IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

PLANNED PARENTHOOD SOUTH ATLANTIC, *et al.*,	)	
	)	CIVIL ACTION
Plaintiffs,	)	Case No. 1:23-cv-480
v.	)	
JOSHUA STEIN, *et al.*,	)	
Defendants.	)	

MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

INTRODUCTION

The North Carolina legislature radically rewrote the state's abortion restrictions over the span of mere days, resulting in a law that is riddled with inconsistencies, irrational requirements, and unconstitutional restrictions. Parts I and II of North Carolina Session Law 2023-14 ("S.B. 20" or "the Act"), DE 1-1, bans abortion after the twelfth week of pregnancy with a few narrow exceptions, makes existing restrictions on abortion more onerous, and adds new, burdensome restrictions. Plaintiff Planned Parenthood South Atlantic ("PPSAT") and Plaintiff Beverly Gray, M.D., (together, "Plaintiffs") seek a temporary restraining order and preliminary injunction against the Act. Plaintiffs are likely to succeed on the merits of their claims that the Act violates the First and Fourteenth Amendments to the U.S. Constitution because the challenged provisions either impose

vague standards on Plaintiffs, are impossible to comply with, are irrational, or violate the Plaintiffs' free speech rights. The provisions of the Act that go into effect on July 1, 2023, should be enjoined in their entirety because Plaintiffs' claims either reach the constitutionality of the Act as whole, or would require enjoining unconstitutional provisions that are so thoroughly intertwined with the core purpose of the Act, that their omission would leave a statute unlike what the legislature intended to be enforced on its own.

If not enjoined before it goes into effect, the Act will impose irreparable harm to Plaintiffs and their patients. Plaintiffs' patients will be subject to unnecessary delays and additional burdens in accessing care, in some cases, denying that care entirely. The Act exposes Plaintiffs to potential criminal liability and disciplinary action, and chills their free speech rights. The other preliminary injunction factors—the balance of equities and public interest—likewise weigh heavily in favor of injunctive relief. For the foregoing reasons, this Court should enjoin Parts I and II of North Carolina Session Law 2023-14 that go into effect on July 1, 2023.[1]

STATEMENT OF FACTS

I. Abortion Is Common, Safe, and Essential Health Care.

Abortion is a basic component of comprehensive health care and is one of the safest medical procedures in the United States. There are two main methods of outpatient

[1] It is unclear whether section 90-21.82A takes effect on July 1, 2023, or October 1, 2023. If this provision does not take effect until October 1, 2023, Plaintiffs move only for a preliminary injunction and not a temporary restraining order on this provision.

abortion: procedural and medication. Although certain abortion methods (e,g., aspiration abortion) are sometimes referred to as "surgical abortion," and are referred to as such in the Act, that is a misnomer, as they do not entail the typical characteristics of surgery, such as an incision into bodily structures. Farris Decl. ¶ 15, attached as Exhibit 1; Compl. ¶ 54, DE 1. These methods are more appropriately characterized as a procedure, or "procedural abortion."[2] Procedural abortion is analogous to other gynecological procedures that take place in outpatient settings in terms of risks, invasiveness, and duration. Farris Decl. ¶¶ 22, 37; Compl. ¶ 55. In addition to being identical to the procedure used to manage miscarriage, procedural abortions are also identical to certain outpatient diagnostic procedures that are used to remove tissue from the uterus for testing. Farris Decl. ¶¶ 22, 37; Compl. ¶ 55. Procedural abortion is far safer than, for example, colonoscopies, and has been provided in an outpatient setting in North Carolina for decades.[3]

The medication abortion regimen in the first trimester typically involves two medications: mifepristone and misoprostol. Farris Decl. ¶ 17; Compl. ¶ 45. The patient first takes the mifepristone and then, several hours or days later (usually 24 to 48 hours), takes the misoprostol. Farris Decl. ¶ 17; Compl. ¶ 45. Mifepristone can be provided pursuant to an evidence-based regimen as soon as pregnancy is detected, and although mifepristone's

[2] Am. Coll. of Obstetricians & Gynecologists, Definition of "Procedures" Related to Obstetrics and Gynecology (reaffirmed Mar. 2023), https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2018/definition-of-procedures-related-to-obstetrics-and-gynecology.

[3] Elizabeth G. Raymond et al., *Mortality of Induced Abortion, Other Outpatient Surgical Procedures and Common Activities in the United States*, 90 Contraception 476 (2014); Farris Decl. ¶¶ 29, 37.

FDA-approved label reflects its usage through 70 days of gestational age, it is safely used off-label at more advanced gestations. Farris Decl. ¶ 41.[4]

Medication abortion and procedural abortion can both be safely provided in an outpatient setting. Farris Decl. ¶¶ 14–15, 32–40; Compl. ¶¶ 55–58. Only 3% of abortions nationwide are performed in hospitals, and abortions at outpatient clinics are often more affordable, easier to navigate, and require less time for patients. Farris Decl. ¶ 32. There is no medical reason to require abortions to take place in hospitals. *Id*. To the contrary, as is true for nearly every medical procedure, fewer complications are seen in settings that perform higher volumes of the same procedure, making abortion clinics like PPSAT safer than hospitals for most abortion patients. *Id.* ¶ 34. Further, in the rare event that a complication arises during a procedural abortion, the complication can nearly always be managed in a clinic. *Id.* ¶ 38. And in the exceedingly rare event of a complication requiring hospital-based care, established policies and protocols ensure the patient's care is safely transferred to a hospital-based provider. *Id.* ¶ 40; Compl. ¶ 60. These are the same policies and protocols that are followed for comparable outpatient gynecological or other procedures, as well as for those that carry greater risks. Compl. ¶ 60.

Abortion is far safer than continuing a pregnancy to term and childbirth. Indeed, the mortality rate for childbirth is approximately 12–14 times greater than that associated with

[4] Am. Coll. of Obstetricians & Gynecologists, Medication Abortion Up to 70 Days of Gestation (Reaffirmed 2023), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/10/medication-abortion-up-to-70-days-of-gestation; Farris Decl. ¶ 18.

abortion. Farris Decl. ¶¶ 28–30. For medication abortion in particular, adverse events (including death, hospitalization, serious infection, and bleeding requiring transfusion) among mifepristone patients are "exceedingly rare, generally far below 0.1% for any individual adverse event."[5] Complications related to carrying a pregnancy to term and childbirth are much more common than abortion-related complications. Farris Decl. ¶¶ 30–31; Compl. ¶ 59.

II. The Legislature Rushed to Enact S.B. 20, Resulting in Contradictory, Irrational, and Unconstitutional Restrictions on Abortion Care.

Prior to the Act, abortion was broadly lawful in North Carolina before 20 weeks of pregnancy. N.C. Gen. Stat. § 90-21.82 (2015). Patients seeking abortion were required to obtain certain state-mandated information from a "qualified professional" 72 hours in advance of the procedure, which could be given either in person or by telephone, and providers were subject to certain reporting requirements. *Id.*

S.B. 20 was passed with breathtaking speed and radically changes North Carolina's abortion restrictions in numerous ways: banning abortion after twelve weeks of pregnancy with a few narrow exceptions, making the mandated counseling requirement more onerous and requiring that it be done in person, and imposing much more burdensome reporting requirements. The Act was negotiated by politicians behind closed doors and passed in less than 72 hours with almost no time for public input or debate. Compl. ¶ 2.

[5] U.S. Food & Drug Admin., Ctr. for Drug Evaluation & Rsch., Medical Review, Application No. 020687Orig1s020, at 47 (Mar. 29, 2016), https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020MedR.pdf; *accord* Farris Decl. ¶ 28.

The Act provides: "It shall be unlawful after the twelfth week of a woman's pregnancy to advise, procure, or cause a miscarriage or abortion." S.B. 20 § 90-21.81A (the "Twelve-Week Ban").[6] After twelve weeks, there are limited exceptions, which include: a) when a physician determines there is a medical emergency, *id.* § 90-21.81B(1); b) through the twentieth week of pregnancy, when the pregnancy is a result of rape or incest, *id.* § 90-21.81B(3); and c) during the first twenty-four weeks of pregnancy if a qualified physician determines there exists a life-limiting anomaly, *id.* § 90-21.81B(4).

The Act contains numerous inconsistencies, internal conflicts, and irrationalities in the Twelve-Week Ban itself. Notably, the Act repeals N.C. Gen. Stat. § 14.45.1, which listed the conditions under which abortion was lawful and was a critical cross-reference in North Carolina's fetal homicide statute, which makes it a crime, punishable by life in prison, to willfully cause the death of an "unborn child." N.C. Gen. Stat. § 14-23.2 (2011). Accordingly, the Act creates confusion about whether lawful abortion remains exempted from the fetal homicide statute.

A physician providing an abortion-inducing drug[7] must follow a host of restrictions, including some that are contradictory. In one section, the Act states that abortion is lawful "during the first 12 weeks of a woman's pregnancy when a medical abortion is procured,"

[6] All citations to the Act herein refer to the sections that are to be codified in the General Statutes of North Carolina on the Act's effective date.

[7] The Act defines "Abortion-inducing drug" as "A medicine, drug, or any other substance prescribed or dispensed with the intent of terminating the clinically diagnosable pregnancy of a woman . . . . This includes the off-label use of drugs such as mifepristone (Mifeprex), misoprostol (Cytotec), and methotrexate." S.B. 20 § 90-21.81(1a).

S.B. 20 § 90-21.81B(2), but in another section, it requires physicians who provide medication abortion to "verify the probable gestational age of the unborn child is no more than 70 days," or ten weeks, *id.* § 90-21.83B(a)(6) (the "Ten-Week Verification Requirement"). Compl. ¶ 49. The Act similarly requires physicians to "[d]ocument in the woman's medical chart the . . . intrauterine location of the pregnancy," S.B. 20 § 90-21.83B(a)(7) (the "Pregnancy Location Requirement"), but it is unclear whether physicians can provide early medication abortion when a patient has a positive pregnancy test but it is too soon to view the location of an intrauterine pregnancy.

