Exhibit 4

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OKLAHOMA

SOUTH WIND WOMEN'S CENTER LLC, d/b/a TRUST WOMEN OKLAHOMA CITY, on behalf of itself, its physicians and staff, and its patients, et al.,	)	
Plaintiffs,	)	
v.	)	
	)	Case No. CIV-20-277-G
J. KEVIN STITT in his official capacity as Governor of Oklahoma, et al.,	)	
Defendants.	)	

DECLARATION OF DANA STONE, M.D.

I, Dana Stone, M.D., declare as follows:

Background

1. I am a board-certified obstetrician/gynecologist, and I provide the following facts and opinions as an expert in obstetrics and gynecology ("OB/GYN").

2. I have been licensed to practice medicine in the State of Oklahoma since 1991. In my private practice, I provide a range of OB/GYN care for patients, including routine and high-risk pregnancy care, fertility evaluation, birth control, comprehensive gynecologic and urologic care, and surgery. I also provide on-call services for inpatient obstetrical care, gynecology consults, and emergency room coverage at Lakeside Women's Hospital, a physician-owned hospital where I have privileges. In addition, I have hospital privileges at Integris Baptist Medical Center.

3. I attended medical school at the University of Oklahoma College of Medicine, and following graduation, completed my residency in OB/GYN at the University of Oklahoma

Health Sciences Center. I have been a practicing OB/GYN in Oklahoma for approximately 25 years.

4. I am a member of the American College of Obstetricians and Gynecologists, the American Medical Association, the Oklahoma State Medical Association, the Oklahoma County Medical Society, and the Oklahoma City Obstetrics and Gynecology Society.

5. I make this declaration based upon my personal knowledge, training and expertise in the field of OB/GYN and am competent to testify thereto.

6. The statements in this declaration are attributable solely to me; I do not speak on behalf of any institution or organization with which I am affiliated.

7. I understand that the Governor of Oklahoma has issued an Executive Order that directs Oklahomans and healthcare providers to postpone "elective surgeries" and "minor medical procedures" until at least April 30. I also understand that Oklahoma has extended that mandate to all abortion services, subject to limited exceptions. I further understand that the Court has issued an order that prevents the State from enforcing the Executive Order if a patient will be delayed beyond the point when she could legally obtain an abortion in Oklahoma, and if patients are seeking medication abortions. The Court's order is temporary, however, and Oklahoma claims that the order should not be maintained or extended.

Summary of Opinions

8. Oklahoma's requirement that all abortion services be postponed at least through April 30 is highly unlikely to conserve medical resources. Women forced to remain pregnant will require a variety of healthcare services, including prenatal care between now and April 30 that should not be delayed and cannot always be provided through telemedicine. These immediate and short-term prenatal healthcare services will require medical resources and in-person contact

with medical providers comparable to, or even greater than, abortion care. The contrary opinions of Oklahoma's declarant, Dr. Michael T. Valley, based upon his OB/GYN practice in Minnesota, are not consistent with my current practice in Oklahoma. Similarly, the contrary opinions of Oklahoma's declarant, Dr. Rita Sanders, based upon her daughter's experience being pregnant in San Francisco, California, are not consistent with my current practice in Oklahoma.

9. In the event Oklahoma's prohibition on abortion services is extended beyond April 30, the healthcare needs of women forced to remain pregnant will only increase. These prenatal healthcare services will require medical resources and in-person contact that far exceed abortion care.

10. The Governor's application of the Executive Order to abortion services treats abortion differently than other healthcare services. I understand that abortion services in Oklahoma are categorically prohibited, except in limited circumstances. Other healthcare services, including services that I provide in my OB/GYN practice, are not categorically prohibited. Rather, in contrast to abortion services, physicians providing other healthcare retain discretion to decide, based upon medical judgment and patients' individual circumstances, whether a particular type of care constitutes "elective" surgery or a "minor" procedure given a patient's circumstances and clinic presentation.

Prenatal Care Through 28 Weeks Gestation

11. As noted above, I understand that Oklahoma is requiring all abortion services to be postponed at least through April 30. I further understand that Oklahoma claims that this will alleviate the strain on the healthcare system or "flatten-the-curve" of hospital visits.

12. Oklahoma's position ignores that women who are denied abortion services will remain pregnant, and pregnant women require healthcare—including healthcare in the short-

term. In fact, pregnant women in Oklahoma, including my own patients, are still receiving regular in-person prenatal care during the COVID-19 pandemic, including a variety of services during the first 22 weeks of pregnancy that should not be postponed and cannot be delivered through telemedicine.

Standard Prenatal Care

13. Under normal circumstances, between 8 weeks gestation and 28 weeks gestation,[1] I have in-person appointments with my pregnant patients every 4 weeks. At these visits, I take the patient's vital signs, conduct a physical examination, and may order an ultrasound. A patient typically has 2 or 3 ultrasounds before 28 weeks gestation, all of which require in-person visits.

