB. Maternal morbidity and fetal outcomes among pregnant women at 22 weeks' gestation or less with complications in 2 Texas hospitals after legislation on abortion. Am J Obstet Gynecol. 2022 Oct;227(4):648-650.e1. doi: 10.1016/j.ajog.2022.06.060. Epub 2022 Jul 5. PMID: 35803323.

activity. Prior to initiation of Texas' near-total abortion ban, these patients would have appropriately been offered induction of labor (i.e., an abortion or miscarriage management) to prevent significant maternal morbidity and mortality. However, because of the vagueness of the Texas 'medical emergency' exception and chilling effect of the law on physicians and hospital administrators, patients with serious medical complications were denied immediate intervention. Twenty-eight patients were included in the study, presenting with a pregnancy complication between 17 - 20 weeks of pregnancy. Characteristics of the patients included 93% with previable rupture of membranes, 4% with fever, 7% with antepartum hemorrhage, 4% with severe hypertension, and 25% with fetal parts in the vagina. Although most reasonable Ob-Gyns would consider each of these scenarios an obstetric emergency requiring immediate intervention, care for each patient was denied and delayed because of the vagueness of the Texas exception language, which is like The Abortion Ban's language. One patient's care was delayed for over three months, forcing her to remain pregnant after rupture of membranes at 19 weeks until 32 weeks of pregnancy, only to then undergo a cesarean section and have the infant die within one day of birth. Ultimately, researchers found that patients with obstetric complications in the peri-viable period experienced significant harm and a 24% increase in maternal morbidity. To add insult to injury, all but one neonate died during the time of the study. Despite a clause to protect maternal life, the Texas abortion ban led to significant harm of pregnant people and did not preserve neonatal life.

13. It's also important to note that Wyoming does not have the medical infrastructure to offer necessary, life-saving care to pregnant patients experiencing emergencies nor to the infants born from abortion refusal in emergency settings. Waiting until someone is actively dying to offer medical intervention is considerably riskier in Wyoming compared to Dallas, Texas. It is my understanding that Wyoming does not have any Level IV or Level III Neonatal Intensive Care

Units (NICU). It is also my understanding that Wyoming has not implemented the American College of Ob-Gyn's Levels of Maternal Care guidelines.[11] If one of the most resourced, busiest maternity hospitals in the country, with a Level IV NICU and a Level IV Maternal Health Designation was not able to prevent significant maternal morbidity and neonatal death under a similar law, it is unclear how pregnant patients in Wyoming will fare any better. This is an unimaginably cruel fate for pregnant people in Wyoming experiencing severe complications in pregnancy.

14. The language of The Abortion Ban is medically inaccurate and does not capture the nuance or reality of healthcare for pregnant people. Pregnancy care is too nuanced to expect that a list of vague "exceptions" to an abortion ban can protect the health and safety of pregnant people suffering from complications.

C. There are several material misstatements or misrepresentations about medical definitions in The Abortion Ban which cause confusion in the delivery of life-saving healthcare and chill physicians from offering the standard of care.

15. Ectopic Pregnancy: Although The Abortion Ban excludes treatment of ectopic pregnancy as part of the law, the definition of ectopic pregnancy as "a pregnancy that occurs when a fertilized egg implants and grows outside the main cavity of the uterus," is incorrect. While the simplest definition of an ectopic pregnancy is an embryo or gestational sac implantation outside of the uterus, the reality of the myriad ways ectopic pregnancy presents is much more nuanced. Ectopic pregnancies are life-threatening and immediate intervention should be offered when diagnosed to prevent severe morbidity and mortality. Most ectopic pregnancies implant in the

[11] https://www.acog.org/programs/lomc/state-implementation

fallopian tubes or in the ovaries - locations that are clearly outside of the uterus. Some ectopic pregnancies have even been observed to implant outside of the reproductive organs and in other places in the abdomen, like the bowel or liver. These, again, are clearly outside of the uterus. However, there are several other locations where ectopic pregnancies can implant that would not necessarily meet the test of this definition, but are ectopic pregnancies, nonetheless. Cervical ectopic pregnancy is a rare form of ectopic pregnancy that is associated with high morbidity and mortality and requires immediate intervention *before* becoming an emergency.[12] While the uterine cervix is different tissue than the uterine body (epithelium vs. smooth muscle), it is contiguous with the uterine body. It is not clear from the definition in The Abortion Ban if a cervical ectopic pregnancy is an ectopic pregnancy according to The State. Cesarean scar ectopic pregnancies (CSEP) become even harder to understand in the setting of The Abortion Ban's definition of ectopic pregnancy. CSEP is when an embryo or gestational sac implants and grows in a prior cesarean section scar and when untreated results in significant maternal morbidity and mortality.[13] Rates of CSEP are rising because of overall rising cesarean section rates. Wyoming has a 26.4% cesarean section rate.[14] A cesarean section scar is clearly in the "main cavity of the uterus" - the incision must be made into the uterus to remove the infant. Although a cesarean scar ectopic pregnancy is an ectopic pregnancy that requires intervention *before* becoming an emergency, it would not be covered by the medically inaccurate definition of ectopic pregnancy in The Abortion Ban. Cornual and interstitial ectopic pregnancies are when an embryo or gestational sac implants in the "upper and lateral portion of the uterus" (top corner) or "within the proximal, intramural