And although the Act provides an exception to the Twelve-Week Ban in cases of rape or incest, it limits the provision of those procedures to hospitals. *Id.* §§ 90-21.81B(3), 90-21.82A(c) (the "Hospitalization Requirement"). This irrational limitation on one of the safest medical procedures will further harm survivors of sexual assault without increasing abortion safety.

The Act also creates a host of new requirements for health care providers both before and after an abortion. Under the Act, patients must make an in-person visit to receive certain state-mandated information at least 72 hours before an abortion, but the Act is internally inconsistent about whether that waiting period restarts if certain information is not available 72 hours before the abortion. *Compare* S.B. 20 §§ 90-21.82(b)(1a) & (a), 90-21.83A(b)(2) & (a) *with* § 90-21.83C (the "Additional 72-Hour Mandate"). The Additional 72-Hour Mandate does not explicitly incorporate the medical emergency exception included in the other 72-hour waiting period sections, *see id.* §§ 90-21.82(b), 90-21.83A(b),

suggesting that providers must wait 72 hours after providing the information required by the section, even when there is a medical emergency.[8] The Additional 72-Hour Mandate also requires the provider to give information that in many circumstances will be impossible to know 72 hours in advance of the abortion, such as whether the abortion is covered by insurance.

The Act also changes the reporting requirements in ways that make compliance impossible. For example, it states that a "report *completed* under this section for a minor shall be sent to the Department and the Division of Social Services *within three days* of the surgical or medical abortion." *Id.* § 90-21.93(a) (emphasis added) (the "Reporting Requirement"). But the Act requires information to be included in the report that will not be known within three days, Compl. ¶¶ 38, 68, including whether a minor who had a medication abortion returned for the scheduled follow-up appointment fourteen days later (S.B. 20 § 90-21.83A(b)(4)(*l.*)), and if the minor did not return, what reasonable efforts were made to encourage them to do so, *id.* § 90-21.93(b)(8) & (9). Similarly, the report must contain the amount of money billed for treatment of complications, *id.* § 90-21.93(b)(11), but complications may not arise in three days, Compl. ¶ 68.

Finally, if a person seeking an abortion is past twelve weeks in pregnancy and does not meet one of the narrow exceptions, the Act is not clear as to whether people can assist

[8] The informed consent provisions contain other inconsistencies that are nearly identical to those litigated before and construed by the district court in *Stuart v. Loomis*, 992 F. Supp. 2d 585, 611 (M.D. N.C. 2014), and, therefore, PPSAT has made a motion pursuant to Federal Rule of Civil Procedure 60(b) to amend the judgment in that case to address those provisions.

these individuals in seeking lawful abortion in other states. The Act states that "[i]t shall be unlawful after the twelfth week of a woman's pregnancy to advise, procure, or cause a miscarriage or abortion." S.B. 20 § 90-21.81A(a) (the "Advising Ban"). It is not clear if this applies to, for example, providing information about how to obtain legal, out-of-state abortions.

A physician who violates the Act is subject to discipline by the North Carolina Medical Board, and any other licensed health care provider who violates the Act is subject to discipline under their respective licensing agency or board. *Id.* § 90-21.88A. Moreover, certain provisions of the Act carry criminal penalties. Relevant here, providing an abortion that does not fit within the Act's exceptions to the Twelve-Week Ban is a felony. *Id.* § 90-21.81B; *see also id.* §§ 14-44 and 14-45.

III. The Act's Restrictions Inflict Irreparable Harm on Plaintiffs and Their Patients.

Due to inconsistent, vague, and impossible-to comply-with provisions, the Act will harm Plaintiffs and their patients by delaying—and even, at times, denying them—necessary health care. For example, under the Additional 72-Hour Mandate, the patient must be provided with the physician's name and hospital admitting privileges and told whether the abortion is covered by the patient's insurance. S.B. 20 § 90-21.83C. But given Plaintiffs' busy medical practices as well as the complexity of their patients' lives, the name of the doctor sometimes changes in the 72 hours before the abortion, including when a doctor has an urgent matter with another patient at another facility, when a doctor or patient is ill, or when a patient is unable to attend their appointment as initially scheduled.

Compl. ¶ 63. Additionally, it is often impossible to tell the patient whether an abortion will be covered by insurance because many insurance companies do not determine coverage until after the abortion. *Id.* ¶ 67. Others may deny coverage weeks after the fact for myriad reasons. *Id.*

The Act is inconsistent as to whether the 72-hour period must be restarted if the name of the physician changes or whether the waiting period cannot start at all if the physician's name is not known 72 hours in advance, and is silent as to how to proceed if insurance coverage information is unknown. Forcing patients to wait another 72 hours in these circumstances will push the patient further into their pregnancy and possibly beyond the new 12-week limit. Compl. ¶ 64. Patients would be forced to reschedule their appointment and rearrange time off from work, childcare, and/or transportation. *Id.* Relatedly, to the extent that the Additional 72-Hour Mandate compels physicians to withhold life- or health-saving abortion care to a patient because the patient was not provided with, *e.g.*, information about the physician's hospital admitting privileges 72 hours earlier, it subjects patients to gratuitous suffering, severe injury, or even death. *Id.* ¶ 66.

The Act's inconsistencies as to when medication abortion is permitted will also harm patients if they are prohibited from accessing medication abortion either before an intrauterine pregnancy can be seen on ultrasound or between ten and twelve weeks of pregnancy. For some patients, medication abortion offers important advantages over procedural abortion. Compl. ¶¶ 46–47. For example, victims of rape and people who have

experienced sexual abuse, molestation, or other trauma may choose medication abortion to feel more in control of the experience and avoid further trauma from having instruments placed in their vagina. *Id.* ¶ 46. Additionally, some health care providers charge more for procedural abortions. *Id.* ¶ 47. And some patients, especially victims of intimate partner violence, may struggle to find necessary support, such as a ride home after a procedure involving sedation. *Id.*

The Hospitalization Requirement will also have devastating consequences for sexual violence survivors. Thousands of North Carolinians suffer sexual abuse each year and desperately need access to abortion. Farris Decl. ¶ 43. For many survivors of rape or incest, pregnancy can trigger flashbacks, dissociative episodes, and other symptoms of trauma. *Id*. The Hospitalization Requirement will limit the number of providers available to these survivors and will increase the cost of abortion, thereby hampering access to abortion. *Id.* ¶¶ 48–51. Further, survivors who present at an outpatient clinic after their twelfth week of pregnancy will be forced to go to a hospital, causing further delays, even though the outpatient clinic would be able to safely provide care. *Id.* ¶ 46.

QUESTIONS PRESENTED

1. Are Plaintiffs likely to prevail on their claims that the Act violates the constitutional rights of due process, equal protection, and speech?

2. Will Plaintiffs and their patients suffer irreparable injury without preliminary injunctive relief?

3. Does the injury to Plaintiffs and their patients outweigh any injury to Defendants?

4. Is preliminary injunctive relief in the public interest?

ARGUMENT

A temporary restraining order or preliminary injunction is warranted upon a showing that: "(1) the party is likely to succeed on the merits of the claim; (2) the party is likely to suffer irreparable harm in the absence of an injunction; (3) the balance of hardships weighs in the party's favor; and (4) the injunction serves the public interest." *HIAS, Inc. v. Trump*, 985 F.3d 309, 318 (4th Cir. 2021). To satisfy the first prong, Plaintiffs "need not establish a certainty of success," but only "a clear showing that they are likely to succeed at trial." *Roe v. U.S. Dep't of Def.*, 947 F.3d 207, 219 (4th Cir. 2020) (cleaned up). Plaintiffs readily meet this test.

I. Plaintiffs Are Likely to Succeed on the Merits of Their Claims That the Act Violates Plaintiffs' and Their Patients' Constitutional Rights.

Plaintiffs are likely to succeed on the merits of their claims. *First*, several of the Act's provisions are vague in violation of the Due Process Clause: a) the Act effectively repeals a cross-reference in the fetal homicide statute that exempts lawful abortions, b) the Ten-Week Verification Requirement contradicts the Act's primary provision permitting both surgical and medication abortion through twelve weeks of pregnancy, c) the Pregnancy Location Requirement is unclear as to whether physicians can provide medication abortion when a patient has a positive pregnancy test but an intrauterine pregnancy cannot yet be seen on an ultrasound, d) the Additional 72-Hour Mandate fails to incorporate a medical emergency exemption, and e) the Additional 72-Hour Mandate also creates confusion about whether the 72-hour period restarts if some of the required

disclosures are not available at the initial visit.

Second, two sections of the Act violate the Due Process Clause because they are impossible to comply with: a) the Additional 72-Hour Mandate requires disclosure of whether the abortion is covered by health insurance—information frequently unavailable before a treatment or procedure—and b) the Reporting Requirement mandates information on a deadline when that information is not yet available.

Third, the Advising Ban is unconstitutionally vague under the Due Process Clause, and, if interpreted to prohibit assisting people accessing lawful out-of-state abortion, it violates the First Amendment.

Finally, the Hospitalization Requirement and the Pregnancy Location Requirement are irrational in violation of the Due Process and Equal Protections Clauses because there is no rational basis for denying North Carolinians access to these evidence-based and safely performed procedures, including in outpatient facilities.

