EXHIBIT 3

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

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

DECLARATION OF LORI WILLIAMS, M.S.N., A.P.R.N., IN SUPPORT OF PLAINTIFFS' SECOND MOTION FOR A PRELIMINARY INJUNCTION AND/OR A TEMPORARY RESTRAINING ORDER

Lori Williams, M.S.N., A.P.R.N., declares and states as follows:

1. I am a nurse practitioner and the Clinical Director at Little Rock Family Planning Services in Little Rock, Arkansas ("LRFP" or "the clinic").

2. In June 2017, I submitted a declaration in support of Plaintiff's Motion for a Preliminary Injunction and/or Temporary Restraining Order against four laws enacted in 2017 that would burden, if not outright eliminate, access to abortion care in Arkansas:

- Act No. 45 (H.B. 1032, or "the D&E Ban");
- Act No. 733 (H.B. 1434 or "the Medical Records Mandate");
- Act. No. 1018 (H.B. 2024 or "the Local Disclosure Mandate"); and
- Act. No. 603 (H.B. 1566, or "the Tissue Disposal Mandate")

3. I submit this declaration in support of Plaintiffs' Second Motion for a Preliminary Injunction and/or a Temporary Restraining Order against the same four laws to confirm and update

information about LRFP's abortion practice, our patients, and the impact the challenged laws would have on our patients' access to safe, legal, and confidential care.

Background and Education

4. I received my bachelor's degree from the University of Arkansas at Fayetteville in 1998, and my Master's degree in science and nursing from Vanderbilt University in 1999.

5. From 2000 to 2004, I worked as a nurse practitioner at Women's Community Health in Little Rock, a clinic that previously provided abortion care in the State. I have worked at LRFP since 2004 and have been the Clinical Director in 2007.

6. As LRFP's Clinical Director, I am responsible for all aspects of our day-to-day operations, including overseeing patient care in coordination with our physicians and other health care professionals, supervising the staff, maintaining policies and procedures, interacting with the Arkansas Department of Health licensing personnel when they visit, inspect, or request information, and ensuring LRFP complies with all laws and regulations. I also interact with patients on a daily basis, including by participating in patient counseling.

7. I am also currently the National Abortion Federation's (NAF) Board Chair and have been on the Board of Directors since 2012. NAF is a professional association of abortion providers including individuals, public and non-profit clinics, Planned Parenthood affiliates, women's health centers, physicians' offices, and hospitals. Among other things, NAF provides accredited continuing medical education exclusively in abortion care to advance the clinical skills and update the medical techniques of abortion providers. I previously served on the NAF committee that is responsible for drafting, reviewing, and updating all clinical-policy guidelines, and routinely attend NAF conferences and communicate with NAF members about abortion care standards and developments.

Abortion Care at LRFP and Our Patients

8. LRFP has operated an abortion clinic in Little Rock since 1973, and has been licensed by the State as an abortion provider since licensing began in the mid-1980s. LRFP also offers health services that are similar to abortion care for patients whose pregnancies end in miscarriage, as well as basic gynecological care, including pap smears, STD testing, and contraceptive counseling and services.

9. Our patients seek abortions for a variety of personal, medical, financial, and family reasons. Many of our patients already have at least one child and have decided they cannot parent another child. Some are young women who feel they are not ready to carry a pregnancy or become a parent yet; others are pursuing school or work opportunities. Some patients have health conditions that make carrying a pregnancy dangerous; others have received a fetal diagnosis. And some of our patients are in unsupportive or abusive relationships, or are pregnant as a result of rape or sexual assault.

10. LRFP provides both medication abortion and abortion procedures. Both methods are safe, effective means to terminate a pregnancy.

11. LRFP offers medication abortion up to 70 days or 10 weeks LMP. Medication abortion involves taking a combination of two pills, mifepristone and misoprostol, after which the patient expels the contents of the uterus in a manner similar to miscarriage while at home.

12. LRFP also provides abortion procedures, neither of which entail incisions into bodily membranes or general anesthesia. LRFP provides two types of abortion procedures: (1) aspiration abortion (which involves the use of gentle suction to safely empty the contents of the uterus); and (2) dilation and evacuation ("D&E") procedures. D&E is the predominant method used throughout the second trimester; involves the use of instruments in addition to suction; and

typically takes longer to perform and requires more time in a recovery room than an aspiration. A small number of D&E procedures performed at LRFP— after approximately 18 or 20 weeks—can require an additional visit to the clinic to dilate the cervix the day before the procedure is performed.

