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.	)	

PLAINTIFFS' RESPONSES TO DEFENDANTS' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

Plaintiffs South Wind Women's Center LLC, d/b/a Trust Women Oklahoma City ("Trust Women"), Dr. Larry A. Burns ("Dr. Burns"), and Comprehensive Health of Planned Parenthood Great Plains Inc. ("Planned Parenthood"), on behalf of their patients, their physicians and staff, and themselves (together, "Plaintiffs") submit this response to Defendants' April 14, 2020 Proposed Findings of Fact and Conclusions of Law (separately, "Defs.' FOF" and "Defs.' COL"), ECF No. 93. Plaintiffs incorporate by reference as though fully set forth herein Plaintiffs' Proposed Findings and Facts and Conclusions of Law (separately, "Pls.' FOF" and "Pls.' COL"), ECF No. 92. Given the emergency nature of these proceedings, Plaintiffs herein address those principal issues in Defs.' FOF and Defs.' COL that Plaintiffs refute. Plaintiffs' decision not to address each and every

paragraph in Defendants' 113-paragraph FOF and their 73-paragraph COL does not constitute an admission of any paragraph.

I. PLAINTIFFS' RESPONSE TO DEFENDANTS' PROPOSED FINDINGS OF FACT

A. Abortion Is Time Sensitive, Essential Health Care

1. Defendants' claim that nearly all medical and surgical abortions are "elective" and capable of being postponed, *see, e.g.*, Defs.' FOF ¶¶ 49–50, 59, 61, 62, is contrary to the consensus view of leading medical organizations in the United States. Leading medical professional organizations, including the American College of Obstetricians and Gynecologists ("ACOG") and the American Medical Association ("AMA") have advised states not to categorize abortion as health care "that can be delayed during the COVID-19 pandemic" given its critical nature for patients, even if those states are requiring postponement of non-time-sensitive health care during the crisis. ACOG, *Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak ("*Joint Statement*") (stating that abortion "is an essential component of comprehensive health care" and "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible."), attached as Ex. 1-5 to Rebuttal Decl. of Mark Nichols, M.D. ("Nichols Decl."), ECF No. 84-1; Br. of ACOG, et al. as Amici Curiae Opp'n Pet. Writ Mandamus at 3–4, 10, *In re Abbott*, No. 20-50264 (5th Cir. Apr. 2, 2020) ("ACOG Br. I"), attached as Ex. 1-3 to Nichols Decl.; *see also* Nichols Decl. ¶ 16; Decl. of Joshua Sharfstein, M.D. Supp. Pls.' Mot. Prelim. Inj. ¶ 8, ECF No. 84-5.

2. ACOG and other leading medical organizations submitted an amicus brief in support of Plaintiffs in opposition to Defendants' appeal from this Court's April 6, 2020 Temporary Restraining Order, which the Tenth Circuit allowed. *See* Br. of ACOG, et al. as Amici Curiae Supp. Pls.' Opp'n Stay Mot. at 3–6, *S. Wind Women's Center LLC v. Stitt*, No. 20-6045 (10th Cir. Apr. 10, 2020) ("ACOG Br. II"). As these amici demonstrate: "Abortion is an essential component of comprehensive health care," and "[t]he medical community recognizes that "[a]ccess to legal and safe pregnancy termination . . . is essential to the public health of women everywhere." ACOG Br. II at 3–4; *see also* ACOG Br. I at 10; Pls.' FOF ¶ 51–52.

3. As ACOG and other major medical organizations have made clear, "[t]he consequences of being unable to obtain an abortion profoundly impact a person's life, health, and well-being." Decl. of Dr. Gillian Schivone Supp. Pls.' Mot. TRO and Prelim. Inj. ("Schivone Decl.") ¶ 24, ECF No. 16-4 (citing *Joint Statement*); Pls.' FOF ¶ 71. "Delays in patients' ability to access abortion inflict numerous harms." Schivone Decl. ¶ 27; *see also* Decl. of Julie Burkhart Supp. Pls.' Mot. TRO and Prelim. Inj. ("Burkhart Decl.") ¶ 16, ECF No. 16-6. "[A]ll pregnancy-related services, including abortion, are time-sensitive and essential health care services that should remain available during the COVID-19 crisis." Burkhart Decl. ¶ 5.

4. Courts have recognized that abortion care cannot be delayed without causing "imminent, irreparable harm" to patients. *Robinson v. Marshall*, No. 2:19-cv-365, 2020 WL 1520243, at *2 (M.D. Ala. Mar. 30, 2020) (granting TRO). As the court explained, a "delay in obtaining an abortion can result in the progression of a pregnancy to a stage at

which an abortion would be less safe, and eventually illegal." *Id.* (citing *Planned Parenthood of Wisc., Inc. v. Van Hollen*, 738 F.3d 786, 796 (7th Cir. 2013).

B. Defendants Mischaracterize Evidence Regarding the Safety of Abortion

1. Defendants' Experts Lack Credibility

5. Defendants offer as expert testimony the declarations of various medical professionals questioning the general safety of abortion procedures and/or the use of PPE, the risks of infection associated with patient contact, and generally supporting the Governor's Executive Oorder, as expanded by the March 27 Press Release (hereinafter "Executive Order"), to apply to all abortions. *See generally* Decl. of Michael T. Valley M.D. ("Valley Decl."), ECF No. 54-4; Decl. of Robert Marier, M.D. ("Marier Decl."), ECF No. 54-6; Decl. of Donna Harrison, M.D. ("Harrison Decl."), ECF No. 54-7; Decl. of Kathy Adams, R.N., ECF No. 82-2. As an initial matter, Defendants presented no evidence that they considered the opinions of these medical professionals or the data on which these opinions were based prior to issuing the Press Release. Additionally, Plaintiffs have serious concerns about the expertise and reliability of Defendants' experts, as discussed below.

Donna Harrison, M.D.

6. Defendants offer Dr. Donna Harrison as an expert in obstetrics and gynecology. Dr. Harrison's declaration supports restrictions on medication abortion by advancing the general position that medication abortion exposes women to significant risks of serious complications. Dr. Harrison opines, among other things, that published studies on the safety of abortion "likely . . . understat[e] complications due to widespread inadequacies in reporting." Harrison Decl. ¶ 13. Dr. Harrison further opines that

medication abortion "actually exposes women to greater risk of serious complications than surgical abortions." *Id.* ¶ 15. But Defendants' claims regarding the safety of abortion are contrary to the views of leading medical authorities based upon published scientific literature. Nichols Decl. ¶¶ 60–69 (citing Nat'l Acads. Scis. Eng'g & Med., The Safety and Quality of Abortion Care in the United States (2018) ("Nat'l Acads. Report"), attached as Ex. 1-4 to Nichols Decl.); Schivone Decl. ¶ 19.

7. Furthermore, other courts, at both the state and federal level, have found Dr. Harrison to be neither reliable nor credible on abortion-related issues. Dr. Harrison previously served as an expert witness for the state of North Dakota, where she provided opinion testimony in support of restrictions on the provision of medication abortion. *See generally MKB Mgmt. Corp. v. Burdick*, 855 N.W.2d 31 (N.D. 2014). The Supreme Court of North Dakota found that "Dr. Harrison's opinions lack scientific support, tend to be based on unsubstantiated concerns, and are generally at odds with solid medical evidence" among other concerns. *Id*. at 68. The federal district court in North Dakota had previously also determined that Dr. Harrison's opinions "lack scientific support," are "based on unsubstantiated concerns," and are "generally at odds with solid medical evidence." *MKB Mgmt. Corp. v Burdick*, No. 09-2011-CV-02205, 2013 WL 9885391, at *7 (N.D. Dist. Ct. July 15, 2013). Another court found that Dr. Harrison's views regarding medication abortion "must be rejected" because they contradict the factual underpinnings of the U.S. Supreme Court's most recent abortion ruling. *Planned Parenthood of Ark. & E. Okla. v. Jegley*, No. 4:15-CV-00784-KGB, 2018 WL 3816925, at *42 (E.D. Ark. July 2, 2018),

vacated, No. 4:15-CV-00784-KGB, 2018 WL 9944527 (E.D. Ark. Nov. 9, 2018), *appeal dismissed*, No. 18-2463, 2018 WL 9944528 (8th Cir. Nov. 9, 2018).

8. Additionally, Plaintiffs question Dr. Harrison's qualification to provide testimony on the question of medication abortion's safety. Dr. Harrison has not practiced medicine in nearly twenty years, but rather has been devoting her time to the American Association of Pro-Life OBGYNs ("AAPLOG"), an advocacy organization of which she is the Executive Director. Harrison Dep. Tr. at 8:18–10:1; 16:11–24, *Reprod. Health Servs. of Planned Parenthood of the St. Louis Reg. v. Mo. Dep't of Health & Senior Servs.* (Mo. Admin. Hr'g Comm'n Aug 28, 2019) (No. 19-0879), attached as Ex. 8-1 to Decl. of Diana O. Salgado ("Salgado Decl.").[1] She has never provided a medication abortion. *Id.* at 83:12–23; Harrison Dep. Tr. at 212:18–21, *MKB Mgmt. Corp. v. Burdick* (N.D. Dist. Ct. Dec. 7, 2012) (No. 09-2011-CV-02205), attached as Ex. 7-9 to Decl. of Ezra Cukor ("Cukor Decl.").