[12] Singh S. Diagnosis and management of cervical ectopic pregnancy. J Hum Reprod Sci. 2013 Oct;6(4):273-6. doi: 10.4103/0974-1208.126312. PMID: 24672169; PMCID: PMC3963313.
[13] https://www.ajog.org/article/S0002-9378(22)00478-1/fulltext
[14] https://www.cdc.gov/nchs/pressroom/sosmap/cesarean_births/cesareans.htm

portion of the fallopian tube that is enveloped by the myometrium," respectively.[15] Myometrium is the smooth muscle of the uterus, so an interstitial ectopic pregnancy occurs partly in the fallopian tube but is covered by uterine tissue. Both cornual ectopic and interstitial ectopic pregnancies are life-threatening and require intervention *before* becoming an emergency. However, it does not appear that treatment of these forms of ectopic pregnancy meet the definition of ectopic pregnancy set forth by The Abortion Ban. Finally, intramural ectopic pregnancy is when a pregnancy implants in the muscle of the uterus (myometrium), but not connected to the lining of the uterus (endometrium).[16] This is yet another example of an ectopic pregnancy that could be described as in "the main cavity of the uterus," but if treatment is delayed or denied could result in uterine rupture and/ or death.

16. Molar pregnancy: Although The Abortion Ban excludes treatment of molar pregnancy as part of the law, the definition of molar pregnancy as, "the development of a tumor or cysts that may or may not include placental tissue from trophoblastic cells after fertilization of an egg that results in spontaneous abortion or intrauterine fetal demise," is incorrect and fails to capture the nuance and individualized care required for the treatment of molar pregnancies. Gestational trophoblastic disease, of which molar pregnancy is a part, is a "spectrum of interrelated disease processes originating from the placenta".[17] While a simple definition of molar pregnancy could be "the development of a tumor or cysts...that results in spontaneous abortion or intrauterine fetal demise," the reality of the myriad ways hydatidiform molar pregnancies present is much more nuanced. Hydatidiform molars, or 'molar pregnancy,' are benign placental tumors with malignant potential and are classified as either partial or complete. Although the two types of molar

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[15] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6207538/

[16] https://pubmed.ncbi.nlm.nih.gov/24034539/

[17] Soper, John T. MD. Gestational Trophoblastic Disease: Current Evaluation and Management. Obstetrics & Gynecology 137(2):p 355-370, February 2021. | DOI: 10.1097/AOG.0000000000004240

pregnancies are different in genetics and clinical presentation, they are both managed by evacuation of the uterus or abortion. A "complete molar pregnancy" presents without evidence of a fetus, fetal tissue, or fetal red blood cells. However, a "partial molar pregnancy" can present with evidence of a fetus, detection of fetal red blood cells, and in some instances, fetal cardiac activity because of the presence of fetal tissue.[18] The Abortion Ban inadequately protects people with partial molar pregnancy from harm by preventing timely care if they present with fetal cardiac activity. Recently, a woman in Oklahoma with a partial molar pregnancy was denied life-saving care because of confusion with a law in Oklahoma with similar language to The Abortion Ban.[19] The woman was bleeding and diagnosed with a partial molar pregnancy where cardiac activity was detected. She was told to wait in the parking lot, bleeding, until the embryonic cardiac activity stopped so the hospital could deliver care. Ultimately, she went to Kansas and received care at a clinic I work at, rather than waiting to hemorrhage in the parking lot. Delaying care in the setting of molar pregnancy significantly increases the risks of hemorrhage, hysterectomy, thyroid storm, and preeclampsia, among other complications. In my own practice, I have cared for someone with a twin pregnancy, where one twin was a normally growing fetus, and the other twin was a hydatidiform mole. Although a highly desired pregnancy, the patient unfortunately developed life-threatening hyperthyroidism and preeclampsia at approximately 20 weeks because of the molar twin. Thankfully, I was able to offer this patient life-saving abortion care *before* she developed a more serious medical condition like thyroid storm or eclampsia - her care was uncomplicated, and she recovered well without intensive care unit (ICU) admission or blood transfusion. The

[18] https://www.ncbi.nlm.nih.gov/books/NBK459155/

[19] https://www.npr.org/sections/health-shots/2023/05/01/1172973274/oklahoma-abortion-ban-exception-life-of-mother-molar-pregnancy

medically inaccurate definitions in The Abortion Ban would have prevented timely care for this patient and likely resulted in significant morbidity to her.

17. Lethal Fetal Anomaly: The Abortion Ban defines lethal fetal anomaly as, "a fetal condition diagnosed before birth and if the pregnancy results in a live birth there is a substantial likelihood of death of the child within hours of the child's birth". As a physician who has provided abortion care for hundreds of patients with lethal fetal anomalies and delivered dozens of babies with lethal fetal anomalies, I have never given a prediction nor seen another physician give a prediction on how many hours it would take for a neonate to die if born alive. From a public health perspective, lethal fetal anomalies are typically described in "first-year mortality rates," not hours. The American College of Ob-Gyns describes lethal fetal anomalies as "likely to be fatal in utero or shortly after birth". This definition is more nuanced, without qualifiers like "substantial" and "within hours," reflecting the true variations in outcomes that can be observed after birth.[20] For example, anencephaly is a lethal fetal condition with a nearly 100% first-year mortality rate.[21] However, some infants born with anencephaly have lived longer than a few hours and there have been a few documented cases of life past one year. These facts do not change the reality that anencephaly is a lethal fetal anomaly, however it's unclear with the language of The Abortion Ban if pregnancies complicated by anencephaly would universally be considered "lethal" in Wyoming. A definition of lethal fetal anomaly based on how many hours an infant will live is essentially a ban on all abortions in the setting of lethal fetal anomaly - because no physician could certify when exactly the neonate would die based on their diagnosis, and they would certainly not risk their career and freedom on that prediction.

