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

PLANNED PARENTHOOD SOUTH ATLANTIC, *et al.*,	)	
Plaintiffs,	)	
v.	)	
JOSHUA STEIN, *et al.*,	)	Case No. 1:23-cv-00480-CCE-LPA
Defendants,	)	
and	)	
PHILIP E. BERGER, *et al.*,	)	
Intervenor-Defendants.	)	

REPLY IN SUPPORT OF PLAINTIFFS' AMENDED MOTION FOR PRELIMINARY INJUNCTION

The Intervenors incorrectly believe that *Dobbs v. Jackson Women's Health Organization* gave state legislatures a free pass to restrict abortion, insulated from judicial review. *Dobbs* did no such thing. The U.S. Constitution requires that in regulating abortion—as in regulating other medical care—states must still act rationally. Although rational basis is a deferential standard, it is not "toothless." *See, e.g., Matthews v. Lucas*, 427 U.S. 495, 510 (1976). Because the Hospitalization and IUP Documentation Requirements are not rationally related to patients' health, they are unconstitutional. The IUP Requirement is also unconstitutionally vague, as this Court has already held.

I. Courts Have Struck Down Numerous Laws Under the Rational Basis Test.

Intervenors are wrong that the rational basis test requires courts to accept at face value the government's claim that a rational relationship to a legitimate state interest exists. If that were true, no rational basis claim would succeed. To the contrary, courts have struck numerous laws under this test. For example, in *United States Department of Agriculture v. Moreno*, 413 U.S. 528 (1973), the Court struck down as irrational a prohibition on food stamps for households composed of unrelated individuals. The Court rejected the argument that the prohibition was rationally related to the goal of preventing fraud after looking at other laws protecting the food stamp program from abuse. *Id*. at 536-37. *See also Romer v. Evans*, 517 U.S. 620, 632 (1996) (holding that, even under rational basis, "we insist on knowing the relation between the classification adopted and the object to be obtained"); *Hooper v. Bernalillo Cnty. Assessor*, 472 U.S. 612, 619-23 (1985); *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 446 (1985); *Zobel v. Williams*, 457 U.S. 55, 61-66 (1892); *Weinberger v. Wiesenfeld*, 420 U.S. 636, 648 (1975); *Catherine H. Barber Mem'l Shelter, Inc. v. Town of N. Wilkesboro Bd. of Adjustment of Town of N. Wilkesboro*, 576 F. Supp. 3d 318, 343 (W.D.N.C. 2021).

Furthermore, any presumption of rationality can be overcome by "common knowledge" or evidence. *Borden's Farm Prods. Co. v. Baldwin*, 293 U.S. 194, 209 (1934); *see also St. Joseph Abbey v. Castille*, 712 F.3d 215, 226 (5th Cir. 2013) (holding that deference to the legislature does not demand that the judiciary ignore the history or context of the law); *Merrifield v. Lockyer*, 547 F.3d 978, 990 (9th Cir. 2008); *Craigmiles v. Giles*,

312 F.3d 220, 224 (6th Cir. 2002).[1] Thorough review is all the more important *because* abortion, which is politically stigmatized, is at issue. As *Moreno* holds, a "desire to harm a politically unpopular group cannot constitute a legitimate governmental interest." 413 U.S. at 534. *See also Romer*, 517 U.S. at 633 (holding that "classifications . . . drawn for the purpose of disadvantaging the group burdened by the law" are irrational); *City of Cleburne*, 473 U.S. at 448.

II. The Hospitalization Requirement Is Unconstitutional

A. The Hospitalization Requirement is not rationally related to abortion safety.

Intervenors attempt to characterize abortion as unsafe to justify *any* abortion restriction as reasonably related to health and safety. Int. Br. at 2. But as discussed, *supra* Part I, *Dobbs* did not give states free rein to regulate abortion without any legitimate safety rationale. Even under rational basis, courts do not "rubber stamp the classification no matter the facts" simply because the government invokes "magic words" like "safety"; rather, the government must "establish that its safety concerns are based on an actual material distinction." *Mem'l Shelter*, 576 F. Supp. 3d at 341.

Intervenors' characterization of abortion safety is flatly wrong: as recognized by expert bodies like the National Academies of Sciences, Engineering, and Medicine and the

[1] Intervenors rely on *Gonzales v. Carhart*, 550 U.S. 124 (2007), to claim that the General Assembly had wide discretion because of the "medical uncertainty" of abortion's safety. Def.-Intervenors' Resp. in Opp'n to Pls.' Am. Mot. for Prelim. Inj. ("Int. Br.") at 10, 29, DE 65. But no such uncertainty exists, as discussed below. Moreover, *Gonzales* held that courts retain an independent duty to review factual findings. 550 U.S. at 165.

American College of Obstetricians and Gynecologists (ACOG), abortion is overwhelmingly safe, including *specifically in outpatient clinics*, where the vast majority of abortions happen. *See* Decl. of Katherine Farris, M.D. ("First Farris Decl."), DE 49-1 ¶¶ 29-38; Rebuttal Decl. of Christy M. Boraas Alsleben, M.D., M.P.H. ("Boraas Rebuttal Decl.") ¶¶ 6-14, 31, attached as Exhibit 1. Indeed, the Attorney General admits abortion is safe, Def. Att'y General Stein's Answer, DE 64 ¶ 76, and the Department of Health and Human Services agrees that "the risk of serious complications related to abortion is low" and the maternal mortality rate is higher for childbirth than abortion, Answer of Kody H. Kinsley, DE 55 ¶¶ 53, 70. Dr. Wubbenhorst's suggestion that abortion safety data is "incomplete," *see* Int. Br. at 2, 10 (citing Decl. of Monique Chireau Wubbenhorst, M.D., M.P.H. ("Wubbenhorst Decl."), DE 65-1 ¶¶ 64, 96, 98, 101), ignores the medical consensus and misunderstands abortion safety data. Boraas Rebuttal Decl. ¶¶ 8-14, 21-24.[2]

The observation that hospitals have more resources than clinics does not help Intervenors. *See* Int. Br. at 9, 12. The operative question is whether these differences matter *for purposes of providing abortion safely after twelve weeks of pregnancy*. *Mem'l Shelter*, 576 F. Supp. 3d at 338. As previously detailed, complications from abortion are extremely rare; complications that arise during the procedure are usually treated on-site; and in the

[2] *See also EMW Women's Surgical Ctr. v. Cameron*, No. 22-CI-3225, at 4 (Cir. Ct. Jefferson Cty., Ky. July 22, 2022) (attached as Exhibit 3) (finding that in her testimony, Dr. Wubbenhorst had been "unable to provide any evidence to support her criticism" of the "accuracy of abortion statistics in general"), *rev'd on other grounds by Cameron v. EMW Women's Surgical Ctr., P.S.C.*, 664 S.W.3d 633 (Ky. 2023).

exceedingly rare event of a complication requiring hospitalization, patients are safely transferred. Memo. of Law in Supp. of Pls.' Am. Mot. for Prelim. Inj. ("Am. PI Memo"), DE 49, at 6; Rebuttal Decl. of Katherine Farris, M.D. ("Farris Rebuttal Decl."), ¶¶ 5-8, attached as Exhibit 2; Boraas Rebuttal Decl. ¶¶ 8, 11, 16, 33-36. Moreover, any characteristics distinguishing hospitals from clinics are relevant only for the very few patients who are sick enough to need those resources and whom PPSAT would not treat. Boraas Rebuttal Decl. ¶ 34.

Contrary to Intervenors' claim, Int. Br. at 4–5, 9, it is not rational to require *all abortion patients* to be hospitalized simply because a very small number may experience a complication requiring hospitalization. Farris Rebuttal Decl. ¶ 8; Boraas Rebuttal Decl. ¶¶ 30-34; *see, e.g.*, *O'Day v. George Arakelian Farms, Inc.*, 536 F.2d 856, 860 (9th Cir. 1976) (finding a law irrational where it was "grossly excessive" in relation to government interest). Indeed, the General Assembly has not required that people go to hospitals for vasectomies or colonoscopies, or to have wisdom teeth removed. Taken to its logical conclusion, Intervenors' argument would allow the legislature to force all medical procedures, no matter how minor, into hospital operating rooms because no procedure is completely risk-free.[3]

[3] Intervenors' "articulat[ion]" of Plaintiffs' argument is a straw man: undoubtedly "the Constitution does not *prohibit* second-trimester surgical abortions to be performed in a hospital." Int. Br. at 10 (emphasis added). What the Constitution prohibits is *requiring* hospitalization for second-trimester abortions, where procedures of equal or greater risk are not subject to that requirement.

Boiled down, Intervenors' only justification for the Hospitalization Requirement is that "[a]bortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life." Int. Br. at 15. But Intervenors do not raise potential life as a state interest for good reason: wherever abortions are performed, they end pregnancy, so the Hospitalization Requirement is not rationally related to any interest in potential life. And in *Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 167–69, 173 (4th Cir. 2000), the Fourth Circuit upheld under rational basis review an abortion regulation because it "largely track[ed]" the "standards and guidelines issued by the ACOG, Planned Parenthood, and the National Abortion Federation" and thus was reasonably directed at promoting health—not because "'distinguishing between abortion services and other medical services'" is rational *per se*, as Intervenors argue. *See* Int. Br. at 15 (quoting *Bryant*, 222 F.3d at 173). The Hospitalization Requirement is irrational for the same reason the *Greenville* regulations were not: it runs counter to all reliable medical evidence and standards.

B. The Hospitalization Requirement draws arbitrary classifications based on stigma.

The Hospitalization Requirement restricts the availability of abortion but not procedures of equal or greater complexity or risk, thereby creating a classification based solely on abortion stigma in violation of the Equal Protection Clause. *See City of Cleburne*, 473 U.S. at 448 (striking down as irrational the city's requirement of a special use permit for a group home for people with mental disabilities while not requiring such a permit for

other similar uses). And where, as here, arbitrary distinctions give rise to both due process and equal protection claims, the two claims are often evaluated together. *See, e.g.*, *St. Joseph Abbey*, 712 F.3d 215; *Craigmiles*, 312 F.3d 220; Am. PI Memo at n.7.

Intervenors argue that the Hospitalization Requirement does not create classes of patients or physicians, but rather classes based on gestational age. Int. Br. at 14. This ignores that while Part II of the Act creates a hospitalization requirement for abortion, N.C. Gen. Stat. § 90-21.82A(c), Part IV provides for "planned birth outside of a hospital setting." N.C. Gen. Stat. § 90-178.4 (as amended by S.B. 20, § 4.3(d), effective Oct. 1, 2023). Rational basis analysis looks at a challenged statute's operation alongside other laws, not just the face of the statute itself. *See, e.g.*, *Moreno*, 413 U.S. at 536-37; *City of Cleburne*, 473 U.S. at 448. By requiring hospitalization for abortion but not procedures of greater risks, like childbirth, and procedures of equal or greater risk, including miscarriage management using identical techniques, Decl. of Christy M. Boraas Alsleben, M.D., M.P.H. ("First Boraas Decl."), DE 49-2 ¶¶ 21, 24, 40; First Farris Decl. ¶ 40, the Hospitalization Requirement imposes stricter requirements on abortion based solely on political stigma. Farris Rebuttal Decl. ¶ 15. Thus, Plaintiffs need not show that the General Assembly was motivated by a "bare desire to harm" patients seeking abortion. Int. Br. at 16. Rather, the absence of a rational relationship to a legitimate state interest demonstrates as much.[4]

[4] Moreover, the General Assembly's line-drawing at twelve weeks is arbitrary and not rationally related to patient safety, because abortion patients receive the same

III. Plaintiffs Are Likely to Succeed on Their Claim that the IUP Documentation Requirement Is Unconstitutional.

A. The IUP Documentation Requirement is unconstitutionally vague.

Intervenors admit that the IUP Documentation Requirement carries criminal penalties, and therefore the standard for Plaintiffs' vagueness challenge is higher.[5] Int. Br. at 18. As this Court held at the TRO stage, Plaintiffs are likely to succeed on that challenge because the Act (1) "broadly allows abortions during the first twelve weeks of pregnancy" while (2) requiring documentation of an intrauterine pregnancy before providing medication abortion, which may be impossible at the earliest stages. TRO, DE 31 at 6-7. Moreover, the Attorney General agrees that the law is vague, Def. Att'y General Joshua H. Stein's Memo. of Law, DE 63 at 14-17, reinforcing Plaintiffs' argument that the statute is subject to arbitrary and discriminatory enforcement. Am. PI Memo at 16-18.

Intervenors attempt to cure the provision's vagueness in two unpersuasive ways. First, they claim that the scienter requirements of other statutory provisions should mollify Plaintiffs' concerns, Int. Br. at 18 (citing N.C. Gen. Stat. §§ 14-23.2(a)(1), 14-44, 14-45), but fail to explain how the scienter requirements for the fetal homicide and unlawful abortion statutes resolve the conflict between the two provisions discussed above. Second,

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aspiration procedure at eleven and thirteen weeks of pregnancy. First Farris Decl. ¶ 21; First Am. Compl., DE 42 ¶ 66; Boraas Rebuttal Decl. ¶ 32.

[5] Intervenors here too rely on *Greenville Women's Clinic*, but the challenged law in that case carried, at most, modest civil penalties, 222 F.3d at 161.

Intervenors combine the two provisions at issue and insert the word "only" to argue that the medication abortion is permitted "only" after the existence of an intrauterine pregnancy is documented. Int. Br. at 19. But this is an attempt to rewrite the statue, and it should be rejected. *See, e.g.*, *Legend Night Club v. Miller*, 637 F.3d 291, 302 (4th Cir. 2011). This Court should hold, as it did in its TRO, that Plaintiffs are likely to succeed on the merits of their vagueness claim.

B. Medication abortion is safe, and the IUP Documentation Requirement does not make patients with ectopic pregnancies safer.

Intervenors misunderstand and mischaracterize the scientific data on medication abortion's safety. For instance, Intervenors cite the FDA's Mifeprex label for the statement that "between 2.9% and 4.6% of women end up in the emergency room due to complications from chemical abortion," Int. Br. at 3, but ignore that the label also says the rate of hospitalization is 0.04-0.6%. Int. Br. Ex. 2, 8 tbl.2. More importantly, the FDA repeatedly has made clear that medication abortion is extremely safe. *See, e.g.*, FDA, *Ctr. for Drug Evaluation & Rsch., Med. Rev., Application No. 020687Orig1s020*, 47 (2016) (serious adverse events among mifepristone patients are "exceedingly rare, generally far below 0.1% for any individual adverse event").[6]

[6] Available at https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020MedR.pdf. *See also 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 Reprod. Health (2019), https://www.ansirh.org/sites/default/files/publications/files/mifepristone_safety_4-23-2019.pdf; Boraas Rebuttal Decl. ¶ 11.

Intervenors also accuse Plaintiffs of providing "unapproved and dangerous drugs," Int. Br. at 22, by providing medication abortion through 11 weeks of pregnancy, *id.* at 3, despite mifepristone's proven safety at that gestational age. *See* First Farris Decl. ¶ 18; Boraas Rebuttal Decl. ¶ 52. This is a particularly startling assertion since the General Assembly amended the Act to *allow* the provision of medication abortion through twelve weeks. *See* Session Law 2023-65, DE 26-1 § 14.1(f); *see also* First Farris Decl. ¶ 18; Boraas Rebuttal Decl. ¶ 52.