9. Plaintiffs further question Dr. Harrison's bias. Dr. Harrison believes that anything that might "disrupt" a pregnancy from the point of fertilization onward—including birth control such as emergency contraception (the "morning-after pill") and intrauterine devices (IUDs)—constitutes homicide. Hr'g Tr. Vol. I (Harrison) 194:21–195:12; 195:23–196:3, *Reprod. Health Servs. of Planned Parenthood of the St. Louis Reg. v. Mo. Dep't of Health & Senior Servs.* (Mo. Admin. Hr'g Comm'n Oct. 28, 2019) (No.

[1] Dr. Harrison does not consider the leading professional association of OB/GYNs in the United States—ACOG—to be a reliable source of medical information because she considers them "extremely ideologically pro abortion." Hr'g Tr. Vol. I (Harrison) at 193:15–194:11, Ex. 8-2 to Salgado Decl.

19-0879) (stating IUDs and emergency contraception can "end the life of a human being"), attached as Ex. 8-2 to Salgado Decl.; *id.* at 196:21–197:11 ("[T]here's no difference between ending the life of a human being inside the womb and ending the life of a human being outside. They are both ending the life of a human being, which is homicide.").

10. In light of the foregoing, Dr. Harrison cannot be considered a credible or reliable source of information on matters relating to abortion and her opinions are entitled to no weight.

Robert M. Marier, M.D., M.H.A.

11. Defendants also offer the declaration of Dr. Robert L. Marier, who is Board Certified in Internal Medicine and Infectious Diseases, as an expert to provide testimony regarding the risks of COVID-19 transmission and the necessity of the Executive Order. Marier Decl.

12. As with Dr. Harrison, Dr. Marier's experience in providing abortion care is questionable. Dr. Marier has "never performed an abortion," and "has not not had any experience with obstetrics or gynecological surgeries since medical school," which led to a finding by a federal district Court that he has a "paucity of knowledge or experience concerning abortion," *June Med. Servs. LLC v. Kliebert*, 250 F. Supp. 3d 27, 61 (M.D. La. 2017) ("*June Medical*"), *rev'd sub. nom. June Med. Servs. LLC v. Gee*, 905 F.3d 787 (5th Cir. 2018), *cert granted,* 140 S.Ct. 35 (Mem) (2019), which undermines the weight of his declaration in support of Defendants' positions.

13. Additionally, whatever probative weight might attach to Dr. Marier's declaration is substantially reduced by Dr. Marier's bias against safe and legal abortion,

which he maintains "should be outlawed in the United States." *June Medical*, 250 F. Supp. 3d at 61. Moreover, Dr. Marier believes life "begins at conception, not implantation which occurs later." Marier Dep. Tr. at 51:6–11, *June Med. Servs. v. Kliebert* (M.D. La. Jan. 28, 2015) (No. 14-CV-525-JWD-RLB), attached as Ex. 7-6 to Cukor Decl. Finally, he maintains that contraceptive measures such as IUDs and Plan B should be illegal. *Id.* at 52:8–10. Based on his anti-abortion views, a federal district court found that Dr. Marier's credibility was "diminished by his bias" against safe and legal abortion and even certain contraception methods. *June Medical*, 250 F. Supp. 3d at 61.

Michael T. Valley, M.D.

14. Defendants also offer the declaration of Dr. Michael T. Valley as an expert opinion to support the general proposition that abortion procedures involve risks to patient safety, that abortion procedures require greater use of personal protective equipment than continued pregnancy, and to offer after-the-fact justification for the Governor's postponement of elective surgeries. Valley Decl.

15. The probative weight of Dr. Valley's declaration is diminished by his expressed anti-abortion views. For example Dr. Valley believes that first-trimester abortions violate the Hippocratic oath. Valley Dep. Tr. 253:12–14, *Nova Health Sys. v. Hunter* (Dist. Ct. Okla. Cty. Sept. 28, 2017) (No. CV-2015-1838) attached as Ex. 7-5 to Cukor Decl. And he does not support "elective abortion" in any instance "where it would not ultimately result in maternal death" unless the fetus has anencephaly. Valley Dep. Tr. 187:12–15, *Burns v. Cline*, (Okla. Dist. Ct. Nov. 23, 2015) (No. CV-2014-1896), attached

as Ex. 7-4 to Cukor Decl. Dr. Valley also opposes abortion in the case of rape. *Id.* at 186:21–23. Due to his strong bias, Dr. Valley's opinion is entitled to no weight.

2. Defendants Misrepresent the Safety of Procedural Abortion and the Rates of Hospital Admission After Abortion

16. Evidence refutes Defendants' claim that "[a]bortion increases the short-term risk that a pregnant woman will need hospitalization." Defs.' FOF ¶ 72. Women who continue their pregnancies are far more likely than those who have abortions to require emergency room visits or hospital care. Pls.' FOF ¶ 64 (citing Nichols Decl. ¶¶ 51, 66; Schivone Decl. ¶ 21). Among pregnant women, one-fifth will visit an emergency room at least once during their pregnancy, and a significant percentage (29%) of those patients will do so more than once. *Id.* (citing Nichols Decl. ¶ 51). Miscarriage, which is common early in pregnancy (it ends approximately 10% of pregnancies in the first trimester and 1 to 5% of pregnancies between 13 to 19 weeks LMP) leads to significant numbers of emergency room visits. *Id.* In sharp contrast, abortion care results in an emergency room visit and abortion related treatment or diagnosis in less than 0.87 % of cases. *Id.; see also* Ushma Upadhyay, *Incidence of Emergency Department Visits and Complications After Abortion*, Obsetrics & Gynecology at 7 (2015), attached as Ex.1-7 to Nichols Decl. ("Upadhyay 2015"). Accordingly, abortion decreases the short-term risk that a pregnant woman will require hospitalization.

17. Defendants' claims regarding the possible complications with abortion do not support the inference that abortion patients are likely to need hospital care. It is undisputed that Plaintiffs' patients "almost never" experience complications that require

hospital transfer. Defs.' FOF ¶ 69 (citing Burkhart Decl. ¶ 31; Burns Decl. ¶ 20 (attesting that in 46 years, Dr. Burns has only sent one patient to the hospital)). While complications associated with both medication and procedural abortion are rare, nearly all such complications can be managed in an outpatient setting. Pls.' FOF ¶ 114–115 (citing Nichols Decl. ¶¶ 61, 64; Schivone Decl. ¶¶ 19–20); *see also id.* ¶ 116. Abortion-related emergency room visits make up only 0.01% of all emergency room visits, and as discussed *supra* ¶ 16 , less than one percent of abortions result in an emergency room visit at which the patient receives a diagnosis, treatment, or diagnosis and treatment for an abortion-related reason. *Id.* at ¶ 115 (citing Nichols Decl. ¶¶ 54, 65; Schivone Decl. ¶ 20; Upadhyay 2015 at 7); Ushma Upadhyay, *Abortion-Related Emergency Department Visits in the United States: An Analysis of a Nat'l Emergency Dep't Sample*, 16 BMC Med. 1, 8 (2018), attached as Ex. 1-10 to Nichols Decl. ("Upadhyay 2018"). Defendants' experts cite no scientific support for their conclusory claims to the contrary. *See* Nichols Decl. ¶ 60; *contra* Defs.' FOF ¶ 69 (citing Harrison Decl. ¶¶ 12–14; Sanders Decl. ¶ 8).

18. Plaintiffs object to the relevance of Defendants' citation to the Fifth Circuit's finding regarding the number of abortion patients annually hospitalized in a different state. Defs.' FOF ¶ 73 (citing *Planned Parenthood of Gr. Tex. Surgical Health Servs. v. Abbott*, 748 F.3d 583, 595 (5th Cir. 2014)). Defendants fail to account for the substantial difference between the annual number of abortions performed in Texas and in Oklahoma. *Compare* Okla. State Dep't of Health, *Abortion Surveillance in Oklahoma 2002-2018 Summary Report* at 4 (June 2019) (reporting an average of 5,410 abortions per year in Oklahoma between 2002 and 2018), attached as Ex. 2-1 to Suppl. Decl. of Julie Burkhart, ECF No.

84-2, *with Abbott*, 428 F.3d at 591 (noting that more than 66,858 people seek abortion in Texas each year). In addition, Defendants fail to note that the Supreme Court subsequently struck down the same Texas law that the Fifth Circuit in *Abbott* upheld, and contrary to the Fifth Circuit, the Supreme Court found that "abortion in Texas was extremely safe with particularly low rates of serious complications." *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2298, 2311 (2016) (noting "[e]xpert testimony to the effect that complications rarely require hospital admission, much less immediate transfer to a hospital from an outpatient clinic").

19. Defendants' claims regarding the risks associated with first-trimester procedural abortion and D&E abortion are exaggerated and scientifially unsupported. Defs.' FOF ¶¶ 81, 90. Defendants rely solely on the conclusory testimony of Dr. Michael Valley, whose opinions are entitled to no weight. *See supra* ¶ 15. Dr. Valley does not acknowledge, let alone dispute, that such complications are rare. Pls.' FOF ¶ 62. To the extent Dr. Valley discusses risks associated with procedural abortion, he fails to differentiate between major and minor complications. Nichols Decl. ¶ 64. The record before the Court supports a finding that major complications arise in only 0.16% of first-trimester procedural abortion and in only 0.41% of second-trimester procedural abortion cases, which includes D&E abortion. Pls.' FOF ¶ 58 (citing Schivone Decl. ¶ 20); *see also* Nichols Decl. ¶ 63; Upadhyay 2015 at 4–5.