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[20] Perinatal palliative care. ACOG Committee Opinion No. 786. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;134:e84–9.

[21] Dickman H, Fletke K, Redfern RE. Prolonged unassisted survival in an infant with anencephaly. BMJ Case Rep. 2016 Oct 31;2016:bcr2016215986. doi: 10.1136/bcr-2016-215986. PMID: 27799226; PMCID: PMC5093842.

D. The Abortion Ban is contradictory and unclear regarding multifetal reduction - it explicitly states abortion for multifetal pregnancy is not allowed, while also stating that abortion is allowed to "save the life or preserve the health" of a fetus.

18. Multifetal pregnancy reduction is a "procedure for reducing the total number of fetuses in a multifetal pregnancy by one or more," and typically occurs when three or more fetuses are present.[22] Higher order multifetal pregnancies significantly increase the risk of both maternal and perinatal morbidity and mortality. Each additional pregnancy in a multifetal pregnancy increases the risk of death for the entire pregnancy and overall "multifetal pregnancies are associated with an approximately fivefold increased risk of stillbirth and a sevenfold increased risk of neonatal death" compared to singleton pregnancies. Therefore, multifetal pregnancy reduction is a procedure offered to save the life of at least one or two of the fetuses. Multifetal reduction decreases the fetal death rate for all multifetal pregnancies and is the most beneficial with very high-order multifetal pregnancies. Multifetal pregnancy reduction, therefore, does "save the life or preserve the health" of one or two fetuses, yet appears to be explicitly excluded as a life-saving measure in The Abortion Ban.

E. Abortion care is overwhelmingly safe and significantly safer than childbirth.

19. Abortion care in the United States is exceedingly safe. The risk of death associated with childbirth is 14 times higher than the risk of death associated with abortion.[23] According to the National Weather Service, the odds of being struck by lightning in your lifetime is 1/15,300 (.0065%).[24] Of 629,898 abortions reported in the United States in 2020, 4 deaths were reported

[22] Dickman H, Fletke K, Redfern RE. Prolonged unassisted survival in an infant with anencephaly. BMJ Case Rep. 2016 Oct 31;2016:bcr2016215986. doi: 10.1136/bcr-2016-215986. PMID: 27799226; PMCID: PMC5093842.
[23] Raymond EG, Grimes DA. The comparative safety of legal induced abortion and childbirth in the United States. Obstet Gynecol. 2012 Feb;119
[24] https://www.weather.gov/safety/lightning-odds

(.00064%).[25] Getting struck by lightning is 10 x more likely than dying from abortion care in the United States. In addition to the exceedingly low rate of mortality associated with abortion, abortion care also has very low morbidity. In an extensive report entitled, "The Safety and Quality of Abortion Care in the United States" published by the National Academies of Science, Engineering, and Medicine, authors found that abortion care in the United States is exceedingly safe and meets many of the attributes of quality healthcare. However, laws like The Abortion Ban reduce the quality of abortion care by delaying care leading to adverse events, decrease efficiency, and decreasing equity in access.[26]

F. Claims that abortion care should be banned based on "fetal pain" are not based in science, nor are those claims supported by leading medical organizations.

20. A systematic review is a research methodology to identify, appraise, and synthesize evidence on a specific research question. Data can then be summarized qualitatively or quantitatively (e.g. meta-analysis, pooled analysis). This process aims to minimize bias and should be reproducible. When attempting to answer complex medical questions, systematic reviews are often preferred because they don't rely on one singular study to arrive at an answer but synthesize all the best available research to derive an evidence-based answer. In a Systematic Multidisciplinary Review published in the *Journal of the American Medical Association*, authors synthesized the scientific literature to explore "whether a fetus feels pain".[27] Authors concluded that "fetal perception of pain is unlikely before the third trimester," because pain perception requires, "conscious recognition of a noxious stimulus," and the neurodevelopmental anatomy

[25] https://www.cdc.gov/mmwr/volumes/70/ss/pdfs/ss7009a1-H.pdf
[26] National Academies of Sciences, Engineering, and Medicine. 2018. The Safety and Quality of Abortion Care in the United States. Washington, DC: The National Academies Press. https://doi.org/10.17226/24950.
[27] Lee SJ, Ralston HJP, Drey EA, Partridge JC, Rosen MA. Fetal Pain: A Systematic Multidisciplinary Review of the Evidence. *JAMA*. 2005;294(8):947–954. doi:10.1001/jama.294.8.947

required to consciously recognize a noxious stimulus does not occur until at least 29-30 weeks of pregnancy. The Society for Maternal Fetal Medicine has published similar findings, and with the support of the American College of Obstetricians and Gynecologists as well as the Royal College of Obstetricians and Gynaecologists, concluded that pain medication should not be given to treat "fetal pain" during abortion procedures because there is a lack of evidence to support its use.[28] They do however recommend opioid analgesia during fetal surgery stating, "Although the fetus is unable to experience pain at the gestational age when procedures are typically performed, we suggest that opioid analgesia should be administered to the fetus during invasive fetal surgical procedures to attenuate acute autonomic responses that may be deleterious, avoid long-term consequences of nociception and physiological stress on the fetus, and decrease fetal movement to enable the safe execution of procedures".[23] This recommendation is often twisted by anti-abortion activists who either do not understand scientific literature or purposefully choose to distort it. The recommendation to administer opioid analgesia during fetal surgery is not to treat "fetal pain" but to prevent a surgical stress response and stop fetal movement to facilitate a safe procedure. Finally, the American College of Obstetricians and Gynecologists has also published a document entitled, "Facts Are Important: Gestational Development and Capacity for Pain," where they clearly state that the human fetus does not have the capacity to feel pain until at least the 3rd trimester.[29] It is clear from a review of the scientific literature that not only are claims about "fetal pain" false, but denying life-saving abortion care based on "fetal pain" contradicts the standard of care.