A. The Act's Requirements Are Unconstitutionally Vague.

"To survive a vagueness challenge, a statute must give a person of ordinary intelligence adequate notice of what conduct is prohibited and must include sufficient standards to prevent arbitrary and discriminatory enforcement." *Manning v. Caldwell for Roanoke*, 930 F.3d 264, 272 (4th Cir. 2019) (en banc); *see also Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972) (explaining that a law must provide "fair warning" by giving "[a] person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly"); *Sessions v. Dimaya*, 138 S. Ct. 1204, 1212

(2018) (beyond guaranteeing "fair notice," the void-for-vagueness doctrine also "guards against arbitrary or discriminatory law enforcement by insisting that a statute provide standards to govern the actions of police officers, prosecutors, juries, and judges"). The Act may be unconstitutionally vague under either theory: lack of notice or lack of standards. *FCC v. Fox Television Stations, Inc.*, 567 U.S. 239, 253 (2012). Here, where several sections of the Act "fail[] to provide any standard of conduct by which persons can determine whether they are violating the statute," the Act is "unconstitutionally vague." *Manning*, 930 F.3d at 274.[9]

1. The application of the fetal homicide statute to lawful abortion is unconstitutionally vague.

North Carolina's fetal homicide statute makes it a crime, punishable by life in prison without parole, to willfully and maliciously cause the death of an unborn child. N.C. Gen. Stat. § 14-23.2. The statute currently exempts from the definition of fetal homicide "[a]cts which cause the death of an unborn child *if those acts were lawful*," N.C. Gen. Stat. § 14-

[9] "The degree of vagueness that the Constitution tolerates—as well as the relative importance of fair notice and fair enforcement—depends in part on the nature of the enactment." *Vill. of Hoffman Ests. v. Flipside, Hoffman Ests., Inc.*, 455 U.S. 489, 498 (1982). Although "[l]ess clarity is required in purely civil statutes . . . laws that nominally impose only civil consequences warrant a 'relatively strict test' for vagueness if the law is 'quasi-criminal' and has a stigmatizing effect." *Manning*, 930 F.3d at 272–73. Where, as here, some sections of the Act carry criminal penalties and others carry livelihood-threatening licensing penalties, a stricter standard of review is applied. *See id.*; *see also, e.g.*, *Little Rock Fam. Plan. Servs. v. Rutledge*, 398 F. Supp. 3d 330, 415 (E.D. Ark. 2019) (finding systemic harassment and stigma against abortion providers); *Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1339 n.4, 1349–52 (M.D. Ala.) (same), *as corrected* (Oct. 24, 2014), *supplemented,* 33 F. Supp. 3d 1381 (M.D. Ala. 2014), and *amended,* No. 2:13CV405-MHT, 2014 WL 5426891 (M.D. Ala. Oct. 24, 2014).

23.7(1) (emphasis added), with a cross-reference to N.C. Gen. Stat. § 14-45.1. Section 14-45.1, in turn, lists the conditions under which abortion is lawful. The Act repeals Section 14-45.1 but fails to replace the fetal homicide statute's cross-reference to 14-45.1 with a reference to the Act. S.B. 20(I) § 1.1. Due to this drafting error, the fetal homicide statute will no longer include a reference to another law outlining when abortion is lawful and therefore exempted from the fetal homicide statute.

Once the repeal of Section 14-45.1 takes effect on July 1, Plaintiffs will lack notice as to whether the fetal homicide statute applies to lawful abortion care. *Fox*, 567 U.S. at 253. Further, the Act leaves prosecutors without "explicit standards" to evaluate the conduct of health care providers, risking "arbitrary and discriminatory" enforcement. *Grayned*, 408 U.S. at 108. Particularly where, as here, criminal penalties apply, "a stricter standard is applied in reviewing the statute for vagueness." *Manning*, 930 F.3d at 272–73; *see also id.* 276–77 (prohibiting "consign[ing] a person to the risk of significant penal consequences without first providing sufficiently definite notice of prohibited activities"). Accordingly, Plaintiffs are likely to succeed on the merits of their due process claim and are entitled to an injunction against the Act.

2. The Ten-Week Verification and Pregnancy Location Requirements are unconstitutionally vague.

The Act fails to provide notice as to when medication abortion is lawful. First, in the principal section, the Act states that abortion is lawful "during the first 12 weeks of a woman's pregnancy when a medical abortion is procured." S.B. 20 § 90-21.81B(2). However, when outlining requirements for medication abortion, the Ten-Week

Verification Requirement mandates physicians "verify the probable gestational age of the unborn child is no more than 70 days," or ten weeks. *Id.* § 90-21.83B(a)(6). This provision suggests that medication abortion is not permitted after ten weeks, despite the general authorization of medication abortion for the first twelve weeks of pregnancy. Similarly, the Pregnancy Location Requirement requires physicians to "[d]ocument in the woman's medical chart the . . . intrauterine location of the pregnancy," *id.* § 90-21.83B(a)(7), even though medication abortion is safely provided when a patient has a positive pregnancy test but the pregnancy cannot yet be seen via ultrasound. Farris Decl. ¶ 41.

This is not a situation of "uncertainty about the normal meaning of the term at issue, but [is] rather about what specific conduct is covered by the statute and what is not," which is the core of a vagueness challenge. *Manning*, 930 F.3d at 274–75 (quoting *Lytle v. Doyle*, 326 F.3d 463, 469 (4th Cir. 2003)). By including two disparate standards, the Act "specifies no standard of conduct," giving Plaintiffs no notice as to whether they can provide early medication abortion and medication abortion between the tenth and twelfth weeks of pregnancy. *See id.* at 278. Further, the Act is vague, because these inconsistencies "invite[] the very type of arbitrary enforcement that the Constitution's prohibition against vague statutes is designed to prevent." *Id.* at 278.

Allowing medication abortion to be provided from a positive pregnancy test through the twelfth week of pregnancy is consistent with the structure and history of the Act. The Act is framed as permitting abortion through the twelfth week of pregnancy, with limited exceptions after that. S.B. 20 § 90-21.81B. Throughout the Act, restrictions on abortion

hinge on that twelve-week mark. *See, e.g.*, *id.* § 131E-153.1 (defining abortion clinic as "[a] freestanding facility . . . for the performance of abortions *during the first 12 weeks of pregnancy*" (emphasis added)); *id*. § 90-21.81A(a) ("It shall be unlawful *after the twelfth week of a woman's pregnancy* to advise, procure, or cause a miscarriage or abortion." (emphasis added)); *id*. § 90-21.81C(a), (b). Indeed, legislators supporting the Act confirmed their intent to permit medication abortion through twelve weeks. Compl. ¶¶ 50–51. Accordingly, Plaintiffs are likely to succeed on their claim that the Act violates their due process rights.

3. The Additional 72-Hour Mandate is unconstitutionally vague.

The Additional 72-Hour Mandate requires that, "at least 72 hours prior to any medical or surgical abortion," the patient be provided with "the physician's full name and specific information for the physician's hospital admitting privileges and whether the treatment or procedure to be performed is covered by the pregnant woman's insurance." S.B. 20 § 90-21.83C. But that section does not incorporate the medical emergency exemption to the 72-hour wait requirement found elsewhere in the Act, and it does not clarify that the waiting period does not restart if certain information is not available 72 hours in advance.

In contrast to the Additional 72-Hour Mandate's silence as to whether required disclosures can be waived in a medical emergency, the two sections of the Act specifically discussing "[i]nformed consent to surgical abortion," *id*. § 90-21.82, and "[i]nformed consent to medical abortion," *id*. § 90-21.83A, explicitly waive the required disclosures "in

the case of a medical emergency." *Id*. §§ 90-21.82(b), 90-21.83A(b). Because the Additional 72-Hour Mandate does not explicitly incorporate by reference these medical emergency waivers, it is unclear whether it can be waived in a medical emergency. The lack of an emergency exception would be disastrous for patients' health and lives.

It is also unclear whether the Additional 72-Hour Mandate restarts if certain required information is not known 72-hours in advance, in conflict with other parts of the Act. Two sections of the Act explain that the waiting period *does not restart* if certain specified information, such as the physician's name and location of their admitting privileges, is not available 72 hours before the abortion. S.B. 20 §§ 90-21.82(b)(1a), 90-21.83A(b)(2). While the same information must be provided pursuant to the Additional 72-Hour Mandate, that section is silent as to whether the waiting period must restart when the information is not known; therefore it is unclear whether the 72-hour period would restart if the physician's name or location of admitting privileges changes in the 72 hours before the abortion. Because of this internal conflict, Plaintiffs are likely to succeed on their claim that the Additional 72-Hour Mandate is unconstitutionally vague.[10]

[10] The Additional 72-Hour Mandate is riddled with errors and superfluous. *See also supra* Part I.B. Indeed, there is significant overlap between the information that must be disclosed to a patient in accordance with the Additional 72-Hour Mandate and that must also be disclosed to patients pursuant to the other two informed consent sections that include the medical emergency waiver; all three provisions require disclosure of the physician's name and admitting privileges. *See* §§ 90-21.83C, 90-21.82(b)(1a)(a.) (name), 90-21.82(b)(1a)(g.) (admitting privileges), 90-21.83A(b) (b)(2)(a.) (name), 90-21.83A(b)(2)(k.) (admitting privileges).

B. The Reporting Requirement and Additional 72-Hour Mandate Violate Due Process Because They Are Impossible to Comply With.

It is impossible to comply with two sections of the Act: 1) the Reporting Requirement, S.B. 20 § 90-21.93(a); and 2) the Additional 72-Hour Mandate's required disclosure about whether the abortion is covered by a patient's insurance, *id.* § 90-21.83C. "The law does not compel the doing of impossibilities." *Hughey v. JMS Dev. Corp.*, 78 F.3d 1523, 1530 (11th Cir. 1996) (citing Black's Law Dictionary 912 (6th ed. 1990)). Laws with which compliance is not possible fail to provide people with adequate notice as to what is prohibited and lead to absurd results; and courts have a duty to construe laws to avoid such results. *See, e.g.*, *United States v. X-Citement Video, Inc.*, 513 U.S. 64, 69–70 (1994); *Hughey*, 78 F.3d at 1529–30 (holding plaintiff's claim under the Clean Water Act failed because it was impossible for defendant to comply with the applicable standard). For example, in a case addressing abortion restrictions, the Seventh Circuit affirmed a preliminary injunction of a Wisconsin law that required doctors who provide abortion to have admitting privileges at a local hospital in part because it was impossible to comply with the law. *Planned Parenthood of Wisconsin, Inc. v. Van Hollen*, 738 F.3d 786, 788–89 (7th Cir. 2013) ("[t]he impossibility of compliance with the statute even by doctors fully qualified for admitting privileges is a compelling reason for the preliminary injunction"); *see also Doe v. Snyder*, 101 F. Supp. 3d 722, 724–25 (E.D. Mich. 2015) (holding law requiring registered sex offenders to have a state identification card violates due process as applied to unhoused plaintiff because it is impossible to obtain a state identification without a residence).

