

# EXHIBIT 2

IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF ARKANSAS  
CENTRAL DIVISION

FREDERICK W. HOPKINS, M.D., M.P.H. <i>et al.</i> ,	)	
	)	
Plaintiffs,	)	Case No. 4:17-cv-00404-KGB
	)	
v.	)	
	)	
LARRY JEGLEY <i>et al.</i> ,	)	
	)	
Defendants.	)	

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**DECLARATION OF WILLIE J. PARKER, MD, MPH, MSc, IN SUPPORT  
OF PLAINTIFFS’ MOTION FOR A SECOND PRELIMINARY INJUNCTION AND/OR  
TEMPORARY RESTRAINING ORDER**

Willie J. Parker, MD, MPH, MSc declares and states the following:

1. I am a board-certified obstetrician-gynecologist (“ob-gyn”) with subspecialty training in family planning, contraception, and abortion. I have 30 years of experience in obstetrics and gynecology, including as the Director of the Division of Family Planning and Preventive Services at the Washington Hospital Center (Washington D.C.); as the Medical Director of Planned Parenthood of Metropolitan Washington, overseeing clinical and laboratory services at five health care centers in Maryland, Virginia, and the District of Columbia; and as an independent abortion provider at outpatient abortion clinics in Alabama, Arkansas, Georgia, Illinois, Mississippi, Nevada, and Washington.

2. I am currently serving as the interim medical director at Little Rock Family Planning Services (“LRFP”) in Little Rock, Arkansas, the only clinic in Arkansas that provides second-trimester abortion care. I became licensed to practice in Arkansas in March 2020, began

providing abortion services at LRFP in April of 2020, and became interim medical director on August 14, 2020. As interim medical director, I oversee clinical practice, ensure the medical services provided at LRFP comply with the standard of care, and supervise others in providing a range of reproductive health care services, including abortion. I am currently the primary provider of abortion care at LRFP. I provide medication abortion up to 10.0 weeks after the patient's last menstrual period ("LMP") and procedural abortion, also referred to as "surgical abortion," up to 21.6 weeks LMP.<sup>1</sup>

3. My professional life is dedicated to providing pregnant people with safe, compassionate abortion care. My commitment to providing this care is driven not only by my medical training and dedication to women's health, but also by my conscience. I feel it is my duty to provide this important service. Providing abortions in the American South is especially important to me because my religion, spirituality, and experiences as a native southerner compel me to use my medical training to provide health care in the most underserved regions of our country.

4. I submit this declaration in support Plaintiffs' Motion for a Second Preliminary Injunction and/or Temporary Restraining Order to enjoin the following four laws:

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<sup>1</sup> Pregnancy is typically dated from the first day of the patient's last menstrual period. The number of weeks appears before the decimal point and the number of days appear after the decimal point, so 10.0 weeks LMP means 10 weeks and zero days since the patient's last menstrual period.

The terms "surgical abortion," "procedural abortion," and "abortion procedure" are used interchangeably in modern medicine. Although many in the medical field still use the term "surgical abortion" to refer to all abortions that use instruments rather than medications, aspiration and D&E abortions are more accurately referred to as "procedural abortions" or "abortion procedures," because neither entail what is commonly considered to be a "surgery," i.e., an incision into bodily membranes. *See* Am. Coll. of Obstetrics & Gynecology ("ACOG"), *Definition of "Procedures" Related to Obstetrics and Gynecology*, ACOG (Jan. 2018), <https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2018/definition-of-procedures-related-to-obstetrics-and-gynecology>.

a. Act 45 (H.B. 1032 or the “D&E Ban”), which bans any abortion in which a physician “purposely dismembers the living” fetus and extracts fetal parts with instruments such as forceps. While this is not a medical description, I understand this law to ban dilation and evacuation, or D&E, procedures—the only outpatient abortion procedure available throughout the second trimester in Arkansas. I understand that Act 45 makes performing such an abortion a felony with severe criminal penalties. If Act 45 were to go into effect, physicians in Arkansas could not start an outpatient second- trimester abortion without putting themselves at risk of felony conviction, license revocation, and civil penalties.

b. Act 722 (H.B. 1434 or the “Medical Records Mandate”) Arkansas Code Annotated Section 20-16-1904(b)(2), which prohibits physicians from performing an abortion unless and until they have requested all “medical records of the pregnant woman relating directly to the entire pregnancy history of the woman” and spent “reasonable time and effort” to obtain those records. I understand that violations of this mandate carry criminal and licensing penalties. If the Medical Records Mandate takes effect, expansive records searches from patients’ past providers will breach their confidentiality and delay abortion care for no medical reason, harming my patients and leaving me uncertain as to when abortions can lawfully proceed.

c. Act 1018 (H.B. 2024 or the “Local Disclosure Mandate”), which amends Arkansas Code Section 12-18-108(a)(1) to require that physicians performing abortions for 14- to 16-year-old patients preserve the “fetal tissue extracted during the abortion” and contact local law enforcement where the patient resides to take custody of that “evidence” in accordance with rules adopted by the Arkansas State Crime

Laboratory. As a result, physicians must (i) inform local police of 14- to 16-year-old patients' abortions when there is no indication of a crime or abuse, (ii) preserve the "tissue for the purpose of DNA testing and examination," and (iii) convey to the patient's local police the tissue labeled with the patient's name and a form specifying (among other things) their residence and parent's name. Local police, in turn, carry the labeled tissue to the state crime lab, where it remains indefinitely. I understand that failure to comply with these requirements constitutes unprofessional conduct under the Arkansas Medical Practices Act. If the Local Disclosure Mandate is allowed to take effect for those 14- to 16-year-olds whose circumstances do not raise any concerns of abuse or criminality (the group on whose behalf Plaintiffs sue), the law will stigmatize and confuse them, either drive them from abortion care in Arkansas or reveal their abortion to police in their community, and involuntarily turn over those young patients' tissue and DNA to the state for possible future testing and analysis.

d. Act 603 (H.B. 1566 or the "Tissue Disposal Mandate"), which I understand would require a physician to ensure that embryonic or fetal tissue from an abortion is disposed in accordance with the Arkansas Final Disposition Rights Act of 2009 (FDRA). The FDRA lays out the relative order of authority of family members when determining what to do with the dead body of their next of kin and requires family members of the deceased be notified of their respective rights. I understand the law has criminal penalties. If the Tissue Disposal Mandate were to take effect, I would no longer be able to provide abortion care confidentially, without disclosing my patients' abortions to other individuals, or to ensure compliance with all of its vague requirements.

