IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants*.	Case No. A 2101148 Judge Alison Hatheway **PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT**

Pursuant to Ohio Rule of Civil Procedure 56, Plaintiffs respectfully move this Court for summary judgment in their favor on Counts I and V of the Second Amended Complaint on the ground that there are no genuine issues of material fact and Plaintiffs are entitled to judgment as a matter of law. Plaintiffs ask the Court to declare that the APC Ban, the Evidence-Based Use Ban, and the Telemedicine Ban violate Article I, Section 22 of the Ohio Constitution, as requested in paragraph 192(a) of the Second Amended Complaint, and to permanently enjoin their enforcement. Plaintiffs request oral argument on their motion, per Hamilton County Local Rule 14(c).

A memorandum in support is attached.

Respectfully submitted,

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IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants*.	Case No. A 2101148 Judge Alison Hatheway **MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT**

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TABLE OF CONTENTS

INTRODUCTION 1

STATEMENT OF UNDISPUTED FACTS 2

I. Abortion Care in Ohio 2

II. The APC Ban and Its Impact 4

A. APC Qualifications and Scope of Practice 4

B. APC Provision of Medication Abortion Care 5

C. The APC Ban 5

D. Impact of the APC Ban 6

III. The Evidence-Based Use Ban and Its Impact 8

A. Off-Label Use of FDA-Approved Drugs, Including Mifepristone 8

B. The Evidence-Based Use Ban 9

C. Impact of the Evidence-Based Use Ban 10

IV. The Telemedicine Ban and Its Impact 11

A. Telemedicine Abortion 11

B. The Telemedicine Ban 12

C. Impact of the Telemedicine Ban 12

PROCEDURAL BACKGROUND 15

STANDARD OF REVIEW 16

ARGUMENT 17

I. The APC Ban Violates the Amendment as a Matter of Law 18

A. The APC Ban Burdens, Penalizes, Prohibits, and Interferes with Ohioans' Abortion Decisions and the Provision of Abortion Care 18

B. The APC Ban Discriminates Against Abortion Patients and Providers 19

C. The APC Ban Does Not Advance Patient Health in Accordance with Widely Accepted and Evidence-Based Standards of Care 20

D. The APC Ban Is Not the Least Restrictive Means of Advancing Patient Health 21

II. The Evidence-Based Use Ban Violates the Amendment as a Matter of Law 22

A. The Evidence-Based Use Ban Burdens, Penalizes, Prohibits, and Interferes with Ohioans' Abortion Decisions and the Provision of Abortion Care 22

B. The Evidence-Based Use Ban Discriminates Against Abortion Patients and Providers 23

C. The Evidence-Based Use Ban Does Not Advance Patient Health in Accordance with Widely Accepted and Evidence-Based Standards of Care 24

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

D. The Evidence-Based Use Ban Is Not the Least Restrictive Means of Advancing Patient Health 25
III. The Telemedicine Ban Violates the Amendment as a Matter of Law 26
A. The Telemedicine Ban Burdens, Penalizes, Prohibits, and Interferes with Ohioans' Abortion Decisions and the Provision of Abortion Care 26
B. The Telemedicine Ban Discriminates Against Abortion Patients and Providers 27
C. The Telemedicine Ban Does Not Advance Patient Health in Accordance with Widely Accepted and Evidence-Based Standards of Care 28
D. The Telemedicine Ban Is Not the Least Restrictive Means of Advancing Patient Health 29
IV. Plaintiffs Will Suffer Irreparable Harm in the Absence of an Injunction, and They Have No Remedy at Law 30
CONCLUSION 31
CERTIFICATE OF SERVICE 34
ARTIFICIAL INTELLIGENCE CERTIFICATION 35

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

TABLE OF AUTHORITIES

Page(s)

CASES

Anderson v. Liberty Lobby, Inc.,
477 U.S. 242 (1986).....16

Bonnell v. Lorenzo,
241 F.3d 800 (6th Cir. 2001).....30

Buckman Co. v. Pls.,
531 U.S. 341 (2001).....24

Cordray v. Planned Parenthood Cincinnati Region,
2009-Ohio-2972.....9, 24

Dillon v. Hamlin,
718 F. Supp. 3d 733 (S.D. Ohio 2024).....30

Doe v. Franklin Cty. Children's Servs.,
No. 2:20-CV-4119, 2020 WL 4698801 (S.D. Ohio Aug. 13, 2020).....30

Dresher v. Burt,
75 Ohio St.3d 280 (1996).....16

Harris v. Columbus,
2016-Ohio-1036 (10th Dist.).....30

In re Hodes & Nauser MDS PA v. Kobach,
No. 23CV03140, 2023 WL 7130406 (Kan.Dist.Ct. 2023).....19

Int'l Res., Inc. v. N.Y. Life Ins. Co.,
950 F.2d 294 (6th Cir. 1991).....30

Isaacson v. State, No. CV2025-017995,
2026 WL 1009001 (Ariz. Super. Feb. 6, 2026).....26, 27, 29, 30

Kallstrom v. City of Columbus,
136 F.3d 1055 (6th Cir. 1998).....31

Magda v. Ohio Elections Comm.,
2016-Ohio-5043 (10th Dist.).....30

McDowell v. Gahanna,
2009-Ohio-6768 (10th Dist.).....16

Northland Family Planning Ctr. v. Nessel,
No. 24-000011, 2025 WL 2098474 (Mich.Ct.Cl. May 13, 2025).....19

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Planned Parenthood Great Nw. v. State,
No. 3AN-19-11710CI, 2024 WL 5411729 (Alaska Super. Sept. 4, 2024).....19, 20

Planned Parenthood of Mont. v. State by & through Knudsen,
570 P.3d 51 (Mont. 2025).....26, 29, 30

Planned Parenthood Sw. Ohio Region v. Ohio Dept. of Health,
No. A 2100870, 2025 WL 546268 (Ohio C.P. Feb. 13, 2025).....20,27, 28

Portage Cty. Educators Assn. v. State Emp. Relations Bd.,
2022-Ohio-3167.....22

Preterm-Cleveland v. Yost,
Franklin C.P. No. 24-cv-2634, 2024 WL 3947516 (Aug. 23, 2024).....6

Robol v. Columbus,
2025-Ohio-973.....16

Robol v. Columbus,
2025-Ohio-2162.....16

Robol v. City of Columbus, Ohio,,
146 S. Ct. 392 (2025).....16

Taverns for Tots, Inc. v. City of Toledo,
307 F. Supp. 2d 933 (N.D. Ohio 2004).....30

Temple v. Wean United, Inc.,
50 Ohio St.2d 317 (1977).....16

Turner v. Turner,
67 Ohio St. 3d 337 (1993).....16

Weaver v. Reagen,
886 F.2d 194 (8th Cir. 1989).....23, 25

Weems v. State by & through Knudsen,
529 P.3d 798 (Mont. 2023).....19

Whitney Woods Homeowners' Ass'n, Inc. v. Steagall,
2025-Ohio-2784 (10th Dist.).....16

STATUTES, RULES, REGULATIONS, AND OTHER

Ohio Const., art. I, § 22..... *passim*

Adm.Code 3701-47-01.....6, 31

Adm.Code 4723-9-10(I).....6, 31

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Adm.Code 4730-2-07(E) 6, 31

Civ. R. 56(C) 16

Civ.R. 56(E) 16

R.C. 2317.56(B) 6, 31

R.C. 2919.11 ..... 6, 31

R.C. 2919.20(E) 2

R.C. 2919.20(F) 2

R.C. 2919.123 ..... 6, 9, 24, 31

R.C. 2919.123(A) 6, 24

R.C. 2919.123(E) 10, 23

R.C. 2919.124 31

R.C. 2919.124(B) 12

R.C. 2919.124(C) 12

R.C. 2919.124(E) 12, 28

R.C. 2919.201 2

R.C. 2925.01(W)(l7) 12

R.C. 3719.06(B) 9, 24

R.C. 4723.28(B)(30) 6, 31

R.C. 4723.44(B)(6) 6, 31

R.C. 4723.50(B)(1) 6, 31

R.C. 4723.99(A) 6

R.C. 4723.151(C) 6, 31

R.C. 4730.02(E) 6, 31

R.C. 4730.03(F) 6, 31

R.C. 4730.25(B)(24) 6, 31

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

R.C. 4730.39(B)(2) 6, 31

R.C. 4730.42(A)(1) 6, 31

R.C. 4730.99(A) 6

R.C. 4730.252 6

R.C. 4731.22 12

R.C. 4731.22(I) 12

R.C. 4743.09 11

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

INTRODUCTION

This case concerns the constitutional right of Ohioans to "make and carry out [their] own reproductive decisions," including whether to have an abortion. Ohio Const., art. I, § 22(A) (Right to Reproductive Freedom with Protections for Health and Safety Amendment (the "Amendment")). To safeguard that right, the people of Ohio passed a constitutional amendment that prohibits the State from "directly or indirectly" burdening, penalizing, prohibiting, interfering with, or discriminating against either an individual's exercise of the right to abortion or any "person or entity" assisting in this exercise, unless the State demonstrates that the challenged law is "the least restrictive means to advance the individual's health in accordance with widely accepted and evidence-based standards of care." *Id.* § 22(B). The State seeks to enforce three sets of laws that burden, penalize, prohibit, interfere with, and discriminate against Ohio patients' ability to obtain abortions—specifically medication abortion—and Plaintiffs' ability to provide that care with no corresponding benefit to patient health (collectively, the "Challenged Laws"). Those laws prohibit:

- The provision of medication abortion care by qualified and skilled advanced practice clinicians ("APCs"), regardless of their education, training, and experience (the "APC Ban");
- Prescribing mifepristone for abortion beyond what is set forth in the U.S. Food and Drug Administration-approved label, including in otherwise safe, widely accepted and evidence-based "off-label" uses (the "Evidence-Based Use Ban"); and
- Providing medication abortion through telemedicine (the "Telemedicine Ban").

This Court previously entered preliminary injunctions, recognizing that Plaintiffs showed a likelihood of success on the merits, that the State failed to carry its stringent burden under the

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Amendment, and that the Challenged Laws are substantially likely to violate the Ohio Constitution. Nothing that the State has put forward in discovery undermines those initial conclusions. To the contrary, the undisputed facts demonstrate that each Challenged Law burdens, penalizes, prohibits, interferes with, and discriminates against individuals exercising their right to abortion and providers assisting them. Further, the State has put forward no evidence from which a trier of fact could reasonably find that any of the Challenged Laws advances patient health in accordance with widely accepted, evidence-based standards of care, much less that they are the least restrictive means of doing so. Accordingly, the Challenged Laws violate the Amendment. This Court should therefore grant Plaintiffs' Motion for Summary Judgment and permanently enjoin the Challenged Laws.

STATEMENT OF UNDISPUTED FACTS

I. Abortion Care in Ohio

Abortion in Ohio is available through 21 weeks, 6 days after the first day of the patient's last menstrual period ("LMP"). *See* R.C. 2919.201, 2919.20(E)–(F). Plaintiffs provide two types of abortion: medication abortion and procedural abortion. *See* Ex. 1, Aff. of Bethany Lewis in Supp. of Pls.' Second Mot. for Prelim. Inj. ¶ 9 (May 8, 2024) ("Lewis PI Aff."); Ex. 2, Aff. of Dr. Adarsh E. Krishen in Supp. of Pls.' Second Mot. for Prelim. Inj. ¶ 13 (May 6, 2024) ("Krishen 2024 PI Aff."). This case concerns medication abortion, which most commonly involves a two-drug regimen of mifepristone and misoprostol. *See* Ex. 3, Aff. of Sharon Liner in Supp. of Pls.' Mot. for TRO & Prelim. Inj. ¶ 23 (Mar. 30, 2021) ("Liner 2021 PI Aff."); Ex. 4, Aff. of Julia Quinn in Supp. of Pls.' Second Mot. for Prelim. Inj. ¶ 10 (May 8, 2024) ("Quinn PI Aff."). Patients first take mifepristone; then, approximately 24 to 48 hours later, patients take misoprostol, which induces uterine contractions and empties the uterus. *See* Ex. 6, Expert Report of Daniel Grossman, M.D. ¶ 10 (Mar. 17, 2026) ("Grossman Opening Rep."); Ex. 4, Quinn PI Aff. ¶ 10; Ex. 3, Liner

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

2021 PI Aff. ¶ 23. Depending upon gestational duration, patients may take additional doses of misoprostol. Ex. 6, Grossman Opening Rep. ¶¶ 37–38; Ex. 7, Rebuttal Expert Report of Bhavik Kumar, M.D., M.P.H. ¶ 53 (June 6, 2026) ("Kumar Rep."). The risks associated with medication abortion increase incrementally as the pregnancy advances. Ex. 6, Grossman Opening Rep. ¶¶ 38, 90. Accordingly, if a patient is delayed in obtaining medication abortion, they may face increased risks. *Id*. at ¶¶ 30, 90, 123.

People seek abortion for many reasons, including financial and caregiving circumstances, pregnancy resulting from rape or abuse, educational and career plans, or simply not wanting to become parents. *See* Ex. 8, Aff. of W.M. Martin Haskell, M.D. in Supp. of Pls.' Second Mot. for Prelim. Inj. ¶ 13 (May 8, 2024) ("Haskell PI Aff."); Ex. 1, Lewis PI Aff. ¶ 13; Ex. 3, Liner 2021 PI Aff. ¶ 30. Just as patients' reasons for seeking abortion vary, so too do their reasons for choosing a particular method of abortion. Many patients prefer medication abortion to procedural abortion. Ex. 6, Grossman Opening Rep. ¶¶ 61–62; Ex. 7, Kumar Rep. ¶¶ 43–44; Ex. 9, Aff. of Sharon Liner, M.D. in Supp. of Pls.' Second Mot. for Prelim. Inj. ¶ 25 (May 8, 2024) ("Liner 2024 PI Aff."). For some with medical conditions such as uterine fibroids, congenital uterine anomalies, or significant introital scarring, medication abortion is the safer option. Ex. 6, Grossman Opening Rep. ¶ 62; Ex. 3, Liner 2021 PI Aff. ¶ 29. Others prefer medication abortion because they can complete the process privately at home, at a time that best fits their circumstances. Ex. 6, Grossman Opening Rep. ¶ 61; Ex. 7, Kumar Rep. ¶ 43; Ex. 3, Liner 2021 PI Aff. ¶ 29. Control over the timing and location of the process may be especially important for patients seeking an abortion to escape a dangerous or abusive situation. Ex. 10, Rebuttal Expert Report of Daniel Grossman, M.D. ¶¶ 66–68 (June 3, 2026) ("Grossman Rebuttal Rep."). For survivors of sexual assault or abuse, medication abortion can feel less invasive and more within their control than

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procedural abortion, reducing the risk of re-traumatization. Ex. 6, Grossman Opening Rep. ¶ 61; Ex. 9, Liner 2024 PI Aff. ¶ 25; Ex. 7, Kumar Rep. ¶ 43; Ex. 2, Krishen 2024 PI Aff. ¶ 35.

II. The APC Ban and Its Impact

A. APC Qualifications and Scope of Practice

Across the United States, APCs, including nurse practitioners ("NPs"), nurse midwives ("NMs"), and physician assistants ("PAs"), occupy an increasingly central position in health care. Ex. 11, Expert Report of Joanne Spetz ¶¶ 15–16, 104 (Feb. 11, 2026) ("Spetz Rep."); *see also* Ex. 12, Nat'l Council of State Boards of Nursing, Inc., *APRN Consensus Model*, available at https://www.ncsbn.org/nursing-regulation/practice/aprn.page (accessed Feb. 26, 2026), at State000204. The United States faces a severe physician shortage, particularly of primary care physicians in rural and medically underserved areas and in communities with lower median household incomes. Ex. 11, Spetz Rep. ¶¶ 59–62. This shortage extends to Ohio, where rural areas have far fewer physicians per resident than urban areas. *Id.* at ¶ 104. APCs are more likely than physicians to practice in rural areas in Ohio and play an important role in delivering health care services to uninsured patients and other vulnerable populations in the state. *Id.*

APCs must satisfy demanding educational, certification, and continuing-education requirements to practice in Ohio. *Id.* at ¶¶ 25–28; Ex. 6, Grossman Opening Rep. ¶ 98; *see* Ex. 12, at State000204 (describing requirements for Advanced Practice Registered Nurses ("APRNs"), including NMs and NPs); Ex. 13, State Medical Board of Ohio, *Physician Assistant Core Licensure Eligibility Requirements*, at State000610–611 (Mar. 20, 2019) (describing State Medical Board of Ohio requirements for PAs).

In Ohio, including at Plaintiffs' health centers, APCs routinely perform procedures of equal or greater complexity and risk than medication abortion. Ex. 6, Grossman Opening Rep. ¶ 111; Ex. 7, Kumar Rep. ¶¶ 56, 58. Their scope of practice spans primary and reproductive health care,

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including testing and treating sexually transmitted infections, screening for cervical and breast cancer, and providing gender-affirming hormone care. Ex. 7, Kumar Rep. ¶ 58. Their scope of practice likewise can cover endometrial biopsies, colposcopies, and the insertion and removal of intrauterine devices and contraceptive implants. Ex. 6, Grossman Opening Rep. ¶¶ 111–117; Ex. 4, Quinn PI Aff. ¶¶ 15–17; Ex. 9, Liner 2024 PI Aff. ¶¶ 33–34; Ex. 2, Krishen 2024 PI Aff. ¶ 19; Ex. 7, Kumar Rep. ¶ 56. APCs also prescribe medications as a matter of course, including misoprostol for miscarriage and other non-abortion care. Ex. 6, Grossman Opening Rep. ¶¶ 113–116; Ex. 2, Krishen 2024 PI Aff. ¶¶ 20–21; Ex. 14, State's Resp. to Pls.' Disc. Reqs. at pp. 18–19, 22–23 (Reqs. for Admission ("RFA") Nos. 2, 13, 15) (Mar. 27, 2026).

B. APC Provision of Medication Abortion Care

Leading medical authorities, such as the American College of Obstetricians and Gynecologists ("ACOG"), the American Public Health Association, the World Health Organization, and the National Academies of Sciences, Engineering, and Medicine ("NASEM"), endorse the provision of abortion by appropriately trained APCs. Ex. 6, Grossman Opening Rep. ¶¶ 102–104; Ex. 11, Spetz Rep. ¶¶ 81–87. Twenty-five states, including Ohio under the preliminary injunction in this case, and the District of Columbia now permit APCs to provide medication abortion. Ex. 6, Grossman Opening Rep. ¶ 107; Ex. 11, Spetz Rep. ¶ 50. APC scope of practice in these states aligns with the substantial and consistent body of research that establishes that APCs provide abortion, including medication abortion, at least as safely and effectively as physicians. Ex. 6, Grossman Opening Rep. ¶ 101; Ex. 7, Kumar Rep. ¶ 56; Ex. 11, Spetz Rep. ¶¶ 79–80, 90; *see also* Ex. 10, Grossman Rebuttal Rep. ¶ 71; Ex. 15, Dep. of Ingrid Skop, M.D. Skop 331:14–332:3 (Sept. 1, 2026) ("Skop Dep.").

C. The APC Ban

Ohio's APC Ban is a collection of statutory and regulatory provisions that prohibit APCs

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from providing abortion care, regardless of their training and experience. *See* R.C. 2317.56(B), 2919.11, 2919.123, 4723.28(B)(30), 4723.44(B)(6), 4723.50(B)(1), 4723.151(C), 4730.02(E), 4730.03(F), 4730.25(B)(24), 4730.39(B)(2), 4730.42(A)(1); Adm.Code 3701-47-01, 4723-9-10(I), 4730-2-07(E). Ohio law expressly bars APCs from prescribing any "drug or device to perform or induce an abortion." R.C. 4723.44(B)(6), 4730.02(E); Adm.Code 4723-9-10(I), 4730-2-07(E). Ohio law separately prohibits any non-physician from providing, selling, dispensing, or administering mifepristone "for the purpose of inducing an abortion in any person or enabling the other person to induce an abortion in any person." R.C. 2919.123(A).[1] Absent this Court's preliminary injunction, an APC who provides abortion care would be subject to professional, civil, *and* criminal penalties. *See* R.C. 4723.28(B)(30) (permitting the imposition of professional sanctions on NMs and NPs), 4723.99(A) (imposing criminal penalties on NMs and NPs), 4730.25(B)(24) (requiring the imposition of professional sanctions on PAs), 4730.252 (permitting civil penalties on PAs), 4730.99(A) (imposing criminal penalties on PAs).

D. Impact of the APC Ban

Since the Court enjoined the APC Ban, APCs have begun providing medication abortion in Ohio, increasing the number of abortion providers in the state. Ex. 7, Kumar Rep. ¶¶ 57, 60. This has expanded the number of locations where medication abortion is available, reducing travel distances for patients and increasing the number of appointments available. *Id.*

If the APC Ban were to go back into effect, it would significantly reduce the number of

[1] The APC Ban also compels a physician, rather than an APC, to meet in person with the patient at least 24 hours before an abortion in order to convey certain state-mandated information. R.C. 2317.56(B). Plaintiffs in this case challenge only the requirement in R.C. 2317.56(B) that the "physician" provides particular disclosures. The disclosures and informed consent requirements themselves are being challenged, and are preliminarily enjoined, in another case in the Franklin County Court of Common Pleas. *See Preterm-Cleveland v. Yost*, Franklin C.P. No. 24-cv-2634, 2024 WL 3947516 (Aug. 23, 2024).

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clinicians able to provide abortions in Ohio. Ex. 6, Grossman Opening Rep. ¶ 122; Ex. 2, Krishen 2024 PI Aff. ¶ 15. Patients would depend exclusively on physicians, restricting the number of available appointments, their timing, and the number of locations offering medication abortion. Ex. 6, Grossman Opening Rep. ¶ 122; Ex. 2, Krishen 2024 PI Aff. ¶ 15; Ex. 7, Kumar Rep. ¶ 61. These harms will fall hardest in rural areas, where physician shortages are most pronounced. *See* Ex. 6, Grossman Opening Rep. ¶ 122; Ex. 11, Spetz Rep. ¶¶ 15, 59, 73, 104.

Enforcement of the APC Ban would also severely impact the health centers of Planned Parenthood Southwest Ohio Region ("PPSWO") and Planned Parenthood of Greater Ohio ("PPGOH"), where APCs provide most patient care. Ex. 9, Liner 2024 PI Aff. ¶ 33; Ex. 2, Krishen 2024 PI Aff. ¶ 17. Apart from their ambulatory surgical facilities ("ASFs"), PPSWO's and PPGOH's health centers are staffed by APCs rather than physicians. *See* Ex. 9, Liner 2024 PI Aff. ¶¶ 4, 33; Ex. 2, Krishen 2024 PI Aff. ¶¶ 15–17. Only four of PPSWO's and PPGOH's clinics—the ASFs in Cincinnati, Kettering (formerly Women's Med Center), Columbus, and Bedford Heights—are staffed by physicians.[2] Ex. 2, Krishen 2024 PI Aff. ¶¶ 13–15; Ex. 9, Liner 2024 PI Aff. ¶ 37; *see* Ex. 7, Kumar Rep. ¶ 2. Before the Court enjoined the APC Ban, PPSWO and PPGOH could thus only provide medication abortion at their ASFs despite operating additional health centers in the state. Ex. 2, Krishen 2024 PI Aff. ¶¶ 13–16, 23; Ex. 9, Liner 2024 PI Aff. ¶¶ 37–38, 44; *see* Ex. 7, Kumar Rep. ¶ 2.

Were the Court's preliminary injunctions lifted, many patients would once again need to travel farther and wait longer for abortion care, compelling them to arrange and pay for time off work, childcare, and transportation, and to bear the additional financial and logistical burdens that

[2] In December 2024, PPSWO took over the ownership and operation of Women's Med Center in Kettering, Ohio. It is now known as the Dayton Surgical Center of PPSWO. *See* Second Am. Compl. ¶¶ 9–10 (July 15, 2025).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

greater travel entails. Ex. 6, Grossman Opening Rep. ¶¶ 122–124; Ex. 9, Liner 2024 PI Aff. ¶¶ 21–22, 47. Those burdens would fall hardest on patients who have lower incomes or are experiencing poverty, patients who are already parents, and patients in unstable or unsafe circumstances, including those experiencing homelessness or intimate partner violence. Ex. 6, Grossman Opening Rep. ¶¶ 123–124; Ex. 2, Krishen 2024 PI Aff. ¶¶ 25–28. These burdens may cause patients delay in obtaining abortions. Ex. 6, Grossman Opening Rep. ¶ 123. Because abortion's risks increase incrementally as pregnancy advances, patients face increased risk if, and when, they ultimately obtain care. Ex. 6, Grossman Opening Rep. ¶¶ 30, 123; Ex. 2, Krishen 2024 PI Aff. ¶ 29; Ex. 9, Liner 2024 PI Aff. ¶ 24. In some instances, the delay may push a patient past the point where they are able to obtain medication abortion altogether, leaving them to undergo a procedural abortion contrary to their preference or medical indication. Ex. 6, Grossman Opening Rep. ¶ 118; Ex. 2, Krishen 2024 PI Aff. ¶ 30; Ex. 9, Liner 2024 PI Aff. ¶ 26. In other instances, the delay could force patients to leave Ohio to obtain an abortion. Ex. 6, Grossman Opening Rep. ¶ 118; Ex. 2, Krishen 2024 PI Aff. ¶ 30; Ex. 9, Liner 2024 PI Aff. ¶ 26. And for still others, difficulties associated with traveling for care or obtaining an appointment may cause them to remain pregnant against their will, exposing them to the escalating health risks that accompany pregnancy. Ex. 6, Grossman Opening Rep. ¶ 118; Ex. 2, Krishen 2024 PI Aff. ¶ 30; Ex. 9, Liner 2024 PI Aff. ¶ 26. The Ban also would compel Plaintiffs' providers and staff to turn patients away, causing those providers moral and emotional distress. Ex. 2, Krishen 2024 PI Aff. ¶ 31; Ex. 4, Quinn PI Aff. ¶ 23.

III. The Evidence-Based Use Ban and Its Impact

A. Off-Label Use of FDA-Approved Drugs, Including Mifepristone

Off-label prescribing—the practice of prescribing an FDA-approved drug in a dosage, protocol, or for an indication other than those on the drug's label—is a routine and well-established feature of modern medical care that allows clinicians to treat patients in accordance with the best

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

available evidence. Ex. 6, Grossman Opening Rep. ¶ 44; Ex. 9, Liner 2024 PI Aff. ¶¶ 7, 13. As many as 20% of all prescriptions are written off-label, including the prescription of aspirin to prevent heart attacks and of bupropion (Wellbutrin) to aid smoking cessation. Ex. 6, Grossman Opening Rep. ¶¶ 44–45. Misoprostol itself was originally approved to treat gastric ulcers and is now widely used off-label for a range of gynecological indications, including for miscarriage and abortion. Ex. 6, Grossman Opening Rep. ¶¶ 42, 45; Ex. 15, Skop Dep. 57:23–58:8; *see id.* 46:24–47:8; *see also* Ex. 14, State's Resp. to Pls.' Disc. Reqs. at pp. 18–19 (RFA No. 2) (admitting that misoprostol may be used in Ohio for miscarriage management); Ex. 15, Skop Dep. 67:14–18. Other than its restrictions on mifepristone, *see infra* Stmt. of Undisputed Facts Part III.B ("SOUF"), Ohio only restricts the off-label use of one other category of FDA-approved drug: certain Schedule III anabolic steroids. *See* R.C. 3719.06(B).

The current FDA label for Mifeprex (the brand name for mifepristone) sets forth the following regimen for medication abortion through 70 days after a patient's LMP: "On day one, the patient takes 200 mg of mifepristone orally; twenty-four to forty-eight hours later, the patient takes 800 mcg of misoprostol buccally (in the cheek pouch)." Ex. 6, Grossman Opening Rep. ¶¶ 33, 51–52. Since 2016, clinical research and practice have shown that mifepristone can safely and effectively terminate a pregnancy beyond 70 days LMP. Ex. 6, Grossman Opening Rep. ¶¶ 54–55; Ex. 9, Liner 2024 PI Aff. ¶ 16.

B. The Evidence-Based Use Ban

Enacted in 2004, the Evidence-Based Use Ban prohibits providers from prescribing mifepristone for abortion in any manner departing from the drug's FDA-approved final printed labeling. R.C. 2919.123; *see also Cordray v. Planned Parenthood Cincinnati Region*, 2009-Ohio-2972, ¶ 35. Ohio imposes no comparable restriction on off-label use of mifepristone for other indications, such as miscarriage management. R.C. 2919.123; Ex. 8, Haskell PI Aff. ¶ 22; Ex. 1,

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Lewis PI Aff. ¶ 24. A provider who prescribes mifepristone for abortion in any manner other than that specified on the FDA-approved label is exposed to felony criminal liability, fines, and professional discipline. R.C. 2919.123(E).

C. Impact of the Evidence-Based Use Ban

Since the Ban was enjoined, some Ohio providers have begun offering medication abortion through 84 days LMP, giving patients roughly two additional weeks in which to access their preferred or medically indicated method of care. Ex. 6, Grossman Opening Rep. ¶ 60; Ex. 7, Kumar Rep. ¶¶ 42, 44. Absent this Court's injunction, Plaintiffs would be prohibited from providing mifepristone for medication abortion after 70 days LMP. Ex. 6, Grossman Opening Rep. ¶¶ 54, 60.

Restricting medication abortion provision to 70 days LMP makes it harder for patients to obtain a medication abortion within the window in which it is available. Ex. 2, Krishen 2024 PI Aff. ¶ 36. As a result, patients past 70 days LMP must either travel out of state at greater expense in order to obtain a medication abortion, undergo a procedural abortion contrary to their preference or medical indication, attempt to self-manage an abortion outside the medical system, or remain pregnant against their will. Ex. 9, Liner 2024 PI Aff. ¶¶ 18–27; Ex. 8, Haskell PI Aff. ¶ 25. These burdens weigh most heavily on patients who have lower incomes or are experiencing poverty and those who already have children. Ex. 9, Liner 2024 PI Aff. ¶¶ 21–22; Ex. 6, Grossman Opening Rep. ¶ 88. And, as with the APC Ban, patients who are delayed in accessing abortion care and forced to remain pregnant for longer as a result of the Evidence-Based Use Ban are exposed to increased health risks. Ex. 6, Grossman Opening Rep. ¶¶ 30, 90–92.

The Evidence-Based Use Ban likewise harms Plaintiffs' providers. The Ban compels providers to deny patients certain safe, evidence-based medication abortion care, against their clinical judgment and contrary to patients' medical needs and preferences. Ex. 9, Liner 2024 PI

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Aff. ¶ 28; Ex. 2, Krishen 2024 PI Aff. ¶ 38. At best, a provider may offer a patient past 70 days LMP a procedural abortion, even where that method is medically riskier for the patient and the provider knows the patient does not want it; otherwise, the provider must turn the patient away. Ex. 9, Liner 2024 PI Aff. ¶¶ 25–26; *see also* Ex. 7, Kumar Rep. ¶ 44.

IV. The Telemedicine Ban and Its Impact

A. Telemedicine Abortion

Telemedicine is the delivery of health care services at a distance through information and communication technology. Ex. 6, Grossman Opening Rep. ¶ 64. Telemedicine expands access to care, especially in rural and medically underserved areas. *Id.* at ¶ 75. This expansion of care does not come at the cost of safety and efficacy. *Id.* at ¶ 68. Ohio has adopted requirements facilitating telemedicine, consistent with efforts in other states to reduce regulatory barriers and expand access. *See* Ex. 16, Aff. of Nathaniel G. DeNicola, M.D., MSHP, FACOG, in Supp. of Pls.' Mot. for TRO & Prelim. Inj. ¶ 39 (Apr. 1, 2021); *see also, e.g.*, R.C. 4743.09.

Medication abortion is one type of care that is provided through telemedicine. *See* Ex. 6, Grossman Opening Rep. ¶ 66. Medication abortion by telemedicine ("TMAB") can be provided through several different models. *Id*. at ¶ 65. For example, under the direct-to-patient model, "a patient with internet access can connect with a health care provider from her own home or another location of her choosing." *Id.* Under a site-to-site model, a patient visits a health center and consults by video with a health care provider located elsewhere. *Id.* In recent years, the direct-to-patient model "has expanded significantly" and "is now the prevailing telehealth abortion model." *Id.* at ¶ 67.

Leading medical authorities, including NASEM, ACOG, and the National Abortion Federation, have concluded that "there is no medical need for medication abortion to be administered in the physical presence of a health care provider." *Id*. at ¶ 71. Indeed, NASEM has

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

found that "[s]creening patients for contraindications and eligibility, providing counseling, and dispensing medication can be done as safely regardless of whether the physician is physically present in the room with the patient." *Id.* And "on the rare occasions when complications do arise, it would not matter whether the patient obtained a medication abortion in person or through telemedicine," because "any complications that do arise after medication abortion occur after the patient has left the clinic." *Id.*; *see also* Ex. 3, Liner 2021 PI Aff. ¶ 47; Ex. 17, Aff. of Adarsh Krishen in Supp. of Pls.' Mot. for TRO & Prelim. Inj. ¶ 16 (Mar. 29, 2021) ("Krishen 2021 PI Aff.").

B. The Telemedicine Ban

The Telemedicine Ban prohibits a physician from providing an "abortion-inducing drug" to a pregnant patient unless the physician is "physically present at the location where the initial dose of the drug or regimen of drugs is consumed at the time the initial dose is consumed." R.C. 2919.124(B). It does *not* similarly restrict the provision of the same medications through telemedicine to manage miscarriage. *See id.*; R.C. 2919.124(C) (applying only where medication is given for the purpose of inducing abortion); Ex. 3, Liner 2021 PI Aff. ¶ 43; Ex. 6, Grossman Opening Rep. ¶¶ 43, 96.

The Telemedicine Ban also imposes significant criminal and professional penalties for noncompliance. R.C. 2919.124(C), (E) (cross-referencing R.C. 4731.22); *see also* R.C. 2925.01(W)(17). For a second or subsequent violation, a physician's medical license is subject to automatic suspension. R.C. 4731.22(I). Ohio imposes the same sanctions for serious offenses, including aggravated murder, kidnapping, and rape. *Id.*

C. Impact of the Telemedicine Ban

Since the Telemedicine Ban was enjoined, PPGOH and PPSWO have been able to offer TMAB to patients throughout Ohio. *See* Ex. 7, Kumar Rep. ¶¶ 17, 20; Ex. 9, Liner 2024 PI Aff.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

¶¶ 8–12. At PPGOH, for example, patients are screened for eligibility twice—once before an appointment is scheduled, and again during the appointment with the provider. Ex. 7, Kumar Rep. ¶¶ 17, 20. The initial screening includes gestational dating and ectopic-pregnancy screening, since ectopic pregnancy risk "renders a patient ineligible for a telemedicine appointment." *Id*. at ¶ 17. Patients who cannot answer the screening questions accurately "do not receive" medication abortion via telemedicine care, "even if that is their preference"; they are scheduled in person instead. *Id*. During the appointment, a clinician conducts a second, "independent eligibility assessment" and "only proceeds" if the patient is eligible and still wants telemedicine care. *Id.* at ¶ 20. That assessment includes gestational dating, "taking a medical history to screen for conditions that are contraindications," and additional screening "for possible ectopic pregnancy or risk of ectopic pregnancy." *Id.* "Patients with a medical reason for a pre-abortion ultrasound are still scheduled for an in-person appointment." *Id.* For example, patients with higher risks for ectopic pregnancy are not eligible for telemedicine care and will instead be scheduled for an in-person appointment. *Id.* at ¶ 22. Patients who describe symptoms that may indicate an ectopic pregnancy are connected with a PPGOH clinician, who may refer them for further treatment or emergency care if their symptoms are particularly concerning. *Id*. Clinicians "can and do regularly refuse" telemedicine care to ineligible patients. *Id.* at ¶ 19.

If a clinician determines that a patient is eligible for TMAB, and the patient wants to receive care via telemedicine, the clinician answers any questions, obtains informed consent, and confirms the patient understands how to use the medications. *Id.* at ¶¶ 25, 28, 35. The informed-consent process "necessarily involves ensuring that the patient is making a voluntary decision and is not being coerced." *Id.* at ¶ 28. PPGOH, for example, trains providers and staff on "how to screen for coercion and what to do if they are concerned that a patient might not be seeking care

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

voluntarily." *Id.* at ¶ 29. And if a patient is unsure of whether to proceed with an abortion, staff "do not proceed with the abortion that day." *Id.* Clinicians also explain what symptoms to expect and what symptoms should prompt the patient to seek medical care. *Id.* at ¶ 35. Further, clinicians provide patients with contact information in case they have further questions or concerns. *Id.* at ¶ 36. Providers also contact patients for additional follow-up; for example, PPGOH conducts routine follow-up with TMAB patients approximately one week and five weeks after their appointment. *Id.* at ¶ 37. Plaintiffs' experience using these protocols to screen for and provide TMAB in Ohio has demonstrated that screening practices "can all be accomplished equally, and sometimes more[] effectively[,] via telemedicine." *Id.* at ¶ 30.

Telemedicine abortion can allow patients to obtain abortion care earlier in pregnancy, closer to home, and with fewer barriers to access. Ex. 6, Grossman Opening Rep. ¶ 64. When providing TMAB, clinics can offer more appointments with shorter wait times and reach more patients. *Id.* at ¶¶ 77, 79. Absent this Court's injunction, the Telemedicine Ban would force patients to travel to a health center, imposing the burdens of distance, delay, cost, and logistics described above. *See supra* SOUF Part II.D; Ex. 6, Grossman Opening Rep. ¶¶ 82–83; Ex. 3, Liner 2021 PI Aff. ¶ 6; Ex. 17, Krishen 2021 PI Aff. ¶ 7. Those burdens may fall hardest on patients who cannot absorb the cost of travel, lost wages, or childcare. *See* Ex. 3, Liner 2021 PI Aff. ¶ 53; Ex. 7, Kumar Rep. ¶ 31. For some, the delay will be sufficient to push them past the point in pregnancy when medication abortion is available or even prevent them from accessing abortion altogether. *See id.* at ¶ 5; Ex. 3, Liner 2021 PI Aff. ¶ 6; Ex. 17, Krishen 2021 PI Aff. ¶ 7; Ex. 5, Aff. of Daniel Grossman in Supp. of TRO & Prelim Inj. ¶¶ 45, 47, 52 (Mar. 30, 2021); Ex. 6, Grossman Opening Rep. ¶ 82.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

PROCEDURAL BACKGROUND

Plaintiffs brought this case in 2021 challenging the Telemedicine Ban under the Ohio Constitution's guarantees of equal protection and substantive due process. The Court preliminarily enjoined the Telemedicine Ban in 2021. Entry Granting Pls.' Mot. for Prelim. Inj. (April 20, 2021) ("First PI Order").[3] In November 2023, Ohioans voted to protect the right to abortion in the Ohio Constitution. *See* Ohio Const., art. I, § 22.

On May 21, 2024, Plaintiffs filed an Amended Complaint, which added a claim challenging the Telemedicine Ban under the Amendment, as well as claims challenging two additional laws under the Amendment: the APC Ban and the Evidence-Based Use Ban.[4] The Court also preliminarily enjoined the APC Ban and Evidence-Based Use Ban, finding that Plaintiffs had "provided substantial evidence" that the two laws violate the "newly enshrined constitutional right to reproductive freedom," and that the State had "fail[ed] to make any argument" that the laws constituted the "least restrictive means" of regulating abortion while advancing patient health. Decision & Order Granting Pls.' Second Mot. for Prelim. Inj. nunc pro tunc Aug. 29, 2024 at 11 (Sept. 10, 2024) ("Second PI Order"). The Court later preliminarily enjoined several additional provisions that could give effect to the APC Ban, once again finding that "Plaintiffs are substantially likely to succeed on their claim" that the additional APC-related provisions violated the Amendment. Decision & Order Granting Pls.' Third Mot. for Prelim. Inj. at 4 (July 8, 2025) ("Third PI Order"). Nothing adduced in discovery alters the conclusions the Court reached in granting the preliminary injunctions. Because the record contains no genuine dispute as to any

[3] While the Telemedicine Ban is currently preliminarily enjoined based on equal protection and substantive due process rights protected under the Ohio Constitution, Plaintiffs now move for summary judgment only under the Amendment.

[4] At this time, Julia Quinn, MSN, WHNP-BC, Women's Med Group Professional Corporation, and Preterm-Cleveland were added as Plaintiffs to the litigation.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

material fact that could alter Plaintiffs' entitlement to judgment as a matter of law, they now move this Court for Summary Judgment.

STANDARD OF REVIEW

Summary judgment is warranted where (1) no genuine issue of material fact exists, (2) the movant is entitled to judgment as a matter of law, and (3) reasonable minds can come to but one conclusion, adverse to the nonmoving party, when the evidence is construed most strongly in that party's favor. *Temple v. Wean United, Inc.*, 50 Ohio St.2d 317, 327 (1977); Civ.R. 56(C). The movant bears the initial burden of identifying the portions of the record showing the absence of a genuine issue of material fact. *Dresher v. Burt*, 75 Ohio St.3d 280, 292–93 (1996). Once the moving party satisfies that burden, the nonmoving party "must set forth specific facts showing that there is a genuine issue for trial." *Id*. at 293; Civ.R. 56(E).

Facts not countered by evidence from the non-moving party are deemed to be true. *See Dresher* at 293. The opposing party's burden cannot be met "with unsupported assertions and conclusions." *Robol v. Columbus*, 2025-Ohio-973, ¶ 32, *appeal not allowed*, 2025-Ohio-2162, *cert. denied sub nom.*, 146 S. Ct. 392 (2025); *see also Dresher* at 293 ("[A]n adverse party may not rest upon the mere allegations or denials of his pleadings."). A dispute is material only if its resolution could affect the outcome under the governing legal standard. *Turner v. Turner*, 67 Ohio St. 3d 337, 340 (1993) (citing *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986)).

In order to obtain a permanent injunction, a party "must demonstrate by clear and convincing evidence that they are entitled to relief under applicable statutory law, that an injunction is necessary to prevent irreparable harm, and that no adequate remedy at law exists." *Whitney Woods Homeowners' Ass'n, Inc. v. Steagall*, 2025-Ohio-2784, ¶ 45 (10th Dist.) (quoting *McDowell v. Gahanna*, 2009-Ohio-6768, ¶ 9 (10th Dist.) (internal quotation marks omitted)).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

ARGUMENT

The Amendment "places a stringent burden on the State" to justify abortion restrictions. *See* Third PI Order at 4. It does so through a three-part test for assessing whether a restriction on abortion is permissible.

First, Plaintiffs bear an initial threshold burden of showing that a challenged law will "directly or indirectly, burden, penalize, prohibit, interfere with, or discriminate against" either: "[a]n individual's voluntary exercise" of the right to abortion, or "[a] person or entity that assists an individual exercising this right." Ohio Const., art. I, § 22(B). In other words, under the Amendment's plain text, Plaintiffs need only show that one of these requirements is met—i.e., that the state law burdens *or* penalizes *or* prohibits *or* interferes with *or* discriminates against the fundamental right to abortion. *Second*, the burden then shifts to the State to demonstrate that the statute advances "*the individual's* health in accordance with *widely accepted* and *evidence-based* standards of care." *Id.* (emphases added). "Under the Amendment, patient health is the only state interest that an abortion regulation may constitutionally advance." Second PI Order at 10; Third PI Order at 4. *Third*, the State must *additionally and independently* show that the statute "is using the least restrictive means" of advancing the patient's health. Ohio Const., art. I, § 22(B); *see* Second PI Order at 10; Third PI Order at 4. The Amendment therefore "offers greater protection of individuals' rights to make their own reproductive choices than those adopted by the U.S. Supreme Court in *Roe* and *Casey*." Second PI Order at 9. As detailed below, no genuine dispute exists that the Challenged Laws burden, penalize, prohibit, interfere with, and/or discriminate against Ohioans' right to abortion and providers' ability to assist them in effectuating that right. And the State has failed to proffer evidence sufficient to create a genuine dispute of material fact that the Challenged Laws protect individuals' health, and has put forward *no evidence* whatsoever that they constitute the least restrictive means of doing so. Accordingly, Plaintiffs are entitled to

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

judgment as a matter of law on Counts I and V of the Second Amended Complaint and respectfully request that this Court grant their motion.

I. The APC Ban Violates the Amendment as a Matter of Law

A. The APC Ban Burdens, Penalizes, Prohibits, and Interferes with Ohioans' Abortion Decisions and the Provision of Abortion Care

Plaintiffs have met their threshold burden to show that the APC Ban burdens, penalizes, prohibits, and interferes with the exercise of the right to abortion.

There is no dispute of material fact that by restricting the provision of medication abortion to physicians, the APC Ban prohibits qualified APCs from providing this care. *Supra* SOUF Part II.D. Doing so shrinks the number of qualified clinicians who may provide that care in Ohio, arbitrarily and unnecessarily limiting patients' access to abortion care. *Id.* It also penalizes qualified APCs for violations of the Ban. *Supra* SOUF Part II.C–D. The APC Ban thus burdens, penalizes, prohibits, and interferes with Plaintiffs' ability to assist patients in exercising their right to abortion.

By constraining the availability and timing of appointments and restricting the number of locations where medication abortion is available, the APC Ban also burdens, penalizes, prohibits, and interferes with patients' ability to exercise their right to abortion. *Supra* SOUF Part II.D. This restriction compels patients to travel farther and wait longer while shouldering the attendant costs, including for transportation, childcare, and time away from work. *Id*. It is undisputed that those delays may push a patient past the gestational limit for medication abortion. *Id*. Such patients could then be forced to choose between undesirable options: undergo procedural abortion contrary to their preference or medical indication, leave the State to obtain the medication abortion they seek, or remain pregnant against their will—thus subjecting them to increased health risks or, in some instances, preventing them from accessing abortion altogether. *Id*.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

This Court has cited these very harms in concluding that Plaintiffs were substantially likely to succeed in showing that these restrictions on the provision of abortion care by APCs unconstitutionally burden the right to abortion. *See* Second PI Order at 11–15. Courts analyzing similar state constitutional amendments, such as Michigan's Reproductive Freedom for All Amendment, have also found these types of harms burden the exercise of the right to abortion. *See Northland Family Planning Ctr. v. Nessel*, No. 24-000011, 2025 WL 2098474, *29 (Mich.Ct.Cl. May 13, 2025). And other courts in states recognizing a fundamental right to abortion have reached similar conclusions. *See, e.g.*, *Weems v. State by & through Knudsen*, 529 P.3d 798, 804–05, 812 (Mont. 2023) (holding limits on APC provision of abortion unconstitutional in part because they cause "limited provider availability," requiring patients to "travel great distances" and, in some cases, rendering them ineligible for medication abortion); *Planned Parenthood Great Nw. v. State*, No. 3AN-19-11710CI, 2024 WL 5411729, *11 (Alaska Super. Sept. 4, 2024) (holding APC restriction unconstitutional in part because, "[w]hen APCs are barred from providing abortion, there are fewer available providers, fewer appointments, and potential for greater delay"); *In re Hodes & Nauser MDS PA v. Kobach*, No. 23CV03140, 2023 WL 7130406, *21 (Kan.Dist.Ct. 2023) (holding limits on APC provision of abortion unconstitutional in part because "[d]elays . . . increase the costs, logistics, and risks to the pregnant woman seeking to avail herself of her fundamental rights, and likely decrease or eliminate access to [abortion-related] services").

B. The APC Ban Discriminates Against Abortion Patients and Providers

In addition to unduly limiting the number of providers able to provide abortions, the APC Ban discriminates against abortion patients and providers by singling out abortion for uniquely unfavorable treatment. Ohio bans APCs from providing abortions, regardless of their training and experience, despite allowing them to provide care of equal or greater complexity and risk. Ex. 6, Grossman Opening Rep. ¶ 111. Ohio also permits APCs to prescribe the very medications used

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

in medication abortion—mifepristone and misoprostol—for other purposes, including miscarriage management. *See id.* ¶ 113; *see also supra* SOUF Part II.A; Ex. 14, State's Resp. to Pls.' Disc. Reqs. at pp. 18–19 (RFA No. 2) (admitting that misoprostol may be used in Ohio for miscarriage management). Similarly, the APC Ban discriminates against patients because it precludes them from obtaining a medication abortion from the provider of their choice and, as a result, potentially forces them to travel farther to receive the care they want. *Supra* SOUF Part II.D. Patients seeking similar care for different reasons—for example, for miscarriage management—do not bear those same burdens. *Id*. This is clear discrimination under the Amendment. Ohio Const., art. I, § 22(B); *see Planned Parenthood Sw. Ohio Region v. Ohio Dept. of Health*, No. A 2100870, 2025 WL 546268, *3 (Ohio C.P. Feb. 13, 2025) (holding, in part, that a challenged abortion regulation unlawfully discriminated against abortion patients and providers because it "has no effect on fetal tissue from comparable health care, such as miscarriage management"); *see also Planned Parenthood Great Nw.*, 2024 WL 5411729, *7 (finding APC restriction violated equal protection guarantee based in part on findings that "[t]here is no difference in skill or training required" to treat abortion or miscarriage, and "APCs are authorized to treat miscarriage in Alaska with medication or aspiration").

C. The APC Ban Does Not Advance Patient Health in Accordance with Widely Accepted and Evidence-Based Standards of Care

Conversely, there is no evidence in the record that could create a genuine dispute as to whether the APC Ban advances patient health in accordance with widely accepted and evidence-based standards of care.

The State has admitted that it "do[es] not have documents or evidence" that the Challenged Laws, including the APC Ban, "are in accordance with evidence-based standards of care." *See* Ex. 18, Aff. of Brianne Brown ¶ 4 (June 22, 2026) ("Brown Aff."); Ex. 19, Aff. of Kim Anderson

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

¶ 4 (June 22, 2026) ("Anderson Aff."); Ex. 20, Aff. of David Geiger ¶ 4 (June 24, 2026) ("Geiger Aff."); Order Granting Ltd. Cont. for Purposes of Expert Deps. (Aug. 25, 2026) ("Aug. 25 Order") (adopting the stipulation that "Defendants will not offer any additional evidence in this case, including for purposes of summary judgment or trial . . . other than as described in [the Brown, Anderson, and Geiger] affidavits"). A substantial body of research establishes that APCs provide medication abortion at least as safely and effectively as physicians, with no evidence that patients face any greater risk of complications. *Supra* SOUF Part II.B. Indeed, the State's sole expert agrees that a study she cites found similar complication and effectiveness rates for medication abortion provided by APCs and by physicians. Ex. 15, Skop Dep. 331:14–332:3. APCs are highly educated, rigorously credentialed, and extensively regulated clinicians who are qualified to provide medication abortion. *Supra* SOUF Part II.A. And there is no dispute that APCs in Ohio can prescribe the identical medications for miscarriage management—further confirming that barring them from providing medication abortion serves no health purpose. *Supra* SOUF Part II.A. As the record contains no evidence from which a trier of fact could conclude that the APC Ban advances patient health in accordance with widely accepted and evidence-based standards of care, the State cannot carry its burden under the Amendment.

D. The APC Ban Is Not the Least Restrictive Means of Advancing Patient Health

Even if the State could show that there exists a genuine factual dispute as to whether the APC Ban advances patient health in accordance with widely accepted and evidence-based standards of care (and it cannot), summary judgment for Plaintiffs would still be warranted given that the State has not put forward *any* evidence that the APC Ban is the least restrictive means of advancing patient health. Under the plain text of the Amendment, the State's failure on this front provides an independent basis for granting Plaintiffs' Motion for Summary Judgment. Ohio Const., art. I, § 22(B).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

The State has not even attempted to introduce evidence that a categorical ban on the provision of medication abortion by every APC in Ohio, regardless of individual training, experience, or competence, is the least restrictive means of advancing patient health. Rather, the State has conceded that despite "a diligent search of [its] records, documents, and materials within [its] custody or control," it "do[es] not have documents or evidence" that the APC Ban is "the least restrictive means to advance a pregnant person's health." *See* Ex. 18, Brown Aff. ¶ 3; Ex. 19, Anderson Aff. ¶ 3; Ex. 20, Geiger Aff. ¶ 3; Aug. 25 Order. This should end the Court's inquiry.

Moreover, regardless of the State's concession, a blanket prohibition barring entire categories of qualified clinicians from providing care within their scope of practice cannot be the least restrictive means of advancing anything. *Supra* SOUF Part II.B; Second PI Order at 14 (finding that the State did not address "how the categorical ban on several types of highly trained, well-credentialed, competent clinicians from providing medication abortion care within their scope of practice constitutes the 'least restrictive means' of advancing patient health"); *cf. Portage Cty. Educators Assn. v. State Emp. Relations Bd.*, 2022-Ohio-3167, ¶ 32 (a "categorical prohibition" cannot survive because it does not advance the State's interest "in the least restrictive way available").

II. The Evidence-Based Use Ban Violates the Amendment as a Matter of Law

A. The Evidence-Based Use Ban Burdens, Penalizes, Prohibits, and Interferes with Ohioans' Abortion Decisions and the Provision of Abortion Care

Plaintiffs have shown that the Evidence-Based Use Ban burdens, penalizes, prohibits, and interferes with an individual's exercise of the right to abortion. It is undisputed that the Evidence-Based Use Ban would prevent patients beyond 70 days LMP from receiving medication abortions, even when that method is medically indicated or preferred. Ex. 6, Grossman Opening Rep. ¶¶ 54, 60. For those patients, it is also undisputed that the Evidence-Based Use Ban leaves only

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

undesirable alternatives: traveling out of state to obtain medication abortion care; undergoing a procedural abortion that may be viewed as more invasive or otherwise not preferred; attempting to manage a medication abortion outside the medical system; or remaining pregnant against their will. *Supra* SOUF Part III.C. As with the APC Ban, the burdens associated with these choices fall hardest on patients who have lower incomes or are experiencing poverty and those who are already parents, and delay in accessing care attributable to the Evidence-Based Use Ban exposes patients to the physiological stressors and incrementally increased medical risks of remaining pregnant longer. *Supra* SOUF Part III.C.

The Evidence-Based Use Ban also burdens, penalizes, prohibits, and interferes with providers' ability to assist patients in accessing constitutionally protected abortion care. It exposes them to felony penalties, fines, and professional discipline if they prescribe mifepristone for abortion consistent with their best medical judgment and evidence-based standards of care. R.C. 2919.123(E); *see also Weaver v. Reagen*, 886 F.2d 194, 198 (8th Cir. 1989) (FDA labeling "not intended to limit or interfere with the practice of medicine nor to preclude physicians from using their best judgment in the interest of the patient"). The Evidence-Based Use Ban also forces providers either to withhold safe, effective care and offer only a procedural abortion—even where a procedural abortion is contraindicated—or to turn their patients away entirely. *Supra* SOUF Part III.C. It thus impinges on the patient-provider relationship and forces providers to disregard patients' individualized medical circumstances and preferences in favor of an outdated, one-size-fits-all regimen. *Supra* SOUF Part III.C.

B. The Evidence-Based Use Ban Discriminates Against Abortion Patients and Providers

There is also no dispute that the Evidence-Based Use Ban discriminates against a patient's right to obtain an abortion, and a provider's ability to assist patients in exercising that right, by

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

singling out abortion for uniquely disfavored treatment. Off-label prescribing is a common, accepted, and essential feature of modern medical practice. *Supra* SOUF Part III.A; *see also Buckman Co. v. Pls.' Legal Comm.*, 531 U.S. 341, 350 (2001) (noting that off-label use "is an accepted and necessary corollary of the FDA's mission"). Yet Ohio restricts off-label use of mifepristone only when it is prescribed "for the purpose of inducing an abortion," R.C. 2919.123(A), and imposes no comparable restriction on the off-label use of mifepristone for other indications, such as miscarriage management. *Supra* SOUF Part III.B; *see also Cordray*, 2009-Ohio-2972 at ¶ 32 (interpreting R.C. 2919.123 to apply to the prescription of mifepristone for "the purpose of inducing an abortion"). Ohio restricts off-label prescribing in only one other instance: the prescription of certain Schedule III anabolic steroids for muscle building and athletic performance. R.C. 3719.06(B); *supra* SOUF Part III.A. That restriction does not apply to constitutionally protected care. The uncontroverted evidence thus shows that the Evidence-Based Use Ban discriminates against patients seeking abortion and clinicians who provide it.

C. The Evidence-Based Use Ban Does Not Advance Patient Health in Accordance with Widely Accepted and Evidence-Based Standards of Care

The State likewise has failed to introduce evidence into the record that could satisfy its burden of proving that the Evidence-Based Use Ban advances patient health at all, let alone in accordance with widely accepted and evidence-based standards of care. As with the APC Ban, the State has admitted that it "do[es] not have documents or evidence" that the Evidence-Based Use Ban is "in accordance with evidence-based standards of care." *See* Ex. 18, Brown Aff. ¶ 4; Ex. 19, Anderson Aff. ¶ 4; Ex. 20, Geiger Aff. ¶ 4; Aug. 25 Order. In contrast, Plaintiffs' experts have cited evidence that mifepristone is safe and effective for medication abortions through at least 84 days LMP. Ex. 6, Grossman Opening Rep. ¶¶ 54–57; Ex. 7, Kumar Rep. ¶¶ 40–42. While they do not bear the burden of doing so, Plaintiffs have also put forward evidence that the Evidence-

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Based Use Ban affirmatively harms patient health by foreclosing a medication abortion beyond 70 days LMP, thereby forcing some patients to choose between undergoing a potentially contraindicated procedural abortion, delaying care, self-managing an abortion outside the medical system, or carrying a pregnancy to term against their will. *Supra* SOUF Part III.C. Each result increases the risk to the patient and that harm flows directly from the Evidence-Based Use Ban.

D. The Evidence-Based Use Ban Is Not the Least Restrictive Means of Advancing Patient Health

Even if the Court were to find that there is a genuine dispute of fact regarding whether the Evidence-Based Use Ban advances patient health (there is not), summary judgment for Plaintiffs would still be warranted because the State has introduced no evidence even *attempting* to show that the Ban is the "least restrictive means" of doing so.

As with the APC Ban, the State has confirmed that it "do[es] not have documents or evidence that the [Evidence-Based Use Ban is] the least restrictive means to advance a pregnant person's health . . . in accordance with evidence-based standards of care." *See* Ex. 18, Brown Aff. ¶¶ 3–4; Ex. 19, Anderson Aff. ¶¶ 3–4; Ex. 20, Geiger Aff. ¶¶ 3–4; Aug. 25 Order. Thus, the State has not shown that a categorical prohibition criminalizing providers' exercise of evidence-based medical judgment and foreclosing safe, accepted uses of mifepristone is the least restrictive means of protecting patients—especially when considered in the context of Ohio's near-universal acceptance of off-label prescriptions. *Supra* SOUF Part III.A; *see Weaver*, 886 F.2d at 198 (FDA labeling "not intended to limit or interfere with the practice of medicine nor to preclude physicians from using their best judgment in the interest of the patient"); Second PI Order at 16 (finding "no evidence to support a categorical ban on off-label use of mifepristone for abortion").

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

III. The Telemedicine Ban Violates the Amendment as a Matter of Law

A. The Telemedicine Ban Burdens, Penalizes, Prohibits, and Interferes with Ohioans' Abortion Decisions and the Provision of Abortion Care

It is undisputed that the Telemedicine Ban burdens, penalizes, prohibits, and interferes with patients' ability to obtain medication abortions. Requiring patients to be physically present with a physician when they take the first medication dose imposes substantial logistical, psychological, and financial burdens on patients. *Supra* SOUF Part IV.C. The State's own expert concedes that the Telemedicine Ban forces patients to arrange additional travel, arrange childcare, take time away from work, and potentially pay to obtain care away from home. *See* Ex. 15, Skop Dep. 313:23–315:15; *see also supra* SOUF Part IV.C. Those hurdles may delay care, increasing the likelihood that patients miss the window to obtain a medication abortion, or to obtain an abortion altogether. *Supra* SOUF Part IV.C.

In preliminarily enjoining the Telemedicine Ban, this Court recognized that the Telemedicine Ban would cause patients to have to travel farther to access abortion, thus reducing its accessibility and imposing "financial, physical, and emotional costs" on patients. First PI Order at 4, 11–12. The State has introduced no evidence to contradict these findings. Courts in states recognizing a fundamental right to abortion regularly hold that restrictions on telemedicine medication abortion burden the exercise of that right. The Montana Supreme Court, for example, found that a telemedicine abortion ban "ma[d]e obtaining abortion care more difficult, more inconvenient, and more costly," "impact[ed] how and when a patient can get a pre-viability abortion," and thus burdened the right to abortion. *Planned Parenthood of Mont. v. State by & through Knudsen*, 570 P.3d 51, 79, 81 (Mont. 2025). An Arizona court, interpreting a similar amendment to the Arizona constitution, held the same. *See Isaacson v. State*, No. CV2025-017995, 2026 WL 1009001, *16 (Ariz. Super. Feb. 6, 2026) (finding TMAB ban was a burden on

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

the fundamental right to an abortion because it "directly infringes on a woman's autonomous decision-making by removing as an option a safe and effective means of obtaining an abortion").

B. The Telemedicine Ban Discriminates Against Abortion Patients and Providers

The Telemedicine Ban also discriminates against a patient's right to obtain an abortion, and a provider's ability to assist them in exercising that right, by singling out abortion for uniquely disfavored treatment. In general, the State of Ohio has worked to reduce barriers and expand access to telemedicine across Ohio. *Supra* SOUF Part IV.A. The discriminatory nature of the Ban becomes even more apparent when one considers that it applies only when medications are prescribed to induce an abortion, not when those same medications are prescribed to manage miscarriage. *Supra* SOUF Part IV.B; Ex. 14, State's Resp. to Pls.' Disc. Reqs. at p. 21 (RFA No. 9) (admitting that prescribing misoprostol to manage a miscarriage need not comply with the Telemedicine Ban); *see also supra* SOUF Part IV.C (providers use mifepristone and misoprostol to treat miscarriage, including through telemedicine). Meanwhile, "Ohio allows medications with far more serious risk profiles than those used in medication abortion to be prescribed via telemedicine, including controlled substances and opioids," First PI Order at 4, and there is no other provision of Ohio state law that restricts the use of telemedicine for a particular type of care, *see id.*; Ex. 14, State's Resp. to Pls.' Disc. Reqs. at pp. 5 (Interrog. No. 1), 19–20 (RFA No. 5). The Telemedicine Ban thus singles out providers who assist patients in exercising their constitutional right to abortion for worse treatment. *Supra* SOUF Part IV.B; *see also* R.C. 2919.124(E). It also singles out medication abortion patients for worse treatment, preventing them from obtaining the care they seek via telemedicine while permitting all others seeking other medical care to do so freely. *Supra* SOUF Part IV.C. That is precisely the disparate treatment the Amendment forbids. Ohio Const., art. I, § 22(B); *see Planned Parenthood Sw. Ohio Region*, 2025 WL 546268, *3 (holding, in part, that a challenged abortion regulation unlawfully discriminated

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

against patients and providers because it treated abortion and miscarriage management differently).

C. The Telemedicine Ban Does Not Advance Patient Health in Accordance with Widely Accepted and Evidence-Based Standards of Care

The State introduced no evidence into the record from which a trier of fact could reasonably conclude that the Telemedicine Ban advances patient health, let alone that it does so based on widely accepted and evidence-based standards of care. As with the other Challenged Laws, the State has conceded that it "do[es] not have documents or evidence" showing that the Telemedicine Ban is "in accordance with evidence-based standards of care." *See* Ex. 18, Brown Aff. ¶ 4; Ex. 19, Anderson Aff. ¶ 4; Ex. 20, Geiger Aff. ¶ 4; Aug. 2025 Order. And the State's expert cannot opine on the safety of Plaintiffs' medication abortion practices because she admits she is unfamiliar with Plaintiffs' telemedicine abortion protocols, and the State has introduced no evidence that those protocols result in increased complications. *See* Ex. 15, Skop Dep. 240:23–242:9; *see also id.* 251:2–6.

Conversely, Plaintiffs' experts have shown that requiring in-person care increases the risk of delay, which itself increases health risks. *Supra* SOUF Part IV.C. Those delays are particularly likely in rural and medically underserved areas where patients may face greater difficulty accessing in-person abortion care. *See* Ex. 6, Grossman Opening Rep. ¶¶ 75–77. It also risks forcing some patients to continue a pregnancy against their will. *Supra* SOUF Part IV.C.

Courts in states recognizing a fundamental right to abortion have found that telemedicine abortion bans provide no benefit to patient health. For example, the Montana Supreme Court affirmed the grant of summary judgment where the State failed to show "that there are 'exacerbated health risks' when telehealth medication abortions are provided," and the State failed to identify "a bona fide health risk that a mandatory in-person follow-up appointment for telehealth

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

medication abortions would alleviate." *Planned Parenthood of Mont.*, 570 P.3d at 80 (citations omitted). The court thus found that the statute "unlawfully substitutes the government's judgment for that of the medical community and the individual's private, autonomous decision-making about their health matters." *Id*. An Arizona court, too, found that "[c]linical standards of practice and evidence-based medicine do not support a ban on telemedicine use for medication abortion," and that "[t]elemedicine abortion is safe and effective, based on accepted clinical standards of practice and evidence-based medicine." *Isaacson*, 2026 WL 1009001, *10.

D. The Telemedicine Ban Is Not the Least Restrictive Means of Advancing Patient Health

Even if the Court were to find that a genuine dispute exists as to whether the Telemedicine Ban advances patient health, Plaintiffs are still entitled to judgment in their favor for the separate and independent reason that the State has put forward no evidence that the Ban is the least restrictive means of advancing such an interest.

The State has conceded that it "do[es] not have documents or evidence" suggesting that the Telemedicine Ban is the "least restrictive means to advance a pregnant person's health." *See* Ex. 18, Brown Aff. ¶ 3; Ex. 19, Anderson Aff. ¶ 3; Ex. 20, Geiger Aff. ¶ 3; Aug. 25 Order. Regardless, the State offers no other evidence that a blanket requirement that clinicians be physically present when the first dose of medication is consumed is the least restrictive means of advancing patient health. And any argument that the Ban is necessary for ensuring that ultrasounds and other in-person tests are conducted in cases where a patient's circumstances may require them simply reinforces why the Ban is not the least restrictive means—it imposes a blanket prohibition on *any* and *all* provision of medication abortion via telemedicine for *all* patients, not narrowly tailored, specific requirements as to the provision of in-person tests or screenings in circumstances where they may be advisable or necessary. Courts assessing other telemedicine abortion bans in other

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

states have held that such blanket restrictions are not narrowly tailored or the least restrictive means of serving any such health interest. *See, e.g.*, *Planned Parenthood of Mont.*, 570 P.3d at 81 (finding that Montana telemedicine ban not narrowly tailored to any health interest); *Isaacson*, 2026 WL 1009001, *16 ("To the extent there is any medical benefit to the Telemedicine Ban, Intervenors have not shown that a complete ban is the least restrictive means to achieve that end.").

IV. Plaintiffs Will Suffer Irreparable Harm in the Absence of an Injunction, and They Have No Remedy at Law

Plaintiffs satisfy the remaining requirements for a permanent injunction: they, and the patients on whose behalf they sue, will suffer irreparable harm in the absence of injunctive relief, and they have no remedy at law. Ohio courts have long recognized that "[a] finding that a constitutional right has been threatened or impaired mandates a finding of irreparable injury." *Magda v. Ohio Elections Comm.*, 2016-Ohio-5043, ¶ 38 (10th Dist.) (citing *Bonnell v. Lorenzo*, 241 F.3d 800, 809 (6th Cir. 2001)); *see also* First PI Order at 11–12; Second PI Order at 16–17; Third PI Order at 5. And absent a permanent injunction, Ohioans seeking abortion care will face medically unnecessary barriers that jeopardize their health—an independent and equally irreparable injury. *See Int'l Res., Inc. v. N.Y. Life Ins. Co*., 950 F.2d 294, 302 (6th Cir. 1991) (likely future harm to an individual's health constitutes irreparable injury); *Taverns for Tots, Inc. v. City of Toledo*, 307 F. Supp. 2d 933, 945 (N.D. Ohio 2004) (harm to health constitutes irreparable harm); *Doe v. Franklin Cty. Children's Servs.*, No. 2:20-CV-4119, 2020 WL 4698801, at *3 (S.D. Ohio Aug. 13, 2020) (weighing "serious harm to [individuals'] health or wellbeing absent injunctive relief" in finding irreparable harm).

Plaintiffs and their patients likewise lack any adequate remedy at law. Ohio affords no damages action to redress a violation of the Ohio Constitution. *See Harris v. Columbus*, 2016-Ohio-1036, ¶ 24 (10th Dist.) ("[T]here is no private right of action for damages based on a violation

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of the Ohio Constitution."); *Dillon v. Hamlin*, 718 F. Supp. 3d 733, 739 (S.D. Ohio 2024). And even if damages were available, they could not undo the physical and emotional harms that Plaintiffs and their patients will suffer. *Cf. Kallstrom v. City of Columbus*, 136 F.3d 1055, 1069 (6th Cir. 1998) (injunctive relief warranted because no legal remedy could compensate for the "physical, psychological, or emotional trauma" inflicted by an unconstitutional disclosure of personal information).

CONCLUSION

For the foregoing reasons, Plaintiffs ask this Court to issue a permanent injunction enjoining Defendants, as well as their officers, agents, servants, employees, attorneys, and those persons in active concert or participation with them, from enforcing R.C. 2317.56(B), 2919.11, 2919.123, 2919.124, 4723.28(B)(30), 4723.44(B)(6), 4723.50(B)(1), 4723.151(C), 4730.02(E), 4730.03(F), 4730.25(B)(24), 4730.39(B)(2), 4730.42(A)(1); Adm.Code 3701-47-01, 4723-9-10(I), 4730-2-07(E), and any other provision of the Ohio Revised Code and the Ohio Administrative Code that could be construed to give the Challenged Laws effect.

Dated: September 30, 2026

Respectfully submitted,

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E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that the foregoing Motion was filed electronically in accordance with this Court's electronic filing guidelines and was served via email in accordance with Civ.R. 5(B)(2)(f) on the 30th day of September, 2026. Notice of this filing will be sent to counsel by operation of this Court's electronic filing system or will be served by regular U.S. mail upon counsel or parties who are not sent electronic notifications.

Dated: September 30, 2026

/s/ Michelle Nicole Diamond
Michelle Nicole Diamond (Pro Hac Vice)
Counsel for Plaintiffs

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ARTIFICIAL INTELLIGENCE CERTIFICATION

Pursuant to Local Rule 49, undersigned counsel certifies that generative artificial intelligence tools, specifically Westlaw AI Deep Research, Microsoft Copilot, and Claude, were used to assist with legal research and in revising Plaintiffs' Motion for Summary Judgment. Counsel carefully reviewed and verified all AI-generated content and suggested revisions before approving their inclusion in the motion.

Dated: September 30, 2026

/s/ Michelle Nicole Diamond
Michelle Nicole Diamond (Pro Hac Vice)
Counsel for Plaintiffs

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EXHIBIT 1

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blewis@preterm.org (Principal) (ID Verified)

E-Signature Notary: Theresa M Sabo (TMS)
May 08, 2024 13:47:06 -5:00 [4120F2982E55] [65.60.211.87]
tess.sabo@gmail.com
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IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A 2101148 Judge Alison Hatheway

AFFIDAVIT OF BETHANY LEWIS, LISW-S, IN SUPPORT OF PLAINTIFFS' SECOND MOTION FOR PRELIMINARY INJUNCTION

I, Bethany Lewis, LISW-S, having been duly sworn and cautioned according to law, hereby state that I am over the age of eighteen years and am competent to testify as to the facts set forth below based on my personal knowledge:

1. I am the Executive Director of Preterm-Cleveland ("Preterm"), a plaintiff in this case. Preterm is a nonprofit clinic in Cleveland that offers sexual health services and reproductive health care, including abortion. Preterm has been serving the greater Cleveland area since 1974.

2. I have held this position since December 2023. As Executive Director, I am responsible for overall administration and management of Preterm, as well as our physicians, clinicians, and administrative staff. I am responsible for developing and approving all of Preterm's policies and procedures, including ensuring compliance with all applicable laws and regulations.

3. I earned a B.A. from Ohio State University in Psychology and Sexuality Studies, and a Masters in Social Work from the University of Michigan with a focus on Community Organizing with children and youth in families and communities. I am a Licensed Independent Social Worker.

4. I submit this affidavit in support of Plaintiffs' Second Motion for a Preliminary Injunction to block the enforcement of the following abortion restrictions: (1) the Advanced Practice

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Page 1 of 7
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Clinician ("APC") Ban [R.C. 2317.56(B), 2919.123, 4723.44(B)(6), 4723.50(B)(1), 4723.151(C), 4730.02(E), 4730.03(F), 4730.39(B)(2), and 4730.42(A)(1), and Ohio Admin. Code 4723-9-10(K) and 4730-2-07(E)], and (2) the Evidence-Based Use Ban [R.C. 2919.123]. I am familiar with these laws because I ensure that the physicians, clinicians, and other staff that I supervise at Preterm comply with them.

5. It is my understanding that the APC Ban prohibits qualified and skilled advanced practice clinicians (i.e., nurse practitioners, certified nurse midwives, and physician assistants) from providing abortion, including medication abortion, regardless of their education, training, and experience.

6. It is also my understanding that the Evidence-Based Use Ban prohibits the prescription of mifepristone for abortion in any way that differs from the express terms of the FDA's mifepristone approval letter and mifepristone's final printed labeling ("FPL"), a practice commonly known as "off-label" use. I understand that, in effect, the Evidence-Based Use Ban imposes a prohibition on providing mifepristone for abortion after 70 days, as dated from the first day of a patient's last menstrual period ("LMP").

7. I understand that violation of these requirements may carry criminal, civil, and/or disciplinary penalties. It is my opinion that, both individually and collectively, these laws impede patients' access to time-sensitive care, risking harm to their health and well-being; interfere with patients' ability to make and carry out their own reproductive decisions; single out patients seeking abortion and their health care providers for discriminatory treatment; and obstruct our staff's ability to exercise their best medical judgment in tailoring care to the needs of each patient.

8. The facts I state here are based on my experience, information obtained in the course of my duties at Preterm, my review of Preterm's business records, and personal knowledge that I

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Page 2 of 7 4F60B6A3-795D

have acquired through my service at Preterm. If called and sworn as a witness, I could and would testify competently thereto.

Care at Preterm

9. Preterm provides an array of sexual and reproductive health care, including pregnancy testing, birth control, STI testing and treatment, yearly gynecological exams, miscarriage management, ultrasounds, as well as both procedural and medication abortion care. Over 90% of our patients come to us for abortion care. Preterm is an ambulatory surgical facility ("ASF") under Ohio law. Preterm is one of only nine clinics providing abortion care in the state.

10. Preterm currently contracts with four physicians who divide among them the four days a week the clinic schedules patients, with at least one physician in the facility every day we are serving patients. Preterm currently does not employ any advanced practice clinicians.

11. Preterm provides medication abortion up to 70 days (10 weeks) LMP, the current legal limit for medication abortion under Ohio law.

12. Most of our patients live in northeast Ohio, but we also see many patients from across the state as well as from other states, including Georgia, Pennsylvania, Tennessee, Florida, and Texas. The majority of our patients are economically disadvantaged. The majority also qualify for Medicaid. Additionally, approximately 65% of our patients already have children.

13. Our patients seek abortion for many reasons. For example, some patients seek abortion because they are unable or unwilling to add another child to their family, pre-existing education, or work responsibilities, existing family or childcare obligations, or a lack of financial resources or emotional support. Some patients simply do not want to be parents at all. Other patients seek an abortion because they are hoping to leave an abusive partner and do not want to risk being tied to

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Page 3 of 7 1800D6B2E1A5

them because of their pregnancy. There are also patients who seek abortion care because their pregnancy is the result of sexual assault.

14. At Preterm we have seen an increase in the demand for appointments since the U.S. Supreme Court's ruling in *Dobbs v. Jackson Women's Health Organization*. As states across the South and Midwest limit or ban abortion, more patients are forced to travel to states such as Ohio, where care remains legal. This influx of patients has only exacerbated the existing strains on Preterm's capacity and scheduling flexibility attributable to the limited number of physicians willing to provide abortion in the state, which in turn delays and burdens patients' access to time-sensitive care.

The Ban on Advanced Practice Clinicians and Its Impact on Preterm and Its Patients

15. I understand that, under current Ohio law, only physicians are allowed to provide abortion care, including medication abortion.

16. In other words, it's my understanding that, despite their qualifications, Ohio law prevents APCs from providing medication abortion, even though (as I understand it) their scope of practice includes nearly identical functions in other contexts, including prescription of the medications used in medication abortion for miscarriage management.

17. If not for the APC Ban, Preterm would hire and train APCs to provide medication abortions, expanding the availability and accessibility of services and appointments. Currently, the caseload of non-abortion services at Preterm is not sufficiently high to support hiring an APC but, absent the APC Ban, Preterm would hire APCs to provide both medication abortion and non-abortion services. This would not only create additional appointment availability for medication abortion patients, but would also free up Preterm's physicians to provide more

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Page 4 of 7 4F60B6A3-795D-4908-B881-B06D5B781E10

procedural abortions, thereby increasing access to and availability of time-sensitive abortion care for all of Preterm's abortion patients.

18. By unnecessarily limiting the pool of available medication abortion providers in Ohio to physicians only, the APC Ban interferes with our patients' exercise of their decision to obtain time-sensitive abortion care. The Ban subjects medication abortion patients to unnecessary delays in accessing abortion care and imposes significant financial and logistical burdens on patients by, among other things, delaying their ability to access care until later in pregnancy and/or forcing them to travel further distances to other clinics in order to obtain timely care, thereby harming (rather than advancing) patient health, safety and well-being.

19. The APC Ban also interferes with Preterm's ability to professionally assist Ohioans seeking to obtain abortions by precluding Preterm from hiring and training APCs to provide medication abortion, which would enable the clinic to expand appointment availability and see more patients sooner, thereby mitigating delays in accessing time-sensitive care.

20. Currently there are only four physicians at Preterm who provide for the increasing number of patients seeking care at our health center. Very often patients struggle to find available appointments that match their needs. Many patients have work schedules that leave them free only on Saturdays. Likewise, many patients are only able to get childcare on certain days which, when combined with the clinic's capacity and scheduling limitations based on our limited number of providers, only further constraints their ability to secure a timely appointment for care, pushing them further into their pregnancy.

21. If not for the APC Ban, we could expand the pool of qualified professionals able to provide medication abortion care by hiring and training APCs to handle the increased patient load. This would mean our patients would have a larger pool of providers and availability of

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appointments from which to choose to obtain medication abortion care, lowering one of the most pervasive barriers to timely access to care for our patients.

The Evidence-Based Use Ban and Its Impact of Preterm and Its Patients

22. It is my understanding that the Evidence-Based Use Ban prohibits providers from prescribing mifepristone in an evidence-based, "off-label" manner for abortion care.

23. I understand that research shows that a regimen of mifepristone and misoprostol to terminate a pregnancy is safe and effective beyond 70 days LMP. However, I also understand that the Evidence-Based Use Ban effectively imposes a 70 day LMP limit on medication abortion care in Ohio by forcing providers to prescribe mifepristone only in accordance with the drug's FPL. In practice, this means that Ohio patients who are pushed past the 70 day LMP limit due to delays in accessing care,[1] or other factors, are precluded from obtaining medication abortion in Ohio, despite the fact that (as I understand it) medication abortion is still safe and effective through at least 77 days LMP.

24. As I understand it, Ohio law does not impose similar restrictions on the use of mifepristone for other purposes, including miscarriage management.

25. By preventing Preterm from offering medication abortion to patients whose pregnancies have passed 70 days LMP and limiting Preterm's physicians' discretion to provide the most appropriate and evidenced-based care, the Evidenced-Based Use Ban interferes with our patients' exercise of their decision to obtain an abortion. The Ban subjects patients to harms associated with being denied a desired medication abortion, which can be particularly distressing for patients who have health conditions that make medication abortion the medically advisable

[1] The risk that a patient may be delayed past the 70 day LMP limit for medication abortion is only heightened by Ohio's mandated 24-hour waiting period and in-person counseling requirement for abortion patients, which, in practice, together often delay patients' access to care for much longer than 24 hours. Preterm is also a plaintiff in a lawsuit challenging the constitutionality of these laws.

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Page 6 of 7

option, and for those who are pregnant as a result of rape or incest, and for whom a procedural abortion may be re-traumatizing due to the insertion of instruments into the vagina. Depriving patients of the ability to obtain a medication abortion after 70 days LMP that could still be safely and effectively provided based on the best available medical evidence forces them to undergo an undesired and potentially medically contraindicated procedural abortion, or to travel out of state for medication abortion, seek care outside the medical system, or carry a pregnancy to term and give birth, all with attendant risks of harm to their health, safety, and well-being.

26. But for the Evidence-Based Use Ban, Preterm would prescribe mifepristone for the termination of pregnancies beyond 70 days LMP, consistent with the best available medical evidence, including through at least 77 days LMP.

FURTHER AFFIANT SAYETH NAUGHT.

Executed on [05/08/2024], 2024.

Bethany Lewis

Bethany Lewis, LISW-S

Sworn and subscribed before me in [Franklin] County, Ohio, this [05/08/2024], 2024.

Theresa M Sabo
Commission # 2016-RE-619622
Electronic Notary Public
State of Ohio
My Comm Exp. Nov 28, 2026

Notarial act performed by audio-visual communication

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EXHIBIT 2

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IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A 2101148 Judge Alison Hatheway

AFFIDAVIT OF DR. ADARSH E. KRISHEN IN SUPPORT OF PLAINTIFFS' SECOND MOTION FOR A PRELIMINARY INJUNCTION

I, Dr. Adarsh E. Krishen, having been duly sworn and cautioned according to law, hereby state that I am over the age of eighteen years and am competent to testify as to the facts set forth below based on my personal knowledge:

1. I have submitted two affidavits in this case: (1) an affidavit dated March 29, 2021, in support of Plaintiffs' Motion for a Temporary Restraining Order Followed by a Preliminary Injunction [hereinafter "Aff."]; and (2) a reply affidavit dated April 16, 2021, in support of Plaintiff's Motion for a Preliminary Injunction [hereinafter "Reply Aff."].

2. I have reviewed both documents in preparing this affidavit. Except as noted below, the facts outlined in my prior affidavits have not changed.

3. My March 29, 2021, affidavit outlined my qualifications. A copy of my curriculum vitae (CV) is attached to this affidavit as Exhibit A.

4. The facts I state here are based on my experience, my review of Planned Parenthood of Greater Ohio's ("PPGOH's") business records, information obtained in the course of my duties at PPGOH, and personal knowledge that I have acquired through my service at PPGOH. If called and sworn as a witness, I could and would testify competently thereto.

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5. As PPGOH's Chief Medical Officer, I supervise physicians and other clinicians, including advanced practice clinicians ("APCs"); manage the provision of all medical services at PPGOH; and am responsible for developing PPGOH's policies and procedures and ensuring compliance with applicable laws and regulations. I am also familiar with the impact that R.C. 2317.56(B), 2919.123, 4723.44(B)(6), 4723.50(B)(1), 4723.151(C), 4730.02(E), 4730.03(F), 4730.39(B)(2), 4730.42(A)(1) and Ohio Adm.Code 4723-9-10(K), and 4730-2-07(E) (collectively, the "APC Ban") and R.C. 2919.123 (the "Evidence-Based Use Ban") have on our operations, our staff, and our patients.

6. I understand that the APC Ban precludes APCs, including nurse practitioners ("NPs"), from providing abortion, including medication abortion, in Ohio, even if that care would otherwise be within the APC's scope of practice.

7. I understand that the Evidence-Based Use Ban prohibits practitioners in Ohio from prescribing mifepristone in an evidence-based, "off-label" manner for abortions. I understand this restriction to require those prescribing mifepristone for abortion care in Ohio to do so in accordance with all of the components of the United States Food and Drug Administration's ("FDA's") final printed label for mifepristone. The label approves the use of mifepristone for abortion through 70-days, as measured from a patient's last menstrual period ("LMP"). This means that the Evidence-Based Use Ban effectively precludes providers from prescribing mifepristone to patients who are beyond 70 days LMP, even though research demonstrates that it is safe and effective through at least 77 days LMP. I also understand that the Evidence-Based Use Ban may be read to restrict the use of misoprostol to the dosage, timing, and route of administration set forth in the FDA label when it is used as part of the two-drug regimen with mifepristone to induce an abortion. This would also preclude providers from using

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evidence-based dosages, timing, and route of administration for misoprostol (when used in conjunction with mifepristone for abortion) that research shows is most effective for some patients.

8. I understand that violating the APC Ban or the Evidence-Based Use Ban may carry criminal, civil, and/or disciplinary penalties.

I. PPGOH's Telemedicine Medication Abortion Protocol

9. In my March 29, 2021, affidavit, I described the telemedicine medication abortion ("TMAB") protocol we had in place at the time. Aff. ¶¶13-14. We subsequently discontinued that TMAB protocol because staffing shortages made it no longer feasible.

10. Recently, PPGOH began piloting a new protocol for eligible medication abortion patients who want to have their Day 2 appointment via telehealth. The Day 1 intake, assessment, and informed consent process for these patients has not changed. Aff. ¶ 13. Rather than needing to have their Day 2 telemedicine appointment at one of our health centers, however, eligible TMAB patients are now given a combination-coded lockbox containing mifepristone and misoprostol, along with nausea and pain medications, at their first appointment. The patient then has their Day 2 appointment at least 24 hours later via a secure video conferencing platform from a location they choose.

11. During the Day 2 appointment, the physician confirms the patient's identity and location, confirms that the patient is certain in their decision to have an abortion, and discusses the patient's symptoms to ensure they do not have changed symptoms that would make them ineligible for medication abortion since their Day 1 visit. The physician also answers any questions the patient has during this appointment. After these discussions, the physician gives the

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

patient the lockbox's combination and watches the patient remove and ingest the mifepristone. The patient then takes the misoprostol 24 to 48 hours later.

12. PPGOH has provided the TMAB lockbox pilot protocol to a small group of initial patients and is working toward offering it more broadly to eligible patients. Anecdotal patient feedback has been overwhelmingly positive. Patients have expressed being grateful that they do not have to physically travel to a clinic twice to receive care and how much they like being able to have their abortion in a comfortable, familiar location. Provider feedback has also been incredibly positive. Providers are glad to be able to offer more patient-centered care rather than having to force patients who are eligible for TMAB to nevertheless make a second, potentially very onerous, trip to a clinic.

II. The APC Ban Harms PPGOH's Patients & Staff

A. PPGOH's Provision of Abortion Care

13. PPGOH operates two facilities licensed as ambulatory surgical facilities ("ASFs") under Ohio law. They are located in Columbus and Bedford Heights (near Cleveland) and both medication and procedural abortions are offered at both sites. PPGOH provides medication abortions through 70 days LMP and procedural abortions through 19 weeks, 6 days LMP at both of its ASFs.[1]

14. Both ASFs have a physician on site each day they are open. While we aim to have both locations open as many days as possible each week,[2] physician staffing challenges can limit our ability to do so. Our ASFs are generally open 5 or 6 days per week, but we are not always

[1] When I submitted my March 29, 2021, affidavit, PPGOH's East Columbus ASF provided procedural abortion through 17 weeks, 6 days LMP. Aff. ¶ 9.
[2] Ideally, at least one of our ASFs would be open seven days per week. This simply is not presently feasible because we do not have enough physicians to staff a full seven-day schedule.

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able to maintain this schedule. Physician staffing is particularly challenging at our Bedford Heights ASF, and there are some weeks when we cannot even staff a full 5-day schedule.

15. Due to Ohio's APC Ban, all of the abortions at PPGOH must be provided by the physicians. Since all of our physicians are needed in the ASFs and only physicians are allowed to provide medication abortion, appointments for medication abortion patients are limited to our two ASF locations in Bedford Heights and Columbus. This burdens our medication abortion patients who do not live near those locations and limits our overall number of available abortion appointments for both medication and procedural abortion. Far more patients need to access abortion than PPGOH has capacity to serve with our current physician staffing.

16. In addition to the two ASFs, PPGOH has 13 health centers[3] that are not ASFs located throughout Ohio.[4] PPGOH's health centers provide a wide range of care, including wellness and preventive care, birth control, pregnancy testing, testing and treatment for sexually transmitted infections, cancer screening, and gender affirming care, among others.

17. PPGOH employs APCs who staff our health centers. At least one NP is on site at each of our non-ASF health centers every day. NPs are highly-skilled medical professionals who are trained and qualified to handle the wide array of care we provide to patients at our health centers. In addition to the education and training necessary to obtain and maintain their licenses, PPGOH has strong internal standards and assesses providers' readiness before they are approved to provide care to our patients. All of our providers also participate in ongoing training and education.

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[3] PPGOH has closed two health centers since my March 29, 2021, affidavit. At that time, PPGOH operated 15 non-ASF health centers. Aff. ¶ 9. PPGOH also provides care to patients via telehealth through our Virtual Health Center, which is staffed by nurse practitioners.

[4] PPGOH's health centers are located in: Akron, Athens, Bedford Heights (separate from the Bedford Heights ASF), Canton, Columbus (two locations), Cleveland (two locations), Kent, Mansfield, Rocky River, Toledo, and Youngstown.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

18. All APCs, including NPs, learn as part of their education and training how to assess patients, when to consult with a physician, and when to refer patients for a higher level of care. All of our NPs have at least one physician available to them for consultation at all times. Each of the physicians with whom PPGOH contracts to provide care in our ASFs participates in PPGOH's Standard Care Arrangement ("SCA") for physician supervision of NPs we employ. Additionally, each of the physicians and NPs is encouraged to contact me whenever they need input on patient care.

19. Some of the care that is within our NPs' scope of practice is far more technically complex, and carries more medical risk, than providing medication abortion. For example, NPs in our health centers routinely perform intrauterine device ("IUD") insertion and removal, Nexplanon[5] insertion and removal, and colposcopies. Our NPs are also trained to perform lidocaine cervical blocks as part of their training as Women's Health Nurse Practitioners. Each of these procedures is more complicated and carries more potential risks than the provision of medication abortion, which is incredibly safe.

20. Our NPs have prescriptive authority and routinely prescribe medications to patients as part of the wide array of care they provide in our health centers, including gender affirming care, pre-exposure HIV prophylaxis (commonly called "PrEP"), and the provision of misoprostol for non-abortion care.

21. One example of non-abortion care where PPGOH's NPs might use misoprostol is when caring for a patient who has had an incomplete abortion–where their pregnancy has ended but some of the pregnancy tissue has not passed naturally. In such cases, our NPs may prescribe misoprostol to prompt the uterus to contract and expel its remaining contents. Using misoprostol

[5] Nexplanon is a long-acting birth control implant that is inserted under the skin in a patient's upper arm via a small incision.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

to help soften the cervix to help with difficult IUD insertions is also within our NPs' scope of practice and care that they provide at PPGOH's health centers.

B. The APC Ban Delays Care and Forces Patients to Travel Unnecessarily

22. The APC Ban harms patients by forcing them to travel to one of our two ASFs to receive care from a physician even though that care can be safely and effectively provided by non-physician clinicians like APCs.[6] Without the APC Ban, PPGOH could begin the process of training APCs to provide medication abortion. This would allow us to potentially expand our services to provide medication abortion at our non-ASF health centers, shortening the distance many patients have to travel to access care. In addition to benefiting our medication abortion patients, this would free up appointments for our procedural abortion patients in our ASFs.

23. PPGOH's patients come from Ohio and other states. Due to the APC Ban and the challenges PPGOH faces recruiting physicians,[7] all of PPGOH's abortion patients have to travel to one of our ASFs for care. Even our Ohio patients may struggle to arrange travel to Columbus or Bedford Heights for care if they do not have a car and live in a neighborhood with poor public transportation, or if they do not live in either city where PPGOH has an ASF. Patients without a car themselves may need to rely on others to borrow one or give them a ride, or somehow cobble together the trip without a car (i.e., using a mix of public transportation and paid fares). In addition to posing logistical challenges, this can result in patients having to disclose to several people that they need assistance getting to their abortion appointment. For example, traveling from either the Mansfield or Norwalk areas to one of our ASFs requires driving over 60 miles

[6] I am aware of, and have submitted an affidavit in, *Preterm-Cleveland, et al. v. Yost*, Franklin C.P. No. 24 CV 002634, in which PPGOH and other plaintiffs challenge Ohio laws mandating an in-person Day 1 appointment followed by a 24-hour waiting period before the patient can receive an abortion. The travel burdens of those requirements and the APC Ban compound to delay care.

[7] Aff. ¶ 24; Reply Aff. ¶¶ 4–8.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

each way. For out-of-state patients, the time and expense required to travel to Ohio for an abortion can increase exponentially.

24. The majority of PPGOH's abortion patients already have children and therefore often must arrange and pay for childcare in order to attend their appointments. This means that some of our patients who are single parents may need to tell two or more people that they need to travel for their appointment either to have someone care for their children near home or to travel with them to care for their children during their appointment. This can compromise the confidentiality of their pregnancy and abortion decision. Other parent-patients must bring their children to their appointments because they have no childcare options. This increases travel-related costs (e.g., an extra bus ticket, needing a larger hotel room, higher food costs to feed more people, etc.) and requires a reliable support person to agree to take time out of their day to accompany the patient to their appointment and serve dual roles of escort and childcare provider while the patient is receiving care. Not every patient has such support available. Reducing travel times can benefit patients by reducing how much time they need childcare and, in some cases, making it possible for them to avoid needing to pay for childcare altogether (such as being able to attend an appointment while their child is in school).

25. The burdens associated with the APC Ban are especially difficult for patients who have less stability in their daily lives. For example, patients who are experiencing intimate partner violence may have immense difficulty getting to medical appointments without being detected by the person who is abusing them—this includes not only finding a way to explain their physical absence, but also obtaining transportation and the funds needed to pay for travel and the abortion care itself. This can endanger the patient, who may experience physical, sexual, or emotional violence if detected, and who might thereafter be subjected to heightened physical

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and/or emotional control by the person who is abusing them. The farther the patient needs to travel, the longer they need to be away and the more difficult these challenges become.

26. Needing to travel a long distance for care is especially burdensome for our patients who are experiencing homelessness. Needing to travel is tremendously difficult for people who do not have a safe, private place to live, or who do not have a secure place to store belongings that they cannot bring with them. In my experience, patients experiencing homelessness sometimes struggle more than other patients to come to an appointment at a scheduled time and may not be able to use online scheduling systems to make or reschedule appointments. The difficulty can be especially acute for patients experiencing homelessness who work and have children. These patients face all the same difficulties that other working and parenting patients face related to needing to take time off work and find childcare, but with added risk and fear that comes with navigating those dynamics with little to no safety net.

27. The financial burdens described above are especially onerous for our patients living on low incomes or experiencing poverty who have to travel long distances to one of our two ASFs, or who need more scheduling flexibility than our ASFs can accommodate given the volume of need. For such patients, attending an appointment for care can mean forgoing basic needs, like having food to eat or hygiene products to use.

28. Young adults–especially students, who have limited financial and transportation resources and often live away from their support system or are traveling for summer internships–also have a particularly challenging time traveling to obtain the care they need.

29. Both of our ASFs have more patients seeking care than we can serve given physician staffing challenges. If we were able to have APCs provide medication abortion, we would be able to increase the number of providers, thereby increasing not only the number of

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available appointments but also the number of health centers from which we could provide abortion care. This would help mitigate geographic barriers to access. The APC Ban precludes us from doing this and forces patients to wait until an appointment is available with a physician at one of our ASFs and to travel longer distances than otherwise necessary to that ASF for care, thereby delaying their access to care. Being forced to remain pregnant against their will harms patients' health and well-being. We have had patients who had previous high-risk pregnancies, or patients with chronic illness, who cannot physically or emotionally endure another pregnancy and suffer needlessly due to a delay in obtaining abortion care. Moreover, while abortion is very safe, its risks increase as pregnancy progresses.

30. Furthermore, delay may impact some patients' ability to have their desired or medically indicated abortion method by pushing them past the point when medication abortion is an option. As discussed below, the Evidence-Based Use Ban compounds this harm.

31. The APC Ban also harms PPGOH's staff. Requiring all abortions to be provided by physicians, and therefore in ASFs, reduces the number of patients we can serve and forces some of our patients to travel much farther than would be necessary if we could offer care in additional locations. This is distressing to providers given how great the need for care is in Ohio and our providers' deep commitment to providing each patient the care they need in a patient-centered, compassionate way. Knowing that the APC Ban prevents us from meeting an acute health care need and forces our patients to jump through unnecessary, onerous hoops is frustrating and demoralizing for providers.

III. The Evidence-Based Use Ban Harms PPGOH's Patients & Staff

32. The current FDA label for mifepristone, which was approved in 2016, contemplates its use through 70 days LMP. The 2016 label also provides the following regimen:

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

the patient first takes 200 mg of mifepristone orally after receiving it in person from a clinician in a clinic setting; then, 24 to 48 hours later, the patient takes 800 mcg of misoprostol by placing it in their cheek pouch (buccal administration). The patient then follows up with a health care provider 7 to 14 days later to confirm pregnancy termination. The FDA later changed the Risk Evaluation and Mitigation Strategy ("REMS") for mifepristone in 2021 and 2023 to remove the in-person dispensing requirement for mifepristone, which allowed for its mailing and for pharmacists to dispense it.[8]

33. Since 2016, research has demonstrated that mifepristone can be safely and effectively used to terminate pregnancy through at least 77 days LMP. Nevertheless, Ohio's Evidence-Based Use Ban prevents abortion providers from caring for patients according to the best medical evidence–instead restricting use to the strict confines of the outdated FDA label.

34. Without the Evidence-Based Use Ban, PPGOH would provide medication abortion to qualified patients beyond 70 days LMP, which would allow PPGOH to provide medication abortion patients with more patient-centered care suited to their individual needs and preferences.

35. Some patients strongly prefer medication to procedural abortion. Losing the option to have a medication abortion can be incredibly distressing for these patients. For example, patients who are pregnant as the result of rape or incest may find the prospect of having medical instruments inserted into their vagina traumatizing and emotionally intolerable. Other patients may need to have a medication abortion based on medical contraindications for

[8] FDA, *Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation* (Mar. 23, 2023), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation (last accessed May 3, 2024).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

procedural abortion, such as an allergy to sedation medications, seizure disorder, or anatomic structural variations, and thus may be unable to access abortion altogether in Ohio.

36. Patients may be unable to access medication abortion before 70 days LMP for many reasons. Some patients may not realize that they are pregnant until they are close to, or beyond, 70 days LMP. Others may be pushed past the legal limit for medication abortion in Ohio due to the challenges I discussed above in scheduling an appointment based on clinic and patient availability and arranging travel to a clinic.

37. The Evidence-Based Use Ban may also be read to prevent us from providing individualized, patient-centered care in prescribing misoprostol for use as part of the two-drug regimen for medication abortion, along with mifepristone. For example, while the regimen set forth in the outdated FDA label indicates that misoprostol should be administered buccally, other routes of administration (e.g., vaginal and oral) are safe and effective, and may in fact be preferred by patients for individual reasons. Nevertheless, the Evidence-Based Use Ban could be read to preclude us from providing misoprostol to our patients in accordance with a protocol that allows for vaginal or oral administration when used alongside mifepristone for abortion.

38. The Evidence-Based Use Ban also harms PPGOH's staff. Having to tell patients who want a medication abortion and are at a point in pregnancy where research demonstrates they can safely and effectively have one that they cannot because they are beyond 70 days LMP is emotionally painful for PPGOH's providers. PPGOH's providers are committed to providing individualized, evidence-based, compassionate care to each patient. Having to deny a patient safe, evidence-based care that the patient wants, and not being able to provide the highest evidence-based standard of care to each patient simply because of the Evidence-Based Use Ban, is therefore deeply distressing. The Challenged Requirements force PPGOH's staff to be

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

complicit in inflicting the laws' harms. Knowing this, and seeing the pain it causes patients, harms our staff.

FURTHER AFFIANT SAYETH NAUGHT.

Adarsh E. Krishen, M.D.
Planned Parenthood of Greater Ohio

Sworn to and subscribed before me this 6th day of May, 2024.

Notary Public



E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

EXHIBIT 3

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. _____ Judge: _____

AFFIDAVIT OF SHARON LINER, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER FOLLOWED BY PRELIMINARY INJUNCTION

I, Sharon A. Liner, M.D., being duly sworn on oath, do depose and state as follows:

1. I am the Medical Director of Planned Parenthood Southwest Ohio Region ("PPSWO"), a plaintiff in this case. I am also PPWSO's Director of Surgical Services. I have worked as a physician for PPSWO since 2004. Throughout that time, I have provided sexual and reproductive health care, including abortion, to our patients.

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

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

4. I submit this affidavit in support of Plaintiffs' Motion for a Temporary Restraining Order Followed by Preliminary Injunction to prevent enforcement of Senate Bill 260 ("SB 260"), which would amend the Ohio Revised Code to further restrict a doctor's ability to provide "abortion-inducing drugs" to patients. I understand that the Ohio legislature has defined an

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

"abortion-inducing drug" broadly to refer to any medication or combination of medications that "causes the termination of a clinically diagnosable pregnancy."[1]

5. I understand that the Act would make it illegal for me to provide an abortion-inducing drug to a pregnant patient, unless I am simultaneously physically present at the location where the patient takes the initial dose.[2] It is my understanding that a separate part of SB 260 makes it illegal for me to "knowingly fail" to be physically present at the patient's location when she first consumes "an abortion-inducing drug" that I provide to someone else "for the purpose of inducing an abortion."[3]

6. If SB 260 takes effect, my PPSWO colleagues and I will have to stop providing telemedicine for medication abortion ("TMAB") to our patients. Despite the dearth of abortion providers in Ohio, and the rapidly expanding use of telemedicine for comparable care, SB 260 will put a complete stop to TMAB, forcing many patients to travel farther and wait longer to obtain an abortion. It will also likely create barriers that, for some patients, will so delay their access that they cannot have an abortion at all. SB 260 will impose on patients other financial, physical, and emotional costs without creating any benefits for our patients. I am gravely concerned about the effect that the Act will have on Ohioans' emotional, physical, and financial wellbeing and the wellbeing of their families.

My Background

7. I am a board-certified family physician with seventeen years of experience in women's health. I am licensed to practice medicine in the State of Ohio. I earned a B.S. in Medical Technology from Michigan State University and graduated from medical school at

[1] SB 260, § 1 (adding R.C. 2919.124(A)(1)).

[2] *Id.* (adding R.C. 2919.124(B)).

[3] *Id.* (adding R.C. 2919.124(C)).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Michigan State University, College of Human Medicine. I completed my residency in Family Medicine at the University of Cincinnati.

8. Since 2002, I have provided abortion in outpatient settings. In my current practice, I provide medication abortion up to 70 days (or 10 weeks) of pregnancy as measured from the first day of a patient's last menstrual period ("LMP") and procedural abortions through 21 weeks, 6 days LMP.

9. 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. My responsibilities include supervision of the physicians and clinicians who provide care and the development of PPSWO's medical policies and procedures.

10. Since 2019, I have overseen the implementation of PPSWO's program to provide medication abortion to patients using telemedicine. I now regularly provide medication abortion via telemedicine for some patients, in addition to doing so through traditional, in-person visits for others.

PPSWO and Its Services

11. PPSWO and its predecessor organizations have provided care in Ohio since 1929. PPSWO is a nonprofit corporation organized under the laws of the State of Ohio and headquartered in Cincinnati, Ohio.

12. PPSWO provides affordable, respectful, and high-quality health care to tens of thousands of patients in southwest Ohio. We provide a broad range of medical services to patients, including birth control; annual gynecological examinations; cervical pap smears; diagnosis and treatment of vaginal infections; testing and treatment for certain sexually transmitted infections ("STIs"); HIV testing; pregnancy testing; and abortion.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

13. PPSWO operates five health centers in southwest Ohio: two in Cincinnati, and one each in Dayton, Hamilton, and Springfield. As discussed in further detail below, one of the Cincinnati centers is an ambulatory surgical facility ("ASF") and has at least one physician present at all times. PPSWO's other four health centers, which are not ASFs, are headed by a non-physician clinician (i.e., a nurse practitioner, midwife, or advanced practice registered nurse). Additional medical professionals, including registered nurses, licensed practical nurses, and medical assistants, help staff each of these centers.

14. We strive to make our services as accessible as possible, particularly for patients in historically underserved communities who may not be able to reach us otherwise. In calendar year 2020, 68% of our patients reported living at or below 110% of the federal poverty line.

15. In FY 2020, more than 40% of PPSWO's patients were patients of color.

16. In 2019, we began offering telehealth services for various types of care. Initially we started with in-office telehealth services, which allow our physicians or other health care providers in one of PPSWO's health centers to talk by video to a patient in a different health center. Although the patient still has to travel to one of our centers, she can schedule an appointment at the center closest to her residence or workplace.

17. In addition to making care more geographically accessible for our patients, in-office telehealth services have helped us serve patients more efficiently.

18. In April 2020, as the COVID-19 pandemic intensified, we launched direct-to-patient telehealth services, through which some patients could obtain care without traveling to a health center at all. Using the direct-to-patient model, a patient with internet access and a video device can connect with one of our highly qualified health care professionals in the comfort of her own home or at another location of her choosing. Not all services are feasible

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

with the direct-to-patient model, but many are. For example, we are able to screen for STIs and order associated testing, counsel on and prescribe birth control, and perform follow-up visits for some types of care.

19. Our use of telehealth to maintain and expand services over the past year and a half is consistent with a general move among healthcare providers in Ohio to use telehealth more extensively. Even before the COVID-19 pandemic began, telehealth use was common in our region.

20. The COVID-19 pandemic has, of course, further accelerated this trend. Our patients are understandably worried about exposure to the coronavirus, which has disproportionately harmed Black communities and other communities of color. We've used our telehealth services, including our in-office model, to allow patients to reduce the extent to which they must travel. Particularly when patients have to travel longer distances, they may also have to rely on individuals in their extended networks or non-traditional modes of transportation to get to our health centers, further increasing the number of individuals with whom they have close contact and, by extension, their potential exposure to coronavirus.

21. The State of Ohio and insurance companies have also increased their focus on facilitating telehealth services during the pandemic, including by ensuring that costs of telehealth visits are reimbursable.

Current Access to Abortion in Ohio

22. There are two main methods of abortion: medication abortion and abortion by procedure, sometimes referred to as "surgical abortion." Both methods are effective in terminating a pregnancy.[4] PPSWO offers both methods of abortion.

[4] Luu Doan Ireland et al., *Medical Compared With Surgical Abortion for Effective Pregnancy Termination in the First Trimester*, 126 Obstetrics & Gynecology 22 (2015).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

23. Medication abortion involves a combination of two medications: mifepristone and misoprostol.[5] Patients take the first medication in the health center and then, twenty-four to forty-eight hours later, take the second medication at a location of their choosing, most often at home, after which the contents of the uterus pass in a manner similar to a miscarriage.

24. Current medical evidence demonstrates that medication abortion is safe and effective through at least eleven weeks LMP. However, Ohio law restricts the first drug used in medication abortion to use as described in the federally approved label, which describes use in pregnancies to 10 weeks or less.[6] Accordingly, although PPSWO would provide medication abortion up to 11 weeks LMP if it could legally do so, it currently cannot provide this method of abortion in Ohio beyond 10 weeks LMP (through 70 days).

25. Surgical abortion is not what is commonly understood to be "surgery"; it involves no incision and no need for general anesthesia. Up to approximately 15 weeks LMP, clinicians use the aspiration abortion technique, which involves dilating the natural opening of the cervix using medications and/or small, expandable rods, inserting a narrow tube into the uterus, and emptying the uterus through suction. To perform abortions after that gestational point in pregnancy, clinicians must dilate the cervix further and use instruments to empty the uterus, which is called the dilation and evacuation ("D&E") technique. Later in the second trimester, the clinician may begin cervical dilation the day before the procedure itself. PPSWO performs surgical abortion through 21 weeks, 6 days LMP.

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[5] Natl. Academies of Sciences, Eng., and Medicine, *The Safety and Quality of Abortion Care in the United States*, at 51 (2018).

[6] R.C. 2919.123; *see* FDA, *Mifeprex (mifepristone) Information* (last updated Feb. 5, 2018), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

26. According to the latest data from the Ohio Department of Health, 61% of all abortions in Ohio in 2019 occurred before 9 weeks LMP, and an additional 26.5% occurred between 9 and 12 weeks.[7]

27. As indicated above, all medication abortions performed by PPSWO (which are non-surgical in nature) involve mifepristone and misoprostol and, because of Ohio law, cannot occur after 70 days of pregnancy.

28. In 2020, PPSWO provided 3,760 abortions, 1,341 (36%) of which were medication abortions. In recent months, approximately 14% of the medication abortions we have provided have been done using our telemedicine model.

29. Given the gestational age of their pregnancies, some patients are only eligible for abortion by procedure. However, for those patients whose pregnancies are under 10 weeks LMP, the method of abortion selected is based on a number of factors. For some patients, medication abortion may be safer than abortion by procedure due to anomalies of the patient's reproductive and genital tract, such as large uterine fibroids or uterus didelphys, as well severe obesity or an extremely flexed uterus, all of which can make it difficult to perform an abortion by procedure. Many patients also prefer medication abortion because they can end their pregnancy at home at a time more convenient for them, and because it allows them more privacy. Survivors of sexual assault may also prefer medication abortion because of associated trauma from that experience, which may be further triggered by the mechanism of procedural abortion.

30. Individuals seek abortion for a multitude of complicated and personal reasons, which may all be compounded by the current pandemic. By way of example, some patients have abortions because they conclude it is not the right time to become a parent or have additional

[7] Ohio Dept. of Health, *Induced Abortions in Ohio, 2019*, at 24 table 8a (2019), https://bit.ly/2NraJ9G.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

children. In 2019, more than 62% of all abortions in Ohio were performed for patients who already had at least one child.[8] Others desire to pursue their education or career, or they lack the necessary financial resources or a sufficient level of partner or familial support or stability.[9] Other patients seek abortions because continuing with the pregnancy could pose a greater risk to their health.[10]

31. The window during which a patient can obtain an abortion in Ohio is limited. Pregnancy is generally forty weeks in duration, but Ohio prohibits abortion after 22 weeks LMP.[11] And, as noted above, after 10 weeks LMP, patients can no longer have a medication abortion in Ohio.

32. Patients generally seek abortion as soon as they are able, but many face logistical obstacles that can delay access to abortion services. Patients will need to schedule an appointment, gather the resources to pay for the abortion and related costs,[12] and arrange

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[8] *Id.* at 10 table 2; *see also* Guttmacher Inst., *Induced Abortions in the United States*, at 1 (2018), https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf; Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Inst., at 7 (2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[9] That strain is all the more apparent if one considers that the vast majority—approximately 75%—of abortion patients nationwide are poor or have low incomes. Guttmacher Inst., *Induced Abortions in the United States*, *supra* fn. 8, at 1.

[10] M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the US*, 13 BMC Women's Health 1, 7 (2013).

[11] R.C. 2919.201. This provision prohibits an abortion "when the probable post-fertilization age of the unborn child is twenty weeks or greater." R.C. 2919.195. "Post-fertilization age" means "the age of the unborn child as calculated from the fusion of a human spermatozoon with a human ovum," R.C. 2919.20(E), which is two weeks before a patient's last menstrual period. Thus, twenty weeks post-fertilization age is 22 weeks LMP.

[12] Ohio prohibits public insurance, including Medicaid, and insurance purchased on the state health exchange from covering abortion services except in the very limited circumstances where a patient's physical health or life is at risk, or where the pregnancy is a result of rape or incest that has been reported to law enforcement. R.C. 9.04, 3901.87; Ohio Adm.Code 5160-17-01.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

transportation to a clinic, time off of work (often unpaid, due to a lack of paid time off or sick leave), and possibly childcare during appointments.[13] Ohio law requires most patients to make these arrangements twice even though they could just as safely obtain care in one visit.[14] Delay results in higher financial and emotional costs to the patient. Minor patients, unless emancipated, must also obtain written consent from a parent or a judicial order before they can receive care.[15]

33. The COVID-19 pandemic has only exacerbated these burdens on patients seeking abortion. It has limited public transit availability, caused layoffs and other work disruptions, shuttered schools and childcare facilities, and otherwise limited patients' options for transportation and childcare support during a time of recommended social-distancing.

34. The majority of abortions performed by PPSWO occur at its Cincinnati Surgical Center. Under Ohio law, any facility (not including a doctor's office) that performs abortion by procedure must be an ASF, and the Cincinnati Surgical Center is PPSWO's only ASF.

35. Until 2019, PPSWO also performed all medication abortions at the Cincinnati Surgical Center as well. Ohio law requires that, at least twenty-fours before an abortion, a physician "meet[] with the pregnant woman *in person*" to describe the nature of the abortion procedure and potential risks.[16] As discussed above, the only health center that routinely has physicians physically present is the Cincinnati Surgical Center. In addition, as described above, all abortion patients—including those who seek medication abortion—must obtain an ultrasound,

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[13] Sarah E. Baum et al., *Women's Experience Obtaining Abortion Care in Texas After Implementation of Restrictive Abortion Laws: A Qualitative Study*, 11 PLoS One 1, 7–8, 11 (2016); Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334, 335 (2006).

[14] R.C. 2919.193–.194 (requiring the physician to determine whether there is a detectable fetal heartbeat, which is done by ultrasound, and if there is a detectable heartbeat, prohibiting an abortion for at least twenty-four hours).

[15] R.C. 2919.12.

[16] R.C. 2317.56(b)(1) (emphasis added).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

even though this step is not medically necessary in every case.[17] Again, the Cincinnati Surgical Center is the only center with staff who are trained to perform and interpret ultrasounds in pregnancy.

36. Beginning in 2019, however, PPSWO began offering medication abortions via in-office TMAB. The initial TMAB process is no different from the normal course for medication abortion patients. A patient seeking TMAB still goes to PPSWO's Cincinnati Surgical Center for her first visit ("Day 1"). As described above, this trip is required by Ohio law because the patient must meet face-to-face with a physician at least twenty-four hours in advance of the abortion, and she must also obtain an ultrasound that only staff at the ASF are trained to provide. At that visit, she thus receives an ultrasound, lab work, medical history assessment, patient education, and a face-to-face consent session with the physician, at which time the physician also answers any questions the patient may have about the abortion procedure, birth control, or other related medical concerns. Patients interested in medication abortion will be screened for contraindications at that time and advised of the potential risks of medication abortion. The patient will then still be required under Ohio law to wait twenty-four hours before obtaining an abortion at a second visit to PPSWO ("Day 2").

37. The key difference between PPSWO's TMAB process and traditional medication abortion appointments is that the patient's Day 2 visit need not occur at our Cincinnati Surgical Center. Instead, the patient can visit either our Hamilton or Dayton health centers. These other health centers may be significantly closer to the patient's home or workplace, or—due to operational considerations—they may have more appointment availability on their schedule.

[17] R.C. 2919.193–.194.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

38. PPSWO's Cincinnati Surgical Center is approximately twenty-four miles from its Hamilton Health Center, and more than fifty-one miles from its Dayton Health Center.

39. Once at the Hamilton or Dayton health centers, a TMAB patient is connected by videoconference with a PPSWO physician located in our Cincinnati Surgical Center. That physician, who is licensed to practice medicine in Ohio, confirms that the patient is firm in her desire to have an abortion and answers any questions that the patient may have. The physician then presses a button in the Cincinnati Surgical Center that remotely opens a cabinet in the other health center from which the patient obtains mifepristone, the first of the two medications involved in the medication abortion. The patient then ingests the mifepristone under observation on the video conference in the health center, after which PPSWO calls a prescription for misoprostol into a pharmacy for the patient to pick up. The patient then takes the misoprostol twenty-four to forty-eight hours later after the mifepristone. Throughout this process, a member of the health center staff will physically accompany the patient in the room to provide in-person assistance if needed, e.g., in case the cabinet does not open as intended, and to provide paperwork to the patient that she can take home with her. Staff who fulfill this role have been trained to do so by our Cincinnati Surgical Center staff.

40. The Hamilton Health Center is the only clinic in Butler County, Ohio, where a patient could obtain an abortion.

41. Our Dayton Health Center is one of only two locations where a patient could obtain an abortion in Montgomery County, Ohio. The other abortion provider in the county offers medication abortion (in-person only) and abortion by procedure. Despite the availability of this other provider, some patients still determine that PPSWO's TMAB services through the Dayton Health Center best fit their needs. For example, some individuals are existing PPSWO

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

patients for other types of care, and they feel most comfortable continuing to see us if they need an abortion.

42. At the time of SB 260's passage, PPSWO had plans to expand its TMAB services to the Springfield Health Center, in addition to the existing options in Dayton and Hamilton. I anticipate that expansion would occur within the next year, but for SB 260.

43. Our experience with TMAB has been overwhelmingly positive. When I provide a Day 2 TMAB visit, I am able to talk to the patient as effectively as I could in our ASF. Although the patient will already have had a consent session and decided on a course of treatment in person during her prior visit, I am able to respond to any new questions the patient may have with ease. The video platform we use is secure and reliable. And it is unquestionably safe to dispense mifepristone, the first of the two medications used in the medication abortion regimen, via site-to-site telemedicine, as we do. Notably, PPSWO also uses the same medication regimen for medication abortion to medically manage the care of some patients experiencing a miscarriage. The dosage and method of administration that we use is exactly the same as with a medication abortion. Yet, as I understand SB 260, if we were to use telemedicine for the medical management of miscarriage via mifepristone or any other medication, SB 260 would not bar that use.

