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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF COLLEEN P. MCNICHOLAS, D.O., M.S.C.I., F.A.C.O.G., IN SUPPORT OF PLAINTIFFS' MOTION FOR NATIONWIDE PRELIMINARY INJUNCTION

I, COLLEEN P. MCNICHOLAS, D.O., M.S.C.I., F.A.C.O.G., declare as follows:

1. I am an obstetrician/gynecologist certified by the American Board of Obstetrics and Gynecology since 2011. I am licensed to practice in Washington, Missouri, Kansas, and Oklahoma. I have extensive experience in the provision of abortion in the outpatient setting, as I am the Medical Director of Trust Women's clinics in Washington, Oklahoma, and Kansas. I also provide abortion services at Planned Parenthood of the St. Louis Region and Southwest Missouri, and I am the provider of record at Planned Parenthood in Columbia, Missouri and in Kansas City, Missouri.

2. Additionally, I am the Director of the Ryan Residency Collaborative, a collaboration between Oklahoma University and Washington University School of Medicine in St. Louis, Missouri, that offers formal training in abortion and family planning to residents in obstetrics/gynecology; the Assistant-Director of the Fellowship in Family Planning at Washington University School of Medicine; and an Associate Professor at Washington University School of Medicine, in the Department of Obstetrics and Gynecology's Division of Family Planning. Through my various academic roles, I have taught numerous medical students and trained nearly 250 residents in family planning as well as a number of family planning fellows.

3. I also have experience providing healthcare services to LGBTQIA communities.[1] At Washington University School of Medicine, I am a member of a physician team developing specialized care for the transgender community in both pediatric and adult settings. Within this multidisciplinary approach, I have specifically helped develop and implement the integration of gynecologic services for transgender patients. The gynecologic care I provide in this space ranges from talking to families about ovary/sperm preservation prior to transition, pre-operative and

[1] This term refers to lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual people and other sexual and gender minority individuals.

operative surgical care for hysterectomies, post-operative vaginal care for transgender women, management of bleeding resulting from hormonal transition, and care surrounding sexually transmitted infections.

4. Additionally, I have spoken and written extensively on the provision of family-building healthcare services to LGBTQIA communities within forums such as the American Medical Association, the Association of American Medical Colleges, and the American College of Obstetricians and Gynecologists. Family-building healthcare services focus on assisting those who fall outside the traditional two-person, opposite sex unit with achieving pregnancy, such as through assisted reproductive technology, surrogacy, and adoption. I have also lectured in multiple venues on the need for gender and sexual minorities to access contraception and abortion care services. I serve on the advisory board of Washington University School of Medicine's OUTmed, a coalition of faculty who work to improve visibility of LGBTQIA communities on campus, ensure LGBTQIA patients and their families can identify competent and caring providers in the network, and assist with evaluation and implementation of medical education curriculum as it pertains to healthcare to LGBTQIA communities.

5. I am a 2007 graduate of the Kirksville College of Osteopathic Medicine. I also have a Master of Science degree in clinical investigation from Washington University, with which I am able to study public health from a research-focused perspective. I completed my residency in obstetrics and gynecology at Washington University School of Medicine in 2011. I then completed a two-year fellowship in family planning at Washington University. My curriculum vitae, which sets forth my experience and credentials more fully, is attached here as Exhibit A.

6. My practice focuses on providing patients with full-spectrum reproductive healthcare, including second-trimester abortions, medical and surgical abortions in the first trimester, contraceptive care, and specialized gynecologic care for LGBTQIA communities,

including gender-affirming surgeries and other therapies. I take a full-spectrum approach to the care I provide because it centers on the patient and what is best for them. Being able to provide full-spectrum reproductive healthcare allows me to develop a level of trust and strengthens the relationship between myself and patients, as they don't have to worry whether all of their needs will be met in ways that are consistent with their values and unique healthcare needs.

7. In many ways, my choice to center my work on abortion care and LGBTQIA communities is predictable. In both instances, patients face tremendous stigma. Their health—and, more broadly, their lives—are inappropriately influenced by ideology and unscientific rhetoric. The consequences of these realities are that our system allows for systemic discrimination, intentional oppression, and overt acceptance that the health and wellbeing of some is more important than that of others. Although healthcare providers cannot assume all of the responsibility to fix the injustices of such a system, they should seriously consider the responsibility they bear for ensuring the best public health outcomes. Optimizing public health outcomes requires equitable access to healthcare centered on scientific evidence, delivered across all geographies, and absent external judgment and stigma, whether the patient be a transgender man seeking a hysterectomy or a cisgender woman needing an abortion.

8. The importance of this approach and the availability of these necessary services goes beyond the obvious health outcomes. Pay inequity, low or nonexistent paid parental leave, and the general lack of supportive structures for pregnant persons and LGBTQIA individuals make it difficult for these populations to attain the level of economic independence necessary to parent the way they may want to. Equitable and comprehensive access to care is one important step to combat these conditions and empower my patients to parent when and in the manner they choose.

9. The services I provide also enable my patients to maximize their health and participate fully in society. Planning for pregnancy and spacing pregnancy are often incredibly

important factors in optimizing pregnancy outcomes. Contraception and abortion are important healthcare interventions that can prevent a host of physical and mental health conditions, including life-threatening conditions that are diagnosed after or worsen during pregnancy. Optimizing health through the use of contraception and abortion is important for pregnancy, but also in the larger context of my patient's lives. My patients often note that their ability to control their reproductive lives is essential to their ability to achieve career and educational goals, and to maintain the economic stability essential for a healthy family unit.

10. The need for reproductive health services is not limited to cisgender, binary, heteronormative populations alone. These services are just as important to patients across a variety of identities, including LGBTQIA individuals. Members of these communities also seek to prevent pregnancy, or build families, and access a whole host of other reproductive health services.

11. I submit this declaration in support of Plaintiffs' challenge to the final rule promulgated by the Department of Health and Human Services relating to "Conscience Rights in Health Care" (the "Denial or Care Rule," or the "Rule"). My opinions are based on my personal knowledge, as well as my training, education, clinical experience, ongoing review of the relevant professional literature, discussions with colleagues, participation in associations, and attendance at conferences in the fields of obstetrics, gynecology, and gynecologic surgery.

Trust Women Seattle

12. Trust Women Seattle, located in Seattle, Washington, opened in June 2017 and provides reproductive healthcare, including abortion services, contraceptive care, and general gynecological care, as well as a growing number of services for LGBTQ patients, including the provision of gender-affirming hormone therapies. The clinic receives Medicaid funding through Washington State and is a "subrecipient" under the Rule.

13. Medicaid funding for non-abortion services at Trust Women allows the clinic to continue providing a full range of reproductive healthcare services to patients. Without such funding, it would be difficult, and likely impossible, for the clinic to stay open.

