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IN THE COURT OF COMMON PLEAS
FOR FRANKLIN COUNTY, OHIO

PRETERM-CLEVELAND, *et al.*,	:	
	:	**Case No. 24CV2634**
Plaintiffs,	:	
	:	**Judge David C. Young**
v.	:	
	:	
ANDY WILSON[1], *et al.*,	:	
	:	
Defendants.	:	
	:	
	:	

THE STATE'S OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Plaintiffs ask this Court to wield Ohio's constitutional Amendment as a sword, weaponizing it into a shield against any regulation of abortion. That is not what Article I, § 22 says or permits. The Amendment expressly protects not only the right to terminate a pregnancy but also the right to continue one, and it preserves the State's authority to enact regulations that advance reproductive health and safety. Plaintiffs have failed, from start to finish, to meet their burden under § 22(A) to show that the statutes "burden, penalize, prohibit, interfere with, or discriminate against" constitutionally protected rights, and their arguments skirt dangerously close to assuming away factual disputes instead of presenting admissible, credible evidence. Even if the statutes implicate § 22(A), they clearly satisfy § 22(B). Defendants' compelling expert testimony demonstrates that 24-hour waiting periods, provider-led in-person counseling, and mandated

[1] Defendant Dave Yost, having been sued in his official capacity prior Attorney General of Ohio, has been replaced inthe case caption as a Defendant with current Attorney General Andy Wilson.

disclosures promote patient understanding, decisional stability, medical safety, and the constitutional right to continue pregnancy—exactly the kinds of protections the Amendment intends. Critically, Plaintiffs have offered no less restrictive alternative that is both effective and empirically grounded and instead rely on assertions devoid of on-point expert support. With mounting disputes at almost every critical issue, the Court cannot irreversibly tilt the factual balance in Plaintiffs' favor. Summary judgment must be denied.

STATEMENT OF FACTS

I. Background of the Challenged Statutory Framework

Mifepristone, a drug used in medication abortions, was approved by the FDA in 2000 under an accelerated approval process within a category of drugs used to treat serious or life-threatening illnesses. *Alliance for Hippocratic Med. v. FDA,* 5th Cir. No. 23-10362, 2023 U.S. App. LEXIS 8898, at *8 (Apr. 12, 2023). The drug was sold under the brand name Mifeprex. *Id.* The FDA concluded that post-approval restrictions were required to ensure the safe prescription and use of the drug, which included: "(1) limiting the drug to pregnant women and girls for use through 49 days gestation; (2) requiring three in-person office visits, the first to administer mifepristone, the second to administer misoprostol, and the third to assess any complications and ensure there were no fetal remains in the womb; (3) requiring the supervision of a qualified physician; and (4) requiring the reporting of all adverse events from the drugs." *Id.*, citing FDA Add. 181-91. Through a change in the federal law, the FDA approved a REMS (Risk Evaluation and Mitigation Strategy) for Mifepristone in 2011 that contained the same requirements. *See* Opp PI, Ex. A.

In approving Mifeprex, the FDA recognized that the medication carries serious risks, including incomplete abortion or serious bleeding that may require surgical intervention and that

can cause maternal death. Opp PI, Ex. B at 4-6, 17; *see id.* at 5 ("Up to 8% of all subjects may experience some type of bleeding for 30 days or more. Excessive uterine bleeding usually requires treatment by uterotonics, vasoconstrictor drugs, surgical uterine evacuation, administration of saline infusions, and/or blood transfusions."). Other risks include serious infection (including sepsis). *Id.* at 5. Mifeprex is contraindicated in ectopic pregnancies and use beyond the gestational date in the approved labeling increases the risk of incomplete abortion and serious, or even fatal, bleeding. *Id.* at 4-5.

As one of Plaintiffs' affidavits makes clear, "incomplete abortion and continuing pregnancy are known outcomes of medication abortion it is more likely [patients] will have an incomplete abortion or continuing pregnancy compared to choosing to have a[] [surgical] abortion." Grossman Aff. ¶ 18. At footnote 7 of their brief, the Clinics cite an FDA Risk Evaluation and Mitigation Strategy, the express goal of which is to "mitigate the risk of **serious complications associated with mifepristone**"(emphasis added). *See* 2d PI at 15 n.7. This risk evaluation further states that to "assure safe use," healthcare providers who prescribe mifepristone "must be specially certified" such that they have the "[a]bility to provide surgical intervention **in cases of incomplete abortion or severe bleeding**" (emphasis added). Opp. PI, Ex A at 7.

The FDA's conclusions regarding Mifeprex were based on a clinical review that identified thousands of adverse events with Mifeprex between 2000 and 2014 involving hundreds of hospitalizations, transfusions, and infections. Mar. 2016 Clinical Review, attached as State's Exhibit C, at 83. Thus, FDA approved Mifeprex with certain restrictions related to the medication's prescribing and dispensing, including that the medication be dispensed only in certain healthcare settings, by or under the supervision of a certified prescriber. Opp. PI, Ex. D.

The FDA put these restrictions in place to help mitigate the serious risks associated with Mifeprex. *See* Opp. PI, Ex. B at 4-6, 17.

On September 23, 2004, Ohio House Bill 126 became effective. The bill created R.C. 2919.123: "Unlawful distribution of an abortion-inducing drug". The statute prohibited the "giv[ing], sell[ing], dispens[ing], administer[ing], or otherwise provid[ing]" mifepristone to another person for the purpose of inducing an abortion unless the person providing the drug is a physician. R.C. 2919.123(A). Moreover, subsection (A) also required physicians administering mifepristone to comply with all provisions of federal law governing its use.

The statute was amended in March 2019 and April 2021, but neither of the foregoing prohibitions was altered.

II. Procedural History

Plaintiffs filed this action on April 1, 2021, seeking temporary, preliminary, and permanent injunctive relief against Ohio's prohibition on the use of the drug mifepristone to induce abortions remotely via telemedicine. Plaintiff Clinics purport to bring this lawsuit on behalf of themselves and their patients. Following the entry of temporary and preliminary injunctions, the case was stayed in July 2022 pending resolution of *State ex rel. Preterm-Cleveland v. Yost*, No. 2022-0803 (Ohio, June 29, 2022). In November 2023, Article I, Section 22 was added to the Ohio Constitution (the "Amendment") which prohibits the State from "burden[ing], penaliz[ing], prohibit[ing], interfer[ing] with, or discriminat[ing] against" individuals' rights to carry out their own "reproductive decisions", or the rights of those assisting such individuals. Ohio Constitution, Article I, Section 22. *Preterm-Cleveland* was dismissed in December 2023.Following the passage of the Amendment, Plaintiffs amended their complaint to add challenges to: (1) a set of Ohio statutes

that prohibit non-physician healthcare providers, referred to in the complaint as advanced practice clinicians, from performing medication-induced abortions; and (2) the statutory prohibition in R.C. 2919.123(B) against the off-label, evidence-based use of mifepristone to induce abortions ("FDA Label Law"). On May 22, 2024, they filed Plaintiffs' Second Motion for Preliminary Injunction, which was granted. After conducting fulsome discovery, Plaintiffs filed a Motion for Summary Judgment. Defendants oppose that Motion.