13. LRFP is one of only two abortion clinics in Arkansas. LRFP is the only clinic that offers abortion procedures and is therefore the only one of the two clinics that offers abortions after 10 weeks LMP.

14. It is important to understand the backdrop against which our patients currently access abortion care, because the 2017 restrictions do not come to LRFP and our patients on a blank slate. Many of our patients struggle in their lives and in their efforts to reach us to access the medical care they need. Each of the 2017 restrictions would place even more obstacles in our patients' path—heightening their anxiety and stress, further delaying their care, and increasing the financial and logistical challenges they face to get to us.

15. State law requires that each patient seeking medication abortion or an abortion procedure at LRFP make at least two in-person trips to the clinic, one for state-mandated counseling and the other for her medical care, separated by a mandatory delay. In the last few years, the mandatory delay between visits has steadily increased from 24 hours, to 48 hours (in 2015), and then, last year, to 72 hours. For patients obtaining abortion care starting at 18 to 20 weeks, the abortion procedure is performed over two days, requiring still another visit to the clinic, so these patients make three visits. In particular if patients receive medication for sedation during their procedure, they must consider whether they have someone to accompany them to the clinic, and their support person's availability may impact when they are able to return, after the mandatory

delay, to receive their medical care. At LRFP, sedation is required for almost every patient obtaining an abortion after 13 weeks.

16. Minors face additional barriers as a result of Arkansas law, which requires that an unemancipated minor obtain either parental consent or a judicial order excusing them from that requirement before they can obtain abortion care. For those that involve a parent, negotiating time when a parent (who may have work or other obligations) can accompany them to the clinic may cause additional delay. And for those who cannot involve a parent, navigating the judicial system to obtain the required order waiving Arkansas's consent requirement can likewise cause delay.

17. LRFP generally provides abortion care three days per week. To accommodate the current State-mandated requirement that patients wait at least 72 hours between their first and second visits to the clinic, LRFP typically provides care on three staggered days each week (i.e., Tuesday, Thursday, Friday; or Tuesday, Friday, Saturday).

18. Our patients come from throughout Arkansas and from other states, and many have low incomes. The percentage of patients needing financial assistance to cover abortion care or associated costs has increased over time—and increased dramatically over the last several months—due to the additional financial strain COVID-19 has put on our patients. Funding from the National Abortion Federation (NAF) is available to women who are at or below 110% of the federal poverty guidelines. The current Arkansas federal poverty level for a three-person household is an annual income of $21,720.[1] Approximately 60% of our patients meet this criteria and obtain some financial assistance from NAF to cover part of the costs of their abortion care. Additionally, even our patients who do not meet NAF's funding criteria struggle to make ends meet and face obstacles in accessing abortion care.

[1] U.S. Dep't of Health & Human Servs., HHS Poverty Guidelines for 2020, https://aspe.hhs.gov/poverty-guidelines

19. Based on my conversations with patients, I am very familiar with the time and effort it takes to make the necessary plans and get themselves to the LRFP and know the anxiety and stress it can cause. Some patients lack access to medical care to confirm the pregnancy, or may not recognize they are pregnant right away, including because they have irregular periods. Patients must arrange for time off work on multiple days, which can be very difficult given that many are in low-wage jobs, where they likely do not receive vacation or sick days, so taking time off means less pay. Patients may also feel they cannot explain to their employers the reason they need to take time off, and routinely report that they cannot risk their employment and confidentiality by taking time off. The stress involved is compounded by the fact that making these arrangements often involves family members or other individuals, which means the patient risks having to disclose the reasons for her travel and appointments—a disclosure many patients are desperate not to make.

20. Patients who already have children must typically arrange and potentially pay for childcare during the time they are traveling to the clinic and receiving care. Patients must also arrange and pay for transportation and, in some cases, a place to stay for 2-3 nights. These logistical arrangements cost money, in addition to the cost of the abortion care itself. Paying for each of these arrangements requires access to funds that many of our patients simply do not have.

21. Making the necessary arrangements and raising funds for travel and other costs associated with seeking care at LRFP can also delay our patients' access to care. I regularly have conversations with LRFP's patients as they schedule and reschedule their appointments and they try to get time off of work, arrange for childcare, and come up with the money to cover their abortion care. Many of our patients face logistical delays in obtaining abortions, including raising the money necessary to pay for a procedure, travel, issues with unsupportive or abusive partners, and a lack of access to medical care to confirm the pregnancy. Additionally, Arkansas is a

relatively large state where transportation can present a major challenge. For example, Fayetteville, where many of our patients live, is approximately 400 miles roundtrip from Little Rock. And in rural parts of the state, there are few public-transportation options and rural residents often live far away from health care providers.

