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MONTANA THIRTEENTH JUDICIAL DISTRICT COURT, YELLOWSTONE COUNTY

PLANNED PARENTHOOD OF MONTANA, et al. Plaintiffs, v. STATE OF MONTANA, by and through AUSTIN KNUDSEN, in his official capacity as Attorney General, Defendant.	Cause No. DV 21–999 Hon. Michael G. Moses **BRIEF IN SUPPORT OF DEFENDANT'S MONT. R. CIV. P. 56 CROSS-MOTION FOR SUMMARY JUDGMENT**

INTRODUCTION

While some states have enacted measures to protect unborn children from painful abortions at 15 weeks' gestation,[1] Montana took a more modest approach in adopting the Pain-Capable Unborn Child Protection Act, protecting human life from unnecessary destruction after 20 weeks. The public policy behind the Act is obvious: after 20 weeks' gestation, abortion typically involves tearing the unborn child limb from limb with medical instruments, causing the dismembered fetus to bleed to death. Yet unborn children at 20 weeks and even younger are given anesthesia and analgesia when undergoing fetal surgery *in utero* to reduce their physiological response to pain. And with gestational-age estimation having a margin of error up to two weeks, the 20-week limit also ensures that no viable fetus is painfully killed through abortion because of a miscalculation.

For decades, *Roe v. Wade*, 410 U.S. 113 (1973), and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), blocked states from enacting meaningful regulation of abortion of this sort. The two cases' "most important rule (that States cannot protect fetal life prior to 'viability') was never raised by any party and has never been plausibly explained." *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2266 (2022). Yet with *Roe* and *Casey* as inspiration and shield, state courts also began to discern a "right" to a pre-viability abortion in their constitutions, despite an absence of textual support, much less any suggestion that "viability" should be a meaningful distinction for when prenatal life enjoyed the protection of law or could be summarily ended. *See, e.g.,* A*rmstrong v. State,* 1999 MT 261, 296 Mont. 361, 989 P.2d 364 (holding Montana's requirement that pre-viability abortions be performed only by competent and licensed physicians violated the Montana constitutional right to privacy).

[1] *See, e.g.,* Miss. Code Ann. § 41-41-191 (2023) and Fla. Stat. Ann. § 390.111 (2023).

When overturning *Roe* and *Casey* last year, the U.S. Supreme Court made clear that "the Constitution does not confer a right to abortion. . . . and the authority to regulate abortion must be returned to the people and their elected representatives." *Dobbs*, 142 S. Ct. at 2279. "Viability" as a legal standard is no more, and any cover it erroneously gave or confusion it inserted into state courts should be jettisoned. When an important state interest like mitigating unnecessary pain from an elective deadly procedure is at stake, Montana can permissibly tailor its health, safety, and welfare laws to ensure that human life is protected from such suffering. Based on the undisputed facts in this case regarding the reality of fetal life at 20 weeks and the nature of the abortion procedure, this Court should uphold the Act.

THE CHALLENGED LAW

The representatives of the people of Montana enacted the Montana Pain-Capable Unborn Child Protection Act ("HB 136" or "the Act"), codified at Mont. Code Ann. §§ 50-20-601–606, to advance the State's legitimate and compelling interests in respecting and preserving prenatal life at all stages of development, protecting maternal health and safety, eliminating gruesome medical procedures, preserving the integrity of the medical profession, and mitigating fetal pain. *Dobbs*, 142 S. Ct. at 2284. The Act promotes respect for and preserves prenatal life, and protects maternal health and safety, by limiting abortions in the second half of pregnancy to instances in which, in the exercise of reasonable medical judgment, an abortion is necessary to protect the life or health of a pregnant woman. The Act is also narrowly tailored to address the State's compelling interest in preventing the unborn from unnecessarily experiencing pain and death by dismemberment in an abortion after 20 weeks' gestation: it prohibits only the most gruesome and destructive acts against a human life in the womb.

PROCEDURAL HISTORY

In August 2021, Plaintiffs sought, and ultimately obtained, a preliminary injunction on the Act and two other statutes relating to abortion. Defendants appealed to the Montana Supreme Court, which specifically reaffirmed that "[a] statute enjoys a presumption of constitutionality," but held that this Court did not manifestly abuse its discretion in finding Plaintiffs had made a prima facie case for injunction under the old lax standard,[2] and remanded the matter for development of the record at trial. *Planned Parenthood of Montana v. State by & through Knudsen*, 2022 MT 157, ¶ 61, 409 Mont. 378, 404, 515 P.3d 301, 317 (citation omitted). The parties engaged in discovery, and Plaintiffs moved for summary judgment on all claims. Defendants oppose Plaintiffs' motion for summary judgment, and bring this cross claim for summary judgment.

STATEMENT OF UNDISPUTED MATERIAL FACTS

1. The Act does not restrict Plaintiffs' performance of abortions on fetuses younger than 20 weeks' gestation. Mont. Code Ann. § 50-20-603(1).

2. Plaintiffs do not perform abortions on fetuses older than 21 weeks, six days' gestation. (Depo. Samuel Dickman, MD, 117:2–20 (Mar. 8, 2023), relevant excerpts attached as **Exhibit A**; Depo. Colleen P. McNicholas, DO, 19:16–20 (Mar. 15, 2023), relevant excerpts attached as **Exhibit B**; Depo. Martha Fuller, 24:2–25:12 (Feb. 6, 2023), relevant excerpts attached as **Exhibit C**.)

3. Plaintiffs typically perform fewer than 10 abortions per year on fetuses more than 20 weeks old, which is "quite a small number of visits" compared to their overall business. (Ex. C at 37:4–38:1.)

[2] The Montana Legislature recently brought Montana's preliminary injunction requirements into line with the federal standard and most other states. *See* Senate Bill 191 (2023)

4. The concept of "viability"—by which is meant the stage of development at which a fetus can survive outside his or her mother's womb—is not a fixed medical definition. (Ex. B at 20:17–21:13.) "Viability" is based on several factors, and varies for each baby. (*Id.* at 22:16–23:23.)

5. A fetus' gestational age may be estimated on the basis of a mother's statement regarding the date of her last menstrual period ("LMP") and by ultrasound examination. Examination by ultrasound sometimes reveals a discrepancy between the fetus' estimated gestational age based on the mother's statement and the physiological features of the fetus revealed by ultrasound. (*Id.* at 94:16–95:16.)

6. In the second trimester of pregnancy, Plaintiffs' policy is not to revise the estimation of the fetus' gestational age from the basis of the mother's statement regarding her LMP unless ultrasound examination reveals a discrepancy of more than 10 days. (*Id.* at 95:17–97:3.)

7. An estimate of a fetus' gestational age based on an ultrasound may be inaccurate by multiple weeks. (Depo. Robin Pierucci, MD, 83:7–11 (Mar. 6, 2023), relevant excerpts attached as **Exhibit D**; Depo. George Mulcaire-Jones, MD, 101:3–8 (Mar. 17, 2023), relevant excerpts attached as **Exhibit E**.) The inaccuracy of this estimate increases with the length of the pregnancy. (Ex. D at 97:9–14.)

8. Anesthesia and analgesia are administered directly to fetuses younger than 20 weeks' gestation during intrauterine surgeries. (Ex. B at 88:1–25, 94:1–13; Ex. D at 156:21–157:9, 174:1–175:5.)

9. One of the purposes of administering pain medication to a fetus during intrauterine surgery is to suppress the fetus' stress response to the surgery. (Ex. B at 88:7–20, 94:7–12.)

10. Fetuses experience better outcomes from intrauterine surgeries if they are administered anesthesia during the surgery. (*Id.* at 91:9–22; Ex. D at 156:21–157:9.)

11. A person may experience pain without being able to describe the sensation. (Ex. D at 118:19–119:16.)

12. There is no scientific or medical consensus that the experience of pain in human adults is the same as in people at other stages of development, such as adolescents, toddlers, or infants (Ex. D at 119:17–120:15, 121:20–23), but the International Association for the Study of Pain does not have different definitions of pain for different age groups. (*Id.* at 131:19–21.)

13. It is difficult to conduct ethical studies on fetal pain without harming the mother or fetus, and because the fetus cannot consent to the study and cannot articulate its experience of noxious stimuli. (Ex. B at 92:11–93:13; Ex. D at 120:16–122:5, 131:4–9.)

14. The human nervous system does not exist in a binary "on/off" state, but along a continuum of ability to sense stimulation during prenatal human development, and develops throughout gestation. (Ex. D at 121:16–20, 130:15–131:9; Depo. Ingrid Skop, MD, Vol. 2, 43:6–15 (Mar. 28, 2023), relevant excerpts attached as **Exhibit F**.)

15. Fetuses develop sensory receptors for painful stimuli called nociceptors, and react to stimuli that are universally understood as painful to adult humans—such as penetration by a needle—in a manner consistent with pain in any other stage of human development. These may include withdrawal from the stimulus, heart rate changes, oxygenation changes, hormonal response, and changes in their facial expressions. (Ex. D at 131:7–9, 133:20–23, 177:10–24, 184:11–185:3, 193:22–195:15, 213:4–214:18; Ex. E at 103:6–21; Depo. Steven J. Ralston, MD, 67:25–68:20, 83:6–85:25 (Mar. 24, 2023), relevant excerpts attached as **Exhibit G**.)

16. Extremely premature babies and unborn fetuses of the same gestational age both exhibit physical reactions and the release of stress hormones in response to noxious stimuli. (Ex. D at 157.23–158:2; Ex. F at 45:5–8.)

17. An abortion of a fetus older than seven to eight weeks requires dilation of the mother's cervix, as the fetus is too large to be extracted without dilation. (Ex. E at 34:12–35:6.)

18. An abortion of a fetus older than 13 weeks requires a dilation and evacuation procedure, or "D&E," in which the abortion provider dismembers the fetus in the mother's uterus with a grasping instrument such as ring forceps, and extracts fetal body parts from the mother's body through her cervix. (*Id.* at 35:17–36:6.)

19. A pregnancy terminated by a D&E procedure is always fatal to the fetus. (*Id.* at 100:21–24.)

20. Plaintiffs' and Defendants' experts are learned experts in the field of medicine and have divergent views on the question of whether a fetus can perceive pain before 20 weeks of age. (Ex. A at 178:5–25; Ex. B at 89:1–10; Ex. D at 135:15–137:15; Ex. E at 104:2–21; Ex. F at 43:6–15; Ex. G at 36:22–37:7; 40:11–16.)

21. Postnatal humans—whether infants, toddlers, children, adolescents, or adults—may be or become incapable of perceiving pain by neurological disorder or injury, or may be rendered incapable of perceiving pain through anesthesia. In no context other than abortion, however, is an individual human's inability to perceive pain a legal threshold beyond which another person or persons may decide to end his or her life without due process. *See, e.g.*, Ex. D at 62:1–19.)

LEGAL STANDARDS

As movant, the State of Montana has the initial burden of showing a lack of genuine issue of material fact. *Kageco Orchards, LLC v. Montana Dep't of Transp.*, 2023 MT 71, ¶ 9, — Mont. —, — P.3d —. The Court will consider the Rule 56 record, "which includes 'the pleadings, the discovery and disclosure materials on file, and any [supporting] affidavits' submitted." *Id.* (quoting Mont. R. Civ. P. 56(c)(3)). "The burden then shifts to the opposing party to either show the existence of a genuine issue of material fact precluding summary judgment or that the moving party is nonetheless not entitled to judgment as a matter of law." *Kageco Orchards* ¶ 9.

Because abortion is not a fundamental right, the State need only demonstrate a rational relation to a legitimate state interest to regulate its practice. The Supreme Court of Montana has articulated three standards of review to be applied to legislation in a constitutional challenge, depending on the nature of the right involved—strict scrutiny, middle-tier scrutiny, or the rational-basis test:

> Legislation that implicates a fundamental constitutional right is evaluated under a strict scrutiny standard, whereby the government must show that the law is narrowly tailored to serve a compelling government interest. If a law or policy affects a right conferred by the Montana Constitution, but is not found in the Constitution's declaration of rights, we apply middle-tier scrutiny. If neither strict scrutiny nor middle-tier scrutiny apply, the rational basis test is appropriate. Pursuant to the rational basis test, the statute must be rationally related to a legitimate government interest.

Montana Cannabis Indus. Ass'n v. State, 2012 MT 201, ¶ 16, 366 Mont. 224, 286 P.3d 1161 (citations omitted).