III. Expert Testimony Submitted by the Parties.

A. Plaintiffs' Expert Evidence

Plaintiffs offered reports and deposition testimony of two expert witnesses to support their claims in this case. Dr. Sharon Liner and Dr. Catherine Romanos. Both experts are abortion providers in Ohio and claim to be harmed by the challenged laws.

B. The State's Expert Evidence

The State submitted expert reports and testimony from Dr. Michael Valley and Pricilia Coleman in defense of the challenged laws. Both experts agree that the challenged laws are beneficial and protect a woman right to make voluntary decisions to either continue or terminate her pregnancy.

IV. Genuine Disputes of Material Fact Precluding Summary Judgment

Plaintiffs' Motion for Summary Judgment fails at the threshold because the record is saturated with sharply conflicting expert opinions on every material issue relevant to the challenged statutory requirements. These unresolved factual disputes—combined with the improper expansion of Defendants' rebuttal reports into untimely affirmative evidence discussed in Section IV. below—require denial of summary judgment.

A. Material disputes exist regarding the comparative medical safety of abortion versus childbirth.

- Plaintiffs' experts (Drs. Romanos, Liner) opine that abortion is ***an extremely safe*** medical procedure with major complication rates far below those associated with childbirth. Romanos Expert Report, attached as Exhibit A, ¶ 58; Liner Report, attached as Exhibit B, ¶ 46.

- Defendants' experts (Drs. Coleman, Valley) assert ***the exact opposite***, claiming abortion is riskier, that the scientific literature is unreliable, and that childbirth carries lower risk. Valley Report., attached as Exhibit C, ¶¶ 30-38; Coleman Report., attached as Exhibit D, ¶¶ 20-38.

These disagreements concern core medical facts, not legal conclusions. They cannot be resolved without weighing credibility and conflicting scientific evidence—tasks reserved exclusively for the factfinder. This sharp division represents a classic factual dispute inappropriate for resolution on summary judgment.

B. Material disputes exist regarding the alleged mental-health consequences of abortion.

- Plaintiffs' experts claim the challenged laws cause mental health issues. Ex. A, ¶ 16; Ex. B ¶ 45,48,60.

- Defendants' experts (especially Dr. Coleman) assert that abortion increases risks of depression, anxiety, substance abuse, and suicide. *See, e.g.,* Ex. D at 8-17; 45-55.

These competing expert opinions create quintessential disputes of material fact.

C. Material fact disputes exist regarding the medical necessity and appropriateness of mandatory ultrasounds and cardiac-activity disclosures.

- Plaintiffs' experts state that ultrasound is not required by the standard of care for all abortion patients and that mandatory disclosure of cardiac activity is medically irrelevant to informed consent. Romanos Deposition, attached as Exhibit E, 278:5-8; Liner Deposition, attached as Exhibit F, 18:12-21.

- Defendants' experts insist such disclosures are medically necessary, ethically required, and protective of patient autonomy. Ex. C ¶¶17-19, Ex. D ¶¶ 39-65.

These opposing views on medical practice standards and patient-care protocols constitute material factual disagreements.

D. Material disputes exist regarding the actual effects and necessity of the 24-hour waiting period and in-person counseling requirement.

- Plaintiffs' experts (Romanos, Liner) testify that the waiting period causes tangible harm—including treatment delays, increased medical risk, heightened logistical and financial burdens, and, in some cases, the complete loss of access to abortion. Ex. A ¶¶ 37-67; Ex. B ¶¶ 44, 50.

- Defendants' experts (Coleman, Valley) claim the waiting period is beneficial—asserting it enhances decisional certainty, reduces "regret," and protects against coercion. Ex. C ¶¶20, 25-27; Ex. D ¶¶ 66-99.

The existence, magnitude, and direction of these alleged effects are disputed, fact-intensive medical questions inappropriate for summary adjudication.

E. Material disputes exist regarding whether miscarriage management and abortion procedures are medically distinguishable.

- Plaintiffs' expert testify that the procedures are identical in risk, method, and clinical management, and thus should not be treated differently under law. Ex. A ¶¶43,80; Romanos Depo, attached as Exhibit E, 152:9-19.

- Defendants' experts maintain meaningful medical and ethical distinctions between the two. Ex. C ¶¶ 21- 24; Ex. D ¶ 145

The conflict creates genuine factual disputes regarding the standard of care and medical equivalency.

F. Material disputes exist regarding the accuracy, relevance, and feasibility of providing the "statistical probability of carrying to term."

- Dr. Romanos testified that such a calculation is not medically valid, not individualized, and not part of any accepted clinical standard. Ex. A ¶¶ 70-72; Ex. E 258:24-258:11.

- Defendants' expert Dr. Valley claims the opposite, asserting that such statistical estimates are feasible, meaningful, and necessary. Ex. C ¶ 14-16;

This disagreement alone establishes a triable factual controversy.

V. Improper Scope of Defendants' Rebuttal Expert Reports

In addition to the numerous factual disputes outlined above, the Court should not consider that Defendants' rebuttal experts—Drs. Lappen and Biggs— as both their expert reports and

testimony far exceed the permissible scope of rebuttal testimony under the governing procedural rules. *See* Motion to Strike filed contemporaneously with this brief.