14. To the extent that the Rule would prevent Trust Women Seattle from continuing to implement its compassionate and non-judgmental approach to care for all patients or its policies regarding emergency treatment, it is unworkable and would undermine the very mission of the clinic.

Medical Ethics

15. To the extent that the Rule permits or encourages staff at healthcare facilities to delay and deny patients information and care based on religious and moral refusals, and to the extent that the Rule conditions federal funding for recipients and subrecipients on permitting such discrimination, it is contrary to medical ethics.

16. When a provider's personal beliefs conflict with a patient's need for care, medical ethics as well as state and federal law require the needs of the patient to take precedence. This expectation within the medical community is clear and well-accepted. In these situations, where providers' interests conflict with patients' interests, providers have a duty to state upfront their conflicting personal beliefs and ensure the patient is immediately transferred to the care of another willing provider.[2]

[2] *See, e.g.*, American College of Obstetricians and Gynecologists Committee on Ethics, *Committee Opinion No. 385: The Limits of Conscientious Refusal in Reproductive Medicine*, 110 Obstetrics & Gynecology 1203 (2007) ("Physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request."); American Medical Association, *Code of Medical Ethics Opinion 1.1.7: Physician Exercise of Conscience*, Ethics, https://www.ama-assn.org/delivering-care/physician-exercise-conscience (last visited June 5, 2019) ("In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer.").

17. The Denial of Care Rule contravenes medical ethics by prioritizing not only the interests of the provider, but also the interests of those not directly providing care to the patient, such as a receptionist, janitor, and other administrative staff. For example, if a receptionist were to turn a patient away because of a disagreement with the healthcare choices of that patient, or even the patient's mere existence as an authentic being, it would undermine patient health and the clinic itself. This overt and allowable stigmatization could lead to loss of patient autonomy through internalization of disapproval, leaving them feeling paralyzed to make the best decisions for themselves or sometimes any decision at all. When patients are turned away or delayed in accessing care, their health, well-being, and privacy suffer.

18. Moreover, medical ethics require healthcare providers to ensure that patients' interests are protected, even in cases where a provider objects on moral or religious grounds to a particular course of treatment. In my opinion, to the extent that the Rule would permit staff to exercise effective veto power over a patient's opportunity to access a healthcare service by omitting information, treatment, or a referral, the Rule runs counter to any reasonable understanding of a healthcare provider's duty to patients. Providers hold knowledge related to health and diseases, and our job as providers is to take that information, make it understandable, and provide it to patients in a way that enables them to make an informed decision in the context of their values and life circumstances. It is not our job to make decisions for our patients, nor is it appropriate to color our care with our own values and circumstances. Moreover, were even administrative staff to exercise such a veto, it would be unconscionable. Staff without medical training and knowledge of a patient's medical history may give a patient incomplete information or deny them care without understanding the full implications for patient health.

Impact on Patients

19. Approximately 43 million pregnant persons in the United States are at risk of unwanted pregnancy.[3] Yet, state restrictions on abortion have contributed to the diminishing number of abortion clinics across the country, which has in turn contributed to diminished access to abortion care.[4] According to the most recent data from 2014, the number of abortion clinics decreased 17% from 2011.[5] In many areas, the lack of abortion care is particularly acute: 89% of counties in the United States do not have an abortion clinic at all,[6] and several states have only one clinic left.[7]

20. But even without state attacks on abortion, it can be difficult for clinics to survive in today's world. Lack of funding, based on defunding efforts and insurance bans, already hampers providers' ability to provide care. In addition, security concerns and provider unavailability pose serious operational hurdles. As a result, clinics in many counties can only provide abortion services on a limited basis, restricted to certain methods, certain gestational ages, specific indications, or on certain days.[8]

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[3] *Contraceptive Use in the United States*, Guttmacher Institute (July 2018), https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states.

[4] *See, e.g.*, Grossman D et al., *Change in Abortion Services after Implementation of a Restrictive law in Texas*, 90(5) Contraception 496 (2014); *see also* White K et al., *The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas*, 105(5) Am. J. of Pub. Health 851, 853-56 (2015).

[5] Jones RK & Jerman J, *Abortion Incidence and Service Availability In the United States, 2014*, 49(1) Persp. on Sexual & Reprod. Health 17 (2017).

[6] *Bad Medicine: How a Political Agenda is Undermining Abortion Care and Access*, National Partnership for Women & Families (Mar. 2018), http://www.nationalpartnership.org/research-library/repro/bad-medicine-third-edition.pdf.

[7] *Id.*

[8] *Id.*

21. Lower-income women are already unable to access contraception at the same rate as higher-income women.[9] These disparities, exacerbated by the increasing restrictions on family planning services, including publicly-funded clinics and services, result in deepening poverty for the most vulnerable women in the United States.[10] In short, many low-income women cannot access the contraceptive services and education they need to avoid unintended pregnancy, and when they become pregnant, it is increasingly difficult to access abortion services.

22. There is no typical abortion patient. A recent study found that 24% were Catholic, 17% were mainline Protestant, 13% were evangelical Protestant, and 8% identified with some other religion.[11]

23. There are a variety of reasons people require pregnancy termination, and each is valid. It is not uncommon for people with wanted pregnancies to require termination, because of fetal anomalies, because the pregnancy threatens the patient's health, or because the pregnancy is simply no longer viable. Yet, I am familiar with numerous instances in which many of these patients are not provided with complete information about the option to terminate, even if it is the most medically appropriate option, simply because their clinician has a personal objection. Patients in these situations have been subjected to last-minute, dire transfers and have even been rejected by providers of non-pregnancy related care as a result of their reproductive choices. I hear stories like

[9] *See* Secura GM et al., *The Contraceptive CHOICE Project: reducing barriers to long-acting reversible contraception*, 203(2) Am. J. of Obstetrics & Gynecology 115.e1 (2010).

[10] *See* Jenna Jerman, Rachel K. Jones & Tsuyoshi Onda, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Institute (May 2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[11] *Id.*

these every month, and I care for people who have been deceived and lied to, resulting in unnecessary stress and delayed procedures.

24. Contraception, an essential form of healthcare, is also already under threat.[12] For example, pharmacists have refused to provide over-the-counter emergency contraception and sought to vindicate their asserted right to deny it in court.[13] And as of 2015, only 60% of federally qualified health centers even offered contraceptive care to more than 10 female persons per year.[14] In my own practice, I have seen patients transferred to us because they were unable to access contraception from their previous provider.