The Declaration of Rights in Article II of the Montana Constitution enumerates many rights in its 35 sections. Abortion is not listed among these rights and is not a fundamental right entitled to strict scrutiny. Neither is abortion a right that is "necessary to enjoy" an Article II enumerated right—see *Wadsworth v. State*, 275 Mont. 287, 299, 911 P.2d 1165, 1172 (1996) (discussing the

implicit right to pursue employment as necessary to enjoy the enumerated right of "pursuing life's basic necessities" in Art. II, Sect. 3)—and therefore not entitled to middle-tier scrutiny.

Montana's regulation of the practice of abortion thus falls to rational-basis review, consistent with many other states and the U.S. Supreme Court's holding in *Dobbs*, 142 S. Ct. at 2283 (identifying rational basis as the governing standard for federal constitutional challenges to state abortion regulations); *see also Planned Parenthood Great Nw. v. State*, 171 Idaho 374, 522 P.3d 1132, 1195 (2023) ("Total Abortion Ban, 6-Week Ban, and Civil Liability Law are all rationally related to. . . legitimate governmental interests."); *Planned Parenthood of the Heartland, Inc. v. Reynolds ex rel. State*, 975 N.W.2d 710, 716 (Iowa 2022), reh'g denied (July 5, 2022) ("[T]he Iowa Constitution is not the source of a fundamental right to an abortion necessitating a strict scrutiny standard of review for regulations affecting that right.")

ARGUMENT

I. PLAINTIFFS ARE ENTITLED TO SUMMARY JUDGMNET BECAUSE NO MATERIAL FACTS ARE IN DISPUTE, AND THE MONTANA PAIN-CAPABLE UNBORD CHILD PROTECTION ACT IS RATIONALLY RELATED TO A LEGITIMATE STATE INTEREST.

A. THE ACT ENJOYS A STRONG PRESUMPTION OF CONSTITUTIONALITY.

Within the power granted by its constitution, Montana may lawfully regulate for the health and safety of its citizens. *Wiser v. Mont. Dep't of Comm*., 2006 MT 20, ¶ 19, 331 Mont. 28, 129 P.3d 133. A challenge to the constitutionality of a statute must overcome a strong presumption that the laws duly passed by the Montana legislature comply with the Montana Constitution. *Harrison v. City of Missoula*, 146 Mont. 420, 425, 407 P.2d 703, 706 (1965). The Montana Supreme Court has repeatedly "held that in determining the constitutionality of any statute that the court will if possible construe the statute as constitutional. The presumption is for constitutionality." *Id.* 407

P.2d at 706. The courts will hold a statute constitutional unless it constitutes a "clear and palpable" violation of "fundamental law." *Id*.

The U.S. Supreme Court has similarly endorsed this presumption of constitutionality in the specific context of regulating abortion:

> States may regulate abortion for legitimate reasons, and when such regulations are challenged under the Constitution, courts cannot "substitute their social and economic beliefs for the judgment of legislative bodies." That respect for a legislature's judgment applies even when the laws at issue concern matters of great social significance and moral substance.

Dobbs, 142 S. Ct. at 2283–84 (citations omitted). Laws regulating abortion are "entitled to a 'strong presumption of validity'" and "must be sustained if there is a rational basis on which the legislature could have thought that it would serve legitimate state interests." *Id.* at 2284.

B. MONTANA MAY, AND DOES, EXERCISE ITS CONSTITUTIONAL AUTHORITY TO PROTECT THE INTERESTS OF THE UNBORN.

Plaintiffs concede the State has a compelling interest in protecting "a particular class of patients." (Doc. 111 at 11.) And it is common ground that obstetricians consider both the expectant mother and her unborn child patients. (Depo. Ingrid Skop, MD, Vol. 1, 59:2–20 (Mar. 28, 2023), relevant excerpts attached as **Exhibit H**.) Moreover, Montana already recognizes the unborn as a class to whom constitutional and statutory protections apply. A fetus as young as eight weeks' gestation, for example, may be the victim of a violent crime. Mont. Code Ann. § 45-5-102 and 116(3) include as a "deliberate homicide" the purposeful or knowing causation of the death of "the fetus of another." *See also* Mont. Code Ann. § 45-5-103 ("mitigated deliberate homicide" includes "purposely or knowingly caus[ing] the death of a fetus of another [while] under the influence of extreme mental or emotional stress"). The interests of the unborn are also protected, without regard to gestational age, in Montana's laws governing trusts and estates. Under Mont. Code Ann. § 72-38-303(6), "a parent may represent and bind the parent's minor *or unborn child* if a

conservator or guardian for the child has not been appointed." (Emphasis added.) Mont. Code Ann. § 41-1-103 provides: "A child conceived but not yet born is to be deemed an existing person, so far as may be necessary for its interests in the event of its subsequent birth."

Montana has long recognized its obligation to protect the interests of the unborn. The Act reasonably advances the State's interest in protecting unborn human life and protecting the unborn from unnecessary pain.

C. THE CONSTITUTIONAL RIGHT TO PRIVACY IS NOT ABSOLUTE, AND THE STATE MAY IMPOSE REASONABLE REGULATIONS ON ABORTION, SUCH AS THE ACT'S LIMIT ON ABORTIONS TO MITIGATE FETAL PAIN.

The Montana Constitution guarantees the right to privacy. Mont. Const. Art. II, § 10. That right, however, is not absolute, and "it does not necessarily follow from the existence of the right to privacy that every restriction on medical care impermissibly infringes that right." *Wiser*, ¶ 15. The Montana Supreme Court has made clear that the right to health care is limited to the right to obtain a "lawful medical procedure" from a "competent" and "licensed" provider. *Id.* at ¶¶ 15–16 (quoting *Armstrong*, 1999 MT 261, ¶ 62). The notion that a procedure must be lawful, and a provider must be competent and licensed, necessarily implies some authority of the State to regulate procedures and providers.

States may act to promote their legitimate interest in respecting and preserving prenatal human life at all stages of development. *Dobbs*, 142 S. Ct. at 2284. The Act only limits abortions in pregnancies after 20 weeks' gestational age, with an exception for life or health of the mother. Rather than relying on a disputed, shifting, and judicially created threshold of viability, by enacting a 20-week limit, representatives of the people of Montana established a clear line that ensures that any unborn child who might survive outside the womb would not unnecessarily die by abortion.

Placing a limit beyond which a developing human fetus may not be aborted except when necessary to protect her mother's life or health is rationally related to preserving prenatal human life.

The Act places no restrictions on abortion until 20 weeks' gestation. This new limit is halfway through a full-term pregnancy. Given the multi-week margin of error even in the most common and accurate methods of estimating gestational age (*see* Ex. D at 83:7–11; Ex. E at 101:3–8), it is at the current edge of viability.[3] (And *Roe*'s "viability" standard is now dead letter in any event.) Because Plaintiffs perform only a tiny fraction of their abortions on fetuses older than 20 weeks, the Act will have a small effect on the number of abortions performed in Montana.

The Act also allows for abortions after 20 weeks when reasonably necessary to protect the life and health of the mother. These modest restrictions on elective abortions are undoubtedly related to the legitimate State interests in respect and preservation of prenatal life, elimination of gruesome medical procedures, and mitigation of fetal pain. *Dobbs*, 142 S. Ct. at 2284. They are not an unconstitutional imposition on the rights to privacy, and they are entitled to a presumption of constitutionality. *Id.* at 2283–84; *Harrison*, 146 Mont. at 425, 407 P.2d at 706.

D. THE STATE MAY PASS LEGISLATION IN AREAS WHERE THERE IS MEDICAL UNCERTAINTY.

The State has a legitimate interest in mitigating fetal pain. *Dobbs*, 142 S. Ct. at 2284. Again, the only abortions related to the Act at issue here are those few abortions Plaintiffs perform on 20- to 22-week-old fetuses. As the recitation of facts above shows, there is no medical certainty on how a 20- to 22-week-old fetus experiences pain as it is dismembered in a dilation and evacuation

[3] Jacqueline Howard, *Born before 22 weeks, 'most premature' baby is now thriving*, CNN (May 6, 2023, 1:10 PM), bit.ly/3AYQPaS (discussing Texas baby Lyla Stensrud, born at 21 weeks and four days gestation in 2014); *Alabama boy named world's most premature infant to survive*, Associated Press (May 6, 2023), 1:13 PM), bit.ly/3NQmtzj (discussing Alabama baby Curtis Means, born at 21 weeks and one day gestation in 2020); Max Matza, *Canadian siblings certified as world's most premature twins*, BBC (May 6, 2023, 1:19 PM), bit.ly/42xPiVk (discussing twins Adiah and Adrial Nadarajah, born at 21 weeks and five days gestation in 2022, breaking the record set by twins in Iowa born in 2018).

abortion. That medical uncertainty bolsters the presumption of constitutionality for the Act. *Harrison*, 146 Mont. at 425, 407 P.2d at 706. The U.S. Supreme Court affirmed this rule:

> The question becomes whether the Act can stand when this medical uncertainty persists. The Court's precedents instruct that the Act can survive this facial attack. The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty. *See Kansas v. Hendricks*, 521 U.S. 346, 360, n.3 (1997); *Jones v. United States*, 463 U.S. 354, 364–65, n.13, 370, (1983); *Lambert v. Yellowley*, 272 U.S. 581, 597 (1926); *Collins v. Texas*, 223 U.S. 288, 297–98 (1912); *Jacobson v. Massachusetts*, 197 U.S. 11, 30–31 (1905); *see also Stenberg*, *supra*, at 969–972, 120 S.Ct. 2597 (KENNEDY, J., dissenting); *Marshall v. United States*, 414 U.S. 417, 427 (1974) ("When Congress undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad").

Gonzales v. Carhart, 550 U.S. 124, 163 (2007) (cleaned up).

II. THE ACT IS A VALID EXERCISE OF CONSTITUTIONAL AUTHORITY TO ENACT POLICY RATIONALLY RELATED TO LEGITIMATE STATE INTERESTS, BUT IT ALSO SURVIVES STRICT SCRUTINY.

A. *ARMSTRONG V. STATE* IS WRONG AND SHOULD NO LONGER BE CONSIDERED GOOD LAW, BUT EVEN IF IT REMAINS, THE ACT SURVIVES STRICT SCRUTINY.

As stated in Defendant's opposition to Plaintiffs' motion for summary judgment, the constitutional challenges to the Act and other statutes related to abortion depend entirely upon the *Roe*- and *Casey*-era case of *Armstrong v. State*, 1999 MT 261, 296 Mont. 361, 989 P.2d 364. While this Court cannot reverse a precedent of the Montana Supreme Court, it must note that *Armstrong* shares many of the same errors as the now-defunct *Roe* and *Casey*: it discerns an unenumerated constitutional right to abortion in the enumerated right to privacy with no basis in constitutional text; it declares without explanation that "viability" is a threshold beyond which the legislature cannot reach the judicially-invented "right"; it imposes policies about who may regulate the medical profession as if it were a legislature; it raises and decides important matters *sua sponte*; and it ignores the history of abortion law in Montana, where abortion was illegal until *Roe* improperly usurped the matter.

On multiple occasions, the Montana Supreme Court has acted to rein in *Armstrong*. *See*, *e.g.*, *Montana Cannabis Indus. Assn.*, ¶ 27 ("In *Wiser*, ¶ 15, this Court circumscribed its holding in *Armstrong* when we stated that 'it does not necessarily follow from the existence of the right to privacy that every restriction on medical care impermissibly infringes that right.'"). Last year the U.S. Supreme Court corrected some decades-old mistakes. *Dobbs*, 142 S. Ct. at 2279. The State of Montana now respectfully requests that Montana courts do the same.

B. PLAINTIFFS' EQUAL PROTECTION AND VAGUENESS CLAIMS ARE UNFOUNDED.

Montana courts should reject Plaintiff's HB 136 claims because the Act is rationally related to a legitimate State interest. Even if *Armstrong* remains, however, the Act should not be enjoined because it is narrowly tailored to serve the State's compelling interest in mitigating fetal pain from a dilation and evacuation abortion at more than 20 weeks' gestation, and thus survives strict scrutiny. In a constitutional exercise of their legislative prerogative, the Montana State Legislature drew only a slightly smaller limit around the previous abortion policy imposed on it by *Roe*, *Casey*, and *Armstrong*.