STANDARD OF REVIEW

"A trial court will grant summary judgment under Civ.R. 56 when the moving party demonstrates that: (1) there is no genuine issue of material fact; (2) the moving party is entitled to judgment as a matter of law; and (3) reasonable minds can come to but one conclusion when viewing the evidence most strongly in favor of the nonmoving party, and that conclusion is adverse to the nonmoving party. *Hernandez v. Ohio Dept. of Rehab. & Correction*, 2017-Ohio-8646, ¶ 12 (10th Dist.), citing *Hudson v. Petrosurance, Inc.,* 127 Ohio St. 3d 54, 2010-Ohio-4505, ¶ 29, 936 N.E.2d 481; *Sinnott v. Aqua-Chem, Inc.*, 116 Ohio St. 3d 158, 2007-Ohio-5584, ¶ 29, 876 N.E.2d 1217. "In seeking summary judgment, the moving party bears the burden of demonstrating that there remain no genuine issues of fact." *Miller v. Bike Ath. Co.*, 80 Ohio St.3d 607, 617 (1998), citing *Mitseff v. Wheeler* (1988), 38 Ohio St. 3d 112, 115. But because summary judgment is a procedural device which decides the litigation, "it must be awarded cautiously with any doubts resolved in favor of the nonmoving party." *Murphy v. Reynoldsburg* (1992), 65 Ohio St.3d 356, 358-59, 1992 Ohio 95. to which the State now responds.

ARGUMENT

I. Article I, Section 22(B) Requires a Textual, Balanced Interpretation That Protects Both the Right to End and the Right to Continue One's Pregnancy and Ensures That All Reproductive Decisions Are Voluntary.

Article I, Section 22(B) begins not with abortion, but with a broad constitutional guarantee: the right to "make and carry out one's own reproductive decisions," expressly including "continuing one's own pregnancy," miscarriage care, contraception, fertility treatment, and abortion. Article I, Sec. 22. The Amendment's structure is deliberately even-handed. It protects

competing and sometimes overlapping reproductive choices, not a single preferred outcome. The Amendment's use of the phrase "including but not limited to" confirms that the enumeration is non-exclusive and that the right necessarily encompasses all reproductive decisions that materially affect a woman's bodily integrity, health, or future reproductive capacity. The placement of "continuing one's own pregnancy" alongside abortion is constitutionally significant; the drafters and voters did not elevate the right to abort above the right to continue, nor did they intend to strip the State of its longstanding role in ensuring that a patient's choice between these protected pathways is made knowingly, freely, and free from distortion or coercion.

Central to the Amendment—and fatal to Plaintiffs' interpretation—is its explicit requirement that reproductive decisions be made "voluntarily." This is not decorative language. It is a constitutional command. A decision cannot be voluntary if it is made in ignorance, haste, misunderstanding, fear, or under pressure the patient herself may not immediately disclose. Nor is voluntariness satisfied merely because a patient expresses a preference. Foundational informed-consent cases have repeatedly rejected the idea that a patient's statement equals an informed, voluntary decision. Courts have long recognized that expression of a choice is not proof that the choice was meaningfully made. In *Truman v. Thomas*, for example, the California Supreme Court held that a physician cannot assume a patient's refusal of treatment is informed simply because the patient communicates a decision; the physician must first disclose the material risks of non-treatment, because voluntariness requires knowledge, not mere resolve. 27 Cal.3d 285, 165 Cal.Rptr. 308, 611 P.2d 902 (1980).

Nothing in the Amendment suggests the electorate intended to upend this widely accepted rule. Indeed, as the public debate preceding adoption made clear, the Amendment was sold to

voters as a restoration of the pre-*Dobbs* landscape—not a radical repudiation of long-standing informed-consent doctrine. Independent civic organizations told voters that the Amendment would return Ohio to the "status quo" of *Roe* and *Casey*, and legal commentators explained that the Amendment would simply put the State back into the legal environment that existed before the federal courts changed course. *See* Opp. PI at 11-14. The informed-consent, in-person, and waiting-period provisions at issue here were all part of that long-standing landscape. Nothing in either the text or voter-facing materials suggests voters intended silently to invalidate decades-old requirements that had repeatedly been upheld as constitutional.

Plaintiffs' interpretation, by contrast, would erase the voluntariness clause entirely. They argue that any mandatory disclosure—even purely factual medical information that courts have long recognized as essential to informed consent—constitutes an impermissible burden. That view is irreconcilable with the text, history, and structure of the Amendment, as well as controlling doctrine governing medical decision-making.

Informed-consent law has never permitted physicians to restrict the scope of disclosure based on their own personal views about what information a patient "should" hear. *Canterbury v. Spence* squarely rejected the idea that a physician may decide what risks are important, explaining that such an approach "arrogates" the decision to the provider when the law requires that the patient, not the physician, direct the choice. 150 U.S.App.D.C. 263, 464 F.2d 772, 784 (1972). *Cobbs v. Grant* similarly emphasized that the scope of disclosure is measured by the patient's need for information—not the physician's subjective preferences. 8 Cal.3d 229, 245, 104 Cal.Rptr. 505, 502 (1972). And Ohio's own Supreme Court, in *Nickell v. Gonzalez*, adopted the reasonable-patient

standard, holding that a risk is material if a reasonable patient, in the physician's knowledge of her condition, "would be likely to attach significance to it." 17 Ohio St.3d 136, 139 (1985).

Under this binding materiality standard, information about fetal cardiac activity, gestational age, pregnancy risks, and the probability of carrying a pregnancy to term is by definition material. These facts bear directly on the nature of the pregnancy, its risks, and the alternatives available. They are relevant not only to a patient choosing to terminate but also to a patient choosing to continue—options equally protected under the Amendment.

The evidentiary record confirms why a statutory baseline is needed. Plaintiffs' own experts acknowledge that they provide information selectively, based on their personal views about what patients should or should not hear. Dr. Romanos admits she resists providing factual information if she believes it may be "distressing" or "harmful," despite simultaneously acknowledging that the same information is clinically relevant to her care. *See, e.g,* Ex. E 147:2-148:3. She further concedes that she assumes most patients are abortion-oriented and rarely return for follow-up, leaving her unable to verify the accuracy of her complication-rate claims. *Id.* 71:3-72:8. These admissions illustrate precisely what informed-consent law forbids: provider-controlled informational gatekeeping, which undermines the patient's autonomy by filtering what she learns through the lens of the provider's preferences.

Dr. Liner's testimony is similar. She acknowledges that she does not systematically track patient outcomes (Liner Depo 56:12-57:7), bases key medical assertions on personal experience rather than comprehensive evidence (*id.* 74:9-22) and would withhold certain information because she believes it unnecessary or potentially upsetting (Ex B ¶ 48). These practices are inconsistent with both statutory requirements and the core principles of patient-centered decision-making

embedded in *Canterbury, Nickell, Largey*, and *Acuna v. Turkish,* 192 N.J. 399, 930 A.2d 416 (2007) ("A physician has a legal duty to disclose to the patient all medical information that a reasonably prudent patient would find material before deciding whether to undergo a medical procedure."). They also confirm that absent uniform baseline protections imposed by statute, voluntariness would vary by clinic, by provider, and even by the provider's mood or worldview on a given day.