[28] https://www.ajog.org/article/S0002-9378%2821%2900965-0/fulltext
[29] https://www.acog.org/advocacy/facts-are-important/gestational-development-capacity-for-pain

III. My Opinions on The Medication Ban

A. The language of The Medication Ban also uses terminology that has no medical meaning ("chemical abortion"). Without using legitimate medical terminology, healthcare providers cannot follow the law because it is unclear what exactly The Medication Ban is referencing.

21. Section 1. W.S. 35-6-120 of The Medication Ban states, "chemical abortions prohibited". As an expert in Ob-Gyn care and one of the few Board-Certified Subspecialists in Complex Family Planning in the United States, I am unclear what exactly a "chemical abortion" is or what constitutes prescribing one. Similar to "separation procedure," no legitimate Ob-Gyn textbook I have ever read or taught students from describes a "chemical abortion." None of the major textbooks in Ob-Gyn practice describe a "chemical abortion". The American College of Obstetricians and Gynecologists does not describe a "chemical abortion" in any of the hundreds of clinical guidelines it publishes. The American Board of Obstetrics and Gynecology does not include "chemical abortion" as required skill or required knowledge for the Qualifying Exam,[30] nor does it include "chemical abortion" as an exam topic as part of the Certifying Exam.[31] The Accreditation Council for Medical Education does not list "chemical abortion" as required knowledge in any of the required Milestones for Ob-Gyn graduate education, nor does it list "chemical abortion" as a tracked procedure with minimum required numbers for graduation.[32] Furthermore, "chemical abortion" is not a procedure code described in the Center for Medicare and Medicaid Services tenth revision of the International Classification of Diseases.[33] Given that

[30] https://www.abog.org/specialty-certification/qualifying-exam/exam-preparation
[31] https://www.abog.org/specialty-certification/certifying-exam/exam-preparation
[32] https://www.acgme.org/specialties/obstetrics-and-gynecology/milestones/
[33] https://www.cms.gov/Medicare/Coding/ICD10

a "chemical abortion" is not a medical procedure that is taught, tracked, described, or able to be coded, it's unclear how physicians can truly comply with The Medication Ban in order to deliver necessary healthcare. I assume "chemical abortion" means medication abortion; however, I personally would not risk my career or freedom on an assumption about invented terminology.

B. Medication abortion is an exceedingly safe, common, and medically necessary method for pregnancy termination, miscarriage management, and treatment of ectopic pregnancy. A ban on medication abortion denies the people of Wyoming access to lifesaving, quality healthcare.

22. Assuming "chemical abortion" means medication abortion, it's important to understand the common medications used for medication abortion, the safety of medication abortion, the prevalence of medication abortion, and the benefits of medication abortion as a pregnancy termination option. Medication abortion is not one medication or one protocol, but instead refers to the use of medications to induce abortion. The most common method of medication abortion in the United States is a two-drug protocol with mifepristone and misoprostol. Mifepristone is a medication that is an analog of norethindrone, a common ingredient in birth control pills in the United States. Of note, a birth control pill with a similar medication, norgestrel, was just approved by the Food and Drug Administration for over-the-counter use.[34] Mifepristone was first derived in the 1980s and approved by the Food and Drug Administration in 2000.[35] When ingested, mifepristone acts as a progesterone receptor antagonist. It strongly binds to progesterone receptors in the body and blocks the action of progesterone in sustaining an early pregnancy.

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[34] https://www.fda.gov/news-events/press-announcements/fda-approves-first-nonprescription-daily-oral-contraceptive

[35] https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation#:~:text=The%20FDA%20first%20approved%20Mifeprex,Tablets%2C%20200%20mg%20in%202019.

Blocking the action of progesterone in early pregnancy causes separation of trophoblastic tissue from the endometrium, or plainly put, mifepristone causes an embryo to start detaching from the uterus by blocking progesterone. Physiologically, this is comparable to the process that happens during spontaneous abortion, also known as miscarriage. Early in the miscarriage process, we observe progesterone levels dropping, which initiates a biochemical cascade to expel the pregnancy from the body. Misoprostol, the second medication commonly taken in the medication abortion process, is a prostaglandin E1 analog. Naturally occurring prostaglandin E1 causes relaxation of smooth muscle and uterine contractions. Prostaglandin E1 was first isolated in the 1950s and it was first approved for use in the United States in the early 1980s. Prostaglandin E1 in the form of alprostadil is used to treat infants with congenital heart defects and adults with erectile dysfunction. Prostaglandin E1 in the form of misoprostol is used to treat gastric ulcers, induce labor for childbirth, prevent and treat postpartum hemorrhage, open a cervix prior to uterine instrumentation, induce abortion in the setting of medication abortion, and assist in the timely passage of tissue in the setting of a miscarriage.