Further, while Intervenors point out that risks associated with abortion increase as pregnancy continues, *see, e.g.,* Int. Br. at 3, they nevertheless defend the rationality of delaying medication abortion until "about five or six weeks LMP." *Id.* at 22. Prohibiting early abortion when it is safest is the model of irrationality.

Intervenors assert that "[c]hemical abortion is contraindicated for women with ectopic pregnancies." *Id.* at 3, 21. But medication abortion is contraindicated for ectopic pregnancies *because it does not treat them*, not because it increases the likelihood of negative outcomes. Farris Rebuttal Decl. ¶ 11; Boraas Rebuttal Decl. ¶ 50. The point of screening patients for ectopic pregnancy is not to prevent the nonexistent "danger[]," Int. Br. at 22, of providing medication abortion to a patient with an ectopic pregnancy. Rather, screening ensures these patients are promptly diagnosed and treated. PPSAT's evidence-based protocol does exactly that.

Contrary to Intervenors' claim, Int. Br. at 22, PPSAT does not "merely ask[] questions about the patient's medical history and current symptoms" to screen for ectopic

pregnancy.[7] Instead, PPSAT performs an ultrasound *and*, if a pregnancy is not visible, conducts further screening for ectopic pregnancy. First Farris Decl. ¶ 52; Farris Rebuttal Decl. ¶ 12. Patients with confirmed or suspected ectopic pregnancies are referred elsewhere for treatment. *Id.*; First Am. Compl. ¶ 54. But if the patient is determined to be at low risk of ectopic pregnancy and decides to proceed with a medication abortion, PPSAT simultaneously provides the medication abortion *and* conducts further testing to rule out ectopic pregnancy, drawing serial blood samples to test the levels of the pregnancy hormone hCG. First Farris Decl. ¶¶ 53–57; *see also* Farris Rebuttal Decl. ¶ 12.

Contradicting their own expert, Intervenors claim that the "only way" to diagnose ectopic pregnancy is by ultrasound, Int. Br. at 22. But as Dr. Wubbenhorst admits, an ectopic pregnancy can be ruled out "based on ultrasound *and quantitative (blood, hCG) pregnancy testing*." Wubbenhorst Decl. ¶ 254 (emphasis added). PPSAT does precisely this. Because medication abortion does not increase the risks associated with an ectopic pregnancy, Boraas Rebuttal Decl. ¶ 50, there is no downside to PPSAT's evidence-based practice of simultaneously providing medication abortion to low-ectopic-risk patients. First Farris Decl. ¶¶ 54. In fact, at least one study showed this protocol leads to earlier detection

[7] Intervenors misrepresent even this component of the screening process. They incorrectly assume that a patient who reports no symptoms will be inaccurately categorized as at low risk of ectopic pregnancy. This ignores the additional steps in PPSAT's protocol and overlooks the fact that patients who report ectopic pregnancy risk factors would not be deemed low-risk, even if asymptomatic. *See* First Farris Decl. ¶ 52; First Boraas Decl. ¶ 49.

of ectopic pregnancy.[8]

Intervenors also claim that a hypothetical patient with an ectopic pregnancy could receive a medication abortion and then not receive treatment for the ectopic pregnancy. But as Intervenors admit, "[t]he IUP documentation requirement neither commands nor prevents a physician from referring a patient for ectopic evaluation." Int. Br. at 24. While PPSAT cannot force patients to return for follow-up based on hCG test results, its protocol ensures those test results (and their potential significance) will be communicated to patients, whereas the IUP Documentation Requirement both denies early medication abortion care *and* does nothing to provide a mechanism for "ensur[ing] the patient is not suffering from an ectopic pregnancy." *Id.* at 24; Farris Rebuttal Decl. ¶ 11. Additionally, Intervenors' suggestion that patients will confuse the symptoms of an ectopic rupture with those of a medication abortion, Int. Br. at 23, is extremely unlikely given PPSAT's thorough counseling and the differences between the severe, sharp pain associated with ectopic rupture versus the midline cramping that medication abortion patients often experience. Boraas Rebuttal Decl. ¶ 53.

Finally, although Intervenors claim that the IUP Documentation Requirement "would prevent serious health consequences to women with undiagnosed ectopic pregnancies," Int. Br. at 22, they callously argue that whether PPSAT's protocol leads to

[8] Alisa B. Goldberg et al., *Mifepristone and Misoprostol for Undesired Pregnancy of Unknown Location*, 139 Obstetrics & Gynecology 771 (2022).

earlier or more accurate diagnosis of ectopic pregnancy "has no bearing on the law" and its rationality. *Id.* at 24. Intervenors' disregard for the health and safety benefits of PPSAT's evidence-based protocol underscores its irrationality. *See Merrifield*, 547 F.3d at 992.

CONCLUSION

For the foregoing reasons, this Court should grant Plaintiffs' amended motion for a preliminary injunction.

Dated: August 18, 2023

Respectfully submitted,

/s/ Jaclyn Maffetore

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CERTIFICATE OF WORD COUNT

Relying on the word count function of Microsoft Word, I hereby certify that this brief is 3,115 words in length and, therefore, complies with the word limitation of 3,125 words for briefs prescribed by Local Rule 7.3(d)(1).

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CERTIFICATE OF SERVICE

I hereby certify that, on August 18, 2023, I electronically filed the foregoing with the clerk of the court by using the CM/ECF system, which served notice of this electronic filing to all counsel of record.

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EXHIBIT 1

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Intervenor-Defendants.	)	

REBUTTAL DECLARATION OF CHRISTY M. BORAAS ALSLEBEN, M.D., M.P.H. IN SUPPORT OF PLAINTIFFS' AMENDED MOTION FOR A PRELIMINARY INJUNCTION

I, Christy M. Boraas Alsleben, M.D., M.P.H., declare as follows:

1. I submit this rebuttal declaration in further support of the Amended Motion for a Preliminary Injunction that Plaintiffs Planned Parenthood South Atlantic ("PPSAT") and Dr. Beverly Gray filed to block two components of North Carolina Session Law 2023-14 ("S.B. 20") (codified as amended by Session Law 2023-65 ("H.B. 190") at N.C. Gen. Stat. art. 1I, Ch. 90 (the "Act")), which bans abortion after twelve weeks of pregnancy with narrow exceptions.

2. I previously submitted a declaration in this case, which I executed on July 24, 2023. Decl. of Christy M. Boraas Alsleben, M.D., M.P.H. in Supp. of Pls.' Am. Mot.

for a Prelim. Inj. ("First Boraas Decl."), DE 49-2. That declaration described my qualifications and experience as a board-certified obstetrician/gynecologist (OB/GYN) and Complex Family Planning physician, an abortion provider at the University of Minnesota Medical Center, M Health Fairview Women's Clinic, Whole Woman's Health Twin Cities, and Planned Parenthood North Central States, as well as an educator, consultant, and published author in the field of obstetrics and gynecology.

3. Like the opinions in my original declaration, the opinions in this rebuttal declaration are based on my education, clinical training, experience as a practicing physician, regular review of medical research in my field, and regular attendance and presentation at professional conferences, including conferences for abortion providers. The literature considered in forming my opinions includes, but is not limited to, the sources cited in this declaration.

4. I have reviewed the declarations submitted by Monique Chireau Wubbenhorst, M.D., M.P.H. and Susan Bane, M.D., Ph.D. Nothing in these declarations alters the conclusions I reached or the opinions I expressed in my prior declaration. I am submitting this rebuttal declaration to respond to certain of the statements and opinions expressed in the declarations I reviewed and to offer additional information about the Hospitalization Requirement and the IUP Documentation Requirement. I also disagree with the inflammatory and misleading language used throughout Drs. Wubbenhorst's and Bane's declarations. The fact that I do not address every statement or issue raised in their declarations does not suggest that I agree with them.

5. I have reviewed the rebuttal declaration of Dr. Katherine Farris, also submitted in further support of Plaintiffs' Amended Motion for a Preliminary Injunction. I agree with Dr. Farris's statements and opinions asserted in her rebuttal declaration.

Abortion is Safe and Essential Health Care

6. Abortion is a critical component of reproductive health care, and it is also one of the safest medical procedures in the United States. The American Medical Association (AMA), the largest general medical association in the country, and the American College of Obstetricians and Gynecologists (ACOG), the largest association of OB/GYN specialists, issue ethical guidance that recognizes abortion's important place within health care.[1] In fact, ACOG has affirmed that access to safe, legal abortion is not only important but necessary: "Women *require* access to safe, legal abortion."[2] These organizations recognize the difficult medical decisions sometimes required in reproductive health care, balancing various forms of benefits and harms and the importance of individual autonomy. Drs. Wubbenhorst's and Bane's assertions to the contrary undermine the compassion, empathy, and humanity of abortion providers, and function only to further stigmatize abortion care and alienate patients and providers.

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[1] *See, e.g.*, Br. of Amici Curiae Am. Coll. of Obstetricians & Gynecologists & the Am. Med. Ass'n in Supp. Of Pls.-Appellees & in Supp. of Affirmance at 2, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 748 F.3d 583 (5th Cir. 2014) (No. 13-51008) ("Access to safe and legal abortion is an important aspect of women's health care.").

[2] ACOG, *Comm. Op. No. 613, Increasing Access To Abortion*, 124 Obstetrics & Gynecology 1060, 1061 (2014) (emphasis added).

7. Intervenors' experts rely on a host of inappropriate conclusions from low quality and/or outdated research to support their conclusions, much of which (1) does not involve second trimester abortion; (2) studied patients in an international context not generalizable to the United States[3]; (3) does not reflect contemporary abortion practice[4]; or (4) suffers from other limitations, such as organizational biases,[5] that render it unreliable. Their approach to summarizing research omits nationally representative, high quality, U.S.-based research and draws conclusions based on conjecture which is not an accepted practice in the field of medicine or in the provision of evidence-based medical care.

8. Dr. Wubbenhorst and Dr. Bane characterize abortion as an unsafe, risky procedure, but the objective fact is that abortion is extremely safe. Leading, reputable, mainstream medical authorities agree, and an abundance of literature supports,[6] that both medication abortion and procedural abortion are two of the safest procedures in medical practice,[7] carry a low risk of complications, and a very low risk of complications requiring

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[3] *See, e.g.*, Declaration of Susan Bane, M.D., Ph.D. ("Bane Decl."), DE 65-3 ¶ 33, (citing a study assessing medication abortion in Finland, Mexico, and South Africa).

[4] *See, e.g.*, Declaration of Monique Chireau Wubbenhorst, M.D., M.P.H ("Wubbenhorst Decl."), DE 65-1 ¶ 39, (citing study that reported on data from 1972-78).

[5] *See, e.g.*, Wubbenhorst Decl. ¶¶ 9-10 (citing the American Association of Pro-Life Obstetricians and Gynecologists' criticisms of credible studies).

[6] *See, e.g.*, Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 217 (2012); Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015); Nat'l Acads. Scis., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States*, at 77-78 (2018), available at http://nap.edu/24950 [hereinafter "Nat'l Acads."].

[7] Nat'l Acads., *supra* note 6, at 77 ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.").

hospitalization, "stand[ing] in contrast to the extensive regulatory requirements that state laws impose on the provision of abortion services."[8] Major complications including those requiring hospitalization, surgery, or blood transfusion, occur in only 0.23% of outpatient abortions.[9]

9. As to medication abortion specifically, the National Academies of Sciences, Engineering, and Medicine—a body of esteemed experts that was established by Congress to provide independent, objective expert analysis and advice to the nation to inform public policy—have explained that "[t]he risks of medication abortion are similar in magnitude to the risks of taking commonly prescribed and over-the-counter medications such as antibiotics and NSAIDs [nonsteroidal anti-inflammatory drugs]," such as ibuprofen and aspirin.[10] Dr. Wubbenhorst takes issue with the assertion that medication abortion is substantially safer than Tylenol and Viagra, and claims that it is untrue because medication abortion "carries a black box warning." Wubbenhorst Decl. ¶¶ 91-95, 119-26.

10. This argument is misleading at best. First, a black box warning is not the sole indicator of a medication's safety. Indeed, commonly purchased over the counter medications such as Aleve, Advil, and Motrin have black box warnings.[11]

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[8] *Id.*

[9] Upadhyay (2015), *supra* note 6, at 181; *see also* Ushma D. Upadhyay et al., *Abortion-Related Emergency Department Visits in the United States: An Analysis of a National Emergency Department Sample*, 16 BMC Med. 1, 1 (2018).

[10] Nat'l Acads., *supra* note 6, at 79.

[11] ThienLy Neal, *What Does an FDA Black Box Warning Mean?*, GoodRx (Oct. 12, 2021), https://www.goodrx.com/healthcare-access/medication-education/fda-black-box-warning.

11. A 2018 report by the National Healthcare Cost and Utilization Project found the rate of hospital stays involving adverse drug reactions caused by antibiotics and similar medications, including aspirin, Tylenol, and Viagra, was 151.5 per 10,000 hospital stays, or 1.515 percent.[12] In contrast, according to the FDA, serious adverse events following medication abortion—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."[13]

12. Dr. Wubbenhorst's suggestion that complications related to medication abortion are underreported to the FDA demonstrates her unfamiliarity with the FDA's regulation of medication abortion and how it monitors prescription drug safety more broadly. Wubbenhorst Decl. ¶¶ 91-95. She ignores that for fifteen years—from mifepristone's approval in 2000 until March 2016—the FDA specifically required that all mifepristone prescribers comprehensively report any serious adverse events associated with mifepristone to the drug manufacturer, and the manufacturer was then required to report all such events to the FDA. This mandatory reporting, imposed as part of the FDA's Risk Evaluation and Mitigation Strategy ("REMS") for mifepristone, included any hospitalizations, transfusions, serious infections, death, or "[o]ther serious and unexpected

[12] Audrey J. Weiss et al., *Adverse Drug Events in U.S. Hospitals, 2010 Versus 2014*, Agency for Healthcare Rsch. & Quality, at 4 (2018); *see also* Advancing New Standards in Reprod. Health, Univ. of Cal. S.F., *Analysis of Medication Abortion Risk and the FDA report, "Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2018"* (2019).

[13] Ctr. for Drug Evaluation & Rsch., *Application Number 020687Orig1s020: Medical Review(s)* U.S. Food & Drug Admin. 1, 47 (2016).

adverse events" associated with mifepristone, as well as ongoing pregnancies.[14] In 2016, the FDA's scientific review team lifted the REMS requirement that all serious adverse events associated with mifepristone be specially reported, explaining that the "FDA has received such reports for 15 years, and it has determined that the safety profile of Mifeprex is well-characterized, that no new safety concerns have arisen in recent years, and that the known serious risks occur rarely."[15] And, after reviewing those 15 years of comprehensive data, the FDA concluded that serious adverse events associated with mifepristone are "exceedingly rare."[16] In other words, the FDA's rigorous data collection for mifepristone far exceeds its data collection for most prescription drugs and aligns with the extensive body of high-quality research confirming that mifepristone is extremely safe.