14. At the first visit, typically around 7 or 8 weeks gestation, I administer a pregnancy test to confirm pregnancy, order an ultrasound, and order an obstetric panel, which consists of several in-person blood and urine tests to check the health of the woman before and during early pregnancy.

15. Around 12 weeks gestation, if the patient is interested in genetic screening, I order a first trimester screen, which is an in-person screening consisting of a blood test and an ultrasound to assess the risk of chromosomal and other fetal abnormalities.

16. If the results from the genetic testing show anything unusual, I refer the patient to a perinatologist or maternal-fetal medicine specialist who does additional testing on the patient around 15 weeks gestation. These tests include chorionic villus sampling (which analyzes a biopsy from the placenta) or amniocentesis (which analyzes fetal cells in a sample of amniotic fluid taken from the gestational sac). Both tests involve the insertion of a needle into the uterus, which can carry a risk of complications requiring additional treatment.

[1] I measure gestational age from the first day of the patient's last menstrual period ("LMP"), so 12 weeks gestation is the same as 12 weeks LMP.

17. Around 19 weeks gestation, I order an anatomy ultrasound for the patient, which requires the patient to make an in-person visit. Between 24 and 28 weeks, I send the patient to the laboratory for a glucose screen to assess for gestational diabetes, which also requires an in-person visit.

18. At 28 weeks I administer a RhoGAM shot to patients with negative blood types to protect the fetus from the mother's antibodies.

19. If a patient has a high-risk pregnancy, she will likely come to see me more frequently and have additional ultrasounds. It is likely she will also make visits to a perinatologist or maternal-fetal medicine specialist.

20. There are many reasons patients are considered to have high-risk pregnancies, and approximately 10-15 % of my patients are high risk. Risk factors for a high-risk pregnancy include being over the age of 35, especially over the age of 40; pre-existing medical conditions such as diabetes or hypertension; gestational diabetes or hypertension; complications with the current pregnancy; obesity; and placental development issues.

21. Pregnant patients also must sometimes make visits to the hospital during the first and second trimesters. If my patients have cramping or bleeding, I may see them in the hospital to treat miscarriage, ectopic pregnancy, or cervical incompetence.

Changes to Prenatal Care Due to COVID-19

22. Like other health care providers, I have instituted measures to reduce the spread of COVID-19 and preserve medical resources, and I have made certain changes to my practice, consistent with the recommendations of medical experts.

23. For example, due to COVID-19, I now combine some in-person visits and/or move some visits to telemedicine. But even during the pandemic, it is still important that a

patient meet with me in-person on several occasions during pregnancy: once before 12 weeks gestation, once around 20 weeks gestation, and once around 26 weeks gestation. A patient also still must obtain her scheduled ultrasounds and laboratory tests, and these all must be done in-person.

24. I disagree with Drs. Valley and Sanders that nearly all prenatal care in early pregnancy can be delayed or moved to telemedicine. As described above, I am still advising my prenatal patients to make in-person visits to the clinic and obtain ultrasounds and lab tests at several critical time points during pregnancy. I know that other Oklahoma prenatal care providers have made similar modifications.

25. Therefore, even during COVID-19, before a patient has reached 28 weeks gestation, she will have met with me in-person at least 3 times, had 2-3 ultrasounds in-person, and visited the laboratory at least twice for testing, 3 times if she chooses to have a first trimester screen.

26. I was especially disturbed to read Defendants' declarant Ms. Adams state that the "pregnancy resource center" where she works is "telling women not to seek prenatal services unless they have an actual medical problem or emergency." Declaration of Kathy Adams R.N. ¶ 9. Prenatal care is essential to ensuring the health of the fetus and pregnant mother. Discouraging preventative and necessary prenatal care, even during the current public health crisis, is medically irresponsible and contrary to the standard of care in Oklahoma.

27. At each of my visits with the patient, I wear a surgical mask to reduce the risk of spreading or contracting coronavirus. I also wear gloves for any pelvic exams. The laboratory and ultrasound technicians also wear gloves. I would expect they are also now wearing surgical masks to reduce transmission of coronavirus.

Comparison with Abortion Services

28. I have reviewed the declarations submitted by Dr. Larry Burns, Julie Burkhart, and Brandon Hill, and I understand the amount of in-person contact, personal protective equipment (PPE), and hospital resources required for abortion. Prenatal care for pregnant women in the first and second trimesters requires in-person contact and medical supplies, including PPE, comparable to, if not greater than, abortion services. As such, patients forced to remain pregnant as a result of Oklahoma's Executive Order, and who receive the recommended prenatal care, will not enable the State to conserve medical resources or result in less risk of viral transmission between now and April 30, 2020.

