IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PRETERM-CLEVELAND, *et al.*,

Plaintiffs,

v.

DAVID YOST, *et al.*,

Defendants.

Case No.: A 2203203

Judge: Christian A. Jenkins

PLAINTIFFS' SUPPLEMENTAL MEMORANDUM IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

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INTRODUCTION

Absent relief from this Court, S.B. 23 will once again impose a ban on abortion from the earliest stages of pregnancy in Ohio. The Ohio Constitution precludes this result for the reasons given in the Court's thorough opinion accompanying its Temporary Restraining Order. The State's Supplemental Opposition takes issue with that decision, but it identifies no evidence or point of law that would call the Court's reasoning into question. Instead, the State devotes the majority of its brief to rehashing arguments about the meaning of the Ohio Constitution's expansive protections for individual liberty, the harm S.B. 23 will inflict on Ohioans, and Plaintiffs' standing to bring this suit, all of which the Court has already considered and rejected. The State never responds directly to any of Plaintiffs' arguments, nor even tries to meet the State's burden of showing that S.B. 23 satisfies strict scrutiny. Plaintiffs respectfully request that the Court enjoin S.B. 23 through trial and judgment in this case.[1]

ARGUMENT

A. Plaintiffs Are Likely to Succeed on the Merits

1. The Due Course of Law Provision Protects the Right to Abortion

a. The *Voinovich* Decision Is Instructive

The Ohio Constitution's broad substantive due process protections encompass the fundamental right to abortion. Rather than engaging substantively with Plaintiffs' textual arguments and the body of case law recognizing that the breadth of these protections encompasses fundamental rights to privacy, procreation, bodily integrity, and freedom of choice in health care decision making under the Ohio Constitution, *see* Memorandum in Support of Motion for

[1] Plaintiffs address each of the arguments in the State's Supplemental Opposition in this brief and, rather than repeating arguments again, respectfully refer the Court to Plaintiffs' prior briefing for issues not raised by the State in the Supplemental Opposition.

Temporary Restraining Order Followed By Preliminary Injunction ("Mot.") at 17-22, the State hones in on the Court's discussion of *Preterm-Cleveland v. Voinovich*, 89 Ohio App. 3d 684, 627 N.E.2d 570 (10th Dist. July 27, 1993). The State's overly formalistic attempt to distinguish *Voinovich* fails to convincingly articulate any reason why the Court should not consider *Voinovich* as support for recognizing a fundamental right to abortion under the Ohio Constitution.

The State argues that because the Tenth District relied on Art. I, Sec. 1, rather than Art. I, Sec. 16, to find an independent right to abortion under the Ohio Constitution, the entire opinion is irrelevant to Plaintiffs' substantive due process claims. Supp. Opp. at 6. But the provisions of the Ohio Constitution are not considered independently and in a void; Ohio courts are directed "give a construction to the Constitution as will make it consistent with itself, and will harmonize and give effect to all its various provisions." *Smith v. Leis*, 106 Ohio St.3d 309, 2005-Ohio-5125, 835 N.E.2d 5, ¶ 59 (citation omitted); *Toledo Edison Co. v. City of Bryan*, 90 Ohio St.3d 288, 292, 2000-Ohio-169, 737 N.E.2d 529 ("Where provisions of the Constitution address the same subject matter, they must be read in pari materia and harmonized if possible."); *see also Steele v. Hamilton Cnty. Cmty. Mental Health Bd.*, 90 Ohio St.3d 176, 181, 736 N.E.2d 10, 15 (2000) (reading Section 1 and Section 16 as providing the basis for the "fundamental right" to refuse medical treatment). The Court's prior decision properly embraced this interpretive principle. The State also fails to acknowledge that Article I, Section 1 is among the relevant constitutional provisions invoked by Plaintiffs, which when read together with Article I sections 16 and 21, clearly establish the protection of a fundamental right to abortion under the Ohio Constitution.

The State makes no further attempt to engage with the Tenth District's textual and historical analysis of Article I, Section 1, which underlie that court's determination that there exists

an independent right to abortion under the Ohio Constitution.[2] Instead, the State tries to frame the Tenth District's application of the federal undue burden standard in *Voinovich* as proof that this Court erred in applying strict scrutiny. This Court, however, is not bound to apply the same standard as the Tenth District, as that court itself acknowledged in *Voinovich.* 89 Ohio App. 3d at 695, n.9 (explaining that despite choosing to apply the undue-burden test at that time, Ohio courts are not required to do so and are "free to find a statute to violate the Ohio Constitution, even though it does not violate the United States Constitution").

b. The HCFA Supports the Right to Abortion Guaranteed by the Ohio Constitution

In addition to taking issue with the Court's consideration of *Voinovich*, the State insists that the constitutional rights of Ohio women today must be defined solely by social and legal mores of the 1850s. State Defendants' Opposition to Plaintiffs' Motion For Preliminary Injunction ("Supp. Opp.") at 8 (arguing that this Court must apply the federal "deeply rooted" standard). The 19th century abortion restrictions and a single prosecution under these statutes cited by the State are not representative of Ohioans' views of abortion at that time,[3] and moreover are irrelevant, as

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[2] The State's brief is also silent on the key differences in language between Ohio's Due Course of Law Clause and the federal Due Process Clause. *See* Mot. at 15-19. These textual differences demonstrate that the Due Course of Law Clause is more protective than its federal counterpart when it comes to bodily integrity. *Id.* Rather than address the unique language in the Ohio clause, the State cites an Ohio Supreme Court case which dealt with a constitutional challenge to several tort reform statutes where the Court found that Section 16's protections were equivalent to federal due process protections. Supp. Opp. at 5, 7 (citing *Arbino v. Johnson & Johnson*, 116 Ohio St.3d 468, 2007-Ohio-6948, 880 N.E.2d 420, ¶ 48). Whatever the Court's conclusion as to the federal and Ohio Constitution's overlap in the circumstances of that case, the Ohio Supreme Court has made clear that it is appropriate to find that the Ohio Constitution provides greater protections when the United States Supreme Court has subsequently narrowed the scope of analogous federal rights. *See, e.g.*, *Humphrey v. Lane*, 89 Ohio St.3d 62, 68, 728 N.E.2d 1039 (2000) (declining to follow federal decision limiting rights because "this court is not bound by federal court interpretations of the federal Constitution in interpreting our own Constitution").

this Court has already recognized. *See* September 12, 2022 Decision and Entry ("Op.") (citing the U.S. Supreme Court's refusal to define rights "by who exercised them in the past"). In addition, the Ohio Constitution has changed since that time, amended in ***2011***, when the majority of Ohioans voted to adopt the HCFA. At the time of this amendment, abortion was legal health care in Ohio and had been for almost 40 years. Indeed, Ohio's early abortion restrictions—which the state argues should preclude this Court from holding that abortion is a fundamental right in Ohio—were repealed by the Ohio Legislature in 1974, long before the HCFA was adopted by popular referendum. *See* R.C. 2901.16. 1972 H 511, eff. 1-1-74.

Moreover, the plain language of the HCFA unambiguously encompasses the right to abortion, so the court need not consider other factors such as the historical context. *Cf. Portage Cnty. Bd. of Commrs. v. City of Akron*, 109 Ohio St.3d 106, 2006-Ohio-954, 846 N.E.2d 478, ¶ 52 (internal citations omitted) ("Following a primary rule of statutory construction, we must apply a statute as it is written when its meaning is unambiguous and definite."). This Court correctly held that "the HCFA represents an express constitutional acknowledgement of the fundamental nature of the right to freedom and privacy in health care decision making," which, when "[r]ead together with other applicable sections of the Ohio Constitution," supports a finding of the right to abortion. Op. at 14-15. The State ignores the Court's textual analysis and instead posits an alternate interpretation of the HCFA that finds no support in the amendment's plain language. The State

[3] Contrary to the State's portrayal, abortion was a common and widely accepted practice in Ohio throughout the 19th century, particularly up to the point of quickening. *See* James C. Mohr, *Abortion in America: The Origins and Evolution of National Policy*, 206-208 (1978) (discussing the findings in a report by a special committee of the Ohio legislature); Loren G. Stern, *Abortion: Reform and the Law*, 59 J. Criminal L. & Criminology 84, 84 n.1 (1968) (defining quickening as "that stage of gestation, usually sixteen to twenty weeks after conception, when the woman feels the first fetal movement"). The prevalence of abortion in Ohio continued even after Ohio passed its first abortion regulations in 1834. *See id.*; Mohr at 206-208.

argues that Subsection (B) should be read to "bar[] the State from adopting a single-payer system that would require citizens to obtain healthcare through the government instead of purchasing it independently." Supp. Opp. at 9. But that is not what Subsection (B) says. It bars any law that "prohibit[s] the purchase or sale of health care or health insurance." The State's incredibly narrow interpretation of the provision is both atextual and improper.[4] The State also argues that the HCFA cannot be read to protect the right to abortion because "it does not speak to abortion at all." *Id.* But the HCFA does speak to "health care," and the plain language "renders the term separate and distinct from the purported target of the amendment – health insurance." Op. at 13. "Abortion, whether procedural or medication, clearly constitutes health care within the ordinary meaning of that term." *Id.*; *see also* R.C. 2919.11 (defining abortion as "the practice of medicine or surgery for the purposes of section 4731.41 of the Revised Code"); Ohio Admin. Code 3701-47-03(A)(1) (same); Ralston Expert Rebuttal Report ¶¶ 13, 16-20, Ex. A.

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[4] Just as the HCFA's text includes both "health care" and "health insurance," arguments in support of the HCFA were not limited to health insurance systems and mandates. Proponents explained that the HCFA "restrains health care costs, permits medical innovation, maintains privacy, and preserves the supremacy of the doctor patient relationship." 1851 Center for Constitutional Law, *Passage of Issue 3 will protect liberty, restrain health care costs, and preserve health care choice and privacy* (Sept. 29, 2011), https://www.healthpolicyohio.org/tools/issue-3-the-health-care-freedomamendment/. The argument in support of the HCFA published on the Ohio Secretary of State website for the purpose of informing voters' decisions begins by urging voters to "[p]rotect your health care freedom, preserve your right to choose your doctor and health insurance, and keep government out of your personal medical decisions." Christopher Littleton et al., *Official Argument for Issue 3*, https://www.ohiosos.gov/globalassets/ballotboard/2011/3-argument-for.pdf (emphasis added) (last visited Oct. 5, 2022). The document goes on to warn that "[w]ithout health care freedom, government can … [p]rohibit you from obtaining private medical treatment." *Id.* These arguments, as well as the plain language of the HCFA, unambiguously demonstrate the HCFA protects private medical decisions about healthcare, such as the decision to have an abortion, against governmental interference.

The State next suggests that Subsection (D), which provides that the HCFA does not "affect any laws calculated to deter fraud or punish wrongdoing in the health care industry," must be read to directly contradict the plain language of the rest of the amendment. According to the State, this provision allows the Ohio General Assembly to prohibit and punish the sale or purchase of health care by simply defining the banned form of healthcare as "wrongdoing." This interpretation would render the protections in Subsections (B) and (C) meaningless. *See Boley v. Goodyear Tire & Rubber Co.*, 125 Ohio St.3d 510, 2010-Ohio-2550, 929 N.E.2d 448, ¶ 21 (in evaluating a statute, "[n]o part should be treated as superfluous unless that is manifestly required, and the court should avoid that construction which renders a provision meaningless or inoperative"). After all, it is unclear why Ohioans would need to amend the Constitution to protect access to health care that the General Assembly has chosen to permit anyway. *See* Supp. Opp. at 11 (arguing that "the Amendment preserves a right to purchase (or refuse to purchase) whatever healthcare the General Assembly allows Ohio physicians to provide").

c. The State Fails to Proffer Evidence or Argument to Meet its Burden Under Strict Scrutiny

Because the fundamental right to abortion is protected by the Ohio Constitution, S.B. 23—which would bar almost all abortions after approximately 6 weeks LMP—is subject to strict scrutiny analysis. Op. at 18. The State thus bears the heavy burden of demonstrating the law is narrowly tailored to serve a compelling state interest. *See Groch v. Gen. Motors Corp.*, 117 Ohio St.3d 192, 2008-Ohio-546, 883 N.E.2d 377, ¶ 155; *Bd. of Educ. of City Sch. of Cincinnati v. Walter*, 58 Ohio St.2d 368, 373-374, 390 N.E.2d 813 (1979); *Crowe v. Owens Corning Fiberglas*, 8th Dist. Cuyahoga No. 732206, 1998 WL 767622, at *4 (Oct. 29, 1998), *aff'd*, 87 Ohio St.3d 204, 718 N.E.2d 923 (Mem) (1999).

The State makes no attempt to meet its burden. Instead, it merely asserts that "the Heartbeat Act survives rational-basis review, because it logically relates to the State's interest in protecting innocent life." Supp. Opp. at 6. The State fails even to attempt to engage with the strict scrutiny analysis that this Court already held applicable. Op. at 15. Beyond this conclusory remark, the State has not shown a compelling interest in protecting potential life as early as six weeks LMP or in protecting women's health. The State also has not argued that SB 23 is narrowly tailored, nor has it addressed the numerous less restrictive alternatives that Plaintiffs identified for promoting the State's interest. *See* Mot. at 26-27.

2. The State Posits and Attacks an Imaginary Decision

Having failed to undermine the Court's actual analysis or the factual record, the State takes aim at a set of hypothetical facts of its own making. It asserts that the Court's order temporarily restraining S.B. 23, "if carried to its logical end," would mean "that the State must permit abortions *for all nine months* of every pregnancy." Supp. Opp. at 4 (emphasis in original). The State bases this misreading on the Court's references to Subsection (B) of the Health Care Freedom Amendment, which, again, says that "[n]o federal, state, or local law or rule shall prohibit the purchase or sale of health care or health insurance." *Id.* at 9 (quoting Ohio Const., art. I, §21(B)). According to the State, the Court's interpretation of that provision "renders unconstitutional all laws prohibiting the performance of any medical procedure," including abortion. *Id.* at 10-11. But holding that state laws restricting abortion or other intimate, personal medical decisions are limited by the Ohio Constitution's protection for reproductive autonomy does nothing of the sort. Plaintiffs and this Court have never suggested otherwise.

As this Court correctly held, several provisions of the Ohio Constitution—"[r]ead together"—"recognize[] a fundamental right to privacy, procreation, bodily integrity and freedom of choice in health care decision making." Op. at 12-14; *supra*, at 1-6. The HCFA bolsters the

emphasis on liberty and personal autonomy contained within other articles of the Ohio Constitution, and reinforces that these protections extend to Ohioans' right to make decisions about their own bodies. Such decisions include those as private and as central to a person's bodily integrity as whether to have an abortion. But the Court need not, and did not, find that the HCFA's "express constitutional acknowledgement of the fundamental nature of the right to freedom and privacy in health care decision making" alone confers the substantive constitutional protections that S.B. 23's infringes. Op. at 14; *see also* Op. at 15 & n.12 (collecting cases supporting "a clear and consistent recognition" of the right to reproductive autonomy).