#### **SUMMARY OF OPINIONS OFFERED & BASES FOR THEM**

5. I submit this declaration in support of Plaintiffs' Motion for a Second Preliminary Injunction and/or Temporary Restraining Order to:

- a. explain current abortion practice at LRFP;
- b. provide my expert opinion regarding abortion practice in the United States and the impact of the D&E Ban, Medical Records Mandate, Local Disclosure Mandate, and Tissue Disposal Mandate on abortion practice at LRFP;
- c. provide my expert opinion that if allowed to take effect, the challenged laws would, at minimum, impose indeterminate delay on patients, breach patient confidentiality and/or bar abortion access for a significant number of patients.

6. I have read Dr. Hopkins' declaration in this case and agree with his descriptions of abortion care, the restrictions the challenged laws place on abortion practice, and the impact those restrictions would have on one's ability to provide safe and confidential abortion care in Arkansas.

7. The information provided in this declaration is based on my personal knowledge unless otherwise noted. The opinions in this declaration are my expert opinions as an ob-gyn and abortion provider, based on my education, training, professional experience, and review of relevant medical literature.

8. My experience and credentials, including my educational background, faculty appointments, and publications in peer-reviewed scientific journals, are more fully set forth in my *curriculum vitae*, a true and accurate copy of which is attached hereto as Exhibit A.

**ABORTION IN ARKANSAS AND IN THE UNITED STATES**

9. LRFP is one of only two entities providing abortion care in Arkansas. LRFP is the only entity providing abortions after 10.0 weeks LMP and the only entity providing procedural abortion in the entire state. The only other entity providing abortion care in Arkansas, Planned Parenthood Great Plains, provides only medication abortion through 10.0 weeks LMP.

10. The first trimester of pregnancy goes to approximately 14.0 weeks LMP. Nationwide, approximately 91% of abortions occur during the first trimester.<sup>2</sup> In Arkansas, approximately 88% of abortions take place in the first trimester.<sup>3</sup>

11. Existing Arkansas law requires that all abortion patients make at least two trips to the clinic. This is because a law passed in 2019 requires patients to receive state-mandated counseling in-person at the clinic, wait 72 hours, and then return to the clinic for care.

12. There are two principal first-trimester abortion methods: medication abortion and aspiration abortion. In a medication abortion, the patient takes two medications that together will induce a process similar to a miscarriage. The patient takes mifepristone on the first day, and misoprostol approximately 24–48 hours later in a location of the patient’s choosing, usually the patient’s home, which causes the uterus to contract and expel the fetal tissue. In Arkansas, medication abortion is available up to 10.0 weeks LMP. In an aspiration abortion, a clinician opens the patient’s cervix and inserts a small tube, or canula, into the cervix and uses gentle suction to evacuate the contents of the uterus. Aspiration abortion is available throughout the first trimester. LRFP is the only provider of aspiration abortion in Arkansas.

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<sup>2</sup> Tara C. Jatlaoui et al., *Abortion Surveillance – United States, 2016*, MMWR Surveillance Summaries, Nov. 29, 2019, at 1, 8, <https://www.cdc.gov/mmwr/volumes/68/ss/pdfs/ss6811a1-H.pdf>.

<sup>3</sup> Ark. Ctr. of Health Stat., *Induced Abortion Report 2019*, at 8 (2020), [https://www.healthyarkansas.com/images/uploads/pdf/Induced\\_Abortion\\_final\\_2019.pdf](https://www.healthyarkansas.com/images/uploads/pdf/Induced_Abortion_final_2019.pdf) (in 2019, of the 2,963 abortions in Arkansas, 2,606 took place before 12.0 weeks from “Probable Post-Fertilization,” which is 14.0 weeks LMP).

13. Dilation and evacuation (“D&E”) is the only outpatient abortion method available throughout the second trimester in Arkansas. During a D&E, a physician dilates the cervix, and then, once the cervix is sufficiently dilated, evacuates the uterus using a combination of suction and instruments. The procedure typically takes under ten minutes. Because the physician dilates the cervix only enough to allow for the safe passage of instruments and removal of tissue, separation of fetal tissue will occur as it is being removed through the cervix.

14. D&E abortions accounted for 100% of second-trimester abortions reported in Arkansas in 2019.<sup>4</sup>Nationally, data suggest D&E accounts for almost all second-trimester abortion procedures in the U.S.<sup>5</sup>The principal alternative method of second-trimester abortion, induction of labor, is generally performed in a hospital, takes place over several hours or days, can entail more pain, discomfort, and distress for the patient, and is far more expensive than D&E.

15. In Arkansas, the D&E procedure takes place over one or two days depending on the medical needs of the patient. For a large majority of LRFP’s second-trimester abortion patients, a physician will be able to safely achieve sufficient dilation in one day using manual dilators and medication, and will evacuate the uterus on the same day. A small number of LRFP’s second-trimester abortion patients will undergo overnight dilation where physicians place osmotic dilators that will expand slowly to gently achieve greater dilation over the course of several hours. Physicians evaluate patient history and circumstances and use their clinical judgment to determine the best dilation protocol for each individual patient. LRFP’s physicians begin the overnight dilation protocol between 18 and 20 weeks LMP.

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<sup>4</sup> *Id.*

<sup>5</sup> Am. Coll. of Obstetricians & Gynecologists, *Practice Bulletin Number 135: Second-Trimester Abortion*, 121 *Obstetrics & Gynecology* 1394, 1394, 1406 (2013).



16. At LRF, if a physician is using overnight dilation in a patient's D&E protocol, that physician will also typically attempt to induce fetal demise by injecting digoxin either directly into the fetus or, if such an injection is not possible, into the amniotic fluid, the day before the procedure when the physician begins dilation. Digoxin can cause fetal demise over the course of 24 hours by causing the fetal heart rate to slow and eventually stop but does not always cause demise. It is LRF's typical protocol to attempt demise, where safe and appropriate, when using overnight dilation, because it demonstrates compliance with federal and state partial birth abortion bans.

17. Because a physician would not extend the procedure by an entire day solely to inject digoxin and give it time to cause demise, this additional step is only taken with the small number of patients for whom overnight dilation is medically appropriate.

18. If a patient requiring overnight dilation returns the next day and the digoxin injection has not caused fetal demise, the physician will still evacuate the patient's uterus on that same day. At this point, physicians will take steps with their forceps—such as compressing fetal parts—in order to cause demise and otherwise demonstrate compliance with existing laws. I understand that under the D&E Ban, such actions would be prohibited.