25. Title X is already under attack from another federal administrative rule, which was recently enjoined nationwide by two district courts.[15] In the healthcare system, including in hospitals, there are already clinician and healthcare providers who impose religious beliefs above scientific fact and refuse to provide the most effective means of contraception, such as IUD's under the auspice that they are abortifacients despite concrete scientific evidence to the contrary. If more individuals are denied access to contraception under the Rule, it will lead to an increase in unintended pregnancy and abortion.

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[12] *See* American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women, *Committee Opinion No. 615: Access to Contraception*, 125 Obstetrics & Gynecology 250 (2015).

[13] *See* Yang YT & Sawicki NN, *Pharmacies' Duty to Dispense Emergency Contraception: A Discussion of Religious Liberty*, 129(3) Obstetrics & Gynecology 551 (2017).

[14] Jennifer J. Frost & Mia R. Zolna, *Response To Inquiry Concerning The Availability Of Publicly Funded Contraceptive Care To U.S. Women*, Guttmacher Institute (May 2017), https://www.guttmacher.org/article/2017/05/guttmacher-murray-memo-2017.

[15] *Oregon v. Azar*, No. 6:19-CV-00317-MC, 2019 WL 1897475 (D. Or. Apr. 29, 2019); *Washington v. Azar*, No. 1:19-CV-03040-SAB, 2019 WL 1868362 (E.D. Wash. Apr. 25, 2019).

26. Additionally, access to LGBTQIA-specific care is limited, and members of these communities are already experiencing discrimination and marginalization within the healthcare system. For example, there are clinicians who explicitly refuse to provide care to LGBTQIA patients or their children. In fact, most of my transgender patients report having had negative experiences with other healthcare providers before their appointment with me. And almost all of my transgender patients that require prolonged hospitalization prefer early discharge, out of fear that hospital staff members might say something hurtful or treat them disrespectfully. Indeed, my transgender patients have reported to me that other providers have repeatedly rescheduled their appointments, intentionally used the wrong pronouns, and even refused to use pronouns at all, calling them "it." I hear stories like this regularly.

27. The Denial of Care Rule threatens to exacerbate this preexisting lack of access to abortion, contraception, and LGBTQIA-specific care. To the extent that it discourages entities like Trust Women from offering any services to which our employees, volunteers, or contractors may possibly object and threatens to remove or even claw back funding from entities that do not comply with such broad requirements, it is unworkable and could force Trust Women and other providers across the country to drastically alter the care we offer to patients or close entirely.

28. The Rule also further stigmatizes abortion, contraception, and care to LGBTQIA communities. By specifically highlighting these types of care as religiously or morally objectionable the Rule suggests that the services are not common, necessary, and important to maintain health, and furthermore suggests that only certain Americans are deserving of comprehensive and dignified healthcare. We have seen the tremendous impact that stigma can have

on patients. For example, abortion stigma fosters fear and psychological stress in patients.[16] When patients perceive the community's disapproval of their choice, they feel the need to maintain secrecy around their decision and experience shame, causing substantial stress.[17] Moreover, this stigma will deter patients from seeking these types of care out of fear of judgment and discrimination.

29. Whether because patients encounter a refuser, providers are forced to close their doors, or patients are deterred from seeking care because of stigma and a justified fear of discrimination, individuals seeking abortion, contraception, and LGBTQIA-specific care will either be delayed or totally denied such care as a result of the Rule.[18]

Impact of Delayed Care

30. A report from the National Academies of Science found that overall abortion is safe, but if anything is making it less safe, it is the number of restrictions being passed in states that create delays and prevent women from accessing care.[19] On average, a pregnant person already must wait at least a week between attempting to make an appointment and actually receiving an

[16] *See* Norris A et al., *Abortion stigma: a reconceptualization of constituents, causes, and consequences*, 21(3 Suppl) Women's Health Issues S49 (2011).

[17] *See* Major B et al., *Abortion and mental health: Evaluating the evidence*, 64(9) Am. Psychol. 863 (2009).

[18] *See, e.g.*, Brief for National Abortion Federation and Abortion Providers as Amici Curiae in Support of Petitioners at 20-35, *Whole Woman's Health v. Cole*, 136 S. Ct. 499 (2015) (No. 15-274); *see also* Yao Lu & David J. G. Slusky, *The Impact of Women's Health Clinic Closures on Preventive Care*, 8(3) Am. Econ. J.: Applied Econ. 100 (2016).

[19] *See* National Academies of Science, Engineering, and Medicine, The Safety and Quality of Abortion Care in the United States (The National Academies Press 2018).

abortion.[20] Some states have mandatory delay laws, which require patients to wait up to 72 hours after receiving certain state-mandated information and their procedure. When paired with the limited number of clinics in each state (in some instances only one), these restrictions on access to care can force a pregnant person to wait weeks for an appointment. Further, insurance bans that prevent coverage for abortion makes it harder for women to come up with the funds necessary, which also creates delays.

31. Delays in obtaining an abortion compound the logistical and financial burdens patients face. Some common factors include having to travel long distances or encountering significantly increased wait times due to the ever-shrinking number of abortion clinics.[21] These delays also increase the cost of an abortion and other associated costs like travel and childcare. The cost of abortion rises as gestational age increases, and abortions during the second trimester are substantially more expensive than in the first trimester.[22] Financial burdens also result from missed work. In one study, delays were shown to have caused 47% of patients to miss an extra day of work

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[20] Finer LB et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74(4) Contraception 334 (2006).

[21] *See generally, e.g.*, *Bad Medicine: How a Political Agenda is Undermining Abortion Care and Access*, National Partnership for Women & Families (Mar. 2018), http://www.nationalpartnership.org/research-library/repro/bad-medicine-third-edition.pdf; *Abortion Wait Times in Texas: The Shrinking Capacity of Facilities and the Potential Impact of Closing Non-ASC Clinics*, Texas Policy Evaluation Project (Oct. 5, 2015), http://sites.utexas.edu/txpep/files/2016/01/Abortion_Wait_Time_Brief.pdf.

[22] *See* Sarah C.M. Roberts et al., *Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women*, 48(4) Persp. on Sexual & Reprod. Health 179, 184 (2016); Jones RK et al., *Differences in Abortion Service Delivery in Hostile, Middle-ground, and Supportive States in 2014*, 28(3) Women's Health Issues 212 (2018).

and caused more than 60% of patients to shoulder the burden of increased transportation costs and lost wages by a family member or friend.[23]

32. Delays in obtaining an abortion can also push patients into later stages of pregnancy before they are able to access care. And although abortion is a very safe procedure, risks increase with later gestational ages.[24] Patients pushed into later stages of pregnancy may also be denied the option to have particular types of abortions. For example, medication abortion is typically available only up to 10 weeks after a woman's last menstrual period. Patients can choose medication abortion for a variety of personal reasons, including that it is more private, less invasive, and allows the patient to drive herself to the clinic for her procedure—an option that is not available for all surgical procedures. Additionally, a second trimester surgical procedure is more complex, costlier, and carries greater risks than a first trimester surgical procedure. Moreover, patients approaching legal limits in their state based on when medication abortion may be prescribed or abortion performed may be forced to seek care in another state if they are delayed in accessing care.[25]

33. For patients with certain medical conditions or indications, delays in obtaining an abortion present even more serious risks. For example, for pregnant persons with cancer, currently undergoing or awaiting initiation of addiction treatment, or with serious cardiovascular conditions, for example, it is medically preferred and safer to perform an abortion at earlier gestational ages without unnecessary delay. There are also pregnant persons for whom medication abortion may be

[23] Sanders JN et al., *The Longest Wait: Examining the Impact of Utah's 72-Hour Waiting Period for Abortion*, 26(5) Women's Health Issues 483 (2016).