20. Defendants' claim that complications associated with abortion "may increase the use of hospital services" is speculative and the record shows otherwise. Defs.' FOF ¶ 91. Major complications from abortion by any method are extremely rare and occur in

less than one-quarter of one percent (0.23%) of cases. Pls.' FOF ¶ 58 (citing Schivone Decl. ¶ 20). Almost all complications associated with abortion—including most cases of hemorrhage, cervical laceration, and incomplete abortion—can be safely and appropriately managed in an outpatient clinic setting. Pls.' FOF ¶ 115; Nichols Decl. ¶ 64; *see also* ACOG Br. II at 6–7. As discussed *supra*, abortion-related emergency room visits make up 0.01% of all emergency room visits, and only 0.87% of abortions result in emergency room visits at which the patient receives a diagnosis or treatment for an abortion related complication. *Id.* (citing Nichols Decl. ¶¶ 54, 65; Schivone Decl. ¶ 20; Upadhyay 2015 at 7); Upadhyay 2018 at 8.

21. Defendants flout extensive scientific evidence advancing the claim that the complication rate for abortion in general, and medication abortion in particular, is unknown or understated. Defs.' FOF ¶¶ 92, 100. Dr. Harrison's speculation does not undermine overwhelming evidence to the contrary. Extensive credible expert testimony and multiple peer-reviewed studies in the record confirm the safety of abortion. Nichols Decl. ¶¶ 60–66; Schivone Decl. ¶ 19; Decl. of Daniel A. Grossman, M.D. Supp. Pls.' Reply Mot. Temp. Inj. ("Grossman Decl.") ¶ 3, attached as Ex. 1-2 to Nichols Decl. Leading medical authorities, including ACOG, the AMA, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association have concluded that legal abortion is one of the safest medical procedures in the United States. Pls' FOF ¶ 57 (citing ACOG Br. II at 4–5; *see also* ACOG Br. I at 6). The National Academies of Sciences, Engineering, and Medicine ("National Academies")—which are chartered by Congress to provide independent, objective analysis of the nation's complex

scientific problems and public policies—have also determined that medication and procedural abortions rarely result in complications and do so at rates of no more than a fraction of a percent. *Id.* (citing Nat'l Acads. Report at 77–78). Indeed, the National Academies has dispelled the notion that complication rates "are unknown" in concluding that available evidence based on "the extensive body of research documenting the safety of abortion care" is "quite robust." Nichols Decl. ¶ 62 (citing Nat'l Acads. Report at 1, 14).

22. Accordingly, as discussed *supra* ¶ 19–21, the record before the Court supports a finding that major complications from abortion by any method are extremely rare. *See* Pls.' FOF ¶ 57–58. More specifically, major complications arise in just 0.31% (i.e., 3 patients out of 1,000) of medication abortion cases (making medication abortion safer than aspirin, Tylenol, and Viagra); 0.16% of first-trimester procedural abortion cases; and 0.41% of second-trimester procedural abortion cases. *Id.* Complications leading to a hospital visit are rarer still. *Id.* ¶ 58.

3. Defendants Misrepresent the Safety of Medication Abortion

23. Plaintiffs dispute Defendants' suggestion that medication abortion patients experience major complications and then go directly to hospitals to receive treatment. Defs.' FOF ¶ 70. Defendants present no evidence of people experiencing major complications from medication abortion going on their own to hospitals. To the extent that Defendants seek to claim that unreported complications should drive up the reported rates, their own expert declarations offer only misrepresentations or unsupported speculation. Valley Decl. ¶ 5; Sanders Decl. ¶ 4. For example, Dr. Harrison counts homicides by third parties as deaths related to medication abortion, when these plainly have no bearing on the

safety of the treatment. She cites a raw number of adverse events but these numbers actually establish an exceedingly low complication rate. For the same reasons discussed above, *see supra* ¶ 21, Dr. Harrison's baseless speculation that complication rates for medication abortion are underreported must be rejected.[2] *See also* Nichols Decl. ¶¶ 67–68; Grossman Decl. ¶¶ 2–8, Nichols Decl. Ex. 1-2.

24. Defendants' reliance on *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2311 (2016), Defs.' FOF ¶ 70, is seriously misplaced, as the Supreme Court held abortion is "extremely safe with particularly low rates of serious complications." 136 S. Ct. at 2381.

25. Credible expert testimony and multiple peer reviewed studies in the record demonstrate that abortion in general and medication abortion specifically carry low risk of complications requiring hospitalization. Pls.' FOF ¶ 115. Studies that account for patients seeking hospital care without transfer by the abortion provider have found that abortion-related emergency room visits make up only 0.01% of all ER visits, and only 0.87% of abortions result in an emergency room visit at which the patient receives a diagnosis, treatment, or diagnosis and treatment for an abortion-related reason. *Id.* (citing Nichols Decl. ¶¶ 54, 65; Schivone Decl. ¶ 20; Upadhyay 2015 at 7); Upadhyay 2018 at 7.

[2] Dr. Harrison hypothesizes without evidence that women seeking follow up care might not disclose that they have had a medication abortion. Decl. of Donna Harrison, M.D., ECF No. 54-7 ¶ 14 When testifying about an equivalent hypothesis in 2017, she could not ground it in any specific data and admitted she had never spoken to any woman, "in a clinical setting" or otherwise, who had done as much. Harrison Dep. Tr. 61:19-63:6, *Okla. Coalition for Reproductive Justice v. Cline*, No. CV-2014-1886 (Okla. Dist. Ct. Feb. 9, 2017), attached as Ex.7-8 to Cukor Decl.

26. Plaintiffs dispute Defendants' attempt to undermine high-quality, peer-reviewed research by baselessly asserting that it undercounts major complications. Defs.' FOF ¶ 101. The study they attack, Upadhyay 2015, defines "major" complication broadly to include "serious unexpected adverse events requiring hospital admission, surgery, or blood transfusion." Grossman Decl. ¶ 20, Nichols. Decl. Ex. 1-2. This definition is similar, if not more inclusive, than the FDA's definition of a "serious adverse event." *Id.* Hemorrhage does not have a standard definition and may be interpreted to mean any degree of bleeding. *Id.* at ¶ 22. Given that bleeding is an expected symptom of medication abortion, unquantified hemorrhage is not necessarily a sign of an adverse event—and certainly not a major one. *Id.* The study counts hemorrhages that led to blood transfusions as "major complications," thereby capturing serious adverse events. *See id.* at ¶ 23. Another study that defined emergency room visits requiring treatment more broadly found rates of 0.15 to 0.21%. for medication abortion. *Id* at ¶ 21.

27. Plaintiffs dispute and find immaterial Defendants' FOF ¶ 71, which seeks to inflate the complication rate for medication abortion by describing an inapplicable study. The study—Ea Mulligan & Haley Messenger, *Mifepristone in South Australia: The First 1343 Tablets*, 40 Austl. Family Physician 5, 343 (May 2011)—draws from a small sample size of the first uses of medication abortion in Australia and does not control for the timing or mode of misoprostol administration, i.e., whether it is administered at the same or different time as mifeprex. Grossman Decl. ¶ 25, Nichols Decl. Ex. 1-2. As a result, it is impossible to tell what, if any, portion of the sample used a medication abortion protocol equivalent to the two-step protocolused in Oklahoma clinics. In any event, the study

concluded that "the rate of any adverse outcome following early abortion is low" and that "little can be made of the likelihood of the most serious adverse outcomes of early abortion except to note that they are rare." *Id.* By omitting crucial information, Defendants mischaracterize a study that furthermore is inapplicable here.

28. As discussed *supra* ¶¶ 17, 20, overwhelming record evidence establishes that abortion, including medication abortion, rarely results in a hospital visit. Pls.' FOF ¶¶ 57–62, 114. Indeed, a continued pregnancy or a colonoscopy is more likely than abortion care to result in an overnight inpatient stay, blood transfusion or surgery. *Id.* at 8.

29. Without defining the term, Defendants seek to characterize medication and surgical abortions as "medical procedures" that should be banned or restricted. Defs.' FOF ¶ 78. Medication abortion is not a procedure; it is two pills taken orally. Pls.' FOF ¶ 54. Plaintiffs do not dispute that procedural abortion is a "medical procedure," although it requires no incisions or anesthesia. Pls.' FOF ¶ 55. And semantics aside, ACOG, the AMA and other major medical groups have filed an amicus brief in this case asserting that abortion is essential, time-sensitive health care that should not be restricted in response to the COVID-19 pandemic. ACOG Br. II at 3–6; *see also id.* at 9 ("While abortion is a safe and common medical procedure, it is also a time-sensitive one for which a delay may increase the risks or potentially make it completely inaccessible. The consequences of being unable to obtain an abortion profoundly impact a person's life, health, and well-being.").

30. Plaintiffs dispute Defendants' characterizations of the relative complication rates of medication and procedural abortion "at the same gestational stage" and find them

immaterial. Defs.' FOF ¶ 93. Record evidence establishes that overall, "medication abortions have an extremely low complication rate relative to other medical procedures, including surgical abortion." Grossman Decl. at ¶ 10, Nichols Decl. Ex. 1-2.

31. Defendants rely on studies with methodological limitations to inaccurately imply that medication abortion is less safe than procedural abortion. The Mulligan and Niinimaki studies cited by Dr. Harrison have serious methodological limitations that undermine their applicability to Plaintiffs' practice: The Mulligan study has a small sample size and does not control for the route or timing of misoprostol administration. Grossman Decl. ¶ 25, Nichols Decl. Ex. 1-2; Harrison Dep. Tr. 97:9-25, Cukor Decl. Ex 7-8 (testifying the study does "not break out" results based on timing of misoprostol and that such timing affects results). The Niinimaki study does not differentiate between medication abortion protocols. Grossman Decl. ¶ 25, Nichols Decl. Ex. 1-2; Harrison Dep. Tr. 98:10–17, Cukor Decl. Ex. 7-8 (testimony of Harrison agreeing that study encompassed several medication abortion protocols and results do not differentiate based on that.). Nor does it define how hemorrhage is quantified and so it could include any degree of bleeding, thereby lumping an expected outcome of medication abortion together with adverse events. Grossman Decl. ¶¶ 22, 25, Nichols Decl. Ex. 1-2; Harrison Dep. Tr. 98:18–99:6, Cukor Decl. Ex 7-8 (acknowledging that hemorrhage is not defined by study and could encompass bleeding of varying levels of severity). Both studies nevertheless concluded that medication abortion is safe and rarely involves serious complications. Grossman Decl. ¶ 25, Nichols Decl. Ex. 1-2.