Here, compliance with the Reporting Requirement is impossible. It requires Plaintiffs to submit a "completed report" to the Department of Health and the Division of Social Services *three days* after a minor's abortion including whether they returned for a follow-up visit that must be scheduled *seven to fourteen days* after the medication abortion, S.B. 20 §§ 90-21.93(a), b(8) & (9), 90-21.83A(b)(4)(*l.*), 90-21.83B(b), and include how much money was billed to cover treatment for complications, *id.* § 90-21.93(b)(11), which may arise more than three days after the abortion.

Additionally, for many patients it will be impossible for Plaintiffs to comply with the Additional 72-Hour Mandate's requirement that the patient be informed of whether the abortion is covered by insurance 72 hours before the abortion. Insurance companies will often not determine whether a procedure is covered until after it is performed, and initial approval of a procedure is not a final determination as to whether the procedure is actually covered; insurance companies may later reject claims they had initially indicated would be covered. Compl. ¶ 67. For these reasons, Plaintiffs are likely to succeed on their claim that it is impossible to comply with these provisions.

C. The Advising Ban is Unconstitutional.

The Act makes it "unlawful after the twelfth week of a woman's pregnancy to advise, procure, or cause a miscarriage or abortion." S.B. 20 § 90-21.81A(a). As written, the Advising Ban is unconstitutionally vague, as it is not clear whether it prohibits people from assisting others to obtain abortions after the twelfth week of pregnancy in other states where such care is lawful. Moreover, to the extent that the Advising Ban prohibits

providing information intended to help others access abortion care in other states where it is lawful, it violates the First Amendment.

1. The Advising Ban Violates the Due Process Clause.

The Advising Ban fails to give notice as to whether Plaintiffs may assist people in obtaining abortions after the twelfth week of pregnancy in other states where such care is lawful. The Advising Ban's terms "do not explain the law's scope or limit the discretion of those charged with enforcing it," to make clear this prohibition only applies to abortions unlawful under North Carolina law. *Carolina Youth Action Project v. Wilson*, 60 F.4th 770, 783 (4th Cir. 2023). The "'test of vagueness applies with particular force in review of laws dealing with speech.'" *Id.* at 781 (quoting *Hynes v. Mayor of Oradell*, 425 U.S. 610, 620 (1976)). This provision directly implicates speech, so the "twin concerns of inadequate notice and arbitrary or discriminatory enforcement are especially pronounced." *Edgar v. Haines*, 2 F.4th 298, 316 (4th Cir. 2021) (internal quotation marks omitted).

2. Given its Vagueness, the Advising Ban Must Be Interpreted in a Manner That Avoids Violating the First Amendment.

The government may not regulate speech because of its message, ideas, subject matter, or content, and laws that do so are presumptively unconstitutional. *Reed v. Town of Gilbert*, 576 U.S. 155, 163 (2015). Such restrictions are subject to strict scrutiny, which requires the government to prove that the restriction is narrowly tailored to serve a compelling state interest. *Id.* at 163–64. Speech restrictions are even more egregious when the government targets particular views taken by speakers on a subject (rather than targeting all views on a given subject). *Rosenberger v. Rector & Visitors of Univ. of Va.*,

515 U.S. 819, 829 (1995). Any interpretation of the Advising Ban that prohibits, for example, providing information about how to obtain legal, out-of-state abortions is a content- and viewpoint-based speech restriction that furthers no legitimate government interest, much less a compelling one, and is not narrowly tailored.[11]

There is no question that the Advising Ban is a content- and viewpoint-based restriction on speech because it silences people on the sole topic of abortion and only prohibits people from providing information and assistance to patients seeking abortion care in places where it is lawful but does not apply to other out-of-state, pregnancy-related services like prenatal care or anti-abortion counseling. It is, therefore, subject to strict scrutiny, but it furthers no legitimate state interest, much less a compelling one. North Carolina has no compelling interest in preventing people from providing information about medical treatments that are legal and available in other states or helping others access those treatments. *See Bigelow v. Virginia*, 421 U.S. 809, 827–28 (1975) (explaining that state's "asserted interest" "in shielding its citizens from information about activities outside [its] borders, activities that [its] police powers do not reach" is "entitled to little, if any weight"). North Carolina "may not, under the guise of exercising internal police powers, bar" Plaintiffs "from disseminating information about an activity that is legal" in another state.

[11] Plaintiffs seek an order ensuring their right to assist individuals who seek *lawful* abortions outside of North Carolina. However, to the extent that this section prohibits an individual from *advocating for or urging* another person to obtain an unlawful abortion, it likely violates the First Amendment. *See Brandenburg v. Ohio*, 395 U.S. 444, 449 (1969) (First Amendment protects "mere advocacy" of unlawful action); *United States v. Miselis*, 972 F.3d 518, 533–38 (4th Cir. 2020) (striking down statutory proscription on "urging" a riot).

Id. at 824–25.

Even if the Advising Ban's content and viewpoint discriminatory censorship served a compelling interest (which it does not), Defendants cannot prove that it is narrowly tailored to further that interest because it sweeps in a large swath of obviously protected speech. *See Ariz. Free Enter. Club's Freedom Club PAC v. Bennett*, 564 U.S. 721, 734 (2011) (government bears burden of proof). When a plaintiff offers a plausible, less-restrictive alternative—here, that the Advising Ban does not apply to helping people obtain abortions out of state where abortion is lawful—"it is the Government's obligation to prove that the alternative will be ineffective to achieve its goals." *United States v. Playboy Ent. Grp., Inc.*, 529 U.S. 803, 816 (2000).

D. The Hospitalization Requirement and the Pregnancy Location Requirement are Irrational.

1. The Hospitalization Requirement.

The Act's requirement that abortions for survivors of rape and incest after the twelfth and through the twentieth week of pregnancy be performed in a hospital violates substantive due process and equal protection. *See* S.B. 20 § 90-21.81B(3). These patients have the substantive due process right to medical treatment, including abortion care, and restrictions on this right are subject to rational basis review. *See Doe v. Settle*, 24 F.4th 932, 943–44, 955 (4th Cir. 2022) ("A substantive due process challenge is considered under rational-basis review unless some fundamental right is implicated."). The Hospitalization Requirement lacks any medical basis or common-sense justification, and it bears no

plausible relationship to any legitimate government interest.

Procedural abortion is as safe as, or safer than, a wide range of other medical procedures—including vasectomies, colonoscopies, wisdom tooth extraction, and tonsillectomies—that are routinely performed on an outpatient basis. Farris Decl. ¶ 29. Nationwide, 97% of abortions are provided in the outpatient setting, yielding an enormous volume of data establishing beyond any doubt the safety of outpatient abortion care. *Id.* ¶ 32. Consistent with this data, the National Academies of Sciences, Engineering, Medicine, as well as major medical associations, have made clear that requirements that abortions be provided in hospitals lack any scientific or medical basis. *Id.* ¶ 33. In fact, fewer complications are seen in settings that perform higher volumes of the same procedure, making abortion clinics like PPSAT safer than hospitals for most abortion patients. *Id.* ¶ 34.

The Supreme Court has repeatedly recognized that hospitalization requirements for abortion serve no legitimate health and safety interest. *See e.g.*, *Whole Woman's Health v. Hellerstedt*, 136 S.Ct. 2292, 2315 (2016) (striking ambulatory surgical center requirement for abortion and recognizing "well supported" district court finding that "requiring all abortion facilities to meet all surgical-center standards does not benefit patients and is not necessary"); *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 435–37 & n.25 (1983) (striking down second trimester abortion hospitalization requirement); *Planned Parenthood Ass'n of Kan. City, Inc. v. Ashcroft*, 462 U.S. 476, 481–82 (1983) (same); *Doe v. Bolton*, 410 U.S. 179, 195 (1973) (same). Although these holdings that such

restrictions violate patients' Fourteenth Amendment right to choose abortion have been overruled by *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022), the factual findings that hospitalization requirements for abortion do not serve any interest in patient health and safety were not. These cases demonstrate that the Hospitalization Requirement is not based on "reasonable speculation," a "plausible reason," or a "conceivable basis." *Settle*, 24 F.4th at 943–44. The irrationality of the Hospitalization Requirement is further underscored by the fact that it applies only to survivors of rape and incest, who are often the most desperate to terminate a pregnancy and who face unique barriers to accessing care, *see supra* Statement of Facts, Part III. There is no rational reason to force patients who have undergone trauma to seek abortion care at hospitals when they could go to outpatient clinics, which are generally cheaper, more accessible, and just as safe.

Absent a health-related justification or an interest in protecting potential life,[12] the only remaining justification for the Hospitalization Requirement is a "bare desire to harm" certain patients, which is not a legitimate state interest. *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 447, 450 (1985); *see also U.S. Dep't of Agric. v. Moreno*, 413 U.S. 528, 534 (1973). As the Fourth Circuit has recognized, "[a]bortion may well be a special case" in some regards, "but it cannot be so special a case that all other professional rights and medical norms go out the window." *Stuart v. Camnitz*, 774 F.3d 238, 255–56 (4th Cir. 2014). Where, as here, the gulf between a legislature's action and "the realities of the

[12] There can be no such interest for the Hospitalization Requirement as the General Assembly has authorized abortions for survivors of rape and incest from the twelfth through the twentieth week of pregnancy.

subject addressed by the legislation" is vast, *Heller v. Doe*, 509 U.S. 312, 321 (1993), the challenged provision fails rational basis review. Because the Hospitalization Requirement fails rational basis scrutiny, it violates Plaintiffs' and their patients' substantive due process rights.

The Hospitalization Requirement also violates equal protection because it irrationally singles out physicians who provide and patients who seek abortion for differential treatment, as compared to those providing and seeking miscarriage management. *See Van Hollen*, 738 F.3d at 790 ("An issue of equal protection of the laws is lurking in this case. For the state seems indifferent to complications from non-hospital procedures other than surgical abortion (especially other gynecological procedures), even when they are more likely to produce complications."); *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r, Ind. Dep't of Health*, 64 F. Supp. 3d 1235, 1257 (S.D. Ind. 2014) ("[Supreme Court precedent] does not . . . authorize the unequal treatment of those providing the exact same procedure, without a rational basis, and equal protection demands otherwise.").