44. It is my opinion that the TMAB services we offer are equivalent in quality to the medication abortion services that occur completely at our ASF in Cincinnati, and for some patients, the TMAB option is superior in meeting their preferences and needs. Patients regularly express appreciation for the opportunity to receive care closer to their homes.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

45. In our experience, the TMAB process helps reduce the travel burden for patients of obtaining a medication abortion and minimizes delays for patients. Patients may also be able to get a TMAB appointment sooner than an appointment for a medication abortion at our ASF.

46. In addition, we have found that some patients prefer TMAB because they are able to do the Day 2 visit at a facility that is not as strongly identified in the community as an abortion provider, and the process may feel less stigmatizing to patients as a result. Abortion protestors, for example, tend to target ASFs that provide abortion in the state. As a result, some patients prefer to complete the Day 2 visit at our Dayton or Hamilton locations, instead of returning to our Cincinnati Surgical Center, because they are less likely to encounter hostile or intimidating protestors as they enter.

47. Complications from medication abortion are rare, but to the extent they happen, it is generally after a patient takes misoprostol. As I discussed above, the patient takes misoprostol twenty-four to forty-eight hours after leaving the health center. We have never had a patient who experienced a complication in the health center that was caused by the initial medication abortion treatment. If complications from medication abortion occur (which, again, have not occurred in the health center at the time a patient takes mifepristone), they can generally be treated in an outpatient setting. Our patients—regardless of the method of abortion used or their reliance on telemedicine—receive the same information about follow-up care and twenty-four-hour contact information in case they need assistance.

The Effects of SB 260

48. If SB 260 takes effect, my PPSWO colleagues and I will have to stop using telemedicine for the Day 2 visit to provide medication abortion to our patients. My colleagues

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

and I simply cannot risk the potential criminal and licensure penalties that would apply to a violation of the Act.

49. As a result of SB 260, the Day 2 TMAB visit would no longer be available in Hamilton and Dayton to our patients. Instead, a patient seeking an abortion in southwest Ohio would have to make two visits either to our ASF in Cincinnati or to Women's Med Center in Dayton, an independent abortion provider. These are the only two abortion clinics that remain in southwest Ohio.

50. Despite the dearth of abortion providers in Ohio, and the rapidly expanding use of telemedicine for comparable care, SB 260 will force many patients to travel farther to obtain an abortion. It will completely eliminate access to abortion in Butler County, where our Hamilton Health Center is located. Our patients in that area will need to make two trips instead of just one to our Cincinnati Surgical Center. Those patients on the other side of our Hamilton Health Center from Cincinnati would have to travel an additional 48 miles (or more) roundtrip to have an abortion.

51. SB 260 will also reduce from two to one the number of facilities where a patient can obtain at least part of her abortion care in the Dayton area. Patients in that area who wish to obtain care from PPSWO will also have to make two trips to our Cincinnati Surgical Center for care. Those patients who live on the other side of our Dayton Health Center from Cincinnati would have to travel an additional 102 miles or more roundtrip to have receive abortion services from PPSWO.

52. We could not alleviate the impact of SB 260 by placing abortion-providing doctors in our non-ASF health centers. PPSWO could not economically sustain those costs, given the anticipated volume of medication abortion patients in those areas. In addition, many of

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

our abortion providers work at PPSWO on a part-time basis only and have other jobs in the Cincinnati area that would make it difficult, if not impossible, for us to assign doctors to other clinics.

53. These travel distances and attendant delays in obtaining access to care will, of course, carry other financial, physical, and emotional costs for our patients. Patients will need to pay more for gas and transportation, schedule longer periods of child care, and—for lengthier delays—potentially pay more for their abortions. Patients whose access to abortion is delayed by the law may also suffer increased risks of incomplete abortion,[18] or a loss of access to medication abortion altogether once they reach 10 weeks of pregnancy. These burdens will fall most heavily on patients with low incomes, patients of color, patients who live far from health centers, patients with children, minor patients, and patients experiencing interpersonal violence.

54. SB 260 may also create barriers that, for some patients, will so delay their access that they cannot have an abortion at all. If an individual is forced to continue a pregnancy against their will, it can pose a risk to their physical, mental, and emotional health, as well as to the stability and wellbeing of their family, including existing children.

55. Abortion is substantially safer than continuing a pregnancy through to childbirth. The risk of death associated with childbirth is far greater than that associated with abortion, and every pregnancy-related complication is more common among women giving birth than among those having abortions.[19] Preventing an individual who wants an abortion from having one can place economic and emotional strain on a family and may interfere with an individual's life

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[18] Natl. Academies, *supra* fn. 5, at 77–78, 162–63.

[19] *Id.* at 74–75 & table 2-4; *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, 215–16 (2012).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

goals. As most patients who seek abortion already have at least one child, families must consider how an additional child will impact their ability to care for the children they already have.

56. Pregnancy, childbirth, and an additional child may also exacerbate an already difficult situation for those who have suffered trauma, such as sexual assault or domestic violence.

* * *

57. For all of these reasons, I believe that SB 260 will deprive PPSWO's patients of access to critical health care and will threaten their health, safety, and lives. It will also require PPSWO to illogically eliminate its telemedicine services for abortion at a time when it and most other medical providers are expanding such access for other kinds of care. And SB 260 will do all of this without creating any benefit whatsoever for our patients, who will be forced to make two trips to Cincinnati to obtain medication that can safely and effectively be dispensed via telemedicine in another health center.

58. This Court's intervention to bar enforcement of the Act and prevent these grave harms is urgently needed. Patients who have their Day 1 visits beginning this Monday or later may be scheduled for Day 2 visits the week of April 12. Although Ohio law only requires twenty-four hours between the face-to-face Day 1 consent session and ultrasound and the Day 2 visit, in practice, that mandate delays patients by several days or a full week because they must schedule two medical visits, not just one. As a result, without an injunction, PPSWO could no longer provide some patients whose Day 1 visits are this coming week with TMAB services the week of April 12.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

FURTHER AFFIANT SAYETH NAUGHT.

Executed this 30 day of March, 2021.

Sharon Liner, M.D.

Signed before me this 30 day of March, 2021

Notary Public



E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

EXHIBIT 4

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A 2101148 Judge Alison Hatheway

AFFIDAVIT OF JULIA QUINN, MSN, WHNP-BC, IN SUPPORT OF PLAINTIFFS' SECOND MOTION FOR A PRELIMINARY INJUNCTION

I, Julia Quinn, MSN, WHNP-BC, having been duly sworn and cautioned according to law, hereby state that I am over the age of eighteen years and am competent to testify as to the facts set forth below based on my personal knowledge:

I. MY QUALIFICATIONS

1. I am an advanced practice registered nurse ("APRN"),[1] a type of advanced practice clinician ("APC"), in the Surgery and Family Planning Departments of Planned Parenthood Southwest Ohio Region ("PPSWO"). Prior to taking my current position, I was a registered nurse ("RN") in the Surgery Department of PPSWO from April 2022 until March 2023. I provide a range of sexual and reproductive health care, well-person care, and gender affirming care to PPSWO's patients in our health centers and I assist physicians who provide abortion care in our surgical center. I also train RNs, NPs, medical students, and residents at PPSWO.

[1] As described below, I am a board-certified nurse practitioner, which is one type of APRN.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

2. Prior to starting at PPSWO, I worked in various roles supporting abortion providers. For example, from May 2019 to February 2022, I was a nurse practitioner ("NP") at Planned Parenthood Southeast where I provided reproductive health care, including medication abortion education and complication management. I also served as a part time RN with two other abortion providers, where I provided pre- and post-procedural abortion care from October 2017 to February 2022.

3. I hold a Bachelors of Science in Nursing and a Masters of Science in Nursing from Emory School of Nursing. I also hold a Bachelors of Arts in Ecology, Evolution, and Organismal Biology from Vanderbilt University.

4. I have been an RN since 2017 and an NP since 2019. I am licensed as an NP and as an RN in Ohio. I am also board certified as a Women's Health Nurse Practitioner ("WHNP"). I also hold a Drug Enforcement Administrative license to prescribe controlled substances as an NP in Ohio.

5. The facts I state here are based on my education, training, and experience; information obtained in the course of my duties at PPSWO; and personal knowledge that I have acquired through my service at PPSWO.

6. I submit this affidavit in support of Plaintiffs' Second Motion for a Preliminary Injunction. I understand that Plaintiffs are challenging Ohio laws that prevent advanced practice clinicians from providing medication abortion in Ohio (collectively, the "APC Ban"), even if they are trained and qualified to do so within their scope of practice. I understand that the challenged laws preclude anyone other than a physician from providing both medication and procedural abortions in Ohio.

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E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

II. ADVANCED PRACTICE CLINICIANS

7. The term APC includes NPs, certified nurse midwives, and physician assistants. APCs have at least masters-level training in medicine and health care. APC training places significant emphasis on recognizing when a patient needs to be referred to another provider, which can include referral to a specialist or to a physician for care beyond an APC's scope of practice. NPs also typically have an educational focus on health promotion and education that emphasizes preventive care and helping patients avoid illness and disease.

8. In Ohio, APCs collaborate with physicians under Standard Care Agreements ("SCAs"), which provide for physician supervision and availability to consult with the APC as needed. The physician does not need to be physically present when the APC provides care. APCs are trained and qualified to safely and effectively treat patients with a high degree of independence. We routinely obtain informed consent from patients for diagnosis and treatment, take patient histories, assess patients physically, diagnose conditions, perform certain procedures, prescribe medication, and provide treatments.

9. In general, as an NP, my scope of practice is determined by my training, education, and experience in practice. Other than the APC Ban, I do not know of any Ohio law that expressly says I cannot provide a certain treatment or procedure to a patient when doing so would otherwise be within my scope of practice.

III. ABSENT THE APC BAN, PROVIDING MEDICATION ABORTION IS WITHIN APCS' SCOPE OF PRACTICE.

10. "Medication abortion" generally refers to the use of two medications, mifepristone and misoprostol, in combination to end a continuing pregnancy. It is available in Ohio for the first 70 days of pregnancy, as measured from the first day of a patient's last

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

menstrual period ("LMP").[2] Patients first take mifepristone, which blocks the hormone progesterone, thereby stopping the pregnancy from further developing. Then, within the next 48 hours, the patient takes the second medication, misoprostol, which causes the uterus to contract and expel its contents in a manner similar to a miscarriage.

11. Absent the APC Ban, providing medication abortion would be within the scope of practice of APCs. Absent the APC Ban, I would train and begin to provide medication abortion to patients in Ohio. Once trained, I would provide medication abortion to PPSWO patients, including providing medication abortion beyond 70 days LMP if the Evidence-Based Use Ban is enjoined. In light of the previously-entered injunction against the Telemedicine Ban, I could provide medication abortion both in person and via telemedicine.

12. APCs are trained to screen patients for medical contraindications before prescribing medications and counsel patients on the risks and benefits of, and alternatives to, different forms of treatment.

13. Medication abortion is extremely safe, and treating the rare complications from medication abortion is generally within APCs' scope of practice. APCs are also trained to recognize when to refer patients to a higher level of care.

14. Further, APCs in Ohio can prescribe mifepristone and misoprostol for non-abortion care. For example, APCs in Ohio can prescribe these medications for miscarriage care and for cervical ripening for Intrauterine Device ("IUD") insertion. Use of these medications for miscarriage care typically involves the same medication regimens, patient assessment, counseling, and risk as use of these medications for induced abortion.

[2] Although research has demonstrated that mifepristone can be safely and effectively used to end a pregnancy at least through 77 days LMP, I understand that Ohio law currently only allows it to be used for abortion according to its Food and Drug Administration ("FDA") label, which allows its use through 70 days LMP.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

15. At PPSWO, my Ohio APC colleagues and I provide other health care, including prescribing medication, that is at least comparable to providing medication abortion in terms of the complexity of screening for contraindications or risk factors, counseling patients, and monitoring for and managing complications. For example, APCs prescribe gender affirming hormone care, which involves screening for risk factors and contraindications, extensive counseling, and frequent follow up, as well as selecting medication routes and doses based on patient goals and risk factors, titrating doses, and managing complications. Another example of comparably complex care provided by APCs in Ohio would be the prescription of pre-exposure HIV prophylaxis (commonly called "PrEP") and post-exposure HIV prophylaxis (commonly called "PEP"), which both involve screening for contraindications and risk factors and monitoring kidney function while patients are taking the medication, as well as extensive counseling regarding risks, alternatives, and use.

16. APCs, including myself, also routinely assess patients for contraception eligibility; counsel them regarding their options, including risks and benefits of different options; and either prescribe or place (with IUDs and Nexplanon) their chosen contraception. Assessing a patient for contraception eligibility can be more complicated than providing medication abortion because some birth control pills that contain estradiol, as well as contraceptive patches and rings, increase a patient's risk for blood clots, and these medications are often taken long term. A patient's risk for blood clots is often multifactorial and nuanced, and APCs routinely navigate assessing this risk compared to risk of pregnancy and counseling patients about weighing risks and alternative methods. In some cases, a patient's risk is high enough to preclude prescribing them an estradiol-containing medication. APCs can, and do, routinely provide patients this care safely and effectively.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

17. Beyond this medication-based care, myself and other Ohio APCs perform various procedures that are more technically complex and/or carry higher risk of complications than medication abortion. This includes inserting IUDs, which can involve using mifepristone or misoprostol for pre-insertion cervical ripening and carries risk of uterine perforation and infection; and removing IUDs, which can require use of instruments in the uterus (when removing an IUD without strings). I also insert and remove Nexplanon contraceptive implants under the upper-arm skin via an incision.

IV. THE APC BAN HARMS PATIENTS IN OHIO

18. The APC Ban is detrimental to patients. Medication abortion is a critical need for many of my patients, and it is frustrating not to be able to help them. In my experience, most patients who seek an abortion want to proceed with treatment as soon as possible after they have made their decision to terminate their pregnancy. At present, I am unable to help them, which delays their care. For example, if I am seeing a patient to insert an IUD, but the patient and I learn at that appointment that they are pregnant and the patient decides they want to have an abortion, I would not be able to conduct their informed consent (or "Day 1" visit) at that same appointment. Instead, the patient would have to make two visits to our ASF in Cincinnati to obtain medication abortion from a physician.

19. If I could provide medication abortion, including providing the state-mandated pre-abortion information and obtaining informed consent, it would increase PPSWO's ability to serve our patients. PPSWO has greater patient volume and need relative to our capacity. PPSWO has a limited number of physicians who currently have to provide all medication and procedural abortions. Having APC capacity to provide medication abortion would free up physician time to

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

serve more patients who need procedural abortions or other forms of complex gynecological care. It could also enable PPSWO to see medication abortion patients more quickly.

20. Absent the APC Ban, PPSWO would also be able to ensure greater continuity of care for our patients. Patients should be able to receive care from a provider of their choosing who is qualified to safely and effectively provide that care. PPSWO's APCs provide a wide range of patient care every day in our health centers. Over time, some patients develop relationships with APCs in our health centers and/or increased comfort with a familiar clinic even if they see different providers at different times. Sexual and reproductive health care is typically extremely intimate and personal, and patients are often more comfortable receiving that sensitive care from a trusted provider and clinic with whom they have established relationships.

21. PPSWO does not have enough physicians to staff both our ambulatory surgical facilities ("ASFs") and health centers with physicians. Thus, all medication abortions are provided at our Cincinnati ASF.[3] This means that, in practice, the APC Ban requires many of PPSWO's patients to have their abortion at a clinic and with a clinician who is new to them, rather than at a clinic and with a clinician they might otherwise choose due to familiarity. It can be difficult for patients to understand and accept that they have to go to a different clinic for care and work with a new person for that care after having already developed a relationship of trust with myself or another APC colleague at one of our health centers. This is particularly true with patients who distrust medical providers.

22. Some patients do not realize that they are pregnant until they come to one of PPSWO's health centers for other care, such as contraception care. The APC Ban can be

[3] The exception to this is telemedicine abortions. Still, all telemedicine abortion patients have to go to the Cincinnati ASF for their Day 1 visit since, under the current law, the state-mandated pre-abortion information must be provided in person and by a physician. *See* R.C. 2317.56, 2919.192–94.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

particularly distressing for these patients, who often expect that they might be able to have an abortion or at least begin the informed consent process required by Ohio law that same day. Instead, we have to send patients to our Cincinnati ASF or another abortion provider to essentially start the process over again with a physician. This can be especially problematic for patients who ultimately decide they want medication abortion care and have a short window to do so, since medication abortion is currently only available in Ohio through 70 days LMP. These patients may not be able to access a medication abortion within 70 days LMP, which then forces them to travel out of state for a medication abortion, attempt to manage their abortion outside of the medical system, have a procedural abortion, or remain pregnant against their will.

23. The need for abortion care in Ohio is great, and I would like to be able to help meet that need. I chose to provide the type of care in the setting that I do because I strongly believe that people should be able to have high quality care—regardless of the type of care they need. Patients want and expect this when seeking medical care. Not being able to provide this type of care because of Ohio's APC Ban prevents me from following principles that I believe are central to compassionate, patient-centered, evidence-based care, such as deeply respecting patient dignity and autonomy. This is distressing. It is especially hard to be unable to take care of patients in the way they want and need because I see colleagues in other states with the same training and qualifications as myself who are able to provide medication abortions, while I am subject to arbitrary, medically unnecessary Ohio laws that prevent me from doing the same.

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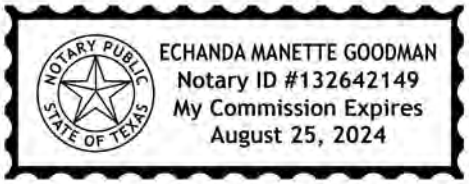
FURTHER AFFIANT SAYETH NAUGHT.

Julia Quinn, MSN, APRN, WHNP-BC
Planned Parenthood Southwest Ohio Region
Julia Quinn who produced Ohio
Drivers License as identification

State of Texas
County of Jefferson

Sworn to and subscribed before me this 8th day of May, 2024.

E'Chanda Manette Goodman
Notary Public
E'Chanda Manette Goodman
Remote Online Notary Public
State of Texas, Jefferson County



This notarial act was an online notarization along with multi-factor authentication and using audio/video recording.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

EXHIBIT 5

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. _____ Judge: _____

EXPERT AFFIDAVIT OF DANIEL GROSSMAN, M.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER FOLLOWED BY PRELIMINARY INJUNCTION

I, Daniel Grossman, M.D., being duly sworn on oath, do depose and state as follows:

1. I am a professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco ("UCSF") and a board-certified obstetrician-gynecologist ("ob-gyn") with over twenty five years of clinical experience. I currently provide clinical services, including abortion services, at Zuckerberg San Francisco General Hospital. I am also a Fellow of the American College of Obstetricians and Gynecologists ("ACOG"), where I previously served as Vice Chair of the Committee on Practice Bulletins for Gynecology. I served on the ACOG Committee on Health Care for Underserved Women from 2014 to 2020, including as Chair from 2018 to 2020. I am also a Fellow of the Society of Family Planning and a member of the American Public Health Association. Additionally, I serve as Director of Advancing New Standards in Reproductive Health ("ANSIRH") at UCSF. ANSIRH conducts innovative, rigorous, multidisciplinary research on complex issues related to people's sexual and reproductive lives. I am a Senior Advisor at Ibis Reproductive Health, a nonprofit research organization, and I am also a researcher with the Texas Policy Evaluation Project, which is based at the University of Texas at Austin. I am a

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

liaison member of the Planned Parenthood National Medical Committee, and between 2012 and 2015, I provided clinical services with Planned Parenthood Northern California (formerly Planned Parenthood Shasta Pacific).

2. My research interests include contraceptive and abortion access, and evaluating the impact of integrating reproductive health and HIV services. My research has been supported by grants from federal agencies and private foundations. I have published over 200 articles in peer-reviewed journals and co-authored several book chapters, and I am a member of the Editorial Board of the journal *Contraception*.

3. A current version of my *curriculum vitae* ("CV"), which sets forth my experience and credentials more fully, is attached to this declaration as Exhibit A. My CV contains a complete list of the publications that I have authored or co-authored.

4. I submit this declaration based on my education, clinical training, experience as a practicing physician over the past 25 years, my own research, and regular review of other medical research in the field. All opinions stated herein are to a reasonable degree of professional certainty.

5. I submit this declaration in support of Plaintiffs' Motion for a Temporary Restraining Order Followed by Preliminary Injunction to prevent enforcement of Senate Bill 260, which I understand would require that a physician who prescribes abortion-inducing medication to a patient be physically present at the location and at the time the patient takes the first dose of medication in the abortion regimen. This effectively bans medication abortion by telemedicine.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Abortion is Common, Safe, and Effective

6. Abortion is one of the most common medical procedures in the United States. Approximately 1 in 4 women in this country will have an abortion by age 45.[1]

7. Women seek abortions for a variety of medical, familial, economic, and personal reasons. Nationally, 59% percent of women who seek abortions have already given birth at least once and have decided that they cannot parent another child at the time they end their pregnancy.[2] A recent study found that the most common reasons women stated for seeking abortion included financial reasons (40%), timing of pregnancy (36%), partner-related reasons (31%), and the need to focus on other children (29%), with most citing multiple reasons.[3]

8. Abortion is one of the safest procedures in contemporary medical practice. A recent analysis of abortion in the United States performed by the National Academies of Sciences, Engineering, and Medicine concluded that abortion is extremely safe, involving minimal risks.[4] Abortion complications are exceedingly rare: nationwide, fewer than one-quarter of 1% (0.23%) of all abortion patients (including patients obtaining all abortion procedures and at all gestational ages) experience a complication that requires hospital admission, surgery, or blood transfusion.[5]

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[1] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 Am. Journal of Public Health 1904, 1908 (2017).

[2] Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Inst., at, 7 (2016), *available at* https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[3] M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the US*, 13 BMC Women's Health 1, 1, 5–6 (2013).

[4] Natl. Academies of Sciences, Eng., and Medicine ("NAS"), *The Safety and Quality of Abortion Care in the United States*, at 77 (2018) ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.").

[5] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 129 table 3 (2015).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

9. In contrast, carrying a pregnancy to term and delivering the baby is significantly riskier than abortion. The national risk of maternal mortality associated with live birth is approximately 14 times higher than that of induced abortion.[6] Moreover, every pregnancy-related complication is more common among women giving birth than among those having abortions. As many as 10% of women who give birth are hospitalized for complications associated with pregnancy aside from hospitalization for delivery.[7]

10. Women of color, and Black and Indigenous women in particular, face heightened risks of maternal mortality and pregnancy-related complications.[8]

11. In the United States, abortion is generally performed by one of the following methods: medication abortion, aspiration abortion, and dilation and evacuation ("D&E").

12. Medication abortion is generally available through 70–77 days after the first day of the patient's last menstrual period ("LMP"), depending on the provider. While it is evidence-based practice to use medication abortion through 77 days LMP,[9] Ohio law restricts the first drug used in medication abortion to use as described in the federally approved label, which describes use in pregnancies to 10 weeks, or 70 days, or less.[10] It involves terminating a

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[6] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 215–16 (2012).

[7] Anne Elixhauser & Lauren M. Wier, HCUP Statistical Brief #113, *Complicating Conditions of Pregnancy and Childbirth, 2008*, Agency for Healthcare Research & Quality (2011), *available at* http://www.hcup-us.ahrq.gov/reports/statbriefs/sb113.pdf; F. Carol Bruce et al., *Maternal Morbidity Rates in a Managed Care Population*, 111 Obstetrics & Gynecology, 1089 (2008).

[8] Emily E. Peters et al., *Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017*, 68 U.S. Dept. of Health & Human Servs./Ctrs. for Disease Control Morbidity & Mortality Weekly Report 423, 423 (2019).

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

[10] R.C. 2919.123; *see* FDA, *Mifeprex (Mifepristone) Information* (last updated Feb. 5, 2018), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

pregnancy through a combination of two medications: mifepristone and misoprostol. Mifepristone works by blocking the hormone progesterone, which is necessary to maintain pregnancy. Misoprostol then causes the cervix to open and the uterus to contract and expel its contents, generally within hours of misoprostol administration, thereby completing the abortion. Medication abortion requires no anesthesia or sedation; women are screened for eligibility and contraindications, receive counseling, and are then provided with the medications.

13. Aspiration abortion, also referred to as suction curettage, entails the use of suction to empty the contents of the uterus. This method is typically used up to 14–16 weeks LMP. An aspiration procedure may also be used in the case of an incomplete medication abortion, which happens if some tissue is retained in the uterus, which can cause continued bleeding or spotting. D&E abortion entails the use of suction and medical instruments to empty the contents of the uterus. This method is typically used beginning at 14–16 weeks LMP. Aspiration procedures and D&E procedures are also referred to as "surgical abortion" or "procedural abortion."

History, Safety, and Effectiveness of Medication Abortion

14. The U.S. Food and Drug Administration ("FDA") is responsible for approval of all drugs that may be offered for sale in the United States. In the normal review process, the FDA determines, based on clinical data provided by the manufacturer, whether the drug is safe and effective for its intended use. It also plays a role in reviewing and approving drug labeling.

15. The FDA first approved mifepristone in 2000. At that time, evidence showed that a particular regimen (dosing, timing and route of administration) of mifepristone and misoprostol was safe and effective for abortion through 63 days LMP, though the FDA approved it for use up to 49 days LMP.[11] Misoprostol was approved by the FDA in 1988 for the indication of reducing

[11] Eric A. Schaff et al., *Low-Dose Mifepristone Followed by Vaginal Misoprostol at 48 Hours for Abortion Up to 63 Days*, 61 Contraception 41 (2000).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

the risk of NSAID (nonsteroidal anti-inflammatory drugs, including aspirin)–induced gastric ulcers in patients at high risk of complications from gastric ulcer.

16. Subsequent research showed that other regimens of mifepristone and misoprostol were safer and more effective, and could be used later in pregnancy. In 2016, the FDA approved an updated label for Mifeprex (the brand name for mifepristone 200 mg) based on this evidence. That label sets forth the following evidence-based regimen for medication abortion through 70 days LMP: On day one, the patient takes 200 mg of mifepristone orally; 24 to 48 hours later, the patient takes 800 mcg of misoprostol buccally (in the cheek pouch); and 7 to 14 days later, the patient follows up with a healthcare provider to confirm that the pregnancy has been terminated.[12]

17. Medication abortion is one of the safest procedures in contemporary medical practice. Major complications following medication abortion are very rare, and as stated above, far rarer than those associated with pregnancy and childbirth.

18. Although complications following medication abortion are rare, the most common are incomplete abortion, described above, and continuing pregnancy, in which the medications are not effective at ending the pregnancy. These complications can almost always be handled in an outpatient setting on a non-emergency basis. In addition, incomplete abortion and continuing pregnancy are known outcomes of medication abortion, about which patients are counseled. Patients make an informed decision when choosing medication abortion, understanding that it is more likely they will have an incomplete abortion or continuing pregnancy compared to choosing to have an aspiration abortion.

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[12] FDA, *MIFEPREX: Highlights of Prescribing Information* (2016), *available at* https://www.accessdata.fda.gov/drugsatfda_docs/*label*/2016/020687s020lbl.pdf.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

19. Like other complications of medication abortion, incomplete abortion occurs after the woman has left the abortion facility. Mifepristone takes 90 minutes to reach peak absorption,[13] so effects on the uterus do not occur sooner, and any bleeding or spotting generally will not start until after the second medication, misoprostol, is taken 24 to 48 hours later at a location of the woman's choosing (usually, her home). If the abortion is incomplete, the patient has the option to take a second dose of misoprostol in order to complete it, to have an aspiration procedure similar to surgical abortion or miscarriage management,[14] or, in some cases, to wait for the tissue to pass without intervention. The risk of an incomplete abortion increases with gestational age, e.g., an incomplete medication abortion is somewhat more likely at 9 weeks LMP than at 7 weeks LMP.

20. A smaller proportion of patients will have a continuing pregnancy. If the patient has a continuing pregnancy, she has the option to take a second dose of misoprostol (sometimes combined with a repeat dose of mifepristone) to complete the abortion, or to have an aspiration procedure. Like the risk of an incomplete abortion, the risk of a continuing pregnancy increases with gestational age.

21. The current FDA-approved Mifeprex label aggregates data from seven United States clinical trials totaling over 16,000 medication abortion patients, including a study I published in 2011. Based on those data, it shows that 97.4% of medication abortion cases were successful using the current evidence-based regimen I describe above.[15] Only 2.6% of patients had a uterine aspiration procedure which, as described below, is typically a non-urgent procedure

[13] *Id.* at § 12.3 (Pharmacokinetics).

[14] An aspiration procedure may be used following a miscarriage to remove any remaining pregnancy tissue from the uterus.

[15] *Id.* at § 14 table 3.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

similar to a surgical abortion or miscarriage management.[16] The reasons for such intervention included ongoing pregnancy, medical necessity (such as to treat an infection or persistent or heavy bleeding), incomplete expulsion, or on the request of a patient who chooses not to wait for the medication abortion process to complete.[17] Similarly, my research shows that medication abortion will fail or be incomplete in approximately 2.0% of cases.[18]

22. Serious complications requiring urgent care are even rarer. My 2017 study, which was published after the FDA approved the updated label for Mifeprex, found that among more than 19,000 medication abortion patients treated in-person or via telemedicine, only 0.26% experienced clinically significant adverse events—defined as treatment given in an emergency department, hospital admission, surgery, blood transfusion, or death (although there were no reported deaths or cases requiring surgery).[19] This finding is in accord with other clinical studies. One large study found that the risk of major complications from medication abortions—defined as serious unexpected adverse events requiring hospital admission, surgery, or blood transfusion—was 0.31%.[20] That study also found that only 0.87% of patients undergoing abortion presented at an emergency department within six weeks of the procedure with an abortion-related complaint and received a related diagnosis or treatment. Another large-scale study showed that only 0.16% of medication abortion patients experienced a significant complication (defined as hospital admission, blood transfusion, emergency department treatment,

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[16] *Id.*

[17] *Id.*

[18] Daniel Grossman et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 Obstetrics & Gynecology, 296, 299 (2011).

[19] Daniel Grossman & Kate Grindlay, *Safety of Medical Abortion Provided Through Telemedicine Compared With In Person*, 130 Obstetrics & Gynecology 778, 780 (2017).

[20] Upadhyay et al., *supra* fn. 5, at 178 table 3.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

intravenous antibiotics administration, infection, or death), and only 0.06% experienced complications resulting in hospital admission.[21]

23. The mifepristone and misoprostol regimen used for medication abortion is also used for miscarriage management,[22] and can be prescribed via telemedicine. This medication regimen is no less safe in the context of medication abortion than it is in the context of miscarriage management.

Ohio's Ban on the Use of Telemedicine in Abortion Care

24. Telemedicine is the delivery of health care services at a distance through information and communication technology.[23] Telemedicine has been used to expand the reach of physicians in many disciplines around the country and found to be safe and effective.[24] Telemedicine for abortion services has the potential to provide abortion services earlier in pregnancy and closer to a patient's home and to help overcome barriers to abortion access in the United States.

25. There are different possible models by which telemedicine can be provided. In a direct-to-patient model, a patient with internet access and a video device can connect with a health care provider from her own home or a location of her choosing. Alternatively, a patient may utilize in-office telemedicine services, in which a patient located in one health center can talk by video to a health care provider in a different location; this is often referred to as a site-to-site model. The latter model is the one most often used for medication abortion in the

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[21] Kelly Cleland et al., *Significant Adverse Events and Outcomes After Medical Abortion*, 121 Obstetrics & Gynecology 166, 169 table 2 (2013).

[22] Courtney A. Schreiber et al., *Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss*, 378 New England Journal of Medicine 2161 (2018).

[23] Daniel A. Grossman et al., *Changes in Service Delivery Patterns After Introduction of Telemedicine Provision of Medical Abortion in Iowa*, 103 Am. Journal of Pub. Health 73, 73 (2013).

[24] Grossman et al., *supra* fn. 18, at 300; *see also* Victoria A. Wade et al., *A Systematic Review of Economic Analyses of Telehealth Services Using Real Time Video Communication*, 10 BMC Health Servs. Research 233 (2010).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

United States, and has been studied by myself and other researchers and found to be safe, effective, and well-liked by patients.

26. Telemedicine for medication abortion has been used in Iowa since June 2008,[25] in Alaska since 2011,[26] Maine and Montana since 2016,[27] Idaho and Nevada since at least 2017,[28] until recently by one clinic in Illinois since 2016,[29] and most recently in Washington, Hawaii, New York, and Oregon through the Gynuity TelAbortion Study.[30] The TelAbortion Study involves a direct-to-patient model of care where patients obtain any needed ultrasound or lab testing locally and have a telemedicine visit with a clinician, who then mails mifepristone and misoprostol to eligible participants.[31] Telemedicine is also being used in Utah to provide state-mandated, pre-abortion informed consent.[32] Providers have found it easy to integrate the new technology for telemedicine into their clinic operations, as it largely requires the same processes and clinic flow as an in-person visit.[33] Providers using telemedicine report that their

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[25] Grossman et al., *supra* fn. 23, at 73–78.

[26] Kate Grindlay & Daniel Grossman, *Telemedicine Provision of Medical Abortion in Alaska: Through the Provider's Lens*, 23 Journal of Telemedicine & Telecare 680 (2016).

[27] Sarah Boden, *Maine Follows Iowa's Lead on Telemed Abortion*, Iowa Pub. Radio (Feb. 29, 2016), *available at* http://www.iowapublicradio.org/post/maine-follows-iowas-lead-telemed-abortion#stream/0; Julia E. Kohn et al., *Introduction of Telemedicine for Medication Abortion: Changes in Service Delivery Patterns in Two U.S. States*, 103 Contraception 151 (2020).

[28] Julia E. Kohn et al., *Medication Abortion Provided Through Telemedicine in Four U.S. States*, 134 Obstetrics & Gynecology 343 (2019).

[29] Angie L. Lourgos, *Illinois Clinic Provides Abortions Via Telemedicine, Which Provides Wider Access But Is Prohibited in 19 States*, The Chicago Tribune (Jan. 19, 2018), *available at* http://www.chicagotribune.com/lifestyles/health/ct-met-telemedicine-abortion-illinois-20171220-story.html; Julia Spitzer, *How One Illinois Clinic Provides Abortions Via Telemedicine*, Becker's Hospital Review (Jan. 19, 2018), *available at* https://www.beckershospitalreview.com/telehealth/how-one-illinois-clinic-provides-abortions-via-telemedicine.html.

[30] Elizabeth Raymond et al., *TelAbortion: Evaluation of a Direct to Patient Telemedicine Abortion Service in the United States*, 100 Contraception 173 (2019).

[31] *Id.*

[32] Sara Daniel et al., *Characteristics of Patients Using Telemedicine Compared With In-Person Visits for State-Mandated Informed Consent Before Abortion in Utah*, 99 Contraception 316 (2020); Katherine Ehrenreich et al., *Women's Experiences Using Telemedicine to Attend Abortion Information Visits in Utah: A Qualitative Study*, 29 Women's Health Issues 407 (2019).

[33] Grindlay & Grossman, *supra* fn. 26, at 682.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

interactions with the patients are essentially the same as an in-person visit.[34] Medication abortion through telemedicine is cost- and medically effective, and acceptability is high among women who choose this model for treatment.[35] In fact, telemedicine patients are more likely to recommend the service to a friend than face-to-face patients.[36]

27. I understand from Plaintiffs' counsel that the Ohio providers utilize a telemedicine for medication abortion model by which patients see a physician in person at one of Plaintiffs' ambulatory surgical facilities for an informed consent visit at least 24 hours prior to obtaining an abortion, as required by Ohio law. At this initial visit, trained staff obtain a medical history, take vital signs, perform an ultrasound, and perform standard lab work. All of this information is reviewed by a physician to determine whether medication abortion is appropriate for the patient, as there are a limited number of medical conditions that might make a patient an inappropriate candidate. The physician has a one-on-one in-person informed consent conversation with the patient, and if there are any concerns about the patient's eligibility for medication abortion the physician will discuss those with the patient at that time. If medication abortion is appropriate, patients have the option of scheduling their second visit at a different health center that may be closer to the patient's home or place of work, at which time they can talk via video conference with a physician located at the ambulatory surgical facility. During this second visit, the physician confirms the patient's decision to seek an abortion and answers any questions the patient may have. The physician then presses a button in the surgical facility that remotely opens a cabinet in the other health center from which the patient obtains the mifepristone. The patient then ingests the mifepristone under observation on the video conference in the health center, after

[34] *Id.* at 683.

[35] Grossman et al., *supra* fn. 18, at 300; *see also* Kate Grindlay et al., *Women's and Providers' Experiences with Medical Abortion Provided Through Telemedicine: A Qualitative Study*, 23 Women's Health Issues e117 (2013).

[36] Grossman et al., *supra* fn. 18, at 300.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

which the physician calls a prescription for misoprostol into a pharmacy for the patient to pick up. The patient then takes the misoprostol 24 to 48 hours after the mifepristone at a location of her choosing, usually at home. During the telemedicine visit, a trained member of the health center staff physically accompanies the patient in the room.

28. Given that a telemedicine model for medication abortion in which the entire process occurs via video conference has been found to be safe and effective, certainly the model utilized in Ohio in which patients are seen in person by a physician prior to an abortion is safe and effective.

29. I am familiar with the Ohio law at issue in this case requiring that a physician who prescribes abortion-inducing medication to a patient be physically present at the location and at the time the patient takes the first dose of medication in the abortion regimen. This requirement serves as a *de facto* ban on using telemedicine for medication abortion. In my opinion, this law offers no health or safety benefits to abortion patients. Instead, it harms people seeking abortion by limiting its availability.

30. I cannot conceive of a medical reason why the prescribing physician, who has consulted with the patient and prescribed mifepristone and misoprostol, would need to be physically present in the room when the drugs are given or dispensed to the patient. I am unaware of any other context in which the medical professional who prescribes a medication is required to be physically present when the medication is given or dispensed to the patient, even for medical treatment far riskier than medication abortion, and medication far riskier than mifepristone. I understand that Ohio law does not require the physical presence of the

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

prescribing professional when any other medication is given or dispensed to a patient, even medications that do pose a risk of serious side effects, such as chemotherapy drugs.[37]

31. Telemedicine for medication abortion is as safe and effective as in-person treatment.[38] The complication rate for medication abortion is exceedingly low (less than 0.5%), whether it is provided in-person or by telemedicine.[39] In a 2011 study I led, we investigated the effectiveness and acceptability of telemedicine for medication abortion compared to in-person medication abortions, and we found that the success rates were very similar: 98.7% for telemedicine patients and 96.9% for in-person patients.[40] No patient in this study required hospitalization.[41] In fact, the overall rate of adverse events in the study was less than 0.3%.[42] Importantly, we found that telemedicine and in-person patients had no significant difference in the occurrence of adverse events.[43]

32. In a 2017 Iowa study, other researchers and I compared the safety of medication abortion between patients receiving services by telemedicine and those having an in-person visit at Planned Parenthood of the Heartland clinics in Iowa from July 1, 2008, to June 30, 2015.[44] In this seven-year study, 8,765 medication abortions were performed with telemedicine, and 10,405 were performed with in-person appointment.[45] We found that medication abortion patients rarely experienced clinically significant adverse events (only 0.26% of the 19,170 patients). These adverse outcomes were uncommon with telemedicine (0.18% of telemedicine patients), and there

[37] Ohio Adm.Code 4731-11-09(C)–(D).

[38] Grossman et al., *supra* fn. 18, at 300; *see also* Wade, *supra* fn. 24, at 233.

[39] Grossman et al., *supra* fn. 18, at 300; *see also* Wade, *supra* fn. 24, at 233.

[40] Grossman et al., *supra* fn. 18, at 299.

[41] *Id.*

[42] *Id.*

[43] *Id.*

[44] Grossman & Grindlay, *supra* fn. 19.

[45] *Id.* at 780.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

were no reported deaths or cases requiring surgery among any of the medication abortion patients.[46] Indeed, there was no significant difference in the prevalence of adverse events between telemedicine and in-person patients.[47]

33. In a 2019 systematic review of evidence regarding telemedicine used for medication abortion, the authors found that the provision of medication abortion via telemedicine is safe, effective, and well-liked by both patients and providers.[48] The review found that clinical outcomes, including the rates of successful abortion, hospitalization, and blood transfusions were similar to those reported for the provision of medication abortion in person.[49] Another analysis of data from Alaska, Idaho, Nevada, and Washington that included 445 telemedicine patients and 4,011 patients receiving medication abortion with an in-person visit confirmed previous findings documenting the safety and effectiveness of telemedicine provision of medication abortion.[50]

34. As the National Academies of Sciences, Engineering, and Medicine concluded, there is no medical need for medication abortion to be administered in the physical presence of a health care provider.[51] Screening women for contraindications and eligibility, providing counseling, and dispensing medication can be done with equal safety regardless of whether the physician is physically present in the room with the patient (and, as is explained above, in Ohio

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[46] *Id.*

[47] *Id.*

[48] Daniel Grossman, Commentary, *Telemedicine for Medical Abortion—Time to Move Towards Broad Implementation*, 126 An Intl. Journal of Obstetrics & Gynecology 1103 (2019).

[49] Margit Endler et al., *Telemedicine for Medical Abortion: A Systemic Review*, 126 An Intl. Journal of Obstetrics & Gynecology 1094, 1097 & table 1, 1100 (2019). The review also found that for gestational age ≤10 weeks, the proportion of patients undergoing surgical intervention, including vacuum aspiration and dilation and curettage, varied in the studies from 0.9% to 19.3%. The authors note these "rates were higher than expected" and that "surgical evacuation rates vary depending on the women's country of residence." *Id.* at 1098–99. Of note, the review included studies of different models of telemedicine, including both direct-to-patient and site-to-site models. The only study included in the review of the site-to-site model, where all patients underwent ultrasound and were in a clinic when they received the mifepristone and misoprostol, found the surgical intervention rate for patients receiving the service by telemedicine to be 0.9%. *Id.* at 1097 table 1.

[50] Kohn et al., *supra* fn. 28.

[51] NAS, *supra* fn. 4, at 79.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

the initial medical screening and eligibility determination are done during the patient's first visit to a health center which includes a one-on-one, in-person visit with a physician). Additionally, on the rare occasions when complications do arise, it would not matter whether the patient obtained a medication abortion in person or through telemedicine. This is so because any complications that do arise after medication abortion occur after the patient has left the clinic.

35. Additionally, the reported low risks of medication abortion are similar in magnitude to the adverse effects of common prescriptions and over-the-counter medications.[52] As the National Academies of Sciences, Engineering, and Medicine, as well as the Iowa study, found, it appears that providing medication abortion in specific facilities or with an in-person visit with the clinician is not necessary to ensure safety, as the risks are essentially the same as common pharmaceuticals routinely dispensed in pharmacies and taken at home.[53] A 2018 report issued by the FDA confirms the very low risk of death associated with medication abortion—a risk that is lower than that reported for penicillin, Tylenol, or Viagra.[54]

36. Consistent with all of this research, in 2020, ACOG, the premier professional membership organization for U.S. obstetrician-gynecologists, updated its practice bulletin focused on medication abortion, which recognized that medication abortion provided using telemedicine is as safe and effective as in-person services, well-liked by patients, and also may help reduce delays to care.[55]

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[52] *Id.* at 58.

[53] *Id.*

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

[55] ACOG, Practice Bulletin No. 225, *Medication Abortion Up to 70 Days of Gestation,* 136 Obstetrics & Gynecology 1, 5 (2020).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

37. Telemedicine furthers public health because it improves access to early medication abortion in underserved areas.[56] The number of abortion providers has declined over the last three decades in the United States, resulting in greater distances and higher costs for some women to obtain treatment.[57] In 2014, there were seventeen facilities providing abortions in Ohio, twelve of which were clinics. But by 2017, there were only fourteen abortion-providing facilities in the state, including only nine clinics, representing a 25% decline in abortion-providing clinics.[58]

38. Telemedicine improves access for disproportionately affected women living on low incomes and those living in rural and underserved areas who are not readily able to travel.[59] In 2017, in the United States, 89% of counties lacked an abortion provider and 38% of women of reproductive age lived in those counties and would have to travel to receive abortion care.[60] In 2017, some 93% of Ohio counties had no clinics that provided abortions, and some 55% of Ohio women lived in those counties.[61]

39. Women in rural areas are disproportionately impacted. In fact, ACOG has expressed ongoing concern over the lack of medical services available to women in rural communities, and has asked ob-gyns to "[f]oster and participate in efforts to utilize effective

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[56] Kohn et al., *supra* fn. 28, at 344.

[57] Grindlay et al., *supra* fn. 35, at e117.

[58] Guttmacher Inst., *State Facts About Abortion: Ohio* (Jan. 2021), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-ohio (citing Rachel K. Jones et al., *Abortion Incidence and Service Availability in the United States, 2017*, Guttmacher Inst. 1, 17 table 4 (Sept. 2019), https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017).

[59] Grindlay et al., *supra* fn. 35, at e117–22.

[60] Guttmacher Inst., *supra* fn. 58 (citing Jones et al., *supra* fn. 58, at 17 table 4).

[61] *Id.* (citing Jones et al., *supra* fn. 58, at 17 table 4).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

telemedicine technologies...to expand and improve services for rural women."[62] According to the 2010 census, 22.1% of Ohio's population is rural.[63]

40. Telemedicine facilitates a patient-centered approach to care, enabling patients to be seen sooner, with greater choice in abortion procedure type, and to be closer to their home.[64] As a result of telemedicine in Alaska, providers were able to schedule additional appointments that better met patients' needs and in turn allowed women to be seen at earlier gestational ages.[65] Telemedicine also expands access to abortion services by allowing clinics to provide more appointments with shorter wait times.[66] In contrast, before telemedicine, clinics in areas without or with few abortion providers had to transport doctors to the clinic. In Alaska, the need to transport physicians limited the ability of one clinic featured in a study to offer abortion services to once or twice a month.[67] This limitation increased the wait time for women to receive an abortion procedure, at times pushing women beyond the gestational limit for medication abortions.[68]

41. Between October 2009 and February 2010, I and other researchers conducted a study in Iowa, in which we performed in-depth interviews with women receiving telemedicine and clinic staff involved in providing medication abortion through telemedicine.[69] The study showed that women opted for the telemedicine visit because of the close proximity, the reduced

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[62] ACOG, Committee Opinion No. 586, *Health Disparities in Rural Women,* 123 Obstetrics & Gynecology 384 (2014, *reaff'd* 2016), *available at* https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co586.pdf?dmc=1&ts=20181105T1932069692.

[63] U.S. Census Bur., *Ohio: 2010 – Population and Housing Unit Counts* (2012), https://www.census.gov/prod/cen2010/cph-2-37.pdf.

[64] Grossman et al., *supra* fn. 18, at 300.

[65] Grindlay & Grossman, *supra* fn. 26, at 681–82.

[66] *Id.*; *see also* Grindlay et al., *supra* fn. 35, at e117–22.

[67] Grindlay & Grossman, *supra* fn. 26, at 681.

[68] *Id.*

[69] Grindlay et al., *supra* fn. 35, at e118.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

amount of time they had to take off from work or school, the lower costs associated with travel, and because they did not have to explain to family, friends, or their boss the reason for traveling to a more distant location, which could compromise the confidentiality of their pregnancy and abortion decision.[70]

42. In the same study, clinic staff cited numerous benefits to introducing telemedicine in their practice: physicians can reach more patients; greater efficiency of resources with patients and providers no longer having to travel long distances, and fewer delays related to travel in severe weather.[71] The greatest perceived impact in the study was enhanced access for patients.[72]

43. I and other researchers conducted another study in Iowa that assessed the effect of a telemedicine model providing medication abortion on service provided in Iowa clinics.[73] In Iowa, abortion access for women in more remote parts of the state increased with telemedicine.[74] Women living farther than 50 miles from the nearest clinic offering surgical abortion were more likely to obtain an abortion after the introduction of telemedicine in Iowa.[75] While the mean distance traveled to the abortion clinic decreased by 2.5 miles after the introduction of telemedicine, telemedicine improved patients' access to abortion care by expanding the number of clinics able to provide medication abortion and benefited patients by reducing travel distance and offering more options for abortion care.[76] In another study of patients undergoing abortion at Planned Parenthood clinics in Montana, the distance traveled to the clinic decreased from 134 to

[70] *Id.* at e118–19.

[71] *Id.* at e120.

[72] *Id.* at e120–21.

[73] Grossman et al., *supra* fn. 23.

[74] *Id.* at 75.

[75] *Id.*

[76] *Id.* at 76.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

115 miles after the introduction of telemedicine; the mean time to appointment also decreased from 14 to 12 days.[77]

44. The Iowa study found that patients had a 46% greater likelihood of having an abortion at or before 13 weeks of gestation when obtaining abortion services after the introduction of telemedicine.[78] Because patients often do not become aware that they are pregnant until about five weeks LMP or later, many patients struggle to access care within the short window that medication abortion is available. By providing more scheduling options and locations closer to patients' homes, telemedicine allows patients to access abortion services earlier in their pregnancies. Thus, access to early abortion care benefits the public health, as reducing second trimester abortions helps to reduce the rare health risks associated with later abortions.

Ohio's Telemedicine Ban Will Harm Patients

45. Based on the available research and my understanding of Plaintiffs' TMAB model, as described above, it is my expert opinion that enforcement of Ohio's telemedicine abortion ban will harm people seeking abortion care in numerous ways. These harms include increased travel burdens; delayed access to abortion; inability to access medication abortion; and being forced to carry an unwanted pregnancy to term.

46. I understand that there are currently four health centers in Ohio, in Dayton, Youngstown, Mansfield, and Hamilton, at which Plaintiffs provide medication abortion by telemedicine. I understand that, as is explained above, while patients currently must travel to one of Plaintiffs' surgical abortion facilities, in Cincinnati, East Columbus, or Bedford Heights, for their 24-hour consent appointment, medication abortion patients may have their appointment to

[77] Kohn et al., *supra* fn. 28, at 151, 153.

[78] Grossman et al., *supra* fn. 23, at 75.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

begin the medication abortion process itself at one of the telemedicine sites. If these telemedicine sites can no longer offer abortion services, patients living near one of these sites will be required to make a second trip to a surgical abortion facility, increasing their travel burden.

47. Research shows that increased travel distance is associated with delays in abortion access and can prevent patients from accessing abortion altogether.[79] It is my professional opinion that Ohio's telemedicine abortion ban will delay some patients' access to medication abortion, past 10 weeks' gestation, after which they will no longer have the option of a medication abortion in Ohio, and that it will prevent still others from accessing abortion altogether. These burdens fall even harder on women with low incomes—women who are less likely to be able to overcome the costs and logistical barriers that the increased travel imposes.

48. Increases in distances traveled mean not only that women must drive farther to access safe, legal, early abortion (or, if they lack access to a car, they must take public transportation), but also must bear the increased financial, logistical, and psychological costs of reaching the nearest abortion provider. This includes making arrangements for additional child care, missed work, and other obligations; making arrangements for additional travel; and securing additional funds.[80] Because the cost of an abortion increases as pregnancy progresses, patients can find themselves in a vicious cycle, where they secure additional funds, but the cost keeps increasing.

49. Women seeking an abortion also face significant personal, social, and financial obstacles. Most abortion patients live on incomes below 200% of the federal poverty level.[81] For

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[79] *See, e.g.*, Jason M. Lindo, J. et al., *How Far Is Too Far? New Evidence on Abortion Clinic Closures, Access, and Abortions*, 55 Journal of Human Resources 1137 (2020).

[80] *See* Liza Fuentes et al., *Women's Experiences Seeking Abortion Care Shortly After the Closure of Clinics Due to a Restrictive Law in Texas*, 92 Contraception 292 (2016).

[81] Jerman et al., *supra* fn. 2, at 11 ("75% of abortion patients are low income, having family incomes of less than 200% of the federal poverty level.").

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

these women in particular, it is a struggle to pull together the resources to take time off from work and arrange transportation to obtain an abortion. One study from Arizona, conducted before that state's mandatory delay law went into effect, found that "the majority of women seeking abortion care had to forego or delay food, rent, childcare, or another important cost to finance their abortion."[82]

50. I understand that the majority of women seeking an abortion in Ohio are already parents, and many have multiple children.[83] Therefore, they need to organize and/or pay for additional childcare when they have health care visits. These women may have inflexible work schedules and must work within narrow time constraints when arranging health care appointments. Some women must conceal these arrangements from abusive or controlling partners or family members.[84]

51. For women who can overcome these barriers, the barriers nonetheless result in delays in seeking care.[85] Indeed, in one study of 1,209 abortion patients, among women who said they would have preferred to have had their abortions earlier, 56% of first-trimester patients reported they were delayed because it took a long time to make arrangements, including 23% who said they needed time to raise money to have the abortion and 6% who said they could not

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[82] Deborah Karasek et al., *Abortion Patients' Experience and Perceptions of Waiting Periods: Survey Evidence before Arizona's Two-Visit 24-Hour Mandatory Waiting Period Law*, 26 Women's Health Issues 60, 64 (2016).

[83] Ohio Dept. of Health, *Induced Abortions in Ohio, 2019*, 9 table 1 (2019), *available at* https://bit.ly/2NraJ9G.

[84] *See* ACOG, Committee Opinion No. 554, *Reproductive & Sexual Coercion*, 121 Obstetrics & Gynecology 411 (2013), *available at* https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co554.pdf ?dmc=1&ts=20190619T2242171002; Jerman et al., *supra* fn. 2, at 7 (59% of abortion patients surveyed already had children and one-third had two or more); Michael B. Lupfer & B.G. Silber, *How Patients View Mandatory Waiting Periods for Abortion*, 13 Family Planning Perspectives 75, 76–77 (1981) (describing problems with delay, including increased expenses and missing additional time at work); Karasek et al., *supra* fn. 82, at 62–63 (31% reported compromised confidentiality because they had to tell someone they did not want to tell); Sarah E. Baum et al., *Women's Experience Obtaining Abortion Care in Texas after Implementaiton of Restrictive Abortion Laws: A Qualitative Study*, 11 PLoS ONE, at 7–8, 11 (2016).

[85] *See* Baum et al., *supra* fn. 84 (observing burdens women faced due to increased travel distances, including delay, due to Texas abortion restrictions, including among women who strongly preferred medication abortion and women who obtained a surgical abortion although they preferred medication).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

find a place to have an abortion near where they lived and so had to arrange for transportation.[86] These barriers, and further delay, also have negative effects on women's mental health.[87]

52. Further, women who are delayed past 10 weeks LMP are unable to access medication abortion in Ohio. Many women prefer medication abortion because they can complete the process in the privacy of their homes, with the company of loved ones, and at a time of their choosing. Some women choose medication abortion because they fear a procedure involving surgical instruments. Victims of rape, or women who have experienced sexual abuse or molestation, may choose medication abortion to feel more in control of the experience and to avoid trauma from having instruments placed in their vagina.

53. For other women, there are medical reasons why medication abortion is better for them than surgical abortion. Some women have medical conditions that make medication abortion a significantly safer option than surgical abortion, including in cases of uterine fibroids, congenital uterine anomalies, or introital scarring related to infibulation.[88] My own research shows that most women who choose medication abortion have a strong preference for this method.[89]

54. When legal abortion is unavailable or difficult to access, some women turn to illegal, and potentially unsafe, methods to terminate unwanted pregnancies.[90] Other women,

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[86] Lawrence B. Finer, *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334, 335 table 1 (2006).

[87] *See* Jenna Jerman et al., *Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States*, 49 Perspectives on Sexual & Reproductive Health 95 (2017).

[88] ACOG, *supra* fn. 55, at 2.

[89] *See* Grossman et al., *supra* fn. 18, at 300 (finding 71% of study participants said they strongly preferred medication abortion).

[90] Daniel Grossman et al., *Self-Induction of Abortion Among Women in the United States*, 18 Reproductive Health Matters 136 (2010); Daniel Grossman et al., *The Public Health Threat of Anti-Abortion Legislation*, 89 Contraception 73, 73 (2014); Texas Policy Evaluation Project, *Research Brief: Texas Women's Experiences Attempting Self-Induced Abortion in the Face of Dwindling Options* (2015), *available at* https://liberalarts.utexas.edu/txpep/_files/pdf/TxPEP-Research-Brief-WomensExperiences.pdf.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

deprived of access to legal abortion, forego the abortions they would have obtained if they could have and, instead, carry unwanted pregnancies to term. These women are exposed to increased risks of death and major complications from childbirth,[91] and they and their newborns are at risk of negative health consequences, including reduced use of prenatal care, lower breastfeeding rates, and poor maternal and neonatal outcomes.[92] These risks are even higher for women living in rural and outlying areas, where there are fewer medical providers.[93] Women forced to carry an unwanted pregnancy to term also may find it harder to bring themselves and their family out of poverty.[94] As compared to women who obtained an abortion, women who wanted but could not access an abortion are more likely to be marginally employed, unemployed, or enrolled in public safety net programs.[95] This economic insecurity could last years.[96] And women who are victims of partner violence will, in many cases, face increased difficulty escaping that relationship (because of new financial, emotional, and legal ties with that partner).[97]

55. It is important to consider abortion restrictions in this context: access to abortion is important to public health, and it is already limited.

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[91] Raymond & Grimes, *supra* fn. 6, at 1272.

[92] Anshu P. Mohllajee et al., *Pregnancy Intention and Its Relationship to Birth and Maternal Outcomes,* 109 Obstetrics & Gynecology 678 (2007); Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 Studies in Family Planning 18 (2008).

[93] Diana G. Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am. of Journal Pub. Health 407 (2018).

[94] *Id.*; Ushma D. Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC Women's Health 1 (2015); Diana G. Foster et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 The Journal of Pediatrics 183; Diana G. Foster et al., *Comparison of Health, Development, Maternal Bonding, and Poverty Among Children Born After Denial of Abortion vs After Pregnancies Subsequent to an Abortion*, 172 JAMA Pediatrics 1053 (2018).

[95] Foster et al., *supra* fn. 93, at 409–13.

[96] *Id.* at 407, 409–13.

[97] Sarah C. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy after Receiving or Being Denied an Abortion*, 12 BMC Medicine 144 (2014).

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FURTHER AFFIANT SAYETH NAUGHT

Executed this 30th day of March, 2021.

Daniel Grossman

Daniel Grossman, M.D.

Signed before me this ____ day of March, 2021

See Attached CA Certificate
Acknowledgement
~~Jurat~~

Notary Public

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ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of San Francisco)

On March 30, 2021 before me, P Ho She, Notary Public,
(insert name and title of the officer)

personally appeared Daniel Grossman,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

P. HO SHE
COMM. # 2283742
NOTARY PUBLIC-CALIFORNIA
SAN FRANCISCO COUNTY
MY COMM. EXP. MAR. 30, 2023

Signature P Ho She (Seal)

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EXHIBIT 6

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IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A 2101148 Judge Alison Hatheway

EXPERT REPORT OF DANIEL GROSSMAN, M.D..

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

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E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

M.D., Julia Quinn, and Planned Parenthood of Greater Ohio

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*,	Case No. A 2101148
Plaintiffs,	Judge Alison Hatheway
v.	
OHIO DEPARTMENT OF HEALTH, *et al.*,	
Defendants.	

AFFIDAVIT OF DANIEL GROSSMAN, M.D..

Now comes affiant Daniel Grossman, M.D., having been first duly cautioned and sworn, deposes and states as follows:

1. I am over the age of 18 and fully competent to make this declaration. I have personal knowledge of the statements and facts contained herein.
2. For the purposes of this litigation, I am providing my expert opinions.
3. I have prepared the report attached to this affidavit as **Exhibit A** and swear to its authenticity and to the faithfulness of the opinions expressed, and to the best of my knowledge, the accuracy of the factual statements made therein.

FURTHER AFFIANT SAYETH NAUGHT

Daniel Grossman

Daniel Grossman, M.D.

State of Florida

County of Broward

Sworn to and subscribed before me this 17th Day of March, 2026.

Daniel Grossman appeared and signed electronically and presented a Driver License as identification

DELINA MONCRIEF
Notary Public - State of Florida
Commission # HH 745927
My Comm. Expires Feb 8, 2030

Delina Moncrief

Delina Moncrief Online Notary

This notarial act conducted online

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

EXPERT REPORT OF DANIEL GROSSMAN, M.D.

I. INTRODUCTION

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. I am over 18 years of age, of sound mind, and in all respects competent to testify.

2. I have actual knowledge of the matters stated herein.

3. In preparing this report, in addition to reviewing the materials cited herein, I have also relied on my years of research and other experience, as set out in my *curriculum vitae* ("CV") (**Exhibit B**) in forming my opinions. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

II. BACKGROUND AND QUALIFICATIONS

4. I am a Professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco ("UCSF") and an obstetrician-gynecologist with over twenty-seven years of clinical experience. I currently provide clinical services, including abortion services, at San Francisco General Hospital. I am the Vice Chair for Advocacy in the UCSF Department of Obstetrics, Gynecology and Reproductive Sciences. I am also a Fellow of the American College of Obstetricians and Gynecologists ("ACOG"), where I previously served as Vice Chair of the Committee on Practice Bulletins for Gynecology, as Chair of the ACOG Committee on Health Care for Underserved Women, and as a member of ACOG's Telehealth Working Group. I am currently a member of ACOG's Abortion Access and Training Expert Work Group. I am also a member of the Society of Family Planning, the American Public Health Association ("APHA"), and the American Medical Association ("AMA"). Additionally, I serve as Director of Advancing New Standards in Reproductive Health ("ANSIRH") at UCSF. ANSIRH

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

conducts innovative, rigorous, multidisciplinary research on complex issues related to people's sexual and reproductive lives. I am also a Senior Advisor at Ibis Reproductive Health, a nonprofit research organization. I am a liaison member of the Planned Parenthood National Medical Committee, and between 2012 and 2015, I provided clinical services with Planned Parenthood Northern California (formerly Planned Parenthood Shasta Pacific). My research has been supported by grants from federal agencies and private foundations. I have published more than 260 articles in peer-reviewed journals, and I am a member of the editorial board of the journal *Contraception*.

5. I have a B.S. in Molecular Biophysics and Biochemistry from Yale University and an M.D. from Stanford University School of Medicine. I completed a residency in Obstetrics, Gynecology, and Reproductive Sciences at UCSF. I am also a board-certified subspecialist in Complex Family Planning.

6. My CV sets forth my experience and credentials more fully and contains a complete list of the publications that I have authored or co-authored.

III. OVERVIEW OF EXPERT OPINIONS AND THE FACTUAL BASIS FOR EXPERT TESTIMONY

7. The facts I state here and opinions I offer are based on my education, clinical training, experience as a practicing physician over the past 27 years, my own research, and regular review of other medical and public health research in the field. All opinions stated herein are to a reasonable degree of medical certainty. I am being compensated at the rate of $250 per hour for my work as an expert in this case.

8. I understand that Senate Bill 260 (the "Telemedicine Ban") requires that a physician who prescribes abortion-inducing medication to a patient be physically present at the location and at

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

the time the patient takes the first dose of medication in the abortion regimen. This effectively bans medication abortion by telemedicine.

9. I also understand that a number of Ohio laws and regulations effectively forbid physician assistants, nurse practitioners, and certified nurse-midwives (collectively, "APCs") from providing abortions, including medication abortions (the "APC Ban").

10. I further understand that Ohio Revised Code 2919.123 (the "Evidence-Based Use Ban"), as interpreted by the Ohio Supreme Court, restricts mifepristone's use to the specific protocol detailed in the current FDA-approved label, including by restricting it to the gestational duration it was approved for, which is 70 days (ten weeks) from a patient's last menstrual period ("LMP"). The Evidence-Based Use Ban prohibits providers from prescribing mifepristone in an evidence-based, "off-label" manner, which is a common part of modern medical practice.

11. I also understand that the Telemedicine Ban, the APC Ban, and the Evidence-Based Use Ban (collectively, the "Challenged Restrictions") have been preliminarily enjoined by the Court in this case.

12. It is my opinion that the Evidence-Based Use Ban restricts clinicians in Ohio from providing evidence-based care. It arbitrarily limits access to medication abortion with no medical benefit and contrary to the best medical evidence. In particular, there are ample studies supporting the use of medication abortion past ten weeks' gestation, the use of a different route of administration for misoprostol when used with mifepristone as part of the two-drug regimen for medication abortion, and the use of different intervals between taking the mifepristone and misoprostol than those detailed in the FDA-approved label. Those who are interested in shortening the interval between mifepristone and misoprostol using non-buccal routes of administering the second medication are similarly denied access to this evidence-based treatment. The effect of these

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

restrictions is to limit patient options by denying some patients the ability to access medication abortion altogether and to reduce patients' satisfaction with care; they may also delay care if patients decide to seek care out of state.

13. It is my further opinion that the Telemedicine Ban offers no health benefits to abortion patients. Instead, it harms people seeking abortion by limiting and delaying its availability. Telemedicine is safe, effective, and well-liked by medication abortion patients. There is no medical reason why a prescribing physician would need to be physically present in the room when the patient takes the initial dose of abortion medication. The same medications are already prescribed via telemedicine for other reasons.

14. Moreover, in my opinion, the APC Ban does nothing to improve patient health. Instead, it harms abortion patients by limiting the availability of abortion providers and thus the availability of abortion for no medical reason. By reducing patient access to important, time-sensitive medical care, it undermines both public health and individual patient health and well-being. APCs routinely provide care of similar or greater complexity and which carry similar or greater risk than medication abortion, including miscarriage care. There is no medical reason to single out medication abortion from all other health care for specialized scope-of-practice regulation. It is the widely accepted clinical standard of practice for APCs to provide abortion within their scope of practice.

15. Individually and cumulatively, the Challenged Restrictions impede, delay, and in some cases may entirely prevent access to medication abortion, or even abortion altogether. They limit patients' access to care, and expose them to substantial financial, logistical, emotional, and physical burdens.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

IV. OPINIONS

A. Abortion Is Common, Safe, and Effective.

16. Abortion is extremely common and safe.

17. Abortion is one of the most common medical procedures in the United States. Approximately 1 in 4 women in this country will have an abortion by age forty-five.[1]

18. Women seek abortions for a variety of medical, familial, economic, and personal reasons. Nationally, 59% percent of women who seek abortions have already given birth at least once and have decided that they cannot parent another child at the time they end their pregnancy.[2] In Ohio in 2025, 59.2% of abortion patients already had at least one child.[3] One study found that the most common reasons women stated for seeking abortion included financial reasons (40%), timing of pregnancy (36%), partner-related reasons (31%), and the need to focus on other children (29%), with most (64%) citing multiple reasons; this aligns with my personal experience as an abortion provider.[4]

19. In the United States, abortion is generally provided by one of the following methods: medication abortion, aspiration abortion, and dilation and evacuation ("D&E"). Aspiration and D&E are both forms of procedural abortion. This report primarily addresses medication abortion.

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[1] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 Am. J. Pub. Health 1904, 1908 (2017).
[2] Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, 7 (2016), https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014 (accessed Feb. 10, 2026),
[3] Ohio Dept. of Health, *Induced Abortions in Ohio, 2025 Report*, 5 table 1 (March 1, 2026) (excluding patients for whom the number of living children was not reported), https://dam.assets.ohio.gov/image/upload/odh.ohio.gov/programs/vital-statistics/abortion-reports/induced-abortions-in-ohio-2025.pdf (accessed March 5, 2026).
[4] M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the US*, 13 BMC Women's Health 29, 1, 5–6 (2013).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

20. Medication abortion is generally available through 70–84 days LMP, depending on the provider.[5] Medical evidence supports the use of medication abortion through at least 84 days LMP.[6] The most common method of medication abortion involves terminating a pregnancy through a combination of two medications: mifepristone and misoprostol. Mifepristone works by blocking the hormone progesterone, which is necessary to maintain the pregnancy. Misoprostol then causes the cervix to open and the uterus to contract and expel its contents, generally within hours of its administration, thereby completing the abortion. It is also safe and effective to terminate a pregnancy using misoprostol alone.[7] When terminating a pregnancy using misoprostol alone, patients generally take three to five doses of 800 mcg of misoprostol every three hours.

21. Medication abortion requires no anesthesia or sedation; patients are screened for eligibility and contraindications, receive counseling, and are then provided with the medications. The same

[5] *See* Rosalyn Schroeder et al., ANSIRH, *Trends in Abortion Services in the United States, 2017-2023* 14 (2024), https://www.ansirh.org/sites/default/files/202408/AFD%20Trends%20in%20Abortion%20Services% 20in%20the%20United%20States%202017-2023_Final%20 UPDATED.pdf (accessed Feb. 14, 2026).

[6] Nathalie Kapp et al., *Medical Abortion in the Late First Trimester: A Systematic Review*, 99 Contraception 77 (2019); Jacqueline Quinn et al., *Safety and Efficacy of Early Medical Abortion at Home Between 10+0 and 11+6 Weeks' Gestation: A Retrospective Review*, 52 British Med. J. Sexual and Reproductive Health 57 (2025); World Health Org., *Abortion Care Guidelines* (2022) at 68–70, https://iris.who.int/server/api/core/bitstreams/59a704cc-4024-412a-97d9-55d86d139602/content (accessed Feb. 10, 2026); Ilana Dzuba et al., *A Repeat Dose of Misoprostol 800 mcg Following Mifepristone for Outpatient Medical Abortion at 64–70 and 71–77 Days of Gestation: A Retrospective Chart Review*, 102 Contraception 104 (2020); Robin Wallace et al., *Expanding Access to Abortion with Mifepristone and Misoprostol Through 84 Days Estimated Gestational Duration*, 151 Contraception (2025).

[7] Elizabeth G. Raymond et al., *Effectiveness and Safety of Misoprostol-Only for First-Trimester Medical Abortion: An Updated Systematic Review and Meta-Analysis*, 127 Contraception (2023); Ruvani Jayaweera, *Medication Abortion Safety and Effectiveness With Misoprostol Alone*, JAMA Open Network (Oct. 27, 2023), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2811114 (accessed Feb. 10, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

regimen is used for the treatment of miscarriages. For both abortion and miscarriage, this regimen can be safely and effectively provided via telemedicine.

22. Aspiration abortion, also referred to as suction curettage or dilation and curettage ("D&C"), entails the use of suction to empty the contents of the uterus. This method is typically used up to 14–16 weeks LMP. An aspiration procedure may also be used in the case of an incomplete medication abortion, which occurs when some tissue is retained in the uterus and can cause continued bleeding or spotting.

23. D&E abortion entails the use of suction and medical instruments to empty the contents of the uterus. This method is typically used beginning at 14–16 weeks LMP. As with medication abortion, aspiration and D&E are also used as treatments for miscarriage.

24. Abortion is one of the safest treatments in contemporary medical practice. An analysis of abortion in the United States performed by the National Academies of Sciences, Engineering, and Medicine[8] concluded that abortion is extremely safe, involving minimal risks.[9] Abortion complications are exceedingly rare: nationwide, fewer than one-quarter of 1% (0.23%) of all abortion patients (including patients obtaining all abortion procedures and at all gestational

[8] The National Academies is a private, non-profit society of distinguished scholars. Established by an Act of Congress, it is charged with providing independent, objective advice to the nation on matters related to science and technology. Expert committees composed of leading scientists, engineers, and health professionals are recruited to address specific questions through rigorous analysis. These specialists produce peer-reviewed consensus reports based on evidence-based evaluations.

[9] Natl. Acads. of Sci., Eng., & Med., *The Safety and Quality of Abortion Care in the United States* 77 (2018), https://nap.edu/catalog/24950/the-safety-and-quality-of-abortion-care-in- the-united-states (accessed Feb. 10, 2026) [hereinafter "Natl. Acads."] ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.").

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

durations) experience a complication that requires hospital admission, surgery, or blood transfusion.[10]

25. In contrast, carrying a pregnancy to term and undergoing delivery is significantly riskier than abortion. The national risk of maternal mortality associated with live birth is approximately fourteen times higher than that of induced abortion,[11] and one recent study concludes that pregnancy-related deaths are more than forty-four times as likely as abortion-related deaths.[12] The United States has the highest maternal mortality rate among high-income countries.[13] In 2023, the maternal mortality rate in the U.S. was 18.6 deaths per 100,000 births,[14] significantly higher than that of other high-income countries.[15] Early research and reporting indicates that the prohibition and criminalization of abortion may be contributing to maternal mortality, even for patients who are experiencing miscarriages or other complications of a wanted pregnancy rather than abortions.[16] My own research has also documented cases of patients whose care while

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[10] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 178–79 tbl.3 (2015).

[11] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 215–16 (2012); *see also* Natl. Acads. *supra* note 9 at 74–76 (calculating mortality risk for live birth to be more than 12.5 times higher than that of induced abortion).

[12] Maria W. Steenland et al., *Pregnancy- and Abortion-Related Mortality in the US, 2018-2021*, (Jan. 21, 2026), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2844131 (accessed Feb. 10, 2026).

[13] World Health Org. et al., *Trends in Maternal Mortality 2000 to 2020* (Feb. 23, 2023), https://www.who.int/publications/i/item/9789240068759 (accessed Feb. 10, 2026).

[14] Donna L. Hoyert, *Health E-Stat 100: Maternal Mortality Rates in the United States, 2023* (2025), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2023/Estat-maternal-mortality.pdf (accessed Feb. 10, 2026).

[15] Munira Z. Gunja et al., *Insights into the U.S. Maternal Mortality Crisis: An International Comparison*, (June 4, 2024), https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison (accessed Feb. 10, 2026) (comparing 2022 mortality rates and finding that the U.S. maternal mortality rate was two to three times higher than that of other high-income countries, and 6.4 times that of Germany, for example).

[16] Rachel Yavinsky et al., *Abortion Bans Linked to Sharp Rise in Sepsis, Infant Death, and Pregnancy-Associated Death, New Research Shows*, Population Research Bureau (Aug. 7, 2025),

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

experiencing a pregnancy-related complication was delayed or denied due to bans on abortion care.[17] Women of color, and Black and Indigenous women in particular, face heightened risks of maternal mortality and pregnancy-related complications.[18] For example, in the U.S. in 2023, the maternal mortality rate for Black women was more than triple that for white women.[19] Notably, while the maternal mortality rate in the U.S. has significantly increased over time, the mortality rate for abortion has not.

26. Deaths are also very rare specifically with medication abortion. Between 2000 and 2024, the FDA identified thirty-six deaths after taking mifepristone among approximately 7.5 million people who used it for medication abortion, which is a rate of 0.48 deaths per 100,000 medication abortions.[20] The death rate associated with medication abortion according to the FDA report is at least fourteen times lower than childbirth.[21] But the disparity is likely even greater: according to an analysis I led, it seems that fourteen of the deaths are likely unrelated to the abortion, including cases of drug overdose, homicide, suicide, and medical conditions unrelated to abortion.[22]

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https://www.prb.org/articles/abortion-bans-linked-to-sharp-rise-in-sepsis-infant-death-and-maternal-mortality-new-research-shows/ (accessed Feb. 10, 2026); Gender Equity Policy Inst., *Maternal Mortality in the United States After Abortion Bans*, (Apr. 2025), https://thegepi.org/maternal-mortality-abortion-bans/ (accessed Feb. 10, 2026); ProPublica, *Life of the Mother: How Abortions Bans Lead to Preventable Deaths*, https://www.propublica.org/series/life-of-the-mother (accessed Jan. 30, 2026) (series of 32 articles to date documenting pregnancy-related deaths in states that have banned or severely restricted abortion following *Dobbs v. Jackson Women's Health Organization*).

[17] Daniel Grossman et al, *Care Post-Roe: Documenting Cases of Poor-Quality Care Since the Dobbs Decision* (Sept. 2024), https://www.ansirh.org/sites/default/files/2024-09/ANSIRH%20Care%20Post-Roe%20Report%209.04.24_FINAL%20EMBARGOED_0.pdf (accessed Feb. 10, 2026).

[18] Emily E. Petersen et al., *Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017,* 68 CDC Morbidity & Mortality Wkly. Rep. 423, 423 (2019).

[19] Hoyert, *supra* note 14, at 1, 4.

[20] Food & Drug Admin., *Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2024*, https://www.fda.gov/media/185245/download (accessed Feb. 9, 2026).

[21] *Id.*; *see also supra* ¶ 25.

[22] ANSIRH, *Analysis of Medication Abortion Risk and the FDA Report "Mifepristone*

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

27. Moreover, as many as 10% of women who give birth are hospitalized for complications associated with pregnancy aside from hospitalization for delivery.[23]

28. A 2015 study confirmed that the complication rate for abortions is much lower than that for childbirth.[24] Based on one year of billing data for women insured under California's Medicaid service, which covers abortion care,[25] the authors identified patients who (1) obtained an abortion covered by California Medicaid and (2) were treated for complications within six weeks of the abortion, either at the facility where they obtained abortion care or at an emergency department. Based on this billing data, which considered all abortion methods at any stage of pregnancy, the authors concluded that 2.11% of abortions resulted in complications, including both major complications (defined as those requiring hospitalization, surgery, or blood transfusion) and minor complications (defined as all non-major adverse events).[26] The majority of complications were minor.[27] Only 0.23% of abortions resulted in major complications.[28] This study concluded that the abortion "complication rate is much lower than that found during childbirth and comparable to that found in the literature, even when [emergency department] visits are included and there is no loss to follow-up."[29]

U.S. Post-Marketing Adverse Events Summary through 12/31/2024" (May 2025), https://www.ansirh.org/sites/default/files/2025-05/Issue%20Brief%20MAB%20SAEs-May2025%20Final_0.pdf (accessed Feb. 10, 2026).

[23] Anne Elixhauser & Lauren M. Wier, *Complicating Conditions of Pregnancy and Childbirth, 2008*, (May 2011), https://www.ncbi.nlm.nih.gov/books/NBK56037/ (accessed Feb. 10, 2026); F. Carol Bruce et al., *Maternal Morbidity Rates in a Managed Care Population*, 111 Obstetrics & Gynecology 1089 (2008).

[24] Upadhyay et al., s*upra* note 10 at 181.

[25] *Id.* at 177.

[26] *Id.* at 179.

[27] *Id.* at 181.

[28] *Id.* at 181.

[29] *Id.* at 181.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

29. Indeed, every pregnancy-related complication is more common in pregnancies resulting in live birth than in pregnancies resulting in abortion.[30] These complications can include hemorrhage, infection, and injury to other organs.[31] Every year in the U.S., an estimated 52,000 women experience severe maternal morbidity,[32] or "unexpected outcomes of labor and delivery that result in significant short- or long-term health consequences,"[33] and this rate has been on the rise over the last few decades.[34] Prenatal pregnancy-related complications include gestational hypertension, gestational diabetes, infection, preeclampsia, as well as depression and anxiety.[35] Patients who ultimately give birth are more likely than patients who have abortions to experience pregnancy-related complications because there is more time for pregnancy-related problems to occur or progress as compared to pregnancies ending in abortion.[36]

30. Although the risks associated with abortion increase with gestational duration, the risks are overall very low.[37] Still, this increasing risk underscores the importance of preventing delay once someone has decided to have an abortion, to avoid exposing the patient to the unnecessary increased risks associated with remaining pregnant longer.

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[30] Raymond & Grimes, *supra* note 11, at 216, 217 fig.1.
[31] *Id*.
[32] William M. Callaghan et al., *Severe Maternal Morbidity Among Delivery and Postpartum Hospitalizations in the United States*, 120 Obstetrics & Gynecology 1029, 1034 (2012).
[33] CDC, *Severe Maternal Morbidity* (May 10, 2024), https://www.cdc.gov/maternal-infant-health/php/severe-maternal-morbidity/index.html (accessed Feb. 10, 2026).
[34] Natl. Inst. of Child Health and Human Development, *Maternal Morbidity and Mortality*, (2020), https://www.nichd.nih.gov/health/topics/factsheets/maternal-morbidity-mortality (accessed Feb. 10, 2026).
[35] Natl. Insts. of Health, *What Are Some Common Complications of Pregnancy?* (May 29, 2024), https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/complications (accessed Feb. 10, 2026).
[36] Raymond & Grimes, *supra* note 11, at 216–17.
[37] Suzanne Zane et al., *Abortion-Related Mortality in the United States, 1998–2010*, 126 Obstetrics & Gynecology 258, 262–63 (2015).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

B. History, Safety, and Effectiveness of Medication Abortion

31. The U.S. Food and Drug Administration ("FDA") is responsible for approval of all drugs that may be offered for sale in the United States. In the normal review process, the FDA determines, based on clinical data provided by the manufacturer, whether a drug is safe and effective for its intended use. It also plays a role in reviewing and approving drug labeling.

32. The FDA first approved mifepristone in 2000. At that time, the FDA approved it for use up to forty-nine days LMP based on a study submitted by the drug's sponsor, *see infra* ¶50, even though more recent evidence showed that a particular regimen (dosing, timing and route of administration) of mifepristone and misoprostol was safe and effective for abortion through sixty-three days LMP.[38] The 2000 FDA label indicated that patients should take 200 mg of mifepristone orally and then 400 mcg of misoprostol orally two days later.[39] Misoprostol was originally approved by the FDA in 1988 for the indication of reducing the risk of NSAID (nonsteroidal anti-inflammatory drugs, including aspirin)-induced gastric ulcers in patients at high risk of complications from gastric ulcer.

33. Subsequent research showed that other regimens of mifepristone and misoprostol were safer and more effective for abortion, and could be used later in pregnancy. In 2016, the FDA approved an updated label for Mifeprex (the brand name for mifepristone 200 mg) based on this evidence. That label sets forth the following evidence-based regimen for medication abortion through seventy days LMP: On day one, the patient takes 200 mg of mifepristone orally; twenty-four to forty-eight hours later, the patient takes 800 mcg of misoprostol buccally (in the cheek

[38] Eric A. Schaff et al., *Low-Dose Mifepristone Followed by Vaginal Misoprostol at 48 Hours for Abortion Up to 63 Days*, 61 Contraception 41 (2000).
[39] FDA, *MIFEPREX: Highlights of Prescribing Information* (2000), https://www.accessdata.fda.gov/drugsatfda_docs/label/2004/020687s010-lbl.pdf (accessed Feb. 17, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

pouch); and seven to fourteen days later, the patient follows up with a healthcare provider to confirm that the pregnancy has been terminated.[40]

34. While the federal Risk Evaluation and Mitigation Strategy ("REMS") for Mifeprex previously required that mifepristone be dispensed in person at a clinic, medical office, or hospital, the patient was not required to take the mifepristone in the presence of the prescriber. In April 2021, the FDA suspended the in-person dispensing requirement for the duration of the COVID-19 pandemic. In December 2021, the FDA announced a permanent modification of the REMS to eliminate entirely the in-person dispensing requirement because it unnecessarily restricts access to care.[41] As part of the modified REMS, in January 2023, FDA issued guidance for pharmacies to become certified to dispense mifepristone.[42]

35. Medication abortion is one of the safest treatments in contemporary medical practice. Major complications following medication abortion are very rare, and as stated above, far rarer than those associated with pregnancy and childbirth.

36. Although complications following medication abortion are rare, the most common are incomplete abortion (when all of the pregnancy tissue is not expelled from the uterus) and continuing pregnancy (when the medications are not effective at ending the pregnancy). These

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[40] FDA, *MIFEPREX: Highlights of Prescribing Information* (2016), https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf (accessed Feb. 10, 2026).

[41] *See* FDA, *Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation* (Feb. 11, 2025), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation (accessed Feb. 10, 2026).

[42] FDA, *Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, (Jan, 17, 2025), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation (accessed Feb. 10, 2026). The 2023 mifepristone REMS and even its initial 2000 approval are currently being challenged in court. *Louisiana v. FDA*, 6:25-cv-01491 (W.D. La. filed Oct. 6, 2025); *Missouri v. FDA*, 2:22-cv-00223 (N.D. Tex. filed Nov. 18, 2022); *Florida v. FDA*, 7:25-cv-00126 (N.D. Tex. filed Dec. 9, 2025).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

complications can almost always be handled in an outpatient setting on a non-emergency basis. In addition, incomplete abortion and continuing pregnancy are known outcomes of medication abortion, about which patients are counseled. Patients make an informed decision when choosing medication abortion, understanding that the risks of it is more likely they will have an incomplete abortion or continuing pregnancy are greater with medication abortion than with aspiration abortion.

37. Incomplete abortion and continuing pregnancy occur after the patient takes the second medication in the drug regimen. Mifepristone takes ninety minutes to reach peak absorption,[43] so any effects on the uterus do not occur sooner, and any bleeding or spotting generally will not start until after the second medication, misoprostol, is taken twenty-four to forty-eight hours later at a location of the patient's choosing (usually, her home). If the abortion is incomplete (meaning that products of conception remain in the uterus but the pregnancy has ended), the patient has the option to take a second dose of misoprostol in order to complete it, to have an aspiration procedure similar to procedural abortion or miscarriage management,[44] or, in some cases, to wait for the tissue to pass without intervention. The risk of an incomplete abortion, though still quite small, increases with gestational duration, *e.g.*, an incomplete medication abortion is somewhat more likely at nine or ten weeks LMP than at seven weeks LMP.

38. A smaller percentage of patients will have a continuing pregnancy after medication abortion (0.7% with the mifepristone-misoprostol regimen).[45] If the patient has a continuing pregnancy, she has the option to take a second dose of misoprostol (sometimes combined with a repeat dose of mifepristone) to complete the abortion, or to have a procedural abortion; rarely, a

[43] FDA, *supra* note 39.
[44] An aspiration procedure may be used following a miscarriage to remove any remaining pregnancy tissue from the uterus.
[45] FDA, *supra* note 40 ¶ 14 tbl.3.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

patient with an ongoing pregnancy after failed medication abortion will decide to continue the pregnancy. Like the risk of an incomplete abortion, the risk of a continuing pregnancy increases with gestational duration.

39. The current FDA-approved label for mifepristone 200 mg aggregates data from seven United States clinical trials totaling over 16,000 medication abortion patients, including a study I published in 2011.[46] These data show that 97.4% of medication abortion cases were successful using the current evidence-based regimen I describe above.[47] Only 2.6% of patients had a uterine aspiration procedure which, as described below, is typically a non-urgent procedure similar to a procedural abortion or miscarriage management.[48] The reasons for such intervention included ongoing pregnancy, medical necessity (such as to treat an infection or persistent or heavy bleeding), incomplete expulsion, or on the request of a patient who chooses not to wait for the medication abortion process to complete.[49]

40. Serious complications requiring urgent care are even rarer. My 2017 study, which was published after the FDA approved the updated label for Mifeprex, found that among more than 19,000 medication abortion patients treated in-person or via telemedicine, only 0.26% experienced clinically significant adverse events—defined as treatment given in an emergency department, hospital admission, surgery, blood transfusion, or death (although there were no reported deaths or cases requiring surgery).[50] This finding is in accord with other clinical studies. The 2015 study by Upadhyay et al. referred to earlier found that the risk of major complications from medication

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[46] Daniel Grossman et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 Obstetrics & Gynecology 296 (2011); FDA, *supra* note 40.
[47] FDA, *supra* note 40 ¶ 14 tbl.3.
[48] *Id.* at ¶ 13.
[49] *Id.*
[50] Daniel Grossman & Kate Grindlay, *Safety of Medical Abortion Provided Through Telemedicine Compared With In Person*, 130 Obstetrics & Gynecology 778, 780 (2017).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

abortions—defined as serious unexpected adverse events requiring hospital admission, surgery, or blood transfusion—was 0.31%.[51] That study also found that only 0.87% of patients undergoing abortion presented at an emergency department within six weeks of the abortion with an abortion-related complaint and received a related diagnosis or treatment. Another large-scale study showed that only 0.16% of medication abortion patients experienced a significant complication (defined as hospital admission, blood transfusion, emergency department treatment, intravenous antibiotics administration, infection, or death), and only 0.06% experienced complications resulting in hospital admission.[52]

41. The FDA carefully monitors reports of complications from medication abortion, and the agency's data are as complete for mifepristone as they are for any other FDA-approved drug. Nearly two decades of post-market experience and clinical studies have confirmed that medication abortion is safe and effective.[53] Specifically, the FDA's review of fifteen years of post-market experience and updated clinical studies highlights the overall safety and efficacy of medication abortion.[54] The FDA's review in connection with proposed changes to the Mifeprex label evaluated the quality of the studies that supported the current label, including whether the literature was an adequate primary information source to support the FDA's conclusion that the current medication abortion protocol is safe. Moreover, the FDA's medical review provides detailed information regarding the medical literature reviewed by the FDA and its reasons for approving the label update. The fourteen major studies and literature reviews relied upon by the FDA in

[51] Upadhyay et al., *supra* note 10, at 178 tbl.3.
[52] Kelly Cleland et al., *Significant Adverse Events and Outcomes After Medical Abortion*, 121 Obstetrics & Gynecology 166, 169 tbl.2 (2013).
[53] *See* Regina Kulier et al., *Medical Methods for First Trimester Abortion (Review)* (2011), https://pmc.ncbi.nlm.nih.gov/articles/PMC7144729/pdf/CD002855.pdf (accessed Feb. 10, 2026).
[54] FDA, Ctr. for Drug Evaluation & Rsch., *Application Number 020687Orig1s020: Medical Review(s) 10–12*, 47-76 (2016), https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020MedR.pdf (accessed Feb. 10, 2026) [hereinafter "FDA Med. Rev."].

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

approving the updated label are listed at Table One of the FDA's Medical Review.[55] The FDA's clinical review team identified key serious adverse events—including hospitalization, serious infection, bleeding requiring transfusion, and ectopic pregnancy—discussed in the medical literature.[56] The FDA team noted that hospitalization rates associated with medication abortion ranged from 0.04% to 0.6% (in a population of over 14,000 women); serious infection occurred in 0% to 0.2% of cases (in a population of over 12,000 women); and rates of transfusion were 0.03% to 0.5% (in a population of over 17,000 women).[57] These rates of adverse events are well within the range of an acceptable level of risk for a medical treatment.[58] The FDA noted that the regimen "has been studied extensively in the literature using U.S. and global sites"[59] and concluded that major adverse events were "exceedingly rare."[60]

42. Misoprostol was developed in the 1970s to treat gastrointestinal ulcers, but because of its action on the uterus and cervix, it is widely used in obstetrics and gynecology, including for the induction of labor and preparation of the cervix before intrauterine procedures, such as hysteroscopy or IUD placement.[61] Women in Latin America have been using misoprostol to

[55] *See id.* at 18 tbl.1; *see also id.* at 91–98 App. 9.5, for the full list of references reviewed by the FDA.
[56] FDA, Ctr. for Drug Evaluation & Rsch., *Application Number 020687Orig1s020: Summary Review*, FDA, 10 (2016), https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020SumR.pdf (accessed Feb. 10, 2026) [hereinafter "FDA Summary Rev."].
[57] *Id.* at 10–11.
[58] FDA Med. Rev., *supra* note 54, at 47.
[59] FDA Summary Rev., *supra* note 56, at 11.
[60] FDA Med. Rev., *supra* note 54, at 47. A recent study confirms that the FDA's modification of the regulation of mifepristone from 2011 to 2023 "has been shaped by scientific evidence and a cautious regulatory approach led by scientists at the agency." Sophie Dilek et al., *The US Food and Drug Administration's Regulation of Mifepristone*, J. Am. Med. Assoc. (Jan. 12, 2026).
[61] *See, e.g.*, Anluzi Che et al., *Efficacy and Safety of Misoprostol Versus Oxytocin for Labor Induction in Women with Prelabor Rupture of Membranes: A Meta-Analysis*, BMC Pregnancy Childbirth (Apr. 2025); Nusrat Lakho et al., *Efficacy and Safety of Misoprostol Compared with Dinoprostone for Labor Induction at Term: An Updated Systematic Review and Meta-Analysis of Randomized Controlled Trials*, Front Med (Lausanne) (Dec. 2024); Noha Salah et al., *The Use of Misoprostol Before Hysteroscopy in Nulliparous Women: A Systematic Review and Meta-Analysis*

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

terminate pregnancies since the late 1980s.[62] A misoprostol-only regimen is used less frequently than a mifepristone-misoprostol regimen to terminate a pregnancy in the United States but is still widely used internationally.[63] Many international studies have confirmed the safety and efficacy of misoprostol for terminating a pregnancy, and I and other American researchers are increasingly confirming these results.[64]

43. The mifepristone and misoprostol regimen and misoprostol-only regimen used for medication abortion are also used for miscarriage management,[65] and they are no less safe in the context of medication abortion than they are in the context of miscarriage management. They can also be prescribed via telemedicine for both indications, as I discuss further below.

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of Randomized Controlled Trials, 24 BMC Pregnancy Childbirth 796 (2024); M. Valeria Bahamondes, *Effect of Vaginal Administration of Misoprostol Before Intrauterine Contraceptive Insertion Following Previous Insertion Failure: A Double Blind RCT*, 30 Human Reproduction 1861 (2015).

[62] Heidi Moseson et al., *How Effective Is Misoprostol Alone for Medication Abortion?*, 2024 New Eng. J. Med.: Evidence 3 (2024); Ilana Löwy et al., *The "Abortion Pill" Misoprostol in Brazil: Women's Empowerment in a Conservative and Repressive Political Environment*, 110 Amer. J. Pub. Health History 5, 677–84 (2020).

[63] *See, e.g.*, Erik Eckholm, *A Pill Available in Mexico Is a Texas Option for Abortion*, (July 13, 2013), https://www.nytimes.com/2013/07/14/us/in-mexican-pill-a-texas-option-for-an-abortion.html (accessed Feb. 10, 2026) (discussing availability of misoprostol in Mexico); Elizabeth G. Raymond et al., *Medication Abortion with Misoprostol-Only: A Sample Protocol*, 121 Contraception (2023) ("In settings where mifepristone is not available, and especially outside the U.S., clinicians and people who self-manage abortion have been using misoprostol-only for decades.").

[64] *E.g.*, Kapp, *supra* note 6, at 81 (discussing international studies); Raymond et al., *supra* note 63 (U.S. review of which I am a co-author).

[65] Justin J. Chu et al., *Mifepristone and Misoprostol Versus Misoprostol Alone for the Management of Missed Miscarriage (MifeMiso): A Randomised, Double-Blind, Placebo-Controlled Trial*, 396 Lancet 770 (2020); Courtney A. Schreiber et al., *Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss*, 378 New Eng. J. Med. 2161 (2018).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

C. The Evidenced-Based Use Ban and Advantages of the Current Evidence-Based Mifepristone Regimen over the Regimen on the Mifepristone Label

1. Evidence-Based, Off-Label Medication Use Is a Routine Part of Modern Medical Care.

44. The practice of prescribing FDA-approved medications according to different evidence-based protocols, in different evidence-based dosages, or for different evidence-based uses than those for which they were approved by the FDA, is common in medicine and referred to as "off-label" or "evidence-based" use of a medication.[66] Indeed, up to 20% of all drugs are prescribed off-label and among some classes of cardiac drugs, off-label use can be as high as 46%.[67] Off-label use of medications may be even more common during pregnancy.[68]

45. For example, this is how aspirin came to be used to prevent heart attacks and Wellbutrin (bupropion), approved by the FDA for use as an antidepressant, came to be used for smoking cessation. Indeed, misoprostol itself was only approved for the prevention and treatment of ulcers (as noted *supra* ¶32) and now has a number of important off-label uses for gynecological treatments; it is used for labor induction, treatment of spontaneous early pregnancy loss, prevention and treatment of postpartum hemorrhage, and cervical priming before uterine procedures such as hysteroscopy.[69]

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[66] Stuart L. Nightingale, *Off-label Use of Prescription Drugs*, 68 Am. Fam. Physician 425 (2003).
[67] Natl. Task Force on CME Provider/Industry Collaboration, *On-Label and Off-Label Usage of Prescription Medicines and Devices, and the Relationship to CME*, https://www.urmc.rochester.edu/medialibraries/urmcmedia/center-experiential-learning/cme/organizing-activities/documents/prescription-usage.pdf (accessed Feb. 10, 2026).
[68] Vitalba Gallitelli et al., *Off-Label Use of Drugs in Pregnancy: A Critical Review of Guidelines, Current Practices, and a Clinical Perspective*, 170 Internatl. J. Gynaecology & Obstetrics 568 (2025).
[69] A. Elati & A. D. Weeks, *The Use of Misoprostol in Obstetrics and Gynaecology*, 116 Brit. J. Obstetrics & Gynaecology 61 (2009); *supra* ¶ 42; *supra* note 61.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

46. It is common that the FDA-approved labeling for a drug does not reflect or account for all of the many evidence-based, accepted ways that the drug is prescribed and used in routine medical practice. That is because only a manufacturer of a drug can apply to have a drug relabeled, the process is very expensive (the manufacturer has to submit and perhaps conduct new research to support the application and pay a large application fee), and there is simply no incentive for the manufacturer to go through this costly process since off-label use is so prevalent and so rarely restricted.[70]

2. Mifepristone Clinical Testing, FDA Approval, and Label Changes

47. Clinical testing of mifepristone began abroad in 1982, and mifepristone was licensed in France and China in 1988. In 1996, Danco Laboratories filed a New Drug Application ("NDA") with the U.S. Food and Drug Administration ("FDA"), requesting approval of mifepristone for distribution in the United States.

48. The FDA does not itself test medications. Rather, it reviews studies submitted by the applicant (known as "clinical trials"). Applicants submit evidence from clinical trials to the FDA to demonstrate that the drug is safe and effective for a particular intended use.

49. In the case of mifepristone, the clinical trials involved approximately 2,100 women who took 600 mg of mifepristone orally and returned to the clinic 36 to 48 hours later to take 400 mcg of misoprostol orally. Those trials showed that this regimen was safe and effective for abortions through 49 days LMP.

50. In September 2000, the FDA approved the NDA, and as part of that approval, as with all medications, approved a Final Printed Labeling ("FPL"), which is an informational document that

[70] Michael Shea et al., *Outdated Prescription Drug Labeling: How FDA-Approved Prescribing Information Lags Behind Real-World Clinical Practice,* 52 Therapeutic Innovation & Regulatory Science 771 (2018).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

provides physicians with guidance about the use for which the drug sponsor requested and received FDA approval. The mifepristone label, therefore, described the regimen used in the clinical trials.[71] Mifepristone is the only medication that has received FDA approval for marketing as an abortion-inducing drug, and therefore, the only medication with an FPL describing an abortion regimen.

51. By the time that mifepristone was made available in the United States, newer research had been conducted showing that a lower dosage of mifepristone (200 mg) combined with a different dosage (800 mcg) and manner of administering misoprostol was equally safe and effective through 63 days LMP. This research also showed that reducing the mifepristone dose decreased side effects. Based on this research, from the time that mifepristone medication abortion became available in the United States, the overwhelming majority of abortion providers offered their patients a regimen different from the one on the FPL.[72] The regimens used have changed over time in response to further medical research. For years before the FDA label was updated in 2016, the regimen most commonly used across the country was a regimen that differed from that detailed in the FDA's approved mifepristone label at the time.

52. In 2016, the FDA approved an updated label for Mifeprex (the brand name for mifepristone 200 mg) based on this evidence. That label sets forth the following evidence-based regimen for medication abortion through 70 days LMP: on day one, the patient takes 200 mg of mifepristone orally; 24 to 48 hours later, the patient takes 800 mcg of misoprostol buccally; and 7 to 14 days

[71] The FPL at the time said that on Day One, the patient read the Medication Guide, signed the Patient Agreement, and received three 200 mg tablets of Mifeprex, taken orally at the health care facility; on Day Three, the patient returned to the health care facility and, unless the abortion has already occurred, received two 200 mcg tablets of misoprostol taken orally; and on Day 14, the patient returned to the health facility to confirm that a complete termination of pregnancy has occurred.

[72] Melanie Wiegerinck et al., *Medical Abortion Practices: A Survey of National Abortion Federation Members in the United States* 78 Contraception 486, 489 (2008) (finding that as early as 2001, just four percent of surveyed providers reported using the FPL regimen).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

later, the patient follows up with a health care provider to confirm the pregnancy has been terminated.[73]

53. Since mifepristone was approved in 2000, an additional layer of regulatory scrutiny was applied to the drug that has limited its distribution; this is currently codified in the drug's Risk Evaluation and Mitigation Strategy (REMS).[74] The REMS requires patients to sign a Patient Agreement Form and clinicians to sign a Prescriber Agreement Form. Prior to 2021, the REMS required that mifepristone be dispensed by a certified prescriber in a hospital, clinic, or medical office. In 2021, the REMS was modified, allowing certified pharmacies to dispense mifepristone on prescription and allowing mailing of the medication; guidance for becoming a certified pharmacy was released in 2023.

3. Research Demonstrates that Mifepristone Is Safe and Effective Beyond 70 Days LMP.

54. The current FDA label describes mifepristone use only through 70 days LMP. However, extensive research and clinical practice demonstrates that it can be safely used beyond 70 days LMP. The Evidence-Based Use Ban prohibits such safe, effective, evidence-based use. According to the ANSIRH Abortion Facilities Database, in 2023, the median gestational duration limit among abortion providers for medication abortion nationwide was eleven weeks' or 77 days' gestation.[75]

55. As noted *supra* ¶ 20 and note 6, studies show that medication abortion is safe and effective through at least 84 days LMP. In a systematic review of medication abortion between 63 and 84 days LMP, Kapp et al. found that medication abortion was safe and 94.6% effective at terminating a pregnancy.[76]

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[73] FDA, *supra* note 40, at 1.
[74] *See, e.g., id.*
[75] Schroeder, *supra* note 5.
[76] Kapp et al., *supra* note 6.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

56. When used at 63 days' gestation or later, medication abortion with mifepristone is more effective when more than one dose of misoprostol is used.[77] In one study from Mexico, use of two doses of misoprostol 800 mcg four hours apart (first dose administered buccally and second administered sublingually) resulted in a complete abortion for 97.7% of patients pregnant at 71–77 days of pregnancy.[78] In that study, among patients pregnant at 71–77 days, 1.4% had an ongoing pregnancy. *See supra* ¶¶ 37–39. Although the study was relatively small (218 patients pregnant at 71–77 days), a serious adverse event occurred in only one patient (0.5%).

57. The Society of Family Planning, a leading organization for studying abortion and contraceptive science, endorses the use of medication abortion up to 84 days LMP.[79] Recent guidance from the National Abortion Federation states that medication abortion using mifepristone and misoprostol or misoprostol-only may be provided up through 97 days of pregnancy (13 weeks 6 days).[80] International organizations also have endorsed medication abortion as safe and effective through at least twelve weeks' (84 days') gestation, including the World Health Organization,[81] the International Federation of Gynecology and Obstetrics,[82] the Royal College of Obstetricians & Gynaecologists (the leading British organization for OB-GYNs),[83] the Board of the Society of

[77] *Id.*
[78] Dzuba et al., *supra* note 6.
[79] Soc. of Family Planning, *Interim Clinical Recommendations: Self-Managed Abortion* (Sept. 2022), https://societyfp.org/wp-content/uploads/2022/06/SFP-Interim-Recommendation-Self-managed-abortion-09.08.22.pdf (accessed Feb. 10, 2026).
[80] Natl. Abortion Fedn., *2026 Clinical Policy Guidelines for Abortion Care* at 21–30, (2026), https://prochoice.org/providers/quality-standards/ (accessed Feb. 10, 2026).
[81] World Health Org., *supra* note 6.
[82] Internatl. Fedn. of Gynecology and Obstetrics, *Mifepristone & Misoprostol Dosing Chart Recommended Regimens 2023*, https://www.figo.org/sites/default/files/2024-01/FIGO-MifeMiso-Chart-11-2023-FINAL_0.pdf (accessed Feb. 10, 2026).
[83] Royal College of Obstetricians & Gynaecologists, *The Care of Women Requesting Induced Abortion: Evidence-based Clinical Guideline Number 7* (Nov. 2011) at 72–73, https://www.rcog.org.uk/media/nwcjrf0o/abortion-guideline_web_1.pdf (accessed Feb. 10, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Obstetricians and Gynaecologists of Canada,[84] and Ipas (a U.S.-based organization that supports reproductive health access internationally).[85]

4. Research Demonstrates that the Interval between Mifepristone and Misoprostol May Be Shortened When Using the Vaginal Route of Administering Misoprostol.

58. Research has shown that the interval between mifepristone and misoprostol may be shortened when using the vaginal route of administration. In one study of 1,080 patients undergoing medication abortion with mifepristone and misoprostol administered vaginally, patients were randomized to take the misoprostol either 6–8 hours after mifepristone or 24 hours after mifepristone.[86] Among those in the shorter interval group, complete abortion occurred in 95.8% of patients and was not statistically different from the group that used the 24-hour interval. Serious adverse events related to medication abortion occurred in only 0.4% of patients in this study. Based on this evidence, the National Abortion Federation Clinical Policy Guidelines for Abortion Care allow the interval between mifepristone and misoprostol to be shortened if misoprostol is administered vaginally. In my experience, some patients have a strong preference to shorten the interval between mifepristone and misoprostol so they can return to work sooner, care for their children, or travel, among other reasons.

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[84] Dustin Costescu et al., *No. 360–Induced Abortion: Surgical Abortion and Second Trimester Medical Methods*, 40 Obstetrics and Gynaecology Canada 750 (2018).

[85] Ipas, *Home Use of Medications up to 12 Weeks Gestation* (Oct. 18, 2022), https://www.ipas.org/clinical-update/english/recommendations-for-abortion-before-13-weeks-gestation/medical-abortion/home-use-of-medications-up-to-11-weeks-gestation/ (accessed Feb. 10, 2026).

[86] Mitchell D. Creinin et al., *A Randomized Comparison of Misoprostol 6 to 8 Hours Versus 24 Hours After Mifepristone for Abortion*, 103 Obstetrics & Gynecology 851 (2004).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

5. Research Demonstrates that Mifepristone Can Be Used to Prepare the Cervix Before Second-Trimester Procedural Abortion.

59. Evidence indicates that mifepristone is safe and effective when used to dilate and soften the cervix before dilation and evacuation (D&E), which—as discussed supra ¶ 19—is a procedural abortion in the second trimester. Based on a review of the evidence, the Society of Family Planning concluded that "adjuvant mifepristone for D&E at 20–24 weeks' gestation has been shown to decrease procedure time and improve providers' sense of ease of procedure without increasing side effects."[87] My understanding is that this use was not permitted in Ohio prior to the preliminary injunction in this case because of the Evidence-Based Use Ban. Thus, the law also negatively impacts patients seeking D&E abortions.

6. Allowing Evidence-Based, Off-Label Use of Mifepristone Benefits Patients by Increasing Access and Allowing Patient-Centered Care.

60. I understand that, since the preliminary injunction in this case, some Ohio abortion providers have begun to offer medication abortion off-label through 84 days LMP. Giving patients two additional weeks to access medication abortion means that more patients have been and will be able to access medication abortion.

61. This expanded access is particularly important for patients who have a preference for medication abortion. Many women prefer medication abortion because they can complete the process in the privacy of their homes, with the company of loved ones, and at a time of their choosing. Some women choose medication abortion because they fear a procedure involving surgical instruments. Victims of rape, or women who have experienced sexual abuse or

[87] Justin Diedrich et al., *Society of Family Planning Clinical Recommendations: Cervical Preparation for Dilation and Evacuation at 20–24 Weeks' Gestation*, 101 Contraception 286, 289 (2020).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

molestation, may choose medication abortion to feel more in control of the experience and to avoid trauma from having instruments placed in their vagina.

62. For others, there are medical reasons why medication abortion is better for them than procedural abortion. Some women have medical conditions that make medication abortion a significantly safer option than procedural abortion, including in cases of uterine fibroids, congenital uterine anomalies, or introital scarring related to infibulation.[88] My own research shows that most women who choose medication abortion have a strong preference for this method.[89]

63. Allowing providers to prescribe mifepristone off-label beyond 70 days LMP to eligible patients increases abortion access. This is particularly true for patients who struggle to access an abortion for the reasons I outline further below, including young people and those who have not given birth previously, as well as those who get pregnant while using hormonal contraception, who may recognize pregnancy later,[90] and patients living on low incomes, who face financial and logistical barriers to access.

D. The Telemedicine Ban

1. Telemedicine Abortion Is Safe and Effective.

64. Telemedicine is the "delivery of health care services at a distance through information and communication technology."[91] Telemedicine has been used to expand the reach of physicians in

[88] ACOG, *Practice Bulletin No. 225, Medication Abortion Up to 70 Days of Gestation*, (Oct. 2020), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/10/medication-abortion-up-to-70-days-of-gestation (accessed Feb. 10, 2026).
[89] *See* Grossman et al (2011)., *supra* note 46, at 300 (finding 71% of study participants said they strongly preferred medication abortion).
[90] Diana Foster et al., *Timing of Pregnancy Discovery Among Women Seeking Abortion*, 104 Contraception 642 (2021); Lawrence B. Finer et al., *Timing of Steps and Reasons for Delay in Obtaining Abortions in the United States*, 74 Contraception 334 (2006).
[91] Daniel A. Grossman et al., *Changes in Service Delivery Patterns After Introduction of Telemedicine Provision of Medical Abortion in Iowa*, 103 Am. J. Pub. Health 73, 73 (2013).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

many disciplines around the country and found to be safe and effective.[92] Telemedicine for abortion services has the potential to allow for the provision of abortion services earlier in pregnancy and closer to a patient's home and to help overcome barriers to abortion access in the United States.

65. There are different possible models by which telemedicine can be provided. In a direct-to-patient model, a patient with internet access can connect with a health care provider from her own home or another location of her choosing. In a site-to-site model, a patient may utilize in-office telemedicine services, in which a patient located in one health center can talk by video to a health care provider in a different location. I understand that neither of these models is permitted by the Telemedicine Ban, which requires providers to be physically present at the same location when the patient takes the initial dose of medication abortion. The site-to-site model was the first one used for medication abortion in the United States, and both models have been studied by myself and other researchers and found to be safe, effective, and well-liked by medication abortion patients.

66. Telemedicine for medication abortion has been used in Alaska since 2011,[93] Maine and Montana since 2016,[94] Nevada since at least 2017,[95] and in Washington, Hawaii, New York, and

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[92] *See* Victoria A. Wade et al., *A Systematic Review of Economic Analyses of Telehealth Services Using Real Time Video Communication*, 10 BMC Health Servs. Rsch. 1 (2010).

[93] Kate Grindlay & Daniel Grossman, *Telemedicine Provision of Medical Abortion in Alaska: Through the Provider's Lens*, 23 J. Telemedicine & Telecare 680 (2016). While telemedicine abortion was used in Iowa beginning in 2008, I understand that the state has since restricted its use. Grossman et al. (2013), *supra* note 91, at 73–78.

[94] Sarah Boden, *Maine Follows Iowa's Lead on Telemed Abortion*, (Feb. 29, 2016), https://www.iowapublicradio.org/ipr-news/2016-02-29/maine-follows-iowas-lead-on-telemed-abortion (accessed Feb. 10, 2026); Julia E. Kohn et al., *Introduction of Telemedicine for Medication Abortion: Changes in Service Delivery Patterns in Two U.S. States*, 103 Contraception 151 (2021).

[95] Julia E. Kohn et al., *Medication Abortion Provided Through Telemedicine in Four U.S. States*, 134 Obstetrics & Gynecology 343 (2019).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Oregon (among other states) beginning in 2016 through the Gynuity TelAbortion Study.[96] The TelAbortion Study involved a direct-to-patient model of care where patients obtained any needed ultrasound or lab testing locally and had a telemedicine visit with a clinician, who then mailed mifepristone and misoprostol to eligible participants.[97] Telemedicine for medication abortion subsequently became available in Minnesota, Colorado, Connecticut, Delaware, the District of Columbia, Illinois, Maryland, Massachusetts, Michigan, Nevada, New Mexico, New Jersey, Rhode Island, Virginia, and Vermont.[98] Providers have found it easy to integrate the new technology for telemedicine into their clinic operations, as it largely requires the same processes and clinic flow as an in-person visit.[99] Providers using telemedicine report that their interactions with the patients are essentially the same as an in-person visit.[100] Medication abortion through telemedicine is cost- and medically effective, and acceptability is high among women who choose this model for treatment.[101]

67. The use of direct-to-patient telemedicine or telehealth to provide medication abortion has expanded significantly in recent years and is now the prevailing telehealth abortion care model.[102] This care model involves a clinician evaluating a patient for eligibility for medication abortion

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[96] Elizabeth G. Raymond et al., *TelAbortion: Evaluation of a Direct to Patient Telemedicine Abortion Service in the United States*, 100 Contraception 173 (2019); Erica Chong et al., *Expansion of a Direct-to-Patient Telemedicine Abortion Service in the United States and Experience During the COVID-19 Pandemic*, 104 Contraception 43 (2021).
[97] *Id.*
[98] Carafem, *Yes, You Deserve Great Abortion Care at Home*, https://carafem.org/at-home-abortion-pills/ (accessed Feb. 10, 2026).
[99] Grindlay & Grossman, *supra* note 93, at 682.
[100] *Id.* at 683.
[101] Grossman et al. (2011), *supra* note 46, at 300; *see also* Kate Grindlay et al., *Women's and Providers' Experiences with Medical Abortion Provided Through Telemedicine: A Qualitative Study*, 23-2 Women's Health Issues e117 (2013).
[102] Soc'y of Family Planning, *Science Says Telehealth Medication Abortion Is Safe and Effective* at 1 (Sept. 6, 2023), https://societyfp.org/wp-content/uploads/2023/09/SFP_ScienceSays_Template-TelehealthMedicationAbortion-f.pdf (accessed Feb. 10, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

using screening questions known as the "no-test protocol."[103] Research has shown that many patients can accurately date their pregnancy and determine whether they are within the gestational duration window of the facility for medication abortion, as well as assess other contraindications to medication abortion.[104] This protocol also involves screening people for risk factors or symptoms of a possible ectopic pregnancy, such as unusual pain or bleeding. Research from the United Kingdom involving over 18,000 patients undergoing medication abortion with the no-test protocol documented that this model of care was safe and effective.[105] Another article reported on over 6,000 medication abortions provided in the U.S. using direct-to-patient telemedicine or telehealth.[106] This research found that the effectiveness of the model was very high, with 97.7% having a complete abortion.[107] The model was also very safe; only 0.25% had a serious adverse event.[108] Research shows that misoprostol-only medication abortion done via direct-to-patient care is also safe and effective.[109]

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[103] Elizabeth G. Raymond et al., *Commentary: No-Test Medication Abortion: A Sample Protocol for Increasing Access During a Pandemic and Beyond*, 101 Contraception 361 (2020).
[104] Lauren J. Ralph et al., *Accuracy of Self-Assessment of Gestational Duration Among People Seeking Abortion*, 226 Am. J. Obstetrics & Gynecology 710.e1 (2022); Lauren J. Ralph et al., *Accuracy of Survey-Based Assessment of Eligibility for Medication Abortion Compared with Clinician Assessment*, 233 Am. J. Obstetrics & Gynecology 44.e1 (2025); Lauren J. Ralph et al., *Accuracy of Self-Assessment of Gestational Duration Among Adolescents Seeking Abortion Using Information in Addition to Date of Last Menstrual Period*, 177 JAMA Pediatrics 642 (2023).
[105] Abigail R.A. Aiken et al., *Effectiveness, Safety and Acceptability of No-Test Medical Abortion (Termination of Pregnancy) Provided Via Telemedicine: A National Cohort Study*, 128 Brit. J. Obstetrics & Gynaecology 1464 (2021).
[106] Ushma D Upadhyay et al., *Effectiveness and Safety of Telehealth Medication Abortion in the USA*, 30 Nature Med. 1191 (2024).
[107] *Id.*
[108] *Id.*
[109] Dana M. Johnson et al., *Safety and Effectiveness of Self-Managed Abortion Using Misoprostol Alone Acquired from an Online Telemedicine Service in the United States*, Perspectives Sex. Reproductive Health 1, 3 (2023).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

68. Telemedicine for medication abortion is as safe and effective as in-person treatment.[110] The prevalence of serious adverse events after medication abortion is exceedingly low (less than 0.5%), whether it is provided in-person or by telemedicine.[111] In a 2011 study I led, we investigated the effectiveness and acceptability of telemedicine for medication abortion compared to in-person medication abortion, and we found that the success rates were very similar: 98.7% for telemedicine patients and 96.9% for in-person patients.[112] No patient in this study required hospitalization.[113] In fact, the overall rate of any adverse event in the study was 1.3%, the majority of which were ongoing pregnancy (0.9%).[114]

69. In a 2017 Iowa study, other researchers and I compared the safety of medication abortion between patients receiving services by telemedicine and those having an in-person visit at Planned Parenthood of the Heartland clinics in Iowa from July 1, 2008, to June 30, 2015.[115] In this seven-year study, 8,765 medication abortions were provided with telemedicine, and 10,405 were provided with an in-person appointment.[116] We found that medication abortion patients rarely experienced clinically significant adverse events (only 0.26% of the 19,170 total patients). These adverse outcomes were uncommon with telemedicine (0.18% of telemedicine patients), and there were no reported deaths or cases requiring surgery among any of the medication abortion patients.[117] Indeed, there was no significant difference in the prevalence of clinically significant adverse events between telemedicine and in-person patients.[118]

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[110] Grossman et al. (2011), *supra* note 46, at 300; *see also* Wade et al., *supra* note 92.
[111] Grossman et al. (2011), *supra* note 46.
[112] *Id*. at 299.
[113] *Id*.
[114] *Id.*
[115] *Id.*
[116] *Id.* at 780.
[117] *Id*.
[118] *Id.*

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

70. In a 2025 systematic review of evidence regarding telemedicine used for medication abortion, the authors found that "telemedicine models for medical abortion in early pregnancy may result in similar outcomes in terms of safety, effectiveness, and acceptability when compared to in-clinic provision."[119] Another analysis of data from Alaska, Idaho, Nevada, and Washington that included 445 telemedicine patients and 4,011 patients receiving medication abortion with an in-person visit confirmed previous findings documenting the safety and effectiveness of telemedicine provision of medication abortion.[120]

71. As the National Academies of Sciences, Engineering, and Medicine concluded, there is no medical need for medication abortion to be administered in the physical presence of a health care provider.[121] Screening patients for contraindications and eligibility, providing counseling, and dispensing medication can be done as safely regardless of whether the physician is physically present in the room with the patient. Additionally, on the rare occasions when complications do arise, it would not matter whether the patient obtained a medication abortion in person or through telemedicine. This is because any complications that do arise after medication abortion occur after the patient has left the clinic.

