Exhibit 6

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, *et al.*, Plaintiffs, vs. UNITED STATES FOOD AND DRUG ADMINISTRATION, *et al.*, Defendants.	CIV. NO. [CIVIL RIGHTS ACTION] **DECLARATION OF EVE ESPEY, M.D., M.P.H., FACOG, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

Eve Espey, M.D., M.P.H., FACOG, declares and states as follows:

1. I make this declaration based on my own personal knowledge. If called to testify, I could and would do so competently as follows.

2. I am an obstetrician-gynecologist licensed in New Mexico and the Chair of the Department of Obstetrics and Gynecology at the University of New Mexico School of Medicine ("UNM") in Albuquerque, New Mexico. I am also a Professor within the Obstetrics and Gynecology Department at UNM.

3. I am a member and Officer of the Council of University Chairs of Obstetrics and Gynecology ("CUCOG"). CUCOG is a nationwide membership association promoting excellence in academic practice and leadership in the field of Obstetrics and Gynecology. CUCOG has 146 members representing the departments of obstetrics and gynecology within or

affiliated with schools of medicine in 48 states, the District of Columbia, Puerto Rico, and Canada, with the department chair as the acting liaison. CUCOG convenes and trains university chairs of Obstetrics and Gynecology in order to support the major missions of academic medicine: the provision of high-quality, safe, effective, and compassionate clinical care, including reproductive health care, in academic settings; the provision of high-quality medical education; and the cultivation of useful, reliable research. In addition, CUCOG provides a leadership learning community for chairs and aspiring chairs.

4. I am also a member and Fellow of the American College of Obstetricians and Gynecologists ("ACOG"), the nation's leading organization of physicians dedicated to the healthcare of women. Among other roles, I serve as the Legislative Chair of ACOG's New Mexico Section.

5. I received my undergraduate degree from the University of California, San Diego, in 1983, and my medical degree from the University of California, Irvine, in 1987. In 1991, I completed my residency in Obstetrics & Gynecology at the University of California, Irvine. In 2002, I received a Master's in Public Health from the University of Washington.

6. I maintain an active Obstetrics and Gynecology practice through UNM, providing a wide spectrum of reproductive health services in both outpatient and hospital settings. My practice is primarily located at the UNM Hospital in Albuquerque, New Mexico, where I provide clinical training to family planning fellows, residents in Obstetrics and Gynecology, and medical students.

7. I submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction. I do so only in my individual capacity and as a member of CUCOG and ACOG, not on behalf of any institution with which I am affiliated.

8. The FDA's In-Person Dispensing Requirement for mifepristone, which requires patients to obtain mifepristone only in person at a clinic, medical office, or hospital, forces my patients seeking abortion and miscarriage care to travel unnecessarily to my clinic to obtain mifepristone even when they will be receiving no other in-person medical services at that time. The Requirement prevents me and my colleagues from minimizing needless viral exposure risks during the pandemic, jeopardizing my own safety and that of my patients and colleagues.

9. The COVID-19 pandemic has had a significant impact on the patients I serve. While I worry about the health and safety of all my patients during the COVID-19 pandemic, I am particularly concerned for my patients who come from communities that, even at the best of times, suffer disparities in both health care access and health outcomes. Over half of my patients have income levels that qualify them for Medicaid. Many of my patients are people of color, and I see a significant number of patients from Native communities. New Mexico is a rural state, and a sizeable number of my patients drive anywhere from one to fifteen hours from their homes to receive care at my practice. Preventing unnecessary in-person visits is critical to mitigating exposure risks for these populations.

10. The pandemic has been particularly devastating for Native Americans living in New Mexico. Although Native Americans make up about 11% of New Mexico's population, cases among tribal communities make up about 60% of all positive cases in New Mexico. As of mid-May, 50% of all people who had died from coronavirus in New Mexico were Native American.[1] The infection rate among members of the Navajo Nation, which spans New Mexico,

[1] Marjorie Childress, *COVID-19 has spread to most New Mexico tribes*, N.M. IN DEPTH (May 13, 2020), http://nmindepth.com/2020/05/13/covid-19-has-spread-to-most-new-mexico-tribes/.

Arizona, and Utah, recently surpassed that of any other state in the country.[2] One report shows that 11% of the population of the Navajo Nation has tested positive for the virus.[3] Unnecessary in-person visits increase the COVID-19 exposure risks for my Native patients whose communities have already been so impacted by the pandemic. For example, I recently provided pregnancy options counseling to a patient from a Native community. After I determined her eligibility for medication abortion and provided comprehensive options counseling, the patient returned to her community to weigh her options. The patient ultimately determined that ending the pregnancy was the best decision for her and her family. However, because of the In-Person Dispensing Requirement, my patient had to drive several hours each way from a COVID-19 hotspot to my office, risking additional COVID-19 exposure for herself, the clinic staff, and anyone with whom she came into contact along the way, simply to pick up a medication that I had already determined was a medically appropriate treatment for her circumstances.

11. New Mexico is a rural state, and my patients often have to travel very long distances to our clinic and thus have to stop along the way for gas, restrooms, and meals, creating additional opportunities for exposure. My low-income patients with small children often struggle to secure childcare, and this particularly has been a problem during the COVID-19 pandemic, when many schools and daycares are closed and many people are not seeing family or friends out of fear of viral transmission. These patients often have to bring their children along for the travel, creating additional exposure risks for their family.

12. For example, I recently diagnosed a low-income patient with early pregnancy loss at my office in Albuquerque. After I counseled the patient, she returned home to Southern New

[2] Hollie Silverman et al., *Navajo Nation surpasses New York state for the highest Covid-19 infection rate in the US*, CNN (May 18, 2020), https://www.cnn.com/2020/05/18/us/navajo-nation-infection-rate-trnd/index.html.

[3] *Id.*

Mexico with the hope that the pregnancy would resolve itself without any medical intervention. When it did not, she decided upon medication for miscarriage management. None of the local providers offered mifepristone and she was concerned about using misoprostol alone because of the much higher risk that she would need a follow-up in-office procedure—which the patient did not want because of the increased viral exposure risk associated with the time in the clinic. Because of the In-Person Dispensing Requirement, I could not prescribe mifepristone for the patient to receive through the mail. My patient had to remain pregnant, knowing the pregnancy was not viable, while she delayed care to raise money for gas, and then had to drive more than three hours each way to and from my office just to pick up the medication. She was unable to secure childcare for her small children, so she brought her mother along to watch the children in the parking lot while my patient came inside to obtain the mifepristone; her mother could not have managed alone with the children at home all day while my patient traveled across the state to get to my office. The time it took her to raise funds and arrange the logistics for this unnecessary travel delayed her in completing the miscarriage by more than a week.

13. As the above examples demonstrate, the In-Person Dispensing Requirement imposes unnecessary and severe risks to the health of my patients, their communities, and the health care providers who treat them. If not for the In-Person Dispensing Requirement, I could provide mifepristone to many of my patients via telehealth—as I do for other care, particularly now during the pandemic—shielding them from unnecessary exposure to a life-threatening virus.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on 5/25, 2020.

Eve Espey, M.D., M.P.H., FACOG