29. Furthermore, I understand that Oklahoma claims that the measures abortion providers have instituted to mitigate the risk of viral transmission are inadequate and "reckless." Defs.' Opp'n Pls.' Mot. TRO/Prelim. Inj. 27. Based upon my review of the declarations of Dr. Burns, Ms. Burkhart, and Mr. Hill, the measures these abortion providers have instituted are comparable to those instituted at my practice, which follows the evolving guidelines for minimizing the risk of viral transmission set by my healthcare system.

Prenatal Care After 28 weeks Gestation

30. Of course, if the Executive Order is extended beyond April 30, women forced to remain pregnant will require significantly greater contact with the healthcare system, particularly during labor and delivery.

31. After 28 weeks gestation, it is generally advised for the patient to have a prenatal visit every 2 weeks. After 36 weeks gestation until delivery, the patient has a prenatal visit every week. In light of COVID-19, these visits may be less frequent for my patients, but because it is

important for the patient to have regular check-ups as they approach delivery, not every visit can be postponed or moved to telemedicine.

32. I perform approximately 10-12 deliveries per month. Significant staffing and medical resources, including PPE, are required for a delivery. For a vaginal delivery, I am in the OR with a surgical technician, a labor nurse, and a nursery nurse. For a cesarean section ("C-section"), another OB/GYN and an anesthesiologist are also in the room.

33. The OB/GYNs wear surgical gowns, gloves, surgical masks, surgical caps, and face shields. The surgical technician typically wears a surgical gown, gloves, a surgical mask, and a surgical cap. Currently, to preserve gowns, the technician is standing further away without a gown. The anesthesiologist and nurses wear surgical masks and gloves.

34. Delivery was recently classified as an "aerosol-generating procedure," meaning there are additional COVID-19 precautions to be observed. Additionally, if a patient is suspected to have COVID-19, everyone in the room also wears an N95 respirator mask.

35. In Oklahoma, patients who have vaginal deliveries are allowed to stay in the hospital for 2 days, and those who have C-sections are allowed to stay for 4 days. In light of COVID-19, the hospitals where I work are making an effort to release patients sooner, but this is not always possible.

Other OB-GYN Care

36. Consistent with the Executive Order, I am delaying elective surgeries and minor medical procedures until after April 30, 2020. The Executive Order gives me the discretion to use my medical judgment to determine if a surgery is "elective" and a procedure is "minor" such that delay is medically appropriate based upon a patient's circumstances and clinic presentation.

37. For example, my colleagues and I are still performing pre-cancer and cancer-related procedures such as loop electrosurgical excision procedures ("LEEPs") and colposcopies. LEEPs are procedures used to remove abnormal cells that may cause cervical cancer. Colposcopies are diagnostic procedures used to detect abnormal cells in the cervix and vagina. Additionally, if a pregnant patient has experienced fetal demise (i.e., a miscarriage), we will perform a cervical dilation with curettage (D&C) to remove the fetal tissue.

38. Using my medical judgment, and in consultation with other medical professionals, I have determined that these procedures are not elective or minor. LEEPs and colposcopies reveal if pre-cancer or cancer is advancing and must be addressed without delay. D&Cs are also time-sensitive because they prevent hemorrhage, an extremely serious and sometimes life-threatening condition. Notably, these procedures are performed outpatient and require minimal PPE, so they do not deplete hospital capacity or the PPE that is needed to cope with the COVID-19 pandemic. I understand why some more complex procedures such as certain cardiac procedures or cancer treatments have been delayed: these procedures require a significant amount of hospital staff and resources, including PPE, and can safely be postponed.

39. I agree with the statement by the American College of Obstetricians and Gynecologists that abortion care is "essential" and "time-sensitive." ACOG et al., Joint Statement on Abortion Access During the COVID-19 Outbreak (Mar. 18, 2020), https://bit.ly/33ULFeI. And further, based on my review of the declarations of Dr. Burns, Ms. Burkart and Mr. Hill, procedural abortions require minimal PPE.[2] However, the Executive Order treats abortion providers, and by extension their patients, differently than other Oklahoma physicians and patients. Abortion providers apparently have no discretion to determine that a

[2] I understand that medication abortions are not surgeries or procedures; they involve giving the patient two prescription medications. Therefore, they should not be included in the Executive Order.

patient's procedural abortion is not elective or minor because, for example, delay would be medically inappropriate, contraindicated, or otherwise detrimental to the patient.

40. There is no medical justification for that differential treatment as the "surgery" involved in abortion is comparable to those performed in OB/GYN practice.

41. Just like any other medical provider in Oklahoma, abortion providers should be able to use their medical judgment to determine the care they will provide during the COVID-19 pandemic.

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

Dana Stone, M.D., F.A.C.O.G

Executed April 8, 2020