72. Consistent with all of this research, in 2020, ACOG updated its practice bulletin focused on medication abortion, which recognized that medication abortion provided using telemedicine is as safe and effective as in-person services, well-liked by patients, and also may help reduce

[119] Amanda Cleeve et al., *The Use of Telemedicine Services for Medical Abortion*, 2025 Cochrane Database of Systematic Reviews 6 (2025).
[120] Kohn et al., *supra* note 95.
[121] Natl. Acads., *supra* note 9, at 79.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

delays to care.[122] The National Abortion Federation 2026 clinical guidelines also state that "providing medication abortion by telemedicine is a safe and acceptable option."[123]

73. The FDA's change to the mifepristone REMS, discussed above, to eliminate altogether the in-person dispensing requirement for mifepristone reflects this wide-ranging and unequivocal evidence of the safety and effectiveness of telemedicine for abortion, as well as its critical importance for increasing access to care.[124]

2. Telemedicine Abortion Fosters Access and Improves Public Health While the Telemedicine Ban Hinders Access and Harms Patients.

74. Telemedicine furthers public health because it improves access to early medication abortion in underserved areas.[125] The number of abortion providers has declined over the last three decades in the United States, resulting in some women having to travel greater distances and pay higher costs to obtain treatment.[126]

75. Telemedicine improves access for disproportionately affected patients living on low incomes and those living in rural and underserved areas who are not readily able to travel.[127] In fact, ACOG has expressed ongoing concern over the lack of medical services available to women in rural communities and has asked OB/GYNs to "[f]oster and participate in efforts to utilize

[122] Comm. on Prac. Bulls.—Gynecology & SFP, *ACOG Practice Bulletin Number 225: Medication Abortion Up to 70 Days of Gestation,* 136 Obstetrics & Gynecology e31, e35 (2020).
[123] Natl. Abortion Fed'n, *supra* note 80, at 21.
[124] The FDA further endorsed telemedicine for medication abortion in a December 2021 letter response to a citizen petition that requested, among other things, that the FDA require three office visits by a patient for medication abortion. The FDA denied the petition as to those proposed visits. Patrizia A. Cavazzoni, Ctr. for Drug Evaluation & Rsch., FDA, *Response Letter from FDA CDER to American Association of Pro-Life Obstetricians and Gynecologists and American College of Pediatricians* (2021), https://www.regulations.gov/document/FDA-2019-P-1534-0016.
[125] Kohn et al., *supra* note 95, at 344.
[126] Grindlay et al., *supra* note 101, at e117.
[127] *Id*. at e117–22.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

effective telemedicine technologies . . . to expand and improve services for rural women."[128] As of 2020, Ohio is among the states with the largest rural populations: nearly 2.8 million Ohioans, or 23.7%, live in rural areas.[129]

76. Telemedicine facilitates a patient-centered approach to care, enabling patients to be seen sooner and to be closer to their home, or in some cases at home.[130] As a result of telemedicine in Alaska, providers were able to schedule additional appointments that better met patients' needs and in turn allowed women to be seen at earlier gestational durations.[131]

77. Telemedicine also expands access to abortion services by allowing clinics to provide more appointments with shorter wait times.[132] In contrast, before telemedicine, clinics in areas without or with few abortion providers had to transport doctors to the clinics. In Alaska, the need to transport physicians limited the ability of one clinic featured in the study to offer abortion services to once or twice a month.[133] This limitation increased the wait time for women to receive an abortion, at times pushing them beyond the gestational limit for medication abortion.[134] A recent study found that telehealth provision of medication abortion is associated with a reduction in measures of psychosocial burden, especially related to travel and feeling forced to wait for care.[135]

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[128] Comm. on Health Care for Underserved Women, *ACOG Committee Opinion Number 586: Health Disparities in Rural Women*, 123 Obstetrics & Gynecology 384, 386 (2014, *reaff'd* 2024).
[129] U.S. Census Bureau, *Nation's Urban and Rural Populations Shift Following 2020 Census* (Dec. 29, 2022), https://www.census.gov/newsroom/press-releases/2022/urban-rural-populations.html (accessed Feb. 10, 2026); U.S. Census Bureau, *Ohio*, https://data.census.gov/profile/Ohio?g=040XX00US39 (accessed Jan. 28, 2026) (noting population of 11,799,448 as of 2020).
[130] Grossman et al. (2011), *supra* note 46, at 300.
[131] Grindlay & Grossman, *supra* note 93, at 681–82.
[132] *Id*.; *see also* Grindlay et al., *supra* note 101, at e117–22.
[133] Grindlay & Grossman, *supra* note 93, at 681.
[134] *Id*.
[135] M. Antonia Biggs et al., *Psychosocial Burden of Seeking Medication Abortion When Using No-Test Telehealth Care Compared to In-Person Care with Ultrasound*, 147 Contraception (2025).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

78. Between October 2009 and February 2010, I and other researchers conducted a study in Iowa, in which we performed in-depth interviews with women receiving medication abortion via telemedicine and clinic staff involved in providing medication abortion through telemedicine using the site-to-site model.[136] The study showed that women opted for the telemedicine visit because they could obtain abortions closer to home, the reduced amount of time they had to take off from work or school, the lower costs associated with travel, and the privacy afforded by not having to explain to family, friends, or their employer the reason for traveling to a more distant location, which could compromise the confidentiality of their pregnancy and abortion decision.[137]

79. In the same study, clinic staff cited numerous benefits to introducing telemedicine into their practice: physicians can reach more patients, resources are preserved because patients and providers do not have to travel long distances, and there are fewer delays related to travel in severe weather.[138] The greatest perceived impact in the study was enhanced access to abortion care for patients.[139]

80. I and other researchers conducted another study in Iowa that assessed the effect of this model providing telemedicine abortion.[140] In Iowa, abortion access for women in more remote parts of the state increased with telemedicine.[141] Women living more than fifty miles from the nearest clinic offering procedural abortion were more likely to obtain an abortion after the introduction of site-to-site telemedicine in Iowa.[142] The mean distance traveled to the abortion clinic decreased by 2.5 miles after the introduction of site-to-site telemedicine, and patients' access

[136] Grindlay et al., *supra* note 101, at e118.
[137] *Id.* at e118–19.
[138] *Id.* at e120.
[139] *Id.* at e120–21.
[140] Grossman et al (2013)., *supra* note 91.
[141] *Id.* at 75.
[142] *Id*.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

to abortion care was improved by expanding the number of clinics able to provide medication abortion, reducing patient travel distance, and offering more scheduling options for abortion care.[143] In another study of patients undergoing abortion at Planned Parenthood clinics in Montana, the mean distance traveled to the clinic decreased from 134 to 115 miles after the introduction of site-to-site telemedicine; the mean time to appointment also decreased from 14 to 12 days.[144]

81. The Iowa study found that patients had a 46% greater likelihood of having an abortion at or before thirteen weeks of gestation when obtaining abortion services after the introduction of telemedicine.[145] Because patients often do not become aware that they are pregnant until about five weeks LMP or later, many patients struggle to access care within the short window that medication abortion is available. By providing more scheduling options and locations closer to patients' homes, telemedicine allows patients to access abortion services earlier in their pregnancies, when the risk of complications is lowest. Thus, access to early abortion care benefits public health, as reducing second trimester abortions helps to reduce the rare but increased risk as pregnancy progresses.

82. Based on the available research, it is my expert opinion that Ohio's telemedicine abortion ban harms people seeking abortion care in numerous ways. These harms may include increased travel burdens; delayed access to abortion; inability to access medication abortion; and being forced to carry an unwanted pregnancy to term. Research shows that increased travel distance is associated with delays in abortion access and can prevent patients from accessing abortion altogether.[146] It is my professional opinion that the Telemedicine Ban specifically will delay some

[143] *Id.* at 75 tbl.2, 76.
[144] Kohn et al., *supra* note 94, at 151, 153.
[145] Grossman et al (2013)., *supra* note 91, at 75.
[146] *See, e.g.*, Jason M. Lindo et al., *How Far Is Too Far? New Evidence on Abortion Clinic Closures, Access, and Abortions*, 55 J. Hum. Res. 1137 (2020).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

patients' access to medication abortion and that it may prevent others from accessing abortion altogether.

83. Increases in distances traveled mean not only that women must drive farther (or, if they lack access to a car, they must take public transportation) to access safe, legal, early abortion, but also must bear the increased financial, logistical, and psychological costs of reaching the nearest abortion provider. This includes making arrangements for someone to care for their children, missed work, and other obligations; making arrangements for additional travel; and securing additional funds for that travel and childcare, etc.[147] Because the cost of an abortion increases as pregnancy progresses, patients can find themselves in a difficult position, where they secure additional funds, but the total cost has increased. Furthermore, abortion after the first trimester is offered at fewer locations, and there are fewer providers than there are for early abortions.[148]

84. These logistical barriers result in delays in seeking care.[149] Indeed, in one study of 1,209 abortion patients, among women who said they would have preferred to have had their abortions earlier, 56% of first-trimester patients reported they were delayed because it took a long time to make arrangements, including 23% who said they needed time to raise money to pay for the abortion and 6% who said they could not find a place to have an abortion near where they lived and so had to arrange for transportation.[150] As noted above *supra* ¶ 18, most abortion patients are parents and must arrange for childcare, which can be harder and more expensive to secure the

[147] *See* Liza Fuentes et al., *Women's Experiences Seeking Abortion Care Shortly After the Closure of Clinics Due to a Restrictive Law in Texas*, 92 Contraception 292 (2016).
[148] Rachel K. Jones et al., *Differences in Abortion Service Delivery in Hostile, Middle-Ground, and Supportive States in 2014*, 28 Women's Health Issues 212, 216 (2018).
[149] Sarah E. Baum et al., *Women's Experience Obtaining Abortion Care in Texas After Implementation of Restrictive Abortion Laws: A Qualitative Study*, 11 PLoS One 1, 5–12 (2016) (observing burdens women faced due to increased travel distances, including delay, due to Texas abortion restrictions, including among women who strongly preferred medication abortion and women who obtained a surgical abortion though they preferred medication).
[150] Finer et al., *supra* note 90, at 335 tbl.1.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

farther they have to travel for care. Many patients need to keep their decision confidential to avoid coercion or punishment from family or friends,[151] which becomes increasingly difficult if they are delayed in the process of seeking abortion care due to longer travel distances.

85. Additionally, a study of abortion in Washington state found that rural women who had to travel more than 75 miles to obtain an abortion were two to three times more likely than women traveling less than 75 miles to terminate after 12 weeks, and that after abortion became less available in Washington, "the proportion of rural women having their abortions at later than 18 weeks more than doubled . . . growing from 2% to 5%," and the proportion of rural women having abortions after 18 weeks was "significantly higher than that among their urban counterparts."[152]

86. Reduced access to abortion (in the form of increasing travel distance) also acts as an absolute barrier for some women. In our research in Texas, we found that when clinics closed, there was a significant association between increasing distance to the nearest clinic and decline in the number of abortions, demonstrating how geographic barriers prevent women from obtaining care.[153] Other research has found similar effects. For example, in their study on Georgia abortion rates, Shelton et al. concluded that "the further a woman must travel in order to obtain an abortion, the less likely she is to get one."[154]

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[151] Comm. on Health Care for Underserved Women, *ACOG Committee Opinion Number 554: Reproductive and Sexual Coercion*, 121 Obstetrics & Gynecology 411 (2013).
[152] Sharon A. Dobie et al., *Abortion Services in Rural Washington State, 1983-1984 to 1993-1994: Availability and Outcomes*, 31 Perspectives on Sexual & Reproductive Health 241, 243 (1999); *see also* Theodore Joyce et al., *The Impact of Mississippi's Mandatory Delay Law on Abortions and Births*, 278 JAMA 653 (1997).
[153] Grossman et al. (2013), *supra* note 91.
[154] James D. Shelton et al., *Abortion Utilization: Does Travel Distance Matter?*, 8 Fam. Plan. Persps. 260, 260 (1976).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

87. Other studies of the impact of travel distance on abortion rates have reached comparable conclusions—longer travel distances to access an abortion provider correlate with lower abortion rates.[155]

88. These burdens fall even harder on patients with low incomes, who are less likely to be able to overcome the costs and logistical barriers that the increased travel imposes. Most abortion patients live on incomes below 200% of the federal poverty level.[156] Ohioans are more likely to be living in poverty than others in the U.S., and Black Ohioans are nearly three times more likely than white Ohioans to be living below the federal poverty level.[157] People with low incomes often face transportation limitations that make it particularly hard for them to travel long distances.[158] An Arizona study found that "the majority of women seeking abortion care had to forego or delay food, rent, childcare, or another important cost to finance their abortion."[159]

89. We also know that some women, faced with such barriers to safe and legal abortion, will take measures to self-abort.[160]

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[155] Robert W. Brown et al., *Provider Availability, Race, and Abortion Demand*, 67 S. Econ. J. 656 (2001); Dobie et al., *supra* note 152.

[156] Rachel K. Jones et al., *Characteristics of Abortion Patients in Protected and Restricted States Accessing Clinic-Based Care 12 Months Prior to the Elimination of the Federal Constitutional Right to Abortion in the United States*, 55 Perspectives on Sexual and Reproductive Health 80 (2023).

[157] *FY 2024 Housing Needs Assessment Sections: Income and Labor*, Ohio Housing Finance Agency, https://ohiohome.org/research/income-labor-23.aspx (accessed Jan. 30, 2026)

[158] Samina T. Syed et al., *Traveling Towards Disease: Transportation Barriers to Health Care Access*, 38 J. of Community Health 976 (2013); Elaine Murakami & Jennifer Young, *Daily Travel by Persons with Low Income*, 1, 6 (1997), https://www.researchgate.net/publication/239490744_Daily_Travel_by_Persons_with_Low_Income (accessed Feb. 10, 2026).

[159] Deborah Karasek et al., *Abortion Patients' Experience and Perceptions of Waiting Periods: Survey Evidence before Arizona's Two-Visit 24-Hour Mandatory Waiting Period Law*, 26 Women's Health Issues 60, 64 (2016).

[160] Daniel Grossman et al., *Self-Induction of Abortion Among Women in the United States*, 18 Reprod. Health Matters 136 (2010).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

90. While abortion is one of the safest medical interventions in contemporary medicine, its risks increase as pregnancy progresses.[161] Thus, restrictions on abortion provision, like the Telemedicine Ban, that result in patients being unnecessarily delayed in accessing care not only force the patient to endure the physiological stressors and risks associated with pregnancy for a longer time, but also subject the patient to increased risks associated with abortion if and when they do obtain that care.[162] Some patients seeking abortion are experiencing debilitating pregnancy symptoms, such as intense nausea, or have a condition that may be exacerbated by pregnancy, such as hypertension.

91. Patients who are unable to access a desired abortion entirely are exposed to increased risks of death and major complications from childbirth,[163] and they and their newborns are at risk of poor maternal and neonatal outcomes.[164] These risks are even higher for women living in rural and outlying areas, where there are fewer medical providers.[165] Women forced to carry an unwanted pregnancy to term also may find it harder to bring themselves and their family out of poverty.[166]

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[161] Natl. Acads., *supra* note 9, at 77–78; Linda Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729, 729, 733 tbl.2, 735 (2004); Mary Gatter et al., *Efficacy and Safety of Medical Abortion Using Mifepristone and Buccal Misoprostol Through 63 Days*, 91 Contraception 269, 269, 272 tbl.2 (2015); Zane et al., *supra* note 37, at 262 tbl.4, 263.

[162] Zane et al., *supra* note 37, at 258.

[163] Raymond & Grimes, *supra* note 11, at 217.

[164] Anshu P. Mohllajee et al., *Pregnancy Intention and Its Relationship to Birth and Maternal Outcomes*, 109 Obstetrics & Gynecology 678 (2007); Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 Studies in Family Planning 18 (2008).

[165] Comm. on Health Care for Underserved Women, *ACOG Committee Opinion Number 586: Health Disparities in Rural Women*, *supra* note 128.

[166] Diana G. Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. Health 407 (2018); *see also* Ushma D. Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC Women's Health 1 (2015); Diana G. Foster et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 J. Pediatrics 183 (2019); Diana G. Foster et al., *Comparison of Health, Development, Maternal Bonding, and Poverty Among Children Born*

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

As compared to women who obtained an abortion, women who wanted but could not access an abortion are more likely to be marginally employed, unemployed, or enrolled in public safety net programs.[167] This economic insecurity could last years.[168] And women who are victims of partner violence will, in many cases, face increased difficulty escaping that relationship (because of new financial, emotional, and legal ties with that partner).[169]

92. Delay can also have negative effects on patients' wellbeing.[170] Indeed, in my experience patients who have decided to end a pregnancy very consistently want to do so as early in the pregnancy as possible, for a variety of personal reasons, and are distressed that delays have pushed them later into pregnancy. Others may fear that they will miss the window to have a medication abortion, or miss the window to have an abortion altogether, and be forced to carry an unwanted pregnancy to term. As a result, delays themselves cause some patients significant and unnecessary emotional distress.

93. Other patients must conceal their travel arrangements from abusive or controlling partners or family members, or from others in their community. According to the U.S. Centers for Disease Control and Prevention, 55.7% of Ohio women experience psychological aggression from an intimate partner in their lifetime.[171] Psychological aggression includes name calling, insulting or humiliating an intimate partner, and behaviors that are intended to monitor and control or threaten

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After Denial of Abortion vs After Pregnancies Subsequent to an Abortion, 172 JAMA Pediatrics 1053 (2018).

[167] Foster et al., *supra* note 166, at 409–13.

[168] *Id.* at 407, 409–13.

[169] Sarah C. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy after Receiving or Being Denied an Abortion*, 12 BMC Medicine 144 (2014).

[170] Jenna Jerman et al., *Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States*, 49 Persps. Sexual & Reprod. Health 95 (2017).

[171] Sharon G. Smith et al., Ctrs. for Disease Control & Prevention, *The National Intimate Partner and Sexual Violence Survey, 2016/2017 State Report*, at 67 (2022), https://www.cdc.gov/nisvs/documentation/NISVS-2016-2017-State-Report-508.pdf (accessed Feb. 10, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

an intimate partner.[172] Being unable to access medication abortion early in pregnancy, when pregnancy is generally less apparent, can be particularly detrimental for these patients. Loss of confidentiality is particularly harmful for the 10% of abortion patients who suffer intimate partner violence.[173] Many abusive partners coerce their victims into becoming and staying pregnant as a means of control. They often monitor their victims to prevent them from accessing abortion services.[174]

94. Women who are forced to carry an unwanted pregnancy to term are more likely to continue having sustained contact with an abusive partner than women who have obtained an abortion.[175] This is likely because people who are victims of partner violence will, in many cases, face increased difficulty escaping that relationship after having a child (because of new financial, emotional, and legal ties with that partner).

95. Based on my decades of clinical experience, unnecessary delay in obtaining a desired abortion can cause psychological impacts because patients are often anxious to terminate their pregnancy for various reasons. Some are survivors of rape and are particularly anxious to terminate their pregnancy because it is a constant, invasive reminder of that traumatic experience.[176] And

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[172] *Id.* at 11.

[173] Audrey F. Saftlas et al., *Prevalence of Intimate Partner Violence Among an Abortion Clinic Population,* 100 Am. J. Pub. Health 1412 (2010).

[174] Elizabeth Miller et al., *Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy,* 81 Contraception 316, 316, 318–20 (2010) (finding that domestic violence is highly correlated with unintended pregnancies due to the reproductive coercion that women face in their abusive relationships, and that one in five women who disclosed domestic violence also reported having experienced pregnancy-promoting behaviors by their abusive partner); Natl. Domestic Violence Hotline, *Reproductive Coercion*, https://www.thehotline.org/resources/reproductive-coercion/ (accessed Feb. 10, 2026).

[175] Roberts et al., *supra* note 169, at 148; Jane Mauldon et al., *Effect of Abortion vs. Carrying to Term on a Woman's Relationship with the Man Involved in the Pregnancy*, 47 Perspectives on Sexual & Reproductive Health 11, 11 (2015).

[176] In addition, the many logistical difficulties of arranging a separate visit to the provider, including taking time off from work and/or school, arranging childcare, and making the necessary

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

some who are certain about their decision are nonetheless anxious about the abortion process itself; this can be especially acute for women who have a history of physical or sexual abuse or a past traumatic medical experience.

96. I cannot conceive of a medical reason why a prescribing physician, who has consulted with the patient and prescribed medication abortion, would need to be physically present in the room when the patient takes the initial dose of medication. I am unaware of any other context in which the medical professional who prescribes an oral medication is required to be physically present when the patient takes it, even for medical treatment far riskier than medication abortion and medication far riskier than mifepristone and misoprostol. I understand that Ohio law does not require the physical presence of the prescribing professional when mifepristone and misoprostol are taken for any reason other than abortion, including miscarriage. For example, in addition to their routine use for managing a miscarriage, misoprostol may be prescribed for the prevention and treatment of gastric ulcers, and mifepristone may be prescribed to treat uterine fibroids and symptoms of Cushing's disease. Nevertheless, it is my understanding that Ohio law does not similarly require that these drugs be provided to each patient in person when they are being prescribed for these non-abortion reasons. In my professional opinion, there is no medical reason for this discriminatory distinction.

E. The Advanced Practice Clinician Ban

97. In my opinion, the APC Ban offers no health or safety benefits to abortion patients. Rather, the APC Ban harms people seeking abortion care by unnecessarily limiting its availability and delaying access to care.

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travel arrangements, are likely to be even more difficult for a patient following a traumatic event such as a rape.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

1. Advanced Practice Clinicians Can Provide Medication Abortion Safely and Effectively.

98. APCs are highly trained medical professionals who practice autonomously in health care settings throughout the country. I understand that, as in other states, to obtain an Advanced Practice Clinician license in Ohio, whether as a NP, a CNM, or as a PA, a clinician must meet rigorous educational, certification, and continuing education requirements.[177]

99. Experience and training, rather than any particular specialty or title, determines an individual clinician's competence to provide medical care, including abortion.

100. APCs have a long history of providing reproductive health care, and along with family physicians, they already provide the majority of women's health care across the country.[178] As described further below, APCs routinely provide care of similar or greater complexity and carrying similar or greater risk than medication abortion.

101. Numerous studies have also shown that APCs provide both medication and aspiration abortion as safely as, or more safely than, physicians.[179] This research demonstrates that

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[177] R.C. 4723.41(A) (NPs and CNMs), 4730.11 (PAs).

[178] *See, e.g.*, Susan Yanow, *It Is Time to Integrate Abortion into Primary Care*, 103 Am. J. Pub. Health 14, 15 (2013).

[179] *See, e.g.*, Lauren Porsch et al., *Advanced Practice Clinicians and Medication Abortion Safety: A 10-Year Retrospective Review*, 101 Contraception 357 (2020); H. Kopp Kallner et al., *The Efficacy, Safety and Acceptability of Medical Termination of Pregnancy Provided by Standard Care by Doctors or by Nurse-Midwives: A Randomised Controlled Equivalence Trial*, 122 Brit. J. Obstetrics & Gynaecology 510, 515 (2014); Brooke Ronald Johnson Jr. et al., *Provision of Medical Abortion by Midlevel Healthcare Providers in Kyrgyzstan: Testing an Intervention to Expand Safe Abortion Services to Underserved Rural and Periurban Areas*, 97 Contraception 160 (2018); Mary Anne Freedman et al., *Comparison of Complication Rates in First Trimester Abortions Performed by Physician Assistants and Physicians*, 76 Am. J. Pub. Health 550, 552–53 (1986); Tracy A. Weitz et al., *Letters: Research Informs Abortion Care Policy Change in California*, 104 Am. J. Pub. Health e3, e3 (2014); Tracy A. Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. J. Pub. Health 454, 456, 458 tbl.2 (2013) (establishing that Advanced Practice Clinicians are "comparably safe providers" and determining that there is a 0.05% risk of major complications following an abortion performed by Advanced Practice Clinicians); Natl. Acads., *supra* note 9, at 118–19.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

medication abortion is just as effective when provided by APCs as when it is provided by physicians, and there is no evidence that patients who receive medication abortion from an APC have a higher risk of experiencing complications associated with abortion than those who receive the same care from a physician.[180]

102. Based on the medical evidence, numerous professional organizations, including ACOG,[181] APHA,[182] the World Health Organization ("WHO"),[183] the National Academies of Sciences, Engineering, and Medicine,[184] the American College of Nurse Midwives,[185] and the American Academy of Physician Assistants[186] endorse APCs' provision of abortion care.

103. For example, ACOG has recognized that "APCs have the foundational skills necessary to be trained to provide medication and procedural abortion care" and that "[i]ncreasing the

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[180] Claudia Diaz Olavarrieta et al., *Nurse Versus Physician-Provision of Early Medical Abortion in Mexico: A Randomized Controlled Non-Inferiority Trial*, 93 Bull. World Health Org. 249, 254 (2015); Ina K. Warriner et al., *Can Midlevel Health-Care Providers Administer Early Medical Abortion as Safely and Effectively as Doctors? A Randomised Controlled Equivalence Trial in Nepal*, 377 Lancet 1155, 1159–60 (2011).

[181] Comm. on Health Care for Underserved Women, *ACOG Committee Opinion Number 815: Increasing Access to Abortion*, 136 Obstetrics & Gynecology e107, e111 (2020) (recognizing that "trained advanced practice clinicians can safely provide abortion services").

[182] APHA, *Provision of Abortion Care by Advanced Practice Nurses and Physicians Assistants*, (Nov. 1, 2011), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants (accessed Feb. 10, 2026).

[183] *Health Worker Roles in Providing Safe Abortion Care and Post Abortion Contraception: Executive Summary*, WHO, 6–10 (2015), https://iris.who.int/bitstream/handle/10665/181043/WHO_RHR_15.15_eng.pdf?sequence=1&isAllowed=y (accessed Feb. 10, 2026).

[184] Natl. Acads., *supra* note 9, at 118–19.

[185] *Position Statement: Midwives as Abortion Providers*, Am. Coll. of Nurse-Midwives, 1 (Mar. 2018), https://midwife.org/wp-content/uploads/2024/10/PS-Midwives-as-Abortion-Providers-FINAL-August-2019.pdf (accessed Feb. 10, 2026) ("Manual vacuum aspiration abortion and medication abortion may be safely provided by trained advance practice clinicians (APCs), including midwives.").

[186] *PAs in Obstetrics and Gynecology*, Am. Acad. of Physician Assistants, 2 (Jan. 2021), https://www.aapa.org/download/19515 (accessed Feb. 10, 2026) ("[PAs] are safe, qualified providers of first trimester abortion care, including surgical aspiration and medication-induced terminations.").

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

availability of trained clinicians who can provide abortion care will allow more patients to access quality health care in their own communities and enable patients to receive care more quickly."[187] Similarly, the APHA states that laws like the APC Ban "do not acknowledge the roles and experience of NPs, CNMs, and PAs, whose scope of primary and specialty practice includes management of conditions and procedures significantly more complex than medication or aspiration abortion."[188]

104. The National Academies has recognized the devastating impact that laws like the APC Ban can have on patients, reporting that such laws:

> can reduce the availability of providers, resulting in inequitable access to abortion care based on a woman's geography. In addition, these policies can limit patients' preferences, as patient choice is contingent on the availability of trained and experienced providers. Limiting choices impacts patient-centered care, and also negatively affects the efficiency of abortion services by potentially increasing the costs of abortion care as the result of requiring the involvement of a physician to perform a procedure that can be provided safely and effectively by an APC.[189]

105. When the FDA first approved mifepristone in 2000, it authorized its provision by or under the supervision of physicians. This clearly contemplated and encompassed provision by APCs under physician supervision. The FDA never required the supervising physician's physical presence.

106. When the FDA updated the labeling for mifepristone in 2016, it removed the physician supervision requirement, allowing APCs to provide medication abortion fully independently.[190]

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[187] *Issue Brief: Advanced Practice Clinicians and Abortion Care Provision*, ACOG, 1–2 (Oct. 2023), https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/issue-briefs/advanced-practice-clinicians-and-abortion-care-provision.pdf (accessed Feb. 10, 2026).
[188] APHA, *supra* note 182.
[189] Natl. Acads., *supra* note 9, at 14, 118–19 (internal citation omitted).
[190] FDA, *supra* note 40.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

This conclusion was based on studies that the FDA recognized found "[n]o differences in serious adverse events, ongoing pregnancy or incomplete abortion . . . between the groups."[191]

107. Twenty-five states and the District of Columbia permit APCs to provide medication abortion (now including Ohio because of the preliminary injunction in this case), and twenty-three states and the District of Columbia allow them to provide procedural abortion.[192] These states reflect the medical consensus that there is no medical reason to prevent APCs from providing medication abortion. Because APCs with appropriate education, training, and clinical experience can provide medication abortion just as safely and effectively as physicians, there is no medical justification for a law that prevents them from doing so.

108. In other states, APCs routinely provide medication abortion without a physician on site, reflecting confidence in properly trained APCs' capacity to provide safe and effective abortion care to patients.

109. As a liaison member of the Planned Parenthood National Medical Committee and as a physician who provided clinical services with Planned Parenthood Northern California (formerly Planned Parenthood Shasta Pacific) between 2012 and 2015, I can attest that the vast majority of medication abortions at Planned Parenthood Northern California were directly provided by APCs. In my previous work at St. Luke's Women's Center, I trained APCs to provide medication abortion, which they did with a high level of competence. It has been my experience that APCs' expertise, judgment, and quality of care in providing medication abortions are at least equivalent to that of physicians.

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[191] FDA Summary Rev., *supra* note 56, at 23.

[192] Diana Taylor et al., *State Abortion Laws and Their Relationship to Scope of Practice*, https://aptoolkit.org/advancing-scope-of-practice-to-include-abortion-care/state-abortion-laws-and-their-relationship-to-scope-of-practice/ (accessed Feb. 10, 2026). This map does not reflect that Rhode Island law allows APCs to provide both procedural and medication abortion. 216-20 R.I. Code R. § 10-6.3 (repealed 2023).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

110. Almost all of the complications associated with medication abortion can be safely and appropriately managed by APCs in an outpatient clinic setting. For example, cases of incomplete abortion are generally managed in the health center through medication or aspiration. Managing complications of medication abortion is within the scope of practice of APCs trained in obstetric and gynecological care, particularly with a physician consistently available for consultation as I understand is the case for Ohio providers. Furthermore, it is comparable to providing miscarriage management, which falls squarely within the scope of practice for Ohio APCs.

2. APCs Provide a Range of Other Complex Procedures.

111. It is my understanding that in Ohio, similar to my experience in California, APCs commonly perform office-based reproductive health procedures that are at least comparable in clinical complexity and risk to providing and managing a medication abortion. Although medication abortion is not a procedure, complications such as bleeding and infection may rarely occur after the treatment. These complications may also occur after other treatments, which I understand APCs in Ohio (as elsewhere) currently provide, including:

a. **endometrial biopsy** (inserting a sterile tube through a patient's cervix into the uterus to suction and remove tissue from the uterine lining), a procedure that is more complex than medication abortion in its technical requirements and risk of complications;

b. **colposcopies** (using instruments to magnify the cervix, identifying signs of cervical cancer or precancerous lesions, performing biopsies, and managing bleeding with the use of hemostatic agents), a procedure that is more complex than medication abortion in its technical requirements and risk of complications;

c. **intrauterine contraceptive device ("IUD") insertion and removal** (sometimes using ultrasound guidance), a procedure that is more complex than

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

medication abortion in its technical requirements and risk of complications, including uterine perforation. In particular, many removals of IUDs without a visible string (potentially requiring use of paracervical block, mechanical cervical dilation, ultrasound guidance, and/or use of instruments in the uterus, such as alligator forceps, IUD thread retriever, or IUD hook)—which are performed by APCs—are more complex than medication abortion. Further, certain difficult removals of contraceptive implants, which are performed by APCs, are more complex than medication abortion, as they require local anesthesia, knowledge of anatomy, and careful dissection and carry a risk of nerve or vascular injury; and

d. Nexplanon (contraceptive implant) insertion and removal, a procedure that is more complex than medication abortion in its technical requirements and risk of complications.

112. CNMs also routinely care for patients giving birth and assume responsibility for managing complications from childbirth like vaginal lacerations and postpartum hemorrhage. This is far more complex than providing medication abortion in its technical requirements and risk of complications.

113. In addition to the procedures above, I understand that APCs in Ohio can prescribe medications for miscarriage management. Comparable doses of mifepristone and misoprostol, the same medications used in medication abortion, can be used to treat miscarriage.[193] Medical miscarriage management requires essentially the same clinician skill and knowledge and carries essentially the same risk to patients as medication abortion.

[193] Chu et al., *supra* note 65; Schreiber et al., *supra* note 65.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

114. I understand from their counsel that APCs at PPGOH and PPSWO prescribe misoprostol in connection with some IUD insertions and removals. And, as explained above, IUD insertions involve risk of uterine perforation, which is not present in the context of medication abortion, and require greater skill than prescription of medication abortion.

115. APCs have prescriptive authority in every state, including Ohio.[194] In Ohio, they are authorized to prescribe controlled substances,[195]including narcotics and other medications that carry far greater risk than the two medications involved in medication abortion.[196]

116. There is no medical or safety reason to prohibit APCs from providing medication abortion while allowing them to prescribe the same medications in other contexts (such as with misoprostol for IUD insertion and removal) and to perform services that are clinically comparable to or of higher complexity and risk than medication abortion.

117. In many areas of medicine, APCs now routinely provide care that was once exclusively or primarily provided by physicians. In addition to medication abortion, colposcopy and endometrial biopsy are two examples. As medical science advances and the nation's health care needs and health care delivery systems evolve, the roles, clinical skills, and competencies of APCs and other medical professionals advance and evolve in response.

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[194] Phillip Zhang & Preeti Patel, StatPearls, *Practitioners and Prescriptive Authority*, (Nov. 13, 2013), https://www.ncbi.nlm.nih.gov/books/NBK574557/#_NBK574557_pubdet_ (accessed Feb. 10, 2026).

[195] U.S. Dept. of Justice Drug Enforcement Administration, Diversion Control Div., Mid-Level Practitioners Authorization by State, https://www.deadiversion.usdoj.gov/drugreg/practioners/practioners.html (accessed Feb. 10, 2026).

[196] U.S. Dept. of Justice Drug Enforcement Administration, *Drug Scheduling*, https://www.dea.gov/drug-information/drug-scheduling (accessed Feb. 10, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

3. The APC Ban is Not Evidence-Based and Harms Patients.

118. It is my opinion that Ohio's APC Ban unnecessarily restricts willing and capable APCs from safely and effectively providing medication abortion care. Laws like Ohio's APC Ban restrict qualified medical professionals from providing care within their scope of practice and do not help patients. Rather, categorical scope-of-practice restrictions like Ohio's APC Ban harm patients seeking medication abortion care in numerous ways given unnecessary limits they impose on the number and geographic distribution of medical professionals available to offer needed health care. These harms include, but are not limited to, harm to patient health and wellbeing associated with delayed access to medication abortion, being forced to remain pregnant longer, and being pushed past the point in pregnancy when medication abortion is available, which may be a patient's preferred method. As an OB-GYN, I have seen how unnecessary delays in access to abortion care cause my patients medical harm.

a) APC Bans Result in Provider Shortages and Care Delays.

119. Banning APCs from providing medication abortion care in accordance with their experience, training, and scope of practice can significantly constrain when and where this care is available. This is particularly true given heightened demand for care placed on an increasingly limited number of physician abortion providers and as more and more states ban or severely restrict abortion access within their borders. These differences in capacity may make the difference for people who already face other obstacles to care, potentially leading to delay or even preventing patients from accessing medication abortion. By prohibiting qualified APCs from providing medication abortion, the APC Ban restricts the medical system's capacity to provide time-sensitive health care to people who need it.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

120. Particularly in the context of the nationwide shortage of both primary care providers[197] and abortion providers,[198] APC bans like Ohio's limit the number of sites where abortion is available in a given state as well as the capacity of those clinics that do provide abortion. The limited pool of abortion providers in the United States has multiple causes. Options are, and historically have been, limited for students and residents who want to be trained in this care.[199] The increase in punitive and restrictive laws being enacted and enforced in states hostile to abortion following the United States Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022), has only exacerbated this. Moreover, clinicians who do seek out and receive abortion training often face institutional barriers to incorporating that care into their practice.[200]

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[197] KFF, *Primary Care Health Professional Shortage Areas (HPSAs)*, (Dec. 31, 2024), https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas (accessed Feb. 10, 2026) (noting that only 47% of need for primary care health professionals is being met nationally); Assn. of Am. Med. Coll., *The Complexities of Physician Supply and Demand: Projections From 2021 to 2036* (Mar. 2024), https://www.aamc.org/media/75236/download (accessed Feb. 10, 2026) ("Comparison of projected supply and demand for Primary Care physicians . . . predicts a shortage of between 20,200 and 40,400 physicians by 2036 . . . .").

[198] Daniel Grossman et al., *Induced Abortion Provision Among a National Sample of Obstetrician-Gynecologists*, 133 Obstetrics & Gynecology 477, 477 (2019); Amanda Michelle Gomez, *Medical School Training Is Exacerbating the Shortage of Abortion Doctors Across the Country*, ThinkProgress (Nov. 28, 2017), https://archive.thinkprogress.org/training-the-next-generation-of-abortion-doctors-45cd46403b6a/ (accessed Feb. 10, 2026); Mara Gordon, *The Scarcity of Abortion Training in America's Medical Schools,* The Atlantic (June 9, 2015).

[199] Eve Espey et al., *Abortion Education in Medical Schools: A National Survey*, 192 Am. J. Obstetrics & Gynecology 640, 640–42 (2005) (17% of U.S. medical schools reported no formal education about abortion in the four years of medical school, and in the third-year OB/GYN rotation, 23% reported no formal abortion education); Jema K. Turk et al., *Sources of Support for and Resistance to Abortion Training in Obstetrics and Gynecology Residency Programs*, 221 Am. J. Obstetrics & Gynecology 156.e1 (2019) (nearly three-quarters of OB/GYN residency programs report at least some institutional or governmental restrictions to training, and reported an average of three types of restrictions); Alison Block et al., *Postgraduate Experiences with an Advanced Reproductive Health and Abortion Training and Leadership Program*, 49 Fam. Med. 706, 707 (2017) (only 6% of family medicine residencies offered opt-out abortion training in 2016).

[200] Lori Freedman et al., *Obstacles to the Integration of Abortion Into Obstetrics and Gynecology Practice*, 42 Persps. on Sexual & Reprod. Health 146, 147–48 (2010); Block et al., *supra* note 199, at 710 (stating that 29% of graduates from an advanced reproductive care training program for

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

121. My own research confirms that fewer abortion providers means that more patients will be delayed in accessing abortion. In a study I published in 2014, my colleagues and I found that, as a result of the number of abortion providers in Texas dropping from 41 to 22, there was a statistically significant increase in the proportion of abortions that occurred in the second trimester, suggesting restrictions on abortion access delayed abortions from the first into the second trimester.[201] We later confirmed this finding in a more detailed analysis of abortion statistics from Texas.[202]

122. At health centers where a physician is already providing abortion, permitting APCs to provide medication abortion expands the number of clinicians who can see abortion patients on a given day, thereby expanding the number and timing of available appointments. It also frees up physicians to see other patients and to focus on more technically complex abortion procedures, allowing both APCs and physicians to provide the full range of care permitted by their training and license. In this way, permitting APCs to provide medication abortion increases patient access to abortion, particularly for people in rural and underserved urban areas.[203] Conversely, when qualified providers are prevented from seeing patients, appointment availability is reduced, creating bottlenecks and delaying patients in accessing care. Limited appointment availability may force some patients to travel farther for abortion care (if they can do so and find a health center where they can get an appointment sooner) or wait until they find an appointment time that fits their schedule. Studies show that the number of appointments available to patients plays a

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family medicine residents reported administrative obstruction as an obstacle to their provision of abortion care, and 27% reported clinic or hospital policies not allowing abortion service provision).

[201] Daniel Grossman et al., *Change in Abortion Services After Implementation of a Restrictive Law in Texas*, 90 Contraception 496, 499–500 (2014).

[202] Kari White et al., *Change in Second-Trimester Abortion After Implementation of a Restrictive State Law*, 133 Obstetrics & Gynecology 771, 771 (2019).

[203] Donna Barry & Julia Rugg, Ctr. for Am. Progress, *Improving Abortion Access by Expanding Those Who Provide Care* (Mar. 26, 2015), https://www.americanprogress.org/wp-content/uploads/sites/2/2015/03/ExpandingAccessToAbortionBrief.pdf (accessed Feb. 10, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

significant role in how promptly patients can access abortion as well as in how many people can access care at all.[204]

b) Delay and Increased Travel Harm Patients

123. As I noted above, unnecessary delays in accessing abortion harms patients. *Supra* ¶ 85. Remaining pregnant for longer presents additional risks, and while abortion is incredibly safe at all gestational durations, the risks do increase with gestational duration. Additionally, as pregnancy progresses, abortion becomes more expensive, is offered at fewer locations, and there are fewer providers than there are for early abortions.[205]

124. Advanced practice clinicians are more likely to provide care in rural areas and underserved settings than are OB/GYNs.[206] In many community health clinics (and a number of Planned Parenthood health centers), APCs are the lead clinicians on site. Eliminating physician-only restrictions increases abortion access by allowing clinics staffed by APCs to begin providing abortion. This also promotes continuity of care, as patients are able to access abortion from the same clinician who provides their routine gynecological or primary care.[207] Care continuity benefits patients by improving communication and trust.

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[204] Lindo et al., *supra* note 146; Andrea M. Kelly, *When Capacity Constraints Bind: Evidence from Reproductive Health Clinic Closures* (Jan. 15, 2020), https://amkelly15.github.io/andiemkelly.com/ReducedCapacity_Kelly_current.pdf (accessed Feb. 10, 2026).

[205] Jones et al., *supra* note 148.

[206] One study, for example, indicates that 49% of NPs and 69% of PAs in California serve rural and vulnerable populations, compared with 35% of OB/GYNs. Diana Taylor et al., *When Politics Trumps Evidence: Legislative or Regulatory Exclusion of Abortion from Advanced Practice Clinician Scope of Practice*, 54 J. Midwifery & Women's Health 4, 6 (2009); *see also* Amanda Van Vleet & Julia Paradise, *Tapping Nurse Practitioners to Meet Rising Demand for Primary Care*, KFF (Jan. 20, 2015), https://www.kff.org/medicaid/tapping-nurse-practitioners-to-meet-rising-demand-for-primary-care/ (accessed Feb. 10, 2026); APHA, *supra* note 182.

[207] *See* ACOG Committee Opinion Number 815, *supra* note 181.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

125. In sum, as the National Academies has recognized, state abortion restrictions like Ohio's APC Ban "have created barriers to optimizing each dimension of quality care. The quality of care is optimal when the care is based on current evidence and when trained clinicians are available to provide abortion services."[208]

[208] Natl. Acads., *supra* note 9, at 10.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

EXHIBIT 7

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A 2101148 Judge Alison Hatheway

REBUTTAL EXPERT REPORT OF BHAVIK KUMAR, M.D., M.P.H.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

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E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

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E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*,	Case No. A 2101148
Plaintiffs,	Judge Alison Hatheway
v.	
OHIO DEPARTMENT OF HEALTH, *et al.*,	
Defendants.	

AFFIDAVIT OF BHAVIK KUMAR, M.D., M.P.H.

Now comes affiant Bhavik Kumar, M.D., M.P.H., having been first duly cautioned and sworn, deposes and states as follows:

1. I am over the age of 18 and fully competent to make this declaration.
2. I am providing my expert opinions for the purpose of this litigation.
3. My rebuttal expert report is attached to this affidavit as Exhibit A. I swear to its authenticity and to the faithfulness of the opinions expressed, and to the best of my knowledge, the accuracy of the factual statements made therein.

FURTHER AFFIANT SAYETH NAUGHT

bhavik kumar

Bhavik Kumar, M.D., M.P.H.

State of Florida, County of Volusia
Sworn to and subscribed before me this 4th Day of June, 2026.
Bhavik Kumar appeared and signed electronically using his Texas DL.

Tiffany L Hargett

TIFFANY L. HARGETT
Notary Public - State of Florida
Commission # HH 461344
My Comm. Expires Nov 5, 2027

This notarial act was an online notarization

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

EXHIBIT A

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*,	Case No. A 2101148
Plaintiffs,	Judge Alison Hatheway
v.	
OHIO DEPARTMENT OF HEALTH, *et al.*,	
Defendants.	

REBUTTAL EXPERT REPORT OF BHAVIK KUMAR, M.D., M.P.H.

I. INTRODUCTION

A. Background to Expert Rebuttal Report

1. I am Chief Medical Officer for Plaintiff Planned Parenthood of Greater Ohio ("PPGOH"), a plaintiff in this case.

2. PPGOH and its predecessor organizations have served patients in northern, central, and southeastern Ohio for decades. PPGOH operates two facilities licensed as ambulatory surgical facilities ("ASFs") under Ohio law, in Columbus and Bedford Heights (outside Cleveland), as well as 11 additional clinics throughout the state and a virtual health center. Both ASFs offer both medication and procedural abortions. Prior to the preliminary injunction of the APC Ban in this case, those two locations were the only locations where PPGOH was able to provide abortion care because they are the only locations staffed by physicians. Since the APC Ban was preliminarily enjoined, PPGOH has been able to offer medication abortion to patients at an additional two health centers located in Athens and Mansfield, and, with the Telemedicine Ban preliminarily enjoined, PPGOH also offers medication abortion via telemedicine to patients throughout Ohio. PPGOH

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

offers medication abortion in-person through 84 days LMP and via telemedicine through 77 days since a patient's last menstrual period ("LMP").

3. I have not previously submitted an expert report in this case. In forming my opinions contained in this report, I have relied upon my education, training, research, and professional experience, including familiarity with scientific and medical literature. I have also relied upon information I have learned through review of PPGOH's business records and in the course of my duties at PPGOH, as well as personal knowledge acquired during my service at PPGOH. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. All opinions stated herein are to a reasonable degree of medical and scientific certainty.

4. My *curriculum vitae* ("CV"), attached as Exhibit B to this expert rebuttal report, includes information about my education, research, and professional experience.

5. In addition to the Expert Report of Dr. Ingrid Skop, M.D., May 1, 2026, ("Skop Rep.") and Expert Report of Donna Harrison, M.D., April 30, 2026 ("Harrison Rep."), I have reviewed the Expert Report of Daniel Grossman, M.D. (Mar. 17, 2026) and agree with Dr. Grossman's opinions about the safety and effectiveness of medication abortion in general, telemedicine provision of medication abortion ("TMAB"), medication abortion provision by advanced practice clinicians ("APCs"), and evidence-based use of mifepristone and misoprostol for pregnancy termination through at least 84 days from the date of the first day of the patient's last menstrual period ("LMP"). I also agree with Dr. Grossman that the Challenged Restrictions at issue in this case impede, delay, and in some cases may entirely prevent access to medication abortion, or even abortion altogether, while harming patient health.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

6. I submit this Rebuttal Expert Report in response to the expert reports of Drs. Skop and Harrison. I respond here to certain statements and opinions they offered. In this Report, I focus primarily on claims Drs. Skop and Harrison make regarding the impact of and necessity for the laws Plaintiffs challenge in this case *in Ohio*. As such, I do not address each and every claim in either of their expert reports. The fact that I do not address a particular statement or opinion made in their reports does not indicate my agreement with that statement or opinion.

7. I am not being compensated for preparation of expert affidavits and reports, and for time spent preparing for or giving deposition or trial testimony; the only payment I am receiving is my standard salary or compensation for my employment at PPGOH, which I would receive regardless of my participation in this lawsuit.

8. I understand that this case involves challenges to Ohio's Telemedicine Ban, R.C. 2919.124; Evidence-Based Use Ban, R.C. 2919.123; and Advanced Practice Clinician Ban. R.C. 2317.56(B), 2919.11, 2919.123, 4723.28(B)(30), 4723.44(B)(6), 4723.50(B)(1), 4723.151(C), 4730.02(E), 4730.03(F), 4730.25(B)(24), 4730.39(B)(2), 4730.42(A)(1); Adm.Code 3701-47-01, 4723-9-10(I), 4730-2-07(E). I am familiar with the requirements these laws impose on medication abortion providers in Ohio. In brief, I understand that, without the preliminary injunction previously entered in this case, those laws would, respectively: preclude Ohio abortion providers from providing medication abortion via telemedicine and, as a result, require patients to travel to a physical health center for care; render medication abortion unavailable to patients after 70 days LMP, even though medical evidence supports medication abortion provision through at least 84 days LMP; and prevent qualified APCs from providing medication abortion by mandating that only physicians can provide that care. I further understand that these laws are enforceable through

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

severe penalties, including both criminal penalties and civil penalties like professional licensing discipline or revocation.

B. Experience and Qualifications

9. I am a board-certified family medicine physician licensed to practice in Ohio and Texas. I have over ten years of experience providing family planning, sexual, and reproductive health care, including abortion. I received my medical doctorate from Texas Tech University School of Medicine in 2010, after which I completed a residency in Family & Social Medicine at Montefiore Medical Center in the Bronx, New York. I then obtained a Master's Degree in Public Health at the Joseph L. Mailman School of Public Health at Columbia University while completing a Fellowship in Family Planning at Albert Einstein College of Medicine in the Bronx, New York.

10. I have published numerous academic articles and have presented extensively on topics related to family planning and abortion care. I also currently serve as board chair-elect of the board of the Society of Family Planning, and I am a past board member of Physicians for Reproductive Health.

11. I have served as Chief Medical Officer ("CMO") of PPGOH since July 2024. Prior to that, I served patients in Ohio as a staff physician for PPGOH beginning in 2023. I have also provided a range of care to patients in other states, including Florida, Louisiana, Kansas, and Texas. I have experience providing both medication and procedural abortion, in addition to a full array of sexual and reproductive health care. I also have experience providing general preventative care, such as well-person visits and breast cancer screenings. In addition to providing in-person care to patients, I have experience providing patients with a range of health care via telemedicine, including abortion care.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

12. In my role as CMO, I supervise physicians and other clinicians, including APCs, and manage the provision of all medical services at PPGOH, including care provided via telemedicine. I am responsible for developing PPGOH's policies and procedures, for supervising training of PPGOH's medical staff, and for approving the types of care individual clinicians may provide (i.e., their "scope-of-practice" or "provider privileging"). Because of the preliminary injunction in this case, that includes training and provider privileging approval for APCs once they are trained and qualified to provide medication abortion. It also includes supervision of PPGOH APCs who provide medication abortion. I also provide direct patient care, including medication and procedural abortions.

II. OPINIONS

13. In my opinion, Drs. Skop and Harrison both offer flawed opinions unsupported by accepted scientific and medical literature about the Telemedicine Ban, the Evidence-Based Use Ban, and the APC Ban. Based upon my education, training, experience, and familiarity with scientific and medical literature, both rely upon propositions that are not evidence-based and on tropes about the "abortion industry" in their reports. Both ignore established evidence demonstrating that medication abortion can be provided safely and effectively via telemedicine, is safe and effective through at least 84 days LMP, and that APCs can and do safely and effectively provide medication abortion.

A. Dr. Skop and Dr. Harrison Offer Incorrect Opinions About TMAB

14. *There is no medical reason to impose the Telemedicine Ban.* Drs. Skop and Harrison paint TMAB as unsafe and argue that pre-abortion ultrasound testing is necessary for gestational dating, ectopic pregnancy screening, and to identify patient coercion. They also argue that medication abortion follow-up care cannot be effectively provided via telemedicine. All of

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

those opinions are incorrect and unsupported. Finally, Drs. Skop and Harrison either misunderstand or unjustifiably discount important benefits of telemedicine for patients.

1. In-Person Pre-Abortion Testing Is Often Medically Unnecessary

15. Based upon my education, training, research, experience, and knowledge of medical and scientific literature, Drs. Skop and Harrison make medically unsupported claims about TMAB safety and efficacy generally, and both fail to justify the opinions they offer regarding the Telemedicine Ban. For example, they argue that an ultrasound is necessary for gestational dating prior to a medication abortion. Skop Rep. ¶¶ 81–84, 89; Harrison Rep. ¶¶ 26–27, 57–58, 61. Another example is Dr. Skop's and Dr. Harrison's incorrect assertions that in-person appointments and ultrasounds are necessary to screen patients for medical contraindications to medication abortion. *See, e.g.*, Skop Rep. ¶ 89; Harrison Rep. ¶¶ 29–30, 59, 61–62. Medical evidence does not support either assertion, nor does my experience as an abortion provider for over ten years and in multiple states, through which experience I have directly provided this care for thousands of people.

a. Mandatory ultrasounds are unnecessary for medication abortion gestational dating or medical eligibility screening

16. Screening patients to assess telemedicine eligibility for medication abortion patients can be done effectively via remote technology and there is no medical reason to force patients to incur the burden and expense of travel for TMAB eligibility screening. PPGOH's protocols are an example of the inaccuracy of Drs. Skop and Harrison's opinions regarding gestational dating and patient medical screening. Patients who are interested in receiving a medication abortion via telemedicine must meet certain criteria in order to be eligible. This includes being in Ohio both at the time of their appointment and when they take the abortion medication, being at least 18 years old, having confirmation that they are pregnant (via home

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

pregnancy test or a health care provider test), and being at 77 days LMP or less on the day of their appointment (to allow time for medication shipping and potential delays due to weather, holidays, etc.). Patients must also be medically eligible for TMAB, including both being eligible to obtain a medication abortion without an ultrasound, and being able to use the MyChart electronic system to access the secure telemedicine platform and messaging.

17. Patients receive an initial screening for all of these eligibility criteria before an initial TMAB appointment is scheduled. The initial screening includes questions aimed at gestational dating, such as the date of the patient's last menstrual period, whether they have regular periods, whether they have a positive pregnancy test (and whether it was more or less than 52 days before the initial screening). They are also asked questions related to ectopic pregnancy[1] risk—such as having had prior ectopic pregnancies or becoming pregnant with an intrauterine device ("IUD") in place—since that renders a patient ineligible for a telemedicine appointment.

18. Our screening protocols are rigorous and effective in ensuring that only patients who are within the appropriate gestational window and who can safely obtain a medication abortion without an ultrasound are eligible for TMAB. Most patients can answer the multiple requisite questions designed to make each of these determinations with sufficient accuracy, and those who cannot, do not receive TMAB, even if that is their preference. Instead, they are scheduled for an in-person appointment where they meet with a clinician to discuss their options (generally either in-person medication abortion with an ultrasound or a procedural abortion). Since we began providing direct-to-patient TMAB at PPGOH, our screening protocols have effectively

[1] An ectopic pregnancy is any pregnancy that implants in an abnormal location, whether outside the uterus (extrauterine) or in an improper area inside the uterus (e.g. at the site of a prior cesarean scar).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

diverted patients who are outside of the gestational window for medication abortion and who have ectopic pregnancy symptoms to in-person appointments.

19. This example highlights another deficiency in Dr. Skop's and Dr. Harrison's reports: neither report addresses the way that TMAB works *in Ohio*. Instead, they rely upon generalizations. For example, Dr. Skop claims that clinicians providing telemedicine abortion "do[] not have the ability to order an ultrasound even if it was deemed necessary[.]" Skop Rep. ¶ 107. This is simply not true in Ohio. As with any care a clinician provides, all clinicians have an ethical duty to only offer and provide patients with medically appropriate treatment. For medication abortion, that duty includes ensuring that the patient is medically eligible for medication abortion—and eligible to receive that care via telemedicine without an ultrasound if the patient chooses TMAB. Consistent with that duty, clinicians can and do regularly refuse to provide patients medication abortion via telehealth if they are not eligible for that form of care (e.g., if it is deemed necessary for them to first have an ultrasound before receiving a medication abortion), and schedule or refer those patients for in-person appointments where they can receive ultrasounds instead.

20. PPGOH's protocols provide an example of how this can work in practice. In addition to the initial screening patients undergo before they are even scheduled for a TMAB appointment with PPGOH, during a TMAB appointment, a clinician conducts an independent eligibility assessment as part of providing medical care. The clinician only proceeds with the TMAB appointment if they conclude based upon their during-appointment assessment that the patient is eligible, and if the patient continues to want to receive care via telemedicine. The during-appointment assessment includes asking the patient questions for gestational dating to determine whether they are at 77 days or less LMP, and assessing whether medication abortion is medically

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

appropriate. The medical appropriateness assessment includes taking a medical history to screen for conditions that are contraindications for medication abortion (for example, allergies or certain chronic medical conditions). Based upon my experience, training, and familiarity with medical and scientific literature, mandatory ultrasounds add nothing to this process and only serve to increase patient burdens. Patients with a medical reason for a pre-abortion ultrasound are still scheduled for an in-person appointment, and patients who do not need one are not forced to have one.

b. Mandatory ultrasounds are unnecessary for ectopic pregnancy screening

21. Drs. Skop and Harrison also both incorrectly assert that an ultrasound is necessary before a medication abortion to screen for ectopic pregnancy. PPGOH's experience and my familiarity with scientific and medical literature demonstrate that patients can be effectively screened for ectopic pregnancy risk without an ultrasound. PPGOH asks every medication abortion patient questions that allow a clinician to screen them appropriately, and our own experience since PPGOH began providing TMAB has demonstrated that these protocols work, as patients outside the gestational age limit for TMAB or with ectopic symptoms have been diverted to in-person care.

22. As I have already described, patients whose initial screening indicates heightened ectopic pregnancy risk are scheduled for an in-person appointment, and in the rare case where a patient screens as possibly having a current ectopic pregnancy they are connected with a clinician to discuss the need for emergent care. For patients who screen as eligible and have a TMAB appointment scheduled, the clinician asks the patient additional questions as part of their during-appointment assessment to screen for possible ectopic pregnancy or risk of ectopic pregnancy, which would make them ineligible for TMAB (such as whether the patient had an IUD in place

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

when they became pregnant, has a history of infections in the reproductive organs, or has any current symptoms that could indicate a possible ectopic pregnancy). Patients who screen as having a higher risk for ectopic pregnancy but do not presently have symptoms of concern for a current ectopic pregnancy are not eligible for TMAB and are instead offered an in-person appointment. This could include, for example, a patient who became pregnant with an IUD in place, but who does not have any symptoms that raise concern of a current ectopic pregnancy. If a patient calls and describes symptoms that present concern that they could currently have an ectopic pregnancy, they are connected with a PPGOH clinician for further counseling and treatment referral, including for emergent care, if needed.

* * *

23. Once the clinician's during-appointment eligibility assessment is complete, they then discuss a patient's medical options and alternatives. If the patient screens as ineligible for TMAB, the clinician does not proceed with a TMAB appointment and instead discusses the patient's options (most commonly an in-person medication abortion or a procedural abortion), answers any questions they have, and helps them schedule another in-person appointment.

24. If at any point a patient decides they prefer to receive care in-person, or the provider determines that they are not medically eligible to receive a medication abortion by TMAB, the clinician does not proceed with providing the medication abortion via telemedicine. Instead, the patient is offered the option to have an in-person appointment scheduled at one of PPGOH's locations. The patient can also choose not to schedule another appointment and to follow up at a different time. In my experience, most patients who are deemed ineligible for TMAB choose to have an appointment scheduled at a physical health center as soon as possible.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

25. For patients whose during-appointment assessment shows that they are eligible for TMAB and who want to receive care via telemedicine, the clinician answers any questions they have, obtains informed consent, and ensures they understand instructions for how to use and feel comfortable using the proposed medications.

2. Patients Can Effectively Be Screened for Coercion Via Telemedicine, and Telemedicine Has Particular Benefits For Patients Experiencing Intimate Partner Violence

26. Drs. Skop and Harrison also argue that patients need to be seen in-person prior to a medication abortion to prevent coercion. Skop Rep. ¶ 121; Harrison Rep. ¶¶ 38–39, 60. Their arguments are both incorrect and incomplete. They are *incorrect* because clinicians can and do effectively screen patients for coercion via telemedicine—with the telemedicine model sometimes making it easier for patients to speak openly with their provider since it allows them more flexibility to pick a safe time and location for their appointment. Dr. Skop's and Dr. Harrison's opinions are also *incomplete* because they fail to consider that patients can also be coerced into becoming or remaining pregnant and they fail to account for the harm that the Telemedicine Ban can cause patients experiencing that level of control from a partner. Based upon my education, training, experience, and knowledge of scientific and medical literature, in these situations the patient may be unable to physically get away from their home to a clinic to receive an abortion to terminate the coerced pregnancy. This can in turn make it harder for them to extricate themselves from the violent relationship in which they were coerced to become or remain pregnant.

27. Dr. Skop's and Dr. Harrison's arguments largely seem to repeat inaccurate anti-abortion talking points that argue that people do not want abortions and only have them because they are pressured or coerced to do so. Harrison Rep. ¶¶ 38–39, 26; Skop Rep. ¶¶ 81, 121. In reality, the vast majority of patients do not experience coercion and are fully capable of making the medical decisions that are right for them. Their unsupported claims in this area also belittle

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

patients and their decision-making capacity in ways that are both inaccurate and offensive to patients. In my experience, people seeking abortion care typically think deeply about their decisions and what is best for them. Assuming they cannot is paternalistic. And all patients deserve to be treated with dignity and to have their autonomy respected.

28. It is a core tenet of medical practice to only proceed with medical care that is voluntary. Clinicians thus have an ethical duty to only provide care, of any kind, that a patient undertakes voluntarily. The informed consent process for all care, including abortion (whether medication or procedural, telemedicine or in-person), thus necessarily involves ensuring that the patient is making a voluntary decision and is not being coerced. Medical education for both physicians and advanced practice clinicians teaches this essential component of informed, ethical medical care that respects and supports patient autonomy.

29. In my experience, abortion providers and abortion clinic staff are well trained to be able to screen for coercion and ensure that patients are consenting to an abortion freely and voluntarily. For example, at PPGOH we build on the understanding of patient autonomy all clinicians have from their education and training by further training providers and staff who interact with patients in how to screen for coercion and what to do if they are concerned that a patient might not be seeking care voluntarily. I and other supervising clinicians are also available to answer questions should a provider or staff member have concerns about which they want a second opinion, or that they are not sure how to approach. If a patient is not sure that they want to receive an abortion, PPGOH staff do not proceed with the abortion that day. If they desire, the patient can be scheduled for another appointment to give them more time to think. They can of course also choose not to schedule another appointment and to instead contact us again when and if they decide that they want to proceed.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

30. The steps I have described can all be accomplished equally, and sometimes more, effectively via telemedicine. For example, PPGOH providers ask patients the same questions and make the same behavioral observations no matter how care is delivered. Having flexibility to decide when and where to have the telemedicine visit also allows patients experiencing interpersonal violence to schedule their appointment for a time where they know they can be away from the person who is abusing them—and not needing to travel significantly shortens the time they need to get away from their partner and potentially explain their absence.

31. Telemedicine also has important benefits for some patients who are especially vulnerable. In addition to the example of interpersonal violence I explained above, telemedicine can also make care more accessible to patients who cannot financially absorb the cost of travel—whether that be due to travel costs, lost wages, childcare or other caregiving costs, or some other source of financial strain. In these ways, being able to offer medication abortion via telemedicine allows us to meet patients where they are to provide them with care they want and deserve.

32. In short, TMAB has many benefits for patients. In my experience, patients often strongly prefer to obtain a medication abortion via telemedicine due to the convenience, privacy, and control it offers and there is no medical reason to deny them that care, especially since coercion can be screened for via telemedicine and TMAB may in fact be safer and preferable for some patients experiencing interpersonal violence.

3. Mandating In-Person Follow-Up Appointments Is Not Necessary to Ensure Medication Abortion Safety and Efficacy

33. Drs. Skop and Harrison also argue that in-person follow-up appointments are necessary to ensure medication abortion safety and efficacy and seem to imply that many medication abortion patients are simply handed medication without any follow-up care. *See, e.g.*, Harrison Rep. ¶¶ 35–36, 44–52; Skop Rep. ¶ 93, 129**.** Both are also simply untrue. Medication

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

abortion follow-up care involves talking with the patient and, later, the patient taking a pregnancy test to confirm that they are no longer pregnant. This care is routinely, effectively provided via telemedicine and with patients taking an at-home urine pregnancy test. In my experience, abortion providers do not tie or condition follow-up care on the modality by which the patient received their care in the first place. For example, PPGOH's medication abortion and follow-up protocols apply to all patients—whether they receive their abortion in person or via telemedicine.

34. Based upon my education, training, experience, and familiarity with scientific and medical literature, there is no medical reason to force patients to travel for in-person follow-up care following a medication abortion. Providers are able to effectively conduct patient follow-up via remote technology, and patients often vastly prefer this over coming to the clinic for an additional appointment. And, if patient follow up reveals that in-person care is necessary, providers can help patients connect with that care, whether that be scheduling them for another outpatient appointment or, very rarely, supporting the patient in accessing a higher level of care via the nearest emergency room. In these rare cases, seeking emergent care is the recommended course irrespective of whether the patient received a medication abortion in-person or via telemedicine.

35. Here again, PPGOH's practices provide an example of this being done effectively in practice. For eligible patients who choose to proceed with an abortion at their telemedicine appointment, our clinicians counsel them about and patients receive written information on what to expect after taking each medication, mifepristone and misoprostol,[2] including what types of symptoms are expected (like bleeding and cramping) and what types of things would be cause for concern that should prompt them to follow up with a clinician (such as abnormally heavy bleeding

[2] Most medication abortions in the United States involve providing the patient a combination of both mifepristone and misoprostol. However, research also demonstrates the safety and effectiveness of misoprostol-only regimens.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

or high-grade fever). Patients are also counseled about symptoms that could indicate potential concern of current ectopic pregnancy (such as pain on only one side of the abdomen) and the importance of promptly seeking emergent care if they experience any of those symptoms.

36. PPGOH is also available to patients 24/7 after an abortion to answer questions or address any concerns they may have. During their appointment, patients are given a written number to call for follow up, which is included in their MyChart after-visit notes. If they forget that or are unable to access their MyChart account, they can also call any of PPGOH's locations and will be routed to PPGOH's centralized follow-up team of staff who review the patient's symptoms, answer questions, provide support and reassurance, and schedule or refer for additional care, if needed. That team receives training in follow-up screening so that they know what to look out for and when to loop a clinician, has access to clinicians they can contact with questions or concerns about which they want input, and can also always contact me via cell phone.

37. PPGOH also conducts routine follow up with medication abortion patients—whether they receive care in person or via telemedicine—approximately one week after their appointment. During these calls, centralized follow-up staff ask patients a series of questions, including when they took the medication, if they had bleeding and cramping as expected, and whether other pregnancy symptoms have begun to decline or resolve (indicating that the pregnancy has very likely passed). If any of these questions screen as potentially concerning, staff flag the patient for a clinician who then follows up with the patient and schedules an in-person appointment if needed. Staff and clinicians can also call me on my cell phone for questions or concerns. What a follow-up plan entails depends upon the specific patient and their needs and can include expectant management (continued monitoring of symptoms to see if they resolve on their own or

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

worsen), scheduling a follow-up appointment with a clinician at no additional cost, or, in rare cases, referring the patient to the nearest emergency room.

38. In addition to this one-week follow up, PPGOH follows up with patients approximately five weeks after their medication abortion appointment, which is when patients are instructed at their initial appointment to test to confirm that they are no longer pregnant using an at-home urine pregnancy test. This follow-up occurs at five weeks because the majority of patients will have a negative urine pregnancy test by that time if the medications worked as intended. At the one-week follow up, patients are counseled on what to watch for between then and the second follow up that could indicate an ongoing concern. This includes resumption of pregnancy symptoms (such as ongoing breast swelling and/or tenderness, nausea, or feeling pregnant, heavy bleeding, pain or discomfort that is worsening, fever or chills, and symptoms of acute anemia (e.g. fatigue, dizziness, and/or lightheadedness)).

39. In my experience, PPGOH's protocols for ensuring that patients receive equally high-quality care whether they are in person or seen via telemedicine are safe and effective. And, in my experience as a physician for over a decade, healthcare that meets people where they are is healthcare that is more tailored and better meets patients' needs for healthier outcomes. It is also my opinion, born out by my training and experience, that abortion providers care deeply about their patients, want to see them get the best care possible, and do not simply send patients pills and then abandon them, as Drs. Skop and Harrison try to suggest. This is another example of Drs. Skop and Harrison basing their opinions on anti-abortion tropes and stigma, not facts.

B. Medical Evidence Supports the Provision of Medication Abortion Through At Least 84 Days LMP

40. *There is no medical reason to impose the Evidence-Based Use Ban.* Based upon my training, experience, my own research, and familiarity with scientific and medical literature,

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Dr. Skop and Dr. Harrison's opinions to the contrary are not based upon current medical evidence. Both Dr. Skop and Dr. Harrison discount the best medical evidence regarding medication abortion safety and efficacy using current medication abortion protocols. Medication abortion is well-studied. Widely accepted evidence in peer reviewed journals demonstrates that it is safe and effective for patients through at least the gestational duration PPGOH offers it—84 days LMP.

41. Both Dr. Harrison and Dr. Skop seem to willfully ignore how common evidence-based medication use is within medical practice generally and try to inaccurately paint evidence-based medication abortion care as somehow aberrant from accepted medical norms. In my education, training, and experience, evidence-based use of medications (sometimes called "off-label" use) is exceedingly common in medicine and there is no medical reason to treat medication abortion differently in this respect from other medications. For example, a medication approved to treat hypertension called propranolol is used off-label for performance anxiety and methotrexate, which is approved for oncologic and rheumatologic conditions, is commonly used in the treatment of ectopic pregnancies.

42. PPGOH's practices are an example of this. PPGOH currently offers in-person medication abortion through 84 days LMP based upon evidence demonstrating the safety and effectiveness of that care. We are currently providing safe, effective care to patients who routinely express gratitude that they are able to receive it. In addition to my education, training, and familiarity with scientific and medical literature, my experience is that medication abortion is safe and effective through at least 84 days LMP and that patients appreciate and benefit from having the option to choose medication abortion through that interval.

43. In my experience, some patients strongly prefer medication over procedural abortion for a variety of reasons. This includes that some patients prefer to have a medication

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

abortion because they want to have more control over the abortion process itself. Medication abortion allows patients to choose, for example, to take the medications at home, where they are comfortable, rather than in a clinical setting, and whether to have anyone of their choosing with them when they take the medication. Others want to avoid undergoing a procedure that involves inserting instruments into the vagina. For patients who have experienced sexual assault, undergoing such a procedure can retraumatize them and cause extreme stress and anxiety. Still other patients choose a medication abortion because they want a process that feels more natural to them, or they have talked to a family member or friend who has described to them a positive experience with medication abortion and want to have a similar experience. And for patients who receive care via telemedicine, medication abortion also obviates the need for the patient to travel to access care (with all of the attendant financial, emotional, and social costs).

44. Some patients prefer medication abortion, while others have indications that make it a better medical option; and in all cases, affording patients all available, medically supported options respects and promotes patient autonomy and allows patients to choose the care that is right for them. There is no medical reason to deny these patients access to care they want and need, and which Ohio clinicians can provide. We have only been able to provide medication abortion through 84 days LMP because the Evidence-Based Use Ban is enjoined in this case. Without the injunction, PPGOH would be forced to stop providing medication abortion at 70 days LMP, despite its safety and effectiveness through at least 84 days LMP and patients' desire for that option.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

C. Dr. Skop Discounts the Experiences of Many Abortion Patients In Ohio, Which Undermines Her Opinions About the Challenged Laws

45. Dr. Skop's report also evinces a stunning lack of insight into the lived reality of many Ohio abortion patients.[3] At one point in her report Dr. Skop characterizes the barriers patients may face to care as simply "minor logistical barriers." Skop Rep. ¶ 60 ("[W]omen who remain uncertain when confronted with minor logistical barriers may pause to reconsider their decision."). In addition to being incredibly demeaning to people seeking abortion care by suggesting that they do not independently undertake decision making regarding their own medical care seriously, Dr. Skop's statement demonstrates that she does not understand the barriers abortion patients actually face when trying to access care. That lack of understanding undermines all of Dr. Skop's opinions about how important telemedicine and evidence-based access through at least 84 days LMP are for abortion access in Ohio.

46. Through my education, training, and experience, including directly serving abortion patients, and familiarity with scientific and medical literature, I know how critical abortion access is for patients. Patients' lives are complicated, their decisions to have an abortion often involve multiple considerations, and their ability to travel to an abortion provider often involves juggling responsibilities and navigating resource scarcity. Indeed, the majority of PPGOH's patients (and abortion patients nationwide) already have one or more children and may already struggle to make ends meet. The rates at which women in Ohio—and particularly women of color in Ohio—experience poverty are alarming. In 2024, approximately 13.1% of women in

[3] Dr. Harrison appears to argue that patients' experiences and preferences should not be considered *at all* given her misunderstanding of medication abortion safety, which is problematic from a medical ethics standpoint in addition to being medically inaccurate, as respecting patient autonomy and decision-making are core tenets of good clinical practice. *See* Harrison Rep. ¶ 37 ("In sum, patient safety should never be sacrificed or subordinated to considerations of convenience or for the practical challenges Plaintiffs identify, such as travel, childcare, or missed work.").

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Ohio lived in poverty,[4] exceeding the national average of 11.6%.[5] The picture for women of color in Ohio is even starker: with rates rising to 22.8% among Black women, 20.5% among Native women, and 20.4% among Latina women in Ohio, compared to 17.8%, 19.4%, and 15.2% nationally, respectively.[6] Additionally, approximately 35% of female-headed households in Ohio live in poverty, with 16.5% of children in Ohio living in poverty.[7]

47. In addition to financial challenges, patients may face personal and/or social barriers to accessing abortion care. In some cases, patients are struggling with substance use, experiencing poverty, are presently unhoused, and/or have an abusive partner—all of which make traveling to an abortion clinic much more difficult, if not impossible. And some patients take longer to make a decision because they want time to consider their options and/or consult their partner, family, friends, clergy, and/or others in deciding to have an abortion. And even after patients learn that they are pregnant and decide they want an abortion, arranging an appointment for an abortion may take some time.

48. My experience working with abortion patients in Ohio underscores this. In my time working at PPGOH—first as a staff physician and now as CMO—I have seen that being able to receive care via telemedicine reduces burdens on PPGOH's patients logistically, financially, and emotionally. Not needing to travel to a clinic saves patients the financial and logistical burdens associated with travel, which include the need to take time off of school or work and lose wages (since most of PPGOH's patients are not salaried employees and Ohio does not have universal

[4] National Women's Law Center, *Women in Poverty, State by State* (Sept. 24, 2025), https://nwlc.org/resource/women-in-poverty-state-by-state/ (accessed June 2, 2026).
[5] United States Census Bureau, *Poverty in the United States: 2024* (2025), https://www2.census.gov/library/publications/2025/demo/p60-287.pdf (accessed June 2, 2026).
[6] National Women's Law Center, *supra* note 4.
[7] *Id.*

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

paid medical leave), to arrange childcare, and to pay for travel. We are only able to offer TMAB because of the injunction in this case.

49. Providing medication abortion via telemedicine also helps patients avoid upsetting and potentially traumatic experiences with anti-abortion protestors who congregate outside of abortion clinics. I have seen this in practice at PPGOH's clinics. While protestors are not present every day, it is something we let patients know that they may experience when coming to a clinic in person because we never know if there will be protestors outside or how many. When I see patients in person on days where protestors are at the clinic—whether that be one protestor or many—I notice a difference in patients' demeanor and the types of questions they ask me. Patients are often visibly stressed and upset; some are crying. Some have had direct interactions with protestors who try to give the impression that they are PPGOH employees in order to get patients to stop and speak to them. During visits on days that protestors are present, patients often ask me questions that in my opinion reflect misinformation they have heard from protestors because they are not questions I commonly receive on days protestors are not present—such as questions about inaccurate claims that abortion negatively impacts future fertility (it does not) or about inaccurate and/or misleading statements about embryonic or fetal development (often things designed to personify the pregnancy and shame the patient). Patients also sometimes come in with pamphlets protestors have given them, which I have observed to include inaccurate and misleading information about gestational development and abortion, graphic photos, and shaming statements about the choice to have an abortion.

50. If the Telemedicine Ban were to go back into effect, we would be forced to stop offering telemedicine as an option for medication abortion despite its safety, effectiveness, and benefits to patients, and despite many patients' strong preference to receive care via telemedicine.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

51. All of the financial, logistical, and social barriers to accessing care I have described help explain why being able to access medication abortion via telemedicine, and through at least 84 days LMP, is so important to health care access and justice in Ohio. Dr. Skop's inability to see and properly account for this undermines the opinions she offers on both topics.

D. Dr. Skop's Opinions About APC Abortion Provision Are Inaccurate

1. APCs Do Not Need To Be Able to Personally Provide Procedural Aspirations In Order to Safely and Effectively Provide Medication Abortion

52. *There is no medical reason to impose the APC Ban.* Dr. Skop's opinions that the APC Ban advances patient health are medically unfounded. Dr. Skop offers unpersuasive opinions about the provision of medication abortion by APCs that are grounded in inaccurate facts about abortion follow-up care and properly-trained APCs' skill and possible scope of practice. For example, she argues that APCs should not be able to provide medication abortion care in Ohio since they cannot provide procedural aspiration in Ohio if a medication abortion fails. Skop Rep. ¶ 123.

53. First, Dr. Skop overstates the risk of incomplete abortion and continuing pregnancy—including by relying upon research looking at outdated regimens that only included one dose of misoprostol rather than current regimens abortion providers use, which increase misoprostol doses as gestational duration increases. *See, e.g. Id.* ¶ 58, fn. 63 (citing two studies that involved medication abortion regimens of mifepristone and a single misoprostol dose).[8] In my

[8] Dr. Harrison makes the same error. For example, her report includes extended discussion and a screenshot of Table 4 of the FDA label for Mifeprex—the name brand for mifepristone—without disclosing that the studies summarized on the label looked at a medication abortion regimen of mifepristone and a single dose of misoprostol no matter how many days LMP the pregnancy was when the medication abortion occurred. *See* Harrison Rep. ¶ 17; *see also* Food & Drug Administration, Mifeprex Label at 12, https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf (accessed June 4, 2026) (introducing Tables 3 and 4, and describing medication abortion regimen of included studies, stating: "Safety and efficacy data from clinical

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

experience and familiarity with abortion providers' practices, providing additional doses of misoprostol based upon research showing that doing so increases efficacy is now a common practice. For example, PPGOH's protocols call for increasing the number of doses of misoprostol patients receive as they get further into pregnancy, and our experience is consistent with research showing that this is a safe, effective practice.

54. Dr. Skop next offers the incorrect premise that a procedural abortion is "needed" in every case where the initially prescribed doses of mifepristone and misoprostol fail to complete an abortion. *See id.* This is inaccurate. Patients may have a number of options depending upon their individual circumstances and whether the pregnancy remains ongoing (a failed abortion) or whether the pregnancy terminated but the patient has not yet expelled all of the pregnancy tissue (an incomplete abortion). These options can include expectant management, taking additional medication, or having an aspiration procedure.

55. Second, Dr. Skop makes notably conflicting statements about APCs and medication abortion provision—on the one hand portraying APCs as low-skill providers, and on the other claiming that "no particular skill is needed" to provide medication abortion. *See, e.g.*, Skop Rep. ¶ 129. In reality, APCs are highly trained and skilled medical professionals who are qualified to provide a wide range of medical care, including medication abortion.

56. Research demonstrates that APCs can provide medication abortion just as safely as physicians. *See, e.g.* ACOG, *Issue Brief: Advanced Practice Clinicians and Abortion Care Provision* (Oct. 2023), https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/issue-briefs/advanced-practice-clinicians-and-abortion-careprovision.pdf?rev=ed4c1757442c4b3f8947154ae5627f6c&hash=15EC3922D4D0609D9162C1A4F1D6831D (accessed June 4, 2026);

studies of mifepristone 200 mg orally followed 24-48 hours later by misoprostol 800 mcg buccally through 70 days gestation are reported below.").

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Lauren Porsch et al., *Advanced Practice Clinicians and Medication Abortion Safety: A 10-Year Retrospective Review*, 101 Contraception 357 (2020). In fact, APCs can provide more complex gynecological care than medication abortion in Ohio and elsewhere, including cervical cancer screening and management, well-women exams, menopause care, IUD insertion and removal, and treating and managing chronic conditions such as endometriosis and Polyendocrine Metabolic Ovarian Syndrome (PMOS). And my experience, including training and working with APCs providing medication abortion care at PPGOH since the APC Ban was enjoined, aligns with and reinforces that APCs can safely and effectively provide medication abortion.

57. For example, PPGOH currently has 6 APCs providing medication abortion care at our Athens and Mansfield locations and via telemedicine, all of them have graduate degrees and, as with any care they provide, they receive any additional training necessary to ensure that they have the skills necessary to safely and effectively provide medication abortion. Any APC that provides medication abortions at a PPGOH clinic falls under my supervision and works with both myself and other physicians who provide abortion care at PPGOH clinics. PPGOH also ensures that APCs are trained and qualified in each type of care they provide, and have demonstrated their ability to competently provide it, before they are allowed to provide that care to patients. We also audit APC charts on a regular basis to ensure ongoing quality of care and provide feedback if needed. This includes APCs who provide medication abortion. Since APCs started providing medication abortion care at PPGOH, my observations have been consistent with the medical evidence demonstrating that APCs can safely and effectively provide medication abortion to patients and that patients appreciate and benefit from the option to receive care from an APC at a clinic closer to where they live. This travel burden reduction can be significant for patients, as

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

PPGOH's Athens and Mansfield locations are both over an hour away from the next closest provider (and far longer for patients who rely on public transportation).

58. At PPGOH, APCs are trained in and provide most methods of contraception, sexually transmitted infection testing and treatment, pre-exposure prophylaxis for HIV, cervical cancer screening, breast cancer screening including exams, gender-affirming hormone care, and primary care. Much of this care is both more technically complex and involves more challenging care assessments and patient counseling than providing medication abortion. In contrast to some of the other care APCs already provide in Ohio, medication abortion is generally comparatively straightforward. At PPGOH, I and other physicians are available to consult on any questions PPGOH APCs have before or during a visit and to assist with any follow up care a patient may need. PPGOH's protocols for training advanced practice clinicians to provide medication abortion are effective, as is PPGOH's supervision of their provision of medication abortion. Allowing APCs to provide medication abortion has increased PPGOH's ability to provide patients with care that meets them where they are. PPGOH's experience also comports with my understanding that APCs being able to provide safe and effective medication abortion care has likewise increased access to care elsewhere.

59. Third, Dr. Skop incorrectly suggests that APCs should not be able to provide medication abortion if they cannot also provide procedural aspiration care if needed after an abortion. This is incorrect and ignores the fact that anyone who provides medication abortion is required to be a certified prescriber for mifepristone, which means that they must either be able to provide aspiration care if needed or refer to someone who can. *See* FDA, *NDA 020687 MIFEPREX Risk Evaluation and Mitigation Strategy (REMS)* (last modified Mar. 2016), https://www.fda.gov/media/164649/download); *see also* Skop Rep. ¶ 122 ("[T]he FDA still

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

requires mifepristone prescribers to have the 'ability to intervene surgically if needed (*or have an arrangement with a provider* who could perform that intervention)[']") (emphasis added). Since the Risk Evaluation and Mitigation Strategy ("REMS")—requirements placed on mifepristone by the Food and Drug Administration—are a universal requirement for clinicians prescribing mifepristone, the same is true for all Ohio APCs who prescribe mifepristone as part of medication abortion care. At PPGOH, if a patient who receives a medication abortion from an APC later requires procedural care, I or another physician can provide that care. Dr. Skop's arguments also do not consider the fact that Ohio law also requires that all APCs practice under a collaborative agreement with a physician practicing in the same or similar specialty to the clinician. *See, e.g.*, R.C. 4723.431 and Adm.Code 4723-8-04 (Advanced Practice Registered Nurses); R.C. 4730.19 (Physician's Assistants).

60. Allowing Ohio APCs to provide medication abortion benefits Ohio patients by expanding the number of providers in the state. Being able to have APCs provide medication abortion care has allowed PPGOH to offer more appointments than we would otherwise be able to, including at more physical locations and via telehealth. This expanded capacity is immensely valuable, especially given how challenging it can be to find physicians willing to provide abortions in Ohio.

61. We have only been able to offer APC-provided care because the APC Ban is enjoined in this case. If the injunction were to be lifted, PPGOH would be forced to revert to only offering abortion care at our two locations in Columbus and Bedford Heights where we have staff physicians. Even if the Telemedicine Ban were to remain enjoined, losing the ability to have APCs provide medication abortion would significantly undermine people's ability to access abortion in Ohio, including their ability to access abortion via telehealth, given the limited number of

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

physicians available and the fact that those physicians would then also need to serve all of PPGOH's patients seeking procedural abortions as well as in-person medication abortions.

2. PPGOH Physician Recruiting Challenges

62. Dr. Skop also makes inaccurate statements about abortion providers' motivations and why more physicians do not choose to provide abortion care. Skop Rep. ¶¶ 124–25. These statements are ill-informed and reflect anti-abortion tropes and bias, not facts. She claims that the shortage of physicians who provide abortions is because most physicians believe that abortion is unethical or immoral and further argues that abortion providers are, essentially, motivated only by profit. Both of these unsupported propositions, in my opinion, demonstrate Dr. Skop's lack of understanding about abortion providers and abortion provision, and betray the degree to which bias against abortion and abortion providers animates her opinions. In making this claim, Dr. Skop misunderstands both the reasons people choose to become abortion providers and the reasons people choose not to.

63. In my experience, physicians choose to provide abortion care because we care deeply about our patients and we want to help them live full, healthy lives. I personally chose to dedicate my life's work to ensuring people have access to abortion care because of how meaningful it is to me to help people lead the lives they choose. Knowing that if people are more able to choose if and when they are pregnant, and if and when they parent a child, it leads to healthier pregnancies, parents, and children motivates me. Access to abortion care is critical for people to be able to lead healthy lives, and build healthy families and communities. As a physician who provides abortion care, profit is not something I am concerned about or that motivates me, and I have never heard anyone at PPGOH talk about profit as a motivation for expanding care and access. And, of course, PPGOH is a nonprofit organization. We work to increase abortion access because we care about

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meeting our patients where they are and providing them with the essential health care they want and deserve, and to which they have a constitutional right in Ohio.

64. Based upon my experience, including currently recruiting and supervising physicians who provide abortions at PPGOH, I am also familiar with some of the reasons people choose not to provide abortion care. Choosing to provide this essential health care means accepting a level of harassment, threats, and risk of physical violence in one's life that many physicians understandably find intolerable for themselves and their families. A report by the National Abortion Federation underscores this. It states that, in 2025, abortion providers reported 81 incidents of death threats or threats of harm, 23 incidents of assault and battery, 40 incidents of stalking, and 4 incidents of arson. *See* National Abortion Federation., *NAF 2025 Violence & Disruption Report*, https://nationalabortionfederation.org/safety-security/2025-naf-violence-disruption/ (accessed June 1, 2026). Many people are simply unwilling to work in a building that could be firebombed.

65. The threat of this type of violence is far from speculative. Only last month, someone broke into a clinic in Ohio operated by Planned Parenthood Southwest Ohio Region ("PPSWO") and ignited a fire inside that caused significant damage. Matthew Cupelli, *Fire at Mount Auburn Planned Parenthood Started by Intruder, CEO Says* (Apr. 10, 2026), https://www.cincinnati.com/story/news/local/2026/04/10/officials-investigating-after-planned-parenthood-caught-fire-overnight/89547920007/ (accessed June 2, 2026); Cameron Knight, *'We Will Not Give Up.' Planned Parenthood Fire Investigated as Arson* (Apr. 14, 2026), https://www.cincinnati.com/story/news/crime/2026/04/14/planned-parenthood-fire-at-cincinnati-ohio-clinic-investigated-as-arson/89590446007/ (accessed June 2, 2026). To my knowledge, that person has not been arrested. As PPSWO CEO Nan Whaley said during a press conference at the

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time: “This is the reality for abortion providers. It is both frightening and infuriating. Extremists are emboldened by baseless attacks and harmful rhetoric on abortion and access to sexual and reproductive health care.” Danielle Dindak, *Leaders Say Fire at Planned Parenthood was Deliberate: ‘Frightening and Infuriating’* (Apr. 14, 2026), https://www.wlwt.com/article/cincinnati-planned-parenthood-fire-update-mayor-pureval-greg-landsman/71011690 (accessed June 2, 2026).

III. CONCLUSION

66. The Telemedicine Ban, Evidence-Based Use Ban, and APC Ban all restrict medication abortion access in Ohio for no medical reason. Each undermines PPGOH’s—and other Ohio abortion providers’—ability to provide our patients with safe, effective, evidence-based care that meets patients where they are and respects their autonomy and dignity. This deprives Ohioans of the ability to access abortion care in Ohio and undermines individual providers’ ability to assist patients in accessing that care.

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EXHIBIT B

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Bhavik Kumar, MD, MPH

EDUCATION & WORK EXPERIENCE

07/2024	**Planned Parenthood Greater Ohio, Chief Medical Officer**
01/2024-05/2024	**Trust Women, staff physician** Wichita, KS
04/2023-07/2024	**Planned Parenthood Greater Ohio, staff physician** Cleveland, OH
04/2022-01/2025	**Plume, staff physician** Telehealth in TX, LA, OH, FL
11/2021 – 03/2022	**Women's Health Care Center, staff physician** New Orleans, LA
12/2018 – 09/2025	**Planned Parenthood Gulf Coast, Medical Director** Houston, TX, New Orleans and Baton Rouge, LA
12/2018-12/2023	**Planned Parenthood CARE, staff physician** Houston, TX
08/2016 - 10/2018	**Whole Woman's Health, Texas Medical Director** Austin, San Antonio, Fort Worth, & McAllen
03/2015 - 08/2016	**Whole Woman's Health, Staff physician** Fort Worth & San Antonio
08/2013 - 07/2015	**Fellowship in Family Planning, Family Medicine** Albert Einstein College of Medicine, Bronx, NY
08/2013 - 07/2015	**Masters in Public Health, Department of Population & Family Health** Joseph L. Mailman School of Public Health at Columbia University, New York, NY
07/2010 - 06/2013	**Residency Program in Family & Social Medicine** Montefiore Medical Center, Bronx, NY
08/2006 - 06/2010	**Doctor of Medicine** Texas Tech University, School of Medicine, Lubbock, TX
08/2002 - 05/2006	**Bachelor of Science, Chemistry w/ Biology minor, cum laude** Southwestern University, Georgetown, TX

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RESEARCH

2025 R. Patil, D. Dethier, M. Fleming et al. (in press) "**Society of Family Planning Committee Statement: Telemedicine in family planning care part 1 – Background and overarching principles**". *Contraception*. 2025;

2025 R. Patil, D. Dethier, M. Fleming et al. (in press). "**Society of Family Planning Clinical Recommendation: Telemedicine in family planning care part 2 – Contraception**". *Contraception*. 2025;

2024 Whitfield B, Sierra G, Lerma K, Goyal V, Thaxton L, **Kumar B,** et al. "**Abortion Return Rates and Wait Times Before and After Texas' Executive Order Banning Abortion During COVID-19**". *AJPH.* 2024;114(10):1013-1023.

2024 Sanchez G, Hasmi SS, Bednar E, Horvath S, **Kumar B**, et al. "**Status of Abortion Curriculum in Genetic Counseling: Survey of Graduate Programs and Recent Graduates in the United States"**. *Journal of Genetic Counseling*. 2024;00,1-11.

2023 Chatillon A, Vizcarra E, **Kumar B,** et al. "**Access to care following Planned Parenthood's termindation from Texas' Medicaid network: A qualitative study**". *Contraception.* 2023;128:110141.

2023 White K, Leyser-Whalen O, Whitfield B, Dane'el A, Andrea A, Rupani A, **Kumar B,** Moayedi G. "**Abortion assistance fund staff and volunteers as patient navigators following an abortion ban in Texas**". *Perspect Sex Reprod Health*. 2023;25:10.1363.

2023 Harris LH, Perritt J, Kumar B. "**Medical Society Responses to State Abortion Bans – No Role for Boycotts".** *JAMA Intern Med.* 2023;183(4):285-6.

2023 Warling A, Treder KM, Brandi K, Kumar B, Fay KE. "**An Ecological Model of Reproductive Coercion**". *J Midwifery Womens Health*. 2023;68(6):697-701.

2022 Cleland K, **Kumar B,** Kakkad N, et al. "**Now is the Time to Safeguard Access to Emergency Contraception as Abortion Restrictions Sweep the United States**". *Contraception.* 2022;114:6-9.

2021 White K, Kumar B, Goyal V, et al. "**Changes in Abortion in Texas Following an Executive Order Ban During the Coronavirus Pandemic**". *JAMA.* 2021;325(7):691–693.

2020 Goyal V, Brooks I, Wallace R, Dermish A, Kumar B, et al. "**Medication Abortion Use Among Low-Income and Rural Texans Before and During State-Imposed Restrictions and After FDA-Updated Labeling."** *AJOG.* 2020 Aug;223(2):236e1-236e8.

2020 Goyal V, Wallace R, Dermish A, Kumar B, et al. "**Factors associated with abortion at 12 or more weeks gestation after implementation of a restrictive Texas law."** *Contraception*. 2020 Nov;102(5):314-317.

2013-2016 **Department of Family and Social Medicine, Albert Einstein COM**

- Future of Family Planning in Texas: Are Family Physicians Ready?

2011-2013 **Department of Family and Social Medicine, Montefiore Medical Center, Bronx, NY**

- Improving the Clinical Experience for Gay and Lesbian Patients at the FHC

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PROFESSIONAL MEMBERSHIPS

National Abortion Federation (NAF)

C. Lalor Burdick award, 2016

Clinical Abortion Staffing Solution

Advisory Member, 2023-current

Society of Family Planning (SFP)

Board member, 2023 – current

Board Chair-Elect, 2026

Physicians for Reproductive Health (PRH)

Leadership Training Academy (LTA), 2014-2015

Board member, 2017-2023

Tiller Advocacy Award, 2023

American Academy of Family Physicians (AAFP)

Texas Academy of Family Physicians (TAFP)

National Abortion and Reproductive Rights Action League (NARAL)

Fighting Spirit award, Texas chapter, 2017

ACADEMIC PRESENTATIONS

Brandi K, **Kumar B**, Thompson I. *The Irvin M. Cushner memorial lecture: Impact of legislative changes on access to abortion*. ACOG 2021, San Diego, CA.

Beck A, **Kumar B**, Mariappuram R. *Protecting young people's access to abortion care*. NAF 2021, virtual, live-session.

Gold M, Villavicencio J, Wang LF, and **Kumar B**. *Enhancing conversations about abortion in family medicine teaching settings: evidence-based communication strategies*. STFM 2021, virtual, recorded.

CERCL-FP. *Intersectional mentoring advances and inclusion practices in family planning*. SFP 2020, virtual, live-session.

Akle A, Labgold K, Lingwall M, White K, **Kumar B**, Leyser-Whalen O, & Njoku O. *Abortion funds and research: Building collaborations that support service delivery and advocacy.* SFP 2020, virtual, recorded session.

Kumar B, Williams S, Julian Z. *Moving forward: finding resiliency as providers of color*. MSFC 2019, Denver, CO.

Horvath S, **Kumar B**, Jacobson J. *Physicians as advocates*. MSFC 2019, Denver, CO.

Bauman DV, Bednarek P, France C, and **Kumar B.** *Stump the abortion trainer! Have experts brainstorm solutions to your training challenges.* NAF 2018, Seattle, WA.

Kumar B, Wallace R, Carr S, Yanow S, and Prine L. *Traveling to provide abortion care in restricted settings: lessons learned, things to consider, and fulfilling the need.* NAF 2017, Montreal, Canada.

Dehlendorf C, Fuentes L, Kerns J, Wallace R, and **Kumar B**. *Prioritizing preferences in reproductive health care: the role of shared decision making*. NAFFP 2015, Chicago, IL.

Kumar B, Paul A, Shields S, Roder N, and Gold M. *Using patient-centered language during genitourinary (GU) exams.* FMEC 2015, Danvers, MA.

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Kumar B, Blank AE, and Gold M. *The Future of Family Planning in Texas: Are Family Physicians Ready?* NAPCRG 2015, Cancun, Q.R.

Kumar B, Rosenstein H, Schonberg D, Stein T, and Gold M. *Providing contraception for our patients: an update on practice guidelines and evidence.* Grand Rounds, Montefiore Medical Center, Department of Family and Social Medicine 2015, Bronx, NY.

Kumar B. *The future of family planning in Texas: are family physicians ready?* Fellowship in Family Planning Annual Meeting 2015, San Francisco, CA.

Kumar B, Wilder V, and Prine L. *Breaking down barriers: exploring barriers in contraception care*. STFM 2015, Orlando, FL.

Amico J, **Kumar B**, Rosenstein H, Bennett A, Schonberg D, Stein T, and Gold M. *"I just can't be pregnant right now: providing patient-centered abortion care in the family medicine setting*. Grand Rounds, Montefiore Medical Center, Department of Family and Social Medicine 2015, Bronx, NY.

Amico J, **Kumar B,** Rosenstein H, Bennett A, and Gold M. *Understanding early aspiration abortion in the family medicine setting.* FMEC 2014, Washington, DC.

Kumar B, Wilder V, Bromfield G, and Prine L. *Breaking down barriers: exploring health disparities in contraception care*. FMEC 2014, Washington, DC.

Kumar B, Parker W, Prine L, and Wilder V. *Racial and ethnic disparities in contraceptive care.* ARHP 2014, Charlotte, NC.

Kumar B and Schonberg D. *Postpartum contraception*. STFM 2014, San Antonio, TX.

Bromfield G, Wilder V, **Kumar B**, Prine LW, and Gold M. *Breaking down barriers: exploring health disparities in contraception care*. STFM 2014, San Antonio, TX.

Kumar B. *The future of family planning in Texas: are family physicians ready?* Fellowship in Family Planning Annual Meeting 2014, Chicago, IL.

Schubert F, Harbatkin D, **Kumar B**, McNicholas C, and Porsch L. *LGBTQ people and abortion care.* National Abortion Federation 2014, San Francisco, CA.

Kumar B and Gold M. *Reproductive rights and abortion care.* Albert Einstein Social Medicine Lecture Series 2014, Bronx, NY.

Schubert F, Summitt A, **Kumar B**, and Gold M. *Full access to reproductive healthcare under the ACA: educating learners to eliminate barriers to care*. FMEC 2013, Philadelphia, PA.

Kumar B, Amico J and Gold M. *Enhancing postpartum contraception*. FMEC 2013, Philadelphia, PA.

Kumar B. *Past, present, and future of abortion in America*. Social Medicine Grand Rounds, Montefiore Medical Center, Department of Family and Social Medicine 2013, Bronx, NY.

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EXHIBIT 8

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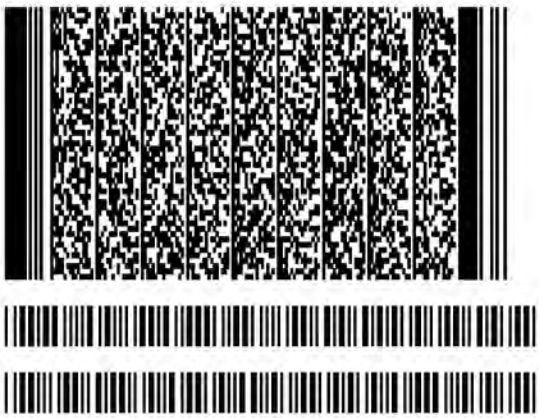
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tess.sabo@gmail.com
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IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A 2101148 Judge Alison Hatheway

AFFIDAVIT OF W.M. MARTIN HASKELL, M.D., IN SUPPORT OF PLAINTIFFS' SECOND MOTION FOR PRELIMINARY INJUNCTION

I, W.M. Martin Haskell, M.D., having been duly sworn and cautioned according to law, hereby state that I am over the age of eighteen years and am competent to testify as to the facts set forth below based on my personal knowledge:

1. I am the sole shareholder and Medical Director of Women's Med Group Professional Corporation ("WMGPC"), which has owned and operated Women's Med Dayton ("WMD") in Kettering, Ohio since 1983. WMGPC was formerly Women's Medical Professional Corporation. WMGPC and its predecessor organizations have provided safe and compassionate reproductive health care in Ohio since 1973.

2. I am a physician with nearly 50 years' experience in women's health. I have been a licensed physician in the state of Ohio since 1974.

3. I earned a B.A. from Ohio Wesleyan University in 1968 and a Doctorate of Medicine from the University of Alabama in 1972. I completed five and one-half years of postgraduate residency training in anesthesia, general surgery, and family practice. I passed my Board exam in family medicine in 1978. I also personally provided abortion care in an outpatient setting from 1978 until 2019.

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Page 1 of 8

4. As owner of WMGPC, I supervise and manage the provision of all abortion care at WMGPC facilities and am responsible for developing and approving WMGPC's policies and procedures. I have also served as the Medical Director of WMD since 1983. As Medical Director of WMD, I supervise physicians and clinicians and oversee the clinic's daily operations, business matters, and compliance with all applicable laws and regulations.

5. I submit this affidavit in support of Plaintiffs' Second Motion for a Preliminary Injunction to block the enforcement of the following abortion restrictions: (1) the Advanced Practice Clinician ("APC") Ban [R.C. 2317.56(B), 2919.123, 4723.44(B)(6), 4723.50(B)(1), 4723.151(C), 4730.02(E), 4730.03(F), 4730.39(B)(2), and 4730.42(A)(1), and Ohio Admin. Code 4723-9-10(K) and 4730-2-07(E)], and (2) the Evidence-Based Use Ban [R.C. 2919.123]. I am familiar with these laws because I have complied with them in my practice and ensure that the physicians, clinicians, and other staff that I supervise at WMD comply with them as well.

6. I understand that these laws interfere with the ability of Plaintiffs to provide and patients to access medication abortion in Ohio by: (1) restricting qualified and skilled advanced practice clinicians from providing abortion care, including medication abortions,, regardless of their education, training, and experience (the APC Ban) and (2) prohibiting abortion providers from prescribing mifepristone for abortion in any way that differs from the express terms of the FDA's mifepristone approval letter and mifepristone's final printed labeling ("FPL"), a practice commonly known as "off-label" use (the Evidenced-Based Use Ban). I understand that violation of these requirements may carry criminal, civil, and/or disciplinary penalties.

7. It is my opinion that these laws, separately and together, restrict access to medication abortion care, are not medically justified, and do not advance patients' health. To the contrary, these laws impede and delay timely access to abortion, impose medical, logistical,

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Page 2 of 8
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financial, emotional and other burdens on abortion patients, and restrict the ability of health care providers to assist patients in exercising their right to abortion, thereby risking harm to patient health and well-being.

8. The facts I state here are based on my experience, information obtained in the course of my duties at WMD, review of WMD business records, and personal knowledge that I have acquired through my service at WMD and my familiarity with medical practice in general and the relevant medical literature and research. If called and sworn as a witness, I could and would testify competently thereto.

Abortion Care at WMD

9. WMD provides an array of reproductive health care, including pregnancy testing, birth control, and abortion care. WMD is an ambulatory surgical facility ("ASF") under Ohio law. WMD is the only abortion provider in the Dayton, Ohio area, and one of only 9 clinics providing abortion care in the state.

10. WMD currently contracts with two physicians who staff the clinic during the 5 days a week it is open, with at least one physician in the facility every day we are open and serving patients. WMD currently does not employ any advanced practice clinicians.

11. WMD provides medication abortion up to 70 days (10 weeks) LMP, the current legal limit for medication abortion under the Evidence-Based Use Ban.

12. WMD serves a diverse patient population. Approximately 50% of our patients are poor or low income and receive some sort of private funding assistance to pay for abortion care at WMD.

13. Our patients seek abortion for a wide variety of deeply personal reasons. For example, some patients seek abortion because they have concluded that they are unable to become

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Page 3 of 8
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a parent for the first time or add another child to their family due to their age, education or work responsibilities, existing caretaking obligations, or a lack of financial resources or emotional support. Some patients do not want to become parents at all. Some patients make the decision to terminate their wanted pregnancy because of pregnancy complications that endanger their health or life or because of a diagnosis of a fetal anomaly. Other patients decide to have an abortion because they are experiencing intimate partner violence and feel that they do not want to be bound to their abusive partner or bring a child into an unsafe environment. There are also patients who seek abortion care because their pregnancy is the result of rape or incest.

The Ban on Advanced Practice Clinicians and Its Impact on WMD and Its Patients

14. It is my understanding that Ohio law prohibits anyone who is not a physician from providing abortion care, including medication abortion care, in the state.

15. What this means is that, despite their experience, training and capabilities, APCs are unable to provide medication abortion to patients in Ohio. This is so even though, as I understand it, APCs have a broad scope of practice that encompasses the provision of near identical care, including the prescription of the same drugs used in medication abortion for miscarriage management.

16. From a qualification and safety perspective there is no reason why APCs should be unable to provide the informed consent discussion or provision of care in regards to medication abortion.

17. But for the APC Ban, WMD would seek to hire and train APCs—including nurse practitioners ("NPs"), certified nurse midwives ("CNMs"), and/or physician assistants ("PAs")—to provide medication abortions. Doing so would enable WMD to increase the number of available abortion appointments and the number of locations from which medication abortion

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Page 4 of 8
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is available. Indeed, if WMD were able to hire and train APCs to provide medication abortion, I would seek to open up a new, second health center located in the greater Cincinnati area, and would hire and train APCs to provide medication abortion there, in order to increase access to medication abortion for patients in a region of the state that is facing an ever growing influx of out-of-state patients seeking care.

18. The APC Ban interferes with and burdens our patients' access to abortion because it subjects medication abortion patients to unnecessary delays in accessing care that increase risks to their health, and it adds to the financial and logistical barriers already associated with obtaining an abortion. As a result of the APC Ban, the number of available abortion providers in the state is unnecessarily limited, meaning that patients have to wait longer and potentially travel farther distances in order to obtain abortion care. If APCs were instead permitted to provide medication abortion in accordance with their training and scope of practice, the pool of available providers could be increased, and, with it, the number of appointments available to patients, as well as the number of geographic locations from which patients could obtain medication abortion. APC provision of medication abortion would also serve to free up physician providers to accommodate more patients seeking procedural abortions sooner. All of this would minimize delays in accessing abortion care, which only harm patient health and well-being,[1] and reduce the financial and logistical obstacles patients face when needing to travel to access care.

19. The APC Ban also interferes with and obstructs WMD's provision of assistance to Ohioans seeking to access abortion. As noted above, there are currently only two physicians who contract with WMD and must provide for the increasing number of patients seeking both medication and procedural abortion care at our health center. But for the APC Ban, we would seek to hire and train APCs to provide medication abortion care, which (as also noted above)

[1] While abortion is always very safe, the risks associated with it increase as pregnancy progresses.

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Page 5 of 8
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would increase our capacity to provide timely, accessible abortion care for all our patients. This would enable both our medication abortion patients and our procedural abortion patients to be seen sooner, reducing delay and its associated harms to patient health and well-being,

The Evidence-Based Use Ban and Its Impact on WMD and Its Patients

20. It is my understanding that the Evidence-Based Use Ban prohibits WMD abortion care providers from prescribing mifepristone for abortion care in any way that departs from the FPL for mifepristone; in other words, it prohibits evidenced-based, "off-label" prescription of mifepristone for abortion.

21. Off-label use of medications pursuant to evidence-based protocols is an essential part of medical practice. In fact, it is common for new uses or dosing regimens to be widespread and well-accepted long before they are reflected in the labeling. Off-label protocols are supported by evidence-based medical practices and providers' exercise of their professional judgment in caring for their patients.

22. Indeed, even mifepristone is routinely prescribed off-label in Ohio outside of the abortion context. Health care providers in Ohio, including those at WMD, are legally permitted to prescribe mifepristone for other non-abortion purposes, including miscarriage management, according to evidence-based, off-label protocols. It is only when it comes to the use of mifepristone for abortion care that providers in Ohio are restricted to prescribing based on an out-dated label that does not comport with the most current, evidenced-based practices.

23. Indeed, research shows that a regimen of mifepristone and misoprostol is safe and effective beyond 70 days LMP, through at least 77 days LMP.[2] Nevertheless the Evidence-Based

[2] *See, e.g.*, Ilana G. Dzuba et al., A Repeat Dose of Misoprostol 800 mcg Following Mifepristone for Outpatient Medical Abortion at 64–70 and 71–77 Days of Gestation: A Retrospective Chart Review, 102 Contraception 104, 104, 106 (2020); Nathalie Kapp et al., Medical Abortion in the Late First Trimester: A Systematic Review, 99 Contraception 77, 77–86 (2019).

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Page 6 of 8 Modification A2

Use Ban precludes providers from prescribing mifepristone for abortion care to patients who are beyond 70 days LMP, even when they are still at a point in pregnancy where extensive medical evidence and widespread practice shows they can safely and effectively undergo a medication abortion. This unnecessarily restricts our patients' ability to obtain their preferred or medically indicated method of abortion.

24. There are patients for whom an evidence-based, off-label mifepristone regimen—including a regimen that allows for use of mifepristone and misoprostol to end a pregnancy after 70 days LMP—is the safest and most effective way to end a pregnancy. This includes patients who are survivors of partner or sexual violence, for whom inserting objects into the vagina may be painful or traumatizing, as well as patients for whom procedural abortion may be contraindicated, such as those with uterine fibroids that significantly distort the cervical canal.[3]

25. If these patients are unable to obtain a medication abortion as a result of the Evidence-Based Use Ban's unnecessary 70 day LMP limit, they will be forced to either undergo an undesired procedural abortion, which may be medically contraindicated; travel out of state to attempt to access medication abortion (and incur related physical and financial costs associated with delayed care and travel); seek medication abortion outside the medical system, at potential risk to their health; or carry to term and give birth.

26. The Evidence-Based Use Ban does not advance patient health, and, in fact, harms patients by unnecessarily restricting their access to medication abortion, potentially delaying their receipt of care, and limiting providers' discretion to use the most appropriate, evidenced-based and safest medical treatments for their patients.

[3] ACOG, Medication Abortion Up to 70 Days Gestation, Practice Bulletin, N 225, October 2020. https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/10/medication-abortion-up-to-70-days-of-gestation

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E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION
Page 7 of 8
www.docverify.com

27. But for the Evidence-Based Use Ban, WMD's providers would prescribe mifepristone for the termination of pregnancies consistent with the best available medical evidence, including through at least 77 days LMP.

FURTHER AFFIANT SAYETH NAUGHT.

Executed on [05/08/2024], 2024.

Martin Haskell

W.M. Martin Haskell, M.D.

Sworn and subscribed before me in Franklin County, Ohio, this [05/08/2024] day of [ ], 2024.

Notary Public

Theresa M Sabo
Commission # 2016-RE-619622
Electronic Notary Public
State of Ohio
My Comm Exp. Nov 28, 2026

Notarial act performed by audio-visual communication

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EXHIBIT 9

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A 2101148 Judge Alison Hatheway

AFFIDAVIT OF SHARON LINER, M.D., IN SUPPORT OF PLAINTIFFS' SECOND MOTION FOR A PRELIMINARY INJUNCTION

I, Sharon Liner, M.D., being duly sworn on oath, do depose and state as follows:

1. I previously submitted an affidavit on March 30, 2021, in support of Plaintiffs' Motion for a Temporary Restraining Order Followed by Preliminary Injunction [hereinafter "Aff."]. I also prepared an expert report pursuant to Ohio Rule of Civil Procedure 26, dated April 28, 2022, which I understand has been disclosed to the then-defendants in this case.

2. I have reviewed both documents in preparing this expert affidavit. Except as noted below, the facts outlined in my prior affidavit and my expert report have not changed. I continue to rely upon the unchanged facts as supplemented by the additional facts discussed below.

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

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

4. As the Medical Director, I supervise all PPSWO clinicians, including physicians and advanced practice clinicians ("APCs"). PPSWO currently employs nurse practitioners ("NPs") and certified nurse midwives ("CNMs"), two types of APCs. I understand that R.C. 2317.56(B), 2919.123, 4723.44(B)(6), 4723.50(B)(1), 4723.151(C), 4730.02(E), 4730.03(F), 4730.39(B)(2), 4730.42(A)(1) and Ohio Adm.Code 4723-9-10(K) and 4730-2-07(E) (collectively, the "APC Ban") make it unlawful for advanced practice clinicians to provide abortion, including medication abortion, regardless of their education, training, and experience.

5. By prohibiting qualified and competent APCs from providing abortion care, including medication abortion, the APC Ban unnecessarily limits the number of abortion providers at PPSWO, and thus the number of locations where abortion can be provided and the number of available appointments. As a result, the APC Ban reduces access to important, time-sensitive abortion care, thereby undermining patient wellbeing and public health. It also exposes patients to financial, logistical, psychological, and medical burdens. The APC Ban has these detrimental effects without advancing patient safety because the medical evidence and extensive experience show that APCs can provide medication abortion just as safely and effectively as physicians.

6. I understand that R.C. 2919.123 (the "Evidence-Based Use Ban") requires that mifepristone, one of the two drugs used in the most common medication abortion regimen, be prescribed only in accordance with the United States Food and Drug Administration's ("FDA's") final printed label for the drug. Practically, this means that mifepristone is available only to patients seen in Ohio within a limited gestational window—through 70 days (10 weeks) of pregnancy, as counted from the first day of a patient's last menstrual period ("LMP")—even though research has demonstrated the efficacy and safety of off-label use of mifepristone through at least 77 days (11 weeks) LMP. I also understand that the law may restrict the dosing and route

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

of administration of the second drug in the most common medication abortion regimen (misoprostol) when it is used alongside mifepristone as part of the two drug regimen to terminate a pregnancy, and there is a risk that a hostile prosecutor could attempt to use the law to restrict other applications of mifepristone for abortion-related purposes (e.g., for cervical ripening prior to a procedural abortion).

7. The Evidence-Based Use Ban restricts the evidence-based use of mifepristone without medical justification. Off-label use of medication is common throughout the field of medicine and allows providers to update their practice according to the best medical evidence. The Evidence-Based Use Ban reduces access to medication abortion by limiting mifepristone prescription to 70 days LMP, despite the fact that research shows that mifepristone is a safe and effective method of terminating a pregnancy through at least 77 days LMP. This means that patients who are more than 70 days LMP pregnant, but still within a window when mifepristone is safe and effective, cannot access medication abortion in Ohio. As a result, their only options are to seek a procedural abortion (potentially against their preference or medical indication), travel out of state to receive a medication abortion, seek medication abortion outside of a medical setting, or carry their pregnancy to term.

I. Telemedicine at PPSWO

8. In my previous affidavit, I detailed the evolution of telemedicine services at PPSWO, including for medication abortion. Aff. ¶¶ 16–20, 36–47. We currently offer telemedicine for non-abortion services via the direct-to-patient model, whereby a patient with internet access and a video device can connect with one of our highly qualified health care professionals in the comfort of their own home or at another location of their choosing.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

9. While it is possible to have a medication abortion via telemedicine in Ohio due to the preliminary injunction in this case, Ohio law still requires that abortion patients travel to a clinic or health center to receive certain state-mandated information in person from a physician at least 24 hours prior to obtaining an abortion.[1] Thus, all abortion patients, including medication abortion patients, must still have two separate appointments.

10. PPSWO previously offered telemedicine medication abortion via the in-office model but stopped doing so for administrative reasons.

11. Recently, PPSWO began to have some patients complete their second visit for a medication abortion via direct-to-patient telemedicine at least 24 hours following their in-person visit to the clinic. Under our new telemedicine medication abortion protocol, at their first in-person appointment, the patient receives a combination-coded secure container containing their doses of mifepristone and misoprostol as well as nausea medication and ibuprofen (a "lockbox"), which they take home with them from the appointment. At least 24 hours later, the patient can do their second visit via telemedicine from their home or another location of their choosing. During that second appointment, the physician confirms the patient's decision to seek an abortion, confirms that they have not had a change in their symptoms or other medical concerns, and answers any questions the patient may have. The physician then gives the patient the combination code to the lockbox, from which the patient removes the mifepristone and shows it to the physician. The physician then observes the patient ingesting the mifepristone. The patient then takes the misoprostol 24 to 48 hours later.