By contrast, the State's experts explain that ensuring accurate and complete informed consent is not merely ethically appropriate but medically indispensable. Dr. Valley, an obstetrician-gynecologist with more than three decades of practice, emphasizes that confirming the location of pregnancy, identifying cardiac activity, determining gestational age, and screening for ectopic pregnancy or medical contraindications are core components of responsible care. He explains that "therapeutic privilege"—the exact practice Plaintiffs invoke to justify withholding information—is inconsistent with ethical norms and directly conflicts with patient autonomy. Dr. Coleman's testimony further highlights the prevalence of coercion, intimate partner violence, and decisional pressure in the abortion-seeking population, underscoring the need for time, direct patient interaction, and disclosure to ensure that a patient's reproductive decision is truly voluntary.

When these principles are applied to the text of Article I, Section 22(B), the conclusion is straightforward: the Amendment's voluntariness clause not only permits but requires the State to maintain a minimum level of factual disclosure, reflective time, and professional evaluation. The threatened decision is irreversible, laden with medical and emotional consequences, and marked by substantial risk of coercion or misinformation. The State's chosen safeguards—disclosure of

material medical information, a brief waiting period, and an in-person consultation—are tailored precisely to ensuring that a patient's decision, whether to terminate or continue her pregnancy, is made with full awareness of relevant facts and without hidden pressures or misunderstandings.

For these reasons, a proper textual interpretation of Article I, Section 22(B) supports the constitutionality of the challenged requirements. They advance voluntary, informed decision-making—the very condition the Amendment requires—and they do so in a manner that seamlessly aligns with both Ohio's informed-consent doctrine and the public understanding of the Amendment's purpose.

II. Even If the Challenged Requirements Impose Some Burden, They Are Constitutional Because They Advance Patient Health and Constitute the Least Restrictive Means of Doing So

Even assuming Plaintiffs could show that the Waiting Period, In-Person Requirement, or State-Mandated Information Requirement impose a burden, they cannot satisfy the Amendment's textual requirement that such burdens be unjustified. Article I, Section 22(B) expressly allows regulation that advances patient health through the least restrictive means. The challenged requirements not only satisfy this standard—they exemplify it. They are modest, well-established protections that promote accurate diagnosis, safeguard voluntariness, and ensure that both pathways protected under the Amendment—termination and continuation—are grounded in informed and intentional decision-making.

The State's interest in ensuring informed and voluntary reproductive decision-making is compelling, deeply rooted in medical ethics, and consistent with long-standing precedent. For decades, courts have recognized that informed consent is essential to patient autonomy, particularly where irreversible medical interventions or significant health risks are involved. *Canterbury v. Spence* held that fully informing the patient of material risks is indispensable to

meaningful choice. *Cobbs v. Grant* reaffirmed that a physician's duty of disclosure is measured not by medical custom but by what a reasonable patient needs to know to decide. And Ohio's binding *Nickell* decision confirms that disclosures about risks, benefits, and alternatives—including the consequences of non-treatment—are material whenever they would matter to a reasonable patient.

The challenged requirements do exactly this. The Waiting Period Requirement ensures that patients have meaningful time to consider the information they receive, consult with loved ones, and reflect privately outside the time-pressured setting of a clinic. Plaintiffs argue that the waiting period imposes unnecessary delay, but both the law and the record show otherwise. Any additional delay typically arises not from the statute but from the clinics' internal scheduling choices, such as offering procedural abortions only in the morning or limiting ultrasound appointments to particular days of the week. *See* Ex A ¶ 50; Ex B ¶ 43. Plaintiffs' own evidence acknowledges as much. Moreover, a 24-hour reflection period is a modest safeguard fully aligned with informed-consent doctrine in cases where patients must make significant, irreversible decisions.

The In-Person Requirement advances patient health in ways Plaintiffs' experts inadvertently confirm. Assessing gestational age, ruling out ectopic pregnancy, identifying medical contraindications, screening for coercion or intimate partner violence, answering patients' questions, and ensuring comprehension of risks and alternatives all require professional, face-to-face interaction. Plaintiffs' providers themselves testify that many of their patients experience complex social, medical, or emotional circumstances that require careful assessment. Yet those same providers maintain that such assessments can be conducted remotely, even though

remote care significantly limits the clinician's ability to detect coercion, clarify misunderstandings, or identify medical danger signals. *See* Ex. D ¶¶ 85-99.

Similarly, the State-Mandated Information Requirement ensures disclosure of material facts Plaintiffs concede they often do not share. Information about cardiac activity, gestational age, fetal development, and the statistical probability of carrying the pregnancy to term is not ideological or moral—it is factual medical information that falls squarely within the category of disclosures required by the reasonable-patient standard. Indeed, these facts are relevant not only to abortion but to the decision to continue the pregnancy, a choice explicitly protected by the Amendment. Plaintiffs' insistence that such information is "irrelevant" or "harmful" cannot overcome Canterbury's foundational rule that physicians may not withhold material information based on personal views about what patients should hear. Voluntariness requires disclosure, even if the truth is emotionally weighty.

The expert record reinforces these principles. Dr. Coleman explains that coercion, intimate partner violence, ambivalence, and decisional pressure are real and empirically documented factors among abortion-seeking patients. Dr. Valley explains that screening for coercion, confirming gestational age, and determining the pregnancy's location all require in-person care and cannot be reliably achieved through remote interaction. Plaintiffs' experts, in turn, acknowledge their unwillingness to consider studies outside ideologically aligned institutions, their reliance on anecdotal experience rather than robust data, and their practice of selectively omitting information they deem upsetting. *See, e.g.,* Ex. E 208: 18-227-23; Ex. F 197:1-199:18. These admissions do not undermine the challenged requirements—they justify them.

Finally, the requirements are the least restrictive means to achieve the State's compelling interest in ensuring voluntary, informed reproductive decision-making. A 24-hour reflection period is minimal. An in-person consultation is the only reliable method to ensure accurate diagnosis and voluntariness. A factual disclosure requirement is the narrowest way to ensure material information reaches the patient, particularly where Plaintiffs' providers admit they frequently withhold it. There is no less restrictive alternative that would ensure voluntariness, accurate medical assessment, and full material disclosure.