13. The studies that Dr. Wubbenhorst and Dr. Bane reference in support of their claims that abortion has a high complication rate have serious limitations. For example, Dr. Wubbenhorst cites multiple studies from Finland by Gissler, et al., to support the argument that death rates are higher after abortion compared to childbirth up to 1 year. Wubbenhorst Decl. ¶ 183. However, this old study reported on pregnancy-associated mortality, defined as death while pregnant or within one year from the end of pregnancy, regardless of cause. The conclusions reached by Gissler et al. are thus flawed and unreliable because they include "all-cause mortality," such as homicide and accidental deaths, for

[14] Ctr. for Drug Evaluation & Rsch., *Application Number 020687Orig1s020: Risk Assessment and Risk Mitigation Review(s)*, U.S. Food & Drug Admin. 1, 10 (2016).

[15] Ctr. for Drug Evaluation & Rsch., Medical Review, *supra* note 13, at 8.

[16] *Id.* at 47.

which abortion cannot logically be the "cause."[17] To argue otherwise would require reliance on illogical correlations. For example, it would be inappropriate to claim that abortion "caused" a patient's death if they died in a car accident months after the procedure. Additionally, the CDC has robust data on deaths attributable to abortion in the U.S. The CDC concluded that the "national case-fatality rate for legal induced abortion for 2013-2019 was 0.43 deaths [] per 100,000 reported legal abortions."[18]

14. In addition, both cite a 2009 study by Niinimäki et al., Wubbenhorst Decl. ¶¶ 32-35; Bane Decl. ¶ 35, but that study included evaluations of medication abortion regimens that have never been used in the United States.[19] More critically, the Niinimäki study (1) was based on a Finnish health registry that coded all follow-up visits as "complications" regardless of the degree of concern; and (2) inappropriately reported "hemorrhage" as all patient reports of heavy bleeding, even if they were within the expected range for medication abortion and did not require treatment.[20] In response to criticism on these points, the authors themselves acknowledged that in the records they

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[17] Mika Gissler et al., *Pregnancy Associated Deaths in Finland 1987-1994: Definition Problems and Benefits of Record Linkage*, 76 Acta Obstetricia et Gynecologia Scandinavica 651 (1997): Mika Gissler et al., *Pregnancy-Associated Mortality After Birth, Spontaneous Abortion, or Induced Abortion in Finland 1987-2000*, 190 Am. J. Obstetrics & Gynecology 422 (2004).

[18] Katherine Kortsmit et al., *Abortion Surveillance—United States, 2020*, 71 Morbidity & Mortality Wkly. Rep. 1, 1, 6 (2022).

[19] Maarit Niinimäki et al., *Immediate Complications After Medical Compared with Surgical Termination of Pregnancy*, 114 Obstetrics & Gynecology 795, 796 (2009).

[20] Mary Fjerstad et al., *Letters to the Editor: Immediate Complications After Medical Compared with Surgical Termination of Pregnancy*, 115 Obstetrics & Gynecology 660 (2010); Niinimäki et al., *supra* note 19, at 799-800.

used, "many of the 'complications' are not really such, but rather concerns or adverse events that bring women back to the health care system. . . . [The] [r]ate of serious, 'real' complications is rare and rather similar between [procedural] and medical abortion."[21]

Abortion is Safer than Carrying a Pregnancy to Term and Giving Birth

15. Contrary to the Intervenors' experts' assertions, *see, e.g.*, Wubbenhorst Decl. ¶¶ 167-72, 179-85, abortion is much safer than carrying a pregnancy to term and childbirth.[22] As Dr. Farris highlighted in her first declaration (DE 49-1 ("First Farris Decl.") at ¶ 33-34) the United States has the highest maternal mortality rate among high-income countries,[23] and in 2021 alone, 1,205 people died of pregnancy-related causes in the U.S.[24] In 2021, the maternal mortality rate increased 40 percent from the previous year,[25] making the rate in the U.S. ten times higher than the estimated rate in other high-income countries.[26] And while the maternal mortality rate in the U.S. has significantly increased, the same has not been true for abortions. Leading researchers have found that

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[21] Fjerstad, *supra* note 20, at 660.

[22] Raymond & Grimes, *supra* note 6, at 217.

[23] Dr. Wubbenhorst uses data from studies in Finland to support her claim that "death rates [were] 4 times higher after abortion compared to childbirth," however this comparison is not appropriate given the United States' uniquely high maternal mortality and morbidity rates. *See* Wubbenhorst Decl. ¶ 183; *see also* Bane Decl. ¶ 33 (citing studies from Finland and other countries besides the U.S.).

[24] Selena Simmons-Duffin & Carmel Wroth, *Maternal Deaths in the U.S. Spiked in 2021, CDC Reports*, NPR (Mar. 16, 2023), https://www.npr.org/sections/health-shots/2023/03/16/1163786037/maternal-deaths-in-the-u-s-spiked-in-2021-cdc-reports#:~:text=The%20U.S.%20rate%20for%202021,deaths%20per%20100%2C000%20in%202020.

[25] Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2021*, Nat'l Ctr. for Health Stats.: Health E-Stats, at 1 (2023).

[26] Selena Simmons-Duffin & Carmel Wroth, *supra* note 24.

legal abortion is approximately 12-14 times safer than continuing a pregnancy through to childbirth.[27]

16. A 2015 study by Upadhyay and colleagues tracked any complications the study population experienced and confirmed that the complication rate for abortions is much lower than that for childbirth.[28] The study's authors examined billing data from a one-year period for women insured under California's Medicaid service, which covers abortion care.[29] The authors identified patients who obtained an abortion covered by California Medicaid through their policy number, including those who were treated for complications within six weeks of the abortion, either at the facility providing abortion care or an emergency department. They concluded that the rate of complication resulting from abortion was 2.11 percent, which includes both major complications (defined as necessitating hospitalization, surgery, or blood transfusion) and minor complications (all non-major adverse events) for all abortion methods in the first trimester, second trimester or later.[30] The majority of complications were minor.[31] For major complications the rate was 0.23 percent.[32] By comparison, the rate of severe complications from childbirth is 144

[27] Raymond & Grimes, *supra* note 6, at 216-17, 217 fig. 1; Nat'l Acads., *supra* note 6, at 37, 75 tbls. 2-4, 77-78.

[28] Upadhyay (2015), s*upra* note 6.

[29] *Id.* at 177.

[30] *Id.* at 179.

[31] *Id.* at 181.

[32] *Id.* at 179-81.

in 10,000, or 1.4 percent.[33] The study concluded that the abortion "complication rate is much lower than that found during childbirth and comparable to that found in the literature, even when [emergency department] visits are included and there is no loss to follow-up."[34]

17. Maternal mortality is not the only risk presented by pregnancy and birth. Every year, an estimated 50-60,000 women in the U.S. experience severe maternal morbidity,[35] or "unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health,"[36] and this rate has been on the rise over the last few decades.[37] Every pregnancy-related complication (such as hemorrhage, infection, and injury to other organs) is more common among people having live births than among those having abortions.[38]

18. Patients who carry their pregnancies to term may also face a multitude of pregnancy-related complications in the antenatal period, including gestational

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[33] *Reproductive Health: Severe Maternal Morbidity*, CDC, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/rates-severe-morbidity-indicator.htm (last visited Aug. 16, 2023).

[34] Upadhyay (2015), s*upra* note 6, at 181.

[35] William M. Callaghan et al., *Severe Maternal Morbidity Among Delivery and Postpartum Hospitalizations in the United States*, 120 Obstetrics & Gynecology 1029, 1034 (2012).

[36] *Severe Maternal Morbidity in the United States*, CDC, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last visited Aug. 16, 2023).

[37] *Rates in Severe Morbidity Indicators per 10,000 Delivery Hospitalizations, 1993–2014*, CDC, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/rates-severe-morbidity-indicator.htm (last visited Aug. 16, 2023).

[38] Raymond & Grimes, *supra* note 6, at 216, 217 fig.1.

hypertension, gestational diabetes, infection, preeclampsia, and depression and anxiety.[39] Pregnancy-related complications are unsurprisingly more common among patients who ultimately give birth than those who have an abortion, since pregnancies ending in abortion are substantially shorter than those ending in childbirth and thus entail less time for pregnancy-related problems to occur or progress.[40]

19. Meanwhile, although the risks associated with abortion increase with gestational age (as Intervenors' experts point out), because they are very low to begin with, abortion remains a very safe procedure even later in the second trimester.[41]

20. Moreover, the salient point from these studies is that once someone has decided to have an abortion, they should not face delays because there are increased risks associated with delaying the procedure and continuing the pregnancy. Therefore, obstacles to obtaining abortion care, like those challenged in this case, can cause patients avoidable harm.

Assertions that Alleged Reporting Deficiencies Compromise Data on Abortion Complications and Maternal Mortality are Without Merit

21. Drs. Wubbenhorst and Bane argue that abortion-related deaths and complications are subject to undercounting and underreporting, but this view is not supported by credible evidence. Further, they do not explain how underreporting of the

[39] *What Are Some Common Complications of Pregnancy?*, Nat'l Insts. of Health, https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/complications (last accessed Aug. 16, 2023).

[40] Raymond & Grimes, *supra* note 6, at 216-17.

[41] Suzanne Zane et al., *Abortion-Related Mortality in the United States, 1998–2010*, 126 Obstetrics & Gynecology 258, 262-63 (2015).

kind they suggest casts doubt on the consensus finding that abortion is less likely to end in complications and death than carrying a pregnancy to term.

22. Intervenors' experts' criticism of the Centers for Disease Control and Prevention's (CDC) data on abortion and abortion-related morbidity, on the theory that there is no comprehensive national data on the occurrence of complications from abortion, is misplaced. *See* Wubbenhorst Decl. ¶¶ 96-104; Bane Decl. ¶¶ 30-31. Importantly, there is also no national reporting requirement for non-mortality complications of pregnancy.

23. The CDC calculates the number of abortions and abortion-related deaths as part of its Pregnancy Mortality Surveillance System, which defines a pregnancy-related death as "a death while pregnant or within 1 year of the end of pregnancy from any cause related to or aggravated by the pregnancy"—a definition that includes both childbirth-related deaths and abortion-related deaths.[42]

[42] *Pregnancy Mortality Surveillance System*, CDC, https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm (last accessed Aug. 16, 2023). The CDC has monitored abortion-related deaths through its Pregnancy Mortality Surveillance System since 1987 using both voluntary reporting by states and other means including "state vital records; media reports, including computerized searches of full text newspaper and other print media databases; and individual case reports by public health agencies, including maternal mortality review committees, health care providers and provider organizations, private citizens, and citizen groups. For each death that possibly is related to abortion, CDC requests clinical records and autopsy reports. Two medical epidemiologists independently review these reports to determine the cause of death and whether the death was abortion related. Discrepancies are discussed and resolved by consensus. Each death is categorized by abortion type as legal induced, illegal induced, spontaneous, or unknown type." Tara C. Jatlaoui et al., *Surveillance Summaries: Abortion Surveillance — United States, 2015*, 67 Morbidity & Mortality Wkly. Rep. 1, 5 (2018).

24. Moreover, the CDC does not rely solely on voluntary reporting by states to generate this data, as Intervenors' experts suggest; it uses death records, linked birth records, fetal death records, and "additional available data from all fifty states, New York City, and Washington, DC."[43] And although the CDC does rely on voluntary reporting to calculate the total number of abortions performed each year, the vast majority of the central health agencies asked to report this data do so.[44] For instance, in 2020, the CDC "request[ed] abortion data from the central health agencies of the 50 states, the District of Columbia, and New York City," and "a total of 49 reporting areas" agreed to provide it.[45]

Intervenors' Experts' Opinions Regarding the Long-term Consequences of Abortion are Not Aligned with Medical Consensus

25. According to the National Academies of Science, Engineering, and Medicine, much of the published literature on abortion's long-term effects on future childbearing and pregnancy outcomes, risk of breast cancer, and adverse mental health outcomes "fails to meet scientific standards for rigorous, unbiased research."[46] The National Academies identified high quality research in these areas and concluded that

[43] CDC, *supra* note 42. Dr. Wubbenhorst is wrong to suggest that research based on Finnish death certificates is a more appropriate basis for calculating mortality rates in the United States. *See* Wubbenhorst Decl. ¶ 171. As the National Academies of Sciences, Engineering, and Medicine concluded, "no clear conclusions regarding the association between abortion and long-term mortality can be drawn from" those studies. Nat'l Acads., *supra* note 6, at 152.

[44] Kortsmit, *supra* note 18, at 1 (2022).

[45] *Id.*

[46] Nat'l Acads., *supra* note 6, at 152.

having an abortion does not increase the risk of preterm birth, breast cancer, or mental health concerns such as depression and anxiety.[47]

26. The Intervenors' experts largely disregard the National Academies report and official positions of professional organizations with specialized expertise that guide the work of OB/GYNs, including abortion providers. Instead, they focus on what they describe as serious data limitations in this area of study, while incorrectly arguing that abortion is uniquely dangerous in the field of obstetrics and gynecology, and medicine more generally. *See, e.g.*, Wubbenhorst Decl. ¶¶ 137-42. In so doing, they overlook high-quality research in the U.S. that refutes many of their critiques.

27. Dr. Bane claims that a prior abortion causes an increased risk of future preterm birth. Bane Decl. ¶¶ 37-38. However, past research is conflicting on any possible link between induced abortion and subsequent preterm birth. Many of these studies are national registry-based making it difficult to assess other confounding variables—factors that may increase both preterm birth and the need for induced abortion. Thus, ACOG has noted that a single induced abortion does not lead to future infertility but has not published guidance stating that induced abortion increases the risk of preterm birth. Additionally, the CDC does not list prior induced abortion as a risk factor for preterm birth. In its report on the quality and safety of abortion care, the National Academies assessed five studies that

[47] *Id.* at 153.

met their inclusion criteria for rigorous, high quality research and concluded that "having an abortion does not increase a woman's risk of . . . preterm birth."[48]

28. Dr. Wubbenhorst and Dr. Bane also opine that there are several studies showing that abortion leads to mental health issues. *See, e.g.*, Wubbenhorst Decl. ¶¶ 51-55; Bane Decl. ¶¶ 39-40. But these opinions rely on methodologically flawed research, including multiple studies by Priscilla Coleman, whose work has been repeatedly discredited by the scientific community.[49]

29. The American Psychological Association has emphatically rejected the notion that abortion is associated with adverse mental health outcomes—on the contrary, *restricting access* to abortion care is associated with worse mental health outcomes.[50] In the Turnaway Study, researchers assessed outcomes for patients who were able to obtain abortions versus those who wanted but could not access abortion care. Patients who had abortions were no more likely to report negative emotions or suicidal thoughts than those who could not obtain an abortion. Rather, patients who could not access an abortion reported more anxiety and stress, lower self-esteem, and lower life satisfaction than

[48] *Id.* at 9, 139-46.

[49] *E.g.*, Julia R. Steinberg et al., *Fatal Flaws in a Recent Meta-Analysis on Abortion and Mental Health*, 86 Contraception 430 (2012); Ellie Kincaid, *Article that Critiqued High-Profile Abortion Study Retracted*, Retraction Watch (Dec. 29, 2022), https://retractionwatch.com/2022/12/29/article-that-critiqued-high-profile-abortion-study-retracted/.

[50] Zara Abrams, *The Facts About Abortion and Mental Health*, Am. Psych. Ass'n, https://www.apa.org/monitor/2022/09/news-facts-abortion-mental-health (last updated Apr. 21, 2023).

patients who were able to obtain an abortion.[51] The APA Task Force on Mental Health and Abortion reached a similar conclusion, finding no greater risk of mental health problems among women who had abortions, including for those patients who chose to terminate a pregnancy because of a fetal anomaly.[52]

Procedural Abortions Can be Safely Provided in Outpatient Facilities

30. As I detailed in my first declaration, the vast majority of procedural abortions can be safely provided in an outpatient facility, and therefore there is no reason to categorically require that all abortions after the twelfth week of pregnancy in cases of rape, incest, or life-limiting fetal anomaly occur in a hospital. *See* First Boraas Decl. ¶ 39.