[1] R.C. 2317.56(B)(l), 2919.193–194. PPSWO, together with other abortion providers, recently filed a lawsuit challenging the constitutionality of these requirements. *See generally Preterm-Cleveland v. Yost*, Franklin C.P. No. 24 CV 002634. I submitted an affidavit in support of Plaintiffs' Motion for Preliminary Injunction in that case.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

12. The medical eligibility requirements and Day 1 visit for this new telemedicine medication abortion protocol are the same as I described in my prior affidavit. Aff. ¶ 36. However, we also ensure that patients have an internet connection, a video device, and a safe and comfortable place from which to conduct the appointment.

II. Effects of the Evidence-Based Use Ban

13. Off-label prescription is common throughout the field of medicine and allows providers to update their practice according to the best medical evidence. For example, misoprostol was originally approved by the FDA as an ulcer medication, but I prescribe it for several gynecological applications, including for medication abortion.

14. The FDA first approved mifepristone in 2000 for use up to 49 days LMP. Even at that time, evidence already showed that an updated regimen (dosage, timing, and route of administration) of mifepristone and misoprostol was safe and effective for abortion through 63 days LMP.[2]

15. Subsequent research showed that other regimens of mifepristone and misoprostol were even safer and more effective and could be used later in pregnancy. In 2016, the FDA approved an updated label for Mifeprex (the brand name for mifepristone) with the following regimen through 70 days LMP: on the first day, the patient takes 200 mg of mifepristone orally; 24 to 48 hours later, the patient takes 800 mcg of misoprostol buccally (in the cheek pouch); and 7 to 14 days later, the patient follows up with a healthcare provider to confirm that the pregnancy has been terminated.[3] Subsequent changes to the Risk Evaluation and Mitigation Strategy ("REMS")

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[2] Schaff et al., *Low-Dose Mifepristone Followed by Vaginal Misoprostol at 48 Hours for Abortion Up to 63 Days*, 61 Contraception 41 (2000).

[3] FDA, *MIFEPREX: Highlights of Prescribing Information* (Mar. 2016), https://www.accessdata.fda.gov/drugsatfda_docs/*label*/2016/020687s020lbl.pdf (last accessed May 3, 2024).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

for mifepristone in 2021 and 2023 lifted the requirement that the drug be dispensed in-person, thereby allowing for its mailing, and allowed pharmacists to dispense mifepristone.[4]

16. Since 2016, new research has shown that mifepristone is a safe and effective way to terminate a pregnancy through at least 77 days LMP.[5]

17. Despite this, Ohio law continues to prohibit mifepristone's use to terminate a pregnancy after 70 days LMP. Thus, PPSWO only provides medication abortion through 70 days LMP. Absent the Evidence-Based Use Ban, PPSWO would provide medication abortion consistent with the best available medical evidence, including through at least 77 days LMP. The gestational limit imposed by the Evidence-Based Use Ban thus limits patients' ability to access medication abortion in Ohio.[6]

18. Many patients seeking to access medication abortion in Ohio may be pushed past the current legal limit for medication abortion (70 days) even though they would otherwise be able to access medication abortion before 77 days LMP. These patients will be forced to travel out of state to obtain medication abortion care if they are able, get a procedural abortion, attempt to manage their own abortion outside the medical system, or remain pregnant against their will.

19. Some patients may not realize they are pregnant until after 70 days LMP and thus are unable to access medication abortion in Ohio.

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[4] FDA, *Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation* (Mar. 23, 2023), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation (last accessed May 3, 2024).

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

[6] The barriers to abortion access described below are compounded by other Ohio laws including the APC Ban and the 24-hour waiting period requirement, which forces most patients to make two trips to the clinic in order to receive an abortion. R.C. 2317.56(B).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

20. As I explained in my prior affidavit, Aff. ¶¶ 34–36, and also described below, *infra* ¶¶ 43, 47, PPSWO conducts all Day 1 visits at our Cincinnati ambulatory surgical center, and we also provide all medication abortions, other than those we provide via telemedicine, at that clinic. Traveling to the clinic is very burdensome for some patients. Even patients who live close to the clinic may have to take unreliable public transportation, cobble together rides from friends or family members, or figure out how to pay for a rideshare service. Others travel to our clinic from distant parts of Ohio or other states. Because we are the nearest abortion provider for people from some parts of Indiana, Kentucky, and West Virginia—all of which ban abortion entirely—we see many out-of-state patients. In the past year, we have seen patients from 16 states, including farther away states such as Florida and Georgia. The in-person visit requirement forces most patients to make two trips to the clinic at least 24 hours[7] apart in order to receive an abortion and thus means that many patients must arrange overnight accommodations. Having to travel to the clinic imposes logistical and financial barriers to many patients and may make them unable to get to the clinic before 70 days LMP. These patients are thus unable to access medication abortion in Ohio.

21. Because many of our patients are already parents, they may need to arrange for childcare to obtain an abortion, which may be an additional cost and a further barrier to getting to our Cincinnati clinic before 70 days LMP. Many patients also lose wages because they have to miss work and do not work in jobs that provide paid time off. These costs are substantial for patients living paycheck to paycheck and can mean the difference between buying groceries for their families that week or not. These logistical barriers and additional costs also prevent some

[7] In practice, the 24-hour delay is often drawn out further. Patients can easily be delayed by more than a week between their first and second appointments.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

patients from getting to the clinic before 70 days LMP. These patients are thus unable to access medication abortion in Ohio.

22. Patients who are able to travel out of state to obtain a medication abortion may incur additional costs associated with traveling further from home such as gas, bus tickets, and even somewhere to stay overnight. They may also need to arrange additional childcare or take additional time off work, also at a greater cost.

23. Patients who are unable to obtain a medication abortion in Ohio may be forced to remain pregnant for longer, imposing medical burdens on them. When some patients come to our clinic seeking abortions, they are very ill and need an abortion as soon as possible. For example, some patients experiencing hyperemesis gravidarum (severe nausea and vomiting) are not able to go about their daily lives as long as they are pregnant because they are too ill. Patients may have other medical conditions necessitating an abortion, such as needing to start cancer treatment. Furthermore, while abortion is incredibly safe, its risks increase with gestational age.

24. Remaining pregnant also imposes both psychological and emotional burdens on patients. Most abortion patients—once they have decided to have an abortion—strongly prefer to end their pregnancy as soon as possible. These burdens may be especially heavy for patients who have become pregnant as a result of rape or incest. For patients experiencing intimate partner violence, remaining pregnant for longer means that their abusive partner is more likely to discover their pregnancy, putting them at risk of violence and retaliation.

25. Some patients who are unable to access medication abortion in Ohio due to the Evidence-Based Use Ban will have to have procedural abortions to terminate their pregnancies, against their preference or medical indication. As I explained in my prior affidavit, some patients have a strong preference for medication rather than procedural abortion, including because of a

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

history of sexual assault. Aff. ¶ 29. For these patients, procedural abortion may feel like a violation of their bodily autonomy and/or traumatic. Yet the Evidence-Based Use Ban may mean some of these patients must have a procedural rather than medication abortion. Some PPSWO patients with a strong preference for medication abortion who are between 71 and 77 days LMP have gone out of state to get a medication abortion rather than have a procedural abortion in Ohio.

26. As I said in my prior affidavit, medication abortion may also be safer than procedural abortion for some patients. Aff. ¶ 29. Some patients between 71 and 77 days LMP may have to undergo an abortion procedure that poses greater medical risk for them as a result of the Evidence-Based Use Ban. For other patients, medication abortion may be the only medically safe option. For example, this may be true for patients with anomalies of the reproductive and genital tract, such as significant uterine fibroids or didelphys, which can make it difficult to perform an abortion by procedure. These patients are forced to travel out of state (if they are able) to get a medication abortion or remain pregnant against their will.

27. Other patients may seek medication abortion outside the medical system, which can carry greater risks than if supervised by a qualified clinician.

28. The Evidence-Based Use Ban also intrudes on the patient-provider relationship. I obtain informed consent from patients for any form of medical care I provide. The purpose of informed consent is to notify a patient of the intended procedure or treatment and advise them of the treatment's or procedure's nature, risks, benefits, and alternatives. Once a patient understands their options, they should be able to choose the treatment that best meets their needs. The Evidence-Based Use Ban takes away the choice of medication abortion for patients seeking to

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

terminate their pregnancies between 71 and 77 days LMP without medical justification and in contravention of best medical practices.

29. The Evidence-Based Use Ban may also impact patients other than those seeking to terminate their pregnancies via medication abortion between 71 and 77 days LMP. It also affects misoprostol use in medication abortion. The FDA label contemplates that patients will take four 200 mcg tablets of misoprostol 24 to 48 hours after mifepristone buccally. Buccal administration of medication means that the patient places the tablets between their cheek and gums for 30 minutes and then swallows any remnants with water or another liquid.[8] However, newer research indicates that for patients who are between 9 and 11 weeks LMP, it is most effective to take a second dose of misoprostol (also four 200 mcg tablets) 4 hours after the first dose.[9] But because the Evidence-Based Use Ban restricts the use of misoprostol to the what is outlined in the FDA label for mifepristone when the drug is used in combination with mifepristone to induce an abortion, we do not provide patients with this evidence-based treatment. Instead, we tell patients to monitor their bleeding (one of the normal effects of medication abortion), and if they do not have the expected bleeding, on an individual basis after assessment, we may instruct them to take an additional dose of misoprostol. However, this is usually at least 24 hours after the first misoprostol dose, rather than 4 hours.

30. Furthermore, some patients may prefer to take misoprostol orally or vaginally, rather than buccally, but we do not instruct them to do so because the Evidence-Based Use Ban precludes those alternative routes of administration. Buccal and vaginal administration have been shown to have similar efficacy and safety; oral administration is slightly less effective and may cause more

[8] FDA, *supra* note 3.
[9] Dzuba et al., *A Repeat Dose*, *supra* note 5.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

nausea, but is nonetheless preferable for some patients.[10] For some patients with extreme nausea, putting anything in their mouth can be difficult. Others may be sensitive to the taste or feel of buccal administration. The standard of care indicates that patients should be able to make this choice for themselves after an informed consent process, but the Evidence-Based Use Ban precludes them from making this choice.

31. There is also a risk that a hostile prosecutor could view the Evidence-Based Use Ban as precluding the use of mifepristone as a dilator for cervical preparation prior to a second trimester procedural abortion. While research indicates this is effective and safe,[11] if we use mifepristone in this manner, we run the risk that those tasked with enforcement will view this as violating the Evidence-Based Use Ban.

III. Effects of the APC Ban

32. Throughout my tenure at PPSWO, I have worked closely with APCs. With the exception of our ambulatory surgical facility ("ASF") in Cincinnati, our clinics[12] are headed and primarily staffed by advanced practice clinicians. PPSWO currently employs 11 nurse practitioners, 2

[10] Young et al., *Comparison of Vaginal and Buccal Misoprostol after Mifepristone for Medication Abortion through 70 days of Gestation: A Retrospective Chart Review*, 115 Contraception 62 (2022); Winikoff et al, *Two Distinct Oral Routes of Misoprostol in Mifepristone Medical Abortion: A Randomized Controlled Trial*, 115 Journal of Obstetrics & Gynecology 1303 (2008); Am. Coll. of Obstetricians & Gynecologists, *Medication Abortion Up to 70 Days of Gestation*, Practice Bulletin No. 225 (Oct. 2020), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/10/medication-abortion-up-to-70-days-of-gestation (last accessed May 3, 2024).

[11] Diedrich et al., *Society of Family Planning Clinical Recommendations: Cervical Preparation for Dilation and Evacuation at 20–24 Weeks' Gestation*, 101 Contraception 286 (2020); Lambert et al., *Adjuvant Misoprostol or Mifepristone for Cervical Preparation with Osmotic Dilators before Dilation and Evacuation*, 132 Contraception (Apr. 2024); Uhm et al., *Mifepristone Prior to Osmotic Dilators for Dilation and Evacuation Cervical Preparation: A Randomized, Double-Blind, Placebo-Controlled Pilot Study*, 107 Contraception 23 (Mar. 2022).

[12] We operate one other health center in Cincinnati as well as one each in Dayton, Hamilton, and Springfield.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

certified nurse midwives, and one APC who is both an NP and CNM. We would also consider employing physician assistants for future open clinician positions.

33. Like other Ohio APCs, PPSWO's APCs provide a broad range of health care services, have broad prescriptive authority, and regularly provide care that is comparable to or higher risk and/or complexity than medication abortion.

34. PPSWO APCs provide gender affirming care, pre-exposure HIV prophylaxis (commonly called "PrEP"), screening and treatment of sexually transmitted infections, intrauterine device insertion and removal, insertion and removal of contraceptive implants, lidocaine cervical blocks, colposcopy, endometrial and vulvar biopsies, loop electrosurgical excision procedures ("LEEPs"), and bartholin cyst treatment, among other forms of care.

35. As part of their education and training, APCs are taught when to refer patients for a higher level of care. I work closely with our APCs and frequently consult with them on complex cases.

36. Because of the APC Ban, however, physicians provide all abortions at PPSWO. I am one of two staff physicians at PPSWO, and three additional per diem physicians also provide abortion care at PPSWO.

37. Because Ohio law requires that procedural abortions be performed at an ASF, we only perform procedural abortions at our Cincinnati ASF. Furthermore, because Ohio law requires that a physician obtain informed consent in-person at least 24 hours prior to obtaining abortion, and our only health center that routinely has physicians present is the Cincinnati ASF, all medication abortion patients must travel to that clinic for their Day 1 appointment. Furthermore, because medication abortion must be provided by a physician in Ohio, all medication abortions

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

provided by PPSWO, other than those provided via telemedicine, take place at the Cincinnati ASF.

38. Our model of staffing our non-ASF facilities with APCs and the Cincinnati ASF with physicians means that most preparation and follow-up care for medication abortion is provided by either physicians or registered nurses. However, one NP, Plaintiff Julia Quinn, currently works at the Cincinnati ASF and is involved in pre- and post-medication abortion care.

39. Absent the APC Ban, it is within the scope of practice of properly trained APCs to provide medication abortion. Research shows that APCs can provide medication abortion as safely and effectively as physicians.[13] Furthermore, I am aware that APCs in other states regularly provide medication abortion care. There is no medical reason why APCs should not be allowed to provide medication abortion.

40. Indeed, it is within the scope of practice of properly trained APCs to provide care throughout the entire medication abortion process. Pre-medication abortion care, including reviewing medical history, screening for contraindications, and if indicated, ultrasound, is within their scope. APCs are also capable of obtaining informed consent from medication abortion patients. I am aware that APCs in other states regularly provide pre-medication abortion care.

41. It is also within the scope of practice of properly trained APCs to provide post-medication abortion care, including ultrasound and addressing rare complications, and I am aware that APCs in other states regularly provide post-medication abortion care. For example, one complication of medication abortion is incomplete abortion, meaning that the pregnancy has ended but there are retained products of conception in the patient's uterus. The most common

[13] Porsch et al., *Advanced Practice Clinicians and Medication Abortion Safety: A 10-year Retrospective Review*, 101 Contraception 357 (May 2020).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

intervention for incomplete abortion is an additional dose of misoprostol, which APCs are more than capable of administering.

42. The APC Ban seriously constrains the availability of medication abortion in Ohio to the detriment of patients' health and wellbeing. Absent the APC Ban, PPSWO would train its current APCs to provide medication abortion (including via telemedicine and beyond 70 days LMP if the Evidence-Based Use Ban were also enjoined), and hire additional APCs as needed to provide this care, and, as a result, could expand medication abortion services.

43. PPSWO currently provides medication abortion 4 to 5 days a week. We currently offer medication abortion appointments Tuesday through Friday and one Saturday per month. All Day 1 medication abortion appointments take place at our Cincinnati ASF, and with the exception of telemedicine appointments, all Day 2 medication abortion appointments also take place at our Cincinnati ASF.

44. Absent the APC Ban, we could offer both Day 1 and Day 2 medication abortion appointments at all five of our health centers, including those sites headed by NPs. We could also likely offer medication abortion appointments additional days of the week and at more times. At our Cincinnati ASF, we might also be able to offer more medication abortion appointments because we would have a greater number of providers.

45. Lifting the APC Ban would mean that all PPSWO clinicians, including physicians and APCs, could practice at the top of their license. Physicians would be able to focus on providing procedural abortions.

46. I anticipate that a greater number of medication abortion appointments will offer additional flexibility to patients and thus increase abortion access in Ohio. As I explained above, *supra* ¶¶ 21–22, many of our patients face logistical barriers to accessing abortion. Being able to

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

offer medication abortion at all of our health centers would reduce travel burdens for patients. For example, our Cincinnati ASF is currently the closest abortion provider for a patient living in Hamilton, Ohio. Instead of having to travel approximately 20 miles in each direction twice to obtain a medication abortion, the patient might be able to obtain a medication abortion closer to their home at our health center in Hamilton.

47. Similarly, patients struggling to take time off of work or school to access medication abortion might have more appointment options. For example, if a patient regularly worked Tuesday through Saturday, they would not be able to access medication abortion on the days we currently offer it without taking time off work—potentially unpaid. However, all of our health centers are open on Mondays, and we might be able to offer medication abortion on Mondays absent the APC Ban, meaning this patient would not lose wages or potentially have to disclose to their employer the reason for their absence from work.

48. Additional medication abortion appointments may mean that patients are able to terminate their pregnancies sooner, reducing the medical and psychological burdens I described *supra* ¶¶ 26–27.

* * *

49. For all of these reasons, I believe that the Evidence-Based Use Ban and the APC Ban deprive PPSWO's patients of access to critical health care and will threaten their health, safety, and lives without creating any health or safety benefit whatsoever for our patients.

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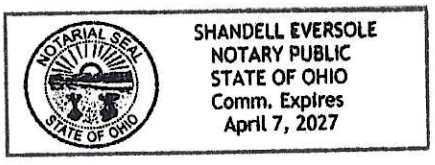
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FURTHER AFFIANT SAYETH NAUGHT.

Sharon Liner, M.D.
Planned Parenthood Southwest Ohio

Sworn to and subscribed before me this 8th day of May, 2024.

Notary Public



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EXHIBIT 10

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IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs,* v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A 2101148 Judge Alison Hatheway

REBUTTAL EXPERT REPORT OF DANIEL GROSSMAN, M.D.

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IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*,	Case No. A 2101148
Plaintiffs,	Judge Alison Hatheway
v.	
OHIO DEPARTMENT OF HEALTH, *et al.*,	
Defendants.	

AFFIDAVIT OF DANIEL GROSSMAN, M.D.

Now comes affiant Daniel Grossman, M.D., having been first duly cautioned and sworn, deposes and states as follows:

1. I am over the age of 18 and fully competent to make this declaration. I have personal knowledge of the statements and facts contained herein.
2. For the purposes of this litigation, I am providing my expert opinions.
3. I have prepared the report attached to this affidavit as Exhibit A and swear to its authenticity and to the faithfulness of the opinions expressed, and to the best of my knowledge, the accuracy of the factual statements made therein.

FURTHER AFFIANT SAYETH NAUGHT

Daniel Grossman

Daniel Grossman, M.D.

State of Florida County of Lee
Sworn to and subscribed before me this 3rd Day of June, 2026.
Daniel Grossman, who appeared by means of online notarization and produced a Drivers License as identification

Autumn Thornton

Autumn Thornton

AUTUMN THORNTON
Notary Public - State of Florida
Commission # HH 351044
My Comm. Expires Jan 19, 2027

This notarial act was an online notarization

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EXHIBIT A

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REBUTTAL EXPERT REPORT OF DANIEL GROSSMAN, M.D.

I. INTRODUCTION

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. I am over 18 years of age, of sound mind, and in all respects competent to testify.

2. I have actual knowledge of the matters stated herein.

3. I previously submitted an Expert Report in this case ("Report" or "Rep."), served on March 17, 2026. In preparing this Rebuttal Expert Report, in addition to reviewing the materials cited herein, I have also relied on my years of education, research, and professional and other experience, as set out in my Report and my updated *curriculum vitae* ("CV"), attached as here **Exhibit B**, in forming my opinions. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. All opinions stated herein are to a reasonable degree of medical and scientific certainty.

4. I have reviewed the expert reports of Drs. Ingrid Skop ("Skop Rep.") and Donna Harrison ("Harrison Rep."), served May 1, 2026, and submit this Rebuttal Expert Report to respond to the opinions they offered. Specifically, I respond to their opinions about medication abortion and its safety and efficacy, including when provided via telemedicine and by advanced practice clinicians ("APCs"). The fact that I do not address a particular statement made in their reports does not indicate my agreement with that statement.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

II. OPINIONS

A. Summary of Opinions

5. As I explained in my Report, medication abortion[1] is extremely safe and effective. In attempting to justify the Challenged Restrictions in this case, Drs. Skop and Harrison argue that medication abortion risks are understated. But in making the suggestion that medication abortion is unsafe, they mischaracterize many of the studies confirming medication abortion's safety, rely on poor quality publications, and present possible symptoms, side effects, outcomes, and complications in a misleading way. Contrary to their assertions, the conclusion that medication abortion is safe and effective is widely accepted in the medical community and well supported by high quality evidence.

6. This medical consensus includes the fact that medication abortion is safe and effective when used beyond 70 days from a patient's last menstrual period ("LMP"), the gestational duration that mifepristone (one of the two drugs used in the most common abortion regimen) is currently approved for by the U.S. Food and Drug Administration ("FDA"), as set forth in the FDA mifepristone label. Off-label use is very common in medicine and safe when done in accordance with evidence-based protocols. Given the proven safety and efficacy of medication abortion, including beyond 70 days LMP, there is no medical reason to prohibit off-label prescribing for mifepristone while allowing it for other medications. Thus, there is no medical justification for the Evidence-Based Use Ban.

7. There is no medical justification for requiring all medication abortion providers to be able to provide follow-up aspiration care. A very small proportion of medication abortion patients

[1] As I noted in my Report, the most common medication abortion regimen in the United States uses a combination of mifepristone and misoprostol. Misoprostol alone is also a safe and effective medication abortion regimen. Rep. ¶¶ 20, 33.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

require this type of follow-up treatment, and when it is required, it can generally be provided in an outpatient setting on a non-urgent basis. The medical consensus, which is based on extensive evidence, is that trained advanced practice clinicians can provide medication abortion, including properly addressing medication abortion complications, as safely and effectively as physicians. Thus, there is no medical justification for the APC Ban.

8. Telemedicine medication abortion is also safe and effective. Contrary to Drs. Skop's and Harrison's assertions, it is not a new way to provide abortion care. Rather, a large body of research confirms its safety and efficacy, including when provided pursuant to a "no-test" protocol. Clinicians can safely and effectively screen patients seeking medication abortion remotely, provide or refer patients for further testing to determine eligibility and assess for any contraindications if necessary, and address any rare complications that arise. There is no medical justification for the Telemedicine Ban.

9. Rather than further patient health, each of these restrictions impairs abortion access, harms the health of people seeking abortions, and impedes providers who endeavor to provide safe, effective, patient-centered abortion care.

B. Medication Abortion Is Extremely Safe and Effective.

10. At the outset, to assess the safety and efficacy of medication abortion, it is important to correctly characterize and be clear about the terminology used to discuss medication abortion outcomes, complications, and side effects.

11. Dr. Skop defines "complication" as an "unanticipated problem that arises following, and as a result of, a procedure." Skop Rep. ¶ 39. She also suggests that "side effects" of medication abortion should be considered complications. *Id.* ¶ 61. Dr. Harrison implies that an "adverse drug reaction" or "adverse reaction" is the same thing as a "complication." Harrison Rep. ¶¶ 11, 18. But as discussed further below, symptoms, side effects, outcomes, complications, and serious adverse

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

events all have different meanings, and researchers and clinicians may use them differently. Thus, to properly assess research on medication abortion safety, we must be clear on the terminology used.

12. Side effects are generally known and occur alongside the intended result of a medication or treatment. While sometimes undesirable, side effects can be positive. For example, drowsiness is a well-known side effect of the allergy drug Benadryl. While this may be undesirable at some times of the day (hence the warning not to operate machinery when taking it, for example), some patients may see drowsiness as a positive side effect of taking Benadryl at night. Patients often consider side effects of medications to be manageable, and side effects often resolve on their own over time.

13. Clinicians counsel patients on what to expect when taking medications to terminate a pregnancy. Rep. ¶ 21. While Dr. Skop calls it "disturbing" that medication abortion patients experience bleeding and cramping, for example, and implies that these should be considered complications, Skop Rep. ¶ 61, these symptoms are not complications but rather are part of the process of passing pregnancy tissue. In fact, whenever a pregnancy ends—be it by childbirth, spontaneous loss, or abortion—there is inevitably bleeding and usually cramping or pain. Patients considering abortion are always counseled about what to expect in terms of the process and symptoms associated with different methods of abortion, how to manage the symptoms, and when to seek follow-up care for complications. Based on that counseling, they are able to evaluate whether they are comfortable with the possibility that they may experience those symptoms and decide whether a particular method is right for them.

14. Because studies on the safety of medication abortion may use the term "complication" or similar terms differently, any analysis of complication rates should look closely at what the study

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

authors considered to be complications. Based on how complications are defined, studies may report different rates of adverse events. However, as even Drs. Skop and Harrison acknowledge, major complications or serious adverse events following medication abortion are very uncommon under any reasonable definition. Skop Rep. ¶ 103; Harrison Rep. ¶ 50. For example, the study by Ushma D. Upadhyay et al. *Incidence of Emergency Department Visits and Complications After Abortion*, which I rely on in my Report, defines "major complications" as "serious unexpected adverse events requiring hospital admission, surgery, or blood transfusion."[2] Using this definition, this study determined that just 0.31% of medication abortion patients experienced "major complications."[3] The Ning Liu et al. article cited by Dr. Skop (¶ 71) defines "serious adverse event" as being comprised of "severe maternal morbidity[], maternal end-organ damage, intensive care unit admission, or death."[4] As Dr. Skop acknowledges, under this definition, just 0.33% of medication abortion patients experienced a serious adverse event.[5]

15. By contrast, other studies use definitions of "serious adverse event" or similar terms that are misleading and, as a result, incorrectly imply that medication abortion is dangerous. For example, the Ethics & Public Policy Center publication Dr. Skop relies on to contend that medication abortion complications are undercounted, Skop Rep. ¶ 30, counts any visit to an emergency room purportedly related to medication abortion as a serious adverse event, regardless

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[2] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 176 (2015).

[3] *Id.* at 178 tbl. 3.

[4] Ning Liu et al., *Short-Term Adverse Outcomes After Mifepristone–Misoprostol Versus Procedural Induced Abortion: A Population-Based Propensity-Weighted Study*, 176 Annals of Internal Medicine 145, 146 (2023).

[5] *Id.* at 145; *see also* FDA, *What Is a Serious Adverse Event?*, https://www.fda.gov/safety/reporting-serious-problems-fda/what-serious-adverse-event (content current as of May 18, 2023) (defining "serious adverse event" as hospitalization, disability, permanent impairment or intervention to prevent permanent impairment, congenital anomaly/birth defect, death or some other life-threatening or serious event).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

of whether treatment was given.[6] But patients often visit the emergency room for reassurance that expected symptoms following medication abortion (such as bleeding) are normal and not cause for concern. In several of the studies cited in my report, approximately half of patients visiting an emergency department after medication abortion did not need to receive treatment for an abortion-related complication; they simply were evaluated and reassured.[7] The mere fact that a patient visits the emergency room does not mean they are experiencing a serious adverse event.[8] Beyond these methodological flaws, the publication is not peer-reviewed and was created by an organization that exists to "advance pro-life policies that protect unborn children by restricting abortion at the state and federal level."[9]

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[6] Jamie Bryan Hall & Ryan T. Anderson, *The Abortion Pill Harms Women: Insurance Data Reveals One in Ten Patients Experiences a Serious Adverse Event*, Ethics & Pub. Policy Ctr. (Apr. 28, 2025), https://media.eppc.org/2025/04/25-04-The-Abortion-Pill-Harms-Women.pdf; *see also* Skop Rep. ¶ 52 (claiming emergency room visits as evidence that medication abortion is not safe). The report claims to identify medication abortions by looking at, *inter alia*, all prescriptions for mifepristone, regardless of the reason for the prescription, and even includes prescriptions for mifepristone without misoprostol. Hall & Anderson, *supra*, at 4. It thus likely includes patients who did not even have a medication abortion because patients might be prescribed mifepristone for other reasons, such as for miscarriage or labor induction, and mifepristone without misoprostol is not a medication abortion regimen. The publication also categorizes other outcomes that would not commonly be considered serious adverse events within its definition such as incomplete abortion or continuing pregnancy (which the publication calls "[r]epeated (surgical) abortion procedures"), *id.* at 5; *contra* ¶¶ 15–17; *see also* Kathi A. Aultman et al., *Deaths and Severe Adverse Events after the use of Mifepristone as an Abortifacient from September 2000 to February 2019*, 36 Issues in Law & Medicine 3, 9–10 (2021) (study co-authored by Dr. Harrison and cited in Skop Rep. ¶ 19 n.8 and Harrison ¶ 45 & n.33 classifying incomplete abortion and continuing pregnancy as severe adverse events), and does not define "hemorrhage," *see infra* ¶ 43. It also includes ectopic pregnancy as a serious adverse event, but medication abortion does not cause ectopic pregnancy. For further critiques of the Ethics & Public Policy Center publication, see Kelly Baden et al., *The War on Mifepristone: How Junk Science and False Narratives Threaten US Abortion Access*, Guttmacher Inst. (Oct. 22, 2025), https://www.guttmacher.org/2025/10/war-mifepristone-how-junk-science-and-false-narratives-threaten-us-abortion-access.

[7] *E.g.*, Upadhyay, *Incidence of Emergency Department Visits and Complications After Abortion*, *supra* note 2, at 182 ("Two thirds of abortion-related ED visits did not result in a diagnosis or treatment, representing visits primarily for symptoms, not complications.").

[8] *See What Is a Serious Adverse Event?*, *supra* note 5.

[9] Ethics & Public Policy Center, *Life and Family Initiative*, https://eppc.org/program/life-and-family-initiative/ (last visited May 19, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

16. The most common complications of medication abortion are incomplete abortion (when the pregnancy has ended but not all of the pregnancy tissue has been expelled from the uterus) and continuing pregnancy (when the medications are not effective at ending the pregnancy). Rep. ¶ 36. Some researchers refer to these as "minor complications,"[10] while other experts consider these "known outcomes" of medication abortion, about which patients are counseled.

17. Regardless of the nomenclature used, incomplete abortion and continuing pregnancy are rare following medication abortion using the mifepristone-misoprostol regimen: less than 2% of patients have an incomplete abortion and less than 1% of patients have a continuing pregnancy.[11]

18. Furthermore, incomplete abortion sometimes resolves with expectant management (the tissue passes without intervention) or can otherwise be treated in an office setting with additional medications or an aspiration procedure. Rep. ¶¶ 37, 110. Similarly, a patient with a continuing pregnancy can also take additional medications or have an aspiration procedure to end the pregnancy. *Id.* ¶ 38.[12]

19. Many datasets and studies, including in FDA adverse event reporting, indicate that some patients require "surgical intervention" following medication abortion.[13] To be clear, "surgical intervention" typically just refers to an aspiration procedure, which is most often used to treat

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[10] *See, e.g.*, Upadhyay, *Incidence of Emergency Department Visits and Complications After Abortion*, *supra* note 2, at 176.

[11] FDA, *MIFEPREX: Highlights of Prescribing Information* 13 tbl. 3 (revised Mar. 2016), https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf [hereinafter "*MIFEPREX* 2016 Label"]; *see also* Upadhyay, *Incidence of Emergency Department Visits and Complications After Abortion*, *supra* note 2, at 189 tbl. 4; Rep. ¶¶ 20, 42, 67 (discussing misoprostol-alone regimen).

[12] *See* Upadhyay, *Incidence of Emergency Department Visits and Complications After Abortion*, *supra* note 2, at 181 (noting 0.16% of patients had major complications following first-trimester aspiration abortion; the aspiration procedure for abortion is nearly identical to that for performed as a follow-up treatment for medication abortion).

[13] *E.g.*, *MIFEPREX* 2016 Label, *supra* note 11, at 13 tbl. 13 (2.6% of patients in U.S. trials using mifepristone-misoprostol regimen through 70 days LMP required "surgical intervention").

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

continuing pregnancy or incomplete abortion.[14] While, as noted above, both of these outcomes are uncommon, it is even rarer that another procedural or surgical intervention would be needed to treat a complication other than incomplete abortion or continuing pregnancy.[15]

20. Drs. Skop's and Harrison's repeated references to other specific serious complications associated with medication abortion are extremely misleading, as they both entirely fail to acknowledge how rarely such complications actually arise. *See, e.g.*, Skop Rep. ¶ 41; Harrison Rep. ¶¶ 45, 48–49. For example, Dr. Harrison cites the risk of clostridium sordellii (a rare bacteria associated with severe infection and death) five times and Dr. Skop three times, neither mentioning the near-zero likelihood (0.00001%) of such an infection resulting from medication abortion.[16] In reality, "there is no evidence of a causal relationship between use of mifepristone and misoprostol and an increased risk of infection or death," including from clostridium sordellii.[17] As ACOG

[14] Procedural abortion, while sometimes referred to as "surgical abortion," is not true surgery because it does not involve cutting into a sterile body cavity. Am. College of Obstetricians and Gynecologists ("ACOG"), *Definition of "Procedures" Related to Obstetrics and Gynecology* (Jan. 2018, reaff'd Mar. 2023), https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2018/definition-of-procedures-related-to-obstetrics-and-gynecology. Instead it involves a non-incisional intervention through a natural body cavity or orifice. This type of procedure is the same whether provided for abortion, as follow-up care for medication abortion, or for miscarriage management. Rep. ¶¶ 23, 37 & n.44, 39.

[15] *See* Daniel Grossman & Kate Grindlay, *Safety of Medical Abortion Provided Through Telemedicine Compared With In Person*, 130 Obstetrics & Gynecology 778, 780 (2017) (no surgeries among over 19,000 medication abortions); Abigail R.A. Aiken et al., *Effectiveness, Safety and Acceptability of No-Test Medical Abortion (Termination of Pregnancy) Provided Via Telemedicine: A National Cohort Study*, 128 Brit. J. Obstetrics & Gynaecology 1464, 1469 (2021) (no major surgeries among over 52,000 medication abortions).

[16] *See* ANSIRH, *Analysis of Medication Abortion Risk and the FDA Report "Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2024"* (May 15, 2025), https://www.ansirh.org/sites/default/files/2025-05/Issue%20Brief%20MAB%20SAEs-May2025%20Final_0.pdf [hereinafter "ANSIRH Adverse Events Analysis"] (10 cases out of approximately 7.5 million medication abortions).

[17] Natl. Acads. of Sci., Eng., & Med., *The Safety and Quality of Abortion Care in the United States* 55 (2018), http://nap.edu/24950 [hereinafter "Natl. Acads. Rev."]. Both of the State's experts cite Marc Fischer et al., *Fatal Toxic Shock Syndrome Associated with* Clostridium Sordellii *After Medical Abortion*, 353 N. Engl. J. Med. 2352 (2005), in support of their claims, Skop Rep. ¶ 43 n.42; Harrison Rep. ¶ 49 n.22, but this article did not use causal language. Fischer at 2358

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

notes, "[f]ollowing concern about serious, rare, and deadly infection with clostridial bacteria in patients undergoing medication abortion [nearly two decades ago], it has since become evident that no specific connection exists between clostridial organisms and medication abortion."[18]

C. Drs. Skop's and Harrison's Assertions Regarding the Purported Deficiencies of Datasets and Studies on Medication Abortion's Safety and Efficacy Are Meritless.

21. Drs. Skop's and Harrison's attempts to cast doubt on numerous high quality studies of medication abortion safety and efficacy are equally unconvincing.

22. First, they attack the FDA's adverse event reporting system for mifepristone. Skop Rep. ¶¶ 21–22, Harrison Rep. ¶¶ 21–22. In doing so, they ignore the fact that for over fifteen years—from mifepristone's initial approval in 2000 until March 2016—the FDA took the unusually stringent step of requiring that all mifepristone prescribers comprehensively report any serious adverse events associated with mifepristone to the drug manufacturer, and the manufacturer was then required to report all such events to the FDA. The mandatory reporting requirement included hospitalizations, transfusions, serious infections, death, or other "serious, unexpected adverse events," and continuing pregnancies.[19] The FDA ordinarily imposes reporting requirements only on manufacturers, not providers, but this requirement was implemented as part of the Risk Evaluation and Mitigation Strategy ("REMS") for mifepristone. *See* Rep. ¶ 34. A REMS is an

("[S]erious infection *can occur after* medically induced abortion, much as it *can occur after* childbirth, spontaneous abortion, and surgical abortion. However, available data suggest that the risk of such infection is low." (emphases added)).

[18] ACOG, *Practice Bulletin Number 225: Medication Abortion Up to 70 Days of Gestation,* 136 Obstetrics & Gynecology e31, e35 (2020).

[19] Ctr. for Drug Evaluation & Rsch., *Application Number 020687Orig1s020: Medical Review(s),* 1, 88 (Mar. 29, 2016), https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020MedR.pdf .

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

FDA drug safety program that helps ensure the benefits of a medication subject to a REMS outweigh its risks.[20]

23. FDA lifted the requirement that all serious adverse events be reported in 2016 only after determining that after fifteen years of receiving reports that "the safety profile of Mifeprex is well-characterized, that no new safety concerns have arisen in recent years, and that the known serious risks occur rarely."[21] Indeed, it concluded that serious adverse events associated with mifepristone are "exceedingly rare."[22]

24. While the FDA altered the serious adverse reporting requirements for mifepristone in 2016, it did not cease monitoring the medication's safety. Instead, the change eliminated an unusual requirement that providers separately report certain non-fatal adverse events to manufacturers. Mifepristone manufacturers are still required to review, collect, and submit all adverse drug experience information received from prescribers in periodic reports to the FDA—more similar to what the FDA relies on for virtually all other prescription medications.[23] Moreover, mifepristone is still subject to a heightened reporting requirement for any potentially associated fatalities.[24]

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[20] FDA, *Risk Evaluation and Mitigation Strategies | REMS* (current as of May 20, 2025), https://www.fda.gov/drugs/drug-safety-and-availability/risk-evaluation-and-mitigation-strategies-rems. While REMS are normally reserved only for drugs with "serious safety concerns," the FDA has nonetheless imposed one on mifepristone despite its safety. For this reason, leading medical groups, including ACOG, the Society of Family Planning, and the Society for Maternal-Fetal Medicine, have advocated for the removal of the mifepristone REMS. ACOG et al., Citizen Petition (Jan. 31, 2025), https://societyfp.org/wp-content/uploads/2025/02/Citizen-Petition-ACOG-SMFM-SFP-1.31.25.pdf. I agree that the mifepristone REMS is medically unnecessary. *See* Mifeprex REMS Study Group, *Sixteen Years of Overregulation: Time to Unburden Mifeprex*, 376 New Eng. J. Med. 790 (2017).

[21] FDA *Medical Review(s)*, *supra* note 19, at 49.

[22] *Id.* at 47. Dr. Skop claims that the FDA complications reporting was never complete, but she misunderstands the FDA's role in regulating drugs.

[23] 21 C.F.R. § 314.80.

[24] FDA, *Risk Evaluation and Mitigation Strategy (REMS) Single Shared System for Mifepristone 200 MG* (last modified May 2021), https://www.fda.gov/media/164651/download?attachment.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

25. Drs. Skop and Harrison assert that the many studies finding medication abortion to be safe and effective are not reliable, including because some of them ignore patients that were lost to follow-up, meaning that whether the patient had complications is unknown. *E.g.*, Skop Rep. ¶ 45.

26. Dr. Skop implies that a disproportionate number of patients lost to follow-up in these studies had complications. *E.g., id.* ¶ 87. But low follow-up rates are a known general limitation in retrospective research studies. Additionally, there is no basis to make the illogical assumption that such patients would have experienced complications at disproportionate rates. In my experience, patients experiencing problems following a medication abortion return for care; it is thus perhaps more likely that those who do not follow up have had a complete medication abortion without complications.

27. Moreover, while it is important to closely analyze the data in any study, loss to follow-up is not inherently a reason to discount the findings of a study.[25] Rather, researchers should assess the characteristics of patients lost to follow-up to determine whether the loss is likely to skew the study's results. Public health researchers have developed widely-accepted methods to determine when loss to follow-up presents concerns such that study results should be discounted and statistical methods to account for missing data.[26]

28. Upadhyay et al. accounted for these critiques of loss to follow-up in *Incidence of Emergency Department Visits and Complications After Abortion* by relying on California Medicaid billing data. Rep. ¶ 28. Relying on these data means that any emergency department visit

[25] *Cf., e.g.*, Jessica D. Rosenberg et al., *An Examination of Loss to Follow-Up and Potential Bias in Outcome Ascertainment in a Study of Direct-to-Patient Telemedicine Abortion in the United States*, 122 Contraception 109996 (2023) (discussing methods to address loss to follow-up in studies on abortion outcomes from research design and statistical analysis perspectives).

[26] *See* Columbia Mailman School of Pub. Health, *Missing Data and Multiple Imputation*, https://www.publichealth.columbia.edu/research/population-health-methods/missing-data-and-multiple-imputation (last visited June 1, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

by Medicaid patients who had an abortion in the preceding six weeks was captured, regardless of whether the abortion provider may have known about the emergency department visit. In other words, there was no loss to follow-up. This study found low complication rates. *Supra* ¶ 14. While Dr. Skop correctly notes that 5.2% of medication abortion patients in the study experienced complications, Skop Rep. ¶ 25, she neglects to mention that just 0.31% experienced major complications. Furthermore, the remaining complications included incomplete abortion, continuing pregnancy, and others who received aspiration care to resolve bleeding or cramping symptoms.[27] Other high-quality record linkage studies confirm that medication abortion is safe and effective.[28]

29. An additional study by Upadhyay et al. (*Abortion-Related Emergency Department Visits in the United States: an Analysis of a National Emergency Department Sample*), analyzing data from a nationally representative sample of emergency department visits—again, accounting for all emergency department visits and thus without loss to follow-up—estimated that, based on the number of abortions nationwide, abortion-related visits constituted just 0.01% of all emergency department visits by women of reproductive age from 2009 to 2013. Most of the abortion-related visits (82.8%) received observation care or an aspiration procedure. It further found that just 0.11% of abortions in the United States resulted in "major incidents" as seen in emergency departments.[29]

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[27] Upadhyay, *Incidence of Emergency Department Visits and Complications After Abortion*, *supra* note 2, at 178, 180, 182.

[28] *E.g.*, Laura Schummers et al., *Abortion Safety and Use with Normally Prescribed Mifepristone in Canada*, 386 N. Engl. J. Med. 57, 58–59, 63 (2022) (finding 0.76% rate of "severe adverse events," defined as any blood transfusion, abdominal surgery, admission to an intensive care unit, or sepsis); Aiken, *supra* note 15, at 1469.

[29] Ushma D. Upadhyay et al., *Abortion-Related Emergency Department Visits in the United States: an Analysis of a National Emergency Department Sample*, 16 BMC Med. 88, Abstract (2018) (defining "major incident" as "requiring blood transfusion, surgery, or overnight inpatient stay"). Although this study does not differentiate between procedural and medication abortion, the low major incident rate still confirms the safety of medication abortion.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

30. Dr. Skop alleges flaws in Dr. Upadhyay's studies and instead relies on research that she and Dr. Harrison co-authored with Jim Studnicki. Skop Rep. ¶¶ 26–29. But as Dr. Skop concedes, the study on which she relies was retracted. *Id.* ¶ 26 n.15.

31. The relevant retraction notice identified "fundamental problems with the study design and methodology, unjustified or incorrect factual assumptions, material errors in the authors' analysis of the data, and misleading presentations of the data . . . demonstrat[ing] a lack of scientific rigor and invalidat[ing] the authors' conclusions in whole or in part."[30] Among these problems is the fact that the study (1) uses emergency room visits as a proxy for complications, *supra* ¶ 15, and (2) includes emergency room visits that followed an abortion even if the visit was unrelated to the abortion.[31]

32. The other Studnicki studies Dr. Skop relies on (of which she and Dr. Harrison are co-authors), Skop Rep. ¶¶ 28–29 & nn. 18–19, fare no better. Both contain these same two flaws, among others.[32] For example, the 2025 study assumes without basis that any patient whose records reflected both a medication abortion and a miscarriage must have visited the emergency department for a medication abortion complication; it does this by assuming that the miscarriage visit was improperly coded.[33] But it is also possible that there are any number of other explanations

[30] SageJournals, *Retraction Notice*, Health Servs. Research & Managerial Epidemiology (Feb. 5, 2024), https://journals.sagepub.com/doi/10.1177/23333928231216699. The Retraction Notice also cites undisclosed conflicts of interest.

[31] Ushma D. Upadhyay and Chris E. Adkins, *Deception by Obfuscation: Studnicki et al.'s Retracted Longitudinal Cohort Study of Emergency Room Utilization Following Abortion*, 134 Contraception 110417, 2 (2024). With regard to (2), even Dr. Skop acknowledges that studies like Studnicki's may document correlation rather than causation. Skop Rep. ¶ 24.

[32] James Studnicki et al., *Comparative Acuity of Emergency Department Visits Following Pregnancy Outcomes Among Medicaid Eligible Women, 2004-2015*, 5 Int'l J. of Epidemiology & Pub. Health Research (2024); James Studnicki et al., *Determining the Period Prevalence and Acuity of Emergency Department Visits Following Induced Abortion Mistakenly Identified as Spontaneous Abortion: An Analytic Observational Prospective Cohort Study*, 9 J. Family Medicine and Primary Care (2025).

[33] Studnicki (2025), *supra* note 32.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

(e.g., that the original medication abortion code was inaccurate) and that the visit was in fact for a miscarriage.

33. Dr. Skop's critiques of the National Academies of Sciences, Engineering, and Medicine's report *The Safety and Quality of Abortion Care in the United States* that I cite in my opening Report, Skop Rep. ¶¶ 63–68, are baseless. First, Dr. Skop claims that the report was "commissioned and funded by six abortion advocacy organizations," and as a result, must be biased. *Id.* ¶¶ 63–64. As I explained in my Report ¶ 24 n.8, the National Academies' committees are made up of leading experts in their fields and produce peer-reviewed reports based on rigorous analysis. The organization's policies contain various checks throughout the study process to ensure their reports are objective and independent. For example, while reports produced by expert committees can be funded either by federal or state agencies, foundations, other private sponsors, or the National Academies' endowment, as their policies make clear, "the National Academies maintain full autonomy in conducting our activities and developing and communicating our advice free from undue influence from sponsors, donors, or other interested parties."[34] Moreover, only after "the review process has been satisfactorily completed and all authors have approved the revised draft" is a report released to sponsors or the public.[35] Committee members "must be free of conflicts of interest, transparent about their relevant relationships and publications, and independent from the sponsors of the committee's work."[36] Except for rare situations in which the

[34] Natl. Acads. of Sci., Eng., & Med., *Process*, https://www.nationalacademies.org/process (last visited June 1, 2026); *see also* Natl. Acads. of Sci., Eng., & Med., *Our Study Process*, https://www.nae.edu/19591/study-process (last visited June 1, 2026) ("Sponsors are not given an opportunity to suggest changes in reports.").

[35] Natl. Acads. of Sci., Eng., & Med., *Guidelines for the Review of Products of the National Academies of Sciences, Engineering, and Medicine*, https://www.nationalacademies.org/guidelines-for-the-review-of-products-of-the-national-academies-of-sciences-engineering-and-medicine (last visited June 1, 2026) [hereinafter "Natl. Acads. Guidelines"].

[36] Natl. Acads. of Sci., Eng., & Med., *Policy on Composition and Balance, Conflicts of Interest, and Independence for Committees Used in the Development of Findings, Conclusions, and*

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

National Academies determine that a conflict of interest is unavoidable and promptly and publicly discloses the conflict of interest, "[a]n individual may not be appointed to a committee charged with developing findings, conclusions or recommendations if the individual has a financial conflict of interest with respect to the issues to be addressed by the committee."[37] In addition, any other information that "could have a significant impact on public perception of the objectivity and value of the committee's work must be disclosed at the time of committee formation and in any report of the committee."[38] And as a final check on quality and objectivity, "[a]ny product by the National Academies of Sciences, Engineering, and Medicine must be reviewed by a diverse group of experts other than its authors prior to release. This independent, rigorous review is a hallmark that distinguishes the National Academies from other organizations offering scientific and technical advice on issues of national importance."[39] Dr. Skop's assertion that the report is biased is thus simply not true.

34. Dr. Skop also criticizes the National Academies' report for—in her opinion—excluding too many studies from its review. Skop Rep. ¶¶ 64, 66–68. But even with strict exclusion criteria designed to focus on studies "reflecting contemporary U.S. abortion practices,"[40] and looking only at the section, "The Safety and Quality of Current Abortion Methods," the report references over 166 studies that were reviewed and considered. The committee writing the report[41] also took a broad view of the type of research it examined in reaching its conclusions, including both experimental studies (controlled trials, systematic reviews, and meta-analyses) and observational

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Recommendations 1 (revised Jan. 30, 2025), https://www.nationalacademies.org/cdn/materials/9fb9fc79-fe56-448a-a76c-e060241a4cee.

[37] *Id*. at 2.

[38] *Id*. at 5.

[39] Natl. Acads. Guidelines, *supra* note 35.

[40] Natl. Acads. Rev., *supra* note 17, at 37.

[41] All committee members, reviewers (including me), and sponsors are disclosed in the report, as is the process that led to the report's creation. *Id.* at v–x, 1–4.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

studies (including cohort studies and case control studies) in its literature review.[42] There is simply no evidence that studies with contrary findings were systematically excluded.

35. Dr. Skop specifically complains that the National Academies excluded studies related to the long-term health effects of abortion, such as increased risk of breast cancer. Skop Rep. ¶ 67. But as the National Academies' report explains, many of the observational studies on abortion's long term health effects suffer from recall bias (systematic differences in study participants' ability to accurately recall information about their health exposures) and selection bias (lack of control group and taking into account confounding factors). For example, women who have abortions often have preexisting health conditions at higher rates than the general population, and the prevalence of such preexisting conditions "may affect future health and pregnancy outcomes."[43] To avoid studies with these types of errors, the committee set forth clear and objective criteria for inclusion.[44] In an attempt to refute the National Academies' well-reasoned methodology and conclusions, Dr. Skop cites to documents from the American Association of Pro-Life Obstetricians and Gynecologists ("AAPLOG," an advocacy group that seeks to eliminate all abortions[45]) and

[42] *See id*. at 38 Box 1-4, Types of Research Reviewed for this Study; *see also id*. at 187, 188 & tbl. D-1, Appendix D, Literature Search Strategy (outlining in detail the scope of each search performed on numerous databases).

[43] Natl. Acads. Rev., *supra* note 17, at 132. Even Dr. Skop does not allege a *causal* relationship for the long-term health risks she claims result from abortion. *E.g.* Skop Rep. ¶ 67 (noting "correlation" between abortion and breast cancer).

[44] Natl. Acads. Rev., *supra* note 17, at 130–33; *see also id.* at 139–47 (explaining criteria for including studies evaluating connection between preterm birth and finding no causal connection), 148–49 (same re breast cancer); 149–52 (same re mental health disorders).

[45] *See* AAPLOG, *Our Mission Statement*, https://aaplog.org/about-us/our-mission-statement/ (last visited June 1, 2026) ("AAPLOG informs and enables the public to better understand the medical and biological fact that life begins at fertilization and that the willful destruction of innocent human lives has no place in the practice of medicine"). Even AAPLOG acknowledges that there is no causal connection between abortion and breast cancer, AAPLOG, *Committee Opinion Number 8: Abortion & Breast Cancer* (Jan. 2020), https://aaplog.org/wp-content/uploads/2025/10/2025.10.16-CO-8-Abortion-Breast-Cancer-WEBSITE-final.pdf (claiming there is a "biologically *plausible* mechanism" for abortion causing breast cancer and calling for more research) (emphasis

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

commentary (rather than a peer-reviewed study) in a journal published by the Catholic Medical Association. Skop Rep. ¶ 67. These commentaries are not consistent with widely accepted scientific evidence.[46]

36. Dr. Skop's suggestion that abortion causes negative mental health outcomes is wrong. Skop Rep. ¶¶ 33, 67. There is no credible evidence that abortion causes trauma or increases the likelihood of mental health disorders. The most recent and robust scientific reviews of the literature—including reports by the American Psychological Association and the Royal College of Psychiatrists in the United Kingdom—have concluded that abortion does not have a negative impact on women's mental health.[47] By contrast, delays in accessing abortion can negatively impact wellbeing, Rep. ¶ 92, and being denied an abortion can negatively impact mental health in the short term.[48]

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added); AAPLOG, *Pro-Life Advocacy*, https://aaplog.org/about-us/pro-life-advocacy/ (last visited June 1, 2026) (referring to the "still controversial Abortion-Breast Cancer link").

[46] *See, e.g.*, Ctrs. for Disease Control & Prevention ("CDC"), *Preterm Birth*, (Nov. 8, 2024), https://www.cdc.gov/maternal-infant-health/preterm-birth/index.html (abortion missing from list of factors associated with preterm birth); Am. Cancer Soc'y, *Abortion and Breast Cancer Risk* (last revised June 7, 2024), https://www.cancer.org/cancer/risk-prevention/medical-treatments/abortion-and-breast-cancer-risk.html ("The most up-to-date scientific research suggests that abortion does not influence a woman's risk for breast cancer."; also noting that ACOG and the National Cancer Institute agree); APA Council on Women's Mental Health, *Myths and Facts Concerning Abortions and Mental Health*, Am. Psych. Assn. (Oct. 24, 2024), https://www.psychiatry.org/news-room/apa-blogs/myths-and-facts-concerning-abortions-and-mental-he (rejecting the myth that abortion causes negative mental health problems).

[47] Vignetta E. Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78 Contraception 436 (2008).

[48] M. Antonia Biggs et al., *Women's Mental Health and Well-Being Five Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74 JAMA Psychiatry 169 (2017). This is one of many articles published in reputable peer-reviewed journals resulting from the United States Turnaway Study. While Dr. Skop briefly critiques the Turnaway Study, Skop Rep. ¶ 67 & n.81, it provides the most recent and rigorous evidence on the effects of abortion on women's mental health. It followed nearly 1,000 women from thirty facilities for five years. The Turnaway Study compared women who had an abortion just below a facility's gestational duration limit to women who sought an abortion but were denied, because they were just beyond the facility's gestational duration limit. It thus improves on the methodological shortcomings of other studies—like those that Dr. Skop and AAPLOG rely on, but that were excluded from the National

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

37. While the National Academies report is an example of high-quality research, Dr. Skop cites many pages on the Charlotte Lozier Institute website (the organization with which she is affiliated, Skop Rep. ¶ 5) as purported evidence for her position. These are not peer-reviewed studies, but instead come from an organization which claims to "lead[] the pro-life movement with groundbreaking scientific, statistical, and medical research."[49]

38. Dr. Skop's and Harrison's suggestions that medication abortion deaths are common are baseless. *See* Skop Rep. ¶¶ 32–34; Harrison Rep. ¶¶ 14, 32, 45. They argue that abortion-related deaths and complications are subject to undercounting and underreporting,[50] but this view is not supported by credible evidence.

39. The CDC has maintained a Pregnancy Mortality Surveillance System that calculates the number of abortions and abortion-related deaths in the United States.[51] That Surveillance System defines a pregnancy-related death as "a death during or within 1 year of the end of pregnancy from any cause related to or aggravated by the pregnancy"—a definition that includes both childbirth-related deaths and abortion-related deaths.[52] As Dr. Skop acknowledges (¶ 32), the CDC does not

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Academies review—by accounting for pre-abortion mental health history and choosing an appropriate comparison group (women who sought but were denied an abortion).

[49] Charlotte Lozier Inst., *About Lozier Institute*, https://lozierinstitute.org/about/ (last visited June 1, 2026).

[50] Dr. Skop's claim that abortions are undercounted, Skop Rep. ¶ 14, would mean that the rate of abortion-related deaths is actually overstated (because the denominator in the equation would increase).

[51] CDC, *Data from the Pregnancy Mortality Surveillance System* (Dec. 18, 2025), https://www.cdc.gov/maternal-mortality/php/pregnancy-mortality-surveillance-data/index.html [hereinafter "*CDC PMSS*"].

[52] *See id*. The CDC has monitored abortion-related deaths through its Pregnancy Mortality Surveillance System since 1987 using both voluntary reporting by states and other means including:

> state or jurisdiction vital records; media reports, including computerized searches of full-text newspaper and other media databases; and individual case reports by public health agencies, including maternal mortality review committees, and any additional data when available. For each death that is possibly related to abortion, CDC requests clinical records and autopsy reports. Two medical epidemiologists

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

rely solely on voluntary reporting by states to generate this data: it also uses death records, linked birth records, fetal death records, and "data from all 50 states, New York City, and Washington, DC." Thus, it does not solely rely on death certificates, contrary to Dr. Skop's suggestion.[53] Furthermore, although the CDC does rely on voluntary reporting to calculate the total number of abortions performed each year, the vast majority of the central health agencies asked to report this data do so.[54] In 2022, the CDC "request[ed] aggregate [abortion] data from the central health agencies of the 50 states, the District of Columbia, and New York City," and "a total of 48 reporting areas" agreed to provide it.[55]

40. Dr. Skop also claims that two Finnish studies on pregnancy-related deaths demonstrate that abortion-related deaths are undercounted in the United States. Even putting aside the fact that pregnancy-related death rates in Finland cannot be generalized to the United States given different health systems and populations, these studies include all deaths where the deceased person had an abortion within the previous year, regardless of whether the deaths were actually caused by abortion.[56] Ultimately, neither these studies nor anything else she cites provide foundation for Dr.

> 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.

Stephanie Ramer et al., *Abortion Surveillance — United States, 2022*, 73 CDC MMWR Surveillance Summaries 1, 4 (2024).

[53] *CDC PMSS*, *supra* note 51.

[54] Ramer, *supra* note 52, at 4.

[55] *Id.* at Abstract.

[56] Mika Gissler et al., *Pregnancy-Associated Mortality After Birth, Spontaneous Abortion, or Induced Abortion in Finland 1987-2000*, 190 Am. J. Obstetrics & Gynecology 422 (2004) (relying on data before medication abortion was even available in Finland); Elina Karalis, *Decreasing Mortality During Pregnancy and for a Year After While Mortality After Termination of Pregnancy Remains High: A Population-Based Register Study of Pregnancy-Associated Deaths in Finland 2001–2012*, British J. of Obstetrics & Gynaecology (2016). For example, the studies include accidental deaths and homicides, neither of which can logically be caused by abortion. The other study cited by Skop does not account for causation and relies primarily on international studies (including these Finnish studies). *See* David C. Reardon and John M. Thorp, *Pregnancy Associated*

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Skop's claim that the "CDC fails to detect most abortion-related deaths." Skop Rep. ¶ 34. Conjecture is not a scientific method.

41. Furthermore, as Dr. Skop acknowledges, the FDA still requires reporting of deaths resulting from medication abortion. *E.g.*, *id.* ¶ 90. As of December 2024, the FDA data confirm just how rare death resulting from medication abortion is: only 0.00048% of medication abortions resulted in death. Rep. ¶¶ 25–26.[57]

D. Drs. Skop and Harrison Cherry Pick Data, Take Them out of Context, and Rely on Poor Quality or Irrelevant Studies.

42. Drs. Skop and Harrison ignore high quality studies and data that do not support their view that medication abortion is dangerous. Instead, they cherry pick data that suits them. However, as detailed below, the data they rely on is either taken entirely out of context, of poor quality, and/or provides no support for their position.

43. In relying on Finnish studies, Drs. Skop and Harrison use irrelevant data and take other findings out of context. *See* Skop Rep. ¶¶ 33, 62, 72–74; Harrison Rep. ¶¶ 12, 16, 22, 46. For example, Dr. Skop claims that these studies found high rates of medication abortion failure and hemorrhage. But one of the studies primarily relates to second trimester medication abortion[58] and

Death in Record Linkage Studies Relative to Delivery, Termination of Pregnancy, and Natural Losses: A Systematic Review With a Narrative Synthesis and Meta-Analysis, 5 SAGE Open Med. (2017). The two American studies this review relies on rely on data before medication abortion was available in the United States (1975–76 and 1989–97), and one even suggests that deaths eight years after an abortion may be attributable to the abortion. *Id.* at tbl. 1.

[57] FDA, *Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2024*, https://www.fda.gov/media/185245/download (last visited June. 2, 2026); ANSIRH Adverse Events Analysis, *supra* note 16. Contrary to Dr. Harrison's assertion (¶ 32), medication abortion does not cause ectopic pregnancy and thus deaths from ectopic pregnancy are unrelated. *See supra* note 6, *infra* ¶¶ 60–61 & notes 80–84.

[58] Maarit Mentula et al., *Immediate Adverse Events After Second Trimester Medical Termination of Pregnancy: Results of a Nationwide Registry Study*, 26 Human Reproduction 927 (2011).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

another through 20 weeks LMP,[59] even though my understanding is that no Plaintiff in this case provides medication abortion in the second trimester. These studies also did not specify what medication abortion regimen was used, did not define hemorrhage, relied on patient self-reporting of bleeding, and thus could have included even patients whose bleeding would have been within the normal range following medication abortion as having experienced hemorrhage.[60] To clarify, while some bleeding is expected when patients take medication abortion, it is very rare for medication abortion to cause hemorrhage involving major blood loss and necessitating follow-up treatment.[61]

44. In response to these criticisms, even the authors of Niinimäki et al. (2009)—upon which Drs. Skop and Harrison both rely—acknowledged these shortcomings in their research, conceding that many of the "complications" reported in their study were "not really such, but rather concerns or adverse events that [brought] women back to the health care system," and stating that their article confirms that the "[r]ate of serious, 'real' complications [from abortion] is rare."[62]

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[59] Maarit Niinimäki et al., *Comparison of Rates of Adverse Events in Adolescent and Adult Women Undergoing Medical Abortion: Population Register Based Study*, BMJ (2011).

[60] Mentula, *supra* note 58, at 928 ("Details of the medical methods used were not available."); Niinimäki (2011), *supra* note 59, at 2 ("The study population consisted of women who had had a medical abortion (mifepristone alone or in combination with misoprostol or other prostaglandins)"); Maarit Niinimäki et al., *Immediate Complications of Medical Compared with Surgical Termination of Pregnancy*, 114 Obstetrics & Gynecology 795 (2009) (same); Mary Fjerstad et al., *Letters to the Editor: Immediate Complications After Medical Compared with Surgical Termination of Pregnancy*, 115 Obstetrics & Gynecology 660 (2010); Maarit Niinimäki et al., *In Reply: Immediate Complications After Medical Compared with Surgical Termination of Pregnancy*, 115 Obstetrics & Gynecology 660 (2010) (noting that "practically all women received 200 mg of mifepristone *after* vaginal administration of misoprostol" (emphasis added)). The most common mifepristone-misoprostol medication abortion regimen involves taking mifepristone *before* misoprostol; the authors also do not specify the misoprostol dosage.

[61] Upadhyay, *Incidence of Emergency Department Visits and Complications After Abortion*, *supra* note 2, at 179–80 (explaining criteria for diagnosis of hemorrhage and finding that 0.14% of medication abortion patients experienced hemorrhage).

[62] Niinimäki (2010), *supra* note 60, at 660.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

45. In making claims about medication abortion being ineffective or unsafe, Drs. Skop and Harrison disregard the medication abortion regimen used in some of the studies they cite. This is particularly relevant to their exaggerations about the inefficacy of medication abortion after 63 days LMP—their main justification for the Evidence-Based Use Ban. As I explained in my Report ¶ 56, when used at or after 63 days LMP, medication abortion with mifepristone is more effective when more than one dose of misoprostol is used.[63] A 2020 study with this regimen found that, of patients whose gestational duration was between 64 and 77 days LMP, just 1.3% had an incomplete abortion and only 0.89% had a continuing pregnancy.[64] In other words, medication abortion is still highly effective after 63 days LMP. While rates of incomplete abortion and continuing pregnancy may increase marginally as gestational duration advances, these rates remain low when applying evidence-based practices. Medication abortion also remains safe after 63 days LMP, with rates of serious adverse events similar to those at earlier gestational durations. Rep. ¶ 56.

46. By contrast, the 9.6% rate of ongoing pregnancy for mifepristone-misoprostol medication abortions and 18.4% rate for misoprostol-alone medication abortions cited by Dr. Skop (¶ 105) resulted from outdated and less effective mifepristone-misoprostol and misoprostol-alone

[63] Nathalie Kapp et al., *Medical Abortion in the Late First Trimester: A Systematic Review*, 99 Contraception 77 (2019); Jacqueline Quinn et al., *Safety and Efficacy of Early Medical Abortion at Home Between 10+0 and 11+6 Weeks' Gestation: A Retrospective Review*, 52 BMJ Sexual & Reproductive Health 57 (2026); World Health Org., *Abortion Care Guidelines* 68–70 (2022), https://iris.who.int/server/api/core/bitstreams/59a704cc-4024-412a-97d9-55d86d139602/content; Ilana Dzuba et al., *A Repeat Dose of Misoprostol 800 mcg Following Mifepristone for Outpatient Medical Abortion at 64–70 and 71–77 Days of Gestation: A Retrospective Chart Review*, 102 Contraception 104 (2020); Robin Wallace et al., *Expanding Access to Abortion with Mifepristone and Misoprostol Through 84 Days Estimated Gestational Duration*, 151 Contraception (2025); Natl. Abortion Fedn., *Clinical Policy Guidelines for Abortion Care 2026*, https://nationalabortionfederation.org/quality-standards/ (last visited June 2, 2026).

[64] Dzuba, *supra* note 63, at 105–06 & tbl. 2.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

regimens than those I discussed in my Report ¶¶ 20, 33, 56.[65] Drs. Skop and Harrison also cite studies to claim high rates of continuing pregnancy for medication abortions after 63 days LMP, but those studies did not involve a repeat dose of misoprostol.[66] The regimen involving a repeat dose of misoprostol is confirmed to have higher efficacy rates. Rep. ¶ 56. Dr. Harrison even cites one study of just 18 patients from 1985 involving mifepristone alone to imply that medication abortion is ineffective, Harrison Rep. ¶ 7; this regimen is never used.

47. Dr. Skop suggests that, because many studies evaluate outcomes only through 63 days gestation, the Plaintiffs in this case are trying to push the limits of safety past that duration despite limited high-quality data and known escalating risks. Skop Rep. ¶ 58. It is true that there is a larger body of evidence evaluating abortion prior to 63 days gestation, but that does not mean that medication abortion beyond this point is untested or unsafe. High-quality systematic reviews, an increasing number of studies, and leading medical groups support the provision of medication beyond 63 days gestation, as does the FDA. Rep. ¶¶ 20, 54.[67] And while Dr. Skop is correct that there is a greater likelihood of having a continuing pregnancy or complications as pregnancy

[65] Kapp, *supra* note 63, at 81; *see also* Elizabeth G. Raymond et al., *Medication Abortion with Misoprostol-Only: A Sample Protocol*, 121 Contraception (2023) (elaborating on misoprostol-alone protocol discussed in my Report ¶ 20).

[66] Ilana G. Dzuba et al., *A Non-Inferiority Study of Outpatient Mifepristone-Misoprostol Medical Abortion at 64–70 Days and 71–77 Days of Gestation*, 101 Contraception 302, 307 (2020) (cited in Skop Rep. ¶ 105; "Since this study was completed, newer evidence demonstrates that more than one misoprostol 800 mcg dose after mifepristone for later-first-trimester outpatient [medication abortion] holds promise."); Elizabeth G. Raymond et al., *First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol: A Systematic Review*, 87 Contraception 26, 29 (2013) (cited in Skop Rep. ¶¶ 65, 69; describing different doses of misoprostol following mifepristone 200 mg, none of which involve a repeat dose of misoprostol); Leonardo Cely-Andrade et al., *Telemedicine for the Provision of Medication Abortion to Pregnant People at up to Twelve Weeks of Pregnancy: A Systematic Literature Review and Meta-Analysis*, 21 Reproductive Health, 18–19 (2024) (cited in Skop ¶ 100; noting that effectiveness increases with "additional doses of misoprostol to the basic drug regimen"); *MIFEPREX* 2016 Label, *supra* note 11 (cited in Harrison Rep. ¶ 17).

[67] Dr. Skop misunderstands the purpose of the REMS and FDA label, *see* Skop Rep. ¶ 58, neither of which ever barred the provision of medication abortion beyond 63 days gestation. *See* Rep. ¶¶ 44–53.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

progresses, the increased risk is small, and medication abortion remains safe and effective when taken according to an evidence-based protocol. Rep. ¶ 90.

48. Dr. Harrison's purported "systematic review" of the studies cited by the FDA in support of its changes to the Mifeprex label in 2016 does not pass scientific muster. Harrison Rep. ¶¶ 65–74. Dr. Harrison critiques these studies because they allegedly failed "to evaluate the safety and efficacy of chemical abortion drugs under the precise conditions prescribed or implied in the updated labeling or current telemedicine dispensing protocols." *Id.* ¶ 65. According to Dr. Harrison, each study relied upon by the FDA when approving the 2016 label should have replicated the exact criteria set forth in the Mifeprex label or the conditions for prescribing allowed when the FDA suspended the in-person dispensing requirement. This ignores the fact that science is an iterative process; studies may try one change to a medication protocol at a time while controlling for remaining factors. It also ignores the large body of research conducted after the FDA completed its review that confirms the safety and efficacy of medication abortion.

E. The Medical Consensus Is That Telemedicine Medication Abortion Is Safe and Effective.

49. Just as Drs. Skop and Harrison are wrong about the literature that confirms that medication abortion in general is safe and effective, they are wrong about the research that confirms that providing medication abortion via telemedicine is safe and effective. The overwhelming body of evidence confirms that telemedicine medication abortion is comparably safe and effective to medication abortion provided in person.

50. As I explained in my Report ¶ 37, for patients using a mifepristone-misoprostol medication abortion regimen, the bleeding or spotting that is an expected part of the medication abortion process generally does not start until after the patient takes misoprostol—24 to 48 hours after taking the mifepristone. Even if the mifepristone is administered in a health center, patients are no

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

longer at a health center when taking the misoprostol. Thus, any rare complications that do arise will occur after the patient has left the health center. *Id.* ¶ 71.[68] For this reason, the complications would be addressed in the same manner regardless of whether the patient received medication abortion via telemedicine. Many of these complications can be managed via telehealth.

51. Dr. Skop selectively cites rates of incomplete abortion, continuing pregnancy, and complications, *see, e.g.*, Skop Rep. ¶ 99, while ignoring the important takeaway of many of these studies: that these rates are no different regardless of whether the medication abortion is provided in person or via telemedicine. *But see id.* ¶ 100 (acknowledging "no difference [in whether the medication abortion was complete] if provided by in-person vs. telemedicine").[69] I summarized

[68] With a misoprostol-only regimen, patients will not start to have symptoms for at least a couple hours after taking the first dose of the medication. In other words, regardless of the medication abortion regimen used, patients will not begin to experience symptoms at a health center even if they take the first dose there.

The only side effect of medication abortion that might arise immediately is an extremely rare (0.0075%), but not serious allergic reaction (with symptoms such as hives). Richard Hausknecht, *Mifepristone and Misoprostol for Early Medical Abortion: 18 Months Experience in the United States*, 67 Contraception 463 (2003). This can be treated via telemedicine on a non-urgent basis. Dr. Harrison claims that in-person screening is required to account for a potential allergy to mifepristone or misoprostol, Harrison Rep. ¶ 14, but the only way to know if a patient is allergic is based on prior experience with the medication. There is no physical test that could be given in person to assess for this.

[69] *See also* Cely-Andrade, *supra* note 66, at 2 (cited in Skop Rep. ¶ 100; "The meta-analysis of studies comparing telemedicine care with standard services reveals that the type of care provided does not affect the effectiveness and safety of MAB, nor does it affect user satisfaction, follow-up, or medication adherence."); Margit Endler et al., *Telemedicine for Medical Abortion: A Systematic Review*, 126 British J. of Obstetrics & Gynaecology 1094 (2019) (cited in Skop Rep. ¶ 98; finding telemedicine medication abortion through telemedicine "acceptable to women and providers" with similar "success rate and safety outcomes . . . to those reported in literature for in-person abortion care"). While Endler et al. found that the need for follow-up procedures was higher among telemedicine patients, the authors acknowledged that rates differed dramatically by "women's country of residence" and thus may "reflect varying local practices in the treatment of incomplete abortion or miscarriage." The study also involved medication abortions beyond 12 weeks LMP, which resulted in higher follow-up procedure rates, and different regimens of medication abortion. *Id.* at 1099–1000 (noting that telemedicine patients "may not have access to repeat doses of misoprostol, which would lower their rate of complete abortion").

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

some of the research confirming this in my Report ¶¶ 67–71.[70]

52. Dr. Skop cites a 2021 Anger et al. study to argue that medication abortion less safe and effective when provided via direct-to-patient telemedicine, Skop Rep. ¶ 97, but a follow-up study by Anger and Raymond (2024) found that the increased risks of incomplete abortion and ongoing pregnancy for telemedicine abortion as compared to in-person abortion "resolved over time," that the difference in abortion-related clinical visits did not persist (and as noted *supra* ¶ 15, clinical or emergency department visits is not an accurate measure of complications), and that "[t]he risk of serious adverse events did not differ by group."[71]

53. Dr. Skop also criticizes a comprehensive study by Aiken et al. (2021) (discussed in my Report ¶ 67 & n. 105), which found that telemedicine abortion patients in the study cohort had just a 0.7% rate of incomplete abortion, 0.53% rate of continuing pregnancy, and 0.02% rate of significant adverse events, all comparable to the results for in-person medication abortion.[72] Dr. Skop claims without support that the study did not use a complete dataset in examining complications of telemedicine abortion, Skop Decl. ¶ 102,[73] even though this is an example of a

[70] More studies in addition to those I cite in my report find that medication abortion via telemedicine is safe and effective. *E.g.*, Abigail R.A. Aiken et al., *Safety and Effectiveness of Self-Managed Medication Abortion Provided Using Online Telemedicine in the United States: A Population Based Study*, 10 Lancet 1, 4 (2022) (96.4% had a complete abortion and just 1.0% experienced a serious adverse event).

[71] Holly A. Anger and Elizabeth Raymond, *Clinical and Service Delivery Outcomes Following Medication Abortion Provided With or Without Pretreatment Ultrasound or Pelvic Examination: An Updated Comparative Analysis*, 140 Contraception, Abstract (2024).

[72] Aiken, *supra* note 15.

[73] Dr. Skop does not include any citation for her claims about "Hospital Episode Statistics (HES)" and comparing complications results to FDA findings. Her allegations appear to derive from an article she co-authored in a journal published by the Alliance for Hippocratic Medicine. Putting aside the methodological issues with this article (some of which are similar to the defects in the Studnicki et al. articles discussed *supra* ¶¶ 30–32), Dr. Skop and her co-authors found that even when including the HES data and counting incomplete abortions as complications, only 1.93% of patients had complications. Ingrid Skop et al., *United Kingdom Data Deficiencies Influencing U.S. FDA Decisions*, 39 Issues in Law & Medicine 32, 46 (2024). This is an example of how Dr. Skop cites comparative data to obscure underlying low rates of complications. The Alliance for

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

record linkage study, which Dr. Skop says address many of what she sees as shortcomings in other abortion studies, *id.* ¶ 24; *see also supra* ¶¶ 26–28.

54. Dr. Skop is right that systematic reviews may give better quality data. Skop Rep. ¶ 98. The systematic reviews she cites confirm that telemedicine medication abortion is safe and effective. *Id.* ¶¶ 98–100.[74] But Dr. Skop errs by cherrypicking results from single studies included in the review, and then implies that the review as a whole found those rates of complications. For example, in her discussion of Cely-Andrade et al. (2024), Dr. Skop claims that an average 1.3% of telemedicine medication abortion patients were hospitalized, *id.* ¶ 100, but she relies on data from just three of the 21 studies in the review, whereas other studies found the average was 0.1%. Ultimately, Dr. Skop's confusion stems from the purpose of this review, which is to assess the comparative safety of telemedicine abortion to in-person medication abortion care. Thus, it included studies assessing a variety of medication abortion regimens and gestational durations across different parts of the world. It therefore should not be used to generalize about the likelihood of different medication abortion complications, but it does stand for the proposition that medication abortion is equally safe and effective, whether provided in person or via telemedicine.[75]

F. Drs. Skop and Harrison Misunderstand Common Telemedicine Medication Abortion Protocols and Demand In-Person Pre-Abortion Testing That Is Often Medically Unnecessary.

55. In addition to critiquing the literature on the safety of telemedicine abortion, Drs. Skop and Harrison also question telemedicine abortion protocols without understanding them.

Hippocratic Medicine, a consortium of anti-abortion medical groups, requires its members to affirm that they "will not help a woman obtain an abortion." Alliance for Hippocratic Medicine, https://allianceforhippocraticmedicine.org/ (last visited June 2, 2026).

[74] *E.g.*, Marit Pearlman Shapiro et al., *No-Test Medication Abortion: A Systematic Review*, 141 Am. J. of Obstetrics & Gynecology 23 (2022) (cited in Skop Rep. ¶ 99; "Medication abortion performed without prior pelvic examination or ultrasonogram is a safe and effective option for pregnancy termination."); *see also supra* note 69.

[75] Cely-Andrade, *supra* note 66.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

56. As I discussed in my Report ¶¶ 34, 53, in April 2021, the FDA suspended the requirement that a clinician dispense mifepristone in person for the duration of the COVID-19 pandemic; it then announced a permanent modification to the REMS to eliminate the in-person dispensing requirement entirely because it unnecessarily restricted access to care. In eliminating the in-person dispensing requirement for mifepristone, in addition to its own data, the FDA analyzed rigorous peer-reviewed research and concluded that there was no "difference in adverse events between periods when in-person dispensing was and was not enforced."[76] Additional scientific evidence published since the FDA completed its most recent review adds further support to the agency's conclusion that medication abortion is safe and effective, including when prescribed via telemedicine.

57. At the outset, it is clear that the State's experts misunderstand common telemedicine medication abortion protocols. *Compare* Rep. ¶ 65 *with e.g.*, Skop Rep. ¶ 107 *and* Harrison Rep. ¶ 63.[77] As I explained in my Report, in the direct-to-patient model of telemedicine abortion a patient can connect remotely with a health care provider from her own home or another location

[76] FDA, *Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, (Apr. 8, 2026), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation; *see* FDA *Medical Review(s)*, *supra* note 19, at 1, 10–12 (describing evaluation process, including review of data from its adverse event reporting system).

[77] A particularly egregious example of this is Dr. Harrison's discussion of over-the-counter medication abortion in India. Though she provides no citation, I assume she draws these statistics from K. Nivedita and Fatima Shanthini, *Is It Safe to Provide Abortion Pills over the Counter? A Study on Outcome Following Self-Medication with Abortion Pills*, 9 J. of Clinical & Diagnostic Research 1 (2015). This study says nothing about telemedicine or the certified pharmacy system established by the most recent mifepristone REMS. *See* Rep. ¶ 53. Furthermore, it contains numerous methodological deficiencies (such as a sample size of only 40 patients) and addresses only patients who reported to a hospital with complications following medication abortion, and thus says nothing about the incidence of complications among medication abortion patients as a whole.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

of her choosing. In this model, a clinician evaluates the patient for eligibility for medication abortion using screening questions known as the "no-test protocol." Rep. ¶ 67.

58. Through the no-test protocol, patients are screened to determine whether they are eligible for a direct-to-patient telemedicine medication abortion. Clinicians refer patients who cannot accurately date their pregnancy, those at higher risk of ectopic pregnancy, or those who are screened as possibly having another contraindication to obtain an ultrasound, in-person exam, or other testing to determine eligibility for a medication abortion. One study cited by Dr. Harrison (¶ 58 n.40) confirms that providers can accurately assess whether an ultrasound is medically necessary when using an appropriate screening protocol.[78] Dr. Skop's claim that clinicians providing telemedicine abortion "do[] not have the ability to order an ultrasound even if it was deemed necessary," Skop Rep. ¶ 107, is unfounded. A patient may either visit the abortion provider to obtain an ultrasound and any other indicated pre-abortion testing, or the abortion provider may refer the patient to another health care provider for an ultrasound and testing.

59. Drs. Skop and Harrison claim that a pre-abortion ultrasound is necessary to assess gestational duration prior to a medication abortion. *Id.* ¶¶ 81–84, 89; Harrison Rep. ¶¶ 26–27, 45, 57–58, 61. When evaluating gestational duration using a no-test medication abortion protocol, providers do not simply ask patients the date of their last menstrual period. In addition to asking about a patient's last menstrual period, providers ask additional questions related to gestational dating, such as about the date they think they may have gotten pregnant.[79] Using these protocols,

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[78] Janina Kaislasuo & Oskari Heikinheimo, *Safety and Accuracy of Dating Unwanted Pregnancies and Detecting Ectopic Pregnancy with the RCOG Decision Aid Without Routine Ultrasound – A Retrospective Analysis From a Large Abortion Service*, 30 European J. of Contraception & Reproductive Health Care 93, Abstract (2025) ("Correct classification of the necessity of an ultrasound was made in 491/494 (99.4%) cases before the women had a scan.").

[79] *E.g.*, Lauren J. Ralph et al., *Accuracy of Self-Assessment of Gestational Duration Among People Seeking Abortion*, 226 Am. J. Obstetrics & Gynecology 710.e1, 710.e3 tbl. 1 (2022)

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

most patients can date their pregnancy with sufficient accuracy for the provider to determine whether they are within the gestational duration window of when medication abortion is effective. Rep. ¶ 67 & n.104. Patients who are unable to do so will be referred for ultrasound to determine their gestational duration and eligibility for medication abortion.

60. Providers can also effectively screen patients for risk of ectopic pregnancy[80] without an ultrasound, contrary to Drs. Skop's and Harrison's suggestions. *See* Skop Rep. ¶¶ 85–88; Harrison Rep. ¶¶ 32, 45, 52. A no-test protocol involves screening people for risk factors for or symptoms of a possible ectopic pregnancy, such as unusual pain or bleeding, as well as a history of a prior ectopic or tubal surgery. If the patient is at risk of an ectopic pregnancy, the provider will refer her for an ultrasound.[81]

61. I agree with Drs. Skop and Harrison that it is important to detect and treat ectopic pregnancies as early as possible. Placing the risk for abortion patients in context, research indicates that rates of ectopic pregnancy are lower in patients seeking abortion than among all pregnant patients.[82] Regardless of whether the patient has an ultrasound beforehand, early access to

[80] An ectopic pregnancy is a condition in which a fertilized egg implants and grows outside the uterus.

[81] *See* Elizabeth G. Raymond et al., *Commentary: No-Test Medication Abortion: A Sample Protocol for Increasing Access During a Pandemic and Beyond*, 101 Contraception 361, 361–62 (2020).

[82] M. Antonia Biggs et al., *Incidence of Ectopic Pregnancy and Diagnostic Accuracy of Ectopic Pregnancy Screening Criteria Among People Seeking Versus Not Seeking Abortion: A Retrospective Case-Control Study*, 35 Women's Health Issues 475, 477–80 (2025) (finding 0.39% of incidence of ectopic pregnancy among people seeking abortion compared to 1.74% among people not seeking abortion and offering explanation for disparate rates). Dr. Skop cites Alisa B. Goldberg et al., *Mifepristone and Misoprostol for Undesired Pregnancy of Unknown Location*, 139 Obstetrics & Gynecology 771 (2022), to suggest that medication abortion patients may have high rates of ectopic pregnancies. Skop Rep. ¶ 87. Critically, however, none of the patients in the study who received medication abortion had ectopics, while the 7.9% who ultimately received treatment for an ectopic pregnancy *never took medication abortion*. Ultimately, Dr. Skop is using an inapposite study about pregnancies of unknown location to argue that telemedicine abortion is dangerous.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

medication abortion can facilitate timely detection of an ectopic pregnancy because a patient with an ectopic pregnancy will not experience the expected effects of the medications, indicating she may have an ectopic pregnancy.[83] Therefore, contrary to Drs. Skop's and Harrison's suggestions, Skop Rep. ¶¶ 87–88; Harrison Rep. ¶¶ 52, 59, medication abortion patients may be *more* rather than less likely to detect an ectopic pregnancy. Moreover, taking medication abortion will not do anything to exacerbate the symptoms of an ectopic pregnancy;[84] it just will not have the effect of ending the pregnancy. Dr. Harrison is incorrect that patients are likely to mistake the symptoms of an ectopic pregnancy with the effects of medication abortion. Harrison Rep. ¶¶ 52, 59. Patients with ectopic pregnancies typically have light or no bleeding, rather than heavy bleeding. The quality and location of pain also often differs for medication abortion and ectopic pregnancy. Medication abortion patients typically experience heavy cramping in the lower midline area of the abdomen, while ectopic pregnancy pain is usually localized to one side of the pelvis or abdomen. Patients are counseled on how to distinguish symptoms associated with medication abortion from ectopic symptoms and on when to contact a clinician for additional support. If a patient has concerns or is unsure, she can also contact a clinician.

[83] Biggs (2025), *supra* note 82, at 479–80 (finding that people seeking abortion received ectopic pregnancy treatment earlier in pregnancy than those not seeking abortion; "[F]or people who receive medication or procedural abortion care without prior confirmation of pregnancy location, they may present to abortion care with ectopic pregnancy symptoms or experience unusual symptoms post-medication abortion, such as lack of bleeding or a positive pregnancy test that may lead them to suspect and detect an ectopic pregnancy earlier than for those not seeking abortion."). A study cited by Dr. Skop ¶ 86 n.106 relying on data from 1972 to 1985—prior to the availability of medication abortion and before first-trimester ultrasound was widely available—is irrelevant. *See* Hani K. Atrash et al., *Ectopic Pregnancy Concurrent with Induced Abortion: Incidence and Mortality*, 162 Am. J. Obstetrics & Gynecology 726 (1990).

[84] Siripanth Nippita, *Society of Family Planning Clinical Recommendation: Management of Undesired Pregnancy of Unknown Location and Abortion at Less Than 42 Days of Gestation*, 150 Contraception 1, 8 (2025).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

62. Also as part of a no-test protocol, abortion providers obtain informed consent from their patients, including making sure that patients understand the risks and benefits of, and alternatives to, medication abortion. Drs. Skop and Harrison are wrong that patients need to get an ultrasound to provide informed consent.[85] A patient can ask questions about gestational development if she considers that relevant to her decision but does not need an ultrasound to learn about gestational development. However, if a patient wants to get an ultrasound prior to an abortion, she can always make an in-person appointment rather than a telemedicine medication abortion. And because the no-test protocol can accurately assess gestational duration for most patients, *supra* ¶ 59, Dr. Harrison's statement that a patient needs an ultrasound to determine gestational duration and thus the true risk of obtaining a medication abortion is misguided.

63. The State's experts also assert that ultrasound or in-person examination is necessary to screen for other contraindications to medication abortion. Skop Rep. ¶¶ 89, 92;[86] Harrison Rep. ¶¶ 29–30, 59, 61–62. Before providing medication abortion, whether via telemedicine or in person, clinicians take detailed medical histories to assess for contraindications to medication abortion. No-test protocols thus screen for medication abortion contraindications, such as severe anemia.[87] Patients with risk factors for contraindications may be referred for further testing, including ultrasound, and those with confirmed contraindications may be ruled ineligible for medication abortion altogether.

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[85] *See MIFEPREX* 2016 Label, *supra* note 11 (FDA label for mifepristone does not require an ultrasound).

[86] Dr. Skop cites conditions that are contraindications for procedural, rather than medication abortion, as justification for this. Skop Rep. ¶ 89; Rep. ¶ 62 (discussing contraindications for procedural abortion).

[87] Lauren J. Ralph et al., *Accuracy of Survey-Based Assessment of Eligibility for Medication Abortion Compared with Clinician Assessment*, 233 Am. J. Obstetrics & Gynecology 44.e1, 44.e3 (2025).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

64. Drs. Skop and Harrison also argue that pre-medication abortion blood testing is necessary, including to determine the patient's Rh status. Skop Rep. ¶¶ 90–91; Harrison Rep. ¶ 31. But as Dr. Skop notes, leading medical organizations, including ACOG, indicate that blood typing is not necessary for an abortion before 12 weeks LMP;[88] that is to say, it is not necessary for *any* medication abortions provided in Ohio since the Plaintiffs only provide medication abortion up to that gestational duration. While Dr. Skop claims that failure to accurately determine gestational duration means that some patients for whom Rhogam would be indicated will not receive it, Skop Rep. ¶ 81, that ignores research demonstrating that no-test protocols can accurately determine how far along a pregnancy is, *supra* ¶ 59. Dr. Skop's citation to outdated studies and practice recommendations does not reflect the medical consensus.

65. Lastly, Drs. Skop and Harrison claim that an in-person visit prior to a medication abortion is necessary to prevent coercion. Skop Rep. ¶ 121; Harrison Rep. ¶¶ 38–39, 60. No study they cite indicates that coercion is more likely when medication abortion is provided via direct-to-patient telemedicine as compared to in person.[89]

66. Drs. Skop's and Harrison's arguments regarding coercion are premised on the misguided assumption that patients could only be coerced to have an abortion, ignoring the reality that they may instead be coerced to become pregnant and carry a pregnancy to term. *See* Rep. ¶¶ 93–94.[90]High-quality data confirms that coercion to have an abortion is rare. The Turnaway Study,

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[88] ACOG, *ACOG Clinical Practice Update: Rh D Immune Globulin Administration After Abortion or Pregnancy Loss at Less Than 12 Weeks of Gestation*, 144 Obstetrics & Gynecology e140 (2024).

[89] In one study of 16 abortion providers cited by Dr. Harrison, providers said that telemedicine may sometimes *improve* detection of coercion. John Joseph Reynolds-Wright et al., *A Qualitative Study of Abortion Care Providers' Perspectives on Telemedicine Medical Abortion Provision in the Context of COVID-19*, 48 BMJ Sexual & Reproductive Health 199, 4 (2022) (discussing challenges of detecting domestic violence during both in-person and virtual interactions).

[90] ACOG, *Committee Opinion Number 554: Reproductive and Sexual Coercion*, 121 Obstetrics & Gynecology 411 (2013).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

the largest study to examine patients' experiences with abortion and unintended pregnancy in the United States, found that among 954 study participants, only one used language indicating overt pressure from a partner to terminate a pregnancy. Indeed, participants who reported experiencing intimate partner violence did not report being coerced by their partner to have the abortion; to the contrary, they identified having an abortion as their best option for leaving the abusive relationship.[91] This finding is reinforced by other studies showing that women who were able to obtain abortions were more likely to be able to exit abusive relationships as compared to women who carried their pregnancy to term.[92]

67. Providers are also trained to screen for coercion. It is the standard of care that, if a provider is at all concerned that a patient is being coerced to end her pregnancy, that provider does not proceed with the abortion.[93] Indeed, abortion providers play a "critical role . . . in ensuring that women arrive at a final decision on their own."[94] Abortion providers have procedures for talking with a patient and making sure they are confident in their decision, and this can be done via a telemedicine appointment just as effectively as in person. Moreover, offering telemedicine appointments does not preclude a patient from making an in-person appointment if they want one (including if they feel that in-person is safer, or more private for them, given their circumstances), nor does it prevent a provider from requesting a patient come into the health center if there is some

[91] Karuna S. Chibber, et al., *The Role of Intimate Partners in Women's Reasons For Seeking Abortion*, 24 Women's Health Issues e131 (2014).
[92] Sarah C.M. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy after Receiving or Being Denied an Abortion*, 12 BMC Medicine 144 (2014).
[93] Anne Baker & Terry Beresford, *Informed Consent, Patient Education, and Counseling* in Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care 48 (Maureen Paul et al., eds., 1st ed., 2009); Heather Gould et al., *Patient Education and Emotional Support Practices in Abortion Care Facilities in the United States*, 22 Women's Health Issues e359 (2012); *see also* Lauren Ralph et al., *The Role of Parents and Partners in Minors' Decisions to Have an Abortion and Anticipated Coping After Abortion*, 54 J. Adolescent Health 428 (2014).
[94] Ralph et al. (2014), *supra* note 93, at 432.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

concern. I have seen no evidence in my extensive clinical experience and research regarding abortion via telemedicine that there is a higher risk of coercion in the telemedicine context than in the context of in-person care. As ACOG notes in its Committee Opinion on intimate partner violence, "[s]tudies have shown that patient self-administered or computerized screenings [for intimate partner violence] are as effective as clinician interviewing in terms of disclosure, comfort, and time spent screening," indicating that this screening may be done effectively in the context of a telemedicine visit.[95]

68. Furthermore, access to telemedicine medication abortion decreases the risk that a patient will be coerced to carry a pregnancy to term because a patient who must make arrangements to travel further from home to access care is less likely to be able to keep their pregnancy and abortion decision confidential from others who may pressure or coerce them to carry to term. *See* Rep. ¶¶ 78, 84, 93. Restrictive laws like the Telemedicine Ban and the APC Ban increase the likelihood that an abuser will discover the pregnancy or the patients' desire to obtain an abortion.

G. Medical Evidence Does Not Support the Need for Medication Abortion Patients to Have an In-Person Follow-Up Appointment.

69. Drs. Skop and Harrison also claim that continuing observation and in-person follow-up visits to an abortion provider are necessary to ensure the safety and efficacy of medication abortion. This does not find support in the medical literature. Indeed, ACOG advises that "[r]outine in-person follow-up is not necessary after uncomplicated medication abortion."[96]

70. Contrary to Dr. Skop's suggestion, pregnancy termination can be confirmed without an in-person follow-up appointment. Skop Rep. ¶ 93. My 2011 article, which she relies on, found that diagnosis of a continuing pregnancy following a medication abortion is accurate without an in-

[95] ACOG, *Committee Opinion Number 518: Intimate Partner Violence*, 119 Obstetrics & Gynecology 412, 414 (2012, *reaff'd* 2025).
[96] *Practice Bulletin Number 225*, *supra* note 18, at e37.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

person follow up appointment.[97] Since 2011, additional research has confirmed these results,[98] and home-testing technology continues to evolve.[99] Patients always have the option to follow up with their provider and may also be referred for tests (such as a blood serum pregnancy test) at a location more convenient for them as needed.

71. Dr. Skop concedes that research supports that APCs can provide medication abortion as safely and effectively as physicians. Skop Rep. ¶ 129; Rep. ¶¶ 101–10. Despite this, her primary justification for the APC Ban is that, to safely provide medication abortion, providers should be able to provide "surgical intervention" (follow-up aspiration procedure) to address incomplete abortion or continuing pregnancy. Skop Rep. ¶¶ 55, 57, 76. While the mifepristone REMS previously required that certified prescribers of mifepristone needed to be able to provide this form of follow-up care, the FDA eliminated this requirement and now allows providers to "have made plans to provide such care through others"[100] (as Dr. Skop acknowledges) because the vast majority of patients do not require follow-up aspiration, and when they do, such follow-up care is rarely urgent, and thus can be managed with a referral.[101] And even if the clinician who provided the medication abortion has the skills to provide aspiration, a patient requiring follow-up aspiration might be able to get that care more conveniently or sooner from another provider. Dr. Skop claims without support that many providers (including APCs) do not have the skills to provide follow-up

[97] Daniel Grossman and Kate Grindlay, *Alternatives to Ultrasound for Follow-Up After Medication Abortion: A Systematic Review*, 83 Contraception 504 (2011).
[98] Nikita Baiju et al., *Effectiveness, Safety and Acceptability of Self-Assessment of the Outcome of First-Trimester Medical Abortion: A Systematic Review and Meta-Analysis*, 126 British J. of Obstetrics & Gynaecology 1536 (2019) (finding no significant difference in complete abortion rates between patients confirming at home as compared to those confirming with an in-person follow-up appointment).
[99] *See Practice Bulletin Number 225*, *supra* note 18, at e37.
[100] FDA, *NDA 020687 MIFEPREX Risk Evaluation and Mitigation Strategy (REMS)* (last modified Mar. 2016), https://www.fda.gov/media/164649/download.
[101] *Practice Bulletin Number 225*, *supra* note 18, at e32–33.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

aspiration care and do not make arrangements to have someone else provide follow-up care. To begin, this ignores a large body of evidence and long history of advanced practice clinicians providing aspiration procedures, including for abortion. Rep. ¶¶ 101, 107.[102] And should the patient require follow-up care that is outside the APC's scope of practice, the APC can easily (as contemplated by the REMS) refer the patient to another provider for care; Dr. Skop provides no evidence that this in any way harms the patient or compromises patient care because there is none. Furthermore, incomplete abortion and continuing pregnancy are often treated with medications, rather than aspiration, and incomplete abortion may resolve without any medical intervention. *Supra* ¶ 18.

72. The idea that clinicians need to be able to provide follow-up aspiration care in order to safely provide medication abortion ignores how medicine is often practiced in reality outside of the context of abortion. For example, a clinician might treat pelvic inflammatory disease with a tuboovarian abscess with antibiotic medications in the first instance. However, those antibiotics could fail, and the patient may require surgical treatment. The clinician who prescribed the medications in the first instance may not have the skills to perform the surgical management.

73. Moreover, limiting provision of medication abortion only to clinicians who can provide aspiration care will limit abortion access.

74. I agree with Dr. Skop that there is a shortage of physicians willing to provide abortion care. Skop Rep. ¶¶ 124–28; Rep. ¶ 120. In addition to the barriers to training in and provision of abortion care that I mention in my report, abortion-related stigma—often resulting in threats to abortion providers—disuades many otherwise qualified providers from providing abortion.[103] Laws like the

[102] *See also, e.g.*, Natl. Acads. Rev., *supra* note 16, at 103–05.
[103] *See* Kate Cockrill et al., *Addressing Abortion Stigma Through Service Delivery*, ANSIRH at 3, 16–17 (Sept. 13, 2013), https://www.ibisreproductivehealth.org/sites/default/files/files/publications/Addressing%20abortion%20stigma%20through%20service%20delivery.pdf.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Challenged Restrictions contribute to this stigma and make it harder for clinicians to provide abortion care. Rep. ¶ 120.[104] But the answer to this is not to exclude additional qualified clinicians from providing this care. Rather, I agree with Dr. Skop and ACOG that APCs can help facilitate "much-needed access to abortion care," Skop Rep. ¶ 128,[105] particularly in underserved areas. Rep. ¶ 121.

75. Drs. Skop and Harrison are incorrect that patients in rural areas will not be able to access care they need in the event of a complication following medication abortion. Skop Rep. ¶ 77; Harrison Rep. ¶ 42. As already explained *supra* ¶ 14, Rep. ¶ 36, complications are rare, and the vast majority can be treated on a non-emergent outpatient basis via a visit to a health center during normal business hours. Dr. Skop's statement that "many" patients present to an emergency room bleeding heavily and needing immediate surgery is a gross exaggeration. *Supra* ¶¶ 28–29. In any event, on the rare occasion when a complication from medication abortion does require treatment in an emergency department, local emergency departments are able to treat these patients, as the treatment for complications from medication abortion is the same as treatment for miscarriage, which emergency departments deal with regularly. Emergency department clinicians would be able to care for the patient regardless of whether they are aware that the patient underwent a medication abortion. In no way are patients from rural areas who choose telemedicine abortion "abandoned and at high risk for adverse events." Skop Rep. ¶ 77. On the contrary, patients from

[104] *See also* Sara Daniel et al., *Obstetrician-Gynecologist Willingness to Provide Medication Abortion with Removal of the In-Person Dispensing Requirement for Mifepristone*, 104 Contraception 73 (2021).

[105] ACOG, *Issue Brief: Advanced Practice Clinicians and Abortion Care Provision* at 1–2 (Oct. 2023), https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/issue-briefs/advanced-practice-clinicians-and-abortion-care-rovision?rev=ed4c1757442c4b3f8947154ae5627f6c&hash=15EC3922D4D0609D9162C1A4F1D6831D.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

rural areas are among those that benefit the most from telemedicine abortion, since it allows them to access care in a more timely manner, closer to home. Rep. ¶¶ 75, 85.

* * *

76. In addition to deviating from the medical consensus on medication abortion safety and efficacy, Drs. Skop and Harrison ignore the very real burdens that the Challenged Restrictions impose on patients attempting to access medication abortion in Ohio. *See* Rep. ¶¶ 60–63, 74–95, 118–24. Dr. Skop is wrong that logistical barriers do not mean that patients cannot access abortion. Skop Rep. ¶ 60. Even those who are ultimately able to access medication abortion may experience delay, which is detrimental to their health. *E.g.*, Rep. ¶ 30. And while Dr. Harrison argues that patient safety should come before "considerations of convenience" and the "practical challenges" of accessing medication abortion, Harrison Rep. ¶ 37, she is wrong to suggest both that the Challenged Restrictions improve patient health and safety, and that enjoining the Challenged Restrictions will impair patient health and safety, for the reasons I describe in this Rebuttal Report as well as in my Report.

77. In sum, the evidence is clear: medication abortion is extremely safe and effective, including when provided via telemedicine, by advanced practice clinicians, and beyond 70 days LMP. Accordingly, there is no medical justification for the Evidence-Base Use Ban, the APC Ban, or the Telemedicine Ban. Rather than promote safety, they unnecessarily delay care and reduce access, thereby undermining patient health.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

EXHIBIT B

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DANIEL A. GROSSMAN, M. D.
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1330 Broadway, Suite 1100
Oakland, CA 94612

Current position

Professor, Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco (UCSF)
Director, Advancing New Standards in Reproductive Health (ANSIRH), a research program in the UCSF Department of Obstetrics, Gynecology and Reproductive Sciences

Education

Sept. 1985-May 1989	Yale University-Molecular Biophysics and Biochemistry	B.S., 1989
Sept. 1989-June 1994	Stanford University School of Medicine	M.D., 1994
June 1994-June 1998	Resident and Administrative Chief Resident, Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco	

Licenses/Certification

1996-Present	California medical licensure (A60282)
2001-Present	Board Certified, American Board of Obstetrics and Gynecology
2022-Present	Board Certified Subspecialist in Complex Family Planning

Principal positions held

Aug. 1998-Feb. 2003 Aug. 2005-2012	Physician, St. Luke's Women's Center, San Francisco, CA
May 2003-Aug. 2005	Health Specialist, The Population Council Regional Office for Latin America and the Caribbean, Mexico City
Aug. 2005-Aug. 2015	Senior Associate (through June 2012), Vice President for Research (starting July 2012), Ibis Reproductive Health
Sept. 2015-Present	Professor, Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco
Sept. 2015-Present	Director, Advancing New Standards in Reproductive Health (ANSIRH)
January 2023-Present	Vice Chair of Advocacy, Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco

Other positions held concurrently

Aug. 1998-Feb. 2003	Director of Medical Student Education, Department of Obstetrics and Gynecology, St. Luke's Hospital
Aug. 1998-Feb. 2003	Vice Chair, Department of Obstetrics and Gynecology, St. Luke's Hospital
Aug. 1998-2015	Assistant Clinical Professor, Bixby Center for Global Reproductive Health, Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

2012-2015	Contract physician, Planned Parenthood Shasta Pacific (now Planned Parenthood Northern California)
Aug. 2015-Present	Senior Advisor, Ibis Reproductive Health
Aug. 2018-Present	Associate Investigator, SPHERE: A Centre of Research Excellence in Sexual and Reproductive Health for Women, Monash University, Melbourne, Australia
May 2024-Present	Affiliated faculty, Philip R. Lee Institute for Health Policy Studies, UCSF

Honors and awards

1988	Howard W. Hilgendorf Jr. Fellowship, Yale University
1988	Robin Berlin Memorial Prize, Yale University
1989	Magna cum laude, Yale University
1990	Medical Scholars Award, Stanford University
1990	Peter Emge Traveling Fellowship, Stanford University
1991-1992	Foreign Language and Area Studies Fellowship, Stanford University
1994	Dean's Award for Research in Infectious Diseases, Stanford University
2007	Ortho Outstanding Researcher Award, Association of Reproductive Health Professionals
2009	Visionary Partner Award, Pacific Institute for Women's Health
2010	Scientific Paper Award, National Abortion Federation
2013	Gerbode Professional Development Fellowship
2013	Abstract selected as one of Top 4 Oral Abstracts at North American Forum on Family Planning
2013	Felicia Stewart Advocacy Award from the Population, Reproductive and Sexual Health Section of the American Public Health Association
2018	Outstanding Resident Teaching Award, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF
2019	Outstanding Resident Teaching Award, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF
2019	Beacon of Science Award, Society of Family Planning
2021	Outstanding Resident Teaching Award, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF
2022	UCSF Chancellor Award for Public Service
2022	Outstanding Resident Teaching Award, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF
2023	Outstanding Resident Teaching Award, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF
2024	University of Utah Visiting Professor in Family Planning
2024	Edward N. Brandt, Jr. Memorial Lecturer at the George Washington University
2024	Croix de Guerriere Award, RISE UP for Breast Cancer Conference
2024	Outstanding Resident Teaching Award, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF
2025	Outstanding Resident Teaching Award, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Key words/areas of interest

Abortion, medication abortion, second-trimester abortion, contraception, over-the-counter access to oral contraception, integration of family planning into HIV care and treatment, self-managed abortion, advocacy, Mexico, Peru, Bolivia, Dominican Republic, South Africa, Kenya

PROFESSIONAL ACTIVITIES

PROFESSIONAL ORGANIZATIONS

Memberships

2000-Present	Fellow, American College of Obstetricians and Gynecologists (ACOG)
2006-Present	Member, Society of Family Planning
2004-Present	Member, American Public Health Association
2013-Present	Member, American Medical Association
2004-2011	Association of Reproductive Health Professionals
2004-2016	International Consortium for Medical Abortion
2006-Present	Liaison Member, Planned Parenthood Federation of America National Medical Committee
2005-Present	Consorcio Latinoamericano contra el Aborto Inseguro (Latin American Consortium against Unsafe Abortion)
2004-Present	Free the Pill Coalition (formerly Working Group on Oral Contraceptives Over-the-Counter)

Service to professional organizations

2008-Present	Society of Family Planning, reviewer of grant proposals, abstract reviewer for annual meeting
2007-2022	American Public Health Association, Governing Councilor (2007-2009, 2010-2014), Section Secretary (2008-2009), abstract reviewer for annual meeting
2005-2012	Consorcio Latinoamericano contra el Aborto Inseguro, member of Coordinating Committee
2006-Present	Free the Pill Coalition (formerly Working Group on Oral Contraceptives Over-the-Counter), working group coordinator (through 2015) and member of steering committee
2010-2016	Steering Committee member, International Consortium for Medical Abortion
2016	External advisor for Marie Stopes International research strategy meeting, March 23-24, 2016, London, UK
2010-2013	Member, Committee on Practice Bulletins-Gynecology, ACOG
2014-2020	Member, Committee on Health Care for Underserved Women, ACOG (Vice Chair of Committee 2016-18, Chair 2018-20)
2017-2018	Member, Telehealth Task Force, ACOG
2018-2021	Member, Telehealth Working Group, ACOG
2019-Present	Member, Abortion Access and Training Expert Work Group, ACOG
2020	Member, Workgroup on Advancing Diversity, Equity and Inclusive Excellence, ACOG

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

SERVICE TO PROFESSIONAL PUBLICATIONS

2013-Present Editorial Board, Contraception
2024-Present Women's Health Distinguished Reviewer, JAMA Internal Medicine
2004-Present Ad hoc reviewer for Obstetrics and Gynecology (10 papers in past 5 years), American Journal of Public Health (4 papers in past 3 years), Reproductive Health Matters (6 articles in past 4 years), Expert Review of Obstetrics and Gynecology (3 review in past year), and Women's Health Issues (4 articles in past 2 years), Lancet (2 reviews in past year)

INVITED PRESENTATIONS (Selected)

International

Second-trimester abortion. Optimizing the Potential for Medication in Pregnancy Termination in South America Conference, Lima, Peru, 2014 (invited talk).

Participation in panel at Harvard University seminar: Politics, Public Health, and Abortion: Examining the Changing Legal Environment in Mexico and Central America, Cambridge, MA, 2014 (invited talk).

Evidence for removing the prescription barrier to hormonal contraception. Annual meeting of the Associacion Française pour la Contraception, Paris, France, March 2015.

Presentations on medical abortion and second-trimester abortion, REDAAS (Red de Acceso al Aborto Seguro) meeting, Buenos Aires, Argentina, May 2015 (invited talk).

Panel participant in panel "Gestational limits for abortion: what purpose do they serve?" and presentations on adolescent pregnancy, telemedicine provision early medical abortion, and second-trimester abortion. Fifth Research Meeting on Unintended Pregnancy and Unsafe Abortion, Mexico City, September 2015 (invited talks).

Moving oral contraceptives over the counter as a strategy to reduce unintended pregnancy. The Human Right to Family Planning Conference, Seattle, WA, October 2015 (invited talk).

Over-the-counter access to hormonal contraception- what are the risks and benefits?, and Introduction of the mifepristone regimen for second-trimester medical abortion in South Africa. XXI FIGO World Congress of Gynecology and Obstetrics, Vancouver, Canada, October 2015 (oral presentations).

Second-trimester abortion. Presentation at the First Latin American Meeting on Public Sector Providers of Legal Abortion, Buenos Aires, Argentina, August 2016 (invited talk).

Safety, effectiveness and acceptability of telemedicine provision of medication abortion in Iowa, NAF regional meeting, Mexico City, September 2017 (invited talk).

Abortion in the United States: A new report on safety and the effects of being denied a wanted abortion. Presentation at "Evidencias y argumentos de salud pública para la legalización del aborto en Argentina," Buenos Aires, Argentina, May 2018 (invited talk).

Self-managed abortion in the United States. Presentation at "Abortion Beyond Bounds," Montreal, Canada, October 2018.

Gestational age limits in the United States: legal and service delivery perspectives. Presentation at "Interrupción del embarazo y edad gestacional," Buenos Aires, Argentina, August 2019 (invited talk).

Telemedicine and abortion care in the United States. Plenary lecture at SPHERE Annual meeting (virtual), Monash University, Melbourne, Australia, November 2020 (invited talk).

Virtual delivery of reproductive health care. Presentation at Australasian Sexual and Reproductive Health Day (virtual), Australia, September 2021.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Access to later abortion in the US post-Dobbs. Presentation at Abortion Providers Group of Aotearoa New Zealand (virtual), New Zealand, September 2022.
Reproductive rights and service delivery in the United States since the *Dobbs* decision, SPHERE webinar, Monash University, Melbourne, Australia, February 2025.
Over-the-counter access to hormonal contraception and self-management approaches to medication abortion, SPHERE Prato Meeting 2025, Prato, Italy, July 2025.
Abortion after 20 weeks, CLACAI webinar launching Good Practice Guide for abortion care from 20 weeks of pregnancy, Buenos Aires, Argentina (virtual), March 2026.

National

Participation in panel entitled Abortion Scholarship: An Interdisciplinary Conversation, at UC Berkeley Symposium Speech, Symbols, and Substantial Obstacles: The Doing and "Undue"ing of Abortion Law since Casey, Berkeley, 2013 (invited talk).
Impact of restrictive abortion law on women in Texas. North American Forum on Family Planning, Seattle, 2013 (oral presentation).
Randomized Trial of Misoprostol versus Laminaria before Dilation and Evacuation in South Africa. Annual meeting of the National Abortion Federation, San Francisco, 2014 (oral presentation).
Introduction of the mifepristone regimen for second-trimester medical abortion in South Africa. Annual meeting of the National Abortion Federation, Baltimore, April 2015 (oral presentation).
Knowledge, opinion and experience related to abortion self-induction in Texas (oral abstract), and participant in panel "Addressing the global need for safe abortion after the first trimester." North American Forum on Family Planning, Chicago, November 2015 (oral presentations).
Participant in panel "Addressing the Challenges Facing Women's Reproductive Health Care," Academy Health National Health Policy Conference, Washington, DC, February 2, 2016 (invited talk).
Panel presentations entitled "Medical abortion restrictions: From label laws to abortion reversal," "Texas: Ground Zero in the Abortion Wars" and "Stolen Lives: Impact of early adolescent pregnancy on all aspects of health," Annual meeting of the National Abortion Federation, Austin, Texas, April 2016.
Panel presentations entitled "Evaluating Reproductive Health Policy at the State Level" and "Translating research into policy: Contributing data to the public debate when it matters most," North American Forum on Family Planning, Denver, November 2016.
Panel presentation entitled "Abortion Outside the Clinic: Imagining Safe and Legal Abortion in a post-Roe World," Physicians for Reproductive Health Grand Rounds, New York University School of Law, New York, March 2017.
"Safety of medication abortion provided through telemedicine: A non-inferiority study" (oral abstract), "Evaluating the provision of early medical abortion by telemedicine" (panel presentation), and "Use of research in evaluating Texas House Bill 2" (panel presentation). Annual meeting of the National Abortion Federation, Montreal, Canada, April 2017.
Using Evidence to Inform Policy in an Era of Alternative Facts, keynote address at Family Planning Symposium, "Family Planning Post-Election: Putting on our Fatigues," San Diego, May 2017.
"Improving access through over-the-counter status" (panel presentation), "Building bridges, not walls: using telemedicine to expand sexual & reproductive healthcare" (panel

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

presentation), and "Expanding access to medical abortion through clinic-to-clinic telemedicine" (panel presentation). North American Forum on Family Planning, Atlanta, October 2017.

"Prevalence of Self-Induced Abortion Attempts among a Nationally Representative Sample of U.S. Women" (oral abstract), "What do we know about self-induced or self-managed abortion in the United States?" (panel presentation). Annual meeting of the National Abortion Federation, Seattle, April 2018.

"Driving Health Equity Through Innovation in Health Care," panel participant at plenary at the 2018 Planned Parenthood Federation of America National Conference, Washington, DC, April 2018.

Innovative Contraceptive Delivery Models. Presentation at National Reproductive Health Title X Conference, Kansas City, July 2018.

"Medication abortion in the United States" and panel participant in "The NASEM Report on Abortion Safety and Quality: implications for research, training, practice and advocacy." North American Forum on Family Planning, New Orleans, October 2018.

Research on telemedicine and abortion care, panel presentation. Annual meeting of the National Abortion Federation, Chicago, May 2019.

Alternative provision models for medication abortion: from pharmacy dispensing to OTC. Annual meeting of the Mifepristone Coalition, New York City, June 2019.

"Medication abortion with pharmacist dispensing of mifepristone: a cohort study" (oral abstract), "'It makes sense': pharmacists' attitudes toward dispensing mifepristone for medication abortion" (poster), "Abortion referral practices among a national sample of obstetrician-gynecologists" (poster). Annual meeting of Society of Family Planning, Los Angeles, October 2019.

Panelist at Society of Family Planning Research Fund Roundtable on medication abortion research (virtual), August 2020.

Panelist, Evidence-Based Guidance on Telehealth Interventions to Improve Health Outcomes in Obstetrics & Gynecology: Best Practices and COVID-19 Updates, ACOG Annual Clinical and Scientific Meeting (virtual), May 2021.

Overview of reproductive health. Meeting of the Association of Prosecuting Attorneys (virtual), October 2021.

Self-managed abortion. Presentation for the Ryan Residency Training Program (virtual), January 2022.

The rise of telehealth medication abortion as a possible mitigation strategy. Presentation at Legislating Abortion: Comparative Legal Perspectives on Statutory Abortion Rights, Harvard Human Rights Journal's Annual Symposium (virtual), March 2022.

Health care provider reporting practices related to self-managed abortion (oral abstract). American Public Health Association annual meeting, Boston, November 2022.

Participation in panel "The View from the Trenches: The Experience of Providers and the Role of Health Systems" at After Dobbs: New Directions in Reproductive Justice, University of California Davis, March 2023.

Advance Provision of Medication Abortion. Presentation at National Abortion Federation Annual Meeting, Denver, May 2023.

Ask the Experts: Medication abortion; Self-managed abortion; Over-the-counter access to contraception. Presentations at ACOG Annual Clinical and Scientific Meeting, Baltimore, May 2023.

Caring for Patients in a Post-Roe World. Presentation at Endocrine Society's Annual Meeting, ENDO 2023, Chicago, June 2023.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

"Self-managed abortion: what is it and what is our role?" and "Over-the-counter contraception: first progestin-only pills, then what?" Presentations at Contraceptive Technology Conference 2023, Atlanta, September 2023.

Care Post-Roe: Documenting poor-quality care since the Dobbs decision. Presentation at U.S. Department of Health and Human Services Roundtable Series: Facilitating reproductive health research post-Dobbs decision: Research networks documenting the consequences post-Dobbs (virtual), September 2023.

Care Post-Roe: Documenting poor-quality care related to abortion bans since the *Dobbs* decision. Poster at Society of Family Planning Annual Meeting, Seattle, October 2023.

Impact of the Dobbs decision on women's health. Panel presentation at RISE UP for Breast Cancer Conference, San Francisco, November 2024

Overview and global perspective on access to reproductive healthcare. Panel presentation at RISE UP for Breast Cancer Conference, San Francisco, February 2026.

<u>Regional and other invited presentations</u>

Impact of family planning cuts and abortion restrictions in Texas. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, 2013.

Improving access to early medical abortion through the use of telemedicine. Office of Population Research seminar, Princeton University, 2014 (invited talk).

Impact of family planning cuts and abortion restrictions in Texas. Grand rounds presentation, Department of Obstetrics and Gynecology, Emory University School of Medicine, Atlanta, Georgia, February 2015.