22. The 72-hour delay and extra-trip requirement exacerbates the financial, emotional, and logistical burdens our patients face. It means our patients may have to spend more money to stay overnight, travel multiple times back and forth to the clinic, miss more days of work or school, and/or pay for more childcare. It also delays their procedure. Despite our best efforts, patients are often delayed more than the mandatory 72 hours because they must find time to come to the Clinic on a day when our schedule matches theirs, and when they can make all the necessary arrangements.

23. Every day one of our patients remains pregnant, she experiences the emotional and physical consequences that patients who have decided to end a pregnancy have chosen not to experience. For patients who are sick or experiencing pregnancy complications, this can be particularly agonizing. Delay can push a patient past the point in pregnancy at which she can receive a medication abortion, requiring a patient who prefers that method to have a procedure. Delay can push a patient from a first-trimester to a second-trimester procedure, or from a one-day procedure in the second trimester to a two-day procedure. Delay can also push a patient beyond the point at which she can obtain an abortion at LRFP and, therefore, in Arkansas, which means she may well not be able to access abortion at all. Because abortion care becomes more complex as pregnancy advances, it also becomes more expensive. Thus, delay also means that patients pay more for the procedure itself.

24. The COVID-19 public health crisis has further exacerbated the difficulties our patients seek accessing abortion care. Our patients have lost jobs, taken pay cuts, or had their hours reduced, as large portions of industry, such as travel and restaurants, cut hours or shut down. This has made the financial cost of abortion care, and the arrangements needed to make multiple trips to the Clinic, even more daunting. Social distancing recommendations mean that patients are less able to rely on others for childcare or to rely on a friend for a ride to the Clinic. And public transit companies like Ozark have capped the number of people on any bus to 10—i.e., 9 passengers and the driver—further limiting public transit in the state.[2]

25. For patients unable to access abortion care at LRFP, there are few options, all of which require substantial travel. While medication abortion is available at another clinic in the state, without LRFP, a patient seeking abortion after 10 weeks LMP would be forced to travel out of state. To my knowledge, the nearest clinics providing abortion care up to 21.6 weeks LMP is in Granite City, Illinois, and Dallas, both of which are approximately 600-700 miles (roundtrip) from Little Rock, Arkansas. To my knowledge, the next-nearest clinic currently providing abortion procedures is in Memphis, Tennessee, where abortion care is available up to 19.6 weeks LMP. Memphis is approximately 300 miles roundtrip from Little Rock, and 600 miles roundtrip from Fayetteville, where many of our patients live. Some women will be unable to make these substantial trips for an abortion procedure and will be forced to carry a pregnancy to term against their will.

Act No. 45 (H.B. 1032) – Ban on D&E Abortions

26. It is my understanding that Act No. 45 will prohibit physicians at the Clinic from performing dilation and evacuation procedures (D&Es), the predominant method of abortion

[2] *See* Ozark Regional Transit, *available at* https://www.ozark.org/.

LRFP provides in the second trimester (beginning at approximately 14 weeks LMP to 21.6 weeks LMP).

27. The D&E Ban would put our physicians and patients to an impossible choice: risk felony penalties for continuing to provide safe, legal abortion care in the second trimester, while imposing an additional procedure, additional delay, and logistical challenges for our patients, or stop providing abortion care as early as approximately 14 weeks LMP. Either would be devastating for our patients in need of second-trimester care.

28. Each year, we provide approximately between 2,000 and 3,000 abortions, of which approximately 15-20% occur during the second trimester. In 2019, LRFP provided 1,950 abortions, 15% of which were in the second trimester. In 2016, LRFP provided approximately 3,000 abortions, 20% of which were in the second trimester.

29. LRFP provides D&E procedures in one or two days depending on the medical circumstances of the patient. Currently, for the majority of LRFP's second-trimester patients, physicians provide a D&E procedure in one day, meaning the dilation and evacuation occur on the same day. This is true for essentially all of our patients who—when they return to the clinic after the 72-hour mandatory delay period—are between 14.0 and 17.6 weeks LMP, and about half of our patients who are 18.0 to 20.0 weeks LMP. A small number of LRFP's second-trimester patients undergo overnight dilation, meaning the dilation process takes place over two days. About half of LRFP's patients between 18.0 to 20.0 weeks, and almost all patients between 20.0 and 21.6 weeks, undergo overnight dilation.

30. In deciding whether a patient will a one-day procedure or whether their dilation process will occur over two days, physicians consider a range of factors—such as the patient's pregnancy history, whether she has had prior vaginal deliveries—that help the physician decide

the time it will take to achieve adequate dilation. For example, a patient who has had a prior vaginal delivery and does not have any significant risk factors, may, in the physician's judgment, be more likely to be able to have their D&E complete in one day.