The procedures used for abortion are also used to manage miscarriage, which are routinely provided in an outpatient setting, and are permitted by the Act. Farris Decl. ¶¶ 9, 22, 26. There is no rational basis for prohibiting a procedure in an outpatient setting if the patient is experiencing an inevitable miscarriage, but fetal demise has not yet occurred, while allowing the exact same procedure, with an identical risk profile, for the same patient in an outpatient setting after demise has occurred. *Id.* There is also no rational basis for

prohibiting outpatient procedural abortion when analogous gynecological procedures like inserting or removing an intrauterine device (which has a higher risk of uterine perforation than aspiration abortion), and loop electrosurgical excision procedures (a technique used to diagnose and treat potentially cancerous cervical cells) are routinely performed in outpatient clinics. *Id.* ¶ 37. Under the Act, outpatient facilities will still be permitted to provide miscarriage care after twelve weeks of gestational age—which as noted above, is identical to abortion care—so there is no rational reason to prevent them from providing abortions to survivors of rape and incest at twelve to twenty weeks of pregnancy. As a result, the Hospitalization Requirement violates equal protection.

2. The Pregnancy Location Requirement.

If interpreted to ban early medication abortion, the Pregnancy Location Requirement is also irrational. Providing early medication abortion when a patient has a positive pregnancy test but the pregnancy cannot be visualized on ultrasound is a safe, evidence-based practice which the State would have no legitimate reason to bar.

Some patients present for abortions at very early gestational ages, and early abortion care is all the more important in light of the Twelve-Week Ban. Farris Decl. ¶ 41. At early stages of a pregnancy, it may be too soon to see an intrauterine gestational sac via ultrasound. *Id*. In such cases, abortion providers follow established protocols for safely administering medication abortion, which have been shown to be safe and effective. *Id.*

Because there is no medical reason for denying medication (but not procedural) abortion care to patients with pregnancies that are too early to see via ultrasound, doing so

does not serve any governmental interest in health or safety. In fact, it does the opposite: forcing patients to wait until a later gestational age before getting a medication abortion unnecessarily exposes them to increased medical risk. Farris Decl. ¶ 11. Patients will be further harmed because they may have strong reasons for choosing medication abortion over procedural abortion. Compl. ¶¶ 46–47. And the Pregnancy Location Requirement does not further any state interest in protecting potential life because a patient denied a medication abortion because the pregnancy cannot be seen via ultrasound can still get a procedural abortion or return later to get a medication abortion.

* * *

Accordingly, Plaintiffs are likely to succeed on the merits of their claim that the Act violates their due process and equal protection rights guaranteed under the Fourteenth Amendment.

II. Plaintiffs Will Suffer Irreparable Harm Absent Immediate Injunctive Relief.

Absent injunctive relief, Plaintiffs and their patients will suffer irreparable harm. The Act will deprive them of their constitutional rights to free speech, due process, and equal protection, which "unquestionably constitutes irreparable injury." *Leaders of a Beautiful Struggle v. Balt. Police Dep't*, 2 F.4th 330, 346 (4th Cir. 2021) (en banc) (internal quotation marks omitted). This alone is sufficient to establish irreparable harm.

The challenged provisions also impose additional harms that "impair[] a court's ability to grant an effective remedy, such as a harm that cannot be compensated by money damages at a later trial." *Int'l Refugee Assistance Project v. Trump*, 265 F. Supp. 3d 570,

629 (D. Md. 2017), *aff'd*, 883 F.3d 233 (4th Cir. 2018). The Act will harm Plaintiffs and their patients by delaying, or even denying, necessary health care. Compl. ¶¶ 62–64; *see generally* Statement of Facts, Part III. If there is no medical emergency exception to the required patient disclosures, the Act could put patients at risk of gratuitous suffering, severe injury, and even death. Compl. ¶ 66. The Act will also harm patients by denying them safe, evidence-based access to medication abortion through twelve weeks of pregnancy. *See* Compl. ¶¶ 46–47. The greater logistics of a procedural abortion may be prohibitive for some patients, especially victims of intimate partner violence. Compl. ¶ 47. And the Act's Hospitalization Requirement will limit the number of providers available to survivors of rape and incest, potentially force retraumatization, and increase the cost of abortion, thereby hampering these patients' access to abortion. Farris Decl. ¶¶ 48–51.

These harms include risks to patients' health, wellbeing, and ability to access necessary health care. If allowed to go into effect in its current form, the Act will irreparably harm Plaintiffs and their patients.

III. The Balance of Equities and Public Interest Weigh Strongly in Favor of an Injunction.

Finally, the balance of equities and public interest likewise weigh heavily in favor of injunctive relief. While Plaintiffs and their patients will suffer grave harm in the absence of an injunction, Defendants are "in no way harmed by issuance of a preliminary injunction which prevents [them] from enforcing" a law that "is likely to be found unconstitutional." *Newsom ex rel. Newsom v. Albemarle Cnty. Sch. Bd.*, 354 F.3d 249, 261 (4th Cir. 2003); *see also Legend Night Club v. Miller*, 637 F.3d 291, 303 (4th Cir. 2011) ("upholding

constitutional rights is in the public interest"). Not only would an injunction preserve constitutional rights, it would also preserve North Carolinians' health and safety by allowing pregnant people to access care without these restrictions and by ensuring Plaintiffs' ability to continue to provide abortion care, as set forth above. *See Fruth, Inc. v. Pullin*, 2015 WL 9451066, at *8 (S.D. W. Va. Dec. 23, 2015) (observing that "an injunction here will safeguard the public health and thereby serve the public interest").

IV. The Bond Should Be Waived.

Because Defendants will suffer no harm under Plaintiffs' proposed preliminary injunction, and because this case implicates fundamental constitutional rights, the Court should exercise its "discretion to . . . waive the security requirement" under Federal Rule of Civil Procedure 65(c) or, in the alternative, set a nominal bond of $100.00. *Pashby v. Delia*, 709 F.3d 307, 322 (4th Cir. 2013); *see also Sogefi USA, Inc. v. Interplex Sunbelt, Inc.*, 538 F. Supp. 3d 620, 631 (S.D. W. Va. 2021); *Citizens for a Responsible Curriculum v. Montgomery Cnty. Pub. Sch.*, 2005 WL 1075634, at *12 (D. Md. May 5, 2005).

CONCLUSION

For the foregoing reasons, this Court should grant Plaintiffs' motion for a temporary restraining order and preliminary injunction restraining Defendants, their employees, agents, delegates, and successors in office, and all those acting in concert with them, from enforcing or facilitating the entirety of Part I and the Hospitalization Requirement of Part II of the Act. These provisions of the Act that will take effect on July 1 should be enjoined in their entirety because Plaintiffs' due process claim based on the application of the fetal

homicide statute to lawful abortion reaches the constitutionality of the Act as whole, and enjoining the other unconstitutional provisions would leave a statute unlike what the legislature intended to be enforced on its own, as they are intertwined with the core purpose of the Act. Plaintiffs further request that the Court waive the requirement for bond or security.

Dated: June 21, 2023

Respectfully submitted,

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CERTIFICATE OF WORD COUNT

Relying on the word count function of Microsoft Word, I hereby certify that this brief is 8,183 words in length and, therefore, complies with the word limitation of 8,500 words requested in the Plaintiffs' consent motion to extend word limits, dated June 21, 2023, DE 10.

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CERTIFICATE OF SERVICE

I hereby certify that, on June 21, 2023, I electronically filed the foregoing with the clerk of the court by using the CM/ECF system, which will send a notice of electronic filing, and will also serve this motion on counsel for Defendants via email, as well as via certified U.S. mail at the addresses listed below if Defendants' counsel has not agreed to email-only service:

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**DECLARATION OF KATHERINE FARRIS, M.D.,
IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION**

I, Katherine Farris, M.D., declare as follows:

1. I am a physician licensed to practice medicine in North Carolina, South Carolina, West Virginia, and Virginia. I am board-certified by the American Board of Family Physicians in family medicine.

2. Since July 2013, I have been Planned Parenthood South Atlantic's (PPSAT's) Interim Affiliate Medical Director, then Affiliate Medical Director, then Chief Medical Officer. As Chief Medical Officer, I am responsible for ensuring the high quality of the medical care that we provide to patients. In this position, I provide oversight, supervision, and leadership on all medical services we provide, including abortion. As part of my role, I collaborate with other members of PPSAT senior management to develop policies and procedures to ensure that the medical services we provide follow evidence-based guidelines and comply with all relevant laws. I also provide direct medical services for PPSAT.

3. I provide a range of family planning and reproductive health care to patients, including (among other things) both medication and procedural abortion, as well as miscarriage care, referrals for ectopic pregnancy care, contraception, and advanced gynecological care—such as complicated Intrauterine Device (IUD) and Nexplanon removals (Nexplanon is a birth control implant placed under the skin in the upper arm)—at PPSAT's North Carolina health centers in Winston-Salem, Charlotte, and Asheville (and periodically in Fayetteville, Wilmington, and Chapel Hill), as well as in the other states in which I am licensed. I have been employed by PPSAT since 2009 in various capacities as a medical doctor.

4. I earned my medical degree from the Northwestern University Medical School in 2000 and completed my residency at Valley Medical Center Family Practice, where I was Chief Resident in my last year. I am often called upon to present at educational institutions as an expert in abortion care and provider advocacy.

5. The facts I state here and the opinions I offer are based on my education, my years of medical practice, my expertise as a doctor and specifically as an abortion provider, my personal knowledge, my review of PPSAT business records, information obtained through the course of my duties at PPSAT, and my familiarity with relevant medical literature and statistical data recognized as reliable in the medical profession.

6. A copy of my *curriculum vitae* is attached as **Exhibit A**.

I. SUMMARY OF OPINIONS

7. I submit this Declaration in support of PPSAT's motion for a temporary restraining order and preliminary injunction against the new North Carolina Session Law 2023-14 ("S.B. 20") which as of July 1, 2023, will bar PPSAT from providing abortion care to survivors of sexual assault and incest after the twelfth week of pregnancy and through the twentieth week of pregnancy and seems to prevent us from providing early medication abortions to patients who have a very early pregnancy that is not yet visible by ultrasound (pregnancy of unknown location).