Plaintiffs' attack on the Act is rooted in *Armstrong*, which, as argued above, improperly invented a right to abortion rooted in the Art. II, § 10 right to privacy. Plaintiffs also assert an equal protection argument based on *Armstrong*, which held that regulation of abortion unconstitutionally distinguishes between a woman who "chooses to terminate her pre-viability pregnancy" and a woman who chooses "to carry the fetus to term." *Armstrong*, ¶ 49. This argument only holds water under *Roe*'s vacated diktat that States may not address abortion prior to viability. The obvious dissimilarity between the two situations in *Armstrong*'s hypothetical is that only one involves the death of a unique individual human entitled to the protection of Montana's law. To use *Armstrong*'s logic, but without resort to its viability invention, it is not a violation of equal

protection for Montana to enact legislation to protect a particular class of individuals (the unborn) from a medically-acknowledged, *bona fide* health risk (death from abortion).

Plaintiffs also assert that the Act should be deemed void for vagueness because it "gives inadequate notice of when abortions are allowed for medical emergencies or to mitigate serious health risks." (Doc. 111 at 13.) This is also unpersuasive. "A statute is void on its face 'if it fails to give a person of ordinary intelligence fair notice that his contemplated conduct is forbidden.'" *State v. Dugan*, 2013 MT 38, ¶ 67, 369 Mont. 39, 67, 303 P.3d 755, 773 (quoting *State v. Nye*, 283 Mont. 505, 513, 943 P.2d 96, 101 (1997)). The Act merely imposes an obligation on abortion providers to exercise "reasonable medical judgment" when determining whether a post-20-week pregnancy constitutes a "medical emergency" for the mother. The law regularly imposes a reasonableness standard in many contexts, and the Plaintiffs' own expert testified that making recommendations to patients based upon his assessment of the risk of death or serious bodily injury is a routine part of his practice. (Ex. G at 32:13–33:9.)

The Act's 20-week limit places no burden on the ability to access elective abortion until halfway through a full-term pregnancy, near or at the current edge of viability. By their own witnesses' admissions, the Act would only proscribe the latest and riskiest of Plaintiffs' practice of second-trimester abortions of 20- to 22-week-old fetuses. And the Act allows for abortions after 20 weeks when reasonably necessary to protect the life and health of the mother. In light of these modest actions and minimal interference with the ability to have an abortion for the compelling interest of mitigating unnecessary fetal pain, the Act satisfies strict scrutiny analysis.

CONCLUSION

For the foregoing reasons, Defendants respectfully request that the Court grant its Cross Motion for Summary Judgment and deny the Plaintiff's petition to enjoin the Montana Pain-Capable Unborn Child Protection Act.

DATED this 12th day of May, 2023.

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ATTORNEYS FOR DEFENDANT

Exhibit A

MONTANA THIRTEENTH JUDICIAL DISTRICT COURT
YELLOWSTONE COUNTY

PLANNED PARENTHOOD OF MONTANA and SAMUEL DICKMAN, M.D., on behalf of themselves and their patients,	)	
Plaintiffs,	)	
v.	)	Case No. DV-21-00999
STATE OF MONTANA, by and through Austin Knudsen, in his official capacity as Attorney General,	)	
Defendant.	)	

DEPOSITION OF SAMUEL DICKMAN, M.D.

On the 8th of March, 2023, beginning at 9:00 a.m., the deposition of SAMUEL DICKMAN, M.D., was heard at Lesofski Court Reporting, 7 West Sixth Avenue, Suite 2C, Helena, Montana, before Holly E. Fox, Court Reporter and Notary Public.

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available to a patient.
Q Okay. So, for instance, I note that PPMT does not perform a procedural abortion beyond 21 weeks, six days; is that correct?
A That's correct.
Q And so that's the policy of PPMT; correct?
A Yes.
Q What happens if it's beyond that timeframe, gestational age? What does PPMT do?
A We're not able to provide an abortion for patients who are past 21 weeks and six days.
Q What is the significance -- just curiosity -- what is the significance of 21 weeks, six days?
A Can you explain what you mean by "significance"?
Q So it's my understanding from deposing Ms. Fuller that a procedural abortion in Montana is only performed to 21 weeks, six days gestation.
A Yes.
Q Is that correct?
A Yes.
Q What is the significance of that number? I mean, it's just kind of an odd number, 21 days -- 21 weeks, six days.
A Historically that's been the gestational age to which Planned Parenthood of Montana provides procedural

job or even close to it.

Q (By Mr. Johnson) So it wouldn't have any impact on your opinion if that were the standard of care?

A No.

Q Okay. You still think that it serves no benefit if that were the standard of care?

MS. DIAMOND: Objection; foundation.

THE DEPONENT: I -- you know, the ability for fetuses to feel pain is widely understood to occur well after 20 weeks. Really, 24 weeks is what I believe, and so -- so it wouldn't change --

Q (By Mr. Johnson) It wouldn't change? Whose opinion is that? What group? Is it the gynecologists and obstetricians?

A I don't know. I would need to look at specific medical societies.

Q So it's -- you don't know whose opinion that is that pain starts at 24 weeks?

A Oh, I think that's -- I mean --

Q Well, I just want to know which group, because there's two camps here.

A I think the widespread medical consensus is that it's around 24 weeks.

Q From whom? Do you know?

A I don't know.

C E R T I F I C A T E

STATE OF MONTANA)
ss.
COUNTY OF LEWIS AND CLARK)

I, HOLLY FOX, Freelance Court Reporter and a Notary Public for the State of Montana, do hereby certify:

That I did report the foregoing sworn deposition after having duly sworn the deponent.

IN WITNESS WHEREOF, I have set my hand and seal on this 19th day of March, 2023.

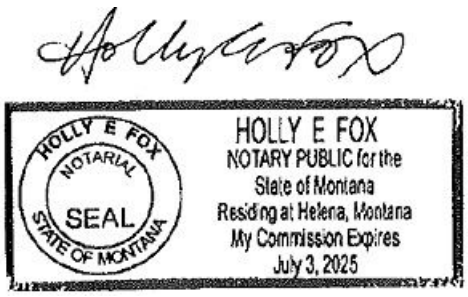


Exhibit B

MONTANA THIRTEENTH JUDICIAL DISTRICT COURT
YELLOWSTONE COUNTY

PLANNED PARENTHOOD OF MONTANA and SAMUEL DICKMAN, M.D., on behalf of themselves and their patients, Plaintiffs,	)	
v.	)	Case No. DV-21-00999
STATE OF MONTANA, by and through Austin Knudsen, in his official capacity as Attorney General, Defendant.	)	

DEPOSITION OF COLLEEN P. MCNICHOLAS, DO, MSCI, FACOG

On the 15th of March, 2023, beginning at 9:00 a.m., the deposition of COLLEEN P. MCNICHOLAS, DO, MSCI, FACOG, was heard via Zoom before Holly E. Fox, Court Reporter and Notary Public.

***** CONFIDENTIAL *****

ultrasound and the -- the opportunity to view the ultrasound and hear the fetal heart sounds; is that correct?

A That's my understanding.

Q So let's start with the easy -- well, we'll -- that's not -- we'll just go through them in order.

Why do you say that House Bill 136 is a ban on abortion?

A Well, House Bill 136 would prohibit abortion after 20 weeks of gestation. And so, again, you know, my opinion is that prohibiting abortion at any gestational age, particularly in this instance, would significantly remove that barrier in Montana from viability to now 20 weeks would then necessarily limit abortion and ban abortion at a certain point in pregnancy.

Q And do you -- are you familiar with Planned Parenthood of Montana's policies as to when they provide a procedural abortion?

A I am familiar that they currently provide abortion up to 21 weeks and six days.

Q So we're talking 13 days here?

A Well, to be clear, the current Montana law allows abortion up to point of viability. I'm not familiar with why there has been on operational decision to stop at 21 weeks and six days. But this -- this law, this statute,

would move that marker for folks from viability to 20 weeks.

Q So you don't know why Planned Parenthood of Montana only does a procedural abortion to 21 weeks, six days?

A What I know is that the current provider is only skilled to that point in pregnancy. But, again, I'm not part of the operational decisions of the affiliate, so I can't speculate on anything other than what I've been told.

Q Okay. But you would agree that on -- in -- for Planned Parenthood of Montana, which is the plaintiff in this case, we're talking a difference of 13 days under the House Bill 136?

A Based on what their current practice is, that is correct. However, again, I want -- I want to be clear that that's not what the -- the current law allows for.

Q The current law allows to the point of viability?

A Correct.

Q Which is a moving target; would you agree?

A Viability is tricky medical concept, yes. And it involves contemplation of many different factors.

Q Right. It also involves a definition of "viability," doesn't it?

A Well, the definition of "viability" is really a legal definition. It's not really -- there isn't a concise

medical definition for that.

Q Let's go back to the next question. The -- viability is a moving target in medicine.

A Viability is a complex medical condition. I don't even know that "condition" is the right word. Concept. It's a complex concept in medicine that really does require a lot of different information. There are maternal factors and fetal factors. There are also some non-modifiable factors. Things like where you deliver, for example, what medications you might have gotten immediately prior to delivery. So there are a number of different components that are essential when you're thinking about how do you predict potential viability.

Q Sure. And it's your opinion that viability is at approximately 24 weeks?

A I think the general medical consensus based on the information that we have, and consistent with how Montana law is written in terms of viability, is that probably at about 24 weeks is when we believe the fetus might have a chance, with additional support, of living outside of the -- out of the uterus.

Q So you would agree with me that viability at 24 weeks under your -- what you believe is the consensus requires that there be assistance with the baby to -- in order to live at 24 weeks?

A The decisions to intervene or resuscitate a fetus are unique to each pregnancy and aren't necessarily universal at any particular point in pregnancy. And, again, I think that reflects sort of the complicated nature of every pregnancy. So I don't believe that it is true that every pregnancy delivered at 24 weeks requires or mandates resuscitation. That's really part of the conversation that the care team has with patients based on their unique factors.

Q But for purposes of Montana's law, resuscitation and assistance is okay with regard to determining viability?

MS. HIATT: Objection; vague.

THE DEPONENT: I'm not sure I understand what you're saying.

Q (By Mr. Johnson) Is it your understanding that viability is -- strike that -- that the determination of viability includes the ability to resuscitate and provide assistance -- medical assistance for the child?

MS. HIATT: Objection; vague.

You can answer.

THE DEPONENT: Viability is not an assessment based on resuscitation availability. It is -- you might make a decision to resuscitate based on your assessment of viability; right? When you consider the fetal factors and

the maternal factors and what resources are available, you might make that determination to resuscitate or to offer resuscitation as part of that package. But the two aren't necessarily tied in the way that I think you're suggesting.

Q (By Mr. Johnson) Well, it isn't your opinion that, in order to be viable, the baby has to be delivered from mother without any medical assistance; is that correct?

A Okay. Now I think I'm understanding a little. There are definitely situations in delivery where babies require resuscitation or assistance, and that is totally appropriate. Yes.

Q Okay. So that isn't -- that doesn't define your definition of viability, whether a baby can just live outside the womb on its own?

A Viability is a legal definition, so --

Q I understand. I'm asking your definition. I didn't ask the legal definition. I asked your definition.

A Well, my opinion is generally based on what I think the scientific evidence is and really what the individual clinical scenario is. And so I think viability changes for each patient, depending on those -- the multitude of factors that are presented in front of you.

Q And it isn't -- let's talk about the consensus.

Who forms the consensus that you were -- that you

Q Okay. And do you -- are you aware that the standard of care for neonatalists [sic] and anesthesiologists doing surgery on an unborn child is to provide pain medication at 15 weeks?

MS. HIATT: Objection; calls for speculation.

MR. JOHNSON: I asked her if she was aware.

THE DEPONENT: I am aware that during fetal surgery there's a multitude of medications used and for a variety of different reasons. And really that, though, the consensus, again, coming from data supported by fetal surgeons, high-risk obstetricians, perinatologists, is that the primary use of those medications is actually not for interruption of a pain signal, but it's actually for a variety of other reasons -- to make the procedure technically more -- technically less complicated -- so, for example, paralysis of the fetus -- and/or to suppress some of the stress response that a fetus might have while undergoing intrauterine surgery, theoretically then preventing some longer-term complications from that stress event.

Q (By Mr. Johnson) So you would acknowledge that they're using anesthesiologists to prevent some of the stress events to the fetus; fair?

A They do use both -- occasionally use anesthesia and analgesia for those two primary purposes.

Q Okay. And -- but it's your opinion that stressing the fetus is not the fetus feeling pain?

A So pain is a complicated sort of -- one, it's a sensory and emotional response. It's a -- it's an experience. It's not a particular stimuli, and it requires not just a stimulus, but it also requires perception and processing of that signal. And, again, the overwhelming amount of literature suggests that at 20 weeks, as this bill suggests, there is no capability of this fetus to feel pain at that point.