32. Plaintiffs object to Defendants' mischaracterizations of the Mifeprex Label to overstate the risks of medication abortion. Defs.' FOF ¶¶ 94–96. The FDA label plainly states that serious adverse reactions occur in less than 0.5% of uses. The label's description of more common adverse reactions, also referred to as side effects, does not suggest medication abortion is unsafe but instead informs patients of potential side effects and counsels them on how to address them. Nichols Decl. ¶ 67.

33. Plaintiffs agree that the Mifeprex "black box" warning says that serious and sometimes fatal adverse events are rare, however Defendants omit key information. The "black box" warning goes on to read: "Serious and sometimes fatal infections and bleeding occur very rarely following spontaneous, surgical, and medical abortions, including following MIFEPREX use. No causal relationship between the use of MIFEPREX and misoprostol and these events has been established." Nichols Decl. ¶ 68, Grossman Decl. ¶ 8 (quoting FDA label), Nichols Decl. Ex. 1-2.

34. Plaintiffs find irrelevant Defendants' statements about the application of a Risk Evaluation and Mitigation Strategy ("REMS") to Mifeprex. Defs.' FOF ¶¶ 97–98. Leading medical groups have disputed whether the REMS is necessary, but the REMS in any event is irrelevant. Nichols Decl. ¶ 69; Grossman Decl. ¶ 9, Nichols Decl. Ex. 1-2. Contrary to Dr. Harrison's insinuation, the fact that Mifeprex has a REMS does not undermine its well-documented safety. Nichols Decl. ¶ 69. The FDA-approved label, in addition to numerous peer reviewed data, makes clear that medication abortion is safe. *See* Nichols Decl. ¶¶ 67–68, *see also supra* ¶ 32.

35. Plaintiffs dispute Defendants' contentions about the rate of incomplete abortion and required follow up care. Defs.' FOF ¶ 99. Defendants' claims are based on their discredited expert's cherry-picking of inapplicable studies. *See supra* ¶ 31. Incomplete abortions are far less common than Defendants claim. Upadhyay 2015 at 6 Table 4 (finding an incomplete abortion rate of 0.87% for medication abortion and 0.42% overall). In any event, incomplete abortions are generally managed in an outpatient setting, with medication or aspiration, and do not require any hospital care. Pls.' FOF ¶¶ 58, 114–115. Defendants' assertion about the risk of hospitalization is also plainly incorrect. Defs.' FOF ¶ 99. The FDA's clinical review team concluded that U.S. hospitalization rates associated with medication abortion are drastically lower than defendants claim--- between 0.04% and 0.06%. Grossman Decl. ¶ 19, Nichols Decl. Ex. 1-2.

36. Defendants are wrong to suggest that it is inappropriate to offer medication abortion up to 11 weeks LMP. While the current FDA protocol contemplates the use of medication up to 10 weeks LMP, medication abortion abortion has been proven safe and effective beyond 10 weeks, Nichols Decl. ¶ 21, and it is "common" and "good medical practice" for physicians to prescribe medications "off-label" in such circumstances. *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 909 (9th Cir. 2014) (enjoining a law requiring physicians to follow the FDA label for medication abortion) (quotations and citations omitted); *Planned Parenthood Sw. Ohio Reg. v. Dewine*, 931 F.3d 530, 535 (6th Cir. 2019) (noting that contra a state law restricting medication abortion to the FDA label, "physician reliance on evidenced-based, 'off-label' protocols is standard medical practice and is often protected in certain areas of state law, including in Ohio.").

4. Plaintiffs Are Safely Providing Abortion Care During COVID-19, While Using Minimal PPE

37. Plaintiffs dispute Defendants' repeated claims that Plaintiffs are using too much PPE and not enough PPE. Defs.' FOF ¶¶ 49–51, 60–61, 63, 89. Plaintiffs' evidence makes clear that procedural abortions require relatively little PPE, especially when it comes to aspiration abortion, and medication abortion (including a medication abortion) uses hardly any PPE. Pls.' FOF ¶ 108. In addition, the measures Plaintiffs instituted to prevent the spread of COVID-19 are in keeping with guidance from the CDC and other leading medical organizations. Pls.' FOF ¶ 99. They are also comparable to the measures instituted at other outpatient medical practices in Oklahoma. *Id.*

38. Desperate to portray abortion providers as using more PPE than they actually are, Defendants wrongly contend that medication abortion requires an in-person follow-up visit to confirm termination or manage major complications such as hemorrhage. Defs.' FOF ¶ 45. First, it is within the standard of care to confirm pregnancy termination without an in-person follow up visit. *See* NAF Sample Guideline: Medication Abortion Telephone Follow-Up, https://5aa1b2xfmfh2e2mk03kk8rsx-wpengine.netdna-ssl.com/wp-content/uploads/Telephone-follow-up-for-medication-abortion.pdf ("Telephone follow-up reduces the need for in-person or laboratory follow-up and is acceptable and safe for patients"); Grossman Decl. ¶ 15, Nichols Decl. Ex. 1-2 ("Patients receive the care they need for medication abortion—whether provided via telemedicine or during an office visit.") Second, major complications from abortion by any method are extremely rare. *See* Pls.' FOF ¶ 58.

39. Next, contrary to Defendants' proposed findings, Defs.' FOF ¶¶ 54, 63, Defendants' own experts and other declarants confirm that Plaintiffs are using adequate PPE. For example, Dr. Valley states that because of the pandemic, many clinics have adopted "occasional use of gloves for an exam," and "using a mask when seeing patients in clinic," and that this "should also be true for the abortion clinics themselves." Valley Decl. ¶ 10. *See also* Decl. of Rita Sanders, D.O. ("Sanders Decl.") ¶ 7, ECF No. 54-8 (referring to wearing, at a hospital in Arkansas, a "cloth mask" and a "regular mask"). Defendants acknowledge that Plaintiffs *are* "using masks throughout the day," Defs.' FOF ¶ 108, and the undisputed evidence is that Plaintiffs are also using gloves when providing care to patients. Pls.' FOF ¶ 108. When providing procedural care, specifically, Plaintiffs also use shoe covers, reusable protective eyewear or a face shield, and sometimes a surgical gown. *Id.*

40. Some of Defendants' experts attack Plaintiffs for not all using N95 respirators, the specialized masks designed to block at least 95% of very small test particles, claiming that it is necessary for all physicians and their staff to use these when performing "surgery." *See* Decl. of Jeremy Haney, M.D. ("Haney Decl.") ¶ 7, ECF No. 54-3 ("For surgery, . . full PPE absolutely must be worn which includes an N95 mask, eye shield, gown, and gloves . . [,] anyone in the operating room needs full PPE as well."); Defs.' FOF ¶ 51; *see also* Sanders Decl. ¶ 10. ("surgeries require 'full and in some cases extra PPE materials,'" but does not define what "full" or "extra" PPE entails). But neither medication nor procedural abortion involves "surgery," as it involves no incision or general anesthesia. Pls.' FOF ¶ 55. Moreover, Plaintiffs do not provide abortions in an "operating

room." Pls.' FOF ¶ 67 (stating Plaintiffs provide abortion care in outpatient abortion clinics). Thus, while some physicians may use N95 masks when providing care that does not involve surgery, Defendants have not shown that the standard of care requires N95 masks for all medical care, including abortion care.

41. Plaintiffs dispute Defendants' contention that "normal pregnancy care does not require as much PPE as normal abortion care," and that prenatal care can be delayed or provided by telemedicine. Defs. FOF ¶¶ 64, 75. These claims are contrary to the standard of care in Oklahoma and elsewhere.[3] As Dr. Stone attests, while some of pregnancy-related appointments can be consolidated or potentially moved to telemedicine during the COVID-19 pandemic, even in the current crisis, medical authorities recommend at minimum that pregnant women obtain in-person care from a physician at 11–13 weeks LMP and again at 18–22 weeks LMP for ultrasounds and blood work necessary to ensure the woman's health and screen for fetal abnormalities.[4] Pls.' FOF ¶ 104. Clinicians wear gloves and a mask at each of these appointments. Pls.' FOF ¶ 111. Even more in-person visits may be necessary if the patient has a pre-existing condition or a complication that makes the pregnancy high risk. Pls.' FOF ¶ 104. Moreover, women who continue their pregnancies are also far more likely than those who have abortions to require emergency room visits or hospital care.

[3] Defendants claim this point is debatable among OB/GYNs locally, Defs.' FOF ¶ 65, but provide no testimony from an OB/GYN that currently provides prenatal care in Oklahoma. Plaintiffs' expert, Dr. Stone, is such a person and disputes Defendants' claims. *See supra*.

[4] Defendants' expert does not dispute that some prenatal visits must be conducted in person. Valley Decl. ¶ 8; Supp. Decl. of Michael T. Valley ("Valley Suppl. Decl.") ¶ 4, ECF No. 96-2.

Pls.' FOF ¶ 64. Thus, the prenatal and other care that pregnant patients receive requires PPE comparable to, if not greater than, abortion services. Pls.' FOF ¶ 110.