8. In particular, while that law states that abortion is lawful "[a]fter the twelfth week and through the twentieth week of a woman's pregnancy, when the procedure is performed by a qualified physician in a suitable facility in accordance with G.S. 90-21.82A when the woman's pregnancy is a result of rape or incest," Section 90-21.82A says that "[a]fter the twelfth week of pregnancy, a physician licensed to practice medicine under this Chapter may not perform a

surgical abortion as permitted under North Carolina law in any facility other than a hospital." S.B. 20 § 90-21.81B(3); *Id*. § 90-21.82A(c).

9. This prohibition is contrary to the standard of care, under which abortions are routinely performed in outpatient settings through twenty weeks; is illogical as a matter of patient health and safety because even once S.B. 20 takes effect, outpatient health centers can still provide this same care in the case of miscarriage; and will only serve to harm patients who have experienced sexual assault.

10. And although the law states it is lawful to provide an abortion "during the first 12 weeks of a woman's pregnancy when a medical abortion is procured," *Id*. § 90-21.81B(2), it also requires the physician to "[d]ocument in the woman's medical chart the probable gestation age and intrauterine location of the pregnancy." *Id*. § 90-21.83B(a)(7). This too will harm patients as not only is it safe to provide medication abortion to patients with positive pregnancy tests but whose pregnancies are too early to document an intrauterine location, but this early abortion care is all the more important given the twelve-week ban.

11. Abortion is extremely safe, but the medical risks associated with abortion increase with gestational age. Denying care to patients whose pregnancies cannot yet be seen on an ultrasound may force them to wait until later in their pregnancies before they can get the care they have chosen. This would expose them to unnecessary medical risk.

II. PPSAT AND ITS SERVICES

12. PPSAT is a non-profit corporation organized under the laws of North Carolina. PPSAT offers a wide range of affordable and reliable reproductive and sexual health care services in our 14 locations across North Carolina, South Carolina, Virginia, and West Virginia. PPSAT operates nine health centers throughout North Carolina, located in Asheville, Chapel Hill,

Charlotte, Durham, Fayetteville, Greensboro, Raleigh, Wilmington, and Winston-Salem. Altogether, these health centers provide a full range of family-planning services, including well-person preventive care visits; breast exams; Pap tests; sexually transmitted infection (STI) testing; a wide range of U.S. Food and Drug Administration (FDA)-approved contraception methods, including highly effective, long-acting reversible contraceptives; pregnancy testing; risk assessments to screen for high-risk issues; referral services for pregnant women; urinary tract infection treatment; cervical cancer and testicular cancer screening; fertility awareness services; and vasectomies. PPSAT provides care to approximately 38,000 patients at its health centers in North Carolina each year.

13. PPSAT provides abortions at six health centers licensed under North Carolina law as abortion clinics located in Asheville, Chapel Hill, Charlotte, Fayetteville, Wilmington, and Winston-Salem. At these health centers, we provide both medication abortion through 77 days gestation as measured from the first day of the last menstrual period (LMP) and procedural abortion up to 13.6 to 19.6 weeks LMP depending on staffing. PPSAT has been providing procedural abortions past 12 weeks LMP for more than fifteen years in North Carolina. During the past five years, only 0.69 percent of PPSAT's North Carolina patients who have received a procedural abortion have sought follow up hospital-based care. Following S.B. 20 taking effect on July 1, PPSAT will be forced to stop providing abortions after the twelfth week pregnancy, including in cases of rape and incest.

III. ABORTION IS COMMON, SAFE, AND CRITICAL HEALTH CARE

A. Abortion Methods Performed in Outpatient Settings.

14. All methods of abortion provided at PPSAT—medication abortion, procedural abortion using aspiration and procedural abortion by dilation and evacuation (D&E)—are simple,

straightforward medical treatments that typically take no more than 10 to 15 minutes, have an extremely low complication rate, are almost always provided in outpatient, office-based settings, and, unlike some other office-based procedures such as vasectomies, involve no incisions.

15. Although aspiration abortion and D&E are both sometimes referred to as "surgical" abortion, they are not what is commonly understood to be surgery. Both aspiration abortion and D&E are done through the natural opening of the vagina and cervix and therefore involve no incisions. Both can be, and almost always are, performed in outpatient clinics like PPSAT by clinicians adhering to widely-accepted medical standards of care. In 2022, 38% of the abortions provided at PPSAT were procedural abortions.

i. Medication Abortion

16. Medication abortion uses medication to cause uterine contractions to empty the uterus. It requires no anesthesia or sedation. PPSAT provides the most common form of medication abortion from the time a patient receives a positive pregnancy test through 11 weeks, or 77 days, LMP.

17. In a typical medication abortion, the patient takes a combination of two prescription drugs—mifepristone (also known as RU-486 or by its trade name, Mifeprex) and misoprostol (also known as a prostaglandin analogue or by its trade name, Cytotec)—a day or two apart. Mifepristone works by blocking the hormone progesterone, which is necessary to maintain pregnancy. Misoprostol causes the cervix to open and the uterus to contract and empty. These same medications are offered as a treatment option to patients who have a miscarriage with retained tissue. Indeed, the process of medication abortion very closely approximates the process of miscarriage.

18. Mifepristone and misoprostol are safe—substantially safer than Tylenol and Viagra, for example.[1] The FDA approved mifepristone, by its brand name Mifeprex, in 2000. Decades of experience with medication abortion since then have resoundingly confirmed its safety and efficacy. Indeed, earlier this year, the FDA modified its dispensing requirements for mifepristone to reflect the ever-growing body of evidence demonstrating the safety and effectiveness of medication abortion.[2] While the FDA-approved labeling for mifepristone reflects its usage through 70 days LMP, there is significant evidence that supports its use through 77 days LMP, as is provided at PPSAT.[3]

ii. Aspiration Abortion

19. Aspiration abortion (also known as suction curettage or dilation & curettage) entails using suction to empty the uterus. It is a straightforward procedure performed in the first and early second trimester. PPSAT provides aspiration abortion up to 14 weeks LMP. A small plastic tube, called a cannula, is passed through the cervical canal. The cannula is attached to a syringe or electrical pump that creates gentle suction to empty the uterus.

20. Prior to starting the suction procedure, the provider dilates the cervix as needed to allow the cannula to enter the uterus. An analgesic such as ibuprofen, an anti-anxiety medication

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[1] *See Analysis of Medication Abortion Risk and the FDA report, "Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2018"*, Advancing New Standards in Reproductive Health (April 2019), https://www.ansirh.org/sites/default/files/publications/files/mifepristone_safety_4-23-2019.pdf.

[2] *See Information About Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, FDA, https://www.fda.gov/drugs/postmarket-drug-safety-information- patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation (last reviewed Mar. 23, 2023).

[3] *See, e.g.*, Ilana G. Dzuba et al., *A Repeat Dose of Misoprostol 800 mcg Following Mifepristone for Outpatient Medical Abortion at 64–70 and 71–77 Days of Gestation: A Retrospective Chart Review*, 102 Contraception 104 (2020); Ilana G. Dzuba et al., *A Non-Inferiority Study of Outpatient Mifepristone-Misoprostol Medical Abortion at 64–70 days and 71–77 Days of Gestation*, 101 Contraception 302 (2020).

such as Ativan or Valium, a local anesthetic such as Lidocaine, and/or moderate sedation may be used during or prior to the procedure.

21. The entire procedure, including administration of local anesthesia, dilating the cervix, and aspirating the uterine contents takes 3 to 5 minutes. It involves no incision, cutting, or suturing.

22. Procedural abortions employ the same procedure and instruments used to treat a miscarriage after embryonic or fetal demise has occurred naturally, and for pregnancies of the same gestational age there is no difference in the risk of complications between a procedure to manage early miscarriage and aspiration abortion. PPSAT currently also provides miscarriage management.

iii. D&E Abortion

23. Dilation and evacuation, or D&E, uses a combination of gentle suction and additional instruments, including specialized forceps, to evacuate the pregnancy contents from the uterus. While we generally refer to procedures starting at 14 weeks LMP as "D&E's", instruments are routinely used in addition to suction starting around 15 weeks LMP, depending on the provider's individual practice and the patient's individual medical characteristics.

24. Prior to the D&E procedure, the provider dilates the patient's cervix to ease and advance cervical dilation, which assures clinical safety. This may be done through medications such as misoprostol, which softens the cervix, and/or the placement of osmotic dilators in the cervix, which gradually swells as it absorbs moisture, causing the cervix to dilate. The provider may also use mechanical dilators or a combination of these techniques. The provider then empties the uterus using instruments or a combination of suction and instruments. Minimal to moderate sedation may be used.

25. In the early part of the second trimester, physicians may perform the cervical preparation and evacuation on the same day. Later in the second trimester, the physician may start the dilation process one day before the evacuation. In most cases, we begin the dilation process for patients from 16 to 20 weeks LMP through the placement of osmotic dilators the day before evacuation.

26. The entire evacuation procedure typically takes 10 to 15 minutes. Like aspiration abortion, D&E does not involve any incision, cutting, or suturing. And like aspiration, the same procedure can be and is used in cases of miscarriage.

B. Abortion is one of the safest procedures in medicine.

27. S.B. 20 does not improve patient health and safety. Abortion is one of the safest procedures in contemporary medical practice and is safely and routinely provided in outpatient settings in countries around the world. Leading medical authorities agree that abortion is one of the safest procedures in medical practice,[4] "stand[ing] in contrast to the extensive regulatory requirements that state laws impose on the provision of abortion services."[5]

28. In fact, major complications, defined as those requiring hospital admission, surgery, or blood transfusion, occur in just 0.23 percent of abortions performed in outpatient, office-based settings.[6]

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[4] Nat'l Acads. of Scis., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States* 77 (2018), available at http://nap.edu/24950 ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.").

[5] *Id.*

[6] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 177 (2015); *see also* Ushma D. Upadhyay et al., *Abortion-related Emergency Room Visits in the United States: An Analysis of a National Emergency Room Sample*, 16 BMC Med. 1, 1 (2018).