The State further misconstrues the Court's decision by asserting that the existence of a fundamental right must preclude all regulation of it. Supp. Opp. at 10. As this Court explained, however, determining whether a law "impinge[s] upon fundamental rights" is only the first step in the constitutional analysis. Op. at 15. If a statute infringes on a fundamental freedom, as S.B. 23 restricts the right to abortion, a court must then proceed to consider whether it "fails the strict scrutiny analysis applicable to [such] enactments." *Id.* For the reasons explained in Plaintiffs' motion and this Court's thorough opinion, the State has failed to carry that burden with respect to S.B. 23—indeed, it has not even *attempted* to defend the law under the applicable constitutional standard, instead resting on its meritless position that only rational basis review applies. But Plaintiffs and this Court have never suggested that every law regulating abortion, to say nothing of the State's hypothetical "ban [on] medical procedures *proven* to confer no medical benefits," will suffer the same fate as S.B. 23. Supp. Opp. at 10 (emphasis in original). In future cases, the State is free to articulate why a challenged regulation is narrowly tailored to serve a compelling interest. Plaintiffs ask for no less than fidelity to the Ohio Constitution, but also no more.

3. S.B. 23 Violates Ohio's Equal Protection and Benefit Clause

The State next asks the Court to revisit its well-considered determination that S.B. 23 violates Ohio's Equal Protection and Benefit Clause. In support, the State merely reiterates arguments the Court has previously rejected and proffers new arguments that are facially implausible. The Court should continue to reject these arguments and again find that S.B. 23 unconstitutionally discriminates against pregnant women. *See* Op. at 16-19.

First, the State misconstrues the scope of Ohio's Equal Protection and Benefit Clause. *See* Supp. Opp. at 12-14. As this Court determined after considering the State's prior briefing on this issue, "[t]he weight of recent authority recognizes that Ohio's Equal Protection and Benefit Clause confers broader protection than its federal analogue." Op. at 17; *see also League of Women Voters of Ohio v. Ohio Redistricting Comm.*, 167 Ohio St.3d 255, 2022-Ohio-65, 192 N.E.3d 379, ¶ 151 (Brunner, J., concurring); *State v. Mole*, 149 Ohio St.3d 215, 2016-Ohio-5124, 74 N.E.3d 368, ¶ 23.

While the Ohio Supreme Court has in the past followed federal decisions in the equal protection area, "there is no mandate to that effect." Op. at 17 (citing *Preterm-Cleveland* at 713 (Petree, J. concurring in part and dissenting in part)). In support of the State's argument, which effectively asks the Court to reconsider its decision, the State cites only one case: *Am. Ass'n of Univ. Professors, Cent. State Univ. Chapter v. Cent. State Univ.*, 87 Ohio St. 3d 55, 60, 717 N.E.2d 286 (1999). That decision is over two decades old, and, when given the opportunity more recently to revisit the scope of the Equal Protection and Benefit Clause, Ohio Supreme Court justices have repeatedly indicated their views that the clause conveys broader protections than its federal counterpart. *See State v. Mole*, 149 Ohio St.3d 215, 2016-Ohio-5124, 74 N.E.3d 368, ¶ 23; *State*

v. Noling, 149 Ohio St.3d 327, 2016-Ohio-8252, 75 N.E.3d 141, ¶ 11; *League of Women Voters of Ohio*, 2022-Ohio-65, ¶ 151 (Brunner, J. concurring).[5]

The State also fails to engage with the text of the Equal Protection and Benefit Clause, under which equal protection is an *affirmative mandate* for the Ohio government. That stands in contrast to the language of the federal constitution, which sets forth only a limitation on the government. *See* Mot. at 28-29 (citing *League of Women Voters of Ohio*, 2022-Ohio-65, ¶ 151 (Brunner, J. concurring)). The fact that the language of the Ohio clause is substantively different, *and stronger,* than the federal analogue is strong evidence that the substance of the protections afforded by the Ohio Constitution are also substantively different than the protections afforded by the federal analogue.

Second, in asserting that S.B. 23 does not deny Ohioans equal protection, the State takes the facially illogical position that S.B. 23 is not a sex-based classification. Supp. Opp. at 12-13. The State claims that S.B. 23 does not regulate pregnant women "directly," but merely prohibits providers "regardless of sex" from performing an abortion. *Id.* at 13. That argument strains credulity. Indeed, the State implicitly acknowledges that S.B. 23 is an impermissible sex-based classification because it insists that "only women can become pregnant." *Id.* And the State ignores the ample body of caselaw concluding that provisions that regulate abortion services burden a suspect class. *See* Mot. at 30-31 (citing *Preterm-Cleveland* at 714 (Petree, J. concurring

[5] The State challenges the weight of Plaintiffs' authority on this point, but its own support is deficient. *American Association of University Professors* focused solely on the issue of whether the Court should diverge from the federal standard of rational-basis review. 87 Ohio St. 3d at 59-60. The Court concluded that in that context, there was "no reason to create such a disturbance." *Id.* at 60. That decision has little bearing on the question before this Court, which involves both a fundamental right and a suspect classification implicating strict scrutiny. And although the State laments that Plaintiffs have not offered a majority opinion regarding the divergence between the Ohio and federal clauses, it advances no criticism on the merits of the authority Plaintiffs cite.

in part and dissenting in part)); *Planned Parenthood Southwest Ohio* at 8). The State also ignores the text of S.B. 23, which expressly and repeatedly targets only "pregnant wom[e]n." *See, e.g.*, 2019 Am.Sub.S.B. No. 23, Section 1, amending R.C. 2919.192(A); *id.*, Section 3(H). Finally, the State fails to engage with Plaintiffs' arguments that S.B. 23 discriminates on the basis of sex by promoting antiquated notions and stereotypes regarding the role of women in society. *See* Mot. at 31; Plaintiffs' Reply In Support of Plaintiffs' Motion for Temporary Restraining Order ("Reply") at 7-8.

B. Plaintiffs and Their Patients Are Suffering and Will Continue to Suffer Irreparable Harm.

"A finding that a constitutional right has been threatened or impaired mandates a finding of irreparable injury." Op. at 19 (collecting cases). Because Plaintiffs have demonstrated a likelihood of success on their constitutional claims, they have demonstrated irreparable harm. *Id.* at 19-20.

The State has no serious response to the Court's prior extensive findings on the harm caused by S.B. 23. *See* Op. at 8-10, 19-20. It asserts that Plaintiffs "rely mostly on injuries they say their *patients* will sustain." Supp. Opp. at 19. But for the reasons explained further below, Plaintiffs have properly brought suit on those patients' behalf. *Infra*, at 13-18. The State's argument on this score is just another attempt to relitigate settled standing doctrine. The State next contends that "patients *have no* right to abortion," and that doctors will still be able to perform at least some abortions. Supp. Opp. at 20. The former argument collapses into the merits (on which the State cannot prevail, Op. at 10-19), and the latter ignores the nature of Plaintiffs' constitutional claims, which challenge the unjustified restrictions on abortion contained with S.B. 23. It is those unlawful restrictions on Ohioans' fundamental rights that cause the irreparable harm here, and the

fact that the State did not commit some *further* constitutional infraction does not obviate the injury caused by S.B. 23.

The State's attempts to downplay Plaintiffs' harms are similarly unavailing. For example, the State's suggestion that Plaintiffs' clinics could continue to operate by "modify[ing] their business practices" (at 20) would be irrelevant even if it were true—the harm here flows directly from S.B. 23's restrictions on the fundamental right to abortion, and halting the provision of constitutionally protected care would cause the very injury Plaintiffs seek preliminary relief to prevent. Similarly, the State's identification of three doctors who find S.B. 23's ban on nearly all abortions "appropriate" or otherwise unobjectionable (at 21) has nothing to do with whether that ban violates the Ohio Constitution, and thus necessarily causes an irreparable harm.[6] And the fact that one of those doctors asserts that he can understand the sweep of the law's exceptions only reinforces Plaintiffs' vagueness concerns, by demonstrating that the State will be able to challenge even good faith efforts to comply with the law by finding "experts" who reach different conclusions about the meaning of its language. *See* Liner Expert Declaration ¶¶ 39-41, Ex. C; Ralston Expert Rebuttal Report ¶¶ 43-52, Ex. A. [redacted] Parker Dep. 58:25-60:9, Ex. D.

[6] Nor does the testimony of the State's three witnesses survive rational analysis. Ralston Expert Rebuttal Report ¶¶ 12-52, Ex. A; Joffe Expert Rebuttal Report ¶¶ 6-22, Ex. B.

C. The Other Factors Relevant to Preliminary Relief Weigh in Favor of Plaintiffs

The State does not seriously contest the Court's finding that enjoining S.B. 23 would not harm third parties and is in the public interest. Critically, it presents no evidence on these points and leaves Plaintiffs' factual submissions regarding the harms of S.B. 23 unrebutted. The State instead contends that where a constitutionally permissible statute is enjoined, the State is harmed. Supp. Opp. at 21. That is nothing more than a tautology, and collapses into the State's (unsuccessful) argument on the merits. If S.B. 23 were constitutionally permissible, there would be no need to address potential harm to third parties because Plaintiffs would not be able to meet the first factor of the preliminary injunction standard. Because the law is unconstitutional, however, the State is not harmed by the law being enjoined. Plaintiffs' likelihood of success on the merits thus dispatches with the State's argument on this factor as well. The State also asserts that the injunction would harm "unborn children." The State cites nothing in support of its contention that a fetus is a cognizable "third party." Finally, the State asserts that an injunction is not in the public interest because giving effect to the will of the people by enforcing laws is in the public interest. Supp. Opp. at 21. Of course, that is not true when the law at issue violates the Ohio Constitution.

D. Settled Precedent Holds Plaintiffs Have Standing to Challenge S.B. 23

Plaintiffs have standing to challenge S.B. 23. Ohio courts have consistently allowed abortion providers to assert standing to challenge abortion restrictions on behalf of their patients. *E.g.*, *Preterm-Cleveland v. Voinovich*, 89 Ohio App. 3d 684, 627 N.E.2d 570 (10th Dist. July 27, 1993); *Planned Parenthood Southwest Ohio Region v. Ohio Dep't of Health*, Hamilton C.P. No. A. 2100870 (Jan. 31, 2022), at 3; *Planned Parenthood Southwest Ohio Region v. Ohio Dep't of Health*, Hamilton C.P. No. A 2101148 (Apr. 19, 2021), at 5. That result follows straightforwardly

from the third-party standing doctrine's broad acceptance in Ohio law. *See* Reply at 2 (collecting cases). But even setting these decisions aside, at a minimum, Ohio courts follow their federal counterparts when assessing standing. *See Brinkman v. Miami Univ.*, 12th Dist. Butler No. CA2006-12-313, 2007-Ohio-4372 ¶ 43. And the U.S. Supreme Court has "long permitted abortion providers to invoke the rights of their actual or potential patients in challenges to abortion-related regulations." *June Med. Servs. LLC v. Russo*, 140 S. Ct. 2103, 2118 (2020) (citing nine Supreme Court cases dating back to 1973 in which providers challenged abortion restrictions). This unbroken line of cases represents far more than "a single, non-binding decision by a trial court." Supp. Opp. at 19. Nothing in *Dobbs* overrules this precedent. To the contrary—*Dobbs*, like this case, was a challenge brought by "an abortion clinic … and one of its doctors," and the Court addressed the merits of plaintiffs' constitutional claims. *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2244 (2022).

Although these decisions suffice to reject the State's arguments (*see* Op. at 7-10), the facts of this case also satisfy the third-party standing test. As the State acknowledges, third-party standing is appropriate where the asserting party "(i) suffers its own injury in fact, (ii) possesses a sufficiently 'close' relationship with the person who possesses the right,' and (iii) shows some 'hindrance' that stands in the way of the claimant seeking relief." *E. Liverpool v. Columbiana Cnty. Budget Comm.*, 114 Ohio St. 3d 133, 2007-Ohio-3759, 860 N.E.2d 705, ¶ 25, citing *Craig v. Boren*, 429 U.S. 190, 196-197 (1976). All three requirements are met here.

First, S.B. 23 injured Plaintiffs when it was in effect and would continue to injure Plaintiffs should it be reinstated. Because of S.B. 23, Plaintiffs were forced to turn away many patients seeking care, and Plaintiff WMGPC may be forced to close its Dayton clinic should S.B. 23 be reinstated. *See, e.g.*, Compl. ¶¶ 57, 62; Liner Expert Declaration ¶ 39, Ex. C; Pierce Dep. 16:3-24,

Ex. E. Dr. Liner, and providers employed or engaged by the other Plaintiffs, are also "threatened with criminal penalties, loss of their medical licenses, civil forfeiture, and civil suits if they provide care in violation of S.B. 23." Compl. ¶¶ 9-14. This threat is heightened because the text of S.B. 23 is unconstitutionally vague, such that providers cannot "fairly inform themselves of the generally proscribed behavior," and the statute "encourage[s] arbitrary or discriminatory enforcement." *State v. Bielski*, 2013-Ohio-5771, 5 N.E.3d 1037, ¶ 12 (quoting *State v. Bennett*, 150 Ohio App.3d 450, 2002-Ohio-6651, 782 N.E.2d 101, ¶ 19).

Specifically, S.B. 23 fails to give providers adequate notice of the circumstances under which they can perform abortions after the detection of cardiac activity. The statute's exception allowing for abortions when a medical condition "so complicates" a pregnancy so as to cause a "substantial and irreversible impairment," R.C. 2919.16(K), is inherently ambiguous, subjective, and susceptible to different interpretations. *See* Liner Expert Declaration ¶ 39, Ex. C; Ralston Expert Rebuttal Report ¶¶ 43-51, Ex. A. These same issues also affect the exception for abortions "designed or intended to prevent the death of the pregnant woman," S.B. 23, Section 1, amending R.C. 2919.195(B)—it gives no indication as to how imminent or how substantial the risk of death must be in order to make the abortion lawful. Indeed, the Ohio Attorney General implicitly recognized this inherent ambiguity and sought to address it by creating a non-binding "explainer" regarding the ambiguous exceptions.[7] When asked to produce emails discussing the "explainer," the State produced at least 37 separate heavily redacted, mostly privileged emails with "Explainer" in the subject line—showing that even creating a non-binding "explainer" was no easy feat. Because S.B. 23 does not "fairly inform" Plaintiffs "of what is prohibited," it violates Plaintiffs'

[7] https://www.ohioattorneygeneral.gov/Media/News-Releases/July-2022/Ohio-Attorney-General-s-Office-Issues-Legal-Explai, last accessed Oct. 5, 2022.

due process rights, and causes them injury. *See State v. Carrick*, 131 Ohio St. 3d 340, 2012-Ohio-608, 965 N.E.2d 264, ¶ 14.[8]

Second, Plaintiffs possess a "sufficiently 'close' relationship with the person who possesses the right." *E. Liverpool*, 2007-Ohio-3759, ¶ 25. On this requirement, the State does not challenge Dr. Liner's relationship with patients, only the clinic Plaintiffs'. For good reason—the Supreme Court has held that the "closeness of the relationship" between a patient and doctor "is patent," as "[a] woman cannot safely secure an abortion without the aid of a physician." *Singleton v. Wulff*, 428 U.S. 106, 117 (1976). This reasoning extends to the clinic Plaintiffs as well, which exist only to serve patients and provide them with healthcare. The State provides no authority or reasoning to support such a distinction between physicians and the clinics in which they provide healthcare services.