II. PLAINTIFFS' RESPONSE TO DEFENDANT'S CONCLUSIONS OF LAW

A. Plaintiffs Meet Either Standard for a Preliminary Injunction

42. Defendants claim that Plaintiffs must satisfy a heightened standard by making a strong showing under both the likelihood of success on the merits and the balance of equities before an injunction can issue. Defs.' COL ¶¶ 5–6. Even assuming Defendants are correct, Plaintiffs have made a sufficiently strong showing under this standard. *See* Pls.' COL Secs. IV and VI.

43. Plaintiffs dispute Defendants' contention that "[c]ourts must be especially reluctant to exercise this equitable relief in time of crisis." Defendants' claim is wholly unsupported; indeed, the case they cite is not about "equitable relief in time of crisis." Defs.' COL ¶ 7. As discussed further below, and as this Court has already concluded, while the government does have authority to "safeguard the public health and the public safety" in an emergency, *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905), that power is not unfettered. TRO at 2, ECF No. 70.

44. Numerous district courts, including this Court, have appropriately provided equitable relief against executive orders issued during the COVID crisis. See Pls.' COL ¶ 53 (citing courts' granting a preliminary injunction in Alabama and TROs in Ohio and Texas against orders issued during the COVID-19 pandemic limiting access to abortion); *see also On Fire Christian Ctr., Inc. v. Fischer*, No. 3:20-CV-264-JRW, 2020 WL

1820249, at *8 (W.D. Ky. 2020) (granting TRO against COVID-19 order, holding "constitutional rights still exist" during the pandemic); Pls.' COL ¶ 4.

B. Plaintiffs Have Third Party Standing.

45. Relying on *Kowalski v. Tesmer,* 543 U.S. 125 (2004), Defendants reiterate their argument that Plaintiffs' lack third party standing to bring this action. Defs.' COL ¶¶ 8–12. As Plaintiffs explain in their proposed Conclusions of Law, Pls.' COL ¶ 1, this is contrary to decades of precedent. As this Court has already found, "[t]he Supreme Court has held that abortion providers have standing to raise constitutional challenges on behalf of their patients. TRO at 1 n.1 (quoting *Singleton v. Wulff*, 428 U.S. 106, 118 (1976) (plurality opinion)). This is particularly true where, as here, the challenged restriction operates directly on clinics and physicians. *See, e.g., Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 62 (1976); *Doe v. Bolton*, 410 U.S. 179, 188 (1973); *see also Singleton*, 428 U.S. at 108 (plurality opinion). The Tenth Circuit adheres to these precedents, which are binding on this Court. *See e.g., Planned Parenthood of Rocky Mountains Servs. v. Owens*, 287 F.3d 910 (10th Cir. 2002).[5]

[5] Moreover, *Kowalski* recognized that third-party standing is appropriate where "enforcement of [a] challenged restriction against the litigant would result indirectly in the violation of third parties' rights." *Id*. at 130. *Kowalski* also reaffirmed the Supreme Court's recognition of third-party standing where a litigant has "a close relationship" to the third party and some "hindrance" prevents the third party's ability to protect his or her own interests. *Id.* at 129–30. The Supreme Court has long held that the physician patient relationship satisfies the "close relationship" factor for purposes of third party standing to challenge abortion regulations. *Singleton*, 428 U.S. at 117. As the Supreme Court noted in *Singleton*, "the constitutionally protected abortion decision is one in which the physician is intimately involved," and it may be that "[a] woman cannot safely secure an abortion without the aid of a physician." *Singleton*, 428 U.S. at 117–18 (plurality op.). Other courts have repeatedly recognized that a "pregnant woman's ability to assert her own rights is

C. Defendants' Application of *Jacobson* and *Casey* is Fundamentally Flawed

1. *Jacobson* does not support Defendants' claim that the police power is absolute during a pandemic.

46. Plaintiffs do not dispute that states retain the power to enact "such reasonable regulations . . . as will protect the public health and the public safety." Defs.' COL ¶ 14; *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11, 25 (1905). However, Defendants fail to acknowledge that *Jacobson* recognizes that "[a] local enactment or regulation, even if based on the acknowledged police powers of a state, must always yield in case of conflict with the exercise by the general government of any power it possesses under the Constitution, or with any right which that instrument gives or secures." *Id*. *See* Pls.' COL ¶¶ 4–13; TRO at 2–3.

47. Plaintiffs dispute Defs.' COL ¶ 16, which argues that public health regulations may *carte blanche* restrict Fourteenth Amendment liberty. Under *Jacobson*, even when seeking to "protect the public health," a state violates the Constitution when its actions (1) "go beyond the necessity of the case," (2) result in "a plain, palpable invasion of rights secured by the fundamental law," or (3) have "no real or substantial relation to" the state's public health goals. 197 U.S. at 28, 31. *See* Pls.' COL ¶¶ 4–13; TRO at 2–3. The cases cited by Defendants all conducted this type of analysis.[6]

beset with obstacles," and "[s]he may be dissuaded from litigating because of her desire to protect her privacy; also, the imminence of mootness renders her claims less capable of assertion." *Planned Parenthood of Minn., Inc. v. Citizens for Cmty. Action*, 558 F.2d 861, 865 n.3.

[6] In *Phillips v. City of New York*, 775 F.3d 538, 543 (2d Cir. 2015) (per curiam), the Second Circuit recognized that under *Jacobson*, a court reviewing a challenge to a state's public health response must still determine whether the action violates the plaintiff's fundamental

48. Plaintiffs dispute that such regulations may cause permanent and total deprivation of individual liberty interests. Defs.' COL ¶ 17. This conclusion is contrary to *Jacobson*, which holds that a state's exercise of its police power may not impose a "plain, palpable invasion of rights." *Jacobson*, 197 U.S. at 31; *see also* TRO at 2, 9; Pls.' COL ¶¶ 4–13.

49. Plaintiffs dispute the relevance of Defendants' proposed conclusions that public health regulations may restrict interstate and foreign commerce, as well as interfere with the constitutional prohibition on uncompensated taking of property. Defs.' COL ¶ 18. This challenged action does not implicate the Commerce Clause or the Takings Clause. To the extent Defendants contend that constitutional limitations imposed by the Commerce Clause and the Takings Clause must always give way to public health regulations, the proposed conclusion is contrary to decisions by other courts, including the U.S. Supreme Court. *See, e.g.*, *Compagnie Francaise de Navigation a Vapeur* 186 U.S. at 397 (confirming that any restriction on interstate and foreign commerce enacted by a state exercising its police powers must not be repugnant to the Constitution); *Hannibal & J.R. St. Co. v. Husen*, 95 U.S. 465, 473–74 (1877) (striking down a Missouri law that limited

rights. In *Reynolds v. McNichols*, 488 F.2d 1378, 1382 (10th Cir. 1973), this Court did not suspend judicial review of an ordinance authorizing detention of persons suspected of carrying venereal disease, but considered whether the ordinance was "illogical or unreasonable." In *Compagnie Francaise de Navigation a Vapeur v. Bd. of Health of State of La.*, 186 U.S. 380 (1902), the Court evaluated whether a quarantine violated the fourteenth amendment. And in *Hickox v. Christie*, 205 F. Supp. 3d 579, 592 (D.N.J. 2016), although the district court found the quarantine order at issue did not violate clearly established constitutional norms, it noted that other courts have struck down quarantine orders that were found to be "arbitrary and unreasonable in relation to their goal of protecting the public health."

commerce in order to "protect domestic cattle against infectious disease" because the law "went beyond the necessity for its exercise"); *Lech v. Jackson*, 791 Fed. App'x 711 (10th Cir. Oct. 29, 2019) (assessing whether property damage incurred during a police action could give rise to a claim under the Takings Clause, and suggesting plaintiffs might have an actionable claim under a different clause of the constitution).

50. Plaintiffs dispute that certain public health restrictions on First Amendment Freedoms justify restrictions in this context. Defs.' COL ¶ 19. To the extent Defendants contend that constitutional rights guaranteed by the First Amendment must always give way to public health regulations, it is not supported by the authorities cited. *See Banzhaf v. F.C.C.*, 405 F.2d 1082, 1101 (D.C. Cir. 1968) (holding that the FCC ruling at issue "[did] not abridge the First Amendment freedoms of speech or press").

51. Plaintiffs dispute that the police power over public health increases during an emergency such that states may disregard individual rights and liberties. Defs.' COL ¶ 20. This proposed conclusion is a misreading of *Jacobson*. *See* TRO at 2–3; Pls.' COL ¶¶ 4–13. In *In re Abbott*, No. 20-50264, 2020 WL 1685929, at *19 (5th Cir. Apr. 7, 2020), the Fifth Circuit acknowledged "individual rights secured by the Constitution do not disappear during a public health crisis." *Id*. One week after issuing that decision, the Fifth Circuit permitted both medication abortions and abortions for women who would be past the legal limit in Texas to continue during the pendency of an appeal of a modified TRO entered by the District Court. *In re Abbott*, No. 20-50296, 2020 WL 1866010, at *2 (5th Cir. Apr. 13, 2020).

52. Defendants provide an inaccurate account of the holding of *Phillips v. City of New York*, 775 F.3d 538, 543 (2d Cir. 2015) (per curiam). Defs.' COL ¶ 23. In *Phillips*, the Second Circuit recognized that even under *Jacobson*, a court must still determine whether a state's action to protect the public health violates fundamental rights. Indeed, the United States Court of Appeals for the Fifth Circuit has held that in determining whether to enjoin enforcement of a COVID-19 executive order against abortion providers, the court should "weigh [the executive order's] benefits and burdens in any particular circumstance." *In re Abbott*, 2020 WL 1685929, at *12.