Because each challenged requirement is directly tied to ensuring voluntary, informed, safe reproductive choices—exactly what Article I, Section 22(B) commands—Plaintiffs cannot show that these laws violate the Amendment. They promote patient health, protect both termination and continuation decisions, and do so through narrowly tailored means fully consistent with Ohio's constitutional text and deeply rooted medical-ethical principles.

III. Application of Article I, Section 22(B) to Each Challenged Requirement

The constitutional analysis becomes even more straightforward when each of the three challenged requirements is considered in turn. Each one serves an independently valid purpose under the Amendment's voluntariness framework, each one addresses risks and informational deficits documented in the record, and each one is narrowly tailored to the State's compelling interest in ensuring that reproductive decisions—whether to terminate or to continue a pregnancy—are made knowingly, reflectively, and free of coercion. In short, these requirements do not frustrate the constitutional right; they safeguard it.

1. The Waiting Period Requirement Advances Reflective, Voluntary Decision-Making and Satisfies the Amendment's Least-Restrictive-Means Standard.

The Waiting Period Requirement ensures that a patient receives material information, has time to digest it, and is able to reflect on the decision outside the physical and psychological pressures of the clinic environment. In the context of an irreversible medical decision that carries emotional significance and non-trivial medical risks, a statutorily guaranteed reflection period is neither unusual nor constitutionally suspect. It is a tailored instrument designed to promote voluntariness—an explicit constitutional requirement.

The record demonstrates exactly why the waiting period is necessary. Plaintiffs' own experts repeatedly state that they assume patients have already decided to have an abortion before receiving any counseling at all. Dr. Romanos, for example, testifies that most patients arrive certain and, as a matter of practice, she treats them as such. Ex A ¶ 30. That assumption alone reveals the constitutional defect in Plaintiffs' approach. A physician cannot assume voluntariness. As *Truman v. Thomas* makes clear, a patient's expression of certainty does not substitute for the physician's duty to ensure she understands the material risks and consequences of her choice.

Plaintiffs insist that the required 24-hour interval imposes harmful delays. But their own testimony belies this claim. Many of the longest delays in the record arise not from the statute, but from Plaintiffs' internal scheduling and operational choices—such as providing procedural abortions only in the morning, restricting ultrasound appointments to limited blocks, or overbooking due to out-of-state travel patterns. *See, e.g.,* Ex. E 162:6-164:5. These are choices clinics are free to make, but they are not constitutionally attributable to the State. A waiting period minimally tailored to ensure reflection is not transformed into a constitutional violation because a clinic chooses to offer certain services at only one time of day.

Nor does the record support Plaintiffs' assertion that a waiting period is medically unnecessary. Informed-consent jurisprudence has never turned on whether the doctor believes the patient needs additional time to reflect. Instead, the law turns on whether a reasonable patient would find time for reflection material to the decision at hand. *Canterbury*, *Cobbs*, *Largey*, and *Nickell* all make clear that medical paternalism cannot substitute for patient autonomy. The State is permitted—and often required—to structure conditions that make reflection meaningful. Indeed, voters were assured that the Amendment would restore the pre-*Dobbs* legal landscape, which included waiting periods that had already been upheld as consistent with informed, voluntary abortion decision-making.

The waiting period also addresses a critical gap in Plaintiffs' evidence: all of their experts admit a systemic lack of reliable follow-up data. *See* Ex. E 71:3-72:8; Ex. F 56: 12-57:7. Plaintiffs' providers operate under a model in which most patients never return after the abortion. They therefore cannot verify the complication rates they assert, nor do they track how many patients later experience regret, conflict, coercion, or medical complications. In such an environment, the State is fully justified in requiring a brief interval that allows for contemplation, clarification, and voluntary commitment to the decision. It is the least restrictive means of promoting voluntariness in a clinical context where Plaintiffs' own practices make systematic tracking impossible.

For these reasons, the waiting period easily satisfies Section 22(B)'s health-advancing and least-restrictive-means requirements. It ensures the patient's decision is informed, reflective, and voluntary—precisely the conditions that the Amendment makes constitutionally indispensable.

2. The In-Person Requirement Protects Patient Health, Ensures Accurate Medical Assessment, and Provides the Only Reliable Means of Screening for Coercion or Pressure.

The In-Person Requirement furthers the State's compelling interest in ensuring voluntary, well-informed reproductive decisions by requiring that the physician meet with the patient face-to-face before the abortion is performed. Plaintiffs characterize this as a needless logistical burden. But the record proves not only that in-person consultation is medically indispensable; it is the **only** means of reliably assessing voluntariness.

A physician cannot ensure that a patient understands the risks, alternatives, and nature of a procedure without observing her demeanor, asking clarifying questions, and responding to concerns in real time. More important still, the physician cannot reliably identify whether the patient is under pressure from a partner, family member, or trafficker unless the physician meets with her in a private, secure environment. Dr. Coleman's testimony makes this point emphatically: empirical literature shows that women seeking abortions experience disproportionately high rates of intimate partner violence, reproductive coercion, or relational pressure. Ex. D ¶¶ 44-65. Because coercion directly nullifies voluntariness, a requirement designed to screen for it falls squarely within the State's constitutional authority.

Medical necessity likewise supports the in-person requirement. Dr. Valley's testimony explains that determining gestational age, identifying ectopic pregnancy, evaluating for contraindications, and performing ultrasound assessments cannot be done remotely with the same reliability. Ex. C ¶¶ 9-13. Plaintiffs treat these clinical steps as optional, yet they are foundational to responsible medical practice—particularly in circumstances where timing, location, and medical risk determine whether the procedure can be safely performed at all. It is telling that even Plaintiffs'

experts concede the importance of these clinical steps but then insist the State may not require them.

Nor does the in-person requirement impose burdens beyond what the Amendment permits. Under Settled informed-consent doctrine, the State may require conditions that ensure the patient's understanding is real rather than presumed. *Canterbury* specifically warns against medical practices in which physicians rely on assumptions about patient understanding rather than ensuring comprehension. The in-person requirement directly cures this risk. It ensures that the physician—not a staff member, not a video, not a pre-printed form—confirms the patient's comprehension and voluntariness before proceeding.