31. In my first declaration, I highlighted the fact that throughout the country, legal abortions are safely and routinely performed in doctors' offices and outpatient health center settings, and only 3% of abortions are performed in hospitals in the U.S. annually.[53] First Boraas Decl. ¶ 32. There are many reasons that patients justifiably prefer abortions in outpatient centers including shorter appointments, lower costs, sedation options, and

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[51] Corinne H. Rocca et al., *Emotions and Decision Rightness Over Five Years Following an Abortion: An Examination of Decision Difficulty and Abortion Stigma*, 248 Soc. Sci. & Med. 112704 (2020); M. Antonia Biggs et al., *Women's Mental Health and Well-being 5 Years After Receiving or Being Denied an Abortion*, 74(2) JAMA Psychiatry 169 (2017); *The Mental Health Impact of Receiving vs. Being Denied a Wanted Abortion,* Advancing New Standards in Reprod. Health (2018).

[52] Brenda Major et al., *Report of the APA Task Force on Mental Health and Abortion*, Am. Psych. Ass'n (2008).

[53] Rachel K. Jones et al., *Abortion Incidence and Service Availability in the United States, 2020*, 54 Persps. on Sexual & Reprod. Health 128, 134 tbl. 3 (2022).

treatment from staff and medical professionals with more experience providing abortions. *See* First Boraas Decl. ¶ 38.

32. Furthermore, while outpatient providers in North Carolina can provide procedural abortions at eleven weeks of pregnancy under the Act, they are not allowed to perform the same procedure at thirteen weeks of pregnancy. There is no difference in the technique or type of risks of an aspiration abortion at the eleventh week of pregnancy versus the thirteenth week of pregnancy.

33. Intervenors' experts describe certain complications that can arise as a result of an abortion after 12 weeks, but for the majority of patients such complications—which are exceedingly rare, as described above—can be treated in the outpatient clinic where the abortion was performed. In my experience, outpatient facilities are well-equipped to treat moderate bleeding, cervical lacerations or tears, and infections.

34. As I described in my first declaration, for patients with certain rare pre-existing conditions that markedly increase the risk of blood loss, such as placenta accreta spectrum disorder, or that require advanced monitoring during anesthesia such as cardiomyopathy or pulmonary hypertension, a hospital abortion may be favorable so that the provider has immediate access to blood products should a transfusion be needed. *See* First Boraas Decl. ¶ 39. In my experience, many times such patients will often seek a hospital abortion in the first instance because of their condition and the associated risks. But more importantly, these conditions are rare and there is no reason to require *all* patients

after 12 weeks to have abortions in hospitals so that these few patients may do so. It is the role of the physician to determine if hospital-based care is required in these rare cases.

35. No medical procedure is entirely risk free. As with many other types of procedures performed in outpatient settings, complications (though rare) may arise during an abortion which outpatient clinics are either well-equipped to treat, or have a protocol to ensure safe transfer to an emergency department. I understand from Dr. Farris's rebuttal declaration that PPSAT has such a protocol for safe transfer.

36. Dr. Bane claims that performing abortions in a hospital "prevents the need for transfer from an outpatient clinic to the nearest hospital facility should complications arise during the surgery, reducing the time for women to receive life-saving interventions." Bane Decl. ¶ 51; *see also* Wubbenhorst Decl. ¶ 216. But this is not necessarily the case. In my experience, transferring a patient between departments within the same hospital can vary greatly depending on the size of the hospital and where each department is located. For example, the operating room where patients are able to access abortion care may be in a different building on a medical campus than the desired unit for postoperative care, such as a surgical intensive care unit.

37. Intervenors' experts claim that hospitals are better equipped than outpatient facilities to support patients who have experienced sexual violence, abuse, or trafficking, but in my experience this too is not always the case. *See* Wubbenhorst Decl. ¶¶ 304, 307; *see also* Bane Decl. ¶ 52. Many providers of reproductive care, including outpatient providers like PPSAT, as I understand from Dr. Farris's rebuttal declaration, receive

training in order to identify patients who are victims of abuse or trafficking, and who have been coerced into either seeking an abortion or continuing a pregnancy, and help direct them to resources where they can receive support.

38. In my experience, not all physicians and staff employed at a hospital receive this type of training. Therefore, staff at the outpatient centers are often better trained to support patients who have experienced abuse, trafficking, or coercion.

39. Further, Dr. Wubbenhorst's statements regarding the instance and impact of coercion surrounding a person's decision to seek abortion are unsupported. *See* Wubbenhorst Decl. ¶ 291. Dr. Wubbenhorst assumes coercion is unidirectional—that people experience coercion only as an effort to force them to choose abortion. In reality, reproductive coercion takes many forms, including pressuring a person to become pregnant and carry a pregnancy to term or to have an abortion, pressuring or coercing a person to have sex, and threatening to leave a relationship if someone does not get pregnant.[54] While most people seeking abortion do not experience coercion, those who do may need extra support and a safe environment to discuss their experiences and options. I understand that PPSAT screens every patient for abortion coercion. Coercion screening is also required at the Planned Parenthood center where I provide care, and I understand it is a requirement that all Planned Parenthood providers ensure that patients considering abortion are not subjected to duress or to coercion of any kind.

[54] ACOG, *Committee Opinion No. 554: Reproductive & Sexual Coercion*, 121 Obstetrics & Gynecology 411, 411 (2013).

40. The Turnaway Study examined patients' experiences with abortion and unintended pregnancy in the U.S., and researchers found that among 954 participants, only one respondent used language that indicated overt pressure from their partner to get an abortion.[55] On the other hand, patients reporting intimate partner violence were more than three times as likely to identify their partner as a reason for wanting an abortion compared to patients not reporting intimate partner violence.[56] But those identifying an abusive partner as a reason for seeking an abortion reported that they were choosing abortion not because their partner was coercing them to do so. Rather, they perceived an abortion as their best option to end the abusive relationship.[57]

41. Intervenors' experts also claim that hospitals have more resources to support patients who have received fetal anomaly diagnoses. *See* Wubbenhorst Decl. ¶¶ 309-26; *see also* Bane Decl. ¶ 52. However, many times, the doctors providing the abortion are not the same doctors diagnosing the fetal anomaly. If the diagnosing doctor is not able to perform the abortion themselves, they may refer the patient to an outpatient provider like PPSAT. Normally, by the time I see a patient who is seeking an abortion due to a life-limiting fetal anomaly, the patient has already received detailed information about the fetal

[55] *See* Diana Greene Foster, *The Turnaway Study: Ten Years, a Thousand Women, and the Consequences of Having—or Being Denied—an Abortion* (2020) (The Turnaway Study studied patients from 21 states over 5 years).

[56] *Id.*

[57] Karuna S. Chibber et al., *The Role of Intimate Partners in Women's Reasons For Seeking Abortion*, 24 Women's Health Issues e131 (2014).

diagnosis and discussed their options with the provider who made the diagnosis and/or their obstetrician, and made the decision to have an abortion.

42. For instance, when I see patients seeking an abortion after receiving a fetal diagnosis from their perinatologist, their records reflect extensive patient education about the diagnosis, the prognosis, and options, including continuing the pregnancy, giving birth, and seeking perinatal hospice care. These patients have already made the extremely personal decision to terminate their pregnancy, and for the majority of these patients their abortion may be safely performed in an outpatient setting.

Medication Abortion is Safe and Effective for Patients with Pregnancies of Unknown Location

43. The Protocol (as defined in my first declaration, First Boraas Decl. ¶ 47) that I, PPSAT, and many other medical institutions use to safely provide medication abortion to patients with pregnancies of unknown location very early in their pregnancy has been shown to be safe and effective, both in research studies and in my daily practice.

44. Intervenors' experts' criticisms mischaracterize the Protocol and are reductive. Dr. Bane states that I and Dr. Farris "claim that HCG levels alone can be used to diagnose an ectopic [pregnancy]." Bane Decl. ¶ 62. This is not true. Dr. Farris and I described a Protocol in which multiple factors, including a detailed conversation with the patient to screen for ectopic pregnancy risks, combined with hCG testing, ultrasonography, and follow up conversations with the patient, are used to determine whether the patient is high- or low-risk for an ectopic pregnancy. First Boraas Decl. ¶ 47. While serial hCG levels are certainly an important factor, they are not the only factor.

45. Dr. Bane also criticizes the Protocol because "approximately one half of women accurately recall their last menstrual period (LMP)," Bane Decl. ¶ 55, implying that providers are making ectopic determinations based on incomplete information from the patients themselves. Her criticism again ignores the multifaceted nature of the Protocol, which does not rely on LMP alone to assess a patient's risk for ectopic pregnancy.

46. As stated in my first declaration, clinicians at both hospitals and outpatient health centers routinely provide detailed counseling and conduct a symptom assessment to identify patients at risk for ectopic pregnancies, including by considering known risk factors, symptoms, and prior and current health history—all of which can be assessed by a detailed conversation with the patient.[58] First Boraas Decl. ¶ 49.

47. When I conduct ectopic screening without ultrasound, I ask patients about their last menstrual cycle (date, timing, regularity, amount of bleeding and cramping, similarity to their regular menstrual cycle, presence of moliminal symptoms); whether they have had a prior ectopic pregnancy, or had treatment and/or hospitalization for pelvic inflammatory disease, or prior tubal sterilization; whether they were using hormonal birth control, an intrauterine device, or oral emergency contraception when they became

[58] *See, e.g.*, Abigail R. Aiken et al., *Effectiveness, Safety and Acceptability of No-Test Medical Abortion (Termination of Pregnancy) Provided via Telemedicine: A National Cohort Study*, 128 British J. Obstetrics & Gynaecology 1464, 1466 (2021) (explaining that patients "were offered a consultation via phone or video call, during which an assessment of eligibility for treatment via telemedicine was made," which included assessing whether "they had a low risk of ectopic pregnancy"); *see also* Upadhyay, Christy M. Boraas et al., *Outcomes and Safety of History-Based Screening for Medication Abortion: A Retrospective Multicenter Cohort Study*, 182 J. Am. Med. Ass'n Internal Med. 482 (2022).

pregnant; whether they have had a pregnancy recently and the outcome of that pregnancy; and whether they are experiencing any symptoms such as abdominal or pelvic pain and/or bleeding that was not typical for a menstrual cycle. I do not rely on one single piece of information to make my assessment.

48. Dr. Wubbenhorst criticizes the St. Paul Study[59] (as defined in my first declaration, First Boraas Decl. ¶ 44), claiming that the rates of loss to follow up were "very high" and thus "no conclusions can be drawn related to risk for complications." Wubbenhorst Decl. ¶ 359. However, the loss to follow up rates of the St. Paul Study are consistent with those documented in abortion care literature and a known general limitation of retrospective research studies. In my experience, patients who experience problems do return for care, making the most likely outcome for those who do not follow up a successful, uncomplicated abortion. Furthermore, in my experience of using the Protocol to administer medication abortion in cases of pregnancies of unknown location, I have seen firsthand that it is a safe and patient-centered practice.

49. Dr. Wubbenhorst also criticizes the Goldberg study,[60] claiming that practitioners took too long to diagnose the pregnancy location for patients that initially presented with a pregnancy of unknown location. *See* Wubbenhorst Decl. ¶ 388. However, because these patients were seeking medical intervention at earlier gestational ages than

[59] Karen Borchert, Christy Boraas et al., *Medication Abortion and Uterine Aspiration for Undesired Pregnancy of Unknown Location: A Retrospective Cohort Study*, 122 Contraception 109980 (2023).

[60] Alisa B. Goldberg et al., *Mifepristone and Misoprostol for Undesired Pregnancy of Unknown Location*, 139 Obstetrics & Gynecology 771, 778 (2022).

most pregnant people do, the Protocol actually led to *earlier* exclusion of ectopic pregnancy than waiting to see whether an intrauterine pregnancy could be diagnosed by ultrasound.[61] Both the St. Paul Study and the Goldberg study showed that early medication abortion is safe for patients that have pregnancies of unknown location who have been screened and determined to be low risk for an ectopic pregnancy.

50. Intervenors' experts incorrectly imply that mifepristone is harmful to patients who have an ectopic pregnancy or who are miscarrying. *See* Wubbenhorst Decl. ¶¶ 246-63 (stating that because ectopic pregnancy is listed as a contraindication on the mifepristone product labeling, it therefore must be ruled out before using mifepristone); *see also* Bane Decl. ¶ 61. However, although mifepristone is not FDA approved for the *treatment* of an ectopic pregnancy (and therefore, is listed as a contraindication), a patient with an ectopic pregnancy who takes mifepristone will not be directly harmed by the medication. Likewise, a patient who is experiencing a miscarriage will not be directly harmed by mifepristone. Although the patient will not be harmed, it is important to identify a patient who has an ectopic pregnancy or is miscarrying, which is why the Protocol includes a robust screening process and emphasizes close surveillance and follow up with each patient. Additionally, the medication regimen of mifepristone and misoprostol is the evidence-based therapy for medical management of miscarriage.

51. Research has shown that the incidence of ectopic pregnancy diagnosis following medication abortion is extremely low (0.02 percent), indicating that pretreatment

[61] *Id.*

screening methods are highly successful.[62] Further, there is no evidence to suggest that medication abortion treatment leads to unusual complications for women with ectopic pregnancies.[63]

52. Dr. Bane also criticizes PPSAT's off-label use of mifepristone through 77 days of pregnancy, Bane Decl. ¶ 54, but ignores the fact that the Act *permits* medication abortion "during the first 12 weeks of a woman's pregnancy." Section 90-21.81B(2). What's more, off-label drug use is common in the medical field, and the off-label usage of mifepristone has been shown to be safe at more advanced gestations than that approved by the FDA.[64] I understand that Plaintiffs provide first-trimester medication abortion through 77 days, which is a safe and common evidence-based practice which I offer to my patients as well.[65]

53. Dr. Bane further criticizes the Protocol, stating that a "woman with an ectopic pregnancy may actually confuse the pain and bleeding of a ruptured ectopic pregnancy with the severe pain and bleeding experienced by chemical abortion drugs." Bane Decl. ¶ 61. In my experience, this is extremely unlikely because generally patients with ectopic

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[62] Caitlin Shannon et al., *Ectopic Pregnancy & Medical Abortion*, 104 Obstetrics & Gynecology 161, 161 (2004).

[63] *Id.*

[64] ACOG, *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.

[65] *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).

pregnancy experience sharp, severe and typically unilateral lower abdominal pain that differs from the more midline cramping and discomfort medication abortion patients often experience. Again, this is why the Protocol includes educating patients about what to expect during a medication abortion, signs and symptoms more associated with ectopic pregnancy and detailed information about what signs or symptoms should prompt immediate evaluation in an emergency department, and recommends close follow up with patients to ensure that the abortion was completed.