19. In my experience, LRF patients, like most abortion patients across the country, are disproportionately people with low incomes. It is common for our patients to struggle to obtain the resources needed to obtain care, arrange for transportation to and from the clinic and, if necessary, arrange for childcare. Laws that create additional hurdles to obtain care, like those

that require additional unnecessary trips to the clinic, force patients to delay care and can put care out of reach for some patients.

20. For medical and financial reasons, patients who are resolved about their decision to seek abortion care should do so without delay. Delay forces patients to continue to experience the physical and emotional symptoms of a pregnancy they have decided to end. Further, though abortion is very safe and far safer than continuing a pregnancy and giving birth, delay in obtaining care can make a patient ineligible for less invasive abortion methods and increases the risks of complications. Delay in seeking care also increases the cost of the procedure, which can, in turn, increase the delay and put care out of reach for some patients.

#### **THE D&E BAN**

21. I have reviewed Act 45. It bans any abortion in which a physician “purposely dismembers the living” fetus and extracts fetal parts with instruments such as forceps. As described above, in the D&E procedure, fetal tissue separation occurs as tissue is removed from the uterus with forceps. Thus, in banning procedures where fetal tissue separation (which the law terms as “dismemberment”) occurs, this law bans D&E. I understand that Act 45 makes a D&E a felony with severe criminal penalties. If Act 45 were to go into effect, physicians in Arkansas could not start any outpatient second-trimester abortion without putting themselves at risk of felony conviction, license revocation, and civil penalties.

22. I understand that the D&E Ban does not apply when fetal demise has occurred prior to the evacuation phase of a D&E. However, under this Ban, there is no safe and reliable way to guarantee fetal demise prior to the evacuation of the uterus with instruments. Indeed, the procedures that Defendants assert a physician could use to cause fetal demise are unreliable, experimental, unsafe and/or unavailable to physicians at LRFPP.

***Defendants' Proposed Means of Complying With the Ban***

23. I understand that Defendants have proposed that providers could use digoxin to guarantee fetal demise before the evacuation of fetal tissue. This is untrue. Digoxin cannot be used to ensure demise in every second-trimester abortion for several reasons.

a. Digoxin injections are virtually unstudied before 18 weeks LMP. There is no way to know whether an injection of digoxin early in the second trimester would be safe or effective at causing demise.

b. Moreover, even if physicians were willing to perform these experimental injections early in the second trimester, doing so would extend the D&E procedure by a day for D&E patients who currently undergo a one-day procedure. As described above, because digoxin takes up to 24 hours to cause demise, these patients would have to make an additional trip to the clinic solely for the purpose of receiving an experimental digoxin injection and giving it time to work. This additional trip would further burden our patients, many of whom, as described above, have low incomes and already face obstacles in obtaining abortion care.

c. Even after 18 weeks, digoxin cannot always be safely injected. Digoxin injections are simply medically inappropriate for some patients. For example, the medication itself may be contraindicated, or other factors, such as quickly advancing dilation, may make delaying evacuation by a day too risky for the patient.

d. As noted above, even where a physician can safely inject digoxin, it sometimes fails to cause demise after 24 hours. No one can know ahead of time for which patients digoxin will fail to cause fetal demise. In such situations, the medically appropriate path would be to continue with the procedure, but, under the Ban, a physician

would have to attempt another demise method, such as a second injection of digoxin, until fetal demise occurs. Repeated doses of digoxin are unstudied, so there is no way to know whether they are safe or effective at causing fetal demise. Moreover, attempting a second injection would further increase the burden on the patient by delaying the procedure for still another 24 hours.

24. I further understand that Defendants have proposed that providers at LRFP could inject potassium chloride to induce fetal demise. The procedure Defendants are suggesting is both risky and highly specialized. Potassium chloride must be injected directly into the fetal heart, which is smaller than a dime in the second trimester. Inadvertent injection of potassium chloride into the patient's circulation can result in severe complications, including death. The specialized training needed to perform this procedure is not a standard part of training for clinicians that provide abortion care. Rather, certain specialists learn to perform the procedure through a three-year subspecialist program in high risk obstetrics *after* completing an ob-gyn residency. I do not have this training, nor do any of my colleagues providing abortion care at LRFP. Even if I were willing to get such training, there is no way for me to obtain it. Returning to any fellowship—let alone one as highly competitive as this one—to learn a single rarely used procedure that is unnecessary for me to continue my current practice is simply not feasible or reasonable.

25. I understand that Defendants have also proposed that providers at LRFP could transect the umbilical cord and wait for fetal demise to occur before evacuating the uterus. This method is also unreliable and can be risky. Physicians cannot know before starting a procedure whether they will be able to successfully locate and transect the cord. The cord may be difficult to reach, and attempting to grasp and transect the cord exposes patients to serious risks including

uterine perforation. Moreover, under this Ban, the procedure could be even more difficult and risky because a physician would not only have to grasp and transect the cord, but do so without grasping fetal parts instead of, or in addition to, the cord. Failure to do so would result in the physician violating the law regardless of whether the cord was transected.

26. I understand that Defendants have claimed that physicians could rely on using an aspiration procedure, as opposed to D&E, to continue to perform any second-trimester abortion. This is not the case. Suction alone may be insufficient to evacuate the uterus and a physician may need to use instruments to evacuate the uterus as quickly and safely as possible. As the pregnancy advances, so does the likelihood suction will be insufficient to complete the procedure. Thus, even providers who start second-trimester procedures with suction are aware that instruments may be necessary to complete any given procedure. Later in the second trimester, instruments will certainly be necessary to complete a procedure.

***The Effect of the D&E Ban***

27. Because there is no way to guarantee fetal demise with every patient, the Ban prohibits abortions beginning as early as 14 weeks LMP. Under this law, providers of second-trimester abortion care in Arkansas would be forced into a position where they can either act in the best interests of their patients or protect themselves from liability, but not both.

28. Patients seeking second-trimester abortion care in Arkansas do so for a variety of reasons. It is not unusual for patients to be delayed in obtaining care for financial reasons or due to difficulty arranging and paying for transportation and/or childcare. Patients might also have medical reasons for seeking care in the second trimester. For example, they might have had difficulty recognizing the pregnancy or only recently learned that continuing the pregnancy posed a risk to their health.