And third, there is "some 'hindrance' that stands in the way of" individual patients seeking relief. The State argues that abortion providers are improper plaintiffs because "an aggrieved patient *could* file suit." Supp. Opp. at 18 (emphasis added). But whether a "court has denied [women] the power to sue," *id.* at 19, is not the applicable standard—if it were, no court could *ever* have recognized a provider's standing. Precedent has instead long held that women seeking

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[8] Plaintiffs and their employees face other direct injuries from S.B. 23 as well. The Ohio Constitution provides that "[n]o person shall be compelled, in any criminal case, to be a witness against himself." Ohio Const. Art. 1, Section 10. The privilege against self-incrimination is implicated when a person "is confronted by substantial and 'real,' and not merely trifling or imaginary, hazards of incrimination." *Marchetti v. United States*, 390 U.S. 39, 53 (1968). S.B. 23 requires physicians to "submit a report to the department of health … that includes all of the information the physician is required to certify in writing or determine" under a number of different subsections, including "division (B) of section 2919.195," the exemption allowing abortions to prevent the death or serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman. R.C. 2919.171(A)(2). Physicians who are compelled to submit these reports face serious "hazards of incrimination," *Marchetti*, 390 U.S. at 53, that are increased by the unconstitutionally vague nature of S.B. 23's exceptions. For similar reasons, the declarations compelled by S.B. 23 directly burden providers' speech rights.

abortions face "several obstacles" to asserting their own rights, including that they "may be chilled from such assertion by a desire to protect the very privacy of [their] decision from the publicity of a court suit" and that an individual woman's claims face "imminent mootness," with any ability to obtain an abortion "irrevocably lost" within months, if not weeks or days, of the need arising. *Singleton*, 428 U.S. at 117; *see also* Op. at 9. These hindrances and more are present here, given that "patients denied abortion services because of S.B. 23 are often under great distress from, for example, not being able to obtain treatment for life threatening cancers, or from fearing job loss and an inability to provide for their families because they must arrange travel out of state on short notice, often without the resources to do so." Op. at 9. All of these circumstances form meaningful obstacles to filing suit—hindrances—and have long been found to be sufficient to support third-party standing. *Supra*, at 13-14. And in any event, because the "enforcement of the challenged restriction *against the litigant* would result indirectly in the violation of third parties' rights," abortion providers are "the obvious claimant" and "the least awkward challenger" to S.B. 23. *June Medical Servs.*, 140 S. Ct. at 2118-2119. That is enough.

Preterm-Cleveland, Inc. v. Kasich, 13 Ohio St. 3d 157, 2018-Ohio-441, 102 N.E.3d 461, does nothing to disturb this result. The State concedes third-party standing was not at issue in that case (at 17), so for all of the reasons given above the Court should once more proceed to the merits of Plaintiffs' claims. But the unique factual circumstances of *Preterm-Cleveland* also mean the decision has little to say about the direct injuries that would be suffered by the clinic Plaintiffs here absent preliminary relief. The plaintiff in *Preterm-Cleveland* claimed an injury based on the need to "amend its practices and protocols, conduct research, and undertake new recordkeeping burdens to avoid criminal prosecution and civil liability of itself and its physicians," and argued that it might "be subject to organizational criminal liability" if the clinic's director failed to make such

changes. *Preterm-Cleveland*, 2018-Ohio-441, ¶ 17. Here, in contrast, a plaintiff clinic faces closure, Compl. ¶ 8, and the unconstitutionally vague exemptions to S.B. 23 mean that providers have no way to provide abortions after the detection of cardiac activity without facing real and arbitrary threats of enforcement. Without being able to know whether they can lawfully perform abortions that fall within the exemptions to S.B. 23, clinics and physicians will be unable to provide significant health care services they presently provide.[9]

E. The Court Should Enjoin S.B. 23's Ban and All of the Provisions that Implement It

Finally, the State argues that even if the Court finds some of S.B. 23 unconstitutional, it should sever and save the rest. But nearly all parts of the statute impose interrelated requirements upon abortion providers and are not severable. "When this court holds that a statute is unconstitutional, severing the provision that causes it to be unconstitutional may be appropriate." *See generally City of Cleveland v. State*, 138 Ohio St. 3d 232, 2014-Ohio-86, 5 N.E.3d 644, ¶. Ohio law sets out three questions for determining whether provisions of a statute are severable:

> (1) Are the constitutional and the unconstitutional parts capable of separation so that each may be read and may stand by itself? (2) Is the unconstitutional part so connected with the general scope of the whole as to make it impossible to give effect to the apparent intention of the Legislature if the clause or part is stricken out? (3) Is the insertion of words or terms necessary in order to separate the constitutional part from the unconstitutional part, and to give effect to the former only?

State v. Noling, 2016-Ohio-8252, 149 Ohio St. 3d 327, 75 N.E.3d 141, ¶ 34 (quoting *Geiger v. Geiger,* 117 Ohio St. 451, 466, 160 N.E. 28 (1927), quoting *State v. Bickford,* 28 N.D. 36, 147 N.W. 407, 409 (1913)). "A portion of a statute can be excised only when the answer to the first question is yes and the answers to the second and third questions are no." *Id.* ¶ 35. Ohio courts

[9] The State does not suggest that *Preterm-Cleveland* undermines Plaintiff Liner's standing to challenge S.B. 23. Nor could it. *Preterm-Cleveland*, 2018-Ohio-441, ¶¶ 26-27 (contrasting clinic's injury to that of the providers it employs).

must apply this severability analysis even when, as here, the challenged statute contains a severability clause. *See Tipp City v. Dakin*, 186 Ohio App. 3d 558, 584, 929 N.E.2d 484 (2010) (citing *State ex rel. English*, 160 Ohio St. 215, 219-220, 115 N.E.2d 395 (1953)). According to these severability principles, this Court should preliminarily enjoin the entirety of S.B. 23, except for R.C. §§ 2317.56(C)(2), 2919.1910, and 5103.11.

This Court cannot sever the bill's other provisions without doing violence to the General Assembly's language and intent (subject to very limited exceptions, as discussed further below). Indeed, the question for this Court is not whether particular provisions of the law are "unproblematic," Supp. Opp. at 23, but whether this court can remove particular provisions without rewriting the law. It is clear that R.C. §§ 2919.19-2919.199, plus the amendment to R.C. § 4731.22(B)(47) (which permits disciplinary action to be taken against physicians who violate S.B. 23's substantive prohibitions), were meant to function as a synthetic whole, the centerpiece of which is the prohibition on performing an abortion after embryonic or fetal cardiac activity can be detected. However, that central prohibition is unconstitutional, as Plaintiffs have demonstrated. Thus, the sections of S.B. 23 relating to R.C. §§ 2919.171, 2919.19-2919.199, 2919.1912, 2919.1913, and § 4731.22(B)(47) should be enjoined in their entirety.

Applying the first prong of the severability inquiry, nearly every provision cross-references S.B. 23's unconstitutional ban on abortion after fetal or embryonic cardiac activity, § 2919.195, thus defying easy separation of the constitutional and unconstitutional portions. *See* R.C. § 2919.171 (modifying abortion reporting requirements to encompass § 2919.195 and interrelated provisions); R.C. § 2919.19 (providing definitions for §§ 2919.191-2919.1910); § 2919.191 (limiting the scope of §§ 2919.192-2919.195); § 2919.195 (banning abortion after fetal cardiac activity); § 2919.197 (limiting the scope of §§ 2919.19-2919.196); § 2919.199 (permitting civil

suits for violations of the ban on abortion after fetal or embryonic cardiac activity and interrelated provisions); § 2919.1912 (imposing fines for violation of § 2919.195 and interrelated provisions); *see also* § 2919.192-194 (requiring procedures to detect and inform the patient of fetal or embryonic cardiac activity in advance of an abortion, and creating an exception to that requirement).

For the same reasons under the second prong of the analysis, S.B. 23's unconstitutional ban on abortion after six weeks permeates each of the other provisions and is therefore "so connected with the general scope of the whole as to make it impossible to give effect to the apparent intention of the Legislature" if § 2919.195 is enjoined but the other sections remain. *Noling*, 2016-Ohio-8252, ¶ 34. The various other sections amended and added by S.B. 23 largely constitute either small changes to definitions or practical requirements for the implementation of the fetal cardiac activity ban. Even § 2919.192 (requiring promulgation of rules to implement detection of fetal cardiac activity, which is required in order to implement the ban on abortion after that stage of pregnancy), § 2919.193 (requiring detection of fetal cardiac activity before an abortion, except in the case of a medical emergency, and notation in the patient's record), and § 2919.194 (requiring an acknowledgement signed by the patient), were enacted to support S.B. 23's central prohibition on performing an abortion after embryonic or fetal cardiac activity is detected. Indeed, although the law prior to S.B. 23 also contained a similar requirement to detect cardiac activity before an abortion, those provisions were modified, renumbered, and re-enacted in S.B. 23, which demonstrates that they were specifically intended to support the enforcement of the ban contained in § 2919.195.[10] The General Assembly's unambiguous intent is also demonstrated by

[10] Plaintiffs acknowledge that, if the Court enjoins S.B. 23 as Plaintiffs have requested here, the prior law will become effective again, as S.B. 23's modifications to that prior law will also be enjoined. That prior law, which was passed as a freestanding bill several years before the Ohio General Assembly passed the current ban on abortion after embryonic or fetal cardiac

S.B. 23's title, which declares the Act is to "Prohibit abortion if detectable heartbeat." In short, the unconstitutional part of S.B. 23 is the very essence of the legislature's intent in passing the law, and the supporting provisions to § 2919.195 therefore cannot be separated from it.[11]

The State ignores this severability framework, asking the Court to enjoin only one subsection of the ban—§ 2919.195(A)—leaving the rest of the statute, including the medical exception to the ban (§ 2919.195(B)) in place. Yet, § 2919.195(B) specifically references § 2919.195(A) and would be nonsensical without it. *See* R.C. 2919.195(B) (stating that § 2919.195(A) does not apply in certain situations). "In order to sever a portion of a statute, [the Court] must first find that such a severance will not fundamentally disrupt the statutory scheme of which the unconstitutional provision is a part." *State ex rel. Maurer v. Sheward*, 71 Ohio St. 3d 513, 523 (1994). This Court should reject the State's invitation to create a new, incoherent statute and instead strike all of the substantive provisions of S.B. 23, as set forth above.

The State also argues that Plaintiffs do not have standing to challenge certain other parts of the statute that do not harm providers or patients. Supp. Op. at 24. But this argument confuses the concepts of standing and severability. Plaintiffs have standing to challenge the abortion restrictions of S.B. 23, and the other interrelated parts of the statute regulating abortion providers must also fall as unseverable. That said, Plaintiffs do not seek to challenge the provisions of S.B.

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activity, required clinics to determine whether fetal cardiac activity exists, offer the patient the opportunity to see or hear it, and provide certain additional information. *See* prior R.C. 2919.191-2919.193. However, the emergency regulation promulgated by the Ohio Department of Health pursuant to R.C. 2919.192 would not be enforceable, as statutory authority for it would be lacking. Ohio Admin. Code 3701-47-07 (requiring a second ultrasound immediately before an abortion procedure to determine whether fetal or embryonic cardiac activity is present).

[11] Plaintiffs do not contend that insertion of words is necessary in order to separate the constitutional and unconstitutional portions of S.B. 23. However, because severance is appropriate only when *all three* factors militate in favor of it, this Court need not consider this third and final factor. *Noling*, 2016-Ohio-8252, ¶ 35.

23 relating only to adoption and foster care (R.C. 2919.1910, 5103.11), which are clearly separable from the unconstitutional abortion ban enacted by S.B. 23. In addition, Plaintiffs also do not challenge R.C. 2919.193 (naming the Act), which has no legal effect. Finally, Plaintiffs do not mount a facial challenge to the modification to R.C. 2317.56(C)(2), regarding the internal Ohio Department of Health process for producing informed consent materials for the Ohio Department of Health. These provisions may be severed and remain effective. But, as described above, the remaining provisions of S.B. 23 are not severable, and thus must all fall together.

F. The Injunction Should Issue Without Bond

This Court has broad discretion to waive the Civ.R. 65(C) bond requirement. *See Vanguard Transp. Sys. Inc. v. Edwards Transfer & Storage Co., Gen. Commodities Div.*, 109 Ohio App.3d 786, 793, 673 N.E.2d 182 (10th Dist. 1996) (recognizing courts have discretion to issue preliminary injunctions without requiring bond). The State did not object to Plaintiffs' request for issuance of the injunction without a bond.

CONCLUSION

For the foregoing reasons, Plaintiffs ask this Court to issue a preliminary injunction enjoining Defendants, their employees, agents, and successors in office, from enforcing S.B. 23.

Dated: October 5, 2022

Respectfully submitted,

/s/ B. Jessie Hill

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CERTIFICATE OF SERVICE

I hereby certify that on October 5, 2022, the foregoing was electronically filed via the Court's e-filing system. I further certify that a copy of the foregoing was served via electronic mail upon counsel for the following parties:

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B. Jessie Hill

Exhibit A

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PRETERM-CLEVELAND, *et al.*, *Plaintiffs,* v. DAVID YOST, *et al.*, *Defendants.*	Case No.: A 2203203 Judge: Christian A. Jenkins **PLAINTIFFS' EXPERT REBUTTAL REPORT OF STEVEN J. RALSTON, M.D., M.P.H.**

I, Steven J. Ralston, M.D., M.P.H., declare as follows:

I. QUALIFICATIONS

1. I am a board-certified obstetrician/gynecologist (OB/GYN) with more than two decades of experience with abortion care, high-risk pregnancies, prenatal diagnosis, and fetal therapy. I am also board certified in maternal-fetal medicine (MFM), which is an area of obstetrics that focuses on the medical and surgical management of high-risk pregnancies.

2. Currently, I am a Clinical Professor at the University of Maryland School of Medicine in Obstetrics, Gynecology and Reproductive Sciences. I am also the Director of the Obstetric Care Unit, where I am responsible for the functioning of the labor and delivery floor, as well as for making sure that our policies and guidelines for the care and treatment of pregnant women are evidence-based and up-to-date. I am also responsible for the education of fellows, residents, and medical students on the labor floor.

3. In addition to providing obstetrical care to patients with wanted pregnancies, I provide abortion care to patients who have made the decision to end a pregnancy. I am therefore

very familiar with the complications that can arise during pregnancy and childbirth and with the relative safety of abortion compared to childbirth.