31. For patients who undergo overnight dilation, our physicians generally also do an additional procedure, a digoxin injection, to attempt to cause fetal demise. The patient then returns the next day when the physician evacuates her uterus. Additionally, we require patients undergoing overnight dilation to spend that overnight within 30 minutes of the Clinic so that our physician is available in the rare instance in which a patient has any problem.

32. In consultation with our physicians, LRFP continues to update our practices to keep in line with evidence-based practices. Since 2017, when I filed my first declaration in this case, LRFP has updated our protocols to reduce the number of patients who undergo overnight dilation, meaning more of our D&E patients have their procedures in one day. Enabling patients to complete D&E procedures in one day means they do not have to make an extra trip to the clinic and that they do not have a digoxin injection.

33. The D&E Ban would prohibit LRFP from providing D&E procedures, without first ensuring demise. Because I understand that it is not possible to ensure demise will be successful before beginning any D&E procedure, and so a physician cannot start a D&E procedure without exposing themselves to criminal liability, the D&E ban threatens to end abortion care at LRFP as early as approximately 14 weeks LMP. In that event, our patients would have no other options for accessing abortion care in Arkansas and would be forced to leave the state for care. The financial, logistical, and emotional burdens of having to leave Arkansas for care would fall especially hard on those who struggle the most to make ends meet, like the 60% percent of our patients who obtain NAF funding. But these burdens will fall on all of our patients in need of second-trimester abortion

care, many of whom struggle financially but do not qualify for funding assistance, and all of whom will face the emotional and physical stress of being forced to continue a pregnancy while they make additional arrangements for out-of-state care.

34. I understand that Defendants have suggested our D&E patients undergo an additional procedure, such as a digoxin injection, as a condition of accessing second-trimester abortion care. That is no solution. First, I understand that digoxin is essentially unstudied for patients before 18 weeks. Second, if our physicians were to attempt a digoxin injection for every patient before 18 to 20 weeks LMP and half of our patients between 18 to 20 weeks—who make up the vast majority of our second-trimester patients—these patients would have to make an additional trip to the Clinic because their one day procedures would become two day procedures. These patients, who currently make two trips to the clinic would have to make three—and spend extra time, overnight, near the clinic. Third, I understand the Ban has no exception for failed demise attempts, so patients may be forced to undergo multiple demise procedures, which could entail repeat trips to the clinic, or may be denied care altogether.

35. Requiring the vast majority of our second-trimester patients to make a further additional trip to the clinic would impose serious additional logistical and financial burdens on these patients, who are the great majority of our second-trimester patients. It would add delay in addition to the delay they already confront for the reasons I discussed above. Requiring every D&E patient to undergo a demise procedure such as a digoxin injection, which takes additional staff time, could also increase the cost of the procedure, imposing another financial burden on our patients.

36. I am aware that Defendants have suggested other demise methods LRFP could use to try to comply with the Ban, such as potassium chloride (KCl) injections or transecting the

umbilical cord. No physician at LRFP has experience with or is trained to perform KCl injections, and I understand these other methods can increase risk to patients and/or are not feasible.

Act 733 (H.B. 1434) – Medical Records Mandate

37. I understand that Act 733 bans abortions sought solely based on the sex of the embryo or fetus. LRFP has never had a patient express that they were seeking abortion solely for this reason.

38. I also understand that Act 733 prohibits a physician from performing an abortion until the physician requests the medical records relating "directly to the entire pregnancy history of the woman" and spends "reasonable time and effort" to obtain those records.

39. Physicians at the clinic request medical records for only a tiny fraction of our patients, on average about 20-25 patients per year. These include patients who have received a fetal diagnosis, decided to end the pregnancy, and then received a referral to us (although in many of those cases, the referring physician has already sent the relevant medical records to the clinic). We may also request a patient's medical records if our physician believes they could be useful because the patient has a pre-existing medical condition.

40. To obtain a patient's medical records, the patient must first sign a form authorizing us to obtain her records. We send this request to the health care provider and then follow up with a phone call if necessary. In general, because our records requests are related to some aspect of the care the patient will receive at the clinic—and therefore are specific and not a request for a patient's full medical history—there is no fee charged for the records. I am aware, however, that some providers charge a fee for records.

41. The time it takes to obtain a limited portion of a patient's medical records from one other health care provider varies. In my experience, it can take a few hours, or up to several weeks.