Q But it does feel stress?

A Feeling is -- again, requires sensory processing, and we don't actually believe that the cortex and sort of the complex navigation and communication between sensory neurons and the cortex are fully formed until much later in pregnancy.

Q Like -- that's your opinion, like in 24 weeks?

A So we know that -- at least the data suggests that although some of the plumbing, or perhaps all of the plumbing, is present at -- starting around 24 to 25 weeks, that there are still other steps that would be required before there is a possibility of perception of pain. Again, remembering that pain is more than just a stimulus; it requires processing and perception. We don't believe that those components, that connection, the transport of

involved in many of these consensus opinions.

Q And are -- we're not talking about the consensus of anesthesiologists?

MS. HIATT: Objection; misstates testimony.

You can answer.

THE DEPONENT: Again, I'm not aware of a standalone opinion on fetal pain out of an isolated anesthesia group.

Q (By Mr. Johnson) Okay. Are you aware of results being better from fetal surgery if the fetus was provided pain medication?

A So --

MS. HIATT: Objection; vague.

Sorry. Go ahead.

THE DEPONENT: So my understanding is one of the most important aspects of providing that medication during fetal surgery is for paralysis. And it makes absolute sense to me that if the fetus isn't moving, when you have such a tiny target -- for example, trying to provide a blood transfusion through a single umbilical vein -- you know, when the fetus is paralyzed via the use of these medications, it makes sense that outcomes would be better.

Q (By Mr. Johnson) Are you aware of -- so you would agree that the outcomes are better in fetal surgery when the fetus is provided pain medication?

A I'm not familiar with specific literature -- you know, I haven't reviewed all the literature on fetal surgery, but I think, given my understanding of why medications are used directly for the fetus in those surgeries, I think there is by -- you know, I can understand there's a certainly biologic plausibility to say -- specifically when we're talking about use for paralysis of the fetus during surgery -- that one can imagine that the technical difficulty of the surgery would be -- would be easier.

Q You would agree with me that it is unethical to study whether an unborn fetus is feeling pain?

MS. HIATT: Objection; vague.

You can answer.

THE DEPONENT: I don't -- hmm. I'm not sure I understand what the question is.

Q (By Mr. Johnson) It's pretty straightforward. It's about as straightforward as I can ask.

Would you agree that it is unethical to study whether a fetus feels pain inside the womb?

MS. HIATT: Same objection.

THE DEPONENT: I would not agree with that.

Q (By Mr. Johnson) So how would one study an unborn child's feeling of pain inside the womb?

A Okay. So that -- thank you for clarification --

is a different question.

Whether we have the capability to study medical outcomes is independent of whether it is ethical to do so. And so I think one of -- I think you're hitting on a very important point, which is that pain is complex, and it is multifaceted, and it is difficult to study even in adult human beings. But that doesn't make it unethical to study. We actually do a lot of studies on pain. And part of what makes it so difficult is its subjective and experiential nature. And, again, that's part of, I think, the strong justification and evidence that intrauterine -- particularly at 20 weeks, as is suggested in this bill -- the possibility of such a phenomenon is essentially zero.

Q So you would disagree with any neonatologist that asserts it's their opinion that a unborn child at 20 weeks feels pain?

A I would say the preponderance of evidence, which has guided consensus documents around this very issue, has concluded that at 20 weeks is it not possible for a fetus to feel pain.

Q And that's ACOG; right?

A The consensus document that I'm referencing is from the Royal College.

Q Okay. The Royal College. Great Britain?

A Correct.

Q Okay. Are you aware that the standard of care for neonatologists and anesthesiologists is to provide pain medication for fetal surgery?

MS. HIATT: Objection; calls for speculation and asked and answered.

Go ahead.

THE DEPONENT: Yeah. Again, based on the literature, yes, I do believe that a variety of medications are used for two primary purposes: Paralysis and reduced stress response in the fetus.

Q (By Mr. Johnson) Okay. And one of those medications is pain medication; right?

A It can be. Yes.

Q Okay. What is the best method to determine gestational age -- strike that.

What is the most reliable method to determine gestational age?

A So determining gestational age and the reliability of such depends on where we are in pregnancy. If folks have regular menses, then we are able to use their last menstrual period as a way of documenting and determining gestational age. When folks are not sure or don't know when their last menstrual period one was, then we rely on ultrasound to do that.

Q Okay. So if the patient knows -- has regular

menstrual cycles, it's your opinion that relying upon the patient's statement of when their last menstrual cycle occurred is the best methodology to determine gestational age?

A That's correct. And oftentimes we don't re-date people's pregnancies unless there is discrepancy of a certain amount when -- when and if we have an ultrasound to compare.

Q Okay. Would an ultrasound confirm what the patient is telling you?

A Yes. Ultrasound is a way to -- is a secondary way to diagnose or determine gestational age.

Q Okay. Would it confirm what the patient is telling you?

A If it is consistent, yes, it would confirm what the patient is telling us.

Q If the ultrasound is different from what the patient has told you, what would you rely upon for determining the gestational age?

A The answer is it depends on where they are in pregnancy. In the very early part of pregnancy -- so less than nine weeks of gestation -- we allow that ultrasound to be different by up to five days, and we would not change the patient's dating.

Q Okay.

C E R T I F I C A T E

STATE OF MONTANA)
ss.
COUNTY OF LEWIS AND CLARK)

I, HOLLY FOX, Freelance Court Reporter and a Notary Public for the State of Montana, do hereby certify:

That I did report the foregoing sworn deposition after having duly sworn the deponent.

IN WITNESS WHEREOF, I have set my hand and seal on this 23rd day of March, 2023.

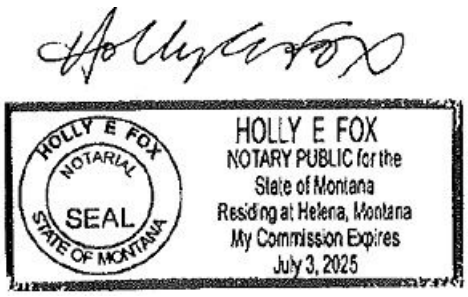


Exhibit C

MONTANA THIRTEENTH JUDICIAL DISTRICT COURT

YELLOWSTONE COUNTY

PLANNED PARENTHOOD OF MONTANA, and SAMUEL DICKMAN, M.D., on behalf of themselves and their patients,

Plaintiffs,

vs.

STATE OF MONTANA, by and through AUSTIN KNUDSEN, in his official capacity as Attorney General,

Defendant.

Cause No. DV 21-00999

CONFIDENTIAL DEPOSITION UPON ORAL EXAMINATION OF PLANNED PARENTHOOD OF MONTANA 30(B)(6) REPRESENTATIVE MARTHA FULLER

BE IT REMEMBERED, that the deposition upon oral examination of Planned Parenthood of Montana 30(b)(6) Representative Martha Fuller, appearing at the instance of the Defendants, was taken at 800 North Last Chance Gulch, Suite 101, Helena,

different from the -- the statement?

A. Yes. We do procedural abortions up to 21 weeks and six days at the Helena Health Center.

Q. Okay. So that -- that has changed, but you have not changed your website.

A. That is correct.

Q. When did that policy change?

A. We have been doing abortion up to 21 weeks, six days, in Helena since around April of 2022.

Q. Okay. So that just changed.

A. Almost a year ago. It was about eight months ago.

Q. So prior to April of 2022 was the 16 weeks accurate?

A. That is correct.

Q. And if a person wanted -- this is prior to the change of April 2022 -- if the person wanted a change -- or wanted an abortion after 16 weeks, where would you refer them to?

A. We did abortions up to 21 weeks, six days at our Billings Heights Health Center.

Q. Okay. We're going to get to that.

Now, if a person wants an abortion beyond 21 weeks, six days, where do you -- where does

Planned Parenthood of Montana refer them to?

A. It really would depend on the circumstances of the patient, how many weeks gestation the pregnancy is, any preference they might have about where they would go. But generally speaking they would be referred out of state to another provider.

Q. Is there a -- Is there another -- Is there a Planned Parenthood of Montana provider that provides an abortion -- a procedural abortion beyond 21 weeks, six days?

A. There is not.

Q. Okay. Thank you.

And then I'm going to refer you to Bates-stamp 34 of Exhibit No. 2. And that looks like that's the Planned Parenthood of Missoula.

A. Yes, that's correct.

Q. And what type of abortions does the Planned Parenthood of Missoula provide?

A. Planned Parenthood of Missoula provides medication abortion.

Q. Okay. And so that's up to 11 weeks.

A. That's correct.

Q. All right. And then I'm going to refer you to Bates-stamp 37. Before I get to that,

recollection of that.

MR. JOHNSON: Perfect.

BY MR. JOHNSON:

Q. So approximately how many abortions did the Billings clinic do procedural -- Billings Heights Clinic procedural -- from when it began the 21-week, six-day procedural abortions until it closed in December of 2021?

A. I would say historically the number of abortions after -- after 20 weeks has been fewer than ten a year, typically.

Q. So that financial impact of House Bill 136 is -- is not substantial with regard to the percentage of funding that we've -- that you've already previously testified.

A. Yes. And as I said, I think it is difficult to know what exactly the financial impact would be because of the factors of, you know, increased appointment availability for those appointments that we would have seen and -- and the ability to do other services during that time.

Q. But ten abortions beyond 20 weeks a year is -- is -- is a minor part of Planned Parenthood of Montana's business. Correct?

A. It is quite a small number of visits

compared to our overall visits, yes.

Q. Sure. Let's go to -- Let's just stick with House Bill 136.

What other impacts do -- does Planned Parenthood of Montana anticipate with regard to House Bill 136? And if you need me to clarify what -- 136, I certainly can.

A. So my understanding is 136 is the ban on abortions after 20 weeks.

Q. Yeah.

A. So the impact of that would be the inability of our providers to provide that care to those patients after 20 weeks -- between 20 weeks and -- beginning at 20 weeks up to 21 weeks and six days, and, I mean, I think that would be the biggest impact, the inability to provide that care to those patients.

Q. Okay. Any other impacts other than financial with regard to House Bill 136 that you can testify here today?

A. You know what, I think the biggest impact, really, is on patient access. We would no longer be able to see those patients after -- you know, beginning at 20 weeks here in Montana. Those patients would need to be referred elsewhere

C E R T I F I C A T E

STATE OF MONTANA)
: ss
COUNTY OF MISSOULA)

I, Mary R. Sullivan, RMR, CRR, and Notary Public for the State of Montana, residing in Missoula, do hereby certify:

That I was duly authorized to and did swear in the witness and report the deposition of PLANNED PARENTHOOD OF MONTANA 30(B)(6) REPRESENTATIVE MARTHA FULLER in the above-entitled cause; that the foregoing pages of this deposition constitute a true and accurate transcription of my stenotype notes of the testimony of said witness, all done to the best of my skill and ability; that the reading and signing of the deposition by the witness have been expressly reserved.

I further certify that I am not an attorney nor counsel of any of the parties, nor a relative or employee of any attorney or counsel connected with the action, nor financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal on February 16, 2023.

Mary Sullivan

MARY SULLIVAN
NOTARY PUBLIC for the
State of Montana
Residing at
Missoula, Montana
My Commission Expires
April 06, 2026

Exhibit D

MONTANA THIRTEENTH JUDICIAL DISTRICT COURT

YELLOWSTONE COUNTY

PLANNED PARENTHOOD OF MONTANA
and SAMUEL DICKMAN, M.D., on behalf
of themselves and their patients,
Plaintiffs,

vs. Case No. DV-21-0999

Hon. Michael G. Moses

STATE OF MONTANA, by and through
AUSTIN KNUDSEN, in his official
capacity as Attorney General,
Defendant.

The Remote Zoom Videoconference Deposition of
ROBIN PIERUCCI, M.D.,
Taken at 726 Montrose Avenue,
Kalamazoo, Michigan,
Commencing at 10:18 a.m.,
Monday, March 6, 2023,
Before Leisa M. Pastor, CSR-3500, RPR, CRR.

A. Yes. The -- and there is a difference in what I submitted to you guys in my testimony as I -- I missed -- I looked at the word because they talk about description, and the -- the updated IASP in 2020, we note that it is okay if you cannot describe your pain, and when I first wrote this piece, I missed that.