4. I was previously Vice Chair, Chief of Obstetrics, Director of Quality for the OB/GYN Department, and Interim Program Director of the OB/GYN Residency Program at Howard University in Washington, D.C. I was also an MFM provider at Howard University Hospital, where I provided care to patients as an MFM specialist in both inpatient and outpatient settings. Additionally, I supervised OB/GYN residents, Family Practice residents, and medical students, and performed other administrative duties. I was also a Clinical Professor of Obstetrics and Gynecology at Howard University College of Medicine where I taught OB/GYN and medical ethics. I have also previously held faculty appointments at the Perelman School of Medicine of the University of Pennsylvania, Harvard Medical School, Tufts University School of Medicine, and Northeastern University. Over the past 20 years, I estimate I have trained hundreds of medical students, residents, and fellows to be OB/GYNs and MFMs, including training dozens of residents and fellows in the provision of abortion care in both the first and second trimesters and specifically in cases involving high-risk patients.

5. I received my medical degree in 1990 from Columbia University (Columbia College of Physicians and Surgeons), completed my OB/GYN residency at Yale-New Haven Hospital in 1994, and completed a fellowship in maternal-fetal medicine at Tufts-New England Medical Center (now known as Tufts Medical Center) in 1998. In addition, I received my Masters in Public Health in Health Law, Bioethics, and Human Rights from Boston University in 2011.

6. In 2008, I founded the Center for Compassionate Care and Perinatal Hospice at Tufts, which brings together a multidisciplinary group of obstetricians, pediatricians, nurses, social

workers, and chaplains to deliver coordinated, patient-centered care to women carrying fetuses that are very likely to die in utero or very shortly after birth.

7. In addition to my clinical expertise in prenatal diagnosis and high-risk obstetrics, I also have a long-standing interest and expertise in medical ethics. As noted above, I received a Masters of Public Health with a focus on bioethics. I have served on the Committee on Ethics for the American College of Obstetricians and Gynecologists (ACOG), including serving as Chair from 2009 to 2012; the Committee on Bioethics of the American Academy of Pediatrics; and the Ethics Committee of the American Society of Reproductive Medicine. I currently sit on ACOG's Ethics Document Review Panel, which is a group of ethics experts that reviews documents produced by ACOG's Committee on Ethics. Through these positions I have authored and/or edited a number of ethics opinions that set national standards of practice and serve as guidelines for clinicians throughout the country. I have served on the Ethics Committee for Tufts Medical Center for 13 years, served on the Ethics Committee for Pennsylvania Hospital from 2017 to 2021, and currently serve on the Ethics Committee of the University of Maryland Medical Center. I have served as a reviewer for the Journal of Law, Medicine, and Ethics. I have also been an ethics educator at Tufts, Harvard, the University of Pennsylvania, Howard University, and the University of Maryland.

8. My opinions are based on my education and experience in abortion care, general obstetrics, high-risk pregnancy, prenatal diagnosis, fetal therapy, and medical ethics.

9. My curriculum vitae, which sets forth my experience and credentials in greater detail and contains a full list of my publications, is attached as Exhibit A.

II. FACTUAL BASIS FOR EXPERT REBUTTAL TESTIMONY

10. In preparation for this report, I have reviewed the following case documents: (1) Senate Bill 23 (S.B. 23) and an "Explainer" concerning the law produced by the Ohio Attorney General; (2) the Expert Report of Dr. C. Brent Boles, M.D. (Boles Rep.); (3) the Expert Report of Dr. Michael S. Parker, M.D. (Parker Rep.); and (4) the Expert Report of Dr. Dennis Sullivan, M.D., M.A. (Sullivan Rep.). I have also familiarized myself with relevant studies cited by Drs. Boles, Parker, and Sullivan in their reports.

11. I understand that, with very limited exceptions, discussed further below, S.B. 23 bans abortions after the detection of embryonic cardiac activity, which occurs starting at approximately six weeks into pregnancy as measured from the first day of a patient's last menstrual period (LMP), and can occur as early as during the fifth week LMP.

III. SUMMARY OF EXPERT REBUTTAL OPINIONS

12. Drs. Boles, Parker, and Sullivan advance three primary medical opinions that I will address in this report. The fact that I do not address a particular opinion or point made in their declarations does not indicate my agreement with that opinion or point.

13. First, Defendants' experts seem to argue that abortion is "not a part of standard health care" on the basis that it does not treat a disease or condition. Sullivan Rep. ¶ 7; Parker Rep. ¶ 14. This is incorrect. As I explain below, abortion care is a vital component of comprehensive reproductive health care, and there are numerous situations in which an abortion is essential to improving the physical health and well-being of a pregnant individual and to avoiding immediate- and long-term negative health outcomes. Conversely, evidence shows that the denial of a wanted abortion may actively harm patient health and well-being, even where the patient would not die if an abortion were not performed. The Defendants' experts' myopic view of abortion care also

ignores the importance of patient autonomy in providing ethical medical care, and the consensus view that a myriad of factors—beyond immediate physical survival—are relevant to patient "health" and should be considered when providing health care.

14. Second, Defendants' experts quibble over the proven safety of abortion, seemingly contending that abortion *is not* safer than continuing a pregnancy to term and giving birth, *see* Sullivan Rep. ¶ 22; Boles Rep. ¶¶ 15-20, that abortion complications are underreported and are not, in fact, "exceedingly rare," Boles Rep. ¶ 21; Parker Rep. ¶ 19, and that abortion increases the risk of breast cancer, premature delivery in future pregnancies, and mental health disorders, Boles Rep. ¶ 25; Sullivan Rep. ¶¶ 23-25; Parker Rep. ¶ 21. As I will explain, these statements are simply not supported by the weight of the medical evidence or the consensus views of the medical community. Put simply, the evidence shows, and every major professional organization representing obstetricians and gynecologists and family planning professionals agrees, that abortion care in the United States is extremely safe—far safer than the alternative of carrying a pregnancy to term and giving birth—and that complications associated with abortion are rare. Moreover, there is no reputable evidence showing that the alleged "risks" that Defendants' experts identify, *see, e.g.,* Boles Rep. ¶ 25 (breast cancer, future preterm delivery, mental health issues), are actually attributable to a prior abortion.

15. Third, Defendants' experts opine that S.B. 23 contains adequate exceptions to its general ban on abortion after the detection of embryonic cardiac activity. *See* Boles Rep. ¶ 12; Parker Rep. ¶¶ 8-12; Sullivan Rep. ¶¶ 19, 21. That is wrong. I have reviewed S.B. 23's limited exceptions and, as I explain below, these exceptions fail to provide physicians with the requisite clarity as to when an abortion may be performed after the detection of embryonic cardiac activity

under the law without risk of prosecution, and are otherwise wholly insufficient to protect the health and well-being of pregnant individuals.

IV. REBUTTAL OPINIONS

A. Abortion is an Essential Component of Health Care

16. At the outset, it is worth addressing Defendants' experts' claim that abortion is not a part of standard health care because it does not treat or cure any disease or medical condition. *See* Sullivan Rep. ¶ 7; Parker Rep. ¶ 14. This is simply untrue. Abortion is most certainly health care—and vital health care at that. Indeed, ACOG, the leading medical organization dedicated to the health of individuals in need of gynecologic and obstetric care, has recognized that "[a]bortion is an essential component of comprehensive, evidence-based health care."[1]

17. Abortion bears many similarities to other important health care, particularly reproductive health care, that physicians provide patients every day. For example, treatment of a miscarriage—which the Defendants' experts presumably would not dispute constitutes health care—is completely indistinguishable from an abortion procedure in most cases; it involves the same medications, medical equipment, and staffing requirements and is an essentially identical medical procedure. Moreover, as with many other forms of health care, physicians perform abortions to alleviate a wide range of medical conditions, particularly those that arise during pregnancy or that are exacerbated by pregnancy. For instance, the treatment for patients with severe preeclampsia in the second trimester of pregnancy is to remove the placenta from the uterus.

[1] Am. Coll. of Obstetricians & Gynecologists, Abortion Policy (Revised and Approved May 2022), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy (last accessed Oct. 3, 2022).

Before the point of fetal viability, that treatment necessitates an abortion.[2, 3] Despite Dr. Boles's assertion that an abortion is necessary to save a pregnant patient's life only in "rare instances," Boles Rep. ¶ 11, at the tertiary care center where I work, we encounter patients with severe, mid-trimester preeclampsia that necessitates an abortion to save the patient's life several times a month. Similarly, molar pregnancies with both a fetus and abnormal placental tissue can cause dangerously high blood pressure and thyroid disease; again, the only treatment for this type of molar pregnancy is an abortion. In these cases, abortion is quite literally life-saving health care.

18. In addition to conditions like preeclampsia that arise as a result of pregnancy, there are numerous conditions that may be exacerbated by pregnancy or which could have an effect on the pregnancy, and which may cause a patient to seek abortion, such as cardiovascular disease, complex pulmonary disease, and cancer. While it may be true that in some cases these conditions *could* be managed throughout pregnancy, Boles Rep. ¶ 28; Parker Rep. ¶¶ 17-18, 27-28, 30, it is frequently the case that continuing a pregnancy with these conditions (or in circumstances where

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[2] Dr. Parker seems to suggest that a physician could treat preeclampsia, and other conditions that may arise around 20 weeks LMP, by inducing labor with the intent of "deliver[ing] a living fetus." Parker Rep. ¶ 25. For conditions like severe preeclampsia, this would be an extremely dangerous course of action, as it would subject the patient to a lengthy labor—perhaps up to several days—placing the patient's life and health at risk during that time. In cases like this, the safest and quickest way to end the pregnancy is an abortion. Likewise, while theoretically a caesarean section or a hysterotomy could also be treatment option in such a case, as with labor and delivery, those impose much greater risks on the patient than a typical, second-trimester abortion procedure.

[3] Dr. Sullivan makes the startling claim that a "heartbeat is a firm basis for demonstrating fetal viability." Sullivan Rep. ¶ 12. This is completely incorrect. In medicine, viability is understood to mean the point at which the fetus can survive outside the womb. The medical consensus is that viability is not possible until approximately 22-24 weeks LMP, though the determination is a medical one that must be made by a physician in each particular case. Embryonic cardiac activity is detectable starting at approximately six weeks LMP—a very early stage of pregnancy and months before viability. Indeed, at six weeks of pregnancy, what Dr. Sullivan calls a "heartbeat" is actually nothing more than electrical activity in the cells that will go on to form the fetal heart later in pregnancy. Embryonic cardiac activity is therefore no basis at all for demonstrating "viability" as OBGYNs use the term.

these conditions are likely to arise) entails risk to the health of the pregnant patient, and often with attendant high risks of neonatal morbidity or mortality.

19. Contrary to Defendants' experts' positions, the ethical practice of obstetrics requires that physicians inform their patients of their medical options, the risks and benefits of and alternatives to any form or course of treatment, and let patients determine for themselves—often in consultation with their partners, families, and religious or spiritual leaders—which risks to their health they are willing to endure over the course of their pregnancies. The medical profession has departed from prior decades' paternalistic model of healthcare, and the ethical practice of medicine today requires physicians respect and account for patient autonomy. Support for patient autonomy (in accordance with the ethical practice of medicine) likewise requires that final decisions about medical care be left to the patients to make for themselves—not dictated to them by their doctors or by politicians.

20. Just as our ethical frameworks have moved away from a paternalistic view of the physician/patient relationship, our conception of healthcare has broadened over the last 50 years. The nation's leading professional association of physicians, the American Medical Association (AMA), has defined health care as "a fundamental human good," which affects every person's "opportunity to pursue life goals, reduces [people's] pain and suffering, helps prevent premature loss of life, and provides information needed to plan for [people's] lives."[4] As reflected in this statement, a patient's physical health is only one of many factors that determine health. Most obviously, a patient's mental health is important to consider, as are factors related to the social determinants of health, including a patient's economic stability, job and housing security, familial

[4] Am. Med. Ass'n, Code of Medical Ethics Op. 11.1.1, Defining Basic Health Care, https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-11.pdf (last accessed Oct. 3, 2022).

and partner support, and ability to provide and care for themselves and any existing children in a safe environment. Neither S.B. 23 nor Defendants' experts acknowledge these important considerations in reaching their conclusions about abortion care. As a provider of abortion care for over two decades, I have personally seen how the ability to access abortion improves the health and well-being of patients and their families by allowing them to decide whether and when to have children, by permitting them to better care for themselves and the children they already have, and by giving them the opportunity to pursue educational opportunities and careers. Viewed in this context, as it must be, abortion is very clearly health care.

B. <u>The Opinions of Defendants' Experts Regarding Abortion Safety Are Far Outside the Mainstream and Refuted by High-Quality Evidence</u>

21. I strongly disagree with the opinions offered by the Defendants' experts that abortion is not significantly safer than its only alternative of carrying a pregnancy to term and giving birth, and that abortion poses unacceptable risks to the health and safety of patients. *See, e.g.,* Boles Rep. ¶¶ 15-21, 25; Parker Rep. ¶¶ 19-21; Sullivan Rep. ¶¶ 22-25.

22. It is first important to emphasize that Drs. Boles, Parker, and Sullivan make sweeping statements regarding abortion practice and safety that are seemingly not informed by any relevant experience providing abortion care, as none of these individuals appears to have any direct, hands-on experience with the provision of abortion.

23. Moreover, as detailed below, Defendants' experts' opinions are at odds with the overwhelming consensus of the medical community and the weight of the reputable academic literature, as demonstrated by (1) the closely considered positions of highly regarded major professional associations, (2) decades of data collected and reported by the U.S. Centers for Disease Control (CDC), and (3) the preeminent 2018 report published by the National Academies

of Sciences, Engineering, and Medicine (the National Academies), and the extensive body of reputable research cited therein.

24. ***The positions of highly regarded professional associations with specialized expertise converge on a single conclusion: abortion is very safe, and it is much safer than childbirth.*** ACOG, for example, is the premier national organization for obstetricians and gynecologists and has more than 58,000 members across the country. It produces clinical management guidelines for patient care, including abortion. Recent ACOG guidance explains that "[a]bortion is extremely safe," that "[s]erious complications from abortions are rare at all gestational ages," and that the "risk of death associated with childbirth is approximately 14 times higher than that with abortion."[5] The Society for Maternal-Fetal Medicine (SMFM) is the major U.S. professional organization representing maternal-fetal medicine specialists, who focus on achieving optimal maternal and fetal outcomes in high-risk pregnancies. SMFM similarly endorses the view that "abortion care by any method" is "safe and effective" and that, "[i]n pregnancies in which complications arise or there are preexisting medical comorbidities (including mental illness), abortion may be required and may be medically safer than carrying a pregnancy to term."[6]

25. Defendants' experts, however, fail to acknowledge the well-considered positions of these reputable organizations. Instead, Dr. Boles cites papers compiled by the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG).[7] AAPLOG is an

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[5] Am. Coll. of Obstetricians & Gynecologists, Committee Op. No. 815: Increasing Access to Abortion, 136 Obstetrics & Gynecology e107, e108 (2020).

[6] Soc'y for Maternal-Fetal Med., Access to Abortion Servs. 1, 1-2 (approved Dec. 2017, revised, re-titled, and reaffirmed June 2020), https://s3.amazonaws.com/cdn.smfm.org/media/2418/Access_to_Abortion_Services_(2020).pdf (last accessed Oct. 3, 2022).