Impact of family planning cuts and abortion restrictions in Texas. Grand rounds presentation, Department of Obstetrics and Gynecology, Baylor University School of Medicine, Houston, Texas, April 2015.

The causes and consequences of unintended pregnancy among women in the US military. San Francisco General Hospital grand rounds, September 2015.

Impact of family planning cuts and abortion restrictions in Texas. Grand rounds presentation, Department of Obstetrics and Gynecology, University of New Mexico School of Medicine, Albuquerque, New Mexico, October 2015.

Using evidence and advocacy to improve second-trimester abortion care in South Africa. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, December 2015.

UCSF/UCH Consortium Annual Supreme Court Review, panel speaker on Whole Woman's Health v. Hellerstedt, San Francisco, July 2016.

American Gynecological Club meeting, presentation on Reproductive Health in Texas and panel participant, San Francisco, September 2016.

Speaking science to the Court: the experience of experts in Whole Woman's Health v. Hellerstedt, panel participant, UC Hastings, San Francisco, October 2016.

How data made the difference in the Texas abortion case before the US Supreme Court. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, November 2016.

Research That Gets Results: A Symposium on Science-Driven Policy Change, panel participant, UCSF, March 2017.

Medication abortion: What is it and how can its potential to improve access to care be realized? Presentation for UCSF Students for Choice, April 2017.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Medication Abortion: Supporting Women Both Inside and Outside the Clinic to Access Safe Care. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, November 2017.

Medication Abortion: Supporting Women Both Inside and Outside the Clinic to Access Safe Care. Grand rounds presentation, Department of Obstetrics and Gynecology, Kaiser San Francisco, March 2018.

Medication Abortion: Supporting Women Both Inside and Outside the Clinic to Access Safe Care. Grand rounds presentation, Department of Obstetrics and Gynecology, University of Arizona College of Medicine, Tucson, June 2018.

Medication Abortion: Supporting Women Both Inside and Outside the Clinic to Access Safe Care. Presentation to Medical Students for Choice, University of Kansas Medical Center, July 2018.

Medication Abortion: Supporting Women Both Inside and Outside the Clinic to Access Safe Care. Grand rounds presentation, Department of Obstetrics and Gynecology, University of Alabama at Birmingham, October 2018.

Self-managed abortion in the US: What's happening, and what is our role? Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, November 2018.

Evidence-based advocacy to improve reproductive health. Annual Creinin Family Planning Lectureship, Department of Obstetrics, Gynecology & Reproductive Sciences, University of Pittsburgh, April 2019.

Evidence-based advocacy to improve reproductive health. Symposium speaker at the 2019 Research Retreat, Department of Obstetrics and Gynecology, University of Colorado, October 2019.

Demedicalizing reproductive health care: from OTC oral contraceptives to self-managed abortion. James C. and Joan Caillouette Lecture at the annual meeting of the Pacific Coast Obstetrical and Gynecological Society, San Diego, October 2019.

Advocacy 101: How to Inform Policy Debates with Your Own Expertise in OB/GYN. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, January 2020.

Telehealth in Obstetrics and Gynecology. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, April 2020.

Abortion care during the COVID-19 pandemic: threats to access and opportunities for innovation. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, November 2020.

Using research evidence to inform policy. Invited plenary for Inquiry Symposium, UCSF School of Medicine, May 2021.

Evidence-based advocacy to improve reproductive health. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UC San Diego, May 2021.

Evidence-based advocacy to improve reproductive health. Grand rounds presentation, Department of Obstetrics & Gynecology, Stanford University School of Medicine, December 2021.

Emergency Gynecological Care in a Post-Roe Landscape: Clinical and Practical Considerations. Grand rounds presentation, Department of Obstetrics & Gynecology, University of Louisville, May 2022.

Addressing Abortion in Primary Care. Grand rounds presentation, Department of General Internal Medicine, San Francisco General Hospital, September 2022.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Practicing in a Post-Roe World, and Social Media to Combat Misinformation. Presentations at ACOG District V, VIII, IX Annual Meeting, Maui, September 2022.

All hands on deck: Strategies to maintain access to reproductive healthcare post-Roe. Presentation at 5th Annual Connors Center for Women's Health and Gender Biology Research Symposium, Harvard Medical School, Boston, November 2022.

Medication Abortion: Clinical and Policy Considerations in a Post-Roe World. Grand rounds presentation, Department of Pediatrics, San Francisco General Hospital, February 2023.

Threat to mifepristone access: How should we respond? Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, February 2023.

Medication abortion with mifepristone and misoprostol: Under attack and ripe with opportunity. Grand rounds presentation, Department of Obstetrics, Midwifery and Gynecology, Alameda Health System, March 2023.

Care Post-Roe: Documenting cases of poor-quality care post-Dobbs. Presentation at San Francisco Gynecological Society, May 2023.

Care Post-Roe: Documenting poor-quality care since *Dobbs*. Presentation at Orange County Women's Summit, UC Irvine, October 2023.

Update on abortion access. Invited presentation in "Healthcare in America," Warren Alpert Medical School, Brown University, November 2023.

Over-the-counter access to oral contraception: from FDA approval to equitable expansion of access. Grand rounds presentation, Department of Obstetrics and Gynecology, University of Utah, February 2024.

Two years after *Dobbs*: Impact on abortion access and pregnancy-related care. Grand rounds presentation, Department of Medicine, UCSF, September 2024.

Two years after *Dobbs*: Impact on abortion access and pregnancy-related care. Grand rounds presentation, Department of Obstetrics, Gynecology & Reproductive Sciences, UCSF, October 2024.

OTHER PROFESSIONAL SERVICE

2007	Member of the International Planned Parenthood Federation Safe Abortion Action Fund Technical Review Panel
2007-2009	Steering committee member of the California Microbicide Initiative
2002-2004	Member, Medical Development Team, Marie Stopes International (London)
2013-2021	Reviewer of fellows' research proposals for the Fellowship in Family Planning
2013-2015	Member of working group on Guidelines for Task Shifting in Abortion Provision convened by World Health Organization
2014	Discovery working group member, Preterm Birth Initiative (PTBi), UCSF
2013-2019	Board member and Secretary (2014-2016), NARAL Pro-Choice America Foundation
2014-2021	Board member, NAF
2015-2019	Board member, Shift/Whole Woman's Health Alliance
2017	Study section member, U54 Contraceptive Center proposal review panel, National Institute of Child Health and Human Development
2020	Reviewer, Health Research Council of New Zealand

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2019-Present	Chair, UCSF Department of Obstetrics, Gynecology & Reproductive Sciences Advocacy Strategy Committee
2020-Present	Member, UCSF Department of Obstetrics, Gynecology & Reproductive Sciences Executive Steering Committee (formerly Leadership Council)
2021-Present	Member of UCSF Institutional Review Board (IRB), Laurel Heights Committee
2021-Present	Member, California Future of Abortion Council
2022	Reviewer, Grand Challenges Canada
2024-Present	Member, UCSF Department of Obstetrics, Gynecology & Reproductive Sciences Grand Rounds Committee

TEACHING

FORMAL SCHEDULED CLASSES:

Qtr	Academic Yr	Institution Course Title	Teaching Contribution	Class Size
W	2008-09	Harvard School of Public Health; GHP502 International reproductive health issues: Moving from theory to practice	Lecturer; 2 lectures	22
W	2009-10	Harvard School of Public Health; GHP502 International reproductive health issues: Moving from theory to practice	Lecturer; 1 lecture	17
F	2014-15	UCSF Coursera course; Abortion: Quality Care and Public Health Implications	Lecturer; 4 lectures	6,000+ (online)
F	2015-16	University of Texas at Austin; Sociology--Reproductive Health and Population in Texas; SS 301 Honors Social Science	Lecturer; 1 lecture	20
S	2016-17	UC Berkeley School of Law; 224.6 - Selected Topics in Reproductive Justice	Lecturer; 1 lecture	12
S	2018-19	University of Texas at Austin; Sociology—Graduate seminar in human fertility	Lecturer; 1 seminar	8
W	2019-20	UCSF: Family Planning and Reproductive Choices elective	Lecturer; 1 lecture	20
S	2020-21	Harvard Medical School; Sex- and Gender-Informed Medicine: Research, Clinical Practice, and Population Health, AISC626.0	Lecturer; 1 lecture	25
S	2025-26	UCSF: Justice and Advocacy in Medicine; session on Reproductive Health Access and Advocacy in the US	Lecturer/discussant; 2 sessions	150

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POSTGRADUATE and OTHER COURSES

Guest lecturer in "Qualitative Research Methods in Public Health," CUNY School of Public Health, September 2011

Women's health from a global perspective. Presentation at Obstetrics and Gynecology Update: What Does the Evidence Tell Us? UCSF CME course, San Francisco, 2007.

Expanding access to medication abortion. Presentation at Obstetrics and Gynecology Update: What Does the Evidence Tell Us? UCSF CME course, San Francisco, 2017.

A world post Roe v. Wade. Presentation at Obstetrics and Gynecology Update: What Does the Evidence Tell Us? UCSF CME course, San Francisco, 2019.

The changing landscape of abortion access. Presentation at Obstetrics and Gynecology Update: What Does the Evidence Tell Us? UCSF CME course, San Francisco, 2020.

Update on abortion regulations. Presentation at Obstetrics and Gynecology Update: What Does the Evidence Tell Us? UCSF CME course, San Francisco, 2021.

A world post-Roe. Presentation at Obstetrics and Gynecology Update: What Does the Evidence Tell Us? UCSF CME course, San Francisco, 2022.

Future of Abortion Care After Roe. Presentation at 46th Annual Antepartum and Intrapartum Management (AIM) CME Conference, San Francisco, June 2023.

Update on abortion access. Presentation at Obstetrics and Gynecology Update: What Does the Evidence Tell Us? UCSF CME course, San Francisco, October 2023.

Update on abortion access. Presentation at Obstetrics and Gynecology Update: What Does the Evidence Tell Us? UCSF CME course, San Francisco, September 2024.

Update on abortion access. Presentation at Obstetrics and Gynecology Update: What Does the Evidence Tell Us? UCSF CME course, San Francisco, October 2025.

Abortion Access in 2025. Presentation at Controversies in Women's Health, UCSF CME course, San Francisco, December 2025

TEACHING AIDS

Contributed to the development of a training slide set on medical abortion in Spanish, 2004

Developed pocket cards on emergency contraception for use by community health workers in the State of Mexico, 2005

Reviewed and provided input on a manual on gynecologic uses of misoprostol published by the Latin American Federation of Obstetric and Gynecologic Societies (FLASOG), 2005

Grossman D. Medical methods for first trimester abortion: RHL commentary (last revised: 3 September 2004). The WHO Reproductive Health Library, No 8, Update Software Ltd, Oxford, 2005.

Grossman D. Medical methods for first trimester abortion: RHL practical aspects (last revised: 3 September 2004). The WHO Reproductive Health Library, No 8, Update Software Ltd, Oxford, 2005.

CLINICAL ACTIVITIES

I provide general gynecologic and complex family planning care, including abortion care, approximately one half-day per week in an outpatient setting at San Francisco General Hospital. I teach fellows, residents, and medical students in the clinic.

RESEARCH AND CREATIVE ACTIVITIES

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PEER REVIEWED PUBLICATIONS

1. Laudon M, Grossman DA, Ben-Jonathan N. Prolactin-releasing factor: cellular origin in the intermediate lobe of the pituitary. Endocrinology 1990; 126(6):3185-92.
2. Grossman DA, Witham ND, Burr DH, Lesmana M, Rubin FA, Schoolnik GK, Parsonnet J. Flagellar serotypes of Salmonella typhi in Indonesia: relationships among motility, invasiveness, and clinical illness. Journal of Infectious Diseases 1995; 171(1):212-6.
3. MacIsaac L, Grossman D, Balistreri E, Darney P. A randomized controlled trial of laminaria, oral misoprostol, and vaginal misoprostol before abortion. Obstetrics and Gynecology 1999; 93(5, pt.1):766-770.
4. Grossman D, Ellertson C, Grimes DA, Walker D. Routine follow-up visits after first-trimester induced abortion. Obstetrics and Gynecology 2004; 103(4):738-45.
5. Lafaurie MM, Grossman D, Troncoso E, Billings DL, Chávez S. Women's perspectives on medical abortion in Mexico, Colombia, Ecuador and Peru: a qualitative study. Reproductive Health Matters 2005;13(26):75-83.
6. Grossman D, Ellertson C, Abuabara K, Blanchard K. Barriers to contraceptive use present in product labeling and practice guidelines. American Journal Public Health 2006;96(5):791-9.
7. Yeatman SE, Potter JE, Grossman DA. Over-the-counter access, changing WHO guidelines, and the prevalence of contraindicated oral contraceptive use in Mexico. Studies in Family Planning 2006; 37(3):197–204.
8. Pace L, Grossman D, Chavez S, Tavara L, Lara D, Guerrero R. Legal Abortion in Peru: Knowledge, attitudes and practices among a group of physician leaders. Gaceta Medica de Mexico 2006; 142(Supplement 2):91-5.
9. Lara D, Abuabara K, Grossman D, Diaz C. Pharmacy provision of medical abortifacients in a Latin American city. Contraception 2006;74(5):394-9.
10. Tinajeros F, Grossman D, Richmond K, Steele M, Garcia SG, Zegarra L, Revollo R. Diagnostic accuracy of a point-of-care syphilis test when used among pregnant women in Bolivia. Sexually Transmitted Infections 2006;82 Suppl 5:v17-21.
11. Clark W, Gold M, Grossman D, Winikoff B. Can mifepristone medical abortion be simplified? A review of the evidence and questions for future research. Contraception 2007;75:245-50.
12. Garcia SG, Tinajeros F, Revollo R, Yam EA, Richmond K, Díaz-Olavarrieta C, Grossman D. Demonstrating public health at work: A demonstration project of congenital syphilis prevention efforts in Bolivia. Sexually Transmitted Diseases 2007;34(7):S37-S41.
13. Díaz-Olavarrieta C, García SG, Feldman BS, Polis AM, Revollo R, Tinajeros F, Grossman D. Maternal syphilis and intimate partner violence in Bolivia: a gender-based analysis of implications for partner notification and universal screening. Sex Transm Dis 2007;34(7 Suppl):S42-6.
14. Harper CC, Blanchard K, Grossman D, Henderson J, Darney P. Reducing Maternal Mortality due to Abortion: Potential Impact of Misoprostol in Low-resource Settings. International Journal of Gynecology and Obstetrics 2007;98:66-9.
15. Grossman D, Berdichevsky K, Larrea F, Beltran J. Accuracy of a semi-quantitative urine pregnancy test compared to serum beta-hCG measurement: a possible tool to rule-out ongoing pregnancy after medication abortion. Contraception 2007;76(2):101-4.

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16. Lara D, van Dijk M, Garcia S, Grossman D. La introducción de la anticoncepción de emergencia en la norma oficial mexicana de planificación familiar (The introduction of emergency contraception into the official Mexican family planning norms). Gaceta Médica de México 2007;143(6): 483-7.
17. Grossman D, Blanchard K, Blumenthal P. Complications after second trimester surgical and medical abortion. Reproductive Health Matters 2008;16(31 Supplement):173-82.
18. Grossman D, Fernandez L, Hopkins K, Amastae J, Garcia SG, Potter JE. Accuracy of self-screening for contraindications to combined oral contraceptive use. Obstetrics and Gynecology 2008; 112(3):572-8.
19. Grossman D. Should the oral contraceptive pill be available without prescription? Yes. British Medical Journal 2008;337:a3044.
20. Levin C, Grossman D, Berdichevsky K, Diaz C, Aracena B, Garcia S, Goodyear L. Exploring the economic consequences of unsafe abortion: implications for the costs of service provision in Mexico City. Reproductive Health Matters 2009;17(33):120–132.
21. Hu D, Grossman D, Levin C, Blanchard K, Goldie SJ. Cost-Effectiveness Analysis of Alternative First-Trimester Pregnancy Termination Strategies in Mexico City. BJOG 2009;116:768–779.
22. Távara-Orozco L, Chávez S, Grossman D, Lara D, Blandón MM. Disponibilidad y uso obstétrico del misoprostol en los países de América [Availability and obstetric use of misoprostol in Latin American countries]. Revista Peruana de Ginecologia y Obstetricia 2009;54:253-263.
23. Lara DK, Grossman D, Muñoz J, Rosario S, Gomez B, Garcia SG. Acceptability and use of female condom and diaphragm among sex workers in Dominican Republic: Results from a prospective study. AIDS Education and Prevention 2009;21(6):538-551.
24. Grossman D, Fernandez L, Hopkins K, Amastae J, Potter JE. Perceptions of the safety of oral contraceptives among a predominantly Latina population in Texas. Contraception 2010;81(3):254-60. (NIHMS155993)
25. Potter JE, White K, Hopkins K, Amastae J, Grossman D. Clinic versus Over-the-Counter Access to Oral Contraception: Choices Women Make in El Paso, Texas. American Journal of Public Health 2010;100(6):1130-6. (NIHMS 221745)
26. Phillips K, Grossman D, Weitz T, Trussell J. Bringing evidence to the debate on abortion coverage in health reform legislation: findings from a national survey in the United States. Contraception 2010;82(2):129-30.
27. Hu D, Grossman D, Levin C, Blanchard K, Adanu R, Goldie SJ. Cost-Effectiveness Analysis of Unsafe Abortion and Alternative First-Trimester Pregnancy Termination Strategies in Nigeria and Ghana. African Journal of Reproductive Health 2010;14(2)85-103.
28. Grossman D, Holt K, Peña M, Veatch M, Gold M. Winikoff B, Blanchard K. Self-induction of abortion among women in the United States. Reproductive Health Matters 2010;18(36):136–146.
29. Grossman D, Grindlay K. Alternatives to ultrasound for follow-up after medication abortion: A systematic review. Contraception 2011;83(6):504-10.
30. Liang S-Y, Grossman D, Phillips K. Women's out-of-pocket expenditures and dispensing patterns for oral contraceptive pills between 1996 and 2006. Contraception 2011;83(6):528-36.

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31. Blanchard K, Bostrom A, Montgomery E, van der Straten A, Lince N, de Bruyn G, Grossman D, Chipato T, Ranjee G, Padian N. Contraception use and effectiveness among women in a trial of the diaphragm for HIV prevention. Contraception 2011;83(6):556-63.
32. Grossman D, White K, Hopkins K, Amastae J, Shedlin M, Potter JE. Contraindications to Combined Oral Contraceptives Among Over-the-Counter versus Prescription Users. Obstet Gynecol 2011;117(3):558–65.
33. Potter JE, McKinnon S, Hopkins K, Amastae J, Shedlin MG, Powers DA, Grossman D. Continuation of prescribed compared with over-the-counter oral contraceptives. Obstet Gynecol 2011;117(3):551–7.
34. Grindlay K, Yanow S, Jelinska K, Gomperts R, Grossman D. Abortion restrictions in the US military: Voices from women deployed overseas. Women's Health Issues 2011;21(4):259-64.
35. Grossman D, Grindlay K, Buchacker T, Lane K, Blanchard K. Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine. Obstetrics and Gynecology 2011;118(2 Pt 1):296-303.
36. Holt K, Grindlay K, Taskier M, Grossman D. Unintended pregnancy and contraceptive use among women in the US military: A systematic literature review. Military Medicine 2011;176(9):1056-64.
37. Harris LH, Grossman D. Confronting the challenge of unsafe second-trimester abortion. Int J Gynaecol Obstet 2011;115(1):77-9.
38. Grossman D, Constant D, Lince N, Alblas M, Blanchard K, Harries J. Surgical and medical second trimester abortion in South Africa: a cross-sectional study. BMC Health Serv Res. 2011;11(1):224.
39. Harries J, Lince N, Constant C, Hargey A, Grossman D. The challenges of offering public second trimester abortion services in South Africa: Health care providers' perspectives. Journal of Biosocial Science 2011;17:1-12.
40. Dennis A, Grossman D. Barriers to Contraception and Interest in Over-the-Counter Access Among Low-Income Women: A Qualitative Study. Perspect Sex Reprod Health 2012;44(2):84-91.
41. Foster DG, Higgins J, Karasek D, Ma S, Grossman D. Attitudes toward unprotected intercourse and risk of pregnancy among women seeking abortion. Women's Health Issues 2012;22(2):e149-55.
42. Foster DG, Karasek D, Grossman D, Darney P, Schwarz EB. Interest in using intrauterine contraception when the option of self-removal is provided. Contraception 2012;85(3):257-62.
43. White K, Potter JE, Hopkins K, Fernández L, Amastae J, Grossman D. Contraindications To Progestin-Only Oral Contraceptive Pills Among Reproductive Aged Women. Contraception 2012;86(3):199-203.
44. Harrington EK, Newmann SJ, Onono M, Schwartz KD, Bukusi EA, Cohen C, Grossman D. Fertility intentions and interest in integrated family planning services among HIV-infected women in Nyanza Province, Kenya: a qualitative study. Infectious Diseases in Obstetrics and Gynecology 2012;2012, Article ID 809682. doi:10.1155/2012/809682.
45. Lessard L, Karasek D, Ma S, Darney P, Deardorff J, Lahiff M, Grossman D, Foster DG. Contraceptive features preferred by women at high risk of unintended pregnancy. Perspectives on Sexual and Reproductive Health 2012;44(3):194-200.

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46. Grossman D, Garcia S, Kingston J, Schweikert S. Mexican women seeking safe abortion services in San Diego, California. Health Care Women Int 2012;33(11):1060-9.
47. Hopkins K, Grossman D, White K, Amastae J, Potter JE. Reproductive health preventive screening among clinic vs. over-the-counter oral contraceptive users. Contraception 2012;86(4):376-82.
48. Potter JE, White K, Hopkins K, McKinnon S, Shedlin MG, Amastae J, Grossman D. Frustrated Demand for Sterilization among Low-Income Latinas in El Paso, Texas. Perspectives on Sexual and Reproductive Health 2012;44(4):228–235.
49. White K, Grossman D, Hopkins K, Potter JE. Cutting family planning in Texas. N Engl J Med 2012;367(13):1179-81.
50. Liang S-Y, Grossman D, Phillips K. User characteristics and out-of-pocket expenditures for progestin-only versus combined oral contraceptives. Contraception 2012;86(6):666-72.
51. Manski R, Dennis A, Blanchard K, Lince N, Grossman D. Bolstering the Evidence Base for Integrating Abortion and HIV Care: A Literature Review. AIDS Research and Treatment 2012 (2012), Article ID 802389. doi:10.1155/2012/802389.
52. Schwarz EB, Burch EJ, Parisi SM, Tebb KP, Grossman D, Mehrotra A, Gonzales R. Computer-assisted provision of hormonal contraception in acute care settings. Contraception 2013;87(2):242-50.
53. Grindlay K, Grossman D. Contraception access and use among U.S. servicewomen during deployment. Contraception 2013;87(2):162-9.
54. Grossman D, Grindlay K, Buchacker T, Potter JE, Schmertmann CP. Changes in service delivery patterns after introducing telemedicine provision of medical abortion in Iowa. Am J Public Health 2013;103(1):73-78.
55. Potter JE, Stevenson AJ, White K, Hopkins K, Grossman D. Hospital variation in postpartum tubal sterilization rates in California and Texas. Obstetrics and Gynecology 2013;121(1):152-8.
56. Grindlay K, Grossman D. Unintended Pregnancy Among Active Duty Women in the United States Military, 2008. Obstetrics and Gynecology 2013;121(2 Pt 1):241-6.
57. Hyman A, Blanchard K, Coeytaux F, Grossman D, Teixeira A. Misoprostol in women's hands: a harm reduction strategy for unsafe abortion. Contraception 2013;87(2):128-30.
58. Grindlay K, Grossman D, Lane K. Women's and Providers' Experiences with Medical Abortion Provided Through Telemedicine: A Qualitative Study. Women's Health Issues 2013;23(2):e117-22.
59. Shedlin M, Amastae J, Potter J, Hopkins K, Grossman D. Knowledge & Beliefs about Reproductive Anatomy and Physiology among Mexican-Origin Women in the U.S.: Implications for Effective Oral Contraceptive Use. Cult Health Sex 2013;15(4):466-79.
60. Newmann SJ, Mishra K, Onono M, Bukusi E, Cohen CR, Gage O, Odeny R, Schwartz KD, Grossman D. Providers' perspectives on provision of family planning to HIV-positive individuals in HIV care in Nyanza Province, Kenya. AIDS Research and Treatment 2013;2013, Article ID 915923. http://dx.doi.org/10.1155/2013/915923.
61. Steinfeld R, Newmann SJ, Onono M, Cohen CR, Bukusi E, Grossman D. Overcoming Barriers to Family Planning through Integration: Perspectives of HIV-

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Positive Men in Nyanza Province, Kenya. AIDS Research and Treatment 2013;2013, Article ID 861983, http://dx.doi.org/10.1155/2013/861983.
62. Henderson JT, Puri M, Blum M, Harper CC, Rana A, Gurung G, Pradhan N, Regmi K, Malla K, Sharma S, Grossman D, Bajracharya L, Satyal I, Acharya S, Lamchhane P, Darney PD. Effects of Abortion Legalization in Nepal, 2001–2010. PLoS ONE 2013;8(5): e64775. doi:10.1371/journal.pone.0064775.
63. Grossman D. Moving oral contraceptives over the counter as a strategy to reduce unintended pregnancy. Annals of Internal Medicine 2013;158(11):839-40.
64. Committee on Practice Bulletins-Gynecology, American College of Obstetricians and Gynecologists, with Steinauer J, Jackson A, Grossman D. Practice Bulletin No 135: Second-trimester abortion. Obstet Gynecol 2013;121(6):1394-1406.
65. Foster DG, Biggs MA, Grossman D, Schwarz EB. Interest in a pericoital pill among women in family planning and abortion clinics. Contraception 2013;88(1):141-6.
66. White K, Hopkins K, Potter JE, Grossman D. Knowledge and attitudes about long-acting reversible contraception among Latina women who desire sterilization. Women's Health Issues 2013;23(4):e257-e263.
67. Grindlay K, Burns B, Grossman D. Prescription requirements and over-the-counter access to oral contraceptives: A global review. Contraception 2013;88(1):91-6.
68. McIntosh J, Wahlin B, Grindlay K, Batchelder M, Grossman D. Insurance and Access Implications of an Over-the-Counter Switch for a Progestin-Only Pill. Perspectives on Sexual and Reproductive Health 2013;45(3):164-9.
69. Grossman D, Grindlay K, Li R, Potter JE, Trussell J, Blanchard K. Interest in over-the-counter access to oral contraceptives among women in the United States. Contraception 2013;88(4):544-52.
70. Grossman D, Onono M, Newmann SJ, Blat C, Bukusi EA, Shade SB, Steinfeld RL, Cohen CR. Integration of family planning services into HIV care and treatment in Kenya: a cluster-randomized trial. AIDS 2013; 27(Suppl 1):S77-S85.
71. Shade SB, Kevany S, Onono M, Ochieng G, Steinfeld RL, Grossman D, Newmann SJ, Blat C, Bukusi EA, Cohen CR. Cost, Cost-efficiency and Cost-effectiveness of Integrated Family Planning and HIV Services in Nyanza, Kenya. AIDS 2013; 27(Suppl 1):S87-S92.
72. van Dijk MG, Lara Pineda D, Grossman D, Sorhaindo A, García SG. The Female Condom: A Promising but Unavailable Method for Dominican Sex Workers, Their Clients, and Their Partners. Journal of the Association of Nurses in AIDS Care 2013;24(6):521-9.
73. White K, Potter JE, Hopkins K, Amastae J, Grossman D. Hypertension among oral contraceptive users in El Paso, Texas. Journal of Health Care for the Poor and Underserved 2013;24(4):1511-21.
74. Withers M, Dworkin S, Harrington E, Kwena Z, Onono M, Bukusi E, Cohen CR, Grossman D, Newmann SJ. Fertility intentions among HIV-infected, sero-concordant Kenyan couples in Nyanza Province, Kenya. Cult Health Sex 2013;15(10):1175-90.
75. Newmann SJ, Grossman D, Blat C, Onono M, Steinfeld RL, Bukusi EA, Shade SB, Cohen CR. Does integrating family planning into HIV care and treatment impact intention to use contraception? Patient perspectives from HIV-infected individuals in Nyanza Province, Kenya. Int J Gynaecol Obstet 2013;123 Suppl 1:e16-23.
76. Grossman D, Fuentes L. Over-the-counter access to oral contraceptives as a reproductive healthcare strategy. Curr Opin Obstet Gynecol 2013;25(6):500-5.

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77. White K, Potter JE, Hopkins K, Grossman D. Variation in postpartum contraceptive method use: Results from the Pregnancy Risk Assessment Monitoring System (PRAMS). Contraception 2014;89(1):57-62.
78. Burns B, Grindlay K, Holt K, Manski R, Grossman D. Military sexual trauma among U.S. servicewomen during deployment: A qualitative study. AJPH 2014;104:345-349.
79. Committee on Practice Bulletins-Gynecology, American College of Obstetricians and Gynecologists, with Creinin M, Grossman D. Practice Bulletin No 143: Medical management of first-trimester abortion. Obstet Gynecol 2014;123(3):676-92.
80. Wahlin B, Grindlay K, Grossman D. Should Oral Contraceptives Be Available Over the Counter? Food and Drug Policy Forum 2014; 4(3).
81. Constant D, Grossman D, Lince N, Harries J. Self-induction of abortion among women accessing second trimester abortion services in the public sector, Western Cape, South Africa: An exploratory study. South African Medical Journal 2014;104(4):302-305.
82. Onono M, Blat C, Miles S, Steinfeld R, Wekesa P, Bukusi EA, Owuor K, Grossman D, Cohen CR, Newmann SJ. Impact of family planning health talks by lay health workers on contraceptive knowledge and attitudes among HIV-infected patients in rural Kenya. Patient Educ Couns 2014;94(3):438-41.
83. Grossman D, White K, Hopkins K, Potter JE. The public health threat of anti-abortion legislation. Contraception 2014;89:73-4.
84. Foster DG, Grossman D, Turok DK, Peipert JF, Prine L, Schreiber CA, Jackson A, Barar R, Schwarz EB. Interest in and experience with IUD self-removal. Contraception 2014;90(1):54-9.
85. Manski R, Grindlay K, Burns B, Holt K, Grossman D. Reproductive health access among deployed U.S. servicewomen: a qualitative study. Military Medicine 2014;1179(6):645-52.
86. Grindlay K, Foster DG, Grossman D. Attitudes Toward Over-the-Counter Access to Oral Contraceptives Among a Sample of Abortion Clients in the United States. Perspect Sex Reprod Health 2014;46(2):83-9.
87. Grossman D, Constant D, Lince-Deroche N, Harries J, Kluge J. A randomized trial of misoprostol versus laminaria before dilation and evacuation in South Africa. Contraception 2014;90(3):234-41.
88. Patel R, Baum S, Grossman D, Steinfeld R, Onono M, Cohen CR, Bukusi EA, Newmann SJ. HIV-positive men's experiences with integrated family planning and HIV services in western Kenya: Integration fosters male involvement. AIDS Patient Care STDS 2014;28(8):418-24.
89. Blanchard K, Chipato T, Ramjee G, Nhemachena T, Harper CC, and the Provider Study Writing Committee (including Grossman D). Clinicians' perceptions and provision of hormonal contraceptives for HIV positive and at-risk women in Southern Africa: an original research article. Contraception 2014;90(4):391-8.
90. DePiñeres T, Baum S, Grossman D. Acceptability and clinical outcomes of first- and second-trimester surgical abortion by suction aspiration in Colombia. Contraception 2014;90(3):242-8.
91. Potter JE, Hopkins K, Aiken ARA, Hubert Lopez C, Stevenson AJ, White K, Grossman D. Unmet Demand for Highly Effective Postpartum Contraception in Texas. Contraception 2014;90(5):488-95.

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92. Grossman D, Baum S, Fuentes L, White K, Hopkins K, Stevenson A, Potter JE. Change in abortion services after implementation of a restrictive law in Texas. Contraception 2014;90(5):496-501.
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E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

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LANGUAGES

Fluent in Spanish, conversant in French.

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EXHIBIT 11

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IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*,	Case No. A 2101148
Plaintiffs,	Judge Alison Hatheway
v.	
OHIO DEPARTMENT OF HEALTH, *et al.*,	
Defendants.	

EXPERT REPORT OF JOANNE SPETZ, Ph.D.

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IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A 2101148 Judge Alison Hatheway

AFFIDAVIT OF JOANNE SPETZ, Ph.D.

Now comes affiant Joanne Spetz, having been first duly cautioned and sworn, deposes and states as follows:

1. I am over the age of 18 and fully competent to make this declaration. I have personal knowledge of the statements and facts contained herein.
2. For the purposes of this litigation, I am providing my expert opinions.
3. I have prepared the report attached to this affidavit as Exhibit A and swear to its authenticity and to the faithfulness of the opinions expressed, and to the best of my knowledge, the accuracy of the factual statements made therein.

FURTHER AFFIANT SAYETH NAUGHT

Joanne Spetz

Joanne Spetz, Ph.D.

State of Florida, County of Broward
by Joanne Spetz appeared by means of online notarization and produced US Passport as identification.

Sworn to and subscribed before me this 11th Day of February, 2026.

SHANTA A. COOPER
Notary Public-State of Florida
Commission # HH 593076
My Commission Expires
January 11, 2029

Shanta A. Cooper

Shanta A. Cooper

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

EXPERT REPORT OF JOANNE SPETZ, Ph.D.

I. INTRODUCTION

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. I am over 18 years of age, of sound mind, and in all respects competent to testify.

2. I have actual knowledge of the matters stated herein.

3. In preparing this report, in addition to reviewing the materials cited herein, I have also relied on my years of research and other experience, as set out in my *curriculum vitae* (**Exhibit B**) in forming my opinions. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

II. BACKGROUND AND QUALIFICATIONS

4. I am the Brenda and Jeffrey L. Kang Presidential Chair in Health Care Financing and Director of the Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco ("UCSF"). I am also a Professor in the Department of Family and Community Medicine and in the School of Nursing at UCSF. In these and previous positions, I have extensively researched nurse practitioners and nurse midwives, the impact of laws and regulatory policies on health behaviors and health workforce labor markets, and the quality of care provided by nurses. I have a particular interest in how the organization and regulation of our health care system affects the provision of, and access to, care.

5. I hold an M.A. and Ph.D. in Economics from Stanford University, which I received in 1993 and 1996, respectively. I also received a Bachelor of Science in Economics from the Massachusetts Institute of Technology in 1990.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

6. I have authored or supervised numerous studies and systematic reviews evaluating how restrictions on nurse practitioners' ("NPs'") and nurse midwives' ("NMs'") scope of practice—that is, rules defining which services NPs and NMs can provide and under what circumstances—affect health care delivery and access to care. I have also led and contributed to research on the roles of physician assistants ("PAs"), including on how insurance payment policies affect their employment and demand for their services in long-term care. I am currently the co-principal investigator of the National Dementia Workforce Study, which is an $81 million project funded by the National Institutes of Health to examine the characteristics of the workforce that serves people with dementia and their impact on health outcomes, including the roles of NPs and PAs.

7. I recently completed a study funded by the National Institutes of Health on how state-level scope of practice regulations of NPs, NMs, clinical nurse specialists, and PAs affect their ability to offer medication treatment for opioid use disorder and previously completed a smaller study on the same topic funded by the National Council of State Boards of Nursing ("NCSBN"). I was also co-investigator for a study funded by NCSBN on state scope of practice regulations and NP prescribing of opioids. I also recently completed two interrelated studies funded by the California Health Care Foundation for which I surveyed 4,000 California-resident NPs, NMs, and licensed midwives to learn how changes in California's scope-of-practice regulations have affected their employment and the care they provide. I recently completed research as a co-investigator evaluating how state NP scope of practice regulations impact access to health care services among those living in underserved areas. I have been a principal investigator on multiple grants from the Robert Wood Johnson Foundation measuring progress toward nationwide implementation of recommendations by the Institute of Medicine's Committee on the

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Future of Nursing, which I discuss in greater detail below. I have also completed reviews of the literature on the effect of NP, NM, and PA scope of practice regulations on access, cost, and quality of health care for the California Health Care Foundation.

8. I am a member of multiple professional societies, such as AcademyHealth, the American Society of Health Economists, the Gerontological Society of America, and the International Health Economics Association; these are the premier professional organizations for the fields in which I conduct research, and their annual conferences draw thousands of attendees. I actively serve as a committee member, abstract reviewer, and presenter for all of these organizations. I currently serve on the editorial board and as a reviewer for several academic journals, including *Medical Care Research and Review*, *Health Affairs*, and *JAMA Network* journals. I presently serve on a National Academies of Sciences, Engineering, and Medicine ("Natl. Academies") Committee on data infrastructure for measuring the care economy, and previously served on two committees, one focused on research on the impact of nurse credentials on quality of care, and the other focused on the managerial implications of generational differences in the workplace.

9. I am being compensated at an hourly rate of $350 per hour for preparation of expert affidavits and reports and $600 per hour for deposition or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

III. SUMMARY OF EXPERT OPINIONS

10. I understand that various state laws prohibit NPs, NMs, and PAs (collectively, "advanced practice clinicians" or "APCs") in Ohio from providing abortion, including medication abortion, regardless of whether such care is within an APC's competency and regardless of patient need, and instead permit only physicians to provide abortion (collectively, the "APC Ban").

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

11. APCs are vital participants in the health care system and their practice authority has expanded and continues to expand over time. They hold prescriptive authority in every state and are key providers of primary, gynecological, maternity, acute, and chronic care nationally, especially for low-income patients and those in rural areas.

12. Ohio's APC Ban undermines APCs' ability to care for patients and is out-of-step with APCs' essential role in the health care systems of Ohio and nationally.

13. APCs provide medication abortion as safely and effectively as physicians. The APC Ban burdens, penalizes, and interferes with APCs who might otherwise provide medication abortion and patients seeking medication abortion in Ohio, both without medical justification.

IV. OPINIONS

14. As a health care economist, I specialize in assessing how systemic structures affect access to and quality of health care. I am deeply familiar with, and have contributed to, the research and literature relating to the role and regulation of APCs in the U.S. health care system.

15. APCs are vital participants in the U.S. health care system. As states and accreditation bodies have heightened educational standards for APCs, a large and growing body of research has confirmed the safety and efficacy of their provision of care, and as the nation's physician shortage crisis has worsened, APCs' practice authority has expanded significantly.[1] APCs safely provide a broader range of services, with fewer conditions and limitations, than ever before.

[1] Natl. Academies, *The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity*, at 87 (2021), https://doi.org/10.17226/25982 (accessed Feb. 6, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

16. Today, APCs hold prescriptive authority in every state, including for controlled substances,[2] and they are key providers of primary, gynecological, maternity, acute, and chronic care across the country. They are particularly likely to serve low-income patients and those living in rural and medically underserved areas. Citing the robust evidence confirming the safety of APC provision of care within their scope of practice and the nation's urgent health care needs, leading authorities—such as the National Academy of Medicine, the Federal Trade Commission, and the National Governors Association—recommend that APCs take on an even greater role in the health care system, practicing to the fullest extent of their education and training.

17. Ohio's APC Ban undermines APCs' ability to care for their patients and is out-of-step with APCs' essential role in the health care systems of Ohio and the nation.

A. Regulation of APCs

18. NPs and NMs are two of the four recognized categories of advanced practice registered nurses ("APRNs") in Ohio and in the United States. Both NPs and NMs hold national certification and are thus called certified nurse practitioners ("CNPs") and certified nurse midwives ("CNMs"), respectively, in Ohio as well as some other states.[3]

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[2] Am. Academy of Physician Assocs., *PA Prescribing* (Apr. 2019), https://www.aapa.org/wp-content/uploads/2017/03/f-833-4-8256527_dk6DMjRR_Prescribing_IB_2017_FINAL.pdf (accessed Feb. 6, 2026); Am. Assn. of Nurse Practitioners, *State Practice Environment*, https://www.aanp.org/advocacy/state/state-practice-environment (accessed Feb. 6, 2026); U.S. Dept. of Justice Drug Enforcement Administration, Diversion Control Div., *Mid-Level Practitioners Authorization by State*, https://www.deadiversion.usdoj.gov/drugreg/practioners/practioners.html (accessed Feb. 6, 2026).

[3] R.C. 4723.41(A); Adm.Code 4723-8-01(A); Ohio Bd. of Nursing, *APRN Licensure and Practice in Ohio*, https://nursing.ohio.gov/education-and-practice/practice-and-prescribing/scopes-of-practice/aprn-licensure-and-practice-in-ohio (accessed Feb. 6, 2026). Nurse anesthetists, who administer anesthesia and provide related care, and clinical nurse specialists, who provide advanced nursing care and acute and chronic care management, are also types of APRNs. *See* Ohio Bd. of Nursing, *APRN Licensure and Practice in Ohio*.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

19. Throughout the country, NPs provide a broad array of health services, including taking health histories and performing physical examinations, providing health education and counseling, diagnosing and treating acute and chronic illnesses, providing immunizations, performing procedures, ordering and interpreting lab tests and x-rays, coordinating patient care across multiple providers, and prescribing and managing medications and other therapies (including at least Schedule III controlled substances in every state and the District of Columbia[4]). The Veterans Health Administration reports that the roles of NPs are similar to those of physicians in primary care.[5]

20. Nationwide, NPs accounted for at least 25% of rural and 23% of nonrural primary care providers in 2016,[6] and in 2021, independently-billing APCs comprised approximately 35% of primary care clinicians and 19% of the obstetrics-gynecology clinical workforce.[7] Furthermore, NPs are a key source of care in community health centers and nurse-managed health centers, which serve nearly 33 million patients a year.[8]

21. Nationally, NMs provide primary and specialized care to patients who need gynecological care, including family planning services and preconception care, as well as care throughout the course of pregnancy and birth, including childbirth, postpartum care, and neonatal

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[4] U.S. Dept. of Justice Drug Enforcement Administration, *supra* note 2.

[5] Alexandra Hobson & Alexa Curtis, *Improving the Care of Veterans: The Role of Nurse Practitioners in Team-Based Population Health Management*, 29 Journal of the Am. Assn. of Nurse Practitioners 644, 645 (2017) ("NPs function in a similar capacity to physicians within the VHA primary care system including serving as primary care providers.").

[6] Hilary Barnes et al., *Rural and Nonrural Primary Care Physician Practices Increasingly Rely on Nurse Practitioners*, 37 Health Affairs 908, 909–10 (2018).

[7] Parth K. Modi et al., *Employment of Independently Billing Advanced Practice Clinicians*, JAMA Health Forum (Sept. 12, 2025), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2838755 (accessed Feb. 6, 2026).

[8] Natl. Assn. of Community Health Ctrs., *2025 Uniform Data System Chartbook: Analysis of the 2023 UDS Data*, at 11 (2025), https://www.nachc.org/wp-content/uploads/2025/05/2025-UDS-Chartbook_Final-05.13.25.pdf (accessed Feb. 11, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

care. NMs "provide initial and ongoing comprehensive assessment, diagnosis and treatment. They conduct physical examinations; independently prescribe medications including but not limited to controlled substances . . . ; admit, manage and discharge patients; order and interpret laboratory and diagnostic tests and order medical devices."[9] NMs can prescribe controlled substances in every state and the District of Columbia.[10] Many NMs also hold certification as NPs.[11]

22. PAs, like NPs and NMs, play a vital role in expanding access to medical care, especially in underserved communities and areas. PAs are licensed health care professionals who practice medicine in collaboration with physicians and other providers. Their responsibilities include diagnosing illness, creating treatment plans, performing procedures, and prescribing medications, including controlled substances. They are recognized and licensed in every U.S. state.[12]

23. APCs' competencies also include recognizing cases when a patient has complex needs requiring evaluation or treatment beyond the clinician's education, training, or skills—just as a physician would refer patients to a specialty provider if the patients' needs are outside of that physician's area of expertise.

24. Throughout the country, APCs are subject to two principal layers of regulation: licensure and scope of practice.

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[9] Am. College of Nurse-Midwives, *Definition of Midwifery and Scope of Practice of Certified Nurse-Midwives and Certified Midwives*, at 1 (Dec. 2011), https://legacy.midwife.org/acnm/files/acnmlibrarydata/uploadfilename/000000000266/Definition%20Midwifery%20Scope%20of%20Practice_2021.pdf (accessed Feb. 6, 2026).

[10] Kathryn Osborne, *Regulation of Controlled Substance Prescribing: An Overview for Certified Nurse-Midwives and Certified Midwives*, 62 Journal Midwifery & Women's Health 341 (2017).

[11] Joanne Spetz et al., Cal. Bd. of Registered Nursing, *2017 Survey of Nurse Practitioners and Certified Nurse-Midwives*, at 15 (Apr. 11, 2018), https://www.rn.ca.gov/pdfs/forms/survey2017npcnm-final.pdf (accessed Feb. 6, 2026).

[12] Am. Academy of Physician Assocs., *List of Licensing Boards*, https://www.aapa.org/advocacy-central/state-advocacy/state-licensing/list-of-licensing-boards/ (accessed Feb. 6, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

1. APC Licensure

25. First, as with many occupations, licensure is "a process that establishes the conditions for entry into an occupation. . . . Generally, an applicant for licensure must demonstrate a minimum degree of competence, based on education and training, to obtain the government's permission to provide professional services in a given jurisdiction."[13]

26. Today, all states, including Ohio, as well as the District of Columbia, require prospective NPs to hold a registered nurse license and demonstrate their competency as an NP through additional certification and/or educational requirements. Ohio, like all states and the District of Columbia, requires completion of a master's, postgraduate, or doctorate degree from an accredited NP program, and 47 states, including Ohio, and the District of Columbia require that the candidate obtain certification from a nationally recognized certifying body such as the American Academy of Nurse Practitioners or the American Nurses Credentialing Center.[14] The certification "tests the applicant's knowledge and skill in diagnosing, determining treatments, and prescribing for their patient population of focus."[15] In Ohio, NPs are licensed as certified nurse

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[13] Daniel J. Gilman & Tara Isa Koslov, Fed. Trade Comm., *Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses*, at 12 (Mar. 2014), https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf (accessed Feb. 6, 2026) [hereinafter "FTC Report"].

[14] *See* Am. Assn. of Nurse Practitioners, *Practice Information by State*, https://www.aanp.org/practice/practice-information-by-state (accessed Feb. 6, 2026) The three states that do not require such national certification for NP licensure (California, Indiana, and New York) instead require either certification or completion of a board-approved master's degree with similar course requirements to those accepted by the national certifying bodies. Natl. Governors Assn., *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care*, at 8 (Dec. 20, 2012), https://www.nga.org/wp-content/uploads/2019/08/1212NursePractitionersPaper.pdf (accessed Feb. 6, 2026); Nev. State Bd. of Nursing, *Licensure Requirements for Advanced Practice Registered Nurse*, https://nevadanursingboard.org/wp-content/uploads/2019/10/APRN-Licensure-Requirements.pdf (accessed Feb. 10, 2026); Kan. Bd. of Nursing, *APRN Initial Application Checklist*, https://ksbn.kansas.gov/aprn-initial-application/ (accessed Feb. 10, 2026).

[15] Natl. Governors Assn., *supra* note 14, at 8.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

practitioners and receive approval to practice as CNPs by the Board of Nursing, which oversees their practice.[16] NP education covers a common range of medical topics including physiology, body systems, and diagnosing and treating illnesses and conditions. Their initial education also includes an area of focus, such as family practice, pediatrics, women's health, adult-gerontology, psychiatry, or acute care.

27. NMs are educated in both midwifery and nursing. As with NPs, today all states and the District of Columbia require NM applicants to hold a registered nurse license and demonstrate their competency through additional certification and/or educational requirements. The District of Columbia and all but one state (Pennsylvania) require completion of a master's, postgraduate, or doctorate degree from an accredited NM program, and all require certification by the American Midwifery Certification Board.[17] In Ohio, NMs are licensed as certified nurse midwives and receive approval to practice as CNMs by the Board of Nursing, which oversees their practice.[18]

28. PAs are generally licensed and regulated by Boards of Medicine, including in Ohio.[19] In all states, an applicant seeking PA licensure must have passed the national certification examination offered by the National Commission on Certification of Physician Assistants.[20] Applicants are eligible to take this exam after completing a nationally-accredited education

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[16] R.C. 4723.41–42.

[17] E. Brie Thumm et al., *American Midwifery Certification Board Certification Demographic and Employment Data, 2016 to 2020: The Certified Nurse-Midwife and Certified Midwife Workforce*, 68 Journal of Midwifery & Women's Health 563 (2023); Pa.Code, Title 49, Ch. 18.2; N.Y. State Edn. Dept., Office of the Professions, *License Requirements for Midwifery*, https://www.op.nysed.gov/professions/midwifery/license-requirements (accessed Feb. 10, 2026).

[18] R.C. 4723.41–42.

[19] R.C. 4730.01 et seq.

[20] Natl. Comm. on Certification of Physician Assistants, *Become Certified*, https://www.nccpa.net/become-certified/ (accessed Feb. 6, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

program.[21] As of January 1, 2021, all accredited PA education programs across the U.S. must confer a graduate degree.[22]

2. APC Scope of Practice

29. The second layer of APC regulation relates to "scope of practice," which defines which professional services an APC is authorized to provide. These rules dictate which patients an APC may treat, what services they may deliver, and the extent to which they are permitted to practice independently (that is, without formal physician oversight or supervision). Scope of practice rules may prevent APCs from performing certain services or treating certain categories of patients unless they first complete additional training, obtain a particular certification, obtain and document a specific form of supervision (e.g., from a physician or a more experienced APRN), or meet other regulatory requirements.

30. APCs' scope of practice is governed by state law under the state's nurse practice act, physician practice act, or other similar practice regulations and is administered and regulated by each state's licensing boards. State legislatures may set the broad outlines of APCs' scope of practice but delegate to the state's licensing boards to flesh out the specific details and enforcement of the rules under penalty of professional discipline. As a general matter, however, these licensing boards do not create detailed lists of procedures, tests, or treatments that APCs are categorically precluded from performing. This is because whether a specific treatment is within a provider's scope of practice is typically linked to the individual APC's education, training, and licensing examinations.

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[21] *Id.*

[22] ARC-PA, *Entry Level Accredited Programs*, https://www.arc-pa.org/entry-level-program/currently-accredited-programs/ (accessed Feb. 6, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

31. Thirty-three U.S. states have implemented scope of practice laws that allow NPs full practice and prescribing independence without any physician oversight, including when prescribing controlled substances.[23] In some of these states, NPs must complete up to five years of practice in formal collaboration or supervision with a physician or experienced NP before the NP can practice without formal oversight.[24] In addition, more than half of all states allow NMs to practice independently without physician oversight.[25] As discussed further below, *infra* ¶ 95, Ohio requires physician oversight for NPs and NMs.

32. In every state, physician assistants are required to have a formal collaboration or supervision agreement with a physician.[26] However, in most states, supervising physicians are not required to be on-site with PAs, and regulations allow PAs substantial autonomy in clinical decisionmaking.[27] As discussed further below, *infra* ¶ 96, Ohio requires physician oversight for PAs.

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[23] Benjamin J. McMichael & Sara Markowitz, *Toward a Uniform Classification of Nurse Practitioner Scope of Practice Laws*, 80 Med. Care Research & Rev. 444 (2023).

[24] Joanne Spetz, Cal. Health Care Found., *California's Nurse Practitioners: How Scope of Practice Laws Impact Care*, at 5–6 (May 2, 2019), https://www.chcf.org/publication/californias-nurse-practitioners/ (accessed Feb. 6, 2026).

[25] Connie Kwong et al., Cal. Health Care Found., *California's Midwives: How Scope of Practice Laws Impact Care*, at 11 tbl.7 (Oct. 2019), https://www.chcf.org/wp-content/uploads/2019/10/CaliforniasMidwivesScopePracticeLawsImpactCare.pdf (accessed Feb. 6, 2026). The exact number of states with full practice independence may vary slightly depending on which professional organization is interpreting the regulations.

[26] Am. Academy of Physician Assocs., *PA State Practice Environment*, https://www.aapa.org/advocacy-central/state-advocacy/state-maps/pa-state-practice-environment/ (accessed Feb. 6, 2026).

[27] *Id.*; Joanne Spetz et al., *Transformation of the Nonphysician Health Professions*, *in* The Healthcare Professional Workforce: Understanding Human Capital in a Changing Industry 51, 57 (2016).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

B. Expanded Role of APCs in the United States Health Care System

33. APCs have taken on an increasingly significant role in the United States health care system over the past several decades, and particularly since the turn of the 21st century. This is a product of four interwoven trends: (1) enhanced educational requirements for APC licensure; (2) growing numbers of APC graduates; (3) steadily expanding APC scope of practice; and (4) greater utilization of APCs' services, particularly in the context of pregnancy care.

1. Enhanced Educational Requirements

34. Education requirements for APCs have become more standardized and formalized in recent decades.

35. Today, all NP programs in the United States are offered at the graduate level and are required to be accredited by a nationally recognized nursing and/or education accreditation body.[28]

36. When the first educational programs for NPs were established in the 1960s and 1970s, they conferred certificates that documented the training they received after becoming licensed registered nurses. At that time, many of the initial graduates of NP programs had received their registered nurse education in diploma programs based in hospitals rather than universities. Since then, registered nurse education has transitioned to post-secondary degrees and NP education has transitioned to graduate degrees.[29]

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[28] Westat for the Office of the Assistant Secy. for Planning & Evaluation, *Impact of State Scope of Practice Laws and Other Factors on the Practice and Supply of Primary Care Nurse Practitioners: Final Report*, at 27 (Nov. 16, 2015), https://aspe.hhs.gov/system/files/pdf/167396/NP_SOP.pdf (accessed Feb. 9, 2026) [hereinafter "ASPE Report"].

[29] Nurse.com, *History Lesson: Nursing Education has Evolved over the Decades* (Nov. 5, 2012), https://www.nurse.com/blog/history-lesson-nursing-education-has-evolved-over-the-decades/ (accessed Feb. 10, 2026); Dominique A. Tobbell, *The Transformation of American Nursing* (2023), https://issues.org/transformation-american-nursing-tobbell/ (accessed Feb. 10, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

37. Certification bodies and state legislatures now uniformly required a graduate degree for new NPs. For example, the National Certification Corporation—the premiere certification body for NPs in the obstetric, gynecologic, and neonatal nursing specialties—began requiring a master's degree for nurses seeking certification as women's health nurse practitioners in 2007.[30]

38. Although midwifery has a long history—women have likely been assisting one another in childbirth for millennia—nurse midwifery was not established as a distinct field until 1925, and national certifications in nurse midwifery were first offered in 1970 by the American College of Nurse Midwives. Since 2010, a graduate degree has been required for new applicants for certification by the American Midwifery Certification Board.[31]

39. For both NPs and NMs, there is a growing trend toward curriculum standardization across institutions.[32] In 2008, after five years of study and debate, a group of nursing accreditation, certification, and licensing organizations, along with several APRN groups, developed a consensus model for the accreditation, education, training, certification, and licensure of APRNs.[33] State boards of nursing in every state have signed onto the APRN consensus model, although changes to rules and regulations are generally required to be approved by the state legislatures. To date, 17

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[30] Jane H. Kass-Wolff & Nancy K. Lowe, *A Historical Perspective of the Women's Health Nurse Practitioner,* 44 Nursing Clinics of N. Am. 271, 277 (2009).

[31] Am. College of Nurse-Midwives, *Essential Facts About Midwives*, http://www.midwife.org/Essential-Facts-about-Midwives (accessed Feb. 9, 2026).

[32] ASPE Report, *supra* note 28, at 27.

[33] Inst. of Medicine of the Natl. Academies, *The Future of Nursing: Leading Change, Advancing Health*, at 106 (2011), https://www.nap.edu/read/12956 (accessed Feb. 9, 2026) [hereinafter "IOM Report"].

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

states have fully enacted the consensus model for all APRN roles.[34] Ohio's education and certification requirements are aligned with the consensus model.[35]

40. Similar to NPs and NMs, PA education began with a variety of certificate and degree programs. The first program at Duke University was a two-year program based on a traditional medical education.[36] Today, all PA education is at the master's degree level, and students must matriculate at an accredited education program in order to take the national licensing examination.[37] The accreditation requirement has promulgated consistent standards for PA education nationwide. After completion of a PA education program, all states require applicants to take and pass the Physician Assistant National Certifying Examination to qualify for licensure.[38]

2. Growing Numbers of APC Graduates

41. Individuals are entering into and graduating from APC post-graduate programs at unprecedented rates. The number of students enrolled in APRN master's programs increased 68.6% between 2006 and 2011, from 56,028 to 94,480 persons.[39] Nearly 40,000 people completed NP education programs in the 2023–24 year,[40] which is more than six times the 6,611 graduates

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[34] Natl. Council of State Bds. of Nursing, *APRN Consensus Model by State* (Jan. 2024) (on file with author). Those states are Alaska, Delaware, Hawaii, Idaho, Kansas, Kentucky, Minnesota, Montana, New Mexico, North Dakota, Oregon, Rhode Island, Utah, Vermont, Washington, West Virginia, and Wyoming.

[35] *Id.* at 3.

[36] *See* James F. Cawley et al., *Origins of the Physician Assistant Movement in the United States*, 25 Journal of the Am. Academy of Physician Assistants 36, 38 (2012).

[37] *See* Am. Academy of Physician Assocs., *Become a PA*, https://www.aapa.org/career-central/become-a-pa/ (accessed Feb. 9, 2026).

[38] Am. Academy of Physician Assocs., *PA Scope of Practice* (Sept. 2019), https://www.aapa.org/download/61319/ (accessed Feb. 9, 2026); Spetz, *supra* note 27.

[39] John K. Iglehart, *Expanding the Role of Advanced Nurse Practitioners—Risks and Rewards*, 368 New England Journal of Medicine 1935, 1937 (2013).

[40] Am. Assn. of Nurse Practitioners, *Research Snapshot: Nurse Practitioner (NP) Student Trends, 2015-2024* (July 2025), https://storage.aanp.org/www/documents/research/NP_Student_Snapshot_2015-2024.pdf (accessed Feb. 9, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

in 2003.[41] From 2007 to 2024, the number of newly certified NMs increased from 285 to 738.[42] Similarly, the number of PA graduates has increased markedly over the decades: there were 767 graduates in 1984–85,[43] approximately 4,554 in 2003,[44] and in 2024, 12,400 people passed a PA certification exam.[45]

42. According to the American Association of Nurse Practitioners, there were more than 461,000 NPs certified to practice in the United States in 2025.[46]

43. According to the American Midwifery Certification Board, as of August 2025, there were 14,941 NMs in the United States.[47]

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[41] U.S. Health Resources & Servs. Administration, *Projecting the Supply and Demand for Primary Care Practitioners Through 2020*, at 16 (Nov. 2013), https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/projecting-primary-care.pdf (accessed Feb. 9, 2026).

[42] *See* Am. Midwifery Certification Bd., *2024 Annual Report*, at 3 (2024), https://www.amcbmidwife.org/docs/default-source/annual-reports/2024-amcb-annual-report.pdf (accessed Feb. 9, 2026).

[43] *See* Physician Assistant Edn. Assn., *Program Report 35: Data from the 2019 Program Survey*, at 33 fig.19 (2020), https://e1.nmcdn.io/assets/paea/wp-content/uploads/2020/11/program-report35-20201014.pdf (accessed Feb. 10, 2026).

[44] *See* Physician Assistant Edn. Assn., *Twentieth Annual Report on Physician Assistant Educational Programs in the United States, 2003–2004*, at 56 (Aug. 2004), https://paeaonline.org/wp-content/uploads/imported-files/20th-Annual-Report-on-Physician-Assistant-Educational-Programs-in-the-United-States-2003-2004.pdf (accessed Feb. 9, 2026).

[45] *See* Natl. Comm. on Certification of Physician Assistants, *2024 Statistical Profile of Recently Board Certified PAs*, at 4 (2025), https://www.nccpa.net/wp-content/uploads/2025/10/2024-Statistical-Profile-of-Recently-Board-Certified-PAs.pdf (accessed Feb. 9, 2026).

[46] Am. Assn. of Nurse Practitioners, *Nurse Practitioners are the Providers of Choice for Millions of Americans* (Oct. 2025), https://storage.aanp.org/www/documents/NP_Infographic.pdf (accessed Feb. 9, 2026); Am. Assn. of Nurse Practitioners, *A Behind-the-Scenes Look at the 2025 Nurse Practitioner Count* (Nov. 11, 2025), https://www.aanp.org/news-feed/a-behind-the-scenes-look-at-the-2025-nurse-practitioner-count (accessed Feb. 9, 2026).

[47] *See* Am. Midwifery Certification Bd., *Certified Nurse-Midwives/Certified Midwives by State* (Aug. 2025), https://www.amcbmidwife.org/docs/default-source/default-document-library/number-of-cnm-cm-by-state---august-2025.pdf (accessed Feb. 9, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

44. The National Commission on Certification of Physician Assistants reported that there were 189,907 certified PAs in the United States in 2024.[48]

3. Expanded Legal Authority for APC Practice

45. Perhaps the most significant change over the past three decades is in the broadening of APC practice authority, commensurate with enhanced training and education requirements, with particularly notable expansions for APRNs.

46. In 1997 alone, 37 states enacted 83 laws expanding scope of practice for APRNs.[49] Between 2004 and 2012, eight additional states liberalized their scope of practice rules for APRNs.[50] Since 2007, 32 states have enacted regulatory changes that have provided NPs with a greater degree of practice authority, including 16 states that now allow NPs to practice without physician oversight.[51] In total, 33 states allow NPs to practice and prescribe medications without physician oversight either immediately upon licensure or after a transitional period with oversight by a physician or experienced NP.[52] In Ohio, they can do so with physician oversight. *Infra* ¶ 95.

47. Today, NPs, NMs, and PAs hold prescriptive authority, including for controlled substances, in all 50 states and the District of Columbia.[53] NPs may prescribe controlled

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[48] *See* Natl. Comm. on Certification of Physician Assistants, *Statistical Profile of Board Certified Physician Assistants*, at 6 (2025), https://www.nccpa.net/wp-content/uploads/2025/05/2024-Statistical-Profile-of-Board-Certified-PAs.pdf (accessed Feb. 9, 2026).

[49] Benjamin G. Druss et al., *Trends in Care by Nonphysician Clinicians in the United States*, 348 New England Journal of Medicine 130, 131 (2003).

[50] ASPE Report, *supra* note 28, at 18; *see also* Iglehart, *supra* note 39, at 1939.

[51] Campaign for Action, *Access to Care: Full Practice Authority for Advanced Practice Registered Nurses in All 50 States* (Mar. 6, 2024), https://campaignforaction.org/wp-content/uploads/2024/03/r13-CCNA-0033_Dashboard-Indicator-Updates2-8-2024_Page_1.jpg (accessed Feb. 9, 2026).

[52] McMichael & Markowitz, *supra* note 23.

[53] Am. College of Nurse-Midwives, *supra* note 31; Kathryn Osborne, *Regulation of Prescriptive Authority for Certified Nurse-Midwives and Certified Midwives: 2015 National Overview*, 60 Journal of Midwifery & Women's Health 519, 530 (2015); Am. Academy of Physician Assocs.,

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

substances, including Schedule III substances—such as products containing less than 90 milligrams of codeine, ketamine, and anabolic steroids—in every state, and Schedule II substances—such as oxycodone, methadone, and fentanyl—in all but four states.[54] As of 2022, 96.2% of NPs prescribed medications, and those in full-time practice wrote an average of 21 prescriptions per day.[55] (My understanding is that mifepristone and misoprostol, used in medication abortion, are relatively lower risk medications that are not controlled substances federally or in Ohio.)

48. Notably, the United States Drug Enforcement Administration (the "DEA") does not place any unique restrictions on APC prescription of controlled substances. APCs may register with the DEA just as physicians do and prescribe controlled substances consistent with any state-specific requirements (such as additional educational or supervision requirements).[56]

49. A similar trend toward expanded practice authority for APCs is visible at the federal level. For example, in 2016, the U.S. Department of Veterans Affairs announced new regulations permitting full practice authority for the nearly 6,000 APRNs in its workforce, allowing them "to practice to the full extent of their education, training, and certification, regardless of State restrictions that limit such full practice authority, except for applicable State restrictions on the authority to prescribe and administer controlled substances, when such APRNs are acting within the scope of their VA employment."[57]

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supra note 2; Phillip Zhang & Preeti Patel, *Practitioners and Prescriptive Authority* (Nov. 13, 2023), https://www.ncbi.nlm.nih.gov/books/NBK574557/ (accessed Feb. 9, 2026).

[54] U.S. Dept. of Justice Drug Enforcement Administration, *supra* note 2.

[55] Ohio Assn. of Advanced Practice Nurses, *NP Fast Facts* (June 9, 2021), https://oaapn.org/2021/06/np-fast-facts/ (accessed Feb. 9, 2026).

[56] *See* U.S. Dept. of Justice Drug Enforcement Administration, *supra* note 2; 21 C.F.R. 1301.11 et seq.

[57] U.S. Dept. of Veterans Affairs, *VA Grants Full Practice Authority to Advance Practice Registered Nurses* (Dec. 14, 2016), https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2847

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

50. The dramatic expansion of APC practice described above has included their provision of abortion, including both medication and aspiration abortion. In 2013, 16 states allowed APCs to provide medication abortion, and only four of these allowed them to perform abortion procedures.[58] Now, 25 states (including Ohio due to the preliminary injunction in this case) and the District of Columbia allow APCs to provide medication abortion, and 23 of these states and the District of Columbia allow them to provide procedural abortion.[59] The number of states allowing APCs to provide abortion has increased even since the preliminary injunction briefing in this case less than two years ago, from 21 states and the District of Columbia allowing APCs to provide medication abortion and 19 states and the District of Columbia allowing them to provide procedural abortions.[60]

4. Increased Utilization of APC Services

51. As the numbers of APCs have increased and their practice authority has expanded, a growing number of Americans are relying on them for care.

52. According to the Kaiser Family Foundation, "NPs are . . . by far, the fastest growing segment of the primary care professional workforce; between the mid-1990s and the mid-2000s, their numbers (per capita) grew an average of more than 9% annually, compared with . . . just 1%

(accessed Feb. 9, 2026). The final regulations did not apply to Certified Registered Nurse Anesthetists.

[58] Tracy A. Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. Journal of Pub. Health 454, 455 fig.1 (2013).

[59] AP Toolkit, *State Abortion Laws and Their Relationship to Scope of Practice*, https://aptoolkit.org/advancing-scope-of-practice-to-include-abortion-care/state-abortion-laws-and-their-relationship-to-scope-of-practice/ (accessed Feb. 9, 2026). This map does not reflect that Rhode Island law allows APCs to provide both procedural and medication abortion. R.I.Code, Title 216, Ch. 20, 10-6.3 (repealed 2023).

[60] *See* Expert Aff. of Joanne Spetz, Ph.D., in Supp. of Pls.' Second Mot. for Prelim. Inj. ¶ 43.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

for primary care physicians."[61] Between 1998 and 2010, the number of Medicare patients receiving care from NPs increased 15-fold.[62] These trends have continued over the past decade, with the number of people working as NPs more than tripling from 91,000 in 2010 to at least 317,466 by 2024.[63] The United States Bureau of Labor Statistics projects that NP employment will grow 40% by 2034.[64]

53. The United States Bureau of Labor Statistics also reported PA employment at 162,700 as of May 2024 and estimates further growth by 20% by 2034.[65]

54. Similarly, the proportion of singleton births (i.e., a birth of a single child) for which an NM was the primary clinician managing the birth, as recorded on the birth certificate, increased nationwide from 5.3% in 1994 to 8.4% in 2013 and further rose to 12% in 2024.[66] The rate of midwife-attended birth in Ohio is similar to the national average, at 12.1% of singleton births in

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[61] Kaiser Family Found., *Improving Access to Adult Primary Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physician Assistants*, at 3 (Mar. 2011), https://www.kff.org/wp-content/uploads/2013/01/8167.pdf (accessed Feb. 9, 2026); David I. Auerbach et al., *Growing Ranks of Advanced Practice Clinicians—Implications for the Physician Workforce,* 378 New England Journal of Medicine 2358, 2359 (2018).

[62] Yong-Fang Kuo et al., *States with the Least Restrictive Regulations Experienced the Largest Increase in Patients Seen by Nurse Practitioners*, 32 Health Affairs 1236, 1236 (2013).

[63] David I. Auerbach et al., *Implications of the Rapid Growth of the Nurse Practitioner Workforce in the US*, 39 Health Affairs 273, 274 (2020); Health Resources & Serv. Administration, *NCHWA Nursing Workforce Dashboard*, https://data.hrsa.gov/topics/health-workforce/nursing-workforce-dashboards (accessed Feb. 9, 2026); *see also* Modi et al., *supra* note 7.

[64] U.S. Bur. of Labor Statistics, *Occupational Outlook Handbook: Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners*, https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm#tab-6 (accessed Feb. 9, 2026).

[65] U.S. Bur. of Labor Statistics, *Occupational Outlook Handbook: Physician Assistants*, https://www.bls.gov/ooh/healthcare/physician-assistants.htm#tab-6 (accessed Feb. 9, 2026).

[66] Sara Markowitz et al., *Competitive Effects of Scope of Practice Restrictions: Public Health or Public Harm?*, 55 Journal of Health Economics 201, 217 (2017); Ctrs. for Disease Control & Prevention, *About Natality, 2016–2024 Expanded*, http://wonder.cdc.gov/natality-expanded-current.html (accessed Feb. 9, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

2024.[67] Nationwide, there were 8,600 NMs working in 2024, and the US Bureau of Labor Statistics projects there will be 9,500 NMs working in 2034.[68]

55. An earlier study evaluating the results of two nationally representative surveys found that the proportion of patients who saw a non-physician clinician (broadly defined) for care rose from 30.6% to 36.1% between 1987 and 1997.[69] Between 2013 and 2019, the percentage of health care evaluation and management visits provided by NPs and PAs to Medicare fee-for-service enrollees increased from 14% to 25.6%, with the likelihood of receiving care from an NP or PA highest among rural residents.[70] Between 2013 and 2021, the proportion of Medicare Part D prescriptions written by NPs and PAs rose from approximately 37.6% to 55.6%.[71] The proportion of Medicare beneficiaries having an NP as their primary provider nearly doubled between 2012 and 2017, and NPs are more likely to care for patients with multiple chronic conditions than patients cared for by physicians.[72] Interestingly, while these trends generally reflect "an increase in the proportion of patients treated by *both* physicians and non-physician clinicians, and a corresponding decrease in the proportions treated by only one of the two types of providers," this has not held true in the context of pregnancy care.[73] Surveys have shown a decrease

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[67] Ctrs. for Disease Control & Prevention, *supra* note 66.

[68] U.S. Bur. of Labor Statistics, *supra* note 64.

[69] Druss et al., *supra* note 49, at 133–34.

[70] Sadiq Y. Patel et al., *Provision of Evaluation and Management Visits by Nurse Practitioners and Physician Assistants in the USA from 2013 to 2019: Cross-Sectional Time Series Study*, 382 BMJ 1 (2023).

[71] Roderick S. Hooker & John M. Zobitz, *Prescribing by Physician Associates and Nurse Practitioners in Older Adults Is Outpacing Traditional Prescribers: Implications for Practice in American Medicine*, 81 Med. Care Research & Rev. 156, 162 (2023).

[72] Taressa K. Fraze et al., *Role of Nurse Practitioners in Caring for Patients with Complex Health Needs*, 58 Med. Care 853, 857 (2020).

[73] Druss et al, *supra* note 49, at 134–35 (emphasis added).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

in the proportion of women receiving pregnancy-related care from physicians and an increase in the proportion receiving such care only from non-physicians.[74]

56. More recently, NPs have been serving as the primary care providers in thousands of retail clinics (walk-in clinics located in retail stores and pharmacies) nationwide, where they treat common conditions such as ear infections and bronchitis at lower cost and greater convenience.[75] In 2023, APCs accounted for 10.3% of all community health center clinical staff, while physicians accounted for only 9.4%.[76] The National Association of Community Health Centers reports that these providers are hiring APCs at higher rates than physicians.[77]

57. APCs are also playing greater roles in health care specialties, such as surgical care and oncology. More than 29,000 PAs worked in surgical specialties in 2024, nearly doubling since 2015;[78] in 2024, nearly 4,000 PAs worked in cardiology, an increase of 75.93% from 2015; and more than 2,250 worked in oncology, an increase of more than 145% from 2015. For oncology patients enrolled in Medicare, NPs accounted for 31.5% of the clinicians providing care in 2013.[79]

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[74] *Id.* at 135.

[75] Rand Corp., *The Evolving Role of Retail Clinics* (Nov. 10, 2016), https://www.rand.org/pubs/research_briefs/RB9491-2.html (accessed Feb. 9, 2026).

[76] Natl. Assn. of Community Health Ctrs., *supra* note 8, at 73 fig.7-1, 78 fig.7-3.

[77] *Id.* at 79 fig.7-4, 81 fig.7-6.

[78] Natl. Comm. on Certification of Physician Assistants, *Annual Report: Statistical Profile of Board Certified PAs by Specialty*, at 7–8 (2025), https://www.nccpa.net/wp-content/uploads/2025/08/2024-Statistical-Profile-of-Board-Certified-PAs-by-Specialty.pdf (accessed Feb. 10, 2026); Natl. Comm. on Certification of Physician Assistants, *Annual Report: 2019 Statistical Profile of Certified Physician Assistants by Specialty*, at 14, 19, 89 (2020), https://www.nccpa.net/wp-content/uploads/2021/05/2019-Specialty-Report-Final-v7_compressed-1.pdf (accessed Feb. 10, 2026).

[79] Lorinda A. Coombs et al., *Nurse Practitioners and Physician Assistants: An Underestimated Workforce for Older Adults with Cancer*, 67 Journal of Am. Geriatrics Soc. 1489 (2019).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

58. Furthermore, a growing number of NPs and PAs work in hospitals, providing acute and emergency care side-by-side with hospitalist physicians.[80] Indeed, health care institutions are increasingly relying on NPs and PAs as lead inpatient care providers, with strong results. For instance, data from two intensive care units ("ICUs") at Columbia Presbyterian Medical Center in New York—where one unit was staffed by medical residents and the other unit was staffed by NPs and PAs—demonstrated equivalent outcomes in hospital mortality, length of hospital stay, length of ICU stay, and discharge destination.[81] According to the American Association of Nurse Practitioners' 2020 national sample survey, more than 45% of NPs employed full-time in the U.S. hold hospital privileges.[82]

C. APCs Play an Outsized Role in Caring for Patients in Rural and Underserved Areas.

59. The United States faces a crisis of physician shortages, particularly in the area of primary care. In a 2024 report, the Association of American Medical Colleges (the "AAMC") projected a shortage of up to 86,000 physicians by 2036, with the shortage for primary care physicians estimated as large as 40,400.[83] The severity of projected shortages depends in part on

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[80] Natl. Comm. on Certification of Physician Assistants, *Annual Report: Statistical Profile of Board Certified PAs by Specialty* (2025), *supra* note 78, at 29; Fred Wu & Michael A. Darracq, *Physician Assistant Utilization in U.S. Emergency Departments; 2010 to 2017*, 42 Am. Journal of Emergency Medicine 132 (2021); Louise Kaplan & Tracy A. Klein, *Characteristics and Perceptions of the US Nurse Practitioner Hospitalist Workforce*, 33 Journal of Am. Assn. of Nurse Practitioners 1173 (2021); Tracy A. Klein et al., *Hiring and Credentialing of Nurse Practitioners as Hospitalists: A National Workforce Analysis*, 11 Journal of Nursing Regulation 33 (2020).

[81] Hayley B. Gershengorn et al., *Impact of Nonphysician Staffing on Outcomes in a Medical ICU*, 139 Chest 1347 (2011).

[82] Am. Assn. of Nurse Practitioners, *2024 Nurse Practitioner Practice Report*, at 15 tbl.1.10 (2024), https://storage.aanp.org/www/documents/no-index/research/2.Practice.NP-Report24.pdf (accessed Feb. 10, 2026).

[83] AAMC, *The Complexities of Physician Supply and Demand: Projections from 2021 to 2036*, at vi–vii (Mar. 2024), https://www.aamc.org/media/75236/download?attachment (accessed Feb. 9, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

the availability of APCs to ease demand for physicians; the AAMC projection model included estimates of the percentage of new demand that could be filled by APCs, ranging from 25% to 50% for primary care and from 20% to 40% for women's health.[84]

60. Fortunately, with growing numbers and expanded practice authority, APCs are stepping up to meet the United States' pressing health care needs. The U.S. Federal Trade Commission (the "FTC") observes that "the United States suffers from widespread distributional problems in the supply of health care professionals[, which] has the greatest impact on America's poorest citizens . . . . [and] [r]ural communities, too, are particularly vulnerable to provider shortages and access problems."[85] But, the FTC notes, "[a]s primary care provider shortages have worsened, APRNs have played an even greater role in alleviating the effects of shortages and mitigating access problems. For example, APRNs make up a greater share of the primary care workforce in less densely populated areas, less urban areas, and lower income areas, as well as in [health professional shortage areas]."[86]

61. The Office of the Assistant Secretary for Planning Evaluation in the U.S. Department of Health and Human Services (the "ASPE") has similarly noted that "NPs are extending access to care in rural and underserved areas and are key providers in health centers."[87] Indeed, 84% of NPs in isolated rural towns are predicted to have their own patient panel (i.e., patients primarily under their care), compared with 57% in urban areas.[88] Primary care practices with NPs are more likely to be located in communities with higher levels of poverty and lower

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[84] *Id.* at 35.

[85] FTC Report, *supra* note 13, at 21 (citations omitted).

[86] *Id.* at 25; Health Resources & Servs. Administration, *What is Shortage Designation?*, https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas (accessed Feb. 10, 2026).

[87] ASPE Report, *supra* note 28, at 10.

[88] *Id.* at 36.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

median household incomes, as well as in rural communities.[89] Furthermore, research has demonstrated that NMs provided care to more women on Medicaid in rural areas of California and Washington than did obstetricians.[90] Since 2018, NP, CNM, and PA employment in federally-qualified health centers, which serve low-income populations, has exceeded physician employment, having increased 285% from 2010 to 2023.[91] These findings are consistent with the original intention of APC education: expand the clinical workforce to fill shortages, particularly in rural communities that faced significant gaps in access to care.

62. In sum, as recognized in *The Future of Nursing* report, the health care system's increased reliance on APCs "has helped ease access bottlenecks, reduce waiting times, increase patient satisfaction, and free physicians to handle more complex cases."[92]

D. Leading Authorities Recommend Allowing APCs to Practice to the Fullest Extent of Their Education and Training.

63. Leading national authorities agree on the need to eliminate scope of practice restrictions that prevent APCs from practicing to their full capacity, including physician oversight requirements and unjustified restrictions on the patients whom APCs may serve or the types of care they may provide.

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[89] Monica O'Reilly-Jacob et al., JAMA Network Open, *Socioeconomic Characteristics of Communities with Primary Care Practices with Nurse Practitioners* (Feb. 28, 2025) https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2830798 (accessed Feb. 10, 2026).

[90] Kevin Grumbach et al., *Who is Caring for the Underserved? A Comparison of Primary Care Physicians and Non-Physician Clinicians in California and Washington*, 1 Annals of Family Medicine 97 (2003).

[91] Natl. Assn. of Community Health Ctrs., *Community Health Center Chartbook 2021*, at fig.5-6 (2022), https://bistatepca.org/wp-content/uploads/2022/05/998e4b7e20eb730d803194ec9aad59c7.pdf (accessed Feb. 10, 2026); Natl. Assn. of Community Health Ctrs., *supra* note 8, at 78 fig.7-3.

[92] IOM Report, *supra* note 33, at 98.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

64. The number one recommendation for the future of nursing in the Institute of Medicine's *Future of Nursing* report is: "Remove scope-of-practice barriers. Advanced practice registered nurses should be able to practice to the full extent of their education and training."[93] Among the examples the report provides of restrictions that "could greatly limit the ability of APRNs to fully utilize their education and training" are laws prohibiting an APRN from performing aspiration abortions.[94]

65. In 2021, the National Academy of Medicine (formerly the IOM) released a new report, *The Future of Nursing 2020–2030*. This report reiterated the recommendation of the original *Future of Nursing* committee that "[a]ll organizations, including state and federal entities and employing organizations, should enable nurses to practice to the full extent of their education and training by removing barriers . . . ."[95]

66. To achieve its goal of removing barriers that impede APRNs from practicing to the full extent of their education and training, the first IOM report recommended (among other things) that the FTC and the Antitrust Division of the Department of Justice "urge[]" states with "unduly restrictive regulations . . . to amend them to allow [APRNs] to provide care to patients in all circumstances in which they are qualified to do so."[96]

67. The FTC has taken up this challenge. In March 2014, it issued a policy paper entitled *Competition and the Regulation of Advanced Practice Nurses*. Based on "the findings of the IOM and other expert bodies—analyses based on decades of research and experience—on issues of APRN safety, effectiveness, and efficiency," as well as the Commission's "own reviews

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[93] *Id.* at 9.
[94] *Id.* at 100–01.
[95] Natl. Academies, *supra* note 1, at 363.
[96] IOM Report, *supra* note 33, at 10–11.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

of pertinent literature and stakeholder views," the FTC advised policymakers that "APRN scope of practice limitations should be narrowly tailored to address well-founded health and safety concerns, and should not be more restrictive than patient protection requires."[97] Specifically, "APRN certification and state licensure requirements should reflect the types of services that APRNs can safely and effectively provide, based on their education, training, and experience."[98]

68. The FTC urges policymakers to consider, for instance:

- Will the regulation significantly impede competition by . . . reducing the[] availability [of health care services]?
- Are there any significant and non-speculative consumer health and safety needs that particular regulatory restrictions . . . are supposed to meet?
- Do those particular regulations actually provide the intended benefits—such as improvements in health care outcomes . . . ?
- When consumer benefits are slight, insubstantial, or highly speculative, a regulation that imposes non-trivial impediments to competition is not justified.
- Are the regulations narrowly tailored to serve the state's policy priorities?[99]

Through letters, legislative testimony, and amicus briefs,[100] the FTC has "consistently urged state legislators to avoid imposing restrictions on APRN scope of practice unless those restrictions are necessary to address well-founded patient safety concerns."[101]

69. Similarly, in 2012, the National Governors Association (the "NGA") released a report entitled *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care*,

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[97] FTC Report, *supra* note 13, at 3–4.

[98] *Id*.

[99] *Id.* at 16–17.

[100] *Id.* at A1–A3. For example, in 2020, the FTC urged Ohio to expand APRN practice authority. Fed. Trade Comm., Letter to Representative Thomas E. Brinkman, Jr. (Jan. 9, 2020), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-ohio-house-representatives-concerning-ohio-house-bill-177/v200005ohiohb177aprnscomment.pdf (accessed Feb. 10, 2026).

[101] FTC Report, *supra* note 13, at 2.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

which concluded that, "[i]n light of the research evidence, states might consider changing scope of practice restrictions and assuring adequate reimbursement for their services as a way of encouraging and incentivizing greater NP involvement in the provision of primary health care."[102]

70. Furthermore, the American Association of Retired People's ("AARP") policy shift in 2010 to support expanding APRNs' scope of practice further illustrates the growing consensus over the past decade. AARP advised: "Current state nurse practice acts and accompanying rules should be interpreted and/or amended where necessary to allow APRNs to fully and independently practice as defined by their education and certification."[103]

71. Similarly, national organizations such as the National Rural Health Association recommend that PA laws be modernized to expand the PA role in meeting health care needs.[104] The American Academy of Physician Assistants has established Six Key Elements of a Modem PA Practice Act, which supports the greatest possible contribution of PAs within their collaborative relationships with physicians.[105]

72. The U.S. Departments of Health and Human Services, Treasury, and Labor issued a report in 2018, observing that scope of practice restrictions may limit clinicians' ability to practice in ways that do not address demonstrable or substantial risks to consumer health and

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[102] Natl. Governors Assn., *supra* note 14, at 11.

[103] IOM Report, *supra* note 33, at 106 (citation omitted).

[104] *See* Roger Wells et al., Natl. Rural Health Assn., *Physician Assistants: Modernize Laws to Improve Rural Access* (2018), https://www.ruralhealth.us/getmedia/a9b65fc6-3c87-46eb-aa60-81446edc2264/2019-NRHA-Policy-Document-Physician-Assistants-Modernize-Laws-to-Improve-Rural-Access.pdf (accessed Feb. 10, 2026).

[105] *See* Am. Academy of Physician Assocs., *The Six Key Elements of a Modern PA Practice Act* (2017), https://www.aapa.org/wp-content/uploads/2017/05/6_KE_Chart_5-5-17.pdf (accessed Feb. 10, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

safety. The agencies recommended that states consider changes to their regulations to allow all health care providers to utilize their full skill set.[106]

73. The rationale underlying these recommendations is consistent: scope of practice barriers needlessly prevent clinicians from fully utilizing their education and training while diminishing APCs' ability to meet patients' pressing health care needs. For instance, the FTC explains: "Potential competitive effects can be especially striking where there are primary care shortages, as in medically underserved areas or with medically underserved populations. When APRNs are free from undue supervision requirements and other undue practice restrictions, they can more efficiently fulfill unmet health care needs."[107] ASPE similarly notes,

> Full NP practice authority is associated with a larger share of NPs providing primary care, and this impact is greater in rural areas. This suggests that the effect of SOP [scope of practice] regulations may be greatest in rural areas where there has historically been a documented need for primary care services.[108]

74. Peer-reviewed research supports this conclusion. For instance, the ASPE report notes that, based on 1996–2010 data, "states relaxing restrictions on SOP experienced growth in the number of routine checkups, improvements in quality of care measures, and decreases in emergency room use by patients with ambulatory-care sensitive conditions."[109]

75. And in a 2016 systematic review of the impact of state NP scope of practice regulations on health care delivery, my colleagues and I determined that "[s]tates granting NPs greater SOP authority tend to exhibit (a) an increase in the number and growth of NPs through

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[106] U.S. Dept. of Health & Human Servs. et al., *Reforming America's Healthcare System Through Choice and Competition*, at 31, 36 (2018), https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf (accessed Feb. 10, 2026).

[107] FTC Report, *supra* note 13, at 4.

[108] ASPE Report, *supra* note 28, at 50.

[109] *Id.* at A-7 (citation omitted).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

higher APRN educational enrollment and migration and (b) greater provision of primary care by NPs and expanded health care utilization, especially among rural and vulnerable populations."[110]

76. Newer studies have confirmed that there is a greater supply of NPs, particularly in federally designated health professional shortage areas and rural communities, when there are fewer restrictions on NPs' practice.[111]

77. Similarly, recent research has documented that the supply of midwives is greater when they are afforded greater practice authority, particularly in rural communities.[112]

78. Research on the role of PAs in expanding access to care has also shown the importance of scope of practice regulations.[113] PAs are more likely than physicians to provide care in rural areas and to low-income and underserved populations.[114]

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[110] Ying Xue et al., *Impact of State Nurse Practitioner Scope-of-Practice Regulation on Health Care Delivery: Systematic Review*, 64 Nursing Outlook 71, 82 (2016).

[111] Ryan Kandrack et al., *Nurse Practitioner Scope of Practice Regulations and Nurse Practitioner Supply*, 78 Med. Care Research & Rev. 208 (2021); Bo Kyum Yang et al., *State Nurse Practitioner Practice Regulations and U.S. Health Care Delivery Outcomes: A Systematic Review*, 78 Med. Care Research & Rev. 183 (2021); Tianyuan Luo et al., *Labor Market Outcomes of Granting Full Professional Independence to Nurse Practitioners*, 60 Journal of Regulatory Economics 22 (2021); Ying Xue et al., *Full Scope-of-Practice Regulation Is Associated with Higher Supply of Nurse Practitioners in Rural and Primary Care Health Professional Shortage Counties*, 8 Journal of Nursing Regulation 5 (2018).

[112] Brittany L. Ranchoff & Eugene R. Declercq, *The Scope of Midwifery Practice Regulations and the Availability of the Certified Nurse-Midwifery and Certified Midwifery Workforce, 2012–2016*, 65 Journal of Midwifery & Women's Health 119 (2020).

[113] *See, e.g.*, Michelle Proser et al., *Community Health Centers at the Crossroads: Growth and Staffing Needs*, 28 Journal of Am. Academy Physician Assistants 49 (2015).

[114] *See* Grumbach, *supra* note 90, at 97; Christine M. Everett et al., *Physician Assistants and Nurse Practitioners as a Usual Source of Care*, 25 Journal of Rural Health 407, 407 (2009); Wells et al., *supra* note 104; Ying Xue et al., *Trends in Primary Care Provision to Medicare Beneficiaries by Physicians, Nurse Practitioners, or Physician Assistants: 2008–2014*, 8 Journal of Primary Care & Community Health 256, 256 (2017).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

E. Medical Evidence Supports and Clinicians' Professional Organizations Endorse Advanced Practice Clinicians' Provision of Abortion Care.

79. Multiple studies have established the safety of abortion care provided by APCs,[115] and medical organizations support this practice.

80. The first study demonstrating the safety of APCs' abortion care, conducted in Vermont and published in 1986, found that complication rates for PAs performing abortion procedures were not statistically different from the complication rates of physicians.[116] Subsequent studies documented similar levels of safety of abortion procedures provided by PAs.[117] Research specific to medication abortion has also confirmed that APCs provide medication abortion with similarly high effective rates and similarly low complication rates as physicians.[118] Based on a review of rigorous research documenting the safety and efficacy of both medication and aspiration abortion provided by APCs, the National Academies of Sciences, Engineering, and Medicine has endorsed APC provision of abortion.[119] Indeed, reviews of the international literature have reported similar results regarding the safety of abortion care provided by APCs, sometimes called "mid-level providers," in other countries.[120]

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[115] Natl. Academies of Science, Eng., & Medicine, *The Safety and Quality of Abortion Care in the United States*, at 102–05 (2018), https://nap.edu/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-united-states (surveying relevant studies) (accessed Feb. 5, 2026).

[116] *See, e.g.*, Mary Anne Freedman et al., *Comparison of Complication Rates in First Trimester Abortions Performed by Physician Assistants and Physicians*, 76 Am. Journal of Pub. Health 550, 550 (1986).

[117] *See* Marlene B. Goldman et al., *Physician Assistants as Providers of Surgically Induced Abortion Services*, 94 Am. Journal of Pub. Health 1352, 1355–56 (2004).

[118] *E.g.*, Lauren Porsch et al., *Advanced Practice Clinicians and Medication Abortion Safety: A 10-Year Retrospective Review*, 101 Contraception 357 (2020).

[119] Natl. Academies of Science, Eng., & Medicine, *supra* note 115, at 103–05.

[120] Sharmani Barnard et al., *Doctors or Mid-Level Providers for Abortion*, Cochrane Database of Systematic Revs. (2015).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

81. The American College of Obstetricians and Gynecologists ("ACOG"), the leading professional organization in the field, published a December 2020 opinion calling for the repeal of requirements that only physicians or obstetrician-gynecologists may provide abortion care.[121] In explaining this position, ACOG stated, "Advanced practice clinicians can provide abortion care at safety rates equal to those of their physician peers." ACOG also stated,"There are robust data affirming advanced practice clinicians' ability to safely provide these services, with complications in the first trimester comparable with those of their physician colleagues", providing multiple citations from the scholarly literature to support these statements.

82. ACOG also recommended in its Committee Opinion on Abortion Training and Education, published in 2014 and reaffirmed in 2019 and 2022, that the pool of non-obstetrician-gynecologist providers, including family physicians and APCs, be expanded by opposing restrictions that limit abortion provision to physicians only.[122] ACOG observed that such restrictions limit both patient access to care and the education and training received by APCs.

83. Physicians for Reproductive Health has also urged policymakers to eliminate burdensome restrictions on the provision of abortion care by APCs.[123]

84. The American Public Health Association has similarly stated: "There is evidence that with appropriate education and training, NPs, NMs, and PAs can competently provide all components of medication abortion care (pregnancy testing counseling, estimating gestational age

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[121] ACOG, *ACOG Committee Statement No. 16* (Feb. 2025), https://www.acog.org/clinical/clinical-guidance/committee-statement/articles/2025/02/increasing-access-to-abortion (accessed Feb. 5, 2026).

[122] ACOG, *ACOG Committee Opinion No. 612* (Nov. 2014), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/11/abortion-training-and-education (accessed Feb. 10, 2026).

[123] Press Release, Physicians for Reproductive Health, *Reproductive Health Care Providers: Abortion Is Essential* (Apr. 1, 2020), https://prh.org/press-releases/reproductive-health-care-providers-abortion-is-essential/ (accessed Feb. 10, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

by exam and ultrasound, medical screening, administering medications, and postabortion follow-up care) . . . ." They further recommended that APCs be engaged in the provision of medication and aspiration abortion, and that scope-of-practice regulations should align with this recommendation.[124]

85. In their comprehensive guidelines for abortion care, the World Health Organization recommends that medication abortion be provided by traditional and complementary medicine professionals such as nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners, specialist medical practitioners, community health workers, and pharmacy workers.[125]

86. The primary international organization for midwifery, the International Confederation of Midwives, agrees that people seeking abortion care should be able to receive such care from midwives.[126] Likewise, the primary national association for nurse-midwives, the American College of Nurse-Midwives, published its own position statement explicitly aligning

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[124] Am. Pub. Health Assn., *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants* (Nov. 1, 2011), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants (accessed Feb. 10, 2026).

[125] World Health Org., *Abortion Care Guideline*, at 69–70 (2022), https://iris.who.int/server/api/core/bitstreams/59a704cc-4024-412a-97d9-55d86d139602/content (accessed Feb. 10, 2026). "Complementary medicine" or "alternative medicine" refers to "additional healthcare practices that are not part of a country's mainstream medicine. Evidence-based complementary medicine has the potential to support mainstream medicine and more comprehensively support people's health and well-being needs." World Health Org., *Traditional, Complementary and Integrative Medicine*, https://who.int/health-topics/traditional-complementary-and-integrative-medicine#tab=tab_1 (accessed Feb. 10, 2026).

[126] Internatl. Confederation of Midwives, *Position Statement: Midwives Provision of Comprehensive Abortion Care* (last edited June 2, 2025), https://internationalmidwives.org/resources/midwives-provision-of-abortion-related-services/ (accessed Feb. 10, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

with the aforementioned statements by the American Public Health Association and International Confederation of Midwives in support of all APCs as abortion providers.[127]

87. The American Academy of Physician Assistants published a position statement in 2021 that also recognizes the role of PAs in providing abortion care. They wrote that PAs "are safe, qualified providers of first trimester abortion care, including surgical aspiration and medication-induced terminations."[128]

F. Research Confirms the Safety of, and Patient Satisfaction with, Health Care by APCs.

88. There is a large body of literature confirming the safety of, and patient satisfaction with, APCs' providing health services within their education and training.

89. For instance, the ASPE report notes, "Patient satisfaction with and consumer acceptance of NPs are high, and clinical outcomes have repeatedly been found equivalent with those of physicians."[129] According to the NGA, "None of the studies in [its] literature review raise concerns about the quality of care offered by NPs. Most studies showed that NP-provided care is comparable to physician-provided care on several process and outcome measures. Moreover, the studies suggest that NPs may provide improved access to care."[130] The FTC wrote in its 2014 report that "FTC staff are not aware of any contrary empirical evidence to support the contention that there are patient harm or risks associated with APRN prescribing of non-controlled substances."[131]

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[127] Am. College of Nurse-Midwives, *Position Statement: Midwives as Abortion Providers* (Apr. 2025), https://midwife.org/wp-content/uploads/2025/04/2025-ps_midwives-as-abortion-providers_amended.pdf (accessed Feb. 10, 2026).

[128] Am. Academy of Physician Assocs., *PAs in Obstetrics and Gynecology*, at 2 (Jan. 2021), https://www.aapa.org/download/19515 (accessed Feb. 10, 2026).

[129] ASPE Report, *supra* note 28, at 10, A-2.

[130] Natl. Governors Assn., *supra* note 14, at 7–8.

[131] FTC Report, *supra* note 13, at 37–38.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

90. Indeed, multiple systematic reviews have found consistent evidence that NPs provide comparable or better care within their scope of practice than do physicians, with comparable or better outcomes.[132] Studies have found safety, accuracy, and satisfaction equivalency between APC and physician care, even for complex, invasive procedures like colonoscopies.[133]

91. These findings hold true in states that grant NPs and NMs full practice and prescriptive authority without physician oversight requirements. For instance, a 2017 analysis of the impact of state NP scope of practice regulations on the quality of primary care provided to Medicare beneficiaries concluded: "Our analyses failed to find support for the outcomes-related arguments of those advocating for restricting the [scope of practice] of NPs on the basis of patient safety and offer support for those who claim that NP [scope of practice] restrictions have real consequences for the health of populations in areas where access to primary care is low."[134]

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[132] *See, e.g.*, Julie Stanik-Hutt et al., *The Quality and Effectiveness of Care Provided by Nurse Practitioners*, 9 Journal of Nurse Practitioners 492, 498 (2013); Mary D. Naylor & Ellen T. Kurtzman, *The Role of Nurse Practitioners in Reinventing Primary Care*, 29 Health Affairs 893, 894–95 (2010); Robin P. Newhouse et al., *Advanced Practice Nurse Outcomes 1990–2008: A Systematic Review*, 29 Nursing Economic$ 1, 18 (2011).

[133] Michele Limoges-Gonzalez et al., *Comparisons of Screening Colonoscopy Performed by a Nurse Practitioner and Gastroenterologists: A Single-Center Randomized Controlled Trial*, 34 Gastroenterology Nursing 210, 212–13, 215 (2011) (no immediate complications reported for either physician or NP groups; no statistically significant differences between physician and NP groups in terms of reported pain, duration of procedure, withdrawal time, sedative and analgesic use, or cecal intubation rates; *greater* neoplasia detection rates in NP group; *greater* satisfaction among patients seen by NPs); M. Phillip Fejleh et al., *Quality Metrics of Screening Colonoscopies Performed by PAs*, 33 Journal of Am. Academy of PAs 43 (2020); Lukejohn W. Day et al., *Non-Physicians Performing Lower and Upper Endoscopy: A Systematic Review and Meta-Analysis*, 46 Endoscopy 401 (2014); Monica Riegert et al., *Experience of Nurse Practitioners Performing Colonoscopy After Endoscopic Training in More Than 1,000 Patients*, 8 Endoscopy Internatl. Open E1423, E1425–27 (2020).

[134] Jennifer Perloff et al., *Association of State-Level Restrictions in Nurse Practitioner Scope of Practice with the Quality of Primary Care Provided to Medicare Beneficiaries*, 76 Med. Care Research & Rev. 1, 18 (2019); *see also, e.g.*, Ellen T. Kurtzman et al., *Does the Regulatory Environment Affect Nurse Practitioners' Patterns of Practice or Quality of Care in Health*

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

92. Similarly, a 2017 review of the impact of changes in state NM scope of practice regulations between 1994 and 2013 found that "states that allow for CNMs fully enabled practice, have on average, little or no differences in maternal health behaviors or infant health outcomes as compared to states with more restrictive SOP."[135] Indeed, the principal exception to this "little or no differences" conclusion is that states that allow CNMs broader practice authority reap the benefits of lower rates of labor inductions and C-sections.[136] The authors concluded: "The results point to the conclusion that restrictions on CNM [scope of practice] primarily serve as barriers to practice and removing these restrictions has the potential to improve the efficiency of the health care system for delivery and infant care."[137]

G. APCs in Ohio

93. I have reviewed Ohio's licensing and practice requirements, and they are consistent with the national landscape I have described. It is my opinion that Ohio restrictions banning APCs from providing abortion, including medication abortion, are out of step with how these clinicians are otherwise regulated.

Centers?, 52 Health Servs. Research 437, 445 (2017) ("[T]here was little evidence to reject the null hypothesis—that is, that state-granted NP independence has no effect on NPs' . . . quality of care—across the outcomes studied.").

[135] Markowitz et al., *supra* note 66, at 202.

[136] *Id.*

[137] *Id.*; *see also* Meg Johantgen et al., *Comparison of Labor and Delivery Care Provided by Certified Nurse-Midwives and Physicians: A Systematic Review, 1990 to 2008*, 22 Women's Health Issues e73, e78 (2012) ("Based on this systematic review, there is moderate to high evidence that CNMs rely less on technology during labor and delivery than do physicians and achieve similar or better outcomes."); Lauren Hoehn-Velasco et al., *Health Outcomes and Provider Choice Under Full Practice Authority for Certified Nurse-Midwives*, 92 Journal of Health Economics 1, 2 (2023) (finding "full practice authority leads to a clear increase in reported CNM/CM-attended deliveries without a noticeable impact on obstetric outcomes (cesarean, induction, adverse neonatal events) or mortality (maternal or neonatal)"); Benjamin McMichael, *Healthcare Licensing and Liability*, 95 Ind. L.J. 821 (2020).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

94. In general, Ohio CNPs and CNMs "may provide to individuals and groups nursing care that requires knowledge and skill obtained from advanced formal education and clinical experience"[138] and based on demonstrated knowledge, skills, and abilities.[139] Specifically, Ohio allows CNPs to "provide preventive and primary care services, provide services for acute illnesses, and evaluate and promote patient wellness within the nurse's nursing specialty, consistent with the nurse's education and certification, and in accordance with rules adopted by the board" under a collaborative practice agreement with an Ohio-licensed physician.[140] Also under a collaborative practice agreement with an Ohio-licensed physician, Ohio CNMs "may provide the management of preventive services and those primary care services necessary to provide health care to women antepartally, intrapartally, postpartally, and gynecologically, consistent with the nurse's education and certification, and in accordance with rules adopted by the board of nursing."[141] Revised regulations established by Ohio Senate Bill 196, which was enacted in 2024 and was jointly supported by the Ohio Association of Advanced Practice Nurses and the Ohio State Medical Association, now expand the authority of CNPs to sign and complete patient care-related forms such as disability certifications and health status documentation.[142]

95. Ohio PAs may perform "services authorized by the supervising physician" that are within the "physician's normal course of practice and expertise." These services include "[o]rdering diagnostic, therapeutic, and other medical services," "[a]ssisting in surgery," and "[a]ny other services that are part of the supervising physician's normal course of practice and

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[138] R.C. 4723.43.

[139] Adm.Code 4723-4-05(D).

[140] R.C. 4723.43(C).

[141] R.C. 4723.43(A).

[142] Ohio Assn. of Advanced Practice Nurses, *Senate Bill 196* (Feb. 10, 2025), https://oaapn.org/2025/02/senate-bill-196/ (accessed Feb. 10, 2026).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

expertise."[143] Ohio's regulation of PAs is aligned with five of six "essential elements" defined by the American Academy of Physician Assistants.[144] The only distinguishing element is that Ohio sets statutory limits to the number of PAs a physician can supervise rather than allowing this determination to be made at the practice level. *See infra* ¶ 96.

96. In Ohio, a physician may not collaborate with more than five APRNs and five PAs in the prescribing component of their practice.[145] The CNP or CNM and physician develop the agreement, which specifies drugs, devices, medical treatments, tests, and procedures that may be prescribed, ordered, and performed by the CNP or CNM.[146]

97. As elsewhere, APCs in Ohio are subject to state and national educational requirements, accreditation requirements, certification requirements, licensing requirements, and continuing education responsibilities.[147]

98. Specifically, an applicant for Ohio CNP or CNM practice must hold a current, active license as a registered nurse in Ohio; a graduate degree in nursing (or in a related field that qualifies the applicant to sit for the certification examination); and professional certification following examination by a national certification board (such as the American Midwifery

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[143] R.C. 4730.20(A).

[144] Timothy Bates et al., Healthforce Ctr. at UCSF, *California's Physician Assistants: How Scope of Practice Laws Impact Care*, at 10 (Sept. 25, 2018), https://www.chcf.org/publication/californias-physician-assistants/ (accessed Feb. 10, 2026); Am. Academy of Physician Assistants, *Number of Key Elements in State PA Law* (Feb. 2020), https://www.aapa.org/wp-content/uploads/2017/01/Six_Key_Elements_Map_5-8-17.pdf (accessed Feb. 10, 2026).

[145] R.C. 4723.431(A)(1) (APRNs); R.C. 4730.21(B) (PAs).

[146] R.C. 4723.431 (APRNs); Adm.Code 4723-8-04 (APRNs); R.C. 4730.19 (PAs).

[147] As to PAs: R.C. 4730.11 (qualifications and requirements for license); R.C. 4730.14 (renewal); R.C. 4730.49 (continuing medical education). As to NPs and NMs: R.C. 4723.41 (application); R.C. 4723.24(C)(2); Adm.Code 4723-8-08 (renewal).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Certification Board, the American Nurses Credentialing Center, the National Certification Corporation, or the American Academy of Nurse Practitioners).[148]

99. Similarly, Ohio PAs must hold a graduate degree from an accredited program "in a course of study with clinical relevance to the practice of physician assistants" and professional certification from a national certification board.[149]

100. Ohio APCs must renew their license to practice biannually.[150] To renew approval to practice in Ohio, an APC must complete continuing education and maintain national certification.[151]

101. As part of a patient care team, CNPs and CNMs have broad practice authority in Ohio, including the authority to prescribe medications.[152] Ohio CNPs and CNMs are allowed to prescribe Schedule II through Schedule VI drugs (including drugs with a high potential for abuse and severe psychiatric or physical dependence, like opioids and amphetamines) provided they have appropriate DEA registration.[153]

102. Ohio similarly allows PAs to prescribe and dispense medications (including controlled substances) and perform minor procedures, provided they practice with physician collaboration.[154] The primary supervising physician must ensure that the PA's scope of practice is

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[148] R.C. 4723.41(A); Ohio Bd. of Nursing, *Approved APRN National Certifying Organizations*, https://nursing.ohio.gov/education-and-practice/education/training-programs/approved-aprn-national-certifying-organizations (accessed Feb. 10, 2026).

[149] R.C. 4730.11.

[150] R.C. 4723.24(A)(1)(c) (APRNs); R.C. 4730.14(A) (PAs).

[151] R.C. 4723.24(C)(2) (APRNs); Adm.Code 4723-8-08 (APRNs); R.C. 4730.14(B) (PAs); R.C. 4730.49 (PAs).

[152] R.C. 4723.43.

[153] R.C. 4723.481; Adm.Code 4723-9-10.

[154] R.C. 4730.15 (prescriptive authority); R.C. 4730.20 (services that may be performed by a PA, including prescriptive authority); R.C. 4730.21 (physician supervision); R.C. 4730.41 (prescriptive authority); R.C. 4730.411 (prescription of Schedule II controlled substances).

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clearly identified and that the delegation of the medical task is appropriate to the skills and competencies of both the supervising physician and the PA.[155]

103. APCs in Ohio are permitted to provide health care services other than early abortion that I understand entail comparable—and sometimes far greater—medical risks, such as delivering babies.[156]

104. As elsewhere, APC practice improves access to care in Ohio, particularly in primary care and in rural areas where there are fewer physicians. In 2023, it was estimated that there were 37,638 physicians in Ohio.[157] The distribution of physicians varied widely between urban and rural areas; in 2021 there were 355.9 physicians per 100,000 population in metropolitan counties, 93.0 per 100,000 in micropolitan counties, and only 38.8 per 100,000 in rural counties. In 2021, there were 4,515 PAs (38.3 per 100,000 population), 14,971 NPs (127.1 per 100,000 population) and 306 CNMs (2.6 per 100,000 population). Moreover, CNPs, CNMs, and PAs were more likely than physicians to practice in rural counties in 2021; 1.6% of CNPs, 1.6% of CNMs, 0.9% of PAs, and 0.5% of physicians were located in a rural county. In rural counties of Ohio in 2021, there were only 172 physicians, compared with 232 CNPs, 5 CNMs, and 42 PAs. These data are consistent with national analyses that report that NPs, NMs, and PAs nationwide are significantly more likely than physicians to practice in rural areas, and they serve a higher proportion of uninsured patients and other vulnerable populations.[158] These data also demonstrate that APCs play an important role in delivering essential health care services in Ohio.

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[155] R.C. 4730.19; R.C. 4730.21.

[156] R.C. 4723.43; Elizabeth Raymond & David Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215 (2012).

[157] AAMC, *U.S. Physician Workforce Data Dashboard*, https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard (accessed Feb. 11, 2026).

[158] Health Resources & Servs. Administration, *Data Downloads*, https://data.hrsa.gov/data/download?data=AHRF#AHRF (accessed Feb. 10, 2026).

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V. CONCLUSION

105. In sum, Ohio's ban on APC provision of abortion, including medication abortion, regardless of the APC's qualifications or the patient's needs, is inconsistent with the nationwide and Ohio-specific trajectory—particularly over the past two decades—toward allowing APCs to perform all services within their education and training, especially in medically underserved areas where the need is greatest.

106. My opinions are based on my education, training, research, and attendance at and participation in conferences relating to health care economics, APC scope of practice, and health care services, as well as on my ongoing review of relevant literature. The literature that informs my opinions includes, but is not limited to, the studies cited in my declaration.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Executed on February 11th, 2026, in San Mateo, California.

JOANNE SPETZ, Ph.D.

Broward County, Florida State

Signed and sworn to before me this day by

Date: 02/11/2026

SHANTA A. COOPER
Notary Public-State of Florida
Commission # HH 593076
My Commission Expires
January 11, 2029

(Official Seal)

State of Florida, County of Broward
by Joanne Spetz appeared by means of online notarization and produced US Passport as identification.

Official Signature of Notary

Notary Public's Printed Name:

Shanta A. Cooper

My commission expires: 01/11/2029

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EXHIBIT 12

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Nursing Regulation

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Licensure

Practice

APRN Consensus Model

APRN Consensus Model Toolkit

Substance Use Disorder

Substance Use Disorder in Nursing

Opioid Toolkit

Substance Use Disorder Educational Materials

APRN Consensus Model

Advanced practice registered nurses (APRN) are a vital part of the U.S. health care system. They are registered nurses educated in a specific role and patient population at a Masters or post-Masters level. APRNs are prepared by education and certification to assess, diagnose and manage patient problems, order tests and prescribe medications.

The Consensus Model for APRN Regulation, Licensure, Accreditation, Certification and Education



NursingAmerica

NCSBN supports an initiative called NursingAmerica to help states align their APRN regulation with the major elements of the Consensus Model for APRN Regulation.

FIND OUT MORE >

About the APRN Consensus Model

APRNs represent a powerful and growing force in the U.S health care system. Released in 2008, the **APRN Consensus Mode** provides guidance for US jurisdictions to adopt uniformity in the regulation of APRN roles, licensure, accreditation, certification and education.

This regulatory framework includes seven main elements:

1. **Title:** Advanced Practice Registered Nurse (APRN)
2. **License:** Holds an APRN license
3. **Four Roles:** Certified Nurse Midwife (CNM), Certified Nurse Practitioner (CNP), Certified Registered Nurse Anesthetist (CRNA) and Clinical Nurse Specialist (CNS)
4. **Education:** Completion of postgraduate education is required
5. **National Certification:** APRNs must pass a nationally accredited certification exam
6. **Independent Practice:** APRNs are granted authority to practice independently without physician oversight such as collaborative/supervisory agreement
7. **Independent Prescribing:** APRNs are granted authority to prescribe without physician oversight such as collaborative/supervisory agreement

APRNs are educated and certified in both their role and one of six population foci:

Family/individual across the life span

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Professional Boundaries

Scope of Practice Decision-Making Framework

Delegation

New Nurses: Key Issues

Transition to Practice

Study results

Discipline

International

Women's health/gender-related

Pediatrics*

Neonatal

Psychiatric/mental health

* The adult-gerontology and pediatric population foci may be further delineated as primary or acute.

Moving Toward Uniformity

Adoption of the Consensus Model elements moves states toward regulatory uniformity. Although there has been significant progress in the integration of components of the Consensus Model in many nurse practice acts, there continue to be states that have not adopted all the elements of this regulatory framework. This can result in a lack of uniformity from one jurisdiction to another.

Keeping in mind, the unique requirements of each jurisdiction, APRNs relocating to another state, providing care across state borders in person, telephonically or virtually must ensure they meet the regulatory requirements of the state where the patient is located at the time care is provided by the APRN.

As long as regulatory requirements differ from state to state, each border represents an obstacle to license portability - potentially preventing access to APRNs and the high-quality care they provide.

APRN Compact

The Consensus Model calls for an APRN Compact to remove these barriers and provide licensure mobility for APRNs.

Learn More About the APRN Compact

APRN Consensus Model Resources

NCSBN has developed numerous resources to enable you to learn more about the Consensus Model.

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EXHIBIT 13

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State Medical Board of Ohio

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Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

Physician Assistant Core Licensure Eligibility Requirements

To be eligible to receive a license to practice as a physician assistant, an applicant must meet all the following requirements:

1. The applicant shall be at least eighteen years of age
2. The applicant shall be of good moral character
3. The applicant shall have the results of a criminal records check (FBI and Ohio BCI) submitted to the Board
4. The applicant shall hold current Certification by the National Commission on Certification of Physician Assistants (NCCPA)
5. The applicant must meet one or more of the routes listed below:

Route 1 - The applicant shall hold a master's or higher degree obtained from a program accredited by the Accreditation Review Commission on Education for the Physician Assistant program (ARC-PA).

Route 2* (see note below) - The applicant shall hold a current, valid license or other form of authority to practice as a physician assistant issued by another jurisdiction and have been in active practice in any jurisdiction throughout the two-year period immediately preceding the date of application.

Route 3* (see note below) - The applicant shall hold a degree obtained from a program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) and meet either of the following experience requirements:

(a) Have experience practicing as a physician assistant for at least two consecutive years, immediately preceding the date of application, while on active duty, with evidence of service under honorable conditions, in any of the armed forces of the United States or the national guard of any state, including any experience attained while practicing as a physician assistant at a health care facility or clinic operated by the United States Department of Veterans Affairs.

(b) Have experience practicing as a physician assistant for at least two consecutive years, immediately preceding the date of application, while on active duty in the United States Public Health Service commissioned corps.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Route 4 - The applicant shall hold both of the following degrees:

(a) A degree other than a master's or higher degree obtained from a program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA)

(b) A Master's or higher degree in a course of study with clinical relevance to the practice of physician assistants and obtained from a program accredited by regional or specialized and professional accrediting agency recognized by the Council for Higher Education Accreditation (CHEA).

Route 5* (see note below) - The applicant shall hold a degree obtained as a result of being enrolled on January 1, 2008, in a program in this state that was accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) but did not grant a Master's or higher degree to individuals enrolled in the program on that date, and completing the program on or before December 31, 2009.

**Unless the applicant had prescriptive authority while practicing as a physician assistant in another jurisdiction, in the military, or in the public health service, the license issued to an applicant who qualifies under Route 2, Route 3 and/or Route 5 above does not authorize the holder to exercise physician-delegated prescriptive authority.*

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EXHIBIT 14

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IN THE COURT OF COMMON PLEAS
FOR HAMILTON COUNTY, OHIO

PLANNED PARETHOOD SOUTHWEST OHIO REGION, *et al*.,	:	
Plaintiffs,	:	Case No. A21 01148
v.	:	Judge Alison Hatheway
OHIO DEPARTMENT OF HEALTH, et al.,	:	
Defendants.	:	

THE STATE'S RESPONSES TO PLAINTIFFS'
FIRST SET OF DISCOVERY REQUESTS

Pursuant to Rules 26 and 33 of the Ohio Rules of Civil Procedure, Defendants Ohio Department of Health ("ODH"), Dr. Bruce Vanderhoff, Kim Rothermel, Harish Kakalara, Erin Keels, and Candy Sue Reinhart ("the State") submit these responses and objections to Plaintiffs Planned Parenthood Southwest Ohio Region ("PPSWO"), Sharon Liner, M.D., Julia Quinn, Planned Parenthood of Greater Ohio, Preterm- Cleveland, and Women's Med Group Professional Corporation ("WMGPC") (collectively "Plaintiffs") First Set of Document Requests.

PRELIMINARY STATEMENT

1. These responses and objections are based on information presently available to the State, and are made without prejudice to, and are not a waiver of, the State's right to rely on other facts or documents at trial.

2. Any information that is obtained through a complaint or an investigation is

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confidential and not subject to discovery in a civil action under Sections 4731.22(F)(5) and 4723.28(I) of the Ohio Revised Code.

3. The State reserves the right to supplement, clarify, revise, or correct any or all of the responses and objections, and to assert additional objections or privileges, in subsequent supplemental response(s). Where privileged documents are protected by applicable state laws or rules, the fact that the State's response does not specifically delineate a state law or rule shall not be deemed to be a waiver of that privilege.

4. No response or objection is an admission or acknowledgement that any Request calls for information that is relevant to the subject matter of this litigation, is proportional to the needs of the case, is authentic, or is admissible at any trial.

GENERAL OBJECTIONS

1. The State objects to the Requests to the extent they do not describe with reasonable particularity each item or category of items to be inspected as required by Rule 34 of the Ohio Rules of Civil Procedure.

2. The State objects to the Requests to the extent they are overly broad, unduly burdensome, vague, duplicative, not reasonably calculated to lead to the discovery of admissible evidence, and not proportional to the needs of the case.

3. The State objects to the Requests, including all definitions and instructions, to the extent they seek information protected by the attorney-client privilege, work-product doctrine, and/or other applicable privileges.

4. The State objects to these Requests to the extent that they seek information not in

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

the State's possession, custody, or control.