So they now, when I looked at that again, I was, like, darn it, look at -- or not darn it, but my goodness, there is an opportunity there that allows some common ground for us to better be able to discuss that just because you can't describe it, which someone who is early in their development cannot, they can still have pain which is -- they needed to make that change because they got appropriately yelled at because people with Alzheimer's, you know, coma, later, other things, they also, I heard, read in one review somewhere that people were upset because it excluded animals. Yes, there's pain by those who are nonverbal.

Q. Okay. So it is opinion today and in your report that fetuses can feel pain within the IASP 2020 definition?

A. Yes.

Q. Okay. All right. One last question about the American College of Pediatricians document.

MR. MILLER: If we could turn to page 1,

thing as viability? Something different? What do you mean by that phrase?

A. It's about -- it's the same because it's a range, once again, based on -- so the national standard is the edge of viability is decreased to about 22 to 23 weeks. Remember, you have babies who don't always get good prenatal care, the moms don't. So the ultrasounds become -- they can have up to, like, a two-week wobble of inaccuracy, which is why all those other factors really come into existence in addition to what else is going on clinically.

If the mom has overwhelming infection, chances of survival decrease. If the baby is missing organ systems that you need for living, that, obviously, changes that calculation. So once again, you have here's some general, you know, statistics that we know help, and then you have to take care of each individual as they present.

Q. Okay. And so does viability or the edge of viability mean the gestational age or range at which all fetuses will survive?

A. No.

Q. Okay.

A. It means that there is a chance that they could survive. It's not a guarantee.

before a baby's born?

A. Mm-hmm.

Q. Okay. And do you perform fetal ultrasounds in your medical practice?

A. No, sir.

Q. Okay. And are you an expert on ultrasound dating of fetal gestational ages?

A. No, I rely on my obstetric friends.

Q. Okay. And does your report have an opinion about the accuracy of fetal ultrasound dating?

A. Other than what I've read in the literature and what every obstetrician I've ever known admits to, which is if later in the pregnancy there can be increasing inaccuracies up to two weeks.

Q. Okay. And that statement about the degree to which a fetal ultrasound is accurate later in pregnancy, that opinion is not in your report, right?

A. It's not an opinion, that's a medical fact.

Q. Okay. And we're talking a little bit about how we'd characterize different gestational ages and whether they're viable. If abortions at 20 to 21 weeks of gestational age are prohibited, does that mean that some abortions before viability are prohibited?

A. Say that again?

Q. Yeah, if abortions at 20 weeks to 21 weeks of

wanted baby will be asking what can be done.

Q. Okay. But in terms of your opinion about viability, there's -- I mean before 20 weeks, that opinion wouldn't be affected by the presence or absence of factors like exposure to antenatal corticosteroids, the sex of the fetus, whether it's a singleton or multiple, and birth weight; is that fair?

A. At this date and time, that's true. What will happen in coming years, I don't know.

Q. Okay. So is it fair to characterize the viability determination as turning on a -- let me rephrase that question. Do you agree that because a multitude of factors relevant to a particular fetus' likelihood of survival will differ from pregnancy to pregnancy, there's no bright-line point at which fetuses become viable?

A. Yeah, that's -- I -- that's probably true.

Q. Okay. And so viability is pregnancy specific as well as resource specific in your opinion; is that fair to say?

A. Supported by the literature. No one can guarantee the outcome of any individual pregnancy, even if it looks like all of the risk factors are minimal. So there's -- you always have to take into account caring for an individual human being, in this case, plural.

which a fetus becomes viable, right?

A. It's not about a lack --

MR. JOHNSON: Objection, calls for a legal conclusion. Go ahead and answer. Thank you.

A. It's not about a lack of understanding. It is a lack of that's not my expertise of evaluating what your laws are.

MR. MILLER: Okay. I think that this would be -- we're on about an hour now. I think this would be an okay spot to take a brief break. Would that be okay with you?

THE WITNESS: Sure.

MR. MILLER: Okay. Let's do just five minutes, maybe, and be back on at 2:05? Okay. Thank you.

(Recess taken at 2:00 p.m.)

(On the record at 2:07 p.m.)

BY MR. MILLER:

Q. Okay. We talked a little bit about this earlier, but how do you define being capable of feeling pain?

A. Are you looking for the IASP definition as a two-part -- part to it? Tissue damage, as well as conscious awareness, which they have had to revise because you can certainly have tissue damage and not be able to describe it or remember the event, and it

still was real.

Q. So is the basis of your definition of being capable of feeling pain the IASP definition?

A. I think it's -- it's close. I think the -- they don't take into the -- they don't take into account that pain is a protective mechanism and human beings move away from pain before they can, quote, think about it or are even cognizant to do so. It is a protective aspect which is what -- something that we see demonstrated in the fetus. It is something we see demonstrated in anencephalic patients, little ones who don't -- literally don't have a cerebral cortex. It is something that we see in adults that have had brain injuries, cortical injuries, and are still capable of having pain. So I think it's -- there's -- that definition is not bad. I think it's incomplete.

Q. Okay. And in assessing fetal pain in your report, were you relying on the IASP definition, or were you relying on the definition of pain that you've just laid out?

A. I think it needs to be taken into account because it is so frequently quoted. So it's an important definition, but it is, once again, you have to look back on where did it come from, and it really is from adults. So like so many things in medicine, what was

created in an adult population doesn't apply completely to -- to other populations of -- whether it's younger ages or different geographic locations, you know, and all the other things that are unique to human beings.

The embryologic development of a human being is very unique, as is toddlerhood and pediatrics and adolescence and all of the different places in our -- in our scope of life that we -- sometimes we're more veterinarian than we are, you know, than we like to admit. There is a lot of physiology that changes. So it shouldn't be surprising that trying to define something as intangible as pain is going to be -- needs to have some unique qualifiers at different ages throughout our entire life span.

Q. So in your opinion, does the IASP definition need to be modified as to fetuses?

A. I think it needs to be broadened with a neonatal filter.

Q. Oh, sorry.

A. No, I -- that's what I think.

Q. So can you describe to me just -- and apologies I'm asking to repeat things, but what does broadened with a neonatal filter mean to you?

A. The fetus reacts to different stimulation. The fetus

has different embryologic anatomical features, and it is difficult from an ethical standpoint to get data on a fetus without doing harm, either to mother or to the developing baby.

For example, the subplate, which is an embryologic structure, so it doesn't -- it's hard to measure, and when you start looking at things as EEGs and MRIs that you're trying to get a sense of brain activity but, you know, for example, an EEG, you know, the electrical -- all those electrodes that you put on the head? They're measuring -- they were designed to measure cortical activity. They're not even designed, much less do they fit, on someone's head who is the size of a walnut to measure subcortical activity.

So what happens is it gets discounted and there is -- the nervous system is not an on/off sort of thing, and I'm pretty sure I did cite -- I did call it more like a dimmer switch. It changes through gestation, and that's not right or wrong, that's just gestationally appropriate. So to discount that the fetus is reacting to something is because it doesn't necessarily line up with an adult definition of pain, I think that's a problem. I think that misses -- and it definitely we have -- we now have enough information to say if we missed this, if we back off

treating, we're going to do harm to those little ones, both acutely and long-term.

Like I say, that's not my opinion, that's what the research is telling us, and it's consistent with what I've clinically seen.

Q. So the IASP definition draws a distinction between nociception and pain, right?

A. Yes.

Q. Okay. And is what I'm hearing you describe about fetal reactions is that -- are you disagreeing with the distinction between nociception and pain that the IASP definition draws?

A. Yes. I think Dr. Anand was the first one in that, even back in '87, who used the two interchangeably, nociception and pain. But that was back in the days when the IASP had not changed its definition and was still claiming that you had to be able to describe it and have an emotional response.

So what, you know, what do you call it when someone is harmed when their body reacts to what you would call pain in an awake and alert adult? If you call that the noxious stimulation, just meaning the transfer of that information along neurologic pathways, you know, do you want to call it pain? Do you want to call it noxious? I don't know that I care

We know that from other studies that babies recognize their parents' voices after birth. I tell parents in the NICU all the time I'm good, but I'm not mom and dad. Watch your little one who has barely got its eyes -- they're still fused shut and they lift up their eyebrows when their parents come in. They recognize their parents. Are they conscious in an adult sense? No. Is there a level of conscious perception even in utero? Yes.

So that's why I want to be careful about, once again, we're applying adult connotations and phrases to embryology when they're having a developmentally appropriate response. It's just not the same as the adult. Does that make sense?

Q. So does -- in your opinion, is the IAS -- the portion of the IASP definition that concerns the sensory and emotional experience part of pain, is that just not necessary to demonstrate in the context of a fetus?

A. I don't think we know what the sensory conscious experience of a fetus is. I think there are different levels of it, and it changes during gestation. I think it exists, but I think making it -- the IASP applies an adult definition that is inappropriate to an embryo and -- or from a -- during fetal development, and during fetal development, noxious

stimulus produces the equivalent of what pain does later, and the babies are neurologically harmed by repeated painful procedures.

That is conclusive in the evidence that we've seen both with the preemies, we haven't -- we can't -- we shouldn't be able to repetitively do harm to a fetus, but we've certainly seen reactions when there's, unfortunately, been puncturing of stuff, and we can see that they react.

Q. Okay. And I apologize if I -- if I do keep kind of asking similar variations of this, but just to be clear, is the IASP definition of pain met for a fetus at --

A. It's met --

Q. Sorry, let me just finish the question, sorry.

Is it met at a gestational age of 20 weeks?

A. It is met as appro -- age appropriate for a 20-week gestational age human being.

Q. Okay. Does the IASP have different definitions of pain for different age groups?

A. No.

Q. Okay. So when you say an age appropriate version of the IASP definition, you're modifying the definition to fetuses?

A. Yes, as I would everything else in medicine. I take

Q. Okay. And you started that answer with "and," but I just want to clarify whether there was a yes there. So there was not a sensory and emotional experience as required by the IASP definition, as written, at 20 weeks gestational age, right?

A. There is not an equivalent adult, you know, fulfillment of an emotional equivalent. Babies don't speak in words.

Q. So setting aside the question of whether there can be a description of an emotional and sensory experience, is there an emotional and sensory experience of pain at 20 weeks gestational age?

A. Not as defined by adults.

Q. So not as defined by adults?

A. No, they're not -- they don't have that developmental capacity.

Q. Do they have the capacity for any emotional and sensory experience of pain at 20 weeks gestational age?

A. They give us indication that nociception, what is painful stimulation of their nervous system, does affect them. No one knows in utero what the emotional ability, capability of a developing fetus is.

Q. Okay. And we do know that there are certain anatomic structures that are developed at different portions in

A. Yes. I do think they couldn't possibly still stay with those statements and see what 22-week babies do --

Q. Okay.

A. -- which -- who are people who have predominantly fetal physiology.

Q. Okay. And so a number of your opinions in your report turn on this analogy between the experiences of born babies to unborn fetuses, right?

A. True.

MR. MILLER: Okay. Can we pull up -- oh, let me just actually ask one more question until we get into documents.

BY MR. MILLER:

Q. So ultimately, setting aside these definitional questions that we've had, your opinion is that fetuses are capable of feeling pain at or before 20 weeks gestational age, right?

A. Yes.

Q. All right. And we talked about a few of the organizations that believe that it is not possible for a fetus to feel pain until a later gestational age, right?

A. Yes.

Q. Do you know is your opinion on the gestational age at

which fetuses begin to feel pain, is that the majority, minority, consensus view? How does the medical community break down in terms of the gestational age of which fetuses can feel pain?

A. Are you asking at what age or if they think a fetus can feel pain?

Q. So if we take your opinion that it's possible for a fetus to feel pain at or before 20 weeks gestational age, so using the 20-week line as the cutoff, are there -- are there medical organizations that have adopted the 20-week line as the gestational age of which fetuses are capable of experiencing pain?

A. I don't know of anyone who has -- I don't know of a medical organization that has specifically adopted 20 weeks as a bright line because that would be silly. There -- everyone -- the literature is continuing to show that at lower and lower ages, there are different -- the nervous system is active, and we're finding out at smaller ages that that activity is present and relevant and, once again, doesn't fulfill adult definitions of what pain looks like, but it -- painful stimulation has ramifications in these little ones.

Q. So are you aware of any medical organizations that have taken the position that fetuses at a gestational

age at or below 20 weeks are capable of feeling pain?

A. I don't know any -- other than obstetricians, I don't know of an organization that's asked that question because every neonatologist that I'm aware of, including all the 1400 people involved in the Vermont Oxford Network, who are neonatologists, or people who care for babies all -- it's a nonquestion. We all believe that our babies are harmed by pain, and they are, by the way, currently decreasing gestational age.