[24] *See* Bartlett LA et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103(4) Obstetrics & Gynecology 729 (2004).

[25] *See* Jenna Jerman et al., *Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States*, 49(2) Persp. on Sexual & Reprod. Health 95 (2017).

medically indicated or preferred, including those with uterine anomalies and those who are survivors of sexual assault who may not be comfortable with an invasive physical exam.

34. Delays in obtaining an abortion can also inflict unnecessary emotional distress and psychological harm. I have found this to be particularly true for pregnant persons who have wanted pregnancies but have made the decision to terminate after receiving a diagnosis of a lethal or grave fetal anomaly, or pregnant persons who have made the decision to end a pregnancy that occurred following rape. Delays also increase the likelihood that a patient will be forced to disclose her decision to have an abortion to others from whom she would prefer to keep the decision confidential.[26]

35. Similarly, delays in obtaining LGBTQIA-specific care can lead to poor physical and mental health outcomes. For example, while all care should be timely, for transgender patients seeking to transition, it is important that they be able to do so as soon as they are ready.[27] Once a patient has identified transitioning as integral to their process of feeling whole, the best mental and physical health outcomes stem from completion of that process.

Impact of Denials of Care

36. If patients are denied care entirely, they will encounter a whole host of additional harms. Denying someone an abortion and forcing them to carry to term increases the risk of serious health harms, including eclampsia and death.[28] In addition, denying someone an abortion can lead

[26] *See, e.g.*, Sanders JN et al., *The Longest Wait: Examining the Impact of Utah's 72-Hour Waiting Period for Abortion*, 26(5) Women's Health Issues 483 (2016).

[27] *See* Nguyen HB et al., *Gender-Affirming Hormone Use in Transgender Individuals: Impact on Behavioral Health and Cognition*, 20(12) Current Psychiatry Rep. 110 (2018).

[28] *See* Gerdts C et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*, 26(1) Women's Health Issues 55 (2016).

to increased risk of life threatening bleeding, cardiovascular complications, risk of diabetes associated with pregnancy, as well as any other risk that results from pregnancy.

37. In fact, ending a pregnancy is safer than continuing a pregnancy, with one study estimating 28.6% of hospital deliveries involve at least one obstetric complication, compared to only 1% - 4% of first-trimester abortions.[29] A pregnant person is 14 times more likely to die from giving birth than as a result of an abortion, which is particularly poignant in the United States, the only developed nation with a rising maternal mortality rate.[30]

38. Being denied a wanted abortion also results in economic insecurity for pregnant persons and their families, and an almost fourfold increase in the odds that household income will fall below the federal poverty level.[31]

39. In 2014, three-fourths of abortion patients were already low income—49% living at less than the federal poverty level, and 26% living at 100-199% of the poverty level.[32] 59% of abortion patients in 2014 had at least one previous birth.[33]

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[29] Berg CJ et al., *Overview of Maternal Morbidity During Hospitalization for Labor and Delivery in the United States: 1993-1997 and 2001-2005*, 113(5) Obstetrics & Gynecology 1075 (2009).

[30] *See* Raymond EG & Grimes DA, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2 Pt 1) Obstetrics & Gynecology 215 (2012) (analyzing data from 1998 to 2005).

[31] *See* Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive And Women Who Are Denied Wanted Abortions in the United States*, 108(3) Am. J. of Pub. Health 407 (2018).

[32] Jenna Jerman, Rachel K. Jones & Tsuyoshi Onda, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Institute (May 2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[33] *Id.*

40. Some patients who are denied abortion care may resort to extremes and even self-harm or attempted self-managed abortion. At least a few times per year I am asked to care for a pregnant person whose reported reason for attempted suicide is not wanting to be pregnant and not being able to secure an abortion. Additionally, the rate of self-managed abortions has risen across the country as abortion has become increasingly difficult to access.[34]

41. Additionally, patients who are denied contraception are less able to safeguard their own health and welfare. The ability to prevent or space pregnancy, facilitated by easy and affordable access to contraception, has significant health benefits.[35] Ensuring the best pregnancy outcomes requires optimizing patient health between pregnancies. Thus, denials of contraception not only increase the rates of unintended pregnancies, but also adversely affect the health of persons who subsequently become pregnant although they have conditions that could make pregnancy dangerous.

42. Furthermore, many patients rely on contraception for other medical conditions, including treatment for endometriosis, polycystic ovarian syndrome, acne, menstrual irregularity, menstrual migraines, and for decreasing the risk of endometrial, ovarian, and colorectal cancers.[36] Thus, denials of contraception can prevent patients from accessing treatment for these conditions.

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[34] *See, e.g.*, *Study Finds at Least 100,000 Texas Women Have Attempted to Self-Induce Abortion*, Texas Policy Evaluation Project (Nov. 17, 2015), https://liberalarts.utexas.edu/txpep/releases/self-induction-release.php.

[35] *See Report of a WHO Technical Consultation on Birth Spacing*, World Health Organization, (2007), http://apps.who.int/iris/bitstream/10665/69855/1/WHO_RHR_07.1_eng.pdf (recommending pregnant persons space their births at least two years apart in order to reduce the risk of maternal morbidity and mortality).

[36] *See* Carrie Armstrong, *ACOG Guidelines on Noncontraceptive Uses of Hormonal Contraceptives*, 82(3) Am. Fam. Physician 288 (2010).

43. Contraceptive coverage is also a necessary component of an equitable society, as it allows pregnant persons and LGBTQIA patients to make decisions about their health, reproductive lives, education, careers, and livelihoods. Denying access to this coverage denies them equal opportunity to aspire, achieve, participate in, and contribute to society based on their individual talents and capabilities.