5. The State objects to each Request insofar as it seeks information that is equally available, discoverable, or accessible to Plaintiffs.

6. The State objects to the Requests to the extent that they seek information that is publicly available, already in Plaintiffs' possession, or in the possession or control of third parties.

7. The State objects to the definition of Defendants set forth in Plaintiffs' first set of discovery requests. Plaintiffs define "Defendants" or "You" or "Your" as referring to "Bruce Vanderhoff, Director of the Ohio Department of Health ("ODH"), the State of Ohio, ODH, and any employee, agent, representative, investigator, consultant, attorney, or any other person acting or purporting to act on behalf of Defendants, the State, or ODH." Such definition is factually incorrect, overbroad, and unduly burdensome, to the extent it purports to enlarge, expand, or in any way alter the plain meaning and scope of the Ohio Rules of Civil Procedure. The State further objects to the definition to the extent that documents or other information are somehow deemed to be in its possession, custody or control of the State. The "State of Ohio" is not a Defendant to this action, and its inclusion in said definition cannot be leveraged to obtain any information or documents in the care, custody, and control of non-parties. The State will only respond to discovery requests to which they have firsthand knowledge and will produce all non-privileged responsive documents only to the extent that they were created or received by the Ohio Department of Health, and are in its possession, custody, or control. The State objects to each Request to the extent that it implies that the State is required to respond to discovery or to produce documents on behalf of various non-party agencies of the State of Ohio. If Plaintiffs seeks information possessed by various non-party state agencies, then Plaintiffs must employ Rule 45 of the Ohio Rules of Civil

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Procedure to obtain such information.

8. The State objects to the Requests as confusing, ambiguous, or vague.

9. The State objects to each Request insofar it seeks production of data beyond those that were created or received by the State and are in the State's possession, custody, or control.

10. The State objects to each Request to the extent it is not limited by any reasonable time period.

11. The State expressly reserves all objections as to competency, relevancy, materiality, and admissibility of the answers contained herein and any objections to future discovery Requests.

12. The State expressly reserves the right to alter, amend, revise, and/or supplement these responses. No response shall be construed as a waiver of any further objection.

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INTERROGATORIES

INTERROGATORY No. 1:

Identify each medication, drug, chemical, medical intervention, medical treatment, and medical procedure that is expressly prohibited under Ohio state law from being provided via the use of telemedicine or required to be provided in-person.

ANSWER: Objection. In addition to the General Objections listed above, the State objects to this Interrogatory to the extent it calls for documents and information protected by the attorney-client privilege, the deliberative process privilege, the common interest privilege, and the attorney work-product doctrine. The State further objects to this Interrogatory to the extent it seeks information that may be the subject of, or more appropriately presented through, expert testimony, which has yet to occur in this case.

Subject to and without waiving this specific objection or the General Objections, Ohio Revised Code § 4743.09 and Ohio Admin. Code Rule 4731-37-01 require that telehealth services must meet the same standard of care as in-person services. So while specific services may not be prohibited by name, any service that requires, for example, hand-on examination, physical procedures, and immediate interventions would be prohibited as they cannot be done within the standard of care via telemedicine. The State's investigation into this case is ongoing. The State reserves the right to supplement its responses to this Interrogatory.

INTERROGATORY No. 2:

Identify each medication, drug, chemical, or device that Ohio state law requires to be prescribed only in accordance with the Final Printed Labeling for the medication, drug, chemical, or device.

ANSWER: Objection. In addition to the General Objections listed above, the State objects to this Interrogatory to the extent it calls for documents and information protected by the attorney-client privilege, the deliberative process privilege, the common interest privilege, and the attorney work-product doctrine. The State further objects to this Interrogatory to the extent it seeks information that may be the subject of, or more appropriately presented through, expert testimony, which has yet to occur in this case.

Subject to and without waiving this specific objection or the General Objections, Rules 4731-33-04(A)(2)(a) and 4730-4-04(A)(2)(a) of the Ohio Administrative Code state that the dosage regime for naltrexone hydrochloride tablets shall strictly comply with FDA approved labeling. The Ohio Pharmacy Board requires that reconstituted neurotoxins follow strict timelines

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

based on manufacturer (FDA) labeling pursuant to OAC 4729-3-02 unless otherwise licensed as a terminal distributor of dangerous drugs under R.C. 4729.541. Ohio explicitly prohibits compounding or dispensing unapproved drugs such as retatrutide and cagrilintide, which lack FDA approval. Doing so may result in licensing discipline. Ohio law under OAC 4731-37-01 mandates that any remote monitoring device used in telehealth be cleared, approved, or authorized by the FDA for its intended purpose. The State's investigation into this case is ongoing. The State reserves the right to supplement its responses to this Interrogatory.

INTERROGATORY No. 3:

Identify all medical interventions, treatments, and procedures that APCs are prohibited from providing under Ohio state law when doing so would otherwise be within their scope of practice.

ANSWER: Objection. In addition to the General Objections listed above, the State objects to this Interrogatory to the extent it calls for documents and information protected by the attorney-client privilege, the deliberative process privilege, the common interest privilege, and the attorney work-product doctrine. The State further objects to this Interrogatory to the extent the phrase "scope of practice" is not defined.

Subject to and without waiving this specific objection or the General Objections, there are several limitations for APCs in Ohio law: 4723.481; 4723-9-10; 4730.20; 4730.201; 4730.411; 4730.02; 4730.202; 4731-11-04; 4731.22; and 4730.44. Specifically, advance practice nurses are prohibited from providing: Drugs/devices on exclusionary formulary; Controlled Schedule II beyond terminal prescriptions; and prescriptions exceeding collaborating physician authority. Physician Assistants cannot provide abortion-inducing drugs/devices; any anesthesia beyond local anesthesia; and cannot engage in independent practice outside delegation or facility policy. The State's investigation into this case is ongoing. The State reserves the right to supplement its responses to this Interrogatory.

INTERROGATORY No. 4:

Identify all state interests served by the Telemedicine Ban. For each interest identified, describe how the interest serves the health of the pregnant person.

ANSWER: Objection. In addition to the General Objections listed above, the State objects to this Interrogatory as overly broad, unduly burdensome, irrelevant, not reasonably calculated to lead to discovery of admissible evidence, and not proportional to the needs of the case. The State further objects to the Interrogatory to the extent it is vague and ambiguous and contains the undefined phrase "an interest in the health of the pregnant person." The State also objects to the

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Interrogatory because it is premature because the deadline for the submission of the State's expert reports has not yet come, and the parties are still engaged in pre-trial fact and expert discovery, including by not limited to, the taking of depositions and written discovery. The State further objects to this Interrogatory to the extent it seeks information that may be the subject of, or more appropriately presented through, expert testimony, which has yet to occur in this case.

Subject to and without waiving this specific objection or the General Objections, the State's investigation into this case is ongoing. Further responding, no Defendant had any involvement in the drafting or enactment of the R.C. 2919.123, or knowledge of the state interests considered or sought to be advanced the Ohio General Assembly by its enactment. To the extent the State has already stated facts or explanations in prior litigation, administrative proceedings, legislative records, this litigation, and/or other communications/documents, the same is incorporated herein. The State, however, reserves the right to supplement its responses to this Interrogatory.

INTERROGATORY No. 5:

For each state interest identified in response to Interrogatory No. 4, state the facts demonstrating that the Telemedicine Ban advances that interest.

ANSWER: Objection. In addition to the General Objections listed above, the State objects to this Interrogatory to the extent it calls for documents and information protected by the attorney-client privilege, the deliberative process privilege, the common interest privilege, and the attorney work-product doctrine. The State also objects to the Interrogatory because it is premature. Discovery has just begun in this case, and the State's investigation into the claims and defenses at issue in this matter is ongoing. It is also premature because the deadline for the submission of the State's expert reports has not yet come, and the parties are still engaged in pre-trial fact and expert discovery, including by not limited to, the taking of depositions and written discovery. The State further objects to this Interrogatory to the extent it seeks information that may be the subject of, or more appropriately presented through, expert testimony, which has yet to occur in this case.

Subject to and without waiving this specific objection or the General Objections, the State's investigation into this case is ongoing. To the extent the State has already stated facts or explanations in prior litigation, administrative proceedings, legislative records, this litigation, or other communications/documents, the same is incorporated herein. Further responding, The State reserves the right to supplement its responses to this Interrogatory.

INTERROGATORY No. 6:

For each health-related interest identified in response to Interrogatory No. 4, state the facts demonstrating that the Telemedicine Ban advances that interest in accordance with widely

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

accepted and evidence-based standards of medical care, and identify sources that support those facts.

ANSWER: Objection. In addition to the General Objections listed above, the State objects to this Interrogatory as overly broad, unduly burdensome, irrelevant, not reasonably calculated to lead to discovery of admissible evidence, and not proportional to the needs of the case. The State further objects to the Interrogatory to the extent it is vague and ambiguous and contains the undefined phrase "an interest in the health of the pregnant person." The State also objects to the Interrogatory because it is premature because the deadline for the submission of the State's expert reports has not yet come, and the parties are still engaged in pre-trial fact and expert discovery, including by not limited to, the taking of depositions and written discovery. The State further objects to this Interrogatory to the extent it seeks information that may be the subject of, or more appropriately presented through, expert testimony, which has yet to occur in this case.

Subject to and without waiving this specific objection or the General Objections, the State's investigation into this case is ongoing. Further responding, no Defendant had any involvement in the drafting or enactment of R.C. 2919.124, or knowledge of the state interests considered or sought to be advanced the Ohio General Assembly by its enactment. To the extent the State has already stated facts or explanations in prior litigation, administrative proceedings, legislative records, this litigation, or other communications/documents, the same is incorporated herein. The State, however, reserves the right to supplement its responses to this Interrogatory.

INTERROGATORY No. 7:

Identify all state interests served by the Evidence-Based Use Ban. For each interest identified, describe how the interest serves the health of the pregnant person.

ANSWER: Objection. In addition to the General Objections listed above, the State objects to this Interrogatory to the extent it calls for documents and information protected by the attorney-client privilege, the deliberative process privilege, the common interest privilege, and the attorney work-product doctrine. The State also objects to the Interrogatory because it is premature. Discovery has just begun in this case, and the State's investigation into the claims and defenses at issue in this matter is ongoing. It is also premature because the deadline for the submission of the State's expert reports has not yet come, and the parties are still engaged in pre-trial fact and expert discovery, including by not limited to, the taking of depositions and written discovery. The State further objects to this Interrogatory to the extent it seeks information that may be the subject of, or more appropriately presented through, expert testimony, which has yet to occur in this case.

Subject to and without waiving this specific objection or the General Objections, the State's investigation into this case is ongoing. To the extent the State has already stated facts or explanations in prior litigation, administrative proceedings, legislative records, this litigation,

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

and/or other communications/documents, the same is incorporated herein. Further responding, The State reserves the right to supplement its responses to this Interrogatory.

INTERROGATORY No. 8:

For each state interest identified in response to Interrogatory No. 7, state the facts demonstrating that the Evidence-Based Use Ban advances that interest.

ANSWER: Objection. In addition to the General Objections listed above, the State objects to this Interrogatory as overly broad, unduly burdensome, irrelevant, not reasonably calculated to lead to discovery of admissible evidence, and not proportional to the needs of the case. The State further objects to the Interrogatory to the extent it is vague and ambiguous and contains the undefined phrase "an interest in the health of the pregnant person." The State also objects to the Interrogatory because it is premature because the deadline for the submission of the State's expert reports has not yet come, and the parties are still engaged in pre-trial fact and expert discovery, including by not limited to, the taking of depositions and written discovery. The State further objects to this Interrogatory to the extent it seeks information that may be the subject of, or more appropriately presented through, expert testimony, which has yet to occur in this case.

Subject to and without waiving this specific objection or the General Objections, the State's investigation into this case is ongoing. Further responding, no Defendant had any involvement in the drafting or enactment of R.C. 2919.123, or knowledge of the state interests considered or sought to be advanced the Ohio General Assembly by its enactment. To the extent the State has already stated facts or explanations in prior litigation, administrative proceedings, legislative records, this litigation, and/or other communications/documents, the same is incorporated herein. The State, however, reserves the right to supplement its responses to this Interrogatory.

INTERROGATORY No. 9:

For each health-related interest identified in response to Interrogatory No. 7, state the facts demonstrating that the Evidence-Based Use Ban advances that interest in accordance with widely accepted and evidence-based standards of medical care, and identify sources that support those facts.

ANSWER: Objection. In addition to the General Objections listed above, the State objects to this Interrogatory to the extent it calls for documents and information protected by the attorney-client privilege, the deliberative process privilege, the common interest privilege, and the attorney work-product doctrine. The State also objects to the Interrogatory because it is premature.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Discovery has just begun in this case, and the State's investigation into the claims and defenses at issue in this matter is ongoing. It is also premature because the deadline for the submission of the State's expert reports has not yet come, and the parties are still engaged in pre-trial fact and expert discovery, including by not limited to, the taking of depositions and written discovery. The State further objects to this Interrogatory to the extent it seeks information that may be the subject of, or more appropriately presented through, expert testimony, which has yet to occur in this case.

Subject to and without waiving this specific objection or the General Objections, the State's investigation into this case is ongoing. To the extent the State has already stated facts or explanations in prior litigation, administrative proceedings, legislative records, this litigation, or other communications/documents, the same is incorporated herein. Further responding, The State reserves the right to supplement its responses to this Interrogatory.

INTERROGATORY No. 10:

Identify all state interests served by the APC Ban. For each interest identified, describe how the interest serves the health of the pregnant person.

ANSWER: Objection. In addition to the General Objections listed above, the State objects to this Interrogatory as overly broad, unduly burdensome, irrelevant, not reasonably calculated to lead to discovery of admissible evidence, and not proportional to the needs of the case. The State further objects to the Interrogatory to the extent it is vague and ambiguous and contains the undefined phrase "an interest in the health of the pregnant person." The State also objects to the Interrogatory because it is premature because the deadline for the submission of the State's expert reports has not yet come, and the parties are still engaged in pre-trial fact and expert discovery, including by not limited to, the taking of depositions and written discovery. The State further objects to this Interrogatory to the extent it seeks information that may be the subject of, or more appropriately presented through, expert testimony, which has yet to occur in this case.

Subject to and without waiving this specific objection or the General Objections, the State's investigation into this case is ongoing. Further responding, no Defendant had any involvement in the drafting or enactment of the Telemedicine law, or knowledge of the state interests considered or sought to be advanced the Ohio General Assembly by its enactment. To the extent the State has already stated facts or explanations in prior litigation, administrative proceedings, legislative records, this litigation, and/or other communications/documents, the same is incorporated herein. The State, however, reserves the right to supplement its responses to this Interrogatory.

INTERROGATORY No. 11:

For each state interest identified in response to Interrogatory No. 10, state the facts demonstrating that the APC Ban advances that interest.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

ANSWER: Objection. In addition to the General Objections listed above, the State objects to this Interrogatory to the extent it calls for documents and information protected by the attorney-client privilege, the deliberative process privilege, the common interest privilege, and the attorney work-product doctrine. The State also objects to the Interrogatory because it is premature. Discovery has just begun in this case, and the State's investigation into the claims and defenses at issue in this matter is ongoing. It is also premature because the deadline for the submission of the State's expert reports has not yet come, and the parties are still engaged in pre-trial fact and expert discovery, including by not limited to, the taking of depositions and written discovery. The State further objects to this Interrogatory to the extent it seeks information that may be the subject of, or more appropriately presented through, expert testimony, which has yet to occur in this case.

Subject to and without waiving this specific objection or the General Objections, the State's investigation into this case is ongoing. To the extent the State has already stated facts or explanations in prior litigation, administrative proceedings, legislative records, this litigation, and/or other communications/documents, the same is incorporated herein. Further responding, The State reserves the right to supplement its responses to this Interrogatory.

INTERROGATORY No. 12:

For each health-related interest identified in response to Interrogatory No. 10, state the facts demonstrating that the APC Ban advances that interest in accordance with widely accepted and evidence-based standards of medical care, and identify sources that support those facts.

ANSWER: Objection. In addition to the General Objections listed above, the State objects to this Interrogatory as overly broad, unduly burdensome, irrelevant, not reasonably calculated to lead to discovery of admissible evidence, and not proportional to the needs of the case. The State further objects to the Interrogatory to the extent it is vague and ambiguous and contains the undefined phrase "an interest in the health of the pregnant person." The State also objects to the Interrogatory because it is premature because the deadline for the submission of the State's expert reports has not yet come, and the parties are still engaged in pre-trial fact and expert discovery, including by not limited to, the taking of depositions and written discovery. The State further objects to this Interrogatory to the extent it seeks information that may be the subject of, or more appropriately presented through, expert testimony, which has yet to occur in this case.

Subject to and without waiving this specific objection or the General Objections, the State's investigation into this case is ongoing. Further responding, no Defendant had any involvement in the drafting or enactment of the "APC Ban," or knowledge of the state interests considered or sought to be advanced the Ohio General Assembly by its enactment. To the extent the State has already stated facts or explanations in prior litigation, administrative proceedings, legislative records, this litigation, and/or other communications/documents, the same is incorporated herein. The State, however, reserves the right to supplement its responses to this Interrogatory.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

INTERROGATORY No. 13:

Identify all persons known to You who have relevant knowledge or information relating to the facts and claims in this litigation or who answered or assisted in answering these Interrogatories, and state with specificity the knowledge or information in that individual's possession.

ANSWER: Objection. In addition to the General Objections listed above, the State objects to this Interrogatory to the extent it calls for documents and information protected by the attorney-client privilege, the deliberative process privilege, the common interest privilege, and the attorney work-product doctrine. The State further objects that the request that it identify "all persons who have firsthand knowledge of the answers to each interrogatory" as overly broad, unduly burdensome, not reasonably calculated to lead to discovery of admissible evidence, and not proportional to the needs of the case.

Subject to and without waiving this specific objection or the General Objections, Amanda Narog, Tyler Herrmann, Andrew Rowan, Kim Anderson, and David Geiger answered or assisted in answering these discovery requests.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

REQUESTS FOR PRODUCTION

DOCUMENT REQUEST No. 1:

All Documents and Communications referred to, identified in, relied on, or used in the preparation of Defendants' Initial Disclosures, including any subsequent amendments made pursuant to Ohio Rule of Civil Procedure 26(E), Defendant's Answer, as appended to its Motion for Leave to File Answer Out of Time, dated October 10, 2024, or responses to any of Plaintiffs' interrogatories or requests for admission.

ANSWER: The State incorporates all General Objections as if set forth herein. Subject to and without waiving the forgoing objections, please see State000001-State000200. The State's investigation into this case is ongoing. The State reserves the right to supplement its responses to this Request.

DOCUMENT REQUEST No. 2:

All Documents and Communications concerning any licensing suspension, revocation, investigation, proceeding, or disciplinary action by the State Medical Board of Ohio or Ohio Board of Nursing related to MAB, TMAB, and/or the Challenged Laws.

ANSWER: Objection. Any information that is obtained through a complaint or an investigation is confidential and not subject to discovery in a civil action under Sections 4731.22(F)(5) and 4723.28(I) of the Ohio Revised Code.

The State also incorporates all General Objections as if set forth herein. Subject to and without waiving the forgoing objections, the State has not identified any responsive documents in its possession, custody, or control. The State's investigation into this case is ongoing. The State, however, reserves the right to supplement its responses to this Request.

DOCUMENT REQUEST No. 3:

All Documents and Communications concerning any licensing suspension, revocation, investigation, proceeding, or disciplinary action by the State Medical Board of Ohio or Ohio Board

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

of Nursing related to the scope of practice of APCs with respect to care for pregnant patients, including miscarriage management and/or the prescription of any FDA-approved drug for Off-Label use.

ANSWER: Objection. Any information that is obtained through a complaint or an investigation is confidential and not subject to discovery in a civil action under Sections 4731.22(F)(5) and 4723.28(I) of the Ohio Revised Code.

The State also incorporates all General Objections as if set forth herein. Subject to and without waiving the forgoing objections, please see State000628-State000630. The State's investigation into this case is ongoing. The State, however, reserves the right to supplement its responses to this Request.

DOCUMENT REQUEST No. 4:

All Documents and Communications concerning the development, drafting, enactment, meaning, interpretation, prior enforcement, current enforcement, or planned enforcement of the Telemedicine Ban.

ANSWER: The State incorporates all General Objections as if set forth herein. Subject to and without waiving the forgoing objections, please see State000092-State000184; 000191-200. The State's investigation into this case is ongoing. The State reserves the right to supplement its responses to this Request.

DOCUMENT REQUEST No. 5:

All Documents and Communications concerning the development, drafting, enactment, meaning, interpretation, prior enforcement, current enforcement, or planned enforcement of the APC Ban.

ANSWER: The State incorporates all General Objections as if set forth herein. Subject to and without waiving the forgoing objections, please see State000092-State000190. The State's investigation into this case is ongoing. The State reserves the right to supplement its responses to this Request.

DOCUMENT REQUEST No. 6:

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

All Documents and Communications concerning the development, drafting, enactment, meaning, interpretation, prior enforcement, current enforcement, or planned enforcement of the Evidence-Based Use Ban.

ANSWER: The State incorporates all General Objections as if set forth herein. Subject to and without waiving the forgoing objections, please see State000001-State000091. The State's investigation into this case is ongoing. The State reserves the right to supplement its responses to this Request.

DOCUMENT REQUEST No. 7:

All Documents and Communications concerning how the Telemedicine Ban affects a pregnant person's ability to access abortion services.

ANSWER: The State incorporates all General Objections as if set forth herein. Subject to and without waiving the forgoing objections, the State has not identified any responsive documents in its possession, custody, or control. The State's investigation into this case is ongoing. The State, however, reserves the right to supplement its responses to this Request.

DOCUMENT REQUEST No. 8:

All Documents and Communications concerning how the APC Ban affects a pregnant person's ability to access abortion services.

ANSWER: The State incorporates all General Objections as if set forth herein. Subject to and without waiving the forgoing objections, the State has not identified any responsive documents in its possession, custody, or control. The State's investigation into this case is ongoing. The State, however, reserves the right to supplement its responses to this Request.

DOCUMENT REQUEST No. 9:

All Documents and Communications concerning how the Evidence-Based Use Ban affects a pregnant person's ability to access abortion services.

ANSWER: The State incorporates all General Objections as if set forth herein. Subject

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

to and without waiving the forgoing objections, the State has not identified any responsive documents in its possession, custody, or control. The State's investigation into this case is ongoing. The State, however, reserves the right to supplement its responses to this Request.

DOCUMENT REQUEST No. 10:

All Documents and Communications between and among Defendants and between Defendants and any other Person or entity concerning or relating to the Challenged Laws, or any of them, including, but not limited to, Documents and Communications concerning the medical necessity and/or the lack of necessity of the Challenged Laws.

ANSWER: The State incorporates all General Objections as if set forth herein. Subject to and without waiving the forgoing objections, the State has not identified any responsive documents in its possession, custody, or control. The State's investigation into this case is ongoing. The State, however, reserves the right to supplement its responses to this Request.

DOCUMENT REQUEST No. 11:

All Documents and Communications regarding the provision of MAB, including TMAB, in Ohio, including the need and demand for, availability of, safety of, efficacy of, or access to MAB, including TMAB, and including but not limited to internal memoranda, meeting agendas and minutes, electronic and physical calendar entries, and communications among Defendants or between Defendants and third parties.

ANSWER: Objection. This request is unduly burdensome, disproportionate to the needs for the case to the extent it seeks all documents and communications related to medication abortion generally**.** Given the challenged statutes in this case, the State has limited its search to abortion care provided by telemedicine.

The State also incorporates all General Objections as if set forth herein. Subject to and without waiving the forgoing objections, please see State000001-000200. The State's investigation into this case is ongoing. The State, however, reserves the right to supplement its responses to this Request.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

DOCUMENT REQUEST No. 12:

All Documents and Communications regarding the prescription of mifepristone by APCs in Ohio, whether for abortion, miscarriage management, or any other purpose.

ANSWER: The State incorporates all General Objections as if set forth herein. Subject to and without waiving the forgoing objections, please see State000092-State000626. The State's investigation into this case is ongoing. The State reserves the right to supplement its responses to this Request.

DOCUMENT REQUEST No. 13:

All Documents and Communications regarding the prescription of misoprostol by APCs in Ohio, whether for abortion, miscarriage management, or any other purpose.

ANSWER: The State incorporates all General Objections as if set forth herein. Subject to and without waiving the forgoing objections, please see State000092-State000626. The State's investigation into this case is ongoing. The State reserves the right to supplement its responses to this Request.

DOCUMENT REQUEST No. 14:

All Documents and Communications concerning whether and to what extent medical interventions, treatments, or procedures related to obstetrics, gynecology, pregnancy or reproductive health are within APC scope of practice, including, but not limited to, whether and to what extent the following are within the APC scope of practice: prescription of controlled substances, including opioids; prescription of mifepristone or misoprostol for miscarriage management or any other purpose; insertion or removal of intrauterine contraception or devices; colposcopy; colonoscopy; vasectomy; endometrial biopsy; endometrial ablation; loop electrosurgical excision procedures; and/or intrauterine insemination.

ANSWER: The State incorporates all General Objections as if set forth herein. Subject

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

to and without waiving the forgoing objections, please see State000201-State000626. The State's investigation into this case is ongoing. The State reserves the right to supplement its responses to this Request.

DOCUMENT REQUEST No. 15:

All Documents Defendants will use to support their defenses or refute Plaintiffs' claims in this case, including the allegations in the Amended Complaint, to the extent they are not already covered by an existing Request.

ANSWER: The State incorporates all General Objections as if set forth herein. Subject to and without waiving the forgoing objections, please see State000001-State000624. The State's investigation into this case is ongoing. The State reserves the right to supplement its responses to this Request.

REQUESTS FOR ADMISSION

REQUEST FOR ADMISSION No. 1:

Admit that mifepristone may be used in Ohio for miscarriage management.

ANSWER: Deny. *See, e.g., Cordray v. Planned Parenthood Cincinnati Region,* 122 Ohio St.3d 361, 2009-Ohio-2972, ¶ 29 *(*"A physician provides mifepristone in accordance with the drug approval letter by administering the drug in conformity with the medical regimen approved by the FDA in that letter. R.C. 2919.123 thus requires physicians in Ohio to conform their use of mifepristone for the purpose of inducing abortions to any gestational limit, dosage indications, or treatment protocols set forth in the drug approval letter.")

REQUEST FOR ADMISSION No. 2:

Admit that misoprostol may be used in Ohio for miscarriage management.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

ANSWER: Admit.

REQUEST FOR ADMISSION No. 3:

Admit that in Ohio, mifepristone may be legally prescribed Off-Label for purposes of medically managing a miscarriage.

ANSWER: Deny. *See, e.g., Cordray v. Planned Parenthood Cincinnati Region,* 122 Ohio St.3d 361, 2009-Ohio-2972, ¶ 29 *(*"A physician provides mifepristone in accordance with the drug approval letter by administering the drug in conformity with the medical regimen approved by the FDA in that letter. R.C. 2919.123 thus requires physicians in Ohio to conform their use of mifepristone for the purpose of inducing abortions to any gestational limit, dosage indications, or treatment protocols set forth in the drug approval letter.")

REQUEST FOR ADMISSION No. 4:

Admit that mifepristone is the only non-controlled substance that Ohio law prohibits from being prescribed for Off-Label use.

ANSWER: Deny. For example, Rules 4731-33-04(A)(2)(a) and 4730-4-04(A)(2)(a) of the Ohio Administrative Code state that the dosage regime for naltrexone hydrochloride tablets shall strictly comply with FDA approved labeling. Naltrexone hydrochloride is not a controlled substance.

REQUEST FOR ADMISSION No. 5:

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Admit that abortion-related services are the only medical services that are prohibited under Ohio law from being provided via telemedicine.

ANSWER: Deny. Ohio Revised Code § 4743.09 and Ohio Admin. Code Rule 4731-37-01 require that telehealth services must meet the same standard of care as in-person services. While specific services may not be prohibited by name, any service that requires, for example, hand-on examination, physical procedures, and immediate interventions would be prohibited as they cannot be done within the standard of care via telemedicine.

REQUEST FOR ADMISSION No. 6:

Admit that medications, drugs, chemicals, or devices that are permitted under Ohio law to be prescribed via telemedicine have risk profiles either equivalent to mifepristone or that pose greater risks than mifepristone.

ANSWER: Deny.

REQUEST FOR ADMISSION No. 7:

Admit that some medications, drugs, chemicals, or devices that are permitted under Ohio law to be prescribed via telemedicine have risk profiles either equivalent to misoprostol or that pose greater risks than misoprostol.

ANSWER: Deny.

REQUEST FOR ADMISSION No. 8:

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Admit that the prescription of mifepristone to medically manage a miscarriage in Ohio would not have to comply with the requirements of the Telemedicine Ban.

ANSWER: Deny. R.C. 2919.124(B) provides that "No physician shall personally furnish or otherwise provide an abortion-inducing drug to a pregnant woman unless the physician is physically present at the location where the initial dose of the drug or regimen of drugs is consumed at the time the initial dose is consumed." '"Abortion inducing drug' means a drug or regimen of drugs that causes the termination of a clinically diagnosable pregnancy, including any drug identified in section 2919.123 of the Revised Code."

REQUEST FOR ADMISSION No. 9:

Admit that the prescription of misoprostol to medically manage a miscarriage in Ohio would not have to comply with the requirements of the Telemedicine Ban.

ANSWER: Admit.

REQUEST FOR ADMISSION No. 10:

Admit that the clinical skill and knowledge necessary to prescribe and oversee the utilization of mifepristone for miscarriage management is the same or similar to the clinical skill and knowledge necessary to prescribe and oversee the utilization of mifepristone for abortion care.

ANSWER: Deny.

REQUEST FOR ADMISSION No. 11:

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Admit that the clinical skill and knowledge necessary to prescribe and oversee the utilization of misoprostol for miscarriage management is the same or similar to the clinical skill and knowledge necessary to prescribe and oversee the utilization of misoprostol for abortion care.

ANSWER: Deny.

REQUEST FOR ADMISSION No. 12:

Admit that APCs in Ohio may legally prescribe mifepristone for miscarriage management and other non-abortion services or procedures when doing so is within their scope of practice.

ANSWER: Deny. *See, e.g., Cordray v. Planned Parenthood Cincinnati Region,* 122 Ohio St.3d 361, 2009-Ohio-2972, ¶ 29 *(*"A physician provides mifepristone in accordance with the drug approval letter by administering the drug in conformity with the medical regimen approved by the FDA in that letter. R.C. 2919.123 thus requires physicians in Ohio to conform their use of mifepristone for the purpose of inducing abortions to any gestational limit, dosage indications, or treatment protocols set forth in the drug approval letter.")

REQUEST FOR ADMISSION No. 13:

Admit that APCs in Ohio may legally prescribe misoprostol for miscarriage management and other non-abortion services or procedures when doing so is within their scope of practice.

ANSWER: Admit to the extent it is within the scope of practice of their supervising physician.

REQUEST FOR ADMISSION No. 14:

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Admit that it can be within an APC's scope of practice to prescribe and oversee the utilization of mifepristone for miscarriage management.

ANSWER: Deny.

REQUEST FOR ADMISSION No. 15:

Admit that it can be within an APC's scope of practice to prescribe and oversee the utilization of misoprostol for miscarriage management.

ANSWER: Admit.

REQUEST FOR ADMISSION No. 16:

Admit that abortion-related services are the only medical services that Ohio has identified as falling outside of an APC's scope of practice.

ANSWER: Deny. For example, R.C. 4730.411 states that in certain situations, a PA can only prescribe a schedule II controlled substance to a patient if: the patient is in terminal condition, the supervising physician initially prescribed it for the patient, and the amount prescribed does not exceed what is necessary for use over a 24-hour period. R.C. 4730.02 also prohibits PA from performing services that are not with their supervising physician's normal course of practice and expertise independent of the PA's training.

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Respectfully submitted,

DAVE YOST
Ohio Attorney General

/s/ Amanda L. Narog
AMANDA NAROG (0093954)
Assistant Attorneys General
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Counsel for Defendant State of Ohio

CERTIFICATE OF SERVICE

I hereby certify that on March 27, 2026, the foregoing was served via email, in both Word and PDF form, to counsel for all parties.

/s/ Amanda L. Narog
Amanda L. Narog (0093954)
Assistant Attorney General

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EXHIBIT 15

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1

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, et al.,
Plaintiffs,
v.
OHIO DEPARTMENT OF HEALTH, et al.,
Defendants.
Case No.: A2101148

VIRTUAL VIDEOTAPED DEPOSITION
of
INGRID SKOP, M.D.
TUESDAY, SEPTEMBER 1, 2026
9:02 A.M. EST

Job No.: 646602
Pages 1 - 361
Reported stenographically by:
Nicholas Buckley,
Certified Shorthand Reporter
Notary No.: 01BU0010687
Expiration: 07/06/2027

2

DEPOSITION of INGRID SKOP, M.D., a Nonparty Witness herein, taken by the Plaintiffs, pursuant to Notice, held via Zoom videoconference, before Nicholas Buckley, a Notary Public within and for the State of New York.

3

A P P E A R A N C E S:

ON BEHALF OF PLAINTIFFS:

CASSIE MITCHELL, ESQUIRE
MICHAELA OLSON, ESQUIRE
MEREDITH BAUM, ESQUIRE
WILMERHALE LLP
7 World Trade Center
New York, New York 10007
(212) 230-8800

ON BEHALF OF PLANNED PARENTHOOD SOUTHWEST OHIO REGION, SHARON LINER, M.D., JULIA QUINN, and PLANNED PARENTHOOD OF GREATER OHIO

CATHERINE PEYTON HUMPHREVILLE, ESQUIRE
123 William Street
9th Floor
New York, New York 10038
(212) 541-7800

(Appearances continued on following page)

4

A P P E A R A N C E S (CONT'D):

ON BEHALF OF DEFENDANTS OHIO DEPARTMENT OF HEALTH, BRUCE VANDERHOFF, KIM ROTHERMEL, HARISH KAKARALA, ERIN KEELS, and CANDY SUE RINEHART:

AMANDA L. NAROG, ESQUIRE
Assistant Attorney General
OHIO ATTORNEY GENERAL'S OFFICE
30 East Broad Street
17th Floor
Columbus, Ohio 43215
(614) 995-0326

ALSO PRESENT:

Vanessa Pai-Thompson, Managing Senior Counsel, Planned Parenthood Federation of America
Emily Nestler, Managing Senior Counsel, Planned Parenthood Federation of America
Ty Laird, Planet Depos Legal Videographer
Brian Russo, Planet Depos Exhibit Technician

* * * *

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

5

----------I N D E X----------

EXAMINATION BY PAGE

ATTORNEY HUMPHREVILLE 12

ATTORNEY NAROG 355

----------E X H I B I T S----------
(Marked for Identification)

DESCRIPTION PAGE

Skop Exhibit 1 21
Expert Report of Ingrid Skop, M.D.

Skop Exhibit 2 92
Retraction Watch article

Skop Exhibit 3 114
FDA website page entitled Information about mifepristone For Medical Termination of Pregnancy Through Ten Weeks Gestation

Skop Exhibit 4 127
Upadhyay 2024 article entitled Effectiveness and safety of telehealth Medication abortion in the USA

Skop Exhibit 5 137
Upadhyay 2015 study entitled Incidence of Emergency Room Department Visits and Complications After Abortion

Skop Exhibit 6 144
Studnicki study entitled A Longitudinal Cohort Study of Emergency Room Utilization Following mifepristone Chemical and Surgical Abortions, 1999–2015

Skop Exhibit 7 149
Studnicki 2024 study entitled Comparative Acuity of Emergency Department Visits Following Pregnancy Outcomes Among Medicaid Eligible Women, 2004-2015

(Index continued on following page)

6

----------E X H I B I T S----------
(Marked for Identification)
(Continued)

DESCRIPTION PAGE

Skop Exhibit 8 165
Studnicki 2025 study entitled Period Prevalence and Acuity of Emergency Department Visits Following Induced Abortion Mistakenly Identified as Spontaneous Abortion

Skop Exhibit 9 178-179
Ethics and Public Policy Center paper dated April 28, 2025

Skop Exhibit 10 193
Gissler study - 2004 article

Skop Exhibit 11 197
Karalis study entitled Decreasing mortality during pregnancy and for a year after while mortality after termination Of pregnancy remains high

Skop Exhibit 12 199
Reardon study entitled Pregnancy-Associated death in record linkage studies relative to delivery

Skop Exhibit 13 203
Mentula study entitled Immediate adverse events after second trimester medical termination of pregnancy: Results in a nationwide registry study

Skop Exhibit 14 210
Niinimaki study entitled Immediate Complications After Medical Compared with Surgical Termination of Pregnancy

Skop Exhibit 15 210
2010 Niinimaki Response

(Index continued on following page)

7

----------E X H I B I T S----------
(Marked for Identification)
(Continued)

DESCRIPTION PAGE

Skop Exhibit 16 216
Niinimaki 2011 article entitled Comparison of rates of adverse events in adolescent and adult women undergoing medical abortion

Skop Exhibit 17 222
Dzuba 2020 study entitled, A non-inferiority study of outpatient mifepristone-misoprostol medical abortion at 64–70 days and 71–77 days of gestation

Skop Exhibit 18 226
Cely-Andrade 2024 article entitled, Telemedicine for the provision of medication abortion to pregnant people up to twelve weeks of pregnancy

Skop Exhibit 19 226
Kapp article entitled, Medical abortion in the late first trimester

Skop Exhibit 20 256
Goldberg study entitled, Mifepristone and Misoprostol for Undesired Pregnancy of Unknown Location

Skop Exhibit 21 271
Grossman 2011 study entitled, Alternatives to ultrasound for follow-up after medication abortion

Skop Exhibit 22 273
Jackson 2012 article entitled, Can women accurately assess the outcome of medical abortion based on symptoms alone?

Skop Exhibit 23 277
Grossman and Grindlay 2017 article entitled, Safety of Medical Abortion Provided Through Telemedicine Compared With In Person

(Index continued on following page)

8

----------E X H I B I T S----------
(Marked for Identification)
(Continued)

DESCRIPTION PAGE

Skop Exhibit 24 284
Anger 2021 article entitled, Clinical and service delivery outcomes following medication abortion provided with or without pretreatment ultrasound or pelvic examination

Skop Exhibit 25 285
Endler systematic review entitled, Telemedicine for medical abortion: a systematic review

Skop Exhibit 26 300-301
Aiken 2021 study entitled, Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine

Skop Exhibit 27 307
Skop paper entitled, United Kingdom Data Deficiencies Influencing U.S. FDA Decisions

Skop Exhibit 28 327
University of Chicago website article

Skop Exhibit 29 338
Reardon article entitled, The Effect of Abortion Decision Rightness and Decision Type on Women's Satisfaction and Mental Health

----------R E Q U E S T S----------

DESCRIPTION PAGE

New article published about Severe Maternal Morbidity and Lozier Institute Ohio documents 71

Legislative testimony in Ohio by Dr. Skop 95

Study regarding second trimester medication abortions 126

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

9

STENOGRAPHER'S NOTE: Please be advised that an UNCERTIFIED ROUGH DRAFT version of this transcript exists. If you are in possession of said rough draft, please replace it immediately with this CERTIFIED FINAL TRANSCRIPT.

All quotations from exhibits are reflected in the manner in which they were read into the record and do not necessarily denote an exact quote from the document.

Quotation marks are used for clarity and do not necessarily reflect a direct quote.

10

P R O C E E D I N G S:

THE TECH: Thank you everyone for attending remotely -- oop, sorry.

Thank you, everyone for attending this proceeding remotely which we anticipate will run smoothly. Please remember to speak slowly and do your best not to talk over one another. Please be aware that we are recording this proceeding for backup purposes. Any off-the-record discussions should be had away from the computer. Please remember to mute your mic for those conversations. Please have your video enabled to help the reporter identify who is speaking. If you are unable to connect with video and are connecting via phone, please identify yourself each time before speaking.

Apologize in advance for any technical-related interruptions, thank you.

THE VIDEOGRAPHER: All right. Please stand by for my recordings.

Here begins Media No. 1 in the videotaped deposition of Ingrid Skop in the matter of Planned Parenthood Southwest Ohio Region, et al., versus Ohio Department of Health,

11

et al., in the Court of Common Pleas, Hamilton County Ohio, Case No. A2101148.

Today's date is September 1, 2026. The time on the video monitor is 9:03 Eastern. The videographer today is Ty Laird, representing Planet Depos, headquartered at 451 Hungerford Drive, Suite 400, Rockville, Maryland 20850.

All parties of this video deposition are attending remotely.

Would counsel please voice-identify themselves and state whom they represent.

ATTORNEY HUMPHREVILLE: My name is Peyton Humphreville for the plaintiffs.

ATTORNEY NAROG: My name's Amanda Narog with the Ohio Attorney's General office, here for the defendants.

ATTORNEY HUMPHREVILLE: Okay. And we're on the record now?

THE VIDEOGRAPHER: Almost.

The court reporter today is Nicholas Buckley, representing Planet Depos.

The witness will now be sworn, and then we may proceed.

I G R I D S K O P, called as a witness, having been first duly sworn by a Notary Public of the

12

State of New York, was examined and testified as follows:

THE COURT REPORTER: Good to go.

ATTORNEY HUMPHREVILLE: Okay. So now we're on the record?

THE COURT REPORTER: Mm-hmm. Yes.

ATTORNEY HUMPHREVILLE: Okay. Great.

EXAMINATION BY ATTORNEY HUMPHREVILLE:

Q Good morning, Dr. Skop. Thank you for being here today. So as I just said, my name is Peyton Humphreville, and I'm an attorney with Planned Parenthood Federation of America and I'm one of the lawyers representing the plaintiffs in this case.

Could you please state and spell your full name for the record?

A Yes. Good morning. My name is Ingrid Skop, I-N-G-R-I-D S-K-O-P.

Q And are you represented by Counsel here this morning?

A Yes, I am.

Q And that's Ms. Narog?

A Yes.

Q And are you represented by any other counsel this morning?

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

13

A No.
Q Okay. I know you've been deposed many times before, but I'd still just like to set some preliminary ground rules and just ask some questions just to make sure we're on the same page with everything.
So your answers today are going to be under oath, which means that you're swearing to the truthfulness and accuracy of what you're saying.
The oath you took today has the same effect as if you were testifying in court.
Do you understand this?
A Yes.
Q Okay. And this deposition is being transcribed by a court reporter, so it's important that you answer audibly because the reporter won't be able to document if you nod or shake your head.
Does that make sense?
A Yes.
Q Okay. And I'm going to ask questions, Ms. Narog may object to some of my questions, but you have to answer my questions unless Ms. Narog instructs you not to answer and you choose to follow that instruction. Okay?

14

A Yes.
Q And then to make it easier for the court reporter, I'll try to wait until you finish with your answer before I start speaking again. And if you do the same and we can all avoid speaking over each other, that'll make things easier for the record. And it's, you know, always a little bit more of a challenge doing things remotely.
But does that sound good?
A Yes.
Q Okay. And I'll do my best to ask the questions clearly. But if you don't understand the question, just let me know and I'll try to rephrase it.
But if you do answer, I'm going to assume you understood my question. Okay?
A Yes.
Q And, you know, I know you have a -- a lengthy -- it's a 56-page report in this case. And I'm sure we'd all like to be able to conclude this as efficiently as possible, so I'll just ask that you listen carefully to my questions and only answer the specific questions that I have asked you.
Can we agree to that?

15

A Yes.
Q Okay. And if at any point either in the moment or later in the deposition you've realized you've said something wrong or you want to clarify something, please just say so. Okay?
A Yes.
Q Okay. And if you have more to say beyond the answer to my specific question, the State's attorney will have a chance to ask you questions at the end of the deposition. Okay?
A Yes.
Q Okay. And if at any point you need a break, please just let me or Ms. Narog know, and we can take one. I'll try to take one every, you know, hour, hour and a half or so.
But if I'm in the middle of a question, you'll have to answer it before we break. Okay?
A Yes.
Q Okay. And then just lastly, with regard to exhibits, you know, it's a little bit different since we're remote, but I'll plan to put the documents in the chat. And I'll also pull them up and share my screen so that, you know, we can all see the same document.
Does that work for you?

16

A Yes.
Q Okay. Any questions about those instructions?
A No.
Q Okay. So I'll note for the record that we're participating remotely. And if you have any -- if you have any technical issues during the deposition, just let me know so we can pause and -- and troubleshoot.
Does that work together -- does that work?
A Yes.
Q Okay. And hopefully we won't encounter any.
Where are you located today?
A Hot San Antonio, Texas.
Q And are you logged on through your laptop, iPad? What -- what sort of device today?
A Lap- -- laptop.
Q Okay. And is anyone else in the room with you?
A Just my dog.
Q Okay. And if anyone other than your dog or another animal comes into the room during the deposition, can you let me know?
A Yes.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

17

Q Okay. Do you have any documents in the room with you?
A I have my computer open to my expert report. That's the only document that I have.
Q Okay. And you don't have any notes with you?
A I did make a note where I put -- reminded myself what page I had discussed certain topics, but that's the only thing. I'm happy to put that away if you would like me to.
Q We'll just ask for a copy of that. We don't need to deal with that right now. We can --
A Okay.
Q -- we can address that later.
Okay. And then do you have any other documents open on your computer, other than your expert report?
A No.
Q Okay. And do you have any other applications open?
A No.
Q Okay. So no e-mail or instant messaging?
A No.
Q Okay. And will you agree to keep other applications and documents closed throughout the

18

deposition?
A Yes.
Q Thank you.
And do you have any computer -- any other computers other than the one you're using for the deposition in the room with you?
A No.
Q Okay. And do you have a cellphone with you right now?
A Yes.
Q Okay. And could you please turn it off or place it in the other room for the duration of the deposition?
A Yes.
Q Thank you.
Is there any reason you can't provide complete and accurate testimony today?
A No.
Q Okay. And are you currently taking any medications, alcohol or other drugs that might impact your ability to give complete and accurate testimony?
A No.
Q Okay. All right. So I'm going to just start with some questions about your understanding

19

of the case we're here for today.
In your own words, what is this case about?
A There are some limitations on abortion in Ohio that are intended to improve the health and safety for the woman seeking abortion, and Planned Parenthood seeks to have those limitations removed.
Q Okay. And who are the plaintiffs in this case?
A The plaintiffs are Planned Parenthood and -- I believe there are some other plaintiffs et al. But primarily Planned Parenthood of Southwest Ohio.
Q Okay. And are you familiar with the Ohio laws that are being challenged in this case?
A Yes, I am.
ATTORNEY HUMPHREVILLE: Okay. I'm going to pull up your expert report. I'll drop this in the chat as well. This is Tab A. And I'll share my screen as well. Give me one second.
THE WITNESS: Would you like me to take my cellphone out while you're doing that?
ATTORNEY HUMPHREVILLE: Oh, sorry. To silence it or turn it off?

20

THE WITNESS: Well, it's silenced, but would you like me to remove it from the room?
ATTORNEY HUMPHREVILLE: If it's -- if it's, you know, silenced and you're not looking at it, that -- that's fine for my purposes.
THE WITNESS: Okay.
Q Okay. And can you see my screen here?
A Yes.
Q Okay. And do you see this document that says "Expert Report of Ingrid Skop, M.D."?
A No. The screenshot I see is a blue something, decoration.
ATTORNEY HUMPHREVILLE: Oh, let's see. Oh, okay. Let's see. Give me one second.
Okay. Let's try that.
(Attorney Humphreville shared Exhibit 1 on the screen.)
Q Okay. Can you see this now that says "Expert Report of Ingrid Skop, M.D."?
A Yes.
Q Okay. And, you know, as -- as I'm going through and sharing any exhibits and you want me to zoom in or anything like that, please just let me know. I'm, you know, getting near the point where I think I need some reading glasses, so I

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

21

don't mind zooming in.
And is this -- does this appear to be a copy of the expert report you submitted in this case?
A It does. It's formatted slightly differently than the one I'm looking at, but it's -- it's the same report.
Q Okay. And -- and this is your electronic signature here on the -- the third page?
A Yes.
ATTORNEY HUMPHREVILLE: Okay. So I'll mark this for identification as Exhibit 1.
(Skop Exhibit 1, Expert Report of Ingrid Skop, M.D., marked for identification.)
ATTORNEY NAROG: Excuse me, Peyton?
ATTORNEY HUMPHREVILLE: Yes.
ATTORNEY NAROG: Can I -- I just wanted to mention, Ingrid, it's in the chat. He put that -- that exhibit in the chat. If you wanted to pull it up yourself and scroll through it, you can just check through it if you want to, to make sure it's your report.
THE WITNESS: Okay. Thank you.
Q And --
ATTORNEY NAROG: Sorry to interrupt.

22

ATTORNEY HUMPHREVILLE: Oh, no -- no worries.
Q I'm just going to look at page 8 here. So in this -- or, sorry -- paragraph 8, excuse me. This is on page 7 of the PDF or page 3 of the expert report.
And in this paragraph you identify four Ohio statutes. So it says here "Section 2919.123, 4723.44," "2919.124" and "2317.56."
Did I read all of those correctly?
A Yes, that's correct.
Q Okay. And did you read each of these statutes in full?
A Yes, I did.
Q When did you do that?
A I read it at the time I wrote the report, which I believe was maybe May of this year.
Q Okay. And did you read them any other time?
A I have not read them in depth since then, no.
Q Okay. And how did you identify those laws as being part of this case?
A Well, I read the initial complaint. And Amanda sent me the laws at issue.
Q Okay. And did Ms. Narog identify any other laws as -- as being at issue in this case?
A No.
Q Okay. And you mentioned that you read the complaint.
Do you know if that was called the complaint or the first amended complaint or the second amended complaint?
A To tell you the truth, I don't recall what its name was.
Q Okay. And do you recall when it was dated?
A No, I don't.
Q Okay. And then how did you approach deciding which laws listed in the complaint to read?
A Well, I -- I read the -- the four laws that were sent to me by Amanda.
Q Okay. And did anyone provide you with a summary of the laws at issue in this case?
A No.
Q Okay. I'm just going to pull -- stop my screenshare.
What is your understanding of Ohio's Right to Reproductive Freedom amendment?
A It allows abortion without restrictions until viability. However, it does allow the State to limit the procedure if it's in the interest of safety and well-being of the woman.
Q Okay. And have you read the amendment?
A Yes, I have.
Q Okay. When did you read it?
A At the time I was producing the report.
Q Okay. And did you read it any -- at any other times?
A No.
Q Okay. And did you provide any advice, guidance, comment or any other form of input to any individual or organization involved in the ballot campaign related to the amendment?
A I was not involved in the ballot campaign.
Q Okay. How did you come to serve as an expert witness in this case?
A I was contacted by the Ohio Attorney General's office.
Q Okay. And who contacted you?
A I believe it was Amanda. I don't recall specifically.
Q Okay. And do you recall when that was?

23

24

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

25

A Probably in the late spring.
Q Of this --
A Of this year.
Q Okay.
A I had -- I had been involved -- I had written a report, I believe, in 2022, which I haven't reviewed recently. But they knew of me, I think, from previous work that I had done with them.
Q Okay. And do you recall for that 2022 report how you first got in contact with the State at that point?
A I do not recall.
Q Okay. And how many times have you communicated with the Ohio Attorney General's Office since they first contacted you?
A Probably a dozen times since the spring, either via e-mail or phone.
Q Okay. Are you being compensated for your participation in this case?
A I'm not personally being compensated. The organization that I work for, Charlotte Lozier Institute, is -- its mission is education related to abortion. And so it's in the context of my job description to perform work like this.

26

So the compensation is going to my employer.
Q Okay. And do you have any knowledge of how much to date Charlotte Lozier Institute has received from the State in this case?
A I don't recall.
Q Okay. And what's your current yearly salary at the Lozier Institute?
A My yearly salary is $168,000.
Q Okay. And do you know -- approximately how many hours you've spent working on this case so far?
A I don't recall. If I did, I would know how much Lozier's been reimbursed. But I -- I did not look at my billing information before this.
Q Okay. Do you have a ballpark?
A Probably in the range of 20 to 30 hours.
Q Okay. And are you being reimbursed for any costs in connection with your testimony?
A If I were to travel, there would be reimbursement, but there's no other cost at this time.
Q Okay. What did you do to prepare for the deposition today?
A I reread my expert report.

27

Q Okay. And did you meet with anyone about the deposition?
A I spoke briefly with Amanda.
Q Okay. And when was that?
A I believe a couple of day -- days ago.
Q Okay.
A Maybe the end of last week.
Q Okay. And when you say --
THE COURT REPORTER: I'm sorry. I'm sorry. I'm sorry. I believe a couple of days ago, I didn't hear the rest of that.
THE WITNESS: I said maybe the end of last week.
Q Okay. When you say "briefly," what do you mean by that?
A As I recall, it was a 30-minute Zoom call.
Q Okay. And was anyone present other than Ms. Narog?
A No.
Q Okay. Did you bring any documents to that meeting?
A No.
Q Okay. And were you shown any documents related to this deposition outside of that meeting?

28

A No.
Q Okay. Other than the complaint that you mentioned, have you reviewed any of the legal filings in this case?
A At the time I produced the report, I did. I have not reviewed them since then.
Q Okay. And what documents were those?
A The legal filings that I reviewed when I did the report?
Q Yes.
A Is that your question?
I could open up my tab and tell you the names of them.
I -- as I recall, it was the -- the legal documents, the initial lawsuit. And, again, I'm not -- not an attorney, so the significance of amended complaints and preliminary injunction requests and those kind of things don't really stick in my mind very much. But I -- it was documents such as that.
I believe I looked at Daniel Grossman's report as well.
Q Okay. And do you recall if you looked at any other expert reports from this case?
A That's all I can recall right now.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

29

Q Okay. Did you do any Ohio-specific research in preparing your report?
A I believe that I did look at -- Charlotte Lozier Institute does state-by-state analysis of the numbers of abortions that is publicly available. And I believe I probably looked at that at the time I produced the report, but I don't think I looked at any other Ohio-specific information.
Q Okay. So you didn't review any Ohio-specific publications?
A I don't think I did.
Q Okay. And then other than the data about the number of abortions in Ohio, did you review any Ohio-specific data?
A I don't think so.
Q Okay. And you said the Charlotte Lozier state-by-state analysis as far as the number of abortions, that's publicly available?
A Yes.
Q Okay. On the -- on the Charlotte Lozier website?
A Yes.
Q Okay. Did you review any documents that we haven't yet talked about to prepare for this

30

deposition?
A No.
Q Okay. Have you spoken to any of the plaintiffs in this case?
A About the case?
Q In -- in general.
A No.
Q Okay. And have you spoken to other abortion providers in Ohio to prepare for this deposition?
A No.
Q Okay. And did you speak with anyone else about this deposition, whether or not it was pre- -- to prepare for it, but just about the deposition?
A No.
Q Okay. Did you do anything else to prepare for today's deposition that you haven't already mentioned?
A Well, in the course of my work, I frequently revisit the data that I've included in my report. So that is -- information is fresh in my mind. This was, in general, related to my job and not specifically this deposition.
Q Okay. And when you were preparing --

31

anything that -- sorry.
Did you do anything to prepare for the deposition today that reminded you of anything you forgot to include in your record?
A I don't think so.
Q And did anything you do to prepare for the deposition today change your mind about any of your opinions you offer in your report?
A No.
Q Okay. So I'm going to go back to talking about your expert report.
When were you asked to write this report?
A As I recall, it was in the spring, maybe April.
Q Okay. And what was your process in writing the report?
A Well, my process is to read the law and, in this case, the Reproductive Freedom documents, to understand what is the law requiring and why is there controversy about the law.
And once I have established that, then, deciding what my opinion -- why I'm being asked for my opinion.
In this case, I feel that there were two large categories: One is safety for women, and

32

one is informed consent.
And so, then, based upon my prior research, I brought in doc- -- referenced documents that demonstrated the points that I was trying to make.
Q Okay. And did you write all of your report?
A I did.
Q Okay. Did anyone edit it?
A No.
Q Okay. And did anyone assist you in preparing it?
A No.
Q Okay. A significant portion of this report overlaps with testimony you've provided in other cases related to abortion; is that right?
A That would be likely. Many times the same issues are -- occur in multiple cases. And so in that case, I probably did refer to things I had previously written.
Of course, I would update and modify them to be specific for this case.
Q Okay. And is any of it copied from anyone else's expert reports?
A Not that I'm aware of.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

33

Q Okay. Are there any sections of this report that are entirely new to this report, versus, you know, the other expert reports you've talked about overlapping?

A There would be because, again, it's specifically related to the Ohio laws that are being challenged.

Q Okay. So I'm just going to read the -- the headings from your report as far as the substance of your expert opinions.

So there's "Abortion Data Deficiencies," "Abortion Safety," "FDA's mifepristone Abortion Protocol," "Changes to Medication Safety Requirements," "Risk of Telemedicine Abortion," "FDA's Reliance on Faulty Data," "Informed Consent" and "Physician Requirement."

So your report contains the entirety of your opinions on the topics that you're offering in this case, right?

A Yes, I believe so.

Q Okay. And you haven't changed your mind about any of your opinions in this report since you signed it?

A No.

Q Okay. And did you make an effort to

34

include in your report all of the relevant facts and data on which your opinions are based?

A Yes, I did.

Q Okay. And did you include citations to all studies you thought supported your statements?

A It is certainly possible that there are other studies that would provide support to what I wrote, but I primarily focused on the studies that I felt were most important to make those points.

Q Okay. And what process did you take to identify studies that could be relevant to your report?

A Well, again, in -- in the course of my work at Lozier, I have examined the peer-reviewed literature on abortion safety, specifically related to mifepristone and so I believe that I am aware of the studies that the abortion industry points to, supposedly demonstrating safety, as well as their deficiencies. And I'm also aware of studies that -- that provide contrary data.

Q Okay. And so aside from your familiarity with the literature through your work at the Lozier Institute, what else did you do to identify studies that were going to be relevant to this report?

35

A I mean, I think it all is encompassed by my work at Lozier, because that's my primary focus, is to know what the literature shows. And also I have been involved in writing peer-reviewed articles and doing original research related to the topic as well. And I believe I did reference most of those.

Q Okay. And through the course of your work, then, with the Lozier Institute, what databases do you search for articles in?

A Well, if you're asking when I -- when I do a literature search, primarily we will look at PubMed to begin. If -- if we're doing more of a systemic review, which we really haven't done that many of those, we may look at Scopus or some other databases. We -- we are generally aware of the articles that are being published in the peer-reviewed literature as their published, so we try to stay up to date on the recent literature.

Q Okay. And so if -- in preparing your report, if you're putting a specific statement in your -- in your report, are you searching to see if there's new articles on the issue or new research on the issue?

A I don't recall specifically doing that

36

because I believe that I generally keep current. As -- as we go, we receive alerts from various periodicals that let us know when new information is coming out.

Q Okay. Are there any other places that you look for studies that you haven't mentioned so far?

A I mean, it's not uncommon that I'll just do a Google search.

Q Okay.

A If -- if there's a specific topic that I'm not sure that I have good articles on to see if anything has been done in that area.

Q Okay. And when you say you get alerts about kind of specific new publications from -- is that specific to certain journals or how does that work?

A Well, two of my colleagues at Lozier subscribe to alerts. One of them runs a -- a database that we call the Lozier Library, where he often becomes aware of new research and then obtains that article and then provides it to the rest of the team.

So at the time I wrote this report, I was not the recipient of the alerts, but my colleagues

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

37

were. And then they were bringing articles, new -- new research to my attention.

Q Okay. And did you read every study in your report?

A I have read every study in my report at some point. I may have not have reread them as I was preparing the report, but I was very familiar with the data that was included in the studies.

Q Okay. And it -- it sounds like you also reviewed other studies and materials that aren't cited in your report; is that right?

A That is correct.

Q Okay. Did anyone suggest that you include a certain study or citation in your report?

A No.

Q Okay. And did anyone suggest that you omit a certain study from your report?

A No.

Q Okay. In paragraph 6 of your report, you say, "In preparing this report, I considered the resources referenced herein, Plaintiff's" complaints -- sorry -- "complaint" -- singular -- "Plaintiff's expert witness reports, and the statutes at issue in this case."

Is there anything else you considered in

38

preparing your report that we haven't yet discussed in?

A I don't think so.

Q Okay. And do you know roughly how many hours you spent drafting this report?

A Well, I think you asked me earlier how many hours I've spent on this. And I said probably 20 to 30 and I would say the majority of that has been spent drafting. Probably 80 percent of that time was spent drafting the report.

Q Okay. And are there any corrections you wish to make to this report before we discuss it?

A No.

Okay. So I'd like to ask you a few questions about your professional background, and I'm just going to turn in your expert report -- let me share my screen again.

(Attorney Humphreville shared Exhibit 1 on the screen.)

Q And this is -- attaches -- I mean, I think the report itself is Exhibit A to the affidavit. And then this is Exhibit B to that same document. And this is the CV attached to your expert report. I'm just scrolling through it.

I -- I know this is just a skimming of it,

39

but this is your CV, right?

A Yes.

Q Okay. And you prepared this document?

A Yes.

Q Okay. And does it include a current and accurate list of all of your credentials? We can go through section by section too, but. . .

A I believe it -- it is accurate regarding my credentials at this time.

Q Okay. And are there any inaccuracies? We can talk section by section if there are any updates. But are there any inaccuracies that you want to point out?

A No. There's no inaccuracies. There may be one or two peer-reviewed articles published since that time that are not included, but. . .

Q Okay. Have you ever been licensed to practice medicine in any state other than Texas?

A No.

Q Okay. So you've never been a licensed physician in Ohio?

A No.

Q Okay. And then aside from continuing medical education, have you completed any training since your residency?

40

A In -- in clinical obstetrics?

Q Sure. We can start with clinical obstetrics.

A I mean, it's -- -- the process of being a board-certified obstetrician involves continued training, board recertification yearly. As a member of a hospital staff, we do training in safety bundles, protocols, drills. So yes, I've -- I've kept up with all of that standard training as a clinician.

Q Okay. And have you completed any kind of non- -- I guess non-medical professional training since your residency?

A Not that I can think of.

Q Okay. So then under your -- it looks like your current roles that you're an adjunct faculty member at the University of the Incarnate Word School of Osteopathic Medicine.

Is that a research position?

A No. I'm a clinical physician, which means that medical students will come when I'm in the hospital, and I'll teach them clinical skills.

Q Okay. And then aside from -- I'm just going to zoom in a little bit more just so we can all see it a little bit better.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

41

A Thank you.
Q Aside from the medical positions listed here, have you held any others?
A I don't think so.
Q Okay. And so you're currently the vice president and director of medical affairs at the Charlotte Lozier Institute; is that right?
A Yes.
Q Okay. And what are your duties in this role?
A So I'm the only medical doctor at Charlotte Lozier; so really if there's any question related to clinical medicine, particularly obstetrics, then it is within my purview.
So I -- I write both peer-reviewed and non-peer-reviewed articles. I -- as we're doing here, I provide expert witness testimony. I frequently speak to various groups, educating them on the issues. I am involved in giving interviews to different media sources, writing op eds.
I'm sure I provide a clinical background many times to people who need to understand it, which can be a variety of types of people. But basically taking my experience as a researcher and

42

as an obstetric clinician to help people understand the issues and what's going on, on the ground in America, particularly post-dogs.
Q Okay. And what's the division of time between the different positions you hold currently?
A Well, expert reports are -- are very small portion of what I do. I would say probably at least 50 percent of my time is spent on research, writing, again, articles either peer or non-peer reviewed and, you know, probably another 20, 30 percent is providing education via media or direct personal education to stakeholders who are interested in understanding the topic.
Q Okay. I should clarify. I meant -- sort of -- sort of your professional time, how much of it is spent on your duties at the Lozier Institute versus your duties as a physician or faculty member?
A Oh, okay. Good question.
So I work full-time, so 40 hours a week. Although it probably ends up being a lot more because I travel frequently.
I do three 24-hour shifts a month as an obstetric hospitalist. I believe that averages to

43

about 15 hours a week. And while I'm working as an obstetric hospitalist, that's when I have a student under my wing. So it's -- it's concurrent with the hospitalist duties that I'm working with the students.
Q Okay. I'd like to just ask you a few more questions about the Charlotte Lozier Institute.
So what -- what is the Lozier Institute?
A It's a 501(c)(3) organization, you might call it a pro-life think tank. We're interested in research, science, statistics related to life issues, specifically I spend most of my time researching abortion.
Q Okay. And when you say it's a -- a pro-life think tank, it opposes abortion, right?
A That's correct.
Q All right. And is it part of Susan B. Anthony Pro-Life America?
A Susan B. Anthony is a lobbying organization, and they created Charlotte Lozier. We are -- again, we have a different tax status; we have a different leadership structure, so I don't know if you would call it necessarily part of, but it was created by SBA and we do have -- continue to have a close relationship with SBA.

44

Q Okay. And --
A But they don't -- they don't tell us what to research. We're independent from that perspective.
Q Okay. And you mentioned it's a -- a lobbying organization.
What does is it lobby related to?
A It is -- Susan B. Anthony's mission is electing pro-life women leaders, but they interact with pro-life politicians, particularly at the national level, but to some extent at the state level as well.
Q Okay. And does the Charlotte Lozier Institute do research that's not related to abortion?
A Yes, we do. In fact we -- we just found out this morning that we're having an article, a peer-reviewed article published on Severe Maternal Morbidity.
Q And is -- is that an article on which you're a coauthor?
A Yes.
Q Okay. And what journal is that going to be published?
A I believe it's the International Journal

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

45

of Women's Health.
Q Okay. And when you say -- I think you said "Severe Maternal Morbidity." Does that include abortion-related morbidity?
A This specific study is looking at pregnancy losses in a prior pregnancy and the association with SMM which almost is a life-threatening event that does not result in the mother in a subsequent pregnancy.
Q And SMM is severe maternal morbidity?
A Yes.
Q Okay. And do your duties in your current role at the Lozier Institute differ from the previous roles that you've held there?
A Not specifically. You're asking about the senior fellow versus vice president?
No, the duties are very similar.
ATTORNEY HUMPHREVILLE: Okay. I'm just going to take this down for right now.
Q So, I guess, I'm going to ask you some questions about kind of your experience as an obstetric-gynecologist.
Have you ever provided an abortion?
A I've never provided an elective abortion, no.

46

Q Okay. And when you say you've "never provided an elective abortion," what do you mean? Have you -- have you provided what you would call non-elective abortions?
A Yeah. I think what I'd like to do is define the term, because the terminology can be confusing.
Legally an abor- -- an induced abortion has the intent of ending the unborn human's life. I have never performed a procedure with the intent of ending the unborn human's life. There have been rare occasions where a pregnancy complication threatened a mother's life before the baby had the ability to survive in an extremely premature situation. So there have been occasions where I have induced labor to end the pregnancy in order to treat the mother's life-threatening complication.
Again, my -- from my perspective, I don't consider that an abortion, even though I recognized at the time that this would ultimately result in the baby's death because he was too young to survive separation.
Q Okay. And were any of those terminations that you're referring to done via medication

47

abortion?
A Medication abortion as the FDA recommends right now uses mifepristone and misoprostol. I am not RIMS-certified which means I don't have access to mifepristone, but in my 30-year career I have used misoprostol for a number of indications, and sometimes in this scenario, misoprostol is the medication that we will use to induce labor.
Q Okay. So you've never provided a medication abortion?
A Well, again, it depends on your definition. If you're saying -- I prefer to use the actual terms of the medicines because it's less confusing. So I've never provided a mifepristone and misoprostol induction, but I have provided misoprostol inductions in those life-threatening situations where I could predict the baby would not survive.
Q Okay. And when you've done those misoprostol inductions, what gestational ages would those be at?
A Well I've -- I've used misoprostol at multiple gestational ages but for the purposes of this discussion, I practiced at a Level 4 NICU hospital which means that from about 22 weeks

48

gestation on, if I needed to induce labor and I might do it with misoprostol, the NICU team would try to save the baby, so that was the age of viability at my hospital.
The more common scenario is what we call pre-viable -- well, it's not the more common scenario, but the -- the situation where I've needed to induce labor predicting that the baby could not survive is in the event of pre-viable, premature rupture of membranes where the membranes have ruptured. It could be 15 weeks. It could be 17 weeks. It could be 21 weeks. But in that zone before we're going to try -- before we think that we can save the baby.
So it's -- it's -- there have been inductions at various gestational ages.
Q And --
A For that reason.
Q Okay. And have you done that before 15 weeks at all?
A I don't think I've -- I mean, certainly I've -- I've dealt with -- essentially what this is -- is a -- is a mid-trimester miscarriage, is a late miscarriage. And so I've cared for miscarriages throughout pregnancy, I would say

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

49

before 15 weeks, typically the -- the treatment that I most commonly would perform would be a D&C, a surgical evacuation.

D -- D & E, the procedure that is done from about 14, 15 weeks on is more complicated. It can have a higher incidence of complications, particularly in doctors who don't perform that a lot. And so in -- in my practice, typically the -- the much later miscarriages beyond, I would say probably 16 weeks or so, I would manage with induction rather than D & E.

Q Okay. So I think -- let me just try to use your words.

So you have not performed misoprostol induction before 15 weeks; is that right?

A That's not technically accurate because misoprostol we use frequently to end -- so if a woman is in the process of having a miscarriage, but it's not actively on -- so if it's actively ongoing, we may not need to know anything or do anything.

But if we know she's going to have a miscarriage, we know the baby has died and yet her body is not in the process of expelling the tissue, then we give a woman three options: We

50

can wait, let her body do it on its own when it will; we can do a surgery which is a D&C in that situation; or we can give misoprostol to help her uterus expel the tissue.

So in that circumstance I've used misoprostol many times at any gestational age. But, again, I guess maybe the way I think about it is I'm not thinking about this as being an induction of labor. But, you know, technically it really is, but we're just dealing with a very small fetus. But we're facilitating her uterine contractions so that her body can expel the pregnancy tissue and the process can be done.

Q Okay. And so to use your words, you've never provided an elective medication abortion, correct?

A With a living fetus, you're -- that is correct.

Q Okay. And, again, with a living fetus you've never provided an elective procedural abortion, right?

A That is correct. So all -- all of the -- all of the medications and all of the procedures that we've discussed can be used to -- to empty the uterus of a living baby or a dead baby and

51

I've done all of the procedures to empty the uterus of dead babies. I've not intentionally done a procedure to end the life of a healthy, living baby.

Q Okay. And so when you say, you know, all of the procedures and all of the medications, you're talking about kind of expected management, medication management and, you know, procedural management?

A That's correct.

Q Okay. Did you ever train to provide -- I'm just going to use your words, elective medication abortion?

A So, again, we received training in the procedures --

Q I'm talking about the medications, not the procedures right now?

A Again, I -- I trained to know how to use misoprostol to empty the uterus.

Q Okay. Have you ever trained to provide mifepristone?

A I have not because the FDA's RIMS does not allow a doctor who is not RIMS-certified to prescribe mifepristone, and I have not chosen to become RIMS-certified and -- as -- is the case

52

actually for most OB-GYNs are not RIMS-certified, and so I have not prescribed mifepristone because I do not have access to the drug.

Q So you've never provided a mifepristone misoprostol abortion, correct?

A Correct.

Q Okay. And have you ever observed mifepristone misoprostol medication abortion?

A I've cared for many women with complications of mifepristone misoprostol medical abortions.

Q My question was, have you observed a mifepristone-misoprostol medication abortion, right?

THE COURT REPORTER: I'm sorry. You've got to slow down with the -- I'm sorry. You've got to slow down with the technical words a little bit.

Could you just repeat the question?

Q Sure. So my question was, you've never observed a mifepristone misoprostol medication abortion, right?

A I have not handed the woman mifepristone misoprostol in order to end the life of her child, but I have been involved and from that perspective

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

53

I've observed the process many times when it did not work the way the woman thought it would and she's needed help to -- to complete the evacuation of her uterus.

Q Okay. And have you ever been in the room when a medical assessment for -- before providing a mifepristone misoprostol medication abortion, have you been in the room when that medical assessment has been performed?

A No.

Q And have you been in the room when informed consent was taken for that type of medication abortion?

A No.

Q Okay.

A And as we're discussing today, there will be no room involved if -- if these laws are removed.

Q All right. We can -- we can talk about telemedicine later.

Have you ever referred a patient for an elective abortion?

A No, I have not.

Q Okay. And are there any circumstances under which you would do so?

54

A To electively end the life of her healthy child, no. I think there are better options for women.

Q Okay. And outside of abortion, are there any procedures or treatments that you wouldn't provide a patient a referral for?

A Well, as a clinician I use my clinical judgment to know what procedures would benefit a patient. And so it is possible that a patient could request a procedure that I don't feel clinically would benefit her. An example might be an elective hysterectomy because she wants to live as a man. There's no, you know, good data that shows any benefit to that procedure, so I would not prefer -- I would not refer for a procedure. And there may be others I'm not thinking of, but that I felt would not provide benefit for a patient.

Q Okay. So other than something related to gender transition or abortion, is there anything you would not refer to that you think of right now?

A I can't think of, but it's possible a patient could request something that I didn't feel would benefit 'em, and in that situation, I would not provide a referral.

55

Q Okay. And have you ever had a patient express that they were considering terminating a pregnancy?

A Yes, I have.

Q And how did you respond to that patient?

A Well, informed consent says let's talk about all of the -- the concerns, the factors involved. And so in that case, I will sit down with a patient and talk to her about the three options in a crisis pregnancy; she can -- she can terminate her pregnancy, she can continue the pregnancy to birth and after birth, she could place the baby for adoption, or she could raise the child herself. So those are the options I discuss with every patient.

But technically in medicine, we don't need to, quote, refer for an abortion because everyone knows that the organization you represent is readily available to provide abortions and does not require a referral. So the patient knows that that is an option, and so I don't need to refer her in that situation.

I tell her all of her options, I give her an ultrasound to show her the humanity of her child, and if she still chooses to -- to have an abortion, she has the autonomy to do that.

56

Q And when you say "everyone knows," have you asked every patient you've ever spoken to whether they know that Planned Parenthood provides abortions?

A I don't need to. You guys do a great job marketing.

Q Okay. So you have not asked every patient that?

A That -- the statement I just made was broadly inclusive. I cannot say that every person in America knows that Planned Parenthood will abort their child, but probably most do.

Q Okay. We were talking about miscarriages earlier. In terms of the types of treatments that you were talking about providing, in what settings would you provide those treatments?

A So when a woman presents with a pregnancy loss, of course the very first thing is making a diagnose generally by ultrasound of the loss, and then having the discussion of those three options, waiting --

Q I'm just going to cut you off for a second here because my question is in what setting would

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

57

you provide those treatments? I'm not asking about all of the stuff leading up to the treatment. I'm asking in what setting would you provide the treatment?

A Are you asking like specifically when I would recommend one treatment over the other?

Q No, I'm saying in what setting? So would you provide it -- would you provide expectant management in an office setting?

A Oh, okay. Okay. I see what you're saying --

(Crosstalk)

Q -- expectant management in an office setting?

A So when I was in private practice, this conversation would generally occur in an office. Currently I don't have an office -- a private office, but I work in a hospital and so I will evaluate women generally in the emergency room that are suffering a miscarriage. And so it will be in the emergency room setting that I would discuss the options with them.

Q Okay. And -- okay. We were -- we were talking about misoprostol, right, that's an FDA-approved drug, correct?

58

A It's FDA-approved, but not for obstetric indications. The FDA approval is for treatment and prevention of ulcers.

Q Okay. And it can also be used for miscarriage management?

A Yes.

Q Okay. And for abortion?

A Yes.

Q And across, you know, kind of those three applications or any others, we're talking about the same medication, misoprostol, right?

A Yes. The -- the dose may be somewhat different depending on the indication, but same drug.

Q Okay. And would you agree that misoprostol is a safe way to treat first carriage -- first trimester miscarriage?

A You know, safe, I believe should be defined more often than it is because every treatment option can have complications. It can have failures. Misoprostol, when used for a miscarriage, about ten to fifteen percent -- some studies say a little bit more -- of the women will not be able to completely evacuate the tissue with the misoprostol alone, and they may require a

59

surgical D&C completion.

So it -- it's an option. It's one of the discussions I have with them, that the gold standard for emptying the uterus is surgical; but if she wants to avoid surgery, then misoprostol is a reasonable option. But, of course, in that situation, I always provide close follow-up for them so that if it does not work, if there is a complication -- it fails, I'm there to help her and to provide the -- the next option that's needed, which I would say is not what we're seeing with telemedicine abortions in America today.

Q Okay. Other than the patients who will -- where misoprostol will not completely evacuate the uterus, are complications rare for misoprostol miscarriage?

A They're rare. They can occur -- the most common complication would be hemorrhage, excessive bleeding, and, again, failure to complete the miscarriage.

Q Okay. Could you estimate how many times you've prescribed misoprostol throughout your career?

A Well, probably thousands of times, certainly in the high hundreds. Not only do we

60

use it for miscarriage management, we can use it for labor induction. We also will sometimes use it for what we call cervical ripening before a gynecologic procedure like a -- maybe a D&C for post-menopausal bleeding. There's -- there's many obstetric indications for misoprostol.

Additionally, it is a medication we use for postpartum hemorrhage so with that in mind, I would definitely say I've prescribed it thousands of time.

Q Okay. And so if you're prescribing a patient misoprostol for miscarriage, would you require the patient to take the misoprostol in your physical presence?

A Generally -- well, what happens in my physical presence is that I definitively make the diagnosis. Because, of course, we would all agree we don't want to assume a woman is miscarrying, provide a medicine that is going to evac- -- empty her uterus if in fact it is a threatened miscarriage, which means that she may have some bleeding or signs of miscarriage but the baby's still alive. So I make the diagnosis in person.

In my clinical practice and in my hospital practice, I don't have the medicine in hand. And

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

61

so I -- when she desires it, I give her a prescription to take and -- and -- and she fills the medication at a pharmacy.

Q Okay. And you would give her instructions on how to take that, then, how to take the medication once she gets it from the pharmacy?

A Yes.

Q Okay. And would those instructions include what types of symptoms would be a reason to call you with -- you know, with follow-up questions or seek follow-up care?

A Yes. I definitely counsel her regarding things that should -- she should reach out to me. But also I schedule a follow-up visit.

Q Okay.

A So I don't just send her out the door and assume no news is good news. I -- I -- I make sure that I do have the opportunity to reevaluate her to see if the medication worked.

Q And you mentioned hemorrhage before so would you counsel her on what is an expected amount of bleeding versus bleeding that would indicate a concern?

THE COURT REPORTER: I'm sorry. Excuse me. I'm having a technical issue. I'm very

62

sorry. I'm actually not hearing what's going on right now. If you'll just give me one second. Can we go off the record momentarily?

(Technical difficulties)

THE VIDEOGRAPHER: We are going off the record at 10:07.

(A recess was taken from 10:07 a.m. to 10:35 a.m.)

We are back on the record at 10:35.

BY ATTORNEY HUMPHREVILLE:

Q Okay. So, Dr. Skop, I think when we left off, we were talking about your prescription of misoprostol for miscarriage. And if you're -- you were describing sending a prescription to a patient -- to a pharmacy for misoprostol and the instructions that you provide a patient on how -- how to take the medication and so forth.

How would you instruct a patient on what is an expected amount of bleeding versus what -- what is an amount of bleeding that is a concern where she should seek additional help?

A Well, I would tell her to expect more bleeding than she would with a normal period, because there's going to be -- the whole point of the misoprostol is to expel tissue. So she's

63

going to see tissue.

You know, I do like to prepare her for the fact that many times she's going to be see her baby. So depending on the gestational age, the baby may be very recognizable. So I explain that to her.

But in terms of the bleeding, generally in obstetrics, if a woman changes pads more than two pads an hour for two hours, so four pads over that period of time, we consider that to be excessive bleeding, and we would tell her she needs to be evaluated at that point.

Q Okay. And typically would the patient after receiving -- filling the prescription take the medication at home, the misoprostol at home for miscarriage?

A The misoprostol at home, yes, because we would expect contractions to start fairly shortly thereafter. So generally she's going to want to be at home when that process begins.

Mifepristone is different, because the mifepristone doesn't immediately start the miscarriage process. So that doesn't necessarily have to be taken at home. But misoprostol generally is.

64

Q Okay. And aside from excessive bleeding, what are the complications a patient could experience from misoprostol for miscarriage?

A The other complication that we do have concerns about is the potential for infection, especially if the tissue is not completely expelled from the uterus. This can really be a source that can feed an infection.

Misoprostol does compromise a woman's immune system slightly as well, so sometimes she may not fight off an infection as easily. So we precaution -- we give her precautions about fevers and chills and things like that.

Other -- I wouldn't describe it as a complication, but we also let her know that she will experience gastrointestinal side effects. So she's very likely to have nauseous, vomiting, diarrhea, GI cramps, because misoprostol works upon the GI tract as well as upon the uterus.

Q Okay. And are there any other complications you would advise her of aside from -- I think you mentioned, you know, it might not completely evacuate the uterus, infection and excessive bleeding and the gastrointestinal side effects?

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

65

A Yeah. There's a complication that's very rarely mentioned, but I think it's very important to be aware of in that misoprostol has been associated with uterine rupture. So on a rare occasion it can cause such intense contractions that the -- the uterus ruptures.

This is more of a concern for a later miscarriage that you're treating. Or a later abortion because, as we know, sometimes women are being given these drugs to self-manage their own abortion at home.

If she's had particularly more than one prior C-section, this does put her at risk for that. And so this is something that I would also warn a patient about if she's had multiple Cesareans.

Q And when you say "a later miscarriage," what do you mean by "later"?

A Well, I think the more tissue -- you know, the bigger the baby is, the more tissue, placental tissue, et cetera, that needs to be expelled, the more work the uterus has to do to expel all of that tissue.

And so, you know, again, it's going to be a gradual increase. So it's not like all of a

66

sudden at 15 weeks there's a risk, whereas there wasn't before.

But just depending on the gestational age, you know, I think that -- that becomes more of a concern with a more advanced gestation and a bigger baby that needs to be expelled.

Q Okay. So recognizing that it's -- it's a continuum, is there, you know, a point at which you would start to advise patients of the risk of uterine rupture from misoprostol for miscarriage?

A Well, again, I would specifically be warning patients who've had prior Cesareans. So a woman without a prior Cesarean is probably very low risk. I mean, it can happen, but it's very low risk.

But -- or other uterine surgeries. So she's had a myomectomy or, you know, some other uterine procedure.

But, again, I would say probably, in general, second trimester and beyond that would be a concern.

But, again, I -- I don't like that these drugs are being used without supervision, even in the late first trimester, because no one's talking about the potential for uterine rupture.

67

Q Okay. And do you provide ultrasounds, Dr. Skop?

A Yes, I do.

Q Okay. And do you sometimes rely on an ultrasound that a patient has received elsewhere?

A Depending on the scenario, I might.

Q Okay. And have you ever prescribed FDA-approved medications off label?

A Yes.

Q Okay. And is -- is that common in the practice of medicine?

A It's estimated about 20 percent of prescriptions are for off-label use.

Q Okay. And I think you said earlier that you've provided misoprostol off label; is that right?

A Yes. Any -- any obstetric indication is off label for misoprostol.

Q Okay. And you've -- you've done that?

A Yes.

Q Okay. Have you ever provided any healthcare service via telehealth?

A Briefly during the COVID pandemic, we did. I -- I don't prefer it. I think that it's better-quality care to have an in-person

68

interaction.

And I believe that my group felt that way because it was not long before we brought patients back into the office and began having face-to-face care again.

Q Okay. And when you provided telehealth, were you doing video visits or another format?

A We did it both ways. Sometimes it was via Zoom calls. Often it was even just via a phone call.

Q Okay. Can you estimate the number of patients you've seen, either -- either via phone or video?

A Maybe 100, 120.

Q Okay. And do you -- do you know what the ratio of those would be of video versus phone?

A Maybe about half and half.

Q Okay. And what types of services were you providing via telehealth in these visits?

A So for a very brief period of time, we closed the office entirely. So it would be obstetric, you know, maybe routine prenatal care. Of course, the disadvantage is you can't do a blood pressure. You can't listen to fetal heart tones. You can't do -- you know, so that was very

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

69

suboptimal.
Occasionally it would be maybe a gynecologic problem that needed to be dealt with semi-emergently, maybe dysfunctional uterine bleeding or something like that.
Again, suboptimal because we weren't able to do a physical exam. We weren't able to really completely evaluate the patient. But at the time when the offices were closed, it was better than nothing.
Q Okay. And did you ever provide -- prescribe any medications via telehealth?
A Sure. I probably did.
Q What kinds?
A So, again, maybe if it was a woman who called with dysfunctional uterine bleeding, you know, I might walk her through the different medication treatment options. And, you know, had she chosen progesterone or oral contraceptive pills or -- or something like that, I might have prescribed it without seeing her.
But, again, the -- the caveat would be that as soon as the office was back open, I would want to bring her in so that we could do that complete evaluation. But this would be more

70

temporizing to help her with her symptoms at that time.
Q Okay. And did you ever obtain informed consent from a patient via telehealth?
A Yes, I would.
Q Okay. Do you use an electronic messaging portal of any kind with patients?
A Well, I don't do -- do that now, because I'm just working in a hospital. But we had a portal, but it would typically go through the -- our -- our phone nurses would -- would send our messages to the patients. So not a direct communication.
Q Okay. And have you ever prescribed medication based on messages exchanged with a patient?
A Yes.
Q And have you ever refilled a prescription based on messages exchanged with a patient?
A Yes.
Q Okay. And what medications would those be?
A You know, I'd say probably most commonly would be maybe birth control pills. Perhaps they were having a concern with one and we had a

71

conversation and decided to change to a different type.
But, again, the -- the caveat here is that I did an in-person evaluation at the beginning. So I never have provided continuing, ongoing care without looking a patient in the eye at some point in doing that initial evaluation.
ATTORNEY HUMPHREVILLE: Okay. And I just want to do a little bit of cleanup because I realize I forgot to mention a couple of things to Ms. Narog after the break.
So Dr. Skop mentioned a new article being published about Severe Maternal Morbidity and also the Lozier Institute Ohio documents.
Could we exchange to get copies of those?
ATTORNEY NAROG: Sure. I -- I think that shouldn't be a problem. But, you know, we'll -- we'll do our best to get those together for you.
ATTORNEY HUMPHREVILLE: Okay.
THE WITNESS: The -- the article that I mentioned, we just got notification today that it was accepted for publication. So it may not be published for a couple more weeks.
ATTORNEY HUMPHREVILLE: Understood.

72

Q And, Dr. Skop, you mentioned that you have a colleague that maintains the sort of, like, Lozier library or the notifications for new publications.
What's that person's name?
A His name is Zach Sluzala, S-L-U-Z-A-L-A.
Q Okay. I'm going to ask you some questions about professional organizations you're a member of, Dr. Skop.
Are you a member of the American Association of Pro-Life Obstetricians and Gynecologists?
A Yes.
Q Okay. And can we agree to call that AAPLOG for short?
A Yes.
Q AAPLOG opposes abortion, right?
A They're pro-life, yes.
Q So they oppose abortion?
A Yes.
Q Are you on the board of AAPLOG?
A Yes, I am.
Q Have you ever been involved in drafting clinical guidance for AAPLOG?
A Yes, I have.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

73

Q Those materials are not peer-reviewed, right?
A The documents I was involved in were not. Increasingly, the guidance that AAPLOG is producing is being peer-reviewed. But I can't tell you how -- what the relative percentages are.
Q Okay. Can you list the steps that AAPLOG goes through in drafting technical guidance?
A Yes. So it will create a committee of people who are interested in the topic. Typically it'll be those who have particular experience, for example, abortion -- a surgical abortion and preterm birth. So this may be people who've previously published peer-reviewed literature about the topic.
It will do a literature search to identify the relevant articles that should be discussed, and then the committee will create a report.
It's very similar to the way that ACOG creates their practice bulletins and committee opinions.
If the evidence warrants putting strength of recommendations, then that will be included in the end. So in the conclusion, it'll say, This is -- There's strong evidence to support this

74

recommendation. There's moderate evidence.
So, again, we'll try to help the reader understand how good is the evidence in support of what we've discussed.
Q And when AAPLOG drafts its clinical guidance, does it consider the embryo or fetus' interest to be as important as the pregnant patient's?
A I think it's important to -- to recognize that AAPLOG, in the Hippocratic tradition, believes that ending human life should not be a necessary practice in medicine.
So the -- the embryo or fetus, it's -- it's not controversial -- is a living human being, albeit dependent upon his mother.
Now, when you say is he as important as the mother, he's a human being. His needs need to be considered.
But as we discussed earlier, there are rare occasions where the lives of both are at risk and the lives of one, the mother, can be saved through an action that ends that fetal or embryonic life, and that is permissible as referenced in the -- the principle of double effect, that sometimes a good effect will have a

75

secondary bad effect.
So that -- that is AAPLOG's position on that.
Q Does whether a patient want to be pregnant impact the calculus for the purpose of AAPLOG's drafting of clinical guidance?
A AAPLOG has a two-patient paradigm. We have two patients. If a woman does not want to be pregnant, there are many very effective methods of contraception in our country.
Once another human being's life is in existence, based upon Hippocratic medicine tradition, his life needs to also be considered. He is also our patient.
Q So does that take into account whether or not the pregnant person wants to be pregnant?
A He's our patient. His needs need to be considered. The woman is our patient. Her needs need to be considered too.
But I would note that wantedness can be a fluctuating variable. Many women become pregnant unexpectedly. They initially don't want to be pregnant. And yet, many of those women, if they continue to carry their baby, do grow to want and desire that baby.

76

So, again, we -- we have concerns for a woman who is in the midst of what she considers to be a crisis pregnancy.
But our counseling and our interventions for her do include helping her to find social and financial resources because, unfortunately, 96 percent of abortions in our country are performed for social or financial reasons.
So we do care whether she initially does not want that baby, but it's not our primary consideration.
And, again, life of any of our patients trumps more minor considerations like social and financial concerns.
Q Okay. So my question is not whether the pregnant patient's needs are taken into account when drafting AAPLOG guidance, but if her wants are taken into account.
ATTORNEY NAROG: Objection.
Asked and answered.
You can answer.
A Yeah. You know, I think in medicine, as I mentioned earlier, sometimes patients come in with a desire. They come in with a want that may -- you know, who knows how it originated?

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

77

A doctor's job is to know what the literature shows, to know what that particular intervention does and then, if he feels it's not going to be in the patient's best interest, the doctor can decline to perform the want or request of the patient.

So I think that's the scenario we're talking about here. She may come in with the request that she wants us to end the life of her child, but the child is also our patient.

And so we do care about these women, but it's not necessarily in the clinical guidance. The clinical guidance is specifically about medical need. And, of course an abortion is going to end our unborn patient's life, and that is a primary consideration.

Q What are your duties as an AAPLOG board member?

A We have quarterly board meetings, so it's to attend the board meetings and to be involved in decision-making regarding the organization as a whole.

Q Have you discussed this case with anyone from AAPLOG?

A I don't believe I have.

78

Q Are you a member of any other professional organizations?

A Yes. I'm a member of the American College of Obstetrics and Gynecologists.

Q Can we call that ACOG for short?

A Yes.

Q You also say on your -- your resume that you're involved with some pregnancy help centers, right?

A Yes.

Q So that's The Source, AWC or Any Woman Can, and Save The Storks; is that right?

A Yes. I'm no longer on the board of The Source. But I'm still active with the other two organizations.

Q So you're not on the board?

Are you involved in any other way with The Source?

A No, I'm not.

Q Do these organizations try to discourage people from seeking an abortion?

A What they do is -- is try to determine the concerns that a woman has with continuing her pregnancy.

And if, as is often the case, it's related to material resources, financial relationship, they try to help her find true solutions to the problems.

79

But, in general, you're right, they -- they would prefer that ending her child's life were not the solution. They want to help her find an alternative solution.

Q They would never provide her with a referral for an abortion, right?

A Well, as I mentioned earlier, referral's not needed. Women know where to obtain abortions. But, in general, we hope that she won't have an abortion.

But if she does, you know, we still care for her. Many come back for post-abortion mental health counseling. Some come back for post-abortion ultrasounds because, in many cases, these drugs are being mailed to them and there's no abortionist available to care for their complications.

Q So these organizations oppose abortion, right?

A They do.

Q Are you personally opposed to abortion, Dr. Skop?

80

A Yes, I am.

Q Do you think pregnant people should have the ability to choose abortion for themselves?

A I think once a human life is in existence, as a society, we should try very hard to solve the problems that are causing women to consider abortion. And as I mentioned, most of the time that is social and financial.

Q So do you think those people should have the ability to choose abortion for themselves?

A Well, if your neighbor's child -- if your neighbor was in financial distress, do you think that they should have the ability to end the life of their two-year-old child because -- to -- to improve their financial situation?

That's analogous to what we're discussing here, because of these are living human beings.

Q Okay. This is a yes-or-no question.

Do you think pregnant people should have the ability to choose abortions for themselves, yes or no?

ATTORNEY NAROG: Objection.

Can we just clarify whether this is her medical opinion or her personal opinion?

ATTORNEY HUMPHREVILLE: I can ask -- ask

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

81

the question however I want.
A If I may reword it, do I think that -- that United States citizens should have the ability to end human life to solve primarily social and financial problems? The answer is no.
Q So do you think that pregnant people should have the ability to choose abortion for themselves?
ATTORNEY NAROG: Objection.
Asked and answered.
A Yeah, I think I've answered the question.
Q Is the answer no?
A Right. We should not end human life for social and financial reasons.
ATTORNEY NAROG: Objection.
Q All right. I'd like to turn to some of your research and publications.
You didn't leave medical school as a trained researcher, did you?
A No, I did not.
Q Okay. And have you trained in empirical research methodology?
A Much of the research that I've done has been self-taught. So I have not taken formal training in -- in research techniques.

82

Q Have you held any academic research positions?
A No, I have not.
Q You've described yourself before as not really a good researcher; is that right?
A That was relationship to the first deposition I ever did. And, yes, I did make that statement because it has been a learning process.
Q When you say it was "a learning process," what do you mean by that?
A Well, again, it's been largely self-taught. For 25 years, I was primarily a clinician, so I did not have a lot of time to, you know, understand how to write peer-reviewed literature.
And of course, I'm -- I'm trying to get better at it. I'm certainly not perfect even today.
But it -- you know, I've made some mistakes, as I think anybody would when they were teaching themselves a fairly complicated skill.
Q Have you taken any academic courses in research methods since that first deposition?
A Not academic. YouTube, other -- other sources of information. But not specifically

83

structured academic.
Q And have you taken any statistics classes since then?
A No, I have not.
Q You also at that time were unable to identify standards of academic integrity in your field; is that right?
A I think what you're referring to is to the fact that I had accidentally plagiarized. Certainly I have learned quite a bit about academic integrity, or the lack thereof, in the peer-reviewed literature since that time.
Q So at that time you were unable to identify standards of academic integrity in your field; is that right?
A I don't recall specifically what you're discussing. That sounds like a very broad question.
Can you be a little more specific?
Q I'll withdraw the question.
All right. The -- the last -- and I'll pull this up just so we can be looking together at the articles in your CV. One second.
All right. Can you see the CV again?
A Yes.

84

Q Okay. So the last article -- I guess, it's actually a book chapter here -- is from 2025. And you mention you have a new article forthcoming.
Aside from the new article, have there -- have you had any other publications since this 2025 book chapter?
A I don't think I have. I -- there -- there are a couple that are very close to publication. But I don't think there's anything in the interim.
Q Other than where you've noted it on your CV, have any of your other articles been retracted?
A No. It was just that one batch that was politically-driven retractions.
Q What makes a journal reputable?
A That's a loaded question.
Q What's your answer to it?
A Well, I've come to discover that many journals that used to have the illusion of good reputations have become very ideologic. For example, there was a recent article in the New England Journal of Medicine related to the Aubrey, the Oxford academician who struggled and ultimately had a bad outcome.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

85

It was very -- it -- it gave no illusion at all of trying to be evidence-based. So, unfortunately, we've seen that from a number of our previously reputable journals.

Q Does whether -- is whether a journal peer-reviewed relevant to whether it's reputable?

A Well, certainly if the peer-reviewed process is followed the way it is in- -- intended, this should improve the reputation of a paper.

Because "peer-review" means that colleagues who are knowledgeable about the topic read the paper, try to discover, is there any -- are there conclusions drawn that are not reasonable? Is the -- is it based upon good evidence? Are there other articles perhaps that should be referenced or other information that should be brought in?

So ideally peer-reviewed does improve a paper because it makes sure that the -- the evidence is trustworthy.

But in our country today, there is a widespread conversation -- not just with me and pro-life people -- there's a widespread conversation about how, in many cases, the peer-reviewed process has been corrupted by

86

ideology, and that, in many cases, conclusions are not replicateable.

So there -- there is a problem across the board in that sometimes even peer-reviewed studies have -- are deeply problematic.

Q So, I guess, maybe a way to kind of drill down on that, is transparency in the peer-review process important?

A Quality in the peer-reviewed process is important. If you're asking -- because some journals do have, like, a double-blinded peer-reviewed process where the peer reviewer does not know the identity of the authors and the author does not know the peer -- the identity of the peer reviewer.

I don't think that's necessarily problematic. That may allow people to be more forthcoming, perhaps if they're -- if they're reviewing something their peers have written, and they -- and they don't want to, you know, hurt their feelings, but they want to talk about a legitimate problem.

So transparency in peer review is not necessarily the standard that we must adhere to, but honesty is. Retracting papers for no other

87

reason than that you don't like the political ramifications of the paper is not appropriate. And, of course, that's what we've experienced.

Q In the retraction notices that you received for your papers, they also identified methodological errors; is that right?

A They say methodological errors occurred. They never identified for us or for the public what those methodologic errors are or were.

So, yeah, they -- they said that, but we haven't seen it. Like, where -- is there a math problem? Like, what -- what is the error?

They -- it was a very vague statement, clearly meant to, you know, provide some justification. But we've not seen what those errors are.

And, you know, according to the -- the COPE retraction guidelines, you need to be able to say, This -- Here's the problem. Here's the -- here's something that was erroneous. Here's, you know, and they've never -- they've never done that.

Q Do you think it's important to be transparent about funding sources in journal articles?

88

A I -- I do think that funding sources should be considered.

Again, the articles that were retracted that we're referencing did note that we -- most of us were affiliated with Charlotte Lozier Institute, so it doesn't take too much research to discover that that was a pro-life funding source.

And, again, on the other side, we see a lot of funding that comes from pro-abortion sources.

So it's important to know, but it doesn't necessarily mean that the conclusions of that paper are erroneous just because they were funded by someone who had a -- a particular bias on the issue as long as the research was done well.

Q Okay. And I'll just remind you to just, like, answer the specific question that I'm asking, because I think we can all get out of here a lot faster if that's the case.

So I was just asking -- I'm asking about kind of general propositions for, you know, the integrity of journals or academic articles. I'm not asking you about these papers specifically that were retracted.

Do you think it's important to be

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

89

transparent about data sources --
A Yes.
Q -- in academic articles?
A Yes.
Q Okay. So it looks like on your CV you have four articles, if I have counted right, in the journal issues in "Law and Medicine."
Is that right?
A That may be right. I -- I don't recall exactly, but. . .
Q You have articles pub- -- let's not worry about the numbers, but you do have articles that are published in issues in Law and Medicine, right?
A Yes.
Q Okay. And that's published by an AAPLOG-affiliated institute, right?
A It used to be. It's currently being published by the Alliance For Hippocratic Medicine.
Q Does the Alliance For Hippocratic Medicine oppose abortion?
A It's Hippocratic. It does not end human life through abortion, yes.
Q You also published an article in

90

Linacre -- I don't know if I'm saying that right -- Linacre Quarterly; is that right?
A Yes.
Q That's the journal of the Catholic Medical Association, right?
A Yes.
Q And the Catholic Medical Association also oppose -- opposes abortion; is that correct?
A Yes.
Q You also say on your CV that you're a reviewer for several journals.
Aside from the issues in Law and Medicine and Linacre Quarterly, are any of these journals affiliated with organizations that oppose abortion?
A Not that I'm aware of.
Q What does it mean for a journal to be "indexed," Dr. Skop?
A To be PubMed-indexed or just indexed?
Q Let's start with PubMed-indexed.
A Well, it means that if someone's doing a PubMed search, that it would lead to results that are published in that journal.
Q And what about "indexed" more broadly, what does that mean?

91

A I'm not really familiar with that broad term. My assumption means it's indexed in some search engine.
Q Okay. And is PubMed-indexing an indication of the journal's credibility?
A Not necessarily.
Q Is it -- could it be one indication of the journal's credibility?
A There are plenty of articles that are not Pub- -- PubMed-indexed that are credible. So I -- I -- I can't say that, you know, you can make a conclusion one way or the other.
Q One of the journals that you're a peer reviewer for is Cureus -- is that how you say that?
A Yes.
Q And Cureus is no longer indexed; is that correct?
A To tell you the truth, I'm not familiar with -- with that.
Q Okay. Give me one second okay.
Okay. Can -- is my screen still sharing? Can you see this article that says "Retraction Watch"?
(Attorney Humphreville shared Exhibit 2 on

92

the screen.)
A Yes, I can see that.
Q Okay. And this says that, "The embattled journal Cureus has been delisted from Web of, Science, loses impact factor"; is that right?
A That's what it says, yes.
Q And it says that Cureus -- I'll just highlight just to help follow along -- "Cureus has retracted about 125 papers since. . .late 2022"; is that right?
A That's what it says, yes.
Q And it also says, "that it has" -- repeated -- "had to repeatedly retract plagiarized articles"; is that right?
A That's what it says.
ATTORNEY HUMPHREVILLE: And I'll -- I'll mark this as -- I think this is Exhibit 2, by the way.
(Skop Exhibit 2, Retraction Watch article, marked for identification.)
Q Does this change anything about your opinion of Cureus?
A You know, it's -- it's hard to know based on that very short article what that says about Cureus.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

93

I mean, obviously nobody wants to have retracted articles. But as I've experienced personally, sometimes retractions are independent of the quality.

So I don't know the reasons for those retractions or the reasons for losing its indexing.

ATTORNEY HUMPHREVILLE: And I'll just note that I also put that document, which is Tab F, in the chat.

Q Your CV also says that you have experience as an expert witness; is that right?

A Yes. I believe I've listed a number of cases there that I've participated in.

ATTORNEY HUMPHREVILLE: Let me just pull -- pull up that list again. Give me one second.

Q So it looks like the last expert report listed here is in April 2026 in Wyoming.

Have you done any -- are there any cases not listed here or since April 2026 where you've provided expert testimony?

A I see that I have not updated it with the Ohio Report, but that's the only other one.

Q All right. And you -- you also note that

94

you've provided legislative testimony here; is that right?

A Here -- yes, I've listed some cases where I've provided legislative testimony.

Q Okay. And let me find. . .

So here it says that you provided "Ohio written legislative testimony" related to "SB 260."

That's the telemedicine law at issue in this case; is that right?

A Yeah -- I apologize that I did not review the previous work that I did for Ohio. So I would be relying upon your understanding of what the -- that work was.

Q I guess my question is, did you provide legislative testimony related to the telemedicine ban at issue in this case?

A It appears that the title of that, "An act to amend. . .and enact" -- I guess that must be some limitations regarding abortion-inducing drugs.

That appears to be the case based upon the title.

Q So you did provide legislative testimony in Ohio; is that right?

95

A That appears to be the case, yes.

ATTORNEY HUMPHREVILLE: All right. Ms. Narog, we'd like a copy of that legislative testimony.

Attorney NAROG: Okay.

Q Do you recall how you ended up providing legislative testimony in Ohio?

A I do not recall how I got involved in that in 2022.

Q And do you recall the nature of your testimony?

A No. Other than what's written here.

Q Okay. In each of these instances for both legislative and expert witness testimony, did you testify in support of laws that restricted or banned abortion?

A I believe that these were all related to abortion limitations, yes.

Q And you testified in support of those limitations?

A Well, if I could explain a little bit about -- my testimony was generally not support or oppose because that's -- that's a lobbyist position. And I -- I work for a 501(c)(3), so I can- -- cannot lobby.

96

So what the testimony would generally entail is, this law requires this limitation. And as a clinical and research expert, here's the reasons that that is reasonable to have that limitation in order to protect the health and safety for women.

So it's a little more subtle, perhaps, but it wasn't a pro or con. It was, here's why the law can be medically justified.

Q And in each situation, you found that the abortion restriction was medically justified?

A Yes.

Q Okay. And you were also an expert witness in a -- I'll withdraw that.

Okay. I'm going to shift now away from your CV. And I'd like to talk about kind of some general medical terminology.

So in your report you say -- you define "complication" as an "unanticipated problem that arises following, and as a result of, a procedure"; is that right.

A Yes, I used that definition.

Q And you cite "rxlist.com" for this definition.

What is that website?

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

97

A It was just a place I found the definition. Again, you can find different definitions at different sites.
But I -- I liked that definition because I thought it was demonstrative of the point I was making in that when women suffer retained tissue, this should be considered a complication, because they did not anticipate that was going to happen.
Q And did you search for other definitions?
A I probably did.
Q And did you -- do you agree there are other possible definitions of "complication"?
A Certainly.
Q Are some complications more severe than others?
A Yes. That's one of the points I made, is that typically the abortion industry only counts what are called "severe adverse events," SAEs. And those are events that require a woman to be hospitalized or perhaps die.
And obviously those are important, but the point I made is there's other important events we should be considering.
Q So -- just so I catch what you're saying, would you -- would you use the term "severe

98

adverse event" for a more serious complication?
A Yes.
Q Okay.
A That's an FDA term, yes.
Q You just referenced -- and you've already said a couple of times -- you've used the term "the abortion industry."
How would you define "the abortion industry"?
A Well, I think that's kind of a shorthand for -- Planned Parenthood, of course, is a leader in that. But there are a number of research institutions that have made it very clear that their goal is to remove all limitations on abortion.
So not -- obviously not in -- very little desire to protect women. So that would be organizations like Advancing New Standards in Reproductive Health. That would be the Guttmacher Institute. There -- there are quite a few. But they -- they work in lock step. It seems as if they do communicate with each other.
I would include the leadership of ACOG as part of that industry, which, as I told you, I'm a member of ACOG. ACOG does not talk to their

99

membership about their abortion advocacy. The leadership just decides, We're going to pretend that we represent all these doctors. But they've made it clear over and over, they want no limitations on abortion.
So, I mean, obviously it's not a -- well-delineated, but it's -- it's -- it's the industry leaders who want no limitations on abortion.
Q In your view, does anyone who provide abortion, are they part of the abortion industry?
A Well, the same way that you might say that I, as a clinician, am part of the medical industry. I mean, technically, that's true.
I -- I -- I would acknowledge that probably not everyone who provides abortion is willing to provide an abortion, you know, throughout nine months of pregnancy. But there are people who are advocating for that.
So, you know, there may be differences of opinion within the industry, but primarily the goal is what we're discussing today and why this lawsuit exists: They don't want any limitations.
Q Would you say that anyone who advocates for abortion access is part of the abortion

100

industry?
A No, not necessarily.
Q Do you think that any studies put out by what you call "the abortion industry" are going to have biased data?
A The data is what the data is.
So if it's -- if it's reported accurately, it's -- it's an -- an objective measurement. But it certainly is the case that researchers on both sides can use their own personal bias to interpret the data.
That's why peer-reviewed literature is so important, that we see, for example, many studies have large numbers of women lost to follow-up, 30 percent, 50 percent, 70 percent.
So when a study is well done, you can look at it and you can say, I'm -- I'm concerned about the conclusions drawn by this study because they had 70 percent of the women lost to follow-up. How can we know anything with certainty?
So that was a long answer, but. . .
Q Do you think any studies by what you call "the abortion industry" are not going to be reliable, then?
A What I do with every study is I look

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

101

specifically at the study. I don't assume that because it was, you know, published by Guttmacher that it's necessarily unreliable.
And, in fact, I've quoted Guttmacher information many times because sometimes they're the only one who really knows how many abortions are occurring, what are the reasons women are having abortions, because they're in the clinics.
So it's not the case that I would disregard out of hand every abortion industry study, but I look at them critically to discover if the conclusions they come to are warranted based on the information in the -- in the study.
Q Okay. I'd like to turn back to our discussion of complications. And you said the FDA defines "serious adverse event." And I think they define it as something that results in death, substantial risk of dying, hospitalization or disability or substantial disruption of a person's ability to conduct normal life functions.
Do you agree with that definition?
A I'm aware of that definition. I think that -- based on what you just read, I'm not sure that transfusion would fall in there. Maybe it does.

102

But, you know, kind of as shorthand, I consider it something that is severe enough that results in hospitalization.
Q Do you agree that a side effect is different from a complication?
A Yes, I do.
Q And not all side effects are bad; is that right?
A Technically. Yeah, I mean, I think we tend to think of a side effect as something undesirable. But a side effect is predictable. So, again, with misoprostol, if a woman has GI side effects, we anticipate that's going to happen. That's not a complication.
Complication, as we've mentioned is -- is unanticipated. We didn't think it was going to happen, like the retained tissue.
Q So, I guess, let's say I take, you know, Benadryl, and I'm taking it for my allergies, but I'm also taking it at night and it, you know, puts me right to sleep.
Would that -- and that's something that I want. I want it to help me sleep or I -- I'm pleased with the side effect.
Would you say that's, for me, a positive

103

side effect?
A Yes.
Q But if I were operating heavy machinery, that might be a negative side effect that it's making me drowsy, right?
A That is true.
Q Okay. If you were conducting some sort of research, would it be important to clearly define "complication"?
A Absolutely.
Q Why?
A So that we can -- well, between studies, we can compare apples to apples, you know? So if -- if some researchers only consider an SAE to be a complication, and then other researchers consider lesser unanticipated effects to be complications, then you're right.
If one -- if one study says 10 percent complications, the other one says 1 percent, but if they have different definitions, then I think we can see that that's problematic and they can't be compared.
Q If a patient has -- let's just call it X treatment and then goes to the emergency room.
Would you say that the emergency room

104

visit in itself is a complication?
A Not necessarily. We don't know why the visit occurred.
Q Okay. And so if the person didn't receive any treatment, wasn't admitted to the hospital, that wouldn't count as a complication; is that right?
A That's nuanced.
So if women are taking mifepristone abortions unsupervised and they are not being accurately counseled about what to expect, and they go to an emergency room and utilize critical and limited emergency room resources, which we all know are very expensive, and ultimately are reassured this is normal, what you're experiencing, and are sent home without a treatment, you could argue that that's not a complication.
But I think as a society with very, very high healthcare cost, that should be a consideration when we're providing these drugs without any supervision or without any follow-up.
So depending on how the article's -- or the study's worded, it can be very reasonable to talk about the women who come in with

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

105

abortion-related concerns even if those concerns don't rise to the level of a complication.
Q So my question wasn't about abortion. Let's say --
A Mm-hmm.
Q -- to stick with the Benadryl example, you know, I take a Benadryl. I fall asleep. I, you know, wake up, and I was like, Whoa, you know, what happened last night? I took this Benadryl. I fell asleep.
And I go to the ER the next day and I say, you know, like, Doctor, I was really tired last night. Like, I don't know what was going on.
And the doctor just says, like, Look, you took a Benadryl. You were sleepy.
Would you say that I experienced a complication just because I went to the ER?
A In that specific example, no. But if one out of 20 people who take Benadryl go to the emergency room, again, that's -- that's something that we should be concerned about even if it doesn't rise to the level of complication. What's going on that all these people have these concerns and are going to the ER.
Q So it's really the specific symptoms that

106

are bringing the patient to the ER that are the complication rather than the ER visit itself?
A Sometime- -- well, again, it's -- it's nuanced. When studies are done that look at rates of ER visits after a particular exposure, many times they're not able to prove causation. But the correlation of many ER visits after a particular exposure can be clinically significant.
So, you know, again, the definition of "complication," different organizations use different definitions. But it doesn't mean that it's not worth researching and commenting on if a lot of ER visits are occurring.
Q But you wouldn't call the ER visit itself a complication, would you?
A Well, it -- again, it depends on the scenario.
If -- if we're studying abortion-related symptoms and -- and there are many ER visits, I think you could -- again, you would have to define your terms, but you could call it a complication.
Q Let's take this outside of the context of abortion.
If we were talking about anything other than abortion, would you say an ER visit is a

107

complication in itself?
A A- -- again, depending on the scenario, you could make that argument.
Q Do you think an ER visit itself is considered a serious adverse event?
A The ER visit itself doesn't tell us what the -- what the event was. So we don't know. It could be a serious adverse event.
But just documenting an ER visit without any other additional coding does not allow us to know if that's an SAE.
Q So serious adverse event and ER visit are not synonymous; is that right?
A That's correct.
Q And complication and ER visit are not synonymous; is that right?
A That's correct.
Q Okay. And do patients sometimes come to the ER and whatever they're experiencing is minor?
A Certainly.
Q Okay. And sometimes it might be something that would resolve without treatment?
A Yes.
Q And sometimes it's also something that could be treated in an outpatient setting; is that

108

right?
A Yes.
Q And going to the ER is different from being admitted to the hospital; is that right?
A That's correct.
Q All right. I have some basic questions about medication abortion. You know, bear with me. I know you're a physician, but I am not.
So there are two medications typically used in medication abortion in the United States; is that right?
A That's correct.
Q Okay. So one is mifepristone?
A Yes.
Q And the other is misoprostol?
A Yes.
Q Okay. And mifepristone is the one that's usually given to patients first as part of a medication abortion; is that right?
A Yes.
Q Okay. And what is the dosage of mifepristone for medication abortion?
A 200 milligrams.
Q Okay. And am I correct in understanding that the way it works is that it blocks

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

109

progesterone?
A That it blocks the receptors so the progesterone cannot enter the cells.
Q Okay. And what function that does blocking the progesterone receptors have as part of the abortion?
A Progesterone is critical for sustaining a pregnancy. The primary effect is that it causes a disruption of the placental attachment to the uterus, which cuts off the blood supply and kills the embryo or fetus.
Q So then after the mifepristone, the patient would take misoprostol, right?
A Yeah, generally 24 to 48 hours later.
Q And what dose would that be?
A 800 micrograms.
Q And misoprostol causes cramping; is that right?
A Well, the cramping is the symptom that occurs because of the uterine contractions. So the misoprostol causes the uterus to -- the muscle to contract.
Q Okay. So then those -- that cramping is what causes the pregnancy to be expelled; is that right?