29. Abortion compares favorably, with a markedly lower complication rate, to other procedures routinely performed in outpatient, office-based settings, including:

- vasectomies, a form of male birth control that involves transecting and cauterizing the vas deferens, the tubes that carry sperm, resulting in complications two percent of the time while major complications requiring hospitalization occur in 0.2–0.8 percent of cases;[7]
- colonoscopies, an exam used to look for changes in the large intestine (colon) and rectum, such as swollen, irritated tissues, polyps or cancer, with a complication rate of 1.6 percent;[8]
- wisdom teeth extraction, a surgical procedure to remove one or more of the four permanent teeth located at the back corners of the mouth, with a complication rate of 6.9 percent;[9] and
- tonsillectomies, surgical removal of the tonsils, with a complication rate of 7.9 percent.[10]

30. Abortion is significantly safer than the alternative of carrying a pregnancy to term and giving birth.[11] The United States has the highest maternal mortality rate among high-income countries (more than four times the rate of others in that group). Most concerningly, it is getting

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[7] Christopher E. Adams & Moshe Wald, *Risks and Complications of Vasectomy*, 36 Urologic Clinics N. Am. 331 (2009).

[8] Isuru Ranasinghe et al., *Differences in Colonoscopy Quality Among Facilities: Development of a Post-Colonoscopy Risk-Standardized Rate of Unplanned Hospital Visits*, 150 Gastroenterology 103, 103 (2016).

[9] Francois Blondeau & Nach G. Daniel, *Extraction of Impacted Mandibular Third Molars: Postoperative Complications and their Risk Factors*, 73 J. Canadian Dental Ass'n 325 (2007).

[10] Jack L. Paradise et al., *Tonsillectomy and Adenotonsillectomy for Recurrent Throat Infection in Moderately Affected Children*, 110 Pediatrics 7 (2002).

[11] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstet. & Gynecol. 215 (2012).

worse. In 2021, the maternal mortality rate increased 40 percent from the previous year.[12] That year alone, 1,205 pregnant women died of pregnancy-related causes in the United States.[13] The Centers for Disease Control and Prevention (CDC) measure maternal mortality rates as the number of maternal deaths per 100,000 live births.[14] In 2021, the maternal mortality rate was 32.9 deaths per 100,000 live births.[15]

31. In contrast, the CDC reported 0.43 deaths per 100,000 legal abortions from 2013 to 2019.[16] While the U.S. maternal mortality rate has significantly increased, there is no evidence that has occurred for abortion care, making legal abortion approximately 12 to 14 times safer than live birth.[17]

C. Abortions are safely performed in outpatient, office-based settings.

32. There is no medical reason to require abortion to take place in hospitals and not abortion clinics. In North Carolina, as is done throughout the country, legal abortions are safely and routinely performed in doctors' offices and outpatient health center settings. Procedural abortions are almost always provided in an outpatient setting; nationwide, only 3% of abortions annually are performed in hospitals.[18] In addition, abortions at outpatient clinics are most often more affordable, easier to navigate, and require considerably less time for patients.

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[12] Donna L. Hoyert, Ctrs. for Disease Control & Prevention, Nat'l Ctr. for Health Stats., *Maternal Mortality Rates in the United States, 2021*, at 1 (2023), available at https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf.

[13] *Id.*

[14] *Id.*

[15] *Id.*

[16] Katherine Kortsmit et al., *Abortion Surveillance—United States, 2020*, 71 Morbidity & Mortality Weekly Rep. 1, 6 (2022), available at https://www.cdc.gov/mmwr/volumes/71/ss/pdfs/ss7110a1-H.pdf.

[17] Nat'l Acads. of Scis., Eng'g, & Med., *supra* note 4, at 75; Raymond & Grimes, *supra* note 11, at 215.

[18] Rachel K. Jones et al., *Abortion incidence and service availability in the United States, 2020*, 54 Perspect. Sex Reprod. Health 128, 134 (2022).

33. According to the National Academies of Sciences, Engineering, and Medicine, "most abortions can be provided safely in office-based settings," and a hospital setting is not clinically necessary.[19] Similarly, major medical associations, including the American College of Obstetricians and Gynecologists (ACOG) and the American Public Health Association, reject the notion that abortions should be performed in hospitals.[20]

34. The technique for a procedural abortion is clinically identical when performed in a hospital or outpatient setting, and there is no scientific evidence indicating that abortions performed in a hospital are safer than those performed in an appropriate outpatient, office-based setting.[21] To the contrary, as is true for nearly every medical procedure, fewer complications are seen in settings that perform higher volumes of the same procedure, making abortion clinics like PPSAT safer than hospitals for most abortion patients.[22] In fact, at least one study demonstrated that second-trimester terminations of pregnancy by D&E in well-selected patients in a dedicated outpatient facility can be safer and less expensive than hospital-based D&E or induction of labor.[23] It is unreasonable, and a waste of hospital resources, to require a procedure to be performed in a hospital when there is no medical indication or benefit. As with any other medical procedure, clinic- or office-based care should be provided in a different setting when a patient's individual medical circumstances dictate such a need.

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[19] *Id.* at 10, 77.

[20] ACOG, *Guidelines for Women's Health Care: A Resource Manual* (4th ed. 2014).

[21] Sarah C. M. Roberts et al., *Association of Facility Type with Procedural-Related Morbidities and Adverse Events Among Patients Undergoing Induced Abortions*, 319 JAMA 2497 (2018).

[22] Steve Sternberg & Geoff Dougherty, *Risks are High at Low-Volume Hospitals*, U.S. News & World Report, May 18, 2015, 12:01 A.M., https://www.usnews.com/news/articles/2015/05/18/risks-are-high-at-low-volume-hospitals.

[23] David K.Turok et al, *Second trimester termination of pregnancy: a review by site and procedure type*, 77 Contraception 155, 155 (2008).

35. PPSAT physicians have low abortion complication rates and superb safety records. Because PPSAT specializes in providing patient-centered, holistic sexual and reproductive health care, PPSAT patients benefit from receiving care from highly experienced and specialized providers and staff. This is particularly important for the patient population we are talking about here—survivors of sexual assault who may be more comfortable with a provider like Planned Parenthood than having to navigate a hospital, especially one to which they need to travel outside of their community.

36. The hallmark features that differentiate hospitals from abortion clinics include system operations requirements, staffing requirements, and building construction requirements.[24] Not only are these features irrelevant and unnecessary in the context of abortion care, they also provide no medical benefit.

37. Unlike invasive surgical procedures, aspiration abortion, which uses gentle suction to empty the uterus, and D&E, which uses a combination of gentle suction and instruments to empty the uterus, do not involve incisions of any kind. In North Carolina, procedures with risks similar to the risks associated with abortion—including inserting or removing and IUD; endometrial biopsy; colposcopy; hysteroscopy (scoping of the cervix and uterus); Loop Electrosurgical Excision Procedure (LEEP) (removing pre-cancerous cells from the cervix); and miscarriage management, which, from a clinical perspective, involves the same procedures as aspiration abortion—are routinely performed in outpatient clinics and physicians' offices rather than in hospitals. And the procedures noted above with higher complication rates than abortion (like colonoscopies and wisdom teeth extraction) are routinely, and without controversy, performed in outpatient, office-based settings throughout North Carolina.

[24] *Compare* 10A N.C. Admin. Code 13B.3201 (hospital requirements) *with* 10A N.C. Admin. Code 14E .0100 *et. seq.* (abortion facility requirements).

38. Even in the rare event abortion complications arise during a procedural abortion, management can nearly always be safely and appropriately administered in an outpatient, office setting.[25] For example, most cases of hemorrhage (the technical term for bleeding) are managed in the clinic setting with uterotonic medications, like misoprostol, that cause uterine contractions and reduce bleeding and with uterine massage.[26] Most cases of cervical laceration are managed in the clinic setting either with Monsel's Solution or suture.[27] Cases of incomplete abortion are generally managed through repeat aspiration or medication, and, at any rate, arise after completion of the procedure and, even if the abortion took place in a hospital, would occur only after the patient leaves the hospital.

39. In the rare event that a patient experiences infection as a result of a procedural abortion, the infection would typically not develop until days after the procedure. At that time, a patient diagnosed with infection would receive treatment with oral antibiotics on an outpatient basis; i.e., they would take the antibiotics at home or a place of their choosing. Oral antibiotics almost always resolve infection without any long-term or permanent injury to the patient. The use of intravenous or intramuscular antibiotics to treat infection arising from procedural abortion is rare, and both can be provided in an outpatient setting.

40. As discussed above, major abortion complications occur in fewer than one-quarter of one percent (0.23 percent) of abortions.[28] In the exceedingly rare event that a higher level of care is needed to manage complications, patients are safely stabilized and transferred to a hospital.

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[25] Roberts et al., *supra* note 21; Nat'l Acads. of Scis., Eng'g, & Med., *supra* note 4.

[26] Jennifer Kearns & Jody Steinhauer, *Management of postabortion hemorrhage*, 87 Contraception 331, 333 (2013).

[27] *Id.*

[28] Upadhyay et al., *Incidence of Emergency Department Visits*, *supra* note 6, at 175.

In the last five years at PPSAT, 0.22 percent of procedural abortion patients have been transferred to a hospital.

D. Medication abortion is safe to provide in early pregnancies before the intrauterine location of the pregnancy can be determined.

41. Some patients present for abortions at very early gestational ages. At early gestational stages, though the patient has a positive pregnancy test, it may be too soon to see an intrauterine gestational sac via ultrasound. PPSAT follows an established protocol for safely administering medication abortion in early pregnancies before the location of the pregnancy can be visualized and determined. Such early administration of medication abortion has been shown to be safe and effective in terminating the pregnancy, and there is no medical reason to deny patients this care.[29]

42. Banning medication abortion, but not procedural abortion, for pregnancies of unknown location is arbitrary and unnecessary. It would force patients either to undergo a procedural abortion, when they feel that a medication abortion is best for them, or to delay their abortion until the pregnancy can be seen within the uterus.