So it's a question that confuses neonatologists, and I will admit that I was completely surprised a number of years when I was first asked about this like it was a big deal. I'm, like, what do you mean? Of course our babies feel pain, and I was shocked to learn that obstetricians didn't think so.

Q. So the -- just to clarify what the opinions are of those neonatologists that you're speaking of, are we talking about opinions regarding born babies' ability to feel pain when you're talking about that consensus?

A. I've never -- no one has ever asked us the question outside of this context. So I don't think anyone knows that answer.

Q. The --

A. I think I've lost your sound. There we go.

Q. No, I was just thinking, sorry.

same amount of stress hormones or other forms of stress that we see with inflammation, with infection, long-term consequences of being born premature.

Gosh, when we treat this, these babies do better. So that's why it is consistent with what we clinically see -- the research is consistent with the clinical that yes, we have underestimated the amount of stress and pain and discomfort that affects our most immature because it was only a couple decades ago that it was, quote, consensus that babies didn't feel pain.

Q. So in the answer that you just gave, you focused on the experiences of born babies. What I'm still trying to figure out is what is it that is allowing you to translate that to the intrauterine experience of the fetus?

A. They're not neurologically different.

Q. Okay.

MR. JOHNSON: Objection, go ahead.

BY MR. MILLER:

Q. Okay. So there's not a -- so it has to do with the anatomical structures of the brain in a similarly aged fetus as compared to a born child; is that the key comparator here?

A. It is. And it's also been proven that the -- I know

people have talked about neural inhibitors, in the uterus, the amniotic fluid which have been shown to have a sedate I have property but not analgesic and certainly not anesthetic which is why fetal surgeons -- fetal surgery anesthesia needs to give the anesthesia directly to the fetus, maternal anesthesia is insufficient to keep the babies as safe in the outcomes as good as it can be, and that's really the big difference.

Q. Okay. So we'll talk about the other factors in the intrauterine environment like those neural inhibitors in a little bit, but again, just focusing on the comparison that's being drawn here.

So when you said that -- or you said that anatomical structures and their similarity is one, and is the fetal response to noxious stimuli in utero, is that another reason that you're able to compare born babies to fetuses, is that the key reason? How does that play?

A. You're trying to pin it down to one thing. It's everything.

Q. Okay. Well -- I'm trying to understand --

A. Stress hormones and the anatomy doesn't change from one side of the uterine wall to the other, and we've seen that they react, we've seen them react in utero.

We've seen them react after they're born at the same gestational ages.

Q. Okay. So you're not ascribing the comparison to any of these factors individually. Would any of these factors individually be sufficient for to you draw the conclusion that fetuses can experience pain in utero?

A. I would say it's the abundance, the abundant weight of everything is additive.

MR. MILLER: Okay. So if we could go off record and then, I think, take another quick break to -- about 3:15 eastern if that would be okay?

THE WITNESS: Sure.

MR. MILLER: Okay. And if you're -- and if you'd prefer that we do fewer breaks and just push for longer here, I'm also glad to do that too. I want to be accommodating of whatever is more comfortable for you.

MR. JOHNSON: How much longer do you anticipate? She's got children.

MR. MILLER: Yeah, I -- we all have children, Thane. I had to leave mine several hours away today to come into the office so I'd have good internet, but he's with grandma today, which is very fun.

So you know, probably another 90 minutes.

Q. Okay. And then you mentioned briefly that there were, you know, additional, more recent changes regarding the administration of anesthesia to fetuses, right?

A. I believe there's been ongoing, yes, there's been newer articles.

Q. Okay. And are you an expert in fetal anesthesia?

A. No, sir.

Q. Okay. Do you know if there are reasons to administer anesthesia to a fetus other than the potential presence of fetal pain?

A. I have heard that keeping an infant still helps the surgeon. That sounds eerily familiar to strapping a baby down, like we used to do, without giving anesthesia, but you could paralyze them. That's frightening.

Q. Okay. So you're not familiar with whether there are -- well, beyond the possibility of a neuralization [sic], you're not familiar with whether or not there are reasons to administer an anesthesia to a fetus other than pain; is that right?

A. That's what you're treating, yes. Sorry, I'm confused on the question.

Q. So you listed one reason why you might administer anesthesia to a fetus regardless of pain -- right?

A. You asked if there was other reasons besides pain and

that's one of them that I'm -- that I'm aware of. I admit that I am not an anesthesiologist.

Q. Okay. So there could be other reasons to administer anesthesia to a fetus that can not feel pain?

A. That is the only one I've come across other than pain.

Q. Okay. But you're not- sure whether there are others; is that fair?

A. I have not read any other -- from other anesthesiologists who have reviewed the topic.

Q. Okay. Okay. All right. Let's turn to -- back to page 11 of document 2. Okay. And towards the end of the first paragraph on this page, you note in your report that, "Another publication noted that although mild noxious stimuli do not seem to be perceived during fetal sleep, major tissue injury occurring as a result of fetal trauma or fetal surgical intervention generates behavioral and physiologic arousal," right? Do you see that?

A. Now I do, yes.

Q. And then in support of that, you've cited at footnote 54 a piece from Brusseau, right?

A. Yes.

MR. MILLER: Okay. Can we please pull up document 17, mark it as the next exhibit, please.

MARKED FOR IDENTIFICATION:

article. In the first -- I'm sorry, in the first full paragraph here, so here the author makes a number of statements about pain, describing it as a "subjective phenomenon, one that would seem to require some degree of conscious activity, and the need for some sort of integrating process to render noxious stimuli into a form of coordinated experience."

Do you see where those references are?

A. Yes, sir.

Q. Okay. Do you agree with the author of this article that some degree of conscious activity beyond nociception and its concomitant stress response is required to demonstrate fetal pain?

A. So the problem with this article is that there --- while there is useful information and I -- the -- there is agreement that a single -- you can't -- he's right in that you cannot state from yes, there is just one thing. So if the one thing is gosh, there's a stress response, you have to look is there other things that are consistent, which there are in some papers, which I did quote, which also show gosh, you know if there's been facial changes, if there is heart rate changes, if there is oxygenation changes, if there is withdrawal.

Once again, just picking and choosing

that -- or what they were measuring because they compared babies that the -- were -- they received a blood transfusion in an area that did not have any nervous innervation of the cord compared to those whose uterine wall was entered, which would be considered a noxious stimulation. So they were comparing painful stimulation to nonpainful stimulation, and that was very intentional. That wasn't by accident that that's why -- that's why they even thought to measure the different hormone levels.

Whether they said in conclusion there's pain, what they measured was when there was painful stimulation by everyone's definition of what would cause pain to a reasonable human being, those -- yes, they had an increased stress response to something that was known to be painful.

Q. So the presence of an increased stress response is not itself determinative of the existence of pain, right?

A. It doesn't determine it, it's a response to what appears to be by any other age in the human life span would be painful.

Q. Okay. But -- as we've --

A. Which is not an inconsistent conclusion that if you punks you are somebody that would be uncomfortable.

Q. Okay. So the -- the hormonal response to noxious

stimulation is in your opinion consistent with the experience of pain in utero, right?

A. Yes.

Q. Okay. And the authors of that, Gitau and the other authors of this piece, you're not aware whether they drew a conclusion about consistency with fetal pain, right?

MR. JOHNSON: (Inaudible).

A. Yes.

MR. MILLER: Sorry, Thane, what was your objection?

MR. JOHNSON: I objected for asked and answered, but go ahead.

BY MR. MILLER:

Q. Okay. All right. And then -- and then just so that we're on the same page, is it possible for there to be a hormonal response with noxious stimulation without the experience of pain?

A. There are -- not to this magnitude.

Q. What do you mean by "not to this magnitude"?

A. There -- I have -- I have seen -- I have heard and I haven't read them enough to follow-up on the studies that there are people who talk about some increases and I think it's the green paper, which I think green is -- I was leaned -- the reason I got to it is

here for cortical connectivity, those babies react to pain, and so I would -- it is consistent that with what we see at the bedside that the other evolving evidence of subplate which is a embryologic structure, it is possible to be sufficient.

There are some people that believe sub -- below the subplate thalamus and brain stem are sufficient. I admit to not knowing an exact answer to all of the evolution of what we are finding but I certainly can say that at the bedside that -- the edge of viability babies do have pain capability so it is not surprising and as an explanation for that, subcort -- cortical activity or being firmly connected to the cortex does not seem to be necessary consistent with the newer information.

Q. Okay. When you -- you described the edge of viability babies as reacting to pain. Is that in your mind distinct from experiencing pain?

A. I don't think you can react if you don't have something that stimulates the nerves. Something has to cause a reaction.

Q. Is the existence of a reaction demonstrative of the experience of pain?

A. I think it can be a -- an -- a -- oh, the sorry, I'm forgetting the words that I want -- a -- a -- it can

be pain that is an unreflective, thank you, that was the word, yes, I think that if -- a withdrawal or a reaction to pain can be an unreflective -- evidence of an unreflective pain response, especially when it's accompanied by, once again, pain is multimodal, looking at other changes in vital signs as well as just movement.

Q. Okay. But you wouldn't suggest that the reaction alone suffices to reach your opinion that if fetus at 22 to 23 weeks gestational age experiences pain, right?

A. I'm suggesting that when I was smacked by a little 22-week hand because we had just tried to start an IV, that that was something that we should pay attention to. The baby didn't like it.

Q. So the -- when you say pay attention to, do you mean that there is -- well, what do you mean by pay attention to?

A. The baby was hurting.

Q. So you're ascribing the experience to the if I see reaction; is that fair to say?

A. Well, yeah, but you're making it sound like -- see the problem with that sentence is out of context, I can see someone else saying so, Dr. Pierucci, if I -- if someone, you know, takes a reflex hammer to a knee and

that's a reaction, do you think that's pain? And no, once again, look at the context of what just happened. Was -- what was done to the baby starting an IV? Was that a painful experience in anyone else? Yes. That could be uncomfortable.

Did they have an appropriate response that is consistent with what anyone else would do when they are in pain? Yes. Should we pay attention to that, especially if there's repeated stimulation like repeated heel pokes because we know that causes damage, yes.

So once again, you can't -- you can't -- you're trying to -- it feels like you're trying to make me state one thing and then other people -- it's this open-ended -- and that's not okay.

Q. Okay. So the physical response provides evidence of the experience of pain, but is not, itself, sufficient to demonstrate the experience of pain in your opinion?

A. Yes. And if you're good clinician at the bedside, if there is one -- if there's something that -- that there is an appropriate response, one should be looking to see are there others, was this coincidence or was this causal?

Q. Okay. And -- and when you're assessing whether it's causal, are you -- what are you looking at to

please, tough a section that concerns fetal facial expressions, right?

A. Yes.

Q. Okay. And is it your opinion that -- that the fetal facial expressions described in your report support your opinion that fetuses can feel pain on or before 20 weeks gestational age?

A. That it is consistent with the literature and what we see at the bedside.

Q. Okay. When you say consistent with the literature and what you see at the bedside, what -- what do you mean?

A. I mean it's consistent with a reaction that occurred in realtime. They actually have a video of here is the injection going into the leg of the fetus, the baby who is not born and here is the facial reaction.

So they -- they have here's the instigation of the painful or noxious stimulus, here is what happened to the baby. The facial reaction was scored on a documented seven-point system that they said you need to have at least five of the seven that -- so that was consistent with what these authors had done, and every other human being or animal who has this same reaction to being poked by a needle, a known uncomfortable painful procedure would be identified as someone who is reacting in a way that is consistent

with pain.

Q. Okay. So these facial images, in your opinion, are consistent with the perception of pain; is that right?

A. Yes.

Q. Okay. Does the -- the image -- do the images indicate that -- that -- let he rephrase that question.

Do they demonstrate that the fetus has perceived pain?

A. They are, once again, for a reasonable -- any physician or actually any parent who would watch their child, born or unborn, demonstrate that response, they would likely leap to the conclusion that a painful something had happened, and their child was reacting. As we've talked about as a doctor, I would prefer more evidence. Is there change in heart rate, physiologic, stress hormones, all the other things but that is what we saw demonstrated is consistent with someone who is in pain.

Q. Okay. So is there anything more that we can draw from these studies than the fact that it is consistent with how you would perceive pain in a born child?