54. Finally, both Dr. Wubbenhorst and Dr. Bane criticize the practice of no-touch ectopic screening and my research showing that use of an ultrasound to rule out an ectopic pregnancy is not medically indicated for most patients. *See* Wubbenhorst Decl. ¶¶ 394-407; Bane Decl. ¶ 60. Contrary to their claims, no-touch screening does not "disregard[]" the seriousness of ectopic pregnancy, and I do not provide medication abortion to patients without assessing gestational age and evaluating for ectopic pregnancy, as Dr. Wubbenhorst suggests. Wubbenhorst Decl. ¶¶ 395, 398. Rather, as discussed above, research and my personal experience have shown that, after thorough screening conversations with patients and trusting that a patient is the most informed person about their own body, it is safe to provide medication abortion to patients whom a physician has determined to be at a low risk for an ectopic pregnancy.[66]

[66] *See* Ushma D. Upadhyay, Christy Boraas (2022), *supra* note 58; Holly A. Anger, Christy Boraas et al., *Clinical and Service Delivery Implications of Omitting Ultrasound Before Medication Provided Abortion via Direct-To-Patient Telemedicine and Mail in the U.S.*, 104 Contraception 659 (2021).

55. If a patient is not determined to be low risk, it would not be appropriate to go forward with a medication abortion, and the patient would be counseled to seek further assessment to determine whether they have an ectopic pregnancy. To be clear, if a patient is determined to be at risk for an ectopic pregnancy, medication abortion is not prescribed.

56. Dr. Bane cites the 2018 ACOG Bulletin to support her position that ultrasounds are required for ectopic evaluation. Bane Decl. ¶ 60. The Bulletin states that "the minimum diagnostic evaluation of a *suspected* ectopic pregnancy is a transvaginal ultrasound evaluation and confirmation of pregnancy."[67] I agree—if an ectopic pregnancy is suspected, ultrasonography is required to ultimately determine the location of the pregnancy. However, if a patient is determined to be low risk—i.e., an ectopic pregnancy is *not suspected*—then ultrasound confirmation of an intrauterine pregnancy is not required before administration of medication abortion in accordance with the Protocol.

57. The safety of my patients is my top priority. As research and my personal experience have shown, with the proper protocol, counseling, surveillance, and follow-up, medication abortion may be safely and effectively administered to low-ectopic-risk patients with pregnancies of unknown location who prefer that method of treatment. Thus, there is no medical reason to require the confirmation of an intrauterine pregnancy before administering medication abortion.

[67] ACOG, *Tubal Ectopic Pregnancy*, 131 Obstetrics & Gynecology e65, e66 (2018) (emphasis added).

* * *

58. In sum, the Hospitalization Requirement and IUP Documentation Requirement impede patient access to care and do not improve patient safety. My opinion is supported by the research cited above, by my education and clinical training, and by my own experiences. Abortion is a critical component of reproductive health care. Nothing in the declarations of Dr. Wubbenhorst and Dr. Bane alters the conclusions I reached or the opinions I expressed in my prior declaration. Instead, Dr. Wubbenhorst's and Dr. Bane's declarations include false and misleading information and inflammatory language that serves only to perpetuate the harmful stigma surrounding abortion.

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

Dated: August 18, 2023

Christy M. Boraas Alsleben, M.D., M.P.H.

EXHIBIT 2

PLANNED PARENTHOOD SOUTH ATLANTIC, *et al.*,	)	
Plaintiffs,	)	Case No. 1:23-cv-00480-CCE-LPA
v.	)	**REBUTTAL DECLARATION OF KATHERINE FARRIS, M.D., IN SUPPORT OF PLAINTIFFS' AMENDED MOTION FOR A PRELIMINARY INJUNCTION**
JOSHUA STEIN, *et al.*,	)	
Defendants,	)	
and	)	
PHILIP E. BERGER, *et al.*,	)	
Intervenor-Defendants.	)	

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

1. I have reviewed the declarations of Drs. Monique Chireau Wubbenhorst and Susan Bane and in response offer the following additional information about Planned Parenthood South Atlantic ("PPSAT"), my medical practice, the Hospitalization Requirement, and the IUP Documentation Requirement. This rebuttal report responds to certain of the statements and opinions expressed in the reports I reviewed; the fact that I do not address every statement or issue raised in their reports does not suggest that I agree with them.

2. I previously submitted a declaration in this case, which I executed on July 24, 2023. Decl. of Katherine Farris, M.D., in Supp. of Pls.' Am. Mot. for Prelim. Inj. ("First Farris Decl."), DE 49-1. That declaration described my qualifications as a board-certified

physician licensed to practice medicine, an expert in abortion care, and PPSAT's Chief Medical Officer.

3. Like the opinions in my original declaration, the opinions in this rebuttal declaration 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.

The Safety of Abortion and PPSAT's Handling of its Rare Complications

4. Intervenors' experts go to great lengths to characterize abortion as unsafe and risky. However, the reality remains that abortion is extremely safe. *See* First Farris Decl. ¶¶ 29-47.

5. Complications from abortions are exceedingly rare, both generally and at PPSAT in particular. Drs. Wubbenhorst and Bane refer to the risk of hemorrhage. *See, e.g.*, Decl. of Monique Chireau Wubbenhorst, M.D., M.P.H. ("Wubbenhorst Decl."), DE 65-1 ¶ 151 , Decl. of Susan Bane, M.D., Ph.D. ("Bane Decl."), DE 65-3 ¶ 35. First, a small amount of bleeding during a procedural abortion is expected and managed; the average procedural abortion patient loses less than 100 cubic centimeters ("ccs") of blood. For comparison, blood loss during a vaginal delivery is closer to 400 ccs in the majority of patients, and blood loss during a Cesarean section is often greater. Hemorrhage, generally understood as losing 500 or more ccs of blood, is rare during a procedural abortion.

Moreover, PPSAT is equipped to treat blood loss in our clinics on the rare occasions when it is necessary to do so. Treatment methods include providing medications (such as misoprostol, methergine, tranexamic acid, or pitocin) or mechanical interventions (such as re-suction, uterine massage, or intrauterine tampenade with a foley catheter) depending on the circumstances of the case. Many of these same treatments would be provided in a hospital in similar circumstances, and they are usually adequate to treat heavy bleeding. Dr. Wubbenhorst's assertion that PPSAT cannot manage potential hemorrhage because of staffing logistics, Wubbenhorst Decl. ¶ 287, is incorrect. For virtually all of the small number of patients affected, hemorrhage happens during or immediately after a procedural abortion, at which point PPSAT is able to treat the patient on-site or, in rare cases, transfer the patient to a hospital for additional care. From January 2020 to June 2023, 0.04% of PPSAT patients in North Carolina were transferred to a hospital for treatment of hemorrhage following an abortion.

6. Another infrequent complication is infection, but this would not develop at the time the patient is in the health center (or the hospital) for an abortion. Rather, it would manifest days after a patient has a procedural abortion or after a medication abortion patient has taken the second medication. If a patient later presents with symptoms of endometritis, which is inflammation of the uterine lining, we confirm endometritis with a physical exam and/or an ultrasound. We then treat the patient with an antibiotic injection, followed up by oral antibiotics. We do a follow-up appointment 48-72 hours after starting antibiotics to make sure that the patient is improving, then have them finish their course

of oral antibiotics and return for another follow-up appointment within seven days. If there is retained pregnancy tissue in the uterus — which is also rare — we offer the patient additional treatment to remove the tissue using medication or a suction procedure. This would be the same treatment as if a patient presented after having an abortion at a hospital.

7. Cervical lacerations from procedural abortion are also incredibly rare. When they do occur, PPSAT is able to treat them with stitches. From January 2020 through June 2023, none of PPSAT's North Carolina abortion patients required hospital transfers as a result of cervical lacerations. Uterine perforation is similarly rare and would be treated with either transfer to a hospital or, if the patient is completely stable, close observation and follow-up. From January 2020 through June 2023, 0.005% of abortion patients at PPSAT in North Carolina were transferred to a hospital for treatment of uterine perforation. Similarly, perforation of the colon (which is much more dangerous, because it exposes the membrane lining the walls of the abdominal cavity to bowel bacteria) can occur during a colonoscopy, and colonoscopies are not required to be performed in hospitals.

8. Overall, PPSAT transferred 31 of its 38,795 North Carolina abortion patients to hospitals in three and a half years. Only 7 of those patients required admission, and all 31 were released in stable condition. These infrequent emergency transfers are not logistically difficult, since PPSAT has relationships with hospitals close to our clinics and we have clear protocols for emergency management while we are awaiting transport and for a smooth hand-off to the receiving institution.

9. The Intervenors and their experts suggest that the Hospitalization Requirement is not burdensome because I and the other PPSAT physicians can just obtain hospital admitting privileges and perform abortions at hospitals. That is not the case. Requiring our physicians to obtain admitting privileges at hospitals would be prohibitively difficult. Admitting privileges are a business agreement based on the amount of business that a health care provider does with a hospital. Because abortion is so safe and hospital transfers are so rare, it would be incredibly difficult and time-consuming for me and other PPSAT providers to obtain them.

10. Furthermore, expense to our patients is also a factor. As I mentioned in my prior declaration, some of the abortions that PPSAT provides are for patients who have been referred to us by hospital providers. First Farris Decl. ¶ 8. Many of those patients prefer to receive an abortion at PPSAT because receiving one in a hospital would be prohibitively expensive. Requiring hospitalization would hurt many people's ability to receive care. Indeed, many abortion providers specifically choose to work in outpatient clinics because we know we will be providing care in settings where all of the patient-facing staff are supportive and non-judgemental of that care and where the care will be much more affordable to patients.

PPSAT's Treatment of Patients with Pregnancies of Unknown Location

11. Contrary to the assertions made by Drs. Wubbenhorst and Bane, the ability to provide immediate abortion care for patients with pregnancies of unknown location offers important benefits to those patients without compromising their safety. *See* Decl.

of Christy M. Boraas Alseben, M.D., M.P.H. in Supp. of Pls.' Am. Mot. for a Prelim. Inj. (DE 49-2) ("First Boraas Decl.") ¶¶ 41-51. Dr. Wubbenhorst in particular states repeatedly that ectopic pregnancy is a contraindication to medication abortion. *See* Wubbenhorst Decl. ¶¶ 247, 251. However, this is not because there is any safety issue with the provision of medication abortion to a patient with an ectopic pregnancy, as she implies, but rather because medication abortion does not treat ectopic pregnancy—i.e., it is not effective, but it is also not harmful as she suggests. PPSAT's protocol for treating patients whose pregnancies are too early to see by ultrasound and who are at low risk of ectopic pregnancy both ensures the timely provision of abortion care *and* that the patient receives further testing to identify or rule out ectopic pregnancy. *See* First Farris Decl. ¶¶ 51-59.

12. We screen patients with pregnancy of unknown location in a variety of ways, including by obtaining a detailed menstrual history, pregnancy history (including history of prior ectopic pregnancy), contraceptive history, and symptom evaluation. Medication abortion is only offered to patients with low risk of ectopic pregnancy, and all of these patients are educated on signs and symptoms to watch for so that they can contact the clinic for further guidance or even report to the emergency department if needed. As my prior declaration describes, when medication abortion is provided to this group of patients, we also draw a blood sample to test the level of the pregnancy hormone human chorionic gonadotropin ("hCG"). *Id*. ¶ 54. Each patient in this situation leaves the clinic with a plan for when to do their next blood test. *See id.* ¶ 56. We warn patients, both verbally and in writing, that an untreated ectopic pregnancy could result in their death, and we conduct

multiple follow-up phone calls. If the provider evaluating the patient has a clinical suspicion of ectopic pregnancy, medication abortion is not offered; rather, the patient is immediately referred for further ectopic evaluation and management.

The General Quality of PPSAT's Care

13. Dr. Wubbenhorst incorrectly implies that hospitals are subject to robust health, safety, and record-keeping standards, whereas abortion clinics are not. *See* Wubbenhorst Decl. ¶¶ 232-36. This characterization is wholly inaccurate. As Dr. Wubbenhorst herself acknowledges, *id.* ¶ 232, the North Carolina Department of Health and Human Services inspects all abortion-providing facilities annually.[1] Abortion providers are also required to submit reports of each abortion "within 15 days after either the (i) date of the follow-up appointment following a medical abortion, (ii) date of the last patient encounter for treatment directly related to a surgical abortion, or (iii) end of the month in which the last scheduled appointment occurred, whichever is later."[2]

14. Additionally, Dr. Wubbenhorst's statements regarding the impact of influence, pressure, and coercion surrounding a person's decision to seek abortion are deeply flawed, and her characterization of PPSAT's practices regarding reproductive coercion are inaccurate and offensive. *See* Wubbenhorst Decl. ¶¶ 290-305. PPSAT screens for abortion coercion and assesses decisional certainty as part of our informed consent and counseling process. We ask every patient a series of questions to assess their confidence

[1] N.C. Gen Stat. § 90-21.81C(g).
[2] *Id.* § 90-21.93.

and whether they have been pressured either to obtain an abortion or to remain pregnant. We ask them these questions without anyone else present in the room, even if a partner or other support person is present for all other parts of the visit. The purpose of these discussions is, among other things, to ensure the patient has considered their options; is confident in their decision to have an abortion; and is making an informed and voluntary decision. During this process, staff are trained to pay close attention to the patient's body language cues in addition to the patient's verbal responses. On the rare occasion a patient exhibits signs of ambivalence or suggests they are not firm in their decision, regardless of whether coercion is a factor, the staff member takes time to explore those feelings with the patient and discuss all their options, including continuing the pregnancy.

15. In my experience, patients sometimes experience negative emotions, not because they are uncertain about their decision to have an abortion, but because of the stigma that people seeking abortions face in North Carolina. While the majority of North Carolinians did not support the law challenged in this case,[3] abortion remains politically stigmatized, and abortion patients often have to pass by anti-abortion extremists outside clinics before they are able to obtain care.

16. Dr. Wubbenhorst also states that she does not know whether abortion clinics can "provide resources to assist women in crisis while engaging law enforcement."

[3] Steve Doyle, *Poll Says Most North Carolinians Don't Support Abortion Restrictions Recently Passed by General Assembly*, Fox 8 (May 11, 2023) https://myfox8.com/news/north-carolina/poll-says-most-north-carolinians-dont-support-abortion-restrictions-recently-passed-by-general-assembly/.

Wubbenhorst Decl. ¶ 304. In fact, that is exactly PPSAT's approach. If a patient indicates that they fear violence if they do not obtain an abortion, staff will offer to engage law enforcement. If the patient feels that involving law enforcement would increase rather than lessen the danger they are in, we will provide the patient with a safe area in the health center from which they may reach out to resources we suggest in order to develop a safety plan. If a patient indicated that they were being threatened and would not otherwise want an abortion, we would not perform one.

Abortion Restrictions Disproportionately Harm Marginalized Communities

17. In an apparent attempt to shock readers, Dr. Wubbenhorst claims that "abortion is a eugenic tool of injustice." Wubbenhorst Decl. ¶ 25. But Dr. Wubbenhorst's assertion that abortion care is driven by eugenics is radically flawed, stigmatizing, and a pretext for treating Black people and people of color as though they are incapable of making their own medical decisions. Ironically, the hallmark of eugenics, ignored by Dr. Wubbenhorst, was the adoption of policies allowing the state to make reproductive decisions for patients, in service of state aims, thus restricting or limiting personal autonomy over reproduction—which is exactly what the law challenged here does.