23. Taken together, mifepristone and misoprostol have over two decades of proven safety and efficacy data in the United States and over three decades of proven safety data for inducing abortion globally. Serious adverse events with medication abortion are exceedingly rare and the incidence of adverse events with medication abortion has been documented through many well-designed, peer reviewed studies. Serious adverse events like blood transfusion, surgery, or hospital admission happen in less than .5% of medication abortions.[36]

[36] https://www.ansirh.org/sites/default/files/publications/files/medication-abortion-safety.pdf

24. In addition to the low risk of morbidity with medication abortion, as previously described, abortion care also has a low risk of mortality. Medication abortion is safer than childbirth, and a person is more likely to be struck by lightning than to die from medication abortion.

25. Medication abortion is an increasingly common method of pregnancy termination. The utilization of medication abortion has increased every year since it was introduced to the United States market in 2000 and now accounts for over half of all abortion care provided in the US.[37] Medication abortion has therefore gained a broad acceptance among healthcare providers and the American public.

26. The popularity of medication abortion among patients is multifactorial. Many patients I care for prefer medication abortion to procedural abortion (aka surgical abortion), when given a choice. Some patients tell me they view medication abortion as "more natural," since it mimics the process of miscarriage. Many patients who have already had miscarriages before tell me they want a medication abortion because they've already experienced something similar, so it offers them peace of mind. Some patients experience significant fear and anxiety with needles and would prefer to avoid procedural abortion when they can. Some patients want the care and support of a loved one through the abortion process, and so they prefer medication abortion because it can be completed in the comfort of their home. Medication abortion also allows people to time their abortion in a more convenient way – like after their children have gone to bed – and so medication abortion offers flexibility in scheduling.

[37] https://www.guttmacher.org/article/2022/02/medication-abortion-now-accounts-more-half-all-us-abortions?gad=1&gclid=CjwKCAjwh8mlBhB_EiwAsztdBFelnO3WMU-oHGBcdm6Av2adHXlQzz0_jhx3L7rYH9aKg_nn9jjUNRoCH4oQAvD_BwE

27. In addition to patient preference, medication abortion might also be medically indicated over procedural abortion for many people. In my practice, there are countless reasons why I might recommend medication abortion over procedural abortion for an individual patient. Medication abortion allows people to be able to access abortion care on their own, without needing a driver. For procedural abortion, we offer sedation with medications that prevent someone from being able to drive home. In large states like Texas and Wyoming, patients often must travel great distances, sometimes hundreds of miles, to be able to access essential healthcare. While some people can travel to their appointment with a support person that can drive them home after receiving sedation, many people cannot. In those situations, I might recommend medication abortion over procedural abortion, so the patient does not have to undergo a procedure without sedation if they don't want to. Some patients also have allergies to the various anesthetic medications we use during procedural abortion, like lidocaine. Again, I might recommend medication abortion for someone who has an anesthetic allergy, so they can have a safe and comfortable experience, rather than a procedural abortion without the benefit of lidocaine. By banning medication abortion, Wyoming is telling patients in these scenarios that they must endure unnecessary pain, rather than receiving the benefit of a safe and common medication that their physician recommends.

28. For a patient with a structural difference in their uterus, I sometimes recommend they choose medication abortion rather than procedural abortion because their anatomical differences make a procedural abortion more challenging. For example, some people I have cared for have a condition called uterine didelphys. This is a rare condition where a person is born with two uteruses and possibly, two cervixes. In my experience with uterine didelphys, one cervix and one uterus are generally much smaller than the other and both have an irregular shape. A person

can get pregnant in either uterus. A small, differently shaped cervix and uterus can present technical challenges to procedural abortion. One uterus could be behind the other uterus in a way that prevents easy visualization by ultrasonography, making procedural guidance challenging. One cervix can be so small that it is barely visible on exam, making entry exceedingly challenging. A didelphys uterus can present serious technical challenges and risks for a safe procedural abortion. In these cases, I have recommended that patients try medication abortion first, with the option for procedural abortion if needed. This prevents attempted instrumentation and reduces the risk of injury in these rare and technically challenging conditions. The patients I cared for were grateful that I was able to counsel them about their options and offer individualized care to best meet their unique needs. In other instances, some patients have large fibroids in their uterus also making entry technically challenging. Fibroids are benign, muscular tumors of the uterus and are found in up to 75% of people. While most fibroids remain just a few centimeters in size, in some cases these fibroids grow so large that a person can look pregnant. In my practice, I have surgically removed fibroids that weigh over 10 lbs. Fibroids can distort the uterine cavity, making visualization or entry technically challenging. In instances of very large fibroids that distort the cervical canal or uterine cavity shape, I have recommended that patients consider medication abortion rather than procedural abortion to prevent instrumentation and reduce the risk of injury. By banning medication abortion, Wyoming is telling patients in similar scenarios that they must endure unnecessary risk, rather than receiving the benefit of a safe and common medication that their physician recommends.

29. Medication abortion might also be a medically necessary choice over procedural abortion for patients with certain medical conditions. In my practice, I have cared for several people with severe, uncontrolled seizure disorder. While anti-convulsant medications can help, I

have cared for people that continue to have seizures despite being on multiple medications to suppress seizures. This is a debilitating condition and one that can present challenges to receiving procedural abortion care. In most of the country, patients do not get general anesthesia when they receive procedural abortion care, but instead get conscious sedation. Conscious sedation reduces pain and causes sleepiness, but it does not immobilize or paralyze a person. Although a procedural abortion is a short procedure, there is a risk of injury to a patient undergoing a procedure while awake if they begin to have convulsions. In patients with very severe seizure disorder that is not able to be controlled with medications, I have recommended they choose medication abortion rather than procedural abortion to prevent this risk. By banning medication abortion, Wyoming is telling patients with complex medical conditions that they must endure unnecessary risk, rather than receiving the benefit of a safe and common medication that their physician recommends.