29. Banning second-trimester abortion in Arkansas would threaten the health and well-being of the people of Arkansas. Pregnant people seeking second-trimester abortion care would undoubtedly face obstacles in seeking care out-of-state given that providers of abortion care (particularly second-trimester abortion care) are scarce, especially in the American South, and the cost of care, which is already very difficult for patients to meet, rises as pregnancy advances.

30. Those who might still be able to obtain care elsewhere will likely experience delay, which, as described above, increases both the medical risks and the financial, logistical, and emotional burden on patients. While abortion is a safe procedure throughout the second trimester, and always safer than continuing the pregnancy to term, the risk increases as the pregnancy advances. Thus, imposing hurdles that cause the patient to be delayed in obtaining abortion care increases the risk of complications.

31. For some patients, these obstacles will be insurmountable. They will be forced to either carry their pregnancies to term or attempt to end their pregnancy without medical assistance, potentially using unsafe methods. As a physician dedicated to providing safe and legal abortion care to those who want it, I am extremely troubled by the idea of people who want to end their pregnancies with the assistance of a medical provider being denied the ability to do so.

#### **THE MEDICAL RECORDS MANDATE**

32. I have reviewed Arkansas Code Annotated Section 20-16-1904(b)(2) and the legislature's full Act 722 that included it. This Medical Records Mandate does not allow physicians to perform any abortion unless and until they have requested all "medical records of

the pregnant woman relating directly to the entire pregnancy history of the woman” and spent “reasonable time and effort” to obtain those records.

33. The scope of the records search required is unclear. The Medical Records Mandate appears to be all-inclusive of any past pregnancies and the current one, though it is imprecise as to the exact scope of records that might “directly relate” to that “entire pregnancy history.” Records directly related to a patient’s entire pregnancy history would seem, at a minimum, to include labor and delivery records from hospitals, records regarding any prenatal care from obstetricians or other physicians, miscarriage records from physicians or emergency rooms, and any records related to a prior abortion. They might include testing and monitoring records created at laboratories, clinics, or ultrasound facilities. And they could include records of care or monitoring necessary for the patient’s own medical conditions exacerbated during the patient’s current or past pregnancy.

34. A patient’s medical records from another health care provider are almost never relevant to or required for abortion care. It is exceedingly rare for me to seek medical records from another clinician prior to providing an abortion. That is because, in almost all situations, medical records play no role in and would not affect abortion health care.

35. On those unusual occasions when I do request medical records, the records typically relate to a patient’s comorbidities, rather than to pregnancy itself. For example, I have on occasion requested records from patients’ other treating physicians, with the patients’ consent, when patients have bleeding disorders or seizure disorders. I have done so to determine whether providing abortion care in an ambulatory setting is appropriate. In very rare circumstances with such comorbidities, care would instead need to take place in a hospital setting.

36. Other patients may come to me with some discrete records or have such discrete records conveyed along with a referral, if a fetal anomaly has been diagnosed in their current pregnancy and they seek further post-abortion tissue testing related to that diagnosis.

37. I do not recall any instance of broadly requesting medical records about a patient's full reproductive history, even from a single other health care provider, before performing an abortion. I certainly have never sought all "medical records of the pregnant woman relating directly to the entire pregnancy history of the woman" from all the patient's past health care providers prior to or as part of abortion care for any of my patients. Seeking and reviewing those historical medical records would not alter or improve the abortion care patients receive or otherwise serve their needs in my care.

38. In those rare instances when I have requested an abortion patient's records from another clinician or facility, securing the records has not been easy. The vast majority of my abortion patients sporadically receive other health care, if any, in indigent-care settings largely funded by the government, including free clinics, walk-in clinics, urgent care, and emergency rooms. My abortion patients typically have no health care "home" that coordinates their care, and instead rely only on episodic visits to different providers and facilities as needed.

39. For example, securing even discrete portions of patient records from the physicians who may have provided care for bleeding or seizure disorders has often required multiple inquiries by my staff (by phone, fax, and/or email) to identify where the records may be held. Once the patient has signed the records release and the request has reached the past provider holding records, it routinely takes several more contacts to obtain them.

40. We press for these records urgently, because abortion is extremely time-sensitive. And even for only the portion of a patient's records that describe her bleeding or seizure



disorders, those requests may take many days to fulfill. If the records do not come quickly enough, I have to rely instead on conversations with a patient's past health care provider or, in very rare instances, refer the patient to care in a non-ambulatory setting.

41. In addition to the Medical Records Mandate's broad though uncertain scope of search for historical records—which bears no relation to providing abortion health care—the statute's reference to “reasonable time and effort” to obtain records is also not at all clear to me. Who judges what's reasonable and against what standard? What, if anything, must be documented? Is “reasonable time and effort” the same for all patients and providers, or does it vary? What if compiling and sending the initial requests itself took considerable time and effort? How much more must be devoted to actually obtaining the records? How can facilities and physicians plan abortion care, and patients try to schedule their care, under such a nebulous rule? This statute provides no definition of “reasonable time and effort” so that I (or any other physicians) can know when it permits abortion care to go forward, whether or not any records have been received.

42. If “reasonable time and effort” is interpreted to encompass the time and effort necessary to secure records for a patient's “entire pregnancy history,” such an effort would easily stretch over weeks or months for any patients with a past pregnancy in addition to their current one. Patients' past care may have occurred elsewhere in Arkansas, in other states, or overseas. Even if records were sought from only a single Arkansas provider who had diagnosed the current pregnancy, it could take days or weeks and would depend on factors outside my control.

43. Because physicians face criminal sanctions and loss of their medical licenses if they proceed with an abortion before permitted under the Medical Records Mandate, and we want to remain in a position to provide health care for our patients in the future, my colleagues

and I would have no choice but to read the Mandate's requirements inclusively. Yet even erring on the side of caution, there are still no firm scope-of-search and "time and effort" standards here with which to comply.

44. The Medical Records Mandate also does not tell my colleagues and me what, if anything, we are to do with any records obtained. Under the terms of the statute, this exhaustive search for records of a patient's entire pregnancy history appears to be a meaningless (though tremendously burdensome) exercise that only interferes with abortion health care.

45. The Medical Records Mandate was enacted as one provision within Act 722, "An Act to Create the Sex Discrimination by Abortion Prohibition Act; And for Other Purposes." This case does not challenge that statute's requirements that we ask each patient if she knows the sex of the embryo or fetus and then inform any LRFP patient that knows the sex "of the prohibition of abortion as a method of sex selection for children."