A. I don't make more or less other than the data that's presented.

Q. Okay. And the data that's presented here are images that in your opinion would be consistent with the

CERTIFICATE OF NOTARY

STATE OF MICHIGAN)
) SS
COUNTY OF MONROE)

I, LEISA PASTOR, certify that this deposition was taken before me on the date hereinbefore set forth; that the foregoing questions and answers were recorded by me stenographically and reduced to computer transcription; that this is a true, full and correct transcript of my stenographic notes so taken; and that I am not related to, nor of counsel to, either party nor interested in the event of this cause.

LEISA PASTOR, CSR-3500, CRR,
Notary Public,
Monroe County, Michigan
My Commission expires: 9/7/27

Exhibit E

MONTANA THIRTEENTH JUDICIAL DISTRICT COURT
YELLOWSTONE COUNTY

PLANNED PARENTHOOD OF MONTANA, and SAMUEL DICKMAN, M.D., on behalf of themselves and their patients,

Plaintiffs,

-vs-

STATE OF MONTANA, by and through Austin Knudsen, in his official capacity as Attorney General.

Defendant.

CAUSE NO. DV-21-00999

DEPOSITION OF GEORGE MULCAIRE-JONES, M.D.

Via Zoom
March 17, 2023
9:10 a.m. - 12:00 p.m.
12:37 p.m. - 3:45 p.m.

abortion to a surgical abortion, a D&E suddenly at 13 weeks.

MS. HIATT: Okay. I think we should probably take a quick break here for the Court conference, and then we can reconvene when that's done. Does that work, Thane?

MR. JOHNSON: That works.

MS. HIATT: Great. We'll go off the record for a little bit. Thank you.

(Whereupon, a recess was taken at 9:54 a.m. to 10:35 a.m.)

Q (BY MS. HIATT) All right. Doctor, thank you. So I think that maybe it would be helpful for me if we would just step back, and if you could describe for me up to 16 weeks, when you're providing surgical evacuation of the uterus for miscarriage management, it sounds like it could be a D&C or it could be a D&E. Could you just describe the difference and when you would use one versus the other?

A Yeah. So it gets down a little bit to some confusion about the nomenclature. And so, first of all, traditionally kind of all of those procedures were lumped under a D&C. So what is common is dilation, which means that you have to progressively

dilate the cervix. Then you have to start that at -- you know, if it's been an incomplete miscarriage, maybe you don't have to dilate. But if it's a fetal demise, you have to dilate starting at even seven or eight weeks, you have to begin that. So that's common to all of those procedures.

And then curettage refers to kind of, if you will, scraping the inside of the uterus to ensure that all of the products of conception are removed. And that is not done as much as it was before because the instrument that was used to finish that process is a sharp curettage, a metal instrument. And that's more likely to injure the endometrium, the lining of the uterus. So now more of the standard of care is to use a suction curettage, where you suck it out with either a handheld or machine curettage.

So all procedures begin with dilation. In terms of removal of products of conception, which means sometimes fetal body parts, is sometimes that's done with a grasping instrument, usually your type of ring forceps. And that is, depending on the circumstances, but that can happen as soon as, you know, 12, 13 weeks. It's always going to happen at 14 to 16 weeks. And then part of that is going to be suction as well, that you're going to suction out the

fluids and some of the placental tissue.

So it's -- I would say in kind of general understanding that a dilation and curettage goes up to 12 weeks, where you're not actually removing fetal parts, as much as you are after 13 weeks where it technically is a dilation and evacuation.

Q Okay. Thank you. That's very helpful. And when you were performing curettage, were you using the sharp curettage or the suction curettage?

A Suction curettage. And then initially I did change my practice because fairly early on with ultrasound availability, if you have ultrasound and do a dilation and curettage, dilation and evacuation, and you have ultrasound, you can see that everything is out. So you don't have to scrape it like we did before ultrasound. So I moved away from using a sharp curettage in general.

Q Okay. And did you provide prophylactic antibiotics on who you did surgical miscarriage management?

A Yes.

Q Okay. And I think you also mentioned that you did medical induction for a miscarriage management; is that right?

A Yes.

22-week -- a 20 to 22-week baby would survive.

Q Okay. So going back to the law, let me just make sure I'm looking at the right -- okay. So Subsection 3, we're looking at Section 3 there. And Subsection 3 says, "When an abortion of an unborn child capable of feeling pain is necessary to prevent a serious health risk to the unborn child's mother, the medical practitioner shall terminate the pregnancy in the manner that in reasonable medical judgment provides the best opportunity for the unborn child to survive, unless it would pose a great risk of either death or" -- it then goes on to say, "substantial and irreversible physical impairment of a major bodily function."

Do you see that?

A Yes.

Q So if the fetus is 22 weeks or less, is there a way of providing an abortion that, quote, "provides the best opportunity for the unborn child to survive," end quote?

A Yes. I would say that if you induced medically, that child would have a chance to survive. Whereas if it was terminated by dilation and evacuation, the baby would have no chance to survive.

Q Okay. And let's say it's at 20 weeks, I

mean is there going to be any chance for that fetus to survive?

A So one thing that you would have to look at is the specific circumstance, because in these late-term abortions, oftentimes the woman doesn't present until late. So there might be a margin of error in her actual dating of her pregnancy. So the 20-week baby may actually be 22 to 23 weeks possibly. And then, again, there's some conditions like uterine growth restriction that would be unusual, but it could happen that that affected the growth of the baby at that point. And based on the biometric measures of the ultrasound, it may be further along.

Q Okay. But how about if the fetus were accurately dated at 20 weeks?

A Would I expect the baby -- I would say that at that point a maternal fetal medicine specialist would decide, in collaboration with the mother and the family, whether they would proceed with a surgical or medical abortion. And, again, the medical abortion at 20 weeks would be very unlikely that that baby would survive.

Q Right. And, in fact, you said you're not aware of any fetus surviving at 20 weeks; right?

A Right. Yeah, the only caveat there is

feeling pain?

A I, I think capable of feeling pain is that there are some kind of neurological response to obnoxious stimulation.

Q And what is the basis for that definition?

A Because of the neurobiology that already shows that there's intact cortical spinal sensory nerve connections that have been established, and the fact that I know when you poke and prod a baby at 20 weeks, that the baby is going to have some sense of that stimulation.

Q Well, how would you know that you can poke and prod a baby at 20 weeks, that they will have that stimulation, if no fetus has survived in 20 weeks?

A Because of the reaction of the baby. If someone does an amniocentesis or is doing like sampling an umbilical cord and accidentally pokes the needle in the baby --

Q I see, so you mean in utero, the reaction of the fetus?

A Yes, the baby had reaction in utero.

Q Okay. Are you familiar with the International Association of Pain?

A I'm not familiar with that as a formal organization. I don't read their literature, et

cetera.

Q Okay. When do you believe fetuses begin feeling pain?

A I would quote what I think is a very balanced definition of that, and that's from a respected neurobiologist, and it's my testimony. "According to 2020 review of fetal pain, current neuroscientific evidence undermines the necessity of the cortex for pain experience. Even if the cortex is deemed necessary for pain experience, there's now good evidence that the thalamic projections into the subplate, which emerge around 12-weeks gestation, are functional equivalent to thalamocortical projections that emerge around 24-weeks gestation. Thus, current neuroscientific evidence supports the possibility of fetal pain before the, quote, 'consensus' cutoff of 24 weeks. Overall the evidence and the balanced reading of that evidence points towards an immediate and unreflected pain experience mediated by the developing function of the nervous system as early as 12 weeks."

Q Okay. Are you quoting from the Derbyshire article?

A I am.

Q And that was published in 2020; right?

CERTIFICATE OF REPORTER

STATE OF MONTANA)
) ss.
County of Cascade)

I, Joan P. Agamenoni, Court Reporter and Notary Public for the State of Montana, residing in Great Falls, Montana, do hereby certify:

That I was duly authorized to and did swear in the witness and report the deposition of GEORGE MULCAIRE-JONES, M.D. in the above-entitled cause;

That the reading and signing of the deposition by the witness have been expressly reserved.

That the foregoing pages of this deposition constitute a true and accurate transcription of my stenotype notes of the testimony of said witness.

I further certify that I am not an attorney nor counsel of any of the parties, nor a relative or employee of any attorney or counsel connected with the action, nor financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal on this the 21st day of March, 2023.

/s/_____
Joan P. Agamenoni
Court Reporter
Notary Public, State of Montana
Residing in Great Falls, Montana.
My Commission expires: 5/24/2024

Exhibit F

MONTANA THIRTEENTH JUDICIAL DISTRICT COURT

YELLOWSTONE COUNTY

PLANNED PARENTHOOD OF MONTANA and SAMUEL DICKMAN, M.D., on behalf of themselves and their patients,	)	
Plaintiffs,	)	
VS.	)	NO.: DV-21-00999
STATE OF MONTANA, by and through AUSTIN KNUDSEN, in his official capacity as Attorney General,	)	
Defendants.	)	

ORAL DEPOSITION OF

INGRID SKOP, M.D.

MARCH 28, 2023

VOLUME 2

ORAL DEPOSITION OF INGRID SKOP, M.D., produced as a witness at the instance of the PLAINTIFFS, and duly sworn, was taken in the above-styled and numbered cause on March 28, 2023, from 11:37 a.m. to 1:08 p.m., via ZOOM video conference before SUSAN GRIGGS, CSR in and for the State of Texas, reported by machine shorthand.

evidence that this emotional processing can occur without that full development but even if not what we do know about the pain arc in a fetus tells us that that is pain. That is pain that that young human being experiences.

Q. And so at what gestational age do you believe that a fetus can begin to feel pain?

A. They -- they start developing sensory neurons at seven weeks. By 12 weeks they have that reflex arc in place and by 18 they have the connections all the way to the thalamus, and I think that that -- you know, so again the -- it's a process, it's always a process of development, but, you know, I think in the 12- to 15-week range we have an organism capable of recognizing that sensation of being torn apart.

Q. And are you aware that that is not consistent with how RCOG views the beginning of fetal pain?

A. Yeah, ACOG and RCOG are both -- I would say it's wishful thinking on their part. And again, they point strongly -- the 2010 RCOG study points strongly at Derbyshire's work in 2010 but they have ignored his work since that time when he has said that he really thinks that we need to set the lower limits. So they didn't like his more recent stuff so they've not quoted him.

Q. Okay. So fair to say you disagree with RCOG

them?

A. Right. I mean, they're following the same outdated science that RCOG and ACOG are.

Q. Okay. And --

A. We're saving 22-weekers. Nobody believes -- I mean, look at them in a NICU. No human being would look at a 22-weeker in a NICU and say that baby cannot feel pain.

MS. DIAMOND: Okay. Let's take a ten-minute break. I just want to look at my notes. Let's go off the record and so I'll try to come and get you back with plenty of time for your next call. Come back at 50 after?

THE WITNESS: Okay.

(Break taken from 12:39 to 12:58 p.m.)

Q. (BY MS. DIAMOND) Couple last things just to wrap up. So before the break we were talking about fetal pain and we talked about RCOG.

Are you familiar with RCOG's 2022 study, Fetal Awareness Evidence Review?

A. I'm not sure that I am.

Q. We can pull that up. So this is what has been previously marked as Tab 50. This is Tab 50 that's been previously marked as Exhibit 34.

Have you seen this 2022 RCOG Fetal

by May 13, 2023;

That the amount of time used by each party at the deposition is as follows:

MICHELLE DIAMOND.....01 HOUR(S):12 MINUTE(S)
MICHAEL RUSSELL......00 HOUR(S):00 MINUTE(S)

That pursuant to information given to the deposition officer at the time said testimony was taken, the following includes counsel for all parties of record:

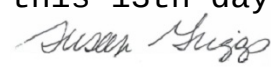
MICHELLE DIAMOND, for the PLAINTIFFS

MICHAEL RUSSELL for the DEFENDANT

That $ _____ is the deposition officer's charges to the Plaintiffs for preparing the original deposition transcript and any copies of exhibits;

I further certify that I am neither counsel for, related to, nor employed by any of the parties or attorneys in the action in which this proceeding was taken, and further that I am not financially or otherwise interested in the outcome of the action.

Certified to by me this 13th day of April, 2023.



SUSAN GRIGGS, Texas CSR 2642
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Charlotte, NC 28208
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Exhibit G

MONTANA THIRTEENTH JUDICIAL DISTRICT COURT

YELLOWSTONE COUNTY

PLANNED PARENTHOOD OF MONTANA, and SAMUEL DICKMAN, M.D., on behalf of themselves and their patients,	)	
Plaintiffs,	)	
-vs-	)	Cause No. DV 21-00999
STATE OF MONTANA, by and through AUSTIN KNUDSEN, in his official capacity as Attorney General,	)	
Defendant.	)	

CONFIDENTIAL

ZOOM DEPOSITION OF STEVEN J. RALSTON, M.D.