[7] For example, drawing on a list of studies compiled by AAPLOG, Dr. Boles asserts that women who have abortions "will remain at increased risk for breast cancer." Boles Rep. ¶¶ 24-25. However, in its exhaustive review of the relevant literature on abortion and breast cancer, the

organization consisting of OB/GYNs who oppose abortion and seek to restrict access to the procedure. In my view, it is a fringe organization that does not in any way represent the views of the majority of OB/GYNs in the country. Rather, it is comprised of a small minority of the profession whose driving mission is to oppose the provision of abortion care. Unlike ACOG, which supports women's decisions both to end and to continue their pregnancies, AAPLOG supports only the decision to carry to term and actively works to eliminate women's ability to end a pregnancy. Likewise, unlike ACOG, whose membership includes OB/GYNs who provide abortions as well as those who do not, AAPLOG's membership only includes those OB/GYNs who oppose providing abortion care to their patients.

26. ***High-quality, scientific evidence supports the medical consensus that abortion is extremely safe.*** That conclusion is demonstrated in the robust 2018 evidence-based findings of a committee of the National Academies. The National Academies is a private, nongovernmental institution that was originally established by congressional charter to provide advice to the nation. After two years of study, the committee published an exhaustive, 208-page, peer-reviewed, evidenced-based report on the safety of abortion care in the United States. The committee was charged with considering eight key questions, including an assessment of "the evidence on the physical and mental health risks of . . . different abortion interventions" and the "evidence on the safety and quality of medical and surgical abortion care."[8] In answering these questions, the

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National Academies determined that much of it was "flawed by recall bias and lack of controls for such clinically important confounding factors as age at first live birth," thereby rendering it unfit for review by the committee." Nat'l Acads. of Scis. Eng'g & Med., *The Safety & Quality of Abortion Care in the United States* at 148 (2018) (hereinafter "NAS Rep.").

[8] NAS Rep., *supra* note 7, at 2.

committee conducted a comprehensive review of the state of the science on the safety and quality of abortion services in the United States.[9]

27. Upon conducting a systematic review of all of this existing evidence,[10] the National Academies concluded that the "clinical evidence clearly shows that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective."[11] The Committee concluded that "the risk of death subsequent to a legal abortion (0.7 per 100,000) is a small fraction of that for childbirth (8.8 per 100,000)," and it emphasized that among the 16.1 million legal abortions performed from 1998 to 2010, there were 108 deaths.[12] The report also concluded that serious complications following abortion are extremely rare.[13]

28. In addition to short-term safety, the National Academies also examined whether abortion has long-term adverse health impacts. After careful consideration of "high-quality research on numerous outcomes," it "conclude[d] that having an abortion does not increase a woman's risk of secondary infertility, pregnancy-related hypertensive disorders, abnormal placentation (after a D&E abortion), preterm birth, breast cancer, or mental health disorders."[14]

29. Defendants' experts either entirely ignore this report (and the extensive academic literature it relies on in reaching its conclusions), or attempt to dismiss it out of hand. Dr. Boles,

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[9] *Id.* at 7; *see also id.*at 80-93 (citing references for the committee's findings on safety and quality of abortion); *id.* at 153-158 (citing references for conclusions on abortion's long-term health effects).
[10] *Id.*
[11] *Id.* at 10.
[12] *Id.* at 74-75.
[13] *See, e.g.*, *id.* at 55 (finding evidence that established that complications after medication abortion "occur[] in no more than fraction of percent of patients,"); *id.* at 60 ("Aspiration abortions rarely result in complications"); *id.* at 63 (concluding that "a range of retrospective cohort studies, case series, chart reviews, and a prospective case series have shown D&E [abortions] to be effective with minimal rates of complications").
[14] *Id.* at 153.

for example, claims that the National Academies report is biased because he did not recognize names of contributors that he considered to be "neutral" on abortion or "pro-life." Boles Rep. ¶ 22. However, the National Academies committee responsible for reviewing the literature and developing findings on the safety of abortion was comprised of thirteen experts from across the country, including distinguished academics from a range of disciplines, such as medicine, epidemiology, nursing, and mental health.[15] Notably, the committee did not include experts whose primary professional role involved the provision of abortion,[16] undermining Dr. Boles's unfounded claims of pro-abortion bias.

30. Dr. Boles also criticizes the National Academies for rejecting certain studies, including those purporting to show a linkage between abortion and negative health outcomes like breast cancer and mental illness. Boles Rep. ¶¶ 23-25. However, the National Academies committee explained its rigorous process for finding the highest-quality evidence and for eliminating, to the greatest extent possible, sources of bias that compromise the reliability of research on abortion.[17] In order to ensure an evidence-based approach to the study of abortion safety, the National Academies excluded low-quality research from review, as well as research

[15] *See id.* at 169-75 (biographies of committee members).
[16] *Id.*
[17] *Id.* at 130-33. The National Academies drew solely on studies that met the following: "for the study population, there was objective medical record or patient registry documentation of a prior induced abortion (excluding spontaneous abortion or miscarriage); the study population (women with a documented abortion) was compared with a control group of women with no documented abortion history; the analysis controlled for mental health status prior to the abortion (if assessing the mental health effects of abortion); the study was published in 2000 or later and included abortions performed in 1980 or later (to help ensure that reported outcomes reflected contemporary abortion methods); the clinical settings and care delivery were similar to those in the United States." *Id.* at 132-33.

unlikely to reflect patient outcomes in the context of contemporary U.S. abortion care.[18] This process of drawing conclusions based on the highest quality, most relevant evidence is standard across reputable medical literature. Thus, contrary to Dr. Boles's attempt to paint the National Academies report as biased based on its exclusion of his preferred studies, the National Academies' decision to exclude unreliable data collected through faulty methods actually *eliminates* bias.

31. The conclusions of the National Academies are not only well-supported by the extensive medical literature cited therein,[19] but are fully consistent with my own experience providing both obstetrical and abortion care to thousands of pregnant women over my decades of practice. I have never had a patient who died as a result of an abortion procedure. I have never had a patient admitted to an intensive care unit as a result of an abortion procedure. Although I wish it were otherwise, I cannot say the same for patients who have continued their pregnancies and given birth. My patients who have faced the most serious medical problems and who have required the most complex medical and surgical interventions were those patients who continued their pregnancies into the third trimester and had either a cesarean or vaginal delivery.

32. ***Official government statistics released by the CDC underscore the very low risk of mortality from abortion.*** Nevertheless, Drs. Boles, Parker, and Sullivan each make claims regarding what they believe to be the limitations of data related to mortality and morbidity rates for abortion and/or childbirth, *see* Boles Rep. ¶¶ 15-17; Sullivan Rep. ¶ 22; Parker Rep. ¶ 23, and Dr. Boles in particular offers a critique of rates based on data from the CDC. Boles Rep. ¶¶ 15-17.

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[18] The National Academies also emphasized that applying these principles was "particularly important with respect to understanding abortion's long-term health effects," because it is "an area in which the relevant literature is vulnerable to bias." *Id.* at 38-39.

[19] *See, e.g., id.* at 80-93 (citing references for the committee's findings on safety and quality of abortion); *id.* at 153-158 (citing references for conclusions on abortion's long-term health effects).

These critiques are totally unfounded and arise from a basic misunderstanding of the methodology used to calculate these widely cited mortality and morbidity rates.

33. Dr. Boles largely ignores the extensive evidence showing the safety of abortion as compared to childbirth from the National Academies,[20] instead focusing his criticism on a single 2012 study by Raymond and Grimes and the data underlying it. Boles Rep. ¶¶ 15-17. As I understand from Plaintiffs' counsel, Plaintiffs did not rely on the Raymond and Grimes study for purposes of showing the relative safety of abortion as compared to childbirth, but instead cited the extensive findings of the National Academies, discussed above. In any event, Dr. Boles's criticism is unfounded. He primarily faults the Raymond and Grimes study for relying on data compiled by the CDC, which he claims is incomplete. Dr. Boles argues that there is "no . . . data set that comprehensively reports deaths from abortion in all 50 states." Boles Rep. ¶ 15. He points to the fact that the CDC's count of annual abortions performed relies on state reporting, and that some states do not report abortion statistics to the CDC. But these arguments do not cast doubt on the well-supported consensus view that abortion is safe and is safer than carrying a pregnancy to term.

34. The abortion-related mortality rates that undergird my opinions on safety depend on the number of abortion-related deaths (the numerator) and the number of abortions performed (the denominator). The denominator for these rates does *not* rely on the CDC's count of abortions performed; rather, it relies on the number of abortions performed annually as collected and reported by the Guttmacher Institute.[21] The Guttmacher Institute conducts an annual survey of

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[20] *Id.* at 74-76 (reviewing the evidence on abortion-related mortality and concluding that "the risk of death subsequent to abortion . . . is a small fraction of that for childbirth").

[21] NAS Rep., *supra* note 7 (citing Suzanne Zane et al., *Abortion Mortality in the United States 1998–2010*, 126 Obstetrics & Gynecology 258 (2015)); *see also* Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215 (2012).

abortion providers, including providers in states that do not report to the CDC regarding the number of abortions performed. Guttmacher's "census" of providers consistently finds a larger number of abortions than does the CDC, and estimates the extent of any undercount that remains.[22]

35. Moreover, the numerator for abortion-related mortality rates reflects the annual number of abortion-related deaths identified by the CDC's Pregnancy Mortality Surveillance System. As the CDC explains,

> Since 1987, CDC has monitored abortion-related deaths through its Pregnancy Mortality Surveillance System. Sources of data for abortion-related deaths have included 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.[23]

Defendants' experts ignore the CDC's thorough and comprehensive approach to identifying abortion-related deaths and, accordingly, their criticism of abortion reporting in the United States—both in terms of the number of abortions performed and the number of abortion-related deaths—has no bearing on the widely reported and relied-upon mortality rates for abortion.

36. Dr. Boles also claims that it is "inappropriate to compare abortion mortality rates and maternal mortality ratios when the two measures are not comparable." Boles Rep. ¶ 17. But Dr. Boles fails to provide any explanation of why the two measures are not comparable—indeed, it is these exact two measures that one must compare in answering questions related to the relative safety of abortion and childbirth. Although he cites a letter written by Dr. Julie Louise Gerberding,

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[22] NAS Report, *supra* note 1, at 26.

[23] Tara C. Jatlaoui et al., Ctrs. for Disease Control & Prevention, Abortion Surveillance— United States, 2015, 67(13), MMWR Surveillance Summaries 1 (2018).

the former director of the CDC, her statement that the two measures are "conceptually different" and "used for different public health purposes" is both obvious and irrelevant to the point Dr. Boles is trying to make. Dr. Gerberding's statement merely reflects that the denominators for each of those figures (i.e., live births vs. case fatality rates) is different.

37. ***Defendants' experts' claim that abortion complications are underreported—and that the medical consensus that abortion complications are exceedingly rare is therefore wrong—is completely baseless.*** Boles Rep ¶ 21; Parker Rep. ¶ 19; Sullivan Rep. ¶ 22. For example, Dr. Boles argues that abortion providers "are not even aware of most of the complications experienced by their patients" because women facing post-abortion complications do not receive follow-up care from the physician who provided the abortion but rather seek treatment from "an Emergency Department physician or an on-call GYN Provider." Boles Rep. ¶ 21. He suggests that abortion is therefore actually more dangerous—by some unknown factor—than existing data indicate.

38. As to the suggestion that complications are subject to a substantial undercount because many occur after a patient leaves the facility where she obtained an abortion, it is standard practice for a facility that provides abortion to maintain "an emergency contact service on a 24-hour basis, where calls are triaged," and a pathway for physician referral available for patients who may have a post-procedure complication.[24] Additionally, in my experience, it is very common for abortion providers to follow up with patients after their procedures, either by telephone within a couple days of the abortion, or by offering an in-person follow-up appointment. It has also been

[24] Nat'l Abortion Fed'n, Clinical Policy Guidelines for Abortion Care 50, Standards 12.7-12.9 (2020); *see also id.* at i (explaining the meaning of NAF standards, recommendations, and options), https://prochoice.org/wp-content/uploads/2020_cpgs_final.pdf (last accessed Oct. 3, 2022).

my experience that if a patient seeks care for a post-abortion issue at another facility, the health care professionals there will commonly inform the abortion provider.

39. Moreover, high-quality research has addressed the possibility that complications that manifest after a patient leaves recovery, such as infection, will result in an underestimate of complication rates, or that patients do not feel comfortable telling subsequent doctors about their abortion history. The findings of this research contradict Dr. Boles. To take just one example, a study by Upadhyay et al. examined 2009-2010 patient-level billing data for women insured under California's fee-for-service Medicaid program, which covers abortion care.[25] The authors identified patients who obtained abortions using the program, and then identified treatment for complications from those abortions at the facility providing abortion care or from subsequent visits to an emergency department within six weeks after an abortion.[26] Because California Medicaid data captures treatment for complications at any site, the authors were able to comprehensively identify complications, and they had the benefit of complete follow-up to identify later-occurring complications.[27] The study concluded that the abortion-related complication rate, including both major and minor complications for any abortion method at any point in pregnancy, was 2.11 per 100 abortions.[28] For major complications (those defined as requiring a hospital admission, surgery, or blood transfusion), the rate was 0.23 per 100 abortions.[29] Summarizing their findings, the authors concluded that the "complication rate [for all procedures] is much lower than that found

[25] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 177 (2015).
[26] *Id.* at 177-79.
[27] *Id.* at 178-79.
[28] *Id.*
[29] *Id.*

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."[30]

40. Thus, even if Defendants' experts were correct that abortion-related mortality and morbidity rates are based on undercounts—and they are not—substantial evidence shows that even a moderate level of inaccuracy in these rates would still not change the central conclusion: Abortion is safe, and it is much safer than childbirth

41. ***The studies relied upon by Defendants' experts are deeply flawed and do not undermine the extensive evidence confirming the safety of abortion.*** Defendants' experts' reports are replete with citations to articles with significant methodological flaws or that do not support the claims they make. For example, Dr. Boles cites Niinimaki et al. for his claim that as many as 20% of patients having a medication abortion will experience a significant adverse event. Boles Rep. ¶ 21 n.8. But that is an outlier study from Finland, based on Finnish (not U.S.) health registry data that document complication rates that significantly higher than the very low documented complications rates in the rest of the published literature. Moreover, the authors of that study inappropriately considered *any* follow-up visit to a health care facility to be a "complication." So, for example, a woman whose bleeding was within the normal range could have been coded as having a "hemorrhage" simply because she sought additional consultation.[31] As the authors themselves later explained, "many of the 'complications' are not really such . . . [The] [r]ate of serious, 'real' complications is rare."[32] Similarly, the Gissler et al. study that Dr. Boles cites, Boles Rep. ¶ 19 n.6, also relied on Finnish (not U.S.) registry data and, as the National Academies found,

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[30] *Id.* at 181.
[31] Mary Fjerstad et al., *Letters to the Editor - Immediate Complications After Medical Compared With Surgical Termination of Pregnancy*, 115 Obstetrics & Gynecology 660 (2010).
[32] Maarit Niinimaki et al., *Immediate Complications After Medical Compared With Surgical Termination of Pregnancy*, 114 Obstetrics & Gynecology 795 (2009).

failed to adjust for individual characteristics and social risk factors, which are likely to differ between women who give birth and those who have abortions.[33] As the National Academies explained, "[w]ithout robust risk adjustments for these social differences, attributing [long-term mortality] outcomes to such factors as having an abortion or not, especially when the outcomes are rare, is inappropriate" and thus "no clear conclusions regarding the association between abortion and long-term mortality can be drawn" from this study.[34]

42. Studies of similarly poor quality are the basis for Drs. Boles's and Sullivan's assertion that abortion leads to a host of mental health problems. Boles Rep. ¶ 25(B)(i)-(iii); Sullivan Rep. ¶¶ 23-25. I am not a mental health professional, and neither are Drs. Boles and Sullivan. But I regularly treat women who seek and obtain abortion care, including those with chronic depression and anxiety as well as other common mental health conditions. It is unsurprising that some women with these conditions experience relapses after abortion, just as some women do after birth. The vast majority of my patients experience relief after abortion due to decreased stress after a pregnancy that they decided to end, as well as gratitude for the excellent, safe care they receive. My observations of patients are consistent with the positions of leading scientific organizations, including the American Psychological Association, the National Academies, and the Royal College of Psychiatrists in the United Kingdom, which have all concluded that abortion does not have a negative impact on patients' mental health.[35]

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[33] NAS Report, *supra* note 7, at 152.
[34] *Id.*
[35] Brenda Major et al., Am. Psychological Ass'n, *Report of the APA Task Force on Mental Health and Abortion* 92 (2008); NAS Rep., *supra* note 7, at 10; Nat'l Collaborating Ctr. for Mental Health, Academy of Medical Royal Colleges, *Induced Abortion and Mental Health: A Systematic Review of the Mental Health Outcomes of Induced Abortion, Including Their Prevalence and Associated Factors* 125 (2011).