44. The Denial of Care Rule will result in increased numbers of LGBTQIA persons experiencing stigmatizing denials of care. Patients who are denied LGBTQIA-specific care will have worse health outcomes.[37] Already today, even without the Rule, as a result of preexisting stigma, lesbian patients in particular are already less likely to disclose their sexual identity and less likely to access primary care.[38] Many transgender patients already experience overt disrespect from their providers, resulting in a tiered level of care.[39] This stigma and discrimination may be particularly acute in rural areas, where perception of provider bias may be more prevalent.[40]

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[37] *See, e.g.*, Sara Berg, *Better Training Needed to Address Shortcomings in LGBTQ Care*, American Medical Association (July 17, 2018), https://www.ama-assn.org/delivering-care/population-care/better-training-needed-address-shortcomings-lgbtq-care; Mark L. Hatzenbuehler et al., *The Impact of Institutional Discrimination on Psychiatric Disorders in Lesbian, Gay, and Bisexual Populations: A Prospective Study*, 100(3) Am. J. of Pub. Health 452 (2010); Amaya Perez-Brumer et al., *"We don't treat your kind": Assessing HIV health needs holistically among transgender people in Jackson, Mississippi*, 13(11) PLoS One 1 (2018).

[38] *See* Zeeman L, *A review of lesbian, gay, bisexual, trans and intersex (LGBTI) health and healthcare inequalities*, Eur. J. of Pub. Health (2018).

[39] *See, e.g.*, Hatzenbuehler ML & Pachankis JE, *Stigma and Minority Stress as Social Determinants of Health Among Lesbian, Gay, Bisexual, and Transgender Youth: Research Evidence and Clinical Implications*, 63(6) Pediatric Clinics of North Am. 985 (2016); Raifman J, *Sanctioned Stigma in Health Care Settings and Harm to LGBT Youth*, 172(8) JAMA Pediatrics 713 (2018).

[40] *See, e.g.*, Willging CE et al., *Brief reports: Unequal treatment: mental health care for sexual and gender minority groups in a rural state*, 57(6) Psychiatric Serv. 867 (2006); Lee MG & Quam JK, *Comparing supports for LGBT aging in rural versus urban areas*, 56(2) J. of Gerontological Soc. Work 112 (2013).

45. Stigmatization and discrimination cause poor health outcomes. When a hospital's cafeteria staff refuse to bring transgender patients their food, for example, this immediately impacts these patients' mental health and may push them out of the healthcare system entirely. For example, patients might sign themselves out of the hospital early and begin to manage their own healthcare decisions in ways that might not optimize their physical health.

46. Denials of care also hinder patients from accessing full-spectrum care, which offers significant benefits. Because so much of the provision of healthcare depends on the relationship between patient and provider, it is to the patient's benefit to access a full spectrum of healthcare from a provider that they know, trust, and have built a robust relationship with. When a provider delivers care consistent with the full scope of their training, the provider has a more comprehensive understanding of the patient's values, communication style, priorities, and motivators, which affords a stronger relationship to deliver the most effective care. But, there are many generalists in OB/GYN and other areas of healthcare that are do not provide full-spectrum care. Denials of care contribute to an increasingly fragmented healthcare system, whereby patients must see even more providers to address various facets of their health. This limits patients' opportunity to seek full-spectrum care.

47. In sum, to the extent that the Rule would permit and even require denials of care and information to patients, consequently increasing stigma and decreasing access to full-spectrum healthcare for reproductive healthcare and LGBTQ patients, the Rule is an assault on the physical and mental health of patients, with compounding harms and drastic consequences that fly in the face of medical ethics.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: June 5, 2019

Respectfully submitted,

/s/ Colleen P. McNicholas
COLLEEN P. MCNICHOLAS, D.O.,
M.S.C.I., F.A.C.O.G.

EXHIBIT A

CURRICULUM VITAE
Colleen Patricia McNicholas, DO, MSCI, FACOG

Date: October 2018

Address:

Department of Obstetrics and Gynecology
Washington University in St. Louis
660 S Euclid Ave
Mailstop 8064-37-1005
St. Louis, Missouri 63110-1094

Present Position:

Associate Professor
Washington University School of Medicine in St. Louis
Department of Obstetrics and Gynecology
Division of Family Planning

Director- Ryan Residency Collaborative
Oklahoma University and Washington University School of Medicine

Assistant-Director- Fellowship in Family Planning
Washington University School of Medicine in St. Louis

Education:

Undergraduate:	1998-2003	Benedictine University Lisle, Illinois B.S. Forensic Chemistry
Graduate:	2003-2007	Kirksville College of Osteopathic Medicine Kirksville, Missouri Doctor of Osteopathy
	2011-2013	Washington University in St. Louis St. Louis, Missouri Masters of Science in Clinical Investigation
Internship:	2007-2008	Atlanta Medical Center Atlanta, Georgia Internship
Residency:	2008-2011	Washington University School of Medicine Residency in Obstetrics and Gynecology
Fellowship:	2011-2013	Washington University School of Medicine Clinical Instructor – Obstetrics and Gynecology Clinical Fellow – Family Planning

Academic Positions/Employment:

2018-	Associate Professor Department of Obstetrics and Gynecology Washington University School of Medicine
2014-2018	Director, Ryan Residency Training Program Washington University School of Medicine

	2013- 2018	Assistant Professor Department of Obstetrics and Gynecology Washington University School of Medicine
	2012-2014	Missouri Baptist Medical Center, St Louis, MO Laborist

University and Hospital Appointments and Committees:

Appointments		
	2013-	Attending Physician Barnes Jewish Hospital St. Louis, MO
	2014-	Director, Ryan Residency Training Program Department of Obstetrics and Gynecology Washington University School of Medicine
	2016-	Co-Director, Fellowship in Family Planning Department of Obstetrics and Gynecology Washington University School of Medicine
	2016-	Obstetrics and Gynecology Performance Evaluation Committee Washington University/Barnes Jewish OB/GYN Residency
	2016-	Washington University School of Medicine Institutional Review Board Member
	2018-	Washington University School of Medicine Committee on Admissions
Committees:		
	2014- 2017 2017-2020	American College of Obstetrics and Gynecology Committee on the Healthcare for Underserved Women Member
	2015- 2017 2017-2020	American College of Obstetrics and Gynecology Underserved Liaison to Committee on Adolescent Health Care
	2015-	International Federation of Gynecology and Obstetrics (FIGO) Women’s Sexual and Reproductive Rights Committee Master Trainer, Integrating Human Rights in Health
	2016-	Ibis Reproductive Healthcare Over the counter oral contraceptive working group Policy Subcommittee
	2017-	MERCK Global Advisory Board on Contraception
	2017-	Washington University School of Medicine OUT Med Advisory Board
Volunteer	2015-	Saturday Neighborhood Health Clinic Washington University School of Medicine Volunteer Attending Physician Faculty, Primary Care