18. Dr. Wubbenhorst fails to provide any evidence that Black people are being targeted by abortion providers with racist intentions. Instead, she states only that in 2020, 52% of the North Carolinians who received abortions were Black women, and that "[t]he percentage of black women undergoing abortion in North Carolina is higher than the national average." Wubbenhorst Decl. ¶¶ 23-24. This argument wrongly suggests that

Black people are passive recipients of abortion care. To the contrary, the Black patients I care for are completely capable of making thoughtful decisions about their reproductive health, just as my white patients are.

19. Advocacy by Black feminists and scholars for a range of reproductive health options, including birth control and safe abortion access, persists today. The claim that "abortion among black women is part of a genocidal plot against black people . . . [has] been rejected—time and again over the years."[4] My Black patients and other patients of color who seek abortion care do so in order to exert their autonomy over their reproductive lives to do what is in their best interest, as well as that of their families. Dr. Wubbenhorst's overreliance on racial disparities in abortion rates is misplaced and fails to recognize the socioeconomic factors that drive higher abortion rates among Black people,[5] as well as the agency Black people are entitled to exercise in determining their reproductive lives.

[4] Br. of Amici Curiae Reprod. Just. Scholars Supporting Pet'rs-Cross-Resp'ts at 19, *June Med. Servs., LLC v. Russo*, 140 S.Ct. 2103 (2020) (Nos. 18-1323, -1460).
[5] Katy Backes Kozhimannil et al., Abortion Access as a Racial Justice Issue, 387 New Eng. J. Med. 1537 (2022).

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

Dated: August 18, 2023

Katherine A. Farris, M.D.

EXHIBIT 3

NO. 22-CI-3225

JEFFERSON CIRCUIT COURT
DIVISION THREE
JUDGE MITCH PERRY

EMW WOMENS
SURGICAL CENTER, et al. PLAINTIFFS

v.

DANIEL CAMERON, et al. DEFENDANTS

OPINION & ORDER GRANTING TEMPORARY INJUNCTION

Introduction

This matter comes before the Court on Plaintiffs' Motion for a Temporary Injunction. The Court held a Hearing on July 6, 2022 where the parties presented expert witness testimony. Both parties have filed proposed Findings of Fact and Conclusions of Law. After careful consideration of the record and the memoranda of the parties, as well as the applicable law, the Court determines that the Temporary Injunction should be granted.

The Plaintiffs have sustained their burden of demonstrating substantial questions on the merits regarding the constitutionality of the challenged laws. As discussed further below, the Court finds that there is a substantial likelihood that these laws violate the rights to privacy and self-determination as protected by Sections 1 and 2 of the Kentucky Constitution, the right to equal protection in Sections 1, 2, and 3, the right to religious freedom in Section 5, and that additionally KRS 311.772 is both an unconstitutional delegation of legislative authority and unconstitutionally vague. For all of these reasons, the Plaintiffs are entitled to injunctive relief pending full resolution of this matter on the merits.

Findings of Fact

I. Procedural Background

On June 24, 2022, the United States Supreme Court issued its opinion in *Dobbs v. Jackson Women's Health Organization*, 142 S.Ct. 2228 (2022). The Supreme Court in *Dobbs* entirely overruled *Roe v. Wade*, 410 U.S. 113 (1973), and returned the issue of abortion to the states. The Attorney General contended that KRS 311.772 ("Trigger Ban") was thereby triggered and became effective on June 24, 2022. On June 27, 2022, the Plaintiffs, two clinics that provide abortions, among other medical services, and the doctor-owner of one of the clinics, filed this lawsuit challenging the constitutionality of the Trigger Ban and KRS 311.7701-7711 ("Six Week Ban"), and seeking a Temporary Restraining Order ("TRO") pending a hearing and ruling on a Temporary Injunction.

The Court held a hearing on June 29, 2022 to consider the TRO. After hearing arguments of all parties, the Court reviewed the filings and subsequently granted the TRO. The Court then held a full evidentiary hearing for the Temporary Injunction on July 6, 2022. Each side presented two expert witnesses. Dr. Ashlee Bergin and Dr. Jason Lindo testified for the Plaintiffs, while Dr. Monique Wubbenhorst and Professor O. Carter Snead testified for the Defendants. After the hearing was concluded, the Court requested the parties file proposed Findings of Fact & Conclusions of Law.

II. Factual Findings

The Plaintiffs are healthcare providers who also provide abortions in Kentucky. Prior to *Dobbs*, EMW Women's Surgical Center ("EMW") provided medication abortion up to 10 weeks from the last menstrual period ("LMP"), and procedural abortion through 21 weeks and 6 days from the LMP. Since entry of the TRO, EMW provides medication abortion up to 10 weeks from the LMP and procedural abortion up to 15 weeks.

The second Plaintiff, Planned Parenthood Great Northwest, Hawai'i, Alaska, Indiana, and Kentucky ("Planned Parenthood"), provides a variety of medical services to patients, and has also been providing abortion services in Louisville, Kentucky since 2020. Before *Dobbs*, Planned Parenthood provided medication abortion up to 10 weeks from LMP, and procedural abortion up to 13 weeks and 6 days from the LMP. After entry of the TRO, Planned Parenthood resumed abortion services as before *Dobbs*.

The final Plaintiff is Dr. Ernest Marshall, a board-certified obstetrician-gynecologist ("OBGYN") who performs abortions at EMW, and is also the owner of EMW.

Defendant Daniel Cameron is the Attorney General of Kentucky. In this role, he has the statutory authority, and duty to ensure proper enforcement and compliance with the laws of the Commonwealth. Defendant Eric Friedlander is the Secretary of the Cabinet for Health and Family Services ("the Cabinet"). In that role, he is responsible for the oversight and licensing of facilities that provide abortions to ensure they comply with applicable state laws. Defendant Michael Rodman is the Executive Director of the Kentucky Board of Medical Licensure ("the Board"). The Board possesses the authority to pursue disciplinary actions against Kentucky physicians for violations of state law. Finally, Defendant Thomas Wine is the Commonwealth's Attorney for the 30th Judicial Circuit. In this capacity, he has authority to pursue criminal prosecutions for crimes committed in Jefferson County.

At the July 6th Hearing, the Plaintiffs first called Dr. Ashlee Bergin. Dr. Bergin is a board-certified OBGYN who provides care at EMW, as well as teaching at the University of Louisville Medical School. Dr. Bergin testified at length regarding the complications that can arise from pregnancy, the relative safety of abortions, and the harms that can result from lack of access to abortions. Video Record ("VR") 10:12:21-10:13:04; 10:13:35-10:13:55; 10:15:50-10:16:15; 10:17:04-10:17:16. The latest records from the Kentucky Department of Public Health Office of Vital Statistics show that of the 4,104 abortions provided in Kentucky in 2020, there were only 30 complications, the majority of which were minor. Pls.' Ex. 3 at 12. Further, there were zero recorded deaths from abortion complications in Kentucky in 2020, whereas there were 16.6 per 100,000 pregnancy-related deaths in 2018, the last year data is available. Pls.' Ex. 3 at 12; Pls.' Ex. 10 at 10. Dr. Bergin testified that at the date of the hearing, EMW had turned away approximately 200 patients, before the TRO was entered. VR 10:20:25-10:20:41. Dr. Bergin also testified that the narrow medical emergency exceptions in the laws at issue are insufficient because it is medically and ethically unacceptable to force a patient deteriorate to the point at which she would become clearly eligible for the exception. VR 10:18:10-10:18-38.

The Plaintiffs next called Dr. Jason Lindo, an economist and causal effects expert. Dr. Lindo testified about the impacts abortion bans have on people, and the likely impact if these abortion bans take effect. Dr. Lindo testified that prenatal care and childbirth are very costly, even to those with medical insurance. VR 12:05:34-12:06:23. Further, these costs are not limited

to purely monetary ones. Pregnancy can lead to significant disruptions to a woman's education and career[1]. VR 12:07:31-12:08:04. Not all Kentuckians are legally protected from pregnancy discrimination in the workplace, or entitled to the reasonable accommodations needed to perform their jobs while pregnant. KRS 344.030(2) (exempting employers with fewer than 15 employees from pregnancy discrimination laws). Additionally, many Kentuckians are not entitled to paid time off for pregnancy, delivery, or recovery. U.S. Dep't of Labor, National Compensation Survey: Employee Benefits in the United States, March 2021, Table 33.

Dr. Lindo further testified that while some Kentuckians will be able to travel to other states to access abortions, not all will be able to afford to, and others will be prevented by the similarly restrictive policies of surrounding states. VR 12:16:19-12:16:41; 12:23:16-12:27:40.

The Defendants first called Dr. Monique Wubbenhorst, an OBGYN and research fellow at the University of Notre Dame de Nicola Center for Ethics and Culture. Dr. Wubbenhorst testified that she questioned the accuracy of abortion statistics in general, but was unable to provide any evidence to support her criticism. VR 2:18:46-2:20:14; 3:01:17-3:01:46. She further challenged the accuracy of maternal mortality statistics, but again was unable to provide any evidence to support her criticisms. VR 2:16:12-2:18-45.

The Defendants also called O. Carter Snead, a professor at the University of Notre Dame Law School and the Director of the de Nicola Center for Ethics and Culture at Notre Dame. Professor Snead has contributed significantly to the field of public bioethics. Professor Snead testified about the ethical concerns of the data indicating that many women who receive abortions are poorer, minorities, or experiencing some sort of life disruption. VR 3:59:15-4:01:29. He expressed concern that these women lacked a real choice, and were likely coerced into obtaining abortions by outside factors. *Id.*

Both Defense witnesses generally expressed views that mirrored the positions of their institutional employer, namely that abortion should have no place in the practice of medicine and should not be provided even in the cases of fatal fetal anomalies, rape, or incest. VR 2:44:37-2:46:09. In a recent statement, the de Nicola Center reaffirmed that position: "The University of Notre Dame is institutionally committed to 'to the defense of human life in all its stages,' recognizing and upholding the sanctity of human life from conception to natural death (cf.,

[1] The Court recognizes that these laws will also impact members of the LGBTQ community. Accordingly, "woman" is used in this Order to refer to all people affected by these laws.

https://news.nd.edu/news/notre-dame-adopts-new-statement-and-principles-in-support-of-life/). For our part, the de Nicola Center is proud to advance that commitment through our own efforts and programming." de Nicola Center Director's Statement on Dobbs v. Jackson Women's Health Organization, June 24, 2022, https://ethicscenter.nd.edu/news/dcec-directors-statement-on-dobbs-v-jackson-womens-health-organization/.

Conclusions of Law

I. Statutory Review

KRS 311.772 ("Trigger Ban") and KRS 311.7701-7711 ("Six Week Ban") were both passed by the General Assembly in 2019. The Trigger Ban prohibits all abortions except in extremely limited medical situations "to prevent the death or substantial risk of death due to a physical condition, or to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman." KRS 311.772(4)(a). The Trigger Ban makes it a Class D felony for anyone to knowingly provide an abortion. KRS 311.772(3)(b). KRS 311.772 is referred to as a trigger law because it would only become effective by the issuance of a U.S. Supreme Court decision "which reverses, in whole or in part, *Roe v. Wade*, 410 U.S. 113 (1973)." KRS 311.772(2)(a).

The Six Week Ban criminalizes abortion once embryonic or fetal cardiac activity is detectable. KRS 311.7704(1); KRS 311.7706(1). This is activity usually detectable around the six week mark of pregnancy, as measured from the first day of the patient's last menstrual period. Like the Trigger Ban, the Six Week Ban provides only very limited medical exceptions, preventing the woman's death or substantial and irreversible impairment of major bodily function. KRS 311.7706(2)(a). A violation of the Six Week Ban is also a Class D felony. KRS 311.990(21)-(22); KRS 532.060(2)(d). Neither the Trigger Ban nor the Six Week Ban contain exceptions for cases of rape or incest.

II. Standing

Kentucky courts have "the constitutional duty to ascertain the issue of constitutional standing … to ensure that only justiciable causes proceed in court." *Commonwealth, Cabinet for Health & Fam. Servs., Dep't for Medicaid Servs. v. Sexton by & through Appalachian Reg'l Healthcare, Inc.*, 566 S.W.3d 185, 192 (Ky. 2018) (emphasis omitted). In *Sexton*, the Kentucky Supreme Court adopted the federal standard for standing as set forth in *Lujan v. Defenders of Wildlife*, 504 U.S. 555 (1992), holding that "for a party to sue in Kentucky, the initiating party

must have the requisite constitutional standing to do so, defined by three requirements: (1) injury, (2) causation, (3) redressability. In order words, [a] plaintiff must allege personal injury fairly traceable to the defendant's allegedly unlawful conduct and likely to be redressed by the requested relief." *Sexton*, 566 S.W.3d at 196.

Here, the Attorney General claims the Plaintiffs lack the standing to bring this suit because the facilities do not have third party standing to represent the rights of their patients. However, the Court finds that the Plaintiffs do have standing to proceed with this suit. While not binding, since Kentucky adopted the federal standing guidelines, federal cases provide persuasive authority. Federal courts have long allowed for third party standing in situations where "enforcement of the challenged restriction against the litigant would result indirectly in the violation of third parties' rights." *Warth v. Seldin*, 422 U.S. 490, 510 (1975). Third party standing should be allowed when: "(1) the interests of the litigant and the third party are aligned, and (2) there is an obstacle to the third party asserting her own rights." *Singleton v. Wulff*, 428 U.S. 106, 114-18 (1976).

Recently, the Supreme Court reaffirmed the practicality of third party standing for abortion providers in *June Medical Services LLC v. Russo*, 140 S.Ct. 2103, 2118 (2020). The Supreme Court concluded that abortion providers had third party standing to assert claims on behalf of their patients because the challenged laws regulated their conduct, including by threat of sanctions, the providers had every incentive to resist efforts at restricting their operations, and the providers were far better positioned than their patients to challenge the restrictions. *Id.* at 2119[2].

Turning then to the standing analysis. The challenged statutes directly prohibit the Plaintiffs from lawfully engaging in both medication and procedural abortions. The Attorney General is attempting to enforce these statutes against the Plaintiffs. An order of this Court preventing enforcement of these statutes would provide the Plaintiffs with adequate relief. Therefore, the Plaintiffs have satisfactorily established all the required elements of standing and can proceed with this suit.

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[2] The Defendants contend that the United States Supreme Court undermined third party standing in *Dobbs* to the point it can no longer be relied upon. While the United States Supreme Court expressed displeasure with how abortion related litigation had proceeded with the doctrine of third party standing, this comment came in dicta, and is therefore not binding upon this Court. *Dobbs*, 142 S.Ct. at 2276.

Relatedly, the other Defendants, the Kentucky Board of Medical Licensure, The Cabinet for Health and Family Services, and the Commonwealth's Attorney, have taken the position that relief should not be granted against them because the Plaintiffs' claims are purely speculative as they have not yet taken any enforcement actions against the Plaintiffs. For the same reasons, this argument is unpersuasive. The Plaintiffs have been forced to modify their medical services and practices in order to avoid the harm and sanctions envisioned by these statutes. The Commonwealth's Attorney could bring criminal prosecutions against the facilities and their practitioners. The Board of Medical Licensure and the Cabinet would then be empowered to bring administrative actions against the facilities and practitioners to prevent them from operating or even practicing medicine again in the state. The relief Plaintiffs seek would merely maintain the long-standing status quo while this litigation proceeds. With that context in mind, the Court concludes that all Defendants are properly before the Court and subject to the relief sought by the Plaintiffs.