For the few patients each year for whom we seek records, we are generally able to obtain these limited records without delaying their abortion care. If there is a risk that waiting for a patient's records could unduly delay her care, it is within the physician's judgement whether to continue to wait for the records or proceed with her care.

42. I am concerned that during the COVID-19 pandemic, there would be additional delays associated with the innumerable records requests LRFP would have to make to comply with the Medical Records Mandate. Medical facilities that are open may be strained with additional patients or reduced or changed staffing as they work to continue to care for patients during this public health emergency, and processing a medical records request from LRFP is unlikely to be the highest priority.

43. Privacy is a paramount concern for our patients, and at the clinic, we work hard to protect it. The clinic is well known as an abortion provider, and any request we make for patient records in and of itself discloses that the patient is likely seeking an abortion. We never request records without a patient's prior written consent, and some patients specifically request that we *not* seek records from another health care provider because they do not want that provider to know of their pregnancy and/or abortion decision.

44. Patients routinely tell me they fear hostility or harassment from their other health care providers for deciding to seek an abortion. Every week, patients ask whether their current health care provider will know that they sought abortion care, whether they have to tell their provider that they had an abortion, or whether LRFP has recommendations for a new provider so that they do not have to return to a provider they fear will shame them for seeking abortion care. For example, a few years ago, the clinic requested a patient's medical records from another one of her doctors; the doctor's wife then reached out to the patient to try to dissuade her from having an

abortion. The fear of this disclosure—if mandatory—could cause patients to hide relevant parts of their medical history, damage the relationship between our patients and physicians, and interfere with their care. The threat of this disclosure could also cause patients to delay or forego abortion care.

45. I do not understand what several of the terms of the Medical Records Mandate mean and therefore do not know how the clinic's physicians can comply with this law.

46. I do not know how much time and effort is "reasonable." I do not know what "reasonable" means if another health care provider ignores or refuses to respond to a records request; when a patient has seen numerous providers in the course of giving birth to her existing children; when a patient cannot remember the providers across her "entire pregnancy history;" or when a patient has received pregnancy-related care in another state or in another country where records may be in another language. Some of our patients may have medical records in other languages, including patients who are immigrants to the U.S. or were otherwise living overseas and who might receive care from providers in those countries. Without a definition of "reasonable time and effort," LFRP and our physicians cannot know when an abortion can lawfully take place, and we will have to err on the side of waiting and pushing for all records.

47. I also do not know the law's definition of "entire pregnancy history." It is impossible to know whether a given set of requested records is all records relating directly to a patient's "entire pregnancy history." Unlike the "reasonable time and effort" phrase, which itself is uncertain, "entire pregnancy history" seems to have no possible exclusions or practical limitations. A patient's "entire pregnancy history" would seem, at a minimum, to cover everything from hospital deliveries, to prenatal care form an obstetrician or primary care physician, to

pregnancy-related care by a cardiologist, mental health professional, or other specialist, to previous abortion, miscarriage, or infertility care.

48. Spending time and effort to obtain medical records for every patient would be an insurmountable undertaking. We see approximately 2,000 to 3,000 abortion patients each year, the majority of whom have had one or more prior pregnancies, during which they received medical care from one or more providers, and/or received prior care for the current pregnancy. I do not see how our physicians could ever comply with this law and spend time and effort to obtain thousands of medical records. While we currently seek records for 20-25 patients per year, requesting records for every patient's "entire" pregnancy history—for their current and prior pregnancies—is an entirely different and far larger scale.

49. In addition, every patient would have to sign a separate form allowing our physicians to obtain a patient's records from *each* health care provider from whom she has received pregnancy-related care. Further, while our current records requests are made for specific reasons and generally no fee is charged, there would typically be a fee when a patient's complete pregnancy-related medical record is requested, which would have to be paid by the patient or the clinic. Any fee would be at the discretion of the previous providers. Pursuing this type of open-ended request from each prior provider would likely require multiple back-and-forth communications with each to have any chance of receiving records.

50. The logistical challenges LRFP and our patients faced to make sure our patients obtained negative COVID-19 tests within 48 hours of their abortion care is only the most recent example of how a new requirement like the Medical Records Mandate puts dramatic strain on our staff. We dedicated one staff person full time to comply with the COVID-19 testing requirement—to ensure that LRFP's patients had negative COVID-19 tests and had them within the required

time frame. We would likely need more than one staff person to try to comply with the Medical Records Mandate. Unlike the COVID-19 test requirement, which did not apply to medication abortion patients, I understand the Medical Records Mandate applies to every patient seeking abortion care. Staff time would be needed to obtain each patient's consent to seek their medical records, to make requests of each of her previous pregnancy-related care providers, to follow up, and to coordinate these efforts with the patient's abortion care.