53. Plaintiffs dispute Defendants' assertion that Plaintiffs bear the burden of proving that "the means prescribed by the state . . . has no real or substantial relation to the protection of the public health and the public safety." Defs.' COL ¶ 24. This is an inaccurate statement of the evidentiary showing required by *Jacobson*. Once it has been shown that a state action places a burden on a fundamental right, it is the State that must demonstrate the benefits to public health outweigh that burden. *See Robinson v. Marshall*, No. 2:19-cv-00365, 2020 WL 1847128 (M.D. Ala. Apr. 12, 2020); *Preterm-Cleveland v. Att'y Gen. of Ohio*, No. 1:19-cv-360, slip op. at 7 (S.D. Ohio Mar. 30, 2020), ECF No. 43 ("Defendants have not demonstrated to the Court . . . that Plaintiffs' performance of these surgical procedures will result in any beneficial amount of net saving of PPE in Ohio such that the net saving of PPE outweighs the harm of eliminating abortion."); *On Fire Christian Ctr., Inc v. Fischer*, No. 3:20-cv-00264-JRW (W.D. Ky. Apr. 11, 2020), ECF No. 6 (finding that Louisville must prove its interest compelling and its regulation of fundamental rights narrowly tailored).

54. Plaintiffs dispute that public health officials' determinations are entitled to deference, absent a "reliable showing of error." Defs.' COL ¶ 26. First, unlike in *Jacobson*, 197 U.S. at 12, where the regulation at issue was enacted by the "board of health of Cambridge," Defendants have presented no evidence that the decision to issue the Press Release expanding the Executive Order to all abortion services was made by "public health officials." The order was issued by the Governor, and Secretary of Health Jerome Loughridge does not claim to have had any role in it. *See* Pls.' FOF ¶ 13. Nor is Defendants' proposed conclusion supported by *Hickox v. Christie*, 205 F. Supp. 2d 579, 592–94 (2016), where the court *did* make its own assessment of whether an 80-hour detention to quarantine a nurse who had been exposed to the Ebola virus was reasonable.

55. Defendants contend that the standard of review of a state action during an emergency is whether that action is unreasonable or arbitrary, Defs.' COL ¶ 22, and that the Court must be deferential, deciding only whether the emergency lacks a "real or substantial relation" to the public health crisis" or whether it is "'beyond all question, a plain, palpable invasion' of the right to abortion." Defs.' COL ¶ ¶ 40, 63. Plaintiffs dispute this incomplete statement of *Jacobson*'s standard, which also requires the court to consider whether an exercise of the police power "go[es] beyond the necessity of the case," "has no real or substantial relation to" its stated goals, and "is, beyond all question, a plain, palpable invasion of rights secured by the fundamental law." If so, "it is the *duty* of the courts to so adjudge, and there, and thereby give effect to the Constitution." *Jacobson*, 197 U.S. at 28, 31 (emphasis added). *See* TRO at 2–3; Pls.' COL ¶¶ 4–13. Defendants also ignore binding precedent holding that: "'To justify the state in . . . interposing its authority in behalf of the

public, it must appear—First, that the interests of the public . . .' require such interference; and, second, that the means are reasonably necessary for the accomplishment of the purpose, and not unduly oppressive upon individuals." *Anaya v. Crossroads Managed Care Sys.*, 195 F.3d 584, 591 (10th Cir. 1999) (quoting *Goldblatt v. Town of Hempstead*, 369 U.S. 590, 594–95 (1962)); *see also* Pls.' COL ¶ 12. Plaintiffs also dispute these conclusions because they entirely disregard the analysis that *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), requires. *See* Pls.' COL ¶¶ 4–13; TRO at 2–3. Defendants' conclusions also assume Defendants considered the impact of abortion services and its alternatives (prolonged pregnancy or out-of-state travel to access abortion services) on the goals pursued in the Executive Order. There is no such evidence in the record.

a. Abortion rights jurisprudence does not cease to exist during a pandemic.

56. Plaintiffs agree with Defendants that the right to abortion is at stake in this case. *See, e.g.*, Defs.' COL ¶¶ 27, 40. And while *Casey* affords states the ability to regulate abortion, Defs.' COL ¶ 27, Defendants rightly concede that "[p]ublic health regulations are . . . impermissible if the burden imposed outweighs the benefits to such an extent that it becomes "undue." Defs.' COL ¶ 31 (citing *Casey*, 505 U.S. at 874; *Whole Woman's Health*, 136 S. Ct. at 2309, 2313 (acknowledging *Whole Woman's Health* reaffirmed the *Casey* standard).

57. However, Plaintiffs dispute Defendants' assertion that "[v]iability is only relevant in abortion regulations when the state's sole justification is its interest in protecting fetal life," citing *Casey*, 505 U.S. at 860. Defs.' COL ¶ 30. In *Casey*, the state professed an

interest in both fetal life *and* individual health, and the Court concluded that neither was strong enough to justify a pre-viability prohibition on abortion, consistent with *Roe v. Wade*'s bright line. *Casey*, 505 U.S. at 878. Since *Roe*, the Supreme Court has repeatedly held that no state interest is sufficient to ban previability abortion access. *Id.*; *see also Whole Woman's Health* 136 S. Ct. at 2320 (viability is "the relevant point at which a State may begin limiting women's access to abortion for reasons unrelated to maternal health"); *Gonzalez v. Carhart*, 550 U.S. 124, 146 (2007). Pls.' COL ¶ 7. Under this clear, binding precedent, federal courts have uniformly struck down previability bans on abortion as incompatible with *Roe*. *See* Pls.' COL ¶ 8.

58. Plaintiffs further dispute Defendants' contention that "because addressing a public health emergency is a compelling interest, it allows state regulations on abortion to survive the undue burden analysis." Defs.' COL ¶ 38.[7] First, the Supreme Court has repeatedly held that no state interest is sufficient to ban previability abortion access. *See* Pls.' COL ¶¶ 7–8. Second, as Defendants acknowledge, Defs.' COL ¶ 31, in applying the undue burden test, courts must "consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Id*. Further, courts have an "independent

[7] In support of this proposition, Defendants mischaracterize First Amendment cases. Neither *Banzhaf* nor *Benson v. Walker*, 274 F. 622, 623 (4th Cir. 1921) applied "strict scrutiny" to an allegedly infringing state action. In *Banzhaf*, the court considered the constitutionality of an FCC ruling requiring broadcasters who aired cigarette ads to air public service announcements about the risks of cigarette smoking. The D.C. Circuit held that the FCC ruling did not ban speech, and that any speech that could conceivably be chilled by the ruling "barely qualifies as constitutionally protected 'speech.'" *Banzhaf*, 405 F.2d at 1101. By contrast, the rights at issue here are fundamental and clearly enjoy constitutional protection. TRO at 2–3; Pls.' COL ¶¶ 7–9.

constitutional duty" to determine the "existence or nonexistence of benefits" based upon the evidence. *Id*. at 2309–10. Pls.' COL ¶ 9.

59. Thus, it does not follow, as Defendants assert, that "in a public emergency, courts must defer to the reasonable choice of elected representatives." Defs.' COL ¶ 39. This proposed conclusion is an inaccurate statement of the standard of judicial review. Indeed, not even the decision in *In re Abbott*, on which Defendants heavily rely, supports stripping courts of their duty to properly determine the constitutionality of executive action in a public health emergency. *See In re Abbott*, 2020 WL 1685929, at *7 (concluding that abortion providers are entitled to relief upon proving that executive order's burdens outweigh its benefits).[8]

[8] Moreover, this proposed conclusion is not supported by any of the cited cases. Many do not address any form of public health emergency. *See Union Dry Goods v. Georgia Pub. Serv. Corp.*, 248 U.S. 372, 374–75 (1919) (challenging Railroad Commission's decision to charge higher utility rates); *Beer Co. v. Massachusetts*, 97 U.S. 25 (1877) (addressing grant of charter permitting plaintiff to sell liquor despite the existence of a prohibitory liquor law in the state); *Miller v. Schoene*, 276 U.S. 272, 279 (1928) (holding that the state had the authority to favor property rights of owners of apple orchards over the rights of nearby owners of red cedar trees infected with cedar rust). The remaining do not hold that a court "must defer" to the decisions of elected state representatives who impose quarantine regimes. *See, e.g. Louisiana v. Texas*, 176 U.S. 1, 13 (1900) (refusing to recognize original jurisdiction in a dispute between Louisiana and Texas over quarantine restrictions); *Hickox v. Christie*, 205 F. Supp. 3d 579, 592 (D.N.J. 2016) (recognizing that "[c]ourts have sometimes struck down quarantine orders, however, when they were found to be arbitrary and unreasonable in relation to their goal of protecting the public health."); *United States v. Shinnick*, 219 F. Supp. 789, 790 (E.D.N.Y. 1963) (deferring to decision of public health officer to quarantine an individual after exposure to smallpox); *Morgan Steamship Co. v. La. Board of Health*, 118 U.S. 455, 464 (1886) (noting that the authority of states to legislate quarantine restrictions may be abrogated should Congress "undertake to provide for the commercial cities of the United States a general system of quarantine"). *United States v. Caltex*, 344 U.S. 149 (1952), which involved rights to compensation during wartime takings by the United States, is even further afield.