III. Injunction Analysis

The standard for a temporary injunction is well established in Kentucky. The party moving for injunctive relief must show: (1) irreparable injury is probable if injunctive relief is not granted; (2) the equities – including the public interest, harm to the defendant, and preservation of the status quo – weigh in favor of the injunction; and (3) there is a "serious question warranting a trial on the merits." *Maupin v. Stansbury*, 575 S.W.2d 695, 699 (Ky. Ct. App. 1978). The Court will examine each of these factors.

A. Irreparable Harm

A party must first show that it will suffer irreparable harm if injunctive relief is not granted. An injury is irreparable if "there exists no certain pecuniary standard for the measurement of the damages." *Cyprus Mountain Coal Corp. v. Brewer*, 828 S.W.2d 642, 645 (Ky. 1992) (quoting *United Carbon Co. v. Ramsey*, 350 S.W.2d 454 (Ky. 1961). The Plaintiffs have demonstrated that they will indeed suffer irreparable harm without injunctive relief.

At the July 6th hearing, Dr. Bergin testified about the harms the Plaintiffs will suffer if injunctive relief is not provided. From the time when the Supreme Court's decision in *Dobbs* was handed down on June 24th to June 30th when the TRO was granted, EMW turned away almost 200 patients. These patients were denied previously scheduled medical care because of the legal uncertainty that resulted from the Trigger Ban and the Six Week Ban. Some of these women may

be able to reschedule their procedures, but others may not. Dr. Bergin testified that EMW has stopped providing abortions after 15 weeks.

Dr. Bergin also testified extensively to the harms and risks that can result from, and be exacerbated by, pregnancy. She testified that the risks presented by abortions are much lower, but do increase the later in the pregnancy the procedure is performed. Thus any delays in scheduling and performing an abortion comes with more serious risks.

Finally, waiting until final judgment on the issues presented here, without injunctive relief, would be effectively meaningless to many people because they would either be past gestational age restrictions or would have been forced to carry their pregnancy to term. Therefore, the Plaintiffs have demonstrated that they would suffer irreparable harm if injunctive relief is not provided.

B. Balance of Equities

Next the Court must consider whether the balance of equities weighs in favor of injunctive relief. This factor includes several components for courts to analyze. Courts balancing the equities of injunctive relief should consider "possible detriment to the public interest, harm to the defendant, and whether the injunction will merely preserve the status quo." *Maupin*, 575 S.W.2d at 699. The Court will examine each of the factors in order.

Public health concerns carry great weight in the public interest analysis. *Beshear v. Acree*, 615 S.W.3d 780, 830 (Ky. 2020). Plaintiffs assert, and this Court agrees, that abortion is a form of healthcare. It is provided by licensed medical professionals in licensed medical facilities, just like many other medical procedures. As such, the denial of this healthcare procedure is detrimental to the public interest.

Additionally, Dr. Lindo testified at length about the economic harms that Kentuckians would suffer under the laws at issue. Dr. Lindo noted that the burden of abortion bans falls hardest on poorer and disadvantaged members of society. By contrast the Defendants presented a baseless claim that the Plaintiffs are essentially advocating for eugenics and fewer minorities in Kentucky. This is a tired and repeatedly discredited claim[3]. It has no legal basis, and the Court disregards it as such.

[3] See further Melissa Murphy, *Race-ing Roe: Reproductive Justice, Racial Justice, and the Battle for Roe v. Wade*, 134 HARV. L. REV. 2025 (April 12, 2021).

Dr. Lindo also testified that these abortion bans will impose not just serious financial costs, but also educational and professional harms on Kentuckians. Pregnancy, childbirth, and the resulting raising of a child are incredibly expensive. Adding another child can put exponential strain on an already struggling family and lead to detrimental outcomes for all involved. An unplanned pregnancy can also derail a woman's career or educational trajectory. Across the United States, approximately 72% of women obtaining abortions are under the age of 30. Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 101 AM.J.PUB.HEALTH 1904, 1907 (2017). This is the stage of life where people are completing their education and establishing a career. All of this is not to say, as the Defendants' witness Professor Snead contends, that all young women who get abortions are financially coerced to do so. Indeed, quite the contrary. This is a decision that has perhaps the greatest impact on a person's life and as such is best left to the individual to make, free from unnecessary governmental interference. In the Court's view, denial of this healthcare option will have a detrimental impact on the public interest, satisfying the first prong of the injunctive relief analysis.

The Court must next consider if the Defendants will suffer any harm by the requested injunctive relief. The Court finds any harm the Defendants may suffer is outweighed by the interests of the Plaintiffs. At the outset, the Court notes the Supreme Court's opinion in *Dobbs* does not become final until 25 days after it was issued on June 24, 2022. Sup. Ct. R 45. Judge Glenn Acree noted in the related appellate court proceedings, 2022-CA-0780, the Defendants will at most suffer the harm of delayed enforcement, as the earliest this law became enforceable was July 19, 2022. This harm, when balanced against the harms of the Plaintiffs, is not sufficient to preclude injunctive relief.

Further, as long recognized, the state has no interest in enforcing an unconstitutional law. *See Harrod v. Whaley*, 239 S.W.2d 480, 482 (Ky. 1951). As the Court will explain further below, the Plaintiffs have established significant doubt as to the constitutionality of the laws at issue. Accordingly, the state's interest in enforcing these laws is uncertain at this stage.

Finally, the requested injunctive relief will merely restore the status quo that has existed in Kentucky for nearly fifty years. This factor weighs strongly in favor of granting the injunctive relief. Based on all of these considerations, the Court finds the balance of equities weighs in favor of granting injunctive relief.

C. Serious Questions Raised

The final factor courts must examine when considering injunctive relief is whether there are serious questions presented that warrant trial on the merits. For the reasons stated below in Section IV, the Court concludes that the Plaintiffs have identified, and sufficiently supported, serious questions such that injunctive relief is warranted.

IV. Constitutional Analysis

At the outset, the Court notes that, despite what some suggest, the inquiry does not end simply because the word "abortion" is not found in the Kentucky Constitution. The Constitution must protect more than just the words explicitly enumerated on the page in order for the purpose behind the words to have effect. To hold otherwise ignores the realities of how constitutions, and laws more generally, are written. It is impossible for any legislative or constitutional body to enumerate every possible future scenario and application. Instead, bodies craft broad sentiments, ideas, and rights they value and choose to protect. It is then the role of the judiciary to interpret the enumerated words and give effect to the meaning behind them. Indeed, "to declare the meaning of constitutional provisions is a primary function of the judicial branch in the scheme of checks and balances that has protected freedom and liberty in this country and in this Commonwealth for more than two centuries. The power of judicial review is an integral and indispensable piece of the separation of powers doctrine. To desist from declaring the meaning of constitutional language would be an abdication of our constitutional duty." *Bevin v. Commonwealth ex rel. Beshear*, 563 S.W.3d 74, 83 (Ky. 2018).

The Court further recognizes that while the parties did not raise every argument analyzed below, it is the duty of courts to consider all legal aspects when evaluating cases. *Community Financial Services Bank v. Stamper*, S.W.3d 737, 740-41 (Ky. 2019). This is so because "applicable legal authority is not evidence and can be resorted to at any stage of the proceedings whether cited by the litigants or simply applied, *sua sponte*, by the adjudicator(s). Nor is legal research a matter of judicial notice, for the issue is one of law, not evidence." *Burton v. Foster Wheeler Corp.*, 72 S.W.3d 925, 930 (Ky. 2002); *see also Mitchell v. Hadl*, 816 S.W.2d 183, 185 (Ky. 1991) ("When the facts reveal a fundamental basis for decision not presented by the parties, it is our duty to address the issue to avoid a misleading application of the law."). That is what this Court will endeavor to do below.

A. Trigger Ban

The Trigger Ban is an arguably unconstitutional delegation of legislative authority, not just to a different branch of government, but to a different jurisdictional body entirely. Since the law was drafted to take effect at a later time if the United States Supreme Court made a certain decision, it violates Sections 27, 28, and 29 of the Kentucky Constitution.

Kentucky is a strict adherent to the separation of powers. "The General Assembly cannot delegate any portion of the legislative function to another authority." *Diemer v. Commonwealth*, 786 S.W.2d 861, 864 (Ky. 1990). The Trigger Ban would create criminal penalties for abortions. Criminal laws fall directly under the umbrella of legislative and nondelegable functions. "What conduct shall in the future constitute a crime in Kentucky or be subject to severe penalties is a matter for the Kentucky legislature to determine in view of the *then existing conditions when the need for such a statute arises*. It is not a matter that may be delegated." *Dawson v. Hamilton*, 314 S.W.2d 532, 536 (Ky. 1958) (emphasis added). The Kentucky Supreme Court held that adopting prospective federal legislation or rules into state statute constituted an impermissible delegation of legislative authority. *Id.* at 535. This is precisely the action the General Assembly took with the Trigger Ban. It impermissibly delegated its legislative authority to a federal body (the United States Supreme Court) in violation of the Kentucky Constitution.

The Plaintiffs also contend the Trigger Ban is unconstitutionally vague. Kentucky laws must be sufficiently clear that a person ordinarily disposed to obey the law is able to "determine whether the contemplated conduct would amount to a violation." *State Bd. for Elementary & Secondary Educ. v. Howard*, 834 S.W.2d 657, 662 (Ky. 1992). The test to determine whether a statute is unconstitutionally vague contains two separate elements: first, does the statute place someone to whom it applies on actual notice as to what conduct is prohibited; and second, is it written in a manner that encourages arbitrary and discriminatory enforcement. *Id.* (citing *Musselman v. Commonwealth*, 705 S.W.2d 476, 478 (Ky. 1986)).

The Trigger Ban does not adequately give actual notice because the date upon which it becomes effective is at best unclear. The General Assembly stated that the Trigger Ban was to take effect "immediately upon … the occurrence of … [a]ny decision of the United States Supreme Court which reverses, in whole or in part *Roe v. Wade*, 410 U.S. 113 (1973)." KRS 311.772(2)(a). On its face this might seem clear enough, but upon closer examination problems arise. Unless specifically stated otherwise in the opinion, United States Supreme Court opinions

do not become final until twenty-five days after the opinion is announced. Sup. Ct. R. 45. Since the opinion in *Dobbs* was announced on June 24, 2022, the opinion did not become final until July 19, 2022. Defendant Cameron however, contends the Trigger Ban became effective immediately on June 24th. Attorneys general in other states with trigger laws have failed to reach a consensus on this matter as well[4]. This uncertainty is sufficient to satisfy the first prong of the analysis.

Secondly, the lack of clarity regarding the date of enforceability creates the risk of arbitrary and discriminatory enforcement because prosecutors across the Commonwealth could reach different conclusions as to when they may begin enforcing the Trigger Ban. Indeed, Defendant Cameron insisted that he has the authority to begin enforcing the law immediately. Defendant Wine has not given any indication when, or if, his office intends to enforce the law. A situation where the Attorney General and Commonwealth's Attorney could be at odds over the enforceability of a criminal law is undesirable for all involved. Accordingly, this second factor of the analysis is met as well. The Plaintiffs have presented serious questions as to the constitutionality of the Trigger Ban.

B. Six Week Ban

Unlike the Trigger Ban, the Six Week Ban does not rely on a decision of the U.S. Supreme Court to become effective. As such, the Six Week Ban and its constitutionality must be examined separately. For the reasons stated below, the Court concludes that the Six Week Ban implicates Sections 1, 2 and 5 of the Kentucky Constitution. The Court will separately examine the Plaintiffs' likelihood of success in Section C.

1. Right to Privacy

Sections 1 and 2 of the Kentucky Constitution broadly protect an individual's rights to liberty and self-determination. The liberty right protected in Sections 1 and 2 have been interpreted to include a similar right to privacy as recognized in the federal Constitution.

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[4] See Advisory from Tex. Att'y Gen. Ken Paxton on Texas Law upon Reversal of *Roe v. Wade* (June 24, 2022), https://www.texasattorneygeneral.gov/sites/default/files/images/executive-management/Post-Roe%20Advisory.pdf, *and* Kelcie Moseley-Morris, *Idaho Attorney General Says Abortion Ban Likely to Take Effect in Late August After SCOTUS Decision*, Idaho Capitol Sun (June 24, 2022) https://idahocapitalsun.com/2022/06/24/idahos-trigger-law-will-abolish-abortions-30-days-after-scotus-ruling-overturning-roe-v-wade/

Commonwealth v. Wasson, 842 S.W.2d 487 (Ky. 1992)[5]. Indeed, the Kentucky Constitution has been held to "offer greater protection for the right of privacy than provided by the Federal Constitution as interpreted by the United States Supreme Court." *Id.* at 491. The right of privacy has been consistently recognized as an integral part of the guarantee of liberty in the 1891 Kentucky Constitution since its inception. *Id.* at 495. The Kentucky Supreme Court has held that the 1891 Constitution prohibits state action "thus intruding upon the inalienable rights possessed by the citizens" of Kentucky. *Commonwealth v. Campbell*, 117 S.W. 383, 385 (Ky. 1909).

The constitutional privacy right protects individuals "against the intrusive police power of the state." *Wasson*, 842 S.W.2d at 492[6]. The Kentucky Supreme Court has recognized that "Kentucky has a rich and compelling tradition of recognizing and protecting individual rights from state intrusion." *Id.* The Defendants here placed great emphasis on the importance of the history and precedent of laws outlawing abortion in the mid to late nineteenth century. However, conduct is "not beyond the protections of the guarantees of individual liberty in our Kentucky Constitution simply because 'proscriptions against that conduct have ancient roots.' Kentucky constitutional guarantees against government intrusion address substantive rights." *Id.* at 493 (quoting *Bowers v. Hardwick*, 478 U.S. 186, 192 (1986)).

Additionally, the history the Defendants rely on is less clear than they contend, and actually tends to potentially weaken their case. At common law, abortion with the consent of the woman was not a crime before quickening[7]. *Mitchell v. Commonwealth*, 78 Ky. 204, 210 (1879). Ten years after the ratification of the current Kentucky Constitution, the Kentucky Supreme Court again held that "[t]here is no statute in this state changing the common-law rule" that "it was not … a punishable offense to produce with the consent of the mother an abortion prior to

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[5] The Court recognizes that *Wasson* was revisited by the Kentucky Supreme Court in *Calloway Cnty. Sheriff's Dept. v. Woodall*, 607 S.W.3d 557 (Ky. 2020). However, *Calloway County* merely modified the analysis courts use for evaluating special legislation. The privacy analysis of *Wasson* was untouched and remains the law of Kentucky.

[6] The Court acknowledges the Defendants' contention that *Wasson* is limited to the context of private sexual activity between consenting adults. The Court is unpersuaded however that *Wasson* is, or should be, limited to that narrow context. The privacy analysis in *Wasson* discusses a much broader and more fundamental right than Defendants acknowledge. As such, the reasoning of the Kentucky Supreme Court in *Wasson* is directly applicable to this context as well.

[7] Quickening is recognized as the moment when a woman first feels fetal movement. This is generally understood not to occur until late in the fourth month or early in the fifth month of gestation. Reva Siegal, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STANFORD L. REV. 261, 281-82 (1992).

the time when she became quick with child." *Wilson v. Commonwealth*, 60 S.W. 400, 401 (Ky. 1901). The Six Week Ban intercedes well before the point of quickening. Contrary to the Defendants' contention, history demonstrates that pre-quickening abortions were permissible. Defendants' reliance on the history and traditions of Kentucky law are therefore misplaced.