110

A The contractions do, yes.
Q And is there bleeding in addition to the contractions and cramping?
A Yes.
Q You said that it would be typically given 24 to 48 hours later.
So the -- the bleeding and the cramping and the contractions that you talked about, those wouldn't start until the misoprostol had been taken; is that right?
A Generally not. On occasion, the process will occur just -- with just the mifepristone. So some women will start bleeding and pass tissue even before they've taken the misoprostol.
But most of the time it occurs after the misoprostol.
Q Do you know what proportion where that would happen for just mifepristone?
A It's in the single digits. Less than -- less than 10 percent, but I don't recall exactly.
Q So aside from allergic reaction to mifepristone, if a patient has complications from medication abortion, those are usually going to happen after the misoprostol; is that right?
A Typically that's the case. But, again,

111

they -- they can have a hemorrhage immediately with just the mifepristone.
Q When you say "immediately," what do you mean?
A Like, you know, within hours of taking mifepristone. Mifepristone -- you know, I mentioned that it -- it works upon the attachment, the placenta, and it also is known that it can affect the uterine blood vessels, which can predispose to hemorrhage.
So in a small percentage, a hemorrhage occurs before the misoprostol. But most of the time it occurs after.
Q And you don't discuss hemorrhage following mifepristone in your report, do you?
A I do believe that I've referenced at least one article that looked at mifepristone-induced hemorrhage looking at the pathophysiology that I just mentioned on the uterine vessels.
Q What is the name of that study?
A I believe the primary author was Miech, M-I-E-C-H.
Q Okay. I'll -- I'll come back to that one.
If you were going to provide a misoprostol-only medication abortion, what would

112

the regimen be?
A If I was going to -- well, I -- I wouldn't if it was for abortion.
But if I was going to use it, for example, for a miscarriage, it can be different regimens. I've seen anywhere from 400 to 800 micrograms.
Sometimes we'll repeat a dose within three to four hours. It can depend on the gestational age, but there are various -- various regimens that can be used.
Q Why would you do a repeat dose?
A Well, if -- if the goal is to expel the tissue and af- -- if after, for example, four hours, the tissue has not been expelled, then it may be that you need to create fresh contractions in attempts to completely empty the uterus.
Q So -- so understanding that you personally would not provide a misoprostol-only abortion, if someone else were going to, would it be the same dosages that you described?
A Yes, it would be.
Q And do you know what the timing of those doses would be?
A Like I said, I've seen ranging anywhere from three to four hours to six to eight ours. So

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

113

there are various regimens published.
ATTORNEY HUMPHREVILLE: All right. I'm going to turn back to your report, and I'm going to show you paragraph 61.
(Attorney Humphreville shared Exhibit 1 on the screen.)
Q So you say here, "The side effects of cramping, vaginal bleeding, hemorrhage, nausea, weakness, fever, chills, vomiting, headache, diarrhea, and dizziness occur in almost all women who undergo a medication abortion." And you cite an FDA website here.
ATTORNEY HUMPHREVILLE: And I'm going to go ahead and pull that FDA -- this is Footnote 67. I'm going to pull that website up. I will put this in the chat.
It's labeled as -- give me one second -- as Tab G. And I'm going to pull it up on my screen as well.
(Attorney Humphreville shared Exhibit 3 on the screen.)
ATTORNEY HUMPHREVILLE: So this is the website that you cite in Footnote 67, "Information About mifepristone For Medical Termination of Pregnancy Through Ten Weeks

114

Gestation."
And I'll mark this as exhibit -- Exhibit 3.
(Skop Exhibit 3, FDA website page entitled Information About mifepristone For Medical Termination of Pregnancy Through Ten Weeks Gestation, marked for identification.)
Q And so this is talking about the -- the FDA REMS.
It says, "The FDA Does Not Recommend Buying mifepristone Online."
It includes related information and links.
So this page doesn't say anything about complications or side effects from medication abortion, does it?
A Yeah, it looks like that was not the best reference. Probably some of these that are included under Labeling would have been a better reference.
Q Okay. And it doesn't say anything about the frequency of the side effects that you list in your report, does it?
A No. Not on this particular document.
Q Okay. And when you say "hemorrhage" in your report here -- I'll just flip back to that

115

tab so we have it in front of us -- when you say "hemorrhage" here, what do you mean by that?
A Yeah, I think that that was a bit of an imprecise usage of the term on my part. What I should have written is "heavy bleeding" because that is -- unfortunately, there's not a standard definition of hemorrhage after abortion. So it's somewhat subjective. I've seen, you know, some articles will call it 150 cc's. Some will cause it -- call it 500 cc's.
So, again, I apologize that was imprecise.
What I meant was "heavy bleeding."
Q And heavy bleeding would be an expected side effect of medication abortion; is that right?
A Yes. That's correct.
Q Okay. So not -- it's not accurate that almost all women would experience hemorrhage as a result of medication abortion?
A That -- that is correct. That was erroneous use of the word in this case.
Q Okay. Some of the other complications that you mention in your report, you mention -- you mention infection, right?
A Yes.
Q And in severe cases, infection can

116

progress to life-threatening sepsis; is that right?
A That's correct.
Q Okay. And infection without sepsis is not necessarily serious, right?
A If an infection occurred that required admission to the hospital for IV antibiotics, which can occur without sepsis -- sepsis would be the infection in the blood -- if it required that hospitalization, it would be categorized as an SAE.
Q Okay. But it's not necessarily serious, right?
A That's correct. It could be treated with outpatient antibiotics.
Q And it's rare for infection to occur as complication of medication abortion, right?
A It's rare, but the FDA maintains a black box warning because, on rare occasions, it can present in an atypical way that can be difficult to recognize. And a number of women have died from that, Clostridium sordellii sepsis.
Q So when you say the "black box warning" for the FDA, I just want to check on this.
You're not an -- holding yourself as an

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

117

expert in FDA regulation, are you?
A No. I just can read the FDA label, and they do have a boxed warning about that.
Q Okay. And would the in- -- injunction in this case do anything to change any FDA labeling, any FDA reporting requirements, any FDA regulation of medication abortion?
ATTORNEY NAROG: Objection.
Calls for a legal conclusion.
Q You can answer that.
A I'm -- I'm not exactly sure if I know what you're asking.
So you're saying, if these laws were removed, would this affect the way the FDA labels the drug?
Q Does -- do the Ohio laws at issue in this case affect the FDA's regulation of medication abortion?
A Right. It doesn't go that direction. The -- Ohio's not able to change what the FDA does.
Q Okay.
A But to some extent, these laws are asking that the drugs be used as the FDA has previously recommended.

118

Q Returning to the infection piece, sepsis is rare as a medication abortion complication; is that right?
A Yes.
Q You also mentioned -- I'm sure I'm going to butcher this name, so please correct me -- Clostridium sordellii; is that right?
A That's good. That was good.
Q Yes.
And that's also rare as a complication of medication abortion, right?
A That's correct.
Q More rare than sepsis?
A Right. So that's a specific type organism involved in sepsis. So, yes, there could be other types of organisms causing sepsis.
Q So more rare than sepsis?
A Right. Right.
Q Okay. And no causal relationship has been established between Clostridium sordellii and medication abortion, correct?
A It depends on how you define "causality." I think that if you use the Bradford Hill criteria, you can make an argument for it.
But I -- I am aware that the FDA has

119

nuanced that discussion by saying we've seen other cases outside of mifepristone use where this has occurred.
So I think that it's accurate to say that that has not been definitively proven to be causal.
Q Okay. And no study that you cite in your report says that there's a causal relationship; is that right?
A That's correct. There -- there are studies that indicate the -- the drugs do impair a woman's immune system, so that -- that concern is there. But you're right, the causality has not been proven.
Q Okay. You also mention retained pregnancy tissue as a potential outcome of medication abortion.
Is that sometimes also referred to as "incomplete abortion"?
A It -- yes, it can be.
Q Incomplete abortion is not an emergency in all situations, right?
A Not in all, but in some.
Q A patient who has a miscarriage can also -- where it's -- where the miscarriage has

120

been treated with medication management, that miscarriage patient could also experience retained products of conception, right?
A Yes.
Q And you could treat retained products of conception for abortion with aspiration; is that right?
A That's typically how it's treated, yes.
Q And also with additional doses of misoprostol?
A Sometimes additional misoprostol will help. Not always.
Q And "continuing pregnancy" is when an abortion fails to end the pregnancy; is that right?
A "Continuing pregnancy" is usually defined as the embryo or the fetus is still alive. And so without a further intervention, this pregnancy can proceed to a live birth.
Q So the -- the medications have -- in the case of medication abortion, is when they have failed to end the pregnancy, right?
A They failed to kill the baby, yes.
Q You would agree, right, that early medication abortion likely does not carry more

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

121

physical risk than childbirth; is that right?
A I would agree it does not carry more physical risk. I would allege that it does carry more mental health risk.
Q I'm going to shift back. When we were talking about your critiques of abortion industry studies, one of the things I think that you mentioned is "loss to follow-up."
And most of the -- the studies generally that you're critiquing in your report based on loss to follow-up, those are called cohort studies, right?
A Yes. They'll identify who they've sold abortions to, and then that cohort, they'll look to see what the outcomes have been, yes. Usually --
(Crosstalk)
A -- retrospective. So they're -- they're looking back on the charts after the abortion has occurred.
Q And they're tracking that group over time; is that right?
A Yes. Yes. That's correct.
Q Okay. Have you ever conducted a cohort study?

122

A No. I -- I don't perform that type of research.
Q Have you ever applied statistical methods to address issues with loss to follow-up?
A Not personally, I've not written that type of a study.
Q Do you have any training or experience that informs your opinion about loss to follow-up that we haven't already discussed?
A Well, the experience is in analyzing peer-reviewed literature, which, as I mentioned, I have not had formal training, but I've had on-the-ground training and -- and -- and worked with others who have had formal training.
So that -- that is the basis of my experience.
Q But you haven't had any statistical training, right?
A That's correct.
Q Some loss to follow-up is expected in cohort studies; is that right?
A That's correct. But abortion studies tend to have extremely high loss to follow-up compared to other -- other studies.
Q You stated that the research that you

123

conduct at Charlotte Lozier is largely about abortion, right?
A Yes. That's safe to say.
Q And have you looked at loss to follow-up rates across different sectors of the medical industry in -- in cohort studies?
A I have not specifically done that, no.
Q You imply in your report that patients lost to follow-up in medication abortion studies have disproportionate levels of complications. So I'll just scroll here to paragraph 87 as an example. One second.
And -- so here you say, you know, patients lost to follow-up in this study may have had ectopic pregnancies elsewhere.
And you're -- you don't cite any research or other sources to support the suggestion that patients lost to follow-up would have higher rates of complications, right?
A I can tell you this statement is based on my clinical experience. I've cared for many women in the emergency room who have had abortion complications, including ectopic pregnancies, and have been told anecdotally, They told me this was safer than Tylenol. I'm not going back to that

124

provider.
So they explained to me why they came to me instead of back to Planned Parenthood.
And I can also tell you based on my experience, when I call Planned Parenthood to tell them about a complication, many times they refuse to talk to me or to obtain that information.
So I -- again, I don't know any more than the abortion industry does whether the loss to follow-up is less likely, equally likely or more likely to have had a complication. None of us know the answer to that question.
But, again, based on my experience, I think it's plausible that they're more likely to have had a complication but just failed to go back to the abortion provider who told them the -- the procedure was safe.
Q So my question was that your report doesn't cite any research or sources to -- to say that patients loss to follow-up have higher rates of complications, right?
A Right. Yeah, we -- we don't know the answer to that question. But we cannot assume, as the abortion industry has done, that that means that they probably had fewer complications.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

125

Q And if you were aware of a source that said that patients lost to follow-up have higher rates of complications, you would have cited it in your report, right?
A Listen to what you're saying, though. How do we know? Like, if they're lost to follow-up we don't, right? So -- so there -- there can't be a peer-reviewed study that says, Oh, this proves that they're more likely to have complications, because we don't know what happened to them by definition. So it's just -- it's a black box for all of us. But it's problematic when there is a large number -- again, I just read a study where 70 percent were lost to follow-up. How does that get published? That's trash. You can't make any conclusions based on 70 percent lost to follow-up.
Q What study are you referring to?
A I -- I could look it up for you. It was -- it was regarding second trimester -- I believe, second trimester medication abortions.
Q What was the name of the author of that? Do you --
A I -- I don't recall. I just remember being so impressed that they were willing to

126

publish what obviously cannot -- conclusions cannot be drawn from.
ATTORNEY HUMPHREVILLE: Okay. We'll -- we'll request a copy of that and follow up.
Q My question, though, was that if you did know of a source that said people lost to follow-up experience higher complications, you would have cited that in your report, right?
A Yeah. If I knew of it, I would have, yes.
Q So you're not aware of a source that says that?
A That's correct.
Q Okay. And a patient lost to follow-up can also experience no complications, right?
A Certainly.
Q Are there established ways that researchers address issues -- sorry, let me rephrase that.
Researchers have established ways to address issues due to loss to follow-up, right?
A There are some proposed ways to do that. One's called multiple imputation. Another one assumes -- let's assume -- let's create a -- sort of a window of possible outcomes. Again, I'm not a statistician. I don't

127

know if there's science behind those or if that's just a science-y way of saying, We took this into account without data to back up the validity of those techniques. I don't know the answer to that.
Q Okay. So you're not trained in multiple imputation?
A No. I can barely say it. No.
Q And you're not trained in other methods related to loss to follow-up, right?
A That -- that's correct. I don't -- I don't have specific knowledge.
ATTORNEY HUMPHREVILLE: Okay. I'm going to pull up one of the studies that you cite in your report related to loss to follow-up.
I'll put this in the chat. This is Tab N, which is the 2024 Upadhyay article you cite in paragraph 45 of your report.
(Skop Exhibit 4, Upadhyay 2024 article entitled Effectiveness and safety of telehealth medication abortion in the USA, marked for identification.)
(Attorney Humphreville shared Exhibit 4 on the screen.)
Q And you note that 26 percent of patients

128

were lost to follow-up in this study?
So is this the Upadhyay article that you cite in your -- I mean, I know you cite multiple Upadhyay articles in your report, but this -- is this the 2024 study related to telemedicine abortion?
A Yes. This is the CHAT study that I referenced.
Q So I'm going to turn to the third page here. It's the third page of the PDF and page 1193 on the -- and I'll -- I'll zoom in further and I'll -- so if we look to the last paragraph here. I'm just going to highlight it.
So it says -- let's see. It says -- sorry -- I'm going to try to highlight it. Well, I'm -- okay.
Well, it says, "In the fourth sensitivity analysis" -- do you need me to scroll in further? Would that be helpful to blow it up a little bit more?
A No, no. I can read it.
Q Okay. "In the fourth sensitivity analysis, we conducted delta-adjusted pattern-mixture modeling to examine the potential impact of loss to follow-up on" -- the reserve --

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

129

"on the observed results."
Do you know what "delta-adjusted pattern-mixture modeling" is?
A No. This is all Greek to me.
Q Okay. And so then continuing here, it then says, "Across a range of delta values, we found the results were largely consistent with the main analysis. Under an extreme scenario in which those outcomes had" -- "unknown outcomes had ten times the odds of an incomplete abortion or serious adverse event, effectiveness for the entire sample would be 93.3%. . .and safety would be 98.9%. . ."
I'm, you know, skipping over the confidence interval brackets just so we can speak English a little bit.
And it says, "Under the opposite and also extreme scenario in which those unknown outcomes had ten times lower odds of an incomplete abortion, the effectiveness would be 98.2%. . .and the safety would be 99.7%. . .with no significant differences in effectiveness and safety between the synchronous and asynchronous groups."
Did I read that right?
A Yes, you did.

130

Q Okay. So this study calculated safety rates for abortions with known outcomes, right?
A That's correct.
Q And also effectiveness rates for abortions with known outcomes, right?
A With known outcomes? Yes, based on their definitions.
Q Okay. And it says that it applied a sensitivity analysis, right?
A That's correct.
Q Okay. And do you know what a "sensitivity analysis" is?
A Only as she's described here, in which she's setting her parameters to say the extremes would be ten times more complications, ten times less complications.
But it -- I don't even know what she's basing that on, that, you know -- how do we know they weren't 15 times, 20 times?
I mean, it sounds like she's -- she's accounting for the loss to follow-up, but I -- I just don't know the validity of what she's -- the -- the numbers that she's chosen.
Also, if I -- if I may, this particular study did not even see the patients in person. It

131

did not do an ultrasound. All it did was send them a text message, an e-mail or a phone call. And even then, one out of four women could not be bothered to respond.
So, you know, it's just a -- I think the point I'm trying to make in this report is that there's just a lot of unknowns in abortion industry papers.
And, you know, they -- and it -- it goes back to the -- the -- the point that they don't require follow-up, that they don't want to see these women after they've had the abortions to make sure they've done okay.
Q Okay. So --
A They think it's apparently okay to just text them and find out what happened to them. I mean, that's a very unscientific way to do follow-up, if you ask me.
Q My question here is about sensitivity analysis.
You haven't conducted a sensitivity analysis before, right?
A That's correct. I have not trained to do these techniques.
(Crosstalk)

132

A Upadhyay did so, you know, she says she's accounted for it. But I -- I still have concerns about the loss to follow-up.
(Crosstalk)
Q Okay. And you don't know what the steps would be to conduct a sensitivity analysis, right?
A No, I don't.
Q And you don't have training in conducting a sensitivity analysis?
A That's correct.
Q Okay. So they conduct -- they did conduct a sensitivity analysis regarding safety rates, though, right?
A Yes. As described.
Q Okay. And so if we look at this heading here where it says, "Safety" -- sorry. There's something slightly weird happening with my technology.
So it says, "Overall, the rate of abortions that were not followed" -- oh, God. God. This is doing the opposite of what I want it to be doing.
Okay. So "Overall, the rate of abortions that was not followed by serious adverse events was 99.7%. . .in the complete case analysis and

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

133

99.8%. . .in the final imputed model."
Did I read that right?
A Yes.
Q Okay. So it found that, applying the statistical analysis, just 0.2 percent of telemedicine abortion patients experience a serious adverse event; is that right?
A That's what they've reported, yes.
Q Okay. And then I'm going to go up to the second page here under "Effectiveness." And it says, Overall, results from the complete case analysis and the imputed models found that 97.7%. . .of abortions were complete with a subsequent known intervention or ongoing pregnancy after the initial treatment.
So 97.7 percent effective applying the statistical analysis, right?
A Yes. That's what they report.
Q And the research didn't just assume that all of the lost to follow-up patients had uncomplicated abortions; is that right?
A That's -- that's correct.
Q Okay. So one of the answers that you offer to -- sorry. I'm going to try to stop sharing my screen, if I can figure out how to do

134

that.
Okay. So one of the --
ATTORNEY HUMPHREVILLE: Actually, you know what? We've been going, I think, for about an hour and a half. So it might be a good time for a break.
Is ten minutes okay?
THE WITNESS: Sure.
ATTORNEY HUMPHREVILLE: Okay.
THE WITNESS: It should work.
THE VIDEOGRAPHER: We're going off the record at 12:06.
(A recess was from 12:06 p.m. to 12:17 p.m.)
THE VIDEOGRAPHER: We are back on the record at 12:17.
BY ATTORNEY HUMPHREVILLE:
Q Okay. So when we left off, Dr. Skop, we were talking about loss to follow-up issues.
And one suggestion you offered to get around loss to follow-up issues is record linkage studies; is that right?
A Yes.
Q And those might show a correlation but not necessarily causation; is that right?
A That's correct.

135

Q Okay. And you say in your report that the -- some of the records linkage studies only rely on abortion-related diagnostic codes, but you think they should be looking at all pregnancy-related codes documenting complications; is that right?
A Because they're specifically in a short time interval after we know an abortion occurred, and because we know that frequently miscoding occurs in which doctors think that a woman's had a miscarriage when, in fact, she's had an abortion. That was the reason for that recommendation, that any -- any regnancy-related event that occurs in that short time period, 30 days or six weeks, would be related to the abortion because we know the abortion occurred.
Q Okay. So just to -- just to take these things one by one, because I'm not, you know, having to document things in the hospital like you are.
So when you say "abortion-related diagnostic codes," can you -- you know, we don't have to get into the specifics of what those codes are, but just, like, at a high level, like, what do you mean by "abortion-related diagnostic

136

codes"?
A Yeah. So the ICD-10 has, I believe -- it has 27 codes that say "induced abortion complicated by infection" or "induced abortion complicated by hemorrhage." So specific to induced abortion. So, again, in some of the studies they only look for those codes.
But the point I was making is that if it is miscoded, as we know happens frequently, for example, if the -- if it was coded as "infection related to miscarriage" researchers would not be looking for that code. But if it was preceded by an abortion, it would definitely be an abortion-related complication.
But the coding can be misleading when it's incorrect.
Q Okay. So let's -- let's dive into, then, some of the studies that you critique. And I'll go with another one of the Upadhyay studies.
So this is -- I'll pull up her 2015 study, and you cite this in paragraph 25 of your report. So I put that in the chat. And I will pull it up and share on my screen.
(Attorney Humphreville shared Exhibit 5 on the screen.)

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

137

Q Okay. And this says, "Incidence of Emergency Room Department Visits and Complications After Abortion."

Is this one of the studies that you cite in your report?

A Yes, it is.

ATTORNEY HUMPHREVILLE: Okay. And I'll -- I'll mark this as Exhibit 4 [sic.].

(Skop Exhibit 5, Upadhyay 2015 study entitled Incidence of Emergency Room Department Visits and Complications After Abortion, marked for identification.)

Q Have you read this study?

A Yes, I have.

Q How many times would you say you've read it?

A Probably a dozen.

Q When was the most recent time?

A I believe it was in June.

Q Okay. So I'm going to kind of try to drill down on some of these coding issues that you're talking about. So I'm going to go to the fourth page of the PDF, and this is page 178 of the study.

So I'm going to start reading the last

138

sentence here where it says, "An ED visit was classified as abortion-related based on the constellation of ICD-9 and Healthcare Common Procedure Coding System or CPT procedure codes used for that visit."

Did I read that right?

A Yes.

Q Okay. And so I know you mentioned ICD-10 before, but ICD-9 codes are about patient diagnoses, right?

A Yeah. That -- this is a 2015 paper. That was the system that was in place at that time.

Q Oh, okay. Thank you for --

A So they updated, I believe, in 2016.

Q Okay. And so you note in your report that they rely on the ICD-9 codes, right?

A Correct.

Q And -- and then the -- do I have it right that the Healthcare Common Procedure Coding System -- is that the same as CPT codes or are those two different things?

A I believe that that one is specific for -- these are more specific for procedures.

Q Okay.

A So ICD would be like a diagnosis. HCPCS or CPT would be a procedure like a D&C.

139

Q Okay. So it's describing the treatment --

A Mm-hmm.

Q -- rather than the diagnosis; is that right?

A Exactly.

Q Okay. So this is saying that the researchers also relied on basically the treatment codes, right?

A That is correct.

Q Okay. So they didn't just rely on the diagnosis codes; is that right?

A That's correct.

Q And then I'm going to go down to the last paragraph in the same column. And I'll start the second sentence, "We defined a complication as any postabortion adverse event that received an abortion-related diagnosis or treatment at any source of care, including EDs and the original abortion facility within 6 weeks of the abortion procedure."

So this is also saying that it relied on the diagnosis -- that it relied on the diagnosis.

So that's the ICD-9 code part, right?

A Correct.

140

Q And so when it says "or treatment," then that's the part that's referring to the -- the CPT code or the -- is it HCPCS code?

A Yes.

Q Okay. So they're saying that they relied on the CPT codes in addition to the ICD-9 codes, right?

A That's correct.

Q Okay. And they're looking at treatments in the ER, right?

A That's correct.

Q And also at the original abortion provider?

A Yes. They do discuss that as well.

Q Okay. And so, then, this is going to be a little bit wordy, but -- and I'm going to skip the specific codes that they mentioned just -- so it says, "To identify complications, the clinically trained reviewers evaluated all: 1) abortion-related diagnoses and treatments identified through the ED visit analysis previously described, (excluding visits having no pathological diagnosis or treatment); 2) ICD-9 codes that indicate abortion-related complications. . .and Healthcare Common Procedure

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

141

Coding System or CPT codes for laparoscopy, laparotomy, and hysterectomy surgeries. . .blood transfusion. . .and antibiotics commonly used to treat abortion-related infections and sepsis, at least 1 day after the abortion; and 3) subsequent medication abortions and aspirations within 6 weeks."

Did I read that right?

A That's correct.

Q So, again, it's saying they looked at the ICD-9 codes, which you mentioned in your reports, right?

A Yes.

Q And also the CPT codes, right?

A That's correct.

Q And the HCPCS codes too, right?

A Yes.

Q And subsequent medication abortions, right?

A Yes.

Q And subsequent aspirations, right?

A Yes.

Q So they didn't just rely on the ICD-9 codes, right?

A That's correct.

142

Q Okay.

A They -- they only relied on ICD-9 codes specific for abortion, but they did actually look at the procedure codes as well.

Q Okay. So then I'm going to look at the -- scroll down to the next page and look at the first full sentence.

So it says, "To produce the most conservative estimate, we included undetermined diagnoses in the overall complications estimate."

Did I read that right?

A Yes.

Q So they're erring on the side of including complications, right?

A I'm not sure that I understand what they mean there. But I don't -- I don't remember if there's more discussion about what they meant by "undetermined diagnoses."

Q Okay. So I'm going to then shift to some other studies that you cite in your report.

So you say that some studies -- some record linkage studies that you coauthored with James Studnicki -- did I say his name right?

A Yes.

Q Okay. That those are more reliable than

143

Dr. Upadhyay's studies, for example; is that right?

A Again, there's -- there's limitations that hopefully I discussed. I'm sure we discussed it in the papers.

But it was more expansive because it did not necessarily limit to only those -- those 20 -- well, I forgot how many there were at ICD-9, but that limited number of codes related to induced abortion.

Q Okay. So I'm going to -- I'm going to walk through, I think, the three records linkage studies from you and -- is it Dr. Studnicki?

A Yes.

Q Okay. You and Dr. Studnicki. So this is going to be -- I'll pull up Tab P, which I put in the chat. This is the 2021 article that you cite in paragraph 28 of your report. And it's called "A Longitudinal Cohort Study of Emergency Room Utilization Following mifepristone Chemical and Surgical Abortions, 1999 to 2015."

This is one of your studies that was retracted, right?

A Yes.

(Attorney Humphreville shared Exhibit 6 on

144

the screen.)

ATTORNEY HUMPHREVILLE: And I'll mark this as -- this will be Exhibit 5 [sic.], by the way.

(Skop Exhibit 6, Studnicki study entitled A Longitudinal Cohort Study of Emergency Room Utilization Following mifepristone Chemical and Surgical Abortions, 1999–2015, marked for identification.)

Q And are all of the coauthors on here affiliated with the Charlotte Lozier Institute?

A This was a research group that was put together by Charlotte Lozier. They're not all employees of Charlotte Lozier.

Q But are they affiliated with Charlotte Lozier?

A For the purpose of this research group, yes.

Q Okay. And was this study funded by the Lozier Institute too?

A Yes, it was.

Q Okay. And so this study looks at emergency room visits following abortion, right?

A Yes.

Q And it says that ER visits are a proxy

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

145

indicator for abortion-related morbidity; is that right?
A That's what we stated in this study.
Q Okay. And what does "proxy indicator" mean in this context?
A Well, it -- there's -- there's -- there's a number we'd like to know. We'd really like to know how many complications. But because of multiple data deficiencies that -- some we've discussed today and many I've discussed in more detail in the expert report, primarily that there's no requirement that complications be reported on a federal level, so the abortionists don't report their complications.
But for many reasons, we can't know the number of complications. But if we -- we can measure the number of ER visits.
And so if we see that there's a tremendous number of ER visits, that can lead us to the possible conclusion that maybe there's something going on after medication abortion that is leading to a large number of ER visits.
We looked at two types. We looked at all ER visits, which, of course, could be an auto accident. So that's not specific to the abortion.

146

But we also specifically looked at codes that were plausibly related to the abortion, like vaginal bleeding, et cetera.
So we looked at both and analyzed both. But as -- as a -- if there's a lot of ER visits, maybe there's a lot of complications. So that was kind of the -- the discussion.
Q Okay. So just -- just so I understand, how would you define "proxy indicator"?
A If we are looking for a result that we cannot measure accurately, which is the -- really, the number of complications, we might be able to get an idea of whether this is a very frequent or infrequent result by looking at another event that we can measure accurately, and that's the number of ER visits.
Q Okay. So it doesn't necessarily say anything about causation, right?
A That's correct.
Q Okay. And -- and as you said, it also includes ER visits that are unrelated to the abortion, right?
A Yes. So we -- again, we measure two types. We measured --
Q Yeah.

147

A -- all comers and then we also looked specifically at the ones that had codes that made us think they were plausibly related to the abortion.
Q Okay. What method do you use to determine if something is a proxy indicator?
A Well, again, it's -- it's -- it's common sense. We'd like to know this, but we can't measure this.
So what -- I mean, I think all of us recognize that people don't go to an emergency room just randomly. They go to an emergency room because they have a concern.
And so this was a way of saying there's a lot of women that have concerns, that have actual, legitimate medical concerns after taking these drugs.
And so the -- the ER visits -- particularly the ER visits that were abortion-related give us an idea about how often are women having significant concerns with these drugs.
Q I guess as a -- as a general matter, is there a -- a scien- -- not specific to this study, but is there a scientific method on how to

148

determine if something is a proxy indicator for something else?
A I'm not aware of the specifics of that. I think it's just common sense, you know, that ER visits do indicate significant concerns.
Q Okay.
A But I -- I don't know the -- the statistical method for determining -- if there is one. I'm not -- not aware.
ATTORNEY HUMPHREVILLE: Okay. I'm going to stop sharing this for a second.
I'm going to pull up the 2024 study, and I'm putting it in the chat as Tab Q, that you did with Dr. Studnicki. I'll share my screen again.
(Attorney Humphreville shared Exhibit 7 on the screen.)
Q So this says, "Comparative Acuity of Emergency Room Department Visits Following Pregnancy Outcomes Among Medicaid Eligible Women, 2004 to 2015."
Is this the article that you coauthored with Dr. Studnicki in 2024?
A Yes, it is.
Q And that you cite in your report?

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

149

A I believe so, yes.
ATTORNEY HUMPHREVILLE: All right. And I'm going to mark this as Exhibit 6 [sic.].
(Skop Exhibit 7, Studnicki 2024 study entitled Comparative Acuity of Emergency Department Visits Following Pregnancy Outcomes Among Medicaid Eligible Women, 2004-2015, marked for identification.)
Q This study was also retracted, right?
A No.
Q I apologize.
Are all of the coauthors of this study affiliated with the Lozier Institute?
A This was, again, the research group that Lozier put together. But as you can see, there's some other institutional affiliations as well.
Q The other -- the people who are affiliated with the other institutions, so Dr. Reardon, for example --
A Yes.
Q -- he also has an association with the Lozier Institute, though, right?
A Yes. That's correct.
Q And so even the ones who have another affiliation, they also have an affiliation with

150

the Lozier Institute, right?
A Yes.
Q Okay. And this one was also funded by the Lozier Institute, correct?
A Yes.
Q Does this one also use ER visits as a proxy for complications from abortion?
A This study specifically looked at the emergency room visits that occurred after known abortions, and it looked at the coding.
So this was an attempt to get more granular data because of the concerns you raised. Just because it's an ER visit, doesn't mean it was a substantial problem.
And so there are five different types of -- five different levels of codes that can be used in an -- in an ER. And we looked to see how many of the visits fell into either the highest or the second-highest acuity code.
So that was -- this was, I would say, a proxy for how sick were the women based upon how high was the code that the doctors caring for them used.
Q I'll get into the codes in a second.
But this -- this one also includes

151

emergency room visits that followed abortion, right, even if it --
A Yes.
Q -- wasn't related to the abortion?
A It looked at all emergency room visits, yes.
Q And it doesn't say anything about the proportion of medication abortion patients who went to the ER, does it?
A I think it's in there somewhere.
Q But is it looking at, let's say, all of the patients nationwide that had medication abortions and what percentage of patients are going to the ER?
A No. This -- this database that we looked at was specific for patients whose abortions were paid for by Medicaid. And there's only 17 states where the state will allow their Medicaid dollars to pay for abortion.
So it was -- it was not a nationwide study. It was more limited. It was in those 17 states and specific for those who had a Medicaid-paid abortion.
Q Okay. But -- but in looking at the results here, and the -- it doesn't say anything

152

about what proportion of medication abortion patients are going to the ER, does it?
A I don't recall if we specifically put that number. We had pre- -- this is the same database and the same years as our prior studies, which we had previously published the percentage of the women that were going to the ER in the prior studies.
So I -- I don't know that we specifically wrote it in this paper.
Q And when you say "the prior studies," are you referring to the 2021 study we were just talking about?
A Yeah. The 2021 and the 2022 were both based on this database.
Q Okay. I'm going to dive into what you were talking about with the codes, and I'm going to scroll to the bottom-left on page 2.
So it discusses the ICD-9 and ICT -- ICD-10 codes, which we talked about before. And then it also talks about the HCPCS codes here.
So it notes related to -- I'm going to look at the -- the second half of them because I think the first half are related to procedural abortions.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

153

So it says, "X7724, X7726, S0190 and S0191."
So those are codes that are for prescription of mifepristone and misoprostol, right?
A I don't recall specifically, but I think that is likely that that is what that's describing.
Q And it would include instances where these medications were prescribed regardless of the reason for the prescription, right?
A So these codes are all occurring after the initial abortion. So if you have -- whatever the initial abortion was, and then you subsequently see a procedural code, what that tells you is that initial abortion failed to expel all the tissue. Either there was an ongoing living pregnancy or retained tissue, and so a procedure was needed.
If you see the drugs mifepristone and misoprostol used after the initial abortion, it tells you it failed and now we're trying to resolve that failure with a repeat dose of the medications.
Q But you said before that it was important to look at not just abortion-related ICD-9 codes

154

and ICD-10 codes, right? Like, you need to look at those for pregnancy more broadly, right?
A Oh, you know what? I'm sorry. I actually just told you incorrectly.
These were the codes that we used to identify the initial abortion.
Q Okay. And so that -- these are for the prescription of it -- for medication abortion you're looking at the codes for prescription of mifepristone, right?
A That -- that's correct. So this is the codes that tells us that the woman took mifepristone and misoprostol or that she had a procedural abortion, allowing us to identify it. And then, subsequently, we looked at the -- the codes that followed that.
Q Okay. So you're using prescription of mifepristone or prescription of misoprostol to say this person had a medication abortion, right?
A That's correct.
Q Even though these codes would be used for any prescription of mifepristone and misoprostol; is that right?
A Specifically, at this time interval, up through 2015, mifepristone was not being used

155

routinely with misoprostol for miscarriage management. This has been a more recent development.
So in this time period, you can really be almost 100 percent certain that when a woman gets the two drugs together, that this is for an induced abortion.
Mifepristone is used for Cushing's syndrome, but she would -- it would not dosed with misoprostol. So the combination of the two tells you it was an induced abortion.
Q Okay. But this is looking at ones that are related to mifepristone, right? And it doesn't necessarily say if it's in combination with misoprostol, right?
A You know, I'm at a disadvantage. I can't remember exactly what those codes refer to. It's possible that the codes may tell us a combination of mif - -- mife and miso, but I -- I don't recall.
Q Okay. And so it's also possible that they don't say anything about the two drugs being used in combination, right?
A I -- I can't answer that question. I don't -- I don't really recall what the specific

156

codes refer to, but. . .
Q Okay. So it's possible but you don't know what these codes are referring to in your own research?
A Well, this article was written about three years ago. And I have not looked -- re-looked up the -- the codes since that time, so I'm a little fuzzy on it.
But it -- at the time, we felt that these reliably would indicate a medication abortion.
Q All right. And then you discussed earlier about the coding for the severity of the visit.
So in this next column here you note, for example, that "99284" is a CPT code to indicate severity, right?
A Right. The -- yeah, the -- the number at the far end is -- the higher that number, the -- the more severe. So the 4 and the 5 were severe and critical visits, both indicating that the woman was quite sick.
Q Okay. And so you don't separately define "severe" in this article, right? You're just relying on these CPT codes?
A That's -- that's what the article's about. We -- we -- we made that clear in our title, that

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

157

this is -- you know, again, there's many things that can be examined. It can get quite complicated. But in this case, we were merely looking at the presence of an abortion or miscarriage or live birth or all reproductive-age women.

So we had several categories of women that we were looking at and looking at the percentage of the ER visits that had these acuity codes, documenting that women who had medication abortion, the highest percentage had high acuity codes, following that with surgical abortion and then beyond that was the women with childbirth, miscarriage and non-pregnant.

So it was just kind of a -- it was a comparison of -- you know, depending on what the preceding event was, how likely were the women to have a -- a code indicating that they were sick.

Q Okay. And the -- this 99284 code for severe -- like, another example of something that could be classified under this code would be, like, dehydration treated with an IV fluid, right?

A It -- there -- there are, like, specific sub-parameters that -- that doctors use to determine which is an appropriate code. So it --

158

you know, average dehydration, maybe not; but severe dehydration with metabolic abnormalities perhaps would have met that criteria.

But the assumption is that the doctors knew what those -- what -- what criter- -- what needed to be met for these codes and that they were correctly coding.

Q Okay. And you -- in another article an example that you give for something that would have that code, 99284, is chest pain requiring testing, right?

A If -- if you say so. I -- I don't recall specifically that example. But that could be the case.

Q Okay. Well, I can pull that up if you'd like. So this is your 2025 article with Dr. Studnicki.

And on page 3 in the left column here, it says, "Severe visits, examples would be chest pain which require testing or admission for observation."

I'll just leave that example.

So that -- that's one example, right, chest pain require testing or an admission for observation, right?

159

A Yes. Yes, that --

Q All right.

A -- that seems plausible.

Q And so that seems plausible or what you wrote in this other article is accurate?

A No. Obviously it's what we wrote. We just read it. But that makes sense because we're dealing with a young, healthy population of women. You would not anticipate that, short of a real problem, that they'd be coming in with chest pain that would require testing.

Q Okay. And even if the testing showed nothing, they could still have a severe code, right?

A That's correct.

Q Okay.

A And we don't have -- we don't know what these showed because we're only looking at codes. We did not pull medical records for this study.

Q Okay. So you don't know what complications the patients actually experienced?

A That's correct. That would be logistically impossible for us to do, to pull all of these records. So we're -- again, we're kind of using a proxy indicator. But that doesn't mean

160

it's not important information to have.

Q Logistically impossible, but that is what Dr. Upadhyay's 2015 study did, right?

A So she has access to all Planned Parenthood's databases. You think --

Q But that --

(Crosstalk)

A -- if we called them up and said, We want to a study, can we see your records, that they'd allow them to have that.

So, yeah, she did because the industry allows her access. They don't allow us access. But we want to find out information, so we're doing the best we can with the data that we can obtain.

Q But the 2015 study we just looked at, that's relying on Medi-Cal data, right, not Planned Parenthood data; is that right?

A You know, she did talk about what happened in the clinics. If you look at the very bottom of the abstract, she said 5 percent of the women who had medication abortion had a complication if you add in the clinic charts to the ER charts. So she did have access to the clinic visits.

But I believe primarily that for the ER

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

161

component of things, she was looking at the Medi-Cal billing data.
So, again, similar to what we did. We looked at Medicaid in 17 states. In hers, she was specifically looking at Medicaid in California.
Q Right. And so she is saying here -- this is going back to the Upadhyay study -- using the abortion data for fee-for-service California Medicaid program.
So she's relying on Medi-Cal or, you know, California Medicaid data, right?
A Yes.
Q And she looked at all of what the specific complications were, right?
A That were paid for by Medicaid, yes.
Q Yeah. And so -- but you're saying it's logistically impossible to look at the specific complications, right, even though this is what --
(Crosstalk)
A No.
Q -- did?
A Well, let me nuance that. In our 2021 and two-thou- -- our 2021 study we actually did look at those codes. So -- so we have access -- we had access through the database to the coding. We

162

didn't have access to the -- the actual charts of the patient.
Now, I'd have to reread Upadhyay's study to -- you know, it may have been that she actually didn't pull charts either.
But some of the Planned Parent -- some of the studies have pulled charts. So I may be forgetting who's done what in which study.
But she was -- she was -- definitely had access to things outside of the ER because she discusses the complications that were happening in the clinics as well.
Q So you're saying you -- you would need to reread it because you're not sure, but you're definitely certain she had access to abortion charts?
ATTORNEY NAROG: Objection.
Mischaracterizes -- mischaracterizes testimony.
You can answer.
A I'm not sure that it makes that much of a difference. I think where we initially got onto this was why we only used coding data. And what I said was, we, as Charlotte Lozier Institute researchers, don't have access to the charts

163

because the abortion industry clearly would not allow us to have access to their charts because we might actually report what was actually there.
Q But the coding data can still show what complications were experienced, right?
A Yeah, within a degree of reason. So the coding data tells you what they thought was going on.
And so it -- it -- you know, if you assume that the codes are correct, then I think it -- it tells you -- and as I said in our 2021 study, we did look at the ones that we thought were reasonably abortion-related versus those that were abortion-associated but not necessarily related.
However, in this particular study, we didn't dive into that degree of granularity. We only looked at the abortion-associated ER visits, and then looked at the coding.
Q Okay. And association is not causation, right?
A That's true -- that's correct.
Q Okay. And I just want to go back to one thing you said about this 2024 study.
So you said that it was looking at live births, abortions and miscarriages. But -- from

164

what I can tell here, looking at the results, it -- it doesn't say anything about miscarriage. It says surgical abortion, live birth or a woman who was never pregnant -- or sorry, and -- and chemical abortion too.
But it doesn't say anything about miscarriage, right?
A Okay. You're -- you're -- you're correct.
Q Okay.
A We did not -- we did not have a cohort about miscarriage.
Q Okay. Okay. I'm going to turn, then, to the 2025 study. So this is "Determining the Period Prevalence of" -- "Period Prevalence and Acuity of Emergency Department Visits Following Induced Abortion Mistakenly Identified As Spontaneous Abortion: An Analytical Observational Perspective Cohort Study."
And I'll put this in the chat as well. This is Tab R -- oops, sorry.
(Attorney Humphreville shared Exhibit 8 on the screen.)
Q So this is a 2025 study that you're a coauthor of, right?
A Yes.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

165

Q And you also cite this in your report?
A Yes.
ATTORNEY HUMPHREVILLE: Okay. I'm going to mark this as -- I think this is Exhibit 7 [sic.] now.
(Skop Exhibit 8, Studnicki 2025 study entitled Period Prevalence and Acuity of Emergency Department Visits Following Induced Abortion Mistakenly Identified as Spontaneous Abortion, marked for identification.)
Q And so I think this is primarily the same researchers, all of these folks are affiliated with the Lozier Institute too?
A Yes. I -- I think there may be an additional author on this one. But, yes, it's the same study group.
Q Okay. And this one was also funded by --
ATTORNEY NAROG: Can I interrupt for one second? I just want to make sure Dr. Skop knows that the chat has all of the studies that you're talking about in case she wanted to open them and be able to review them herself.
Dr. Skop, are you able to access the chat?
THE WITNESS: I can access the chat. I --
(Crosstalk)

166

ATTORNEY NAROG: Open all the exhibits in case you want to open them on your own screen.
THE WITNESS: Yeah. Let me see. Earlier I tried to download one, and it -- it wouldn't open. So let me see if that is the case.
But I -- I -- I do recall these studies pretty well.
ATTORNEY NAROG: Okay.
THE COURT REPORTER: May I ask who's talking right now? I'm sorry, I can't tell.
ATTORNEY NAROG: I'm sorry. This is Amanda Narog from the Ohio Attorney General's office.
THE COURT REPORTER: Thank you.
THE WITNESS: Okay. Yes. I -- I have them available if I want to look at them. Thank you.
Q All right. And so this is another one looking at ER visits and not specifically complications from abortion, right?
A Yes. This one took it an additional step and compared the ones that were correctly coded or -- it compared the ones that were incorrectly coded as a miscarriage versus the others, and it looked at the acuity code.

167

So, in other words, if the doctors didn't know what was going on, if they were not aware that this was an abortion complication, was there a difference in the acuity codes that were assigned to the patients?
Q Okay. So before we dive into the -- the miscoding issue, I'm going to go scroll to the second page under "Methods."
And so on the bottom-right here, first it talks about the -- how surgical abortion was defined. And then it says, Medical abortion was defined as the presence of HCPS code 790 [sic.] and no evidence of surgical abortion 45 days prior.
Did I read that right?
A Yes.
Q Okay. And so this is the HCPS [sic.] code that's for the prescription of mifepristone, right?
A Yes. Yes. Mifepristone and misoprostol.
Q It's the prescription for mifepristone, right?
A I'll tell you what. Let me -- if you don't mind, I'm going to put it into Google just to make sure that I'm answering correctly.

168

Q Okay. I'll let you Google that, but just, you know, just for the future, we're not going to be accessing other browsers and stuff like that.
A Right. I -- I understand that. But you're asking me to tell you what these codes mean, and I -- I can't -- I don't recall right offhand without looking them up because, you know, there's -- there's 10,000 codes in these coding banks. So I don't actually have them all memorized.
Q Okay. So does that refresh your memory as to what code this is?
A Yes. This is a mifepristone code.
Q Okay. And I'll ask you to close the browser now, please.
A Okay. I did.
Q Okay. And so that doesn't say anything about whether or not misoprostol was also prescribed, correct?
A That specific code does not, but it's -- I don't know of anybody advocating using mifepristone without misoprostol. So, in general, when it's being done for an induced abortion, it's the combination of the drugs.
Q Does mifepristone have non-abortion

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

169

applications?
A Only in the use -- it's used as Korlym, which is used for Addison's Disease. It's a hypercortisol state for adrenal problems.
Q And --
A It -- it is my understanding that there's a separate code that's used when it's used for that indication. But I can't tell you what that code is, but --
(Crosstalk)
THE COURT REPORTER: I didn't hear that whole question. I'm sorry.
ATTORNEY HUMPHREVILLE: Sorry, go ahead.
THE COURT REPORTER: Could you repeat the question? I didn't hear it.
Q I think -- I'm not sure if it was -- can mifepristone also be used as part of procedural abortion?
A I don't think that it is, and it certainly was not used at this time. The -- they specifically -- we specifically made the point that we looked to see that there was not a procedural abortion code preceding this, which would, in that case, indicate that the mifepristone was being done -- was being given for

170

a failed procedural abortion.
But, yeah, I'm not aware of -- certainly not in 2025 when this study concluded, I'm not aware of anybody using mifepristone for cervical priming or anything like that before a surgical abortion.
Q Okay. And were you providing surgical abortions in 2015?
A Was I?
Q Yeah.
A No. But I do D&Cs, which is exactly the same procedure, but it just doesn't kill a human being.
So I -- I know the procedures, even if I wasn't using it for the same indication.
Q All right. So -- and this would include prescriptions of mifepristone regardless of the reason for the prescription, right?
A I mean, if you want me to, I can look to see if there's a separate code that's used for Korlym. But --
Q I would like you to just -- it's a yes-or-no question of whether it would include mifepristone regardless of the reason for the prescription if it were coded in this way.

171

A Again, the only two reasons in 2015 were hypercortisolism and induced abortion.
So -- and Korlym is used infrequently. So it is possible that we could have picked up a few -- prescriptions for mifepristone for hypercortisolism that we accidentally thought were induced abortions, but it's very unlikely that that represented very many prescriptions --
(Crosstalk)
Q Okay. But this code says it's the prescription of this drug.
It doesn't specifically say anything about medication abortion; is that correct?
A That -- that's correct as we defined it here. Yes.
Q Okay. So I want to then talk about the kind of, like, miscoding issue that you were mentioning.
So a couple sentences later, it says, "The subset of abortion-related visits" -- sorry -- "The subset of abortion-related visits defined by ICD-10 Code 004.xx was considered" -- miscoded.
And then -- or, sorry -- "was considered correctly" -- sorry, let me start over.
"The subset of abortion-related visits

172

defined by ICD-10 Code O04.xx were considered correctly coded and the subset of abortion-related visits defined by ICD-10 O03.xx were considered miscoded."
So this is basically saying in the case of -- I'm just going to limit it to medication abortion here -- that in the case of medication abortion, if the ICD-10 code said "abortion" and the HPC -- HCPCS code said "mifepristone," we're considering that correctly coded, right?
A Right. So O04, anything beyond that, is a complication related to induced abortion, according to the coding.
O03, anything beyond that is considered a complication related to spontaneous abortion, which is a miscarriage.
So we're -- we're saying if it -- if it has the O04, they recognized that there was an induced abortion; whereas, if they had the O03, they did not recognize, they were unaware and they thought it was a miscarriage.
Q Okay. And so this is assuming that it -- if the ICD-10 code says "miscarriage," so it's one of the O03 ones, and the HCPCS code said "mifepristone," you're considering that a

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

173

miscoding, right?
A That's correct.
Q Okay. And so it's assuming that the miscarriage was improperly coded, right?
A Right. Because we assumed that the initial code was -- was correctly coded for a mifepristone-induced abortion.
Q Okay. And so there -- it's assuming that then the abortion-related code was not miscoded?
A You mean the -- O04? Yes, we --
Q Oh, sorry.
A -- assume that was not miscoded because that indicates that there was a. . .
Q Let -- let me rewind.
So in the case where there was a mismatch where it says the mifepristone HCPCS code --
A Mm-hmm.
Q -- and the miscarriage ICD-10 code, it's assuming that the -- that the miscarriage code is the part that's wrong, right?
A That's correct. Because at the -- the seminal study that used mifepristone for miscarriage was not published until 2016 in The New England Journal. So at this time period, no one was using mifepristone for miscarriage.

174

So we knew if she got mifepristone, she got it for induced abortion. And then -- and then -- so we knew that was correct.
And then we knew that if the subsequent codes did not match, that those codes were incorrect.
Q Okay. And so it's not -- it's -- but it -- so you're saying it's not possible that someone could have put in the HCPCS code in error?
A I mean, anything's possible. People can make coding errors. But, again, we're doing the best we can with the data that's available because our country does not require mandatory reporting of abortion complications. If it did, our job would be a lot easier. We're doing the best we can to find out what is happening after these mifepristone abortions.
So it's -- it's very reasonable to use the methodology we did, although it is certainly possible that a very, very small number could have been incorrectly coded at the beginning.
But at -- at some level, you have to assume that the people who are assigning the mifepristone codes know what they're doing. And so that was the assumption that we made.

175

Q Okay. And you don't offer a reason for the assumption in this paper, right?
A I -- I -- you know, whether we discuss that in the sort of detail that you and I are discussing right now, I don't remember.
But, again, you know, you have to -- you have to start with an assumption that your initial code is correct in order to do any kind of a study.
Q Okay. And so you're assuming that it's the miscarriage that's incorrect, not the abortion that's incorrect, right?
A Well, the -- the setting that this is all occurring in is that, increasingly, women are being told by abortion providers like Planned Parenthood, if you have a complication and need to go the emergency room, you do not have to tell the provider that you had an abortion; you can pretend it's a miscarriage. It won't change your care.
Well, our 2022 paper showed that it did change the care if the doctors didn't know what's going on.
But the whole point is, this is in the setting of increasingly women are being told it's okay to lie about the abortion. And so that makes

176

it much more likely that the miscoding is because the woman didn't tell the doctor or perhaps the doctor didn't ask the question of whether she'd had an abortion.
But there's -- there's a lot of reasons that we would expect it to be more likely that the complication is miscoded as a miscarriage than that the abortionist who provided the mifepristone didn't know what they were doing and miscoded, if that makes sense.
Q Right. So you're not separately doing any sort of determination that it is, in fact, the miscarriage code that's incorrect, not the abortion code that's incorrect?
A How would you like me to do that separate determination, since Planned Parenthood won't let me get access to their records?
Q I'm not a researcher --
A I can't do it --
(Crosstalk)
A We can't -- you know, at some level, you have to say, This is the most likely scenario, even if you recognize that there could be a few exceptions to the rule.
But that's what we're doing. We know that

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

177

mifepristone in 2015 and down to 2004 when we started this study, we knew that virtually every prescription for mifepristone was being given for induced abortion. So that was just the clinical reality on the ground.

So we assume that when we saw a mifepristone prescription, that it was being used to provide an induced abortion.

And then, again, in the setting of women increasingly being told, you don't have to talk about your abortion, you don't have to tell the ER doctors what's really going on, we -- we documented that, in that case, many of these were miscoded. And it was a tremendous number, over 80 percent.

But, again, this is -- just speaks to the data deficiencies on this topic in our country, that there's intentional efforts underway to obscure the data, to confuse the data.

And, of course, that has nothing but benefit for the abortion industry when they want to say this is very safe and it hardly ever hurts women.

But, you know, these studies are actually showing a different conclusion.

178

Q When you refer to your 2022 study, are you referring to a Post-Talk Explanatory Analysis of Induced Abortion Complications Mistaken For Miscarriage in the Emergency Room?

A Yes.

Q Okay. And that's the another one of the ones that was retracted, right?

A Yes.

ATTORNEY HUMPHREVILLE: Okay. I'm going to shift to talk about the ethics in public policy paper that you cite in paragraph 30 of your report. So I'll put that in the chat as well, and I will put that up and share my screen.

(Attorney Humphreville shared Exhibit 9 on the screen.)

Q All right. So this says, "The Abortion Pill Harms Women: Insurance Data Reveals One in Ten Patients Experiences a Serious Adverse Event."

Is this the Ethics and Public Policy paper that you cite in your report?

A Yes. I believe it is.

ATTORNEY HUMPHREVILLE: Okay. And I'll mark this as Exhibit 8 [sic.].

(Skop Exhibit 9, Ethics and Public Policy

179

Center paper dated April 28, 2025, marked for identification.)

Q This is not a peer-reviewed study, right?

A That's correct.

Q So it wasn't published in a scientific journal?

A That's correct. It was self-published, I believe, by this organization.

Q All right. And the Ethics and Public Policy Center opposes abortion, right?

A That's correct.

Q The authors of this study don't say what dataset they're relying on, do they?

A I don't recall how they described the dataset. I'm -- I'm familiar with the dataset, but I don't know how they referenced it in this paper.

Q Okay. What is the dataset that you say you're familiar with?

A It -- it's a -- it's a very large insurance database. It includes all of the Medicaid-paid abortions, Medicare, which is -- of course, is much less common, given who the Medicare population is. I believe it has VA. It has a significant amount of private insurance-paid

180

abortions.

So it is the largest, that I'm aware of, database that can be mined for information regarding abortions and then the subsequent events.

Q And does this have a name, this dataset?

A I'm not sure what its name is. I just -- I know it exists.

Q Okay. And have you relied on it before?

A Not in peer-reviewed papers, no.

Q Okay. And this doesn't -- this paper doesn't say what diagnosis codes they used, right?

A To determine complications, you're absolutely correct. It lists some, but not all, and that's one of the reasons that it has been criticized. We don't know exactly what all the complications they're reporting refer to.

Q Okay. And it also considers emergency room visits to be complications, right?

A I -- I don't remember how they phrased it. I think they do report emergency room visits. But whether that was a priori a complication related to the abortion, yes, and not -- let's see. I'm sorry. It's jumping around. Let me make sure I'm reading --

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

181

(Crosstalk)
A ER visits related to the abortion. Yeah, there you go. Okay.
Q Okay. And then I'm going to scroll down to page 4 here. Or -- sorry.
So it says, "In our data, a mifepristone abortion was identified in one of three ways: Procedure code S0199."
So that's the procedure code we were talking about before, right? Sorry. It's right --
A You know, I'm not -- the coding may have changed because they -- the -- our database that we looked at was 20 -- up to 2015. This is looking at data from, I believe, 2025.
And so I don't recall specifically if that's exactly -- actually, I'm looking at the -- our paper, S0190. They're using S0199.
So they're using a slightly different code and probably --
Q Okay.
A -- because the coding has been -- has changed over that time period.
Q Okay. And then it says, "A prescription for mifepristone (with or without misoprostol

182

within the next three days)," right?
A Yes.
Q And so if prescribed without misoprostol, that would not be for medication abortion, right?
A So, again, it's -- it's not a standard to use mifepristone alone for abortion because it doesn't work that well. But they -- they are saying here they're looking specifically at the mifepristone prescriptions.
So, again, I wasn't involved in this study. This is how they did their methodology.
Q Right.
And it says the -- the data years are 2017 to 2023, right?
A Yes.
Q And so that's after the period that you're talking about where some providers started to use mifepristone for other purposes, right?
A That's correct.
ATTORNEY HUMPHREVILLE: Okay. All right. I'm going to move on to talking about abortion-related deaths.
So you say in -- and I'll just pull back up your report just to reference this paragraph. Give me one second.

183

(Attorney Humphreville shared Exhibit 1 on the screen)
Q So in paragraph 19 you say that there have been 23 deaths related to medication abortion, right?
A Reported by the FDA.
Q Yeah.
A I'm sure there have been more deaths that the FDA doesn't know about.
Q And the FDA also estimates that there have been approximately 7.5 million medication abortions in the U.S. as of a couple years ago, right?
A That's -- yeah, that's their estimation. Again, we don't know because nobody requires reporting.
Q Okay. So I -- I think what you're getting at is your assertions in your report that abortion-related deaths are undercounted.
Is the CDC the best source available for statistics about the numbers of abortion-related mortality in the U.S.?
A The CDC reports this information. That doesn't mean that their data is complete or high-quality.

184

Primarily they look at death certificates to determine whether they need to investigate. And it's been documented, as I think I discussed elsewhere in my report, that many, many, many times death certificates do not know about the abortion and don't report that.
Because maternal mortality can occur up to a year after the end of pregnancy. So, you know, particularly when we're talking about a mental health death of despair, suicide, substance overdose that may have been initiated by an induced abortion, the CDC does not have the ability to detect that type of data.
Q All right. So I'm -- I'm -- on the screen here I have paragraphs -- paragraph 32 right now that talks about some of these things that you're saying as far as the CDC.
So you say that it's, you know, not complete data. But you would agree that there's not a better source for this data, right?
A Well, in the United States --
Q Yes, in the United States.
A -- they're -- they're the ones that are tracking it.
You know, again, in European countries, as

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

185

I mention in the report, we see substantially higher numbers, particularly mental health deaths.
But the CDC really is the only one who's doing any tracking on this, other than maybe independent pro-life groups like Operation Rescue who keep an eye on this kind of stuff.
But the CDC is the only official tracking.
Q So if it's the only tracker, it would make it the best tracker, right?
A It's still a terrible-quality tracker. Yeah, I'm not going to call it best for anything. It is the only tracker. But we could do a better job, if we had the will.
Q All right. So you mentioned that the CDC relies upon death certificates primarily -- and just highlighting the language there on this.
So you're not citing anything in your report about, like, any CDC pages here, right?
A I may not have cited it, but I've read this parti- -- what I've said in this statement on the CDC documents saying that is primarily -- they do say, We also consider information obtained through LexisNexis searches, media reports.
But I -- I don't remember if I report -- or if I referenced it here. There was an

186

independent researcher who looked only at medical malpractice cases over a certain period of time related to abortion-related deaths and discovered 40 percent more deaths than the CDC had reported during that same time period.
So even though they say they look at LexisNexis, they clearly, at least in that time period, did not.
So it's -- it's -- it's not documented anywhere, like, whether they make much of an effort or whether they just let information come to them passively.
Q Okay. So there's no citation to a CDC page here, right?
A I did not put one, but that is -- it is citable.
Q Okay. It's citable, but you didn't cite it, right?
A That -- that's correct.
Q Okay. And when you say there's an independent researcher, who is that independent researcher?
A His name was Mark Crutcher. He wrote a book about it. It's an older book, I want to say, maybe from -- I don't know. It's at least 20

187

years old, but. . .
Q Okay. And that doesn't say anything about -- do you know the name of the book?
A I don't recall right offhand.
Q Okay. And you don't cite this in your report, right?
A I don't think it's in this particular report, but. . .
Q Okay. Can you provide a copy of this?
A I mean, I'm -- I'm happy to take a picture. Do you want me to mail you my book or --
Q I think if you can get us -- if we -- later on --
A Yeah, I can -- I can take a picture of the page that references what I just told you.
Q Okay. And then just looking at the next paragraph here to -- which also -- paragraph 33, you don't cite any CDC sources there either, right?
A You know -- let's see. Dr. Berg is a CDC researcher. She's involved in the Gissler studies. But it doesn't look like I have a specific CDC source for you there.
Q Okay. And just -- just honing in on some of the specific language. So you say in this

188

highlighted sentence, "for many reasons these deaths may not be documented."
Are you aware of any specific abortion-related death that has not been documented?
A Yes, I am.
Q What death is that?
A Well, there's -- again, there was a -- a year in Maryland where there were four deaths documented via public record. And at that -- on that particular year, the CDC documented only one death.
So there have been -- there have been a number of occasions where people have documented lower numbers with the CDC than state records actually reported.
But, again, nobody really knows the magnitude. And those are only specifically regarding the ones that occurred from physical complications.
European records linkage studies tell us women are six times as likely to commit suicide in the year following abortion compared to childbirth.
So we know that as far as mental deaths

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

189

go, there's probably likely to be many more following abortion than following childbirth.
But the CDC does not have a system in place to collect that data. They seem wholly uninterested in collecting that type of data.
And so it's just not something that is provable, but it can be surmised based on the European data.
Q So we'll get to the European data in a second.
But as far as these four Maryland deaths, what year was that?
A I -- I don't recall. If you want to -- I mean, we can -- we can -- if you want, we can go together through the Operation Rescue website, because they've got a lot of these documented there.
It --
Q So Operation Rescue is your source for that?
A No. But it is a source.
Q Okay. So where -- what is -- where have these four Maryland deaths been documented? Is it in a peer-reviewed study? I'm not asking that as a joke, I'm trying to figure out where --

190

A Yeah. I know that -- and just FYI, that's the reason that our peer-reviewed papers were retracted, because the -- you know, the -- the acknowledgement that if something doesn't exist in a peer-reviewed form, it's not -- it doesn't exist.
I mean, this is based upon records data. This is based upon Maryland maternal mortality data compared to the CDC data for that same year. So, you know, I forget where I read it. I could certainly try to track it down.
But the point is that it has been documented on a number of occasions that the CDC reports fewer abortion-related deaths than other reliable sources, like LexisNexis and Maryland State Department of Health data.
So there's a disparity. So it's been documented many times that the CDC does not reliably collect all abortion-related death data.
And, in fact, if you're familiar with the maternal mortality crisis discussion in our country, for about 12 years, the U.S. CDC did not report any maternal -- this is not even related to abortion. This is just maternal mortality in general.

191

Q Let's -- let's stop there, because I'm just going to try to talk about things related to abortions. So we can -- you know, I think we can talk for ages, and I know you have a lot of experience with maternal mortality, but I want to just stay focused on the issues in this case.
So when you prepared your report here, you made an effort to be accurate, right?
A Yes.
Q Okay. And you said earlier that you made an effort to include all relevant facts and data, right?
A I said that. That doesn't necessarily mean that I linked every reference that I'm aware of related to this very complex topic, because, clearly, I didn't.
Q Okay. And so you -- you say that there are these other deaths, but you don't cite anything to support that in your report, right? You say there are higher-quality European studies, right?
A Yeah. I believe I cited those. Those are the Gissler studies.
Q Okay. You also say in paragraph 33, "It is likely that many deaths" -- or sorry. Well,

192

"It is likely that many deaths from mental health issues" -- well, actually, let me save that for -- because I'll talk about the European studies in a second.
But -- okay. So yeah, I'm going to -- I'll withdraw that question.
So let's turn to talk about some of these European studies that you're referring to.
So starting with the -- the Gissler one that you reference, this is in Footnote 25 here, so that's relying on Finnish data, right?
A Yes.
Q Okay. And the Finnish health system is different from that of the U.S., right?
A Yes.
Q And the Finnish population is also different from that of the U.S., right?
A Yes.
Q Okay. So data from Finland is not necessarily going to be translatable to the U.S. context, right?
A The safety signals that we see in Finland should concern us in the U.S. where nothing about abortion data is mandatorily collected at a federal level.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

193

Q Okay. My question is, the data from Finland is not necessarily going to translate to the U.S., right?
A The data is not looking at the same patient population. There are differences, yes. But it is still important clinical data.
ATTORNEY HUMPHREVILLE: Okay. So let's -- let's dive into some of these studies. We can start with the Gissler study that you cite in your report. So I'll put that in the chat and I'm going to pull that up as well.
So this is a 2004 article.
(Attorney Humphreville shared Exhibit 10 on the screen.)
Q Is this the Gissler study that you cite in your report?
A Let's see. Here we go.
It's one of the ones. I think I cited several.
ATTORNEY HUMPHREVILLE: Okay. I'm going to mark this as Exhibit 9 [sic.].
(Skop Exhibit 10, Gissler study - 2004 article, marked for identification.)
Q Do you know when medication abortion became available in Finland?

194

A I'm not familiar with Finland. It became available in the United States in 2000.
Q Okay. If I told you it became available in 2000 in Finland as well, would that sound right?
A That would be -- yeah, that sounds plausible.
Q Okay. And so if medication abortion didn't exist in Finland until the year 2000, this period covered wouldn't provide data about deaths from medication abortion, right?
A Yeah. The point of this is that it's -- it's looking at the actual deaths versus the reported deaths, documenting how severe the data deficiencies are related to abortion data collection in general.
Q Okay. So --
A But it could be extrapolated to medication abortion, because the same systems that try to hide data are still in place with medication abortion.
Q Okay. But you would agree that the complications from medication abortion differ from those of procedural abortion, right?
A They can; they don't necessarily. I think

195

both -- both methods of abortion, the common complications are hemorrhage, retained tissue, infection.
Q All right. So I'm going to look at -- sorry, let me just find the -- the last -- sorry, give me one second.
All right. So if we look down to the second page under "Methods," it says, We used the terms and definitions for deaths related to pregnancy first developed in 1986 by the US CDC, ACOG and the Maternal Mortality Study Group. Pregnancy-related death was defined as death of the woman while pregnant or within one year of the termination of the pregnancy, regardless of the cause of death.
Did I read that right?
A No. It's -- you meant pregnancy-associated death. You said related.
Q Oh, sorry. So it says, "Within one year of the termination of the pregnancy, regardless of the cause of death," right?
A That's correct.
Q Okay. So this is saying that the abortion need not have caused the death, correct?
A It's -- it's merely temporally associated.

196

We don't know the cause.
Q Okay. And is that true of the other Finnish studies that you cite for the proposition that abortion deaths are undercounted in the U.S. too, that they're just looking at did a death occur within the --
(Crosstalk)
A Right. So -- so Finland was only looking at coding and records and death -- and death certificates. They also were not -- like, in order to determine pregnancy-relatedness, you need to get all of the medical records and you need to do a deep dive, which is, as you might imagine, very work-intensive. That's what the maternal mortality review committees are doing.
So this was -- this was a high-level overview. They looked at all the reproductive-age women who died, and they linked them, how many of them had an abortion within a year? How many of them gave birth within a year?
And then they made a comparison documented as -- as I noted, that a woman was many more times likely to be dead a year after an abortion than after she gave birth to a child.
But they did not obtain the data necessary

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

197

to prove -- prove causality.
ATTORNEY HUMPHREVILLE: Okay. I'm going to pull up also the Karalis study. And I'll put that in the chat.
(Attorney Humphreville shared Exhibit 11 on the screen.)
Q So this is a -- another one of the Finnish studies that you cite, right?
A Yes.
ATTORNEY HUMPHREVILLE: All right. And this is going to be Exhibit 10 [sic.].
(Skop Exhibit 11, Karalis study entitled Decreasing mortality during pregnancy and for a year after while mortality after termination of pregnancy remains high, marked for identification.)
Q So on the first page here of "Main outcome measures," it says, "Pregnancy-associated mortality during pregnancy and up to 1 year after the end of the pregnancy."
So this is also the same metric as the Gissler study, right?
A Yes.
I -- let me just look at Gissler real quick.

198

So I think Gissler only looked at, like, pregnancy associated. Karalis looked at pregnancy associated and then it compared it to the metrics in the non-pregnant population of women?
Q Okay. But she's looking at everyone -- for the pregnant population, anyone who died within one year after the end of pregnancy, whether that was birth or abortion, right?
A That is correct.
Q Okay. And so this would include an accident, for example?
A Yes. Yes.
Q Okay. I'm going to depart from the Finnish studies for a second because in that same section of your report, you also cite a 2017 Reardon and Thorpe article, which I just put in the chat, "Pregnancy-Associated death in record linkage studies relative to delivery, termination of pregnancy, and natural losses."
(Attorney Humphreville shared Exhibit 12 on the screen.)
Q Is this the study that you cite in your report?
A Yes, it is.
ATTORNEY HUMPHREVILLE: All right. And

199

I'll mark this as Exhibit 11 [sic.].
(Skop Exhibit 12, Reardon study entitled Pregnancy-Associated death in record linkage studies relative to delivery, termination of pregnancy, and natural losses, marked for identification.)
ATTORNEY HUMPHREVILLE: And bear with me because I'm going to have to rotate this document because it --
THE WITNESS: Yeah, the graph's in there sideways.
ATTORNEY HUMPHREVILLE: Yeah, exactly. So hopefully I did this right. Okay.
Q So this is page 6 of the study and it's talking about all of the studies that it includes within its review.
So first it lists a 1978 U.S. study.
Was medication abortion available in the U.S. in 1978?
A No.
Q Okay. And then we talked about these -- some of the Gissler studies.
These three are looking at -- the last year of the study is 1994, right?
A Yes.

200

Q And so medication abortion was not available in Finland at that time, right?
A That's correct.
Q Okay. And then the next one, it says -- it's another Reardon study, and it says, "Medicaid eligible and fertile age women in California With pregnancy outcome in 1989."
Was medication abortion available in 1989 in the U.S.?
A No, it was not.
Q Okay. And then we have two more Gissler studies stopping in 2004, right -- or, sorry -- the data stopping in 2000.
So that's not considering medication abortion, right?
A That's correct.
Q Okay. And then the next page, these are all international studies too, right?
A Yeah. Again, you just can't get this data in the United States.
Q Yeah. And so these date back to before medication abortion was available, right?
A The one in Denmark might have included medication abortion because it went up to 2004. But I -- I don't recall when Denmark began using

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

201

mifepristone.
Q Okay. Is it fair to say it was well after 1980?
A Oh, yeah, certainly. The beginning of the study. I agree.
Q Okay. And so the vast majority of those studies --
A Mm-hmm.
Q -- that -- are -- are not going to include data related to medication abortion?
A That's correct.
Q Okay. And so the conclusions about abortion-related deaths in this -- in this study overall, in the Reardon review, those are not actually about medication abortion deaths specifically, right?
A To point out, he pulled 989 studies and only 11 were curious about induced abortion deaths.
So he used the data that he had. We shouldn't say we can make any conclusion about medication abortion. We should ask, Why is no one looking anymore? Why did they stop studying this after the Finland group stopped looking at it?
But you're right. We can't say anything

202

about medication abortion.
But the common -- the common pathways that lead to death is often deaths of despair from the abortion itself, and that can be extrapolated that this could occur after a medication abortion, as well as a procedural abortion.
Q All right. I'm going to keep going with some other of the Finnish studies and just try to power through. I got a -- a few more Finnish studies and then maybe we can take a lunch break. All right?
A Okay.
Q Okay. So the next one I'm going to pull up is a name that surely I'm going to mispronounce. This is 2009 --
A Oh, Niinimaki --
Q -- Niinimaki study. It has kind of a cover page for some reason, "Immediate adverse events after second trimester medical termination of pregnancy: Results in a nationwide registry study" -- or, sorry. This is --
THE WITNESS: Mentula.
ATTORNEY HUMPHREVILLE: Oh, this is -- okay. Let me see real quick.
(Attorney Humphreville shared Exhibit 13

203

on the screen.)
ATTORNEY HUMPHREVILLE: Okay. So this is, okay, Mentula. Okay. Yes, sorry. A Mentula study. Niinimaki is a coauthor. I apologize.
So this is another one of the Finnish studies that you cite in your report, right?
A Yes.
ATTORNEY HUMPHREVILLE: Okay. And I'm going to mark this as Exhibit 12 [sic.].
(Skop Exhibit 13, Mentula study entitled Immediate adverse events after second trimester medical termination of pregnancy: Results in a nationwide registry study, marked for identification.)
Q Do -- so this is looking at both first and second trimester medication abortion, right?
A Yes, but they're -- they're broken down and so we know how each group did.
Q Okay. And do you know whether any of the abortion providers in Ohio are providing medication abortion in the second trimester?
A Do I know whether -- whether they are?
Q Yes.
A I'm not privy to that information. But if these laws go away, I'm assuming they will be.

204

Because the abortion providers are not shy about the fact that they're violating the FDA's REMS protocol every day. Many of them advertise past the ten-week gestational limit that the FDA set.
Q All right. So I'm going to dive into this study.
This study does not define hemorrhage; is that right?
A That is one of the criticisms of the study, yes.
Q Okay. And then you also cite -- I'm going to scroll down to page 931 of this study because you refer to a citation on that page.
So you note that in the first trimester 7.9 percent of patients had a surgical evacuation following their medication abortion.
But looking at Table II here, it says that 2.3 percent had the surgical evacuation at the time of the medication abortion; is that right?
A Yes.
Q Okay. And so some of the 7.9 percent that you mention are not actually failed abortions; is that right?

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

205

A I don't believe they told us why those -- those surgical evacuations were being performed. Very likely it was for hemorrhage that they felt the need to intervene so quickly.
But I don't -- I don't think we have that data.
Q You say "very likely," but it doesn't say that in this article, does it?
A No. I think we just have to, you know, assume what -- what we know about the clinical scenario. But they -- they did not specify whether those were failed or what the other reason might have been.
Q Okay. Now I'm actually going to move to Niinimaki study. I'll pull that in the chat as well and pull it up.
(Attorney Humphreville shared Exhibit 14 on the screen.)
Q So this is a 2009 article called "Immediate Complications After Medical Compared With Surgical Termination of Pregnancy?"
Is this another one of the Finnish studies you cite in your report?
A Yes, it is.
Q Okay. And you note in your report that

206

this study relies on different medication abortion regimens than in the U.S., right?
A That's my understanding, yes.
Q Okay. And just looking at -- I'm going to scroll down to the second page, the right-hand column. It says, "Medical abortion was defined as the use of mifepristone alone or in combination with misoprostol or other prostaglandins."
Did I read that right?
A Yes.
Q So it has mifepristone-alone abortions, right?
A They -- I think they're talking about that specific code being used alone.
Like I said, I'm not aware that anybody clinically gives only mifepristone.
Q But this says mifepristone alone, right?
A Yeah. Well, similar to the way we defined it in ours. We used just the mifepristone code.
Q Okay. But you didn't look at the underlying dataset here?
A I'm sorry. I -- I --
Q Have you reviewed the underlying dataset in this study?
A In -- in this Niinimaki study?

207

Q Yes.
A I mean, I -- I read the tables. I -- of course, I don't have the ability to look at their underlying dataset. I have to believe that they represented their dataset accurately.
Q Okay. And so it says, "mifepristone-alone abortions," right?
A That's what -- well, they said if there was a mifepristone code alone.
Q Does it say --
(Crosstalk)
A I don't think that they're -- I don't think that they're saying that they were -- that there were a lot of mifepristone-alone abortions. I think they're just saying this is -- this is how we determined that an abortion occurred, by looking specifically for the mifepristone code.
Q Okay. And does this say anything about mifepristone codes right here?
A Let's see. I -- I lost my place. We're top -- we're in the top --
Q Here. I have it highlighted right here --
A Okay.
Q -- if you want to look at it.
Does this say anything right here about

208

the codes for mifepristone alone?
A I don't see it on your screen. Can you tell me what page we're on and I'll -- I'll find it.
Q Oh. Am I not screensharing right now? Sorry.
A Uh-uh.
Q Oh, I apologize.
A That's all right.
Oh, I did find it. It's the top of page 796.
Q Yeah. And I should have it up on my screen now. I apologize.
A Yeah. Let's see.
Q So it says -- this part that I have highlighted, this does not say anything about the codes for mifepristone alone, right?
A Yeah, you're right. They -- they do -- they do say that -- mifepristone alone. But I don't think they meant it. I think that they -- again, because nobody's using -- mifepristone alone only results in abortion about 25 percent of the time or less.
So it doesn't -- it's not a good -- it's not a good way to do an abortion. But --

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

209

Q Okay.
A -- but I agree. That's what they say, so we'll -- for the sake of argument, we'll say that they thought some of these were only mifepristone.
Q Okay. And then it also includes mifepristone with prostaglandins other than misoprostol, right?
A Yeah. There's a few others. Gemeprost and some European prostaglandins that have been used that we don't use here in the United States.
Q Okay. And then I'm going to pull up a back-and-forth -- this is a letter to the editor to this journal about this study. I put it in the chat.
So it says, "Immediate complications after medical compared with surgical termination of pregnancy." And it says, "To the editor" -- and then over on the right side here, "in reply."
So these are, you know, some doctors that have -- and I guess one is a nurse practitioner, actually -- who wrote in about this.
And then in reply, scrolling down, we can see that this is from -- this response letter is from Niinimaki.
A Mm-hmm.

210

ATTORNEY HUMPHREVILLE: So I'll -- oh, and I -- I should have marked the original Niinimaki article, which is Tab X, that will be Exhibit 13 [sic.].
(Skop Exhibit 14, Niinimaki study entitled Immediate Complications After Medical Compared With Surgical Termination of Pregnancy, marked for identification.)
ATTORNEY HUMPHREVILLE: And then this one, Tab Y, will be Exhibit 14 [sic.].
(Skop Exhibit 15, 2010 Niinimaki Response, marked for identification.)
Q So then it says here -- give me one second.
This is the portion of the Niinimaki response, "Regarding the medical abortion, practically all women receive 200 milligrams of mifepristone after vaginal administration of misoprostol as recommended in the Finnish guidelines."
Did I read that right?
A Yes.
Q So this is a case where they're doing misoprostol before the mifepristone; is that right?

211

A That's what they're saying, yes.
Q Okay. And then turning back to the Niinimaki article, this one doesn't define hemorrhage either, right?
A I believe that's the case, yes.
Q Okay. And so that would include women who may have been within the normal range of bleeding but just returned to the healthcare provider for reassurance, right?
A Yeah, it's hard -- it's hard to know since they didn't provide a definition how clinically significant the bleeding was that they reported.
Q Okay. So I'm going to go back Niinimaki's letter.
And just note -- it says here, "Based on correspondence with" -- this is with one of the coauthors of the Niinimaki article -- "in Finnish health registries, any return visit to the health facility, even for additional consultation, is categorized as a complication. Thus, a woman who's bleeding may have been within the normal range but who sought reassurance could have been coded as hemorrhage."
So this is reporting what the authors of the Niinimaki article said, right?

212

A Yes.
Q Okay. And you rely on this Niinimaki study in your report to say that 15.6 percent of medication abortion patients experience hemorrhage, right?
A So I -- I use the data that I can. Again, there's just very little good data about abortion as we've discussed over and over.
I reported what this -- what this study reported. I am aware of this conversation that you've just shown me. And I would point out, if you look at these -- if you Google these women who wrote this, very, very pro-abortion.
So, you know, again, you're right. It's nuanced. I don't believe that the hemorrhage rates are as high as this study says either, but I did include it in my report because it's -- it's -- it's part of the peer-reviewed literature available, which is quite limited.
Q So you don't believe that the rate of hemorrhage is that high, but you decided to include that --
A No --
(Crosstalk)
A What I -- what I would say --

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

213

Q Let me finish my question. Let me finish my question.
You don't believe that it's as high as 15.6 percent hemorrhage, but you still cited that in your report without any caveat; is that correct?
A I reported what these researchers reported. If I used my own definition of "hemorrhage," I -- I think that it is likely that it was not as high as what they reported.
But I can't -- I don't have access to their data. I can only say what they said in their peer-reviewed article, and -- and that's what I did. So that's just part of the data that's available.
But, again, as -- as you pointed out, they did not give a definition for what a hemorrhage is. We don't know how clinically significant all of those were. But they did report that it was much more substantial -- 15 percent versus 2.1 percent.
So whatever the definition was, it was seven or eight times higher after medication abortion. So that's something that should be important to all of us.

214

If abortion providers really cared about the women, they'd be giving them all surgical abortions instead of letting them self-manage their own abortion with mifepristone.
And they wouldn't be suing to overturn laws that try to put a -- a minimum standard in place so that women get counseled and get pre-abortion testing to decide if they're appropriate for this procedure.
Q Dr. Skop, I understand you think there are limitations to the data. I want to focus on these specific questions so we can, you know, get through this and --
A Okay.
Q -- get to lunch. So let's -- let's put aside what abortion providers are suing about.
So I'm going to now just scroll to another part of this -- sorry, let me just find what I'm looking for here.
So you said you're aware of this exchange. And also I'm going to just read to you another part of the letter from the authors of the study.
It says, "Thus, many of the 'complications' are not really such, but rather concerns or adverse events that bring women back to the health system," right?
A Yes.
Q So this is saying that, basically, it's capturing all encounters with the health system, not just complications, right?
A No. I don't believe they're saying that. I think it's -- it's capturing the times that women come back to the health system with concerns. I -- I would assume that they're not including a routine follow-up visit as a complication.
But I think they're saying right here, concerns or adverse events that bring the women back to the healthcare system.
Q Okay. And so concerns are not necessarily complications, right?
A They're not complications, but they're concerns for the women, which should be, you know, a factor that we consider as well.
Q Okay. And I'm just going to touch on one more Niinimaki article. Let me pull that one up.
So this is a 2011 article. And this is "Comparison of rates of adverse events in adolescent and adult women undergoing medical abortion."

215

216

So is this another one of the Finnish studies that you cite in your report?
A Yes, it is.
ATTORNEY HUMPHREVILLE: And I'll mark this as Exhibit 15 [sic.].
(Skop Exhibit 16, Niinimaki 2011 article entitled Comparison of rates of adverse events in adolescent and adult women undergoing medical abortion, marked for identification.)
Q This one doesn't define "hemorrhage" either, right?
A It does not.
Q Okay. And it also includes second trimester abortion, right?
A It does. And as I recall, it did not specifically separate them out. This was a little more confusing to get good data from because they put them all in the same group.
Q Okay. And then I'm just going to scroll down to page 2 here where it talks about study group. And it's says, in the right-hand column here, "The study population consisted of women who had a medical abortion (mifepristone alone or in combination with misoprostol or other prostaglandins) at 20 weeks or less of gestation."

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

217

So this is also including mifepristone-alone medication abortions, right?
A It appears to be.
Q And it's also including mifepristone in combination with prostaglandins other than misoprostol, right?
A Yes.
ATTORNEY HUMPHREVILLE: Okay. I'm -- I think we can take a break there. Is -- I'm -- I'm a quick eater and I'm in my home, so it's easy to get food.
But I -- I don't know if 30 minutes would be long enough for everyone else.
THE VIDEOGRAPHER: Let me take us off the record really quick.
We are going off the record at 13:59.
(A lunch recess was from 1:59 p.m. to 2:31 p.m.)
THE VIDEOGRAPHER: We are back on the record at 14:31.
ATTORNEY HUMPHREVILLE: Okay. And I'll just note that I made an error, which thank you to the court reporter team for identifying that I had kind of missed one of my exhibit numbers along the way. So I was a number behind.
So I was at 15, really should have been at

218

16. And that's true from, I think, what I had marked as -- said was Exhibit 4 on -- so exhibit -- what I was saying was 4 should have been 5 so forth.
So I apologize for the error.
BY ATTORNEY HUMPHREVILLE:
Q Okay. Dr. Skop, I would like to turn to what the FDA requires in terms of reporting for medication abortion.
Mifepristone is still subject to more stringent reporting requirements than the vast majority of other FDA-approved medications; is that correct?
A The only reporting requirement right now is deaths. If -- if that's the case, that the FDA doesn't even care about deaths associated with other medicins -- medicines, then that may be true. But that's suboptimal.
Q So you don't know what the FDA requires for other medications as far as reporting of complications?
A The FDA really seems to be a don't-ask-don't-tell policy on most drugs. They use the adverse events monitoring system, which is purely voluntarily.

219

Q So my question is, you're not familiar with what's required for reporting for other drugs?
A That is correct.
Q Okay. I'm going to turn to what has been called either the evidence-based use ban in this case or the FDA Label Law. I'm going to call it the -- "the Label Law" just because that's just a little bit shorter.
Will you know what I'm talking about if I say "the Label Law"?
A You're talking about the current label for mifepristone use?
Q Sorry. The Ohio law that says --
A Oh.
Q -- you have to -- you can only prescribe medication abortion pursuant -- based on the FDA label.
A Okay. I understand what you're talking about.
Q Okay. And it seems like your primary objection to off-label prescription of mifepristone is that it should be limited to 70 days after a patient's last menstrual period; if that's -- is that right?

220

A I have a lot of objections because all of things that are being allowed outside of the FDA's REMS certification make the drug use more dangerous for women. We can talk about all of those, if you want, but the -- but --
(Crosstalk)
Q So let's break part the -- the label. And I -- I -- I'm not going to talk about the REMS right now. I'm just going to talk about the FDA label. Okay?
A Yes.
Q Okay. So you would agree that if medication abortion provision is restricted to 70 days LMP, that someone who is 75 days LMP would not be able to get a medication abortion; is that right?
A If the label were being followed.
Q Okay.
A No. I'm sorry. Can I caveat that?
Q Yes.
A They can get a surgical abortion anytime they want. They should just not take a medication abortion that's more likely to harm them.
Q Sorry, so that would be prevented from getting a medication abortion at 75 days LMP,

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

221

right?
A They could do a surgical abortion, which is safer for them.
Q But they would not be able to get a medication abortion, right?
A If, as you postulated, we're limiting it to 70 days, then, by definition, they would not be able to get it at 75.
ATTORNEY HUMPHREVILLE: Okay. So I'm going to dive into some of the studies that you cite related to the gestational age limit for medication abortion.
So one of them is a 2020 Dzuba study. So this is -- I'm going to put that in the chat here, and I'll pull it up as well. Give me one second.
(Attorney Humphreville shared Exhibit 17 on the screen.)
Q Okay. So this says, "A non-inferiority study of outpatient mifepristone-misoprostol" -- medication -- "medical abortion at 64 to 70 days and at 71 to 77 days gestation?"
You cite this study in your report, right?
A Yes.
ATTORNEY HUMPHREVILLE: Okay. And this will be Exhibit 17.

222

(Skop Exhibit 17, Dzuba 2020 study entitled, A non-inferiority study of outpatient mifepristone-misoprostol medical abortion at 64–70 days and 71–77 days of gestation, marked for identification.)
Q And give me one second. I'm going to scroll down.
All right. So this is the -- page 307 of the study. And I'm going to read right here. It says, "Since this study was completed, newer evidence demonstrates that more -- one" -- sorry -- "Since this study was completed, newer evidence demonstrates that more than one misoprostol 800 microgram dose after mifepristone for later-first-trimester outpatient Medication Abortion holds promise for improved outcomes."
Did I read that right?
A Yes.
Q And you don't cite a follow-up study from Dzuba about a repeat dose of misoprostol, do you?
A There's a specific reason that I cited this study. And I would -- I would note that if we're asking women all by themselves to determine when they need another dose of misoprostol, then, again, we're abandoning our patient relationship.

223

You know, you --
Q Dr. Skop --
A -- guys are asking that we take away all the supervision of the drugs. And now you're going to just give the woman another drug and say, Well, if it doesn't -- you don't think it works, try -- try another drug.
I mean, this is really poor patient care.
Q So, Dr. Skop, I'm just going to stop you there.
So, first, I just want to say, you keep saying, "you guys," "you guys," referring to me.
We're -- we're talking about the Ohio laws at issue. Okay? We're not talking about me.
So can we agree --
A Yeah.
Q -- the --
A I apologize. I don't mean you specifically. I'm talking about Planned Parenthood when I say that, who I think you represent.
Q I do represent Planned Parenthood. And then I'm just going to say, my question was -- is, you don't cite a follow-up study from Dzuba related to a repeat dose of misoprostol, do you?

224

A I don't because 13.4 percent failures I think speaks for itself.
Q Okay. And --
A In the -- in the -- in the current study.
Q Even though this says n additional dose of misoprostol may hold promise for improved outcomes, you didn't look -- you didn't cite another study?
A No. I don't think I need to. I think I made my point. 13.4 percent is a lot of failures. And now you're saying, Well, maybe if we just give them more doses of the drug to use by themselves that things will be better.
I mean, again, I think that anybody listening can understand, that's very poor-quality care. That shows a blatant disregard for women seeking abortion to --
Q Okay. So even though this study says there's additional evidence, you didn't think to look for that evidence, did you?
A No. Because I think that the point I was trying to make about using it at more advanced gestational ages increases failures. I think the, quote, "non-inferiority study" demonstrates that conclusively.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

225

13.7 failures versus 7.7 percent failures with 8.7 percent, almost one in ten of those women, their baby continues to live. It fails entirely.

So this -- I mean, in my mind, I don't know why they would think that this is data that should be used to support using this drug beyond the FDA's protocols. To me, it's saying the FDA was right to set a limit where they did.

Q All right. I'm going to pull up another study. This is -- I'm going to put it in the chat and pull it up.

(Attorney Humphreville shared Exhibit 18 on the screen.)

This is a 2024 article by -- I'm not sure if I'm saying it right -- but Cely-Andrade, "Telemedicine for the provision of medication abortion to pregnant people up to twelve weeks of pregnancy: A systematic literature review and meta-analysis".

You also cite this study in your report, right?

A Yes, I believe I do.

Q Okay. And did this study -- this study also reached a similar conclusion, right, that

226

effectiveness increases with additional doses of misoprostol, right?

A That's correct.

ATTORNEY HUMPHREVILLE: Okay. All right. And I forget if I said, but this is -- that's going to be Exhibit 18.

(Skop Exhibit 18, Cely-Andrade 2024 article entitled, Telemedicine for the provision of medication abortion to pregnant people up to twelve weeks of pregnancy, marked for identification.)

Q And then I'm going to move to the Kapp article that you cite in your report. This is "Medical Abortion in the Late First Trimester, a Systematic Review."

You cite this study in your report as well, right?

A Yes.

ATTORNEY HUMPHREVILLE: Okay. And this will be Exhibit 19.

(Skop exhibit 19, Kapp article entitled, Medical abortion in the late first trimester, marked for identification.)

Q So you say in your report that between 9 and 12 weeks LMP, 9.6 percent of

227

mifepristone-misoprostol abortions will fail and 18.4 percent of misoprostol alone.

I'm going to turn to page 3 of the PDF here.

So the study you're referring to -- or sorry. Page -- sorry, give me one second. What page am I on? Sorry. This is not cooperating for me, clearly, right now. Let me just -- okay.

Okay. So this says -- this is where this has this information.

So it's referring to one small study in Tunisia comparing nine to 12 weeks.

So that's -- that's the data that you're referring to, right?

A I might have to have you back up and -- and remind me of the questions or maybe show me on my report. I --

Q Sure. So in -- in your report in --

A Uh-huh.

Q -- paragraph 105, you say that 9.6 percent of mifepristone and misoprostol abortions will fail between nine to 12 weeks and 18.4 percent of misoprostol alone, right?

A I think where I'm getting that, if you look at the abstract, that information is in the

228

abstract about midway in the paragraph with results, 9.4 versus 81.6 percent complete abortion.

Q Okay. And so let's look at the specifics of that. Let me find it real quick.

So this is the study within it that it's referring to. I'm -- I'm going to rotate it, don't worry. This one's hard because it's like, you know, two different things. Okay.

A Right.

Q So this is referring to a study of 122 -- okay. This is -- my scrolling is being a little finicky -- 122 women in Tunisia, right?

A That's correct.

Q And it is noting the regimen here. So it says, "Mifepristone 200 milligrams followed 48 hours later by 400 micrograms oral Misoprostol," right?

A That's what they say. And then vaginal misoprostol.

Q And that's different -- sorry.

Where are you referring to, where it says "vaginal" --

A Where -- where it says -- so "oral miso," and then "Misoprostol 800 micrograms PV," which I

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

229

think is per vagina.
I --
Q Oh --
(Crosstalk)
A -- that specific study. But as I recall, they gave the initial 400, and then they subsequently gave 800 vaginally. So --
Q Well, I -- I think what this study is doing is that it's comparing -- and we can go back to the next page that I was talking about -- but it's comparing people who had a mifepristone-misoprostol abortion with people who had a misoprostol-only abortion?
A Oh, I see. Okay. That particular study, "Dalenda." Okay. That's -- it's not really clear the way they wrote it. But I -- I would believe you if you say that that's probably what they were looking at.
Q Okay. I mean, we can go back and look at this next page that describes what they did, if you'd like.
A No, that's okay. I think we're okay.
Q Okay. And so 200 milligrams mifepristone followed by 400 micrograms misoprostol, that's different than the FDA regimen, right?

230

A Well, of course, by definition this is different, because FDA limits it to ten weeks.
Q But the dosages are different here, right?
A That's correct.
Q Okay. And this is -- in the U.S. it's more common to have an 800 microgram dose of misoprostol, right, under the FDA label?
A That is correct. But you're isolating one study. There were multiple studies included in this systematic review.
Q Okay. And is -- are the numbers that you're referring to taking into account all of the studies in the systematic review?
A One would anticipate, because it's the numbers they report in the abstract. So generally abstract is going to have the top line -- I mean, I didn't do the math myself, but that would be very misleading if they wrote their abstract and only put the results of one out of -- one, two, three, four, five, six, seven, eight -- looks like there's -- there's a ton of studies.
So, again, you -- when you read an abstract, you assume they're telling you the cumulative data of the studies they reviewed.
Q So did you review this whole article, Dr. Skop, or just the abstract?

231

A No. I read the whole article, but I didn't do the math myself. I assume these researchers could do their own math.
But the -- the assumption, which I think anybody reading an article would be, is that the abstract is going to contain the top line information.
They say this search strategy 3383 [sic.] articles, "nine of which met the inclusion criteria. Medical abortion, as compared to surgical abortion, was effective. . ."
And then they gave those -- oh, okay. I -- I see what you're saying. So may -- maybe that was specific for the Dalenda study. But I don't recall if the others --
Q Okay. So let's just stick on this one study for now.
So you would agree that 200 milligrams of mifepristone followed by 400 micrograms of misoprostol is different than the regimen on the FDA label, right?
A That's correct.
Q And -- this also doesn't involve a repeat dose of misoprostol; is that correct?

232

A Apparently not.
Q Okay. And then for misoprostol, it says, "800 micrograms PV," as you noted.
You don't cite any other studies about misoprostol alone regimens for medication abortion in your report, do you?
A I don't recall if I have. But I've written about that extensively. I know that there are a lot of other misoprostol studies. And studies consistently tell us that misoprostol is even worse than mifepristone versus misoprostol.
I would draw your attention to when they look at all the studies, there was at least one study in which the failure rate was 21.4 percent.
So, again, these are very high failure rates compared to the studies that look at the use of these drugs at less than nine or ten weeks.
Q What page are you referring to there?
A In the abstract, just below what we just discussed, they -- we talked about the comparison, 90.4 versus 81.6, and then they say, "Complete abortion rates for all regimens investigated."
So, again, all these studies put together ranged from 78.6 percent to 24.6 percent.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

233

Q And did you compare the regimens in those studies -- in all of those studies to the regimens that are used by the plaintiffs for medication abortion?
A No, I didn't.
But the point is, there's a reason the FDA drew the line where they did. And the reason is, because when you go beyond ten weeks, you get a lot more failures. Every study demonstrates that.
Q You would agree that the rate of failures for medication abortion varies dependent on the specific regimen of medications used, correct?
A That may be the case, but I'm not really aware of studies that have put all these different regimens head to head.
But I'm aware of much data that tells us that the higher gestational age, the more likely you are to have failures. And I think that that's what all of these studies that I've referenced are demonstrating.
Q Even though you did not look at the specific dosage and say, Is this what the regimen is that's being provided beyond 70 days?
A Well, it -- let's look at that.
So obviously we talked about Dalenda,

234

which was a different regimen. Let's find out where that 78.6 percent came from.
Q So, Dr. Skop, I'm just focusing right now on what you cited in your report. We're not going to go through this whole study right now.
A But -- but I -- I cited the systematic review, didn't I?
Q Right.
And I'm -- I'm referring to the -- the -- the data that you put in your report. This is not a time for you to testify about everything that this study is saying. This is a time for you to answer my questions about what you have cited here and what I'm asking about this study.
Do you understand that?
A Sure.
Q Okay. So you did not compare all of the different regimens in this study, correct, in your report?
A Specifically in my report, I didn't talk about those. But now that I'm eyeballing them, most of them --
Q That was my question, Dr. Skop.
A -- most of them do replicate --
ATTORNEY NAROG: Objection.

235

You need to let the witness finish answering her questions -- answer your questions.
Q You did not cite -- you -- in your report, you do not compare different medication abortion regimens in this study; is that correct?
A I don't believe I discuss the different regimens in my report.
Q Okay. I'd like to pivot to talking about the telemedicine abortion law that's at issue in this case.
What is your understanding of this law?
A It requires an in-person visit, which allows face-to-face counseling. It allows looking a person in the eye to make sure that they genuinely desire the abortion.
And it involves -- although it doesn't say explicitly, but the way it works in clinical scenarios, if the woman is uncertain about her last menstrual period, for example, an ultrasound will be done.
So it gives the doc- -- the prescriber the opportunity to do the appropriate pre-abortion testing.
So, again, that improves safety for the

236

woman by making a more accurate diagnosis of gestational age, ruling out an ectopic pregnancy, making sure that the woman truly desires the abortion.
Q All right. And so specifically, just to drill down, this law requires that the clinician be physically present when the patient takes the first medication as part of a medication abortion, right?
A Yes.
Q Okay. And it doesn't mandate anything about where the second medication is taken, right?
A No. Generally, that's done at home.
Q Okay. And the -- Ohio's telemedicine abortion law doesn't mandate that an ultrasound be performed before the abortion, does it?
A It doesn't. But when they're in person, it's very easy to do an ultrasound. When it's done through telemedicine -- we're seeing this happen all over our country right now, that women are ordering these things without in-person prescribing. And in many cases, they need ultrasounds and they're not getting 'em.
Q Okay.
A So that's what this law seeks to prevent,

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

237

a lazy doctor giving the drugs out to a woman when he has not confirmed her actual gestational age, increasing her risk of complications.

Q My -- my -- the next few questions I'm going to ask are just about what Ohio's law does, and they are yes-or-no questions.

Ohio's law does not mandate pre-abortion blood testing; is that correct?

A That's correct.

Q And it also doesn't mandate in-person follow-up appointments, does it?

A No --

ATTORNEY NAROG: Objection.

Calls for a legal conclusion.

You can answer.

A It does not.

Q Okay.

A Although, that would be good care if it did.

Q Okay. Let's talk about your understanding of how telemedicine abortion works.

You talk about the "no-test" model in your report.

Are there any other models of telemedicine abortion in the U.S.?

238

A Yes. Theoretically, telemedicine could have the potential to do testing if -- if it was determined that the testing was needed. So it -- it could happen.

But experience, clinical experience since 2021, when the FDA removed the in-person dispensing requirement, is that increasingly this is not being done.

That's what you call a no-test in that they're just handing out the pills out willy-nilly without documenting the woman's gestational age, without doing testing to determine if she is at higher risk for complications.

Q Okay. So is it your understanding that under -- let me just rewind for a second.

Are you familiar with what's called a site-to-site model of telemedicine?

A Yes. I believe that's where you have a prescriber at one location. He's on the -- the telemedicine screen. The patient's at another location. He does the test. And then somebody opens a drawer at the other location and gives the woman the -- the -- the drug.

But, again, that's not what Ohio's going to allow if they remove this requirement. What

239

they're going to allow is women taking these drugs without any testing, and it's going to increase their risk of complications.

Q Okay.

A Because that's what we've seen happen across our country.

Q Is your under understanding that under a no-test protocol, patients never receive an ultrasound?

A No. And that's interesting. I'm glad you brought that up.

Most of the studies that they point to when they say it's safe to do telemedicine, most of those have all the standard pre-abortion testing still being done. Dr. Grossman, one of our witnesses, his 2017 study, ultrasounds on every woman.

So they point at those type of studies and say, Well, there doesn't seem to be a difference, which would an anticipate. If you're doing all the right testing, there wouldn't be a difference.

But what it actually allows is no-test means there's no-test. That means if a woman screens high risk, if she's had two prior ectopic pregnancies and we need to rule out an ectopic,

240

she's not getting an ultrasound.

If she says, I have no idea when my last menstrual period was, I could be 10 weeks, I could be 14 weeks --

THE COURT REPORTER: I'm sorry. You need to slow down a little. You need to slow down a little bit. It's too fast, Miss. I'm sorry.

If a woman receives --

THE WITNESS: Sure.

THE COURT REPORTER: -- please. If she -- ectopic pregnancies -- if we need to rule out an ectopic pregnancy, can you start from there, please?

A Right. If it's indicated to rule out an ectopic pregnancy, she's not getting an ultrasound.

Q Okay. So let's just pause there. I understand that you have very strong feelings about telemedicine abortion, so I'm going to ask that you try to restrict your narration and just answer my questions. Okay, Dr. Skop?

A Yes.

Q Okay. Do you know what the practices of the plaintiffs in this case are when it comes to no-test telemedicine abortion?

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

241

A At the present time, hopefully they're not providing them because it's illegal.
Q My question is, do you know what their practices are?
A Do I know what Planned Parenthood's practice in general is?
Q I'm saying, in -- for the plaintiffs in this, who are abortion providers in Ohio, do you know what their practices are with regard to no-test medication abortion?
A Their practice should be not doing it, because it's --
Q Do you know what their practices are, yes or no?
A I don't know if they're breaking the law or not.
Q My question -- so is that a no, you do not know what their practices are?
A I don't know if they're breaking the law, yes. That is -- that is the answer.
Q You don't know what their practices are; is that --
A Correct.
Q -- correct?
A Correct.

242

Q Okay. And do you know what the practices of other abortion providers in Ohio are?
A No, I don't.
Q Okay. And have you spoken to any abortion providers in Ohio about their no-test medication abortion protocols?
A No. But I know what other doctors throughout the United States are doing, and they're not testing.
Q Okay. So you say in your report -- I think this is kind of what you're referring to -- "The abortion providing website often does not have the ability to order an ultrasound even if it was deemed necessary."
And I'll just pull up this part of your report for reference. This is in paragraph 107. Give me one second.
So "the abortion providing website often does not have the ability to order an ultrasound even if it was deemed necessary".
You don't cite anything in support of this statement, do you?
A I believe later in the report, I cite some examples. I know the Christina Francis and the AAPLOG video. I -- I could provide you with more

243

references because we just did an extensive report on that at Lozier.
But in this particular instance, I did not give a specific citation, although I know it's happening.
Q Okay. And what's the name of that report that you're referring to that the Lozier Institute did?
A I don't recall the -- the name. The primary author was Mia Steupert.
Q Okay. But you don't cite that article here, do you?
A I -- I did not, I don't believe.
Q Okay. And that's not a peer-reviewed study, is it?
A That's correct. That's just looking on the websites and -- and documenting what they do and don't do.
Q Okay. And do you know whether the plaintiffs in this case have the ability to provide ultrasounds?
A I would assume they have the ability. But whether they'll do it if -- if all limitations go away and nobody's supervising them, I cannot say.
Q Okay. You don't -- you're assuming, but

244

you don't know whether or not they have the ability to do so?
A I mean, ideally, when they provide an in-person, they should have that ability. But, again, you know, the standards are very low. So it's -- it's hard to say whether they always do have that ability.
Q And do you know whether or not they refer for ultrasounds as part of --
A Again, I can't speak specifically to their practices.
Q Okay. And do you know how often they would refer to -- refer patients for ultrasound as part of a no-test medication abortion protocol?
A Not specific to Ohio. But I believe that there are -- some of the articles that are honest where they say, We do a screening and then if a woman screens high risk, we do an ultrasound.
So in other words, you know, not everybody need -- you know, somebody who's low risk, retrospectively, probably didn't need the ultrasound. But the women that are high risk need it.
I do know that ACOG has estimated that about 50 percent of women are inaccurate in

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

245

reporting their last menstrual period.
So I would say, based on that, probably half of the women do need an ultrasound. But whether that is happening, I don't know.
Q All right. Let's talk about gestational dating, since you just mentioned that.
What is your understanding of how the plaintiffs in this case assess patients' gestational age using a no-test medication abortion protocol?
A They ask them their last menstrual period, and they ask them how certain they are about it. And if they say, you know, whatever the date is and it makes them within ten weeks and they report that they're certain, they don't do anything else.
Q And what's that understanding based on?
A Well, I've read the no-test protocols. I've probably referenced them in the report.
Q Okay. And you've talked about --
A The Society for Family Planning has a no-test protocol that I'm certain I referenced.
Q Okay. And have you talked to any of the plaintiffs in this case about what their protocol is for determining gestational age?
A No, I haven't. I haven't talked to the

246

plaintiffs. But I have read many Planned Parenthood articles. You know, one would presume Planned Parenthood would have similar protocols. But, again, I don't -- I don't know that to be the case.
Q Okay. And do you know whether, as part of screening for a no-test medication abortion, the plaintiffs would ever refer for an ultrasound to determine gestational age?
A Well, they should, because that's what the protocol says. If a woman's high-risk, she needs an ultrasound.
Q Do you know whether or not they are doing that?
A No. I don't know what they're doing.
Q Okay. Then in paragraph 83, I'll just scroll up to that real quick.
You cite here some different studies about how accurate abortion patients are in estimating their gestational age, so specifically looking at the studies in paragraph 100 and paragraph 101.
You don't compare the methods for estimating gestational age in these studies to those for -- to -- for a no-test medication abortion, do you?

247

A Well, the -- the two ways to -- to estimate a gestational age are to ask a woman her last menstrual period or to do an ultrasound and do measurements. So those are the two options.
And I've mentioned here in this paragraph that last menstrual period dating, numerous data sources tell us that this is less accurate than ultrasound, which is the gold standard.
Q But you don't compare the protocols set forth in these studies to what's in a no-test medication abortion protocol, do you?
A I -- I'm not exactly sure if I understand your question. I don't know that anybody's done a study where they say, How many times did you get it wrong? They're not publishing that.
So I -- I -- I mean, basically what -- what I'm proving through these studies is LMP dating is suboptimal compared to ultrasound dating. No-test protocol assumes LMP is correct unless it has some compelling reason to think otherwise. So, therefore, many women are not getting ultrasounds who probably could benefit from them.
Q So is your testimony that there is not research about the accuracy of the gestational

248

dating methods in a no-test medication abortion protocol specifically?
ATTORNEY NAROG: Objection.
Mischaracterizes testimony.
A No. I think that -- honestly, once they publish studies saying it's okay to do no-test, in which case, they always had the opportunity to do an ultrasound when it was indicated, those are the studies they published.
Since that time, even though we know that many women who it is indicated are not getting ultrasounds, nobody has published any subsequent data telling us how that's working out for us in the real world.
So if you're looking for a peer-reviewed study, you're not going to find it. They published what they wanted to publish. It does not replicate what happens in the real world, but that's where we are today.
Q So you -- you don't cite any studies after -- this most recent one is in 2014.
You don't cite any later studies than that about the accuracy of gestational dating without an ultrasound, right?
A Those are the studies that I cited, but

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

249

physiology doesn't change. I mean, there's still going to be inaccurate LMP dating. There's still going to be -- ultrasound is still going to be the gold standard. So we wouldn't expect there to be differences.

But, yeah, I mean, I -- I cited enough studies, I think, to make my point. But I don't have -- you know, I didn't add onto it with more recent studies saying exactly the same thing.

Q Okay. And none of these studies talk specifically about pregnancy dating as part of a no-test medication abortion protocol, correct?

A No. They had not really envisioned that they were going to lower their standards so much at the -- at the time that these studies were written.

Q Okay. I'd like to turn to ectopic pregnancy.

What is your understanding of how the plaintiffs in this case assess for a risk of ectopic pregnancy using a no-test medication abortion protocol?

A They ask them if they have any risk factors for an ectopic. ACOG has told us that half of the women with ectopics do not have risk

250

factors.

Q Okay.

A So they do a very suboptimal screening exam.

Q And what is your understanding of the plaintiffs' protocols based on?

A The plaintiffs' protocols? I don't know the plaintiffs' protocols.

Q Okay. Well, that was my question, about what is your understanding of what the plaintiffs' protocols is.

So you're -- you're saying you don't have an understanding of what their screening process is for ectopic pregnancy?

A Can -- can I ask a question? Because I may be confused. Are -- are these laws not -- are these laws not being enforced? So the plaintiffs are doing no-test protocols right now?

Q These laws are currently enjoined.

What I'm asking you about is your -- your report and your studies that are in there.

A Okay. I don't know specifically what they're doing in Ohio. But I know that women are the same across the country, and I know that these no-test protocols have proven themselves to be

251

dangerous.

Q Okay. And so you don't have any knowledge about what the plaintiffs in this case are doing to screen no-test patients for ectopic pregnancy, right?

A That's correct.

Q Okay. So I'm going to turn to a couple paragraphs later. Some of the citations in paragraphs 85 through 88 where you're talking about ectopic pregnancy.

Let me just -- so in paragraph 105 here, you cite an ACOG bulletin about ectopic pregnancy; is that right?

A Let's see. Can you -- you said paragraph 105? Can you --

Q Oh, sorry. It's Footnote 105, I apologize.

A Oh, 100. Okay.

Q At the end of the page --

A Okay. Yes.

Q Okay. And that's about ectopic pregnancy in general, right?

A Yes.

Q And it doesn't say anything about abortions specifically; is that right?

252

A That particular practice bulletin does not.

Q Okay. And so it doesn't say anything about delay in recognizing an ectopic pregnancy following a medication abortion, does it?

A Any type of delay can result in the same outcome, regardless of whether a mifepristone abortion has been done or not. So it does talk about delay in diagnosis in that practice bulletin.

Q Okay. But not in the context of medication abortion, right?

A That's correct.

Q Okay. And then in paragraph 10 -- or sorry -- Footnote 106, you cite a 1990 study; is that right?

A That's correct. That's the only one I found that actually looked at the relative risk of ectopics, how they do with -- if a woman has an abortion.

But it makes sense to think that the pain and bleeding she anticipates from the abortion may delay diagnosis.

Q Okay. But you don't cite a study for that proposition, right? You're just. . .

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

253

A Well, I mean, this study demonstrates they're more likely to die if they're doing an -- an abortion.

Because in -- like I said, the clinical assumption is that what -- what are the risk fact- -- what causes a woman to seek care with an ectopic? It's pain and bleeding. What does she expect with a mifepristone abortion? Pain and bleeding.

So it makes sense that she's not going to present as early because she's going to be anticipating those warning signs as normal for the abortion.

Q And so this study specifically, though, which is from 1990, you're saying you didn't find a more recent study about ectopic pregnancy and abortion; is that right?

A You know, I think that there -- I do have a case report. I think I put it in there somewhere. But where a lady had, like, two liters of blood in her belly, because, again, she was undergoing abortion and it was delayed in the diagnosis.

But as far as I know, there's not anything more recent than 1990 that looks at this question.

254

Q Okay. And in 1990, medication abortion was not available, right?

A Right.

Q Okay. And do you know what the author is on the case study that you're referring to?

A No, I don't. I would be surprised if I didn't put it in my report, but I may have not.

Q Okay. And then you also have in Footnotes 107 and 108, there's a Marion article, "Ectopic Pregnancy: history, incidence, epidemiology and risk factors," and an "ACOG Ectopic Pregnancy Frequently Asked Questions."

These aren't about ectopic pregnancy and abortion, right?

A No. I think the FAQ was about the risk -- how many women with ectopics had risk factors.

Q Okay.

A Where they acknowledged that half of them don't have risk factors.

Q Okay. So you say in your report that ectopic implantations occur in only 2 percent of pregnancies. I can scroll to that part specifically. Let me find it.

And -- but you -- you don't cite any studies in your report that talk about the

255

incidence of ectopic pregnancies among patients seeking abortions specifically, do you?

A I don't believe I did. I am aware that there are studies that say the incidence is less than in -- than what I reported in the general population.

And that makes sense because the average age that women seek abortion is higher than the average age in which ectopic pregnancies are diagnosed.

So, again, most women with ectopic will probably be diagnosed with their ectopic before their abortion. But if they do come in early for an abortion and an ultrasound is not done to rule out an ectopic, if they have an ectopic, it could have a delayed diagnosis and could lead to a catastrophic outcome.

Q So you know of studies that say the incidence of ectopic pregnancy among abortion patients is less, but you did not include a citation to that in your study, in --

A I'm -- I'm aware of that. But the point is, if it's there and if we don't look for it and if we delay the diagnosis, we've done that woman a disservice, even if that's less than 2 percent of

256

women.

ATTORNEY HUMPHREVILLE: All right. So I'm going to look at this Goldberg study, then, that you cite in the next paragraph. And I'll pull that up. One second.

(Attorney Humphreville shared Exhibit 20 on the screen.)

Q Okay. So this is "Mifepristone and Misoprostol For Undesired Pregnancy of Unknown Location?"

You cite this in your report, right?

A I did.

Is it possible to put it in the chat?

Q Yep.

A Thanks.

Q It's in the chat.

A Okay.

ATTORNEY HUMPHREVILLE: All right. And I'll mark this as Exhibit 20.

(Skop Exhibit 20, Goldberg study entitled, Mifepristone and Misoprostol for Undesired Pregnancy of Unknown Location, marked for identification.)

Q So this study is about patients with pregnancies of unknown location, right?

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

257

A Yes.
Q And so that means that their pregnancy could not be located on an ultrasound; is that right?
A That's correct.
Q Okay. And it's comparing patients who started medication abortion right away compared to patients who did not start medication abortion right away, right?
A That is correct.
Q Okay. And it calls -- it starts that -- calls that second group the "delay-for-diagnosis group," right, where they didn't start the medication abortion, right?
A Yes.
Q Okay. And so when you refer to the 7.9 percent of patients whose treatment was delayed, you're referring to people who did not take medication abortion; is that right?
A That is correct.
Q Okay. I'm going to scroll down to the eighth page of this PDF and read where it starts under "Discussion" here. So I'll just highlight where it says Discussion for reference.
So it says, "For patients with undesired

258

pregnancies who have pregnancy of unknown location on initial ultrasonogram, we found that initiating medication abortion with mifepristone on the day of presentation, with simultaneous close serial hCG follow-up (same-day-start), was associated with: 1) shorter time to rule out ectopic pregnancy, 2) shorter time to complete abortion, and 3) lower rate of successful medication abortion and a higher rate of ongoing pregnancy when compared to delay for diagnosis."
Additionally, in the same day -- additionally, in the same-day-start group, we found no evidence of an increase in serious adverse events, emergency department visits, or nonadherence with follow-ups.
So this is saying patients who took medication abortion ruled out ectopic pregnancy more quickly compared to those who did not; is that right?
So this is one short -- we're talking about comparing the people who started medication abortion to the people who did not. And it says, "shorter time to rule out ectopic pregnancy" for the people who started medication abortion on that same day.

259

Is that right?
A That is what they reported.
Can I describe an important nuance? All of these women knew that they had a pregnancy of unknown location and they were all followed very closely.
This is very, very different than a woman taking drugs who has no idea that she's at risk for an ectopic pregnancy, without any follow-up, which is what's happening in the real world and in many of these no-test protocols.
So it -- you're -- you're absolutely correct, they found what they found. But this is not the same scenario as giving the drugs to someone who has not had an ultrasound at all, does not even know to be concerned about the possibility of an ectopic. Which these women obviously knew that there was a possibility. They were getting serial quants. They were being followed closely.
So this is really not replicating real-world conditions.
Q Okay. So it's not replicating real-world conditions, but you chose to cite it related to ectopic pregnancy risks for medication abortion,

260

nonetheless?
A I did, because I wanted -- the point that I wanted to make is, these were pretty high incidences. And, again, it doesn't matter with -- like, ideal -- or, like, statistically, we would expect the incidence to be the same in each cohort, because they came in with an ectopic. The drugs doesn't cause the ectopic. We know that this was just a pre-existing condition. So, you know, statistically we'd expect it to be about even.
But there -- there were some significant problems that happened to these women. There were ruptured tubes. There was laparotomies. You know, the whole point is, this is something we should take very seriously instead of lackadaisically saying, Well, it doesn't happen that often and probably we'll figure it out before she dies.
I mean, that's just -- you know, the point I make is, we need to do ultrasounds early in pregnancy.
And I think it's also worth pointing out that they do report that the women who took these drugs early -- so this is very early in pregnancy,

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

261

probably in the five-week gestational range before we can see a pregnancy in the uterus -- they failed more often. So the drugs, again, in that window of time, don't work very well either, which is, you know, just an aside, but --

Q So --

(Crosstalk)

Q So let's just break apart a few of the things that you're saying here.

So just to clarify, all of the patients in this study received an ultrasound; is that right?

A That's correct. That's how they knew they had a pregnancy of unknown location.

Q Right.

And the patients who received medication abortion were quicker to rule out ectopic pregnancy than the patients who did not receive medication abortion; is that correct?

A That's what they reported, yes.

Q Okay. And you also said that the drugs didn't cause the ectopic pregnancy; is that right?

A That's -- that's correct. It would have been pre-existing.

Q Okay. And this also says that for the patients who initiated medication abortion on the

262

first day, that they had a shorter time to complete the abortion; is that right?

A I think they said they had a shorter time to diagnose this. I can't explain why that would be. I -- I don't know if that was statistically significant.

But, again, they're all being followed very closely. So we would anticipate that, you know, the diagnosis would be timely for all groups.

But what I did point out is that they were more likely to have failed the abortion, the women who -- who got the abortion pills too early.

Q Okay. But they had -- this says they had a shorter time to complete an abortion, correct? You can look at where I have it on the screenshare.

A Yeah. Okay.

Q Shorter time to complete an abortion, right?

A Yes. And that makes sense because there's -- there's less tissue there, right, because they're getting the drugs a little bit earlier.

Q Okay. And then it also says, with the

263

same-day-start group, there was no evidence of an increase in rates of serious adverse events, emergency department visits or nonadherence with follow-up, right?

A Right. Because they were diagnosing them quickly in both groups.

Q Okay. You don't cite any studies about whether medication abortion patients are more or less likely to rule out -- more or less likely to detect an ectopic pregnancy compared to other pregnant patients, do you?

A Whether the patients themselves are more likely to detect it or whether the doctors are?

Q My question is, do you cite any studies one way or another about whether medication abortion patients are more or less likely to detect an ectopic pregnancy compared to other pregnant patients? You don't cite any studies that says that one way or another in your report, right?

A I -- I'm not aware that there's any studies looking at that, just in general. Certainly, if they have an ultrasound, they're more likely to be detected than if they don't have an ultrasound.

264

Q Okay. So you don't cite any studies, right?

A That -- that's correct.

Q Okay. What is your understanding of how the plaintiffs in this case assess for medical contra- -- contraindications using a no-test medication abortion protocol?

A Well, as we've discussed, I am not privy to Ohio of Planned Parenthood medication abortion no-test protocol. All I know is what I've seen from the Society of Family Planning, you know, which, presumably, they might follow.

But I -- I don't -- I don't know the details of that.

Q Okay. So you don't know whether the patients -- sorry -- the -- the plaintiffs would ever refer for an ultrasound based on potential medical contraindications, do you?

A I'd like to think they would. But, again, I don't have their protocols.

Q Okay. So you say -- I'll pull it up right here -- in paragraph 62 of your report -- you say -- sorry. Let me make sure I'm in the right spot.

You say, "there are certain women who are

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

265

at even higher risk of medication abortion failure due to preexisting factors. It is unlikely" -- of -- "they are notified of this when they are screened and counseled by an organization that has only medication abortion to offer."

You don't cite any studies for that proposition, do you?

A No. This is just my common sense.

Q Okay. And then you mention some risk factors at the end of this paragraph, so maternal age, prior C-section delivery, prior manual placental removal. You also mention women with five or more deliveries.

All of these things are something that could be orally screened for; is that right?

A That is correct.

Q Okay. And then in paragraph 89 of your report -- let me scroll down to that -- you say, anatomic abnormalities, such uterine fibroids, septum or unusual interpretation, and abnormal placentation may not be detected without ultrasound and could complicate the abortion procedure and place the woman's life in danger.