D. Plaintiffs Are Likely to Succeed on the Merits

60. Defendants make crucial errors in their argument that Plaintiffs are unlikely to succeed on the merits.

61. Plaintiffs dispute Defendants' principal argument that "the benefit of emergency action is a compelling interest justifying a temporary delay of access to abortion services." Defs.' COL ¶ 49; *see also* Defs.' COL ¶ 51 ("A delay in abortion services is justified because of the state's compelling interest in protecting public health by preventing viral spread, limiting use of PPE, and preserving hospital resources."). Nor do Plaintiffs' agree that "[i]t is "obvious" that this "is a valid emergency response to the COVID-19 pandemic" (citing *In re Abbott*, 2020 WL 1685929, at *8). Defs.' COL ¶ 54.

62. Plaintiffs dispute that the Executive Order simply imposes "delays," but that aside, Defendants' argument is premised on their incorrect view that states have unlimited discretion to invoke their police power during a public health emergency. According to Defendants, the Court must "not venture to determine whether its benefits outweigh its burdens in every particular respect in the midst of an emergency," because it would 'practically strip' the State of its ability to protect its citizens during a crisis. Defs.' COL ¶ 55 (citing *Jacobson*, 197 U.S. at 37. As Plaintiffs explain above, *see supra* Part (II)(C)(1), Defendants' reading of *Jacobson* is patently wrong. See TRO at 2–3; Pls.' COL ¶¶ 4–13. And, as Judge Lucero observed in his concurrence to the Tenth Circuit's dismissal of Defendants' appeal of the TRO, the State's "hypothetical scenarios are just that—hypothetical. *S. Wind Women's Center LLC v. Stitt*, No. 20-6045, 2020 WL 1860683, at *3 (10th Cir. Apr. 13, 2020) (Lucero, J., concurring).

63. Plaintiffs further dispute "that it cannot be said that the challenged Executive Order 'lacks a 'real and substantial relation' to the public health crisis.'" Defs.' COL ¶ 54 (quoting *In re Abbott*, 2020 WL 1685929, at *8 (quoting *Jacobson*, 197 U.S. at 31)). Contrary to Defendants' blanket assertion that the Executive Order meets this standard, Plaintiffs have demonstrated that the record is clear that banning and delaying abortion services would not prevent viral spread, would not decrease the use of PPE and would not preserve hospital resources. *See* Pls.' FOF ¶¶ 72–76, 79, 82, 86–87, 90, 92–93, 101–04, 109–12. Thus, the disconnect between the means employed by the State and the benefits achieved renders the Executive Order invalid under *Jacobson*, as it has "no real or substantial relation to the protection of the public health and the public safety." 197 U.S. at 31.

64. *In re Abbott* does not help Defendants. Defs.' COL ¶ 55. Contrary to Defendants' view that this Court must rubber-stamp the Exective Order, the Fifth Circuit has directed the district court in that case to weigh the burdens and benefits of Texas's COVID-19 abortion ban. *In re Abbott*, 2020 WL 1685929, at *12. Also, the Fifth Circuit has more recently permitted the district court's TRO to remain in place with respect to both medication abortions and abortions for women who would be past the legal limit in Texas. *In re Abbott*, 2020 WL 1866010, at *2.

65. Defendants further contend that a delay that applies equally to all elective procedures is by definition not pretextually targeting any particular elective procedure. Defs.' COL ¶ 53. Plaintiffs dispute this proposed conclusion as irrelevant and contradicted by the record because the Press Release does single out abortion services for differential

treatment. As this Court has already found, other medical providers have discretion to determine whether a medical service is an "elective surgery" or "minor medical procedure." TRO at 4; Pls.' FOF ¶ 6. No other medication is subjected to the Executive Order. Pls.' FOF ¶ 8. Plaintiffs further object that this proposed conclusion finds no support in *Lawton v. Steele*, 152 U.S. 133 (1894) which does not hold, as Defendants seem to suggest, that if a state action impacts all citizens equally, such action is necessarily justified.

66. Plaintiffs further dispute Defendants' conclusion that the Executive Order is valid after weighing the burdens associated with forcing patients to delay their abortions against the benefits to the State's asserted interests. Defs.' COL ¶ 57. Indeed, Defendants hardly engage in this analysis; in any event, the record in this case does not support Defendants' conclusion.

67. Defendants' contention that a delay of surgical abortion is justified because of the extensive interpersonal contact,[9] use of PPE, and risk of complications requiring hospitalization attendant to surgical abortions, Defs.' COL ¶ 57, is not supported by the evidence in this case. *See* Pls.' COL ¶¶ 33–47. Plaintiffs have followed all CDC guidelines

[9] Plaintiffs note that Defendants did not raise limiting interpersonal contact as a justification for the Executive Order in the press release, and state officials have consistently cited only an interest in conservation of PPE and hospital resources. The State may not advance novel justifications for its actions partway through litigation. See *United States v. Virginia*, 518 U.S. 515, 533 (1996) ("The justification must be genuine, not hypothesized or invented post hoc in response to litigation."); *N. Carolina State Conference of NAACP v. McCrory*, 831 F.3d 204, 237 (4th Cir. 2016) (rejecting state's changed rationale for a voting law after it "recogniz[ed] the weakness of that justification, during the litigation of this case."); *cf. Kisor v. Wilkie*, 139 S. Ct. 2400, 2417 (2019) (recognizing no judicial deference is owed to an agency's "'convenient litigating position' or 'post hoc rationalization advanced' to 'defend past agency action against attack.'" (citations omitted)).

to screen patients and staff for exposure to COVID-19 and have undertaken strict measures to minimize interpersonal contact during procedural abortions. Pls.' FOF ¶¶ 97–99. Delay of procedural abortions ultimately *increases* patients' interpersonal contact with health care providers, as they either remain pregnant and require additional treatment, or must return to clinics for further visits. Pls.' FOF ¶¶ 73, 75, 101–104; Pls.' COL ¶ 41 And Plaintiffs' use of PPE as they care for their patients is minimal, especially compared to other medical care for conditions such as pregnancy. Pls.' FOF ¶¶ 108–112.

68. Notably, Oklahoma has repeatedly stated that it has significant stockpiles of PPE that are sufficient to meet all of its needs, with more on the way. Pls.' FOF ¶¶ 105–106. Indeed, on April 15, 2020, the Governor publicly announced that the State would begin lifting the prohibition on elective surgeries on April 24, one week ahead of schedule, because the State has sufficient hospital beds and PPE to care for COVID-19 patients: "Elective surgeries will be able to resume starting on April 24th. We suspended them to protect hospital beds in case of a surge & to protect PPE for our health care workers treating #COVID19 patients. **Based on our data, we now feel confident about our hospital numbers and PPE**." Governor J. Kevin Stitt (@GovStitt), Twitter (Apr. 15, 11:33 PM), https://bit ly/3cBcUhR (emphasis added).[10]

69. Nor is Defendants' claim that abortion has a high risk of complications requiring hospitalization accurate. Pls.' FOF ¶¶ 57–61, 114; Pls.' COL ¶ 43. Indeed, the

[10] As the district court in *Robinson* observed, "[w]ith respect to any PPE that is conserved, the defendants have not put forward evidence regarding how it might be used or re-directed to hospitals that are experiencing shortages." *Robinson*, 2020 WL 1847128, at *11 n.16.

Supreme Court has recognized the low risk of complications associated with abortion procedures. Pls.' FOF ¶ 50.

70. The evidence in the record also refutes Defendants' contention that "a delay of medication abortion is justified because of the risk of complications requiring hospitalizations." Defs.' COL ¶ 58. Medication abortions are safe and complications are extremely rare. Pls.' FOF ¶¶ 56, 58, 61; *see also supra* Part (I)(B)(3). Nor do medication abortions require excessive use of PPE (in fact, hardly any is used) such that it could possibly impact Oklahoma's PPE reserves. Pls.' FOF ¶¶ 108–112. But denying patients access to medication abortions, which can be performed earlier in the pregnancy and may be the more appropriate option for some patients, would cause substantial harm. Pls.' FOF ¶¶ 80–83. Providers of medication abortions do not use PPE "sparingly"—they use it appropriately for a treatment that has limited risks of viral transmission. Pls.' FOF ¶¶ 98–99, 108.

71. Plaintiffs object further to Defendants' conclusion that women seeking medication abortions will likely remain eligible for legal abortion after the expiration of the Executive Order. Defs.' COL ¶ 59. Courts across the country have recognized the burdens that stem from making medication abortion unavailable. *See* Pls.' COL ¶ 27.

72. Defendants' bold contention that the Executive Order "validly includes those abortions that would be unavailable after the expiration of the challenged Executive Order" must be rejected. Defs.' COL ¶ 60; *see also* Defs.' COL ¶ 73. As this Court has already acknowledged in its TRO, it is a plain violation of Plaintiffs' patients' rights and ignores the plain holding of *Jacobson*. *See* TRO at 9–10; Pls.' COL ¶¶ 15–22.

73. Plaintiffs also dispute Defendants' contention that a delay of all elective abortion services is justified in the case of the Plaintiff who requires physicians to make interstate travel to perform services. Defs.' COL ¶ 61. This post-hoc argument is unlawful discrimination against physicians who provide abortion services. Paragraph 6 of the Executive Order relaxes the licensing requirements of Oklahoma law so that health care providers from other states may travel to and practice in Oklahoma. Imposing a travel restriction on Plaintiffs' health care professionals that does not apply to any other health care provider is not justified and a state's "police power cannot be exercised with an 'unequal hand.'" *Jew Ho v. Williamson*, 103 F. 10, 23 (C.C.N.D. Cal. 1900) (holding that quarantine of Chinese residents "cannot be continued" because it was both "oppressive" and "discriminatory"); *see* Pls.' COL ¶ 6.