Volunteer Attending Physician Faculty, Americore Homeless

Medical Licensure and Board Certification:

Licensure

Missouri, Kansas, Oklahoma, Washington
Illinois Pending

Board Certification:

2014- current	American Board of Obstetrics and Gynecology General Obstetrics and Gynecology Diplomate

Honors and Awards:

2001	Gregory Snoke Memorial Scholarship
2001	American Chemical Society Analytical Achievement Award
2001	American Chemical Society Division of Analytical Chemistry 2001 Undergraduate Award
2002	PGG Industries Foundation J. Earl Burrell Scholarship
2003	Senior Academic Award: College of Arts and Science
2006	Presidents Award: Women in Medicine
2011	Kody Kunda Resident Teaching Award
2012	ACOG Health Policy Rotation, LARC Program January 2013
2012	Physicians for Reproductive Health and Choice (PRCH) Leadership Training Academy
2012	President's Award: St. Louis Gynecologic Society, best research presentation
2016	Fellowship in Family Planning, Warrior Award
2016	Physicians for Reproductive Health, Voices of Courage: A Benefit Celebrating Extraordinary Abortion Providers
2016	2015 Roy M. Pitkin Award, Obstetrics and Gynecology (The Green Journal)
2018	Massingill Family Scholarship, 2018 Robert C. Cefalo Leadership Institute
2018	ACOG District VII Mentor of the year award

Editorial Responsibilities:

2011-	*Reviewer*, Contraception
2011-	*Reviewer*, Journal of Family Planning and Reproductive Health Care
2012-	*Reviewer*, American Journal of Obstetrics and Gynecology
2012-	*Reviewer*, European Journal of Obstetrics and Gynecology and Reproductive Biology
2013-	*Reviewer*, Obstetrics and Gynecology

Professional Societies and Organizations:

2003-	Medical Students for Choice
2006-2011	Association of Reproductive Health Professionals
2006-	American Congress of Obstetricians and Gynecologists

Leadership Roles

- 2013: The American College of Obstetricians and Gynecologists/Bayer HealthCare Pharmaceuticals Research Fellowship in Contraceptive Counseling (Selection committee)

- 2012-2018: American Congress of Obstetrics and Gynecology Congressional Leadership Conference, participant
  - 2015: Presenter, Reproductive Health Legislation in the States
  - 2016: Presenter, Reproductive Health Legislation in the States

- 2014-2020: Committee on Health Care for Underserved Women
  - Author, CO-Healthcare for Women with Disabilities
  - Author, Policy statement- Marriage and Family Equality
  - ACOG Liaison, AAMC Family Building Webinar series
  - Author, CO- Trauma informed care

- 2015-current: Committee on Adolescent Health Care, Underserved Liaison

- 2015-current: Missouri ACOG Section Advisory Committee, Member
  - 2015- current: Member, Legislative Committee

2006- Gay and Lesbian Medical Association
2006- Women in Medicine
Leadership Roles

- 2010-current Board Member
- 2016: Chair of annual conference, Aug 2016
- 2018-2020: Board Treasurer

2008-2011 St. Louis Obstetrics and Gynecology Society
Leadership Roles: resident board member
2011- Society of Family Planning

Invited Presentations:

2001 Cadmium's effect on Osteoclast Apoptosis
12th Annual Argonne Symposium for Undergraduates in Science, Engineering and Mathematics

2002 Cadmium's effect on Osteoclast Apoptosis
2002 Experimental Biology Conference

2012 Contraception for medically complicated women
Women in Medicine Annual meeting

2013 The troubling trend of legislative interference.
Washington University School of Medicine, OBGYN Grand Rounds.

2013 An update on abortion: Why lesbians and those who treat them should care
The Gay and Lesbian Medical Association

2013 Findings from the Contraceptive CHOICE Project. Are you meeting your patient's contraceptive needs?
Washington University School of Medicine Annual OB/GYN Symposium

2013 Legislative interference and the impact on public health.
Washington University Brown School of Social Work.

2014 Business of Medicine Medical Student Elective Course
Legislating Medicine
Washington University School of Medicine

2014 Practical tips for your first RCT, lessons learned
Lecture in Randomized Control Trial course

2014 Uniting tomorrow's leaders of the RJ movement with providers of today
National Abortion Federation Annual Meeting

2014 Systems based practice and advocating for your patients
Washington University School of Medicine OB/GYN residency core lecture

2014 Abortion in sexual minority populations
National Abortion Federation

2014 Complications of uterine evacuation
St. Louis University OB/GYN Grand Rounds

2014 Medical contraindications in CHOICE Participants using combined hormonal contraception
Over the Counter Oral Contraceptive Working Group

2015 Implementing immediate postpartum LARC
Kansas University OB/GYN grand rounds

2015 The evidence for immediate Post-partum IUD insertion
Kansas City Gynecologic Society

2105 Business of Medicine Medical Student Elective Course
Legislating Medicine
Washington University School of Medicine

2015 Getting Politics Out of the Exam Room: Combating Legislative Interference in the Patient-Provider Relationship
National Abortion Federation Annual Meeting

2015 Are you meeting your patient's contraceptive needs?
Tennessee Department of Health.

2015 Colorado Initiative to reduce unintended pregnancy (webinar): Reducing Unplanned Pregnancies in Colorado through Strategies to Promote Long-Acting Reversible Contraception
Huffington Post, Live

2105 Method mix it up: Expanding options to meet the unique contraceptive needs of young people
FIGO World Conference

2015 Getting to Yes-Interventions to Increase LARC Acceptance with a Focus on IUC
Nurse Practitioners Women's Health Annual Symposium

2015 Put your megaphone where your mouth is: Getting your professional society to speak up
Forum on Family Planning

2015 When Politics Trumps Science- Why is Birth control at Center Stage?
Carbondale Illinois Grand Rounds

2016 Using research to effectively advocate

Physicians for Reproductive Health Leadership Training Academy

2016 Partial Participation and Abortion Training in Residency: A Structure for Optimizing Learning and Clinical Care
APGO/CREOG

2016 Are we meeting the needs of our teen and adolescent patients? Our role in preventing unintended pregnancy. Barnes Jewish Hospital/Washington University School of Medicine CME Outreach.