30. Finally, I have also recommended medication abortion rather than procedural abortion for patients that have previously survived sexual violence. Over half of women have been victims of sexual violence in their lifetime and women of ethnic and racial minority groups are more likely to have experienced sexual violence.[38] Victims of sexual violence often struggle with receiving medical care, especially gynecology care. The trauma from sexual violence often keeps people from even seeking medical care. Although I approach all the healthcare I provide from a trauma-informed care lens, some patients suffer from such severe trauma that they cannot even tolerate a vaginal ultrasound, let alone a procedural abortion via the vagina. For patients that suffer from trauma after sexual assault, I recommend they choose medication abortion rather than procedural abortion to prevent re-traumatization. I have also provided procedural abortion for

[38]https://www.cdc.gov/violenceprevention/sexualviolence/fastfact.html#:~:text=Sexual%20violence%20is%20common.&text=One%20in%204%20women%20and,harassment%20in%20a%20public%20place.

patients with a history of sexual violence. While some do well, others begin suffering from severe anxiety and panic once I start the procedure. In these instances, I have stopped the procedure and offered medication abortion as an alternative to continuing, to prevent them further harm and trauma. People who have experienced sexual violence need access to medication abortion as an alternative to procedural abortion. By banning medication abortion, Wyoming is telling survivors of sexual violence they must endure unnecessary re-traumatization, rather than receiving the benefit of a safe and common medication that their physician recommends.

31. While mifepristone and misoprostol are used to induce abortion, they are also important drugs in the management of miscarriage. Together, mifepristone and misoprostol improve the efficacy of miscarriage management when patients are trying to avoid a surgical procedure.[39] While The Medication Ban does not appear to directly restrict the use of these medicines for miscarriage care in Wyoming, from my experience in Texas, I know The Medication Ban will have a chilling effect on access to these medicines for miscarriage care.[40] Afraid of violating abortions laws, pharmacists in Texas have refused to fill prescriptions for misoprostol in the setting of miscarriage care.[41] In my own practice, I have diagnosed patients with miscarriage and recommended mifepristone and misoprostol, but national pharmacies have refused to provide mifepristone to my patients for *miscarriage* because they worried about violating *abortion* laws. It's important to note that like The Medication Ban, Texas abortion laws also exclude their enforcement on miscarriage care, yet my patients and others across the state are being denied the

[39] Schreiber CA, Creinin MD, Atrio J, Sonalkar S, Ratcliffe SJ, Barnhart KT. Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss. N Engl J Med. 2018 Jun 7;378(23):2161-2170. doi: 10.1056/NEJMoa1715726. PMID: 29874535; PMCID: PMC6437668.

[40] https://slate.com/news-and-politics/2022/05/abortion-texas-pharmacies-refusing-prescriptions-misoprostol-methotrexate.html

[41] https://www.dallasnews.com/news/public-health/2022/07/18/pharmacists-are-in-limbo-under-texas-abortion-laws/

medications. This chilling effect on pharmacists has resulted in federal civil rights investigations and ongoing litigation across the country.[42] Laws like The Medication Ban not only remove access to critical medications for abortion care without any legitimate public health benefit, but they also negatively impact access to care for people experiencing miscarriage.

32. While mifepristone and misoprostol are the most common medications used for medication abortion in the United States, many other drugs can also induce abortion, and access to these drugs will be impacted by The Medication Ban. Prior to the introduction of mifepristone to the US market, medication abortion was often completed by using methotrexate. Methotrexate is a dihydrofolate reductase inhibitor that is a common chemotherapy and immunosuppressive agent. Through its actions on folate synthesis, methotrexate can inhibit DNA synthesis, thereby stopping the proliferation of rapidly dividing cells.[43] This mechanism of action has proven methotrexate to be an effective medication for the treatment and/ or management of rheumatoid arthritis, juvenile idiopathic arthritis, psoriasis, lupus, inflammatory bowel disease, certain gynecologic cancers, and ectopic pregnancy. The use of methotrexate in the treatment of induced abortion has fallen out of favor in the past twenty years since the introduction of mifepristone to the US market. Even though methotrexate is no longer used for medication abortion, bans on medication abortion have resulted in decreased access to methotrexate for its use in these other important medical conditions.[44]

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[42] https://www.npr.org/sections/health-shots/2022/07/13/1111348722/pharmacies-may-violate-civil-rights-if-they-refuse-meds-linked-to-abortion-feds-

[43] https://www.ncbi.nlm.nih.gov/books/NBK556114/#:~:text=Methotrexate%20(MTX)%20is%20an%20anti,wide%20variety%20of%20neoplastic%20diseases.

[44] https://www.cnn.com/2022/07/22/health/abortion-law-medications-methotrexate/index.html

33. Clearly, banning medication abortion as a method of pregnancy termination has no plausible safety benefit for the people of Wyoming and for some people, medication abortion is preferrable or medically necessary in comparison to procedural abortion. In addition, banning medication abortion has a cascade of negative healthcare access implications for people with other health conditions that utilize the same medications. Banning this method of pregnancy termination only serves to limit access to essential healthcare for the people of Wyoming.