51. I understand that the state's lawyers have suggested that the Medical Records Mandate applies only to those patients who state they know the sex of the fetus. Since the law itself does not limit the Medical Records Mandate, I understand the clinic and our physicians would need a court declaration or settlement agreement with the State narrowing the law to rely on any such reading.

52. Even if the law applied only to those patients who know the sex of the fetus, the uncertainties and the harms created by the law would still remain. In general, patients who know the sex of the fetus are farther along in pregnancy, and patients who come to LRFP farther along in pregnancy may come because of a maternal indication or a fetal diagnosis. These patients necessarily have seen at least one prior pregnancy-related medical provider. Any mandatory search for the medical records related to their entire pregnancy history would delay those patients at a time when medical risks, costs, and logistical challenges are significantly increasing, and interfere with all of those patients' timely access to care.

53. Ultrasound examinations at LRFP to date the gestational age before an abortion do not include advising the patient of the sex of the fetus, if it is possible to determine that from the exam. During prenatal care, a higher-resolution type of ultrasound exam is used than is necessary to date a pregnancy's gestational age.

54. The law also fails to specify, once we receive any records, what if any steps the physician is supposed to take with regard to those records. It appears that we must undertake these massive records searches, try to collect as many historical records as possible, and then store all the records for no reason.

55. Even if our physicians could comply with this law—which seems impossible—doing so would at the very least entail unacceptable delays, costs, privacy violations, and therefore medical and emotional harm for our patients.

Act 1018 (H.B. 2024) – Local Disclosure Mandate

56. The clinic takes its state mandatory reporting responsibility seriously and recognizes its importance. We work hard to ensure we comply with the law and protect our patients' health and safety.

57. As explained above, under Arkansas law, a patient under age 18 must obtain the consent of one parent prior to obtaining an abortion, or alternatively seek a judicial bypass. In 2019, the clinic provided abortions to five minors under the age of 14, and all had parental consent; the clinic provided abortions to 53 patients under 17, and all had parental consent except two, who obtained judicial bypasses. These numbers are typical: the vast majority of our abortion patients under the age of 17 have obtained a parent's consent.

58. A few of our minor patients are married, and their husband may or may not be involved in their decision to have an abortion.

59. Under the Child Maltreatment Act, I report suspected abuse to the Arkansas State Police's Child Abuse Hotline. I routinely participate in counseling minor patients, who commonly feel comfortable discussing the age of their partner with us, as we are their health care provider. I

report to the Arkansas State Police for all patients for whom it is appropriate, including for patients age 13 or younger. As far as I know, the majority of our reports do not lead to any investigation.

60. In general, when a crime has already been reported, law enforcement are involved before the minor visits the clinic, and call the clinic before the minor patient arrives. The same is true for adult patients where rape is involved. We provide care for the patient that is informed by the knowledge that a crime has been reported. We also know from the outset there is an investigation and we preserve the tissue with the patient's consent and/or in response to a case-specific legal process. Under those circumstances, we are not initiating the process or making phone calls to local law enforcement who are not already involved. And, to be clear, when there is an active investigation, law enforcement is responsive, and LRFP is generally contacted prior to the abortion to discuss evidence collection.

61. I understand that Act 1018 expands a different obligation. Under an existing law, for every abortion patient who is 13 years old or younger, the clinic must preserve tissue and have local law enforcement in the jurisdiction in which the minor resides pick it up. Local law enforcement are to take the tissue to the state crime laboratory, where it apparently remains indefinitely. In conveying the tissue to local law enforcement, we must provide them with a form that identifies the patient, her address, and if known, her sexual partner. That fetal tissue transmittal form is attached. I understand that Act 1018 changes that requirement to apply to all patients under the age of 17, even though for the vast majority of such patients, there is no suspected maltreatment or crime. Based on my experience with current law and my conversations with our patients, I am concerned about the impact of this change.

62. As current law requires, when providing an abortion for any patient who is 13 or younger, the clinic freezes and preserves the tissue. (The tissue collected from an abortion

procedure invariably includes both embryonic/fetal tissue and maternal tissue.) But when I then contact the police department in the jurisdiction where the minor lives to trigger the local police's role under this law, they are rarely familiar with the law and its requirement that they pick up the tissue, and they do not reliably do so.

63. Often, I must explain the law to them and try to convince them to pick it up. This may involve multiple phone conversations, which takes me away from other obligations at the clinic, including patient care. I have developed an email I send with the form, explaining the law and the local department's role in retrieving the tissue. It routinely takes weeks or months for local law enforcement in Arkansas to collect the tissue. When an officer comes to pick up it up, I make clear to the officer that the tissue is frozen. I am not notified if or when the tissue arrives at the State Crime Lab, but I believe that most officers understand it should go directly there.