Furthermore, the laws that the Defendants seek to enforce would at the very least potentially obligate the state to investigate the circumstances and conditions of every miscarriage that occurs in Kentucky. This would lead to an unprecedented level of intrusion and invasiveness, rarely seen before in this state. Kentucky has a long and proud history of limiting governmental intrusion and overreach. The Six Week Ban flies directly in the face of that tradition.

The Six Week Ban will have wide ranging effects on family planning decisions that are traditionally protected from governmental imposition. It not only compromises a woman's right to self-determination protected in Section 2 of the Kentucky Constitution by taking away the choice to have an abortion in many instances, but also undercut a woman's choice to have children at all. Many people are justifiably concerned about having children now due to a very real fear around many of the complications that may arise during the pregnancy, as outlined by Dr. Bergin in her testimony. Women have legitimate concerns about their ability to receive adequate care, and the possibility their health and safety will be deemed subordinate to the life of a fetus. Already, laws similar to the ones at issue here, are creating confusion and concern in healthcare settings as doctors, in order to avoid incurring civil and criminal liability, are forced to wait until women are in dire medical conditions before interceding[8]. There is further uncertainty regarding the future legality and logistics of In Vitro Fertilization. The implications of constitutional protections beginning from the very moment of fertilization raises a whole host of concerns for the continued legal feasibility of IVF.

These laws intrude into the traditionally protected familial sphere, and as such require exceedingly compelling justifications in order to pass constitutional muster.

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[8] Arey, et al., *A Preview of the Dangerous Future of Abortion Bans – Texas Senate Bill 8*, NEW ENGLAND JOURNAL OF MEDICINE, June 22, 2022, (last visited July 12, 2022), https://www.nejm.org/doi/full/10.1056/NEJMp2207423

2. Equal Protection

Furthermore, Sections 1, 2, and 3 of the Kentucky Constitution function much the same way as the Equal Protection Clause of the 14th Amendment of the Federal Constitution. *D.F. v. Codell*, 127 S.W.3d 571, 575 (Ky. 2003). The goal of Equal Protection is to ensure that similarly situated persons are treated alike. *Vision Mining, Inc. v. Gardner*, 364 S.W.3d 455, 465 (Ky. 2011). The challenged statutes may run afoul of this protection by imposing obligations, restrictions, and penalties on the woman, and possibly physicians, but not on the man. As defined by statute, the man is at least 50% responsible for the creation of the fetus, yet contrary to the woman, he bears no legal consequences for his contribution. As similarly situated parties to the creation of life, the woman and the man must be treated equal under the law.

Additionally, there is no other context in which the law dictates that a person's body must be used against her will, even to aid or save the life of another. Section 2 of the Kentucky Constitution grants a right to self-determination that protects people from "absolute and arbitrary power over [their] lives, liberty, and property." Ky. Const. § 2. People cannot be legally coerced into giving blood or donating organs. Bone marrow transplants are not compulsory. When a person dies, their organs can be utilized only if they consent to being an organ donor. These laws grant less bodily autonomy to pregnant women than in any of these other instances, or at any other time in the woman's life. Only in the context of pregnancy is a woman's bodily autonomy taken away from her. This is a burden that falls directly, and only, on females. It is inescapable, therefore, that these laws discriminate on the basis of sex.

3. Religious Freedom

Section 5 of the Kentucky Constitution protects both the free exercise of religion and prohibits the establishment of a state religion. The Six Week Ban infringes upon those rights as well, but primarily upon the prohibition on the establishment of religion. Defendants' witnesses at the July 6th hearing advocated for, and agreed with what the General Assembly essentially established in these laws, independent fetal personhood[9]. They argue that life begins at the very moment of fertilization and as such is entitled to full constitutional protection at that point. However, this is a distinctly Christian and Catholic belief. Other faiths hold a wide variety of views on when life begins and at what point a fetus should be recognized as an independent

[9] The General Assembly uses the term "unborn human beings" to refer to fetal personhood.

human being[10]. While numerous faith traditions embrace the concept of "ensoulment," or the acquisition of personhood, there are myriad views on when and how this transformation occurs[11]. The laws at issue here, adopt the view embraced by some, but not all, religious traditions, that life begins at the moment of conception.

The General Assembly is not permitted to single out and endorse the doctrine of a favored faith for preferred treatment. By taking this approach, the bans fail to account for the diverse religious views of many Kentuckians whose faith leads them to take very different views of when life begins. There is nothing in our laws or history that allows for such theocratic based policymaking. Both the Trigger Ban and the Six Week Ban implicate the Establishment and Free Exercise Clauses by impermissibly establishing a distinctly Christian doctrine of the beginning of life, and by unduly interfering with the free exercise of other religions that do not share that same belief.

All of these considerations together stand for the proposition that governmental intrusion into the fundamentally private sphere of self-determination as contemplated by these laws is to be prohibited. Having recognized that the Six Week Ban necessarily involves several fundamental rights, the Court will next analyze whether the law withstands constitutional scrutiny.

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[10] David Masci, *Where Major Religious Groups Stand on Abortion*, PEW RESEARCH CENTER, June 21, 2016, (last visited Jul 11, 2022), https://www.pewresearch.org/fact-tank/2016/06/21/where-major-religious-groups-stand-on-abortion/

[11] See Vatican Sacred Congregation for the Doctrine of the Faith, Declaration on Procured Abortion, at n.19 (Nov. 18, 1974), available at https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19741118_declarationabortion_en.html; Presbyterian Church (U.S.A.), Abortion/ Reproductive Choice Issues ("We may not know exactly when human life begins[.]"), available at https://www.presbyterianmission.org/what-we-believe/socialissues/abortion-issues/; United Church of Christ, Statement on Reproductive Health and Justice (noting the "many religious and theological perspectives on when life and personhood begin"), available at https://d3n8a8pro7vhmx.cloudfront.net/unitedchurchofchrist/le gacy_url/455/reproductive-health-and-justice.pdf?1418423872; Evangelical Lutheran Church in America, Social Statement on Abortion at 1, 3 n.2 (1991) (explaining that embryology provides insight into the "complex mystery of God's creative activity" but that individual interpretation of the scientific information leads to various understandings of when life begins), available at http://download.elca.org/ELCA%20Resource%20Repository/Abo rtionSS.pdf; National Council of Jewish Women, Abortion and Jewish Values Toolkit at 16 (2020), available at https://www.ncjw.org/wpcontent/uploads/2020/05/NCJW_ReproductiveGuide_Final.pdf.

C. Constitutional Scrutiny Analysis

As established in Section B above, the Six Week Ban implicates numerous fundamental rights protected by the Kentucky Constitution. Strict scrutiny is the highest level of scrutiny courts apply. It applies to analysis of statutes that "impact a fundamental right or liberty explicitly or implicitly protected by the Constitution." *Beshear v. Acree*, 615 S.W.3d 780, 816 (Ky. 2020). To survive strict scrutiny, "the government must prove that the challenged action furthers a compelling governmental interest and is narrowly tailored to that interest." *Id.* The seldom used intermediate scrutiny is generally used when evaluating discrimination based on gender. *D.F. v. Codell*, 127 S.W.3d 571, 575 (Ky. 2003). Intermediate scrutiny requires the government to "prove its action is substantially related to a legitimate state interest." *Id.* (citing *Steven Lee Enters v. Varney*, 36 S.W.3d 391, 394). Under either standard, the Plaintiffs have demonstrated serious questions regarding the validity of the Six Week Ban.

It is well established in statutory interpretation that courts must always presume the legislature did not intend for a statute to produce absurd results. *Beshear v. Acree*, 615 S.W.3d 780, 804 (Ky. 2021), citing *Layne v. Newberg*, 841 S.W.2d 181, 183 (Ky. 1992). However, followed to its logical conclusions, the theory of "independent fetal personhood" that is created by both the Trigger Ban and the Six Week Ban would have far-ranging implications and could lead to unintended consequences and absurd results. For instance, do child support obligations now begin from the moment of fertilization? Does a fetus gain a legal claim as an heir to the father's estate at the moment of fertilization? Would a pregnant woman be able to claim her fetus as a dependent on her tax returns? Would a company that schedules a pregnant woman to work be in violation of child labor laws? Or, if a pregnant woman commits a crime and is sentenced to serve time in prison, would the rights of the fetus be violated by sharing the same confinement as the woman? The answer to all of these is surely "no."[12] With these considerations in mind, the Court will now evaluate the previously identified constitutional provisions.

[12] A further example of the unintended chaos these laws will bring comes from a pregnant woman in Texas who recently received a ticket for driving in a High-Occupancy Vehicle (HOV) lane. She is currently challenging the ticket in court arguing that since Texas has recognized independent fetal personhood, the two-person minimum occupancy to use the HOV Lane was satisfied. https://www.cnn.com/2022/07/11/us/pregnant-woman-hov-lane/index.html

1. Right to Privacy

The Defendants argue that the state has a compelling interest in protecting what it calls "unborn human beings." As established at the July 6th Hearing, a fetus cannot survive on its own outside of the womb until it has reached a gestational age between twenty and twenty-five weeks. The Six Week Ban intercedes well before the point of viability, indeed at a point before many women even know they are pregnant. The state's interest in protecting potential fetal life before the point of viability has traditionally been viewed as insufficient to justify total or near total bans on abortion in courts across the country[13]. While the decisions of other states are not binding upon this Court, the reasoning behind those decisions is both informative and persuasive. This Court agrees with many other courts that the state's purported interest in protecting potential fetal life pre-viability is not a compelling enough state interest to justify such an unparalleled level of intrusion and invasiveness into the fundamental area of choosing whether or not to bear a child. The fundamental right for a woman to control her own body free from governmental interference outweighs a state interest in potential fetal life before viability. As the Court has previously recounted, Kentucky has a prodigious history of protecting privacy at a greater level than the federal Constitution. See *Wasson*, 842 S.W.2d at 491. Surely, if this heightened privacy right stands for anything, it stands for the proposition that Kentuckians should have control over basic family planning choices, free from governmental interference.

2. Equal Protection

Next, the Court turns to the Equal Protection analysis. There are two equally necessary parties to the creation of human life, a male and a female. As established above in Section IV(B), these laws impose unilateral obligations and responsibilities on only the female, and none on the male. Laws that discriminate on the basis of sex are not unconstitutional per se, but must pass intermediate scrutiny in order to be constitutional. *Codell*, 127 S.W.3d at 575. This requires the government to show that its action is substantially related to a legitimate state interest. *Id.* The Defendants again argue that the state has a legitimate interest in protecting fetal life, and that by

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[13] *Valley Hosp. Ass'n v. Mat-Su Coal. for Choice*, 948 P.2d 963, 971 (Alaska 1997); *Comm. to Def. Reprod. Rts. v. Myers*, 625 P.2d 779, 793-797 (Cal. 1981); *In re T.W.*, 551 So.2d 1186, 1192-94 (Fla. 1989); *Women of Minn. v. Gomez*, 542 N.W.2d 17, 31-32 (Minn. 1995); *Armstrong v. State*, 989 P.2d 364, 380-384 (Mont. 1999); *Planned Parenthood of Middle Tenn. v. Sundquist*, 38 S.W.3d 1, 18 (Tenn. 2000); *Right to Choose v. Byrne*, 450 A.2d 925, 934-37 (N.J. 1982); *Hodes & Nauser, MDs, P.A. v. Schmidt*, 440 P.3d 461, 496 (Kan. 2019).

nearly banning all abortions these laws will achieve that goal. However, the Defendants have again failed to meet their burden. The Defendants have proffered no legitimate reason why the woman must bear all the burdens of these laws while the man carries none. As similarly situated parties, they must be treated equally under the law. These laws fail to do that, and therefore the Plaintiffs have established a substantial question as to the merits.

3. Religious Freedom

Turning finally to the analysis of Section 5 of the Kentucky Constitution, Kentucky courts have consistently held that the purpose of Section 5 is to guarantee religious freedom. *Lawson v. Commonwealth*, 164 S.W.2d 972, 975-76 (Ky. 1942). The Kentucky Constitution states that "no preference shall ever be given by law to any religious sect, society or denomination." Ky. Const. § 5. This provision mandates "a much stricter interpretation than the Federal counterpart found in the First Amendment's 'Establishment of Religion clause.'" *Neal v. Fiscal Court, Jefferson County.*, 986 S.W.2d 907, 909-10 (Ky. 1999), citing *Fiscal Court of Jefferson County. v. Brady*, 885 S.W.2d 681 (Ky. 1994).

This is not a particularly close call. As discussed above, by ordaining that life begins at the very moment of fertilization, the General Assembly has adopted the religious tenets of specific sects or denominations. The General Assembly ignored the contending positions of other faiths regarding the origins and beginnings of life. It is true that the General Assembly has sweeping authority to legislate for the public good, but expressly encasing the doctrines of a preferred faith, while eschewing the competing views of other faiths, is an arguable violation of Section 5's prohibition on the establishment of religion[14]. Section 5 protects Kentuckians in their choice to worship, how they worship, and to be free from the imposition of a particular faith by the government. As Kentucky courts have long held, "under our institutions there is no room for that inquisitorial and protective spirit which seeks to regulate the conduct of men." *Campbell*, 117 S.W. at 387. For all of these reasons, the Plaintiffs have again at the very least established a substantial question as to the merits of this law.

[14] It is further notable that the two witnesses the Defendants called to testify at the July 6th Hearing were both affiliated with a religious institution that expressly promotes and advocates the view adopted by the General Assembly, further deepening the implicit connection between the state and a favored faith.

Conclusion

The Court here is tasked not with finding whether the Kentucky Constitution explicitly contains the right to an abortion, but rather with discerning whether the laws at issue constituting near total bans on abortion violate the rights of privacy, self-determination, equal protection, and religious freedom guaranteed by the Kentucky Constitution. The Plaintiffs have demonstrated at the very least a substantial question as to the merits regarding the constitutionality of both the Trigger Ban and the Six Week Ban. As such, they are entitled to injunctive relief until the matter can be fully resolved on the merits. Therefore, with the Court being sufficiently advised;

IT IS ORDERED THAT Plaintiffs' Motion for a Temporary Injunction is **GRANTED**. The Defendants are enjoined from enforcing KRS 311.772 and KRS 311.7701-7711, pending full resolution of this matter on the merits, until further order of this Court. The previously filed bond is continued. Accordingly, the Temporary Restraining Order issued on June 30, 2022 is hereby dissolved pursuant to CR 65.03(5).

ENTERED IN COURT
DAVID L. NICHOLSON, CLERK
JUL 22 2022
BY _____ DEPUTY CLERK

HON. MITCH PERRY, JUDGE

Date: July 22, 2022

Time: 10:00 am

CC:

Hon. Michele Henry
Counsel for Plaintiffs

Hon. Heather Gatnarek
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Hon. Hana Bajramovic
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Hon. Brigitte Amiri
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Hon. Kendall Turner
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Hon. Victor Maddox
Hon. Christopher Thacker
Hon. Lindsey Keiser
Counsel for Daniel Cameron

Hon. Leanne Diakov
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Hon. Wesley Duke
Counsel for Office of the Secretary of Kentucky's Cabinet for Health and Family Services

Hon. Jason Moore
Counsel for the Office of the Commonwealth's Attorney, 30th Judicial Circuit