C. Like The Abortion Ban, the "exception" language of The Medication Ban is too vague to allow physicians to use their medical judgment to prevent serious harm for people with pregnancy complications.

34. Assuming "chemical abortion" means medication abortion, The Medication Ban allows an exception to the prohibition on medication abortion only with:

> *"Treatment necessary to preserve the woman from an imminent peril that substantially endangers her life or health, according to appropriate medical judgment, or the pregnancy is the result of incest as defined by W.S.6-4-402 or sexual assault as defined by W.S. 6-2-301. As used in this paragraph, "imminent peril" means only a physical condition and shall not include any psychological or emotional conditions. No medical treatment shall form the basis for an exception under this paragraph if it is based on a claim or diagnosis that the pregnant woman will engage in conduct which she intends to result in her death or other self-harm.*

As with the term "chemical abortion," there is no medical definition or guidance for the terms "imminent peril" or "substantially endangers her life". Furthermore, there is no medical textbook that delineates what are clear "physical conditions" and what are clear "psychological or emotional conditions". The meanings and application of these phrases do not appear in textbooks, are not taught in medical school, and are not part of the training or certification of Ob-Gyn's.

35. As previously described in this Declaration, I have personally been prevented from providing life-saving abortion care for a patient because of the language of the medical emergency law in Texas, like The Medication Ban language. Hospital leadership decided that a patient with severe heart failure was not actively dying at that moment and therefore would not allow us to provide her the care that was needed to sustain her life and prevent further harm to her heart. It is unconscionable in modern medical practice to withhold interventions or treatments that would prevent someone from critically decompensating, until they are actively dying, but that is exactly the result of vague exception language like that found in The Medication Ban.

36. Just like with The Abortion Ban, when considering The Medication Ban, it's important to assess the capacity of Wyoming's medical infrastructure to offer the necessary, life-saving care to pregnant patients experiencing emergencies and to the infants born from abortion refusal in emergency settings. As I have described, Wyoming does not have the maternal or neonatal levels of care available to prevent significant maternal morbidity and neonatal death in the setting of delayed intervention with The Medication Ban.

37. The language of The Medication Ban is medically inaccurate and does not capture the nuance or reality of healthcare for pregnant people. Pregnancy care is too nuanced to expect that a list of "exceptions" to an abortion ban can protect the health and safety of pregnant people suffering from complications.

D. The "exception" language of The Medication Ban specifically excludes the leading cause of maternal death in the United States – preventing physicians from using their medical judgment to reduce maternal death in Wyoming.

38. Assuming "chemical abortion" means medication abortion, The Medication Ban allows an exception to the prohibition on medication abortion only when the person is in "imminent peril," however:

> *"..."imminent peril" means only a physical condition and shall not include any psychological or emotional conditions. No medical treatment shall form the basis for an exception under this paragraph if it is based on a claim or diagnosis that the pregnant woman will engage in conduct which she intends to result in her death or other self-harm."*

Other than to further ban access to abortion care, it is unclear why The Medication Ban would exclude mental illness as a treatable exception. Mental illness involves one of the most important organs in the body, the brain. How mental illness is not a 'physical condition,' when it involves an illness of a physical organ has no basis in medical reality. It is also important to note that The Medication Ban attempts to describe mental illness by using terminology to suggest it something other than a medical illness. This ideology is not supported by modern medical practice. Mental illness is a 'physical' illness, in the same way diabetes, arthritis, or a broken bone are.

39. Four in five maternal deaths in the United States are preventable and the leading cause of pregnancy related death in the United States is from mental health conditions, specifically death by suicide and overdose.[45] Creating an exception to a medically dangerous law like The Medication Ban yet excluding the #1 cause of maternal death in that exception makes no logical sense and serves no public benefit.

40. Wyoming currently has only one state-operated psychiatric hospital.[46] They do not take admissions of pregnant people after-hours or on the weekends. Pregnant people in Wyoming

[45] https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html
[46] https://health.wyo.gov/behavioralhealth/statehospital/

already struggle to get the healthcare they need for the leading cause of maternal death. Excluding mental illness in The Medication Ban is irresponsible and will not truly help the people of Wyoming.

E. Like The Abortion Ban, The Medication Ban contains several instances of material misstatements, omissions, vague terminology, or misrepresentations about medical definitions in causing confusion in the delivery of life-saving healthcare and chill physicians from offering the standard of care.

41. Contraception: Although The Medication Ban allegedly does not restrict contraception, The Medication Ban's language is too vague to protect access to birth control and will likely result in restrictions on some contraceptives. The Medication Ban claims it does not apply to:

> *"The sale, use, prescription or administration of any contraceptive agent administered before conception or before pregnancy can be confirmed through conventional medical testing."*

I assume "conception" means fertilization in this portion of The Medication Ban. Fertilization is when a sperm meets an egg, but before pregnancy has happened. Pregnancy is when an embryo implants. The Medication Ban conflates fertilization with pregnancy, which is scientifically inaccurate. Some birth control methods, like the intrauterine device (IUD), primarily work by preventing fertilization, but theoretically *might* prevent implantation, after fertilization. The Medication Ban could also effectively ban access to one of the most effective forms of contraception through this vague language. The conflation of fertilization with pregnancy has been previously used to restrict access to the IUD and to emergency contraception and the language in

The Medication Ban should be alarming to anyone wanting to retain access to birth control in Wyoming.[47]

42. Pregnant or pregnancy are incorrectly defined by The Medication Ban, creating confusion. Pregnancy is when an embryo implants. A person cannot be pregnant until they have established a connection to the embryo through implantation. However, The Medication Ban defines pregnancy as the *"condition of a woman who has a human embryo or fetus within her as the result of conception"*. The Medication Ban makes a new definition for pregnancy, creating further confusion with compliance as described.