46. I am not aware of any abortions occurring in Arkansas "solely on the basis of the sex of the unborn child," and would be personally opposed to performing any such abortion. I have explored my own moral convictions in this regard and have a firm personal position, but I have not encountered a patient who expressed that the sex of the fetus was the sole reason for seeking an abortion.

47. To the extent that the Medical Records Mandate is supposed to be in service of preventing "Sex Discrimination by Abortion," it does not serve that aim, because as explained below, it instead only serves to delay and prevent care, waste resources, breach confidentiality, and cause confusion. The sex of the embryo or fetus cannot be determined during the earliest stages of pregnancy. Though testing can determine sex as pregnancy progresses, it is not

common for my patients at LRFP to have undergone any testing that would reveal the sex of the embryo or fetus prior to their seeking abortion.

48. The ultrasound examinations performed as part of routine prenatal care cannot determine the sex of the fetus before the fourteenth week of pregnancy, because male and female fetuses develop physically in the same way up to that point. It is typically a prenatal ultrasound performed at 18–22 weeks that might reveal the sex of the fetus during pregnancy, if the patient desires that information. (After a patient comes to LRFP for an abortion, ultrasound is used to date the gestational age of the pregnancy. That type of ultrasound exam relies on less powerful ultrasound technology than is used later in pregnancy for prenatal care, and does not include informing the patient of the sex of the embryo or fetus, even if it might be determinable—i.e., at or after 14 weeks LMP.)

49. There is also a blood test that can disclose information about sex sooner than ultrasound, but that test typically occurs only for the purpose of assessing the risk of chromosomal abnormalities in wanted pregnancies and is only available to those with private health insurance coverage and access to optimal prenatal care. The vast majority of the abortion patients we see at LRFP would not have access to such blood testing.

50. Thus, only a small minority of abortion patients come to LRFP knowing the sex of the fetus. Patients with knowledge of the sex are almost always seeking abortion only after learning of a fetal diagnosis. Those patients are usually quite upset and express reasoning behind their care decision that has nothing to do with sex-selection.

51. Medical records related to a patient's pregnancy history, especially if any past pregnancy resulted in a miscarriage, an ectopic pregnancy, or an abortion, and not a live birth, would be extremely unlikely to contain any record of the sex of the developing embryo or fetus.

In pregnancies that end in miscarriage, ectopic pregnancy, or abortion, sex-identification is not a standard part of the medical record and in many instances may not even be known at the time of care. As above, it is possible that historical records regarding a wanted pregnancy that was terminated only after a fetal diagnosis might reflect the sex of the fetus, but the notation under such circumstances would not indicate any sex selection.

52. Medical records are obviously not necessary to determine the sex of past pregnancies carried to term—i.e., the sex of any children of my patients. My patients could inform me directly about their children, but again, that information—whether from the patients or their medical records—would not tell me anything about their current abortion decision-making and the factors that are motivating it.

53. In all of these instances, medical records from a patient’s past pregnancy history would not give me any information about whether the patient today sought abortion “solely on the basis of sex.” Indeed, no medical records could reveal my patients’ current intentions and reasons for coming to LRFP for an abortion during their current pregnancy.

54. In light of all this, I am baffled as to any reason for the Medical Records Mandate, how to determine the parameters of the search necessary to comply with it, what to review in or do with any records received, and whether and in what manner I must have LRFP incorporate all of the requested records from patients’ entire pregnancy histories into its medical records system.

55. I understand that the State has argued that the medical records search must take place only for those patients who disclose to me that they know the sex of the fetus, although the Medical Records Mandate itself does not appear to be so limited.

56. That interpretation is especially baffling, because in that circumstance the patient has already demonstrated knowledge of sex in the current pregnancy, there is no need for any

medical record search to attempt to determine the same, and we will have made explicit to the patient, as required by law, that abortions solely for sex-selection are not permitted. As I have explained above, any medical records from other providers would not reveal the patient's current, personal decision-making about the abortion. Historical records of her past care would be unlikely to contain even a notation of the sex of any past pregnancies, let alone evidence that would illuminate the patient's state of mind regarding the current one.

***The Effects of the Medical Records Mandate***

57. While the purpose of, let alone utility of, the Medical Records Mandate is not apparent, the harmful impact it will have on my patients is clear.

58. The searches required by the Medical Records Mandate will reveal to our patients' other health care providers that they have sought abortions. Both LRFP and I are well known as abortion providers. In addition, given the time-sensitive nature of abortion care, we will have to press other providers for speed and explain the need for speed to them (without any way to ensure it, especially since we are making broad requests for records that could be many years old).

59. Through its wide net of searches, the Medical Records Mandate breaches patients' confidentiality despite the fact that virtually all patients are desperate to keep the fact of their abortion private. Many are tearful in requesting reassurance from my staff and me that their abortion care will be disclosed to no one, including their other doctors. Patients routinely ask for reassurance that other health care providers will not be able to tell that they have had an abortion from routine gynecological exams or other check-ups in the future.

60. Confidentiality is a bedrock principle of medical practice because it is foundational to the physician-patient relationship. Patients must be able to share relevant

information with their physician so that the physician can provide the best care, and patients must be able to trust that the physician will keep that information confidential.<sup>6</sup> Except in very limited circumstances not applicable to the Medical Records Mandate, patients are entitled to voluntarily decide whether and with whom their health information is shared.<sup>7</sup> These foundational protections extend not only to adults, but also to minors accessing reproductive health care.<sup>8</sup>

61. Under the Medical Records Mandate, however, each patient will be required to sign a medical records request for each one of their providers over their “entire pregnancy history” in order to access abortion care, and we will have to transmit those requests to all the prior providers. Unfortunately, because of judgments about and opposition to abortion, even by some in the medical community, this forced disclosure opens patients up to condemnation and negative treatment by others.

62. As described above, the Medical Records Mandate will also delay abortion care. The mandate contains no exceptions and requires a records’ search for each patient’s entire pregnancy history. It requires “reasonable time and effort” for that search, but does not make clear what “time and effort” is “reasonable” under the law, or what, if any, actions are required

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<sup>6</sup> See *AMA Code of Medical Ethics Opinion 3.2.1: Confidentiality*, Am. Med. Ass’n, <https://www.ama-assn.org/delivering-care/ethics/confidentiality> (last visited Nov. 12, 2020).