64. For most Arkansas patients 13 or younger, the local police typically do arrive eventually to collect the tissue. In one example from the past year, though, tissue has simply not been picked up by the local Arkansas police department. I have left numerous voicemail messages with the department, as each time I call I get only an answering machine. That department has not responded or taken any steps to retrieve the tissue.

65. For patients who are 13 or younger and reside out of state, I make the same significant efforts to contact the local police department where the minor resides, as the law requires. On at least two occasions that I remember, however, that out-of-state local law enforcement never came to pick up the tissue. Communicating with and involving out-of-state law enforcement in these situations continues to be a problem. Out-of-state local law enforcement (like most of the local Arkansas police departments) do not understand why I am calling, or why they should comply with this Arkansas law, when there is no criminal activity.

66. On some occasions, the police personnel I contact under this law have lectured me and preached anti-abortion rhetoric, including telling me that the clinic is taking a life.

67. Unlike the State Child Abuse Hotline, which is associated with a unit whose staff have specialized training in child maltreatment and handling these complicated issues, local law enforcement does not have the same kind of specialized unit or training.

68. The local police departments I communicate with can be very small (with as few as two officers) and operate in small communities. While I comply with the law, this makes me uncomfortable because I am disclosing to people in the patient's community—people who may know her and her family—that she has had an abortion. In one instance I can remember, a patient's relative worked for the local police department to whom I had to make this disclosure. The patient and her parents were fearful of the consequences of the relative knowing about the patient's abortion care, but were forced to decide between the patient's abortion (and disclosing it to this relative) or forgoing care in Arkansas. The patient and her parents reluctantly accepted that disclosure to that local police department would have to occur, with the department taking the tissue and other information on the tissue transmission form, because the patient felt strongly she needed an abortion.

69. Since the law that applies to minors 13 and under has been in effect, LRFP has never been contacted about the use in any active crime investigation of fetal tissue obtained under this law and stored at the State crime laboratory.

70. By expanding the requirement from all patients under age 14 to all patients under age 17, Act 1018 increases the number of patients who lose the confidentiality of their abortion decision. This can be incredibly disturbing for minors, who may not want people in their community to know this private information and fear that they will suffer harassment or violence

if others find it out. In my experience, minors have an especially strong interest in maintaining the privacy of their care and they can be especially fearful about the consequences of disclosure, given their relative lack of independence and options compared to adults, should this private medical information be disclosed. We would need to counsel patients that such disclosure would occur, and the fear it creates could cause some patients to delay or forego abortion care. And, for the few minors who obtain a judicial bypass—which by law must be confidential and allows the minor to obtain an abortion *without* disclosure to her parents—the Mandate could result in disclosure to their parents.

71. There are a number of questions about this law that we would not be able to answer for patients. The law does not specify what happens to the tissue collected at the crime lab, or any restrictions on its use.

72. Further, this requirement could be read to prevent our physicians from offering medication abortion to any patients under the age of 17, because with this method, there is no way to preserve tissue. This would take away an important abortion method from certain patients who want it, who would have to have an abortion procedure they preferred to avoid.

Act 603 –Tissue Disposal Mandate

73. I understand that under Act 603, a physician or a facility providing abortion care or miscarriage treatment must ensure that all embryonic or fetal tissue is disposed of in accordance with the Arkansas Final Disposition Rights Act (FDRA).

74. The clinic currently contracts with a service provider that transports tissue generated at the clinic. In addition, each year, a few patients wish to have their tissue cremated; these patients make those arrangements themselves.

75. To comply with a 2015 Arkansas law, each patient consents in writing to having the embryonic or fetal tissue from her abortion disposed of.

76. It is unclear what many aspects of the new law mean. First, it is unclear how Act 603 would affect disposal of tissue from a medication abortion, or medication abortion techniques used to complete miscarriage. In a medication abortion or miscarriage treated by medications, the patient passes the pregnancy tissue at home over a period of hours or days, and she collects and disposes of it as she would during menstruation or a miscarriage that occurs naturally. It is not clear how we can ensure that tissue after a medication abortion or miscarriage is disposed of in accordance with the FDRA. I understand that the Department of Health issued a regulation acknowledging that this is unclear, and stating that the Tissue Disposal Mandate does not apply to medication abortion. I do not understand, however, why the new law would apply to tissue from abortion procedures but not to tissue from medication abortion.