C. S.B. 23's Exceptions are Vague and Insufficient to Protect Pregnant Patients' Lives, Health and Well-Being

43. Drs. Boles, Parker, and Sullivan argue that S.B. 23's exceptions to its general ban on abortions after embryonic cardiac activity are straightforward. Dr. Boles, for example, claims that the exceptions permit an "intellectually honest physician to rationally and objectively assess the clinical situation and formulate a treatment plan." Boles Rep. ¶ 12. Dr. Parker claims that the exceptions are both "open-ended" and "not vague" and that a "reasonably prudent" and "competent" physician would not "struggle to understand or apply these exceptions." Parker Rep. ¶¶ 9-11. And Dr. Sullivan asserts that the exceptions are "sufficiently clear." Sullivan Rep. ¶ 21. Having reviewed the exceptions myself, I strenuously disagree with these claims.

44. As an initial matter, the language of the exceptions is extremely vague. Terms like "substantial" and "serious" are not medically defined. What constitutes a "serious risk" or a "substantial . . . impairment" will vary according to the determination of the individual physician providing care in any given case. Moreover, S.B. 23 forces physicians determining whether a particular patient's condition poses a "serious risk" of "substantial" impairment to consider the law's harsh penalties. Faced with the threat of losing one's medical license or of potentially being prosecuted and imprisoned, many physicians will proceed extremely cautiously.

45. Dr. Parker suggests that any physician "hesitant to act on their decision due to lack of understanding or fear of consequences" should seek a second opinion, including from "a physician sub-specialty trained in Maternal-Fetal Medicine." Parker Rep. ¶ 11. As an MFM with decades of experience, I am confident that seeking such second opinions would not solve the problems posed by the fundamentally unclear exceptions to S.B. 23. MFMs are not legal experts, and seeking a second opinion from one will not provide a physician with a clear solution in any particular case as to how to provide care under S.B. 23's exception free of legal risk. And, in the

time it takes a physician to seek and obtain legal advice, a patient's condition could worsen, subjecting her to even greater unnecessary risks to her health and well-being.

46. Even if it were clear which conditions fell within the exceptions to S.B. 23, the law would still force many women to become seriously ill before they could access abortion care. For example, pregnant women with severe cardio-pulmonary disease may be able to tolerate the physiological changes of the first trimester but will become predictably more ill as pregnancy proceeds. But under S.B. 23, such a patient could not receive an abortion earlier in pregnancy, even though it would be safer than either continuing the pregnancy to term or receiving a more complex abortion procedure later in pregnancy when her health has deteriorated.

47. Additionally, there are conditions which, while not posing a threat of severe bodily impairment or death, are nonetheless severely debilitating. To take just one example, some women experience hyperemesis while pregnant, which causes them to suffer constant nausea and frequent vomiting. This condition can be so severe that it prevents women from working, taking care of their children, and from completing the basic tasks of daily life; it may also require frequent and/or lengthy hospitalizations. Under S.B. 23's limited exceptions, a woman in this situation who desires an abortion—and any family members dependent on her for their own wellbeing—would be forced to suffer throughout the entirety of her pregnancy.

48. Furthermore, S.B. 23's exceptions exclude the possibility that an abortion may be provided for mental health reasons. This distinction between physical and mental health conditions—and the prioritizing of the former over the latter—reflects an antiquated view of health and harms patients. For example, someone who has suffered debilitating postpartum depression or psychosis after a previous pregnancy may wish to avoid the risk of that outcome occurring again. There is no medically certain way to prevent these postpartum mental health conditions and so the

patient may decide to seek an abortion. No matter how severely her mental health deteriorated in the past, that patient would never be able to receive an abortion in Ohio under S.B. 23's narrow exceptions. This is simply not appropriate medical care.

49. Moreover, as I have discussed, physicians treating patients today must consider factors that go far beyond the physical (and even mental) health of the individual patient. That is, they must be attuned to the many social determinants of health that affect their patients' lives. S.B. 23's exceptions completely ignore these factors. Under the law's narrow exceptions, numerous other considerations that determine a patient's physical and mental health and well-being—e.g., financial inability to provide care for a child or another child; serious disruptions to one's education and career; the need to leave an abusive spouse or partner; becoming pregnant as a result of rape, or incest—would never be enough to justify a patient's need for abortion care under S.B. 23. Any law whose exceptions so utterly fail to account for the many complex and critical reasons why an individual might seek abortion are hopelessly inadequate.

50. The fact that Ohio law provides some examples of conditions that constitute or may constitute a "serious risk of the substantial and irreversible impairment of a major bodily function" does not alleviate my concerns about the vagueness and insufficiency of these exceptions. Indeed, in attempting to define what these exceptions are, the legislature clearly misunderstands clinical medicine and makes distinctions between physical and mental conditions that are neither logical, ethical, nor medically accurate. In listing exceptions, it implies that other reasons may *not* be acceptable and, therefore, physicians may hesitate to proceed with a wanted abortion under those circumstances, unnecessarily delaying care. Even Dr. Parker acknowledges this risk. Parker Rep. ¶ 11 (stating that "[c]reating a detailed list . . . would make [him] more concerned about the criminal penalty if [he] acted on a diagnosis not included on [the] list."). The only ethically

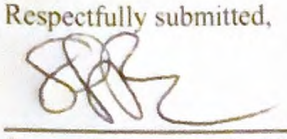
justifiable way to determine whether a particular health care treatment is appropriate in a given case is through shared decision-making between the physician and the patient. S.B. 23 inappropriately and dangerously takes that decision out of the physician's and patient's hands.

51. Finally, S.B. 23's exceptions do not include cases of fetal anomalies, not even lethal fetal anomalies. In my practice, I assess the health and wellbeing of my patients' fetuses in utero using ultrasound and other means. I routinely diagnose fetal anomalies through these means and provide care to patients who receive such diagnoses. While some of my patients who receive fetal diagnoses choose to continue their pregnancies, many do not. The absence of any exception for fetal conditions—no matter how severe or incompatible with life—makes no sense to me as a physician. Without such an exception, women will be forced to carry their pregnancies to term, even when faced with a lethal fetal condition. They will endure all of the typical discomforts—as well as the risks of severe complications—inherent in every pregnancy and then will have to bear the pain and risks of childbirth. Some fetal anomalies predispose women to serious medical conditions such as preeclampsia. For some women, the fetal anomaly may preclude them from having a safe vaginal delivery, forcing them to undergo a cesarean section. A cesarean not only carries significant risks as a major abdominal surgery, but it may force the woman to have the procedure in all future births as well. Continuing a pregnancy complicated by a fetal anomaly may also put a woman at an increased risk of stillbirth, which can predispose the woman to even more pregnancy complications. And even if stillbirth does not occur, the woman will be forced to deliver an infant that, in the case of a lethal fetal anomaly, will die shortly after it is born.

52. For even my patients who have chosen to continue their pregnancies, having a child die shortly after birth can cause significant grief and anguish. Forcing this outcome upon women who would otherwise choose an abortion is incalculably cruel. I hope never to have to tell a patient

of mine that that is her only choice. Because of S.B. 23, however, physicians in Ohio will be forced to do just that.

Respectfully submitted,



Steven Ralston, M.D., M.P.H.

Dated: October 3, 2022

CERTIFICATE OF SERVICE

I hereby certify that on October 3, 2022, the foregoing was served via electronic mail upon counsel for the following parties:

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Exhibit B

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PRETERM-CLEVELAND, *et al.*, *Plaintiffs,* v. DAVID YOST, *et al.*, *Defendants.*	Case No.: A 2203203 Judge: Christian A. Jenkins **PLAINTIFFS' EXPERT REBUTTAL REPORT OF STEVEN JOFFE, M.D., M.P.H.**

I. QUALIFICATIONS

1. I am the Art and Ilene Penn Professor of Medical Ethics & Health Policy and Professor of Pediatrics at the University of Pennsylvania Perelman School of Medicine. In this capacity, I teach and conduct research into various topics related to medical ethics. I also serve as Chair of the Department of Medical Ethics and Health Policy and as Chief of its Medical Ethics Division. In this role, I oversee faculty, trainees, and staff and supervise our biomedical ethics research initiatives. In addition, I serve as Director of the Penn Postdoctoral training program in the Ethical, Legal, and Social Implications of Genetics and Genomics.

2. In addition to my work in medical ethics, I trained as a pediatrician and as a pediatric hematologist/oncologist. Until 2019, I practiced at the Children's Hospital of Philadelphia, where I took care of children undergoing bone marrow transplants for cancer and other serious diseases. I ended my clinical practice in 2019 to focus on my research, teaching, and administrative responsibilities.

3. I have authored and co-authored over 150 peer-reviewed research articles and chapters in medical textbooks, including numerous articles and chapters on issues of medical ethics. In addition, I regularly speak and present on bioethical issues that arise in clinical practice to a variety of different audiences at national medical conferences, as well as at medical centers and universities.

4. I have also led and been a member of numerous national and institutional ethics committees. Between 2008 and 2017, I was the Chair of the Bioethics Committee of the Children's Oncology Group, which is the world's largest pediatric cancer research organization. Between 2007 and 2022, I was a member of the Pediatric Ethics Subcommittee of the Food and Drug Administration. Between 2001 and 2009, I was the Co-Chair of the Ethics Advisory Committee at Dana-Farber Cancer Institute at Harvard Medical School. Between 2010 to 2013, I was a member of the US Department of Health and Human Services Secretary's Advisory Committee for Human Research Protections. At various points, I have also been a member of the ethics advisory committees at Boston Children's Hospital and at the Children's Hospital of Philadelphia. I have completed four fellowships, including a medical ethics fellowship at Harvard Medical School and a professional ethics faculty fellowship at the Center for Ethics and Professions at Harvard University. In addition to my medical degree, I have a Master of Public Health degree in epidemiology.

5. My education, training, and experience are set forth more fully in my curriculum vitae, a copy of which is attached hereto as Exhibit A.

II. OPINIONS TO BE EXPRESSED AND REASONS AND BASES FOR THEM

6. I have been asked by counsel for Plaintiffs to review and respond to the expert report that Dr. Dennis Sullivan has submitted in this litigation.[1] As part of my preparation of this report, I have reviewed the Expert Report of Dr. Dennis Sullivan, M.D., M.A., many of the supporting documents cited by Dr. Sullivan, and the materials listed in my report.

7. I provide the following opinions as an expert in medical ethics. The opinions herein are based on my knowledge and experience caring for patients, teaching medical ethics, advising physicians, hospitals, and medical associations on medical ethics, research and publications on medical decision making by patients and physicians, and academic literature on principles of medical ethics.

8. I have reviewed the text of Senate Bill 23 ("S.B. 23"), the statute that is challenged in this case. I understand that, with limited exceptions, S.B. 23 bans abortions after the detection of embryonic cardiac activity, which occurs starting at approximately six weeks into pregnancy (as measured from the first day of a patient's last menstrual period, or "LMP"), and can occur as early as during the fifth week LMP. I also understand from Plaintiffs' counsel that the State has attempted to justify S.B. 23's ban on abortions by the State's purported interest in protecting potential life. *See* Opp. to TRO at 20.

9. Although my report is primarily directed at the opinions offered by Dr. Sullivan on medical ethics as they pertain to S.B. 23, as noted below, it is my opinion, based on my

[1] This expert report responds to Dr. Sullivan's arguments related to medical ethics as they pertain to S.B. 23. While I do not address other opinions contained in Dr. Sullivan's report, my silence on a particular point or opinion of Dr. Sullivan's should not be interpreted as agreement on that point.

training, experience, and expertise in biomedical ethics, that the State's justifications for S.B. 23 are inconsistent with the central tenets of medical ethics.

III. REBUTTAL OPINION

10. Medical ethics is a system of moral principles that provides standards of professional conduct within the practice of medicine for patients' benefit. A patient seeking medical care places an extraordinary degree of trust in a medical provider—patients must tell doctors extremely private information, put their bodies in the doctor's hands, and trust the doctor to perform medical interventions. The system of medical ethics is necessary to inform and govern that trust-based relationship—the medical profession requires that providers adhere to ethical principles in order to be worthy of the trust that patients and society place in them.

11. Ethical physician behavior recognizes that patients' rights and interests are paramount. The central tenets of medical ethics are (1) respect for patients' autonomy as individuals, including the obligation to act on patients only with their informed consent ("autonomy"); (2) acting in patients' best interests ("beneficence"); (3) avoiding unnecessary harm to patients ("non-maleficence"); and (4) promoting justice for patients and for society.[3]

12. These tenets stem from the patient's basic human right to be treated with respect and consideration for their health and well-being and to make autonomous decisions. The World Medical Association's Declaration of Geneva, also known as the "Modern Hippocratic Oath,"

[3] Tom L. Beauchamp & James F. Childress, Principles of Biomedical Ethics (7th ed. 2009).

requires physicians to attest that the "health and well-being of [their] patient[s] will be [their] first consideration" and that they "will respect the autonomy and dignity of [their] patient[s]."[4]

13. While Dr. Sullivan acknowledges these principles are widely accepted, *see* Report at ¶ 15, he contends that in all cases other than where there is a serious threat to the patients' life or health, the balance of the principles weighs in favor of requiring a patient to continue a pregnancy against her will and prohibiting her from getting an abortion. *See id. at* ¶¶ 7, 18. He does this by assuming that the application of non-maleficence toward the fetus is itself a universally accepted proposition, and further by finding that the application of non-maleficence toward the fetus[5] trumps virtually all other considerations.