43. Ectopic pregnancy is omitted from The Medication Ban entirely and it is unclear if The Medication Ban prevents physicians in Wyoming from treating ectopic pregnancies before they result in catastrophic emergencies. I have previously described the various forms of ectopic pregnancy in this Declaration. Ectopic pregnancy is when an embryo implants outside of the normal location within the uterine endometrium. Some ectopic pregnancies must be treated surgically, and some ectopic pregnancies should or must be treated with medications because of their location. The Medication Ban is too vague and medically inaccurate to determine if the treatment of some ectopic pregnancies with methotrexate constitutes a "chemical abortion". Most ectopic pregnancies implant in the fallopian tubes or in the ovaries. When diagnosed in these locations prior to rupture, methotrexate is the preferred treatment to prevent surgical intervention. As ectopic pregnancy has been omitted from The Medication Ban language, and pregnancy has been vaguely and inaccurately defined, treatment of ectopic pregnancy with methotrexate might constitute "chemical abortion". Cervical ectopic pregnancy is a rare form of ectopic pregnancy that is associated with high morbidity and mortality and requires immediate intervention *before*

[47] https://www.theatlantic.com/health/archive/2014/03/heres-why-hobby-lobby-thinks-iuds-are-like-abortions/284382/

becoming an emergency.[48] Because of the increased risk for bleeding with surgical intervention in cervical ectopic pregnancies, treatment with methotrexate is often preferred. Again, it is possible The Medication Ban prohibits the safest method of treating cervical ectopic pregnancies.

44. Lethal Fetal Anomaly: The Medication Ban does not provide exceptions in cases of lethal fetal anomaly. As a physician who has provided abortion care for hundreds of patients with lethal fetal anomalies and delivered dozens of babies with lethal fetal anomalies, I know this can be a devastating time for parents. While some people choose to have a procedural abortion in this setting, others choose to have a medication abortion so that they may hold their infant and grieve after the termination. The Medication Ban strips grieving parent from the opportunity to terminate their pregnancies in the way they choose and to grieve in whatever way is best for them.

IV. Banning procedural abortion and/or medication abortion as options for pregnancy termination is a violation of all four basic pillars of medical ethics: autonomy, non-maleficence, beneficence, & justice.

45. Autonomy in healthcare establishes that patients ultimately have the power and right to make their own medical decisions without coercion, even if the decision is different from the recommendations of their healthcare provider. Patients themselves, not healthcare providers nor politicians, ultimately decide what medical interventions and risks are acceptable for them. Every healthcare intervention comes with risks and the duty of a physician is to accurately provide non-biased counseling about the risks, benefits, and alternatives of any treatment course to support patient autonomy. As I have described, there are countless situations where a patient might choose

[48] Singh S. Diagnosis and management of cervical ectopic pregnancy. J Hum Reprod Sci. 2013 Oct;6(4):273-6. doi: 10.4103/0974-1208.126312. PMID: 24672169; PMCID: PMC3963313.

medication abortion over procedural abortion for their pregnancy termination. Educating patients on the risks, benefits, and alternatives to both abortion options, and offering both options to patients, is fundamental to upholding autonomy in medical care.

46. Non-maleficence is the ethical principle commonly known as "do no harm". The concept of non-maleficence obligates physicians to refrain from causing intentional or unintentional harm to their patients. Complying with The Abortion Ban and The Medication Ban would cause a direct conflict with a physician's obligation of non-maleficence to their patients for all the reasons described above.

47. Beneficence dictates that as healthcare providers, we must actively work to help the patients we serve. We must offer medication abortion as an option for pregnancy termination, not only because it supports patient autonomy, but also because the option serves the "better good" for patients. While non-maleficence compels a physician not to harm patients, beneficence also compels physicians to help patients. For the thousands of I have cared for by providing abortion through medication or surgery, I know directly from my interactions with them that providing abortion was an act of beneficence. Furthermore, submitting this Declaration in opposition to The Abortion Ban and The Medication Ban and to help preserve access to medication abortion for the people of Wyoming is beneficence.

48. Finally, the ethical principle of justice dictates that healthcare should be fair and equitably distributed. The Abortion Ban and The Medication Ban will deny people in Wyoming access to procedural abortion and to medication abortion, while they are available to people in neighboring Colorado or Utah, thus violating the principle of justice. From my experience, I know that banning abortion does not stop abortions for everyone. The latest public health research describes how the overturning of *Roe v Wade* resulted in disruptions of healthcare for over 80,000

people and likely about 25,000 people were not able to access the abortion care they needed.[49] Abortion bans across the United States have forced tens of thousands of people to travel hundreds of miles to access abortion care, while thousands of others have not been able to travel to receive that care. Abortion bans result in unequal access to healthcare and violate the ethical principle of justice.

I declare under penalty of perjury under the laws of the State of Wyoming that the foregoing is true and correct. Executed at Dallas, Texas.

Dated this 17th day of July 2023.

Ghazaleh Kinney Moayedi

[49] https://societyfp.org/research/wecount/