77. Second, the Tissue Disposal Mandate has no exception for tissue that is sent to a pathology laboratory for additional testing. Each year, the clinic sends the pregnancy tissue for a few patients to pathology if, for example, the physician suspects a molar pregnancy (an abnormal growth of fetal tissue that can become a tumor) or the patient had received a fetal diagnosis, and she requests further testing. Our physicians cannot "ensure" tissue is disposed of in accordance with the FDRA when others are responsible for ultimately disposing of it. The same would be true of tissue collected by local law enforcement under the Local Disclosure Mandate.

78. Third, because the FDRA sets out rules for who has the right to control the disposition of the remains of a deceased family member, the Tissue Disposal Mandate requires that those who provide abortion care and miscarriage management ensure people other than the patient are aware of their right to be involved in decisions about the disposal of embryonic or fetal

tissue before it is disposed. This would require the clinic to at least try to notify third parties about each patient's abortion or miscarriage care—which would cause, at a minimum, delay and unacceptable disruptions of confidentiality, invasions of privacy, and threats to our patient's safety.

79. As a practical matter, before performing an abortion or providing miscarriage care, the physicians and the clinic need to know that the tissue can be disposed of in compliance with the law. In other words, not knowing that tissue can be disposed of in compliance with the law threatens our continued ability to provide care. This would be devastating for our patients.

80. As a result of the Mandate, our physicians would, at a minimum, have to try to notify various third parties before each patient's abortion. This would be a terrible invasion of our patients' privacy. For example, I understand that only people at least 18 years old have the right to determine disposition under the FDRA. This seems to mean, for our patients under 18 years old and whose boyfriends or partners are also under 18 years old, her parents—and his parents—would have a right to make decisions about disposition. But those parents can make that decision only if they know of the abortion. This would seem to conflict with Arkansas's judicial bypass process, which allows a minor to end her pregnancy without parental consent.

81. And, for a patient who is, for example, 17 years old, and has a boyfriend who is 18 years old, it seems that he would have the right to make a decision about disposition but she would not.

82. For our patients who are over 18, I understand that, under the FDRA, one "parent" may decide how to dispose of remains when the other parent is absent only after "reasonable efforts have been unsuccessful in locating the absent surviving parent."

83. This seems to require the physicians, the clinic, or the patient to make reasonable efforts to contact the man involved in the woman's pregnancy before the tissue can be disposed of. It is not clear what "reasonable efforts" means.

84. This requirement is also very concerning because, as I explained above, privacy is of the utmost importance to our patients. Each of our patients makes her own decision about the people with whom she will share her decision to have an abortion. A patient may not tell a partner or spouse about her abortion because she fears harassment or violence. Other patients may have become pregnant by someone who is no longer in their life or with whom they never shared a relationship. And, others are pregnant as a result of coerced sex or sexual assault. Patients themselves are in the best position to know all of the circumstances and to decide with whom, if anyone, to share their highly personal decision to have an abortion.

85. The Mandate would nevertheless require attempts to locate this other "parent" prior to disposing of the tissue. This is incredibly invasive and risks our patients' safety. Because of these concerns, I expect that patients would forgo obtaining an abortion in the state rather than disclosing their abortion decision. The law could also delay a patient's abortion or miscarriage care while the physicians are trying to locate the other "parent" or the "grandparents" involved for minor patients.

86. Even if we were to attempt to delay notifying the various third parties until *after* a patient's abortion, which would leave both the clinic and patients in limbo, I would have many of the same concerns about the impact on patient safety and confidentiality. If patients knew their abortion would be disclosed after it occurs, that would (again) cause some to try to seek care out of state or potentially discourage them altogether. There would be no way for them to control how relatives involuntarily advised about their abortion reacted or to limit further communication of

their personal medical information. Additionally, I have concerns about the clinic's ability to properly store tissue for days, weeks, or more as notifications under the FDRA played out and to navigate the clinic's role when various third parties could claim it, forcing the clinic into the middle of these potentially protracted disputes. While LRFP preserves tissue for evidence collection, this preservation is necessary in very few cases; requiring tissue be preserved for an uncertain amount of time for every abortion patient would be a significantly different scale.

87. Finally, our patients have a range of very personal ways that they think of the pregnancies they decide to end, or the pregnancies they wanted but lost. Asking them to agree to disposition of embryonic or fetal tissue as "parents," and according to the rules for the remains of deceased persons, as the FDRA seems to imply, imposes one very particular view on all patients, many of whom do not share that view.

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

Executed on November 2nd, 2020 in Little Rock, Arkansas

Lori Williams, M.S.N., A.P.R.N.