14. It is not. The question of how to strongly to weigh the moral status of the fetus in applying the principle of non-maleficence to it is an open one. Even more importantly, the application of the principle of non-maleficence toward the fetus is itself highly contested. By avoiding that debate, Dr. Sullivan fails to consider the obligations of the clinicians towards the pregnant patient, including toward her well-being and autonomy. Indeed, Dr. Sullivan's failure to consider the interests of the pregnant patient, beyond her life and serious threats to her health, represents a profound failure to respect her as a person, which medical ethics requires.

15. An important distinction to bear in mind—one that Dr. Sullivan's arguments elide—is the distinction between morality and ethics. "Morality" refers to a system of values and obligations that an individual applies to her own life and that governs her treatment of

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[4] World Medical Association, Declaration of Geneva, https://www.wma.net/policies-post/wmadeclaration-of-geneva/ (last visited Oct. 2, 2022).

[5] I use "fetus" to encompass both fetal and embryonic stages of pregnancy. At the roughly 6-week mark at issue in this case, the patient is pregnant with an embryo, not yet a fetus.

others. Individual morality varies from person to person and, in this context, from physician to physician. Furthermore, for many people, individual morality includes commitments based in religious values, which vary greatly in our diverse and pluralistic society. "Ethics," particularly when used in the professional context, as in "medical ethics," is—as explained above—a much more specific concept that relates to an individual's responsibilities and obligations in a particular role. Thus, even though individual physicians may live life according to their own set of moral principles, all physicians are required to provide patient care under the same universal, baseline set of ethical principles. In the context of abortion care, individual physicians may have different views on the morality of abortion.[6] However, the profession supports the provision of abortion care as consistent with medical-ethics principles.[7]

16. The principles of medical ethics demand that it is the *patient's* values and intentions rather than the healthcare provider's that should play the primary role in determining the moral status of the fetus. Consequently, the moral status that Dr. Sullivan accords to the fetus without question is specific to him and others who share his commitments; it is not necessarily applicable to patients who do not share his philosophical or religious views. In reality, the moral status accorded to the fetus is contingent on both the circumstances of the

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[6] *See, e.g.*, American Medical College ("AMA"), H-5.990 Policy on Abortion (2009) ("The issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs."), https://policysearch.amaassn.org/policyfinder/detail/Policy%20on%20Abortion%20H-5.990?uri=%2FAMADoc%2FHOD.xml-0-4541.xml.

[7] *See, e.g.*, Brief of Amici Curiae of ACOG and AMA in Support of Plaintiffs-Appellees & in Support of Affirmance, at 2, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, No. 13-51008 (5th Cir. Dec. 19, 2013) ("Access to safe and legal abortion is an important aspect of women's health care."); ACOG Comm. Op. No. 815, *Increasing Access to Abortion*, at 2 (Replaces ACOG Comm. Op. No. 613, Nov. 2014, reaffirmed 2017) ("[Women] require access to safe, legal abortion.").

pregnancy and the values and intentions of the pregnant patient. For example, in the event that a fetus has a serious congenital anomaly, some patients might choose not to continue in their pregnancy, while other patients might wish to make every effort to carry the pregnancy to term. In either instance, it is the values and intentions of the patient that determines the moral status accorded to the fetus, and consequently should determine the obligations of the healthcare provider to the fetus.

17. Instead of considering the intentions and values of the patient, Dr. Sullivan seeks to impose his view of the moral status of a fetus or embryo on all physicians. But this is not a universal view and is, in fact, the subject of much debate. Specifically, Dr. Sullivan asserts that life begins at conception. *See* Report at ¶ 9. This is a philosophical and religious construct rather than a medically agreed-upon truth.[8] In fact, there are a wide range of views as to what moral status should be accorded to a fetus.[9] The breadth and diversity of these factors renders it false to declare that "we can definitively conclude that the humanity of the unborn begins at conception." Report at ¶ 12.

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[8] *See* Ruth Macklin, *Personhood in the Bioethics Literature*, 61 Milbank Mem'l Fund Quarterly/Health & Soc'y 35, 38-39 (1983) ("Two additional, general characterizations of personhood in the bioethics literature are worth noting . . . The first feature is the almost total absence of attempts to demonstrate a strictly scientific basis for determining when personhood begins. . . [T]here are no serious proponents of a strictly scientific criterion for personhood in the bioethics literature. . . My survey of the bioethics literature did not reveal a single proponent of the view that when personhood begins is a straightforward scientific question.").

[9] *See id.* at 40 ("[T]here remains such intractable and wide disagreement over the meaning of 'person,' about the criteria for its correct application, and about the true conditions for its proper use in practice[.]"); Elissa Strauss, *When Does Life Begin? It's Not So Simple,* Slate (Apr. 4, 2017) ("Many religious traditions, including a number of denominations of Christianity, are ambivalent about the beginnings of life. The Evangelical Lutheran Church in America and many American Baptists don't believe abortion is akin to murder. Presbyterians concede that they 'may not know exactly when human life begins' and encourage their followers to make their own careful decisions on abortion. Unitarians are more overtly pro-choice and 'believe not only in the value of life itself but also in the quality of life.'").

18. By seeking to impose his own moral views, Dr. Sullivan short-circuits a key ethical consideration involved in the provision of abortion: namely, how to weigh the moral status of a fetus relative to the interests, including the well-being, of the pregnant patient. Dr. Sullivan's report makes it clear that he is only willing to do that difficult weighing in the extreme cases in which there is an imminent threat to the pregnant patient's life or health. *See* Report at ¶ 13. In an exceptional circumstance, Dr. Sullivan acknowledges that "the balance rests with saving the mother's life[.]" *Id.* at ¶ 18. Dr. Sullivan thus oversimplifies the care physicians owe their pregnant patients in all scenarios, not just extreme cases. In doing so, he ignores the fact that balancing takes place at all times. Dr. Sullivan avoids this balancing by presumptively according the fetus a specific moral status—a status presumably drawn from his own moral or religious beliefs and one that fails to respect the diversity of views that different people hold on this deeply personal issue.

19. Critically, Dr. Sullivan also omits the proper role of autonomy in ethical balancing. He accurately identifies autonomy as a key tenet of medical ethics but too narrowly defines the role of medicine in respecting and promoting patients' autonomy over their own lives. The medical principle of autonomy suggests that, as Dr. Sullivan puts it, "[p]atients and their surrogates should be able to make their own decisions." Report at ¶ 15. Yet, contrary to Dr. Sullivan's opinion, these decisions are not limited to being empowered to accept or decline specific medical procedures, but instead expand to empowering patients to set the direction of their own lives. Healthcare professionals thus play an instrumental role in enabling this autonomy in their patients. This includes through the provision of abortion, which has

significant ramifications not only for patients' health and physical and mental well-being, but also for the course of their lives and abilities to live in accordance with their own values.

20. Dr. Sullivan acknowledges the balancing that must occur between the interests of the pregnant person and the interests of the fetus, but he still errs in his analysis by confining his consideration primarily to issues of non-maleficence and by weighing the interests of the fetus over those of the pregnant patient in all but the most extreme cases. In fact, he entirely discounts the interests, wishes, and values of the pregnant patient except in case of serious threat to her life or health. *See* Report at ¶¶ 18-19. This is not consistent with the mainstream view of medical ethics and improperly privileges the interest of the fetus over the autonomy and well-being of the pregnant patient.

21. It is contrary to well-established medical-ethics principles for a physician to deny a medical intervention to a pregnant patient without taking into account their specific pregnancy intentions or the stage of their pregnancy. This is the proper recognition of the autonomy of the pregnant patient and is the ethical position adopted by the American College of Obstetricians and Gynecologists (ACOG), the leading medical association of women's healthcare physicians. For example, the ACOG Committee on Ethics promotes decision-making guidelines centered around the physician's obligation to "act in a way that is likely to benefit the patient."[10] ACOG has stated that "[f]or situations in which [maternal and fetal] interests diverge, the pregnant woman's

[10] ACOG Comm. Op. No. 390, *Ethical Decision Making in Obstetrics and Gynecology,* at 3 (Dec. 2007, reaffirmed 2016).

autonomous decisions should be respected."[11] "[E]ven though views about the moral status of the fetus and the obligations that status confers differ widely, support of such moral pluralism does not justify an erosion of clinicians' basic obligations to protect the safety of women who are, primarily and unarguably, their patients."[12] This is why ACOG "strongly opposes any effort that impedes access to abortion care and interferes in the relationship between a person and their healthcare professional" and has stated that "[i]ndividuals seeking abortion must be afforded privacy, dignity, respect, and support, and should be able to make their medical decisions without undue interference by outside parties."[13]

22. In short, though Dr. Sullivan recognizes that the principle of non-maleficence requires balancing with other obligations, he asserts a near-absolute obligation of non-maleficence toward the fetus and elevates it at the expense of the patient's autonomy, health, and well-being. *See* Report at ¶ 18. Dr. Sullivan's Report barely considers the interests of the pregnant person at all. This lack of consideration flows from his own highly personal set of philosophical and religious beliefs, beliefs which lead him to accord a weightier moral status to the fetus than to the pregnant patient unless her life or health are seriously threatened. But the imposition of personal views on all physicians and patients is at odds with the contemporary ethical practice of medicine. Medical ethics demands that the balancing of interests and values

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[11] ACOG, Comm. Op. No. 385, *The Limits of Conscientious Refusal in Reproductive Medicine*, at 3 (Nov. 2007, reaffirmed 2016).

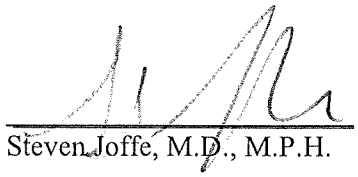
[12] *Id.*

[13] ACOG, *Abortion Policy*, https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy (last visited Oct. 2, 2022).

involved should be led by the patient, including in the provision of abortion by health care professionals.

Respectfully submitted,

Dated: October 3, 2022



Steven Joffe, M.D., M.P.H.

CERTIFICATE OF SERVICE

I hereby certify that on October 3, 2022, the foregoing was served via electronic mail upon counsel for the following parties:

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Michelle Nicole Diamond (Pro Hac Vice)

Exhibit C

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PRETERM-CLEVELAND, *et al.*, *Plaintiffs,* v. DAVID YOST, *et al.*, *Defendants.*	Case No.: A 2203203 Judge: Christian A. Jenkins EXPERT DECLARATION OF SHARON LINER IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Sharon A. Liner, M.D., declare as follows:

1. I am a board-certified family physician with 19 years of experience in women's health. I am licensed to practice medicine in the state of Ohio. For nearly 17 years, I have been the Director of Surgical Services and, since October 2018, the Medical Director of Planned Parenthood Southwest Ohio Region (PPSWO) in Cincinnati, Ohio. I have worked as a physician at PPSWO since 2004, and have provided abortion in an outpatient setting since 2002.

2. I earned a B.S. in Medical Technology from Michigan State University and graduated from medical school at Michigan State University, College of Human Medicine. I completed my residency in Family Medicine at the University of Cincinnati.

3. In my current roles as the Director of Surgical Services and Medical Director at PPSWO, I oversee all medical services that we provide, including abortion. This includes supervising other physicians and clinicians, developing PPSWO's policies and procedures, and providing direct reproductive health care to patients. In my current practice, I provide medication abortions up to 10 weeks of pregnancy as measured from the first day of a patient's last menstrual period (LMP) and surgical abortions through 21 weeks 6 days LMP.

4. I understand Senate Bill 23 (S.B. 23) makes it a crime to perform an abortion once embryonic cardiac activity has been detected, which is typically around 5-6 weeks LMP. This has the effect of severely limiting abortion access in Ohio.

5. On September 2, 2022, I submitted a declaration in support of Plaintiffs' Motion for Temporary Restraining Order Followed by Preliminary Injunction. I hereby incorporate that declaration by reference.

6. The information in this declaration is based on my personal and professional knowledge unless otherwise noted, and my opinions are based on my education, training, and expertise. If called and sworn as a witness, I could and would testify competently thereto.

PPSWO and its Services

7. PPSWO is a nonprofit corporation organized under the laws of Ohio with its headquarters in Cincinnati, Ohio.

8. PPSWO provides affordable, respectful, and high-quality health care to tens of thousands of patients in southwest Ohio each year. We operate four health centers in the greater Cincinnati and Miami Valley regions. Those health centers provide a wide range of reproductive health services, including well-woman exams, screening for breast and cervical cancer, contraception and contraceptive counseling, and testing and treatment for sexually transmitted diseases. Approximately 75% of the patients treated at our health centers have low-incomes.

9. PPSWO also operates a licensed ambulatory surgical facility (ASF) in Cincinnati where we provide abortions.

S.B. 23 Does Not Protect Patient Health

10. I am familiar with Ohio's ban on abortion after detection of embryonic cardiac activity. Prohibiting physicians from providing abortions after approximately 6 weeks LMP

except in extraordinarily limited circumstances contravenes the standard of care and will compromise physicians' ability to provide essential, evidence-based healthcare to pregnant Ohioans.

S.B. 23 Bans the Majority of Abortions in Ohio

11. For most patients with a normally developing pregnancy, embryonic cardiac activity can be detected on an ultrasound starting at approximately 6 weeks LMP, but can sometimes be detected as early as 5 weeks LMP. This is a very early stage in pregnancy. An embryo does not become a fetus until approximately 8 to 10 weeks LMP. At four weeks LMP, a transvaginal ultrasound might show the gestational sac as a ring within the uterus, but the yolk sac and embryo likely would not yet be visible. At 5 weeks LMP, the ultrasound might show the yolk sac as well as the gestational sac. By 6 weeks LMP, the ultrasound image would include the gestational sac, the yolk sac, and the embryo, and the electrical impulse that constitutes embryonic cardiac activity at this stage would usually be visible as a flicker within the embryo. Sometimes this flicker is visible as early as partway through the fifth week LMP.

12. Patients generally obtain an abortion as soon as they are able, but most patients are at least 6 weeks LMP by the time they have an abortion because they do not learn they are pregnant before 6 weeks LMP. Some people have fairly regular menstrual cycles; a 4-week cycle is common. In a person with a regular 4-week cycle, fertilization typically occurs at 2 weeks LMP. Thus, a person with a highly regular, 4-week cycle would already be 4 weeks LMP when she misses her period, and before that time, most over the counter pregnancy tests would not be sensitive enough to detect a pregnancy. Many people can also have menstrual cycles of different lengths. Some people can go 6 to 8 weeks or more without experiencing a menstrual period. It is also common for people to have irregular menstrual cycles for a variety of reasons, including

certain medical conditions, contraceptive use, obesity, and age. Teens commonly have irregular cycle lengths. In addition, breastfeeding can suppress menstruation for months, after which a person's cycles can be irregular for a period of time.