<sup>7</sup> *Id.*

<sup>8</sup> Am. Coll. of Obstetricians & Gynecologists’ Comm. on Adolescent Health Care, *Committee Opinion 803: Confidentiality in Adolescent Health Care* (Apr. 2020), <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/04/confidentiality-in-adolescent-health-care>; Am. Acad. of Pediatrics Comm. on Adolescents, *The Adolescent’s Right to Confidential Care When Considering Abortion*, *Pediatrics*, Feb. 2017, at e20163861; Carol Ford et al., *Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine*, 35 *J. Adolescent Health*, 160 (2004); *AMA Code of Medical Ethics Opinion 2.2.2: Confidential Health Care for Minors*, Am. Med. Ass’n, <https://www.ama-assn.org/delivering-care/ethics/confidential-health-care-minors> (last visited Nov. 12, 2020).

once records are received, so that an abortion can legally proceed. It harms my patients and puts me in an untenable bind, because it makes proceeding too soon under this unclear law a criminal offense, yet abortion is time sensitive and any delay in abortion care increases patients' medical risks. Delay also causes some patients to have to undergo a more complex and more costly procedure, and can even make the patient ineligible for abortion in Arkansas. The law's delay and diversion of resources seriously interferes with, rather than aids, proper medical care.

### **THE LOCAL DISCLOSURE MANDATE**

63. As I have already noted, reproductive health care is provided confidentially under important principles of medical ethics. For both adult patients and minor patients, abortion care is a private matter. To state the obvious: Physicians do not, as a matter of course, disclose the fact that a patient has sought this confidential care to any members of the patient's local community. Nor is it routine to compel a patient to provide the State with a tissue sample for possible DNA analysis as a requirement for accessing abortion care.

64. Yet the Local Disclosure Mandate requires my colleagues at LRFP and me to treat all 14- to 16-year-old abortion patients as crime victims and the tissue from their abortion as "evidence." Under this law, we can only allow 14- to 16-year-olds access to abortion on the condition that, immediately thereafter, their local police department be informed of their abortion and be called to transport the resulting tissue to the Arkansas Crime Laboratory, labeled with their name and birth date, among other information. We must inform these young patients that the tissue from their abortion will then remain at the Arkansas Crime Laboratory for possible DNA analysis at some future point in time and that they have no choice in the matter. A parent, who almost always accompanies 14- to 16-year-old patients, also has no choice in the matter,

and the parent's name and address will also be disclosed to local police in connection with the abortion and kept on file at the state crime laboratory.

65. For those few 14- to 16-year-olds who use judicial bypass to access abortion, and do not disclose their abortion to a parent, the Local Disclosure Mandate has no exception. It still requires disclosure of their abortion to the local police where they live, along with their parent's name and address; collection of the tissue from their abortion; and storage of it with the State.

66. The Local Disclosure Mandate's dragnet for all these young patients is shocking. I am not aware of any comparable law in the many other jurisdictions where I practice or have practiced abortion care.

67. LRFP challenges the Local Disclosure Mandate for that vast majority of 14- to 16-year-olds who come to the clinic to obtain an abortion after sexual activity under circumstances that do not indicate any potential abuse or criminality. Based on my many years of experience providing abortion care to patients of all ages, including hundreds of such 14- to 16- year-olds, I cannot imagine any such 14- to 16-year-olds who would not be very distressed by this law.

68. The staff at LRFP and I take seriously our obligation as mandatory reporters of any suspicion of child abuse, whether sexual or otherwise. We understand that clinicians' mandatory reporting of suspicions of child abuse is one of the limited, but important, exceptions to confidential health care of any kind. We therefore strictly adhere to the Arkansas Child Maltreatment Act ("CMA") and call the state's specialized child abuse hotline in any case in which the CMA's comprehensive definitions of abuse warrant reporting.

69. I listen and look carefully during my interactions with each patient, and take note of any physical clues, such as tears or bruises. I also speak with all minor patients separately



from their parent or guardian to allow the patient to share freely. Whenever there is any sense of something unsaid, I have learned to continue the conversation and to explore in more depth how the patient is feeling. Clinicians' training and experience provides us with tools to identify signs of sexual and other abuse and to serve the state as mandatory reporters when there is any reason to call the hotline.

70. We also have experience cooperating with law enforcement during active criminal investigations. When criminal allegations have been made, LRFP and I are well-versed in assisting victims in that context.

***The Effects of the Local Disclosure Mandate***

71. The Local Disclosure Mandate treats ordinary health care patients—for example, a 16-year-old who is pregnant after consensual sex with another teenager—as participants in activity that warrants “evidence” gathering and the involvement of both local law enforcement and the state crime lab. It creates a horrible dilemma for 14- to 16-year-olds just seeking health care.

72. When we initially meet with patients seeking abortion, including 14- to 16-year-old patients, we describe each step of the care we will provide for them and answer any questions they may have. If the Local Disclosure Mandate takes effect, we will have to describe ahead of time to all 14- to 16-year-old patients the required notification to their local police department, the preservation of tissue as evidence, the information about their private lives that will go along with that tissue, and the eventual storage of it and possible DNA testing at the Arkansas Crime Laboratory.

73. I have no doubt that setting forth these mandatory consequences of abortion care for 14- to 16-year-olds in Arkansas will be confusing and troubling to the patients on whose

behalf we challenge the Local Disclosure Mandate. These required consequences shroud their abortion, and the sexual intercourse that resulted in their pregnancy, in criminality and condemnation, even though there is no indication of any crime and they are in the clinic to obtain constitutionally protected medical care. This law is very likely to shame and humiliate them.

74. In addition, because many in Arkansas and throughout the South oppose abortion, the Local Disclosure Mandate will create ongoing fear in my patients. The law does not merely preserve “evidence,” but labels that evidence with the patient’s name and requires explicit notice to a local police officer in communities that may be very small. It breaches the patient’s and their family’s privacy and instills fear from the fact that their neighbors in law enforcement will now know of their abortion, their home address, and perhaps their sexual partner’s name, as requested on the State’s fetal tissue transmission form.

75. When we describe the Local Disclosure Mandate to 14- to 16-year-olds and explain how it must play out under Arkansas law, I anticipate that it will be so troubling to some of those young patients that they will delay their care or be deterred from obtaining an abortion in this state, even though they are clear in their desire for an abortion. Because of the Local Disclosure Mandate, patients may attempt to abort their pregnancy on their own, possibly using unsafe methods, or attempt to travel to another state to receive care without these draconian conditions. Even if some patients initially dissuaded by the Local Disclosure Mandate do eventually come back to LRF and proceed with their abortion despite this law’s consequences, the dilemma it creates for them will have delayed their care as they searched for and did not succeed in finding other options.