Finally, the requirement is narrowly tailored. Plaintiffs' suggestion that videoconferencing or remote counseling provides an adequate alternative is contradicted by the expert record. Remote evaluation cannot reliably assess a patient's affect, safety, or privacy; it cannot prevent the possibility that an abusive partner is off-camera; and it cannot ensure accurate medical screening. Ex. D ¶¶ 86-99. The in-person requirement therefore represents the least restrictive means of achieving a constitutionally commanded goal: verifying voluntariness through direct, professional assessment.

3. The State-Mandated Information Requirement Ensures Disclosure of Material Medical Facts Necessary for Voluntary, Informed Decision-Making.

The State-Mandated Information Requirement furthers two intertwined constitutional interests: it ensures that patients receive material medical information necessary to make an informed decision, and it prevents physician-based suppression of information that has decisive significance for many reasonable patients. The disclosures—gestational age, fetal cardiac activity, pregnancy risks, alternatives, and the statistical probability of carrying the pregnancy to term—are

not moral judgments, ideological messages, or philosophical pronouncements. They are factual, medically relevant components of the patient's condition and options.

Under *Nickell v. Gonzalez* and *Canterbury v. Spence*, such information is unquestionably material. A reasonable patient deciding whether to terminate or continue a pregnancy would attach significance to the presence of cardiac activity, the likelihood of continuing pregnancy, and the risks associated with either path. Plaintiffs insist that information about cardiac activity or probability of live birth has no bearing on an abortion patient's decision. But that assertion collapses upon inspection. It is both empirically implausible and legally irrelevant. Patients cannot exercise genuine autonomy if physicians or clinics strategically curate which medical facts to disclose. The law of informed consent does not tolerate such selectivity.

The record reveals that Plaintiffs' experts often withhold precisely this information. Dr. Romanos testifies that she avoids providing cardiac-activity disclosures because she believes they may upset some patients. Ex A ¶ 35. Dr. Liner concedes that she would filter clinically relevant information based on her subjective assessment of its emotional impact. Ex B ¶48. These practices demonstrate exactly why the legislature imposed uniform disclosure standards. Voluntariness cannot depend on each provider's personal discomfort or ideological commitments.

Nor does the State-Mandated Information Requirement compel ideological speech in violation of medical-speech jurisprudence. Courts have drawn a clear line between factual, noncontroversial medical information—which the State may require—and compelled ideological messaging, which it may not. *NIFLA v. Becerra* reaffirmed that government may mandate disclosure of "purely factual and uncontroversial information" in the medical context without triggering heightened scrutiny. The disclosures required here fall cleanly on the permissible side

of that line. The existence of cardiac activity, gestational age, and the statistical probability of bringing a pregnancy to term are factual matters grounded in objective medical evidence. They do not convey moral conclusions, value judgments, or philosophical positions about abortion; they simply inform the patient of her biological reality.

Moreover, these disclosures advance not only the right to abortion but also the right to "continue one's own pregnancy"—a right expressly named in the Amendment. A patient who decides to continue her pregnancy is equally entitled to know the medical facts about fetal development and the likelihood of carrying to term. Plaintiffs' position, which would deny the State the ability to require dissemination of this information, would strip constitutional meaning from that parallel right.

Finally, the statutory disclosures are the least restrictive means to ensure that all patients—not just those whose providers choose to fully inform them—receive the material facts necessary to make a voluntary, informed choice. There is no less burdensome mechanism that would achieve the same ends, particularly given the record evidence that Plaintiffs' experts themselves often decline to provide this information absent a legal mandate.

IV. Plaintiffs' Assertions Fail Because Their Expert Evidence Demonstrates Systemic Bias, Selective Disclosure, and Deep Variability in Provider Practices, Confirming the Necessity of Statutory Baselines.

At summary judgment, Plaintiffs bear the burden of showing that no genuine disputes of material fact exist. Yet the record they have constructed—particularly through their own expert testimony—exposes substantial factual disputes concerning clinical practices, informational variability, coercion screening, the reliability of Plaintiffs' complication claims, and the voluntariness of patient decision-making. Far from demonstrating that the challenged statutes

violate Article I, Section 22(B), Plaintiffs' own evidence reaffirms why these statutory guardrails are necessary to protect the voluntariness and autonomy the Amendment expressly safeguards.

1. Plaintiffs' Experts Disclose Structural and Institutional Biases That Undermine Voluntariness and Confirm the Need for Independent, Uniform Information Standards.

The most striking feature of Plaintiffs' expert evidence is the pervasive and unqualified assumption that any patient who contacts an abortion clinic intends to terminate her pregnancy and requires no additional time, information, or clinical engagement. Dr. Romanos testifies repeatedly that in her experience, "almost all" patients arrive already certain of their decision. Ex. E 125:3-5., and she treats them accordingly. That assumption is not merely a clinical judgment—it is a foundational bias that shapes every counseling interaction in her practice. The patient's decisional posture is not explored; it is presumed. Questions of coercion are viewed as exceptional; decisional ambivalence is discounted; and the possibility that a patient desires to continue the pregnancy—an expressly protected constitutional interest—is effectively removed from the clinical frame.

Such assumptions contradict the core of informed-consent doctrine. *Canterbury v. Spence* makes clear that the physician's duty of disclosure arises precisely because patients are not always aware of the risks, consequences, or alternatives relevant to the choice at hand.

Treating abortion as a foregone conclusion flips informed consent on its head and elevates physician assumptions over patient autonomy. Plaintiffs' experts do not merely fail to prevent this problem—their testimony confirms they do not recognize it as a problem at all.

Dr. Liner's account reveals similar institutional bias. Throughout her testimony, Dr. Liner repeatedly frames the statutory requirements as imposing "unnecessary" or "harmful" delays, but she simultaneously acknowledges that she and her clinic do not verify complication rates, rarely

gather long-term follow-up data, and rely "primarily on experience" rather than comprehensive evidence when making sweeping claims about safety or decisional certainty. Ex. F 74:9-22; Ex B ¶ 15. Her testimony exposes a practice culture driven more by institutional mission and patient assumptions than by individualized assessment of risk, coercion, or comprehension.

These expert admissions confirm that voluntariness—the Amendment's central requirement—is compromised when disclosure flows through the lens of provider preference, institutional ideology, or assumptions about patient certainty. It is precisely because Plaintiffs' clinics overwhelmingly serve abortion-seeking populations, with organizational missions centered around abortion access, that a uniform, statutory baseline of material disclosures is necessary. Without such protections, voluntariness becomes whatever the provider—rather than the patient—deems sufficient.

2. Plaintiffs' Experts Acknowledge Their Own Filtering of Information, Resulting in Disparate, Provider-Driven Consent Practices Contrary to Established Informed-Consent Standards.