2016 The emerging role of physicians as advocates
St Louis OB/GYN Society

2016 Legislation and Advocacy
Washington University School of Medicine- Elective course
Gun violence as a public health issue

2016 Legislative advocacy and the impact on public health
Washington University, Brown School of Social Work

2017 GOV 101
Learning to advocate at the MO legislature

2017 Reevaluating the longevity of LARC
GrandRounds, BayState Medical Center

2018 Ryan Residency Program Annual Meeting
Patient and Community Advocacy in Residency Training

2018 Physician advocacy, the key to public health
Keynote Speaker
Washington University
Center for Community Health Partnership & Research (CCHPR)
Global Health Center Summer Research Program

2018 XXII World Congress of Gynecology and Obstetrics
Whether, when, and how many: a global movement toward reproductive freedom
Rio de Janeiro, Brazil

2018 Domestic and Global epidemiology of abortion
Washington University, Brown School of Social Work

Research Support:

3125-946435
Role: Principal Investigator
MERCK
Ovarian function with prolonged use of the implant
Award: January 2017-June2018
Award Amount: $279,126

U01DK106853 (Colditz, Sutcliffe)
Role: Co-investigator
NIH/NIDDK
LUTS prevention in adolescent girls and women across the lifespan
Award: 07/01/2015-06/31/2020

(Peipert, McNicholas)
Role: Co-Principal Investigator
Anonymous Donor
EPIC: Evaluating prolonged use of the IUD/implant for Contraception
Award: Sep8, 2014 – Aug 31, 2018
Award Amount: $ 1,000,000

National Institutes of Health- Loan Repayment Program
Role: Principal Investigator
EPIC: Evaluating prolonged use of the IUD/implant for Contraception
Aug 17, 2014- July 31, 2017
Award Amount: $70,000
Aug 1, 2016- July 31, 2018
Award Amount: $70,000
Aug 1, 2018- July 31, 2020

81615 (Peipert, McNicholas)
Role: Co-Principal Investigator
William and Flora Hewlett Foundation
LIFE: Levonorgestrel Intrauterine system For Emergency Contraception; a multicenter randomized trial
June1, 2014- May 31, 2015
Award Amount: $351,500

IRG-58-010-57 (McNicholas)
Role: Principal Investigator
American Cancer Society Institutional Research Grant (ACS-IRG)
Evaluating the impact of the IUD on HPV and cervical cancer risk
January 1, 2014-December 31, 2014
Award Amount: $30,000

SFPRF12-1 (McNicholas)
Role: Principal Investigator
Society of Family Planning Research Fund
Effectiveness of Prolonged use of IUD/Implant for Contraception (EPIC)
January 2012 – July 2014
Award Amount: $70,000

UL1 TR000448 (Evanoff)
Role: Postdoctoral MSCI Scholar
NIH-National Center for Research Resources (NCRR)
Washington University Institute of Clinical and Translational Sciences (ICTS)
July 1, 2011 – June 30, 2013

5T32HD055172-03 (Macones, Peipert)
Role: Clinical fellow, trainee
NIH T32 Research Training Grant
July 1, 2011 – June 30, 2013

Bibliography:

Peer-reviewed Publications:

1. Allsworth JE, Hladky KJ, Hotchkiss T, McNicholas C, Rohn A. Discussion: 'Douching and the risk for sexually transmitted disease' by Tsai et al. *Am J of Obstet and Gynecol* 2009;200(1):e11-4.

2. Stoddard A, McNicholas C, Peipert JF. Efficacy and safety of long-acting reversible contraception. *Drugs*. 2011 May 28;**71**(8): p. 969-80. PMID: 21668037

3. McNicholas C, Hotchkiss T, Madden T, Zhao Q, Allsworth J, Peipert JF. Immediate postabortion intrauterine device insertion: continuation and satisfaction. *Women Health Iss.* 2012 Jul-Aug; 22(4):e365-369. PMID: 22749197

4. McNicholas C, Peipert JF. Long-acting reversible contraception for adolescents. *Curr Opin Obstet Gyn.* 2012 Oct; 24(5):293-298. PMID: 22781078

5. McNicholas C, Peipert JF. Initiation of long-acting reversible contraceptive methods (IUDs and implant) at pregnancy termination reduces repeat abortion. *Evid Based Med.* 2013 Jun;18(3):e29. PMID: 23161505

6. McNicholas C, Madden T, Zhao Q, Secura G, Allsworth JE, Peipert JF. Cervical lidocaine for IUD insertional pain: a randomized controlled trial. *Am J Obstet Gynecol. 2012* Nov;207(5):384 e381-386. PMID: 23107081

7. McNicholas C, Zhao Q, Secura G, Allsworth J, Madden T, Peipert J. Contraceptive failures in overweight and obese combined hormonal contraceptive users. *Obstet Gynecol*. 2013 March; 121(3):585-92. PMID: 23635622

8. McNicholas C. Transcending politics to promote women's health. *Obstet Gynecol.* 2013 Jul;122(1):151-3. PMID: 23743460

9. Eisenberg D, McNicholas C, Peipert JF. Cost as a barrier to long-acting reversible contraceptive (LARC) use in adolescents. *J Adolescent Health*. 2013 Apr;52(4 Suppl):S59-63. PMID: 23535059

10. Grentzer J, McNicholas C, Peipert J. Use of the etonorgestrel-releasing implant. *Expert Rev. of Obstet and Gynecol.* 8 (4), 337-344. 2013

11. Secura G, McNicholas C. Long-acting reversible contraceptive use among teens prevents unintended pregnancy: a look at the evidence. *Expert Rev. of Obstet Gynecol*. 8(4), 297-299. 2013

12. McNicholas C, Peipert JF, Madipati R, Madden T, Allsworth, J Secura G. Sexually transmitted infection prevalence in a population seeking no-cost contraception. *Sex Transm Dis.* 2013 July;40(7):546-51. PMID: 23965768

13. Sehn JK, Kuroki LM, Hopeman MM, Longman RE, McNicholas CP, Huettner PC. Ovarian complete hydatidiform mole: case study with molecular analysis and review of the literature. *Hum Pathol*. 2013 Dec;44(12):2861-4. PMID: 24134929

14. Madden T, McNicholas C, Zhao Q, Secura G, Eisenberg D, Peipert JF. Association of Age and Parity with IUD Expulsion. *Obstet Gynecol.* 2013 Oct; 124 (4): 718-26. PMID: 4172535

15. Secura G, Madden T, McNicholas C, Mullersman J, Buckel C, Zhao Q, Peipert JF. No-Cost Contraception Reduces Teen Pregnancy, Birth, and Abortion. *New Engl J Med.* 2104 Oct; 371(14); 1316-23. PMCID: 4230891

16. McNicholas C, Madden T, Secura G, Peipert JF. The Contraceptive CHOICE Project Round Up: What we did and what we learned. *Clin Obstet Gynecol.* 2014 Dec; 57(4); 635-43. PMCID: 4216614

17. McNicholas C, Maddipati R, Swor E, Zhao Q, Peipert JF. Use of the Etonogestrel Implant and Levonorgestrel Intrauterine Device Beyond the U.S. Food and Drug Administration-Approved Duration. *Obstet Gynecol,* 2015 Mar; 125(3):599-604.