76. The Local Disclosure Mandate breaches these young patients’ confidentiality and forces them to live in fear of further breaches in perpetuity. Because they have chosen abortion,

the mandate turns over their private medical care details and the tissue from their medical procedure to remain in law enforcement custody indefinitely. This law allows any future DNA testing or examination of that tissue at the state crime lab. It adds anxiety and shame to what should solely be medical care, and enlists me and other physicians in imposing this veneer of criminality, disclosing confidential information to young patients' local police, and creating the weighty fears that accompany the law's involuntary steps.

77. Many 14- to 16-year-olds will have had limited experience with the health care system prior to their abortion. The Local Disclosure Mandate's stigmatizing requirements and breaches of confidentiality may have a lasting negative impact on those patients' willingness to seek out health care in the future.

78. Irrationally, these same disturbing consequences do not flow from miscarriage or ectopic pregnancy care for young people, or from obstetrics care, even though the patients are of the same age and their reproductive health care likewise reveals prior sexual activity. Only patients seeking abortion are subject to this generalized involvement of law enforcement and invasion of health care privacy.

79. In addition, it is unclear to me whether I can offer medication abortion to 14- to 16-year-old patients consistent with the Local Disclosure Mandate. The mandate nowhere specifies that medication abortion is excluded and can proceed despite the clinic's inability to preserve tissue, and the rules implementing the mandate refer to abortion by medication. I understand, however, that the State argues that the Local Disclosure Mandate does not apply to medication abortion.

80. If, as the State argues, the Local Disclosure Mandate applies only to procedural abortion and not medication abortion, then that has yet another harmful effect: It condemns only

those patient's choosing procedural abortion, or who are later in their pregnancy and cannot access medication abortion, to the invasion of privacy and humiliation of this law. The State's interpretation makes one particular medical method trigger significant consequences for the patient when another method accomplishing the same result does not. In this way, too, the Local Disclosure Mandate interferes with young patient's medical decision-making and imposes outcomes that make no sense under the circumstances of the patients on whose behalf we challenge the law.

### **THE TISSUE DISPOSAL MANDATE**

81. I understand that the Tissue Disposal Mandate requires that abortion providers ensure embryonic and fetal tissue is disposed in compliance with the Final Disposition Rights Act (FDRA), a law that lays out the relative order of authority of family members when determining what to do with the dead body of their next of kin. The Mandate imports this complex scheme into the abortion context and imposes criminal penalties on physicians for failure to ensure tissue is disposed of in accordance with the FDRA.

82. I understand that, in the normal course, under the FDRA, if a person dies without appointing a person to make decisions about their remains, the FDRA assigns that right to family members in the order set out in the FDRA: the surviving spouse, the surviving child or children, the surviving parent or parents, and so on. Only individuals who are at least 18 years old have rights under the FDRA, so individuals who are under 18 have no decision-making rights under the law.

83. I understand that when the disposition right is assigned to one of the decedent's parents and one parent is "absent," the right is assigned to the remaining parent only after "reasonable efforts have been unsuccessful in locating the absent surviving parents." Ark. Code

Ann. § 20-17-102(d)(1)(E)(ii). Also, when there is more than one person who shares the disposition right, those individuals must make “reasonable efforts” to notify others before remains are disposed. *Id.* § 20-17-102(d)(3)(A). The FDRA does not define “absent” or “reasonable efforts.”

84. I also understand that the FDRA indicates that a person may forfeit disposition rights for certain reasons—for example, if they do not exercise their “right of disposition within two (2) days of notification of the death of the decedent or within five (5) days of the decedent’s death, whichever is earlier.” *Id.* § 20-17-102(e)(1)(B).

85. Before discussing the details of what the Mandate would require, it is important to understand that, as a practical matter, physicians and clinics need to know that each step of the medical care they provide can be accomplished, both practically and legally, before undertaking it. Otherwise, providing care jeopardizes our licenses and may expose us to other penalties, including civil liability or criminal prosecutions. As is relevant here, physicians cannot start abortion care without knowing that the tissue can lawfully be disposed of.

86. LRFP’s existing protocols govern the lawful disposition of fetal tissue. Tissue from abortion procedures is disposed of by an authorized service provider, and patients who wish to have their tissue cremated may arrange that themselves. Tissue from a medication abortion is not passed at the facility, but at the patient’s home.

87. As discussed further below, transposing the FDRA onto the abortion context would lead to absurd and harmful results. For example, the Tissue Disposal Mandate would require me to make reasonable efforts to notify a patient’s sexual partner as the “father” of the embryo or fetus about their right to make a shared decision about tissue from the patient’s abortion. For patients under age 18, I would be required to make reasonable efforts to notify their

parents and their sexual partner's parents—as the “grandparents” of the tissue—who all share equal rights to make decisions about tissue. There is no exception for minors who have obtained a judicial bypass.

***The Effect of the Tissue Disposal Mandate***

88. Because the Mandate would require me to make reasonable efforts to notify others about my patients' abortion care, it would require me to violate my professional ethical obligations, including to breach the confidentiality that is essential to the physician-patient relationship, and put my patient in potential danger, which I would not do.<sup>9</sup> However, because the law is unclear in numerous ways, I would not be able to comply with it even if I were willing to violate my ethical obligations to keep my patients' care confidential. The Mandate thus puts me in an impossible situation, and would force me to stop providing care, as attempting to comply would violate both my ethical obligations and expose me to criminal penalties.

89. First, by requiring me to attempt to notify other individuals of the patient's abortion decision, the Mandate conditions a patient's ability to obtain an abortion on forfeiting the confidentiality of their abortion decision. This breach of patient confidentiality, which can also increase the risk to patients' personal safety or that they experience retribution for their decision, contradicts my ethical obligations to my patients.