74. Nor can Defendants justify banning abortion services by arguing "Plaintiffs themselves are turning away *symptomatic* abortion seekers, including for medication abortion, requiring them to postpone their abortion." Defs.' COL ¶ 62 (emphasis added). This proposed conclusion is illogical. A provider's postponement of services until a patient no longer exhibits the symptoms of COVID-19 is not equivalent to a categorical four- or five-week ban on abortions in the State. By this reasoning, Oklahoma should close all consumer offices and businesses to eliminate the risk of transmission by asymptomatic customers and employees. But Oklahoma has not imposed such stringent social distancing measures. Pls.' FOF ¶ 100. In fact, the businesses that are permitted to operate under the Executive Order include dry cleaners, sporting goods stores, pet grooming facilities, liquor stores, and marijuana dispensaries. Pls.' FOF ¶ 9.

1. The Large Fraction Test Doesn't Apply and Plaintiffs Nonetheless Meet it

75. Finally, Defendants incorrectly assert that Plaintiffs are required to, and have failed to, demonstrate that a large fraction of relevant "cases" will be unable to legally obtain an abortion after the expiration of the Executive Order. Defs.' COL ¶¶ 41, 43, 65.

76. The large fraction test (like the undue burden standard itself) is wholly inapplicable to previability bans. Furthermore, it would clearly be met here even if applicable. The Supreme Court has held that previability abortion bans are facially unconstitutional whether they apply to one woman or many. *See, e.g., Casey,* 505 U.S. at 879 ("Regardless of whether exceptions are made for particular circumstances, a State may not prohibit *any woman* from making the ultimate decision to terminate her pregnancy before viability." (emphasis added)); *see Jane L. v. Bangerter,* 809 F. Supp. 865, 870 (D. Utah 1992) (facially enjoining a previability ban without applying the large fraction test), *aff'd in relevant part,* 61 F.3d 1493 (10th Cir. 1995), *cert. granted, judgment rev'd sub nom. on unrelated grounds Leavitt v. Jane L.*, 116 S. Ct. 2068 (1996*).*

77. Futhermore, contrary to Defendants' assertion that Plaintiffs must show that a large fraction of "cases" will be "legally unable to obtain an abortion after the expiration of the Executive Order," Defs.' COL ¶ 65, a law that imposes an undue burden on a large fraction of women seeking abortion for whom it is relevant is facially unconstitutional, even if it does not outright prevent them from obtaining an abortion. *See Gonzales v. Carhart*, 127 S. Ct. 1610, 1639, 167 L. Ed. 2d 480 (2007) (interpreting *Casey* as "indicating a spousal-notification statute would impose an undue burden 'in a large fraction of the cases in which [it] is relevant' and holding the statutory provision facially invalid.");

Planned Parenthood Ariz., Inc 753 F.3d at 914 (applying the large fraction test to a restriction on medication abortion that increased costs and imposed delay on patients). A restriction imposes an undue burden if it fails to confer benefits that justify its burdens on abortion access. *Whole Woman's Health*136 S. Ct. at 2310.

78. Additionally, the Supreme Court has made clear that the relevant group of women for purposes of the test is the group for whom the law imposes "an actual rather than an irrelevant restriction." *Casey*, 505 U.S. at 895 (opinion of the Court); *see also Whole Woman's Health*, 136 S. Ct. at 2313, 2320 (rejecting the argument that the large fraction test applies to "'all women,' 'pregnant women' or even 'the class of *women seeking abortions* identified by the State'" (quoting *Casey*, 505 U.S. at 894–95)); *see also Casey*, 505 U.S. at 894 (opinion of the Court) ("The proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant.").

79. Thus, even if the large-fraction analysis applied in this context, the Executive Order and Press Release impose an undue burden or an outright ban for 100% of women for whom it is relevant—women seeking medication and pre-viability procedural abortions who: are delayed, obtain abortions at the expense of increased travel and cost, cannot obtain the type of abortion that is best for them, or cannot obtain an abortion at all because of the Executive Order. Plaintiffs have established that no state interest justifies the burdens for any of these women. That "one hundred percent correlation" well exceeds any conceivable threshold for facial relief. *See, e.g., Isaacson v. Horne*, 716 F.3d 1213, 1230 (9th Cir. 2013) (concluding in the case of a 20-week gestational age ban that, even if the large-fraction

analysis applied, "there is a one hundred percent correlation between those whom the [challenged] statute affects and its constitutional invalidity as applied to them," which "is sufficient to require declaring the statute entirely invalid"); *Planned Parenthood Ariz., Inc.*, 753 F.3d at 914, 917 (facially enjoining a law that applied to women who would have received medication abortion under an evidence-based regime in its absence (the "relevant" group), even if "some women who are denied a medication abortion under the evidence-based regimen will nonetheless obtain an abortion.").

80. The Executive Order imposes an undue burden or a ban in *every* relevant application, and are therefore facially unconstitutional.

E. Equitable Factors

81. Plaintiffs dispute Defendants' claim that the Executive Order and March 27 Press Release impose no irreparable harm. Defs.' COL ¶ 67. Citing *Casey*, Defendants argue that Plaintiffs will not suffer irreparable harm because precedent allows abortion to be delayed. *Id.* But *Casey* dealt with a 24-hour waiting period—not a minimum five week delay that Defendants seek to impose on all Oklahomans under the Executive Order. Nor can Defendants credibly argue that the Executive Order only imposes delays, when the undisputed evidence makes clear that the Executive Order has already caused at least ten patients to be turned away who would have been pushed beyond the legal limit for abortions in Oklahoma (i.e., 22 weeks LMP) under the Executive Order. Pls.' FOF ¶ 70. Plaintiffs have readily established irreparable harm. See Pls.' COL ¶¶ 48–53.

82. Plaintiffs further dispute Defendants' balancing of the hardships and public interest factors of the preliminary injunction standard. Defendants' claim to irreparable

harm is "the undermining of their ability to manage a public health crisis." Defs.' COL ¶ 68. That Defendants feel "undermined" cannot seriously outweigh the clear constitutional harms the Executive Order imposes on Plaintiffs' patients. Courts have not hesitated to enter injunctions against unconstitutional state action, even if the effect is to "undermine[]" state officials. See Pls.' COL ¶¶ 7, 8, 53. Every court that has reviewed a COVID-19 executive order that prohibits abortions has enjoined application of the order to require a patient to delay her abortion to the point that she would be unable to obtain one. Pls.' COL ¶ 19.

83. While Plaintiffs do not dispute that the public has an interest in "avoiding the risk of exposure to SARS-CoV-2 to hundreds or thousands of Oklahomans," Defs.' COL ¶ 69, the evidence does not come close to demonstrating that banning or delaying abortion is necessary to prevent such risk. On the contrary, Plaintiffs have established the measures they have instituted to prevent the spread of COVID-19 are in keeping with guidance from the CDC and other leading medical organizations, with other outpatient medical practices in Oklahoma, and even with the opinions of many of Defendants' experts. Pls.' FOF ¶ 99.

84. Defendants' claims about the "risk[s] created by the rejection of social distancing for elective abortions," Defs.' COL ¶ 71, are belied by the numerous businesses and services (e.g., dry cleaners, sporting goods stores, pet grooming) that have been exempted from the Executive Order. Pls.' FOF ¶ 9. Moreover, all other health care providers are allowed to continue to provide care to their patients, using their discretion and best medical judgment to decide whether that care is a prohibited "elective surgery" or

"minor medical procedure." TRO at 4; *see also* Decl. of Dana Stone, M.D. ¶¶ 36–41, ECF No. 84-4 (noting that she has the discretion to decide which OB/GYN procedures to delay).

85. Plaintiffs also dispute that the public has an interest in avoiding "using more PPE and hospital resources for elective abortions and attendant complications." Defs.' COL ¶ 69. The record refutes this conclusion. Rather, it demonstrates that the Executive Order will ultimately force patients to obtain more health care, undertake risky out-of-state travel (rather than stay at home), and/or take desperate, unsafe measures to end their pregnancy—all of which increases the chances that patients will end up taxing an already overburdened health care system. *See* Pls.' FOF Sec. IV. Moreover, as discussed further above, *see supra* Parts (I)(B)(2) and (I)(B)(3), the credible evidence in the record demonstrates that both medication and procedural abortion carry a low risk of complications and a very low risk that hospitalization would be necessary to treat a complication. Pls.' FOF ¶ 114. At bottom, Defendants believe that their right to address a public health emergency is unfettered, but there is no public interest "in enforcing a law that is likely constitutionally infirm." *U.S. Chamber of Commerce v. Edmondson*, 594 F.3d 742, 771 (10th Cir. 2010).

CONCLUSION

86. The AMA noted about the pandemic its regret that "elected officials in some states are exploiting this moment to ban or dramatically limit women's reproductive healthcare."[11] This leading organization of American physicians—the very people on the

[11] Patrice A. Harris, President, AMA, AMA Statement on Government Interference in Reproductive Healthcare (Mar. 30, 2020), https://bit.ly/2X4OAjT.

front line of fighting the virus—voiced its opposition to "government intrusion in medical care" at this critical moment in our nation's history, emphasizing that physicians and patients "should be the ones deciding" which medical services "need to be performed, and which ones can wait." *Id.*

87. Abortion is an essential component of comprehensive healthcare and is time-sensitive care. Without injunctive relief, Plaintiffs will be forced to continue turning away patients, resulting in immediate and irreparable harm for which no adequate remedy at law exists. Patients delayed in accessing abortion will suffer increased risks to their health, wellbeing, and economic security. Patients who are unable to access abortion at all will be forced to carry pregnancies to term, imposing far greater strains on an already-taxed healthcare system. Countless Oklahomans' fundamental constitutional right to abortion

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Respectfully Submitted,

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