Do you say "abortion procedure" here because these are risk factors -- or these are

266

contraindications for procedural abortion; is that right?

A No, not necessarily. For example, a uterine fibroid is going to be more likely to bleed more heavily than -- if a woman has fibroids than if she doesn't. I mean, that's just -- we just know that to be the case.

So these could -- these could apply to procedural abortions, but they could apply to medical abortions too.

So, again, you know, unusual orientation, obviously if you're doing a surgical abortion and she has an acutely retroflexed uterus, you could -- you know, without an ultrasound you might not recognize that, and you could perforate the uterus.

But, you know, some of these are more specific for procedural abortions, but I think these are all situations that doctors would probably like to know.

Multi- -- I think I talked about multiple pregnancies at some point. But if you've got twins, you've got twice the amount of tissue. And so, again, the failure rate's going to be higher for a medication abortion.

267

Q Okay. And you don't cite any studies for this proposition here, right?

A Well, I -- I know that at some point I -- I cited ACOG's ultrasound bulletin. And that's where -- you know, the things that you look for on ultrasound.

But, yeah, I didn't -- I didn't specifically put a study there.

But 30 years of experience, I can just tell you these are things doctors know. Sometimes we don't actually have to point to the peer-reviewed literature to describe what's common sense for us.

Q Okay. You also say in your report, "abortion advocates have recently stated that RhoGAM is not necessary in the first trimester."

When you say "abortion advocates" here, who are you referring to?

A Society of Family Planning, ACOG. The studies have been authored by -- in many cases, by people who are known to be abortion advocates. So it's easy to see where the -- the motivation is coming from.

ACOG, in their -- in their guidance, they said to test for it except with shared decision --

268

if it -- if it would -- slow -- basically, slow down the abortion. Then you can use shared decision-making, which is their way of saying, you can just blow that off if you want, if you -- if it turns out that you're going to have to order some tests that the woman's going to have to do.

So it's -- it's -- it's very problematic because, you know, we've -- we've given RhoGAM consistently in the first trimester for pregnancy losses for decades. And, suddenly, they've just rewritten the rules.

Q So your opinion conflicts with ACOG here?

A What's that?

Q Your opinion conflicts with ACOG here; is that right?

A Well, ACOG loves abortion. They -- they love having these -- these drugs out on the streets. I mean, they've -- they've said that over and over and over again.

So, yeah, I -- I -- I do not feel that they're doing women a -- you know, a service by taking away their protection for their future babies.

Q So it conflicts with ACOG -- your opinion conflicts with ACOG on this point?

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

269

A On this point, yeah --
ATTORNEY NAROG: Objection.
A -- but I should note that, as of a couple years ago, ACOG agreed with me. So they just recently rewrote the rules when they got the opportunity to provide these drugs without testing.
Q Okay. And your opinion also conflicts with the Society for Family Planning, right?
A Well, I mean, that's -- that's basically the -- the professional organization for the abortion providers.
So, yeah, that one's quite a biased society.
Q So --
A I would note that the Society for Maternal-Fetal Medicine, which is the high-risk OB doctors -- who also, by the way, do like abortion -- but they have much more nuanced recommendations. Because it turns out that if complications do occur because RhoGAM has not been given, they're going to be the ones treating the complications.
So if you look at their advice, you actually see that they differ from what ACOG says,

270

because they realize they -- they will be the ones cleaning up the messes when these women have complications.
Q So just to return to my prior question.
Your opinion conflicts with the Society for Family Planning when it comes to pre-abortion blood testing; is that right?
A That's correct.
Q Okay. And you don't cite any Society for Maternal-Fetal Medicine bulletins here, do you?
A I don't remember if I did or not. I might have.
Q Do you see any in these footnotes right here?
A Oh, yeah. The Horvath 111, is the Society of Family Planning committee consensus. That's -- that's what I was describing.
Q Okay. But that's not a Society for Maternal-Fetal Medicine bulletin, right?
A Oh, no. Yeah, I -- I may not have -- I may not have referenced that one.
Q Okay. And you don't cite any current practice guidance that says pre-abortion blood testing is necessary for a first trimester abortion, do you?

271

A Well, no, because who's writing the guidance? It's ACOG.
Q Okay.
A And they -- they love having these pills out there without any supervision, so. . .
Q Okay. I'm going to turn to the statements in your report about in-person follow-up appointments following telemedicine abortion.
So one of the studies here you cite is a 2011 Grossman study called "Alternatives to ultrasound for follow-up after medication abortion: a systematic review."
You cite this in your report, right?
A I believe so.
ATTORNEY HUMPHREVILLE: Okay. And this will be -- I think I'm at Exhibit 21 now.
(Skop Exhibit 21, Grossman 2011 study entitled, Alternatives to ultrasound for follow-up after medication abortion, marked for identification.)
Q Okay. And just looking at the first page where it says "Conclusions," it says, "Alternatives to routine in-person follow-up visits after medication abortion are accurate at diagnosing ongoing pregnancy. Additional research

272

is needed to demonstrate the accuracy, acceptability and feasibility of alternative follow-up modalities in practice, particularly of home-based urine testing combined with self-assessment and/or clinician-assisted assessment."
Did I read that right?
A Yes.
Q Okay. And so they say that it's possible to accurately assess ongoing pregnancy without an in-person follow-up, right?
A That's what Grossman says. Again, this is like the fox guarding the henhouse. So we have to take it with a grain of salt.
Q Okay. And the --
(Crosstalk)
Q The authors here also recommended additional follow-up research, right?
A Yes.
Q Okay. And I'm going to pull up the other study that you cite here. This is a 2012 Jackson article "Can women accurately assess the outcome of medical abortion based on symptoms alone?"
You cite this study in your report as well, right?

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

273

A Yes.
ATTORNEY HUMPHREVILLE: Okay. And this is going to be Exhibit 22.
(Skop Exhibit 22, Jackson 2012 article entitled, Can women accurately assess the outcome of medical abortion based on symptoms alone?, marked for identification.)
Q So if I go to the second page here, and a little more than halfway down the right-hand column, it says, "A woman's assessment of" -- sorry. This highlighting is being a little screwy.
"A woman's assessment of abortion outcome at the follow-up visit was evaluated by routinely asking about pregnancy symptoms, expulsion and bleeding patterns."
So did this study just base -- it was just based on pregnancy symptoms and the degree of bleeding, right?
A That's the questions they asked the women.
I don't recall. There might have been a pregnancy test involved. I've forgotten exactly what they were assessing here.
Let's see.
Q Okay. So maybe it would be helpful. . .

274

A Uh-huh.
Q Let me just -- so I -- I think what it's looking at is how the self-assessment compared with the clinical assessment, right?
A Yes. Yes.
Q Okay. And so it didn't involve at-home testing in the case of these patients, right?
A No. But presumably they did a clinical evaluation to determine whether the pregnancy was ongoing.
Q Okay. And so the 2011 study we were just talking about recommends additional research, but you don't cite any studies that came after 2012, right?
A You know, unfortunately, they just kind of like skipped past that. They said, Oh, we can probably get away with not doing the follow-up.
And so then, since that time, a lot of studies are just -- they just don't do the follow-up.
Remember, I told you about the -- Upadhyay's CHAT study where they didn't even bother to, like, touch the patient, bring 'em in. They just send them a text or an e-mail, Hey, how's it going?

275

So that's -- that's really what it's devolved to since that time.
Q So did you look for any studies after 2012 about whether or not medication abortion follow-up visits are necessary?
A In 2016, the FDA took away the requirement for follow-up. So you're just not going to have too much data after that time. It doesn't mean it wasn't necessary. It just means the FDA decided to make it as easy as possible to -- to get these drugs out to women.
Q So do you cite any studies between 2012 and 2016?
A No.
(Crosstalk)
A I think the studies I cited made my point.
Q Okay. And so did you look for other studies after 2012?
A No. I -- I just -- you know, in -- in many of these cases, I would put a couple of examples to illustrate what I was talking about and -- and move on.
Q Okay. And if you had a more recent study that showed that an in-person follow-up was necessary, you would have cited it, right?

276

A Yeah. I'd love it, but nobody's doing those studies.
Q Okay.
ATTORNEY HUMPHREVILLE: Okay. I think it might be a good time to take a break. Is -- is ten minutes okay?
THE WITNESS: Sure.
ATTORNEY HUMPHREVILLE: Okay. So we'll come back at 50 after the hour.
THE VIDEOGRAPHER: Going off the record --
THE WITNESS: Okay.
ATTORNEY HUMPHREVILLE: -- at 15:40.
(A recess was from 3:40 p.m. to 3:53 p.m.)
THE VIDEOGRAPHER: We are back on the record at 15:53.
BY ATTORNEY HUMPHREVILLE:
Q Okay. Dr. Skop, I'm going to shift to talk about some of the studies you cite on telemedicine abortion, starting with the 2017 Grossman and Grindlay article that you cite in paragraph 94 of your report.
So I'll put that in the chat, and I will share my screen.
(Attorney Humphreville shared Exhibit 23 on the screen.)

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

277

Q So this is called "Safety of Medical Abortion Provided Through Telemedicine Compared With In Person."
You cite this in your report, right?
A Yes.
ATTORNEY HUMPHREVILLE: Okay. And then this will be Exhibit 23.
(Skop Exhibit 23, Grossman and Grindlay 2017 article entitled, Safety of Medical Abortion Provided Through Telemedicine Compared With In Person, marked for identification.)
Q So looking at the first page here, it says, "During the study period, 8,765 telemedicine and 10,405 in-person medical abortions were performed. Forty-nine clinically significant adverse events were reported (no deaths or surgery; .18% of telemedicine patients with any serious adverse event. . .and 0.32 of in-person patients. . .The difference in adverse event prevalence was 0.13. . ."
Did I read that right?
A Yes.
Q Okay. So according to that passage, both telemedicine and in-person patients included in

278

the study, less than .4 percent experienced clinically significant adverse events, right?
A Right. So these are hospitalizations we're talking about.
Q Does it say "hospitalizations" or does it say "clinically significant adverse events"?
A Well, as we discussed before, that's the definition of significant adverse event is something serious enough to -- to land somebody in the hospital.
Q Okay. And are you reading the definition for significant adverse event here when you say it's about hospitalization?
A Well, we can -- we can continue. But the point I would make is that those are the most significant complications. This is not all complications.
Q Okay.
ATTORNEY NAROG: Peyton, would you be able to put this exhibit in the chat, please?
ATTORNEY HUMPHREVILLE: Oh, I sorry. I put it in --
(Crosstalk)
ATTORNEY NAROG: It's no problem.
ATTORNEY HUMPHREVILLE: I apologize.

279

ATTORNEY NAROG: That's okay.
THE COURT REPORTER: Who was that, by the way?
ATTORNEY NAROG: Amanda Narog for the Ohio Attorney General's office.
Q And so it actually found that the rate of adverse events for telemedicine abortion was even lower than for in-person medication abortion, right?
A That's what they reported.
Q Okay. All right. I'm going to turn to talking about in paragraph 97 of your report, you cite a 2023 -- sorry -- 2001 [sic.] article by Anger, et al.
Are you aware that Holly Anger also authored a follow-up study in 2004?
A Can you tell me what --
Q So this is in Footnote 121. The article that you cite is a 2001 Anger article.
A Oh. I -- I didn't put that study. No, I just recorded this one.
Q Okay. So you don't cite the 2004 [sic.] Study, right?
A I --
(Crosstalk)

280

A Clearly, I did not study it -- I did not cite every study that could be cited. I -- I cited what I cited.
Q Okay. I'm going to pull up this 2004 -- sorry, 2024 -- I don't know why I can't keep saying that right.
A I was confused about that.
Q "Clinical and service delivery outcomes following medication abortion provided with or without pretreatment ultrasound or pelvic examination: An updated comparative analysis." And I'll put this in the chat too.
So have you reviewed this 2024 article before?
A I believe I've seen this one, yes.
Q Okay. And if we go to the second page here, at the bottom of the left-hand column, it says, "These data differ slightly from those used in that paper," referring to the 2021 paper, "because of new information obtained since that time."
Did I read that right?
A Yes.
Q Okay. And then if we scroll down to page 5, this highlighted text here says,

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

281

"Importantly, our new results appear to mitigate the findings of possible drawbacks of No-Test Medication Abortion reported in our prior paper. Among participants screened in the period of the prior study, those in the No-Test group were significantly more likely than those in the Test group to require a procedure to fully complete the abortion and to have unplanned clinical visits for abortion-related reasons.

"However, these elevated risks did not persist: in the later study group, abortion outcomes were similar in the two groups, and the No-Test group was less likely to have unplanned abortion-related visits after the treatment."

So the new information found in this follow-up study said that higher documented failure rates in the no-test abortion group that you reference in paragraph 97 of your report, those discrepancies did not actually hold; is that right?

A That's what this follow-up study reports. I do want to, if I may, describe the difference between screening and not doing a test; screening, determining high risk and doing a test; and just letting the chips fall where they may where almost

282

nobody gets ultrasounds or gets screened. So those --

Q My --

A -- those are three completely different groups.

Q My question, Dr. Skop, is about, in this study they found that over time the higher documented failure rates that you talk about in your report did not persist, correct?

A Yeah. I guess they reevaluated the data to find what they wanted, yeah.

Q Okay. And when you say "they reevaluated the data to find" -- what you wanted -- "what they wanted," what's your basis for saying that?

A Is -- isn't that what this -- if you don't mind, I'd like to look at this. Because I -- if I didn't reference this study, I may need to -- I'm sure that I've seen it, but I may need to reacquaint myself with the limitations of the study.

Q Well, let's look at --

A So they were -- they were reanalyzing the same data. So they went back and they said, Let's see if we can make it look better.

And so then they reanalyzed it and then

283

they said, Oh, what we found before, we're not seeing now.

I think that's my interpretation of -- of these two studies.

Q Okay. You -- you said earlier you're familiar -- you were aware of this 2024 study, correct?

A Yeah, I am aware of it. But I -- I don't think you recognize how prolific the abortion industry is with studies. So there's a lot of studies out there. So I can't say I have them all memorized.

Q So I'm not asking you to have them memorize. I'm saying, you're aware of this study.

You cited the 2021 study in your report, but you didn't think to cite the 2024 follow-up study; is that correct?

A Apparently, I did not cite the follow-up study, no.

Q Okay. And so the higher documented failure rates did not hold, according to the 2024 study, right?

A Sorry, I'm -- I'm just reading -- I'm reminding myself of the study.

Q We -- we can move on.

284

A Uh-huh.

Q If you don't know the answer, that's okay.

I'm going to turn to another report that you cite -- another systematic review that you cite in your report.

So in paragraph 98 of your report, you cite --

ATTORNEY HUMPHREVILLE: Oh, and I -- I for- -- I don't think I marked that for exhibit -- for -- as an exhibit.

But the 2024 Anger study is going to be Exhibit 23 [sic.].

(Skop Exhibit 24, Anger 2021 article entitled, Clinical and service delivery outcomes following medication abortion provided with or without pretreatment ultrasound or pelvic examination, marked for identification.)

ATTORNEY HUMPHREVILLE: And then I'm going to put an Endler systematic review that you cite in the chat as well. So I'm sharing this on my screen.

(Attorney Humphreville shared Exhibit 25 on the screen.)

Q This is "Telemedicine for medical abortion: a systematic review?"

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

285

Is this a study that you cite in your report as well, Dr. Skop?
A Yes, it is.
ATTORNEY HUMPHREVILLE: Okay. And I'll mark this as Exhibit 25.
(Skop Exhibit 25, Endler systematic review entitled, Telemedicine for medical abortion: a systematic review, marked for identification.)
Q So this one is a literature review looking at a bunch of different studies across different countries; is that right?
A I -- yes.
Q Okay. And according to this passage on the first page, it says, "Based on a synthesis of mainly self-reported data, medical abortion through telemedicine seems to be highly acceptable to women and providers, success rate and safety outcomes are similar to those reported in literature for in-person care, and surgical evacuation rates are higher."
Did I read that right?
A Yes.
Q Okay. And so it found that telemedicine is highly acceptable to patients, right?
A Yeah, those are all the subjective

286

conclusions they draw.
Q Yeah. And to providers?
A Well, yeah. I mean, the providers aren't caring for the complications. So it's -- it's easy for them.
Q Okay.
A It's very acceptable.
Q And it also found that telemedicine has a similar success rate to in-person abortion care, right?
A That's -- yes, that's what they report.
Q Okay. And also that telemedicine has similar safety outcomes to in-person abortion care, right?
A Yeah. Telemedicine, when they're -- yeah.
Q Okay.
A When they're -- the -- so I just want to point out here. We're not talking necessarily no-test in this review. We're talking prescribe via telemedicine as opposed to in person.
But many of these studies actually do the same testing. So this is the critical difference, what we need to be discussing, are the women who need testing getting it?
Q Okay. And you cite in your report the

287

higher aspiration evacuation rates, so I'm going to hone in on that. I'm going to turn to page 6 of the PDF, which is -- oop, sorry -- page 1099 in the study. And I'm going to start reading the highlighted language where it -- it's talking about the higher surgical evacuation rates.
And then it says, "One study from WoW," which is Women on The Web, I believe, "showed that surgical evacuation rates may vary" -- or sorry -- "surgical evacuation rates vary depending on the woman's country of residence, and another that a minority of women report that evacuation was performed for excessive bleeding or infection.
"It is therefore possible that the differing rates of surgical evacuation reflect varying local practices in the treatment of incomplete abortion or miscarriage."
So this is indicating that follow-up aspiration depends on what country the patient is in; is that right?
A That's what she says. But, you know, this is the -- absolutely, Ohio does not want to follow this model. She does no-testing, she mails these drugs out thousands of miles away and nobody is available to care for those women. And she has

288

huge numbers lost to follow-up.
Q Okay. So I'm focusing on this study, Dr. Skop, because you cite it in your report for the proposition that aspiration abortion rates are higher. So that's why I'm referring to the study, since you are relying it for the aspiration rate.
A Right.
Q So if you don't think it's a reliable study, I -- I'm referring to it because you cited in your report.
A Yeah. Yeah. Yeah. So basically what she's saying is when I send drugs to -- I don't know -- South African countries that don't have a good medical system, they may have fewer surgical completions.
Is that a good thing? They're just letting these women continue to bleed for weeks and months with this retained tissue.
I think that she's what she's telling us, that more developed countries are more likely to intervene. So these women don't end up needing blood transfusions. They don't end up having excessively poor outcomes.
So -- you know, because it doesn't make any sense, right? Like, if these drugs work the

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

289

same way in every women, if there's no difference between races, then -- then we ought to be seeing the same thing, except I think what she's telling us is she's giving these drugs in -- in countries and systems that don't have the ability to intervene quickly.

Q Okay. And that's not what this passage says here; is that correct?

A That's -- that's what I interpret from what she's saying.

Q Okay. So it says here that it differs based on country, and the rest of that is your editorializing, correct?

A Yeah. Because, otherwise, why -- why would it be different?

Q Okay. And then it countries, "Rates of continuing pregnancy and surgical evacuation for women using telemedicine" -- for medication -- "for medical abortion were significantly higher at greater than 12 weeks gestation compared with under 12 weeks gestation and higher than those reported in the literature for abortion at over 12 weeks after in-person abortion care."

Sorry. "Women performing abortion in hospital at over 12 weeks received misoprostol at

290

regular intervals until abortion occurs."

Sorry. Let me just scroll to the next page.

"However, women performing abortion through telemedicine may not have access to repeat doses of misoprostol, which would lower their rate of complete abortion."

And so one of the reasons for incomplete abortion, this notes, is that women may not have access to additional doses of misoprostol, right?

A Yes. And she made a very articulate argument for why these abortions should be supervised instead of just mailed out and -- good luck.

Q Okay. But she's not saying -- sorry.

She's saying basically that additional misoprostol leads to higher completion rates; is that correct?

A That is correct. If the women had a doctor supervising them who could tell them, You need more misoprostol, then perhaps there would be less surgery.

Q Okay. I'm going to turn back to the Cely-Andrade study that we discussed earlier, which is -- it's Tab AB, and it's Exhibit 18.

291

And so -- let's see. So, first, you note in your report -- actually, let's just -- you say that 8.9 percent of telemedicine patients -- this is in paragraph 100 of your report -- 8.9 percent of telemedicine abortions failed in the literature review.

So I'm going to look at what this says here under "Effectiveness." So it says, "In the studies that focused on telemedicine patients, the average effectiveness was 91.9."

So if we're subtracting, that's actually 8.1 percent, right, not 8.9 percent; is that right?

A That seems right, yes.

Q Okay. And it goes on to say, "Moreover, additional doses of misoprostol were administered after 3 to 4 hours: six studies reported doses of up to 400 micrograms, three studies reported doses up to 800 micrograms, and one study reported doses of up to 1,600 micrograms.

"According to the results, increasing additional doses resulted in higher effectiveness rates."

So this is essentially saying that if you do repeat doses of misoprostol, you're increasing

292

the effectiveness of the medication abortion; is that right?

A That's correct.

Q Okay. I'm going to turn to page 17 here, because you also talk about ER visits in your report, citing this study.

And you note that in one study -- you say an average of 7.8 percent patients -- of patients were evaluated in the emergency room.

And so here under "Emergency department visits" on the right-hand side, it says in one study, the frequency was 7.8 percent.

But that's just one study, right, not the whole review?

A That's correct.

Q Okay. And it says that, another cross-section study "compared this outcome between telemedicine patients and standard patients. The frequency of the emergency department visits in the telemedicine group was 0.1% while it was 0.2% in the standard group. No significant risk difference was observed between two groups of interest."

So in this other study, just .1 percent of telemedicine abortion patients visited the ER,

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

293

right?
A That's correct.
Q And that's actually lower than the medication abortion patients who received in-person care, right?
A Yes.
Q Okay. And then you also say that 4.1 percent of patients required antibiotics in your report; is that right?
A I -- that may be the case. I don't have my report here in front of me.
Q I'll show you. It's in paragraph 100.
So you say, "4.1% required antibiotics," right?
A Okay.
Q And you're citing this study.
So then under Antibiotics, it says that there was an average of 4.1 percent across three studies.
And then it goes on, "In the other two studies, the average incidence of antibiotic treatment in the telemedicine group was 0.4%" -- and -- "0.05% in the standard group."
So in some of these studies, the proportion receiving antibiotics was much lower,

294

right?
A Correct.
Q So it wasn't 4.1 percent average across all the studies in the review, right?
A Can you show me again what I said? How I -- how I worded that in my --
Q Sure. You said, "An average of," and then skipping the ER part that we just talked about, "4.1% required antibiotics."
Did I read that right?
A Yeah. Can you back up to the beginning of that paragraph?
Okay. Yeah, I see what you're saying. Uh-huh.
Q Okay. So you cite some of the studies in this systematic review, but not all of them; is that right?
A Right. I should have said "from three studies."
Q Okay. And then you next say, "1.3% were hospitalized," right?
A Yes.
Q Okay. So I'm going to look at the "Hospitalization" results in this study.
So in the left-hand column here, it says,

295

"In three studies that solely considered telemedicine patients, the average occurrence of this event," meaning hospitalization, "was 1.3%.
"In the other three comparative studies, no statistically significant differences were observed between the telemedicine group, which had an average hospitalization rate of 0.1%, and the standard care group, which had an average hospitalization rate of 0.2%.
"In the subgroup meta-analyses (based on gestational weeks), no differences were found in hospitalization rates following medication abortion."
So this isn't saying that, across all the studies in this report, that 1.3 were hospitalized; is that right?
A That is the case. Again, three studies. And I would note, the certainty of this evidence was low.
Q Okay.
A So they're saying this is not good evidence.
Q Okay. But you chose to cite this report's hospitalization results in your report, correct?
A Of my three -- of those three studies,

296

yes.
Q Okay. And the other three studies found that the hospitalization rate was 0.1 percent, right?
A That's what they record, yes.
Q Okay. And that it was actually lower than for in-person care, right?
A You know, again, like, the comparison between the groups, I think we have to ask ourselves the questions about how were they testing? You know, there's a lot of differences between these studies. These were not apples and oranges studies in -- in many cases.
Q Okay. And so when you chose to cite the 1.3 percent versus the 0.1 percent, were you looking at all of the different medication abortion protocols, telemedicine protocols when you chose to cite the 1.3 percent versus the 0.1 percent?
A Well, I -- I don't recall that I looked at the specific protocols. Did you want to show those to me? Do you feel like those were differences in doses as well that we should discuss?
Q No, I'm not -- I'm -- you're saying that

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

297

the studies need to look at the different protocols, but then you're saying that you didn't look at the different protocols when you cited only part of the evidence here; is that right?

A Yeah, I think that you're really demonstrating my point that the data is very sparse. It's very -- in many cases, it's comparing apples to oranges.

And so I could have said more accurately "up to 1.3 percent hospitalization" because that certainly was documented in several of those studies.

Q So you choose to cite studies where the data is sparse; is that right?

A You know, the data is sparse everywhere because these studies -- well, for the data deficiencies that we discussed earlier. We -- we do the best we can. We cite the studies that we can.

I'm citing to you abortion industry studies that tell me, for example, all these women requiring additional doses of misoprostol. Why on earth would we want to take away the follow-up visit when a doctor might determine she needs more misoprostol when we know that many times they do

298

need more misoprostol?

Why would we want to take that away? Why are we removing all these safeguards, using a beyond-ten-weeks gestational age knowing that more people are going to fail and then saying, You know what? We're not even going to have a doctor involved here.

So I think that -- you know, these studies -- I mean, of course, there's -- there's limitations in this data. But I think when you look between the lines, you see a lot of evidence that Ohio should not let the abortionists just willy-nilly mail these drugs out with minimal testing.

It's going to hurt women. I think that that's what these studies are showing us, if we read between the lines.

Q And you choose to cite studies that you say compare apples and oranges; is that right?

A Again, these studies are all we got. Okay? There's just not a lot. The abortion industry, once it finds a result it likes, it moves on and it doesn't repeat that study. So we do the best we can and we cite what we have.

But, again, the certainty of the evidence

299

was low, right here in the middle of this thing. So if the certainty of the evidence is low and you're going to recommend a new intervention, a new way of doing something, you should call for more studies. You shouldn't say, We have the answer, because you've already told me the certainty of the evidence was low.

So this is what we're dealing with with abortion studies, is they -- they find something; they like the number and they just move. And they don't really care if 30, 50, 70 percent of the women are lost to follow-up. They invent statistical techniques to try to justify that loss to follow-up.

Q Okay. And so just, lastly, on this report you say, "0.5% had a blood transfusion," right?

A Yes.

Q Okay. And so I'm going to turn to paragraph 18 here -- or, sorry, page 118. Let me find this. Oh, sorry. It's -- give me one second. Okay. This is actually page 16, I apologize.

So then here it says, "In the subgroup meta-analyses (based on gestational weeks), no differences were found in the need for blood

300

transfusion following medication abortion," right?

A That's what they say.

Q Okay. So the risk for blood transfusion is the same regardless of in-person or telemedicine, right?

A Let's see. That's correct. It might be worthwhile to look at the gestational ages that they were looking at.

Q Okay. Well, let's -- let's just move on for now.

You also cite a 2002 Aiken's -- sorry -- 2021 Aiken study, which I'll put in the chat. And this is in paragraph 102 of your report.

So this is called "Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study."

This is the study you cite in your report, right?

A I believe so, yes.

ATTORNEY HUMPHREVILLE: Okay. And I'll mark this as Exhibit 26.

(Skop Exhibit 26, Aiken 2021 study entitled, Effectiveness, safety and

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

301

acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine, marked for identification.)

Q So this one is comparing patients who had an in-person assessment, including an ultrasound, and then -- and took mifepristone at a clinic with patients who are assessed with a no-test protocol; is that right? I -- I can go to the relevant methods, if you'd like.

A Mm-hmm. Yes. Yes. This is the U.K. study.

Q And so there's --

A There's significant problems with detecting complications in the U.K. study.

Q Okay. And we -- we get can into that in a second.

But it's essentially comparing in-person assessment patients, including ultrasound, with patients who are assessed using a no-test protocol, right?

A Mm-hmm. And they were -- they were measuring complications that occurred before the woman left the clinic, which is not when medication abortion complications occur.

Q Sorry. Can you say that again?

302

A The -- there's two systems for measuring complications in the U.K. They were looking at the abortion notification system complications, which merely measures complications that occur before a woman leaves the clinic. Those might pick up complications on surgical abortions.

But she hasn't even completed the medication abortion regimen at the time that she leaves the clinic.

And so it's been documented that this is a very flawed study, 50,000 abortions, because they didn't actually look at the HES, the hospital episode system, which is the one that would have detected the complications.

Q Okay. So let's -- let's get into that for a -- in a second. I just want to look at the results here on the first page.

So it says, Mean waiting time from referral to treatment was 4.2 percent days shorter in the telemedicine-hybrid model and more abortions were provided under six weeks gestation.

So this is saying patients had shorter wait times, right?

A Right. They just got online, did a video and got the drugs in their hands right away.

303

Q Okay. And more of them had abortions earlier in pregnancy too, right?

A That's correct.

Q Okay. And then it says, "Treatment success" -- 9 -- "98.8% versus 98.2%."

So that's, in both groups, less than 2 percent had failed abortions, right?

A Based on the system they looked at. But, again, they didn't look at both systems. So this was very incomplete data.

Q Okay. And it's actually higher for the telemedicine group than the in-person group, right?

A What they've reported. I -- I -- I doubt that's really statistically significant.

Q Okay. But it's -- 98.8 percent is higher than 98.2 percent, right?

A Yeah, yeah. You're right. It doesn't make sense, though. Like, why would it be more effective to use telemedicine? I mean, at least you could make the argument we don't think it's worse. But how is it that they get more effective?

You know, again, it just goes back to the data deficiencies. We don't really know.

304

Q And then the serious adverse events were 0.02 percent versus 0.04 percent, right?

A Yeah. That's what they report, yes.

Q Okay. So less than .05 percent for both groups, right?

A Yeah. Based upon the data system they looked at, not the hospital episode system.

Q Okay. And, again, it was slightly lower for the telemedicine group than the in-person group, right?

A Based on the data they had.

Q Okay. And less than 0.2 percent of patients in both groups -- or, sorry -- 0.2 percent of patients in both groups had ectopic pregnancies, right?

A Yes.

Q And that's lower than the 2 percent statistic that you cite in your report, right?

A For the reasons I mentioned above. Most of these abortions are occurring above six weeks gestation. Most ectopics have been diagnosed by that time.

Q Okay. So you mentioned before that this is relying on the abortion notification system data, right?

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

305

A Primarily. Because there's not -- they don't have a system that links those two in the U.K.
Q Okay. And this article doesn't say anywhere that it was relying on abortion notification system data, does it?
So if I do a search for the term here "abortion notification system," that says no results, right?
A Yeah.
Q Okay. And what about ANS? Well, that's showing obstetric --
(Crosstalk)
A That's the same way, yeah.
Q Not a good example because ANS appears in a lot of text.
But it does not say "abortion notification system" anywhere in this article, right?
A Apparently.
Q Okay. And it doesn't say anywhere that it's relying on abortion notification system data alone, right?
A That's correct. But we -- we just know from people on the ground who understand how the systems works that they actually don't link the

306

two systems.
Q Okay. And so the other system you're talking about, that's the hospital episode statistics; is that right?
A That's true, yes.
Q Okay. And then this article doesn't mention hospital episode statistics either, right?
A Right. She just waves a wand and says, Somehow we know about these complications.
Q Okay. So from what I can tell -- okay. Just looking, I guess, at paragraph 102 of your report where you talk about this study, you're not citing anything other than looking at Footnote 126 here.
You're only citing the Aiken study, right?
A Yeah. I would be surprised -- I've read a peer-reviewed study on this. I would think I might have cited it, but perhaps I didn't.
Q Yeah. So you say, "When HES data is also examined, it estimates ten times the complication rate reported by these researchers and relied upon by the FDA."
And then this is just citing to the Aiken study, right?
A Can you show the me the footnotes at the

307

bottom?
Q Yeah. So this is Footnote 126 right here.
A Okay. Yeah, apparently, that's the case.
Q Okay. And so you say you have a peer-reviewed study on this. I think this is the "United Kingdom Data Deficiencies Influencing U.S. FDA Decisions" paper that you're a coauthor of; is that right?
A Yeah, that's correct.
Q Okay. So I'm going to put that in the chat and I'll pull that up here as well. Can't get this to. . .
(Attorney Humphreville shared Exhibit 27 on the screen.)
Q Okay. So is this the article that you're a coauthor of that you're referring to?
A Yes.
ATTORNEY HUMPHREVILLE: Okay. This is going to be Exhibit 27.
(Skop Exhibit 27, Skop paper entitled, United Kingdom Data Deficiencies Influencing U.S. FDA Decisions, marked for identification.)
Q So this is in the Journal of Law and Medicine, right?
A Issues in Law and Medicine, yes.

308

Q Oh, I apologize. Issues in Law and Medicine, right?
A Yes. That's correct.
Q Okay. So you say on page 12 of this study that one of your concerns about the ANS data versus the HES data is that it does not include -- it doesn't include evacuation of retained products of conception as a complication, right?
A Yes. That was one of the concerns.
Q Okay. But the Aiken study does include retained products of conception treated with surgical management in its data, right? I can turn back to that study, if you'd like.
A It's okay. I've got it here.
Q So if you look on page 7, Table 2 -- wait. Sorry. I. . .
A Right. They report that data, that -- that this is the comparison of effectiveness. But they did not -- I don't believe they specifically called that a complication.
Q Okay. Let me -- sorry, I'm having a little bit of trouble navigating on my screen right now.
So I'm going to turn to page 7 here. And it says, "Continuing pregnancy treated with

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

309

surgical management" -- or, sorry -- "retained products treated with surgical management," right?

A Yes.

Q Okay. So that -- this does take into account retained products that were evacuated, right?

A So it discusses that, yes. We don't think that it's the complete number, because, again, the systems don't link. And so they -- they get the abortion information from the ANS.

But there's -- there's no really discussion of how they're able to know that the HES are, you know, related to the abortions since there's -- there's no common patient identifying information between the two systems.

And, as I said, I don't -- there's -- they're talking about effectiveness in terms of expelling the tissue here, but they didn't specifically call that a complication.

They have -- of course, they -- the significant adverse events, as I said earlier, they -- they tend to think that's really the only thing worth talking about in terms of complications.

Q Okay. So here in the Aiken study, just .7

310

percent had retained products treated with surgical management, right?

A That they detected, yes.

Q Okay. And you say that the ANS data doesn't include evacuation of retained products, right?

A Well, the ANS data is the information that is known at the time the woman's in the abortion clinic. So, you know, if her retained products are diagnosed at a hospital three days later, ANS doesn't know about it. It's the HES system that knows about it.

Q Okay. So you say in your report that the -- or, sorry -- in your study, you say that the ANS data doesn't include retained products treated with surgical management, but the study does include retained products treated with surgical management, right?

A What I -- what I -- the nuance is that in my paper I say, "These are not considered complications."

I'm not saying this report doesn't talk about it, because it does, but they don't consider that a complication.

And, again, remember, some of the studies

311

that we've looked at already today had 10, 13 percent failures requiring surgery in those late -- because, remember, this is all the way in the first trimester. This goes up, I believe, to 12 weeks.

So it doesn't -- shouldn't we be asking questions, again, okay, in the U.K., they have a tenth of the complications that we've documented in some of the other studies?

I mean, people should be asking questions when they see data that's this disparate, why is -- why is that happening? And in this case, it's happening because they're not picking up all the complications.

Q Okay. So then you say in your study, which includes retained products as a complication, right? Turning back to --

A Well, my -- my study was a critical analysis of Aiken's studies, documenting the -- the reason that we felt her data was flawed. But we do report -- I think it's later --

Q Yeah. I have this up here, if you --

A Yeah. Anyway, we do report that alternative systems tell us much higher complication rates.

312

Q Right. And so looking at page 15 of the PDF or 46 of the journal of your study, you say, when you're including incomplete abortion, "the HES documented 19.3 complications per 1000 abortions or approximately 2 percent."

And so even when you include -- or I'll just stop there.

So --

A Yeah.

Q -- it's still under 2 percent complications in the HES data, right?

A For hospitalizations.

Q Okay. And the HES data also includes higher gestational ages, including over 20 weeks, right?

A Well, the HES data would be all complications that come in -- into the hospital or the ER.

So it could include -- yeah. So it could include higher gestational age abortions. Typically about 90 percent of abortions are done at less than 12 weeks. So the -- the vast majority would be early abortions that the HES is picking up.

Q Okay. But it includes abortions after 20

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

313

weeks too?
A It would. I believe in the U.K. they do limit it to 24 weeks.
Q Okay. So it includes abortions after 20 weeks, correct?
A It would include some -- some late abortions, yes.
Q Okay. And it would include non-medication abortions, right?
A That's correct.
ATTORNEY HUMPHREVILLE: Okay. Okay. I think we can maybe take a break now. Maybe we can come back at 45 after the hour.
THE WITNESS: Okay.
ATTORNEY NAROG: Sure. Can I ask real quick, how long we've been on the record?
THE VIDEOGRAPHER: Going off the record at 16:37.
(A recess was from 4:37 p.m. to 4:51 p.m.)
THE VIDEOGRAPHER: We are back on the record at 16:51.
BY ATTORNEY HUMPHREVILLE:
Q All right. So you mentioned a couple things in your report about women traveling to abortion clinics.

314

So patients who cannot obtain medication abortion at home will need to travel to a clinic; is that right?
A So if -- if it's being dispensed in person, yes, they would need to travel to the clinic.
Q Okay. And you say in your report that going to a clinic will involve additional travel time, correct?
A Well, if they need to travel, it will take time to travel, yes.
Q Okay. And there's financial cost associated with travel, right?
A Well, certainly there can be, the cost of gas.
Q Okay. Or like a bus ticket, let's say?
A Right. So, again, convenience should not trump safety. But, yeah, there will be cost involved in making the decision and seeking the action to end a human life, yes.
Q Okay. And people might have to take time off work; is that right?
A Yes, they might need to do that. They're going to do that regardless because the medication abortion process is not something they're going to

315

be able to do at work. Their bodies are going into labor.
Q Okay. But they would need to take time off work to travel to the health center, correct?
A To be evaluated to see if they're an appropriate candidate, yes. That would -- that's -- that's typically how medicine works. People take time off to go be evaluated to see if they're a candidate for a particular treatment.
Q Okay. And they might also have to arrange child care if they have to go to an in-person appointment; is that right?
A Yeah, certainly. I mean, there's -- this is how it works in medicine. You might need to arrange child care.
Q Okay. And then just pulling up your report real quickly, in paragraph 60 you say, "there is no medical evidence that a modest increase in travel time imperils women's health."
You don't cite anything for this, right?
A Right. There's no evidence --
Q Okay.
A -- to cite.
Q And then you also say in this paragraph, "Women who are firmly committed to obtaining an

316

abortion can still readily access one, whereas, women who remain uncertain when confronted with minor logistical barriers may pause to reconsider their decision."
You don't cite anything in support of this statement either, do you?
A I do not.
Q Okay. And your report does not address the topic of whether the FDA Label Law burdens patients seeking abortions in Ohio, right?
A I mean, if a minor inconvenience of traveling for an evaluation you consider a burden, I would not. I would consider that standard care.
Q Okay. So you're saying that the APC ban can cause additional travel; is that right?
A Can you repeat that question?
Q Sorry. Sorry. Sorry. I got my laws confused for a second.
I'll -- I'll withdraw the question.
Okay. So, I guess, just to drill down on it again, does the FDA Label Law -- you're not offering an opinion on whether the FDA Label Law burdens patients seeking an abortion in Ohio, right?
A I'm not offering an opinion.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

317

Q Okay.
A I'm just making a common sense statement here.
Q Okay. And your report also doesn't address whether the APC ban burdens patients seeking abortions in Ohio, right?
A There's no reason it should burden patients. Perhaps it burdens abortion providers who can't find enough doctors willing to end human life, but not patients.
Q Okay. So it burdens -- the APC ban burdens providers?
A If they can't find enough abortionists --
Q Okay.
A -- that are physicians.
Q Okay. All right. I'm going to turn to talking about the APC ban.
Nothing in Ohio law requires physicians to have specific training before they can provide a medication abortion, right?
A I don't believe there is anything in the law.
Q Okay. And nothing in the law requires them to have training in aspiration before they can provide medication abortion; is that right?

318

A Not in the law. But the FDA in their label -- in order to become a mifepristone provider, you attest that you have the ability to accurately determine gestational age and rule out an ectopic; you have the ability to provide surgery in the event it does not work or there is a medical emergency.
So they say, I have the ability to do it, which common sense would tell you that they would then do it if it was needed. But you're right, it doesn't specifically say they will. It just says they have the ability.
But the APCs don't have the ability to do that. So what they're -- because they're not trained in surgery.
ATTORNEY HUMPHREVILLE: And, I mean, I just wanted to notice -- note that you're on mute. So I think you might have said something along the way, and I just don't want to silence your objections or any other comments.
You're still on mute, though.
THE WITNESS: You're talking to Amanda?
ATTORNEY HUMPHREVILLE: Yes.
THE WITNESS: Okay.
ATTORNEY NAROG: I hit my space bar and it

319

wasn't working. Sorry. I had to put you on mute because I've got a dog here too and she decided she was going to howl like an idiot. So --
ATTORNEY HUMPHREVILLE: Totally fine.
ATTORNEY NAROG: All right.
ATTORNEY HUMPHREVILLE: -- I just didn't want you to --
ATTORNEY NAROG: Okay.
ATTORNEY HUMPHREVILLE: -- be missing that.
Q Okay. And I should have said up front that when I use the term "APC ban," that's the same as what's also called -- I think you call it in your report the "Physician Requirement."
But you understand what I mean by "APC ban," right?
A Yes, I do.
Q Okay. And APC means advanced practice clinician.
What categories of practitioners count as APCs?
A So this could be a nurse practitioner. This could be a physician assistant, midwife.
So these are healthcare professionals, but

320

they do not have the -- they don't go to medical school. They don't have the extensive anatomical knowledge that doctors do. And they are not completing OB-GYN residencies.
Q Okay. And what's your basis -- what's the basis for your understanding about APC's scope of practice?
A Well, I've -- I've definitely read some documents from different states. It can vary state to state.
It used to be the case that they were always supervised. I understand there are some states that will allow them to practice without supervision.
But, again, this is -- it's an example of lowering the standard of care. Instead of a doctor, who has that extensive anatomic and surgical knowledge, we're now saying, we're just going to let people who have had less training hand out these drugs, knowing full well they don't have the surgical ability to care for complications.
Q Okay. I'm just going to ask -- because, you know, I'm running a little short on my time -- that you just answer my specific questions.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

321

And so --
A. Okay.
Q. -- my question was about your understanding of APC's scope of practice, not anything beyond -- related to the APC ban.
So you mentioned physician supervision of APCs.
Have you -- you didn't review the collaborative practice agreement requirement for APCs in Ohio, did you?
A. I don't recall that I have.
Q. Okay. You don't cite those in your report, right?
A. I don't think so.
Q. Okay. And did you speak to the plaintiffs in this case about their collaborative practice agreements?
A. No, I didn't.
Q. Okay. And you don't cite any studies in your report about nurse practitioners' scope of practice, right?
A. I don't believe I did.
Q. Okay. And about -- what about -- about nurse midwives' scope of practice, do you cite any studies in your report?

322

A. I mean, I discuss somewhat what they typically do. But I -- if you're asking me -- am I citing a document that's scope of practice, no, I don't believe I did that.
Q. Okay. And nothing about PA's scope of practice either, right?
A. True.
Q. Okay. Did you speak to any APCs in Ohio about their scope of practice?
A. No, I did not.
Q. Okay. And you don't cite any articles about nurse practitioner education, right?
A. I think I do cite the fact that they are not trained in surgical skills in their professional training.
Q. Okay. But do you cite a document for that proposition?
A. I don't recall if I cited a document, but I think we -- it -- it's readily available that they're not trained surgically.
Q. Okay. And you don't cite anything about nurse practitioner training, right?
A. Other than what's in my report.
Q. Okay. And you don't cite anything about continuing education requirements for nurse

323

practitioners either, right?
A. Well, I'm sure they don't get CME on learning how to do surgery, so. . .
Q. You don't cite anything about their continuing education, do you?
A. No.
Q. Okay.
A. You -- you've got my report. You know what I've cited.
Q. Okay. And you also don't cite anything about nurse midwife education, training or continuing education, do you?
A. I don't believe so.
Q. Okay. And you don't cite anything about physician assistant education, training or continuing education, right?
A. The point is, none of these people have the skills to take care of the complications. Bottom line.
Q. Okay. And did you conduct a survey of all clinical training programs for APCs throughout the country about what training APCs are receiving?
A. No. It's not necessary. They're not getting surgical training.
Q. Okay. And did you conduct a survey of all

324

APC programs in Ohio about the training that they're receiving?
A. No. They're also not getting surgical training.
Q. Okay. So let -- let's drill down on that.
So you say in paragraph 55 something similar to what you're saying here.
So you say -- I'm just going to share my screen so we're all looking at the same thing.
(Attorney Humphreville shared Exhibit 1 on the screen.)
Q. So you say, "non-physician prescribers generally lack the surgical skills needed to manage complications."
You don't cite anything to support this statement, right?
A. I -- I don't. But it is a true statement.
Q. Okay. And then as -- and you continue, that, "As a result, many women experiencing adverse events are ultimately forced to seek care" -- in an already over- -- "in already overburdened emergency departments."
You don't cite anything for that either, right?
A. I didn't, but I could certainly reference

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

325

the Studnicki studies of which I've been a coauthor, which we demonstrated that extensively, that women are coming to ERs with these complications.

Q Okay. And that doesn't -- that study doesn't say anything about APCs providing abortion specifically, does it?

A No. It talks about surgery that's needed that the APCs are not trained to do.

Q Okay. And when you say in -- just go to paragraph 122.

So you say here at the -- the last sentence of this paragraph, "Optimally, the provider with whom a woman has established a provider-patient relationship would be available to provide the treatment of complications the drugs cause, something APCs are unable to do."

So I want to talk about some of these complications a little bit more, and specifically focus on failed or incomplete abortion.

So you testified earlier that one way to treat an incomplete abortion -- an incomplete or failed abortion would be additional medication, right?

A That is correct.

326

Q Okay. And if someone is trained to provide medication abortion, they would also be able to provide the same medications again; is that right?

A If there was follow-up. But, again, Ohio would like to take away the requirement for any additional follow-up.

Q Okay. But if there -- if they -- if someone came in for a follow-up appointment, the same APC would be able to provide them the same medications; is that right?

A They could. But, again, you know, just like when we discussed miscarriage management, sometimes even additional meds don't work and surgery is needed. And they cannot provide that intervention.

Q Okay. And not all patients who experience incomplete or failed medication abortion will need -- or sorry.

Not all patients who experience incomplete medication abortion will need aspiration, right?

A A certain percentage of them will be able to expel the tissue with additional misoprostol --

Q Okay.

A -- as we've discussed.

327

Q And then in paragraph 123 here, you reference the University of Chicago. And it says, "Unlike our OB-GYN partners, midwives do not perform surgeries.'" And you cite to a University of Chicago website.

I'm just going to pull that up really quickly. And I'll put this in the chat as well share.

ATTORNEY HUMPHREVILLE: So this will be Exhibit 28, I believe.

(Attorney Humphreville shared Exhibit 28 on the screen.)

(Skop Exhibit 28, University of Chicago website article, marked for identification.)

Q So this article doesn't say anything about midwives performing aspirations specifically, right?

A No. I think the point was that U -- U of C was saying they don't do surgeries. Aspiration is a minor surgery, so --

Q Okay.

A -- doc -- documenting my point that they're not going to be able to provide the surgical intervention.

Q And the words "procedure" and "surgery" are not synonymous in medicine; is that right?

328

A The abortion industry was the one who reinvented the term. They used to call these "surgical abortions." They decided to rename them "procedural" because it's less scary. They can -- you know.

But, you know, depending on where you look, the definitions may be pretty much the same.

Q Okay. But they're not necessarily synonymous, "procedure" and "surgery," correct?

A Well, it depends on the, you know, setting in which you're using the terms.

Q Okay.

A I would say that if you're using the terms to re- -- to refer to the procedure or the intervention that is needed when these drugs fail and misoprostol -- additional misoprostol fails, either term is correct.

Q Okay.

A It's describing a suction aspiration, both of them.

Q Okay. And this article is about midwives, so it doesn't say anything about nurse practitioners, right?

A No. This is specific to midwives.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

329

Q And it doesn't say anything about physician assistants, right?
A Right.
Q And it doesn't say anything about midwives at other institutions, right?
A Right. But none of them do surgery, period.
Q Okay. And you don't cite any studies in your report that address whether or not trained APCs can safely provide aspiration procedures, right?
A I did not cite those. I'm aware that they have -- again, an uncomplicated aspiration, there have been situations where they've trained advanced practiced clinicians to do those. But that doesn't take into account variations in anatomy, complicated procedures.
Again, the best quality for care for a patient is to have a surgeon who knows what they're doing, not someone who's had a -- a short course on how to do a very uncomplicated aspiration.
Q So you would agree that APCs can be trained to perform early suction aspiration; is that right?

330

A I mean, a trained monkey can probably be trained to perform an uncomplicated one. The whole point is, we want to have the doctor to have the skills if it's complicated to really be able to care -- to understand the anatomy to be able to care for the woman.
Q So is that yes, an APC could be trained to provide a first trimester aspiration?
A Apparently it's been done in some settings. WHO is training women in sub-Saharan Africa using papayas in place of a uterus. So whether you consider that good training, you know, probably depends on your perspective. I would not consider that good training.
Q So is your answer yes?
A The question was?
Q That APCs can be trained to safely provide first trimester abortion?
A I would caveat it --
Q Sorry, first trimester aspiration is --
A In -- in some settings, APCs have been trained to do uncomplicated abortions. And in the limited studies that have been performed in this setting, there has not been diagnos- -- documented higher complications.

331

This does not mean that if these -- these APCs were unsupervised out there trying to do things that they don't really have a lot of experience doing, there's nothing to say that that's going to continue to be the case, that they may be actually hurting women.
Q Okay. You also say in your report that no APCs received specific training in abortion provision or aspiration in their clinical training program.
You don't cite anything for that proposition, right?
A No. Apparently not.
Q Okay. And then the only study that you cite related to APC provision of abortion is a article by Lauren Porsch from 2020, and you note that it found that medication abortion had similar complication rates regardless of whether provided by an APC or a physician, right?
A Yeah. It makes sense. They're just handing them the drugs.
Q Okay. And the effective -- effectiveness rate was also similar regardless of whether the medication abortion was provided by an APC or physician, right?

332

A Yeah. And the effectiveness rate is -- is similar if you hand it out through a -- a drawer that pops open remotely controlled. It's not the way that the drugs are given. It's are -- is the women being evaluated appropriately? And is that provider available to care for the complications?
That's the concern that Ohio needs to address.
Q Okay. And you say at the end of this paragraph, "It is likely that many of these women were dumped on the emergency system because APCs cannot perform the needed interventions."
You don't cite anything for this proposition, right?
A That's correct. I've just seen it in practice.
Q Okay. And --
A It's my lived experience.
Q And you don't know whether or not the advanced practice clinicians in the studies were trained to provide aspiration or not, were they? Or, sorry.
You don't know whether or not the APCs in the study were trained to provide aspiration, do you?

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

333

A You know, that is interesting on these studies. They don't address that fact. One would think if they had trained them, they would have addressed it. So my conclusion is they did not train them.

Q Okay. But the studies do not specify that, correct?

A The studies do not specify.

Q Okay. And you don't cite any other studies in your report about whether APCs can safely provide medication abortion, right?

A The studies that I've cited, I've cited. I -- you know, I'm sure that there are others that could be cited, but what's there is there.

Q Okay. And you also note in your report that there's a shortage of OB-GYNs willing to provide abortion, right?

A Yes.

Q So you would agree that if APCs are barred from providing abortion, there will be fewer available abortion providers, right?

A And we need to ask ourselves the question, if it's -- if it's necessary medical care, what is every OB-GYN not doing it?

Q Okay. So my question is if that OB-gynes

334

cannot provide abortion, there will be -- or, sorry.

If -- if APCs cannot provide abortion, there will be fewer available providers, correct?

A How is Ohio not able to find enough doctors to do abortions?

Q This is a yes-or-no question, Dr. Skop. Will there --

A How many -- how many obstetricians do you have in the state? Seems like you should be able to find enough without having to lower your standards for APCs.

Q So, again, when you say "you," this is about what is happening in this case, not anything about myself.

A Yeah.

Q So I'm going to ask you again, if only physicians are able to perform abortion in Ohio, meaning APCs are unable to do so, there will be fewer available proportion -- abortion providers, yes or no?

A There should be enough abortion providers.

Q Dr. Skop, I'm going to instruct you to please answer my question.

Is it yes or is it no?

335

A I don't know. Maybe these APCs don't want to do abortions either. I don't know. But it doesn't take that many obstetricians to provide abortions for a state the size of Ohio. Y'all don't need to lower your standards.

Q If there are fewer abortion providers, that are going to be fewer abortion appointments; is that right?

A I don't know. Maybe somebody could work overtime if they really, you know, provide -- open up more appointments.

Q Okay. I'd like to shift to talking about informed consent and some of your opinions related to informed consent.

Have you talked to any of the plaintiffs in this case about their informed consent practices for medication abortion?

A No, I have not.

Q Okay. And have you talked to any other abortion providers in Ohio about their informed consent practices?

A No, I have not.

Q Okay. And you haven't reviewed any of the plaintiffs' informed consent materials, have you?

A I've seen informed consent materials from

336

Planned Parenthood. I don't know that it was specific to Ohio. I don't know if their material is the same throughout the country or not.

Q Okay. And you've never obtained informed consent from -- for a telemedicine abortion, right?

A That's correct.

Q And you've never obtained informed consent for an abortion at all, right?

A That's correct.

Q Okay. You say in your report that it's better to obtain informed consent for an abortion in person rather than via telemedicine.

You don't cite any studies to support this statement, right?

A I don't. But, again, that -- I think that's based on common sense. It's always better to be in the room with a patient. You can read nonverbal communication, see who's standing just off screen, perhaps coercing.

So, yeah, I think that -- as I told you earlier, my brief experience with telemedicine was that I -- I felt like it was suboptimal compared to in-person medicine.

Q Okay. And you would agree that there is

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

337

no study documenting that in-person obtaining informed consent for telemedicine -- for -- sorry.
Let me rephrase that, because that was not very artful.
You would agree that there's no study documenting that it's better to obtain informed consent in person rather than via telemedicine for medication abortion, right?
A So that, by definition, would be -- need to be done by the abortion industry because they're the ones doing it. And they're not going to do that study because they want to provide this by telemedicine.
So, again, that's -- that's information that's never going to be available. But we can -- we can use our intuition based on other medical procedures, telemedicine versus in person, and it's -- it's unanimous.
I mean, there's -- there's -- unrelated to abortion, there's quiet a bit of documentation in the literature that in person is better than telemedicine.
Q Okay. So you would agree there's no study documenting this, then?
A That's correct.

338

Q Okay. So you cite in footnote -- or sorry -- paragraph 119 a Reardon article. Let me pull that up.
I will put it in the chat as well.
(Attorney Humphreville shared Exhibit 29 on the screen.)
Q So this is a study called "The Effect of Abortion Decision Rightness and Decision Type on Women's Satisfaction and Mental Health."
You cite this in your report, right?
A Yes.
ATTORNEY HUMPHREVILLE: Okay. And I'll mark this as Exhibit 29.
(Skop Exhibit 29, Reardon article entitled, The Effect of Abortion Decision Rightness and Decision Type on Women's Satisfaction and Mental Health, marked for identification.)
Q So this study doesn't compare the informed consent process for a telemedicine abortion patient versus in-person abortion patients, right?
A No. It documents that some women obtain abortions even though that's not what they want.
Q Okay. And then I'm going to turn back to paragraph 121 of your report.

339

(Attorney Humphreville shared Exhibit 1 on the screen.)
Q And here you're saying that in-person dispensing is necessary to prevent coercion.
You didn't cite anything in this paragraph, right?
A No. I apparently did not. I could have cited some media reports that demonstrate that ordering online has resulted in men getting the drugs and coercing women.
Q Okay. And --
A But there's not -- there's not a peer-reviewed study.
Q Okay. And you didn't -- you don't cite any studies in your report about the incidence of coercion to have a -- a telemedicine abortion, right?
A No. In the Reardon study, 10 percent of the women retrospectively felt that they had been coerced. But none of the abortion industry studies have -- have looked at this question. They probably do not want to know the answer.
Q Okay. And the Reardon study does not define coerced, does it?
A No. I think that it was left to the women

340

to decide if that -- if they felt they had been coerced.
Q Okay. And did you look for any studies about the incidence of corrosion to have a telemedicine abortion?
A I probably have looked. I am not aware that that has been addressed.
Again, that's -- that's an issue that the industry would prefer to ignore.
Q Okay. So you don't have any evidence that in-person informed consent better prevents coercion than telemedicine, right?
A Only my common sense to recognize that if I can see everything that's going on in a room, that's a better scenario than if I see someone on a screen and I have no idea what's going on off screen. I can't see their full body. I can't read many of their -- much of their body language.
So it really makes sense, I think, knowing what we know of human nature, that in person is better than telemedicine.
Q Okay. And -- I'll just stop sharing for a second.
Do you know what protocols the plaintiffs in this case used to screen patients for coercion?

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

341

A No, I do not.
Q Okay. Do you know what protocols they used to screen patients for domestic violence?
A No, I do not.
Q Okay. So I'd -- I'd like to talk about something you've referenced a couple of times today, which is long-term health consequences from abortion. And looking at -- I'm going to look at paragraph 67 of your report.
Okay. Let me just share my screen again.
(Attorney Humphreville shared Exhibit 1 on the screen.)
Q So for paragraph 67 -- I'll just scroll out so we can see both the paragraph and the cites.
So you cite to a few different AAPLOG bulletins, right?
A I do in the interest of space because those bulletins do have extensive bibliographies citing from the peer-reviewed literature. So rather than me citing all 75 studies that I've referenced here, I cite to AAPLOG, and they've cited the 75 studies.
Q Okay. And those aren't peer-reviewed themselves, though, right?

342

A The AAPLOG, essentially, systematic review, I do not believe was. Although, I think they've done one more recently that is -- may have been peer-reviewed.
Q But the ones you cite in your report are not peer-reviewed, correct?
A Probably not.
Q Okay.
A But they do include the references to the peer-reviewed literature.
Q Okay. And you say there is a correlation between abortion and breast cancer, right?
A There's a couple of things. That's very, very difficult to study. But we do know that a woman who brings her first pregnancy to term, it does protect her from breast cancer. That's -- that's actually been known for -- for, you know, centuries.
Q So you're not offering the opinion that abortion causes breast cancer, right?
A I'm not offering that opinion. I think the -- it's not a settled question. There is some physiologic plausibility for how it could increase risk. But I'm -- I'm not willing to say based on the literature right now that we know the answer.

343

But we certainly don't know that the answer is no.
Q Okay. And are you aware that ACOG disagrees with the claim that there's a link between abortion and breast cancer?
A Yes, I'm aware. ACOG, as I've stated repeatedly, loves abortion. And so they're always willing to downplay any negative data related to abortion.
Q Okay. And are aware that ACOG disagrees with the claim that there's a link between abortion and preterm birth?
A I am. But I think it's interesting because the Institute of Medicine, which is what became the National Association of -- of Medicine has actually documented that. Probably been 15 years or so ago.
But it used to be that you could say things like that. And -- and, you know, unfortunately to- -- in today's world, it's become so politicized you're not even allowed to state that for women who may be at risk for preterm birth.
We do know that the populations that have extremely high abortion numbers also have

344

extremely high preterm birth numbers. So there is a correlation.
Q Okay. And the more recent -- you referred to the Institute of Medicine.
The more recent National Academy study that you refer to in your report said there's no link between abortion and preterm birth; is that right?
A Yeah. And I -- I -- I've demonstrated conclusively here, they looked at, like, a handful of studies, hand-picked, cherry-picked studies. Ignored many, many studies. And, of course, when we looked at their funding, we see what it -- what their motivation was.
So I -- I think this one has been discredited, in my mind --
(Crosstalk)
Q Okay. And you're also aware that the American Psychological Association disagrees with the claim that there's a link between abortion and mental health disorders, right?
A It's more nuanced. Their statement is there's no evidence that a single wanted -- single abortion of an unwanted pregnancy in the first trimester -- anyway, their -- their statement is

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

345

so nuanced that they end up leaving the women who have multiple abortions, those who have late abortions, those who maybe wanted their baby but have an abortion for other reasons.

So even they, by the way they phrased it, are -- are acknowledging that there are -- that they're aware there are some reason that are at much higher risk for mental health complications.

Q But they do not say that abortion causes mental health disorders, correct?

A They say that in that very specific subgroup that they looked at, that there's no evidence that it causes mental health complications.

But they also -- I think it's interesting in their silence. It doesn't improve mental health either.

So if you're going to end human life, there ought to be some kind of a benefit. And they've proven that -- or proven in their silence that they don't think there's any mental health benefit to having an abortion either.

Q Okay. The other paper that you cite here is a Reardon paper.

This is -- Dr. Reardon's affiliated with

346

the Lozier Institute, right?

A Yes, he is.

Q And this is an article in Linacre Quarterly, right?

A Yes.

Q And it's more of a commentary on the "Turnaway Study" rather than sort of its own peer-reviewed research, right?

A That's correct.

Q Okay. I'm going to go down to paragraph 117 in your report.

So you say here that "Post-abortion regret is common."

You don't cite anything for that proposition, right?

A I didn't, but I could. There are quite a number of articles that document that.

Q Okay. But you -- you testified earlier that you made an attempt to be -- to include everything that you thought was relevant in your report, right?

A Yeah, I -- I did testify that. That doesn't mean that I was saying at that time that every single article from the peer-reviewed literature has been cited here. That's clearly

347

not the case.

Q Okay. So you are asserting that post-abortion regret is common, but you're not citing anything in support, right?

A Actually, I did cite the proliferation of counseling centers and programs in churches and pregnancy resource centers. So --

Q Okay.

A -- I've seen it in my lived experience that these women do suffer regret and they do require counseling in many cases.

Q And you cite that in your report? You cite something for that proposition?

A Well, that's -- that's -- in the sentence, again, that's not going to be, like, a peer-reviewed statement. So I did not cite to the peer-reviewed literature.

But it's -- it's -- it's easily verifiable to discover that there are a lot of post-abortion counseling programs.

Q Okay. And you're not an expert in mental health, right?

A No, I'm not.

Q Okay. Okay. We touched previously on -- I'm going to stop sharing my screen.

348

We touched briefly on the National Academies -- or the -- I guess, that's short for National Academies of Science, Engineering and Medicine, right?

A That's correct.

Q Okay. And this is a nonpartisan institution created by congress, right?

A That's -- that's -- yeah, that's their mandate.

Q Okay.

(Crosstalk)

A I would argue about the nonpartisan part related to abortion, but that's -- that's what it's -- that's what they say.

Q Okay. And the members of National Academies are chosen by peers for their distinguished contributions to medicine and health; is that right?

A That's correct.

Q Okay. And when you were preparing your report, did you review the National Academies' guidelines for the review of products of the National Academies of Sciences, Engineering and Medicine?

A I do not believe I did.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

349

Q Okay. And did you review their policy on composition balance -- conflict of interest and independence for committees used in the development of findings, conclusions and recommendations?

A No. I just noticed how many studies they ignored.

Q Okay. And your opinions on abortion safety conflict with those of the National Academies', right?

A Yes.

Q Okay. And you testified earlier that you are a member of ACOG.

Is that the largest professional organization for OB-GYNs?

A Yes, it is.

Q Okay. And you're a fellow with ACOG, right?

A Ye- -- yes.

Q Okay. You would agree that it's a major medical organization?

A Yes.

Q Okay. And you would also agree that their journal is well accepted, right?

A They -- their journal is prestigious and

350

influential.

But, again, regarding abortion, they don't ask their members what -- how we feel about it, whether we feel like they should be lobbying the way that they do. It's -- that's the leadership only making that decision.

Q Okay. And you would also agree that ACOG provides good literature reviews, right?

A I found their practice bulletins very helpful. Again, you know, some of the -- the bulletins related to abortion, I -- I have some problems with.

But, in general, if it's a non-politicized medical topic, they do a good job.

Q Okay. And you cite many of those practice bulletins in your report, right?

A I did, yes.

Q Okay. Including related to abortion, right?

A Yes, I did. Because, again, sometimes there just wasn't that much data.

Q Okay.

A So you use what you can.

Q And do you rely on their nonclinical -- or, sorry, non-abortion clinical guidance in your

351

practice?

A I often do, yes.

Q And would you say that the ACOG researchers that put together practice bulletins and committee opinions are knowledgeable about the topics they're publishing on?

A I believe that to be the case, yes.

Q Okay. And aside from abortion and gender dysphoria -- actually, I think we discussed that earlier -- or, sorry.

Aside from abortion and gender dysphoria, are there any topics on which you agree -- disagree with ACOG?

A There have been other topics that I have taken exception to.

Q Can you name any specifically?

A They asked us to recommend the COVID vaccine to pregnant women. They told us that it was safe. And then as I think anybody's who's been paying attention to the news recently recognizes, there was no data regarding safety. So they told us it was safe before they had any data. That's an ideologic recommendation.

Q Would you agree that the American Medical Association is also a major medical association?

352

A It is. But it does not represent most doctors. I think only about 17 percent of doctors are members of the AMA. So it has lost much credibility.

Q Okay. And -- but you cite to the AMA in your report, right?

A Yes. I -- I believe it was related to informed consent.

Q Okay. And your opinions on abortion conflict with those of the American Medical Association; is that right?

A Right. They -- they also, for eugenic reasons, promote abortion.

Q Okay. And would you agree the American Psychological Association is also a major medical association?

A Yes.

Q Okay. A few more questions.

Has your medical license ever been suspended or revoked?

A No.

Q Okay. And have you ever been denied a license to practice medicine by any state?

A No.

Q Has a patient or former patient ever filed

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

353

a complaint against you with a disciplinary body?
A No.
Q Okay. Have you ever been named as a defendant in a lawsuit?
A There have -- let's see. There was a medical malpractice lawsuit lodged against me.
Q Okay. When was that?
A It was shortly after residency, so maybe 1997.
Q Okay. And what was the outcome of that case?
A I settled. It was a -- related to a baby that did not do well after delivery.
Q Okay. And have you been named as a defendant in any other lawsuits?
A I'm not sure how official they were. I know that there were some letters to attorneys, other people on medical malpractice fishing expeditions, but nothing ever came of those.
Q Okay. And do you know -- oh, sorry. I didn't mean to cut you off.
A Yeah. I -- I think that that's -- as my recollection, that's the situation.
Q Okay. And do you recall what those were about?

354

A You know, again, those have been probably 20-plus years ago. I -- I don't really recall the specifics.
Q Okay. And have you ever been accused of professional misconduct?
A No.
Q Have you ever been fired from any position?
A No.
Q Have you ever been asked to resign or leave a job?
A No.
Q Okay. Have you ever resigned from a position while an investigation against you was pending?
A No.
Q Okay. Are you currently under investigation of any kind?
A No.
ATTORNEY HUMPHREVILLE: Okay. I -- I think that's probably it, but I'd like to just take a short break. I think I have, like, five minutes left, but --
THE WITNESS: Okay.
ATTORNEY HUMPHREVILLE: -- if anything,

355

it'll just be, like, a tiny bit of cleanup.
So can we take maybe a ten-minute break, come back at 45?
THE WITNESS: Okay.
THE VIDEOGRAPHER: Going off the record at 17:36.
(A recess was from 5:37 p.m. to 5:48 p.m.)
THE VIDEOGRAPHER: We are back on the record at 17:48.
ATTORNEY HUMPHREVILLE: All right. I have no further questions, so I'll turn the witness to Ms. Narog.
ATTORNEY NAROG: Okay. I just have a couple of questions for you, Dr. Skop.
EXAMINATION BY ATTORNEY NAROG:
Q Earlier today you were asked about statistical and research training, and you testified that you did not have any such training after medical school.
Did you have statistical training in medical school?
A Yes. It's a standard part of medical school to under- -- to be taught about statistics, about how to read peer-reviewed literature and perform studies.

356

You know, I -- I guess I was just thinking the question was related to whether I had formal training since medical school.
But the school I went to, Washington University in St. Louis, is generally considered one of the top five medical schools in the country. And it trains a tremendous number of MD/PhD students, so those would be my classmates.
So I think we probably did obtain much better research training at that medical school than I may have obtained elsewhere.
Q You were also questioned about -- ques- -- about statements and opinions in your report that did not have a citation following the statement or opinion.
For those statements and opinions, what did you base that statement or opinion on?
A Well, in many cases, those statements were based upon knowledge that I had gained from peer-reviewed literature that I had referenced elsewhere. So, in other words, if it was the same topic, I may not have re-referenced it.
There may have been other references that I did not put in the report but that I know just from my general knowledge of the literature.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

357

And then, of course, as I mentioned, I've been a practicing OB-GYN for 30 years. So in that period of time you do gain quite a bit of clinical experience and skills.

And so some of these are conclusions that I can draw based on my knowledge of the literature and also my clinical experience with women.

Q In your opinion, why should patients meet in person with a provider before a medication abortion as required under Ohio law?

A Because this is going to provide them with the best possible care. Women seeking abortion should not be given a lower standard of medical care.

As I discussed, the doctor needs to be able to look her in the eye. He needs to be able to make sure that she understands the immensity of her decision, that she knows about alternatives.

Because as the Reardon studies show us, many women have abortions when actually they would rather give birth. They don't think they have alternatives.

So alternative counseling is a critical part of informed consent counseling. Again, that's best done face-to-face, understanding the

358

emotional state of the woman, making sure that there's no coercion going on.

The woman needs, in many cases, pre-abortion testing, ultrasounds. Even without an ultrasound, a physical examination can tell a doctor a lot.

Labs. Finding out if a woman is severely anemic. If so, she should not have a medication abortion because the blood loss, which is usually pretty substantial, could cause her to need a blood transfusion.

So the -- the counseling, the affirming that the woman really desires the abortion. And, you know, we didn't talk about it, but the 24-hour waiting period means she has time to think about her decision.

Wouldn't we all have our hearts broken to think that there's a number of women in Ohio who rush into abortions when, in fact, in retrospect, they realize that was not what they wanted. They ended a human life, the life of their own child, and, in fact, they had not had adequate time and adequate counseling to think through the decision to make sure that's what they really wanted.

So those are the reasons that these

359

limitations are so important: For the safety of women, to make sure that they're making the decision that they can live with in the future.

ATTORNEY NAROG: Thank you, Dr. Skop. I have nothing further.

ATTORNEY HUMPHREVILLE: I don't have anything for redirect.

THE VIDEOGRAPHER: All right. Are we ready to go off the record?

ATTORNEY NAROG: We are.

THE VIDEOGRAPHER: This marks the end of the deposition of Dr. Ingrid Skop. We're going off the record at 17:53.

(Time noted: 5:53 p.m.)

360

ACKNOWLEDGMENT OF DEPONENT

I, INGRID SKOP, M.D., do hereby acknowledge that I have read and examined the foregoing testimony and the same is a true, correct, and complete transcription of the testimony given by me and any corrections appear on the attached errata sheet signed by me.

_____ _____

(SIGNATURE) (DATE)

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

CERTIFICATE OF SHORTHAND REPORTER-NOTARY PUBLIC

I, Nicholas Buckley, Certified Shorthand Reporter, the officer before whom the foregoing deposition was taken, do hereby certify THAT the foregoing transcript is a true and correct record of the testimony given;

THAT said testimony was taken by me stenographically and thereafter reduced to typewriting under my direction; that reading and signing was not requested;

AND THAT I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand this 8th day of September, 2026.

Nicholas Buckley

Nicholas Buckley

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

EXHIBIT 16

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. _____ Judge: _____

EXPERT AFFIDAVIT OF NATHANIEL G. DENICOLA, MD, MSHP, FACOG, IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER FOLLOWED BY PRELIMINARY INJUNCTION

I, Nathaniel G. DeNicola, being duly sworn on oath, do depose and state as follows:

1. I am a board-certified obstetrician-gynecologist ("OB-GYN") and the Chair of the Presidential Task Force on Telehealth at the American College of Obstetricians and Gynecologists ("ACOG"), the largest professional membership organization for OB-GYNs in the nation. I provide in-patient clinical obstetrics care at Sibley Memorial Hospital, which is affiliated with Johns Hopkins Medicine, in Washington, D.C., and generalist obstetrics and gynecology in private practice with Caduceus Medical Group in Orange County, California. I frequently write and present on issues related to telehealth, and I rely on telehealth, including virtual visits with patients, in my own clinical practice with Caduceus.

2. I submit this affidavit in support of Plaintiffs' Motion for a Temporary Restraining Order Followed by Preliminary Injunction to prevent enforcement of Senate Bill 260 ("SB 260"). I understand that SB 260 would require that a physician who prescribes an abortion-inducing medication be physically present at the location and at the time that an abortion patient takes the first dose of such medication. It is my understanding that SB 260 would ban the provision of

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

medication abortion by telemedicine, which is used by Plaintiffs in this case to provide care to Ohio patients.

3. The facts I state here and the opinions I offer are based on my education, medical and public health training, experience as a medical doctor, work in national medical society policy, regular review of relevant literature and statistical data recognized as reliable in the medical and public health fields, and my attendance and presentations at professional conferences.

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

I. CREDENTIALS AND EXPERIENCE

5. I received my M.D. from the University of California, Irvine School of Medicine in 2006, and then completed my residency in obstetrics and gynecology at Tulane University from 2007 to 2011. I also received an M.S. in Health Policy Research in 2013 from the University of Pennsylvania and a B.S. in Biology in 2002 from the University of Notre Dame.

6. I currently provide in-patient clinical obstetric care at Sibley Memorial Hospital in Washington, D.C. In that role, I regularly encounter and treat the full range of complications that patients may experience during pregnancy and childbirth.

7. I also currently serve as the Medical Director for the Caduceus Medical Group, a private, multidisciplinary medical group of primary care physicians and specialists who serve patients at five locations in Orange County, California. I provide obstetrics and gynecological care to approximately 200 patients per month at Caduceus and guide the group's COVID-19 care, especially in telehealth provision. Of note, Caduceus was the first COVID-19 testing and treatment site in Orange County that was entirely run by telemedicine. To date, Caduceus has treated more than 2,500 patients diagnosed with COVID-19.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

8. Before assuming my current positions, I served as an Assistant Professor in obstetrics and gynecology at the George Washington University Hospital, as a Penn Medicine Clinician in obstetrics and gynecology at the Hospital of the University of Pennsylvania, as a Clinical Instructor in obstetrics and gynecology at the University of Pennsylvania Perelman School of Medicine ("Perelman"), and as an Attending Physician in gynecology at the Veterans Affairs Hospital of Philadelphia.

9. I received training in medication and procedural abortion during my residency and fellowship. Although I do not provide abortion in my current clinical practice, I routinely diagnose and treat miscarriages, which I manage in my practice through administration of misoprostol (Cytotec), one of the medications used for medication abortion.

10. Alongside my clinical duties, I serve as the Chair of ACOG's Presidential Task Force on Telehealth and as a member of ACOG's Committee on Obstetrical Practice. In addition, I act as the ACOG Liaison to the Executive Council on Environmental Health of the American Academy of Pediatrics.

11. I have substantial health policy expertise, including with respect to telemedicine and related innovations in the medical field. I served as a Senior Fellow with the Penn Social Media and Health Innovation Lab from 2013 to 2016. The Lab is part of the University of Pennsylvania's Center for Innovation, which helps translate discoveries and ideas developed at the University into new products and businesses for the betterment of society. I also served as a Senior Fellow with the Leonard Davis Institute of Health Economics at Perelman from 2011 to 2016. The Institute focuses on research and data regarding health care delivery and vulnerable populations, among other issues. From 2012 to 2013, I served as a Merkin Fellow at the Engelberg Center for Health Care Reform at the Brookings Institution, a nonprofit public policy organization based in

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Washington, D.C., that provides high-quality research and policy recommendations on a range of public policy issues.

12. Through my policy work, research, and clinical practice, I have significant experience evaluating telehealth models and the factors, including regulatory barriers, that may affect whether those models are successful. As Chair of the Task Force on Telehealth for ACOG, I have consulted with medical groups across the country to help them establish their telehealth services. As Medical Director at Caduceus, I routinely evaluate our on-site telehealth services, including with respect to data protection, technology specifications, provider feedback, and patient satisfaction. My research primarily focuses on examining the impact and assessing the implementation of telehealth in the field of obstetrics and gynecology. I recently led a team of researchers in a critical systematic review of 47 national telehealth studies, a process that involved screening nearly 5,000 studies. My research has been published in highly regarded, peer-reviewed journals, including *Obstetrics & Gynecology*.

II. FACTUAL BASIS FOR EXPERT TESTIMONY

13. I understand from Plaintiffs' counsel that state law currently requires Plaintiffs' medication abortion patients to make two trips to a health center to obtain an abortion, the first for a state-mandated ultrasound and in-person consent visit with a physician (the "Day 1 visit"), and the second at least 24 hours later to obtain the medication abortion itself (the "Day 2 visit").

14. It is my understanding that the Day 1 visit is always in person with a physician at one of the Plaintiffs' ambulatory surgical facilities. During that visit, trained staff obtain a medical history, perform an ultrasound, and perform standard lab work. A physician then reviews this information to determine whether medication abortion is appropriate for the patient and has a one-on-one, in-person informed consent conversation with the patient. It is my understanding that the

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

physician will discuss any concerns about the patient's eligibility for medication abortion with the patient at that time.

15. It is my understanding that—in the absence of telemedicine—the Day 2 visit would also have to take place in person at an ambulatory surgical facility operated by Plaintiffs. However, Plaintiffs currently offer site-to-site telemedicine for the Day 2 visit, meaning that the patient still goes to a health center operated by Plaintiffs, but she may elect one closer to her home or workplace than the ambulatory surgical facility used for the Day 1 visit. At that Day 2 visit, the patient speaks with a physician located in the ambulatory surgical facility via video and audio. The physician will confirm the patient's decision to seek an abortion and answer any questions the patient may have. The physician then presses a button in the surgical facility that remotely opens a cabinet in the other health center from which the patient obtains mifepristone, the first medication used by Plaintiffs for medication abortion. The patient ingests the mifepristone under observation on the video conference in the health center before leaving. It is my understanding that throughout this process, a trained member of the health center staff physically accompanies the patient in the room.

16. As I understand Plaintiffs' practice, the patient then obtains the second medication (misoprostol) used to complete the abortion. The patient takes the misoprostol 24 to 48 hours after the mifepristone at a location of her choosing.

17. I understand from Plaintiffs' counsel that even before SB 260 the applicable law forbade abortion providers from dispensing mifepristone outside of a health center (i.e., direct-to-patient telemedicine for the Day 2 visit is not possible) and permitted only physicians to perform abortions in the state (regardless of whether other advanced practice clinicians may prescribe or dispense other medications).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

18. I have been asked to address the use of telemedicine in the United States; research findings based on outcomes of site-to-site and direct-to-patient telemedicine, particularly with respect to safety and efficacy and patient satisfaction; and my opinions with respect to Plaintiffs' use of telemedicine to deliver medication abortion and how it compares to comparable forms of care provided via telemedicine.

III. DEFINING TELEMEDICINE

19. The Telehealth Resource Center, a leading national consortium of telehealth networks, defines telehealth to mean "a collection of means or methods" that use telecommunications technologies "for enhancing . . . health care, public health, and health education delivery and support."[1] Telehealth is thus generally understood to refer to any health care delivery enhanced by telecommunication.

20. The umbrella term "telehealth" is very broad. It can refer, for example, to remote observation of ultrasound recordings by maternal-fetal medicine and reproductive endocrinology experts, bladder diary tracking with smartphone apps, postpartum blood pressure monitoring with Wi-Fi-connected devices, and fertility tracking with patient-generated data.

21. "Telemedicine" is a subtype of "telehealth" that is often used to refer to traditional clinical diagnosis and monitoring delivered live to patients via audio and/or video. Telemedicine allows patients to see and hear specialists and other health care providers who are physically distant, but they still do so in real-time.[2] Real-time audio-visual communication also has been used

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[1] ACOG, Presidential Task Force on Telehealth, *Committee Opinion No. 798: Implementing Telehealth in Practice*, 135 Obstetrics & Gynecology e73, e74 (2020), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2020/02/implementing-telehealth-in-practice.pdf.

[2] *Id.*

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

for clinical scenarios like peer-to-peer consultation, ultrasound imaging review, and directed physical examinations.[3]

22. The goal of telehealth is to better facilitate care coordination and collaboration, improve quality of care and compliance, reduce hospital admissions and readmissions, reduce unnecessary face-to-face office visits and corresponding cancellations, and improve access to care and follow-up for individuals located in rural and other medically underserved communities.

23. Some telemedicine is provided site-to-site, meaning that the patient is still required to visit a doctor's office or other health care setting to receive care, but one or more of the health care providers she sees will be remote.

24. This use of telemedicine is particularly common in rural or other medically underserved areas, where trained physicians, including specialists, may not be readily available or even present in the local medical community. Through site-to-site telemedicine, patients can visit local clinics where health care professionals, such as nurses, midwives, and physician assistants, are on staff and can assist with taking a patient's medical history, performing blood work, taking vital signs, and other tasks. The patient can then ultimately be treated by a physician who is remote.

25. In addition to the site-to-site model described above, many health care providers are using a direct-to-patient model for telemedicine. Under that model, the patient can receive some types of care at any location of her choosing, most often from the comfort of her own home, so long as she has access to the internet or, in some cases, just a telephone.

IV. TRENDS IN TELEMEDICINE USE

26. The use of telemedicine has dramatically accelerated since March 2020, when the COVID-19 pandemic began. This change has been driven in part by an interest in minimizing viral

[3] *Id.* at e75.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

exposure, but other factors have contributed as well, including action by many states and the federal government to waive regulatory requirements that have long posed barriers to the provision of telemedicine.[4]

27. However, even before the COVID-19 pandemic, there was a clear trend in the United States toward greater reliance on telemedicine.

28. As the federal Centers for Medicare and Medicaid Services have recognized, "[t]elemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations between provider and patient)."[5] Likewise, the U.S. Department of Health and Human Services ("HHS") has acknowledged that virtual visits can "cut[] down on commuting, travel in bad weather, time off from work, [and the] need for child care."[6] That agency also recognizes that "[u]sing virtual health care tools can shorten wait times to see a provider and expand the range of access to specialists who live further away."[7]

29. In my practice in Southern California, Caduceus Medical Group uses telemedicine on a daily basis. Although telemedicine is often used to increase access to patients in rural areas, we have also found it useful in the large, urban setting in which we operate.

30. At Caduceus, our COVID-19 patients are treated exclusively via telemedicine for safety reasons. The initial testing is conducted with a drive-up appointment that consists of a virtual

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[4] Ateev Mehrotra et al., *Rapidly Converting to "Virtual Practices": Outpatient Care in the Era of Covid-19*, New England Journal of Medicine Catalyst (Apr. 1, 2020), https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0091.

[5] Ctrs. for Medicare & Medicaid Servs., *Telemedicine*, https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html (accessed Mar. 26, 2021).

[6] Health Resources & Servs. Administration, *What Is Telehealth?*, https://telehealth.hhs.gov/patients/understanding-telehealth/ (updated Feb. 25, 2021).

[7] *Id.*

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

screening visit, followed by a curbside swab. Test results, treatment, and follow-up are all conducted with video visits.

31. For non-COVID-19 patients, we also employ the same telemedicine options for visits, such as counseling and follow-up visits, that do not require a physical examination. We still use in-person visits where medically appropriate, such as for annual physicals and procedures that can only be done by a physician in person.

32. We also use a site-to-site telemedicine model frequently. We have an urgent care facility that is not staffed in person by physicians, but patients who go there may be seen remotely by a physician at one of our other offices as needed.

33. The need for telemedicine in obstetrics and gynecology is particularly acute. Approximately 6% of the nation's obstetricians and gynecologists practice in rural communities, yet 15%, or approximately 46 million people, live in rural communities. Through telehealth, regionalized obstetric care relationships and partnerships can be tightened between health centers, hospitals, and providers of obstetric care (obstetricians, family physicians, advanced practice nurse practitioners, and midwives).

34. For example, researchers from the University of Arkansas for Medical Sciences ("UAMS") have reported on efforts to expand medical access, including perinatal care, to rural communities in that state through telemedicine.[8] Through its rural telemedicine network, UAMS has "connected nearly 40 hospitals and other local health agencies."[9] Its investment in telehealth dates at least to the 1990s, and it began using telemedicine for high-risk obstetrical care in 2003.[10]

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[8] Curtis Lowery, et al., *ANGELS and University of Arkansas for Medical Sciences Paradigm for Distant Obstetrical Care Delivery*, 196 Am.Journal of Obstetrics & Gynecology 534.e1 (2007).

[9] *Id.* at 534.e3.

[10] *Id.* at 534.e3–.e4.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Through the network, Arkansas's only group of maternal-fetal medicine specialists, located in Little Rock, provides consultations to patients and clinicians around the state via site-to-site telemedicine.[11] Through the obstetrical telemedicine program, a local sonographer in a rural community can perform an ultrasound for a pregnant patient, for example, while a specialist in Little Rock reviews the ultrasound images in real time. These specialists can also be used for emergency obstetrical consultations and to coordinate the transfer of high-risk patients to UAMS.[12]

35. With regard to postpartum depression follow-up, telehealth overcomes the barrier of having to travel to see a specialist and allows for screening in the weeks and months after childbirth to prevent the exacerbation of depressive symptoms. Videoconferencing can be used for check-in visits with a nurse, obstetrician, or other obstetric service provider, or with a psychiatric physician or psychotherapist who can adjust medications as necessary without having the patient travel to an office for a face-to-face encounter.

36. Telemedicine has also been effective at reducing the number of in-person prenatal visits while maintaining positive clinical outcomes. In one high-quality study, investigators compared perinatal outcomes in 117 women opting for a regimen of nine in-person prenatal visits and five virtual prenatal visits to outcomes with outcomes in 941 women receiving up to twelve in-person prenatal visits. There were no significant differences in rates of cesarean birth, preterm birth, neonatal intensive care unit admissions, or birth weight, though there was a higher rate of preeclampsia in the virtual visit cohort, likely a product of the relatively small sample size (10 patients with preeclampsia).[13] Existing research also suggests that a mix of in-person and virtual

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[11] *Id.*

[12] *Id.* at 534.e4–.e5.

[13] Bethann M. Pflugeisen et al., *Virtual Visits: Managing Prenatal Care with Modern Technology*, 41 Am.Journal of Maternal/Child Nursing 24 (2016); Bethann M. Pflugeisen & Jin Mou, *Patient Satisfaction with Virtual Obstetric Care*, 21 Maternal & Child Health Journal 1544 (2017).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

prenatal care appointments in some studies has been associated with an increase in patient satisfaction and a reduction in pregnancy-related stress.[14]

37. In the gynecological field, one recent expert consensus document identified evidence supporting the use of telemedicine to assess and medically manage, for example, some abnormal uterine bleeding and chronic pelvic pain ("CPP"). It suggested that management of CPP via telemedicine could include prescription of hormonal therapy and multimodal pain management using amitriptyline, cimetidine, hydroxyzine, or pentosan polysulfate.[15]

V. TRENDS IN THE REDUCTION OF LEGAL BARRIERS TO TELEMEDICINE

38. The removal of legal and regulatory barriers to telemedicine has expanded its use. For example, many states have now enacted telemedicine parity laws, which mandate that similar in-person and telehealth service costs be reimbursed equally through public and/or private health insurance.

39. I understand from Plaintiffs' counsel that Ohio's Medicaid program reimburses for many services provided by live video telemedicine and telephone calls and does not require an initial, in-person patient visit to do so (though Medicaid does not cover abortion services, regardless of how they are provided, except in extremely narrow circumstances); that Ohio requires coverage parity by private insurers for telemedicine services; and that Ohio law permits the prescription of medication, including controlled substances under certain conditions, via telemedicine. These aspects of Ohio law are consistent with my knowledge of efforts in many

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[14] Julie R. Whittington et al., *Telemedicine in Low-Risk Obstetrics*, 47 Obstetrics & Gynecology Clinics of N.Am. 241, 242 (2020).

[15] Cara L. Grimes et al., *Guidance for Gynecologists Utilizing Telemedicine During COVID-19 Pandemic Based on Expert Consensus and Rapid Literature Reviews*, 150 Internatl.J.of Gynecology & Obstetrics, 288, 292–93 (2020).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

other states to reduce regulatory barriers to telemedicine and thereby increase availability of this mode of care.

40. Outside of the medication-abortion context, and with the possible exception of opioids, which have a greater risk profile than mifepristone, I am not aware of any law around the country that identifies a particular type of health care and bars its provision via telemedicine, particularly in conjunction with potential criminal penalties for physicians. Although there are some medical services that must be provided in person, in my experience, a provider's determination as to whether telemedicine for a particular type of care may be used is guided by general standards of practice and medical ethics, subject as well to a patient's own preferences and ability to obtain care via telemedicine given any applicable insurance reimbursement requirements that might apply.

41. I also understand from Plaintiffs' counsel that SB 260 does not bar the use of telemedicine for miscarriage management. Providers managing miscarriage medically may rely on a number of medication regimens, depending on patient needs, provider preference and experience, and the availability of particular medications in the provider's clinical setting. Although I generally use only misoprostol to manage miscarriage (the second of the two medications used for medication abortion), some providers in fact use the same medication regimen (mifepristone followed by misoprostol) as is used by Plaintiffs for medication abortion. It is my understanding from Plaintiffs' counsel that SB 260 would not bar the provision of either of these regimens by telemedicine so long as they are intended to treat miscarriage, not induce abortion. Other than with respect to medication abortion, I am not aware of any law around the country that bars provision of medication via telemedicine only for specific purposes, while leaving the same use of that medication via telemedicine permissible for other purposes. In my

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

opinion, there is no medical justification for such a distinction in the context of mifepristone or misoprostol.

IV. OPINIONS REGARDING PLAINTIFFS' MODEL FOR TMAB

42. As I understand Plaintiffs' model of telemedicine for medication abortion ("TMAB"), it involves live, two-way (or real-time) synchronous care delivered via audio and video. Because the patient is in a health center when telemedicine is used, the model is best characterized as site-to-site telemedicine, as described above.

43. However, unlike many site-to-site telemedicine models, the TMAB model used by Plaintiffs actually involves (during the Day 1 visit) an *in-person* ultrasound and lab work, counseling, and determination of a treatment plan with a physician. Telemedicine plays no role in that process, and is instead limited to Day 2, when a physician confirms by video and audio that the patient is firm in her decision to have an abortion, addresses any questions, and actually dispenses the first medication in the abortion regimen.

44. It is my expert opinion that this model is safe and effective for patients. In particular, last year, my colleagues and I published a systematic review to evaluate evidence on the comparative effectiveness of telehealth as an alternative or adjunct to usual reproductive health care for women, with a focus on family planning, low- and high-risk obstetrics, and gynecology.[16] This systematic review was designed to identify and review existing evidence on the effects of mobile media, remote monitoring and care-delivery, patient-generated data, and virtual visits in women's health care delivery. The synthesis aimed to organize existing evidence into clinically meaningful areas where telehealth has been applied in reproductive health care.

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[16] Nathaniel DeNicola et al., *Telehealth Interventions to Improve Obstetric and Gynecologic Health Outcomes*, 135 Obstetrics & Gynecology 371 (2020).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

45. Four studies were identified that evaluated interventions related to induced abortion, all of which were related to medication abortion. Three cohort studies evaluated the provision of medication abortion using telehealth in a clinic system in Iowa; a fourth study dealt with the use of telehealth for follow-up after a medication abortion.

46. Of the studies involving TMAB provision, one compared the prevalence of clinically significant adverse events between patients receiving telehealth services compared with those receiving in-person services over a period of seven years.[17] The analysis found that telehealth provision was non-inferior to in-person provision in terms of these safety outcomes. The second cohort study found that effectiveness of the medication abortion was similar between patients receiving telehealth services and those receiving in-person services; some measures of acceptability were significantly higher among telehealth patients.[18] Finally, the third cohort study evaluated changes in the service delivery statistics of the clinic system in the two years after telehealth was introduced compared with the two years prior.[19] With TMAB, patients were significantly more likely to obtain a medication abortion and to obtain a first-trimester abortion. Travel distance to the clinic decreased slightly.

47. Taken together, these findings suggest that TMAB improves access to early abortion with similar clinical outcomes compared with in-person provision. Put another way, evidence from other states suggests that a ban on the use of telemedicine in the provision of

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[17] Daniel Grossman & Kate Grindlay, *Safety of Medical Abortion Provided Through Telemedicine Compared With In Person*, 130 Obstetrics & Gynecology 778 (2017).

[18] Daniel Grossman et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 Obstetrics & Gynecology 296 (2011).

[19] Daniel A. Grossman, *Changes in Service Delivery Patterns After Introduction of Telemedicine Provision of Medical Abortion in Iowa*, 103 Am.Journal Pub.Health 73 (2013).

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

medication abortion will reduce patient access to early abortions without any benefit to patients with respect to clinical outcomes.

48. In my opinion, an in-person visit is not necessary to provide counseling that ensures a patient understands the risks and benefits of medication abortion and is firm in her decision to have an abortion, though I understand that this type of counseling in Plaintiffs' model occurs in person on Day 1 anyway. So long as I have previously examined patients at an in-person visit, I regularly provide preoperative counseling to those patients via telemedicine, even for surgical procedures such as hysterectomies, removal of ovarian cysts, and tubal ligation. The medical risks of these procedures are greater than those associated with medication abortion. In my experience, preoperative counseling for these procedures is effective virtually and in person.

49. In my opinion, it is not medically necessary for a doctor to be physically present at the time that a patient takes mifepristone. A partial analogy in my own practice is clinical management of miscarriage. A patient who has experienced a suspected miscarriage will generally have an in-person visit with my practice to confirm the miscarriage by ultrasound and discuss potential treatment options. Depending on the patient's medical circumstances and other unique needs, I could work with the patient to manage the miscarriage at that visit by prescribing medication or by performing a dilation and curettage ("D&C"), a procedure that removes tissue from the uterus. It is not uncommon, however, that patients experiencing a miscarriage prefer "expectant management," which means waiting to see if the pregnancy tissue passes on its own without medical intervention. In that circumstance, I will advise the patient regarding the benefits and risks of expectant management and discuss that course of action with her, including the need to follow up within one week of our visit.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

50. However, if a patient were to decide in the days immediately following that visit that she no longer wanted to use a monitoring approach, she could schedule a virtual visit with me, at which time I would revisit earlier counseling about options for treatment by medication or D&C and make a new plan of care with the patient. For a patient selecting medical management, I would then prescribe misoprostol (Cytotec), a medication that induces uterine contractions and which can be obtained from a pharmacy. This medication is the second of two medications that abortion providers use to perform medication abortion. A patient experiencing a miscarriage would then use Cytotec in her own home without video supervision by a health care professional.

51. I also prescribe opioids to some patients, for example, to treat post-operative pain. I am never required to be physically present at the time the patient takes that medication, nor would there be any medical justification for such a requirement. Patients are able to take that medication in their own homes without any medical supervision—in person or via telemedicine—at the time of ingestion.

52. For all these reasons, it is my opinion that SB 260's prohibition on TMAB is not medically necessary and will not provide any benefit to patients. It stands in stark contrast to the efforts made by many states, including Ohio, to expand the use of telemedicine, including for care that is comparable to medication abortion.

53. It is also my opinion, based on my experience, training, and existing clinical evidence, that SB 260 will reduce patient access to early abortions and increase the distance that patients must travel to obtain an abortion. It will do so without any corresponding medical benefit to patients and will in fact deprive some patients of an effective mode of care that fits their needs.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

EXHIBIT 17

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. _____ Judge: _____

AFFIDAVIT OF ADARSH KRISHEN, M.D., M.M.M., IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER FOLLOWED BY PRELIMINARY INJUNCTION

I, Adarsh Krishen, M.D., M.M.M., being duly sworn on oath, do depose and state as follows:

1. I am a board-certified physician with over 30 years of experience in family medicine. I am licensed to practice medicine in the state of Ohio. Since 2017, I have been the Chief Medical Officer of Planned Parenthood of Greater Ohio ("PPGOH"). I have also been a Clinical Professor of Family and Community Medicine at Northeast Ohio Medical University in Rootstown, Ohio, since 2013.

2. In my role as Chief Medical Officer of PPGOH, I supervise physicians and clinicians, manage the provision of all medical services at PPGOH, and am responsible for developing PPGOH's policies and procedures. I also provide medication abortion, including via telemedicine.

3. Previously, I worked for 25 years as Associate Director at Summa Family Medicine Residency in Akron, Ohio. In that role, I provided care to patients, taught residents, and served as the Clinical Director of the Family Medicine Center of Akron.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

4. I completed my Bachelor of Science in Chemistry at Kent State University in 1982, and I received my Medical Degree from Northeast Ohio Medical University in 1986. I completed three years of residency (post-graduate) in Family Medicine at Akron City Hospital in Akron, Ohio, in 1989. I earned a Masters in Medical Management from Carnegie Mellon University in 2009. I have been a Fellow of the American Academy of Family Physicians since 2003.

5. The information in this declaration is based on my education, years of medical practice, my personal knowledge and knowledge obtained through the course of my duties at PPGOH, and my review of PPGOH business records.

6. I submit this declaration in support of Plaintiffs' Motion for a Temporary Restraining Order Followed by Preliminary Injunction to prevent enforcement of Senate Bill 260 ("SB 260"), which I understand would prevent PPGOH physicians from providing medication abortion to patients unless they are physically present at the patient's location when she takes the first medication of the medication abortion regimen. SB 260, Section 1, 2020 Ohio Laws File 113 (adding R.C. 2919.124(B)). I understand that this will effectively ban medication abortion by telemedicine.

7. If SB 260 takes effect and PPGOH can no longer offer medication abortion by telemedicine, our patients will have to travel farther to obtain an abortion. This will likely create hurdles for some patients that will delay their abortion to the point that they are no longer eligible for a medication abortion and their only option will be a procedural abortion, and for still others will so delay their access that they are not able to obtain an abortion at all. For patients who are able to obtain an abortion despite the barriers erected by SB 260, they will be subjected

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

to financial, physical, and emotional costs with no benefit. I am extremely concerned about the harm SB 260 will cause PPGOH's patients.

PPGOH and The Services It Provides

8. PPGOH was formed in 2012 through a merger of several local and regional Planned Parenthood affiliates that had served patients in Ohio for decades. PPGOH serves patients in northern, eastern, and central Ohio, and provides a broad range of medical services, including birth control, gynecological examinations, cervical pap smears, vasectomies, testing and treatment for sexually transmitted infections, HIV testing, pregnancy testing, and procedural and medication abortions.

9. PPGOH provides both procedural and medication abortions at our ambulatory surgical facilities ("ASFs") in East Columbus and Bedford Heights. At the East Columbus ASF we provide procedural abortions up to 17 weeks 6 days of pregnancy, as dated from the first day of the patient's last menstrual period ("LMP") and at the Bedford Heights ASF we provide procedural abortions up to 19 weeks 6 days LMP. PPGOH provides medication abortions through 70 days of pregnancy. Our ASFs have at least one physician present at all times. PPGOH also has 15 other health centers, which are not ASFs and where the on-site care is provided by non-physician clinicians, usually nurse practitioners. All of these facilities also have additional staff, including registered nurses and health care assistants.

10. In 2018, PPGOH began using telemedicine to provide medication abortion ("TMAB") at our Mansfield Health Center, and we expanded the use of TMAB in 2019 to our Youngstown Health Center. We chose these health centers to target geographical areas from which the greatest numbers of patients traveled to reach our ASFs in order to best reduce the burdens our patients face in accessing care. We intend to expand our TMAB services to

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

additional health centers in the future, including as soon as the third quarter of 2021, and to continue to focus on geographical locations from which patients currently travel to reach our ASFs.

11. When the COVID-19 pandemic began, along with many other health care providers in Ohio and elsewhere, we further expanded our use of telemedicine services to also include contraception and emergency contraception visits, evaluation for sexually transmitted and urinary infections, provision of PrEP for HIV prevention, and some primary care, including ongoing management of diabetes and hypertension. We have plans to continue expanding the services we offer via telemedicine, and in particular gender-affirming care. We provide non-abortion services using a direct-to-patient model whereby patients can be located in their home or another location of their choosing and can connect via video conference to a provider located in one of our health centers. We can therefore serve patients from all over the state with this model.

12. For at least 10 years before PPGOH began offering TMAB, all abortion services, including all medication abortion services, were provided at our two licensed ASFs in East Columbus and Bedford Heights. Ohio law requires that patients meet with a physician in person at least 24 hours prior to an abortion to comply with state-mandated informed consent processes, and receive a pre-abortion ultrasound. R.C. 2919.193 and 2919.194. In addition, only physicians may perform abortions. *See, e.g.*, R.C. 4723.44(B)(6) and 4730.02. Under these and other applicable laws, patients must therefore make two visits to a health center. Before PPGOH began offering TMAB, both visits took place at one of our two ASFs because that is where our doctors and ultrasound equipment are.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

13. For patients seeking an abortion via TMAB, the initial visit ("Day 1") is the same as for all abortion patients. The visit takes place at one of the two ASFs, and includes trained staff taking the patient's medical history and vital signs, and performing an ultrasound and lab work. The patient also meets one-on-one with a physician who reviews the patient's history and any available test results, discusses with the patient her eligibility for a medication abortion, provides state-mandated information and materials, reviews and signs informed consent paperwork, and answers any questions the patient may have.

14. Following the Day 1 visit, patients have the option to return to one of the ASFs for their second visit to begin the medication abortion regimen, or they can instead visit one of the two TMAB sites, which may be closer to their home or place of work, or may have availability for an appointment sooner than the ASFs. If patients choose TMAB, their second visit ("Day 2") will take place at either the Mansfield or Youngstown health centers. At the Day 2 visit, trained staff accompanies the patient in the exam room, and the patient visits with a physician who is located at one of the ASFs via secure video conference. The physician confirms that the patient is certain in her decision to have an abortion and answers any questions the patient may have. The physician then presses a button that remotely opens a cabinet at the TMAB site, from which the patient retrieves mifepristone, the first medication in the medication abortion regimen. The patient ingests the mifepristone while still on video conference and being observed by the physician. PPGOH then sends a prescription for misoprostol, the second medication in the process, to a pharmacy for the patient to pick up. The patient then takes the misoprostol 24 to 48 hours later at a location of her choosing, usually her home. Our physicians give all medication abortion patients, including TMAB patients, information about follow-up care and how to contact PPGOH 24 hours per day in case of any urgent questions or concerns.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

15. In 2020, 7% of the medication abortions PPGOH provided were done via TMAB.

16. TMAB is extremely safe. In fact, in 2019 and 2020, PPGOH's complication rate for TMAB was slightly lower than our overall medication abortion complication rate, which is consistent with the complication rates reported in the national academic literature. Complications from medication abortion do not occur until after the patient has left the health center and gone home, and so there is no medical reason for a physician to be present in person when a patient takes the mifepristone. A critical part of PPGOH's mission is to make our services, including abortion services, as accessible for our patients as possible. A significant proportion of our patient population is composed of people from historically underserved communities that face steep barriers to accessing medical care. In 2020, 31% of our abortion patients were Black, and approximately 39% of PPGOH's abortion patients had incomes at or below 110% of the federal poverty line. Offering services, including medication abortion, through telemedicine has allowed us to reduce patient travel time to access care, which reduces the financial and logistical hurdles patients must overcome.

17. PPGOH's experience with TMAB has been very positive. Patients consistently provide us feedback that they appreciate the option to have their second visit in their local community without the need for travel, and that the service is efficient and effective. From the provider perspective, TMAB feels essentially the same as an in-person appointment. The technology is highly efficient, and the visits feel just as personalized. There is no medical need for in-person contact to provide the necessary care to the patient since all the elements of the telehealth visit are identical to the in-clinic visit. We are able to provide equivalent, high quality care via TMAB.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

18. PPGOH uses the same medication regimen for medication abortion to treat patients experiencing a miscarriage. The dosage and method of administration of the medications are exactly the same. As I understand SB 260, if we were to use telemedicine for the treatment of miscarriage and prescribe this same medication regimen, the law would not prevent us from doing so.

The Effects of SB 260

19. If SB 260's ban takes effect, PPGOH will be forced to stop providing medication abortion via telemedicine, despite telemedicine's rapidly expanding use for other similar care in Ohio and elsewhere.

20. Many patients would be forced to travel significantly longer distances to obtain an abortion if SB 260 goes into effect, as it would completely eliminate abortion access in Richland and Mahoning counties. Patients in those areas would need to make two trips instead of just one to one of our ASFs.

21. Traveling from the Mansfield area to one of our ASFs requires driving approximately 75 miles each way, and patients would need to make this trip twice. Other abortion providers in the state are no closer.

22. From the Youngstown area to our Bedford Heights ASF is an approximately 60-mile drive, and the only closer in-state option in Akron is not significantly closer, at approximately 55 miles away. Our East Columbus ASF is much farther away—approximately 180 miles.

23. SB 260 would also prevent us from expanding TMAB services in the future to additional health centers in geographic areas of Ohio from which patients must currently travel burdensome distances to reach our ASFs.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

24. We cannot remove these burdens by beginning in-person MAB services at the current TMAB health centers because it would not be cost effective, nor would it be flexible enough for our patients. We do not have enough abortion patients at the TMAB sites to fill a full day's schedule for a physician, and attempting to do so would force patients to schedule a visit for specific, limited days, rather than the current model which includes flexibility for patients to schedule a TMAB appointment whenever a physician at the ASF, which is fully staffed, has an open appointment. Moreover, we would need to hire an additional physician to staff the TMAB health centers, as our current physicians' schedules are fully booked, and it is extremely difficult to hire a physician to provide abortion in Ohio. It can take over a year to hire a physician even for our ASFs, and I expect it would take even longer, if it would be possible at all, to find a provider to staff limited hours at a health center outside a major city.

25. Increased travel for an abortion will burden our patients in myriad ways. The need to travel farther means patients need to pay more for transportation, take more time off work, schedule longer periods of child care, and potentially pay more for an abortion, all of which can create barriers that can cause a patient to delay a procedure. Delays caused by increased travel mean patients will need to seek abortion later in pregnancy, which may mean patients are pushed past the point in pregnancy when they can obtain a medication abortion, which in Ohio is 70 days after a patient's last menstrual period. Other patients may be delayed so late into pregnancy that they are not able to obtain an abortion at all. Patients who cannot obtain an abortion and are forced to carry a pregnancy to term face risks to their physical and mental health, economic well-being, and family stability.

26. For all these reasons, SB 260 will severely burden PPGOH's patients, and this court's intervention is necessary to prevent serious harms. Without relief, PPGOH will not be

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

able to provide patients the option to schedule their Day 2 visit for a TMAB appointment beginning April 12, 2021. This will affect patients whose Day 1 visits are during the second half of next week (the week of April 5) and thereafter, as there is usually a one- to two-day wait between Day 1 and Day 2 visits.

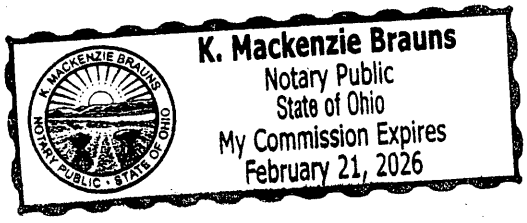
FURTHER AFFIANT SAYETH NAUGHT.

Executed this 29th day of March, 2021.

Adarsh Krishen, M.D., M.M.M.

Signed before me this 29th day of March, 2021

Notary Public



E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

EXHIBIT 18

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

IN THE COURT OF COMMON PLEAS
FOR HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*,	:	Case No. A 2101148
Plaintiffs,	:	Judge Alison Hatheway
v.	:	
OHIO DEPARTMENT OF HEALTH, *et al.*,	:	
Defendants.	:	

AFFIDAVIT OF BRIANNE BROWN ON BEHALF OF DEFENDANTS OHIO DEPARTMENT OF HEALTH AND BRUCE VANDERHOFF

Now Comes affiant Brianne Brown, having been first duly cautioned and sworn, deposes and states as follows:

1. Affiant Information

I, Brianne Brown, am over the age of 18 and fully competent to make this declaration. I have personal knowledge of the statement and facts contained herein. I am an authorized representative of both the Ohio Department of Health and Director of Health Bruce Vanderhoff.

2. Purpose of Affidavit

This affidavit is provided in lieu of a Rule 30(b)(5) deposition in the above captioned case pursuant to the agreement between counsel to substitute affidavits for deposition testimony.

3. Diligent Search—Least Restrictive Means

The Ohio Department of Health ("Department") has conducted a diligent search of its records, documents, and materials within its custody or control. As a result of that search, the

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Department does not have documents or evidence that the Challenged Laws are the least restrictive means to advance a pregnant person's health.

4. Diligent Search – Evidence-Based Standards of Care

The Department has conducted a diligent search and does not have documents or evidence showing that the Challenged Laws are in accordance with evidence-based standards of care.

5. State Evidence Regarding Abortion Statistics

To the best of Affiant's knowledge and based on the Department's diligent search, the Department possesses no evidence concerning statistics on abortions performed in Ohio other than what is contained in the Ohio Department of Health's Induced Abortion Reports. The Department will not offer testimony regarding those reports.

6. Witness Commitments for Trial and Motions Practice

No witness from the Department will serve as a witness at trial or offer an affidavit in support of any motion, including any motion relying on produced documents or any of the State's discovery responses.

7. Limitations on Documents and Testimony

No documents or testimony from the Department will be offered as evidence at trial, for summary judgment, or for any other motion, other than documents already produced to date in discovery.

8. Future-Acquired Evidence

Nothing in this affidavit prevents the Department from producing materials acquired after the date of this attestation that did not previously exist and could not have been obtained as of the date of this attestation, including ongoing abortion reporting or investigative materials, subject to the Court's discretion, the rules of evidence, the Ohio Rules of Civil Procedure, and a showing of

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

good cause. The Department shall notify Plaintiffs promptly if they learn of such evidence. If the Department later introduces such evidence, Plaintiffs shall have an opportunity to conduct a deposition of the Department on that evidence.

9. Accuracy of Statements

The statements in this affidavit are true and accurate to the best of Affiant's knowledge, information, and belief.

FURTHER AFFIANT SAYETH NAUGHT

Executed on June 22, 2026

Brianne R. Brown

Brianne Brown

NOTARIAL SEAL STATE OF OHIO

RENATA Y STAFF
Attorney At Law
Notary Public, State of Ohio
My commission has no expiration date
Sec. 147.03 R.C.

Notarized by Renata Y SB

No expiration date

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

EXHIBIT 19

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

IN THE COURT OF COMMON PLEAS5
FOR HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*,	:	Case No. A 2101148
Plaintiffs,	:	Judge Alison Hatheway
v.	:	
OHIO DEPARTMENT OF HEALTH, *et al.*,	:	
Defendants.	:	

AFFIDAVIT OF KIMBERLY ANDERSON ON BEHALF OF DEFENDANTS KIM ROTHERMEL AND HARISH KAKARALA

Now Comes affiant Kimberly Anderson, having been first duly cautioned and sworn, deposes and states as follows:

1. Affiant Information

I, Kimberly Anderson, am over the age of 18 and fully competent to make this declaration. I have personal knowledge of the statement and facts contained herein. I am an authorized representative of both Kim Rothermel and Harish Kakarala.

2. Purpose of Affidavit

This affidavit is provided in lieu of a Rule 30(b)(5) deposition in the above captioned case pursuant to the agreement between counsel to substitute affidavits for deposition testimony.

3. Diligent Search—Least Restrictive Means

Kim Rothermel and Harish Kakarala have conducted a diligent search of their records, documents, and materials within their custody or control. As a result of that search, they do not

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

have documents or evidence that the Challenged Laws are the least restrictive means to advance a pregnant person's health.

4. Diligent Search – Evidence-Based Standards of Care

Kim Rothermel and Harish Kakarala have conducted a diligent search and do not have documents or evidence showing that the Challenged Laws are in accordance with evidence-based standards of care.

5. State Evidence Regarding Abortion Statistics

To the best of Affiant's knowledge and based on their diligent search, Kim Rothermel and Harish Kakarala possess no evidence concerning statistics on abortions performed in Ohio.

6. Witness Commitments for Trial and Motions Practice

No witness for Kim Rothermel or Harish Kakarala will serve as a witness at trial or offer an affidavit in support of any motion, including any motion relying on produced documents or any of the State's discovery responses.

7. Limitations on Documents and Testimony

No documents or testimony from Kim Rothermel and Harish Kakarala will be offered as evidence at trial, for summary judgment, or for any other motion, other than documents already produced to date in discovery.

8. Future-Acquired Evidence

Nothing in this affidavit prevents Kim Rothermel and Harish Kakarala from producing materials acquired after the date of this attestation that did not previously exist and could not have been obtained as of the date of this attestation, including ongoing abortion reporting or investigative materials, subject to the Court's discretion, the rules of evidence, the Ohio Rules of Civil Procedure, and a showing of good cause. Kim Rothermel and Harish Kakarala shall notify

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Plaintiffs promptly if they learn of such evidence. If Kim Rothermel and Harish Kakarala later introduce such evidence, Plaintiffs shall have an opportunity to conduct a deposition on that evidence.

9. Accuracy of Statements

The statements in this affidavit are true and accurate to the best of Affiant's knowledge, information, and belief.

FURTHER AFFIANT SAYETH NAUGHT

Executed on 4/22/2026

Kimberly Anderson

Kimberly Anderson

Sworn to and signed before me, Colin Defew, Notary Public on this 22 day of June, 2026.

Notarial Seal
STATE OF OHIO

Colin G. De Pew
Notary Public, State of Ohio
My Commission Expires
Does not expire
2019 AT 808913

Notary Public

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

EXHIBIT 20

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

IN THE COURT OF COMMON PLEAS
FOR HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*,	:	Case No. A 2101148
Plaintiffs,	:	Judge Alison Hatheway
v.	:	
OHIO DEPARTMENT OF HEALTH, *et al.*,	:	
Defendants.	:	

AFFIDAVIT OF DAVID GEIGER ON BEHALF OF DEFENDANTS ERIN KEELS AND CANDY SUE RINEHART

Now Comes affiant David Geiger, having been first duly cautioned and sworn, deposes and states as follows:

1. **Affiant Information**

I, David Geiger, am over the age of 18 and fully competent to make this declaration. I have personal knowledge of the statement and facts contained herein. I am an authorized representative of both Erin Keels and Candy Sue Rinehart.

2. Purpose of Affidavit

This affidavit is provided in lieu of a Rule 30(b)(5) deposition in the above captioned case pursuant to the agreement between counsel to substitute affidavits for deposition testimony.

3. Diligent Search—Least Restrictive Means

Erin Keels and Candy Sue Rinehart have conducted a diligent search of their records, documents, and materials within their custody or control. As a result of that search, they do not

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

have documents or evidence that the Challenged Laws are the least restrictive means to advance a pregnant person's health.

4. Diligent Search – Evidence-Based Standards of Care

Erin Keels and Candy Sue Rinehart have conducted a diligent search and do not have documents or evidence showing that the Challenged Laws are in accordance with evidence-based standards of care.

5. State Evidence Regarding Abortion Statistics

To the best of Affiant's knowledge and based on their diligent search, Erin Keels and Candy Sue Rinehart possess no evidence concerning statistics on abortions performed in Ohio.

6. Witness Commitments for Trial and Motions Practice

No witness for Erin Keels or Candy Sue Rinehart will serve as a witness at trial or offer an affidavit in support of any motion, including any motion relying on produced documents or any of the State's discovery responses.

7. Limitations on Documents and Testimony

No documents or testimony from Erin Keels or Candy Sue Rinehart will be offered as evidence at trial, for summary judgment, or for any other motion, other than documents already produced to date in discovery.

8. Future-Acquired Evidence

Nothing in this affidavit prevents Erin Keels and Candy Sue Rinehart from producing materials acquired after the date of this attestation that did not previously exist and could not have been obtained as of the date of this attestation, including ongoing abortion reporting or investigative materials, subject to the Court's discretion, the rules of evidence, the Ohio Rules of Civil Procedure, and a showing of good cause. Erin Keels and Candy Sue Rinehart shall notify

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN

Plaintiffs promptly if they learn of such evidence. If Erin Keels and Candy Sue Rinehart later introduce such evidence, Plaintiffs shall have an opportunity to conduct a deposition on that evidence.

9. Accuracy of Statements

The statements in this affidavit are true and accurate to the best of Affiant's knowledge, information, and belief.

FURTHER AFFIANT SAYETH NAUGHT

Executed on June 24, 2026

David Geiger

Notary

NOTARIAL SEAL STATE OF OHIO

Marcie Pastrick
Attorney at Law
Notary Public, State of Ohio
My Commission Has No Expiration
Section 147.03 R.C.

E-FILED 09/30/2026 9:08 PM / CONFIRMATION 1896233 / A 2101148 / JUDGE HATHEWAY / COMMON PLEAS DIVISION / MOTN