18. Grentzer J, Peipert J, Zhao Q, McNicholas C, Secura G, Madden T. Risk-based screening for Chlamydia trachomatis and Neisseria gonorrhoeae prior to intrauterine device insertion. *Contraception* 2015 Jun; S0010-7824(15)00250-4. PMID:26093189

19. Mejia M, McNicholas C, Madden T, Peipert J. Association of Baseline Bleeding Pattern on Amenorrhea with Levonorgestrel Intrauterine System Use. *Contraception.* 2016 Nov;94(5):556-560. PMID: 27364099

20. Hou M, McNicholas C, Creinin M. Combined Oral Contraceptive Treatment for Bleeding Complaints with the Etonogestrel Contraceptive Implant: A Randomized Controlled Trial. *Eur J Contracept Reprod Health Care.* 2016 Oct;21(5):361-6. PMID: 27419258

21. Zigler RE, Peipert JF, Zhao Q, Maddipati R, McNicholas C. Long-acting reversible contraception use among residents in obstetrics/gynecology training programs. *Open Access J of Contracept*. 2017 Jan; 2017(8) 1—7. PMID: 29386949

22. Zigler RE, McNicholas C. Unscheduled vaginal bleeding with progestin-only contraceptive use. *Am J of Obstet and Gynecol*. 2017 May;216(5):443-450. PMID: 27988268

23. McNicholas C, Swor E, Wan L, Peipert JF. Prolonged use of the etonogestrel implant and levonorgestrel intrauterine device: 2 years beyond Food and Drug Administration-approved duration. *Am J Obstet Gynecol*. 2017 Jan 29. PMID:28147241

24. McNicholas C, Peripert JF. Is it time to abandon the routine pelvic exam in asymptomatic nonpregnant women? *JAMA* 2017 Mar 7;317(9):910-911. PMID:28267835

25. McNicholas C, Madden T. Meeting the Contraceptive Needs of a Community: Increasing Access to Long-Acting Reversible Contraception. *MO Med*. 2017 May-Jun; 114(3):163-167. PMID:30228573

26. Iseyemi A, Zhao Q, McNicholas C, Peipert JF. Socioeconomic Status As a Risk Factor for Unintended Pregnancy in the Contraceptive CHOICE Project. *Obstet Gynecol*. 2017 Sep;130(3):609-615. PMID: 28796678

27. McNicholas C, Klugman J, Zhao Q, Peipert J. Condom Use and Incident Sexually Transmitted Infection after Initiation of Long-Acting Reversible Contraception. *Am J of Obstet and Gynecol.* 2017 Dec;217(6):672.e1-672.e6. PMID: 28919400

28. Zigler RE, Madden T, Ashby C, Wan L, McNicholas C. Ulipristal Acetate for Unscheduled Bleeding in Etonogestrel Implant Users: A Randomized Controlled Trial. *Obstet Gynecol*. 2018 Oct;132(4):888-894. PMID: 30130151

Non-Peer Reviewed Invited Publications:

1. McNicholas C. Rev. of Recent advances in obstetrics and gynecology, *Royal Society of Medicine Press*, 2008.

2. McNicholas C, Levy B. The original minimally invasive hysterectomy; no hospitalization required. *Expert Rev. of Obstet and Gynecol*. 8(2), 1-3. 2013

Chapters:

1. Gross G, McNicholas C. Rev. of Shoulder dystocia and birth injury: prevention and treatment, by James A. O'Leary 3rd Ed
2. McNicholas C, Peipert JP. Pelvic inflammatory disease. *Practical Pediatric and Adolescent Gynecology*. Oxford. Wiley-Blackwell. ISBN: 978-0-470-67387-4.
3. McNicholas C, Madden T., *2015 Contraceptive counseling for obese women.* In E. Jungheim (Ed) Obesity and Fertility. Springer, New York. ISBN 978-1-4939-2611-4

Abstracts:

1. McNicholas C, Maddipati R, Secura G, Peipert J. Use of the contraceptive implant beyond the FDA-approved duration. Poster Presentation. North American Forum on Family Planning. Miami, FL October 2014.

2. McNicholas C, Swor E, Peipert J, Secura G. Serum etonogestrel levels in women using the contraceptive implant beyond the FDA-approved duration. *Oral Presentation. North American Forum on Family Planning*. Seattle, WA October 2013.

3. McNicholas C, Zhao Q, Peipert J, Secura G. Condom use and incident sexually transmitted infection after initiation of long-acting reversible contraception. *Oral Presentation. 40th Annual Scientific Meeting of the Infectious Diseases Society for Obstetrics and Gynecology*. Sante Fe, NM Aug 2013.

4. McNicholas C, Madden T, Zhao Q, Secura G, Allsworth JE, Peipert JP. Cervical lidocaine for IUD insertional pain: a randomized controlled trial. *Poster Presentation*. *North American Forum on Family Planning*. Denver, CO. October 2012.

5. McNicholas C, Maddipati R, Allsworth J, Madden T, Peipert J, Secura G. Baseline sexually transmitted infection prevalence in a low risk urban population. *Oral Presentation*. *39th Annual Scientific Meeting of the Infectious Diseases Society for Obstetrics and Gynecology.* Whistler, BC Aug 2012.

6. McNicholas C, Maddipati R, Allsworth J, Madden T, Peipert J, Secura G. An epidemiologic comparison of *Chlamydia Trachomatis* and *Trichomonas Vaginalis*: Information from the Contraceptive CHOICE Project. *Poster Presentation*, *39th Annual Scientific Meeting of the Infectious Diseases Society for Obstetrics and Gynecology*. Whistler, BC Aug 2012.

7. McNicholas C, Madden T, Zhao Q, Secura G, Allsworth J, Peipert J. Cervical lidocaine for IUD insertional pain: a randomized control trial. *Oral Presentation.* *St. Louis Gynecologic Society*. April 2012.

8. Madden T, McNicholas CP, Secura GM, Allsworth JE, Zhao Q, Peipert JF. Rates of Expulsion and Continuation of Intrauterine Contraception at 12 months in Nulliparous and Adolescent Women. *Oral Presentation, Association of Reproductive Health Care Providers.* Sept 2010.

9. McNicholas CP, Madden T, Secura GM, Allsworth JE, Zhao Q, Peipert JF. Rates of Expulsion and Continuation of Intrauterine Contraception at 12 months in Nulliparous and Adolescent Women. *Oral Presentation, Rothman Resident Research Day.* April 2010.

10. McNicholas C. Acute Myelogenous Leukemia (AML) in an HIV Patient. A Diagnosis of exclusion and the implications of Cytogenetics. *Publication and Poster presentation Seaton Hall Research Colloquium.* May 2006.