IV. IMPACT ON PPSAT PATIENTS

A. Impact on Rape and Incest Survivors

43. Thousands of North Carolinians suffer sexual abuse each year, and they desperately need access to abortion. Because of the non-consensual nature of rape and incest, these survivors are at heightened risk of unwanted pregnancy. And many of them are also the most desperate to terminate a pregnancy because of the traumatic circumstances in which that pregnancy is occurring. The physical aspects of pregnancy, including the sense of losing control of one's body,

[29] *See, e.g.*, Alisa B. Goldberg et al., *Mifepristone and Misoprostol for Undesired Pregnancy of Unknown Location*, 139(5) Obstet Gynecol. 771 (2022) (Rate of successful medication abortion was 85.4% in pregnancies where location was unknown).

can be particularly traumatic to patients who are otherwise not in control of their bodies or their lives. For these survivors, pregnancy can trigger flashbacks, dissociative episodes, and other symptoms of re-traumatization.

44. Additionally, many abuse or sexual assault survivors have health reasons for seeking an abortion. There is a strong association between intimate partner violence, incest, and mental health problems, and women may feel they are not healthy enough to parent a child. Or they may need psychiatric medications that are inadvisable during pregnancy.

45. It is already hard for those who have experienced intimate partner violence to access abortion care in many instances. In particular, it can be difficult if not impossible for victims to escape their partner's physical, emotional, and financial control long enough to access an abortion, as they must often do so secretly. In cases where they have been physically isolated from the community, they may not be able to leave their homes to seek routine medical care in the hours or days directly following the assault, let alone later have access to transportation and financial means to access other follow-up services or abortion providers.

46. Even when survivors are able to access reproductive care, the process of finding a way to do so can delay them substantially, making them more likely to need abortion after twelve weeks of pregnancy. These survivors may also be unsure of the gestational age of their pregnancies, so they may present to outpatient clinics for the state-mandated informed consent visit, but find they are beyond their first 12 weeks of pregnancy. Under S.B. 20, those patients would have to be referred to a hospital provider despite the clinic being able to safely provide the care, forcing the patient who has already experienced trauma to present to and share their story with another provider.

47. And, if the hospital-based provider will not accept the state-mandated informed consent visit from the clinic (or if they cannot due to the clinic not having been able to provide the name of the physician or the insurance information required by Section 90-21.83C, a provision also challenged in this case), it would force the patient to receive that information again and to restart the 72 hour waiting period.

48. Even if a rape or incest survivor already knew they were beyond their twelfth week of pregnancy, they will have fewer options for care because there are not likely to be many hospitals in the state that will provide abortions.

49. In addition, abortions at hospitals are generally much more expensive than they would be at PPSAT. Patients who are able to get an appointment at a hospital may also face lengthy wait times, added stress, complicated paperwork and other logistical requirements, loss of confidentiality, and possibly increased medical risk from providers who may provide abortion care infrequently. Particularly when general anesthesia is used, as is done in many hospitals, the total appointment time, post-procedure recovery time, staffing and facility requirements, costs, and procedure risks increase.

50. Though hugely variable, abortions in hospitals can cost thousands of dollars. Given that only one in three Americans can comfortably cover a $400 emergency expense, the financial burden of an abortion at a hospital will be insurmountable for many would-be patients.[30] At PPSAT, patients can obtain an abortion, as at other outpatient abortion clinics, for a fraction of the cost charged by hospitals. At PPSAT, the cost of an abortion varies based on gestational age from $620 to $1720.

[30] Bd. of Governors of the Fed. Reserve Sys., *Report on the Economic Well-Being of U.S. Households in 2021*, at 36 (May 2022), available at https://www.federalreserve.gov/publications/files/2021-report-economic-well-being-us-households-202205.pdf.

51. Due to cost alone, if a patient could find a hospital willing to provide their abortion, hospital treatment would not be feasible for many of PPSAT's patients. Arranging for transportation, childcare, and taking time off work to come to PPSAT is challenging enough. Studies demonstrate increased barriers to access increase the likelihood a patient will not receive care.[31] A majority of patients seeking abortion are already parents. Many have multiple jobs or jobs with inflexible or unpredictable schedules with no paid sick leave. Some are compromised by physical and/or mental health conditions or struggle with a substance abuse disorder.

52. Studies also demonstrate that increased barriers to access increase the likelihood a patient will not receive care.[32] In addition, delay of any kind is particularly concerning because, while abortion is safe, its risks increase with gestational age, as does the invasiveness of the procedure and the need for deeper levels of sedation.

53. For all of these reasons, limiting access to care for survivors of rape and sexual assault will cause great harm even to those who are able to access care in a North Carolina hospital. But for many others, S.B. 20 will put that care out of reach and the only remaining options will be to travel out of state to get an abortion or attempt to manage their abortion outside of the medical system. In practice, for many, this will mean that they will be forced to remain pregnant and ultimately give birth against their will.

B. Impact on Access To Early Abortion Care

54. If PPSAT is unable to offer medication abortion to patients who present with a positive pregnancy test but a pregnancy of unknown location, this too will be devastating for

[31] *See e.g.*, Benjamin P. Brown et al., *Association of Highly Restrictive State Abortion Policies With Abortion Rates, 2000-2014*, 3 JAMA Network Open 1, 1 (2020) ("A highly restrictive policy climate, when compared with a less restrictive one, was associated with a … 17% decrease [in] the median abortion rate….").

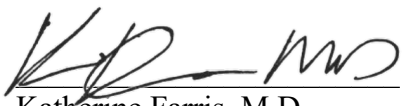
[32] *Id*.

patients. This is especially so because S.B. 20 already imposes a requirement that patients make two trips to a health center to access care (in addition to the follow up appointment that is required to be scheduled for medication abortion patients). If we cannot go forward providing medication abortion to these patients, they may need to make another, wholly medically unnecessary trip which will further delay their access to care. Early access to care is always preferable, but this is even more so because S.B. 20 bans almost all abortions after 12 weeks.

55. In these ways (and many others), S.B. 20 is not only harmful to our patients, but also impairs PPSAT and its physicians' ability to practice their profession and to satisfy their personal and professional missions and obligations of providing high-quality, evidence-based comprehensive reproductive health care to people in North Carolina.

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

Dated: June 21, 2023



Katherine Farris, M.D.

EXHIBIT A

Katherine A. Farris, M.D.

Employment

Planned Parenthood South Atlantic Winston-Salem/Raleigh, NC

Chief Medical Officer: April 2020 – present

Duties of Affiliate Medical Director with increased focus on strategic planning, oversight of new service lines including Primary Care, and increased advocacy work in support of PPSAT mission.

Affiliate Medical Director: December 2014 – April 2020

Clinical, policy, and administrative oversight for 14 health centers located throughout NC, SC, VA, and WV.

Laboratory Director: December 2014 – present

Oversight of non-waived laboratories WS, NC; AVL, NC; WILM, NC; CLT, NC; waived laboratory VIE, WV

Interim Abortion Facility Administrator: December 2019 – March 2020

Acting Vice President of Patient Services: March – June 2016; May – August 2017

Interim Affiliate Medical Director: July 2013 – December 2014

Reproductive Health Care: September 2009-present

Provision of comprehensive family planning services to women of all ages as well as STI counseling, testing and treatment to men and women.

PPFA Succession Planning Task Force, Member: April 2017 – March 2021

Task force was charged with addressing some of the systemic challenges of abortion provider training and recruitment at Planned Parenthood affiliates.

Medical Directors Council (MeDC), Mentor: 2015 – present

Serve as mentor to new Medical Directors/Chief Medical Officers at other PPFA Affiliates.

BetterHealth IT Board of Directors,

Member: September 2020 – present

Chair, Compliance Committee: January 2023 – present

Board member for the organization responsible for providing revenue cycle services and supporting and rolling out Epic electronic medical records system across PPFA affiliates.

(Prior to merger and name change January 2015, organization was named Planned Parenthood Health Systems, Inc.)

Heywood Medical Group/Henry Heywood Hospital Westminster/Gardner, MA

Family Practice/Obstetrics: August 2003 – May 2007

Meetinghouse Family Practice; 16 Wyman Rd.; Westminster, MA 01473

Provision of full-spectrum family medicine including comprehensive family planning and reproductive health care.

Planned Parenthood League of Massachusetts Boston/Worcester, MA

Reproductive Health Care: August 2003 – May 2007

Provision of comprehensive family planning services to women of all ages.

Education

Valley Medical Center Family Practice Residency Renton, WA

Chief Resident: 2002-2003

Residency: 2001-2003

Internship: 2000-2001

Northwestern University Medical School Chicago, IL

Degree: MD, 1995-2000

Northwestern University College of Arts and Sciences Evanston, IL

Degree: BA, 1991-1995

Major: Molecular and Cellular Biology Minor: Religion Studies

Certifications/Special Training

Physician for Reproductive Health, Leadership Training Academy Fellow 2018-2019
Basic Life Support/AED, Provider: renewed 10/2021
Title X Family Planning Program Training, Provider: 2015
CLIA Laboratory Director Training, Training for non-waived laboratory director: 2013
Single-rod Hormonal Implant Insertion Training, Provider: 2011, Certificate #30001820273

Professional Organizations / Positions

American Academy of Family Physicians (AAFP): 1995-present
North Carolina Academy of Family Physicians: 2007-present
National Abortion Federation (NAF): 2003-2005, 2018-present
Physicians for Reproductive Health: 2018-present
American College of Obstetricians and Gynecologists: 2020-present
Massachusetts Academy of Family Physicians: 2003-2007
Washington Academy of Family Physicians (WAFP): 2000-2003
American Medical Women's Association (AMWA): 1995-2000
Northwestern University Chapter President: 1997-1998
Vice-President: 1996-1997

Licenses

NC Physician License, active: 143375-2009
WV Physician License, active: 26126
VA Physician License, active: 0101265486
SC Physician License, active: MMD.84073 MD
American Board of Family Physicians, Board Diplomate

Honors/Awards

Sylvia Clark Award for Creativity in Clinical Services – Recipient 2023
Honors a clinical services provider team from a Planned Parenthood affiliate who, through their creativity in clinical services, have demonstrated special commitment and ingenuity in applying the PPFA mission to ensure access to reproductive and sexual health care for all.

Press Ganey Patient Experience Top Performing Provider 2020
Ranked in the top 10% of providers across the country for providing the highest level of patient experience.

2002 Roy Virak Memorial Family Practice Resident Scholarship Recipient
Awarded by the Washington Academy of Family Practice on the basis of academic achievement, excellence in patient care, and strong service to the community.