90. As described above, confidentiality is a bedrock principle of medical practice because it is foundational to the physician-patient relationship. Patients must be able to share information with their physician so that the physician can provide the best care, and patients

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<sup>9</sup> For LRFP to know tissue from an abortion procedure could be disposed of lawfully, these efforts to notify would need to be made before any abortion started. Requiring efforts to notify others about my patient's abortion after the patients obtain care would raise the same concerns, as the fact remains that I could no longer guarantee my patients' confidential care.

must be able to trust that information will be kept confidential.<sup>10</sup> Additionally, except in very limited circumstances that do not exist here, patients are entitled to decide whether and with whom their health information is shared.<sup>11</sup> These foundational protections extend to minors accessing reproductive health care.<sup>12</sup>

91. Violating patient confidentiality interferes with patient autonomy, acts against a patient's wishes, and can cause harm. Patients may have a variety of reasons for wanting to keep their abortion private, including from the person by whom they became pregnant. Some patients go to great lengths to keep their abortions private. Some want and need to keep their abortion private from partners who are unsupportive or abusive, for personal safety reasons. Patients may fear other forms of retribution stemming from the stigma associated with abortion, or concern that their partner will disagree with their decision, try to interfere with it, or punish them for considering or accessing abortion care. Patients experiencing intimate partner violence may also fear for the safety of their existing children, including fear that a partner could retaliate against her for her abortion decision by harming her children. Or, patients may simply want to keep their abortion confidential because it is their private medical decision involving intimate personal matters. It is not the State's place to force patients to share their personal medical information with anyone.

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<sup>10</sup> See *AMA Code of Medical Ethics Opinion 3.2.1: Confidentiality*, *supra* note 6.

<sup>11</sup> *Id.*

<sup>12</sup> Am. Coll. of Obstetricians & Gynecologists' Comm. on Adolescent Health Care, *supra* note 8; see also, e.g., *AMA Code of Medical Ethics Opinion 2.2.2: Confidential Health Care for Minors*, *supra* note 8.

92. Minors have many of the same fears and reasons for keeping their abortions private. Although most minor abortion patients involve one parent, both the parent and the minor patient are often emphatic about maintaining their privacy from the other parent. Thus, they do not want any required disclosure of their abortion to both parents—let alone both parents of the person by whom they became pregnant. The judicial bypass process recognizes that minors have a right to keep their abortions private and permits minors to access abortion care without involving any parent. The Mandate, however, has no judicial bypass process and appears to require efforts to notify a minor's parents (and their sexual partner's parents) even if the minor has obtained a judicial bypass. It is counter-intuitive (and likely harmful) for me to inform the minor's parents about the minor's abortion if the minor has already obtained a judicial bypass.

93. The Mandate would also put me at odds with my patients by requiring me to pressure patients to provide me with the names of the individual(s) I needed to inform about their rights under the FDRA, as I could face penalties for failing to try to notify the proper people. Again, this would violate principles of medical ethics—it would be acting contrary to their autonomy, and do harm, rather than good, to my patients.

94. Enforcement of the Mandate would also interfere with patient autonomy because it appears designed to send the message to patients that tissue from an abortion should be treated like a deceased person, a family member—regardless of whether the patient views the tissue that way. It replaces the diversity of views patients have about their pregnancy with the State's, and decentralizes the patient's life, dignity and autonomy, and her decision-making. Coercing patients to think about their pregnancy and their options as the State dictates can cause a patient anxiety and confusion. Requiring health care providers to be part of the State's scheme is particularly cruel and would undermine the trust in the physician-patient relationship.



95. Second, I have serious concerns about whether I would even be able to comply with all of the requirements of the Mandate. To start, the Mandate appears to eliminate medication abortion as an option for patients. Because tissue from a medication abortion is disposed of outside the abortion facility, there is no way for a provider to “ensure” that tissue from a medication abortion is disposed of in compliance with the FDRA. Eliminating medication abortion would be significantly harmful to patients, including those for whom medication abortion is medically indicated or for those who are living with domestic violence who can present a medication abortion as a miscarriage. I understand Defendants have said the Mandate does not prohibit medication abortion. In that case, I do not understand why tissue from a medication abortion, and the state-mandated decision-making about its disposal, would be treated differently than tissue from an abortion procedure.

96. I am also unsure what “reasonable efforts” must be taken to notify a patient’s sexual partner. What efforts are enough? What happens if I am unable to notify the proper person or people? What if I am unable to get information that would enable me to try to notify the proper people? For example, I do not know what I am supposed to do if a patient refuses to tell me who to notify, or whether I am under an obligation to try to confirm that the name the patient gives is indeed the “father” under the FDRA. I am also unclear as to what it means for the patient’s sexual partner to be “absent” and what efforts I must take to confirm their absence.

97. These examples further complicate my ethical concerns and my obligation to respect patient autonomy. It may be in the best interest of my patient to refuse to give me this information, but it would be in my best interest to get this information from my patient so I could avoid the Mandate’s penalties. Under these circumstances—where the patient and physician have conflicting interests—it would be inappropriate for me to provide care.

98. Other aspects of how the Mandate applies in the abortion context are unclear: How do I comply with the requirement that disposition rights are contingent on assuming “liability for the costs of such arrangements”? If disputes arise after efforts to notify the individuals in the line of decision-making authority that the FDRA specifies, what do I as a physician have to do to “ensure” that eventual compliance occurs? The Mandate has inserted abortion into a detailed scheme for deciding on the disposition of the dead bodies, without in any way specifying how that scheme is to be translated to abortion care.

99. I understand Defendants have suggested that the clinic could comply with the law by preserving tissue for five days before disposing of it. But the FDRA emphasizes the importance of making “reasonable efforts” to notify those individuals with disposition rights, so the Defendants’ suggestion does nothing to address my concerns about confidentiality. Additionally, forcing patients to wait five days to see whether I could reach their sexual partner or parent(s) and to tell them about the patient’s abortion—regardless of the patient’s wishes— would be confusing and anxiety-provoking for patients. As described above, for some who are at risk of abuse, the wait could be truly terrifying. If Defendants mean to suggest LRFP could hold on to tissue for five days and do nothing, the suggestion seems inconsistent with the requirements of the FDRA. Even if circumstances unfold as Defendants suggest—or perhaps hope—they will, and there was some way to avoid notifying others about the patient’s abortion, the five-day wait punishes and stigmatizes my patients simply because they are seeking abortion care.

100. If the Tissue Disposal Mandate took effect, I would be unable to continue providing abortion care under the vague, unethical, and burdensome mandates it creates for my patients and myself. Even if the Mandate did not apply to medication abortion and that option

continued to be available, the Mandate would have devastating consequences for my patients and me. Because LRFP is the only clinic in the State that provides abortion procedures, my abortion procedure patients would be forced to leave the State for this care, carry their pregnancies to term against their will, or attempt to terminate their pregnancies without the assistance of a medical provider.

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

Executed this 12th day of November, 2020.

Handwritten signature of Willie J. Parker, M.D. in black ink.

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Willie J. Parker, M.D.