One of the most salient—and damaging—features of Plaintiffs' evidence is the concession that providers intentionally withhold certain medical facts because they deem them unnecessary, upsetting, or stigmatizing. Dr. Romanos testifies that she refrains from disclosing fetal cardiac activity or the statistical likelihood of carrying to term because she believes such information may be "harmful" or "distressing." Ex. E 145:17-146:19. Dr. Liner similarly acknowledges that she and her colleagues provide information selectively, based on their personal judgments about its emotional impact. Ex. F 137: 12-20.

The law does not permit such selective gatekeeping. *Cobbs v. Grant* and *Canterbury* establish that a physician may not withhold material information merely because he believes the patient should not hear it.

In *Nickell v. Gonzalez*, the Ohio Supreme Court held that the physician's subjective view of importance is irrelevant; the question is what a reasonable patient would consider significant. And *Acuna v. Turkish* held that physicians must disclose all medical information material to the decision, even if the decision implicates moral, relational, or emotional factors.

Plaintiffs' experts openly reject this standard. Their testimony describes an approach in which medical information is funneled through the provider's interpretive lens before reaching the patient. The resulting practice is not uniform, objective, or patient-centered; instead, it varies by physician, clinic, and circumstance. Article I, Section 22(B)'s voluntariness requirement cannot be satisfied by such inconsistent, subjective, and ideologically inflected practices.

Nor can Plaintiffs salvage their position by asserting that patients "do not want" information about fetal development or probability of carrying to term. *Canterbury* forecloses that argument as well. A patient's discomfort with information does not eliminate its materiality or the physician's duty to convey it. Informed consent requires full disclosure of material risks, benefits, and alternatives—even if the information is weighty, emotional, or difficult. The statutory requirements impose exactly that minimal, material baseline.

3. Plaintiffs' Evidence Reveals Significant Variability Across Clinics and Providers, Undermining Their Claim That Their Practices Satisfy the Amendment Without Statutory Safeguards.

Plaintiffs rely heavily on the assertion that they already provide "comprehensive informed consent" and therefore require no statutory baseline. But their own evidence shows the opposite. The practices described by Plaintiffs' experts differ by provider, clinic, patient demographics, and even scheduling constraints.

For example, Dr. Romanos's testimony suggests that ultrasound is sometimes used for confirmation of gestational age but not always disclosed in meaningful terms to patients. Dr. Liner

describes practices in which nurses or educators, not physicians, provide most counseling, with the physician's involvement limited to answering questions immediately before the procedure. Plaintiffs also acknowledge that for many patients, there is only a single point of interaction before the abortion is performed, and that interaction is structured around the assumption of abortion, not exploration of alternatives.

This variability stands in stark contrast to the consistent, patient-centered disclosure required by law. Under *Largey*, *Nickell*, *Canterbury*, and *Acuna*, material-risk disclosure cannot depend on the identity, habits, or ideological inclinations of the provider. Yet Plaintiffs' evidence reflects exactly that kind of unpredictability. The statutory requirements correct this by ensuring that every patient—regardless of clinic or physician—receives the same core factual information necessary to make a voluntary, informed decision.

The variability also confirms a genuine dispute of material fact. Whether Plaintiffs' existing consent practices satisfy the Amendment's voluntariness requirement is not a question that can be resolved on summary judgment, especially given the experts' repeated admissions about selective disclosure, filtered counseling, and assumptions of patient certainty.

4. Plaintiffs' Experts Admit They Lack Reliable Data on Complications, Undermining Their Claims That Delays or In-Person Evaluations Are Medically Unnecessary.

As already discussed, Plaintiffs repeatedly assert that the challenged requirements impose medically unnecessary delays and risks. But the record reflects a striking, systemic lack of follow-up data among Plaintiffs' own providers. Dr. Romanos candidly admits that most patients never return to the clinic after their abortion, meaning she lacks longitudinal information about complications, adverse events, or medical sequelae. Ex. E 71:3-72:8.

Without reliable follow-up data, Plaintiffs' assertion that complications are "rare" is not grounded in empirical evidence; it is based on incomplete and potentially biased information. The absence of data also renders Plaintiffs' claims about the supposed safety of their current practices speculative at best. The State, by contrast, is entitled to require measures—such as in-person evaluation, reflection time, and disclosure of material medical facts—that enhance patient safety and voluntariness in the face of uncertainty.

This evidentiary gap alone defeats Plaintiffs' claims at summary judgment. If Plaintiffs cannot establish the safety of their existing practices, much less demonstrate that statutory requirements do not meaningfully advance safety or voluntariness, they cannot show that the State's regulatory framework violates Article I, Section 22(B).

5. Plaintiffs Offer No Evidence of Concrete Patient Harm, and Their Experts' Assertions of Emotional or Psychological Distress Are Speculative, Anecdotal, and Unsupported.

A notable feature of the record is the complete absence of any patient plaintiffs or any identified patient harmed by the waiting period, the in-person requirement, or the mandated disclosures. Plaintiffs instead rely on generalized anecdotes of hypothetical or unnamed patients who "might" experience distress or "may" feel stigmatized by factual disclosures. These assertions are speculative, unquantified, and contradicted by informed-consent doctrine, which does not permit physicians to withhold material facts on the ground that the truth may upset a patient.

Indeed, Plaintiffs' own experts admit that most of their patients arrive "already certain" of their decision, and Dr. Romanos testifies that none of the challenged requirements affect patient decision-making. Ex. E 146:23-147:1. Those admissions alone defeat any claim of patient harm. If

patients are so certain that no disclosure could change their minds, then Plaintiffs cannot establish that the requirements burden, penalize, or interfere with the exercise of the right.

The absence of concrete harm creates another insurmountable factual dispute: Plaintiffs' hypothetical claims cannot override the State's expert testimony establishing the positive benefits of reflection time, accurate diagnosis, and uniform disclosure. At minimum, these competing accounts create genuine issues of material fact precluding summary judgment.

6. Plaintiffs' Expert Evidence, Taken as a Whole, Reinforces That the Challenged Requirements Are Necessary to Protect the Very Voluntariness the Amendment Commands.

Ultimately, Plaintiffs' expert submissions do not support their claims. They dismantle them. The experts' admissions about selective information practices, assumptions of patient intent, reliance on limited follow-up data, and variability among clinics confirm that the State is constitutionally justified—and indeed obligated—to impose uniform baseline requirements ensuring that reproductive decisions are fully voluntary.