13. Also, pregnancy itself is not always easy to detect. Some pregnant patients experience light bleeding that occurs when a fertilized egg is implanted in the uterus. This implantation bleeding is often mistaken for a menstrual period. Further, although some pregnant people experience nausea and vomiting or other symptoms early in pregnancy, many do not.

14. Even after a patient learns she is pregnant, making the decision to terminate a pregnancy, arranging an appointment for an abortion, and actually obtaining an abortion takes time. Patients typically need to gather funds for an abortion and for any related travel, and arrange for time off work, child care, and transportation to an abortion provider. These logistical difficulties are compounded by Ohio law requiring that patients make two visits to a health center at least 24 hours apart in order to obtain an abortion.

15. The bottom line is that obtaining an abortion before 5 or 6 weeks LMP, when embryonic cardiac activity can be detected, is extraordinarily difficult, if not impossible, for the vast majority of patients.

Abortion is Safe, Common Medical Care

16. Legal abortion is extremely common in the United States. According to published studies, approximately one in four women in this country will have had an abortion by the age of forty-five.

17. The decision whether or not to obtain an abortion is a profoundly personal choice. Some patients choose to obtain an abortion because they are realistically facing serious health risks, including long-term risks to their physical or mental health. This includes risks short of

death or a serious risk of substantial and irreversible physical impairment of a major bodily function. Some patients are victims of domestic abuse and choose to obtain an abortion because of concerns that a pregnancy will result in further harm to them from their abusers. Some are patients of "advanced maternal age" with pregnancies with increased risk of birth defects. Some have families already and cannot afford another child. Some simply are not able to have a child at that point in their lives.

18. In Ohio and the United States generally, by far the largest percentage of abortions occur in the first trimester of pregnancy.[1] Abortions are performed using either medication or a procedure (also known as a surgical or procedural abortion). Medication abortions are available in Ohio up to 10 weeks LMP[2], and involve the ingestion of two types of medication in pill form approximately 24 hours apart that results in a process similar to a miscarriage. Procedural abortions are performed by dilating, or opening, the uterine cervix and then using suction, sometimes in combination with instruments, to empty the uterus.

19. Legal abortion is one of the safest medical procedures in the United States. Abortion is substantially safer than continuing a pregnancy through childbirth. The mortality rate for abortion in the United States is 0.7 per 100,000 procedures as compared to 8.8 per 100,000 for childbirth. In other words, the risk of death from childbirth is more than 12 times higher than that

[1] For example, in 2019, 79.3% of abortions were performed at less than 9 weeks' gestation, and nearly all (92.7%) were performed at less than 13 weeks' gestation. Katherine Kortsmit et al., *Abortion Surveillance - United States, 2019*, Morbidity & Mortality Weekly Report (Nov. 26, 2021), https://www.cdc.gov/mmwr/volumes/70/ss/ss7009a1.htm (accessed Oct. 3, 2022)

[2] R.C. 2919.123 restricts the administration of abortion-causing medication to no later than 10 weeks LMP.

from abortion.[3] Abortion is also safer than other common medical procedures such as colonoscopies (2.9 per 100,000) and adult tonsillectomies (2.9-6.3 per 100,00).[4]

20. Complications from abortions are rare. Less than 1% of patients obtaining abortions experience a serious complication, and the risk of a patient experiencing a complication that requires hospitalization is even lower, at approximately 0.3%.[5] When complications do occur, they can usually be managed in an outpatient setting, either at the time of an abortion or during a follow-up visit. By contrast, every pregnancy-related complication is more common among patients having live births than among those having abortions.

21. Although abortion is very safe, the physical risks associated with abortion—as is true with pregnancy generally—increase with gestational age, so delays in accessing abortion increase risks to the patient.

Health Risks of Pregnancy and Childbirth

22. Even in an uncomplicated pregnancy, an individual experiences a wide range of physiological challenges, the majority of which may not occur until well after 6 weeks LMP. Individuals experience a quicker heart rate, a substantial rise in their blood volume, digestive difficulties, increased production of clotting factors, significant weight gain, changes to their breathing, and a growing uterus. These and other changes put pregnant patients at greater risk of blood clots, nausea, hypertensive disorders, and anemia, among other complications. Although many of these complications can be mild and resolve without medical intervention, some require

[3] Nat'l Acads. of Scis. Eng'g & Med., *The Safety & Quality of Abortion Care in the United States* at 74 (2018).
[4] *Id.* at 75.
[5] Ushma Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 175 (2015).

evaluation and occasionally urgent or emergent care to preserve the patient's health or save their life.

23. Pregnancy stresses most major organs. By mid-pregnancy, a pregnant person needs to pump 50 percent more blood than usual, resulting in an increased heart rate. The increased blood flow, in turn, enlarges the kidneys, and the liver must produce more clotting factors to prevent hemorrhage when the placenta separates from the uterus. These changes increase the chances of blood clots or thrombosis. Pregnancy also deeply affects the lungs: they must work harder to clear not only the carbon dioxide created by the patient's own body, but also the carbon dioxide produced by the fetus. As the pregnancy progresses, the lungs are compressed by the growing fetus, leaving most pregnant women feeling chronically short of breath. Indeed, every organ in the abdomen—e.g., intestines, liver, spleen—is increasingly compressed throughout pregnancy by the expanding uterus.

24. Pregnancy can also exacerbate preexisting health conditions, including diabetes, kidney disease, hypertension and other cardiac diseases, autoimmune disorders, and asthma and other pulmonary diseases. It can lead to the development of new and serious health conditions as well, such as hyperemesis gravidarum, preeclampsia, deep vein thrombosis, and gestational diabetes. Many people seek emergency care at least once during a pregnancy, and people with comorbidities (either preexisting or those that develop as a result of their pregnancy) are significantly more likely to do so. People who develop pregnancy-induced medical conditions are at higher risk of developing the same condition in subsequent pregnancies.

25. Pregnancy may also induce or exacerbate mental health conditions. Those with histories of mental illness may experience a return of their illness during pregnancy. These mental health risks can be higher for patients with unintended pregnancies, who may face physical and

emotional changes and risks that they did not choose to take on. Pregnant people with a prior history of mental health conditions also face a heightened risk of postpartum illness, which may go undiagnosed for months or even years.

26. Even a normal pregnancy with no comorbidities or complications can suddenly become life-threatening during labor and delivery. For example, during labor, increased blood flow to the uterus places the patient at risk of hemorrhage and, in turn, death. Hemorrhage leading to blood transfusion is the leading cause of severe maternal morbidity. Other potential adverse events include unexpected hysterectomy (the surgical removal of the uterus), ruptured uterus or liver, stroke, respiratory failure, kidney failure, hypoxia (an absence of sufficient oxygen in bodily tissue to sustain function), and amniotic fluid embolism (a condition in which the fluid surrounding a fetus during pregnancy enters the patient's bloodstream).

27. Many Ohioans deliver via cesarean section ("C-section") rather than vaginally.[6] A C-section is an open abdominal surgery that requires hospitalization for 3-4 days on average, and carries even higher risks of hemorrhage, infection, venous thromboembolism (blood clots), and injury to internal organs, including major blood vessels, the bowel, ureter, and bladder, as compared to vaginal delivery. It can also have long-term risks, including an increased risk of placenta accreta in later pregnancies (when the placenta grows into and possibly through the uterine wall causing a need for complicated surgical interventions, massive blood transfusions, hysterectomy, and risk of maternal death), placenta previa in later pregnancies (when the placenta covers the cervix, resulting in vaginal bleeding and requiring bed rest), and bowel or bladder injury

[6] Centers for Disease Control and Prevention, *Cesarean Delivery Rate by State* (last reviewed Feb. 25, 2022), available at https://www.cdc.gov/nchs/pressroom/sosmap/cesarean_births/cesareans.htm (accessed Oct. 3, 2022).

in future deliveries. Individuals with a history of C-sections are also more likely to need C-sections with subsequent births.

28. The starkest risk of carrying a pregnancy to term is death. In Ohio, women died from pregnancy-related causes at a ratio of 14.7 per 100,000 live births from 2008 through 2016.[7] In 2018, the maternal mortality rate was 14.1 per 100,000 live births.[8]

29. The maternal mortality rate in Ohio is significantly higher for Black women. In Ohio, Black women are two-and-a-half times more likely to die from a cause related to pregnancy than white women.[9]

30. S.B. 23 does not provide any exceptions for severe or lethal fetal anomalies. S.B. 23 will thus also add to the pain of patients and their families who receive fetal diagnoses later in pregnancy. There is no prenatal testing for fetal anomalies available at 6 weeks LMP or earlier that could detect these anomalies. Indeed, many anomalies cannot be identified until 18 to 20 weeks LMP, as the fetal anatomy scan is not conducted in most pregnancies until 20 weeks LMP. Often these pregnancies are wanted throughout the first trimester of pregnancy and into the second. As I discussed in my previous declaration, we have seen patients whose pregnancies have been diagnosed with severe fetal anomalies who had to be referred out of state to obtain care due to the restrictive nature of S.B. 23.

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[7] Ohio Dept. of Health, *A Report on Pregnancy-Associated Deaths in Ohio 2008 - 2016*, https://odh.ohio.gov/know-our-programs/pregnancy-associated-mortality-review/reports/pregnancy-associated-deaths-ohio-2008-2016 (accessed Oct. 3, 2022).
[8] Centers for Disease Control & Prevention, *Maternal Mortality by State, 2018*, https://www.cdc.gov/nchs/maternal-mortality/MMR-2018-State-Data-508.pdf (accessed Oct. 3, 2022).
[9] Ohio Dept. of Health, *A Report on Pregnancy-Associated Deaths in Ohio 2008 - 2016*, https://odh.ohio.gov/know-our-programs/pregnancy-associated-mortality-review/reports/pregnancy-associated-deaths-ohio-2008-2016 (accessed Oct. 3, 2022) (Black women in Ohio have a maternal mortality rate of 29.5 deaths per 100,000 compared to 11.5 deaths per 100,000 births for white women).

Economic, Social, and Emotional Harms Caused by Denial of Abortion Care

31. In addition to the physical and mental health risks associated with forced pregnancy and childbirth, people who are forced to bear a child against their will also face a host of economic and social harms. Due to structural barriers that limit access to contraceptives, people with lower incomes experience disproportionately high rates of unintended pregnancies. For people already facing an array of economic hardships, the cost of pregnancy can have especially long-term and severe impacts on their family's financial security. Some side-effects of pregnancy render patients unable to work, or unable to work the same number of hours as they otherwise would. For example, some patients with hyperemesis gravidarum must adjust their work schedules because they vomit throughout the day. Others with conditions like preeclampsia must severely limit activity for a significant amount of time. These conditions may result in job loss, especially for people who work unsteady jobs, such as jobs without predictable schedules, paid sick or disability leave, or other forms of job security.

32. Pregnancy-related health care and childbirth are some of the most expensive hospital-based health services, especially for complicated or at-risk pregnancies. This financial burden can weigh most heavily on patients without insurance. Even insured pregnant patients must often still pay for considerable labor and delivery costs out of pocket.

33. Beyond childbirth, raising a child is expensive, both in terms of direct costs and due to lost wages. On average, women experience a large and persistent decline in earnings following the birth of a child, an economic loss that compounds the additional costs associated with raising a child.

34. Some pregnant patients also face an increased risk of violence perpetrated by an intimate partner, with the severity of such violence sometimes intensifying during or after

pregnancy. Homicides, the majority of which are caused by an intimate partner, are a leading cause of maternal mortality.

35. Women who seek but are denied an abortion are, when compared to those who are able to access abortion, less likely to be employed full-time, more likely to be raising children alone, more likely to receive public assistance, more likely to not have enough money to meet basic living needs than women who received an abortion, and less likely to be able to exit abusive relationships.[10] The children they already have are also more likely to suffer measurable reductions in achievement of child developmental milestones and an increased chance of living in poverty.[11]

36. Women who seek but who are denied an abortion are, when compared to those who are able to access abortion, more likely to moderate their future goals, and less likely to be able to exit abusive relationships. Research shows that 95% of women who obtain abortions continue to believe it was the right decision for them three years later.[12]

S.B. 23's Limited Exceptions

37. I understand S.B. 23 would permit abortions only in two extremely limited circumstances: abortion after cardiac activity is detected is permitted only if the abortion is necessary (1) to prevent the woman's death, or (2) to prevent a "serious risk of the substantial and irreversible impairment of a major bodily function." S.B. 23, Section 1, amending R.C. 2919.195(8).

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[10] Diana G. Foster, M. Antonia Biggs, Lauren Ralph et. al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, American Journal of Public Health. 108(3): 407-413 (Mar. 2018).
[11] *Id.*
[12] Corinne H. Rocca et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, 10 PLoS One 1, 10 (2015).

38. The statute defines "'[s]erious risk of the substantial and irreversible impairment of a major bodily function' [to mean] any medically diagnosed condition that so complicates the pregnancy of the woman as to directly or indirectly cause the substantial and irreversible impairment of a major bodily function."[13] A "medically diagnosed condition that constitutes a 'serious risk of the substantial and irreversible impairment of a major bodily function' includes pre-eclampsia, inevitable abortion, and premature rupture of the membranes," and "may include, but is not limited to, diabetes and multiple sclerosis," but "does not include a condition related to the woman's mental health."[14]

39. The vague language of these exceptions offers providers no clarity as to which medical situations qualify as those creating a "serious risk of the substantial and irreversible impairment of a major bodily function." Even the specifically enumerated conditions vary widely in severity and it is not clear how sick a patient must be as a result of one those conditions before an abortion would be legal under S.B. 23. Physicians will not be willing to provide abortions under these exceptions except in the most grave medical situations, as providing an abortion to a patient who does not 100% clearly fall under an exception could cause a physician to lose not only their medical license, but their freedom. As a result, physicians have been forced to turn away patients experiencing significant health issues due to uncertainty as to whether the statutory definition applies to their circumstances. As I explained in my prior declaration, while S.B. 23 was in effect, I met with a patient who needed an abortion to be able to access needed chemotherapy treatment for recurrent cancer. Though I requested documentation from her

[13] R.C. 2919.16(K).
[14] *Id.*

provider to support a medical exemption under S.B. 23, her provider did not feel comfortable providing such documentation and we were forced to refer the patient elsewhere.

40. Moreover, even if the exception were clear as to exactly how serious a patient's medical condition was required to be in order for the exception to apply, the exception certainly leaves out many patients whose medical conditions are serious and life altering, but not serious enough to fall within the exception. These patients will be forced to carry their pregnancies to term and suffer the consequences to their physical health.

41. As stated in my declaration submitted in support of Plaintiffs' Motion for Temporary Restraining Order, I have seen firsthand that these exceptions are unworkable and have not provided any relief from the impacts of S.B. 23.

Respectfully submitted,

Dated: October 3, 2022

Sharon Liner, M.D.

CERTIFICATE OF SERVICE

I hereby certify that on October 3, 2022, the foregoing was served via electronic mail upon counsel for the following parties:

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Exhibit D – Placeholder for Deposition of Michael S. Parker, M.D., Filed with the Court for In Camera Review

Exhibit E – Placeholder for Deposition of Allegra Pierce, Filed with the Court for In Camera Review