On the 24th day of March, 2023, beginning at 9:00 a.m., the deposition of STEVEN RALSTON, M.D., appearing at the instance of Defendant, was heard at the Offices of Lesofski Court Reporting, 7 West Sixth Avenue, Helena, Montana, pursuant to the Montana Rules of Civil Procedure, before Lisa R. Lesofski, Registered Professional Reporter, Notary Public.

MR. JOHNSON: That's fine.

A. So I think it would be clear if it said something like abortions can be performed after 20 weeks if the physician believes that it is in the best medical interest of the patient to perform that abortion.

Q. (By Mr. Johnson) Don't you -- I mean, so in your previous answer you testified that House Bill 136 does not use language that is used in the medical practice. Is that the language that is used in medical practice, your medical practice, what the physician believes?

A. In my medical practice, if I'm going to recommend a procedure, recommend a therapy, I justify that procedure, that therapy in the medical record by saying why I think it's indicated and that I have obtained informed consent from the patient for that procedure.

Q. But don't you operate under -- don't you make decisions based upon the risk of death or serious bodily injury in your practice?

A. So when I'm getting informed consent from patients and we talk about risks and benefits and alternatives to any numbers of procedures and therapies I might be offering, those are certainly

things that I take into consideration but they are not the only things. There are many other things besides serious bodily injury. I forget exactly what language you just used.

Q. I used the language poses a risk of death or serious bodily injury.

A. That is just one of many things that we consider when we are choosing what kinds of therapies or procedures to recommend for patients.

Q. But you would agree that that is not out of the ordinary to make decisions as a physician making a decision based upon a risk of death or serious bodily injury to the patient, correct?

MR. COWIT: Objection, vague, argumentative.

A. So, again, I think that when I'm making clinical decisions, I include many things and what my understanding of this law is that it says words like serious, and I'm not sure what you mean by serious. Not you but the Montana legislature. So is it serious in my view? Is it serious in the patient's view? Is it serious in the legislature's view? I'm not sure.

Q. (By Mr. Johnson) My question to you is would you agree in your practice you make decisions,

Anand and Hickey, and it was cited by Dr. Perucci. I don't know if you reviewed Dr. Perucci's report or not in preparation for this deposition.

A. I did review Dr. Perucci's report, yes.

Q. In her report she indicates that it was the consensus in the early '90s that babies did not feel pain.

MR. COWIT: Objection, foundation. Thane, if you're going to be reading from the report, it might be helpful to put it up on the screen.

MR. JOHNSON: I'm not sure if we can. Let's just skip that. We can go on.

Q. (By Mr. Johnson) Let's take you to Exhibit 76, your report.

MR. JOHNSON: I'm trying to do this as efficiently as possible for the court reporter, Dylan.

MR. COWIT: Yeah, I appreciate that. Thank you. Let us know what makes the most sense from your perspective.

Q. (By Mr. Johnson) And it's paragraph 12 of your report, Doctor. There it is. It is your medical opinion that an unborn child does not feel -- in fact, I think it's any child does not feel pain before 24 weeks. Tell me what your

opinion is.

MR. COWIT: Objection, vague.

A. I think the essence of my opinion is that prior to 24 weeks' gestation that the connections within the fetal brain are immature and are not sufficient to allow for even a rudimentary processing of pain to happen in the cerebral cortex.

Q. (By Mr. Johnson) And that includes both a child that is born and unborn, is that correct, meaning both --

MR. COWIT: Objection, vague.

Q. (By Mr. Johnson) -- both a fetus and the living child out of the womb?

A. I believe my opinion was about fetuses.

Q. So it's inside the womb?

A. It's inside the womb.

Q. Okay. And so...

A. But I will say that I think the same is true that before 24 weeks if a baby was born, those connections don't exist and so --

Q. So -- go ahead. Sorry to interrupt you. That's my bad.

A. Yeah. And the same connections don't exist before 24 weeks.

Q. So is it your opinion that both a fetus --

MR. JOHNSON: Okay. Just fetal pain?

MR. COWIT: Yes. That's the topic that we've designated him as an expert on.

MR. JOHNSON: Okay.

Q. (By Mr. Johnson) But it is still your testimony that a child that is living cannot feel pain to 24 weeks. Is that fair?

MR. COWIT: Objection, vague, and I'll continue to make an objection to scope on any questioning along those lines.

A. I think my testimony is that until 24 weeks gestation the essential connections that are required within the brain don't exist but connections between the thalamus and the cortex begin at 24 weeks. So that if pain were going to be possible, it would not be possible until 24 weeks.

Q. (By Mr. Johnson) Both in utero and out of utero?

MR. COWIT: Objection, scope.

A. Yes.

Q. (By Mr. Johnson) Thank you. And am I correct that your definition of pain is based upon the IASP definition in front of you, which is Exhibit 34, second page, the RCOG December 2022 study?

A. So they clearly don't know every clinician and surgeon that are doing these kinds of procedures because I'm a clinician doing these kinds of procedures and I don't advocate for the use of fetal analgesia as standard practice.

Q. Okay. So you do disagree with that. And we're going to get to what your practice is and it's contrary to this though, isn't it?

A. Again, I'm just saying that they said to their knowledge there are no -- that all clinicians and surgeons do this and I don't think that's true.

Q. Would you agree that the use of anesthesiology and analgesia provides a necessary immobility for the fetus with regard to surgery?

A. For some surgeries, yes.

Q. And it also prevents dangerous fetal physiologic reaction or stress response to the surgery?

A. Yes.

Q. And would those two, I mean, moving to a noxious stimuli and having stress be indicative of pain?

A. So I think it would help to sort of just understand what happens when we do things to fetuses. When we touch a fetus, when we cut a fetus

and a pain fiber is stimulated, that pain fiber then sends a signal to the spinal cord, which will sometimes send a signal back to the place that it came from there and there be a reflexive movement. That is not pain. That is a reflex and doesn't mean that there is any pain at all because it never got to the brain at all.

Second, there are physiologic reactions to the fetus, an increase in heart rate perhaps or other stress hormones like cortisol might increase. Those are not happening through any activity of the brain whatsoever. Those are happening because of various hormones and endocrinologic factors within the fetus. Again, reflexes of blood vessels and heart rate that have nothing to do with the brain and if they have nothing to do with the brain, then there is no question of pain because the brain is required for pain. Those are reactions to noxious stimuli. Those are physiologic reactions to the noxious stimuli that are not pain.

Q. That's not my question. Are they indicative of pain? So, for instance, if I take a needle and poke you in the arm with it and insert it, I mean, and it's a big needle so you're going to feel it, would movement be an indicator of your

have the sufficient structures necessary before 24 weeks to have a pain experience.

Q. But you are not a neuroscientist. Is that safe to say?

A. That's correct.

Q. Okay. Do you think a fetus feels anything?

MR. COWIT: Objection, vague.

A. So I think the fetuses have a complex network of nerves that send signals to the spinal cord, the spinal cord sends signals to the thalamus, that there are sensing neurons throughout the nervous system and throughout the craniovascular system that are sensing blood pressure, temperature, et cetera. So there are things that are being sensed but I don't think the fetus is processing those sensations as an awake fully developed human would because, A, they're not awake; B, they don't have mature brains the way that fully developed humans do; C, before 24 weeks they don't have connections to the primary place where those sensory, where those sensations are interpreted, which is the cortex.

Q. (By Mr. Johnson) Okay. Would a -- do you believe a fetus would sense a needle?

MR. COWIT: Objection, vague.

A. So if by sense you mean the fetus says oh, I am being touched by something in my arm, no, I don't think the fetus has that kind of sense. Does the fetus have nerve fibers that fire when a needle is placed into its arm? Yes, those nerve fibers fire. They go to the spinal cord, those nerves, then transmit signals up to the brain, to the thalamus initially and then up to the cortex. Prior to 24 weeks they don't get to the cortex. After 24 weeks they do get to the cortex. How the cortex then interprets those signals will depend on the physiologic state of the fetus and without being awake or conscious, I don't think the fetus can sense it in that sense.

Q. (By Mr. Johnson) Okay.

A. It's argued twice there.

Q. But you would agree that a fetus may move as a result of a needle?

A. I agree that fetuses can have reflexive responses to many stimuli, including needles, yes.

Q. Okay. And you would agree that in response to a needle, a fetus may increase its heartbeat?

MR. COWIT: Objection, vague.

A. It may also decrease its heartbeat.
Q. (By Mr. Johnson) But it may increase its heartbeat, agreed?
A. Yes.
Q. Correct?
A. Yes.
Q. I just couldn't hear that. Sorry. I didn't mean to be rude there.
You would also agree that other stress hormones are triggered in a fetus as a result of a needle?
A. They could be, yes, depending on where the needle is and what it's doing.
Q. Okay. And you would agree that a potential increase in heartbeat, potential stress hormones, and potential movement in a fetus in response to a needle can occur 20 weeks gestational age?
A. I'm sorry. How many weeks?
Q. 20 weeks.
A. Yes.
Q. Okay. Thank you. Would you agree that physiologically a fetus at 20 weeks on one side of the uterine wall is the same as if it were in a NICU on the other side of the uterine wall?

Exhibit H

MONTANA THIRTEENTH JUDICIAL DISTRICT COURT
YELLOWSTONE COUNTY

PLANNED PARENTHOOD OF MONTANA and SAMUEL DICKMAN, M.D., on behalf of themselves and their patients, Plaintiffs,	(	DV-21-00999
vs.	(	Hon. Michael G. Moses
STATE OF MONTANA, by and through Austin Knudsen, in his official capacity as Attorney General, Defendant.	(	

****

REMOTE ORAL DEPOSITION OF

INGRID SKOP, M.D.

VOLUME 1

MARCH 23RD, 2023

****

REMOTE ORAL DEPOSITION of INGRID SKOP, M.D., produced as a witness at the instance of the Plaintiffs, and duly sworn, was taken in the above-styled and numbered cause on the 23rd of March, 2023, from 11:02 a.m. to 5:02 a.m., remotely via videoconference, before Stephanie McClure Lopez, CSR, in and for the State of Texas, reported by machine shorthand, in San Antonio, Texas, pursuant to the Montana Rules of Civil Procedure, and the provisions stated on the record or attached hereto.

It worked out well them for them, very prolife family.

But right now my strongest motivation is as an obstetrician. I practice a two-patient paradigm that they're both my patient, the woman and the unborn child, and I have come to the conclusion through my years of practice as well as my research in the literature that women -- although an abortion may alleviate their immediate crisis, it really does not improve their life over the long run, it -- you know, as I mentioned I've cared for many women who have suffered emotionally in the aftermath of abortion.

So, I have the portion that I do now, of course, because of my unborn patient -- it's deadly for him -- but also for the women what I have seen suffer. So, I come at it from -- from a pro-woman position, I believe, that I just think that for 50 years women have been offered a suboptimal resolution to their crises when there's far better ways we can help them. Start big, providing better contraception in the first place so they don't have these unintended pregnancies.

Q. Okay. Going back to some of the articles that you published, you published articles in the -- and tell me if I get pronunciation wrong -- The Linacre Quarterly; is that right?

A. Yes, ma'am.

MONTANA THIRTEENTH JUDICIAL DISTRICT COURT
YELLOWSTONE COUNTY

PLANNED PARENTHOOD OF MONTANA, and SAMUEL DICKMAN, M.D., on behalf of themselves and their patients, Plaintiffs,	DV-21-00999
vs.	Hon. Michael G. Moses
STATE OF MONTANA, by and through Austin Knudsen, in his official capacity as Attorney General, Defendant.	

REPORTER CERTIFICATION
INGRID SKOP, M.D.
TAKEN ON MARCH 23RD, 2023

I, Stephanie McClure Lopez, Certified Shorthand Reporter in and for the State of Texas, hereby certify pursuant to the Rules and/or agreement of the parties present to the following:

That this deposition transcript is a true record of the testimony given by the witness named herein, after said witness was duly sworn or affirmed by me.

The witness ___x____ was/ _____ was not requested to review the deposition.

I further certify that I am neither attorney nor counsel for, related to, nor employed by any of the parties to the action in which this testimony was taken. Further, I am not a relative nor employee of any attorney of record in this cause, nor do I have a financial interest in this action.

SUBSCRIBED AND SWORN to on this 14th day of April, 2023.

_____
STEPHANIE McCLURE LOPEZ, CSR
Texas CSR 3483; Expiration: 7/31/24
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