The record demonstrates that voluntariness cannot be ensured by Plaintiffs' existing practices, which are fragmented, subjective, and influenced by institutional preference. The State's requirements cure these deficiencies by guaranteeing that all patients receive accurate, material information; have time to reflect; and are professionally evaluated in conditions that protect their safety, autonomy, and ability to exercise the choice the Amendment expressly protects.

For these reasons, Plaintiffs' own evidence establishes substantial, outcome-determinative disputes of material fact, confirms the necessity of statutory protections, and forecloses summary judgment.

V. Because Plaintiffs Cannot Demonstrate Any Violation of Article I, Section 22(B), and Because the State Has Shown the Requirements Advance Patient Health Through the Least Restrictive Means, Summary Judgment Must Be Denied.

The Amendment does not establish an unqualified right to immediate abortion on demand. It protects a broad spectrum of reproductive decisions—including the decision to continue a pregnancy—and expressly requires that all such decisions be voluntary. As demonstrated in Sections I through IV, the challenged requirements advance that constitutional mandate by ensuring that patients receive material medical facts, undergo proper clinical evaluation, and have sufficient time to reflect before making an irreversible choice. Plaintiffs have not met—indeed, cannot meet—their burden of proving that the Waiting Period, the In-Person Requirement, or the State-Mandated Information Requirement violate Article I, Section 22(B).

Plaintiffs' failure rests on several independent grounds. First, the constitutional text itself forecloses their interpretation. The Amendment preserves the State's authority to impose requirements that ensure voluntariness and protect patient health so long as those requirements constitute the least restrictive means of achieving those ends. The State has demonstrated at length—and Plaintiffs' evidentiary submissions unintentionally reinforce—that each of the challenged statutory measures is precisely calibrated to advance voluntariness, accuracy, and safety. The law requires a minimal reflection period, a personal meeting with a physician, and the disclosure of factual medical information necessary for an informed decision. These are modest, well-established tools of medical regulation and are universally recognized as foundational to informed consent.

Second, the historical and legal context further undermines Plaintiffs' claims. When Ohio voters adopted the Amendment, the dominant public message was that it would restore the "status quo" under Roe and Casey. As your prior filings reflect, major civic organizations publicly assured

voters that the Amendment reinstated the pre-Dobbs framework governing abortion regulation, under which waiting periods and informed-consent disclosures had long been upheld.

Plaintiffs offer no evidence that voters were told the Amendment would silently erase these long-standing requirements. To the contrary, their theory demands a constitutional meaning directly at odds with both the text and the voters' understanding.

Third, Plaintiffs' factual record is riddled with admissions that directly contradict their legal claims. They insist that the statutory requirements burden, penalize, or interfere with their patients' exercise of reproductive rights. Yet their experts simultaneously assert that "almost all" patients are certain when they arrive, that the requirements do not change decision-making, and that the primary source of delay is the clinics' own scheduling protocols—not the law. Plaintiffs cannot square these admissions with the claim that the requirements "prohibit" or "penalize" anything within the meaning of the Amendment. Their evidence simply does not support their legal theory.

Fourth, Plaintiffs cannot escape the reality that their own practices create substantial risks to voluntariness. As shown in Sections II and III, their experts admit to selective information practices, inconsistent counseling processes, a lack of reliable follow-up data, and deeply entrenched assumptions about patient certainty. These deficiencies go to the heart of why a uniform statutory baseline is required. A constitutional right defined in terms of voluntariness cannot be protected by clinical practices that presuppose the very voluntariness they fail to verify. Plaintiffs' admissions—standing alone—create multiple genuine issues of material fact concerning voluntariness, medical necessity, and the adequacy of Plaintiffs' current practices. Summary judgment cannot lie in the face of such contradictions.

Fifth, the State has established that the challenged requirements are not merely permissible—they are the least restrictive means of achieving the Amendment's objectives. A 24-hour reflection period is minimal. Meeting with a physician ensures the accuracy of medical assessment and the detection of coercion. The statutory disclosures ensure that patients receive factual, non-ideological information about their pregnancies. Plaintiffs offer no alternative mechanism that would ensure voluntariness with fewer restrictions, nor do they meaningfully dispute the medical necessity of these safeguards. Their argument is, in essence, that any regulation—no matter how narrow, justified, or widely accepted—constitutes an impermissible burden. The Amendment's text, structure, and history reject that premise.

Sixth, the absence of any concrete patient harm further defeats Plaintiffs' claims at summary judgment. They have identified no patient whose rights were infringed by these statutes and no evidence that the statutory requirements prevent any patient from exercising her constitutional choices. Their reliance on speculative emotional or psychological harms cannot overcome either the State's evidentiary record or binding informed-consent precedent. As courts have long recognized, the mere possibility that factual medical disclosures may cause discomfort does not render them unconstitutional. *Canterbury*, *Cobbs*, and *Nickell* each require disclosure precisely because difficult truths are often material to autonomous decision-making. Plaintiffs' preference to shield patients from information is not an adequate basis to invalidate statutes that protect patient autonomy.

Finally, this record simply cannot support summary judgment under Ohio law. Plaintiffs must show the absence of any genuine issue of material fact, yet the factual disputes here are legion: whether Plaintiffs' practices adequately safeguard voluntariness; whether coercion screening is

reliably performed; whether complication rates cited by Plaintiffs are accurate; whether disclosure of cardiac activity and gestational development is material to a reasonable patient; whether Plaintiffs withhold information; whether Plaintiffs' scheduling, rather than statutory requirements, is responsible for delays; and whether the challenged requirements are the least restrictive means of advancing patient health. These are quintessential factual questions for a trier of fact—not grounds for summary judgment.

In the end, the challenged statutes do not frustrate the Amendment; they fulfill it. They ensure that the choice to terminate or continue a pregnancy—each equally protected—is made knowingly, deliberately, and voluntarily. They protect patient health, promote informed agency, and preserve the dignity and autonomy the Amendment demands. Plaintiffs have not shown otherwise. Because genuine issues of material fact abound, and because the State has demonstrated that the challenged requirements are constitutionally justified, the Court must deny Plaintiffs' Motion for Summary Judgment.

CONCLUSION

For all these reasons, the State respectfully requests that the Court deny Plaintiffs' Motion for Summary Judgment.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that the foregoing was filed electronically and served via electronic mail this 25th day of June 25, 2026:

/s/ Amanda L. Narog
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